

Report on Government Services 2009

Volume 2:
*Health, Community Services,
Housing*

*Steering Committee
for the Review of
Government
Service Provision*

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The Productivity Commission acts as the Secretariat for the Steering Committee.

Secretariat

Steering Committee for the Review of Government Service Provision
Productivity Commission
LB 2 Collins Street East Post Office
Melbourne VIC 8003

Level 28
35 Collins Street
Melbourne VIC 3000

Tel: (03) 9653 2100 or Freecall: 1800 020 083
Fax: (03) 9653 2359
Email: gsp@pc.gov.au
<http://www.pc.gov.au/gsp>

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

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Acronyms and abbreviations

AACR	Australasian Association of Cancer Registries
AAGR	average annual growth rates
AAP	asthma action plan
AAT	Administrative Appeals Tribunal
ABS	Australian Bureau of Statistics
ACAM	Australian Centre for Asthma Monitoring
ACAP	Aged Care Assessment Program
ACAT	aged care assessment team
ACE	adult community education
ACER	Australian Council for Educational Research
ACFI	aged care funding instrument
ACHS	Australian Council on Healthcare Standards
ACIR	Australian Childhood Immunisation Register
ACOSS	Australian Council of Social Services
ACSAA	Aged Care Standards and Accreditation Agency
ACSES	The Australian Council of State Emergency Services
ACSQHC	Australian Commission for Safety and Quality in Health Care
ACT	Australian Capital Territory
ADR	Alternative Dispute Resolution
AEDI	Australian Early Development Index

AFAC	Australasian Fire Authorities Council
AFP	Australian Federal Police
AGCCCS	Australian Government Census of Child Care Services
AGPAL	Australian General Practice Accreditation Limited
AGPN	Australian General Practice Network
AHCA	Australian Health Care Agreement
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHV	Aboriginal Housing Victoria
AIC	Australian Institute of Criminology
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AIJA	Australian Institute of Judicial Administration
AJJA	Australasian Juvenile Justice Administrators
ALLS	Adult Literacy and Life Skills
ANTA	Australian National Training Authority
ANZPAA	Australia and New Zealand Police Advisory Agency
AODTS-NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
AQF	Australian Qualifications Framework
AQTF	Australian Quality Training Framework
AR-DRG v 5.0	Australian refined diagnosis related group, version 5.0
ARHP	Aboriginal Rental Housing Program
ARIA	Accessibility and Remoteness Index for Australia

ARO	Authorised Review Officer
ASGC	Australian Standard Geographical Classification
ASO	ambulance service organisation
ASOC	Australian Standard Offence Classification
ASSNP	‘Core Activity Need for Assistance’
ATSB	Australian Transport Safety Bureau
Aust	Australia
AVETMISS	Australian Vocational Education and Training Management Information Statistical Standard
BBF	Building a Better Future
BEACH	Bettering the Evaluation and Care of Health
CAA	Council of Ambulance Authorities
CACP	Community Aged Care Package
CAD	computer aided dispatch
CAEPR	Centre for Aboriginal Economic Policy Research
CALD	culturally or linguistically diverse background
CAP	conditional adjustment payment
CAP	Crisis Accommodation Program
CAWG	Court Administration Working Group
CCB	Child Care Benefit
CCTR	child care tax rebate
CD-ROM	Compact Disc Read Only Memory
CDSMAC	Community and Disability Services Ministers’ Advisory Council
CFA	Country Fire Authority

CHIP	Community Housing and Infrastructure Program
CI	confidence interval
CIS	Complaints Investigation Scheme
COAG	Council of Australian Governments
CPG	Court Practitioners Group
CRA	Commonwealth Rent Assistance
CRC	COAG Reform Council
CRS	Commonwealth Rehabilitation Services
CRS	Complaints Resolution Scheme
CSDWG	Children's Services Data Working Group
CSHA	Commonwealth State Housing Agreement
CSMAC	Community Services Ministers' Advisory Council
CSTDA	Commonwealth State/Territory Disability Agreement
CURF	confidentialised unit record file
DCIS	ductal carcinoma in situ
DDHCS	Department of Disability, Housing and Community Services
DEEWR	Department of Education, Employment and Workplace Relations
DEST	Department of Education, Science and Training
DET	Department of Education (NSW)
DHAC	Department of Health and Aged Care
DHS	Department of Human Services (Vic)
DHSH	Department of Human Services and Health
DiRCS	Differences in Recorded Crime Statistics

DoCS	Department of Community Services (NSW)
DoHA	Department of Health and Ageing
DPIE	Department of Primary Industries and Energy
DSE	Department of Sustainability and Environment
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EACH-D	EACH Dementia
ECET	Early childhood, education and training
EMA	Emergency Management Australia
ERP	estimated resident population
ESO	emergency services organisation
EYL	early years learning
FaCS	Department of Family and Community Services
FaCSIA	Department of Families, Community Services and Indigenous Affairs
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FDC	family day care
FDCQA	Family Day Care Quality Assurance
FESA	Fire and Emergency Services Authority of WA
FNA	fine needle aspiration
FSO	fire services organisation
FTE	full time equivalent
FWE	full time workload equivalent
GDP	gross domestic product

GP	general practitioner
GPA Accreditation <i>plus</i>	General Practice Australia ACCREDITATION <i>plus</i>
GPII	General Practice Immunisation Incentives Scheme
GSP	gross state product
GSS	General Social Survey
GST	goods and services tax
HACC	Home and Community Care
HILDA	Household Income and Labour Dynamic Australia
HMAC	Housing Ministers' Advisory Council
HOIST	New South Wales Population Health Survey 2007
HREOC	Human Rights and Equal Opportunity Commission
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
ICD-10	International Classification of Diseases and Related Health Problems Revision 10
ICD-10-AM	Australian modification of the International Standard Classification of Diseases and Related Health Problems, version 10
ICH	Indigenous community housing
ICHO	Indigenous Community Housing Organisation
ICT	information and communication technology
IGA	Intergovernmental Agreement
IPD	Implicit Price Deflator
ISO	International Organisation for Standardisation
ISS	Inclusion Support Subsidy

JET	Jobs, Education and Training
JJNMDS	Juvenile Justice National Minimum Data Set
LBOTE	Language background other than English
LCL	lower confidence limit
LDC	long day care
LGCSA	Local Government Community Services Association of Australia
LMOs	local medical officers
LSAC	Longitudinal Study of Australian Children
MBI	Modified Barthel Index
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
MFS	Metropolitan Fire Service
MHENMDS	Mental Health Establishments National Minimum Data Set
MHS	mental health services
MPS	multi-purpose services
na	not available
NAHA	National Affordable Housing Agreement
NAP	National Assessment Program
NAPLAN	National Assessment Program – Literacy and Numeracy

NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NBCC	National Breast Cancer Centre
NBOCC	National Breast and Ovarian Cancer Centre
NCAC	National Childcare Accreditation Council
NCAG	National Corrections Advisory Group
NCCH	National Centre for Classification in Health
NCIRS	National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases
NCPASS	National Child Protection and Support Services data working group
NCSCH	National Cancer Statistics Clearing House
NCSIMG	National Community Services Information Management Group
NcSP	National Cervical Screening Program
NCVER	National Centre for Vocational Education Research
NEAT	Department of Natural Resources Environment and the Arts
NEHIPC	National E-Health Information Principal Committee
NESB	non-English speaking background
NHCDC	National Hospital Cost Data Collection
NHDC	National Health Data Committee
NHIMPC	National Health Information Management Principal Committee
NHMP	National Homicide Monitoring Program
NHMRC	National Health and Medical Research Council

NHPAC	National Health Priority Action Council
NHPC	National Health Performance Committee
NHS	National Health Survey
NIDP	National Information Development Plan
NISC	National Industry Skills Committee
NMDS	national minimum data set
NMHS	National Mental Health Strategy
NNDSS	National Notifiable Diseases Surveillance System
no.	number
NOOSR	National Office of Overseas Skills Recognition
NP	National Partnership
np	not published
NPPs	National Partnership Payments
NQC	National Quality Council
NRCP	National Respite for Carers Program
NRF	National Reporting Framework
NSCSP	National Survey of Community Satisfaction with Policing
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NSOC	National Senior Officials Committee
NSSC	National Schools Statistics Collection
NSW RFS	New South Wales Rural Fire Service
NSW	New South Wales
NSWFB	New South Wales Fire Brigade

NT	Northern Territory
NTES	National Territory Emergency Services
NTSC	National Training Statistics Committee
OCYFS	Office for Children, Youth and Family Support (ACT)
OECD	Organisation for Economic Co-operation and Development
OID	Overcoming Indigenous Disadvantage
OMP	other medical practitioners
OSHC	outside school hours care
OSHCQA	Outside School Hours Care Quality Assurance
PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
PDF	Portable Document Format
PhARIA	Pharmacy Access/Remoteness Index of Australia
PHCRIS	Primary Health Care Research and Information Service
PHOFAs	Public Health Outcome Funding Agreements
PIP	Practice Incentives Program
PISA	Program for International Student Assessment
PMRT	Performance Measurement and Reporting Taskforce
PSM	ABS Population Survey Monitor
PWI	personal wellbeing index
QFRS	Queensland Fire and Rescue Service
QIAS	Quality Improvement and Accreditation System
Qld	Queensland

RACGP	Royal Australian College of General Practitioners
RAV	Rural Ambulance Victoria
RCS	resident classification scale
RFDS	Royal Flying Doctor Service
ROSC	return of spontaneous circulation
RPBS	Repatriation Pharmaceutical Benefits Scheme
RPL	recognition of prior learning
RRMA	Rural, Remote and Metropolitan Areas
RSE	relative standard error
RTO	Registered Training Organisation
S/TEC	State Emergency Service/Territory Emergency Service
SA	South Australia
SAAP CAD	SAAP Coordination and Development Committee
SAAP NDCA	SAAP National Data Collection Agency
SAAP	Supported Accommodation Assistance Program
SAAS	SA Ambulance Services
SAR	service activity reporting
SAT	school-based apprenticeships and traineeship
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SCRGSP	Steering Committee for the Review of Government Service Provision
SDAC	Survey of Disability, Ageing and Carers
SE	standard error
SEM	standard error of the mean

SES	socioeconomic status
SES	State Emergency Services
SEWB	Social and Emotional Wellbeing
SIQ	standard Indigenous question
SLA	statistical local area
SMHWB	Survey of Mental Health and Wellbeing
SmR	standardised mortality ratios
SOMIH	state owned and managed Indigenous housing
SPPs	Specific Purpose Payments
SPRC	Social Policy Research Centre
SSAT	Social Security Appeals Tribunal
SWPE	standardised whole patient equivalent
TAFE	technical and further education
Tas	Tasmania
TAS	Tasmanian Ambulance Service
TCP	Transition Care Program
TFS	Tasmania Fire Service
TGR	total growth rate
TIMSS	Trends in International Mathematics and Science Study
TVET	technical and vocational education and training
UCC	user cost of capital
UCL	upper confidence limit
URTI	upper respiratory tract infection
USAR	Urban Search and Rescue

VDHS	Victorian Department of Human Services
VET	vocational education and training
VF	ventricular fibrillation
VHC	Veterans' Home Care
Vic	Victoria
VT	ventricular tachycardia
WA	Western Australia
WGIR	Working Group on Indigenous Reform
WHO	World Health Organisation

Glossary

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

Access Measures how easily the community can obtain a delivered service (output).

Appropriateness Measures how well services meet client needs and also seeks to identify the extent of any underservicing or overservicing.

Constant prices See ‘real dollars’.

Cost effectiveness Measures how well inputs (such as employees, cars and computers) are converted into outcomes for individual clients or the community. Cost effectiveness is expressed as a ratio of inputs to outcomes. For example, cost per life year saved is a cost effectiveness indicator reflecting the ratio of expenditure on breast cancer detection and management services (including mammographic screening services, primary care, chemotherapy, surgery and other forms of care) to the number of women’s lives that are saved.

Current prices See ‘nominal dollars’.

Descriptors Descriptive statistics included in the Report that relate, for example, to the size of the service system, funding arrangements, client mix and the environment within which government services are delivered. These data are provided to highlight and make more transparent the differences among jurisdictions.

Effectiveness Reflects how well the outputs of a service achieve the stated objectives of that service (also see program effectiveness).

Efficiency	Reflects how resources (inputs) are used to produce outputs and outcomes, expressed as a ratio of outputs to inputs (technical efficiency), or inputs to outcomes (cost effectiveness). (Also see ‘cost effectiveness’ and ‘technical efficiency’.)
Equity	Measures the gap between service delivery outputs or outcomes for special needs groups and the general population. Equity of access relates to all Australians having <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

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Attachment tables

Attachment tables are identified in references throughout this preface by an 'A' suffix (for example, table EA.3). A full list of attachment tables is provided at the end of this preface, and the attachment tables themselves are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

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

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

management issues: mental health and breast cancer (chapter 12). These services are selected for reporting as they:

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

The Australian, State, Territory and local governments spent \$51.3 billion (expressed in 2006-07 dollars) on public hospitals, medical services (including payments to general practitioners [GPs] and other specialist practitioners), community and public health, medications and public dental services in 2006-07. These areas of health care activity accounted for 84.9 per cent of government recurrent health expenditure in 2006-07 (table EA.4). Total public health expenditure by Australian and State and Territory governments on breast cancer screening was \$134 million in 2006-07 (table 12A.6). This includes funding by the Australian Government to states and territories through the Public Health Outcome Funding Agreements (PHOFAs). There are no specific estimates of government expenditure on the management of breast cancer for 2006-07, as reliable estimates have not yet been developed. Government recurrent expenditure on specialist mental health services was estimated to be around \$4.5 billion in 2006-07 (tables 12A.35 and 12A.36). Some of this expenditure was on psychiatric care provided by public (non-psychiatric) hospitals (chapters 10 and 12).

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

Box E.1 Some common health terms

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

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

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

Primary health care: services that:

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

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

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

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

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

Other government services — such as education, public housing, sanitation and water supply — also influence health outcomes. These are not formally part of Australia's health system and are not the subject of the health chapters. Education

(chapters 4 and 5) and public and community housing (chapter 16) are included in other chapters of the Report.

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

Profile of health services

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

Roles and responsibilities

The Australian Government's health services activities include:

- funding States and Territories through the Australian Health Care Agreements to deliver public hospital services
- providing rebates to patients for medical services provided by GPs and specialists and delivering public health programs
- funding the PBS
- funding high level residential aged care services
- funding private health insurance rebates
- funding for improved access to primary health care, specialist services and infrastructure for rural and remote communities
- funding Indigenous-specific primary health
- promulgating and coordinating health regulations
- undertaking health policy research and policy coordination across the Australian, State and Territory governments
- funding hospital services and the provision of other services through the Department of Veterans' Affairs
- funding the Medicare Safety Net.

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

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

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

Funding

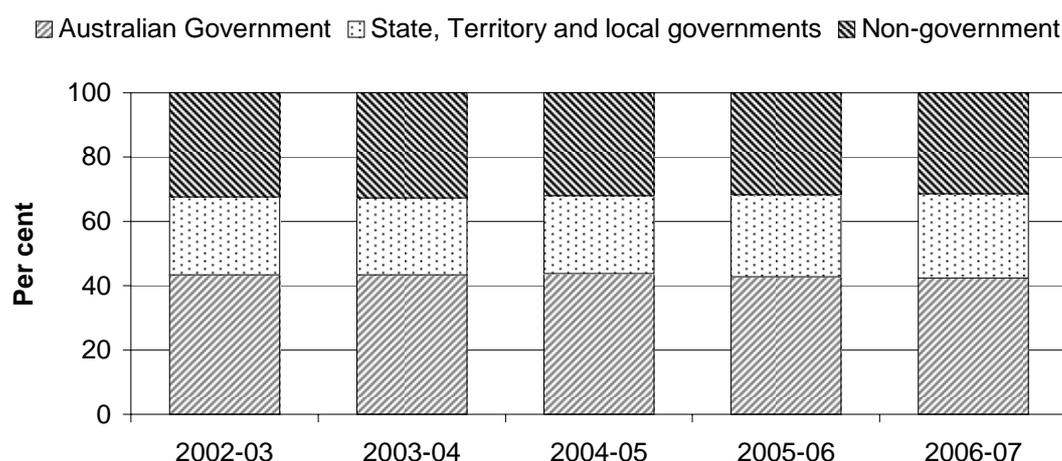
Funding the components of Australia's health care system is a complicated process. The Australian Government subsidises many of the services provided by the non-government sector (mostly through the MBS, the PBS, the private health insurance rebate and the Medicare Safety Net) and contributes funding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

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

insurance funds and other non-government institutions also contribute funding to a range of health care providers, both government and non-government.

In 2006-07, the Australian, State, Territory and local governments spent \$64.5 billion on health services, which represents 68.7 per cent of total health expenditure. The Australian Government accounted for the largest proportion of health care expenditure in Australia — \$39.9 billion or 42.4 per cent of the total in 2006-07. State, Territory and local governments contributed \$24.7 billion or 26.2 per cent of total health expenditure in that year [Australian Institute of Health and Welfare (AIHW) 2008d)]. These shares have remained relatively constant over the past 10 years. The remainder was paid by individuals, health insurance funds and workers compensation and compulsory motor vehicle third party insurance providers (figure E.1 and tables EA.1 and EA.7).

Figure E.1 Total health expenditure, by source of funds (2006-07 dollars)^{a, b, c, d}



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

Source: AIHW (2008) *Health Expenditure Australia 2006-07*, Cat. no. HWE 42, Health and Welfare Expenditure Series no. 35, AIHW, Canberra; table EA.1.

Size and scope of sector

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be \$94.0 billion in 2006-07 (table EA.1). This total was estimated to account for 9.0 per cent of gross domestic product in 2006-07, the same percentage as the previous year and an increase of 1.3 per cent from the 7.7 per cent of GDP in

1996-97 (AIHW 2008d). This indicates that health expenditure grew faster than the economy as a whole over the decade to 2006-07.

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 1996-97 and 2006-07, the average annual rate of growth in real expenditure was 4.9 per cent for the Australian Government, 5.2 per cent for State, Territory and local governments, and 3.9 per cent for non-government sources (AIHW 2008d).¹

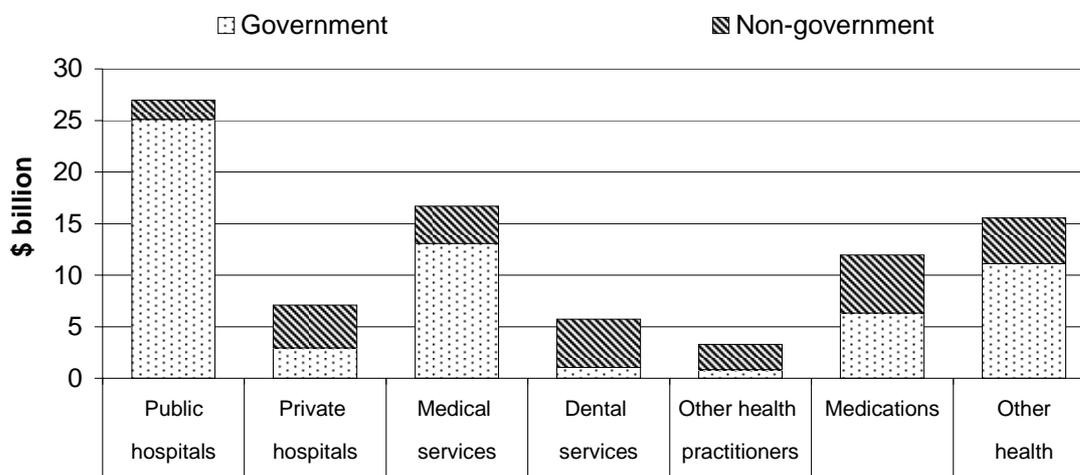
The introduction of programs supporting private health insurance was a significant factor in the increase in expenditure by the Australian Government in the late 1990s. On 1 January 1999, the Australian Government replaced the Private Health Insurance Incentive Scheme with a 30 per cent rebate on private health insurance premiums. Australian Government expenditure on the rebate has increased each year from \$2.3 billion in 2002-03 to \$3.5 billion in 2006-07 in current prices (that is, not adjusted for inflation) (AIHW 2008d).

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

Public hospitals were the single largest item of recurrent health care expenditure by government and non-government sources in 2006-07. Total real expenditure on public hospitals (which excludes expenditure on community and public health services, dental and ambulance services and health research undertaken by public hospitals) was \$27.0 billion, of which governments paid \$25.1 billion (figure E.2). Public hospitals accounted for 41.5 per cent of government recurrent expenditure on health care services in 2006-07. Medical services accounted for \$13.1 billion of government expenditure (21.6 per cent of total health expenditure) and medications accounted for \$6.3 billion (10.4 per cent) (table EA.2).

¹ There was a break in series due to differences in definitions of public hospital and public hospital services between 2002-03 and 2003-04.

Figure E.2 **Recurrent health expenditure, by area of expenditure, 2006-07**^{a, b, c, d, e, f}



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

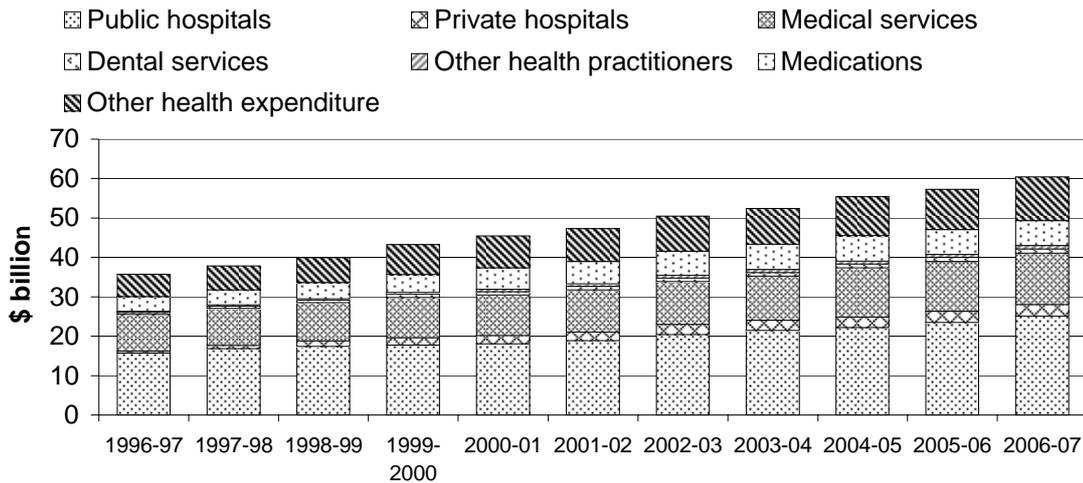
Source: AIHW (2008) *Health Expenditure Australia 2006-07*, Cat. no. HWE 42, Health and Welfare Expenditure Series no. 35, AIHW, Canberra; tables EA.2 and EA.3.

The relative share of government recurrent health expenditure allocated to public hospitals has fallen from 44.1 per cent in 1996-97 to 41.5 per cent in 2006-07. 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 19.6 per cent between 1996-97 and 2006-07 (albeit from a relatively low base), compared with 5.3 per cent for medications and 4.8 per cent for public hospitals (table EA.2). 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 expenditure on private hospitals meant it also grew as a proportion of government health care expenditure over the period 1996-97 to 2006-07. Government expenditure on private hospitals increased from 1.4 per cent

of government health expenditure in 1996-97 to 4.8 per cent in 2006-07, while the proportion of expenditure on medication slightly decreased from 10.5 per cent to 10.4 per cent over the same period (table EA.2).

Figure E.3 Government recurrent expenditure, by area of expenditure (2006-07 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 13. ^d Other health expenditure includes community and public health services, funding for aids and appliances, administration, private hospitals, ambulance services (reported in chapter 9), research, dental services and public psychiatric hospitals. ^e Real (constant price) estimates have been calculated by applying the AIHW total health price index (table EA.7).

Source: AIHW (2008) *Health Expenditure Australia 2006-07*, Cat. no. HWE 42, Health and Welfare Expenditure Series no. 35, AIHW, Canberra; table EA.2.

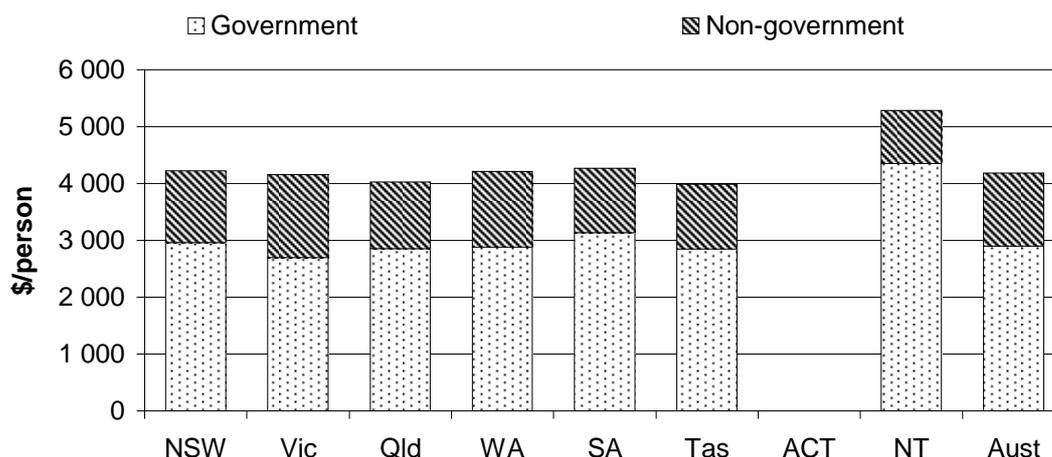
Health expenditure per person

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 2006-07 (expressed in 2006-07 dollars) was \$4508 (table EA.5). Total health expenditure per person in Australia increased from \$4283 in 2002-03 to \$4508 in 2006-07 (expressed in 2006-07 dollars) (table EA.5). The average annual growth rate in average health expenditure per person (expressed in 2006-07 dollars) from 2002-03 to 2006-07 was 1.3 per cent (table EA.5).

Government real recurrent health expenditure per person in Australia increased from \$2774 in 2002-03 to \$2897 in 2006-07 (expressed in 2006-07 dollars). Non-government recurrent expenditure per person in Australia rose from \$1270 in

2002-03 to \$1288 in 2006-07 (expressed in 2006-07 dollars) (figure E.4 and table EA.6).

Figure E.4 Recurrent health expenditure per person by source of funds, excluding high level residential aged care, 2006-07 (2006-07 dollars)^{a, b, c}



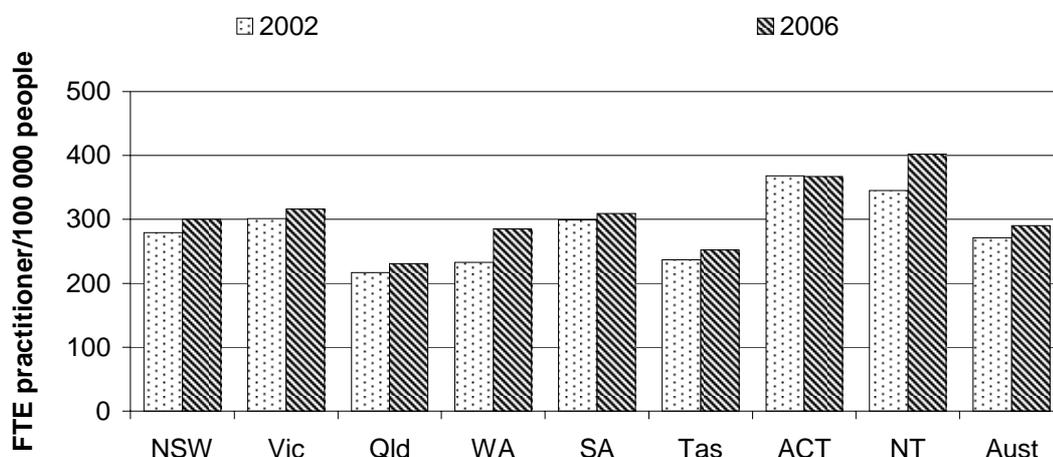
^a Includes expenditure on high level residential aged care (reported in chapter 13) and ambulance services (reported in chapter 9). ^b Government expenditure includes expenditure by the Australian, State, Territory and local governments. ^c ACT per person figures are not calculated, as the expenditure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

Source: AIHW (2008) *Health Expenditure Australia 2006-07*, Cat. no. HWE 42, Health and Welfare Expenditure Series no. 35, AIHW, Canberra; table EA.6.

Health workforce

In 2006, there were 62 425 registered medical practitioners in Australia working in medicine. A further 1263 were in the medical labour force but on extended leave or looking for work. The majority of employed practitioners working in medicine were clinicians (93.2 per cent), of whom 39.5 per cent were primary care practitioners (mainly general practitioners), 34.8 per cent were specialists, 13.1 per cent were specialists-in-training, 11.3 per cent were hospital non-specialists and 1.3 per cent were other clinicians (AIHW 2008a). The number of full time equivalent (FTE) practitioners per 100 000 people by jurisdiction is illustrated in figure E.5.

Figure E.5 **Employed medical practitioners^{a, b}**

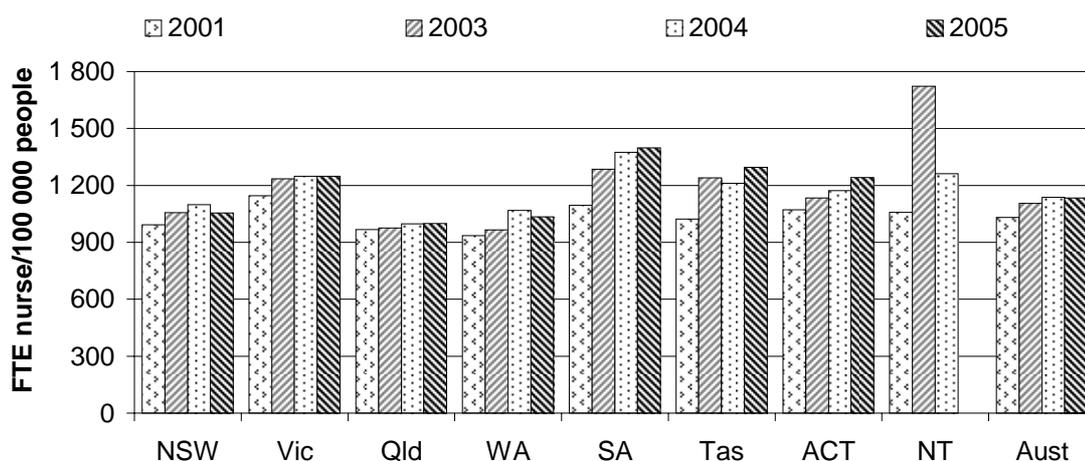


^a FTE practitioner rate (per 100 000 people) based on a 45-hour week. ^b Number of 'employed medical practitioners' does not include medical practitioners on extended leave.

Source: AIHW (2008) *Medical labour force 2006*, Cat. no. HWL 42, National Health Labour Force Series no. 41, AIHW, Canberra; table EA.8.

The number of FTE nurses per 100 000 people by jurisdiction is illustrated in figure E.6. The national increase in the FTE nurse rate in Australia arose from both an increase in the number of nurses employed and an increase in average hours worked (AIHW 2008b).

Figure E.6 **Employed nurses^{a, b, c}**



^a FTE nurse rate (per 100 000 people) based on a 35-hour week. ^b Number of 'employed nurses' does not include nurses on extended leave. ^c Data for the NT for 2005 are not available.

Source: AIHW (2008) *Nursing and midwifery labour force 2005*, AIHW Cat. no. HWL 40, National Health Labour Force Series no. 39, Canberra; AIHW (2005) *Nursing and midwifery labour force 2003*, AIHW Cat. no. HWL 31, National Health Labour Force Series no. 31, Canberra; table EA.9.

Overview of Indigenous health

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

Data are reported against several of these indicators for Indigenous Australians as well as for all Australians. The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. The AIHW (2005) report *Improving the Quality of Indigenous Identification in Hospital Separations Data* found that Indigenous patient data was of acceptable quality for analytical purposes only for Queensland, WA, SA, and public hospitals in the NT. Following new assessments of the quality of Indigenous identification in 2007, the National E-Health Information Principal Committee (NEHIPC) has approved NSW Indigenous patient data as acceptable in quality for analytical purposes, from the 2004-05 reference year. NEHIPC has also approved Victorian data as acceptable from 2004-05, but data were not reported for the years prior to 2006-07. Efforts to improve Indigenous identification across states and territories are ongoing.

The reported data are not necessarily representative of other jurisdictions. Because of improvements in data quality over time, caution also should be used in time series analysis of the data.

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

A number of recent publications include more comprehensive data on the health status of Indigenous people and Indigenous health-related factors. These include *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* [Australian bureau of Statistics (ABS) and AIHW 2008], *Aboriginal and Torres Strait Islander Health Performance Framework 2006 Report: Detailed Analysis* (AIHW 2007), *Overcoming Indigenous Disadvantage: Key Indicators 2007* (SCRGSP 2007) and *Australia's Health 2008* (AIHW 2008c).

Contributing factors

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

There are relatively low education levels among Indigenous people. Indigenous school retention rates remain considerably lower than those for non-Indigenous school students, although the disparity between the two groups is slowly lessening. (ABS and AIHW 2008). In 2007, the apparent retention rate for Indigenous full-time students from years 7 and 8 to year 10 was 91 per cent and to year 12 was 43 per cent. This compares with apparent retention rates for non-Indigenous students of almost 100 per cent to year 10 and 76 per cent to year 12. Indigenous retention to year 10 and beyond has steadily increased over last 10 years from 83 per cent in 1998 to 91 per cent in 2007. This trend is particularly evident at the year 11 level, where the apparent retention from years 7 and 8 rose from 52 per cent to 70 per cent in 2007 (see chapter 4, table 4A.123).

Indigenous people have relatively low employment and income levels that may create financial barriers to accessing health services. Average weekly income for Indigenous people was \$548.97 in 2006, while the weekly income for non-Indigenous people was \$769.07 (see Statistical appendix tables AA.2, AA.7, AA.16 and AA.17). Between 2001 and 2006, the unemployment rate for Indigenous people aged 15–64 years decreased from 20 per cent to 16 per cent. However, the unemployment rate for Indigenous Australians was still three times the rate for non-Indigenous Australians (16 per cent compared with 5 per cent), similar to the rate ratios from the 2001 Census (20 per cent compared with 7 per cent) (ABS 2007d).

There are high imprisonment rates among Indigenous people. Indigenous prisoners represented 25 per cent of the total prisoner population (see chapter 8, table 8A.1). After adjusting for age differences, the Indigenous imprisonment rate was 1630 per 100 000 adult Indigenous population, 13 times the non-Indigenous rate at 30 June 2008 (see chapter 8, table 8A.4). High imprisonment rates may contribute to poorer health status of Indigenous people.

Indigenous people have relatively high rates for health risk factors such as obesity, smoking, substance abuse and violence. In 2004-05, 50 per cent of Indigenous people aged 18 years and over were daily cigarette smokers. In 2004-05, while Indigenous adults were twice as likely to have abstained from alcohol consumption in the last 12 months, as compared with the non-Indigenous population, over half of

Indigenous adults (55 per cent) reported drinking alcohol at short term risky to high risk levels at least once in the last 12 months.² Around 16 per cent (similar to the proportion of non-Indigenous people) reported long term risky to high risk alcohol consumption in the week prior to interview (where long term risky to high risk alcohol consumption equates to average daily consumption of more than 50 millilitres per day for males and more than 25 millilitres per day for females for the previous seven days prior to interview). During 2004-05, Indigenous people were more than four times as likely to be in hospital for alcohol-related mental and behavioural disorders as other people (SCRGSP 2007).³

Geographic distance to health services, particularly in remote and very remote areas, contributes to health disadvantage of Indigenous people. In 2006, a total of 417 (35 per cent) discrete Indigenous communities⁴ were located 100 kilometres or more from the nearest Aboriginal Primary Health Care Centre and of those, 92 (22 per cent) were larger communities with a population of 50 or more people. A total of 372 discrete Indigenous communities (31 per cent) were located 100 kilometres or more from the nearest community health centre and of these, 90 (24 per cent) were larger communities. A total of 755 (64 per cent) discrete Indigenous communities were located 100 kilometres or more from the nearest hospital. On a population basis, 25 per cent of Aboriginal and Torres Strait Islander people living in communities were 100 kilometres or more from the nearest hospital (ABS 2007b).

Many Indigenous people live in inadequate and overcrowded housing, particularly in remote and very remote areas. There were around 20 700 overcrowded Indigenous households (14 per cent) and 102 400 Indigenous people (27 per cent) living in overcrowded conditions in 2006. There has been some improvement in rates of overcrowding, with the proportion of Indigenous households that were overcrowded decreasing from 16 per cent in 2001 to 14 per cent in 2006 (ABS and AIHW 2008).

² Short term risky to high risk alcohol consumption is mainly associated with ‘binge’ drinking. The National Health and Medical Research Council (NHMRC) Australian Alcohol Guidelines (2001) on which the definitions of risky and high risk drinking are based, are currently under revision.

³ Short term risk is the risk of harm in short term associated with given levels of alcohol consumption on any one occasion. Long term risk is associated with regular daily patterns of alcohol consumption and defined by the average daily intake of alcohol over the seven days of the reference week.

⁴ A geographic location, bounded by physical or cadastral (legal) boundaries, and inhabited or intended to be inhabited predominantly (i.e. greater than 50 per cent of usual residents) by Aboriginal or Torres Strait Islander peoples, with housing or infrastructure that is managed on a community basis.

Government policies and programs

The majority of government expenditure on Indigenous health is made through mainstream health programs (AIHW 2008e). In addition, the Australian, State and Territory governments fund Indigenous-specific health programs and undertake coordination and research activities. Indigenous people are high users of public hospital and community health services, and comparatively low users of medical, pharmaceutical, dental and other health services which are mostly privately provided.

Most Australian Government expenditure on Indigenous-specific health programs is directed to primary health. State and Territory governments fund a range of community and public health programs that specifically target Indigenous people within their jurisdictions (see chapter 11).

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

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

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

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

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

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

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

Expenditure

It is not always possible to make accurate estimates of health expenditure for Indigenous people and their corresponding service use. For example, Indigenous status is not always clearly stated or recorded. Data on Indigenous status are often unavailable for privately funded services (although they are available for many publicly funded health services).

The scope and definition of health expenditure also have some limitations. For the Indigenous health expenditure data presented below, health covers those services that are directed mainly towards improving health and/or reducing the effects of illness or injury. That is a relatively narrow definition which excludes a number of supportive ‘welfare’ services and the impact of living conditions on health, for example, housing, sanitation and nutrition. There are also other (non-health) agency contributions to health expenditure, such as those incurred within education departments and prisons, that are not included.

Indigenous health expenditure can also be difficult to identify, as the majority of health expenditure on Indigenous people is allocated through mainstream health programs — admitted and non-admitted patient services, community health services, medical and medications health services, and public health services. A small proportion of health expenditure is allocated through programs directly targeting Indigenous people, the most significant being the Aboriginal and Torres Strait Islander Health Care Services. In total, approximately one-fifth of the estimated health expenditure for Indigenous people in 2004-05 came from programs that were specifically designed for them. There may also be some inconsistencies across data providers resulting from limitations of financial reporting systems and different reporting mechanisms (AIHW 2008e).

The most recent estimates of health services expenditure for Indigenous people are for 2004-05 (AIHW 2008e). Between 1995-96 and 2004-05 there has been little change in the per person health expenditure ratio for Indigenous people compared to non-Indigenous people. Total recurrent government and non-government expenditure on health services for Indigenous people was estimated at \$2304 million in 2004-05 or 2.8 per cent of national expenditure on health services, the same proportion as for 2001-02. In 2004-05, \$1.17 per person was spent on Indigenous health for every \$1.00 spent on the health of non-Indigenous Australians. Average total health expenditure per Indigenous person was \$4718 compared with \$4019 per person estimated for non-Indigenous Australians (table E.1). The three largest categories of health expenditure were hospitals, medical services and medications. Together they accounted for 66.7 per cent of all

Australian health expenditure in 2004–05 and 58.8 per cent of the spending that was allocated to Indigenous people (table E.1).

Expenditure per person on public hospitals for Indigenous people was around twice that for non-Indigenous people for both admitted and non-admitted patient services. Conversely, expenditure on medical services, dental and other health practitioners and medications were less than half those for non-Indigenous people. Expenditure on aids and appliances were 29 per cent of the non-Indigenous average. However, spending on community health services was over six and a half times that for other Australians and expenditure for both patient transport and public health were well above the national average (table E.1). Indigenous people tend to rely disproportionately on public hospitals for reasons of access, cost and culture as well as health. In many of the areas where Indigenous people live, hospital admission is the only practical way of delivering anything but the simplest services, and hospital emergency rooms are the most accessible source of affordable medical treatment, including GP-type care. Indigenous people were admitted to public hospitals at nearly two and a half times the rate for non-Indigenous Australians (AIHW 2008e).

Table E.1 Total expenditure on health services for Indigenous and non-Indigenous people, by type of health good or service, current prices, Australia, 2004-05

<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	1 080.7	27 337.6	3.8	2 213	1 386	1.60
Public hospital ^a	1 048.6	21 042.7	4.7	2 147	1 067	2.01
Admitted patient services	799.4	16 226.8	4.7	1 637	823	1.99
Non-admitted patient services	249.2	4 815.8	4.9	510	244	2.09
Private hospital	32.1	6 295.0	0.5	66	319	0.21
High-level residential care	41.7	6 283.4	0.7	85	319	0.27
Patient transport	103.5	1 369.9	7.0	212	69	3.05
Medical services	164.6	14 483.5	1.1	337	734	0.46
Community health services	497.8	3 052.7	14.0	1 019	155	6.59
Dental and other health practitioners	78.0	7 811.8	1.0	160	396	0.40
Medications	109.4	11 056.4	1.0	224	561	0.40
Aids and appliances	18.6	2 591.4	0.7	38	131	0.29
Public health	88.9	1 350.3	6.2	182	68	2.66
Research	46.0	1 669.0	2.7	94	85	1.11
Health administration (nec)	74.6	2 254.5	3.2	153	114	1.34
Total	2 304.0	79 260.4	2.8	4 718	4 019	1.17
Population (2004-05 estimate)	488 335	19 721 423	2.5			

^a Public hospital services exclude any dental services, community health services, patient transport services, public health and health research undertaken by the hospital.

Source: AIHW (2008) *Expenditure on Health for Aboriginal and Torres Strait Islander Peoples 2004-05*, Cat. no. HWE 40, Health and welfare expenditure series no. 32, AIHW, Canberra.

Ninety-three per cent of spending was through programs managed by governments, and 67 per cent was managed by State and local governments. Indigenous people made proportionally lower use of purely private services. That was an entirely different pattern from that for non-Indigenous Australians, for whom the three sources of supply were almost equally important (table E.2).

Table E.2 Total expenditure on health for Indigenous people, by program, 2004-05

<i>Management</i>	<i>Indigenous</i>		<i>Non-Indigenous</i>	
	<i>Total expenditure (\$ million)</i>	<i>Per cent</i>	<i>Total expenditure (\$ million)</i>	<i>Per cent</i>
Through State and local government programs	1 537.1	66.7	26 844.1	33.9
Through Australian Government programs ^a	604.7	26.2	28 163.4	35.5
<i>Total through Government programs</i>	<i>2 141.8</i>	<i>93.0</i>	<i>55 007.4</i>	<i>69.4</i>
Through non-government arrangements	162.2	7.0	24 253.0	30.6
Total	2 304.0	100.0	79 260.4	100.0

^a Patient co-payments under Medicare and PBS (\$19.2 million Aboriginal and Torres Strait Islander peoples, \$2766.4 million non-Indigenous)

Source: AIHW (2008) *Expenditure on Health for Aboriginal and Torres Strait Islander Peoples 2004-05*, Cat. no. HWE 40, Health and welfare expenditure series no. 32, AIHW, Canberra.

Spending through Australian Government programs was slightly lower per person for Indigenous people than for other Australians, while spending through State and local government programs for Indigenous people was 2.3 times that for non-Indigenous people. This reflects Indigenous people's greater reliance on public hospitals and community health services than on the services of private medical and pharmaceutical providers with which the Australian Government is more involved (table E.3).

Table E.3 Expenditure per person on health services, by program, 2004-05

<i>Management</i>	<i>Indigenous</i>	<i>Non-Indigenous</i>	<i>Ratio</i>
Through State and local government programs	3 148	1 361	2.31
Through Australian Government programs ^a	1 238	1 428	0.87
<i>Total through Government programs</i>	<i>4 386</i>	<i>2 789</i>	<i>1.57</i>
Through non-government arrangements	332	1 230	0.27
Total	4 718	4 019	1.17

^a Patient co-payments under Medicare and PBS (\$39 per Aboriginal and Torres Strait Islander person, \$140 per non-Indigenous person) are included here, but note they are shown elsewhere in this report as expenditure incurred by the non-government sector.

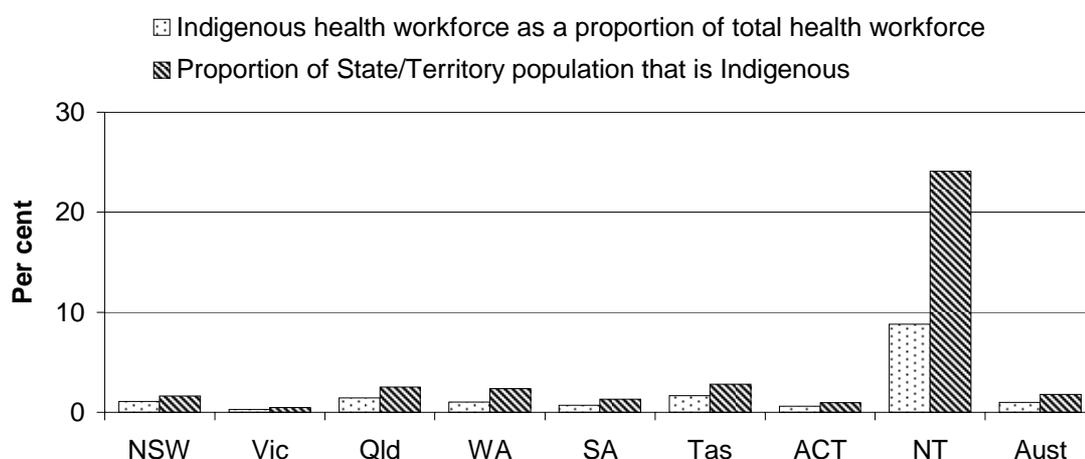
Source: AIHW (2008) *Expenditure on Health for Aboriginal and Torres Strait Islander Peoples 2004-05*, Cat. no. HWE 40, Health and welfare expenditure series no. 32, AIHW, Canberra.

Indigenous health workforce

Indigenous people aged 15 years and over were under-represented in almost all health-related occupations, in 2006 (ABS and AIHW 2008). This can potentially contribute to Indigenous peoples' reduced access to health services. One patient satisfaction survey found that the presence of an Indigenous doctor at a community health centre was a main reason for Indigenous people attending the clinic. In addition, the number of Indigenous patients attending the clinic increased markedly following the arrival of the Indigenous doctor and other changes in the service designed to make it more welcoming. Patients reported that an Indigenous doctor was 'more understanding of their needs' (DoHA 2006b).

In 2006, Indigenous people accounted for 1.0 per cent of the health workforce, but were 1.8 per cent of the total population (aged 15 years and over). Indigenous health workers are under-represented in each State and Territory (figure E.7).

Figure E.7 **Indigenous health workforce as a proportion of total health workforce, by jurisdiction, 2006^{a, b, c}**

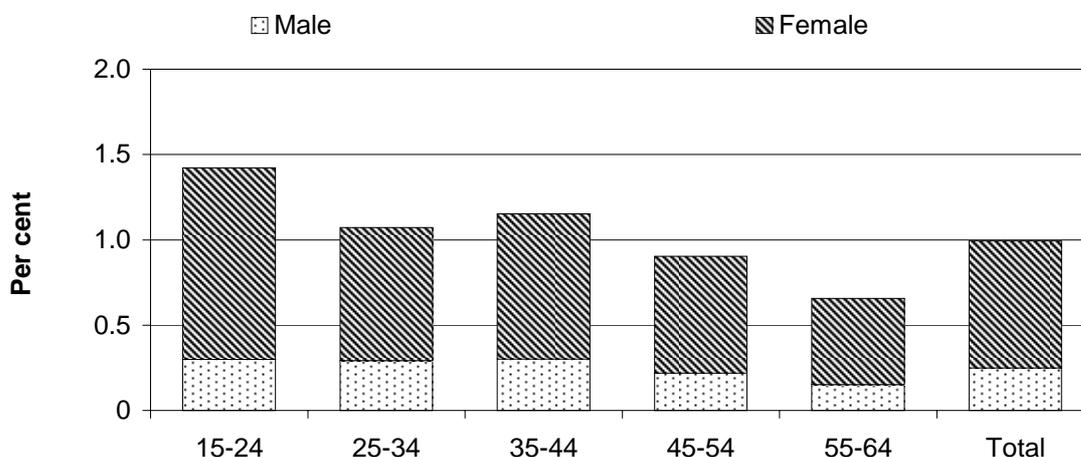


^a Aged 15 years and over. ^b Cells in this table have been randomly adjusted to avoid the release of confidential data. ^c Australian total data includes other territories.

Source: ABS (unpublished), ABS (2007) *2006 Census of Population and Housing*, Canberra; table EA.10.

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

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



Source: ABS (unpublished), 2006 Census of Population and Housing; table EA.11.

Indigenous health workforce by occupation

In 2006, there were 100 Indigenous people working as medical practitioners and 1223 Indigenous people working as midwifery and nursing professionals (table E.4).

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

Table E.4 **Indigenous persons employed in selected health-related occupations (per cent), 2006^{a, b}**

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

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

Source: ABS (unpublished), *2006 Census of Population and Housing*; table EA.12.

Self-assessed health

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

Data quality

Good quality data are needed to assess the effectiveness of programs and to evaluate policies designed to improve health services and outcomes for Indigenous people. Despite recent improvements, the quality of estimates of Indigenous health information is limited by problems with the underlying data. Some of the problems associated with Indigenous health data are outlined in (ABS 2007a), and (ABS and AIHW 2008) 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.

- Inconsistent data definitions and differences in the accuracy of identifying Indigenous status have led 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.

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.

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 provide a variety of services in different settings to fulfil these objectives.

Measuring the effectiveness, equity and efficiency of Australia's health system is a complex task. It must account for the performance of a range of services (such as prevention and medical intervention) and of service providers (such as community health centres, GPs and public hospitals), and account for the overall outcomes generated by the health system. The appropriate mix of services — including the prevention of illness and injury, and medical treatment (prevention versus medical

intervention) — and the appropriate mix of service delivery mechanisms (community-based versus hospital-based) play an important role in determining outcomes. Other relevant factors are external to the health system, such as the socioeconomic and demographic characteristics of the population, available infrastructure and the environment.

Box E.2 Overall objectives of the health system

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

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

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

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

Medical intervention strategies are implemented after a diagnosis.

The former National Health Performance Committee developed the National Health Performance Framework to guide the reporting and measurement of health service performance in Australia. A number of groups involved in health performance indicator development have adopted this framework for use within specific project areas and in publications.

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

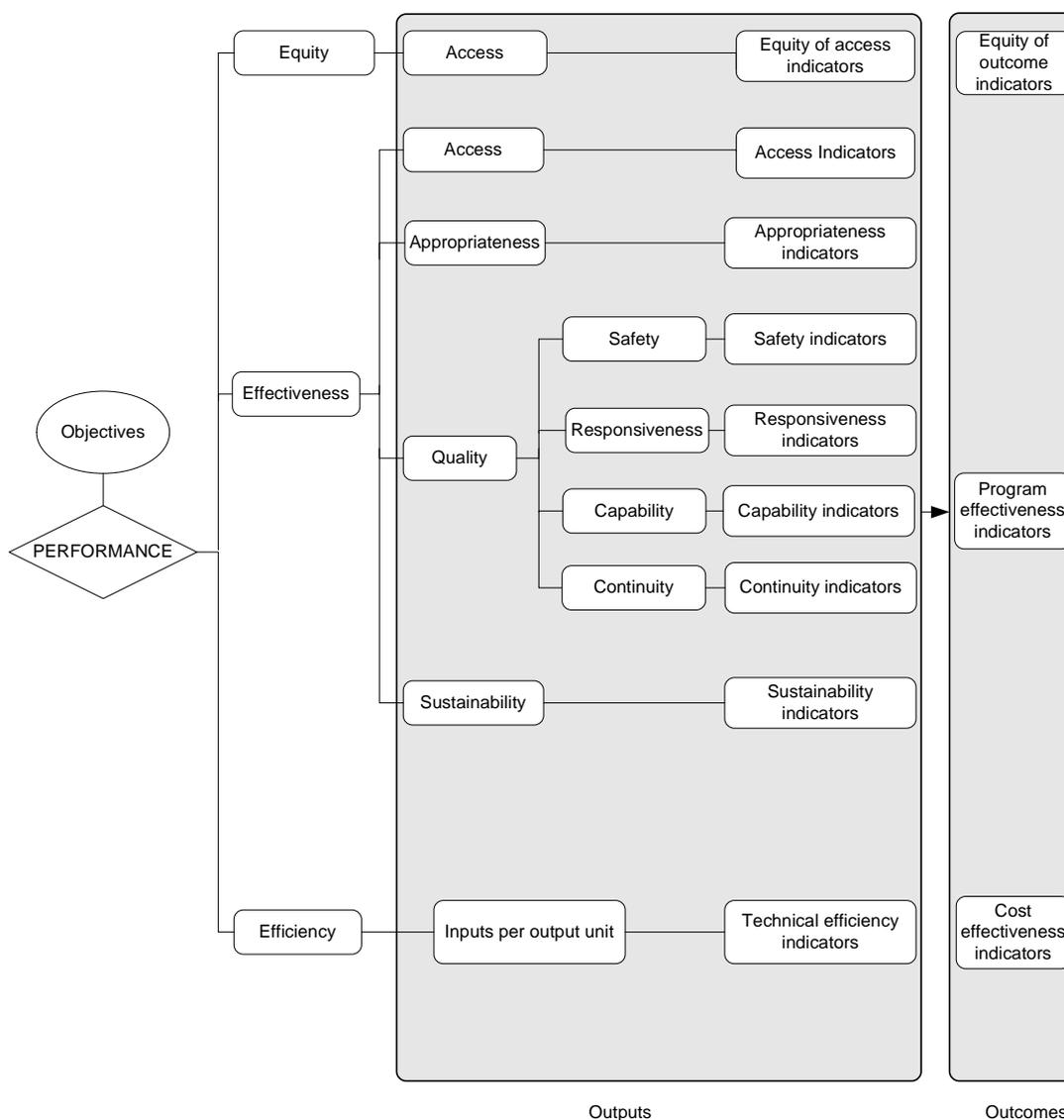
dimensions of the health system in the National Health Performance Framework that were not explicitly covered in the general Review framework:

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

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

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

Figure E.9 Performance indicator framework for health services



Selected indicators of health outcomes

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

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

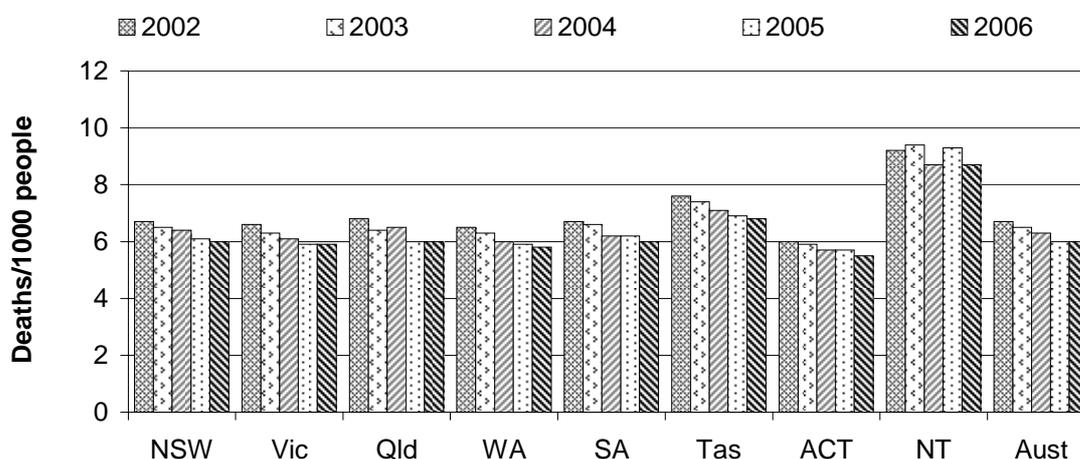
Data on health outcomes presented in this preface include self-assessed health status, mortality rates (for infants and all people), causes of death, life expectancy at birth, median age at death and birthweight. Where possible, data are presented for Indigenous people as well as the Australian population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

Mortality rates

Most components of the health system can influence mortality rates, although there may be a delay 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 133 700 deaths in Australia in 2006 (ABS 2007a), which translated into an age standardised mortality rate of 6.0 per 1000 people (figure E.10). Death rates over the last 20 years have declined for all states and territories (ABS 2007a).

