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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

Foreword	III
Contents	V
Steering Committee	XII
Acronyms and abbreviations	XIV
Glossary	XXII
Terms of Reference	XXV
PART A INTRODUCTION	
1 The approach to performance measurement	1.1
1.1 Aims of the Review	1.1
1.2 The role of government in delivering services	1.2
1.3 Reasons for measuring comparative performance	1.3
1.4 Scope	1.5
1.5 Approach	1.8
1.6 Using the data in this Report	1.18
1.7 Related performance measurement exercises	1.20
1.8 References	1.22

2	Recent developments in the Report	2.1
2.1	Developments in reporting	2.1
2.2	Gaps in reporting	2.4
2.3	Progress with key data issues	2.5
2.4	‘Cross-cutting’ issues	2.22
2.5	Related Review projects	2.25
2.6	References	2.27

PART B EDUCATION

B	Education preface	B.1
3	School education	3.1
3.1	Profile of school education	3.2
3.2	Framework of performance indicators	3.13
3.3	Key performance indicator results	3.17
3.4	Future directions in performance reporting	3.68
3.5	Jurisdictions’ comments	3.69
3.6	Definitions of key terms and indicators	3.79
3.7	Supporting tables	3.82
3.8	References	3.88
4	Vocational education and training	4.1
4.1	Profile of vocational education and training	4.2
4.2	Framework of performance indicators	4.9
4.3	Key performance indicator results	4.10
4.4	Future directions in performance reporting	4.63
4.5	Jurisdictions’ comments	4.63
4.6	Definitions of key terms and indicators	4.73
4.7	Supporting tables	4.77
4.8	References	4.80

PART C JUSTICE

C	Justice preface	C.1
----------	------------------------	------------

5	Police services	5.1
5.1	Profile of police services	5.2
5.2	Framework of performance indicators	5.5
5.3	Indicators relevant to all police services	5.7
5.4	Community safety	5.18
5.5	Crime	5.26
5.6	Road safety	5.44
5.7	Judicial services	5.52
5.8	Capital costs in the costing of police services	5.61
5.9	Future directions in performance reporting	5.61
5.10	Jurisdictions' comments	5.62
5.11	Information on sample data	5.71
5.12	Definitions of key terms and indicators	5.73
5.13	Supporting tables	5.78
5.14	References	5.81
6	Court administration	6.1
6.1	Profile of court administration services	6.1
6.2	Framework of performance indicators	6.20
6.3	Key performance indicator results	6.21
6.4	Future directions in performance reporting	6.47
6.5	Jurisdictions' comments	6.47
6.6	Definitions of key terms and indicators	6.56
6.7	Supporting tables	6.59
6.8	References	6.60
7	Corrective services	7.1
7.1	Profile of corrective services	7.2
7.2	Framework of performance indicators	7.9
7.3	Key performance indicator results	7.11
7.4	Future directions in performance reporting	7.29
7.5	Jurisdictions' comments	7.30
7.6	Definitions of key terms and indicators	7.39
7.7	Supporting tables	7.45
7.8	References	7.48

PART D EMERGENCY MANAGEMENT

8	Emergency management	8.1
8.1	Overview of emergency management	8.1
8.2	Framework for measuring the performance of emergency management	8.9
8.3	Fire events	8.12
8.4	Ambulance events	8.36
8.5	Road rescue events	8.51
8.6	Future directions in performance reporting	8.54
8.7	Jurisdictions' comments	8.55
8.8	Definitions of key terms and indicators	8.65
8.9	Supporting tables	8.68
8.10	References	8.70

Volume 2

Contents	III
Acronyms and abbreviations	X
Glossary	XVIII

PART E HEALTH

E	Health preface	E.1
9	Public hospitals	9.1
9.1	Profile of public hospitals	9.1
9.2	Framework of performance indicators for public hospitals	9.18
9.3	Key performance indicator results for public hospitals	9.19
9.4	Profile of maternity services	9.63
9.5	Framework of performance indicators for maternity services	9.64
9.6	Key performance indicator results for maternity services	9.65
9.7	Future directions in performance reporting	9.82
9.8	Definitions of key terms and indicators	9.83
9.9	Supporting tables	9.88
9.10	References	9.92

10	Primary and community health	10.1
10.1	Profile of primary and community health	10.2
10.2	Framework of performance indicators	10.12
10.3	Key performance indicator results	10.13
10.4	Future directions in performance reporting	10.59
10.5	Definitions of key terms and indicators	10.62
10.6	Supporting tables	10.65
10.7	References	10.68
11	Health management issues	11.1
11.1	Overview of health management	11.1
11.2	Framework for measuring the performance of health management	11.2
11.3	Breast cancer	11.4
11.4	Mental health	11.33
11.5	Future directions in performance reporting	11.69
11.6	Jurisdictions' comments	11.70
11.7	Definitions of key terms and indicators	11.80
11.8	Supporting tables	11.87
11.9	References	11.90
 PART F COMMUNITY SERVICES		
F	Community services preface	F.1
12	Aged care services	12.1
12.1	Profile of aged care services	12.3
12.2	Framework of performance indicators	12.23
12.3	Key performance indicator results	12.23
12.4	Future directions in performance reporting	12.54
12.5	Jurisdictions' comments	12.54
12.6	Definitions of key terms and indicators	12.64
12.7	Supporting tables	12.67
12.8	References	12.70

13	Services for people with a disability	13.1
13.1	Profile of specialist disability services	13.2
13.2	Framework of performance indicators	13.11
13.3	Key performance indicator results	13.13
13.4	Future directions in performance reporting	13.71
13.5	Jurisdictions' comments	13.71
13.6	Definitions of key terms and indicators	13.81
13.7	Supporting tables	13.88
13.8	References	13.90
14	Children's services	14.1
14.1	Profile of children's services	14.2
14.2	Framework of performance indicators	14.8
14.3	Key performance indicator results	14.11
14.4	Future directions in performance reporting	14.53
14.5	Jurisdictions' comments	14.54
14.6	Definitions of key terms and indicators	14.64
14.7	Supporting tables	14.68
14.8	References	14.74
15	Protection and support services	15.1
15.1	Profile of child protection and out-of-home care services	15.2
15.2	Framework of performance indicators for child protection and out-of-home care services	15.12
15.3	Key child protection and out-of-home care services performance indicator results	15.12
15.4	Future directions in child protection and out-of-home care services performance reporting	15.42
15.5	Profile of supported accommodation and assistance services	15.43
15.6	Framework of performance indicators for supported accommodation and assistance services	15.47
15.7	Key supported accommodation and assistance performance indicator results	15.49
15.8	Future directions in supported accommodation and assistance performance reporting	15.74
15.9	Jurisdictions' comments	15.76

15.10	Definitions of key terms and indicators	15.86
15.11	Supporting tables	15.94
15.12	References	15.105
PART G HOUSING		
16	Housing	16.1
16.1	Profile of housing and housing assistance	16.3
16.2	Framework of performance indicators	16.22
16.3	Key performance indicator results	16.26
16.4	Future directions in performance reporting	16.72
16.5	Jurisdictions' comments	16.73
16.6	Definitions of key terms and indicators	16.83
16.7	Supporting tables	16.89
16.8	References	16.93
A	Statistical appendix	A.1

Acronyms and abbreviations

AAT	Administrative Appeals Tribunal
ABS	Australian Bureau of Statistics
ABSCQ	Australian Bureau of Statistics Classification of Qualifications
ACAP	Aged Care Assessment Program
ACAT	Aged care assessment team
ACCHS	Aboriginal Community Controlled Health Service
ACCMIS	Aged and Community Care Management Information System
ACE	adult community education
ACH	annual curriculum hour
ACHS	Australian Council on Healthcare Standards
ACIR	Australian Childhood Immunisation Register
ACPR	Australasian Centre for Policing Research
ACSAA	Aged Care Standards and Accreditation Agency
ACSQHC	Australian Commission on Safety and Quality in Health Care
ACT	Australian Capital Territory
ADR	Alternative Dispute Resolution
AFAC	Australasian Fire Authorities Council
AFP	Australian Federal Police
AG	Activity Group
AGCCCS	Australian Government Census of Child Care Services
AGPAL	Australian General Practice Accreditation Limited
AGR	annual growth rate
AHCA	Australian Health Care Agreement
AHIF	Affordable Housing Innovations Fund

AHO	Affordable Housing Organisation
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
ANTA	Australian National Training Authority
APY	Anangu Pitjantjatjara Yanunytjatjara Lands
AQF	Australian Qualifications Framework
AR-DRG	Australian refined diagnosis related group
ARHP	Aboriginal Rental Housing Program
ARIA	Accessibility and Remoteness Index for Australia
ARO	Authorised Review Officer
ASBA	Australian School Based Apprenticeship
ASCED	Australian Standard Classification of Education
ASGC	Australian Standard Geographical Classification
ASO	Ambulance Service Organisation
ASOC	Australian Standard Offence Classification
ATSI	Aboriginal and Torres Strait Islander Services
Aust	Australia
AVETMISS	Australian Vocational Education and Training Management Information Statistical Standard
BEACH	Bettering the Evaluation and Care of Health
CAA	Council of Ambulance Authorities
CACP	Community Aged Care Package (program)
CAD	Coordination and Development committee
CAP	Crisis Accommodation Program
CARDS	Court Assessment Referral Drug Scheme
CCB	Child Care Benefit
CCTV	closed circuit television
CD ARIA	Census District Accessibility and Remoteness Index for Australia
CD-ROM	Compact Disc Read Only Memory
CDS	core data set

CDSMAC	Community and Disability Services Ministers' Advisory Council
CFA	Country Fire Authority
CHINS	Community Housing and Infrastructure Needs Survey
CHIP	Community Housing and Infrastructure Program
CHP	Community Housing Program
CI	confidence interval
CISP	Courts Integrated Services Program
COAG	Council of Australian Governments
CRA	Commonwealth Rent Assistance
CRS	Commonwealth Rehabilitation Services
CSDA / CSTDA	Commonwealth State Disability Agreement / Commonwealth State/Territory Disability Agreement
CSHA	Commonwealth State Housing Agreement
CSMAC	Community Services Ministers' Advisory Council
CSTDA	Commonwealth State/Territory Disability Agreement
DAC	delivery following primary caesarean
DCIS	ductal carcinoma in situ
DEA	data envelopment analysis
DECS	Department of Education and Children's Services (WA)
DEET	Department of Employment Education and Training
DEST	Department of Education, Science and Training
DEWR	Department of Employment and Workplace Relations
DFEEST	Department of Further Education, Employment, Science and Technology (WA)
DHS	Department of Human Services (Vic)
DHSH	Department of Human Services and Health
DoHA	Department of Health and Ageing
DPIE	Department of Primary Industries and Energy
DRG	Diagnosis related group
DVA	Department of Veterans' Affairs

EACH	Extended Aged Care at Home (program)
EMA	Emergency Management Australia
ERP	estimated resident population
EWG	Evaluation Working Group
FaCS	Department of Family and Community Services
FaCSIA	Department of Families, Community Services and Indigenous Affairs
FDC	Family Day Care
FDCQA	Family Day Care Quality Assurance
FTE	full time equivalent
FWE	full time workload equivalent
GDP	gross domestic product
GIR	Getting it Right
GPII	General Practice Immunisation Incentives scheme
GP	general practitioner
GSP	gross state product
GSS	General Social Survey
HACC	Home and Community Care (program)
HbA1c	glycated haemoglobin
HILDA	Household Income and Labour Dynamics Australia
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
ICD-10-AM	Australian modification of the International Standard Classification of Diseases and Related Health Problems, version 10
ICHO	Indigenous Community Housing Organisations
ICMS	Integrated Courts Management System
IHIA	Indigenous Housing and Infrastructure Agreement
IMF	Integrated Monitoring Framework
IPD	Implicit Price Deflator
ISC	Industry Skills Council

ITAB	Industry Training Advisory Body
JET	Jobs, Education and Training
JJNMDS	Juvenile Justice National Minimum Data Set
K10	Kessler – 10 scale
KPI	Key Performance Indicators
LBOTE	Language background other than English
LMO	local medical officer
LOTE	language other than English
MBS	Medicare Benefits Schedule
MCATSIA	Ministerial Council on Aboriginal and Torres Strait Islander Affairs
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MCVTE	Ministerial Council on Vocational and Technical Education
MDS	minimum data set
MOU	Memorandum of understanding
NALP	National Accelerated Literacy Program
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCAC	National Childcare Accreditation Council
NCAG	National Corrections Advisory Group
NCCJS	National Centre for Crime and Justice Statistics
NCPASS	National Child Protection and Support Services data working group
NCSIMG	National Community Services Information Management Group
NCVER	National Centre for Vocational Education Research
NDC	National Data Collection
NDCA	National Data Collection Agency
NESB	non-English speaking background
NFD	not further defined
NHCDC	National Hospital Cost Data Collection

NHMP	National Homicide Monitoring Program
NHMRC	National Health and Medical Research Council
NHPC	National Health Performance Committee
NIDP	National Information Development Plan
NISC	National Industry Skills Committee
NMDS	national minimum data set
NMHS	National Mental Health Strategy
no.	number
np	not published
NQC	National Quality Council
NRCPP	National Respite for Carers Program
NRF	National Reporting Framework
NSCSP	National Survey of Community Satisfaction with Policing
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NSMHS	National Survey of Mental Health Services
NSOC	National Senior Officials Committee
NSW	New South Wales
NT	Northern Territory
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OECD	Organisation for Economic Co-operation and Development
OMP	other medical practitioner
OSHC	Outside School Hours Care
OSHCQA	Outside School Hours Care Quality Assurance
PBS	Pharmaceutical Benefits Scheme
PDF	Portable Document Format
PIP	Practice Incentives Program
PISA	Program for International Student Assessment
PMRT	Performance Measurement and Reporting Taskforce
POEM	Partnership Outreach Education Models

QIAS	Quality Improvement and Accreditation System
Qld	Queensland
QMERIT	Queensland Magistrates Early Referral into Treatment
QPA	Quality Practice Accreditation
RACGP	Royal Australian College of General Practitioners
RPBS	Repatriation Pharmaceutical Benefits Scheme
RPL	recognition of prior learning
RRMA	Rural, Remote and Metropolitan Areas
RSE	relative standard error
RTO	Registered Training Organisation
SA	South Australia
SAAP	Supported Accommodation Assistance Program
SACE	South Australian Certificate for Education
SAR	service activity reporting
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SCRGSP	Steering Committee for the Review of Government Service Provision
SDA	service delivery area
SDAC	Survey of Disability, Ageing and Carers
SE	standard error
SEWB	Social and Emotional Wellbeing
SIMC	Statistical Information Management Committee
SLA	statistical local area
SMART	SAAP Management and Reporting Tool
SMES	small-to-medium sized enterprises
SMS	short messaging service
SOL	Sex Offence Directions List
SOMIH	state owned and managed Indigenous housing
SSAT	Social Security Appeals Tribunal
TAFE	technical and further education

Tas	Tasmania
TGR	total growth rate
TIMSS	Trends in International Mathematics and Science Study
UCC	user cost of capital
ULN	upper limit of normal
VBAC	vaginal birth following primary caesarean
VCAL	Victorian Certificate of Applied Learning
VET	vocational education and training
Vic	Victoria
WA	Western Australia

Glossary

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

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

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

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

PART E

HEALTH

E Health preface

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

Health services in Australia are delivered by a variety of government and non-government providers in a range of service settings (box E.1). The Report primarily concentrates on the performance of public hospitals (chapter 9), primary and community health services (including general practice) (chapter 10) and the interactions among different service mechanisms for dealing with two health management issues: mental health and breast cancer (chapter 11). These services are selected for reporting as they:

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

The Australian, State, Territory and local governments spent \$34.6 billion on public (non-psychiatric) hospitals, medical services (including payments to general practitioners [GPs] and other specialist practitioners) and community and public health in 2004-05. These three areas of health care activity accounted for 64.5 per cent of government recurrent health expenditure in 2004-05 (table EA.4). Public health expenditure on breast cancer screening was \$118 million in 2004-05 (table 11A.5). There are no specific estimates of government expenditure on the management of breast cancer for 2004-05. Government recurrent expenditure on specialist mental health services was estimated to be around \$3.8 billion in 2004-05 (tables 11A.20 and 11A.21). Some of this expenditure was on psychiatric care provided by public (non-psychiatric) hospitals (chapters 9 and 11).

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

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

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

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

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

Primary health care: services that:

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

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

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

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

- public health programs, other than those for breast cancer and mental health

-
- funding for specialist medical practitioners.

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), however, are included in other chapters of the Report.

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

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

Profile of health services

This section provides a brief overview of Australian health services as a whole. More detailed descriptions of public hospitals, primary and community health services, and mental health and breast cancer services are provided in chapters 9, 10 and 11 respectively.

Roles and responsibilities

The Australian Government's health services activities include:

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

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

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

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

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

Funding

Funding the components of Australia's health care system is a complicated process. The Australian Government subsidises many of the services provided by the non-government sector (mostly through the MBS, the PBS, the private health insurance rebate and the Medicare Safety Net) and contributes funding to a number

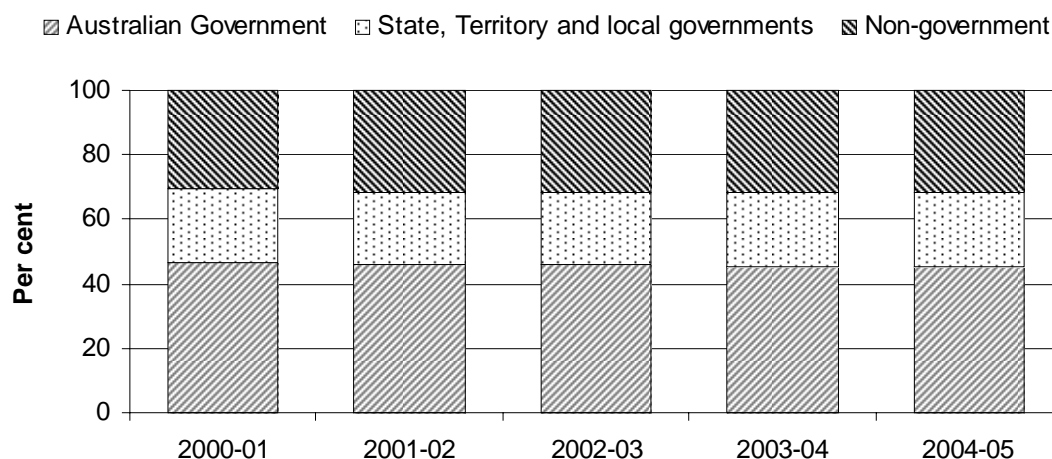
of nationally coordinated public health programs. It also provides funding under the AHCAs to the states and territories for public hospital services.

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

The Australian, State, Territory and local governments spent \$57.2 billion on health services (expressed in 2003-04 dollars)¹ which represents 68.2 per cent of total health expenditure in 2004-05. The Australian Government accounted for the largest proportion of health care expenditure in Australia — \$38.2 billion (expressed in 2003-04 dollars) or 45.6 per cent of the total in 2004-05. State, Territory and local governments contributed \$19.0 billion (expressed in 2003-04 dollars) or 22.6 per cent of total health expenditure in that year. These shares have remained relatively constant over the last five years. The remainder was paid by individuals, health insurance funds and workers compensation and compulsory motor vehicle third party insurance providers (figure E.1 and table EA.1).

¹ The published source data from the AIHW use 2003-04 as the base year. The same base year is used here for consistency.

**Figure E.1 Total health expenditure, by source of funds
(2003-04 dollars)^{a, b, c, d}**



^a Includes recurrent and capital expenditure. ^b Includes expenditure on high level residential aged care (reported in chapter 12) and ambulance services (reported in chapter 8). ^c Expenditure by Australian Government and non-government sources has been adjusted for tax expenditure in relation to private health incentives claimed through the taxation system. ^d 'Non-government' includes expenditure by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurers.

Source: AIHW (2006a); table EA.1.

Size and scope of sector

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be \$83.8 billion in 2004-05 (in 2003-04 dollars) (table EA.1). This total was estimated to account for 9.8 per cent of gross domestic product in 2004-05, up from 9.4 per cent in 2003-04 and 8.1 per cent in 1994-95 (AIHW 2006a). This indicates that health expenditure grew faster than the economy as a whole over the decade to 2004-05.

The growth of total health expenditure over the past decade was largely the result of an increase in expenditure by the Australian, State, Territory and local governments, which grew proportionally faster than expenditure by non-government sources. Between 1994-95 and 2004-05, the average annual rate of growth in real expenditure was 5.5 per cent for the Australian Government, 6.3 per cent for State, Territory and local governments, and 4.3 per cent for non-government sources (AIHW 2006a).

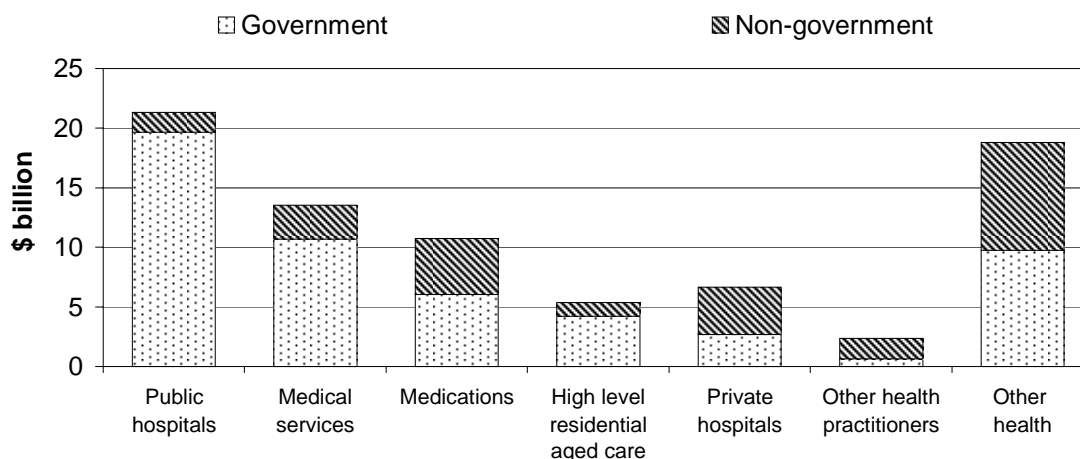
The introduction of programs supporting private health insurance was a significant factor in the increase in expenditure by the Australian Government in the late 1990s. On 1 January 1999, the Australian Government replaced the Private

Health Insurance Incentive Scheme with a 30 per cent rebate on private health insurance premiums. Australian Government expenditure on the rebate has increased each year from \$2.0 billion in 2000-01 to \$3.0 billion in 2004-05 in current prices (AIHW 2006a).

The Medicare Safety Net, introduced in March 2004, has also contributed to increased Australian Government expenditure. Under the Medicare Safety Net patients are reimbursed for 80 per cent of their out-of-pocket costs for medical treatment received in a non-hospital setting once a certain threshold is reached in a calendar year. Total Medicare Benefits Schedule Medicare Safety Net expenditure was \$280.6 million in the year ending 31 December 2005 (DoHA 2006).

Public hospitals were the single largest item of recurrent health care expenditure by government and non-government sources in 2004-05. Total real expenditure on public hospitals was \$21.3 billion of which governments paid \$19.7 billion (in 2003-04 dollars) (figure E.2). Public hospitals accounted for 36.6 per cent of government recurrent expenditure on health care services in 2004-05. Medical services accounted for \$10.7 billion of government expenditure (19.9 per cent of total health expenditure) and medications accounted for \$6.0 billion (11.2 per cent) (table EA.2).

**Figure E.2 Recurrent health expenditure, by area of expenditure, 2004-05
(2003-04 dollars)^{a, b, c, d, e, f}**



^a Government funding of recurrent health expenditure is not adjusted for non-specific tax expenditures. ^b Almost all expenditure on medical services relates to services provided by practitioners on a fee-for-service basis, including those provided to private patients in hospitals. Excluded are the medical component of hospital care provided to public hospital inpatients and the outpatient medical services provided at public hospitals. ^c Medications include (but are not limited to) those provided under the PBS. ^d High level residential aged care services cover services to those residents requiring and receiving a level of care that falls within one of the four highest levels of care. These services are commonly classified as health services expenditure, but are discussed separately in this Report (chapter 12). ^e Government funding on other health practitioners includes DVA funding and DoHA hearing services (audiology component) which was previously included in 'other health'. ^f Other health expenditure includes ambulance, other institutional health nec., dental services, community health, aids and appliances, public health, other non-institutional health nec., administration and research.

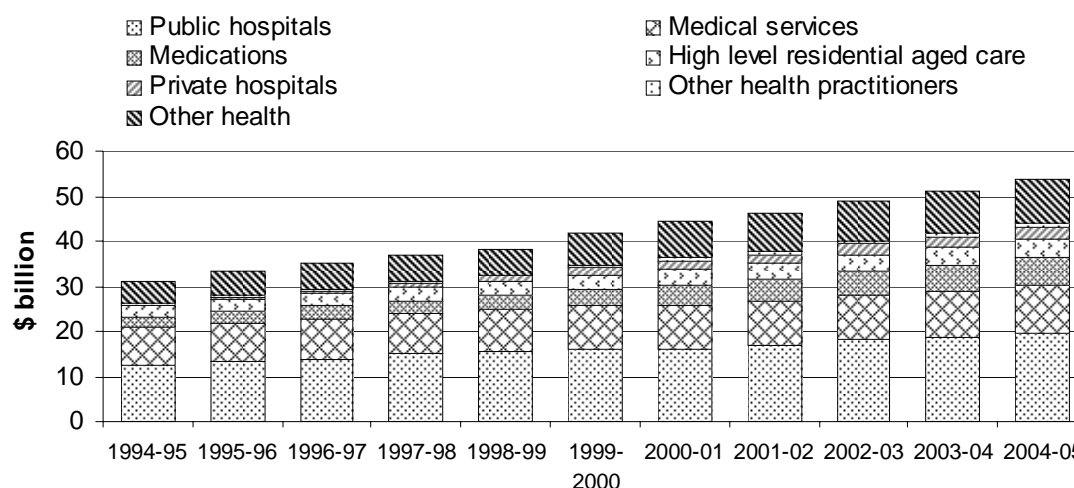
Source: AIHW (2006a); tables EA.2 and EA.3.

The relative share of government recurrent health expenditure allocated to public hospitals has fallen since 1994-95, when it was 40.3 per cent, to 36.6 per cent in 2004-05. This decline reflects the more rapid growth over the decade of government expenditure on private hospitals and medications (figure E.3 and table EA.2). The average annual growth rate of government real recurrent expenditure on private hospitals was 24.4 per cent between 1994-95 and 2004-05 (albeit from a relatively low base), compared with 11.0 per cent for medications and 4.6 per cent for public hospitals (AIHW 2006a). Policy measures introduced over the decade that were aimed at restraining growth in government health expenditure included the restriction of Medicare provider numbers, initiatives to encourage the use of generic medication brands, and increases in co-payments for medications.

The high annual growth in expenditures on medications and private hospitals meant they also grew as a proportion of government health care expenditure over the period 1994-95 to 2004-05. Government expenditure on medications increased from 6.8 per cent of government health expenditure in 1994-95 to 11.2 per cent in

2004-05, while expenditure on private hospitals increased from 1.0 per cent to 5.0 per cent over the same period (table EA.2).

Figure E.3 Government recurrent expenditure, by area of expenditure (2003-04 dollars)^{a, b, c, d, e}



^a Medications include (but are not limited to) those provided under the PBS. ^b Almost all expenditure on medical services relates to services provided by practitioners on a fee-for-service basis, including those provided to private patients in hospitals. Excluded are the medical component of hospital care provided to public hospital inpatients, and the outpatient medical services provided at public hospitals. ^c High level residential aged care is reported in chapter 12. ^d Other health expenditure includes community and public health services, funding for aids and appliances, administration, private hospitals, ambulance services (reported in chapter 8), research, dental services and public psychiatric hospitals. ^e Real (constant price) estimates have been calculated by applying the AIHW total health price index (table EA.8).

Source: AIHW (2006a); table EA.2.

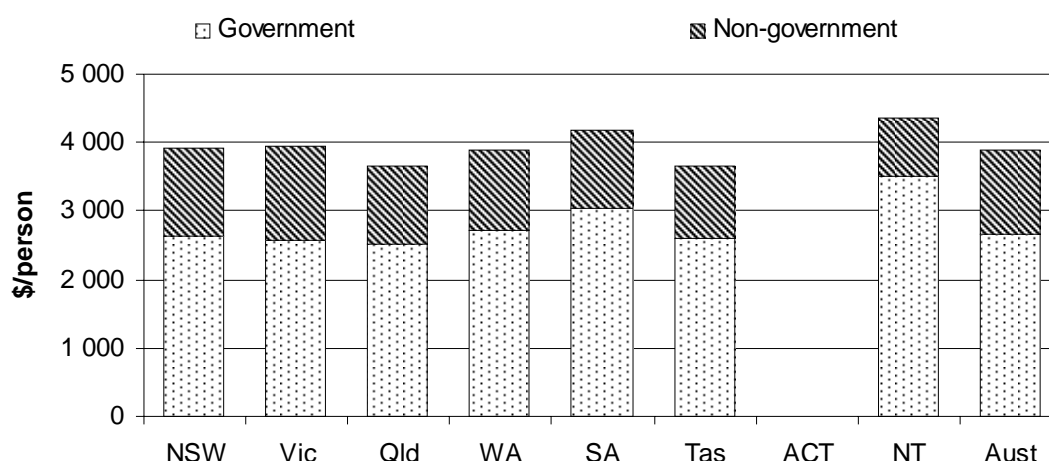
Health expenditure per person

Health expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics. Nationally, total health expenditure (recurrent and capital) per person in 2004-05 was \$4138 (table EA.5). The average annual growth rate in average health expenditure per person (expressed in 2003-04 dollars) from 2000-01 to 2004-05 was 4.0 per cent (table EA.5). Average health expenditure per person in Australia increased from \$3539 in 2000-01 to \$4138 in 2004-05 (in 2003-04 dollars) (table EA.5).

Government real recurrent health expenditure per person in Australia increased from \$2291 in 2000-01 to \$2655 in 2004-05 (in 2003-04 dollars). Non-government recurrent expenditure per person in Australia rose from \$1044 in 2000-01 to \$1240 in 2004-05 (in 2003-04 dollars) (figure E.4 and table EA.6). Information on

expenditure per person excluding high level residential aged care is available in table EA.7.

Figure E.4 Recurrent health expenditure per person by source of funds, 2004-05 (2003-04 dollars)^{a, b, c}



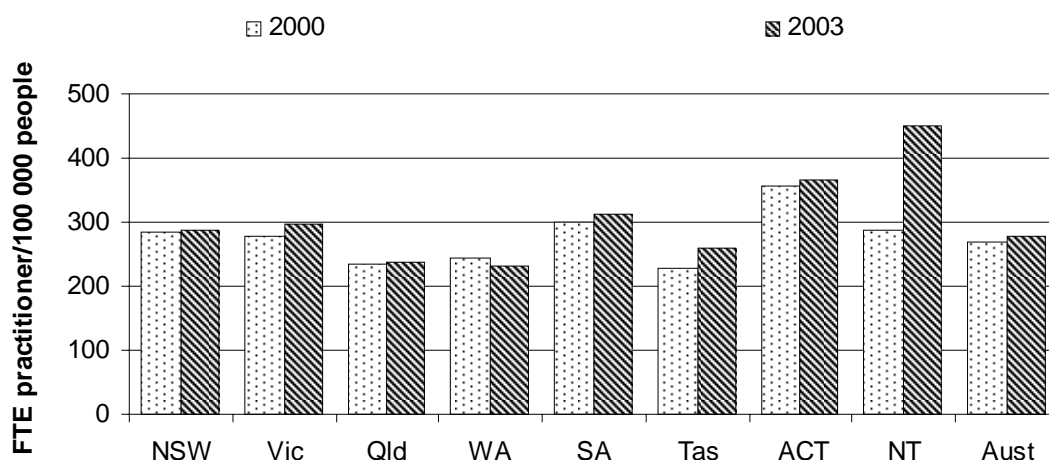
^a Includes expenditure on high level residential aged care (reported in chapter 12) and ambulance services (reported in chapter 8). ^b Government expenditure includes expenditure by the Australian, State, Territory and local governments. ^c ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditures for NSW residents. Thus the ACT population is not the appropriate denominator.

Source: AIHW (2006a); table EA.6.

Health workforce

In 2003, there were 56 207 registered medical practitioners in Australia working in medicine. A further 841 were in the medical labour force but on extended leave or looking for work in the medical labour force. The majority of employed practitioners working in medicine were clinicians (92.2 per cent), of whom 42.3 per cent were primary care practitioners (mainly general practitioners), 34.9 per cent were specialists and 22.8 per cent were either specialists-in-training or hospital non-specialists (AIHW 2005c). The number of full time equivalent (FTE) practitioners per 100 000 people by jurisdiction is illustrated in figure E.5.

Figure E.5 **Employed medical practitioners^a**

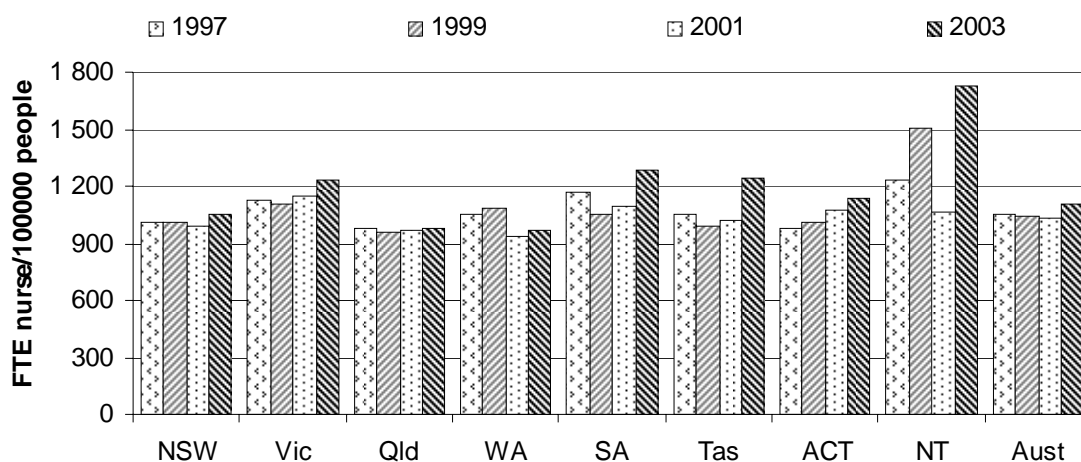


^a FTE practitioner rate (per 100 000 people) based on a 45-hour week.

Source: AIHW (2005c); table EA.9.

The number of FTE nurses per 100 000 people by jurisdiction is illustrated in figure E.6. The increase in employed nurses in the NT arose from both an increase in the number of nurses employed and an increase in average hours worked (AIHW 2005d).

Figure E.6 **Employed nurses^a**



^a FTE nurse rate (per 100 000 people) based on a 35-hour week.

Source: AIHW (2005d); table EA.10.

Overview of Indigenous health

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

Australian Indigenous people are more likely to experience disability and significantly lower quality of life due to poorer health, and to have shorter life expectancies than the rest of the Australian population (SCRGSP 2005). These patterns are reflected in Australian data on: mortality, life expectancy and birthweights (later in this preface); hospital separation rates; hospitalisation rates for diabetes, assault and infectious pneumonia; fetal, neonatal and perinatal death rates (chapter 9); and suicide (chapter 11).

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

Contributing factors

Many interrelated factors contribute to the poor health status of Indigenous people relative to that of other Australians. These include cultural, socioeconomic, geographic and environmental health factors. Recent reports have highlighted:

- Language and cultural barriers to accessing health and health-related services — in 2002 approximately 11 per cent of Indigenous people aged 18 years and over reported difficulties understanding or being understood by service providers. Indigenous people living in remote areas were more likely to report experiencing difficulties than those in non-remote areas (ABS and AIHW 2005).
- Relatively low education levels — nationally in 2004, Indigenous students were around half as likely to continue to year 12 as non-Indigenous students (SCRGSP 2005).
- Relatively low employment and income levels that lead to financial barriers to accessing health services — in 2004-05 the full time employment rate for Indigenous people was much lower than that for non-Indigenous people for both

males and females. Both household and individual incomes were lower on average for Indigenous people than for non-Indigenous people (ABS unpublished).

- Relatively high imprisonment rates — after adjusting for age differences, Indigenous people were 11 times more likely than other Australians to be imprisoned at 30 June 2004 (SCRGSP 2005).
- Relatively high rates for health risk factors such as obesity, smoking, harmful alcohol use, substance abuse and violence — in 2004-05, 50 per cent of Indigenous people aged 18 years and over claimed to be cigarette smokers and 16 per cent reported risky/high risk alcohol consumption in the week prior to interview (where risky/high risk alcohol consumption equates to more than 50 millilitres per day for males and more than 25 millilitres per day for females). During 2004-05, Indigenous people were more than four times as likely to be in hospital for alcohol-related mental and behavioural disorders as other people (ABS 2006c).
- Geographic distance to health services, particularly in remote and very remote areas — in 2001, 606 discrete Indigenous communities were located 25 kilometres or more from the nearest primary health care centre, and 943 communities were 50 kilometres or more from the nearest acute care hospital (ABS and AIHW 2005).
- Inadequate and overcrowded housing, particularly in remote and very remote regions — in 2002, 26 per cent of Indigenous people aged 15 years and over (72 600 people) lived in overcrowded households (SCRGSP 2005).

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

In addition, a wide range of government provided or funded services (other than health services) seek to address the environmental, socioeconomic and other factors that affect Indigenous health. These services include government schools, housing, justice and correctional services, which are discussed elsewhere in this Report. The Steering Committee publication, *Overcoming Indigenous Disadvantage: Key Indicators 2005* (SCRGSP 2005), examines these and other multiple contributors (and their complex cross-links) to health outcomes for Indigenous people.

Government policy and programs

The majority of government expenditure on Indigenous health is made through mainstream health programs (AIHW 2005a). In addition, the Australian, State and Territory governments fund Indigenous-specific health programs and undertake coordination and research activities. Most Australian Government expenditure on Indigenous-specific health programs is directed to Indigenous-specific primary health. State and Territory governments fund a range of community and public health programs that specifically target Indigenous people within their jurisdictions (see chapter 10).

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

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

The National Strategic Framework is complemented by a National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004–2009 (SEWB Framework), which was agreed by the Australian Health Ministers Advisory Council in March 2004. The

SEWB Framework sits within the context of the National Strategic Framework for Aboriginal and Torres Strait Islander Health and the Third National Mental Health Plan. For a discussion of the Third National Mental Health Plan (see chapter 11).

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

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

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

The Aboriginal and Torres Strait Islander Health Performance Framework has been developed under the auspices of Australian Health Minister's Advisory Council to support the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH). The Health Performance Framework is designed to measure the impact of the NSFATSIH and inform policy analysis, planning and program implementation.

Expenditure

It is not always possible to make accurate estimates of health expenditure for Indigenous people and their corresponding service use. For example, Indigenous status is not always clearly stated or recorded. Data on Indigenous status are often unavailable for privately funded services (although they are available for many publicly funded health services). The scope and definition of health expenditures also have some limitations. Other (non-health) agency contributions to health expenditure, such as those incurred within education departments and prisons are

not included. There may also be some inconsistencies across data providers resulting from limitations of financial reporting systems and different reporting mechanisms (AIHW 2005a).

The most recent estimates of health services expenditure for Aboriginal and Torres Strait Islander peoples are for 2001-02 (AIHW 2005a). Total recurrent government and non-government expenditure on health services for Indigenous people was estimated at \$1788.6 million in 2001-02. This was equivalent to \$3901 per Indigenous person compared with \$3308 per non-Indigenous person (table E.1). Because Indigenous people relied heavily on publicly funded health care providers, government expenditures were much higher for them than for other people — \$3614 per person compared with \$2225 (AIHW 2005a). Expenditure per person was higher for Indigenous people than non-Indigenous people for admitted patient services in public hospitals and for non-admitted patient services in hospitals. It was also higher for community health services. Expenditure per person was lower for Indigenous people than non-Indigenous people for admitted patient services in private hospitals, medical services, dental and other professional services, pharmaceuticals, aids and appliances and for services for older people (table E.1).

Factors which contribute to the higher levels of health expenditure on Indigenous people include their average higher levels of morbidity and a much larger proportion who live in remote Australia where the cost of service provision is higher.

Table E.1 Total expenditure on health, Indigenous and non-Indigenous people, by type of health good or service, current prices, Australia, 2001-02^a

<i>Health good or service type</i>	<i>Total expenditure (\$ million)</i>			<i>Expenditure per person (\$)</i>		
	Indigenous	Non-Indigenous	Indigenous share (%)	Indigenous	Non-Indigenous	Ratio
Hospitals	849.5	21 456.9	3.8	1 852.8	1 132.0	1.6
Admitted patient services	682.5	17 927.4	3.7	1 488.4	945.8	1.6
Private hospital	11.5	5 057.1	0.2	25.1	266.8	0.1
Public hospital	671.0	12 870.2	5.0	1 463.3	679.0	2.2
Non-admitted patient services	142.4	3 116.5	4.4	310.6	164.4	1.9
Emergency departments	34.6	615.7	5.3	75.5	32.5	2.3
Other services	107.8	2 500.8	4.1	235.1	131.9	1.8
Public (psychiatric) hospitals	24.7	413.0	5.6	53.8	21.8	2.5
Medical services	99.6	11 112.5	0.9	217.2	586.3	0.4
Medicare benefit items	75.9	9 185.4	0.8	165.5	484.6	0.3
Other	23.7	1 927.2	1.2	51.7	101.7	0.5
Community health services ^{b, c}	439.9	2 810.5	13.5	959.3	148.3	6.5
Dental services ^b	21.8	3 734.2	0.6	47.6	197.0	0.2
Other professional services	16.9	2 252.4	0.7	36.8	118.8	0.3
Pharmaceuticals	66.2	9 011.6	0.7	144.4	475.4	0.3
Benefit-paid ^d	42.3	5 471.8	0.8	92.2	288.7	0.3
Other pharmaceuticals	23.9	3 539.8	0.7	52.2	186.8	0.3
Aids and appliances	15.8	2 474.0	0.6	34.5	130.5	0.3
Services for older people	49.9	4 591.6	1.1	108.8	242.3	0.4
Patient transport	62.8	892.7	6.6	137.0	47.1	2.9
Public health activities	72.5	1 029.9	6.6	158.2	54.3	2.9
Other health services (nec)	50.6	1 458.9	3.4	110.4	77.0	1.4
Health administration (nec)	43.1	1 883.6	2.2	94.0	99.4	0.9
Total	1 788.6	62 708.9	2.8	3 900.8	3 308.4	1.2

^a Total expenditure by type of health good or service is the same as total funding. ^b Community health services include State and Territory government expenditure on dental services. ^c Includes \$186.3 million in OATSIH expenditure through Indigenous-specific primary health care services. The Indigenous ratio for the non-Indigenous-specific primary health care services component of community health is estimated at 4.06:1 and for the non-Indigenous-specific primary health care services component it is estimated at 1.07:1. ^d Includes estimates of benefits through the PBS and RPBS.

Source: AIHW (2005a).

In 2001-02, governments are estimated to have provided 92.7 per cent of the funding for expenditure on health goods and services for Indigenous people. States and territories contributed 49.5 per cent and the Australian Government, an estimated 43.1 per cent. Non-government sources such as injury compensation

insurers, private health insurers and out-of-pocket payments supported the remaining funding by users of services (AIHW 2005a).

The majority of health expenditure on Indigenous people was allocated through mainstream health programs — admitted and non-admitted patient services, community health services, medical and 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 and Torres Strait Islander Health Care Services.

About 70.5 per cent of expenditure on health goods and services for Indigenous people were provided through State and Territory and local government programs (table E.2). Almost half (47.5 per cent or \$849.5 million) was allocated to services provided by hospitals (AIHW 2005a). Programs managed by the Australian Government, including Medicare and the PBS, accounted for nearly a quarter of expenditure (23.4 per cent). Non-government health services accounted for 6.2 per cent of expenditure (table E.2), which comprised principally dental services, non-benefit pharmaceuticals, and aids and appliances (AIHW 2005a).

Indigenous people's use of primary, secondary and tertiary health services differed from that of non-Indigenous people. Primary health services are those provided to entire populations (community health services and public health activities) and also those provided in, or flowing from, a patient-initiated contact with a health service. Secondary and tertiary services are those generated within the system by, for example, referral or hospital admission (AIHW 2005a). Average expenditure per person for Indigenous Australians was higher for both primary and secondary/tertiary care services than it was for non-Indigenous Australians. Higher Indigenous spending on primary care services came from a much higher use of community health services by Indigenous people. The higher Indigenous spending on secondary/tertiary services was largely in hospitals (AIHW 2005a).

Indigenous Australians have a significantly poorer health status (measured in terms of life expectancy, mortality rates and morbidity), than non-Indigenous Australians. It could therefore be expected that per capita investment of health resources to Aboriginal and Torres Strait Islanders would be higher than for other Australians.

Table E.2 Expenditure on health for Indigenous people, by program, 2001-02

<i>Program responsibility</i>	<i>Total expenditure (\$ million)</i>	<i>Per cent of total</i>
Through State and Territory and local government programs ^a	1 260.5	70.5
Through Australian Government programs ^b	418.1	23.4
Australian Government Health and Ageing portfolio programs	408.8	22.9
Medicare and PBS ^b	118.4	6.6
Indigenous-specific programs ^c	218.3	12.2
Other Health and Ageing portfolio programs	72.1	4.0
Department of Veterans' Affairs programs	9.3	0.5
RPBS	1.3	0.1
Other DVA programs	8.1	0.5
Non-government health services ^d	110.0	6.2
Total	1 788.6	100.0

^a Includes Australian Government direct expenditure of \$9.1 million on public hospitals. ^b Patient co-payments of \$10.8 million under Medicare and PBS are included. ^c Excludes benefits paid for medical services under exclusions from Section 19(2) of the *Health Insurance Act 1973* and for pharmaceuticals under Section 100 of the *National Health Act 1953* in respect of remote area AHSs. ^d Includes private hospital services, dental services, other professional services and health aids and appliances.

Source: AIHW (2005a).

Self-assessed health

In the National Aboriginal and Torres Strait Islander Health Survey 2004-05, just over three-quarters (78 per cent) of the Indigenous people aged 18 years or over reported their health as either, good, very good or excellent and 22 per cent reported their health as fair or poor. Taking into account differences in age structure, Indigenous people overall were almost twice as likely to report their health as fair or poor, than non-Indigenous Australians (ABS 2006c).

Data quality

Good quality data are needed to assess the effectiveness of programs and to evaluate policies designed to improve health services and outcomes for Indigenous people. Despite recent improvements, the quality of the information and estimates on Indigenous health expenditures is limited by underlying data and the calculation methodology. Some of the problems associated with Indigenous health data are outlined in (ABS 2005), and (ABS and AIHW 2006) including:

- Indigenous people are not always accurately or consistently identified in administrative health data collections (such as hospital records and birth and

death registrations), given variation in definitions, different data collection methods and inaccurate or incomplete recording of Indigenous status.

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

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

Coverage of Indigenous Australians is especially a concern in some collections, and therefore, data analysis has been limited to jurisdictions with known better coverage. For hospital separations and recent mortality data, only NT, WA, SA and Queensland have been assessed as having acceptable data quality. These four jurisdictions represent 60 per cent of Australia's Indigenous population. Work is underway to improve data quality and this work is being informed by the Health Performance Framework.

Framework for measuring the performance of the health system

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

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

Box E.2 Overall objectives of the health system

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

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

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

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

Medical intervention strategies are implemented after a diagnosis.

The National Health Performance Committee has developed the National Health Performance Framework to guide the reporting and measurement of health service

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

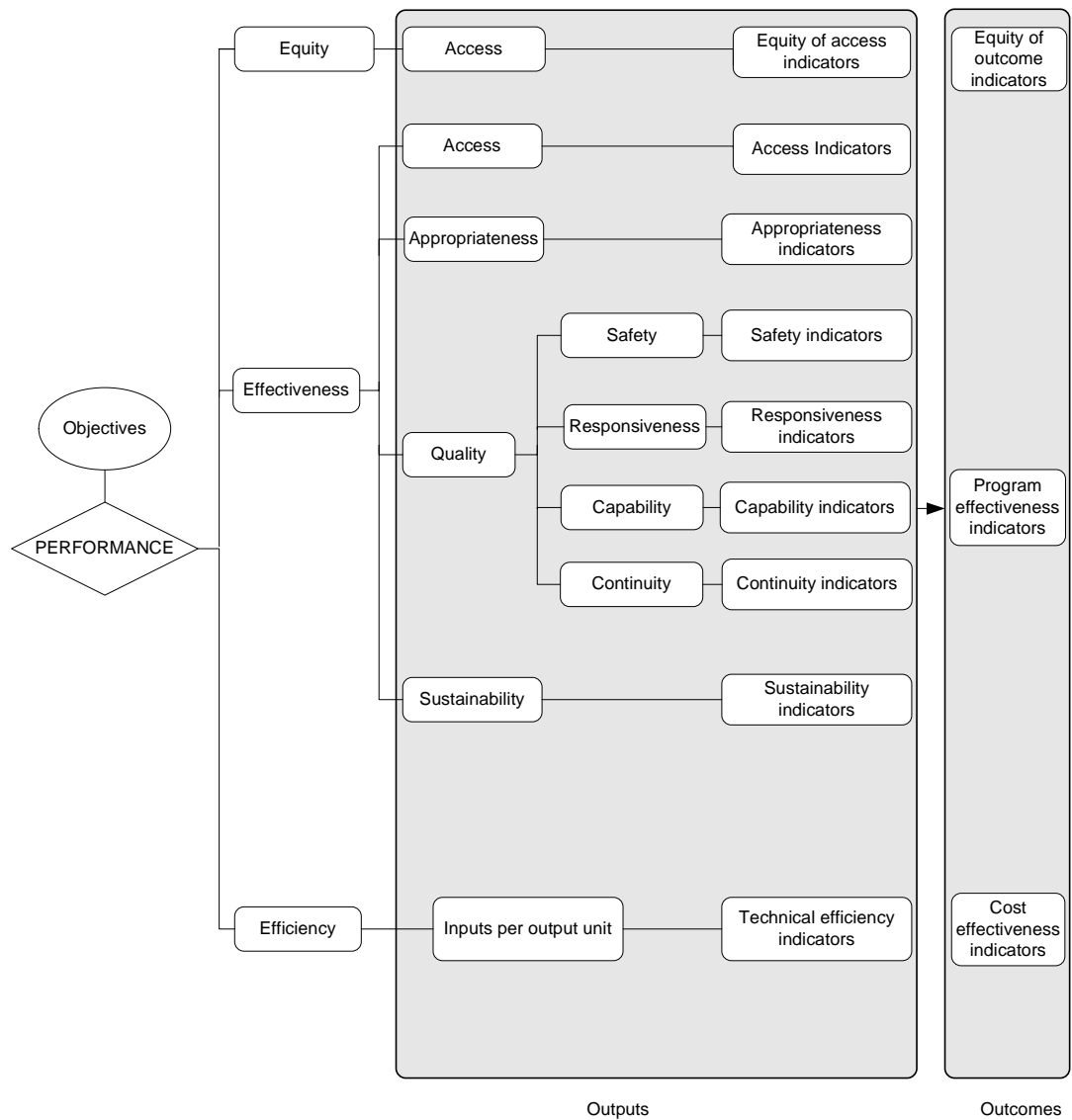
In the 2004 Report, the Steering Committee sought to align the general Review framework with the National Health Performance Framework as far as possible, for application to government health services. Complete alignment was not possible, given the different terms of reference of the two committees. The performance framework for health services in this Report thus reflects and concords with both the general Review framework and the National Health Performance Framework. It differs from the general Review framework (see chapter 1) in two respects. First, it includes four subdimensions of quality — safety, responsiveness, capability and continuity — and, second, it includes an extra dimension of effectiveness — sustainability (figure E.7). These additions are intended to address the following key performance dimensions of the health system in the National Health Performance Framework that were not explicitly covered in the general Review framework:

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

Other aspects and dimensions of the Steering Committee's framework of performance indicators are defined in chapter 1. The Steering Committee has applied this performance framework to health services in two ways. It has developed, first, detailed performance indicator frameworks for significant providers (public hospitals, and primary and community health services) and second, separate frameworks to examine the appropriate mix of services (including

the prevention of illness and injury, and medical treatment) and the appropriate mix of service delivery mechanisms. The latter are measured by focusing on two health management issues: breast cancer and mental health. These performance indicator frameworks are discussed in chapters 9, 10 and 11.

Figure E.7 **Performance indicator framework for health services**



Selected indicators of health outcomes

It is difficult to isolate the effect of health care services on the general health of the population. Socioeconomic factors (such as residential location, income levels and

employment rates) and the provision of non-health care government services (such as clean water, sewerage, nutrition, education and public housing) each contribute to overall health outcomes. The outcomes and effectiveness of health services are also influenced by population factors external to governments' control, including geographic dispersion, age and ethnicity profiles, and socioeconomic status. Appendix A summarises some of the demographic and socioeconomic factors that can influence health outcomes and government expenditure.

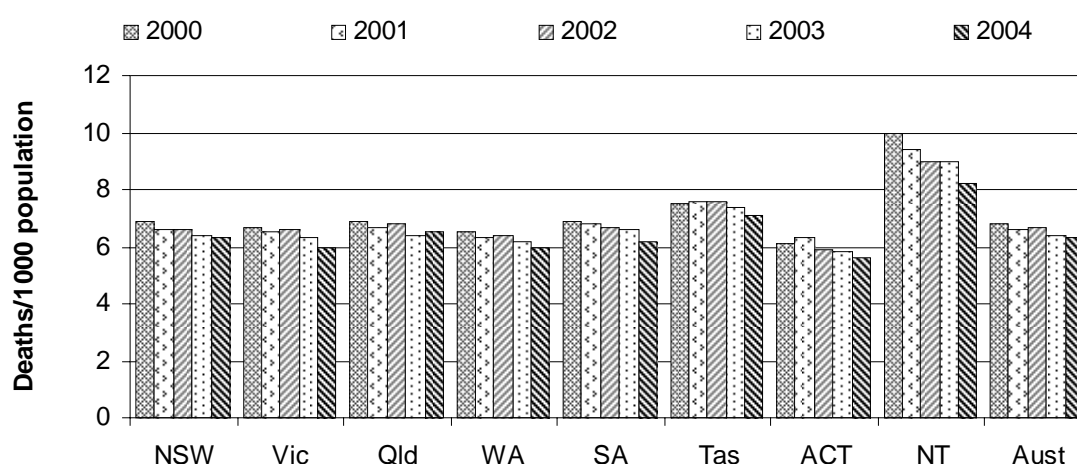
Data on health outcomes presented in this preface include self-assessed health status, mortality rates (for infants and all people), causes of death, life expectancy at birth, median age at death and birthweight. Where possible, data are presented for Indigenous people as well as the Australian population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

Mortality rates

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

There were 132 508 deaths in Australia in 2004 (ABS 2005), which translated into an age standardised mortality rate of 6.3 per 1000 people (figure E.8). Death rates over the last 20 years have declined for all states and territories (ABS 2005).

Figure E.8 **Mortality rates, age standardised^a**



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

Source: ABS (2005); table EA.11.

Indigenous mortality rates

Data on Indigenous people are limited by the accuracy and extent to which Indigenous people are identified in hospital records. Identification varies across states and territories. The report prepared by the AIHW and endorsed by relevant Australian Health Ministers' Advisory Council committees titled *Improving the Data Quality of Indigenous Identification in Hospital Separations Data* recommends the following:

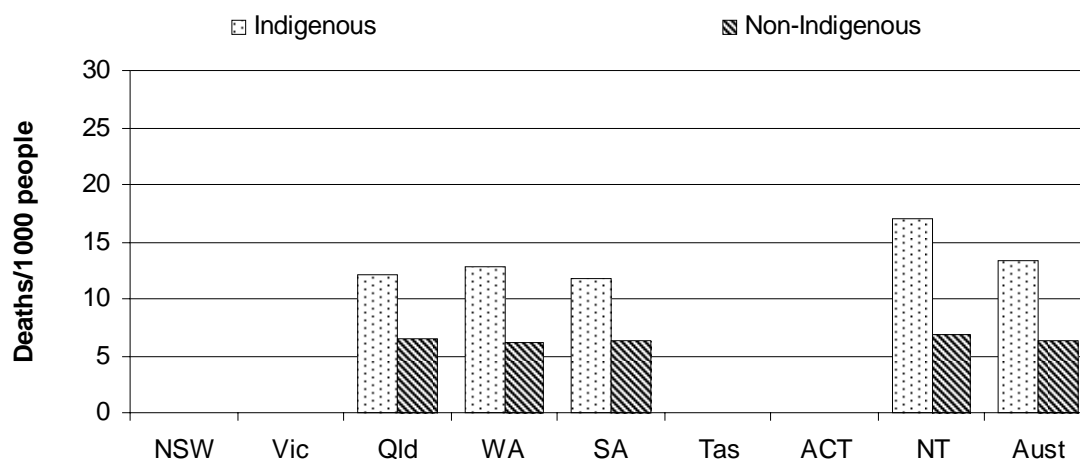
- Only data from Queensland, WA, SA and the NT should be used for analytical purposes (either at the individual or aggregate level).
- Analyses based on data for Queensland, WA, SA and the NT in aggregate are limited by jurisdictional differences in data quality and the data are not necessarily representative of the jurisdictions excluded.
- Caution should be exercised in using Queensland, WA, SA and the NT time series data for analysis (either individually or in aggregate). Changes in hospitalisation rates for Indigenous people may be a result of changes in the ascertainment of Indigenous status for Indigenous patients (AIHW 2005b).

Data on Indigenous mortality are collected through State and Territory death registrations. The completeness of the identification of Indigenous Australians in these collections varies significantly across states and territories. Because of this variation, care is required in making comparisons on the data. The NT, WA, SA and Queensland in that order are generally considered to have the best coverage of death registrations for Indigenous people.² For these four jurisdictions combined, the overall rates of mortality for Indigenous people were around twice as high as mortality rates for non-Indigenous people in 2000–2004 (figure E.9 and table EA.11). The exact magnitude of this difference cannot be established at this time due to variable identification of Indigenous Australians in death records. Reported mortality rates under estimate the true mortality of Indigenous Australians (ABS and AIHW 2005).

Due to the relatively small number of Indigenous deaths and the consequent volatility in annual mortality rates, the data are presented for the five year period 2000–04. To improve the comparability of age-related mortality rates, indirect age standardisation methods have been used for both the Indigenous and total population rates.

² The term 'coverage' refers to the number of Indigenous deaths registered as a percentage of the number of expected deaths based on the 2001 Census based experimental Indigenous population estimates and projections.

Figure E.9 **Mortality rates, age standardised, by Indigenous status, five year average, 2000–2004^{a, b}**



^a Standardised death rates use total persons in the 2001 Australian population as the standard population.

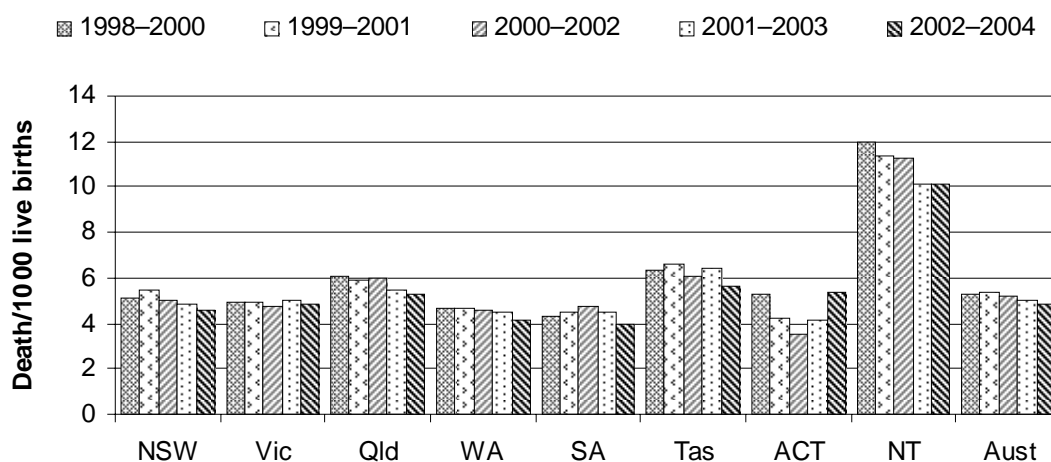
^b Data for NSW, Victoria, Tasmania and the ACT are of insufficient quality to be published.

Source: ABS Deaths Australia (unpublished); table EA.11.

Infant mortality rates

The infant mortality rate is defined as the number of deaths of children under 1 year of age in a calendar year per 1000 live births in the same year. Infant mortality rates are presented in this Report as an average over three years to reduce the volatility inherent in the annual rates due to small numbers and annual fluctuations (figure E.10). The infant mortality rate in Australia declined from 5.3 deaths per 1000 live births over the period 1998–2000 to an average of 4.8 deaths per 1000 live births over the period 2002–2004 (figure E.10).

Figure E.10 Infant mortality rate, three year average^a



^a Figures for Australia include 'Other territories'.

Source: ABS (2005); table EA.12.

Indigenous infant mortality rates

For the period 2002–2004, the average infant mortality rate for Indigenous children is publishable for NSW, Queensland, WA, SA and the NT. While the ability to detect significant changes in Indigenous infant mortality can be affected by the small numbers involved, it is clear that Indigenous infant mortality rates remain markedly higher than the national average for all Australians (tables EA.12 and EA.13).

Principal causes of death

The most common causes of death among Australians in 2004 were: diseases of the circulatory system (including heart disease, heart attack and stroke), cancers, and diseases of the respiratory system (including influenza, pneumonia and chronic lower respiratory diseases) (tables E.3 and EA.14). Malignant neoplasms (cancers) were the main underlying cause of 28.7 per cent of all deaths in 2004 (ABS 2006b) and ischaemic heart disease was the primary cause of a further 18.5 per cent (ABS 2006b).

Table E.3 Cause of death, age standardised death rates, 2004^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
Cancers ^b	181	179	184	176	178	214	157	167
Lung cancer ^c	35	34	37	35	34	37	25	36
Diabetes mellitus	14	20	16	19	15	26	18	44
Mental and behavioural disorders	16	17	15	13	15	18	17	36
Diseases of the nervous system	21	21	22	26	20	30	29	11
Diseases of the circulatory system	233	207	239	200	218	232	193	262
Heart disease ^d	117	106	130	105	113	120	86	146
Heart attack ^e	61	53	69	57	62	53	32	48
Stroke ^f	61	51	61	49	53	47	61	41
Diseases of arteries, arterioles and capillaries	12	11	12	10	11	19	11	15
Diseases of the respiratory system	57	51	55	48	61	57	45	80
Influenza and pneumonia	16	13	16	14	25	11	12	17
Chronic lower respiratory diseases	27	28	29	23	23	38	25	52
Diseases of the digestive system	22	20	22	22	22	18	21	43
Accidents	24	24	29	24	25	34	18	38
Transport accidents	7	8	9	10	10	14	5	17
Suicide ^g	9	10	12	10	12	19	8	25
All causes	632	604	647	597	618	711	562	822

^a Standardised death rate per 100,000 of the mid-year 2002 population. Rounded to whole numbers.

^b Malignant neoplasms. ^c Cancer of the trachea, bronchus and lung. ^d Ischaemic heart disease and heart attacks. ^e Acute myocardial infarction. ^f Cerebrovascular diseases. ^g Intentional self-harm.

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

Causes of death for Indigenous people

In the jurisdictions for which age standardised death rates are available by Indigenous status (Queensland, WA, SA and the NT), death rates were far higher for Indigenous people than for non-Indigenous people during the period 1999–2001. In particular, Indigenous people died from rheumatic heart disease at a rate that was up to 19.4 times that for non-Indigenous people. They died from diabetes at a rate that was up to 15.9 times higher than that for non-Indigenous people; from pneumonia at a rate that was up to 14.3 times that for non-Indigenous people; and

from assault at a rate that was up to 12.6 times that for non-Indigenous people (tables EA.15 and E.4).³

Table E.4 Cause of death, age standardised Indigenous mortality ratios, 1999–2001^{a, b, c}

	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>NT</i>
Lung cancer	2.7	1.1	2.0	1.7
Diabetes ^d	13.2	15.9	12.2	9.2
Circulatory diseases ^e	4.1	5.4	4.7	5.0
Coronary heart disease	4.3	4.9	4.9	4.0
Rheumatic heart disease	19.4	10.4	np	np
Respiratory diseases	4.8	5.8	7.8	6.2
Pneumonia	9.4	13.0	14.3	10.4
Injury and poisoning ^f	2.0	3.5	3.7	2.2
Road vehicle accidents	1.1	3.5	3.6	1.6
Other accidents	1.9	3.9	6.0	1.7
Self-harm	3.9	3.2	4.3	3.1
Assault	5.4	12.6	5.0	10.3

^a Age standardised mortality rate for Indigenous people divided by the age standardised mortality rate for non-Indigenous people. Calculated from death rates per 100 000 people aged less than 75 years.

^b Indigenous deaths data reported in SIMC 2004 and quoted in this table do not reflect ABS revised Indigenous population estimates for 1999 and 2000, nor are they adjusted for differences in the extent of Indigenous identification across jurisdictions or across causes of death. ^c Excludes deaths for which Indigenous status was not stated. ^d Diabetes as an underlying cause or part of a multiple cause. ^e Includes all heart disease, acute myocardial infarction (heart attack) and cerebrovascular diseases (stroke). ^f External causes of death such as land and water transport accidents, falls, poisonings, drowning, other accidents, self-harm and assault. **np** Not published.

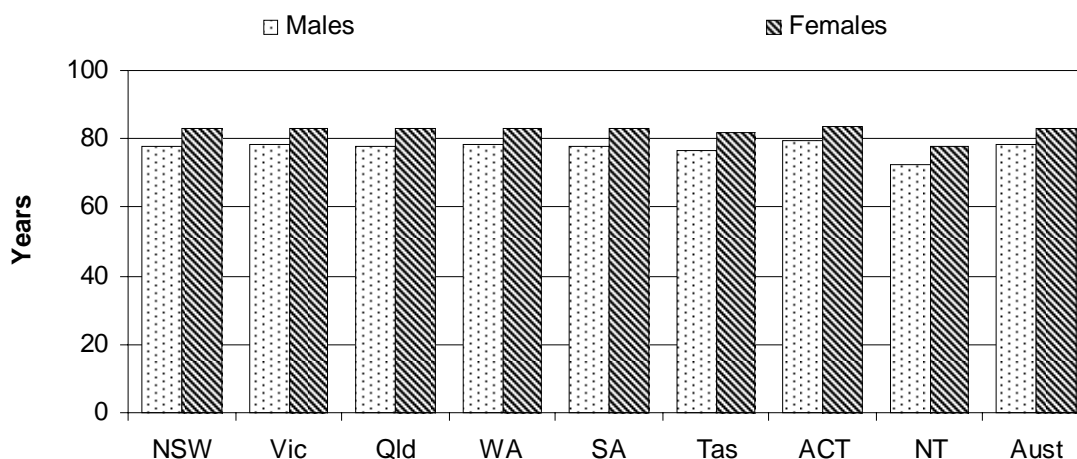
Source: SIMC (2004); table EA.15.

Life expectancy

The life expectancy of Australians improved dramatically during the twentieth century. The average life expectancy at birth in the period 1901–1910 was 55.2 years for males and 58.8 years for females (ABS 2006a). It has risen steadily in each decade since, reaching 78.1 years for males and 83.0 years for females in 2002–2004 (figure E.11).

³ Indigenous deaths data reported in SIMC 2004 and quoted in this Report do not reflect ABS revised Indigenous population estimates for 1999 and 2000, nor are they adjusted for differences in the extent of Indigenous identification across jurisdictions or across causes of death.

Figure E.11 Average life expectancy at birth, by sex, three year average, 2002–2004



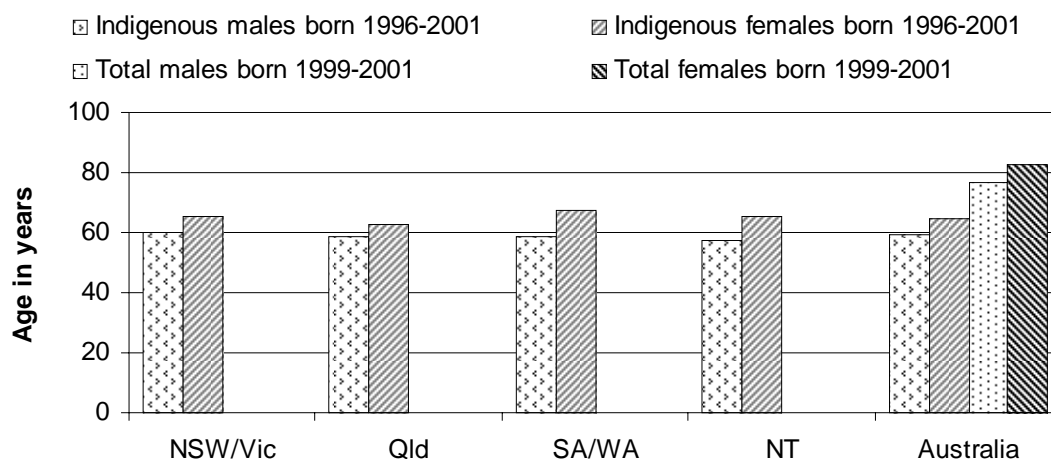
Source: ABS (2005); table EA.16.

Indigenous life expectancy

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

The life expectancies of Indigenous Australians are considerably lower than those of non-Indigenous Australians. ABS experimental population estimates indicate a life expectancy at birth of 59.4 years for Indigenous males and 64.8 years for Indigenous females born from 1996 to 2001 (figure E.12 and table EA.17). In a similar, but not directly comparable time period (1999–2001) the rates for all Australians were 77.0 years for all males and 82.4 years for females. Variations in life expectancy between Indigenous males and females and for Indigenous Australians in different states and territories should be interpreted with care as they are sensitive to the demographic assumptions and differences in data quality across jurisdictions.

Figure E.12 **Life expectancy at birth, Indigenous 1996–2001, total population 1999–2001^{a, b, c}**



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

Source: ABS (2005); table EA.17.

Median age at death

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

For all Australian males and females in 2004, the median age at death was 76.8 years and 82.6 years respectively (figure E.13 and table EA.18). In the jurisdictions for which the data were available for Indigenous people in 2004 the median age at death for male Indigenous Australians varied between 55.8 and 43.8 years. The median age at death for female Indigenous Australians varied between 63.6 years and 53.5 years (figure E.13 and table EA.18).

Figure E.13 Median age at death, by sex and Indigenous status, 2004^a



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

Source: ABS (2005); table EA.18.

Birthweight of babies

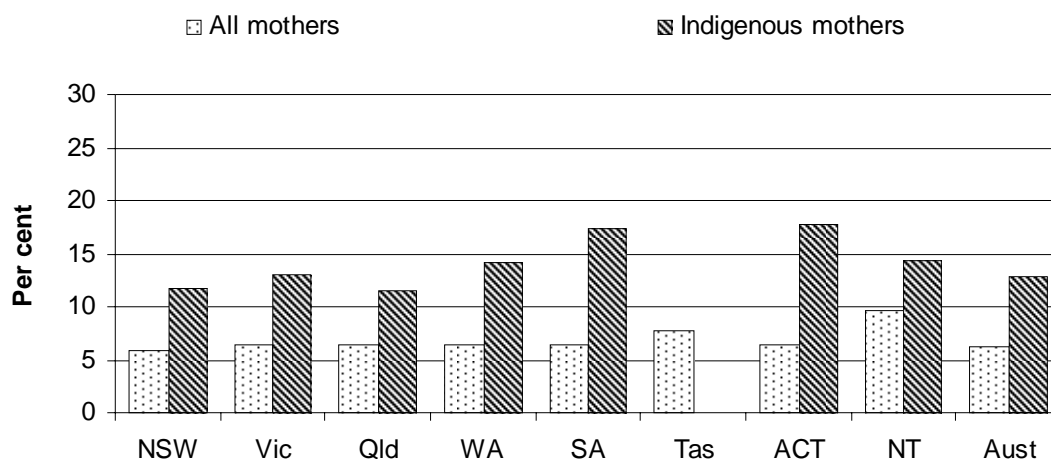
The birthweight of a baby is an important indicator of its health status and future wellbeing. In 2003, 91.8 per cent of liveborn babies in Australia weighed between 2500 and 4499 grams (Laws and Sullivan 2005). The average birthweight for all live births was 3372 grams. In 2003, the average birthweight of liveborn babies of Indigenous mothers was 3160 grams (tables EA.19 and EA.20). This was 212 grams lighter than the average of 3372 grams for liveborn babies of non-Indigenous mothers⁴ (Laws and Sullivan 2005).

Babies are defined as low birthweight if they weigh less than 2500 grams, very low birthweight if they weigh less than 1500 grams and extremely low birthweight if they weigh less than 1000 grams (Laws and Sullivan 2005). In 2003, 6.3 per cent of all liveborn babies in Australia weighed less than 2500 grams (figure E.14). They included 1.1 per cent of babies who weighed less than 1500 grams (table EA.19).

Among live babies born to Indigenous mothers in 2003, the proportions with low and very low birthweights were around twice the proportions born to all Australian mothers, with 12.9 per cent weighing less than 2500 grams and 2.4 per cent weighing less than 1500 grams (figure E.14 and table EA.20).

⁴ Figures for births to Indigenous mothers exclude Tasmania.

Figure E.14 **Babies with birthweights under 2500 grams, by Indigenous status, 2003^{a, b, c}**



^a Proportion of live births with birthweights under 2500 grams. ^b In the ACT 15.2 per cent of women who gave birth were non-ACT residents. Care must be taken when interpreting percentages. For example, the proportion of liveborn low birthweight babies for ACT Aboriginal or Torres Strait Islander residents was 8.6 per cent in 2003. ^c Data for Indigenous mothers for Tasmania were not available because the 'Not stated' category for Indigenous status was not able to be distinguished from the 'Neither Aboriginal nor Torres Strait Islander origin' category.

Source: Laws and Sullivan (2005); tables EA.19 and EA.20.

Future directions

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

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

The availability of hospital separations data for Indigenous people is significantly reduced in the 2007 Report compared to previous Reports. Analysis into the quality of Indigenous identification of hospital admitted patient statistics has shown that while the quality is good in some jurisdictions, in other jurisdictions it is poor (AIHW 2005b). Research studies conducted at various times since 1997-98 have shown substantial under identification (and incorrect identification) of Indigenous status in hospital data in several jurisdictions.

The National Committees such as Australian Hospital Statistics Advisory Committee, the Statistical Information Management Group and the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data have agreed and endorsed recommendations on the use of hospital data and strategies for improvement. Consequently, Indigenous hospital separations data are only available for Queensland, WA, SA and the NT. Data from NSW, Victoria, Tasmania and the ACT were considered to be of insufficient quality.

The AIHW is currently developing a methodology and sampling strategy (funded by AHMAC and Department of Health and Aging) that will allow each jurisdiction to carry out a validation process to get a more recent indication of the current level of under identification in their hospital data. At the end of this project, the jurisdiction will be in a better position to assess whether the situation has improved. The AIHW is also currently undertaking another project funded by the National Health and Medical Research Council, AHMAC and Department of Health and Aging to develop best practice guidelines for identification.

Although some jurisdictions have improved the quality of Indigenous hospital separations data, the lack of progress and ongoing evaluation of data quality in other jurisdictions is disappointing (the problem has been known for ten years). The Steering Committee supports the work of the AIHW to assist jurisdictions to assess the quality of their data, however, primary responsibility for improvement rests with jurisdictions and the Steering Committee strongly encourages all jurisdictions to address this issue as a matter of urgency.

Supporting tables

Supporting tables are identified in references throughout this preface by an 'A' suffix (for example, table EA.3 is table 3 in the electronic data tables). Supporting tables are provided on the CD-ROM enclosed with the Report. Supporting tables can be found on the Review web page (www.pc.gov.au/gsp). The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2007\Attach_stat_app.xls and in Adobe PDF format as \Publications\Reports\2007\Attach_stat_app.pdf. Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

Table EA.1	Total health expenditure, by source of funds (2003-04 dollars)
Table EA.2	Government recurrent health expenditure, by area of expenditure (2003-04 dollars)
Table EA.3	Non-government recurrent health expenditure by area of expenditure (2003-04 dollars)
Table EA.4	Recurrent health expenditure, by source of funds and area of expenditure, 2004-05
Table EA.5	Total health expenditure per person (2002-03 dollars)
Table EA.6	Recurrent health expenditure per person by source of funds (2003-04 dollars)
Table EA.7	Recurrent health expenditure per person, by source of funds, excluding high level residential aged care (2003-04 dollars)
Table EA.8	Total health price index
Table EA.9	Employed medical practitioners
Table EA.10	Employed nurses
Table EA.11	Mortality rates, age standardised for all causes (per 1000 people)
Table EA.12	Infant mortality rate, three year average (per 1000 live births)
Table EA.13	Indigenous Infant mortality rates, selected years
Table EA.14	All Australians causes of death, standardised death rates 2004
Table EA.15	Suicide deaths, by Indigenous status
Table EA.16	All Australians average life expectancy at birth (years)
Table EA.17	Indigenous life expectancy at birth (years)
Table EA.18	Median age at death (years)
Table EA.19	Birthweights, live births, all mothers, 2003
Table EA.20	Birthweights of babies of Indigenous mothers, live births, by State and Territory 2003

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9 Public hospitals

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

A profile of public hospitals is provided in section 9.1. A framework of performance indicators for public hospitals is outlined in section 9.2. Section 9.3 contains the key performance indicator results for public hospitals. A profile of maternity services provided by public hospitals is outlined in section 9.4. Section 9.5 presents the performance indicator framework for public hospital maternity services and section 9.6 reports the key performance indicator results for these services. Future directions in reporting are discussed in section 9.7. Terms and definitions are summarised in section 9.8. Section 9.9 lists the supporting tables for this chapter. Section 9.10 lists references used in this chapter.

Reporting on public hospitals has been improved this year through the development of an indicator on ‘workforce sustainability’. The indicator reports the following measures for each of the nurse and medical practitioner workforces by region and over time:

- proportion of the workforce who are new entrants (aged under 30 years)
- proportion of the workforce who are near retirement (aged 55 years or over)

9.1 Profile of public hospitals

Definition

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

- acute care services to admitted patients

-
- sub-acute and non-acute services to admitted patients (for example, rehabilitation, palliative care, or long stay maintenance care)
 - emergency, outpatient and other services to non-admitted patients¹
 - mental health services, including services provided to admitted patients by designated psychiatric/psychogeriatric units
 - public health services
 - teaching and research activities.

This chapter focuses on acute care services provided to admitted patients and emergency services provided to non-admitted patients in public hospitals. These services comprise the bulk of public hospital activity and, in the case of 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 included in this chapter, although their role is diminishing in accordance with the National Mental Health Strategy. Under the strategy, the provision of psychiatric treatment is shifting away from specialised psychiatric hospitals to mainstream public hospitals and the community sector. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in ‘Health management issues’ (see chapter 11).

Some common health terms relating to hospitals are defined in box 9.1. Other terms and definitions are included in section 9.8.

Box 9.1 Some common terms relating to hospitals

Patients

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

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

(Continued on next page)

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 (AIHW 2001a).

Box 9.1 (Continued)

Types of care

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

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

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

Hospital outputs

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

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

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

Other common health terms

AR-DRG (Australian refined diagnosis related group): a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 5.1 is based on the ICD-10-AM classification.

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

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

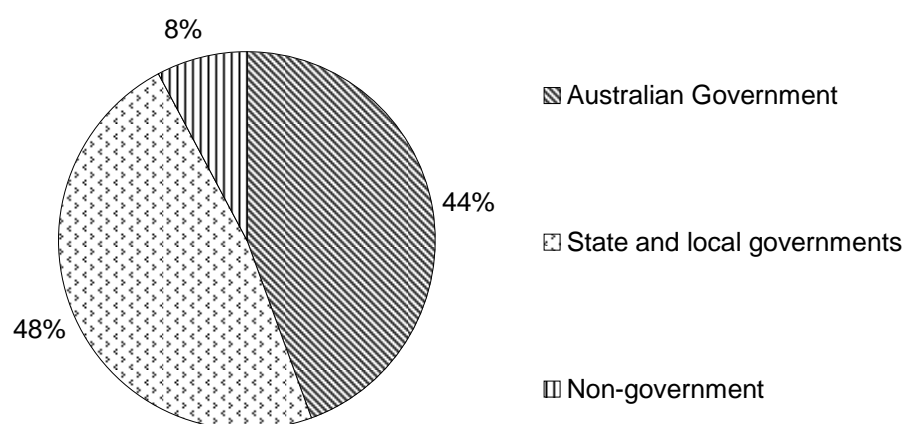
Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was \$21.8 billion in 2004-05 (table 9A.1). In real terms, expenditure increased by 4.9 per cent between 2003-04 and 2004-05 (AIHW 2006a).

The majority of total public hospital recurrent expenditure is spent on admitted patients. Non-admitted patients account for a much smaller share. For selected public hospitals, in 2004-05, the proportion of total public hospital recurrent expenditure that related to the care of admitted patients (based on the admitted patient cost proportion) ranged from 69.1 per cent to 77.5 per cent across jurisdictions (AIHW 2006a).

Funding for public hospitals comes from a number of sources. The Australian, State and Territory governments, health insurance funds, individuals, and workers compensation and compulsory motor vehicle third party insurance contribute to expenditure on public hospitals. Governments contributed about 92.2 per cent of funding for public (non-psychiatric) hospitals in 2004-05 (figure 9.1). Public (non-psychiatric) hospitals accounted for 35.4 per cent of government recurrent expenditure on health services in 2004-05 (AIHW 2006b).

Figure 9.1 **Recurrent expenditure, public (non-psychiatric) hospitals, by source of funds, 2004-05**

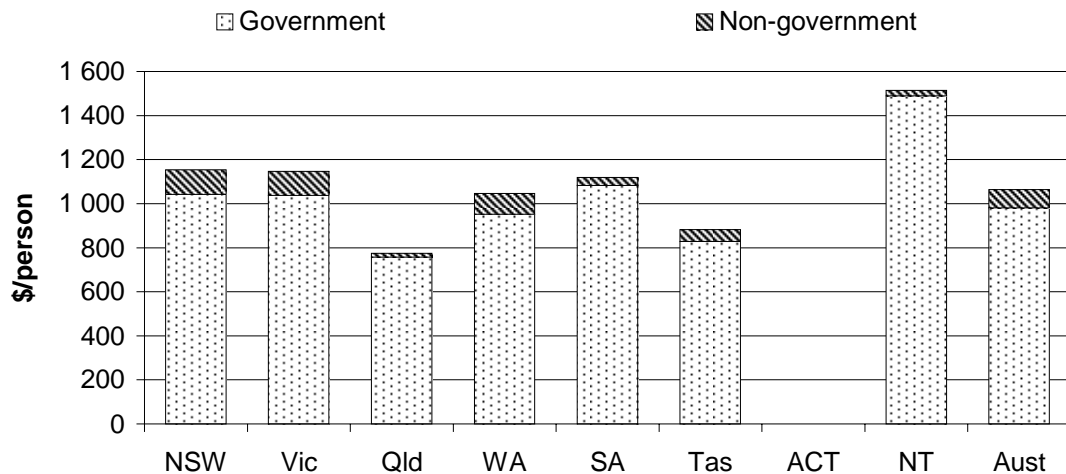


Source: AIHW (2006b).

In 2004-05, public hospitals (non-psychiatric hospitals) received \$1.7 billion from non-government sources — an amount that accounted for 7.8 per cent of all recurrent expenditure (AIHW 2006b). Non-government expenditure in each jurisdiction comprised revenue from health insurance funds, individuals and

workers' compensation and compulsory third-party motor vehicle insurers as well as other sources. The proportion of hospital revenue per person funded from non-government sources varied across jurisdictions in 2004-05 (figure 9.2).

Figure 9.2 **Source of public (non-psychiatric) hospital recurrent expenditure, 2004-05^{a, b, c}**



^a Government expenditure excludes depreciation. Non-government expenditure on depreciation is included in recurrent expenditure. ^b Non-government expenditure includes expenditure by health insurance funds, individuals, workers' compensation, compulsory third-party motor vehicle insurers and other sources. ^c ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditures for NSW residents. Thus the ACT population is not the appropriate denominator.

Source: AIHW (2006b); ABS Australian Demographic Statistics (unpublished); table 9A.2.

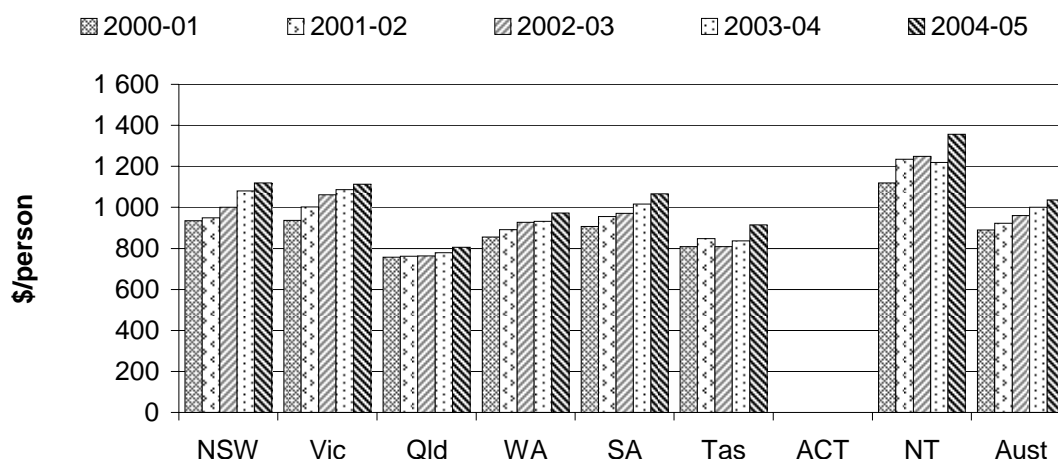
Expenditure data in figures 9.1 and 9.2 are from *Health Expenditure Australia* (AIHW 2006b) and are not directly comparable with other expenditure data used in this chapter, which are drawn from *Australian Hospital Statistics* (AIHW 2006a). The data in *Health Expenditure Australia* have a broader scope than the data in *Australian Hospital Statistics* and include some additional expenditures (such as those relating to blood transfusion services) (Australian Institute of Health and Welfare (AIHW) unpublished).

In 2004-05, government real recurrent expenditure on public hospitals (in 2003-04 dollars) was \$1037 per person for Australia, up from \$891 in 2000-01 (figure 9.3). It is difficult to make comparisons between jurisdictions based on these recurrent expenditure data due to differences in the coverage of the data. Some of the differences are:

- the inclusion by some jurisdictions of expenditure on community health services as well as public hospital services

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

Figure 9.3 Real recurrent expenditure per person, public hospitals (including psychiatric) (2003-04 dollars)^{a, b, c, d, e, f, g}



^a Expenditure data exclude depreciation and interest payments. ^b Recurrent expenditure on purchase of public hospital services at the State, or area health service-level, from privately owned and/or operated hospitals is excluded. ^c Expenditure data are deflated using the hospital/nursing home care price index from AIHW (2006b). ^d NSW expenditure against primary and community care programs is included from 2000-01. For 2003-04 and 2004-05, hospital expenditure recorded against special purposes and trust funds is excluded. ^e Queensland pathology services were purchased from a statewide pathology service rather than being provided by hospital employees. ^f For 2000-01, data for six small Tasmanian hospitals are incomplete. For 2001-02, data for two small hospitals are not included and data for one small hospital are incomplete. For 2002-03, data for one small hospital are not included and data for five other small hospitals are incomplete. For 2003-04, data for five small hospitals are not included. For 2004-05, data for one hospital are not included. ^g ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditures for NSW residents. Thus the ACT population is not the appropriate denominator.

Source: AIHW (2002, 2003, 2004, 2005a, 2006a, 2006b); ABS Australian Demographic Statistics (unpublished); table 9A.3.

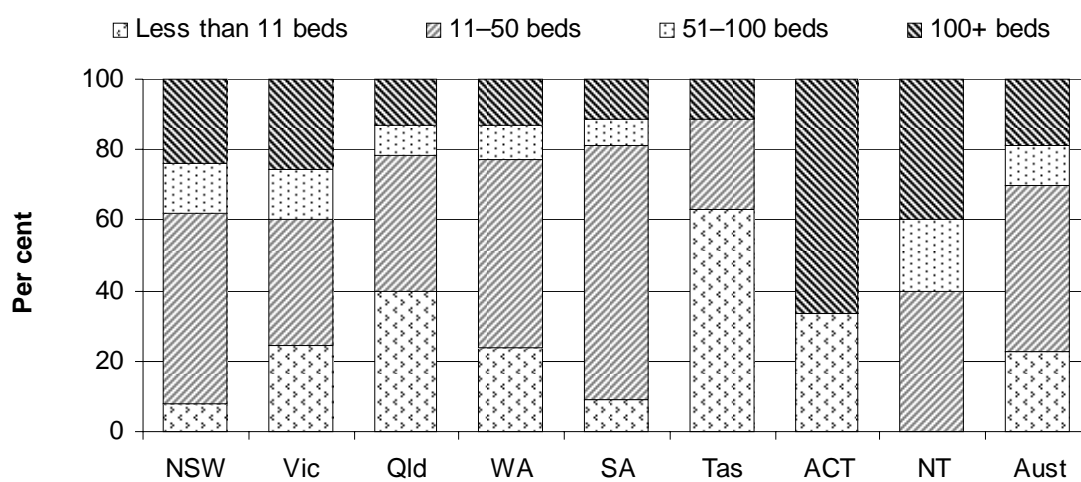
Size and scope of sector

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

Hospitals

In 2004-05, Australia had 759 public hospitals (including 20 psychiatric hospitals) (AIHW 2006a). Although 70.1 per cent of hospitals had 50 or fewer beds, these smaller hospitals represented only 17.9 per cent of total available beds (figure 9.4 and table 9A.4).

Figure 9.4 Public hospitals, by size, 2004-05^{a, b, c, d}



^a The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of hospital buildings or campuses. ^b Size is based on the average number of available beds. ^c The comparability of bed numbers can be affected by the casemix of hospitals including the extent to which hospitals provide same day admitted services and other specialised services. ^d The count of hospitals in Victoria is a count of the campuses that report data separately to the National Hospital Morbidity Database.

Source: AIHW (2006a); table 9A.4.

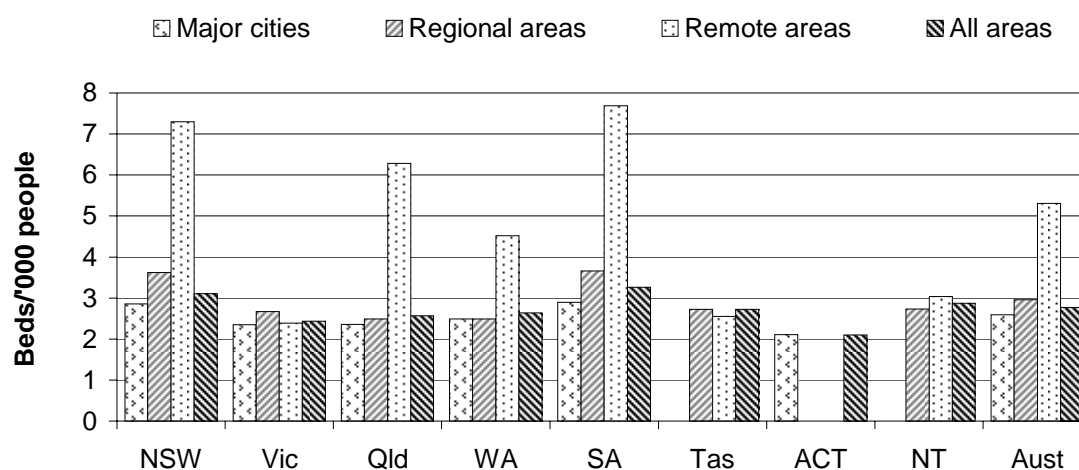
Beds

There were 55 112 available beds in public hospitals in 2004-05 (table 9A.4). The concept of an available bed (the definition of which is under review) is becoming less important in the overall context of hospital activity, particularly in light of increasing same day hospitalisations and the provision of hospital-in-the-home care (AIHW 2006a).

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

Nationally, more beds were available per 1000 people in remote areas (figure 9.5), although this finding does not indicate access in remote areas to particular types of service or the distance required to travel to these services. The patterns of bed availability may also reflect a number of factors including patterns of availability of other health care services, patterns of disease and injury and the relatively poor health of Indigenous people, who have higher population concentrations in remote areas (AIHW 2006a). These data also need to be viewed in the context of the age and sex structure (see appendix A) and the morbidity and mortality (see 'Health preface') of the population in each State and Territory.

Figure 9.5 Available beds, public hospitals, by location, 2004-05^{a, b, c, d}



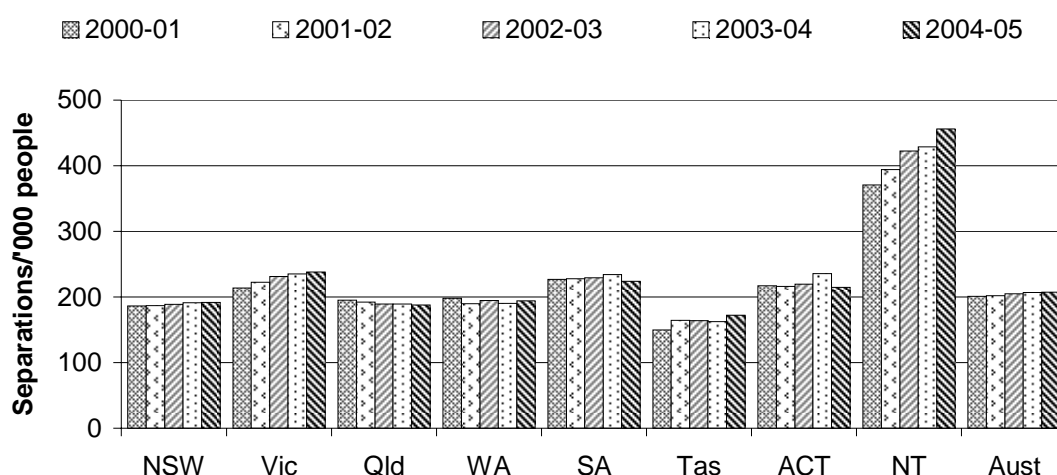
^a An 'available bed' is one that is immediately available to be used by an admitted patient. A bed is immediately available for use if it is located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period. Both occupied and unoccupied beds are included. Surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded, and beds designated for same day non-admitted patient care are excluded. Beds in wards that were closed for any reason (except weekend closures for beds/wards staffed and available on weekends only) are also excluded (NHDC 2003). ^b Analysis by remoteness area is of less relevance to geographically smaller jurisdictions and those jurisdictions with small populations residing in remote areas (such as Victoria) (AIHW 2006a). ^c Tasmania and the NT do not have major cities and the ACT does not have remote areas. ^d There were no available beds in regional areas in the ACT.

Source: AIHW (2006a); table 9A.5.

Total separation rates

There were approximately 4.3 million separations from public (non-psychiatric) hospitals in 2004-05 (table 9A.6). Nationally, this translates into 207.3 separations per 1000 people (figure 9.6).

Figure 9.6 Separation rates in public (non-psychiatric) hospitals^{a, b}



^a Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement. ^b Data are directly age standardised to the Australian population at 30 June 2001.

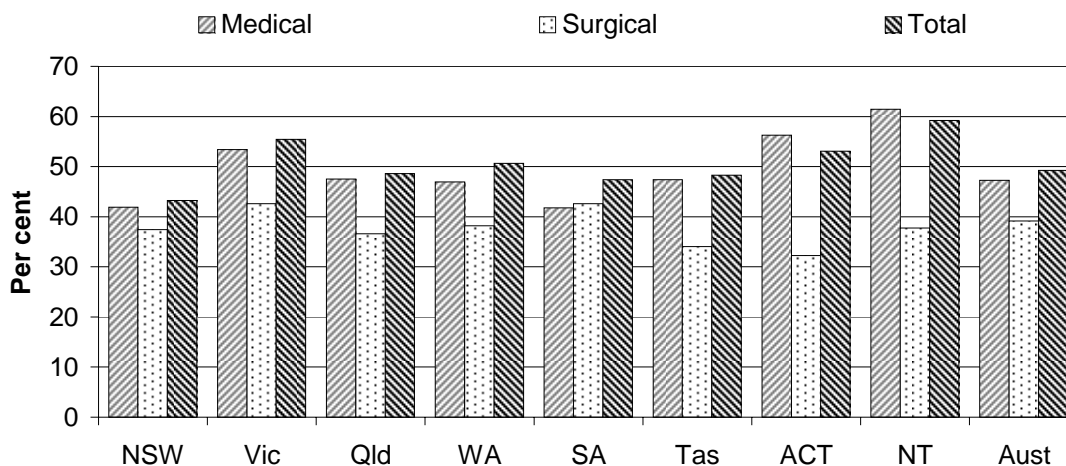
Source: AIHW (2002, 2003, 2004, 2005a, 2006a); table 9A.7.

Same day separations in public (non-psychiatric) hospitals increased by 2.1 per cent between 2003-04 and 2004-05, although same day separations as a proportion of total separations remained relatively constant over this period. Overnight separations in public (non-psychiatric) hospitals increased by 1.6 per cent between 2003-04 and 2004-05 (table 9A.7).

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

Variations in admission rates can reflect different practices in classifying patients as either admitted same day patients or outpatients. The extent of differences in classification practices can be inferred from the variation in the proportion of same day separations across jurisdictions. Jurisdictions that have a high proportion of same day separations are likely to have a lower threshold for admitting patients rather than treating them as outpatients. This is particularly true of medical separations. Significant variation across jurisdictions in the proportion of same day medical separations was evident in 2004-05 (figure 9.7). Lower jurisdictional variation is likely in admission practices for surgical procedures, as reflected by the lower variability in the proportion of same day surgical separations.

Figure 9.7 Proportion of medical, surgical and total separations that were same day, public (non-psychiatric) hospitals, 2004-05^a



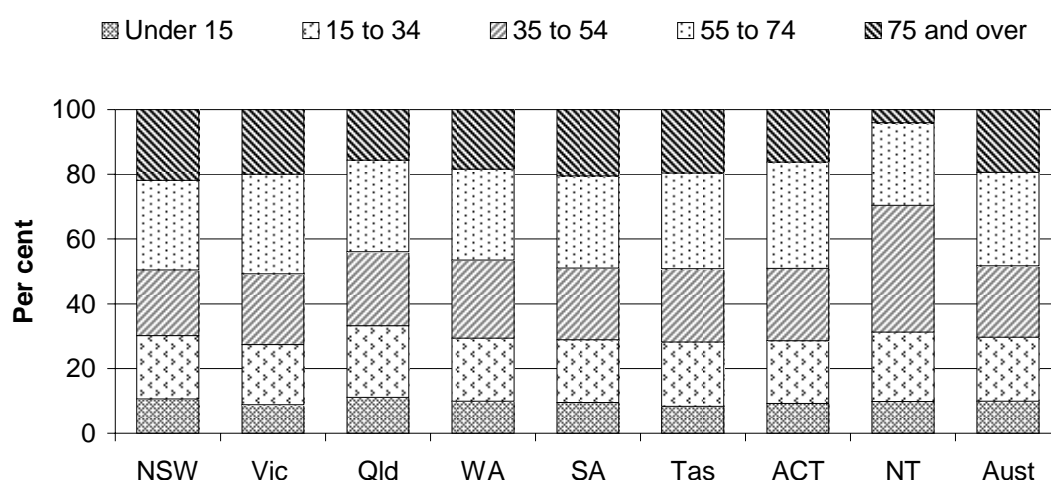
^a 'Total' includes medical, surgical, chemotherapy, radiotherapy and 'other' separations based on AR-DRG version 5.1 categories.

Source: AIHW (unpublished); table 9A.8.

Separations by age group

Persons aged 55 years and over accounted for almost half of the separations in public hospitals (48.2 per cent) in 2004–05, even though they accounted for only 23.7 per cent of the estimated resident population at 31 December 2004 (figure 9.8 and AIHW 2006a). The proportion of hospital separations for this and other age groups varies across states and territories (figure 9.8). This variation largely reflects differences in the age profiles of jurisdictions (see table AA.1).

Figure 9.8 Separations by age group, public hospitals, 2004-05^a



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

Source: AIHW (2006a); table 9A.9.

Separation rates for Indigenous patients

Data on Indigenous patients are limited by the accuracy and extent to which Indigenous people are identified in hospital records. Identification varies across states and territories. The report prepared by the AIHW and endorsed by relevant Australian Health Ministers' Advisory Council committees titled *Improving the Data Quality of Indigenous Identification in Hospital Separations Data* recommends the following:

- Only data from Queensland, WA, SA and the NT should be used for analytical purposes (either at the individual or aggregate level).
- Analyses based on data for Queensland, WA, SA and the NT in aggregate are limited by jurisdictional differences in data quality and the data are not necessarily representative of the jurisdictions excluded.
- Caution should be exercised in using Queensland, WA, SA and the NT time series data for analysis (either individually or in aggregate). Changes in hospitalisation rates for Indigenous people may be a result of changes in the ascertainment of Indigenous status for Indigenous patients (AIHW 2005b).

In 2004-05, separations for Indigenous people accounted for around 6.3 per cent of total separations and 10.2 per cent of separations in public hospitals in Queensland, WA, SA and the NT (table 9.1), but the Indigenous population made up only around 3.5 per cent of the population in these jurisdictions (table AA.4). Most Indigenous

separations (91.6 per cent) in these jurisdictions occurred in public hospitals. The low proportion of private hospital separations for Indigenous people may be due partly to a lower proportion of Indigenous patients being correctly identified in private hospitals and partly to their lower use of private hospitals.

Table 9.1 Separations, by Indigenous status and hospital sector, 2004-05
a, b

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	Total ^c
Public hospital separations ('000)										
Indigenous	np	np	56.2	38.6	14.3	np	np	50.3	np	159.4
Non-Indigenous	np	np	664.4	344.7	342.2	np	np	25.5	np	1 376.7
Not reported	np	np	13.2	–	9.1	np	np	0.1	np	22.4
Total	np	np	733.8	383.3	365.6	np	np	75.9	np	1 558.5
Private hospital separations ('000)										
Indigenous	np	np	3.7	9.0	0.3	np	np	np	np	14.7
Non-Indigenous	np	np	513.0	299.7	208.6	np	np	np	np	1 021.3
Not reported	np	np	160.1	–	3.0	np	np	np	np	163.0
Total	np	np	676.8	308.7	211.8	np	np	np	np	1 197.4
Indigenous separations as proportion of total separations (%)										
Public hospitals	np	np	7.7	10.1	3.9	np	np	66.3	np	10.2
Private hospitals	np	np	0.6	2.9	0.1	np	np	np	np	1.2
All hospitals	np	np	4.2	6.9	2.5	np	np	np	np	6.3
Separations in public hospitals as a proportion of separations in all hospitals (%)										
Indigenous	np	np	93.8	81.1	98.3	np	np	np	np	91.6
Non-Indigenous	np	np	56.4	53.5	62.1	np	np	np	np	57.4

^a Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement. ^b Identification of Indigenous patients is not considered complete and completeness varies across jurisdictions. The AIHW advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for the purpose of analysis (AIHW 2005b). Nevertheless, data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions. ^c The total rates include data only for Queensland, WA, SA, and the NT. – Nil or rounded to zero. np Not published.

Source: AIHW (2006a); table 9A.10.

In 2004-05, on an age standardised basis, 907.0 public hospitals separations (including same day separations) for Indigenous patients were reported per 1000 Indigenous people in Queensland, WA, SA and the NT (table 9.2). This rate was markedly higher than the corresponding rate for these jurisdictions' total population of 205.2 per 1000 (table 9.2). Incomplete identification of Indigenous people limits the validity of comparisons over time, as well as across jurisdictions.

Table 9.2 Estimates of public hospital separations per 1000 people, by reported Indigenous status^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld^c</i>	<i>WA^c</i>	<i>SA^c</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^c</i>	<i>Aust</i>	<i>Total^d</i>
2000-01										
Indigenous	np	np	671.6	852.2	772.6	np	np	1 031.6	np	np
Total population	np	np	195.5	199.7	228.8	np	np	370.9	np	np
2001-02										
Indigenous	np	np	676.5	752.7	743.6	np	np	1 129.6	np	np
Total population	np	np	192.5	190.7	229.7	np	np	394.3	np	np
2002-03										
Indigenous	np	np	685.2	809.4	788.1	np	np	1 223.3	np	np
Total population	np	np	189.4	195.4	231.0	np	np	422.5	np	np
2003-04										
Indigenous	np	np	710.9	789.3	853.9	np	np	1 286.2	np	np
Total population	np	np	189.3	191.0	235.9	np	np	428.9	np	np
2004-05										
Indigenous	np	np	733.6	821.5	822.2	np	np	1 441.0	np	907.0
Total population	np	np	188.1	195.2	225.3	np	np	456.2	np	205.2

^a The rates are directly age standardised to the Australian population at 30 June 2001. ^b Identification of Indigenous patients is not considered complete and completeness varies across jurisdictions and time.

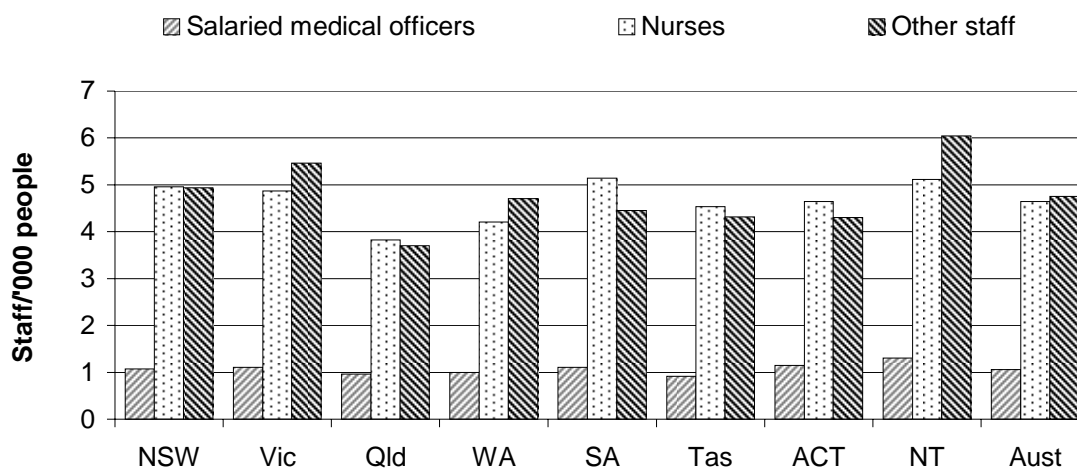
^c The AIHW advised that only data for Queensland, WA, SA and the NT are of acceptable quality. Nevertheless, data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality and changes in hospitalisation rates for Indigenous people over time might be the result of improved identification. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions (AIHW 2005b). ^d For 2004-05, total rates include data only for Queensland, WA, SA, and the NT. **np** Not published.

Source: AIHW (unpublished); table 9A.11.

Staff

In 2004-05, nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (4.6 per 1000 people in Australia) (figure 9.9). Comparing data on FTE staff across jurisdictions needs to be undertaken with care because these data are affected by differences across jurisdictions in the recording and classifying of staff. The outsourcing of services with a large labour related component (for example, food services and domestic services) can have a large impact on hospital staffing figures. Differences in outsourcing may explain some of the differences in FTE staff in some staffing categories and across jurisdictions (AIHW 2006a).

Figure 9.9 **Average FTE staff per 1000 people, public hospitals, 2004-05^{a, b, c, d, e, f}**



^a 'Other staff' include diagnostic and allied health professionals, other personal care staff, administrative and clerical staff, and domestic and other staff. ^b Where average FTE staff numbers were not available, staff numbers at 30 June 2005 were used. Staff contracted to provide products (rather than labour) are not included. ^c Staff per 1000 people are calculated from ABS population data at 31 December 2004 (table AA.2). ^d For Victoria, FTEs may be slightly understated. ^e Queensland pathology services staff employed by the State pathology service are not included. ^f Data for five small Tasmanian hospitals are not included.

Source: AIHW (2006a); ABS Australian Demographic Statistics (unpublished); tables 9A.12 and AA.2.

Activity — admitted patient care

There were around 4.3 million acute, sub-acute and non-acute separations in public hospitals in 2004-05. Of these, acute separations accounted for 95.9 per cent, newborns with some qualified days² accounted for 1.0 per cent and rehabilitation care accounted for 1.5 per cent (table 9A.13). (Palliative care, non-acute care and other care made up the residual.) Public psychiatric hospitals accounted for around 0.4 per cent of total separations in public hospitals in 2004-05. Of the total number of separations in public (non-psychiatric) hospitals, 49.2 per cent were for same day patients (table 9A.6).

Table 9.3 shows the 10 AR-DRGs with the highest number of overnight acute separations in public hospitals for 2004-05. These 10 AR-DRGs accounted for 17.0 per cent of all overnight acute separations.

² All babies born in hospital are admitted patients, but only qualified days for newborns are included in the patient day count under the Australian Health Care Agreements.

Table 9.3 Ten AR-DRGs (version 5.1) with the most overnight acute separations, public hospitals, 2004-05^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Separations for AR-DRGs as a proportion of all overnight acute separations (%)									
Vaginal Delivery W/O Cat/Severe CC	4.5	4.6	4.4	4.1	3.2	4.1	5.2	3.8	4.3
Chest Pain	2.3	1.9	2.5	1.4	2.0	1.4	1.4	2.0	2.1
Oesophagitis, Gastroent & Misc Digestive Systm Disorders									
Age>9 W/O Cat/Severe CC	1.8	1.6	1.8	1.8	2.0	1.7	1.3	1.0	1.7
Caesarean Delivery W/O Cat/Severe CC	1.6	1.7	2.0	1.5	1.3	1.6	1.9	1.5	1.7
Antenatal and other Obstetric Admission	1.6	1.5	1.8	1.9	1.4	1.4	1.5	3.0	1.6
Cellulitis (Age >59 W/O Cat/Severe CC) or Age <60	1.2	1.3	1.6	1.7	1.0	1.1	1.6	4.9	1.4
Vaginal Delivery Single Uncomplicated W/O Other Condition	1.1	0.7	1.8	0.9	0.8	1.0	1.3	1.4	1.1
Respiratory Infections/Inflammations W/O CC	1.1	1.0	1.1	1.2	1.0	1.0	1.1	1.8	1.1
Bronchitis and Asthma Age <50 W/O CC	1.1	1.0	0.9	1.1	1.2	0.6	0.7	0.6	1.0
Chronic Obstructive Airways Disease W Cat/Severe CC	1.1	1.0	0.8	0.8	1.0	1.0	0.4	1.3	1.0
Ten AR-DRGs with the most overnight acute separations (%)	17.5	16.2	18.6	16.4	15.0	15.0	16.4	21.2	17.0
Total overnight acute separations ('000)	729	510	361	182	181	43	28	31	2 065

cat = catastrophic. cc = complications and co-morbidities. sev = severe. w/o = without. w = with. ^a Includes separations for which the care type was reported as 'acute' or 'newborn with qualified days', or was not reported. ^b Totals may not add as a result of rounding. ^c Excludes same day separations and separations where patients stayed over 366 days.

Source: AIHW (unpublished); table 9A.14.

Table 9.4 lists the 10 AR-DRGs that accounted for the most patient days (18.1 per cent of all patient days recorded) in 2004-05. Schizophrenic disorders associated with mental health legal status accounted for the largest number of patient days, followed by vaginal delivery without complicating diagnosis.

Table 9.4 Ten AR-DRGs (version 5.1) with the most patient days, public hospitals, 2004-05^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Patient days for AR-DRGs as a proportion of all patient days (%)									
Schizophrenia Disorders W Mental Health Legal Status	3.2	3.4	4.4	4.1	3.9	2.5	2.0	1.0	3.5
Vaginal Delivery W/O Cat/Sev CC	2.5	2.6	2.3	2.5	1.8	2.1	2.5	2.4	2.4
Tracheostomy or Ventilation >95 hours	2.3	2.4	2.2	2.4	2.5	2.1	2.5	2.3	2.3
Major Affective Disorders Age <70 W/O Cat/Sev CC	2.0	1.8	2.2	2.8	2.5	2.3	2.6	1.3	2.1
Schizophrenia Disorders W/O Mental Health Legal Status	1.7	1.4	1.1	1.9	1.4	3.2	0.9	2.0	1.6
Chronic Obstructive Airways Disease W Cat/Sev CC	1.7	1.4	1.3	1.3	1.3	1.6	0.7	1.6	1.5
Caesarean Delivery W/O Cat/Sev CC	1.3	1.5	1.5	1.3	1.1	1.1	1.5	1.4	1.4
Cellulitis (Age >59 W/O Cat/Sev CC) or Age <60	1.0	1.3	1.3	1.1	0.7	0.8	1.2	3.4	1.1
Respiratory Infections/Inflammations W Cat CC	1.3	1.3	0.7	0.8	1.1	0.6	0.8	0.9	1.1
Respiratory Infections/Inflammations W Sev or Moderate CC	1.1	1.1	0.9	0.9	1.0	1.0	1.1	2.5	1.1
Ten AR-DRGs with the most patient days (%)	18.0	18.1	18.0	19.1	17.5	17.4	15.8	18.7	18.1
Total patient days ('000)	4 153	2 692	1 793	1 000	985	265	164	171	11 223

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

Source: AIHW (unpublished); table 9A.15.

Activity — non-admitted patient services

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

example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids (AIHW 2001a).

A total of 42.6 million individual occasions of service were provided to non-admitted patients in public hospitals in 2004-05 (table 9.5). In addition, public hospitals also delivered 396 498 group sessions during this time (a group session is defined as a service provided to two or more patients, excluding services provided to two or more family members) (table 9A.16). In public hospitals in 2004-05, accident and emergency services comprised 14.1 per cent of all occasions of service to non-admitted patients. 'Other medical, surgical and obstetric services', 'pathology services' and 'allied health' were the most common types of outpatient care (table 9.5).

Table 9.5 Ten most common types of individual non-admitted patient care, public hospitals, 2004-05^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^b</i>	<i>Aust</i>
Occasions of service for the most common types of non-admitted patient care as a proportion of all occasions of service for non-admitted patients (%)									
Accident and emergency	10.8	19.2	14.4	13.2	22.1	13.9	19.2	27.9	14.1
Outpatient services									
Other medical/surgical/obstetric	21.8	22.5	24.9	13.2	38.5	29.8	44.1	23.1	22.9
Allied health	8.2	15.1	5.8	20.1	10.5	11.0	8.9	3.3	10.2
Pathology	12.3	10.0	29.5	14.9	..	23.9	7.3	20.9	15.4
Radiology and organ imaging	3.8	7.9	8.9	8.2	12.7	8.6	13.5	17.3	6.8
Pharmacy	4.7	5.9	6.7	3.9	–	7.7	0.1	7.5	5.0
Mental health	4.9	10.2	1.0	0.8	1.1	0.2	0.9	–	4.1
Dental	4.0	2.5	3.9	0.3	0.3	0.2	–	–	3.0
Other non-admitted services									
Community health	10.7	3.9	1.9	18.2	–	0.1	2.1	–	7.6
District nursing ^c	11.2	2.4	0.8	4.0	–	–	–	–	5.8
Ten most common types of non-admitted patient care (%)	92.4	99.6	97.8	96.7	85.2	95.3	96.3	100.0	94.9
Total occasions of service for non-admitted patients ('000)	18 525	6 863	8 885	4 496	2 141	875	487	371	42 643

^a Individual non-admitted patient care services. Excludes group sessions. Reporting arrangements vary significantly across jurisdictions. ^b Radiology figures for the NT are underestimated and pathology figures relate to only three of the five hospitals. ^c Justice Health (formerly known as Corrections Health) in NSW reported 996 917 district nursing occasions of service. Their services may not be typical of district nursing. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2006a); table 9A.16.

9.2 Framework of performance indicators for public hospitals

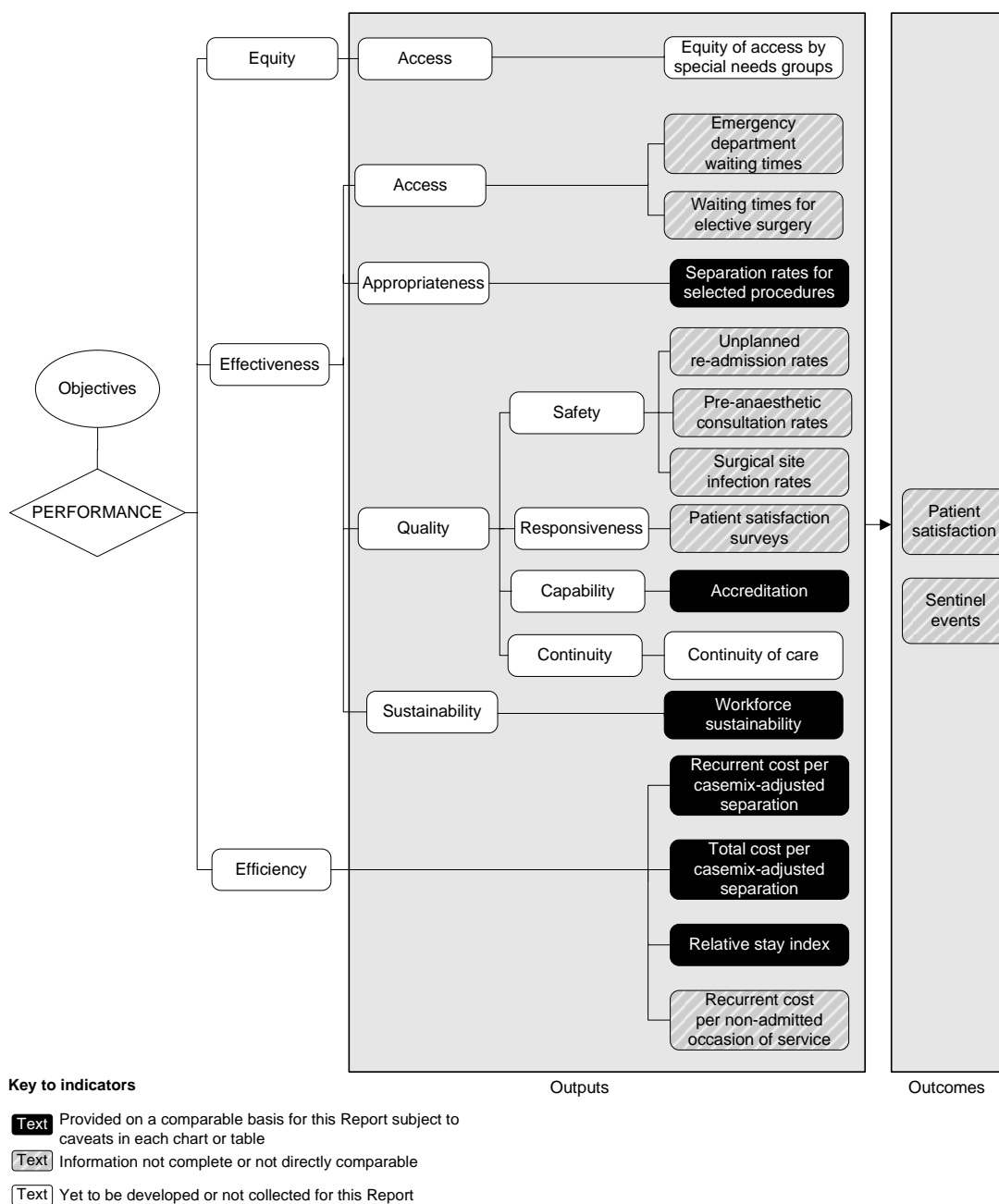
The performance indicator framework is based on the shared government objectives for public hospitals (box 9.2). The performance indicator framework shows which data are comparable in the 2007 Report (figure 9.10). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective. The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions of quality and sustainability that have been added to the standard Review framework for health services.

Box 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
- equitably and efficiently delivered.

Figure 9.10 Performance indicators for public hospitals



9.3 Key performance indicator results for public hospitals

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

As discussed in section 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 as desired from the analysis of some data differs across jurisdictions. Similarly, psychiatric treatments are provided in public (non-psychiatric) hospitals at different rates across jurisdictions.

Outputs — equity — access

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

Equity of access by special needs groups

The Steering Committee has identified ‘equity of access by special needs groups’ as an indicator of equity of access to public hospitals. This indicator is for development in future reports (box 9.3).

Box 9.3 Equity of access by special needs groups

‘Equity of access by special needs groups’ is a output-equity indicator of governments’ objective to provide accessible services. This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report.

Outputs — effectiveness — access

Emergency department waiting times

‘Emergency department waiting times’ are an indicator of effectiveness of access to public hospitals (box 9.4).

Box 9.4 Emergency department waiting times

‘Emergency department waiting times’ is a output–equity indicator of governments’ objective to provide accessible services. It measures the proportion of patients seen within the benchmarks set according to the urgency of treatment required.

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

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

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

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

^a The triage category indicates the urgency of the patient’s need for medical and nursing care.

The comparability of emergency department waiting times data across jurisdictions may be influenced by differences in data coverage (table 9.6) and clinical practices — in particular, the allocation of cases to urgency categories. The proportion of patients in each triage category who were subsequently admitted may indicate the comparability of triage categorisations across jurisdictions and thus the comparability of the waiting times data (table 9A.17).

Nationally, in 2004-05, 100 per cent of patients were seen within the triage category 1 timeframe and 76 per cent of patients were seen within the triage category 2 timeframe. For all triage categories, 69 per cent of patients were seen within triage category timeframes (table 9.6).

Table 9.6 Emergency department patients seen within triage category timeframes, public hospitals, 2004-05 (per cent)

<i>Triage category</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
1 — Resuscitation ^a	100	100	100	98	99	96	100	100	100
2 — Emergency	75	86	71	75	72	76	70	61	76
3 — Urgent	60	81	54	67	58	67	50	61	64
4 — Semi-urgent	66	73	57	65	62	64	52	55	65
5 — Non-urgent	87	89	85	91	89	91	83	86	88
Total	68	79	59	70	63	68	58	62	69
Data coverage ^b	76	88	64	68	68	84	100	100	76

^a Resuscitation patients whose waiting time for treatment was less than or equal to two minutes are considered to have been seen on time. ^b Data coverage is estimated as the number of occasions of service with waiting times data divided by the number of accident and emergency department occasions of service expressed as a percentage. This may underestimate coverage because some occasions of service are for other than emergency presentations, for which waiting times data are applicable. For 2004–05 data (unlike previous years), the occasions of service with waiting times data is the number of occasions of service reported with episode-level data. For some jurisdictions, the number of emergency department occasions of service reported to the Non-admitted Patient Emergency Department Care Database exceeded the number of accident and emergency occasions of service reported to the National Public Hospital Establishments Database. For these jurisdictions the coverage has been estimated as 100 per cent.

Source: AIHW (2006a); table 9A.17.

Waiting times for elective surgery

‘Waiting times for elective surgery’ is an indicator of effectiveness of access to public hospitals (box 9.5).

Box 9.5 Waiting times for elective surgery

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

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

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

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

(Continued on next page)

Box 9.5 (Continued)

'Elective surgery waiting times by clinical urgency category' reports the proportion of patients who have:

- had extended waits (waited longer than the clinically desirable time) at a particular census date
- been admitted from waiting lists after an extended wait.

The three generally accepted urgency categories for elective surgery are:

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

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

A smaller proportion of patients who have experienced extended waits at a particular census date and at admission is desirable.

Not all elective surgery is covered by these measures. The measures do not fully cover all the in-scope procedures (87 per cent in 2004-05) (table 9.7), and the in-scope procedures are defined as excluding a range of procedures that may be regarded as surgery, such as elective procedures involving the insertion of a stent.

Patients on waiting lists who were not subsequently admitted to hospital are excluded from both measures (box 9.5). Patients may be removed from waiting lists because they are admitted as emergency patients for the relevant procedure, no longer need the surgery, die, are treated at another location, decline to have the surgery, or cannot be contacted by the hospital (AIHW 2006a). In 2004-05, 14.8 per cent of patients were removed from waiting lists for reasons other than elective admission (AIHW 2006a).

The two measures are affected by variations across jurisdictions in the method used to calculate waiting times for patients who transferred from a waiting list managed by one hospital to a waiting list managed by a different hospital (AIHW 2006a). For patients who were transferred from a waiting list managed by one hospital to that managed by another, the time waited on the first list is included in the waiting time reported for some but not all states and territories (AIHW 2006a). NSW, Victoria, Queensland, WA and the ACT reported the total time waited on all waiting lists. This approach may have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions. SA and

Queensland have indicated that patients do not commonly switch between waiting lists managed by different hospitals in their jurisdictions (AIHW 2006a).

Nationally, in 2004-05, 90 per cent of patients were admitted within 217 days and 50 per cent were admitted within 29 days (table 9.7). The proportion of patients that waited more than a year was 4.8 per cent. Nationally, waiting times at the 50th percentile changed little between 2000-01 and 2004-05. In 2000-01, 27 days were waited at the 50th percentile, this increased to 29 days by 2004-05. However, there were different trends in different jurisdictions and for different sized hospitals over that period (figure 9.11 and table 9A.18).

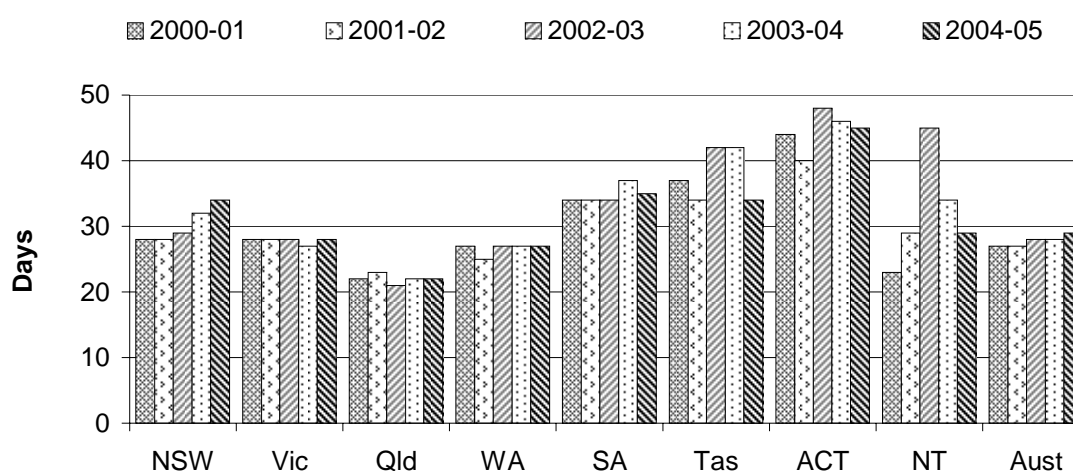
Table 9.7 Elective surgery waiting times, public hospitals, 2004-05

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Number of days waited at:										
50th percentile	no.	34	28	22	27	35	34	45	29	29
90th percentile	no.	294	200	105	197	201	352	368	266	217
Proportion who waited more than 365 days	%	6.9	4.0	1.8	3.8	4.0	9.5	10.1	5.9	4.8
Estimated coverage of elective surgery separations ^a	%	100	79	96	72	62	90	100	100	87

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

Source: AIHW (2006a); table 9A.18.

Figure 9.11 Days waited for elective surgery by the 50th percentile, public hospitals



Source: AIHW (2002, 2003, 2004, 2005a, 2006a); table 9A.18.

‘Elective surgery waiting times by urgency category’ are not comparable across jurisdictions because clinicians have systematically different approaches to categorisation by urgency. States and territories with lower proportions of patients in category 1 were also the states and territories that had relatively smaller proportions of patients in this category that were ‘not seen on time’. Victoria and the ACT, for example, had the lowest proportions of patients in category 1 and also had the lowest proportions of patients in category 1 that had extended waits (tables 9.8, 9A.23 and 9A.32). The apparent variation in performance thus appears to be related to the classification practices employed. Jurisdictional differences in the classification of patients by urgency category in 2004-05 are shown in table 9.8

While ‘elective surgery waiting times by urgency category’ are not comparable across jurisdictions, this measure has the advantage, over ‘overall elective surgery waiting times’, of aligning with the objective of providing hospital services within a clinically desirable period.

Table 9.8 Classification of elective surgery patients, by clinical urgency category, 2004-05 (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
Patients on waiting lists								
Category 1	10.9	1.7	7.1	8.0	7.2	na	2.7	8.0
Category 2	30.6	43.4	33.9	29.3	21.9	na	45.0	34.6
Category 3	58.6	54.9	59.0	62.7	70.9	na	52.3	57.4
Total	100.0	100.0	100.0	100.0	100.0	na	100.0	100.0
Patients admitted from waiting lists								
Category 1	42.5	21.3	35.2	35.6	35.0	na	37.7	42.1
Category 2	29.7	46.2	44.4	25.3	24.7	na	40.0	35.8
Category 3	27.9	32.6	20.4	39.1	40.3	na	22.2	22.1
Total	100.0	100.0	100.0	100.0	100.0	na	100.0	100.0

^a Categories may not add to 100 per cent due to rounding. **na** not available.

Source: State and Territory governments (unpublished).

Reporting of ‘elective surgery waiting times by clinical urgency category’ includes the proportion of patients waiting on the date of the census who had been waiting an extended period, as well as the proportion of patients with extended waits at admission. Census data do not represent the completed waiting time of patients (unlike patients with extended waits at admission).

Data were available from all jurisdictions (except Tasmania) for ‘elective surgery waiting times by clinical urgency category’ for this Report.

- Public hospital census data for NSW at 30 June 2005 suggest that 38.9 per cent of category 1 patients on the waiting list were subject to extended waits, as were 40.2 per cent of category 2 patients and 10.6 per cent of category 3 patients,

resulting in an overall rate of 22.7 per cent for all patients. Of patients admitted to hospital from waiting lists in 2004-05, 21.7 per cent of category 1 patients were subject to extended waits, 28.8 per cent of category 2 patients and 20.8 per cent of category 3 patients were subject to extended waits, resulting in an overall rate of 23.6 per cent for all patients (table 9A.21).

- Public hospital census data for Victoria at 30 June 2005 suggest that 0.7 per cent of category 1 patients on the waiting list were subject to extended waits, as were 42.3 per cent of category 2 patients and 20.8 per cent of category 3 patients, resulting in an overall rate of 29.7 per cent for all patients. Of patients admitted to hospital from waiting lists in 2004-05, no category 1 patients were subject to extended waits, 23.6 per cent of category 2 patients and 8.7 per cent of category 3 patients were subject to extended waits, resulting in an overall rate of 13.7 per cent for all patients (table 9A.23).
- Public hospital census data for Queensland at 1 July 2005 suggest that 5.4 per cent of category 1 patients on the waiting list were subject to extended waits, as were 11.3 per cent of category 2 patients and 30.5 per cent of category 3 patients, resulting in an overall rate of 22.2 per cent for all patients. Of patients admitted to hospital from waiting lists in 2004-05, 10.4 per cent of category 1 patients were subject to extended waits, as were 9.4 per cent of category 2 patients and 8.5 per cent of category 3 patients, resulting in an overall rate of 9.6 per cent for all patients (table 9A.25).
- Public hospital census data for WA at 30 June 2005 suggest that 40.9 per cent of category 1 patients on the waiting list were subject to extended waits, as were 52.4 per cent of category 2 patients and 24.9 per cent of category 3 patients, resulting in an overall rate of 34.2 per cent for all patients. Of patients admitted to hospital from waiting lists in 2004-05, 17.8 per cent of category 1 patients were subject to extended waits, as were 31.8 per cent of category 2 patients and 7.6 per cent of category 3 patients, resulting in an overall rate of 17.3 per cent for all patients (table 9A.27).
- Public hospital census data for SA at 30 June 2005 suggest that 19.8 per cent of category 1 patients on the waiting list were subject to extended waits, as were 27.9 per cent of category 2 patients and 13.5 per cent of category 3 patients, resulting in an overall rate of 17.1 per cent for all patients. Of patients admitted to hospital from waiting lists in 2004-05, 20.0 per cent of category 1 patients were subject to extended waits, as were 24.9 per cent of category 2 patients and 9.4 per cent of category 3 patients, resulting in an overall rate of 16.9 per cent for all patients (table 9A.29).
- Public hospital census data for the ACT at 30 June 2005 suggest that no category 1 patients on the waiting list were subject to extended waits, whereas 60.5 per cent of category 2 patients and 39.4 per cent of category 3 patients were

subject to extended waits, resulting in an overall rate of 45.3 per cent for all patients. Of patients admitted from waiting lists in 2004-05, 10.7 per cent of category 1 patients were subject to extended waits, as were 68.6 per cent of category 2 patients and 20.7 per cent of category 3 patients, resulting in an overall rate of 32.5 per cent for all patients (table 9A.32).

- Public hospital census data for the NT at 30 June 2005 suggest that 61.4 per cent of category 1 patients on the waiting list were subject to extended waits, as were 64.2 per cent of category 2 patients and 42.2 per cent of category 3 patients resulting in an overall rate of 55.9 per cent for all patients. Of patients admitted from waiting lists in 2004-05, 17.2 per cent of category 1 patients were subject to extended waits, as were 30.5 per cent of category 2 patients and 14.9 per cent of category 3 patients, resulting in an overall rate of 21.5 per cent for all patients (table 9A.34).

Attachment 9A includes data on ‘elective surgery waiting times’ by hospital peer group, specialty of surgeon and indicator procedure (tables 9A.18, 9A.19 and 9A.20). Tasmanian data for 2000-01 are reported in table 9A.31. All jurisdictions (except Tasmania) also provided data on urgency category waiting times by clinical specialty for 2004-05 (tables 9A.22, 9A.24, 9A.26, 9A.28, 9A.30, 9A.33 and 9A.35).

Outputs — effectiveness — appropriateness

Separation rates for selected procedures

‘Separation rates for selected procedures’ is an indicator of the appropriateness of public hospital services (box 9.6).

Box 9.6 Separation rates for selected procedures

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

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

Higher/lower rates are not necessarily associated with inappropriate care. Large jurisdictional variations in rates for particular procedures, however, may require investigation to determine whether underservicing or overservicing is occurring.

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

The 'separation rates for selected procedures' reported here include all hospitals and reflect the activities of both public and private health systems.³ The most common procedures in 2004-05 were endoscopies, lens insertions, arthroscopic procedures and caesarean sections (table 9.9). For all procedures, separation rates varied across jurisdictions. Statistically significant and material differences in the separation rates for these procedures may highlight variations in treatment methods across jurisdictions. Table 9A.36 presents standardised separation rate ratios — comparing the separation rate in each jurisdiction with the national rate — along with confidence intervals for each ratio.

³ Data include public acute, public psychiatric, private acute, private psychiatric and private free-standing day hospital facilities. Some private hospitals are not included, which may result in undercounting of some procedures, particularly procedures more likely to be performed in private hospitals (AIHW 2006a).

Table 9.9 Separations for selected procedures or diagnoses per 1000 people, all hospitals, by patient's usual residence, 2004-05^{a, b, c, d}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total ^e
<i>Procedure/diagnosis</i>									
Appendectomy	1.3	1.3	1.5	1.6	1.4	1.3	1.4	1.6	1.4
Coronary artery bypass	0.7	0.7	0.8	0.4	0.6	0.5	0.5	0.9	0.7
Coronary angioplasty	1.7	1.7	1.3	1.5	1.5	1.3	1.8	1.2	1.6
Caesarean section: separation rate	3.7	3.8	4.4	4.3	4.0	3.3	3.3	4.2	4.0
separations per 100 in-hospital births ^f	28.1	30.5	32.3	33.2	32.4	25.9	27.8	29.5	30.3
Cholecystectomy	2.2	2.3	2.3	2.2	2.4	2.1	1.9	1.6	2.3
Diagnostic gastrointestinal endoscopy	25.4	32.7	28.6	26.8	24.5	15.7	11.1	19.0	27.5
Hip replacement	1.3	1.4	1.2	1.5	1.4	1.4	1.6	0.8	1.3
Revision of hip replacement	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.1	0.2
Hysterectomy ^g	1.3	1.3	1.4	1.6	1.7	1.3	1.3	1.2	1.4
Lens insertion	8.2	7.5	9.0	8.3	7.1	3.0	6.4	7.0	7.9
Tonsillectomy	1.7	1.8	1.6	1.7	2.3	0.8	1.2	0.8	1.7
Myringotomy	1.3	1.8	1.4	2.0	3.1	1.1	1.1	0.7	1.6
Knee replacement	1.6	1.2	1.4	1.5	1.5	1.1	2.0	0.9	1.4
Prostatectomy	1.3	1.5	1.2	1.3	1.1	1.2	1.1	1.6	1.3
Arthroscopic procedures ^h	5.0	6.0	4.8	7.3	8.6	4.0	6.2	8.1	5.8

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

Source: AIHW (2006a); table 9A.36.

Outputs — effectiveness — quality

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

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

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

Various states and territories publicly report performance indicators for public hospital quality. Some have adopted the same indicators as reported here. In NSW, for example, reporting of Australian Council on Health Care Standards (ACHS) 'surgical site infection rates' is mandatory for public hospitals. Both the WA and Tasmanian health department annual reports include information on 'unplanned re-admission rates'. All Victorian hospitals are required to publish annual quality care reports that include safety and quality indicators for infection control, medication errors, falls monitoring and prevention, and pressure wound monitoring and prevention.

Safety

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

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

public hospitals in the Comparative Report Service (Clinical Indicators) is generally voluntary, so the data are not necessarily drawn from representative samples of hospitals (box 9.7).

Box 9.7 Reporting of ACHS clinical indicators

The data for the clinical indicators of 'unplanned re-admissions to hospital', 'pre-anaesthetic consultation rates' and 'surgical site infection rates' come from the ACHS. The ACHS's method for reporting clinical indicators is explained in *Determining the Potential to Improve Quality of Care* (ACHS 2003). The ACHS reports the average (that is, mean) rate of occurrence of an event and the performance of hospitals at the 20th and 80th centiles. Where a lower rate implies better quality, national performance at the 20th centile represents the rate at, or below which, the best performing 20 per cent of ACHS reporting hospitals performed. Where a higher rate implies better quality, national performance at the 80th centile represents the rate at, or above which, the best performing 20 per cent of ACHS reporting hospitals performed. This method is designed to allow hospitals to determine whether their performance is above or below average, and what scope may exist for improvement.

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

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

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

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

(Continued on next page)

Box 9.7 (Continued)

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

Source: ACHS (unpublished, 2003).

Safety — unplanned re-admission rates

‘Unplanned re-admission rates’ are an indicator of hospital safety (box 9.8). These estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are potentially unreliable. The statistical terms used to describe this indicator are explained in box 9.9.

Box 9.8 Unplanned re-admission rates

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

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

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

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

Box 9.9 **Definition of terms for ACHS clinical indicators**

centile: value separating one 100th parts of a distribution in order of size. Where a lower rate implies better quality, national performance at the 20th centile represents the rate at, or below which, the best performing 20 per cent of ACHS reporting hospitals performed. Where a higher rate implies better quality, national performance at the 80th centile represents the rate at, or above which, the best performing 20 per cent of ACHS reporting hospitals performed.

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

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

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

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

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

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

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

stratum rate: mean rates for a particular jurisdiction.

Source: ACHS (2001).

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2005, the mean rate of ‘unplanned re-admissions’ was 2.8 per 100 admissions (table 9.10). The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th

centile, there would be 1.8 per cent (or 21 917) fewer re-admissions to these public hospitals (ACHS unpublished). National performance at the 20th centile shows the rate at, or below which, the best performing 20 per cent of ACHS reporting hospitals performed.

These national results are based on approximately one quarter of total public hospital separations. The number of ACHS reporting hospital separations used to derive this indicator was 1.2 million in 2005 (ACHS unpublished), whereas the total number of separations in 2004-05 (excluding patient deaths) was 4.2 million (AIHW 2006a).

For jurisdictions with more than five hospitals reporting 'unplanned re-admissions' to the ACHS Comparative Report Service, the mean rates of unplanned re-admissions in 2005 are shown in table 9.10. The coverage of the ACHS data may differ across these states. Data for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals reported 'unplanned re-admissions' in each of those jurisdictions.

Table 9.10 **Unplanned re-admissions, ACHS reporting public hospitals, 2005^a**

	<i>Unit</i>	<i>Results</i>
National rate	%	2.8
National performance at 80th centile (rate)	(%)	5.0
National performance at 20th centile (rate)	(%)	0.9
NSW		
Numerator (re-admissions)	no.	15 791
Denominator (separations)	no.	451 498
Rate	%	3.5
Standard error (±)		0.2
ACHS reporting hospitals	no.	63
Victoria		
Numerator (re-admissions)	no.	6 742
Denominator (separations)	no.	277 856
Rate	%	2.4
Standard error (±)		0.3
ACHS reporting hospitals	no.	33
Queensland		
Numerator (re-admissions)	no.	3 162
Denominator (separations)	no.	125 852
Rate	%	2.5
Standard error (±)		0.4
ACHS reporting hospitals	no.	13
WA		
Numerator (re-admissions)	no.	1 944
Denominator (separations)	no.	148 147
Rate	%	1.3
Standard error (±)		0.4
ACHS reporting hospitals	no.	31
SA		
Numerator (re-admissions)	no.	3 855
Denominator (separations)	no.	80 099
Rate	%	4.8
Standard error (±)		0.5
ACHS reporting hospitals	no.	11

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

Source: ACHS (unpublished); tables 9A.37; 9A.38, 9A.39; 9A.40 and 9A.41.

Safety — pre-anaesthetic consultation rates

‘Pre-anaesthetic consultation rates’ are an indicator of hospital safety (box 9.10). Due to a redevelopment of the ACHS’s anaesthetic indicators between their 2004 and 2005 data collection there has been a significant reduction in the number of hospitals providing data for this indicator for this year’s Report. Pre-anaesthetic consultation rate estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are potentially unreliable. The statistical terms used to describe this indicator are explained in box 9.9.

Box 9.10 Pre-anaesthetic consultation rates

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

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

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

Source: ACHS (2004).

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2005, the mean rate of ‘pre-anaesthetic consultations’ was 87.3 per 100 procedures (table 9.11). The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 80th centile, there would be 12.5 per cent (or 659) more pre-anaesthetic consultations in these public hospitals (ACHS unpublished). National performance at the 80th centile shows the rate at, or above which, the best performing 20 per cent of ACHS reporting hospitals performed.

These national results are based on approximately 0.4 per cent of total public acute hospital anaesthetic procedures. The number of ACHS reporting hospital procedures used to derive this indicator was 5250 in 2005 (ACHS unpublished).

Whereas the estimated total number of anaesthetic procedures in 2004-05 was 1.3 million (AIHW 2006a).

NSW was the only jurisdiction with five or more hospitals reporting 'pre anaesthetic consultations' to the ACHS Comparative Report Service in 2005 (table 9.11). Data for 2005 for other jurisdictions are not reported separately because fewer than five hospitals reported 'pre-anaesthetic consultations' in each of those jurisdictions. Data for previous years are reported for Victoria, Queensland and SA in tables 13A.43, 13A.44 and 13A.45 respectively.

Table 9.11 **Pre-anaesthetic consultation rates, ACHS reporting public hospitals, 2005^a**

	<i>Unit</i>	<i>Results</i>
National rate	%	87.3
National performance at 80th centile (rate)	(%)	99.8
National performance at 20th centile (rate)	(%)	84.8
<i>New South Wales</i>		
Numerator (pre-anaesthetic consultations)	no.	1 794
Denominator (procedures)	no.	1 949
Rate	%	92.0
Standard error (\pm)		9.5
ACHS reporting hospitals	no.	5

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

Source: ACHS (unpublished); table 9A.42.

Safety — surgical site infection rates

'Surgical site infection rates' are reported for four frequently performed procedures — hip prosthesis, knee prosthesis, lower segment caesarean section and abdominal hysterectomy (box 9.11). These estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that the data may be potentially unreliable. The statistical terms used to describe this indicator are explained in box 9.9.

Box 9.11 Surgical site infection rates

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

This indicator is calculated as the average (that is, mean) rate of post-operative in-hospital occurrence of surgical site infection rates for selected surgical procedures (see section 9.8 for definitions). Rates are reported for hip and knee prosthesis, lower segment caesarean section and abdominal hysterectomy. Low ‘surgical site infection rates’ are consistent with the quality standards required in the public hospital sector.

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

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2005, the mean ‘surgical site infection rate’ for hip prosthesis surgery was 2.1 per 100 separations. The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 0.4 per cent (or 14) fewer infections after hip prosthesis surgery in these public hospitals (ACHS unpublished). National performance at the 20th centile shows the rate at, or below which, the best performing 20 per cent of ACHS reporting hospitals performed.

The mean ‘surgical site infection rate’ following knee prosthesis surgery was 1.5 per 100 separations. The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 0.5 per cent (or 15) fewer infections following knee prosthesis surgery in these public hospitals (ACHS unpublished).

The mean ‘surgical site infection rate’ following lower segment caesarean section surgery was 1.3 per 100 separations. The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 0.7 per cent (or 74) fewer infections following lower segment caesarean section surgery in these public hospitals (ACHS unpublished).

The mean ‘surgical site infection rate’ following abdominal hysterectomy surgery was 1.6 per 100 separations. The ACHS estimated that if the performance of all Australian public hospitals matched national performance at the 20th centile, there

would be 1.1 per cent (or 9) fewer infections following abdominal hysterectomy surgery (ACHS unpublished).

These national results are based on approximately 25 per cent of hip prosthesis, 30 per cent of knee prosthesis, 20 per cent of lower segment caesarean section and 10 per cent of abdominal hysterectomy surgical procedures. The number of ACHS reporting hospital surgical procedures in 2005 used to derive this indicator was 3217 for hip prosthesis, 3257 for knee prosthesis, 10 156 for lower segment caesarean section and 769 for abdominal hysterectomy, whereas the total number of these surgical procedures in 2004-05 was around 13 200 for hip prosthesis, 9700 for knee prosthesis, 47 400 for lower segment caesarean section and 8200 for abdominal hysterectomy surgical procedures (AIHW 2006a).

For jurisdictions with more than five hospitals reporting 'surgical site infections' to the ACHS Comparative Report Service, the mean rates in 2005 are shown in table 9.12. The coverage of the ACHS data may differ across these states. 'Surgical site infection rates' for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals participated in the ACHS Comparative Report Service.

Table 9.12 Surgical site infections, ACHS reporting public hospitals, by selected procedure, 2005^{a, b}

	<i>Unit</i>	<i>Hip prosthesis</i>	<i>Knee prosthesis</i>	<i>Lower segment caesarean section</i>	<i>Abdominal hysterectomy</i>
National rate	%	2.1	1.5	1.3	1.6
National performance at 80th centile (rate)	(%)	2.5	2.3	3.3	1.2
National performance at 20th centile (rate)	(%)	1.7	1.1	0.6	0.4
NSW					
Numerator (infections)	no.	9	3	10	np
Denominator (procedures)	no.	575	657	1 253	np
Infection rate	%	1.6	0.5	0.8	np
Standard error (±)		0.2	0.2	0.3	np
ACHS reporting hospitals	no.	10	9	9	np
Victoria					
Numerator (infections)	no.	25	11	np	np
Denominator (procedures)	no.	554	453	np	np
Infection rate	%	4.5	2.4	np	np
Standard error (±)		0.2	0.2	np	np
ACHS reporting hospitals	no.	5	5	np	np
Queensland					
Numerator (infections)	no.	14	13	32	5
Denominator (procedures)	no.	820	938	4 627	477
Infection rate	%	1.7	1.4	0.7	1.0
Standard error (±)		0.2	0.2	0.2	0.6
ACHS reporting hospitals	no.	11	11	10	7
WA					
Numerator (infections)	no.	8	13	31	np
Denominator (procedures)	no.	609	705	1 629	np
Infection rate	%	1.3	1.8	1.9	np
Standard error (±)		0.2	0.2	0.3	np
ACHS reporting hospitals	no.	7	7	10	np

(Continued on next page)

Table 9.12 (Continued)

	<i>Unit</i>	<i>Hip prosthesis</i>	<i>Knee prosthesis</i>	<i>Lower segment caesarean section</i>	<i>Abdominal hysterectomy</i>
SA					
Numerator (infections)	no.	np	np	31	np
Denominator (procedures)	no.	np	np	1 667	np
Infection rate	%	np	np	1.9	np
Standard error (\pm)		np	np	0.3	np
ACHS reporting hospitals	no.	np	np	6	np

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

Source: ACHS (unpublished); tables 9A.46, 9A.47, 9A.48, 9A.49, 9A.50.

Responsiveness — patient satisfaction surveys

The use of ‘patient satisfaction surveys’ is an indicator of responsiveness in public hospitals (box 9.12). In previous editions of this Report, this indicator provided information on whether, and when, jurisdictions have conducted patient satisfaction surveys in recent years. This section now reports how jurisdictions *use* patient satisfaction surveys to improve the quality of public hospital services.

Box 9.12 Patient satisfaction surveys

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

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

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

- In Victoria, survey findings were used by hospitals to inform quality improvement initiatives, including professional development programs (table 9A.69).
- In Queensland, individual hospital reports were disseminated to District and General Managers of Area Health Services for analysis. These managers identify low performance areas and develop action plans for improvement (table 9A.70).
- In WA, each participating hospital receives detailed information from the survey that is used to inform service improvement. Hospitals can also request a workshop to assist in the interpretation of the survey results. In addition many hospitals use patient satisfaction scores as hospital-based performance indicators. Some more specific examples of how hospitals have used the survey to improve public hospital quality include:
 - development of display posters and pamphlets that are given to patients to inform them of their rights and responsibilities and the complaint procedure
 - implementation of a fast track system to reduce waiting time in the Emergency Department
 - introduction of a pictorial booklet and pre-operation unit tours for paediatric patients to reduce anxiety and improve communication
 - movement of patient care plans from the nurse station to patient bedside in order to encourage communication (table 9A.71).
- In SA, each hospital was asked to formulate action plans in response to the survey. These action plans were to target specific service and/or care areas. While it is too early to report on changes made as a result of the 2005 Survey, for those hospitals that submitted action plans in response to the 2003 Survey substantial improvements in satisfaction scores were made in the service and care areas targeted (table 9A.72).
- In Tasmania, the results of the surveys were used to make a number of recommendations, including that there should be:
 - additional training provided to staff regarding the new electronic beds

-
- improved facilities for patients utilising psychiatric care (including increased diversional therapy)
 - increased use of the services provided by volunteers (table 9A.73).
 - In the ACT, the results of one survey (focussing on emergency departments) were used to improve training for junior medical officers and nurses. Junior medical officers now receive training to help them communicate better with patients, such as when explaining diagnoses and post-care and the reasons for time delays. Nurses received similar assistance regarding explaining emergency department process and time delays. Education was also provided to junior and senior medical officers regarding patient satisfaction scores and feedback (table 9A.74).

Capability — hospital accreditation

‘Hospital accreditation’ is an indicator of capability in public hospitals (box 9.13). Data for this indicator are shown in figure 9.12.

Box 9.13 Accreditation

‘Accreditation’ signifies professional and national recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals may seek accreditation through the ACHS Evaluation and Quality Improvement Program, Business Excellence Australia (previously known as the Australian Quality Council), the Quality Improvement Council, and through certification as compliant with the International Organization for Standardization’s (ISO) 9000 quality family or other equivalent programs. Jurisdictions apply specific criteria to determine which accreditation programs are suitable. Quality programs require hospitals to demonstrate continual adherence to quality improvement standards to gain and retain accreditation.

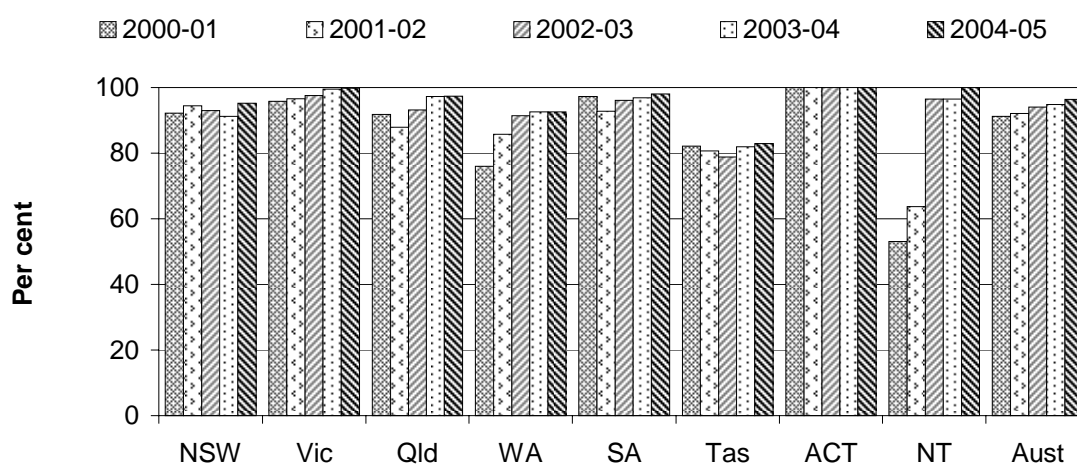
‘Accreditation’ is reported as the ratio of accredited beds to all beds in public hospitals, because the number of beds indicates the level of hospital capacity or activity. Accreditation of healthcare facilities has contributed significantly to quality practices and system wide awareness of quality issues, although accreditation processes could be improved (ACSQHC 2002). High levels of accreditation amongst hospitals are associated with high quality standards in the public hospital sector.

(Continued on next page)

Box 9.13 (Continued)

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

Figure 9.12 Proportion of accredited beds, public hospitals^{a, b}



^a Where average available beds for the year were not available, bed numbers at 30 June were used.

^b Includes psychiatric hospitals.

Source: AIHW (2006a and various issues); table 9A.51.

Continuity — continuity of care

The Steering Committee has identified 'continuity of care' as an indicator of the continuity aspect of public hospital quality. This indicator is for development in future reports (box 9.14).

Box 9.14 Continuity of care

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

Outputs — effectiveness — sustainability

Workforce sustainability

‘Workforce sustainability’ is an indicator of public hospital sustainability and is reported for the first time this year (box 9.15).

Box 9.15 Workforce sustainability

The ‘workforce sustainability’ indicator helps determine whether sustainability problems might arise in the delivery of current/future public hospitals services. Labour is the most significant and costly resource used in providing public hospital services (figure 9.17). Nurses and medical practitioners are the most significant groups of skilled professionals employed in public hospitals (figure 9.9). The sustainability of ‘public hospital’ services is affected by a number of factors relating to these groups, in particular, whether the number of new entrants (those aged under 30 years are used as a proxy measure) are sufficient to maintain the existing workforce, and the proportion of the workforce who are close to retirement (those aged 55 years and over are used as a proxy measure).

Two measures are reported for the nurse and medical practitioner workforces. The proportion of each workforce who are:

- new entrants (aged under 30 years)
- close to retirement (aged 55 years and over).

These measures are reported by region and over time.

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

Limitations exist with using the sustainability of the whole nurse and medical practitioner workforce to indicate sustainability of public hospitals services. The limitations are that it assumes:

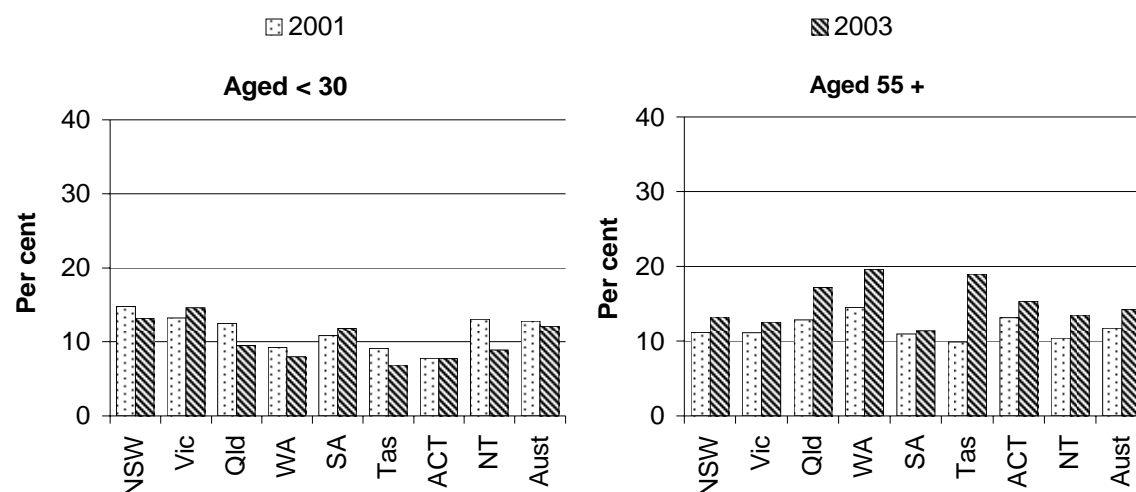
- all nurses and medical practitioners are in the potential workforce for public hospitals
- the proportions of new entrants and those close to retirement are the same for the public hospital workforce as the total nurse and medical practitioner workforce.

These indicators cannot substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. They can, however, indicate that further attention should be given to the issue.

Source: National Health Performance Committee (2004).

The proportions of the nursing workforce (which includes midwives) who are new entrants or potential retirees are shown in figure 9.13. Nursing workforce data by region are shown in table 9A.52.

Figure 9.13 New entrants to and potential retirees from the nursing workforce (per cent)^a

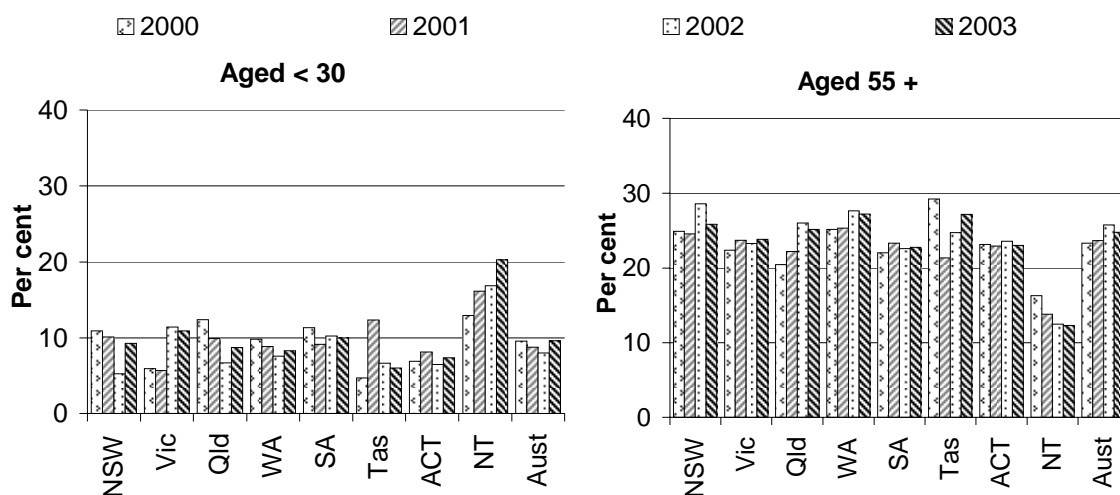


^a The following are included in the count of registered and enrolled nurses (including midwives) in the workforce: those who are employed in nursing, on extended leave and looking for work in nursing.

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

The proportions of the medical practitioner workforce who are new entrants or potential retirees are shown in figure 9.14. Medical practitioner workforce data by region are shown in table 9A.53.

Figure 9.14 **New entrants to and potential retirees from the medical practitioner workforce (per cent)^a**



^a The following are included in the count of medical practitioners in the workforce: those who are employed as a medical practitioner, on extended leave and looking for work as a medical practitioner.

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

Outputs — efficiency

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

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

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

regarding data comparability, the Steering Committee initiated a study, reported in *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001). The aim of the study was to examine the extent to which differences in asset measurement techniques applied by participating agencies may affect the comparability of reported unit costs.

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

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

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

Recurrent cost per casemix-adjusted separation

‘Recurrent cost per casemix-adjusted separation’ is an indicator of the efficiency of public hospitals (box 9.16). ‘Recurrent cost per casemix-adjusted separation’ data are presented in figure 9.15.

Box 9.16 Recurrent cost per casemix-adjusted separation

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

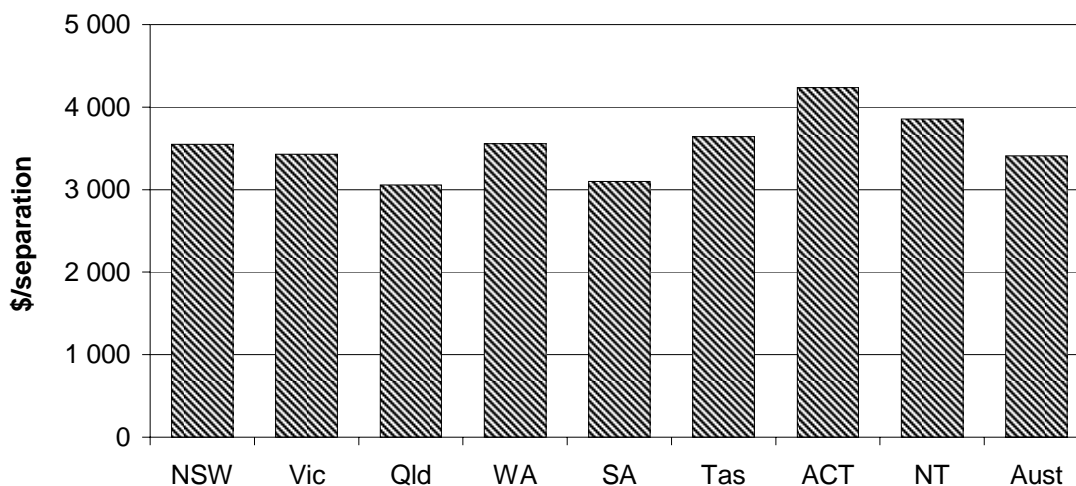
This measure includes overnight stays, same day separations, private patient separations in public hospitals and private patient recurrent costs. It excludes non-acute hospitals, mothercraft hospitals, multipurpose hospitals, multipurpose services, hospices, rehabilitation hospitals, psychiatric hospitals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

All admitted patient separations and their costs are included, and most separations are for acute care. Cost weights are not available for admitted patients who received non-acute care (about 3 per cent of total admitted patient episodes in 2004-05), so the cost weights for acute care are applied to non-acute separations also. The admitted patient cost proportion is an estimate only.

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

Lower ‘recurrent cost per casemix-adjusted separation’ may reflect more efficient service delivery in public hospitals. This indicator needs to be viewed, however, in the context of the set of performance indicators as a whole. A hospital may be a low cost provider of services, yet provide services ineffectively — for example, relatively low unit costs may be associated with inferior service quality.

Figure 9.15 **Recurrent cost per casemix-adjusted separation, 2004-05**^{a, b, c, d, e, f, g}

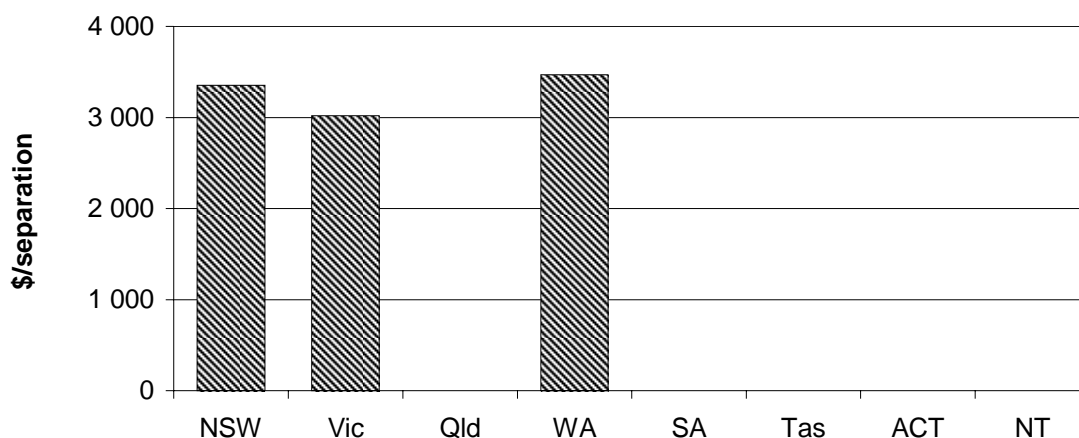


^a Excludes depreciation and the user cost of capital, spending on non-admitted patient care and research costs. ^b Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights are from the National Hospital Morbidity Database, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2003–04 AR-DRG v 5.0 cost weights (DHA 2005). ^c Excludes separations for which the care type was reported as 'newborn with no qualified days', and records for hospital boarders and posthumous organ procurement. ^d Psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute hospitals and multi-purpose services are excluded from these data. The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included. ^e Of the selected hospitals, three small hospitals had their admitted patient cost proportion estimated by the Health and Allied Services Advisory Council ratio. Admitted patient cost proportion was previously called the inpatient fraction. ^f Hospital recurrent expenditures on Indigenous and non-Indigenous people may differ (AIHW 2001b). These differences may influence jurisdictional variation in unit costs. ^g NT data need to be interpreted in conjunction with the cost disabilities associated with hospital service delivery in the NT.

Source: AIHW (2006a); table 9A.54.

Experimental estimates of 'recurrent cost per casemix-adjusted separation' for acute non-psychiatric patients are reported for NSW, Victoria and WA (figure 9.16). (These estimates relate to a subset of the selected public hospitals reported in figure 9.15 and are not available for other jurisdictions.) The experimental estimates aim to overcome the need to apply cost weights for acute care to non-acute care separations (box 9.16). The effect of restricting the analysis to acute non-psychiatric admitted patients was to decrease the estimated recurrent cost per casemix-adjusted separation for the subset of hospitals (figure 9.16) by 4.2 per cent for NSW, 10.7 per cent for Victoria and 2.4 per cent for WA (AIHW 2006a).

Figure 9.16 **Recurrent cost per acute non-psychiatric casemix-adjusted separation, subset of hospitals, 2004-05^{a, b, c, d, e, f}**



^a Excludes psychiatric hospitals, mothercraft hospitals, hospices, small non-acute, un-peered and other hospitals, rehabilitation facilities, and multi-purpose services. This subset excludes hospitals where the inpatient fraction was equal to the acute inpatient fraction and more than 1000 non-acute patient days were recorded. Also excludes hospitals where the apparent cost of not acute patients exceeded \$1000 per day and more than \$1 000 000 of apparent expenditure on non-acute patients days was reported. ^b Acute separations are those where the care type is acute, newborn with qualified days, or not reported. Psychiatric separations are those with psychiatric care days. ^c Average cost weight from the National Hospital Morbidity Database, based on acute and unspecified separations and episodes of newborn care with qualified days, using the 2003-04 AR-DRG version 5.0 cost weights (DHA 2005). ^d Cost estimates include adjustment for private patient medical costs: \$154 for New South Wales, \$76 for Victoria and \$88 for Western Australia. ^e These estimates are not available for Queensland, SA, Tasmania, the ACT and the NT. ^f Data are from table A3.13 in AIHW (2006a).

Source: AIHW (2006a); table 9A.54.

‘Recurrent cost per casemix-adjusted separation’ is affected by differences in the mix of admitted patient services produced by hospitals in each jurisdiction. Hospitals have been categorised by ‘peer groups’ to enable those with similar activities to be compared. The dominant peer classification is the ‘principal referral and specialist women’s and children’s’ category. This category includes:

- metropolitan hospitals with more than 20 000 acute casemix-adjusted separations per year
- rural hospitals with more than 16 000 acute casemix-adjusted separations per year
- acute women’s and children’s hospitals with more than 10 000 acute casemix-adjusted separations per year.

In 2004-05, these hospitals accounted for 69.9 per cent of public acute and psychiatric hospital expenditure and 68.7 per cent of separations (AIHW 2006a). The data for principal referral hospitals (excluding specialist women’s and

children's hospitals) are presented in table 9.13. Detailed data for all peer groups are presented in table 9A.55.

Table 9.13 Recurrent cost per casemix-adjusted separation, principal referral public hospitals, 2004-05^{a, b, c}

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Hospitals	no.	23	15	14	3	4	2	1	2	64
Average beds per hospital	no.	411	563	390	552	404	405	495	230	444
Average separations per hospital	no.	33 298	60 158	35 917	58 857	48 206	34 602	47 496	32 258	42 526
Average cost weight	no.	1.18	0.98	1.06	1.09	1.12	1.07	1.09	0.78	1.07
Cost per casemix-adjusted separation	\$	3 622	3 368	3 102	np	np	3 490	np	3 739	3 401
Recurrent expenditure on principal referral hospitals	\$m	4 593	4 248	2 263	np	np	333	np	238	13 835
Recurrent expenditure on all public hospitals	\$m	7 850	5 774	3 274	2 033	1 701	459	389	282	21 762

^a Principal referral hospitals are classified as metropolitan hospitals with more than 20 000 acute casemix-adjusted separations per year and rural hospitals with more than 16 000 acute casemix-adjusted separations per year. ^b Expenditure data exclude depreciation and the user cost of capital, spending on non-admitted patient care and research costs. ^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 2003-04 AR-DRG version 5.0 cost weights (DHA 2005). **np** Not published.

Source: AIHW (2006a); table 9A.55.

Total cost per casemix-adjusted separation

'Total cost per casemix-adjusted separation' is an indicator of the efficiency of public hospitals (box 9.17). Total cost includes both the recurrent costs (as discussed above) and the capital costs associated with hospitals services. Results for this indicator in 2004-05 are reported in figure 9.17. Labour costs accounted for the majority of costs per casemix-adjusted separation in all jurisdictions.

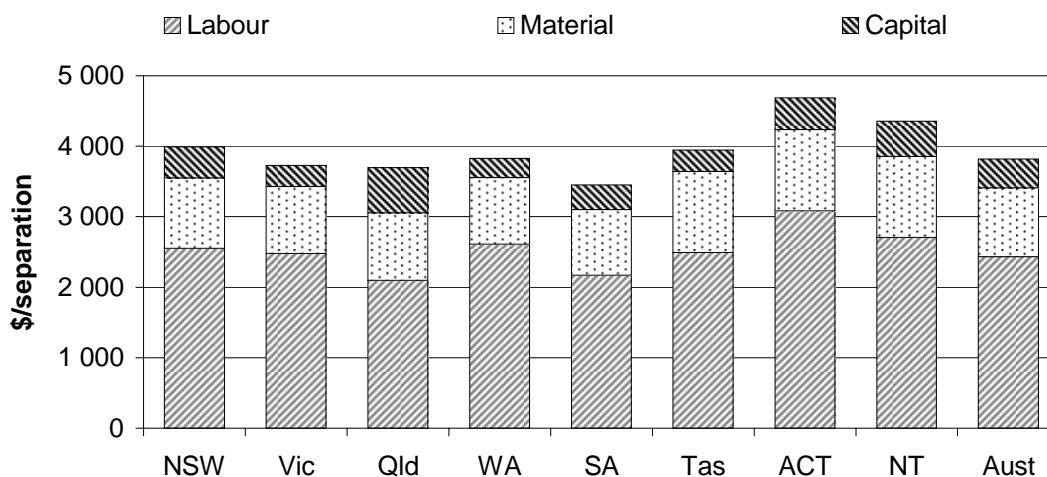
Box 9.17 Total cost per casemix-adjusted separation

‘Total cost per casemix-adjusted separation’ is a output–efficiency indicator of governments’ objective to deliver services in a cost effective manner. This indicator is defined as the recurrent cost per casemix-adjusted separation plus the capital costs per casemix-adjusted separation. Recurrent costs include labour and material costs, and capital costs include depreciation and the user cost of capital for buildings and equipment. The indicator is included because it allows the full cost of hospital services to be considered in a single measure. The hospitals included in this measure are the same as for recurrent cost per casemix-adjusted separation (box 9.16).

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

A lower ‘total cost per casemix-adjusted separation’ may reflect more efficient service delivery in public hospitals. This indicator needs to be viewed, however, in the context of the set of performance indicators as a whole because a hospital may be a low cost provider of services yet provide services ineffectively — for example, relatively low unit costs may be associated with inferior service quality.

Figure 9.17 **Total cost per casemix-adjusted separation, public hospitals, 2004-05^{a, b, c}**



^a 'Labour' includes medical and non-medical labour costs. 'Material' includes other non-labour recurrent costs, such as repairs and maintenance (table 9A.54). ^b 'Capital cost' includes depreciation and the user cost of capital for buildings and equipment that is associated with the delivery of admitted patient services in the public hospitals as described in the data for recurrent cost per casemix-adjusted separation. 'Capital cost' excludes the user cost of capital associated with land (reported in table 9A.56). ^c Variation across jurisdictions in the collection of capital related data suggests the data are only indicative. The capital cost per casemix-adjusted separation is equal to the capital cost adjusted by the inpatient fraction, divided by the number of casemix-adjusted separations.

Source: AIHW (2006a); State and Territory governments (unpublished); tables 9A.54 and 9A.56.

Relative stay index

The 'relative stay index' is an indicator of the efficiency of public hospitals (box 9.18). Data for this indicator are reported in figure 9.18. The 'relative stay index' is reported by patient election status and by medical, surgical and other AR-DRGs in tables 9A.57 and 9A.58 respectively.

Box 9.18 Relative stay index

'Relative stay index' is a output–efficiency indicator of governments' objective to deliver services efficiently. The 'relative stay index' is defined as the actual number of acute care patient days divided by the expected number of acute care patient days adjusted for casemix. Casemix adjustment allows comparisons to take account of variation in types of service provided but not other influences on length of stay, such as Indigenous status. Acute care separations only are included. Section 9.8 contains a more detailed definition outlining exclusions from the analysis.

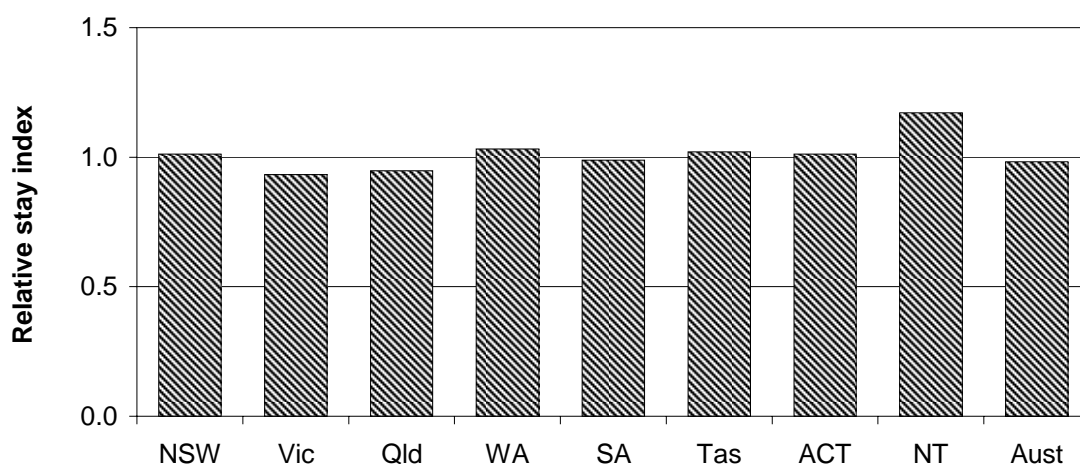
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Box 9.18 (Continued)

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

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

Figure 9.18 Relative stay index, public hospitals, 2004-05^{a, b}



^a Includes separations for which the care type was reported as 'acute' or 'newborn with qualified days', or was not reported. ^b The relative stay index is based on all hospitals and is estimated using the indirect standardisation method and AR-DRG version 5.1. The indirectly standardised relative stay index is not strictly comparable between jurisdictions but is a comparison of the jurisdiction with the national average based on the casemix of the jurisdiction.

Source: AIHW (2006a); table 9A.57.

Recurrent cost per non-admitted occasion of service

'Recurrent cost per non-admitted occasion of service' is an indicator of the efficiency of public hospitals (box 9.19).

Box 9.19 Recurrent cost per non-admitted occasion of service

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

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

Lower recurrent cost per non-admitted occasion of service may reflect more efficient service delivery in public hospitals. This indicator needs to be viewed, however, in the context of the set of performance indicators as a whole because a hospital may be a low cost provider of services yet provide services ineffectively — for example, relatively low unit costs may be associated with inferior service quality. This indicator does not adjust for the complexity of service — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids (AIHW 2000).

These data are not comparable across jurisdictions, given differences in practice. Reporting categories vary across jurisdictions, and further inconsistencies arise as a result of differences in outsourcing practices. In some cases, for example, outsourced occasions of service may be included in expenditure on non-admitted services, but not in the count of occasions of service. Jurisdictions able to supply 2004-05 data for this indicator reported the following results for non-admitted patient services:

- In NSW, the emergency department cost per occasion of service was \$210 for 1.9 million occasions, the outpatient cost per occasion of service was \$82 for 14.5 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was \$94 for 19.5 million occasions (table 9A.59).
- In WA, the emergency department cost per occasion of service was \$348 for 591 257 occasions, the outpatient cost per occasion of service was \$126 for 3.3 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was \$117 for 5.0 million occasions (table 9A.61).
- In SA, the emergency department cost per occasion of service was \$308 for 468 827 occasions, the outpatient cost per occasion of service was \$185 for 1.3 million occasions and the overall cost per occasion of service (emergency plus outpatient) was \$215 for 1.8 million occasions (table 9A.62).
- In Tasmania, the emergency department cost per occasion of service was \$332 for 104 752 occasions and the outpatient cost per occasion of service was \$103

for 442 990 occasions. An overall cost per occasion of service was not available (table 9A.63).

- In the ACT, the emergency department cost per occasion of service was \$448 for 93 779 occasions, the outpatient cost per occasion of service was \$87 for 529 491 occasions and the overall cost per occasion of service (emergency plus outpatient) was \$141 for 623 270 occasions (table 9A.64).

Victoria collects data on the basis of cost per non-admitted patient encounter. An encounter includes the clinic visit and all ancillary services provided within a 30 day period either side of the clinic visit. Based on cost data from nine hospitals, the average cost per encounter was \$140 for 1.1 million encounters in 2004-05 (table 9A.60).

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

Outpatient data were contributed by 162 public hospitals for all types of public hospital outpatient clinics (tier 0) (table 9A.65). These data suggest that 'cost per non-admitted clinic occasions of service' for the public hospitals sector in 2004-05 was \$136 for 12.8 million occasions (table 9A.65). 'Cost per non-admitted clinic occasions of service' data are also shown for seven categories of outpatient clinics (tier 1) (table 9.14). These tier 1 outpatient clinics data were provided by 49 public hospitals. Emergency department data, provided by 159 public hospitals, show the 'cost per occasion of service for emergency departments' by triage class (table 9.15).

Table 9.14 Non-admitted clinic occasions of service for tier 1 clinics, sample results, public sector, 2004-05^{a, b, c}

	<i>Occasions of service</i>	<i>Average cost</i>
	no.	\$/occasion of service
Allied health and/or clinical nurse specialist	880 565	89
Dental	14 571	229
Medical	970 851	242
Obstetrics and gynaecology	277 516	178
Paediatric	100 839	229
Psychiatric	62 586	207
Surgical	672 586	153
Total	2 979 514	169

^a Includes depreciation costs. ^b Based on 49 public sector hospitals. ^c Excludes Victorian outpatient data.

Source: Australian Government Department of Health and Ageing, *NHCDC*, Round 9 (2004-05); table 9A.67.

Table 9.15 Emergency department average cost per occasion of service, public hospitals, by triage class, 2004-05 (dollars)^{a, b, c, d, e}

<i>Triage category</i>	<i>Population estimated — average cost per occasion of service^f</i>	<i>Actual — average cost per occasion of service</i>
Admitted triage 1	969	1 000
Admitted triage 2	570	582
Admitted triage 3	505	513
Admitted triage 4	438	441
Admitted triage 5	358	354
Non-admitted triage 1	615	644
Non-admitted triage 2	422	427
Non-admitted triage 3	378	370
Non-admitted triage 4	293	279
Non-admitted triage 5	219	215
Did not wait ^g	92	99
Total	357	356

^a Not all hospitals that submit data to the *NHCDC* submit emergency department data. The emergency department national database contains only acute hospitals with emergency department cost and activity.

^b Based on data from 159 public sector hospitals. ^c Victorian emergency department data are not included. Victoria is working to rectify this problem. ^d Costing and admission practices vary across jurisdictions and hospitals. ^e Depreciation costs are included. ^f Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. ^g 'Did not wait' means those presentations to an emergency department who were triaged but did not wait until the completion of their treatment, at which time they would have been either admitted to hospital or discharged home.

Source: Australian Government Department of Health and Ageing, *NHCDC*, Round 9 (2004-05); table 9A.66.

Outcomes

Patient satisfaction

‘Patient satisfaction’ is an outcome indicator of public hospital quality (box 9.20). In 2005, the Steering Committee engaged Health Policy Analysis Pty Ltd to undertake a study reviewing patient satisfaction and responsiveness surveys conducted in relation to public hospital services in Australia. The study identified and examined current patient satisfaction surveys conducted by State and Territory governments that are relevant to measuring ‘public hospital quality’. A major objective of the study was to identify points of commonality and difference between patient satisfaction surveys and their potential for concordance and/or for forming the basis of a minimum national data set on public hospital ‘patient satisfaction’ or ‘patient experience’.

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

Box 9.20 Patient satisfaction

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

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

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

Jurisdictions reported the following results from patient satisfaction surveys:

- The Victorian Patient Satisfaction Monitor was conducted from 2000 to 2006, using a mailout questionnaire of adult inpatients receiving acute care in Victorian public hospitals. For March 2005 to February 2006, 16 741 patients answered the questionnaire which represented a response rate of 40.5 per cent. The statewide Overall Care Index was 79. The statewide scores achieved for the six sub-indices of care ranged from 76.2 to 83.2 (table 9A.69).
- In Queensland, a mailout survey was conducted of admitted patients in public hospitals from March–August 2005. The survey sample was 16 705, with a response rate of 50 per cent. The statewide Overall Care Index was 67. The statewide scores achieved for the six sub-indices of care ranged from 63 to 71 (table 9A.70).
- In WA, a computer assisted telephone interview survey was conducted from February 2006–June 2006. The total sample was 7912, with an 84 per cent response rate. Three patient groups are reported on; child and adult patients admitted between 2 and 34 nights, and maternity patients. The patient-rated overall indicator of satisfaction scores for these child, adult and maternity patients were 87.3, 80.7 and 78.7 respectively. (These scores are weighted by the importance of each issue as ranked by the patient and scored from 0 to 100, where 100 is the highest possible overall satisfaction score, taking into account all of the satisfaction domains measured) (table 9A.71).
- In SA, a computer assisted telephone interview survey was conducted from April 2005–October 2005. Interviews were completed with 4440 patients, which represented a response rate of 84.7 per cent. The overall satisfaction score was 87.2 (scored from 0 to 100, being least to most satisfied). The scores achieved for the seven individual areas of care ranged from 79.1 to 92.8 (table 9A.72).
- In Tasmania, two hospital-specific questionnaire surveys were conducted in 2005-06. For survey 1, the sample was 360 with a response rate of 41 per cent. Of those who responded, 92.5 indicated they were very satisfied with the overall care provided. For survey 2, the sample was 400 with a response rate of 100 per cent. The results achieved for the seven individual aspects of the survey reported ranged from 70 to 97 per cent (table 9A.73).
- In the ACT, two hospital-specific surveys were conducted in 2005-06. For survey 1 (a mailout survey), the sample was 161 with a response rate of 33 per cent. The overall patient satisfaction score was 75.9. For survey 2 (a questionnaire survey), the sample was 444 with a response rate of 41 per cent. Overall, 93 per cent of patients were fairly or very satisfied with all aspects of their hospital stay and 87 per cent were helped quite a bit or a great deal by their hospital stay (table 9A.74).

Sentinel events

‘Sentinel events’ are an outcome indicator of public hospital quality and safety (box 9.21). Data for 2004-05 are available for NSW, Victoria and SA only (table 9.16). It is anticipated that data for all jurisdictions will be available for future reports.

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

Box 9.21 Sentinel events

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

Australian health ministers have agreed on a national core set of sentinel events for which all public hospitals are required to provide data. The 8 nationally agreed core sentinel events are:

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

(Continued on next page)

Box 9.21 (Continued)

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

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

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

Table 9.16 Nationally agreed core sentinel events, 2004-05 (number)

<i>Sentinel event</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
1. Procedures involving the wrong patient or body part ^a	14	25	na	na	10	na	na	na	na
2. Suicide of a patient in an in-patient unit ^b	8	4	na	na	4	na	na	na	na
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure	5	5	na	na	4	na	na	na	na
4. Intravascular gas embolism resulting in death or neurological damage	—	—	na	na	1	na	na	na	na
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility	—	1	na	na	—	na	na	na	na
6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs	2	1	na	na	—	na	na	na	na
7. Maternal death or serious morbidity associated with labour or delivery ^c	3	9	na	na	1	na	na	na	na
8. Infant discharged to the wrong family	—	—	na	na	—	na	na	na	na
Total	32	45	na	na	20	na	na	na	na

^a Includes non-invasive procedures; for example, a CT-scan or X-Ray to the incorrect part of the body or wrong patient, whilst not being 'invasive' still involves an unnecessary procedure for the patient.

^b Suicides of patients 'under care' (as opposed to 'in care') are excluded. Patients who suicide whilst on leave or after absconding have not formally been discharged and are still 'in care' and therefore are included.

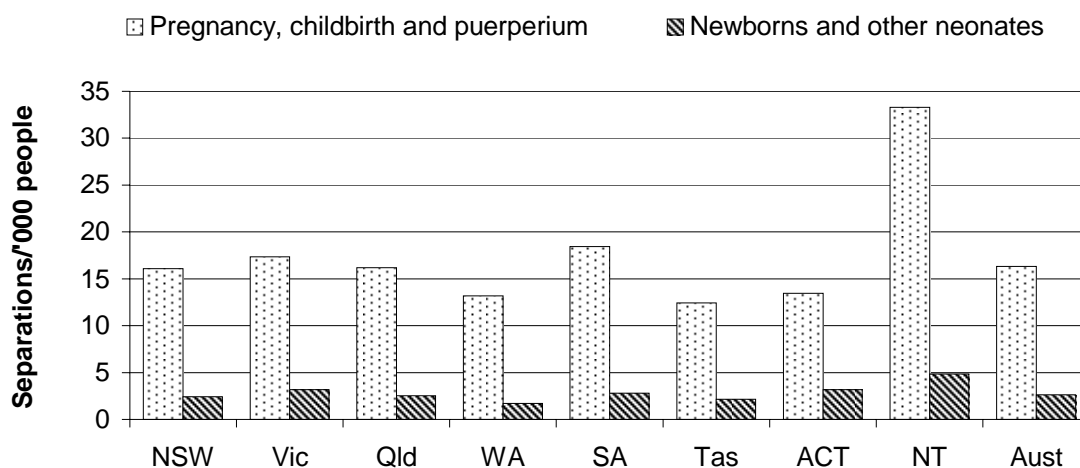
^c Excludes maternal deaths that occur prior to the onset of labour or delivery. **na** Not available. — Nil or rounded to zero.