Figure E.10 **Mortality rates, age standardised^a**



^a Deaths per 1000 standard population. Standardised death rates use total persons in the 2001 Australian population as the standard population.

Source: ABS (2007) *Deaths 2006, Australia*, Cat. no. 3302.0, ABS, Canberra; table EA.13.

Indigenous mortality rates

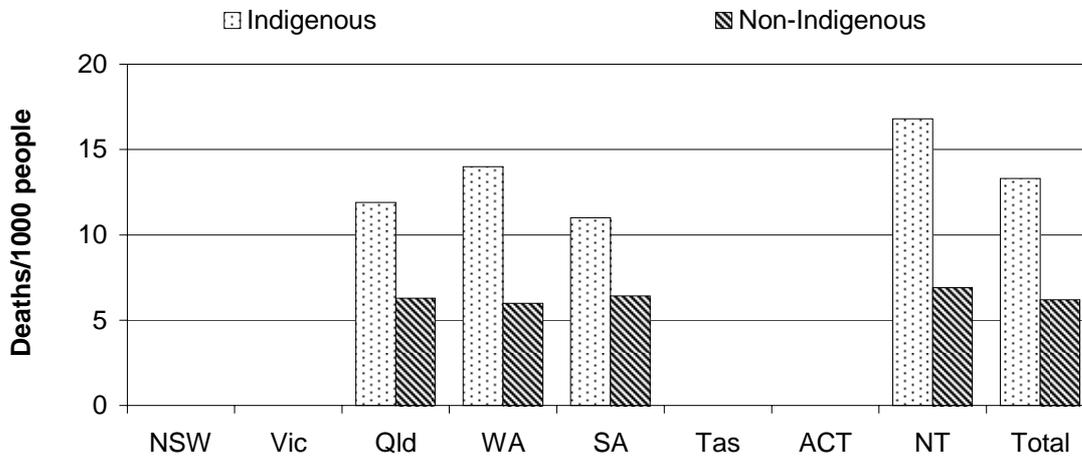
Data on Indigenous mortality are collected through State and Territory death registrations. The completeness of the identification of Indigenous Australians in these collections varies significantly across states and territories. Because of this variation, care is required in making comparisons on the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

Due to the relatively small number of Indigenous deaths and the consequent volatility in annual mortality rates, the data are presented for the five year period 2002–2006. To improve the comparability of age-related mortality rates, indirect age standardisation methods have been used for both the Indigenous and total population rates.

The NT, WA, SA and Queensland in that order are generally considered to have the best coverage of death registrations for Indigenous people.⁵ For these four jurisdictions combined, the overall rates of mortality for Indigenous people were just over twice as high as mortality rates for non-Indigenous people in 2002–2006 (figure E.11 and table EA.13). The exact magnitude of this difference cannot be established at this time due to variable identification of Indigenous Australians in death records. Reported mortality rates under-estimate the true mortality of Indigenous Australians (ABS and AIHW 2008).

⁵ The term ‘coverage’ refers to the number of Indigenous deaths registered as a percentage of the number of expected deaths based on the 2001 Census based experimental Indigenous population estimates and projections.

Figure E.11 Mortality rates, age standardised, by Indigenous status, five year average, 2002–2006^{a, b, c, d}



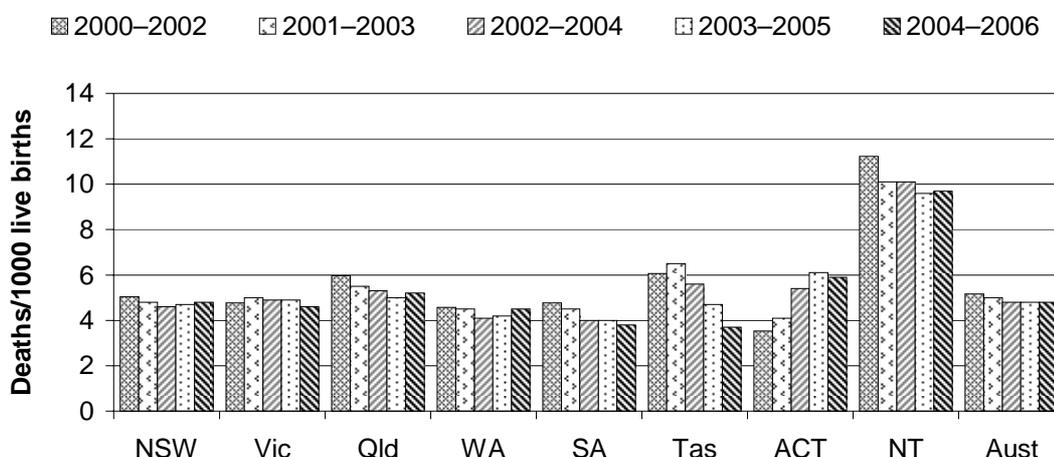
^a Deaths per 1000 standard population. Standardised death rates use total persons in the 2001 Australian population as the standard population. ^b Total, Indigenous and non-Indigenous mortality rates are for Queensland, WA, SA and NT combined. ^c Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians 1991 to 2009 (ABS cat. no. 3238.0, low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for comparison with the Indigenous population are derived by subtracting Indigenous population projections from total Estimated Resident Population and should be used with care, as these data include deaths and population units for which Indigenous status were not stated. ERP used in calculations are final ERP based on 2006 Census. ^d Includes non-Indigenous and not stated Indigenous status.

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

Infant mortality rates

The infant mortality rate is defined as the number of deaths of children under 1 year of age in a calendar year per 1000 live births in the same year. Infant mortality rates are presented in this Report as an average over three years to reduce the volatility inherent in the annual rates due to small numbers and annual fluctuations. The infant mortality rate in Australia declined from 5.2 deaths per 1000 live births over the period 2000–2002 to an average of 4.8 deaths per 1000 live births over the period 2004–2006 (figure E.12).

Figure E.12 Infant mortality rate, three year average^{a, b}



^a Figures for Australia include 'other territories'. ^b Four infant deaths were coded to an incorrect state of usual residence in 2005, which led to the revision of the rate of the ACT.

Source: ABS (2007) *Deaths 2006, Australia*, Cat. no. 3302.0, ABS, Canberra.; table EA.14.

Indigenous infant mortality rates

For the period 2004–2006, the average infant mortality rate for Indigenous children is publishable for NSW, Queensland, WA, SA and the NT. Although the small numbers involved affect the ability to detect significant changes in Indigenous infant mortality, it is clear that Indigenous infant mortality rates are markedly higher than the average for all Australians (tables EA.14 and EA.15).

Principal causes of death

The most common causes of death among Australians in 2006 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.5 and EA.16). In 2006, malignant neoplasms (cancers) were the main underlying cause of death of 30 per cent of all registered deaths and ischemic heart disease was the primary cause of a further 17 per cent of deaths (ABS 2008a).

Table E.5 Cause of death, age standardised death rates, 2006^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	176	177	173	176	178	193	159	216
Lung cancer ^c	32	34	35	36	33	41	28	47
Diabetes mellitus	13	19	16	18	17	28	16	47
Mental and behavioural disorders	23	24	20	19	23	28	21	40
Diseases of the nervous system	21	23	20	24	23	28	19	17
Diseases of the circulatory system	210	188	210	190	199	221	181	242
Heart disease ^d	103	95	112	95	98	117	76	131
Heart attack ^e	53	46	59	50	47	50	30	55
Stroke ^f	55	44	55	45	50	43	53	47
Diseases of arteries, arterioles and capillaries	10	10	10	10	10	12	11	9
Diseases of the respiratory system	51	45	47	43	52	47	48	97
Influenza and pneumonia	12	12	12	10	15	7	11	5
Chronic lower respiratory diseases	24	25	25	21	23	32	22	78
Diseases of the digestive system	20	20	20	19	20	23	21	41
Accidents	24	24	26	27	23	31	21	53
Transport accidents	6	8	9	10	9	12	4	24
Suicide ^g	7	9	8	10	11	15	9	13
All causes	605	586	599	583	602	679	552	869

^a Standardised death rate per 100 000 of the mid-year 2006 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. Care should be taken in interpreting numbers of suicide deaths due to limitations in the data.

Source: ABS (2008) *Causes of Death 2006, Australia*, Cat. no. 3303.0, ABS, Canberra; table EA.16.

Causes of death for Indigenous people

In the jurisdictions for which age standardised death rates are available by Indigenous status (Queensland, WA, SA and the NT), death rates were far higher for Indigenous people than for non-Indigenous people during the period 2002–2006. In particular, Indigenous people died from diabetes at a rate that was up to 11.2 times that for non-Indigenous people; from cirrhosis and other diseases of liver at a rate that was up to 8.6 times that for non-Indigenous people; and from diseases of the urinary system at a rate that was 5.8 times that for non-Indigenous people.

The standardised death rate per 100 000 for all causes was 2.9 times higher for Indigenous people than for non-Indigenous people (tables E.6 and EA.17).

Table E.6 Leading causes of death, indirect age-standardised death rate ratio, 2002–2006 (per 100 000 standard population)^{a, b, c}

	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>NT</i>	<i>Total</i>
<i>Underlying causes of death</i>					
Trachea and lung cancers	1.9	1.7	1.5	2.2	1.9
Diabetes	10.8	11.8	8.5	9.9	11.2
Ischaemic heart diseases ^d	2.8	2.9	3.2	3.7	3.0
Strokes	1.8	2.6	1.8	3.1	2.1
Influenza and pneumonia	2.6	6.8	3.8	6.3	3.9
Chronic lower respiratory diseases ^e	3.1	4.1	2.9	4.1	4.1
Cirrhosis and other diseases of liver	5.7	9.7	7.1	10.7	8.6
Diseases of the urinary system	3.5	6.2	4.0	12.8	5.8
Certain conditions originating in the perinatal period	2.1	3.2	1.7	3.3	2.7
Symptoms, signs and ill-defined conditions	2.7	6.3	5.0	2.6	4.5
Land transport accidents	1.8	3.5	2.7	2.6	2.9
Intentional self-harm [suicide]	2.3	2.0	3.5	3.1	2.7
All causes	2.4	3.0	2.5	3.6	2.9

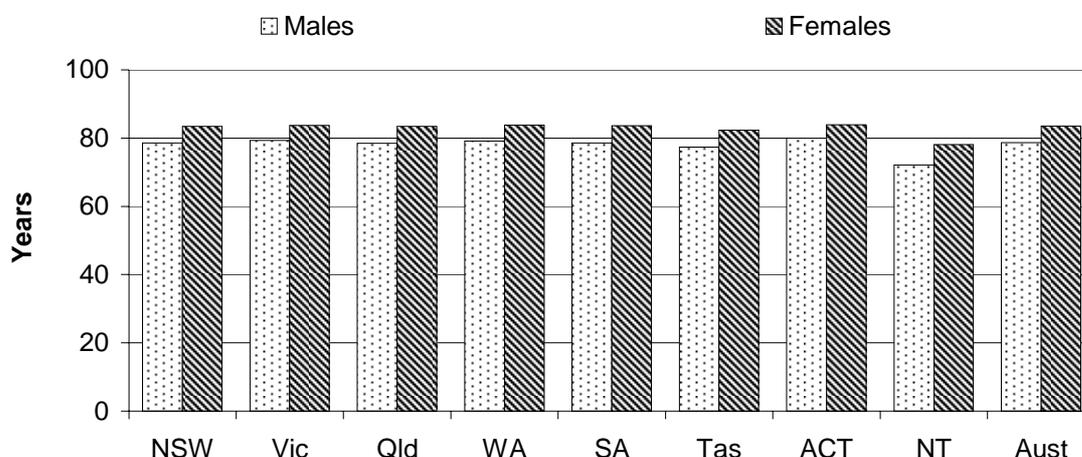
^a Calculations of rates for the Indigenous population are based on ABS *Experimental Projections, Aboriginal and Torres Strait Islander Australians* (ABS cat. no. 3238.0, low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for comparison with the Indigenous population are derived by subtracting Indigenous population projections from Total Estimated Resident Population and should be used with care, as these data include deaths and population units for which Indigenous status were not stated. Population estimates have not been re based using 2006 Census data as re-based data are not yet available for the Indigenous population. ^b Coded according to the International Classification of Diseases and Related Health Problems Revision 10 (ICD-10). ^c Indigenous rate divided by non-Indigenous rate. ^d Ischaemic heart diseases include angina, heart attacks, blocked arteries of the heart. ^e Chronic lower respiratory disease include diseases such as asthma, bronchitis and emphysema.

Source: ABS (unpublished) *Causes of Death 2006*; table EA.17.

Life expectancy

The life expectancy of Australians improved dramatically during the twentieth century and so far during twenty first century. The average life expectancy at birth in the period 1901–1910 was 55.2 years for males and 58.8 years for females (ABS 2008b). It has risen steadily in each decade since, reaching 78.7 years for males and 83.5 years for females in 2004–2006 (figure E.13).

Figure E.13 Average life expectancy at birth, 2004–2006^{a, b}



^a Figures for Australia include 'other territories'. ^b Three year average.

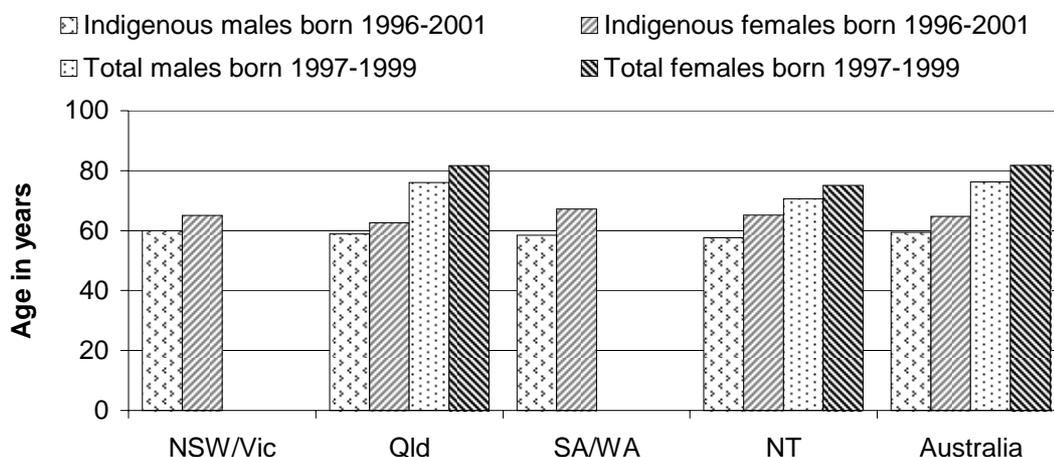
Source: ABS (2007) *Deaths 2006, Australia*, Cat. no. 3302.0, ABS, Canberra; table EA.18.

Indigenous life expectancy

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

The life expectancies of Indigenous Australians are considerably lower than those of non-Indigenous Australians. ABS experimental population estimates indicate a life expectancy at birth of 59.4 years for Indigenous males and 64.8 years for Indigenous females born from 1996 to 2001 (figure E.14 and table EA.19). In a similar, but not directly comparable time period (1997–1999) the rates for all Australians were 76.2 years for all males and 81.8 years for females. Variations in life expectancy between Indigenous males and females and for Indigenous Australians in different states and territories should be interpreted with care as they are sensitive to the demographic assumptions and differences in data quality across jurisdictions. The ABS has produced a discussion paper regarding this issue (ABS 2008c).

Figure E.14 **Life expectancy at birth, Indigenous 1996–2001, total population 1997–1999^{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 Life expectancy data for Indigenous males and Indigenous females are for the period 1996–2001. Data for total males and females cover the period 1997–1999, the approximate mid-point of the Indigenous data. ^c For Tasmania and the ACT, use life tables for NSW and Victoria.

Source: ABS (2007) *Deaths 2006, Australia*, Cat. no. 3302.0, ABS, Canberra; table EA.19.

Median age at death

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

For all Australian males and females in 2006, the median age at death was 77.3 years and 83.3 years respectively (figure E.15 and table EA.20). In the jurisdictions for which the data were available for Indigenous people, in 2006 the median age at death for male Indigenous Australians varied between 45.4 and 59.3 years. The median age at death for female Indigenous Australians varied between 55.3 and 64.8 years (figure E.15 and table EA.20).

Figure E.15 Median age at death, by sex and Indigenous status, 2006^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 (2007) *Deaths 2006, Australia*, Cat. no. 3302.0, ABS, Canberra; table EA.20.

Birthweight of babies

The birthweight of a baby is an important indicator of its health status and future wellbeing. In 2006, 91.8 per cent of liveborn babies in Australia weighed between 2500 and 4499 grams (Laws and Hilder 2008). The average birthweight for all live births was 3370 grams. In 2006, the average birthweight of liveborn babies of Indigenous mothers was 3169 grams (tables EA.21 and EA.22). This was 209 grams lighter than the average of 3378 grams for liveborn babies of non-Indigenous mothers (Laws and Hilder 2008).⁶

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 Hilder 2008). In 2006, 6.4 per cent of all liveborn babies in Australia weighed less than 2500 grams (figure E.16). This included 1.1 per cent of babies who weighed less than 1500 grams (table EA.21).

Among live babies born to Indigenous mothers in 2006, the proportions with low and very low birthweights were around twice the proportions born to all Australian mothers, with 12.4 per cent weighing less than 2500 grams and 2.3 per cent weighing less than 1500 grams (figure E.16 and table EA.22).

⁶ Figures for births to Indigenous mothers exclude Tasmania.

Figure E.16 **Low birthweight babies (under 2500 grams), by Indigenous status, 2006^{a, b}**



^a Proportion of live births with birthweights under 2500 grams. ^b In the ACT, 16.3 per cent of women who gave birth were non-ACT residents. Care must be taken when interpreting percentages. For example, the proportion of liveborn low birthweight babies born in the ACT to ACT resident Aboriginal or Torres Strait Islander women in 2006 where the birthweight was less than 2500 grams was 10.8 per cent.

Source: Laws, P. and Hilder, L. (2008) *Australia's Mothers and Babies 2006*, AIHW Cat. no. PER 46, National Perinatal Statistics Unit (Perinatal Statistics Series no. 22), AIHW, Sydney; tables EA.21 and EA.22.

Future directions

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

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

Reform of Specific Purpose Payments

In December 2007, COAG agreed to reform Specific Purpose Payments (SPPs). SPPs are financial agreements between the Australian Government and State and Territory governments involving a contribution by the Australian Government to the funding of services which are considered a joint Australian and State and

Territory government responsibility. The Australian Health Care Agreement was such an SPP.

At its 29 November 2008 meeting, COAG agreed to six new National Agreements, five of which are associated with a National SPP. In the area of health and ageing, there is a Australian Health Care Agreement associated with the National Health Care SPP (COAG November 2008). Under the reforms, the Australian Health Care Agreement contains the objectives, outcomes, outputs and performance indicators for health and ageing. The performance of governments in achieving these mutually agreed outcomes will be assessed by the COAG Reform Council (CRC). The Steering Committee has been requested by COAG to provide the SPP performance information to the CRC (COAG July 2008).

The National Agreements/SPPs will be supplemented by a range of National Partnerships (NPs): project, facilitation and reward agreements. Funding for NPs may be conditional on states and territories meeting agreed milestones and performance benchmarks.

The Steering Committee and the Health Working Group will ensure that reporting in this chapter reflects the COAG priorities identified in the Australian Health Care Agreement, National Health Care SPP and relevant NPs.

Attachment tables

Attachment tables are identified in references throughout this preface by an 'EA' suffix (for example, table EA.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Table EA.1	Total health expenditure, by source of funds (2006-07 dollars)
Table EA.2	Government recurrent health expenditure, by area of expenditure (2006-07 dollars)
Table EA.3	Non-government recurrent health expenditure by area of expenditure (2006-07 dollars)
Table EA.4	Recurrent health expenditure, by source of funds and area of expenditure, 2006-07
Table EA.5	Total health expenditure per person (2006-07 dollars)
Table EA.6	Recurrent health expenditure per person by source of funds, excluding high level residential aged care (2006-07 dollars)
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Table EA.8	Employed medical practitioners
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Table EA.10	Indigenous health workforce, by State/Territory, 2006
Table EA.11	Indigenous people in health workforce as a proportion of total health workforce, by age group and sex, 2006
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10 Public Hospitals

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Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 10A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables themselves are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

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

10.1 Profile of public hospitals

Definition

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

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

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

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

In WA in 2006-07, two private hospitals which provided a substantial amount of public hospital services through contract arrangements were split, resulting in the creation of two new public hospital reporting units to cover the public separations from these two hospitals. This represents a change in reporting arrangements that may affect comparisons over time.

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

Box 10.1 **Some common terms relating to hospitals**

Patients

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

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

Types of care

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

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

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

Hospital outputs

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

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

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

(Continued on next page)

Box 10.1 (Continued)

Other common health terms

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

Source: AIHW (2006a, 2008c); NCCH (2008).

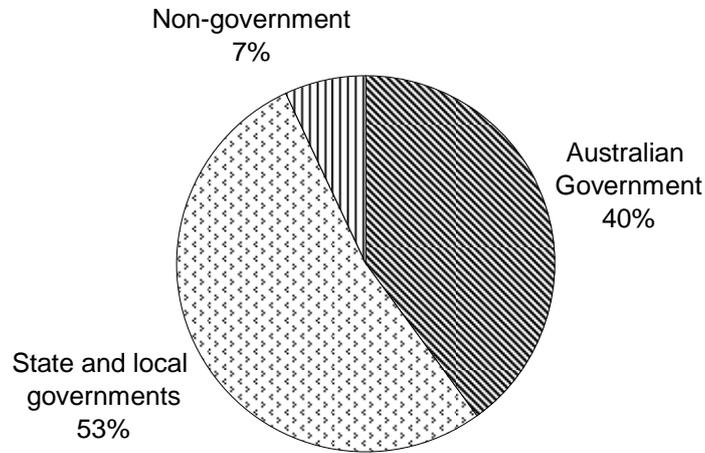
Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was \$26.3 billion in 2006-07 (table 10A.1). In real terms, expenditure increased by 5.6 per cent between 2005-06 and 2006-07 (AIHW 2008a).

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 2006-07, the proportion of total public hospital recurrent expenditure that related to the care of admitted patients (based on the admitted patient cost proportion) ranged from 69.0 per cent to 78.0 per cent across jurisdictions (AIHW 2008a).

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 93.1 per cent of funding for public hospitals in 2006-07 (figure 10.1). Public hospitals accounted for 40.8 per cent of government recurrent expenditure on health services in 2006-07 (AIHW 2008b).

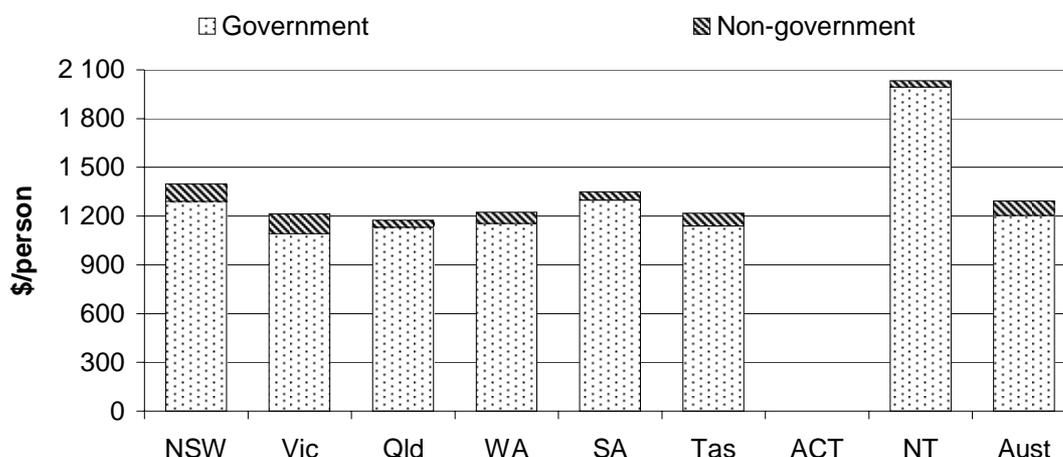
Figure 10.1 **Recurrent expenditure, public hospitals, by source of funds, 2006-07**



Source: AIHW 2008, *Health expenditure Australia 2006–07*, AIHW Cat. no. HWE 37 (Health and Welfare Expenditure Series No.30), Canberra.

In 2006-07, public hospitals received \$1.9 billion from non-government sources — an amount that accounted for 6.9 per cent of all recurrent expenditure (table 10A.2). 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 2006-07 (figure 10.2).

Figure 10.2 Source of public hospital recurrent expenditure, 2006-07^{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.

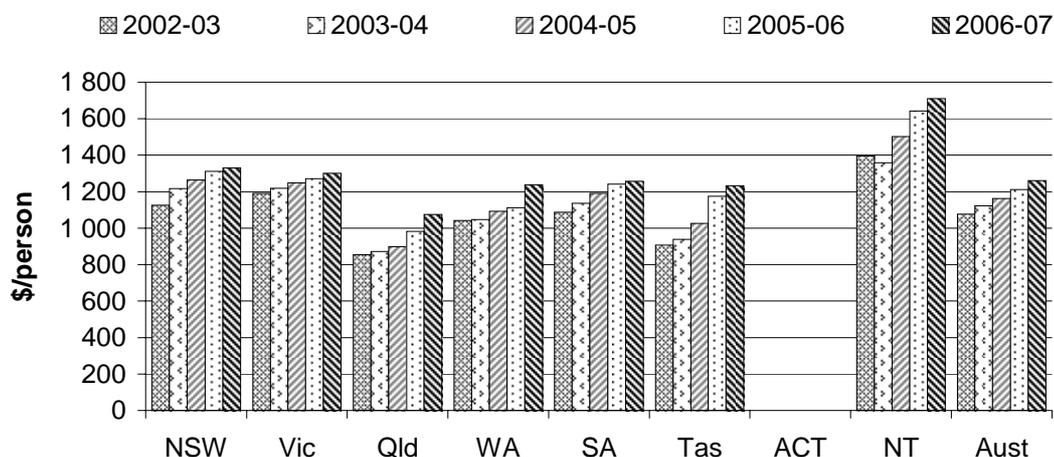
Source: AIHW 2008, *Health expenditure Australia 2006-07*, AIHW Cat. no. HWE 37 (Health and Welfare Expenditure Series No.30), Canberra; ABS (unpublished), derived from Australian Demographic Statistics, December Quarter 2007, Cat. no. 3101.0; table 10A.2.

Expenditure data in figures 10.1 and 10.2 are from *Health Expenditure Australia 2006-07* (AIHW 2008b) and are not directly comparable with other expenditure data used in this chapter, which are drawn from *Australian Hospital Statistics 2006-07* (AIHW 2008a). 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 2006-07, government real recurrent expenditure on public hospitals (in 2005-06 dollars) was \$1260 per person for Australia, up from \$1078 in 2002-03 (figure 10.3). It is difficult to make comparisons between jurisdictions based on these recurrent expenditure data due to differences in the coverage of the data. Some of the differences are:

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

Figure 10.3 **Real recurrent expenditure per person, public hospitals (including psychiatric) (2006-07 dollars)^{a, b, c, d, e, f, g, h}**



a Expenditure data exclude depreciation and interest payments. **b** Recurrent expenditure on purchase of public hospital services at the State, or area health service level, from privately owned and/or operated hospitals is excluded. **c** Expenditure data are deflated using the hospital/nursing home care price index from AIHW (2008b). **d** NSW hospital expenditure recorded against special purposes and trust funds is excluded from 2003-04. **e** Queensland pathology services were purchased from a statewide pathology service rather than being provided by hospital employees. **f** Data for WA for 2006-07 include expenditure for public patients at Joondalup and Peel Health Campuses. Expenditures for these patients are not included in previous years. **g** For 2002-03, data for one small Tasmanian hospital is not included and data for five other small hospitals are incomplete. For 2003-04, data for five small hospitals are not included. For 2004-05 and 2005-06, data for one hospital are not included. **h** ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditures for NSW residents. Thus the ACT population is not the appropriate denominator.

Source: AIHW (2005a, 2006a, 2006b, 2007a, 2008b), *Health expenditure Australia*, AIHW Cat. no. HWE 35 (Health and Welfare Expenditure Series No.42), Canberra; ABS (unpublished), derived from Australian Demographic Statistics, December Quarter 2007, Cat. no. 3101.0; table 10A.3.

Size and scope of sector

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

Hospitals

In 2006-07, Australia had 758 public hospitals (table 10A.4) (including 19 psychiatric hospitals) (AIHW 2008a). Although 71.2 per cent of hospitals had 50 or

fewer beds, these smaller hospitals represented only 17.4 per cent of total available beds (figure 10.4 and table 10A.4).

Figure 10.4 **Public hospitals, by size, 2006-07^{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 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.4.

Beds

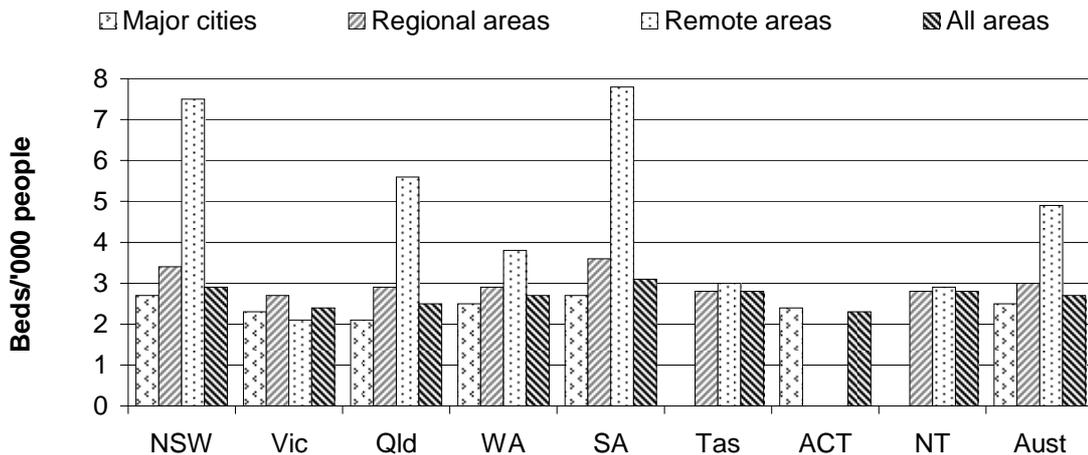
There were 55 904 available beds in public hospitals in 2006-07 (table 10A.4). The concept of an available bed (the definition of which is under review) is becoming less important in the overall context of hospital activity, particularly in light of increasing same day hospitalisations and the provision of hospital-in-the-home care (AIHW 2008a).

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

Nationally, more beds were available per 1000 people in remote areas (figure 10.5). The patterns of bed availability may reflect a number of factors including patterns of availability of other health care services, patterns of disease and injury and the relatively poor health of Indigenous people, who have higher population

concentrations in remote areas (AIHW 2006a). These data also need to be viewed in the context of the age and sex structure (see appendix A) and the morbidity and mortality (see 'Health preface') of the population in each State and Territory.

Figure 10.5 Available beds, public hospitals, by location, 2006-07^{a, b, c, d}



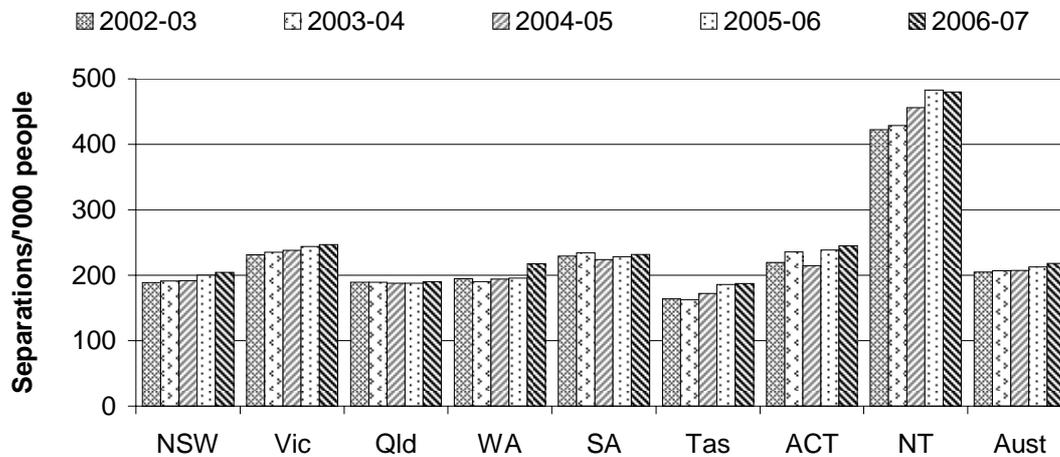
^a An 'available bed' is one that is immediately available to be used by an admitted patient. A bed is immediately available for use if it is located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period. Both occupied and unoccupied beds are included. Surgical 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 2008a). ^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 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.5.

Total separation rates

There were approximately 4.6 million separations from public (non-psychiatric) hospitals in 2006-07 (table 10A.6). Nationally, this translates into 218.0 separations per 1000 people (figure 10.6).

Figure 10.6 Separation rates in public (non-psychiatric) hospitals^{a, b, c}



^a Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement. ^b Rates are directly age standardised to the Australian population at 30 June 2001. ^c Data for WA for 2006-07 includes separations for public patients at Joondalup and Peel Health Campuses. Separations for these patients are not included in previous years.

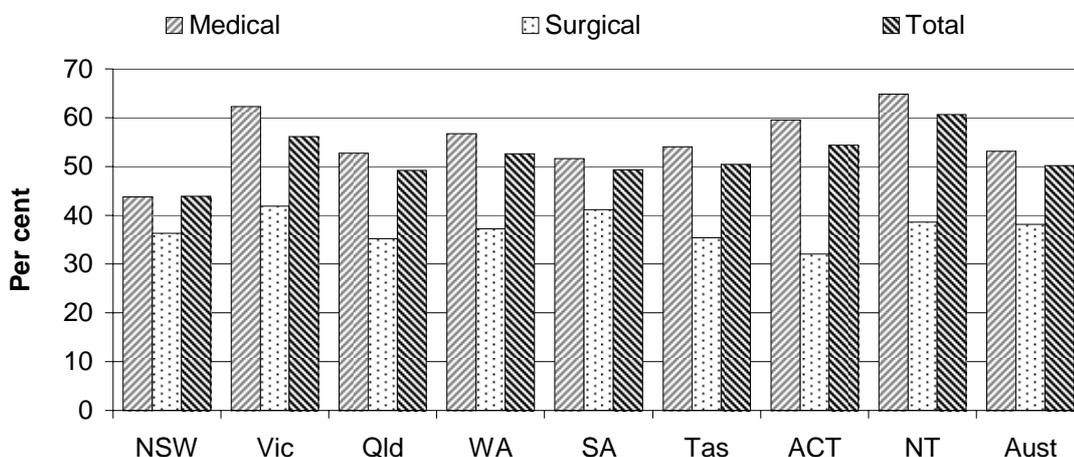
AIHW (various years), *Australian Hospital Statistics*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.7.

Same day separations in public (non-psychiatric) hospitals increased by 5.3 per cent between 2005-06 and 2006-07, although same day separations as a proportion of total separations remained relatively constant over this period. Overnight separations in public (non-psychiatric) hospitals increased by 3.5 per cent between 2005-06 and 2006-07 (table 10A.7).

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

Variations in admission rates can reflect different practices in classifying patients as either admitted same day patients or outpatients. The extent of differences in classification practices can be inferred from the variation in the proportion of same day separations across jurisdictions for certain conditions or treatments. This is particularly true of medical separations. Significant variation across jurisdictions in the proportion of same day medical separations was evident in 2006-07 (figure 10.7). Lower jurisdictional variation is likely in admission practices for surgical procedures, as reflected by the lower variability in the proportion of same day surgical separations.

Figure 10.7 Proportion of medical, surgical and total separations that were same day, public (non-psychiatric) hospitals, 2006-07^a



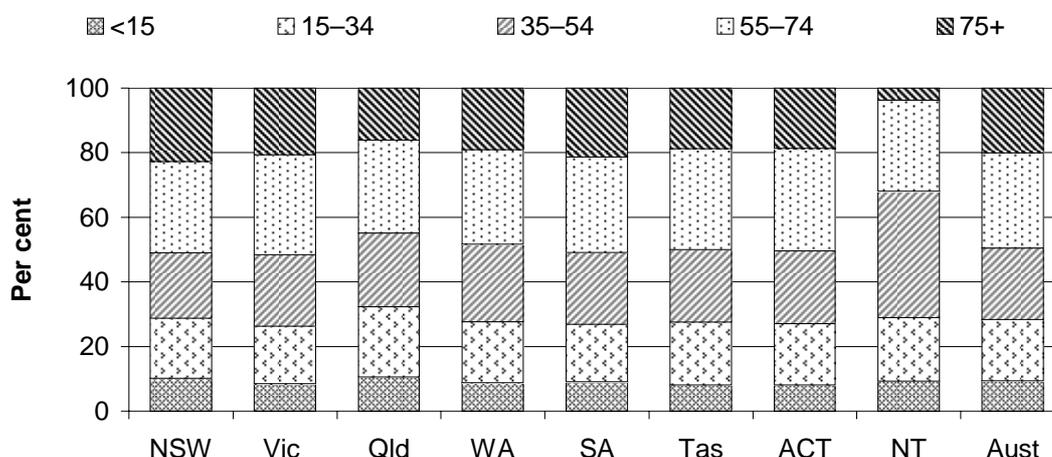
^a 'Total' includes medical, surgical, chemotherapy, radiotherapy and 'other' separations based on AR-DRG version 5.1 categories.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 10A.8.

Separations by age group

Persons aged 55 years and over accounted for almost half of the separations in public hospitals (49.5 per cent) in 2006-07, even though they accounted for only 23.9 per cent of the estimated resident population at 30 June 2006 (figure 10.8 and AIHW 2008a). The proportion of hospital separations for this and other age groups varies across states and territories (figure 10.8). This variation largely reflects differences in the age profiles of jurisdictions (see table AA.1).

Figure 10.8 Separations by age group, public hospitals, 2006-07^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 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.9.

Separation rates for Indigenous patients

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

The available data are not necessarily representative of other jurisdictions. Because of improvements in data quality over time, caution also should be used in time series analysis of the data.

In 2006-07, separations for Indigenous people accounted for around 3.5 per cent of total separations and 5.3 per cent of separations in public hospitals in NSW, Victoria, Queensland, WA, SA and the NT (table 10.1), but the Indigenous population made up only around 2.5 per cent of the population in these jurisdictions (tables AA.2 and AA.7). Most separations involving Indigenous patients (94.4 per cent) in these jurisdictions occurred in public hospitals. The low

proportion of private hospital separations for Indigenous people may be due partly to a lower proportion of Indigenous patients being correctly identified in private hospitals in addition to their lower use of private hospitals.

Table 10.1 Separations, by Indigenous status of patient and hospital sector, 2006-07^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	Total ^c
Public hospital separations ('000)										
Indigenous	50.6	11.4	60.2	42.3	17.3	np	np	57.9	np	239.6
Non-Indigenous	1 394.5	1 296.1	710.6	408.6	362.1	np	np	27.9	np	4 199.9
Not reported	17.0	6.7	13.8	–	11.2	np	np	–	np	48.8
Total	1 462.1	1 314.2	784.6	450.9	390.6	np	np	85.8	np	4 488.4
Private hospital separations ('000)										
Indigenous	1.1	0.5	3.9	8.3	0.5	np	np	np	np	14.2
Non-Indigenous	797.1	755.4	654.5	280.9	225.5	np	np	np	np	2 713.5
Not reported	10.1	5.5	83.6	–	3.3	np	np	np	np	102.6
Total	808.4	761.4	742.0	289.2	229.3	np	np	np	np	2 830.3
Indigenous separations as proportion of total separations (%)										
Public hospitals	3.5	0.9	7.7	9.4	4.4	np	np	67.4	np	5.3
Private hospitals	0.1	0.1	0.5	2.9	0.2	np	np	np	np	0.5
All hospitals	2.3	0.6	4.2	6.8	2.9	np	np	np	np	3.5
Separations in public hospitals as a proportion of separations in all hospitals (%)										
Indigenous	97.8	96.0	94.0	83.6	97.4	np	np	np	np	94.4
Non-Indigenous	63.6	63.2	52.1	59.3	61.6	np	np	np	np	60.8

^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. ^b Identification of Indigenous patients is not considered complete and completeness varies across jurisdictions. The AIHW advised that only data for NSW, Victoria, Queensland, WA, SA and the NT are considered to be acceptable for the purpose of analysis. Nevertheless, data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions. ^c The total includes data only for NSW, Victoria, Queensland, WA, SA, and the NT. – Nil or rounded to zero. **np** Not published.

Source: AIHW 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.10.

In 2006-07, on an age standardised basis, 787.5 public hospitals separations (including same day separations) for Indigenous patients were reported per 1000 Indigenous people in NSW, Victoria, Queensland, WA, SA and the NT (table 10.2). This rate was markedly higher than the corresponding rate for these jurisdictions' combined total population of 218.7 per 1000 (table 10.2). Incomplete identification of Indigenous people limits the validity of comparisons over time, as well as across jurisdictions.

Table 10.2 Estimates of public hospital separations per 1000 people, by Indigenous status of patient^{a, b}

	NSW ^c	Vic	Qld ^c	WA ^{c,d}	SA ^c	Tas	ACT	NT ^c	Aust	Total ^e
2002-03										
Indigenous	np	np	685.2	809.4	788.1	np	np	1223.3	np	np
Total population	np	np	189.4	195.4	231.0	np	np	422.5	np	np
2003-04										
Indigenous	np	np	710.9	789.3	853.9	np	np	1286.2	np	np
Total population	np	np	189.3	191.0	235.9	np	np	428.9	np	np
2004-05										
Indigenous	np	np	733.6	821.5	822.2	np	np	1441.0	np	907.0
Total population	np	np	188.1	195.2	225.3	np	np	456.2	np	205.2
2005-06										
Indigenous	495.6	np	745.4	845.2	875.0	np	np	1548.0	np	792.1
Total population	204.7	np	188.5	198.8	229.7	np	np	491.4	np	205.7
2006-07										
Indigenous	528.0	624.3	756.7	876.5	929.3	np	np	1584.8	np	787.5
Total population	205.9	246.6	218.7	218.1	232.6	np	np	480.6	np	218.7

^a The rates are directly age standardised to the Australian population at 30 June 2001. ^b Identification of Indigenous patients is not considered complete and completeness varies across jurisdictions and time. ^c AIHW advice on data of acceptable quality limits reporting across jurisdictions for various years. Nevertheless, data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality and changes in hospitalisation rates for Indigenous people over time that may include a component due to improved identification. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions. ^d Data for WA for 2006-07 includes separations for public patients at Joondalup and Peel Health Campuses. Separations for these patients are not included in previous years. ^e Total rates include data for Queensland, WA, SA, and the NT for all years, and for 2005-06 incorporate NSW and for 2006-07 incorporate NSW and Victoria. Total rates before 2005-06 are not comparable with the 2005-06 total and total rates before 2006-07 are not comparable with the 2006-07 total. **np** Not published.

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

Separations with a procedure recorded for Indigenous patients

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

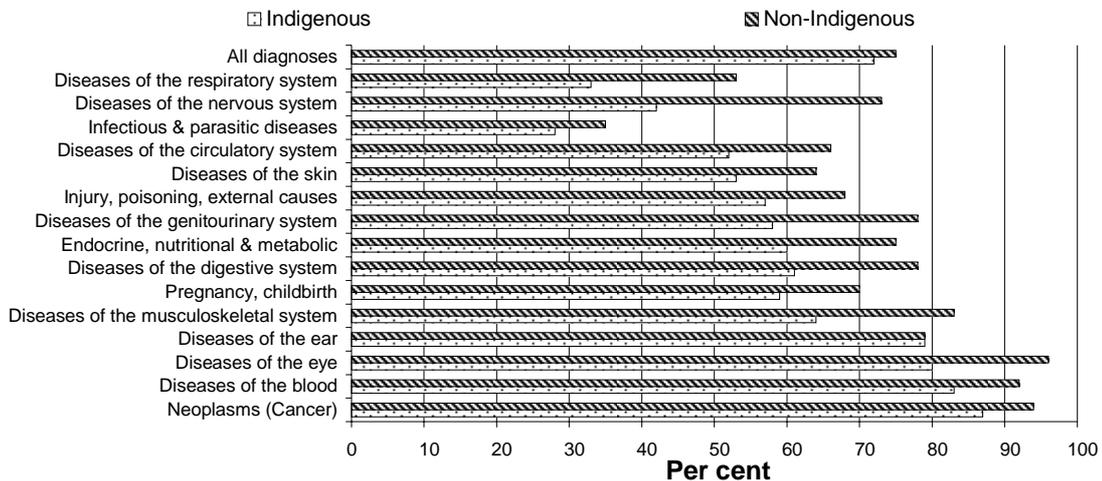
Data for NSW, Victoria, Queensland, WA, SA and NT public hospitals for separations with a procedure recorded by principal diagnosis are presented in figure 10.9. Separations with a procedure recorded both by jurisdiction and by remoteness are presented in figures 10.10 and 10.11, and include data for all

patients treated in public hospitals and public patients treated in private hospitals. Private hospital data are not published for the NT, but the extent to which public patients are treated in private hospitals in that jurisdiction is limited.

In the period July 2005–June 2007, excluding care involving dialysis, consistently lower proportions of separations with a procedure were recorded for Indigenous patients compared with non-Indigenous patients in almost all categories of principal diagnosis (figure 10.9). The differences can be observed across all jurisdictions for which data are available (figure 10.10). While remoteness is associated with progressively reduced rates of separation with a procedure recorded for all patients, differences were more pronounced for Indigenous patients (figure 10.11).

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

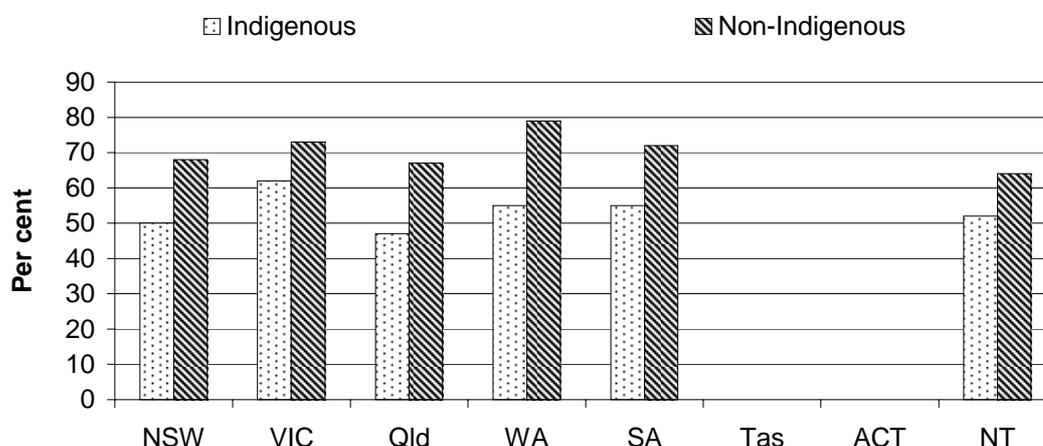
Figure 10.9 Separations with a procedure recorded by principal diagnosis, by Indigenous status of patient, July 2005–June 2007^{a, b}



^a Includes patients treated in public hospitals and public patients treated in private hospitals in NSW, Victoria, Queensland, WA, SA and NT. ^b 'All diagnoses' excludes care involving dialysis.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database, table 10A.12.

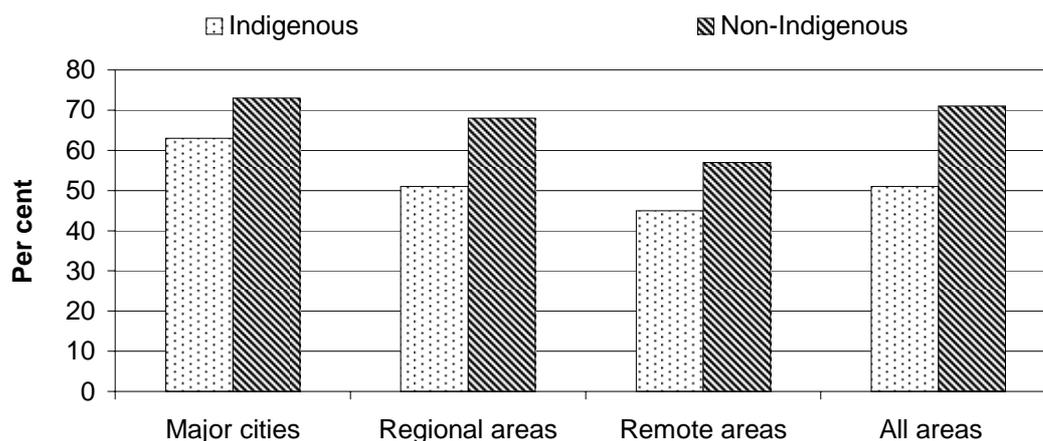
Figure 10.10 Separations with a procedure recorded, by Indigenous status of patient, July 2005–June 2007^{a, b, c}



^a Includes all patients treated in public hospitals and public patients treated in private hospitals. Private hospital data for NT were not available therefore results for NT include public hospital data only. ^b The AIHW advised that only data for NSW, Victoria, Queensland, WA, SA and the NT are considered to be acceptable for the purpose of analysis. Nevertheless, data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions. ^c 'All diagnoses' excludes care involving dialysis.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database, table 10A.13.

Figure 10.11 Separations with a procedure recorded, by Indigenous status of patient and remoteness, July 2005–June 2007^{a, b}



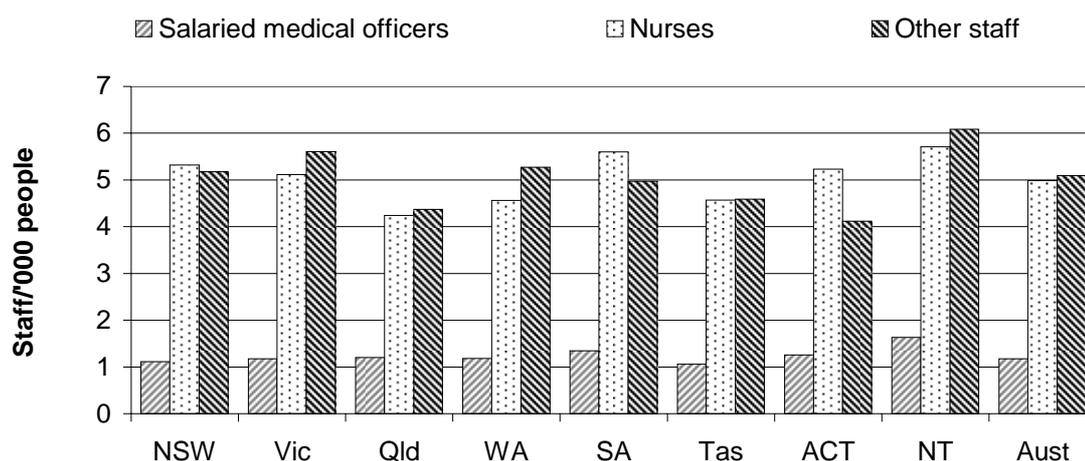
^a Includes all patients treated in public hospitals and public patients treated in private hospitals in NSW, Victoria, Queensland, WA, SA and NT. Private hospital data for NT were not available therefore results for NT include public hospital data only. ^b 'All diagnoses' excludes care involving dialysis.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database, table 10A.14.

Staff

In 2006-07, nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (5.0 per 1000 people in Australia) (figure 10.12). Comparing data on FTE staff across jurisdictions needs to be undertaken with care because these data are affected by differences across jurisdictions in the recording and classifying of staff. The outsourcing of services with a large labour related component (for example, food services and domestic services) can have a large impact on hospital staffing figures. Differences in outsourcing may explain some of the differences in FTE staff in some staffing categories and across jurisdictions (AIHW 2008a).

Figure 10.12 **Average FTE staff per 1000 people, public hospitals, 2006-07^{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 2006 were used. Staff contracted to provide products (rather than labour) are not included. ^c Staff per 1000 people are calculated from ABS population data at 31 December 2006 (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 two small Tasmanian hospitals are not included.

Source: AIHW 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; ABS (unpublished), derived from Australian Demographic Statistics, December Quarter 2007, Cat. no. 3101.0; tables 10A.15 and AA.2.

Activity — admitted patient care

There were around 4.7 million acute, sub-acute and non-acute separations in public hospitals in 2006-07. Of these, acute separations accounted for 96.2 per cent, newborns with some qualified days accounted for 1.0 per cent, and rehabilitation care accounted for 1.5 per cent (table 10A.16). Palliative care, non-acute care and

other care made up the residual. Public psychiatric hospitals accounted for around 0.3 per cent of total separations in public hospitals in 2006-07. Of the total number of separations in public (non-psychiatric) hospitals, 50.2 per cent were for same day patients (table 10A.6).

Table 10.3 shows the 10 AR-DRGs with the highest number of overnight acute separations in public hospitals for 2006-07. These 10 AR-DRGs accounted for 17.6 per cent of all overnight acute separations.

Table 10.3 Ten AR-DRGs (version 5.1) with the most overnight acute separations, public hospitals, 2006-07^{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>
Separations for AR-DRGs as a proportion of all overnight acute separations (%)									
Vaginal Delivery W/O Catastrophic or Severe CC	4.4	4.8	4.6	4.6	3.4	4.2	5.2	3.5	4.5
Chest Pain	2.5	2.1	2.7	1.7	2.7	1.4	0.9	2.2	2.3
Caesarean Delivery W/O Catastrophic or Severe CC	1.8	1.9	2.2	1.9	1.5	1.9	2.0	1.6	1.9
Oesophagitis, Gastroent & Misc Digestive Systm Disorders Age>9 W/O Cat/Sev CC	2.0	1.8	1.8	1.8	2.0	1.6	1.4	0.9	1.9
Antenatal & Other Obstetric Admission	1.5	1.3	1.9	2.0	1.3	1.7	1.4	2.8	1.6
Cellulitis (Age >59 W/O Catastrophic or Severe CC) or Age <60	1.3	1.3	1.7	1.7	1.3	1.2	1.4	5.3	1.5
Vaginal Delivery Single Uncomplicated W/O Other Condition	1.2	0.6	1.7	1.0	0.8	1.2	1.6	1.3	1.1
Abdominal Pain or Mesenteric Adenitis W/O CC	1.0	1.1	1.0	1.0	1.1	0.8	0.9	0.6	1.0
Bronchitis and Asthma Age <50 W/O CC	1.1	0.9	0.7	0.9	1.2	0.7	0.7	0.7	0.9
Heart Failure and Shock W/O Catastrophic CC	1.0	0.9	0.8	0.9	0.9	1.1	0.7	0.6	0.9
Ten AR-DRGs with the most overnight acute separations (%)	17.9	16.5	19.1	17.5	16.3	15.8	16.2	19.4	17.6
Total overnight acute separations ('000)^c	788	543	381	203	192	46	31	33	2217

cat = catastrophic. cc = complications and comorbidities. sev = severe. w/o = without. w = with. ^a Includes separations for which the care type was reported as 'acute' or 'newborn with qualified days', or was not reported. ^b Excludes same day separations and separations where patients stayed over 366 days. ^c Total is for all overnight separations (not just the ten listed in table).

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 10A.17.

Table 10.4 lists the 10 AR-DRGs that accounted for the most patient days (18.0 per cent of all patient days recorded) in 2006-07. Schizophrenic disorders

associated with mental health legal status accounted for the largest number of patient days, followed by vaginal delivery without complicating diagnosis.

Table 10.4 Ten AR-DRGs (version 5.1) with the most patient days, public hospitals, 2006-07^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Patient days for AR-DRGs as a proportion of patient days (%)									
Schizophrenia Disorders W Mental Health Legal Status	3.0	3.8	4.7	3.9	3.7	1.6	2.7	1.6	3.6
Vaginal Delivery W/O Catastrophic or Severe CC	2.4	2.6	2.4	2.7	1.8	2.1	2.7	2.1	2.4
Tracheostomy or Ventilation >95 hours	2.3	2.3	2.4	2.2	2.5	2.5	2.4	2.2	2.3
Major Affective Disorders Age <70 W/O Catastrophic or Severe CC	1.9	1.8	2.0	2.8	2.8	1.7	2.4	1.0	2.1
Schizophrenia Disorders W/O Mental Health Legal Status	1.9	1.1	1.0	1.9	1.6	3.9	1.2	1.1	1.5
Caesarean Delivery W/O Catastrophic or Severe CC	1.4	1.6	1.6	1.6	1.2	1.3	1.6	1.4	1.5
Chronic Obstructive Airways Disease W Catastrophic or Severe CC	1.4	1.4	1.4	1.1	1.6	1.4	0.9	1.5	1.4
Cellulitis (Age >59 W/O Catastrophic or Severe CC) or Age <60	1.0	1.2	1.3	1.4	1.1	1.0	1.1	3.2	1.2
Respiratory Infections/Inflammations W Catastrophic CC	1.1	1.3	0.8	0.7	1.2	0.8	0.9	1.5	1.1
Heart Failure and Shock W/O Catastrophic CC	1.1	0.9	0.9	1.0	1.0	1.3	0.8	0.4	1.0
Ten AR-DRGs with the most patient days (%)	17.6	17.8	18.5	19.1	18.5	17.5	16.7	16.1	18.0
Total patient days ('000)^c	4 404	2 797	1 909	1 053	1 079	279	163	190	11 873

cat = catastrophic. cc = complications and comorbidities. sev = severe. w/o = without. w = with. ^a Includes separations for which the care type was reported as 'acute' or 'newborn with qualified days', or was not reported. ^b Excludes same day separations and separations where patients stayed over 366 days. ^c Total is for all overnight separations (not just the ten listed in table).

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 10A.18.

Activity — non-admitted patient services

There is no agreed classification system for services to non-admitted patients, so activity is difficult to measure consistently and cannot be compared across

jurisdictions. As well as differences in the way data are collected, differing admission practices lead to variation in the services reported across jurisdictions. In addition, states and territories may differ in the extent to which these types of service are provided in non-hospital settings (such as community health centres) (AIHW 2006a). Services to non-admitted patients are measured in terms of occasions of service. Differences in the complexity of the occasion of service are not taken into account — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids (AIHW 2001a).

A total of 46.1 million individual occasions of service were provided to non-admitted patients in public acute hospitals in 2006-07 (table 10.5). In addition, public hospitals also delivered 345 409 group sessions during this time (a group session is defined as a service provided to two or more patients, excluding services provided to two or more family members) (table 10A.19). In public acute hospitals in 2006-07, accident and emergency services comprised 14.6 per cent of all individual occasions of service to non-admitted patients. ‘Other medical, surgical and obstetric services’ (23.9 per cent), ‘pathology services’ (15.7 per cent) and ‘pharmacy’ (10.0 per cent) were the most common types of non-admitted patient care (table 10.5).

Table 10.5 Non-admitted patient occasions of service, by type of non-admitted patient care, public acute hospitals, 2006-07^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	11.4	20.2	13.9	15.6	24.1	13.5	19.6	29.4	14.6
Pathology	11.4	10.4	32.9	11.9	..	22.3	7.1	19.7	15.7
Radiology and organ imaging	3.9	7.8	8.8	8.8	10.7	9.0	13.6	14.6	6.7
Pharmacy ^c	16.2	6.0	5.8	4.1	–	8.5	0.2	8.1	10.0
Other medical/surgical/obstetric	23.7	21.7	24.1	14.0	43.4	33.9	49.8	26.0	23.9
Mental health	4.2	9.7	1.2	0.8	0.6	..	0.4	–	3.7
Dental	2.9	2.6	2.7	0.2	0.5	1.5	–	–	2.3
Allied health	4.0	14.7	5.4	19.9	9.2	10.0	3.5	2.3	7.9
Other non-admitted services									
Community health	7.3	3.4	1.8	17.2	0.4	..	1.9	–	5.9
District nursing ^d	6.7	3.1	1.1	3.7	0.6	–	–	–	4.1
Most common types of non-admitted patient care (%)	91.7	99.6	97.5	96.2	89.6	98.7	96.1	100.0	94.8
Total occasions of service for non-admitted patients ('000)	20 285	7 269	9 948	4 667	2 139	923	492	418	46 141

^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 a large number of occasions of service that may not be typical of pharmacy. ^d Justice Health (formerly known as Corrections Health) in NSW reported a large number of occasions of service that may not be typical of district nursing. .. Not applicable. – Nil or rounded to zero.

Source: AIHW 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.19.

10.2 Framework of performance indicators for public hospitals

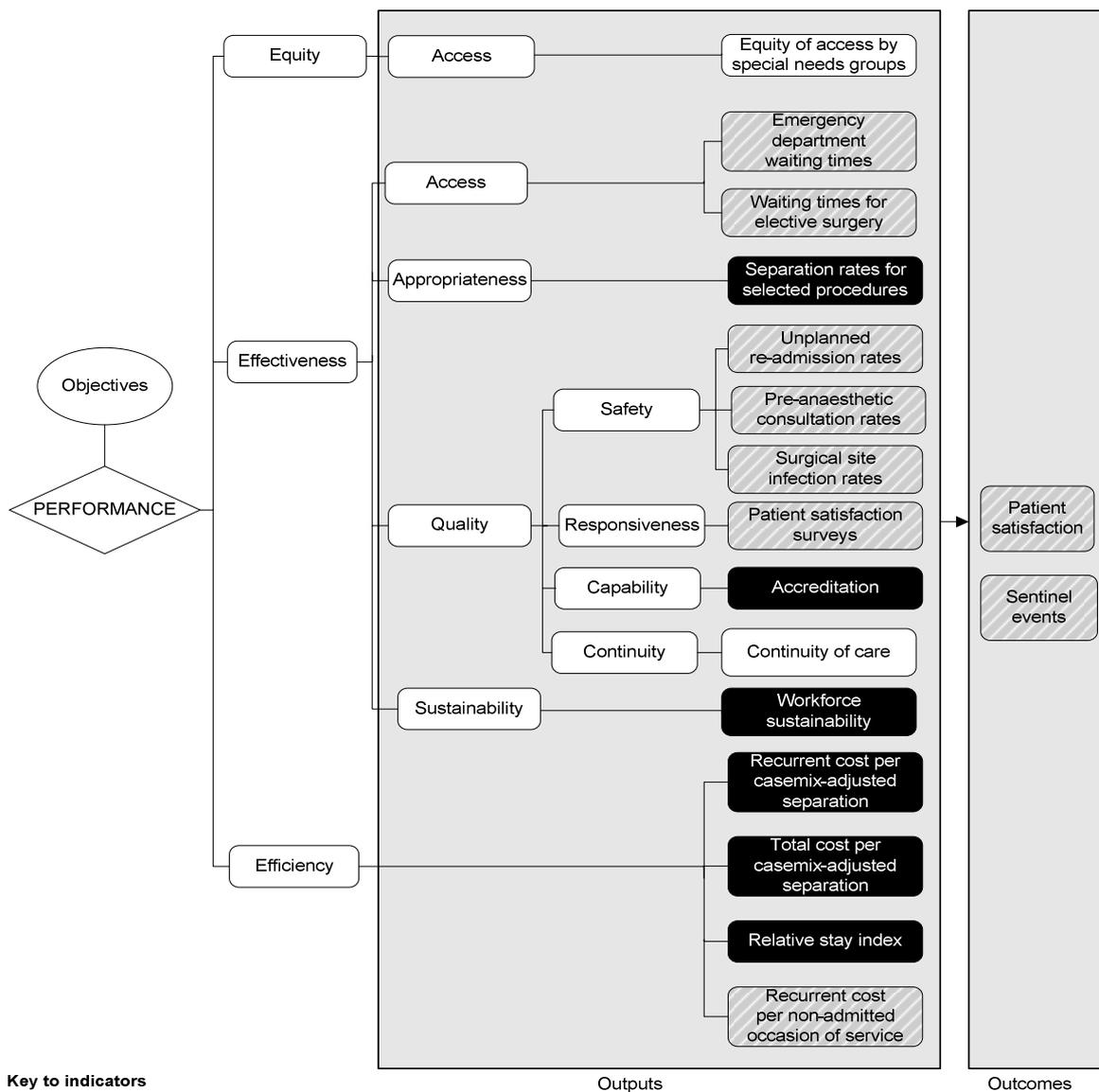
The performance indicator framework is based on the shared government objectives for public hospitals (box 10.2). The performance indicator framework shows which data are comparable in the 2009 Report (figure 10.13). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective. The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions of quality and sustainability that have been added to the standard Review framework.

Box 10.2 Objectives for public hospitals

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

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

Figure 10.13 Performance indicators for public hospitals



Key to indicators

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

10.3 Key performance indicator results for public hospitals

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

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

Outputs

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

Equity — access

Equity indicators measure how well a service is meeting the needs of certain groups in society (see chapter 1). Public hospitals have a significant influence on the equity of the overall healthcare system. While access to public hospital services is important to the community in general, it is particularly important 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

‘Equity of access by special needs groups’ is an indicator of governments’ objective to provide accessible services (box 10.3).

Box 10.3 Equity of access by special needs groups

‘Equity of access by special needs groups’ measures the performance of agencies providing services for three identified special needs groups: Indigenous people; people living in communities outside the capital cities (that is, people living in other metropolitan areas, or rural and remote communities); and people from a non-English speaking background.

‘Equity of access by special needs groups’ has been identified as a key area for development in future reports.

Effectiveness — access

Emergency department waiting times

‘Emergency department waiting times’ is an indicator of governments’ objective to provide accessible services (box 10.4).

Box 10.4 Emergency department waiting times

‘Emergency department waiting times’ 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.

Data reported for this indicator are not directly comparable.

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

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

Nationally, in 2006-07, 99 per cent of patients were seen within the triage category 1 timeframe and 78 per cent of patients were seen within the triage

category 2 timeframe. For all triage categories, 70 per cent of patients were seen within triage category timeframes (table 10.6).

Table 10.6 Emergency department patients seen within triage category timeframes, public hospitals, 2006-07 (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	98	98	99	96	100	100	99
2 — Emergency	87	82	67	71	72	72	77	56	78
3 — Urgent	71	73	57	59	56	62	47	54	65
4 — Semi-urgent	74	67	60	61	63	61	49	48	66
5 — Non-urgent	89	88	87	87	87	87	81	87	88
Total	76	74	61	64	63	64	54	55	70
Data coverage ^b	81	89	64	72	69	96	100	100	78

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

Source: AIHW 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.20.

Waiting times for elective surgery

‘Waiting times for elective surgery’ is an indicator of governments’ objective to provide accessible services (box 10.5).

Box 10.5 **Waiting times for elective surgery**

Two measures are reported for 'Waiting times for elective surgery':

- '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.

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

The three generally accepted urgency categories for elective surgery are:

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

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

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

The elective surgery waiting times data are provided for waiting lists managed by public acute hospitals. The data collection covers most public hospitals that undertake elective surgery. In 2006-07, the elective surgery waiting times data covered 87 per cent of separations for elective surgery in public acute hospitals.

Data reported for this indicator are not directly comparable.

Patients on waiting lists who were not subsequently admitted to hospital are excluded from both measures. 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 2008a). In 2006-07, 14.5 per cent of

patients were removed from waiting lists for reasons other than elective admission (AIHW 2008a).

Comparisons between jurisdictions should be made with caution due to differences in clinical practices and classification of patients across Australia. The two measures are affected by variations across jurisdictions in the method used to calculate waiting times for patients who transferred from a waiting list managed by one hospital to a waiting list managed by a different hospital. For patients who were transferred from a waiting list managed by one hospital to that managed by another, the time waited on the first list is included in the waiting time reported for some but not all states and territories (AIHW 2008a). NSW, Victoria, Queensland, WA, SA and the ACT reported the total time waited on all waiting lists. This approach may have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions. Queensland has indicated that patients rarely switch between waiting lists managed by different hospitals in their jurisdiction (AIHW 2008a).

Nationally, in 2006-07, 90 per cent of patients were admitted within 226 days and 50 per cent were admitted within 32 days (table 10.7). The proportion of patients who waited more than a year was 3.1 per cent. Nationally, waiting times at the 50th percentile increased by four days between 2002-03 and 2006-07. In 2002-03, 28 days were waited at the 50th percentile and this increased to 32 days by 2006-07. However, there were different trends in different jurisdictions and for different sized hospitals over that period (figure 10.14 and table 10A.21).

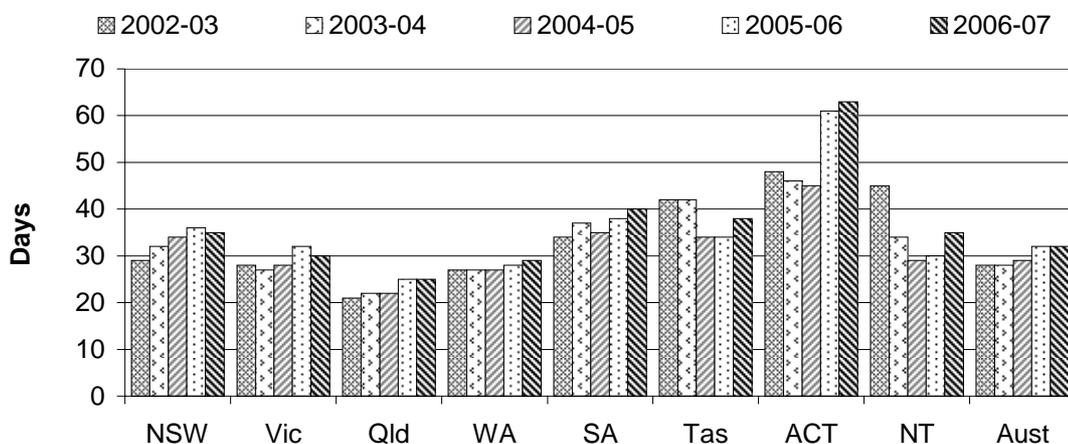
Table 10.7 Elective surgery waiting times, public hospitals, 2006-07

	<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 days waited at:										
50th percentile	no.	35	30	25	29	40	38	63	35	32
90th percentile	no.	260	208	142	225	206	343	364	370	226
Proportion who waited more than 365 days	%	1.9	3.3	2.5	4.6	3.9	9.2	9.9	10.2	3.1
Estimated coverage of elective surgery separations ^a	%	100.0	79.0	96.0	67.0	64.0	100.0	100.0	100.0	87.0

^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 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.21.

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



Source: AIHW (various years), *Australian Hospital Statistics*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.21.

‘Elective surgery waiting times by urgency category’ data not only provide an indication of the extent to which patients are seen within a clinically desirable time, but also draw attention to the variation in the way in which patients are classified across jurisdictions. Jurisdictional differences in the classification of patients by urgency category in 2006-07 are shown in table 10.8. The states and territories with lower proportions of patients in category 1 also had relatively smaller proportions of patients in this category who were ‘not seen on time’. Victoria and the ACT, for example, had the lowest proportions of patients in category 1 and also had the lowest proportions of patients in category 1 who had extended waits (tables 10.8, 10A.26 and 10A.35).

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

Table 10.8 Classification of elective surgery patients, by clinical urgency category, 2006-07 (per cent)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
Patients on waiting lists								
Category 1	4.1	2.5	8.5	7.9	7.9	6.6	2.7	10.1
Category 2	28.3	43.9	39.3	34.7	24.6	49.6	50.2	41.6
Category 3	67.7	53.6	52.3	57.4	67.5	43.8	47.1	48.3
Total	100.0	100.0	100.1	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	33.2	24.5	38.1	33.0	33.8	42.2	29.7	47.7
Category 2	33.0	47.8	43.8	29.2	27.7	37.5	47.5	35.1
Category 3	33.8	27.7	18.1	37.8	38.5	20.3	22.8	17.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: State and Territory governments (unpublished).

Reporting of 'elective surgery waiting times by clinical urgency category' includes the proportions of patients with extended waits at admission across jurisdictions. The proportions of patients on waiting lists who had already had an extended wait at the date of the census are reported in tables 10A.24, 10A.26, 10A.28, 10A.30, 10A.32, 10A.34, 10A.35 and 10A.37. Census data do not represent the completed waiting time of patients (unlike patients with extended waits at admission).

Of patients admitted from waiting lists in NSW in 2006-07, the percentage of patients classified to each category and the percentage with an extended wait were:

- 33.2 per cent were classified to category 1, of whom 12.9 per cent had an extended wait
- 33.0 per cent were classified to category 2, of whom 25.5 per cent had an extended wait
- 33.8 per cent were classified to category 3, of whom 4.4 per cent had an extended wait.

Overall in NSW, 14.2 per cent of all patients experienced extended waits (table 10A.24).

Of patients admitted from waiting lists in Victoria in 2006-07, the percentage of patients classified to each category and the percentage with an extended wait were:

- 24.5 per cent were classified to category 1, of whom zero per cent had an extended wait
- 47.8 per cent were classified to category 2, of whom 25.3 per cent had an extended wait

-
- 27.7 per cent were classified to category 3, of whom 8.5 per cent had an extended wait.

Overall in Victoria, 14.5 per cent of all patients experienced extended waits (table 10A.26).

Of patients admitted from waiting lists in Queensland in 2006-07, the percentage of patients classified to each category and the percentage with an extended wait were:

- 38.1 per cent were classified to category 1, of whom 13.2 per cent had an extended wait
- 43.8 per cent were classified to category 2, of whom 17.7 per cent had an extended wait
- 18.1 per cent were classified to category 3, of whom 11.7 per cent had an extended wait.

Overall in Queensland, 14.9 per cent of all patients experienced extended waits (table 10A.28).

Of patients admitted from waiting lists in WA in 2006-07, the percentage of patients classified to each category and the percentage with an extended wait were:

- 33.0 per cent were classified to category 1, of whom 28.8 per cent had an extended wait
- 29.2 per cent were classified to category 2, of whom 44.0 per cent had an extended wait
- 37.8 per cent were classified to category 3, of whom 24.3 per cent had an extended wait.

Overall in WA, 31.6 per cent of all patients experienced extended waits (table 10A.30).

Of patients admitted from waiting lists in SA in 2006-07, the percentage of patients classified to each category and the percentage with an extended wait were:

- 33.8 per cent were classified to category 1, of whom 22.5 per cent had an extended wait
- 27.7 per cent were classified to category 2, of whom 22.1 per cent had an extended wait
- 38.5 per cent were classified to category 3, of whom 9.5 per cent had an extended wait.

Overall in SA, 17.4 per cent of all patients experienced extended waits (table 10A.32).

Of patients admitted from waiting lists in Tasmania in 2006-07, the percentage of patients classified to each category and the percentage with an extended wait were:

- 42.2 per cent were classified to category 1, of whom 25.0 per cent had an extended wait
- 37.5 per cent were classified to category 2, of whom 46.1 per cent had an extended wait
- 20.3 per cent were classified to category 3, of whom 22.6 per cent had an extended wait.

Overall in Tasmania, 32.4 per cent of all patients experienced extended waits (table 10A.34).

Of patients admitted from waiting lists in the ACT in 2006-07, the percentage of patients classified to each category and the percentage with an extended wait were:

- 29.7 per cent were classified to category 1, of whom 7.2 per cent had an extended wait
- 47.5 per cent were classified to category 2, of whom 49.1 per cent had an extended wait
- 22.8 per cent were classified to category 3, of whom 30.4 per cent had an extended wait.

Overall in the ACT, 32.4 per cent of all patients experienced extended waits (table 10A.35).

Of patients admitted from waiting lists in NT in 2006-07, the percentage of patients classified to each category and the percentage with an extended wait were:

- 47.7 per cent were classified to category 1, of whom 19.2 per cent had an extended wait
- 35.1 per cent were classified to category 2, of whom 43.0 per cent had an extended wait
- 17.2 per cent were classified to category 3, of whom 39.9 per cent had an extended wait.

Overall in the NT, 31.1 per cent of all patients experienced extended waits (table 10A.37).

Attachment 10A includes data on ‘elective surgery waiting times’ by hospital peer group, specialty of surgeon and indicator procedure (tables 10A.21, 10A.22 and 10A.23). All jurisdictions (except Tasmania) also provided data on urgency category waiting times by clinical specialty for 2006-07 (tables 10A.25, 10A.27, 10A.29, 10A.31, 10A.33, 10A.36 and 10A.38).

Effectiveness — appropriateness

Separation rates for selected procedures

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

Box 10.6 Separation rates for selected procedures

‘Separation rates for selected procedures’ is defined as separations per 1000 people for certain procedures, and for caesarean section separations per 100 in-hospital births. The procedures are selected for their frequency, for being elective and discretionary, and because alternative treatments are sometimes available.

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

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

Data reported for this indicator are comparable.

The ‘separation rates for selected procedures’ reported here include all hospitals and reflect the activities of both public and private health systems. The most common procedures of those reported in 2006-07 were lens insertions, caesarean sections and cholecystectomies (table 10.9).

For all procedures, separation rates varied across jurisdictions. Statistically significant and material differences in the separation rates for these procedures may highlight variations in treatment methods across jurisdictions. Table 10A.39 presents standardised separation rate ratios — comparing the separation rate in each jurisdiction with the national rate — along with confidence intervals for each ratio.

Table 10.9 Separations for selected procedures or diagnoses per 1000 people, all hospitals, by patient's usual residence, 2006-07^{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>Total^d</i>
<i>Procedure/diagnosis</i>									
Coronary artery bypass	0.7	0.6	0.7	0.4	0.7	0.5	0.4	0.9	0.6
Coronary angioplasty	1.7	1.7	1.3	1.5	1.4	1.5	1.4	1.0	1.6
Caesarean section: separation rate	4.3	4.3	4.9	4.8	4.4	4.2	3.6	4.4	4.4
separations per 100 in-hospital births ^e	29.7	31.4	33.4	33.3	33.2	27.9	28.5	30.5	31.4
Cholecystectomy	2.2	2.3	2.3	2.2	2.3	2.0	2.0	1.8	2.2
Hip replacement	1.3	1.4	1.2	1.6	1.4	1.7	1.5	0.8	1.3
Revision of hip replacement	0.2	0.2	0.1	0.2	0.1	0.2	0.2	0.1	0.2
Hysterectomy ^f	1.3	1.2	1.3	1.3	1.5	1.5	1.3	1.1	1.3
Lens insertion	8.3	7.6	9.3	8.2	7.0	6.2	6.2	7.9	8.1
Tonsillectomy	1.8	1.8	1.8	1.9	2.5	1.3	1.9	1.1	1.8
Myringotomy	1.3	1.6	1.3	1.7	2.9	1.1	1.7	0.6	1.5
Knee replacement	1.7	1.3	1.5	1.7	1.5	1.4	1.7	0.8	1.5
Prostatectomy	1.3	1.5	1.3	1.3	1.3	1.4	1.1	0.9	1.4

^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. Excludes multiple procedures/diagnoses for the same separation within the same group. ^b The procedures and diagnoses are defined using ICD-10-AM codes. ^c Rates per 1000 people were directly age standardised to the Australian population at 30 June 2001. ^d Includes other territories. Excludes non-residents and unknown state or territory of residence. ^e Caesarean sections divided by separations for which in-hospital birth was reported. This is an approximate measure of the proportion of all births that are by caesarean section because births out of hospital are not included. ^f Includes hysterectomies for females aged 15–69 years only. Rate is determined using total population for state or territory.

Source: AIHW 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.39.

Effectiveness — quality

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

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

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

Safety

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

Data for the 'safety' indicators come from the ACHS Comparative Report Service (Clinical Indicators). The ACHS data are collected for internal clinical review by individual hospitals. They are predominantly used to demonstrate the potential for improvement across Australian hospitals, if all hospitals could achieve the same

outcomes as the hospitals that achieve the best outcomes for patients. When interpreting results of these indicators, emphasis needs to be given to the potential for improvement. Statewide conclusions cannot be drawn because participation by public hospitals in the Comparative Report Service (Clinical Indicators) is generally voluntary, so the data are not necessarily drawn from representative samples of hospitals (box 10.7).

Box 10.7 Reporting of ACHS clinical indicators

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

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

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

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

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

(Continued on next page)

Box 10.7 (Continued)

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

Source: ACHS; (unpublished, 2003).

Safety — unplanned re-admission rates

‘Unplanned re-admission rates’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality (box 10.8). 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). These estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are potentially unreliable. The statistical terms used to describe this indicator are explained in box 10.9.

Box 10.8 Unplanned re-admission rates

'Unplanned re-admission rates' show the rate at which patients unexpectedly return to hospital within 28 days for further treatment of the same condition or a condition related to the initial admission. The '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.

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

Box 10.9 Definition of terms for ACHS clinical indicators

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

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

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

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

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

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

rate: the sum of the numerators divided by the sum of the denominators, which is also the weighted mean of the individual rates of the ACHS reporting hospitals. This weighted 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 2007, the mean rate of ‘unplanned re-admissions’ was 2.3 per 100 admissions (table 10.10). The ACHS estimated that if the performance

of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 1.1 per cent (or 9879) 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 fifth of total public hospital separations. The number of ACHS reporting hospital separations used to derive this indicator was around 903 000 in 2007 (ACHS unpublished), whereas the total number of separations in 2006-07 was around 4.7 million (AIHW 2008a). 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 2007 are shown in table 10.10. The coverage of the ACHS data may differ across these states. Data for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals reported 'unplanned re-admissions' in each of those jurisdictions.

Table 10.10 **Unplanned re-admissions, ACHS reporting public hospitals, 2007^a**

	<i>Unit</i>	<i>Results</i>
National rate (per 100 separations)	%	2.3
National performance at 80th centile (rate)	(%)	5.2
National performance at 20th centile (rate)	(%)	1.2
NSW		
Numerator (re-admissions)	no.	7 482
<i>Denominator (separations)</i>	no.	351 684
Rate (per 100 separations)	%	2.1
Standard error (\pm)		0.2
ACHS reporting hospitals	no.	57
Victoria		
Numerator (re-admissions)	no.	4 005
<i>Denominator (separations)</i>	no.	151 314
Rate (per 100 separations)	%	2.6
Standard error (\pm)		0.3
ACHS reporting hospitals	no.	33
Queensland		
Numerator (re-admissions)	no.	3 454
<i>Denominator (separations)</i>	no.	109 874
Rate (per 100 separations)	%	3.1
Standard error (\pm)		0.3
ACHS reporting hospitals	no.	16
WA		
Numerator (re-admissions)	no.	2 038
<i>Denominator (separations)</i>	no.	132 368
Rate (per 100 separations)	%	1.5
Standard error (\pm)		0.3
ACHS reporting hospitals	no.	22
SA		
Numerator (re-admissions)	no.	1 282
<i>Denominator (separations)</i>	no.	31 115
Rate (per 100 separations)	%	4.1
Standard error (\pm)		0.6
ACHS reporting hospitals	no.	6

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

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

Safety — pre-anaesthetic consultation rates

‘Pre-anaesthetic consultation rates’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality. 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 (box 10.10).

Following a redevelopment of the ACHS’s anaesthetic indicators between their 2004 and 2005 data collections, there has been a reduction in the number of hospitals providing data for this indicator. Pre-anaesthetic consultation rate estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are potentially unreliable. The statistical terms used to describe this indicator are explained in box 10.9.

Box 10.10 Pre-anaesthetic consultation rates

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

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

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

Source: ACHS (2004).

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2007, the mean rate of ‘pre-anaesthetic consultations’ was 91.9 per 100 procedures (table 10.11). The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 80th centile, there would be 8.0 per cent (or 701) 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.

NSW was the only jurisdiction with five or more hospitals reporting ‘pre-anaesthetic consultations’ to the ACHS Comparative Report Service in 2007 (table 10.11). Data for 2007 for other jurisdictions are not reported separately because fewer than five hospitals reported ‘pre-anaesthetic consultations’ in each of those jurisdictions. Data for 2005 are reported for Victoria in table 10A.46.

Table 10.11 Pre-anaesthetic consultation rates, ACHS reporting public hospitals, 2007^a

	<i>Unit</i>	<i>Results</i>
National rate (per 100 separations)	%	91.9
National performance at 80th centile (rate)	(%)	100.0
National performance at 20th centile (rate)	(%)	92.8
<i>New South Wales</i>		
Numerator (pre anaesthetic consultations)	no.	2 858
Denominator (procedures)	no.	2 858
Rate (per 100 separations)	%	100
Standard error (±)		0.8
ACHS reporting hospitals	no.	6

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

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

Safety — surgical site infection rates

‘Surgical site infection rates’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality. Surgical site infections can result in serious consequences for individual patients, place a significant burden on the health system and are influenced by the safety of hospital practices and procedures. ‘Surgical site infection rates’ are reported for four frequently performed procedures — hip prosthesis, knee prosthesis, lower segment caesarean section and abdominal hysterectomy (box 10.11). These estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that the data may be potentially unreliable. The statistical terms used to describe this indicator are explained in box 10.9.

Box 10.11 **Surgical site infection rates**

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

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

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

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2007, the mean ‘surgical site infection rate’ for hip prosthesis surgery was 1.3 per 100 separations (table 10.12). 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 0.47 per cent (or 29) 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 1.2 per 100 separations (table 10.12). 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 0.68 per cent (or 48) 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 0.9 per 100 separations (table 10.12). 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 0.57 per cent (or 121) 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 1.9 per 100 separations (table 10.12). The ACHS estimated that if the performance of all Australian public hospitals matched national performance at the

20th centile, there would be 0.3 per cent (or 3) fewer infections following abdominal hysterectomy surgery (ACHS unpublished).

For jurisdictions with more than five hospitals reporting 'surgical site infections' to the ACHS Comparative Report Service, the mean rates in 2007 are shown in table 10.12. The coverage of the ACHS data may differ across these states. 'Surgical site infection rates' for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals participated in the ACHS Comparative Report Service.

Table 10.12 Surgical site infections, ACHS reporting public hospitals, by selected procedure, 2007^{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 (per 100 separations)	%	1.3	1.2	0.9	1.9
National performance at 80th centile (rate)	(%)	1.5	1.7	1.8	2.6
National performance at 20th centile (rate)	(%)	0.9	0.5	0.3	1.6
NSW					
Numerator (infections)	no.	28	35	8	np
Denominator (procedures)	no.	1 489	2 005	2 630	np
Infection rate (per 100 separations)	%	1.9	1.7	0.3	np
Standard error (±)		0.1	0.2	0.2	np
ACHS reporting hospitals	no.	12	11	11	np
Victoria					
Numerator (infections)	no.	21	12	np	np
Denominator (procedures)	no.	1 144	785	np	np
Infection rate (per 100 separations)	%	1.8	1.5	np	np
Standard error (±)		0.2	0.3	np	np
ACHS reporting hospitals	no.	5	5	np	np
Queensland					
Numerator (infections)	no.	6	7	25	13
Denominator (procedures)	no.	1 378	1 726	8 224	728
Infection rate (per 100 separations)	%	0.4	0.4	0.3	1.8
Standard error (±)		0.1	0.2	0.1	0.2
ACHS reporting hospitals	no.	10	10	11	6
WA					
Numerator (infections)	no.	8	7	32	np
Denominator (procedures)	no.	859	1 190	2 443	np
Infection rate (per 100 separations)	%	0.9	0.6	1.3	np
Standard error (±)		0.2	0.3	0.2	np
ACHS reporting hospitals	no.	7	8	9	np

(Continued on next page)

Table 10.12 (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	39	np
Denominator (procedures)	no.	np	np	4 502	np
Infection rate (per 100 separations)	%	np	np	1	np
Standard error (\pm)		np	np	0.2	np
ACHS reporting hospitals	no.	np	np	5	np

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

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

Responsiveness — patient satisfaction surveys

‘Patient satisfaction surveys’ is a proxy indicator of governments’ objective to deliver services that are high quality and responsive to individual patient needs (box 10.12). This section reports how jurisdictions use patient satisfaction surveys to improve the quality of public hospital services. The ‘patient satisfaction’ indicator reports satisfaction ratings taken from each jurisdiction’s patient surveys (box 10.20).

Box 10.12 Patient satisfaction surveys

The ‘Patient satisfaction surveys’ indicator provides information on how jurisdictions used patient satisfaction surveys to improve public hospital quality in recent years.

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. 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.

Data reported for this indicator are not directly comparable.

Some jurisdictions have provided general information about use of patient satisfaction surveys. 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.

- In NSW a mailout survey was conducted in February 2007 of overnight admitted patients, same day admitted patients, paediatric admitted patients, adult rehabilitation admitted patients, non-admitted emergency patients, community health patients and non-admitted outpatients. Area health services have developed action plans to respond to top priority areas for improving patient experience identified in the inaugural 2007 patient survey. Improvement in these areas will be measured by repeat surveys in 2008 and 2009 (table 10A.73).
- In Victoria a survey was conducted between 1 March 2007 and 29 February 2008 using a mailout questionnaire to adult acute and sub-acute patients of Victorian public hospitals. Hospitals are provided with a six monthly report (if they have had more than 30 respondents). The report provides them with information and an overall care index score as well as scores for six sub-indices. The scores are benchmarked with similar hospitals and the state average for all hospitals. Using this information the health services can identify areas for improvement (table 10A.74).
- In Queensland, computer assisted telephone interviews were conducted with medical patients discharged between 1st July and 31st December 2007. Each hospital's detailed results are fed back and are used in planning service improvements. The process taking place is as follows:
 - hospital survey results are disseminated to hospitals
 - hospitals review their results in detail and determine areas for improvement
 - hospitals develop Action Plans to address areas for improvement
 - hospitals implement Action Plans
 - governance units at an Area or State level monitor the implementation of Action Plans (table 10A.75).
- In WA, a computer assisted telephone interview survey was conducted between February 2008 and June 2008 for admitted patients and emergency department patients. In WA, each participating hospital in the state receives a detailed survey report, and by request, a workshop to assist in the interpretation of the survey results and communicate the results back to hospital staff. Reports identify aspects of health care that are most important to their patients, scale scores for those aspects of health care, patient rated outcomes and overall indicators of satisfaction. Scale scores are compared with previous years and with peer hospitals and significant differences identified. The hospitals use this

information to support strategic plans for improvements; identify areas where patients are highly satisfied; and in the accreditation process. Some examples of how hospitals have used the survey to improve public hospital quality include development of bedside patient information packages, improved discharge coordination procedures, improved call bell systems and lighting, and improved pre-admission services (table 10A.76).

- In SA, a computer assisted telephone interview survey was conducted between June 2007 and July 2007 of adult patients who had attended an emergency department. Survey results will inform the public hospital system of the key areas of care and service that are important to patients as well as the areas of care and service that require improvement from the patients perspective (table 10A.77).
- In Tasmania, a mailout survey was conducted for both admitted patients and emergency department patients from 1 June 2007 to 31 August 2007. Each hospital was provided an individual report which was analysed by safety and quality managers and senior management. The information captured has informed business and strategic plans for quality improvement activities in the hospitals. Evaluation of interventions as a result of survey information will be possible with further focused surveying in early 2009 (table 10A.78).
- In the ACT, the three most recent surveys were conducted at two different hospitals, one in 2007 and the other two in 2007-08. Survey 1 covered admitted patients in acute wards, Day surgery patients and Emergency Department patients. Surveys 2 and 3 covered eligible patients who had been discharged from the hospital during the reporting period. Information from surveys has been communicated back to staff in the form of posters, discussions in staff meetings and scoreboard displays. A program called Simply Better has been rolled out to improve communication with patients by staff, regarding patients' plan of care, pain management and duration of care. In addition, as a result of feedback from surveys, a number of quality improvement projects have occurred, including the Fasttrack program, food services projects for older people, changes in car parking and planned improvements to the layout of Emergency Department (table 10A.79).
- In the NT, various surveys were conducted in 2007 and 2008 across a variety of admitted patients in public acute care hospitals and outpatients. There has been an increase in the number of Aboriginal Liaison Officers, and resources have been developed to assist with informing patients of their rights and responsibilities in different languages and using different communication tools. Visual tools have also been developed and seating and facilities in waiting areas have been increased (table 10A.80).

Capability — hospital accreditation

‘Hospital accreditation’ is an indicator of governments’ objective to provide public hospital services that are of high quality (box 10.13). Data for this indicator are shown in figure 10.15.

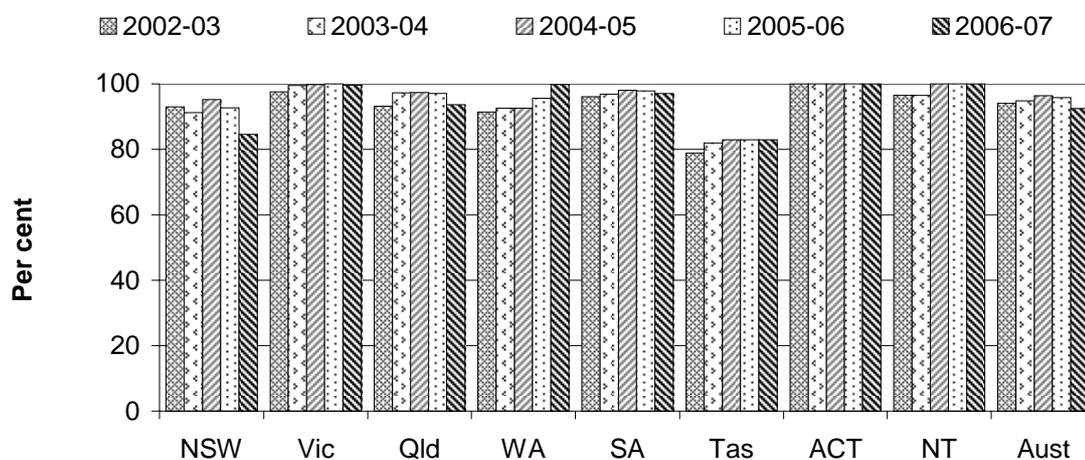
Box 10.13 Accreditation

‘Accreditation’ is defined as the ratio of accredited beds to all beds in public hospitals. The number of beds indicates the level of hospital capacity or activity. ‘Accreditation’ signifies professional and national recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals 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 Organisation for Standardization’s (ISO) 9000 quality family or other equivalent programs. Jurisdictions apply specific criteria to determine which accreditation programs are suitable. Quality programs require hospitals to demonstrate continual adherence to quality improvement standards to gain and retain accreditation.

It is not possible to draw conclusions about the quality of care in those hospitals that do not have ‘accreditation’. Public hospital accreditation is voluntary in all jurisdictions except Victoria, where it is mandatory for all public hospitals (excluding those that provide only dental or mothercraft services). The costs of preparing a hospital for accreditation are significant, and a low level of accreditation 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).

Data reported for this indicator are comparable.

Figure 10.15 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 (various years), *Australian Hospital Statistics*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.54.

Continuity — continuity of care

‘Continuity of care’ is an indicator of governments’ objective to provide public hospital services that are of high quality (box 10.14).

Box 10.14 Continuity of care

Continuity of care measures the provision of uninterrupted, timely, coordinated healthcare, interventions and actions across programs, practitioners and organisations.

Continuity of care has been identified as a key area for development in future reports.

Effectiveness — sustainability

Workforce sustainability

‘Workforce sustainability’ is an indicator of governments’ objective to provide sustainable public hospital services (box 10.15).

Box 10.15 Workforce sustainability

The 'workforce sustainability' indicator reports age profiles for nurse and medical practitioner workforces. It shows the proportions of registered nurses and medical practitioners in ten year age brackets, both by jurisdiction and by region.

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

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

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

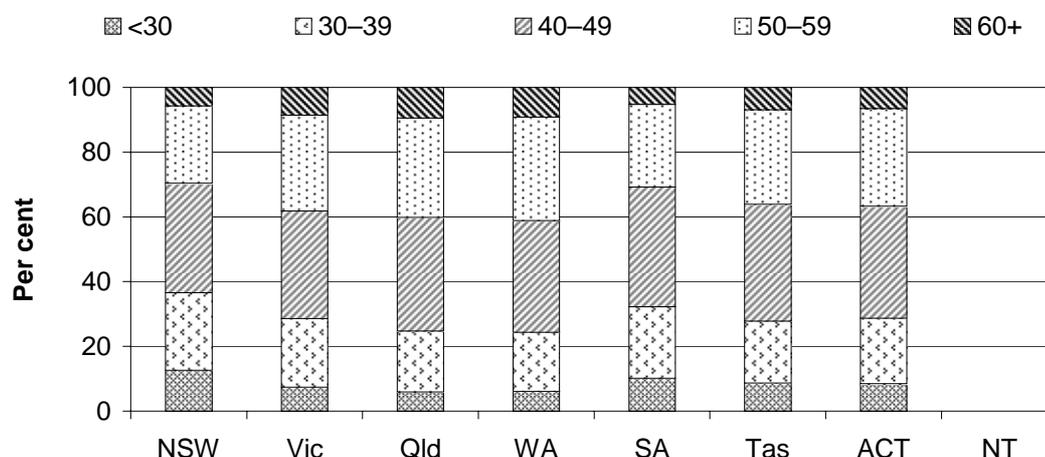
These measures are not a substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. They can, however, indicate that further attention should be given to workforce sustainability for public hospitals.

Data reported for this indicator are comparable.

Source: National Health Performance Committee (2004).

Data for 2006 were available for the medical workforce but not for the nursing workforce. Nursing workforce data for 2005 were first reported in the 2008 Report and are reported again this year. The age profile of the nursing workforce (which includes midwives) for each jurisdiction, except the NT, is shown in figure 10.16. Nursing workforce data by region are shown in figure 10.17.

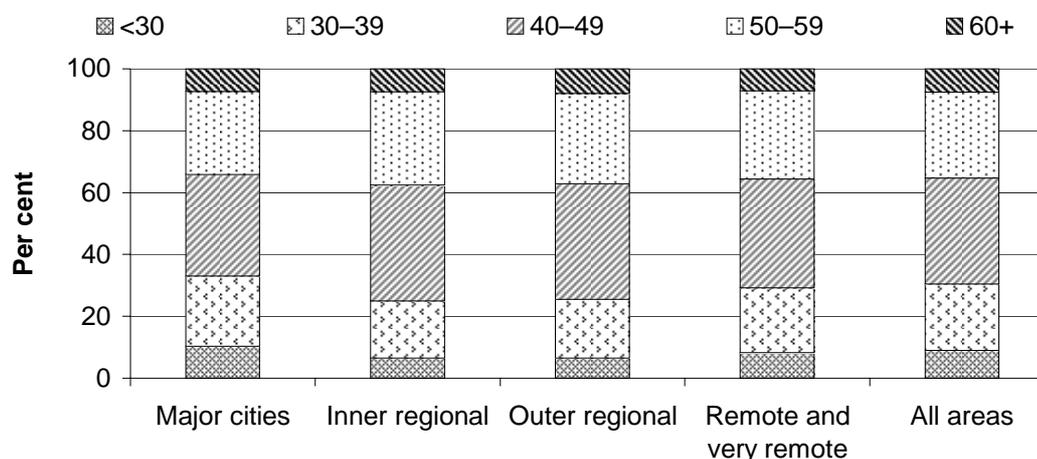
Figure 10.16 Nursing workforce, by age group, 2005^{a, b}



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

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

Figure 10.17 Nursing workforce, by age group and region, 2005^a

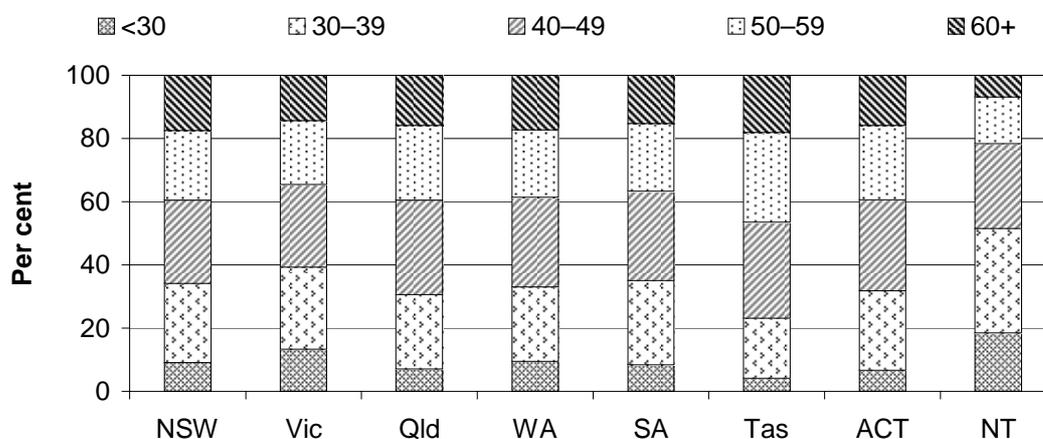


^a Includes registered and enrolled nurses (including midwives) who are employed in nursing, on extended leave and looking for work in nursing.

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

The age profile of the medical practitioner workforce in 2006 for each jurisdiction is shown in figure 10.18. Medical practitioner workforce data for 2006 by region are shown in figure 10.19.

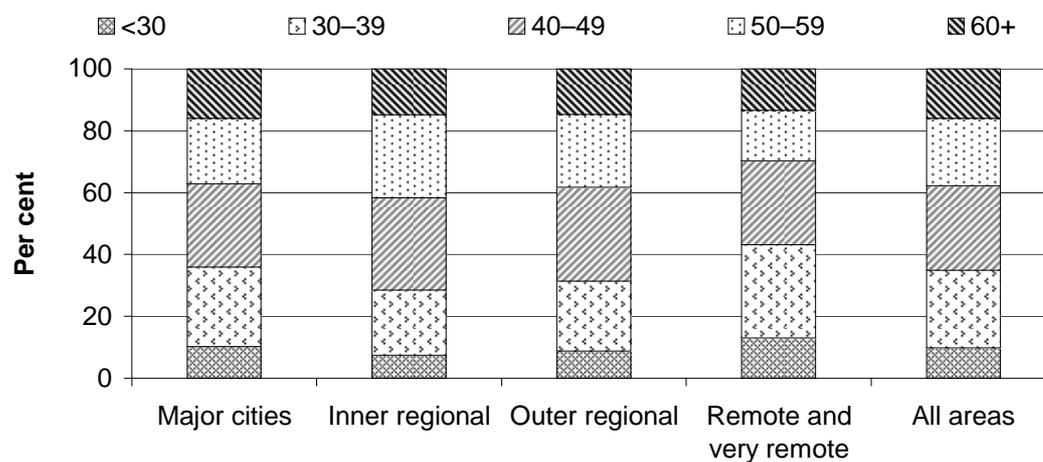
Figure 10.18 Medical practitioner workforce, by age group, 2006^{a, b}



^a Includes employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine. ^b Estimates for the NT should be treated with caution due to the low response rate (28.6 per cent) in that jurisdiction to the AIHW Medical Labour Force Survey.

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

Figure 10.19 Medical practitioner workforce, by age group and region, 2006^a



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

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

Efficiency

Two approaches to measuring the efficiency of public hospital services are used in this Report: the 'cost per casemix-adjusted unit of output' (the unit cost) and the

‘casemix-adjusted relative length of stay index’. The latter is used because costs are correlated with the length of stay at aggregate levels of reporting.

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

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

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

Care needs to be taken, therefore, in comparing unit costs across jurisdictions. Differences in counting rules, the treatment of various expenditure items (for example, superannuation) and the allocation of overhead costs have the potential to affect such comparisons. In addition, differences in the use of salary packaging 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 governments’ objective to deliver services in a cost effective manner (box 10.16). ‘Recurrent cost per casemix-adjusted separation’ data are presented in figure 10.20.

Box 10.16 Recurrent cost per casemix-adjusted separation

‘Recurrent cost per casemix-adjusted separation’ 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.

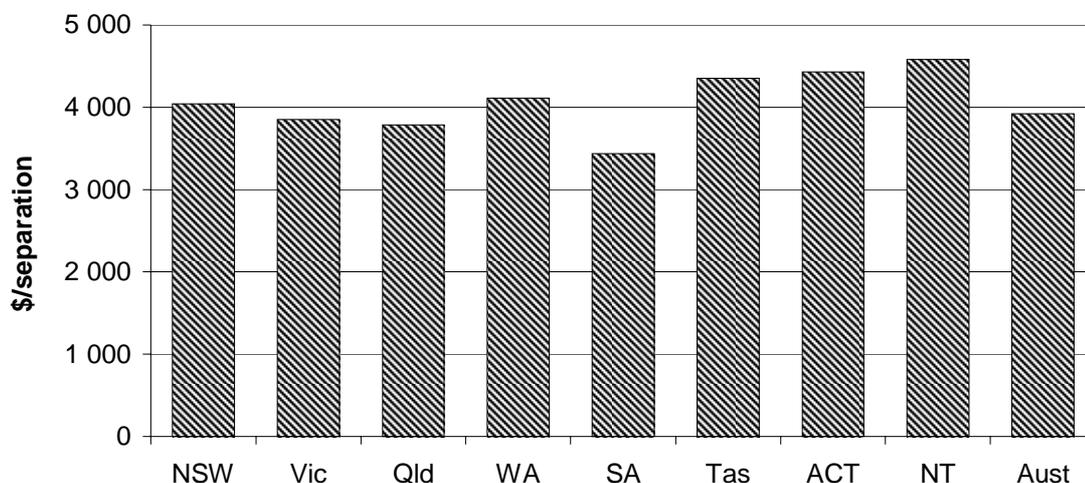
All admitted patient separations and their costs are included, and most separations are for acute care. Cost weights are not available for admitted patients who received non-acute care (2.3 per cent of total separations in 2006-07), so the same cost weights for acute care are applied to non-acute separations. The admitted patient cost proportion is an estimate only.

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

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

Data reported for this indicator are comparable.