Source: DHS (2005); NSW Department of Health (2005b); SA Government (unpublished); table 9A.76.

9.4 Profile of maternity services

Maternity services (defined as AR-DRGs relating to pregnancy, childbirth and the puerperium, and newborns and other neonates) accounted for 9.3 per cent of total acute separations in public hospitals (table 9A.78) and around 10.7 per cent of the total cost of all acute separations in public hospitals in 2004-05 (table 9A.77). Figure 9.19 shows the rate of acute separations per 1000 people for maternity services across jurisdictions in 2004-05.

Figure 9.19 **Separation rates for maternity services, public hospitals, 2004-05^{a, b}**



^a The puerperium refers to the period of confinement immediately after labour (around six weeks).

^b Newborns and other neonates include babies aged less than 28 days or babies aged less than one year with admission weight of less than 2500 grams.

Source: AIHW (2006a); tables AA.2 and 9A.78.

In Australian public hospitals in 2004-05, vaginal deliveries without complicating diagnosis accounted for a substantial proportion of the separations for pregnancy, childbirth and the puerperium (27.8 per cent) (tables 9A.78 and 9A.79). In the context of all AR-DRGs in public hospitals, vaginal deliveries without complicating diagnosis comprised the largest number of overnight acute separations (4.3 per cent of all separations) (table 9.3) and the second highest cost (\$332.8 million) (table 9A.79).

The complexity of cases across jurisdictions for maternity services is partly related to the mother's age at the time of giving birth. The mean age of mothers giving birth varied across jurisdictions in 2003, 2004 and 2005 (table 9.17).

Table 9.17 Mean age of mothers at time of giving birth, public hospitals

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA^a</i>	<i>Tas</i>	<i>ACT^b</i>	<i>NT^c</i>
2003								
First birth	27.5	27.4	25.2	25.8	26.0	26.6	27.4	23.5
Second birth	29.8	29.7	27.8	28.3	28.8	29.1	29.6	26.0
Third birth	31.1	31.2	29.6	29.8	30.5	30.2	31.2	27.4
All births	29.4	29.3	27.6	28.0	28.3	29.0	29.2	26.1
2004								
First birth	27.7	28.1	25.3	25.9	26.8	25.2	27.6	23.9
Second birth	29.9	30.3	27.9	28.4	29.2	27.5	30.4	26.3
Third birth	31.3	31.8	29.6	29.7	30.8	28.8	31.2	27.7
All births	29.5	29.9	27.7	28.0	28.8	27.8	29.5	26.4
2005								
First birth	27.8	27.7	25.5	25.9	26.6	na	27.7	24.2
Second birth	29.9	29.9	28.0	28.6	29.4	na	29.5	26.3
Third birth	31.4	31.4	29.5	29.9	31.1	na	31.0	28.0
All births	29.6	29.5	27.8	28.1	28.9	na	29.3	26.5

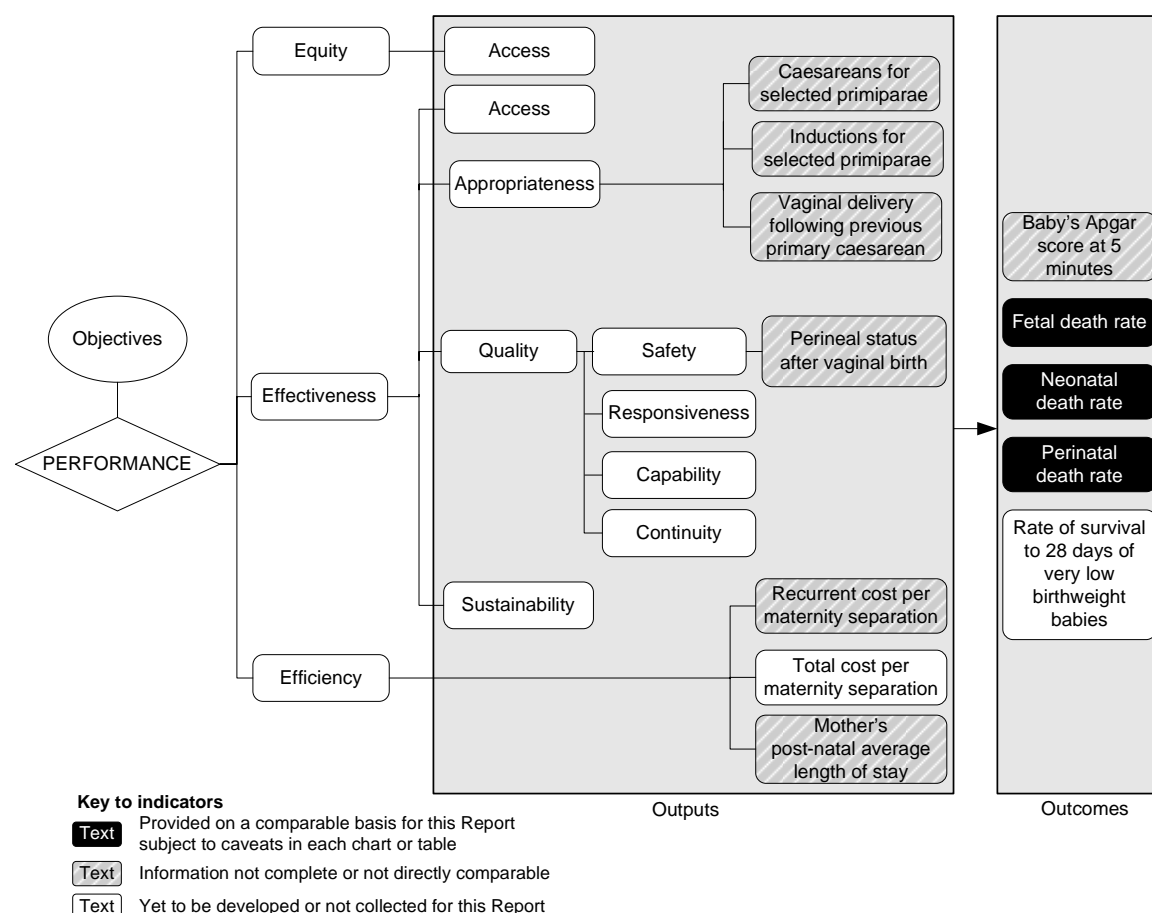
^a Age in 2004 and 2005 is based on exact age (years) to 4 decimal places. In 2003, it was based on completed years. ^b ACT 2005 data are preliminary. ^c NT data for 2003 and 2004 have been revised. **na** Not available.

Source: State and Territory governments (unpublished).

9.5 Framework of performance indicators for maternity services

The performance framework for maternity services is outlined in figure 9.20, and has the same objectives as those for public hospitals in general. The framework is under development by the Steering Committee and, as with all the performance indicator frameworks, will be subject to regular review. The performance indicator framework shows which data are comparable in the 2007 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability that have been added to the standard Review framework for health services.

Figure 9.20 Performance indicators for maternity services



9.6 Key performance indicator results for maternity services

Outputs — equity — access

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

Outputs — effectiveness — access

The Steering Committee has identified the effectiveness of access to maternity services as an area for development in future reports. Effectiveness of access

indicators will measure access to appropriate services for the population as a whole, particularly in terms of affordability and/or timeliness.

Outputs — effectiveness — appropriateness

Caesareans and inductions for selected primiparae

‘Caesarean and induction rates for selected primiparae’ are indicators of the appropriateness of maternity services in public hospitals (box 9.22).

Box 9.22 Caesareans and inductions for selected primiparae

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

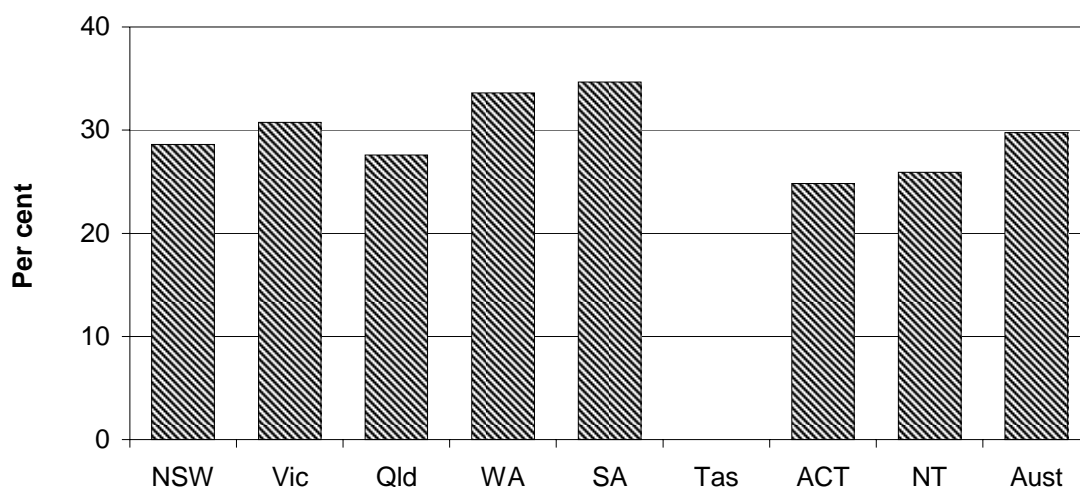
‘Caesareans and inductions for selected primiparae’ are reported for women aged between 25–29 years who have had no previous deliveries, with a vertex presentation (that is, the crown of the baby’s head is at the lower segment of the mother’s uterus) and a gestation length of 37–41 weeks. This group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

The indicator is defined as the number of inductions or caesareans for the selected primiparae divided by the number of the selected primiparae who give birth. High intervention rates may indicate a need for investigation.

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

Induction rates for selected primiparae in public hospitals are reported in figure 9.21. Induction rates for private hospitals are shown in table 9A.80 for comparison. They are higher than the rate for public hospitals in all jurisdictions for which data are available (except the ACT). Data for all jurisdictions for earlier years are included in tables 9A.81–88.

Figure 9.21 Inductions for selected primiparae, public hospitals, 2005^{a, b, c}

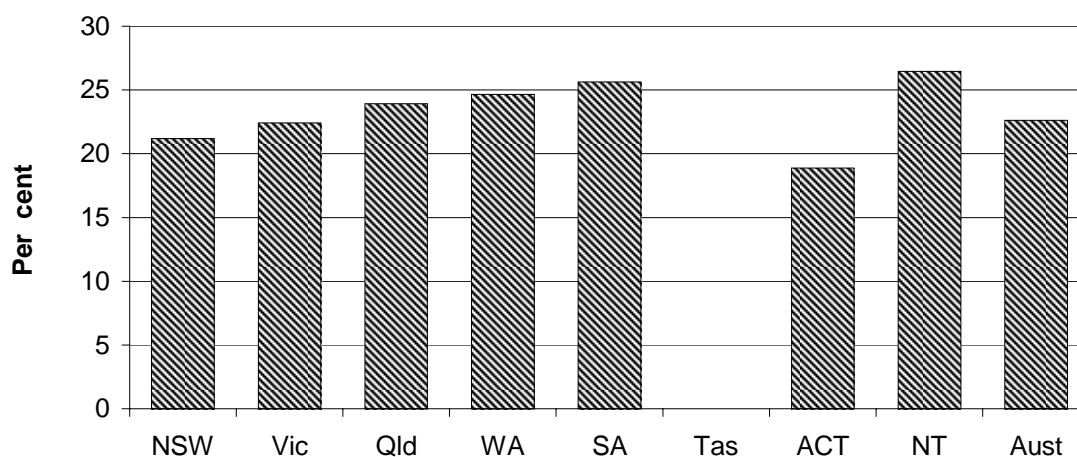


^a Data for Tasmania are not available. ^b ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2005, 15.0 per cent of women who gave birth in the ACT were not residents. ^c Rate for Australia includes only jurisdictions for which data are available.

Source: State and Territory governments (unpublished); table 9A.80.

Caesarean rates for selected primiparae in public hospitals are reported in figure 9.22. Caesarean rates for private hospitals are shown in table 9A.80 for comparison. They are higher than the rate for public hospitals in all jurisdictions for which data are available. Data for all jurisdictions for earlier years are included in tables 9A.81–88.

Figure 9.22 **Caesareans for selected primiparae, public hospitals, 2005^{a, b, c}**



^a Data for Tasmania are not available. ^b ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2005, 15.0 per cent of women who gave birth in the ACT were not residents. ^c Rate for Australia includes only jurisdictions for which data are available.

Source: State and Territory governments (unpublished); table 9A.80.

Vaginal birth following previous primary caesarean

‘Vaginal birth following previous primary caesarean’ is an indicator of the appropriateness of maternity services in public hospitals (box 9.23).

Box 9.23 Vaginal birth following previous primary caesarean

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

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

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

Data for ‘vaginal birth following a previous primary caesarean’ are sourced from the ACHS Comparative Report Service (Clinical Indicators) and collected for internal clinical review by individual hospitals. The ACHS data are predominantly used to demonstrate the potential for improvement across Australian hospitals if all hospitals could achieve the same outcomes as those of hospitals with the best outcomes for patients. Statewide conclusions cannot be drawn from the data because healthcare organisations contribute to the ACHS on a voluntary basis, so the data are not necessarily drawn from representative samples (box 9.7). Estimated rates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are potentially unreliable. The statistical terms used to describe this indicator are explained in box 9.9.

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2005, the mean rate of ‘vaginal birth following a previous primary caesarean’ was 17.6 per 100 deliveries (table 9.18). Given the uncertainty regarding whether high/low rates of vaginal birth following a previous primary caesarean are desirable, this Report does not include potential centile gains for this indicator.

The mean rates of ‘vaginal birth following a primary caesarean’ in 2005 are shown in table 9.18 for jurisdictions with more than five hospitals reporting to the ACHS Comparative Report Service. The coverage of the ACHS data may differ across these states. Data for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals reported ‘vaginal birth following a primary caesarean’ in each of those jurisdictions.

Table 9.18 Vaginal births following previous primary caesarean, public hospitals, 2005^{a, b}

	<i>Unit</i>	<i>Results</i>
National rate	(%)	17.6
National performance at 80th centile (rate)	(%)	21.6
National performance at 20th centile (rate)	(%)	13.5
NSW		
Numerator (no. of VBACs)	no.	598
Denominator (no. of DACs)	no.	3 581
Rate	%	16.7
Standard error (±)		0.6
ACHS reporting hospitals	no.	35
Victoria		
Numerator (no. of VBACs)	no.	328
Denominator (no. of DACs)	no.	2 000
Rate	%	16.4
Standard error (±)		0.8
ACHS reporting hospitals	no.	22
Queensland		
Numerator (no. of VBACs)	no.	164
Denominator (no. of DACs)	no.	693
Rate	%	23.7
Standard error (±)		1.4
ACHS reporting hospitals	no.	8
WA		
Numerator (no. of VBACs)	no.	164
Denominator (no. of DACs)	no.	1 108
Rate	%	14.8
Standard error (±)		1.1
ACHS reporting hospitals	no.	12
SA		
Numerator (no. of VBACs)	no.	202
Denominator (no. of DACs)	no.	944
Rate	%	21.4
Standard error (±)		1.2
ACHS reporting hospitals	no.	10

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

Source: ACHS (unpublished); tables 9A.89, 9A.90, 9A.91, 9A.92 and 9A.93.

Outputs — effectiveness — quality

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

Safety — perineal status after vaginal birth

‘Perineal status after vaginal birth’ is an indicator of the safety of maternity services (box 9.24).

Box 9.24 Perineal status after vaginal birth

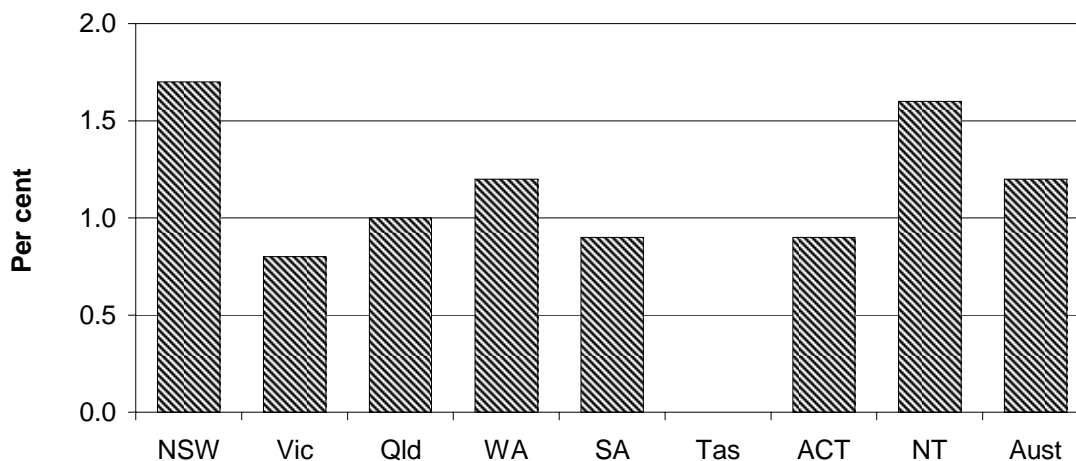
‘Perineal status after vaginal birth’ is a output–equity indicator of governments’ objective to provide safe and high quality services. Perineal lacerations caused by childbirth are painful, take time to heal and may result in ongoing discomfort and debilitating conditions such as faecal incontinence.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

‘Perineal status after vaginal birth’ is the state of the perineum following a vaginal birth (NHDC 2003). A third or fourth degree laceration is a perineal laceration or rupture (or tear following episiotomy) extending to, or beyond, the anal sphincter (see section 9.8 for definitions) (NCCH 1998).

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

The proportion of mothers with third or fourth degree lacerations to their perineum following vaginal births is shown in figure 9.23. More information on ‘perineal status after vaginal birth’ (including the proportion of mothers with intact perineum following vaginal births) is contained in attachment table 9A.94.

Figure 9.23 **Perineal status — mothers with third or fourth degree lacerations after vaginal births, 2003^{a, b, c}**



^a For multiple births, the perineal status after birth of the first child was used. ^b Data for Tasmania are not available in a form that are comparable with other jurisdictions. ^c Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths.

Source: Laws and Sullivan (2005); table 9A.94.

Responsiveness

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

Capability

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

Continuity

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

Outputs — effectiveness — sustainability

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

Outputs — efficiency

Recurrent cost per maternity separation

‘Recurrent cost per maternity separation’ is an indicator of the efficiency of maternity services in public hospitals (box 9.25).

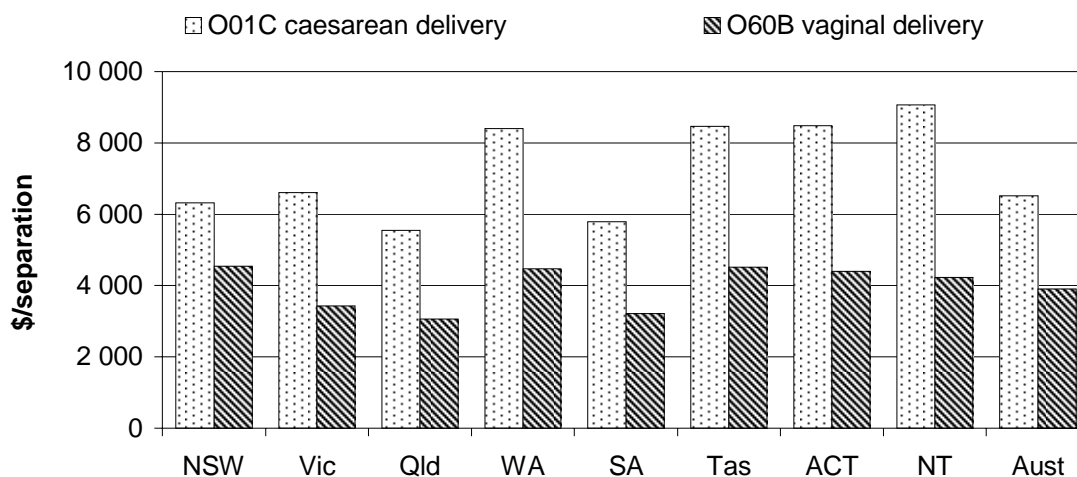
Box 9.25 Recurrent cost per maternity separation

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

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

Data are reported for the two most common maternity AR-DRGs: caesarean delivery without catastrophic or severe complications and co-morbidities; and vaginal delivery without catastrophic or severe complications and co-morbidities (figure 9.24). Data for a number of other maternity related AR-DRGs are shown in table 9A.95. Data are sourced from the NHCDC. The NHCDC is a voluntary annual collection, the purpose of which is to calculate between-DRG cost weights. The samples are not necessarily representative of the set of hospitals in each jurisdiction. Therefore, an estimation process has been carried out to create representative national activity figures from the sample data.

Figure 9.24 **Estimated average cost per separation for selected maternity-related AR-DRGs, public hospitals, 2004-05^{a, b}**



^a Includes AR-DRG O01C caesarean delivery without catastrophic or severe complications and co-morbidities and AR-DRG O60B vaginal delivery without catastrophic or severe complications and co-morbidities.

^b Average cost is affected by a number of factors including admission practices, sample size, remoteness and the types of hospital contributing to the collection. Direct comparisons between jurisdictions are difficult because there are differences in hospital costing systems.

Source: Australian Government Department of Health and Ageing, *NHCDC*, Round 9 (2004-05); table 9A.95.

Total cost per maternity separation

The Steering Committee has identified the ‘total cost per maternity separation’ (recurrent cost plus capital cost) as an indicator of the efficiency of public hospital maternity services, but no data are available for this Report (box 9.26).

Box 9.26 Total cost per maternity separation

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

Mothers average length of stay

‘Mothers average length of stay in hospital’ is an indicator of the efficiency of maternity services in public hospitals (box 9.27). Data are reported for the two most common maternity AR-DRGs: caesarean delivery without catastrophic or severe

complications and co-morbidities; and vaginal delivery without catastrophic or severe complications and co-morbidities (figure 9.25).

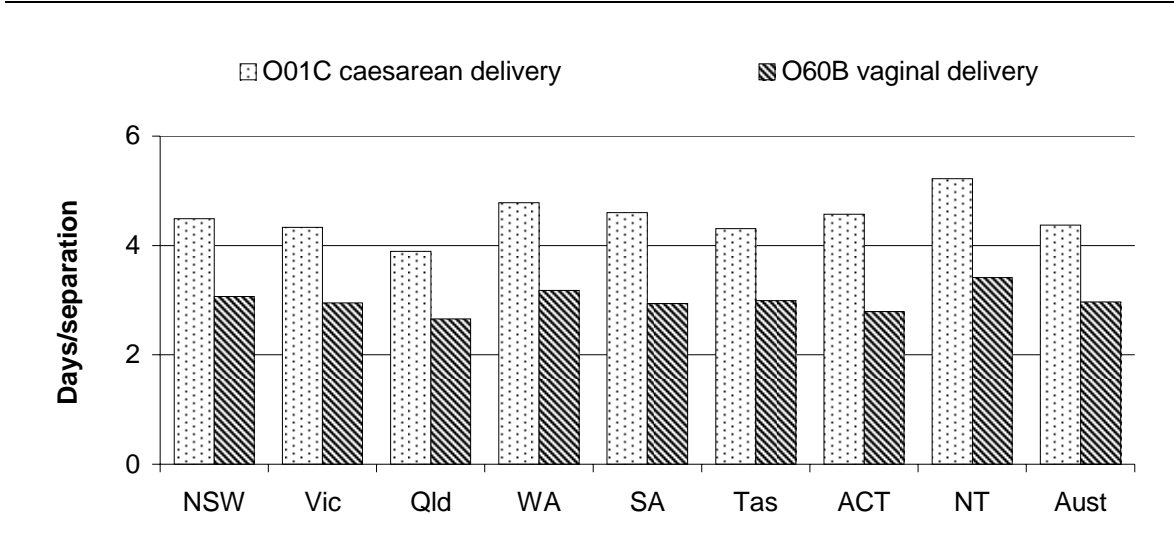
Box 9.27

Mothers average length of stay

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

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

Figure 9.25 **Average length of stay for selected maternity-related AR-DRGs, public hospitals, 2004-05^a**



^a Includes AR-DRG O01C caesarean delivery without catastrophic or severe complications and co-morbidities and AR-DRG O60B vaginal delivery without catastrophic or severe complications and co-morbidities.

Source: Australian Government Department of Health and Ageing, *NHCDC*, Round 9 (2004-05); table 9A.95.

Outcomes

Apgar score

‘Apgar score of babies at five minutes after birth’ is an indicator of the outcomes of maternity services (box 9.28). ‘Low’ Apgar scores for babies by birthweight

category are contained in table 9.19. The range of Apgar scores for 2001 to 2005 are reported in table 9A.96.

Box 9.28 Apgar score at five minutes

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

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

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

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

Table 9.19 Live births with an Apgar score of 3 or lower, five minutes post-delivery, public hospitals, 2005

<i>Birthweight (grams)</i>	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^a</i>	<i>NT^b</i>
Less than 1500	no.	767	620	478	267	240	na	55	46
Low Apgar	%	18.4	19.2	14.4	10.1	15.4	na	9.1	23.9
1500–1999	no.	910	586	565	282	224	na	57	59
Low Apgar	%	1.4	0.9	0.7	1.4	–	na	1.8	–
2000–2499	no.	2 701	1 953	1 645	741	621	na	137	169
Low Apgar	%	0.6	0.6	0.4	0.3	0.3	na	1.5	1.2
2500 and over	no.	62 819	42 376	34 911	14 665	12 078	na	2 585	2 607
Low Apgar	%	0.2	0.1	0.1	0.1	0.1	na	0.2	0.4

^a ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2005, 15.0 per cent of women who gave birth in the ACT were not residents. ^b In the birthweight category less than 1500g, the data exclude one baby with an unknown Apgar score. **na** Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 9A.96.

Fetal death rate

The 'fetal death rate' is an indicator of the outcomes of maternity services (box 9.29).

Box 9.29 Fetal death rate

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

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

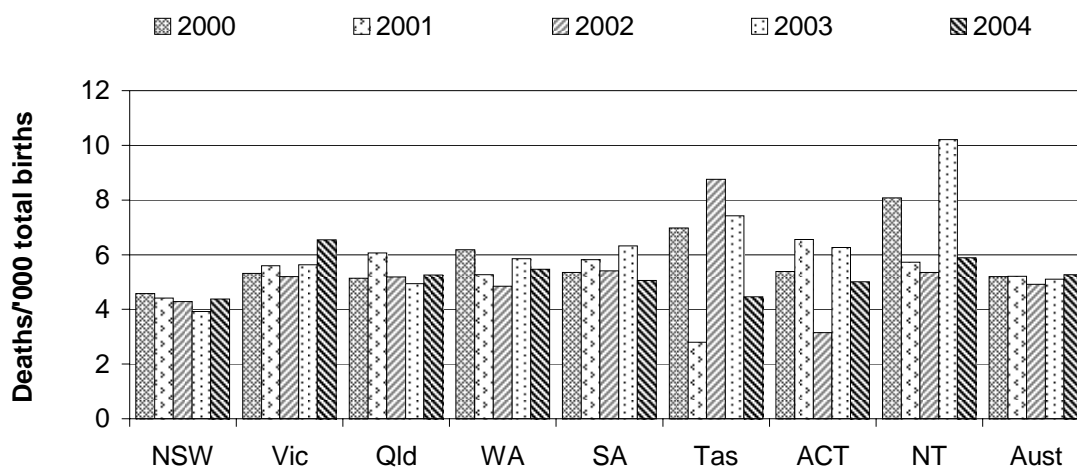
The 'fetal death rate' is calculated as the number of fetal deaths divided by the total number of births (live births and fetal deaths combined), by State or Territory of usual residence of the mother. The rate of fetal deaths is expressed per 1000 total births. This indicator is also reported by Indigenous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

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

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

Fetal death rates are reported in figure 9.26. Nationally, fetal death rates remained stable over the period 2000–2004 although there was variation over this period in some jurisdictions (these annual fluctuations are generally a result of the low incidence of fetal deaths and small populations). National time series for fetal death rates are included in table 9A.99. Fetal deaths rates by Indigenous status are shown in figure 9.29.

Figure 9.26 **Fetal death rate^{a, b}**



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

Source: ABS Deaths, Australia (unpublished); table 9A.97.

Neonatal death rate

The ‘neonatal death rate’ is an indicator of the outcomes of maternity services (box 9.30).

Box 9.30 Neonatal death rate

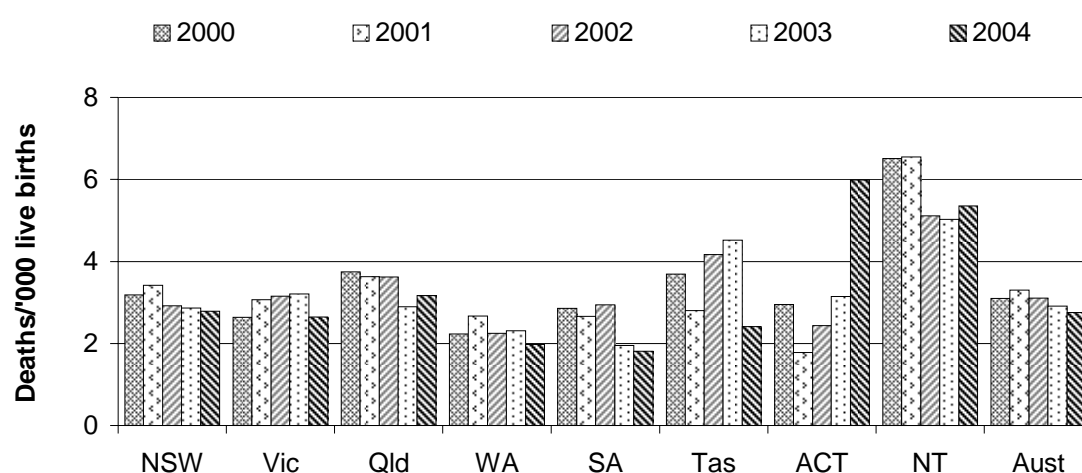
Neonatal death is the death of a live born infant within 28 days of birth (see section 9.8 for a definition of a live birth). As for fetal deaths, a range of factors contribute to neonatal deaths. The influence of maternity services for admitted patients, however, is greater for neonatal deaths than for fetal deaths, through the management of labour and the care of sick and premature babies.

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

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

Neonatal death rates are reported in figure 9.27. Nationally, neonatal death rates generally declined over the period 2000–2004, although there was variation over this period in some jurisdictions (these annual fluctuations are generally a result of the low incidence of neonatal deaths and small populations). National time series for neonatal death rates are included in table 9A.99. Neonatal death rates by Indigenous status are shown in figure 9.29.

Figure 9.27 **Neonatal death rate^{a, b}**



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

Source: ABS Deaths, Australia (unpublished); table 9A.98.

Perinatal death rate

The ‘perinatal death rate’ is an indicator of the outcomes of maternity services (box 9.31). Perinatal death rates are shown in figure 9.28. Perinatal death rates by Indigenous status are shown in figure 9.29. National time series for perinatal death rates are included in table 9A.99.

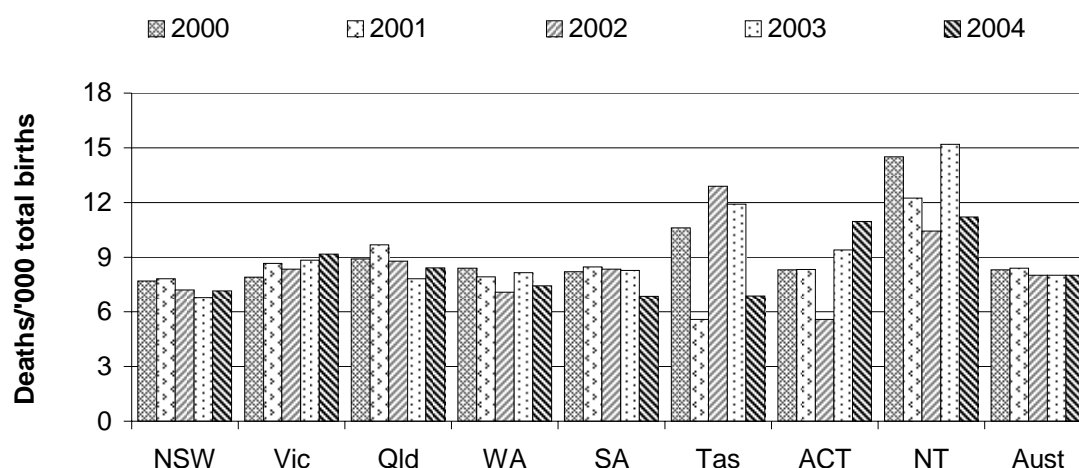
Box 9.31 Perinatal death rate

A perinatal death is a fetal or neonatal death (boxes 9.29 and 9.30).

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

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

Figure 9.28 Perinatal death rate^{a, b}



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

Source: ABS Deaths, Australia (unpublished); table 9A.100.

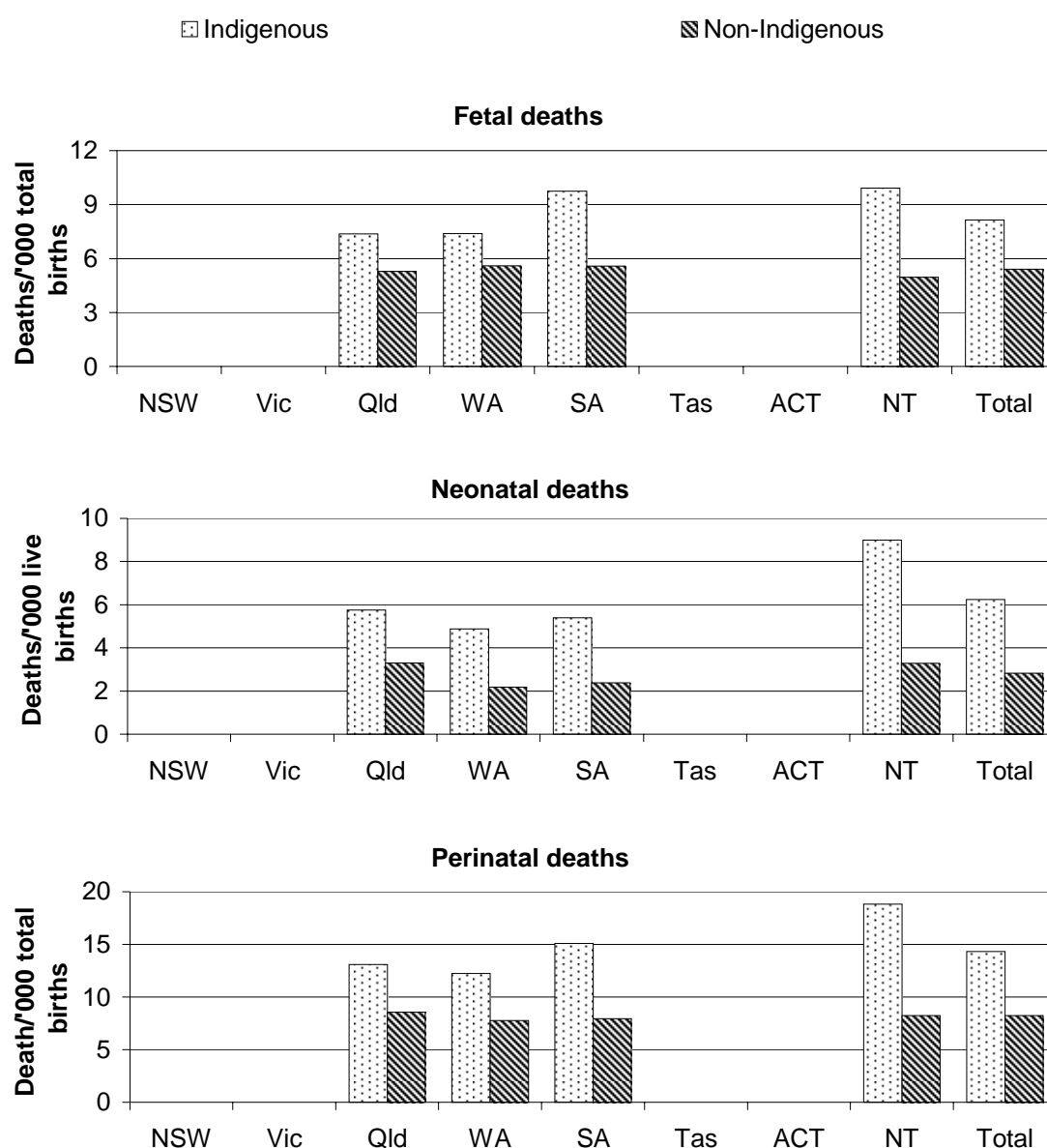
Fetal, neonatal and perinatal deaths for Indigenous people

Fetal, neonatal and perinatal deaths data by Indigenous status are available for Queensland, WA, SA and the NT only. Data are for the period 2000–2004 combined. Data for other states and the ACT are not included due to small numbers or poor coverage rates (ABS 2004).⁴ In those jurisdictions for which data are

⁴ The implied coverage of Indigenous deaths, for the period 1999 to 2003, ranges from 95 per cent in the NT, to 45 per cent and 43 per cent in NSW and Victoria respectively (SCRGSP 2005).

available, the fetal, neonatal and perinatal death rates for Indigenous people are higher than these death rates for non-Indigenous people (figure 9.29).

Figure 9.29 **Fetal, neonatal and perinatal deaths, by Indigenous status, 2000–2004^a**



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

Source: ABS Deaths, Australia (unpublished); table 9A.101.

Rate of survival to 28 days of very low birthweight babies

The Steering Committee has identified the ‘rate of survival to 28 days of very low birthweight babies’ as an indicator of the outcomes of maternity services (box 9.32). No data for this indicator are currently available.

Box 9.32 Rate of survival to 28 days of very low birthweight babies

‘Rate of survival to 28 days of very low birthweight babies’ is an outcome indicator of governments’ objective to provide high quality services. This indicator has been identified for development and reporting in future. Data were not available for the 2007 Report.

9.7 Future directions in performance reporting

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

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

The Steering Committee is seeking to extend reporting on hospital accreditation. In addition to current reporting of the proportion of hospital beds that are accredited (section 9.3), future reports might include information on ‘how well’ hospitals meet accreditation standards. This would involve reporting, for example, whether hospitals exceed accreditation standards by a large or small margin, or whether they practice ‘continuous improvement’.

9.8 Definitions of key terms and indicators

Accreditation	Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals may seek accreditation through the ACHS Evaluation and Quality Improvement Program, the Australian Quality Council (now known as Business Excellence Australia), the Quality Improvement Council, the International Organisation for Standardization 9000 Quality Management System or other equivalent programs.
Acute care	Clinical services provided to admitted or non-admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.
Admitted patient	A patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients may receive acute, sub-acute or non-acute care services.
Admitted patient cost proportion	The ratio of admitted patient costs to total hospital costs, also known as the inpatient fraction.
Allied health (non-admitted)	Occasions of service to non-admitted patients at units/clinics providing treatment/counselling to patients. These include units providing physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy.
Apgar score	Numerical score used to evaluate a baby's condition after birth. The definition of the reported indicator is the number of babies born with an Apgar score of 3 or lower at 5 minutes post-delivery, as a proportion of the total number of babies born. Excludes fetal deaths in utero before commencement of labour.
AR-DRG	Australian Refined Diagnosis Related Group — a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 5.1 is based on the ICD-10-AM classification.
Average length of stay	The mean length of stay for all patient episodes, calculated by dividing total occupied bed days by total episodes of care.
Caesarean section	Operative birth through an abdominal incision.
Casemix adjusted	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted by AR-DRG into categories of patients with similar clinical conditions and requiring similar hospital services. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.
Casemix-adjusted separations	The number of separations adjusted to account for differences across hospitals in the complexity of episodes of care.
Catastrophic	An acute or prolonged illness usually considered to be life threatening or with the threat of serious residual disability. Treatment may be radical and is frequently costly.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Cost of capital	The return foregone on the next best investment, estimated at a rate of

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

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

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

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

9.9 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 9A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2007\Attach9A.xls and in Adobe PDF format as \Publications\Reports\2007\Attach9A.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

Table 9A.1	Recurrent expenditure, public hospitals (including psychiatric hospitals), current prices, (\$ million)
Table 9A.2	Recurrent expenditure, public (non-psychiatric) hospitals, by source of funding, 2004-05
Table 9A.3	Recurrent expenditure per person, public hospitals (including psychiatric) (2003-04 dollars)
Table 9A.4	Public hospitals (including psychiatric hospitals) by hospital size, 2004-05
Table 9A.5	Available beds per 1000 people, by region, public hospitals (including psychiatric) (number)
Table 9A.6	Summary of separations, public hospitals 2004-05
Table 9A.7	Separations, public (non-psychiatric) hospitals
Table 9A.8	Separations, public (non-psychiatric) hospitals, 2004-05
Table 9A.9	Separations in public hospitals, by age group, 2004-05
Table 9A.10	Separations by hospital sector and by Indigenous status, 2004-05
Table 9A.11	Indicative estimates of separations per 1000 people, by reported Indigenous status (number)
Table 9A.12	Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals)
Table 9A.13	Separations, by type of episode of care, public hospitals (including psychiatric), 2004-05
Table 9A.14	Australian refined diagnosis related groups (AR-DRGs) version 5.1 with the highest number of overnight acute separations, public hospitals, 2004-05
Table 9A.15	Top 10 AR-DRGs (version 5.1) with the most patient days, excluding same day separations, public hospitals, 2004-05
Table 9A.16	Non-admitted patient occasions of service, by type of non-admitted patient care, public hospitals, 2004-05
Table 9A.17	Emergency department waiting times, by triage category, public hospitals, 2004-05

Table 9A.18	Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals
Table 9A.19	Elective surgery waiting times, by specialty of surgeon
Table 9A.20	Elective surgery waiting times, by indicator procedure
Table 9A.21	NSW elective surgery waiting times by clinical urgency category, public hospitals (per cent)
Table 9A.22	NSW elective surgery waiting times, public hospitals, by specialty, 2004-05
Table 9A.23	Victorian elective surgery waiting times by clinical urgency category, public hospitals (per cent)
Table 9A.24	Victorian elective surgery waiting times, public hospitals, by specialty, 2004-05
Table 9A.25	Queensland elective surgery waiting times, by clinical urgency category, public hospitals (per cent)
Table 9A.26	Queensland elective surgery waiting times, public hospitals, by specialty, 2004-05
Table 9A.27	WA elective surgery waiting times, by clinical urgency category, public hospitals (per cent)
Table 9A.28	WA elective surgery waiting times, public hospitals, by specialty, 2004-05
Table 9A.29	SA elective surgery waiting times, by clinical urgency category, public hospitals
Table 9A.30	SA elective surgery waiting times, public hospitals, by specialty, 2004-05
Table 9A.31	Tasmanian elective surgery waiting times, by clinical urgency category, public hospitals
Table 9A.32	ACT elective surgery waiting times, by clinical urgency category, public hospitals
Table 9A.33	ACT elective surgery waiting times, public hospitals, by specialty, 2004-05
Table 9A.34	NT elective surgery waiting times, by clinical urgency category, public hospitals
Table 9A.35	NT elective surgery waiting times, public hospitals, by specialty, 2004-05
Table 9A.36	Separations for selected procedures or diagnoses per 1000 people, all hospitals, by patient's usual residence 2004-05
Table 9A.37	Unplanned re-admissions, public hospitals, NSW
Table 9A.38	Unplanned re-admissions, public hospitals, Victoria
Table 9A.39	Unplanned re-admissions, public hospitals, Queensland
Table 9A.40	Unplanned re-admissions, public hospitals, WA
Table 9A.41	Unplanned re-admissions, public hospitals, SA
Table 9A.42	Pre-anaesthetic consultations, public hospitals, NSW
Table 9A.43	Pre-anaesthetic consultations, public hospitals, Victoria
Table 9A.44	Pre-anaesthetic consultations, public hospitals, Queensland
Table 9A.45	Pre-anaesthetic consultations, public hospitals, SA
Table 9A.46	Surgical site infections for selected procedures, NSW public hospitals, 2005
Table 9A.47	Surgical site infections for selected procedures, Victorian public hospitals, 2005

Table 9A.48	Surgical site infections for selected procedures, Queensland public hospitals, 2005
Table 9A.49	Surgical site infections for selected procedures, WA public hospitals, 2005
Table 9A.50	Surgical site infections for selected procedures, SA public hospitals, 2005
Table 9A.51	Proportion of accredited beds in public hospitals (per cent)
Table 9A.52	Nursing workforce (includes midwives), by region (per cent)
Table 9A.53	Medical practitioner workforce, by region (per cent)
Table 9A.54	Recurrent cost per casemix-adjusted separation, selected public hospitals, 2004-05
Table 9A.55	Costs and utilisation by hospital peer group, public hospitals (including psychiatric), 2004-05
Table 9A.56	Capital cost per casemix-adjusted separation — indicative estimates for inpatient services at major public acute hospitals, 2004-05
Table 9A.57	Relative stay index for patients in public hospitals, by patient election status, 2004-05
Table 9A.58	Relative stay index, indirectly standardised, patients in public hospitals, by medical, surgical and other type of diagnosis related group, 2004-05
Table 9A.59	NSW recurrent cost per non-admitted patient occasion of service, public hospitals, 2004-05
Table 9A.60	Victorian recurrent cost per encounter, public hospitals
Table 9A.61	WA recurrent cost per non-admitted patient occasion of service, public hospitals, 2004-05
Table 9A.62	SA recurrent cost per non-admitted patient occasion of service, public hospitals, 2004-05
Table 9A.63	Tasmanian recurrent cost per non-admitted patient occasion of service, public hospitals, 2004-05
Table 9A.64	ACT recurrent cost per non-admitted patient occasion of service, public hospitals, 2004-05
Table 9A.65	Non-admitted clinic occasions of service reported at Tier 0 clinics, sample results, public sector, Australia, 2004-05
Table 9A.66	Emergency department average cost per occasion of service, by triage class, public sector, Australia, 2004-05
Table 9A.67	Non-admitted clinic occasions of service for Tier 1 clinics, sample results, public sector, Australia, 2004-05
Table 9A.68	NSW patient evaluation of hospital services
Table 9A.69	Victorian patient evaluation of hospital services
Table 9A.70	Queensland patient evaluation of hospital services
Table 9A.71	WA patient evaluation of hospital services
Table 9A.72	SA patient evaluation of hospital services
Table 9A.73	Tasmanian patient evaluation of hospital services
Table 9A.74	ACT patient evaluation of hospital services

Table 9A.75	NT patient evaluation of hospital services
Table 9A.76	Nationally agreed core sentinel events (number)
Table 9A.77	Separations, same day separations, patient days, average length of stay and costs for MDC 14 and MDC 15, public hospitals, Australia, 2004-05
Table 9A.78	Separations by major diagnostic category, public hospitals, 2004-05
Table 9A.79	10 Diagnosis related groups with highest cost, by volume, public hospitals, Australia, 2004-05
Table 9A.80	Intervention rates for selected primiparae, 2005
Table 9A.81	Intervention rates for selected primiparae, NSW
Table 9A.82	Intervention rates for selected primiparae, Victoria
Table 9A.83	Intervention rates for selected primiparae, Queensland
Table 9A.84	Intervention rates for selected primiparae, WA
Table 9A.85	Intervention rates for selected primiparae, SA
Table 9A.86	Intervention rates for selected primiparae, Tasmania
Table 9A.87	Intervention rates for selected primiparae, ACT
Table 9A.88	Intervention rates for selected primiparae, NT
Table 9A.89	Rate of vaginal delivery following primary caesarean, public hospitals, NSW
Table 9A.90	Rate of vaginal delivery following primary caesarean, public hospitals, Victoria
Table 9A.91	Rate of vaginal delivery following primary caesarean, public hospitals, Queensland
Table 9A.92	Rate of vaginal delivery following primary caesarean, public hospitals, WA
Table 9A.93	Rate of vaginal delivery following primary caesarean, public hospitals, SA
Table 9A.94	Perineal status after vaginal births, 2003
Table 9A.95	Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 5.0) in public hospitals, 2004-05
Table 9A.96	Baby's Apgar scores at five minutes, by birthweight, public hospitals
Table 9A.97	Fetal deaths
Table 9A.98	Neonatal deaths
Table 9A.99	Neonatal, fetal and perinatal death rates, Australia (400g/20 weeks)
Table 9A.100	Perinatal deaths
Table 9A.101	Perinatal, neonatal and fetal deaths, by Indigenous status 2000–2004

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10 Primary and community health

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

- Home and Community Care program services (see chapter 12, ‘Aged care’)
- public hospital emergency departments and outpatient services (see chapter 9, ‘Public hospitals’)
- community mental health services (see chapter 11, ‘Health management issues’).

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

Descriptive information about primary and community health services is contained in section 10.1. A framework of performance indicators is presented in section 10.2, and key performance indicator results are discussed in section 10.3. Future directions for reporting are covered in section 10.4, and relevant terms are defined in section 10.5. Section 10.6 lists the supporting tables for this chapter. Supporting tables are identified in references throughout the chapter by an ‘A’ suffix (for example, table 10A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Section 10.7 lists references used in this chapter.

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

- data are reported for the ‘availability of public dentists’ indicator for the first time
- Indigenous data are reported for the ‘hospitalisations for vaccine preventable conditions’, ‘potentially preventable acute conditions’ and ‘potentially preventable chronic conditions’ indicators.

10.1 Profile of primary and community health

Definitions, roles and responsibilities

General practitioners (GPs) are a significant part of the medical practitioner workforce. The medical practitioner workforce comprises doctors trained in a specialty (including general practice) and other medical practitioners (OMPs). The Royal Australian College of General Practitioners (RACGP) defines a GP as ‘a medical practitioner who provides primary comprehensive and continuing care to patients and their families within the community’ (Britt *et al.* 2007). Most of the data in this chapter include two types of medical practitioner who provide GP services:

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

While the majority of GPs provide services as part of a general practice, some GPs are also employed by hospitals or other organisations in full time or part time capacities. General practice is the business structure within which one or more GPs and other staff such as practice nurses provide and supervise healthcare for a group of patients. General practices are predominantly privately owned, by either the GPs or corporate entities. In Australia, general practices are an important source of primary healthcare. The services they provide include: diagnosing and treating illness (both chronic and acute); providing preventative care through to palliative care; referring patients to consultants, allied health professionals, community health services and hospitals; and acting as gatekeepers for other healthcare services (DHFS 1996). Definitions for common health terms are provided in section 10.5.

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

the emergency department staff (Van Konkelenberg, Esterman, Van Konkelenberg 2003).

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

The Australian Government also subsidises the cost of many prescription medicines through the PBS. The PBS aims to provide all Australians affordable, reliable and timely access to prescription medicines. Around 80 per cent of prescriptions dispensed in Australia are subsidised under the PBS. Users make a co-payment with the Australian Government paying the remaining cost for drugs eligible for subsidy. For concession card holders the co-payment is currently \$4.70. For other people, or general consumers, the co-payment is currently \$29.50. These amounts are normally adjusted in line with inflation on 1 January each year. Both concession card holders and general consumers are subject to a safety net threshold. Once spending within a calendar year has reached the relevant threshold, PBS medicines will generally be cheaper or free for the rest of the calendar year for these people. The 2006 safety net threshold is \$960.10 for general patients and \$253.80 for people holding a concession card (DoHA 2006b).

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

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

the community health services covered in this chapter is in health services for Indigenous people.

The Australian Government also supports patients with chronic conditions and complex care needs to access certain allied health services under Medicare. Eligible patients are able to receive a Medicare rebate for up to five allied health services each calendar year, on referral from a GP.

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

Funding

General practice

Almost all of the services provided by private GPs are at least partly funded by the Australian Government through Medicare and the DVA. This is illustrated by data from the annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia. The BEACH survey found that 94.0 per cent of all encounters with GPs in 2005-06 were for services at least partly funded by Medicare or the DVA (table 10.1). The Australian Government also provides payments to GPs through the Practice Incentives Program (PIP) and the General Practice Immunisation Incentives Scheme (GPPI) (DHAC 2000). These payments are included in the data for Australian Government expenditure presented below (figure 10.19). The Australian Government also invests in general practice through the Divisions of General Practice Program.

The Australian Government spent approximately \$4.9 billion, or \$239 per person, on general practice in 2005-06, including through Medicare, non-Medicare funding, expenditure by the DVA and other funding programs (figure 10.19). This does not

give a complete picture of government expenditure on primary health because it does not include expenditure on Indigenous primary health care services, other community health services, and services delivered through hospital accident and emergency departments. These types of primary healthcare are more prevalent in rural and remote areas. Accordingly, expenditure on primary health is understated, particularly in jurisdictions with larger proportions of Indigenous people and people living in rural and remote areas. The Health preface includes expenditure data for Indigenous primary and community health services for 2001-02 (tables E.1 and E.2).

Table 10.1 GP encounters, by source of funding, 2005-06^{a, b, c}

	<i>Number^d</i>	<i>Rate^e</i>	<i>95% LCL</i>	<i>95% UCL</i>
	no.	no./100 encounters	no./100 encounters	no./100 encounters
GPs participating in the BEACH survey	1 017	..	..	..
Total encounters for which BEACH data were recorded	101 993	..	..	..
Encounters with missing data	7 310	..	..	..
Direct encounters	92 617	97.8	97.5	98.1
No charge	431	0.5	0.4	0.5
Medicare paid ^f	89 011	94.0	93.4	94.6
Workers compensation	2 190	2.3	2.1	2.5
Other paid (hospital, State, etc.)	995	1.1	0.6	1.5
Indirect encounters ^g	2 066	2.2	1.9	2.5

UCL = upper confidence limit. LCL = lower confidence limit. ^a April 2005 to March 2006. ^b An 'encounter' is any professional interchange between a patient and a GP (Britt *et al.* 2000). ^c Data from the BEACH survey may not be directly comparable with the other data on medical practitioners that are reported in this chapter. ^d Number of encounters after post-stratification weighting for GP activity and GP age and sex. ^e Missing data removed. Percentage base (N = 101 993). ^f Includes Australian Government payments made through the DVA. ^g Indirect consultations are those at which the patient is not seen by the GP but that generate a prescription, a referral, a certificate or another service. .. Not applicable.

Source: Britt *et al.* (2007); table 10A.1.

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Expenditure on the PBS and RPBS was around \$5.8 billion, or \$285 per person, in 2005-06. Expenditure on the PBS was around \$5.4 billion in 2005-06, 80.0 per cent of which was expenditure on concessional patients (table 10.2). Data on government expenditure on pharmaceuticals is also presented in the 'Health preface.'

Table 10.2 **PBS and RPBS expenditure, 2005-06 (\$ million)^a**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS general ^b	363.8	264.6	204.4	102.1	80.9	21.7	22.4	6.4	1 066.3
PBS concessional ^c	1 497.3	1 090.9	804.7	362.5	380.1	124.2	45.1	13.1	4 318.0
PBS doctor's bag	3.5	2.6	2.2	0.6	0.7	0.2	0.1	–	10.1
PBS total	1 864.7	1 358.1	1 011.3	465.2	461.7	146.2	67.7	19.6	5 394.4
RPBS total ^d	160.7	100.7	101.2	35.1	35.6	14.2	6.7	0.9	455.1
Total	2 025.4	1 458.7	1 112.5	500.3	497.3	160.3	74.4	20.5	5 849.5
\$ per capita	297.4	288.3	276.6	246.0	321.4	328.7	227.3	100.0	285.4

^a State and territory level data are only available on a cash basis for general, concessional and doctor's bag categories. These figures are not directly comparable to those published in the DoHA annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements. ^b Includes PBS general ordinary and safety net. ^c Includes concessional ordinary and concessional free safety net. ^d Includes RPBS ordinary and RPBS safety net. – Nil or rounded to zero.

Source: DoHA (unpublished).

Community health services

Expenditure data are not available for all of the community health services covered in this chapter. The Australian Institute of Health and Welfare (AIHW) publishes expenditure data on community and public health, and dental services. The former category, however, includes public health activities that are not covered in this chapter, such as food safety regulation and media campaigns to promote health awareness. The dental services category includes private dental services (funded by insurance premium rebates and non-government expenditure) that are also not reported in this chapter. In 2004-05, government expenditure on community and public health was \$5.6 billion, with State, Territory and local government providing 68.3 per cent and the Australian Government providing 22.7 per cent of this expenditure (table 10.3). Australian Government direct outlay expenditure on dental services was \$82 million in 2004-05, and State, Territory and local government expenditure was \$503 million (table 10.3).

Table 10.3 **Estimated funding on community and public health, and dental services, 2004-05 (\$ million)^{a, b}**

	<i>Australian Government</i>			<i>State and local govt</i>	<i>Total govt</i>	<i>Non-govt</i>	<i>Total</i>
	<i>Direct outlays</i>	<i>Premium rebates</i>	<i>Total</i>				
Community and public health ^c	1 265	–	1 265	3 804	5 069	500	5 569
Dental services ^d	82	368	450	503	954	4 110	5 064

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

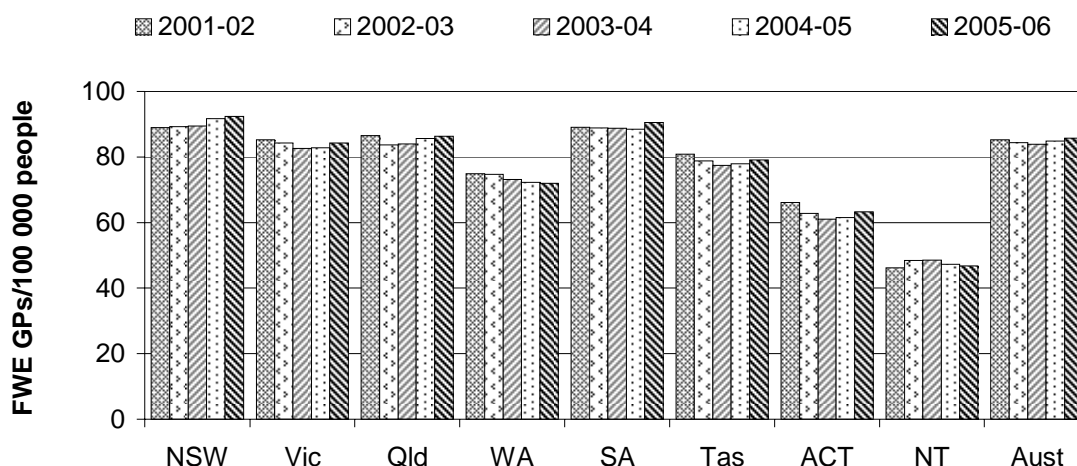
Source: AIHW (2006d).

Size and scope

General practice

There were 25 146 vocationally recognised GPs and OMPs billing Medicare in Australia in 2005-06. On a full time workload equivalent (FWE) basis, there were 17 649 vocationally recognised GPs and OMPs. This was equal to 85.8 recognised GPs and OMPs per 100 000 people (table 10A.3). These data exclude services provided by GPs working with the Royal Flying Doctor Service and GPs working in Indigenous-specific primary health care services and public hospitals. In addition, the data are based on Medicare claims, which for some GPs (particularly in rural areas) pay for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid through Medicare. The numbers of FWE vocationally recognised GPs and OMPs per 100 000 people across jurisdictions are shown in figure 10.1.

Figure 10.1 **Availability of GPs (full time workload equivalent)^a**



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

Source: DoHA (unpublished); table 10A.3.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

There were around 184 million services provided under the PBS and RPBS in 2005-06, amounting to 9.0 scripts per person. There were around 168 million services provided under the PBS in 2005-06, of which 83.8 per cent were concessional (table 10.4).

Table 10.4 **PBS and RPBS services, 2005-06 (million services)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS general ^a	9.2	6.7	5.1	2.6	2.0	0.6	0.6	0.2	26.8
PBS concessional ^b	48.5	35.9	26.4	12.0	12.3	4.2	1.3	0.4	141.1
PBS doctor's bag	0.1	0.1	0.1	—	—	—	—	—	0.4
PBS total	57.8	42.7	31.5	14.6	14.3	4.8	1.9	0.6	168.3
RPBS total ^c	5.3	3.4	3.3	1.2	1.2	0.5	0.2	—	15.2
Total	63.1	46.1	34.8	15.8	15.5	5.3	2.1	0.6	183.5
Services per capita	9.3	9.1	8.7	7.8	10.0	11.0	6.5	3.0	9.0

^a Includes PBS general ordinary and safety net. ^b Includes concessional ordinary and concessional free safety net. ^c Includes RPBS ordinary and RPBS safety net. — Nil or rounded to zero.

Source: DoHA (unpublished).

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 10A.41–10A.49 provide information on community health programs in each jurisdiction. The more significant of these programs are described below. Other community health programs provided by some jurisdictions include:

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

Community health programs that address mental health, home and community care, and aged care assessments are reported in chapters 11 (Health management) and 12 (Aged care).

Maternal and child health

All jurisdictions provide maternal and child health services through their community health programs. These services include: parenting support programs (including antenatal and postnatal programs); early childhood nursing programs; disease prevention programs (including childhood immunisations); and early intervention and treatment programs related to child development and health. Some jurisdictions also provide specialist programs through child health services, including hearing screening programs, and mothers and babies residential programs. Performance indicators for maternity services in public hospitals are reported in chapter 9.

Public dental services

All jurisdictions provide some form of public dental service for primary school children. Some jurisdictions also provide dental services to secondary school students. In SA, Tasmania, and the NT, for example, general dental care (including preventative care) is provided for school children up to 18 years of age [tables 10A.49 (SA), 10A.50 (Tasmania) and 10A.52 (NT)].

States and territories also provide some general dental services and a limited range of specialist dental services to disadvantaged adults (holders of concession cards issued by Centrelink). In some states, specialist dental services are provided mainly by qualified dental specialists; in others, they are provided in dental teaching

hospitals as part of training programs for dental specialists (National Advisory Committee on Oral Health 2004). A number of jurisdictions indicated to the Review that they provided public dental services in 2004-05 targeted at disadvantaged people (tables 10A.41–10A.49).

Alcohol and other drug treatment

Alcohol and other drug treatment activities range from a brief intervention to long term residential treatment. Types of treatment include detoxification, pharmacological treatment (also known as substitution or maintenance treatment), counselling and rehabilitation. The data included here have been sourced from a report on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AIHW 2006a). That report excluded some treatment activities, including opioid pharmacotherapy treatment where it is the only treatment provided. The report also excluded data for the majority of Indigenous substance use services and Indigenous community healthcare services that also provide alcohol and other drug treatment services and are funded by the Australian Government.

A total of 635 alcohol and other drug treatment services contributed 2004-05 data for the National Minimum Data Set. Of these, 321 (50.6 per cent) identified as government providers and 314 (49.4 per cent) identified as non-government providers (table 10A.8). All of the non-government providers received some government funding for 2004-05. A total of 121 812 clients were registered for treatment in 2005-06, of whom 65.9 per cent were male (AIHW 2006a). Alcohol was reported as the most common principal drug of concern for which clients sought treatment (37.2 per cent of treatment episodes). Cannabis was the next most common drug of concern (23.0 per cent of treatment episodes), followed by heroin (17.2 per cent of treatment episodes) and amphetamines (10.9 per cent of treatment episodes) (AIHW 2006a). Further information on alcohol and other drug treatment services funded by governments is included in tables 10A.41–10A.49.

Indigenous community healthcare services

Indigenous Australians utilise a range of primary health care services including private general practitioners and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services in all jurisdictions. These services are planned and governed by local Indigenous communities and aim to deliver holistic and culturally appropriate health and health-related services. Funding is provided by Australian, State and Territory governments. In addition to these health care services, health programs for Indigenous Australians are funded by

a number of jurisdictions. In 2005-06 these programs included services such as health information, promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 10A.41–10A.49).

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

For 2004-05, SAR data are reported for 141 Indigenous primary healthcare services (table 10A.4). Of these services, 53 (37.6 per cent) were located in remote or very remote areas (table 10A.5). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 10A.6). An episode of healthcare is defined in the SAR data collection as contact between an individual client and staff of a service to provide healthcare. Nearly 1.6 million episodes of healthcare were provided by participating services in 2004-05 (table 10.5). Of these, around 548 000 (34.6 per cent) were in remote or very remote areas (table 10A.5). The services included in the SAR data collection employed 1845 full time equivalent health staff (as at 30 June 2005). Of these health staff, 1141 were Indigenous (61.8 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous, however, were relatively low (0.9 per cent and 14.4 per cent respectively) (table 10A.7).

Table 10.5 Estimated Indigenous episodes of healthcare by surveyed services ('000)^a

	<i>NSW and ACT</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>NT</i>	<i>Aust</i>
2000-01	349	131	187	327	147	12	189	1342
2001-02	357	136	214	313	144	18	233	1416
2002-03	423	130	234	337	140	20	216	1499
2003-04	430	169	267	302	142	22	280	1612
2004-05	415	151	254	274	145	23	323	1585

^a An episode of healthcare involves contact between an individual client and staff of a service to provide healthcare. Group work is not included. Transport is included only if it involves provision of healthcare/information by staff. Episodes of healthcare provided at outreach locations are included — for example, episodes at outstation visits, park clinics and satellite clinics — as are episodes delivered over the phone.

Source: DoHA SAR (unpublished).

10.2 Framework of performance indicators

The performance indicator framework is based on the shared government objectives for primary and community health (box 10.1). The framework provides information on equity, effectiveness and efficiency, and distinguishes outputs from outcomes. This approach is consistent with the general performance indicator framework for this Review that has been agreed by the Steering Committee (chapter 1). The framework will evolve as better indicators are developed and as the focus and objectives for primary and community health change. In particular, the Steering Committee plans to develop and report against more indicators relating to community health services.

Box 10.1 Objectives for primary and community health

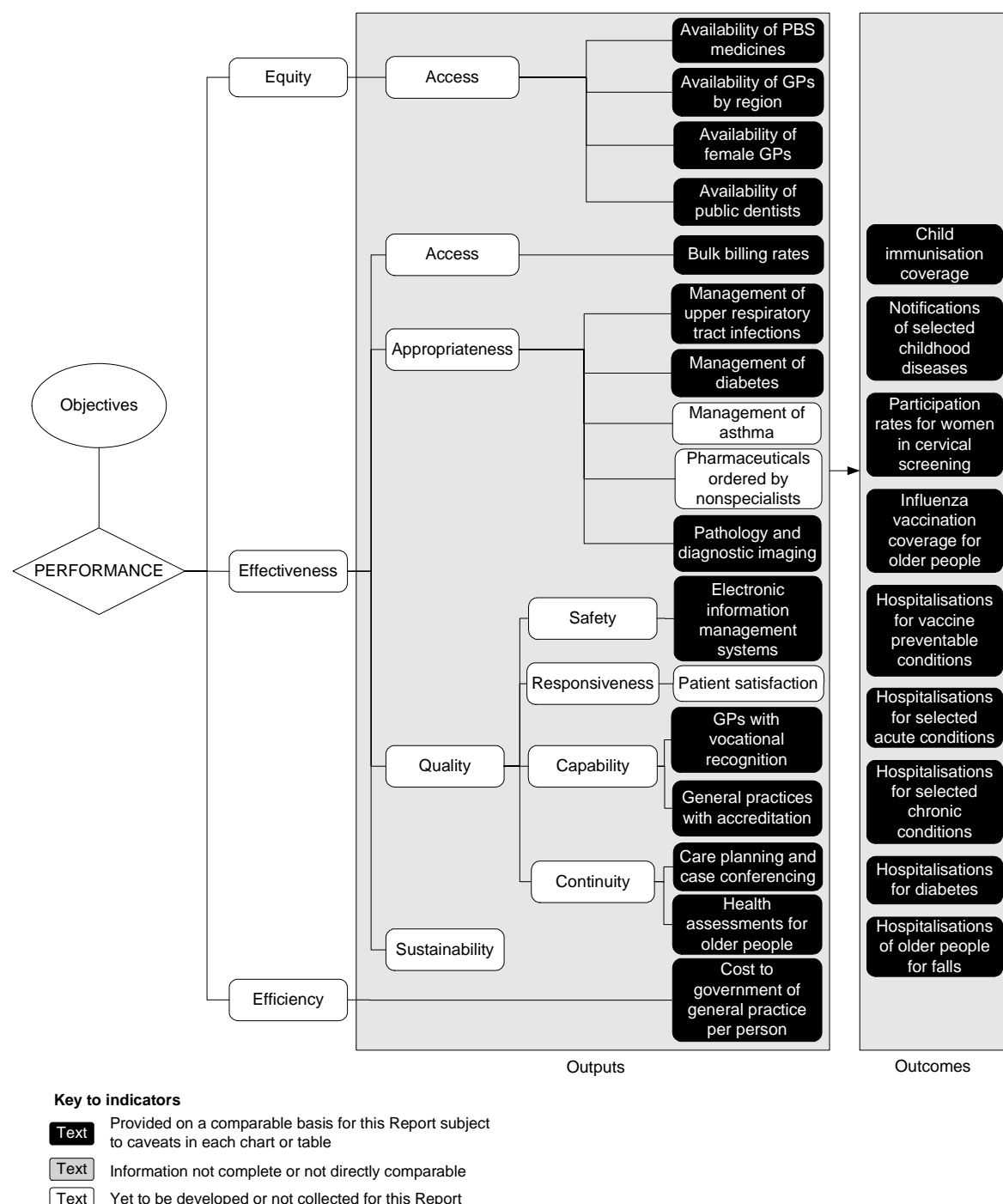
Primary and community health services aim to promote the health of Australians by:

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

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

The performance indicator framework shows which data are comparable in the 2007 Report (figure 10.2). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (section 1.6). The ‘Health preface’ explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability that have been added to the standard Review framework for health services.

Figure 10.2 Performance indicators for primary and community health



10.3 Key performance indicator results

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

statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter.

Equity

For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. This includes equal access for groups who may have special needs, or difficulties in gaining access to services, due to English language proficiency, gender, age, disability, ethnicity or geography (chapter 1).

Problems with accessing primary and community health services have contributed to the generally poor health status of Indigenous people relative to other Australians (see the 'Health Preface' and SCRGSP 2005). Geographic, language, gender or other barriers can also have an impact on access to primary and community health services for other groups of people, including people living in rural and remote areas and people who speak languages other than English.

Access

Three indicators of equity of access to primary and community health services are reported this year: 'availability of PBS medicines' (box 10.2); 'availability of FWE GPs by region' (box 10.3); and 'availability of female GPs' (box 10.4). 'Availability of PBS medicines' is reported for the first time this year. A fourth indicator, 'availability of dental services' is included in the framework but data are not available for reporting against it (box 10.5).

Availability of PBS medicines

Box 10.2 Availability of PBS medicines

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

Three measures are presented for this indicator:

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

(Continued on next page)

Box 10.2 (Continued)

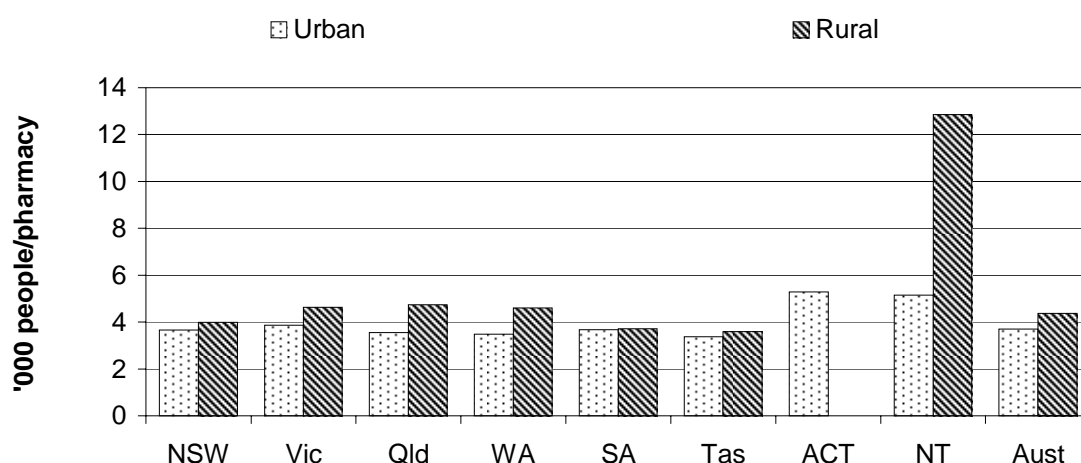
A decrease in people per pharmacy indicates improved availability of PBS medicines. An increase in PBS expenditure per person indicates improved availability of PBS medicines. An increase in the proportion of PBS prescriptions filled at a concessional rate indicates an improved access to PBS prescriptions.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

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

The distribution of pharmacies underlies access to the PBS. Across Australia, there were 3700 people per pharmacy in urban areas and 4376 people per pharmacy in rural areas in 2005-06. In all states and territories, the number of people per pharmacy was higher in rural than in urban areas (except in the ACT, which has no rural statistical areas) (figure 10.3).

In addition to pharmacies, 81 medical practitioners and 176 hospitals were approved to supply PBS medicines to the community in 2005-06. There were 79 medical practitioners and 63 hospitals located in rural areas (table 10A.10). These additional services may help to improve access to PBS medicines in some locations.

Figure 10.3 People per pharmacy, 2005-06^a



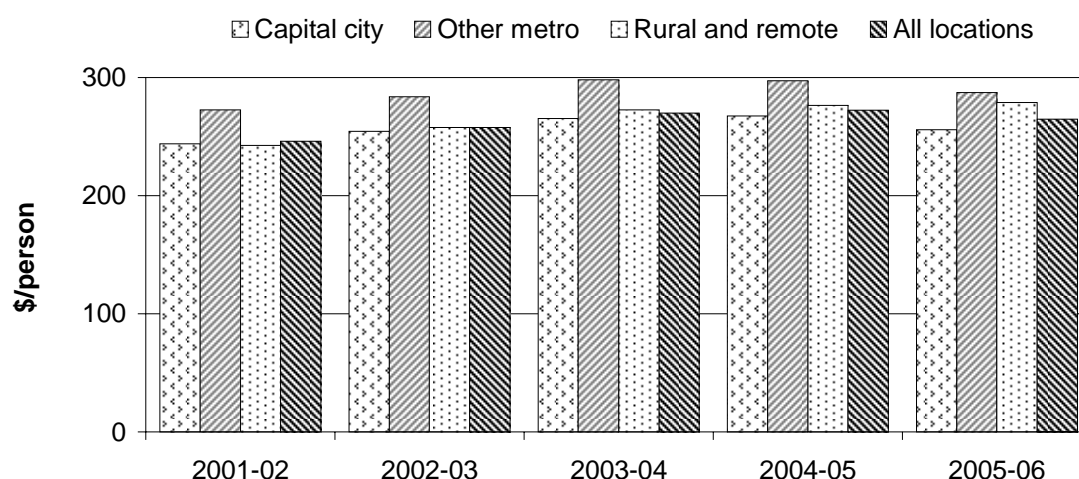
^a Pharmacies measured using the Accessibility/Remoteness Index of Australia modified for Pharmacies (PHARIA). Urban = PHARIA 1. Rural = PHARIA 2-6. The ACT has no rural statistical areas.

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

For Australia as a whole, PBS expenditure per person has increased each year over the period 2001-02 to 2004-05, with a decrease in 2005-06. PBS expenditure per

person has been higher in rural and remote areas than in capital cities for the period 2002-03 to 2005-06 (in 2005-06 dollars) (figure 10.4).

Figure 10.4 PBS expenditure per person (2005-06 dollars)^a



^a Locality level data are only available on a cash basis for general and concessional categories. These figures are not directly comparable to those published in DoHA's annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements.

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

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory (although this is not available by regional location) in table 10A.9. Australia-wide, 83.8 per cent of prescriptions were concessional in 2005-06.

Availability of GPs by region

Box 10.3 Availability of GPs by region

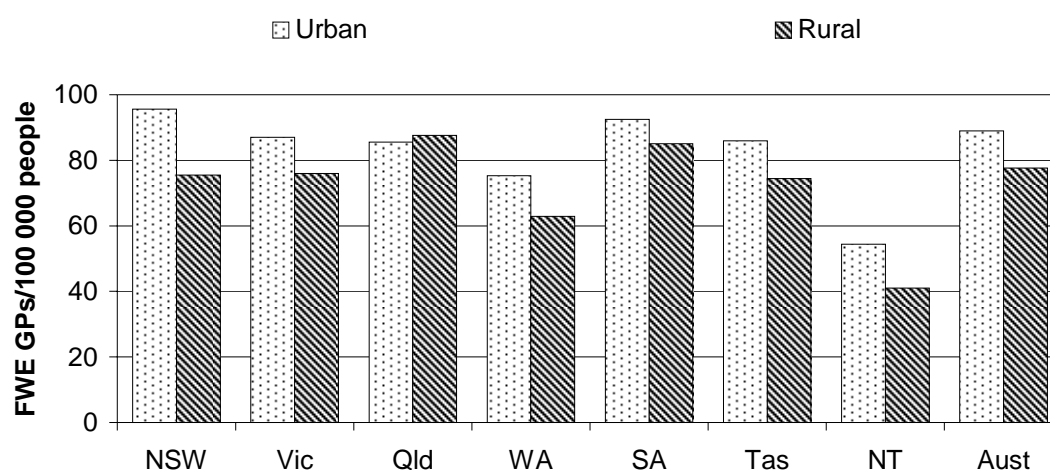
The availability (or supply) of GPs by region affects people's access to general practice services, particularly in rural and remote areas. Low availability can result in increased travel distance to a practice, increased waiting times to see a GP, and difficulty in booking long consultations. Low availability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

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

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

In terms of FWE GPs per 100 000 people, in all states and territories except Queensland there were more GPs available in urban than rural areas in 2005-06 (figure 10.5). The bulk billed proportion of non-referred attendances was generally lower in rural and remote centres, except other remote areas, than in capital cities or other metropolitan centres (table 10A.15).

Figure 10.5 Availability of GPs (full time workload equivalent), 2005-06^{a, b, c}



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

Source: DoHA (unpublished); table 10A.12.

Availability of female GPs

Box 10.4 Availability of female GPs

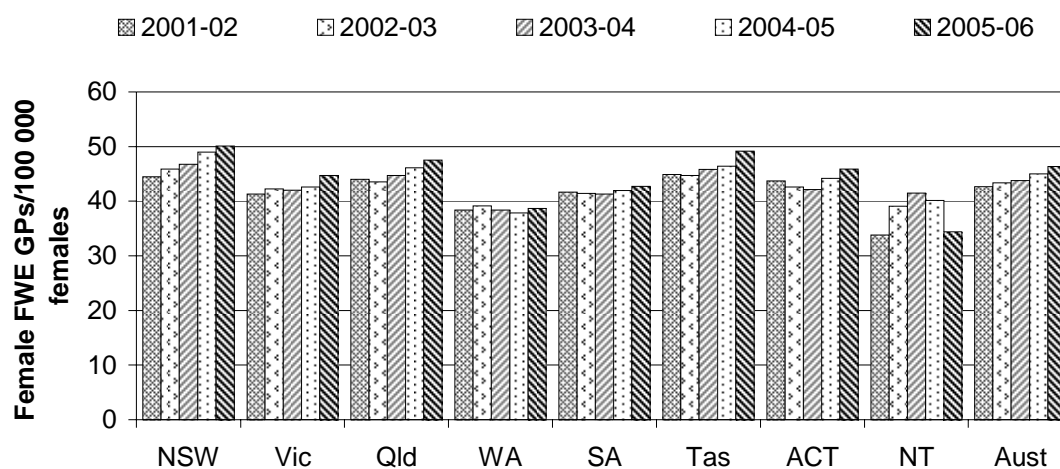
This indicator measures equity of access, recognising that some female patients prefer to discuss health matters with, and to receive primary healthcare from, a female GP.

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

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

In 2005-06, 37.4 per cent of Australia's GPs were female. This represented 27.1 per cent of FWE GPs (tables 10A.3 and 10A.13). In 2005-06, there were 46.3 female FWE GPs per 100 000 females in Australia (figure 10.6).

Figure 10.6 Availability of female GPs (full time workload equivalent)^a



^a Data relate to recognised GPs and OMPs.

Source: DoHA (unpublished); table 10A.13.

Availability of public dentists

Box 10.5 Availability of public dentists

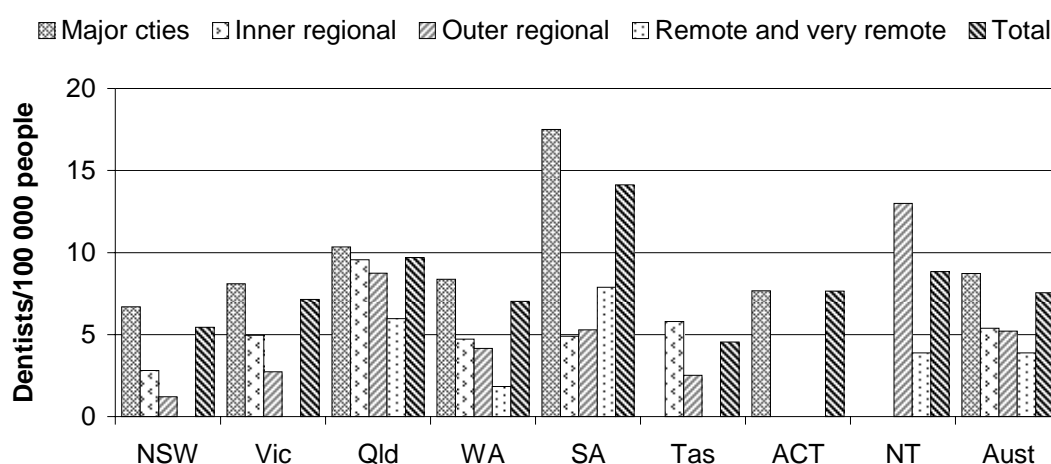
The availability (or supply) of public dentists by region affects people's access to public dental services, particularly in rural and remote areas. Low availability can result in increased travel distance to a dentist and increased waiting times to see a dentist.

The indicator is defined as the number of public dentists per 100 000 people by region.

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

Data for 'availability of public dentists' are reported for the first time this year. In 2003 there were more public dentists per 100 000 people in major cities than in regional or remote areas for all states and territories (figure 10.7). There were more public dental therapists per 100 000 people in inner and outer regional than in major cities or remote and very remote areas (table 10A.14).

Figure 10.7 Availability of public dentists, 2003^{a, b, c}



^a Data for the NT are based on data from the 2002 NT collection as there was no data collection in the NT in 2003. ^b There were no public dentists in remote and very remote areas in NSW, Victoria or Tasmania. There were no public dentists in inner regional areas in the ACT. ^c Tasmania had no major cities. The ACT had no outer regional, or remote and very remote areas. The NT had no major cities or inner regional areas.

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

Effectiveness

Access

‘Bulk billing rates’ (box 10.6) is currently the only indicator reported against effectiveness and access.

Bulk billing rates

Box 10.6 Bulk billing rates

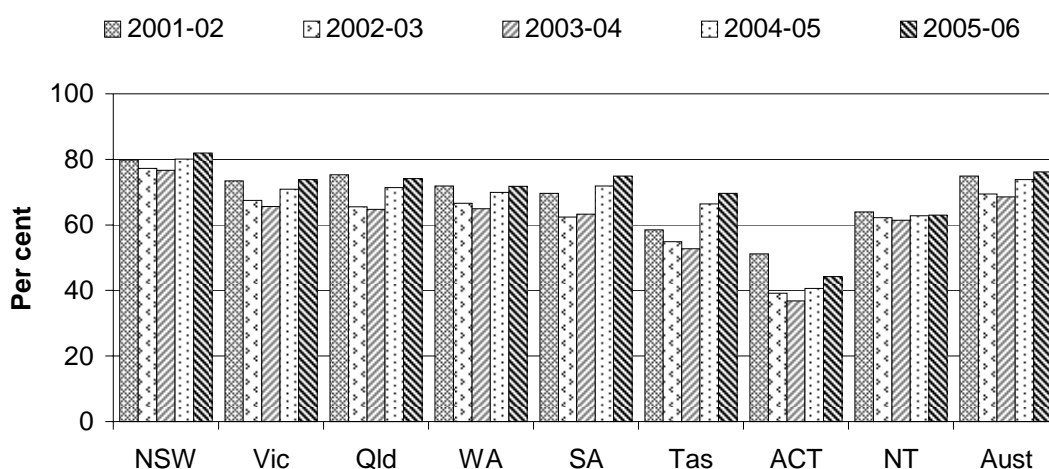
Patient visits to GPs are classed as non-referred attendances under Medicare. Patients are either bulk billed or required to pay part of the cost of the non-referred attendance. Where a patient is bulk billed, the GP bills Medicare Australia directly and since 1 January 2005 receives 100 per cent of the Schedule fee (the patient's rebate) as full payment for the service. The 100 per cent Medicare rebate applies to most services provided by a GP. The patient makes no out-of-pocket contribution. The bulk billed proportion of non-referred attendances indicates the affordability of GP services.

The indicator is defined as the number of non-referred attendances that were bulk billed as a proportion of all non-referred services.

A higher proportion of bulk billed attendances indicates greater affordability of GP services. This indicator, however, does not provide information on whether the services are appropriate for the needs of the people receiving them.

Australia-wide, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 76.2 per cent in 2005-06. This proportion varied across jurisdictions (figure 10.8). The bulk billed proportion of non-referred attendances was higher in capital cities than in rural areas or remote centres (table 10A.15).

Figure 10.8 **Non-referred attendances that were bulk billed^a**



^a Data for 2003-04, 2004-05 and 2005-06 include attendances by practice nurses.

Source: DoHA (2006a); table 10A.16.

Appropriateness

Three indicators of the appropriateness of GP services are reported here: the ‘management of upper respiratory tract infections’ (box 10.7); ‘management of diabetes’ (box 10.8); and ‘pathology tests and diagnostic imaging ordered by non-specialists’ (box 10.11). In previous reports ‘management of diabetes’ and ‘hospitalisations for diabetes’ (box 10.27) were reported as one ‘management of diabetes’ outcome indicator.

The Steering Committee has also identified ‘management of asthma’ (box 10.9) and ‘pharmaceuticals ordered by non-specialists’ (box 10.10) as indicators of the appropriateness of GP services. Data for these indicators, however, were not available for the 2006 Report.

Box 10.7 Management of upper respiratory tract infections

Upper respiratory tract infections without complications are most often caused by viruses. Antibiotics have no efficacy in the treatment of viral infections but are still frequently prescribed when viruses occur. Unnecessarily high antibiotic prescription rates for upper respiratory tract infections have the potential to increase pharmaceutical costs and to increase antibiotic resistance in the community.

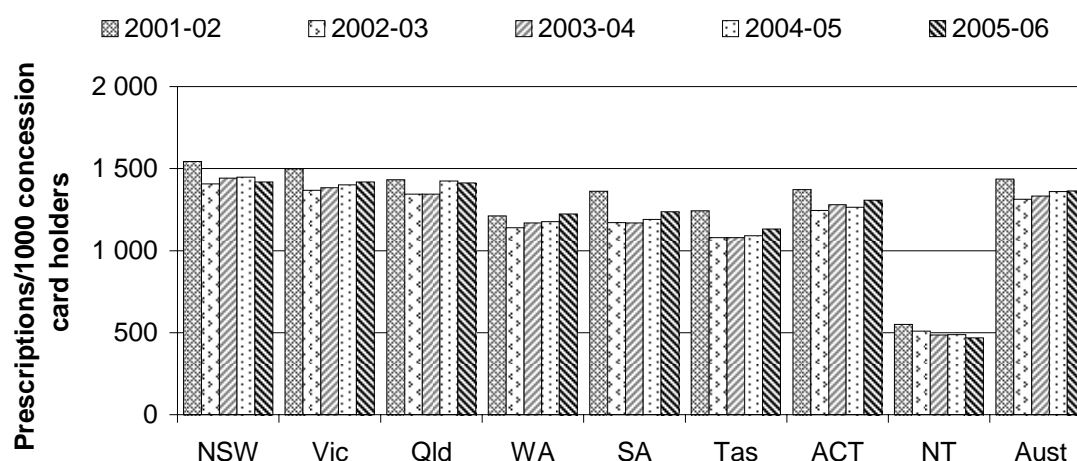
Ideally, this indicator would be based on the total population, but data restrictions mean it is based only on PBS concession card holders. The indicator is defined as the number of prescriptions for the oral antibiotics used most commonly to treat upper respiratory tract infection provided to PBS concession card holders per 1000 PBS concession card holders.

A reduction in the prescription rate may indicate that GPs are offering more appropriate treatment for viral infections.

Due to the effects of population ageing, the complexity of pharmaceutical needs of concession card holders may increase. In addition, the selected oral antibiotics may be prescribed for illnesses other than upper respiratory tract infections. The trend in the prescription of oral antibiotics should nevertheless be downwards if GPs more closely follow guidelines for the treatment of upper respiratory tract infections.

Australia-wide, the prescription rate for the oral antibiotics used most commonly to treat upper respiratory tract infection in 2005-06 was 1363.2 per 1000 PBS concession card holders (figure 10.9).

Figure 10.9 Rate of prescription of the oral antibiotics used most commonly to treat upper respiratory tract infections



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

Box 10.8 Management of diabetes

GPs and community healthcare services can play a significant role in the management of diabetes. Their role is to diagnose patients, enrol them in structured care and follow best practice condition management guidelines, including where early intervention is warranted.

Poorly controlled diabetes mellitus results in the development of associated conditions. The most common are renal, circulatory and ophthalmic complications that usually require admission to hospital. Over time, good management is likely to start to noticeably affect patients' secondary care requirements, preventing avoidable admissions to hospitals.

Three performance measures relating to the management of diabetes are reported:

- the proportion of adults with diabetes who have been diagnosed and placed on a Divisions of General Practice diabetes register. An increase in this proportion indicates improved patient management and monitoring
- the proportion of people on the Divisions' diabetes registers who have had a glycaemic control assessment. An increase in this proportion indicates improved patient management and monitoring
- the proportion of those who have had a glycaemic control assessment who are at risk of future complications — that is, they have glycated haemoglobin (HbA1c) greater than 2 per cent above the upper limit of normal (ULN). A decrease in this proportion indicates improved disease control.

While good primary and community healthcare 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.

Management of diabetes — diabetes register

The National Divisions Diabetes Program Data Collation Project was carried out in 2002-03 and had several components. One component was the collation of the quality of care and health outcomes data from the Divisions of General Practice that had a diabetes program and a diabetes register that had operated for at least three years. Divisions participated on a voluntary basis, and 16 supplied complete data.

Nationally in 2002, 17.9 per cent of adults with diabetes were on the Divisions' diabetes registers (table 10.6). These data are based on a small and not necessarily representative number of Divisions of General Practice that voluntarily took part in a national data collection.

Table 10.6 Management of adults with diabetes by participating Divisions of General Practice, 2002^{a, b, c, d, e}

	<i>Number</i>	<i>Per cent</i>
Estimated adults with diabetes in population from participating Divisions ^f	126 386	100.0
Adults with diabetes who are on a Divisions register	22 575	17.9
Patients for whom HbA1c measurement is known	13 325	100.0
Patients for whom HbA1c measurement is known having a glycaemic control assessment in a 6 month period	6 132	46.0
Patients having a glycaemic control assessment in a 6 month period for whom HbA1c measured with result >2% of ULN	1 144	18.7

^a The AusDiab survey (from which these data were sourced) was not representative of Aboriginal and Torres Strait Islander people. ^b The results reported for glycaemic control are for the period 1 January 2002 to 30 December 2002. Glycated haemoglobin (HbA1c) levels are reported as being within a certain percentage from the ULN. The reagents and units of measurement used are different in different laboratories. The normal range is established by a set of standard samples which the lab tests using its particular reagents and equipment. For this reason, every laboratory reports a normal reference range when it reports an HbA1c result. Labs may also report whether a given result is within 1 per cent of the ULN range for their particular testing method, or 'good', 'poor' etc. ^c Divisions participated on a voluntary basis (19 participated and 16 supplied complete data). The duration of Division registers varied from three to seven years, averaging 4.4 years with a median of five years. ^d Adults are persons aged 25 years or over. ^e Around half the people with diabetes are not aware that they have the condition. ^f The estimated number of people with diabetes in a Division has been calculated using population data from the 2001 Census Division and then applying the AusDiab age-specific prevalence rates.

Source: Centre for GP Integration Studies (2003).

Management of diabetes — glycaemic control assessments

Where a patient has been diagnosed with Type 2 diabetes, accepted clinical guidelines suggest that GPs should regularly monitor a number of important elements, including glycaemic control, blood pressure, weight, foot status, lipids, microalbumin level and eye status. The RACGP/Diabetes Australia guidelines recommend assessment every three to six months for Type 1 diabetes, (otherwise known as insulin dependent diabetes or juvenile onset diabetes because peak onset is much earlier in life) and every six to 12 months for Type 2 diabetes (also known as non-insulin dependent or maturity onset diabetes), and a target of HbA1c within 1 per cent of the ULN. Evidence from the UK Prospective Diabetes Study demonstrated that keeping HbA1c within 1 per cent of the ULN reduces the risk of developing complications from diabetes. Where levels are more than 2 per cent above the ULN, early intensive intervention is important to prevent complications.

In 2002, 46.0 per cent of registered adults with Type 2 diabetes with a known HbA1c measurement, had undergone a glycaemic control assessment in the previous six months (table 10.6).

Management of diabetes — patients at risk of complications

Of the people who had undergone a glycaemic control assessment in 2002, 18.7 per cent had HbA1c levels above the point at which there is an increased likelihood of complications (2 per cent above the ULN) (table 10.6). The proportion of adults with Type 2 diabetes with HbA1c levels in this range may initially reflect an increase in the impact of risk factors on changing population cohorts. Over time, however, regular testing and good management by GPs is likely to result in a decline in the proportion of people with diabetes in the category most at risk of complications.

Management of asthma

The Steering Committee has identified ‘management of asthma’ as an indicator of the appropriateness of GP services (box 10.9). Data for this indicator, however, were not available for the 2007 Report.

Box 10.9 Management of asthma

‘Management of asthma’ has been identified as an indicator of appropriateness, but a specific measure has not yet been developed.

Pharmaceuticals ordered by non-specialists

The Steering Committee has identified ‘pharmaceuticals ordered by non-specialists’ as an indicator of the appropriateness of GP services (box 10.10). Data for this indicator, however, were not available for the 2007 Report.

Box 10.10 Pharmaceuticals ordered by non-specialists

‘Pharmaceuticals ordered by non-specialists’ has been identified as an indicator of appropriateness, but no data are currently available.

Box 10.11 Pathology tests ordered and diagnostic imaging referrals by non-specialists (vocationally recognised GPs and OMPs)

The number of pathology tests ordered and diagnostic imaging referrals by vocationally recognised GPs and OMPs per person in the population is used to report on the appropriateness of diagnosis and prescribing patterns.

Four measures are reported:

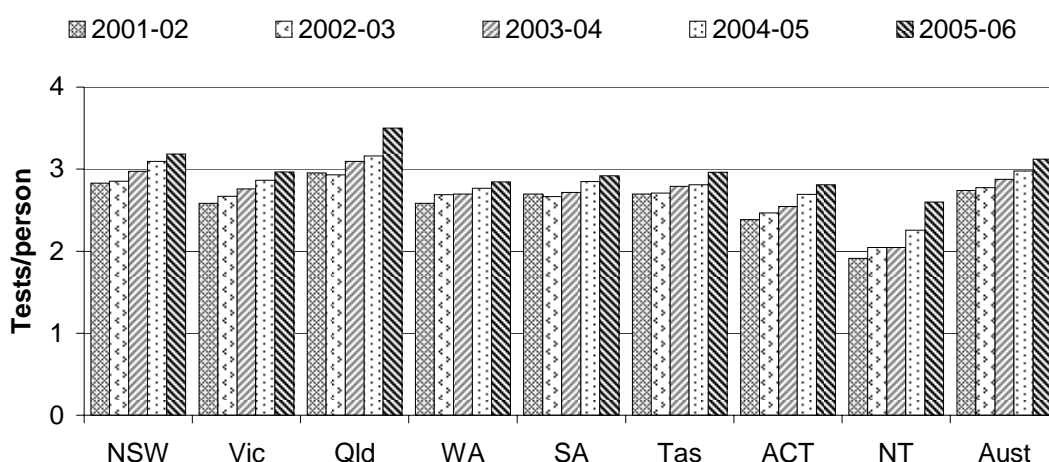
- pathology tests ordered by vocationally recognised GPs and OMPs per person
- diagnostic imaging referrals from vocationally recognised GPs and OMPs per person
- benefits paid per person for pathology tests
- benefits paid per person for diagnostic imaging.

In all cases, the data include only tests and referrals rebated through Medicare.

Differences across jurisdictions and over time may indicate inappropriate use of these services in diagnosis and treatment. While high levels may indicate GPs' over-reliance on these diagnostic tools, low levels may also indicate underuse. It is not possible to determine what might be the appropriate levels. Reporting these data contributes to the discussion of such issues.

Nationally, the number of pathology tests ordered per person increased from 2.7 in 2001-02 to 3.1 in 2005-06 (figure 10.10). These data represent only pathology tests rebated through Medicare. In general, Medicare benefits are payable for a maximum of three tests performed on a specimen. Data on the number of tests performed but not rebated are not available. Pathology services for some areas of WA, SA, the ACT and the NT were funded by the Australian Government through health program grants until 2001-02, so these data may underestimate the number of pathology tests ordered in some jurisdictions before 2002-03 (although the amounts are relatively insignificant).

Figure 10.10 Pathology tests ordered by GPs^a

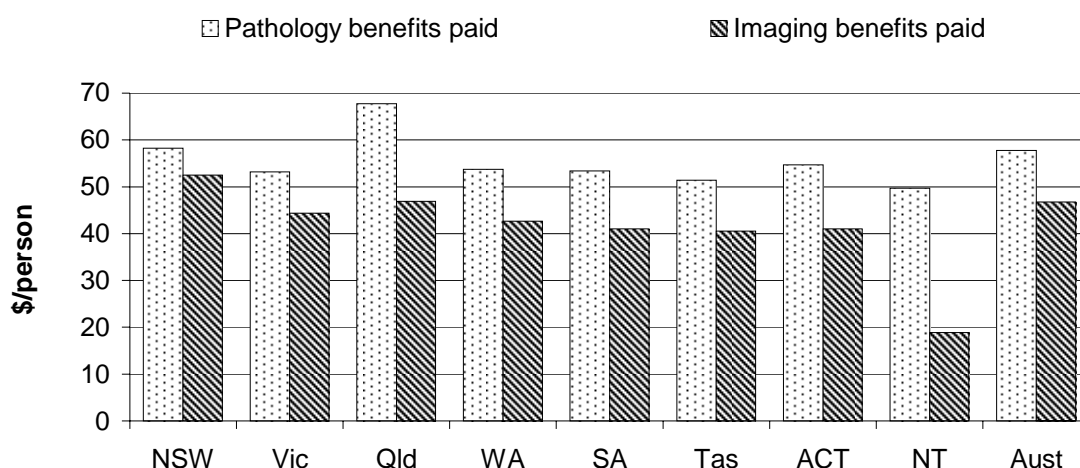


^a Data include tests ordered by vocationally recognised GPs and OMPs. Data include tests ordered at the request of a patient (patient episode initiated items).

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

Australian Government expenditure (under Medicare) on pathology tests amounted to \$1.2 billion in 2005-06, equal to \$58 per person. Nationally, Medicare benefits worth \$961.7 million were paid for diagnostic imaging in 2005-06, equal to \$47 per person (figure 10.11).

Figure 10.11 Benefits paid for pathology tests and diagnostic imaging, 2005-06^a

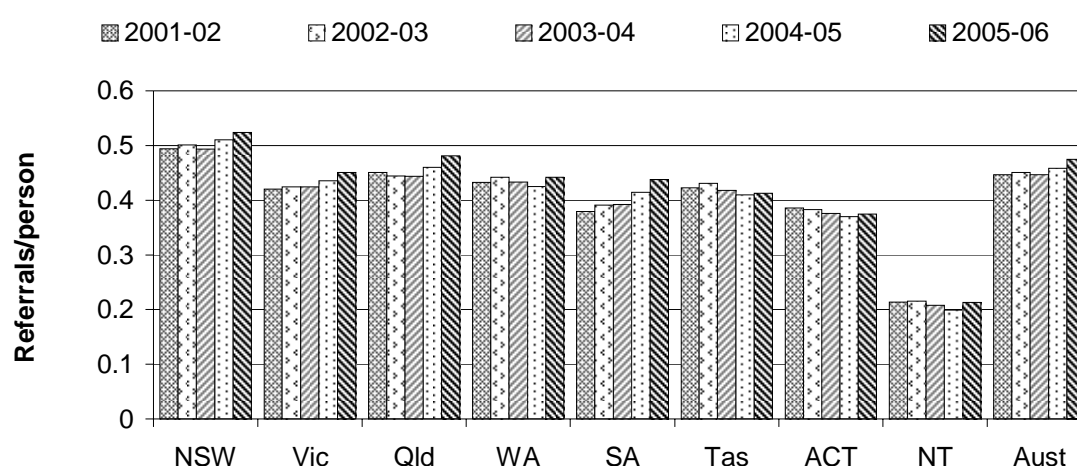


^a Includes benefits paid through Medicare (including DVA data) for pathology tests ordered, and diagnostic imaging referred, by vocationally recognised GPs and OMPs.

Source: DoHA (unpublished); tables 10A.18 and 10A.19.

Nationally, the number of diagnostic imaging referrals per person remained relatively constant over the five years to 2005-06 (figure 10.12). The difference in the number of pathology tests ordered per person and the imaging referrals per person might be because up to three tests can be ordered with one pathology specimen, whereas each imaging referral results in only one test.

Figure 10.12 **Diagnostic imaging referrals from GPs^a**



^a Data relate to vocationally recognised GPs and OMPs.

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

Quality — safety

General practices with electronic information management systems

The Practice Incentives Program (PIP) provides payments to general practices based on patients' ongoing healthcare needs (rather than on service volumes), promoting activities such as: the use of electronic information management systems; after-hours care; the teaching of medical students; the employment of practice nurses; and improved chronic disease management.

Under the PIP Information Management, Information Technology initiative, two incentives encourage the computerisation of practices: first, the electronic prescribing incentive paid for the use of bona fide electronic prescribing software to generate the majority of prescriptions; and second, an incentive paid for the use of computer systems to send and/or receive clinical information. Computerisation of general practices can improve the safety (in terms of quality and effectiveness) of GP services (box 10.12).

Box 10.12 General practices with electronic clinical information management systems

The proportion of general practices with electronic information management systems is an indicator of safety because such systems can reduce prescribing and dispensing errors. Reductions in these types of error reduce the likelihood of harm to patients from adverse drug reactions. Electronic information management systems can also improve other aspects of quality by providing access to timely clinical data and improving the maintenance of patient health records. Use of such technology can, for example, facilitate the management of screening and other preventive health activities for patients (DHAC 2000).

Two measures of this indicator are reported:

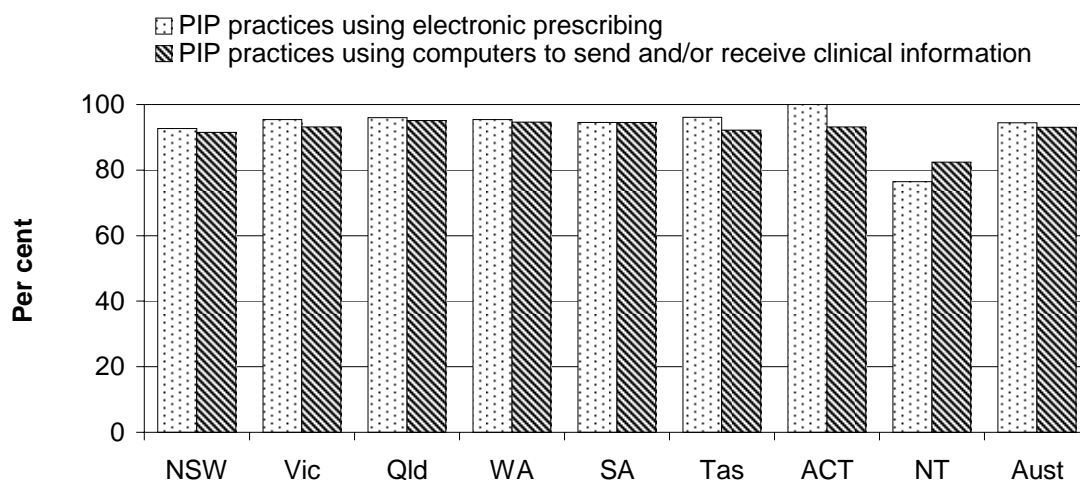
- the proportion of PIP practices that use electronic prescribing
- the proportion of PIP practices that use computers to send/or receive clinical information.

An increase in these proportions may indicate an improvement in the level of safety in patient management by general practices.

The PIP does not include all practices in Australia. PIP practices covered around 80 per cent of Australian patients (measured as standardised whole patient equivalents) in May 2004 (DoHA unpublished).

Australia-wide, 94.4 per cent of PIP practices used electronic prescribing systems in May 2006. Of PIP practices, 93.1 per cent had the capacity to send and/or receive clinical information via use of computer technology in May 2006 (figure 10.13).

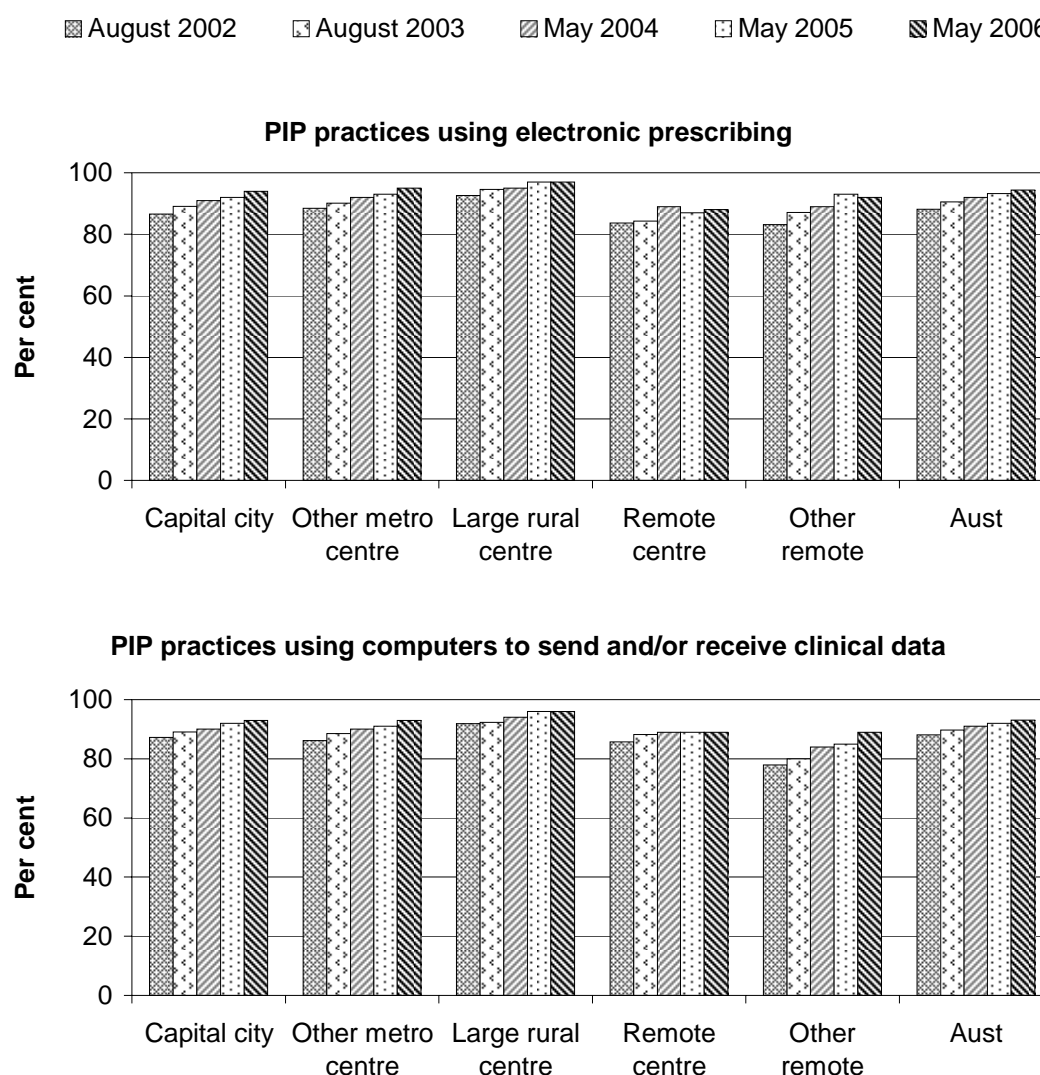
Figure 10.13 PIP practices using computers for clinical purposes, May 2006



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

In May 2006, PIP practices in rural areas were more likely than PIP practices in metropolitan areas or remote areas to use computers to send and/or receive clinical information and to use electronic prescribing. Computer use by PIP practices has generally been trending upwards over the period August 2002 to May 2006 for each remoteness area (figure 10.14). Remote practices in the NT have difficulty meeting the accreditation requirements to qualify for the PIP, which affects the coverage of these data.

Figure 10.14 **PIP practices using computers for clinical purposes, by area^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 = 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: DoHA (unpublished); table 10A.21.

Quality — responsiveness

Patient satisfaction

The Steering Committee has identified ‘patient satisfaction’ as an indicator of the quality of GP services in terms of their responsiveness to patients (box 10.13). Data for this indicator, however, were not available for the 2007 Report.

Box 10.13 Patient satisfaction

‘Patient satisfaction’ has been identified as an indicator of responsiveness, but no data are currently available.

Quality — capability

Two indicators of the quality of GP services, in terms of the GPs’ capability to provide services, are reported here: first, the proportion of GPs with vocational registration (box 10.14); and second, the proportion of general practices with accreditation (box 10.15).

GPs with vocational registration

Box 10.14 GPs with vocational registration

Since 1996, a GP can only achieve vocational registration by attaining Fellowship of the RACGP. GPs can attain Fellowship through the successful completion of a formal general practice training program or through the ‘practice eligible’ route. Once vocational registration is achieved, GPs must demonstrate ongoing involvement in continuing professional development activities in order to maintain their Fellowship status (DoHA unpublished).

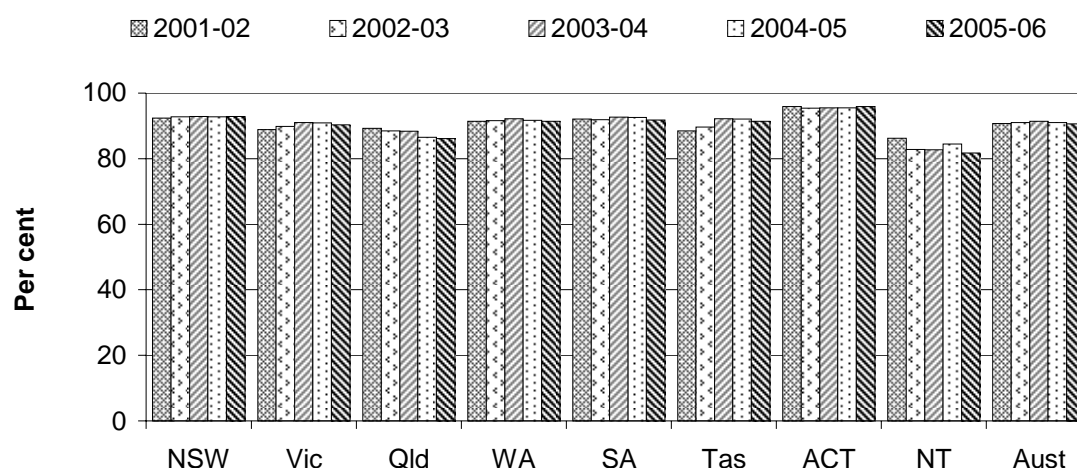
The measure reported is the proportion of FWE GPs with vocational registration.

An increase in the proportion of GPs with vocational registration may indicate an improvement in the ability of the GP workforce to deliver high quality services. GPs without vocational registration, however, do not necessarily deliver services of a lower quality.

The proportion of GPs with vocational registration remained relatively constant over the five years to 2005-06 (figure 10.15). The proportions of GPs with

vocational registration were highest in capital cities, other metro centres and large rural centres and lowest in remote areas in 2005-06 (table 10A.22).

Figure 10.15 GPs (full time workload equivalent) with vocational registration



Source: DoHA (unpublished); table 10A.23.

General practices with accreditation

Box 10.15 General practices with accreditation

Accreditation of general practice is a voluntary process of peer review that involves the assessment of general practices against a set of standards developed by the RACGP. Accredited practices, therefore, have been assessed as complying with a set of national standards.

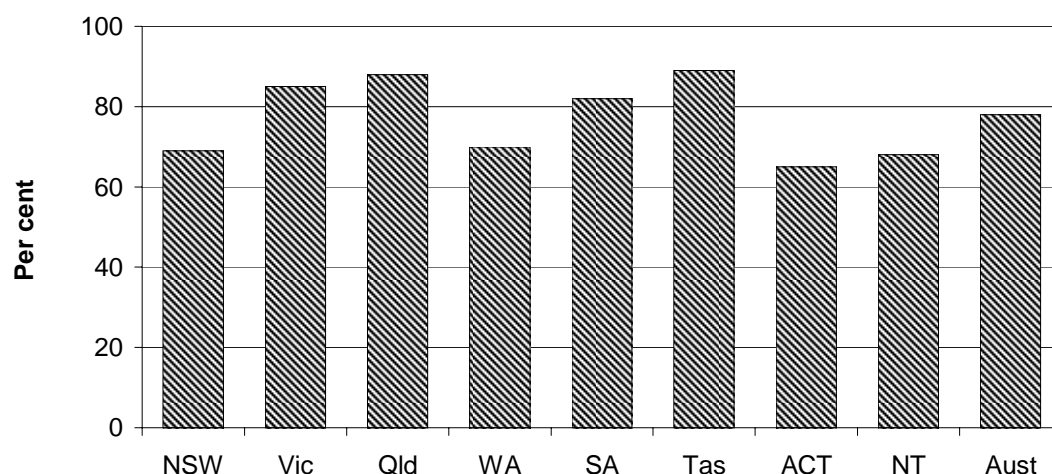
The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and Quality Practice Accreditation (QPA). This indicator is defined as the number of general practices accredited by AGPAL as a proportion of all general practices in Australia. Data on general practices accredited by QPA are not available for publication in this Report.

While an increase in the proportion of practices with accreditation may indicate an improvement in the capacity of general practices to deliver high quality services, the exclusion of QPA accredited practices from the indicator makes this interpretation uncertain.

A further caveat is that general practices without accreditation might not deliver lower quality services. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.

In June 2006, 4242 general practices (representing 78.0 per cent of general practices estimated by AGPAL) were accredited with AGPAL Australia-wide (figure 10.16).

Figure 10.16 **Australian general practices that are AGPAL accredited, June 2006^a**



^a Data should be used with caution as they are based on an estimate of the number of General Practices as there is no central registration of General Practices in Australia.

Source: AGPAL (unpublished); table 10A.24.

Quality — continuity

The continuity aspect of the quality of primary healthcare services relates to the sector's ability to provide uninterrupted, coordinated services across programs, practitioners, organisations and levels over time. Two indicators of this aspect of quality are reported here: first, the use of care planning and case conferencing (box 10.16); and second, the use of health assessments for older people (box 10.17).

Care planning and case conferencing

Box 10.16 Care planning and case conferencing

Care planning and case conferencing refer to chronic disease management items in the Medicare Benefits Schedule (MBS). These items provide a structured approach to health care for people with chronic or terminal medical conditions, including people with complex, multidisciplinary needs, through either GP managed care or multidisciplinary team-based care. The rationale for the indicator is that GPs with some experience using care planning and case conferencing are more likely to continue to use those options when they have the potential to improve patient care.

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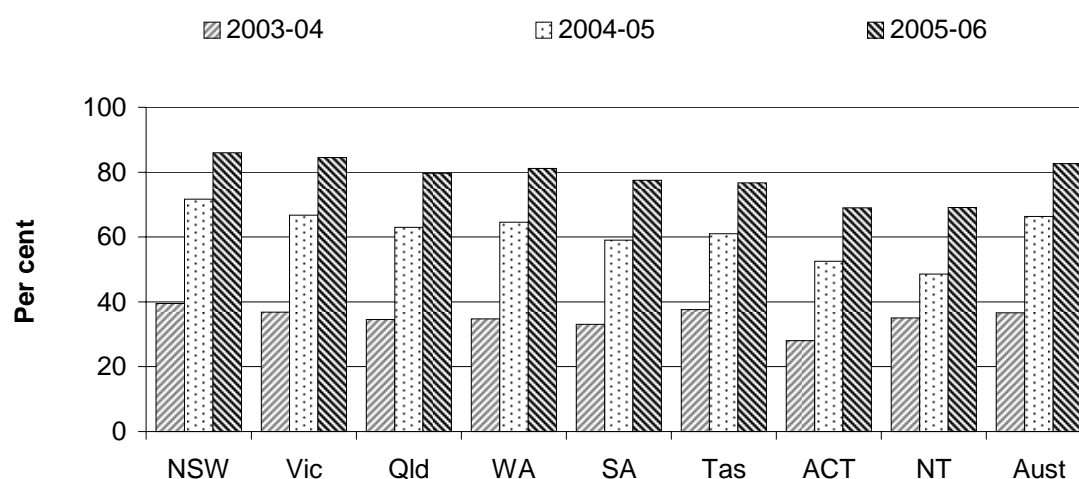
Box 10.16 (Continued)

This indicator is defined as the proportion of GPs who used the chronic disease management items for care planning and case conferencing at least once during a 12 month period.

An increase in the proportion of GPs who use these chronic disease management items may indicate an improvement in the continuity of care provided to people with chronic or terminal medical conditions, including people with complex, multidisciplinary care needs.

Nationally, 82.7 per cent of GPs used the chronic disease management items for care planning and case conferencing in 2005-06 (figure 10.17).

Figure 10.17 GP use of chronic disease management Medicare items for care planning and case conferencing^a



^a The increase in the number of general practitioners using chronic disease management MBS items for care planning and/or case conferencing in 2004-05 may be due to the introduction of the Strengthening Medicare allied health and dental care initiative on 1 July 2004. This initiative provides access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs who are being managed under an EPC team-based care plan. The increase in the number of general practitioners using chronic disease management MBS items for care planning and case conferencing in 2005-06 appears to be linked to the introduction of six new chronic disease management MBS items in July 2005. These items enable GPs to provide GP only care planning services to patients, in addition to team-based care planning.

Source: DoHA (unpublished); table 10A.25.

Box 10.17 Health assessments for older people

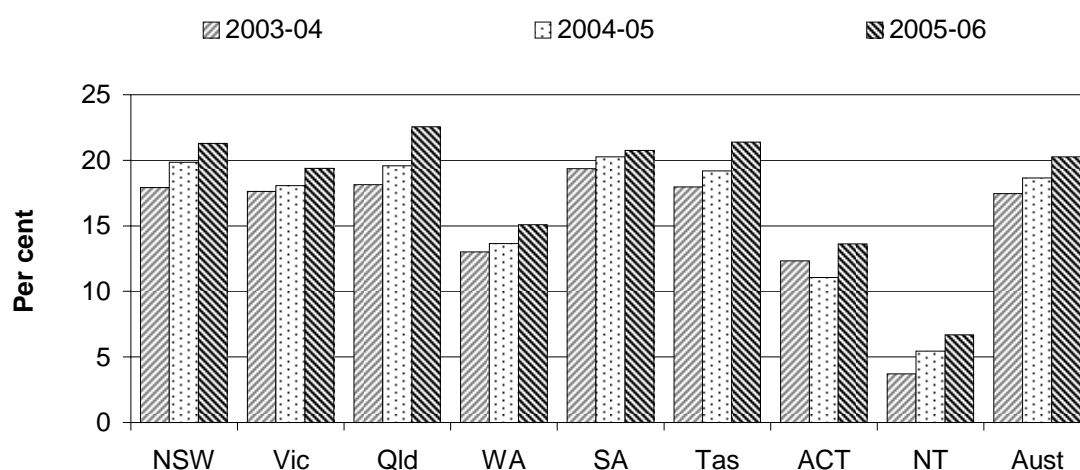
An annual voluntary assessment for older people is an MBS item that allows a GP to undertake an in-depth assessment of a patient's health. Health assessments cover the patient's health and physical, psychological and social functioning, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient.

This indicator is defined as the proportion of older people who received a voluntary health assessment. Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The lower age range for Indigenous people recognises that they face increased health risks at a much earlier age, compared with most other groups in the population. It also broadly reflects the difference in average life expectancy for the two population groups (see the 'Health preface').

An increase in the proportion of eligible older people who received a voluntary health assessment may indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.

Nationally, the proportion of older people who received a voluntary health assessment increased from 17.5 per cent in 2003-04 to 20.3 per cent in 2005-06 (figure 10.18).

Figure 10.18 Older people who received a voluntary health assessment^a



^a Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities.

Source: DoHA (unpublished); table 10A.26.

Sustainability

The Steering Committee has identified the sustainability of primary and community health as a key area for development in future reports.

Efficiency

Cost to government of general practice per person

The 'cost to government of general practice per person' is one indicator of the efficiency of general practice (box 10.18). Nationally, the recurrent cost to the Australian Government of general practice was \$239 per person in 2005-06 (figure 10.19).

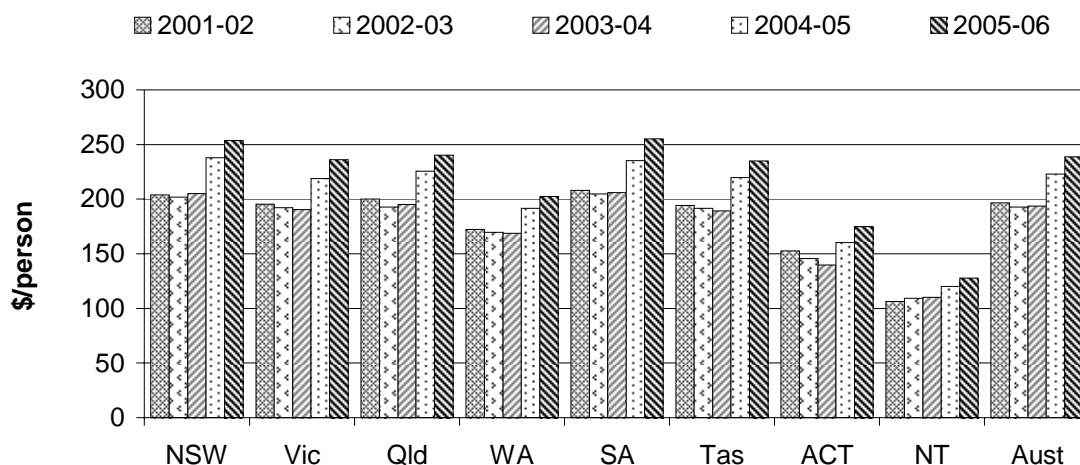
Box 10.18 Cost to government of general practice per person

The 'cost to government of general practice per person' is an indicator of efficiency. It is defined as the cost to government of general practice (including the cost of Medicare, non-Medicare funding such as for the PIP, and expenditure by the DVA) per person in the population.

A lower cost per person may indicate higher efficiency. This is likely to be the case, however, only where the lower cost is associated with services of equal or superior effectiveness.

This indicator needs to be interpreted with care because a lower cost per person may reflect service substitution between primary healthcare and hospital services or specialist services (the latter two both being potentially higher cost than primary care). Further, the indicator also does not include costs for all primary healthcare services. Some primary healthcare services are provided by salaried GPs in community health settings, particularly in rural and remote areas through accident and emergency departments and Indigenous-specific primary health care services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, and where a salaried GP delivery model pertains.

Figure 10.19 **Australian Government real expenditure per person on GPs (2005-06 dollars)^a**



^a The data include Medicare, PIP, DVA, Divisions of General Practice and General Practice Immunisation Incentives Scheme payments. DVA data cover consultations by local medical officers (LMOs), whether vocationally recognised GPs or not. From available files, it is not possible to extract the amounts paid to LMOs (as opposed to specialists) for procedural items. It is expected, however, that the amounts for these services are small compared with payments for consultations. The Australian Government invests in general practice through the Divisions of General Practice Program.

Source: DoHA (unpublished); table 10A.2.

Outcomes

Indicators of both intermediate and final primary and community health outcomes are reported here. ‘Child immunisation coverage’, for example, indicates the intermediate outcome of immunisation against disease (box 10.19). ‘Notifications of selected childhood diseases’ indicate the final outcome — the incidence of diseases — that child immunisation can prevent (box 10.20). The other reported outcome indicators relate to cervical screening (box 10.21), influenza vaccinations for older people (box 10.22) and potentially preventable hospitalisations (box 10.23).

Child immunisation coverage

Box 10.19 Child immunisation coverage

The 'child immunisation coverage' indicator is an indicator of outcomes for primary and community health services because one of the objectives of GPs and community health services is the achievement of high immunisation coverage levels for children. Many providers deliver child immunisation services (table 10.7). GPs are encouraged to achieve high immunisation coverage levels under the General Practice Immunisation Incentives Scheme, which provides incentives for the immunisation of children under seven years of age.

Two measures of this indicator are reported:

- the proportion of children aged 12 months to less than 15 months who are fully immunised. Children assessed as fully immunised at 12 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b and hepatitis B
- The proportion of children aged 24 months to less than 27 months who are fully immunised. Children assessed as fully immunised at 24 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, and measles, mumps and rubella.

An increase in the proportion of children who are fully immunised indicates a reduction in the risk of children contracting a range of diseases, including measles, whooping cough and *Haemophilus influenzae* type b.

Data on valid vaccinations supplied to children under 7 years of age from the Australian Childhood Immunisation Register (ACIR) are shown in table 10.7. Around 90.7 per cent of Australian children aged 12 months to less than 15 months at 30 June 2006 were assessed as fully immunised (figure 10.20).

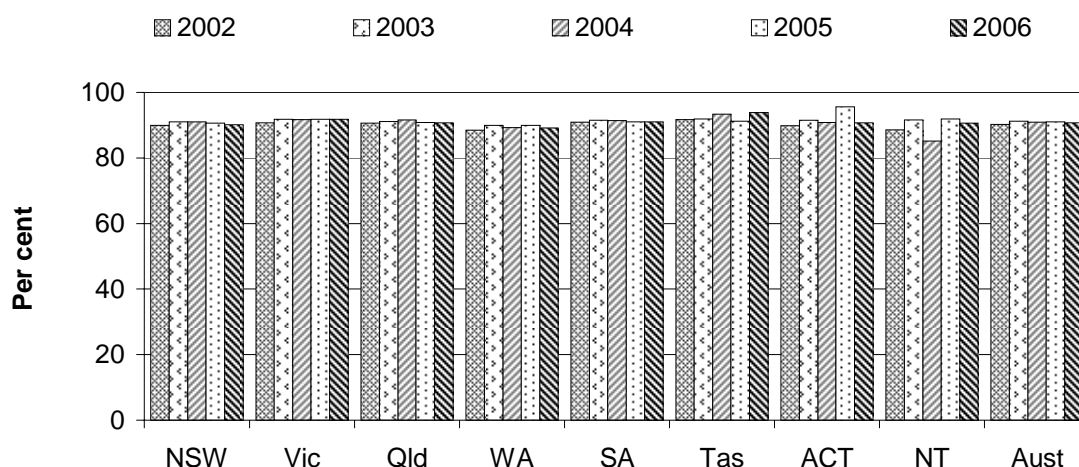
Table 10.7 Valid vaccinations supplied to children under 7 years of age, by provider type, 1996–2006 (per cent)^{a, b}

<i>Provider</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GP	83.6	52.3	82.6	63.5	68.7	85.9	38.2	3.2	70.5
Council	6.1	46.4	7.4	7.1	17.5	13.2	–	–	17.4
State or Territory health department	–	–	–	5.8	0.1	0.1	24.5	0.3	1.0
Flying doctor service	–	–	0.3	–	0.1	–	–	–	0.1
Public hospital	2.3	0.4	3.0	5.4	3.3	0.2	0.9	7.5	2.3
Private hospital	0.1	–	–	–	–	–	–	0.9	0.1
Indigenous health service	0.5	0.1	0.7	0.6	0.4	–	0.2	8.9	0.6
Indigenous health worker	–	–	0.5	–	0.1	–	–	0.2	0.1
Community health centre	7.3	0.8	5.5	17.7	9.8	0.6	36.3	79.0	8.0
Community nurse	–	–	–	–	–	–	–	–	–
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

^a 1 January 1996 to 30 June 2006. Data relates to the State or Territory in which the immunisation provider was located. ^b A valid vaccination is a National Health and Medical Research Council's Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. – Nil or rounded to zero.

Source: DoHA (unpublished); table 10A.27.

Figure 10.20 Children aged 12 months to less than 15 months who were fully immunised^{a, b, c}

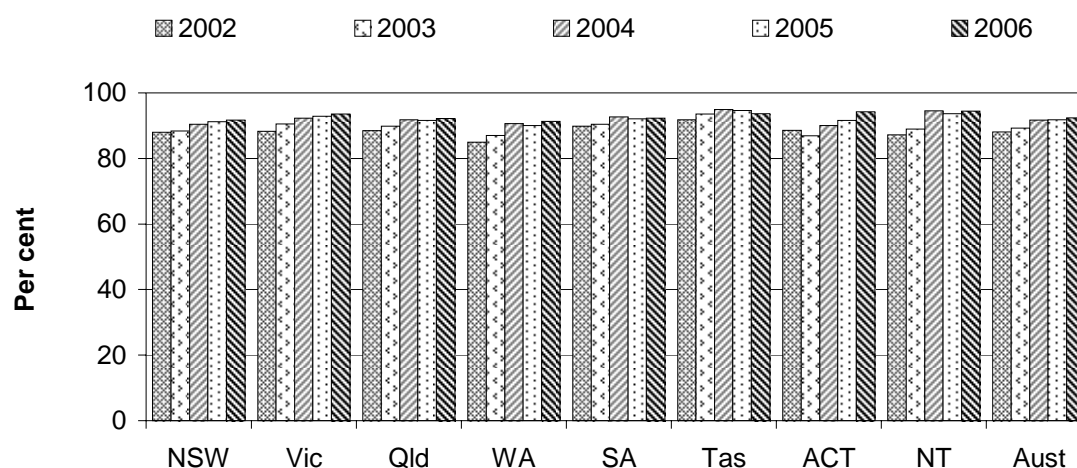


^a Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. ^b The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000). ^c There may be some under-reporting by providers, so vaccine coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

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

Nationally, 92.4 per cent of children aged 24 months to less than 27 months at 30 June 2006 were assessed as being fully immunised (figure 10.21).

Figure 10.21 **Children aged 24 months to less than 27 months who were fully immunised^{a, b, c}**



^a Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child was located. ^b The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000). ^c There may be some under-reporting by providers, so vaccine coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

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

Notifications of selected childhood diseases

Box 10.20 Notifications of selected childhood diseases

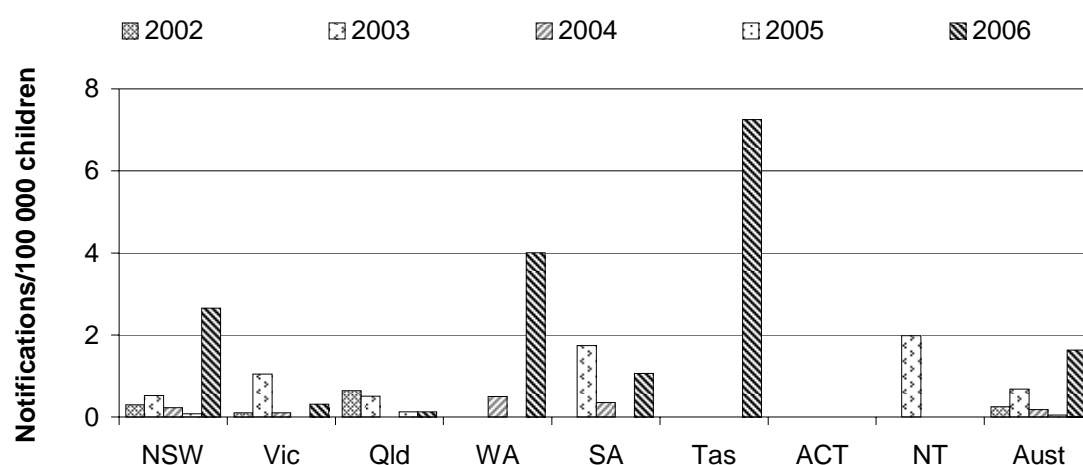
Notification rates for selected childhood vaccine preventable diseases (measles, pertussis [whooping cough] and *Haemophilus influenzae* type b) are an outcome indicator of primary and community health because the activities of GPs and community health services can influence the prevalence of these diseases through immunisation (and consequently the notification rates). These childhood diseases are nationally notifiable diseases — that is, if they are diagnosed, there is a requirement to notify the relevant State or Territory authorities. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs for one in 25 cases.

For each disease, the rate of notifications is defined as the number of notifications for children aged 0–14 years per 100 000 children in that age group.

A reduction in the notification rate for the selected diseases indicates the effectiveness of the immunisation program.

In 2006, there were 65 notifications of measles in Australia to 31 August. This represented a national notification rate for measles of 1.6 per 100 000 children aged 0–14 years and was a large increase on recent years (figure 10.22), although was low when compared to the rates of the mid-1990s. In 1994, for example, there were 3088 notifications of measles for children aged 0–14 years, representing a rate of 80.0 per 100 000 children in that age group. Since 2000, the number of annual notifications for measles in Australia has been below 100, with some jurisdictions reporting no notifications in some years (table 10A.30).

Figure 10.22 **Notifications of measles among children aged 0–14 years^{a, b}**

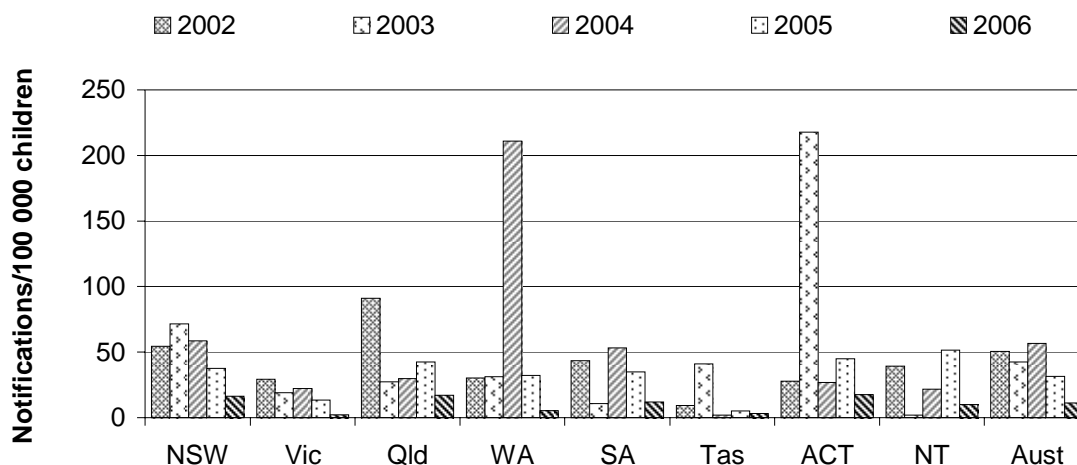


^a Notifications for 2006 are to 31 August. ^b Where a notification rate for a particular year is nil, no notifications were made in that jurisdiction.

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

In 2006, there were 449 notifications of pertussis (whooping cough) across Australia. This represented a notification rate of 11.3 per 100 000 children aged 0–14 years (figure 10.23).

Figure 10.23 **Notifications of pertussis (whooping cough) among children aged 0–14 years^{a, b}**

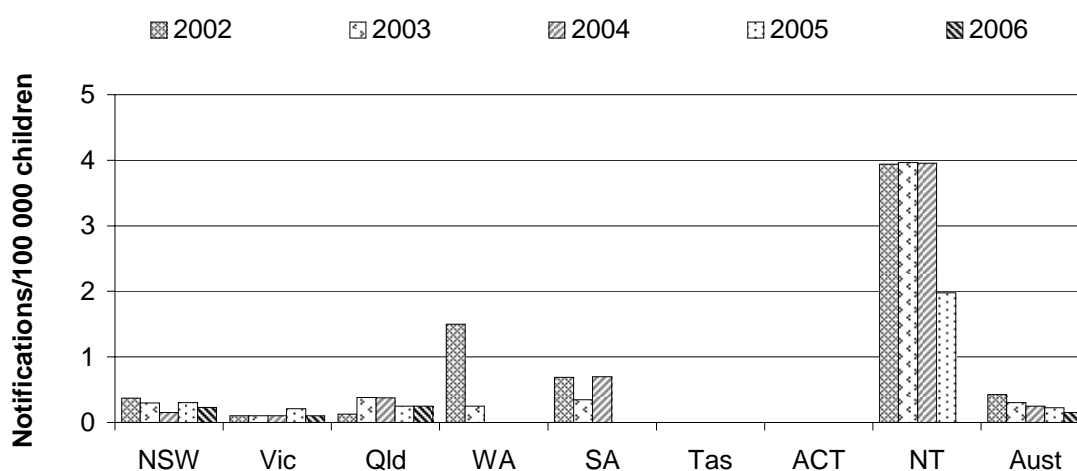


^a Notifications for 2006 are to 31 August. ^b Where a notification rate for a particular year is nil, no notifications were made in that jurisdiction.

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

In recent years, notification rates for *Haemophilus influenzae* type b have remained low. In 2006, the notification rate Australia-wide was 0.2 per 100 000 children aged 0–14 years (figure 10.24).

Figure 10.24 **Notifications of *Haemophilus influenzae* type b among children aged 0–14 years^{a, b}**



^a Notifications for 2006 are to 31 August. ^b Where a notification rate for a particular year is nil, no notifications were made in that jurisdiction.

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

Participation rates for women in cervical screening

‘Participation rates for women in cervical screening’ is an indicator of primary and community healthcare outcomes (box 10.21).

Box 10.21 Participation rates for women aged 20–69 years in cervical screening

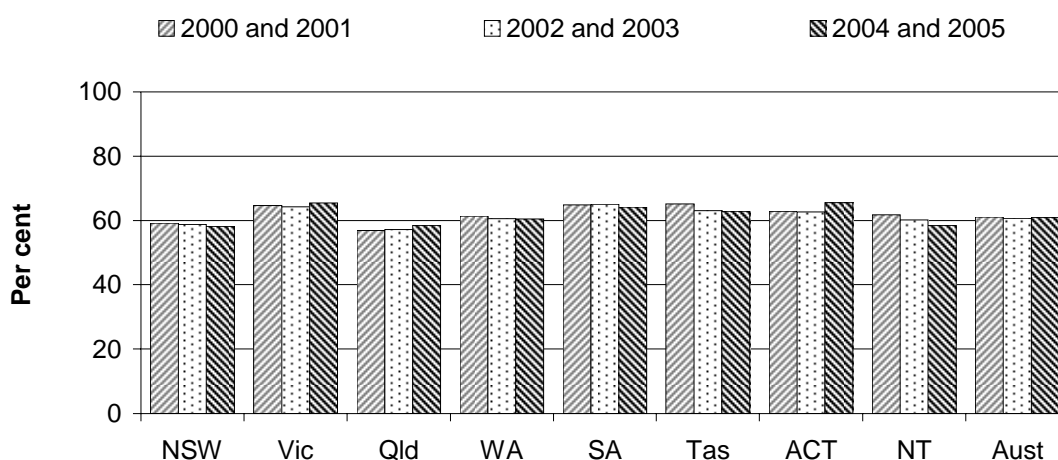
The ‘cervical screening rate for target population’ (women aged 20–69 years) is an outcome indicator for primary and community healthcare. It is estimated that up to 90 per cent of the most common type of cervical cancer (squamous cervical cancer) may be prevented if cell changes are detected and treated early (Mitchell, Hocking, Saville 2003). A range of healthcare providers offer cervical screening tests (Pap smears). The National Cervical Screening Program involves GPs, gynaecologists, family planning clinics and hospital outpatient clinics.

This indicator is defined as the number of women aged 20–69 years who are screened over a two year period, as a proportion of all women aged 20–69 years. Adjustments are made to account for differences in the female age distribution across states and territories, and to remove from the population of women 20–69 years old (the rate denominator) those who have had a hysterectomy.

An increase in the proportion of women aged 20–69 years who have been screened would be expected to result in a reduction in the number of women dying from this disease.

During 2004 and 2005, the national age standardised participation rate for women aged 20–69 years in cervical screening was 61.0 per cent (figure 10.25).

Figure 10.25 Age standardised participation rates for women aged 20–69 years in cervical screening^a



^a Age-standardised rates are standardised to the 2001 Australian population.

Source: AIHW (2006c); AIHW (unpublished); table 10A.33.

Influenza vaccination coverage for older people

The 'influenza vaccination coverage for older people' is an indicator of primary and community healthcare outcomes (box 10.22). The hospitalisation rate of people for influenza and pneumonia is included as a separate indicator (box 10.24).

Box 10.22 Influenza vaccination coverage for older people

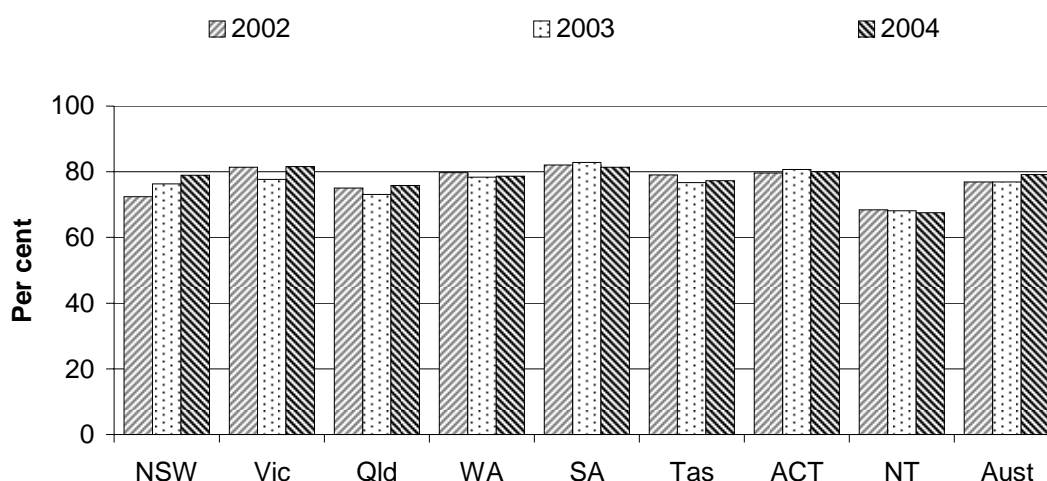
Each year, influenza and its consequences result in many older people being hospitalised, as well as a considerable number of deaths. Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (National Health Performance Committee unpublished). GPs provide the majority of influenza vaccinations for older people.

The indicator is defined as the proportion of people aged 65 years or over who have been vaccinated against influenza.

An increase in the proportion of older people vaccinated against influenza reduces the risk of older people contracting influenza and suffering consequent complications.

Through the National Influenza Vaccine Program for Older Australians, the Australian Government funds free vaccines for Australians aged 65 years or over (AIHW 2005c). In 2004, 79.1 per cent of people aged 65 years or over were vaccinated against influenza in Australia (figure 10.26).

Figure 10.26 Influenza vaccination coverage, people aged 65 years or over



Source: AIHW (2003, 2004, 2005c); table 10A.34.

Potentially preventable hospitalisations

The following five outcome indicators relate to potentially preventable hospitalisations for a range of conditions. The first three indicators — hospitalisations for vaccine preventable conditions (box 10.24), selected acute conditions (box 10.25) and selected chronic conditions (box 10.26) — were developed by the National Health Performance Committee, based on empirical research (box 10.23). The two other outcome indicators in this category relate to hospitalisations for diabetes (box 10.27) and the hospitalisation of older people for falls (box 10.28).

Box 10.23 Development of, and rationale for, potentially preventable hospitalisation indicators

The definitions adopted for vaccine preventable conditions, acute conditions and chronic conditions indicators were based on the *Victorian Ambulatory Care Sensitive Conditions Study* (DHS 2002). This study built on research into ambulatory care sensitive conditions (for example, Billings, Anderson and Newman 1996; Bindman *et al.* 1995; Weissman, Gatsonis and Epstein 1992), which was recently the subject of systematic review and empirical analysis.

These studies show that the availability of non-hospital care explains a significant proportion of the variation between geographic areas in hospitalisation rates for the specified conditions. Other explanations for this variation include variation in the underlying prevalence of the conditions, clinical coding standards and the likelihood that a patient will be treated as an outpatient rather than an admitted patient. Potentially preventable hospitalisations will never be entirely eliminated, but the variation across geographic areas demonstrates considerable potential for strengthening the effectiveness of non-hospital care.

Source: National Health Performance Committee (2004).

Vaccine preventable hospitalisations

‘Vaccine preventable hospitalisations’ is an indicator of primary and community healthcare outcomes (box 10.24).

Box 10.24 Vaccine preventable hospitalisations

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for vaccine preventable conditions. This influence occurs mainly through the provision of vaccinations and the encouragement of high rates of vaccination coverage for target populations.

This indicator is defined as the number of hospital separations for influenza and pneumonia, and other vaccine preventable conditions per 100 000 people. (Adjustments are made to account for differences in the age structure of populations across states and territories.)

A reduction in hospitalisation rates may indicate improvements in the effectiveness of the vaccination program. Effective treatment by primary health providers may also reduce hospitalisations.

A comparison of Indigenous people and all other people is also made by presenting the ratio of age standardised hospital separation rates of Indigenous people to all people. A ratio of close to one is desirable as it implies that Indigenous people have similar separation rates to all people.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation for vaccine preventable conditions. Examples are the number and virulence of influenza strains from year to year.

Australia-wide, the age standardised hospital separation rate for all vaccine preventable conditions was 0.7 per 1000 people in 2004-05. Nationally, influenza and pneumonia accounted for 77.6 per cent of age standardised hospitalisations for vaccine preventable conditions in 2004-05 (table 10.8).

Table 10.8 **Standardised hospital separations for vaccine preventable conditions, by state and territory of usual residence, per 1000 people, 2004-05^a**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Influenza and pneumonia	0.55	0.43	0.53	0.63	0.46	0.35	0.41	1.42	0.52
Other conditions	0.17	0.19	0.10	0.16	0.13	0.08	0.05	0.40	0.15
Total^b	0.72	0.61	0.63	0.79	0.58	0.43	0.45	1.82	0.67

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Totals may not equal the sum of the individual conditions due to rounding.

Source: AIHW (2006b).

The age standardised hospital separation rate of Indigenous people for all vaccine preventable conditions was 3.7 per 1000 Indigenous people in 2004-05 for Queensland, WA, SA and the NT combined. The quality of Indigenous identification is considered acceptable for the purposes of analysis for these

jurisdictions. Over 80 per cent of vaccine preventable separations for Indigenous people were accounted for by influenza and pneumonia in 2004-05 (table 10.9).

Table 10.9 Standardised hospital separations of Indigenous people for vaccine preventable conditions, per 1000 Indigenous people, 2004-05^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total^c</i>	<i>Aust</i>
Influenza and pneumonia	np	np	1.4	4.4	2.2	np	np	4.9	3.0	np
Other conditions	np	np	0.4	0.9	0.5	np	np	1.2	0.7	np
Total	np	np	1.9	5.3	2.8	np	np	6.2	3.7	np

^a Separation rates are directly age standardised to the Indigenous population at 30 June 2001. ^b Includes data only for Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the four states and territories are not necessarily representative of the other jurisdictions. ^c Total comprises Queensland, WA, SA and the NT only. **np** not published.

Source: AIHW (unpublished).

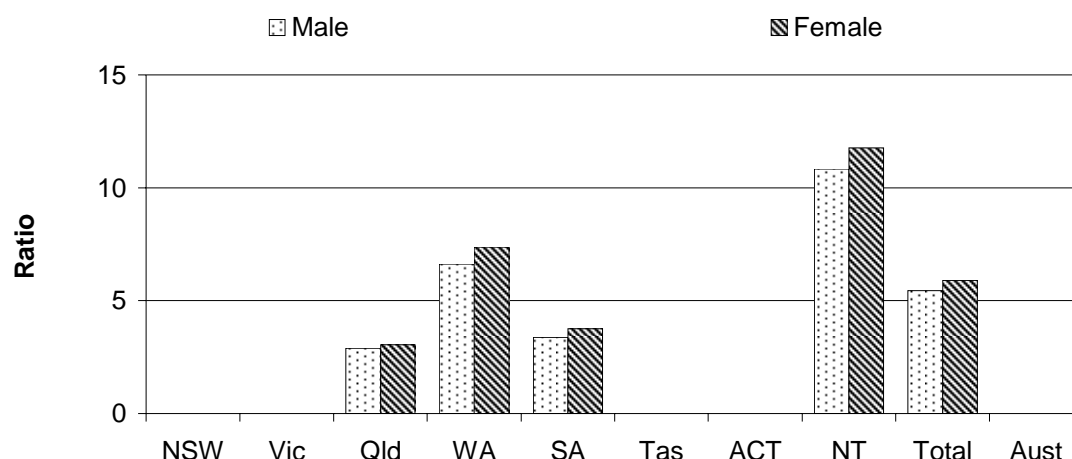
Data on Indigenous patients are limited by the accuracy and extent to which Indigenous people are identified in hospital records. Identification varies across states and territories. The report prepared by the AIHW and endorsed by relevant Australian Health Ministers' Advisory Council committees titled *Improving the Data Quality of Indigenous Identification in Hospital Separations Data* recommends the following:

- Only data from Queensland, WA, SA and the NT should be used for analytical purposes (either at the individual or aggregate level).
- Analyses based on data for Queensland, WA, SA and the NT in aggregate are limited by jurisdictional differences in data quality and the data are not necessarily representative of the jurisdictions excluded.
- Caution should be exercised in using Queensland, WA, SA and the NT time series data for analysis (either individually or in aggregate). Changes in hospitalisation rates for Indigenous people may be a result of changes in the ascertainment of Indigenous status for Indigenous patients (AIHW 2005b).

Standardised hospital separation ratios for infectious pneumonia illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in age distributions. For both males and females there was a marked difference in 2004-05 between the separation rates for Indigenous people and those for the total population for infectious pneumonia diagnoses. For Queensland, WA, SA and the NT combined the separation rate for Indigenous males was 5.4 times higher than those for all

Australian males. The separation rate for Indigenous females was 5.9 times the rate for all females (figure 10.27).

Figure 10.27 Ratio of age standardised hospital separation rates of Indigenous people to all people for infectious pneumonia, 2004-05^{a, b, c, d, e}



^a The ratios are indirectly standardised using the estimated resident populations of Indigenous people and non-Indigenous people at 30 June 2004, and hospital separations data for Queensland, WA, SA, and the NT public hospitals. ^b Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among jurisdictions. The variation in the number of Indigenous separations per 1000 Indigenous population across the states and territories suggests variation in the proportion of Indigenous persons who were identified as such in the hospital morbidity data collections and/or in the total population. The AIHW advised that only data from Queensland, WA, SA and the NT are considered to be of acceptable quality. ^c NT data are for public hospitals only. ^d Total comprises Queensland, WA, SA and the NT only. A total for Australia is not available. ^e Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Care should be taken when comparing the two.

Source: AIHW (unpublished); tables 10A.35 and 10A.36.

Hospitalisations for selected acute conditions

Box 10.25 Hospitalisations for selected acute conditions

The effectiveness of primary and community healthcare services has a significant influence on the rates of hospitalisation for the following selected acute conditions: dehydration and gastroenteritis; pyelonephritis (kidney inflammation caused by bacterial infection); perforated/bleeding ulcer; cellulitis; pelvic inflammatory disease; ear, nose and throat infections; dental conditions; appendicitis; convulsions and epilepsy; and gangrene.

(Continued on next page)

Box 10.25 (Continued)

Hospital separation rates for the selected acute conditions are calculated per 100 000 people and adjusted to account for differences in age distributions across State and Territory populations.

A reduction in hospitalisation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation. An example is the underlying prevalence of the conditions. Public health measures not covered in this chapter may also influence the hospitalisation rates.

Of the selected acute conditions, dental conditions, and dehydration and gastroenteritis had the highest rates of hospitalisation nationally in 2004-05 (table 10.10).

Table 10.10 Standardised hospital separations for potentially preventable acute conditions, by state and territory of usual residence, per 1000 people, 2004-05^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Dehydration and gastroenteritis	1.92	2.50	2.19	1.97	2.46	1.46	1.12	1.92	2.14
Pyelonephritis ^b	1.95	2.21	2.11	2.14	1.91	1.36	1.46	3.01	2.05
Perforated/bleeding ulcer	0.24	0.26	0.21	0.29	0.24	0.21	0.27	0.15	0.24
Cellulitis	1.41	1.56	1.51	1.35	1.33	1.15	1.27	3.40	1.47
Pelvic inflammatory disease	0.24	0.27	0.27	0.27	0.25	0.20	0.20	0.57	0.26
Ear, nose and throat infections	1.59	1.48	1.78	1.77	2.35	1.20	1.27	1.98	1.67
Dental conditions	2.04	2.96	2.67	3.35	2.87	1.67	1.54	1.89	2.57
Appendicitis	0.15	0.17	0.15	0.21	0.12	0.16	0.25	0.27	0.16
Convulsions and epilepsy	1.63	1.50	1.55	1.43	1.64	1.44	1.32	2.79	1.57
Gangrene	0.14	0.21	0.23	0.20	0.19	0.18	0.05	0.67	0.19
Total^c	11.31	13.11	12.67	12.97	13.36	9.03	8.76	16.66	12.31

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Kidney inflammation caused by bacterial infection. ^c Totals may not equal the sum of the individual conditions due to rounding.

Source: AIHW (2006b).

The age standardised hospital separation rate of Indigenous people for all potentially preventable acute conditions was 36.8 per 1000 Indigenous people in 2004-05 for Queensland, WA, SA and the NT combined. The quality of Indigenous identification is considered acceptable for the purposes of analysis for these jurisdictions. Over half of potentially preventable acute separations for Indigenous

people were accounted for by convulsions and epilepsy, pyelonephritis and cellulitis in 2004-05 (table 10.11).

Table 10.11 Standardised hospital separations of Indigenous people for potentially preventable acute conditions, per 1000 Indigenous people, 2004-05^{a, b}

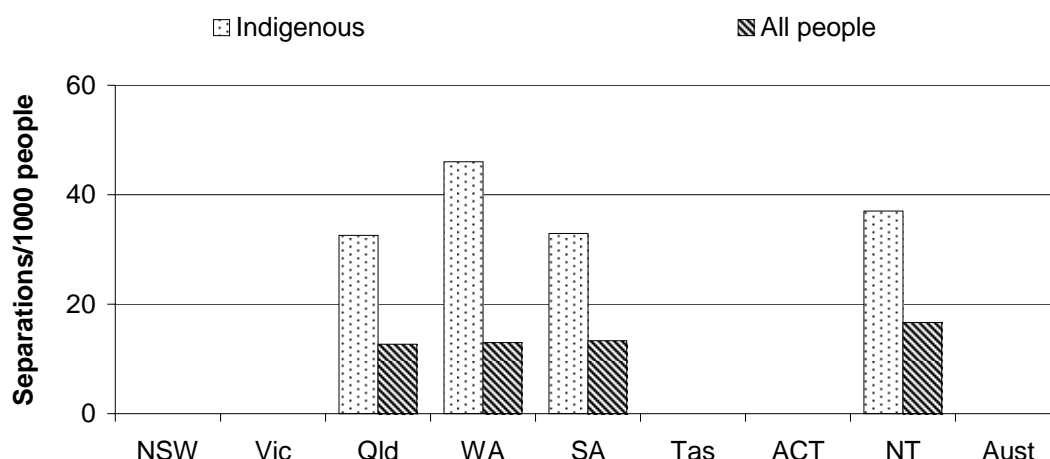
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total^c</i>	<i>Aust</i>
Dehydration and gastroenteritis	np	np	3.1	4.7	5	np	np	4.0	3.9	np
Pyelonephritis ^d	np	np	7.3	9.2	5.7	np	np	7.8	7.7	np
Perforated/bleeding ulcer	np	np	0.4	0.6	0.4	np	np	0.2	0.4	np
Cellulitis	np	np	5.9	6.1	2.4	np	np	6.7	5.8	np
Pelvic inflammatory disease	np	np	0.6	0.9	0.6	np	np	1.5	0.9	np
Ear, nose and throat infections	np	np	4.0	5.2	3.8	np	np	3.2	4.1	np
Dental conditions	np	np	3.0	3.7	3.3	np	np	2.9	3.2	np
Appendicitis	np	np	0.2	0.4	0.3	np	np	0.3	0.3	np
Convulsions and epilepsy	np	np	6.4	13.3	10.9	np	np	8.9	9.0	np
Gangrene	np	np	1.6	1.9	0.4	np	np	1.5	1.5	np
Total	np	np	32.6	46.0	32.9	np	np	37.0	36.8	np

^a Separation rates are directly age standardised to the Indigenous population at 30 June 2001. ^b Includes data only for Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the four states and territories are not necessarily representative of the other jurisdictions. ^c Total comprises Queensland, WA, SA and the NT only. ^d Kidney inflammation caused by bacterial infection. **np** Not published.

Source: AIHW (unpublished).

The age standardised hospital separation rate of Indigenous people for all potentially preventable acute conditions was higher than that for all people in 2004-05 for Queensland, WA, SA and the NT (figure 10.28).

Figure 10.28 **Standardised hospital separations for potentially preventable acute conditions, 2004-05^{a, b, c}**



^a Indigenous separation rates are per 1000 of the Indigenous population and are directly age standardised to the Indigenous population at 30 June 2001. All people separation rates are per 1000 people and are directly age standardised to the Australian population at 30 June 2001. ^b Includes data only for Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the four states and territories are not necessarily representative of the other jurisdictions. A total for Australia is not available. ^c Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Care should be taken when comparing the two.

Source: AIHW (unpublished).

Hospitalisations for selected chronic conditions

Box 10.26 Hospitalisations for selected chronic conditions

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for the following selected chronic conditions: asthma; congestive cardiac failure; diabetes complications; chronic obstructive pulmonary disease; iron deficiency anaemia; hypertension; and nutritional deficiencies. (Diabetes is considered in detail in a separate indicator.)

Hospital separation rates for the selected chronic conditions are calculated per 1000 people and adjusted to account for differences in age distributions across State and Territory populations.

A reduction in hospitalisation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation. An example is the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

Of the selected chronic conditions (excluding diabetes, which is discussed below) chronic obstructive pulmonary disease and angina had the highest rates of hospitalisation nationally in 2004-05. The hospitalisation rate for diabetes complications, however, was more than three times higher than the rate for either of these conditions (table 10.12).

Table 10.12 Standardised hospital separations for potentially preventable chronic conditions, by state and territory of usual residence, per 1000 people, 2004-05^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Asthma	1.97	1.89	1.76	1.82	2.50	1.00	1.01	1.43	1.89
Congestive cardiac failure	1.79	2.10	2.07	1.90	1.95	1.60	1.45	2.84	1.94
Diabetes complications	6.71	10.08	9.29	22.50	8.04	10.72	4.74	13.30	9.77
Chronic obstructive pulmonary disease	2.65	2.52	2.88	2.56	2.71	2.52	1.51	6.93	2.67
Angina	1.82	1.99	2.73	1.73	1.86	1.78	1.41	2.67	2.03
Iron deficiency anaemia	0.82	1.40	0.89	1.32	0.88	0.82	0.63	1.00	1.03
Hypertension	0.30	0.26	0.37	0.25	0.30	0.22	0.12	0.19	0.29
Nutritional deficiencies	0.01	0.01	—	0.02	—	0.01	—	0.02	0.01
Rheumatic heart disease ^b	0.09	0.09	0.17	0.10	0.09	0.06	0.10	0.81	0.11
Total^c	15.21	19.27	18.97	31.22	17.16	17.99	10.21	27.21	18.71

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease. ^c The total is not the sum of the individual conditions because diabetes complications overlap other categories. — Nil or rounded to zero.

Source: AIHW (2006b).

The age standardised hospital separation rate of Indigenous people for all potentially preventable chronic conditions was 65.7 per 1000 Indigenous people in 2004-05 for Queensland, WA, SA and the NT combined. The quality of Indigenous identification is considered acceptable for the purposes of analysis only for these jurisdictions. Excluding diabetes, which is discussed below, chronic obstructive pulmonary disease, congestive cardiac failure and angina were the three highest sources of potentially preventable chronic separations for Indigenous people in 2004-05 (table 10.13).

Table 10.13 Standardised hospital separations of Indigenous people for potentially preventable chronic conditions, per 1000 Indigenous people, 2004-05^{a, b}

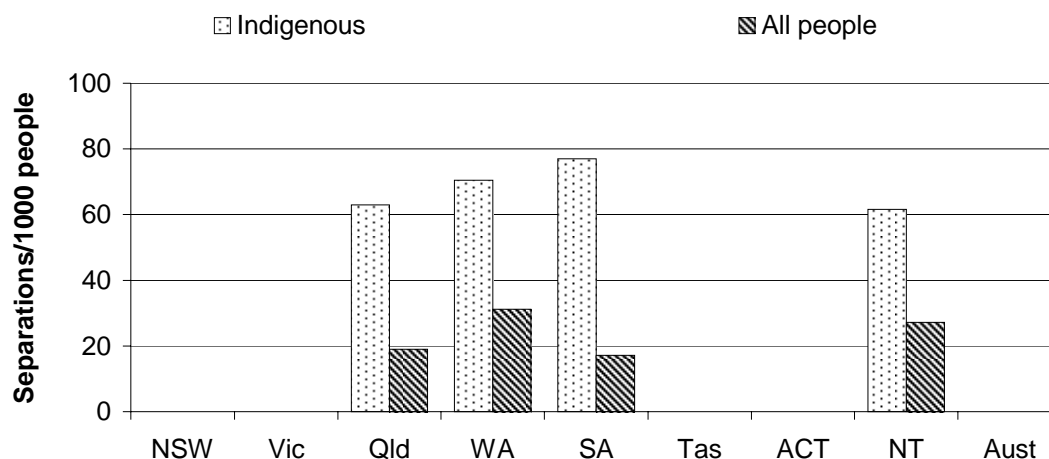
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total^c</i>	<i>Aust</i>
Asthma	np	np	4.2	8.6	4.9	np	np	2.6	5.1	np
Congestive cardiac failure	np	np	7.7	8.5	11.2	np	np	6.5	8.0	np
Diabetes complications ^d	np	np	33.4	38.0	44.4	np	np	30.6	34.9	np
Chronic obstructive pulmonary disease	np	np	14.0	13.4	16.0	np	np	18.0	14.8	np
Angina	np	np	7.1	6.0	6.2	np	np	5.6	6.4	np
Iron deficiency anaemia	np	np	1.2	2.3	1.3	np	np	2.4	1.7	np
Hypertension	np	np	1.7	0.9	2.0	np	np	0.6	1.3	np
Nutritional deficiencies	np	np	–	–	–	np	np	–	–	np
Rheumatic heart disease ^e	np	np	–	–	–	np	np	–	–	np
Total	np	np	63.0	70.5	77.0	np	np	61.6	65.7	np

^a Separation rates are directly age standardised to the Indigenous population at 30 June 2001. ^b Includes data only for Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the four states and territories are not necessarily representative of the other jurisdictions. ^c Total comprises Queensland, WA, SA and the NT only. ^d Diabetes complications does not include records with a principal diagnosis of renal dialysis and an additional diagnosis of diabetes. ^e Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease. – Nil or rounded to zero. **np** Not published.

Source: AIHW (unpublished).

The age standardised hospital separation rate of Indigenous people for all potentially preventable chronic conditions was higher than that for all people in 2004-05 for Queensland, WA, SA and the NT (figure 10.29).

Figure 10.29 **Standardised hospital separations for potentially preventable chronic conditions, 2004-05^{a, b, c}**



^a Indigenous separation rates are per 1000 of the Indigenous population and are directly age standardised to the Indigenous population at 30 June 2001. All people separation rates are per 1000 people and are directly age standardised to the Australian population at 30 June 2001. ^b Includes data only for Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. It should be noted that data for the four states and territories are not necessarily representative of the other jurisdictions. A total for Australia is not available. ^c Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Care should be taken when comparing the two.

Source: AIHW (unpublished).

Hospitalisations for diabetes

Box 10.27 Hospitalisations for diabetes

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for diabetes.

Hospital separation rates for patients with diabetes mellitus as the principal diagnosis, and for patients with a lower limb amputation and a principal or additional diagnosis of diabetes are reported. These rates are calculated per 100 000 people and adjusted to account for differences in the age distribution of State and Territory populations.

A reduction in these rates may indicate an improvement in GPs and community health providers' management of patients' diabetes.

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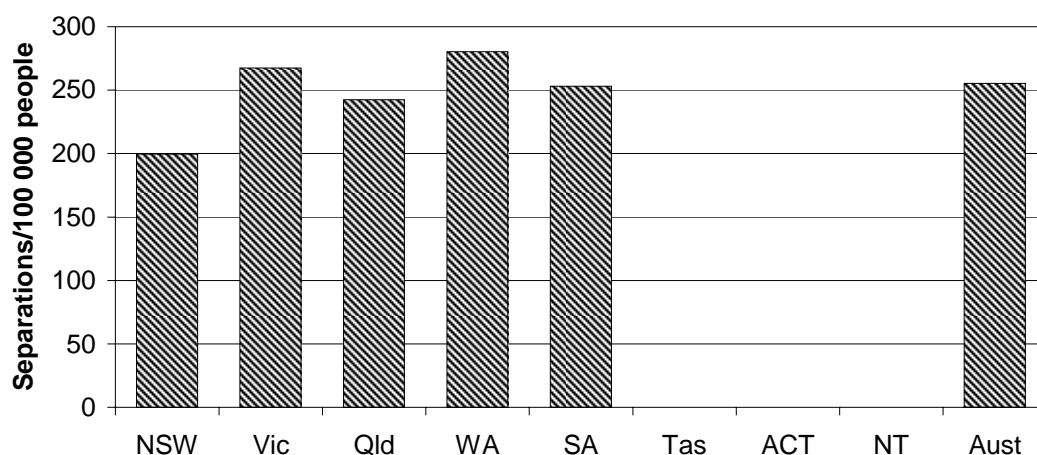
Box 10.27 (Continued)

A comparison of Indigenous and all other people is also made by presenting the ratio of age standardised hospital separation rates of Indigenous people to all people. A ratio of close to one is desirable as it implies that Indigenous people have similar separation rates to all people.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation. An example is the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

Australia-wide, the age standardised hospital separation rate in 2004-05 where the principal diagnosis was Type 2 diabetes mellitus was 255.3 separations per 100 000 people (figure 10.30).

Figure 10.30 **Standardised hospital separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2004-05^{a, b, c, d, e}**



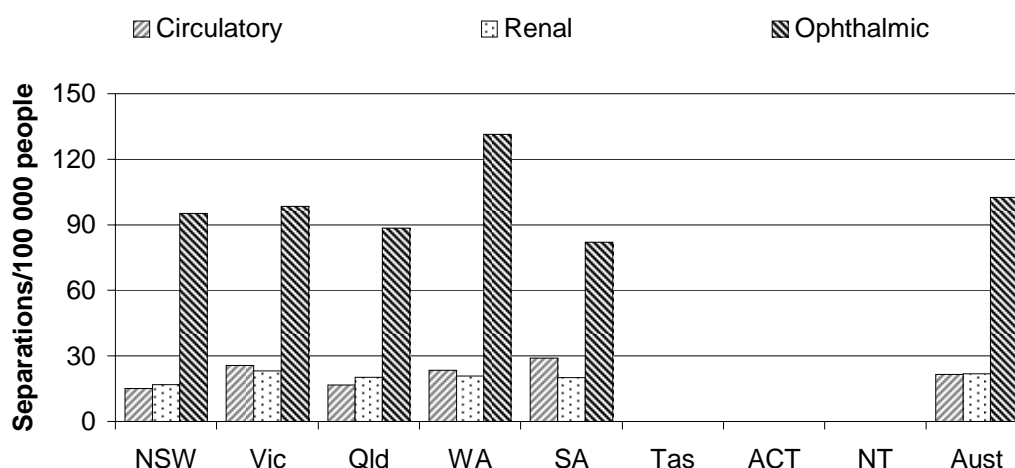
^a These data are not person-based, but episode-based. A person who is admitted to hospital, for example, three times in the year, will be counted three times. ^b Results for individual complications may be affected by small numbers, and need to be interpreted with care. ^c Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. ^d Morbidity data are coded under coding standards that may differ over time and across jurisdictions. ^e Data for Tasmania, the ACT and the NT are not published separately (due to hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW unpublished; table 10A.37.

The three most common complications from Type 2 diabetes that led to hospitalisation in 2004-05 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 10.31). Each patient may

have one or more complication (circulatory, renal and ophthalmic) for each diabetes hospital separation.

Figure 10.31 Standardised hospital separations for Type 2 diabetes mellitus as principal diagnosis, by selected complications, all hospitals, 2004-05^{a, b, c, d, e}



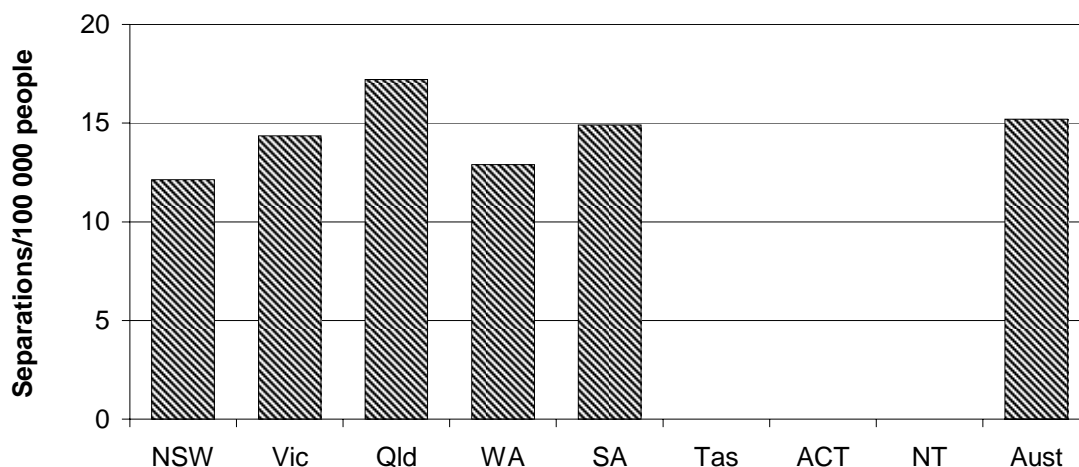
^a These data are not person-based, but episode-based. A person who is admitted to hospital, for example, three times in the year, will be counted three times. ^b Results for individual complications may be affected by small numbers, and need to be interpreted with care. ^c Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. ^d Morbidity data are coded under coding standards that may differ over time and across jurisdictions. ^e Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW unpublished; table 10A.37.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but the number of people accessing ambulatory services is not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect hospital separations rates. This effect is partly reflected in the substantial variation in the proportion of separations that are 'same day' across jurisdictions. Nationally, 46.9 per cent of separations for Type 2 diabetes were same day in 2004-05 (table 10A.38).

Amputation of a lower limb can be a serious outcome of diabetes-related complications. In 2004-05, there were 15.2 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 10.32).

Figure 10.32 **Standardised hospital separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2004-05^{a, b, c}**



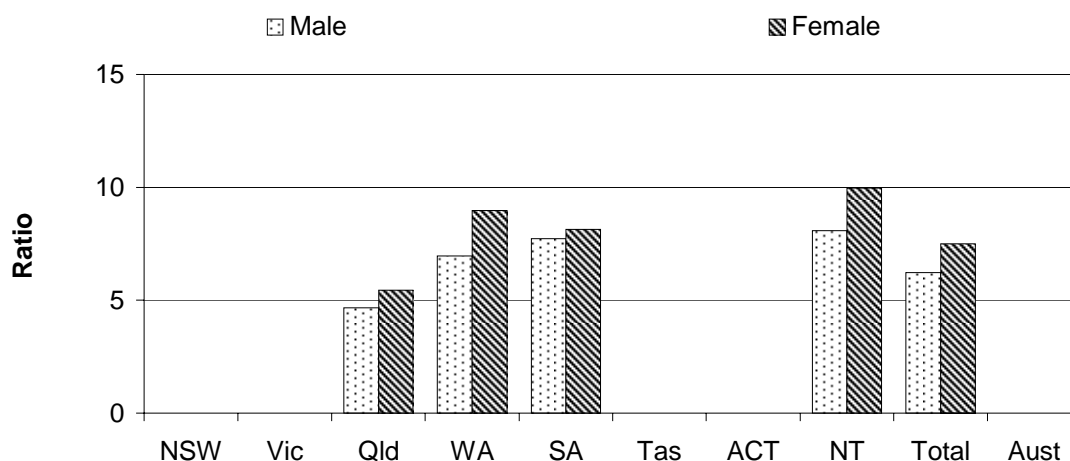
^a Includes unspecified diabetes. Separation rates are directly age standardised to the Australian population at 30 June 2001. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x.....for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation. ^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. ^c Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished); table 10A.39.

Age standardised hospital separation ratios for all diabetes diagnoses illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in age distributions. For both males and females there was a marked difference in 2004-05 between the separation rates for Indigenous people and those for the total population for all diabetes diagnoses.¹ The quality of Indigenous identification is considered acceptable for the purposes of analysis for Queensland, WA, SA and the NT. For these jurisdictions combined the separation rate for Indigenous males was 9.3 times higher than those for all Australian males. The separation rate for Indigenous females was 12.5 times the rate for all females (figure 10.33).

¹ 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes.

Figure 10.33 Ratio of age standardised hospital separation rates of Indigenous people to all people for all diabetes diagnoses, 2004-05^{a, b, c, d, e, f}



^a The ratios are indirectly standardised using the estimated resident populations of Indigenous people and non-Indigenous people at 30 June 2004, and hospital separations data for Queensland, WA, SA, and the NT public hospitals. ^b Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among jurisdictions. The variation in the number of Indigenous separations per 1000 Indigenous population across the states and territories suggests variation in the proportion of Indigenous persons who were identified as such in the hospital morbidity data collections and/or in the total population. The AIHW advised that only data from Queensland, WA, SA and the NT are considered to be of acceptable quality. ^c 'All diabetes' refers to separations with a principal and/or additional diagnosis, except where dialysis is the principal diagnosis. ^d NT data are for public hospitals only. ^e Total comprises Queensland, WA, SA and the NT only. A total for Australia is not available. ^f Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Care should be taken when comparing the two.

Source: AIHW (unpublished); tables 10A.35 and 10A.36.

Hospitalisations of older people for falls

Box 10.28 Hospitalisation of older people for falls

The effectiveness of primary and community healthcare has an influence on the rates of hospitalisation of older people for falls. Primary and community healthcare can help to prevent falls occurring or may assist in reducing the severity of injury from a fall and also the chance of hospitalisation.

The indicator is defined as the number of hospital separations for older people with a reported external cause of falls per 1000 older people, adjusted to take account of differences in State and Territory age distributions. Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over.

(Continued on next page)

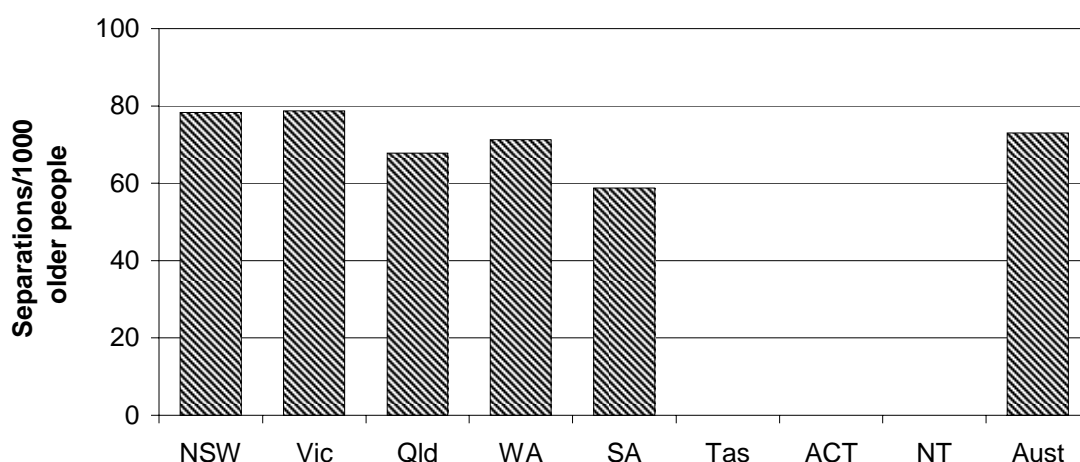
Box 10.28 (Continued)

A reduction in the rate of hospitalisation due to falls may indicate improvements in the effectiveness of primary healthcare services provided to older people who are at risk of falls.

Factors outside the control of the primary healthcare system, however, also influence the rates of hospitalisation. These include the support available to older people from family and friends, and the provision of aged care services such as Home and Community Care program services and residential care.

Nationally, the hospital separation rate in 2004-05 for older people with injuries due to falls was 73.0 per 1000 older people (figure 10.34).

Figure 10.34 **Hospital separations for older people with a reported external cause of falls, 2004-05^{a, b, c}**



^a Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over. ^b Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia. ^c Separation rates are crude rates using 2004 population of Indigenous aged 55 years or over plus population of non-indigenous aged 75 year or over as denominator.

Source: AIHW (unpublished); table 10A.40.

10.4 Future directions in performance reporting

While the topic of this chapter is all primary and community health services, the indicators still focus heavily on general practice services. This focus partly reflects the lack of data available on a nationally consistent basis to support reporting against indicators for other primary and community health services. The Steering

Committee has identified possible areas for which indicators may be available for inclusion in the 2008 Report or future reports. These include:

- dental health services
- community-based drug and alcohol treatment services
- additional indicators relating to the use of the MBS chronic disease management items.

In addition, a number of currently reported indicators have been identified as candidates for possible reporting improvements. These are:

- management of asthma
- General Practices with accreditation
- management of diabetes
- management of upper respiratory tract infection.

The scope of this chapter may also be further refined to ensure the most appropriate reporting of primary health services against the Review's terms of reference and reporting framework (chapter 1).

Indigenous health

Barriers to accessing primary health services contribute to the poorer health status of Indigenous people compared to other Australians (see the 'Health preface'). In recognition of this issue, the Steering Committee has identified primary and community health services for Indigenous people as a priority area for future reporting. The Steering Committee will examine options for including indicators of the accessibility of primary and community health services to Indigenous people. The Aboriginal and Torres Strait Islander Health Performance Framework developed under the auspices of the Australian Health Ministers' Advisory Council will inform the selection of future indicators of primary and community health services to Indigenous people (see the 'Health preface').

The availability of hospital separations data for Indigenous people is significantly reduced in the 2007 Report compared to previous Reports. Analysis into the quality of Indigenous identification of hospital admitted patient statistics has shown that while the quality is good in some jurisdictions, in other jurisdictions it is poor (AIHW 2005a). Consequently, Indigenous hospital separations data are only available for Queensland, WA, SA and the NT. Data from NSW, Victoria, Tasmania and the ACT were considered to be of insufficient quality. Although some jurisdictions have improved the quality of Indigenous hospital separations

data, the Steering Committee considers that the lack of progress and ongoing evaluation of data quality in other jurisdictions is disappointing as the problem has been known for ten years.

The AIHW is developing a methodology and sampling strategy that will allow each jurisdiction to carry out a validation process to get a more recent indication of the current level of under identification in their hospital data. At the end of this project, the jurisdictions will be in a better position to assess whether the situation has improved. The AIHW is also currently undertaking another project to develop best practice guidelines for identification. The Steering Committee supports the work of the AIHW to assist jurisdictions to assess the quality of their data, however, primary responsibility for improvement rests with jurisdictions and the Steering Committee strongly encourages all jurisdictions to address this issue as a matter of urgency.

10.5 Definitions of key terms and indicators

Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Cervical screening rates for target population	Proportion of women aged 20–69 years who are screened for cervical cancer over a two year period.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Divisions of General Practice	Geographically-based networks of GPs. Currently there are 119 Divisions of General Practice, 8 State Based Organisations and the Australian Divisions of General Practice. The Divisions of General Practice Program evolved from the former Divisions and Projects Grants Program established in 1992. The Divisions of General Practice Program aims to contribute to improved health outcomes for communities by working with GPs and other health services providers to improve the quality and accessibility of health care at the local level.
Full time workload equivalents	A measure of medical practitioner supply based on claims processed by Medicare in a given period, calculated by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that period. Full time equivalents are calculated in the same way as FWE except that full time equivalents are capped at 1 for each practitioner.
Fully immunised at 12 months	A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine and three doses of HbOC (HibTITER) (or two doses of PRP-OMP [PedvaxHIB]).
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine, four doses of HbOC (HibTITER) (or three doses of PRP-OMP [PedvaxHIB]) and one dose of measles, mumps, rubella vaccine.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.

General practitioner (GP)	<p>Vocationally recognised GPs — medical practitioners who are vocationally recognised under s.3F of the Health Insurance Act 1973 (Cwlth), hold Fellowship of the RACGP or equivalent (Fellowship of the RACGP has been required since 1996, to achieve vocational recognition) or hold a recognised training placement</p> <p>Other medical practitioners — medical practitioners who are not vocationally recognised GPs.</p>
Health management	An ongoing process beginning with initial client contact and including all actions relating to a client. Includes: assessment/evaluation; education of the person, family or carer(s); diagnosis and treatment; management of problems associated with adherence to treatment; and liaison with, or referral to, other agencies.
Immunisation coverage	A generic term indicating the proportion of a target population that is fully immunised with a particular vaccine or the specified vaccines from the National Immunisation Program for that age group.
Management of upper respiratory tract infections	Number of prescriptions ordered by GPs for the oral antibiotics most commonly used in the treatment of upper respiratory tract infections per 1000 people with PBS concession cards.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive Medicare reimbursement.
Non-referred attendances that are bulk billed	Number of non-referred attendances that are bulk billed and provided by medical practitioners, divided by the total number of non-referred non-specialist attendances.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (DoHA 2004). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.
Notifications of selected childhood diseases	Number of cases of measles, pertussis and <i>Haemophilus influenzae</i> type b notified to State and Territory health authorities.
Other medical practitioner (OMP)	A medical practitioner other than a recognised GP who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances. These practitioners are only able to access the lower A2 Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.
Per person benefits paid for GP ordered pathology	Total benefits paid for pathology tests ordered by GPs, divided by the population.

Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging tests referred by GPs, divided by the population.
Primary healthcare	The primary and community healthcare sector includes services that: <ul style="list-style-type: none"> • provide the first point of contact with the health system • have a particular focus on illness prevention or early intervention • are intended to maintain people's independence and maximise their quality of life through care and support at home or in local community settings.
Prevalence	The proportion of the population suffering from a disorder at a given point in time (point prevalence) or during a given period (period prevalence).
Proportion of GPs who are female	Number of all FWE GPs who are female, divided by the total number of FWE GPs.
Proportion of GPs with vocational recognition	Number of FWE GPs who are vocationally recognised, divided by the total number of FWE GPs.
Proportion of general practices registered for accreditation	Number of practices that have registered for accreditation through AGPAL, divided by the total number of practices in the Divisions of General Practice.
Proportion of general practices with electronic information management systems	Number of practices with electronic prescribing and/or electronic connectivity that are registered under the PIP, divided by the total number of practices registered.
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Reasons for encounter	The expressed demand of the patient for care, as perceived and recorded by the GP.
Recognised immunisation provider	A provider recognised by the Medicare Australia as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist on the Medicare database earning at least half of his/her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than would otherwise be possible without the test.
Vocationally recognised general practitioner	A medical practitioner who is vocationally recognised under s.3F of the Health Insurance Act 1973 (Cwlth), holds Fellowship of the RACGP or equivalent or holds a recognised training placement, and who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances.

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 format as \Publications\Reports\2007\Attach10A.xls and in Adobe PDF format as \Publications\Reports\2007\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).

Table 10A.1	Types of encounter, 2005-06
Table 10A.2	Australian Government real expenditure per person on GPs (2005-06 dollars)
Table 10A.3	Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs
Table 10A.4	Indigenous primary healthcare services for which service activity reporting (SAR) data is reported (number)
Table 10A.5	Services and episodes of healthcare by services for which service activity reporting (SAR) data is reported, by remoteness category (number)
Table 10A.6	Proportion of services for which service activity reporting (SAR) data is reported that undertook selected health related activities, 2004-05 (per cent)
Table 10A.7	Full time equivalent health staff employed by services for which service activity reporting (SAR) data is reported, as at 30 June 2005 (number)
Table 10A.8	Alcohol and other drug treatment services, by sector, 2004-05 (number)
Table 10A.9	PBS services, 2005-06
Table 10A.10	Approved providers of PBS medicines, by urban and rural location, 2005-06
Table 10A.11	PBS expenditure per person, by urban and rural location, (2005-06 dollars)
Table 10A.12	Availability of GPs by region
Table 10A.13	Female GPs
Table 10A.14	Availability of public dental practitioners per 100 000 people, 2003
Table 10A.15	Non-referred attendances that were bulk billed, by region (per cent)
Table 10A.16	Non-referred attendances that were bulk billed (per cent)
Table 10A.17	Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and dispensed to patients (per 1000 people with Pharmaceutical Benefits Scheme [PBS] concession cards)
Table 10A.18	Pathology tests ordered by vocationally recognised GPs and other medical practitioners (OMPs), real benefits paid (2005-06 dollars) and number of tests
Table 10A.19	Diagnostic imaging ordered by vocationally recognised GPs and other medical practitioners (OMPs), real benefits paid (2005-06 dollars) and number of referrals
Table 10A.20	Practices under the Practice Incentives Program (PIP) using computers for clinical purposes

Table 10A.21	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes
Table 10A.22	Proportion of full time workload equivalent (FWE) GPs with vocational recognition, by region (per cent)
Table 10A.23	Number and proportion of full time workload equivalent (FWE) GPs with vocational recognition
Table 10A.24	General practices accredited by Australian General Practice Accreditation Limited
Table 10A.25	GP use of chronic disease management Medicare items for care planning and case conferencing
Table 10A.26	Annual voluntary health assessments for older people
Table 10A.27	Valid vaccinations supplied to children under seven years of age, by type of provider, 1996–2006
Table 10A.28	Children aged 12 months to less than 15 months who were fully immunised (per cent)
Table 10A.29	Children aged 24 months to less than 27 months who were fully immunised (per cent)
Table 10A.30	Notifications of measles, children aged 0–14 years
Table 10A.31	Notifications of pertussis (whooping cough), children aged 0–14 years
Table 10A.32	Notifications of Haemophilus influenzae type b, children aged 0–14 years
Table 10A.33	Participation rates of women in cervical screening programs, by age group (per cent)
Table 10A.34	Influenza vaccination coverage, people aged 65 years or over
Table 10A.35	Ratio of age standardised hospital separations for Indigenous males to all males 2004-05
Table 10A.36	Ratio of age standardised hospital separations for Indigenous females to all females, 2004-05
Table 10A.37	Standardised hospital separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2004-05 (per 100 000 people)
Table 10A.38	Separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, all episode types, 2004-05 (per cent)
Table 10A.39	Standardised hospital separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2004-05
Table 10A.40	Separation rates of older people for injuries due to falls, 2004-05
Table 10A.41	Australian Government, community health services programs
Table 10A.42	New South Wales, community health services programs
Table 10A.43	Victoria, community health services programs
Table 10A.44	Queensland, community health services programs
Table 10A.45	Western Australia, community health services programs
Table 10A.46	South Australia, community health services programs
Table 10A.47	Tasmania, community health services programs

Table 10A.48 Australian Capital Territory, community health services programs

Table 10A.49 Northern Territory, community health services programs

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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, which represent some activities of the Australian, 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, while jurisdictions' comments relating to all the health chapters appear in section 11.6. Definitions are listed in section 11.7. Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 11A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Section 11.8 lists the supporting tables for this chapter and section 11.9 lists references used in the chapter.