Figure 10.20 **Recurrent cost per casemix-adjusted separation, 2006-07^{a, b, c, d, e, f, g}**

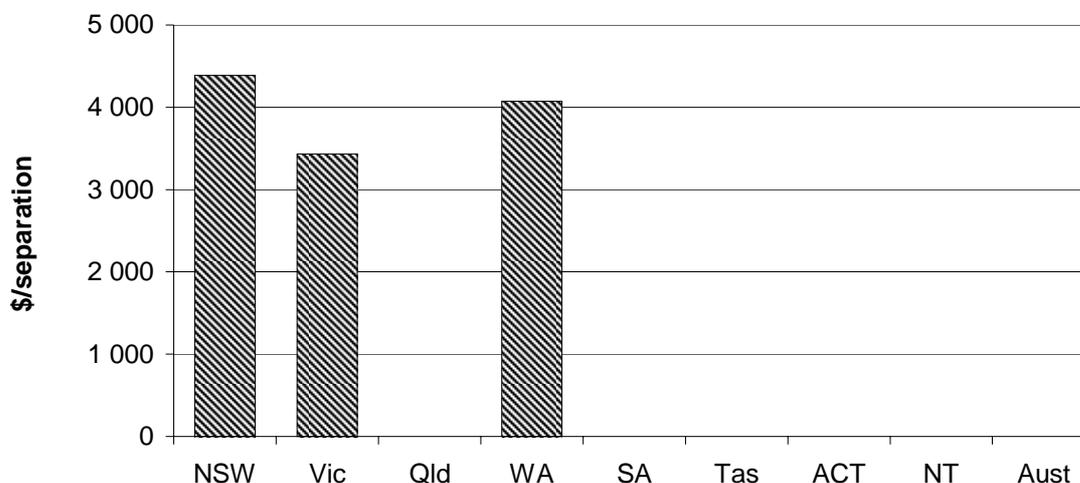


^a Excludes depreciation and the user cost of capital, spending on non-admitted patient care and research costs. ^b Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights are from the National Hospital Morbidity Database, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2005-06 AR-DRG v 5.1 cost weights (DoHA 2006). ^c Excludes separations for which the care type was reported as 'newborn with no qualified days', and records for hospital boarders and posthumous organ procurement. ^d Psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute hospitals and multi-purpose services are excluded from these data. The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included. ^e Of the selected hospitals, three small hospitals had their admitted patient cost proportion estimated by the Health and Allied Services Advisory Council ratio. Admitted patient cost proportion was previously called the inpatient fraction. ^f Hospital recurrent expenditures on Indigenous and non-Indigenous people may differ. 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 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.59.

Experimental estimates of 'recurrent cost per casemix-adjusted separation' for acute non-psychiatric patients are reported for NSW, Victoria and WA (figure 10.21). (These estimates relate to a subset of the selected public hospitals reported in figure 10.20 and are not available for other jurisdictions.) The experimental estimates aim to overcome the need to apply cost weights for acute care to non-acute care separations (box 10.16). The effect of restricting the analysis to acute non-psychiatric admitted patients was to increase the estimated recurrent cost per casemix-adjusted separation for the subset of hospitals by 3.9 per cent for NSW, and to decrease this cost by 10.9 per cent for Victoria and 4.1 per cent for WA (AIHW 2008a).

Figure 10.21 **Recurrent cost per acute non-psychiatric casemix-adjusted separation, subset of hospitals, 2006-07^{a, b, c, d, e, f}**



^a Excludes psychiatric hospitals, sub-acute, non-acute and unpeered hospitals. This subset excludes hospitals where the inpatient fraction was equal to the acute inpatient fraction and more than 1000 non-acute patient days were recorded. Also excludes hospitals where the apparent cost of non-acute patients exceeded \$1000 per day and more than \$1 million of apparent expenditure on non-acute patients days was reported.

^b Separations are those where the care type is acute, newborn with qualified days, or not reported. Psychiatric separations are those with psychiatric care days. ^c Average cost weight from the National Hospital Morbidity Database, based on acute, newborn with at least one qualified day, or not reported, using the 2005-06 AR-DRG version 5.1 cost weights (DoHA 2006). ^d Cost estimates include adjustment for private patient medical costs: \$217 for NSW, \$112 for Victoria and \$148 for WA. ^e These estimates are not available for Queensland, SA, Tasmania, the ACT or the NT. ^f Data are from table A1.11 of AIHW (2008a).

Source: AIHW 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.59.

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

The dominant peer classification is the ‘Principal referral and Specialist women’s and children’s’ category. The 81 hospitals representing this group had an average of 40 979 separations each at a cost of \$3959 (table 10A.60 and table 10.13). Data for each of the hospital peer groups are presented in table 10.13. Detailed data for all peer groups are presented in table 10A.60.

Table 10.13 Recurrent cost per casemix-adjusted separation, by hospital peer group, 2006-07 (\$ million)^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Hospital peer group									
Principal referral and Specialist women's and children's	4 139	3 839	3 866	4 084	3 478	4 323	np	4 523	3 959
Large	3 773	3 876	3 554	3 998	3 767	..	np	..	3 833
Medium	3 760	3 724	3 195	4 338	3 053	..	..	..	3 659
Small acute	4 016	4 740	3 314	4 384	3 046	5 358	..	4 969	4 002
All hospitals ^d	4 042	3 853	3 786	4 111	3 436	4 354	4 430	4 580	3 922

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

Source: AIHW 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.60.

Total cost per casemix-adjusted separation

'Total cost per casemix-adjusted separation' is an indicator of governments' objective to deliver services in a cost effective manner (box 10.17). Total cost includes both the recurrent costs (as discussed above) and the capital costs associated with hospitals services. Results for this indicator in 2006-07 are reported in figure 10.22. Labour costs accounted for the majority of costs per casemix-adjusted separation in all jurisdictions.

Box 10.17 Total cost per casemix-adjusted separation

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

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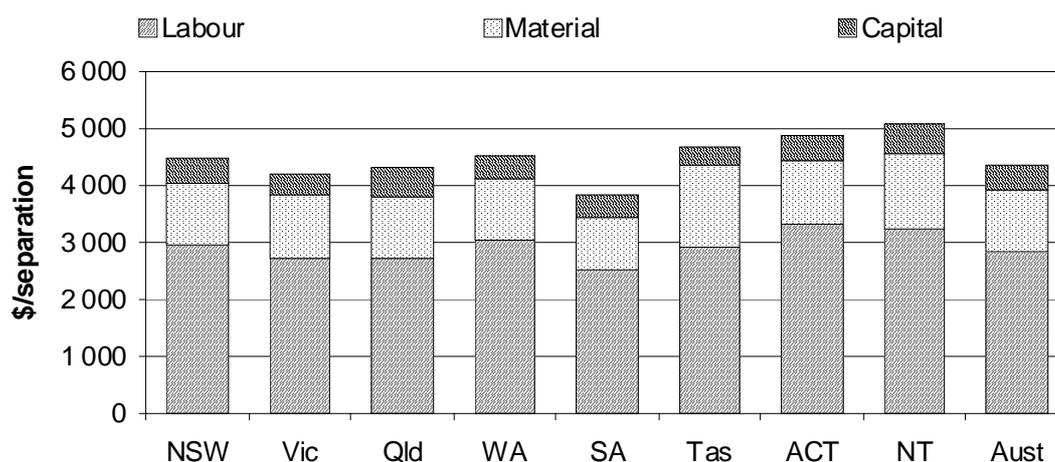
Box 10.17 (Continued)

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

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

Data reported for this indicator are comparable.

Figure 10.22 **Total cost per casemix-adjusted separation, public hospitals, 2006-07^{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 10A.59). ^b 'Capital cost' includes depreciation and the user cost of capital for buildings and equipment that is associated with the delivery of admitted patient services in the public hospitals as described in the data for recurrent cost per casemix-adjusted separation. 'Capital cost' excludes the user cost of capital associated with land (reported in table 10A.61). ^c Variation across jurisdictions in the collection of capital related data suggests the data are only indicative. The capital cost per casemix-adjusted separation is equal to the capital cost adjusted by the inpatient fraction, divided by the number of casemix-adjusted separations.

Source: AIHW 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; State and Territory governments (unpublished); tables 10A.59 and 10A.61.

Relative stay index

'Relative stay index' is an indicator of governments' objective to deliver services efficiently (box 10.18). Data for this indicator are reported in figure 10.23. The

'relative stay index' is reported by patient election status and by medical, surgical and other AR-DRGs in tables 10A.62 and 10A.63 respectively.

Box 10.18 Relative stay index

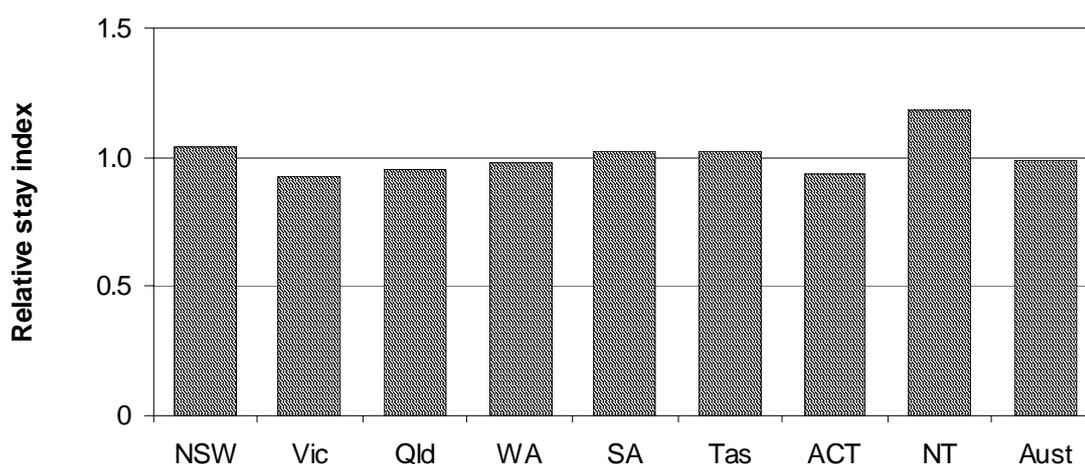
The 'relative stay index' is defined as the actual number of acute care patient days divided by the expected number of acute care patient days adjusted for casemix. Casemix adjustment allows comparisons to take account of variation in types of service provided but not other influences on length of stay,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

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

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

Data reported for this indicator are comparable.

Figure 10.23 Relative stay index, public hospitals, 2006-07^{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 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; table 10A.62.

Recurrent cost per non-admitted occasion of service

'Recurrent cost per non-admitted occasion of service' is an indicator of governments' objective to deliver services in a cost effective manner (box 10.19).

Box 10.19 Recurrent cost per non-admitted occasion of service

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.

Non-admitted occasions of service (including emergency department presentations and outpatient services) account for a significant proportion of hospital expenditure.

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

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

These data are not comparable across jurisdictions. Reporting categories vary across jurisdictions, and further inconsistencies arise as a result of differences in outsourcing practices. In some cases, for example, outsourced occasions of service may be included in expenditure on non-admitted services, but not in the count of occasions of service. Jurisdictions able to supply 2006-07 data for this indicator reported the following results for non-admitted patient services:

- In NSW, the emergency department cost per occasion of service was \$206 for 2.2 million occasions, the outpatient cost per occasion of service was \$98 for 14.5 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was \$108 for 19.5 million occasions (table 10A.64).
- In WA, the emergency department cost per occasion of service was \$390 for 643 000 occasions, the outpatient cost per occasion of service was \$201 for 2.6 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was \$184 for 3.8 million occasions (table 10A.66).
- In SA, the emergency department cost per occasion of service was \$299 for 515 000 occasions, the outpatient cost per occasion of service was \$234 for 1.4 million occasions and the overall cost per occasion of service (emergency plus outpatient) was \$251 for 1.9 million occasions (table 10A.67).

-
- In Tasmania, the emergency department cost per occasion of service was \$308 for 150 000 occasions and the outpatient cost per occasion of service was \$96 for 480 000 occasions. An overall cost per occasion of service was not available (table 10A.68).
 - In the ACT, the emergency department cost per occasion of service was \$518 for 96 000 occasions, the outpatient cost per occasion of service was \$96 for 581 000 occasions and the overall cost per occasion of service (emergency plus outpatient) was \$156 for 677 000 occasions (table 10A.69).

Victoria collects data on the basis of cost per non-admitted patient encounter. An encounter includes the clinic visit and all ancillary services provided within a 30 day period either side of the clinic visit. Based on cost data from 14 hospitals, the average cost per encounter was \$152 for 1.2 million encounters in 2006-07 (table 10A.65).

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

Outpatient data were contributed by 171 public hospitals for all types of public hospital outpatient clinics (tier 0). These data suggest that 'cost per non-admitted clinic occasions of service' for the public hospitals sector in 2006-07 was \$205 for 12.0 million occasions (table 10A.70). 'Cost per non-admitted clinic occasions of service' data are also shown for seven categories of outpatient clinics (tier 1) (table 10.14). These tier 1 outpatient clinics data were provided by 171 public hospitals. Emergency department data, provided by 174 public hospitals, show the 'cost per occasion of service for emergency departments' by triage class (table 10.15).

Table 10.14 Non-admitted clinic occasions of service for tier 1 clinics, sample results, public sector, 2006-07^{a, b, c}

	<i>Occasions of service</i>	
	no.	Average cost \$/occasion of service
Allied health and/or clinical nurse specialist	1 327 894	114
Dental	15 719	207
Medical	1 841 634	315
Obstetrics and gynaecology	718 055	226
Paediatric	179 148	240
Psychiatric	78 058	245
Surgical	1 041 200	207
Total	5 201 708	226

^a Includes depreciation costs. ^b Based on 171 public sector hospitals. ^c Excludes Victorian outpatient data.

Source: DoHA, 2008, *National Hospital Cost Data Collection Cost Report, Round 11 (2006-07)*, Australian Government, Canberra; table 10A.72.

Table 10.15 Emergency department average cost per occasion of service, public hospitals, by triage class, 2006-07 (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	1 061	1 092
Admitted triage 2	636	658
Admitted triage 3	549	575
Admitted triage 4	475	496
Admitted triage 5	324	354
Non-admitted triage 1	578	615
Non-admitted triage 2	444	456
Non-admitted triage 3	387	403
Non-admitted triage 4	289	302
Non-admitted triage 5	178	192
Did not wait ^g	64	68
Total	358	380

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

^b Based on data from 174 public sector hospitals. ^c Victorian emergency department data are not included.

^d Costing and admission practices vary across jurisdictions and hospitals. ^e Depreciation costs are included.

^f Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. ^g 'Did not wait' means those presentations to an emergency department who were triaged but did not wait until the completion of their treatment, at which time they would have been either admitted to hospital or discharged home.

Source: DoHA, 2008, *National Hospital Cost Data Collection Cost Report, Round 11 (2006-07)*, Australian Government, Canberra; table 10A.71.

Outcomes

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

Patient satisfaction

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

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

Box 10.20 Patient satisfaction

The 'patient satisfaction' indicator reports satisfaction ratings taken from each jurisdiction's patient surveys. Results are expressed in percentage terms or as scale scores. Patient satisfaction surveys are different from other sources of hospital quality data, because they provide information on hospital quality from the patient's perspective.

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.

Data reported for this indicator are not directly comparable.

Jurisdictions reported the following results from patient satisfaction surveys:

- In NSW a mailout survey was conducted in February 2007 of overnight admitted patients, same day admitted patients, paediatric admitted patients, adult rehabilitation admitted patients, non-admitted emergency patients, community health patients, non-admitted outpatients. The sample size was 216 575 and the response rate was 37.5 per cent. The overall Care Received Rating (good, very good, excellent) was 88.1 per cent (table 10A.73).
- In Victoria a survey was conducted between 1 March 2007 and 29 February 2008 using a mailout questionnaire to adult acute and sub-acute patients of Victorian public hospitals. During this period, 14 503 patients answered the questionnaire, which represented a response rate of 40.0 per cent. The statewide Overall Care Index was 78.1. The Overall Care Index (used to provide information used in this year's Victorian Patient Satisfaction Monitor (VPSM) annual report) is constructed from 25 individual survey questions from the VPSM survey and provides an overall measure of excellence. The Rating is: 20–40 poor to fair; 40–60 fair to good; 60–80 good to very good; 80–100 very good to excellent. An excellent score would only be achieved if every patient rated every question at the highest level (table 10A.74).
- In Queensland, computer assisted telephone interviews were conducted with medical patients discharged between 1st July and 31st December 2007. The sample size was approximately 15 000 with a response rate of 78.5 per cent. An interim analysis of survey results showed that medical patients in Queensland public hospitals were satisfied overall with their medical care (table 10A.75).
- In WA, a computer assisted telephone interview survey was conducted between February 2008 and June 2008 for admitted patients and emergency department patients. The sample size was 5086 admitted patients and 1585 emergency department patients, with 91.0 per cent of eligible admitted patients responding and 88.6 per cent of eligible emergency patients responding. The patient-rated overall indicator of satisfaction scores for each of the patient groups were as follows; child admitted (0–34 nights), 77.6; adult admitted (0–34 nights), 78.5; older admitted patients (75+ years), 80.5; long stay patients (+35 nights), 74.2; child emergency 76.0; and adult emergency 75.5. These scores are weighted by the importance of each issue as ranked by the patient and scored from 0 to 100, where 100 is the highest possible overall satisfaction score, taking into account all of the satisfaction domains measured (table 10A.76).
- In SA, a computer assisted telephone interview survey was conducted between June 2007 and July 2007 of adult patients who had attended an emergency department. There were 1535 completed interviews with a response rate of 75.9 per cent. The overall satisfaction score was 82.2 (scored from 0 to 100, being least to most satisfied). The highest satisfaction levels were found in the

Areas of 'Coordination and Consistency of Care' and 'Meeting Personal as well as Clinical Needs'. Statewide satisfaction was lowest for the Area of Residential Aspects of the Hospital (table 10A.77).

- In Tasmania, a mailout survey was conducted for both admitted patients and emergency department patients from 1 June 2007 to 31 August 2007. The sample size was 2868 admitted patients and 1248 emergency department patients, with 47.4 per cent of eligible admitted patients responding and 42.5 per cent of eligible emergency patients responding. For admitted patients the overall mean score for the standard questions was 80.7. For emergency department patients the overall mean score for the standard questions was 79.6 (table 10A.78).
- In the ACT, the three most recent surveys were conducted at two different hospitals, one in 2007 and the other two in 2007-08. Survey 1 covered admitted patients in acute wards, Day surgery patients and Emergency Department patients. Surveys 2 and 3 covered eligible patients who had been discharged from the hospital during the reporting period. Survey 1 sample size was 225 inpatients, 207 day surgery patients and 122 Emergency Department patients. Survey 2 had 453 sent questionnaires, and survey 3 had 459 sent questionnaires. Survey 1 had a 42 per cent response rate for Inpatients, a 59 per cent response rate for day surgery and a 25 per cent response rate for Emergency Department. Survey 2 had a response rate of 41.1 per cent, and Survey 3 had a response rate of 38.3 per cent. The average satisfaction level from the Survey 1 across Day Surgery, Emergency Department and Acute Inpatient areas was 78.6 per cent. The result from Survey 2 indicated that 94 per cent of patients reported that they were either satisfied or very satisfied with their stay at the hospital. This rating slightly decreased by 2 per cent in Survey 3 with 92 per cent of patients surveyed either very satisfied or satisfied with their hospital stay (table 10A.79).
- In the NT, various surveys were conducted in 2007 and 2008 across a variety of admitted patients in public acute care hospitals and outpatients. Surveys are conducted face to face often with the assistance of Aboriginal Liaison officers and members of the volunteer services. Sample sizes of the surveys have differed and on average the response rate has been 40 per cent. 84.3 per cent of respondents agreed medical explanations were provided when necessary, 78.3 per cent agreed they were told about their rights and responsibilities, and 83.5 per cent said the area/ward was clean and tidy (table 10A.80).

Sentinel events

‘Sentinel events’ is an indicator of governments’ objective to deliver public hospital services that are safe and of high quality (box 10.21). Data for 2006-07 are available for all jurisdictions (table 10.16). For the ACT a total only is included. Data for 2005-06 are reported in table 10A.81.

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

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

Box 10.21 **Sentinel events**

'Sentinel events' is defined as the number of reported adverse events that occur because of hospital system and process deficiencies and which result in the death of, or serious harm to, a patient. Sentinel events occur relatively infrequently and are independent of a patient's condition (DHS 2004). Sentinel events have the potential to seriously undermine public confidence in the healthcare system.

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

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

A 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).

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

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

Table 10.16 Nationally agreed core sentinel events, 2006-07 (number)^a

<i>Sentinel event</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA^b</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	9	20	33	6	29	1	np	na	98
2. Suicide of an admitted patient	10	11	2	3	3	–	np	na	29
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure	9	8	3	2	3	–	np	na	25
4. Intravascular gas embolism resulting in death or neurological damage	–	–	–	–	–	–	np	na	–
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility	–	1	1	–	–	–	np	1	3
6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs	3	3	6	2	–	–	np	na	14
7. Maternal death or serious morbidity associated with labour or delivery	1	2	4	2	1	–	np	1	11
8. Infant discharged to the wrong family	–	–	–	–	–	–	np	na	–
Total	32	45	49	15	36	1	7	2	187

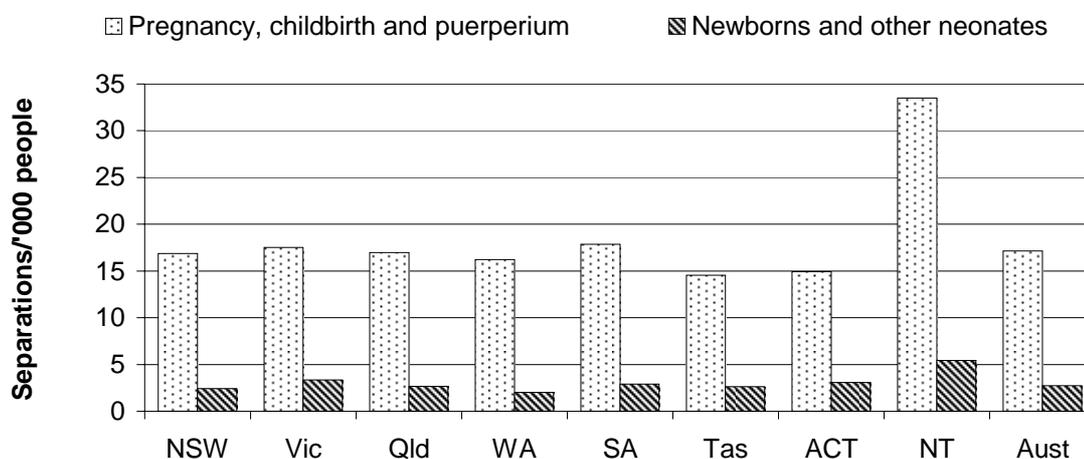
^a Sentinel event definitions can vary across jurisdictions. ^b Includes public and private hospitals. **na** Not available. – Nil or rounded to zero. **np** Not published.

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

10.4 Profile of maternity services

Maternity services (defined as AR-DRGs relating to pregnancy, childbirth and the puerperium, and newborns and other neonates) accounted for 9.2 per cent of total acute separations in public hospitals (table 10A.83) and around 11.0 per cent of the total cost of all acute separations in public hospitals in 2006-07 (table 10A.82). Figure 10.24 shows the rate of acute separations per 1000 people for maternity services across jurisdictions in 2006-07.

Figure 10.24 **Separation rates for maternity services, public hospitals, 2006-07^{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 2008a, *Australian Hospital Statistics 2006-07*, Health services series no. 31. Cat no. HSE 55, AIHW, Canberra; ABS (unpublished), derived from Australian Demographic Statistics, December Quarter 2007, Cat. no. 3101.0; tables AA.2 and 10A.83.

In Australian public hospitals in 2006-07, vaginal deliveries without complicating diagnosis accounted for a substantial proportion of the separations for pregnancy, childbirth and the puerperium (28.4 per cent) (tables 10A.83 and 10A.84). In the context of all AR-DRGs in public hospitals, vaginal deliveries without complicating diagnosis comprised the largest number of overnight acute separations (4.5 per cent of all separations) (table 10.3) and the second highest cost (\$415.0 million) (table 10A.84).

The complexity of cases across jurisdictions for maternity services is partly related to the mother's age at the time of giving birth. The mean age of mothers giving birth varied across jurisdictions in 2005, 2006 and 2007 (table 10.17).

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

	<i>NSW</i>	<i>Vic</i>	<i>Qld^a</i>	<i>WA</i>	<i>SA^b</i>	<i>Tas</i>	<i>ACT^c</i>	<i>NT</i>
2005								
First birth	27.8	27.7	25.5	25.9	26.6	25.1	27.6	24.2
Second birth	29.9	29.9	28.0	28.6	29.4	27.3	29.7	26.3
Third birth	31.4	31.4	29.5	29.9	31.1	29.4	31.0	28.0
All births	29.6	29.5	27.8	28.1	28.9	27.2	29.3	26.5
2006								
First birth	27.1	27.7	25.5	26.0	26.8	24.8	27.7	23.8
Second birth	30.4	29.9	28.1	28.5	29.4	27.7	30.1	26.3
Third birth	31.6	31.5	29.6	29.8	31.0	29.6	31.5	28.2
All births	29.3	29.5	27.9	28.1	29.0	27.2	29.6	26.5
2007								
First birth	28.1	27.8	27.1	26.0	26.9	na	28.0	24.1
Second birth	30.2	30.0	28.0	28.5	29.4	na	30.3	26.4
Third birth	31.4	31.5	29.7	30.0	31.1	na	31.4	27.8
All births	29.1	29.6	27.9	28.1	29.0	na	29.7	26.6

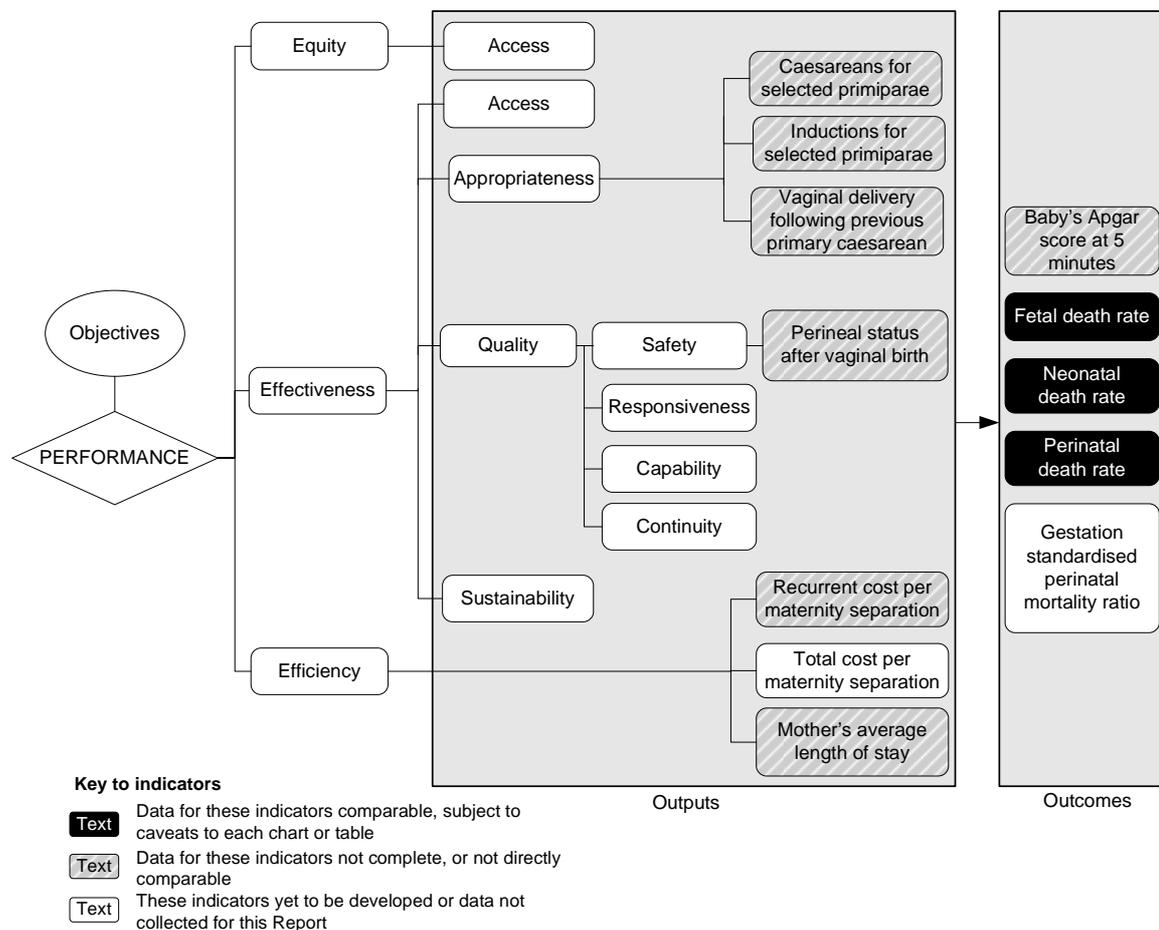
^a 2006 data exclude mothers whose age was 'not stated'. ^b Age is based on exact age (years) to 4 decimal places. ^c ACT 2007 data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. Between 2005 and 2007, 16.1 per cent of women who gave birth in the ACT were not residents. **na** Not available.

Source: State and Territory governments (unpublished).

10.5 Framework of performance indicators for maternity services

The performance framework for maternity services is outlined in figure 10.25, and has the same objectives as those for public hospitals in general. The framework is under development by the Steering Committee and, as with all the performance indicator frameworks, will be subject to regular review. The performance indicator framework shows which data are comparable in the 2009 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 10.25 Performance indicators for maternity services



10.6 Key performance indicator results for maternity services

Outputs

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

Equity — access

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

Effectiveness — access

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

Effectiveness — appropriateness

Caesareans and inductions for selected primiparae

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

Box 10.22 Caesareans and inductions for selected primiparae

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

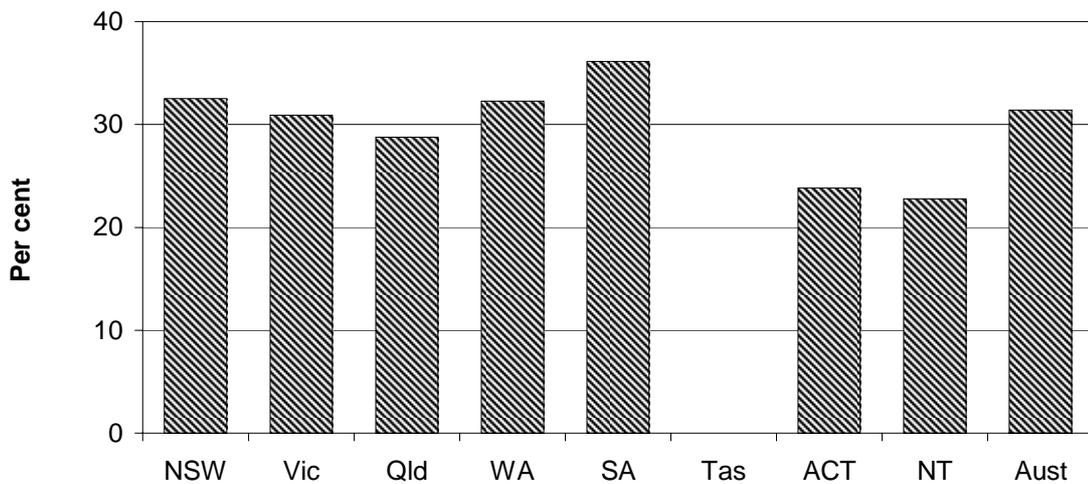
These indicators are defined as the number of inductions or caesareans for the selected primiparae divided respectively by the number of the selected primiparae who give birth. High intervention rates may indicate a need for investigation.

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

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

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

Figure 10.26 Inductions for selected primiparae, public hospitals, 2007^{a, b, c}

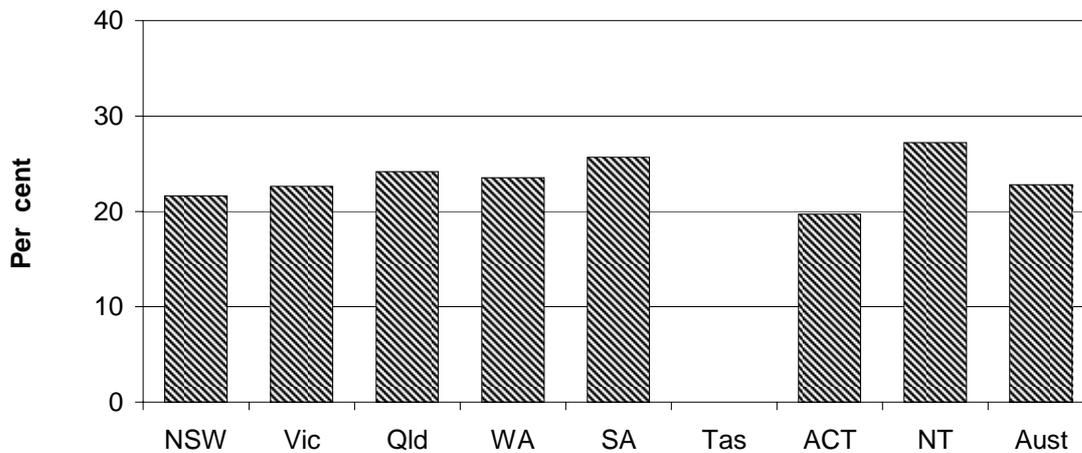


^a Data for Tasmania are not available. ^b ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2007, 16.6 per cent of women who gave birth in the ACT were not residents. ^c Rate for Australia includes only jurisdictions for which data are available.

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

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

Figure 10.27 **Caesareans for selected primiparae, public hospitals, 2007^{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 2007, 16.6 per cent of women who gave birth in the ACT were not residents. ^c Rate for Australia includes only jurisdictions for which data are available.

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

Vaginal birth following previous primary caesarean

‘Vaginal birth following previous primary caesarean’ is an indicator of the appropriateness of maternity services in public hospitals (box 10.23). 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 over-medicalisation of labour, poorer health outcomes and/or unnecessary costs.

Box 10.23 Vaginal birth following previous primary caesarean

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 reported for this indicator are not complete or directly comparable.

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

The mean rates of 'vaginal birth following a primary caesarean' in 2007 are shown in table 10.18 for jurisdictions with more than five hospitals reporting to the ACHS Comparative Report Service. The coverage of the ACHS data may differ across these states. Data for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals reported 'vaginal birth following a primary caesarean' in each of those jurisdictions.

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2007, the mean rate of 'vaginal birth following a previous primary caesarean' was 16.2 per 100 deliveries (table 10.18).

Given the uncertainty regarding whether high/low rates of vaginal birth following a previous primary caesarean are desirable, this Report does not include potential centile gains for this indicator.

Table 10.18 Vaginal births following previous primary caesarean, public hospitals, 2007^{a, b}

	<i>Unit</i>	<i>Results</i>
National rate	(%)	16.2
National performance at 80th centile (rate)	(%)	22.5
National performance at 20th centile (rate)	(%)	11.2
NSW		
Numerator (no. of VBACs)	no.	427
Denominator (no. of DACs)	no.	2 672
Rate	%	16.0
Standard error (±)		1.1
ACHS reporting hospitals	no.	32
Victoria		
Numerator (no. of VBACs)	no.	449
Denominator (no. of DACs)	no.	2 136
Rate	%	21.0
Standard error (±)		1.3
ACHS reporting hospitals	no.	26
Queensland		
Numerator (no. of VBACs)	no.	185
Denominator (no. of DACs)	no.	2 170
Rate	%	8.5
Standard error (±)		1.2
ACHS reporting hospitals	no.	10
WA		
Numerator (no. of VBACs)	no.	250
Denominator (no. of DACs)	no.	1 469
Rate	%	17.0
Standard error (±)		1.5
ACHS reporting hospitals	no.	12
SA		
Numerator (no. of VBACs)	no.	264
Denominator (no. of DACs)	no.	1 322
Rate	%	20.0
Standard error (±)		1.6
ACHS reporting hospitals	no.	12

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

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

Effectiveness — quality

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

Safety — perineal status after vaginal birth

‘Perineal status after vaginal birth’ is an indicator of governments’ objective to provide safe and high quality services (box 10.24). 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.

Box 10.24 Perineal status after vaginal birth

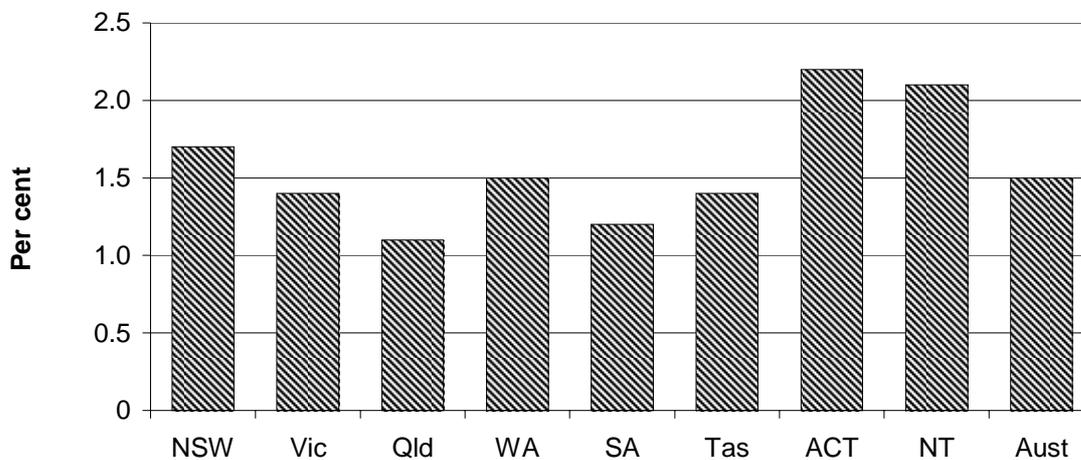
‘Perineal status after vaginal birth’ is the state of the perineum following a vaginal birth (NHDC 2003). A third or fourth degree laceration is a perineal laceration or rupture (or tear following episiotomy) extending to, or beyond, the anal sphincter (see section 10.8 for definitions) (NCCH 2008).

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

Data reported for this indicator are not directly comparable.

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

Figure 10.28 **Perineal status — mothers with third or fourth degree lacerations after vaginal births, 2006^{a, b, c}**



^a For multiple births, the perineal status after birth of the first child was used. ^b Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths. ^c Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2006, 16.3 per cent of women who gave birth in the ACT were not residents.

Source: Laws P. and Hilder L., 2008, Australia's Mothers and Babies 2006, AIHW Cat. No. PER 46, AIHW National Perinatal Statistics Unit (Perinatal Statistics Series No. 22), Sydney; table 10A.99.

Responsiveness

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

Capability

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

Continuity

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

Effectiveness — sustainability

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

Efficiency

Recurrent cost per maternity separation

‘Recurrent cost per maternity separation’ is an indicator of governments’ objective to deliver cost effective services (box 10.25).

Box 10.25 Recurrent cost per maternity separation

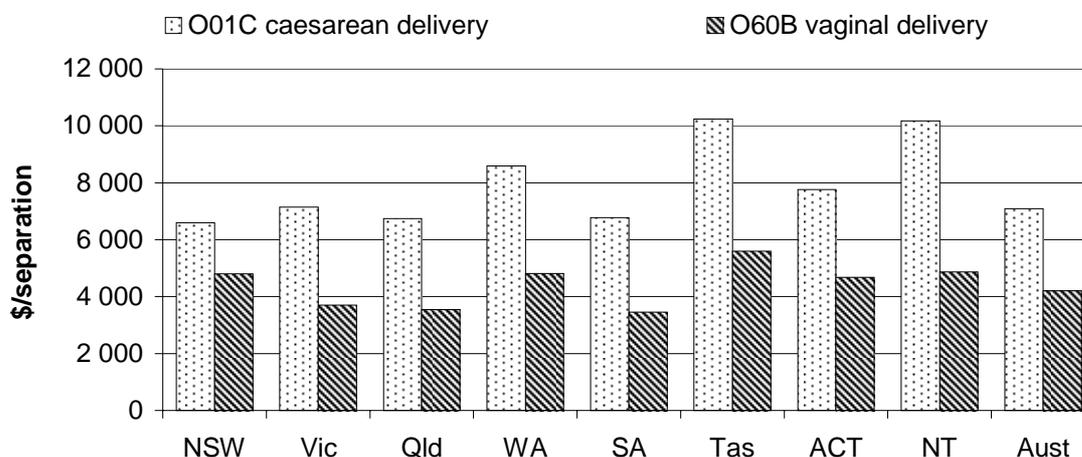
‘Recurrent cost per maternity separation’ is presented for the two AR-DRGs (version 5.1) that account for the largest number of maternity patient days: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities.

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

Data reported for this indicator are not directly comparable.

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

Figure 10.29 **Estimated average cost per separation for selected maternity related AR-DRGs, public hospitals, 2006-07^{a, b}**



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

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

Source: DoHA, 2008, *National Hospital Cost Data Collection Cost Report, Round 11 (2006-07)*, Australian Government, Canberra; table 10A.100.

Total cost per maternity separation

‘Total cost per maternity separation’ (recurrent cost plus capital cost) is an indicator of governments’ objective to deliver cost effective services (box 10.26).

Box 10.26 Total cost per maternity separation

‘Total cost per maternity separation’ as a measure of the efficiency of public hospital maternity services.

Total cost per maternity separation has been identified as a key area for development in future reports.

Mother’s average length of stay

‘Mother’s average length of stay’ is an indicator of governments’ objective to deliver services efficiently (box 10.27). Data are reported for the two most common maternity AR-DRGs: caesarean delivery without catastrophic or severe

complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities (figure 10.30).

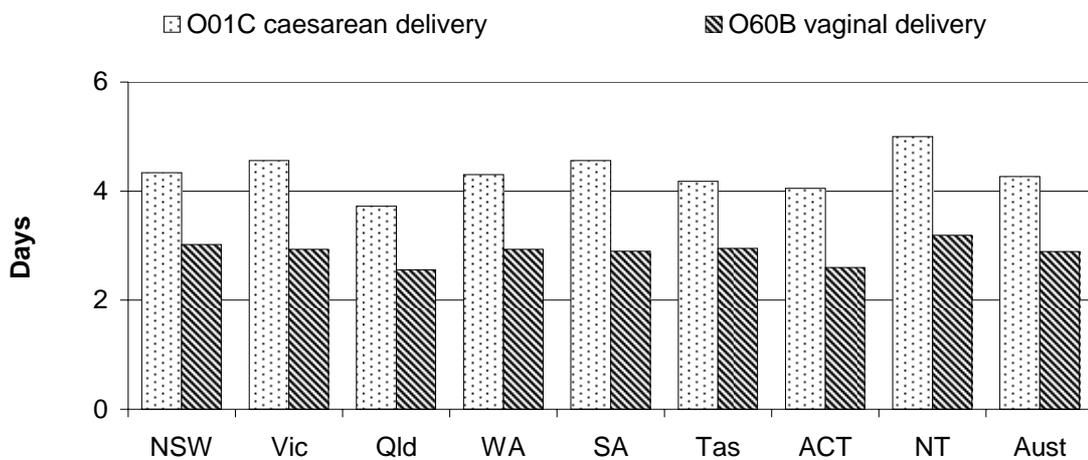
Box 10.27 Mother’s average length of stay

‘Mother’s average length of stay’ is defined as the total number of patient days for the selected maternity AR-DRG (version 5.1), 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.

Data reported for this indicator are not directly comparable.

Figure 10.30 Average length of stay for selected maternity-related AR-DRGs, public hospitals, 2006-07^a



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

Source: DoHA, 2008, *National Hospital Cost Data Collection Cost Report, Round 11 (2006-07)*, Australian Government, Canberra. table 10A.100.

Outcomes

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

Apgar score

‘Apgar score at five minutes’ is an indicator of governments’ objective to deliver maternity services that are safe and of high quality (box 10.28). ‘Low’ Apgar scores for babies by birthweight category are contained in table 10.19. The range of Apgar scores for 2003 to 2007 are reported in table 10A.101.

Box 10.28 Apgar score at five minutes

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.

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

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

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

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

Table 10.19 Live births with an Apgar score of 3 or lower, five minutes post-delivery, public hospitals, 2007

<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</i>
Less than 1500	no.	774	658	526	289	215	na	49	57
Low Apgar	%	15.9	17.3	12.6	9.3	12.6	..	20.4	14.0
1500-1999	no.	942	712	606	344	195	na	74	45
Low Apgar	%	1.8	1.3	1.2	1.2	0.5	..	–	–
2000-2499	no.	2 827	2 067	1 654	858	653	na	146	166
Low Apgar	%	0.6	0.5	0.5	0.5	0.7	..	1.4	1.8
2500 and over	no.	66 970	46 496	38 622	16 111	13 194	na	2 876	2 721
Low Apgar	%	0.2	0.1	0.1	0.1	0.1	..	0.4	0.3

^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 2007, 16.6 per cent of women who gave birth in the ACT were not residents. **na** Not available. **..** Not applicable. **–** Nil or rounded to zero.

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

Fetal death rate

The ‘fetal death rate’ is an indicator of governments’ objective to deliver maternity services that are safe and of high quality (box 10.29).

Box 10.29 Fetal death rate

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

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

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

(Continued on next page)

Box 10.29 (Continued)

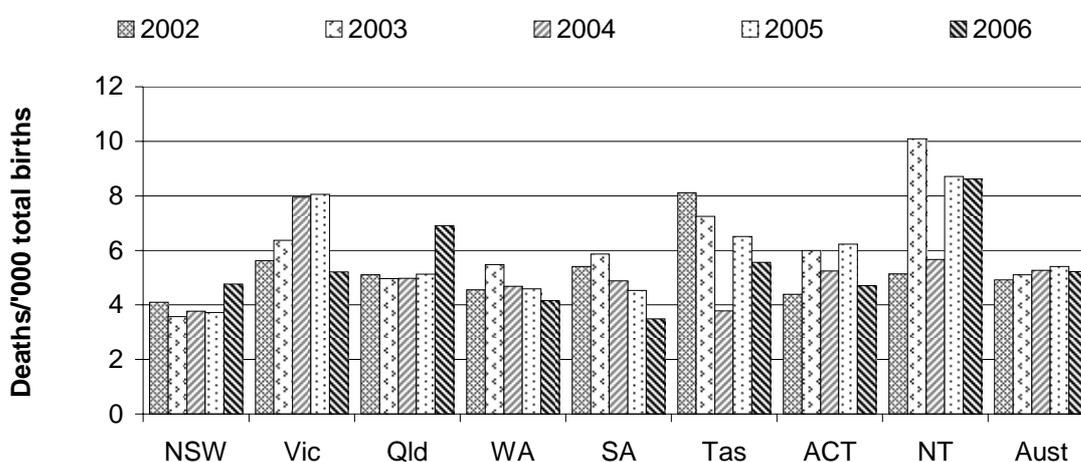
Low fetal death rates may indicate high quality maternity services. In jurisdictions where the number of fetal deaths is low, small annual fluctuations in the number affect the annual rate of fetal deaths.

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

Data reported for this indicator are comparable.

Fetal death rates are reported in figure 10.31. Nationally, fetal death rates remained stable over the period 2002–2006 although there was variation over this period in some jurisdictions (these annual fluctuations are generally a result of the low incidence of fetal deaths and small populations). National time series for fetal death rates for the period 1994 to 2006 are included in table 10A.104. Fetal deaths rates by the Indigenous status of the mother are shown in figure 10.34.

Figure 10.31 Fetal death rate^{a, b}



^a Foetal deaths data in 2006 is available by state of registration only. ^b Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of fetal deaths and small populations.

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

Neonatal death rate

The ‘neonatal death rate’ is an indicator of governments’ objective to deliver maternity services that are safe and of high quality (box 10.30).

Box 10.30 Neonatal death rate

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

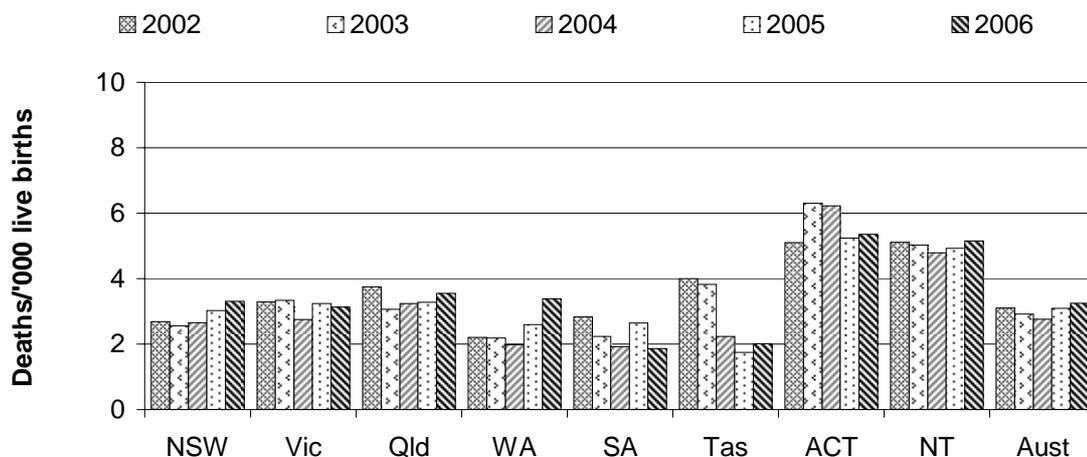
The 'neonatal death rate' is calculated as the number of neonatal deaths divided by the number of live births registered. The rate of neonatal deaths is expressed per 1000 live births, by state or territory of usual residence of the mother. This indicator is also reported by the Indigenous status of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

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

Data reported for this indicator are comparable.

Neonatal death rates are reported in figure 10.32. Nationally, neonatal death rates have been reasonably steady over the period 2002–2006, although there was variation over this period in some jurisdictions (these annual fluctuations are generally a result of the low incidence of neonatal deaths and small populations). National time series for neonatal death rates for the period 1994 to 2006 are included in table 10A.104. Neonatal death rates by the Indigenous status of the mother are shown in figure 10.34.

Figure 10.32 Neonatal death rate^{a, b}



^a All neonatal deaths of liveborn infants. Birthweight and gestation not available for 2006 data. 2006 data is not directly comparable to earlier years. ^b Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of neonatal deaths and small populations.

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

Perinatal death rate

The 'perinatal death rate' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.31). Perinatal death rates are shown in figure 10.33. Perinatal death rates by the Indigenous status of the mother are shown in figure 10.34. National time series for perinatal death rates for the period 1994 to 2006 are included in table 10A.104.

Box 10.31 Perinatal death rate

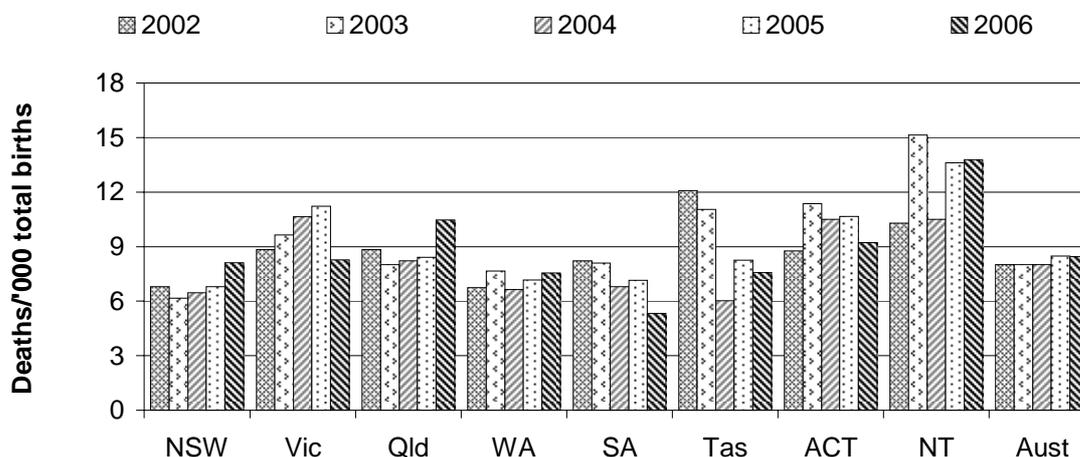
A perinatal death is a fetal or neonatal death (boxes 10.29 and 10.30).

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

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

Data reported for this indicator are comparable.

Figure 10.33 Perinatal death rate^{a, b}



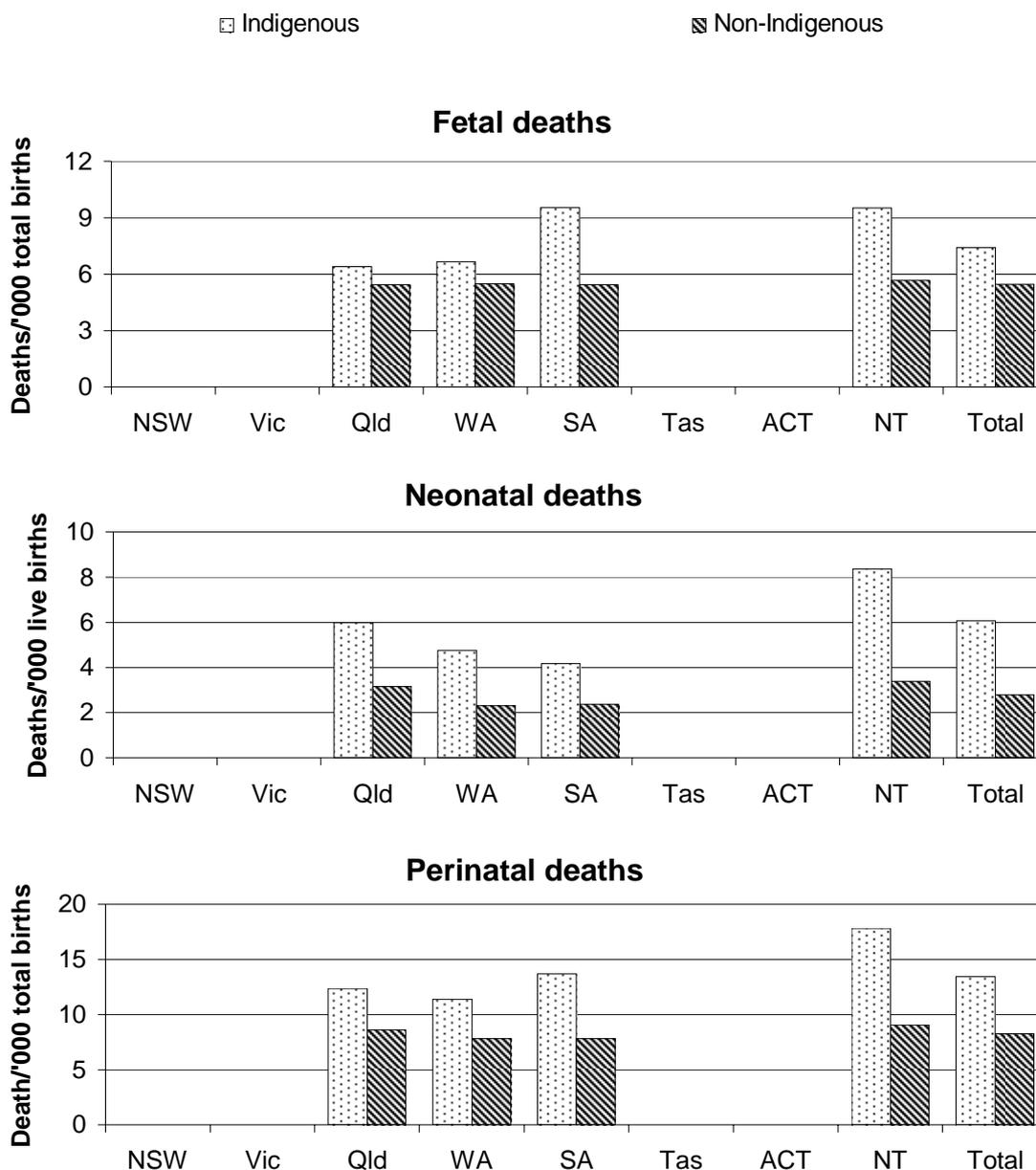
^a Foetal deaths data in 2006 is available by state of registration only. Perinatal counts for 2006 contain all neonatal deaths of liveborn infants. Birthweight and gestation data was not available for 2006 neonatal deaths. 2006 data is not directly comparable to earlier years. ^b Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of perinatal deaths.