11.1 Overview of health management

Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. This chapter examines the performance of a number of services in influencing outcomes for women with breast cancer and for people with a mental illness. Measuring performance in the management of a health problem involves measuring the performance of service providers and the overall management of a spectrum of services, including prevention, early detection and treatment 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, as are asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and musculoskeletal conditions. These areas represent almost 80 per cent of the total burden of disease and injury in

Australia, and their management offers considerable scope for reducing this burden (AIHW 2003b).

Appropriate management of breast cancer and mental health will have a large effect on the health and wellbeing of many Australians. Both are subjects of programs designed to improve public health. Public health programs require the participation of public hospitals, primary and community health services, and other services. The performance of public hospitals is discussed in chapter 9 and the performance of primary and community health services generally is discussed in chapter 10.

Several additions and improvements have been made to the chapter this year:

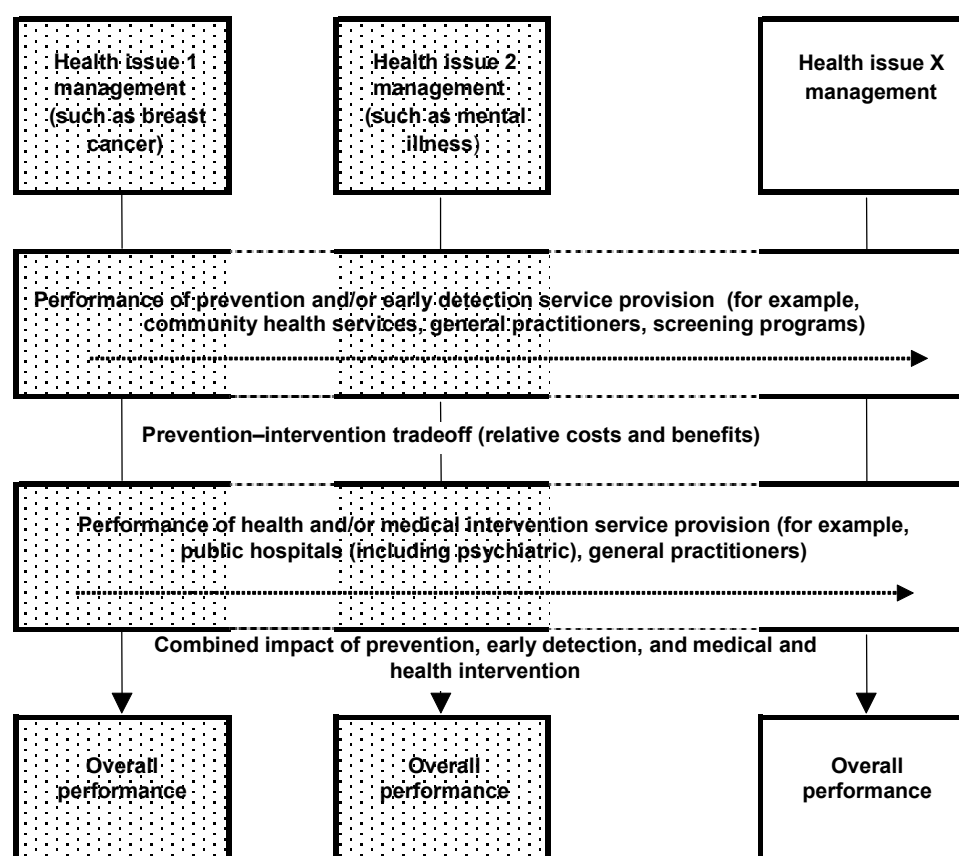
- Changes to the breast cancer framework include:
 - the ‘participation rate for women from special needs groups in BreastScreen programs’ has been reclassified as an indicator of the equity of access, rather than as a program outcome
 - the ‘participation rate for women in BreastScreen target age group’ has been reclassified as an indicator of how effective the program is at accessing its target age group, rather than as a program outcome
 - the ‘interval cancer rate’ has been reclassified as an early detection program outcome, rather than as an indicator of the safety of the early detection program.
- The indicator ‘services reviewed against the national standards’ has been changed from ‘specialised public mental health services reviewed against the national standards for mental health services’ to the ‘percentage of services that had completed an external review and been assessed as meeting all or most standards’.
- The number of paid consumer and carer consultants employed within public sector mental health services is reported as part of the ‘consumer/carers participation’ indicator for the 2007 Report.

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 primary and community health services report the performance of particular service delivery mechanisms. The appropriateness of the mix of services (prevention versus intervention) and the appropriateness of the mix of delivery mechanisms (hospital-based versus community-based) are the focus of

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

Figure 11.1 The Australian health system — measurement approach



The appropriate mix of services — including the prevention of illness and injury, medical treatment and the appropriate mix of service delivery mechanisms — is measured by focusing on a health management issue (represented by the vertical arrows). As in previous years, the chapter covers breast cancer detection and management, and specialised mental health services. The breast cancer management framework integrates 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 11.1).¹ Tumours may expand locally by invading surrounding tissue, or they may spread via the lymphatic or vascular systems to the rest of the body. If left untreated, most malignant tumours result in the death of the affected person (AIHW 2003a). The focus of this Report is on invasive cancers, although some data are reported on *ductal carcinoma in situ* (DCIS — noninvasive tumours residing in the ducts of the breast).

Box 11.1 Some common health terms used in breast cancer detection and management

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

BreastScreen Australia: BreastScreen Australia is the national mammographic population screening program. It is aimed at well women, without symptoms or family history. It provides free screening mammograms at two-yearly intervals for women aged 50–69 with the aim of reducing deaths from breast cancer in this target group through early detection of the disease. Women aged 40–49 years and 70 years and over are eligible to attend but are not actively targeted. Services provided by BreastScreen Australia include all screening and assessment services to the point of diagnosis. The program includes health promotion activities, information provision, counselling and data collection across the screening and assessment pathways. BreastScreen Australia is jointly funded by the Australian, State and Territory governments.

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

(Continued on next page)

¹ Breast cancer in males is very rare. It is not examined in this Report.

Box 11.1 (Continued)

health management: an ongoing process beginning with initial client contact and including all actions relating to the client: assessment/evaluation; education of the person, family or carer(s); diagnosis; and treatment. Problems associated with adherence to treatment and liaison with, or referral to, other agencies are also included.

incidence rate: the proportion of the population newly diagnosed with a particular disorder or illness during a given period (often expressed per 100 000 people).

invasive cancer: a tumour whose cells invade healthy or normal tissue.

prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

screening: the performance of tests on apparently well people to detect disease at an earlier stage than would otherwise be the case.

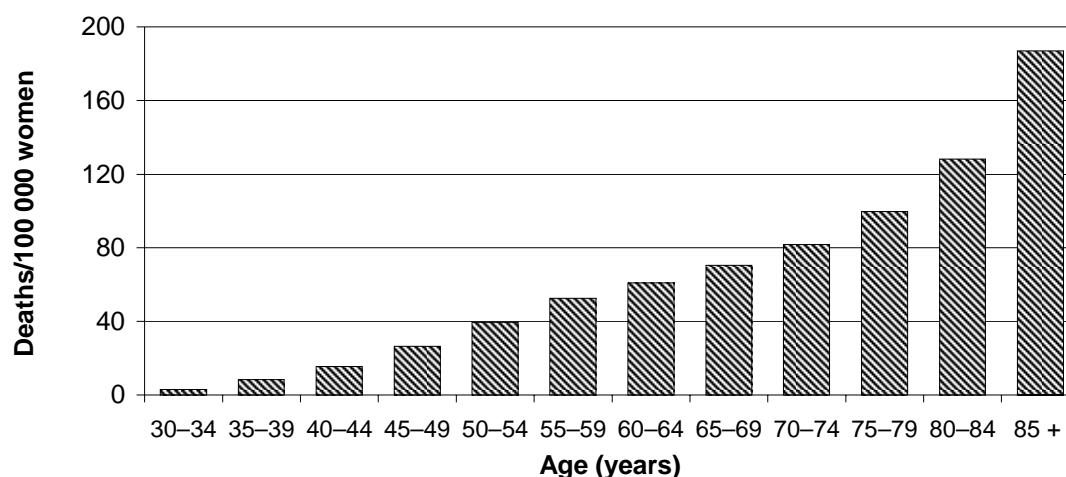
screening round (first): a woman's first visit to a BreastScreen Australia service.

screening round (subsequent): a woman's second or subsequent visit to a BreastScreen Australia service.

total mastectomy: removal of the breast (also known as a simple mastectomy).

Breast cancer was responsible for 2641 female deaths in 2004, making it one of the most frequent causes of death from cancer for females (ABS 2006a). The strong relationship between age and the mortality rate from breast cancer is shown for the period 2000–2004 in figure 11.2. Women aged 40–44 years had an annual average mortality rate over this period of 15.5 per 100 000, whereas women aged 75–79 years had an annual average mortality rate of 99.7 per 100 000.

Figure 11.2 **Annual average mortality rates from breast cancer, by age group, 2000–2004**



Source: AIHW (unpublished); table 11A.1.

Incidence and prevalence

Breast cancer is the most prevalent type of cancer affecting Australian women. In 2001, the estimated risk of a woman in Australia developing breast cancer before the age of 75 years was one in eleven (AIHW and AACR 2004). The number of new cases of breast cancer diagnosed in Australian women increased from an annual average of 10 262 over the period 1995–99 to an annual average of 11 301 over the period 1998–2002 (table 11.1). The increase in the number of cases detected reflected both an increase in the underlying rate of breast cancer, as well as the early detection of cancers that previously would not have been discovered for some years, primarily through the activity of BreastScreen Australia (AIHW 2003a).

Annual average age standardised incidence rates of breast cancer are presented in figure 11.3. Breast cancer incidence data are averaged over five year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases but relatively large variations in rates from year to year. The Australian incidence rate increased from an annual average of 113.0 per 100 000 women for the period 1994–98 to an annual average of 115.0 for the period 1998–2002.

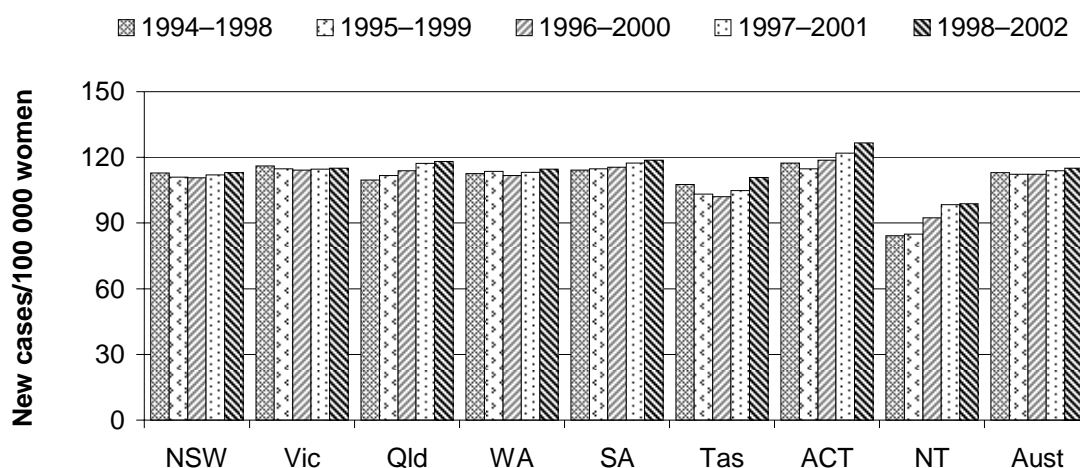
Table 11.1 **Annual average new cases of breast cancer diagnosed (number)^a**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
1995–1999	3 511	2 676	1 786	938	911	248	148	45	10 262
1996–2000	3 576	2 724	1 879	951	930	250	158	50	10 519
1997–2001	3 703	2 792	1 995	993	962	262	168	54	10 930
1998–2002	3 818	2 862	2 075	1 037	990	282	181	55	11 301

^a A new case is defined as a person who has a cancer diagnosed for the first time. One person may have more than one cancer, so may be counted twice in incidence statistics if it is decided that the two cancers are not of the same origin.

Source: AIHW (unpublished); table 11A.2.

Figure 11.3 **Annual average age standardised incidence rates of breast cancer for women of all ages^{a, b}**

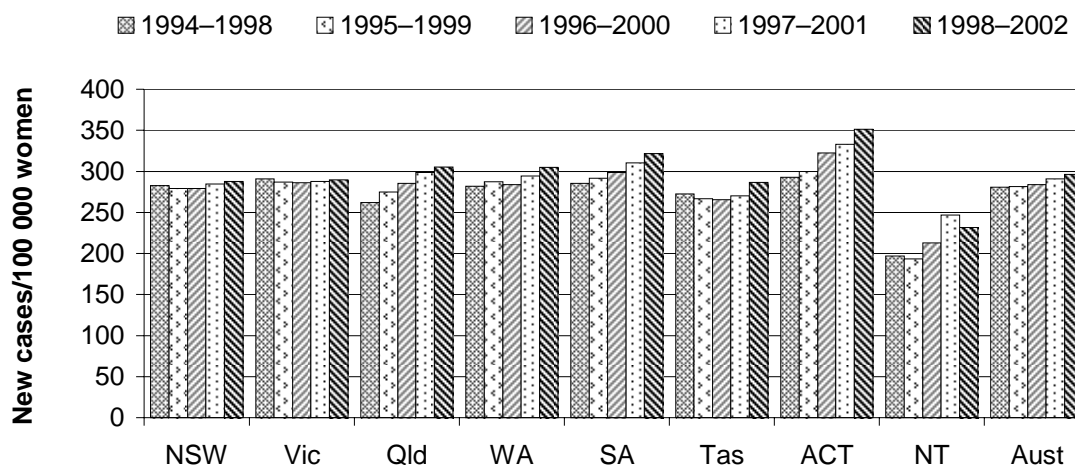


^a Incidence refers to the number of new cases of breast cancer per 100 000 women. ^b Rates are age standardised to the Australian 2001 population standard.

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

Annual average age standardised incidence rates of breast cancer for women aged 50–69 years are shown in figure 11.4.

Figure 11.4 Annual average age standardised incidence rates of breast cancer for women aged 50–69 years^{a, b}



^a Incidence refers to the number of new cases of breast cancer per 100 000 women. ^b Rates are age standardised to the Australian 2001 population standard.

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

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 general practitioner (GP) services and community-based women's health services; screening services; acute services based in hospitals, including both inpatient and outpatient services; private consultations for a range of disciplines; and post-acute services, including home-based and palliative care (DHS 1999).

A fundamental component of breast cancer control is the use of screening mammography to enable early detection of breast cancer. There is evidence that population-based screening of women aged 50–69 years can reduce deaths from breast cancer. According to the National Breast Cancer Centre, women whose cancer is diagnosed before it has spread outside the breast have a 90 per cent chance of surviving five years. The five year survival rate drops to 20 per cent if the cancer spreads to other parts of the body before diagnosis (NBCC 2003). It is generally accepted that cancers detected early may be treated more conservatively and that these women have a higher likelihood of survival.

BreastScreen Australia, jointly funded by the Australian, State and Territory governments, undertakes nationwide breast cancer screening. It targets women aged 50–69 years for screening once every two years. The program aims to have 70 per cent or more of women aged 50–69 years participating in screening over a 24 month

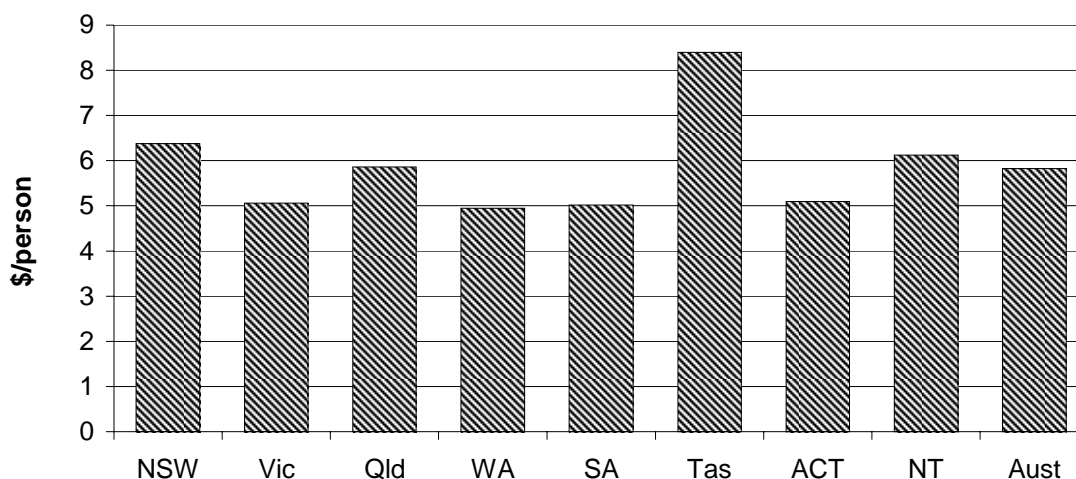
period. All recruitment activities undertaken by BreastScreen Australia specifically target women in this age group, although women aged 40–49 years and those over 70 years may also use the service.

Services provided by BreastScreen Australia in each State and Territory include all screening and assessment services to the point of diagnosis. The program includes health promotion activities, information provision, counselling and data collection across the screening and assessment pathways. Each jurisdiction manages a central BreastScreen registry to ensure women with a screen detected abnormality receive follow-up treatment and to enable women to be invited for re-screening at the appropriate interval. Data collected from the registries allow for quality assurance, monitoring and evaluation of the program. All jurisdictions perform fine needle aspiration biopsy and core biopsies as part of their assessment services, but some jurisdictions do not include open biopsies in the funded program (table 11A.4).

Information on BreastScreen Australia program performance is published by the Australian Institute of Health and Welfare (AIHW) in the BreastScreen Australia monitoring reports, the most recent of which was published in 2006 (AIHW 2006b).

Governments spent around \$118.5 million on breast cancer screening in 2004-05 (table 11A.5). Estimates of government expenditure on breast cancer screening per person are presented by jurisdiction in figure 11.5. These estimates include Australian, State and Territory government expenditure. Differences across jurisdictions partly reflect variation in the proportion of women in the target age group for breast cancer screening, data deficiencies and collection methods, as well as the nature of the services and their relative efficiency. Some differences may also be due to the geography of a State or Territory, and to the proportion of the target population living in rural and remote areas. The data therefore need to be interpreted with care.

Figure 11.5 Public health expenditure on breast cancer screening, 2004-05^{a, b, c, d, e, f, g}



^a In every jurisdiction, BreastScreen Australia is a joint initiative funded by both the State or Territory government and the Australian Government under the Public Health Outcome Funding Agreements. ^b The data need to be interpreted with care because of data deficiencies, differences across jurisdictions relating to the use of cash accounting and accrual methods, the treatment of corporate and central office costs, differences in methods used to collect expenditure figures, and differences in the interpretation of public health expenditure definitions. ^c The Australian total includes Australian Government direct project expenditure, database or registry and other program support, population health non-grant program costs and running costs. ^d Medicare funding for radiographic breast examinations is excluded because it is not public health expenditure. ^e Victorian data include depreciation. ^f Data for the ACT include expenditure on BreastScreen ACT and the Cancer Registry. ^g Data for the NT for direct expenditure include public health information systems, disease surveillance and epidemiological analysis, public health communication and advocacy, public health policy, program and legislation development, and public health workforce development.

Source: AIHW (2006c and 2007); ABS, Estimated Residential Population Cat. no. 3101.0 (unpublished); tables AA.2 and 11A.5.

The number of women aged 40 years or over screened by BreastScreen Australia indicates the size of the BreastScreen Australia program. Around 828 000 women in this age group were screened in 2005, compared with 837 000 in 2001 (table 11.2).

Table 11.2 Number of women aged 40 years or over screened by BreastScreen Australia^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2001	298 613	188 677	171 337	71 432	69 774	20 702	12 160	4 414	837 109
2002	294 027	187 714	177 281	69 697	68 571	22 204	11 793	4 166	835 453
2003	289 913	188 782	180 396	76 059	69 182	22 424	10 651	4 547	841 954
2004	270 598	198 743	191 084	78 773	69 882	23 107	9 995	4 045	846 227
2005	235 812	197 627	199 981	81 351	70 909	25 440	11 901	4 482	827 503

^a First and subsequent screening rounds, for women aged 40 years or over.

Source: State and Territory governments (unpublished); table 11A.6.

Breast cancer is diagnosed outside the BreastScreen program when women elect to screen privately or when they have symptoms which make it inappropriate for the diagnosis to be made through screening. For these women, GPs are critical as the initial point of referral to specialists for diagnosis and treatment services. Relevant clinical disciplines include surgery, plastic and reconstructive surgery, pathology, radiation and medical oncology, nursing, diagnostic radiology, radiography, physiotherapy, allied health, and psychological and psychiatric services. Post-acute services include a range of further treatments, such as radiotherapy and chemotherapy (most of which take place on a same day or outpatient basis) and a range of follow-up and palliative care services (DHS 1999).

Inpatient separations in public hospitals for selected breast-cancer related Australian refined diagnosis related groups (AR-DRGs)² in 2004-05 are presented in table 11.3. Most of the data relating to breast cancer detection and management in this Report are provided by BreastScreen Australia. At present, data for breast cancer services other than screening are limited.

Table 11.3 Separations for selected AR-DRGs related to breast cancer, public hospitals, 2004-05 (per 10 000 people)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Breast cancer related conditions									
Major procedures for malignant breast conditions	2.9	3.0	2.5	2.8	2.8	2.6	3.7	1.7	2.8
Minor procedures for malignant breast conditions	1.0	1.3	1.3	1.0	0.9	1.4	0.6	0.5	1.1
Skin, subcutaneous tissue and plastic breast procedures	2.7	3.3	3.3	3.2	5.8	2.0	1.7	1.8	3.2
Other skin, subcutaneous tissue and breast procedures	12.0	22.7	21.3	18.9	25.1	17.6	8.3	11.0	18.2
Malignant breast disorders (age >69 years w CC)	0.6	0.6	0.5	0.2	0.7	1.2	0.3	np	0.6
Malignant breast disorders (age <70 years w CC) or (age >69 years w/o CC)	0.3	0.8	0.4	1.5	0.5	0.7	0.3	np	0.6
All conditions	1 931.6	2 378.9	1 797.7	1 880.3	2 294.2	1 749.0	1 904.0	3 731.8	2 051.4

w/o CC = without complications and co-morbidities. w CC = with complications and co-morbidities.

^a Care needs to be taken when comparing jurisdictions because admission practices vary. ^b AR-DRG version 5.1. **np** Not published.

Source: AIHW (2006a); table 11A.7.

² AR-DRGs are a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 5.1 is based on the ICD-10-AM classification (see chapter 9 for more detail).

Framework of performance indicators

The indicators developed to report on the performance of breast cancer detection and management are based on the shared government objectives for managing the disease (box 11.2). The 'Health preface' explains the performance indicator framework for health services as a whole, including the health services subdimensions for quality and sustainability that have been added to the standard Review framework. Breast cancer prevention is excluded from the framework in the absence of definitive primary preventative measures, although there are known associated risk factors. There are ongoing trials examining possible preventative interventions for the small proportion of the population at high risk of breast cancer due to the presence of BRCA1 or BRCA2 genetic variations.

The performance indicator framework shows which data are comparable in the 2007 Report (figure 11.6). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

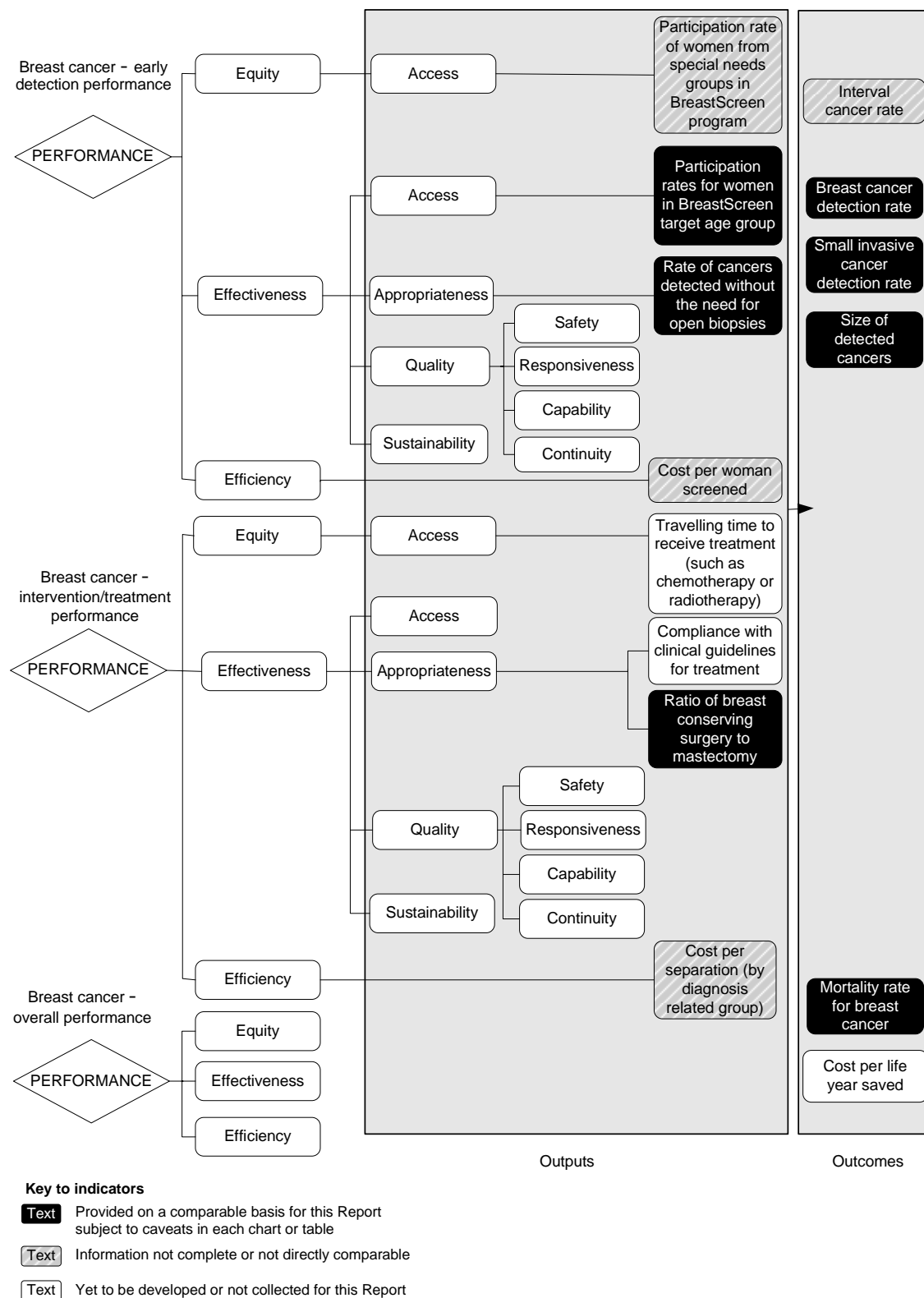
Some changes have been made to the breast cancer detection and management framework for the 2007 Report:

- the 'participation rate for women from special needs groups in BreastScreen programs' indicator has been reclassified from being an outcome to an indicator of equity of access
- the 'participation rate for women in BreastScreen target age group' indicator has been reclassified from being an outcome to an indicator of how effective the program is at accessing its target age group
- the 'interval cancer rate' has been reclassified as an early detection program outcome, rather than as an indicator of early detection program safety.

Box 11.2 Objectives for breast cancer detection and management

The objectives for breast cancer detection and management are to reduce morbidity and mortality attributable to breast cancer, and to improve the quality and duration of life of women with breast cancer in a manner that is equitable and efficient.

Figure 11.6 Performance indicators for breast cancer detection and management



The framework for breast cancer detection and management focuses on achieving a balance between early detection and treatment. It has a tripartite structure — that is, performance indicators presented relate to early detection, intervention and overall performance.

Key performance indicator results

Given the significant amounts of available data relating to breast cancer screening, screening is the focus of reporting. Data relating to the management and treatment of breast cancer are less readily available, and a Steering Committee priority is to extend reporting in this area in the future.

Ongoing monitoring of the BreastScreen Australia program involves reporting program performance against specific indicators such as participation, detection of small invasive cancers, sensitivity, detection rate for ductal carcinoma in situ, recall to assessment and rescreening rates. Data is collected at the jurisdictional level and provides an overview of the performance of the Program.

In addition, each of the BreastScreen Australia services is assessed against 173 National Accreditation Standards as part of their accreditation process. These Standards include a number of indicators that collectively assess the safety of the services provided by individual BreastScreen Australia services.

Outputs

Early detection — participation rate of women from selected community groups in BreastScreen programs

The ‘participation rate of women from selected community groups in BreastScreen programs’ is an indicator of equity of access (box 11.3).

Box 11.3 Participation rate of women from selected community groups in BreastScreen programs

The ‘participation rate of women from selected community groups’ — that is, Indigenous women, women from non-English speaking backgrounds (NESB) and women living in rural and remote areas — in breast cancer screening is an indicator because women from these groups may experience particular language, cultural and geographic barriers to accessing breast cancer screening. This indicator measures the performance of the BreastScreen program in overcoming these barriers. This reflects the importance of screening to the early detection of breast cancers. Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

The participation rate measures the proportion of the eligible population in the community group attending the screening program within a 24 month period. Participation rates for community groups that are at, or close to, those for the total population indicate success in overcoming group-specific barriers to access.

The national age standardised participation rate for Indigenous women aged 50–69 years has tended to increase in recent years, but remains below the non-Indigenous participation rate in that age group, although this may be influenced by problems with the identification of Indigenous status (table 11A.9). For the same 24 month period and age group, the national participation rate for NESB women (42.7 per cent) was also lower than that of the national total female population, as was that of women living in rural and remote areas (50.5 per cent) (table 11.4). Care needs to be taken when comparing data across jurisdictions, given differences in the collection of data by Indigenous, NESB, and rural and remote status across jurisdictions.

Table 11.4 Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2004 and 2005 (24 month period) (per cent)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Indigenous ^c	33.9	37.3	50.2	29.8	33.1	34.9	44.8	18.9	36.1
Non-English Speaking Background ^d	43.0	33.6	63.1	55.2	52.5	41.5	73.4	11.1	42.7
Metropolitan or capital city ^e	61.7	57.9	58.7	54.9	60.7	56.0	55.6	47.3	59.0
Rural and remote, or rest of State ^f	36.2	56.7	58.7	57.6	65.7	57.5	..	40.3	50.5
All women aged 50–69 years	51.2	57.5	58.6	55.6	62.1	57.4	55.3	43.9	55.7

^a First and subsequent rounds. ^b Rates are standardised to the 2001 Australian population standard. ^c Those women who self-identify as being of Aboriginal or Torres Strait Islander descent. ^d Women who speak a language other than English at home. ^e 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 Includes 'large rural centre' statistical local areas where most of the population resides in urban centres with a population of 25 000 or more; 'small rural centre' (statistical local areas in rural zones containing urban centres with populations between 10 000 and 24 999); 'other rural area' (all remaining statistical local areas in the rural zone); 'remote centre' (statistical local areas in the remote zone containing populations of 5000 or more) and 'other remote area' (all remaining statistical local areas in the remote zone). – Nil or rounded to zero. .. Not applicable.

Source: State and Territory governments (unpublished); tables 11A.8 and 11A.9.

Early detection — participation rate of women in the BreastScreen target age group

The 'participation rate of women in the BreastScreen target age group' is an indicator of how effective the program is at accessing its target population (box 11.4).

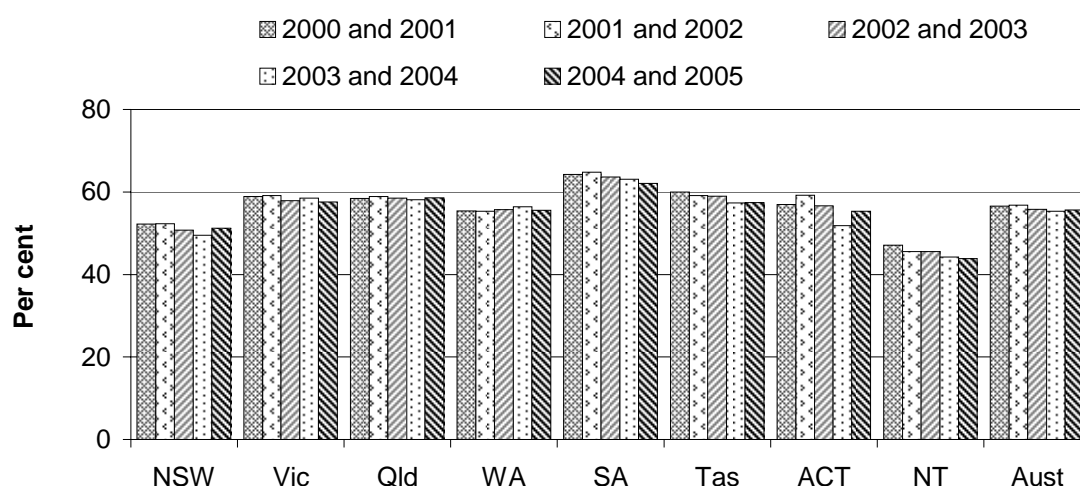
Box 11.4 Participation rate of women in the BreastScreen target age group

The 'participation rate of women in the BreastScreen target age group' of 50–69 years is an indicator of how effective the program is at accessing its target population. It reflects the importance of screening to the early detection of breast cancers. Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

The participation rate measures the proportion of the eligible population attending the screening program within a 24 month period. Higher screening participation rates are more desirable. The aim under the National Accreditation Standards (2004) is that at least 70 per cent of women aged 50–69 years participate in screening over a 24 month period. Recruitment activities undertaken by BreastScreen specifically target women in this age group although access to the program is also provided for women aged 40–49 years and 70 years or over (BreastScreen Australia 2004).

The participation of women aged 50–69 years in BreastScreen Australia screening programs was 55.7 per cent in the 24 month period 2004 and 2005 (figure 11.7).

Figure 11.7 Age standardised participation rates of women aged 50–69 years in BreastScreen Australia screening programs (24 month period)^{a, b}



^a The participation rate is the number of women resident in the jurisdiction who were screened during the reference period, divided by the number of women resident in the jurisdiction, using the ABS estimated resident population. This value represents the estimated population at the midpoint of the reference period. It is an average of the two estimated resident populations for the two calendar years (by adding both years and dividing by two). The 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. ^b Rates are standardised to the 2001 Australian population standard. Source: State and Territory governments (unpublished); table 11A.8.

Early detection — rate of cancers detected without the need for open biopsies

The ‘rate of cancers detected without the need for open biopsies’ is an indicator of the effectiveness of early detection (box 11.5).

Box 11.5 Rate of cancers detected without the need for open biopsies

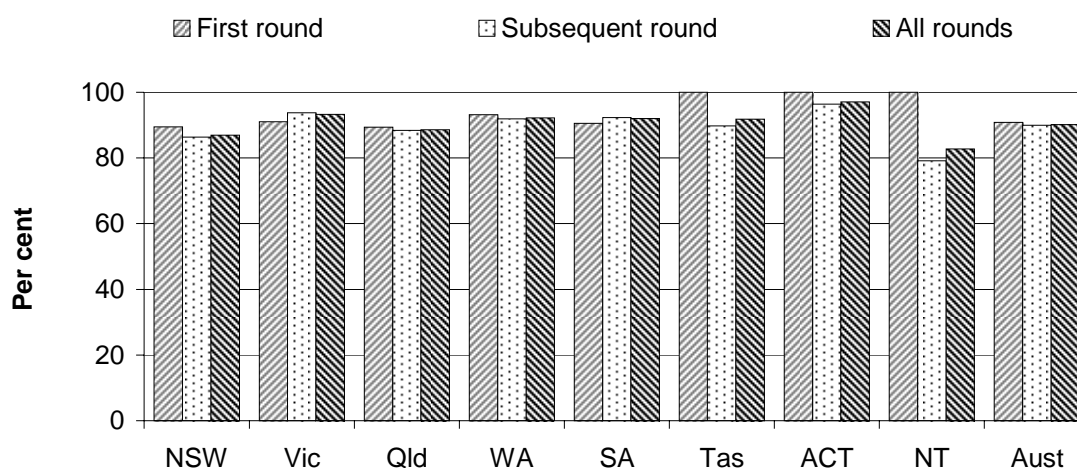
The 'rate of cancers detected without the need for open biopsies' is an indicator of the effectiveness of BreastScreen Australia in diagnosing breast cancer without the need for invasive procedures.

This indicator is defined as the number of diagnoses made without a diagnostic open biopsy, as a proportion of all breast cancers detected (invasive and DCIS). High rates of cancers detected without the need for open biopsies indicates effectiveness in detecting malignancies while minimising the need for invasive procedures.³

The BreastScreen Australia National Accreditation Standards (2004) state that 75 per cent or more of invasive cancers or DCIS should be diagnosed without the need for a diagnostic open biopsy (BreastScreen Australia 2004).

In 2005, for women attending their first screening round, the rate of cancers detected without the need for open biopsies was 90.8 per cent Australia wide. For women attending a subsequent round the rate was 90.0 per cent Australia wide (figure 11.8).

Figure 11.8 Rate of cancers detected without the need for open biopsies, all women, 2005



Source: State and Territory governments (unpublished); table 11A.10.

³ A breast biopsy is a procedure for obtaining a breast tissue specimen for microscopic examination to establish a diagnosis.

Early detection — cost per woman screened

The ‘cost per woman screened’ is an indicator of the efficiency of early detection performance (box 11.6).

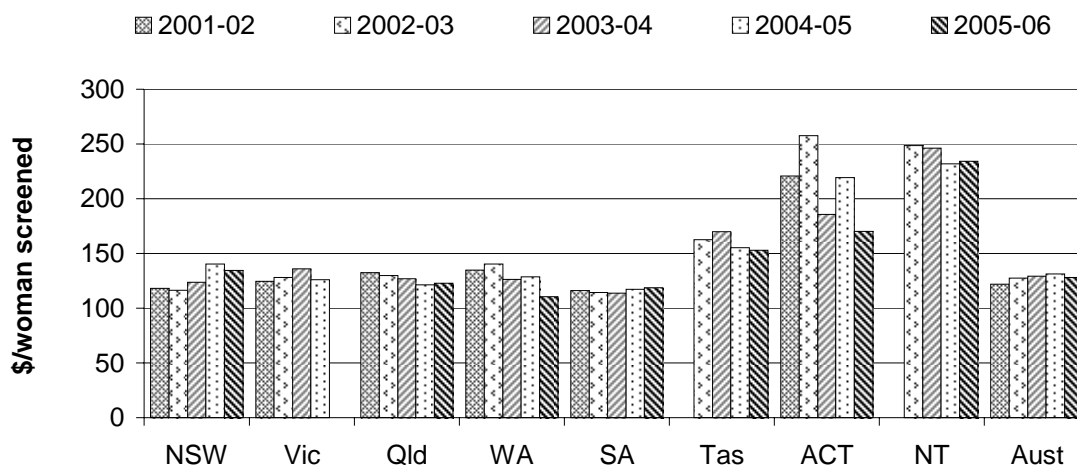
Box 11.6 Cost per woman screened

The ‘cost per woman screened’ is an indicator of the efficiency of the breast cancer screening program. An objective of breast cancer detection and management is that services are provided in an efficient manner.

‘Cost per woman screened’ measures the total cost of providing services (including screening, assessment and program management), divided by the number of women screened. A low ‘cost per woman screened’ can indicate efficiency, but caution must be used when interpreting indicators in this way because the cost does not provide any information on the quality of service provided.

Care needs to be taken when making comparisons across jurisdictions. There are potential differences in the items included in the measures of cost (particularly in the treatment of depreciation and capital asset charges, and the inclusion of subsidies). There may also be differences across jurisdictions in the scope of activities being costed. The Review is working to identify these differences across jurisdictions to improve data comparability in future (table 11A.12). Preliminary estimates of costs in each jurisdiction are presented in figure 11.9. The average cost per woman screened in Australia in 2005-06 was \$128.

Figure 11.9 Real cost per woman screened, BreastScreen Australia services (2005-06 dollars)^{a, b, c, d, e, f}



^a Constant price expenditure (in 2005-06 dollars) using the Gross Domestic Product price deflator (table AA.26). ^b Data for NSW do not include subsidies. ^c Data for Queensland include depreciation and user cost of capital for 2001-02 and 2002-03. ^d Data for Tasmania are not available for 2001-02. ^e Data for the NT are not available for 2001-02. ^f Data for Victoria for 2005-06 are not available.

Source: State and Territory governments (unpublished); ABS (unpublished) National Accounts: National Income Expenditure and Productivity; tables AA.26 and 11A.11.

Intervention/treatment — travelling time to receive treatment

The Steering Committee has identified a woman's 'travelling time to receive treatment' as an indicator of the equity of intervention and treatment performance (box 11.7). Data on this indicator, however, were not available for the 2007 Report.

Box 11.7 Travelling time to receive treatment

The Steering Committee has identified the 'travelling time to receive treatment' indicator for development and reporting in future. This indicator relates to access to breast cancer intervention and treatment services such as chemotherapy or radiotherapy. A fast 'travelling time to receive treatment' suggests that intervention and treatment services are accessible in terms of distance travelled. A fast travelling time also implies that services are well located in terms of the population served.

Intervention/treatment — compliance with clinical guidelines for treatment

The Steering Committee has identified 'compliance with clinical guidelines for treatment' as an indicator of the effectiveness and appropriateness of intervention

and treatment performance (box 11.8). Data on this indicator, however, were not available for the 2007 Report.

Box 11.8 Compliance with clinical guidelines for treatment

The Steering Committee has identified the 'compliance with clinical guidelines for treatment' indicator for development and reporting in future. This indicator relates to the appropriateness of breast cancer intervention and treatment. Compliance with clinical guidelines and treatment suggests breast cancer intervention and treatment are appropriate.

Intervention/treatment — ratio of conserving surgery to mastectomy

The ratio of 'conserving surgery to mastectomy' is an indicator of the appropriateness of intervention and treatment performance (box 11.9).

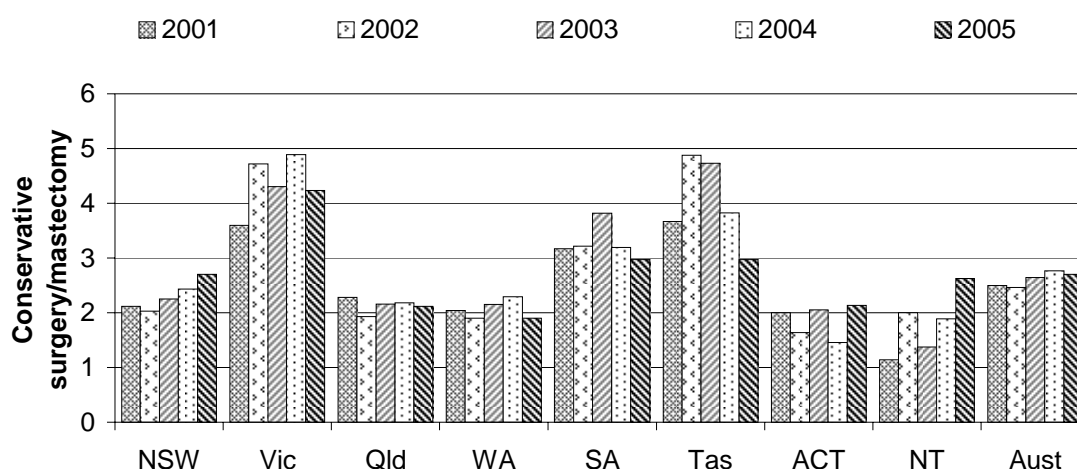
Box 11.9 Ratio of conserving surgery to mastectomy

The ratio of 'conserving surgery to mastectomy' is an indicator of the appropriateness of breast cancer intervention and treatment that aims to reduce morbidity and mortality. It can also reflect the early detection of breast cancer, because breast conserving surgery is more likely to be possible when cancers are detected at an early stage.

The ratio is defined as the number of cases for which breast conserving surgery or no surgery was performed, divided by the number of cases requiring mastectomy. Breast conserving surgery removes the breast cancer but not the whole breast. In terms of intervention and treatment, the ratio should reflect the appropriate mix of treatment. In terms of early detection of breast cancer, a high ratio is desirable. Other factors — such as the surgeon's judgment as to the best treatment for the patient — can also affect the type of surgery undertaken.

Data for this indicator are derived from BreastScreen Australia and represent only a portion of the total possible treatment information available. BreastScreen Australia aims to diagnose small cancers that can be treated more effectively and with reduced morbidity for women, so these data are not necessarily a good indication of general clinical practice relating to breast cancer. In 2005 the ratio of conserving surgery to mastectomy averaged 2.7:1 nationally, but varied across jurisdictions (figure 11.10).

Figure 11.10 **Ratio of conserving surgery to mastectomy^a**



^a Applies for women of all ages.

Source: State and Territory governments (unpublished); table 11A.13.

Intervention/treatment — cost per separation by diagnosis related group

The ‘cost per separation by diagnosis related group’ is an indicator of the efficiency of intervention and treatment performance (box 11.10).

Box 11.10 Cost per separation by diagnosis related group

‘Cost per separation by diagnosis related group’ is a proxy indicator of efficiency. An objective of breast cancer detection and management is to provide services in an efficient manner.

This indicator is defined as the cost of care per separation in public hospitals for selected breast cancer related conditions. A low cost per separation can indicate efficiency, but caution must be used when interpreting the indicator in this way, because the cost per separation does not provide any information on the quality of service provided. In addition, not all intervention strategies are reported.

Data for this indicator are sourced from the National Hospital Cost Data Collection (NHCDC) and are based on the AR-DRG classification version 5.0. The NHCDC is an annual collection of hospital cost and activity data covering the financial year before the collection period. Participation in the NHCDC is voluntary, so the samples are not necessarily representative of all hospitals in each jurisdiction (although this is improving over time). Therefore, an estimation process has been carried out to create representative national activity figures from the sample data. In

addition, the purpose of the NHCDC is to calculate DRG cost weights, not to compare the efficiency of hospitals (DHA 2005).

Table 11.5 summarises costs per separation for selected breast cancer AR-DRGs. The average cost of major procedures for malignant breast conditions across Australia was \$5835 per separation in 2004-05; minor procedures for malignant breast conditions cost \$2993 per separation on average. Table 11A.14 summarises the average length of stay (in public hospitals) associated with each AR-DRG.

Table 11.5 Average cost per separation, public hospitals by selected breast cancer AR-DRGs, 2004-05 (dollars)^{a, b, c}

AR-DRG	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Major procedures for malignant breast conditions	5 425	6 376	5 464	6 308	5 265	5 865	6 997	8 152	5 835
Minor procedures for malignant breast conditions	3 036	2 800	3 208	3 026	2 915	2 737	3 345	3 477	2 993
Malignant breast disorders, age > 69 years w CC	4 909	4 547	4 003	5 988	5 394	4 775	5 951	np	4 764
Malignant breast disorders, age <70 years w CC or age >69 w/o CC	1 546	1 744	2 055	620	1 287	2 715	1 217	np	1 453

w CC = with complications and co-morbidities. w/o CC = without complications and co-morbidities.
^a Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. ^b Average cost is affected by a number of factors, some of which are admission practices, sample size, remoteness and the types of hospital contributing to the collection. Direct comparison across jurisdictions is difficult because there are differences in hospital costing systems. ^c In accordance with NHCDC methodology, depreciation and some capital costs are included in these figures, except for Victoria, which does not include depreciation. **np** Not published due to low volume and privacy concerns.

Source: DHA 2006; table 11A.14.

Outcomes

Early detection — interval cancer rate

The ‘interval cancer rate’ is an outcome indicator of the effectiveness of early detection (box 11.11).

Box 11.11 Interval cancer rate

An interval cancer is an invasive breast cancer diagnosed in the interval between a negative screening result and the next scheduled screening examination. The purpose of the 'interval cancer rate' indicator is to help determine how effective the BreastScreen Australia program is in detecting breast cancer at an early stage. Measuring the interval cancer rate helps to obtain an early measure of the likely impact of the screening program on mortality.

The 'interval cancer rate' is defined as the number of interval cancers per 10 000 women screened. A low interval cancer rate is desirable because it suggests the breast screening process is effective in detecting breast cancer.

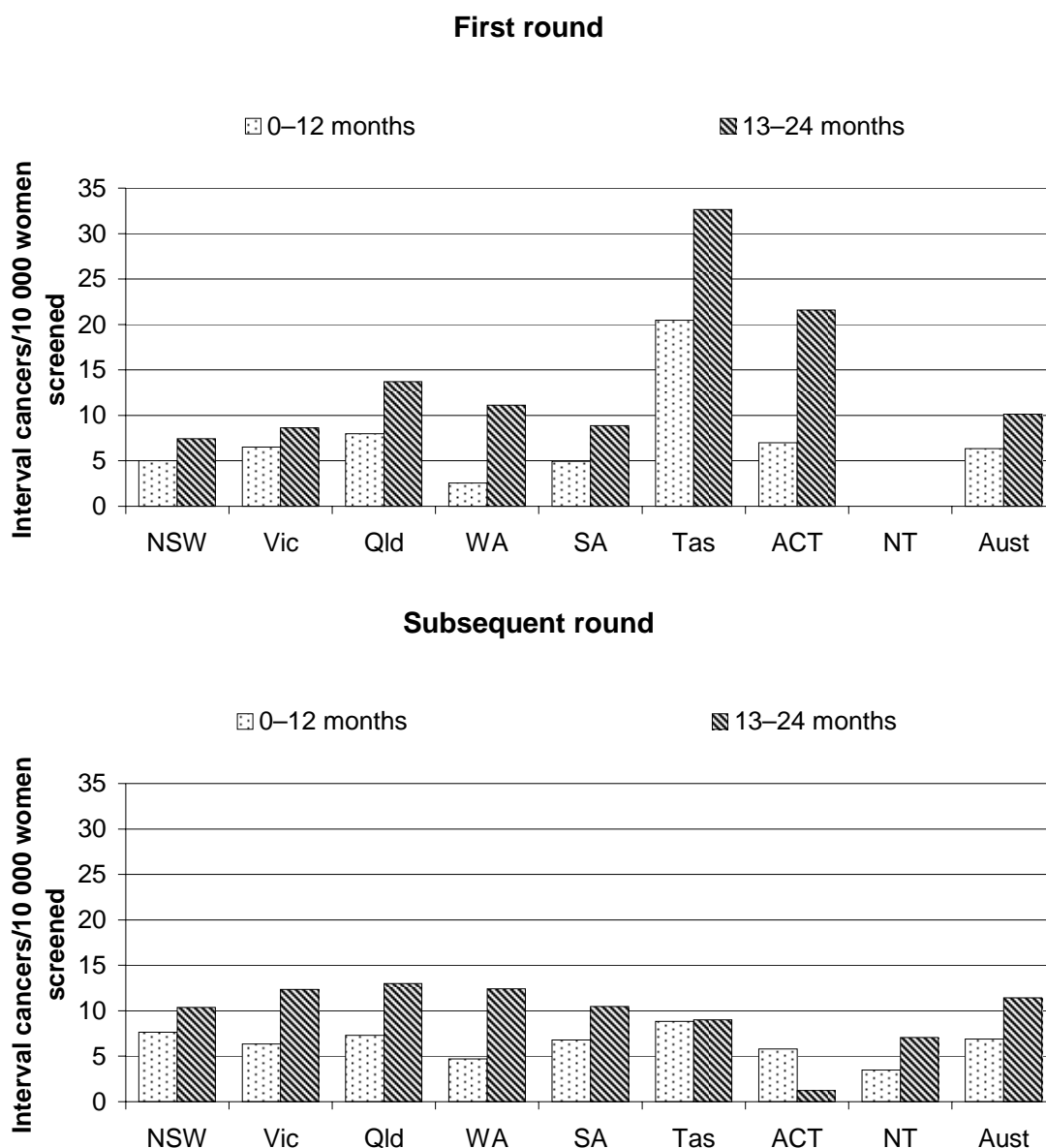
This rate needs to be interpreted in conjunction with the breast cancer detection indicators.

There is a time lag in obtaining data for this indicator, because the detection period falls between the last screening visit in the reference screening year and the next scheduled screening appointment. Following that period, a further time lag is required for the reporting of those cancers to the cancer registry, before a process of data matching can occur between each jurisdiction's screening program and its cancer registry. As a result, the most recent data available for this Report are for women screened during 2002. Stratification is by first and subsequent screening rounds to allow for expected variation in interval cancer rates between rounds.

Figure 11.11 presents the age standardised interval cancer rate by screening round for women aged 50–69 years. Differences in the rates across jurisdictions may be caused by differences in the policies of the BreastScreen services in each jurisdiction. Some jurisdictions (such as SA and some services in NSW) do not further investigate an abnormality of the breast if the mammogram appears normal, even when a symptom is reported. These women are advised to visit their GP for a referral to a diagnostic service. This could have the effect of increasing the jurisdiction's interval cancer rate and reducing their cancer detection rate if an invasive breast cancer is subsequently diagnosed outside the breast cancer screening program. Comparisons across jurisdictions therefore need to be made with care.

In 2002, for all women aged 50–69 years in the first round of screening, the interval cancer rate 0–12 months following screening was 6.3 per 10 000 women screened. In subsequent rounds this increased to 6.9 per 10 000 women screened. Interval cancer rates 13–24 months following screening are also shown in figure 11.11.

Figure 11.11 **Age standardised interval cancer rate, women aged 50–69 years, 2002^{a, b, c}**



a Rates are expressed as the number of interval cancers per 10 000 women screened. **b** The numbers used to measure this indicator were 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** Data for the NT were zero in the first round for 0–12 and 13–24 months.

Source: State and Territory governments (unpublished); table 11A.15.

Early detection — breast cancer detection rate

The ‘breast cancer detection rate’ is an outcome indicator of early detection (box 11.12).

Box 11.12 Breast cancer detection rate

The 'breast cancer detection rate' is an indicator of the effectiveness of screening services in identifying breast cancers at an early stage. Early detection of cancers while they are still small and localised to the breast is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

The 'detection rate' is the number of detected cancers per 10 000 women screened. While a high incidence of breast cancer is not desirable, a high rate of detecting these cancers is desirable.

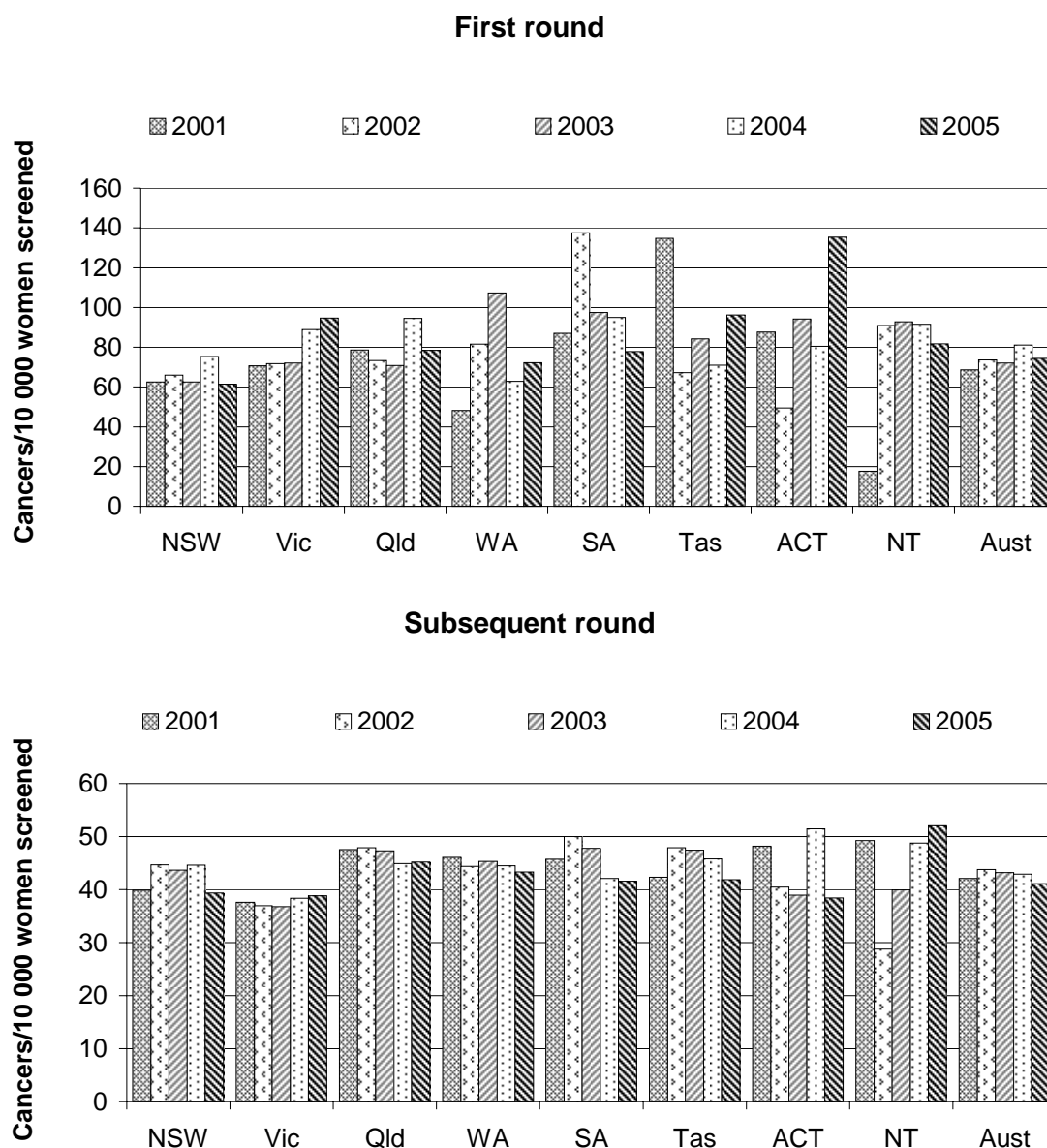
The following relevant BreastScreen Australia National Accreditation Standards for detection rates are based on the expected Australian rates (BreastScreen Australia 2004):

- Greater than or equal to 50 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with invasive breast cancer.
- Greater than or equal to 35 per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with invasive breast cancer.
- Greater than or equal to 12 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with DCIS.
- Greater than or equal to seven per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with DCIS.

It is important to consider together all of the following rates: the invasive cancer detection rate, the small invasive cancer detection rate, the DCIS detection rate and the interval cancer rate.

Figure 11.12 reports the age standardised number of invasive cancers detected per 10 000 women screened aged 50–69 years, by screening round. DCIS detected per 10 000 women screened is reported in table 11A.16. (Relevant definitions can be found in box 11.1 and section 11.7.)

Figure 11.12 **Age standardised breast cancer detection rate for women aged 50–69 years, invasive cancers^a**



^a Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen service in 1998.

Source: State and Territory governments (unpublished); table 11A.16.

Early detection — small invasive cancer detection rate

The ‘small invasive cancer detection rate’ is an outcome indicator of early detection performance (box 11.13).

Box 11.13 Small invasive cancer detection rate

The 'small (less than 15 millimetres in diameter) invasive cancer detection rate' is an indicator of the early detection of breast cancers. Early detection of cancers while they are still small and localised to the breast is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

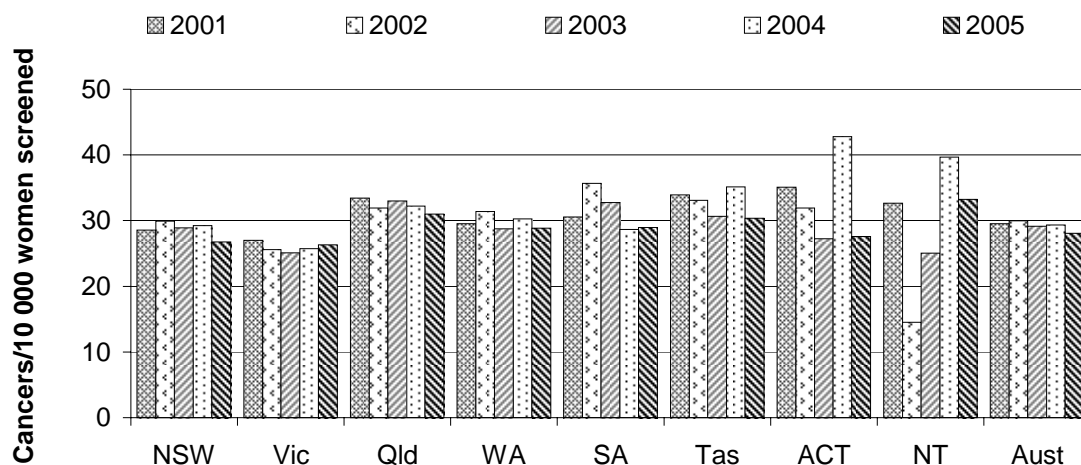
The 'small invasive cancer detection rate' is defined as the number of invasive cancers detected with a diameter of 15 millimetres or less, per 10 000 women screened. It is desirable that a high proportion of cancers detected are small cancers: detection of small cancers is generally associated with increased survival rates and reduced morbidity and mortality, leading to some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998).

The BreastScreen Australia National Accreditation Standards (2002) specify that 25 or more women per 10 000 women aged 50–69 years who attend screening are expected to be diagnosed with a small (15 millimetres or less) invasive breast cancer (BreastScreen Australia 2002).

It is important to consider together all of the following rates: the invasive cancer detection rate, the small invasive cancer detection rate, the DCIS detection rate and the interval cancer rate.

Age standardised rates for small invasive cancer detection for women aged 50–69 years screened by BreastScreen Australia in 2005 are reported in figure 11.13. This shows that the rate for Australia was 28.1 cancers per 10 000 women screened in 2005.

Figure 11.13 **Age standardised small diameter cancer detection rate for women aged 50–69 years, all rounds of screening^{a, b}**



^a Small diameter cancers are defined as invasive cancers up to and including 15 millimetre diameter. Prior to the 2003 Report, small diameter cancers were defined as 10 millimetre in diameter or less, so data are not comparable to data published before the 2003 Report. ^b Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen service in 1998.

Source: State and Territory governments (unpublished); table 11A.17.

Early detection — size of detected cancers

The ‘size of detected cancers’ is an outcome indicator of the success of early detection (box 11.14).

Box 11.14 Size of detected cancers

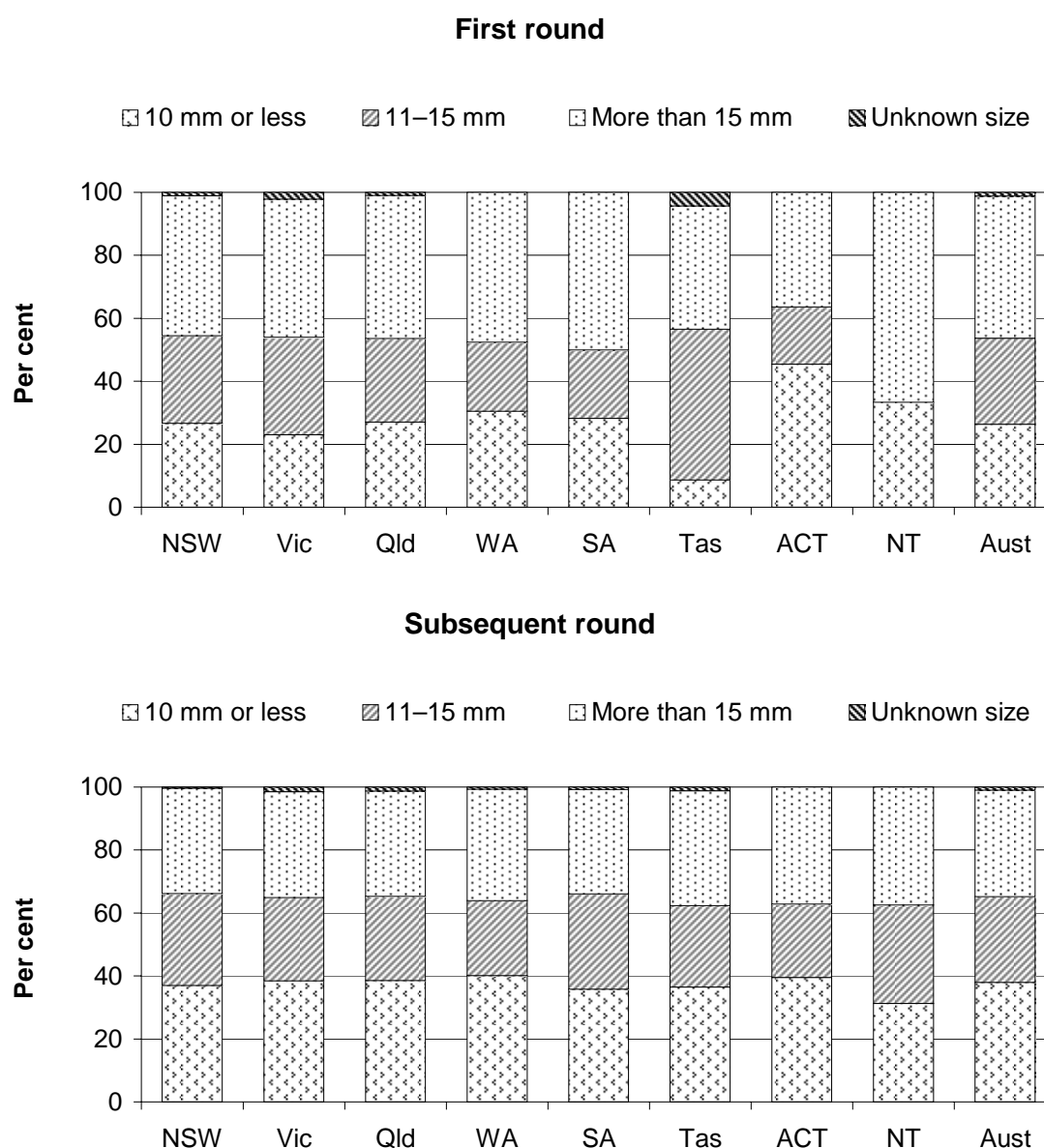
The ‘size of detected cancers’ is an indicator of the early detection of breast cancers. Detection of small cancers (those with a diameter of 15 millimetres or less) is generally associated with increased survival rates and reduced morbidity and mortality, leading to some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998).

This indicator measures detected invasive cancers by size of cancer, as a proportion of total detected invasive cancers for women aged over 40 years. High detection of small cancers relative to large cancers is desirable because it is likely to result in reduced morbidity and mortality.

Data are reported by round because larger cancers are expected to be found in the first round of screening. In subsequent rounds, cancers should be smaller if the program is achieving its objective (that is, early detection of small cancers through regular two yearly screening).

Figure 11.14 presents the proportion of cancers by size by screening round for 2005. The data are from BreastScreen Australia and cover only its clients. The data reflect that larger cancers tend to be discovered in the first round and that smaller cancers tend to be detected in subsequent rounds.

Figure 11.14 Detected invasive cancers, women aged over 40 years, by screening round and size of cancer 2005^{a, b}



^a Non-breast malignancies were not counted. ^b For small jurisdictions, fluctuations due to small numbers can make comparisons unreliable.

Source: State and Territory governments (unpublished); table 11A.18.

Overall performance — mortality rate for breast cancer

The ‘mortality rate for breast cancer’ is an outcome indicator of overall performance (box 11.15).

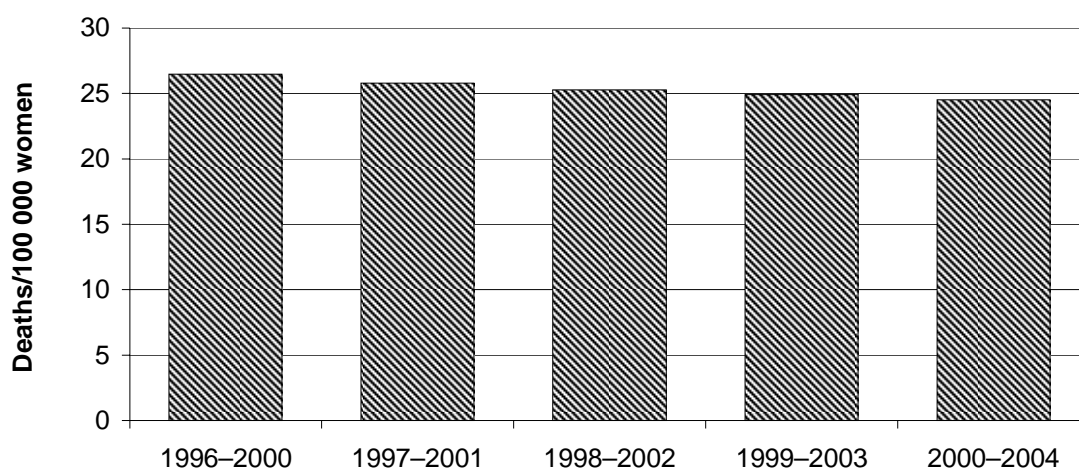
Box 11.15 Mortality rate for breast cancer

The ‘mortality rate for breast cancer’ is an outcome indicator of the effectiveness of both early detection and treatment services for breast cancer. It expresses mortality from breast cancer per 100 000 women as a five year rolling average.

Breast cancer mortality data are averaged over five year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases but relatively large variation in rates from year to year. Caution still needs to be used, however, when comparing results for smaller jurisdictions (table 11A.1).

Age standardised mortality rates are the most appropriate measure for looking at changes in mortality rates. The average annual age standardised mortality rate for breast cancer declined from 26.5 per 100 000 women over the period 1996–2000 to an average of 24.5 per 100 000 women over the period 2000–2004 (figure 11.15).

Figure 11.15 Annual average age standardised mortality rate from breast cancer, all ages^a

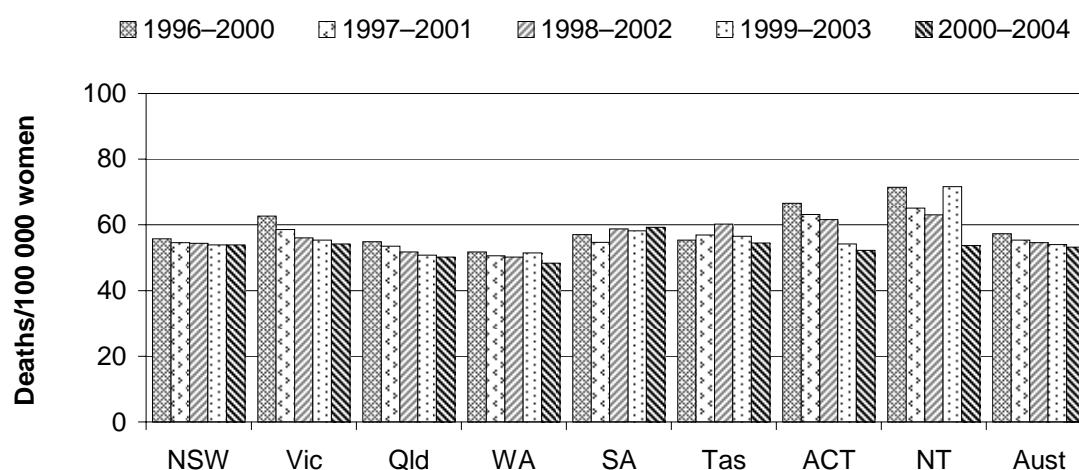


^a Age standardised to the Australian population at 30 June 2001.

Source: AIHW (unpublished); table 11A.1.

The annual average age standardised mortality rate from breast cancer for women aged 50–69 years also declined, from 57.3 per 100 000 women over the period 1996–2000 to 53.2 per 100 000 women over the period 2000–2004 (figure 11.16).

Figure 11.16 Annual average age standardised mortality rate from breast cancer, women aged 50–69 years^a



^a Age standardised to the Australian population at 30 June 2001.

Source: AIHW (unpublished); table 11A.1.

Overall performance — cost per life year saved

The Steering Committee has identified ‘cost per life year saved’ as an outcome indicator of the efficiency of overall performance (box 11.16). Data for this indicator, however, were not available for the 2007 Report.

Box 11.16 Cost per life year saved

The Steering Committee has identified the ‘cost per life year saved’ as an indicator for development and reporting in future. The indicator is a measure of the efficiency of breast cancer detection and management services.

11.4 Mental health

Profile

This section covers specialist mental health care services that treat mostly low prevalence but severe disorders. GPs are also important service providers for people with a mental disorder (chapter 10), but this Report does not include performance information on GPs' services for people with a mental illness. Alcohol and drug treatment services are not covered here, but are briefly described in chapter 10. Some common terms used in mental health management are outlined in box 11.17.

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). There is a wide range of mental disorders that can affect an individual's functioning and quality of life. Each of these disorders is unique in terms of its incidence across the lifespan, causal factors and treatments.

This chapter reports on specialist mental health care services only. The performance of other health and related service providers is examined more closely in chapter 9 ('Public hospitals'), chapter 10 ('Primary and community health') and chapter 12 ('Aged care services'). Mental health patients often have complex needs and may access a number of other services, such as those covered in chapter 3 ('School education'), chapter 7 ('Corrective services'), chapter 8 ('Emergency management') and chapter 13 ('Services for people with a disability').

Box 11.17 Some common terms relating to mental health

acute services: the National Survey of Mental Health Services (NSMHS) defines acute services as 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 treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide short term treatment. Acute services may focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms.

ambulatory care services: mental health services dedicated to the assessment, treatment, rehabilitation and/or care of non-admitted inpatients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.

community residential services: staffed residential units established in community settings that provide specialised treatment, rehabilitation and/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 a 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 and/or social abilities. For the purposes of the Chapter it includes mental illness and psychiatric disability.

mental health: the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.

mental health problem: diminished cognitive, emotional and/or social abilities, but not to the extent that the criteria for a mental disorder are met.

mental health promotion: activities designed to improve the mental health functioning of people through prevention, education and intervention activities and services.

(Continued on next page)

Box 11.17 (Continued)

mental illness prevention: interventions that occur before the initial onset of a disorder.

non-acute services: rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services focus on disability and the promotion of personal recovery. They are also characterised by an expectation of substantial improvement over the short term to medium term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. Non-acute services also consist of extended care services that provide care over an indefinite period for patients who have a stable but severe level of functional impairment and inability to function independently without extensive care and support. Patients of extended care services usually show a relatively stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness. Treatment effort focuses on preventing deterioration and reducing impairment. Improvement is expected only over a long period.

non-government organisations: private not-for-profit community managed organisations that receive State and Territory government funding specifically to provide community support services for people affected by a mental disorder. Programs provided by non-government organisations may include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.

outpatient services (community-based): services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings physically separated within hospital sites. Services provided may also include outreach or domiciliary care as an adjunct to services provided from the centre base.

outpatient services (hospital-based): services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. Services provided may also include outreach or domiciliary care as an adjunct to services provided from the clinic base.

prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

specialised care service: services whose primary function is to provide treatment, rehabilitation or community support targeted to people affected by a mental disorder. This criterion is applicable regardless of the source of funds. Such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function.

Source: DHA (2002).

Prevalence

As part of the National Health Survey in 2004–05, the ABS surveyed adults on the level of psychological distress that they had experienced in the four weeks before the survey. This survey used the Kessler-10 (K10) scale, which measures non-specific psychological distress. The scale consists of 10 questions about non-specific psychological distress and seeks to measure the level of current anxiety and depressive symptoms that a person might have experienced in the four weeks before the interview (ABS 2006b).⁴ The 2004–05 data showed that, nationally, 61.8 per cent of those aged 18–64 years had experienced a low level of distress, 24.7 per cent had experienced moderate distress and 13.4 per cent had experienced a high or very high level of distress. Generally, people aged 65 years or over were less likely to experience moderate and high to very high levels of distress, compared with the younger age group (table 11.6). Overall, in percentage terms, more females than males had experienced moderate and high to very high levels of distress (table 11A.19).

In the 2003 ABS Survey of Disability, Ageing and Carers (ABS 2004), 16.1 per cent of all people with a disability (636 900 out of 3.96 million people) reported a mental or behavioural disorder as the main health condition causing their disability. Among people who had a disability that caused a profound or severe core activity limitation (around 1.2 million people or 31.4 per cent of all people with a disability), 23.4 per cent reported a mental or behavioural disorder as their main health condition (ABS 2004).

⁴ Respondents were asked whether in the previous four weeks they had felt: tired for no good reason; nervous; so nervous nothing could calm them down; hopeless; restless or fidgety; so restless they could not sit still; depressed; everything was an effort; so sad that they could not be cheered up; and worthless. For each question, there is a five level response scale based on the amount of time that the respondent reported experiencing the particular problem. Generally, each item was scored from 1 for ‘none of the time’, to 5 for ‘all of the time’. Scores of the 10 questions were then summed, yielding a minimum possible score of 10 and a maximum possible score of 50. Low scores indicated low levels of psychological distress and high scores indicated high levels of psychological distress (ABS 2006b).

Table 11.6 K10 level of psychological distress, 2004–05 (per cent of population)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^c</i>	<i>Aust</i>
18–64 years									
Low	62.3	59.9	61.3	65.7	61.6	66.3	60.6	na	61.8
Moderate	25.0	26.0	24.3	21.7	25.3	20.4	27.0	na	24.7
High and very high	12.7	13.8	14.4	12.6	13.0	13.2	12.4	na	13.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
65 years or over									
Low	67.9	68.4	63.8	77.8	72.5	71.1	63.0	na	68.6
Moderate	20.0	21.6	21.9	15.0	18.9	18.9	27.3	na	20.2
High and very high	12.1	9.5	14.1	7.2 (d)	8.6	10.0 (d)	9.7	na	11.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Total adults									
Low	63.2	61.3	61.6	67.5	63.6	67.2	60.9	na	62.9
Moderate	24.1	25.3	23.9	20.7	24.1	20.1	27.0	na	24.0
High and very high	12.6	13.1	14.3	11.8	12.2	12.6	12.1	na	13.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0

^a Psychological distress as measured by the K10 scale. ^b Numbers may not add up to 100 due to rounding.

^c Separate estimates for the NT are not available for this survey, but the NT contributed to national estimates.

^d Estimate has a relative standard error of 25–50 per cent and needs to be interpreted with caution.

na Not available. **np** Not published.

Source: ABS (2006b); table 11A.19.

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 residential aged care services.

State and Territory governments are the primary sources of funding and service delivery for specialist public mental health services. The Australian Government also provides funding to states and territories via the Australian Health Care Agreements and to private psychiatrists and GPs through the Medicare Benefits

Schedule and to individuals through the Pharmaceutical Benefits Scheme, Medicare Safety Net and the Department of Veteran's Affairs (DVA). The Australian, State and Territory governments also fund other services that people with mental disorders can access, such as emergency relief, employment, accommodation, income support, rehabilitation, residential aged care and other services for older people and people with a disability (chapters 12 and 13).

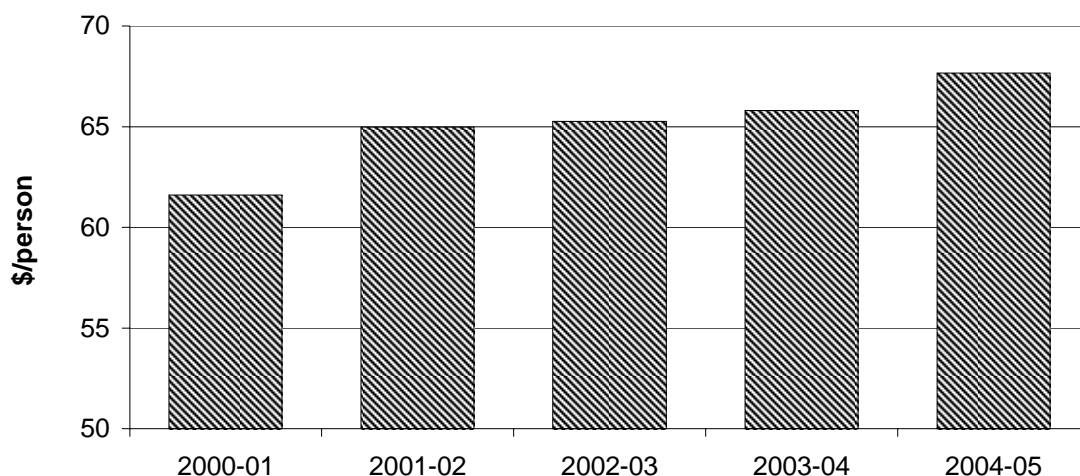
Funding

Real government recurrent expenditure of around \$3.8 billion was allocated to mental health services in 2004-05 (tables 11A.20 and 11A.21).⁵ State and Territory governments made the largest contribution (\$2.4 billion, or 64 per cent), although this included some Australian Government funds under the Australian Health Care Agreements (table 11A.21). The Australian Government spent \$1.4 billion. Real Australian Government expenditure per person rose from \$66 in 2003-04 to \$68 in 2004-05 (figure 11.17). National average State and Territory expenditure per head in 2004-05 was \$118, up from \$111 in 2003-04 (table 11A.21).

Data in this Report relating to publicly funded mental health services come from State and Territory governments. These data for 2004-05 are preliminary and should be interpreted with care.

⁵ The data include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Australian Government funds'.

Figure 11.17 Real Australian Government recurrent expenditure on mental health services per person (2004-05 dollars)^{a, b}



^a 2004-05 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2007*. ^b Constant price expenditure for all years (2004-05 dollars), using the implicit price deflator for non-farm gross domestic product (table 11A.55).

Source: DHA (unpublished); tables 11A.22 and 11A.55.

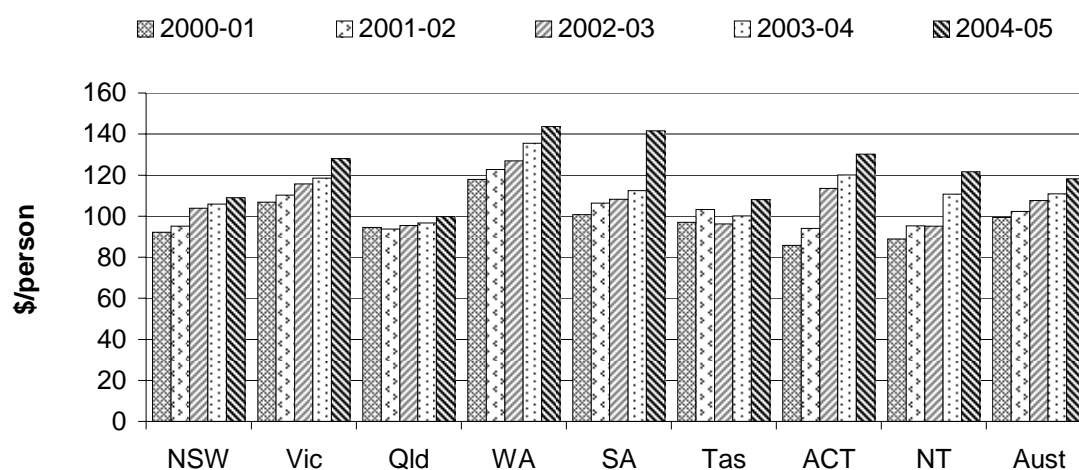
The largest component of Australian Government expenditure on mental health services in 2004-05 was expenditure under the Pharmaceutical Benefits Schedule for psychiatric medication (\$626 million). Expenditure on psychiatric medication increased by an annual average rate of 5.8 per cent between 2000-01 and 2004-05 and rose from 42.0 per cent of Australian Government expenditure on mental health services in 2000-01 to 45.7 per cent in 2004-05. The annual rate of growth of expenditure on psychiatric medication has declined over the reporting period (from 9.9 per cent from 2000-01 to 2001-02 to 1.3 per cent from 2003-04 to 2004-05) (table 11A.20).

In 2004-05, Medicare Benefits Schedule payments for consultant psychiatrists accounted for 15.6 per cent of Australian Government expenditure on mental health services, followed by expenditure for mental health care by GPs (14.7 per cent). The residual was provided by DVA (8.9 per cent), the National Mental Health Strategy (NMHS) (8.0 per cent), private hospital insurance premium rebates (4.5 per cent), and research and other time limited program and project support (2.0 per cent) (table 11A.20).

Real expenditure per person at State and Territory discretion has increased over time (figure 11.18). Data in figure 11.18 for State and Territory government expenditure include Australian Government funds provided as part of base grants under the Australian Health Care Agreements, but exclude special purpose grants provided for mental health reform and also funding provided to states and territories

by the DVA. The data are thus referred to as expenditure 'at State and Territory discretion'. The data in figure 11.18 exclude depreciation. Estimates of depreciation are presented in table 11A.24. State and Territory government expenditure estimates excluding revenue from other sources and other Australian Government funds are presented in table 11A.23. The revenue categories are subject to minimal validation and may be inconsistently treated across jurisdictions. In addition, it is not possible to extract revenue from other sources and other Australian Government funds uniformly across time.

Figure 11.18 Real recurrent expenditure at the discretion of State and Territory governments, per person (2004-05 dollars)^{a, b, c, d, e, f}

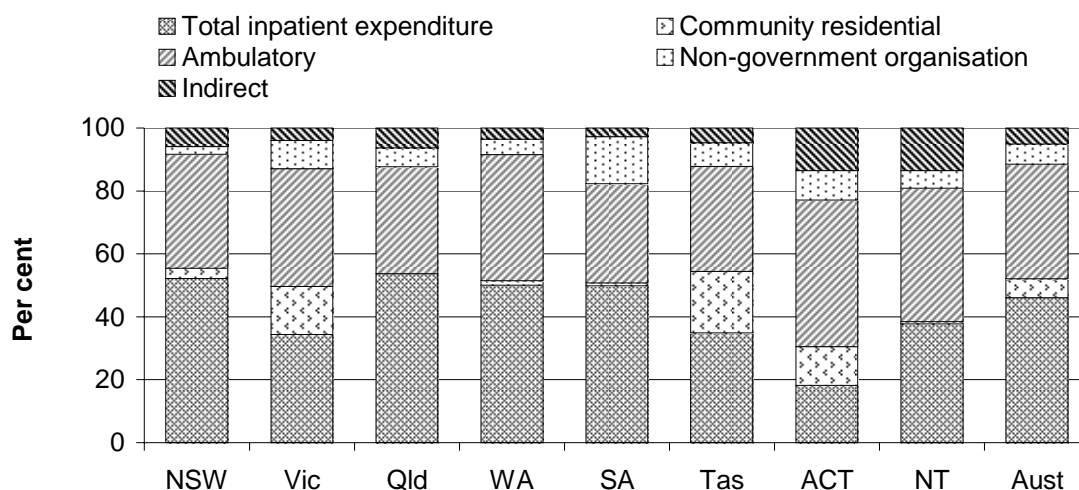


^a 2004-05 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*. ^b Constant price expenditure (2004-05 dollars), using State and Territory implicit price deflators for general government final consumption on hospital clinical services (table 11A.54). ^c Estimates of State and Territory government spending include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Australian Government funds', but exclude Australian Government funding provided under the NMHS and through the DVA. ^d Depreciation is excluded for all years. Depreciation estimates are reported in table 11A.24. ^e Funding is a mix of Australian Government funds provided under the base grants of the Australian Health Care Agreements, funds provided by State and Territory governments and revenue from other sources noted above (footnote c). ^f SA data for 2004-05 contains a one-off payment of around \$25 million made to NGOs for services to be provided over the subsequent 2-3 year period.

Source: State and Territory governments (unpublished); table 11A.21; DHA (unpublished); table 11A.54.

Figure 11.19 shows how expenditure at the discretion of State and Territory governments was distributed across the range of mental health services in 2004-05. It does not show the distribution of the Australian Government expenditure discussed under figure 11.17.

Figure 11.19 **State and Territory recurrent expenditure, by service category, 2004-05^{a, b, c, d, e, f, g}**



^a 2004-05 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*. ^b Includes all spending regardless of source of funds. ^c Depreciation is excluded. Depreciation estimates are reported in table 11A.24. ^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 non-government organisations artificially segregates the mental health data. Given that the role of non-government organisations varies across jurisdictions, the level of non-government organisation resourcing does not accurately reflect the level of community support services available. ^f Queensland does not fund community residential services, but it funds a number of extended treatment services (both campus and non-campus-based), which provide longer term inpatient treatment and rehabilitation services with full clinical staffing for 24 hours a day, seven days a week. ^g SA data for 2004-05 contains a one-off payment of around \$25 million made to NGOs for services to be provided over the subsequent 2-3 year period.

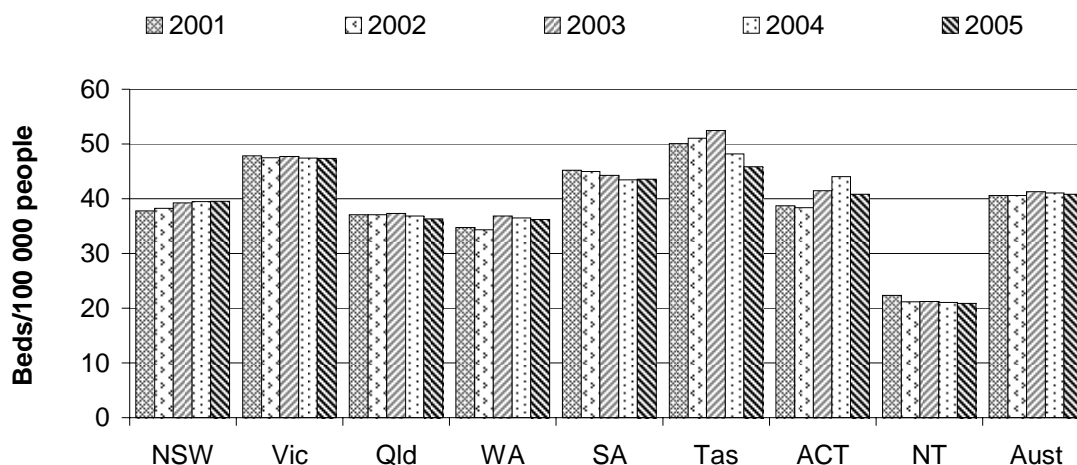
Source: State and Territory governments (unpublished); table 11A.25.

Size and scope of sector

The number of mental health beds

Beds are counted as those immediately available for use at 30 June by admitted patients if required. They are available immediately — or within a reasonable period of time — for use if located in a suitable place for care with nursing or other auxiliary staff available. Also included are beds in wards that are temporarily closed for reasons such as renovation or strike, but that would normally be open. Figure 11.20 presents the number of beds per 100 000 people for public hospitals and community residential facilities combined.

Figure 11.20 **Mental health beds in public hospitals and publicly funded community residential units, 30 June^{a, b}**

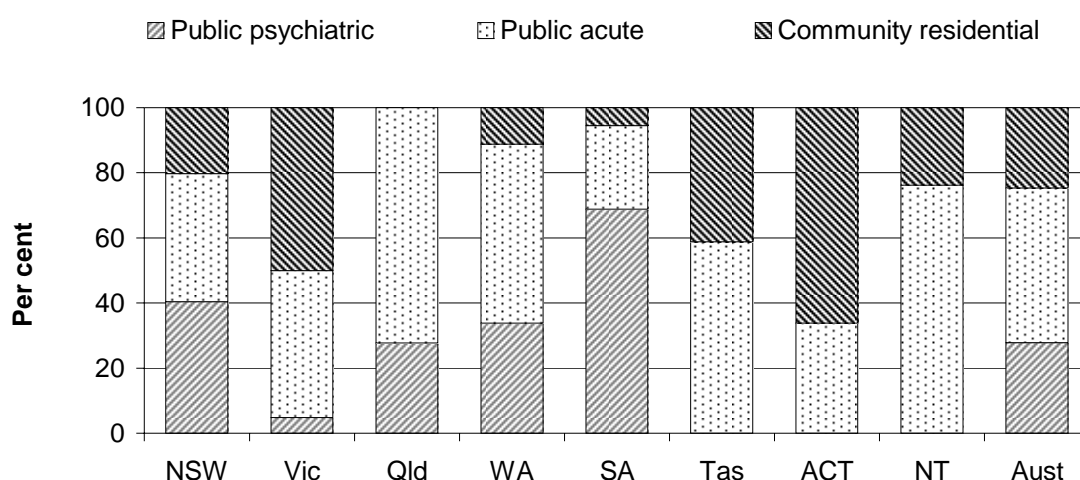


^a 2005 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*. ^b Includes beds in public hospitals and publicly funded community residential units.

Source: State and Territory governments (unpublished); table 11A.26.

Figure 11.21 presents the number of beds by service category for 2005. These data show the differences in service mix across states and territories. Queensland does not fund community residential services, but it funds a number of extended treatment services (both campus- and non-campus-based) that provide longer term inpatient treatment and rehabilitation services with full clinical staffing for 24 hours a day, seven days a week. Queensland does not report these beds as community residential beds because it considers them to be substantially different from beds described as such in other states and territories.

Figure 11.21 **Beds, by service category, 30 June 2005^{a, b, c}**



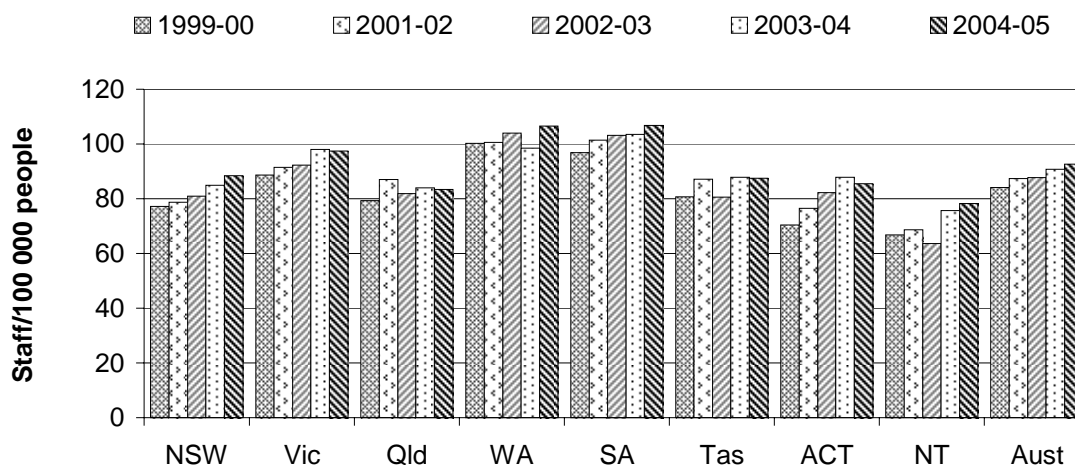
^a 2005 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*. ^b Queensland does not fund community residential services, but it funds a number of campus-based and non-campus-based extended treatment services. These services are reported either as beds in public acute hospitals or beds in public psychiatric hospitals. ^c Tasmania, the ACT and the NT did not have public psychiatric beds in 2005.

Source: State and Territory governments (unpublished); table 11A.26.

Staff

Figure 11.22 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 other medical officers who are neither registered as psychiatrists within the State or Territory, nor are formal trainees of the Royal Australian and New Zealand College of Psychiatrists’ Postgraduate Training Program. ‘Nursing’ consists of registered and non-registered 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, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents and who are not formally qualified or are still training in nursing or allied health professions. Definitions for staffing categories are provided in more detail in section 11.7.

Figure 11.22 **FTE health professional direct care staff per 100 000 people^{a, b, c}**



^a 2004-05 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*. ^b Includes health professional occupational categories only. ^c Community residential incorporates all staffed community-based units, regardless of the number of hours that staff are present.

Source: State and Territory governments (unpublished); table 11A.27.

Nursing staff comprise the largest FTE component of health care professionals employed in mental health services. Across Australia in 2004-05, 60.2 nurses per 100 000 people were working in specialised mental health services, compared with 21.9 allied health care staff and 10.5 medical staff (table 11A.27). FTE direct care staff employed in specialised mental health services, by service setting, are reported in table 11A.28.

Services provided

Estimating activity across the specialised mental health services sector is problematic. Data for patient days are provided in figure 11.23 by acute, non-acute and 24 hour staffed community residential care (as defined in box 11.17).⁶ Hospital inpatient days and community residential patient days are included in figure 11.23, but other types of community service are not covered. Collection of data outlining community mental health care patient contacts commenced in July 2000 as part of the national minimum data set, although there are difficulties with data quality. The earlier caveat for the apparent absence of community residential beds in Queensland also applies to the data in figure 11.23.

⁶ Under the NSMHS, patient days are all days or part days for which the patient was in hospital during the survey period, regardless of the original date of admission or discharge.

Figure 11.23 **Mental health patient days, 2004-05^{a, b, c, d}**



^a 2004-05 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*. ^b Queensland does not fund community residential services, but it funds a number of campus-based and non-campus-based extended treatment services. Data from these services are included as non-acute. ^c The ACT and the NT did not provide mental health care in non-acute units. ^d The NT did not provide mental health care in 24 hour staffed community residential facilities.

Source: State and Territory governments (unpublished); table 11A.29.

In public psychiatric hospitals in 2003-04, there were 12 905 overnight separations and 1283 same day separations with specialised psychiatric care (table 11A.30). In public acute hospitals there were 70 293 overnight separations and 5749 same day separations with specialised psychiatric care. Schizophrenia accounted for a large proportion of overnight separations related to mental disorders in public hospitals (24.1 per cent in public acute hospitals and 26.9 per cent in public psychiatric hospitals) (table 11A.30).

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 represented 6–10 per cent of all same day separations. Work for the Mental Health Classification and Service Costs Project suggested that the majority of same day hospitalisations are better described as ambulatory care and involve consumer attendance at a variety of day and group-based programs that otherwise could be provided in community settings (Buckingham *et al.* 1998).

Services by general practitioners

Limited data are available on GP care of mental health patients. The following data are collected from a sample of 1000 GPs as part of the BEACH (Bettering the

Evaluation and Care of Health) survey. In 2005-06, 11.1 of every 100 encounters with a GP involved mental health problems. The most frequently reported mental health related problem managed in GP encounters was depression (3.6 per 100 GP encounters). Anxiety (1.8 per 100 GP encounters) and sleep disturbance (1.6 per 100 GP encounters) were the next most common psychological problems managed. In 2005-06, depression was the fourth most frequently managed problem by a GP (Britt *et al.* 2007).⁷

Indigenous patients

Limited data are available on specialised psychiatric care of Indigenous patients in hospital. Comparisons are difficult because data on Indigenous status are incomplete and Indigenous people and other Australians may differ in their use of hospital services relative to other health services. The data reflect a range of factors, such as: the spectrum of public, primary care and post-hospital care available; Indigenous people's access to these as well as hospital services; social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disorders. The average length of stay for Indigenous people was slightly more than that for the total population (table 11.7).

Table 11.7 Specialised psychiatric care, by Indigenous status, 2003-04^{a, b, c}

No.	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
Indigenous	109	2 295	2 404	54 406	54 051	23.7	23.6
Total population	3 492	30 779	34 271	941 723	934 985	20.7	30.4

^a The completeness of data on Indigenous status varies, so these data need to be used with care.

^b Specialised psychiatric care refers to separations in which at least one day of specialised psychiatric care was received. ^c Data are for Queensland, WA, SA and the NT only.

Source: AIHW (2005b); table 11A.31.

Schizophrenia disorders accounted for a large proportion of overnight specialised psychiatric care separations reported for Indigenous patients in Australia in 2003-04 (30.7 per cent). They also accounted for around 37.4 per cent of patient days for Indigenous patients and a similar percentage of psychiatric care days (37.6 per cent) (table 11A.32).

⁷ A GP often managed more than one problem at a single encounter. Problems managed reflect the GP's understanding of the health problem presented by the patient.

Framework of performance indicators

The distinction between prevention and intervention is difficult to maintain 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, determining the most appropriate setting for providing treatment, and emphasising early intervention. The indicators used in this Report focus on service delivery reforms that commenced under the First National Mental Health Plan (1993–1998) and were extended under the Second and Third Plans (1998–2003 and 2003–2008 respectively). The second plan emphasised promoting mental health and preventing mental illness. The performance indicator framework will be redeveloped in future reports to reflect these components of mental illness management and the new mental health plan.

The framework of performance indicators for mental health services builds on government objectives for mental health service delivery (box 11.18) as encompassed in the NMHS. The framework reports on the equity, effectiveness and efficiency of specialised mental health services. It covers a number of service delivery types (institutional and community-based services) and indicators of systemwide performance. Improving the framework is a priority of the Review and the Australian Health Ministers Advisory Council's National Mental Health Working Group.

Box 11.18 Objectives for mental health service delivery

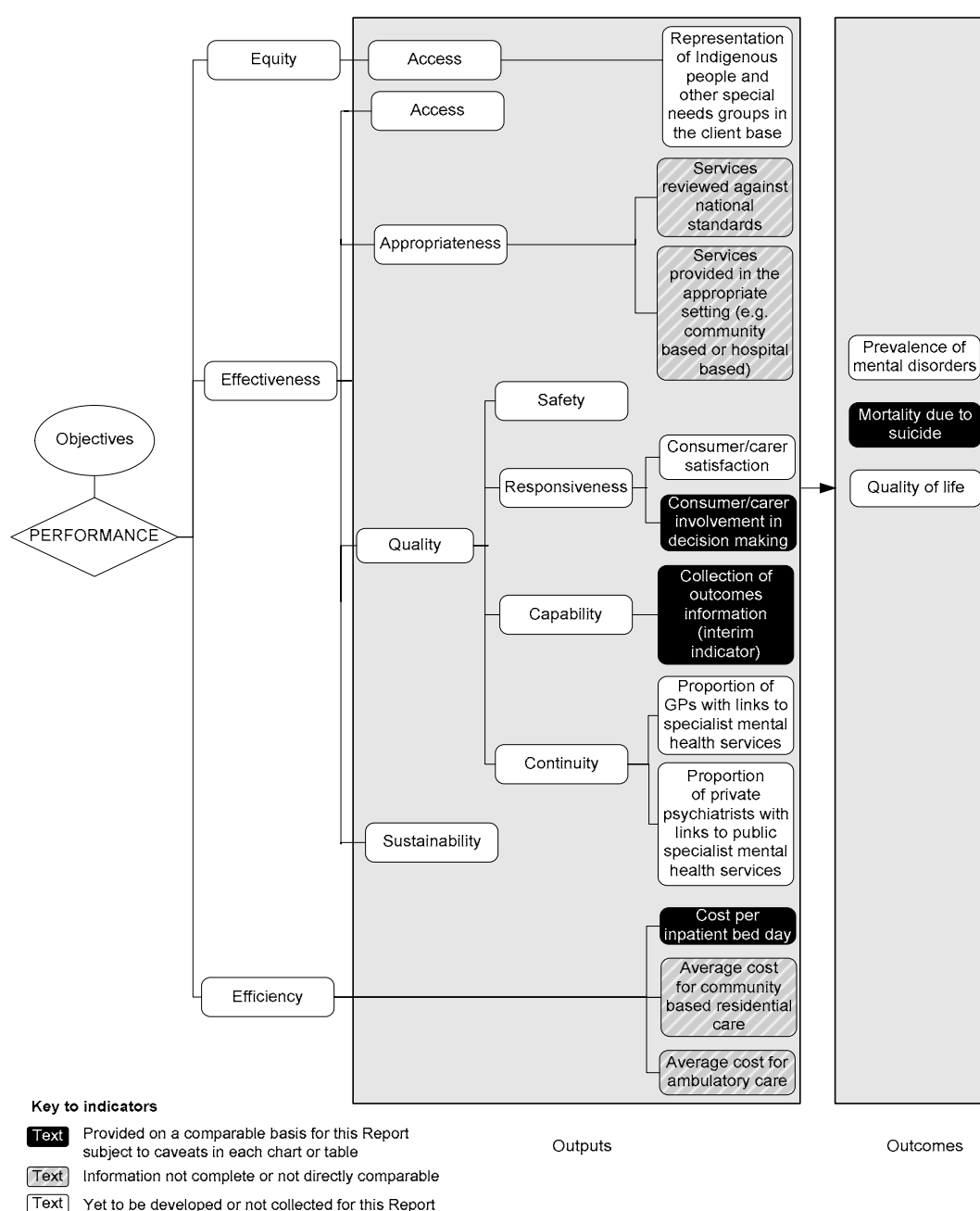
Key objectives include to:

- 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
- 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 2007 Report (figure 11.24). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The ‘Health preface’ explains the performance indicator framework for health services as a whole, including the sub-dimensions for quality and sustainability that have been added to the standard Review framework for health services.

Figure 11.24 **Performance indicators for mental health management**



Key performance indicator results

Outputs

Equity — representation of Indigenous people and others in the client base

The Steering Committee has identified the ‘representation of Indigenous people and other special needs groups in the client base’ as a key area for development in future reports (box 11.19).

Box 11.19 Representation of Indigenous people and other special needs groups in the client base
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The ‘representation of Indigenous people and other special needs groups in the client base’ is an indicator of governments’ aim to provide mental health services in an equitable manner, including access to services by special needs groups such as Indigenous people.

Access

The Steering Committee has identified access as an area for reporting, but no indicators have yet been developed.

Appropriateness — services reviewed against the national standards

‘Services reviewed against the national standards for Mental Health Services and assessed as meeting all or most standards’ is an effectiveness indicator of mental health management (box 11.20).

Box 11.20 Services reviewed against the national standards

‘Services reviewed against the national standards for Mental Health Services and assessed as meeting all or most standards’ is a process indicator of appropriateness, reflecting progress being made in meeting the national standards for mental health care. Data are reported separately for the proportion of services assessed at level 1 and at level 2, where level 1 and level 2 are defined as:

- Services assessed at level 1. The number of specialised public mental health services that have formally been reviewed against the National Standards for Mental Health Services by an external accreditation agency and assessed as meeting all Standards.
- Services assessed at level 2. The number of specialised public mental health services that have formally been reviewed against the National Standards for Mental Health Services by an external accreditation agency and assessed as meeting some but not all Standards.

The national standards are outlined in box 11.21.

External accreditation agencies, such as the Australian Council on Healthcare Standards, undertake accreditation of a parent health organisation (for example, a hospital) that may cover a number of specialist services, including mental health services. Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the national standards; rather, assessment against the national standards must be specifically requested and involves a separate review process.

Box 11.21 The National Standards for Mental Health Services

The National Standards for Mental Health Services were developed under the First National Mental Health Plan for use in assessing service quality and as a guide for continuous quality improvement in all Australian mental health services. They comprise 11 major criteria:

1. rights
2. safety
3. consumer and carer participation
4. promoting community acceptance
5. privacy and confidentiality
6. prevention and mental health promotion
7. cultural awareness
8. integration
9. service development
10. documentation
11. delivery of care.

Source: DHA (2002).

Data in table 11.8 show the percentage of specialised public mental health services that have completed an external review process against the National Standards for Mental Health Services and have been assessed as meeting ‘all standards’ (level 1) or of meeting ‘some but not all Standards’ (level 2).

Table 11.8 Specialised public mental health services reviewed against the National Standards for Mental Health Services (per cent)

	NSW	Vic ^a	Qld	WA	SA	Tas	ACT	NT	Aust
2002-03									
Level 1	na	na	31.1	na	11.7	na	81.3	–	na
Level 2	na	na	62.2	na	14.6	na	na	–	na
2003-04									
Level 1	na	100.0	84.2	na	49.5	na	81.3	50.0	na
Level 2	na	–	9.2	na	5.6	na	na	–	na
2004-05									
Level 1	73.4	100.0	80.0	64.5	72.7	46.9	87.5	50.0	74.8
Level 2	0.6	–	7.5	12.9	2.7	–	–	50.0	2.2

^a Victoria has some services currently in the process of re-accreditation.

na Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 11A.33.

Appropriateness — services provided in the appropriate setting

‘Services provided in the appropriate setting’ is an effectiveness indicator of mental health management (box 11.22).

Box 11.22 Services provided in the appropriate setting

‘Services provided in the appropriate setting’ is an indicator of the development of local comprehensive mental health service systems advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental disorders and of providing continuity of care, so consumers can move between services as their needs change. The strategy advocates:

- a reduced reliance on stand-alone psychiatric hospitals
- the expanded delivery of community-based care integrated with inpatient care
- mental health services being mainstreamed with other components of health care.

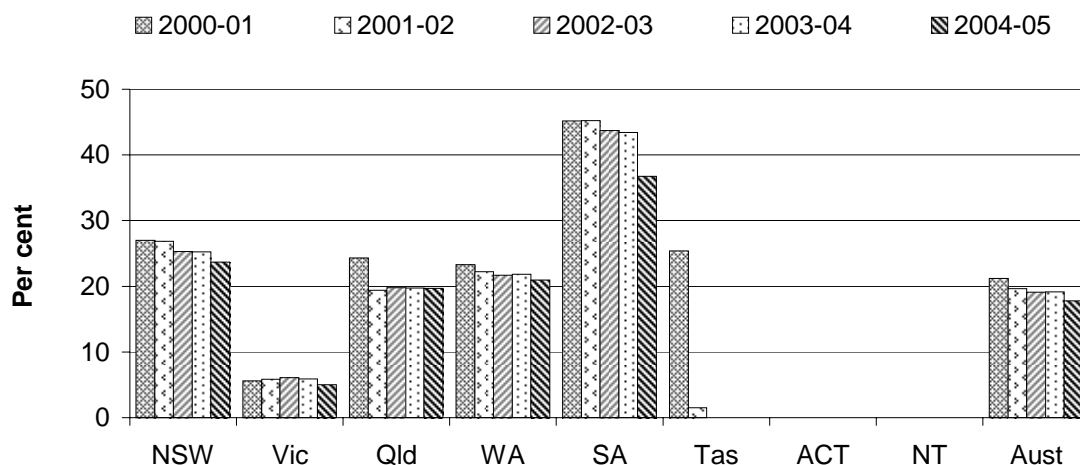
More appropriate treatment options can be provided if the service setting is substituted by encouraging the treatment of patients in community settings and public (non-psychiatric) hospitals rather than in stand-alone psychiatric hospitals.

Two measures of ‘services provided in the appropriate setting’ are reported.

- Recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total spending on mental health services. A low proportion for this indicator is desirable, reflecting a low reliance on stand-alone hospitals.
- Acute patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals. A high proportion for this indicator is desirable, reflecting greater mainstreaming of mental health services.

Figure 11.25 shows recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total expenditure on mental health services.

Figure 11.25 Recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total expenditure on mental health services^{a, b, c}

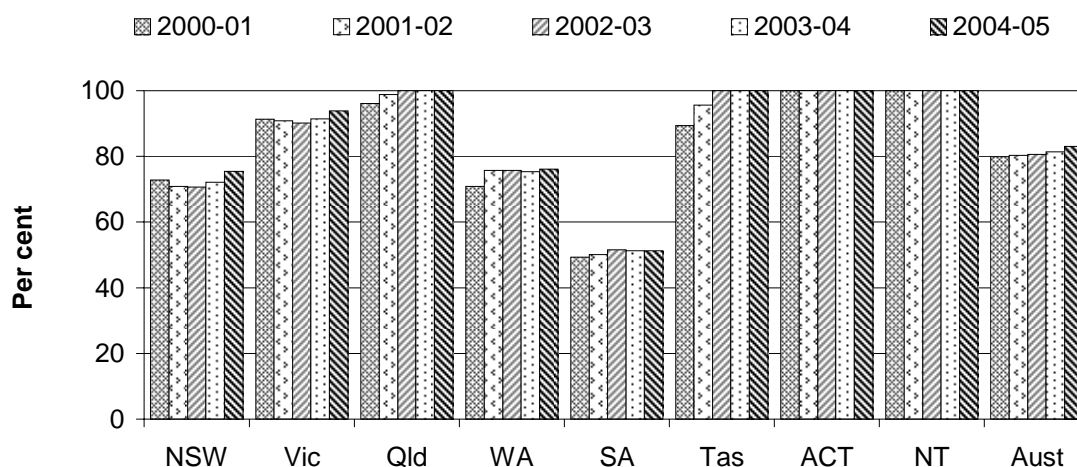


^a 2004-05 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*. ^b The ACT and the NT do not have public psychiatric hospitals. Tasmania did not have public psychiatric hospitals in 2002-03, 2003-04 or 2004-05. ^c SA data for 2004-05 contains a one-off payment of around \$25 million made to NGOs for services to be provided over the subsequent 2-3 year period.

Source: State and Territory governments (unpublished); table 11A.34.

Figure 11.26 shows acute patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals. The proportion of acute patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals has increased slightly over the period from 2000-2001 to 2004-05.

Figure 11.26 **Acute patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals^a**



^a 2004-05 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*.

Source: State and Territory governments (unpublished); table 11A.34.

Quality — consumer and carer satisfaction

The Steering Committee has identified ‘consumer and carer satisfaction’ as an area for development in future reports (box 11.23).

Box 11.23 Consumer and carer satisfaction

‘Consumer and carer satisfaction’ is an indicator of satisfaction with both clinician’s responses and with services provided in all areas of mental health. Both are important aspects of the NMHS.

Quality — consumer and carer involvement in decision making

‘Consumer and carer involvement in decision making’ is an effectiveness indicator of mental health management (box 11.24).

Box 11.24 Consumer and carer involvement in decision making

‘Consumer and carer involvement in decision making’ is an important aspect of the NMHS. It is an indicator of consumers’ and carers’ involvement at the service delivery level, where they have the opportunity to influence the services they receive.

The indicator relates to the arrangements that allow consumers and carers to contribute to local service planning and delivery in specialised mental health services. Arrangements are grouped into four categories:

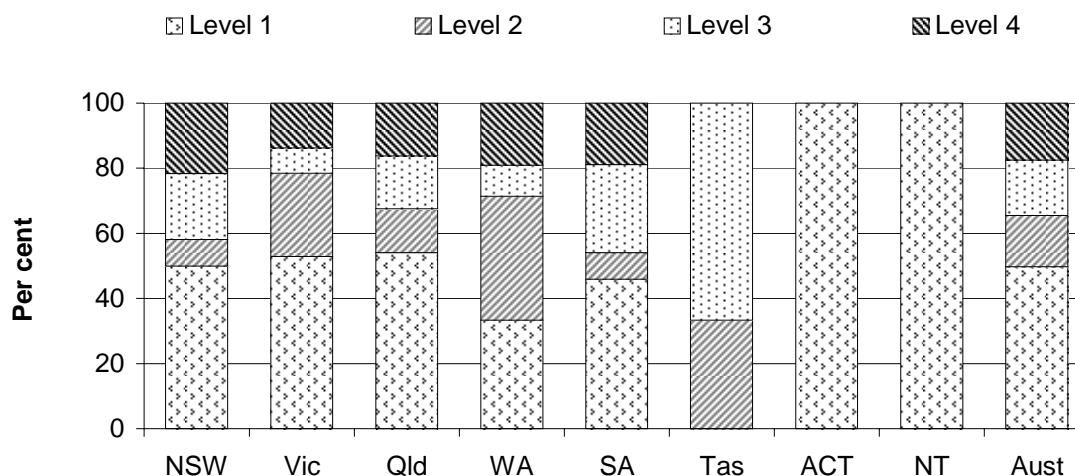
- level 1 — appointment of a person to represent the interests of consumers and carers on the organisation management committee, or a specific consumer and carer advisory group to advise on all aspects of service delivery
- level 2 — a specific consumer and carer advisory group to advise on some aspects of service delivery
- level 3 — participation of consumers and carers in broad-based committees
- level 4 — other/no arrangements.

An organisation can be classified at only one level. A high proportion of organisations with level 1 arrangements is desirable, while a high proportion of organisations with level 4 arrangements is undesirable.

‘Paid consumer and carer consultants per 10 000 clinicians’ reports the number of paid consumer consultants per 10 000 clinical staff and the number of paid carer consultants per 10 000 clinical staff. Higher numbers of these imply a greater chance that paid consumers and carers can be involved in decision making.

Figure 11.27 illustrates the degree of consumer and carer participation in decision making. Consumer and carer involvement in decision making will be considered for improved reporting in the future.

Figure 11.27 Organisations with consumer and carer participation in decision making, 2005^{a, b, c, d, e}



^a 2004 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*. Non-government organisations are included only where they provide staffed residential services.

^b NSW advised that the government has no authority to require consumer participation in services delivered through the primary care program. ^c Victoria advised that its model of consumer consultants fits poorly with the Australian Health Care Agreement categories. It has paid consumer consultants working in mental health services. Many agencies report these consultants 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 the National Survey of Mental Health Services does not accurately represent consumer and carer participation strategies used in WA. High priority is given to the involvement of consumers and carers at a state, regional and health service level in developing a responsive mental health service. Several key consumer and carer advisory groups are supported and provided with financial assistance by the Office of Mental Health. Collectively, these groups provide advice and representation on consumer and carer issues. The Department of Health Executive has endorsed stage 1 of a comprehensive 'Consumer Participation Plan'. The Plan outlines a framework for a coordinated statewide consumer participation system. Stage 1 introduces initiatives related to education, training and advocacy, that will result in the introduction of consumer consultants in all public Mental Health Services in WA. ^e An expanded range of indicators of consumer and carer participation are reported in the National Mental Health Report.

Source: State and Territory governments (unpublished); table 11A.35.

Table 11.9 illustrates the number of paid consumer and carer consultants per 10 000 clinicians. This is the first time this indicator has been reported and many jurisdictions either do not have paid consultants or are unable to extract the data.

Table 11.9 Paid consumer and carer consultants per 10 000 clinical staff^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Paid consumer consultants per 10 000 clinicians									
2003	na	na	19.5	na	12.6	na	na	–	na
2004	25.9	na	21.6	na	16.4	na	na	–	na
2005	26.7	na	24.4	na	23.7	na	na	–	na
Paid carer consultants per 10 000 clinicians									
2003	na	na	3.2	na	–	na	na	–	na
2004	1.4	na	3.1	na	–	na	na	–	na
2005	3.3	na	3.1	na	–	na	na	–	na

^a 2004-05 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*. – Nil or rounded to zero. **na** Not available. .. Not applicable.

Source: State and Territory governments (unpublished); table 11A.35.

Quality — collection of outcomes information (interim indicator)

The ‘Collection of outcomes information’ is an interim effectiveness indicator of mental health management (box 11.25).

Box 11.25 Collection of outcomes information (interim indicator)

The ‘Collection of outcomes information’ is an interim indicator until information on client outcomes is available. Establishing a system for the routine monitoring of consumer outcomes was introduced as part of the National Mental Health Plan 2003–2008. Jurisdictions are introducing a collection that will enable reporting in future (section 11.5).

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 in collection
- processes established to ensure uniformity in collection
- funding for information systems to store, analyse and report on the data
- a national approach to data analysis, reporting and benchmarking (DHA 2002).

This indicator is the proportion of specialised mental health services that have introduced routine collection of consumer outcome measurement. A high proportion is desirable for this indicator.

The percentages of specialised mental health services that have introduced routine consumer outcome measurement are shown in table 11.10.

Table 11.10 Specialised mental health services that introduced the routine collection of consumer outcome measurement (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
June 2003	77.3	72.6	47.1	7.4	–	94.4	100.0	100.0	63.3
June 2004	100.0	98.1	100.0	71.0	49.5	94.4	100.0	100.0	82.9
June 2005	100.0	98.2	100.0	100.0	78.1	96.9	100.0	100.0	93.2

^a Data are based on reports from jurisdictions. Jurisdictions report at varying levels, reflecting differences in service structure — for example, data may be reported at area health service level or at hospital level, with each level containing a number of specialist mental health services. Data are thus aggregated. – Nil or rounded to zero.

Source: State and Territory governments; table 11A.36.

Quality — proportion of general practitioners with links to specialist mental health services

The Steering Committee has identified the ‘proportion of GPs with links to specialist mental health services’ as an indicator of the effectiveness of mental health management (box 11.26). Data for this indicator were not available for the 2007 Report.

Box 11.26 Proportion of general practitioners with links to specialist mental health services

The ‘proportion of GPs with links to specialist mental health services’ is an indicator of the objective of mental health service delivery to provide continuity of care. GPs can be an important first point of contact for those with a mental illness.

Quality — proportion of private psychiatrists with links to public specialist mental health services

The Steering Committee has identified the ‘proportion of private psychiatrists with links to public specialist mental health services’ as an indicator of the effectiveness of mental health management (box 11.27). Data for this indicator were not available for the 2007 Report.

Box 11.27 Proportion of private psychiatrists with links to public specialist mental health services

The 'proportion of private psychiatrists with links to public specialist mental health services' is an indicator of the objective of mental health service delivery to provide continuity of care.

Sustainability

The Steering Committee has identified sustainability as an area for reporting but no indicators have yet been identified.

Efficiency

Data for 2004-05 are preliminary and will be further validated as part of the production of the annual National Mental Health Report. They therefore need to be interpreted with caution.

Efficiency — cost per inpatient bed day

'Cost per inpatient bed day' is an efficiency indicator of mental health management (box 11.28).

Box 11.28 Cost per inpatient bed day

The 'cost per inpatient bed day' is a proxy indicator of the efficiency of mental health service delivery. An aim of mental health service delivery is to provide services in an efficient manner.

This indicator is defined as the cost of providing inpatient services per inpatient bed day. A low cost per inpatient bed day can indicate efficiency, although caution must be used because the cost per inpatient bed day does not provide any information on the quality of service provided.

This indicator is affected by factors such as differences in the client mix and average length of stay. The client mix in inpatient settings may differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings rather than in the community. Longer lengths of stay may also be associated with lower average inpatient day costs because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care.

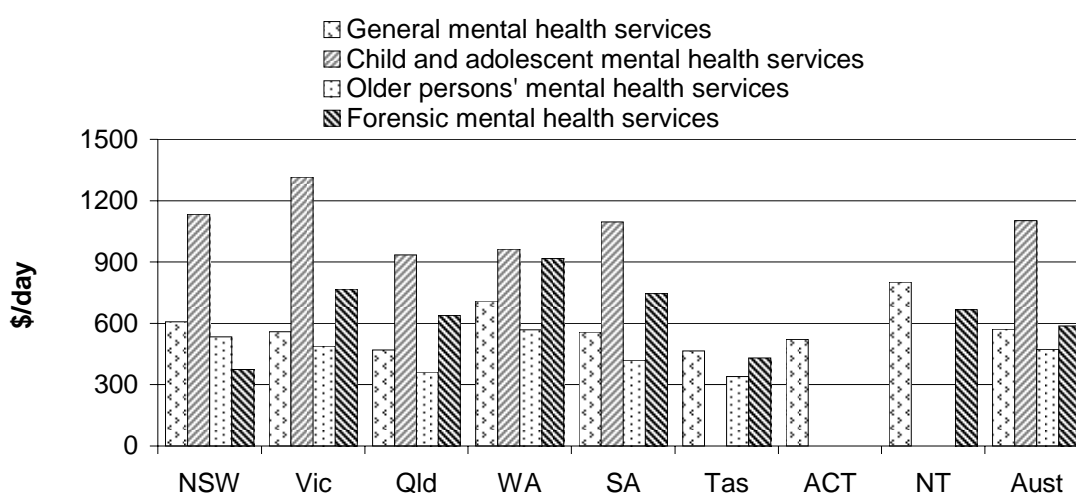
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Box 11.28 (Continued)

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), but casemix data for specialised mental health services are not available.

Reported real inpatient costs per day are disaggregated by inpatient program type (general mental health services, child and adolescent mental health services, older persons' mental health services and forensic mental health services) and hospital type (psychiatric hospitals [acute units], psychiatric hospitals [non-acute units] and general hospitals). Disaggregating these data improves comparability across jurisdictions. Real inpatient costs per day are presented in figures 11.28 (by inpatient program type) and 11.29 (by hospital type). Changes over time partly reflect institutional change in accordance with the NMHS.

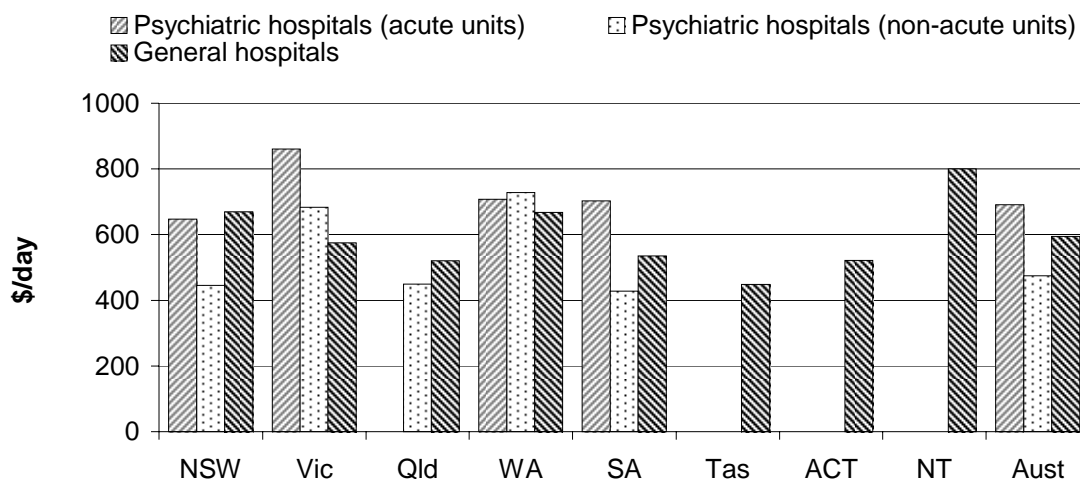
Figure 11.28 **Real average recurrent cost per inpatient bed day, public hospitals, by inpatient program type, 2004-05^{a, b, c, d, e, f}**



^a 2004-05 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*. ^b Depreciation is excluded. ^c Costs are not adjusted for differences in the complexity of cases across jurisdictions and may reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). ^d Constant price expenditure (in 2004-05 dollars), using State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 11A.54). ^e Queensland advised that it provides older persons' mental health services using different service models, including campus-based and non-campus-based options. All service types are reported as older persons' mental health services, which may have the effect of lowering the average patient day costs compared with the costs of jurisdictions that report older persons' care units separately. ^f In 2004-05, child and adolescent mental health services were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Older persons' mental health services programs were not available, or could not be separately identified, in the ACT and the NT. Tasmanian figures include child and adolescent mental health services within the general mental health services category. Forensic mental health services was not available, or could not be separately identified, in the ACT.

Source: State and Territory governments (unpublished); DHA (unpublished); table 11A.37.

Figure 11.29 Real average recurrent cost per inpatient bed day, public hospitals, by hospital type, 2004-05^{a, b, c, d, e, f, g}



^a 2004-05 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*. ^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 (in 2004-05 dollars), using State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 11A.54). ^e Mainstreaming has occurred at different rates in different jurisdictions. Victoria advised that the data for psychiatric hospitals comprise mainly forensic services, because nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means the client profile and service costs are very different from those of a jurisdiction in which general psychiatric treatment still occurs mostly in psychiatric hospitals. ^f Queensland data for general hospitals include costs associated with extended treatment units that report through general acute hospitals. ^g Tasmania, the ACT and the NT did not have psychiatric hospitals in 2004-05.

Source: State and Territory governments (unpublished); DHA (unpublished); tables 11A.38.

Efficiency — average cost for community-based residential care

The 'average cost for community-based residential care' is an efficiency indicator of mental health management (box 11.29).

Box 11.29 Average cost for community-based residential care

The 'average cost for community-based residential care' is an indicator of the efficiency of mental health service delivery. An aim of mental health service delivery is to provide services in an efficient manner.

This indicator is defined as the cost of providing community-based residential care per patient day. A low average cost can indicate efficiency, although caution must be used because the average cost does not provide any information on the quality of service provided.

These data are likely to be affected by institutional changes occurring as a result of the NMHS. In addition, differences across jurisdictions in the types of patient admitted to community residential care affect average costs in these facilities. Average recurrent costs to government per patient day for these services are reported for both the care of adults and the care of older people. The distinction is made to reflect the differing unit costs of treating the two groups.

The average recurrent cost to government per patient day for community residential services is presented in table 11.11. For general adult units in 2004-05, the average cost to government per patient day for 24 hour staffed community residential services was an estimated \$326 nationally. For non-24 hour staffed community residential units, the average cost to government per patient day was \$202 nationally.

For jurisdictions that had community-based older persons' care units in 2004-05, the average recurrent cost to government per patient day for 24 hour staffed community residential services was \$272 nationally (table 11.11).

Table 11.11 Average recurrent cost to government per patient day for community residential services, 2004-05^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld^d</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
General adult units									
24 hour staffed units	306	324	na	301	191	431	405	na	326
Non-24 hour staffed units	na	136	na	136	293	na	74	67	202
Older persons' care units									
24 hour staffed units	288	270	na	na	na	294	142	na	272
Non-24 hour staffed units	na	na	na	na	na	..	..	..	na

^a 2004-05 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2007*. ^b Depreciation is excluded, although treated differently across 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 Queensland does not fund community residential services, although it funds a number of campus-based and non-campus-based extended treatment services. **na** Not available. **..** Not applicable.

Source: State and Territory governments (unpublished); table 11A.39.

Efficiency — average cost for ambulatory care

The 'Average cost for ambulatory care' is an efficiency indicator of mental health management (box 11.30).

Box 11.30 Average cost for ambulatory care

The 'average cost for ambulatory care' is an indicator of the efficiency of mental health service delivery. An objective of mental health service delivery is to provide services in an efficient manner.

This indicator is defined as the cost of providing ambulatory care per treated patient in the community. A low average cost can indicate efficiency, although caution must be used because the average cost does not provide any information on the quality of service provided.

The provision of ambulatory treatment, rehabilitation and support to non-inpatients, and post-acute care are important components of service provision, and the Steering Committee has identified continued improvement in reporting in these areas as a priority.

Unit costs (dollars per treated patient in the community) for 2004-05 are presented here for all states and territories. The data reported for this indicator are unreliable, however, and comparisons across jurisdictions are not possible for several reasons. First, information about service costs across jurisdictions is incomplete. Second, the

absence of unique patient identifiers in many jurisdictions means clients who use mental health services other than their usual service may be counted twice. This double counting may artificially reduce average costs in some states or territories. Victoria, WA and the NT have statewide systems of unique identifiers, so the potential for overcounting of patients in these jurisdictions is relatively low compared with that in other jurisdictions. Third, differences across jurisdictions in the complexity of cases treated, the service options available for treatment and the admission practices adopted reduce the comparability of data across states and territories. Finally, cost components such as depreciation are not measured consistently across jurisdictions.

- NSW reported ambulatory care unit costs of \$1509 per treated patient in the community in 2004-05, with 24.5 per cent of services (accounting for 12.1 per cent of expenditure) not reporting (table 11A.40).
- Victoria reported ambulatory care unit costs of \$2844, with 12.8 per cent of services (accounting for 2.7 per cent of expenditure) not reporting (table 11A.41).
- Queensland reported ambulatory care unit costs of \$1653 with all services reporting (table 11A.42).
- WA reported ambulatory care unit costs of \$2525, with all services reporting (table 11A.43).
- SA reported ambulatory care unit costs of \$1735, with 5.6 per cent of services (accounting for 3.2 per cent of expenditure) not reporting (table 11A.44).
- Tasmania reported ambulatory care unit costs of \$2030 with all services reporting (table 11A.45).
- The ACT reported ambulatory care unit costs of \$1532, with 16.7 per cent of services (accounting for 0.7 per cent of expenditure) not reporting (table 11A.46).
- The NT reported ambulatory care unit costs of \$1695, with all services reporting (table 11A.47).
- Across Australia, average ambulatory care unit costs per treated patient in the community were \$1930, with 14.5 per cent of services (accounting for 4.8 per cent of expenditure) not reporting (table 11A.48).

Outcomes

Prevalence of mental disorders

The Steering Committee has identified the ‘prevalence of mental disorders’ as an indicator for development in future reports (box 11.31).

Box 11.31 Prevalence of mental disorders

The ‘prevalence of mental disorders’ is an outcome indicator of the objective of mental health service delivery to prevent and reduce mental health problems where possible.

There are no nationally comparable data on the prevalence of mental disorders treated by specialised mental health services, other than the data discussed in the profile (section 11.4).

Mortality due to suicide

‘Mortality due to suicide’ is an outcome indicator of mental health management (box 11.32).

Box 11.32 Mortality due to suicide

‘Mortality due to suicide’ is an indicator because evidence indicates that people with a mental disorder are at a higher risk of suicide than are the general population. (They are also at a higher risk of death from other causes, such as cardiovascular disease.)

This indicator is reported as the suicide rate per 100 000 people for all people, people aged 15–24 years, people living in capital cities, people living in other urban areas, people living in rural areas and Indigenous people. While the performance of mental health services is important in reducing suicide, other government services also play a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by serious mental illness, some of whom have either attempted, or indicated the intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government departments, non-government organisations and other special interest groups. Any impact on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including police, education, housing, justice and community services agencies.

(Continued on next page)

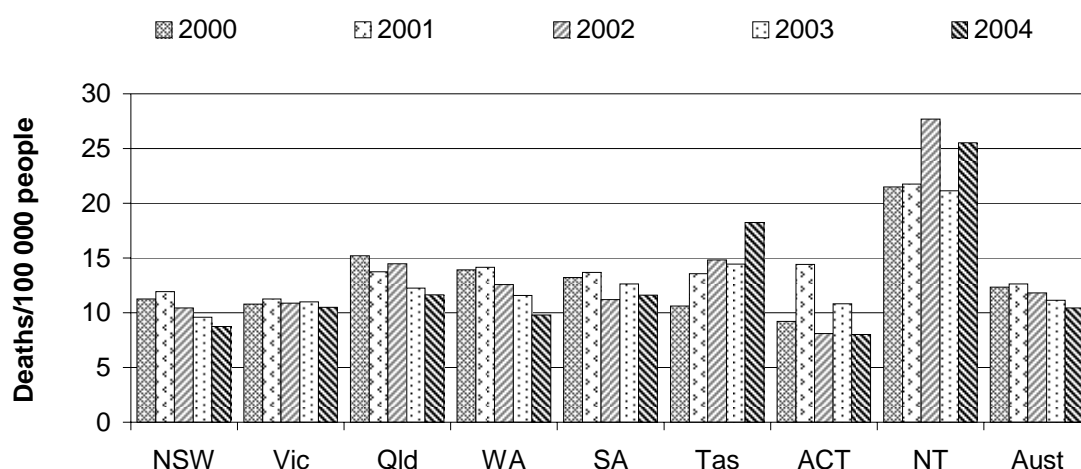
Box 11.32 (Continued)

In addition, many factors outside the control of mental health services may influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often, a combination of these factors can increase the risk of suicidal behaviour.

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 2004, 2098 deaths by suicide were recorded in Australia — equivalent to 10.4 deaths per 100 000 people. The national rate fell each year from 1997 to 2000, followed by a slight increase in 2001 and then further falls in 2002, 2003 and 2004. The rate for males (16.8 per 100 000 males) was almost four times that for females (4.3 per 100 000 females) in 2004 — a ratio that was constant over the 10 years to 2004 (figure 11.30 and table 11A.49). The quality of suicide data can be affected by changes in the way information is reported by certifiers, by lags in completion of coroner cases and the processing of the findings. There has been an increase in recent years in the number of open coroners' cases. Where cases are not finalised and the findings are not available to the ABS in time for publication of causes of death statistics, deaths are coded to other accidental, ill-defined or unspecified causes rather than suicide. The causes of death statistics are not revised once a coronial enquiry is finalised. Part of the reported decline in the number of deaths due to suicide may therefore reflect the increase in open coroners' cases when the statistics were finalised.

Figure 11.30 **Suicide rate^{a, b, c}**



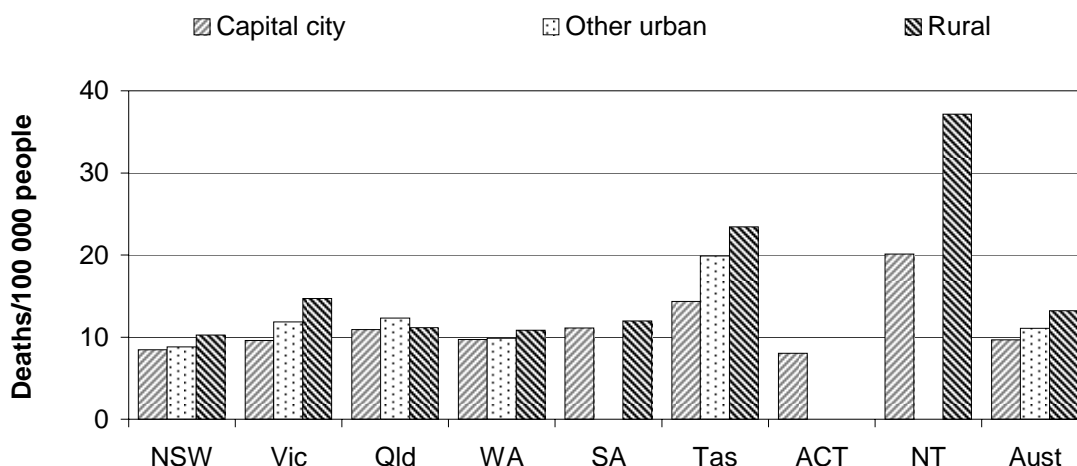
^a By year of registration of death. Year-to-year variation can be influenced by coronial workloads. ^b The death rate is age standardised to the mid-year 2001 population. ^c Low populations can result in small variations in the number of suicides appearing as large changes in rates (which are not statistically significant).

Source: ABS (various issues, Cat. no. 3303.0); table 11A.50.

In 2004, suicide was the second leading cause of death (after transport accidents) for people aged 15–24 years, accounting for 19.6 per cent of deaths in this age group. Suicide was the leading cause of death for 25–34 year olds in 2004, with 22.6 per cent of deaths in this age group resulting from suicide (ABS 2006a). Table 11A.51 shows suicide death rates for 15–24 year olds for all states and territories.

Nationally the suicide rate in 2004 was higher in rural areas. There were 9.7 suicides per 100 000 people in capital cities and 11.1 suicides per 100 000 people in other urban areas, compared with 13.2 suicides per 100 000 people in rural areas in Australia in 2004 (figure 11.31).

Figure 11.31 Suicide rate, by area, 2004^{a, b, c, d, e}



^a 'Other urban' comprises centres with more than 20 000 people. 'Rural' comprises all areas except capital cities and other urban. ^b Death rate is age standardised to the mid-year 2001 population. ^c By year of registration of death. Year-to-year variation can be influenced by coronial workloads. ^d The ACT does not have any 'other urban' or 'rural' areas. ^e The NT and SA do not publish data for 'other urban'.

Source: ABS (unpublished); table 11A.52.

The Indigenous suicide rate is presented for the period 2000–2004 for four jurisdictions: Queensland, WA, SA and the NT (table 11A.53). The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions. After adjusting for age differences between populations, the suicide rates for Indigenous people for the period 2000–2004 in the jurisdictions for which data are presented in table 11A.53 are at least twice as high as the rates for the non-Indigenous populations in those jurisdictions in 2004.

Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some jurisdictions are not published. In addition, Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The 'Health preface' discusses the quality of Indigenous mortality and other data.

Quality of life

The Steering Committee has identified 'quality of life' as an indicator for development in future reports, but no indicators have yet been developed (box 11.33).

Box 11.33 Quality of life

'Quality of life' is an outcome indicator of the objective of mental health service delivery to prevent and reduce mental health problems so as to improve the quality of life for people with a mental illness.

11.5 Future directions in performance reporting

Breast cancer

Key challenges for improving reporting of breast cancer include:

- expanding the scope of reporting to include management of breast cancer
- further developing indicators of outcomes
- improving the measurement and comparability of existing indicators.

Existing performance data for breast cancer management place more emphasis on the performance of State and Territory BreastScreen Australia programs than on the treatment and ongoing management of breast cancer. This emphasis is largely due to the relative availability of breast cancer screening data across jurisdictions. The Review aims to expand reporting to incorporate treatment and clinical outcomes data.

The BreastScreen Australia program is being reviewed over July 2006 to June 2008. The evaluation will examine the benefits of the program and the risks associated with mammographic screening at two-yearly intervals for various age groups including the impact of assessment and investigation of women without a subsequent breast cancer diagnosis. The evaluation will address the appropriateness and adequacy of the reporting arrangements and key performance indicators for the Program. The Review will draw upon this evaluation when determining an appropriate indicator of early detection safety.

For some indicators, such as waiting times, the population variance provides an indication of how equitably people are treated. It avoids the definitional problems associated with other measures and fits in well with a quality improvement perspective. A small number of indicators which are best suited to reporting variance will be considered for inclusion in the 2008 Report.

Mental health

Key challenges for improving the reporting of mental health management are similar to those of the past year:

- improving the reporting of effectiveness and efficiency indicators for Indigenous, rural/remote and other special needs groups
- revising the performance indicator framework to account for the Third National Mental Health Plan, to ensure reporting remains consistent with government policy objectives for mental health
- improving the reporting of effectiveness/efficiency indicators for community-based mental health care.

A set of key performance indicators for use in Australia's public sector mental health services has been developed, based on the National Health Performance Framework and linked to the strategic directions of the National Mental Health Plan 2003–2008. Data on all indicators are currently available through existing collections. Work is proceeding on their implementation. Further work is required to develop indicators and measures for their collection in the areas of safety and responsiveness of services. This will then provide data covering all the domains of the National Health Performance Framework. Further information can be found in NMHWG Information Strategy Committee Performance Indicator Drafting Group (2005). The Review will investigate including some or all of the new indicators in future reports

11.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this section of the Report. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status).

Australian Government comments

“ The Australian Government contributed \$660 million towards the \$1.1 billion Council of Australian Governments (COAG) reform package to achieve better health for all Australians. The initiatives include establishing a new approach to promotion, prevention and early intervention, and providing better care for people in the community, including rural and remote Australia, for older people in hospitals and for younger people with disabilities in nursing homes.

Over four years, the Australian Government will also provide an additional \$120 million to fund 605 new medical places, \$93 million to fund 1000 more nursing places, and about \$31 million to increase its contribution towards the cost of nurses' clinical training.

The 2006 Federal Budget provided \$1.9 billion in new funding over five years to improve services for people with a mental illness, their families and carers. This represents the Australian Government's commitment to the COAG National Action Plan on Mental Health. Key measures under the Australian Government's mental health package include: a major increase in clinical and health services available in the community and new team work arrangement for psychiatrists, GPs, psychologists and mental health nurses; new non-clinical and respite services for people with mental illness and their families and carers; an increase in the mental health workforce; and new programs for community awareness.

Through the 2003-08 Australian Health Care Agreements the Australian Government will maintain its commitment to the public hospital system. Assistance will be provided to the States and Territories of up to \$42 billion over five years, an increase of \$10 billion over the previous Agreements. This includes funding for Mental Health, Palliative Care and the Pathways Home program. State and Territory governments are responsible for ensuring the provision of public hospital services free of charge to public patients on the basis of clinical need and within clinically appropriate times. In 2003-04, \$7.5 billion was provided to States and Territories towards the provision of public hospital services.

The Australian Government is committed to achieving sustainable gains in the health of Aboriginal and Torres Strait Islander Australians. In 2006-07 the Australian Government committed \$485.8 million for Indigenous-specific health programs across the Health and Ageing portfolio. This includes funding to increase access to mainstream primary health care through health brokerage services in urban and regional areas; funding for additional health professionals in rural and remote areas; continuation of the Healthy for Life program, funding to combat petrol sniffing and other substance abuse, and to assist Indigenous health services in responding to mental illness and related substance abuse. These funds are in addition to the funding provided through mainstream programs, such as Medicare and the Pharmaceutical Benefits Scheme, which are becoming more responsive to meeting the health needs of Indigenous Australians.

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New South Wales Government comments

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New South Wales supports the ongoing development and monitoring of performance indicators for health. These provide a framework for understanding the delivery of services both within and between jurisdictions.

The 2004-05 reporting period was a year in which the NSW health system began a major undertaking to change the way health care is provided in NSW. Like other international systems, the NSW health system faces many pressures that impact on the capacity to deliver quality health services. These include:

- increasing demand for health services
- population changes, particularly the ageing of the population
- clinical workforce shortages
- changes in the nature of illness
- introduction of new technologies
- increasing expectations of patients and providers.

In 2004, NSW developed a range of new strategies to cope with demand more effectively. These strategies include additional funding for increased bed capacity, and also for rural and regional hospitals and community-based health services to enable people to receive health care closer to home.

This is complemented by a number of business redesign strategies to improve performance to meet increasing demand, these include:

- Patient Flow Units
- Clinical services re-design
- Better ways of managing emergency patient demand and admission
- Predictable surgery plans.

NSW has adopted a performance framework to support the implementation of these strategies and monitor progress to achieving targets.

NSW is pleased with the inclusion of new performance indicators in this year's report, particularly those relating to primary and community health and the quality of public hospital performance.

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Victorian Government comments

“ The 2006 Report on Government Services continues to provide valuable insights into the performance of key areas of public service provision. However, a key challenge continues to be the development of the Report so that it better reflects performance and outcomes of changing models of care both within and across traditional service systems, for example, Victoria’s strong focus on expanding the provision of community based care/service options and improving the integration of care across traditional organisational and program boundaries, as exemplified in the Care in your community: A planning framework for integrated ambulatory health care, is not currently captured in the measures reported.

In other areas, existing performance measures for public hospitals are becoming less useful in measuring performance, due to differences across States and Territories in how services are provided. One clear illustration of this occurs in the data on breast cancer separation rates, where differences in admission practices and service provision outside the hospital setting may largely account for what otherwise might appear to be significant differences in the level of provision of chemotherapy and radiotherapy services across jurisdictions. Another example relates to the continuing validity of available beds as a measure of health system capacity. This measure is being rendered less meaningful due to the growing shift of services from hospital to the community (for example, dialysis, rehabilitation and hospital in the home), together with new models of care such as short stay units for emergency patients and the growing trend to same day services.

Victoria strongly supports the expansion of the Report to better capture emerging new models of care as well as ensuring that the interrelationships between services across the health and aged care systems are better captured. This reflects the reality that many consumers will use multiple services and their satisfaction and health outcomes will be impacted by performance dimensions related to continuity of care, timely referral between services, and coordinated management of care and information.

A focus on interface issues is also important in recognising that, even for consumers without complex care needs, the availability of one type of health or aged care service can strongly influence the utilisation of related services. Victorian data demonstrate the direct relationship between access to affordable general practice services and the demand on public hospital emergency departments for primary-care type services. Similarly, the utilisation of acute hospitals by older people is impacted by the availability of timely assessment, rehabilitation and aged care services across different service settings.

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Queensland Government comments

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The Report on Government Services provides a valuable source of comparative information on key publicly provided health services. Queensland has performed well across a range of health indicators.

Queensland Health delivers a comprehensive health service to Queensland's population of more than 4 million people, including health promotion, disease prevention, acute hospital and non-admitted patient services, rehabilitation, mental health services, community-based care and aged care.

The Queensland Government is continuing to implement health system reforms through a five-year plan launched in October 2005, Action Plan: Building a better health service for Queensland. The action plan addresses pressures identified in the independent review of the health system led by Peter Forster, the Queensland Health Systems Review, including rapid population growth, an ageing population, new medicines and technologies, worldwide critical staff shortages across all health professions and insufficient community-based health infrastructure.

Under the action plan, the Queensland Government invested almost \$6.4 billion in just over five years to relieve pressure on health services, and this investment has been increased to \$9.7 billion. Much of this extra funding has been allocated to improve wages and other conditions for health services staff. In 2005-06, \$548 million was invested, including \$42 million extra for elective surgery, \$38 million extra for emergency departments and \$31 million extra for intensive care units.

Excellent results have been achieved in 2005-06 in relation to the key area of clinical staff recruitment under the action plan:

- 272 extra doctors were appointed by May 2006, which represented good progress towards the target of 300 appointments by December 2006
- 1082 extra nurses were appointed by May 2006, which exceeded the target of 500 appointments by December 2006
- 413 extra allied health staff were appointed by May 2006, which exceeded the target of 400 appointments by December 2006.
- Other key initiatives included:
 - \$155 million investment in the Queensland Strategy for Chronic Disease 2005-2015 which aims to prevent chronic diseases and risk factors, improve quality of life and reduce avoidable hospital admissions
 - establishment of clinical networks to improve results for patients
 - establishment of the Health Quality and Complaints Commission
 - hospital upgrades and redevelopments and other capital works.

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Western Australian Government comments

“ The commitment to providing high-quality safe and accessible health care to all Western Australians continues. Whilst the recommendations of the Health Reform Committee remain the focus of the reform agenda, WA Health has broadened its approach, incorporating reform into the everyday business of delivering and improving the health care system. The reform program is providing more community care options. The changing focus is towards proactive and patient-participatory care models that are community-based.

Healthy Workforce – The number of undergraduate and postgraduate scholarships for nurses and midwives was doubled. Thirty-six registered nurse practitioners were established with 67 currently completing qualifications. More than 80% of the workforce required for delivering the Mental Health Strategy was recruited. The Healthy Workforce Strategic Framework was developed to guide workforce planning for the next decade. A Chief Health Professions Officer is being recruited to communicate allied health/health sciences staff views.

Healthy Hospitals – The new Metropolitan Infrastructure Development Plan maps the capital works needed to implement clinical reconfiguration. Planning for the new \$742 million Fiona Stanley Hospital is underway, new hospitals and health resource centres around the state were opened. The Healthy@Home ambulatory care program increased the number and range of services patients received in settings other than hospitals. Hospital in the Home services are saving about 100 hospital beds a day. Eight chronic disease management teams now provide community care across the metropolitan area and 24-hour phone coaching and advice for people with diabetes or chronic respiratory disease.

Healthy Partnerships – Fourteen Clinical Networks were established giving a comprehensive health care planning system that better fits community need. Partnership with local university and research institutes will see the building of two multi-million dollar medical and biotech research centres. Joint initiatives are underway with key stakeholders including consumer groups and GP divisions.

Healthy Communities – The Consumer, Carer & Community Engagement Framework developed assists staff in implementing effective engagement strategies. The first specialised eating disorder clinic opened, breast cancer services were upgraded and more localised dialysis services provided to make it easier for patients and to relieve some pressure on the tertiary hospital system. After consultation, the WA Aboriginal Primary Care Action Plan was developed, aligning Aboriginal Health with the rest of the population and the reform vision.

Healthy Resources – Procurement reform has been delivering a healthy benefit from better buying and utilisation activities saving \$16.5 million in 2005-06.

Healthy Leadership – Through initiatives such as the Leading 100 Emerging Health Leaders program, the Vital Leadership program for middle and senior managers, and the Executive Focus program, a healthier culture is developing. The WA Health Operational Plan has been developed and will build on the strengths of the health system and the third year of the health reform agenda.

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South Australian Government comments

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The Department of Health is committed to protecting and improving the health of all South Australians by providing leadership in health reform, policy development and planning. One of the challenges for the Department of Health is achieving the health targets in SA's Strategic Plan. This involves monitoring and developing strategies to achieve the targets relating to healthy life expectancy, infant mortality, psychological distress, smoking, overweight and obesity, and Aboriginal wellbeing. Work on the SA Strategic Plan has continued throughout 2006, with an extensive community consultation conducted across SA. This was undertaken to prioritise issues and develop specific recommendations for improving the plan. Suggestions for changes to existing plan targets and ideas for how to achieve those targets formed part of this process.

Guided by findings from the Generational Health Review of the SA health system, the SA Government has progressed its commitment to reform of the State's health system by increasing prevention, early intervention and health promotion. Preventative health care has been central to health planning in SA with the establishment of the GP Plus health care centres. The centres aim to make health care more accessible by increasing collaboration between general practice and other community based health providers.

The GP Plus health care centres, in collaboration with other agencies, will provide a range of services including: antenatal and postnatal care, child health services, parenting groups, nutrition services, diabetes education, counselling for adults and families, mental health care, self management programs for people with chronic illness such as diabetes, heart and respiratory disease and education programs to promote good health and wellbeing.

Other health initiatives being undertaken in SA include:

- Increased funding for elective surgery procedures;
- Funding 50 nurses to provide support in GP clinics;
- Increasing the number of mental health workers to provide services in GPs' offices and therapy for young people;
- Extra doctors and specialists for hospitals, including an increase in emergency department doctors for public hospitals; and
- Expansion of the Family Home Visiting program for families with newborns.

Strengthening primary health care will be paramount in addressing health inequalities among our Indigenous population as well as other disadvantaged groups, and improving the health of the whole community.

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Tasmanian Government comments

“ In responding to the growth in demand and cost within a sustainable budget setting, and the Government's firm commitment to improving the health status and wellbeing of Tasmanians, a number of major strategies are being progressed by the Department of Health and Human Services (DHHS). These include building systems and processes to ensure the sustainability of frontline service delivery; increasing capacity in the service system; developing innovative approaches to service delivery; and a focus on quality and safety.

During 2004-05, the period for which most of the data in the public hospital chapter reports, the Tasmanian Government assumed management of the Mersey Campus of the North West Regional Hospital. This was after a decade of private ownership and management. This was accompanied by the provision of additional funding for the Mersey Campus and for an increase in ambulance services in the region.

DHHS is currently developing a Statewide Primary Health Plan which will provide a strategic planning tool for the provision of primary health services in Tasmania over the next ten years. At the same time, the Department is developing a Tasmanian Clinical Services Plan to look at the needs and priorities across the state and the roles that individual hospitals play in meeting these needs. These plans will fit together to provide a statewide framework for sustainable health services at the primary and tertiary levels.

Initiatives implemented in 2005-06 to maintain and improve acute health services include developments at the Royal Hobart Hospital included a Geriatric Evaluation and Management Unit, a new Department of Emergency Medicine and neonatal/paediatric intensive care units. A new Department of Emergency Medicine is planned at the Launceston General Hospital and a Hospital Medical Equipment Fund to support the long-term sustainability of acute care services has been established.

Mental health reform includes the implementation of a model of care for Mental Health Services that is integrated, comprehensive, multi-disciplined and focused on recovery. This will include a twenty-four hour, seven day a week triage service to provide a single point of entry to Mental Health Services, which will enhance effective patient assessment and treatment.

Community service initiatives include:

- a comprehensive dental care package that will abolish fees for clients requiring emergency dental treatment, establish additional dental surgeries in the state's hospitals, and implement a scheme for purchasing additional private treatment for eligible adults waiting for general dental care; and
- the implementation of the new palliative care service delivery model to ensure clients can access palliative care appropriate to their needs.

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Australian Capital Territory Government comments

“ ACT Health has six key health service delivery agencies: The Canberra Hospital, Calvary Public Hospital (run by Calvary Health Care Limited), Community Health, Mental Health ACT, the Capital Region Cancer Service and the Aged Care and Rehabilitation Service. A range of health promotion, public and environmental health services are run by the Population Health Division and there is a small core of policy and corporate staff in other divisions who support the service providers in meeting their goals. Only around 300 of the approximately 4500 ACT Health staff are employed outside the service agencies.

The ACT provides a near complete range of health services to its own residents, as well as to many people living in adjoining regions of NSW. In 2004-05, 95 per cent of ACT residents requiring public hospital services were treated within the ACT. Some of the remaining 5 per cent of patients referred interstate were those requiring very specialised high-cost, low volume services, such as organ transplantations, which are clinically unviable within the relatively small population of the region. Others may have needed medical attention while travelling outside the ACT, or chose to seek treatment in another jurisdiction for personal or family reasons.

The ACT supports the reporting of data across jurisdictions as a means of evaluating the performance of its own health system against other States and Territories and over time. However, comparisons of data across jurisdictions need to be treated with caution, because the size of the ACT's population can make indicators for selected services and target groups subject to large variations over time. Furthermore, readers need to be aware of the ACT's role as a service hub for the entire region and keep in mind that approximately 25 per cent of all ACT public hospital separations relate to NSW residents.

Caution also needs to be exercised when comparing costs across jurisdictions, because States and Territories may use different accounting methods for costing their health services. Smaller jurisdictions such as the ACT are more likely to be disadvantaged when it comes to economies of scale.

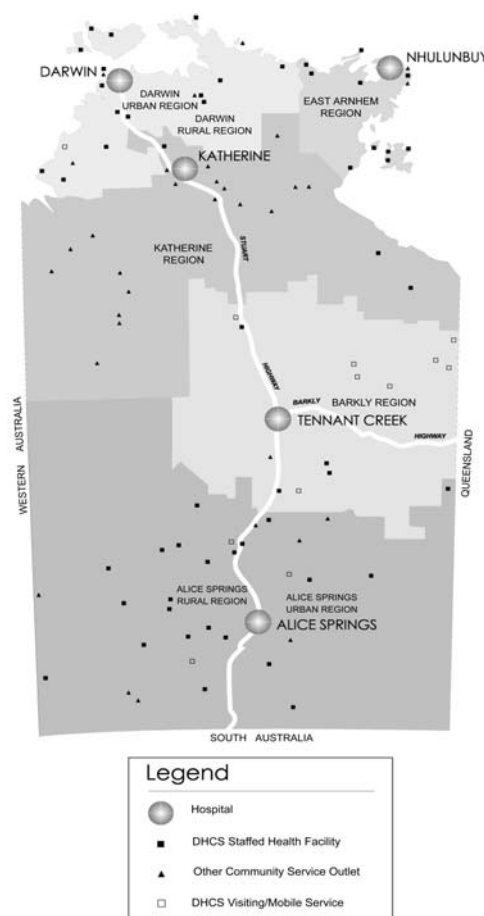
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Northern Territory Government comments

“ The Department of Health and Community Services is the major provider and funding source for hospital, health and community services in the Territory.

Comparing performance data with other jurisdictions has some difficulty due to the geographic spread, sparse population, extreme climate variations and difficulty of access to services for people living in remote areas, illustrated by the adjacent NT service outlet map.

Services are integrated between five public hospitals, a network of 98 community health centres and 100 GP practices. Hospitals are located in five population centres with a total of 620 inpatient beds. A feature of health services in the NT is the movement of people from outlying areas to hospitals, intra hospital transfers and travel assistance to receive some specialist services interstate to overcome access barriers.



Few GPs in smaller communities and only one private hospital result in a greater reliance on public health services in the NT than elsewhere. The employment of health professionals in making the system work, both in numbers and continuity of service, is paramount. ROGS indicates that FTE Practitioners and Nurses ratios per 100 000 people is the highest in the NT of any jurisdiction. In part, this has contributed to the declining deaths of infants and reduced mortality rates in the NT over a five year period, as cited in the Health Preface. Despite the absence of GPs in many smaller communities, immunisation rates compare favourable with other jurisdictions, an important beginning for a later healthier life.

The challenge for the Territory is to improve the wellbeing of Indigenous people to approximate that of the total population, particularly improvements in life expectancy/median age of death. While expenditure on hospitals dominates the health budget, more monies in the NT are targeted at preventing and arresting chronic diseases through primary care, environmental health and nutrition services. Activities in these areas will be better reported in ROGS Primary and Community Care sections over time as indicators are developed and information collected.

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11.7 Definitions of key terms and indicators

AR-DRG v5.0 (Australian refined diagnosis related group, version 5.0)	A patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG v5.0 is based on the ICD-10-AM classification.
Casemix adjustment	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted into diagnosis related groups (AR-DRGs) that represent a class of patients with similar clinical conditions requiring similar hospital services.
General practice	The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients. This definition includes medical practitioners who work solely with one specific population, such as women's health 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), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.
Incidence rate	Proportion of the population suffering from a disorder or illness for the first time during a given period (often expressed per 100 000 people).
Separation	An episode of care for an admitted patient, which can be a total hospital stay, or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care.
Breast cancer	
Breast conserving surgery	An operation to remove the breast cancer but not the breast. Types of breast conserving surgery include lumpectomy (removal of the lump), quadrantectomy (removal of one quarter of the breast) and segmental mastectomy (removal of the cancer as well as some of the breast tissue around the tumour and the lining over the chest muscles below the tumour).
Cost per woman screened	The total cost of the provision of breast screening services, divided by the number of women screened. The total cost 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 (less than or equal to 15 millimetres) invasive breast cancers detected per 10 000 women screened.
<i>Ductal carcinoma in situ</i>	Abnormal cells that involve only the lining of a duct. The cells have not spread outside the duct to other tissues in the breast. Also known as intraductal carcinoma.
Invasive cancer	A tumour whose cells invade healthy or normal tissue.
Modified radical mastectomy	Surgery for breast cancer in which the breast, some of the lymph nodes under the arm, the lining over the chest muscles, and sometimes part of the chest wall muscles are removed.

Mortality rate from breast cancer	The age-specific and age standardised mortality rates of women who die as a result of breast cancer, expressed per 100 000 women in the population.
Participation	The number of women resident in the catchment area screened, divided by the number of women resident in the catchment area, expressed as a per cent. If a woman is screened more than once during the reference period, then only the first screen is counted.. Catchment area is a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or statistical local area.
Radiation therapy	The use of high energy radiation from X-rays, gamma rays, neutrons, and other sources to kill cancer cells and shrink tumours. Radiation may come from a machine outside the body (external beam radiation therapy) or from materials called radioisotopes. Radioisotopes produce radiation and can be placed in or near the tumour or in the area near cancer cells. This type of radiation treatment is called internal radiation therapy, implant radiation, interstitial radiation or brachytherapy. Systemic radiation therapy uses a radioactive substance (such as a radiolabeled monoclonal antibody) that circulates throughout the body.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than otherwise would be the case.
Screening round (first)	A woman's first visit to a BreastScreen Australia mammography screening service.
Screening round (subsequent)	A woman's visit to a BreastScreen Australia mammography screening service when she has previously attended such a service.
Size of detected cancers	The percentage of invasive cancers detected, classified according to tumour size.
Total mastectomy	Removal of the breast — also known as simple mastectomy.

Mental health

Acute services	<p>Services that 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 focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services may:</p> <ul style="list-style-type: none"> • focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms • target the general population or be specialist in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, and forensic mental health services.
Affective disorders	A mood disturbance, including mania, hypomania, bipolar affective disorder, depression and dysthymia.

Ambulatory care services	Mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted inpatients, but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.
Anxiety disorders	Feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder.
Available beds	<p>The number of immediately available beds for use by admitted patients if required at 30 June. Beds are immediately available for use if located in a suitable place of care with nursing or other auxiliary staff available within a reasonable period. Includes beds in wards that are temporarily closed due to factors such as renovations or strikes but that would normally be open and, therefore, available for admission of patients.</p> <p>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.</p>
Child and adolescent mental health services	Services principally targeted at children and young people up to the age of 18 years. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on children or adolescents.
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.
Co-morbidity	The simultaneous occurrence of two or more disorders such as depressive disorder with anxiety disorder, or depressive disorder with anorexia.
Consumer and carer involvement in decision making	Consumer and carer participation arrangements in public sector mental health service organisations according to the scoring hierarchy (levels 1–4) developed for monitoring State and Territory performance under Medicare Agreements Schedule F1 indicators.
Cost per inpatient bed day	The average patient day cost according to the inpatient type.
Depression	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration may be affected.
Forensic mental health	Services principally providing assessment, treatment and care of mentally disordered individuals whose behaviour has led them to

services	commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained.
General mental health services	<p>Services that principally target the general adult population (18–65 years old) but that may provide services to children, adolescents or the aged. Includes, therefore, those services that cannot be described as specialist child and adolescent, older persons' or forensic services.</p> <p>General mental health services include hospital units whose principal function is to provide of some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, post-natal depression, anxiety disorders).</p>
Inpatient services	Services provided to admitted patients in 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 and/or social abilities.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental disorder.
Mental health promotion	Activities designed to improve the mental health functioning of persons through prevention, education and intervention activities and services.
Mental illness prevention	Interventions that occur before the initial onset of a disorder.
Mortality rate from suicide	The percentage of the population who die as a result of suicide.
Non-acute services	<p>Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services focus on disability and the promotion of personal recovery. They are also characterised by an expectation of substantial improvement over the short to medium term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. Non-acute services also consist of extended care services that provide care over an indefinite period for patients who have a stable but severe level of functional impairment and inability to function independently without extensive care and support. Patients of extended care services usually show a relatively stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness. Treatment effort focuses on preventing deterioration and reducing impairment. Improvement is expected only over a long period.</p>
Non-government organisations	Private not-for-profit community managed organisations that receive State and Territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the non-government organisation sector may include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and

	support services for families and primary carers.
Older persons' mental health services	Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged persons. Excludes general mental health services that may treat older people as part of a more general service.
Outpatient services — community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They may include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services — hospital-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They may include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Patient days (occupied bed days)	<p>All days or part days for which 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 the following:</p> <ul style="list-style-type: none"> • For a patient admitted and discharged on different days, only the day of admission is counted as a patient day. • Admission and discharge on the same day are equal to one patient day. • Leave days are not included when they involve an overnight absence. • A patient day is recorded on the day of return from leave.
Percentage of facilities accredited	The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of disorders.
Psychiatrist	A medical practitioner with specialist training in psychiatry.
Public health	The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional services.
Schizophrenia	A combination of signs and symptoms that may include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour.
Specialised mental health services	Services whose the primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental disorder or psychiatric disability. This

Specialised residential services

Staffing categories (mental health)

criterion applies regardless of the source of funds. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function.

Services provided in the community that are staffed by mental health professionals on a 24 hour basis.

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 not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

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: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialist categories of registered nurses.

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) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, pharmacists, speech pathologists and dieticians.

Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.

Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.

Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, wardsmen, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.

Administrative and clerical staff: staff engaged in administrative and

	<p>clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories.</p> <p><i>Domestic and other staff:</i> staff involved in the provision of food and cleaning services. Includes all staff not elsewhere included (for example, maintenance staff, tradespersons, gardening staff).</p>
Stand-alone hospitals	<p>Beds within health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under the management control of a general hospital.</p>
Substance use disorders	<p>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).</p>

11.8 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 11A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Definitions for the indicators and descriptors in this attachment are in section 11.7 of the chapter. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2007\Attach11A.xls and in Adobe PDF format as \Publications\Reports\2007\Attach11A.pdf. This file is available in Adobe PDF format on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (details on the inside front cover of the Report).

Breast cancer

Table 11A.1	Mortality rates from breast cancer for women, by age
Table 11A.2	Number of new cases of breast cancer, five year averages
Table 11A.3	Incidence rates of breast cancer, five year averages
Table 11A.4	BreastScreen Australia: Scope of services provided in each jurisdiction, 2005
Table 11A.5	Expenditure on breast cancer screening (current dollars)
Table 11A.6	Number of women screened by BreastScreen Australia
Table 11A.7	Separations and separation rates for selected AR-DRGs related to breast cancer, public hospitals 2004-05
Table 11A.8	Participation rates of women in BreastScreen Australia, (24 month period)
Table 11A.9	Participation rates of women screened by BreastScreen Australia, by special needs groups (24 month period) (first and subsequent rounds) (per cent)
Table 11A.10	Rate of cancers detected without the need for open biopsies, all women (per cent)
Table 11A.11	Real cost per woman screened (2005-06 dollars)
Table 11A.12	Scope of activities and expenditure items included in cost per woman screened calculations
Table 11A.13	Breast conserving surgery to mastectomy
Table 11A.14	Selected breast and other cancer AR-DRGs, public sector, population estimated, 2004-05
Table 11A.15	Interval cancer rate for women, by age, per 10 000 women screened
Table 11A.16	Breast cancer detection rate, by BreastScreen Australia
Table 11A.17	Rate of detection of small diameter (15mm or less) invasive cancers, BreastScreen Australia, all rounds of screening
Table 11A.18	Detected invasive cancers, by size and round, women aged over 40 years

Mental health

Table 11A.19	Level of psychological distress K10, 2004-05 (per cent)
Table 11A.20	Real estimated Australian Government expenditure on mental health services (2004-05 \$'000)
Table 11A.21	Real estimated recurrent expenditure at the discretion of State and Territory governments (2004-05 dollars)
Table 11A.22	Real Australian Government recurrent expenditure on mental health services per person (2004-05 dollars)
Table 11A.23	Real estimated recurrent expenditure at the discretion of State and Territory governments — excluding other revenue (2004-05 dollars)
Table 11A.24	Depreciation (current prices \$'000s)
Table 11A.25	Total state and territory recurrent expenditure on specialised mental health services (current prices)
Table 11A.26	Number of beds at 30 June, specialised mental health services
Table 11A.27	Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people)
Table 11A.28	Full time equivalent (FTE) direct care staff employed in specialised mental health services, by service setting (per 100 000 people)
Table 11A.29	Mental health patient days
Table 11A.30	Separations, with psychiatric care, public hospitals, Australia 2003-04
Table 11A.31	Specialised care separations reported for Indigenous patients, Australia 2003-04
Table 11A.32	Specialised psychiatric care separations reported for Indigenous patients, Australia 2003-04
Table 11A.33	Specialised public mental health services reviewed against National Standards for Mental Health Services, 30 June
Table 11A.34	Services provided in the appropriate setting (per cent)
Table 11A.35	Consumer and carer participation
Table 11A.36	Percent of specialised mental health services that have introduced routine consumer outcome measurement
Table 11A.37	Average patient day costs, by inpatient program type, public hospitals (2004-05 dollars)
Table 11A.38	Average patient day costs, by hospital type, public hospitals (2004-05 dollars)
Table 11A.39	Average cost to government (recurrent) per patient day for community-based residential services (2004-05 dollars)
Table 11A.40	Average cost to government (recurrent) per treated patient in the community NSW (2004-05 dollars)
Table 11A.41	Average cost to government (recurrent) per treated patient in the community Victoria (2004-05 dollars)
Table 11A.42	Average cost to government (recurrent) per treated patient in the community Queensland (2004-05 dollars)

Table 11A.43	Average cost to government (recurrent) per treated patient in the community WA (2004-05 dollars)
Table 11A.44	Average cost to government (recurrent) per treated patient in the community SA (2004-05 dollars)
Table 11A.45	Average cost to government (recurrent) per treated patient in the community Tasmania (2004-05 dollars)
Table 11A.46	Average cost to government (recurrent) per treated patient in the community ACT (2004-05 dollars)
Table 11A.47	Average cost to government (recurrent) per treated patient in the community NT (2004-05 dollars)
Table 11A.48	Average cost to government (recurrent) per treated patient in the community Australia (2004-05 dollars)
Table 11A.49	Suicides and mortality rate, by sex, Australia
Table 11A.50	Suicide deaths and death rate
Table 11A.51	Suicide deaths and death rate, 15–24 year olds
Table 11A.52	Suicide deaths and suicide death rate, by area
Table 11A.53	Suicide deaths, by Indigenous status
Table 11A.54	Deflators used to calculate real state and territory mental health expenditure
Table 11A.55	Deflator used to calculate real Australian Government mental health expenditure
Table 11A.56	Estimated resident populations used in mental health per head calculations

11.9 References

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PART F

COMMUNITY SERVICES

F Community services preface

Families are the principal providers of care for children, older people and people with a disability (ABS 2001). Community services aim to help families to undertake these roles and aim to fulfil these roles when families are not in a position to provide care. Community services covered by this Report encompass 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 (child protection, supported placements, and supported accommodation and assistance) (see chapter 15).

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 2003) (box F.1).

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' (AIHW 1997, p. 3). They may include financial assistance and relief to people in crisis, and housing assistance of a short term or transitional nature, but they 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).

As in previous years, this preface includes descriptive data obtained from the Australian Institute of Criminology (AIC) on the number and detention rates of young people in detention. In addition, it includes data on the number of young people on community-based orders in each jurisdiction, provided by the AIHW. Community services expenditure data in this Preface were aggregated from the individual chapters in this Report.

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 funding and delivery systems are too varied to enable aggregate community services reporting.

Box F.1 **Community service activities**

Personal and social support — activities that provide support for personal or social functioning in daily life. Such activities promote the development of personal skills for successful functioning as individuals, family members and members of the wider community. Personal and social support activities include the provision of information, advice and referral, personal advocacy, counselling, domestic assistance and personal assistance. The purpose of such support may be to enable individuals to live and function in their own homes or normal places of residence.

Support for children, families and carers — including children's services, which aim to meet the care, education and development needs of children. Activities that seek to protect children from abuse and neglect or harm, through statutory intervention and support for families are also included.

Training, vocational rehabilitation and employment — activities that assist people who are disadvantaged in the labour market by providing training, job search skills, help in finding work, placement and support in open employment or, where appropriate, supported employment.

Financial and material assistance — activities that enhance personal functioning and facilitate access to community services, through the provision of emergency or immediate financial assistance and material goods.

Residential care and supported accommodation — activities provided in special purpose residential facilities, including accommodation in conjunction with other types of support, such as assistance with necessary day-to-day living tasks and intensive forms of care such as nursing care.

Corrective services [in relation to young people and people with intellectual and psychiatric disabilities on court orders] — activities that involve correctional and rehabilitative supervision and the protection of public safety, through corrective arrangements and advice to courts and parole boards.^a

Service and community development and support — activities that provide support aimed at articulating and promoting improved social policies; promoting greater public awareness of social issues; developing and supporting community-based activities, special interest and cultural groups; and developing and facilitating the delivery of quality community services. Activities include the development of public policy submissions, social planning and social action, the provision of expert advice, coordination, training, staff and volunteer development, and management support to service providers.

^a This preface uses the term 'juvenile justice' to refer to detention and community-based supervision services for young people who have committed or allegedly committed an offence while considered by law to be a juvenile.

Source: AIHW (2003).

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
- 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 juvenile justice services are provided primarily by government, while residential care, accommodation support and other community services activities are provided primarily by non-government organisations.

Expenditure

Community services expenditure reported in this preface relates only to the activities as defined in the relevant chapters. Total expenditure by governments has been calculated based on the 2005-06 expenditure totals for aged care services, services for people with a disability, children's services and protection and support services.

Total government recurrent expenditure on community services covered by this Report was estimated to be \$15.9 billion in 2005-06 (table F.1). This was equivalent to 1.7 per cent of gross domestic product in that year, and 9.1 per cent of total government outlays (table F.1 and ABS 2006).

Between 2001-02 and 2005-06, real community services government recurrent expenditure increased by \$2.6 billion, or 19.4 per cent (table F.1). The largest proportional increase in real expenditure was on protection and support services, which increased by 39.0 per cent between 2001-02 and 2005-06. Services for people with a disability increased by 22.5 per cent, aged care services by 18.9 per cent and children's services by 6.1 per cent.

Table F.1 Government recurrent expenditure on community services (2005-06 dollars)^{a, b, c}

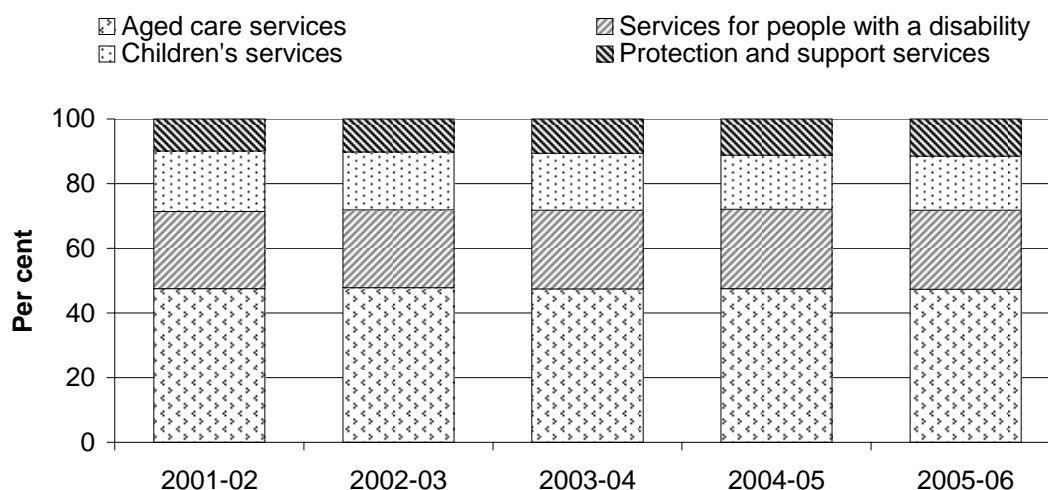
	<i>Unit</i>	<i>Aged care services</i>	<i>Services for people with a disability</i>	<i>Children's services</i>	<i>Protection and support services</i>	<i>Total</i>
2001-02	\$m	6 329	3 173	2 498	1 315	13 315
2002-03	\$m	6 659	3 339	2 501	1 419	13 918
2003-04	\$m	6 943	3 556	2 578	1 552	14 630
2004-05	\$m	7 301	3 777	2 575	1 722	15 375
2005-06	\$m	7 526	3 887	2 651	1 829	15 892
Increase 2001-02 to 2005-06	%	18.9	22.5	6.1	39.0	19.4

^a Data for 2001-02 to 2004-05 have been adjusted to 2005-06 dollars using the gross domestic product (GDP) price deflator. ^b Data for aged care published in earlier reports differs due to revised data. ^c Totals may not add as a result of rounding.

Source: Australian, State and Territory governments (unpublished); tables 12A.42–12A.44, 12A.46, 13A.5, 14A.4, 15A.1 and 15A.167.

In 2005-06, almost half (47.4 per cent) of community services government recurrent expenditure related to aged care services, 24.5 per cent related to services for people with a disability, 16.7 per cent to children's services, and 11.5 per cent related to protection and support services. These proportions have been fairly consistent from 2001-02 to 2005-06 (figure F.1).

Figure F.1 Government recurrent expenditure on community services



Source: Australian, State and Territory governments (unpublished); tables 12A.42–12A.44, 12A.46, 13A.5, 14A.4, 15A.1 and 15A.167.

Size and scope

Data on the number of organisations that provide community services are obtained from the Australian Bureau of Statistics (ABS) Community Services Survey, which was last conducted in 1999-2000. Almost 9300 organisations were providing community services (covering the not-for-profit, government and for-profit sectors) at 30 June 2000. Across the three sectors, these organisations employed 341 400 people, including 277 300 employed in direct service provision. A further 299 400 volunteers assisted in community service activities (ABS 2001). (For information on the size and scope of the community services sector and output measures for community services in 1999-2000, see SCRGSP 2004, p. F.4.)

An important issue for governments is to determine how to assist community services clients in meeting their complex needs and how to assess performance in meeting these needs. Governments have introduced case management at the client level 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.

Juvenile justice

The juvenile justice system is responsible for dealing with young people (predominantly aged 10–17 years) who have committed or allegedly committed an offence while considered by law to be a juvenile. Each jurisdiction has its own legislation that dictates the policies and practices of its juvenile justice system. While this legislation varies in detail, its intent is similar across jurisdictions. Key elements of juvenile justice systems in all jurisdictions include, for example: the diversion of young people from the more formal criminal justice system (courts) where appropriate; detention as a last resort; victim's rights; the acceptance of responsibility by the young person appropriate to developmental stage for his or her behaviour; and community safety.

The juvenile justice system in each jurisdiction comprises several organisations, each with a different primary role and responsibility in dealing with young people. These include:

- police, who are usually the young person's first point of contact with the system. Where considered appropriate, the police may administer warnings or cautions

and, in some jurisdictions, use conferencing to divert the young person from proceeding to court

- courts (usually a special children's or youth court), where matters relating to the charges against the young person are heard. The courts are largely responsible for decisions regarding bail (and remand) and sentencing options if the young person admits guilt or is found guilty by the court
- juvenile justice agencies, which are responsible for the supervision and case management of young people on a range of community-based legal arrangements and in detention, and for the provision of a wide range of services aimed at crime prevention and reduction. Many of the services provided by juvenile justice agencies are aimed at: rehabilitating young people; minimising the level, and future involvement of young people in the justice system; reducing the over representation of Indigenous young people in the justice system; maintaining the young person's connection with family, culture and community; providing young people with an appropriate level of care and safety (duty of care); increasing young people's accountability to victims; and improving community safety.

Diversion of young offenders

In most jurisdictions, the majority of young people involved with the justice system are diverted through a range of mechanisms such as police cautions, conferences and unsupervised orders, and do not generally become clients of juvenile justice agencies. Informal warnings, police cautions, and community, family or youth justice conferences are now part of the spectrum of legislated responses to juvenile crime. Additionally, some jurisdictions use infringement notices as a response to a wide range of regulatory, transport and environmental offences allegedly committed by young people. Responsibility for administering the options available for more minor offences — warnings (informal cautions), formal cautions, and infringement notices — rests mainly with police in all jurisdictions. Responsibility for administering the diversionary processes available for more serious offences lies with juvenile justice authorities and courts in each jurisdiction.

Conference referrals can originate from both police and courts in most jurisdictions. Conditions of entitlement and eligibility, along with the range and/or definition of offences that can be dealt with via conferencing, vary across jurisdictions.

Diverting appropriate young people from the formal court system, or minimising the involvement of young people with the justice system through a conferencing process, can take considerable resources, depending on the judicial system in the jurisdiction and the number of young people involved. While comparable national

data are not yet available to illustrate the level of diversion, the juvenile justice agencies in NSW and Queensland have provided information on the number of young people dealt with by means of diversion. These data are not comparable across the two jurisdictions.

The 2004-05 data from the NSW Bureau of Crime Statistics and Research that are available to the NSW Department of Juvenile Justice show that 18 776 warnings were administered to young people, 9243 cautions were given and 933 police referrals to youth justice conferences were made. The NSW Department of Juvenile Justice data show 1326 conferences (from 1672 police and court referrals) were convened for young people in 2004-05 (Department of Juvenile Justice unpublished). In Queensland, 1927 conferences were held for people aged 10–17 years in 2005-06, up from 1763 in 2004-05 (Department of Communities unpublished).

In addition to youth conferences, juvenile justice agencies in all jurisdictions provide pre-sentence reports for young people (who may or may not subsequently become clients) to the courts as required.

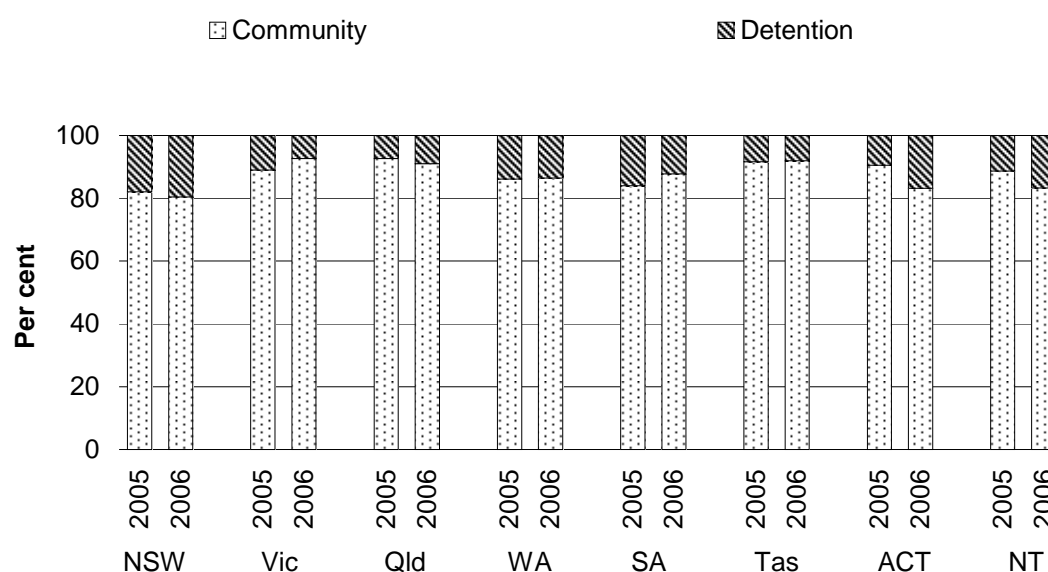
Clients of juvenile justice agencies

The first report of the Juvenile Justice National Minimum Data Set (JJ NMDS), covering data from 2000-01 to 2003-04, was released in February 2006 (AIHW 2006). The JJ NMDS provides information about young people who are supervised by juvenile justice agencies. Pre-sentence and sentenced supervision both within the community and in detention are included in the JJ NMDS. Elements of the juvenile justice system which do not require juvenile justice agency supervision (such as police and court actions) are not included in the scope of the JJ NMDS.

Of those young people who become clients of juvenile justice agencies, most are supervised on community-based orders, including parole. The JJ NMDS shows that, during 2003-04, 12 992 young people received supervision from a juvenile justice agency. Of these young people, 10 556 had community-based supervision, 5357 had detention-based supervision, with some young people experiencing both (AIHW 2006). More recent unpublished AIHW data show that at June 2005 the majority of young people aged 10–17 years who were supervised by juvenile justice agencies – between 82.1 per cent and 92.7 per cent – were in the community, rather than in detention. At June 2006, between 80.4 per cent and 92.7 per cent of young people supervised by juvenile justice agencies were in the community, rather than in detention (figure F.2). These figures do not include any juveniles aged 10–17 years who were supervised in the adult correctional system.

These data were collected at a point in time, so they need to be interpreted with care, particularly for jurisdictions with smaller populations where a small change to the number of young people in detention can make a significant difference to their relative proportion.

Figure F.2 Proportion of juvenile justice clients aged 10–17 years who were supervised in the community and in detention centres, at 30 June ^{a, b, c, d, e, f, g, h, i, j}



			NSW	Vic	Qld	WA	SA	Tas	ACT	NT
2005	Community	%	82.1	89.0	92.7	86.1	84.0	91.6	90.5	88.7
2005	Detention	%	17.9	11.0	7.3	13.9	16.0	8.4	9.5	11.3
2006	Community	%	80.4	92.7	91.0	86.4	87.8	91.9	83.2	83.3
2006	Detention	%	19.6	7.3	9.0	13.6	12.2	8.1	16.8	16.7

^a Includes only those young people who were under the supervision or case management of juvenile justice agencies on a pre- or post-sentence legal arrangement or order (for example, supervised bail, remand, a community services order, parole and detention). ^b Juvenile justice agencies also have additional clients in detention and community supervision who are over 17 years of age. The figure does not include juvenile justice clients over 17 years of age at 30 June 2005 or 30 June 2006. ^c Clients may be on multiple orders at any one time. The distribution in the figure, therefore, is based not on order type but on where the client was located at 30 June 2005 or 30 June 2006. ^d Kariiong Juvenile Correctional Centre detainees are excluded for 2005 and 2006 for NSW. ^e On 1 July 2005, Victoria enacted legislative amendments that raised the age jurisdiction of the Criminal Division of the Children's Court from 16 to include 17 year olds. ^f In Queensland, juvenile justice legislation applies to those young people who were aged 10–16 years at the time of the offence. These data, however, include 17 year olds who were still on supervision in the juvenile justice system as at 30 June 2005 and 30 June 2006. ^g WA data exclude persons subject to Juvenile Justice Team Referrals. WA data for 2005 have been amended from the 2006 Report to exclude 18 year old individuals. ^h SA data for 2005 have been revised since the 2006 Report following quality assurance processes. ⁱ Tasmanian data for 2005 have been revised since the 2006 Report to exclude individuals aged 18 years and over. ^j NT data excludes pre-probation, presentencing reports and other types of assessments.

Source: AIHW unpublished (data supplied by State and Territory governments).