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

Fetal, neonatal and perinatal deaths for Indigenous people

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

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



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

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

Gestation standardised perinatal mortality ratio

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

Box 10.32 Gestation standardised perinatal mortality ratio

This measure of perinatal mortality (box 10.31) is standardised according to gestational age. It excludes infants less than 20 weeks gestation or where gestation is unknown, weighing less than 400 grams, terminations of pregnancy and deaths due to congenital malformations (DHS 2007). This indicator has been identified for development and reporting in the future. Data were not available for the 2009 Report.

10.7 Future directions in performance reporting

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

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

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

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

Reform of Specific Purpose Payments

In December 2007, COAG agreed to reform Specific Purpose Payments (SPPs). SPPs are financial agreements between the Australian Government and State and Territory governments involving a contribution by the Australian Government to the funding of services which are considered a joint Australian and State and Territory government responsibility. The Australian Health Care Agreement was such an SPP.

At its 29 November 2008 meeting, COAG agreed to six new National Agreements, five of which are associated with a National SPP. In the area of health and ageing, there is a Australian Health Care Agreement associated with the National Health Care SPP (COAG November 2008). Under the reforms, the Australian Health Care Agreement contains the objectives, outcomes, outputs and performance indicators for health and ageing. The performance of governments in achieving these mutually agreed outcomes will be assessed by the COAG Reform Council (CRC). The Steering Committee has been requested by COAG to provide the SPP performance information to the CRC (COAG July 2008).

The National Agreements/SPPs will be supplemented by a range of National Partnerships (NPs): project, facilitation and reward agreements. Funding for NPs may be conditional on states and territories meeting agreed milestones and performance benchmarks.

The Steering Committee and the Health Working Group will ensure that reporting in this chapter reflects the COAG priorities identified in the Australian Health Care Agreement, National Health Care SPP and relevant NPs.

10.8 Definitions of key terms and indicators

Accreditation	Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals may seek accreditation through the ACHS Evaluation and Quality Improvement Program, the Australian Quality Council (now known as Business Excellence Australia), the Quality Improvement Council, the International Organisation for Standardization 9000 Quality Management System or other equivalent programs.
Acute care	Clinical services provided to admitted or non-admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.
Admitted patient	A patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients may receive acute, sub-acute or non-acute care services.
Admitted patient cost proportion	The ratio of admitted patient costs to total hospital costs, also known as the inpatient fraction.
Allied health (non-admitted)	Occasions of service to non-admitted patients at units/clinics providing treatment/counselling to patients. These include units providing physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy.
Apgar score	Numerical score used to evaluate a baby's condition after birth. The definition of the reported indicator is the number of babies born with an Apgar score of 3 or lower at 5 minutes post delivery, as a proportion of the total number of babies born. Excludes fetal deaths in utero before commencement of labour.
AR-DRG	Australian Refined Diagnosis Related Group - a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 5.1 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,

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

Mortality rate	The number of deaths per 100 000 people.
Neonatal death	Death of a live born infant within 28 days of birth. Defined in Australia as the death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Neonatal death rate	Neonatal deaths divided by the number of live births registered.
Nursing workforce	Registered and enrolled nurses who are employed in nursing, on extended leave or looking for work in nursing.
Medical practitioner workforce	Registered medical practitioners who are employed as medical practitioners, on extended leave or looking for work as a medical practitioner.
Non-acute episode of care	Clinical services provided to admitted and non-admitted patients, including planned geriatric respite, palliative care, geriatric evaluation and management and services for nursing home type patients. Clinical services delivery by designated psychiatric or psychogeriatric units, designated rehabilitation units and mothercraft services are also considered non-acute.
Non-admitted occasions of service	Occasion of examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service establishment. Services may include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.
Non-admitted patient	A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.
Perinatal death	Fetal death or neonatal death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Perinatal death rate	Perinatal deaths divided by the total number of births (that is, live births registered and fetal deaths combined).
Perineal laceration (third or fourth degree)	A 'third degree' laceration or rupture during birth (or a tear following episiotomy) involves the anal sphincter, rectovaginal septum and sphincter NOS. A 'fourth degree' laceration, rupture or tear also involves the anal mucosa and rectal mucosa (NCCH 2008).
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.

	<p>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).</p>
Puerperium	The period or state of confinement after labour.
Real expenditure	Actual expenditure adjusted for changes in prices.
Relative stay index	<p>The actual number of patient days for acute care separations in selected AR-DRGs divided by the expected number of patient days adjusted for casemix. Includes acute care separations only. Excludes: patients who died or were transferred within 2 days of admission, or separations with length of stay greater than 120 days, AR-DRGs which are for 'rehabilitation', AR-DRGs which are predominantly same day (such as R63Z chemotherapy and L61Z admit for renal dialysis), AR DRGs which have a length of stay component in the definition, and error AR-DRGs.</p>
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</p>

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

10.9 Attachment tables

Attachment tables are identified in references throughout this chapter by an '10A' suffix (for example, table 10A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Table 10A.1	Recurrent expenditure, public hospitals (including psychiatric hospitals), current prices, (\$ million)
Table 10A.2	Recurrent expenditure, public hospitals, by source of funding, 2006-07
Table 10A.3	Recurrent expenditure per person, public hospitals (including psychiatric) (2005-06 dollars)
Table 10A.4	Public hospitals (including psychiatric hospitals) by hospital size, 2006-07
Table 10A.5	Available beds per 1000 people, by region, public hospitals (including psychiatric) (number)
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11 Primary and community health

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Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 11A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables themselves are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

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

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

The primary and community health sector is the part of the healthcare system most frequently used by Australians. It is important in preventative health care and in the

detection and management of illness and injury, through direct service provision and referral to acute (hospital) or other healthcare services as appropriate.

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

- data are reported for the first time against the indicator ‘management of asthma’
- data are reported for a new measure of the indicator ‘management of diabetes’.

11.1 Profile of primary and community health

Definitions, roles and responsibilities

Primary and community healthcare services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Those funded largely by government include general practice, community health services, the PBS and public dental services. Government also provides some funding for the use of private dental and allied health services by particular populations, for example people with long-term health conditions and/or mental health problems (through Medicare), and through the private health insurance rebate.

General practice

General practice is a major provider of primary healthcare in Australia. It is defined by the Royal Australian College of General Practitioners (RACGP) as ‘the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities’ (RACGP 2005). General practice is the business structure within which one or more general practitioners (GPs) and other staff, such as practice nurses, provide and supervise healthcare for patients presenting to the practice. General practices are predominantly privately owned, by GPs or corporate entities.

General practice data reported in this chapter relate mainly to services provided by two types of medical practitioner:

- GPs who are vocationally recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or equivalent, or hold a recognised training placement
- other medical practitioners (OMP) — medical practitioners who are not vocationally recognised GPs.

Services provided in general practice include:

- diagnosis and treatment of illness (both chronic and acute) and injury
- preventative care through to palliative care
- referrals to consultants, allied health professionals, community health services and hospitals.

Definitions for common health terms are provided in section 11.5.

Access to general practice services may influence the utilisation of other, more costly health services. For example, perceived or actual lack of access to GP services may lead to presentations at emergency departments for conditions better managed in the primary and community health sector (Van Konkelenberg, Esterman, Van Konkelenberg 2003). Proximity and convenience of emergency departments, as well as the level of trust and regard for emergency department staff, have also been found to relate to inappropriate emergency department attendance.

The Australian Government provides the majority of general practice income through Medicare fee for service and other payments. The remainder comes 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.

While the majority of GPs provide services as part of a general practice, some are employed by hospitals, community health services or other organisations, in full time or part time capacities.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

The Australian Government subsidises the cost of around 80 per cent of prescription medicines through the Pharmaceutical Benefits Scheme (PBS) (DoHA 2008a). The PBS aims to provide affordable, reliable and timely access to prescription medicines for all Australians. Users make a co-payment, currently \$5.00 for concession card holders and \$31.30 for general consumers. The Australian Government pays the remaining cost of medicines that are eligible for the subsidy. Co-payment amounts are normally adjusted in line with inflation on 1 January each year.

Co-payments are also subject to a safety net threshold. Once spending within a calendar year has reached the threshold, PBS medicines are generally cheaper or free for the rest of the calendar year. The 2008 safety net threshold is \$1141.80 for general consumers and \$290.00 for concession card holders (DoHA 2008b).

The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides subsidised pharmaceutical medicines, dressings and other items to war veterans and war widows. The RPBS is administered by the Department of Veterans' Affairs (DVA). Drugs eligible for subsidy under the RPBS may not be eligible under the PBS.

Community health services

Community health services usually comprise multidisciplinary teams of salaried health and allied health professionals, who aim to protect and promote the health of particular communities (Quality Improvement Council 1998). The services may be provided directly by governments (including local governments) or indirectly, through a local health service or community organisation funded by government. State and Territory governments are responsible for most community health services. The Australian Government's main role in the community health services covered in this chapter is in health services for Indigenous people. In addition, the Australian Government provides targeted support to improve access to community health services in rural and remote areas. There is no national strategy for community health and there is considerable variation in the services provided across jurisdictions.

Allied health services

While some allied health professionals are employed in community health services, allied health services are delivered mainly in the private sector. Governments provide some funding for private services through insurance schemes and private insurance rebates. The Australian Government also makes certain allied health services available under Medicare to patients with chronic conditions and complex care needs, and improves access to allied health services in rural and remote areas.

Dental services

The Australian Government and the states and territories play different roles in supporting dental services in Australia's mixed system of public and private dental health care. The states and territories have the main responsibility for the delivery of major public dental health care programs, primarily directed at children and disadvantaged adults. The Australian Government supports the provision of dental

services primarily through the 30 per cent private health insurance rebate. The Australian Government also provides Medicare funding for dental services for patients with chronic conditions and complex care needs, and for a limited range of medical services of an oral surgical nature. In addition, the Australian Government provides funding for the dental care of war veterans and full-time and part-time members of the Australian Defence Force. It also has a role in the provision of dental services through Community Controlled Aboriginal Medical Services. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink.

Funding

General practice

The Australian Government funds the majority of general practice services, primarily through Medicare and the DVA. The annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia found that 95.2 per cent of all encounters with GPs in 2007-08 were for services at least partly funded by Medicare or the DVA (Britt *et al.* 2008) (table 11.1).

Table 11.1 GP encounters, by source of funding, 2007-08^{a, b, c}

	Number ^d	Per cent of all encounters ^e	95% LCL	95% UCL
GPs participating in the BEACH survey	953	..	..	..
Total encounters for which BEACH data were recorded	95 898	..	..	..
Encounters with missing data	8 311	..	..	..
Direct encounters	86 359	98.6	98.4	98.8
No charge	386	0.4	0.4	0.5
Medicare paid ^f	83 418	95.2	94.9	95.6
Workers compensation paid	2 000	2.3	2.1	2.5
Other paid (hospital, State, etc.)	577	0.7	0.5	0.8
Indirect encounters ^g	1 225	1.4	1.2	1.6

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

Source: Britt *et al.* (2008), *General practice activity in Australia 2007-08*, Cat. no. GEP 22; table 11A.1.

The Australian Government also provides funding for general practice services under initiatives such as:

- the Practice Incentives Program (PIP)
- the General Practice Immunisation Incentives Scheme (GPII)
- the Divisions of General Practice (DGP).

Australian Government expenditure on general practice in 2007-08 was \$5.6 billion, or \$264 per person (figure 11.26).

Not all Australian Government funding of primary healthcare services is captured in these data. Funding is also provided for services delivered in non-general practice settings, particularly in rural and remote areas; for example, hospital emergency departments, Indigenous primary healthcare and other community health services, and the Royal Flying Doctor Service. Thus, expenditure on general practice understates expenditure on primary healthcare, particularly in jurisdictions with large populations of Indigenous people and people living in rural and remote areas. The Health preface includes expenditure data for Indigenous primary and community health services for 2004-05.

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on the PBS and RPBS was around \$6.4 billion, or \$301 per person, in 2007-08. Expenditure on the PBS was around \$5.9 billion in 2007-08, of which 79.3 per cent was for concessional patients (table 11.2). Government expenditure on pharmaceuticals data are also presented in the 'Health preface.'

Table 11.2 **PBS and RPBS expenditure, 2007-08 (\$ 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	406.5	291.3	237.6	128.3	91.4	24.3	25.0	7.1	1 211.6
PBS concessional ^c	1 631.8	1 184.3	884.0	388.1	414.3	136.0	47.8	14.4	4 700.6
PBS doctor's bag	4.8	3.2	3.0	1.0	1.0	0.3	0.2	0.1	13.5
PBS total	2 043.1	1 478.8	1 124.6	517.4	506.8	160.6	72.9	21.5	5 925.6
RPBS total ^d	157.0	96.2	101.3	35.5	34.5	13.5	6.8	0.9	445.6
Total	2 200.1	1 575.0	1 225.8	552.8	541.2	174.1	79.7	22.4	6 371.3
\$ per capita	317.6	300.2	289.9	259.4	340.0	351.2	233.9	103.1	300.8

^a State and Territory level data are only available on a cash basis for general, concessional and doctor's bag categories. These figures are not directly comparable to those published in the DoHA annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as dispensing conducted under s.100 of the *National Health Act 1953* [Cwlth]). ^b Includes PBS general ordinary and safety net. ^c Includes concessional ordinary and concessional free safety net. ^d Includes RPBS ordinary and RPBS safety net.

Source: DoHA (unpublished), derived from the PBS data system.

Community health services

Overall government expenditure data for the community health services covered in this chapter are not available. Expenditure data reported here also cover services such as food safety regulation and media campaigns to promote health awareness, as well as private dental services (funded by insurance premium rebates and non-government expenditure) (table 11.3).

In 2006-07, government expenditure on community and public health was \$5.8 billion, of which State, Territory and local governments provided 74.6 per cent, and the Australian Government 25.4 per cent (table 11.3). Australian Government direct outlay expenditure on dental services was \$114 million in 2006-07, while State, Territory and local government expenditure was \$519 million (table 11.3). In some states and territories, additional expenditure is incurred through schemes that fund the provision by private practitioners of public dental health services for eligible people.

Table 11.3 Estimated funding on community and public health, and dental services, 2006-07 (\$ million)

	<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^a</i>	<i>Total</i>				
Community and public health ^b	1 469	–	1 469	4 322	5 792	304	6 095
Dental services ^c	114	414	528	519	1 047	4 690	5 737

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

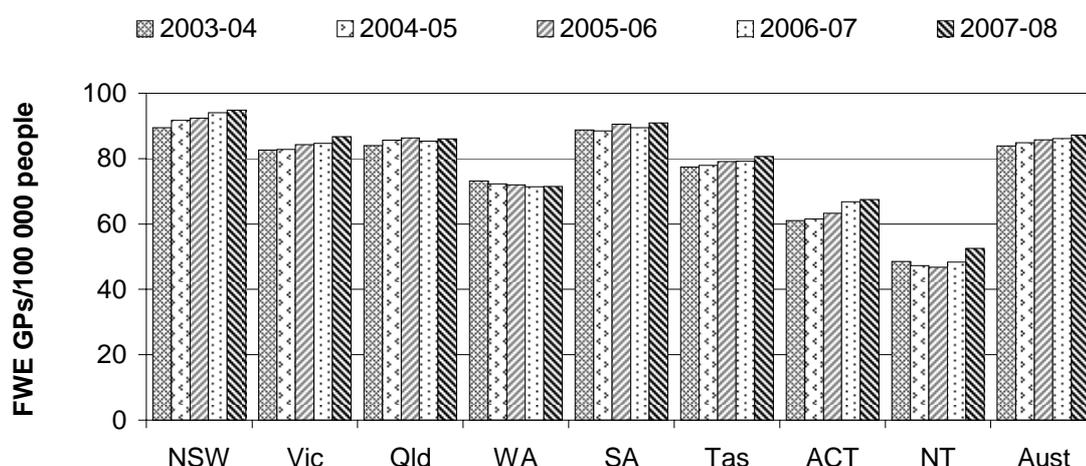
Source: AIHW (2008), *Health Expenditure Australia 2006-07*, Cat. no. HWE 42.

Size and scope

General practice

There were 26 212 vocationally recognised GPs and OMPs billing Medicare in Australia in 2007-08. On a full time workload equivalent (FWE) basis, there were 18 613 vocationally recognised GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 87.2 FWE recognised GPs and OMPs per 100 000 people (table 11A.3). These data exclude services provided by GPs working with the Royal Flying Doctor Service and GPs working in Indigenous primary health care services and public hospitals. In addition, the data are based on Medicare claims, which for some GPs (particularly in rural areas) pay for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid through Medicare. The numbers of FWE vocationally recognised GPs and OMPs per 100 000 people across jurisdictions are shown in figure 11.1.

Figure 11.1 Availability of GPs (full time workload equivalent)^a



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

Source: DoHA (unpublished), derived from the MBS data system; table 11A.3.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

There were around 186 million services provided under the PBS and RPBS in 2007-08, amounting to 8.8 scripts per person. There were around 171 million services provided under the PBS in 2007-08, of which 85.7 per cent were concessional (table 11.4).

Table 11.4 PBS and RPBS services, 2007-08 (million services)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
PBS general ^a	8.1	5.9	4.8	2.5	1.8	0.5	0.5	0.1	24.1
PBS concessional ^b	50.3	37.7	27.9	12.1	12.8	4.4	1.4	0.4	146.8
PBS doctor's bag	0.1	0.1	0.1	–	–	–	–	–	0.3
PBS total	58.5	43.6	32.7	14.6	14.5	4.9	1.9	0.6	171.3
RPBS total ^c	4.9	3.2	3.2	1.1	1.1	0.5	0.2	–	14.3
Total	63.4	46.8	35.9	15.7	15.7	5.3	2.1	0.6	185.6
Services per capita	9.2	8.9	8.5	7.4	9.8	10.7	6.1	2.9	8.8

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

Source: DoHA (unpublished), derived from the PBS data system.

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 11A.52–11A.60 provide information on community health programs in each jurisdiction. The more significant of these programs are described below. Other community health programs provided by some jurisdictions include:

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

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

Maternal and child health

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

Public dental services

All jurisdictions provide some form of public dental service for primary school children. Some jurisdictions also provide dental services to secondary school students. In WA, SA, Tasmania, and the NT, for example, general dental care (including preventative care) is provided for school children up to 18 years of age (tables 11A.56 [WA], 11A.57 [SA], 11A.58 [Tasmania] and 11A.60 [NT]).

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

hospitals as part of training programs for dental specialists (National Advisory Committee on Oral Health 2004). A number of jurisdictions indicated to the Review that they provided public dental services in 2007-08 targeted at disadvantaged people (tables 11A.52–11A.60).

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 2008a). Treatment activities excluded from that report include opioid pharmacotherapy treatment where no other treatment is provided, the majority of services for Indigenous people that are funded by the Australian Government, treatment services within the correctional system, and treatment units associated with acute care and psychiatric hospitals.

A total of 633 alcohol and other drug treatment services reported 2006-07 data to the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS). Of these, 305 (48.2 per cent) identified as government providers and 328 (51.8 per cent) identified as non-government providers (table 11A.8). All of the non-government providers received some government funding for 2006-07. There were 147 325 reported closed treatment episodes in 2006-07 (see section 11.5 for a definition of closed treatment episode). Clients seeking treatment for their own substance use, of whom 67.4 per cent were male, accounted for 140 475 closed treatment episodes (AIHW 2008a).

Alcohol was the most commonly reported principal drug of concern in closed treatment episodes for clients seeking treatment for their own substance abuse (42.3 per cent). Cannabis was the next most common drug of concern (22.8 per cent), followed by opioids (14.4 per cent; heroin accounted for 10.6 per cent) and amphetamines (12.3 per cent) (AIHW 2008a). Further information on alcohol and other drug treatment services funded by governments is included in tables 11A.52–11A.60.

Indigenous community healthcare services

Indigenous Australians use a range of primary health care services, including private general practitioners and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services in all jurisdictions.

These services are planned and governed by local Indigenous communities and aim to deliver holistic and culturally appropriate health and health-related services. Funding is provided by Australian, State and Territory governments. In addition to these healthcare services, health programs for Indigenous Australians are funded by a number of jurisdictions. In 2007-08, these programs included services such as health information, promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 11A.52–11A.60).

Data on Aboriginal and Torres Strait Islander primary healthcare services that receive funding from the Australian Government are 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 2006-07, SAR data are reported for 146 Indigenous primary healthcare services (table 11A.4). Of these services, 54 (37.0 per cent) were located in remote or very remote areas (table 11A.5). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 11A.6). An episode of healthcare is defined in the SAR data collection as contact between an individual client and staff of a service to provide healthcare. Over 1.6 million episodes of healthcare were provided by participating services in 2006-07 (table 11.5). Of these, around 582 000 (35.2 per cent) were in remote or very remote areas (table 11A.5).

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

	<i>NSW and ACT^b</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>NT</i>	<i>Aust</i>
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
2005-06	505	179	240	281	101	29	347	1681
2006-07 ^c	440	177	253	284	114	31	354	1652

^a An episode of healthcare involves contact between an individual client and service staff to provide healthcare. Group work is not included. Transport is included only if it involves provision of healthcare and/or information by staff. Outreach provision, for example episodes at outstation visits, park clinics and satellite clinics, is included. Episodes of health care delivered over the phone are included. ^b Data for NSW and the ACT have been combined for confidentiality purposes. ^c 2006-07 data are preliminary results.

Source: DoHA (unpublished), derived from the Service Activity Reporting data collection.

The services included in the SAR data collection employed 2198 full time equivalent health staff (as at 30 June 2007). Of these, 1351 were Indigenous (61.5 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous were relatively low (3.2 per cent and 13.3 per cent, respectively) (table 11A.7).

11.2 Framework of performance indicators

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

Box 11.1 Objectives for primary and community health

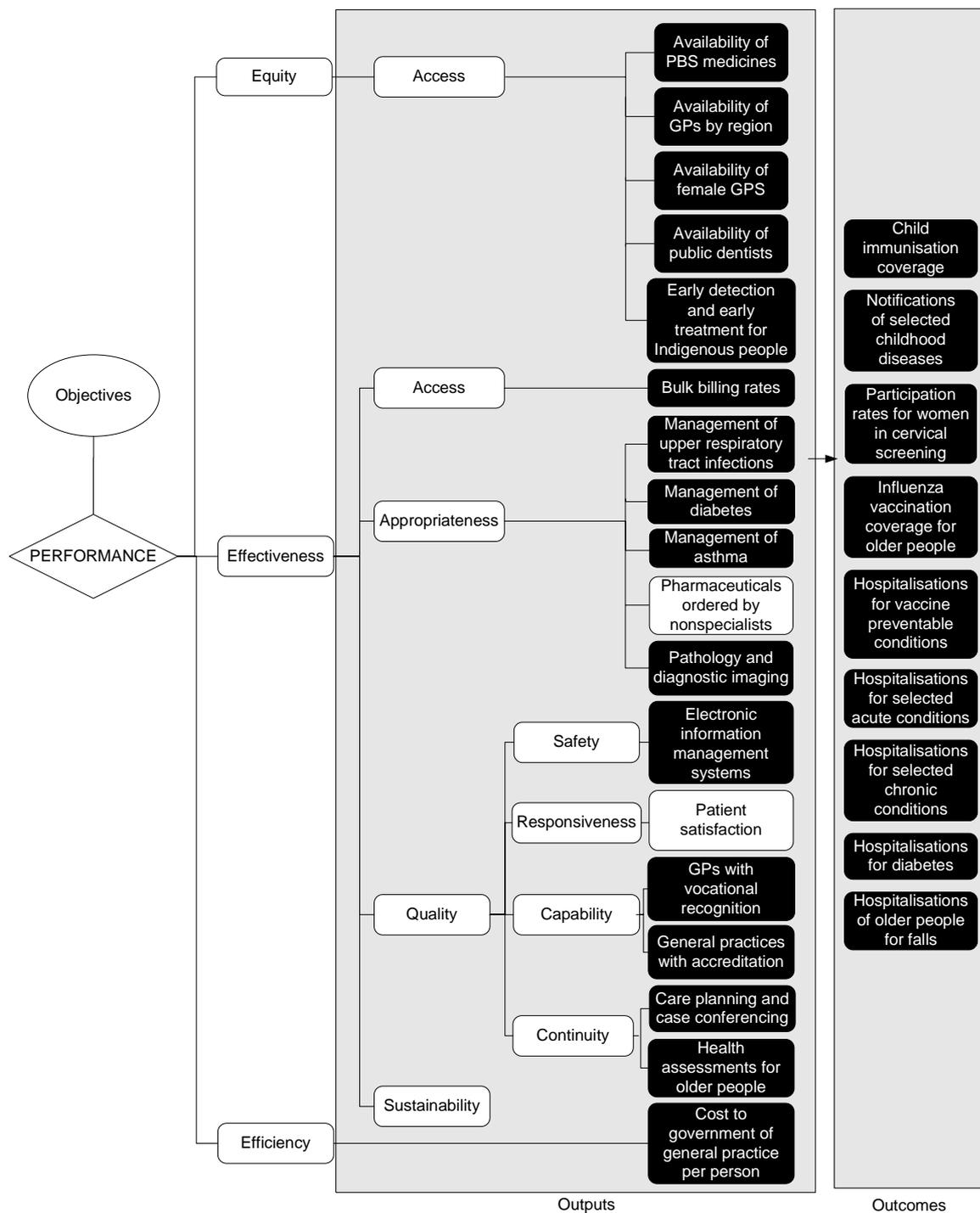
Primary and community health services aim to promote the health of Australians by:

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

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

The performance indicator framework shows which data are comparable in the 2009 Report (figure 11.2). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see section 1.6). The ‘Health preface’ explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability that have been added to the standard Review framework.

Figure 11.2 Performance indicators for primary and community health



Key to indicators

Text Data for these indicators comparable, subject to caveats to each chart or table

Text Data for these indicators not complete or not directly comparable

Text These indicators yet to be developed or data not collected for this Report

11.3 Key performance indicator results

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

Outputs

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

Equity

For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. Access to primary and community health services may be affected through factors such as disability, socioeconomic circumstance, age, geographic distance, cultural issues and English language proficiency (see chapter 1). Such issues have contributed to the generally poor health status of Indigenous people relative to other Australians (see the 'Health Preface' and SCRGSP 2007).

Access

Five indicators of governments' objective to provide equitable access to primary and community health services are reported:

- 'availability of PBS medicines'
- 'availability of FWE GPs by region'
- 'availability of female GPs'
- 'availability of public dentists'
- 'early detection and early treatment for Indigenous people'.

Availability of PBS medicines

'Availability of PBS medicines' is an indicator of governments' objective to provide equitable access to PBS medicines (box 11.2). Medicines are important in treating illness and can also be important in preventing illness from occurring. The availability of medicines is therefore a significant determinant of people's health

and medicines should be available to those who require them regardless of where they live or socioeconomic circumstance.

Box 11.2 Availability of PBS medicines

‘Availability of PBS medicines’ is measured in three ways:

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

‘People per pharmacy by region’ is defined as the estimated resident population (ERP), divided by the number of pharmacies, in urban and in rural regions. A decrease in people per pharmacy may indicate greater availability of PBS medicines.

‘PBS expenditure per person by region’ is defined as expenditure on PBS medicines, divided by the ERP, in urban and in rural regions. An increase in PBS expenditure per person may indicate improved availability of PBS medicines.

‘The proportion of PBS prescriptions filled at a concessional rate’ is defined as the number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled. An increase in the proportion of PBS prescriptions filled at a concessional rate may indicate improved availability of PBS prescriptions to disadvantaged people.

It is also important that there are not large discrepancies in these measures by region.

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

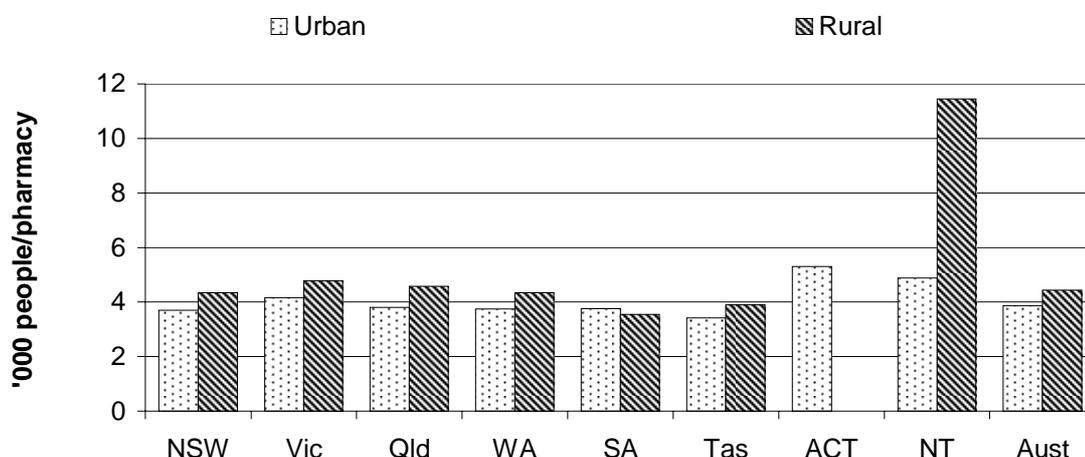
Data for this indicator are comparable.

Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, there were 3863 people per pharmacy in urban areas and 4436 in rural areas in 2007-08. In most states and territories, the number of people per pharmacy was higher in rural areas than in urban areas (figure 11.3).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 71 medical practitioners and 224 hospitals — 71 private and 153 public¹ — approved to supply PBS medicines to the community in 2007-08. The medical practitioners as well as 74 of the public hospitals were located in rural areas (table 11A.9).

¹ PBS approved private hospitals supply medicines to patients of the hospital (inpatients and outpatients), while public hospitals provide medicines only to patients on discharge.

Figure 11.3 People per pharmacy, 2007-08^a

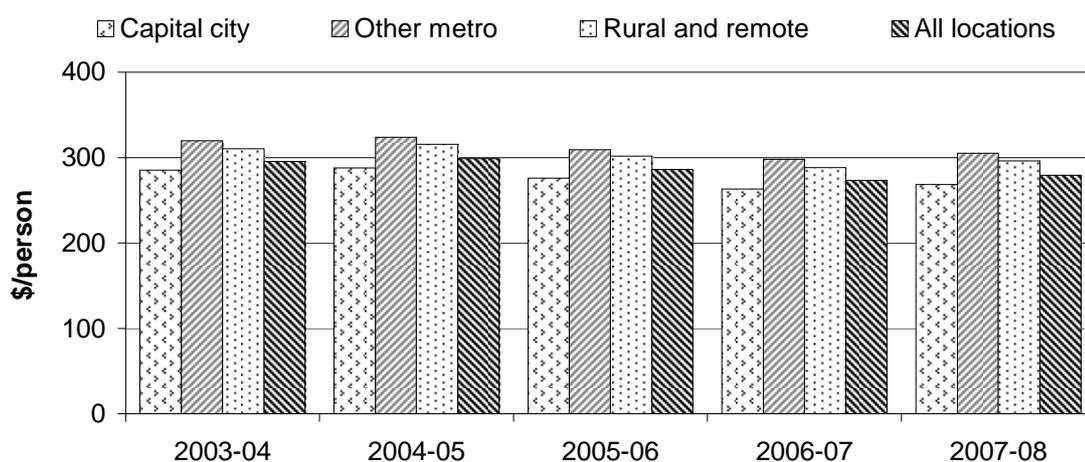


^a Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PHARIA 1. Rural = PHARIA 2-6. The ACT has no rural statistical areas.

Source: DoHA (unpublished), derived from Medicare Australia, the ABS 2006 Census of Population and Housing and the University of Adelaide's National Centre for Social Applications of Geographic Information Systems; table 11A.9.

Nationally, PBS expenditure per person increased from \$273 in 2006-07 to \$279 in 2007-08 (figure 11.4). PBS expenditure per person was higher in rural and remote areas than in capital cities for the period 2003-04 to 2007-08 (in 2007-08 dollars).

Figure 11.4 PBS expenditure per person (2007-08 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 include other categories administered under special arrangements (such as medications dispensed under s.100 of the *National Health Act 1953* [Cwlth]).

Source: DoHA (unpublished), derived from the PBS data system; table 11A.11.

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 11A.9. These data are not available by regional location. Australia-wide, 85.7 per cent of prescriptions subsidised under the PBS were concessional in 2007-08.

Availability of GPs by region

‘Availability of GPs by region’ is an indicator of governments’ objective to provide equitable access to primary healthcare services (box 11.3). Low availability may be associated with an increase in distance travelled and waiting times to see a GP, and increased difficulty in booking long consultations. Low availability may also reduce bulk billing rates through reducing 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.

Box 11.3 Availability of GPs by region

‘Availability of GPs by region’ is defined as the number of FWE GPs per 100 000 people, by region.

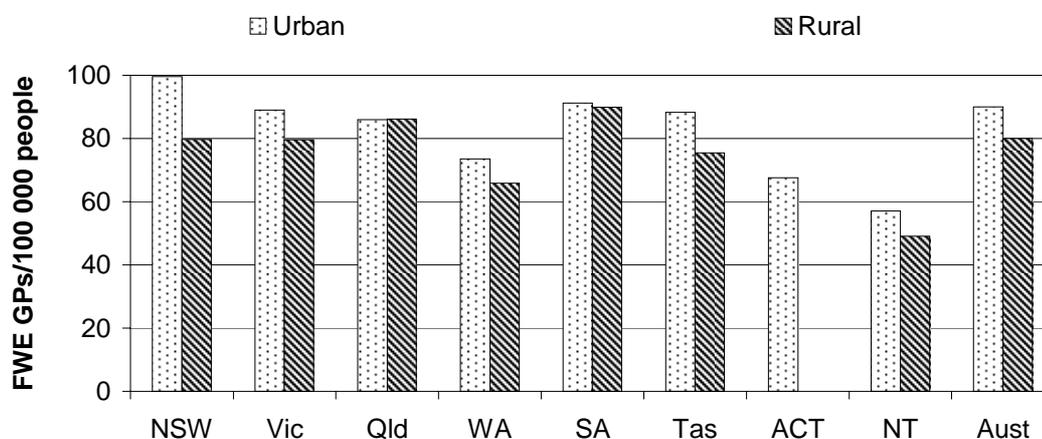
An increase in the availability of GPs may indicate improved access to GP services, particularly in rural and remote regions.

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

Data for this indicator are comparable.

In terms of FWE GPs per 100 000 people, there were more GPs available in urban than in rural areas in almost all states and territories in 2007-08 (figure 11.5). The bulk billed proportion of non-referred attendances was generally lower in rural and remote areas, excepting ‘other remote’ areas, than in capital cities and ‘other metropolitan centres’ (table 11A.20).

Figure 11.5 **Availability of GPs (full time workload equivalent), 2007-08^{a, b, c}**



^a Geographical locations are based on the Rural, Remote and Metropolitan Areas (RRMA) classification. Urban areas consist of capital city and other metro areas. Rural areas consist of large rural centres, small rural centres, other rural areas, remote centres, other remote areas and other areas. ^b FWE GP numbers include vocationally recognised GPs and OMPs billing Medicare, who are allocated to a jurisdiction based on the postcode of their major practice. ^c The ACT has no rural areas.

Source: DoHA (unpublished), derived from the MBS data system; table 11A.12.

Availability of female GPs

‘Availability of female GPs’ is an indicator of governments’ objective to provide equitable access to GPs for women who prefer to discuss health matters with, and to receive primary healthcare from, a female GP (box 11.4).

Box 11.4 Availability of female GPs

‘Availability of female GPs’ is defined as the number of female FWE GPs per 100 000 females.

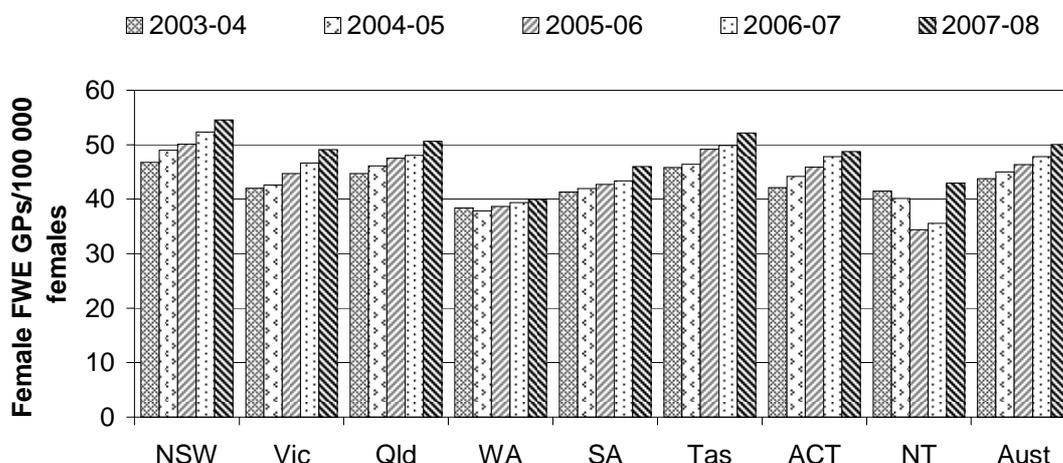
A higher rate means it is more likely that female patients who prefer to visit female GPs will have their preference met.

This indicator 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.

Data for this indicator are comparable.

In 2007-08, 38.7 per cent of Australia’s GPs — 28.9 per cent of FWE GPs — were female (tables 11A.3 and 11A.13). The number of FWE GPs per 100 000 females increased from 43.8 to 50.0 in the period 2003-04 to 2007-08 (figure 11.6).

Figure 11.6 Availability of female GPs (full time workload equivalent)^a



^a Data relate to vocationally recognised GPs and OMPs billing Medicare, who are allocated to a jurisdiction based on the postcode of their major practice.

Source: DoHA (unpublished), derived from the MBS data system; table 11A.13.

Availability of public dentists

‘Availability of public dentists’ is an indicator of governments objective to provide equitable access to dental services. 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 (box 11.5).

Box 11.5 Availability of public dentists

‘Availability of public dentists’ is defined as the number of full time equivalent (FTE) public dentists per 100 000 people by region.

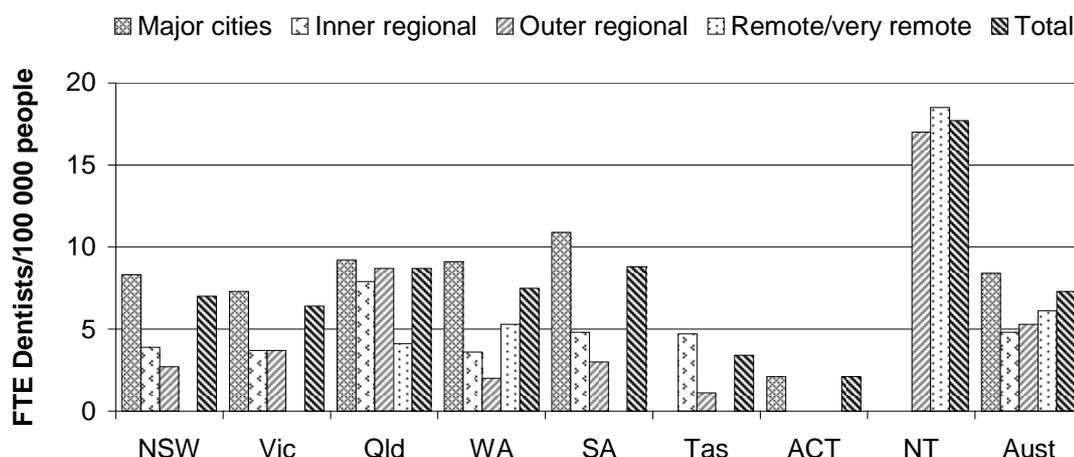
An increase in the availability of public dentists indicates improved access to dental services.

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

Data for this indicator are comparable.

Nationally, there were more FTE public dentists per 100 000 people in major cities than in regional or remote areas in 2006 (figure 11.7; table 11A.14).

Figure 11.7 Availability of public dentists, 2006^{a, b, c}



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

Source: AIHW (unpublished), derived from the National dental labour force collection; table 11A.14.

Early detection and early treatment for Indigenous people

‘Early detection and early treatment for Indigenous people’ is an indicator of governments’ objective to provide equitable access to primary and community healthcare services for Indigenous people (box 11.6).

The high prevalence of preventable and/or treatable health conditions in the Indigenous population is strongly associated with relatively poor health outcomes for Indigenous people (AIHW 2007a; SCRGSP 2007). Early detection and early treatment refers to the identification of individuals who are at high risk for, or in the early stages of, such conditions. Early detection and early treatment services provide opportunities for timely prevention and intervention measures, and their availability and uptake is understood to be a significant determinant of people’s health.

Voluntary health assessments and checks are Medicare Benefit Schedule (MBS) items that allow GPs to undertake comprehensive examinations of patient health, including physical, psychological and social functioning. They are available for older Australians as well as for Indigenous people of all ages, as the prevalence of preventable and/or treatable conditions is high in both population groups.

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

'Early detection and early treatment for Indigenous people' is measured in four ways:

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

'Older people who received a voluntary health assessment by Indigenous status' is defined as the proportion of older people who received a voluntary health assessment by Indigenous status. A reduction in the gap between the proportion of all older people and older Indigenous people that received a health assessment indicates improved access to early detection and early treatment services for Indigenous people.

'Older Indigenous people who received a voluntary health assessment, time series' is defined as the proportion of older Indigenous people who received a voluntary health assessment in successive years of a five year period. An increase is desirable as it indicates improved access to these services.

'Indigenous people who received a voluntary health assessment or check by age group' is defined as the proportion of Indigenous people who received a voluntary health assessment/check, in each of the three age groups for which they are available. A reduction in the gap between the proportion of Indigenous people in different age groups that received a health assessment/check may indicate more equitable access to early detection and treatment services within the Indigenous population.

'Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services' is defined as the proportion of Aboriginal and Torres Strait Islander primary healthcare services that included early detection activities in the services provided. An increase is desirable as it indicates improved access to early detection and treatment services for Indigenous Australians.

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

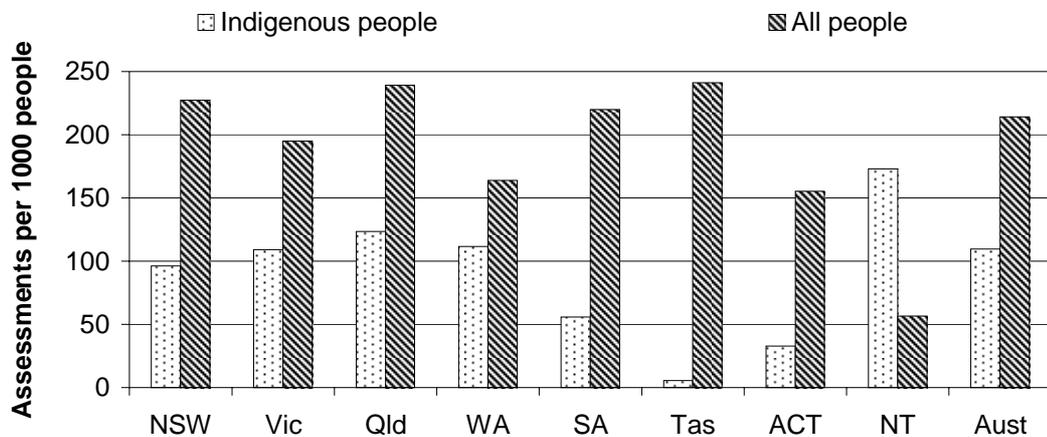
Data for this indicator are comparable.

For this indicator, older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The larger age range for Indigenous people recognises that they typically face increased health risks at younger ages than most

other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the 'Health preface').

Figure 11.8 shows that in 2007-08 the proportion of Indigenous older people who received an annual health assessment was considerably lower than the proportion of all older people who received an annual health assessment. This suggests that access to early detection and early treatment services may not be equitable.

Figure 11.8 Older people who received an annual health assessment by Indigenous status, 2007-08^{a, b}

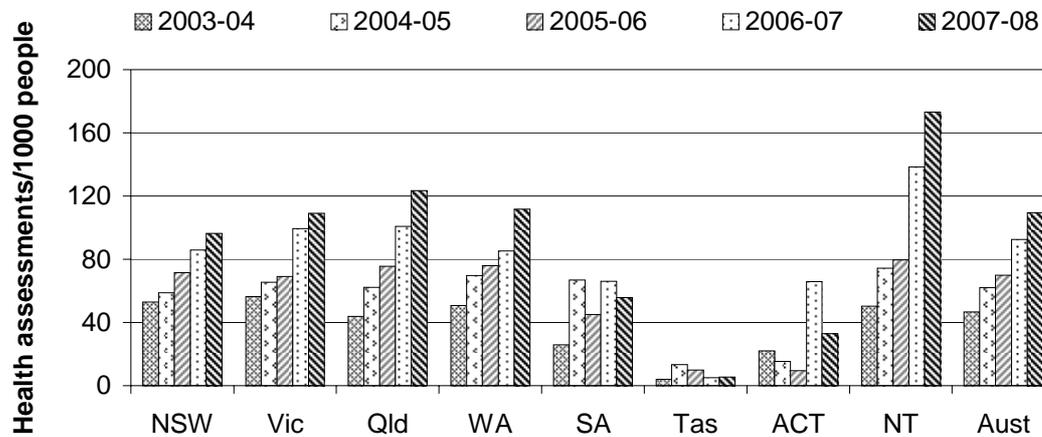


^a Older people are defined as Indigenous people aged 55 years or over and non-Indigenous people aged 75 years or over. ^b Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This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

Source: Medicare Australia (unpublished), derived from *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 9 October 2008); ABS 2004, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0; ABS 2008, *Australian demographic statistics March quarter 2008*, Cat. no. 3101.0; ABS (unpublished), derived from *2006 Census of Population and Housing*; table 11A.16.

Figure 11.9 shows that the proportion of older Indigenous people who received an annual health assessment steadily increased in most jurisdictions between 2003-04 and 2007-08. This indicates that access to early detection and early treatment services for this population has improved in these jurisdictions.

Figure 11.9 Older Indigenous people who received an annual health assessment^a



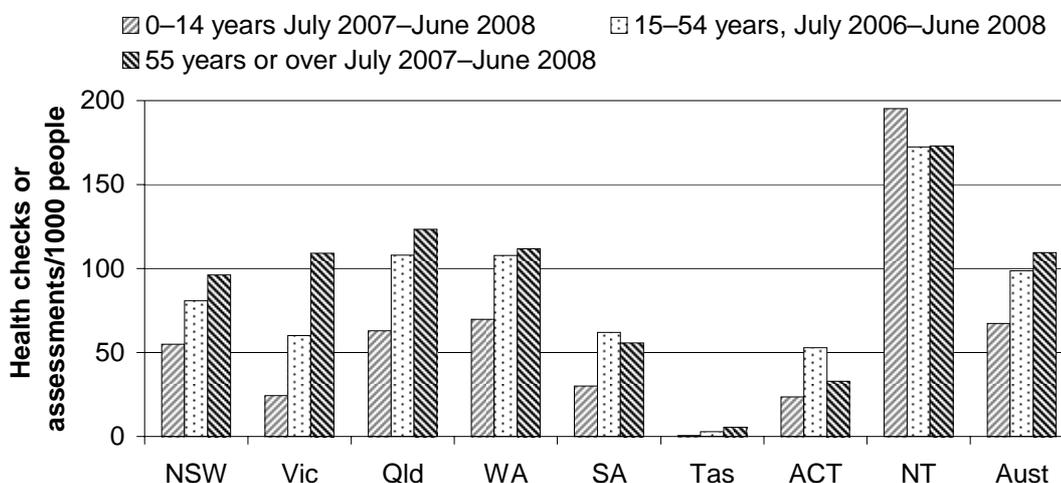
^a Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous people.

Source: Medicare Australia (unpublished), derived from *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 9 October 2008); ABS 2004, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0; ABS 2008, *Australian demographic statistics March quarter 2008*, Cat. no. 3101.0; ABS (unpublished), derived from *2006 Census of Population and Housing*, table 11A.17.

Health check MBS items were introduced for Indigenous people aged 15–54 years in May 2004, and Indigenous children aged 0–14 years in May 2006. Health checks are available annually for children aged 0–14 years, and biennially for 15–54 year olds.

Figure 11.10 shows that the proportion of the eligible Indigenous population that received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions. This may in part reflect differences in how long the items have been available, as factors such as awareness and administrative requirements affect the uptake of new MBS items (AIHW 2007a).

Figure 11.10 Indigenous people who received a health check or assessment by age^{a, b}



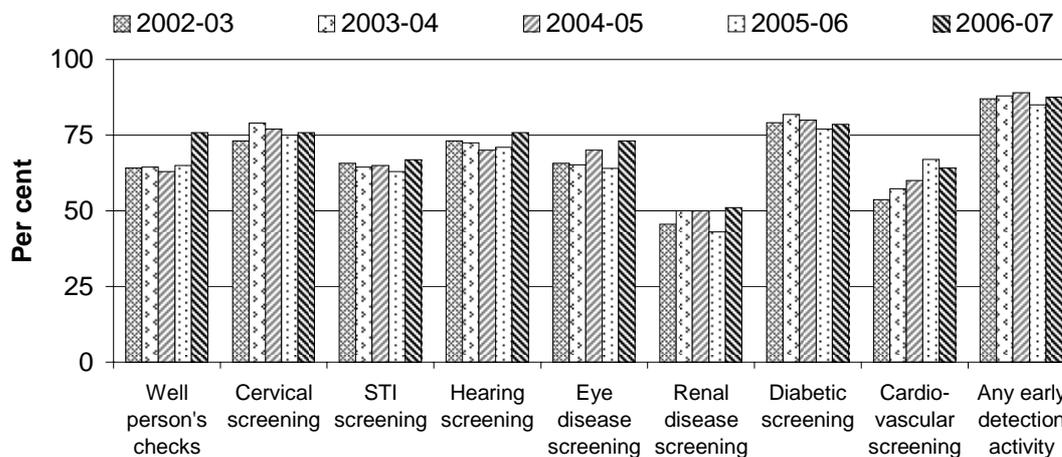
^a Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous people.

^b Health checks for 0-14 year olds, and health assessments for those aged 55 years or over, are available annually. Data for these age groups are for the period 1 July 2007 to 30 June 2008. Health checks for 15-54 year olds are available biennially, and these data are for the period 1 July 2006 to 30 June 2008.

Source: Medicare Australia (unpublished), derived from *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 9 October 2008); ABS 2004, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0; ABS 2008, *Australian demographic statistics March quarter 2008*, Cat. no. 3101.0; ABS (unpublished), derived from *2006 Census of Population and Housing*; table 11A.18.

Figure 11.11 shows the proportion of Indigenous primary healthcare services for which SAR data are reported that provided various early detection services over the five year period to 2006-07.

Figure 11.11 Indigenous primary healthcare services for which SAR data are reported that provided early detection services



Source: DoHA (unpublished), derived from the Service Activity Reporting data collection (SAR); table 11A.19.

Effectiveness

Access

'Bulk billing rates' is currently the only indicator reported against effectiveness and access.

Bulk billing rates

'Bulk billing rates' are an indicator of governments' objective to provide affordable access to GP services (box 11.7).

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.

Box 11.7 Bulk billing rates

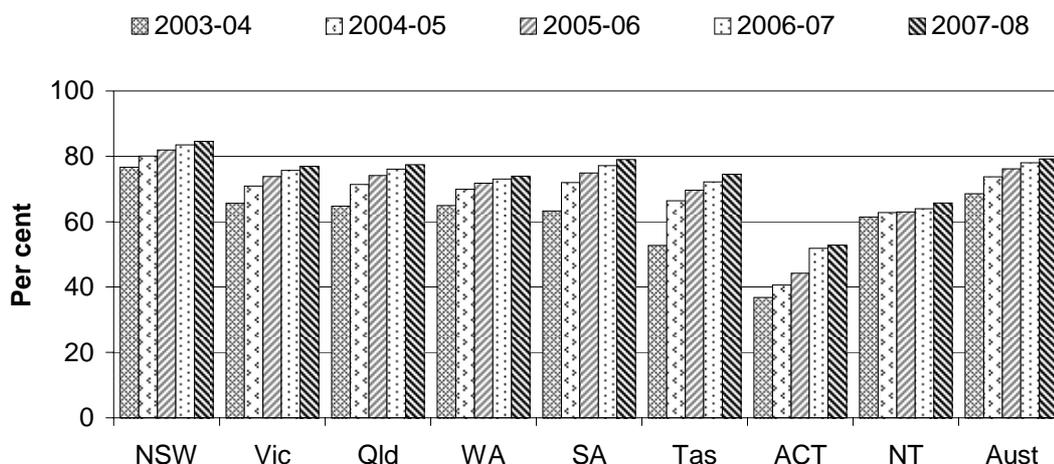
'Bulk billing rates' is defined as the number of non-referred attendances that were bulk billed as a proportion of all non-referred attendances.

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

Data for this indicator are comparable.

Australia-wide, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 79.2 per cent in 2007-08. For all jurisdictions, this proportion increased in the period 2003-04 to 2007-08 (figure 11.12). The bulk billed proportion of non-referred attendances was highest in capital cities and other remote areas (table 11A.20).

Figure 11.12 Non-referred attendances that were bulk billed^a



^a Includes attendances by practice nurses since 2003-04.

Source: DoHA (unpublished), derived from the MBS data system; table 11A.21.

Appropriateness

Four indicators of the appropriateness of GP services are reported:

- 'Management of upper respiratory tract infections'
- 'Management of diabetes'
- 'Management of asthma'

-
- 'Pathology tests and diagnostic imaging ordered by non specialists.

Management of upper respiratory tract infections

'Management of upper respiratory tract infections' is an indicator of governments' objective to ensure that antibiotics are used appropriately and effectively (box 11.8).

Upper respiratory tract infection (URTI) without complication is most often caused by a virus. Antibiotics have no efficacy in the treatment of viral infections, but are nevertheless frequently prescribed for viral infections. Unnecessarily high rates of antibiotic prescription for URTI have the potential to increase pharmaceutical costs and to increase antibiotic resistance in the community.

Box 11.8 Management of upper respiratory tract infections

'Management of upper respiratory tract infections' is defined as the number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat upper respiratory tract infection [URTI]) that are provided to PBS concession card holders, per 1000 PBS concession card holders.

A downward trend in the prescription rate may indicate that GPs' management of URTI more closely follows guidelines.

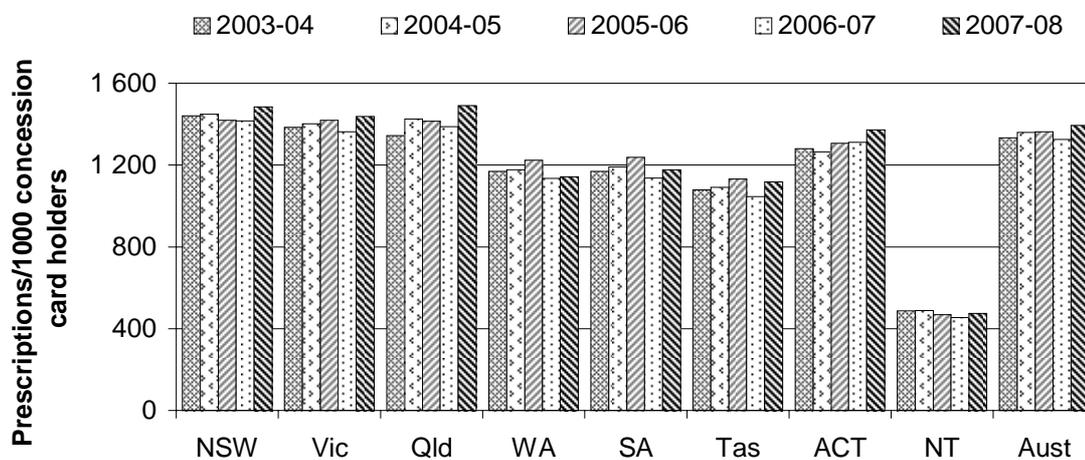
The selected antibiotics may be prescribed for illnesses other than URTI; the indicator provides no information about the condition for which they were prescribed. Data are available only for PBS concession card holders.

Data for this indicator are comparable.

Caution should be used in the interpretation of this indicator over time, as pharmaceutical needs of concession card holders may increase in complexity due to the effects of population ageing.

Australia-wide, the prescription rate for the oral antibiotics most commonly used to treat upper respiratory tract infection in 2007-08 was 1394 per 1000 PBS concession card holders. Prescription rates for these antibiotics fluctuated around the same level in most states and territories between 2003-04 and 2007-08 (figure 11.13).

Figure 11.13 Rate of prescription of the oral antibiotics used most commonly to treat upper respiratory tract infection



Source: DoHA (unpublished), derived from the PBS data system; table 11A.22.

Management of diabetes

‘Management of diabetes’ is an indicator of governments’ objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 11.9).

Diabetes mellitus is a chronic disease of increasing prevalence. People with diabetes² are at high risk of serious complications such as cardiovascular, eye and kidney disease. Appropriate management in the primary and community health sector can prevent or minimise the severity of such complications (AIHW 2008b).

Patient compliance with measures to manage diabetes is also a critical determinant of the occurrence and severity of complications.

² Diabetes refers to diabetes mellitus. Diabetes insipidus is not considered here.

Box 11.9 Management of diabetes

The 'proportion of people with diabetes mellitus who have received an annual cycle of care within general practice' is defined as the number of MBS items for completion of a cycle of care for patients with established diabetes mellitus that are claimed, divided by the estimated number of people with diabetes mellitus.

The number of people with diabetes is estimated by applying diabetes prevalence data from the ABS 2004-05 National Health Survey (NHS) to the estimated resident population. Estimates should be treated with caution due to the changing prevalence of diabetes over time.

A high proportion of people with diabetes who have received an annual cycle of care within general practice is desirable.

Various factors influence the uptake of MBS items by GPs. As appropriate management of diabetes by GPs who do not claim the rebates is not captured in this measure, these data should be considered as minimum estimates.

Data reported against this indicator are comparable.

Type 2 diabetes is the most common form of diabetes and is largely preventable. Diabetes has been identified as a National Health Priority Area for Australia.

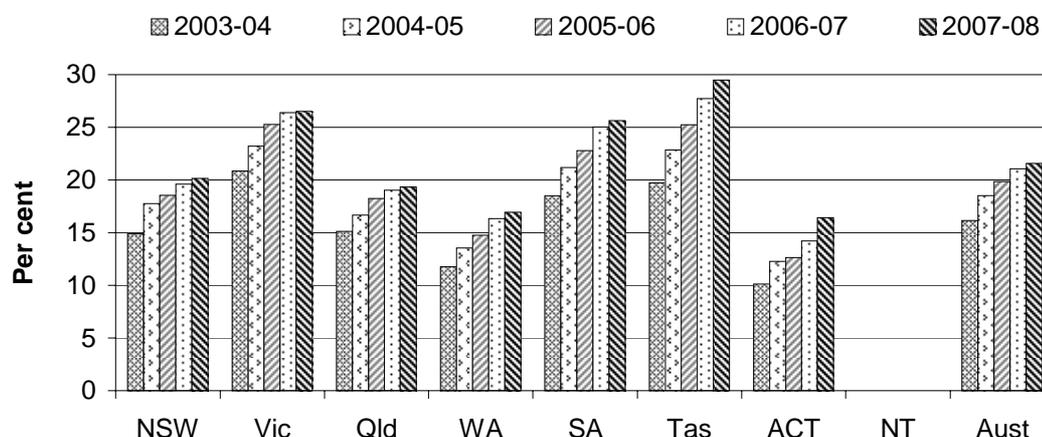
Since 2001, rebates have been available to GPs under the Medicare Benefits Scheme (MBS) on completion of a annual cycle of care for diabetes. The 'required annual cycle of care' is generally based on the RACGP's clinical guidelines for the management of Type 2 diabetes in general practice.³ The need for a standard definition of 'annual cycle of care' has been identified (AIHW 2007b).

The measure 'proportion of people with diabetes mellitus who have received an annual cycle of care within general practice' is reported for the first time against the indicator 'management of diabetes'.

The proportion of people with diabetes receiving a annual cycle of care within general practice increased for all jurisdictions for which data are available in the period 2003-04 to 2007-08 (figure 11.14). Nationwide, 21.6 per cent of people with diabetes received the annual cycle of care in 2007-08 (excluding the NT).

³ An exception is the frequency of glycosolated heamoglobin (HbA1c) testing. Royal Australian College of General Practitioners (RACGP) clinical guidelines specify testing of HbA1c at least 6 monthly for adults and 3 monthly for children and adolescents. The MBS annual cycle of care requires only annual testing of HbA1c (with no differentiation according to age).

Figure 11.14 **People with diabetes mellitus who have received an annual cycle of care within general practice^{a, b, c, d}**



^a Data are minimum estimates as they do not account for GPs who provide the annual cycle of care but do not claim the MBS rebate. ^b The clinical guidelines are for Type 2 diabetes, while the MBS items do not specify a particular type of diabetes. Clinical guidelines represent the minimum level of care required. ^c Estimates for all years are based on 2004-05 NHS prevalence data. They should be treated with caution as the prevalence of diabetes changes over time. ^d 2004-05 NHS data are not available for the NT.

Source: Medicare Australia (unpublished), derived from *Medicare Benefits Schedule Item Statistics Reports*, available: http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed 9 October 2008); ABS (2006), *National Health Survey: Summary of Results; State Tables, 2004-05*, Cat. No. 4362.0; ABS (2008), *Australian demographic statistics March quarter 2008*, Cat. no. 3101.0; table 11A.23.

Management of asthma

‘Management of asthma’ is an indicator of governments’ objective to ensure appropriate and effective management of chronic disease in the primary and community health sector. Data are reported for the first time in this Report against the measure ‘proportion of people with asthma who have an asthma action plan’ (box 11.10).

Asthma is a common chronic disease among Australians, particularly children, and is associated with wheezing and shortness of breath (ACAM 2008). Asthma may be intermittent or persistent, and varies in severity. Many symptoms of asthma respond readily to treatment. Asthma is an identified National Health Priority Area for Australia.

Written asthma action plans (AAP) enable people with asthma to recognise and respond quickly and appropriately to deteriorating asthma symptoms (ACAM 2008). This can prevent or reduce the severity of acute asthma episodes. AAPs have been associated with a reduction in hospitalisations and urgent GP visits

for asthma. AAPs have been included in clinical guidelines for asthma management for nearly 20 years (ACAM 2008).

Box 11.10 Management of asthma

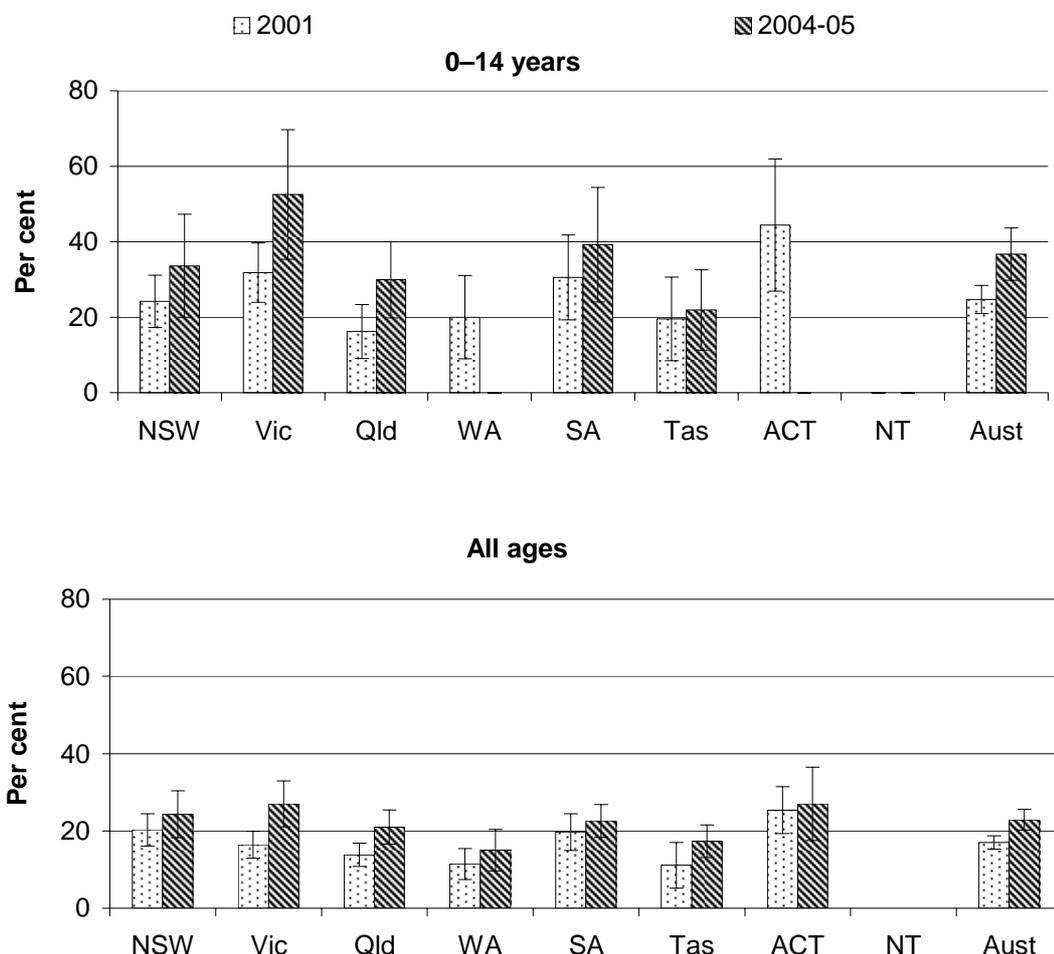
The 'proportion of people with asthma who have an asthma action plan' is defined as the number of people with asthma who have a written asthma action plan, divided by the estimated number of people with asthma.

A high proportion of people with asthma who have an asthma action plan is desirable.

Data reported against this indicator are comparable.

Australia wide, 22.9 per cent of NHS respondents with current asthma reported having a written asthma action plan (AAP) in 2004-05, compared with 17.0 per cent in 2001 (figure 11.15). Children aged 0–14 years with current asthma were most likely to report having an AAP in 2001 (24.7 per cent) and 2004-05 (36.7 per cent).

Figure 11.15 Proportion of people with asthma who have a written asthma action plan^{a, b}



^a Separate estimates for the NT are not available for this survey, but the NT sample contributes to the national estimates. ^b Data from the 2004-05 survey for children aged 0-14 years for WA and the ACT have relative standard errors greater than 50 per cent. They are considered too unreliable for general use and are not published, but the data contribute to the national estimates.

Source: ABS (unpublished), derived from the National Health Survey 2001, 2004-05; table 11A.24.

Pharmaceuticals ordered by non-specialists

‘Pharmaceuticals ordered by non-specialists’ has been identified as an indicator of governments’ objective to ensure the appropriateness of primary healthcare services (box 11.11).

Box 11.11 Pharmaceuticals ordered by non-specialists

'Pharmaceuticals ordered by non-specialists' is yet to be defined.

Data for this indicator were not available for the 2009 Report.

Pathology tests and diagnostic imaging ordered by non-specialists

'Pathology tests and diagnostic imaging ordered by non-specialists' is an indicator of governments' objective to ensure that primary healthcare services are appropriate (box 11.12).

Pathology tests and diagnostic imaging are important tools used by GPs in the diagnosis of many diseases, and in monitoring response to treatment. Their underuse may contribute to the misdiagnosis of disease, and to relatively poor treatment decisions. Excessive use may reflect overreliance on tools to support the diagnostic process. What constitutes appropriate levels of use cannot be determined. However, reporting differences across jurisdictions and over time contributes to the discussion of these issues.

Box 11.12 Pathology tests ordered and diagnostic imaging referrals by non-specialists (vocationally recognised GPs and OMPs)

Four measures of 'pathology tests ordered and diagnostic imaging referrals by non-specialists' are reported:

- pathology tests ordered by vocationally recognised GPs and OMPs, that are rebated through Medicare, per person
- diagnostic imaging referrals by vocationally recognised GPs and OMPs, that are rebated through Medicare, per person
- Medicare benefits paid per person for pathology tests
- Medicare benefits paid per person for diagnostic imaging.

High levels may indicate overreliance by GPs on these diagnostic tools, while low levels may indicate underuse.

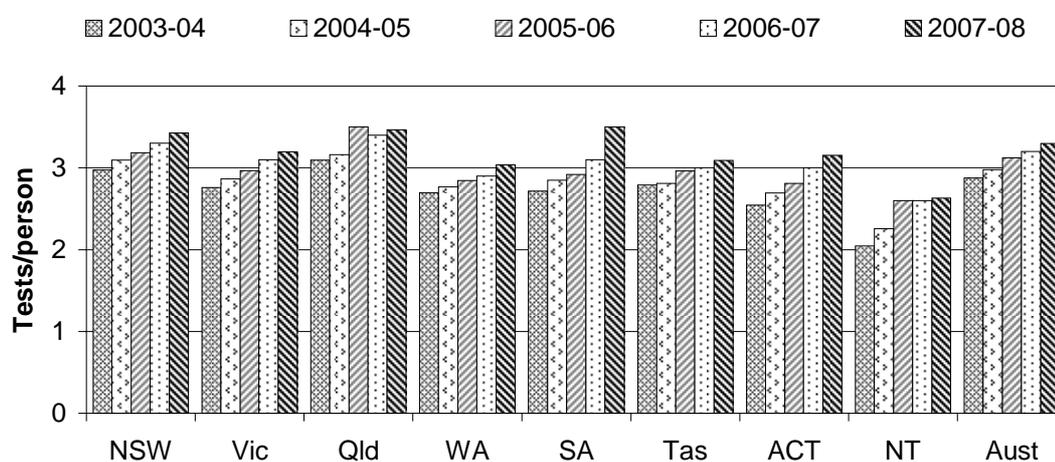
Data for this indicator are comparable.

Pathology tests and diagnostic imaging ordered by vocationally recognised GPs and OMPs and rebated through Medicare Australia is used as a proxy in reporting against this indicator. While data for the total number of pathology tests ordered and diagnostic imaging referrals made by GPs are not available from Medicare, data are available for those that are rebated through Medicare. The number of pathology

tests ordered may be higher than the number rebated through Medicare (where multiple tests are ordered, rebates are provided only for the three most expensive tests). Radiologists may identify a need for more or different imaging procedures than those for which patients are referred. Information about differences between the number of pathology tests ordered and the number of rebates claimed, and differences between the number of imaging procedures ordered by GPs and the number of rebates claimed, is not available.

Nationally, the number of pathology tests ordered and rebated through Medicare per person increased from 2.9 in 2003-04 to 3.3 in 2007-08 (figure 11.16).

Figure 11.16 Pathology tests ordered by GPs and rebated through Medicare^a

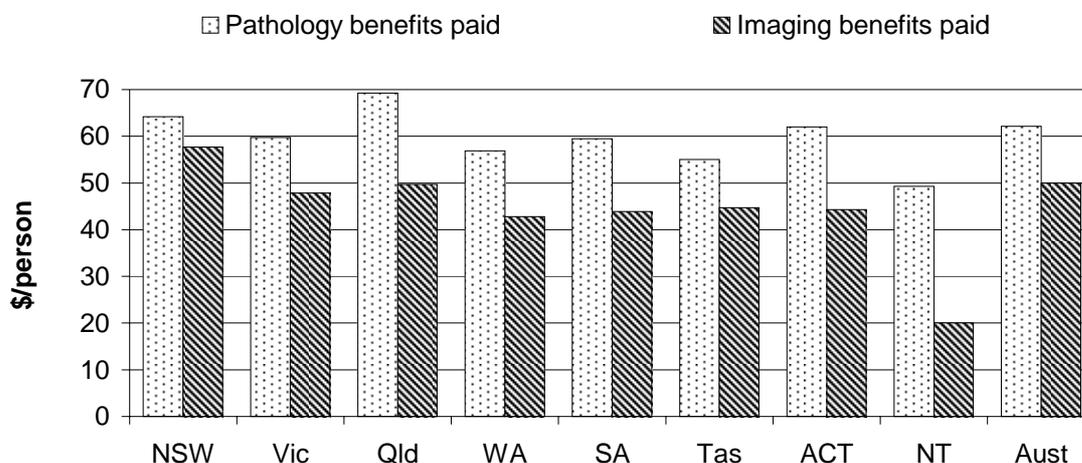


^a Data include tests ordered by vocationally recognised GPs and OMPs and rebated through Medicare. Data include patient episode initiated items.

Source: : DoHA (unpublished), derived from the MBS data system and unpublished DVA data; table 11A.25.

Australian Government expenditure (under Medicare) on pathology tests amounted to \$1.3 billion in 2007-08, equal to \$62 per person. Nationally, Medicare benefits worth \$1.1 billion were paid for diagnostic imaging in 2007-08, equal to \$50 per person (figure 11.17).

Figure 11.17 Benefits paid for pathology tests and diagnostic imaging, 2007-08^a

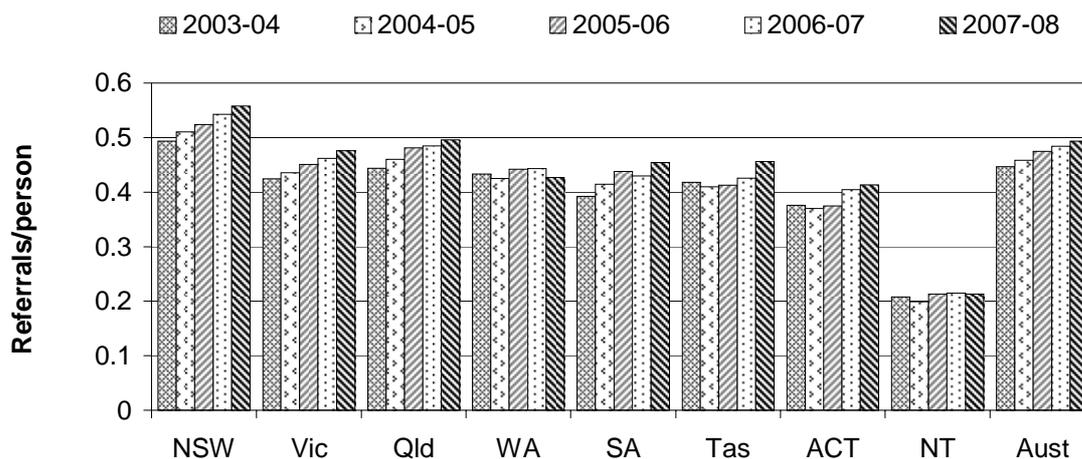


^a Includes benefits paid through Medicare (including DVA data) for pathology tests ordered, and diagnostic imaging referred, by vocationally recognised GPs and OMPs.

Source: DoHA (unpublished), derived from the MBS data system and unpublished DVA data; tables 11A.25 and 11A.26.

Nationally, there has been a gradual upward trend in the number of diagnostic imaging referrals per person between 2003-04 and 2007-08 (figure 11.18).

Figure 11.18 Diagnostic imaging referrals from GPs^a



^a Data relate to vocationally recognised GPs and OMPs.

Source: : DoHA (unpublished), derived from the MBS data system and unpublished DVA data; table 11A.26.

General practices with electronic information management systems

‘General practices with electronic information management systems’ is an indicator of governments’ objective to improve patient safety through minimising errors of prescribing and dispensing (box 11.13). Such errors may cause harm to patients through adverse drug reactions.

Electronic information management systems may also improve other aspects of quality by providing access to timely clinical data and improving the maintenance of patient health records. Use of such technology can, for example, facilitate best practice chronic disease management and preventative health activities such as screening (DHAC 2000).

Box 11.13 General practices with electronic clinical information management systems

‘General practices with electronic information management systems’ has two measures:

- the ‘proportion of practices enrolled in the Practice Incentives Program (PIP) that maintain secure electronic patient records’
- ‘the proportion of PIP practices that manage patient records predominantly using secure electronic management systems’.

An increase in these proportions may indicate that the likelihood of patient harm due to prescribing or dispensing errors in general practice is reduced.

The PIP does not include all practices in Australia. PIP practices covered around 81 per cent of Australian patients (measured as standardised whole patient equivalents) in 2006-07 (DoHA unpublished; table 11A.32).

Data for this indicator are comparable.

The Practice Incentives Program (PIP) provides financial incentives to general practices to support quality care, and improve access and health outcomes. The PIP promotes activities such as:

- use of electronic information management systems
- the provision of after hours care
- teaching medical students
- employment of practice nurses
- improving the management of chronic disease.

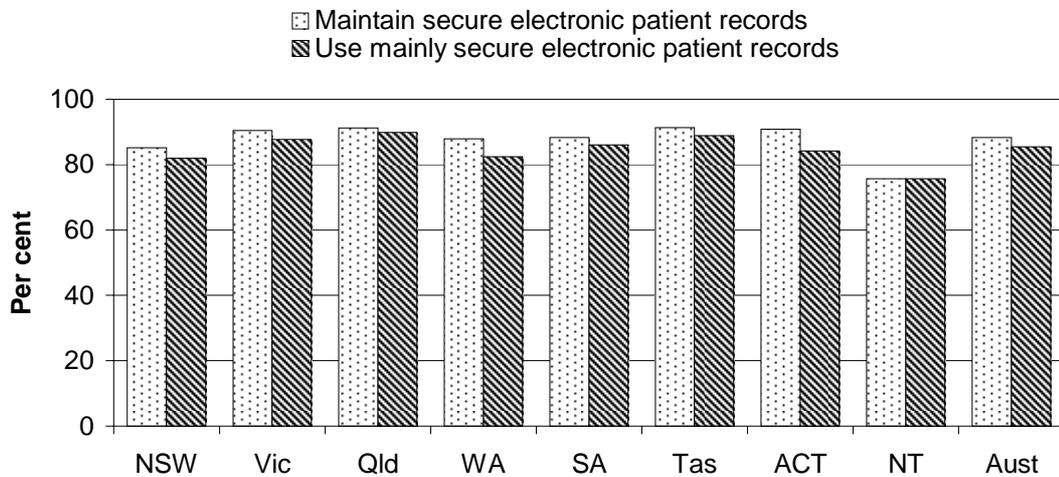
The PIP Information Management, Information Technology initiative provides two incentives to encourage the computerisation of practices:

- The first incentive requires that practices maintain electronic patient records, including clinical data on allergies/sensitivities for the majority of active patients, and implement appropriate information security measures
- The second incentive requires that practices, in addition, use electronic patient records to record and store clinical information on the majority of active patients, including current and past major diagnoses and current medications.

These replaced previous incentives for electronic prescribing and transmission of clinical data in November 2006. Data relating to previous incentives are reported in tables 11A.27 and 11A.28.

Australia-wide, 88.3 per cent of PIP practices maintained secure electronic patient records in May 2008. Patient records were managed predominantly using secure electronic management systems in 85.4 per cent of PIP practices (figure 11.19).

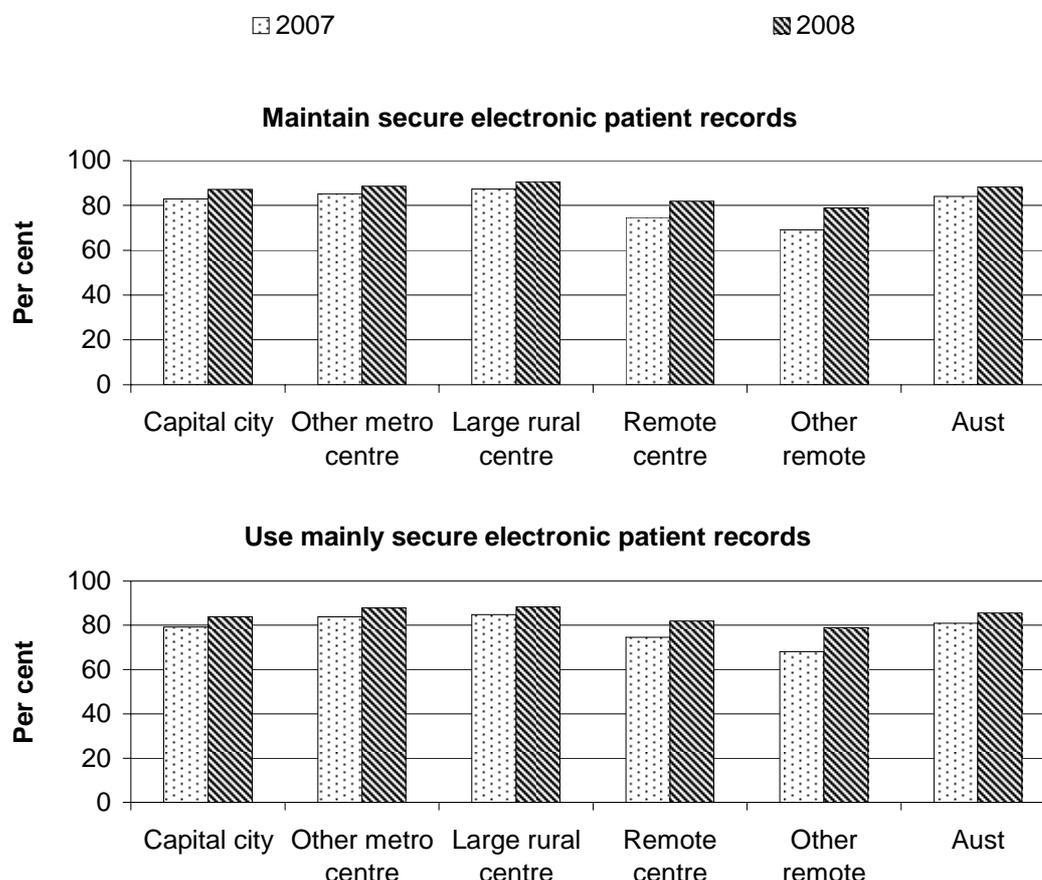
Figure 11.19 PIP practices using computers for clinical purposes, May 2008



Source: DoHA (unpublished), derived from the MBS and PIP data systems; table 11A.27.

There was an increase in the proportion of PIP practices that maintained secure electronic patient records, and that predominantly used secure electronic systems to manage patient records, in all areas from 2007 to 2008 (figure 11.20). For both incentives, the uptake by PIP practices in metropolitan and rural areas was higher than in remote areas and other remote areas. Remote practices in the NT have difficulty meeting accreditation requirements for PIP participation, which affects the coverage of these data.

Figure 11.20 PIP practices using computers for clinical purposes by area, May^a



^a Geographical locations are based on the Rural, Remote and Metropolitan Areas (RRMA) classification. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more SLAs that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone. SLA = statistical local area.

Source: DoHA (unpublished), derived from the MBS and PIP data systems; table 11A.28.

Quality — responsiveness

Patient satisfaction

‘Patient satisfaction’ has been identified for development as an indicator of governments’ objective to ensure GP services are responsive to the needs of patients (box 11.14).

Box 11.14 Patient satisfaction

'Patient satisfaction' is yet to be defined.

Data for this indicator were not available for the 2009 Report.

Quality — capability

Two indicators of the quality of GP services, relating to GPs' capability to provide services, are reported here: the proportion of GPs with vocational registration; and the proportion of general practices with accreditation.

GPs with vocational registration

'GPs with vocational registration' is an indicator of governments' objective to ensure the GP workforce has the capability to deliver high quality services (box 11.15). Vocationally registered GPs are considered to have the values, skills and knowledge necessary for competent unsupervised general practice within Australia (RACGP 2007).

Box 11.15 GPs with vocational registration

'GPs with vocational registration' is defined as the proportion of FWE GPs with vocational registration.

An increase in the proportion of FWE GPs with vocational registration may indicate an improvement in the capability of the GP workforce to deliver high quality services. However, GPs without vocational registration may deliver services of equally high quality.

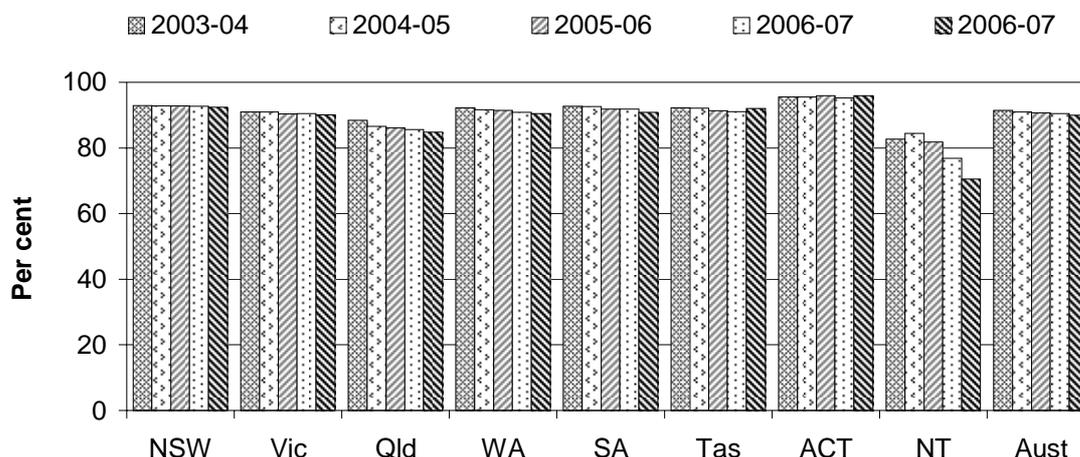
Data for this indicator are comparable.

Since 1996, a GP can only achieve vocational registration by attaining Fellowship of the Royal Australian College of General Practitioners (RACGP) or equivalent. GPs can attain Fellowship through the successful completion of a formal general practice training program or through the 'practice eligible' route. Once vocational registration is achieved, GPs must demonstrate ongoing involvement in continuing professional development activities in order to maintain their Fellowship status (DoHA unpublished).

The proportion of FWE GPs with vocational registration remained relatively constant over the five years to 2007-08 (figure 11.21). The proportion of FWE GPs

with vocational registration was highest in capital cities and other metro centres, and lowest in other remote areas, in 2007-08 (table 11A.29).

Figure 11.21 GPs (full time workload equivalent) with vocational registration



Source: DoHA (unpublished), derived from the MBS data system; table 11A.30.

General practices with accreditation

‘General practices with accreditation’ is an indicator of governments’ objective to ensure the general practitioner workforce has the capability to provide high quality services (box 11.16). 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.

Box 11.16 General practices with accreditation

‘General practices with accreditation’ is defined as the number of general practices that are accredited as a proportion of all general practices in Australia.

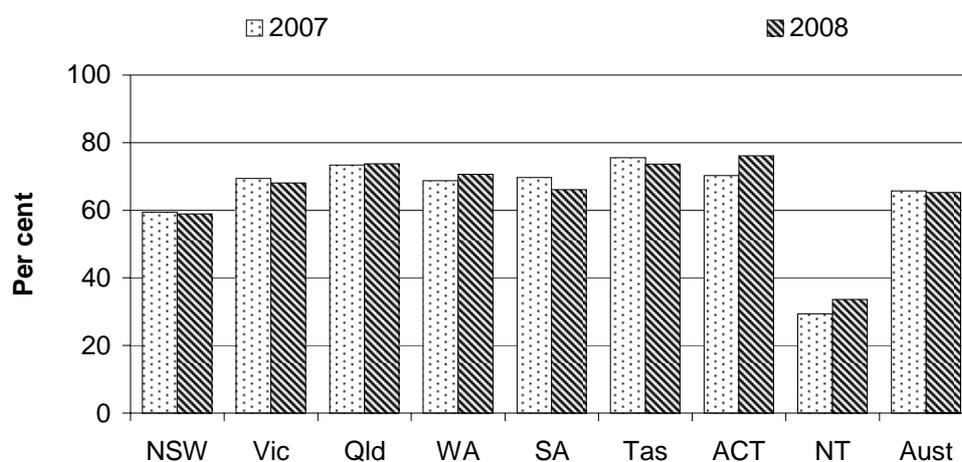
An increase in the proportion of practices with accreditation may indicate an improvement in the capability of general practice to deliver high quality services. However, general practices without accreditation may deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.

Data for this indicator are comparable.

The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and General Practice Australia ACCREDITATION *plus* (GPA Accreditation *plus*).

In June 2008, 4740 general practices — representing 65.3 per cent of general practices — were accredited Australia-wide (figure 11.22).

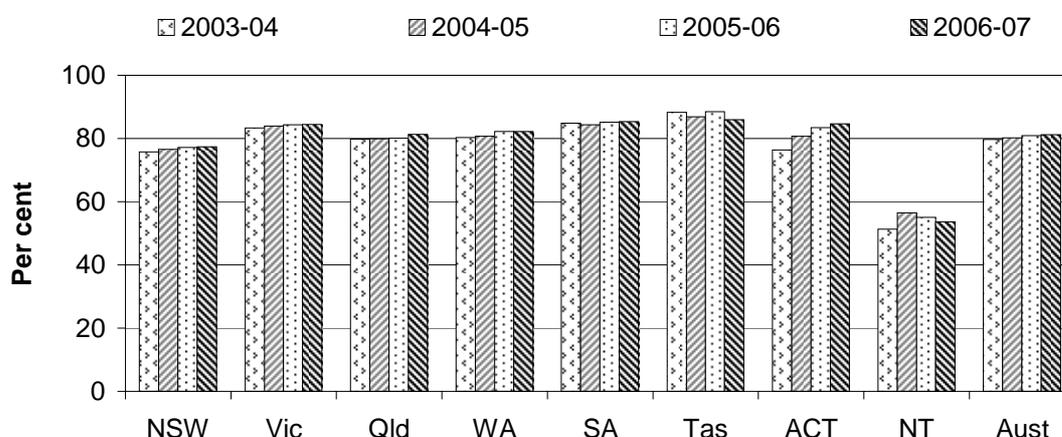
Figure 11.22 **General practices with accreditation, at 30 June**



Source: AGPAL (unpublished); GPA Accreditation *plus* (unpublished); Primary Health Care Research and Information Service (PHC RIS), DoHA (unpublished), derived from the 2007-08 Annual Survey of Divisions of General Practice; table 11A.31.

The proportion of patients attending accredited practices provides useful additional information relating to accreditation. For this measure, PIP practices provide a proxy for accredited practices, as accreditation is a requirement for PIP registration. Australia-wide, the proportion of patients — measured as standardised whole patient equivalents (SWPEs) — seen in PIP practices has varied little in the period from 2003-04 to 2006-07 (figure 11.23).

Figure 11.23 Proportion of patients in PIP practices^a



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

Source: DoHA (unpublished), derived from the PIP and MBS data systems; table 11A.32.

Quality — continuity

The continuity aspect of the quality of primary healthcare services relates to the timely, coordinated provision of services that address the needs of individual patients. For example, chronic disease imposes a significant burden on the health and wellbeing of Australians. Patients may need a range of services from within and outside the health sector. Continuity of care can help prevent or delay the progression of many circulatory, respiratory, endocrine, nutritional and metabolic diseases (NHPAC 2006). Two indicators of this aspect of the quality of GP services are reported here: the use of care planning and case conferencing; and the use of health assessments for older people.

Care planning and case conferencing

‘Care planning and case conferencing’ is an indicator of governments’ objective to improve the continuity of care provided to people with chronic or terminal medical conditions (box 11.17).

Chronic disease management items in the Medicare Benefits Schedule (MBS) allow for the preparation and regular review of care plans for individuals with chronic or terminal medical conditions, through GP managed or multidisciplinary team-based care. GPs with some experience using care planning and case conferencing may be

more likely to continue to use those options when they have the potential to improve patient care.

Box 11.17 Care planning and case conferencing

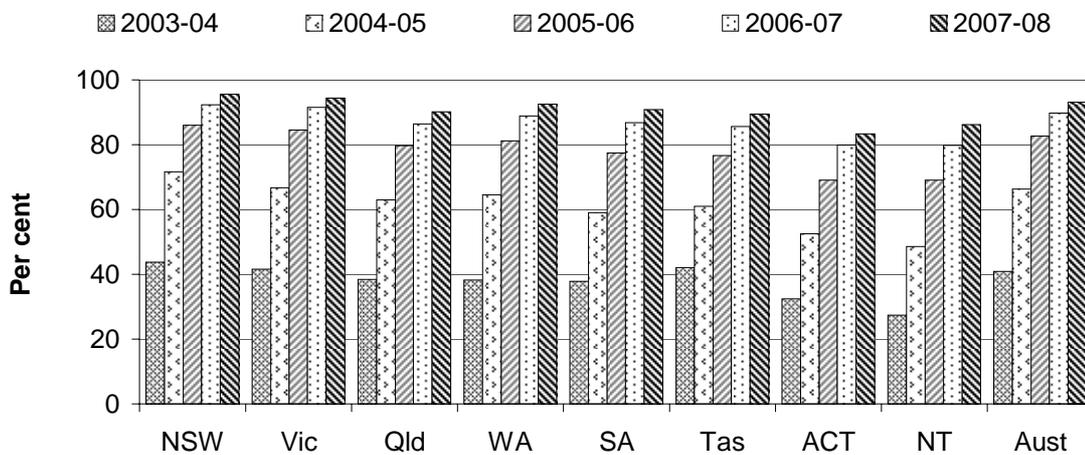
‘Care planning and case conferencing’ is defined as the proportion of GPs who used the Medicare Benefits Schedule (MBS) chronic disease management items for care planning or case conferencing at least once during a 12 month period.

An increase in the proportion of GPs who use these chronic disease management items may indicate an improvement in the continuity of care provided to people with chronic or terminal medical conditions, including people with complex, multidisciplinary care needs.

Data for this indicator are comparable.

Nationally, 93.1 per cent of GPs used the chronic disease management items for care planning or case conferencing in 2007-08 (figure 11.24).

Figure 11.24 GP use of chronic disease management Medicare items for care planning and case conferencing^a



^a The increase in the number of GPs using chronic disease management MBS items for care planning or case conferencing in 2004-05 may be due to the introduction of the Strengthening Medicare initiative on 1 July 2004. This initiative provided access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP. The continued increase in subsequent years may be linked to the introduction of additional chronic disease management MBS items on a number of occasions.

Source: DoHA (unpublished), derived from the MBS data system; table 11A.33.

Health assessments for older people

'Health assessments for older people' is an indicator of governments' objective to improve population health outcomes through the provision of prevention as well as early detection and treatment services (box 11.18).

Annual voluntary health assessments for older people are MBS items that allow a GP to undertake an in-depth assessment of a patient's health. Health assessments cover the patient's health and physical, psychological and social functioning, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient (see also box 11.6).

Box 11.18 Health assessments for older people

'Health assessments for older people' 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.

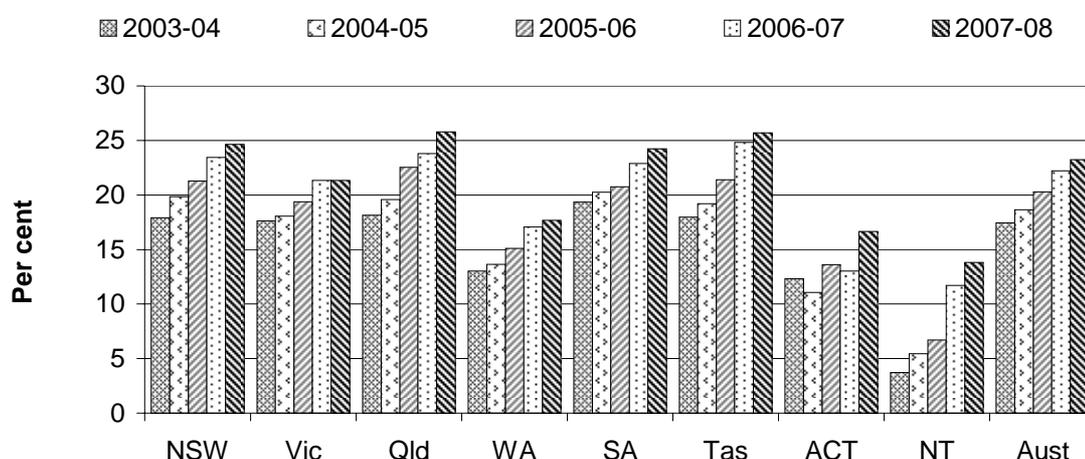
An increase in the proportion of eligible older people who received a voluntary health assessment may indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.

Data for this indicator are comparable.

The larger age range for Indigenous people recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the 'Health preface'). Results for Indigenous people are reported under equity indicators (see box 11.6).

There has been a steady increase in the proportion of older people receiving a voluntary health assessment in most jurisdictions, in the period 2003-04 to 2007-08. Nationwide, this proportion increased from 17.5 per cent in 2003-04 to 23.2 per cent in 2007-08 (figure 11.25).

Figure 11.25 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), derived from the MBS data system; table 11A.34.

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 an indicator of governments’ objective to provide primary healthcare services in an efficient manner (box 11.19).

Box 11.19 Cost to government of general practice per person

‘Cost to government of general practice per person’ is defined as the cost to government of general practice per person in the population.

A lower cost per person may indicate higher efficiency. However, this is likely to be the case only where the lower cost is associated with services of equal or superior effectiveness.

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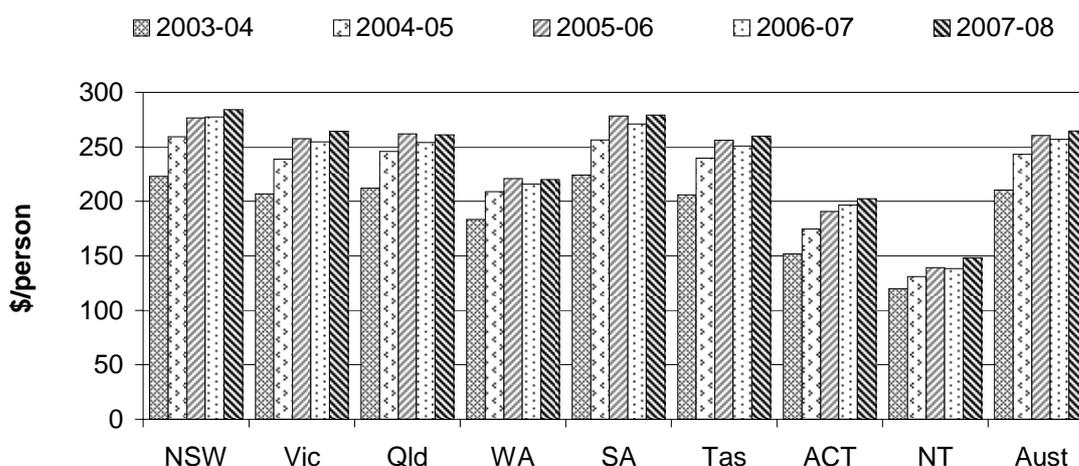
Box 11.19 (Continued)

This indicator needs to be interpreted with care because a lower cost per person may reflect service substitution between primary healthcare and hospital services or specialist services (the latter two both being potentially higher cost than primary care). Further, the indicator does not include costs for all primary healthcare services. Some primary healthcare services are provided by salaried GPs in community health settings, particularly in rural and remote areas, through accident and emergency departments, and Indigenous-specific primary health care services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.

Data for this indicator are comparable.

Nationally, the recurrent cost to the Australian Government of general practice was \$264 per person in 2007-08 (figure 11.26).

Figure 11.26 Australian Government real expenditure per person on GPs (2007-08 dollars)^a



^a The data include Medicare, DVA, PIP, Divisions of General Practice (DGP) and General Practice Immunisation Incentives Scheme (GPPI) 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.

Source: DoHA (unpublished), derived from the MBS, PIP, GPPI and DGP data systems, and unpublished DVA data; table 11A.2.

Outcomes

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

Indicators of both intermediate and final primary and community health outcomes are reported here. ‘Child immunisation coverage’ indicates the intermediate outcome of immunisation against disease (box 11.20). ‘Notifications of selected childhood diseases’ is an indicator of the final outcome — the incidence of diseases — that child immunisation can prevent (box 11.21). Also reported are outcome indicators related to cervical screening (box 11.22), influenza vaccinations for older people (box 11.23) and ‘potentially preventable hospitalisations’ (box 11.24).

Child immunisation coverage

‘Child immunisation coverage’ is an indicator of governments’ objective to achieve high immunisation coverage levels for children, in order to prevent selected childhood diseases (box 11.20).

Box 11.20 Child immunisation coverage

‘Child immunisation coverage’ has two measures:

- ‘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 for this indicator are comparable.

Many providers deliver child immunisation services (table 11.6). GPs are encouraged to achieve high immunisation coverage levels under the General Practice Immunisation Incentives Scheme, which provides incentives for the immunisation of children under seven years of age.

Data on valid vaccinations supplied to children under 7 years of age are shown in table 11.6. Around 91.2 per cent of Australian children aged 12 months to less than 15 months at 30 June 2008 were assessed as fully immunised (figure 11.27).

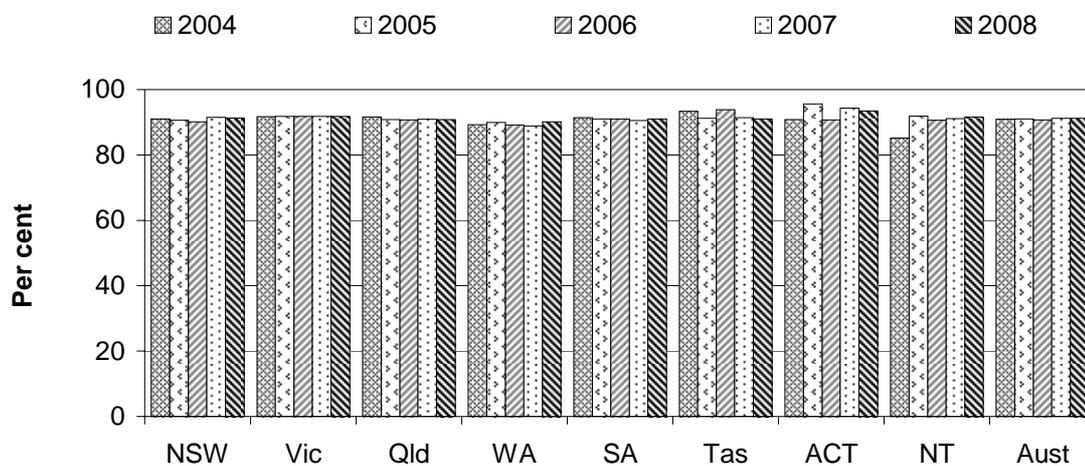
Table 11.6 Valid vaccinations supplied to children under 7 years of age, by provider type, 1996–2008 (per cent)^{a, b}

<i>Provider</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^c</i>	<i>NT</i>	<i>Aust</i>
GP	84.0	52.9	82.6	63.8	68.8	86.6	40.9	3.4	70.9
Council	5.8	45.7	7.2	6.6	18.4	12.6	na	na	17.1
State or Territory health department	–	na	–	6.1	0.1	0.1	20.8	0.3	0.9
Flying doctor service	–	na	0.3	–	0.1	na	na	na	0.1
Public hospital	2.1	0.5	3.0	5.4	2.8	0.2	0.8	7.5	2.3
Private hospital	0.1	–	–	–	na	–	–	0.9	0.1
Indigenous health service	0.5	0.1	0.7	0.6	0.5	–	0.2	9.3	0.6
Indigenous health worker	–	na	0.5	na	0.1	na	na	0.2	0.1
Community health centre	7.4	0.8	5.7	17.6	9.3	0.6	37.3	78.3	8.0
Community nurse	na	–	na	na	na	na	–	na	–
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 2008. Data relate to the State or Territory in which the immunisation provider was located. ^b A valid vaccination is a National Health and Medical Research Council's Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. ^c Due to changes in provider classification in the ACT between 1996 and 2008, some vaccinations undertaken by ACT Health's Maternal and Child Health nurses are reported under 'State or Territory health departments' and some are reported under 'Community health centre'. The total proportion of vaccinations provided by ACT Health during this period was 58.1 per cent. **na** Not available. – Nil or rounded to zero.

Source: DoHA (unpublished), derived from the Australian Childhood Immunisation Register (ACIR); table 11A.35.

Figure 11.27 Children aged 12 months to less than 15 months who were fully immunised^{a, b, c}

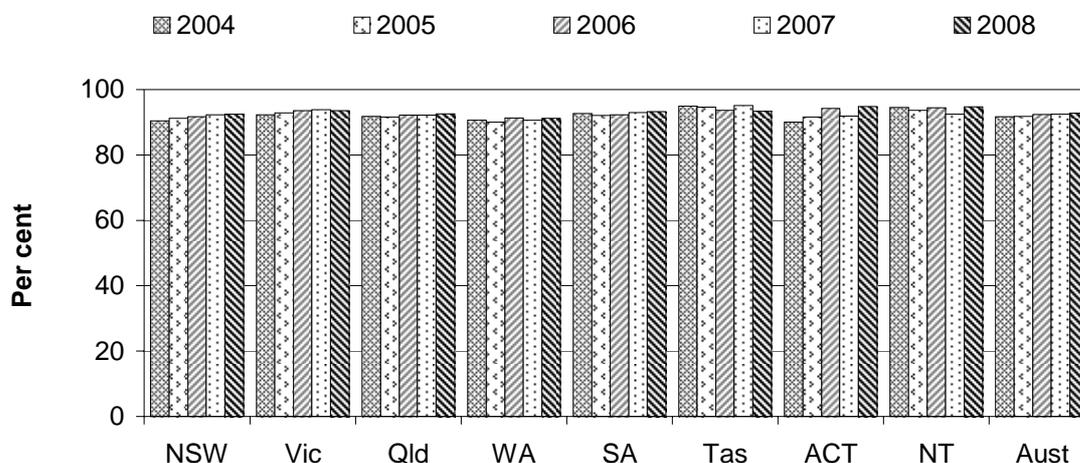


^a Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. ^b The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare. ^c There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

Source: DoHA (unpublished), derived from ACIR; table 11A.36.

Nationally, 92.8 per cent of children aged 24 months to less than 27 months at 30 June 2008 were assessed as being fully immunised (figure 11.28).

Figure 11.28 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 Australia. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare Australia (NCIRS 2000). ^c There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

Source: DoHA (unpublished), derived from ACIR; table 11A.37.

Notifications of selected childhood diseases

'Notifications of selected childhood diseases' is an indicator of governments' objective to improve population health outcomes through the prevention of selected childhood vaccine preventable diseases (box 11.21).

Measles, pertussis (whooping cough) and *Haemophilus influenzae* type b⁴ are nationally notifiable diseases — that is, if they are diagnosed, there is a requirement to notify the relevant State or Territory authority. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs for one in 25 cases. The activities of GPs and community health services can influence the prevalence of these diseases through immunisation (and consequently the notification rates).

⁴ *Haemophilus influenzae* type b is a bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (DoHA 2008c).