Juvenile detention

The following data relate to juvenile detention only and do not describe the operation of community-based services, which, as noted above, supervise the majority of juvenile offenders. Jurisdictions also have different definitions of a juvenile, which may have an impact on the number and rates reported for people aged 10–17 years.

Data on the number of juveniles in detention include those on remand as well as those sentenced. In some jurisdictions (for example, WA), juveniles who have been arrested and have not yet appeared before a court, are also held in a detention centre.

The AIC publishes an annual report on juveniles in detention who are either on remand, or sentenced, or both. The AIC data detail the number of young people aged 10–17 years held in juvenile detention centres at the end of each quarter. The AIC data is more current than that available from the JJ NMDS.

The AIC uses ABS experimental projections for its estimates of the Indigenous population (ABS 2004). These data include a range of estimates (low and high). The AIC data are based on high level estimates, unlike other sections of this Report.

Nationally, the daily average number of people aged 10–17 years detained in juvenile detention centres decreased from 611 to 595 between 2000-01 and 2004-05 (table F.2).

Table F.2 Daily average population of people aged 10–17 years in juvenile detention (number)^{a, b}

	<i>NSW^c</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2000-01	223	62	87	103	59	43	17	17	611
2001-02	217	62	89	108	56	27	17	16	590
2002-03	220	64	96	106	65	25	17	24	616
2003-04	209	62	91	122	50	26	18	13	590
2004-05	218	53	89	110	58	33	15	22	595

^a Average based on population of juvenile detention centres on the last day of each quarter of the financial year. ^b Due to rounding, the Australian total may differ from the combined total of all jurisdictions. ^c NSW data from 31 March 2005 include Kariiong Juvenile Correction Centre detainees, sourced from the NSW Department of Corrective Services.

Source: AIC (unpublished).

Nationally, the rate of detention of people aged 10–17 years per 100 000 in the population aged 10–17 years fell from 28.4 per 100 000 in 2000-01 to 26.9 per 100 000 in 2004-05, although there were substantial differences across jurisdictions (table F.3).

Table F.3 Average rate of detention of people aged 10–17 years in juvenile detention, per 100 000 people aged 10–17 years^a

	<i>NSW^b</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2000-01	31.1	12.0	21.0	46.2	36.4	61.8	46.6	68.6	28.4
2001-02	30.0	11.9	20.9	47.9	34.1	48.6	47.4	63.0	27.2
2002-03	30.3	12.1	22.3	47.0	40.2	45.1	45.9	94.0	28.1
2003-04	28.7	11.6	20.7	53.5	30.5	47.8	49.8	53.0	26.8
2004-05	29.9	9.9	19.9	48.3	35.7	59.0	41.1	85.2	26.9

^a Detention rates are based on average population of juvenile detention centres on the last day of each quarter of the financial year. ^b NSW data from 31 March 2005 include Kariong Juvenile Correction Centre detainees, sourced from the NSW Department of Corrective Services.

Source: AIC (unpublished).

Nationally, females made up 9.1 per cent of the total population of juvenile detention centres at 30 June 2005. Males made up 90.9 per cent of the national population of juvenile detention centres at 30 June 2005 (table F.4).

Table F.4 Males and females as a proportion of the total population aged 10–17 years in juvenile detention (per cent)

	<i>NSW^a</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Males									
30 June 2001	90.5	89.4	91.8	83.5	87.5	97.3	88.0	100.0	89.6
30 June 2002	92.1	93.0	84.5	89.9	85.1	96.2	80.0	100.0	90.1
30 June 2003	92.8	93.4	89.1	90.5	85.9	89.5	87.0	100.0	91.1
30 June 2004	93.4	91.9	95.6	86.4	92.2	100.0	93.8	100.0	92.4
30 June 2005	94.9	82.5	93.9	85.8	88.1	91.4	80.0	100.0	90.9
Females									
30 June 2001	9.5	10.6	8.2	16.5	12.5	2.7	12.0	–	10.4
30 June 2002	7.9	7.0	15.5	10.1	14.9	3.8	20.0	–	9.9
30 June 2003	7.2	6.6	10.9	9.5	14.1	10.5	13.0	–	8.9
30 June 2004	6.6	8.1	4.4	13.6	7.8	–	6.3	–	7.6
30 June 2005	5.1	17.5	6.1	14.2	11.9	8.6	20.0	–	9.1

^a NSW data from 31 March 2005 onwards include Kariong Juvenile Correction Centre detainees. – Nil or rounded to zero.

Source: AIC (unpublished).

The daily average number of Indigenous young people aged 10–17 years detained in juvenile detention centres was 322 in 2004–05 (table F.5).

Table F.5 Daily average population of Indigenous people aged 10–17 years in juvenile detention (number)^a

	<i>NSW^b</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2000-01	86	7	53	71	13	na	4	12	246
2001-02	92	7	53	71	19	na	5	12	259
2002-03	98	10	54	80	28	na	4	19	295
2003-04	98	14	54	92	18	6	4	12	298
2004-05	111	12	53	87	28	7	6	19	322

^a Average based on population of juvenile detention centres on the last day of each quarter of the financial year. ^b NSW data from 31 March 2005 include Kariiong Juvenile Correction Centre detainees, sourced from the NSW Department of Corrective Services.

Source: AIC (unpublished).

Nationally, the daily average detention rate for Indigenous people aged 10–17 years in 2004-05 was 322.8 per 100 000 Indigenous people aged 10–17 years. This rate compared to 12.9 per 100 000 for the non-Indigenous population aged 10–17 years (table F.6). 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.

Table F.6 Average rate of detention of Indigenous people aged 10–17 years in juvenile detention, per 100 000 people^{a, b, c}

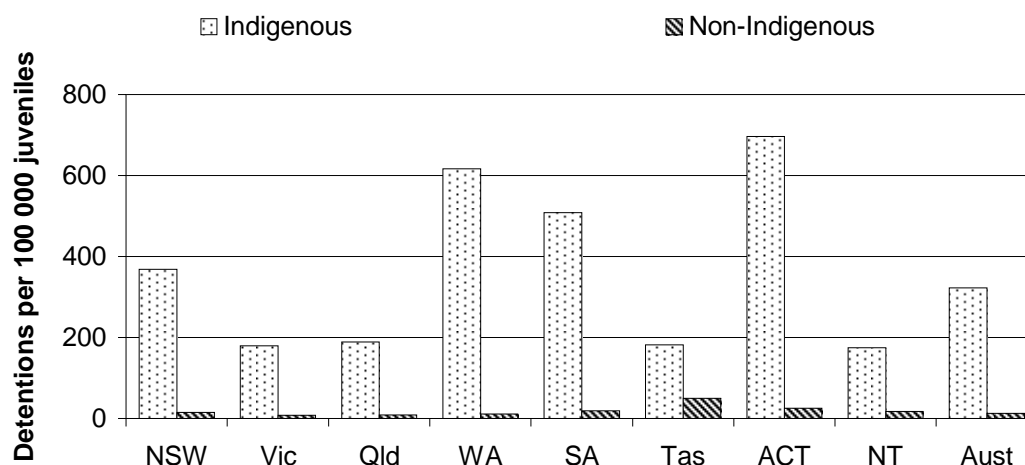
	<i>NSW^d</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Indigenous									
2000-01	324.9	142.4	222.2	565.4	265.9	na	524.7	121.4	294.5
2001-02	351.4	135.8	221.1	555.6	388.2	na	624.4	119.9	307.9
2002-03	353.8	173.6	212.0	604.7	538.1	na	458.6	182.6	326.6
2003-04	339.3	231.0	202.6	671.8	333.2	158.7	503.2	108.6	310.1
2004-05	368.5	179.4	189.0	616.3	508.3	181.9	696.8	174.9	322.8
Non-Indigenous									
2000-01	19.9	10.7	8.7	15.1	29.3	na	36.4	26.6	16.0
2001-02	17.9	10.7	8.8	17.3	23.0	na	35.7	23.7	15.0
2002-03	17.5	10.3	10.3	12.2	23.8	na	36.9	30.9	14.9
2003-04	15.9	9.1	8.9	13.8	20.3	39.6	39.4	12.2	13.9
2004-05	15.4	7.8	8.5	10.8	19.2	49.8	25.4	17.4	12.9

^a Detention rates are based on average population of juvenile detention centres on the last day of each quarter of the financial year. ^b Indigenous rates were calculated using high series population data provided by the ABS. Any variation in derived rates may be due to the assumptions and limitations of the base population data. ^c 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. ^d NSW data from 31 March 2005 include Kariiong Juvenile Correction Centre detainees, sourced from the NSW Department of Corrective Services. **na** Not available.

Source: AIC (unpublished).

The over representation of Indigenous young people in detention across jurisdictions in 2004-05 is shown in figure F.3.

Figure F.3 Average rate of detention of Indigenous and non-Indigenous people aged 10–17 years in juvenile detention, per 100 000 people, 2004-05^{a, b, c, d}



^a Detention rates are based on average population of juvenile detention centres on the last day of each quarter of the financial year. ^b Indigenous rates were calculated using high series population data provided by the ABS. Any variation in derived rates may be due to the assumptions and limitations of the base population data. ^c 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. ^d NSW data from 31 March 2005 include Kariiong Juvenile Correction Centre detainees, sourced from the NSW Department of Corrective Services.

Source: AIC (unpublished); table F6.

Future directions in performance reporting

Community services

The Steering Committee intends to improve reporting on the characteristics of community service providers and their activities. In addition, there are many interactions across the various community services. Ongoing investigation of crosscutting and interface issues may allow improved reporting of community services as a whole.

Juvenile justice

The juvenile justice system is part of the broader justice framework (discussed in the Justice preface) and has important links with community services such as child protection and support services.

The availability of comparable juvenile justice data as a result of the further refinement of the JJ NMDS and the development of related performance measures will provide an opportunity to present broader comparative data on the performance of juvenile justice systems in the Report.

The Australasian Juvenile Justice Administrators has formed a sub-committee to develop national performance indicators. Two types of measures, relating to the performance of juvenile justice agencies and the performance of the broader juvenile justice system, are being considered. This performance information may be available for inclusion in future Reports.

References

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12 Aged care services

The aged care system comprises all services specifically designed to meet the care and support needs of frail older Australians. This chapter focuses on government funded residential and community care for older people and services designed for the carers of older people. Some government expenditure on aged care is not reported, but continual improvements are being made to the coverage and quality of the data. The services covered include:

- residential services, which provide high care, low care and residential respite care (box 12.1)
- community care services, which include Home and Community Care (HACC) program services, Community Aged Care Packages (CACPs), the Extended Aged Care at Home (EACH) program 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)
- assessment services, which are largely provided by Aged Care Assessment Teams (ACATs).

A profile of aged care services appears in section 12.1. A framework of performance indicators is outlined in section 12.2 and key performance results are discussed in section 12.3. Future directions in performance reporting are discussed in section 12.4. Jurisdictions' comments are reported in section 12.5. Section 12.6 contains definitions for data and indicators. Section 12.7 lists the supporting tables for this chapter. Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Section 12.8 lists references used in this chapter.

Additions and improvements made to the chapter this year include:

- provision of information on the Transition Care Program (TCP)
- reporting 'aged care recipients from special needs groups' as an indicator of equity of access

¹ Unless otherwise stated, HACC expenditure excludes the Department of Veterans' Affairs expenditure on VHC.

- Provision of information on EACH Dementia
- reporting of expenditure by jurisdiction on the National Respite for Carers Program (NRCP)
- relocation of the technical component of the age standardisation discussion to the Report Statistical Appendix and integration of descriptive material on age specific usage rates into the main body of the chapter.

Older Australians also use other government services covered in this Report, including disability services (chapter 13), specialised mental health services (chapter 11), housing assistance (chapter 16) and services across the full spectrum of the health system (preface E and chapters 9–11). There are also interactions between these services that are likely to affect performance results in this Report — for example, the number of operational residential aged care places may affect demand for public hospital beds, and changes in service delivery in the public hospital sector may affect demand for residential and community aged care.

Box 12.1 Interpreting residential aged care data

This chapter describes the characteristics and performance of residential aged care in terms of residential services, residents (clients), places and locality.

- *Residential services data.* This chapter groups residential services for reporting purposes based on the eight level Resident Classification Scale (RCS) profile of residential services' clients.
 - Aged care homes with 80 per cent or more residents classified as RCS 1–4 are described as high care services.
 - Aged care homes with 80 per cent or more residents classified as RCS 5–8 are described as low care services.
 - A service that is neither high care nor low care as defined above is called a mixed service.

These categories have been used for descriptive purposes and do not have any legal foundation under the *Aged Care Act 1997* (Cwlth). Similarly, the choice of 80 per cent as a cut-off is arbitrary but considered appropriate for descriptive purposes.

- *Residents data.* This chapter classifies clients as high care or low care based on their RCS assessment. High care residents have been assessed as RCS levels 1–4, and low care residents have been assessed as RCS levels 5–8.
- *Places data.* Part 2.2 of the Aged Care Act details the processes for planning and allocating subsidised services to meet residential aged care needs and community care needs. Planning is based on a national formula for people aged 70 years or over for high and low care. High care places are planned to meet the needs of residents with care needs equivalent to RCS levels 1–4. Low care places are planned to meet the needs of residents with care needs equivalent to RCS levels 5–8.

(Continued on next page)

Box 12.1 (Continued)

Although a needs match is expected when residents enter vacant places (that is, vacant low care places should usually be filled by low care residents), this can change over time with 'ageing in place', which allows a low care resident who becomes high care to remain within the same service until he or she is discharged.

- *Locality data.* Geographic data are based on the ABS Australian Standard Geographic Classification of Remoteness Areas (ABS 2003). Data are classified according to an index of remoteness that rates each ABS Census district based on the number and size of towns, and the distance to major towns and urban centres.

12.1 Profile of aged care services

Service overview

Services for older people are provided on the basis of the frailty or functional disability of the recipients rather than specific age criteria. Nevertheless, in the absence of more specific information, this Report uses people aged 70 years or over as a proxy for the likelihood of a person in the general population requiring these services. Certain groups (notably Indigenous people) may require various services at a younger age. For Indigenous people, those aged 50 years or over are used as a proxy for the likelihood of requiring aged care services. The Australian Government also uses these age proxies for planning the allocation of residential care, CACPs and EACH packages.

Government funded aged care services covered in this chapter relate to the three levels of government (Australian, State and Territory, and some local) involved in service funding and delivery. The formal, publicly funded services covered represent only a small proportion of total assistance provided to frail older people. Extended family and partners are the largest source of emotional, practical and financial support for older people: more than 90 per cent of older people living in the community in 2003 who required help with self-care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 2004a). Many people receive assistance from both formal aged care services and informal sources. Older people also purchase support services in the private market, and these services are not covered in this chapter.

Roles and responsibilities

Assessment services

The Australian Government established the Aged Care Assessment Program (ACAP) in 1984, based on the assessment processes used by State and Territory health services to determine (1) eligibility for admission into residential care and (2) the level of care required (and thus the subsidy paid to such services). The core objective of the ACAP is to assess the needs of frail older people and recommend appropriate services. Assessment and recommendation by ACATs are mandatory for admission to residential care or receipt of a CACP, EACH package, EACH Dementia package or TCP. People may also be referred by ACATs to other services, such as those funded by the HACC program. An ACAT referral is not mandatory for receipt of other services, such as HACC and VHC services.

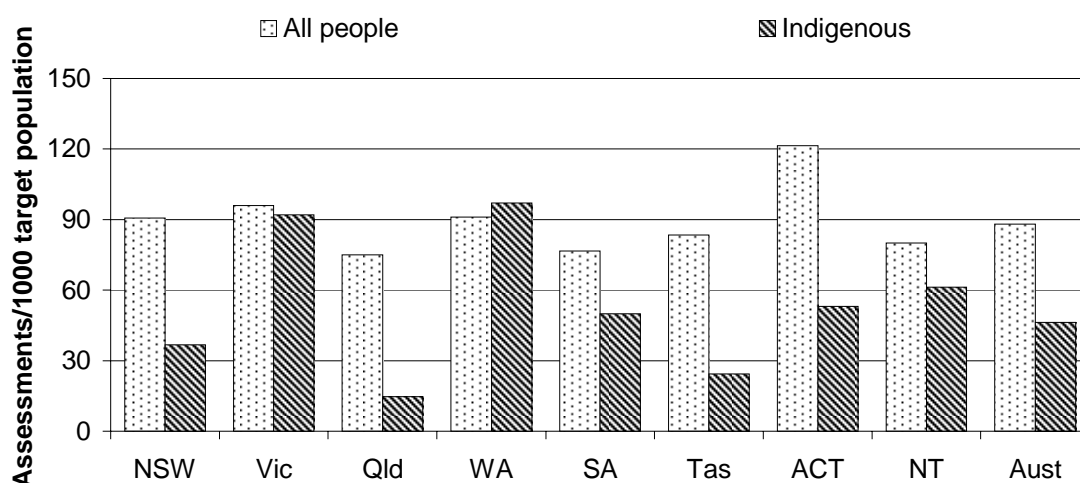
State and Territory governments are responsible for the day-to-day operation and administration of the ACAP and provide the necessary accommodation and support services. The scope and practice of the teams differ across and within jurisdictions, partly reflecting the service setting and location (for example, whether the team is attached to a residential service, a hospital, or a community service). This has an effect on program outputs.

The number of assessments per 1000 target population varied across jurisdictions in 2004-05. The national rate was 88.1 assessments per 1000 people aged 70 years or over and Indigenous people aged 50 years or over and 46.3 per 1000 Indigenous people aged 50 years or over (figure 12.1).

Residential care services

Religious and private for-profit organisations were the main providers of residential care at June 2006, accounting for 29.7 per cent and 32.0 per cent respectively of all Australian Government subsidised residential aged care places. Community-based organisations and not-for-profit charitable organisations accounted for a further 14.5 per cent and 16.1 per cent respectively. State, Territory and local governments provided the remaining 7.7 per cent (figure 12.2).

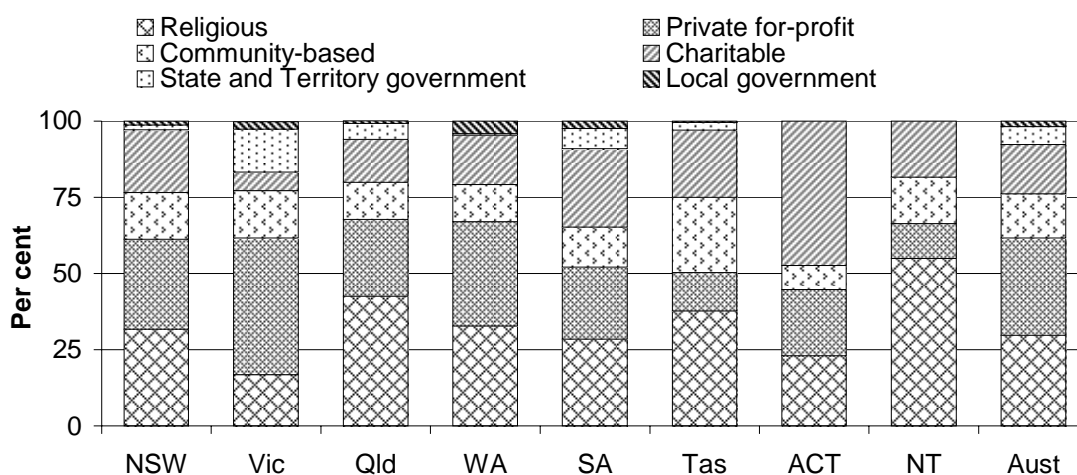
Figure 12.1 Aged Care Assessment Team assessment rates, 2004-05^{a, b, c, d}



^a Includes ACAT assessments for all services. ^b 'All people' includes all assessments of people aged 70 years or over and Indigenous people aged 50 years or over per 1000 people aged 70 years or over and Indigenous people aged 50 years or over. ^c 'Indigenous' includes all assessments of Indigenous people aged 50 or over per 1000 Indigenous people aged 50 years or over. ^d The number of Indigenous assessments is based on self-identification of Indigenous status.

Source: Department of Health and Ageing (DoHA) (unpublished); table 12A.38.

Figure 12.2 Ownership of residential places, June 2006^{a, b}



^a 'Community-based' residential services provide a service for an identifiable community based on locality or ethnicity, not for financial gain. ^b 'Charitable' residential services provide a service for the general community or an appreciable section of the public, not for financial gain.

Source: DoHA (unpublished); table 12A.4.

The Australian Government is responsible for most of the regulation of Australian Government subsidised residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local

governments 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).

Box 12.2 Examples of regulatory arrangements for residential services

The Australian Government controls the number of subsidised places. In May 2004, following a recommendation of the Review of Pricing Arrangements in Residential Aged Care, the Australian Government adopted a new ratio of 108 places for each 1000 people in the population aged 70 years or over. Of the 108 places, 88 are residential care places (40 high care and 48 low care) and 20 are community care places (CACP and EACH packages).

- Services are expected to meet regional targets for places for concessional residents. These targets range from 16 per cent to 40 per cent of places, and aim to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care. (The criteria for being deemed a concessional resident are based on home ownership and occupancy, receipt of income support and the level of assets held at entry.)
- Extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted.
- To receive an Australian Government subsidy, an operator of an aged care service must be approved under the Aged Care Act as a provider of aged care.
- Principles (regulations) created under the Aged Care Act establish the obligations of approved providers relating to quality of care and accommodation.

Various Australian Government, State and Territory laws govern regulatory arrangements for residential care. State and Territory legislation may prescribe matters such as staffing, the dispensing of medication and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, and fire prevention and firefighting measures. Staff wages and conditions are generally set by jurisdiction-based awards. Local government by-laws may also apply (for example, waste disposal rules).

Community care services

The main community care programs reported in this chapter — the HACC, CACP and VHC programs — fund services that aim to provide practical assistance to enable frail older people (HACC and CACP), people with a disability (HACC) and veterans (VHC) to continue living in or return to the community. These services also provide assistance to carers. They are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers.

Flexibly funded services

Flexible care addresses the needs of care recipients in ways other than that provided through mainstream residential and community care. Flexible care provided under the Aged Care Act includes EACH packages, EACH dementia packages, Innovative Care Places, Multi-purpose Service Aged Care and the TCP. In addition, flexible models of care are provided under the National Aboriginal and Torres Strait Islander Aged Care Strategy.

- The EACH program provides high level aged care to people in their own homes, complementing CACPs, which provide low level care. There were 2575 operational EACH places at 30 June 2006 (table 12A.35).
- EACH Dementia provides high level care in the home to people with complex care needs associated with dementia, as an alternative to high level residential care. There were 601 operational EACH Dementia places at 30 June 2006.
- The Aged Care Innovative Pool provides flexible care subsidies for alternative care options. Pilots have been conducted at the interface between aged care and other types of care. Evaluations of a number of the pilots were completed during 2005-06 and have, for example, informed the implementation of the Transition Care Program and the EACH Dementia program (DoHA unpublished).
- The Multi-purpose Service program supports the integration and provision of health and aged care services for small rural and remote communities. At 30 June 2006, there were 94 operational Multi-purpose Services with a total of 2259 flexible aged care places. Some of the MPS serve more than one location (DoHA unpublished).

Transition care services

The TCP provides goal oriented, time limited and therapy focused care to help eligible older people complete their recovery after a hospital stay. Transition care is expected to:

- enable a significant proportion of care recipients to return home, rather than enter residential care
- optimise the functional capacity of those older people who are discharged from Transition Care to residential care
- reduce inappropriate extended lengths of hospital stay for older people.

Following a decision by health ministers in May 2004 and an announcement in the Australian Government's 2004-05 Budget, the Australian Government and the states and territories have collaborated in the design and implementation of the

program, which is jointly funded by the Australian Government and the states and territories.

Transition care can be provided in either a home-like bed based setting or in the community, and is for older people who would otherwise be eligible for residential care. A person may enter transition care only directly upon discharge from hospital. The average duration of care is expected to be 8 weeks, with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks. When fully established, it is estimated that transition care will assist up to 13 000 people annually.

As there are significant service system differences between and within jurisdictions, different local operating circumstances, and different implementation processes and timetables, the TCP is likely to operate with some differences between jurisdictions that are likely to be reflected in national data collections.

By 30 June 2006 the Australian Government had allocated 1507 flexible aged care places to transition care, of which 595 were operational. A total of 2000 places will be allocated by June 2007. Most jurisdictions began delivering transition care services in 2005-06 (DoHA unpublished).

Indigenous-specific services

Aboriginal and Torres Strait Islander people access mainstream services, as well as those managed by Aboriginal and Torres Strait Islander organisations. There are 29 services funded under the Aged Care Act that operate under the auspices of those organisations, providing 744 places at 30 June 2006. In addition, at 30 June 2006 there were 580 operational flexible aged care places, delivered under the National Aboriginal and Torres Strait Islander Aged Care Strategy. These flexible care places help ensure that Aboriginal and Torres Strait Islander people can access culturally appropriate care services as close as possible to their communities (DoHA unpublished). The Australian Government approved an additional 150 places to be allocated over three years.

Funding

Assessment services

The Australian Government provided grants to State and Territory governments to operate 119 ACATs in 2004-05 (table 12A.54). There were 115 ACATs at 30 June 2006. In 2005-06, the Australian Government provided funding of \$55.5 million

nationally for aged care assessment (table 12A.46). ACAT expenditure per person aged 70 years or over (plus per Indigenous persons aged 50–69 years) was \$28 nationally during 2005-06 (table 12A.47). Some States and Territories also contribute funding for ACATs.

Residential care services

The Australian Government provides most of the recurrent funding for residential aged care services — \$5.3 billion in 2005-06, comprising DoHA expenditure of \$4.5 billion (table 12A.42) and Department of Veterans' Affairs (DVA) expenditure of \$806.5 million (table 12A.44). State and Territory governments also provide some funding for public sector beds. Residents provide most of the remaining service revenue, with some income derived from charitable sources and donations.

Experimental estimates of State and Territory government expenditure have been collected for some states and territories, for three categories of residential care (table 12.1). The categories are defined in section 12.6. The data definitions need further development, so comparisons across jurisdictions need to be made with care.

Table 12.1 Experimental estimates of State and Territory government expenditure on residential aged care 2005-06 (\$ million)

	<i>NSW</i>	<i>Vic^a</i>	<i>Qld^b</i>	<i>WA</i>	<i>SA</i>	<i>Tas^c</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Adjusted subsidy reduction									
supplement	4.3	15.3	5.8	2.3	na	1.5	..	..	29.2
EBA supplement	..	54.0	25.7	..	na	..	..	..	79.7
Rural small nursing home									
supplement	..	5.6	na	4.5	na	10.7	..	0.4	21.1

EBA = enterprise bargaining agreement. ^a Victorian data include payments for both generic aged care places and specialist mental health services. ^b Queensland Health provided approximately \$25.7 million in supplementation. ^c Tasmanian data are for 2005-06 for the adjusted subsidy reduction supplement and rural small nursing home supplement. Rural small nursing home supplement is an estimation based on the average bed day cost across all State operated small rural residential aged care services and recognises extra cost of operating very small services in rural and remote areas together with higher-cost public sector EBA and staffing levels. **na** Not available. **..** Not applicable.

Source: State and Territory governments (unpublished).

The Australian Government annual RCS subsidy for each occupied place varies according to the client's level of dependency. At June 2006, the average annual RCS subsidy per residential place was \$31 009 nationally (table 12.2). Variations in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents. Low care subsidy rates (RCS levels 5–8) are the same in all states and territories. High care subsidy rates (RCS levels 1–4) are being

adjusted towards a uniform national rate by July 2006, under the Australian Government's Funding Equalisation and Assistance Package.

The combined number of operational high care and low care residential places per 1000 people aged 70 years or over at June 2006 was 41.8 and 43.8 respectively on a national basis (table 12.3). Nationally, the proportion of low care places relative to high care places rose between 2002 and 2006 (table 12A.10).

Table 12.2 Average annual Australian Government RCS subsidy per occupied place, and the dependency levels of high care and low care residents, June 2006

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Average annual Australian Government RCS subsidy per residential place ^a										
All RCS levels	\$	31 347	30 673	30 401	30 046	32 480	31 426	31 472	31 472	31 009
Proportion of high care residents ^b										
RCS 1	%	23.7	26.1	17.8	23.7	26.2	18.8	30.6	20.7	23.4
RCS 2	%	26.0	21.2	25.6	21.1	25.3	25.5	16.6	27.7	24.1
RCS 3	%	14.5	13.4	19.0	13.6	16.5	21.6	16.0	21.2	15.4
RCS 4	%	5.4	5.6	6.2	6.3	5.6	6.8	6.0	3.6	5.8
Proportion of low care residents										
RCS 5	%	11.2	13.9	11.1	15.4	10.6	10.4	13.3	6.0	12.2
RCS 6	%	9.4	10.7	9.8	11.0	8.5	8.3	9.6	5.2	9.8
RCS 7	%	9.3	8.6	9.7	8.7	7.1	8.5	7.8	10.9	8.9
RCS 8	%	0.5	0.3	0.8	0.3	0.3	0.1	0.2	4.7	0.5

^a Includes only subsidies based on the RCS. Average Australian government payments, including subsidies and supplements, totalled \$43 952 per high care resident (RCS 1-4), \$15 757 per low care resident (RCS 5-8) and \$34 599 for all permanent residents. ^b Differences in average annual subsidies reflect differences in the dependency of residents.

Source: DoHA (unpublished); table 12A.5.

**Table 12.3 Operational high care and low care residential places,
30 June 2006^{a, b}**

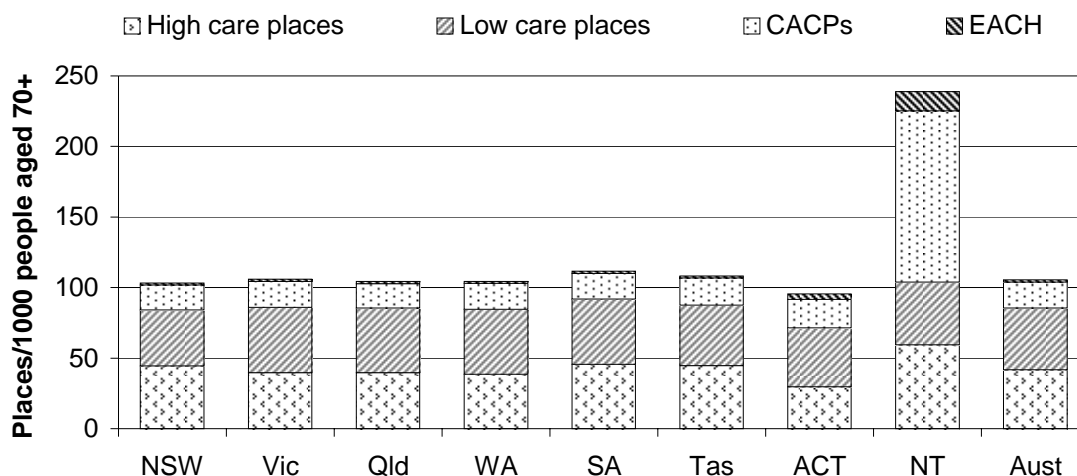
	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Number of places per 1000 people aged 70 years or over										
High care places	no.	44.4	39.7	39.6	38.5	45.6	44.8	29.7	59.5	41.8
Low care places	no.	39.7	46.3	45.9	46.1	46.2	42.8	41.8	44.3	43.8
Total places	no.	84.1	86.0	85.5	84.7	91.8	87.6	71.5	103.8	85.6
Proportion of places										
High care places	%	52.8	46.2	46.3	45.5	49.7	51.1	41.5	57.3	48.8
Low care places	%	47.2	53.8	53.7	54.5	50.3	48.9	58.5	42.7	51.2

^a Excludes places that have been 'approved' but are not yet operational. Includes multi-purpose and flexible services attributed as high care and low care places. ^b For this Report, Australian Government planning targets are based on providing 108 places per 1000 people aged 70 years or over. In recognition of poorer health among Indigenous communities, however, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT).

Source: DoHA (unpublished); table 12A.10.

The combined number of high care residential places, low care residential places, CACPs, EACH packages, EACH dementia packages, other flexible care places and TCP places at 30 June 2006 was 105.8 per 1000 people aged 70 years or older (figure 12.3). The Australian Government's targets for the provision of residential and community care places were outlined previously (box 12.2).

Figure 12.3 Operational residential places, CACPs and EACH packages, 30 June 2006^{a, b, c, d, e}



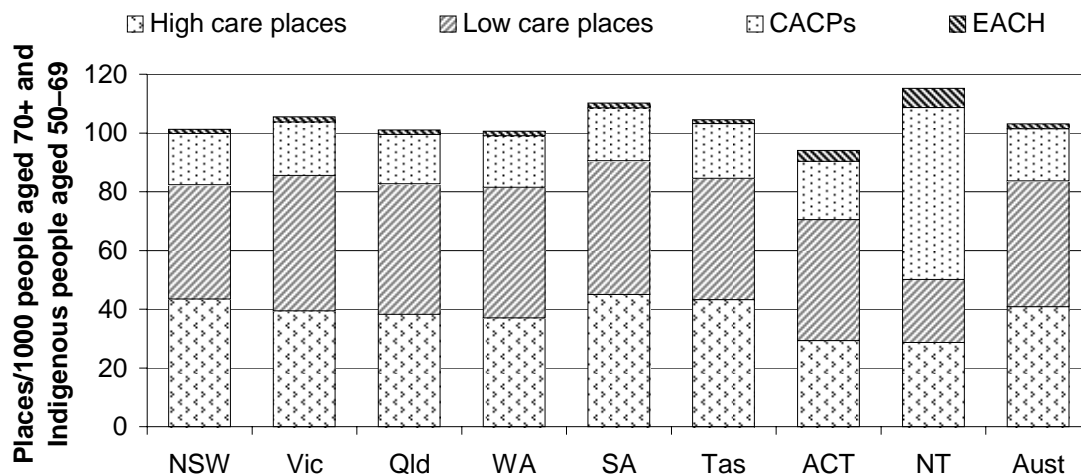
^a Excludes places that have been approved but are not yet operational. ^b 'Ageing in place' may result in some low care places being filled by high care residents. ^c For this Report, Australian Government planning targets are based on providing 108 places per 1000 people aged 70 years or over. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). ^d CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (see boxes 12.1 and 12.2 for an interpretation of residential care data and Australian Government planning targets). ^e EACH Dementia places and TCP are not shown (table 12A.10).

Source: DoHA (unpublished); table 12A.10.

The number of operational places can also be shown using the target population that incorporates Indigenous people aged 50–69 years (figure 12.4). Use of this 'adjusted' target population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Age specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage at 30 June 2005 are reported in tables 12A.57 to 12A.63.

Figure 12.4 **Operational residential places, CACPs and EACH packages adjusted for Indigenous people age 50-69, 30 June 2006^{a, b, c, d, e}**



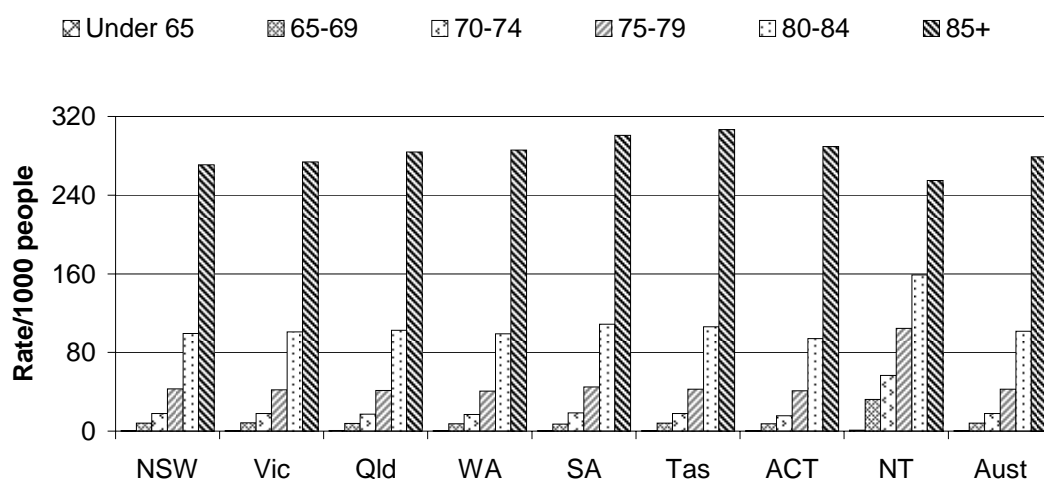
^a Places do not include those that have been approved but are not yet operational. ^b 'Ageing in place' may result in some low care places being filled by high care residents. ^c CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (boxes 12.1 and 12.2 contain an interpretation of residential care data and Australian Government planning targets). ^d CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas with a high Indigenous population (such as the NT) may have a higher proportion of CACPs. ^e EACH Dementia places and TCP places are not shown (table 12A.11).

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

Presentation of age-specific usage rates raises particular data issues. In particular, if the numbers of people within a particular range for a given service are small, this may lead to apparently large fluctuations in growth rates. This can be seen from some of the usage rates identified for the EACH program, which, whilst growing rapidly, is doing so from a relatively small base.

Age-specific rates in this Report are for 2005 due to data unavailability. The national age specific usage rates per 1000 persons for high and low residential care, CACP and EACH in combination at 30 June 2005 is 0.5 for people under 65 rising to 279.1 for people over 85. These rates vary across jurisdictions (figure 12.5).

Figure 12.5 Permanent aged care residents, CACP and EACH recipients at 30 June 2005: age specific usage rates per 1000 persons by jurisdiction^{a, b}

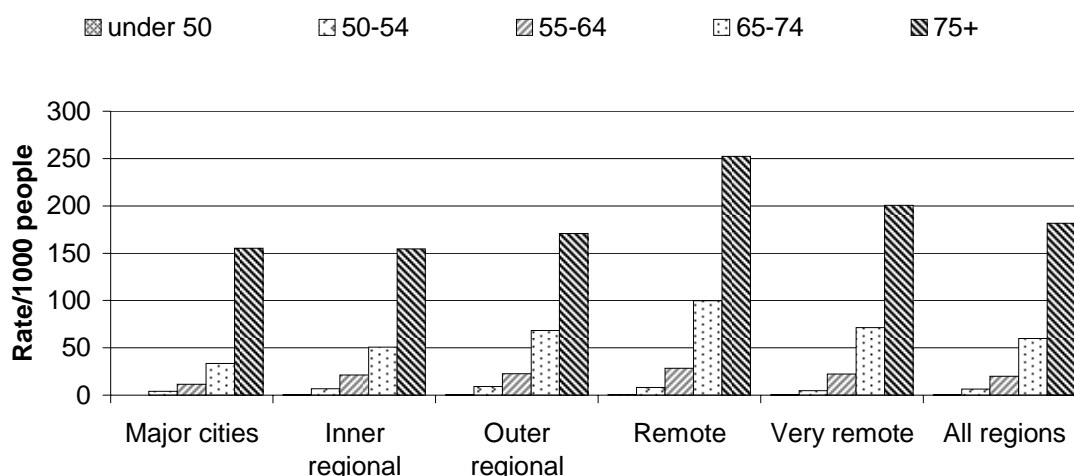


^a Data based on AIHW analysis of the DoHA Australian Community Care Management Information System (ACCMIS) database and ABS population data. ^b Residents without a recorded RCS were omitted.

Source: AIHW (unpublished); table 12A.59.

The national age specific usage rates per 1000 Indigenous persons for high and low residential care and CACP in combination at 30 June 2005 is 0.3 for people under 50 rising to 181.6 for people over 75. The data show that Indigenous people tend to access these services at a younger age than the population as a whole. These rates vary by remoteness category (figure 12.6).

Figure 12.6 Indigenous permanent residents classified as high or low care and Indigenous CACP at 30 June 2005: age specific usage rates per 1000 persons by remoteness^{a, b}



^a Data based on AIHW analysis of ABS data and unpublished DoHA data. The Australian Standard Geographical Classification (ASGC) population figures for the Indigenous population at 30 June 2005 were derived by the AIHW from the 2001 Census ASGC data and the experimental estimates and projections of the Indigenous population which includes age and sex breakdowns by states and territories. ^b Residents without a recorded RCS were omitted.

Source: AIHW (unpublished); table 12A.63.

Community care services

Total government expenditure on HACC was \$1.4 billion in 2005-06, consisting of \$857.8 million from the Australian Government and \$551.1 million from the State and Territory governments. The Australian Government contributed 60.9 per cent, while State and Territory governments funded the remainder (table 12A.43). Recipients of community care services may also contribute towards the cost of their care.

The Australian Government funds the CACP, EACH and EACH Dementia programs, spending \$356.6 million, \$65.3 million and \$1.21 million respectively on the programs in 2005-06 (table 12A.46). CACPs, EACH and EACH Dementia packages are also part funded by client contributions. Australian Government expenditure data by jurisdiction on a range of other community care programs targeting older people are contained in table 12A.46 and data on expenditure per head of the target population by jurisdiction are contained in table 12A.47.

The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was \$139.4 million in 2005-06 (table 12A.46). The DVA also provided \$91.4 million for the VHC program during

2005-06 (table 12A.45), which does not include expenditure for in-home and emergency respite home care. In 2005-06:

- Commonwealth Carer Respite Centres provided an estimated 126 000 occasions of service to assist about 56 000 carers
- Commonwealth Carer Resource Centres assisted about 31 000 carers (DoHA unpublished).

A breakdown of Australian Government expenditure on the NRCP by state and territory is provided in table 12.4.

Table 12.4 Australian Government expenditures, National Respite for Carers Program, by state and territory, 2005-06 (\$million)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>National</i>	<i>Total</i>
Commonwealth Carer Respite Centres										
	16.01	12.02	11.30	4.97	4.74	2.15	1.05	1.64	–	53.88
Respite services										
	25.76	18.68	14.70	7.04	6.74	2.25	1.81	2.33	–	79.31
National projects ^c										
	–	–	–	–	–	–	–	–	6.22	6.22
Total	41.77	30.70	26.00	12.01	11.48	4.40	2.86	3.97	6.22	139.41

^a Commonwealth Carer Respite Centres coordinate respite services, help carers access them, and arrange individual respite when needed. ^b Respite services reports funding for services directly providing respite care.

^c National project is for Carers Australia.

– Nil or rounded to zero.

Source: DoHA (unpublished)

Size and scope of sector

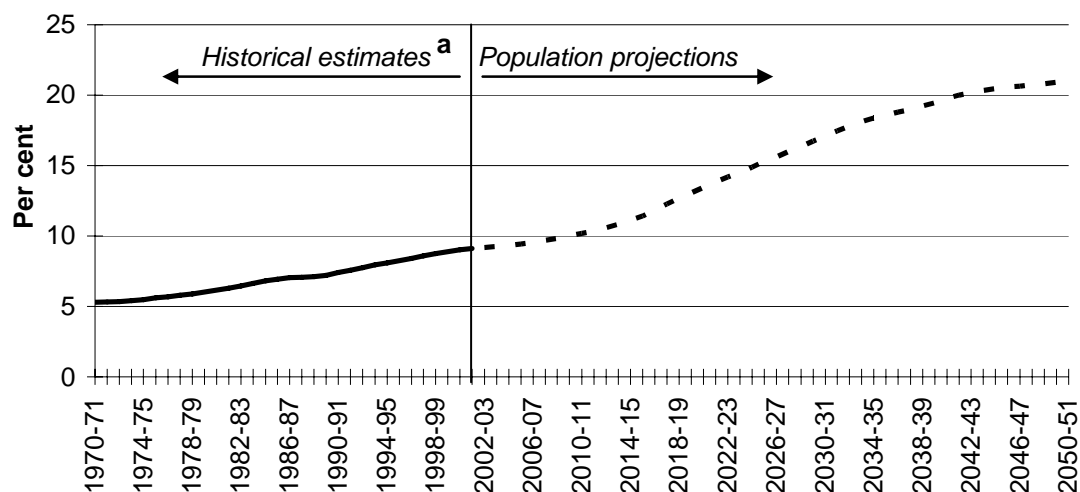
Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of people aged 70 years or over in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically in the 21st century (figure 12.7). The proportion of older people is 9.4 per cent nationally but varies across jurisdictions (figure 12.8). A breakdown by locality is provided in attachment table 12A.3. Higher life expectancy for females resulted in all jurisdictions having a higher proportion of older females than older males.

Demographic profiles affect the demand for aged care services because females use aged care services (particularly residential services) more than males. Females are more likely to use residential services partly because they tend to live longer (that

is, there are more women than men in the older population) and they are less likely to have a partner to provide care.

Figure 12.7 Persons aged 70 years or over as a proportion of the total population



^a Historical estimates are based on the ABS Census of Population and Housing that is held at five year intervals.

Source: ABS States and Population by Age and Sex (unpublished); ABS Population Projections (unpublished).

Figure 12.8 Estimated proportion of population aged 70 years or over, by gender, June 2006

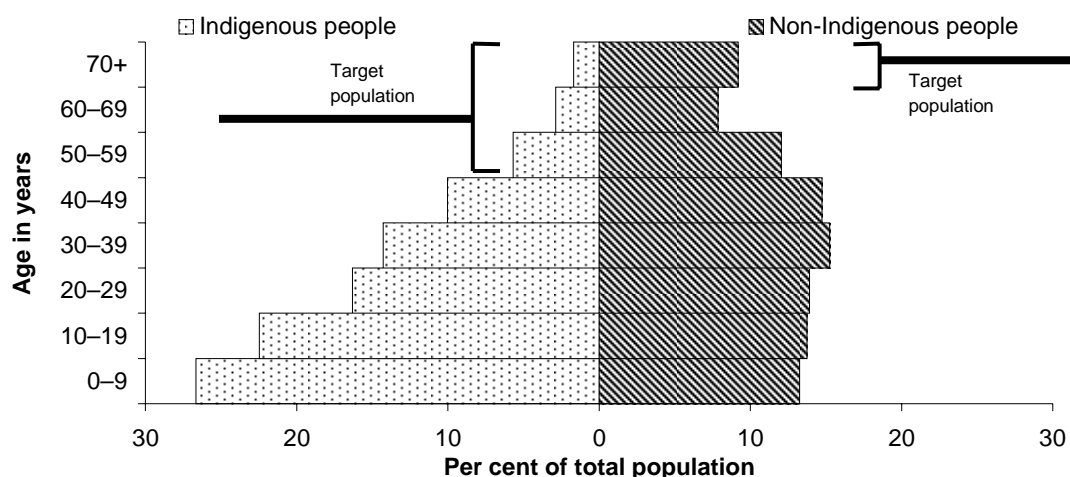


Source: ABS Population Projections by Statistical Local Area (SLA) 2002–2022 (unpublished); table 12A.1.

Characteristics of older Indigenous people

The ABS estimates that about 54 100 Indigenous people were aged 50 years or over in Australia at 30 June 2006 (table 12A.2). Although the Indigenous population is also ageing, there are marked differences in the age profile of Indigenous Australians compared with non-Indigenous Australians (figure 12.9). The ABS estimates that for both males and females, life expectancy at birth in the Indigenous population is around 17 years less than in the total Australian population (2004b). These figures indicate that Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 12.9 Age profile and target population differences between Indigenous and other Australians, June 2001



Source: ABS (2004c).

Residential care services

The size and location of residential services — which may influence the costs of service delivery — vary across jurisdictions. Nationally, there were 163 468 mainstream operational places in residential care services (72 886 in predominantly high care services, 19 293 in predominantly low care services and 71 289 in services with a mix of high care and low care residents) at June 2006 (tables 12A.6–9). These figures exclude flexible care places in a residential setting.

As the trend towards ‘ageing in place’ (box 12.3) increases, there has been a steady increase in the number of services categorised as providing a mix of high care and low care places. In June 2002, 30.5 per cent of all places were located in services offering both high care and low care places. This proportion increased to

36.5 per cent of places in June 2003 and then decreased to 33.4 per cent of places in June 2004, but increased to 39.6 per cent in June 2005 and 43.6 per cent in June 2006 (tables 12A.6 and 12A.9; SCRCSSP 2003; SCRGSP 2004, 2005, 2006).

Box 12.3 Ageing in place in residential care

In its Objects, the *Aged Care Act 1997* (Cwlth) aims to:

... encourage diverse, flexible and responsive aged care services that:

- (i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and*
- (ii) facilitate the independence of, and choice available to, those recipients and carers.*

Further, the *Aged Care Act* explicitly aims to encourage and facilitate 'ageing in place'. The Act does not define 'ageing in place', but one useful definition is 'the provision of a responsive and flexible care service in line with the person's changing needs in a familiar environment'. In effect, 'ageing in place' refers to a resident remaining in the same residential aged care service as his or her care needs increase from low level to high level. This is changing the profile of people in services.

The *Aged Care Act* does not establish any 'program' or require any residential aged care service to offer ageing in place. Rather, it creates the opportunity for providers to choose to provide the full continuum of care, by removing the legislative and administrative barriers that prevented this outcome in the past.

The concept of 'ageing in place' is linked to the outcomes of increasing choice and flexibility in residential aged care service provision. These are difficult outcomes to measure. Data on 'ageing in place' is reported for the indicator 'intensity of care'.

Source: DoHA (unpublished).

The client profile of services that had predominantly low care residents in 2000 has changed over time, with low care residents staying in their current service as their dependency levels rise, and with aged care services expanding and diversifying. Low care services are generally smaller (as measured by number of places) than high care services. At June 2006, 64.9 per cent of low care services had 60 or fewer places (table 12A.8), compared with 46.9 per cent of high care services (table 12A.7).

Age specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage at 30 June 2005 are included in the Report at tables 12A.57 to 12A.63.

Community care services

Services provided under the HACC program include domestic assistance and home maintenance, personal care, food services, respite care, transport, allied health care and community nursing (box 12.4).

Box 12.4 HACC Services

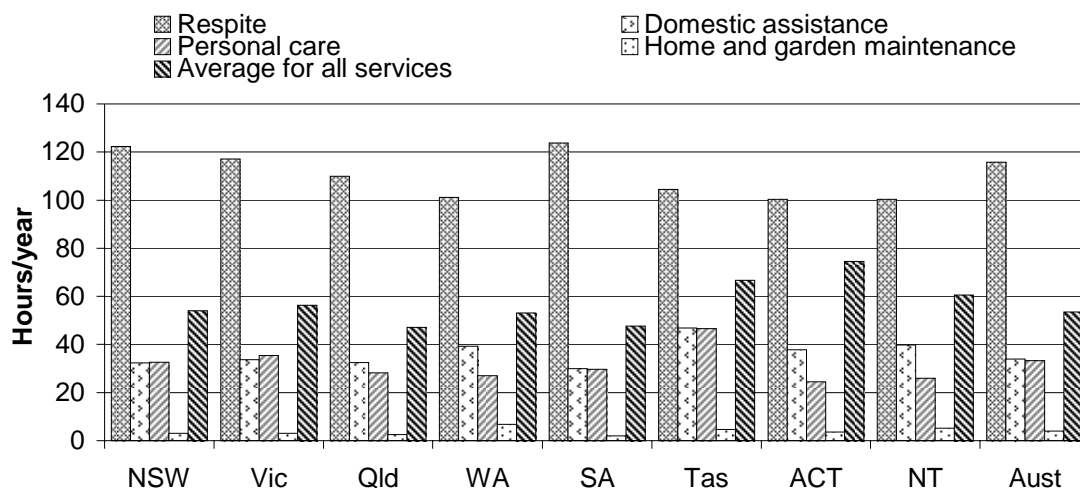
HACC services are basic maintenance and support services, including allied health care, assessment, case management and planning, centre-based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, personal and respite care, social support, meals, home modification, linen service, goods and equipment, and transport.

Not all HACC services are directed towards the ageing population described in this chapter. The target population is defined as people living in the community who are at risk, without these services, of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with a disability, and their carers.

Figure 12.16 provides a more detailed breakdown of the age structure of HACC recipients. Approximately 68 per cent of the program's recipients are aged 70 years or over, but the program is also an important source of community care for younger people with a disability and their carers with nearly 12 per cent of recipients under 50 years (table 12A.33). (Chapter 13 covers services for people with a disability, which manifests before the age of 65 years, that were provided under the Commonwealth State/Territory Disability Agreement.)

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 78 539 people approved for VHC services in 2005-06 (table 12A.45). The program offers veterans and war widows/widowers who hold a Gold or White Repatriation Health Card home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport, social support and delivered meals, are also available under the DVA's arrangements with State and Territory governments. Eligibility for VHC services is not automatic, but based on assessed need. The average number of hours approved per year for veterans who were eligible to receive home care services was 53.52 nationally in 2005-06 (figure 12.10).

Figure 12.10 **Average number of hours approved for Veterans' Home Care, 2005-06^a**



^a VHC recipients fall into two categories: those veterans who transferred to the VHC program from the HACC program (transitional veterans) and those that did not (non-transitional veterans). The number of hours approved per year is for non-transitional veterans and relates to services that were approved to occur in 2005-06. The average for all services takes into account relative usage of each service.

Source: DVA (unpublished); table 12A.45.

Provision of CACPs is an alternative home-based service for older people assessed by ACATs as eligible for care equivalent to low level residential care (RCS levels 5–8). A CACP typically provides 5-6 hours of direct assistance per week. The EACH program is similar to the CACP program but targets people who would otherwise be eligible for high level residential aged care. An EACH package typically provides 15–20 hours of direct assistance each week. The main distinctions between the HACC, CACP and EACH programs are summarised in table 12.5.

Table 12.5 Distinctions between the HACC, CACP and EACH programs

	<i>HACC</i>	<i>CACPs</i>	<i>EACH</i>
Range of services ^a	Wider range of services available	Narrower range of services available	Narrower range of services available
Relationship to residential care	Aims to prevent premature or inappropriate admission	Substitutes for a low care residential place	Substitutes for a high care residential place
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory	ACAT assessment mandatory
Funding	Cost shared by the Australian, State and Territory governments and client contributions	Funded by the Australian Government and client contributions	Funded by the Australian Government and client contributions
Target client groups ^b	Available to people with profound, severe and moderate disability and their carers. Not age specific.	Targets older people with care needs similar to low level residential care	Targets older people with care needs similar to high level residential care
Size of program	\$1.4 billion funding in 2005-06 At least 793 472 clients in 2005-06 ^c	\$356.6 million funding in 2005-06 35 316 operational places at 30 June 2006 ^d	\$65.3 million funding in 2005-06 2575 operational places at 30 June 2006

^a HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. ^b Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care — for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have levels of need that would exceed the level available under CACPs and EACH. ^c Based on 83 per cent of HACC funded agencies that submitted Minimum Data Set data for 2005-06. Consequently, the total number of clients will be higher than those reported here. ^d Excludes flexible care delivered in a community setting.

Source: DoHA (unpublished).

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards home-based care — have meant that the HACC, VHC, CACP and EACH programs have become increasingly important components of the aged care system. During 2005-06, the HACC program delivered approximately 12 194 hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years (table 12A.20). The total number of CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2002 and June 2006, from 14.7 to 17.8 (table 12A.11).

12.2 Framework of performance indicators

The framework of performance indicators aims to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the general performance indicator framework and service process diagram outlined in chapter 1 (see figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicators relate to government objectives in the aged care sector (box 12.5). At this stage, no outcome indicators are reported for aged care services.

Box 12.5 Objectives for aged care services

The aged care system aims to promote the wellbeing and independence of frail older people and their carers through the funding and delivery of care services that are:

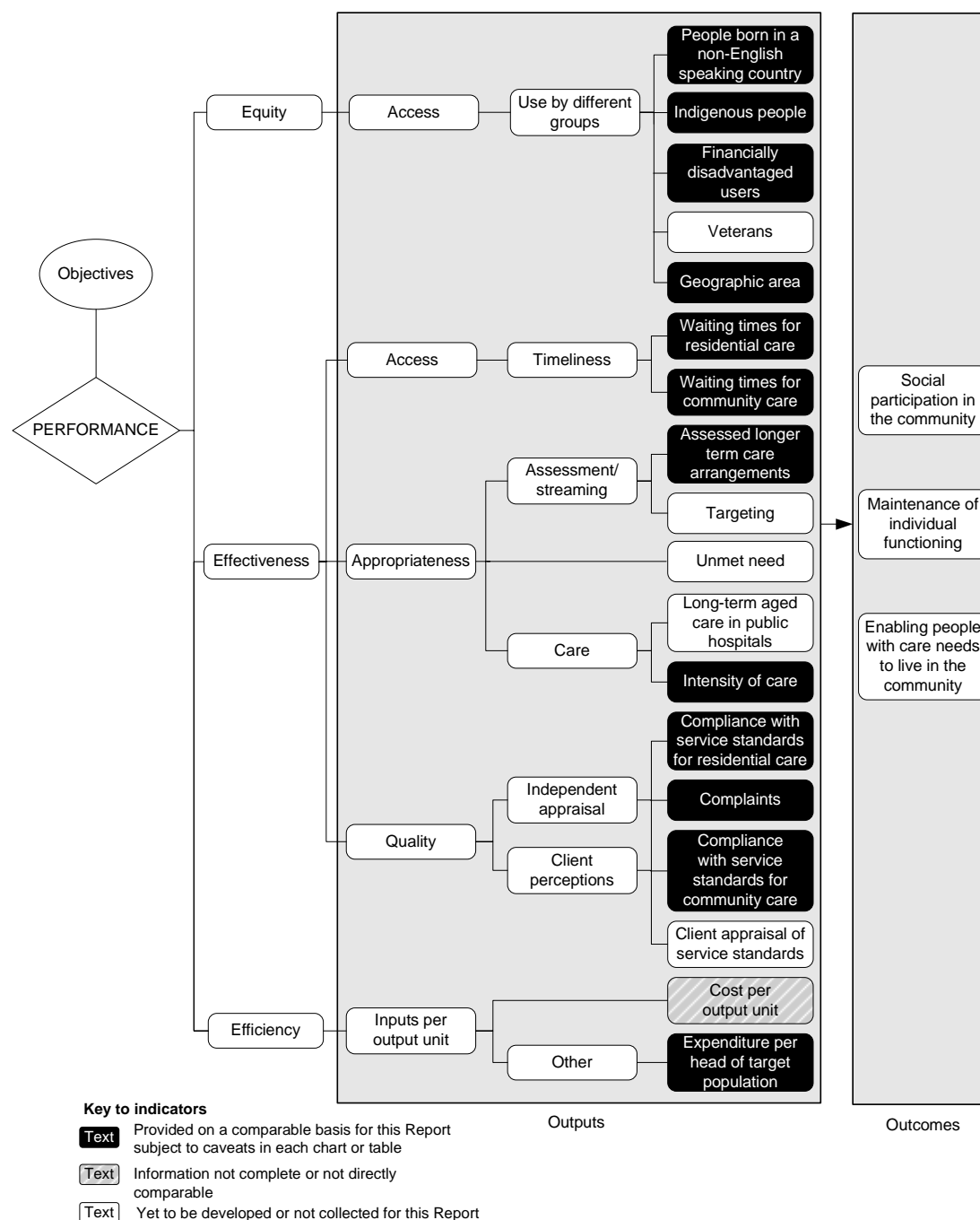
- accessible
- appropriate to needs
- high quality
- efficient.

The performance indicator framework shows which data are comparable in the 2007 Report (figure 12.11). 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).

12.3 Key performance indicator results

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

Figure 12.11 Performance indicators for aged care services



Outputs

Equity — Access

Use by different groups

‘Use by different groups’ is an output indicator of equity (box 12.6).

Box 12.6 Use by different groups

A key national objective of the aged care system is to provide equitable access to aged care services for all people who require these services. ‘Use by different groups’ is a proxy indicator of equitable access. Various groups are identified by the Aged Care Act and its principles (regulations) as having special needs, including people from Indigenous communities, people born in non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans (including widows and widowers of veterans). The indicator is reported for each special needs group except veterans, using the following definitions:

- the number of people born in non-English speaking countries using residential services, CACPs, EACH and HACC services, divided by the number of people born in non-English speaking countries aged 70 years or over benchmarked against the rate at which the general population accesses the service
- the number of Indigenous people using residential services, CACP, EACH and HACC services, divided by the number of Indigenous people aged 50 years or over (because Indigenous people tend to require aged care services at a younger age than the general population) benchmarked against the rate at which the general population accesses the service
- for financially disadvantaged users — access to residential services is defined as the number of new residents classified as concessional or assisted divided by the number of new residential places
- for people living in rural and remote areas — the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years for major cities, inner regional areas, outer regional areas, remote areas and very remote areas
- the rate of contacts with Commonwealth Carelink Centres for Indigenous people compared with all people.

(Continued on next page)

Box 12.6 (Continued)

In general, usage rates for special needs groups similar to those for the broader aged care population are desirable, but interpretation of results differs for some special needs groups because:

- there is evidence that Indigenous people have higher disability prevalence rates than those of the general population, which suggests a greater level of need for services compared with those in the broader aged care population
- for financially disadvantaged users, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional residents. These targets range from 16 per cent to 40 per cent of new places, depending on the service's region. Usage rates equal to or higher than the minimum rates are desirable.

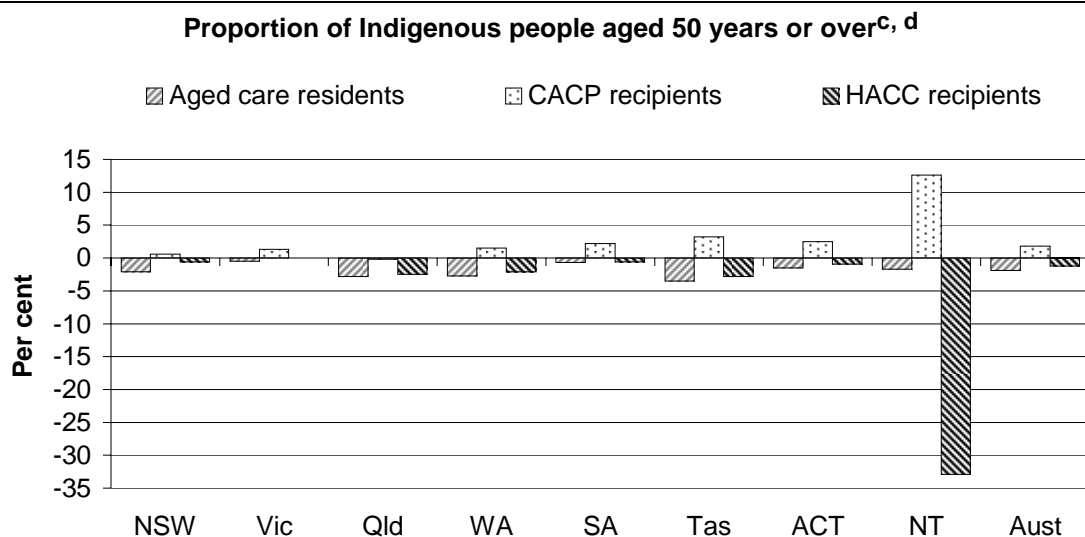
Several factors need to be considered in interpreting the results for this set of indicators:

- Cultural differences may influence the extent to which people born in non-English speaking countries use different types of services.
- Cultural differences and geographic location may influence the extent to which Indigenous people use different types of services.
- The availability of informal care and support may influence the use of aged care services in different population groups.

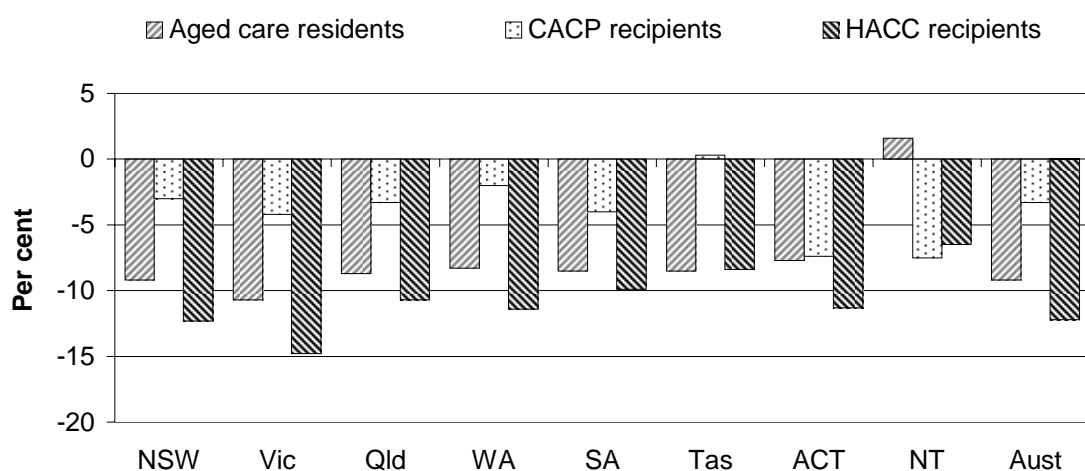
Access to residential services by recipients from special needs groups

The proportion of Indigenous aged care recipients and those born in a mainly non-English speaking country accessing aged care services at 30 June 2006, with the exception of the NT, was lower across the jurisdictions than their proportion of the population as a whole. Figure 12.12 reflects the variation in the rate of access of the special needs target population from their proportion in the population as a whole. If the special needs group accessed services at the same rate as the general population, all bars in the chart would be at zero. If they access services at a greater rate the bar would be positive, if they access services at a lower rate, the bar would be negative (figure 12.12). Care should be taken in interpreting this figure as the magnitude of variations are also influenced by the proportion of the special needs group in the population as a whole (table 12A.18).

Figure 12.12 **Variation in the rate of access of the special needs target population from their proportion in the population as a whole, June 2006 (per cent)^{a, b}**



Proportion of residents born in a mainly non-English speaking country aged 70 years or over^e



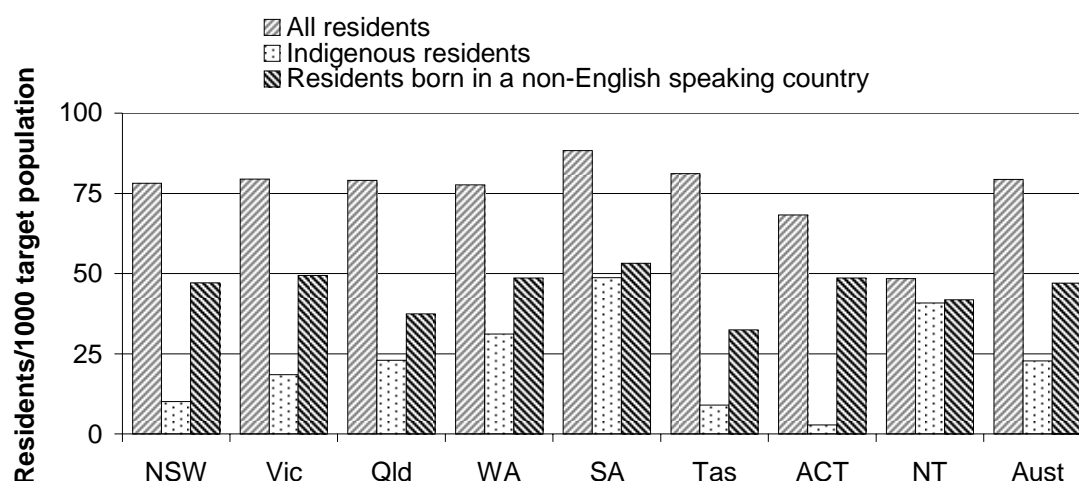
^a The proportion of a HACC agencies that submitted data for the year varied between jurisdictions and actual service levels were higher than stated. ^b Reports provisional HACC data that have not been validated and may be subject to revision. ^c Charts Indigenous aged care residents, CACP recipients and HACC clients as a proportion of all aged care residents, CACP recipients and HACC clients respectively. ^d The magnitude of the variation in the NT partly reflects the relatively large proportion of Indigenous people in the population. ^e Charts aged care residents, CACP recipients and HACC clients from a non-English speaking country as a proportion of all aged care residents, CACP recipients and HACC clients respectively.

Source: DoHA (unpublished); tables 12A.18.

In all jurisdictions at 30 June 2006, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential

services (22.8 and 47.0 per thousand of the relevant target populations respectively), compared with the population as a whole (79.3 per thousand) (figure 12.13).

Figure 12.13 Residents per 1000 target population, 30 June 2006^{a, b, c}



^a All residents data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years.

^b Indigenous residents data are per 1000 Indigenous people aged 50 years or over. ^c Data for residents from a non-English speaking country are per 1000 people from non-English speaking countries aged 70 years or over.

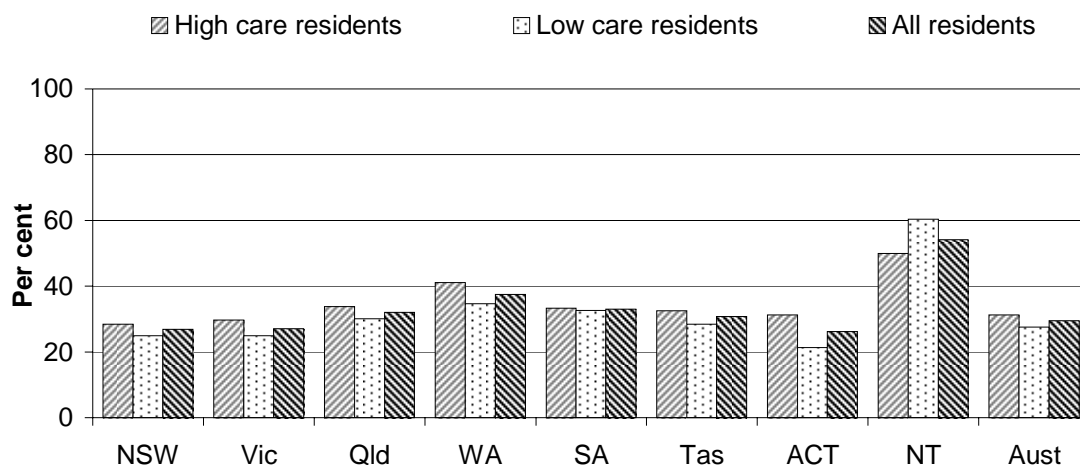
Source: DoHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Age specific usage rates for these services, by jurisdiction and remoteness are included in the Report. These data suggest there is significant variation in usage rates by remoteness area. In general, differences amongst jurisdictions are less marked than differences between remoteness area (tables 12A.13, 12A.15, 12A.17, 12A.57, 12A.59, 12A.60, 12A.62 and 12A.63).

Access to services by financially disadvantaged users

The proportion of all new residents classified as concessional or assisted residents during 2005-06 was 29.5 per cent nationally but varied across jurisdictions (figure 12.14). A decline in the proportion of concessional and assisted residents over the past few years is due to the Australian Government concessional validation program which finished on 30 June 2005 and since then to assets testing undertaken by Centrelink and the Department of Veterans' Affairs.

Figure 12.14 New residents classified as concessional or assisted residents, 30 June 2006^a



^a Concessional residents are those who receive an income support payment and have not owned a home for the previous two or more years (or whose home is occupied by a 'protected' person, such as the care recipient's spouse or long term carer), and have assets of less than 2.5 times the annual single basic age pension. Assisted residents are those meeting the above criteria, but with assets between 2.5 and 4.0 times the annual single basic age pension.

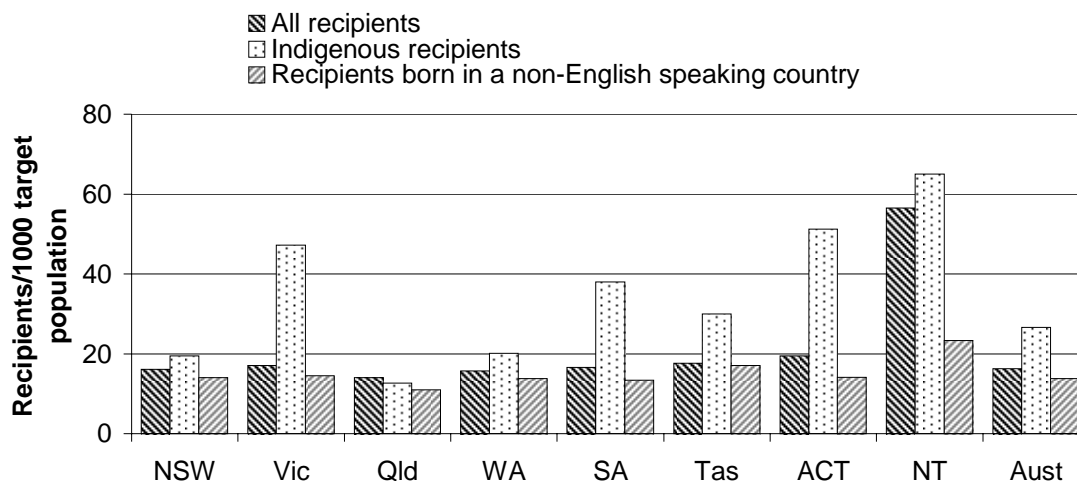
Source: DoHA (unpublished); table 12A.19.

Access to community aged care packages

The number of CACP recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years has grown in recent years, but is still small relative to the number of recipients of residential care. At June 2006, 16.3 per 1000 of the target population received CACP services compared with 79.3 recipients of residential care, although this varied across jurisdictions (table 12A.12).

The number of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over was 26.6 nationally and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 13.8 nationally (figure 12.15).

Figure 12.15 **Community Aged Care Package recipients per 1000 target population, 30 June 2006^{a, b, c, d, e}**



^a All recipients data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. ^b Indigenous recipients data are per 1000 Indigenous people aged 50 years or over. ^c Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 70 years or over. ^d The ACT has a very small Indigenous population aged 50 years or over (table 12A.2), and a small number of packages will result in a very high provision ratio. ^e CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas such as the NT have a higher rate of CACP recipients per 1000 people.

Source: DoHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Age-sex specific usage rates for CACP and EACH, by jurisdiction, remoteness and Indigenous usage vary between jurisdictions and remoteness categories for CACP. For EACH, the differences are less marked. However, the EACH program is small but growing rapidly (tables 12A.58–64).

Access to the Home and Community Care program

Home and Community Care services are provided in the client's home or community for people with a severe, profound or moderate disability and their carers. The focus of this chapter is people 70 years and over and Indigenous people aged over 50.

The proportion of HACC recipients aged 70 years or over during 2005-06 was 68.2 per cent (table 12A.32). The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years was 12 194 nationally, and the number of meals provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 was 5380 nationally (table 12.6). HACC agencies that submitted the data as a proportion of all HACC agencies varies across jurisdictions so comparisons between jurisdictions should be made with care.

Table 12.6 HACC services received, 2005-06 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)^{a, b, c}

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA^d</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Percentage of agencies that reported MDS data	%	81	90	91	97	89	83	100	94	86
Total hours ^e										
Major cities	hrs.	8 582	13 950	11 940	16 797	9 083	..	10 750	..	11 621
Inner regional	hrs.	9 190	19 462	10 597	16 458	6 953	10 179	..	..	12 420
Outer regional	hrs.	10 888	27 887	11 004	17 906	6 927	9 852	..	7 544	13 130
Remote	hrs.	13 963	27 675	11 736	16 934	13 430	12 538	..	23 083	14 950
Very remote	hrs.	9 717	..	16 052	21 404	26 886	26 721	..	52 365	25 232
All areas	hrs.	8 522	16 114	11 533	16 976	8 840	10 216	10 770	20 625	12 194
Total meals ^f										
Major cities	no.	4 491	5 328	5 289	5 686	957	..	3 873	..	4 637
Inner regional	no.	6 687	8 832	5 455	5 928	477	5 475	..	..	6 407
Outer regional	no.	8 089	8 879	5 419	5 376	1 435	7 040	..	9 132	6 346
Remote	no.	7 605	5 028	5 493	7 405	1 875	5 826	..	18 994	6 739
Very remote	no.	1 791	..	8 844	19 769	8 456	7 813	..	53 066	19 738
All areas	no.	5 295	6 333	5 430	6 064	1 041	6 022	3 882	20 866	5 380

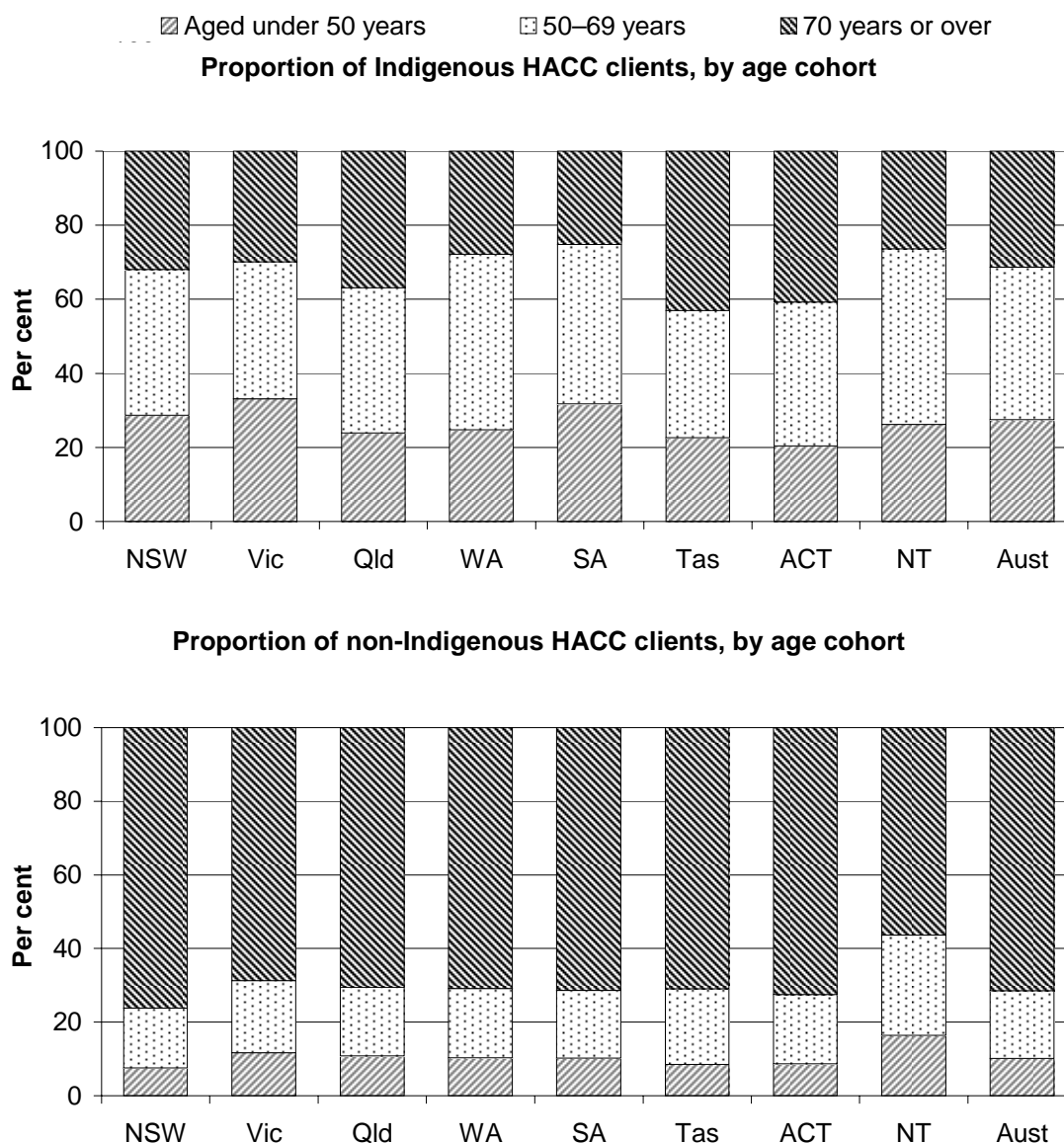
^a Data represent HACC services received by people aged 70 years or over plus Indigenous people aged 50–69 years (tables 12A.20–12A.25) as distinct from HACC services received by HACC target population in all age groups (tables 12A.26–12A.31). ^b The proportion of HACC agencies that submitted data for the year varied between jurisdictions and actual service levels were higher than stated. ^c Reports provisional HACC data that have not been validated and may be subject to revision. ^d The number of meals may be understated in SA due to slow implementation of the Minimum Data Set by Meals on Wheels. ^e See table 12A.20 for a full list of categories. ^f Includes home meals and centre meals.

.. Not applicable.

Source: DoHA (unpublished); tables 12A.20–12A.25.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2005-06. This reflects the difference in morbidity and mortality trends between Indigenous people and the general population. The proportion of Indigenous HACC clients who are aged 70 years and over is 31.3 per cent and the proportion of non-Indigenous HACC clients who are aged 70 years and over is 71.5 per cent (figure 12.16). The high rate of missing data for Indigenous people will also inflate the figures presented.

Figure 12.16 Recipients of HACC services by age and Indigenous status, 2005-06^a



^a Reports provisional HACC data that have not been validated and may be subject to revision.

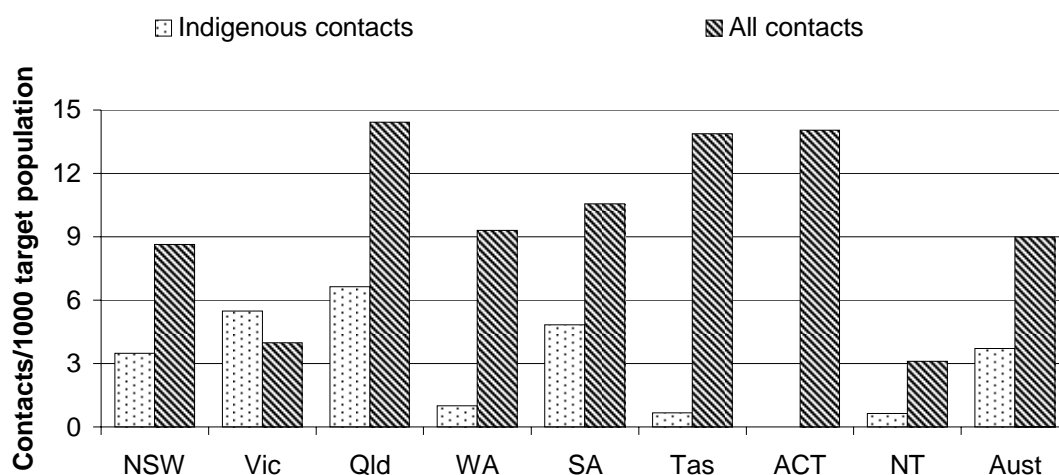
Source: DoHA (unpublished); table 12A.33.

Access by Indigenous people to Commonwealth Carelink Centres

Commonwealth Carelink Centres are information centres for older people, people with disabilities and those who provide care and services. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. The national rate at which Indigenous people

contacted Carelink Centres at 30 June 2006, was 3.7 people per 1000 Indigenous people in the target population. The rate for all Australians was 9.0 per 1000 people in the target population. These figures varied across jurisdictions (figure 12.17).

Figure 12.17 **Commonwealth Carelink Centres, contacts per 1000 target population, by Indigenous status, 30 June 2006^{a, b, c}**



^a Contacts with Carelink include phone calls, visits, emails and facsimiles. ^b Indigenous contacts refer to contacts by Indigenous people per 1000 Indigenous people in the target population. ^c All contacts refers to contacts per 1000 target population.

Source: DoHA (unpublished); table 12A.55.

Effectiveness

Timeliness of access — waiting times for residential care

The indicator ‘waiting times for residential care’ is an output indicator of effectiveness (box 12.7).

Box 12.7 Waiting times for residential care

‘Waiting times for residential care’ is an output measure of effectiveness, reflecting the timeliness with which people are able to access residential care.

The indicator ‘elapsed time between ACAT approval and entry into residential care service’ measures the period between a client’s approval for care and his or her entry into care and is defined as the percentage of people who are admitted to residential care within three months of their ACAT approval. The relevant terms are defined as follows:

- ACAT approval — the approval date of an ACAT assessment
- entry into a residential care service — the date of admission to a residential care service.

Shorter waiting times (measured by higher rates of admission to residential care within three months of ACAT approval) are desirable.

This indicator needs to be interpreted with care. It may be influenced by a range of factors, such as:

- clients with ACAT assessments who do not enter residential care (for example, who die before entering care)
- residential placement offers that are not accepted
- the availability of alternative community care, informal care and respite services
- the availability and distribution of operational residential care services
- building quality and perceptions about quality of care, which influence client choice of preferred service
- delays between the date of ACAT assessments and their approval
- priority allocations (for example, special needs groups)
- hospital discharge policies and practices.

The Steering Committee acknowledges the limitations of the current indicator (box 12.8) and supports redevelopment for improvement. The current indicator will continue to be reported until improved data are available.

Box 12.8 Entry period for residential care

The Australian Institute of Health and Welfare (AIHW) conducted a detailed study of 1999-2000 ACAT assessment data and entry into residential care (AIHW 2002). The 'entry period' is the time between ACAT assessment of a person as eligible for residential aged care, and that person's entry into a residential aged care service.

The study found that one of the main determinants of a short entry period is whether the resident has an ACAT assessment performed while in hospital rather than when living at home. A longer entry period is also strongly related to whether the resident used a CACP or residential respite care before admission.

Recommendations for residential care remain active for 12 months. Some people assessed by an ACAT and recommended for residential aged care may not take up a residential place within this period. People often do not act on the recommendation immediately. They may believe they are capable of continuing to manage at home and that they do not need admission. Others receive recommendations for both residential aged care and a CACP, and take up the latter.

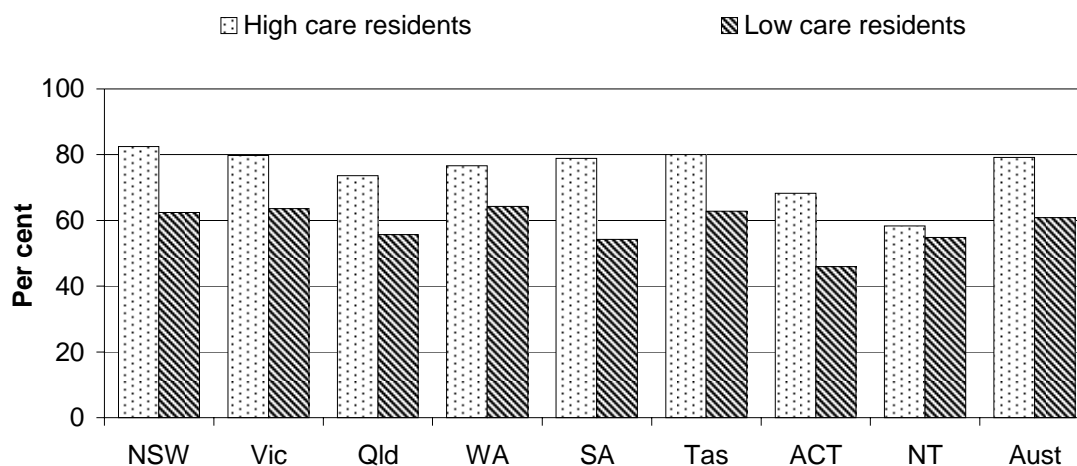
The AIHW found that many factors affect the entry period but are not linked to the performance of the aged care system. It recommended that the entry period for residential care not be used as a performance indicator.

Source: AIHW (2002).

Overall, 72.0 per cent of all people entering residential care during 2005-06 did so within three months of being assessed by an ACAT, and 45.8 per cent entered within one month of their ACAT assessment (table 12A.36). In the calculation of entry period, the most recent ACAT assessment prior to entry is used.

Nationally, a greater proportion of people entering high care residential services entered within three months of assessment (79.2 per cent), compared with the proportion entering low care residential services within that time (60.9 per cent). The proportion of people entering high care residential services within three months of being assessed and the proportion of people entering low care residential services within three months of being assessed varied across jurisdictions (figure 12.18).

Figure 12.18 People entering residential care within three months of their ACAT assessment, 2005-06



Source: DoHA (unpublished); table 12A.36.

Timeliness of access — waiting times for community care

The indicator 'waiting times for community care' is an output indicator of effectiveness (box 12.9) and reported using CACP data.

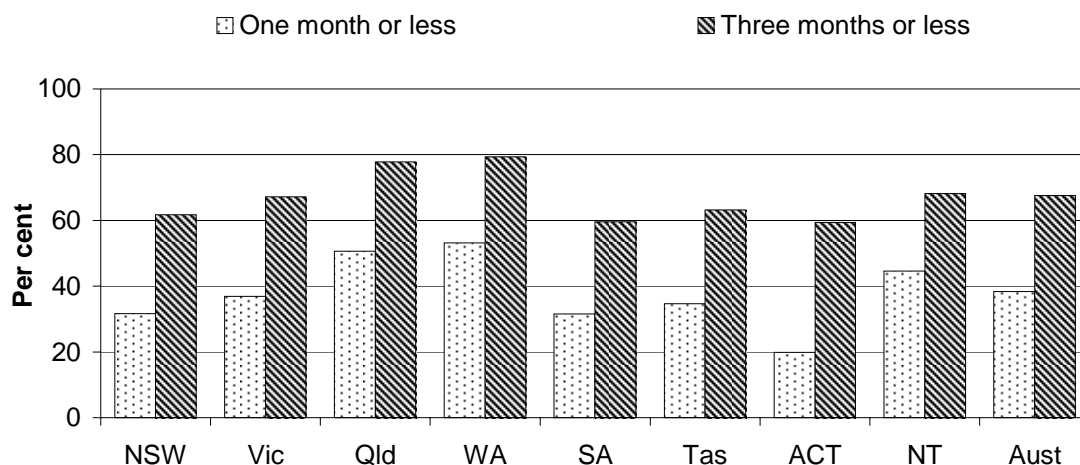
Box 12.9 Waiting times for community care

'Waiting times for community care' is an output measure of effectiveness and reflects the timeliness with which people are able to access CACPs. The indicator measures the period between a client's approval for care and his or her receipt of care, and is defined as the elapsed time between an ACAT approval and receipt of a CACP. Shorter waiting times (or higher rates of receipt of a CACP within one month or within three months of an ACAT approval) are considered desirable.

This indicator needs to be interpreted with care. Some ACAT assessed clients may choose not to receive a CACP, alternative community care options may be available, or varying fee regimes might influence choice.

Overall, 67.6 per cent of all people receiving a CACP during 2005-06 received it within three months of being assessed by an ACAT. This proportion varied across jurisdictions (figure 12.19). On average, 38.4 per cent started receiving a CACP within one month of their ACAT assessment (table 12A.36).

Figure 12.19 People commencing a CACP within one or three months of their ACAT assessment, 2005-06



Source: DoHA (unpublished); table 12A.36.

Appropriateness — assessed longer term care arrangements

The indicator ‘assessed longer term arrangements’ is an output indicator of effectiveness (box 12.10) that measures the proportion of clients referred to community care, compared to residential care.

Box 12.10 Recommended longer term living arrangements

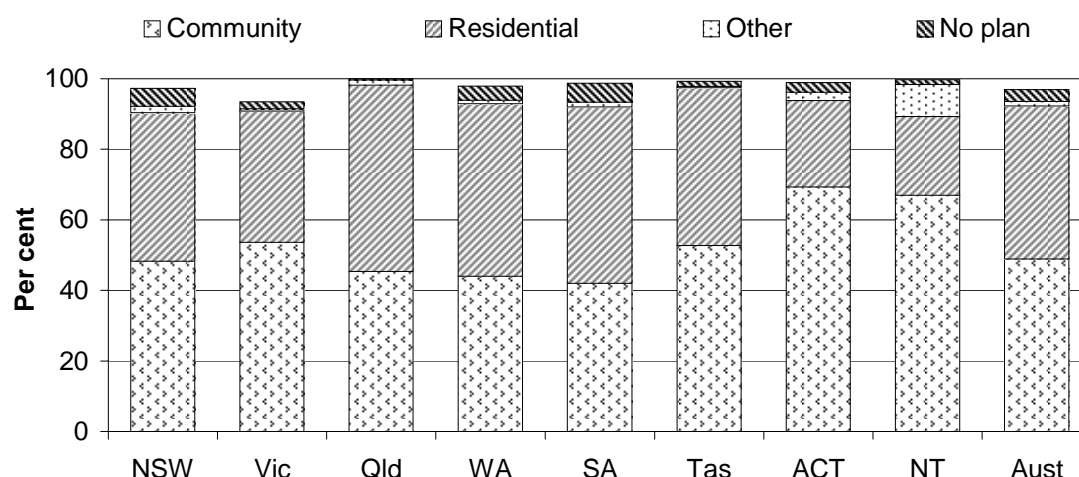
‘Assessed longer term living arrangements’ is an indicator of appropriateness. The purpose is to measure how effectively clients are allocated to the services that best meet their needs.

This indicator is defined as the proportion of ACAT clients recommended to remain at home or in residential care (permanent or respite). (Aged care assessments are mandatory for admission to residential care or for receipt of a CACP or an EACH package.)

The results for this indicator show the distribution of recommended living arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions may reflect external factors such as geographic dispersion of clients and service availability, but also client preferences and views on the types of client best served by community-based services. The distribution of ACAT recommendations for various living arrangements are influenced by the degree to which any pre-selection process refers people requiring residential care to ACATs for assessment. Jurisdictions with lower overall assessment rates may operate a filtering process to focus assessments on individuals who are more likely to require residential care.

The national proportion of ACAT clients referred to residential care in 2004-05 was 43.4 per cent and the proportion remaining in the community was 48.9 per cent. No long term plan was made for 3.3 per cent, which included deaths, cancellations and transfers. These proportions vary across jurisdictions (figure 12.20).

Figure 12.20 **Recommended longer term living arrangements of ACAT clients, 2004-05^a**



^a 'No plan' includes deaths, cancellations and transfers.

Source: DoHA (unpublished); table 12A.37.

Appropriateness — targeting

The 'targeting' indicator has not yet been developed (box 12.11).

Box 12.11 Targeting

The Steering Committee has identified 'targeting' as an indicator of appropriateness. It will be developed for reporting in the future.

Appropriateness — unmet need

The indicator 'unmet need' is an output indicator of effectiveness (box 12.12).

Box 12.12 **Unmet need**

‘Unmet need’ is an appropriateness indicator. The purpose of the indicator is to measure the extent to which demand for services to support older people requiring assistance with daily activities is met.

Defining and determining the level of need at an individual level, let alone at a population level, are complex tasks. Perceptions of need and unmet need are often subjective. Data for this indicator are drawn from the ABS 2003 Survey of Disability, Ageing and Carers and reflect people aged over 65 years who self-identified as having a need for assistance with at least one everyday activity, and the extent to which that need was met (fully, partly or not at all).

While low rates of unmet need are theoretically desirable, direct inferences about the demand for services from these data need to be made with care, because the data do not:

- reveal the intensity of care required by those who identify an unmet need — there is no indication of whether the need can readily be met informally or by formal home care, or whether the person may require residential care
- reflect the degree of unmet demand for a specific type of service. Differences across jurisdictions in the proportion of unmet need can reflect different policy approaches to targeting services. Some governments may choose to focus on those with the greatest degree of need for care and on fully meeting their needs. By contrast, other governments may choose to provide a lower level of service to a greater number of people, while only partly meeting the needs of those with the greatest need for care. Both policy approaches to the targeting of services are valid
- reflect the past and possible future duration of the need — that is, whether it is long term or transitory
- reflect whether the need relates to a disability support service, aged care service or medical care, and thus whether it is a State, Territory or Australian Government responsibility.

Persons aged 65 years or over and who were living in households, who needed assistance with at least one everyday activity in 2003 and whose needs for assistance were not met comprised over one third (35.7 per cent) of all those needing assistance (table 12.7).

Table 12.7 Older persons needing assistance with at least one everyday activity: extent to which need was met, 2003^a

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^b</i>
Persons with a need not fully met	'000	108.0	98.8	76.3	29.0	30.1	9.6	na	na	358.6
All persons needing assistance	'000	306.9	269.8	214.7	80.8	92.2	27.8	na	na	1 005.2
Self-reported total or partial unmet need	%	35.2	36.6	35.5	35.9	32.6	34.5	na	na	35.7

^a Aged 65 years or over, living in households. ^b Australian total includes data for the ACT and the NT. **na** Not available.

Source: ABS 2003 Survey of Disability, Ageing and Carers.

Appropriateness — long term aged care in public hospitals

An indicator 'long term aged care in public hospitals' has not yet been developed (box 12.13).

Box 12.13 Long term aged care in public hospitals

'Long-term aged care in public hospitals' is an indicator of the appropriateness of care. Acute inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term. Low incidence is desirable.

The Steering Committee has identified this indicator for development and reporting in future.

Appropriateness — intensity of care

The indicator 'intensity of care' is an output indicator of effectiveness (box 12.14).

Box 12.14 Intensity of care

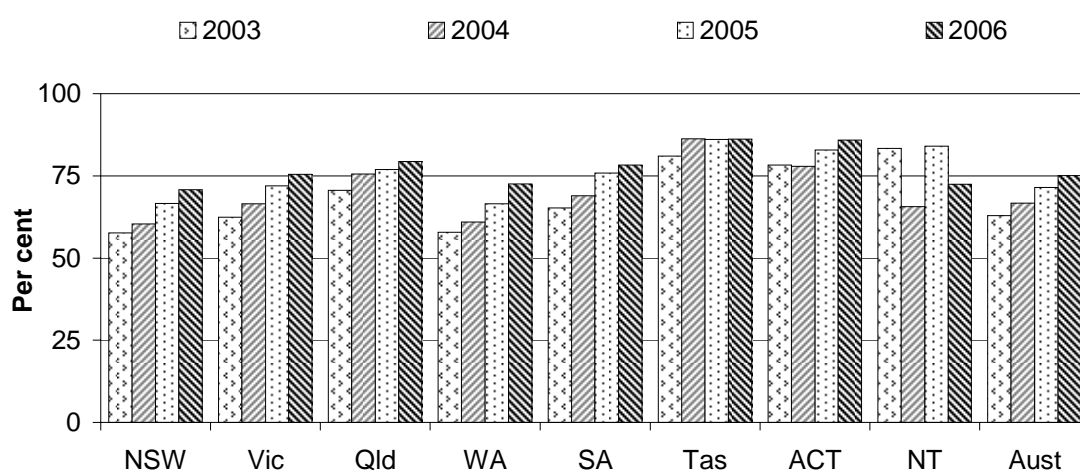
'Intensity of care' is an indicator of appropriateness, reflecting the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The Aged Care Act aims explicitly to encourage 'ageing in place' to increase choice and flexibility in residential aged care service provision (box 12.3).

This indicator needs to be viewed from the perspective of the system as a whole. The implication of ageing in place is that some places that were allocated for low care will be occupied by high care residents (or, conversely, allocated for high care and occupied by low care residents). Information about the use of operational residential aged care places is provided to demonstrate the impact of ageing in place on the aged care service system over time (figure 12.22).

Higher rates of ageing in place are desirable, in the context of a flexible system that meets the need for low level care either in residential facilities or in the community.

From June 2003 to June 2006, there was a steady increase in the proportion of people who stayed in the same residential aged care service when changing from low care to high care, from 62.9 per cent to 75.0 per cent nationally (figure 12.21). In June 2006, the proportion was higher in inner regional areas (79.8 per cent), outer regional areas (78.2 per cent) and remote areas (86.1 per cent) than in major cities (72.6 per cent) and very remote areas (68.0 per cent) (table 12A.53).

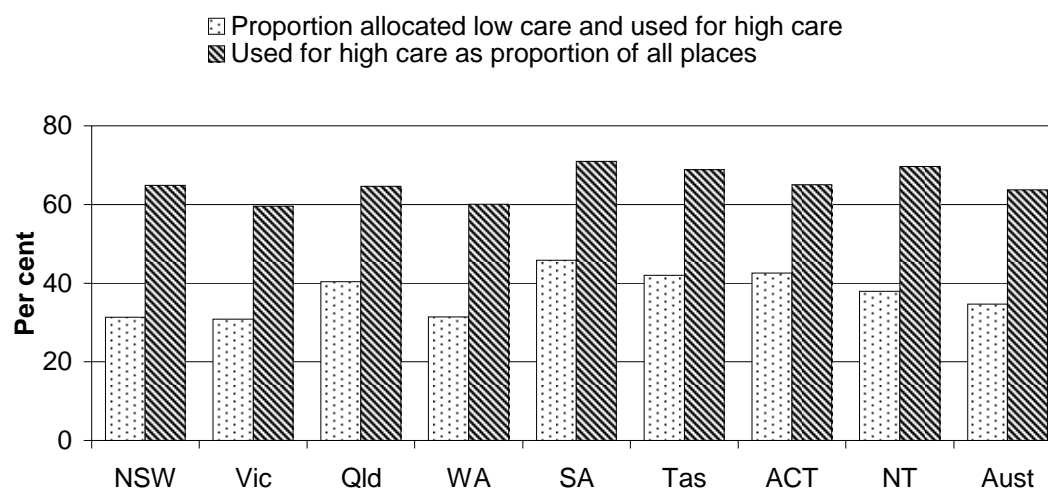
Figure 12.21 **Proportion of residents who changed from low care to high care and remained in the same aged care service, June**



Source: DoHA (unpublished); table 12A.53.

Nationally, 34.7 per cent of low care places in 2005-06 were occupied by residents with high care needs (figure 12.22). These data are provided by remoteness area in table 12A.56.

Figure 12.22 Utilisation of operational residential places, 30 June 2006



Source: DoHA (unpublished); table 12A.56.

Quality — compliance with service standards for residential care

The indicator ‘compliance with service standards for residential care’ is an output indicator of effectiveness (box 12.15).

Box 12.15 Compliance with service standards for residential care

‘Compliance with service standards for residential care’ is an indicator of the quality of care. The purpose of the indicator is to monitor the extent to which residential care facilities are complying with accreditation or certification standards. The extent to which they comply implies a certain level of care and service quality.

Since 2001, Australian Government funded residential services have been required to meet accreditation standards (which comprise 44 expected outcomes), against which each residential service is assessed. The accreditation indicator reflects the period of accreditation granted. High rates of approval for three year accreditation are desirable.

(Continued on next page)

Box 12.15 (Continued)

There are three steps in the accreditation process.

- A residential service applies for accreditation to the Aged Care Standards and Accreditation Agency (ACSAA), based on a self-assessment of performance against the accreditation standards.
- A team of registered quality assessors reviews the application, conducts an onsite assessment of the residential service and prepares a report based on observations of the living environment, care practices and relevant documentation such as care plans. Residents, relatives, staff and management are also interviewed.
- An authorised decision maker from ACSAA then considers the report, in conjunction with any submission from the residential service and other relevant information (including information from DoHA) and decides whether to accredit and, if so, for how long.

The number of residents per room is also an output indicator of quality. Lower rates of residents per room are generally desirable because they imply a higher service quality of accommodation.

As part of the Australian Government's certification requirements for residential aged care buildings, by 31 December 2008 every service that existed prior to July 1999 will be required to have no more than four residents accommodated in any room, no more than six residents sharing each toilet and no more than seven residents sharing each shower. For new buildings since July 1999, an average for the whole service of not more than 1.5 residents per room is required. No room may accommodate more than two residents, there must be no more than three residents per toilet and no more than four residents per shower or bath.

Accreditation decisions and other information relating to the accreditation standards, the aged care standards and ACSAA are publicly available via the ACSAA's web site (www.accreditation.aust.com). The accreditation process is summarised in box 12.15.

At 30 June 2006, 92.8 per cent of residential aged care services had been granted an accreditation approval for a period of three years or more. This proportion varied across jurisdictions (table 12.8).

Table 12.8 **Accreditation decisions on residential aged care services, 30 June 2006^a**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Accreditation period										
<2 years	%	1.6	3.5	5.2	1.4	5.8	3.3	–	6.7	3.2
2 years or more but <3years)	%	3.2	2.7	5.8	2.5	6.5	5.6	13.0	13.3	3.9
3 years or more	%	95.2	93.8	89.0	96.0	87.7	91.1	87.0	80.0	92.8
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Accredited services										
	no.	936	818	501	278	276	90	23	15	2 937

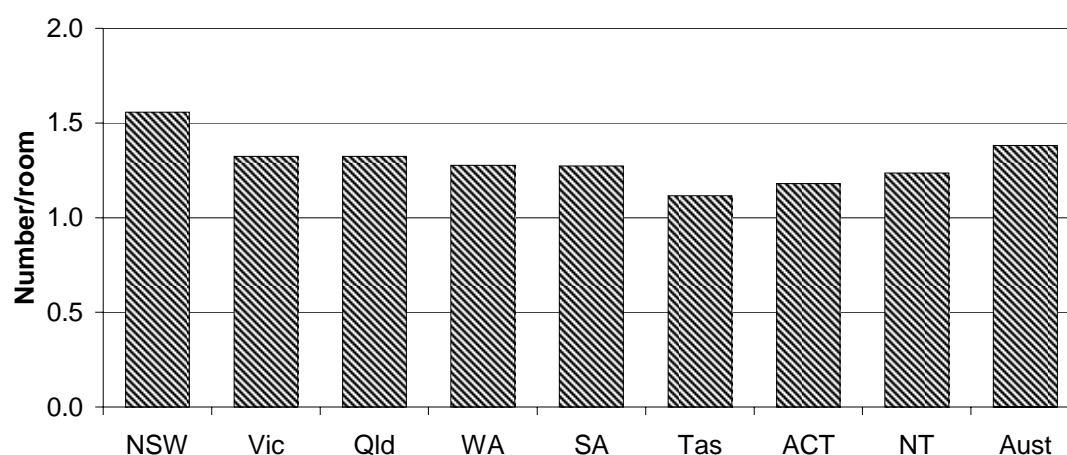
^a NT data will be variable due to small numbers.

– Nil or rounded to zero.

Source: ACSAA (unpublished); table 12A.39.

Existing services are required to meet privacy and space requirements by 2008. Since 2001 all new services must meet these targets from the time of construction. The average number of residents per room at July 2006 was 1.38 nationally (figure 12.23).

Figure 12.23 **Average residents per room in residential aged care facilities, July 2006**



Source: DoHA (unpublished); table 12A.40.

Quality — complaints

The indicator ‘complaints’ is an output indicator of effectiveness (box 12.16).

Box 12.16 Complaints

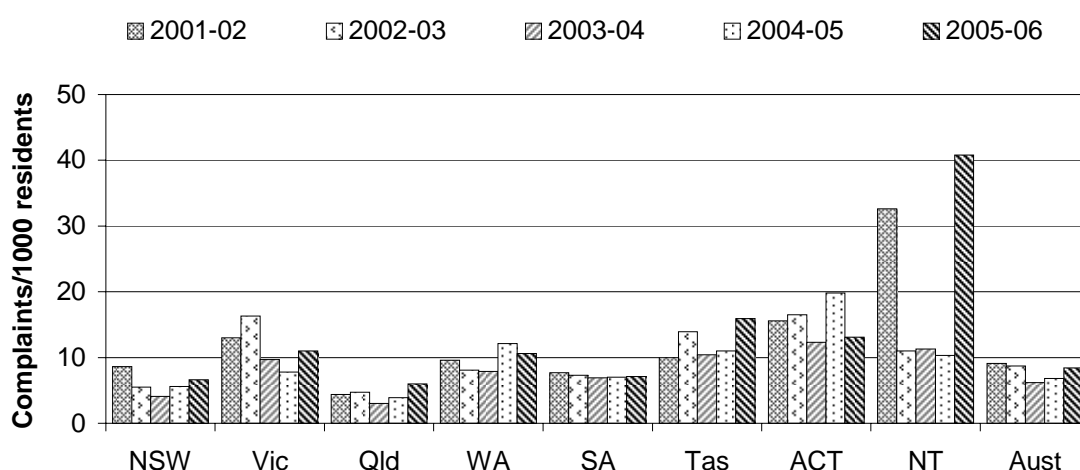
'Complaints' is used in this report as an indicator of the quality of care. The purpose of the indicator is to monitor the level of complaints received by the Complaints Resolution Scheme in each State and Territory. If service recipients make official complaints, they may be dissatisfied with an element of the service provided.

All aged care services are required to have an internal complaints system. The Aged Care Complaints Resolution Scheme is a free complaints system run by the DoHA and overseen by an independent Commissioner for Complaints. The scheme is available to anyone who wishes to make a complaint about an Australian Government funded aged care service, including residents of aged care facilities and their families, staff and people receiving CACPs and EACH packages. The indicator measures the number of complaints per 1000 residents. A low rate of complaints is desirable.

The rate at which complaints occur is influenced by the propensity of clients and their families or service staff to complain, their knowledge of the complaints system, and perceptions of the effectiveness of the complaints system. In many cases, complaints may be resolved without the need to involve the Complaints Resolution Scheme.

In 2005-06, the Complaints Resolution Scheme received approximately 1260 new complaints, compared with 1004 in 2004-05 (table 12A.41). The number of complaints registered per 1000 residents in 2005-06 was 8.4 nationally. This varied across jurisdictions (figure 12.24).

Figure 12.24 **Aged Care Complaints Resolution Scheme complaints per 1000 residents^a**



^a NT data will be variable due to small numbers. The number of complaints varied from 4 to 16.

Source: DoHA (unpublished); table 12A.41.

Quality — compliance with service standards for community care

The indicator ‘compliance with service standards for community care’ is an output indicator of effectiveness (box 12.17).

Box 12.17 Compliance with service standards for community care

‘Compliance with service standards for community care’ is an output indicator of quality. The purpose of the indicator is to monitor the extent to which individual agencies are complying with service agreement standards.

The HACC national service standards provide HACC funded agencies with a common reference point for internal quality control, by defining aspects of service quality and expected outcomes for consumers. States and territories are required to include the standards in all service agreements. The HACC national service standards instrument has been developed to measure through a service appraisal process the extent to which individual agencies are complying with the standards. Monitoring and compliance with the standards are now a major part of service reviews.

The indicator measures the number of HACC agencies appraised against the standards divided by the total number of HACC agencies. This indicator also measures the percentage of individual agencies that comply with the service standards, through data on the outcomes of service standard appraisals. It should be noted that the standards are not an accreditation system.

A total of 3207 HACC agencies were identified for appraisal over the three year cycle 2001-02 to 2003-04. The number of these agencies appraised was 2711 (85 per cent). This proportion varied across jurisdictions (table 12.9). The outcomes of these appraisals was a national average score of 16.0 out of 20 (table 12.10). In the course of the initial three year appraisal process, in the absence of detailed implementation guidelines, each State and Territory adopted individual approaches when assessing agencies against the National Service Standards Instrument (State and Territory governments unpublished).

Table 12.9 HACC National Service Standards appraisals over the three year cycle ending 2003-04^a

	<i>Unit</i>	<i>NSW^b</i>	<i>Vic</i>	<i>Qld^c</i>	<i>WA^d</i>	<i>SA^e</i>	<i>Tas^f</i>	<i>ACT</i>	<i>NT^g</i>	<i>Aust</i>
Appraisals	no.	1 095	481	706	168	161	58	31	11	2 711
HACC agencies	no.	1 487	481	730	178	161	58	31	81	3 207
Proportion of agencies assessed	%	74	100	97	94	100	100	100	14	85

^a Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those reported. ^b The total number of agencies identified for NSW are those targeted in the appraisal plan as at 2001-02. The Integrated Monitoring Framework implemented by NSW in 2005-06 will cover new agencies since that time. NSW has completed all remaining appraisals in 2004-05. ^c Reviews in Queensland are conducted by an external agency on a three year contract. In Queensland there were 730 agencies at the beginning of the contract period. There were 808 agencies in Queensland at the commencement of the 2004-05 contract. ^d The number of WA agencies appraised is lower than expected because some agencies amalgamated. ^e SA has an additional 21 exempt agencies. ^f Two agencies were exempt from the appraisal process in Tasmania. ^g NT data are variable due to small numbers.

Source: State and Territory governments (unpublished).

Table 12.10 HACC National Service Standards results of appraisals over the three year cycle ending 2003-04^{a, b, c}

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
High (17.5 – 20)	no.	607	157	276	108	51	12	25	na	1 236
Good (15 – 17.4)	no.	337	168	191	28	37	11	2	na	774
Basic (10 -14.9)	no.	132	123	142	34	50	24	3	na	508
Poor (less than 10)	no.	19	33	97	4	23	11	1	na	188
Average score	no.	17.2	15.5	14.8	17.0	14.5	13.2	17.9	na	16.0

^a Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those listed. ^b The results of the appraisals will reflect different methodologies applied across each State and Territory. ^c For details about the method of determining the average score, see table 12A.64.

Source: State and Territory governments (unpublished); table 12A.64.

Quality — client appraisal of service standards

The indicator ‘client appraisal of service standards’ has not yet been developed (box 12.18).

Box 12.18 Client appraisal of service standards

‘Client appraisal of service standards’ is an output indicator of quality. This indicator aims to monitor client satisfaction with services received. The Steering Committee has identified this indicator for development and reporting in future.

Efficiency

Inputs per output unit — cost per output unit

The indicator ‘cost per output unit’ is an output indicator of efficiency (box 12.19).

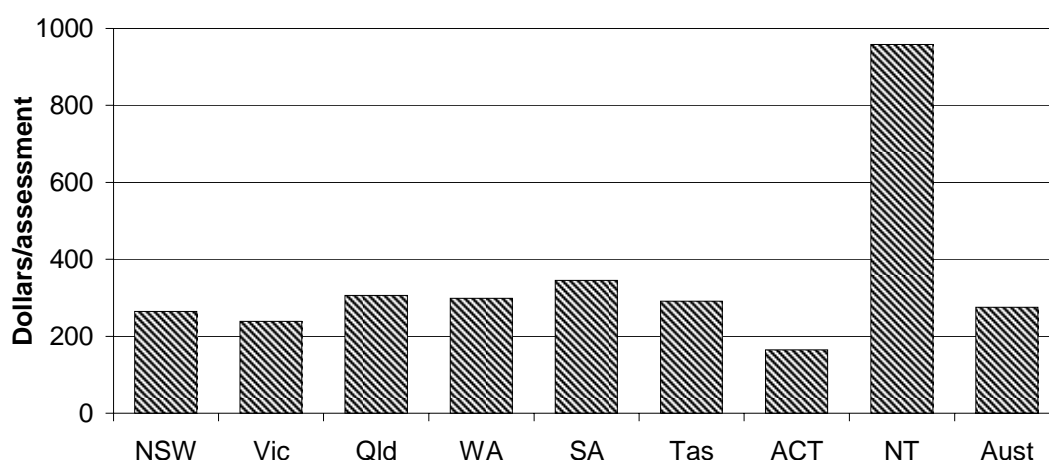
Box 12.19 Cost per output unit

A proxy efficiency indicator, ‘cost per assessment’, has been developed as work in progress to measure efficiency for ACATs. It is defined as expenditure on ACATs divided by the number of ACAT assessments completed.

This indicator needs to be interpreted with care. While high or increasing expenditure per assessment may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as greater time spent with clients) or changes in the characteristics of clients (such as their geographic location). Similarly, low or declining expenditure per assessment may reflect improving efficiency or less time spent with clients (for example). This indicator includes only Australian Government expenditure, although states and territories also contribute to the cost of ACAT assessments.

Cost per aged care assessment during 2004-05 averaged \$275 nationally (figure 12.25). The cost per assessment is calculated using the total number of assessments and also includes clients aged less than 70 years.

Figure 12.25 **Aged care assessment unit costs, 2004-05 (dollars)^{a, b, c}**



^a Only includes Australian Government expenditure on ACAT. ^b ACAT referrals and operations vary across jurisdictions. ^c The high cost for each assessment in the NT may be influenced by the remoteness of people requiring assessments, clients having English as a second or third language, and a lack of supporting health and community services infrastructure to assist with assessments.

Source: DoHA (unpublished); table 12A.54.

Inputs per output unit — expenditure per head of target population

The indicator ‘expenditure per head of target population’ is an output indicator of efficiency (box 12.20).

Box 12.20 Expenditure per head of target population

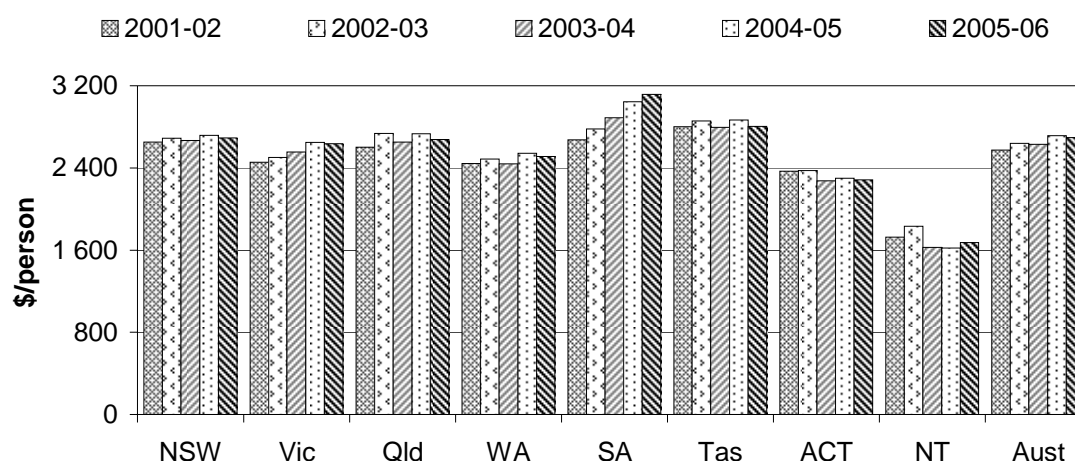
A proxy indicator of efficiency is ‘expenditure per head of target population’. It reflects the objective of ensuring services for frail older people are provided efficiently. The indicator is defined as government inputs (expenditure) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years. Expenditure per person in the target population is reported for three main service types: residential services, CACP and HACC services.

This indicator needs to be interpreted with care. While high or increasing expenditure per person may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as better quality of services) or in the characteristics of clients receiving the service (such as their geographic location or level of care need). Similarly, low or declining expenditure per assessment may reflect improving efficiency or a decrease in service standards.

Australian Government expenditure (including expenditure by the DVA) on residential care services per person aged 70 years or over plus Indigenous people

aged 50–69 years increased nationally from \$2574 (in 2005-06 dollars) in 2001-02 to \$2694 in 2005-06. This figure varied across jurisdictions (figure 12.26).

Figure 12.26 Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2005-06 dollars)^{a, b}

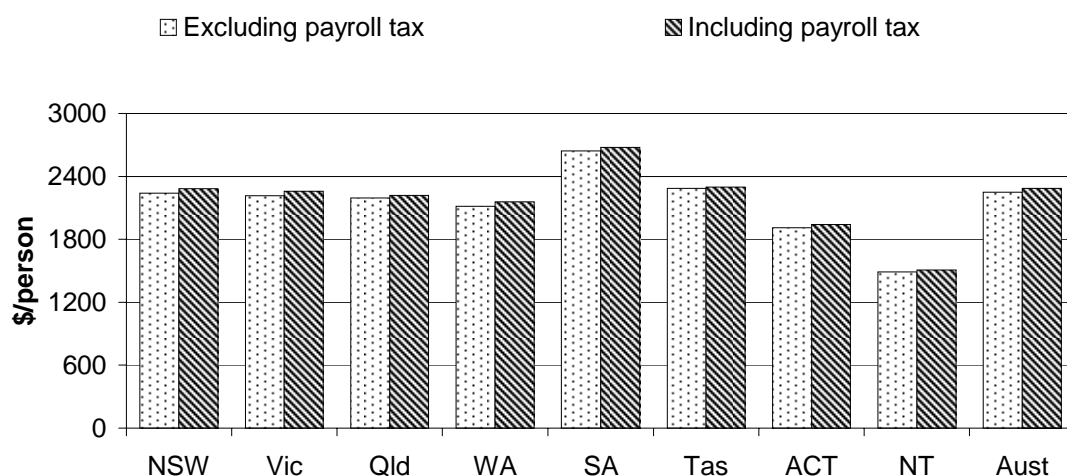


^a Includes payroll tax. ^b Includes expenditure by DVA.

Source: DoHA (unpublished); DVA (unpublished); table 12A.49.

Payroll tax has been separately identified in Australian Government expenditure. DoHA expenditure on residential aged care per person aged 70 or over plus Indigenous people aged 50–69 years was \$2287 nationally (including payroll tax) and \$2250 nationally (excluding payroll tax) in 2005-06. These rates varied across jurisdictions (figure 12.27). DVA expenditure on residential aged care in 2005-06 was \$806.5 million nationally (including payroll tax) and \$792.3 million (excluding payroll tax) (table 12A.44).

Figure 12.27 Australian Government (DoHA) expenditure on residential aged care, per person aged 70 years or over plus Indigenous people aged 50–69 years, 2005-06^a

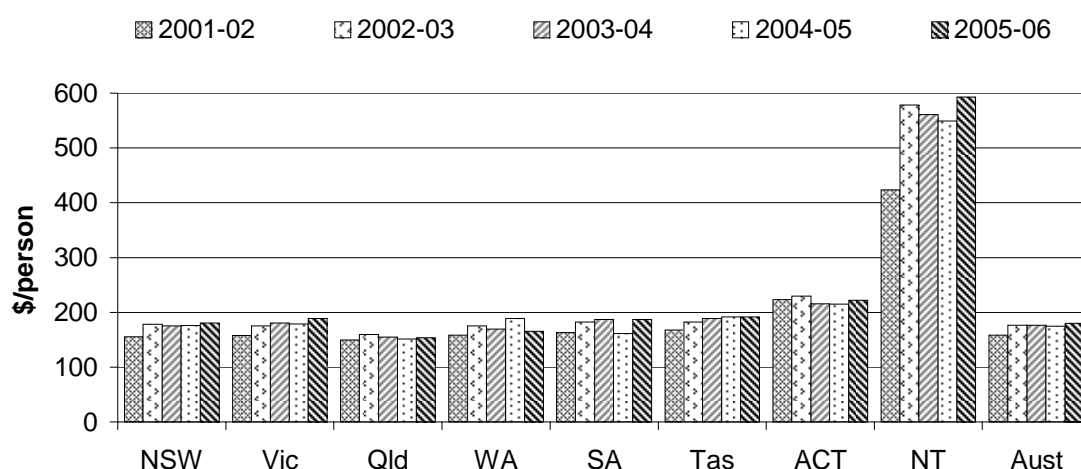


^a Data in this table exclude DVA expenditure on residential aged care.

Source: DoHA (unpublished); table 12A.48.

Australian Government expenditure on CACPs per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions in 2005-06. Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from \$158 (in 2005-06 dollars) in 2001-02 to \$180 in 2005-06 (figure 12.28).

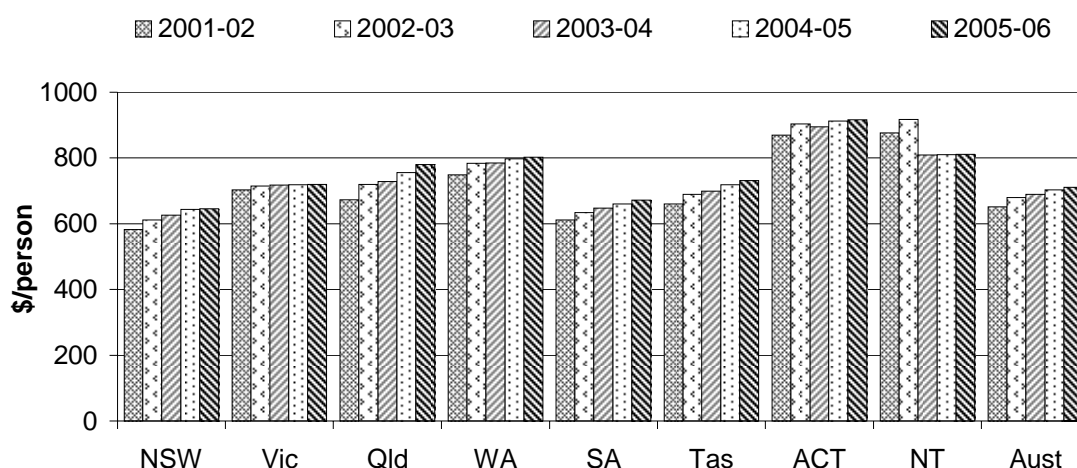
Figure 12.28 Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2005-06 dollars)



Source: DoHA (unpublished); table 12A.52.

Australian, State and Territory government expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions. Nationally, real expenditure increased from \$652 (in 2005-06 dollars) in 2001-02 to \$711 in 2005-06 (figure 12.29). These figures reflect expenditure against the population regarded as the proxy for this chapter (see page 12.3), which is not the same as the HACC target population. Expenditure per person in the HACC target population is reported in table 12A.50.

Figure 12.29 Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2005-06 dollars)^{a, b, c}



^a People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person and definition of the HACC target population is contained in table 12A.50.

^b This figure only represents expenditure under HACC Amending Agreements. ^c Reports provisional HACC data that have not been validated and may be subject to revision.

Source: DoHA (unpublished); table 12A.51.

Outcomes

Three outcomes indicators have been identified for development and reporting in future:

- social participation in the community (box 12.21)
- maintenance of individual functioning (box 12.22)
- enabling people with care needs to live in the community (box 12.23).

Social participation in the community

Box 12.21 Social participation in the community

‘Social participation in the community’ is an outcome indicator that measures the wellbeing and independence of frail older people. An indicator will be developed to show the extent to which older people participated in community, cultural or leisure activities. Higher rates of participation in the community are more desirable.

The Steering Committee has identified this indicator for development and reporting in future.

Maintenance of individual functioning

Box 12.22 Maintenance of individual functioning

‘Maintenance of individual functioning’ is an outcome indicator that reflects the objective for aged care services to promote the health, wellbeing and independence of frail older people. The indicator is defined as:

- maintenance of, or minimised decline in, residents’ level of functioning reflected by a movement of clients to a higher level of need as indicated by a change in classification on the resident classification scale
- length of stay in residential care for a given level of frailty or age at entry.

The Steering Committee has identified this indicator for development and reporting in future.

Enabling people with care needs to live in the community

Box 12.23 Enabling people with care needs to live in the community

‘Enabling people with care needs to live in the community’ is an outcome indicator that reflects the objective of community care to delay entry to residential care and will measure levels of dependency on entry to residential care for those who have been receiving community care.

The Steering Committee has identified this indicator for development and reporting in future.

12.4 Future directions in performance reporting

For several aspects of aged care services, indicators are not fully developed and there is little performance reporting. Priorities for the future include:

- continued improvement of efficiency indicators, including for HACC services and assessment services
- further development of outcome indicators
- improved reporting of waiting times for residential aged care
- further work on reporting the indicator ‘long term aged care in public hospitals’
- improved reporting of State and Territory expenditure on residential aged care.

12.5 Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data about each jurisdiction that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

“ Access to and appropriateness of aged care services continued to improve during 2005-06. At 30 June 2006 there were 204 869 operational aged care places, exceeding the Australian Government's target of 200 000 places in 2006, set in 2001. This represents 105.8 places for every 1 000 people aged 70 and over, up from 102.4 in June 2005. Growth is on track to reach 108 operational places per 1 000 people aged 70 and over in 2007.

Growth was fastest in community care with an 18 per cent increase during the year. This reflects the Australian Government's response to older people's preference to remain at home while receiving care, wherever possible. The 2005-06 financial year also saw the introduction of the Extended Care at Home Dementia (EACH-D) program, which provides care packages to those at the highest end of the community care continuum. EACH-D packages assist people with dementia who experience difficulties in their daily life because of behavioural and psychological symptoms associated with their dementia.

The Transition Care Program commenced delivery of services during 2005-06. The program is a collaborative undertaking between the Australian Government and states and territories that provides time limited support and therapy focused care to older people who have just completed a hospital stay. 2000 Transition Care places will be allocated by June 2007.

During 2005-06 providers undertook some \$2.2 billion worth of improvements to building quality in residential aged care, involving 25 per cent of all homes. Of this, \$771 million was spent on new buildings. 95 per cent of aged care homes now meet the 2008 Certification privacy and space standards.

Quality in residential care will be further improved through a \$90.2 million package of reforms that includes more robust complaints and compliance arrangements and a new Office for Aged Care Quality and Compliance, with enhanced powers and responsibilities. With other initiatives announced in the 2006-07 Budget, the value of the Australian Government's response to allegations of abuse of the elderly in aged care will be more than \$100 million over 4 years.

The Australian Government's Veterans' Home Care (VHC) program has been enormously successful since it was established in 2001. However, the veteran cohort is ageing and becoming frailer and an increasing number of war widows are entering the program. To address these issues, the Australian Government will be conducting an independent review of the VHC program in 2007 to identify any changes necessary to ensure that the program continues to meet the needs of veterans and war widows/widowers over the coming years.

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New South Wales Government comments

- The NSW Government continues its commitment to providing services to older people and their carers which maximise their independence and participation in community life, promote their health and wellbeing and provide information and support to enable them to access appropriate services.
- In 2005-06 NSW continued to expand the Home and Community Care (HACC) Program with the allocation of \$30 million in additional funding, bringing the total HACC budget to more than \$448 million. This included \$21 million for additional services, of which 10 per cent were designed for people with dementia and 30 per cent were for older people in disadvantaged communities. These additional services had a continuing emphasis on basic support including domestic assistance, personal care, transport, centre-based day care and respite.
- The NSW government has been providing high quality services to the people in need. A recent customer satisfaction survey by an independent market research company of Home Care Services the largest HACC service providers in NSW, found that 94 per cent of those surveyed were satisfied with the service they received, with 67 per cent highly satisfied.
- NSW has commenced the Transitional Aged Care program, which aims to help reduce hospital length of stay and readmission rates for older people, and the premature admission to long-term residential aged care.
- The Clinical Services Redesign program has seen a number of clinical service systems undergo significant redesign to provide a better focus on patients. Integrating models of care and management of older people and people with chronic disease will be particularly addressed in the coming year.
- NSW Health continues to invest in innovative aged care services such as Aged Care Service Evaluation Teams (ASETS) in public hospitals, Emergency Medical Units (EMUs) and COMPACKS, brokering packages of community care. These are in addition to the comprehensive range of acute, community, rehabilitation, mental health and geriatric services targeting older people. During 2005, ASETs assessed 42 369 older people in NSW Emergency Departments enabling the identification of health and social issues that informed care planning and risk minimisation, 39 per cent of these people could be discharged directly from the Emergency Department.
- NSW also promotes active participation of carers in the health service through continued funding of the NSW Carers Program. The program has funded 71 Non Government Organisations (NGOs) to provide direct education and support through one off local carer grants of 1–3 years duration, with some specifically targeting carers of older people.

Victorian Government comments

“ During 2005-06 Victoria has continued to emphasise innovation in responding to age care challenges. New initiatives and enhancements have built on the foundations of Victoria’s long-standing emphasis on community-based care, supported by public sector involvement in residential aged care.

In assessment, a framework for assessment in HACC has been developed that aims to improve the consistency and quality of assessments in the HACC Program. The framework incorporates the agreed ‘common arrangements’ that are part of the Commonwealth’s community care reforms and aims to ensure assessments are responsive to special needs groups such as CALD clients, Aboriginal clients and younger people with disabilities. Victoria has also commenced the pilot of an electronic comprehensive assessment tool for older people, the InterRAI Home Care. ACAS managers in Victoria have identified the use of a common assessment tool as a key factor in improving the quality and consistency of ACAS assessments.

The Victorian dementia framework Pathways to the Future, 2006 and Beyond — Dementia Framework for Victoria, and an Implementation Plan 2006–08 were launched in April 2006. This was accompanied by expanded funding for dementia services and projects.

The DHS policy framework Recognising and supporting care relationships was launched in August 2006, supported by three action plans from Disability Services, Mental Health, and for older people.

New programs to assist supported residential services and people in insecure accommodation were introduced during the year including assertive outreach, HACC, dental and mental health services targeted to people who are homeless or living in insecure housing.

Following a report on responses to elder abuse, a range of measures is to be implemented in community and provider education, legal services and other responses to raise the awareness of and assist in the prevention of elder abuse.

In residential care, a pilot program offering surplus government land sites to not-for-profit aged care providers will proceed, to facilitate the establishment of high-care aged care places in inner-Melbourne, where development has been limited by the price of suitable land.

A suite of quality initiatives aimed at building a quality of care focus into the strategic management and day-to-day operation of public sector residential aged care facilities has been introduced.

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Queensland Government comments

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Queensland has continued to support the programs and services that improve the quality of life of older people and has worked closely with the Australian Government and all State and Territory jurisdictions to renegotiate the HACC Amending Agreement. This program is important because it provides services at the beginning of the aged care continuum, and is instrumental in helping older people to remain in their own homes.

Planning for future services for older people has been based on the initiatives outlined in Queensland Health's Directions for Aged Care 2004–2011 and will continue to align with the Statewide Health Services Plan.

Queensland has received provisional approval for 273 transition care places, with a further 78 expected to be offered in 2006-07. Plans to operationalise all places are well underway, with 103 places already approved. The remainder are expected to receive approval by the end of 2006. Queensland has developed a hub and spoke model with services being provided through a mix of Queensland Health and non-government organisations. The program has been well received by the community with places experiencing high occupancy levels.

In response to a number of national incidents involving abuse of elderly residents in aged care facilities, the Queensland Government has developed a number of measures to address the issue for State Government facilities. These have focused on:

- improved training and support for all staff so that they fully understand the components of physical, sexual and financial abuse and are able to identify other symptoms of abuse of older people;
- protocols and mechanisms to improve reporting of abuse through enhanced training programs of all staff and volunteers to increase awareness of the process for acting on elder abuse incidents.

Since 2001, Queensland Health has embarked on a \$120 million redevelopment program which has resulted in the replacement of a number of the State's Residential Aged Care Facilities.

Over the past 5 years, Queensland Health has provided new replacement facilities at Roma, Dalby, Townsville, Redland, Maryborough, Redcliffe, Warwick, replacement accommodation for 80 residents at Sandgate, with new facilities at Wondai under construction and Nambour in the design phase. In addition the program has provided air conditioning Oakey and Zillmere.

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Western Australian Government comments

“ In February 2006, the Department of Health Western Australia launched the Clinical Network for Aged Care (CNAC). The CNAC has been formed through integration of the WA Aged Care Ministerial Advisory Committee (WAACMA), the Clinical Advisory Committee (CAC) and the WA Community Care Reform Advisory Group (WACCRAAG).

The CNAC provides a forum to support multi sectorial and multi disciplinary relationships to be strengthened, with an emphasis on partnerships and collaboration, while supporting a new approach to the planning and delivery of aged care services that is responsive, flexible and focused on the real needs of the older person.

The WACCRAAG will continue to provide advice to the WA Department of Health's Aged Care Policy Directorate (ACPD) in regard to working towards common arrangements in community care as outlined in the Australian Government's A New Strategy for Community Care: The Way Forward and the February 2006 Council of Australian Governments (COAG) decision to improve access to services for frail older people by strengthening the performance of the Aged Care Assessment Program (ACAP), and simplifying entry points for the Home and Community Care Program (HACC).

Carers WA have been contracted to develop and pilot a training program for all HACC funded agencies to raise awareness of the Carers' Recognition Act 2004 (WA), and to support agencies to formally recognise carers as key partners in the delivery of care.

In March 2006 the WA HACC Program adopted a Wellness Approach to Community Home Care (WATCH) philosophy as its policy position for future growth in service delivery. The aim of WATCH is to support a move towards maximising physical and psychosocial function for people accessing HACC services, resulting in optimal levels of functional and social independence.

The Northern Transition Care Service commenced operating on January 1st 2006. This service, which provides 50 flexible care places to elderly clients living in the North Metropolitan Area Health Service Region, mainstreamed the pilot program, which successfully operated since 2002. Work is currently underway to mainstream the Intermittent Care Service pilot operating in the South Metropolitan Area Health Service Region to enable a metropolitan area wide Transition Care Program.

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South Australian Government comments

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Improving with Age – Our Ageing Plan for South Australia was officially launched by the Minister for Ageing in February 2006. The Plan serves as a policy framework for implementation across Government and reinforces the ongoing commitment to ageing in SA. In brief, the Plan focuses on maximising the citizenship and independence of older people and ensuring they have opportunities and choices to remain connected to their communities. The Plan highlights five key action areas:

- Enabling Choice and independence
- Valuing and recognising contribution
- Providing safety, security and protection
- Delivering the right services and the right information
- Staying in front

A number of Kick-Start initiatives have already been identified as part of implementing the Plan. These include mapping of ageing services across SA to improve planning, and an elder abuse conference held in June 2006 on World Elder Abuse Awareness Day. Another Kick-Start initiative was funded to research ways of supporting Aboriginal Elders by services following them as they move for cultural, family or climatic reasons. Delivering services in remote and mobile communities remains a challenge, and will continue to be a focus of service development, in the HACC and ACAP programs.

The Carers Recognition Act commenced in SA in December 2005. It requires Government organisations and Government funded services to report annually on the action they take to ensure that those whom they employ are aware of, and understand the Carers Charter, and take action to reflect the principles of the Carers Charter in how services are provided. Additionally such organisations must consult carers or those people or organisations that represent carers in policy and program development, or in strategic or operational planning which is relevant to carers and those they care for.

A review of the processes of planning, funding, contracting, monitoring, reporting and evaluating the provision of services under the HACC program in SA commenced in 2005-06. The goal of this review is to recommend and implement process improvements that meet the needs of key partners and stakeholders, increase efficiency, ensure value for money in the provision of HACC services, and expedite reporting. Some of the processes are being introduced in 2006-07, and it is anticipated that improvements will occur as community care reform continues to progress at the national level.

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Tasmanian Government comments

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- Service demand issues posed by population ageing have become a central focus of social and economic planning within Australia and internationally. Those issues are of particular concern for Tasmania, with current projections indicating that by 2021, this state will have the highest proportion in Australia (22 per cent) of its population aged 65 years or more. A Tripartite Agreement for Population Ageing in Tasmania, signed by Tasmania's three spheres of government in August 2006, will offer the opportunity to work together on common issues to improve the coordination of planning for aged care services and healthy ageing programs.
- While demand for community services is increasing, evidence confirms better outcomes for older people and lower costs to governments through enabling older people to live independently and as long as possible in their own homes. The Tasmanian Government is committed to that principle and in 2006 it again fully matched the Australian Government's growth offer in the Home and Community Care (HACC) Program. Greater demand means that HACC services must increasingly be targeted at high-needs clients and this can result in fewer, but more complex and longer, home visits.
- While longer-term service reform planning is essential, existing service models must be resourced and, where necessary, enhanced in the shorter term. The Tasmanian Department of Health and Human Services is responding to that challenge by implementing a comprehensive management reform strategy to develop better processes and systems to support frontline service delivery. Improvements in achievement, quality and access are critical to ensure sustainable services, both in terms of resources and outcomes for clients. Fundamental to the continued provision of sustainable health and human services is the development of a flexible and skilled workforce and investment in new infrastructure.
- Tasmania made a considerable investment in 2005-06 with an expansion in transition care services and the establishment of a new geriatric evaluation and management unit. Sub-acute planning work is continuing with a review of rehabilitation services and the development of psycho-geriatric service pathways. Tasmania is also continuing to implement the major service changes outlined in the Palliative Care in Tasmania: Current Situation and Future Directions report (2004).

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Australian Capital Territory Government comments

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The ACT Government remains committed to assisting older people and their carers by providing better access to appropriate services and promoting independence and participation in community life.

The Home and Community Care (HACC) program was enhanced by an additional \$1.64 million in 2005-06 to assist people to remain in the community. The focus of additional HACC funding provided additional community transport, centre based day care, personal care, domestic assistance, counselling, podiatry and respite care. The enhanced service delivery of HACC services in the ACT has provided more options for older people and their carers, and helps avoid premature entry into residential aged care.

The ACT Transitional Therapy and Care Program is jointly funded by the Australian and ACT Governments to provide a restorative, therapeutic and social model of care for older people leaving hospital to improve their physical functioning. In December 2005, 10 places were allocated under the Transition Care Program. From 1 July 2006, an additional 25 places were allocated and operationalised in the Transitional Therapy and Care Program. The ACT now has 15 residential and 20 community transitional places.

The ACT Government is constructing a 60 bed facility comprised of 28 sub-acute and post acute beds, 12 Geriatric Evaluation Management beds and a 20 bed psycho-geriatric unit at Calvary Hospital. This facility will enhance the care options provided to older Canberrans by the Aged Care and Rehabilitation Service. Construction is expected to be complete by January 2007.

The Australian Government has made available 174 new residential and 35 community aged care places in 2006-07. In response to the Australian Government's increased allocation, the ACT Government through its Land Development Agency has released land in Nicholls on the north side of Canberra, to accommodate an additional 100 aged care beds and 150 independent living units. The Chief Minister's Department has recently completed a 'Retirement Accommodation and Residential Aged Care in the ACT 2006 – 2026, Demand and Supply Report'. The report provides the framework for planning for an ageing population and includes a targeted land release strategy and improved planning processes.

The Minister for Health, Katy Gallagher officially launched an Elder Abuse Awareness Campaign for the ACT on the 16 May 2006. The awareness campaign is being promoted through television, print and electronic media and is supported by information kits containing fact sheets. A comprehensive elder abuse web page has been developed with links to the fact sheets. A summary of the information is available at <http://www.ageing.act.gov.au/elderabuse>.

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Northern Territory Government comments

“ The unique environmental and socio-economic factors in the NT create specific challenges in the provision of aged care services for both the NT and Australian Government, particularly in providing appropriate and sustainable aged care services to remote Indigenous communities. The high proportion of people living in remote settings and lack of a major metropolitan centre creates increased cost structures for all services, particularly due to the cost of travel, staff retention and recruitment.

Data quality remains an ongoing challenge for providers in the NT, given the need to integrate funds across aged care and disability programs to create viable services, especially in remote communities. Data quality issues can distort results in individual programs. During 2005-06 the NT put a lot of effort in improving the participation rates as well as the quality of the Home and Community Care (HACC) National Minimum Data Set (MDS) from providers. This involved working collaboratively with HACC service agencies and providing them with ongoing training and support and the roll out of web based data entry system throughout the NT. There remains an ongoing challenge of ensuring good data quality from the large number of small and dispersed providers, particularly given that these providers receive funds from multiple funding sources.

In 2005-06 quality initiatives have improved including commencement of the second round of quality reviews of the HACC services.

During 2005-06 the NT Government placed great emphasis on supporting carers of the frail aged, people with a disability, those with a chronic disease and people with mental illness. A new Carers Recognition Act with specific Carers' Charter was developed. This is in recognition of carer's contribution to the community. The Act will come into effect in 2006-07. In addition, subsidies and concessions on cost of essential services similar to those available to pensioners was extended to carers in the NT and \$1.05 million was allocated by NT Government for these concessions in 2006-07.

NT potential population estimates in the report are based on small sample sizes and subsequently have high standard error rates. Indicators based on these estimates need to be interpreted with caution. In addition small variations in NT aged care data appears in magnified proportions in the report.

”

12.6 Definitions of key terms and indicators

Adjusted subsidy reduction supplement	Payments made to equalise the recurrent funding paid by the Australian Government as adjusted subsidy reduction places to public sector residential care operators. The states and territories provide top-up funding for residential aged care places at a rate set by the Department of Health and Ageing from 1 July each year.
Aged care	<p>Formal services funded and/or provided by governments, that respond to the functional and social needs of frail older people, and the needs of their carers. Community aged care services aim to optimise independence and to assist frail older people to stay in their own homes, while residential care services provide accommodation and care for those who can no longer be assisted to stay at home.</p> <p>The majority of aged care services assist in activities of daily living such as personal care (for example, bathing and dressing), housekeeping and meal provision, and are delivered by trained aged care workers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists. These services generally aim to maintain function rather than treat illness or rehabilitate, and are distinguished from the health services described in Part E of this Report. Assessment of care needs is also an important component of aged care.</p> <p>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.</p>
Ageing in place in residential care	<p>An approach that aims to provide residents with appropriate care and increased choice by allowing them to remain in the same facility regardless of changes in their level of care needs. It also allows couples with different levels of care needs to be cared for in the same facility. The main facet of 'ageing in place' is that funding is tied to the assessed care needs of the client rather than to the services provided by the facility.</p> <p>One of the objectives of Australian Government aged care legislation is 'to promote ageing in place through the linking of care and support services to the places where older people prefer to live' (<i>Aged Care Act 1997</i> (Cwlth), s.2-1 [1j]).</p>
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	<p>A complaint by the affected care recipient or his or her representative, or anyone else, to the Secretary about anything that:</p> <ul style="list-style-type: none">• may be a breach of the relevant approved provider's responsibilities under the <i>Aged Care Act 1997</i> or the Aged Care Principles• the complainant thinks is unfair or makes the affected care recipient dissatisfied with the service.

Disability	A limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.
EBA supplement	Payments made to supplement services for the extra costs associated with public sector enterprise bargaining agreements over and above those required by other wage Awards.
Elapsed time between ACAT approval and entry into a residential care service	The measure of the elapsed time between ACAT approval and entry into a residential care service. It has been used in past years as an indicator of access to residential care.
High/low care recipient	Recipient of a high level of residential care (that is, a level to RCS levels 1–4) or a recipient of a low level of residential care (that is, a level corresponding to RCS levels 5–8). If the person is approved as a recipient of a high level of care, that person can receive care at any care classification level (<i>Approval of Care Recipients Principles 1997</i> , s.5-9). A person approved as a recipient of a low level of care can be classified only as RCS 5–8 (<i>Classification Principles 1997</i> , 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 (<i>Aged Care Act 1997</i> (Cwlth)); also refers to 'beds' (<i>Aged Care (Consequential Provisions) Act 1997</i> (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 <i>Aged Care Act 1997</i> , a person who is being provided with residential care through an aged care service conducted by an approved provider under the Act.
Respite care	Alternative care arrangements for dependent people living in the community, with the primary purpose of giving their carer a short term break from their usual caring commitments.
Rural small nursing home supplement	Payments made by states and territories to small sized high care public sector residential aged care facilities (up to 30 places) that are located in rural areas. Three levels of supplement are paid to facilities varying in size from 10 to 20 and 30 places.
Special needs groups	Section 11-3 of the <i>Aged Care Act</i> , specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from non-English speaking countries; people who live in rural or remote areas; and people who are financially or socially disadvantaged. Principles (Regulations) made under s. 11-3 also specify veterans as a special needs group.

Veterans

Veterans, their war widows, widowers and dependents who are eligible for treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlements Act 1986* (Cwlth).

12.7 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2007\Attach12A.xls and in Adobe PDF format as \Publications\Reports\2007\Attach12A.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

Table 12A.1	Males and females aged 70 years or over, June 2006 (estimated)
Table 12A.2	Target population data, by location ('000)
Table 12A.3	Proportion of people aged 70 years and over by locality, June 2006
Table 12A.4	Ownership of aged care residential places, June 2006
Table 12A.5	Average annual Australian Government RCS subsidy per occupied place and the dependency level of aged care residents, June 2006
Table 12A.6	Size and distribution of all residential aged care services, June 2006
Table 12A.7	Size and distribution of residential aged care services with over 80 per cent high care residents, June 2006
Table 12A.8	Size and distribution of residential aged care services with over 80 per cent low care residents, June 2006
Table 12A.9	Size and distribution of mixed residential aged care services, June 2006
Table 12A.10	Operational number of aged care places per 1000 people aged 70 years or over
Table 12A.11	Operational number of aged care places per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years
Table 12A.12	Aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years
Table 12A.13	Aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years by locality
Table 12A.14	Aged care recipients from a non-English speaking country
Table 12A.15	Aged care recipients from a non-English speaking country per 1000 people from a non-English speaking country aged 70 years and over by locality
Table 12A.16	Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over and as a proportion of all recipients
Table 12A.17	Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over by locality
Table 12A.18	Aged care recipients from special needs groups, June 2006 (per cent)
Table 12A.19	Proportion of new residents classified as concessional or assisted residents, 2005-06 (per cent)
Table 12A.20	HACC services received per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 2005-06
Table 12A.21	HACC services received within major cities per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 2005-06

Table 12A.22	HACC services received within inner regional areas per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 2005-06
Table 12A.23	HACC services received within outer regional areas per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 2005-06
Table 12A.24	HACC services received within remote areas per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 2005-06
Table 12A.25	HACC services received within very remote areas per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 2005-06
Table 12A.26	HACC services received per 1000 HACC target population, 2005-06
Table 12A.27	HACC services received by clients within major cities per 1000 of the HACC target population for major cities, 2005-06
Table 12A.28	HACC services received by clients within inner regional areas per 1000 HACC target population for inner regional areas, 2005-06
Table 12A.29	HACC services received by clients within outer regional areas per 1000 HACC target population for outer regional areas, 2005-06
Table 12A.30	HACC services received by clients within remote areas per 1000 HACC target population for remote areas, 2005-06
Table 12A.31	HACC services received by clients within very remote areas per 1000 HACC target population, 2005-06
Table 12A.32	HACC client characteristics, 2005-06
Table 12A.33	Distribution of HACC clients, by age and Indigenous status, 2005-06 (per cent)
Table 12A.34	Comparative characteristics of Indigenous HACC clients, 2005-06
Table 12A.35	Australian Government Activity Measures on Aged Community Care Programmes, 2005-06
Table 12A.36	Elapsed time between ACAT approval and entry into residential service or CACP service, 2005-06
Table 12A.37	Recommended longer term care arrangements of Aged Care Assessment Teams (ACAT) clients, 2000–2001 to 2004–2005
Table 12A.38	Aged care assessments
Table 12A.39	Accreditation decisions on residential aged care services, June 2006
Table 12A.40	Average number of residents per room
Table 12A.41	Aged Care Complaints Resolution Scheme complaints
Table 12A.42	Australian Government real expenditure on residential aged care, CACPs and EACH (2005-06 \$ million)
Table 12A.43	Real expenditure on HACC services (2005-06 \$ million)
Table 12A.44	Department of Veterans' Affairs residential expenditure and clients
Table 12A.45	Veterans' Home Care (VHC), 2005-06
Table 12A.46	Australian Government expenditure on Aged Community Care Programs, 2005-06 (\$ million)
Table 12A.47	Australian Government expenditure on Aged Community Care Programs per person aged 70 years or over plus Indigenous people aged 50–69, 2005-06
Table 12A.48	Australian Government (DHA only) real expenditure on residential aged care and CACPs, per person aged 70 years or over plus Indigenous people aged 50–69 years (2005-06 dollars)
Table 12A.49	Australian Government (DHA and DVA) real expenditure on residential services, per person aged 70 years or over plus Indigenous people aged 50–69 years (2005-06 dollars)
Table 12A.50	Australian, State and Territory government expenditure on HACC services per HACC target population (nominal dollars)

Table 12A.51	Australian, State and Territory government real expenditure on HACC services, per person aged 70 years or over plus Indigenous people aged 50–69 years (2005-06 dollars)
Table 12A.52	Australian Government real expenditure on CACPs, per person aged 70 years or over plus Indigenous people aged 50–69 years 2005-06 dollars)
Table 12A.53	Ageing in place: residents changing from low care to high care in the same facility
Table 12A.54	Aged care assessment — activity and costs, 2004-05
Table 12A.55	Access to Commonwealth Carelink Centres, 2005-06
Table 12A.56	Utilisation of residential aged care places, by remoteness category, 30 June 2006
Table 12A.57	Permanent aged care residents at 30 June 2005: age-sex specific usage rates per 1000 persons by jurisdiction
Table 12A.58	CACP and EACH recipients at 30 June 2005: age-sex specific usage rates per 1000 persons by jurisdiction
Table 12A.59	Permanent aged care residents, CACP and EACH recipients at 30 June 2005: age-sex specific usage rates per 1000 persons by jurisdiction
Table 12A.60	Permanent aged care residents at 30 June 2005: age-sex specific usage rates per 1000 persons by remoteness
Table 12A.61	CACP and EACH recipients at 30 June 2005: age-sex specific usage rates per 1000 persons by remoteness
Table 12A.62	Permanent aged care residents, CACP and EACH recipients at 30 June 2005: age-sex specific usage rates per 1000 persons by remoteness
Table 12A.63	Indigenous permanent residents classified as high or low care and Indigenous CACP at 30 June 2005: age-sex specific usage rates per 1000 persons by remoteness
Table 12A.64	HACC National Service Standards appraisals — results of appraisals

12.8 References

- ABS (Australian Bureau of Statistics) 2001, *Estimated Residential Population, by Age and Sex*, Cat no. 3101.0, Canberra.
- 2003, *Australian Standard Geographic Classification*, Cat no. 1216.0, Canberra.
- 2004a, *Survey of Disability, Ageing and Carers, 2003*, Cat no. 4430.0, Canberra.
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- 2004c, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, Cat no. 3238.0, Canberra.
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13 Services for people with a disability

The Australian, State and Territory governments aim to maximise opportunities for people with a disability to participate actively in the community, by providing services and support for people with a disability, their families and carers.

This chapter focuses mainly on services covered by the third Commonwealth State/Territory Disability Agreement (CSTDA), which applies to the period 1 July 2002 to 30 June 2007. The CSTDA forms the basis for the provision and funding of services for people with a disability, where the person's disability manifests before the age of 65 years and for which they require ongoing or long term episodic support. Specialist psychiatric disability services are excluded from the chapter to improve data comparability across jurisdictions.

Services for people with a disability can be grouped into income support, disability support services and relevant generic services provided to the community as a whole. This Report generally does not report information on income support. Disability support services are primarily delivered under the CSTDA, as well as through programs such as Home and Community Care (HACC) and Commonwealth Rehabilitation Services (CRS) Australia. Performance information on the HACC program is provided in the 'Aged care services' chapter (chapter 12). CRS Australia's services are not covered in this Report.

Some mainstream services provided to the community as a whole are covered elsewhere in this Report — for example, school education (chapter 3), vocational education and training (VET) (chapter 4), public hospital care (chapter 9), specialised mental health services (chapter 11) and public housing (chapter 16). 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.

Significant improvements in the reporting of services for people with a disability in this year's Report are the inclusion of:

- data on disability prevalence rates among Indigenous people
- descriptive information on younger people with a disability in residential aged care facilities
- access indicators for community support and respite services

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- data reported against the ‘service use by severity of disability’ and ‘service use by special needs groups — Indigenous people’ indicators for community support and respite services
 - data on the participation of people with a disability in education and training and their highest level of educational and training attainment.

A profile of services provided under the CSTDA for people with a disability appears in section 13.1. A framework of performance indicators is outlined in section 13.2. The performance of jurisdictions is discussed in section 13.3 and future directions for performance reporting are discussed in section 13.4. Section 13.5 contains jurisdictions’ comments and section 13.6 provides definitions of the data descriptors and indicators. Section 13.7 lists the supporting tables for this chapter. Supporting tables are identified in references throughout the chapter by an ‘A’ suffix (for example, table 13A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Section 13.8 lists references used in this chapter.

13.1 Profile of specialist disability services

Service overview

The CSTDA defines ‘specialist disability services’ as ‘services or initiatives specially designed from time to time to meet the needs of people with disabilities’ (CSTDA 2003, p. 10). A definition of disability is provided in box 13.1.

Box 13.1 Definition of disability

The International Classification of Functioning, Disability and Health defines disability as being an experience for the person involved that may include the impairment of their body structure and function, limitation of their activity and restriction of their participation in life areas. The International Classification of Functioning, Disability and Health also recognises the role of physical and social environmental factors in affecting disability (WHO 2001).

The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC) was conducted in 1981, 1988, 1993, 1998 and 2003, and was based on the International Classification of Functioning, Disability and Health and its predecessor. The 2003 survey defined a disability as a limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.

(Continued on next page)

Box 13.1 (Continued)

Self-care, mobility and communication are defined as core activities. The ABS defines levels of core activity limitation as follows:

- mild — where a person does not need assistance and has no difficulty with self-care, mobility and/or communication, but uses aids or equipment
- moderate — where a person does not need assistance, but has difficulty with self-care, mobility and/or communication
- severe — where a person sometimes needs assistance with self-care, mobility and/or communication tasks; has difficulty understanding or being understood by family or friends; or can communicate more easily using sign language or other non-spoken forms of communication
- profound — where a person is unable, or always needs assistance, to perform self-care, mobility and/or communication tasks.

The CSTDA (2003, p. 9) defines people with disabilities who are eligible for CSTDA funded services:

People with disabilities attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is likely to be permanent and results in substantially reduced capacity in at least one of the following:

- self-care/management
- mobility
- communication

requiring significant ongoing and/or long term episodic support and which manifests itself before the age of 65.

Source: ABS (2004c); WHO (2001); CSTDA (2003).

Details of the specialist disability services provided under the CSTDA are outlined in the following section on roles and responsibilities. Mechanisms for the funding and delivery of these services differ across jurisdictions as a result of policy differences. Further contextual information is provided in appendix A.

Roles and responsibilities

The CSTDA defines the roles and responsibilities of the Australian, State and Territory governments in the provision of services to people with a disability. Its agreed purposes are listed in box 13.2.

Box 13.2 The purposes of the CSTDA

The purposes of the CSTDA are to:

- provide a national framework to underpin the provision of specialist disability services across Australia, and outline a means for measuring and publicising the progress of governments towards achieving this national framework
- outline the respective and collective roles and responsibilities of governments in the planning, policy setting and management of specialist disability services
- provide for accountability to funders in respect of funds contributed by one government which are expended by another government
- establish the financial arrangements for making funds available for the provision of specialist disability services
- define the persons eligible for services under this Agreement and acknowledge they may require services provided outside the Agreement
- provide for a nationally consistent approach to quality across specialist disability services
- provide for funds to address key national and strategic research, development and innovation priorities.

Source: CSTDA (2003, pp. 4–5).

The Australian Government administers the following services:

- open employment services that provide assistance to people with a disability in obtaining and/or retaining paid employment in the open labour market
- supported employment services that provide support to, and employment for, people with a disability within the same organisation.

Prior to 1 December 2004, the Australian Government also administered services that provided both open and supported employment assistance.

State and Territory governments administer the following services:

- accommodation support services that provide support to people with a disability in accommodation settings (hostels, institutions and group homes), and in their own home (including attendant/personal care, in-home support and alternative family placements)
- community access services that provide opportunities for people with a disability to gain and use their abilities to enjoy their full potential for social independence — including learning and life skills development and recreation/holiday programs

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- community support services that help people with a disability to integrate and participate in the community, including case management, counselling, early intervention therapy and other therapy services
 - respite care services that provide relief or support (for limited periods) to families and carers of people with a disability who are living in the community.

Australian, State and Territory governments have continuing responsibility for the following services:

- advocacy services that enable people with a disability to increase their control over their lives by representing their interests and views in the community
- information services that provide accessible information to people with a disability, their carers, families and related professionals about disabilities, specific and generic services and equipment; and promote the development of community awareness
- print disability services that produce alternative communication formats for people who, by reason of their disability, are unable to access information provided in a print medium
- research and development projects relating to:
 - the provision of services funded under the CSTDA
 - the achievement of the national framework under the CSTDA for people with a disability.

The CSTDA does not apply to the provision of:

- disability services and activities provided under the *Veterans' Entitlements Act 1986* (Cwlth)
- services with a specialist clinical focus, regardless of whether those services are provided to people eligible to receive services under the CSTDA.

Family and friends meet most needs of people with a disability. In 2003, an estimated 474 600 primary carers provided the majority of informal help with self-care, mobility and communication for people with a disability — an increase of 5.3 per cent on the number in 1998 (ABS 1999, 2004c). Recognising the cost of providing such informal support, the Australian Government provides income support in the form of the Carer Payment and other financial assistance through the Carer Allowance to carers of people with a disability (box 13.3). This financial assistance is not included under the CSTDA funding arrangements.

Box 13.3 Australian Government supplementary and income support arrangements

The Australian 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 payments include the Disability Support Pension, the Carer Payment, the Carer Allowance, the Sickness Allowance and the Mobility Allowance. Outlays on payments to people with a disability in 2005-06 (on an accrual basis) amounted to \$8.3 billion for the Disability Support Pension, \$1.2 billion for the Carer Payment (includes expenditure on carer bonus), \$1.3 billion for the Carer Allowance (includes expenditure on carer bonus), \$85.4 million for the Sickness Allowance and \$95.9 million for the Mobility Allowance (Department of Family, Community Services and Indigenous Affairs (FaCSIA) (unpublished) and Department of Employment and Workplace Relations (DEWR) (unpublished)). These income support arrangements do not constitute a CSTDA service.

At 30 June 2006, there were 712 163 recipients of the Disability Support Pension, 105 058 recipients of the Carer Payment, 382 926 recipients of the Carer Allowance, and 51 669 recipients of the Mobility Allowance. There were also 7510 recipients of the Sickness Allowance (table 13A.2).

Source: FaCSIA (unpublished); DEWR (unpublished); table 13A.2.

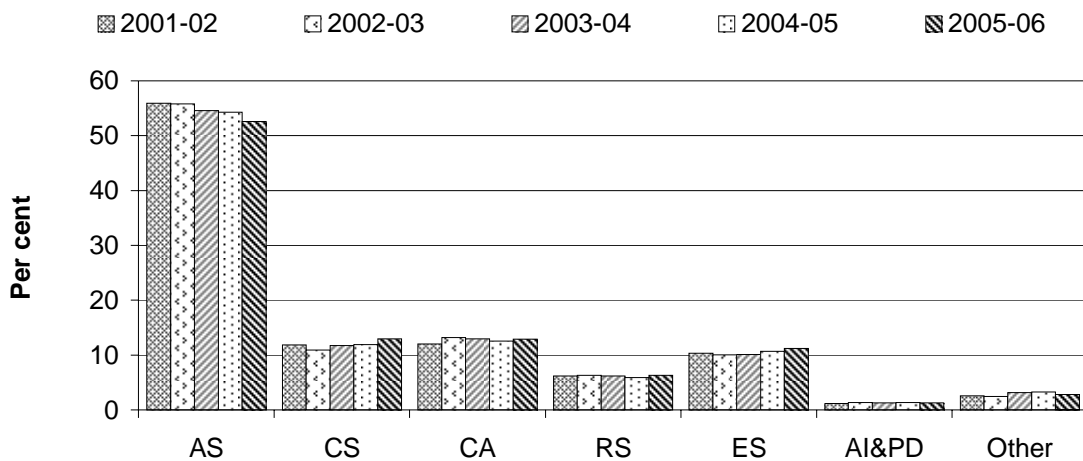
Funding

Under the CSTDA, Australian and State and Territory governments fund both government and non-government providers of services for people with a disability. Total government expenditure on CSTDA funded services was \$3.9 billion in 2005-06 — a real increase of 2.9 per cent on the expenditure in 2004-05 (\$3.8 billion) (table 13A.5). State and Territory governments funded the majority of this expenditure in 2005-06 (72.5 per cent, or \$2.8 billion). The Australian Government funded the remainder (27.5 per cent, or \$1.1 billion), which included \$595.1 million in transfer payments to states and territories (tables 13A.6 and 13A.7).

Direct government expenditure on CSTDA funded services (that is, excluding expenditure on administration) was \$3.6 billion in 2005-06 (table 13A.3). The distribution of direct government expenditure varied across jurisdictions in 2005-06. The main areas of State and Territory government expenditure were accommodation support services (52.6 per cent of total direct service expenditure), community access and community support services (both 12.9 per cent of total direct service expenditure) (figure 13.1). Employment services were the main area of Australian Government expenditure in 2005-06 (11.2 per cent of total direct

service expenditure and 89.6 per cent of Australian Government direct service expenditure) (table 13A.4).

Figure 13.1 Direct expenditure on CSTDA funded services, by service type^a



AS = accommodation support; CS = community support; CA = community access; RS = respite services; ES = employment services; AI&PD = advocacy, information and print disability. ^a See table 13A.3 for detailed notes accompanying expenditure data.

Source: Australian, State and Territory governments (unpublished); table 13A.4.

Size and scope

Disability prevalence

The 2003 ABS SDAC estimated that people with a core activity limitation, schooling or employment restriction accounted for 13.0 per cent of the total Australian population aged 5–64 years in 2003 (ABS 2004c). This proportion comprised 4.0 per cent who had a profound or severe core activity limitation, a further 6.6 per cent who had a mild to moderate core activity limitation, and 2.4 per cent who had a schooling or employment restriction only (ABS 2004c). Tables 13A.9 and 13A.10 contain additional information from the SDAC on people with a disability.

Aboriginal and Torres Strait Islander people

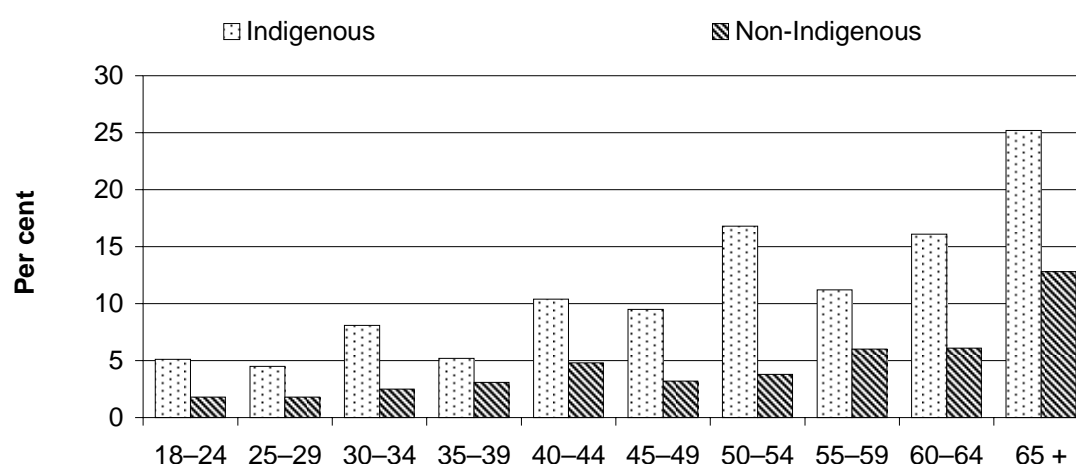
Indigenous people have significantly higher rates of profound or severe core activity limitation than non-Indigenous people. The Australian Institute of Health and Welfare (AIHW) estimated that the proportion of Indigenous people aged over 18 years who had a profound or severe core activity limitation was approximately

2.4 times that of non-Indigenous people in 2002 (AIHW 2006c). This estimate is based on data from the ABS's General Social Survey (GSS) and National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and takes into account differences in the:

- age structure of the Indigenous and non-Indigenous populations
- method that was applied in remote areas for the two surveys (for further details on the difference in method see AIHW 2006c).

The difference (in rate ratio terms) between the populations is most marked for people aged 50–54 years and those aged 30–34 years (figure 13.2).

Figure 13.2 Proportion of age groups who have a profound or severe core activity limitation, by Indigenous status, 2002^a



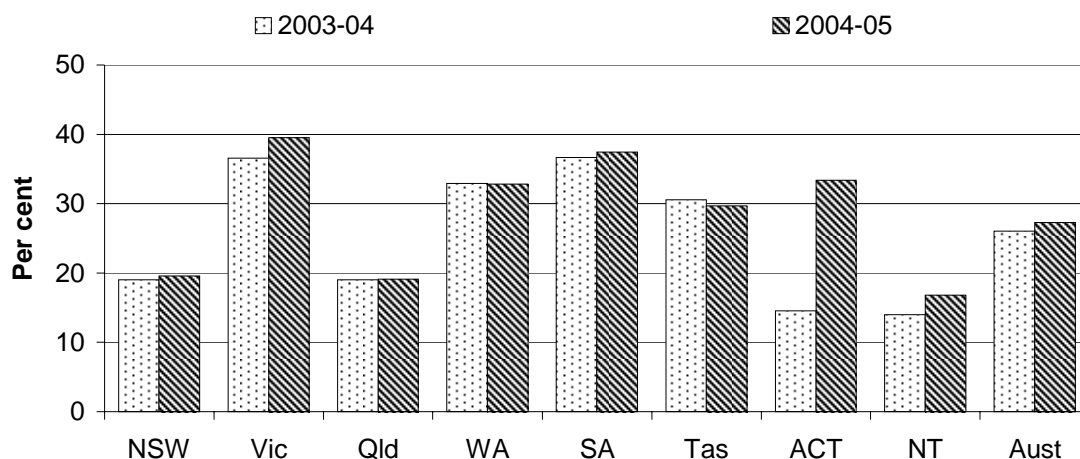
^a For the NATSISS, there were a number of differences in the 'screening' questions used to establish disability status and disability type for persons living in remote and non-remote areas. While a 'common' set of questions was asked in both remote and non-remote areas, some additional questions were asked in non-remote areas only. The expanded set of screening questions asked in non-remote areas is referred to as the 'broader criteria', the smaller set is referred to as the 'common criteria'. For the reported proportions, the relative impact of the broader criteria on the Indigenous estimate in non-remote areas was calculated and applied as a weight to the estimate for remote areas. The non-Indigenous estimates from the GSS are based on the broader criteria only (AIHW 2006c).

Source: AIHW (2006c).

Use of CSTDA funded services

In 2004-05, 190 124 people were reported as using services provided under the CSTDA (excluding users who received specialist psychiatric disability services only) (table 13A.1). Nationally, this is 27.3 per cent of the estimated potential population (that is, people aged under 65 years who had the potential to require specialist disability services at some time) (figure 13.3).

Figure 13.3 Users of CSTDA funded services as a proportion of the estimated potential population^{a, b, c, d, e, f, g}

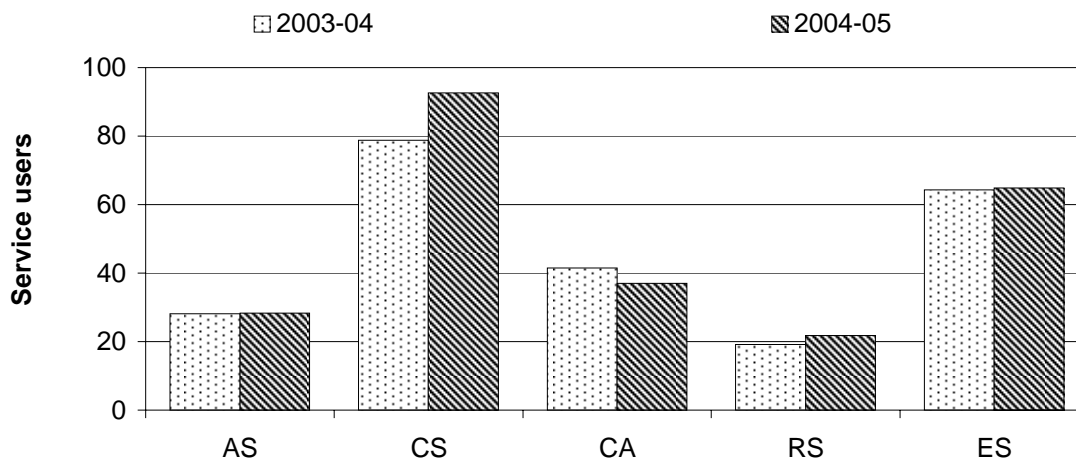


^a Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. For 2003-04, the NT has population estimates of less than 9000. ^b Individuals might have accessed services from more than one State or Territory during the relevant period. ^c The potential population estimates (national age- and sex-specific rates applied to each jurisdiction) for CSTDA funded services are the number of people aged under 65 years, with profound or severe core activity limitations, multiplied by the Indigenous factor for that jurisdiction. See section 13.6 for detailed information on the estimated potential population and the Indigenous factor. ^d Data for users of CSTDA funded services exclude specialist psychiatric disability services identified by the jurisdiction. ^e Data quality continues to improve following the implementation of the CSTDA National Minimum Data Set (NMDS). However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet and service user response rates between jurisdictions and across years, for example, should be taken into account when interpreting these data. ^f The service type outlet response rate was 93 per cent nationally in 2003-04 — 100 per cent for WA, SA, Tasmania and the Australian Government; 97 per cent for Queensland; 95 per cent for the NT; 94 per cent for Victoria; 93 per cent for the ACT; and 80 per cent for NSW. The service type outlet response rate was 94 per cent nationally in 2004-05 — 100 per cent for WA, SA and the Australian Government; 99 per cent for Queensland; 98 per cent for the ACT; 96 per cent for Tasmania; 92 per cent for Victoria; 85 per cent for NSW and 70 per cent for the NT. ^g For the ACT, improved data capture for therapy services resulted in an increased service user count between 2003-04 and 2004-05.

Source: ABS (2003a, 2004a, 2004d); AIHW (2005a, 2005b, 2006a, 2006b, 2006c); AIHW analysis of the 2003 ABS SDAC data; table 13A.1.

Service user numbers varied across service types (figure 13.4). Accommodation support, community access, community support and respite services reported 136 307 users and employment services reported 64 835 users.

Figure 13.4 Users of CSTDA funded services, by service type ('000)^{a, b}



AS = accommodation support; CS = community support; CA = community access; RS = respite services; ES = employment services. ^a Data for users of CSTDA funded services exclude specialist psychiatric disability services identified by the jurisdiction. ^b Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet and service user response rates between jurisdictions and across years, for example, should be taken into account when interpreting these data.

Source: AIHW (2005a, 2005b, 2006a, 2006b); table 13A.1.

Younger people with a disability in residential aged care

At its February 2006 meeting, the Council of Australian Governments (COAG) made a commitment to start to reduce the number of younger people with a disability living in residential aged care. COAG agreed to establish a five-year program, beginning in July 2006, with funding of up to \$122 million from the Australian Government and up to \$122 million from State and Territory governments. Funding for this program is separate and in addition to the general funding provided under the CSTDA. At 1 December 2006, the Australian Government and several jurisdictions had signed bilateral agreements, and the remaining jurisdictions were considering agreements.

There are three elements to the program:

- Move younger people with a disability currently accommodated in residential aged care into appropriate supported disability accommodation where it can be made available and if this is what clients choose.
- Divert future admission of younger people with a disability who are at risk of admission to residential aged care into more appropriate forms of accommodation.

-
- Enhance the delivery of specialist disability services to those younger people with a disability who choose to remain in residential aged care or for whom residential aged care remains the only available suitable supported accommodation option.

Progress on the implementation of the program will be monitored and reported. The initial priority for the program will be people aged under 50, and participation will be voluntary. On 30 June 2006, there were 6731 people aged under 65 years living in residential aged care of whom 1049 were aged under 50 years (Australian Government unpublished).

13.2 Framework of performance indicators

The framework of performance indicators is based on the Australian, State and Territory governments' shared objectives under the CSTDA (box 13.4).

Box 13.4 Objectives of government funded services for people with a disability

The performance data for this Report cover services provided under the CSTDA. Through the CSTDA, governments strive to enhance the quality of life experienced by people with a disability by assisting them to live as valued and participating members of the community.

In working towards this objective, governments have five policy priorities, to:

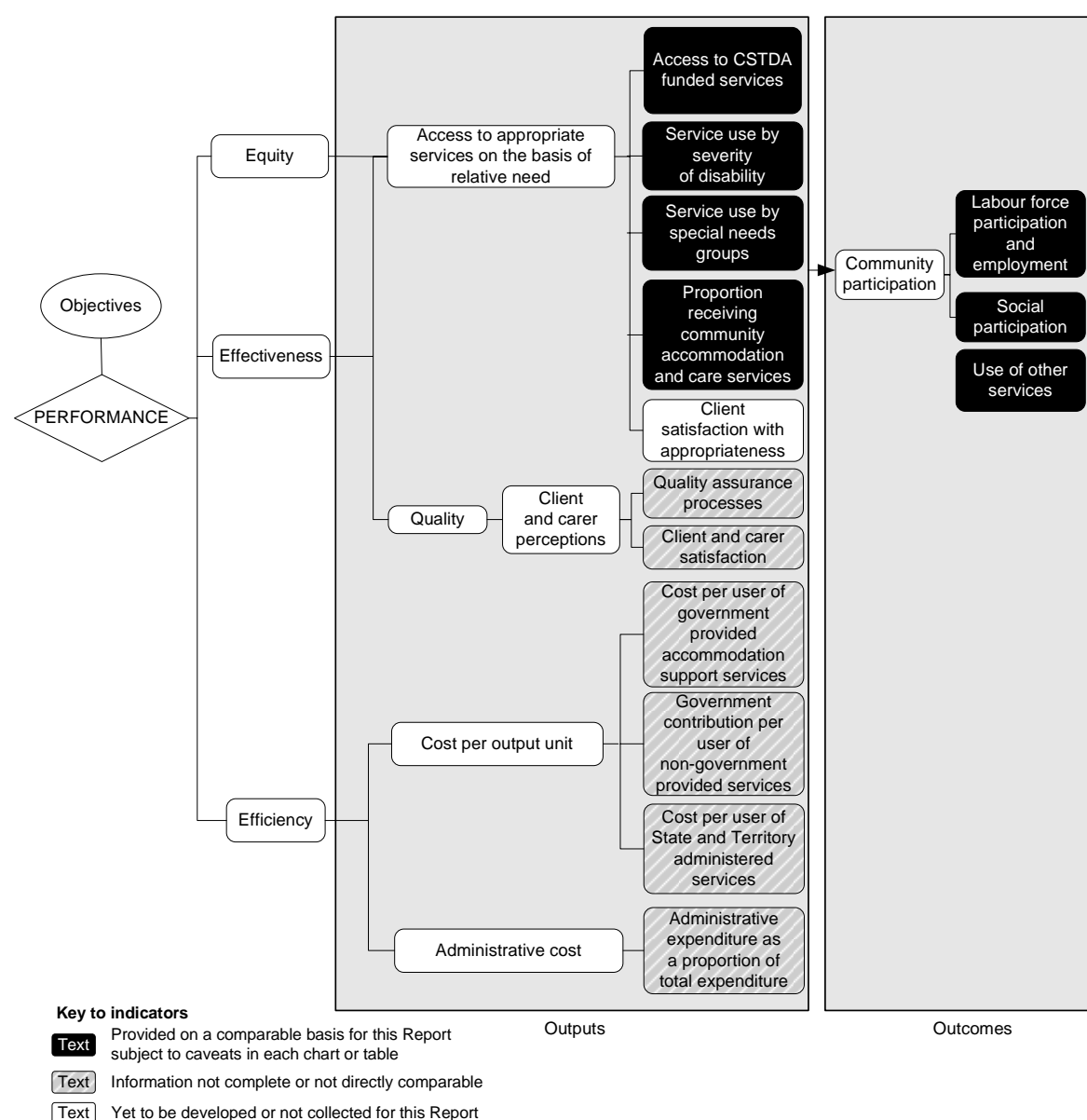
- strengthen access to generic services for people with a disability
- strengthen across government linkages — bilateral agreements between the Australian Government and each State and Territory have been negotiated to improve services
- strengthen individuals, families and carers
- improve long term strategies to respond to, and manage, demand for specialist disability services
- improve accountability, performance reporting and quality.

Source: CSTDA (2003).

The performance indicator framework shows which specialist disability services data are comparable in the 2007 Report (figure 13.5). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). This year the three access indicators ('access to

accommodation', 'access to employment' and 'access to community access') have been combined into one in the framework ('access to CSTDA funded services'). This was done to reduce repetition and improve presentation. The same measures for these services are reported. Access measures for two additional services (community support and respite) are also reported under this indicator for the first time.

Figure 13.5 Performance indicators for services for people with a disability



The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of government funded services for people with a disability. This is consistent with the general

performance indicator framework and service process diagram (figures 1.2 and 1.3, chapter 1) on which the Steering Committee has agreed.

Proxy efficiency indicators focus on unit costs and administrative costs. Effectiveness and equity indicators focus on access to appropriate services and service quality. Outcome indicators focus on the participation of people with a disability in the community.

13.3 Key performance indicator results

Different delivery contexts, locations and client characteristics may affect the equity, effectiveness and efficiency of specialist disability services. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter.

The performance indicator results reported in this chapter generally relate to CSTDA funded services. This Report includes service user data for 2004-05. These data were sourced from the CSTDA National Minimum Data Set (NMDS) collection, which is coordinated by the AIHW. The CSTDA NMDS collection was implemented in 2002-03, with national data from the first collection available for the period 1 January 2003 to 30 June 2003. Before its implementation, service user data for this chapter were sourced from the Commonwealth State Disability Agreement (CSDA) Minimum Data Set (MDS). The most significant change from the CSDA MDS to the CSTDA NMDS collection is that, for most service types, funded agencies are required to provide information about all service users throughout the year (rather than just those who received a service on a snapshot day). Other information on the implementation of the CSTDA NMDS is contained in box 13.6 of the 2006 Report and in AIHW (2003).

When considering the indicator results derived using service user data, comparisons between jurisdictions and between the 2003-04 and 2004-05 data should be undertaken with care. While the implementation of the CSTDA NMDS continues to improve data quality, quality is still affected by a number of factors. In particular, the proportion of service users and service outlets that provided data (response rates) and the 'not stated' rates of particular data items vary across jurisdictions and between 2003-04 and 2004-05.

Outputs

Equity and effectiveness — access to appropriate services on the basis of relative need

The following equity and effectiveness access indicators are reported:

- ‘access to CSTDA funded services’
- ‘service use by severity of disability’
- ‘service use by special needs groups’
- ‘proportion of accommodation support service users receiving community accommodation and care services’.

Access to CSTDA funded services

‘Access to CSTDA funded services’ is an indicator of access to specialist disability services on the basis of relative need (box 13.5).

Box 13.5 Access to CSTDA funded services

The proportion of the estimated potential population using CSTDA funded services is an output–access indicator of governments’ objective to provide access to government funded or provided specialist disability services on the basis of relative need and available resources. Measures are reported for accommodation support, employment, community access, community support and respite services.

This indicator is defined as the number of people using a particular CSTDA funded service divided by the ‘potential population’ for that service. The potential population is an estimate that broadly indicates the number of people with the potential to require specialist disability services at some time.

The potential population estimate for *accommodation support*, *community access* and *community support services* is the number of people aged under 65 years with profound or severe core activity limitations, multiplied by the Indigenous factor for a jurisdiction. The potential population estimate for *employment services* is the number of people aged 15–64 years with severe or profound core activity limitations, multiplied by both the Indigenous factor and the labour force participation rate for a jurisdiction. The potential population estimate for *respite services* is the number of people aged under 65 years with profound or severe core activity limitations who also reported a primary carer, multiplied by the Indigenous factor for a jurisdiction. The potential populations are further defined in section 13.6.

(Continued on next page)

Box 13.5 (Continued)

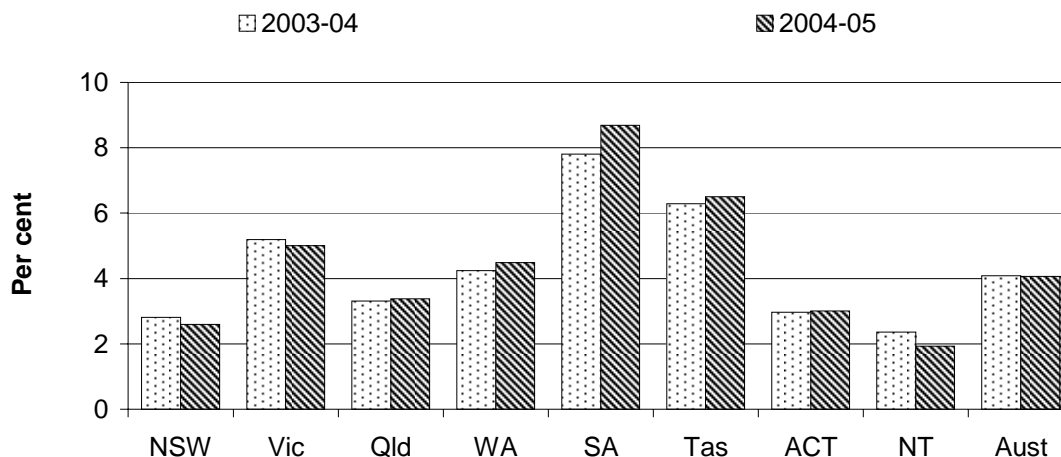
A higher proportion of the relevant estimated potential population using a particular CSTDA service suggests greater access to this service.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or accessed by those most in need. In addition, not all people in the estimated 'potential population' will need the service or seek to access the service in the relevant period.

The numerators and denominators of the access measures do not match fully. The numerator of an access measure includes service users of all ages who have profound, severe, or moderate to no core activity limitations. The denominator, which is the 'potential population', is an estimate of the number of people who have a profound or severe core activity limitation and are aged under 65 years only. So while the numerator includes people who are aged 65 and over and/or people who have moderate to no core activity limitations this is not the case for the denominator. It would be helpful, therefore, to consider the results of this indicator in conjunction with the 'service use by severity of disability' indicator. The 'service use by severity of disability' indicator provides information in relation to access to specialist disability services on the basis of relative need, where level of core activity limitation is used as a proxy for relative need.

Nationally, 4.1 per cent of the estimated potential population were using CSTDA funded accommodation support services in 2004-05 (figure 13.6).

Figure 13.6 Users of CSTDA funded accommodation support services as a proportion of the estimated potential population^{a, b, c, d, e, f, g}

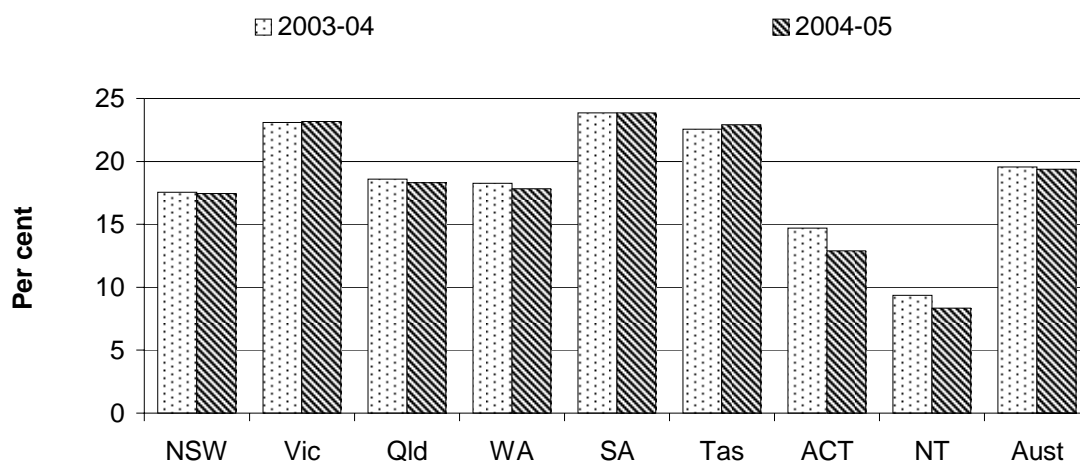


^a Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. For 2003-04, the NT has population estimates of less than 9000. ^b Individuals might have accessed services from more than one State or Territory during the relevant period. ^c The potential population estimates (national age- and sex-specific rates applied to each jurisdiction) for accommodation support services are the number of people aged under 65 years, with profound or severe core activity limitations, multiplied by the Indigenous factor for that jurisdiction. See section 13.6 for detailed information on the estimated potential population and the Indigenous factor. ^d Data for users of CSTDA funded accommodation support services exclude specialist psychiatric disability services identified by the jurisdiction. ^e Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet and service user response rates between jurisdictions and across years, for example, should be taken into account when interpreting these data. ^f NSW experienced low and varied data response rates for 2003-04 and 2004-05. This led to the underreporting of service user numbers for both years and affected the comparability of the data across the two years. ^g Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users.

Source: ABS (2003a, 2004a, 2004d); AIHW (2005a, 2005b, 2006a, 2006b, 2006c); AIHW analysis of the 2003 ABS SDAC data; table 13A.11.

During the reporting period, the Australian Government had responsibility for employment services under the CSTDA and provided most services through funding non-government organisations. Nationally, 19.4 per cent of the estimated potential population were using CSTDA funded employment services in 2004-05 (figure 13.7).

Figure 13.7 Users of CSTDA funded employment services as a proportion of the estimated potential population for employment services
a, b, c

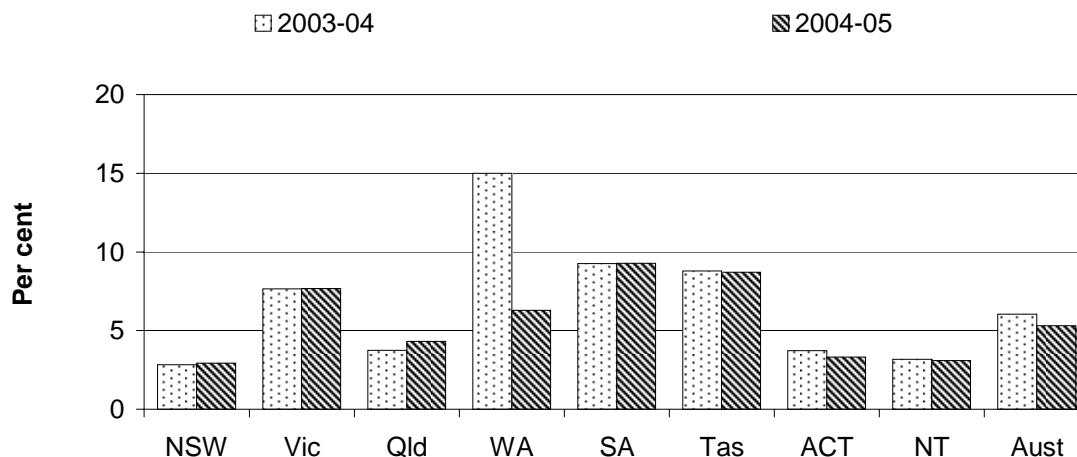


a Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. Tasmania, the ACT and the NT have population estimates of less than 9000. **b** Individuals might have accessed services from more than one State or Territory during the relevant period. **c** The potential population estimates (national age- and sex-specific rates applied to each jurisdiction) for employment services are the number of people aged 15–64 years with severe or profound core activity limitations, multiplied by both the Indigenous factor and the labour force participation rate for that jurisdiction. See section 13.6 for detailed information on the estimated potential population and the Indigenous factor.

Source: ABS (2003a, 2003b, 2004a, 2004b, 2004d); AIHW (2005a, 2005b, 2006a, 2006b, 2006c); AIHW analysis of the 2003 ABS SDAC data; table 13A.12.

Nationally, 5.3 per cent of the estimated potential population were using CSTDA funded community access services in 2004-05 (figure 13.8).

Figure 13.8 Users of CSTDA funded community access services as a proportion of the estimated potential population^{a, b, c, d, e, f, g}

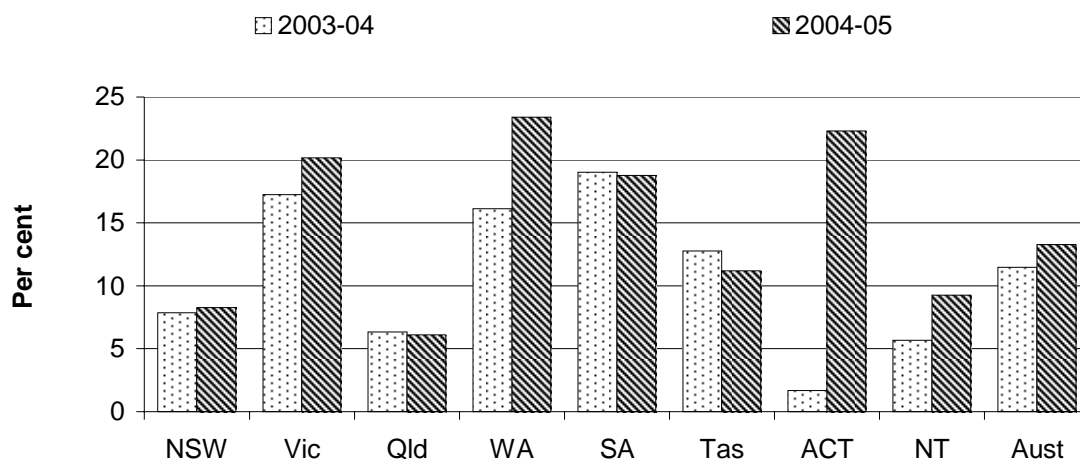


^a Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. For 2003-04, the NT has population estimates of less than 9000. ^b Individuals might have accessed services from more than one State or Territory during the relevant period. ^c Data for users of CSTDA funded community access services exclude specialist psychiatric disability services specifically identified by the jurisdiction. ^d Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet and service user response rates between jurisdictions and across years, for example, should be taken into account when interpreting these data. ^e NSW experienced low and varied data response rates for 2003-04 and 2004-05. This led to the underreporting of service user numbers for both years and affected the comparability of the data across the two years. ^f Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users. ^g The decrease in the number of WA service users in 2004-05 is due to a change in reporting by one recreation agency.

Source: ABS (2003a, 2004a, 2004d); AIHW (2005a, 2005b, 2006a, 2006b, 2006c); AIHW analysis of the 2003 ABS SDAC data; table 13A.13.

'Access to community support services' is reported for the first time in this Report. Nationally, 13.3 per cent of the estimated potential population were using CSTDA funded community support services in 2004-05 (figure 13.9).

Figure 13.9 Users of CSTDA funded community support services as a proportion of the estimated potential population^{a, b, c, d, e, f, g}

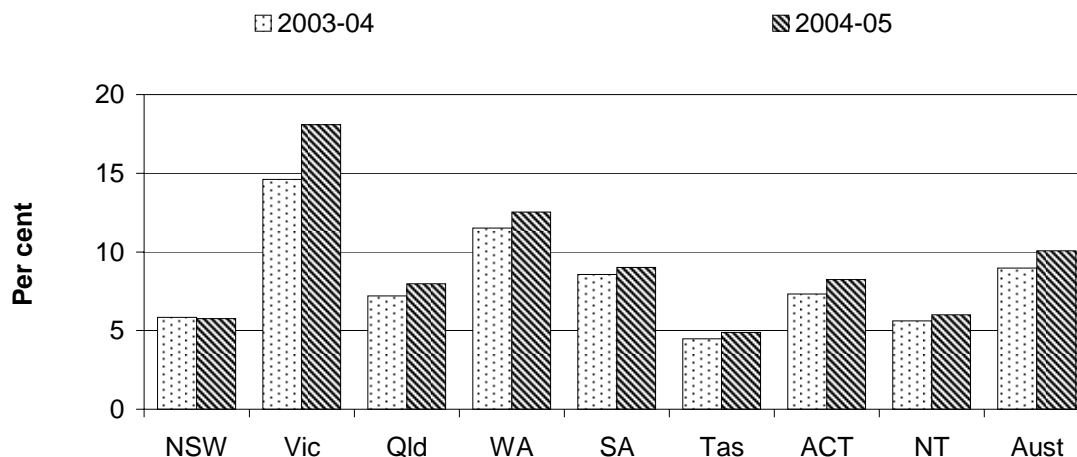


^a Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. For 2003-04, the NT has population estimates of less than 9000. ^b Individuals might have accessed services from more than one State or Territory during the relevant period. ^c Data for users of CSTDA funded community support services exclude specialist psychiatric disability services specifically identified by the jurisdiction. ^d Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet and service user response rates between jurisdictions and across years, for example, should be taken into account when interpreting these data. ^e NSW experienced low and varied data response rates for 2003-04 and 2004-05. This led to the underreporting of service user numbers for both years and affected the comparability of the data across the two years. ^f The increase in the number of WA service users in 2004-05 is due to the inclusion of data from a new electronic database for the first time. ^g For the ACT, improved data capture for therapy services has resulted in an increased service user count for 2004-05. However, this figure continues to undercount service user numbers as it does not include casual clients of therapy services.

Source: ABS (2003a, 2004a, 2004d); AIHW (2005a, 2005b, 2006a, 2006b, 2006c); AIHW analysis of the 2003 ABS SDAC data; table 13A.14.

‘Access to respite services’ is reported for the first time in this Report. Nationally, 10.1 per cent of the estimated potential population were using CSTDA funded respite services in 2004-05 (figure 13.10).

Figure 13.10 Users of CSTDA funded respite services as a proportion of the estimated potential population for respite services^{a, b, c, d, e}



^a Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. Tasmania, the ACT and the NT have population estimates of less than 9000. ^b Individuals might have accessed services from more than one State or Territory during the relevant period. ^c Data for users of CSTDA funded community support services exclude specialist psychiatric disability services specifically identified by the jurisdiction. ^d Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet and service user response rates between jurisdictions and across years, for example, should be taken into account when interpreting these data. ^e NSW experienced low and varied data response rates for 2003-04 and 2004-05. This led to the underreporting of service user numbers for both years and affected the comparability of the data across the two years.

Source: ABS (2003a, 2004a, 2004d); AIHW (2005a, 2005b, 2006a, 2006b, 2006c); AIHW analysis of the 2003 ABS SDAC data; table 13A.15.

Service use by severity of disability

‘Service use by severity of disability’ is an indicator of access to specialist disability services on the basis of relative need (box 13.6). This indicator provides additional information for interpreting the access to CSTDA funded accommodation support, employment, community access, community support and respite services measures reported above.

Box 13.6 Service use by severity of disability

The proportion of people accessing CSTDA funded services by severity of core activity limitation is an output (access) indicator of governments' objective to use available resources to target services to people with the greatest level of need.

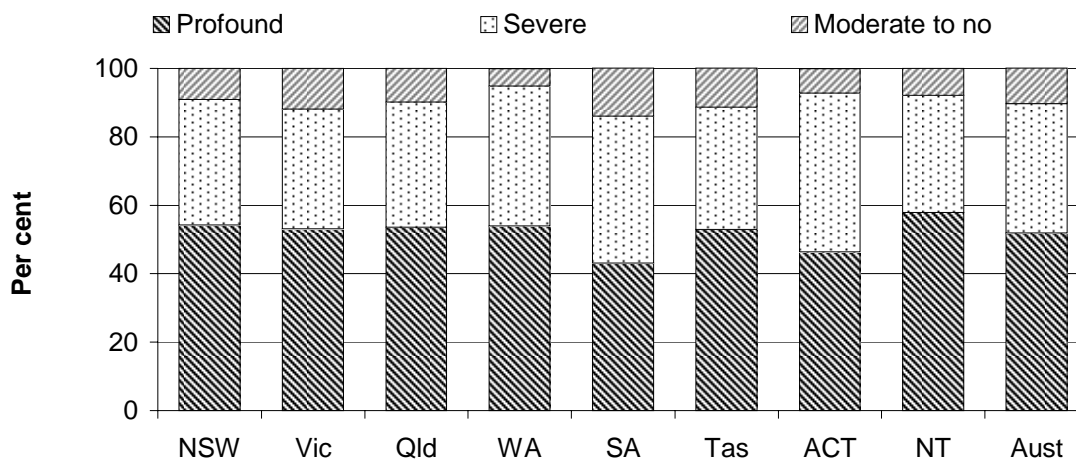
This indicator is defined as the proportion of people who access CSTDA funded services, by severity of core activity limitation. Three categories of core activity limitations are reported: profound, severe, and moderate to no core activity limitation. Measures are reported for accommodation support, employment, community access, community support and respite services.

A higher proportion of people with a profound or severe core activity limitation using a particular service type suggests greater access to this service type for those with the greatest level of need.

This indicator does not provide information on whether services are appropriate for the needs of the people receiving them or appropriately targeted to those with the greatest level of need in terms of access to other formal and informal support. The need for services is assumed to vary according to the level of core activity limitation and so core activity limitation is used as one proxy for relative need. It is important to note that core activity limitation data are self/carer identified, not based on formal clinical assessments of individual limitations. In addition, there are other factors that may also be important in determining relative need, such as the complexity of a service user's needs.

Nationally, 51.9 per cent of users of CSTDA funded accommodation support services in 2004-05 had a profound core activity limitation, 37.8 per cent had a severe core activity limitation and 10.4 per cent had moderate to no core activity limitations (figure 13.11).

Figure 13.11 Users of CSTDA funded accommodation support services, by severity of core activity limitation, 2004-05^{a, b, c, d, e}

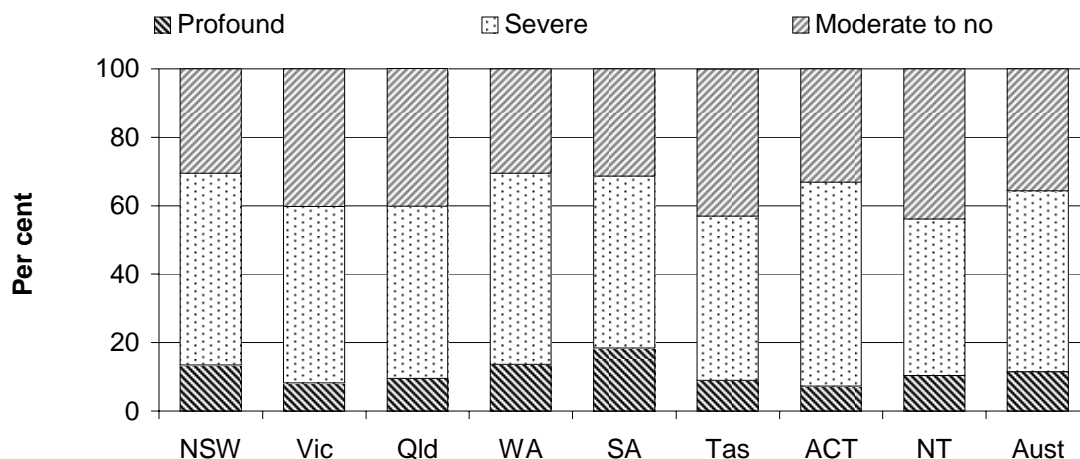


^a Severity of core activity limitation is derived using data on level of support needed in one or more of the support areas: self-care, mobility, and communication. Service users with a profound core activity limitation reported always needing support in one or more of these areas. Service users with a severe core activity limitation reported sometimes needing support in one or more of these areas. Service users with a moderate to no core activity limitation reported needing no support in all of these areas. ^b Individuals might have accessed services from more than one State or Territory during 2004-05. ^c Data exclude 1459 service users who did not report on a need for support with any of the areas: self-care, mobility, or communication. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Data for service users of CSTDA funded accommodation support services exclude specialist psychiatric disability services identified by the jurisdiction. ^e Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality.

Source: AIHW (2006a, 2006b); table 13A.16.

Nationally, 11.5 per cent of users of CSTDA funded employment services in 2004-05 had a profound core activity limitation, 52.9 per cent had a severe core activity limitation and 35.6 per cent had moderate to no core activity limitations (figure 13.12).

Figure 13.12 Users of CSTDA funded employment services, by severity of core activity limitation, 2004-05^{a, b, c, d}

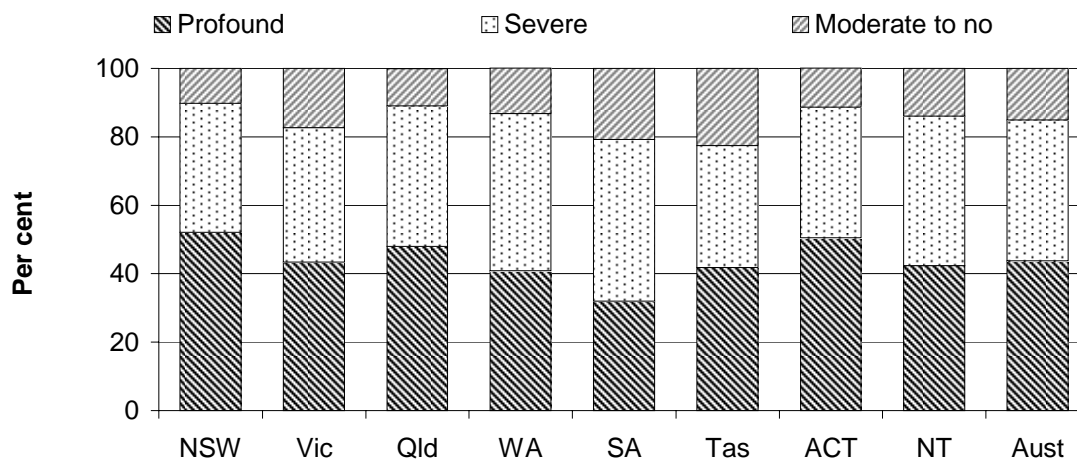


^a Severity of core activity limitation was derived using data on the level of support needed in one or more of the support areas: self-care, mobility, and communication. Service users with a profound core activity limitation reported always needing support in one or more of these areas. Service users with a severe core activity limitation reported sometimes needing support in one or more of these areas. Service users with a moderate or no core activity limitation reported needing no support in all of these areas. ^b Individuals might have accessed services from more than one State or Territory during 2004-05. ^c Data exclude 2003 service users who did not report on a need for support with any of the areas: self-care, mobility, or communication. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Severity of core activity limitation relates to the level of support needed in the areas of self care, mobility and communication. It does not necessarily relate to the level of support needed to find or maintain employment.

Source: AIHW (2006a, 2006b); table 13A.17.

Nationally, 43.8 per cent of users of CSTDA funded community access services in 2004-05 had a profound core activity limitation, 41.1 per cent had a severe core activity limitation and 15.1 per cent had moderate to no core activity limitations (figure 13.13).

Figure 13.13 Users of CSTDA funded community access services, by severity of core activity limitation, 2004-05^{a, b, c, d, e, f}

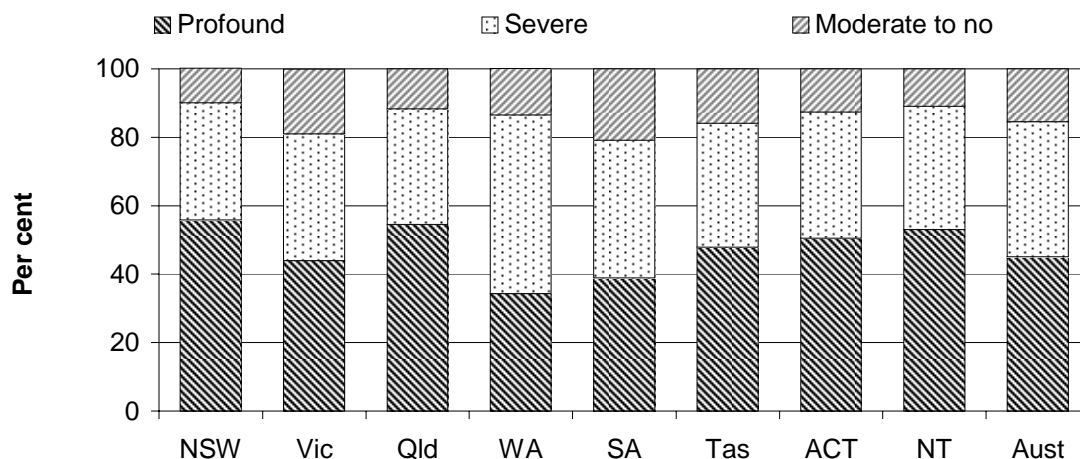


^a Severity of core activity limitation was derived using data on the level of support needed in one or more of the support areas: self-care, mobility, and communication. Service users with a profound core activity limitation reported always needing support in one or more of these areas. Service users with a severe core activity limitation reported sometimes needing support in one or more of these areas. Service users with a moderate or no core activity limitation reported needing no support in all of these areas. ^b Individuals might have accessed services from more than one State or Territory during 2004-05. ^c Data exclude 4517 service users who did not report on a need for support with any of the areas: self-care, mobility, or communication. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Data for service users of CSTDA funded community access services exclude specialist psychiatric disability services specifically identified by the jurisdiction. ^e Service users who accessed the service type 'recreation/holiday programs' (service type 3.02) were not required to complete the item on support needs; however, those who did provide a response are included in the data. ^f Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality.

Source: AIHW (2006a, 2006b); table 13A.18.

Use by severity of disability data for CSTDA funded community support services is reported for the first time in this Report. Care should be taken when interpreting this measure due to the high rate of missing data. Nationally, 45.1 per cent of users of CSTDA funded community support services in 2004-05 had a profound core activity limitation, 39.5 per cent had a severe core activity limitation and 15.4 per cent had moderate to no core activity limitations (figure 13.14).

Figure 13.14 Users of CSTDA funded community support services, by severity of core activity limitation, 2004-05^{a, b, c, d, e}

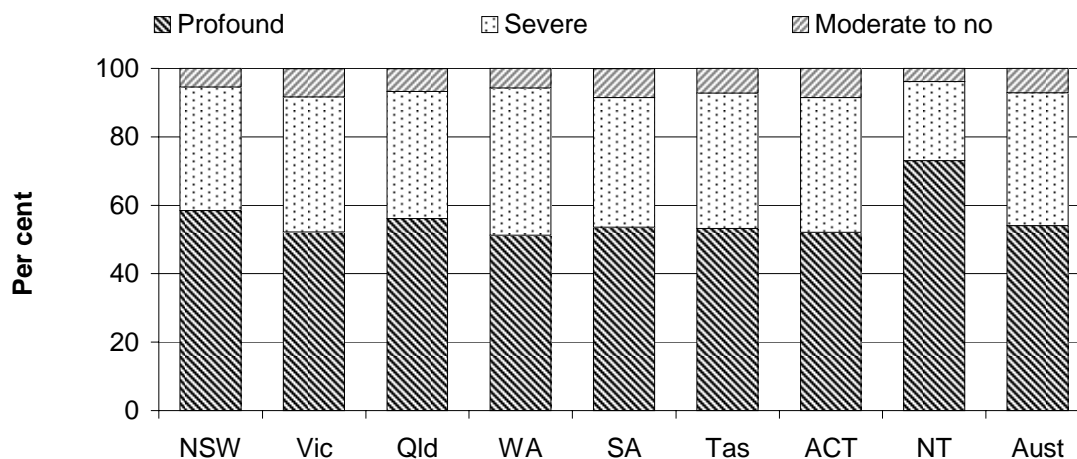


^a Severity of core activity limitation was derived using data on the level of support needed in one or more of the support areas: self-care, mobility, and communication. Service users with a profound core activity limitation reported always needing support in one or more of these areas. Service users with a severe core activity limitation reported sometimes needing support in one or more of these areas. Service users with a moderate or no core activity limitation reported needing no support in all of these areas. ^b Individuals might have accessed services from more than one State or Territory during 2004-05. ^c Data exclude 30 297 service users who did not report on a need for support with any of the areas: self-care, mobility, or communication. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Data for service users of CSTDA funded community support services exclude specialist psychiatric disability services specifically identified by the jurisdiction. ^e Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality.

Source: AIHW (2006a, 2006b); table 13A.19.

Use by severity of disability data for CSTDA funded respite services is reported for the first time in this Report. Nationally, 54.1 per cent of users of CSTDA funded respite services in 2004-05 had a profound core activity limitation, 38.8 per cent had a severe core activity limitation and 7.1 per cent had moderate to no core activity limitations (figure 13.15).

Figure 13.15 Users of CSTDA funded respite services, by severity of core activity limitation, 2004-05^{a, b, c, d, e}



^a Severity of core activity limitation was derived using data on the level of support needed in one or more of the support areas: self-care, mobility, and communication. Service users with a profound core activity limitation reported always needing support in one or more of these areas. Service users with a severe core activity limitation reported sometimes needing support in one or more of these areas. Service users with a moderate or no core activity limitation reported needing no support in all of these areas. ^b Individuals might have accessed services from more than one State or Territory during 2004-05. ^c Data exclude 2824 service users who did not report on a need for support with any of the areas: self-care, mobility, or communication. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Data for service users of CSTDA funded respite services exclude specialist psychiatric disability services specifically identified by the jurisdiction. ^e Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality.

Source: AIHW (2006a, 2006b); table 13A.20.

Service use by special needs groups

An additional indicator of access is the comparison between the representation of all people with a disability who use CSTDA funded services and the representation of people with a disability from special needs groups (box 13.7). The numerators and denominators of the 'service use by special needs groups' measures do not match fully. The numerators of the measures include service users of all ages whereas the denominators (populations) include people aged under 65 years only.

Box 13.7 Service use by special needs groups

The proportion of people from special needs groups accessing CSTDA funded services is an output (access) indicator of governments' objective that access to appropriate services should be equitable for all members of the community. The three special needs groups reported here are:

- people from outer regional and remote/very remote locations
- people identified as Indigenous
- people who were not born in Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland or the United States — that is, people born in a non-English speaking country.

This indicator compares the proportion of service users per 1000 people from a particular special needs group with the proportion of service users per 1000 people outside the special needs group. The disability service types reported are accommodation support, employment, community access, community support and respite services. For accommodation support, community access, community support and respite services, people aged under 65 years are included in the population counts for both the special needs groups and the people outside the special needs groups. For employment, only people aged 15–64 years are included in these population counts.

Holding other factors constant, the proportion of service users per 1000 people from a special needs group should not vary significantly from the proportion of service users per 1000 people outside the special needs group. While a markedly lower proportion may represent reduced access for a special needs group, it may also represent strong alternative support networks (and thus a lower level of need), or the individual choice of people with a disability not to access CSTDA funded services. Similarly, while a higher proportion may suggest poor service targeting or the lack of alternate support networks, it may also reflect the special needs group having a greater prevalence of disability.

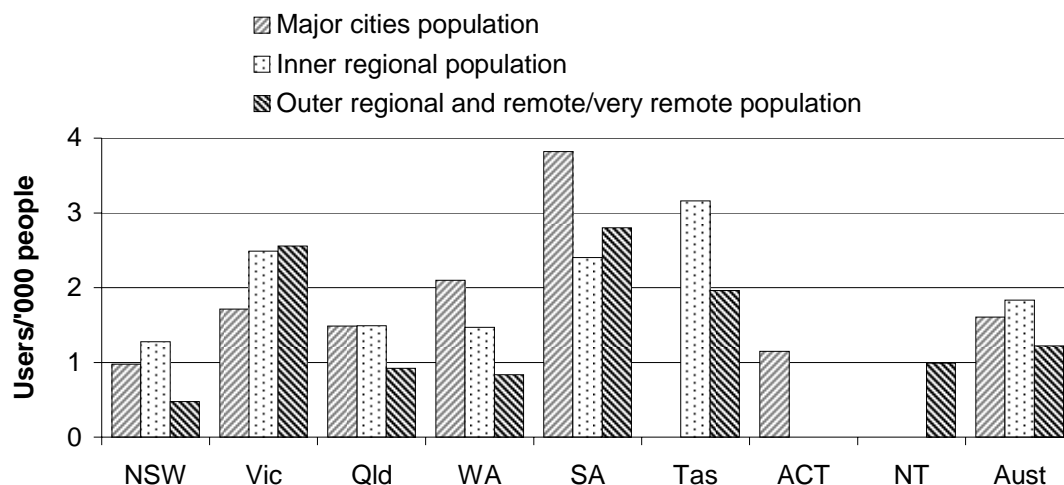
The CSTDA funded services are provided on the basis of need and available resources. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. The indicator also does not take into account differences in:

- the prevalence of disability between people in the special needs group and people outside the special needs groups — this may be a significant issue when comparing Indigenous and non-Indigenous populations' access to services
- the level of informal assistance that is available for people in special needs groups and outside the special needs groups. Results for outer regional and remote/very remote users of accommodation support services, for example, need to be considered with care because alternatives to government funded accommodation support services may be more readily available in these areas. Specifically, accommodation support services in outer regional and remote/very remote areas are largely provided informally, making use of local area coordinators and local community resources.

Service use by special needs groups — people in outer regional and remote/very remote areas

Nationally, the proportion of the outer regional and remote/very remote population who used CSTDA funded accommodation support services in 2004-05 (1.2 service users per 1000 people aged under 65 years) was lower than that of the major cities and inner regional populations (1.6 and 1.8 service users per 1000 people aged under 65 years, respectively) (figure 13.16). Comparisons between the outer regional and remote/very remote populations' and major cities and inner regional populations' access to CSTDA funded services should be undertaken with care. Outer regional and remote/very remote areas have a higher proportion of Indigenous people than major cities and inner regional areas and therefore the prevalence of disability may differ for these populations.

Figure 13.16 Users of CSTDA funded accommodation support services per 1000 people, by geographic location, 2004-05 ^{a, b, c, d, e, f, g, h, i, j, k, l}

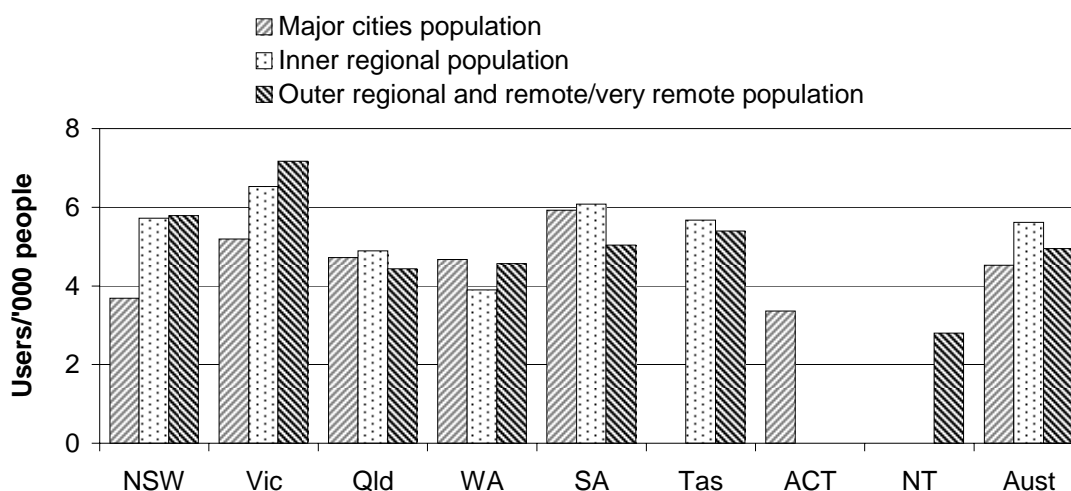


^a Data on outer regional and remote/very remote users per 1000 people were derived by dividing the number of outer regional and remote/very remote service users by the number of outer regional and remote/very remote people aged under 65 years, multiplied by 1000. The 'outer regional and remote/very remote' classification was derived by adding outer regional, remote and very remote data. ^b The State and Territory data on the Australian population were derived by the AIHW from ABS statistical local area (SLA) population estimates for June 2004. ^c The number of service users in each geographic location was estimated based on service users' residential postcodes. Some postcode areas were split between two or more geographic locations; in this case, the data were weighted according to the proportion of the population of the postcode area in each geographic location. ^d Individuals might have accessed services from more than one State or Territory during 2004-05. ^e Data exclude 290 service users whose postcode was not reported. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^f Data for service users of CSTDA funded accommodation support services exclude specialist psychiatric disability services identified by the jurisdiction. ^g Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^h Comparisons of access between the outer regional and remote/very remote population and other populations should be undertaken with care. Outer regional and remote/very remote areas have a higher proportion of Indigenous people than other areas and therefore the need for services may be greater in outer regional and remote areas due to the higher prevalence of disability. ⁱ NSW experienced low data response rates. This led to the significant underreporting of service user numbers. ^j Tasmania does not have major cities. ^k The ACT does not have outer regional and remote/very remote areas. ACT data for service users per 1000 people in inner regional areas are not published as they are based on a small number of service users. ^l The NT does not have major cities or inner regional areas.

Source: AIHW analysis of ABS SLA population estimates for June 2004; AIHW (unpublished); table 13A.21.

Nationally, the proportion of the outer regional and remote/very remote population who used CSTDA funded employment services in 2004-05 (5.0 service users per 1000 people aged 15–64 years) was higher than the proportion of the major cities population (4.5 service users per 1000 people aged 15–64 years) and lower than the proportion of the inner regional population (5.6 service users per 1000 people aged 15–64 years) (figure 13.17).

Figure 13.17 Users of CSTDA funded employment services per 1000 people, by geographic location, 2004-05^{a, b, c, d, e, f, g, h}



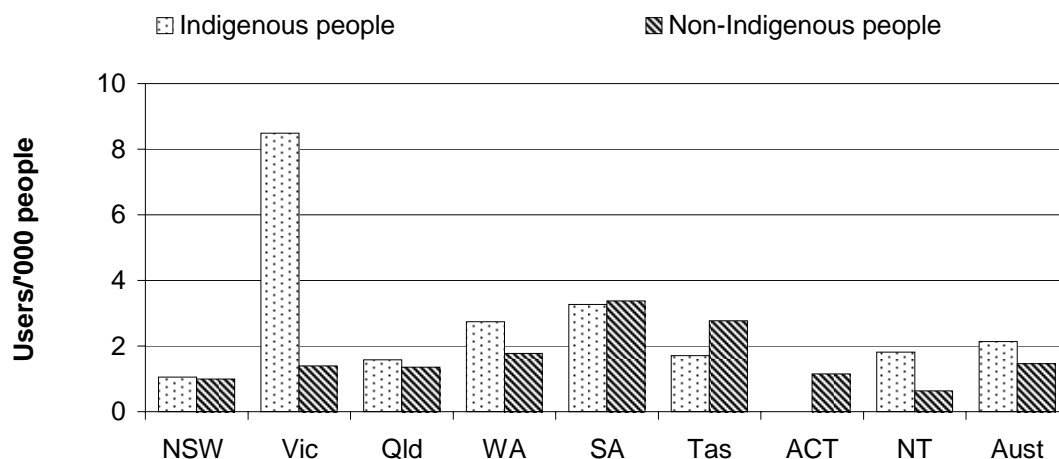
^a Data on outer regional and remote/very remote users per 1000 people were derived by dividing the number of outer regional and remote/very remote service users by the number of outer regional and remote/very remote people aged 15–64 years, multiplied by 1000. The 'outer regional and remote/very remote' classification was derived by adding outer regional, remote and very remote data. ^b The State and Territory data on the Australian population were derived by the AIHW from ABS SLA population estimates for June 2004. ^c The number of service users in each geographic location was estimated based on service users' residential postcodes. Some postcode areas were split between two or more geographic locations; in this case, the data were weighted according to the proportion of the population of the postcode area in each geographic location. ^d Data exclude ten service users whose postcode was not reported. ^e Individuals might have accessed services from more than one State or Territory during 2004-05. ^f Comparisons of access between the outer regional and remote/very remote population and other populations should be undertaken with care. Outer regional and remote/very remote areas have a higher proportion of Indigenous people than other areas and therefore the need for services may be greater in outer regional and remote areas due to the higher prevalence of disability. ^g Tasmania does not have major cities. The ACT does not have outer regional and remote/very remote areas. The NT does not have major cities or inner regional areas. ^h The rate for the inner regional population in the ACT is not reported as nearly all users of ACT services who are from inner regional areas are from NSW residential postcodes.

Source: AIHW analysis of ABS SLA population estimates for June 2004; AIHW (unpublished); table 13A.22.

Service use by special needs groups — Indigenous people

Nationally, the proportion of the Indigenous population who used CSTDA funded accommodation support services in 2004-05 (2.1 Indigenous service users per 1000 Indigenous people aged under 65 years) was higher than the proportion of the non-Indigenous population who used these services (1.5 service users per 1000 non-Indigenous people aged under 65 years) (figure 13.18). Comparisons between Indigenous and non-Indigenous populations' access to services need to be undertaken with care as the prevalence of disability is significantly different for these two populations (figure 13.2).

Figure 13.18 Users of CSTDA funded accommodation support services per 1000 people, by Indigenous status, 2004-05^{a, b, c, d, e, f, g, h, i}

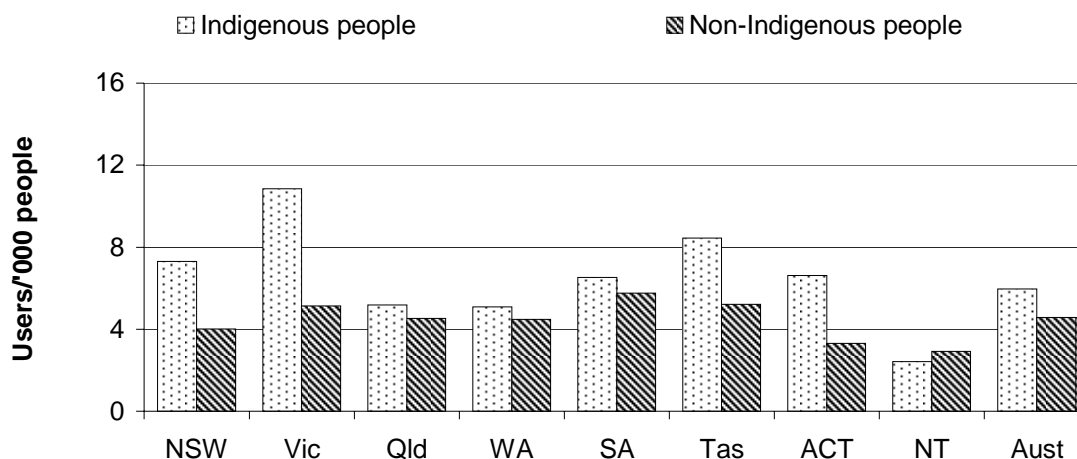


^a Users per 1000 people were derived by dividing the number of service users by the number of people aged under 65 years, multiplied by 1000. ^b Where Indigenous status was inconsistently recorded for the same user, the user was counted as an Indigenous Australian. ^c Data for all service users exclude 2436 service users whose Indigenous status was not reported, so accommodation support service users per 1000 total population aged under 65 years may differ from other figures. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Data for users of CSTDA funded accommodation support services exclude specialist psychiatric disability services identified by the jurisdiction. ^e Individuals might have accessed services from more than one State or Territory during 2004-05. ^f Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^g Comparisons of the Indigenous and non-Indigenous populations' access to services should be undertaken with care. The need for services is likely to be greater for Indigenous people than non-Indigenous people due to the higher prevalence of disability. The AIHW estimated that the proportion of Indigenous people aged over 18 years who had a profound or severe core activity limitation is approximately 2.4 times that of non-Indigenous people. ^h NSW experienced low data response rates. This led to the significant underreporting of service user numbers. ⁱ ACT data for service users per 1000 Indigenous people are not published as they are based on a small number of service users.

Source: ABS (2004a, 2004d); AIHW (unpublished); table 13A.23.

Nationally, the proportion of the Indigenous population who used CSTDA funded employment services in 2004-05 (6.0 Indigenous service users per 1000 Indigenous people aged 15–64 years) was higher than the proportion of the non-Indigenous population who used these services (4.6 service users per 1000 non-Indigenous people aged 15–64 years) (figure 13.19).

Figure 13.19 Users of CSTDA funded employment services per 1000 people, by Indigenous status, 2004-05^{a, b, c, d, e}

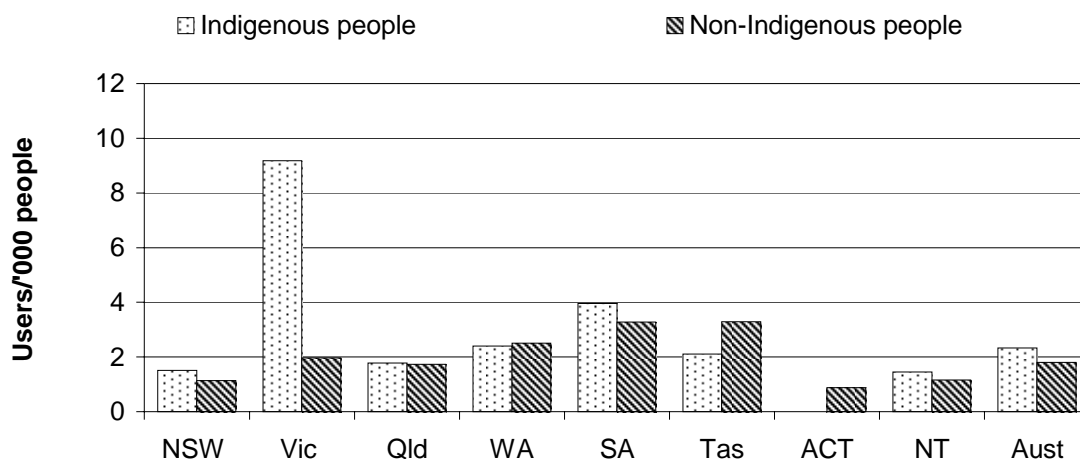


^a Users per 1000 people were derived by dividing the number of service users by the number of people aged 15-64 years, multiplied by 1000. ^b Data for all service users exclude 2665 service users whose Indigenous status was not reported, so employment service users per 1000 total population aged 15-64 years may differ from other figures. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^c Individuals might have accessed services from more than one State or Territory during 2004-05. ^d Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^e Comparisons of the Indigenous and non-Indigenous populations' access to services should be undertaken with care. The need for services is likely to be greater for Indigenous people than non-Indigenous people due to the higher prevalence of disability. The AIHW estimated that the proportion of Indigenous people aged over 18 years who had a profound or severe core activity limitation is approximately 2.4 times that of non-Indigenous people.

Source: ABS (2004a, 2004d); AIHW (unpublished); table 13A.24.

Nationally, the proportion of the Indigenous population who used CSTDA funded community access services in 2004-05 (2.3 Indigenous service users per 1000 Indigenous people aged under 65 years) was higher than the proportion of the non-Indigenous population who used these services (1.8 service users per 1000 people aged under 65 years) (figure 13.20).

Figure 13.20 Users of CSTDA funded community access services per 1000 people, by Indigenous status, 2004-05^{a, b, c, d, e, f, g, h, i, j}

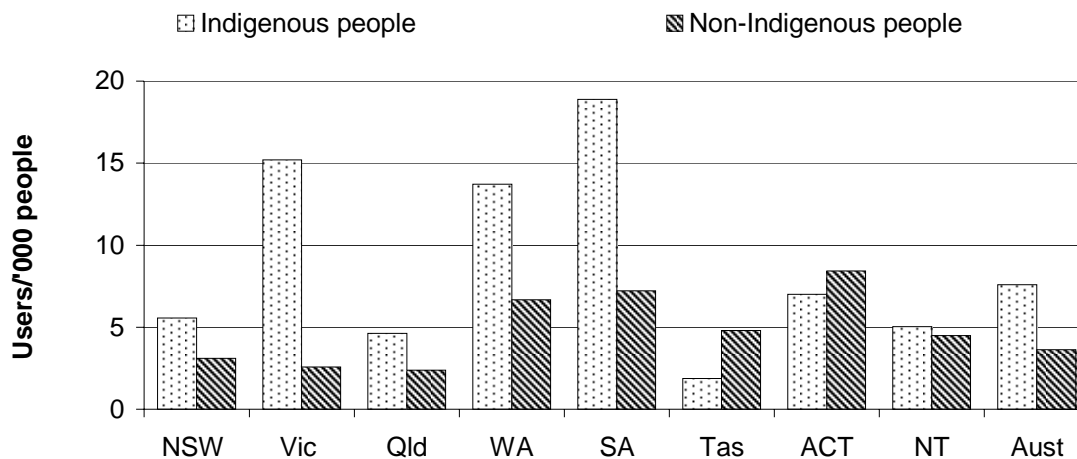


^a Data for users per 1000 people were derived by dividing the number of service users by the number of people aged under 65 years, multiplied by 1000. ^b Where Indigenous status was inconsistently recorded for the same user, the user was counted as an Indigenous Australian. ^c Data for all service users exclude 5222 service users whose Indigenous status was not reported, so community access service users per 1000 total population aged under 65 years may differ from other figures. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Service users who accessed the service type 'recreation/holiday programs' (service type 3.02) were not required to complete the item on Indigenous status; however, those who did provide a response are included in the data. ^e Data for users of CSTDA funded community access services exclude specialist psychiatric disability services specifically identified by the jurisdiction. ^f Individuals might have accessed services from more than one State or Territory during 2004-05. ^g Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^h Comparisons of the Indigenous and non-Indigenous populations' access to services should be undertaken with care. The need for services is likely to be greater for Indigenous people than non-Indigenous people due to the higher prevalence of disability. The AIHW estimated that the proportion of Indigenous people aged over 18 years who had a profound or severe core activity limitation is approximately 2.4 times that of non-Indigenous people. ⁱ NSW experienced low data response rates. This led to the significant underreporting of service user numbers. ^j ACT data for service users per 1000 Indigenous people are not published as they are based on a small number of service users.

Source: ABS (2004a, 2004d); AIHW (unpublished); table 13A.25.

Nationally, the proportion of the Indigenous population who used CSTDA funded community support services in 2004-05 (7.6 Indigenous service users per 1000 Indigenous people aged under 65 years) was higher than the proportion of the non-Indigenous population who used these services (3.6 service users per 1000 people aged under 65 years) (figure 13.21).

Figure 13.21 Users of CSTDA funded community support services per 1000 people, by Indigenous status, 2004-05^{a, b, c, d, e, f, g, h}

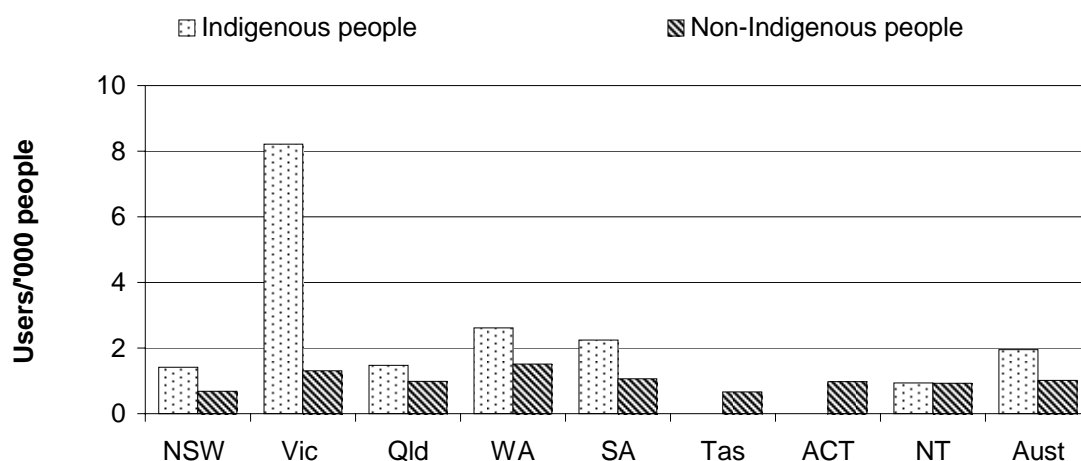


^a Data for users per 1000 people were derived by dividing the number of service users by the number of people aged under 65 years, multiplied by 1000. ^b Where Indigenous status was inconsistently recorded for the same user, the user was counted as an Indigenous Australian. ^c Data for all service users exclude 27 356 service users whose Indigenous status was not reported, so community support service users per 1000 total population aged under 65 years may differ from other figures. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Data for users of CSTDA funded community support services exclude specialist psychiatric disability services specifically identified by the jurisdiction. ^e Individuals might have accessed services from more than one State or Territory during 2004-05. ^f Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^g Comparisons of the Indigenous and non-Indigenous populations' access to services should be undertaken with care. The need for services is likely to be greater for Indigenous people than non-Indigenous people due to the higher prevalence of disability. The AIHW estimated that the proportion of Indigenous people aged over 18 years who had a profound or severe core activity limitation is approximately 2.4 times that of non-Indigenous people. ^h NSW experienced low data response rates. This led to the significant underreporting of service user numbers.

Source: ABS (2004a, 2004d); AIHW (unpublished); table 13A.26.

Nationally, the proportion of the Indigenous population who used CSTDA funded respite services in 2004-05 (1.9 Indigenous service users per 1000 Indigenous people aged under 65 years) was higher than the proportion of the non-Indigenous population who used these services (1.0 service users per 1000 people aged under 65 years) (figure 13.22).

Figure 13.22 Users of CSTDA funded respite services per 1000 people, by Indigenous status, 2004-05^{a, b, c, d, e, f, g, h, i}



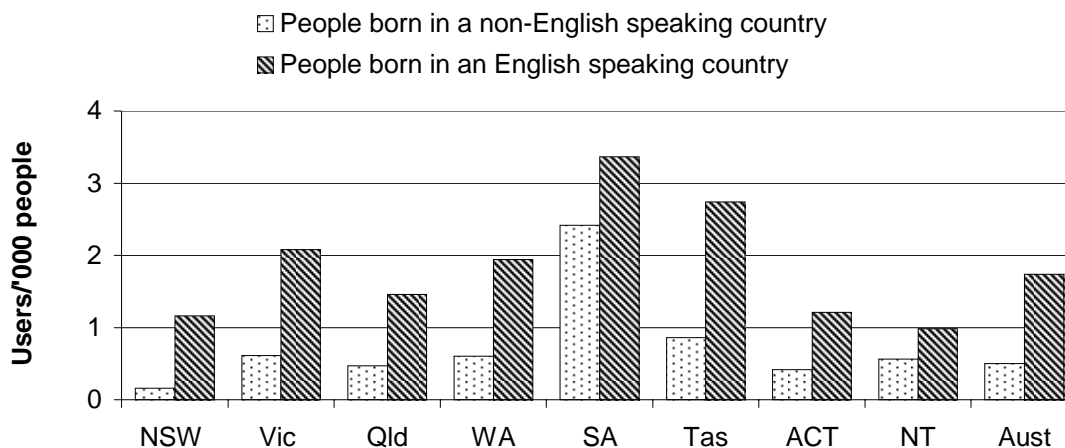
^a Data for users per 1000 people were derived by dividing the number of service users by the number of people aged under 65 years, multiplied by 1000. ^b Where Indigenous status was inconsistently recorded for the same user, the user was counted as an Indigenous Australian. ^c Data for all service users exclude 3667 service users whose Indigenous status was not reported, so respite service users per 1000 total population aged under 65 years may differ from other figures. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Data for users of CSTDA funded respite services exclude specialist psychiatric disability services specifically identified by the jurisdiction. ^e Individuals might have accessed services from more than one State or Territory during 2004-05. ^f Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^g Comparisons of the Indigenous and non-Indigenous populations' access to services should be undertaken with care. The need for services is likely to be greater for Indigenous people than non-Indigenous people due to the higher prevalence of disability. The AIHW estimated that the proportion of Indigenous people aged over 18 years who had a profound or severe core activity limitation is approximately 2.4 times that of non-Indigenous people. ^h NSW experienced low data response rates. This led to the significant underreporting of service user numbers. ⁱ Tasmanian and ACT data for service users per 1000 Indigenous people are not published as they are based on a small number of service users.

Source: ABS (2004a, 2004d); AIHW (unpublished); table 13A.27.

Service use by special needs groups — people born in a non-English speaking country

Nationally, the proportion of people born in a non-English speaking country who used CSTDA funded accommodation support services in 2004-05 (0.5 service users per 1000 people aged under 65 years) was lower than the proportion of people born in an English speaking country who used these services (1.7 service users per 1000 people aged under 65 years) (figure 13.23).

Figure 13.23 Users of CSTDA funded accommodation support services per 1000 people, by country of birth, 2004-05^{a, b, c, d, e, f, g, h, i}

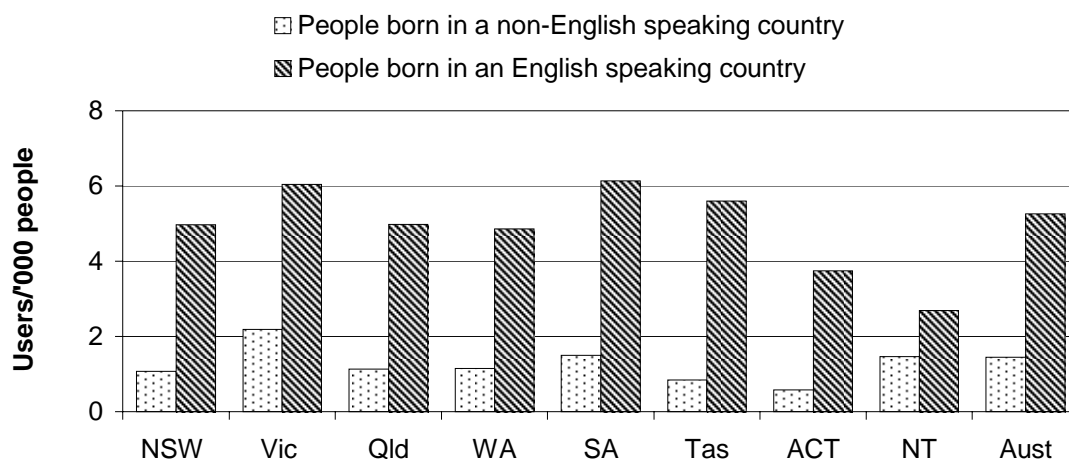


^a Data for service users per 1000 people were derived by dividing the number of service users by the number of people aged under 65 years, multiplied by 1000. ^b Data for service users born in a non-English speaking country were based on responses for country of birth in English Proficiency Groups 2–4 (which includes all countries except Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States). ^c The State and Territory data on people born in a non-English speaking country were derived from country of birth data for the corresponding 2001 Australian Census proportional distribution of the population of states and territories. Estimates exclude people whose country of birth was not stated or who were visitors to Australia from overseas. ^d Individuals might have accessed services from more than one State or Territory during 2004-05. Where country of birth was inconsistently recorded for the same service user, the service user was counted as having been born in a non-English speaking country. ^e Data for all service users exclude 866 service users whose country of birth was not reported, so accommodation support service users per 1000 total population aged under 65 years may differ from other figures. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^f Data for service users of CSTDA funded accommodation support services exclude specialist psychiatric disability services identified by the jurisdiction. ^g Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^h Comparisons of the Indigenous and non-Indigenous populations' access to services should be undertaken with care. The need for services is likely to be greater for Indigenous people than non-Indigenous people due to the higher prevalence of disability. The AIHW estimated that the proportion of Indigenous people aged over 18 years who had a profound or severe core activity limitation is approximately 2.4 times that of non-Indigenous people. ⁱ NSW experienced low data response rates. This led to the significant underreporting of service user numbers.

Source: ABS (2004a; 2005); ABS Australian Census of Population and Housing (unpublished); AIHW (unpublished); table 13A.28.

Nationally, the proportion of people born in a non-English speaking country who used CSTDA funded employment services in 2004-05 (1.4 service users per 1000 people aged 15–64 years) was lower than the proportion of people born in an English speaking country who used these services (5.3 service users per 1000 people aged 15–64 years) (figure 13.24).

Figure 13.24 **Users of CSTDA funded employment services per 1000 people, by country of birth, 2004-05^{a, b, c, d, e}**



^a Data for service users per 1000 people were derived by dividing the number of service users by the number of people aged 15–64 years. ^b Data for service users born in a non-English speaking country were based on responses for a country of birth in English Proficiency Groups 2–4 (which includes all countries except Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States). ^c The State and Territory data on people born in a non-English speaking country were derived from country of birth data for the corresponding 2001 Australian Census proportional distribution of the population of states and territories. Estimates exclude people whose country of birth was not stated or who were visitors to Australia from overseas. ^d Individuals might have accessed services from more than one State or Territory during 2004-05. ^e Data for all service users exclude 2248 service users whose country of birth was not reported, thus employment service users per 1000 total population aged 15–64 years might differ from other figures. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator.

Source: ABS (2004a; 2005); ABS Australian Census of Population and Housing (unpublished); AIHW (unpublished); table 13A.29.

Proportion of CSTDA funded accommodation support service users receiving community accommodation and care services

The ‘proportion of accommodation support service users receiving community accommodation and care services’ is an indicator of access to appropriate services (box 13.8). Governments provide or fund accommodation support services to people with a disability in institutional/residential settings and through community accommodation and care services. Institutional or residential accommodation support services are provided in both institutions and hostels. Community accommodation and care services are provided in group homes and other community settings. The accommodation support services provided in other community settings are attendant care/personal care, in-home accommodation support, alternative family placement and other accommodation support.

Box 13.8 Proportion of CSTDA funded accommodation support service users receiving community accommodation and care services

It is an objective of governments to assist people with a disability to live as valued and participating members of the community. State and Territory governments generally seek, if possible, to provide accommodation support services to people with a disability outside of institutional/residential settings. Community accommodation and care services are considered to provide better opportunities for people with a disability to be involved in their community.

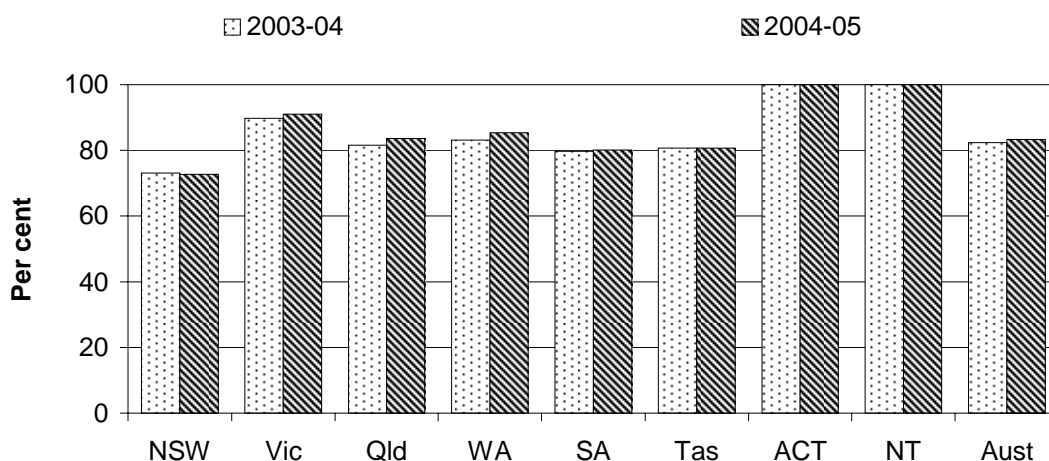
This indicator is defined as the number of people using a CSTDA funded community accommodation and care service divided by the total number of people using CSTDA funded accommodation support services (excluding people who use specialist psychiatric disability services only).

A higher proportion of people accessing CSTDA funded community accommodation and care services is likely to provide better opportunities for people with a disability (who need accommodation support) to be involved in their community.

The CSTDA funded services are provided on the basis of need and available resources. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

Nationally, 83.3 per cent of users of CSTDA funded accommodation support service received community accommodation and care services in 2004-05 (figure 13.25).

Figure 13.25 Users of community accommodation and care services as a proportion of all CSTDA funded accommodation support service users^{a, b, c, d, e, f}



^a Individuals might have accessed services from more than one State or Territory and/or from both accommodation service type categories (institutional/large residential or community accommodation and care services). ^b Data for service users of CSTDA funded accommodation support services exclude specialist psychiatric disability services identified by the jurisdiction. ^c Community accommodation and care services include group homes, attendant care/personal care, in-home accommodation support, alternative family placement and other accommodation support. ^d Data quality continues to improve following the implementation of the CSTDA NMDS. However, this indicator needs to be interpreted with care due to a number of factors impacting on data quality. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^e NSW experienced low and varied data response rates for 2003-04 and 2004-05. This led to the underreporting of service user numbers for both years and affected the comparability of the data across the two years. ^f Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users.

Source: AIHW (2005a, 2005b, 2006a, 2006b); table 13A.30.

Client satisfaction with appropriateness

The Steering Committee has identified 'client satisfaction with appropriateness' as an indicator of access to services that are appropriate to client needs (box 13.9). This indicator is for development in future reports. Data for this indicator are currently not available.

Box 13.9 Client satisfaction with appropriateness

'Client satisfaction with appropriateness' will provide an output indicator of government's objective to provide services to people with a disability that are appropriate to their needs. This indicator will measure the appropriateness of these services relative to the service user's need, from the service user's perspective.

Equity and effectiveness — quality of services

The following equity and effectiveness quality indicators are reported:

- ‘Quality assurance processes’
- ‘Client and carer satisfaction’.

Information on quality assurance processes for providers of specialist disability services in 2005-06 are available for eight jurisdictions — the Australian Government, NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT. Client/carers satisfaction data are included for Queensland (2004 data) and WA (2006 data).

Quality assurance processes

‘Quality assurance processes’ are an indicator of the quality of specialist disability services (box 13.10). All services funded under the CSTDA are required to comply with national standards, so most jurisdictions have been examining ways of implementing quality assurance monitoring systems for specialist disability services.

Box 13.10 Quality assurance processes

‘Quality assurance processes’ are an indicator of quality related to governments’ objective to deliver and fund services for people with a disability that meet a certain standard of quality.

This indicator is defined as the proportion of government and non-government disability service outlets that have been assessed (either by an assessing agency or through a self-assessment process) against service standards or performance indicators.

A higher proportion of disability service outlets that have been accredited against service standards or performance indicators suggests an improvement in the quality of specialist disability services delivered or funded by government.

This indicator does not provide information on whether the standards and performance indicators of the quality assurance processes are appropriate. In addition, service outlets that are not quality assessed do not necessarily deliver services of lower quality.

Data on quality assurance processes in 2005-06 are reported in box 13.11. These quality assurance processes data relate to service providers from all disability service types provided under the CSTDA. Data come from service quality reviews and self-assessment processes. The jurisdictions implementing monitoring of

quality assurance processes expect to review all service providers in a rolling process over several years.

Box 13.11 Quality assurance processes for specialist disability services

The quality assurance processes data reported below relate to CSTDA funded services.

Australian Government

Australian Government funded disability employment assistance organisations are required to meet quality standards as a prerequisite for continued funding. The disability employment services quality assurance standards comprise 12 standards and 26 key performance indicators. Since 31 December 2004 around 380 (100 per cent) organisations have been required to be assessed by independent accredited certification bodies and have achieved certification against the revised standards. Organisations' compliance with the quality standards continue to be monitored by certification bodies through a programme of surveillance audits.

NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT

In 2005-06, different quality assurance processes were in place in NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT, but these jurisdictions collected data on similar indicators. Specialist disability services providers (outlets and organisations) refer to providers of accommodation support; community support; community access; respite; advocacy, information and print disability; and other support services. The evaluation processes relate to both government and non-government service outlets.

In NSW, the Integrated Monitoring Framework (IMF) was introduced in 2005-06. Under the IMF, service providers report annually regarding their compliance with funding requirements and against performance indicators. Service providers are monitored through an on-site service review against 23 Key Performance Indicators (KPI). For any areas identified as not being fully met against the requirements of a KPI, a service provider is required to complete an Action Plan. In August 2006, all funded service providers were required to return an annual accountability report for 2005-06. On-site monitoring under the IMF commenced in October 2005, with 180 service outlets having completed an on-site service review.

In Victoria, by December 2005, 60 (of a possible 382) government and non-government disability service organisations had participated in an independent strategic review. The program of strategic review has now ceased, however, evaluation of the program contributed to a revision of the Quality Framework for Disability Services, which will include an independent quality monitoring mechanism. A Monitoring Framework for the Health, Housing and Community Services Sectors was also introduced in Victoria during 2005, and all funded disability service providers have gone through an initial desktop review.

(Continued on next page)

Box 13.11 (Continued)

In Queensland, the Disability Sector Quality System was introduced in 2004. Disability services that are recurrently funded or provided by Disability Services Queensland have four years from 1 July 2004 to become certified against service standards. As at 30 June 2006, 15 services (out of a possible 250 non-government and government services) have undertaken an external assessment with a further 140 services scheduled to be externally assessed in the 2006-07 financial year.

In WA, 26.6 per cent (186 of 698) of total service outlets had been independently monitored (comprehensive and abridged monitoring) against the service standards, and 86.0 per cent (160 of 186) of the assessed disability service outlets had been quality assured against all assessed service standards. Outlets that are not independently assessed are required to provide a self-assessment. The number of outlets that completed self assessments was 511.

In SA, service providers are required to meet quality assurance criteria before they can provide CSTDA funded services. From 2006-07 the criteria have been further enhanced to include participation in an independently audited quality assurance system. As of May 2006, 48 per cent (66 of 136) of agencies were engaged in the Service Excellence Framework, however, a significant number of agencies are involved in other independently assessed quality assurance programs.

In Tasmania, the evaluation process was re-developed. As a result, no new evaluations were undertaken in this period. Of the total number of service outlets that had previously undergone a comprehensive evaluation against the service standards, 100 per cent (43 out of 43) were monitored through service development plans. Service development plans were also provided by 56.1 per cent of all non-evaluated service outlets (92 out of 164).

In 2005, Disability ACT implemented a new quality improvement system for all funded agencies. Following an assessment against the National Disability Services Standards, all agencies developed quality improvement action plans. In 2005-06, external consultants audited five agencies and Disability ACT assisted these agencies to work through audit recommendations. In 2006, agencies provided progress reports and revised action plans for 2006–2007.

Source: Australian, NSW, Victorian, Queensland, WA, SA, Tasmanian and the ACT governments (unpublished).

Client and carer satisfaction

‘Client and carer satisfaction’ is an indicator of the quality of specialist disability services (box 13.12). Data are available for reporting for Queensland and WA only. It is anticipated that data for other jurisdictions will be included in future reports.

Box 13.12 Client and carer satisfaction

‘Client and carer satisfaction’ is an output (quality) indicator designed to provide information on satisfaction with the quality of services received. It is an indicator of governments’ objective to deliver and fund quality services for people with a disability that meet the needs and goals of the client (or carer of the client) receiving them.

Overall client and carer satisfaction ratings and satisfaction with individual services are reported. Results are taken from a client and carer satisfaction survey and are expressed in percentage terms.

A higher proportion of clients and carers satisfied is desirable because it suggests the service received was of a higher quality and better met the needs and goals of the client (or carer).

This indicator will be further developed over time as data become available from more jurisdictions.

Queensland conducted a consumer satisfaction survey for specialist disability services in late November 2004. Overall, 85 per cent of service users and 73 per cent of carers across Queensland were satisfied with the services they received. The survey provided results according to the type of disability services received and showed the following:

- 92 per cent of service users and 85 per cent of carers were satisfied with accommodation support services
- 87 per cent of service users and 78 per cent of carers were satisfied with accommodation (supported community living) services
- 81 per cent of service users and 65 per cent of carers were satisfied with community support services
- 85 per cent of service users and 82 per cent of carers were satisfied with respite services
- 85 per cent of service users and 74 per cent of carers were satisfied with community access services
- 81 per cent of service users and 63 per cent of carers were satisfied with local area coordination services
- 75 per cent of service users were satisfied with their quality of life
- 87 per cent of service users considered that disability services enhanced their environment and well being (Disability Services Queensland 2006).

WA conducted a carer and client satisfaction study in 2006. In this study, 1250 disability services clients of all ages (or their carers) were asked whether they

were satisfied with services. Questions about specific services were combined with two global satisfaction questions. Overall, 77 per cent of people responded that they were happy with their quality of life. Across the six CSTDA service types, 65–93 per cent of clients were satisfied with the services they received (WA Government (unpublished)).

Efficiency — cost per output unit

The following cost per output unit efficiency indicators are reported:

- ‘Cost per user of government provided accommodation support services’
- ‘Government contribution per user of non-government provided services’
- ‘Cost per user of State and Territory administered services’.

This Report includes 2005-06 expenditure data provided by Australian, State and Territory governments. However, as 2005-06 service user data from the CSTDA NMDS collection were not available for this Report, the cost per service user efficiency indicators are reported for 2004-05. Expenditure data might differ from information reported elsewhere (such as in departmental annual reports) because the financial counting rules and definitions used to calculate expenditure may differ. Data in this Report may also differ from information reported elsewhere because the data here exclude users of specialist psychiatric disability services.

It is an objective of the Review to report comparable estimates of costs. Ideally, such comparisons would include the full range of costs to government. Where the full costs cannot be counted, costs are estimated on a consistent basis. The jurisdictional expenditure data included in this Report do not yet include the user cost of capital, so do not reflect the full costs of government funded services.

Considerable effort has been made to document any differences in calculating the reported efficiency indicators. Concerns remain over the comparability of the results, because jurisdictions use somewhat different methods of data collection (table 13.1). Expenditure data reported in this section are from individual jurisdictions’ collections and may differ from cost per service user data reported elsewhere.

Table 13.1 Comparability of expenditure estimates for government provided specialist disability services, by items included

<i>Expenditure</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aus Gov</i>
Superannuation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basis of estimate									
	Accrual	Accrual	Accrual	Accrual	Cash	Accrual	Accrual	Accrual	Accrual
Workers compensation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Payroll tax ^a									
Actual	✓	✓	✓	X	X	✓	X	✓	..
Imputed	X	✓	X	✓	✓	X	✓	X	..
Apportioned umbrella department costs	✓	✓	✓	..	✓	✓	✓	✓	✓
Basis of apportioning									
Departmental formula	✓	✓	✓	..	✓	✓	X	✓	✓
% of FTE employees	X	X	X	..	X	✓	✓	X	X
Long service leave									
Entitlements	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basis of estimate									
	Accrual	Accrual	Accrual	Accrual	Cash	Accrual	Accrual	Accrual	Accrual
Depreciation	✓	✓	✓	✓	X	X	✓	X	✓

FTE = full time equivalent. ^a Actual payroll tax amounts are included in cost (expenditure) per user data for NSW, Victoria, Tasmania and the NT because the actual payroll tax amounts are not separately identified at the service delivery area level. For the other jurisdictions, no payroll tax amounts (actual or imputed) are included. .. Not applicable.

Source: Australian, State and Territory governments (unpublished).

Government and non-government provided services

Efficiency indicators are reported for both government and non-government provided services. Government provision means that a service is both funded and directly provided by a government department, agency or local government. Non-government provision is a service purchased or part-funded by a government department or agency, but provided by a non-government organisation. Non-government service providers may receive funds from the private sector and the general public in addition to funding, grants and input tax concessions (such as payroll tax exemptions) from governments. Data on funds received by non-government service providers from the private sector and the general public are not included in this Report.

When considering the results of the efficiency indicators, it is important to note that services provided by local governments are counted as:

- government for the service user data
- non-government by some states for the expenditure data.

This discrepancy between service user data and expenditure data for local government services only applies to accommodation support services provided in group homes and other community settings. It is not relevant for Queensland, Tasmania, the ACT and the NT. For the 2008 Report, local government provided services data will be classified consistently for all jurisdictions.

Accommodation support services

Governments provide or contribute funding to accommodation support services for people with a disability in institutional/residential settings and through community accommodation and care. In recent years, there has been an ongoing process of relocating people with a disability from institutional/residential accommodation to community accommodation (including group homes and other community accommodation). As a result, total government expenditure on accommodation support services in institutional/residential settings has decreased, with a corresponding increase in expenditure on community accommodation and care services.

Cost per user of government provided accommodation support services

‘Cost per user of government provided accommodation support services’ is an indicator of the efficiency of specialist disability services (box 13.13).

Box 13.13 Cost per user of government provided accommodation support services

‘Cost per user of government provided accommodation support services’ is an output (efficiency) indicator of governments’ objective to provide specialist disability services in an efficient manner. A set of indicators are reported under this heading for a range of service types.

This indicator is defined as the net government expenditure per user of government provided accommodation support services in institutional/residential settings, group homes and other community settings.

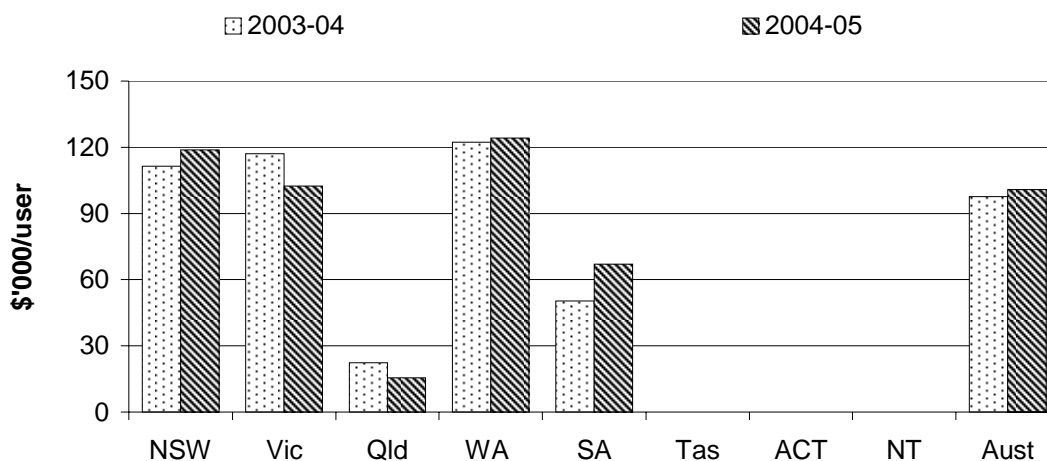
Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service.

Efficiency data are difficult to interpret. While high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided. Increasing expenditure may also reflect the changing needs of service users — for example, as the population of accommodation support service users ages, their support needs are also likely to increase. Similarly, low or declining expenditure per unit of output may reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Cost per user of government provided accommodation support services — institutional/residential settings

Nationally, estimated annual government expenditure on accommodation support services in institutional/residential settings was \$100 763 per service user in 2004-05. There were no government provided accommodation support services in institutional/residential settings in Tasmania, the ACT or the NT (figure 13.26).

Figure 13.26 Estimated annual government expenditure per user of government provided accommodation support services in institutional/residential settings (2004-05 dollars)^{a, b, c, d, e}



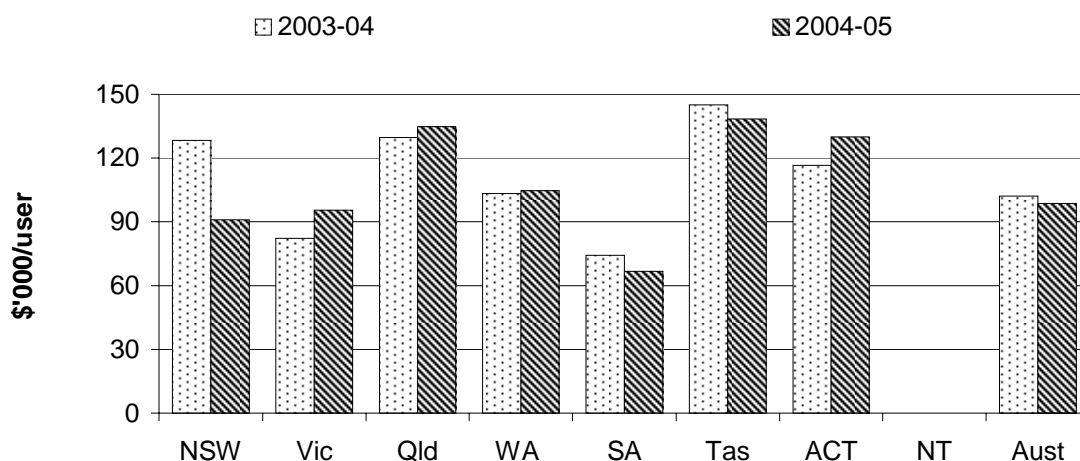
^a The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. ^b Service type outlet response rates (figure 13.3 notes) and service user response rates by outlet (table 13A.32) should be taken into consideration when interpreting this indicator. ^c NSW experienced low and varied data response rates for 2003-04 and 2004-05. This led to the underreporting of service user numbers for both years and affected the comparability of the data across the two years. ^d Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users. ^e There were no government provided accommodation support services in institutional/residential settings in Tasmania, the ACT and the NT.

Source: AIHW (unpublished); State and Territory governments (unpublished); table 13A.31.

Cost per user of government provided accommodation support services — group homes

Nationally, estimated annual government expenditure on government provided accommodation support services in group homes was \$98 629 per service user in 2004-05. There were no government providers of accommodation support services in group homes in the NT (figure 13.27).

Figure 13.27 **Estimated annual government expenditure per user of government provided accommodation support services in group homes (2004-05 dollars)^{a, b, c, d, e, f}**



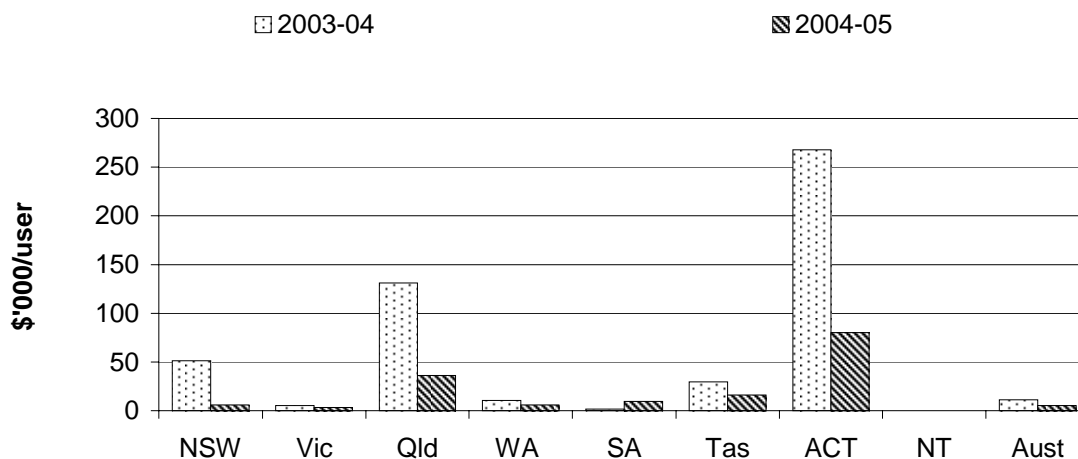
^a The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. ^b Service user data used to derive this indicator include users of services provided by local government, while NSW, Victorian, WA and SA expenditure data exclude services provided by local governments. Thus this indicator needs to be interpreted with care. ^c Service type outlet response rates (figure 13.3 notes) and service user response rates by outlet (table 13A.32) should be taken into consideration when interpreting this indicator. ^d NSW experienced low and varied data response rates for 2003-04 and 2004-05. This led to the underreporting of service user numbers for both years and affected the comparability of the data across the two years. ^e Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users. ^f There were no government provided accommodation support services in group homes in the NT.

Source: AIHW (unpublished); State and Territory governments (unpublished); table 13A.31.

Cost per user of government provided accommodation support services — other community settings

Nationally, estimated annual government expenditure on government provided accommodation support services in other community settings was \$5178 per service user in 2004-05. There were no government providers of accommodation support services in other community settings in the NT (figure 13.28).

Figure 13.28 Estimated annual government expenditure per user of government provided accommodation support services in other community settings (2004-05 dollars)^{a, b, c, d, e, f, g, h}



^a The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. ^b Service user data used to derive this indicator include users of services provided by local government, while NSW, Victorian, WA and SA expenditure data exclude services provided by local governments. Thus this indicator needs to be interpreted with care. ^c Service type outlet response rates (figure 13.3 notes) and service user response rates by outlet (table 13A.32) should be taken into consideration when interpreting this indicator. ^d NSW experienced low and varied data response rates for 2003-04 and 2004-05. This led to the underreporting of service user numbers for both years and affected the comparability of the data across the two years. ^e Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users. ^f For Queensland, improved direct attribution of expenditure to service types resulted in a significant reduction in expenditure per user between 2003-04 and 2004-05. ^g The change in expenditure per user in the ACT (between 2003-04 and 2004-05) is the result of care arrangement changes for a small number of high care need service users. ^h There were no government provided accommodation support services in other community settings in the NT.

Source: AIHW (unpublished); State and Territory governments (unpublished); table 13A.31.

Government contribution per user of non-government provided services

'Government contribution per user of non-government provided services' is an indicator of the efficiency of specialist disability services (box 13.14).

Box 13.14 Government contribution per user of non-government provided services

Governments directly provide services to service users and also fund non-government service providers to deliver these services. The government contribution per user of non-government provided services is an output (efficiency) indicator of governments' objective to provide specialist disability services in an efficient manner. The focus on the contribution of governments reflects the Steering Committee's terms of reference, which require it to report on services funded and/or delivered by government.

A set of indicators are reported under this heading for a range of government funded service types. This indicator is defined as the net government expenditure per user of the following non-government provided services:

- accommodation support services in:
 - institutional/residential settings
 - group homes
 - other community settings
- employment services (reported per employment service user assisted).

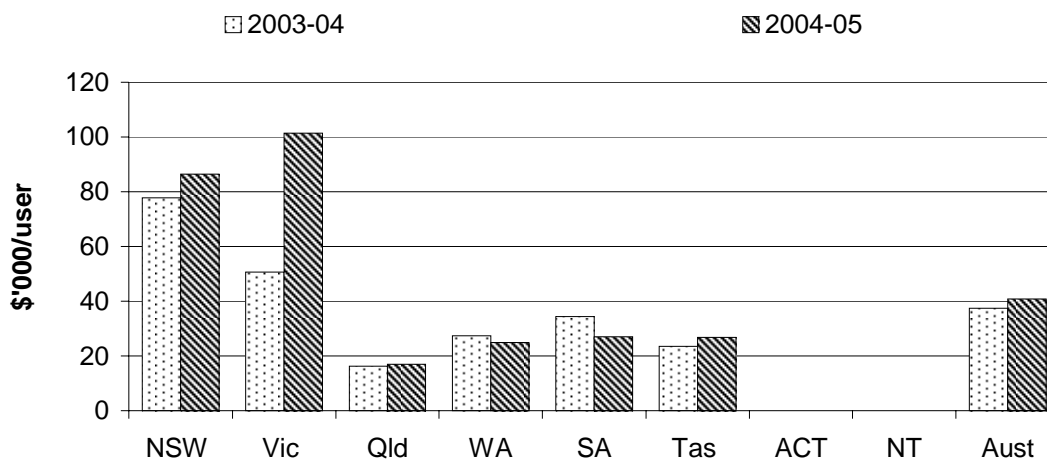
Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service. Efficiency data, however, are difficult to interpret.

While high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of service users. Similarly, low or declining expenditure per unit of output may reflect improving efficiency, or lower quality less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Government contribution per user of non-government provided services — accommodation support services in institutional/residential settings

Nationally, estimated annual government funding of non-government provided accommodation support services in institutional/residential settings was \$40 828 per service user in 2004-05 (figure 13.29). There were no non-government provided accommodation support services in institutional/residential settings in the ACT and the NT.

Figure 13.29 Estimated annual government funding per user of non-government provided accommodation support services in institutional/residential settings (2004-05 dollars)^{a, b, c, d, e}



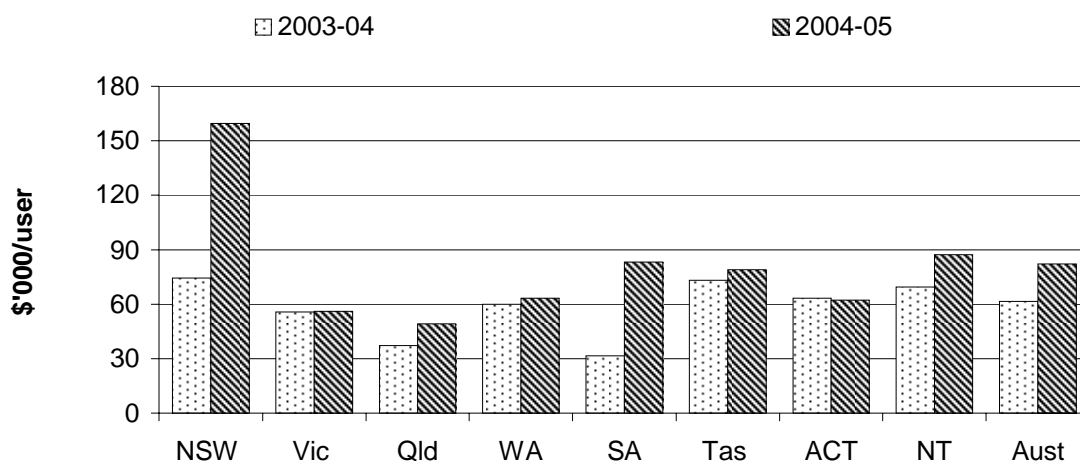
^a The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. ^b Service type outlet response rates (figure 13.3 notes) and service user response rates by outlet (table 13A.32) should be taken into consideration when interpreting this indicator. ^c NSW experienced low and varied data response rates for 2003-04 and 2004-05. This led to the underreporting of service user numbers for both years and affected the comparability of the data across the two years. ^d The Victorian cost per service user for 2004-05 is overstated due to a move towards community based and individualised settings, which was not reflected in the expenditure data. ^e There were no government provided accommodation support services in other community settings in the ACT and the NT.

Source: AIHW (unpublished); State and Territory governments (unpublished); table 13A.31.

Government contribution per user of non-government provided services — accommodation support services in group homes

Nationally, estimated annual government funding of non-government provided accommodation support services in group homes was \$82 203 per service user in 2004-05 (figure 13.30).

Figure 13.30 **Estimated annual government funding per user of non-government provided accommodation support services in group homes (2004-05 dollars)^{a, b, c, d, e}**



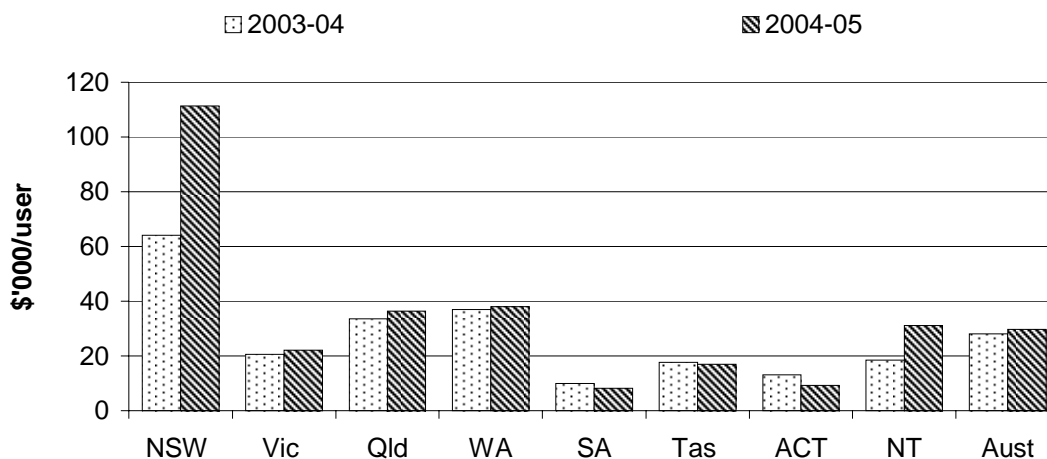
^a The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. ^b Service type outlet response rates (figure 13.3 notes) and service user response rates by outlet (table 13A.32) should be taken into consideration when interpreting this indicator. ^c Service user data used to derive this indicator exclude users of services provided by local government, while NSW, Victorian, WA and SA expenditure data include services provided by local governments. The ACT and the NT do not have services provided by local governments. Thus this indicator needs to be interpreted with care. ^d NSW experienced low and varied data response rates for 2003-04 and 2004-05. This led to the underreporting of service user numbers for both years and affected the comparability of the data across the two years. ^e Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users.

Source: AIHW (unpublished); State and Territory governments (unpublished); table 13A.31.

Government contribution per user of non-government provided services — accommodation support services in other community settings

Nationally, estimated annual government funding of non-government provided accommodation support services in other community settings was \$29 649 per service user in 2004-05 (figure 13.31).

Figure 13.31 Estimated annual government funding per user of non-government provided accommodation support services in other community settings (2004-05 dollars)^{a, b, c, d, e}



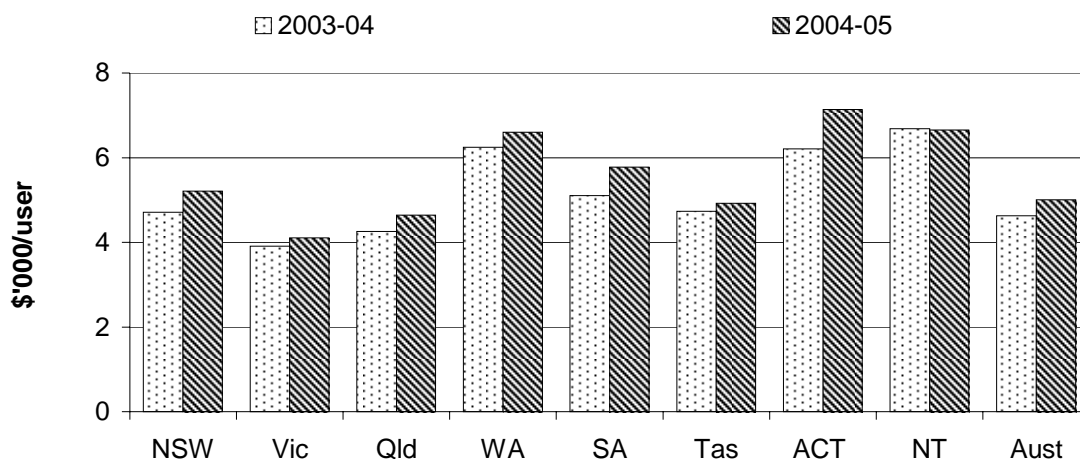
^a The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. ^b Service user data used to derive this indicator exclude users of services provided by local government, while NSW, Victorian, WA and SA expenditure data include services provided by local governments. The ACT and the NT do not have services provided by local governments. Thus this indicator needs to be interpreted with care. ^c Service type outlet response rates (figure 13.3 notes) and service user response rates by outlet (table 13A.32) should be taken into consideration when interpreting this indicator. ^d NSW experienced low and varied data response rates for 2003-04 and 2004-05. This led to the underreporting of service user numbers for both years and affected the comparability of the data across the two years. ^e Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users.

Source: AIHW (unpublished); State and Territory governments (unpublished); table 13A.31.

Government contribution per employment service user assisted

Assistance with employment for people with a disability was the responsibility of the Australian Government under the CSTDA in 2004-05. Nationally, for all employment services, government expenditure per service user assisted was \$5005 in 2004-05 (figure 13.32).

Figure 13.32 **Government contribution per employment service user assisted (2004-05 dollars)^a**



^a This indicator is derived using service user data provided by the AIHW. Cost per employment service user data may differ from those reported in the Australian Government's annual report, as the Australian Government and the AIHW use different rules to count the number of employment service users. The Australian Government focuses on the total number of service outlets used, whereas the AIHW focuses on the number of service users, irrespective of the number of service outlets the individual accesses. In addition, the Australian Government includes independent workers (1004 persons in 2003-04 and 804 persons in 2004-05) in calculating service user numbers, whereas the AIHW does not.

Source: Australian Government (unpublished); AIHW (unpublished); table 13A.33.

Nationally, estimated annual government expenditure per service user in 2004-05, by employment service type, was \$3652 on open services (employed in the open labour market), \$8286 on supported services (employed by the service provider) and \$2801 on open and supported mixed services (table 13A.34).

Cost per user of State and Territory administered services

'Cost per user of State and Territory administered services' is an indicator of the efficiency of specialist disability services (box 13.15).

Box 13.15 Cost per user of State and Territory administered services

‘Cost per user of State and Territory administered services’ is an output (efficiency) indicator of governments’ objective to provide specialist disability services in an efficient manner.

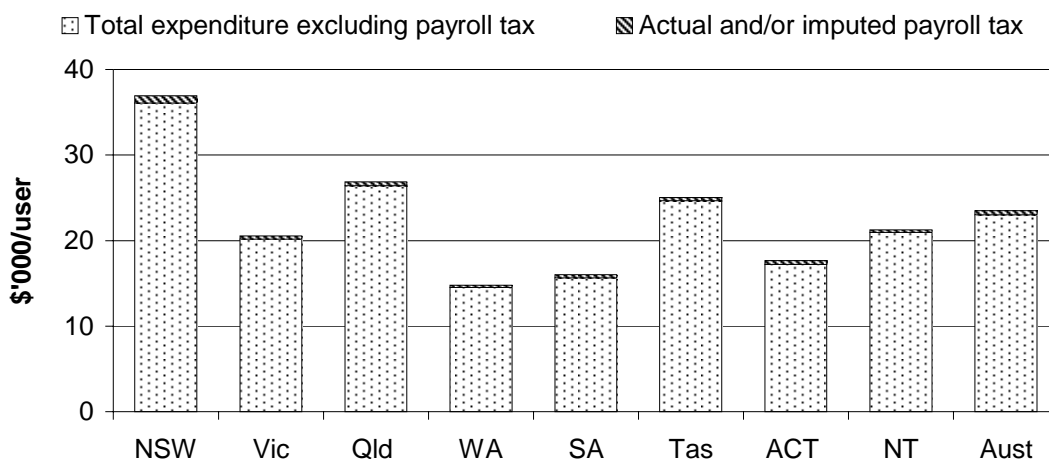
This indicator is defined as government expenditure on CSTDA State and Territory administered services per service user. Data are reported separately for government expenditure net of payroll tax and for government expenditure including actual and/or imputed payroll tax.

Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service.

Efficiency data, however, are difficult to interpret. While high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of service users. Similarly, low or declining expenditure per unit of output may reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Total estimated government expenditure per user of CSTDA State and Territory administered specialist disability services in 2004-05 is reported both net of payroll tax and including actual and/or imputed payroll tax. Nationally, estimated expenditure per service user was \$23 005 excluding payroll tax and \$23 453 including actual and/or imputed payroll tax (figure 13.33).

Figure 13.33 Estimated annual government expenditure per user of CSTDA State and Territory administered services, 2004-05^{a, b, c, d}



^a In some jurisdictions (NSW, Victoria in part, Queensland, Tasmania and the NT), payroll tax data is actual; in other jurisdictions (Victoria in part, WA, SA and the ACT), payroll tax data is imputed. ^b Government expenditure per service user for Australia excludes Australian Government expenditure on State and Territory administered services that was not provided as transfer payments. ^c Payroll tax data for Queensland includes paid payroll tax and accrued payroll tax. ^d In the NT, payroll tax relates to government service provision and excludes expenditure for program management and administration.

Source: AIHW (unpublished); State and Territory governments (unpublished); table 13A.35.

Efficiency — administrative cost

Administrative expenditure as a proportion of total expenditure

‘Administrative expenditure as a proportion of total expenditure’ is an indicator of the efficiency of the administration of specialist disability services (box 13.16). The proportion of total expenditure on administration is not yet comparable across jurisdictions because they apportion it using different methods. Administrative expenditure data are useful, however, for indicating trends within jurisdictions over time.

Nationally, administrative expenditure as a proportion of total government expenditure on specialist disability services (excluding payroll tax) decreased from 8.6 per cent in 2004-05 to 8.4 per cent in 2005-06 (figure 13.34).

Box 13.16 Administrative expenditure as a proportion of total expenditure

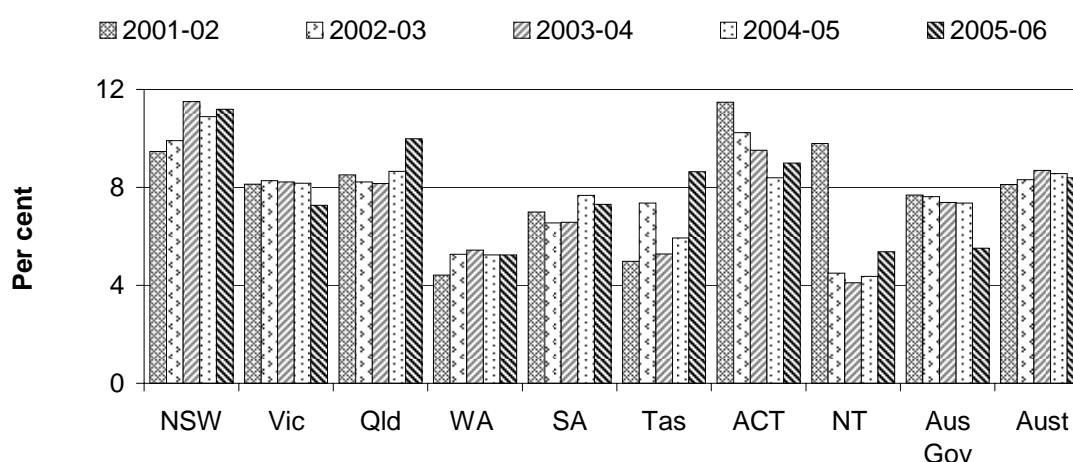
Administrative expenditure as a proportion of total expenditure is an output (efficiency) indicator of governments' objective to provide specialist disability services in an efficient manner. Administrative expenditure in this context represents the costs incurred by government agencies in administering CSTDA funded services.

This indicator is defined as government expenditure on administration as a proportion of total CSTDA expenditure.

Holding other factors constant (such as service quality and accessibility), a decrease in administrative expenditure as a proportion of total CSTDA expenditure may reflect an increase in administrative efficiency.

Efficiency data are difficult to interpret. While high or increasing administrative expenditure as a proportion of total expenditure may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the administrative services provided. Similarly, low or declining administrative expenditure as a proportion of total expenditure may reflect improving efficiency, or lower quality less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Figure 13.34 Administrative expenditure as a proportion of total expenditure^{a, b, c, d, e}



^a See table 13.1 for an explanation of different methods of apportioning departmental costs. ^b Data exclude payroll tax. ^c Australian Government administrative expenditure is an estimate, based on average staffing levels. ^d For the ACT in 2005-06 the method of apportioning administrative expenditure changed as a result of internal restructure and an inclusion of some corporate overhead costs. ^e NT expenditure is underreported in 2001-02. For 2002-03, the method of apportioning administrative expenditure changed, resulting from a re-alignment of some costs previously reported under this category to direct service delivery. The NT changed from cash to accrual accounting in 2002-03, limiting the comparability of expenditure with previous years.

Source: Australian, State and Territory governments (unpublished); table 13A.36.

When actual or imputed payroll tax is included, the average national administrative expenditure as a proportion of total CSTDA expenditure was 8.3 per cent in 2005-06 (table 13A.36). Payroll tax data need to be interpreted with caution, however, because some jurisdictions (NSW, Victoria [in part], Queensland, Tasmania and the NT) have provided payroll or payroll tax data on the basis of direct service delivery expenditure for government provided services, and others (WA, SA and the ACT) have provided the data on the basis of total expenditure for government provided services. Real total CSTDA expenditure is reported in table 13A.8, both excluding and including actual or imputed payroll tax amounts.

Outcomes

The following outcome indicators are reported:

- ‘Labour force participation and employment of people with a disability’
- ‘Social participation of people with a disability’
- ‘Use of other services’.

Labour force participation and employment rate data from the ABS’s *2005 Survey of Education and Training Experience, Australia* are reported for all jurisdictions. Social participation data for 2004 from the Household, Income and Labour Dynamics in Australia (HILDA) Survey¹ are also reported for all jurisdictions. For WA, 2006 social participation data are also included.

The participation of people with a disability in education and training in 2005 and their levels of attainment are also included. These data are sourced from the ABS’s *2005 Survey of Education and Training Experience, Australia*.

Interpreting data for the outcome indicators

The results for the outcome indicators are derived using survey data. To assist with making comparisons between jurisdictions, and different disability status groups, 95 per cent confidence intervals are presented. Confidence intervals are a standard way of expressing the degree of uncertainty associated with survey estimates or performance measurement. An estimate of 80 with a confidence interval of ± 2 , for example, means that if another sample had been drawn, or if another combination of

¹ The HILDA Survey was initiated, and is funded, by the Australian Government through the Department of Families, Community Services and Indigenous Affairs. Responsibility for the design and management of the Survey rests with a group comprising: the Melbourne Institute of Applied Economic and Social Research (University of Melbourne), the Australian Council for Educational Research and the Australian Institute of Family Studies.

test items had been used, there is a 95 per cent chance that the result would lie between 78 and 82. The learning outcomes proportion for a jurisdiction, therefore, can be thought of in terms of a range. If one jurisdiction's rate ranges from 78–82 and another's from 77–81, then it is not possible to say with confidence that one differs from the other (because there is unlikely to be a statistically significant difference). Where ranges do not overlap, there is a high likelihood that there is a statistically significant difference. To say that there is a statistically significant difference means there is a high probability that there is an actual difference; it does not imply that the difference is necessarily large or important.

Labour force participation and employment of people with a disability

'Labour force participation and employment of people with a disability' is an indicator of outcomes for specialist disability services (box 13.17). Detailed definitions and calculations of labour force participation and employment rates are provided in section 13.6.

Box 13.17 Labour force participation and employment of people with a disability

'Labour force participation and employment of people with a disability' is an outcome indicator of governments' objective of assisting people with a disability to participate fully in the community. Participation in the labour force and employment is important to the overall well being of people with a disability, particularly in terms of the opportunity for self-development and interaction with people outside the home.

This indicator is defined as the labour force participation and employment rates of people aged 15–64 years with a disability (by level of core activity limitation). Labour force participation rates and employment rates of people aged 15–64 years without a disability are also reported.

A higher labour force participation or employment rate for people with a disability is likely to increase the quality of life of people by providing greater opportunities for self-development and interaction with people outside the home.

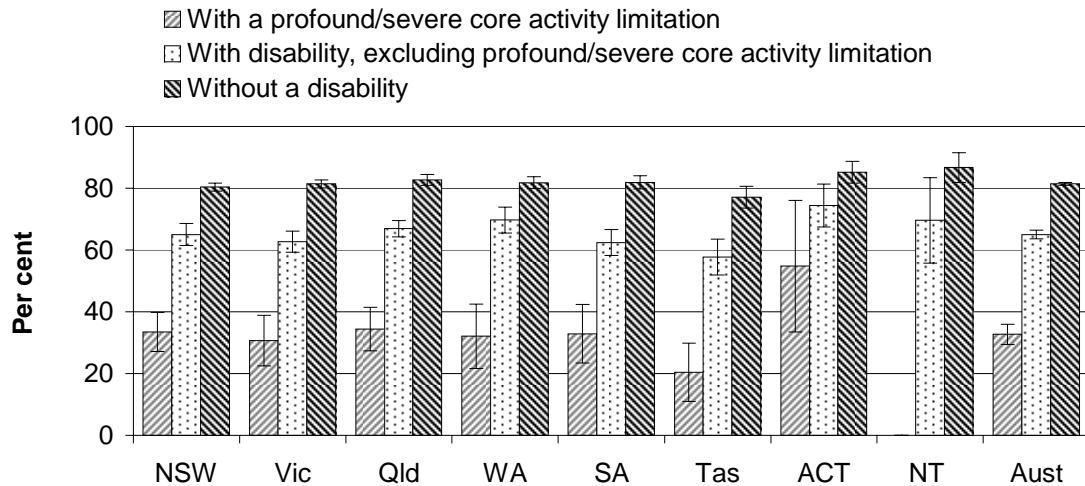
This indicator does not provide information on why people choose not to participate in the labour force and why people are not employed. Finally, it does not provide information on whether the jobs that people find are appropriate or fulfilling.

Labour force participation

Nationally, the estimated labour force participation rate of people aged 15–64 years with a profound or severe core activity limitation in 2005 (32.7 ± 3.3 per cent) was below the rate for other people with a disability, excluding those with a profound or

severe core activity limitation (65.0 ± 1.4 per cent) and the rate for people without a disability (81.4 ± 0.5 per cent) (figure 13.35).

Figure 13.35 Estimated labour force participation rates of people aged 15–64 years, by disability status, 2005^{a, b, c, d}



^a Due to differences in collection methodology, the data collected by the ABS Disability Module (used in the Survey of Education and Training Experience) relate to a broader 'disability and long-term health condition' population than the 'disability' population obtained from the much more detailed SDAC — however, the characteristics of the populations are similar. The data are suitable for population comparisons, but not for prevalence updates between SDAC surveys. ^b Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self-care. ^c Error bars represent the 95 per cent confidence interval associated with each point estimate. ^d Data with relative standard errors (RSEs) over 50 per cent are not published. This is the case for the labour participation rate for people in the NT with a profound or severe core activity limitation.

Source: ABS Survey of Education and Training Experience (unpublished); table 13A.37.

The labour force participation rates of people aged 15–64 years with a profound or severe core activity limitation by geographic location, country of birth and Indigenous status, in 2005 are reported in table 13A.39. Nationally, the estimated labour force participation rate of people with a profound or severe core activity limitation was:

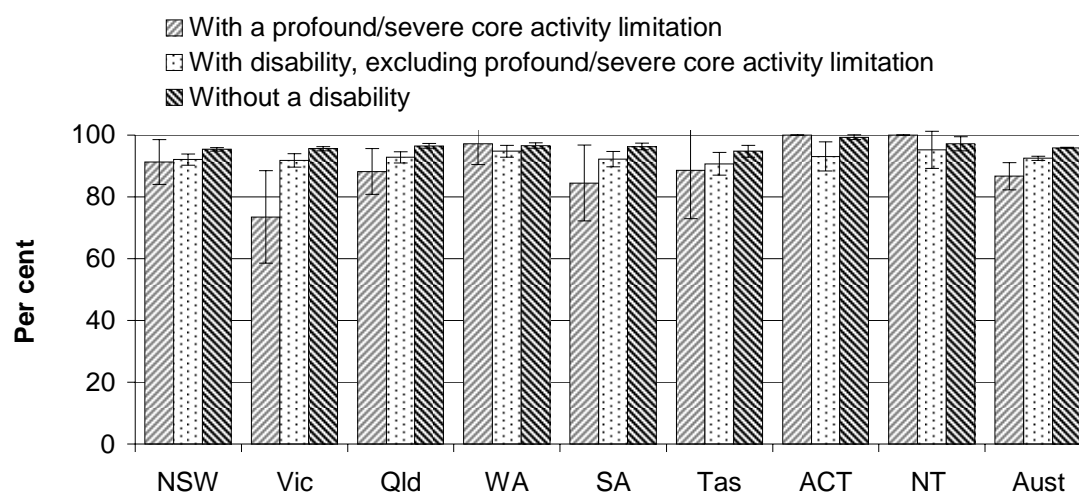
- 30.1 ± 7.0 per cent for those living in outer regional and remote areas, no different to the rate for those living in major cities and inner regional areas (33.1 ± 3.6 per cent)
- 23.6 ± 7.1 per cent for those born in a non-English speaking country, below the rate for those born in an English speaking country (34.5 ± 3.5 per cent)
- 23.0 ± 16.5 per cent for Indigenous people, no different to the rate for non-Indigenous people (33.0 ± 3.4 per cent) (table 13A.39).

Additional labour force participation data for 2003 from the ABS's SDAC are shown in tables 13A.38 and 13A.40.

Employment

Nationally, the estimated employment rate of people aged 15–64 years with a profound or severe core activity limitation in 2005 (86.7 ± 4.4 per cent) was below the rate for other people with a disability, excluding those with a profound or severe core activity limitation (92.5 ± 0.7 per cent) and below the proportion for people without a disability (95.9 ± 0.2 per cent) (figure 13.36).

Figure 13.36 Estimated employment rates of people aged 15–64 years, by disability status, 2005^{a, b, c}



^a Due to differences in collection methodology, the data collected by the ABS Disability Module (used in the Survey of Education and Training Experience) relate to a broader 'disability and long-term health condition' population than the 'disability' population obtained from the much more detailed SDAC — however, the characteristics of the populations are similar. The data are suitable for population comparisons, but not for prevalence updates between SDAC surveys. ^b Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self-care. ^c Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS Survey of Education and Training Experience (unpublished); table 13A.37.

The employment rates of people aged 15–64 years with a profound or severe core activity limitation by geographic location, country of birth and Indigenous status, in 2005 are reported in table 13A.39. Nationally, the estimated employment rate of people with a profound or severe core activity limitation was:

- 96.9 ± 6.3 per cent for those living in outer regional and remote areas, above the rate for those living in major cities and inner regional areas (85.3 ± 5.2 per cent)

- 81.9 \pm 23.8 per cent for those born in a non-English speaking country, no different to the rate for those born in an English speaking country (87.3 \pm 9.2 per cent)
- 96.0 \pm 9.0 per cent for Indigenous people, no different to the rate for non-Indigenous people (86.5 \pm 4.7 per cent) (table 13A.39).

Additional employment rate data for 2003 from the ABS's SDAC are shown in tables 13A.38 and 13A.40.

Social participation of people with a disability

'Social participation of people with a disability' is an indicator of outcomes for specialist disability services (box 13.18).

Box 13.18 Social participation of people with a disability

'Social participation of people with a disability' is an outcome indicator of governments' objective to assist people with a disability to live as valued and participating members of the community.

This indicator is defined as the proportion of people aged 15–64 years with a disability (by level of core activity limitation) who participate in selected social or community activities. The proportion of people without a disability who participate in these activities is also reported. Two measures are reported:

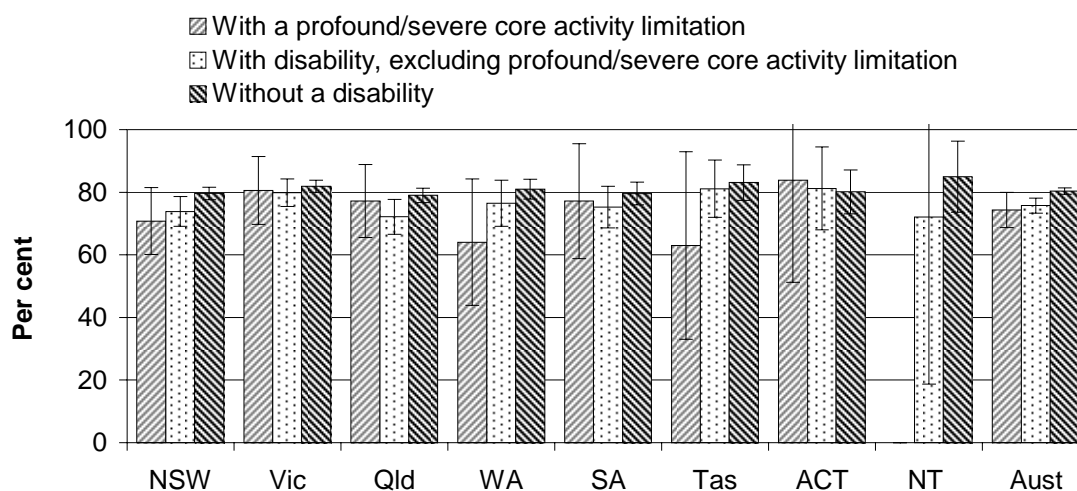
- estimated proportion who participated in social get togethers with friends/relatives not living with them more than once a month
- estimated proportion who were a current active member of a sporting/hobby/community based association.

A higher proportion of people aged 15–64 years with a disability who participate in social or community activities reflects their greater integration in the community.

This indicator does not provide information on the degree to which the identified types of social or community activities contribute to people's quality of life. It also does not provide information on why some people did not participate.

Nationally, the estimated proportion of people with a profound or severe core activity limitation aged 15–64 years who participated more than once a month in social get togethers with friends/relatives not living with them in 2004 was 74.4 \pm 5.6 per cent, no different to the proportion for other people with a disability, excluding profound or severe core activity limitation (75.7 \pm 2.4 per cent) or the proportion for people without a disability (80.3 \pm 1.0 per cent) (figure 13.37).

Figure 13.37 Estimated proportion of people aged 15–64 years who participated more than once a month in social get togethers, by disability status, 2004^{a, b, c, d}

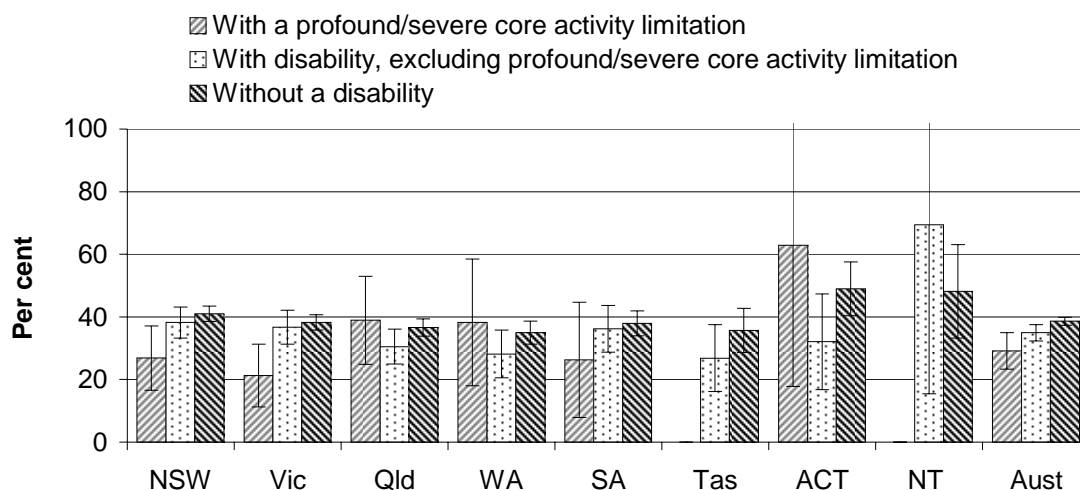


^a Due to differences in collection methodology, the data collected by the HILDA Survey relate to a broader 'disability and long-term health condition' population than the 'disability' population obtained from the much more detailed SDAC — however, the characteristics of the populations are similar. The data are suitable for population comparisons, but not for prevalence updates between SDAC surveys. ^b Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self-care. ^c Error bars represent the 95 per cent confidence interval associated with each point estimate. ^d Data with RSEs over 50 per cent are not published. This is the case for the people in the NT with a profound or severe core activity limitation.

Source: HILDA Survey; table 13A.41.

Nationally, the estimated proportion of people with a profound or severe core activity limitation aged 15–64 years who were a current active member of a sporting/hobby/community based association in 2004 was 29.1 ± 5.8 per cent, no different to the proportion for other people with a disability, excluding profound or severe core activity limitation (34.9 ± 2.6 per cent), but below the proportion for people without a disability (38.6 ± 1.3 per cent) (figure 13.38).

Figure 13.38 **Estimated proportion of people aged 15–64 years who were a current active member of a sporting/hobby/community based association, by disability status, 2004^{a, b, c, d}**



^a Due to differences in collection methodology, the data collected by the HILDA Survey relate to a broader 'disability and long-term health condition' population than the 'disability' population obtained from the much more detailed SDAC — however, the characteristics of the populations are similar. The data are suitable for population comparisons, but not for prevalence updates between SDAC surveys. ^b Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self-care. ^c Error bars represent the 95 per cent confidence interval associated with each point estimate. ^d Data with RSEs over 50 per cent are not published. This is the case for people in Tasmania and the NT with a profound or severe core activity limitation.

Source: HILDA Survey; table 13A.41.

In 2006, WA conducted a survey of users of disability services (or their carers) on their participation in various social activities. Results of this survey are provided in box 13.19. Data from the 2003 ABS SDAC on the social participation of people with a disability are in table 13A.42.

Box 13.19 Social participation of people with a disability in WA

In 2006, 1250 randomly selected users of disability services (or their carers) were surveyed on their participation in a range of social activities. The questions used in the survey were based largely on previous surveys but were modified to align with the International Classification of Functioning categorisation of functions.

The surveyed service users (or carers) were asked if they participated in the activities 'often', 'sometimes', 'rarely' or 'never'. The 'often' and 'sometimes' categories were combined to indicate participation in these activities. Surveyed service users were also asked whether they wanted to participate in the activities 'more often', 'less often' or 'not change'.

The following are the reported results of service users' participation, where:

- 70 per cent reported going out to entertainment (for example, movies, restaurants and concerts), 15 per cent reported never going out to entertainment and 54 per cent reported wanting to participate in these activities more often
- 57 per cent reported being involved in group leisure or sport, 36 per cent reported never being involved in group leisure or sport and 48 per cent reported wanting to participate in these activities more often
- 82 per cent reported being involved in individual activities such as going to the park, walking or swimming, 10 per cent reported never being involved in individual activities and 42 per cent reported wanting to participate in these activities more often
- 41 per cent reported attending cultural, religious or community events, 47 per cent reported never being involved in these events and 17 per cent reported wanting to participate in these activities more often
- 66 per cent reported communicating with people other than carers, friends or family members, 19 per cent reported never communicating with these people and 34 per cent reported wanting to communicate with these people more often.

Source: WA Government (unpublished).

Use of other services

'Use of other services' is an indicator of outcomes for specialist disability services (box 13.20). In previous reports, the 'use of other services' indicator referred to other chapters of the Report only. This indicator has been enhanced for this year's Report by the inclusion of data under this indicator on the participation of people with a disability (by level of core activity limitation) in educational and training and their educational and training attainment.

Box 13.20 Use of other services

'Use of other services' is an outcome indicator of governments' objective of enhancing the quality of life experienced by people with a disability by assisting them to gain access to mainstream government and community services and facilities.

This indicator is defined as the proportion of people with a disability (by level of core activity limitation) who:

- participated in schools, VET and universities
- reached certain levels of educational and training attainment.

These proportions are also reported for people without a disability.

Higher proportions of people with a disability participating in education and training or having reached particular levels of educational and training attainment is desirable as it suggests greater access to mainstream government educational and training services.

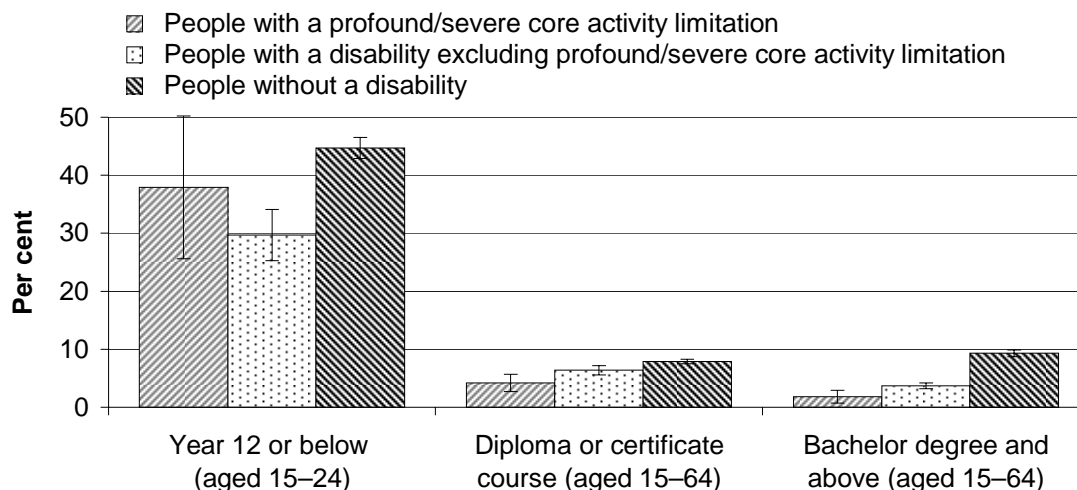
This indicator does not provide information on the degree to which the services contribute to people's quality of life. It also does not provide information on why some people do not access these services.

Nationally in 2005, the proportion of people with a profound or severe core activity limitation:

- aged 15–24 who participated in schools was 37.9 ± 12.3 per cent, no different to the proportion for other people with a disability, excluding those with a profound or severe core activity limitation (29.7 ± 4.4 per cent) or the proportion for people without a disability (44.7 ± 1.8 per cent)
- aged 15–64 who participated in VET was 4.2 ± 1.5 per cent, no different to the proportion for other people with a disability, excluding those with a profound or severe core activity limitation (6.4 ± 0.8 per cent), but below the proportion for people without a disability (7.9 ± 0.4 per cent)
- aged 15–64 who participated in university was 1.8 ± 1.1 per cent, below the proportion for other people with a disability, excluding those with a profound or severe core activity limitation (3.7 ± 0.5 per cent) and the proportion for people without a disability (9.3 ± 0.6 per cent) (figure 13.39).

Available jurisdictional results are reported in table 13A.43.

Figure 13.39 Estimated proportion of people who participated in education and training, by disability status, 2005^{a, b, c}



^a Due to differences in collection methodology, the data collected by the ABS Disability Module (used in the Survey of Education and Training Experience) relate to a broader 'disability and long-term health condition' population than the 'disability' population obtained from the much more detailed SDAC — however, the characteristics of the populations are similar. The data are suitable for population comparisons, but not for prevalence updates between SDAC surveys. ^b Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self-care. ^c Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS Survey of Education and Training Experience (unpublished); table 13A.43.

Nationally in 2005, the proportion of people with a profound or severe core activity limitation aged 15–64 whose highest level of educational attainment was:

- year 10 was 20.7 ± 3.1 per cent, no different to the proportion for other people with a disability, excluding those with a profound or severe core activity limitation (20.6 ± 1.0 per cent) and above the proportion for people without a disability (15.3 ± 0.7 per cent)
- year 11/12 was 18.1 ± 2.3 per cent, no different to the proportion for other people with a disability, excluding those with a profound or severe core activity limitation (20.6 ± 1.2 per cent) and below the proportion for people without a disability (27.2 ± 0.6 per cent)
- diploma/certificate course was 24.8 ± 3.9 per cent, no different to the proportion for other people with a disability, excluding those with a profound or severe core activity limitation (29.3 ± 1.1 per cent) or the proportion for people without a disability (26.2 ± 0.8 per cent)
- bachelor degree and above was 7.9 ± 1.9 per cent, below the proportion for other people with a disability, excluding those with a profound or severe core activity

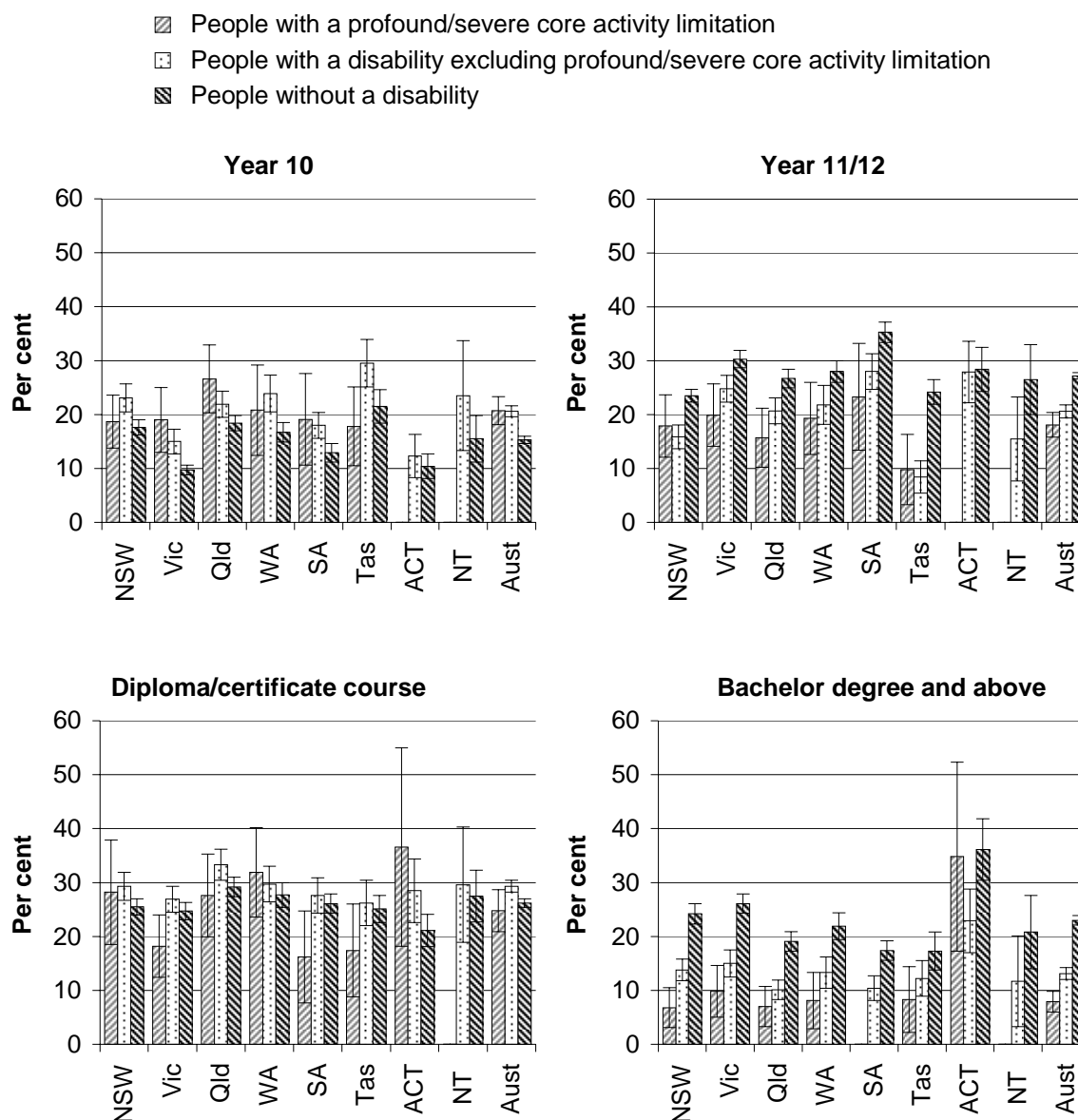
limitation (13.1 ± 1.1 per cent) and the proportion for people without a disability (23.0 ± 0.9 per cent) (figure 13.40).

There was a proportion of people, in all groups in 2005, whose level of educational attainment was not determined, or whose level of attainment was year 9 or below. For people with a profound or severe core activity limitation, the proportion was 28.5 per cent. For people with a disability, excluding those with a profound or severe core activity limitation, the proportion was 16.4 per cent, and for people without a disability, the proportion was 8.3 per cent (table 13A.44).

Data on the participation of people with a disability in various government services are also incorporated in the performance indicator frameworks for other chapters of this Report. Participation is reported for VET (see chapter 4), children's services (see chapter 14) and public, community and State owned and managed Indigenous housing (see chapter 16). In addition, the following chapters include data on services provided to people with a disability:

- 'School education' (chapter 3) reports data on students with a disability in the student body mix.
- 'Health management issues' (chapter 11) reports performance data on specialised mental health services.
- 'Aged care services' (chapter 12) reports data on HACC services received, including those received by people with a profound, severe or moderate core activity limitation, disaggregated by jurisdiction and geographic location.

Figure 13.40 Level of highest educational attainment, by estimated proportion of people aged 15–64, by disability status, 2005^{a, b, c, d}



^a Due to differences in collection methodology, the data collected by the ABS Disability Module (used in the Survey of Education and Training Experience) relate to a broader 'disability and long-term health condition' population than the 'disability' population obtained from the much more detailed SDAC — however, the characteristics of the populations are similar. The data are suitable for population comparisons, but not for prevalence updates between SDAC surveys. ^b Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self-care. ^c Error bars represent the 95 per cent confidence interval associated with each point estimate. ^d Data with RSEs over 50 per cent are not published. This is the case for data related to people with a profound or severe core activity limitation in SA (bachelor degree and above), the ACT (year 10 and year 11/12) and the NT (diploma/certificate course). For the NT, there were no people identified by the Survey with a profound or severe core activity limitation who had the other levels of attainment.

Source: ABS Survey of Education and Training Experience (unpublished); table 13A.44.

13.4 Future directions in performance reporting

There is scope for further improvements in reporting against the current framework, including improving the data on service quality. The Steering Committee intends to address limitations over time by:

- considering whether the most recent year's service user data are available for reporting
- classifying services provided by local governments as government to ensure consistency across data sources
- investigating reporting a performance indicator on younger people with a disability in residential aged care facilities for future reports
- reporting national client and carer satisfaction with service quality
- reporting more complete, current, ongoing quality assurance processes data.

Reporting on quality assurance processes is expected to become more complete and comparable over time, with refinements to performance indicators and data collections.

13.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

“ During 2005-06 the Australian Government has continued to build on gains made with reforms to business services, designed to enable services to operate as viable commercial enterprises while delivering quality employment outcomes for people with more significant disability.

The two-year phase-in of the new case based funding model for business services is now complete. The new arrangements have addressed historical funding inequities between services and funding now more closely matches individual support needs of workers, with explicit links between funding and employment outcomes. To help meet the demand for supported employment opportunities, an additional 380 places were allocated to business services in 2005-06.

The 2005-06 Quality Strategy evaluation confirms that disability employment services have made significant progress in providing a quality service to people with disability and that the independent certification of these services against legislated Quality Standards has played an important part in achieving this outcome. A major achievement of the Quality Strategy is that around 80 per cent of business services now pay their workers pro rata award-based wages, with the remaining services making steady progress towards this outcome.

The flexible assistance available through the *Security, Quality Services and Choice for People with Disabilities* package announced in April 2004 is proving to be a vital support for both business services and consumers with low productivity. Over 90 per cent of business services have participated in the package processes and \$27.6 million in funding has been approved so far to boost the viability of business services.

Other initiatives include the launch of a new website, BizAbility.com.au, showcasing the products and services provided by business services. Grants are also available to help business services build new alliances across the sector and attend events to promote their products. A new Rural and Remote Service Supplement was also introduced.

The Australian Government has worked closely with CRS Australia and business services to provide ongoing support to consumers with low productivity. Independent case managers help these consumers to decide if they wish to stay at work with additional assistance or explore non-vocational activities. Around 1420 consumers have been approved for case management assistance and of those assisted to date, around 80 per cent have chosen to stay in employment.

Full case based funding for the Disability Employment Network (formerly Disability Open Employment Services) was successfully implemented from 1 July 2005, providing stronger links between service funding and outcomes delivered.”

New South Wales Government comments

“ The NSW Government continued its commitment to providing services to people with a disability and their carers to assist them to live independently and participate in community life. Improving services to people with a disability has been a prime focus in NSW with funding increasing by \$640 million to \$1.1 billion during the past nine years.

In May 2006, the NSW Government announced its 10-year Plan, *Stronger Together: a new direction for disability services: 2006–2016*. It represents more than \$1 billion in additional funding over the next five years and a reshaping of the system to provide fairer and easier access to deliver more flexible and responsive support.

In NSW, the demand for disability accommodation is growing and we now assist more than 5000 people with their accommodation needs. In the last five years, more than 1000 people with a disability have received new group home accommodation — including relocation of people in boarding houses, large residential centres, in respite centres. A further 600 people received accommodation support through the Attendant Care Program and Emergency Response funding.

In 2005-06, funding was announced for around 1000 respite places ranging from limited to intensive support. The type of respite offered will be in line with the needs of the individual and their family or carer — whether it is centre-based, in-home or a combination of the two.

NSW aims for a mix of services that are flexible and responsive to the family's needs and assist families to remain together. To meet this need, the Behaviour Intervention Service has expanded, ensuring that there is locally based expertise. Additional funding has also ensured that more than 80 non-government organisations will be available to provide early childhood intervention services with \$2 million allocated for the purchase of equipment. New Intensive Family Support services will also give families access to a range of support services including counselling, education, support networks and assistance in developing sustainable family routines. Children's casework consultants were also appointed and will have a key role in facilitating systemic changes to improve service quality.

A new Community Participation program for school leavers means that service users and their families will be given greater flexibility and choice of the types of support they receive. Clients and families will also be allocated a minimum of 18 hours support a week for at least 48 weeks a year with increased hours available in 2006-07.

The NSW Government has input considerable efforts into improving the CSTDA MDS data return rate and the quality of data submitted.

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Victorian Government comments

“ The Victorian Government is committed to strengthening the options available to improve the lives of people with a disability. An emphasis on individual choice, carer support and early intervention help to enable people to live independently in the community.

The Disability Act 2006 was passed by Parliament in May 2006, and takes effect on 1 July 2007 unless proclaimed earlier. Consistent with the Victorian State Disability Plan 2002–2012, the Act’s objectives include:

- Promoting and protecting the rights of people with a disability.
- Creating mechanisms to make communities more accessible to people with a disability.
- Regulating disability services to ensure they are high quality and accountable to people with a disability and to government.
- Ensuring more transparent and accountable regulation of compulsory treatment of people with an intellectual disability, as recommended by the Victorian Law Reform Commission.

In 2005-06, some key achievements included:

- the ongoing redevelopment of Kew Residential Services, with 360 residents having moved into 73 community houses
 - the continued focus on the Individual Planning and Support approach with the provision of an additional 192 Support and Choice packages, 34 Transitional Assessment and Support packages, 424 Behaviour Intervention Support Therapy (BIST) packages and Aids and Equipment for over 4700 people
 - the ongoing commitment to families caring for family members with a disability with the provision of 565 respite episodes, which has been matched by the Commonwealth with an additional 565 respite episodes
 - the establishment of the inaugural Board of Directors of the Disability Housing Trust in February 2006. The Trust Board will establish its organisational structure to enable progress towards identification of the initial tranche of suitable capital projects to deliver additional housing opportunities for people with a disability
 - the ongoing commitment to ensuring Shared Supported Accommodation facilities reflect the best standard available for those living and working in them with the refurbishment and renewal project. All 27 new buildings are currently at design, tender, or construction stages, and the 20 refurbishment projects are at planning stage.
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Queensland Government comments

“ Through the continual implementation of legislative and administrative reforms, disability services in Queensland continue to be delivered via a fairer, more responsive and efficient system supported throughout the State. The Queensland Government continued to fulfil its responsibilities for the administration of specialist disability services under the *Commonwealth State/Territory Disability Agreement 2002–2007* (CSTDA). Queensland increased total funding for the provision of specialist disability services (including expenditure on specialist psychiatric disability services) by \$68 million to \$505.7 million in 2005-06. The increased funding enabled additional provision of accommodation support, community support, community access, respite, advocacy and information and print disability services across the State.

Queensland continued the momentum set in previous years to provide more services through established programs, such as the Adult Lifestyle Support Program — which assisted an additional 103 people to maintain living arrangements and build social relationships in their community. This increased the total number of people supported through this program to 1430. Increased support was also established in a greater number of regional and remote areas through the Local Area Coordinator Program, which helped 2908 families to access assistance in their local area.

We also strengthened our focus on early intervention strategies, providing early support to an additional 236 families supporting children with a disability. The total number of families to receive support was 1186. We will also implement early intervention strategies to reduce the long term demands and impacts of children aged 0–5 years with autism with complex and challenging behaviours. This initiative, introduced in 2006, will pay long-term dividends. An additional 61 adults with a disability who were at risk of becoming homeless as a result of closure or change in operations of private hostel accommodation were assisted through the Hostels Response Program. This increased the number supported through this program to 91. Through the Strengthening Non-Government Organisations Strategy, Queensland also assisted 136 service providers to purchase or replace assets. Additionally, under this Strategy, training was also delivered to 70 service providers to strengthen planning capacity skills.

Queensland continued its focus on enhancing the responsiveness of disability services through community consultation on proposed improvements in the key areas of assessment, prioritisation, services and funding approaches. The results were published in May 2006 and distributed to all key stakeholders. These results will inform government consideration for future improvements to the service system. The *Disability Services Act 2006* will commence on 1 July 2006. The new Act provides the strongest foundation ever in Queensland for promoting the rights of people with a disability, increasing their wellbeing and encouraging their participation in the life of the community. It includes measures to safeguard the rights and safety of people with a disability, increasing their protection from abuse and neglect, and combines with existing systems such as the Disability Sector Quality System to improve the quality of disability services.

Western Australian Government comments

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The WA Government has continued its focus on developing and sustaining services for people with disabilities and their carers, strengthening partnerships with the disability sector, other government departments and local government, to build welcoming communities for people with disabilities and their families.

The third Strategic Plan was developed for the period 2006–2010, with the vision that ‘all people live in welcoming communities which facilitate citizenship, friendship, mutual support and a fair go for everyone’.

The joint ACROD-Commission community awareness campaign, *Open Your Mind. Count Us In* which ran statewide as a series of television, print, and outdoor advertisements between November 2004 and January 2005 has moved into a new phase. The new *Count Us In* website, an online tool kit providing community, schools and businesses with detailed information and resources to enable them to be more inclusive has been established, as well as, the *Count Us In!* curriculum support package which provides resource materials and guidelines for teachers to teach school children about disability rights and the importance of being an inclusive society.

Fair Play, a strategic framework aimed at making sport and recreation more inclusive for people with disabilities, was developed in collaboration with the Department of Sport and Recreation to guide sports clubs and recreation centres in creating opportunities for people with disabilities to participate.

The *Aboriginal People with Disabilities: Getting Services Right*, a policy guide and resource package was developed following a four-year statewide consultation project with more than 300 stakeholders and is a firm commitment to making disability services more culturally appropriate and welcoming to Aboriginal people with disabilities. The tri-state agreement was signed in July 2005 to ensure a coordinated approach to the provision of disability services to the Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara lands covering 350 000 km² across WA, SA and the NT.

The 2006 Consumer Satisfaction Survey was undertaken to determine the level of satisfaction of service users with the services provided or funded by the Commission, and to explore social participation, quality of life, experiences of carers, awareness and use of the Commission’s complaints processes, and community inclusion.

As part of its commitment to improve data quality under the NMDS, WA is currently developing an online web-based system for the collection of client and service data in consultation with all non government agencies.

The Disability Research Network website which aims to improve communication and collaboration between researchers working in the area of disability in WA was developed and launched in October 2005.

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South Australian Government comments

“ The Disability Services Office was renamed the Office for Disability and Client Services (ODACS) to be more inclusive of people with functional support needs, rather than just those with a diagnosed disability. ODACS continued its focus on improved service delivery, deinstitutionalisation and the needs of special groups.

Some key achievements for 2005-06 include:

- Establishment of two new respite homes and a group home in country regions — Clare, Strathalbyn and Murray Bridge.
- Established services for people with a psychiatric disability initially targeting homeless people and rough sleepers.
- Collaboration with Department of Health to meet high health care needs of people with disabilities.
- Established a protocol between agencies in the disability sector and Commonwealth Aged Care Assessment Teams to prevent younger people from being admitted to Aged Care facilities.
- \$1 million Trust Fund established to support Disability Arts.
- Extended eligibility criteria to include functional disabilities which would open up services to more people.
- Supported Accommodation Task Force established to improve access to supported accommodation for people with a disability through the development of a comprehensive Accommodation Services Plan for SA.
- Major review and enhancement of contracting procedures will lead to improved performance monitoring of funded agencies.
- Enhancements to Provider Panel requirements to ensure funded agencies implement continuous quality improvement and limit the use of self-employed subcontractors.
- ODACS now has the lead role in coordinating the whole of government reporting process for Disability Action Plans across the State.
- Support provided for service development in the Aboriginal communities (Pukatja, Amata and Ernabella)
- Partnership established with Autism SA to streamline services and a joint registration system which will improve access.
- Taken responsibility for the overall coordination of services to people in Supported Residential Facilities, thereby extending services to a wider client group.
- Research into unmet need for people with psychiatric disability and an audit of waiting list for disability services (intellectual, brain injury and adult physical and neurological).

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Tasmanian Government comments

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The Tasmanian Government is committed to a comprehensive social justice approach to disability. In December 2005, the *Disability Framework for Action 2005–2010* was released. This whole-of-government framework seeks to remove barriers and enable people with disabilities to enjoy the same rights and opportunities as other Tasmanians.

The effective delivery of specialist disability services through the Department of Health and Human Services' (DHHS) Disability Services business unit is an important aspect of the Government's broader commitment to people with a disability.

Key strategic priorities guiding the Department's approach to the development of the disability service system include:

- building systems and processes to ensure the sustainability of frontline service delivery
- increasing the capacity of the service system
- developing innovative approaches to service delivery
- a focus on quality and safety.

Challenges for Disability Services in 2005-06 included workforce capacity issues, rising costs and an increasing demand for services. The key drivers were a range of factors including the increasing complexity of client need, changing community expectations and the growing and ageing population.

Budget initiatives for 2005-06 included the investment of an additional \$3 million in the *Care in the Community* initiative to provide individualised services to enable people with a disability to remain supported in their local community. A key outcome of this initiative is improved quality of life for people with a disability, their families and carers.

A number of significant projects were developed and implemented by Disability Services in 2005-06. These include:

- the *Living Independently* Project, under which the management of all disability group homes currently managed by the DHHS is being transferred to non-government organisations over a three year period; and
- the Intensive Support Service incorporating the commencement of the Intensive Support Training Strategy, client support and planning of accommodation facilities associated with the service.

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Australian Capital Territory Government comments

“ The Department of Disability, Housing and Community Services, through Disability ACT (DACT), continued to advance its strategic plan as outlined in *Future Directions: a framework for the ACT 2004–2008*:

- Promote an inclusive society,
- Strengthen the capacity of individuals with a disability and their families to maximise control over their lives,
- Improve planning and use of available resources, and
- In partnership with the Community Sector, strengthen the sustainability and responsiveness of the Service Delivery Sector.

Recent initiatives have included:

- The implementation of a community governance structure to implement *Future Directions: 2004–2008*.
- After extensive community consultation, DACT has developed an Individual Support Package (ISP) policy and procedures manual to ensure a more equitable and transparent ISP process. In 2005-06, 161 individuals with a disability were supported through Individual Support Packages. \$8.2 million is distributed through these packages on a recurrent yearly basis.
- In 2006, DACT commenced a Review of the Role of Government as Disability Services Provider. Community consultations commenced in August 2006 with a final in-principle report to Government expected in mid-2007 on what services are best provided by Government and what services are best provided by the community sector.
- In 2005, DACT implemented a new quality improvement system for all its funded agencies which included a baseline assessment against the National Disability Services Standards. DACT is currently working with other government and community agencies on an agreement to use a ‘whole-of-community sector’ Quality Framework, using a local tool called *Raising the Standard* to minimise agencies’ multiple reporting obligations.
- In 2006, DACT commenced the development of a Workforce Development Strategy using a consultation process and building on the work of the former Workforce Reform Working Group.
- DACT has developing three new person-centred services: *A Family-centred Flexible Intensive Response Model* for families with children with high support needs; a new accommodation support service for people with acquired brain injury; and *Frameworks*, a day options service for young people with disabilities who have completed school and are unlikely to access full-time employment.
- *A Young People in Residential Aged Care Program* is also being developed for people aged under 65 with a disability who currently live in residential aged care accommodation or are at risk of entering residential aged care.

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Northern Territory Government comments

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The unique environmental and socio-economic factors in the NT create specific challenges in the provision of specialist disability services for both the NT Government and Australian Government, particularly in providing appropriate and sustainable disability services to remote Indigenous communities

Promoting access to disability services in remote communities and for Indigenous people remains a priority for the NT Government. The introduction of trans-disciplinary practice has substantially improved access to assessment and allied health services in recent years. There is now a need to adopt new models of support provision in other areas such as accommodation support and day programs.

During 2005-06, the NT put a lot of effort in improving the participation rates as well as the quality of the NMDS from providers. This involved working collaboratively with disability service agencies and providing them with ongoing training and support and the roll out of web based data entry system throughout the Territory. There remains an ongoing challenge of ensuring good data quality from the large number of small and dispersed providers, particularly given that these providers receive funds from multiple funding sources.

During 2005-06, the NT Government placed great emphasis in supporting carers of people with a disability, frail aged and those with a chronic disease and people with mental illness. A new Carers' Recognition Act with specific Carers' Charter was developed. This is in recognition of carer's contribution to the community. The Act will come into effect in 2006-07. In addition, subsidies and concessions on cost of essential services similar to those available to pensioners was extended to carers in the NT and \$1.05 million was allocated by NT Government for these concessions in 2006-07.

During 2005-06, the NT Government commissioned an independent and whole of Government review on the provision of services to people with a disability and their carers. This review will be complete in 2005-06 and will form the basis of a future reform strategy focused on improvement in access, quality and responsiveness of disability services.

NT potential population estimates in the report are based on small sample sizes and subsequently have high standard error rates. Indicators based on these estimates need to be interpreted with caution. In addition small variations in NT disability services data appears in magnified proportions in the report.

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13.6 Definitions of key terms and indicators

Accommodation support service users receiving community accommodation and care services	People using the following CSTDA accommodation support services: group homes; attendant care/personal care; in-home accommodation support; alternative family placement and other accommodation support (types 1.04–1.08), as a proportion of all people using CSTDA accommodation support services (excludes specialist psychiatric disability services). See AIHW (2006b) for more information on service types 1.04–1.08.
Administration expenditure as a proportion of total expenditure	The numerator — expenditure (accrual) by jurisdictions on administering the disability service system as a whole (including the regional program management and administration, the central policy and program management and administration, and the disability program share of corporate administration costs under the umbrella department, but excluding administration expenditure on a service that has been already counted in the direct expenditure on the service) — divided by the denominator — total government expenditure on services for people with a disability (including expenditure on both programs and administration, direct expenditure and grants to government service providers, and government grants to non-government service providers).
Core activities as per the 2003 ABS SDAC	Self-care — showering or bathing, dressing, eating, toileting and bladder or bowel control; mobility — getting into or out of a bed or chair, moving about the usual place of residence, going to or getting around a place away from the usual residence, walking 200 metres, walking up and down stairs without a handrail, bending and picking up an object from the floor, using public transport (the first three tasks contribute to the definitions of profound and severe core-activity limitation); and communication — understanding and being understood by strangers, family and friends.
Cost per user of government provided accommodation support services — group homes	The numerator — government expenditure (accrual) on government provided accommodation support services in group homes (as defined by CSTDA NMDS service type 1.04) — divided by the denominator — the number of users of government provided accommodation support services in group homes.
Cost per user of government provided accommodation support services — institutional/residential settings	The numerator — government expenditure (accrual) on government provided accommodation support services in institutional/residential settings (as defined by CSTDA NMDS service types 1.01, 1.02 and 1.03) — divided by the denominator — the number of users of accommodation support services in institutional/residential settings. See AIHW (2006b) for more information on service types 1.01–1.03.
Cost per user of government provided accommodation support services — other community settings	The numerator — government expenditure (accrual) on government provided accommodation support services in other community settings (as defined by CSTDA NMDS service types 1.05–1.08) divided by the denominator — the number of users of government provided accommodation support services in other community settings.
Disability	A multidimensional experience that may involve effects on organs or body parts, and effects on a person's participation in areas of life. Correspondingly, three dimensions of disability are recognised in the International Classification of Functioning, Disability and Health: body structure and function (and impairment thereof), activity (and activity limitations) and participation (and participation restriction).

	<p>(WHO 2001). The classification also recognises the role of physical and social environmental factors in affecting disability outcomes.</p> <p>The ABS 2003 SDAC defined 'disability' as the presence of one or more of 17 limitations, restrictions or impairments, which have lasted, or are likely to last, for a period of six months or more: loss of sight (not corrected by glasses or contact lenses); loss of hearing where communication is restricted; or an aid to assist with, or substitute for, hearing is used; speech difficulties; shortness of breath or breathing difficulties causing restriction; chronic or recurrent pain or discomfort causing restriction; blackouts, fits or loss of consciousness; difficulty learning or understanding; incomplete use of arms or fingers; difficulty gripping or holding things; incomplete use of feet or legs; nervous or emotional condition causing restriction; restriction in physical activities or in doing physical work; disfigurement or deformity; mental illness or condition requiring help or supervision; long term effects of head injury; stroke or other brain damage causing restriction; receiving treatment or medication for any other long term conditions or ailments and still restricted; any other long term conditions resulting in a restriction.</p>
Employment rate for people with a profound or severe core activity limitation	<p>Total estimated number of people aged 15–64 years with a profound or severe core activity limitation who are employed, divided by the total estimated number of people aged 15–64 years with a profound or severe core activity limitation in the labour force, multiplied by 100.</p>
Employment rate for total population	<p>Total estimated number of people aged 15–64 years who are employed, divided by the total number of people aged 15–64 years in the labour force, multiplied by 100.</p>
Funded agency	<p>An organisation that delivers one or more CSTDA service types (service type outlets). Funded agencies are usually legal entities. They are generally responsible for providing CSTDA NMDS data to jurisdictions. Where a funded agency operates only one service type outlet, the service type outlet and the funded agency are the same entity.</p>
Geographic location	<p>Geographic location is based on the ABS's Australian Standard Geographical Classification of Remoteness Areas which categorises areas as 'major cities', 'inner regional', 'outer regional', 'remote', 'very remote' and 'migratory'. The criteria for Remoteness Areas are based on the Accessibility/Remoteness Index of Australia, which measures the remoteness of a point based on the physical road distance to the nearest urban centre in each of five size classes (ABS 2001).</p> <p>The 'outer regional and remote/very remote' classification used in this Report was derived by adding outer regional, remote and very remote data.</p>
Government contribution per user of non-government provided employment services	<p>The numerator — Australian Government grant and case-based funding expenditure (accrual) on specialist disability employment services (as defined by CSTDA NMDS service types 5.01 [open], 5.02 [supported], 5.03 [combined open and supported]) — divided by the denominator — number of service users who received assistance. See AIHW (2006b) for more information on service types 5.01–5.03.</p>

Government contribution per user of non-government provided services — accommodation support in group homes	The numerator — government expenditure (accrual) on non-government provided accommodation support services in group homes (as defined by CSTDA NMDS service type 1.04) — divided by the denominator — the number of users of non-government provided accommodation support services in group homes.
Government contribution per user of non-government provided services — accommodation support in institutional/residential settings	The numerator — government expenditure (accrual) on non-government provided accommodation support services in institutional/residential settings (as defined by CSTDA NMDS service types 1.01, 1.02 and 1.03) — divided by the denominator — the number of users of non-government provided accommodation support services in institutional/residential settings.
Government contribution per user of non-government provided services — accommodation support in other community settings	The numerator — government expenditure (accrual) on non-government provided accommodation support services in other community settings (as defined by CSTDA NMDS service types 1.05–1.08) — divided by the denominator — the number of users of non-government provided accommodation support services in other community settings.
Indigenous factor	<p>The potential populations were estimated by applying the 2003 national age- and sex- specific rates of profound or severe core activity limitation to the age and sex structure of each jurisdiction in the current year. As Indigenous people have significantly higher disability prevalence rates and greater representation in some CSTDA funded services than non-Indigenous people, and there are differences in the share of different jurisdictions' populations who are Indigenous, a further Indigenous factor adjustment was undertaken. The Indigenous factor was multiplied by the 'expected current population estimate' of people with a profound or severe core activity limitation in each jurisdiction to derive the 'potential population'.</p> <p>The following steps were undertaken to estimate the Indigenous factors.</p> <ul style="list-style-type: none"> • Data for all people (weighted) were calculated by multiplying the data for Indigenous Australians by 2.4 and adding the data for non-Indigenous Australians. Hence Indigenous Australians are weighted at 2.4 and non-Indigenous Australians at one. • Data for all people (weighted per person) were calculated by dividing the all people (weighted) data by the sum of the Indigenous Australians data and the non-Indigenous Australians data. • The Indigenous factors were then calculated by multiplying the all people (weighted per person) data by 100 and dividing by the all people (weighted per person) total for Australia (AIHW 2006b).
Labour force participation rate for people with a profound or severe core activity limitation	<p>The total number of people with a profound or severe core activity limitation in the labour force (where the labour force includes employed and unemployed people), divided by the total number of people with a profound or severe core activity limitation who are aged 15–64 years, multiplied by 100.</p> <p>An employed person is a person who, in his or her main job during the remuneration period (reference week):</p>

	<ul style="list-style-type: none"> • 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. <p>An unemployed person is a person aged 15–64 years who was not employed during the remuneration period, but was looking for work.</p>
Labour force participation rate for the total population	Total number of people aged 15–64 years in the labour force (where the labour force includes both employed and unemployed people) divided by the total number of people aged 15–64 years, multiplied by 100.
Mild core activity limitation	Not needing assistance with, and has no difficulty performing, core activity tasks, but uses aids and equipment (as per the ABS 2003 SDAC).
Moderate core activity limitation	Not needing assistance but having difficulty performing a core activity task (as per the ABS 2003 SDAC).
Non-English speaking country of birth	People with a country of birth other than Australia and classified in English proficiency groups 2, 3 or 4 (DIMA 1999). These countries include countries other than New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States.
Payroll tax	<p>A tax levied on employers based on the value of wages and certain supplements paid or payable to, or on behalf of, their employees (SCRCSSP 1999). Payroll tax arrangements for government funded and delivered services differ across jurisdictions. Differences in the treatment of payroll tax can affect the comparability of unit costs across jurisdictions and services. These differences include payroll tax exemptions, marginal tax rates, tax-free thresholds and clawback arrangements (see SCRCSSP 1999).</p> <p>There are two forms of payroll tax reported:</p> <ul style="list-style-type: none"> • <i>actual</i> — payroll tax actually paid by non-exempt services • <i>imputed</i> — a hypothetical payroll tax amount estimated for exempt services. A jurisdiction's estimate is based on the cost of salaries and salary related expenses, the payroll tax threshold and the tax rate.
Potential population	<p>Potential population estimates are used as the denominators for the performance measures reported under the indicator 'access to CSTDA funded services'.</p> <p>The term 'potential population' is not the same as the population needing the services. Rather, it indicates those with the potential to require disability support services, which include individuals who meet the service eligibility criteria but who do not demand the services.</p> <p>The potential population for CSTDA funded accommodation and community access and community support services is the number of people aged under 65 years who have a profound or severe core activity limitation, adjusted for the Indigenous factor. The potential population for CSTDA funded employment services is the number of people aged 15–64 years with a profound or severe core activity limitation, adjusted for the Indigenous factor and the labour force</p>

participation rate. The potential population for CSTDA funded respite services data is the number of people under 65 years with a profound or severe core activity limitation who have a primary carer, adjusted for the Indigenous factor.

The ABS concept of a 'profound or severe' core activity limitation that relates to the need for assistance with everyday activities of self-care, mobility and communication was argued to be the most relevant population for specialist disability services. The relatively high standard errors in the prevalence rates for smaller jurisdictions, as well as the need to adjust for the Indigenous population necessitated the preparation of special estimates of the 'potential population' for specialist disability services.

Briefly, the potential population was estimated by applying the 2003 national age- and sex- specific rates of profound or severe core activity limitation to the age and sex structure of each jurisdiction in the current year, to give an 'expected current estimate' of people with a profound or severe core activity limitation in that jurisdiction. These estimates were adjusted by the Indigenous factor to account for differences in the proportion of jurisdictions' populations who are Indigenous. Indigenous people have been given a weighting of 2.4 in these estimates, in recognition of their greater prevalence rates of disability and their relatively greater representation in CSTDA funded services (AIHW 2006c).

Primary carer	A primary carer is a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities (communication, mobility and self-care) (ABS 2004c).
Primary disability group	Disability group that most clearly expresses the experience of disability by a person. The primary disability group can also be considered as the disability group causing the most difficulty to the person (overall difficulty in daily life, not just within the context of the support offered by a particular service).
Profound core activity limitation	Unable to, or always needing assistance to, perform a core activity task (as per the ABS 2003 SDAC).
Real expenditure	Actual expenditure (accrual) adjusted for changes in prices, using the GDP(E) price deflator, and expressed in terms of current year dollars.
Schooling or employment restriction	<p><i>Schooling restriction:</i> 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.</p> <p><i>Employment restriction:</i> as a result of disability, being permanently unable to work; being restricted in the type of work they can do; needing at least one day a week off work on average; being restricted in the number of hours they can work; requiring an employer to provide special equipment, modify the work environment or make special arrangements; needing to be given ongoing assistance or supervision; and/or finding it difficult to change jobs or to get a preferred job.</p>
Service	A service is a support activity provided to a service user, in accord with the CSTDA. Services within the scope of the collection are those for which funding has been provided during the specified period by a government organisation operating under the CSTDA.

Service type	The support activity that the service type outlet has been funded to provide under the CSTDA. The NMDS classifies services according to 'service type'. The service type classification groups services into seven categories: accommodation support; community support; community access; respite; employment; advocacy, information and print disability; and other support services. Each of these categories has subcategories.
Service type outlet	A service type outlet is the unit of the funded agency that delivers a particular CSTDA service type at or from a discrete location. If a funded agency provides, for example, both accommodation support and respite services, it is counted as two service type outlets. Similarly, if an agency is funded to provide more than one accommodation support service type (for example, group homes and attendant care), then it is providing (and is usually separately funded for) two different service types — that is, there are two service type outlets for the funded agency.
Service user	A service user is a person with a disability who receives a CSTDA funded service. A service user may receive more than one service over a period of time or on a single day.
Service users with different levels of severity of core activity limitation	<p>Data on service users with different levels of severity of core activity limitation are derived by the AIHW based on the level of support needed in one or more of the three areas of daily living: self-care, mobility and communication. Service users with:</p> <ul style="list-style-type: none"> • a profound core activity limitation reported 'always needing support' in one or more of these areas • a severe core activity limitation reported 'sometimes needing support' in one or more of these areas • moderate to no core activity limitations reported needing 'no support' (including needing no support but using aids) in all of these areas.
Severe core activity limitation	Sometimes needing assistance to perform a core activity task (as per the ABS 2003 SDAC).
Users of CSTDA accommodation support services	People using one or more accommodation support services that correspond to the following CSTDA NMDS service types: 1.01 large residential/institutions (more than 20 places); 1.02 small residential/institutions (7–20 places); 1.03 hostels; 1.04 group homes (less than seven places); 1.05 attendant care/personal care; 1.06 in-home accommodation support; 1.07 alternative family placement; and 1.08 other accommodation support.
Users of CSTDA community access services	People using one or more services that correspond to the following CSTDA NMDS service types: 3.01 learning and life skills development; 3.02 recreation/holiday programs; and 3.03 other community access. See AIHW (2006b) for more information on service types 3.01–3.03.
Users of CSTDA community support services	People using one or more services that correspond to the following CSTDA NMDS service types: 2.01 therapy support for individuals; 2.02 early childhood intervention; 2.03 behaviour/specialist intervention; 2.04 counselling; 2.05 regional resource and support teams; 2.06 case management, local coordination and development; and 2.07 other community support. See AIHW (2006b) for more information on service types 2.01–2.07.
Users of CSTDA employment services	People using one or more services that correspond to the following CSTDA NMDS service types: 5.01 open employment; 5.02 supported employment; and 5.03 combined open and supported employment.

Users of CSTDA respite services People using one or more services that correspond to the following CSTDA NMDS service types: 4.01 own home respite; 4.02 centre-based respite/respite homes; 4.03 host family respite/peer support respite; 4.04 flexible/combination respite; and 4.05 other respite. See AIHW (2006b) for more information on service types 4.01–4.05.

13.7 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 13A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2007\Attach13A.xls and in Adobe PDF format as \Publications\Reports\2007\Attach13A.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

Table 13A.1	Users of Commonwealth State/Territory Disability Agreement (CSTDA) government and non-government provided services, by service type
Table 13A.2	Recipients of Disability Support Pension, Mobility Allowance, Carer Payment, Carer Allowance and Sickness Allowance ('000)
Table 13A.3	Real government direct service delivery expenditure, by service type (2005-06 dollars) (\$'000)
Table 13A.4	Government expenditure, by service type (per cent)
Table 13A.5	Government expenditure, by type (\$'000)
Table 13A.6	Total government expenditure, by source of funding (2005-06 dollars) (\$'000)
Table 13A.7	Government expenditure, by source of funding (per cent)
Table 13A.8	Real government direct service delivery and total expenditure adjusted for payroll tax (2005-06 dollars) (\$'000)
Table 13A.9	People aged 5–64 years with a disability, 2003
Table 13A.10	People aged 0–64 years with a profound or severe core activity limitation who received help as a proportion of those who needed help, 2003 (per cent)
Table 13A.11	Users of CSTDA accommodation support services, as a proportion of the total estimated potential population for accommodation support services
Table 13A.12	Users of CSTDA employment services, as a proportion of the total potential population for employment services
Table 13A.13	Users of CSTDA community access services, as a proportion of the total potential population for community access services
Table 13A.14	Users of CSTDA community support services, as a proportion of the total potential population for community support services
Table 13A.15	Users of CSTDA respite services, as a proportion of the total potential population for respite services
Table 13A.16	Users of CSTDA accommodation support services, by severity of core activity limitation
Table 13A.17	Users of CSTDA employment services, by severity of core activity limitation
Table 13A.18	Users of CSTDA community access services, by severity of core activity limitation

Table 13A.19	Users of CSTDA community support services, by severity of core activity limitation
Table 13A.20	Users of CSTDA respite services, by severity of core activity limitation
Table 13A.21	Users of CSTDA accommodation support services, by geographic location
Table 13A.22	Users of CSTDA employment services, by geographic location
Table 13A.23	Users of CSTDA accommodation support services, per 1000 people, by Indigenous status
Table 13A.24	Users of CSTDA employment services, per 1000 people, by Indigenous status
Table 13A.25	Users of CSTDA community access services, per 1000 people, by Indigenous status
Table 13A.26	Users of CSTDA community support services, per 1000 people, by Indigenous status
Table 13A.27	Users of CSTDA respite services, per 1000 people, by Indigenous status
Table 13A.28	Users of CSTDA accommodation support services, per 1000 people, by country of birth
Table 13A.29	Users of CSTDA employment services, per 1000 people, by country of birth
Table 13A.30	Users of CSTDA community accommodation and care services as a proportion of all accommodation support service users (per cent)
Table 13A.31	Real government expenditure per user of CSTDA accommodation support services (2004-05 dollars)
Table 13A.32	Service user data response rates for CSTDA funded accommodation support service type outlets (per cent), 2004-05
Table 13A.33	Australian Government funding per user of non-government provided employment services
Table 13A.34	Real Australian Government funding per user of non-government provided employment services (2004-05 dollars)
Table 13A.35	Total estimated expenditure per service user, State and Territory government administered programs, 2004-05
Table 13A.36	Government administration expenditure as a proportion of total expenditure on services (per cent)
Table 13A.37	Labour force participation and employment, 2005 (per cent)
Table 13A.38	Labour force participation and employment, 2003 (per cent)
Table 13A.39	Labour force participation and employment of people with a profound or severe core activity limitation, by special needs groups, 2005 (per cent)
Table 13A.40	Labour force participation and employment of people with a profound or severe core activity limitation, by special needs groups, 2003 (per cent)
Table 13A.41	Social participation, by disability status, 2004 (per cent)
Table 13A.42	Social activities participated in by people with a profound or severe core activity limitation, 2003 (per cent)
Table 13A.43	Participation in education and training, by disability status, 2005
Table 13A.44	Educational and training attainment, by disability status, 2005

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. In this chapter, child care services is the care provided to children aged less than 13 years (that is, 0–12 years), usually by someone other than the child's parents or guardian. Preschool services are the services provided to children mainly in the year or two before they begin full time schooling.

Most of the data in this chapter relate to services that are supported by the Australian, State and Territory governments and provided for children aged less than 13 years. Local governments also plan, fund and deliver children's services. Due to data limitations, the only local government data included are where Australian, State and Territory government funding and licensing are involved. An outline of the chapter is provided below.

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; a framework of performance indicators is outlined in section 14.2. The data on performance 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. Section 14.7 lists the supporting tables for this chapter. Supporting tables are identified in references throughout the chapter by an 'A' suffix (for example, table 14A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Section 14.8 lists the references used in this chapter.

Major improvements to reporting on children's services this year include:

- updated data from the Australian Bureau of Statistics (ABS) Child Care Survey and the Australian Government's Census of Child Care Services
- reporting on utilisation rates in centre-based long day care and family day care
- improvements to the comparability of data, for example, the reporting on 'accredited child care services' and 'non-standard hours of care: child care services' is fully comparable.

14.1 Profile of children's services

Service overview

Children's services are provided using a variety of service delivery types that can be grouped into the following six broad categories:

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

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

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

Preschool — comprises services usually provided by a qualified teacher on a sessional basis in dedicated preschools. Preschool programs or curricula may also be provided in long day care centres and other settings. These services are primarily aimed at children in the year before they commence full time schooling, although younger children may also attend in all jurisdictions except Victoria. In Victoria, WA and Tasmania, the preschool program is known as kindergarten.

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

Other services — comprise government funded services to support children with additional needs or in particular situations (including children from an Indigenous

or non-English speaking background, children with a disability or of parents with a disability, and children living in regional and remote areas).

Roles and responsibilities

The Australian Government and the State/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 Australian Government's roles and responsibilities for child care include:

- paying Child Care Benefit to families using approved child care services or registered informal carers
- funding the National Childcare Accreditation Council (NCAC) to administer quality assurance systems for children's services
- funding organisations to provide information, support and training to service providers
- providing operational and capital funding to some providers.

State and Territory governments' roles and responsibilities vary across jurisdictions. Generally, State and Territory governments are responsible for preschool services. Other roles and responsibilities 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 children's services providers
- 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
- providing dispute resolution and complaints management processes.

Quality of care

Governments seek to ensure that children's services provide a satisfactory quality of care, through:

- licensing, quality assurance, measuring performance against standards, and outcomes linked to funding
- providing curriculum and policy support and advice
- training and development of management and staff.

Licensing

Providers of children's services must meet legislative and regulatory requirements regarding safety standards, staff qualifications, child/staff ratios, health and safety requirements, and child development, in order to obtain a licence to operate. State and Territory governments set the requirements, monitor performance and administer licences.

The Australian, State and Territory governments have jointly developed national standards for centre-based long day care, family day care and outside school hours care services. These standards express a national view about the level of care all Australians can expect from the different types of child care service available to them. The extent of implementation of these standards vary across jurisdictions.

Quality assurance

The Australian Government has implemented quality assurance systems for Australian Government funded centre-based long day care services, family day care services and outside school hours care services. To be eligible for Child Care Benefit and other funding support, child care services have to register and satisfactorily participate in quality assurance. Quality assurance is designed to build on, and complement, the State and Territory government licensing requirements (where they exist).