Box 11.21 Notifications of selected childhood diseases

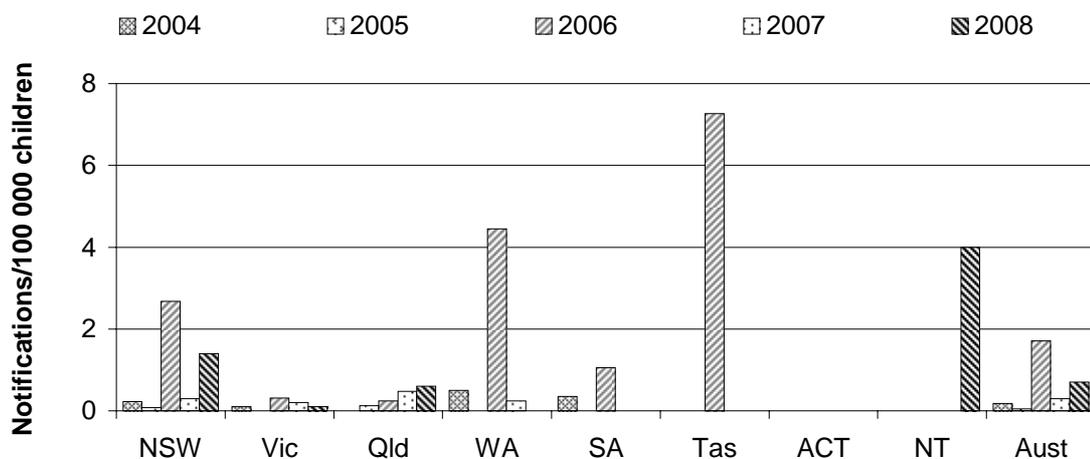
'Notifications of selected childhood diseases' is defined as the number of notifications for children aged 0–14 years per 100 000 children in that age group.

A reduction in the notification rate for the selected diseases indicates the effectiveness of the immunisation program.

Data for this indicator are comparable.

In 2008, there were 26 notifications of measles across Australia to 31 August (table 11A.38). This was the second time in the five year period 2004–2008 that notifications numbered more than 15 — there were 68 notifications in 2006. The national notification rate in 2008 was 0.7 per 100 000 children aged 0–14 years (figure 11.29).

Figure 11.29 Notifications of measles per 100 000 children aged 0–14 years^{a, b}

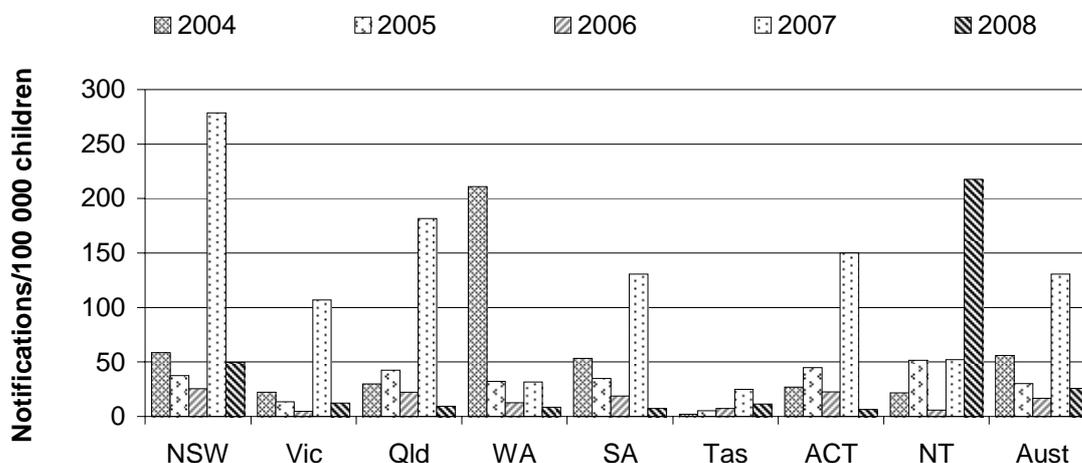


^a Notifications for 2008 are to 31 August. ^b Where a notification rate for a particular year is zero, no notifications were made in that jurisdiction.

Source: DoHA (unpublished), derived from the National Notifiable Diseases Surveillance System (NNDSS), ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.38.

Australia-wide, there were 1029 notifications for pertussis (whooping cough) across Australia to 31 August in 2008. The national notification rate in 2008 was 25.9 per 100 000 children aged 0–14 years (figure 11.30).

Figure 11.30 Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years^a

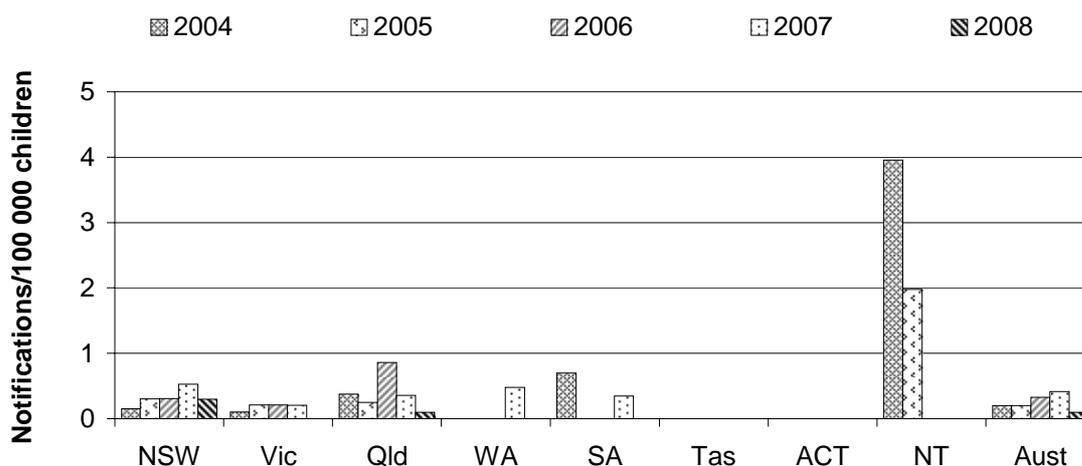


^a Notifications for 2008 are to 31 August.

Source: DoHA (unpublished), derived from the NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.39.

In recent years, notification rates for *Haemophilus influenzae* type b have remained low. In 2008, the notification rate Australia-wide to 31 August was 0.1 per 100 000 children aged 0–14 years (figure 11.31).

Figure 11.31 Notifications of *Haemophilus influenzae* type b among children aged 0–14 years^{a, b}



^a Notifications for 2008 are to 31 August. ^b Where a notification rate for a particular year is zero, no notifications were made in that jurisdiction.

Source: DoHA (unpublished), derived from the NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.40.

Participation rates for women in cervical screening

‘Participation rates for women in cervical screening’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to cervical cancer through the provision of early detection services (box 11.22).

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.

Box 11.22 Participation rates for women aged 20–69 years in cervical screening

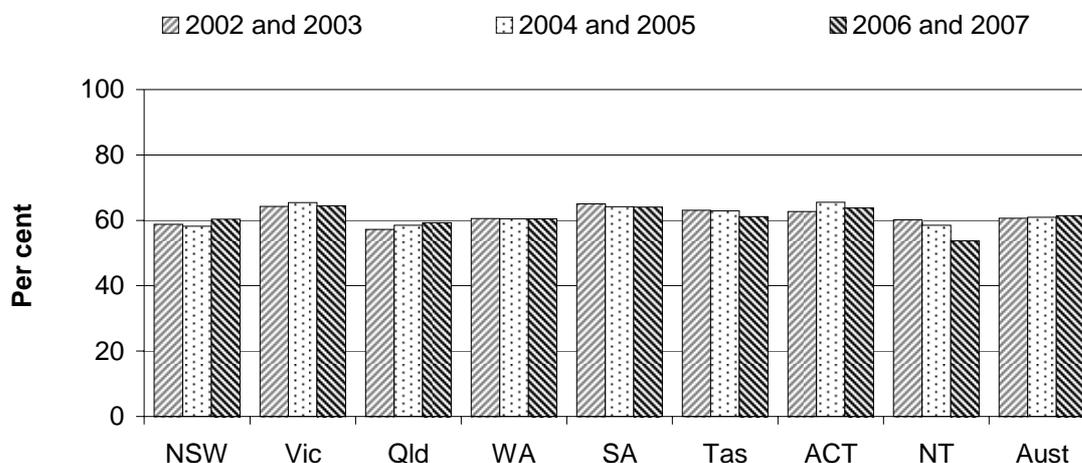
‘Participation rates for women in cervical screening’ is defined as the number of women aged 20–69 years who are screened over a two year period, as a proportion of all women aged 20–69 years.

An increase in the proportion of women aged 20–69 years who have been screened is desirable.

Data for this indicator are comparable.

The national age-standardised participation rate for women aged 20–69 years in cervical screening was 61.5 per cent for the 24 month period 1 January 2006 to 31 December 2007 (figure 11.32). For most jurisdictions, participation rates have remained about the same since the screening period of 2002 and 2003.

Figure 11.32 **Participation rates for women aged 20–69 years in cervical screening^{a, b, c, d}**



^a Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the ABS estimated resident population and age-standardised to the 2001 Australian population. ^b Eligible female population adjusted for estimated proportion who have had a hysterectomy. ^c Excludes women who have opted off the cervical cytology register. ^d Number of women screened includes all women screened in each jurisdiction (not just those women resident in each jurisdiction), except for Victoria and the ACT.

Source: AIHW (2008), *Cervical screening in Australia 2005–2006*, Cat. no. CAN 36; AIHW (unpublished), derived from the Cervical Cytology Registry; table 11A.41.

Influenza vaccination coverage for older people

‘Influenza vaccination coverage for older people’ is an indicator of governments’ objectives to reduce the morbidity and mortality attributable to vaccine preventable disease (box 11.23).

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 (DoHA and NHMRC 2008). GPs provide the majority of influenza vaccinations for older people.

Box 11.23 Influenza vaccination coverage for older people

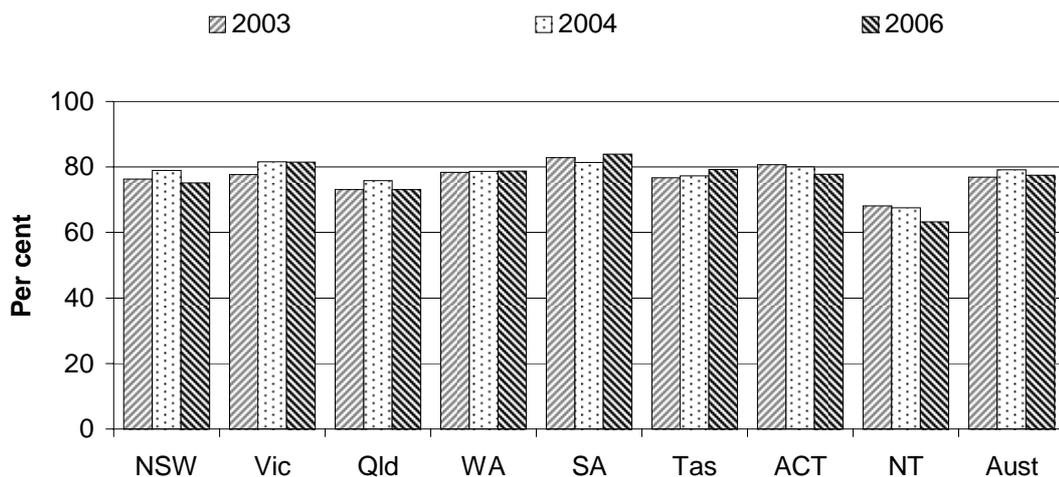
'Influenza vaccination coverage for older people' is defined as the proportion of people aged 65 years or over who have been vaccinated against influenza.

An increase in the proportion of older people vaccinated against influenza reduces the risk of older people contracting influenza and suffering consequent complications.

Data for this indicator are comparable.

Through the National Influenza Vaccine Program for Older Australians, the Australian Government funds free vaccines for Australians aged 65 years or over (AIHW 2005a). In 2006, 77.5 per cent of people in Australia aged 65 years or over were vaccinated against influenza.

Figure 11.33 Influenza vaccination coverage, people aged 65 years or over^a



^a The Adult Vaccination Survey was not conducted in 2005.

Source: AIHW 2004, 2005, *Influenza Vaccine Survey: Summary Results*, Cat. no. PHE 51, PHE 56; DoHA (unpublished), derived from the 2006 *Adult Vaccination Survey*; table 11A.42.

Potentially preventable hospitalisations

Five indicators are reported for potentially preventable hospitalisations. The first three indicators — hospitalisations for vaccine preventable conditions, selected acute conditions and selected chronic conditions — were developed by the National Health Performance Committee, based on empirical research. The fourth relates to hospitalisations for diabetes and the fifth to the hospitalisation of older people for falls.

Box 11.24 Potentially preventable hospitalisation indicators

Potentially preventable hospitalisations refer to hospital admissions that may be avoided by appropriate management in the primary healthcare sector and/or the broader community. They include vaccine preventable, acute and chronic conditions, defined according to the Victorian Ambulatory Care Sensitive Conditions Study (DHS 2002). This study built on research into ambulatory care sensitive conditions (for example, Billings, Anderson and Newman 1996; Bindman et al. 1995; Weissman, Gatsonis and Epstein 1992) that had recently been the subject of systematic review and empirical analysis.

These studies show that the availability of non-hospital care explains a significant proportion of the variation between geographic areas in hospitalisation rates for the specified conditions. Other explanations for this variation include variation in the underlying prevalence of the conditions, clinical coding standards and the likelihood that a patient will be treated as an outpatient rather than an admitted patient. Potentially preventable hospitalisations will never be entirely eliminated, but the variation across geographic areas demonstrates considerable potential for strengthening the effectiveness of non-hospital care.

Source: NHPC (2004).

Data are reported against these indicators for Indigenous Australians as well as for all Australians. The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. The AIHW (2005b) report *Improving the Quality of Indigenous Identification in Hospital Separations Data* found that Indigenous admitted patient data were of acceptable quality for analytical purposes only for Queensland, WA, SA, and public hospitals in the NT. Following new assessments of the quality of Indigenous identification, the National Health Information Management Principal Committee (NHIMPC, now the National e-Health and Information Principal Committee [NEHIPC]) has approved Indigenous admitted patient data for NSW and Victoria as acceptable in quality for analytical purposes, from the 2004-05 reference year. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered to be acceptable for the purpose of analysis.

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

Vaccine preventable hospitalisations

‘Vaccine preventable hospitalisations’ is an indicator of governments’ objective to reduce hospitalisations for vaccine preventable conditions (box 11.25). 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. Effective treatment of such conditions by primary health providers may also reduce hospitalisations.

Box 11.25 Vaccine preventable hospitalisations

‘Vaccine preventable hospitalisations’ is defined as the number of hospital separations for influenza and pneumonia, and other vaccine preventable conditions, per 1000 people. A reduction in hospital separation rates may indicate improvements in the effectiveness of the vaccination program.

Data are reported for Indigenous people as well as for all people. Adjustments are made to account for differences in the age structures of these populations across states and territories. A reduction in the gap in hospital separation rates between Indigenous and all people may indicate greater equity of access to primary healthcare services.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation for vaccine preventable conditions; for example, the number and virulence of influenza strains from year to year.

Data for this indicator are comparable.

Australia-wide, the age standardised hospital separation rate for all vaccine preventable conditions was 0.6 per 1000 people in 2006-07. Nationally, influenza and pneumonia accounted for 74.1 per cent of hospital separations for vaccine preventable conditions in 2006-07 (table 11.7).

Table 11.7 **Separations for vaccine preventable conditions, by state and territory of usual residence, per 1000 people, 2006-07^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^b</i>
Influenza and pneumonia	0.5	0.4	0.5	0.4	0.4	0.4	0.4	1.3	0.4
Other conditions	0.1	0.2	0.1	0.1	0.1	–	0.1	0.7	0.2
Total^c	0.6	0.6	0.6	0.5	0.5	0.5	0.4	2.0	0.6

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Includes other territories and excludes overseas residents and unknown state of residence. ^c Totals may not equal the sum of individual conditions due to rounding. – Nil or rounded to zero.

Source: AIHW (2008), *Australian Hospital Statistics 2006-07*, Cat. no. HSE 55; table 11A.43.

The age standardised hospital separation rate of Indigenous people for all vaccine preventable conditions was 2.7 per 1000 Indigenous people in 2006-07 for NSW, Victoria, Queensland, WA, SA and the NT combined. The quality of Indigenous identification is considered acceptable for the purposes of analysis only for these jurisdictions. Around 74 per cent of vaccine preventable separations for Indigenous people were accounted for by influenza and pneumonia in 2006-07 (table 11.8).

Table 11.8 Separations of Indigenous people for vaccine preventable conditions, per 1000 Indigenous people, 2006-07^{a, b}

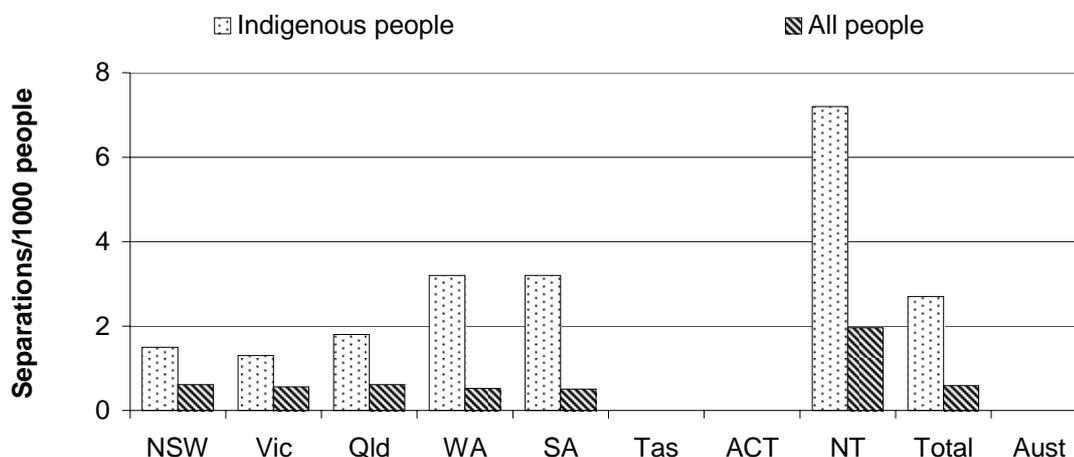
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^c</i>	<i>Total^d</i>	<i>Aust</i>
Influenza and pneumonia	1.1	0.9	1.3	2.9	2.1	np	np	4.8	2.0	np
Other conditions	0.4	0.4	0.4	0.3	1.0	np	np	2.4	0.7	np
Total^e	1.5	1.3	1.8	3.2	3.2	np	np	7.2	2.7	np

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Published data are not necessarily representative of Tasmania and the ACT. ^c NT data are for public hospitals only. ^d Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis. ^e Totals may not equal the sum of individual conditions due to rounding. **np** not published.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.43.

The age standardised hospital separation rate of Indigenous people for vaccine preventable conditions was higher than that for all people in 2006-07 in all jurisdictions for which data were published (figure 11.34).

Figure 11.34 **Separations for vaccine preventable conditions, 2006-07^{a, b, c, d, e}**



^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Published data are not necessarily representative of Tasmania and the ACT. ^c Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. ^d NT data for Indigenous people are for public hospitals only. ^e Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis.

Source: AIHW (2008), *Australian Hospital Statistics 2006-07*, Cat. no. HSE 55; AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.43.

Age standardised hospital separation rate ratios for infectious pneumonia illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in the age structures of the populations. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. For both males and females there was a marked difference in 2006-07 between the separation rates for Indigenous people and those for the total population for infectious pneumonia diagnoses. For NSW, Victoria, Queensland, WA, SA and the NT combined, the separation rate for Indigenous males was higher than that for all Australian males, and the separation rate for Indigenous females was higher than the rate for all females (tables 11A.46 and 11A.47).

Hospitalisations for selected acute conditions

‘Hospitalisations for selected acute conditions’ is an indicator of governments’ objective to reduce hospitalisations due to acute conditions through the delivery of effective primary healthcare services (box 11.26).

Box 11.26 Hospitalisations for selected acute conditions

'Hospitalisations for selected acute conditions' is defined as the number of hospital separations for the following selected acute conditions per 1000 people: 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.

A reduction in hospitalisation separation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

The indicator is reported for Indigenous people as well as for all people. Adjustments are made to account for differences in the age structures of these populations across states and territories. A reduction in the gap in hospital separation rates between Indigenous and all people may indicate greater equity of access to primary healthcare services.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, the underlying prevalence of the conditions. Public health measures not covered in this chapter may also influence hospitalisation rates.

Data for this indicator are comparable.

Of the selected acute conditions, dental conditions and dehydration and gastroenteritis had the highest rates of hospitalisation nationally in 2006-07 (table 11.9).

Table 11.9 Separations for potentially preventable acute conditions, by state and territory of usual residence, per 1000 people, 2006-07^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^b</i>
Appendicitis	0.2	0.2	0.1	0.2	0.2	0.1	0.2	0.2	0.2
Cellulitis	1.6	1.6	1.7	1.4	1.6	1.4	1.4	4.5	1.6
Convulsions and epilepsy	1.7	1.5	1.6	1.4	1.6	1.6	1.3	3.3	1.6
Dehydration and gastroenteritis	2.2	3.1	2.4	2.2	2.7	2.1	1.8	2.1	2.5
Dental conditions	2.3	2.8	2.7	3.5	3.1	1.8	1.6	2.0	2.7
Ear, nose and throat infections	1.6	1.4	1.6	1.5	2.4	1.3	1.2	2.3	1.6
Gangrene	0.1	0.3	0.2	0.2	0.2	0.2	0.1	0.7	0.2
Pelvic inflammatory disease	0.2	0.3	0.3	0.2	0.2	0.2	0.3	0.5	0.3
Perforated/bleeding ulcer	0.2	0.3	0.2	0.3	0.2	0.2	0.2	0.3	0.2
Pyelonephritis ^c	2.1	2.4	2.2	2.1	2.0	1.6	2.2	3.6	2.2
Total^d	12.3	13.7	13.0	13.1	14.3	10.4	10.4	19.5	13.0

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Includes other territories and excludes overseas residents and unknown state of residence. ^c Kidney inflammation caused by bacterial infection. ^d Totals may not equal the sum of individual components as more than one acute condition may be reported for a separation.

Source: AIHW (2008), *Australian Hospital Statistics 2006-07*, Cat. no. HSE 55; table 11A.44.

The age standardised hospital separation rate of Indigenous people for all potentially preventable acute conditions was 31.1 per 1000 Indigenous people in 2006-07 for NSW, Victoria, Queensland, WA, SA and the NT combined. Over half of potentially preventable acute separations for Indigenous people were accounted for by convulsions and epilepsy, pyelonephritis, and cellulitis in 2006-07 (table 11.10).

Table 11.10 Separations of Indigenous people for potentially preventable acute conditions, per 1000 Indigenous people, 2006-07^{a, b}

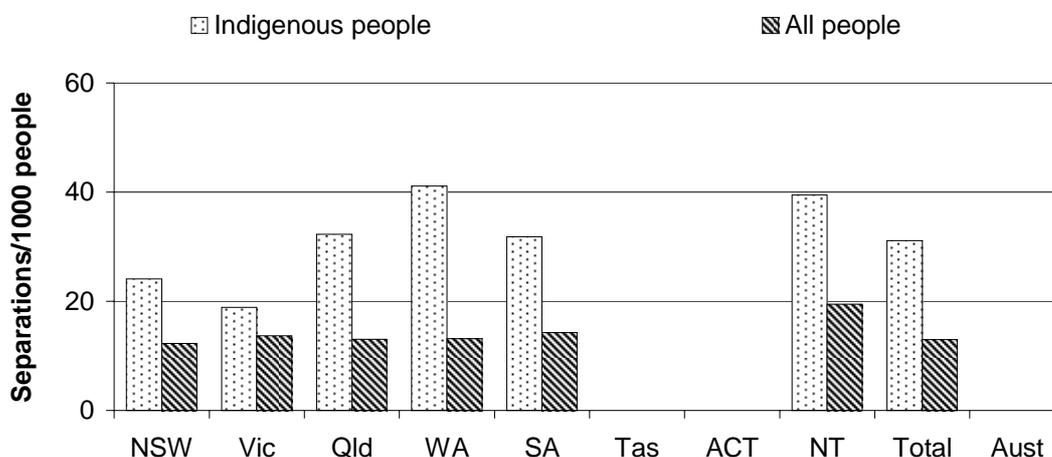
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^c</i>	<i>Total^d</i>	<i>Aust</i>
Appendicitis	0.2	0.2	0.3	0.4	0.2	np	np	0.4	0.3	np
Cellulitis	3.5	2.1	5.4	6.0	4.4	np	np	7.1	4.8	np
Convulsions and epilepsy	6.1	4.7	6.5	10.4	8.0	np	np	10.4	7.4	np
Dehydration and gastroenteritis	3.1	2.6	4.4	3.6	3.9	np	np	3.3	3.6	np
Dental conditions	2.4	2.9	3.2	3.8	4.4	np	np	3.4	3.1	np
Ear, nose and throat infections	2.9	1.7	2.9	4.0	3.8	np	np	3.5	3.1	np
Gangrene	0.3	0.3	1.1	2.7	0.8	np	np	1.8	1.1	np
Pelvic inflammatory disease	0.4	0.2	0.5	0.9	0.8	np	np	1.3	0.6	np
Perforated/bleeding ulcer	0.6	0.1	0.4	0.5	0.5	np	np	0.4	0.5	np
Pyelonephritis ^e	4.6	4.0	7.7	8.9	5.2	np	np	7.9	6.5	np
Total^f	24.1	18.9	32.3	41.1	31.8	np	np	39.5	31.1	np

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Published data are not necessarily representative of Tasmania and the ACT. ^c NT data are for public hospitals only. ^d Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis. ^e Kidney inflammation caused by bacterial infection. ^f Totals may not equal the sum of individual conditions due to rounding. **np** not published.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.44.

The age standardised hospital separation rate of Indigenous people for all potentially preventable acute conditions was higher than that for all people in 2006-07 in all jurisdictions for which data were published (figure 11.35).

Figure 11.35 **Separations for potentially preventable acute conditions, 2006-07**^{a, b, c, d, e}



^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Published data are not necessarily representative of Tasmania and the ACT. ^c Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. ^d NT data for Indigenous people are for public hospitals only. ^e Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis.

Source: AIHW (2008), *Australian Hospital Statistics 2006-07*, Cat. no. HSE 55; AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.44.

Hospitalisations for selected chronic conditions

‘Hospitalisations for selected chronic conditions’ is an indicator of governments’ objective to reduce hospitalisations due to selected chronic conditions through delivery of effective primary and community healthcare services (box 11.27).

Box 11.27 Hospitalisations for selected chronic conditions

‘Hospitalisations for selected chronic conditions’ is defined as the number of hospital separations for the following selected chronic conditions per 1000 people: asthma; congestive cardiac failure; diabetes complications; chronic obstructive pulmonary disease; angina; iron deficiency anaemia; hypertension; nutritional deficiencies; and rheumatic heart disease. A reduction in hospitalisation separation rates may indicate improvements in the effectiveness of primary and community healthcare providers’ treatment of these conditions.

(Continued on next page)

Box 11.27 (Continued)

This indicator is reported for Indigenous people as well as for all people. Adjustments are made to account for differences in the age structures of these populations across states and territories. A reduction in the gap in hospital separation rates between Indigenous and all people may indicate greater equity of access to primary healthcare services.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

Data for this indicator are comparable.

Of the selected chronic conditions chronic obstructive pulmonary disease, congestive cardiac failure, asthma and angina had the highest rates of hospitalisation nationally in 2006-07 (except for diabetes complications). The hospitalisation rate for diabetes complications was more than three times higher than the rate for any of these conditions (table 11.11).

Table 11.11 Separations for potentially preventable chronic conditions, by state and territory of usual residence, per 1000 people, 2006-07^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^b</i>
Angina	1.6	1.8	2.5	1.6	1.5	1.7	1.1	2.4	1.8
Asthma	2.0	1.9	1.4	1.4	2.6	1.4	1.2	1.5	1.8
Chronic obstructive pulmonary disease	2.5	2.5	2.7	2.2	2.8	2.4	1.7	5.5	2.6
Congestive cardiac failure	1.9	2.1	1.9	1.9	1.9	1.6	1.9	2.5	1.9
Diabetes complications	7.4	9.0	10.2	26.4	8.4	13.4	5.3	15.3	10.4
Hypertension	0.3	0.3	0.4	0.2	0.3	0.3	0.2	0.2	0.3
Iron deficiency anaemia	1.0	1.7	1.0	1.4	1.3	1.2	0.7	1.1	1.2
Nutritional deficiencies	–	–	0.0	0.0	–	0.0	–	0.1	0.0
Rheumatic heart disease ^c	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.8	0.1
Total^d	15.7	18.1	19.0	34.3	17.7	21.2	11.4	27.3	19.1

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Includes other territories and excludes overseas residents and unknown state of residence. ^c Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease. ^d Totals may not equal the sum of individual components as more than one chronic condition may be reported for a separation. – Nil or rounded to zero.

Source: AIHW (2008), *Australian Hospital Statistics 2006-07*, Cat. no. HSE 55; table 11A.45.

The age standardised hospital separation rate of Indigenous people for all potentially preventable chronic conditions was 57.4 per 1000 Indigenous people in 2006-07 for NSW, Victoria, Queensland, WA, SA, and the NT combined. The quality of Indigenous identification is considered acceptable for the purpose of

analysis only for these jurisdictions. Excluding diabetes complications (discussed below), chronic obstructive pulmonary disease, congestive cardiac failure and angina had the highest potentially preventable chronic hospitalisation rates for Indigenous people in 2006-07 (table 11.12).

Table 11.12 Separations of Indigenous people for potentially preventable chronic conditions, per 1000 Indigenous people, 2006-07^{a, b}

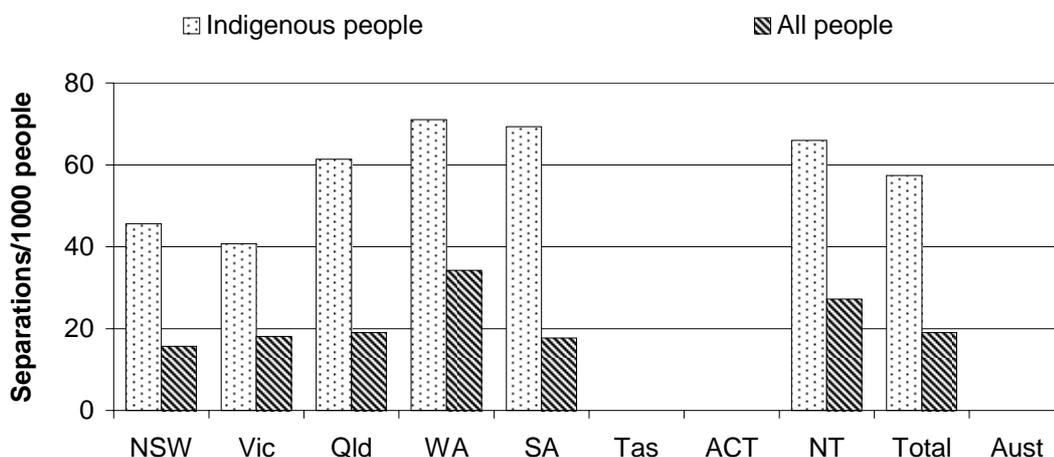
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^c</i>	<i>Total^d</i>	<i>Aust</i>
Angina	5.2	6.4	7.9	5.8	4.0	np	np	4.5	5.9	np
Asthma	4.1	2.4	3.3	4.9	4.4	np	np	4.0	3.9	np
Chronic obstructive pulmonary disease	12.3	9.6	11.7	12.4	14.0	np	np	15.8	12.4	np
Congestive cardiac failure	5.0	2.6	7.7	8.7	7.1	np	np	7.1	6.5	np
Diabetes ^e	21.6	20.5	35.1	44.0	41.0	np	np	36.4	31.7	np
Hypertension	0.6	0.2	1.4	0.7	1.4	np	np	0.7	0.9	np
Iron deficiency anaemia	1.6	2.3	1.7	2.2	1.8	np	np	2.4	1.9	np
Nutritional deficiencies	–	0.1	–	–	–	np	np	0.1	–	–
Rheumatic heart disease ^f	0.2	0.4	0.8	0.9	2.0	np	np	1.7	0.8	np
Total^g	45.6	40.7	61.4	71.0	69.3	np	np	66.0	57.4	np
Total excluding diabetes complications	28.8	24.1	34.6	35.7	34.6	np	np	36.4	32.3	np

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Published data are not necessarily representative of Tasmania and the ACT. ^c NT data are for public hospitals only. ^d Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis. ^e Excludes separations with a principal diagnosis of renal dialysis and an additional diagnosis of diabetes. ^f Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease. ^g Totals may not equal the sum of individual conditions due to rounding. – Nil or rounded to zero. **np** not published.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.45.

The age standardised hospital separation rate of Indigenous people for all potentially preventable chronic conditions was higher than that for all people in 2006-07 in all jurisdictions for which data were published (figure 11.36).

Figure 11.36 **Separations for potentially preventable chronic conditions, 2006-07^{a, b, c, d, e}**



^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Published data are not necessarily representative of Tasmania and the ACT. ^c Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. ^d NT data for Indigenous people are for public hospitals only. ^e Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis.

Source: AIHW (2008), *Australian Hospital Statistics 2006-07*, Cat. no. HSE 55; AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.45.

Hospitalisations for diabetes

‘Hospitalisations for diabetes’ is an indicator of governments’ objective to reduce hospitalisations due to diabetes through the provision of high quality, appropriate and effective management of diabetes in the primary and community health sector (box 11.28).

Box 11.28 Hospitalisations for diabetes

‘Hospitalisations for diabetes’ has two measures:

- Hospital separation rates for patients with diabetes mellitus as the principal diagnosis
- Hospital separation rates for patients with a lower limb amputation as well as a principal or additional diagnosis of diabetes.

(Continued on next page)

Box 11.28 (Continued)

Hospital separation rates are defined as hospital separations per 100 000 people. Rates are adjusted to account for differences in the age structures of State and Territory populations.

A reduction in these rates may indicate an improvement in GPs' and community health providers' management of patients' diabetes.

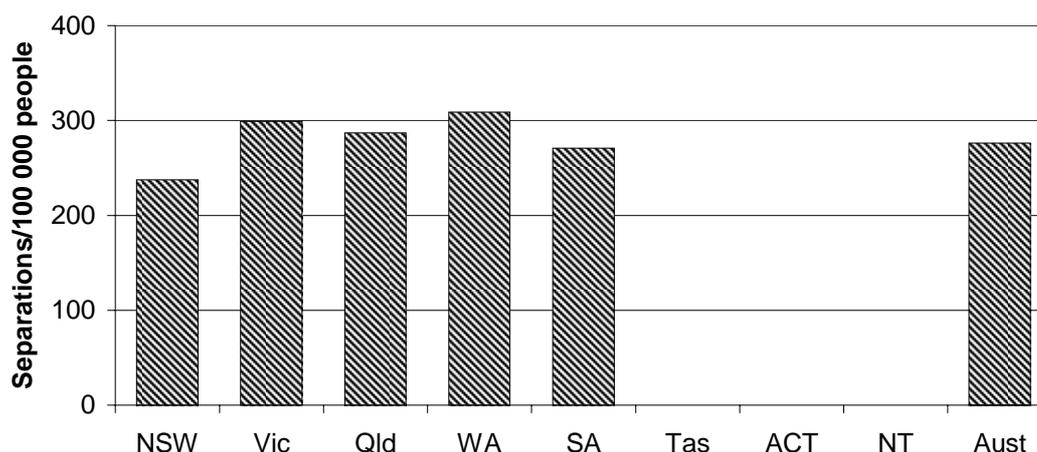
A comparison is made between Indigenous and all other people in the ratio of age standardised hospital separation rates of Indigenous people to all people. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

Data for this indicator are comparable.

Australia-wide, the age standardised hospital separation rate in 2006-07 where the principal diagnosis was Type 2 diabetes mellitus was 276.3 separations per 100 000 people (figure 11.37).

Figure 11.37 Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2006-07^{a, b, c, d}

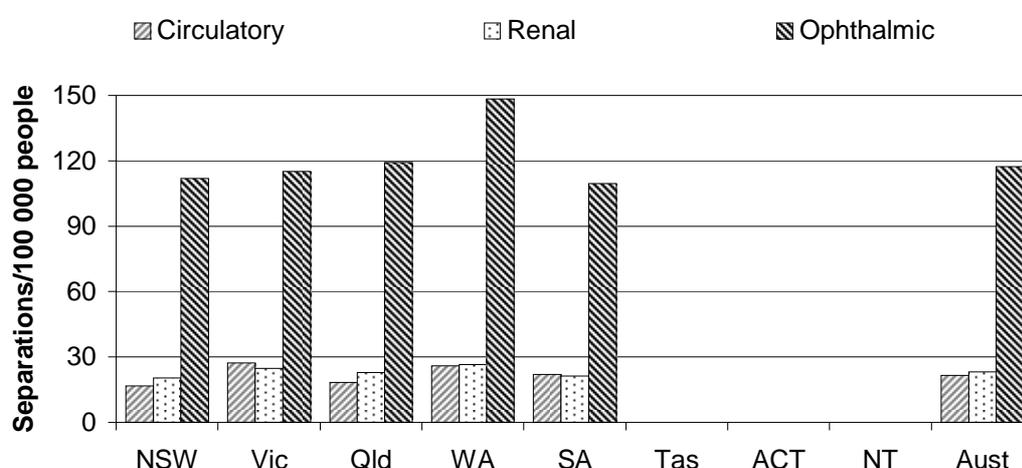


^a Results for individual complications may be affected by small numbers, and need to be interpreted with care. ^b Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. ^c Morbidity data are coded under coding standards that may differ over time and across jurisdictions. ^d Data for Tasmania, the ACT and the NT are not published separately (due to hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.48.

The three most common complications from Type 2 diabetes that led to hospitalisation in 2006-07 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.38). Each patient may have one or more complication (circulatory, renal and ophthalmic) for each diabetes hospital separation.

Figure 11.38 Proportion of separations for principal diagnosis of Type 2 diabetes mellitus by selected complications, all hospitals, 2006-07^{a, b, c, d}



^a Results for individual complications may be affected by small numbers, and need to be interpreted with care. ^b Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. ^c Morbidity data are coded under coding standards that may differ over time and across jurisdictions. ^d Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

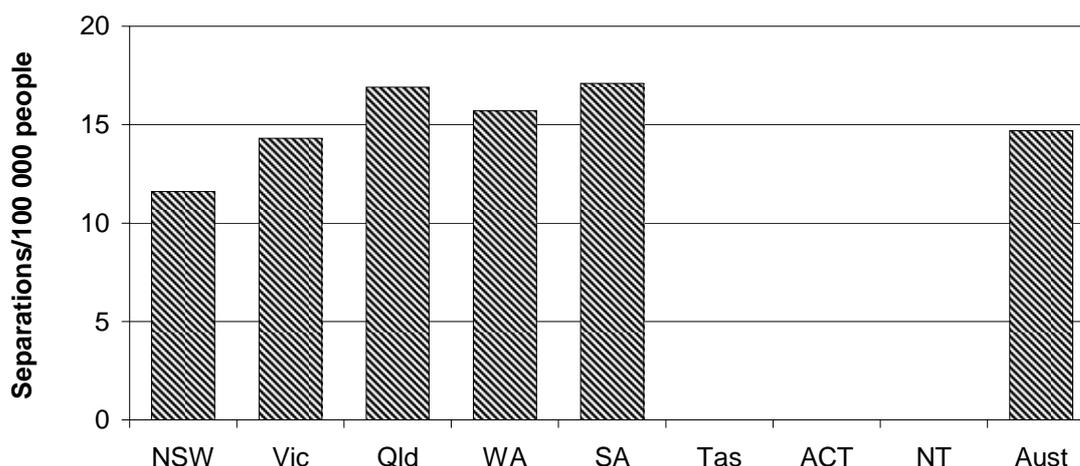
Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.48.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but the number of people accessing ambulatory services is not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients affect hospital separation rates. This effect is partly reflected in the substantial variation in the proportion of separations that are 'same day' across jurisdictions. Nationally, 48.4 per cent of separations for Type 2 diabetes were same day in 2006-07 (table 11A.49).

Amputation of a lower limb can be an outcome of serious diabetes-related complications. In 2006-07, there were 14.7 hospital separations per 100 000 people

(age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 11.39).

Figure 11.39 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2006-07^{a, b, c}**



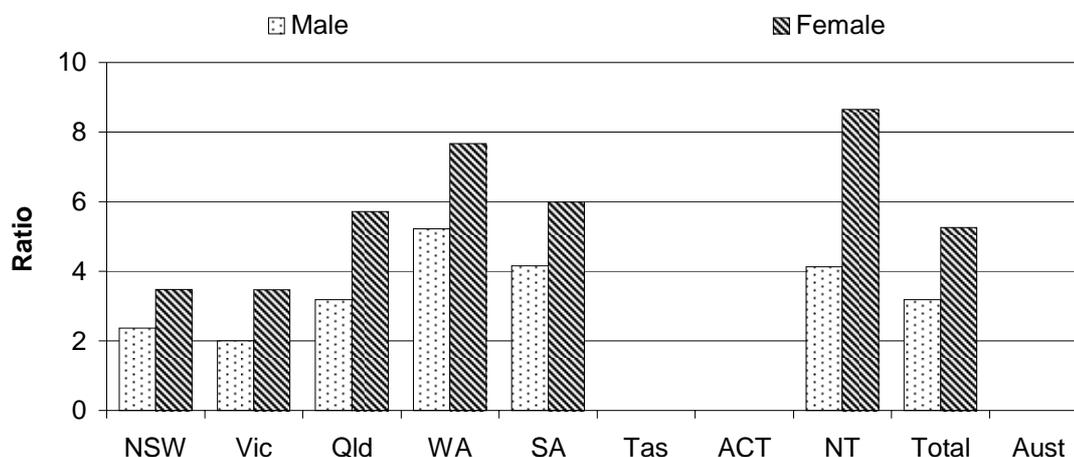
^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation. ^c Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.50.

Age standardised hospital separation ratios for all diabetes diagnoses⁵ illustrate differences between the rate of hospital admissions for Indigenous people and that for all Australians, taking into account differences in the age structures of the two populations. For both males and females there was a marked difference in 2006-07 between the separation rates for Indigenous people and those for the total population for all diabetes diagnoses. The quality of Indigenous identification is considered acceptable for the purpose of analysis only for NSW, Victoria, Queensland, WA, SA and the NT. For these jurisdictions combined, the separation rate for Indigenous males was 3.2 times higher than those for all Australian males. The separation rate for Indigenous females was 5.3 times the rate for all females (figure 11.40).

⁵ 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes, except where dialysis is the principal diagnosis.

Figure 11.40 Ratio of separation rates of Indigenous people to all people for all diabetes diagnoses, 2006-07^{a, b, c, d, e, f, g}



^a Ratios are directly age standardised to the Australian population at 30 June 2001. ^b Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. ^c 'All diabetes' refers to separations with a principal and/or additional diagnosis of diabetes, except where dialysis is the principal diagnosis. ^d Patients aged 75 years and over are excluded. ^e Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Published data are not necessarily representative of Tasmania and the ACT. ^f NT data are for public hospitals only. ^g Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; tables 11A.46 and 11A.47.

Hospitalisations of older people for falls

'Hospitalisations of older people for falls' is an indicator of governments' objective to reduce preventable hospitalisations through the delivery of effective primary and community health services (box 11.29). Effective primary and community healthcare may reduce the likelihood of falls and/or assist in reducing the severity of injury.

Box 11.29 Hospitalisation of older people for falls

'Hospitalisations of older people for falls' is defined as the number of hospital separations for older people with a reported external cause of falls per 1000 older people, adjusted to take account of differences in State and Territory age distributions. Older people are defined as aged 65 years or over for this indicator.

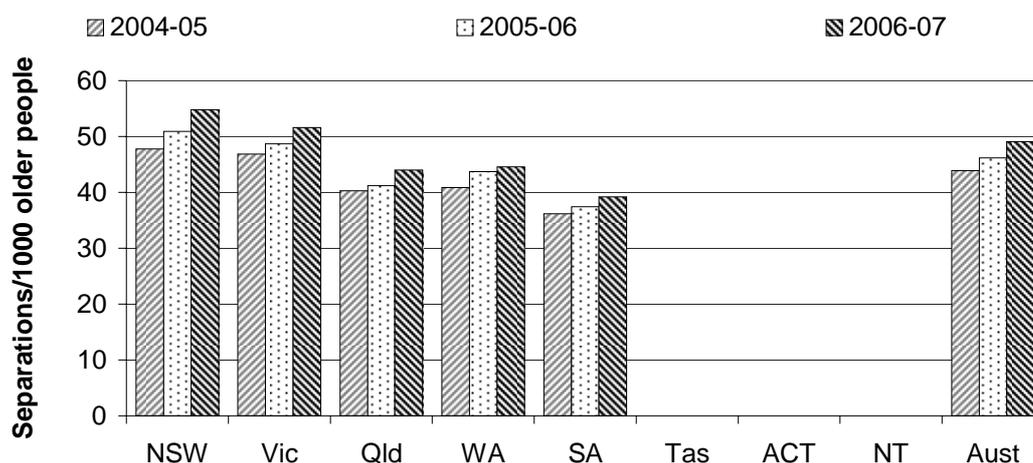
A reduction in the rate of hospitalisation due to falls may indicate improvements in the effectiveness of primary and community healthcare services provided to older people who are at risk of falls.

Factors outside the control of the primary healthcare system also influence the rates of hospitalisation. These include the support available to older people from family and friends, and the provision of aged care services such as Home and Community Care program services and residential care.

Data for this indicator are comparable.

In all jurisdictions for which data are published, separation rates for older people with injuries due to falls have gradually increased in the period 2004-05 to 2006-07 (figure 11.41). Nationally, the separation rate per 1000 older people increased from 43.9 in 2004-05 to 49.1 in 2006-07.

Figure 11.41 Separations for older people with a reported external cause of falls^{a, b, c}



^a Older people are defined as people aged 65 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 the estimated population aged 65 years or over at December 31 as the denominator.

Source: AIHW (unpublished), derived from the National Hospital Morbidity Database; table 11A.51.

11.4 Future directions in performance reporting

While the topic of this chapter is all primary and community health services, the indicators remain heavily focused on general practice services. This partly reflects the lack of data available on a nationally consistent basis to support reporting against indicators for other primary and community health services. The Steering Committee has identified possible areas for which indicators may be available for inclusion in the 2010 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, the currently reported indicator ‘management of upper respiratory tract infection’ has been identified for reporting improvements.

The scope of this chapter may also be further refined to ensure the most appropriate reporting of primary health services against the Review’s terms of reference and reporting framework (see chapter 1).

Indigenous health

Barriers to accessing primary health services contribute to the poorer health status of Indigenous people compared to other Australians (see the ‘Health preface’). The Steering Committee has identified primary and community health services for Indigenous people as a priority area for future reporting. The Steering Committee will continue to examine options for the inclusion of further such indicators. The Aboriginal and Torres Strait Islander Health Performance Framework developed under the auspices of the Australian Health Ministers’ Advisory Council will inform the selection of future indicators of primary and community health services to Indigenous people.

The completeness of Indigenous identification in hospital admitted patient statistics remains variable across states and territories. There has been some improvement, for example, data for NSW and Victoria are now considered to be of acceptable quality for the purpose of analyses, whereas on previous assessment this was not the case. The quality of data for Tasmania and the ACT is considered to be too poor for publication. Continued efforts to improve Indigenous identification are necessary in order to better measure the performance of primary and community health services in relation to the health of Indigenous Australians. The AIHW is currently undertaking a project to develop best practice guidelines for identification.

Reform of Specific Purpose Payments

In December 2007, the Council of Australian Governments (COAG) agreed to reform Specific Purpose Payments (SPPs). SPPs are financial agreements between the Australian Government and State and Territory governments involving a contribution by the Australian Government to the funding of services which are considered a joint Australian and State and Territory government responsibility. The Australian Health Care Agreement was such an SPP.

At its 29 November 2008 meeting, COAG agreed to six new National Agreements, five of which are associated with a National SPP. In the area of Health and Ageing, there is a National Health Care Agreement associated with the National Health Care SPP (COAG November 2008). Under the reforms, the National Health Care Agreement contains the objectives, outcomes, outputs and performance indicators for Health and Ageing services. The performance of governments in achieving these mutually agreed outcomes will be assessed by the COAG Reform Council (CRC). The Steering Committee has been requested by COAG to provide the SPP performance information to the CRC (COAG July 2008).

The National Agreements/SPPs will be supplemented by a range of National Partnerships (NPs): project, facilitation and reward agreements. Funding for NPs may be conditional on states and territories meeting agreed milestones and performance benchmarks.

The Steering Committee and the Health Working Group will ensure that reporting in this chapter reflects the COAG priorities identified in the National Health Care Agreement, National Health Care SPP and relevant NPs.

11.5 Definitions of key terms and indicators

Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Annual cycle of care for people with diabetes mellitus within general practice	<p>The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice, based on RACGP guidelines.</p> <p>MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines.</p>
Asthma Action Plan	<p>An asthma action plan (AAP) is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional.</p> <p><i>Source: ACAM (Australian Centre for Asthma Monitoring) 2007, Australian asthma indicators: Five-year review of asthma monitoring in Australia. Cat. no. ACM 12, AIHW, Canberra.</i></p>
Cervical screening rates for target population	Proportion of women aged 20–69 years who are screened for cervical cancer over a two year period.
Closed treatment episode	A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for three months or more. Clients may be involved in more than one closed treatment episode in the data collection period.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Divisions of General Practice	<p>Geographically-based networks of GPs. There are 111 Divisions of General Practice, 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN).</p> <p>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.</p>

Full time workload equivalents (FWE)	A measure of medical practitioner supply based on claims processed by Medicare in a given period, calculated by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that period. Full time equivalents (FTE) are calculated in the same way as FWE except that FTE are capped at 1 per practitioner.
Fully immunised at 12 months	A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine and three doses of HbOC (HibTITER) (or two doses of PRP-OMP [PedvaxHIB]).
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine, four doses of HbOC (HibTITER) (or three doses of PRP-OMP [PedvaxHIB]) and one dose of measles, mumps and rubella vaccine.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.
General practitioner (GP)	Vocationally recognised GPs — medical practitioners who are vocationally recognised under s.3F of the Health Insurance Act 1973 (Cwlth), hold Fellowship of the RACGP, ACRRM, or equivalent (From 1996, vocational registration was available only to GPs who attained Fellowship of the RACGP; since April 2007, it has also been available to Fellows of the ACRRM), or hold a recognised training placement. Other medical practitioners — medical practitioners who are not vocationally recognised GPs.
Health management	An ongoing process beginning with initial client contact and including all actions relating to a client. Includes: assessment/evaluation; education of the person, family or carer(s); diagnosis and treatment; management of problems associated with adherence to treatment; and liaison with, or referral to, other agencies.
Immunisation coverage	A generic term indicating the proportion of a target population that is fully immunised with a particular vaccine or the specified vaccines from the National Immunisation Program for that age group.
Management of upper respiratory tract infections	Number of prescriptions ordered by GPs for the oral antibiotics most commonly used in the treatment of upper respiratory tract infections per 1000 people with PBS concession cards.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive Medicare reimbursement.
Non-referred attendances that are bulk billed	Number of non-referred attendances that are bulk billed and provided by medical practitioners, divided by the total number of non-referred non-specialist attendances.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (DoHA 2004). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.

Notifications of selected childhood diseases	Number of cases of measles, pertussis and <i>Haemophilus influenzae</i> type b notified to State and Territory health authorities.
Other medical practitioner (OMP)	A medical practitioner other than a vocationally recognised GP who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.
Per person benefits paid for GP ordered pathology	Total benefits paid for pathology tests ordered by GPs, divided by the population.
Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging tests referred by GPs, divided by the population.
Primary healthcare	<p>The primary and community healthcare sector includes services that:</p> <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 either of the two accreditation bodies, AGPAL and GPA ACCREDITATION plus, divided by the total number of practices in the Divisions of General Practice.
Proportion of general practices with electronic information management systems	Number of practices that maintain and/or use predominantly secure electronic patient records, that are registered under the PIP, divided by the total number of practices registered.
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Reasons for encounter	The expressed demand of the patient for care, as perceived and recorded by the GP.

Recognised immunisation provider

A provider recognised by Medicare Australia as a provider of immunisation to children.

Recognised specialist

A medical practitioner classified as a specialist on the Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.

Screening

The performance of tests on apparently well people to detect a medical condition at an earlier stage than would otherwise be possible without the test.

Vocationally recognised general practitioner

A medical practitioner who is vocationally recognised under s.3F of the Health Insurance Act 1973 (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances.

11.6 Attachment tables

Attachment tables are identified in references throughout this chapter by a '11A' suffix (for example, table 11A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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Table 11A.27	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes
Table 11A.28	Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region
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Table 11A.39	Notifications of pertussis (whooping cough), children aged 0–14 years
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Table 11A.43	Separations for selected vaccine preventable conditions, 2006-07 (per 1000 people)
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Table 11A.48	Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2006-07 (per 100 000 people)
Table 11A.49	Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2006-07 (per cent)
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Table 11A.58	Tasmania, community health services programs
Table 11A.59	Australian Capital Territory, community health services programs
Table 11A.60	Northern Territory, community health services programs

11.7 References

- ACAM (Australian Centre for Asthma Monitoring) 2008, *Asthma in Australia 2008*, Cat. no. ACM 14, AIHW Asthma Series 3, AIHW, Canberra.
- AIHW (Australian Institute of Health and Welfare) 2005a, *2004 Adult Vaccination Survey: summary results*. AIHW Cat. no. PHE 56, Canberra.
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12 Health management issues

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Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables themselves are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the management of breast cancer and mental health, which represent some activities of the Australian, State and Territory governments in health management.

12.1 Overview of health management

Health management is the ongoing process beginning with initial client contact and including all actions relating to the client: assessment/evaluation; education of the person, family or carer(s); diagnosis; and treatment. Problems associated with adherence to treatment and liaison with, or referral to, other agencies are also included.