The broad objective of the quality assurance systems is to ensure that children in care have stimulating, positive experiences and interactions that nurture all aspects of their development. The quality assurance systems do this by defining good quality child care, providing a way to measure the quality of care provided by the service and identifying areas for ongoing quality improvement. Services participating in the quality assurance system are required to progress through the five step process, outlined in figure 14.1.

```
graph TD; 1[1. Registration:  
All childcare services  
have to be registered  
with NCAC to receive  
Childcare Benefit.] --> 2[2. Self assessment:  
Each registered provider  
assesses its own  
performance against  
requirements.]; 2 --> 3[3. Validation:  
Providers are reviewed  
by a third party  
'validator', who reports  
results to NCAC.]; 3 --> 4[4. Moderation:  
A moderator assesses the  
provider's practices, guided  
by information from the self  
assessment, the validator's  
report and completed  
surveys.]; 4 --> 5[5. Accreditation decision:  
NCAC makes the  
accreditation decision. To  
be accredited a provider  
must achieve a rating of  
'satisfactory' or higher on  
all quality areas.]; 5 --> 1; 5 --> 2;
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1. Registration:
All childcare services have to be registered with NCAC to receive Childcare Benefit.

2. Self assessment:
Each registered provider assesses its own performance against requirements.

3. Validation:
Providers are reviewed by a third party 'validator', who reports results to NCAC.

4. Moderation:
A moderator assesses the provider's practices, guided by information from the self assessment, the validator's report and completed surveys.

5. Accreditation decision:
NCAC makes the accreditation decision. To be accredited a provider must achieve a rating of 'satisfactory' or higher on all quality areas.

Funding performance standards and outcomes

- the employment of higher qualified staff than required by licensing or minimum standards
- self-assessment of quality
- a demonstration of the delivery of quality educational and recreational programs.

Funding

Total Australian, State and Territory government expenditure on children's services was approximately \$2.68 billion in 2005-06, compared with \$2.60 billion (in real terms) in 2004-05 (tables 14A.4, 14A.5, 14A.29, 14A.38, 14A.47, 14A.56, 14A.65, 14A.74, 14A.83, 14A.92).

Australian Government expenditure accounted for 75.4 per cent (\$2.02 billion) of total government expenditure on children's services in 2005-06 (table 14A.4). State and Territory government expenditure on children's services in 2005-06 was approximately \$659.4 million (tables 14A.4, 14A.5, 14A.29, 14A.38, 14A.47, 14A.56, 14A.65, 14A.74, 14A.83, 14A.92).

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 (83.3 per cent, or \$549.5 million) (table 14A.5).

The Australian Government provides supplementary funding to support the participation of Indigenous children in preschool programs. In 2004, an estimated \$12.5 million was provided to education providers for 7729 full time equivalent Indigenous preschool enrolments (DEST unpublished).

Size and scope

Child care services

The Australian Government supported 588 866 child care places in 2005 — an increase of 4.8 per cent on the number in 2004. The majority of Australian Government supported child care places were outside school hours care places (44.4 per cent), followed by centre-based long day care places (42.0 per cent), family day care places (12.8 per cent), occasional care places (0.5 per cent) and other care places (0.3 per cent) (table 14A.8).

State and Territory governments supported at least 204 932 preschool places in 2005-06 (tables 14A.30, 14A.39, 14A.48, 14A.57, 14A.66, 14A.75, 14A.84 and 14A.93).

In 2005-06, over 111 413 children aged 12 years or younger attended State and Territory government funded and/or provided child care and 788 904 children aged 12 years or younger attended Australian Government approved child care services (tables 14A.10, 14A.31, 14A.40, 14A.49, 14A.58, 14A.67, 14A.76, 14A.85, 14A.94). Some children attend both Australian and State/Territory funded child care

and some services receive funding from both Australian and State/Territory governments.

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 younger children.

The age from which children may attend preschool varies across jurisdictions. Victoria contributes funding towards a preschool program for all 4 year old children, which is the year before they begin schooling. In all the other jurisdictions, children may begin preschool at a younger age in some circumstances (for example, Indigenous children, children with English as a second language, gifted children, and children from vulnerable families).

This disparity in the age from which children may access preschool services reduces 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)
- younger children attending preschool services.

Approximately 243 557 children attended State and Territory funded and/or provided preschool services in 2005-06. The majority (88.7 per cent, or approximately 216 083 children) were to begin full time schooling the following year (table 14A.11).

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 sectors in the direct delivery of children's services. The limited data on the management type of child care need to be interpreted with care because the scope of data collection varies across jurisdictions. Available data on the management type of preschool services, is more complete than that for child care services, and indicate considerable variation across jurisdictions (table 14.1).

Table 14.1 **Proportion of State and Territory licensed and/or registered children's services, by management type, 2005-06 (per cent)^a**

	<i>NSW</i>	<i>Vic^b</i>	<i>Qld</i>	<i>WA</i>	<i>SAC^c</i>	<i>Tas^d</i>	<i>ACT</i>	<i>NT^e</i>
Child care								
Community managed ^f	30.5	37.6	35.9	20.0	40.2	51.3	84.1	73.8
Private ^g	66.4	48.2	60.7	76.2	34.9	24.2	15.9	26.2
Government managed	3.1	14.2	3.4	3.8	24.9	24.5	–	–
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Preschool								
Community managed ^f	89.8	74.9	23.2	na	4.9	na	9.2	2.7
Private ^g	10.2	7.9	22.2	na	–	26.1	–	na
Government managed	na	17.1	54.6	100.0	95.1	73.9	92.0	97.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

^a Includes all Australian, State and Territory government supported services. ^b All government managed preschools in Victoria are managed by local government. ^c The majority of government managed services are small occasional care programs attached to government preschools providing a total of 224 FTE places (FTE equals 50 hours per week). ^d Preschools include funded non-government preschools. ^e 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. ^f Community managed services include not-for-profit services provided or managed by parents, churches or co-operatives. ^g Private for-profit services provided or managed by a company, private individual or non-government school. **na** Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); tables 14A.34, 14A.43, 14A.52, 14A.61, 14A.70, 14A.79, 14A.88 and 14A.97.

14.2 Framework of performance indicators

The framework of performance indicators is based on common objectives for children's services endorsed by the then Community Services Ministers' Advisory Council (CSMAC)¹ (box 14.1). The relative emphasis placed on each objective varies across jurisdictions.

¹ Now known as the Community and Disability Services Ministers' Advisory Council (CDSMAC).

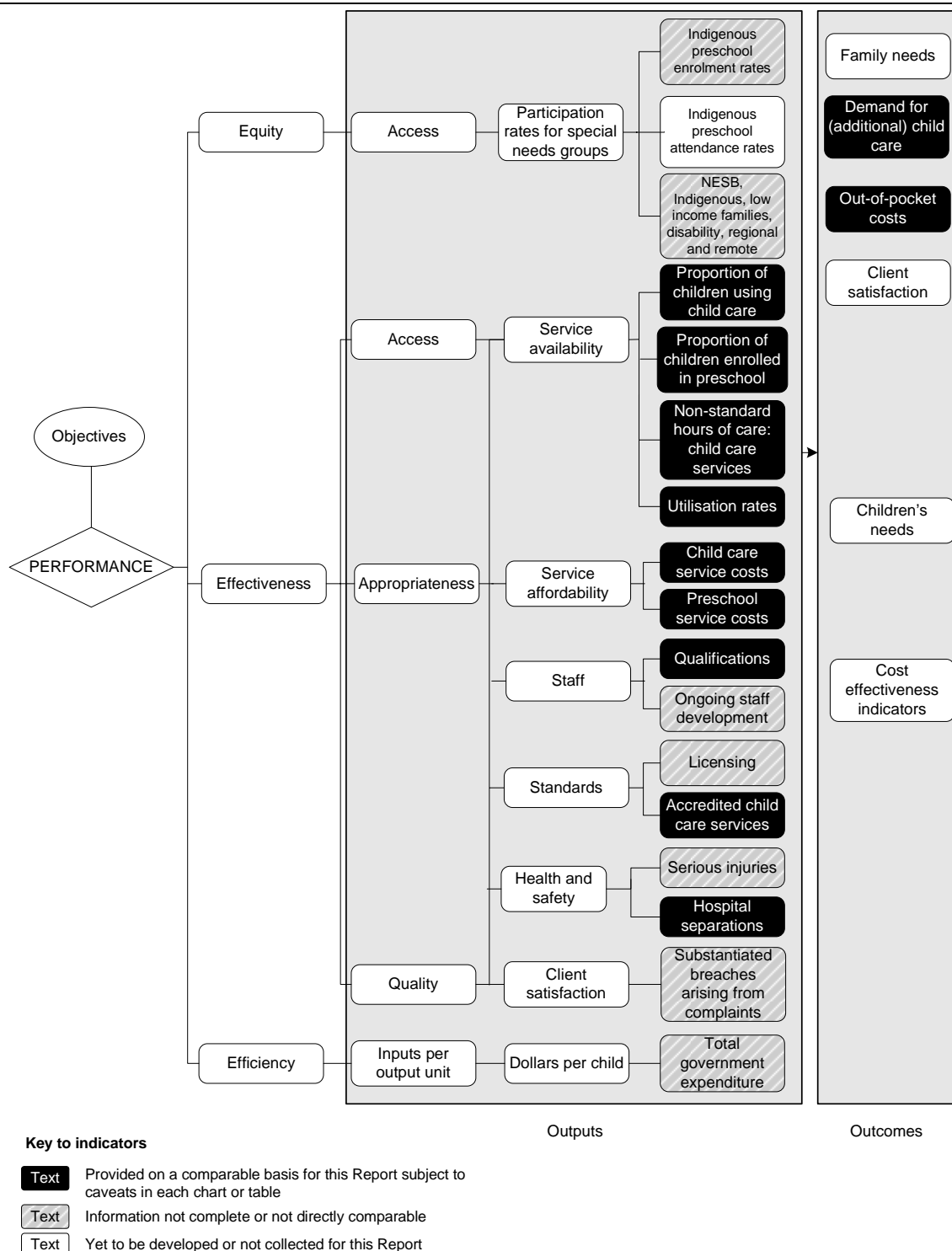
Box 14.1 Objectives for children's services

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
- provide these services in an equitable and efficient manner.

A performance indicator framework consistent with these objectives is summarised in figure 14.2. The framework shows which data are provided on a comparable basis in the 2007 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 14.2 Performance indicators for children's services



14.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the equity, effectiveness and efficiency of children's services. Some 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. Definitions of key terms and indicators are in section 14.6.

Outputs

Equity

Access — participation rates for special needs groups

'Participation rates for special needs groups' is an indicator of equitable access to services (box 14.2).

Box 14.2 Participation rates for special needs groups

'Participation rates for special needs groups' is an output (equity — access) indicator of governments' objective to ensure that:

- all Australian families have equitable access to child care and preschool services
- there is no discrimination between groups
- there is consideration of the needs of those groups which may have special difficulty accessing services.

This indicator is defined as the proportion of children using child care services who are from targeted special needs groups, compared with the representation of these groups in the community. Data are reported separately for child care and preschool services. Targeted special needs groups include children from a non-English speaking background, children from an Indigenous background, children from low income families, children with a disability, and children from regional and remote areas. 'Indigenous preschool enrolment rates' are used as a proxy for 'Indigenous preschool attendance rates' (see figure 14.3).

The representation of special needs groups among children's services users being broadly similar to their representation in the community, may suggest equity of access.

The data indicate that the representation of children in special needs groups among users of Australian Government supported child care is sometimes substantially

different across jurisdictions (table 14.2). It is important to note that due to the unavailability of certain data items, the Australian Government data exclude flexible and innovative services, which are targeted towards children from these groups. At a national level, the patterns for children from special needs groups were:

- children from a non-English speaking background participated in child care at a similar rate (10.7 per cent) to this group's representation in the community (11.2 per cent)
- the representation of children from an Indigenous background among child care users was lower (1.7 per cent) than this group's overall representation in the community (4.6 per cent)
- children from low income families participated in child care at a slightly lower rate (26.4 per cent) than this group's representation in the community (28.7 per cent)
- the representation of children with a disability among child care users was lower (2.7 per cent) than their overall representation in the community (7.7 per cent)
- the proportion of children in regional areas attending child care was lower (29.0 per cent) than the proportion of children who live in regional areas (33.0 per cent)
- the proportion of children in remote areas attending child care was lower (1.0 per cent) than the proportion of children who live in remote areas (3.1 per cent).

Table 14.2 Proportion of children (aged 0–12 years) from special needs groups attending Australian Government approved child care services, 2006 (per cent)

<i>Representation</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Children from non-English speaking backgrounds									
In child care services	16.5	12.5	5.1	6.4	7.9	2.6	9.5	9.1	10.7
In the community ^a	15.0	14.2	4.9	7.2	7.5	1.7	9.5	25.3	11.2
Indigenous children									
In child care services ^b	1.5	0.7	2.1	2.1	2.0	1.0	0.7	11.3	1.7
In the community ^c	4.2	1.1	6.6	6.6	3.5	7.1	2.6	40.9	4.6
Children from low-income families									
In child care services ^d	25.0	26.6	28.3	27.3	29.0	29.2	10.6	17.2	26.4
In the community ^e	28.6	27.0	29.6	31.4	29.0	38.8	12.1	30.6	28.7
Children with a disability									
In child care services	3.2	2.4	2.2	2.5	3.8	2.3	1.9	4.2	2.7
In the community ^f	8.0	6.8	7.6	8.9	8.8	6.2	7.5	np	7.7
Children from regional areas									
In child care services ^b	25.4	25.7	36.2	19.3	18.3	99.4	0.1	79.3	29.0
In the community ^g	28.9	28.4	45.2	24.5	26.8	97.8	0.2	49.5	33.0
Children from remote areas									
In child care services ^b	0.2	–	1.2	3.6	1.9	0.6	..	20.7	1.0
In the community ^h	0.8	0.1	4.5	8.7	4.6	2.2	..	50.5	3.1

^a Data relate to children aged 0–12 years at June 2001, who spoke a language other than English at home, and were obtained from the ABS 2001 *Census of Population and Housing*. ^b These numbers do not include innovative or flexible services that receive direct funding from the Australian Government and are targeted towards children from these groups. ^c Data relate to children aged 0–12 years at June 2005 and were obtained from ABS *Experimental Indigenous population projections*, low series. ^d Data relate to children in child care services from families with a gross annual household income of less than \$33 361 (the cut-off point for receiving the maximum amount of child care benefits as at May 2006). ^e Data relate to children aged 0–12 years from families with a gross annual parental income of less than \$31 755. The Family Tax Benefit and the one-off payment to families, officially referred to as "Family Assistance Legislative Amendment (More help for families — 'One-off' payments)", have been excluded from the calculation of parental income. The data were obtained from the ABS 2003-04 *Survey of Household Income and Housing*. ^f Data are estimated from the ABS 2003 *Survey of Disability, Ageing and Carers* and relate to children aged 0–12 years. Due to the small sample size, data for NT are not published. ^g Data relate to children aged 0–12 years at June 2005 and were obtained from the ABS *Estimated resident population by Remoteness Area*. The data include Inner Regional Australia and Outer Regional Australia. Caution should be exercised with small proportions, as they are generally less reliable than larger proportions. ^h Data relate to children aged 0–12 years at June 2005 and were obtained from the ABS *Estimated resident population by Remoteness Area*. The data include Remote Australia and Very Remote Australia. Caution should be exercised with small proportions, as they are generally less reliable than larger proportions. .. Not applicable – Nil or rounded to zero. np Not published.

Source: AGCCCS (unpublished); ABS 2001 *Census of Population and Housing* (unpublished); ABS *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2009* (cat. no. 3238.0); ABS 2003-04 *Survey of Household Income and Housing* (unpublished); ABS 2003 *Survey of Disability, Ageing and Carers* (unpublished); ABS *Estimated Resident Population Collection* (unpublished); table 14A.20.

Previous reports have compared the participation of special needs groups in preschool with the representation of these groups in the community, for children aged 0–12 years. While children aged 0–12 years is an appropriate comparator for child care services (as they include Outside School Hours Care), a more appropriate comparator for preschool services is the 3–5 years age group.

In this report, data on the representation of special needs groups for children aged 3–5 years in government funded preschools are provided in table 14.3. The data provide a broad indication of the relative access to preschool for special needs groups. Data on representation of special needs groups in State and Territory child care and preschools, for children aged 0–12, can be found in attachment tables 14A.35, 14A.44, 14A.53, 14A.62, 14A.71, 14A.80, 14A.89 and 14A.98.

Nationally, the proportion of preschool attendees in 2005-06 who were from special needs groups were generally similar to their representation in the community, though some groups are over represented in some jurisdictions and under represented in others.

Table 14.3 Proportion of children (aged 3–5 years) from special needs groups attending State and Territory funded or provided preschools, 2005-06 (per cent)

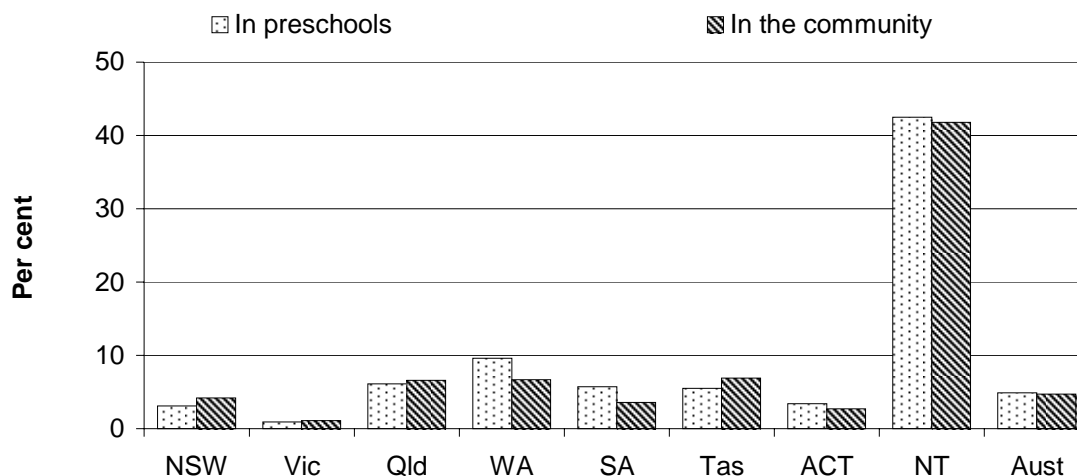
<i>Representation</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Children from non-English speaking backgrounds									
In preschool services	8.2	13.3	2.8	na	9.4	na	15.1	na	7.0
In the community ^a	16.6	15.6	5.3	7.6	8.1	1.7	10.2	27.0	12.3
Indigenous children									
In preschool services ^b	3.1	0.9	6.1	9.6	5.7	5.5	3.4	42.5	4.9
In the community ^c	4.2	1.1	6.6	6.7	3.6	6.9	2.7	41.8	4.7
Children with a disability									
In preschool services ^d	6.5	10.2	2.0	2.8	15.4	na	4.3	8.4	6.4
In the community ^e	7.7	6.5	8.6	10.2	8.3	7.2	14.3	np	8.0
Children from regional areas									
In preschool services ^b	32.6	31.7	50.7	23.3	29.3	98.2	0.2	45.2	37.2
In the community ^f	28.3	27.8	44.6	24.5	26.5	97.5	0.2	49.2	32.5
Children from remote areas									
In preschool services ^b	1.2	0.2	8.2	9.8	5.8	1.8	..	54.8	4.8
In the community ^g	0.9	0.1	4.8	9.1	4.6	2.5	..	50.8	3.3

^a Data relate to children aged 3–5 years at June 2001, who spoke a language other than English at home, and were obtained from the ABS 2001 *Census of Population and Housing*. ^b These numbers do not include innovative or flexible services that receive direct funding from the Australian Government and are targeted towards children from these groups. ^c Data relate to children aged 3–5 years at June 2005 and were obtained from ABS *Experimental Indigenous population projections*, low series. ^d Data are not directly comparable between jurisdictions because there is no national definition or standard on children with a disability. ^e Data are estimated from the ABS 2003 *Survey of Disability, Ageing and Carers* and relate to children aged 3–5 years. Due to the small sample size, data for the NT are not published. ^f Data relate to children aged 3–5 years at June 2005 and were obtained from the ABS *Estimated resident population by Remoteness Area*. The data include Inner Regional Australia and Outer Regional Australia. Caution should be exercised with small proportions, as they are generally less reliable than larger proportions. ^g Data relate to children aged 3–5 years at June 2005 and were obtained from the ABS *Estimated resident population by Remoteness Area*. The data include Remote Australia and Very Remote Australia. Caution should be exercised with small proportions, as they are generally less reliable than larger proportions. .. Not applicable. na Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); ABS 2001 *Census of Population and Housing* (unpublished); ABS *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2009* (cat. no. 3238.0); ABS 2003 *Survey of Disability, Ageing and Carers* (unpublished); ABS *Estimated Resident Population Collection* (unpublished).

Nationally, the proportion of preschool enrolments from Indigenous backgrounds (4.9 per cent) largely reflects the proportion of the population from Indigenous backgrounds (4.7 per cent) (figure 14.3).

Figure 14.3 **Proportion of preschool enrolments of Indigenous children, 2005-06^{a, b, c}**



^a Data relate to children aged 3–5 years at June 2005 and were obtained from ABS *Experimental Indigenous population projections*, low series. ^b Data for the representation in preschool services are from State and Territory enrolment data. ^c All Indigenous data relate to people who self-identify as being of Aboriginal and/or Torres Strait Islander descent.

Source: ABS *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2009* (cat. no. 3238.0); State and Territory governments (unpublished).

Effectiveness

Service availability — proportion of children using child care services

An indicator of community access to child care services is the proportion of children in the target population who use the services (box 14.3).

Box 14.3 Proportion of children using child care

‘Proportion of children using child care’ is an output (service availability) indicator of governments’ objective to ensure that all Australian families have equitable access to child care services.

This indicator is defined as the proportion of children using child care services in the target age groups.

A higher proportion of children using the services may indicate a higher level of service availability. This indicator does not provide information on parental preferences for using child care or other factors, such as school starting age, which may impact on use of care.

Access to children's services differs according to the service type. The workforce and employment status of parents may influence children's access to services. Those services eligible for Child Care Benefit, for example, give a high priority to children at risk and children of parents with work-related child care needs. Occasional care services give priority to parents requiring care to meet other needs (such as to attend appointments, take care of personal matters or have temporary respite from full time parenting). Details of the labour force and employment status of parents whose children use these services are shown in table 14A.15.

Table 14.4 shows the proportion of children in the relevant age groups attending Australian, State and Territory government funded and/or provided child care. Different data collection approaches and the exclusion of certain services funded by some jurisdictions reduce the comparability of these data across jurisdictions.

Table 14.4 Proportion of children using Australian, State and Territory government funded and/or provided child care, 2005-06^{a, b}

Age	NSW ^c	Vic	Qld	WA	SA ^d	Tas	ACT	NT	Aust
0–5 years	52.0	29.1	42.8	26.6	35.5	37.6	41.9	24.3	40.1
6–12 years	13.3	14.0	18.0	9.0	23.5	14.3	22.5	14.3	14.9
0–12 years	30.9	20.8	29.0	16.8	28.8	24.6	31.3	19.1	26.2

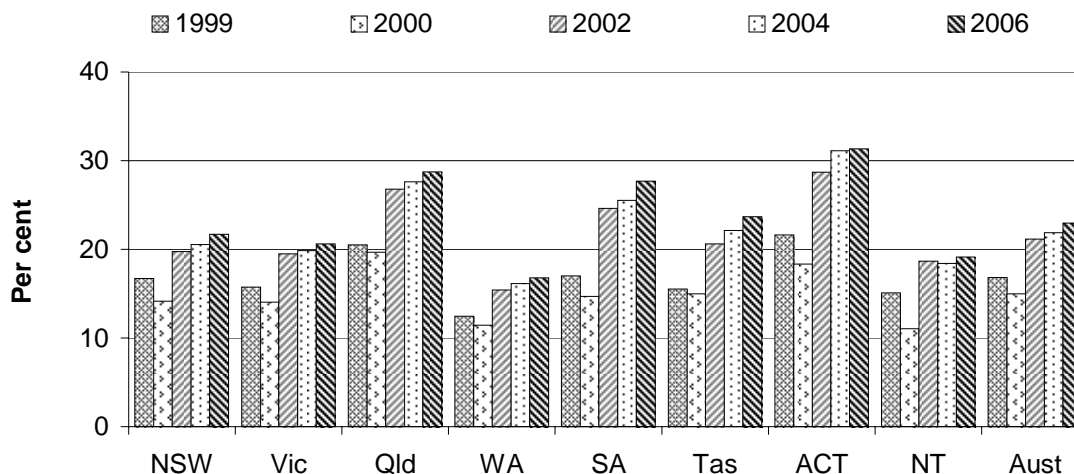
^a Australian Government data are estimated and weighted from the Australian Government Census of Child Care Services (AGCCCS). In 2006, numbers are based on preliminary data and there may be changes to the final data. ^b Population as at June 2006. ^c NSW data are not comparable with data for other states and territories. ^d SA excludes children in non-government preschools.

Source: AGCCCS May 2006 (unpublished); State and Territory governments (unpublished); Australian Bureau of Statistics (ABS) *Australian Demographic Statistics* (unpublished), Canberra; tables 14A.1, 14A.10, 14A.31, 14A.40, 14A.49, 14A.58, 14A.67, 14A.76, 14A.85 and 14A.94.

The majority of children attending Australian Government approved child care in 2006 (approximately 524 348, or 66.5 per cent) were aged 0–5 years (table 14A.10). Nationally, 23 per cent of children aged 0–12 years attended Australian Government approved child care services in 2006 (figure 14.4).

The average hours of attendance in child care in 2006 varied considerably across jurisdictions, for all types of service. Nationally, average attendance per child at centre-based long day care centres was 19.0 hours per week, while the average attendance per child at family day care was 17.7 hours per week. The national average attendance per child at occasional care was 10.3 hours per week and the national average attendance at vacation care during school holidays was 2.5 days per week (table 14A.9).

Figure 14.4 **Proportion of children aged 0–12 years using Australian Government approved child care^{a, b, c, d}**



^a Excludes children cared for in neighbourhood model services. ^b Data for, 1999, 2002, 2004 and 2006 are drawn from the respective AGCCCS, while data for 2000 are drawn from Centrelink administrative data. The AGCCCS and Centrelink data are not fully comparable and interpretation needs to be made with care. In 2006, AGCCCS numbers are based on preliminary data and there may be changes to the final data. ^c Data for WA exclude children attending Department of Education provided kindergartens for 4 year olds, who would otherwise be in child care. ^d The Australian total includes children in other territories.

Source: AGCCCS May 1999, May 2002, March 2004 and May 2006 (unpublished); Centrelink administrative data August 2000 (unpublished); ABS *Australian Demographic Statistics* (unpublished), Canberra; table 14A.10.

Service availability — proportion of children enrolled in preschool

An indicator of community access to preschool services is the proportion of children in the target population who use the services (box 14.4).

Box 14.4 Proportion of children enrolled in preschool

‘Proportion of children enrolled in preschool’ is an output (service availability) indicator of governments’ objective to ensure that all Australian families have equitable access to preschool services.

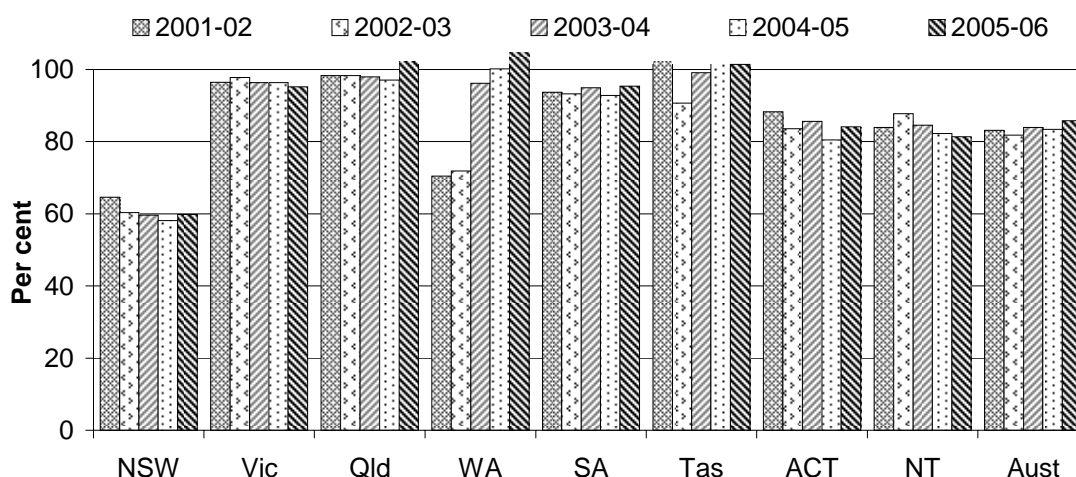
This indicator is defined as the proportion of children using preschool services in the target age groups. Two measures are reported:

- the percentage of children attending preschool in the year before the commencement of full-time schooling
- the percentage of younger children attending preschool.

A higher proportion of children using the services may indicate a higher level of service availability. This indicator does not provide information on parental preferences for using preschool or other factors, such as school starting age, which may impact on use of preschool.

Nationally in 2005-06, 85.7 per cent of children of 4 years of age attended funded and/or provided preschool in the year immediately before they commenced school. There is some double counting in several jurisdictions, as well as issues with synchronisation of data collection times, leading to overestimation of the enrolment rates being reported in some states and territories (figure 14.5).

Figure 14.5 Proportion of children attending State and Territory government funded and/or provided preschool services in the year 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 4 years in all states and territories. Data for estimated resident population are up to six months out of sequence with the data for children using State or Territory government funded and/or provided preschool services in year before full time school. 'Year before full time school' includes a number of non-4 year olds. ^b There is some double counting of children in NSW, Qld, WA and NT because some children moved in and out of the preschool system throughout the year and some children accessed more than one sessional program. As a result, the number of children reported in preschool exceeds the number of children in the target population. There is no double counting for Victoria, SA, Tasmania and the ACT because a snapshot is used for each year's data collection. ^c NSW data are not comparable with data for other states and territories because the data do not include preschools managed by the NSW Department of Education or the non-government school sector, or children who are receiving a preschool program in a long day care centre. ^d Victorian data include some children attending funded preschool services conducted in centre-based long day care centres and independent schools. ^e WA data for 2001–2003 exclude the non-government sector. Changes to the school entry age (introduced in 2001) have also impacted on numbers. ^f Data for SA exclude children in non-government preschools.

Source: State and Territory governments (unpublished); ABS *Australian Demographic Statistics* (unpublished), Canberra; table 14A.11.

Younger children in NSW, Queensland, SA, the ACT and the NT were able to attend government funded preschool services in 2005-06. For these jurisdictions, around 10.9 per cent of children aged 3 years attended preschool services in that year (approximately 27 474 children). Participation in 2005-06 differed across jurisdictions, in part due to variation in policies on access to funded preschool services (table 14A.11).

All jurisdictions except NSW and Victoria provided data on the average hours of attendance for government funded and/or provided preschool services in 2005-06. For those jurisdictions that provided data, the average attendance of children in the year immediately before they commenced full time schooling was at least 11 hours per week (tables 14A.48, 14A.57, 14A.66, 14A.75 and 14A.84).

Service availability — non-standard hours of care in child care services

An indicator of the community's access to flexible child care services is the proportion of child care services offering 'Non-standard hours of care' (box 14.5).

Box 14.5 Non-standard hours of care: child care services

'Non-standard hours of care: child care services' is an output (service availability) indicator of governments' objective to ensure government funded and/or provided child care services meet the needs of all users.

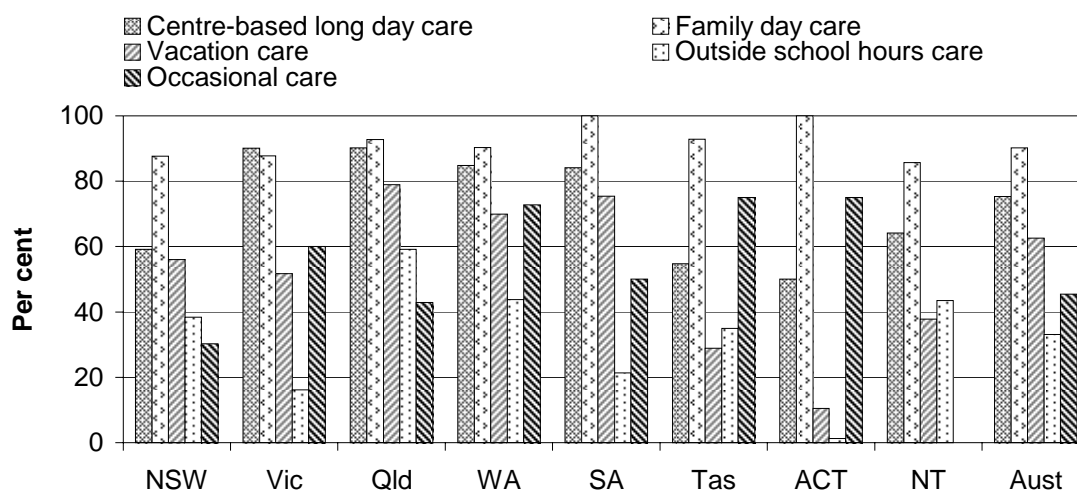
This indicator is defined as the number of child care services providing non-standard hours of care divided by the total number of services. Data are reported by service type.

A higher proportion of services providing non-standard hours of care may suggest a greater flexibility of services to meet the needs of families.

This indicator does not provide information on the demand for non-standard hours of care. It also provides no information on how closely available non-standard hours services match the needs of users.

Provision of non-standard hours of care may be influenced by a range of factors such as costs to services and parents, demand for care, availability of carers, and compliance with occupational and health and safety requirements. Figure 14.6 shows the proportion of services that provided non-standard hours of care by service type.

Figure 14.6 Australian Government approved child care services providing non-standard hours of care, by service type, 2006^a



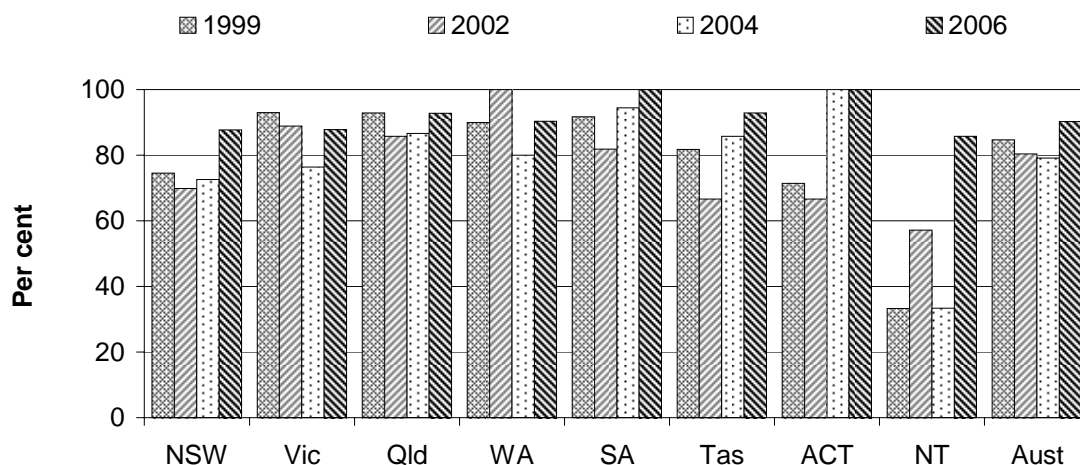
^a Data are estimated and weighted from the AGCCCS. In 2006, numbers are based on preliminary data and there may be changes to the final data.

Source: AGCCCS May 2006 (unpublished); table 14A.16.

The provision of non-standard hours of care by Australian Government approved family day care schemes in different jurisdictions is shown in figure 14.7.

Limited data are available on services not included in the Australian Government Census of Child Care Services (AGCCCS) that were offering non-standard hours of care. New South Wales and SA were able to provide data on the proportion of their preschools that offered non-standard hours in 2005-06 (tables 14A.35 and 14A.71).

Figure 14.7 Australian Government approved family day care services providing non-standard hours of care^a



^a Data are estimated and weighted from the AGCCCS. In 2006, numbers are based on preliminary data and there may be changes to the final data.

Source: AGCCCS May 1999, May 2002, March 2004 and May 2006 (unpublished); table 14A.16.

Service availability — utilisation rates

‘Utilisation rates’ is an indicator of equitable and adequate access to children’s services (box 14.6).

Box 14.6 Utilisation rates

‘Utilisation rates’ is an output (service availability) indicator of governments’ objective to ensure all Australian families have equitable and adequate access to children’s services.

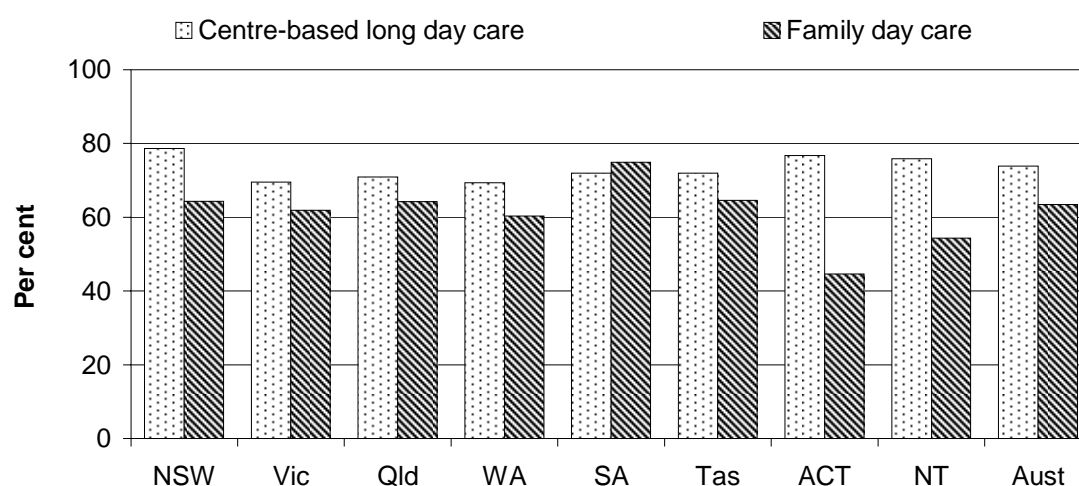
Utilisation refers to the level of usage of a service and can be measured in a number of ways, including vacancy levels and capacity to provide more hours of care. Utilisation rates can also measure how efficiently existing assets are being used. Although governments do not always directly own or operate children’s services, the level of utilisation may be relevant where governments provide targeted capital or operational funding to establish or maintain services. The indicator on utilisation rates of children’s services is calculated as the total child hours paid for as a percentage of total available hours, for centre-based long day care and family day care.

The desirable level of utilisation will depend on a number of factors. High levels of utilisation may be desirable as a measure of efficiency in situations where a community does not require additional services. An alternative view of high utilisation rates is that services are less accessible as there is less spare capacity.

The utilisation rates in Australian Government approved centre-based long day care and family day care services in different jurisdictions are shown in figure 14.8.

Nationally, utilisation rates were generally higher for centre-based long day care (73.8 per cent) than for family day care (63.5 per cent) in 2006.

Figure 14.8 Utilisation rates, centre-based long day care and family day care, 2006 (per cent)^{a, b}



^a Data are estimated and weighted from the AGCCCS. In 2006, numbers are based on preliminary data and there may be changes to the final data. ^b Family day care data exclude in-home care.

Source: AGCCCS May 2006 (unpublished); table 14A.17.

Service affordability — child care service costs

An indicator of the affordability (and thus accessibility) of children's services is the 'child care service cost', represented by average weekly fees for child care services (box 14.7).

Box 14.7 Child care service costs

'Child care service costs' is an output (service affordability) indicator of governments' objective to ensure all Australian families have equitable access to children's services regardless of their financial circumstances.

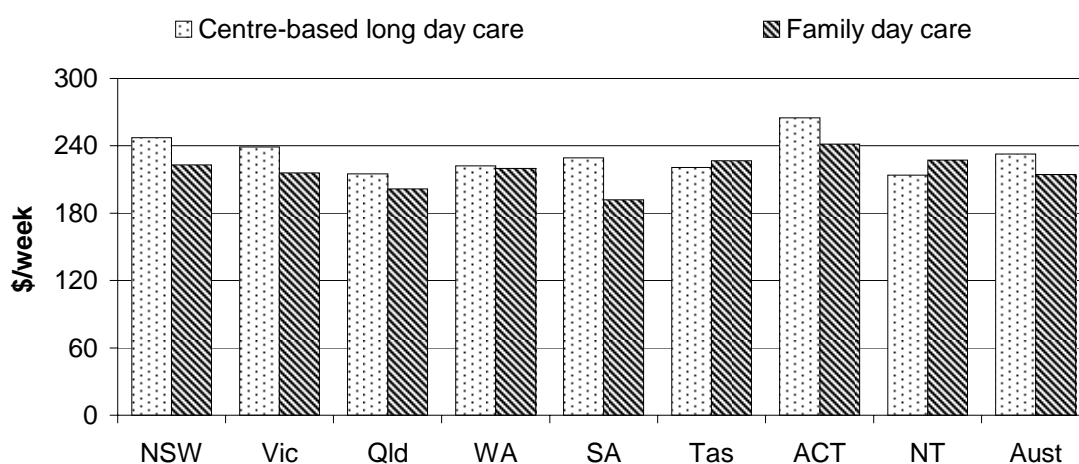
This indicator is defined as average weekly fees for 50 hours of care by service type.

Provided the service quality is held constant, lower service costs are more desirable.

Fee data need to be interpreted with care because fees are independently set by service providers. Charging practices, including fees, are commercial decisions made by individual services, so there is significant variation in the fees charged by services. Fee variation occurs as a result of factors including State and Territory licensing requirements, award wages, and whether fees include charges for additional services such as nappies and meals.

Nationally, average weekly fees for 50 hours of care in 2006 were higher for centre-based long day care services (\$233) than for family day care (\$214), as shown in figure 14.9.

Figure 14.9 Average fees charged by Australian Government funded child care services, 2006 (\$/week)^{a, b, c, d}



^a Average fees based on 50 hours of care in the Census reference week. ^b Data are estimated and weighted from the AGCCCS. In 2006, numbers are based on preliminary data and there may be changes to the final data. ^c Family day care data exclude in-home care. ^d Family day care fee includes parent levy.

Source: AGCCCS May 2006 (unpublished); table 14A.26.

Service affordability — preschool service costs

'Preschool service costs' is an indicator of the affordability and accessibility of preschool services (box 14.8).

Box 14.8 Preschool service costs

'Preschool service costs' is an access (service affordability) indicator of governments' objective that all Australian families have equitable access to children's services regardless of their financial circumstances.

This indicator is defined as the weekly cost of preschool per child (after subsidies received by families). Data are reported as the median weekly cost per child.

Provided the service quality and quantity is held constant, lower weekly costs represents more affordable preschool.

Various factors influence preschool costs and care needs to be exercised when interpreting results.

- There may be differences between jurisdictions in the number of hours and sessions attended by children each week.
- Preschool services are provided by a mix of providers (community, private and government). Differences in charging practices, including fees, may be due to commercial or cost recovery decisions made by individual services. Fee variation can also occur as a result of charges for additional services such as meals and materials.
- Fees may reflect higher land values and rental fees charged in major cities.
- Some jurisdictions provide targeted fee relief that lowers fees for some children.

Further detail about the mix of providers of preschool (community, private and government) is provided in tables 14A.34, 14.A.43, 14A.52, 14.A61, 14.A70, 14.A79, 14.A88 and 14.A97.

Preschool service costs per child may also depend on the time spent in preschool. Of the 257 100 children attending preschool in the reference week in 2005:

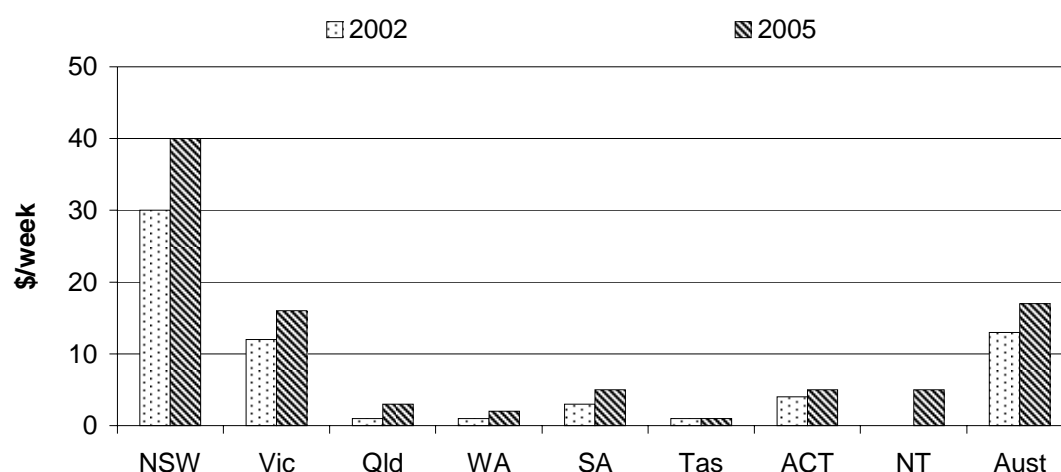
- 10.6 per cent attended preschool for less than five hours per week
- 21.3 per cent attended for between five and nine hours per week
- 40.7 per cent attended for between 10 and 14 hours per week
- 19.2 per cent attended for between 15–19 hours per week
- 8.2 per cent attended for more than 20 hours per week (ABS 2006).

Data for this indicator were obtained from the ABS 2005 *Child Care Survey*. This is a household-based survey, with parents responding to questions about use of child care and preschool services. Some children attend a preschool program within another child care setting, for example in a long day care service, where the costs would generally be higher than in preschool. It is expected that in most of these cases, the parent would report the type of service as (for example) a long day care

centre, rather than preschool, but in some instances the parent may report the type of service as preschool. Box 14.19 includes further information about the 2005 Child Care survey.

Nationally, the median cost (the middle value in the distribution of fees paid per child) of preschool per child in 2005 was \$17 per week. In 2002, the median costs were \$13 per week (figure 14.10). Table 14A.27 provides additional information on the preschool service costs for children by cost range for selected jurisdictions.

Figure 14.10 Children who attended preschool, median weekly cost per child (after subsidies), 2002, 2005^{a, b, c, d, e}



^a Net costs per child after subsidies have been received. Some children attending preschool services may be eligible for the minimum rate of the Child Care Benefit. ^b The estimates are not based on standardised measures of child age, hours of service provided or preschool service delivery mechanisms. ^c In Victoria and NSW, a fee subsidy is paid directly to services to reduce fees paid by eligible families such as those holding approved concession cards or meeting specified income thresholds. ^d The estimates for Tasmania and the ACT have a relative standard error between 25 per cent and 50 per cent and should be used with caution. ^e For 2005, the estimates for Queensland, WA, Tasmania and NT have high relative standard errors and should be used with caution.

Source: ABS 2002, 2005 *Child Care Surveys* (unpublished); table 14A.27.

Quality

An important focus of Australian, 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 the proportion of qualified staff, the rate of ongoing staff development, the extent of licensing, the proportion of services that have achieved quality accreditation, the number of serious injuries, and the number of substantiated breaches arising from complaints. These data need to be treated with caution because there are differences in reporting across jurisdictions.

Staff — qualifications

Staff qualifications are an indicator of staff quality (box 14.9).

Box 14.9 Qualifications

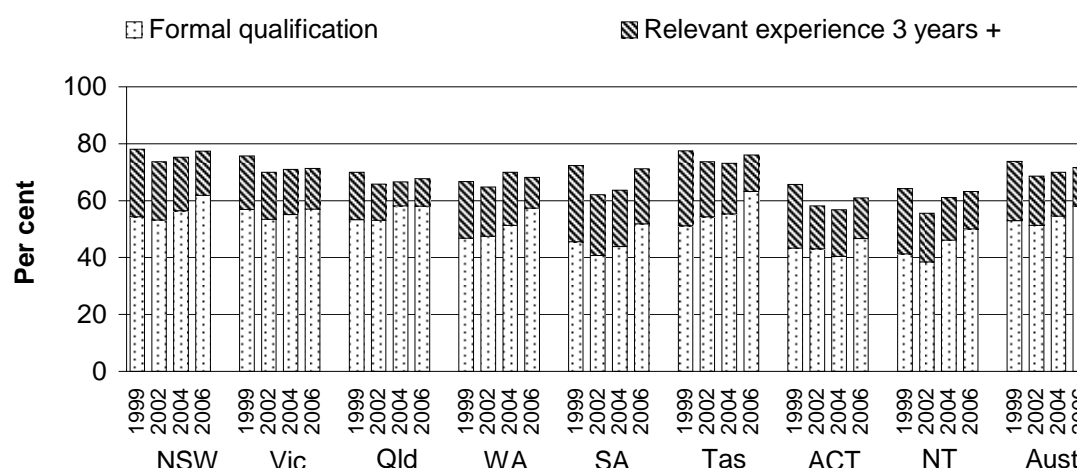
‘Qualifications’ in children’s services is an output (staff) indicator of governments’ objective to ensure staff in government funded or provided children’s services are able to provide services which meet the needs of children. In particular this means ensuring staff have the training and experience to provide a safe and nurturing environment that fulfils the educational and development needs of children.

This indicator is defined as the proportion of primary contact staff with relevant formal qualifications or three or more years of relevant experience.

Some studies and research (for example, OECD 2006) have shown a link between a higher proportion of qualified and experienced primary contact staff and a higher quality service, suggesting that this is desirable.

Nationally, there were 84 379 primary contact staff employed in Australian Government approved child care in 2006 (table 14A.13). The proportion of primary contact staff with relevant formal qualifications or three or more years of relevant experience across jurisdictions over this period is reported in figure 14.11.

Figure 14.11 **Paid primary contact staff employed by Australian Government approved child care services, by qualification^{a, b, c, d}**

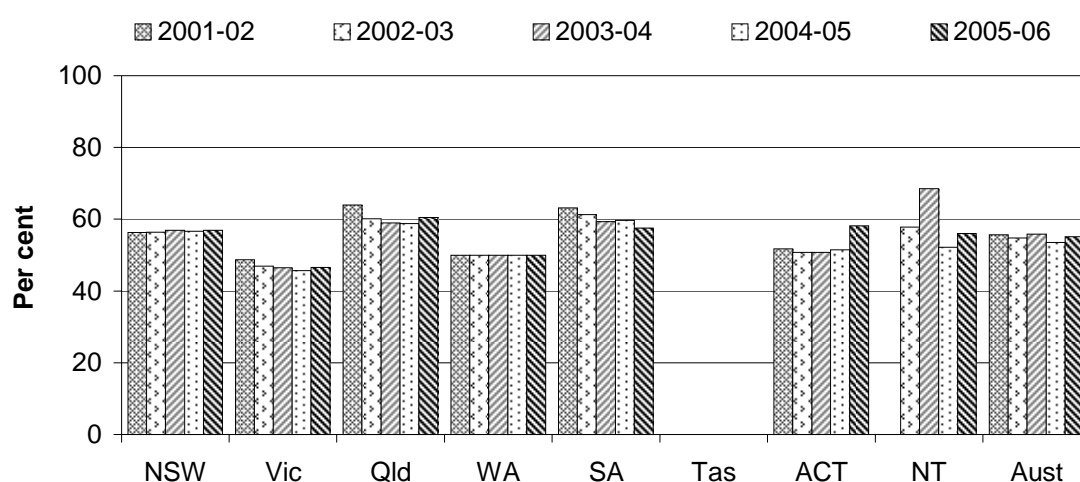


^a There may be double counting of staff where staff work in more than one centre. ^b The ‘Three or more years relevant experience’ category excludes staff with a relevant formal qualification. ^c Data for some years do not cover all services, which limits the comparability over time. ^d Data are estimated and weighted from the AGCCCS. In 2006, numbers are based on preliminary data and there may be changes to the final data.

Source: AGCCCS May 1999, May 2002, March 2004 and May 2006 (unpublished); table 14A.13.

Some data are available on the qualifications of staff employed by preschool services that received funding from State and Territory governments. The proportion of preschool primary contact staff with a relevant formal qualification is reported in figure 14.12. The comparability of these data is limited, however, by the different licensing and funding arrangements across jurisdictions.

Figure 14.12 Paid primary contact staff with a relevant formal qualification employed by State and Territory funded and/or managed preschools^{a, b, c}



^a All preschool services in NSW, Victoria and Queensland must have at least two staff, of whom one must have a relevant formal qualification. ^b In WA, all preschool teachers must have a formal qualification. The data assumes that every teacher has an aide. Qualifications of aides are unknown and so reported as zero. ^c Data for Tasmania and some years in the NT are not available.

Source: State and Territory governments (unpublished); tables 14A.33, 14A.42, 14A.51, 14A.60, 14A.69, 14A.78, 14A.87 and 14A.96.

Ongoing staff development

Ongoing development of the skills and competencies of child care and preschool staff is an indicator of staff quality (box 14.10).

Box 14.10 Ongoing staff development

'Ongoing staff development' in children's services is an output (staff) indicator of governments' objective to ensure staff in government funded or provided children's services are able to provide services that meet the needs of children. In particular, this means ensuring staff have the training and experience to provide a safe and nurturing environment that fulfils the educational and development needs of children.

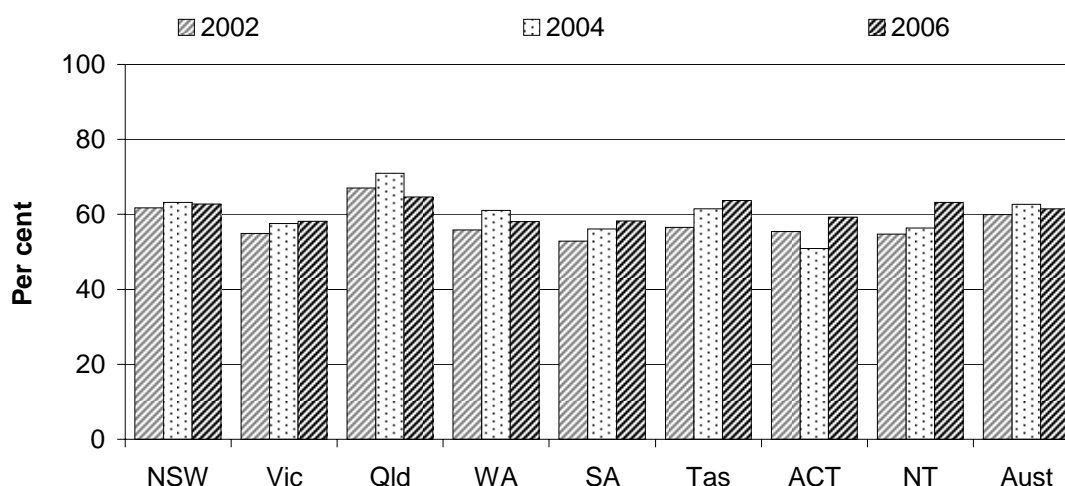
This indicator is defined as the proportion of staff who undertook relevant in-service training in the previous 12 months.

A high rate of in-service training suggests a relatively high quality of service.

This indicator does not provide information on whether the ongoing development undertaken by staff is adequate or sufficiently relevant to improve the quality of the service provided.

Nationally, more than 60 per cent of paid staff working in Australian Government child care services in 2006 undertook relevant in-service training in the previous 12 months (figure 14.13). Limited data are available on training by paid child care and preschool staff employed by State and Territory funded and/or managed service providers. New South Wales, Victoria, Queensland and the ACT were able to provide data on the proportion of preschool staff undertaking training in 2005-06 (tables 14A.33, 14A.42, 14A.51 and 14A.87).

Figure 14.13 **Staff in Australian Government child care services who undertook relevant in-service training in previous 12 months^{a, b, c}**



^a There may be double counting of staff where staff work in more than one centre. ^b Data for some years do not cover all services, which limits the comparability over time. ^c Data are estimated and weighted from the AGCCCS. In 2006, numbers are based on preliminary data and there may be changes to the final data.

Source: AGCCCS May 2002, March 2004 and May 2006 (unpublished); table 14A.14.

Standards

The Australian Government and the State and Territory governments support the quality of care provided by children's services through:

- accreditation and licensing
- provision of curriculum and policy support and advice
- training and development of management and staff.

Standards — licensing

State and Territory governments are responsible for licensing children's services in their jurisdiction (box 14.11).

Box 14.11 Licensing

'Licensing' is an output (standards) indicator of governments' objective to ensure government funded or provided children's services meet the minimum standards considered necessary to provide a safe and nurturing environment, and to meet the educational and development needs of children.

This indicator has been identified for development and reporting in future. Descriptive information is reported for some jurisdictions as an interim measure. This information includes the number of licensed services.

A higher proportion of licensed services may indicate a higher level of regulatory control over services.

This indicator does not provide information on the degree to which licensing translates into higher quality service outcomes above the minimum standards of care. State and Territory governments also undertake other activities aimed at the promotion of quality, such as publishing curriculum materials and other resources, and undertaking consumer education.

State and Territory licensing requirements establish the foundations for quality of care by stipulating enforceable standards to support the health, safety, welfare and development needs of children in formal child care settings. Accreditation of services is built on this platform.

Licensed children's services may include centre-based long day care, occasional care, preschools, family day care services and outside school hours care. Australian, State and Territory governments have developed national standards for centre-based long day care, family day care services and outside school hours care. Jurisdictions refer to these standards when writing regulations. The extent of implementation of these standards varies across Australia.

The types of service covered by legislation vary across jurisdictions (table 14.5).

Table 14.5 State and Territory licensing of children's services, 2006

Service type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Centre-based long day care ^a	✓	✓	✓	✓	✓	✓	✓	✓
Occasional care ^b	✓	✓	✓	✓	✓	✓	✓	✓
Family day care schemes/agencies ^c	✓	x	✓	x	✓	✓	✓	x
Family day care carers ^d	x	x	x	✓	x	x	x	x
Outside school-hours care	x	x	✓	✓	x	✓	✓	x
Home-based care ^e	✓	x	x	x	✓	✓	x	x
Other care ^f	x	x	x	x	x	✓	x	x
Preschool/kindergarten ^g	✓	✓	✓	x	x	x	✓	✓

^a In the ACT and Victoria, services are licensed as centre-based children's services. ^b In SA, occasional care services operated by community groups or individuals are licensed. Government-operated occasional care is not licensed, but must operate to licensing standards. ^c In Qld, family day care schemes are licensed as home-based care. ^d Family day care providers in WA are individually licensed. Family day carers in NSW, Queensland and Tasmania are not required to be licensed, provided they are registered through a family day care scheme. In SA, Family Day Care providers are regulated by approvals and cannot advertise unless approved by the State. ^e In SA, baby sitting agencies must be licensed if they are referring nannies and babysitters to parents to care for children in the child's own home. In Qld, stand-alone care provided in a home is not licensed, but is required to meet a set of minimum standards. ^f NSW has the capacity to approve child minding services in retail shopping centres under the *Children's Services Regulation 2004*. NSW is also moving towards regulation of out of school hours services. Under the *Child Care Act 2001*, Tasmania has the capacity to licence other forms of care, for example, in-home child care and nanny agencies. ^g In Qld, preschool services delivered in community based kindergartens are licensed. In SA, preschools are operated by the State Government, independent schools or as licensed child care centres. In Tasmania, kindergartens not in government schools are registered with the Schools Registration Board. In ACT, playschools and independent preschools are licensed. In the NT, independent preschools and kindergartens for 3 year olds are licensed.

Source: State and Territory governments (unpublished).

Standards — accredited child care services

The NCAC administers quality assurance systems for long day care centres, family day care schemes and outside school hours care services across Australia (box 14.12).

Box 14.12 Accredited child care services

‘Accredited child care services’ is an output (standards) indicator of governments’ objective to ensure government funded or provided child care services meet the standards considered necessary to provide a safe and nurturing environment, and to meet the educational and development needs of children. Accredited services have been independently evaluated against a series of national quality standards for the specific child care service type.

This indicator is defined as the number of child care services that are accredited by NCAC as a proportion of services fully assessed. Data are reported for centre-based long day care services, family day care schemes and outside school hours care services.

A higher proportion of centres that have been accredited is more desirable.

This indicator does not provide information on the degree to which accreditation translates into higher quality service outcomes.

To become accredited under NCAC quality assurance systems, service providers are required to achieve and maintain the quality standards set out for each service type. NCAC has developed the following standards:

- the Quality Improvement and Accreditation System (QIAS) for centre-based long day care centres
- Family Day Care Quality Assurance (FDCQA) for family day care schemes
- Outside School Hours Care Quality Assurance (OSHCQA) for outside school hours care services.

The standards include the expected performance against a variety of ‘quality areas’, depending on the type of service. For example, the QIAS details performance against the following seven ‘quality areas’:

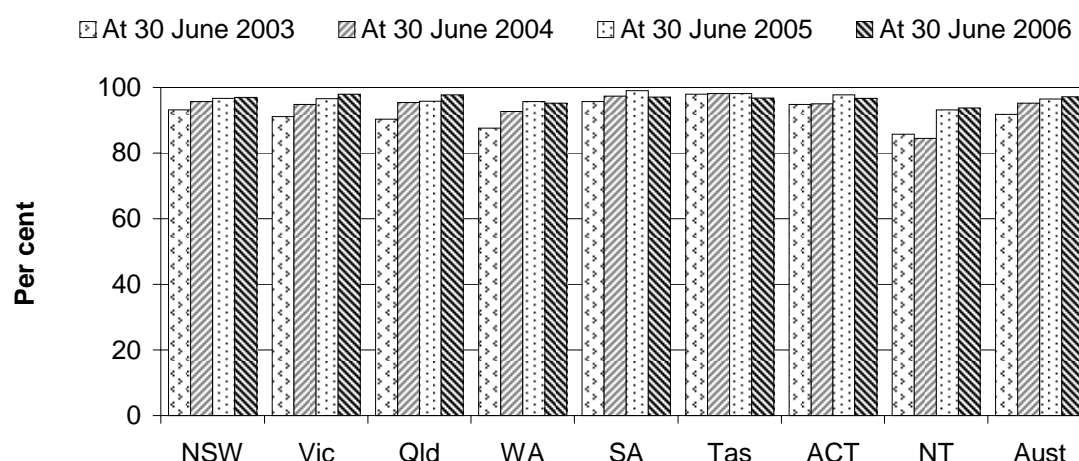
- staff relationships with children and peers
- partnerships with families
- programming and evaluation
- children’s experiences and learning
- protective care and safety
- health, nutrition and wellbeing
- managing to support quality.

The NCAC accreditation systems are Australian Government initiatives linked to Child Care Benefit funding. All centre-based long day child care services are

required to participate in the QIAS to be eligible for approval for Child Care Benefit purposes, and the majority of centre-based long day child care services participate.

Nationally, of the 5043 centres registered to participate in the QIAS at 30 June 2006, 4308 centres had received an accreditation decision (table 14A.2). Of the centres assessed, 97.2 per cent (4187 centres) were successful in achieving accreditation (figure 14.14). The centres that do not meet accreditation standards (121 centres) are required to submit another self study report to NCAC within six months of the date of NCAC's accreditation decision. At 30 June 2006, a further 735 centres (14.6 per cent of those registered to participate in QIAS) were in self study, review or moderation, or awaiting an accreditation decision (table 14A.2).

Figure 14.14 Accredited centres as a proportion of centres fully assessed under the Quality Improvement and Accreditation System^{a, b}



^a Figures may change daily and are updated every six weeks following an NCAC meeting. ^b Results for Tasmania, the ACT and the NT may be unduly influenced by the relatively small number of services (89, 94 and 56 respectively at 30 June 2006) participating in the process.

Source: NCAC (unpublished); table 14A.2.

Family day care schemes have submitted self-study reports since July 2002, with 284 out of 318 schemes accredited at 30 June 2006. Thirty-three schemes were not accredited and one was in self study, validation or moderation, or awaiting an accreditation decision (table 14A.2).

All services providing before school, after school and vacation care were required to register with NCAC by 30 September 2003. At 30 June 2006, there were 3025 outside school hours care services registered to participate in OSHCQA (table 14A.2). Of the 1062 services that had received an accreditation decision at 30 June 2006, 86.3 per cent (917 services) were successful in achieving

accreditation. A further 1963 services had not yet completed the accreditation process.

Health and safety — serious injuries

‘Serious injuries’ is an indicator of child care services’ success in providing a safe environment (box 14.13).

Box 14.13 Serious injuries

‘Serious injuries’ is an output (health and safety) indicator of governments’ objective to ensure children’s services meet the care, educational and development needs of children in a safe and nurturing environment.

This indicator is defined as the number of serious injuries per registered or licensed service provider. A serious injury is defined as an injury requiring hospitalisation or a visit to, or by, a medical doctor.

A higher rate of injury does not provide information on whether a jurisdiction has lower service safety and quality, or a more effective reporting and monitoring regime. All else being equal, a low injury rate may indicate a high level of safety.

Data on the number of serious injuries and the number of serious injuries per registered or licensed service provider were limited for 2005-06. Although most jurisdictions could provide some information, the small incident numbers, different approaches to defining serious injuries and differences in data collection approaches mean that jurisdictions’ data cannot be directly compared. Tables 14A.36, 14A.45, 14A.54, 14A.90 and 14A.99 provide a breakdown of the available information for NSW, Victoria, Queensland, the ACT and the NT.

Health and safety — hospitalisations for external causes of injury occurring in children’s services

At present, jurisdictions do not have comparable administrative collections on serious injuries occurring in children’s services. One source of comparable information is hospitalisations data. ‘Hospital separations for external causes of injury’ is a proxy indicator of children’s services’ success in providing a safe environment (box 14.14).

Box 14.14 Hospital separations for external causes of injury

'Hospital separations for external causes of injury' is an output (health and safety) indicator of governments' objective to ensure that children's services meet the care, educational and developmental needs of children in a safe and nurturing environment.

This indicator is defined as the number of hospital separations for children aged 0–4 years resulting from an external cause of injury occurring in 'school' expressed as a proportion of total hospital separations for children aged 0–4 years resulting from an external cause of injury.

Low or decreasing hospitalisations for external causes of injury for children aged 0–4 years occurring in a 'school' may indicate better performance towards achieving the objective of providing the care, educational and development needs of children in a safe and nurturing environment.

Limiting the data to children aged 0–4 reduces the likelihood that the 'school' place of occurrence includes children in full time compulsory schooling, which children generally attend when they are 5 years old or more. For children in the older age group it is not possible to separate injuries that occur in a children's service from those that occur in a full time formal school setting, and so they are excluded from the indicator.

For children aged 0–4 years, the term 'school' incorporates a range of formal children's services settings including kindergarten, preschool and centre-based child care services. Family day care services, which are typically provided in the carer's home, are not likely to be covered by this term. External cause refers to the environmental event, circumstance or condition that causes the injury. Persons admitted to hospital as a result of a pre-existing existing illness or condition (such as asthma), are excluded.

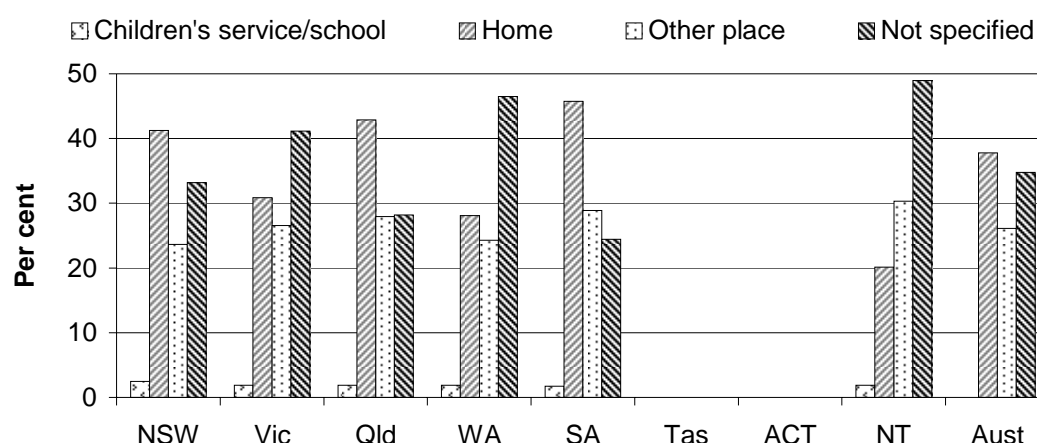
All hospital separation data need to be interpreted with care. Nationally, no place of occurrence was reported for 34.8 per cent of hospitalisations of children aged 0–4 years in 2004-05. As a result, this indicator should be interpreted as the minimum proportion of hospital separations for an external cause of injury that occurred in children's services.

In 2004-05, there were 28 448 injuries to children aged 0–4 years that resulted in a hospital admission in Australia (table 14A.28). Males accounted for approximately 55.7 per cent of these admissions. In total, the most common causes of injury to children aged 0–4 years were falls (24 per cent), complications of medical and surgical care (19 per cent) and exposure to mechanical forces (18 per cent). (Australian Institute of Health and Welfare unpublished). Males and females generally experienced similar causes of injury.

Place of occurrence was recorded for 65.2 per cent of hospitalisations for children aged 0–4 years in 2004-05 (table 14A.28). Of those injuries for which a place of occurrence was recorded in 2004-05, 59.1 per cent occurred in the child's home. This reflects the fact that children in this age group spend the majority of their time

in the home and about half do not attend formal care. Across jurisdictions, around 2 to 3.5 per cent of injuries were reported as occurring at a ‘school’ (which includes day nursery, centre-based child care, and public or private kindergartens and preschools) (figure 14.15).

Figure 14.15 Hospital separations for external causes of injury for children aged 0–4 years, by place of occurrence as a proportion of the total, 2004-05^{a, b, c, d, e}



^a External cause refers to the environmental event, circumstance or condition that causes the injury. People admitted to hospital as a result of a pre-existing existing illness or condition, such as asthma, are excluded.

^b A hospital separation is an episode of care for a person admitted to a hospital. ^c Separations without an external cause and those for which care type was reported as newborn with no qualified days, and records for hospital boarders or posthumous organ procurement are excluded. ^d Data are withheld for injuries in Tasmania and the ACT due to the small number of injuries reported. Data on the number of accidents occurring in children's services at a national level in 2004-05 are also withheld, as a consequence. ^e Due to the high levels of non-reporting for place of occurrence, all hospital separations data need to be interpreted with care.

Source: Australian Institute of Health and Welfare *Australian Hospital Statistics* 2004-05 (unpublished); table 14A.28.

Client satisfaction — monitoring and inspection regimes

All states and territories set standards of expected performance of children's services, based on the relevant legislation, regulation and/or licensing conditions. The jurisdictions monitor performance against the standards in order to ensure high-quality services are delivered to the community. Table 14.6 provides an overview of the monitoring and inspection regimes that operate in the jurisdictions.

Table 14.6 shows that there are broad commonalities in the monitoring and inspection regimes across jurisdictions. However, there is variability in the recording of breaches and a variety of penalties applied for breaches. This has

hindered the reporting of comparable data across jurisdictions for monitoring and inspection.

Table 14.6 State and Territory monitoring and inspection regimes, for licensed children's services 2005-06

<i>Monitoring activities</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld^a</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
<i>Proactive monitoring:^b</i>	✓	✓	✓	✓	✓	✓	✓	✓
Required frequency of inspections	Annual	Annual	Biannual	At least once per licence period (3 years)	Biannual	Quarter	Quarter	Biannual
Estimated share announced visits ^c	75%	7%	46%	55%	70%	99%	60%	80%
Estimated share unannounced inspections ^d	25%	93%	54%	45%	30%	1%	40%	20%
<i>Reactive monitoring:^e</i>	✓	✓	✓	✓	✓	✓	✓	✓
Data provided on substantiated breaches arising from complaints ^f	x	✓	x	✓	x	✓	✓	✓
<i>Sanctions for breaches:^g</i>	✓	✓	✓	✓	✓	✓	✓	✓
Under-performing services incur follow-up or more frequent inspections	✓	✓	✓	✓	✓	✓	✓	✓
Number of prosecutions initiated against services during 2005-06 ^h	–	1	–	2	–	–	–	–

^a Information for Queensland excludes state and non-state preschools, but includes kindergartens.

^b 'Proactive monitoring' refers to the ongoing program of visits/inspections to services that are determined by legislation and/or the monitoring policies in each jurisdiction. ^c Announced visits are scheduled with the service provider, and include, but are not limited to, consultative and advisory meetings. ^d Unannounced inspections of services are used to assess performance against licence conditions, including, but not limited to, investigations of complaints. Unannounced inspections allow the operation of the service to be monitored under normal operational circumstances. ^e A 'reactive monitoring' regime may be triggered by either a complaint or a service's failure to comply with legislative requirements. ^f See detailed data in attachment tables 14.A46, 14.A64, 14A.82, 14A.91, 14A.100. ^g Jurisdictions may apply a wide range of actions to underperforming services. These actions may include administrative and/or statutory sanctions, including prosecution. Not all sanctions are included in this table. ^h 'Prosecutions' refer to all prosecutions against services that are brought under the relevant children's services Act in each jurisdiction. – Nil or rounded to zero.

Source: State and Territory governments (unpublished).

Client satisfaction — substantiated breaches arising from complaints

‘Substantiated breaches arising from complaints’ is an indicator of community satisfaction with child care services (box 14.15). Breaches identified as a result of normal monitoring and inspection visits are excluded from these data.

Box 14.15 Substantiated breaches arising from complaints

‘Substantiated breaches arising from complaints’ is an output (client satisfaction) indicator of governments’ objective to ensure government funded or provided children’s services meet the needs and expectations of users.

This indicator is defined as the number of substantiated breaches arising from complaints divided by the total number of registered or licensed services. Results are presented by service type. Data on the proportion of substantiated breaches arising from complaints against which action was taken are also reported.

A higher rate of complaints does not provide information on whether a jurisdiction has lower service safety and quality, or a more effective reporting and monitoring regime. All else being equal, a higher rate of breaches arising from complaints may suggest a lower quality service

Complaints data need to be interpreted with care, because:

- some jurisdictions give priority to developing client groups who are well informed, as part of improving their service delivery. Clients who are well informed may be more likely to make a complaint than are clients without access to this information
- the number of approved care providers or parent users per service differs in each service across states and territories
- complaints management systems vary across jurisdictions.

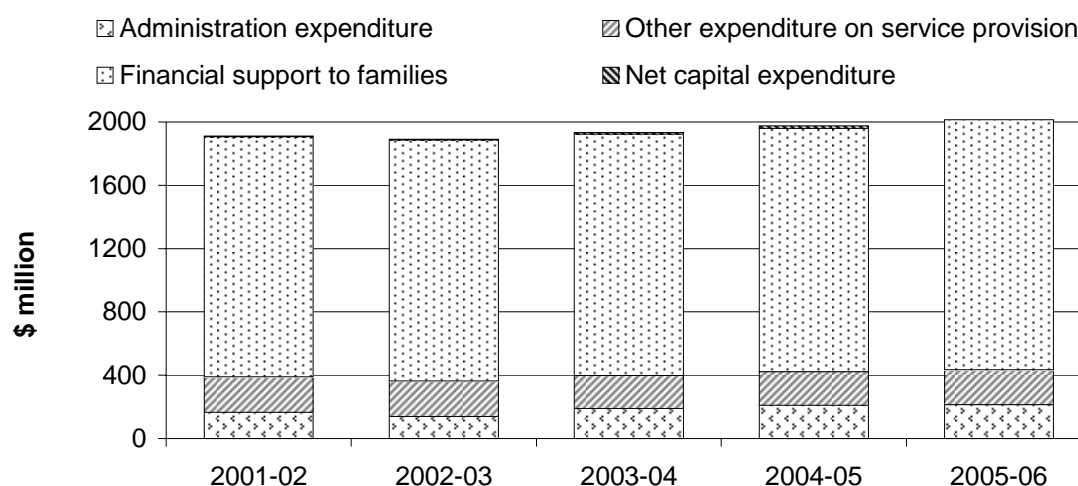
Breaches of legislation, regulations or conditions can relate to a broad range of requirements. Some requirements have serious implications for the quality of care provided to children (such as requirements to undertake criminal record checks for staff and requirements to install smoke detectors). Other requirements do not necessarily directly affect the quality of care (such as requirements to display licensing information). Similarly, action taken by regulatory authorities in response to a breach can range from a requirement to comply within a specified time frame through to licensing action or prosecution.

Victoria, WA, Tasmania, the ACT and the NT provided data on the number of substantiated breaches arising from complaints and allegations of regulation breaches made to the State and Territory government regulatory bodies in 2005-06 (tables 14.A46, 14.A64, 14A.82, 14A.91 and 14A.100).

Efficiency

Australian Government expenditure accounted for 75.4 per cent (\$2.02 billion) of total government expenditure on children's services in 2005-06. The major component of Australian Government expenditure was financial support to families through assistance with fees, which accounted for 78.2 per cent (\$1.58 billion) of Australian Government expenditure on children's services. Other expenditure on service provision² accounted for a further 10.9 per cent (\$219.9 million), and administration expenditure and net capital expenditure accounted for the remaining 10.6 per cent (\$214.6 million) and 0.3 per cent (\$6.6 million) respectively (figure 14.16).

Figure 14.16 Australian Government real expenditure on children's services (2005-06 dollars)



Source: Department of Family, Community Services and Indigenous Affairs (FaCSIA) (unpublished); table 14A.4.

State and Territory government expenditure on children's services in 2005-06 was approximately \$659.4 million, of which other expenditure on service provision comprised around 50.1 per cent (\$330.5 million). Administration expenditure, net capital expenditure and financial support to families accounted for 43.8 per cent (\$288.6 million), 3.3 per cent (\$21.8 million) and 3 per cent (\$19.5 million) respectively (tables 14A.4, 14A.7, 14A.29, 14.A.38, 14.A47, 14.A.56, 14.A65, 14.A74, 14.A83, 14.A92).

²'Other expenditure on service provision' includes 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.

Differences in reported efficiency 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. Information on the comparability of the expenditure is shown in table 14A.6.

Inputs per output unit — total government expenditure (dollars per child)

Total government expenditure (Australian Government and State and Territory governments) on children's services per child aged 0–12 years in Australia is a proxy indicator of efficiency (box 14.16).

Box 14.16 Total government expenditure

'Total government expenditure' per child is an output (efficiency) indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources.

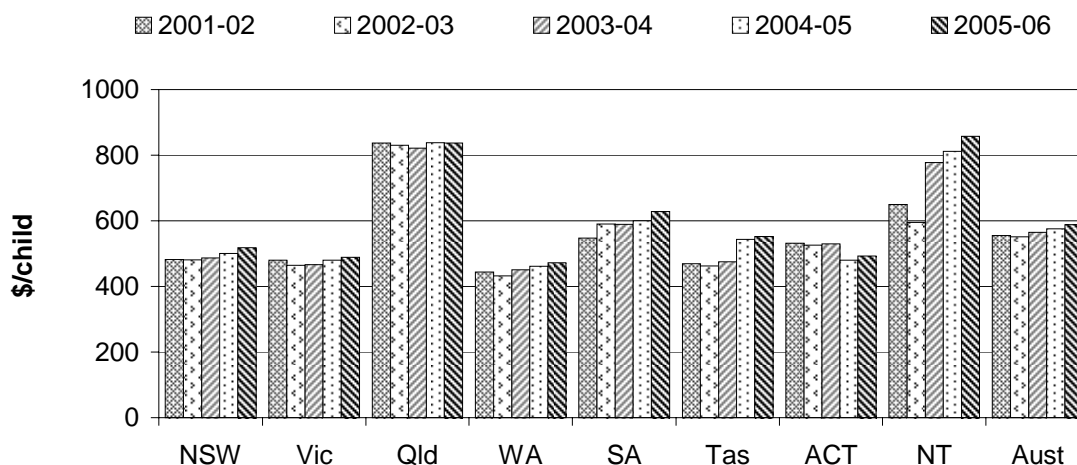
This indicator is defined as Australian Government expenditure and State and Territory governments expenditure on children's services per child aged 0–12 years in Australia. All Australian Government expenditure reported for this indicator is provided for child care services, whereas State and Territory government expenditure covers both child care and preschool services.

Expenditure data per child is reported separately for the Australian Government and State and Territory government, as well as a combined expenditure figure per child.

All efficiency data need to be interpreted with care. Changes in expenditure per child could represent changes in government funding policy. While high or increasing unit costs may reflect deteriorating efficiency, they may also reflect increases in the quality or quantity of service provided. Similarly, low or declining expenditure per child may reflect improving efficiency or lower quality or quantity. Provided the level and quality of, and access to, services remains unchanged, lower expenditure per child can indicate greater efficiency of government expenditure.

After adjusting for inflation to calculate the 'real' value of expenditure in previous years, Australian Government expenditure on children's services at a national level increased between 2001-02 and 2005-06 (figure 14.17).

Figure 14.17 Australian Government real expenditure on children's services per child aged 0–12 (2005-06 dollars)^{a, b}



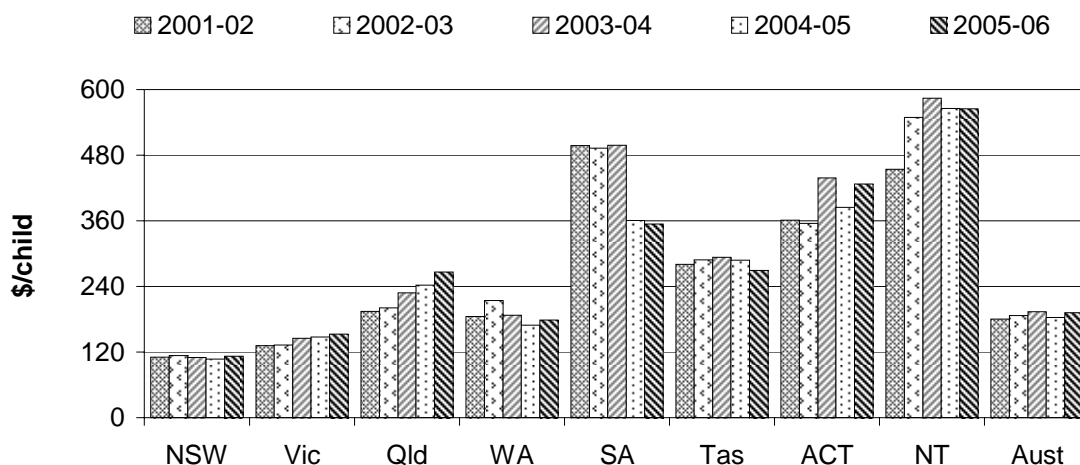
^a Includes administration expenditure, other expenditure on service provision, financial support to families and net capital expenditure on child care services. ^b The Australian total includes a component of expenditure that cannot be disaggregated by State and Territory.

Source: FaCSIA (unpublished); ABS *Australian Demographic Statistics* (unpublished); table 14A.21.

Data were sought from all State and Territory governments on their expenditure 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.

Figure 14.18 shows the variation in total real expenditure per child aged 0–12 years by State and Territory governments over the period 2001-02 to 2005-06.

Figure 14.18 **State and Territory government real expenditure on children's services per child aged 0–12 (2005-06 dollars)^{a, b, c, d, e}**

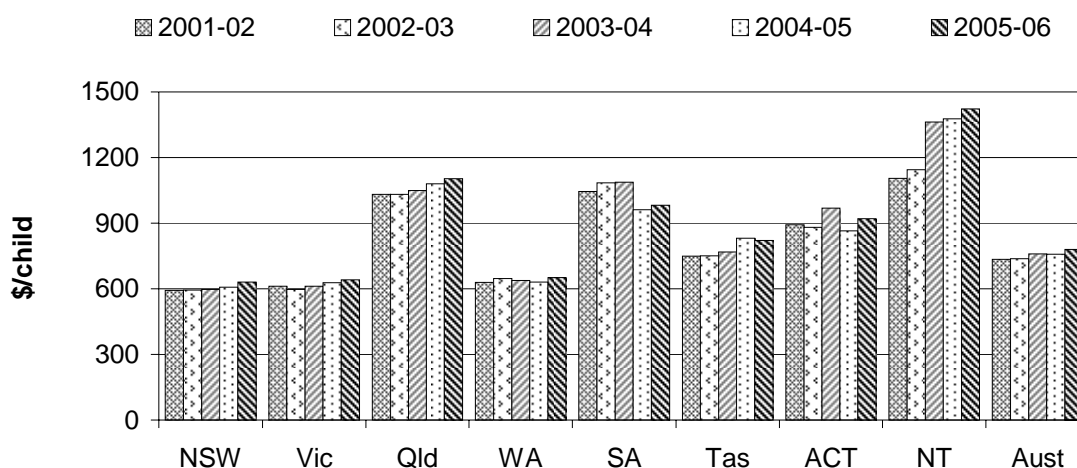


^a Includes administration expenditure, other expenditure on service provision, financial support to families, and net capital expenditure on child care and preschool services. ^b The increase in Queensland expenditure for 2004-05 is the result of improved reporting processes. This specifically captures information relating to a newly developed output of Child Care Policy and Services, and includes previously unreported information, namely indirect costs, head office overheads and expenditure on policy advice and development. ^c WA expenditure for 2001-02 declined in response to the changes in the school entry age and the associated move to full time schooling for pre-year 1 children. ^d WA data for 2003-04 and 2004-05 exclude expenditure on the non-government sector. ^e The decrease in SA expenditure per child aged 0–12 years in 2004-05 and 2005-06 is due to the exclusion of all Australian Government contributions, which SA currently administers, from the total state/territory real expenditure on children's services.

Source: State and Territory governments (unpublished); ABS *Australian Demographic Statistics* (unpublished); table 14A.22.

Figure 14.19 shows the combined expenditure from both the Australian Government and the State and Territory governments per child aged 0–12 years over the period 2001-02 to 2005-06.

Figure 14.19 Total government real expenditure on children's services per child aged 0–12 (2005-06 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 from both Australian Government (for child care services only) and State and Territory Governments (for child care services and preschool services).
^b See notes to figure 14.18 for further detail on State and Territory governments' expenditure data.

Source: FaCSIA (unpublished); State and Territory governments (unpublished); ABS Australian Demographic Statistics (unpublished), tables 14A.21 and 14A.22.

Outcomes

Family needs

'Family needs' is an indicator of the outcomes of children's services (box 14.17).

Box 14.17 Family needs

'Family needs' in children's services is an outcome (effectiveness) indicator of governments' objective to provide children's services that provide support for families in caring for their children.

This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report.

Demand for (additional) child care

'Demand for additional child care services' is an indicator of the success of children's services in meeting the needs of the community (box 14.18).

Box 14.18 Demand for (additional) child care

‘Demand for (additional) child care’ provides an outcome indicator of governments’ objective to ensure children’s services meet the requirements of all Australian families. Expressed need for child care indicates the extent to which children’s services are not meeting demand by families.

The indicator is defined as the proportion of children aged under 12 years for whom additional services were required in the four weeks before the survey interview.

A lower proportion of children for whom additional services were required indicates demand by families is being met to a greater extent.

Data for this indicator were obtained from the ABS 2005 *Child Care Survey*. Box 14.19 includes further information about the 2005 survey.

Box 14.19 ABS Child Care Survey

The ABS Child Care Survey is conducted every three years throughout Australia, as a supplement to the Labour Force Survey. The latest survey was conducted in June 2005.

Information was collected in relation to children aged 0–12 years living in a sample of private dwellings (in previous surveys, the age group covered was children aged 0–11 years). In each selected household, detailed information about each child’s child care was collected for a maximum of two children. Data were collected for approximately 10 200 children in total.

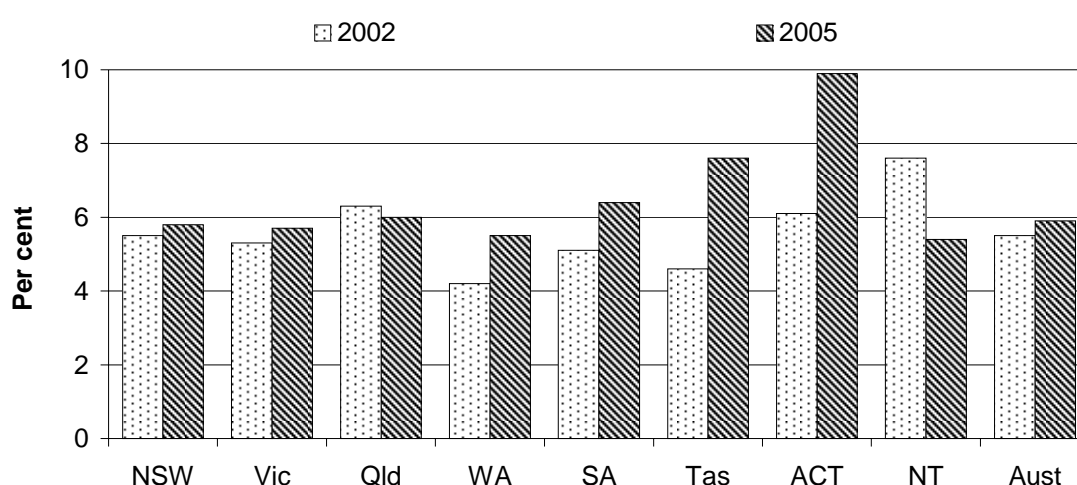
The survey included information about whether parents’ needs for child care were met. Those families not already using child care or preschool services were asked whether there was any time in the previous four weeks when they wanted to use any child care or preschool services for their child but did not. Those families already using child care or preschool services were asked a similar question to determine whether they had wanted to use any more services in the previous four weeks.

Estimates from the surveys are subject to sampling variability. They may differ from estimates that would have been produced by a census. Estimates for the smaller jurisdictions are based on small sample sizes and, consequently, are subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution.

Aggregated survey data also need to be interpreted with care generally, because over and undersupply of child care places can be specific to particular areas, including small and remote communities. Further, the data will not reflect changes in population in some areas since June 2005.

Nationally, no additional child care or preschool services were required in the previous four weeks for the majority (94.1 per cent) of children aged under 12 years in 2005. This figure has remained relatively steady since 2002, when 94.5 per cent did not require additional services in the previous four weeks (figure 14.20). In 2005, additional child care services were required for approximately 184 500 children aged under 12 years. A further 4100 children aged under 12 years required additional preschool services in the previous four weeks (table 14A.24).

Figure 14.20 Proportion of children aged under 12 years for whom additional formal child care was required, 2002, 2005^a

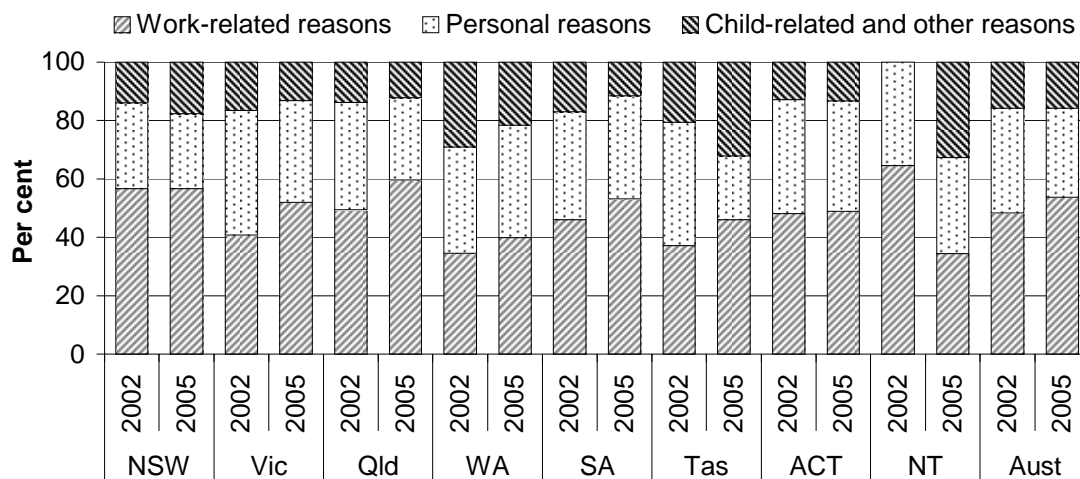


^a Estimates for the smaller jurisdictions are based on small sample sizes and, consequently, are subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution.

Source: ABS 2002, 2005 *Child Care Survey* (unpublished); table 14A.23.

Nationally, work-related reasons were the most commonly cited for needing additional formal care in 2005 (53.7 per cent of children aged 0–11 in 2005 compared with 48.4 per cent in 2002). Personal reasons for needing additional formal care were reported for 30.5 per cent of children aged 0–11 years in 2005, compared with 35.8 per cent in 2002 (figure 14.21). The category ‘child-related and other reasons’ was steady, reported for 15.8 per cent of children in both 2002 and 2005 (table 14A.24).

Figure 14.21 Children aged under 12 years who required additional child care services by main reason required, 2002, 2005^a

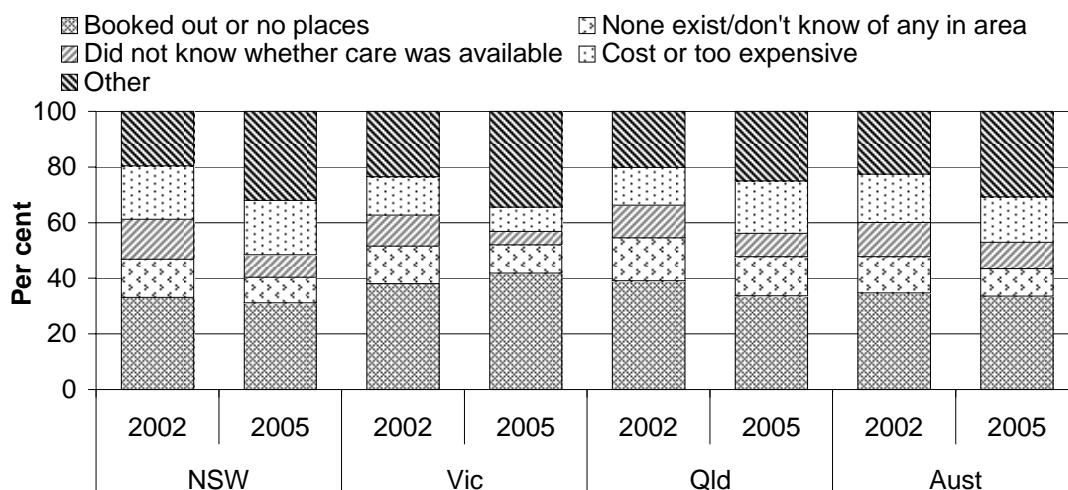


^a Estimates are based on small sample sizes and, consequently, are subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution.

Source: ABS 2002, 2005 *Child Care Survey* (unpublished); table 14A.24.

Parents who required additional child care services in the past 4 weeks, but were unable to access extra services, were asked about the barriers to access. The most commonly cited reason for not using the additional services required in the previous four weeks was a lack of available places ('booked out or no places') (table 14A.25). In 2005, this reason was reported for 33.6 per cent of children aged 0–11 years, a similar proportion to 2002 (34.8 per cent). 'No services exist/don't know of any in area' was reported for 9.9 per cent of children, compared with 12.9 per cent in 2002. 'Did not know whether care was available' was reported for 9.4 per cent of children in 2005, compared with 12.4 per cent in 2002. The cost of services was given as the reason for not using the additional services required in the previous four weeks for 16.4 per cent of cases in 2005, similar to 17.3 per cent in 2002 (figure 14.22).

Figure 14.22 Children aged under 12 years by main reason additional child care services not used, 2002, 2005^{a, b}



^a Due to the high sampling error, data for WA, SA, Tasmania, the ACT and the NT were suppressed. They are included in the Australian total. ^b 'Other' includes 'other service related' reasons, 'child-related' reasons and 'other' reasons why additional services were not used.

Source: ABS 2002, 2005 *Child Care Survey* (unpublished); table 14A.25.

Out-of-pocket costs

'Out-of-pocket costs' of child care is an indicator of the affordability and accessibility of child care services (box 14.20).

Box 14.20 Out-of-pocket costs

'Out-of-pocket costs' is an outcome indicator of governments' objective that all Australian families have equitable access to children's services regardless of their financial circumstances.

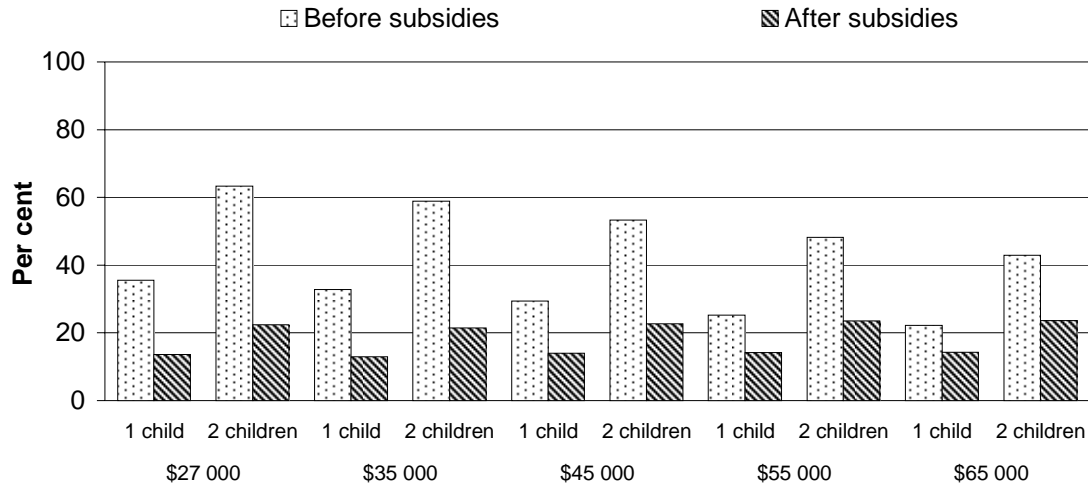
This indicator is defined as the proportion of weekly disposable income that representative families spend on child care services before and after the payment of child care subsidies. Data are estimated for families with a 60:40 income split and gross annual income of \$27 000, \$35 000, \$45 000, \$55 000 and \$65 000. Families are assumed to have either one or two children who attend full time care (equal to 50 hours per child per week) in centre-based long day care and family day care.

Lower out-of-pocket costs for child care as a proportion of weekly disposable income (after child care subsidies) represents more affordable child care. Similar percentages across income groups suggest a more equitable outcome.

Care needs to be exercised when interpreting results, however, because a variety of factors may influence child care fees.

After the payment of child care subsidies, out-of-pocket costs as a proportion of weekly family income in 2006 was generally similar across income bands compared to the case before subsidies were paid (figure 14.23).

Figure 14.23 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, 2006^{a, b, c}

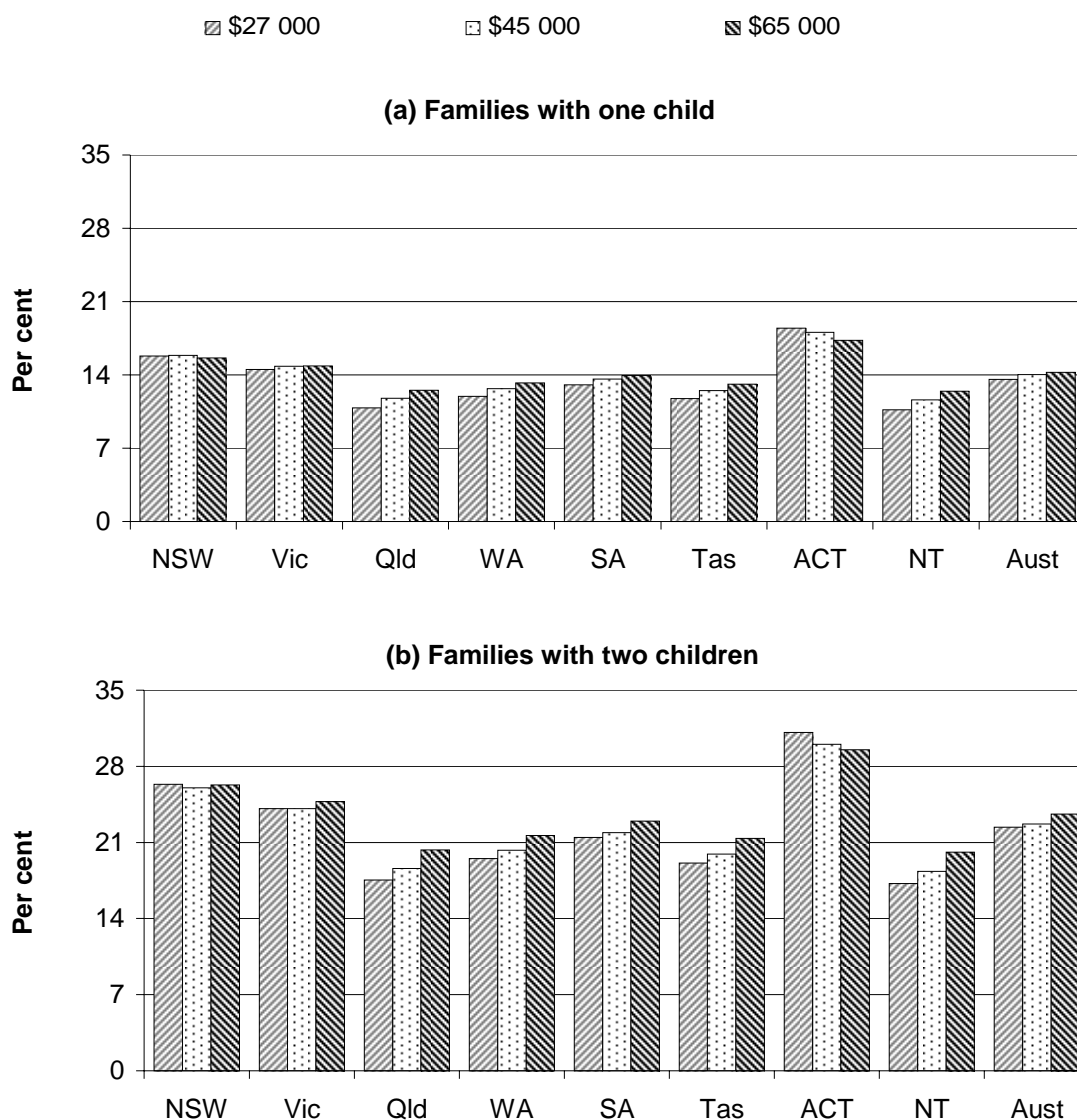


^a Disposable income calculations are based on 20 March 2006 social security rates, Child Care Benefit and taxation parameters. Calculations are modelled on dual income couple families (60:40 income split) with one or two dependent children aged under 5 years. ^b Out-of-pocket cost calculations are based on May 2006 average fees. ^c Data are based on estimated and weighted fee data from the AGCCCS. In 2006, numbers are based on preliminary data and there may be changes to the final data.

Source: AGCCCS May 2006 (unpublished); table 14A.18.

Figure 14.24 shows out-of-pocket costs (after subsidies) in 2006 for centre-based long day care for families with one child and with two children in care across jurisdictions. Out-of-pocket costs (after subsidies) for family day care in 2006 are shown in figure 14.25.

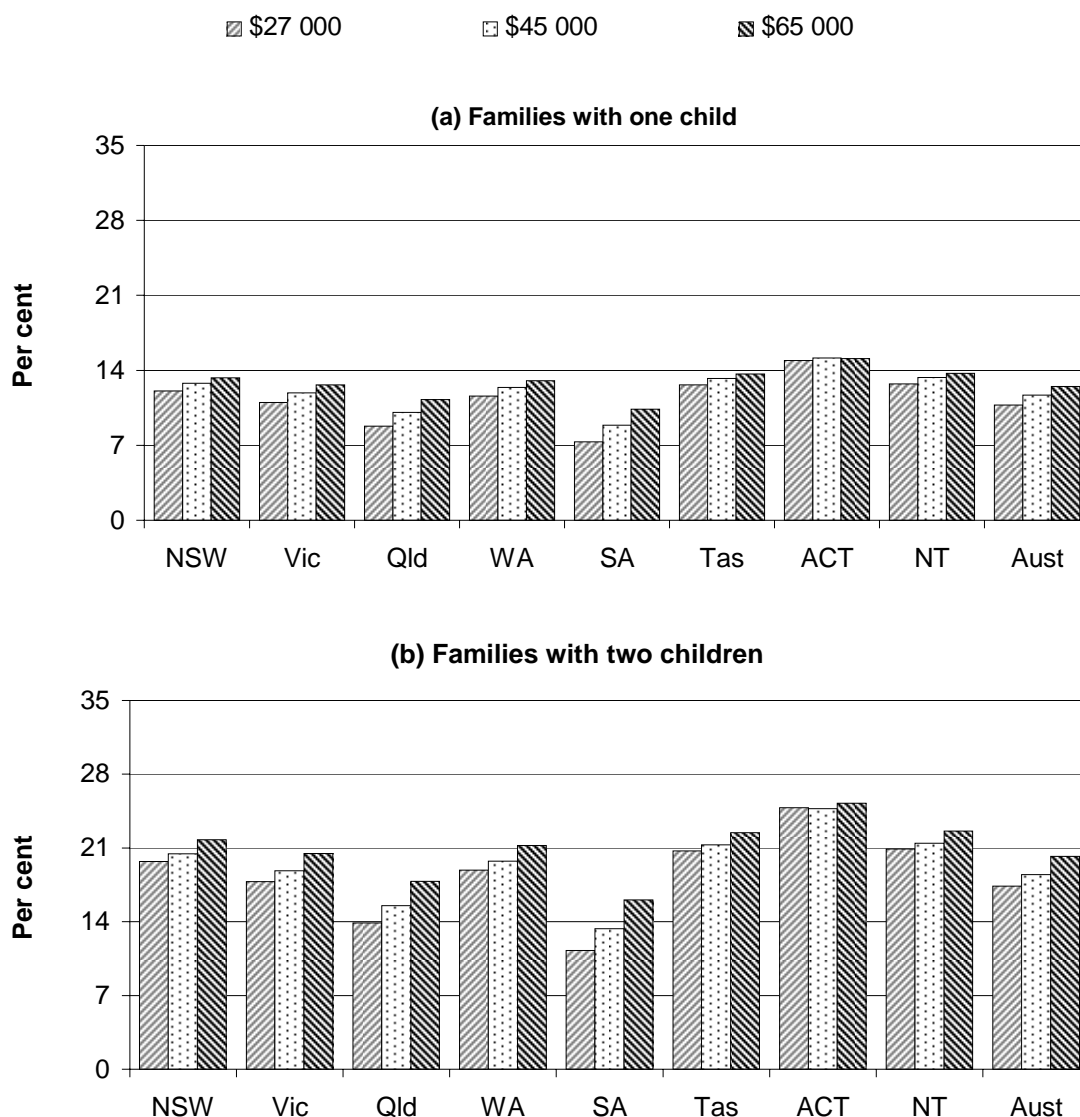
Figure 14.24 **Out-of-pocket costs for centre-based long day care (after subsidies), as a proportion of weekly disposable income, by gross annual family income, 2006^{a, b, c, d, e}**



^a Disposable income calculations are based on 20 March 2006 social security rates, taxation parameters and non-child care benefits, rebates and Medicare. Calculations are modelled on dual income couple families (60:40 income split) with one or two dependent children aged under 5 years. ^b Disposable income figures do not include Child Care Benefit nor have child care out-of-pocket costs been deducted. ^c Average weekly amount paid assumes full-time (50 hours per week) child care used by each child. ^d Care needs to be exercised when interpreting results because a variety of factors may influence fees and the level may not be fully comparable across jurisdictions. ^e Data are based on estimated and weighted fee data from the AGCCCS. In 2006, numbers are based on preliminary data and there may be changes to the final data.

Source: AGCCCS May 2006 (unpublished); table 14A.18.

Figure 14.25 **Out-of-pocket costs for family day care (after subsidies), as a proportion of weekly disposable income, by gross annual family income, 2006^{a, b, c, d, e, f}**



^a Disposable income calculations are based on 20 March 2006 social security rates, taxation parameters and non-child care benefits, rebates and Medicare. Calculations are modelled on dual income couple families (60:40 income split) with one or two dependent children aged under 5 years. ^b Disposable income figures do not include Child Care Benefit nor have child care out-of-pocket costs been deducted. ^c Average weekly amount paid assumes full-time (50 hours per week) child care used by each child. ^d Care needs to be exercised when interpreting results because a variety of factors may influence fees and the level may not be fully comparable across jurisdictions. ^e Excludes in-home care. ^f Data are based on estimated and weighted fee data from the AGCCCS. In 2006, numbers are based on preliminary data and there may be changes to the final data.

Source: AGCCCS May 2006 (unpublished); table 14A.19.

Client satisfaction

‘Client satisfaction’ is an outcome indicator of children’s services meeting users needs (box 14.21).

Box 14.21 Client satisfaction

‘Client satisfaction’ is an outcome indicator of governments’ objective to ensure children’s services meet the needs and expectations of all users.

This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report.

Children’s needs

‘Children’s needs’ is an outcome indicator of children’s services meeting children’s needs (box 14.22).

Box 14.22 Children’s needs

‘Children’s needs’ in children’s services is an outcome (effectiveness) indicator of governments’ objective to provide children’s services that meet the care, education and development needs of children, in a safe and nurturing environment.

This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report.

Cost-effectiveness

‘Cost-effectiveness’ is an outcome indicator of children’s services meeting family needs (box 14.23).

Box 14.23 Cost effectiveness

‘Cost effectiveness’ in children’s services is an outcome (cost effectiveness) indicator of governments’ objective to provide children’s services in an effective and efficient manner.

This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report.

14.4 Future directions in performance reporting

The Steering Committee is committed to improving the comparability, completeness and overall quality of reported data for all indicators included within the performance indicator framework.

Improving reporting of existing indicators

Changes in the children's services industry have required jurisdictions to revise collection methods, and these revisions have reduced the comparability of data across years and across jurisdictions. Further work is planned to improve the consistency and comparability of performance information across jurisdictions. It will take some time before these improvements are reflected in the chapter.

Future indicator development

The Review will continue to improve the appropriateness and completeness of the performance indicator framework. Future work on indicators will focus on:

- developing an access indicator for Indigenous preschool attendance
- revising the quality indicators for health and safety, and substantiated breaches arising from complaints
- developing indicators to measure the extent to which children's services meet family needs, including investigating an outcome indicator of client satisfaction
- developing indicators to measure the extent to which children's services meet children's needs
- completing the quality indicators for licensing, accreditation and registration
- improving the government expenditure efficiency indicators
- conducting a rolling revision of all indicators within the framework.

Improving the completeness and comparability of data

National Minimum Data Set

The National Community Services Information Management Group (NCSIMG) has developed a National Minimum Data Set (NMDS) for children's services. The NMDS provides a framework for collecting a set of nationally comparable data and assists the development of comparable performance indicators and descriptors. It

covers information about the organisations that provide child care and preschool services, the characteristics of workers delivering these services and the characteristics of the children who attend them.

The data items in the NMDS have been pilot tested and were endorsed by the NCSIMG in 2005. The project has since received funding from CDSMAC to conduct a cost benefit analysis of the various implementation options. This analysis is expected to be completed by June 2007.

Data collection

Consistency in the data collected by State and Territory governments is an important goal to improve data comparability. There is still room for improvement in the data collection process. One way of improving comparability is to collect data in a (preferably common) sample week that is representative of a typical standard week (and does not include any public holidays) in each State and Territory.

Another way to improve the consistency of data is to use common definitions. Although the children's service NMDS is yet to be implemented, several jurisdictions are reviewing their statistical collections and incorporating definitions from the NMDS where possible. As the NMDS definitions are more widely adopted in jurisdictions' separate collections, there will be better comparability of data across jurisdictions.

The Council of Australian Governments' (COAG) National Reform Agenda Human Capital Stream includes indicative outcomes about early childhood development. The Steering Committee will monitor the implementation of the National Reform Agenda, including any data developments that are relevant to children's services.

14.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

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The Australian Government, in consultation with the states and territories, has developed the National Agenda for Early Childhood to better coordinate and guide future initiatives in the provision of services for families and children across all levels of government. There are four key action areas: healthy families with young children; early learning and care; supporting families and parenting; and creating child-friendly communities. The Australian Government endorsed the National Agenda in December 2005, and it is currently with the state and territory jurisdictions for endorsement.

In the 2006-07 Budget, the Australian Government announced major changes to child care including:

- the uncapping of Outside School Hours Care and Family Day Care (FDC) places. This means that 99 per cent of child care places are uncapped
- the removal of the limit of one FDC service to a region. Services are now free to operate in any area and FDC carers can register with the service of their choice
- \$50.8 million over four years for the Child Care Compliance Strategy. This initiative will reduce incorrect child care payments to services and families by focussing on education of families and services on their obligations for approved funding and targeting services committing fraud
- increased funding for Jobs, Education and Training (JET) Child Care Fee Assistance, which provides extra help with the cost of approved child care for eligible parents on income support who are undertaking activities such as job search, work, study or rehabilitation. JET Child Care Fee Assistance helps low income parents enter or re-enter the workforce by covering most of the cost of child care fees.

A substantial investment was announced for the new Child Care Management System to better meet the needs of families, service providers and the government. This initiative will standardise and simplify Child Care Benefit (CCB) administration, including the capability to lodge CCB data electronically.

State and Territory based Professional Support Co-ordinators have been established to nationally focus professional support to child care services. Indigenous Professional Support Units also provide advice, support and training to Indigenous-run childcare services and work collaboratively with other service providers to ensure that all child care is culturally appropriate and accessible for Indigenous children and families. Sixty-seven regionally based Inclusion Support Agencies have also been established to coordinate assistance to child care services to build their skills and capacity to include children with additional needs into child care.

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New South Wales Government comments

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The central feature of the NSW Government's Early Childhood Services Policy is its focus on the importance of the early years of life through a system of good quality children's services that are responsive to the needs of children, regardless of their age or service type attended, and in the context of their families and the communities in which they live.

The NSW Government supports a wide range of children's services, including preschools, long day care, occasional care, mobile services, family day care, home based care and vacation care. This support is provided through initiatives including funding, licensing, training and research.

Children's services have been recognised for the benefits they provide for children's healthy development, and for early intervention benefits. Early childhood experiences crucially affect the health and wellbeing of children, and the attainment of further competence at later ages. NSW continues to implement strategies to improve access to and participation in children's services for all children, especially those with additional needs.

The NSW regulatory framework recognises the integrated nature of early childhood education and care. All licensed early childhood services are required by regulation to provide an education program tailored to each child's intellectual, physical, social and emotional development and employ appropriately qualified teaching staff.

For this reason, the structure of the children's services chapter continues to pose difficulties in comparing the performance of NSW with that of other jurisdictions. The chapter is based on distinguishing preschool from child care, which does not reflect the integrated delivery of early childhood education in NSW. NSW urges caution in use or interpretation of these data in relation to the number of children that access a preschool program.

Preschools are an integral part of children's services in NSW. The Government has conducted a comprehensive review of preschool services resulting in the NSW Preschool Investment and Reform Plan.

The NSW Government Plan aims for every four year old in NSW to have access to a quality preschool program. To achieve this, the NSW Government has made a significant investment in strengthening and expanding the services that are available to children in their year prior to school. This investment was announced in the NSW 2006-07 budget, with a total investment in preschool programs over the first four years of \$85 million.

The Plan seeks to strengthen existing community-based services, provide extra places in high need localities and improve access use for disadvantaged families and children. The financial investment will be underpinned by a reform program designed to make the preschool sector more flexible and ultimately more viable. It will also ensure consistency of service across preschools in NSW.

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Victorian Government comments

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In 2005-06 the Department of Human Services undertook a range of initiatives outlined in *A Fairer Victoria*. This included investment of \$101.8 million to improve child and family support services, create a new Office for Children, make kindergarten programs more available in childcare centres, better protect children from abuse and boost support for families most in need of additional assistance.

The Department of Human Services established a register of outside school hours care services and family day care schemes as the first step in moving to regulate these services and commenced work on reviewing the Children's Services Regulations 1998.

Minor capital grants were allocated to community based childcare centres, kindergartens and outside school hours care programs, totalling \$5.9 million.

The 2006-07 Budget provided:

- \$6.2 million in 2006-07 to improve pay and conditions for the State's kindergarten teachers and to improve the quality of kindergarten services for the future. This funding supports the development of a new classification structure to help attract new graduates and introduce a new validation process to assess the skills of kindergarten teachers before they move to higher classifications. This is part of the \$31.2 million wage outcome over four years reached in December 2005
- \$12.5 million over four years allocated to maintain the supplementation of per capita grants to kindergartens to cover the impost of the new wage structure and indexation on fees. This funding will help make kindergarten fees more affordable for families
- \$668 000 over two years to develop new service delivery and quality regulations for outside school hours care and family day care services
- \$7.2 million to contribute to the establishment of children's centres in the six fastest growing municipalities in the State, as part of the *Growing Communities, Thriving Children* initiative.

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Queensland Government comments

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The Queensland Government continues to promote, support and monitor the provision of high quality services for children and families.

Recognising the important role that early childhood education and care services play in the delivery of family support services, the Office for Children was established, drawing together the child care and family support programs of the Queensland Department of Communities. Planning began on the development of a whole of government framework for prevention and early intervention, and exploration of new models of integrated children's services continued, including planning for the development of four integrated early years centres.

The department continues to work collaboratively with the child care sector to enhance and streamline the legislative standards. This has included undertaking a review of the transport provisions in the legislation and implementing an amendment to the Child Care Regulation 2003 and the Queensland Development Code: Part 22 – Child Care Centres. The amendments streamline and clarify legislative requirements and enhance the simplicity and measurability of building standards.

In addition, school age care services have been licensed for the first time in Queensland. To support these services in meeting the licensing standards almost \$370 000 was allocated to 370 services for equipment upgrades.

A significant achievement of the Queensland Government has been the child care training initiatives which, by June 2006, had assisted 2720 child care staff (including trainees and apprentices) to become qualified. Of these graduates, 105 were Indigenous child care professionals working in Far North Queensland. In 2005-06 a key focus of the Child Care Training Plan was to assist staff working in school age care services to complete an approved qualification.

In 2005 and 2006 trials for the implementation of a preparatory year of schooling continued, representing a major reform to the provision of early childhood education in Queensland. In 2007, after 33 years of providing high quality preschool education, Queensland's sessional preschool programs in State and non-State schools will be replaced by the full-time, non-compulsory preparatory year. The Queensland Government will invest up to \$350 million in capital works in both State and non-State schools to implement the preparatory year. The preparatory year will be a school-based provision recognised as the first year of school and will be governed by education legislation and regulations. The community kindergarten sector will move to a targeted one year provision for children in the year prior to the preparatory year. The Queensland Government will continue to support pre-school education through the provision of targeted funding for the community kindergarten sector and funding for pre-preparatory education in identified Indigenous communities.

The Queensland Government continues in its commitment to using data and research to inform planning and decision making and is working towards enhancing the availability, integrity and comparability of data for future reports.

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Western Australian Government comments

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In 2006, the Department for Community Development implemented new child care regulations under the *Children and Community Services Act 2004*.

The implementation of the new regulations will be completed in two stages. Stage one has involved improvements that flowed from the commencement of the *Children and Community Services Act 2004*. The second stage will cover complex issues such as staffing, group sizes, transport and infrastructure. A Child Care Regulations Consultative Committee will provide advice on the further development of the regulations and the consultation process.

The State Government provided additional funding of \$3.6 million over four years into the Child Care Licensing and Standards Unit to allow for an increased emphasis on compliance. The additional funding allowed for: the appointment of a director, a senior legal officer, a new information and reporting officer, increases to the number of licensing staff; and the implementation of an investigation and prosecution team.

The Child Care Advisory Committee reports to the Minister for Community Development and focuses on child care regulations, processes for regulatory changes, and service delivery to Indigenous, rural and remote communities.

The Department completed its 2004-05 contract with the Australian Government to provide training for the outside school hours care sector to implement the *Child Care Services Quality Assurance Program*. A further contract of \$253 060 was awarded for July 2005 to November 2006.

The Department of Education and Training provides access to an 11-hour per week, free, universal kindergarten program for eligible children. The kindergarten year is the first of two pre-compulsory years of schooling with most children attending both years. Twenty eight Aboriginal kindergartens provide culturally appropriate programs with an emphasis on literacy, numeracy and family and community involvement.

The *Western Australian Curriculum Framework* defines the outcomes of schooling for all students from kindergarten to year 12, and is mandated for all schools. For government schools, the *Outcomes and Standards Framework* is used to plan, monitor and improve children's progress and achievements. In the pre-compulsory years the focus is on social, emotional, physical, literacy and numeracy development and learning within an integrated, interactive program.

Other initiatives include: the Home-School Links strategy to build positive relationships between teachers and parents/caregivers; the Pre-primary Profile project to support continuity of education between home, pre-compulsory and compulsory schooling; and the Fundamental Movement Skills project which encourages children's participation in physical activity.

The Literacy and Numeracy Review Taskforce was established this year to improve the literacy and numeracy levels of all students. The Taskforce will consult with the community before presenting its final report.

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South Australian Government comments

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The Department of Education and Children's Services (DECS) continued to meet the challenges of providing responsive, high quality early childhood services for children and their families during 2005-06.

In June 2005, the Government announced the establishment of 10 new Children's Centres for Early Development and Parenting. Each Children's Centre will work with the community to improve health, learning, development, care and wellbeing for children from birth to age eight and their families through responsive, inclusive and integrated programs and services. Three Children's Centres are currently operational with a further three due for completion during 2006. By 2011 at least 20 Children's Centres will be established.

As part of the Early Years Literacy Program, additional funding was provided to preschools with an average enrolment of more than eight Aboriginal three year olds. The provision of this resource was aimed at building upon the learning of Aboriginal three year olds, providing additional professional learning and research opportunities, recognising and promoting current effective practices, and developing sustainable teaching and learning approaches to support the literacy learning of these children.

The Learning Together program continued to increase the number of families engaged in its programs aimed at addressing social, economic and educational inequality. In the 2005-06 State Budget a further \$4.2 million over the next four years was committed by the Government to support the five existing Learning Together early intervention programs delivering expert help for parents and young children at risk.

DECS continued to facilitate access to and participation in preschools for children and families from culturally and linguistically diverse backgrounds through its "Preschool Bilingual Program". During 2005-06, 644 children received bilingual support each term.

A new facility to cater to the special needs of more than 70 students with disabilities officially opened in Adelaide's south. The new facility houses the South Australian School for the Vision Impaired and Kilparrin Teaching and Assessment School and Services. The facility has been designed for students with vision and other sensory impairment and additional disabilities.

In conjunction with the Department of Further Education, Employment, Science and Technology, DECS launched the Upskills program, a joint initiative aimed at increasing the supply of diploma qualified staff in long day care centres. The program enabled 91 child care workers to commence traineeships in the Diploma of Children's Services.

The fourth "Our Children the Future" conference was held in June 2005. This early years conference was held in Adelaide over three days. Over 1200 participants from local, interstate and international destinations attended the conference.

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Tasmanian Government comments

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Over the past five years the Tasmanian Government has gradually been moving away from a model of service provision focussed on the priorities of single Agencies or departments, towards a whole-of-government approach informed by the needs of communities and individuals. In relation to children's services, the key Agencies are increasingly working together to meet the needs of children and families.

Of particular note is the strategic focus on the early years in both the Department of Health and Human Services and the Department of Education and their close collaboration in a number of early childhood development initiatives.

Ongoing work is focussing on developing an overall whole-of-government strategic plan articulating overarching policy goals and developing a shared vision and priorities for action in the early years.

The implementation of the *Child Care Act 2001* is continuing with all centre based care class 1 (0–5 years), approved registration bodies (Family Day Care Schemes) and centre based care class 2 (5–12 years) services licensed. The latter are currently in Stage 2 of a three stage implementation of licensing standards. In consultation with the sector, In-Home Child Care licensing standards have been developed for both the service providers and the carers. These will be implemented in 2006-07 and are understood to be the first of their kind across the nation. Work is continuing with adjunct care services to develop the conditions under which they are exempted from the requirement to be licensed under the Act.

Following amendments to the Act late in 2005, new processes for the assessment of fitness and propriety for child care personnel have also commenced. In addition to streamlining previous processes, the amendments have introduced the concept of a 'responsible person', that is, those persons providing advice and making decisions on behalf of the child care service, who are not the licensee, owner/operator or person-in-charge.

The biggest challenge faced by the Child Care Unit and the sector is the lack of qualified staff further exacerbated by the increasing number of child care services. The Department is continuing to consider both short and long-term strategic ways to assist services in this crisis: through working in consultation with other organisations and peak bodies and implementing funding options, such as mentorship and scholarships and a new initiative, 'Skills to Care', which focuses on supporting newly qualified workers in senior roles and succession planning for child care service management positions.

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Australian Capital Territory Government comments

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The ACT Government has a vision for the children of Canberra that encourages and supports them to reach their full potential. The ACT Children's Plan is the whole of government policy framework for children up to 12 years of age that guides decisions about policies, programs and services for the period 2004-2014. The ACT Children's Plan Community Network Forum was established in 2005 as a forum to foster partnerships between the ACT government and the community in implementing the ACT Children's Plan.

The Children's Services Unit within the Office for Children, Youth and Family Support has responsibility for the licensing and monitoring of children's services in the ACT to ensure 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 playschools. Funding is also provided to assist with a range of children's services programs.

The Office for Children, Youth and Family Support (the Office) within the Department of Disability, Housing and Community Services works in partnership with the community to provide care and protection services to children and young people, and family and community support to meet the needs of the people of Canberra. Services include provision of appropriate care and protection strategies for children and young people, youth justice services, family support activities, and the monitoring and licensing of children's services.

The Office is committed to improving the care and protection of children and young people and actively promotes children and young people's participation in a range of community activities. A strategic focus of the Office is to embed child centred practice in the way it works to support children and families. Children's Services is working collaboratively to support vulnerable children and families through a range of innovative early intervention programs.

The Department of Education and Training is responsible for providing preschool services for all eligible children in the year immediately prior to their entry to school. The ACT Government initiative to increase preschool provision from 10.5 hours to 12 hours per week was supported by a commitment of \$8 million over three years, commencing in 2004. This initiative was fully implemented in 2006 with all preschools offering 12 hours of preschool in either a full day (2 x 6 hours) or half day (3 x 4 hours) program designed to support parental choice.

The ACT Department of Education and Training has developed a new curriculum framework for Preschool to Year 10 which is being trialled and validated in 2007 for implementation in 2008.

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Northern Territory Government comments

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The Territory has a number of characteristics that have resulted in unique approaches to providing children's services in the NT. These characteristics include a small and young population dispersed across one-sixth of the national landmass, a high proportion of the children 0–12 are Indigenous (about 40 per cent) of which 75 per cent live in small remote communities and towns, diseconomies of scale, and environments ranging from desert to tropical climates.

The NT is increasingly focusing attention on improving the health and wellbeing of Indigenous children, supporting families and communities to care for and protect children, strengthening early learning and promoting service integration, quality and viability.

Comparability for reporting purposes continues to be difficult. For example, the data consistently show lower participation levels of Indigenous children in child care services, however the data do not include participation in other children's services and activities such as innovative child care centres, JET creches, mobile services and playgroups which are preferred service models in many Indigenous communities.

New legislation, which gives emphasis to prevention and early intervention measures to promoting children's wellbeing and development, has been drafted. This legislation includes provisions for the regulation of a broader scope of children's services as well as contemporary approaches to investigation and response to child maltreatment.

The NT Government provides access to universal preschool education for four year-old children, and for some three year-olds. At five years of age, children commonly attend all-day universally available transition education. Trials of earlier age of entry to transition and preschool education is continuing across the Territory, enabling children turning four by 30 June to enrol in trial sites in term 1.

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14.6 Definitions of key terms and indicators

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 that administer policy for, fund and license/accredit child care and preschool services in each jurisdiction.
Centre-based long day care	Services aimed primarily at 0–5 year olds that are provided in a centre, usually by a mix of qualified and other staff. Educational, care and recreational programs are provided based on the developmental needs, interests and experience of each child. In some jurisdictions, primary school children may also receive care before and after school, and during school vacations. Centres typically operate for at least eight hours per day on normal working days, for a minimum of 48 weeks per year.
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 hours 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 or younger at 30 June of each year (unless otherwise stated).
Children from low income families	Families who are receiving the maximum rate of Child Care Benefit.
Children from non-English speaking backgrounds	Children living in situations where the main language spoken is not English.
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.
Disability related care	Care of children who have a developmental delay or disability (including a intellectual, sensory or physical impairment), or who have parent(s) with a disability.
External cause (of injury)	The environmental event, circumstance or condition that causes an injury.
Family day care	Services provided in the carer's home. The care is largely aimed at 0–5 year olds, but primary school children may also receive care before and after school, and during school vacations. Central coordination units in all states and territories organise and support a network of carers, often with the help of local governments.
Financial support to families	Any form of fee relief paid by governments to the users of children's services (for example, 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 Child Care Benefit) and/or services for which the government has primary responsibility for delivery.
Hospital separation	An episode of care for a person admitted to a hospital. It can be a total hospital stay (from admission to discharge, transfer or death) or portions of hospital stays beginning or ending in a change of type of care (for example from acute to rehabilitation) that cease during a reference period.
Indigenous Children	Children of Indigenous descent who identify as being Indigenous and are accepted as such by the community in which they live.
Informal child care	Child care arrangements provided privately (for example, by friends, relatives, nannies) for which no government assistance (other than the minimum rate of Child Care Benefit for Registered Care) is provided. Such care is unregulated in most states and territories.
In-home care	Care provided by an approved carer in the child's home. Families eligible for in-home care include those where the parent(s) or child has an illness/disability, those in regional or remote areas, those where the parents are working shift work or non-standard hours, those with multiple births (more than two) and/or more than two children under school age, and those with a breastfeeding mother working from home.
In-service training	Formal training only (that is, structured training sessions that may be conducted in-house or externally), including training in work or own time but not training towards qualifications included in obtaining formal qualifications. It includes: <ul style="list-style-type: none"> • management or financial training • training for additional needs children (such as children with a disability, Aboriginal or Torres Strait Islander children and children from a culturally diverse background) • other child care-related training • other relevant courses (such as a first aid certificate).
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.
Net capital expenditure	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. Capital expenditure does not include expenditure on fixed assets which falls below threshold capitalisation levels, depreciation or costs associated maintaining, renting or leasing equipment.

Non-standard hours of care	<p>Defined by service type as:</p> <ul style="list-style-type: none"> • centre-based long day care — providers of service for more than 10 hours per day on Monday to Friday and/or service on weekends • preschool — providers of service for more than six hours per day • family day care — providers of service for more than 50 hours per week and/or service overnight and/or on weekends • vacation care — providers of service for more than 10 hours per day • before school hours care — providers of service for more than two hours before school • after school care — providers of service for more than three hours after school • occasional care — providers of service for more than eight hours per day • other — providers of service for more than 10 hours per day.
Occasional care	<p>Services usually provided at a centre on an hourly or sessional basis for short periods or at irregular intervals for parents who need time to attend appointments, take care of personal matters, undertake casual and part time employment, study or have temporary respite from full time parenting. These services provide developmental activities for children and are aimed primarily at 0–5 year olds. Centres providing these services usually employ a mix of qualified and other staff.</p>
Other expenditure on service provision	<p>Includes all recurrent expenditure on government funded and/or provided child care and preschool services except administration and financial support to families. It includes one-off, non-capital payments to peak agencies that support child care and preschool service providers.</p>
Other services	<p>Government funded services to support children with additional needs or in particular situations (including children from an Indigenous or non-English speaking background, children with a disability or of parents with a disability, and children living in regional and remote areas).</p>
Outside school hours care	<p>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.</p>
Preschools	<p>Services usually provided by a qualified teacher on a sessional basis in dedicated preschools. Preschool programs or curricula may also be provided in long day care centres and other settings. These services are primarily aimed at children in the year before they commence full time schooling (that is, when children are 4 years old in all jurisdictions), although younger children may also attend in most jurisdictions.</p>
Primary contact staff	<p>Staff whose primary function is to provide care and/or preschool services to children.</p>
Real expenditure	<p>Actual expenditure adjusted for changes in prices. Adjustments were made using the GDP price deflator and expressed in terms of final year prices.</p>
Recurrent expenditure	<p>Expenditure that does not result in the creation or acquisition of fixed assets (new or second hand). It consists mainly of expenditure on wages, salaries and supplements, purchases of goods and services, and the consumption of fixed capital (depreciation).</p>

Regional and remote areas	<p>Geographic location is based on the ABS's Australian Standard Geographical Classification of Remoteness Areas, which categorises areas as 'major cities', 'inner regional', 'outer regional', 'remote', 'very remote' and 'migratory'. The criteria for remoteness areas are based on the Accessibility/Remoteness Index of Australia, which measures the remoteness of a point based on the physical road distance to the nearest urban centre in each of five size classes (ABS 2001).</p> <p>The 'regional' classification used in this chapter was derived by adding data for inner regional and outer regional areas. The 'remote' classification was derived by adding data for remote, very remote and migratory areas.</p> <p>In previous reports, geographic location data was based on the rural, remote and metropolitan areas classification (DPIE and DSHS 1994).</p>
Serious injury	Injury requiring hospitalisation or a visit to (or by) a doctor.
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	<p>The categories for which data were collected, namely:</p> <ul style="list-style-type: none"> • centre-based long day care • family day care • outside school hours care <ul style="list-style-type: none"> – vacation care – before/after school care • occasional care • 'other' care • preschool services.
Special needs group	An identifiable group within the general population who may have special difficulty accessing services. Special needs groups for which data are reported in this chapter include: children from a non-English speaking background, Indigenous children, children from low income families (Australian Government child care only), children with a disability, and children from regional or remote areas.
Substantiated breach arising from a complaint	An expression of concern about a child care or preschool service, made orally, in writing or in person to the regulatory authority, 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.

14.7 Supporting tables

The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2007\Attach14A.xls and in Adobe PDF format as \Publications\Reports\2007\Attach14A.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

All jurisdictions data

Table 14A.1	Estimated resident population, children aged 12 years and younger ('000)
Table 14A.2	Progress in the Quality Improvement and Accreditation System, Family Day Care Quality Assurance, and Outside School Hours Care Quality Assurance, Australia (number)
Table 14A.3	Australian Government real expenditure on children's services (2005-06 dollars) (\$'000)
Table 14A.4	Total government real expenditure on children's services (2005-06 dollars) (\$'000)
Table 14A.5	State and Territory Government real expenditure on child care and preschool services (2005-06 dollars) (\$'000)
Table 14A.6	Comparability of expenditure — items included, 2005-06
Table 14A.7	Treatment of assets by children's services agencies, 2005-06
Table 14A.8	Places provided by Australian Government approved child care services (number)
Table 14A.9	Average attendance at Australian Government approved child care services
Table 14A.10	Children aged 0–12 years using Australian Government approved child care services
Table 14A.11	Children aged 0–5 years using State and Territory Government funded and/or provided preschool services, by age
Table 14A.12	Staff employed by Australian Government approved child care services
Table 14A.13	Paid primary contact staff employed by Australian Government approved child care services, by qualification
Table 14A.14	Staff in Australian Government approved child care services who undertook relevant in-service training in previous 12 months
Table 14A.15	Children aged 0–11 years using services, by employment status of parents (per cent)
Table 14A.16	Service availability during non-standard hours for Australian Government approved child care services (per cent)
Table 14A.17	Utilisation rates, centre-based long day care and family day care, 2006 (per cent)
Table 14A.18	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 incomes, May 2006 (per cent)

Table 14A.19	Out-of-pocket costs of child care for families with children in full time family day care, as a proportion of weekly disposable income, by gross annual family incomes, May 2006 (per cent)
Table 14A.20	Representation of special needs groups in attendees at Australian Government approved child care services (per cent)
Table 14A.21	Australian Government expenditure on child care services per child aged 0–12 years (2005-06 dollars) (\$/child)
Table 14A.22	Total State/Territory government real expenditure on children's services per child aged 0–12 years (2005-06 dollars) (\$/child)
Table 14A.23	Children aged 0–11 years by whether (additional) preschool or formal care was required in the previous four weeks, 2002, 2005
Table 14A.24	Children aged 0–11 years who required (additional) preschool or formal care by main reason required, 2002, 2005
Table 14A.25	Children aged 0–11 years by main reason (additional) preschool or formal care required in the previous four weeks, not used, 2002, 2005
Table 14A.26	Average fees charged by Australian Government funded services, 2004 and 2006 (\$/week) (2006 dollars)
Table 14A.27	Children who attended preschool, weekly cost per child (after subsidies), 2002, 2005
Table 14A.28	Hospital separations for external cause of injuries, persons aged 0–4 years, all hospitals, by place of occurrence

Single jurisdiction data – NSW

Table 14A.29	State Government real expenditure on child care and preschool services, New South Wales (2005-06 dollars) (\$'000)
Table 14A.30	Characteristics of child care and preschool services not included in the Australian Government Census of Child Care Services, New South Wales
Table 14A.31	Children aged 0–12 years using State Government funded and/or provided child care and preschool services, by age, New South Wales
Table 14A.32	Staff employed by State Government funded and/or managed child care and preschool service providers, New South Wales
Table 14A.33	Paid staff employed by State Government funded and/or managed child care and preschool service providers, by qualification and experience, New South Wales
Table 14A.34	Licensed and/or registered service providers, by management type, New South Wales
Table 14A.35	Service availability during non-standard hours and participation by target groups, New South Wales
Table 14A.36	Number of serious injuries sustained per registered or licensed service provider, New South Wales
Table 14A.37	Substantiated breaches arising from complaints about State Government registered or licensed service providers, New South Wales

Single jurisdiction data – Vic

Table 14A.38	State Government real expenditure on child care and preschool services, Victoria (2005-06 dollars) (\$'000)
Table 14A.39	Characteristics of child care and preschool services not included in the Australian Government Census of Child Care Services, Victoria
Table 14A.40	Children aged 0–12 years using State Government funded and/or provided child care and preschool services, by age, Victoria
Table 14A.41	Staff employed by State Government funded and/or managed child care and preschool service providers, Victoria
Table 14A.42	Paid staff employed by State Government funded and/or managed child care and preschool service providers, by qualification and experience, Victoria
Table 14A.43	Licensed and/or registered service providers, by management type, Victoria
Table 14A.44	Service availability during non-standard hours and participation by target groups, Victoria
Table 14A.45	Number of serious injuries sustained per registered or licensed service provider, Victoria
Table 14A.46	Substantiated breaches arising from complaints about State Government registered or licensed service providers, Victoria

Single jurisdiction data – Qld

Table 14A.47	State Government real expenditure on child care and preschool services, Queensland (2005-06 dollars) (\$'000)
Table 14A.48	Characteristics of child care and preschool services not included in the Australian Government Census of Child Care Services, Queensland
Table 14A.49	Children aged 0–12 years using State Government funded and/or provided child care and preschool services, by age, Queensland
Table 14A.50	Staff employed by State Government funded and/or managed child care and preschool service providers, Queensland
Table 14A.51	Paid staff employed by State Government funded and/or managed child care and preschool service providers, by qualification and experience, Queensland
Table 14A.52	Licensed and/or registered service providers, by management type, Queensland
Table 14A.53	Service availability during non-standard hours and participation by target groups, Queensland
Table 14A.54	Number of serious injuries sustained per registered or licensed service provider, Queensland
Table 14A.55	Substantiated breaches arising from complaints about State Government registered or licensed service providers, Queensland

Single jurisdiction data – WA

Table 14A.56	State Government real expenditure on child care and preschool services, Western Australia (2005-06 dollars) (\$'000)
Table 14A.57	Characteristics of child care and preschool services not included in the Australian Government Census of Child Care Services, Western Australia

Table 14A.58	Children aged 0–12 years using State Government funded and/or provided child care and preschool services, by age, Western Australia
Table 14A.59	Staff employed by State Government funded and/or managed child care and preschool service providers, Western Australia
Table 14A.60	Paid staff employed by State Government funded and/or managed child care and preschool service providers, by qualification and experience, Western Australia
Table 14A.61	Licensed and/or registered service providers, by management type, Western Australia
Table 14A.62	Service availability during non-standard hours and participation by target groups, Western Australia
Table 14A.63	Number of serious injuries sustained per registered or licensed service provider, Western Australia
Table 14A.64	Substantiated breaches arising from complaints about State Government registered or licensed service providers, Western Australia

Single jurisdiction data – SA

Table 14A.65	State Government real expenditure on child care and preschool services, South Australia (2005-06 dollars) (\$'000)
Table 14A.66	Characteristics of child care and preschool services not included in the Australian Government Census of Child Care Services, South Australia
Table 14A.67	Children aged 0–12 years using State Government funded and/or provided child care and preschool services, by age, South Australia
Table 14A.68	Staff employed by State Government funded and/or managed child care and preschool service providers, South Australia
Table 14A.69	Paid staff employed by State Government funded and/or managed child care and preschool service providers, by qualification and experience, South Australia
Table 14A.70	Licensed and/or registered service providers, by management type, South Australia
Table 14A.71	Service availability during non-standard hours and participation by target groups, South Australia
Table 14A.72	Number of serious injuries sustained per registered or licensed service provider, South Australia
Table 14A.73	Substantiated breaches arising from complaints about State Government registered or licensed service providers, South Australia

Single jurisdiction data – Tas

Table 14A.74	State Government real expenditure on child care and preschool services, Tasmania (2005-06 dollars) (\$'000)
Table 14A.75	Characteristics of child care and preschool services not included in the Australian Government Census of Child Care Services, Tasmania
Table 14A.76	Children aged 0–12 years using State Government funded and/or provided child care and preschool services, by age, Tasmania
Table 14A.77	Staff employed by State Government funded and/or managed child care and preschool service providers, Tasmania

Table 14A.78	Paid staff employed by State Government funded and/or managed child care and preschool service providers, by qualification and experience, Tasmania
Table 14A.79	Licensed and/or registered service providers, by management type, Tasmania
Table 14A.80	Service availability during non-standard hours and participation by target groups, Tasmania
Table 14A.81	Quality indicators: number of serious injuries sustained per registered or licensed service provider, Tasmania
Table 14A.82	Substantiated breaches arising from complaints about State Government registered or licensed service providers, Tasmania

Single jurisdiction data – ACT

Table 14A.83	State Government real expenditure on child care and preschool services, Australian Capital Territory (2005-06 dollars) (\$'000)
Table 14A.84	Characteristics of child care and preschool services not included in the Australian Government Census of Child Care Services, Australian Capital Territory
Table 14A.85	Children aged 0–12 years using State Government funded and/or provided child care and preschool services, by age, Australian Capital Territory
Table 14A.86	Staff employed by State Government funded and/or managed child care and preschool service providers, Australian Capital Territory
Table 14A.87	Paid staff employed by State Government funded and/or managed child care and preschool service providers, by qualification and experience, Australian Capital Territory
Table 14A.88	Licensed and/or registered service providers, by management type, Australian Capital Territory
Table 14A.89	Service availability during non-standard hours and participation by target groups, Australian Capital Territory
Table 14A.90	Number of serious injuries sustained per registered or licensed service provider, Australian Capital Territory
Table 14A.91	Substantiated breaches arising from complaints about State Government registered or licensed service providers, Australian Capital Territory

Single jurisdiction data – NT

Table 14A.92	State Government real expenditure on child care and preschool services, Northern Territory (2005-06 dollars) (\$'000)
Table 14A.93	Characteristics of child care and preschool services not included in the Australian Government Census of Child Care Services, Northern Territory
Table 14A.94	Children aged 0–12 years using State Government funded and/or provided child care and preschool services, by age, Northern Territory
Table 14A.95	Staff employed by State Government funded and/or managed child care and preschool service providers, Northern Territory
Table 14A.96	Paid staff employed by State Government funded and/or managed child care and preschool service providers, by qualification and experience, Northern Territory
Table 14A.97	Licensed and/or registered service providers, by management type, Northern Territory

Table 14A.98	Service availability during non-standard hours and participation by target groups, Northern Territory
Table 14A.99	Number of serious injuries sustained per registered or licensed service provider, Northern Territory
Table 14A.100	Substantiated breaches arising from complaints about State Government registered or licensed service providers, Northern Territory

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15 Protection and support services

Protection and support services aim to assist individuals and families who are in crisis or experiencing difficulties that hinder personal or family functioning. These services assist by alleviating the difficulties and reducing the potential for their recurrence.

This chapter reports on:

- *child protection services*: the functions of government that receive and assess allegations of child abuse and neglect, and/or harm to children and young people, provide and refer clients to family support and other relevant services, and intervene to protect children
- *out-of-home care services*: care for children placed away from their parents for protective or other family welfare reasons
- *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. A framework of performance indicators is outlined in section 15.2 and data are discussed in section 15.3. Future directions in child protection and out-of-home care performance reporting are outlined in section 15.4.

A profile of supported accommodation and assistance services funded under the Supported Accommodation Assistance Program (SAAP) appears in section 15.5. A framework of performance indicators for these services is outlined in section 15.6 and data are discussed in section 15.7. Future directions in SAAP performance reporting are discussed in section 15.8.

Jurisdictions' comments on both child protection and out-of-home care services, and supported accommodation and assistance services are reported in section 15.9. Definitions of data descriptors and indicators are provided in section 15.10. A list of supporting tables is provided in section 15.11. Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 15A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Section 15.12 lists references used in this chapter.

15.1 Profile of child protection and out-of-home care services

Service overview

Child protection services

Child protection services are provided to protect children and/or young people aged 0–17 years who are at risk of harm within their families, or whose families do not have the capacity to protect them. These services include:

- receiving and responding to reports of concern about children or young people, including investigation and assessment where appropriate
- providing support services (directly or through referral), where harm or a risk of significant harm is identified, to strengthen the capacity of families to care safely for children
- initiating intervention where necessary, including applying for a care and protection order through a court and, in some situations, placing children or young people in out-of-home care to secure their safety
- ensuring the ongoing safety of children and young people by working with families to resolve protective concerns
- working with families to reunite children (who were removed for safety reasons) with their parents as soon as possible (in some jurisdictions, restoration may occur in voluntary placements as well)
- securing permanent out-of-home/alternative care when it is determined that a child is unable to be returned to the care of his or her parents, and working with young people to identify alternative supported living arrangements where family reunification is not possible.

Research suggests that children and families who come into contact with the protection and support system often share common social and demographic characteristics. Families with low incomes or that are reliant on pensions and benefits, those that experience alcohol and substance abuse, or a psychiatric disability, and those that have a family history of domestic violence are over represented in the families that came into contact with the protection and support system (Department of Human Services 2002). Studies have also highlighted the high incidence of child abuse and neglect within some Indigenous communities, compared with non-Indigenous communities. These studies include the final report of the WA Inquiry into Response by Government Agencies to Complaints of

Family Violence and Child Abuse in Aboriginal Communities (Gordon Report 2002), which found high levels of violence and child abuse within Aboriginal communities in WA, and Family violence among Aboriginal and Torres Strait Islander peoples (AIHW 2006a), which found that Indigenous families across Australia experienced high levels of violence, compared with non-Indigenous families.

Out-of-home care services

Out-of-home care services provide care for children and young people aged 0–17 years who are placed away from their parents or family home for reasons of safety or family crisis. These reasons include abuse, neglect or harm, illness of a parent and the inability of parents to provide adequate care. The placements may be voluntary or made in conjunction with care and protection orders.

Out-of-home care services are either home-based care (for example, foster care, care with the child's extended family or other home-based arrangements), facility-based care (for example, community residential care) or independent living (which is often intensively supported) as a transition to full independence or supported placements. Across jurisdictions, there has been a shift away from the use of facility-based (or residential) care towards foster care and other forms of home-based care, including relative/kinship care. Intensive family support services are increasingly perceived as an alternative to the removal of the child from his or her home for child protection reasons (box 15.1).

Box 15.1 Intensive family support services

Intensive family support services are specialist services, established in each jurisdiction, that aim to:

- prevent the imminent separation of children from their primary caregivers as a result of child protection concerns
- reunify families where separation has already occurred.

Intensive family support services differ from other types of child protection and family support services referred to in this chapter, in that they:

- are funded or established explicitly to prevent the separation of, or to reunify, families
- provide a range of services as part of an integrated strategy focusing on improving family functioning and skills, rather than providing a single type of service

(Continued on next page)

Box 15.1 (Continued)

- are intensive in nature, averaging at least four hours of service provision per week for a specified short term period (usually less than six months)
- generally receive referrals from a child protection service.

Intensive family support services may use some or all of the following strategies: assessment and case planning; parent education and skill development; individual and family counselling; anger management; respite and emergency care; practical and financial support; mediation, brokerage and referral services; and training in problem solving.

Expenditure data indicate that recurrent expenditure on intensive family support services across all jurisdictions was at least \$119.8 million in 2005-06. This expenditure has increased in real terms each year from \$64.0 million in 2001-02 (table 15A.21). This represents an average annual increase in expenditure of 16.9 per cent over this four year period. Tables 15A.21–24 provide additional information about families and children who were involved with intensive family support services during 2005-06.

A complementary suite of services not currently included in this Report, but intended for inclusion in future Reports, are known as child protection treatment and support services. These are targeted to at-risk families where there are concerns about the safety and wellbeing of children. They may be less intensive in nature and include services that strengthen family relationships in response to concerns about the welfare of a child and may have either an early intervention or support reunification orientation.

Child protection treatment and support services provide educational services, clinical services including counselling, group work and other therapeutic interventions, and domestic violence services, where the child is the direct recipient of the service and s/he is, has, or is likely to become, a client of child protection.

Source: Australian Institute of Health and Welfare (AIHW) (unpublished).

Roles and responsibilities

State and Territory governments fund child protection, out-of-home care, family support (including intensive family support) and other relevant services. These services may be delivered by the government or the non-government sector. State and Territory community services departments are responsible for investigating and assessing reports to the department, providing, or referring families to, support services, and intervening where necessary (including making court applications when an order is required to protect a child and placing children in out-of-home care).

Other areas of government also have 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, and may also work on child protection assessments with State and Territory community services departments
- courts, which decide whether a child will be placed on an order
- education and child care services, which provide services for these children and also conduct mandatory reporting and protective behaviours education in some jurisdictions
- health services, which support the assessment of child protection matters and deliver therapeutic, counselling and other services.

A range of appointments, schemes and charters have been introduced by jurisdictions in recent years, to enable additional protection for clients of the child protection system. Examples of these are listed in box 15.2.

Box 15.2 Initiatives in place to enable additional protection for clients

<i>NSW</i>	The Commission for Children and Young People initiates and influences broad and positive change for children and young people. The Office of the Children's Guardian promotes the best interests and rights of all children in out-of-home care, through accreditation and monitoring of out-of-home care agencies to ensure services are of the highest standard.
<i>Vic</i>	The Child Safety Commissioner promotes child safe practices and environments across the community. Part of his role is to monitor the quality of out-of-home care services. A charter of rights for children in care is near completion.
<i>Qld</i>	The Commission for Children and Young People and the Child Guardian provides a Community Visitor Scheme, investigates complaints and undertakes systemic monitoring and auditing of services. A Departmental complaints system has also been established in the Department of Child Safety.
<i>WA</i>	A charter of rights for children in care has been developed in consultation with children and young people in care and non-government organisations. The Advocate for Children in Care provides advocacy and complaints management services for children and young people in care. A Standards Monitoring Unit was established in April 2006 to develop and monitor standards for protection and care.

(Continued on next page)

Box 15.2 (Continued)

SA	The Office of the Guardian monitors and assesses care, and advocates for, and advises on, the circumstances and needs of children and systemic issues affecting the quality of out-of-home care.
Tas	The Commissioner for Children's functions include promoting the rights and well-being of children, examining the policies, practices and services provided for children and any laws affecting the health, welfare, care, protection and development of children.
ACT	The ACT Public Advocate's functions include monitoring the provision of services, and protecting and acting as an advocate for the rights of children and young people. The Public Advocate must refer systemic issues concerning young people to the Human Rights Commission for consideration. The Official Visitors' role is to investigate complaints made by or on behalf of children and young people in institutions or shelters concerning their care. The Commissioner for Human Rights and Discrimination ensures the rights of children and young people are upheld.
NT	A review of the NT Community Welfare Act has resulted in draft legislation which is before the NT Legislative Assembly. Children's Commissioner and child death review functions are being considered.

Source: State and Territory governments (unpublished).

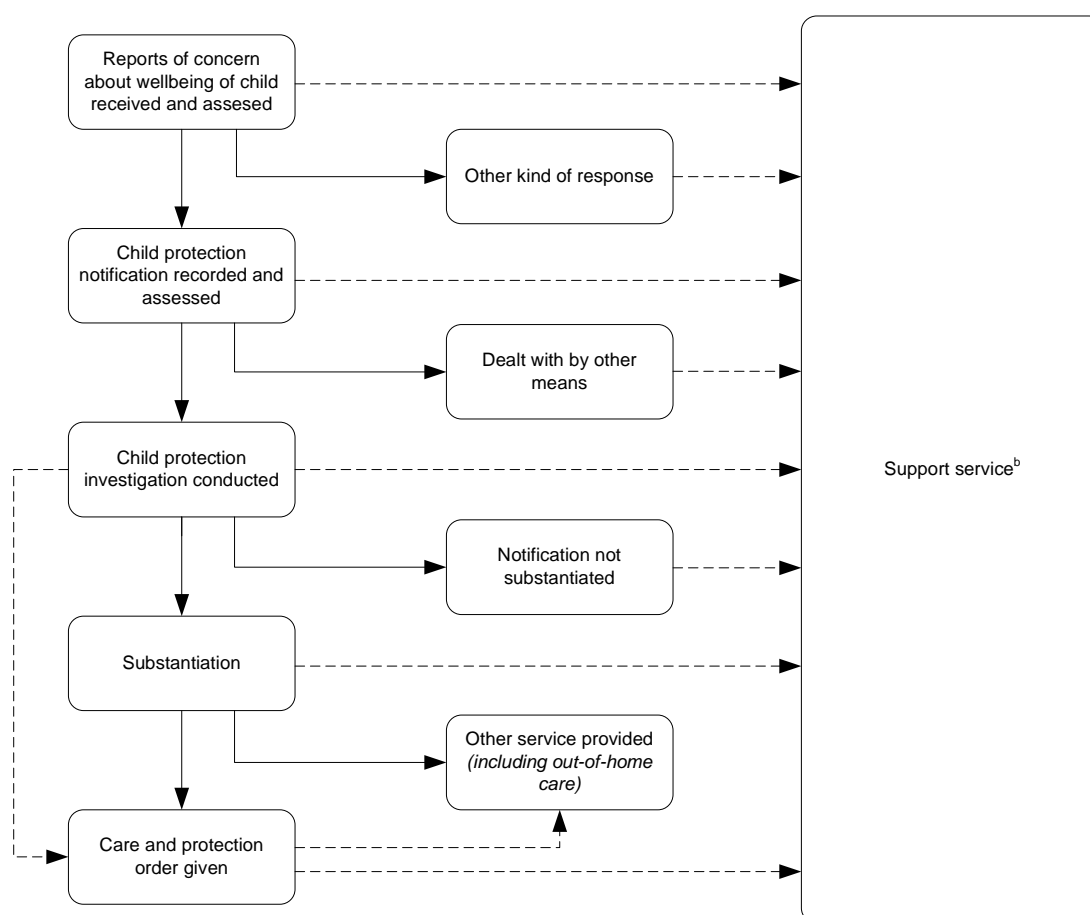
Size and scope

The child protection system

Child protection legislation, policies and practices vary across jurisdictions, but the broad processes in child protection systems are similar (figure 15.1).

State and Territory community services departments are advised of concerns about the wellbeing of children through reports to these departments. 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 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 2004-05 were school personnel, police, parents and guardians, other relatives and friends, and neighbours (AIHW 2006b).

Figure 15.1 The child protection system^a



^a Dashed lines indicate that clients may or may not receive these services, depending on need. ^b Support services include family support or family preservation services provided by community service departments and referrals to other agencies.

Notification

Jurisdictions count notifications at different points in the response to a report, ranging from the point of initial contact with the source of the report to the end of a screening and decision making process. This means the number of notifications is not strictly comparable across jurisdictions.¹

All jurisdictions except Victoria, Tasmania, the ACT and the NT screen incoming reports before deciding whether they will be counted as a notification, thus reducing

¹ Child protection services, care and protection orders and out-of-home care relate to children aged 0–17 years. Rates of children subject to 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.

the proportion of reports that become notifications. WA undertakes a further screening process designed to differentiate between reports about harm/maltreatment and child and family concerns. This further reduces the number of notifications, as only reports about child harm/maltreatment are included in this Report.

In all jurisdictions, notifications are investigated, based on the policies and practices in that jurisdiction. Once it has been decided that an investigation is required, the investigation process is similar across jurisdictions. The community services department may obtain further information about the child and his or her family by checking information systems for any previous history, undertaking discussion/case planning with agencies and individuals, interviewing/sighting the child and/or interviewing the caregivers/parents. At a minimum, the child is sighted whenever practicable, and the child's circumstances and needs are assessed. This investigation process determines whether the notification is substantiated or not substantiated (figure 15.1).

Nationally, 165 586 children aged 0–16 years were the subject of child protection notifications in 2005-06, although notifications are defined differently across jurisdictions. Nationally, the rate of notifications per 1000 children in the population aged 0–16 years was 36.5 in 2005-06 (table 15A.8). The total number of notifications for each jurisdiction for 2005-06 (including cases where a child is the subject of more than one child protection notification) is identified in table 15A.5.

Data on the number of notifications are collected early in the child protection process and often before the agency has full knowledge of the child's family circumstances. This lack of information and the inherent difficulties in identifying Indigenous status mean that data on the number of notifications by Indigenous status (table 15A.8) need to be interpreted with care due to low reliability.

Substantiation

The criteria for substantiation vary across jurisdictions. In the past, child protection legislation and policy focused on the identification and investigation of narrowly defined incidents that were broadly grouped as types of abuse or neglect. Across all jurisdictions, however, the focus is shifting away from the actions of parents and guardians, toward the desired outcomes for the child, the identification and investigation of actual and/or likely harm to the child, and the child's needs.

If an investigation results in substantiation, intervention by the relevant community services department may be needed to protect the child. This intervention can take a number of forms, including one or more of referral to other services, supervision and support, an application to court, and a placement in out-of-home care.

Nationally, 34 336 children aged 0–16 years were the subject of a substantiation in 2005-06. The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–16 years was 7.6 (table 15A.8). The number and rate of children aged 0-16 years who were the subject of a substantiation has increased since 2001-02. Nationally, 25 313 children were the subject of a substantiation in 2001-02, which represented a rate of 5.7 per 1000 children in the population aged 0-16 years (SCRCSSP 2003a).

Nationally, 6033 Indigenous and 28 303 non-Indigenous children were the subject of a substantiation in 2005-06. The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–16 years was 29.5 for Indigenous children and 6.5 for non-Indigenous children (table 15A.8). The total number of substantiations for 2005-06 (including cases where a child is the subject of more than one substantiation) is identified at table 15A.5.

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.

Nationally, 27 188 children aged 0–17 years were on care and protection orders at 30 June 2006. The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 5.6 (table 15A.8). The number and rate of children aged 0-17 years who were the subject of a care and protection orders has increased since 2001-02. At 30 June 2002, 20 557 children were the subject of a care and protection order, which represented a rate of 4.3 per 1000 children in the population aged 0-17 years (SCRCSSP 2003a).

Nationally, 6520 Indigenous and 20 668 non-Indigenous children were on care and protection orders at 30 June 2006. The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 29.9 for Indigenous children and 4.5 for non-Indigenous children (table 15A.8). Further information on children on care and protection orders is included in the attachment tables to this Report. Table 15A.6 identifies the number of children admitted to and discharged from care and protection orders by Indigenous status, 2005-06. Table 15A.7 identifies the number of children on care and protection orders at by type of order and Indigenous status at 30 June 2006.

Out-of-home care

Out-of-home care is one of a range of services provided to families and children where there is a need to provide safe care for a child. The services are intended to place a child in out-of-home care only if this will improve the outcome for the child and only when it is not possible to maintain the child within their family. If it is necessary to remove the child from his or her home, then placement with the wider family or community is sought where possible, particularly in the case of Indigenous children (AIHW 2006b). Continued emphasis is 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.

Nationally, 25 454 children were in out-of-home care at 30 June 2006. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 5.3 (table 15A.11). The number and rate of children aged 0–17 years in out-of-home care has increased since 2001-02. At 30 June 2002, 18 880 children were in out-of-home care, which represented a rate of 4.0 per 1000 children in the population aged 0–17 years (SCRCSSP 2003a).

Nationally, 6497 Indigenous children and 18 957 non-Indigenous children were in out-of-home care at 30 June 2006. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 29.8 for Indigenous children and 4.1 for non-Indigenous children (table 15A.11). Further information on children in out-of-home care is included in the attachment tables to this Report. Table 15A.12 identifies the number of children in out-of-home care by Indigenous status and placement type as at 30 June 2006. Table 15A.13 identifies the number of children in out-of-home care by Indigenous status and whether on a care and protection order as at 30 June 2006. Table 15A.14 identifies the number of children in out-of-home care by Indigenous status and length of time in continuous out-of-home care as at 30 June 2006. Table 15A.15 identifies the number of children who exited care during the year 2005-06 by Indigenous status and length of time spent in care.

Funding

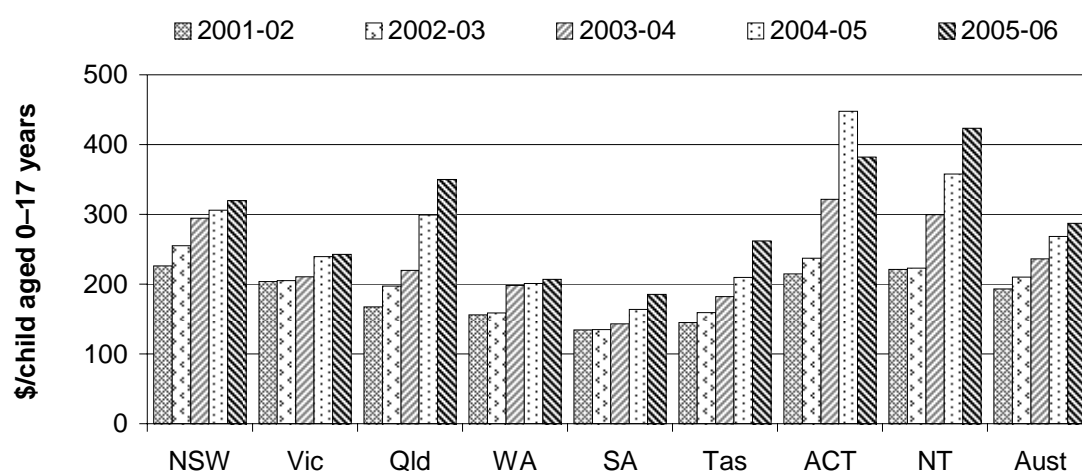
Recurrent expenditure on child protection and out-of-home care services was at least \$1.4 billion across Australia in 2005-06 — a real increase of \$96.2 million (7.5 per cent) from 2004-05. Nationally, out-of-home care services accounted for the majority (61.9 per cent, or \$857.8 million) of this expenditure. Some jurisdictions have difficulty in separating expenditure on child protection from expenditure on out-of-home care services. Nationally, annual real expenditure on

child protection and out-of-home care services has increased by \$453.9 million from \$930.9 million since 2001-02, an average annual increase over the four year period of 10.4 per cent (table 15A.1).

Nationally, real recurrent expenditure per child aged 0–17 years on child protection and out-of-home care services was \$287.11 in 2005-06 (figure 15.2). Real recurrent expenditure per child aged 0–17 years increased in all jurisdictions between 2001-02 and 2005-06 and has increased nationally each year since 2001-02. In 2001-02 the real recurrent expenditure per child aged 0–17 years was \$193.24 (table 15A.1). This represents an average annual increase over the four year period of 10.4 per cent.

It is an objective of the Review to report comparable estimates of costs. Ideally, the full range of costs to government would be determined on a comparable basis across jurisdictions. Where full costs cannot be counted, costs should be estimated on a consistent basis across jurisdictions. In the area of child protection, however, there are differences across jurisdictions in the calculation of expenditure. Table 15A.4 identifies the level of consistency across jurisdictions for a number of expenditure items. The scope of child protection systems also varies across jurisdictions, and expenditure on some services may be included for some jurisdictions, but not for others.

Figure 15.2 Real recurrent expenditure on child protection and out-of-home care services (2005-06 dollars)



Source: State and Territory governments (unpublished); table 15A.1.

15.2 Framework of performance indicators for child protection and out-of-home care services

The framework of performance indicators for child protection and out-of-home care services is based on shared government objectives (box 15.3).

Box 15.3 Objectives for child protection and out-of-home care services

The aims of child protection services are to:

- protect children and young people at risk of harm within their family or in circumstances in which the family of the child or young person does not have the capacity to protect them
- assist families to protect children and young people.

The aim of out-of-home care services is to provide quality care for children and young people aged 0–17 years who cannot live with their parents for reasons of safety or family crisis.

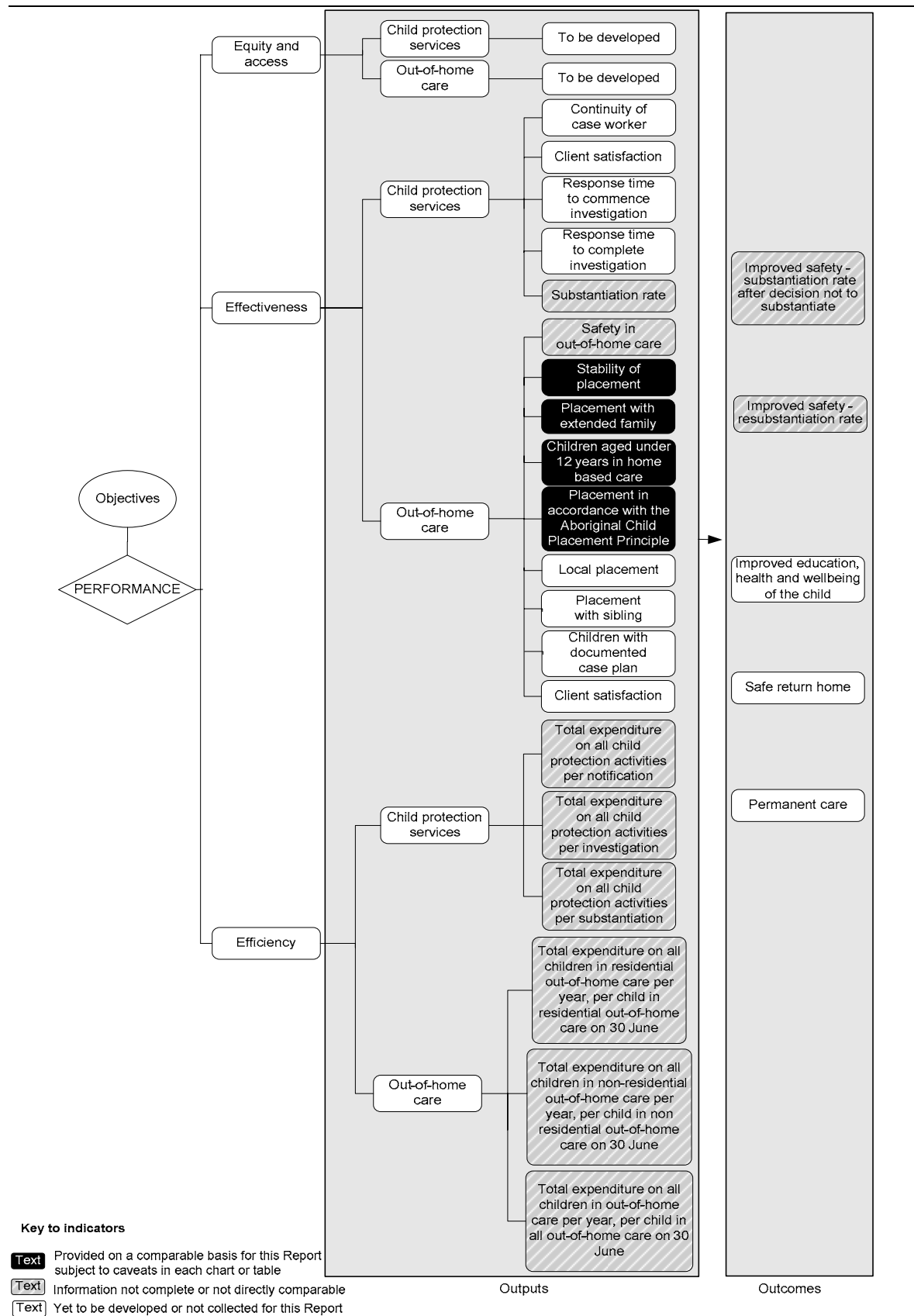
Child protection and out-of-home care services should be provided in an efficient and effective manner.

The performance indicator framework shows which data are comparable in the 2007 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The performance indicator framework and those indicators that are comparable in the 2007 Report are shown in figure 15.3.

15.3 Key child protection and out-of-home care services performance indicator results

Different delivery contexts, locations and types of client may affect the equity/access, effectiveness and efficiency of child protection services. Appendix A contains detailed statistics that may assist in interpreting the performance indicators.

Figure 15.3 Performance indicators for child protection and out-of-home care services



In the 2007 Report, experimental data is included for the first time in relation to the ‘pathways’ project. This project develops an activity-based costing methodology to calculate efficiency indicators for child protection and out-of-home care services. The existing proxy indicators will remain in place until the pathways project is further developed.

Outputs

Equity and access

Equity and access indicators are a key area for further development in future reports (box 15.4).

Box 15.4 Access to child protection and out-of-home care services by equity groups

These will be indicators of governments’ objective to ensure that all clients have fair and equitable access to services on the basis of relative need and available resources. These indicators are under development.

Effectiveness

Child protection services — continuity of case worker

‘Continuity of case worker’ is an output indicator of the effectiveness of child protection services (box 15.5).

Box 15.5 Continuity of case worker

‘Continuity of case worker’ is an output indicator of governments’ objective to ensure child protection services are delivered in an effective manner. The turnover of workers is a frequent criticism of the quality of child protection services. Effective intervention requires a productive working relationship between the worker and the child and family.

This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report.

Child protection services — client satisfaction

‘Client satisfaction’ is an output indicator of the effectiveness of child protection services (box 15.6).

Box 15.6 Client satisfaction

Client satisfaction is an output indicator of governments’ objective to provide high quality services that meet the needs of recipients.

This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report.

Box 15.7 provides examples of steps taken in seven jurisdictions to monitor, assess and promote client satisfaction in relation to child protection and out-of-home care.

Box 15.7 **Developments in client satisfaction**

<i>NSW</i>	An evaluation of the Early Intervention Program is planned. This program targets vulnerable families with children aged 0–8 years. A sample of families and children receiving services will be surveyed during the evaluation to ascertain whether they are satisfied the program is meeting their needs.
<i>Vic</i>	A survey of child protection clients and families in 2001 was designed to gather information on the clients' and families' experience of child protection, in order to enhance future service delivery, and to improve client and family outcomes. The survey findings identified a range of specific strengths in child protection practice, including that in the majority of cases, child protection intervention improved the safety and life circumstances of young people. The survey also identified a range of areas for practice improvement.
<i>Qld</i>	In December 2005 and February 2006, the Commission for Children and Young People and Child Guardian undertook a survey of children and young people in care. The survey sought their views on their current placement, their Child Safety Officer and the child protection system in general. It is anticipated that these surveys will be conducted regularly. CREATE is funded to engage samples of children and young people to gain more information about how child protection services affect them. This information is provided back to the Department.
<i>WA</i>	Children and young people provided with leaving care services were surveyed on a range of matters including satisfaction with the service, the extent to which they learnt new skills, their confidence to manage in the future and the extent to which they were supported in regard to care and safety. Questions relating to client-focused service delivery were included in the survey for the first time in 2005-06.
<i>Tas</i>	A 2004 survey targeted at children, young people, and families involved in Family Group Conferencing determined that this program is valued by clients of all ages and supported the continued use of external facilitators to ensure independence in the conferencing process. An out-of-home care consultation process found feedback from young people with out-of-home care experience to be critical in identifying focal points for service and system improvements.
<i>ACT</i>	CREATE released a report in July 2004 based on qualitative interviews of children and young people in out-of-home care in the ACT. This report recommended the development of a charter of rights for children and young people in care in the ACT. The Government will develop a charter in consultation with children and young people.
<i>NT</i>	A participation survey of children and young people in care was funded in 2005 and an evaluation of case work attitudes was also undertaken. As a result, out-of-home care core training for staff has been restructured to incorporate the participation of young people in care planning.

Source: State and Territory governments (unpublished).

Child protection services — response time to commence investigation

‘Response time to commence investigation’ is an output indicator of the effectiveness of child protection services (box 15.8).

Box 15.8 Response time to commence investigation

‘Response time to commence investigation’ is an output indicator of governments’ objective to minimise the risk of harm to the child by responding to notifications of possible child protection incidents and commencing investigations in a timely manner.

This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report, although progress is underway to implement measures and definitions for future Reports.

Child protection services — response time to complete investigation

‘Response time to complete investigation’ is an output indicator of the effectiveness of child protection services (box 15.9).

Box 15.9 Response time to complete investigation

‘Response time to complete investigation’ is an output indicator of governments’ objective to minimise the risk of harm to the child by responding to notifications of possible child protection incidents and completing investigations in a timely manner.

This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report, although progress is underway to implement measures and definitions for future Reports.

Child protection services — substantiation rate

‘Substantiation rate’ is an output indicator of the effectiveness of child protection services (box 15.10).

Box 15.10 Substantiation rate

The 'substantiation rate' is an output indicator of governments' objective to target investigations to those notifications where a substantive child abuse/neglect incident has occurred. It also provides an indication of the extent to which government has avoided the human and financial costs of an investigation where no harm has occurred.

This indicator is defined as the proportion of finalised investigations where harm or risk of harm was substantiated.

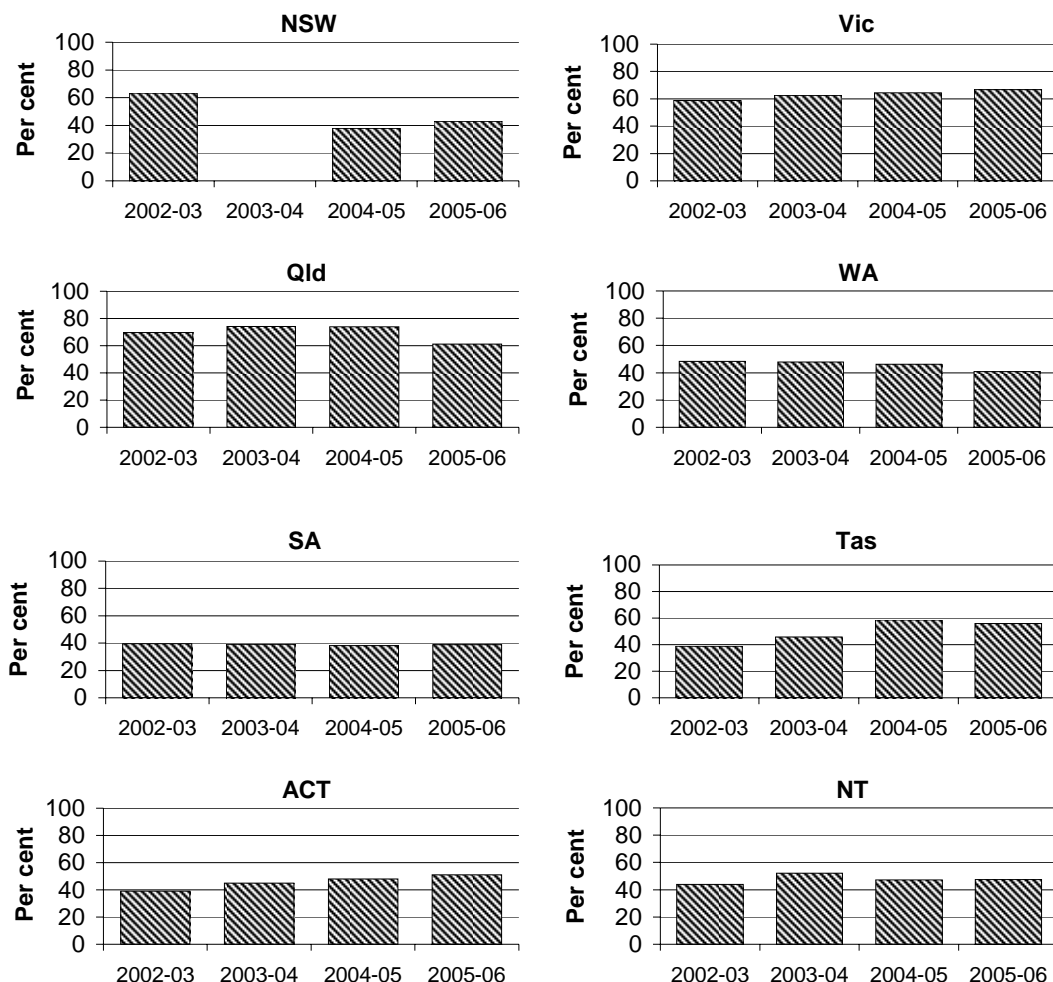
The substantiation rate should be neither 'very high' nor 'very low'. A very low substantiation rate may suggest that notifications and investigations are not accurately targeted at appropriate cases, with the undesirable consequence of distress to families and undermining the chances that families will voluntarily seek support. Very low substantiation rates may also indicate that the scarce resources of the child protection system are being overwhelmed and that screening should be tightened. A very high substantiation rate may indicate that either some appropriate cases are being overlooked at notification and investigation or that the criteria for substantiation are bringing 'lower risk' families into the statutory system.

Finalised investigations that were substantiated may fluctuate because of policy, funding and practice change, such as better targeting of investigative resources, the impact of mandatory reporting or other factors such as increased community awareness and willingness to notify suspected instances of child abuse, neglect or harm.

Data that are comparable across jurisdictions are not available for this indicator because definitions of substantiation vary across jurisdictions, but data are comparable within each jurisdiction over time unless otherwise stated (figure 15.4).

Due to the difficulties in identifying the source of annual fluctuations in substantiation rates, changes over time within jurisdictions are more appropriately used to prompt further analysis, rather than used as definitive performance information.

Figure 15.4 Proportion of finalised child protection investigations that were substantiated^{a, b}



^a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates should not be compared across jurisdictions. ^b NSW child protection data are not comparable over time because of computer system changes in 2002-03 and 2003-04. NSW was unable to provide data for 2003-04 due to the introduction of its current new client information system.

Source: AIHW *Child protection notifications, investigations and substantiations, Australia* data collection (unpublished); tables 15A.33, 15A.50, 15A.67, 15A.84, 15A.101, 15A.118, 15A.135 and 15A.152.

Out-of-home care — safety in out-of-home care

‘Safety in out-of-home care’ is an output indicator of effectiveness (box 15.11).

Box 15.11 Safety in out-of-home care

‘Safety in out-of-home care’ is ‘an output indicator of governments’ objective to provide children who are under the care of the State with a safe home environment. The indicator reflects the safety of clients in care situations.

This indicator is defined as the proportion of substantiations where those responsible for harm or risk were carers or other people living in households providing out-of-home care.

A low proportion of substantiations is desirable.

Four jurisdictions (Qld, WA, SA and ACT) provided 2005-06 data on the incidence of child protection substantiations where the person believed responsible for harm or risk to the child was either the carer or another person living in the household providing out-of-home care. WA provided data on abuse by foster carers or workers in placement services, but not abuse by others living in the household (table 15A.20).

Out-of-home care — stability of placement

‘Stability of placement’ is an output indicator of effectiveness (box 15.12).

Box 15.12 Stability of placement

‘Stability of placement’ is an output indicator of governments’ objective to provide high quality services that meet the needs of recipients on the basis of relative need and available resources.

This indicator is defined as the number of placements that a child has had during a period of continuous out-of-home care.

A low number of child placements (one or two) per period of care is desirable, but must be balanced against other placement quality indicators, such as placements in compliance with the Aboriginal Child Placement Principle, local placements and placements with siblings.

Children may have multiple placements for good reasons, (for example, an initial placement followed by a longer term placement) or it may be desirable to change placements to achieve better child–family compatibility. It is not desirable for a child to stay in an unsatisfactory or unsupportive placement. Also, older children are more likely to have multiple placements as they move towards independence and voluntarily seek alternate placements.

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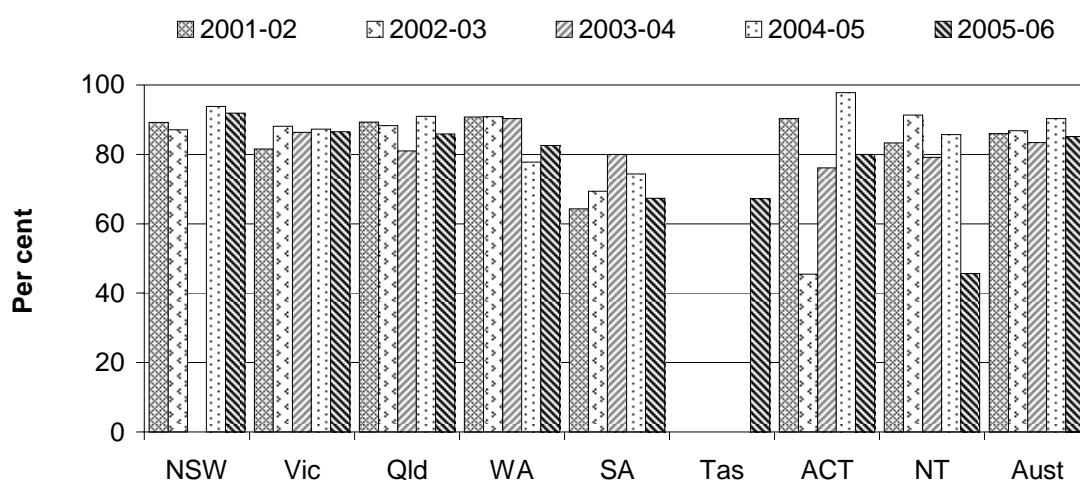
Box 15.12 (Continued)

Data are collected only for children who are on orders and who exit care during the reporting period. There are limitations to counting placement stability using an exit cohort rather than entry cohort longitudinal data, because the sample is biased to children from recent entry cohorts with relatively short stays in care, and these children are likely to have experienced fewer placements.

For children placed away from their family for protective reasons, stability of placement is an important indicator of service quality, particularly for those children who require long term placements. Data were collected on the number of different placements for children on a care and protection order who exited out-of-home care in 2005-06. Data were grouped according to the length of time in care (less than 12 months and 12 months or more).

Nationally, 85.1 per cent of the children on a care and protection order who exited care after less than 12 months experienced only one or two placements in 2005-06. This proportion varied across jurisdictions (figure 15.5).

Figure 15.5 **Proportion of children on a care and protection order exiting care after less than 12 months, who had 1 or 2 placements^{a, b, c, d}**

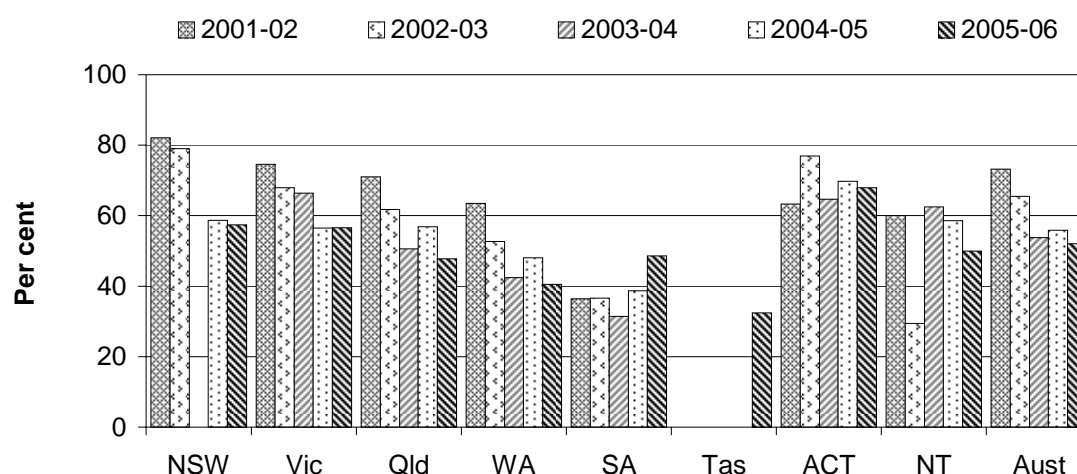


^a Data refer to children exiting care during the relevant financial year. ^b Refer to footnotes in the source tables for information about what each jurisdiction's data include. ^c NSW child protection data from 2002-03 onwards are not comparable with data for previous years. NSW was unable to provide data for 2003-04 due to the introduction of a new client information system. ^d Data for Tasmania were not available prior to 2005-06.

Source: AIHW *Children in out-of-home care, Australia* data collection (unpublished); table 15A.19.

Across jurisdictions, children who had been in out-of-home care longer tended to have had more placements. The proportion of children exiting care in 2005-06 after 12 months or more who had experienced one or two placements was 52.0 per cent nationally but varied across jurisdictions (figure 15.6).

Figure 15.6 Proportion of children on a care and protection order exiting care after 12 months or more, who had 1 or 2 placements^{a, b, c, d}



^a Data refer to children exiting care during the relevant financial year. ^b Refer to footnotes in the source table for information about what each jurisdiction's data include. ^c NSW child protection data from 2002-03 are not comparable with data for previous years. NSW was unable to provide data for 2003-04 due to the introduction of a new client information system. ^d Data for Tasmania were not available prior to 2005-06.

Source: AIHW *Children in out-of-home care, Australia* data collection (unpublished); table 15A.19.

Out-of-home care — placement with extended family

'Placement with extended family' is an output indicator of effectiveness (box 15.13).

Box 15.13 Placement with extended family

‘Placement with extended family’ is an output indicator of governments’ objective to provide services that meet the needs of the recipients on the basis of relative need and available resources.

This indicator is defined as the proportion of all children in out-of-home care who are placed with relatives or kin who receive government financial assistance to care for that child.

A reasonably high rate for this indicator is considered desirable.

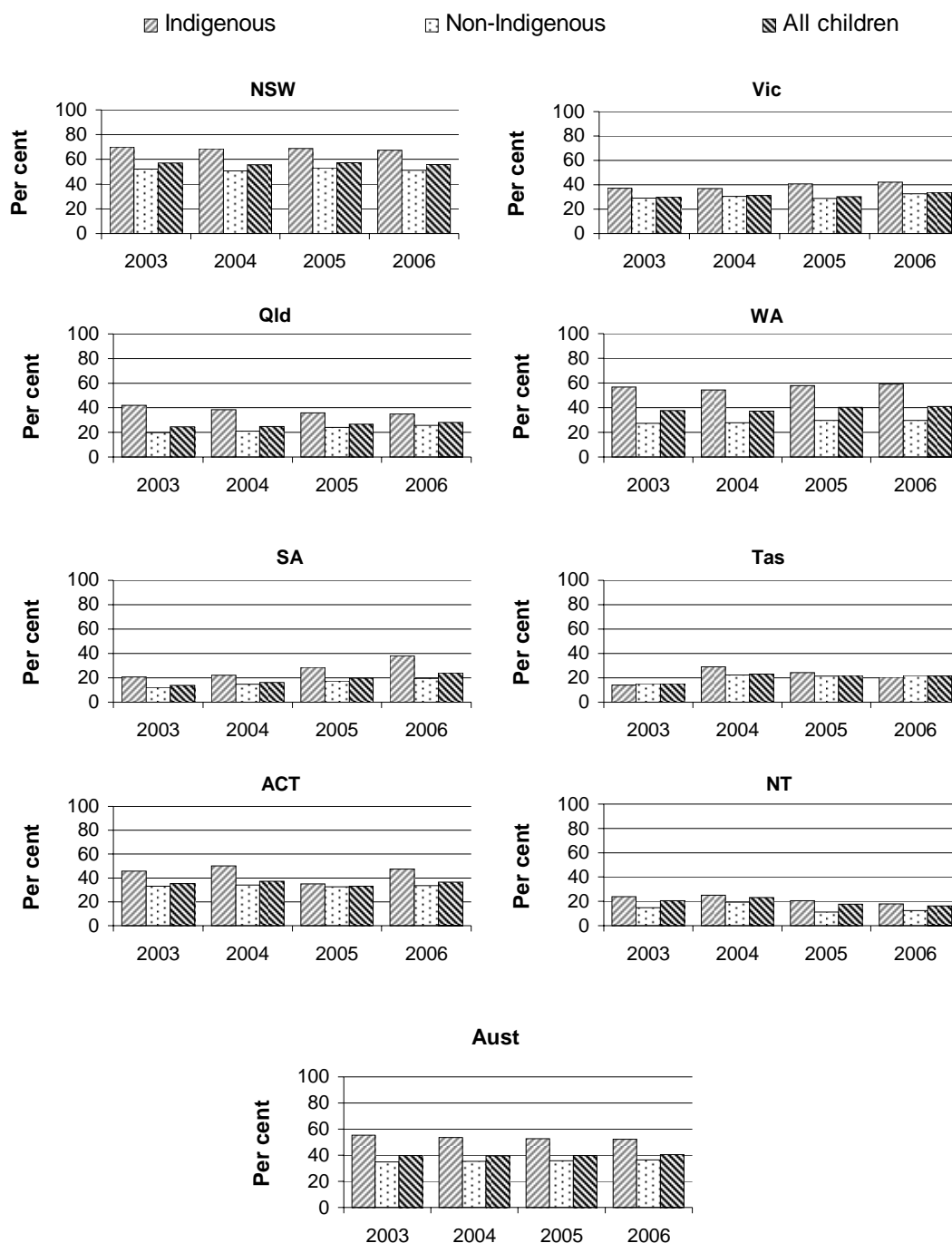
This needs to be considered with other factors in the placement decision.

Placing children with their relatives or kin is generally the preferred out-of-home care placement option. This option is generally associated with better long term outcomes due to increased continuity, familiarity and stability for the child. Relatives are more likely to have or form long term emotional bonds with the child. Placement with familiar people can help to overcome the loss of attachment and belonging that can occur when children are in placed out-of-home care.

Placements with extended family may not always be the best option. Long standing family dynamics may undermine the pursuit of case goals such as reunification, and the possibility of intergenerational abuse needs to be considered. In addition, depending on the individual circumstances of children, it may be more important to have a local placement that enables continuity at school, for example, rather than a distant placement with relatives.

The proportion of children placed with relatives or kin at 30 June 2006 was greater for Indigenous children than for non-Indigenous children in most jurisdictions and nationally (figure 15.7).

Figure 15.7 Proportion of children in out-of-home care placed with relatives/kin, by Indigenous status, 30 June



Source: AIHW *Children in out-of-home care, Australia* data collection (unpublished); tables 15A.16, 15A.39, 15A.56, 15A.73, 15A.90, 15A.107, 15A.124, 15A.141 and 15A.158.

Out-of-home care — children aged under 12 years in home-based care

‘Children aged under 12 years in home-based care’ is an output indicator of effectiveness (box 15.14).

Box 15.14 Children aged under 12 years in home-based care

‘Children aged under 12 years in home-based care’ is an output indicator of governments’ objective to provide services which meet the needs of the recipients. This indicator is defined as the number of children under 12 years of age placed in home-based care divided by the total number of children under 12 years in out-of-home care.

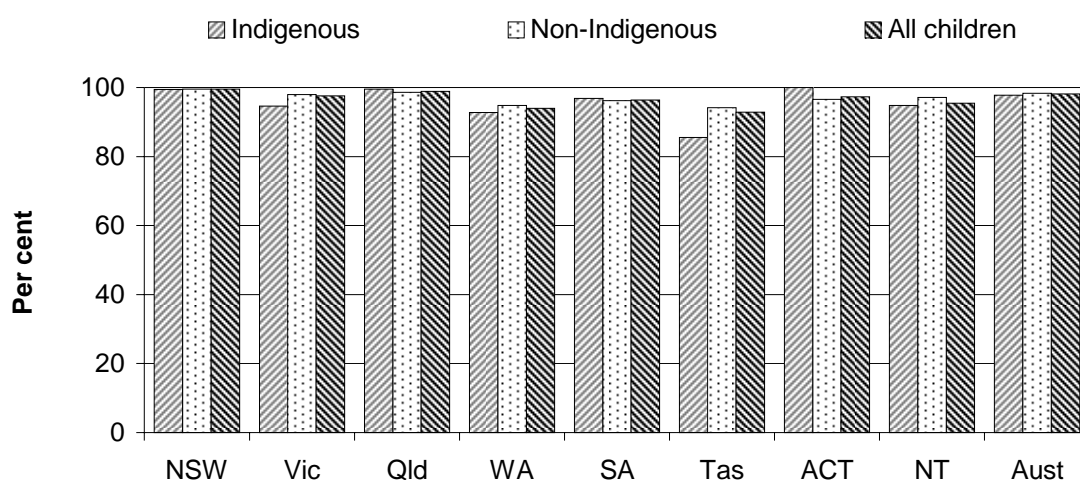
A high rate for this indicator is considered desirable.

Placing children in home-based care is generally considered to be in their best interests, particularly for younger children. Children will generally make better developmental progress (and have more ready access to normal childhood experiences) in family settings rather than in residential care.

This indicator should be interpreted in conjunction with other placement indicators.

The proportion of all children aged under 12 years in care who were placed in home-based care (excluding family group homes) at 30 June 2006 was 98.1 per cent nationally and exceeded 92 per cent in all jurisdictions. In all jurisdictions the proportion of Indigenous children aged under 12 years who were placed in home-based care was similar to that of non-Indigenous children (figure 15.8).

Figure 15.8 Proportion of children aged under 12 years in out-of-home care and in a home based placement, by Indigenous status, 30 June 2006^a



^a Family group homes are not classified as being home based care.

Source: AIHW *Children in out-of-home care, Australia* data collection (unpublished); table 15A.18.

Out-of-home care — placement in accordance with the Aboriginal Child Placement Principle

‘Placement in accordance with the Aboriginal Child Placement Principle’ is an output indicator of effectiveness (box 15.15).

According to the Aboriginal Child Placement Principle (NSW Law Reform Commission 1997), the following hierarchy or placement preference should be pursued in protecting the safety and welfare of Indigenous children:

- Placement with the child’s extended family (which includes Indigenous and non-Indigenous relatives/kin).
- Placement within the child’s Indigenous community.
- Placement with other Indigenous people.

All jurisdictions have adopted this principle, either in legislation or policy.

Box 15.15 Placement in accordance with the Aboriginal Child Placement Principle

‘Placement in accordance with the Aboriginal Child Placement Principle’ is an output indicator of governments’ objective to protect the safety and welfare of Indigenous children while maintaining the cultural ties and identity of Indigenous children in out-of-home care. Placing Indigenous children in circumstances consistent with the Aboriginal Child Placement Principle is generally considered to be in their best interests.

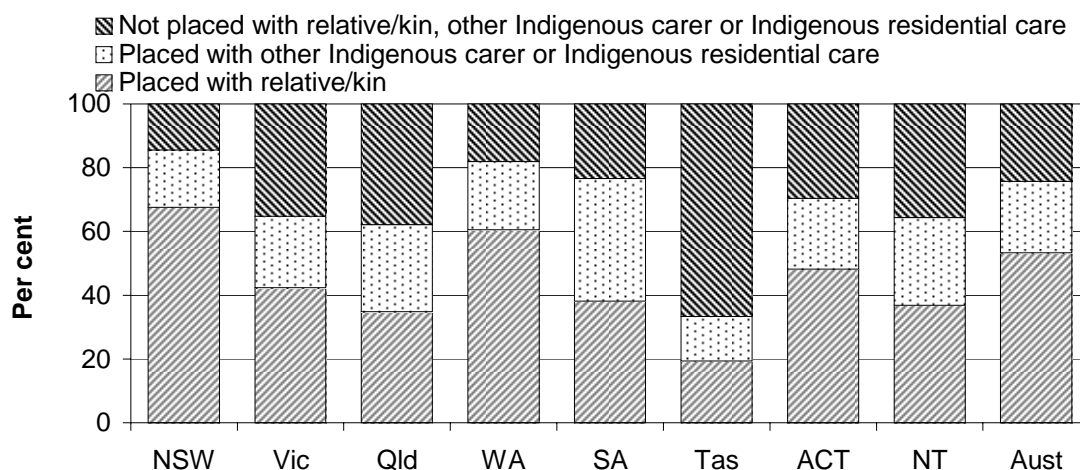
This indicator is defined as the number of Indigenous children placed with the child’s extended family, Indigenous community or other Indigenous people, divided by the total number of Indigenous children in out-of-home care. Data are reported separately for children placed (i) with relative/kin, (ii) with other Indigenous carer or Indigenous residential care, and (iii) not placed with relative/kin, other Indigenous carer or Indigenous residential care.

A high proportion of children placed in accordance with the principle is desirable.

This is one factor among many that must be considered in the placement decision.

The proportion of Indigenous children in out-of-home care at 30 June 2006 who were placed with Indigenous or non-Indigenous relatives or kin or with another Indigenous carer or in Indigenous residential care varies across jurisdictions (figure 15.9).

Figure 15.9 **Placement of Indigenous children in out-of-home care, 30 June 2006^{a, b, c}**



^a Excludes Indigenous children living independently and those whose living arrangements were unknown.

^b 'Placed with other Indigenous carer' includes those living in Indigenous residential care. ^c Data for Tasmania and the ACT relate to a small number of Indigenous children (98 and 82 respectively) in care at 30 June 2006.

Source: AIHW *Children in out-of-home care, Australia* data collection (unpublished); table 15A.17.

Out-of-home care — local placement

'Local placement' is an output indicator of the effectiveness of out-of-home care services (box 15.16).

Box 15.16 Local placement

Local placement is an output indicator of governments' objective to provide services which meet the needs of the recipients.

This indicator is defined as the proportion of children attending the same school after entering out-of-home care. Data will be provided for 3 and 12 months after entering care.

A high rate of 'local placement' is desirable.

A placement close to where a child lived prior to entering out-of-home care is believed to enhance the stability, familiarity and security of the child. It enables some elements of the child's life to remain unchanged (for example, they can continue attending the same school and retain their friendship network). It may also facilitate family contact if the child's parents continue to live nearby.

(Continued on next page)

Box 15.16 (Continued)

This indicator should be balanced against other quality indicators. This is one factor among many that must be considered in the placement decision. For example, placement with a sibling or relative might preclude a local placement. Also, a child might move from a primary to a secondary school.

Data collections for local placement are being developed. Data, however, were not available for the 2007 Report.

Out-of-home care — placement with sibling

‘Placement with sibling’ is an output indicator of the effectiveness of out-of-home care services (box 15.17).

Box 15.17 Placement with sibling

‘Placement with sibling’ is an output indicator of governments’ objective to provide services which meet the needs of the recipients.

This indicator is defined as the proportion of children who are on orders and in out-of-home care at 30 June who have siblings also on orders and in out-of-home care, who are placed with at least one of their siblings.

A high rate of placement with siblings is desirable.

Placement of siblings together promotes stability and continuity. It is a long standing placement principle that siblings should be placed together, where possible, in the interests of their emotional wellbeing. Children are likely to be more secure and have a sense of belonging within their family when placed with siblings.

This is one factor among many that must be considered in the placement decision. In circumstances of sibling abuse, or when a particular child in a family has been singled out as the target for abuse or neglect, keeping siblings together might not be appropriate.

Data collections for placement with sibling are being developed. Data, however, were not available for the 2007 Report.

Out-of-home care — children with documented case plan

‘Children with documented case plan’ is an output indicator of the effectiveness of out-of-home care services (box 15.18).

Box 15.18 Children with documented case plan

‘Children with documented case plan’ is an output indicator of governments’ objective to provide services that meet the needs of the recipients.

This indicator is defined as the proportion of children on an order and in out-of-home care who have a documented case plan.

A high rate is desirable because all children should have a case plan.

The quality of the case plan must also be considered and the mere existence of a case plan does not guarantee that appropriate case work is occurring that meets the child’s needs.

Case planning is essential to structured and purposeful work to support children’s optimal development. Case plans outline intervention goals such as improved parent–child attachments, reunification or other forms of permanency, and set out the means to achieve these goals, such as frequency of family contact and any remedial or special services considered appropriate for the individual child. Case plans also allow for the monitoring of a child’s time in care.

Data collections for children with documented case plan are being developed. Data, however, were not available for the 2007 Report.

Out-of-home care — client satisfaction

‘Client satisfaction’ as an output indicator of the effectiveness of out-of-home care services (box 15.19).

Box 15.19 Client satisfaction

Client satisfaction is an output indicator of governments’ objective to provide high quality services that meet the needs of recipients.

This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report.

Some information on jurisdictions’ development of initiatives which may assist to measure client satisfaction in the future is included on pages 15.15-16.

Efficiency

Understanding the efficiency of the child protection systems that they administer helps State and Territory governments to identify the key cost drivers of their systems and to weigh the efficacy of options for addressing child protection issues.

Challenges in reporting efficiency for child protection systems

Current efficiency data for child protection services has several limitations, including:

- *different systems and priorities across jurisdictions* — child protection systems in Australia have evolved independently under the auspices of State and Territory governments (section 15.1). This has resulted in variations in the processes and emphases placed on different service delivery paradigms – such as different approaches to diversionary options (figure 15.1).
- *limitations of current information systems* — in most jurisdictions, it is difficult to identify explicit resources expended on child protection services, out-of-home care services and other support services for families. This is due in part to the historic structure of information systems and the embedding of the government agencies responsible for child protection issues within larger community services departments. Table 15A.4 identifies the level of consistency in expenditure data across jurisdictions.

As a result, cost allocations reflect the historic nature of information systems and do not necessarily provide an accurate reflection of the costs involved in provision of various child protection and out-of-home care services. This has limited reporting on efficiency to relatively poor proxy indicators (box 15.21).

In April 2002, the Review initiated a project to improve efficiency data for a national framework of protection and support pathways (box 15.20).

Box 15.20 The pathways project

The pathways project developed and tested a model that will ultimately allow jurisdictions to calculate more meaningful, comparable and robust efficiency measures (the 'pathways method'). The model is based on a top-down application of the activity-based costing method. A set of eight national pathways has been developed as a high level representation of the services that a protection and support client could receive in any jurisdiction. Each pathway consists of common activity groups which act as the 'building blocks' for each of the pathways. The aggregate cost of each activity group within the pathway will allow for the unit cost of an individual pathway to be determined.

These activity groups and pathways will provide additional utility for jurisdictions in managing the business of child protection services. Implementation of the model has the potential to improve the quality of national reporting of protection and support services efficiency measures. Activity-based data can also result, over time, in measures of the cost savings associated with early intervention strategies.

The activity groups are:

- Activity Group 1 Receipt and assessment of initial information about a potential protection and support issue
- Activity Group 2 Provision of generic/non-intensive family support services
- Activity Group 3 Provision of intensive family support services
- Activity Group 4 Secondary information gathering and assessment
- Activity Group 5 Provision of short term protective intervention and coordination services
- Activity Group 6 Seeking a court order
- Activity Group 7 Provision of longer term protective intervention, support and coordination services
- Activity Group 8 Provision of out-of-home care services.

Detailed definitions of activity groups are included in section 15.10.

Before jurisdictional reporting against the activity groups can be undertaken with confidence, further refinement of activity group definitions and counting rules is required. Development work, including further data testing in these areas will continue.

Source: SCRCSSP (2003b).

Some experimental results from the Pathways model, provided by some jurisdictions, are included in table 15.1. These data are preliminary and will be subject to further analysis and refinement. The data do not represent unit costs and should be interpreted with caution. Due to differing internal management systems across jurisdictions, there may be significant variation between jurisdictions in relation to specific activities or expenditures that are included in each activity group.

The data reflect a combination of allocation of direct costs (those costs which can be clearly identified by a jurisdiction to a particular activity group) and indirect costs (which form part of the overall expenditure base, but which cannot be identified in a specific activity group and hence have been allocated amongst the activity groups). These indirect allocations have been approximated by each jurisdiction amongst the eight activity groups.

Table 15.1 provides an approximation of the proportionate allocation of expenditure amongst the eight activity groups for each participating jurisdiction. The expenditure base used for the pathways project differs from the expenditure base used to calculate the existing proxy efficiency indicators for child protection and out-of-home care services (figures 15.10 and 15.11).

The proportion of expenditure allocated to Activity group 8 (Out-of-home care) is the most significant and varies from 41 per cent to 45 per cent across reporting jurisdictions. The proportion allocated to Activity group 3 (Provision of intensive family support services) is the lowest overall and is 4 per cent for each jurisdiction. The proportions allocated to Activity groups 1 (Receipt and assessment of initial information about a potential protection and support issue) and 6 (Seeking a court order) each accounted for less than 10 per cent across reporting jurisdictions.

Table 15.1 Proportion of expenditure by activity group – experimental estimates (per cent)^{a, b, c, d}

	AG1	AG2 ^e	AG3	AG4	AG5	AG6	AG7	AG8	Total
Vic	3	24	4	5	4	7	8	44	100
SA	4	8	4	13	10	8	7	45	100
Tas	6	2	4	12	17	9	10	41	100

AG = Activity Group. AG1 Receipt and assessment of initial information about a potential protection and support issue. AG2 Provision of generic/non-intensive family support services. AG3 Provision of intensive family support services. AG4 Secondary information gathering and assessment. AG5 Provision of short term protective intervention and coordination services. AG6 Seeking a court order. AG7 Provision of longer term protective intervention, support and coordination services. AG8 Provision of out-of-home care services.

^a Includes direct and indirect expenditure. ^b These experimental data have been derived from expenditure allocations in different years by the various participating jurisdictions, but may be applied indicatively to 2005-06. ^c These experimental percentage allocations are derived from total expenditure allocations which vary from totals used to derive costs presented elsewhere in the chapter. ^d Totals may not add to 100 as a result of rounding. ^e Expenditure items included in calculating proportional expenditure for Activity Group 2 may vary across jurisdictions.

Source: Victoria, SA and Tasmanian governments (unpublished).

These data will continue to be refined for future Reports, along with further developments to enable full implementation of the pathways project. Development of unit costs is anticipated for the 2008 Report.

Child protection services proxy efficiency indicators

There are several proxy indicators of efficiency for child protection services (box 15.21).

Box 15.21 Child protection services proxy efficiency indicators

Three child protection efficiency measures are included as output indicators of governments' objective to maximise the benefit to the community through the efficient use of taxpayer resources: 'total expenditure on all child protection activities, per notification', 'total expenditure on all child protection activities, per investigation', and 'total expenditure on all child protection activities, per substantiation'.

These indicators are defined, respectively, as:

- the total expenditure on all child protection activities divided by the number of notifications
- the total expenditure on all child protection activities divided by the number of investigations
- the total expenditure on all child protection activities divided by the number of substantiations.

These indicators are imperfect proxy indicators and need to be interpreted with care.

Because each of these proxy indicators is based on total expenditure on child protection activities, they do not represent, and cannot be interpreted as, unit costs for notifications, investigations or substantiations.

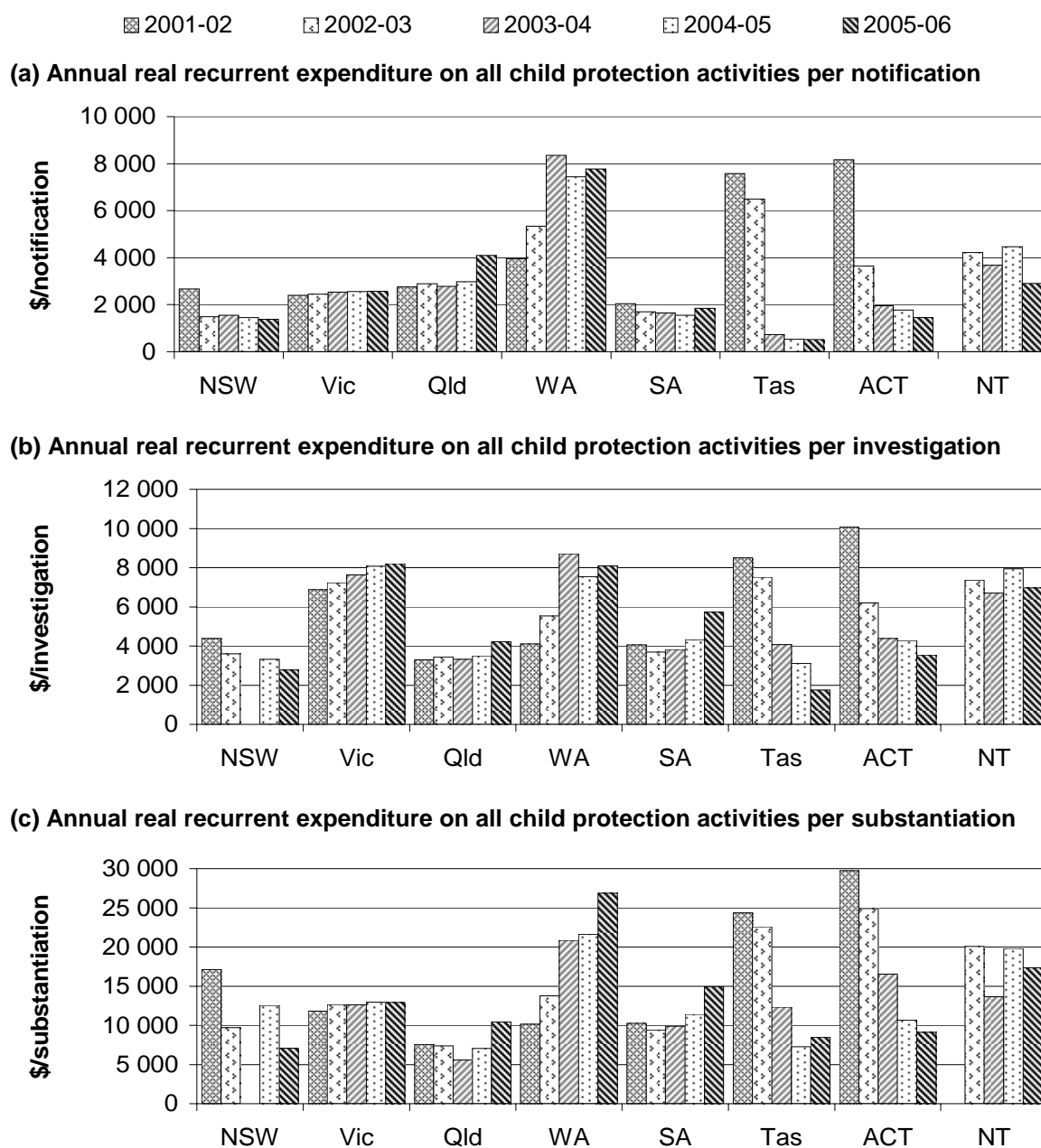
These proxy indicators cannot be added together to determine overall cost of child protection services.

Lower expenditure per notification/investigation/substantiation may suggest more efficient services but may indicate lower quality or different service delivery models.

These measures are included as interim measures only, and will be replaced by a more robust method under development (box 15.20). Better efficiency indicators would relate expenditure on particular child protection activities to a measure of output of those activities. Work is in progress to develop an activity-based costing method that will allow this type of reporting from existing information systems.

Total expenditure on all child protection activities per notification, all child protection activities per investigation and all child protection activities per substantiation from 2000-01 to 2004-05 varied between jurisdictions (figure 15.10).

Figure 15.10 Child protection efficiency indicators (2005-06 dollars)^{a, b, c, d, e}



^a Real expenditure based on ABS gross domestic product price deflator (2005-06 = 100) (table AA.26).

^b These data are derived from proxy indicators and cannot be interpreted as the unit costs for 'expenditure per notification', 'expenditure per investigation' or 'expenditure per substantiation' because each is based on the total expenditure of all child protection activities. They cannot be added together to derive a total cost for child protection activities. Differences across jurisdictions reflect the quantity of the three activities rather than a difference in unit costs. ^c NSW data from 2002-03 onwards are not comparable with data for previous years. NSW was able to provide limited data for 2003-04 due to the introduction of a new client information system. ^d NT was unable to provide data for 2001-02. ^e Information for Tasmania from 2003-04 should not be compared with previous years because of a change in recording practices that has been adopted as a result of centralisation of the intake service. Every call regarding a child is now recorded as a notification, whereas previously, child protection workers made the decision locally about whether the call was a notification based on the risk to the child.

Source: State and Territory governments (unpublished); table 15A.2.

Out-of-home care proxy efficiency indicators

There are several proxy indicators are included as output indicators of efficiency for out-of-home care efficiency (box 15.22).

Box 15.22 Out-of-home care proxy efficiency indicators

Three proxy out-of-home care efficiency measures are output indicators of governments' objective to maximise the benefit to the community through the efficient use of taxpayer resources: 'total expenditure on all children in residential out-of-home care per year, per child in residential out-of-home care on 30 June', 'total expenditure on all children in non-residential out-of-home care per year, per child in non-residential out-of-home care on 30 June', and 'total expenditure on all children in out-of-home care per year, per child in all out-of-home care on 30 June'.

These indicators are defined respectively as:

- the total annual expenditure on residential out-of-home care divided by the number of children in residential out-of-home care at 30 June
- the total annual expenditure on non-residential out-of-home care divided by the number of children in non-residential out-of-home care at 30 June
- the total annual expenditure on all out-of-home care divided by the number of children in all out-of-home care at 30 June

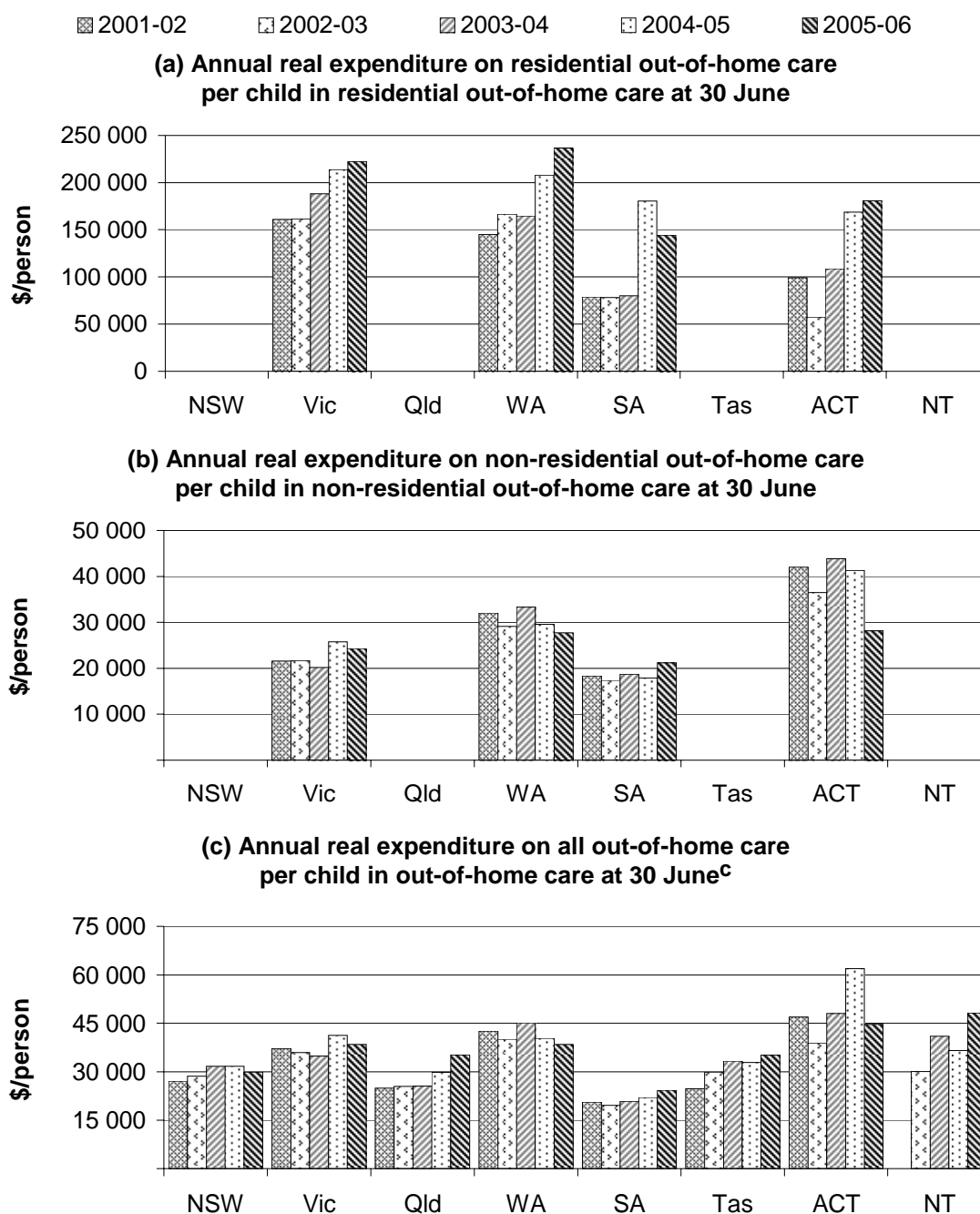
These indicators are imperfect proxy indicators and need to be interpreted with care. Low expenditure per child in care may suggest more efficient services but may also indicate lower service quality.

These indicators should be interpreted with care because they do not represent unit cost measures. Expenditure per child in care at 30 June overstates the cost per child because significantly more children are in care during a year than at a point in time. In addition, the indicator does not reflect the length of time that a child spends in care.

These measures are included as interim measures only, and will be replaced by a more robust method under development (box 15.20). Better efficiency indicators would relate expenditure on particular out-of-home care activities to a measure of output of those activities. Work is currently in progress to develop an activity based costing method which will allow this type of reporting from existing information systems.

Victoria, WA, SA and the ACT were able to separate expenditure on out-of-home care into residential care and non-residential care. This annual expenditure to 30 June for 2001-02 to 2005-06 varied across these jurisdictions (figures 15.11a and 15.11b). All jurisdictions provided data on total expenditure on out-of-home care per child in care to 30 June for 2001-02 to 2005-06, which varied across jurisdictions (figure 15.11c).

Figure 15.11 Out-of-home care efficiency indicators (2005-06 dollars)^{a, b}



^a Real expenditure based on ABS gross domestic product price deflator (2005-06 = 100) (table AA.26).

^b These data do not represent unit costs of providing out-of-home care services. ^c NT were unable to provide data for 2001-02.

Source: State and Territory governments (unpublished); table 15A.3.

Outcomes

Improved safety — substantiation rate after decision not to substantiate

‘Substantiation rate after decision not to substantiate’ is an outcome indicator of child protection and out-of-home care services (box 15.23).

Box 15.23 Improved safety — substantiation rate after decision not to substantiate

‘Improved safety — substantiation rate after decision not to substantiate’ is an outcome indicator of governments’ objective to reduce the risk of harm to children by appropriately assessing notifications of possible child protection incidents.

This indicator is defined as the proportion of children who were the subject of an investigation in the previous financial year that led to a decision not to substantiate, and who were later the subject of a substantiation within three or 12 months of the initial decision not to substantiate. The year reported relates to the year of the initial decision not to substantiate.

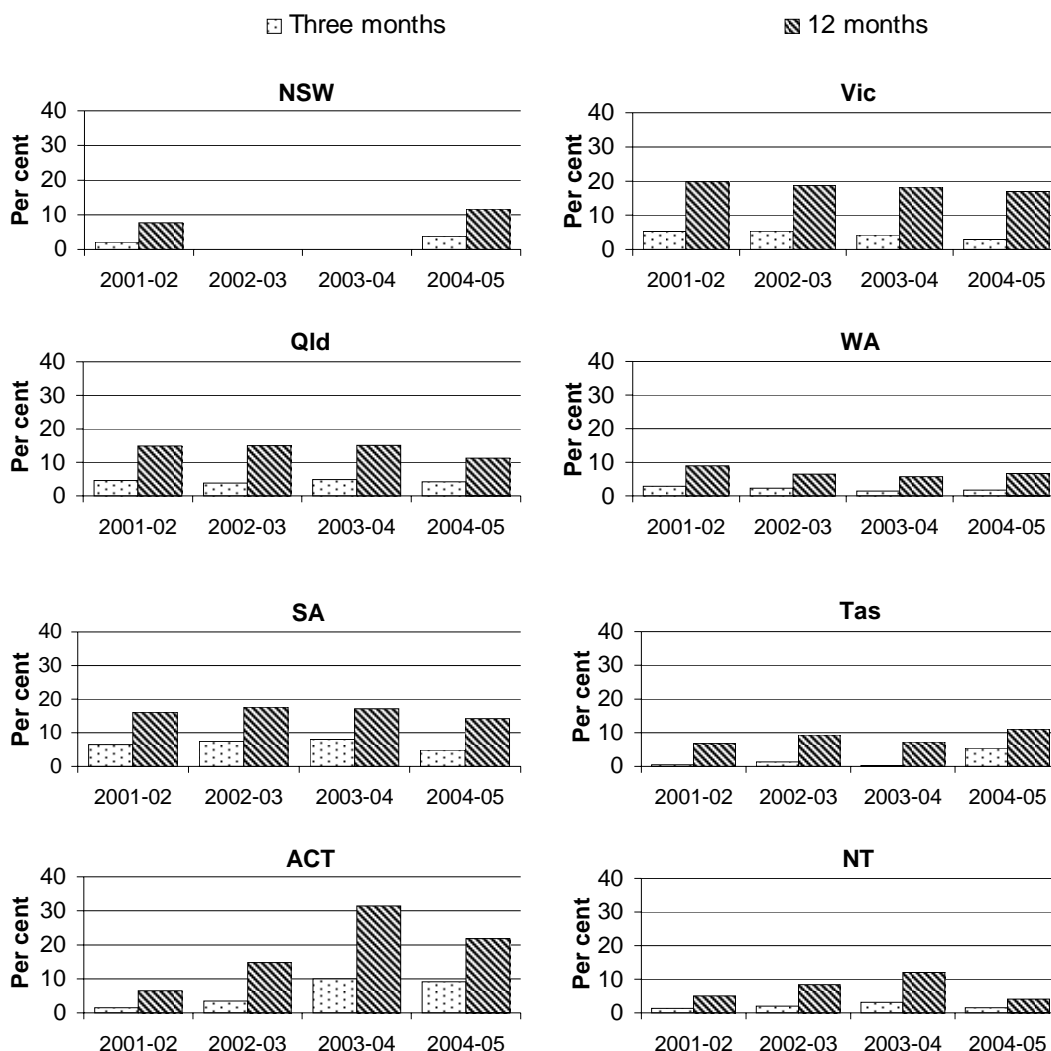
This indicator partly reveals the extent to which an investigation has not succeeded in identifying the risk of harm to a child who is subsequently the subject of substantiated harm. It also provides a measure of the adequacy of intervention offered to children in terms of protecting them from further harm.

A low rate for this indicator is generally desirable. However, reported results may be affected by the finalisation of investigations, factors beyond the control of child protection services, or a change in circumstances after the initial decision not to substantiate was made. A demonstrable risk of harm might not have existed in the first instance. In addition, this indicator does not distinguish between subsequent substantiations which are related to the initial notification (that is, the same source of risk of harm), and those which are unrelated to the initial notification (that is, a different source of risk of harm).

This indicator should be considered with other outcome indicators.

Data that are comparable across jurisdictions are not available for this indicator because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time until 2002-03. Data from 2003-04 onwards are based on a different counting rule to previous years (figure 15.12).

Figure 15.12 Improved safety — substantiation rate within 3 and/or 12 months after a decision not to substantiate^{a, b, c}



^a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. ^b NSW was unable to provide data for 2003-04 due to the introduction of a new client information system. As this indicator is calculated using two years of data, 2002-03 rates are also not available for NSW. ^c The counting rule for this indicator has been changed for 2003-04 onwards, which may have resulted in a lowering of the rate for some jurisdictions in 2003-04 and 2004-05. Therefore care should be taken when comparing 2003-04 and 2004-05 with other years. SA applied the earlier counting rule, from 2001-02 to 2004-05.

Source: AIHW *Child protection notifications, investigations and substantiations, Australia* data collection (unpublished); tables 15A.9, 15A.31, 15A.48, 15A.65, 15A.82, 15A.99, 15A.116, 15A.133 and 15A.150.

Improved safety — resubstantiation rate

The ‘resubstantiation rate’ is an outcome indicator of child protection and out-of-home care services (box 15.24).

Box 15.24 Improved safety — resubstantiation rate

‘Resubstantiation rate’ is an outcome indicator of governments’ objective to reduce the risk of harm and to prevent the recurrence of abuse and neglect or harm to children. This indicator also partly reveals the extent to which intervention by child protection services has succeeded in preventing further harm.

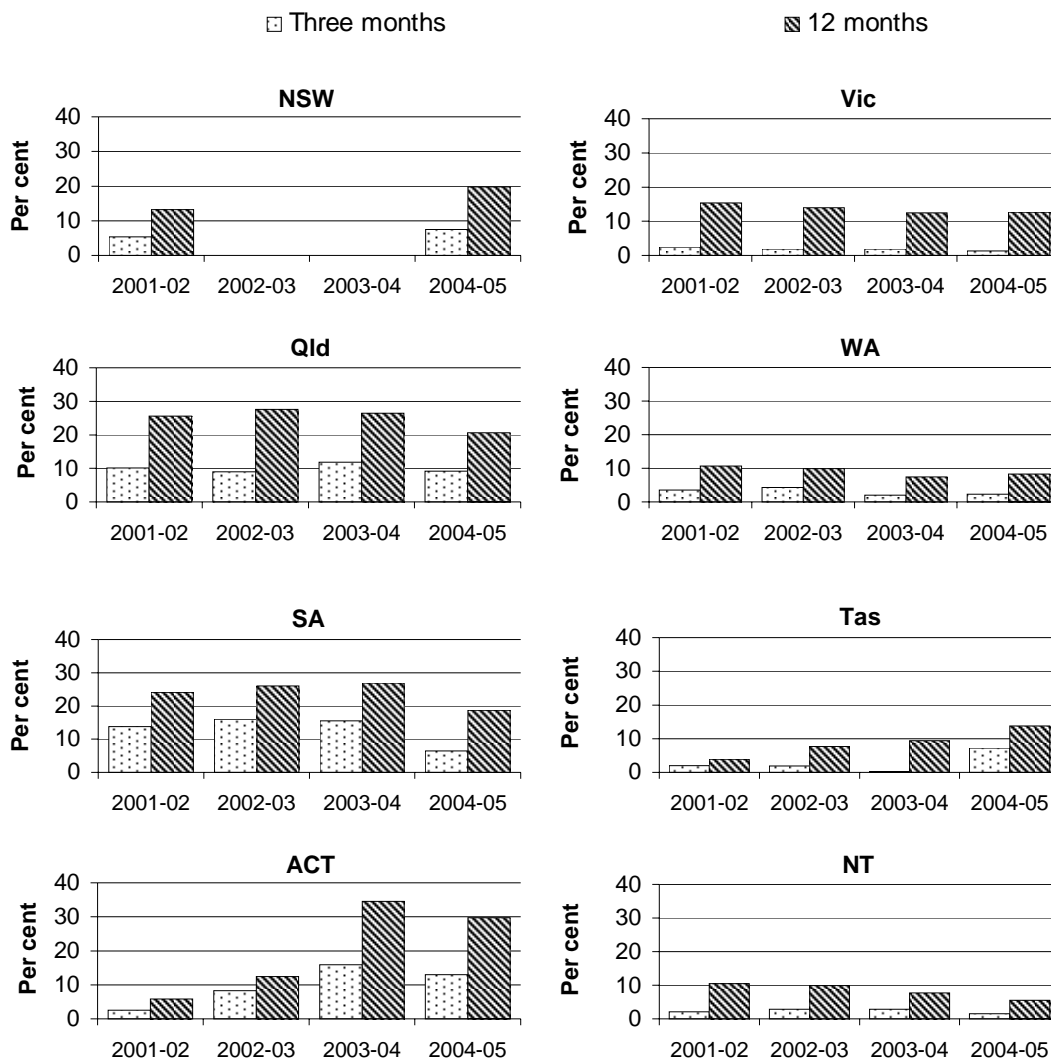
This indicator is defined as the proportion of children who were the subject of a substantiation in the previous financial year, who were subsequently the subject of a further substantiation within the following three or 12 months. The year reported relates to the year of the original substantiation.

A low rate for this indicator is generally desirable. However, reported results may be affected by the finalisation of investigations, factors beyond the control of child protection services, such as changes in the family situation (for example, illness, unemployment or a new partner). In addition, this indicator does not distinguish between subsequent substantiations that are related to the initial notification (that is, the same source of risk of harm) and those that are unrelated to the initial notification (that is, a different source of risk of harm).

This indicator should be considered with other outcome indicators.

Data that are comparable across jurisdictions are not available for this indicator because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time until 2002-03. Data from 2003-04 onwards are based on a different counting rule to previous years (figure 15.13).

Figure 15.13 Improved safety — resubstantiation rate within 3 and/or 12 months after a substantiation^{a, b, c}



^a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. ^b NSW was unable to provide data for 2003-04 due to the introduction of a new client information system. As this indicator is calculated using two years of data, 2002-03 rates are also not available for NSW. ^c The counting rule for this indicator has been changed for 2003-04 onwards, which may have resulted in a lowering of the rate for some jurisdictions in 2003-04 and 2004-05. Therefore care should be taken when comparing 2003-04 and 2004-05 with other years. SA applied the earlier counting rule, from 2001-02 to 2004-05.

Source: AIHW *Child protection notifications, investigations and substantiations, Australia* data collection (unpublished); tables 15A.10, 15A.32, 15A.49, 15A.66, 15A.83, 15A.100, 15A.117, 15A.134 and 15A.151.

Improved education, health and wellbeing of the child

‘Improved education, health and wellbeing of the child’ is an outcome indicator of child protection and out-of-home care services (box 15.25).

Box 15.25 Improved education, health and wellbeing of the child

‘Improved education, health and wellbeing of the child’ is an outcome indicator of governments’ objective to maximise children’s life chances by ensuring children in care have their educational, health and wellbeing needs met.

This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report, although progress is underway to collect information on educational outcomes for future Reports.

Safe return home

‘Safe return home’ is an outcome indicator of child protection and out-of-home care services (box 15.26).

Box 15.26 Safe return home

‘Safe return home’ is an outcome indicator of governments’ objective to remove the risk of harm to the child while maintaining family cohesion. For children who cannot be protected within their family and are removed from home, often the best outcome is when effective intervention to improve their parents’ skills or capacity to care for them enables them to return home.

This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report.

Permanent care

‘Permanent care’ is an outcome indicator of child protection and out-of-home care services (box 15.27).

Box 15.27 Permanent care

‘Permanent care’ is an outcome indicator of governments’ objective to provide appropriate care for children who cannot be safely reunified with their families. Appropriate services are those that minimise the length of time before stable, permanent placement is achieved.

This indicator has been identified for development and reporting in future. Data, however, were not available for the 2007 Report.

15.4 Future directions in child protection and out-of-home care services performance reporting

Improving national child protection data

Between 2000 and 2003, the National Child Protection and Support Services (NCPASS) Data Working Group, under the auspices of the National Community Services Information Management Group, reviewed the reporting framework used to collect the national child protection data. The review aimed to 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
- are more comprehensive
- have increased consistency and comparability.

The review resulted in the development of a broader framework to count responses to calls received by community services departments about the safety and wellbeing of children. The responses include those that occur outside the formal child protection system. The new framework incorporates data elements such as the provision of advice and information, the assessment of needs, and the provision of general and intensive family support services.

The AIHW, in conjunction with the NCPASS, has developed data dictionaries to support the new reporting framework. These dictionaries have undergone initial data testing and it is envisaged that they will be used by jurisdictions to provide unit record data. This will provide more detailed child protection and out-of-home care data than is currently available with aggregated data.

It is anticipated that NCPASS will be developing comparative data in relation to response times to commence and complete investigations for inclusion in the 2008 Report, in addition to some material relating to educational outcomes for children on orders.

Further development of the pathways activity-based costing project will reduce the reliance on proxy efficiency indicators for child protection and out-of-home care and enable more detailed and comparative analysis of efficiency indicators.

15.5 Profile of supported accommodation and assistance services

Service overview

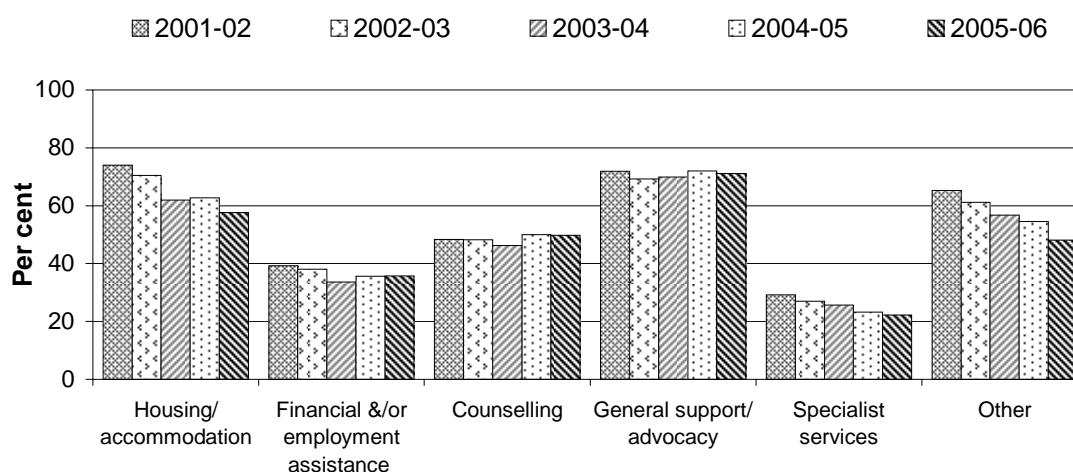
Supported accommodation and assistance services aim to assist people who are homeless or at imminent risk of becoming homeless as a result of a crisis, including women and children escaping domestic violence.

The primary focus of SAAP is to use a case management approach to support homeless people, and adults 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.

Most of the SAAP information in this Report is sourced from the SAAP National Data Collection (NDC). In 2005-06, the Client Collection of the SAAP NDC underwent some significant changes resulting from the introduction of the new core dataset and the new linkage key. Some of the data items in the Client Collection have changed. The new linkage key used in estimating the number of clients now contains a different combination of letters in clients' names and surnames and requires clients' date of birth instead of year of birth. Therefore, some SAAP data for this year are not directly comparable to those in previous years. Since 2004-05, there has also been a change in the definition of a SAAP support period. This may have an effect on the reported number of support periods.

Nationally, in 2005-06, housing and accommodation services were provided in 57.6 per cent of support periods. Financial and employment assistance (35.7 per cent), counselling (49.8 per cent), general support and advocacy (71.1 per cent), and specialist services (22.2 per cent) were also commonly provided. There has been some change in the proportions of types of service provided by SAAP agencies over time. In 2001-02, housing and accommodation constituted 74.0 per cent of support periods and specialist services constituted 29.2 per cent. Agencies may provide more than one type of service during a single support period (figure 15.14).

Figure 15.14 **Services received during a SAAP support period^a**



^a Totals do not add to 100 per cent because agencies may provide more than one type of service during a single support period.

Source: SAAP National Data Collection Agency (NDCA) *Administrative Data and Client Collections* (unpublished); table 15A.163.

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 adults and children escaping domestic violence. At least 1294 agencies are funded under the SAAP program, and most target principally one of these client groups. Services were delivered in 2005-06 by agencies targeting:

- young people (36.0 per cent of agencies)
- women escaping domestic violence (22.9 per cent)
- families (9.1 per cent)
- single men (6.9 per cent)
- single women (3.6 per cent)
- multiple client groups (21.5 per cent) (table 15A.164).

The proportions of agencies targeting the client groups listed above have remained relatively stable since 2001-02.

Agencies also vary in their service delivery model. The most common models in 2005-06 were the provision of medium term to long term supported accommodation (35.9 per cent) and the provision of crisis or short term supported accommodation (35.2 per cent). Agencies also provided services other than accommodation, such as

outreach support (4.6 per cent of agencies), day support (2.1 per cent), and telephone information and referral (1.4 per cent). A further 13.4 per cent of agencies provided multiple services and 1.8 per cent provided agency support (table 15A.165). The proportions of agencies delivering particular service models listed above have remained relatively stable since 2001-02.

Families and children in crisis (such as those escaping domestic violence or experiencing homelessness) are often subject to considerable stress, violence and transience, all of which have a negative impact on children. As a result, some children assisted by SAAP may have also had contact with child protection and out-of-home care services or may have been subject to a current or past order. In 2003-04, it is estimated that 33 per cent of SAAP clients were women escaping domestic violence. Of the 52 700 accompanying children accessing SAAP, 66 per cent were children who accompanied a female parent or guardian escaping domestic violence (AIHW 2005).

Close links also exist between SAAP services and other forms of housing assistance reported in the Housing chapter (chapter 16), which focuses on the performance of government in providing public, Indigenous and community housing under the Commonwealth State Housing Agreement (CSHA), and the Commonwealth Rent Assistance (CRA) program. In particular, the Housing chapter includes data on accommodation funded under the Crisis Accommodation Program. This is a special purpose program under the CSHA which provides funding to State and Territory housing authorities to support SAAP agencies, by providing infrastructure funding for SAAP accommodation. Some individuals and families utilise both SAAP services and services described in the Housing chapter, as people tend to move from homelessness to social housing.² In 2005-06, for example, approximately 13.3 per cent of former SAAP clients, who requested assistance with obtaining or maintaining independent housing, had moved to public housing (figure 15.32).

Roles and responsibilities

The Australian, 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 the distribution of funding to SAAP funded agencies. Non-government agencies, with some local government participation, deliver most SAAP services. Research, strategy, and other planning and development activities are coordinated at the national level by the SAAP National Coordination and

² Social housing is generally understood to include public and community housing. For further information on these forms of housing assistance, see chapter 16, box 16.2.

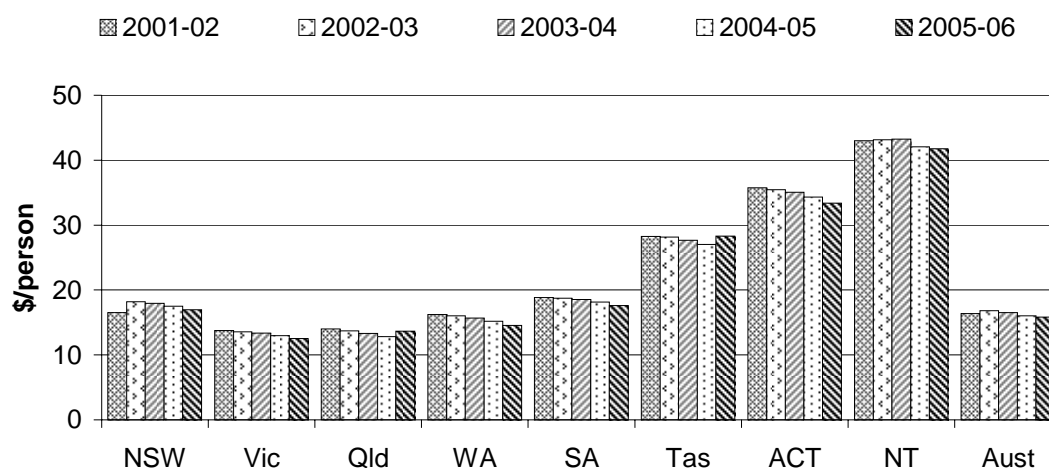
Development Committee (which includes representatives of the Australian Government and each State and Territory government).

Funding

Recurrent funding of SAAP services was \$323.9 million in 2005-06 (table 15A.167), of which the Australian Government contributed 55.1 per cent and the States and Territory governments contributed 44.9 per cent (table 15A.166). These proportions have remained relatively stable since 2001-02. Recurrent SAAP funding per person in the total population in 2005-06 was \$15.80 nationally. This figure varied across jurisdictions but has relatively stable nationally since 2001-02 (figure 15.15).

In 2005-06, some jurisdictions made recurrent allocations in addition to the amounts determined in agreements between those jurisdictions and the Australian Government. These additional funds are not included in the above figures.

Figure 15.15 **Real recurrent SAAP funding per person in the residential population (2005-06 dollars)^{a, b, c}**



^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 Real recurrent funding is calculated using ABS gross domestic product expenditure implicit price deflator 2005-06 = 100 (table AA.26).

Source: Department of Families, Community Services and Indigenous Affairs (FaCSIA) (unpublished); table 15A.168.

15.6 Framework of performance indicators for supported accommodation and assistance services

The framework of performance indicators for supported accommodation and assistance services is based on the shared government objectives for SAAP services (box 15.28).

Box 15.28 Objectives for SAAP services

The overall aim of SAAP is to provide transitional supported accommodation and a range of related support services, to help people who are homeless or at imminent risk of homelessness to achieve the maximum possible degree of self-reliance and independence. Within this aim, the goals are to:

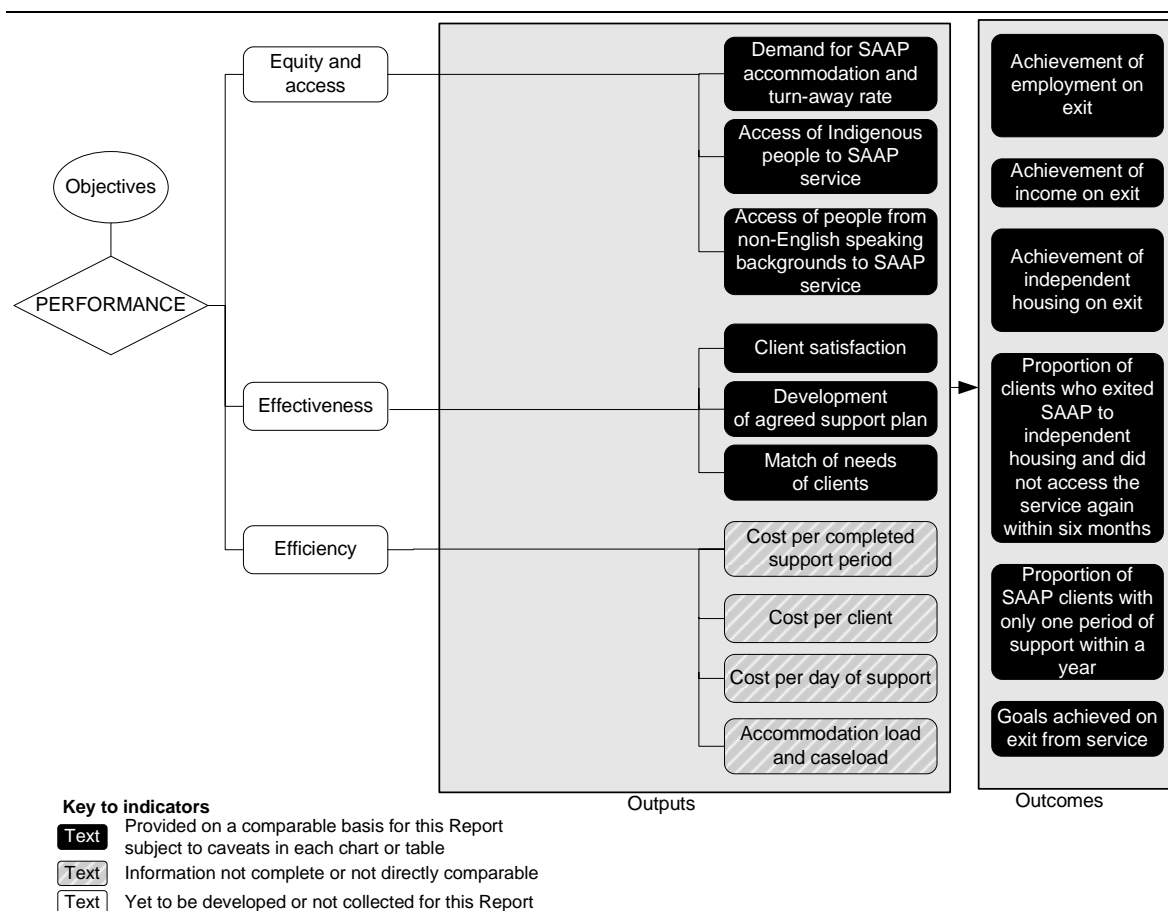
- resolve crises
- re-establish family links where appropriate
- re-establish the capacity of clients to live independently of SAAP.

SAAP services should be provided in an equitable and efficient manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of SAAP services (figure 15.16).

The performance indicator framework shows which data are comparable in the 2007 Report (figure 15.16). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 15.16 Performance indicators for SAAP services



In the 2007 Report, there are a number of improvements in reporting performance of SAAP services. The equity and access indicator in previous Reports ‘proportion of people who receive a service’ is now presented as three separate indicators ‘demand for SAAP accommodation and turn away rate’, ‘access of Indigenous people to SAAP service’ and ‘access of people from non-English speaking backgrounds to SAAP service’. The outcome indicator in previous Reports ‘achievement of independent living’ is now presented as two separate indicators ‘achievement of independent housing on exit’ and ‘achievement of employment on exit’. The outcome indicator in previous Reports ‘not returning to SAAP services within the year or six months’ is now presented as two separate indicators ‘proportion of SAAP clients with only one period of support within a year’ and ‘proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months’.

15.7 Key supported accommodation and assistance performance indicator results

The data collection for SAAP allows for the measurement of the number of clients and of the number and types of services provided to clients, but is subject to some limitations (box 15.29).

Box 15.29 Information needs to be considered when analysing SAAP data

The following information needs to be considered when analysing SAAP data.

- Informed consent is an essential component of the integrity of the data. The principle of client/consumer rights (which underpins informed consent) recognises that clients do not receive services under a mandatory order. They have the right to accept or reject the services offered, as they have the right to provide or not provide information while receiving SAAP services.
- Clients consented to provide personal details for the SAAP client collection for 86.6 per cent of support periods in 2005-06. A weighting system has been developed to adjust for agency non-participation (92.9 per cent of agencies participated in the client collection) and non-consent (SAAP NDCA *Administrative Data and Client Collection*, unpublished).

Outputs

Equity and access

Demand for SAAP accommodation and turn away rate

‘Demand for SAAP accommodation and turn away rate’ is an output (equity and access) indicator of SAAP services (box 15.30).

Box 15.30 Demand for SAAP accommodation and turn away rate

‘Demand for SAAP accommodation and turn away rate’ is an output indicator of governments’ objective to ensure all Australians have equitable access to SAAP services on the basis of relative need. The indicator measures the extent to which the demand for accommodation is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation cannot be provided with that assistance (although one-off assistance may be provided).

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Box 15.30 (Continued)

Two measures of the proportion of people who receive services are reported for all SAAP clients: daily turn-away rate for accommodation; and ratio of unmet demand to total demand for accommodation.

Daily request turn-away rate for accommodation is defined as the daily average number of people whose valid requests for immediate accommodation were unmet, divided by the daily average total number of people who made valid requests for immediate accommodation.

Ratio of unmet demand to total demand is defined as the daily average total number of people whose valid requests for immediate accommodation were unmet, divided by the daily average number of people who made valid requests for immediate accommodation, and those who were continuing their accommodation from the previous day.

A higher proportion of valid requests receiving assistance is desirable.

Data for assessing access to SAAP services are sourced from the Demand for Accommodation Collection and the Client Collection. The Demand for Accommodation Collection measures the levels of met and unmet demand for SAAP accommodation by collecting information about requests for accommodation by individuals or groups over two weeks each year. These data are used in conjunction with Client Collection data to calculate the ‘turn-away’ rate for demand for SAAP accommodation.

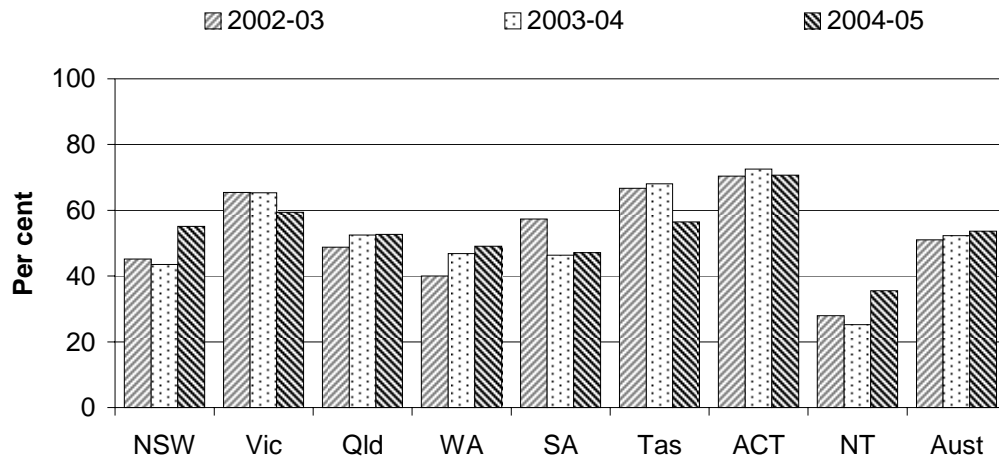
The Demand for Accommodation Collection collects data on ‘valid unmet requests’ for immediate accommodation. ‘Valid unmet requests’ excludes requests made at an agency, where the person or group is determined to be inappropriate for the agency, where there is no fee-free accommodation available at that time, or where proffered assistance is refused. For the Client Collection, the accommodation status of a client on a particular day is based on the reported periods of accommodation within a support period.

As only data from agencies that participated in both the Client Collection and the Demand for Accommodation Collection are used for the calculations, data included in this Report may understate activities of SAAP agencies. Additionally, the two week sample period over which data are collected may not be representative of the eventual success of clients accessing SAAP services over the full year (see notes to tables 15A.169-170).

Data on the proportion of people with valid requests for SAAP accommodation who were turned away are included for the years 2002-03 to 2004-05. Nationally, 53.7 per cent of adults and unaccompanied children requesting immediate SAAP

accommodation on a given day were turned away in 2004-05. The proportion varied across jurisdictions (figure 15.17).

Figure 15.17 Daily turn away rate of adults and unaccompanied children requesting immediate SAAP accommodation, December and May^{a, b, c}

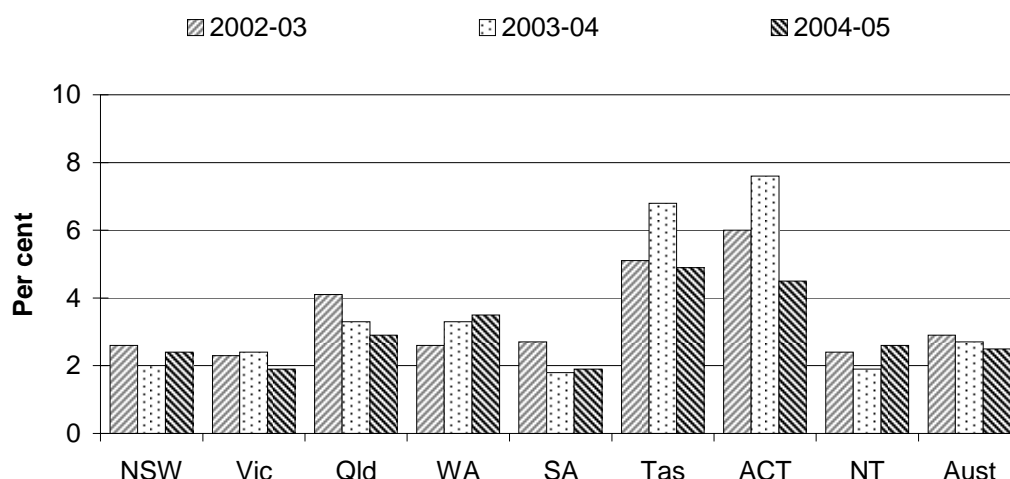


^a A two-week Demand for Accommodation Collection is conducted annually to gather information about homeless people whose requests for accommodation were unable to be met by SAAP agencies. The collections were held in December and May of each financial year. ^b Comparisons between years should be treated with caution, due to variation in participation rates, differing imputation methods and because the collections were held on different dates each year. ^c See notes to table 15A.169 for more detailed data caveats.

Source: AIHW (2004, 2006c); SAAP NDCA *Client and Demand for Accommodation Collections* (unpublished); table 15A.169.

Nationally, the number of adults and unaccompanied children who made valid requests for SAAP accommodation but could not be accommodated accounted for 2.5 per cent of the total demand for SAAP accommodation in 2004-05. This proportion varied across jurisdictions. Total demand for SAAP accommodation is measured by the total number of people who made requests for immediate SAAP accommodation, and those who were continuing their accommodation from the previous day (figure 15.18).

Figure 15.18 Ratio of unmet demand to total demand for SAAP accommodation by adults and unaccompanied children, December and May^{a, b, c}



^a A two-week Demand for Accommodation Collection is conducted annually to gather information about homeless people whose requests for accommodation were unable to be met by SAAP agencies. The collections were held in December and May of each financial year. ^b Comparisons between years should be treated with caution, due to variation in participation rates, differing imputation methods and because the collections were held on different dates each year. ^c See notes to table 15A.170 for more detailed data caveats.

Source: AIHW (2004, 2006c); SAAP NDCA *Client and Demand for Accommodation Collections* (unpublished); table 15A.170.

Some requests for SAAP accommodation were not met for a number of reasons in 2005-06, including a lack of available accommodation (63.0 per cent of those requests that were unmet were for this reason), no vacancies at the referral agency (23.8 per cent), and insufficient staff (1.3 per cent) (table 15A.178).

Access of Indigenous people to SAAP service

‘Access of Indigenous people to SAAP service’ is an output (equity and access) indicator of SAAP services (box 15.31).

Box 15.31 Access of Indigenous people to SAAP service

‘Access of Indigenous people to SAAP service’ is an output indicator of governments’ objective to ensure all Australians have equitable access to SAAP services on the basis of relative need. The indicator measures the extent to which the demand for assistance from Indigenous people is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation, or support, cannot be provided with that assistance (although one-off assistance may be provided).

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Box 15.31 (Continued)

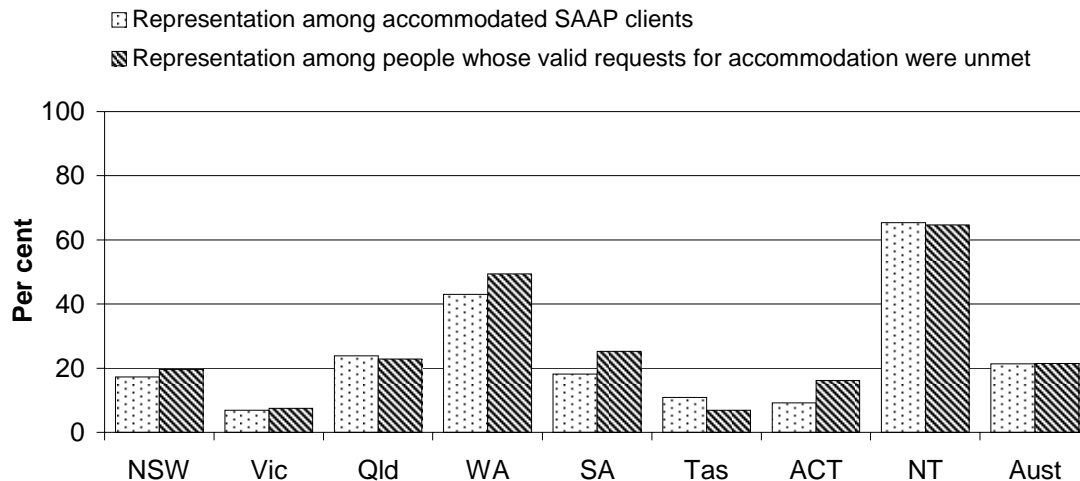
This indicator is defined as the comparison between the representation of Indigenous people among all people whose valid requests for SAAP accommodation were unmet and their representation among SAAP clients who were accommodated during the year.

Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as Indigenous people) is particularly important.

A high and equivalent proportion of valid requests receiving assistance is desirable.

Nationally, Indigenous people made up 21.4 per cent of all people whose valid requests for accommodation did not result in accommodation assistance in 2005-06 — a proportion no different to that of Indigenous clients among all accommodated SAAP clients (21.4 per cent). This result varied across jurisdictions (figure 15.19).

Figure 15.19 Proportion of Indigenous people among all accommodated SAAP clients and among people whose valid requests for accommodation were unmet, 2005-06^a



^a See notes to table 15A.171 for details of data definitions.

Source: SAAP NDCA Client and Demand for Accommodation Collections (unpublished); table 15A.171.

Access of people from non-English speaking backgrounds to SAAP service

‘Access of people from non-English speaking backgrounds to SAAP service’ is an output (equity and access) indicator of SAAP services (box 15.32).

Box 15.32 Access of people from non-English speaking backgrounds to SAAP service

'Access of people from non-English speaking backgrounds to SAAP service' is an output indicator of governments' objective to ensure all Australians have equitable access to SAAP services on the basis of relative need. The indicator measures the extent to which the demand for assistance from people from non-English speaking backgrounds is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation, or support, cannot be provided with that assistance (although one-off assistance may be provided).

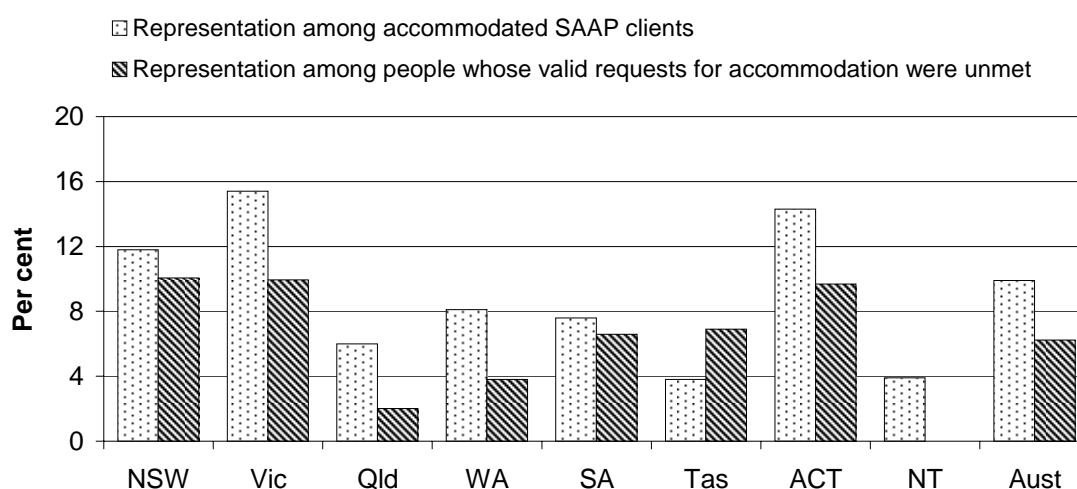
This indicator is defined as the comparison between the representation of people from non-English speaking backgrounds, among all people whose valid requests for SAAP accommodation were unmet, and their representation among SAAP clients who were accommodated during the year.

Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as people from non-English speaking backgrounds) is particularly important.

A high and equivalent proportion of valid requests receiving assistance is desirable.

Nationally, the proportion of people from non-English speaking backgrounds among all people whose valid requests for accommodation did not result in accommodation assistance was 6.2 per cent in 2005-06 — lower than that of people from non-English speaking backgrounds among all accommodated SAAP clients (9.9 per cent). This result varied across jurisdictions (figure 15.20).

Figure 15.20 Proportion of people from non-English speaking backgrounds among all accommodated SAAP clients and among people whose valid requests for accommodation were unmet, 2005-06^a



^a See notes to table 15A.172 for details of data definitions.

Source: SAAP NDCA Client and Demand for Accommodation Collections (unpublished); table 15A.172.

Effectiveness

Client satisfaction

‘Client satisfaction’ is an output indicator of the effectiveness of SAAP services (box 15.33).

Box 15.33 Client satisfaction

‘Client satisfaction’ is an output indicator of governments’ objective to provide high quality services that meet the needs of SAAP recipients.

The indicator is defined as the proportion of clients whose overall satisfaction with the assistance they had received from the SAAP service was either ‘good’ or ‘really good’.

A higher proportion suggests greater client satisfaction with the overall SAAP service.

Data for the client satisfaction indicator are sourced from the national SAAP client satisfaction survey, which is conducted periodically. As a result, new data for this indicator are not available for this Report. Data on client satisfaction relating to a four week period beginning 11 November 2003 were included in the 2005 Report (SCRGSP 2005, pp. 15.47-48; Colmar Brunton Social Research 2004).

Development of agreed support plan

‘Development of agreed support plan’ is an output indicator of the effectiveness of SAAP services (box 15.34).

Box 15.34 Development of agreed support plan

‘Development of agreed support plan’ is an output indicator of governments’ objective to provide high quality services that are appropriately targeted to meet the needs of SAAP clients.

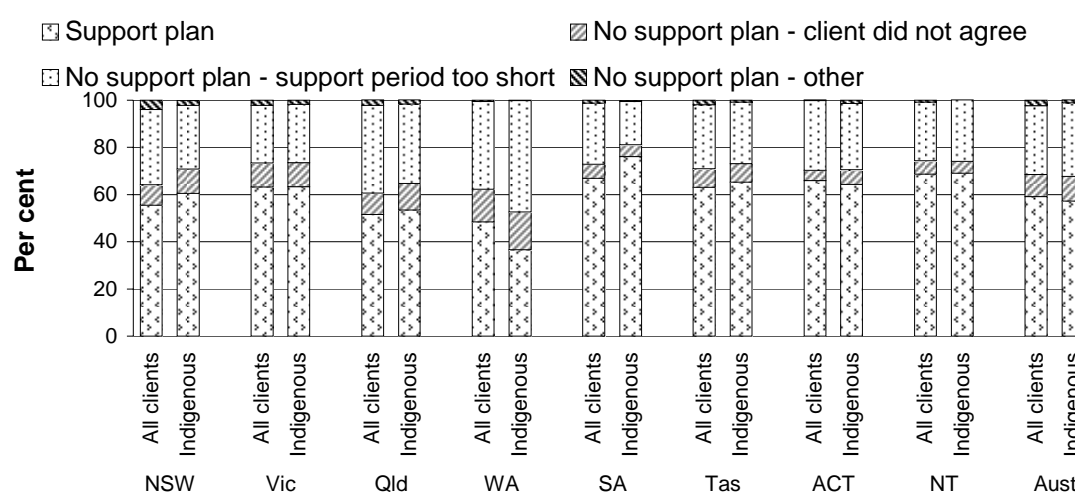
This indicator is defined as the number of closed support periods with an agreed support plan divided by the total number of support periods. Data are reported for all SAAP clients, and separately for Indigenous people.

A higher proportion of support periods with agreed support plans is desirable. In some instances, however, a support plan may be judged to be inappropriate (such as when a support period is short term).

Counting rules for this indicator were changed for this Report. Only ‘closed’ support periods are now included for 2005-06 data. This excludes previously counted ‘ongoing’ support periods where outcomes of the support cannot be determined and is consistent with other support period data in the Report.

Nationally, there was an agreed support plan for 59.2 per cent of support periods for all clients in 2005-06 (compared with 57.2 per cent for Indigenous clients). This proportion varied across jurisdictions (figure 15.21).

Figure 15.21 Support periods, by the existence of a support plan, 2005-06^a



^a See notes to tables 15A.173-174 for more details.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); tables 15A.173-174.

Match of needs of clients

‘Match of needs of clients’ is an output indicator of the effectiveness of SAAP services (box 15.35).

Box 15.35 Match of needs of clients

'Match of needs of clients' is an output indicator of governments' objective to ensure that SAAP services meet their client's individual needs. This is a measure of appropriateness. The range of services needed is broad (ranging from meals to laundry facilities to long-term accommodation), so the effect of not providing these services varies.

This indicator is defined as the number of clients who were provided with the services they needed and clients who were referred to another agency, divided by the total number of SAAP clients.

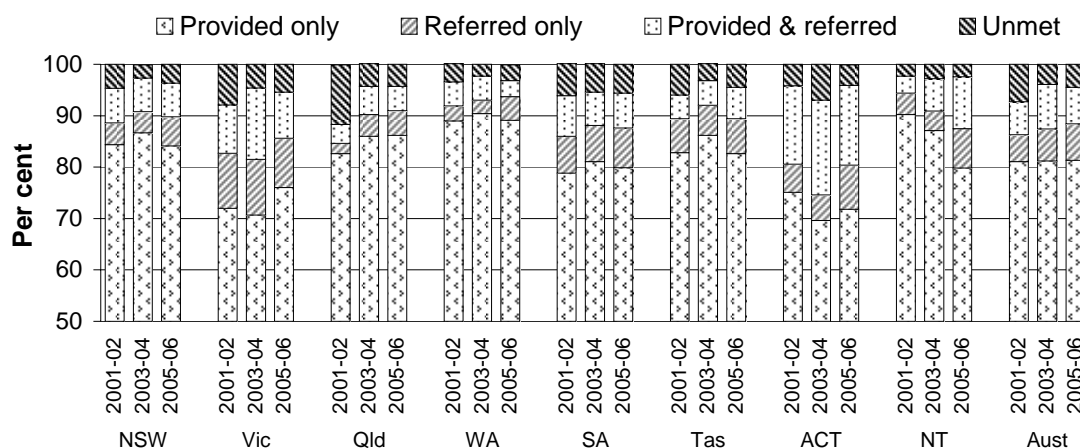
Data are reported for all SAAP clients, and separately for Indigenous people and people from non-English speaking backgrounds.

A higher proportion of clients who received services they needed, or who were referred to another agency, is desirable.

Counting rules for this indicator were changed for this Report. Only 'closed' support periods are now included for 2005-06 data. This excludes previously counted 'ongoing' support periods where outcomes of the support cannot be determined and is consistent with other support period data in the Report.

Nationally, the proportion of clients who received needed services (including services provided by the initially approached agencies and/or referrals to another agency) was 95.5 per cent in 2005-06 (figure 15.22).

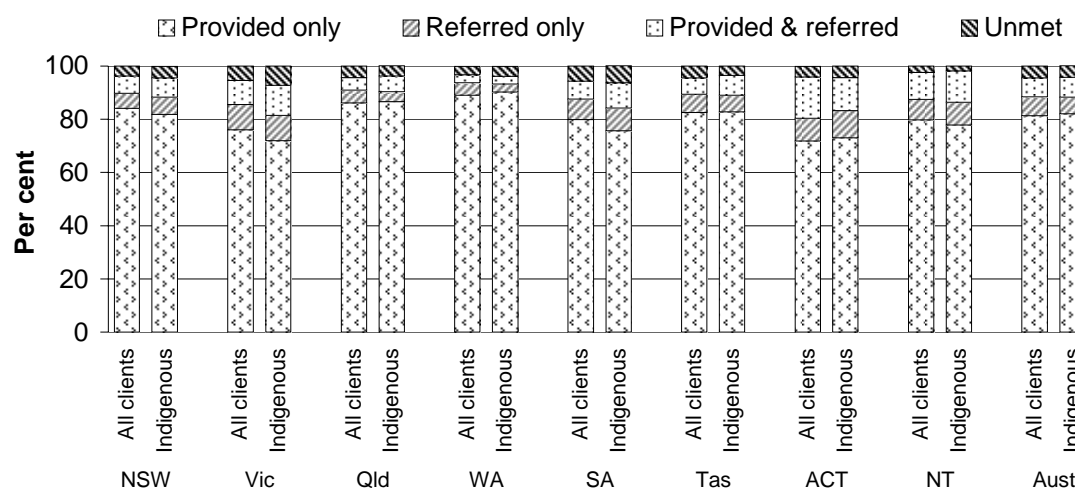
Figure 15.22 SAAP clients, by met and unmet support needs



Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.175.

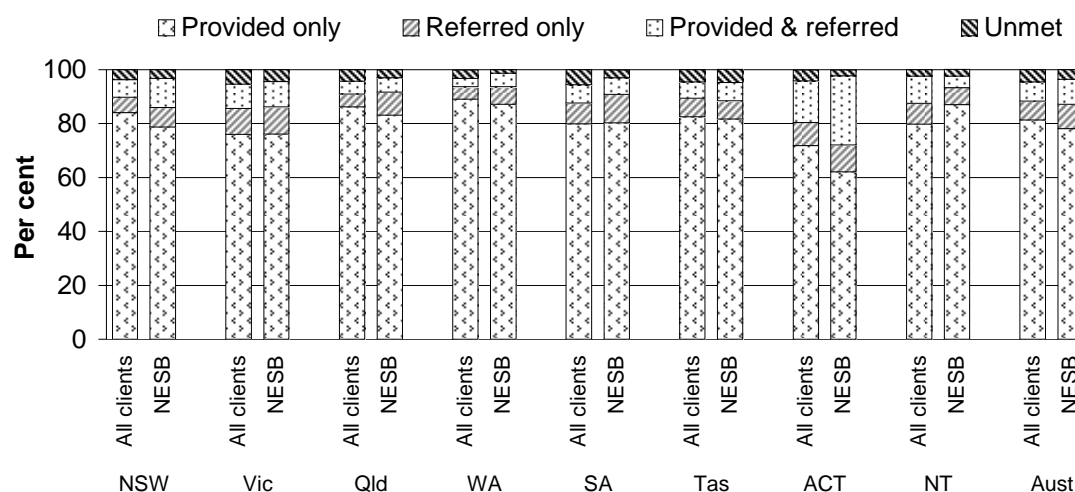
The proportions for Indigenous clients (95.7 per cent) and clients from a non-English speaking background (96.4 per cent) who received needed services in 2005-06 were similar to that for all clients. These proportions varied across jurisdictions (figures 15.23 and 15.24).

Figure 15.23 Indigenous clients, by met and unmet support needs, 2005-06



Source: SAAP NDCA Administrative Data and Client Collections (unpublished); tables 15A.175-176.

Figure 15.24 Clients from non-English speaking backgrounds, by met and unmet support needs, 2005-06



NESB = Non-English speaking background.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); tables 15A.175 and 15A.177.

Efficiency

Across jurisdictions, there are varying treatments of expenditure items (for example, superannuation) and different counting and reporting rules for generating financial data. Results reported on efficiency indicators may reflect these differences.

The funding figures used in calculating the following efficiency indicators include recurrent allocations to agencies provided by some jurisdictions in addition to the amounts determined in the agreements between these jurisdictions and the Australian Government.

Cost per completed support period

‘Cost per completed support period’ is an output indicator of the efficiency of SAAP services (box 15.36).

Box 15.36 Cost per completed support period

‘Cost per completed support period’ is an output indicator of governments’ objective to maximise the availability and quality of services through the efficient use of taxpayer resources. This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost).

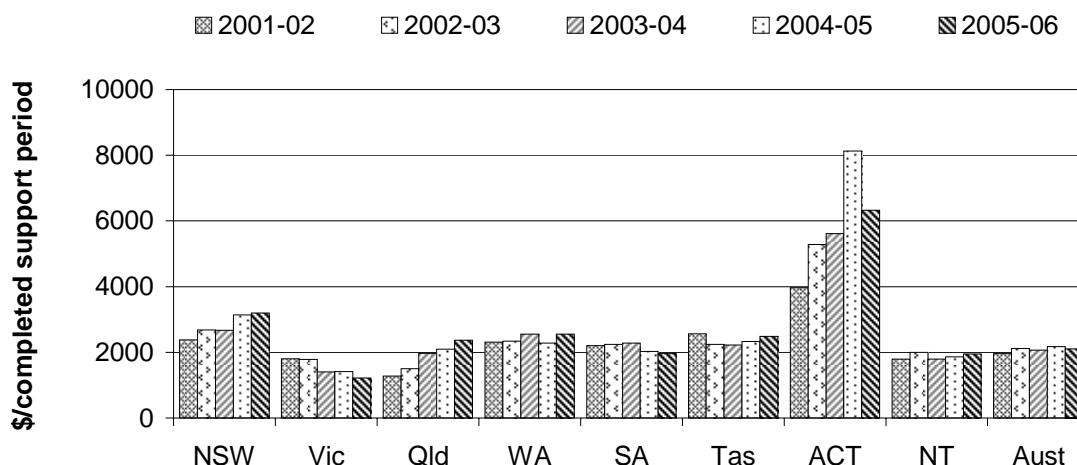
This indicator is defined as total expenditure on SAAP services divided by the number of completed support periods (excluding casual and potential clients, and accompanying children).

A lower cost per completed support period is desirable, but may also indicate lesser service quality.

Unit cost analyses include only expenditure by service delivery providers. Unit cost indicators should also include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the Commonwealth State Housing Agreement through a special purpose program (the Crisis Accommodation Program).

The recurrent cost per completed support period (excluding casual and potential clients, and accompanying children) averaged \$2100 nationally and varied across jurisdictions in 2005-06 (figure 15.25).

Figure 15.25 **Real recurrent cost per completed support period
(2005-06 dollars)^a**



^a See notes to table 15A.179 for detailed data caveats.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.179.

Cost per client

‘Cost per client’ is an output indicator of the efficiency of SAAP services (box 15.37).

Box 15.37 Cost per client

‘Cost per client’ is an output indicator of governments’ objective to maximise the availability and quality of services through the efficient use of taxpayer resources. This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost).

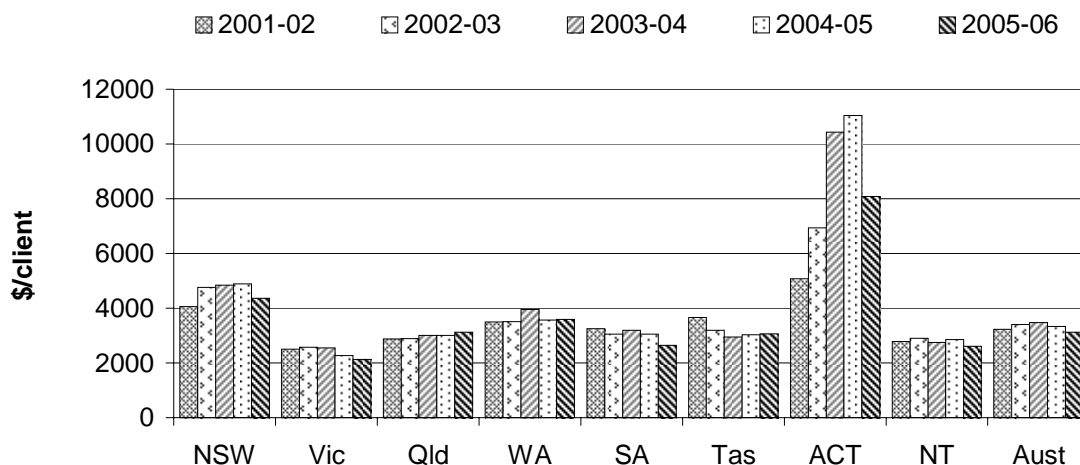
This indicator is defined as total expenditure on SAAP services divided by the number of clients accessing a bed or place over the year.

A lower cost per client is desirable, but may also indicate lesser service quality.

Unit cost analyses include only expenditure by service delivery providers. Unit cost indicators should also include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the Commonwealth State Housing Agreement through a special purpose program (the Crisis Accommodation Program).

Nationally, the recurrent cost per client accessing SAAP services was \$3130 and varied across jurisdictions in 2005-06 (figure 15.26).

Figure 15.26 Real recurrent cost per client accessing SAAP services (2005-06 dollars)^a



^a See notes to table 15A.180 for detailed data caveats.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.180.

Cost per day of support

‘Cost per day of support’ is an output indicator of the efficiency of SAAP services (box 15.38).

Box 15.38 Cost per day of support

‘Cost per day of support’ is an output indicator of governments’ objective to maximise the availability and quality of services through the efficient use of taxpayer resources. This indicator provides a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost).

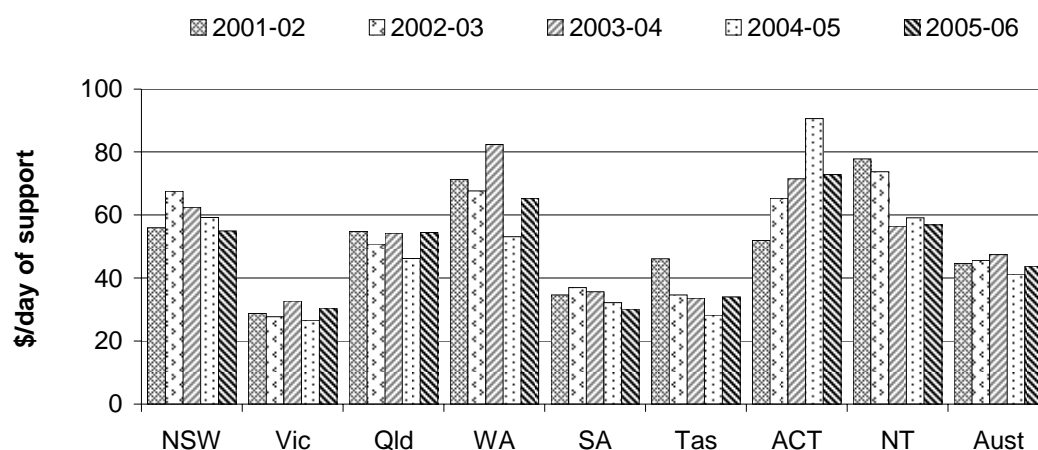
This indicator is defined as total expenditure on SAAP services divided by the number of days of support for SAAP clients receiving support and/or supported accommodation (excluding casual and potential clients, and accompanying children).

A lower cost per day of support is desirable, but may also indicate lesser service quality.

Unit cost analyses include only expenditure by service delivery providers. Unit cost indicators should include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the Commonwealth State Housing Agreement through a special purpose program (the Crisis Accommodation Program).

The recurrent cost per day of support for SAAP clients averaged \$44 nationally and varied across jurisdictions in 2005-06 (figure 15.27).

Figure 15.27 Real recurrent cost per day of support for homeless clients (2005-06 dollars)^a



^a See notes to table 15A.181 for detailed data caveats.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.181.

Accommodation load and caseload

‘Accommodation load’ and ‘caseload’ are output indicators of the efficiency of SAAP services (box 15.39).

Box 15.39 Accommodation load and caseload

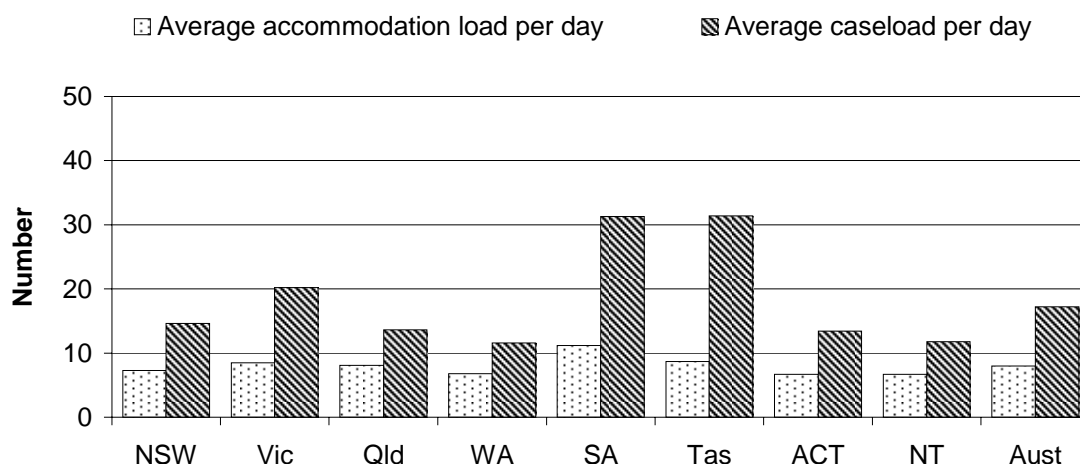
‘Accommodation load’ and ‘caseload’ are indicators of governments’ objective to maximise the availability and quality of services through the efficient use of taxpayer resources. Average accommodation load and caseload are output indicators of efficiency, and they indicate levels of output by agencies.

The average accommodation load is defined as the average number of people accommodated per day per agency. The average caseload is defined as the average number of people being supported per day per agency.

Higher loads may mean greater efficiency or, alternatively, a lesser quality service. Accommodation load and caseload are likely to be affected by the size of the agencies funded under the SAAP Program.

The national average daily accommodation load and caseload per agency were 8.0 and 17.2 respectively, and this varied across jurisdictions in 2005-06 (figure 15.28).

Figure 15.28 **Average accommodation load and caseload per day, 2005-06^a**



^a See notes to table 15A.182 for descriptions of how accommodation load and caseload were estimated.

Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); table 15A.182.

Outcomes

An important outcome of SAAP services is clients' achievement of self-reliance and independence. Characteristics that may indicate whether clients can live independently include their income, housing status and workforce status. These characteristics are recorded at the end of a client's support period.

Achievement of employment on exit

'Achievement of employment on exit' is an outcome indicator of SAAP services (box 15.40).

Box 15.40 Achievement of employment on exit

‘Achievement of employment on exit’ is an outcome indicator of governments’ objective to enable clients to participate as productive and self-reliant members of society at the end of their support period.

Achievement of employment is defined as the number of SAAP clients who sought assistance to obtain or maintain employment and training, and achieved employment after SAAP support, divided by the total number of clients who sought assistance to obtain or maintain employment. Support periods reported relate to these clients only.

This indicator compares these clients’ employment status before and after they requested SAAP support.

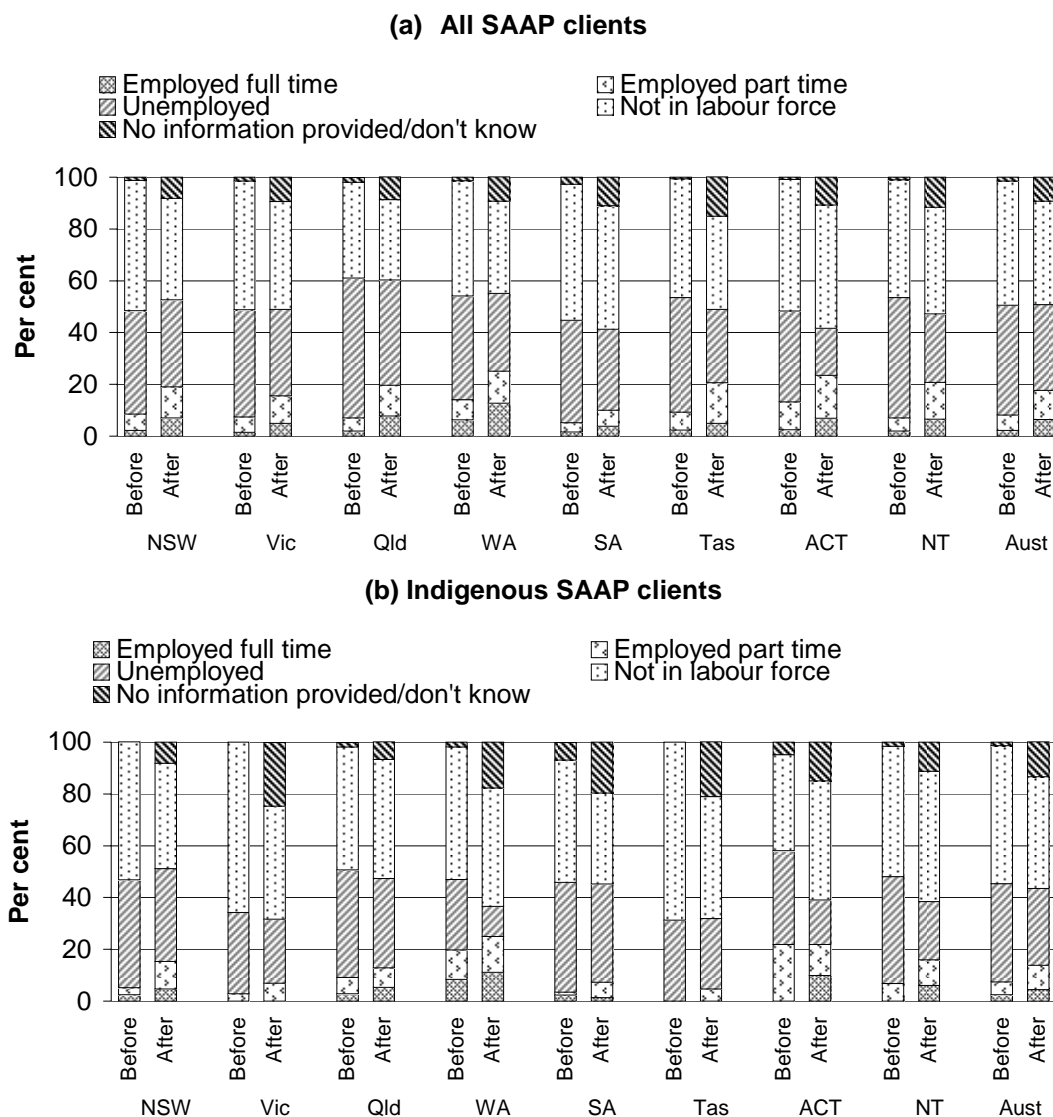
This indicator relates to relatively short term outcomes — that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but more difficult to measure.

Higher proportions of achievement of employment are desirable.

Nationally, of those clients who sought assistance to obtain or maintain employment and training when entering SAAP in 2005-06, the proportion of clients who were employed either full-time or part-time increased from 8.2 per cent before support to 17.7 per cent after support (6.4 per cent full time and 11.3 per cent part time). The proportions of clients who were unemployed decreased from 42.3 per cent before support to 33.1 per cent after support. The proportions of clients who were not in the labour force decreased from 48.0 per cent before support to 39.9 per cent after support. These proportions varied across jurisdictions (figure 15.29, table 15A.185 and table 15A.186).

Nationally, of those Indigenous clients who sought assistance to obtain or maintain employment and training when entering SAAP in 2005-06, the proportion of clients who were employed either full-time or part-time increased from 7.4 per cent before support to 13.8 per cent after support (4.5 per cent full time and 9.3 per cent part time). The proportion of clients who were unemployed decreased from 38.0 per cent before support to 29.7 per cent after support. The proportion of clients who were not in the labour force decreased from 53.3 per cent before support to 43.1 per cent after support. These proportions varied across jurisdictions (figure 15.29 and table 15A.187).

Figure 15.29 **Changes in labour force status of clients who needed assistance to obtain/maintain employment and training before/after SAAP support, 2005-06^a**



^a Data are for people who requested assistance with obtaining or maintaining employment when entering SAAP services.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); tables 15A.185-187.

Achievement of income on exit

‘Achievement of income on exit’ is an outcome indicator of SAAP services (box 15.41).

Box 15.41 Achievement of income on exit

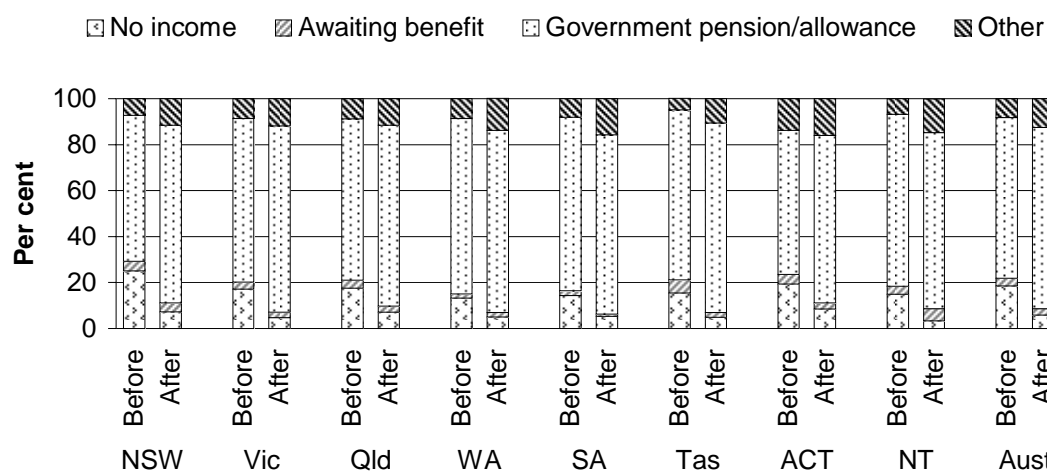
'Achievement of income on exit' is an outcome indicator of governments' objective to enable clients to participate independently in society at the end of their support period. A client's independence and self-reliance is enhanced when the client experiences a positive change in income source (for example, from having no income support to obtaining some income, including wages and/or benefits) on exit from SAAP services.

This indicator is defined as the number of clients who requested assistance to obtain or maintain a pension or benefit and exited SAAP with an income source, divided by the total number of clients who requested assistance to obtain or maintain a pension or benefit.

A high proportion of clients who requested income assistance and exited SAAP with an income source is desirable.

Nationally, the proportion of clients who did not have income and requested income assistance was 5.9 per cent after SAAP assistance in 2005-06 — a 12.6 per cent decrease from 18.5 per cent before SAAP assistance (figure 15.30). The proportion of Indigenous clients who did not have income and requested income assistance also decreased after SAAP assistance nationally (5.0 per cent compared with 16.1 per cent before SAAP assistance) (figure 15.31). Both before and after the SAAP assistance, the income source for the majority of SAAP clients is a government pension/allowance (figures 15.30 and 15.31).

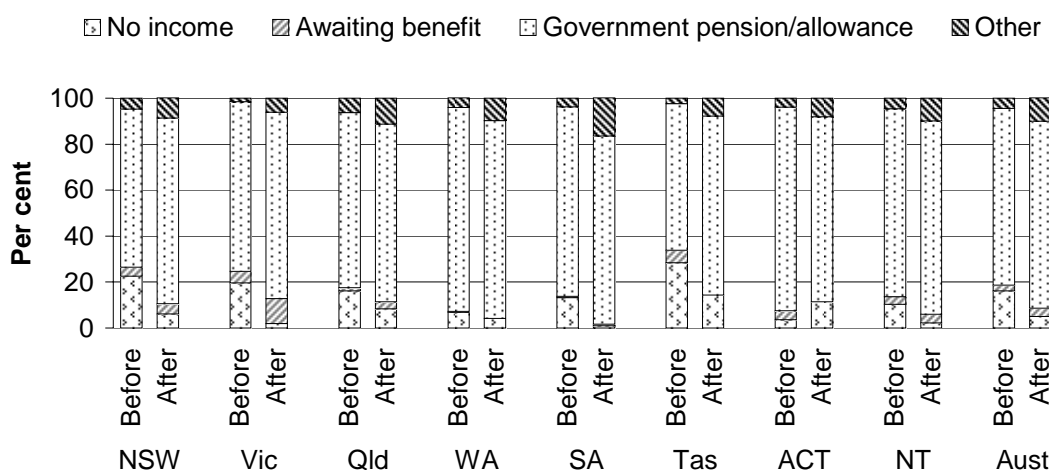
Figure 15.30 **Source of income immediately before/after SAAP support of clients who needed assistance to obtain/maintain a pension or benefit, 2005-06^a**



^a 'Other' includes other, don't know and no information provided.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.191.

Figure 15.31 **Source of income immediately before/after SAAP support of Indigenous clients who needed assistance to obtain/maintain a pension or benefit, 2005-06^a**



^a 'Other' includes other, don't know and no information provided.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.192.

Achievement of independent housing on exit

'Achievement of independent housing on exit' is an outcome indicator of SAAP services (box 15.42).

Box 15.42 Achievement of independent housing on exit

'Achievement of independent housing on exit' is an outcome indicator of governments' objective to enable clients to participate as productive and self-reliant members of society at the end of their support period.

Achievement of independent housing is defined as the number of support periods of clients who requested assistance with obtaining or maintaining independent housing achieving independent housing at the end of a support period, divided by the total number support periods of clients who requested assistance with obtaining or maintaining independent housing.

This indicator relates to relatively short term outcomes — that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but more difficult to measure.

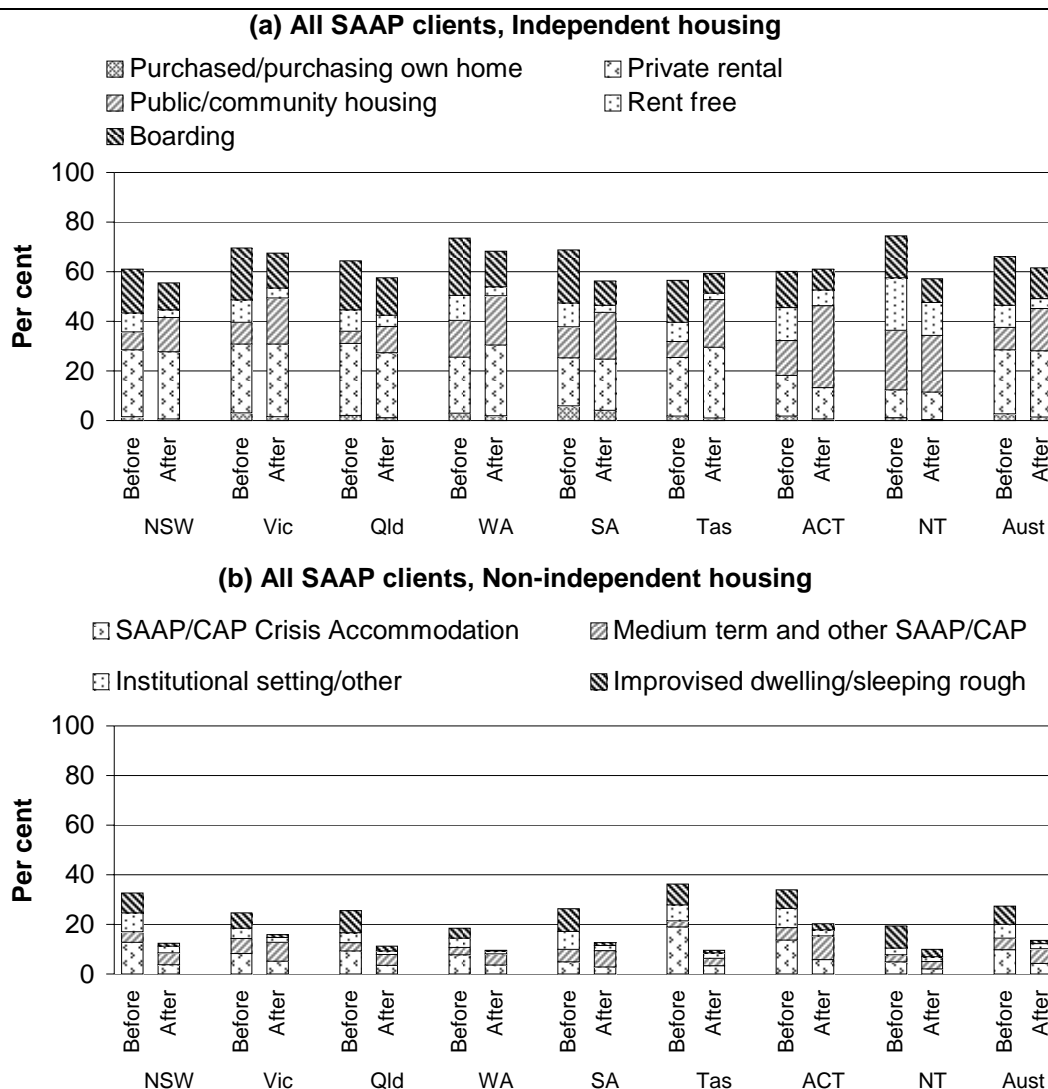
Higher proportions of independent housing are desirable.

Nationally, 61.5 per cent of clients who requested assistance with obtaining or maintaining independent housing achieved independent housing at the end of a support period in 2005-06. This included clients who moved or returned to private rental housing (26.7 per cent), to public rental housing (13.3 per cent), and those who were boarding (12.4 per cent) (figure 15.32).

Among Indigenous clients, on a national basis, 58.3 per cent of clients who requested assistance with obtaining or maintaining independent housing achieved independent housing at the end of a support period in 2005-06, including those who moved or returned to private rental housing (17.5 per cent), to public rental housing (17.8 per cent), and who were boarding (13.0 per cent) (figure 15.32).

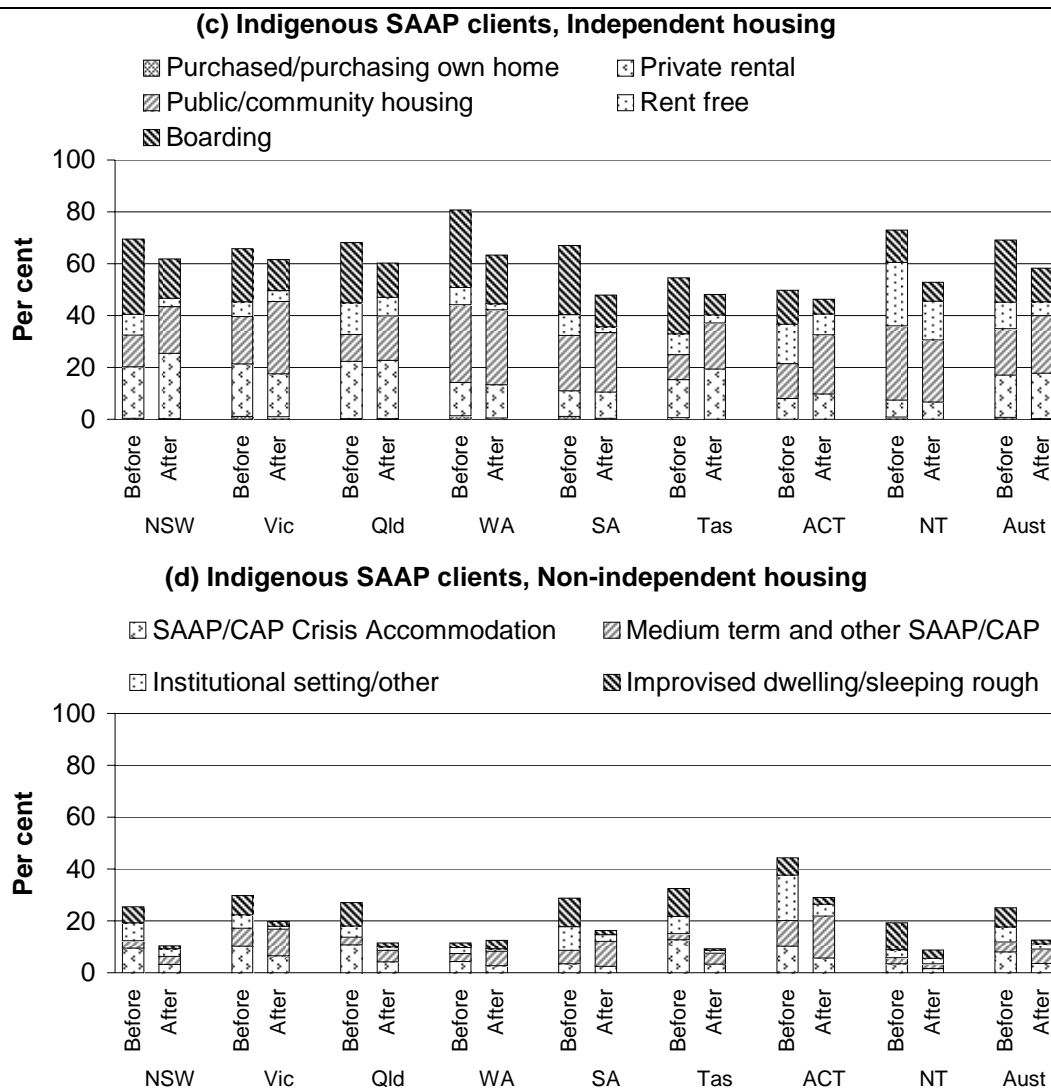
Clients who did not achieve independent housing at the end of a support period in 2005-06 included those who moved to, or continued to live in, short to medium term SAAP accommodation and other forms of non-independent accommodation (figure 15.32).

Figure 15.32 Accommodation type before and after SAAP support, for clients who requested assistance with obtaining or maintaining housing, 2005-06^a



(Continued on next page)

Figure 15.32 (Continued)



^a High levels of 'don't know' and 'no information provided' categories in the "after SAAP Support" data may mean that some clients who achieved independent or non-Independent housing are not represented here (see attachment tables for more information).

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); tables 15A.183-184.

Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months

'Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months' is an outcome indicator of SAAP services (box 15.43).

Box 15.43 Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months

'Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months' is an outcome indicator of governments' objective to enable clients to participate independently in society at the end of their support period.

This indicator is defined as the number of clients who exit to independent housing and do not return to SAAP within six months, divided by the total number of SAAP clients.

A higher proportion of clients not returning to the program within six months is desirable.

A number of SAAP clients who need long term assistance may access SAAP services a number of times before their needs are met on a permanent basis. Ongoing contact with SAAP agencies may also lead to an improvement in living skills and self-reliance.

Estimates of clients exiting SAAP support to independent housing and not returning to SAAP within six months are affected by the data issues discussed in box 15.29. The most recent data available are from 2004-05 and may not represent all clients — for example, at the national level, only 62.3 per cent of clients provided information on their accommodation after exiting (table 15.2). Given the potential for data bias, these estimates should be interpreted with care.

Table 15.2 Indicative estimates of clients who exited SAAP to independent housing and did not return within six months, 2004-05^a

<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Clients who provided information on accommodation after exit from support									
no.	13 100	25 300	9 000	5 200	4 800	2 200	900	1 900	62 500
As a proportion of total clients									
%	57.0	72.5	54.2	61.2	53.9	51.2	64.3	67.9	62.3
Clients recorded as exiting to independent accommodation and not returning within six months									
no.	5 300	12 500	3 700	2 500	1 700	1 200	400	1 100	28 400
Indicative estimates of clients exiting to independent housing and not returning within six months									
%	40.5	49.4	41.1	48.1	35.4	54.5	44.4	57.9	45.4

^a See notes to table 15A.190 for more details of how the estimates were calculated and data caveats.

Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); table 15A.190.

Strategies are being implemented to improve the quality of these data, including improving client consent rates and the collection of exit information. It is anticipated that over time data will become sufficiently robust to allow comparative performance assessment.

Proportion of SAAP clients with only one period of support within a year

‘Proportion of SAAP clients with only one period of support within a year’ is an outcome indicator of SAAP services (box 15.44).

Box 15.44 Proportion of SAAP clients with only one period of support within a year

‘Proportion of SAAP clients with only one period of support within a year’ is an outcome indicator of governments’ objective to enable clients to participate independently in society at the end of their support period.

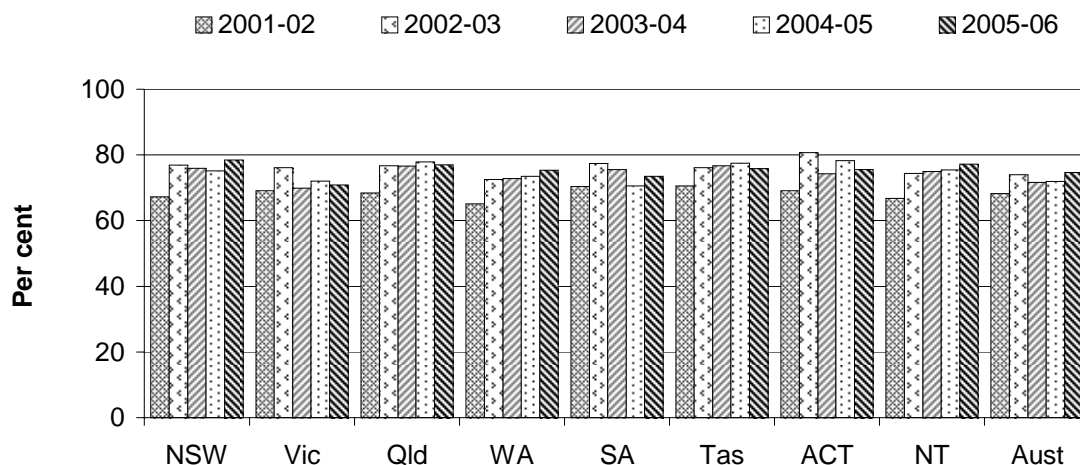
This indicator is defined as the number of clients with only one support period during the year, divided by the total number of SAAP clients.

A higher proportion of clients with only one support period during the year is desirable.

It may be appropriate for some clients to receive more than one support period in a given period of time (for example, moving from crisis accommodation to medium term accommodation). One group that makes multiple use of SAAP is single adults, especially older single men. A number of SAAP clients who need long term assistance may access SAAP services a number of times before their needs are met on a permanent basis. Ongoing contact with SAAP agencies may also lead to an improvement in living skills and self-reliance.

Nationally, 74.7 per cent of SAAP clients had only one support period in 2005-06 (figure 15.33). The proportion for Indigenous clients was similar (75.1 per cent) (table 15A.189).

Figure 15.33 **Proportion of SAAP clients with only one period of support within a year ^a**



^a Data from 2001-02 are based on estimated support periods per client, rather than on observed support periods per client as included in previous Reports.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.188.

Goals achieved on exit from service

‘Goals achieved on exit from service’ is an outcome indicator of SAAP services (box 15.45).

Box 15.45 Goals achieved on exit from service

‘Goals achieved on exit from service’ is an outcome indicator of governments’ objective to ensure SAAP services meet the needs and expectations of users.

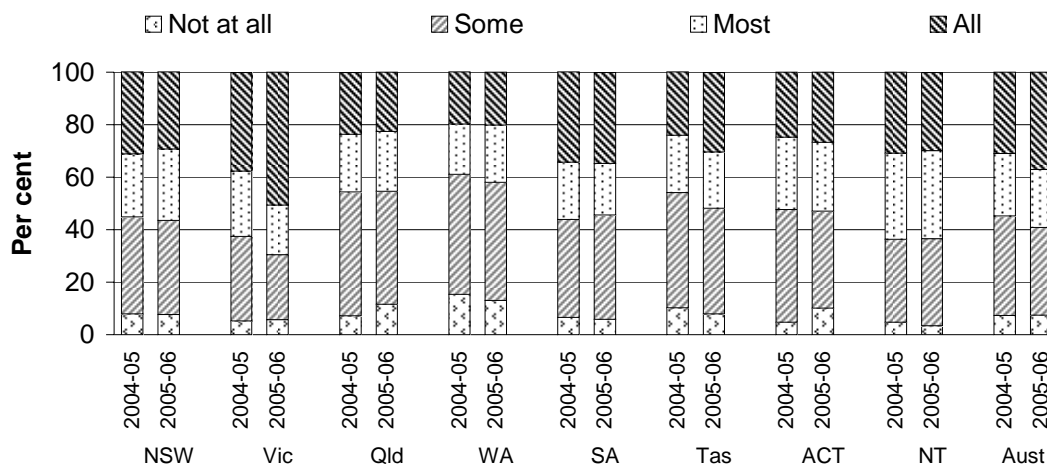
This indicator is defined as the number of clients whose case management goals are fully or mostly achieved by the end of the support period, divided by the total number of clients with case management goals in a given period.

The data is identified from a questionnaire completed by clients.

A high proportion of achieved goals is desirable.

Nationally, case management goals were fully or mostly achieved by the end of the support period for 59.2 per cent of clients in 2005-06 (figure 15.34).

Figure 15.34 **Goals achieved on exit from SAAP services**



Source: SAAP NDCA Client and Administrative Data Collections (unpublished); table 15A.193.

15.8 Future directions in supported accommodation and assistance performance reporting

Under SAAP V (2005–2010), a new performance framework was developed and incorporated into the Multilateral Agreement. The new performance framework contains some of the same performance indicators as SAAP IV but new emphases have been placed on client outcome information. Four levels of client outcomes are identified in the SAAP V Program Logic developed by a working group of the Coordination and Development Committee (CAD). Information on some client outcome indicators can be obtained from the SAAP National Data Collection and reported on a regular basis, but information on some higher level client outcome indicators can only be obtained from targeted research. Three specific research projects will be carried out under SAAP V to obtain this information. These projects are: SAAP Impact on client self-reliance, measuring the number of clients with high and complex needs and Client Satisfaction and Exit survey.

An Evaluation Working Group (EWG) consisting of representatives from the Australian and State/Territory governments has been established to develop an evaluation framework for SAAP V. The EWG has been conducting a rolling evaluation process for SAAP V and is currently examining the data and research implications with a view to putting in place any new data and research activities required for evaluation over the life of SAAP V. These data and research activities include research on longer term housing outcomes for SAAP clients entering public housing and private rental housing, a survey of SAAP agencies to determine views

on the achievement of SAAP V strategic directions, an analysis of the evaluations undertaken on each of the Innovation and Investment Fund projects, the three client outcome projects mentioned above, and other data and research projects. These developments are likely to provide improved outcome focussed data for future Reports.

Improving data from Indigenous clients

An Indigenous data training package is being developed by the NDCA at the AIHW in collaboration with the Information Sub-committee of the CAD. Members of the Indigenous Reference Group consist of SAAP Indigenous representatives from NSW, Victoria, Queensland, WA and NT, together with staff from the NDCA, Queensland Department of Communities, and FaCSIA. The Reference Group provided input to develop the package based on current SAAP data training content but with an Indigenous specific focus. It is anticipated that the package will encourage more Indigenous agencies to participate in the SAAP data collection and demonstrate to Indigenous agencies the value of collecting SAAP data for Indigenous clients. This development will improve the quality and coverage of Indigenous data in future Reports.

SMART 6

A new version of the SAAP Management and Reporting Tool (SMART) is being planned for release in 2007. Currently 55 per cent of SAAP agencies are using SMART to collect SAAP data. It is envisaged that the deployment of SMART 6 will see the phasing out of paper questionnaires. The rollout of SMART 6 will first take place at agencies that are currently using SMART, with eventual implementation in all agencies. These developments are anticipated to provide greater coverage and improved quality of data for future Reports.

15.9 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

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Supported Accommodation Assistance Program (SAAP)

The Multilateral Agreement for SAAP V was signed by all partners in September 2005 and all Bilateral Agreements were signed by the end of January 2006. Under the Agreement total resources available to the program will increase by almost \$350 million to an estimated \$1.82 billion over the life of SAAP V (2005–2010). The Australian Government's contribution to SAAP V totals \$932 million over five years.

One of the significant differences between the SAAP IV and SAAP V Agreements is the jointly-funded Innovation and Investment Fund worth around \$125 million. The Australian Government initiated the establishment of the Fund to drive strategic reform in the SAAP sector. The focus of the Fund is on identifying ways of reducing the high rates of return to SAAP services by improving pre-crisis intervention, post-crisis transition and linkages with other services, including mental health and employment support services. The Australian Government's contribution to the Innovation and Investment Fund is \$40 million with \$39 million provided directly to State/Territory governments.

Total spending for SAAP in 2005-06 was \$324 million. Of that amount, \$179 million was contributed by the Australian Government, and State and Territory governments contributed \$145 million.

The Australian government provided funding of \$10.4 million over four years in the 2004-05 Budget for the Household Organisational Management Expenses Advice Program. This programme builds on the success of the Family Homelessness Prevention Pilots which was introduced in 2001.

An extension of the National Homelessness Strategy (NHS) was announced in the 2005-06 budget with funding of \$10 million over four years. The NHS includes demonstration projects which trial innovative models to prevent or respond to homelessness and communication activities to disseminate the knowledge base on homelessness.

The Reconnect programme provides early intervention assistance to young people aged 12–18, who are homeless or at risk of homelessness to improve the level of engagement with their family, education, training or work and with the community. The 2006-07 budget allocated \$22.72 million for the Reconnect programme. This includes funding to provide combined Reconnect and Job Placement Employment and Training services to assist newly arrived young people and their families from culturally and linguistically diverse backgrounds. There are 98 Reconnect services across Australia. Since its inception in 1999 Reconnect services have provided support to over 50 000 young people and their families.

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New South Wales Government comments

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Child protection and supported placements

The NSW Guidelines for Child Protection Intervention have been a central part of the NSW child and family service system for almost two decades. While not intended to replace individual agencies policies and procedures, the Guidelines are the key source document to advise and guide professionals and agencies in key child protection interagency issues. Following a comprehensive review of the Guidelines which commenced in 2004 and led by the Child Protection Senior Officers' Group, who consulted extensively across the sector, a new edition of the guidelines was made electronically available to practitioners in September 2006.

The Department of Community Services (DoCS) Early Intervention Program is a voluntary, targeted program that supports vulnerable children and families to prevent them from entering or escalating in the child protection system. This Program is progressively rolling out across NSW, and will deliver \$150 million for early intervention services and the employment of 350 new dedicated early intervention caseworkers by 2008.

An important feature of the Early Intervention Program is that families can access the full range of services and supports they require through a single entry point, either through the DoCS early intervention team, or an identified non-government agency called a Lead Agency. This is intended to promote accessible, efficient and consistent service provision and a more collaborative approach to service delivery. Families in the Early Intervention Program can access core funded services which are home visiting, parenting programs and quality childcare, coordinated by their case manager. The case manager works closely with families over an extended period, fostering and promoting family strengths, facilitating access to support services that meet identified family needs, all with a focus on strengthening positive parent-child relationships and optimising long term benefits for children including school readiness.

Supported Accommodation Assistance Program (SAAP)

Implementing SAAP V in year one Agreement has been truncated due to the delay in finalising the Multilateral and Bilateral Agreements. In NSW the focus was on finalising the critical operational policy frameworks that SAAP will operate under. These include, SAAP V Regional Planning, Performance Monitoring Framework and Good Practice Guidelines.

Priority was given to communicating the strategic directions of SAAP V, in particular the expectations and requirements of service providers to implement SAAP V, the regional planning processes and expectations and the process for implementing a Performance Monitoring Framework and Good Practice Guidelines.

SAAP V Regional Planning is due for completion by July 2007 and this will describe the reforms required over the remaining three years of SAAP V.

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Victorian Government comments

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Child protection and supported placements

The Minister for Children launched the ‘every child every chance’ reforms for vulnerable children in April 2006. These reforms form part of a broader reform of child and family services aimed at helping all children to grow, thrive and reach their full potential. A critical milestone in these reforms was the passage of two new Acts, the *Child Wellbeing and Safety Act*, which is the framework legislation for services for all children, and the *Children, Youth and Families Act*, which is detailed legislation targeted at vulnerable children and families. These Acts were given royal assent in December 2005.

The *Children, Youth and Families Act* will commence operation in March 2007. The Act provides the necessary legal foundations to create a more integrated system of child, youth and family services — a system that focuses on vulnerable children’s safety, health, learning, well-being and development. It provides the necessary legal authorities for new ways of working that will connect families to the services they need earlier and to make these services more accessible and more adaptable to the changing needs of today’s families. Strong focus is given to keeping Aboriginal children connected to their culture and community.

As part of these changes, the Department of Human Services is working closely with community service organisations and Aboriginal services to strengthen support services for vulnerable families.

Supported Accommodation Assistance Program (SAAP)

Victoria continued to implement development of the integrated homelessness assistance responses outlined in the Victorian Homelessness Strategy, particularly in relation to the integrated response to family violence.

An additional \$13.4 million is being invested over four years from 2005-06 to improve housing and support services for women and children experiencing family violence, as part of the Victorian Government’s \$35.1 million package to reduce family violence. This approach aims to reduce family violence through a response that involves support services, police and courts working together to improve integrated responses to family violence.

The *Consumer Charter* was implemented which sets out the rights and responsibilities of people who use homelessness services. Funding was provided to enhance the homelessness advocacy program delivered through the Council to Homeless Persons and to implement the peer educator support program. Six peer educators — people who are or have been homeless — provide expert advice to government, organisations and consumers as well as providing peer support to consumers about consumer rights.

A protocol for responding to people who are homeless in public places was developed for the use of police and other services during the Commonwealth Games and has been implemented for ongoing guidance.

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Queensland Government comments

Child protection and supported placements

The Queensland Government remains committed to the ongoing reform of the child protection system and a record operating budget has been allocated for 2005-06, a 45 per cent unprecedented increase on 2004-05, to support children and young people who have been harmed or who are at risk of harm.

Significant collaboration between government and non-government agencies to improve outcomes for children and young people in the child protection system include:

- the appointment of Child Safety Directors in 11 government agencies to facilitate integrated government service provision
- the development of Education Support Plans and piloting the Health Passport initiative to provide a health assessment and plan for all children and young people in care, which will be fully implemented in January 2007
- the implementation of 'Evolve' (the therapeutic and behaviour support services) for children and young people in care with significant psychological, behavioural issues and/or disability behaviour support needs
- the establishment of ten early intervention services 'Referral for Active Intervention' to provide support to families and children aged 0 to 8 years at high risk of renotification.

Supported Accommodation Assistance Program (SAAP)

In 2005-06, the Queensland Government continued to address homelessness as a whole-of-government issue requiring an integrated response. Work continued on the implementation of the 'Responding to Homelessness' initiative, which will provide a continuum of integrated responses to the needs of homeless people. The continuum of services ranges from Homelessness Early Intervention services right through to Integrated Service Hubs and Crisis Accommodation and Support services for rough sleepers.

Over the year Queensland continued to experience the fastest population growth of any state or territory, with an increase of 2.0 per cent over the past year, compared with national population growth of 1.3 per cent. This level of growth continues to put pressure on demand for services in Queensland and this is particularly evident in South East Queensland.

There continued to be a very low supply of affordable rental accommodation in Queensland, with a rental accommodation vacancy rate of 1.9 per cent across the state. The resources boom has also created homelessness crises in specific regions, where demand for limited supplies of accommodation has caused dramatic rental increases and led to displacement of people on low incomes.

Cyclone Larry also left many people homeless in Far North Queensland and had a dramatic impact on demand for SAAP services.

Western Australian Government comments

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Child protection and supported placements

The Department for Community Development implemented the *Children and Community Services Act 2004* on 1 March 2006. The Act provides for a continuum of responses to safeguard or promote a child's wellbeing, strengthens legal protection for people who report concerns to the Department, provides an expanded range of options when intervention is required for the protection of children and greater emphasis on transparency and accountability when working with families in need and children in the CEO's care.

A Charter of Rights for Children in Care, a requirement under the new Act, has been drafted in consultation with children and young people. The Department has implemented the requirements that an Aboriginal or Torres Strait Islander agency is consulted regarding the prospective placement of an Indigenous child, and that an Indigenous department officer is involved when making a placement arrangement for an Indigenous child.

The 2005-06 Budget allocated new funding of more than \$10 million over four years for a range of new and expanded services for children in care, including an advocate for children in care, intensive individual placements, expanded counselling services and an intensive support and treatment placement team.

The Department engaged Ms Gwenn Murray to examine cases of substantiated harm to children in care between April and September 2005. An Implementation Committee chaired by the Director General and including stakeholder representatives has developed an implementation strategy, action plan and performance indicator framework for all 43 recommendations.

Supported Accommodation Assistance Program (SAAP)

The SAAP V Multilateral Agreement was signed on 30 September 2005 and the Western Australian Bilateral Agreement was signed on 25 January 2006.

Development and approval of 10 Innovation and Investment Fund pilot projects proposals are to be implemented in 17 SAAP services throughout WA commencing in 2006-07.

Sector campaigning and Department research indicate an increase in base funding is required for SAAP services to maintain existing service provision.

The Western Australian Government applied the higher state indexation to the State component of SAAP funding and additional funding of \$1.5 million has been allocated over and above the SAAP V Multilateral Agreement to continue this arrangement for the duration of SAAP V.

Training and Technology Grants were provided to SAAP services to assist service providers to better meet SAAP National Data Collection requirements.

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South Australian Government comments

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Child protection and supported placements

In 2005, the Children's Protection (Miscellaneous) Amendment Act was passed, continuing the government's child protection reform program: Keeping them Safe. The Act strengthens the legislative base for the care and protection system in SA, provides a stronger commitment to ensure that children and their families have access to support service, builds community capacity to protect children through the establishment of child-safe environments, establishes common standards across all sectors for criminal history checking, and extends mandatory reporting of suspected child abuse.

Significant progress has been made in the development of across government agreements and programs for prevention and early intervention programs to support families to safely care for their children (for example, the Family Home Visiting Program).

South Australia has experienced significantly increased demand for out-of-home care placements for children and young people (a 12.6 per cent increase between 2004-05 and 2005-06). Increased emphasis on finding relative care placement has improved the proportion of children in out-of-home care living with their relatives or kin. Work commenced during the year to develop a Blueprint for the future of Alternative Care services in SA to improve the capacity to meet children's needs.

Supported Accommodation Assistance Program (SAAP)

In addition to the national strategic directions of the SAAP V Agreement, SA has negotiated the following priorities:

- addressing the needs of Indigenous people who are homeless
- State wide programs that assist adults and accompanying children
- homeless people with complex needs.

Initiatives to address the additional priorities in 2005-06 included:

- the restructure of the Anglican Community Care SAAP service in Mount Gambier to refocus the service and provide early intervention and prevention services for people, who are homeless, in crisis and have been placed on a waiting list for a vacancy in a SAAP service
- \$1 million SAAP Restructure Funding for 14 innovative projects. The selected projects represent program initiatives in line with the SAAP V reforms and demonstrated good practice models, particularly those which address the service requirements for clients with complex needs needing a range of responses.

The data for SA in 2005-06 indicate that the number of Indigenous people who are homeless, the number of accompanying children, and the number of people who are in receipt of a disability pension are in significant numbers in SA SAAP agencies.

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Tasmanian Government comments

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Child protection and supported placements

The Tasmanian Government has commenced reforming the child protection system within the broader health and human services change agenda. A wide-ranging review of Tasmania's child protection system was released in November 2006. The review was jointly undertaken by the Department of Health and Human Services and the Commissioner for Children. The review provided recommendations on a number of service reforms as well as providing the framework for a new strategic plan.

In 2005-06, the Tasmanian Government increased staffing and program funding for the child protection service and implemented a new statewide induction program for child protection practitioners. The Formal Kinship Care Program has also been fully implemented.

Improvements to the child protection service include the trial of an Early Support Program initiative aimed at diverting notified children at risk and families of concern into targeted non-government support services. A range of new therapeutic services is also currently under development.

Supported Accommodation Assistance Program (SAAP)

A significant initiative for the SAAP in Tasmania was the commencement in 2005-06 of the Quality Development Project. The three-year project will map the updated service standards to the Quality Improvement Council's (QIC) standards for community organisations, conduct both internal and external assessments of all services, and work with each organisation to enhance its performance and develop a culture of continual improvement. By the end of June 2006 most of the preliminary work had been completed and the mapping of the SAAP standards to the QIC standards was well underway.

During the reporting period four emergency accommodation services were redeveloped. Two purpose-built facilities were constructed for young men's services. Reports indicate a marked improvement in clients' self-esteem and security, and better management practices by staff by being able to separate high and low needs clients. Two other services, a service for women and children and a multi-target service, redeveloped their service delivery models and moved from a *shelter-based* model to a *decentralised* model with a single intake centre. Staff report that this has provided increased privacy and anonymity for clients and increased role delineation for workers.

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Australian Capital Territory Government comments

Child protection and supported placements

The ACT has continued to implement reforms outlined in The Territory as Parent and the Territory's Children reports. Some reforms include:

- during 2005-06, Care and Protection Services have continued to receive an increased number of child protection reports and additional demand for out-of-home care placements. Additional residential programs (almost doubling available residential placements) and specialist foster care places for children and young people have been provided
- a renewed focus on stabilising long-term care arrangements for children and young people through the use of Enduring Parental Responsibility orders
- the establishment of a Placement Manager position to co-ordinate, approve and select appropriate placements that meet the needs for children and young people requiring out of home care
- the expansion and promotion of the Aboriginal and Torres Strait Islander Services, enabling the provision of family and youth support, and an Indigenous Foster Carer program.

Supported Accommodation Assistance Program (SAAP)

The ACT Homelessness Strategy — Breaking the Cycle entered its second year of implementation, with a range of reforms being implemented in the SAAP sector. The "Pathways Projects" and the Housing ACT reforms are the first stage for the provision of services to people who are experiencing or are at risk of homelessness. There were also changes to service models such as shifts away from congregate care, supported by the addition of stand alone properties to the service system. Reforms at the ACT's largest SAAP provider have progressed, and it is now managed as a Community Housing site which better reflects the site's provision of longer term accommodation. Public housing has introduced a range of reforms designed to reinforce its role as the post-crisis housing provider, and SAAP's complementary role to enable housing applicants in SAAP services to more easily access public housing.

In 2004-05 there were eight SAAP or SAAP-like services that did not participate in the SAAP National Data Collection. These agencies receive 15 per cent of the total ACT funding (\$2 131 670). Plans are in place over the next two years to ensure all non-participating agencies will be included in future data collections.

Factors influencing ACT results in previous reports continue in 2006. The small size of ACT service providers leads to proportionally larger overhead and indirect costs compared to larger jurisdictions. The ACT has the highest median rents for private rental in Australia placing extreme pressure on the public housing system and impacting on clients' length of stay in, and transition from SAAP.

Northern Territory Government comments

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Child protection and supported placements

The Northern Territory Government continued the development of the Family and Children's Services (FACS) program in 2006. Increased funding commenced in December 2003 with the intent of improving child protection services and systems over a period of 5 years. The increased funding has been used to build on the child protection workforce, to raise foster care payment rates, and to ensure quality of care for children in out-of-home care. Other initiatives resulted in the employment of additional Indigenous apprentices and cadets, and the tailoring of services to some of the highest needs children in out-of-home care by means of a specialist carer model.

An enhanced training program has been established to increase the opportunities for new and existing staff. This is achieved via mandatory induction training, specialist training, and opportunistic training in line with the FACS Training Framework.

A combined Police/FACS Child Abuse Task Force has recently been established to respond to systemic maltreatment and severe physical and sexual abuse notifications across the NT. A second phase of the initiative is a cross Government Community Action Planning strategy to develop community based activities that address abuse issues. This, coupled with the local 'Peace at Home' Police/FACS initiative in Katherine, broadens the response mechanisms to statutory investigations in the region.

Supported Accommodation Assistance Program (SAAP)

During 2005-06 the NT undertook a mapping and capacity audit of SAAP services that included an agency self-assessment against the NT SAAP Service Standards, scrutiny of agency performance reports including financial statements and a agency consultation in the form of a site visit. Individual agency reports were provided to each agency and an overall report was produced.

Findings were that SAAP services are generally at or near capacity and that they generally comply with SAAP Service Standards. One area that needs more work is around corporate governance. In response to these findings, a one year project has commenced with a focus on assisting individual agencies to improve their human and financial resource management.

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15.10 Definitions of key terms and indicators

Child protection and out-of-home care services

Activity Group 1 (pathways)

Receipt and assessment of initial information about a potential protection or support issue

Activities that are typically associated with receipt and assessment of initial information including receipt and recording of information, review of department databases, initial assessment of information and decisions about the appropriate response. This activity can also include consultation, with possible provision of advice. Activities by NGOs may be included if appropriate.

Activity Group 2 (pathways)

Provision of generic/non-intensive family support services

Activities that are typically associated with provision of lower level family support services at various stages including identification of family needs, provision of support services and diversionary services, some counselling and active linking of the family to support networks. Services are funded by government but can be delivered by either the relevant agency or a Non-government organisation (NGO). This bundle of services does not involve planned follow-up by the relevant agency after initial service delivery. The services will be delivered under voluntary arrangements between the relevant agency and family. Clients may receive these services more than once.

Activity Group 3 (pathways)

Provision of intensive family support services

Activities that are typically associated with provision of complex or intensive family support services including provision of therapeutic and in-home supports such as counselling and mediation, modelling of positive parenting strategies, referrals to intensive support services that may be provided by NGOs, advocacy on behalf of clients and intensive support for a family in a residential setting. This includes protection and treatment support services. These activities services may be provided if diversionary services are inappropriate to the case and may lead to statutory services being provided to the client.

Activity Group 4 (pathways)

Secondary information gathering and assessment

Activities that are typically associated with secondary information gathering and assessment are currently counted as 'investigations' in the Report on Government Services. As part of this activity group a decision may be made to substantiate or not substantiate. Information gathering activities include:

- sighting the child;
- contacting people with relevant information about the child or family (for example, teachers, police, support services);
- interviewing the child, sibling(s) and parents;
- observing family interactions;
- obtaining assessments of the child and/or family;
- conducting family group conferences;
- liaising with agencies providing services to the child and family;
- recording a substantiation or non-substantiation decision; and
- case conferences with partners and contributors in the investigation and assessment process.

Activity Group 5 (pathways)

Provision of short-term protective intervention and coordination services

Activities that are typically associated with provision of short-term protective intervention and coordination services including:

- working with the family to address protective issues;
- developing networks of support for the child;
- monitoring and reviewing the safety of the child;
- monitoring and reviewing family progress against case planning goals;
- case conferences with agencies providing services to the child and/or family, internal discussions and reviews; and

	<ul style="list-style-type: none"> specialist child-focused therapeutic support
Activity Group 6 (pathways) Seeking a court order	Activities that are typically associated with seeking court orders including: <ul style="list-style-type: none"> preparing applications for the order; preparing reports for the court; obtaining assessment reports to submit to the court; informing parties to the court proceedings, including parents, the child, and lawyers; informing and briefing legal counsel or internal court groups; going through internal pre-court review processes; attending court; and conducting family group conferences.
Activity Group 7 (pathways) Provision of longer-term protective intervention and coordination services	Activities that are typically associated with provision of longer-term protective intervention and coordination services including: <ul style="list-style-type: none"> monitoring the child or young person's progress and development (for example, social development and education progress) and undertaking activities that facilitate progress and development; meeting any specific requirements of any court order; reviewing appropriateness of the order for the circumstances of the child or young person. This usually occurs at intervals established by the court or in legislation; reporting back to court;
Activity Group 8 (pathways) Provision of out-of-home care services	long term cases involving out-of-home care Activities that are typically associated with provision of out-of-home care services including: <ul style="list-style-type: none"> finding suitable placement(s) for the child; assisting the child or young person to maintain contact with his/her family; in some cases, staff payments for recruiting and training carers; assessing suitability of potential kinship carers. assisting the child or young person to maintain contact with their family; working to return the child home; and assisting the child or young person as they prepare to leave care as the end of the order approaches.

Care and protection orders

Legal orders or administrative/voluntary arrangements involving the community services department, issued in respect of an individual child who is deemed to be in need of care and/or protection. Community services department involvement may include:

- total responsibility for the welfare of the child (for example, guardianship)
- responsibility for overseeing the actions of the person or authority caring for the child
- responsibility for providing or arranging accommodation, or reporting or considering the child's welfare.

The order may have been from a court, children's panel, minister of the Crown, authorised community services department officer or similar tribunal or officer.

Care and protection orders are categorised as:

- finalised guardianship and finalised custody orders sought through a court
- finalised supervision and other finalised court orders that give the department some responsibility for the child's welfare (excluding interim orders)
- interim and temporary orders (including orders that are not finalised)
- administrative or voluntary arrangements with the community services department, for the purpose of child protection.

Children are counted only once, even if they are on more than one care and protection order.

Child

A person aged 0–17 years.

Child at risk

A child for whom no abuse or neglect can be substantiated but where there are reasonable grounds to suspect the possibility of prior or future abuse or neglect, and for whom continued departmental involvement is considered warranted.

Child concern reports

Reports to 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.

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.

Exited out-of-home care

Where a child does not return to care within two months.

Family based care

Home-based care (see 'placement types').

Family group homes	Residential child care single dwelling establishments that have as their main purpose the provision of substitute care to children. They are typically run like family homes, with a limited number of children who eat together as a family group and are cared for around the clock by resident substitute parents.
Foster care	Care of a child who is living apart from his or her natural or adoptive parents in a private household, by one or more adults who act as 'foster parents' and are paid a regular allowance by a government authority or non-government organisation for the child's support. The authorised department or non-government organisation provides continuing supervision or support while the child remains in the care of foster parents.
Foster parent	Any person (or such a person's spouse) who is being paid a foster allowance by a government or non-government organisation for the care of a child (excluding children in family group homes).
Guardian	Any person who has the legal and ongoing care and responsibility for the protection of a child.
Indigenous person	Person of Aboriginal or Torres Strait Islander descent who identifies as being an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he or she is associated. If Indigenous status is unknown, then a person is considered to be non-Indigenous.
Investigation	An investigation of child abuse and neglect that involves identifying harm or risk of harm to the child, determining an outcome and assessing protective needs. It includes the interviewing or sighting of the subject child where practicable.
Investigation finalised	Where an investigation is completed and an outcome is recorded by 31 August.
Investigation not finalised	Where an investigation is commenced but an outcome is not recorded by 31 August.
Length of time in continuous out-of-home care	The length of time for which a child is in out-of-home care on a continuous basis. A return home of less than seven days is not considered to break the continuity of placement.
Non-respite care	Out-of-home care for children for child protection reasons.
Notification	Contact with an authorised department by persons or other bodies making allegations of child abuse or neglect, or harm to a child.
Other relative	A grandparent, aunt, uncle or cousin, whether the relationship is half, full, step or through adoption, and can be traced through or to a person whose parents were not married to each other at the time of the child's birth. This category includes members of Aboriginal communities who are accepted by that community as being related to the child.
Out-of-home care	Overnight care, including placement with relatives (other than parents) where the government makes a financial payment. Includes care of children in legal and voluntary placements (that is, children on and not on a legal order) but excludes placements made in disability services, psychiatric services, juvenile justice facilities and overnight child care services.

Placement types

Four main categories:

- facility-based care (placement in a residential building where the purpose is to provide placement for children and where there are paid staff, including placements in family group homes)
- home-based care (placement in the home of a carer who is reimbursed for expenses for the care of the child). The three subcategories of home-based care are foster care/community care, relative/kinship care and other
- independent living (including private board)
- other (including unknown).

Relatives/kin

Family members other than parents, or a person well known to the child and/or family (based on an existing relationship).

Respite care

Out-of-home care on a temporary basis for reasons other than child protection — for example, when parents are ill. Excludes emergency care provided to children who are removed from their homes for protective reasons.

Safety in out-of-home care

The proportion of children in out-of-home care who are the subject of a child protection substantiation, where the person believed responsible for the child abuse, neglect or harm is living in the household (or was a worker in a residential care facility).

Stability of placement

Number of placements for children who have exited out-of-home care and do not return within two months. Placements exclude respite or temporary placements lasting less than seven days. Placements are counted separately where there is:

- a change in the placement type — for example, from a home-based to a facility-based placement
- within placement type, a change in venue or a change from one home-based placement to a different home-based placement.

A particular placement is counted only once, so a return to a previous placement is another placement.

Substantiation

Notification for which an investigation concludes there is reasonable cause to believe that the child has been, is being or is likely to be abused, neglected or otherwise harmed. It does not necessarily require sufficient evidence for a successful prosecution and does not imply that treatment or case management is, or is to be, provided.

Supported accommodation and assistance

Accommodation

Crisis or short term accommodation, medium term to long term accommodation, and other SAAP funded accommodation (which comprises accommodation at hostels, motels and hotels, accommodation in caravans, community placements and other SAAP funded arrangements).

Accommodation load (of agencies)	The number of accommodation days divided by the number of days for which the agency is operational during the reporting period, where the number of accommodation days equals the sum of accommodation days for all clients of an agency who are supported during the reporting period. The average accommodation load is the mean value of all agencies' accommodation loads. Support periods without valid accommodation dates are assigned the interquartile modal duration of accommodation for agencies of the same service delivery model in the same jurisdiction.
Agency	The body or establishment with which the State or Territory government or its representative agrees to provide a SAAP service. The legal entity has to be incorporated. Funding from the State or Territory government could be allocated directly (that is, from the government department) or indirectly (that is, from the auspice of the agency). The SAAP service could be provided at the agency's location or through an outlet at a different location.
Caseload (of agencies)	The number of support days (the sum of support days for all clients of the agency who are supported during the reporting period) divided by the number of days for which the agency is operational during the reporting period. The average caseload is the mean value of all agencies' caseloads. Support periods without valid support dates are assigned the interquartile modal duration of support for agencies of the same service delivery model in the same jurisdiction.
Casual client	A person who is in contact with a SAAP agency and receives one-off assistance for generally not more than one hour, and who does not establish an ongoing relationship with an agency.
Client	A person who receives supported accommodation or support.
Crisis or short term supported accommodation	Supported accommodation for periods of generally not more than three months (short term), and for persons needing immediate short term accommodation (crisis).
Cross-target/multiple/general services	SAAP services targeted at more than one primary client group category — for example, SAAP services for single persons regardless of their gender.
Day support	Support provided only on a walk-in basis — for example, an agency that provides a drop-in centre, showering facilities and a meals service at the location of the SAAP agency.
Homeless person	<p>A person who does not have access to safe, secure and adequate housing. A person is considered to not have such access if the only housing to which he or she has access:</p> <ul style="list-style-type: none"> • is damaged, or is likely to damage, the person's health • threatens the person's safety • marginalises the person by failing to provide access to adequate personal amenities or the economic and social supports that a home normally affords • places the person in circumstances that threaten or adversely affect the adequacy, safety, security and affordability of that housing • is of unsecured tenure. <p>A person is also considered homeless if living in accommodation provided by a SAAP agency or some other form of emergency accommodation.</p>

Indigenous person	A person who is of Aboriginal and/or Torres Strait Island descent, who identifies as being an Aboriginal and/or Torres Strait Islander, and who is accepted as such by the community with which they are associated.
Medium term to long term supported accommodation	Supported accommodation for periods over three months. Medium term is around three to six months and long term is longer than six months.
Multiple service delivery model	SAAP agencies that use more than one service delivery model to provide SAAP services — for example, crisis or short term accommodation and support, as well as day support (that is, the provision of meals).
Non-English speaking background services	Services that are targeted at persons whose first language is not English.
One-off assistance	Assistance provided to a person who is not a client, such as the provision of a meal, a shower, transport, money, clothing, telephone advice, information or a referral.
Ongoing support period	A support period for which, at the end of the reporting period, no support end date and no after-support information are provided.
Outlet	A premise owned/managed/leased by an agency at which SAAP services are delivered. Excludes accommodation purchased using SAAP funds (for example, at a motel).
Outreach support services	Services that exist to provide support and other related assistance specifically to homeless people. These clients may be isolated and able to receive services and support from a range of options that enhance their flexibility (for example, advocacy, life skills and counselling). Generalist support and accommodation services may also provide outreach support in the form of follow-up to clients where they are housed. In this context, support is provided 'off site'.
Providers	Agencies that supply support and accommodation services.
Real expenditure	Actual expenditure adjusted for changes in prices. Adjustments are made using the GDP(E) price deflator and expressed in terms of final year prices.
Recurrent funding	Funding provided by the Australian, State and Territory governments to cover operating costs, salaries and rent.
Referral	When a SAAP agency contacts another agency and that agency accepts the person concerned for an appointment or interview. A referral is not provided if the person is not accepted for an appointment or interview.
SAAP service	Supported accommodation, support or one-off assistance that is provided by a SAAP agency and intended to be used by homeless persons.
Service delivery model	The mode or manner in which a service is provided through an agency. The modes of service delivery could be described as crisis or short term accommodation and support; medium term to long term accommodation and support; day support; outreach support; telephone information; and referral or agency support. An agency may deliver its services through one or more of these means of delivery.

Service provider	A worker or volunteer employed and/or engaged by a SAAP agency, who either directly provides a SAAP service or in some way contributes to the provision of a SAAP service. Includes administrative staff of an agency, whether paid or not paid.
Single men services	Services provided for males who present to the SAAP agency without a partner or children.
Single women services	Services provided for females who present to the SAAP agency without a partner or children.
Support	SAAP services, other than supported accommodation, that are provided to assist homeless people or persons at imminent risk of becoming homeless to achieve the maximum possible degree of self-reliance and independence. Support is ongoing and provided as part of a client relationship between the SAAP agency and the homeless person.
Support period	<p>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:</p> <ul style="list-style-type: none"> • support ceases because the SAAP client terminates the relationship with the SAAP agency • support ceases because the SAAP agency terminates the relationship with the SAAP client • no support is provided to the SAAP client for a period of three months. <p>A support period is relevant to the provision of supported accommodation or support, not the provision of one-off assistance.</p>
Supported accommodation	Accommodation provided by a SAAP agency in conjunction with support. The accommodation component of supported accommodation is provided in the form of beds in particular locations or accommodation purchased using SAAP funds (for example, at a motel). Agencies that provide accommodation without providing support are considered to provide supported accommodation.
Telephone information and referral	Support delivered via telephone without face-to-face contact. Support provided may include information and/or referral.
Total funding	Funding for allocation to agencies (not available at the individual client group level) for training, equipment and other administration costs.
Unmet demand	A homeless person who seeks supported accommodation or support, but is not provided with that supported accommodation or support. The person may receive one-off assistance.
Women escaping domestic violence services	Services specifically designed to assist women and women accompanied by their children, who are homeless or at imminent risk of becoming homeless as a result of violence and/or abuse.
Youth/young people services	Services provided for people who are independent and above the school leaving age for the State or Territory concerned, and who present to the SAAP agency unaccompanied by a parent/guardian.

15.11 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 15A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2007\Attach15A.xls and in Adobe PDF format as \Publications\Reports\2007\Attach15A.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

All jurisdiction data

Table 15A.1	State and Territory Government real recurrent expenditure on child protection and out-of-home care services (2005-06 dollars)
Table 15A.2	State and Territory Government real recurrent expenditure on child protection services, per notification, per investigation and per substantiation (2005-06 dollars)
Table 15A.3	State and Territory Government real recurrent expenditure on out-of-home care services (2005-06 dollars)
Table 15A.4	Comparability of government recurrent expenditure — items included, 2005-06
Table 15A.5	Child protection notifications, investigations and substantiations by Indigenous status 2005-06
Table 15A.6	Children admitted to and discharged from care and protection orders by Indigenous status, 2005-06 (number)
Table 15A.7	Children on care and protection orders at by type of order and Indigenous status, at 30 June 2006 (number)
Table 15A.8	Children in notifications, investigations and substantiations and children on care and protection orders: number and rate per 1000 children in the target populations by Indigenous status, 2005-06
Table 15A.9	Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, 2004-05
Table 15A.10	Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, 2004-05
Table 15A.11	Children in out-of-home care: number and rate per 1000 children aged 0–17 years by Indigenous status, 2005-06
Table 15A.12	Children in out-of-home care by Indigenous status and placement type, 30 June 2006 (number)

Table 15A.13	Children in out-of-home care by Indigenous status and whether on a care and protection order, 30 June 2006 (number)
Table 15A.14	Children in out-of-home care by Indigenous status and length of time in continuous out-of-home care, 30 June 2006 (number)
Table 15A.15	Children who exited care during the year 2005-06 by Indigenous status and length of time spent in care (number)
Table 15A.16	Children in out-of-home care placed with relatives/kin by Indigenous status, 30 June
Table 15A.17	Indigenous children in out-of-home care by relationship of caregiver, 30 June 2006
Table 15A.18	Children aged under 12 years in out-of-home care and in a home based placement by Indigenous status, 30 June 2006
Table 15A.19	Children on a care and protection order and exiting out-of-home care during the year by number of placements, by the length of time in out-of-home care (number)
Table 15A.20	Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, 2005-06
Table 15A.21	Intensive family support services: number of services, total real recurrent expenditure and real recurrent expenditure per child
Table 15A.22	Intensive family support services: number of children aged 0–17 years commencing intensive family support services by Indigenous status and gender
Table 15A.23	Intensive family support services: number of children aged 0–17 years commencing intensive family support services by age
Table 15A.24	Intensive family support services: number of children aged 0–17 years in intensive family support services by living situation at commencement of the program
Table 15A.25	Target population data used for annual data, December ('000)
Table 15A.26	Target population data used for end of financial year data, March ('000)
Single jurisdiction data — NSW	
Table 15A.27	Child protection notifications, investigations and substantiations by Indigenous status, New South Wales
Table 15A.28	Children admitted to and discharged from care and protection orders by Indigenous status, New South Wales (number)
Table 15A.29	Children on care and protection orders at 30 June by type of order and Indigenous status, New South Wales (number)
Table 15A.30	Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, New South Wales
Table 15A.31	Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, New South Wales

Table 15A.32	Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, New South Wales
Table 15A.33	Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, New South Wales
Table 15A.34	Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, New South Wales
Table 15A.35	Children in out-of-home care at 30 June, by Indigenous status and placement type, New South Wales (number)
Table 15A.36	Children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, New South Wales (number)
Table 15A.37	Children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, New South Wales (number)
Table 15A.38	Children who exited care during the year by Indigenous status and length of time spent in care, New South Wales (number)
Table 15A.39	Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, New South Wales
Table 15A.40	Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, New South Wales
Table 15A.41	Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, New South Wales
Table 15A.42	Children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, New South Wales (number)
Table 15A.43	Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, New South Wales

Single jurisdiction data — Vic

Table 15A.44	Child protection notifications, investigations and substantiations by Indigenous status, Victoria
Table 15A.45	Children admitted to and discharged from care and protection orders by Indigenous status, Victoria (number)
Table 15A.46	Children on care and protection orders at 30 June by type of order and Indigenous status, Victoria (number)
Table 15A.47	Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, Victoria
Table 15A.48	Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Victoria
Table 15A.49	Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Victoria

Table 15A.50	Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, Victoria
Table 15A.51	Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, Victoria
Table 15A.52	Children in out-of-home care at 30 June, by Indigenous status and placement type, Victoria (number)
Table 15A.53	Children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, Victoria (number)
Table 15A.54	Children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, Victoria (number)
Table 15A.55	Children who exited care during the year by Indigenous status and length of time spent in care, Victoria (number)
Table 15A.56	Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, Victoria
Table 15A.57	Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, Victoria
Table 15A.58	Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, Victoria
Table 15A.59	Children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, Victoria (number)
Table 15A.60	Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, Victoria

Single jurisdiction data — Qld

Table 15A.61	Child protection notifications, investigations and substantiations by Indigenous status, Queensland
Table 15A.62	Children admitted to and discharged from care and protection orders by Indigenous status, Queensland (number)
Table 15A.63	Children on care and protection orders at 30 June by type of order and Indigenous status, Queensland (number)
Table 15A.64	Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, Queensland
Table 15A.65	Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Queensland
Table 15A.66	Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Queensland
Table 15A.67	Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, Queensland
Table 15A.68	Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, Queensland

Table 15A.69	Children in out-of-home care at 30 June, by Indigenous status and placement type, Queensland (number)
Table 15A.70	Children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, Queensland (number)
Table 15A.71	Children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, Queensland (number)
Table 15A.72	Children who exited care during the year by Indigenous status and length of time spent in care, Queensland (number)
Table 15A.73	Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, Queensland
Table 15A.74	Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, Queensland
Table 15A.75	Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, Queensland
Table 15A.76	Children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, Queensland (number)
Table 15A.77	Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, Queensland

Single jurisdiction data — WA

Table 15A.78	Child protection notifications, investigations and substantiations by Indigenous status, Western Australia
Table 15A.79	Children admitted to and discharged from care and protection orders by Indigenous status, Western Australia (number)
Table 15A.80	Children on care and protection orders at 30 June by type of order and Indigenous status, Western Australia (number)
Table 15A.81	Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, Western Australia
Table 15A.82	Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Western Australia
Table 15A.83	Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Western Australia
Table 15A.84	Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, Western Australia
Table 15A.85	Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, Western Australia
Table 15A.86	Children in out-of-home care at 30 June, by Indigenous status and placement type, Western Australia (number)
Table 15A.87	Children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, Western Australia (number)

Table 15A.88	Children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, Western Australia (number)
Table 15A.89	Children who exited care during the year by Indigenous status and length of time spent in care, Western Australia (number)
Table 15A.90	Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, Western Australia
Table 15A.91	Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, Western Australia
Table 15A.92	Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, Western Australia
Table 15A.93	Children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, Western Australia (number)
Table 15A.94	Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, Western Australia

Single jurisdiction data — SA

Table 15A.95	Child protection notifications, investigations and substantiations by Indigenous status, South Australia
Table 15A.96	Children admitted to and discharged from care and protection orders by Indigenous status, South Australia (number)
Table 15A.97	Children on care and protection orders at 30 June by type of order and Indigenous status, South Australia (number)
Table 15A.98	Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, South Australia
Table 15A.99	Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, South Australia
Table 15A.100	Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, South Australia
Table 15A.101	Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, South Australia
Table 15A.102	Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, South Australia
Table 15A.103	Children in out-of-home care at 30 June, by Indigenous status and placement type, South Australia (number)
Table 15A.104	Children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, South Australia (number)
Table 15A.105	Children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, South Australia (number)
Table 15A.106	Children who exited care during the year by Indigenous status and length of time spent in care, South Australia (number)

Table 15A.107	Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, South Australia
Table 15A.108	Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, South Australia
Table 15A.109	Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, South Australia
Table 15A.110	Children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, South Australia (number)
Table 15A.111	Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, South Australia

Single jurisdiction data — Tas

Table 15A.112	Child protection notifications, investigations and substantiations by Indigenous status, Tasmania
Table 15A.113	Children admitted to and discharged from care and protection orders by Indigenous status, Tasmania (number)
Table 15A.114	Children on care and protection orders at 30 June by type of order and Indigenous status, Tasmania (number)
Table 15A.115	Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, Tasmania
Table 15A.116	Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Tasmania
Table 15A.117	Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Tasmania
Table 15A.118	Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, Tasmania
Table 15A.119	Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, Tasmania
Table 15A.120	Children in out-of-home care at 30 June, by Indigenous status and placement type, Tasmania (number)
Table 15A.121	Children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, Tasmania (number)
Table 15A.122	Children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, Tasmania (number)
Table 15A.123	Children who exited care during the year by Indigenous status and length of time spent in care, Tasmania (number)
Table 15A.124	Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, Tasmania
Table 15A.125	Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, Tasmania

Table 15A.126	Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, Tasmania
Table 15A.127	Children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, Tasmania (number)
Table 15A.128	Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, Tasmania

Single jurisdiction data — ACT

Table 15A.129	Child protection notifications, investigations and substantiations by Indigenous status, Australian Capital Territory
Table 15A.130	Children admitted to and discharged from care and protection orders by Indigenous status, Australian Capital Territory (number)
Table 15A.131	Children on care and protection orders at 30 June by type of order and Indigenous status, Australian Capital Territory (number)
Table 15A.132	Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, Australian Capital Territory
Table 15A.133	Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Australian Capital Territory
Table 15A.134	Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Australian Capital Territory
Table 15A.135	Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, Australian Capital Territory
Table 15A.136	Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, Australian Capital Territory
Table 15A.137	Children in out-of-home care at 30 June, by Indigenous status and placement type, Australian Capital Territory (number)
Table 15A.138	Children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, Australian Capital Territory (number)
Table 15A.139	Children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, Australian Capital Territory (number)
Table 15A.140	Children who exited care during the year by Indigenous status and length of time spent in care, Australian Capital Territory (number)
Table 15A.141	Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, Australian Capital Territory
Table 15A.142	Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, Australian Capital Territory

Table 15A.143	Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, Australian Capital Territory
Table 15A.144	Children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, Australian Capital Territory (number)
Table 15A.145	Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, Australian Capital Territory

Single jurisdiction data — NT

Table 15A.146	Child protection notifications, investigations and substantiations by Indigenous status, Northern Territory
Table 15A.147	Children admitted to and discharged from care and protection orders by Indigenous status, Northern Territory (number)
Table 15A.148	Children on care and protection orders at 30 June by type of order and Indigenous status, Northern Territory (number)
Table 15A.149	Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, Northern Territory
Table 15A.150	Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Northern Territory
Table 15A.151	Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Northern Territory
Table 15A.152	Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, Northern Territory
Table 15A.153	Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, Northern Territory
Table 15A.154	Children in out-of-home care at 30 June, by Indigenous status and placement type, Northern Territory (number)
Table 15A.155	Children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, Northern Territory (number)
Table 15A.156	Children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, Northern Territory (number)
Table 15A.157	Children who exited care during the year by Indigenous status and length of time spent in care, Northern Territory (number)
Table 15A.158	Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, Northern Territory
Table 15A.159	Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, Northern Territory
Table 15A.160	Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, Northern Territory

Table 15A.161	Children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, Northern Territory (number)
Table 15A.162	Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, Northern Territory
SAAP data	
Table 15A.163	Composition of support in SAAP support periods
Table 15A.164	SAAP agencies by primary target group
Table 15A.165	SAAP agencies by service delivery model
Table 15A.166	Nominal recurrent SAAP program funding by Australian Government, and State and Territory governments
Table 15A.167	Total recurrent SAAP program funding
Table 15A.168	Real recurrent SAAP program funding per person in the total population (2005-06 dollars)
Table 15A.169	Daily turn-away rate of adults and unaccompanied children requesting immediate SAAP accommodation, December and May
Table 15A.170	Daily total unmet demand for SAAP accommodation by adults and unaccompanied children, December and May
Table 15A.171	Proportion of Indigenous people among all accommodated SAAP clients and among people whose valid requests for accommodation were unmet
Table 15A.172	Proportion of people from non-English speaking backgrounds among all accommodated SAAP clients and among people whose valid requests for accommodation were unmet
Table 15A.173	Support periods, by the existence of a support plan, all clients
Table 15A.174	Support periods, by the existence of a support plan, Indigenous clients
Table 15A.175	Support needs of all clients, met and unmet
Table 15A.176	Support needs of Indigenous clients, met and unmet
Table 15A.177	Support needs of clients from non-English speaking backgrounds, met and unmet
Table 15A.178	Potential clients unable to be supported, main reason for support not provided, Australia
Table 15A.179	Recurrent cost per completed support period (2005-06 dollars)
Table 15A.180	Recurrent cost per client accessing services (2005-06 dollars)
Table 15A.181	Real recurrent cost per day of support for homeless clients (2005-06 dollars)
Table 15A.182	Average accommodation load and caseload per day
Table 15A.183	Change in clients' type of housing as a result of SAAP support

Table 15A.184	Change in type of housing as a result of SAAP support, Indigenous clients
Table 15A.185	Labour force status of clients before SAAP support
Table 15A.186	Change in labour force status of clients after SAAP support
Table 15A.187	Change in labour force status of Indigenous clients after SAAP support
Table 15A.188	SAAP clients who exited from the service and who returned to SAAP agencies before the end of that year
Table 15A.189	Indigenous SAAP clients who exited from the service and who returned to SAAP agencies before the end of that year
Table 15A.190	Indicative estimates of clients exiting to independent housing and not returning within six months
Table 15A.191	Source of income immediately before/after SAAP support of all clients who needed assistance to obtain/maintain a pension or benefit
Table 15A.192	Source of income immediately before/after SAAP support of Indigenous clients who needed assistance to obtain/maintain a pension or benefit
Table 15A.193	The extent that clients case management goals have been achieved

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PART G

HOUSING

16 Housing

Governments play a significant role in the Australian housing market, directly through housing assistance and indirectly through policies associated with land planning and taxation. The Australian, State and Territory governments share responsibility for housing assistance. Direct assistance includes public and community housing, home purchase and home ownership assistance, Indigenous housing, State and Territory rental assistance (such as State and Territory provided bond loans, guarantees and assistance with rent payments and advance rent payments, relocation expenses and other one-off grants) and Commonwealth Rent Assistance (CRA).

This chapter focuses on the performance of governments in providing public, Indigenous and community housing under the Commonwealth State Housing Agreement (CSHA) (box 16.1) and CRA. Close links exist between the housing services covered in this chapter and other government programs and support services discussed elsewhere in the Report, such as:

- the Supported Accommodation Assistance Program (SAAP), which provides accommodation and other services for homeless people or those at imminent risk of becoming homeless (chapter 15)
- services delivered by the Australian, State and Territory governments and community organisations to promote independent living, including services for people with a disability (chapter 13), mental health services (chapter 11) and aged care services, such as the Home and Community Care program (chapter 12).

A profile of housing and housing assistance is presented in section 16.1. This provides the context for assessing the performance indicators presented later in the chapter. All jurisdictions have agreed to develop and report comparable indicators, and a framework of performance indicators is outlined in section 16.2. The data are discussed in section 16.3, and future directions for performance reporting are discussed in section 16.4. Jurisdictions' comments are reported in section 16.5 and definitions are listed in section 16.6. Section 16.7 lists the supporting tables for this chapter and section 16.8 lists references used in the chapter.

Box 16.1 **Commonwealth State Housing Agreement**

The CSHA is an agreement made between the Australian, State and Territory governments under the *Housing Assistance Act 1996* (Cwlth) to provide strategic direction and funding certainty for the provision of housing assistance. The aim of this agreement is to provide appropriate, affordable and secure housing assistance for those who most need it, for the duration of their need.

The 2003 CSHA came into effect on 1 July 2003 and will run until 30 June 2008, and includes bilateral agreements between the Australian Government and each State and Territory government and an overarching multilateral agreement. There are generally separate bilateral agreements for mainstream and Indigenous housing in each jurisdiction. Bilateral agreements are intended to provide greater flexibility for states and territories to respond to their particular housing needs.

A national ten year strategy to improve Indigenous housing, Building a Better Future, was agreed in 2001 by Australian, State and Territory ministers. State Indigenous Bilateral Agreements are the primary vehicle for implementing the national Building a Better Future strategy. The desired strategy outcomes are better housing and housing services, more housing, improved partnerships, greater effectiveness and efficiency, and improved performance linked to accountability and coordination of services.

Funding arrangements

The majority of funding under the 2003 CSHA is provided by the Australian Government, taking the form of general assistance funding (public housing, home purchase assistance and private rental assistance) and specified funding for identified programs: the Aboriginal Rental Housing Program (ARHP), the Crisis Accommodation Program (CAP) and the Community Housing Program. The majority of CSHA funding is distributed to State and Territory governments on a modified per person basis, with the State and Territory governments contributing additional funding from their own resources to 'match' (in part) Australian Government funding allocations.

Roles and responsibilities

Under the CSHA, the Australian Government has responsibility for:

- ensuring the outcomes pursued through the agreement are consistent with broader national objectives, particularly in relation to support for individuals and communities
- advising State and Territory governments of Australian Government objectives to be achieved under the agreement
- reporting to the Commonwealth Parliament on performance against agreed outcomes and targets of housing assistance provided under the agreement.

State and Territory governments have responsibility for:

- developing housing assistance strategies that are consistent with Australian, State and Territory government objectives and that best meet the circumstances of the State or Territory
- developing, implementing and managing services and programs to deliver agreed outcomes
- reporting on a basis that enables performance assessment by the Australian, State or Territory governments, based on agreed performance indicators.

Source: CSHA (2003).

Public, State owned and managed Indigenous housing (SOMIH) and community housing information has been obtained from the State and Territory governments, except where otherwise indicated. The Australian Institute of Health and Welfare (AIHW) collects and collates these data and produces annual data collection manuals and reports. The data manuals and data reports are available from the AIHW web site at www.aihw.gov.au (AIHW 2006c, 2006d and 2006e). CRA data were obtained from the Department of Family and Community Services and Indigenous Affairs (FaCSIA). Data on satisfaction, location and amenity were obtained from national social housing surveys of public housing, community housing and SOMIH tenants.

Housing assistance not covered

This chapter does not cover a number of government funded and provided housing services, including:

- the Crisis Accommodation Program (CAP), including the Victorian Transitional Housing Management Program under the CSHA, which provides capital funding for accommodation for homeless people
- non-CSHA programs, including those provided by the Department of Veterans' Affairs (DVA)
- CRA paid by the DVA or paid to Abstudy recipients on behalf of the Department of Education, Science and Training (DEST)
- the First Home Owners Grant, provided by the Australian Government and delivered through State and Territory governments
- some Indigenous housing and infrastructure assistance provided by Australian, State and Territory governments, land councils and Indigenous community organisations
- non-Indigenous community housing not funded under the CSHA
- home purchase assistance
- private rent assistance funded by States and Territories.

16.1 Profile of housing and housing assistance

Service overview

The Australian Bureau of Statistics (ABS) 2001 Census of Population and Housing (ABS 2002) 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, and 2.8 per cent resided in other tenure types (table 16A.66). For a number of reasons, including non-response, misunderstanding, 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

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 single person households increased from 18.1 per cent to 22.9 per cent over this period (ABS 2002).

The average Indigenous household is larger than the average non-Indigenous household. In 2001, the average non-Indigenous Australian household size was 2.6 people, whereas the average household with at least one Indigenous person was 3.5 people (ABS and AIHW 2005).

Why government provides housing assistance

Australia’s private housing stock houses the majority of the population. Most Australian households can access accommodation either through owner occupation or by renting from a private landlord. Many households, however, face problems in acquiring or accessing suitable private accommodation for reasons of cost, discrimination, availability, location and/or adequacy. The price of rental dwellings can be prohibitive for people on lower incomes. Further, stock may not be available in the private rental market for households with special accommodation needs. Housing assistance from the Australian, State and Territory governments can help these households.

Roles and responsibilities

Each level of government has different roles and responsibilities in housing and housing assistance:

¹ Public housing tenants appear to be undercounted in the 2001 Census (and in previous censuses).

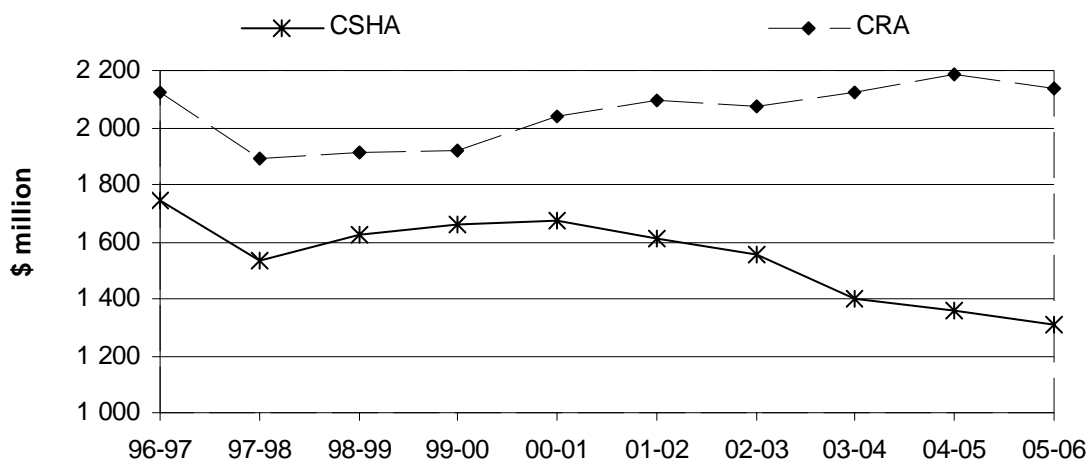
² This estimate is based on data received from jurisdictions regarding the number of community housing dwellings in each jurisdiction, combined with data from the ABS 2001 Census on the total number of dwellings in each jurisdiction.

-
- The Australian Government provides CRA and shares responsibility with State and Territory governments for housing assistance provided under the CSHA (box 16.1). The Australian Government also influences the housing market through other direct and indirect means, including taxation and home purchase assistance.
 - State and Territory governments provide housing assistance under the CSHA, such as assistance for the homeless, public housing, community housing, Indigenous rental housing, private rental assistance and home purchase assistance. Some 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.
 - Local governments implement planning regulations and are sometimes involved in providing community housing.

Funding

The Australian, State and Territory governments provided \$1.3 billion (contributing 72.2 per cent and 27.8 per cent respectively) for housing programs under the CSHA in 2005-06 (FaCSIA 2006). Public and community housing accounted for the majority of CSHA funding in 2005-06. The Australian Government also provided \$2.1 billion for CRA in 2005-06. Real expenditure on CSHA assistance declined by 25.1 per cent between 1996-97 and 2005-06 (figure 16.1). Real expenditure on CRA increased by 0.5 per cent over the same period (table 16A.73).

Figure 16.1 Real government expenditure on CSHA assistance and CRA (2005-06 dollars)^a



^a Data may not be comparable over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.73.

Source: CSHA (1999); FaCS (1999); FaCS (various years); FaCSIA (2006); FaCSIA (unpublished); table 16A.73.

Public housing is the largest form of assistance provided under the CSHA. Given the capital intensive nature of provision of social housing, additional assistance to annual funding is provided through the use of \$65 billion of housing stock owned by housing authorities in 2004-05 (calculated from 2004-05 State and Territory CSHA national financial statements).

Table 16.1 is a summary table that presents government expenditure including and excluding capital costs, on a per capita and per dwelling basis. It also includes the CRA per capita expenditure and per income unit figures to present the overall level of government housing assistance covered in this chapter. More detailed analysis of the cost components for public housing is presented in table 16.14.

Nationally, average direct cost per capita on public housing was approximately \$86 in 2005-06. Average direct cost plus capital costs per capita on public housing was \$346 (table 16.1).

Nationally, average direct cost per dwelling on public housing was approximately \$5145 in 2005-06. Average direct cost plus capital costs per capita on public housing was \$20 613 (table 16.1).

It is important to note the differences in housing assistance operations across jurisdictions when discussing expenditure per capita on public housing. It is also important to note that the per capita data could have been influenced by historic

arrangements (such as previous years' investment) that might have influenced the overall size of the public housing sector relative to the size of the population. Reporting direct cost per public housing dwelling addresses some of these issues.

Table 16.1 Government housing assistance, 2005-06^a

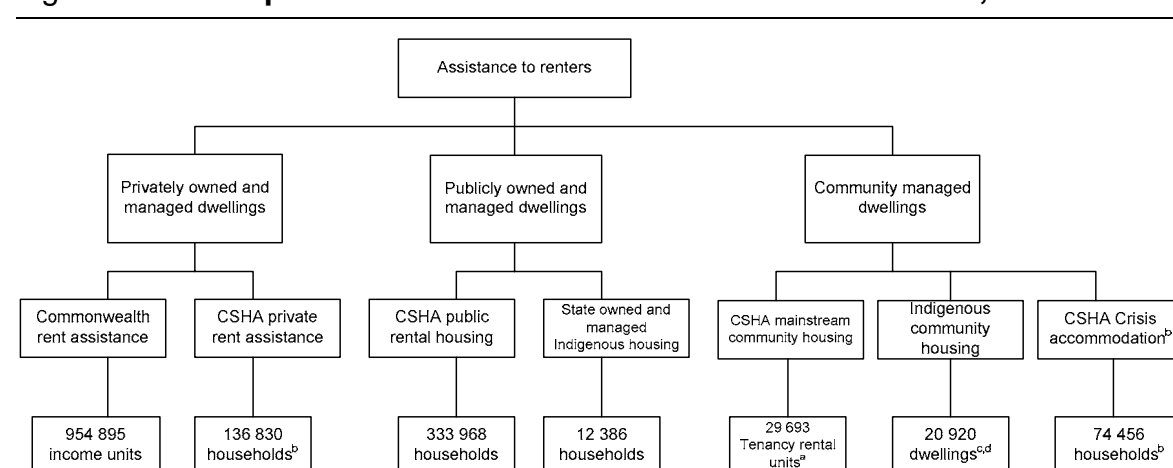
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Government expenditure on public housing in \$									
<i>Per capita</i>									
Direct cost	93	55	59	83	154	164	256	247	86
Direct cost including capital cost	414	245	255	300	468	430	1 017	643	346
<i>Per dwelling</i>									
Direct cost	5 122	4 233	4 719	5 382	5 283	6 813	7 685	9 304	5 145
Direct cost including capital cost	22 721	18 988	20 402	19 456	16 088	17 877	30 477	24 174	20 613
CRA expenditure									
<i>Per capita</i>	107	92	134	92	96	110	52	59	105
<i>Per income unit</i>	2 250	2 213	2 279	2 206	2 169	2 207	2 073	2 182	2 236

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.80.

Source: FaCSIA (unpublished); State and Territory governments (unpublished); table 16A.80.

Figure 16.2 illustrates the range of government assistance to renters.

Figure 16.2 Recipients of rental assistance across rental sector, 2006



^a Additional dwellings are funded under programs other than CSHA; however, data about these dwellings are not available. ^b For year ending 30 June 2005. ^c At 30 June 2006. ^d Includes permanent dwellings managed by funded or unfunded Indigenous community housing organisations. 18 927 of these dwellings were managed by organisations administered by the State governments and 1993 were managed by organisations administered by the Australian Government.

Source: AIHW (2007b).

CSHA funding data for 2004-05 and 2005-06 financial years are presented in table 16.2.

Table 16.2 **CSHA funding, 2004-05 and 2005-06 (\$ million)^a**

Funding arrangements	2004-05	2005-06
Base funding grants	733.8	743.9
Aboriginal Rental Housing Program	102.1	93.3
Crisis Accommodation Program	40.1	40.7
Community Housing Program	64.7	65.6
State matching grants	359.2	364.1
Total	1 299.9	1 307.6

^a Includes Public Housing, Home Purchase Assistance and Private Rental Assistance Programs.

Source: FaCSIA (2006); FaCSIA (unpublished).

Size and scope

Housing assistance is provided in various forms, and models for delivering assistance can vary within and across jurisdictions. The main forms of assistance are outlined in box 16.2. This chapter focuses on four forms of assistance: public housing, SOMIH, community housing, and CRA.

Box 16.2 **Forms of housing assistance**

There are several main forms of housing assistance.

- *Public housing*: dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation. The CSHA is the main source of funding for public housing along with internally generated rental revenues and the proceeds of asset sales.
- *Community housing*: rental housing provided for low to moderate income or special needs households, managed by community-based organisations that are at least partly subsidised by government. Community housing models vary across jurisdictions, and the housing stock may be owned by a variety of groups including government.
- *Indigenous housing*: State owned housing targeted at Indigenous households (referred to as 'SOMIH' in this report) and houses owned or leased and managed by Indigenous community housing organisations and community councils in major cities, regional and remote areas.

(Continued on next page)

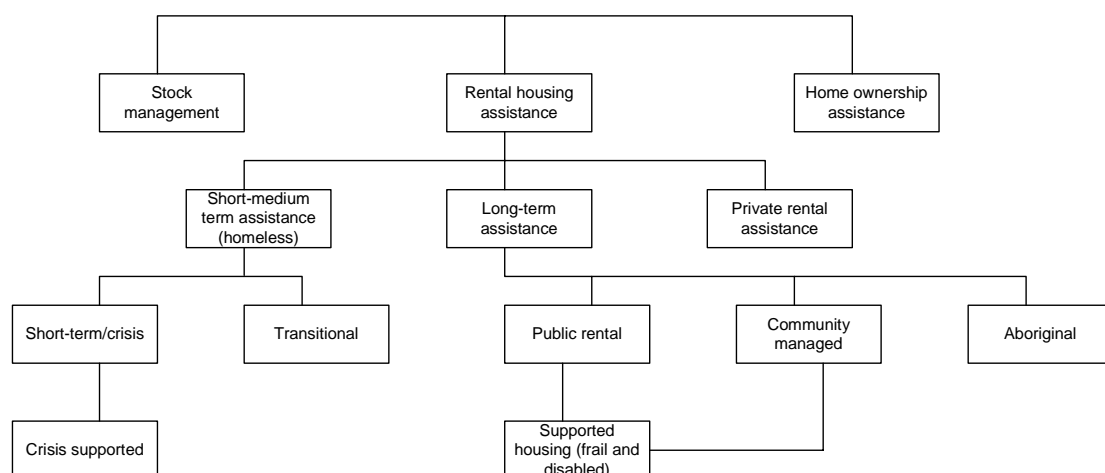
Box 16.2 (Continued)

- *Crisis accommodation*: accommodation services to help people who are homeless or in crisis. Services are generally provided by non-government organisations and many are linked to support services funded through SAAP. Sources of government funding include CAP through the CSHA, which provides funding for accommodation, and SAAP funding for live-in staff, counselling and other support services.
- *Home purchase assistance*: assistance provided by State and Territory governments to low income households to help with home purchases or mortgage repayments does not fall within the CSHA, nor does the grant provided under the First Home Owner's Scheme, a Commonwealth initiative administered by State and Territory governments.
- *Private rental assistance*: assistance funded by State and Territory governments to low income households experiencing difficulty in securing or maintaining private rental accommodation. This assistance may include ongoing or one-off payments to help households meet rent payments, one-off payments for relocation costs, guarantees or loans to cover the cost of bonds, and housing assistance advice and information services. Assistance may be provided by community-based organisations funded by government.
- The chapter also reports on CRA, which is a non-taxable income support supplement paid by the Australian Government to income support recipients or people who receive more than the base rate of the Family Tax Benefit Part A and who rent in the private rental market.

Source: CSHA (2003); FaCS (2003).

A snapshot presenting different forms of CSHA housing assistance for vulnerable people is presented through the example for Victoria (figure 16.3).

Figure 16.3 **Forms of CSHA housing assistance for low income Victorians**



Source: VDHS (2001, p. 4).

Public housing

Public housing comprises those dwellings owned (or leased) and managed by State and Territory housing authorities. The CSHA is the main source of funding for public housing. A total of 333 967 public housing dwellings were occupied at 30 June 2006 (table 16A.1). Public housing is available to people on low incomes and those with special needs. Although people with a disability represented 19 per cent of the total population in 2003, 40.6 per cent of public housing tenants were people with a disability (ABS 2003).³

Public housing rents are generally set at market levels, and rebates are granted to low income tenants (so they generally pay no more than 25 per cent of their assessable income in rent), to provide affordable housing. Public housing allocations are constrained by the amount of housing stock available and are income tested. The proportion of total households residing in public housing in 2001 (4.5 per cent nationally) is presented for all jurisdictions in table 16A.69. Information on the proportion of income paid in rent by public housing tenants is contained in table 16A.74. Details of multiple family composition, non-rebated and other public households excluded from data are presented in table 16A.81.

Community housing

Community housing is generally managed by not-for-profit organisations or local governments, which perform asset and tenancy management functions. A major objective of community housing is to increase social capital by encouraging local communities to take a more active role in planning and managing appropriate and affordable transitional and long term rental accommodation. Community housing is also intended to provide a choice of housing location, physical type and management arrangements. Some forms of community housing also allow tenants to participate in the management of their housing.

Community housing programs aim to achieve links between housing and services that are best managed at the community level, including services for people with a disability, and home and community care. Notwithstanding their common objectives, community housing programs vary within and across jurisdictions in their administration and types of accommodation (box 16.3).

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.

Box 16.3 **Models of community housing**

Community housing models vary across jurisdictions in terms of their scale, organisational structure and financing arrangements, and the extent to which the community or government has management responsibility and ownership of the housing stock. Table 16A.70 lists the relevant community housing programs in each jurisdiction.

Some community housing models are:

- *regional or local housing associations*, whereby the associations provide property and tenancy management services, and community groups provide support services to tenants
- *joint ventures and housing partnerships*, whereby a range of church, welfare, local government agencies and other organisations provide resources in cooperation with State and Territory governments
- *housing cooperatives*, which are responsible for tenant management and maintenance, while government, a central finance company or an individual cooperative owns the housing stock
- *community management and ownership*, whereby not-for-profit or community housing associations both own and manage housing
- *local government housing associations*, which provide low cost housing within a particular municipality, are closely involved in policy, planning, funding and/or monitoring roles, and may directly manage the housing stock
- *equity share rental housing*, whereby housing cooperatives wholly own the housing stock and lease it to tenants (who are shareholders in the cooperative and, therefore, have the rights and responsibilities of cooperative management).

Source: State and Territory governments (unpublished).

Funding for community housing is typically either fully or partly provided by governments to not-for-profit organisations or local governments. Australian Government funding for community housing amounted to 7.0 per cent (\$65.6 million) of total CSHA funding provided by the Australian Government in 2005-06 (FaCSIA unpublished). There were 29 693 CSHA community housing dwellings in Australia at June 2006 (table 16A.25).⁴ Table 16A.71 presents the proportion of all households residing in community housing in each jurisdiction in 2001 (0.4 per cent nationally).

⁴ Data are based on survey results except for Queensland and the NT. Results, therefore, are affected by survey non-response. Details of community housing survey response rates and associated information are presented in table 16A.83.

Indigenous housing

Government funded Indigenous housing includes both State managed and community managed housing. The State managed component is generally funded by ARHP and may be supplemented by untied CSHA funds and State matching funds. Community managed Indigenous housing may be financed from ARHP funds, supplementary State funds, untied CSHA funds, and funds from other sources. Details of mixed composition, non-rebated and other households excluded from data for SOMIH are presented in table 16A.82.

State Owned and Managed Indigenous Housing⁵

SOMIH dwellings are defined as those rental housing dwellings owned and managed by government and allocated only to Indigenous Australians (AIHW 2006d). They include dwellings managed by government Indigenous housing agencies for allocation to Indigenous tenants. There were 12 893 dwellings identified in the 2005-06 SOMIH collection (table 16A.14).

SOMIH is only one of a number of programs designed to provide housing assistance to Indigenous people. Indigenous Australians are eligible for assistance under Indigenous community managed housing (where community agencies carry out tenancy management functions), the mainstream public and community housing programs, CRA and other government housing programs (both Indigenous-specific and mainstream).

The ACT and the NT are not included in the SOMIH data collection. The ACT does not receive funding for, or administer, any Territory owned and managed Indigenous housing programs; in the NT, ARHP funding is directed to community managed Indigenous housing. 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 Indigenous housing organisations that manage permanent dwellings for people in 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. Allocation of funds for the construction, major upgrade and renovation of dwellings in communities are based on highest need, determined by an objective needs measurement model. Housing management and maintenance funds are allocated to Indigenous Community Housing Organisations based on the quantum of their responsibilities. The NT

⁵ The territories are not included in the data collection for this program, so are not included in the section heading.

government cannot differentiate between the various funding sources, given its commitment under the CSHA and the Indigenous Housing and Infrastructure Agreement to 'pool' most funds earmarked for Indigenous housing and associated infrastructure in the NT.

In NSW, a separate statutory organisation — the Aboriginal Housing Office — is responsible for planning, administering and expanding policies, programs and the asset base for Aboriginal housing in that State. Funding for the office comes from the CSHA and the State Government (in addition to its CSHA commitments).

Some other jurisdictions are increasingly pooling funding but currently report SOMIH data separately. Queensland administers a separate Aboriginal and Torres Strait Islander Housing Program, which includes ARHP funds, untied CSHA funds and State funds, and does not report separately against the ARHP component of the program funds (which forms more than one third of total funding).

Indigenous community housing

There has been considerable progress in the development of national Indigenous community housing data over the last few years. In 2005 the AIHW published *Indigenous housing indicators 2003-04*, the first indicator based report on the National Reporting Framework for Indigenous housing (NRF). The report includes administrative data on Indigenous community housing provided by the jurisdictions, as well as data from other sources such as the ABS Census and the 2001 Community Housing and Infrastructure Needs Survey (CHINS). This is a biennial report with the 2005-06 report to be released in mid 2007.

The AIHW report *Indigenous housing needs 2005: a multi-measure needs model* was released in October 2005. The report presents data from the five endorsed dimensions of housing need — homelessness, overcrowding, affordability, dwelling condition and connection to essential services. The report examines the extent of need by tenure type and assesses differences between Indigenous and non-Indigenous households.

In October 2005 Housing Ministers agreed to a reform strategy for Indigenous community housing that included the need to collect dwelling and organisation level data, including data on dwelling condition, in order to monitor improvements in the sector. The development of national organisation and dwelling level data will be the focus of data development activities over the next few years.

The most recent national Indigenous community housing data show that at 30 June 2006 there were 613 Indigenous community housing organisations in

Australia. Indigenous community housing organisations managed a total of 20 920 permanent dwellings (table 16A.37).

The average weekly rent collected for Indigenous community housing in 2005-06 was \$54 per dwelling (table 16A.40) and the rent collection rate was 94.0 per cent (AIHW 2007a). At 30 June 2006 the national occupancy rate for Indigenous community housing permanent was 90.4 per cent (table 16A.38).

Data from the 2001 CHINS provide information on dwelling condition and maintenance expenditure. Seventy percent of dwellings managed by Indigenous community housing organisations were in need of minor or no repair, 18.9 per cent were in need of major repair and 8.4 per cent were in need of replacement (table 16A.39). In 2001 the average annual maintenance expenditure per dwelling was \$1870 (table 16A.40).

CRA

CRA is a non-taxable supplementary payment provided by the Australian Government to help with the cost of private rental housing. It is available to recipients of income support payments, including those who receive more than the base rate of the Family Tax Benefit Part A and who pay private rent above minimum thresholds. Private rent includes rent paid under both formal tenancy agreements and informal arrangements, such as board and lodging paid to a family member. It also includes mooring and site fees (for boats and caravans) and payments for retirement village services.

CRA is paid at 75 cents for every dollar above the threshold until a maximum rate is reached. The maximum rates and thresholds vary according to a customer's family situation and number of children (table 16.3). For single people without dependent children, the maximum rate may also vary according to whether accommodation is shared with others. Rent thresholds and maximum rates are indexed twice per year (March and September) to reflect changes in the consumer price index.

Because CRA is a national payment, FaCSIA seeks to ensure CRA customers who have the same income unit characteristics and who pay the same amount of rent receive the same amount of assistance wherever they live. There were 941 306 income units (where an income unit is defined as either a single person or a couple with or without dependents)⁶ receiving CRA at 3 March 2006 (table 16A.42). The

⁶ Dependents are defined as young persons for whom the person or partner receives the Family Tax Benefit. The benefit is not payable for children receiving Youth Allowance or any other income security payment. Children aged over 16 years for whom the Family Tax Benefit is not payable are regarded as separate income units.

proportion of CRA recipients by income unit type is presented in table 16A.43. Data on the number and proportion of Indigenous income units receiving CRA by income unit type are presented in tables 16A.44 and 16A.45, respectively.

The maximum rate of assistance was received by 66 per cent of CRA recipients at 3 March 2006 (table 16A.57). There was little variation in the average level of assistance across locations at 3 March 2006 (table 16A.56), even though rents varied considerably by location. At 3 March 2006, the average payment across Australia was \$82 per fortnight (approximately \$2145 per year) (table 16A.56).

Table 16.3 Eligibility and payment scales for CRA, 20 March to 19 September 2006 (\$ per fortnight)^a

<i>Income unit type</i>	<i>Minimum rent to be eligible for CRA</i>	<i>Minimum rent to be eligible for maximum CRA</i>	<i>Maximum CRA</i>
Single, no dependent children	89.60	223.73	100.60
Single, no children, sharer	89.60	179.02	67.07
Couple, no dependent children	145.80	272.47	95.00
Single, one or two dependent children	117.88	275.61	118.30
Single, three or more dependent children	117.88	296.15	133.70
Partnered, one or two dependent children	174.44	332.17	118.30
Partnered, three or more dependent children	177.44	352.71	133.70
Partnered, illness separated, no dependent children	89.60	223.73	100.60
Partnered, temporarily separated, no dependent children	89.60	216.27	95.00

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.41.

Source: FaCSIA (unpublished); table 16A.41.

Diversity of State and Territory housing assistance operations

State and Territory governments have similar broad objectives for providing housing assistance. Individual jurisdictions, however, emphasise different objectives depending on their historical precedents and ways of interacting with community sector providers. Jurisdictions also face differing private housing markets. 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 the following additional information on the key operating parameters characterising housing assistance provision in their jurisdictions.

Public housing and State Owned and Managed Indigenous Housing

Eligibility criteria for access to public housing, such as income and asset definitions and limits, vary across jurisdictions. In most cases, jurisdictions require that applicants be Australian citizens or permanent residents and not own or part-own residential property. All jurisdictions require eligible applicants to be resident in the respective State or Territory. All State and Territory governments prioritise access to public housing by segmenting their waiting lists in some way. Segments are defined differently across jurisdictions, but generally reflect urgent need/homelessness and an inability to access appropriate private market accommodation. Most jurisdictions provide security of tenure after an initial probationary period. Most jurisdictions also have periodic reviews of eligibility to ensure that tenants are meeting the other terms of their tenancy agreement. Rebated rents result in the majority of households paying no more than 25 per cent of their assessable income in rent (the rent-to-income ratio). Definitions of assessable income vary across jurisdictions (table 16.4).

Table 16.4 Public housing policy context, 2006^a

	NSW ^b	Vic ^c	Qld	WA ^d	SA ^e	Tas ^f	ACT	NT ^g
Eligibility								
Income limit per week (\$) ^h	395	356	609	430	638	411	490	572
'Other' asset limits (\$) ^h	None	30 000	None	36 400 cash	270 500	34 473	40 000 liquid assets	40 500
Minimum age	18	15	None	18	None	16	16	16
Waiting listⁱ								
Segmented by:	Wait turn and priority (two segments)	Priority (four segments)	Priority (two segments)	Priority (three segments)	Need (four segments)	Need (four segments)	Need (three segments)	Wait turn and priority (two segments)
Tenure								
Probationary period	None	None	None	None	6 months	3–6 months	None	3–6 months
Fixed term	3, 6 or 18 months	5 years	None	3 months	None	1–3 years	None	2 year then 5 year
Ongoing	Yes	Lifetime after age 65	Yes	Ongoing	Ongoing after probation	In some cases, particularly older persons	Lifetime tenure	Leases extended
Tenancy review	Prior to the end of the tenancy	To commence in 2008	Review at 6 months and 4 or 10 years	Annual	None	Fixed term leases reviewed at end of each term	None	Prior to each lease extension
Rebated rent setting								
Rent-to-income ratio	25-30	25	25	23 or 25	25	23–25	25	18 or 23

(Continued on next page)

Table 16.4 (Continued)

a At 30 June. **b** Interest accrued from cash assets is assessed as income less the first \$5000 of each person's savings. Applicants under the age of 18 years must demonstrate living skills to be eligible for housing. New tenancies from 1 July 2005 were signed to 18-month interim tenancies. From 5 December 2005 new thresholds and rules determine whether a tenant is eligible for a rent subsidy and the percentage of income they will pay as rent. Their household's gross assessable income, household size and age of household members are used when assessing the household's eligibility for a rent subsidy. For rebated rents, varied concessional rates are applicable to certain age groups and some pensioners. For households whose tenancy commenced on or after 5 December 2005, the Family Tax Benefit Part A and Part B received are assessed at 15 per cent. Where the tenancy commenced prior to 5 December 2005 the Family Tax Benefit Part A and Part B received was assessed at 12 per cent from 5 December 2005, with an increase of 1 per cent every 6 months until the assessment rate reaches 15 per cent. **c** Public housing tenancies in Victoria are ongoing tenancies (not fixed term) that are subject to review after 5 years. For households that require major disability modifications, discretion may be applied to extend the asset limit to \$60 000. **d** Income limit for those in north west remote areas is \$550 per week. Those aged over 60 years are subject to a cash asset limit of \$80 000. A rent-to-income ratio of 23 per cent can apply for groups such as seniors, people with disabilities and people living in remote locations. **e** The same definition as the Centrelink asset test threshold for a single person who does not own their own home is used. Most households pay a rent-to-income ratio of 25 per cent of assessable income in rent, except aged residents in cottage flat and bedsitter flat accommodation (for whom the ratio is 19 per cent and 17 per cent respectively) and households receiving less than the single Newstart Allowance (for whom the ratio is 19.5 per cent). **f** For people aged over 55 years, the asset limit is \$35 000. **g** There is discretion to accept applications for people under 16 years. The rent-to-income ratio is 18 per cent for aged pension recipients. **h** Limits are for a single person. **i** Two segment lists generally consist of 'priority' and 'wait turn'.

Source: State and Territory governments (unpublished).

The proportion of public housing located in regional and remote areas using the Australian Standard Geographical Classification remoteness area structure (ASGC remoteness areas) is shown in table 16.5.

Table 16.5 Public housing — regional and remote area concentrations, 2005-06 (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Major cities	80.8	72.1	61.5	70.5	77.5	—	99.9	—	71.5
Inner regional	15.2	22.4	19.6	9.6	6.9	72.8	0.1	—	16.8
Outer regional	3.7	5.4	16.5	9.6	13.8	26.3	—	69.2	9.4
Remote	0.3	—	1.8	7.0	1.8	0.6	—	26.9	1.7
Very remote	0.1	—	0.6	3.3	0.2	0.3	—	3.9	0.5

^a Further information to the data included in this table and/or its interpretation is provided in table 16A.1.
— Nil or rounded to zero.

Source: AIHW (2006b); table 16A.1.

Eligibility criteria for access to SOMIH are generally consistent with those for public housing once an applicant has been confirmed as Indigenous. The management of waiting lists varies across jurisdictions — for example, a number of jurisdictions use the same list for both public housing and SOMIH. Terms of tenure are the same as those for public housing for a number of jurisdictions (table 16.6).

Table 16.6 SOMIH housing policy context, 2006^a

	NSW ^b	Vic ^c	Qld	WA ^d	SA ^e	Tas ^f
Eligibility						
Income limit per week (\$) ^g	395	356	609	430	638	411
'Other' asset limits (\$) ^g	None	30 000	None	36 400 in cash	270 500	34 473
Minimum age	18	15	None	18	None	16
Waiting list						
Details	Combined with public housing	Combined with public housing	Combined with public housing	Combined with public housing	Need (Four segment)	Priority, similar to public housing
Tenure						
Probationary period	None	None	None	None	6 months	3–6 months
Fixed term	3, 6 or 18 months	5 years	None	3 months	None	1–3 years
Ongoing	Yes	Lifetime after age 65	Yes	Ongoing	Ongoing after probation	Dependant on housing history
Tenancy review	Prior to the end of the tenancy	To commence in 2008	Review at 6 months and 4 or 10 years	Annual	None	Fixed term leases reviewed at end of each term

^a At 30 June. ^b Interest accrued from cash assets is assessed as income less the first \$5000 of each person's savings. Applicants under the age of 18 years must demonstrate living skills to be eligible for housing. New tenancies from 1 July 2005 were signed to 18-month interim tenancies. From 5 December 2005 new thresholds and rules determine whether a tenant is eligible for a rent subsidy and the percentage of income they will pay as rent. Their household's gross assessable income, household size and age of household members are used when assessing the household's eligibility for a rent subsidy. For rebated rents, varied concessional rates are applicable to certain age groups and some pensioners. For households whose tenancy commenced on or after 5 December 2005, the Family Tax Benefits Part A and Part B received are assessed at 15 per cent. Where the tenancy commenced prior to 5 December 2005 the Family Tax Benefits Part A and Part B received was assessed at 12 per cent from 5 December 2005, with an increase of 1 per cent every six months until the assessment rate reaches 15 per cent. CRA is assessed at 100 per cent. ^c Tenancies in Victoria are ongoing tenancies (not fixed term) that are subject to review after 5 years. For households that require major disability modifications, discretion may be applied to extend the asset limit to \$60 000. Indigenous households generally access long term accommodation through the General Rental program or housing managed by the Aboriginal Housing Board of Victoria. ^d The income limit for those in north west remote areas is \$550 per week. Those aged over 60 years are subject to a cash asset limit of \$80 000. ^e The same definition as the Centrelink asset test threshold for a single person who does not own their own home is used. Most households pay a rent-to-income ratio of 25 per cent of assessable income in rent and households receiving less than the single Newstart Allowance (for whom the ratio is 19.5 per cent). ^f For people aged over 55 years the asset limit is \$35 000. Applications outside the guidelines may be considered where there are extenuating circumstances in relation to income, asset and age criteria. ^g Limits are for a single person.

Source: State and Territory governments (unpublished).

The proportions of SOMIH located by ASGC remoteness areas are shown in table 16.7.

Table 16.7 SOMIH — regional and remote area concentrations, 2005-06 (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Total</i>
Major cities	41.1	38.3	13.1	28.6	60.7	—	34.0
Inner regional	32.1	37.0	14.9	7.9	7.7	82.2	22.2
Outer regional	20.1	24.3	44.6	22.0	17.8	17.8	26.0
Remote	5.2	0.4	10.3	20.1	6.0	—	8.5
Very remote	1.5	—	17.1	21.4	7.8	—	9.3

^a Further information to the data included in this table and/or its interpretation is provided in table 16A.14.
— Nil or rounded to zero.

Source: AIHW (2006a); table 16A.14.

Community housing

Eligibility criteria for community housing are generally consistent with those for public housing in each jurisdiction. Most jurisdictions do not require community housing organisations to segment waiting lists.

For the data that are available, the proportions of community housing located in regional and remote areas using (ASGC remoteness areas) are shown in table 16.8.

Table 16.8 Community housing — regional and remote area concentrations, 2005-06 (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Major cities	68.5	71.6	37.3	54.6	85.8	—	100.0	—	64.5
Inner regional	23.9	23.7	24.9	25.9	8.4	63.7	—	—	21.9
Outer regional	7.4	4.4	26.9	13.4	4.4	35.7	—	71.3	10.9
Remote	0.1	0.3	4.2	5.8	1.3	0.6	—	20.7	1.5
Very remote	—	—	6.6	0.3	0.1	—	—	8.0	1.3

^a Further information to the data included in this table and/or its interpretation is provided in table 16A.25.
— Nil or rounded to zero.

Source: AIHW (2007c); table 16A.25.

Private rental markets

Tight private rental markets (vacancy rates below 3.0 per cent) were evident in all states in June 2006. Capital city vacancy rates in the private rental market for all jurisdictions are reported in table 16A.67. Capital city median rents varied across

jurisdictions. Median rents for three bedroom houses and two bedroom flats or units are reported in table 16A.68.

16.2 Framework of performance indicators

Previous reports presented separate performance indicator frameworks for public, SOMIH and community housing. Increasing convergence between the frameworks over time means that, for this Report, public, SOMIH and community housing adopt a common performance indicator framework. (CSHA funded community housing is presented in a separate framework, because of data comparability issues. No performance indicator data are currently reported for Indigenous community housing.)

The performance indicator frameworks are consistent with the general performance indicator framework agreed by the Steering Committee (see chapter 1). They also draw on the framework developed for the 1999 CSHA and reflect the national objectives of that agreement (and of the new CSHA that took effect in 2003 (box 16.4). The new CSHA places greater emphasis on Australian, State and Territory governments improving housing outcomes for Indigenous people, and governments have committed to improving access to mainstream housing options for Indigenous people living in urban and regional areas. This is the third year that data are reported under the new agreement. Work is being undertaken on the performance indicators to improve the quality and scope of national performance information. A separate performance indicator framework is adopted for reporting on CRA (figure 16.6).

Box 16.4 Objectives for public and community housing under the 2003 CSHA

The principles guiding the 2003 CSHA are to:

1. maintain a core Social Housing sector to assist people unable to access alternative suitable housing options
2. develop and deliver affordable, appropriate, flexible and diverse housing assistance responses that provide people with choice and are tailored to their needs, local conditions and opportunities
3. provide assistance in a manner that is non-discriminatory and has regard to consumer rights and responsibilities, including consumer participation
4. commit to improving housing outcomes for Indigenous people in urban, regional and remote areas, through specific initiatives that strengthen the Indigenous housing sector and the responsiveness and appropriateness of the full range of mainstream housing options
5. ensure housing assistance links effectively with other programs and provides better support for people with complex needs, and has a role in preventing homelessness
6. promote innovative approaches to leverage additional resources into Social Housing, through community, private sector and other partnerships
7. ensure that housing assistance supports access to employment and promotes social and economic participation
8. establish greater consistency between housing assistance provision and outcomes, and other social and economic objectives of government, such as welfare reform, urban regeneration, and community capacity-building
9. undertake efficient and cost-effective management which provides best value to governments
10. adopt a cooperative partnership approach between levels of government towards creating a sustainable and more certain future for housing assistance
11. promote a national, strategic, integrated and long term vision for affordable housing in Australia through a comprehensive approach by all levels of government.

Source: CSHA (2003, p.4).

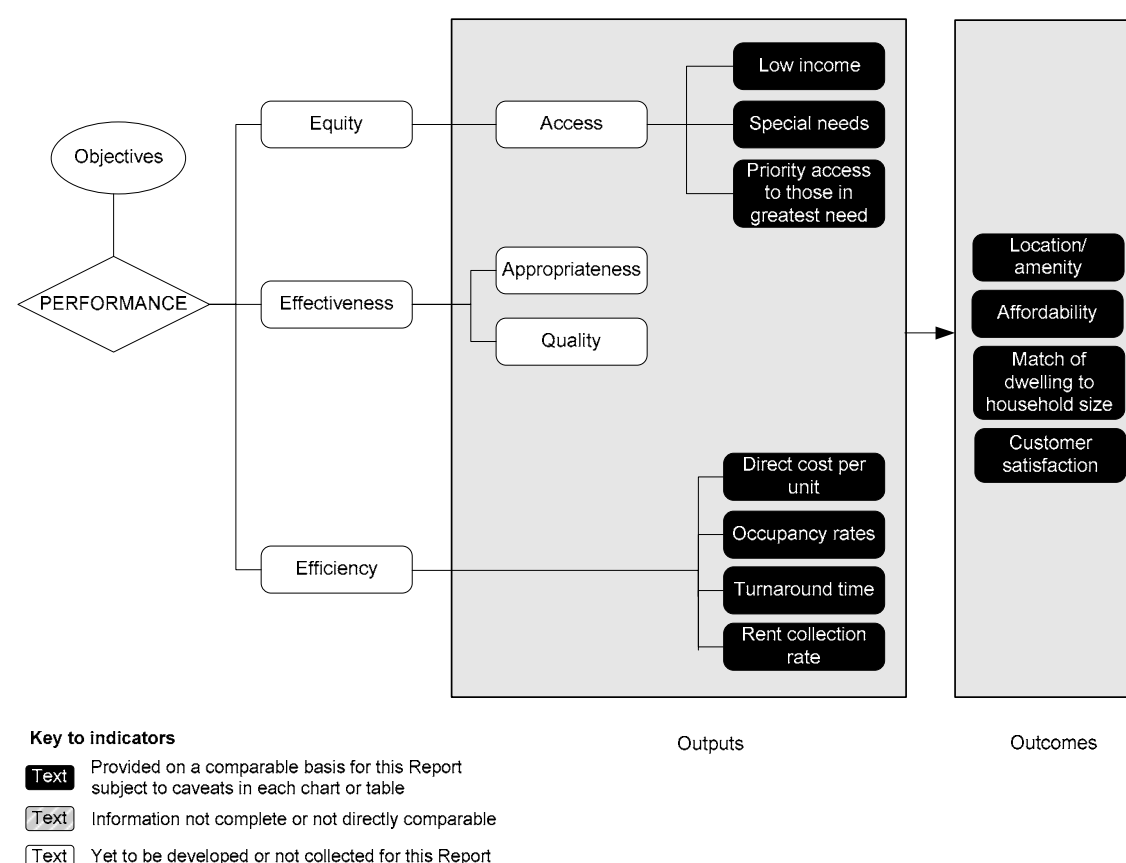
The performance indicator frameworks show which data are comparable in the 2007 Report (figures 16.4, 16.5 and 16.6). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

The frameworks reflect the adoption by governments of accrual accounting and depict the Review's focus on outcomes, consistent with demand by governments for

outcome oriented performance information. The frameworks also accentuate the importance of equity. More detail on the general report framework, along with the differences between outputs and outcomes, can be found in chapter 1.

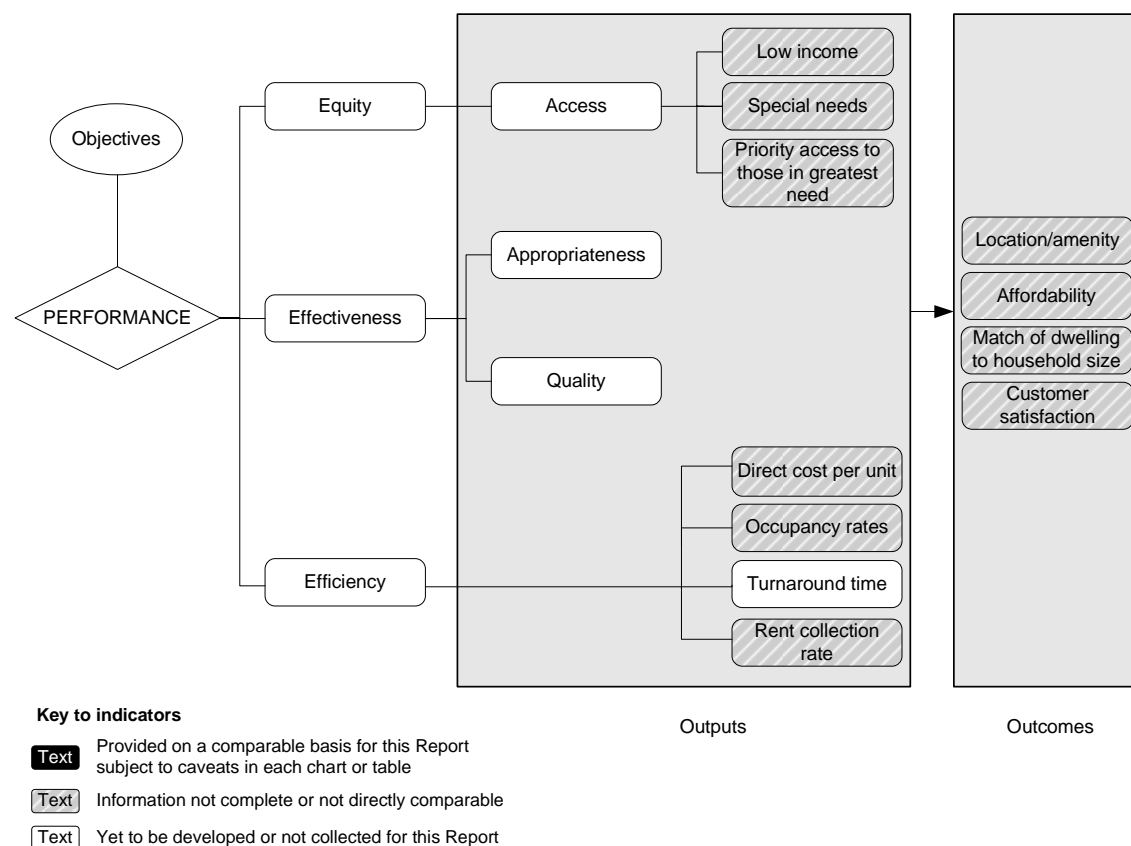
Comparable data are presented for the full range of indicators in the performance measurement framework for public housing and SOMIH (figure 16.4).

Figure 16.4 Performance indicators for public housing and SOMIH



While public, SOMIH and community housing use a common framework, the delivery method for public housing and SOMIH differs from that for community housing. State and Territory governments deliver public housing and SOMIH, while community organisations and sometimes local government deliver community housing. The turnaround time performance indicator has been removed from the CSHA community housing data collection by the National Housing Data Agreement Management Group following their review of the national performance reporting framework, and so no data were available for this Report.

Figure 16.5 Performance indicators for CSHA funded community housing

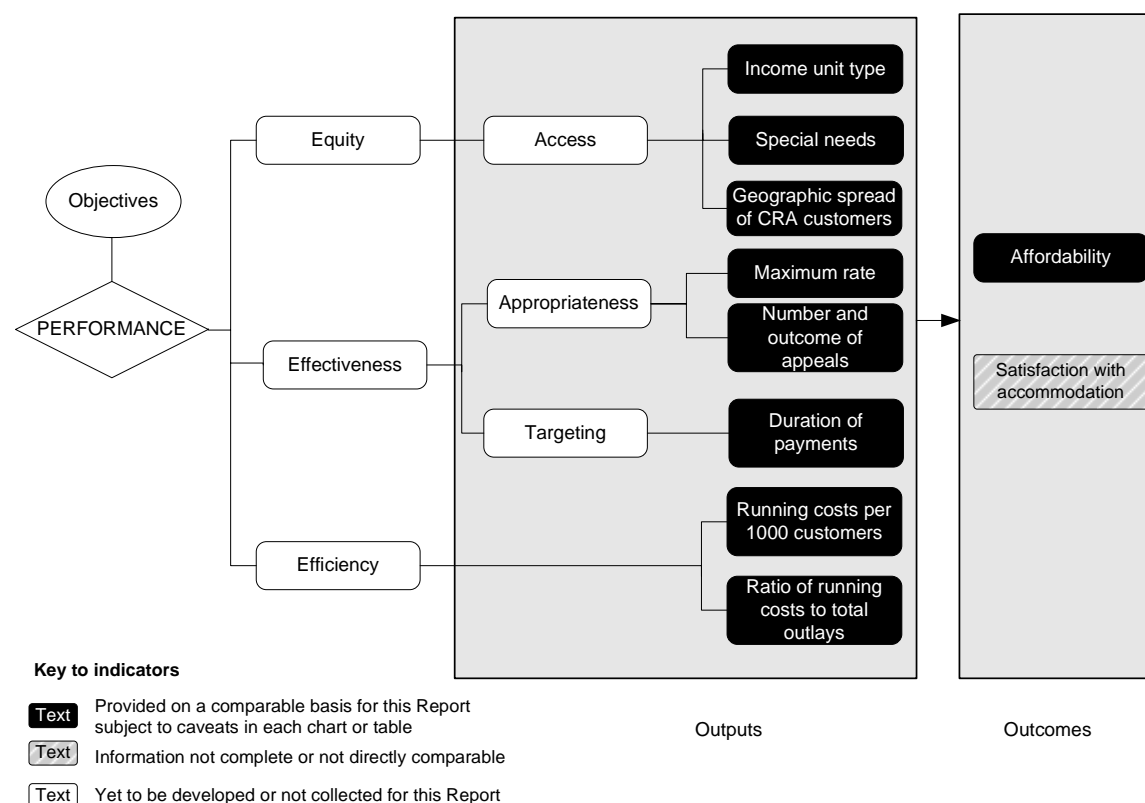


The performance indicators for CRA differ from those for public, SOMIH and CSHA funded community housing because CRA has different objectives and delivery methods. Reporting for CRA uses a performance indicator framework (figure 16.6) based on the CRA objective outlined in box 16.5.

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 that they face (Newman 1998). This assistance should be delivered in an equitable and efficient manner. CRA is also governed by other objectives relating to the primary income support payment.

Figure 16.6 Performance indicators for CRA



16.3 Key performance indicator results

Performance indicator results are comparable between public housing and SOMIH, but are not comparable to community housing because data quality and coverage can differ. More information on definitions is provided in a box for each indicator.

Public housing and SOMIH

Different delivery contexts, locations and types of customer may affect the performance of public housing and SOMIH reported in this chapter. For example, SOMIH and Indigenous community housing dwellings are slightly more likely than main stream public or community housing dwellings to be located in regional or remote areas (tables 16.5 and 16.9). Care therefore needs to be taken in interpreting performance indicator results, and the qualifications presented with the data need to be considered.

Some contextual information on public housing can be found in table 16A.1. Some descriptive data on SOMIH are included in table 16A.14. As outlined in section 16.1, the ACT and the NT are not included in the SOMIH data collection.

Outputs

Equity — low income

The first equity indicator reported for public housing and SOMIH is ‘low income’ (box 16.6).

Box 16.6 Equity — low income

‘Low income’ is an output indicator of the CSHA guiding principles, measuring low income need status of all households receiving assistance. The ‘low income’ performance indicator measures the number of new low income households as a proportion of all new households. Two measures of low income performance indicator are reported:

- the proportion of new households with low income A — households where all members receive an income equivalent to or below 100 per cent of the government income support benefits at the pensioner rate (pension rates have been selected for calculating this indicator because they are higher than allowance rates)
- the proportion of new households with low income B — households with an income above 100 per cent of the government income support benefits at the pensioner rate, but below the effective cut-off for receiving any government support benefits.

High values for these measures indicate a high degree of access for low income households.

The proportion of new tenancies allocated to low income A households for public housing in 2005-06 is presented in table 16.9. The proportion of new tenancies allocated to low income B households is reported in the attachment (table 16A.2).

Table 16.9 Public housing — low income A households as a proportion of all new households (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>New low income A households as proportion of all new households</i>									
2001-02	94.6	93.0	90.4	83.8	89.7	93.1	92.0	87.0	91.4
2002-03	92.9	90.4	90.3	86.8	89.6	90.6	88.9	87.4	90.4
2003-04	94.7	92.4	90.5	87.9	87.5	89.1	87.7	87.6	91.2
2004-05	94.0	92.5	88.1	85.8	87.1	80.8	89.4	85.6	90.0
2005-06	94.5	93.3	87.3	88.2	87.6	89.8	87.1	85.3	90.9

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.2.

Source: AIHW (2002c, 2003c, 2004c, 2005c, 2006b); table 16A.2.

The proportion of new tenancies allocated to low income A households for SOMIH in 2005-06 is presented in table 16.10. The proportion of new tenancies allocated to low income B households is reported in the attachment (table 16A.15).

Table 16.10 SOMIH — low income A households, as a proportion of all new households (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Total</i>
<i>New low income A households as proportion of all new households</i>							
2001-02	89.6	88.1	83.1	81.3	87.3	95.5	85.8
2002-03	91.5	87.8	89.7	89.1	86.5	87.2	89.2
2003-04	94.4	90.5	83.3	93.5	89.2	89.5	90.6
2004-05	94.2	87.7	76.1	92.9	86.0	86.0	88.0
2005-06	95.9	88.2	89.2	88.6	86.5	93.3	90.4

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.15.

Source: AIHW (2002a, 2003a, 2004a, 2005a, 2006a); table 16A.15.

The proportion of low income households to all new households was similar for public housing and SOMIH. There were only slight variations across jurisdictions.

Equity — special needs

The second equity indicator reported for public housing and SOMIH is 'special needs' (box 16.7).

Box 16.7 Equity — special needs

‘Special needs’ is an output indicator of the CSHA guiding principles, measuring special needs status of all households receiving assistance. The ‘special needs’ performance indicator presents the proportion of new tenancies allocated to households with special needs.

A high value for this measure indicates a high degree of access for special needs households.

New public housing tenancies allocated to households with special needs are presented in table 16.11.

Table 16.11 **Public housing — new tenancies allocated to households with special needs (per cent)^a**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2001-02	50.9	35.3	36.2	36.2	73.5	48.1	31.4	52.0	43.9
2002-03	52.4	43.7	38.9	44.7	59.0	49.9	35.3	62.8	48.1
2003-04	53.6	45.9	58.2	49.9	58.9	65.7	33.0	73.0	53.5
2004-05	55.7	47.1	62.7	64.8	63.2	67.6	48.4	100.0	58.2
2005-06	55.7	58.9	61.9	67.7	61.1	66.1	52.7	63.1	59.8

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.3.

Source: AIHW (2002c, 2003c, 2004c, 2005c, 2006b); table 16A.3.

The proportion of new tenancies allocated to special needs households for SOMIH is presented in table 16.12.

Table 16.12 **SOMIH — new tenancies allocated to households with special needs (per cent)^a**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Total</i>
2001-02	35.8	31.7	38.3	25.2	70.5	44.9	35.2
2002-03	35.8	49.7	41.0	37.4	37.8	50.6	39.5
2003-04	44.6	44.2	46.3	40.8	39.5	60.3	43.6
2004-05	51.5	45.4	45.2	49.2	42.1	66.7	48.1
2005-06	48.8	42.8	46.8	53.2	45.3	62.3	48.8

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.16.

Source: AIHW (2002a, 2003a, 2004a, 2005a, 2006a); table 16A.16.

The proportion of new tenancies allocated to households with special needs steadily increase over time for both public housing and SOMIH at the national level while there were fluctuations within the jurisdictions.

Equity — priority access to those in greatest need

The final equity indicator reported for public housing and SOMIH is ‘priority access to those in greatest need’ (box 16.8). Differences in State and Territory housing assessment policies can influence comparability for this indicator.

Box 16.8 Priority access to those in greatest need

‘Priority access to those in greatest need’ is an output indicator of the CSHA guiding principles to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes are such that those in greatest need have first access to housing. It measures the proportion of new allocations to those in greatest need. Greatest need households are defined as low income households that at the time of allocation are homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs.

Reported data reflect the proportions of greatest need allocation overall and greatest need households waiting for less than three months to more than two years. As time to allocation reflects greatest need allocations as a proportion of all allocations for the time period, these numbers are not cumulative. A high value for this indicator, particularly for short time frames, represents a high degree of access of those in greatest need without these people waiting long periods of time.

The proportion of new allocations to those in greatest need in 2005-06 for public housing is presented in table 16.13.

Table 16.13 Public housing — proportion of new allocations to those in greatest need, 2005-06 (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total for year ending 30 June	21.9	69.3	17.5	27.0	40.4	93.5	86.5	27.8	38.1
Proportion of new allocations to those in greatest need, by time to allocation									
<3 months	47.3	77.2	57.4	45.6	60.7	94.8	89.7	23.4	61.7
3–<6 months	39.4	70.2	56.0	66.1	60.9	95.1	88.0	41.9	60.8
6 months–<1 year	22.2	73.4	34.0	28.8	52.9	93.8	90.4	42.3	48.4
1–<2 years	13.8	69.6	13.7	2.0	30.9	86.5	80.3	19.7	28.3
2+ years	2.2	33.5	3.2	0.2	2.7	84.0	64.6	8.5	5.7

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.4.

Source: AIHW (2006b); table 16A.4.

The proportion of new allocations to those in greatest need for 2005-06 for SOMIH is presented in table 16.14.

Table 16.14 SOMIH — proportion of new allocations to those in greatest need, 2005-06 (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Total</i>
Total for year ending 30 June	8.2	23.9	11.9	28.4	79.4	na	26.3
Proportion of greatest need allocations to new allocations, by time to allocation							
<3 months	17.5	28.6	22.6	37.9	71.7	na	36.8
3–<6 months	11.9	35.7	40.0	72.5	100.0	na	41.7
6 months–<1 year	1.6	27.3	14.8	23.7	85.7	na	25.1
1–<2 years	5.2	31.3	4.8	–	88.6	na	20.7
2+ years	–	–	3.3	–	72.2	na	5.5

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.17. **na** Not available. – Nil or rounded to zero.

Source: AIHW (2006a); table 16A.17.

Efficiency — direct cost per unit

The efficiency indicator identified for public housing and SOMIH is ‘direct cost per unit’ (box 16.9).

Box 16.9 Direct cost per unit

‘Direct cost per unit’ has been identified as an output indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It measures the cost of providing assistance per dwelling. ‘Direct cost per unit’ can be defined as the total administration costs and the costs of maintaining the operation of dwellings. Two related measures are also reported for public housing:

- gross cost per unit — gross cost to government (administration and operating costs plus capital costs)
- net cost per unit — net cost to government (cost excluding rents received from tenants).

Holding other factors equal, a lower direct cost per unit suggests an improvement in efficiency.

Due to a high level of capital expenditure in housing, gross and net cost per unit are predominantly driven by the user cost of capital (box 16.10). Caution must therefore be used when interpreting the indicator because the user cost of capital and service delivery models differ across the jurisdictions. The cost per dwelling indicators also do not provide any information on the quality of service provided (for example, the standard of dwellings).

The costs incurred by jurisdictions in providing public housing and SOMIH include:

- administration costs (the cost of the administration offices of the property manager and tenancy manager)
- operating costs (the costs of maintaining the operation of the dwelling, including repairs and maintenance, rates, the costs of disposals, market rent paid and interest expenses)
- depreciation costs
- the user cost of capital (the cost of the funds tied up in the capital used to provide public housing and SOMIH). Box 16.10 provides a discussion of the user cost of capital.

In 2001, the Steering Committee completed a research project to assess the impact of asset measurement factors (such as depreciation and asset valuation methods) on the comparability of cost data in the Report. The results of this study are summarised in chapter 2. Box 16.11 summarises the results relating to housing.

Treatment of assets by housing agencies for each jurisdiction is presented in table 16A.72.

Box 16.10 The user cost of capital

The 'user cost of capital' for government services is the cost of having funds tied up in the capital used to deliver services (for example, houses and land in public housing). It makes explicit the opportunity cost of using the funds to deliver services rather than investing them elsewhere or using them to retire debt. It is calculated by applying a jurisdictional cost of capital rate to the value of government assets (see chapter 2 for details of the determination of a cost of capital rate). The costs of capital for land and other assets are shown separately, to allow users to consider any differences in land values across jurisdictions when assessing the results. Land values make up a large part of the user cost of capital and are largely beyond the control of jurisdictions.

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

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

(Continued on next page)

Box 16.10 (Continued)

The Steering Committee accepts that asset valuation data are imperfect. It also considers that non-recognition of the cost of capital used by departments to deliver services can result in a significant underestimation of costs for those services for which government capital is a major input. While the measurement of capital costs in this Report is not perfect, using an imputed costing is preferable to not costing government capital at all. The rate used for the user cost of capital is based on a weighted average of rates nominated by jurisdictions (currently 8 per cent).

Box 16.11 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 the study, *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001). The aim of the study was to examine the extent to which differences in asset measurement techniques applied by participating agencies affect the comparability of reported unit costs.

The relative capital intensity associated with the provision of public housing increases the potential for differences in asset measurement techniques to have a material impact on total unit costs. The results of this study suggest, however, that the adoption under the CSHA of a uniform accounting framework has largely avoided this impact. The results are discussed in more detail in chapter 2.

Source: SCRCSSP (2001).

The direct, gross and net costs to government per dwelling in 2005-06 for public housing are presented in table 16.15.

Care needs to be taken in interpreting the cost of delivering public housing. Cost data for some jurisdictions are either more complete than other cost data or collected on a more consistent basis. Administration costs and operating costs, for example, may not capture all costs incurred by government, so could understate the total costs of public housing. In addition, some jurisdictions had difficulty separating costs for public housing from those for other housing assistance activities. There may also be double counting of some expenditure items in the cost calculations for some jurisdictions. The user cost of capital, for example, is intended to capture all the costs of funding assets used to produce the services, but reported operating costs (apart from interest payments, which have been adjusted for) may already include some of these costs.

Interest payments have been subtracted from other capital costs (depreciation and the indicative user cost of capital) to obtain the total capital cost, gross cost and net cost to government, rendering these data not comparable with those published before 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. Prior to the 2002 Report, it had not been possible to avoid this double counting.

Payroll tax is excluded from total recurrent cost for public housing. This was done for the first time in the 2004 Report, making the cost data not comparable with the data published in prior reports. (Chapter 2 elaborates on the reasons for excluding payroll tax from the cost calculations.)

Table 16.15 Public housing — direct cost of providing assistance (excluding capital) per dwelling^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2001-02	4 034	3 027	4 150	4 260	4 248	6 788	6 231	7 252	4 140
2002-03	4 494	3 247	4 179	4 258	4 538	6 392	6 375	9 285	4 407
2003-04	4 822	3 515	4 394	4 693	4 609	6 021	7 746	10 053	4 695
2004-05	4 743	3 735	4 476	5 119	4 885	6 175	8 153	9 475	4 801
2005-06	5 122	4 233	4 719	5 382	5 283	6 813	7 685	9 304	5 145

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.5.

Source: AIHW (2006b); State and Territory governments (unpublished); table 16A.5.

The direct cost per dwelling for SOMIH is presented in table 16.16. Rent received from tenants has not been deducted.

As with other indicators, it is not appropriate to compare the direct cost of providing assistance per dwelling for public housing with the direct cost of providing assistance per dwelling for SOMIH, because there is greater scope for economies of scale in administration costs with public housing, which is a much larger program overall.

SOMIH dwellings are also slightly more concentrated in regional and remote areas where the cost of providing housing assistance is potentially greater. The need to construct culturally appropriate housing (possibly requiring a higher standard of amenities) may also affect the cost per dwelling. Finally, different cost structures may apply to the programs. Construction of dwellings, for example, under SOMIH may involve a skills development element to allow for training of apprentices in regional areas.

Table 16.16 SOMIH — direct cost of providing assistance per dwelling^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Total</i>
2001-02	9 192	4 963	5 654	4 800	4 540	2 958	6 297
2002-03	5 056	4 682	6 028	5 397	7 917	3 686	5 690
2003-04	5 684	4 737	6 296	6 059	5 469	3 425	5 702
2004-05	5 057	4 794	6 134	6 857	4 116	4 886	5 451
2005-06	5 364	6 208	6 582	7 589	6 931	5 551	6 354

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.18.

Source: AIHW (2002a, 2003a, 2004a, 2005a, 2006a); table 16A.18.

Efficiency — occupancy rate

The second efficiency indicator reported for public housing and SOMIH is the ‘occupancy rate’ (box 16.12).

Box 16.12 Occupancy rate

The ‘occupancy rate’ is an output indicator of the efficiency of housing utilisation. It represents the proportion of dwellings occupied. The term ‘occupied dwelling’ refers to dwellings occupied by tenants who have a tenancy agreement with the relevant housing authority. A high value for this indicator suggests higher efficiency of housing utilisation. Occupancy is influenced by both turnover and housing supply and demand.

The national average proportion of public rental stock occupied at 30 June 2006 was 97.8 per cent. There was only slight variation across jurisdictions (table 16.17).

Table 16.17 Public housing — occupancy rates (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2002	98.1	96.4	97.5	95.4	94.2	95.7	98.7	95.0	96.8
2003	98.3	96.5	97.9	95.7	94.9	96.8	98.7	93.9	97.1
2004	98.7	96.6	98.7	95.3	95.4	97.4	97.2	93.8	97.4
2005	98.7	97.3	98.6	95.6	96.1	98.0	98.1	94.1	97.7
2006	98.6	97.5	98.9	96.2	96.2	98.4	98.7	95.6	97.8

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.6.

Source: AIHW (2002c, 2003c, 2004c, 2005c, 2006b); table 16A.6.

The proportion of total SOMIH stock occupied at 30 June 2006 is presented in table 16.18.

Table 16.18 SOMIH — occupancy rates (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Total</i>
2002	97.9	96.6	94.6	95.2	91.2	92.7	95.4
2003	97.6	96.1	94.2	94.4	91.8	95.8	95.2
2004	98.0	96.7	96.8	94.1	92.2	98.2	96.0
2005	97.4	95.8	96.1	94.2	91.8	97.7	95.5
2006	97.4	96.7	96.8	94.1	93.5	98.3	96.1

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.19.

Source: AIHW (2002a, 2003a, 2004a, 2005a, 2006a); table 16A.19.

Efficiency — turnaround time

The third efficiency indicator reported for public housing and SOMIH is ‘turnaround time’ (box 16.13).

Box 16.13 Turnaround time

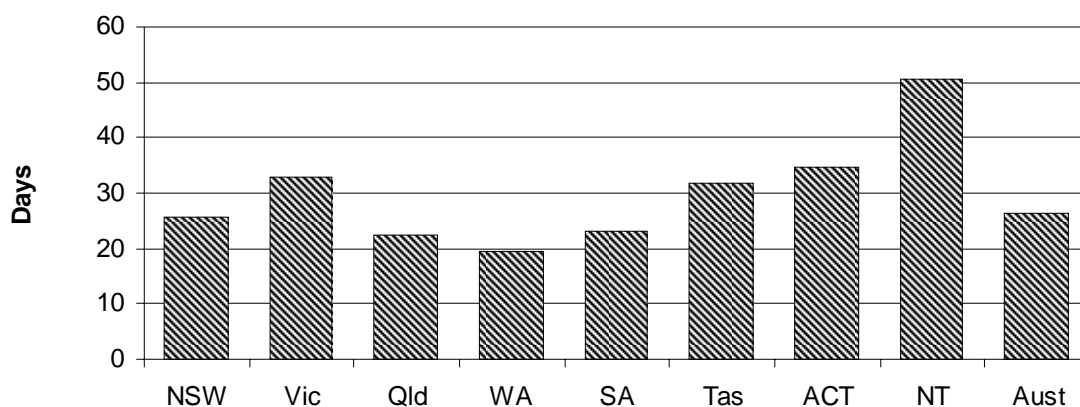
‘Turnaround time’ is an output indicator of the average time taken for occupancy of available dwelling stock to rent through normal processes. A low turnaround time suggests efficient housing allocation.

‘Normal’ vacancies exclude properties that are offline or are undergoing major redevelopment and where there is no suitable applicant but include hard-to-let properties as this relates to tenancy management.

This indicator may be affected by changes in maintenance programs and stock allocation processes, and some jurisdictions may have difficulty excluding stock upgrades. Cultural factors may also influence the national average turnaround time for SOMIH dwellings relative to public housing dwellings. Following the death of a significant person, for example, a dwelling may need to be vacant for a longer period of time (Morel and Ross 1993). A higher proportion of SOMIH dwellings in regional and remote areas may also contribute to delays in completing administrative tasks and maintenance before dwellings can be re-tenanted.

The average number of days for vacant stock to remain unallocated in 2005-06 is presented in figure 16.7 for public housing and figure 16.8 for SOMIH.

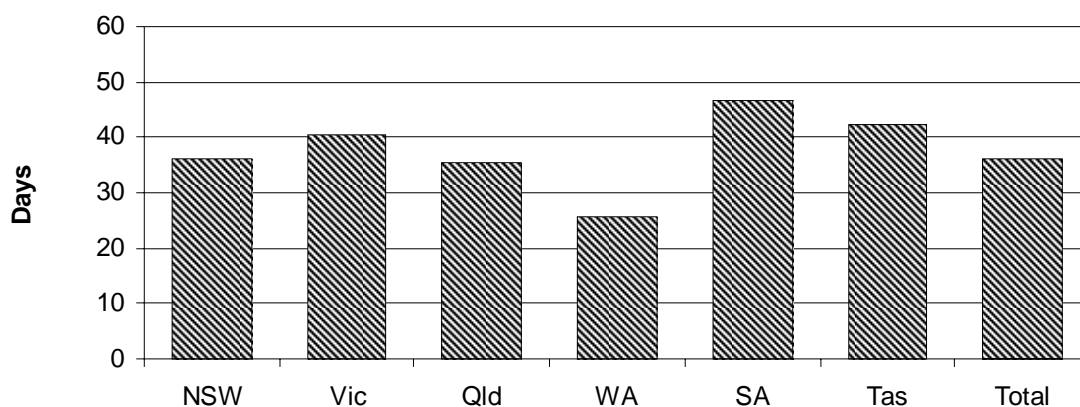
Figure 16.7 **Public housing — average turnaround time, 2005-06^a**



^a Data may not be comparable between jurisdictions and making comparisons between them could be misleading. Reasons for this are provided in table 16A.7.

Source: AIHW (2006b); table 16A.7.

Figure 16.8 **SOMIH — average turnaround time, 2005-06^a**



^a Data may not be comparable between jurisdictions and making comparisons between them could be misleading. Reasons for this are provided in table 16A.20.

Source: AIHW (2006a); table 16A.20.

Efficiency — rent collection rate

The final efficiency indicator reported for public housing and SOMIH is 'rent collection rate' (box 16.14).

Box 16.14 Rent collection rate

'Rent collection rate' is an output indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It is the total rent actually collected as a proportion of the total rent charged. A high proportion suggests efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a proportion of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of this indicator's reported results. Further, payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

Rent collected as a proportion of the total rent charged in 2005-06 is presented in table 16.19 for public housing and table 16.20 for SOMIH.

Table 16.19 **Public housing — total rent collected as a proportion of total rent charged (per cent)^a**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2001-02	99.2	99.8	98.8	101.0	97.8	100.7	100.0	97.9	99.3
2002-03	100.5	99.8	99.3	101.0	98.3	99.7	99.9	97.5	99.8
2003-04	99.7	99.3	99.8	101.9	100.0	102.2	99.3	99.9	99.9
2004-05	101.2	101.1	100.6	103.2	100.5	99.7	100.0	102.8	101.1
2005-06	100.1	100.1	100.2	101.7	100.8	103.8	99.8	100.7	100.4

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.8.

Source: AIHW (2002c, 2003c, 2004c, 2005c, 2006b); table 16A.8.

Table 16.20 **SOMIH — total rent collected as a proportion of total rent charged (per cent)^a**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Total</i>
2001-02	99.9	98.8	97.3	103.0	92.6	99.1	98.5
2002-03	102.3	98.1	97.2	101.9	107.9	98.8	101.4
2003-04	104.1	99.8	101.3	103.1	97.0	102.2	101.8
2004-05	97.7	100.6	100.4	103.9	93.8	99.6	99.2
2005-06	100.5	99.0	99.7	104.3	94.7	103.8	100.0

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.21.

Source: AIHW (2002a, 2003a, 2004a, 2005a, 2006a); table 16A.21.

Outcomes

Location/amenity

‘Location/amenity’ is an outcome indicator of success in meeting tenants’ needs (box 16.15).

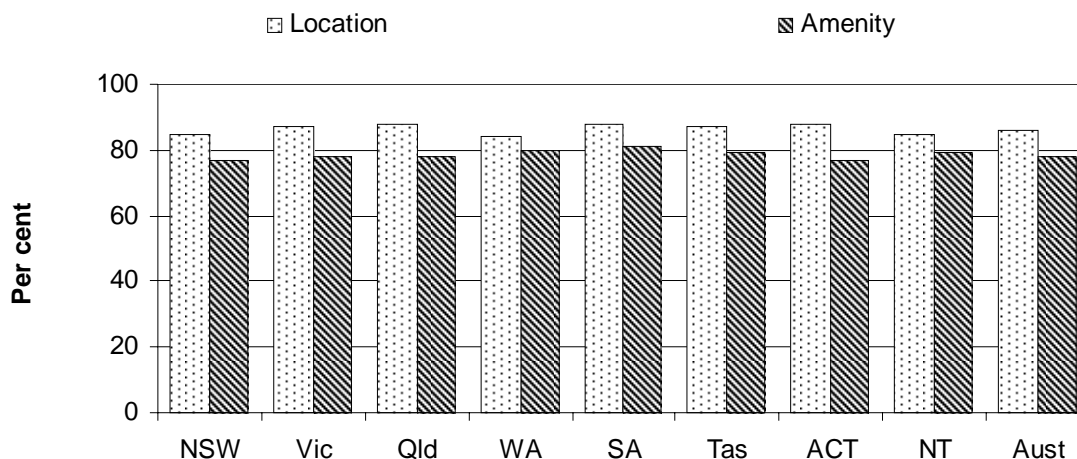
Box 16.15 Location/amenity

‘Location/amenity’ is an outcome indicator of the CSHA guiding principles to provide housing assistance that is appropriate to the needs of different households. The location/amenity indicator is a survey-based measure of the proportion of tenants rating location and amenity aspects as important and as meeting their needs. A higher level of satisfaction with location and amenity implies the provision of housing assistance more appropriate to household need.

The data for public housing are taken from the 2005 National Social Housing Survey for public rental housing. Tenants were asked whether particular aspects of the location and amenity of their dwellings were important to them and, if so, whether they felt their needs were met. The precision of survey estimates depends on the respondent sample size and the size of the sample estimate. Larger sample sizes with high response rates result in higher precision, as do larger sample estimates for a given or similar sample size. If, for example, 90 per cent of surveyed respondents chose an answer, then there would be more certainty about the actual population’s views than if 50 per cent of respondents chose it. Care thus needs to be taken in interpreting small differences in results. Further information on the sample size is provided in tables 16A.9 and 16A.10.

The proportion of public housing tenants rating their current home as meeting their needs is reported in figure 16.9.

Figure 16.9 Public housing — proportion of tenants rating their current home as meeting their location and amenity needs, 2005^a



^a Further information pertinent to the data included in this table and/or its interpretation is provided in tables 16A.9 and 16A.10.

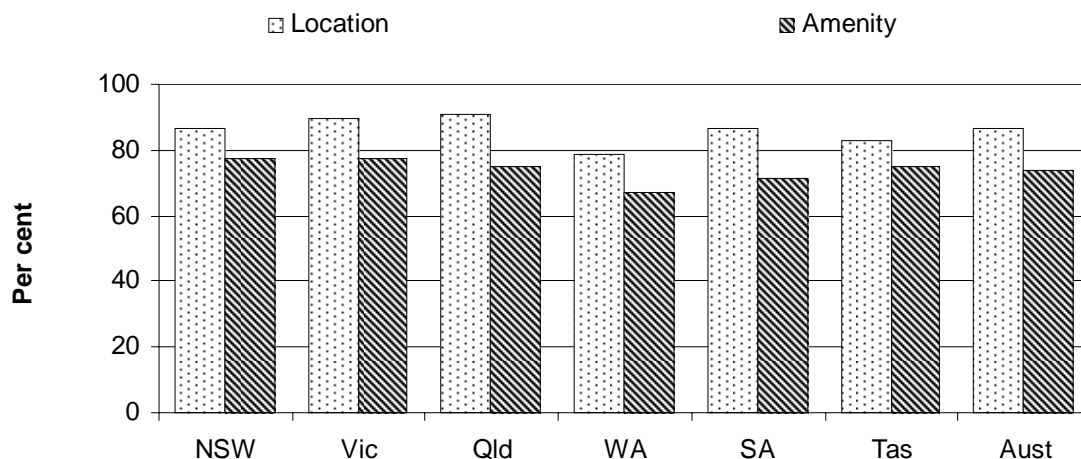
Source: AIHW (2006b); tables 16A.9 and 16A.10.

During 2004-05, all states participated in the first National Housing Survey of SOMIH. As for the National Social Housing Survey undertaken biennially for public and community housing, the survey seeks to determine tenants' level of satisfaction with various parameters of service and gauge housing outcomes.

SOMIH tenants were asked whether particular aspects of the location and amenity of their dwellings were important to them and, if so, whether they felt their needs were met. The methodology for the survey was face to face interviews with a clustered sample of tenants. This report includes results at both State and national levels.

Nationally, 86.5 per cent of tenants for whom location was important felt that their needs were met, and of those tenants for whom amenity was important 74.0 per cent felt that their needs were met (figure 16.10). Caution should be taken when comparing the SOMIH survey results with the public housing survey results, due to the different demographic profile of Indigenous customers and the different survey methodology issued that is a mail-out survey for the public housing survey and interviews for SOMIH survey. These differences may affect the results.

Figure 16.10 **SOMIH — proportion of tenants rating their current home as meeting their location and amenity needs, 2005^a**



^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.22.

Source: AIHW (2006a); table 16A.22.

Customer satisfaction

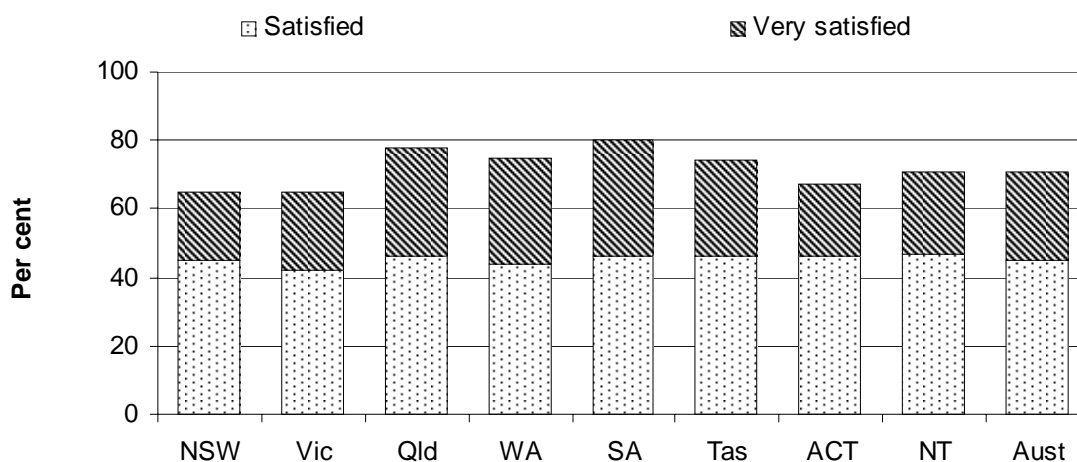
‘Customer satisfaction’ is an outcome indicator (box 16.16).

Box 16.16 Customer satisfaction

‘Customer satisfaction’ is an outcome indicator because one aim of the CSHA is to provide housing assistance that is appropriate for different households. Customer satisfaction is a survey measure of satisfaction with the overall service provided by the State or Territory housing authority. A higher percentage for customer satisfaction may imply better housing assistance provision.

Data for public housing are sourced from the 2005 National Social Housing Survey for public rental housing. Nationally in 2005, 71 per cent of tenants were either satisfied or very satisfied with the service provided (figure 16.11).

Figure 16.11 Public housing — customer satisfaction, 2005^a

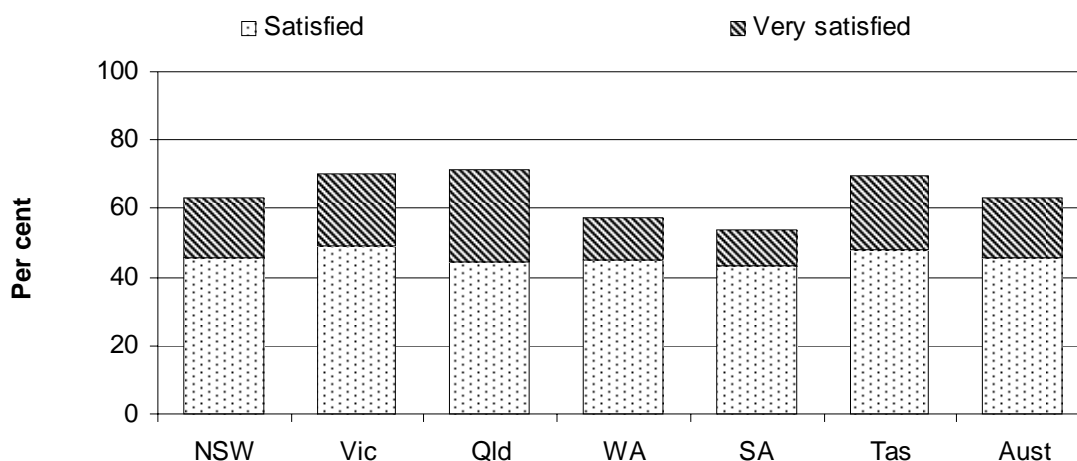


^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.13.

Source: AIHW (2006b); table 16A.13.

Results for SOMIH are taken from the 2005 National Social Housing Survey of SOMIH. Nationally 63 per cent of respondents were either satisfied or very satisfied with the overall service provided by their State housing authority (figure 16.12).

Figure 16.12 SOMIH — customer satisfaction, 2005^a



^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.22.

Source: AIHW (2006a); table 16A.22.

Affordability

‘Affordability’ is an outcome indicator of ability to access suitable housing (box 16.17).

Box 16.17 Affordability

‘Affordability’ is an outcome indicator that aims to measure housing affordability for CSHA housing tenants. Two measures are reported:

- a subsidy per tenant derived by dividing the total rebated amount by the total number of households
- the proportion of rebated households spending less than 30 per cent of their income in rent.

High subsidy per tenant and high proportion of households spending less than 30 per cent of their income in rent imply better affordability.

The subsidy per tenant and the proportion of households spending less than 30 per cent of their income in rent for public housing at 30 June 2006 is presented in table 16.21. Information on the amount of income paid in rent by public housing tenants as a proportion of income can be found in table 16A.74.

Table 16.21 **Public housing — subsidy per tenant and proportion of households spending 30 per cent or less of their income in rent^a**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Subsidy per tenant (\$)									
2006	106.6	70.6	73.0	54.6	60.8	66.1	122.8	93.8	83.2
Proportion of rebated households spending 30 per cent or less of their income in rent									
2006	100.0	99.9	100.0	99.5	99.7	98.3	99.2	99.0	99.7

^a Data may not be comparable between jurisdictions and making comparisons between them could be misleading. Reasons for this are provided in table 16A.11.

Source: AIHW (2002c, 2003c, 2004c, 2005c, 2006b); table 16A.11.

The subsidy per tenant and the proportion of rebated households spending less than 30 per cent of their income in rent for SOMIH at 30 June 2006 is presented in table 16.22. Information on the amount of income paid in rent by SOMIH tenants as a proportion of income can be found in table 16A.75.

Table 16.22 SOMIH — subsidy per tenant and proportion of households spending less than 30 per cent of their income in rent^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Total</i>
Subsidy per tenant (\$)							
2006	89.7	87.9	84.3	69.3	72.2	74.0	81.8
Proportion of rebated households spending 30 per cent or less of their income in rent							
2006	100.0	99.6	100.0	99.5	99.1	97.0	99.2

^a Data may not be comparable between jurisdictions and making comparisons between them could be misleading. Reasons for this are provided in table 16A.23.

Source: AIHW (2002a, 2003a, 2004a, 2005a, 2006a); table 16A.23.

Match of dwelling to household size

‘Match of dwelling to household size’ is an outcome indicator (box 16.18).

Box 16.18 Match of dwelling to household size

‘Match of dwelling to household size’ is an outcome indicator of the CSHA guiding principles is to provide housing assistance that is appropriate to the needs of different households, such as household size. It measures the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

The proxy occupancy standard was revised to remove the four bedroom cap. The revised occupancy measure has been applied for the first time in the 2007 Report. Data from previous years can not be compared.

Proxy occupancy standard for appropriate sized dwelling, by household structure

<i>Household structure</i>	<i>Bedrooms required</i>
Single adult only	1 bedroom
Single adult (group)	1 bedroom (per adult)
Couple with no children	2 bedrooms
Sole parent or couple with one child	2 bedrooms
Sole parent or couple with two or three children	3 bedrooms
Sole parent or couple with four children	4 bedrooms
Sole parent or couple with more than four children	equal to number of children

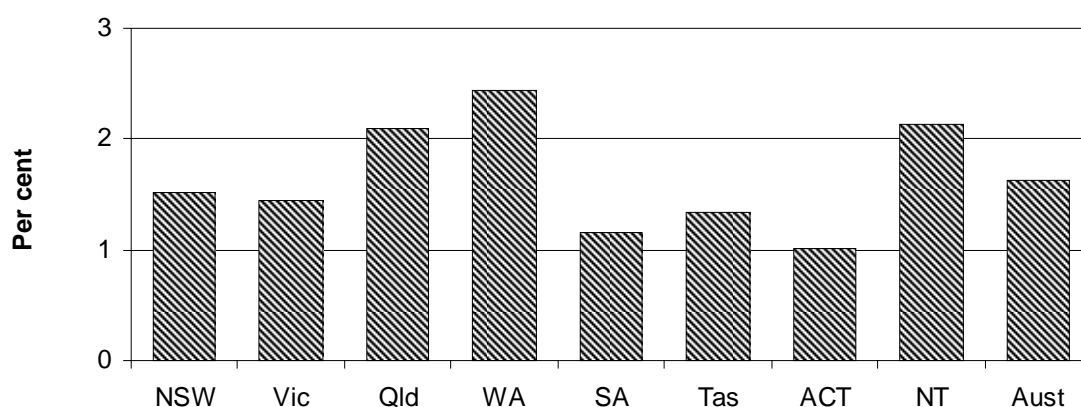
Source: AIHW (2006c).

A low proportion indicates a low proportion of overcrowded households.

Multi income unit households were included in the 2006 Report for Victoria and Queensland. They are included for the first time in the 2007 Report for NSW, WA, SA and the ACT. Therefore, multi income unit households are now included for all jurisdictions except Tasmania and the NT.

The proportion of households with overcrowding for public housing is illustrated in figure 16.13. Information on moderate overcrowding and underutilisation for public housing can be found in table 16A.77.

Figure 16.13 Public housing — proportion of households with overcrowding at 30 June, 2006^{a, b}

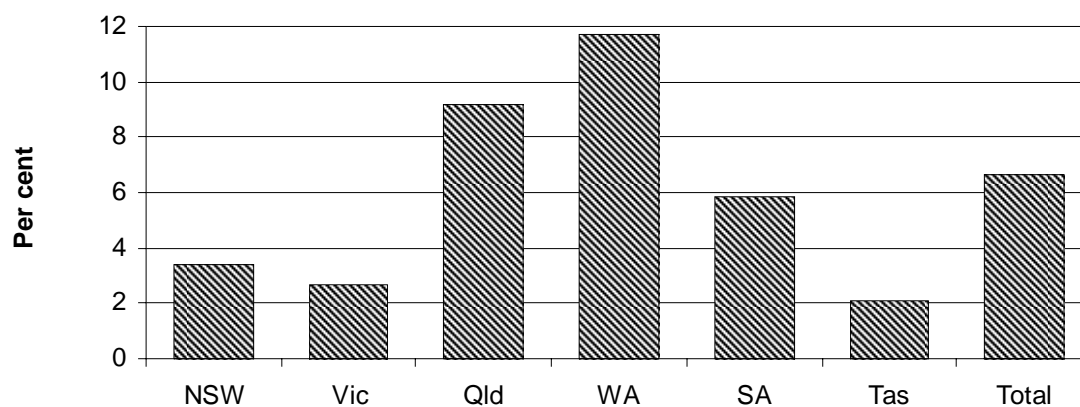


^a Data may not be comparable between jurisdictions and making comparisons between them could be misleading. Reasons for this are provided in table 16A.12. ^b The proxy occupancy standard was revised to remove the four bedroom cap for the 2006 data. Data from previous years can not be compared.

Source: AIHW (2006b); table 16A.12.

The proportion of households with overcrowding for SOMIH is illustrated in figure 16.14. Information on moderate overcrowding and underutilisation for SOMIH can be found in table 16A.78.

Figure 16.14 **SOMIH — proportion of households with overcrowding at 30 June, 2006^{a, b}**



^a Data may not be comparable between jurisdictions and making comparisons between them could be misleading. Reasons for this are provided in table 16A.24. ^b The proxy occupancy standard was revised to remove the four bedroom cap for the 2006 data. Data from previous years can not be compared.

Source: AIHW (2006b); table 16A.24.

Community housing

This section includes data on the 10 performance indicators in the community housing framework (figure 16.5).

Community housing data have three sources:

- Jurisdictions' administrative data, collected by the State or Territory government body with responsibility for administering the community housing program in the jurisdiction. The NT provided only administrative data.
- Community housing provider survey data, collected from the community organisations (providers) that manage the service delivery.
- Survey data collected via the National Social Housing Survey.

For the community housing provider survey data, response rates, along with changes to the definitions and counting rules used over time, can influence the comparability of the data. Comparisons over time using community housing data thus need to be made with care. Table 16A.83 outlines the survey response rates and associated information for each jurisdiction for each year from 2000-01 to 2005-06. Performance indicator results are not comparable between public, community housing and SOMIH sections.

Some descriptive data on community housing are contained in table 16A.25. Table 16A.70 lists State and Territory programs included in the community housing data collected.

Outputs

Equity — low income

The first equity indicator reported for community housing is 'low income' (box 16.19).

Box 16.19 Low income

‘Low income’ is an output indicator of the CSHA guiding principles is to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. This indicator assesses the low income need status of all households receiving assistance. It measures the number of low income households as a proportion of all households (new and existing). A high proportion indicates a high degree of access by low income households.

The low income indicator is measured differently for community housing than for public housing. The community housing indicator is based on the low income B cut-offs used in the public rental housing data collection. Data are reported on all households, rather than just new households.

At 30 June 2006, across those jurisdictions able to provide data, the number of low income households as a proportion of all households is presented in table 16.23.

Table 16.23 Community housing — the number of low income households as a proportion of all households^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2002	97.6	100.0	97.4	94.6	95.6	91.2	97.4	na	97.6
2003	96.6	100.0	95.7	37.4	89.8	53.3	92.4	na	88.2
2004	96.6	99.5	93.3	95.7	94.0	72.2	95.6	na	95.6
2005	88.9	98.5	98.2	87.5	91.6	93.5	97.5	na	91.8
2006	89.8	93.8	81.9	97.8	97.3	95.1	97.7	na	90.3

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.26. **na** Not available.

Source: AIHW (2002b, 2003b, 2004b, 2005b, 2007c); table 16A.26.

Equity — special needs

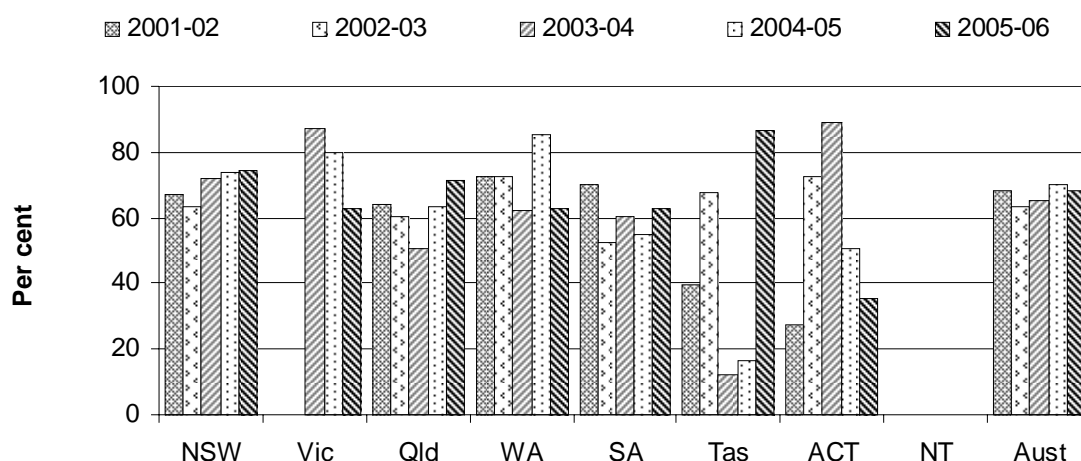
The second equity indicator reported for community housing is ‘special needs’ (box 16.20).

Box 16.20 Special needs

‘Special needs’ is an output indicator of the CSHA guiding principles is to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures the proportion of new tenancies allocated to special needs households. New tenancies are reported as a proxy for all households receiving assistance. Special needs households are defined as those households that have either a household member with a disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members. A high proportion indicates a high degree of access by these special needs households.

The proportion of new tenancies allocated to special needs households in 2005-06 is presented in figure 16.15.

Figure 16.15 **Community housing — new tenancies allocated to households with special needs^{a, b}**



^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.27. ^b Data for the NT and Victoria for 2001-02 and 2002-03 are not available.

Source: AIHW (2002b, 2003b, 2004b, 2005b, 2007c); table 16A.27.

Equity — priority access to those in greatest need

The final equity indicator reported for community housing is ‘priority access to those in greatest need’ (box 16.21).

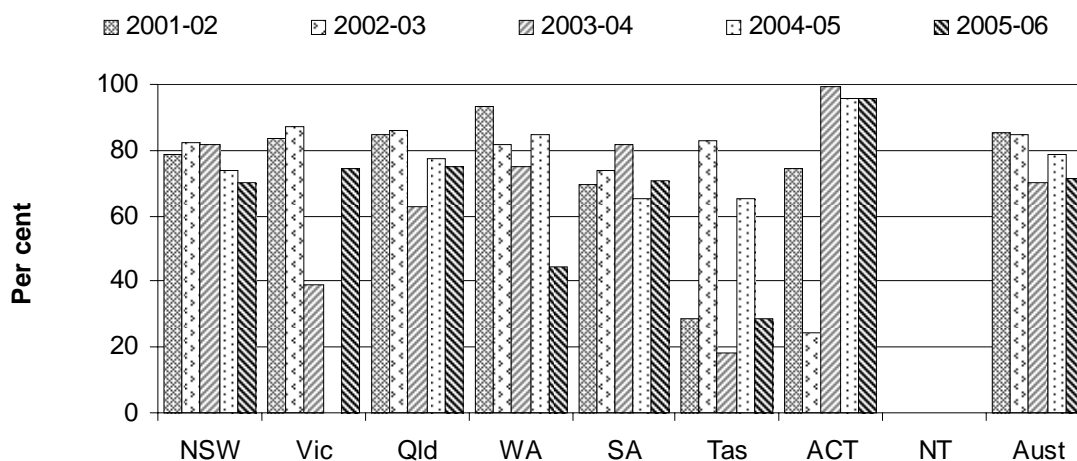
Box 16.21 Priority access to those in greatest need

'Priority access to those in greatest need' is an output indicator of the CSHA guiding principles is to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes are such that those in greatest need have first access to housing. It measures the proportion of new allocations to those in greatest need.

Greatest need households are defined as low income households that at the time of allocation are homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs. High values for this indicator represent a high degree of access by those in greatest need.

The proportion of new allocations to those in greatest need is presented in figure 16.16. Differences in State and Territory housing allocation policies can influence comparability for this indicator, because the majority of jurisdictions do not require community housing organisations to segment waiting lists.

Figure 16.16 **Community housing — proportion of new allocations to those in greatest need^{a, b}**



^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.28. ^b Data for the NT and Victoria for 2002-03 are not available.

Source: AIHW (2002b, 2003b, 2004b, 2005b, 2007c); table 16A.28.

Efficiency — direct cost per unit

The efficiency indicator identified for community housing is ‘direct cost per unit’ (box 16.22).

Box 16.22 Direct cost per unit

‘Direct cost per unit’ has been identified as an output indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It measures the cost of providing assistance per dwelling. ‘Direct cost per unit’ can be defined as the total administration costs and the costs of maintaining the operation of dwellings. It does not include any cost of capital.

Holding other factors equal, a lower cost per unit suggests an improvement in efficiency.

The cost per dwelling indicators do not provide any information on the quality of service provided (for example, the standard of dwellings).

The ‘direct cost per unit’ at 30 June 2005 is presented in table 16.24. For community housing, data on direct cost per unit are reported with a one year lag to allow community housing providers an extra year to collate financial data.

Table 16.24 Community housing — direct cost per unit (dollars)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2000-01	2 767	na	3 600	7 626	3 791	na	na	na	4 058
2001-02	2 722	na	3 221	3 844	3 614	7 236	na	na	3 210
2002-03	8 036	3 679	4 187	5 048	4 362	5 173	na	na	5 636
2003-04	9 224	5 167	4 291	7 861	3 751	7 712	na	na	6 529
2004-05	9 400	6 667	5 509	8 013	6 995	11 365	na	na	7 744

^a Data may not be comparable between jurisdictions and making comparisons between them could be misleading. Reasons for this are provided in table 16A.29. **na** Not available.

Source: AIHW (2002b, 2003b, 2004b, 2005b, 2007c); table 16A.29.

Efficiency — occupancy rate

A second efficiency indicator reported for community housing is the ‘occupancy rate’ (box 16.23).

Box 16.23 Occupancy rate

The 'occupancy rate' is an output indicator of the efficiency of housing utilisation. It is the proportion of dwellings occupied. The term 'occupied dwelling' refers to dwellings occupied by tenants who have a tenancy agreement with the relevant community housing organisation. A higher occupancy rate suggests higher efficiency of housing utilisation. Occupancy is influenced by both turnover and housing supply.

The proportion of community housing occupied at 30 June 2006 is presented in table 16.25. The NT occupancy rates are based on the assumption that all dwellings are occupied.

Table 16.25 Community housing — occupancy rates (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2002	98.2	95.6	94.8	97.2	95.8	100.0	94.7	100.0	96.5
2003	97.8	96.3	96.1	100.4	95.6	98.3	97.4	100.0	97.0
2004	98.6	98.1	95.0	99.8	95.4	99.8	95.8	100.0	97.5
2005	98.2	94.5	95.7	98.0	95.1	98.9	89.8	100.0	96.5
2006	98.4	93.7	97.2	94.1	96.5	99.8	89.8	100.0	96.6

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.30.

Source: AIHW (2002b, 2003b, 2004b, 2005b, 2007c); table 16A.30.

Efficiency — turnaround time

The third efficiency indicator identified for community housing is 'turnaround time' (box 16.24).

Box 16.24 Turnaround time

'Turnaround time' is an output indicator of the time taken to reallocate normally vacant properties after they have been vacated, acquired or newly constructed. The indicator measures the average time taken in days for normal vacant dwellings to be occupied. The length of time taken to rent untenanted dwellings affects allocations of housing, waiting times, the length of waiting lists and rent foregone. A low turnaround time suggests efficient housing allocation. All jurisdictions aim to minimise turnaround times.

'Normal' vacancies exclude properties that are offline or are undergoing major redevelopment and where there is no suitable applicant but include hard-to-let properties as this relates to tenancy management.

Data for turnaround time are not reported for community housing due to the complex and diverse nature of tenant allocation processes which impact on data quality.

Efficiency — rent collection rate

The fourth efficiency indicator reported for community housing is ‘rent collection rate’ (box 16.25).

Box 16.25 Rent collection rate

‘Rent collection rate’ is an output indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It is the total rent actually collected as a proportion of the rent charged. A high proportion suggests efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a proportion of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of this indicator’s reported results. Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

For community housing, data on rent collection rate are reported with a one year lag to allow community housing providers an extra year to collate financial data (table 16.26). As with public housing, payment arrangements for rent in some jurisdictions mean the rent collected over a 12 month period may be higher than rent charged over that period.

Table 16.26 Community housing — total rent collected as a proportion of total rent charged (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2000-01	92.5	na	98.6	99.2	97.8	na	97.6	na	95.5
2001-02	98.5	na	92.6	97.5	97.9	98.7	98.9	na	97.1
2002-03	98.8	98.6	83.8	100.5	97.3	98.9	99.7	na	95.7
2003-04	99.4	96.1	98.6	98.0	97.8	101.2	92.6	na	98.3
2004-05	99.5	96.3	98.3	102.6	97.8	100.4	100.3	na	99.0

^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.31. **na** Not available.

Source: AIHW (2002b, 2003b, 2004b, 2005b, 2007c); table 16A.31.

Outcomes

Location/amenity

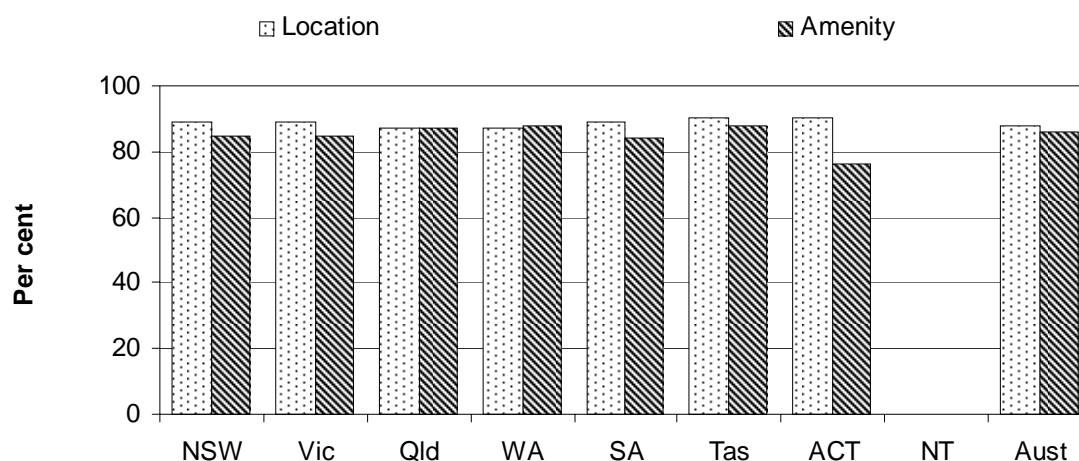
‘Location/amenity’ is an outcome indicator of success in meeting tenants’ needs (box 16.26).

Box 16.26 Location/amenity

'Location/amenity' is an outcome indicator of the CSHA guiding principles to provide housing assistance that is appropriate to the needs of different households. The location/amenity indicator is a survey-based measure of the proportion of tenants rating location and amenity aspects as important and as meeting their needs. Higher levels of satisfaction with location and amenity imply the provision of housing assistance that satisfies household needs.

The data for this indicator are from the 2005 Community Housing National Social Housing Survey. Community housing tenants were asked whether particular aspects of the location and amenity of their dwellings were important to them and, if so, whether they felt their needs were met. The proportions of tenants satisfied with the location and amenity of their dwelling in April/May 2005 are presented in figure 16.17. As with public housing, the precision of survey estimates depends on the survey sample size (see the discussion of location/amenity for public housing). More information on the sample size is provided in tables 16A.32 and 16A.33.

Figure 16.17 **Community housing — tenants satisfied with location and amenity aspects of their dwelling, 2005^{a, b}**



^a Further information pertinent to the data included in this table and/or its interpretation is provided in tables 16A.32 and 16A.33. ^b Data for the NT are not available.

Source: AIHW (2007c); tables 16A.32 and 16A.33.

Affordability

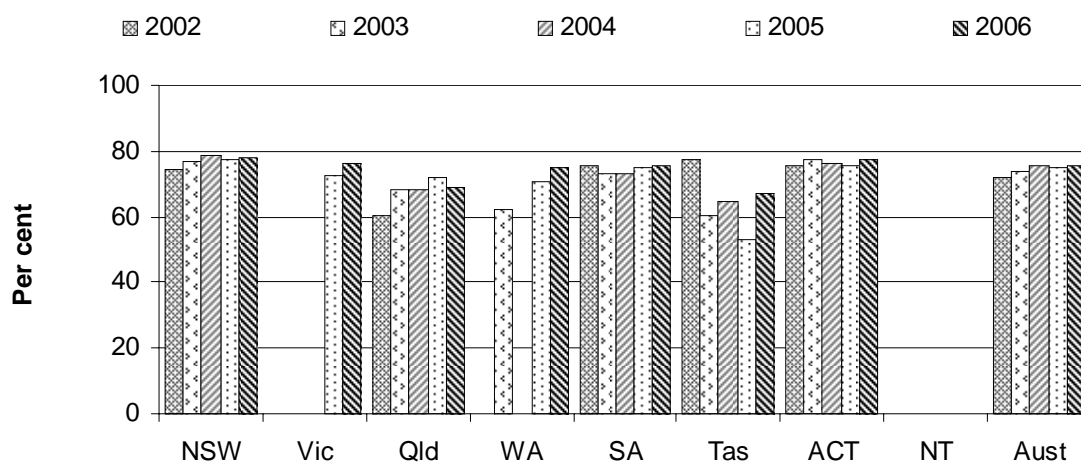
'Affordability' is an outcome indicator (box 16.27).

Box 16.27 Affordability

‘Affordability’ is an outcome indicator of the CSHA guiding principles to provide affordable housing to assist people who are unable to access suitable housing. It measures the proportion of household income left after paying rent. A high proportion indicates that housing is affordable. This affordability measure differs from that reported for public housing and SOMIH.

The proportion of household income left after paying rent is presented in figure 16.18. Differences in the definition of assessable income, including the treatment of CRA in rent assessment, may affect the comparability of this indicator’s reported result. More information on affordability for community housing can be found in table 16A.76.

Figure 16.18 **Community housing — proportion of income left after paying rent^{a, b, c}**



^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.34. ^b Data for the NT, Victoria for 2002, 2003 and 2004 and WA for 2002 are not available. ^c Data for WA for 2004 are not published.

Source: AIHW (2002b, 2003b, 2004b, 2005b, 2007c); table 16A.34.

Match of dwelling to household size

‘Match of dwelling to household size’ is an outcome indicator (box 16.28).

Box 16.28 Match of dwelling to household size

'Match of dwelling to household size' is an outcome indicator of the CSHA guiding principles to provide housing assistance that is appropriate to the needs of different households, such as household size. It measures the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

The proxy occupancy standard was revised to remove the four bedroom cap. The revised occupancy measure has been applied for the first time in the 2007 Report. Data from previous years can not be compared.

Proxy occupancy standard for appropriate sized dwelling, by household structure

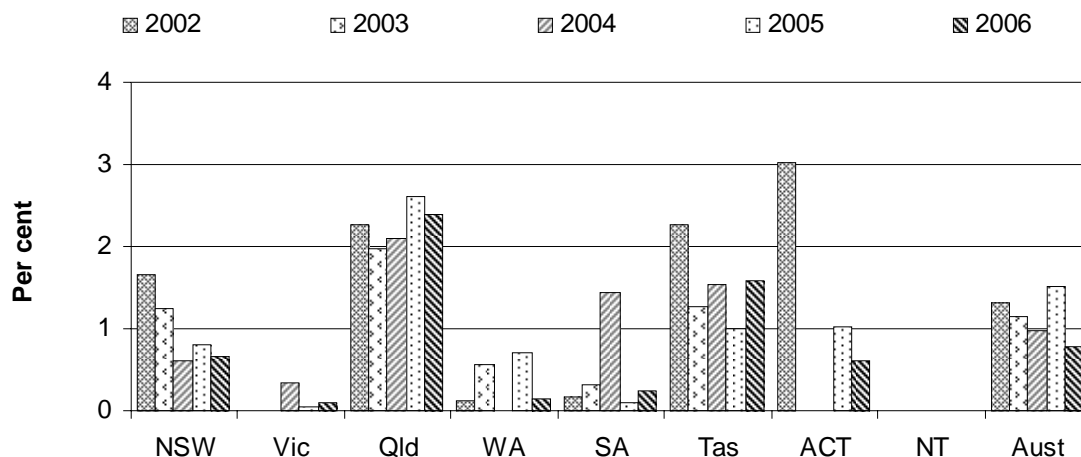
<i>Household structure</i>	<i>Bedrooms required</i>
Single adult only	1 bedroom
Single adult (group)	1 bedroom (per adult)
Couple with no children	2 bedrooms
Sole parent or couple with one child	2 bedrooms
Sole parent or couple with two or three children	3 bedrooms
Sole parent or couple with four children	4 bedrooms
Sole parent or couple with more than four children	equal to number of children

Source: AIHW (2006c).

A low proportion indicates a low proportion of overcrowded households.

The proportion of community households with overcrowding is illustrated in figure 16.19. Information on moderate overcrowding and underutilisation for community housing can be found in table 16A.79.

Figure 16.19 **Community housing — proportion of households with overcrowding^{a, b}**



^a Data may not be comparable between jurisdictions and over time and making comparisons between them could be misleading. Reasons for this are provided in table 16A.35. ^b Data for the NT, Victoria for 2002 and 2003 and WA for 2004 are not available.

Source: AIHW (2002b, 2003b, 2004b, 2005b, 2007c); table 16A.35.

Customer satisfaction

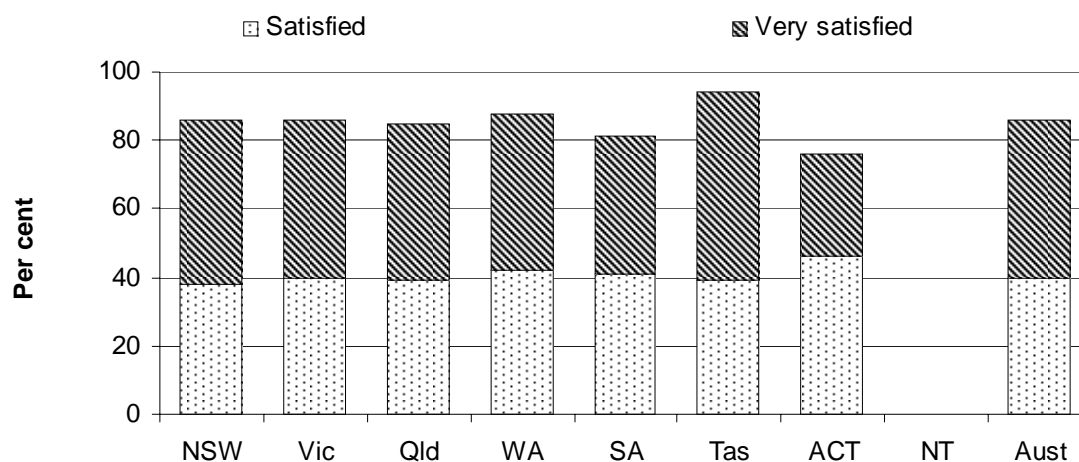
‘Customer satisfaction’ is an outcome indicator (box 16.29).

Box 16.29 Customer satisfaction

‘Customer satisfaction’ is an outcome indicator because one aim of the CSHA is to provide housing assistance that is appropriate to different households. Customer satisfaction is a survey measure of satisfaction with the overall service provided by the State or Territory housing authority. A higher proportion of satisfied customers may imply better housing assistance provision.

The data for this indicator are from the 2005 Community Housing National Social Housing Survey. Nationally, in April/May 2005, 86.0 per cent of tenants were satisfied or very satisfied with the services provided by their community housing organisation (figure 16.20).

Figure 16.20 **Community housing — customer satisfaction, 2005^{a, b}**



^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.36. ^b Data for the NT are not available.

Source: AIHW (2007c); table 16A.36.

Commonwealth Rent Assistance

Data for CRA recipients are only for individuals and families paid CRA by Centerlink under the *Social Security Act 1991* or family assistance law. It includes amounts paid under the Social Security Act with payments now administered by the Department of Employment and Workplace Relations (DEWR) and DEST. It does not include equivalent payments made by the Department of Veterans Affairs, or payments made with Abstudy on behalf of DEST.

Data are generally for those entitled to CRA at 3 March 2006. Centerlink recorded 941 306 individuals and families as being entitled to CRA with a social security or family assistance payment for that day. Other published figures may include individuals and families who were paid CRA in the previous fortnight, some of whom were only entitled to payment for an earlier period (table 16.27).

Important eligibility requirements for CRA (which is paid automatically once eligibility has been established) are (1) the receipt of an income support payment or more than the base rate of the Family Tax Benefit Part A, and (2) liability to pay rent.

Outputs

Equity — access — income unit type

The first access indicator is ‘income unit type’ (box 16.30).

Box 16.30 Income unit type

Access to CRA by ‘income unit type’ is an output indicator of the objective of CRA to provide financial assistance in an equitable manner. This indicator measures the number and proportion of eligible income support recipients receiving CRA by income unit type. The level of access experienced by different income unit types across States and Territories is influenced by a number of factors, including (but not restricted to) the size of their respective base populations and the levels of home ownership. CRA is a demand driven payment that has no benchmark in terms of the mix of customers. This indicator provides descriptive information only.

Of the 941 306 income units receiving CRA at 3 March 2006, 30 168 (approximately 3.2 per cent) self-identified as Indigenous. Single people with no children represented approximately 51.5 per cent of income units receiving CRA and 37.5 per cent of Indigenous income units receiving CRA (table 16.27). The figures for the total number and proportion of income units by the income unit type

disaggregated at the jurisdiction level are presented in tables 16A.42, 16A.43, 16A.44 and 16A.45.

Table 16.27 Income units receiving CRA, by income unit type, 2006^a

<i>Type of income unit</i>	<i>Income units</i>	<i>Proportion of</i>	<i>Indigenous income units</i>	<i>Proportion of</i>
		<i>CRA recipients</i>		<i>Indigenous CRA recipients</i>
	no.	%	no.	%
Single, no dependent children aged under 16	363 736	38.6	8 741	29.0
Single, no children, sharer	121 227	12.9	2 583	8.6
Single, one or two dependent children aged under 16	189 598	20.1	8 152	27.0
Single, three or more dependent children aged under 16	36 746	3.9	2 708	9.0
Partnered, no dependent children aged under 16	79 965	8.5	1 610	5.3
Partnered, one or two dependent children aged under 16	102 456	10.9	3 738	12.4
Partnered, three or more dependent children aged under 16	44 803	4.8	2 508	8.3
Partnered, illness or temporarily separated	2 594	0.3	na	na
Partnered, temporarily separated	194	–	na	na
Unknown income unit	na	na	na	na
Total	941 306	100.0	30 168	100.0

^a Further information pertinent to the data included in this table and/or its interpretation is provided in tables 16A.42, 16A.43, 16A.44 and 16A.45. **na** Not available. – Nil or rounded to zero.

Source: FaCSIA (unpublished); tables 16A.42, 16A.43, 16A.44 and 16A.45.

Equity — access — special needs

The second access indicator is ‘special needs’ (box 16.31).

Box 16.31 Special needs

'Special needs' access to CRA is an output indicator of the objective of CRA to provide income support recipients and low income families with financial assistance. This indicator provides the proportions of special needs income units receiving CRA, including Indigenous income units, those with a member receiving a Disability Support Pension and CRA recipients by geographic classification. This indicator provides an overview of the level of assistance provided to disadvantaged groups and facilitates comparison with special needs groups in public housing. CRA is a demand driven payment that has no benchmark in terms of the level of assistance provided to special needs customers. Additional measures of special need, which include a geographic dimension, are reported under 'affordability'.

Table 16.28 illustrates the number and proportion of income units receiving CRA at 3 March 2006 by jurisdiction, Indigenous status and geographic location.

Overall, 58.7 per cent of total income units receiving CRA at 3 March 2006 were located in capital cities, while 41.3 per cent were in the rest of the State/Territory. For Indigenous income units receiving CRA, 34.3 per cent were located in capital cities, while 65.7 per cent lived in the rest of the State/Territory. For non-Indigenous income units receiving CRA, 59.5 per cent were located in capital cities, while 40.5 per cent lived in the rest of the State/Territory (table 16.28).

People who own their own home are not entitled to CRA. Indigenous people receiving social security benefits are less likely to own their own home, and therefore are more likely to receive CRA. Nationally, 6.4 per cent of Indigenous income units are home owners receiving social security benefits, while 44.1 per cent of non-Indigenous income units are home owners receiving social security benefits (FaCSIA unpublished).

Table 16.28 Income units receiving CRA, by Indigenous status and geographic location, 2006^a

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Non-Indigenous</i>										
Income units	no.	307 678	203 414	219 540	79 373	65 967	22 984	7 592	4 356	911 138
In capital city	%	55.0	70.2	44.3	76.6	77.3	42.6	99.5	79.5	59.5
In rest of State	%	45.0	29.8	55.7	23.4	22.7	57.4	0.5	20.5	40.5
Non-Indigenous income units as proportion of all CRA recipient income units	%	96.3	99.1	95.5	96.8	98.0	95.8	98.4	80.9	96.8
Non-Indigenous population, as proportion of total population	%	97.9	99.4	96.6	96.5	98.2	96.2	98.7	70.2	97.6
<i>Indigenous</i>										
Income units	no.	11 692	1 945	10 377	2 612	1 368	1 007	124	1 031	30 168
In capital city	%	26.8	46.9	28.3	55.5	62.6	34.9	100.0	56.4	34.3
In rest of State	%	73.2	53.1	71.7	44.5	37.4	65.1	—	43.6	65.7
Indigenous income units as proportion of all CRA recipient income units	%	3.7	0.9	4.5	3.2	2.0	4.2	1.6	19.1	3.2
Indigenous population, as proportion of total population	%	2.1	0.6	3.4	3.5	1.8	3.8	1.3	29.8	2.4
Total income units	no.	319 370	205 359	229 917	81 985	67 335	23 991	7 716	5 387	941 306

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.46. — Nil or rounded to zero.

Source: FaCSIA (unpublished); table 16A.46.

Equity — access — geographic spread of CRA customers

The third access indicator is the ‘geographic spread of CRA customers’ (box 16.32).

Box 16.32 Geographic spread of CRA customers

The ‘geographic spread of CRA customers’ provides descriptive information about rents, average levels of assistance, and the proportion of private rental stock occupied by CRA recipients within regions. This information is useful in examining differences across states and territories, and capital cities/rest of State. The indicator can provide some insight into the responsiveness of CRA to regional variations in rent and the extent to which recipients are able to exercise choice in where to live.

Two measures are presented:

- maps showing CRA recipients as a proportion of private rental stock (from 2001 Census) across Australia and within each capital city
- the average CRA entitlement across locations.

Additional measures of geographic spread are reported under ‘affordability’.

Results for income units receiving CRA as a proportion of income units in each capital city receiving a social security income support benefit or more than the base rate of the Family Tax Benefit are mapped in tables 16A.47–16A.55. Information on the average CRA entitlement across locations is contained in table 16A.56.

The ratio of CRA recipients to private rental stock between and within capital cities varies but the patterns are complex. The maps should be interpreted with caution because they compare CRA recipients in March 2006 with 2001 Census data and make no allowance for changes in private rental stock (FaCSIA unpublished).

Effectiveness — appropriateness — maximum rate

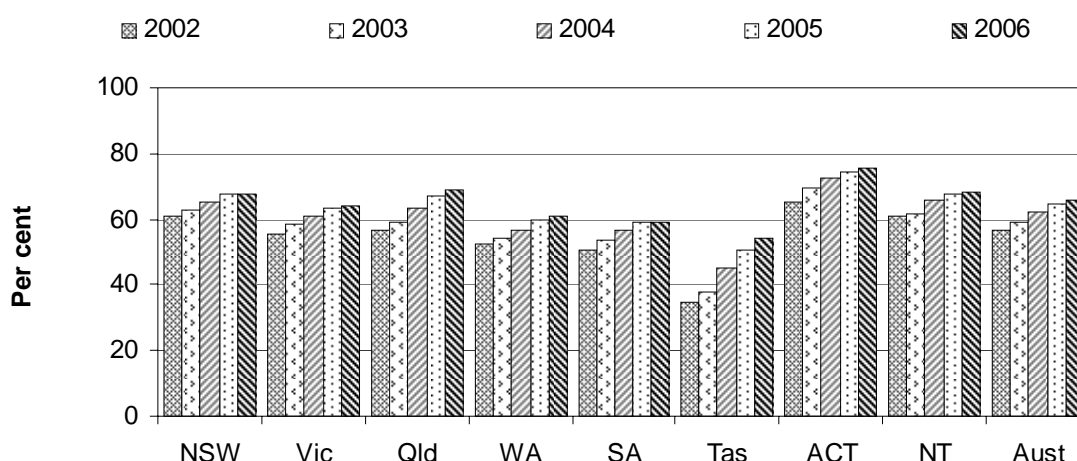
The first effectiveness indicator is the proportion of income units receiving the ‘maximum rate of CRA’, by jurisdiction and payment type (box 16.33).

Box 16.33 Maximum rate of CRA

The 'maximum rate of CRA' indicator is an output indicator of the appropriateness of CRA. It measures the proportion of income units receiving the maximum rate of CRA, and can be used to monitor the adequacy of CRA over time. The effectiveness of the payment against rents is reflected in increasing/decreasing proportions of units on the maximum rates of assistance. An increasing proportion of income units receiving the maximum rate of assistance suggests that CRA is becoming less effective against rent increases. A decreasing proportion suggests that CRA is increasing faster than rents.

At 3 March 2006, 66 per cent of income units receiving CRA across Australia qualified for the maximum rate of CRA payments (figure 16.21). The figure indicates an upward trend in the measure.

Figure 16.21 **Proportion of income units receiving CRA paying enough rent to receive maximum assistance^a**



^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.57.

Source: FaCSIA (unpublished); table 16A.57.

Effectiveness — appropriateness — number and outcome of appeals

The second effectiveness indicator is the 'number and outcome of appeals' (box 16.34).

Box 16.34 Number and outcome of appeals

The 'number and outcome of appeals' is an output indicator of the appropriateness of decisions related to the payment of CRA. There is a formal review process for decisions related to the payment of CRA. Customers 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, which is an independent body with decision making powers. Either the customer or FaCSIA, DEWR or DEST can seek an Administrative Appeals Tribunal review of the Social Security Appeals Tribunal's decisions. The indicator measures the outcomes of all CRA appeals finalised. A high proportion of original decisions affirmed would imply that the original decisions were appropriate.

There were 305 finalised appeals to an authorised review officer in 2005-06, which represented approximately 0.03 per cent of income units receiving CRA. The original decision was affirmed or appeal dismissed for approximately 62.6 per cent of finalised appeals to an authorised review officer (ARO), 56.4 per cent of appeals to the Social Security Appeals Tribunal (SSAT) and 28.6 per cent of appeals to the Administrative Tribunal (AAT) (table 16.29).

Table 16.29 Outcome of all CRA appeals finalised in 2005-06

<i>Outcome</i>	<i>Appeals to ARO</i>		<i>Appeals to SSAT</i>		<i>Appeals to AAT</i>	
	no.	%	no.	%	no.	%
Original decision affirmed or appeal dismissed	191	62.6	31	56.4	4	28.6
Original decision set aside	59	19.3	15	27.3	2	14.3
Original decision varied	45	14.8	4	7.3	–	–
Appeal withdrawn	10	3.3	5	9.1	8	57.1
Total finalised^a	305	100.0	55	100.0	14	100.0

– Nil or rounded to zero.

Source: FaCSIA (unpublished); table 16A.58.

Effectiveness — targeting — duration of payments

'Duration of payments' is an indicator of the effectiveness of targeting (box 16.35).

Box 16.35 Duration of payments

'Duration of payments' is a targeting indicator whose objective is to provide information on the level of long-term and short-term dependence on CRA payments. The indicator presents the number of customers receiving CRA benefits at the beginning and at the end of the year, as well as the number of CRA recipients who were in receipt of CRA benefits at the beginning of the year and still in receipt a year later.

Nationally, 941 120 income units were receiving CRA payments at March 2005, and 941 306 income units were receiving CRA at the end of March 2006. Out of those, 665 715 income units were receiving CRA at both times, implying a high degree of dependence on CRA (table 16.30). The remaining 275 591 income units started to receive CRA during the year and were receiving assistance at the end of the year. Other families received assistance for only part of the year. Unpublished FaCSIA data show that while CRA was paid on average to just over one million individuals each fortnight in 2005-06, over 1.4 million individuals were entitled to assistance during the financial year (FaCSIA unpublished).

Table 16.30 Duration of Payments, 2006^a

<i>State/Territory</i>	<i>Number of Income units at the beginning of the year</i>	<i>Number of Income units at the end of the year</i>	<i>Number of same Income units at the beginning and the end of the year</i>
	no.	no.	no.
NSW	315 414	319 370	230 010
Victoria	204 309	205 359	144 617
Queensland	231 820	229 917	162 688
WA	85 122	81 985	57 416
SA	67 040	67 335	47 474
Tasmania	23 726	23 991	16 466
ACT	7 969	7 716	4 296
NT	5 385	5 387	2 630
Total	941 120	941 306	665 715

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.59.

Source: FaCSIA (unpublished); table 16A.59.

Efficiency — running costs per 1000 customers

The first efficiency indicator reported for the CRA is 'running costs per 1000 customers' (box 16.36).

Box 16.36 Running costs per 1000 customers

‘Running costs per 1000 customers’ is an output indicator of CSHA guiding principles to provide financial assistance in an efficient manner. Low running costs per 1000 customers would imply high efficiency for a given service level.

Nationally, the running costs per 1000 customers were 54 000 for 2005-06 (table 16A.60).

Efficiency — ratio of running costs to total outlays

The second efficiency indicator reported for the CRA is the ‘ratio of running costs to total outlays’ (box 16.37).

Box 16.37 Ratio of running costs to total outlays

The ‘ratio of running costs to total outlays’ is an output indicator of CRA’s guiding principles to provide financial assistance in an efficient manner. A low ratio would imply high efficiency for a given service level.

Nationally, the ratio of running costs to total outlays was 2.4 per cent for 2005-06 (table 16A.61).

Outcomes

Affordability

‘Affordability’ is one of two outcome indicators reported for CRA (box 16.38).

Box 16.38 Affordability

'Affordability' is an outcome indicator of the CRA objective to provide income support recipients and low income families in the private rental market with financial assistance. CRA is intended to improve affordability, not to achieve a particular benchmark. Program performance is best judged by trends over a number of years. This indicator measures the proportions of income units spending more than 30 per cent and 50 per cent of their income on rent with and without CRA. A lower proportion of recipients spending 30 per cent and 50 per cent of income on rent with CRA implies improved affordability.

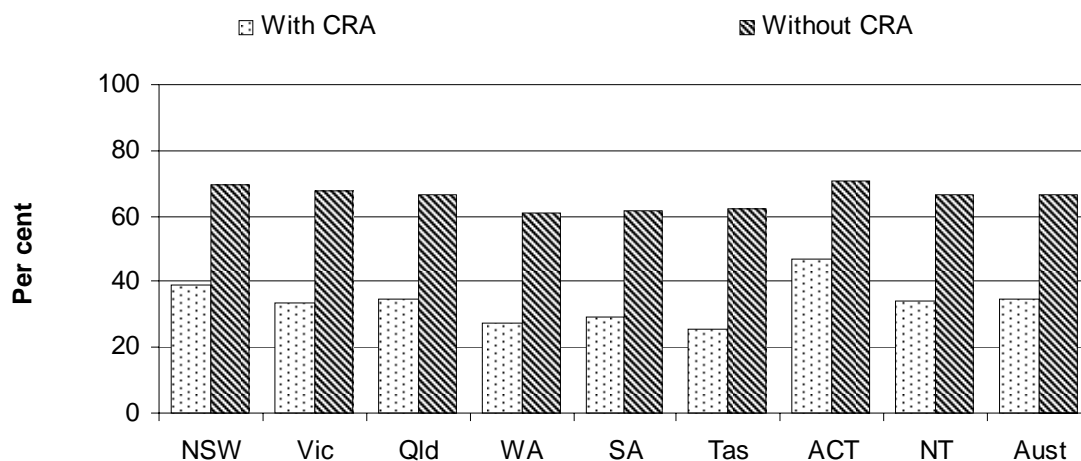
Affordability outcomes (with and without CRA) have been provided for all income units receiving CRA, Indigenous income units receiving CRA, and Disability Support Pension income units receiving CRA.

Information on the proportion of income spent on rent (with and without CRA) by Australians living in State capital cities and rest of State regions, income units where one or more members' self-identify as Indigenous Australians and income units where one or more members receive a Disability Support Pension is presented in tables 16A.62–16A.64.

Nationally, if CRA were not payable, then at 3 March 2006, 66.7 per cent of income units receiving CRA would have paid more than 30 per cent of their income on rent. Accounting for CRA payments (thereby reducing the rent paid by the amount of the assistance) this proportion falls to 34.9 per cent (figure 16.22).

Without CRA, 26.0 per cent of recipients across Australia would have spent more than 50 per cent of their income on rent, while with CRA the proportion is 9.0 per cent (table 16A.65).

Figure 16.22 Income units paying more than 30 per cent of income on rent, with and without CRA, 2006^a

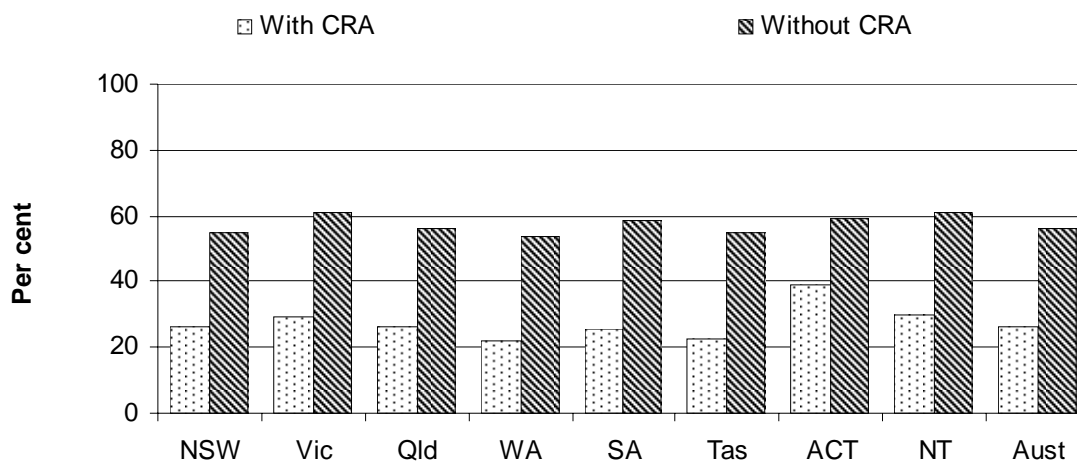


^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.62.

Source: FaCSIA (unpublished); table 16A.62.

Nationally, if CRA were not payable, then 55.9 per cent of the Indigenous income units receiving CRA would have spent more than 30 per cent of income on rent at 3 March 2006. Taking CRA into account, this proportion falls to 26.1 per cent (figure 16.23). Similarly, if CRA were not payable, then 19.1 per cent of Indigenous income units across Australia would have spent more than 50 per cent of income on rent at 3 March 2006. Accounting for CRA payments this proportion decreases to 5.9 per cent (table 16A.65).

Figure 16.23 Indigenous income units receiving CRA paying more than 30 per cent of income on rent, with and without CRA, 2006^a

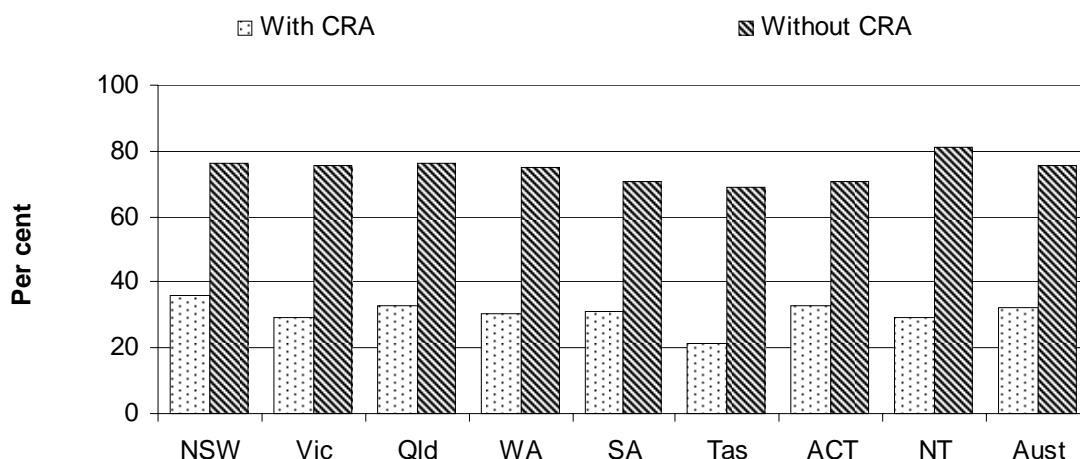


^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.63.

Source: FaCSIA (unpublished); table 16A.63.

Nationally, if CRA were not payable, then 75.5 per cent of all income units with a member receiving a Disability Support Pension would have spent more than 30 per cent of income on rent at 3 March 2006. Accounting for CRA payments this proportion decreases to 32.6 per cent (figure 16.24). Similarly, if CRA were not payable, then 27.8 per cent of income units receiving a Disability Support Pension would have spent more than 50 per cent of income on rent at 3 March 2006. Accounting for CRA payments, this proportion decreases to 6.3 per cent (table 16A.65).

Figure 16.24 **Income units receiving a Disability Support Pension paying more than 30 per cent of income on rent, with and without CRA, 2006^a**



^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.64.

Source: FaCSIA (unpublished); table 16A.64.

Satisfaction with accommodation

The second outcome indicator is ‘satisfaction with accommodation’ (box 16.39). The survey used for this indicator in previous reports has been discontinued and data for this indicator were not available for the 2007 Report.

Box 16.39 Satisfaction with accommodation

‘Satisfaction with accommodation’ is an outcome indicator of whether the housing is appropriate to the needs of the CRA recipient.

Data for this indicator were not available for the 2007 Report.

Some information about satisfaction with accommodation has been derived from the Household Income and Labour Dynamics Australia (HILDA) survey. The survey does not reliably identify all CRA recipients but can be used to identify social security recipients who reside in private rental accommodation and are potentially eligible for CRA.

Information from Wave 4 of the survey, conducted from August 2004 to February 2005 is presented in tables 16.31 and 16.32.

Overall, 67 per cent of social security recipients living in private rental properties expressed a preference to stay in the area in which they live, while 13 per cent expressed a preference to leave the area. When asked to rate their satisfaction with the home in which they live using a scale of 0 to 10, 11 per cent expressed some dissatisfaction (rating it less than 5) and 37 per cent expressed high satisfaction with a rating of 9 or 10.

Table 16.31 Satisfaction with location of housing (per cent)^{a, b}

	<i>Strong preference to stay</i>	<i>Moderate preference to stay</i>	<i>Unsure/no strong preference to stay or leave</i>	<i>Moderate preference to leave</i>	<i>Strong preference to leave</i>
Location %	40.6	26.1	20.5	6.7	6.1

^a Respondents getting income support and living in private rental accommodation ^b Based on 861 valid responses.

Source: FaCSIA (unpublished).

Table 16.32 Satisfaction with quality of housing (per cent)^{a, b}

	<i>Totally dissatisfied</i>						<i>Totally satisfied</i>					
	0	1	2	3	4	5	6	7	8	9	10	
Quality %	0.8	1.3	2.1	3.4	3.6	9.2	7.0	13.4	22.1	15.6	21.5	

^a Respondents getting income support and living in private rental accommodation ^b Based on 902 valid responses.

Source: FaCSIA (unpublished).

16.4 Future directions in performance reporting

Further developing indicators and data

Improved reporting on housing provision to Indigenous Australians continues to be a priority. All states, territories and the Australian Government have committed to improving their reporting against the NRF, the nationally endorsed performance indicator framework for Indigenous housing.

Jurisdictions have implemented action plans to improve the availability and reliability of data on Indigenous Australians accessing main stream housing assistance.

In the 2008 Report, a performance indicator framework for Indigenous community housing will be developed and data for some indicators will be reported.

The Working Group will continue to improve the quality of mainstream community housing and financial data that are published in the Report.

Affordable housing

In August 2005, State, Territory and Australian Government Ministers for Housing, Local Government and Planning adopted a three-year Framework for National Action on Affordable Housing. This national framework and program for action has been developed to provide practical support for individual agency endeavours, and will guide coordinated efforts, across jurisdictions and portfolios.

The framework extends beyond traditional public and community housing responses to affordability and acknowledges that no individual housing lever is sufficient to resolve affordability in its own right and combinations of certain levers are mutually reinforcing and could amplify benefits.

It includes the identification of delivery, financing and management vehicles to support increased investment in affordable housing, and to develop parallel policies that impact on the housing market as a whole. These include market efficiency measures, financing, land supply and planning mechanisms and taxation. Housing Ministers have acknowledged that many of these fall outside their own areas of portfolio responsibility.

16.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

“The 2003 Commonwealth State Housing Agreement (CSHA) aims to maintain a core Social Housing sector to assist people unable to access alternative housing options in the private rental market. It is recognised that states are implementing wide-ranging reforms to the management and delivery of housing assistance and that these reforms will continue. The performance framework introduced under the 1999 CSHA continues to support the measurement of the guiding principles of the 2003 CSHA. The 2003 CSHA has a particular emphasis on timely reporting and demonstrated progress in achieving performance objectives.

A total of around \$4.75 billion over five years to 2007-08 provides strategic direction and funding certainty. Programs funded include public housing, Aboriginal rental housing program (ARHP) community housing program (CHP) and crisis accommodation program (CAP).

Over \$280 million has also been allocated in the 2005-06 Budget through the Community Housing and Infrastructure Program (CHIP) to increase access to safe, healthy and sustainable housing and related services for Indigenous families and communities. CHIP provides for community housing and housing related environmental health infrastructure in rural and remote areas, and for community housing in urban areas. This funding is either directed through state and territory governments or to specific community housing organisations. CHIP funding was formerly appropriated to the Aboriginal and Torres Strait Islander Services (ATSIS).

In the 2005 Budget, the Australian Government committed \$102.8 million over four years for the *Healthy Indigenous Housing* measure which will focus on progressing the principles and objectives of *Building a Better Future — Indigenous Housing to 2010*, with an emphasis on the delivery of sustainable outcomes, and contributing to sustainable Indigenous communities.

Rent Assistance is provided as a financial supplement and has the flexibility to cope with changing demand and provide customers with more choice about where they live and the quality of their housing. This choice can involve a trade-off with other expenses and with the consumer's after-housing income.

The Rent Assistance program has no specific benchmark for affordability. The adoption of an affordability benchmark would fail to recognise the element of choice exercised by customers who place a higher value on housing than others in comparable circumstances. Customers may, for example, choose to pay higher rent for a property that is well-located, thus trading off housing and transport costs.

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New South Wales Government comments

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The past year has been one of significant change in social housing in NSW. Changes arising from the *Reshaping Public Housing Reforms* announced in April 2005 have been progressively introduced to the Department of Housing's clients of public housing and to clients of the Aboriginal Housing Office. The reforms are designed to provide a more sustainable and fair public housing system that will help those in greatest need.

Changes to income eligibility to enter public housing and the introduction of fixed term tenancies of two, five or ten years for new tenants will mean public housing is provided to those in greatest need for the duration of their need. Improving the sustainability of tenancies for the increasingly complex social housing tenant profile has underpinned the development of a Housing and Human Services Accord. This is a formal agreement between NSW Government human service agencies providing an overarching framework for both government and non-government agencies to work in partnership linking support and housing services.

Changes designed to improve viability include a rent policy to better reflect tenant circumstances and the introduction of tenant water usage charges. Improvements to the delivery of maintenance services as well as a major public housing asset reconfiguration program to align changing client housing needs with the size, location and disability modifications of properties will also improve viability and the capacity to provide appropriate cost effective services.

The last ten years have seen rising housing values across many areas of NSW. However, for many people, particularly first home buyers and low income vulnerable households, there has been a corresponding increase in difficulty in finding appropriate and affordable housing. The NSW Government, whilst not holding the majority of levers to address these issues, has been developing innovative ways to boost the stock of affordable housing.

The NSW social housing sector continues to play a vital role in the provision of affordable housing for low income and special needs clients. In 2005-06, the Department of Housing managed over 127 600 public housing properties. The community housing sector, with over 14 300 properties, is also a major provider and a recently announced growth strategy proposes a significant expansion in this sector. The Aboriginal Housing Office currently owns nearly 4300 properties and registered Aboriginal community housing organisations manage around 5000 properties. A range of innovative products, initiatives and services to respond to changing mainstream and Indigenous housing needs and priorities continue to be developed and implemented across the social housing sector.

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Victorian Government comments

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Victoria continues to provide innovative solutions to address demand for social housing in an environment characterised by diminishing housing affordability in the private sector, increasing complexity of customer needs, declining capital funding through the Commonwealth State Housing Agreement and the ageing of social housing properties.

A key focus for Victoria is the expansion of social housing for low-income households. In 2005-06, Victoria funded the acquisition of 1017 new social housing units, including 24 properties for the Aboriginal Rental Housing Program. Acquisition strategies employed by Victoria ensure that customers are housed in locations with accessibility to employment opportunities, transport and amenities.

Victoria has continued to develop a platform for the growth of a strong and viable social housing sector. In 2005-06, the Office of the Registrar of Housing Agencies was established to implement the new regulatory provisions of the *Housing Act 1983* made in 2004-05. The Office of the Registrar is responsible for the registration and monitoring of non-government not-for-profit housing agencies. So far, five agencies have been registered as Housing Associations and one agency has been registered as a Housing Provider. In 2005-06 partnership approaches to housing acquisition led to the delivery of 260 new homes.

An environment of strong demand for public housing and declining capital funding has necessitated a highly targeted approach to housing allocations in Victoria, ensuring that priority is given to people who are homeless, those with specific medical or support needs and those experiencing family violence. The high level of targeting has contributed to a growing level of complexity in customer need to which the Office of Housing is continuing to respond with a range of tailored programs that integrate homelessness services with long-term housing and support.

To improve areas experiencing economic and social disadvantage, Victoria is undertaking community renewal and improving economic participation through the Neighbourhood Renewal program. Four new sites were launched in 2005-06, bringing the total number of sites in the program to 19. One of the program's most important outcomes is providing employment opportunities through specific job creation programs. Work experience and accredited training has been provided to over 1000 neighbourhood renewal residents, 60 per cent of which proceeded into further employment and/or training.

Recognising the importance of maintaining the asset in line with community standards, Victoria has upgraded 2607 properties in 2005-06, 633 of which were in Neighbourhood Renewal areas.

Since 1999 the Victorian government has provided an additional \$453 million above its matching obligations under the Commonwealth State Housing Agreement to improve services and grow social housing.

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Queensland Government comments

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In 2005-06, the department began implementing major reforms to the way housing services are delivered. The department is confronting the challenges of growing and changing demand by increasing the supply of social housing, greater targeting services to the housing needs faced by clients, ensuring greater coordination of social housing resources across providers and investigating new and innovative approaches to provide housing. Clients will benefit from this integration of housing programs by finding it easier to navigate through the social housing system. The department, through the phased implementation of one social housing system, is moving from a wait-turn allocation system for social housing, to allocating assistance based on the level of housing need.

- The waiting lists for public housing and SOMIH have been combined so that all Indigenous peoples are automatically considered for public housing and SOMIH and common eligibility criteria apply. Tenancies commencing after 1 January 2006 or in dwellings with five or more bedrooms or full wheelchair accessibility, will have their ongoing eligibility regularly assessed to ensure clients are assisted for the duration of their housing need.
- The department is continuing to work on reforms with the 450 community and local government providers that manage approximately 10 000 social housing dwellings, including about 4000 in discrete Indigenous communities. The reforms will achieve a more robust and planned network of funded organisations that coordinate services as part of one social housing system.
- While promoting access to mainstream programs and services, the department will continue to provide grant funding to the 34 discrete Indigenous communities to enable community councils to continue to provide and maintain rental properties. In 2005-06, the department conducted a property condition audit and tenant survey on all government-funded housing in these communities. The results will inform the development of a plan for each community to raise and sustain the standard of housing and improve the provision of housing services within Indigenous communities.
- The department has continued working on increasing the availability of affordable housing to Queenslanders on low incomes. This is being achieved by leading Queensland's response to affordable housing issues, with measures including grant funding to affordable housing providers such as the Brisbane Housing Company, providing grant funding to support the residential services industry and residential budget accommodation providers, responding to the decline of traditional low-cost private sector housing such as caravan parks, and working in partnership with local government in planning for affordable housing.

The department will continue to contribute to initiatives that coordinate housing and support services in the areas of homelessness and mental health, improving housing in Indigenous communities, influencing the private market for affordable housing and addressing systemic barriers to the provision of affordable housing.

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Western Australian Government comments

“ The Real Estate Institute of Western Australia reports that the median house price in Perth for the year 2005-06 increased by 33.9 per cent and by 29.4 per cent for the State as a whole. Land values increased by 48.3 per cent for Perth and by 49.3 per cent for the state. The median weekly rent in Perth increased by 23.1 per cent. Additionally during 2005-06 the building industry was working at capacity, with demand outstripping supply. This has resulted in fewer contractors tendering on housing construction projects, and increased costs.

These increases have had, and will continue to have, an impact across the entire housing sector. The public housing waiting list has increased by 7.8 per cent over the last two years, and continues to rise. The number of new occupations has decreased by 20.9 per cent over the same period. The main reason for this is that there are fewer options for people wishing to leave public housing – home purchase has become too expensive and private rents have increased considerably. Less people leaving public housing reduces the number of people on the waiting list who can be offered housing. These factors have also resulted in the median waiting time for public housing increasing by 13.8 per cent since 2003-04.

The state's population is expected to grow to 2.5 million people by 2026, an increase of 32 per cent. The Commission currently caters for a high proportion of people with disabilities and seniors, and this demand will grow as WA's population ages. Homelessness also remains a major challenge.

A priority in 2005-06 was to establish a strategic direction to improve the services and products available to our clients. In order to better cater for these challenges a statement of Strategic Intent was released. The idea behind the statement is to focus on three key areas:

- having more people in houses
- improving Aboriginal communities
- improving buildings and infrastructure

By focusing attention on these key areas, significant health, community and economic benefits should be delivered to the WA community.

Some 70 000 WA households on incomes of \$40 000 or less are increasingly experiencing housing stress as they struggle to access affordable housing. In September 2005 the draft Housing Strategy Western Australia, a framework for the future delivery of affordable housing was released, with a consultation period ending 31 March 2006. Cabinet has agreed to the Department of Housing and Works and the Department for Planning and Infrastructure leading and implementing affordable housing initiatives on behalf of the State Government. Among the initiatives are ongoing development and sale of low cost housing lots, increased rental bonds limits and development of models for the incorporation of affordable housing in land held by the East Perth Redevelopment Authority and the WA Land Authority.”

South Australian Government comments

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2005-06 was a significant year for housing in SA with the announcement of major housing reforms and the pursuit of affordable housing outcomes at both a State and National level. In May 2006 a major structural reform of current governance arrangements in housing was announced to achieve more effective delivery of the Government's strategic policy agenda and improved housing outcomes for South Australians.

During the year a number of significant initiatives were undertaken including:

- Establishment of the Affordable Housing Innovations Unit to pursue private, community and government partnerships for the supply of new affordable and high needs housing. During 2005-06, the Affordable Housing Innovations Fund (AHIF) balance grew from \$15.4 million to \$40.5 million.
- Commitment of \$16.7 million (46.5 per cent) from additional funding approved for the AHIF in 11 affordable and high need partnership projects totalling \$35.9 million to produce 137 houses and a 14 bedroom residential facility. The 11 projects involve management by Not-for-Profit Organisations, various needs groups and combinations of partner equity, borrowing and CRA inclusive rent models.
- Continue management of approximately 52 777 properties and allocation of approximately 4300 properties to new tenants. The Office for Aboriginal Housing housed 229 in Indigenous specific dwellings in the Anangu Pitjantjatjara Yanunytjatjara Lands program.
- Construction of over 550 new social housing properties. Most achieved 5 star energy ratings and met the Department's Adaptability Standards.
- Acquisition of 27 dwellings for Indigenous housing which included transfers from mainstream public housing programs and purchases on the open market. In addition the Fixing Houses for Better Health Program surveyed and undertook significant repairs to houses in eight Indigenous communities.
- Assistance to approximately 17 000 low income South Australians access private rental accommodation through the provision of bond assistance and advance rental payments.
- Development of a new Vision Plan for Community Housing.
- Opening of the Lakeview Transitional Accommodation Centre in Port Augusta.
- Launch of 'Common Ground Adelaide' modelled on the successful New York program to provide an integrated range of support services available on-site for both homeless and low income tenants.
- Investment of an additional \$15 million to accelerate urban renewal programs in areas with high concentrations of older social housing stock. Existing projects were progressed as well as the announcement of the new Playford North project.

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Tasmanian Government comments

“As a part of the Department of Health and Human Services, Housing Tasmania works collaboratively with internal and external partners to provide a range of housing assistance options for people on low incomes. A number of challenges are faced by Housing Tasmania, in that the client group is changing and now presents with multiple needs in addition to a requirement for affordable housing; and in the current climate of limited resources, available funds are declining in real terms and new supply responses are necessary to meet demand.

During the year, Housing Tasmania continued to focus on developing a range of innovative housing models to meet the increasingly diverse needs of its client base. Achievements included the acquisition of a supported residential facility to house up to 30 people who prefer living in a communal environment; a significant program of public housing property acquisition and modification, particularly addressing the needs of people with a disability; an enhanced private rent assistance program that provides increased support for tenancies at risk; and home ownership assistance.

In 2005-06 the first phase of a Service Delivery Review was progressed. Its aim is to improve the capacity of the organisation to respond to emerging service delivery issues through increased role clarity, skill development, clearly identified service standards, better communication and enhanced organisational support structures.

Housing Tasmania also supported the implementation of community capacity building and urban renewal initiatives. This included a community grants program, and education and training initiatives involving the upgrade of public housing properties. These initiatives build on community development activities undertaken in previous years.

Opportunities to provide innovative housing options and increase investment in social housing were also progressed. A Memorandum of Understanding was signed with six 'not for profit' organisations to contribute to the establishment of an Affordable Housing Organisation (AHO). Ongoing funding of \$6 million per annum was committed to support the AHO and to provide a secure lease for investors who lease properties to the Organisation. Up to 700 new dwellings will be generated via this program and will be leased to low income earners.

In 2005-06, the Bilateral Indigenous Housing and Infrastructure Agreement (IHIA) 2005–2008 was also endorsed. Upon the successful completion of the staged implementation process, it is planned that Housing Tasmania will undertake responsibility for program management including strategic planning and management of pooled funds for SOMIH and Indigenous Community Housing Organisations.

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Australian Capital Territory Government comments

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The ACT Government strives to meet public and community housing objectives under the 2003 Commonwealth State Housing Agreement through organisational development initiatives and innovative partnership arrangements.

Spotless P & F Pty Ltd was contracted to manage the delivery of repairs and maintenance services for public housing in the ACT from 1 July 2005. The new contract contains a number of enhancements including a performance management system with measures for client satisfaction with maintenance delivery as well as cost and quality. 60 700 works orders were raised in the first year of the contract, expending \$27 million in repairs, maintenance and improvement works.

Housing and Community Services continued to work on sustainable tenancies and communities through a comprehensive consultation process undertaken to inform future developments in housing in the ACT through the Ministerial Housing Summit and the Consumer Housing Forum, both held in February 2006. The Summit and Consumer Forum were preceded by five Ministerial Advisory Forums on the topics of tenant participation, community housing, appeals and complaints; disability housing and public/private partnerships. The reconstitution of the Joint Champions Group, comprising tenant representatives and Housing and Community Services staff, and Regional Tenant Forums held in June 2006 has further enhanced tenant participation by providing opportunities for tenants to have direct contact with staff from tenancy regions and to identify local issues and concerns.

Annual Client Service Visits for existing tenants (including a visit within the first three months of a new tenancy) continue to be an important tool in helping to ensure housing assistance is appropriate and tailored to peoples needs. The meeting of targets for these visits is directly reflected in the significant increase in ACT tenants' overall satisfaction with service reported in the National Social Housing Survey 2005 with the ACT achieving its highest satisfaction rating since the survey commenced. A local client satisfaction survey conducted during 2006 used the same parameters as the National Social Housing Survey with the outcome being that overall tenant satisfaction increased to 69 per cent. This result reflects a continuing improvement in how tenants view Housing and Community Services' service delivery.

Amendments to the Public Rental Housing Assistance Program were introduced on 7 June 2006 to ensure that the allocation of housing assistance is targeted towards clients most in need. The changes will ensure Housing ACT has the flexibility to more appropriately respond to the needs of applicants with high and complex needs. In line with these amendments, all applicants on the wait turn list will be re-assessed and their priority status updated in accordance with the new housing needs categories. The intention is to house people in the new Priority category within three months. The changes position Housing and Community Services' as the post crisis-housing provider and as part of the service continuum where SAAP provides the crisis response.

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Northern Territory Government comments

“ The NT has continued to implement the overarching housing strategy *Home Territory 2010*. This has seen a consolidation of the financial viability of the State housing authority, Territory Housing, and an increasing focus on providing better services to those Territorians with special needs and increasing the availability of affordable housing options.

A total of 513 households were assisted into home ownership during 2005-06. This included:

- 78 sales to public housing households;
- 406 low to middle income households assisted through the HomeNorth Xtra scheme; and
- 29 public housing households assisted through the HomeNorth Xtra scheme.

There has been an increase in the proportion of Indigenous public housing tenants from 25 per cent in June 2003 to 32 per cent in June 2006.

In the Territory overall, 32 per cent of public housing households are classified as Indigenous, although this varies greatly by region — for instance, in Tennant Creek 66 per cent of public housing households are classified as Indigenous.

Territory Housing is committed to meeting the current and emerging needs of Indigenous clients, both through programs such as Indigenous Housing Assistance Scheme and living skills initiatives. Urban Living Skills training is provided for tenants without previous experience living in urban areas.

As part of the 20 Year Plan to improve health, education and safety outcomes for Indigenous Territorians, the Northern Territory Government has announced a significant package of measures that will improve economic and social outcomes for Indigenous Territorians and provide a significant boost to the regional economy.

The centrepiece of this package is an extra \$100 million investment in remote housing over the next five years. The package also includes a commitment that Territory Housing will work in partnership with existing Indigenous housing organisations to manage delivery and maintenance in the bush.

The 20 Year Plan will be realised through a transformation of Indigenous housing from welfare housing to a strong mix of social community and public housing, private rental housing and private ownership. The Plan will also target private sector investment in housing and it will involve partnerships between government, Aboriginal organisations and private investors.

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16.6 Definitions of key terms and indicators

Public, community and SOMIH

Administration costs	<p>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:</p> <ul style="list-style-type: none">• employee expenses (for example, superannuation, compensation, accrued leave and training)• supplies and services expenses (including stationery, postage, telephone, office equipment, information systems and vehicle expenses)• rent• grants and subsidies (excluding rental subsidies)• expenditure incurred by other government agencies on behalf of the public housing agency• contracted public housing management services.
Affordability	<p>‘Affordability’ is an outcome indicator that aims to measure housing affordability for CSHA housing tenants. Two measures are reported:</p> <ul style="list-style-type: none">• a subsidy per tenant derived by dividing the total rebated amount by the total number of households• the proportion of households spending less than 30 per cent of their income in rent.
Assessable income	<p>The income used to assess eligibility for housing assistance and to calculate the rental housing rebate that allows a household to pay a rent lower than the market rent. Definition may vary across jurisdictions.</p>
Customer satisfaction	<p>A survey measure of the proportion of customers expressing different degrees of satisfaction with the overall service provided.</p>
Depreciation costs (as per the Australian Accounting Standards 13–17)	<p>Depreciation calculated on a straight-line basis at a rate that realistically represents the useful life of the asset.</p>
Direct costs	<p>Total administration costs and the costs of maintaining the operation of dwellings.</p>
Disability (as per the ABS Survey of Disability Ageing and Carers)	<p>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.</p>
Dwelling	<p>A structure or a discrete space within a structure intended for people to live in or where a person or group of people live. Thus a structure that people actually live in is a dwelling regardless of its intended purpose, but a vacant structure is only a dwelling if intended for human residence. A dwelling may include one or more rooms used as an office or workshop provided the dwelling is in residential use.</p>
Greatest need	<p>Low income households that at the time of allocation were subject to one or more of the following circumstances:</p> <ul style="list-style-type: none">• homelessness• their life or safety being at risk in their accommodation• their health condition being aggravated by their housing• their housing being inappropriate to their needs

	<ul style="list-style-type: none"> • their rental housing costs being very high.
Household	For the purpose of the public, community and SOMIH collections, the number of tenancy agreements is the proxy for counting the number of households. A tenancy agreement is defined as a formal written agreement between a household (a person or group of people) and a housing provider, specifying details of a tenancy for a particular dwelling.
Indigenous household	A household with one or more members (including children) who identify as Aboriginal and/or Torres Strait Islander.
Location/amenity	A survey-based measure of the proportion of tenants rating location and amenity aspects as important and meeting their needs.
Low income household	<p>A public housing or SOMIH household whose members are assessed as having a low income according to the following definitions. Households are assigned an income status based on total household gross income and the composition of the household:</p> <ul style="list-style-type: none"> • low income A households are those in which all household members have incomes at or below the maximum pension rate • low income B households are those that have incomes that would enable them to receive government income support benefits below the maximum pension. <p>A community housing household which has a gross weekly income equivalent to or below the income cut-off specified for their household composition. The community housing low income measure is based on the low income B cut-offs as outlined above.</p>
Maintenance costs	Costs incurred to maintain the value of the asset or to restore an asset to its original condition. The definition includes day-to-day maintenance reflecting general wear and tear, cyclical maintenance, performed as part of a planned maintenance program and other maintenance, such as repairs as a result of vandalism.
Market rent	Aggregate market rent that would be collected if the public rental housing properties were available in the private market.
Match of dwelling to household size	The proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure. Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.
Moderate Overcrowding	Where one additional bedroom is required to satisfy the proxy occupancy standard.
New household	Households that commence receiving assistance for the financial year.
Occupancy rate	The proportion of dwellings occupied.
Occupied dwelling	Dwellings occupied by tenants who have a tenancy agreement with the relevant housing authority.
Overcrowding	Where two or more additional bedrooms are required to meet the proxy occupancy standard.
Priority access to those in greatest need	Allocation processes to ensure those in greatest need have first access to housing. This is measured as the proportion of new allocations to those in greatest need.
Principal tenant	The person whose name appears on the tenancy agreement. Where this is not clear, it should be the person who is responsible for rental

	payments.														
Proxy occupancy standard	<p>A measure of the appropriateness of housing related to the household size and tenancy composition. The measure specifies the bedroom requirements of a household.</p> <table> <tr> <th><i>Household structure</i></th><th><i>Bedrooms required</i></th></tr> <tr> <td>Single adult only</td><td>1</td></tr> <tr> <td>Single adult (group)</td><td>1 (per adult)</td></tr> <tr> <td>Couple with no children</td><td>2</td></tr> <tr> <td>Sole parent or couple with one child</td><td>2</td></tr> <tr> <td>Sole parent or couple with two or three children</td><td>3</td></tr> <tr> <td>Sole parent or couple with four children</td><td>4</td></tr> </table> <p>For sole parent or couple households with four or more children the dwelling size in terms of bedrooms should be the same value as the number of children in the household.</p>	<i>Household structure</i>	<i>Bedrooms required</i>	Single adult only	1	Single adult (group)	1 (per adult)	Couple with no children	2	Sole parent or couple with one child	2	Sole parent or couple with two or three children	3	Sole parent or couple with four children	4
<i>Household structure</i>	<i>Bedrooms required</i>														
Single adult only	1														
Single adult (group)	1 (per adult)														
Couple with no children	2														
Sole parent or couple with one child	2														
Sole parent or couple with two or three children	3														
Sole parent or couple with four children	4														
Public rental dwelling	Public rental properties covered by the CSHA. Excludes properties administered under Community Rental Housing, the ARHP or transitional/emergency accommodation for people who are homeless and in crisis (the Crisis Accommodation Program).														
Relocated household	A household, either rebated or market renting, that relocates (transfers) from one public or community rental dwelling to another.														
Rent charged	The amount in dollars that households are charged based on the rents they are expected to pay. The rents charged to tenants may or may not have been received.														
Rent collection rate	The total rent actually collected as a proportion of the total rent charged.														
Special needs household	A household with a member(s) who has a disability or is aged 24 years or under, or 75 years or over (50 years or over for SOMIH), or (except for SOMIH) is Indigenous.														
Tenancy	For the purpose of the public, community and SOMIH collections, counting the number of tenancy agreements is the proxy for counting the number of households. A tenancy (rental) unit is defined as the unit of accommodation on which a tenancy agreement can be made. It is a way of counting the maximum number of distinct rentable units that a dwelling structure can contain.														
Tenant or tenant household	The usual members of a household occupying a public, community or SOMIH 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.														
Tenantable dwelling	A dwelling where maintenance has been completed, whether occupied or unoccupied at 30 June. All occupied dwellings are tenantable.														
Total gross household income	The value of gross weekly income from all sources (before deductions for income tax, superannuation etc.) for all household members, expressed as dollars per week. The main components of gross income are current usual wages and salary; income derived from self-employment, government pensions, benefits and allowances; and other income comprising investments and other regular income.														
Turnaround time	The average time taken in days for normally vacant dwellings to be occupied.														

Underutilisation	Where there are two or more bedrooms additional to the number required in the dwelling to satisfy the proxy occupancy standard.
Untenantable dwelling	A dwelling not currently occupied by a tenant, where maintenance has been either deferred or not completed at 30 June.

Commonwealth Rent Assistance

Affordability	The proportions of recipients spending more than 30 per cent and 50 per cent of their income on rent with and without CRA.
Dependent child	<p>A person under 18 years who is the dependant of another person (an adult) if the adult is legally responsible for the day-to-day care, welfare and development of the child, if the child is not a dependent child of another person, and if the child is wholly or substantially in the adult's care.</p> <p>A young person aged 18–24 years may be regarded as the dependant of another person if he or she is wholly or substantially dependent on that other person. A young person aged 21 years or over cannot be regarded as a dependant unless undertaking full time study. A young person cannot be regarded as a dependant if he or she receives an income support payment.</p> <p>Operationally, a child is regarded as a dependant of another person (the parent) if the parent receives the Family Tax Benefit for the care of the child. A dependent child is regarded as a member of the parental income unit.</p> <p>The maximum rate of CRA depends on the number of children for whom the recipient or partner receives more than the base rate of the Family Tax Benefit Part A. Although the Family Tax Benefit may be paid for a child aged 16 years or over, it cannot be paid at more than the base rate. It may also be paid at not more than the base rate if a parent has not taken appropriate steps to obtain maintenance from a child's other parent.</p>
Duration of payments	Broadly presents dependence on CRA by showing the percentage of people who are in receipt of CRA payments at a given point in time and who are still dependent on the CRA payments a year later.
Eligible income support customers	Customers in receipt of an income support payment or more than the base rate of the Family Tax Benefit Part A. CRA is automatically paid once eligibility is established. The only eligible customers who are not paid are those affected by Centrelink errors in recording information or by program errors.
Geographic spread of CRA customers	<p>Two measures are presented:</p> <ul style="list-style-type: none"> • CRA recipients as a proportion of income units in each capital city receiving a social security income support benefit or more than the base rate of the Family Tax Benefit • the average CRA entitlement across locations.
Income unit	<p>One person or a group of related people within a household who share command over income. The only recognised relationships are (1) marriage (registered or defacto) and (2) adult and dependent child. Operationally, an income unit may consist of:</p> <ul style="list-style-type: none"> • a single person with no dependent child • a sole parent with a dependent child • a couple (registered or defacto) with no dependent child

	<ul style="list-style-type: none"> • a couple (registered or defacto) and any dependent children. <p>A non-dependent child, including any child receiving Youth Allowance or some other income support payment, is not regarded as part of the parental income unit. Rather, he or she is regarded as a separate income unit.</p>
Income unit type	The number and proportion of eligible income support recipients receiving CRA, by income unit type.
Low income	Income of CRA recipients, by quintiles of family income received per week.
Maximum rate	Proportion of CRA recipients receiving the maximum rate of CRA.
Number and outcome of appeals	The outcomes of all CRA appeals finalised: (1) the number of customers who appealed to an authorised review officer, and (2) the proportions of appeals where the decision was affirmed, set aside or varied, or the appeal was withdrawn.
Number and proportion of CRA recipients, by income unit type	A point-in-time indicator showing the number of CRA recipients by income unit type, and the proportion of recipients within each income unit category. Includes data on Indigenous recipients.
Number and proportion of CRA recipients, by payment type	A point-in-time indicator showing the number of CRA recipients by the type of primary payments received, and the proportion of recipients within each payment type category.
Payment type	The number and proportion of income support recipients receiving CRA, by the primary payment type received.
Primary payment type	Each income unit receiving CRA is assigned a primary payment type, based on the payment(s) received by each member. This is used to monitor the extent to which assistance is provided to families and individuals that primarily depend on different forms of assistance. The primary payment is determined using a hierarchy of payment types, precedence being given to pensions, then other social security payments that attract CRA, and then the Family Tax Benefit. Within this overall structure a lower precedence is given to payments that are made only to the partners of a social security payment. If both members of a couple receive a payment of the same rating, the male is regarded as the primary member of the couple. No extra weight is given to the payment type with which CRA is paid.
Proportion of income spent on rent with and without CRA	<p>A point-in-time indicator, measuring the proportion of income units spending more than 30 per cent and 50 per cent of their income on rent, both with and without CRA. The proportion of income spent on rent is calculated as follows:</p> <ul style="list-style-type: none"> • with CRA: rent (minus CRA) divided by total income from all sources, excluding CRA • without CRA: rent divided by total income from all sources, excluding CRA.

Ratio of running costs to total outlay for CRA	Total running costs for the CRA program as a proportion of total outlay.
Rent	Amount payable as a condition of occupancy of a person's home. Includes site fees for a caravan, mooring fees and payment for services provided in a retirement village. Rent encompasses not only a formal tenancy agreement, but also informal agreements between family members, including the payment of board or board and lodgings. Where a person pays board and lodgings and cannot separately identify the amount paid for lodgings, two thirds of the payment is deemed to be for rent. There is no requirement that rent be paid; a person whose rent is in arrears may remain eligible for assistance, provided Centrelink is satisfied that the liability is genuine.
Running costs per 1000 CRA customers	Total running costs for the CRA program per 1000 CRA customers.
Sharer	Some single people are subject to a lower maximum (sharer) rate of CRA. The lower rate may apply to only a single person (with no dependent child) who shares a major area of accommodation. The lower rate does not apply to those receiving the Disability Support Pension or Carer Payment, those in nursing homes or boarding house accommodation, or those paying for both board and lodgings. A person is not regarded as a sharer solely because he or shares with a child (of any age) if the child does not receive CRA.
Satisfaction with location of housing	Satisfaction with the location of housing rather than with the CRA payment, as measured by the FaCSIA General Customer Survey. The indicator measures the proportion of respondents satisfied with the quality of their housing, broken down into categories of 'poor', 'just okay', 'good' and 'great'.
Satisfaction with quality of housing	Satisfaction with the quality of housing rather than with the CRA payment, as measured by the FaCSIA General Customer Survey. The indicator measures the proportion of respondents satisfied with the quality of their housing, broken down into categories of 'poor', 'just okay', 'good' and 'great'.
Special needs	The proportions of special needs income units receiving CRA, such as regional and remote Australians and Indigenous recipients, by benefit type.
Total income from all sources	<p>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:</p> <ul style="list-style-type: none"> • one-time payments • arrears payments • advances • Employment or Education Entry Payments • the Mobility Allowance • the Maternity Allowance • the Child Care Assistance Rebate. <p>In most cases, private income reflects the person's current circumstances. Taxable income for a past financial year or an estimate of taxable income for the current financial year is used where the income unit receives more than the minimum rate of the Family Tax Benefit but no other income support payment.</p>

16.7 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 16A.3 is table 3 in the electronic data tables). Section 16.7 contains a complete list of the supporting tables. Supporting tables can be found on the Review web page (www.pc.gov.au/gsp). The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2007\Attach_stat_app.xls and in Adobe PDF format as \Publications\Reports\2007\Attach_stat_app.pdf. Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

Public housing

Table 16A.1	Descriptive data
Table 16A.2	Low income households as a proportion of all new households (per cent)
Table 16A.3	Proportion of new tenancies allocated to households with special needs (per cent)
Table 16A.4	Greatest need allocations as a proportion of all new allocations (per cent)
Table 16A.5	Financial indicators of public housing, 2005-06 (dollars per dwelling)
Table 16A.6	Occupancy rates as at 30 June (per cent)
Table 16A.7	Average turnaround times for vacant stock (days)
Table 16A.8	Total rent collected as a proportion of total rent charged (per cent)
Table 16A.9	Proportion of tenants rating location aspects as important and meeting their needs, 2005 (per cent)
Table 16A.10	Proportion of tenants rating amenity aspects as important and meeting their needs, 2005 (per cent)
Table 16A.11	Subsidy per tenant and proportion of households spending less than 30 per cent of their income in rent
Table 16A.12	Proportion of households with overcrowding at 30 June (per cent)
Table 16A.13	Tenant satisfaction

SOMIH

Table 16A.14	Descriptive data
Table 16A.15	Low income households as a proportion of all new households (per cent)
Table 16A.16	Proportion of new tenancies allocated to households with special needs (per cent)
Table 16A.17	Greatest need allocations as a proportion of all new allocations (per cent)
Table 16A.18	Direct cost of providing assistance per dwelling
Table 16A.19	Occupancy rates as at 30 June (per cent)
Table 16A.20	Average turnaround times for vacant stock (days)
Table 16A.21	Total rent actually collected as a proportion of total rent charged (per cent)

Table 16A.22	State owned and managed Indigenous housing satisfaction survey, 2005
Table 16A.23	Subsidy per tenant and proportion of rebated households spending less than 30 per cent of their income in rent
Table 16A.24	Proportion of households where dwelling size is not appropriate due to overcrowding (per cent)
Community housing	
Table 16A.25	Descriptive data
Table 16A.26	The number of low income households, as a proportion of all households (per cent)
Table 16A.27	Proportion of new tenancies allocated to households with special needs (per cent)
Table 16A.28	Greatest need allocations as a proportion of all new allocations (per cent)
Table 16A.29	Direct cost per unit
Table 16A.30	Community housing occupancy rates at 30 June (per cent)
Table 16A.31	Total rent collected as a proportion of total rent charged (per cent)
Table 16A.32	Proportion of tenants rating location aspects as important and meeting their needs, 2005
Table 16A.33	Proportion of tenants rating amenity aspects as important and meeting their needs, 2005 (per cent)
Table 16A.34	Proportion of income left after paying rent, as at 30 June (per cent)
Table 16A.35	Proportion of households with overcrowding at 30 June (per cent)
Table 16A.36	Tenant satisfaction
Table 16A.37	Permanent Indigenous community housing dwellings, 30 June 2006
Table 16A.38	Occupied permanent Indigenous community housing dwellings, Australia, 30 June 2006
Table 16A.39	Condition of permanent Indigenous community housing dwellings, 2001 (per cent)
Table 16A.40	Average annual maintenance expenditure and weekly rent received per permanent dwelling, Indigenous community housing (dollars)
CRA	
Table 16A.41	Eligibility and payment scales for CRA 2006 (\$ per fortnight)
Table 16A.42	Number of income units receiving CRA, 2006 (no.)
Table 16A.43	Proportion of CRA recipients, 2006 (per cent)
Table 16A.44	Number of Indigenous income units receiving CRA, 2006 (no.)
Table 16A.45	Proportion of Indigenous CRA recipients, 2006 (per cent)
Table 16A.46	Income units receiving CRA, by Indigenous status and geographic location, 2006
Table 16A.47	Geographic spread of CRA recipients March 2006, Sydney
Table 16A.48	Geographic spread of CRA recipients March 2006, Melbourne
Table 16A.49	Geographic spread of CRA recipients March 2006, Brisbane

Table 16A.50	Geographic spread of CRA recipients March 2006, Perth
Table 16A.51	Geographic spread of CRA recipients March 2006, Adelaide
Table 16A.52	Geographic spread of CRA recipients March 2006, Hobart
Table 16A.53	Geographic spread of CRA recipients March 2006, Canberra
Table 16A.54	Geographic spread of CRA recipients March 2006, Darwin
Table 16A.55	Geographic spread of CRA recipients March 2006, Australia
Table 16A.56	Average CRA entitlement, by location, 2006
Table 16A.57	Income units receiving maximum rate of CRA, by jurisdiction (per cent)
Table 16A.58	Outcome of all CRA appeals finalised in 2005-06
Table 16A.59	Duration of payments, by State and Territory, 2006
Table 16A.60	Running costs per 1000 customers (dollars)
Table 16A.61	Ratio of running costs to total outlays (per cent)
Table 16A.62	Number and proportion of income units receiving CRA spending over 30 per cent of income on rent, with and without CRA, 2000-01 to 2005-06
Table 16A.63	Proportion of Indigenous income units receiving CRA, spending over 30 per cent of income on rent, with and without CRA, 2000-01 to 2005-06 (per cent)
Table 16A.64	Proportion of income units receiving a Disability Support Pension and CRA spending over 30 per cent of income on rent, with and without CRA, 2000-01 to 2005-06 (per cent)
Table 16A.65	Proportion of income spent on rent with and without CRA, income units with more than 50 per cent of income spent on rent, 2000-01 to 2005-06 (per cent)
Descriptive Information	
Table 16A.66	Housing composition, by tenure type, 2001 (per cent)
Table 16A.67	Moving annual trend vacancy rates, private housing market, by capital city, June 2006 (per cent)
Table 16A.68	Median market rents, private housing market, by capital city, June quarter 2006 (dollars/week)
Table 16A.69	Households residing in public housing, 2001 (per cent)
Table 16A.70	State and Territory programs included in the community housing data collection, 2005-06
Table 16A.71	Households residing in community housing, 2001 (per cent)
Table 16A.72	Treatment of assets by housing agencies, 2005-06
Table 16A.73	Government expenditure on CSHA assistance and CRA
Table 16A.74	Rebated public housing households paying assessable income on rent, by proportion of income (per cent)
Table 16A.75	Rebated State owned and managed Indigenous housing households paying assessable income on rent, by proportion of income (per cent)
Table 16A.76	Community housing households paying assessable income on rent, by proportion of income (per cent)

Table 16A.77	Proportion of households in public housing with moderate overcrowding or underutilisation, 30 June (per cent)
Table 16A.78	Proportion of households in State owned and managed Indigenous housing with moderate overcrowding or underutilisation, (per cent)
Table 16A.79	Proportion of households in community housing with moderate overcrowding or underutilisation at 30 June (per cent)
Table 16A.80	Government housing assistance, 2005-06
Table 16A.81	Public housing, non-rebated and multiple family households excluded
Table 16A.82	State owned and managed Indigenous housing, non-rebated and multiple family households excluded
Table 16A.83	Community housing survey response rates and associated information

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A Statistical appendix

A.1 Introduction

This appendix contains contextual information to assist the interpretation of the performance indicators presented in the Report. The following six key factors in interpreting the performance data are addressed:

- *Australia's population.* Section A.2 presents data on population characteristics, including 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, education and employment.* Section A.4 summarises the income and employment characteristics of Australians, including educational attainment and workforce participation.
- *Statistical concepts used in the Report.* Section A.5 provides technical information on the key statistical concepts used in the Report.
- *List of source tables.* Section A.6 lists the supporting tables for this appendix. Supporting tables are identified in references throughout the appendix by an 'AA' suffix (for example, table AA.3 is table AA.3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report.
- *References.* Section A.7 lists references used in this chapter.

A.2 Population

The Australian people are the principal recipients 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 the Report. A more detailed exposition is provided in the Australian Bureau of Statistics (ABS) annual publication *Australian Social Trends* (ABS 2006a). In the statistical

appendix and attachment tables, population totals for the same year can vary because they are drawn from different ABS sources depending on the information required — for example, some data are from the Census (ABS 2002a) and others from the Australian Demographic Statistics.

Most of the service areas covered by the Report use population data from tables AA.1 and AA.2 for descriptive information (such as expenditure per person in the population) or performance indicators (such as participation rates for vocational education and training [VET]).

Population size and trends

More than three quarters of Australia's 20.3 million people lived in the eastern states as at 30 June 2005, with NSW, Victoria and Queensland accounting for 33.3 per cent, 24.7 per cent and 19.5 per cent respectively of the nation's population. Western Australia and SA accounted for a further 9.9 per cent and 7.6 per cent respectively of the population, while Tasmania, the ACT and the NT accounted for the remaining 2.4 per cent, 1.6 per cent and 1.0 per cent respectively (table AA.1).

Nationally, the average annual growth rate of the population between 2001 and 2005 was approximately 1.2 per cent. The growth across jurisdictions ranged from 2.3 per cent in Queensland to 0.5 per cent in SA and the ACT (table AA.2, calendar year estimates).

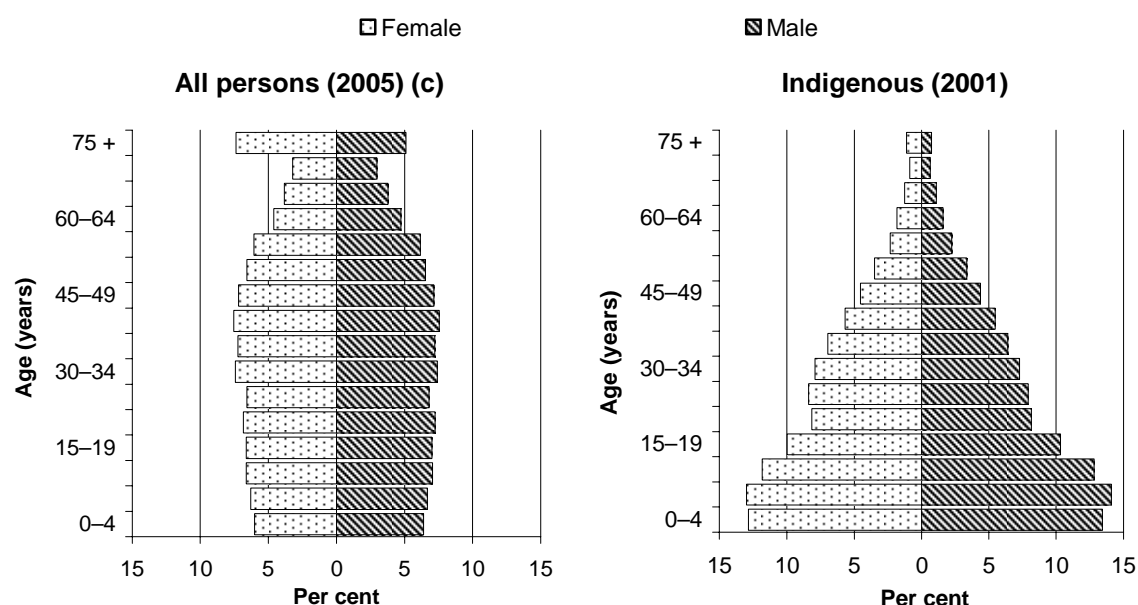
Population, by age and sex

As in most other developed economies, greater life expectancy and declining fertility have contributed to an 'ageing' of Australia's population. The experiences of Indigenous Australians, however, are markedly different (figure A.1). At 30 June 2005, 9.3 per cent of Australia's population was aged 70 years or over, in contrast to 1.7 per cent of Australia's Indigenous population at 30 June 2001 (tables AA.1 and AA.7). Across jurisdictions, the proportion of people aged 70 years or over ranged from 11.1 per cent in SA to 2.7 per cent in the NT (table AA.1).

Approximately half (50.3 per cent) of the population at June 2005 was female. This distribution was similar across all jurisdictions except the NT, which had a relatively low representation of women in its population (47.4 per cent) (table AA.1). The proportion of women in the population varies noticeably by age.

Nationally, approximately 56.9 per cent of people aged 70 or over were female, compared with 48.7 per cent of people aged 14 years or younger (table AA.1).

Figure A.1 **Population distribution, Australia, by age and sex, 30 June^{a, b}**



^a Totals may not add as a result of rounding. ^b Includes other territories. ^c Preliminary data.

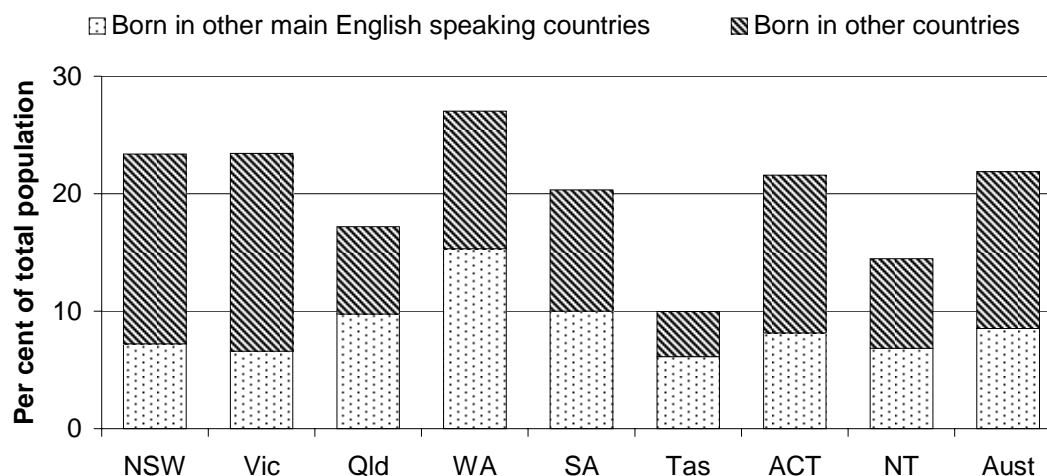
Source: ABS (2001); ABS Australian Demographic Statistics (unpublished); tables AA.1 and AA.7.

Population, by ethnicity and proficiency in English

New Australians face specific problems when accessing government services. Language and culture can be formidable barriers for otherwise capable people. Cultural backgrounds can also have a significant influence on the support networks offered by extended families. People born outside Australia accounted for 21.9 per cent of the population in August 2001 (8.5 per cent from the main English speaking countries and 13.3 per cent from other countries).¹ Across jurisdictions, the proportion of people born outside Australia ranged from 27.0 per cent in WA to 10.0 per cent in Tasmania. The proportion from countries other than the main English speaking countries ranged from 16.8 per cent in Victoria to 3.9 per cent in Tasmania (figure A.2).

¹ The ABS defines the main English speaking countries as the United Kingdom, Ireland, New Zealand, Canada, the United States and South Africa.

Figure A.2 **People born outside Australia, by country of birth, August 2001^{a, b, c}**



^a Born outside Australia excludes overseas visitors. ^b The ABS defines other main English speaking countries as the United Kingdom, Ireland, New Zealand, Canada, the United States and South Africa. ^c Born in other countries includes inadequately described, at sea and not elsewhere classified.

Source: ABS (2002a); table AA.4.

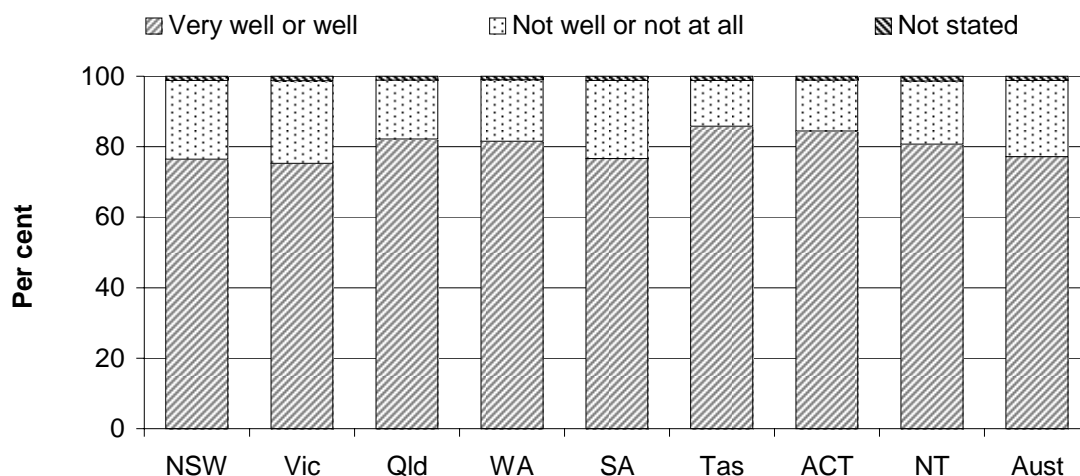
Of the population born outside Australia, in August 2001 88.5 per cent spoke only English, or spoke another language as well as speaking English very well or well. The proportion of the total population born outside Australia who did not speak English well or at all ranged from 29.3 per cent in Victoria to 2.7 per cent in Tasmania (tables AA.1 and AA.3).

Across jurisdictions in August 2001, the proportion of the population who were born outside Australia and who spoke a language other than English ranged from 58.4 per cent in Victoria to 22.7 per cent in Tasmania. The proportion of this group who were born outside Australia and who did not speak English well or at all ranged from 13.6 per cent in Victoria to 2.9 per cent in Tasmania (table AA.3).

Figure A.3 shows proficiency in English of people born overseas who speak another language. Of those people born overseas who spoke another language, 77.2 per cent also spoke English very well or well. The proportion who did not speak English well or at all ranged from 23.5 per cent in Victoria to 13.0 per cent in Tasmania.

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 AA.5). The most common languages spoken were Chinese languages, Italian, Greek and Arabic (including Lebanese).

Figure A.3 **People born overseas who spoke another language, by proficiency in English, August 2001^{a, b, c}**



^a Excludes overseas visitors and people who did not state their birthplace. ^b Includes other territories. ^c 'Not stated' includes cases where language spoken at home was stated but proficiency in English was not stated, and cases where both language spoken at home and proficiency in English were not stated.

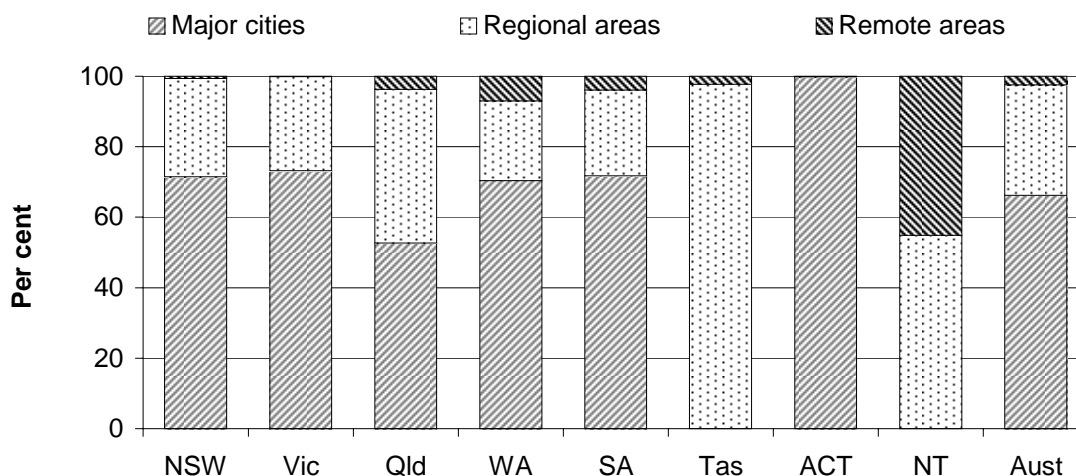
Source: ABS (2002a); table AA.3.

The most and least common languages other than English spoken in people's homes varied across jurisdictions in August 2001. The most extreme variation was in the NT, where 15.4 per cent of people spoke an Australian Indigenous language (67.6 per cent of the total persons who spoke a language other than English in their homes) (table AA.5).

Population, by geographic location

The Australian population is highly urbanised, with 66.2 per cent of the population located in major cities as at 30 June 2005 (figure A.4). Across jurisdictions, this proportion ranged from 99.8 per cent in the ACT to 52.7 per cent in Queensland (table AA.6). Tasmania and the NT by definition have no major cities. In Tasmania, 97.7 per cent of the population lived in regional areas. Australia-wide, 2.5 per cent of people lived in remote areas. The NT was markedly above this average, with 45.1 per cent of people living in remote areas.

Figure A.4 Estimated residential population, by geographic location, June 2005^{a, b, c}



^a Preliminary data. ^b Geographic location is based on the Remoteness Structure outlined in the 2001 Australian Standard Geographic Classification (ASGC). ^c 'Australia' includes other territories.

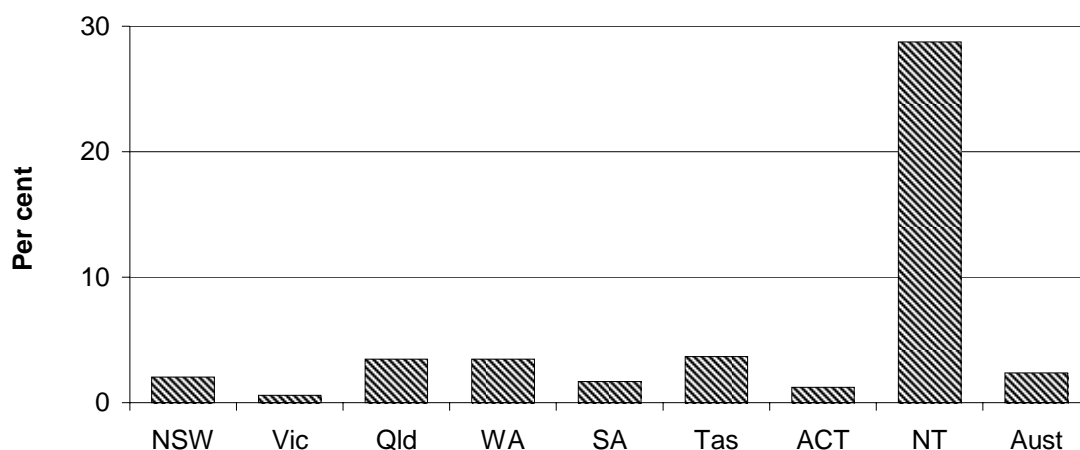
Source: ABS Australian Demographic Statistics (unpublished); table AA.6.

Indigenous population profile

There were an estimated 458 520 (230 994 female and 227 526 male) Indigenous people in Australia at 30 June 2001, accounting for approximately 2.4 per cent of the population (tables AA.2 and AA.7). The proportion of people who were Indigenous was significantly higher in the NT (28.8 per cent) than in any other jurisdiction. Across the other jurisdictions, the proportion ranged from 3.7 per cent in Tasmania to 0.6 per cent in Victoria (figure A.5). Nationally, the Indigenous population is projected to grow to 528 645 people in 2009 (table AA.8).

The majority of Indigenous people (79.8 per cent) at August 2001 spoke only English at home, while 8.8 per cent spoke an Indigenous language and English very well or well. However, 3 per cent spoke English not well or not at all (5.6 per cent did not state proficiency in any specific language) (table AA.9).

Figure A.5 **Indigenous people as a proportion of the population, 30 June 2001^a**



^a 'Australia' includes other territories.

Source: ABS (2001); ABS Australian Demographic Statistics (unpublished); tables AA.2 and AA.7.

A.3 Family and household

Family structure

There were 5.6 million families in Australia in 2005. Across jurisdictions, the number of families ranged from 1.8 million in NSW to 39 000 in the NT. The average family size across Australia was 3.0 people (unchanged since 2002). Across jurisdictions, the average ranged from 3.1 people in NSW and the NT and 2.9 people in Tasmania (table AA.10).

Lone parent families may have a greater need for government support and particular types of government services (such as child care for respite reasons). Nationally, 18.9 per cent of children aged under 15 years lived in one parent families in 2005; 18.7 per cent of families with children aged under 15 years were lone mother families and 2.7 per cent had a father only. Across jurisdictions, the proportion of children aged under 15 years living in one parent families ranged from 25.1 per cent in the NT to 17.9 per cent in the ACT (table AA.11).

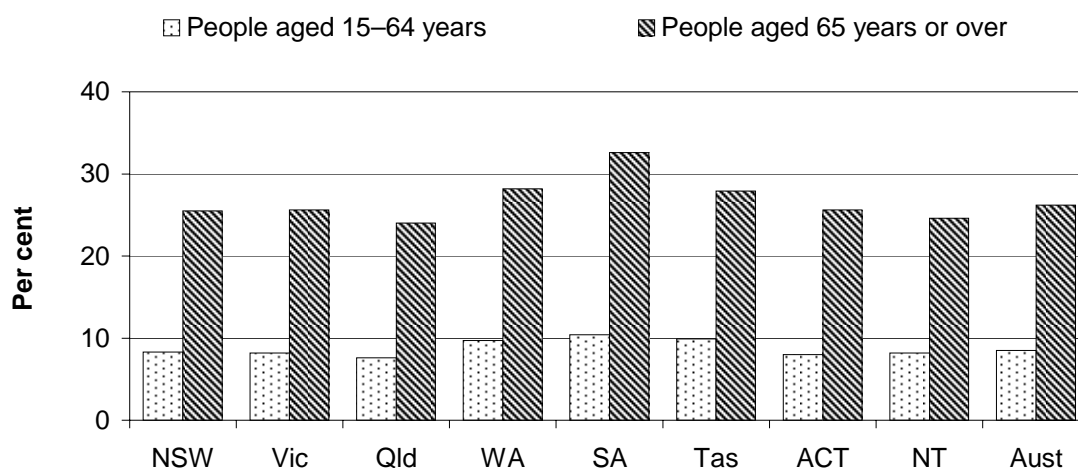
Employment status also has implications for the financial independence of families. Nationally, 15.7 per cent of children aged under 15 years in 2003-04 lived in families where no parent was employed. Across jurisdictions, the proportion ranged from 24.4 per cent in Tasmania to 8.0 per cent in the ACT (table AA.12).

Household profile

There were 7.4 million households in Australia in 2001 (table AA.14). Close to one quarter (24.5 per cent) of these were lone person households. Across jurisdictions, the proportion of lone person households ranged from 28.0 per cent in SA to 21.3 per cent in the NT.

The proportion of people aged 65 years or over who lived alone in June 2005 was considerably higher than that for people aged 15–64 years — nationally, 26.2 per cent compared with 8.5 per cent respectively. Across jurisdictions, the proportion of people aged 65 years or over who lived alone ranged from 32.6 per cent in SA to 24.0 per cent in Queensland (figure A.6).

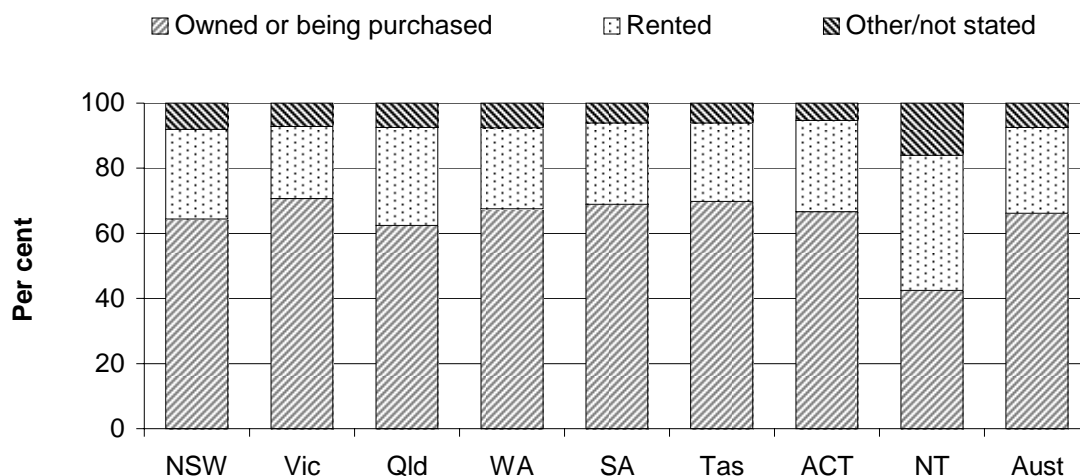
Figure A.6 **Proportion of population who lived alone, by age group, June 2005**



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

Nationally, the majority of occupied private dwellings (66.2 per cent, or 4.7 million dwellings) in August 2001 were owned or were being purchased. Home ownership was highest in Victoria (70.7 per cent) and lowest in the NT (42.5 per cent). Australians rented 26.3 per cent of dwellings (21.5 per cent from private rental sources, 4.5 per cent from government and 0.3 per cent from unspecified sources) (table AA.15). Across jurisdictions, the proportion of dwellings that were rented was highest in the NT (41.5 per cent) and lowest in Victoria (22.1 per cent) (figure A.7).

Figure A.7 **Occupied private dwellings, by tenure type and landlord type, August 2001^{a, b}**



^a 'Rented' includes rented dwellings where the landlord type was not stated. ^b 'Other' includes dwellings being occupied rent free or under a life tenure scheme.

Source: ABS (2002a); table AA.15.

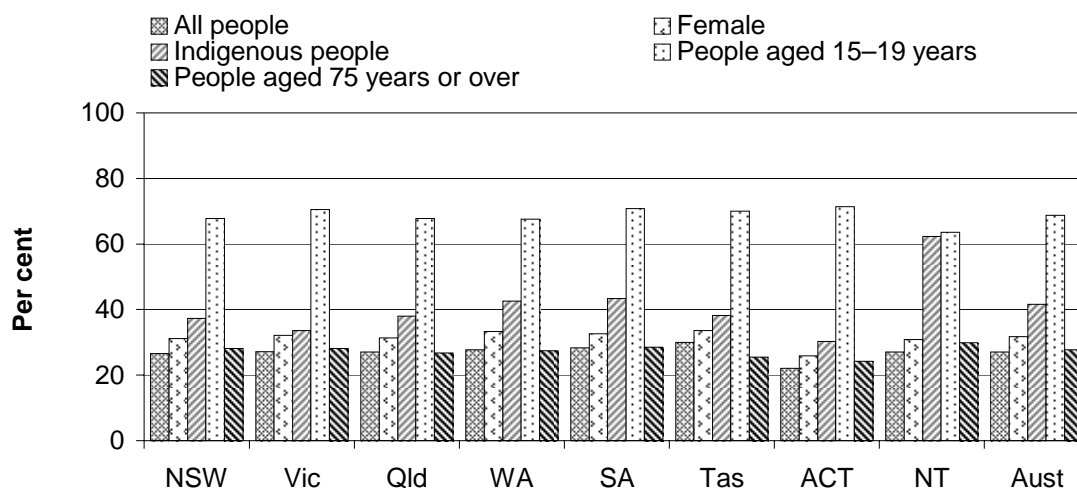
A.4 Income, education and employment

Income

Nationally, 27.1 per cent of people aged 15 years or over in August 2001 had a weekly individual income of \$199 or less (table AA.16). The proportion was considerably higher for younger people (68.8 per cent for people aged 15–19 years), Indigenous people (41.6 per cent), females (31.8 per cent) but similar for older people (27.7 per cent for people aged 75 years or over) (figure A.8).

Nationally, 17.7 per cent of the total population was receiving income support in 2005. The age pension was received by 9.4 per cent of the population, while 3.5 per cent received a disability support pension and 2.2 per cent received a single parent payment. A further 2.6 per cent of the population received some form of labour market allowance in 2005 (figure A.9).

Figure A.8 Weekly individual income of \$199 or less, by sex, Indigenous status and age, August 2001^a



^a 'Australia' includes other territories.

Source: ABS (2002a); ABS (2002b); tables AA.16–AA.18.

Figure A.9 Proportion of total population on income support, June 2005^{a, b}



^a Data for the labour market allowance from 2001 excludes Newstart customers who received a nil rate of payment. ^b Data for the disability support pension includes payments to people living overseas.

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

The proportion of the population receiving the age pension in 2005 ranged from 11.5 per cent in SA to 3.0 per cent in the NT; the proportion receiving a disability support pension ranged from 5.2 per cent in Tasmania to 2.2 per cent in the ACT; and the proportion receiving a single parent payment ranged from 2.9 per cent in the

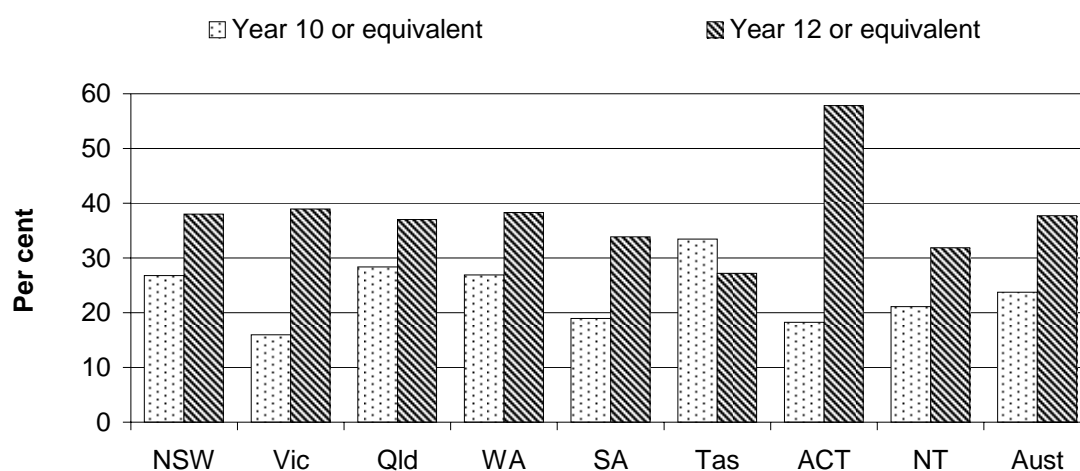
NT to 1.6 per cent in the ACT. The proportion receiving a labour market allowance in 2005 ranged from 6.2 per cent in the NT to 1.6 per cent in the ACT.

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 as the highest level of schooling. A further 23.8 per cent (3.5 million people) had completed year 10 or equivalent schooling, excluding the 3.4 per cent (500 000 people) who were still at school (many of whom were studying in year 11 or 12, and had completed year 10). 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 non-Indigenous people aged 15 years or over who had completed year 12 or equivalent schooling (39.5 per cent) was considerably higher than the proportion of Indigenous people (16.8 per cent) in August 2001. Across jurisdictions, the proportion of Indigenous people aged 15 years or over who had completed year 12 or equivalent schooling ranged from 36.4 per cent in the ACT to 7.1 per cent in the NT. The proportion of non-Indigenous people who had completed year 12 or equivalent was highest in the ACT (59.8 per cent) and lowest in Tasmania (28.4 per cent) (figure A.11).

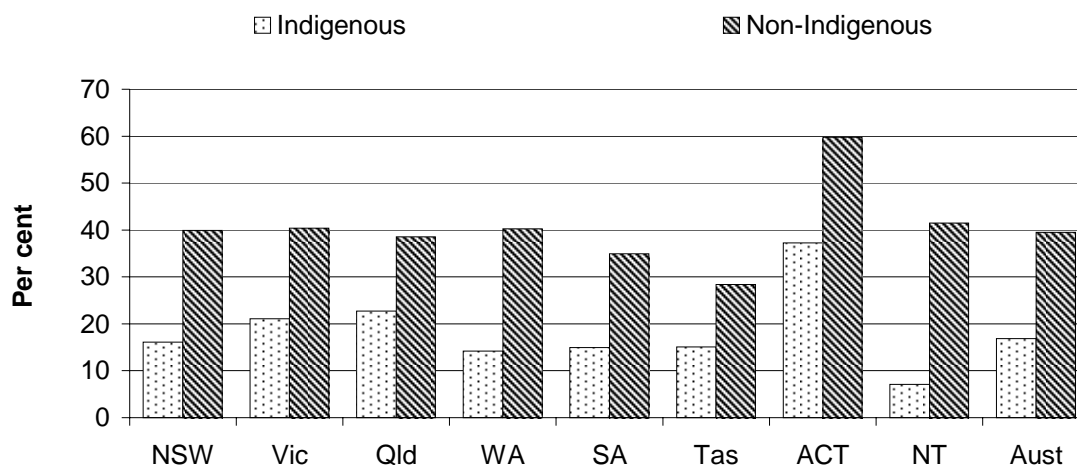
Figure A.10 **People aged 15 years or over, by highest year of school completed, August 2001^{a, b, c}**



^a Refers to primary or secondary schooling. ^b 'Australia' includes other territories. ^c 'All persons' includes Indigenous status not stated.

Source: ABS (2002b); table AA.20.

Figure A.11 People aged 15 years or over who had completed year 12 or equivalent, by Indigenous status, August 2001^{a, b}

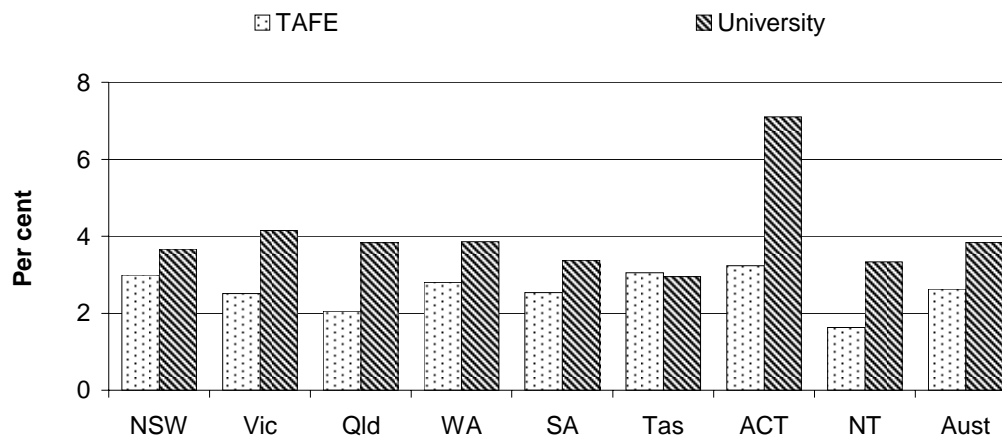


^a Refers to primary and secondary schooling. ^b 'Australia' includes other territories.

Source: ABS (2002b); table AA.20.

Tertiary education in Australia is principally provided by universities and technical and further education (TAFE) institutes. Nationally, 6.5 per cent of the population were attending university or TAFE in August 2001 (3.8 per cent at university and 2.6 per cent at TAFE). 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 2.9 per cent in Tasmania (figure A.12).

Figure A.12 Proportion of population attending higher education institutions, August 2001^{a, b}

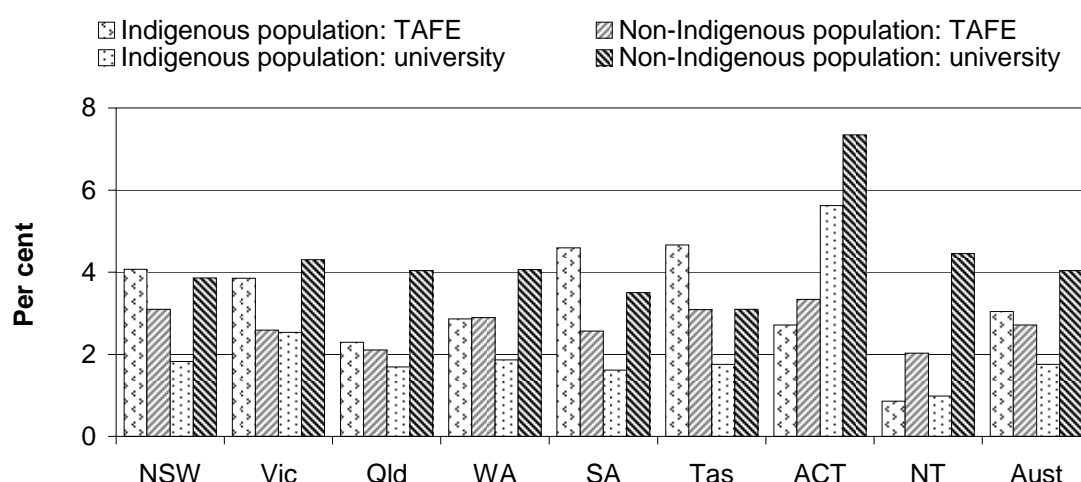


^a 'Australia' includes other territories. ^b 'University' includes other tertiary institutions.

Source: ABS (2002b); table AA.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 (figure A.13).

Figure A.13 Proportion of population attending higher education, by Indigenous status, August 2001^{a, b}



^a 'Australia' includes other territories. ^b 'University' includes other tertiary institutions.

Source: ABS (2002b); table AA.21.

Employment and workforce participation

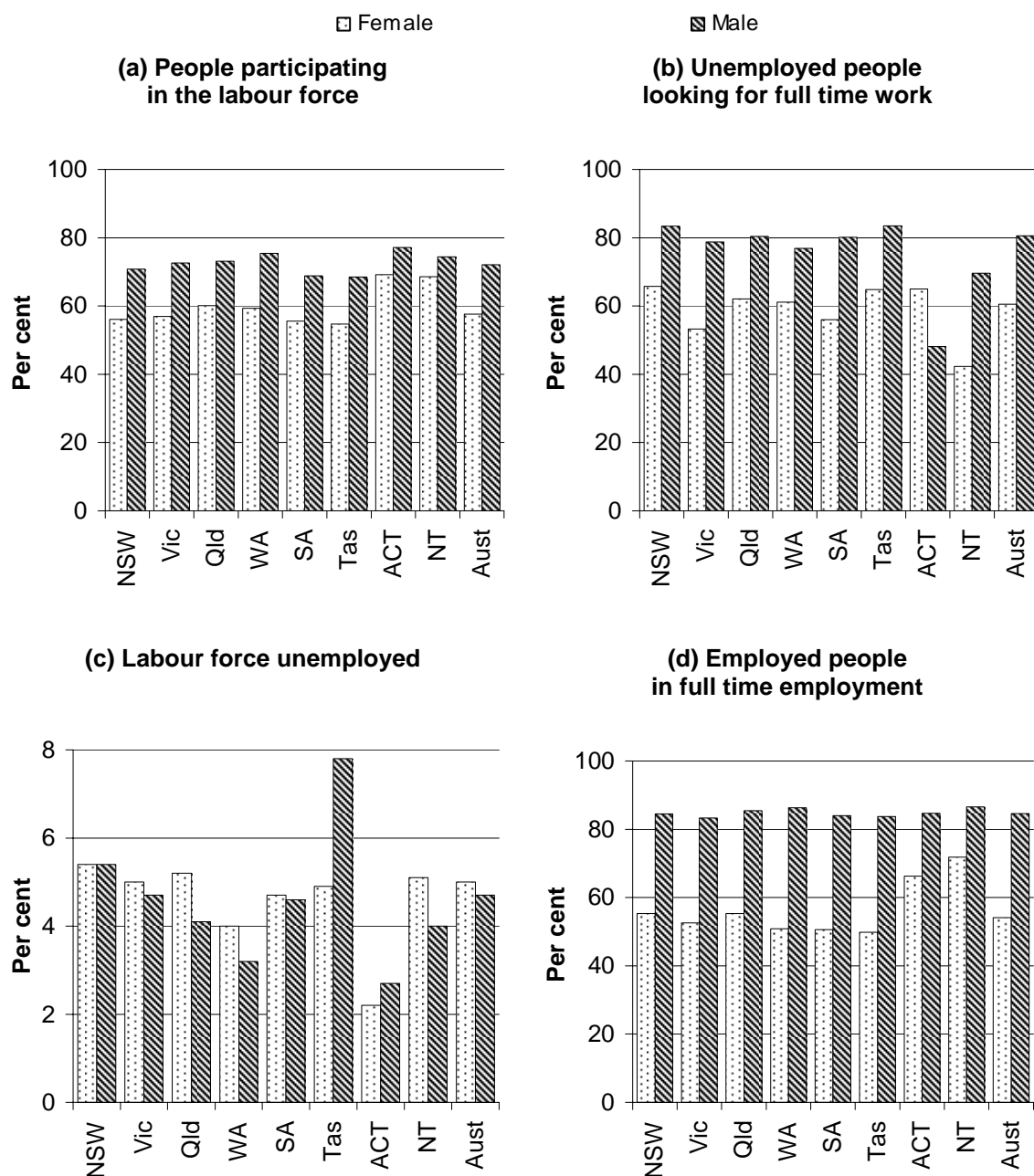
There were 10.7 million people aged 15 years or over in the labour force in Australia in June 2006. Of these, 95.2 per cent were employed. This means 4.8 per cent of the participating labour force were unemployed at June 2006. The majority of employed persons (70.8 per cent) were in full time employment. A further 515 000 people were looking for either full time work (71.2 per cent of those looking for work) or part time work (28.8 per cent) (table AA.22).

Across jurisdictions, the proportion of employed people in full time employment in June 2006 ranged from 79.9 per cent in NT to 68.0 per cent in Tasmania. The unemployment rate ranged from 6.5 per cent in Tasmania to 2.5 per cent in the ACT. The proportion of unemployed people looking for full time work ranged from 77.1 per cent in Tasmania to 55.3 per cent in the ACT (tables AA.22 and AA.24).

The unemployment rate needs to be interpreted within the context of labour force participation rates, which were higher for males than for females in all jurisdictions

(figure A.14a). Nationally, fewer unemployed females were looking for full time work than males, 60.6 per cent and 80.6 per cent respectively (figure A.14b).

Figure A.14 Labour force outcomes for people aged 15 years or over, by sex, June 2006



Source: ABS (2006b); tables AA.22–AA.24.

The unemployment rate for females was higher than that for males in all jurisdictions except NSW, Tasmania and the ACT (figure A.14c). A greater

proportion of employed males than of employed females had full time employment in all jurisdictions. The difference between male and female full time employment ranged from 35.4 percentage points in WA to 14.7 percentage points in the NT (figure A.14d).

General economic indicators

Gross Domestic Product (GDP) is the total market value of goods and services produced in Australia within a given period. Australia's GDP is the total of all State and Territory Gross State Product (GSP). The GSP for NSW accounted for 34.3 per cent of national gross product, compared with 1.2 per cent for the NT. Growth from the previous year's GSP (in current prices) was highest for WA (9.1 per cent) and lowest for Victoria (3.3 per cent). Across Australia, the GSP per person was \$44 107 in 2004-05 (table AA.25).

A.5 Statistical concepts used in the Report

Reliability of estimates

Outcome and quality indicators are reported from surveys (including surveys of client and community perception) for a number of services covered in this Report. Police services, for example, use a survey to obtain an indicative level of community satisfaction with the services that police agencies provide. The potential for sampling error — that is, the error that occurs by chance because the data are obtained from only a sample and not the entire population — means that the reported responses may not indicate the true responses.

Standard error

The standard error (SE) is one measure of the variability that occurs as a result of surveying a sample of the population. There are two chances in three (67 per cent) that a survey estimate is within one SE of the figure that would have been obtained if the population had been surveyed, and about 19 chances in 20 (95 per cent) that it is within approximately two SEs. There is a 95 per cent probability that the true value of 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 SE of an estimate can be obtained from either

(1) the tables in chapters reporting the estimates and relative standard errors (RSEs) or (2) the RSE tables produced at the end of each of the relevant attachments. Linear interpolation needs to be used to calculate the SEs of estimates falling between the sizes of estimates listed in these tables.

Relative standard error

The SE can be expressed as a proportion of the estimate — known as the RSE, which is determined by dividing the SE of the estimate $SE(x)$ by the estimate x and expressing it as a percentage:

$$RSE(x) = \frac{SE(x)}{x}$$

If, for example, 4.3 million people in NSW were estimated to be satisfied with a service, and the SE was approximately $\pm 34\ 100$ people, then the $RSE(x)$ would be equal to 0.0078, or 0.78 per cent. The RSE 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 as ‘satisfied’ or ‘very satisfied’) and the denominator (the estimated size of the population). The formula for the RSE of a proportion is:

$$RSE\left(\frac{x_1}{X}\right) = \sqrt{[RSE(x_1)]^2 - [RSE(X)]^2}$$

where x_1 is estimated as the number of persons from jurisdiction x responding as ‘satisfied’ or ‘very satisfied’, and X is the estimated population of jurisdiction x .

Testing for statistical differences

The chance that an estimate falls within a certain range of the true value is known as the *confidence* of the estimate. For any particular survey, there is a tradeoff between the confidence of the estimate and the range of error (in terms of SEs) attached to the estimate. The appropriate level of reliability chosen depends on the purpose of obtaining the estimate. The lower the level of confidence required, the smaller the range the estimate will fall within (for example, we might be able to be 90 per cent

confident the true result lies between 18 and 20, but if we want to be 95 per cent confident, we might have to increase the possible range to between 16 and 22).

Confidence intervals (CIs) — the value ranges within which estimates are likely to fall — can be used to test whether the results reported for two jurisdictions are statistically different. If the CIs for the results overlap, then there can be little confidence that the estimated results differ from each other.

For example, assume survey data estimated a result of 60 per cent for NSW, with a 95 per cent CI of ± 3.2 per cent, and a result of 58 per cent for Queensland, with a 95 per cent confidence interval of ± 1.15 per cent.

These results imply that we can be 95 per cent sure the true result for NSW lies between 56.8–62.3 per cent, and the true result for Queensland lies between 56.5–59.5 per cent. As these two ranges overlap, we cannot be sure that the true results for NSW and Queensland are statistically different.

Expressed mathematically, the estimated response is within the 95 per cent confidence interval:

$$\left(\frac{x_1}{X} - \frac{y_1}{Y}\right) - 1.96 \sqrt{\text{RSE}\left(\frac{x_1}{X}\right) \times \frac{x_1}{X} + \text{RSE}\left(\frac{y_1}{Y}\right) \times \frac{y_1}{Y}}$$

and

$$\left(\frac{x_1}{X} - \frac{y_1}{Y}\right) + 1.96 \sqrt{\text{RSE}\left(\frac{x_1}{X}\right) \times \frac{x_1}{X} + \text{RSE}\left(\frac{y_1}{Y}\right) \times \frac{y_1}{Y}}$$

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 the difference between jurisdiction x 's response and jurisdiction y 's response is statistically significant.

Growth rates

Average annual growth rates

Given that data in the Report cover different periods, compound annual averages have been used to facilitate more meaningful comparisons of changes over time.

The formula for calculating a compound annual growth rate (AGR) is:

$$\text{AGR} = \left[\left(\frac{P_v}{P_0} \right)^{\left(\frac{1}{n-1} \right)} - 1 \right] \times 100$$

where AGR is the annual growth rate
 P_v is the present value
 P_0 is the beginning value
 n is the number of periods.

Summing and taking averages of growth rates

Total growth rate

The formula for calculating a total growth rate (TGR) from AGRs is:

$$\text{TGR} = \Pi_t (1+r)_t - 1$$

that is, the total growth over the period, TGR, is found by taking the product (Π) of each $(1+r)_i$ and deducting 1. If, for example, the sample ranges of growth rates are:

6 per cent in 2002-03 to 2003-04
6 per cent in 2003-04 to 2004-05
8 per cent in 2004-05 to 2005-06

where TGR is the total growth rate
 t is the year (2001, 2002, 2003... n)
 n is the final period

then the total growth over the period 2002-03 to 2005-06 can be calculated as:

$$\begin{aligned} r_T &= [\Pi_i (1+r)_i - 1] \times 100 \\ &= [(1.06) \times (1.06) \times (1.08) - 1] \times 100 \\ &= (1.213488 - 1) \times 100 \\ &= 21.3 \text{ per cent.} \end{aligned}$$

Average growth rates

The formula for the average of growth rates is:

$$r_A = \left\{ \left[\prod_i (1 + r_i) \right]^{\frac{1}{t}} - 1 \right\} \times 100$$

This involves first finding the total growth over the period, then finding the average. Note that t is the count of growth rates being averaged, not the years. For example:

$$\begin{aligned} r_A &= \{ [(1.06 \times 1.06 \times 1.08)^{\frac{1}{3}} - 1] \times 100 \} \\ &= \{ [(1.213488)^{\frac{1}{3}} - 1] \times 100 \} \\ &= [(1.066625) - 1] \times 100 \\ &= 6.66 \text{ per cent.} \end{aligned}$$

Gross domestic product deflators

Table AA.26 in the attachment contains GDP deflators for 1996-97 to 2005-06. Financial data in the Report are often deflated by the GDP deflator (except in some health chapters and chapter 4 on VET, which use service-specific deflators) to calculate real dollars.

The general formula used to re-base GDP deflators is as follows:

$$N_t = 100 \times \frac{O_t}{B}$$

where N_t is the new index based in year t
 O_t is the current index for year t
 B is the current index for the year that will be the new base.

Age standardisation of data

How age profiles can distort observed service usage patterns

The age profile of Australians varies across jurisdictions and across different cultural and linguistic backgrounds (see for example the different age profiles of Indigenous and all Australians, figure A.1). Variations in age profiles are important because the likelihood of needing certain services (such as aged care services) increases with age. As a result, observed differences in service usage rates by different cohorts within the community may arise from different age profiles, rather

than from different usage patterns. One method of eliminating this distortion from the data is to standardise for the age profiles of different groups.

Method of standardisation

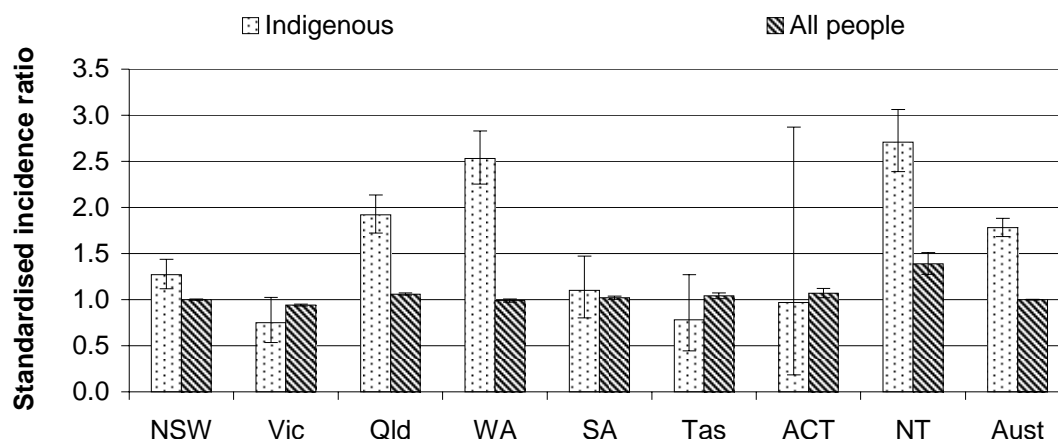
Either direct or indirect standardisation can be used. Indirect standardisation is presented here because it is more appropriate when comparing small populations. This method applies standard age-specific usage rates (in this case, average Australian rates) to actual populations (different groups within states and territories), and compares observed numbers of clients with the numbers that would have been expected if average rates had applied. Comparisons are made via the standardised incidence ratio. A value greater than 1.0 in this ratio means that use is higher than would be expected if the particular group had the same usage rate as that of the Australian population as a whole. A value below 1.0 means use is lower than expected. Age standardisation generally covers use by all age groups, so the resulting standardised incidence ratios compare use by complete population groups.

Application of indirect standardisation

In the following illustration, the combined use of permanent residential aged care and Community Aged Care Packages (CACPs) by Indigenous people is compared with average service use by all Australians (using 2001 data). The resulting standardised incidence ratios are presented in figure A.15. The error bars in the figure show how accurate the comparisons are—if an error bar goes across the value of 1.0, then the usage rate by that population group is not significantly different from the average use by all Australians.

Figure A.15 shows that Indigenous people had a higher than average combined use of CACPs and permanent residential aged care — nationally, about 80 per cent higher. This result reflects the higher age-specific usage rates of CACPs for Indigenous people at all ages, and of permanent residential aged care for those Indigenous people aged under 75 years (table A.1). Results vary across jurisdictions.

Figure A.15 **Standardised incidence ratio for use of CACP and permanent residential aged care (combined), 30 June 2001^{a, b, c}**



^a The Indigenous ratio is per 1000 Indigenous people aged 50 or over, the all people ratio is per 1000 Indigenous people aged 50 or over and non-Indigenous people aged 70 or over. ^b The calculations use indirect age standardisation against use by all people Australia-wide. ^c ACT data are based on a very small Indigenous population and have high standard errors.

Source: AIHW (unpublished); table AA.27.

Table A.1 **Age-specific usage rates of CACPs and permanent residential aged care (per 1000 people), 30 June 2005^{a, b}**

Age (years)	CACP recipients		Permanent aged care residents	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
50-54	4.1	0.1	2.5	0.7
55-59	9.8	0.3	5.8	1.4
60-64	19.2	0.8	8.8	2.8
65-69	36.3	1.8	15.4	5.9
70-74	48.5	3.9	28.7	13.5
75+	82.1	17.8	106.8	102.0

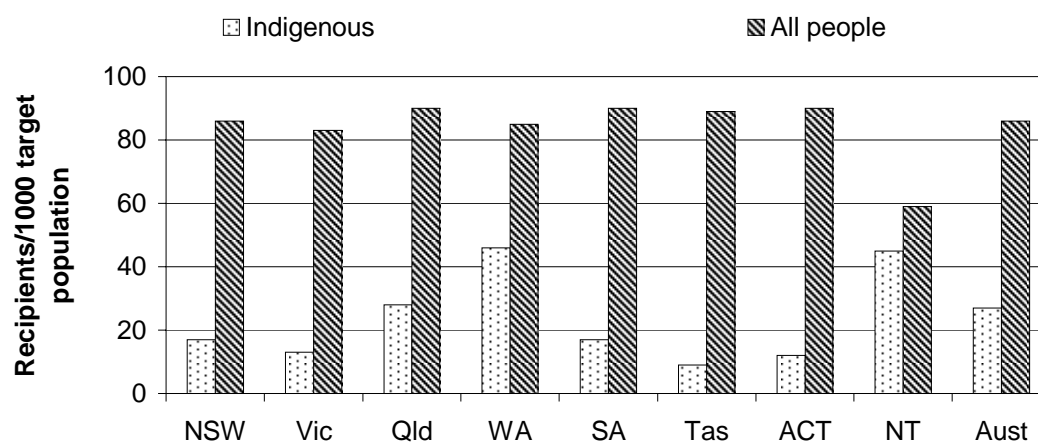
^a Excludes clients of multipurpose and flexible services. ^b Cases with missing data on Indigenous status have been pro rated within gender/age groups.

Source: AIHW 2006a, AIHW 2006b.

The age standardised rates are quite different from those that result from comparing use with the target group population (clients per 1000 in the target group). The target group measure (figure A.16) suggests that combined use of CACPs and permanent residential aged care is much lower for Indigenous people than for all people. Figure A.16 also suggests that use of the two services for all people is much lower in the NT than in other jurisdictions; this difference is not apparent after age standardisation (figure A.15), indicating that the difference in this measure is the

result of the relatively young age structure of the NT (even within the two subgroups of people 70 years and over and Indigenous people 50 years and over).

Figure A.16 Ratio of CACP recipients and permanent residents (combined) to 1000 persons in target population, 30 June 2001^a



^a Indigenous ratio is per 1000 Indigenous people aged 50 years or over, 'all people' ratio is per 1000 Indigenous people aged 50 years or over and non-Indigenous people aged 70 years or over.

Source: AIHW (unpublished); table AA.27.

A.6 Supporting tables

Supporting tables are identified in references throughout this appendix by an 'AA' suffix (for example, table AA.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2007\Attach_stat_app.xls and in Adobe PDF format as \Publications\Reports\2007\Attach_stat_app.pdf. The files containing the supporting tables can also be found on the Review web pages (www.pc.gov.au/gsp). Users without access to the CD-ROM can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

Population

Table AA.1	Estimated resident population by age and sex, 30 June 2005 ('000)
Table AA.2	Estimated resident population by calendar and financial year
Table AA.3	Proficiency in spoken English of people born overseas, August 2001 ('000)
Table AA.4	Persons by country of birth, August 2001 ('000)
Table AA.5	Persons by language spoken at home, August 2001 ('000)
Table AA.6	Estimated resident population by geographic location, 30 June 2005
Table AA.7	Preliminary estimated resident Indigenous population by age and sex, 30 June 2001
Table AA.8	Experimental projection of the Indigenous population, 2000 to 2009 (number)
Table AA.9	Language spoken at home by Indigenous people and proficiency in spoken English, by sex, August 2001 (number)

Family and household

Table AA.10	Family structure, 2001–2005
Table AA.11	Family structure: lone parents, 2001–2005 (per cent)
Table AA.12	Families and work (per cent)
Table AA.13	Families and persons in families in occupied private dwellings by Indigenous status and family type, August 2001
Table AA.14	Household structure, 2001–2005
Table AA.15	Occupied private dwellings by tenure type and landlord type, August 2001 ('000)

Income, education and employment

- Table AA.16** Persons aged 15 years and over, by weekly individual income and sex, August 2001
- Table AA.17** Persons aged 15 years and over by weekly individual income and Indigenous status, August 2001
- Table AA.18** Persons aged 15 years and over, by weekly individual income and age, August 2001
- Table AA.19** Income support, June, 2001–2005
- Table AA.20** People aged 15 years or over, by highest level of schooling completed and Indigenous status, August 2001 ('000)
- Table AA.21** Type of educational institution attending by Indigenous status, August 2001 ('000)
- Table AA.22** Labour force profile of the civilian population aged 15 years or over by sex, June 2006
- Table AA.23** Labour force participation rate of the civilian population aged 15 years or over by sex, (per cent)
- Table AA.24** Unemployment rate of labour force participants aged 15 years or over by sex, (per cent)

General economic indicators

- Table AA.25** Gross State Product, 2000–01 to 2004–05
- Table AA.26** Gross Domestic Product price deflator (index)

Statistical concepts

- Table AA.27** Age standardisation data, June 2001

A.7 References

- ABS (Australian Bureau of Statistics) 2001, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0, Canberra.
- 2002a, *Census of Population and Housing: Basic Community Profiles*, Australia, Cat. no. 2002.0, DX Database, viewed 18 July 2002, unpublished.
- 2002b, *Census of Population and Housing: Indigenous Community Profiles*, Australia, Cat. no. 2002.0, DX Database, viewed 18 July 2002, unpublished.
- 2006a, *Australian Social Trends*, Cat. no. 4102.0, Canberra.
- 2006b, *Labour Force Survey*, Cat. no. 6291.0, Canberra.
- AIHW (Australian Institute of Health and Welfare) 2006a, *Residential Aged Care in Australia 2004-05: A Statistical Overview*, Cat. no. AGE 45, Aged Care Statistics Series no. 22, Canberra.
- 2006b, *Community Aged Care Packages in Australia 2004-05: A Statistical Overview*, Cat. no. AGE 47, Aged Care Statistics Series no. 23, Canberra.

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