This chapter examines the performance of a number of services in influencing outcomes for women with breast cancer and for people with a mental illness. Breast cancer and mental illness are significant causes of morbidity and mortality in Australia. Cancer control and mental health are identified by governments as national health priority areas (as are asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and musculoskeletal conditions). The national health priority areas represent almost 80 per cent of the total burden of disease and injury in Australia, and their management offers considerable scope for reducing this burden (AIHW 2003b).

Breast cancer detection and management services comprise a number of major components: primary care and community-based services, including general practitioner (GP) services and community-based women's health services; screening services; acute services based in hospitals, including both inpatient and outpatient services; private consultations for a range of disciplines; and post-acute services, including home-based and palliative care (DHS 1999). Relevant clinical disciplines include surgery, plastic and reconstructive surgery, pathology, radiation and medical oncology, nursing, diagnostic radiology, radiography, physiotherapy, allied health, and psychological and psychiatric services. Post-acute services include a range of further treatments, such as radiotherapy and chemotherapy (most of which take place on a same day or outpatient basis) and a range of follow up and palliative care services (DHS 1999).

Specialised mental health management services include a range of government and non-government service providers offering promotion, prevention, treatment and management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, Aboriginal health workers, Aboriginal mental health workers, public hospitals with specialised psychiatric units and stand-alone psychiatric hospitals all provide specialised mental health care. In addition, a number of health services provide care to mental health patients in a non-specialised health setting — for example, GPs, Aboriginal community controlled health services, public hospital emergency departments and outpatient departments, and

public hospital general wards (as opposed to specialist psychiatric wards). Some people with a mental illness are cared for in residential aged care services.

Both breast cancer and mental health are the subject of programs designed to improve public health. Public health programs require the participation of public hospitals, primary and community health services, and other services. The performance of public hospitals is discussed in chapter 10 and the performance of primary and community health services generally is discussed in chapter 11.

Several improvements have been made to the chapter this year:

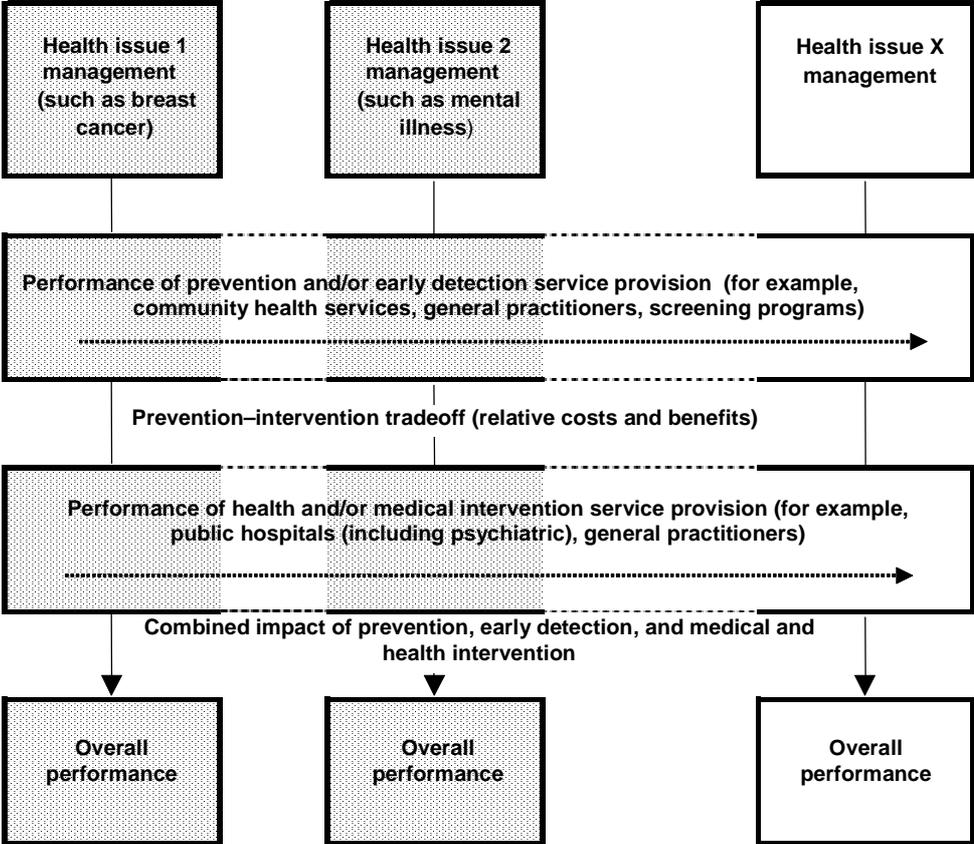
- the inclusion of data from the ABS's 2007 *National Survey of Mental Health and Wellbeing* on the following:
 - the prevalence of mental illnesses/disorders
 - the participation of people with mental illnesses/disorders in the labour force, employment and study
 - the use of services for mental health by people with mental illnesses/disorders
- the reporting of data on the proportion of the population receiving clinical mental health care
- the reporting of expenditure on community-based services as a proportion of total spending on mental health services (a replacement measure for recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total expenditure on mental health services). This change reflects the progress that has been made toward reforms recommended under the National Mental Health Strategy (NMHS)
- the inclusion of data for the following mental health indicators for the first time:
 - 'rates of community follow up for people within the first seven days of discharge from hospital'
 - 'readmissions to hospital within 28 days of discharge'.

12.2 Framework for measuring the performance of health management

Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. Measuring performance in the management of a health problem involves measuring the performance of service providers, and the overall management of a spectrum of services, including prevention, early detection and treatment programs.

The ‘Health preface’ of this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and primary and community health services report the performance of particular service delivery mechanisms. The appropriateness of the mix of services (prevention versus intervention) and the appropriateness of the mix of delivery mechanisms (hospital-based versus community-based) are the focus of reporting in this chapter. The measurement approach is represented diagrammatically in figure 12.1.

Figure 12.1 The Australian health system — measurement approach



The appropriate mix of services — including the prevention of illness and injury, medical treatment and the appropriate mix of service delivery mechanisms — is measured by focusing on a specific health management issue (represented by the vertical arrows). As in previous years, the chapter covers breast cancer detection and management, and specialised mental health services. The breast cancer management framework integrates early detection and medical intervention strategies, which should inform the decisions in the allocation of resources between these two strategies. The mental health framework provides information on the

interaction and integration arrangements between community-based and hospital-based providers in meeting the needs of Australians with a mental illness.

12.3 Breast cancer

Profile

Breast cancer is a disease whereby uncontrolled or malignant cell division leads to the formation of a tumour or tumours in a woman's breast (box 12.1).¹ Tumours may expand locally by invading surrounding tissue, or they may spread via the lymphatic or vascular systems to the rest of the body. If left untreated, most malignant tumours result in the death of the affected person (AIHW 2003a). The focus of this Report is on invasive cancers, although some data are reported on ductal carcinoma in situ (DCIS) — noninvasive tumours residing in the ducts of the breast.

Box 12.1 Some common health terms used in breast cancer detection and management

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

BreastScreen Australia: BreastScreen Australia is the national mammographic population screening program. It is aimed at well women without symptoms. It provides free screening mammograms at two-yearly intervals for women aged 50–69 years 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 or 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 rare. It is not examined in this Report.

Box 12.1 (Continued)

incidence rate: the proportion of the population newly diagnosed with a particular disorder or illness during a given period (often expressed per 100 000 people).

invasive cancer: a tumour whose cells invade healthy or normal tissue.

prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

screening: the performance of tests on apparently well people to detect disease at an earlier stage than would otherwise be the case.

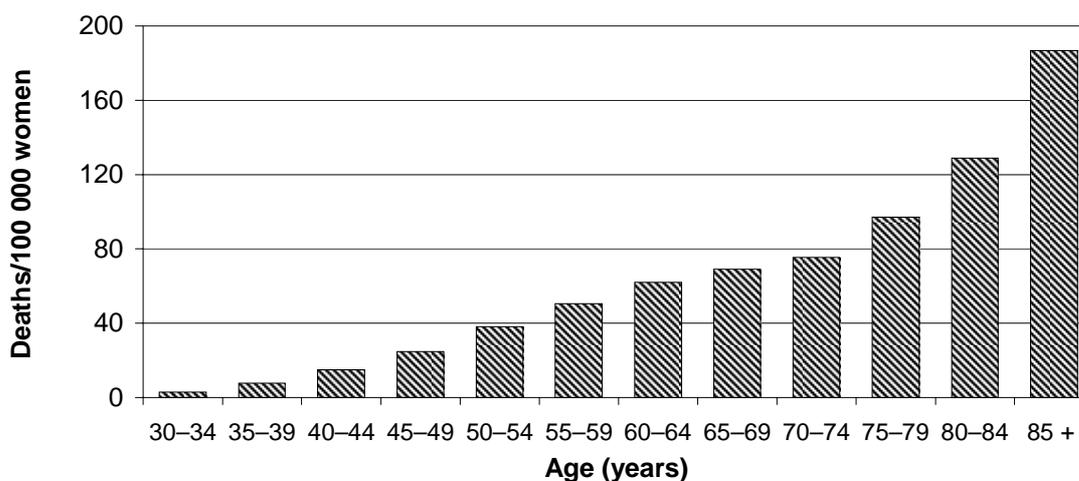
screening round (first): a woman's first visit to a BreastScreen Australia service.

screening round (subsequent): a woman's second or subsequent visit to a BreastScreen Australia service.

total mastectomy: removal of the breast (also known as a simple mastectomy).

Breast cancer was responsible for 2618 female deaths in 2006, making it one of the most frequent causes of death from cancer for females (ABS 2008a). The strong relationship between age and the mortality rate from breast cancer is shown for the period 2002–2006 in figure 12.2. For women aged 40–44 years at diagnosis the annual average mortality rate over this period was 15.0 per 100 000, whereas for women aged 75–79 years at diagnosis, the annual average mortality rate was 97.0 per 100 000.

Figure 12.2 Annual average mortality rates from breast cancer, by age group, 2002–2006

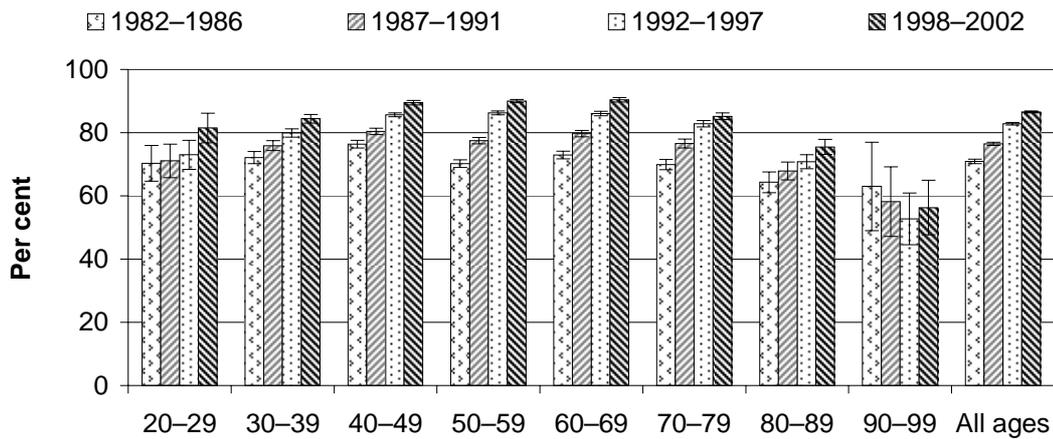


Source: Australian Institute of Health and Welfare (AIHW) (unpublished), derived from the AIHW National Mortality Database; table 12A.1.

Relative survival after diagnosis of breast cancer in females is better than for other cancers. The relative survival rate 10 years after diagnosis was 73.6 per cent for women diagnosed in 1992–1997 (AIHW and NBCC 2006). For women diagnosed during the period 1998–2002, the relative survival rate was 96.7 per cent one year after diagnosis, and 86.6 per cent five years after diagnosis.

There was a significant increase in the five year relative survival rate after diagnosis of breast cancer in females between 1982–1986 and 1998–2002 (figure 12.3). Five year relative survival for breast cancer in Australia over the period 1998–2002 increased with age at diagnosis from the age group 20–29 years (81.5 per cent) to a peak for the age groups 40–49 years (89.5 per cent), 50–59 years (90.0 per cent) and 60–69 years (90.4 per cent). The five year relative survival rate declined with age at diagnosis for women over 70 years (figure 12.3).

Figure 12.3 **Breast cancer five year relative survival at diagnosis, by age group^a**



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

Source: AIHW and NBCC (2006) *Breast cancer in Australia: an overview, 2006*, Cancer series no. 34, Cat. no. CAN 29; table 12A.2.

Incidence and prevalence

Breast cancer is the most prevalent type of cancer affecting Australian women. In 2003, the estimated risk of a woman in Australia developing breast cancer before the age of 75 years was one in eleven (AIHW and AACR 2007). The number of new cases of breast cancer diagnosed in Australian women increased from an annual average of 10 942 over the period 1997–2001 to an annual average of 12 005 over the period 2001–2005 (table 12.1). The increase in the number of cases

detected reflected both an increase in the underlying rate of breast cancer, and the early detection of cancers that previously would not have been discovered for some years, primarily through the activity of BreastScreen Australia (AIHW 2003a).

Table 12.1 Annual average new cases of breast cancer diagnosed (number)^a

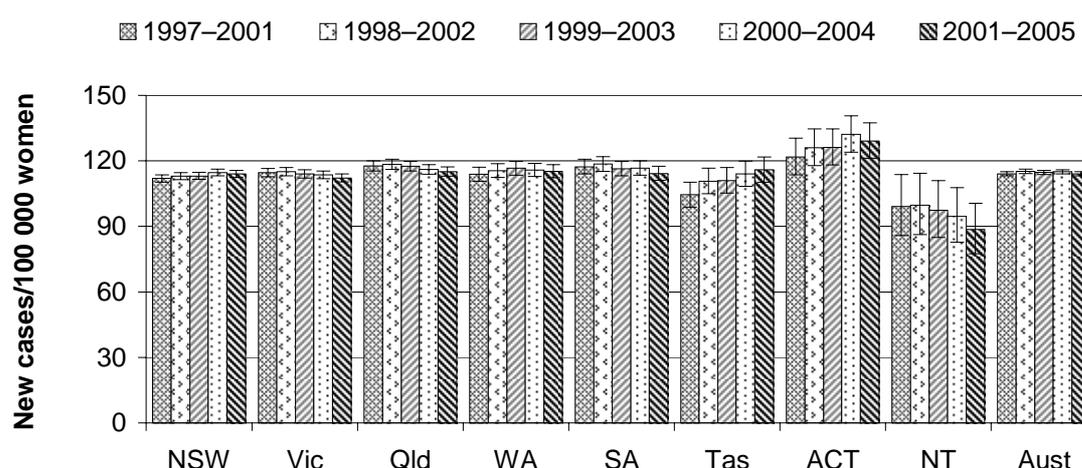
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
1997–2001	3 701	2 793	2 002	1 000	962	262	168	54	10 942
1998–2002	3 816	2 865	2 081	1 046	990	282	181	55	11 315
1999–2003	3 897	2 895	2 137	1 087	989	288	187	59	11 539
2000–2004	4 026	2 945	2 184	1 112	1 009	303	200	61	11 839
2001–2005	4 073	2 969	2 240	1 139	1 009	314	200	61	12 005

^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), derived from the National Cancer Statistics Clearing House (NCSCH); table 12A.3.

Annual average age standardised incidence rates of breast cancer are presented in figure 12.4. Breast cancer incidence data are averaged over five year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases and relatively large variations in rates from year to year. Australia-wide, the annual average incidence rate from the period 1997–2001 to the period 2001–2005 fluctuated between 114.1 and 115.2 per 100 000 women.

Figure 12.4 Annual average age standardised incidence rates of breast cancer for women of all ages^{a, b}

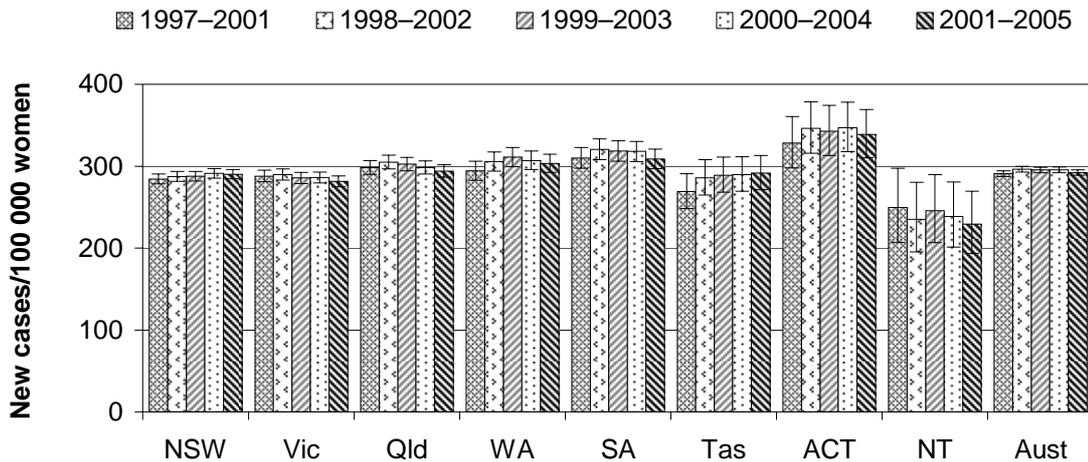


^a Incidence refers to the number of new cases of breast cancer per 100 000 women. ^b Rates are age standardised to the Australian 2001 population standard.

Source: AIHW (unpublished), derived from the NCSCH; table 12A.4.

Annual average age standardised incidence rates of breast cancer for women aged 50–69 years are shown in figure 12.5.

Figure 12.5 **Annual average age standardised incidence rates of breast cancer for women aged 50–69 years^{a, b}**



^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), derived from the NCSCH; table 12A.4.

Size and scope of breast cancer detection and management services

A fundamental component of breast cancer control is the use of screening mammography to enable early detection of breast cancer. There is evidence that population-based screening of women aged 50–69 years can reduce deaths from breast cancer. According to the National Breast and Ovarian Cancer Centre (NBOCC — formerly the National Breast Cancer Centre [NBCC]), 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.

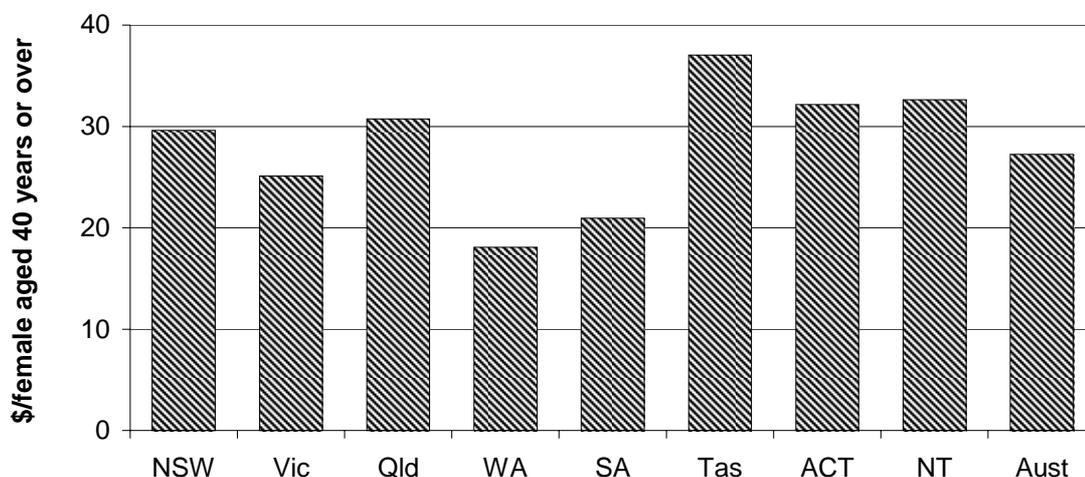
The BreastScreen Australia Program, jointly funded by the Australian, State and Territory governments, undertakes nationwide breast cancer screening. It targets women aged 50–69 years for screening once every two years. The Program aims to have 70 per cent or more of women aged 50–69 years participating in screening over a 24 month period. Recruitment activities undertaken by BreastScreen Australia specifically target women in this age group, although the service is also available to women aged 40–49 years, and 70 years or over.

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. Assessment services funded under the BreastScreen Australia Program include fine needle aspiration and core biopsies and, in some states and territories, open biopsies. Open biopsies are funded outside the Program in Queensland, SA, Tasmania and the NT (table 12A.5).

Each jurisdiction manages a central BreastScreen Australia registry to ensure women with an abnormality detected at screening are recalled for assessment 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. Information on BreastScreen Australia 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 2008 (AIHW 2008a).

Governments spent around \$134 million on breast cancer screening in 2006-07 (table 12A.6). Estimates of government expenditure on breast cancer screening per woman aged 40 years or over are presented by jurisdiction in figure 12.6. These estimates include Australian, State and Territory government expenditure. Differences across jurisdictions partly reflect variation in the proportion of women in the target age group for breast cancer screening, data deficiencies and collection methods, as well as the nature of the services and their relative efficiency. Some differences may also be due to the geography of a State or Territory, and to the proportion of the target population living in rural and remote areas. The data therefore need to be interpreted with care.

Figure 12.6 **Public health expenditure on breast cancer screening, 2006-07^{a, b, c, d, e, f, g}**



^a In every jurisdiction, BreastScreen Australia is a joint initiative funded by both the State or Territory government and the Australian Government under the Public Health Outcome Funding Agreements. ^b The data need to be interpreted with care because of data deficiencies, differences across jurisdictions relating to the use of cash accounting and accrual methods, the treatment of corporate and central office costs, differences in methods used to collect expenditure figures, and differences in the interpretation of public health expenditure definitions. ^c The Australian total includes Australian Government direct project expenditure, database or registry and other program support, population health non-grant program costs and running costs. ^d Medicare funding for radiographic breast examinations is excluded because it is not public health expenditure. ^e Victorian data include depreciation. ^f Data for the ACT include expenditure on BreastScreen ACT and the Cancer Registry. ^g Data for the NT for direct expenditure include public health information systems, disease surveillance and epidemiological analysis, public health communication and advocacy, public health policy, program and legislation development, and public health workforce development.

Source: AIHW (unpublished), derived from the AIHW Health Expenditure Database; ABS (unpublished), derived from *Estimated Residential Population*, Cat. no. 3101.0; tables AA.1 and 12A.6.

The number of women aged 40 years or over screened by BreastScreen Australia indicates the size of the BreastScreen Australia Program. Nearly 837 000 women in this age group were screened in 2007, compared with 842 000 in 2003 (table 12.2).

Table 12.2 **Number of women aged 40 years or over screened by BreastScreen Australia^a**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2003	289 913	188 782	180 396	76 059	69 182	22 424	10 651	4 547	841 954
2004	270 598	198 743	191 084	78 773	69 882	23 107	9 995	4 045	846 227
2005	235 812	197 627	199 981	81 351	70 909	25 440	11 901	4 481	827 502
2006	257 211	202 462	200 992	88 667	67 476	24 963	11 446	4 136	857 353
2007	249 193	195 288	202 372	81 629	67 508	24 041	12 277	4 635	836 943

^a First and subsequent screening rounds, for women aged 40 years or over.

Source: State and Territory governments (unpublished); table 12A.7.

Breast cancer is diagnosed outside the BreastScreen Australia Program when women access mammographic services privately, are outside the age range for the program, or have symptoms which make it inappropriate for them to attend for screening. For these women, GPs are critical as the initial point of referral to specialists for diagnosis and treatment services.

Inpatient separations in public hospitals for selected breast cancer related Australian refined diagnosis related groups (AR-DRGs)² in 2006-07 are presented in table 12.3.

Table 12.3 Separations for selected AR-DRGs related to breast cancer, public hospitals, 2006-07 (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	3.0	3.4	2.6	3.0	2.9	2.5	3.7	1.5	3.0
Minor procedures for malignant breast conditions	1.0	1.2	1.1	1.0	1.0	1.1	0.9	0.6	1.0
Skin, subcutaneous tissue and breast plastic operating room procedures	3.2	3.3	3.2	3.5	5.8	3.4	2.3	2.5	3.4
Other skin, subcutaneous tissue and breast procedures	12.7	23.2	18.6	18.9	20.5	16.4	9.5	13.0	17.7
Malignant breast disorders (Age >69 W CC) or W (Cat or Sev CC)	0.6	0.6	0.4	0.4	0.9	0.7	0.2	0.3	0.6
Malignant breast disorders (Age>69 W/O CC) or W/O (Cat or Sev CC)	0.3	0.8	0.4	1.4	0.6	1.6	np	0.5	0.6
All conditions^c	2 071.9	2 478.7	1 836.2	2 108.0	2 412.7	1 932.0	2 139.7	3 986.7	2 172.4

W=with. W/O=without. CC=complications and co-morbidities. Cat or Sev=catastrophic or severe. ^a Care needs to be taken when comparing jurisdictions because admission practices vary. ^b AR-DRG version 5.1. ^c The total includes separations for which the care type was reported as acute, or newborn with qualified patient days, or was not reported. Crude rate based on the Australian population as at 31 December 2006. **np** Not published.

Source: AIHW (2008) *Australian hospital statistics 2006-07*, Cat. no. HSE 55; table 12A.8.

Framework of performance indicators

The indicators developed to report on the performance of breast cancer detection and management are based on the shared government objectives for managing the disease (box 12.2). The 'Health preface' explains the performance indicator

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 10 for more detail).

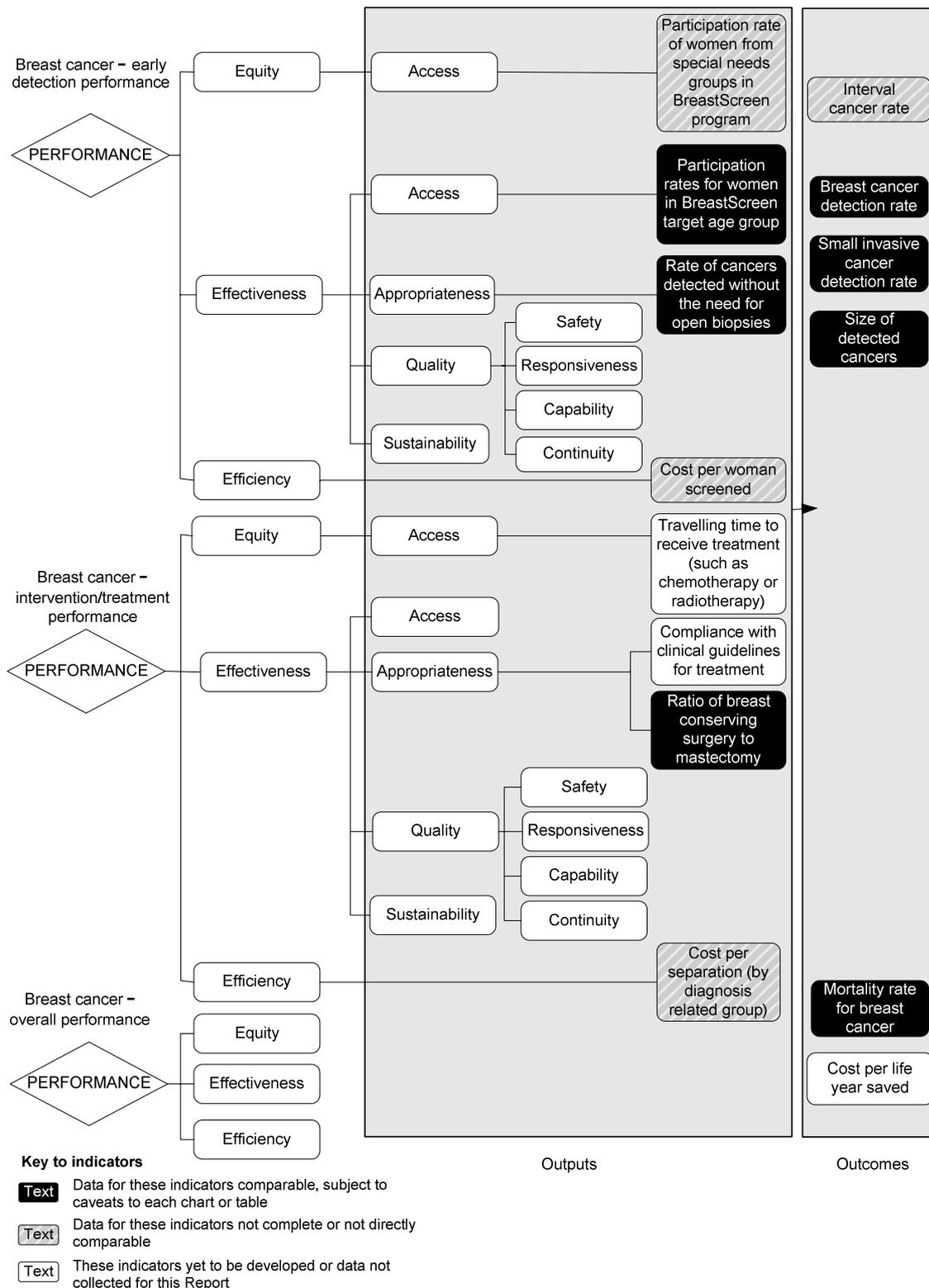
framework for health services as a whole, including the health services subdimensions for quality and sustainability that have been added to the standard Review framework. The framework for breast cancer detection and management focuses on achieving a balance between early detection and treatment. It has a tripartite structure — that is, performance indicators presented relate to early detection, intervention and overall performance. Breast cancer prevention is excluded from the framework in the absence of definitive primary preventative measures, although there are known associated risk factors. There are ongoing trials examining possible preventative interventions for the small proportion of the population at high risk of breast cancer due to the presence of BRCA1 or BRCA2 genetic variations.

The performance indicator framework shows which data are comparable in the 2009 Report (figure 12.7). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Box 12.2 Objectives for breast cancer detection and management

The objectives for breast cancer detection and management are to reduce morbidity and mortality attributable to breast cancer, and to improve the quality and duration of life of women with breast cancer, in a manner that is equitable and efficient.

Figure 12.7 Performance indicators for breast cancer detection and management



Key performance indicator results

Data relating to breast cancer screening are readily available through the BreastScreen Australia Program, while data relating to the management and treatment of breast cancer are limited. Hence, most of the breast cancer detection and management data in this Report are provided by BreastScreen Australia, and screening is currently the main focus of reporting. It is a Steering Committee priority to extend reporting in the area of the management and treatment of breast cancer.

Ongoing monitoring of BreastScreen Australia 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 are collected at the jurisdictional level and provide an overview of the performance of the Program.

In addition, each BreastScreen Australia service is assessed against 173 National Accreditation Standards as part of their accreditation process. These Standards include a number of indicators that collectively assess the safety of the services provided by individual BreastScreen Australia services.

Outputs

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

Early detection — participation rate of women from selected community groups in BreastScreen Australia programs

‘Participation rate of women from selected community groups in BreastScreen Australia programs’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer through early detection strategies, in a manner that is equitable (box 12.3).

Box 12.3 Participation rate of women from selected community groups in BreastScreen Australia programs

The 'participation rate of women from selected community groups in BreastScreen Australia programs' is defined as the proportion of the eligible population in each selected 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 equitable access to early detection services.

Data reported for this indicator are not directly comparable.

Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality. Indigenous women, women from non-English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas may experience particular language, cultural and geographic barriers to accessing breast cancer screening.

In 2006–07, the national age standardised participation rate for Indigenous women aged 50–69 (40.3 per cent) was below the total participation rate in that age group (56.1 per cent), although this may be influenced by the quality of Indigenous identification in screening program records (table 12.4, table 12A.10). For the same 24 month period and age group, the national participation rate of 49.7 per cent for NESB women was also lower than that of the national total female population (table 12.4, table 12A.11). Care needs to be taken when comparing data across jurisdictions, given differences in the collection of data by Indigenous and NESB status.

Table 12.4 Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2006 and 2007 (24 month period) (per cent)^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Indigenous ^c	41.7	36.1	51.6	34.7	35.3	31.3	36.6	26.5	40.3
NESB ^d	54.7	36.5	65.0	64.8	54.0	22.2	35.0	37.0	49.7
All women aged 50–69 years	56.0	55.9	56.6	57.5	55.8	54.2	57.0	40.2	56.1

^a First and subsequent rounds. ^b Rates are standardised to the 2001 Australian population standard. ^c Those women who self-identify as being of Aboriginal or Torres Strait Islander descent. ^d Non-English speaking background (NESB) is defined as speaking a language other than English at home.

Source: State and Territory governments (unpublished); ABS (2008) *Population by Age and Sex, Australian States and Territories, June 2002-2007*, Cat. no. 3201.0; ABS (unpublished), derived from *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2009*, Cat. no. 3238.0; ABS (unpublished), derived from *2006 Census of Population and Housing*; tables 12A.9–12A.11.

Updated data for participation rates by geographic location were not available for the 2009 Report. Historical data are presented in table 12A.12.

Early detection — participation rate of women in the BreastScreen Australia target age group

The ‘participation rate of women in the BreastScreen Australia target age group’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer through early detection strategies (box 12.4).

Box 12.4 Participation rate of women in the BreastScreen Australia target age group

The ‘participation rate of women in the BreastScreen Australia target age group’ is defined as the number of women aged 50–69 years attending the screening program within a 24 month period, divided by the estimated population of women aged 50–69 years.

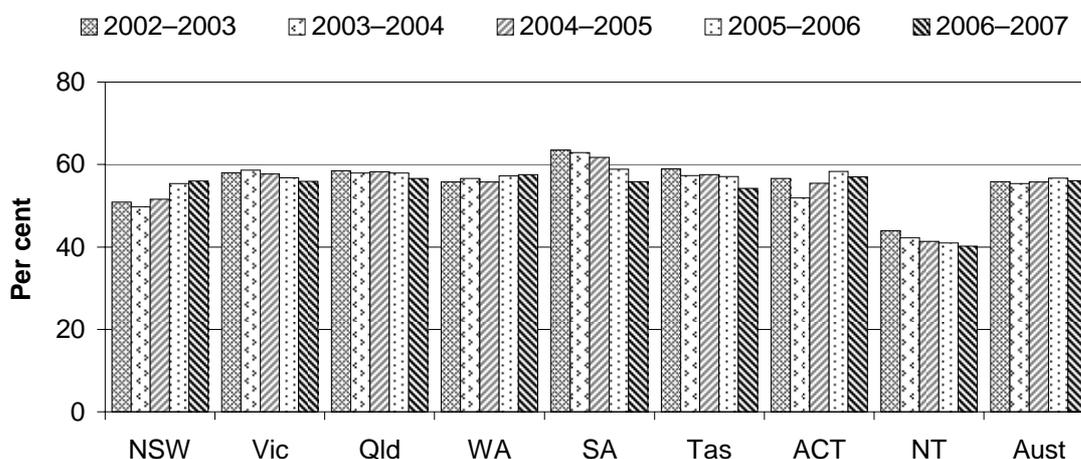
Increased screening participation rates are desirable.

Data reported for this indicator are comparable.

Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality. 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 Australia specifically target women in this age group (BreastScreen Australia 2004). Access to the program is also provided for women aged 40–49 years and 70 years or over.

The national participation rate of women aged 50–69 years in BreastScreen Australia screening programs was 56.1 per cent in the 24 month period 2006 and 2007. At a national level, the participation rate has been relatively steady since the 2002–2003 24 month period, well below the 70 per cent aim under the National Accreditation Standards (figure 12.8).

Figure 12.8 Age standardised participation rates of women aged 50–69 years in BreastScreen Australia screening programs (24 month period)^{a, b}



^a The participation rate is the number of women resident in the jurisdiction who were screened during the reference period, divided by the number of women resident in the jurisdiction, using the ABS estimated resident population. This value represents the estimated population at the midpoint of the reference period. It is an average of the two estimated resident populations for the two calendar years (by adding both years and dividing by two). ^b Rates are standardised to the 2001 Australian population standard.

Source: State and Territory governments (unpublished); ABS (2008) *Population by Age and Sex, Australian States and Territories, June 2002–2007*, Cat. no. 3201.0; table 12A.9.

Early detection — rate of cancers detected without the need for open biopsies

The ‘rate of cancers detected without the need for open biopsies’ is an indicator of governments’ objective to provide appropriate early detection services (box 12.5).

Box 12.5 Rate of cancers detected without the need for open biopsies

The ‘rate of cancers detected without the need for open biopsies’ is defined as the number of cancers detected without open biopsy, as a proportion of all breast cancers detected (invasive and DCIS).

A higher rate of cancers detected without the need for open biopsies is desirable.

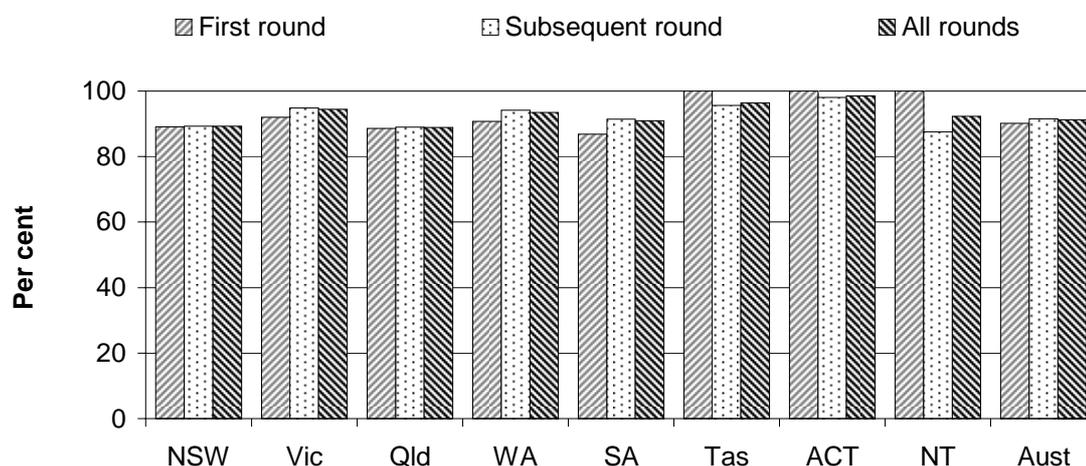
Data reported for this indicator are comparable.

Diagnosis of breast cancer involves histological examination of tissue samples collected by fine needle aspiration (FNA), core biopsy or open biopsy. Open biopsy is the most invasive of these procedures.

High rates of cancers detected without the need for open biopsies indicates effectiveness in detecting malignancies while minimising the need for invasive procedures. 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 2007, for women attending their first screening round, the rate of cancers detected without the need for open biopsies was 90.2 per cent Australia wide. For women attending a subsequent round the rate was 91.5 per cent Australia wide, well above the National Accreditation Standard of 75 per cent (figure 12.9).

Figure 12.9 Rate of cancers detected without the need for open biopsies, all women, 2007



Source: State and Territory governments (unpublished); table 12A.13.

Early detection — cost per woman screened

The ‘cost per woman screened’ is an indicator of governments’ objective to provide early detection services in an efficient manner (box 12.6).

Box 12.6 Cost per woman screened

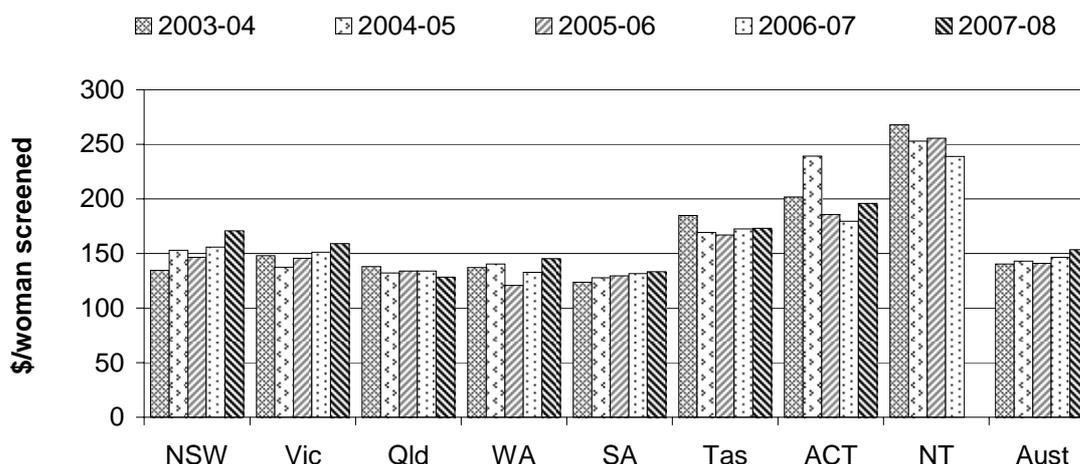
The 'cost per woman screened' is defined as the total cost of providing early detection services (including screening, assessment and program management), divided by the number of women screened.

Caution must be used when interpreting this indicator. While the cost per woman screened may reflect efficiency, it may also reflect the quality of service, and characteristics of the target population such as, the number and type of barriers to service access.

Data reported for this indicator are not directly comparable.

Care needs to be taken when making comparisons across jurisdictions. There are potential differences in the items included in the measures of cost (particularly in the treatment of depreciation and capital asset charges, and the inclusion of subsidies). There may also be differences across jurisdictions in the scope of activities being costed. The Review is working to identify these differences across jurisdictions to improve data comparability in future (table 12A.15). Preliminary estimates of costs in each jurisdiction are presented in figure 12.10. The average cost per woman screened in Australia in 2007-08 was around \$154.

Figure 12.10 Real cost per woman screened, BreastScreen Australia services (2007-08 dollars)^{a, b, c}



^a Constant price expenditure (in 2007-08 dollars) using the Gross Domestic Product price deflator (table AA.26). ^b Data for NSW do not include subsidies. ^c Data for the NT for 2007-08 are not available.

Source: State and Territory governments (unpublished); tables AA.26 and 12A.14.

Intervention/treatment — travelling time to receive treatment

‘Travelling time to receive treatment’ has been identified for development as an indicator of governments’ objective to provide breast cancer intervention and treatment services in an equitable manner (box 12.7).

Box 12.7 Travelling time to receive treatment

‘Travelling time to receive treatment’ is yet to be defined.

Data for this indicator were not available for the 2009 Report.

Intervention/treatment — compliance with clinical guidelines for treatment

‘Compliance with clinical guidelines for treatment’ has been identified as an indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer, and to improve the quality and duration of life of women with breast cancer, through provision of effective and appropriate intervention and treatment services (box 12.8).

Box 12.8 Compliance with clinical guidelines for treatment

‘Compliance with clinical guidelines for treatment’ is yet to be defined.

Data for this indicator were not available for the 2009 Report.

Intervention/treatment — ratio of conserving surgery to mastectomy

The ‘ratio of conserving surgery to mastectomy’ is an indicator of governments’ objective to improve the quality of life of women with breast cancer through appropriate intervention and treatment services (box 12.9).

Box 12.9 Ratio of conserving surgery to mastectomy

'Ratio of conserving surgery to mastectomy' is defined as the number of cases for which breast conserving surgery or no surgery was performed, divided by the number of cases for which a mastectomy was performed.

Breast conserving surgery removes the breast cancer but not the whole breast. Caution should be used in interpreting this indicator, as clinical and familial factors are important determinants of the most appropriate treatment. For cases identified through early detection services such as BreastScreen Australia, a higher ratio may indicate more appropriate intervention and treatment services.

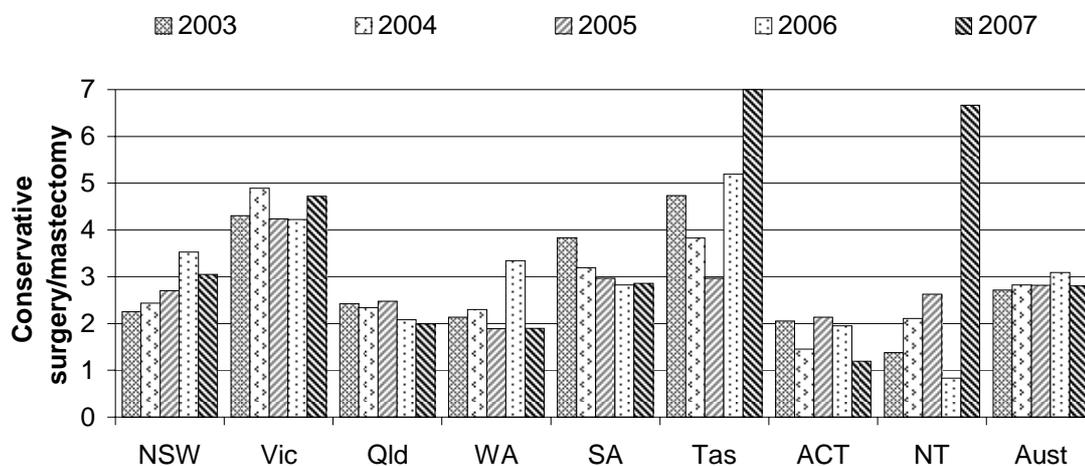
Data reported for this indicator are comparable.

Early detection of breast cancer is associated with reduced cancer size and greater probability of being confined to the breast, two of the clinical determinants for appropriate treatment (NBOCC 2004). Breast conserving surgery or radiation therapy alone may be indicated for a greater proportion of women with breast cancer identified through the BreastScreen Australia program, an early detection service, than for women with breast cancer diagnosed outside the program.

Data for this indicator are for women diagnosed only within the BreastScreen Australia program. They represent only a portion of breast cancer treatment information, and are not necessarily representative of general clinical practice.

In 2007, the ratio of conserving surgery to mastectomy averaged 2.8:1 nationally, but varied across jurisdictions (figure 12.11).

Figure 12.11 Ratio of conserving surgery to mastectomy^{a, b}



^a Applies for women of all ages. ^b The numbers used to measure this indicator were small, resulting in large variations from year to year. It is advisable to view this indicator over time rather than from one year to the next.

Source: State and Territory governments (unpublished); table 12A.16.

Intervention/treatment — cost per separation by diagnosis related group

‘Cost per separation by diagnosis related group’ is an indicator of governments’ objective to provide breast cancer intervention and treatment services in an efficient manner (box 12.10).

Box 12.10 Cost per separation by diagnosis related group

‘Cost per separation by diagnosis related group’ is a proxy indicator of efficiency, defined as the cost of care per separation in public hospitals for selected breast cancer related conditions.

Caution must be used when interpreting this indicator. While a low cost per separation may indicate efficiency, no information on the quality of service is provided.

Data reported for this indicator are not directly comparable.

‘Cost per separation by diagnosis related group’ data are sourced from the National Hospital Cost Data Collection (NHCDC) and are based on the AR-DRG classification version 5.1. The NHCDC is an annual collection of hospital cost and activity data. Participation in the NHCDC is voluntary, and participants are not necessarily a representative sample of the hospitals in each jurisdiction (although coverage is improving over time). An estimation process has been carried out to

create representative national activity figures from the sample data. Further, the purpose of the NHCDC is to calculate DRG cost weights, not to compare the efficiency of hospitals (DoHA 2008b).

Table 12.5 summarises costs per separation for selected breast cancer AR-DRGs. The average cost of major procedures for malignant breast conditions across Australia was \$6393 per separation in 2006-07; minor procedures for malignant breast conditions cost \$3295 per separation on average. Table 12A.17 summarises the average length of stay (in public hospitals) associated with each AR-DRG.

Table 12.5 Average cost per separation, public hospitals by selected breast cancer AR-DRGs, 2006-07 (dollars)^{a, b, c}

AR-DRG	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Major procedures for malignant breast conditions	5 907	6 520	6 474	7 873	5 455	6 433	6 994	6 780	6 393
Minor procedures for malignant breast conditions	3 350	3 127	3 539	3 154	3 384	2 892	3 411	2 907	3 295
Malignant breast disorders (Age >69 W CC) or W (Cat or Sev CC)	4 628	3 757	5 446	6 032	6 064	5 228	5 125	2 299	4 709
Malignant breast disorders (Age>69 W/O CC) or W/O (Cat or Sev CC)	2 392	2 476	2 493	1 145	1 188	1 814	np	1 588	1 979

W=with. W/O=without. CC=complications and co-morbidities. Cat or Sev=catastrophic or severe. ^a Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. ^b Average cost is affected by a number of factors, including admission practices, sample size, remoteness and the types of hospital contributing to the collection. Direct comparison across jurisdictions is difficult because there are differences in hospital costing systems. ^c In accordance with NHCDC methodology, depreciation and some capital costs are included in these figures, except for Victoria, which does not include depreciation. **np** Not published due to low volume and privacy concerns.

Source: DoHA (2008) *National Hospital Cost Data Collection Cost Report Round 11, (2006-07)*, v5.1; table 12A.17.

Outcomes

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

Early detection — interval cancer rate

‘Interval cancer rate’ is an outcome indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer, through provision of effective early detection services (box 12.11).

Box 12.11 Interval cancer rate

The 'interval cancer rate' is defined as the number of interval cancers per 10 000 women at risk of interval or screen-detected breast cancer, where:

- an interval cancer is an invasive breast cancer diagnosed in the interval between a negative screening result and the next scheduled screening examination
- women at risk of interval or screen-detected breast cancer are those aged 50–69 years, with no personal history of breast cancer, in the period between a negative screening result and the next scheduled screening examination.

A lower interval cancer rate is desirable because it suggests that early detection of breast cancer services are effective. Caution should be applied when comparing data as differences in the interval cancer rate may also reflect different policies regarding diagnostic and administrative procedures.

This indicator should be interpreted in conjunction with the breast cancer detection indicators.

Data reported for this indicator are not directly comparable.

An interval cancer is an invasive breast cancer diagnosed in the interval between a negative screening result and the next scheduled screening examination, a period of 24 months in the case of routine screening (less in the case that more frequent screening is recommended). The cancer may have been present (but not detected) at the most recent screening episode, or may not have been present. A high rate of interval cancer may suggest that screening services are not optimally effective in the early detection of breast cancer.

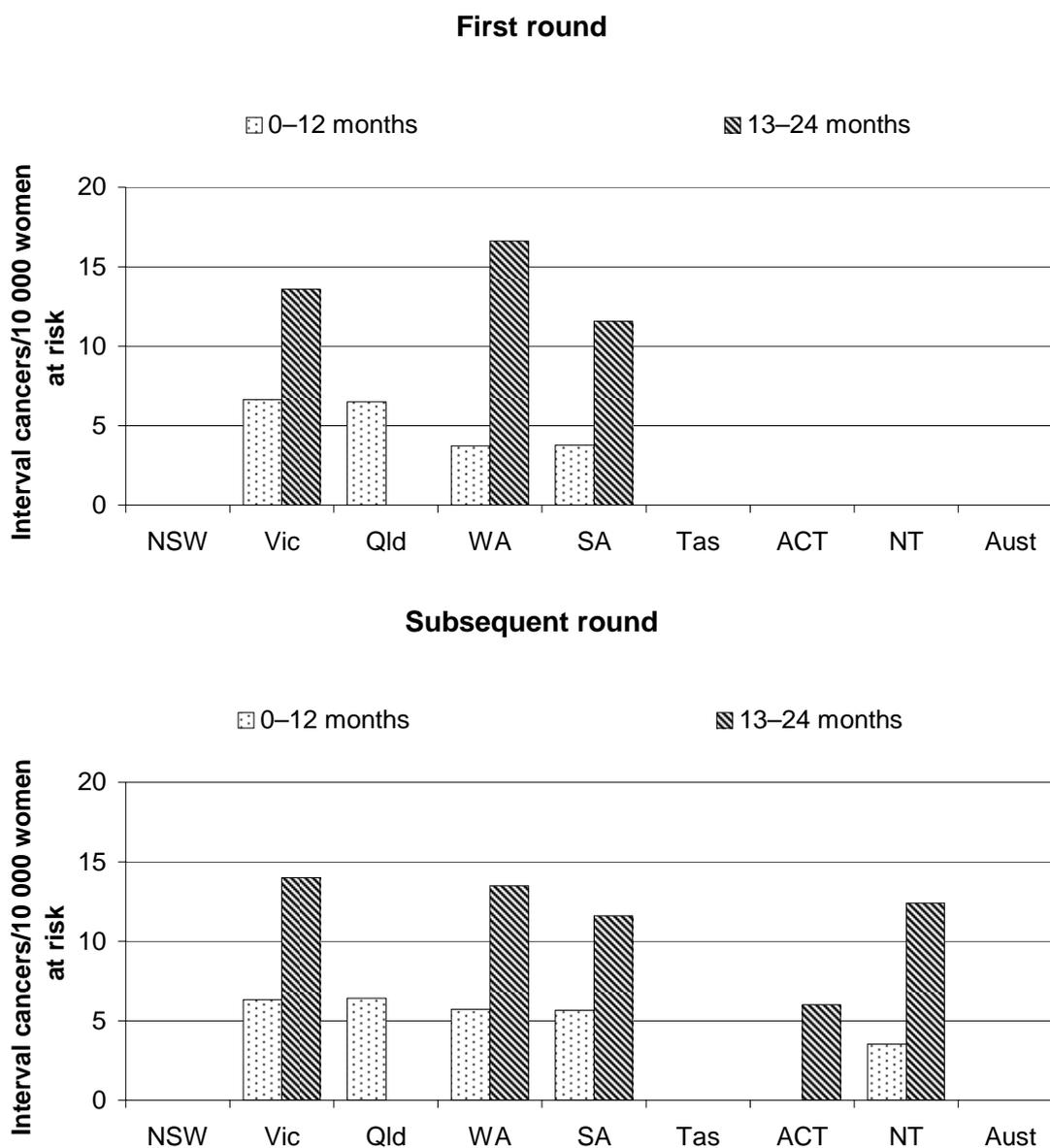
There is a time lag in data availability for this indicator. Interval cancer may be detected up to 24 months following a routine negative screening episode. It may then be several months before the diagnosis of invasive cancer is recorded in the cancer registry. BreastScreen Australia programs identify interval cancers diagnosed outside the program through a process of data matching between cancer registry and BreastScreen Australia data. Thus, for women screened in any given year, the number of interval cancers cannot be determined until several years later. The most recent data available for this Report are for women screened during 2004.

Policy variation between jurisdictions may be reflected in interval cancer rates, and comparisons across jurisdictions need to be made with care. For example, policies differ in relation to women whose mammograms appear normal but who report symptoms of breast abnormalities. Some jurisdictions conduct further diagnostic procedures, which may be reflected in a higher cancer detection rate and lower interval cancer rate. Where these women are instead advised to visit their GP for

referral to a diagnostic service (such as in SA and some services in NSW), cancers subsequently detected may be reflected in increased interval cancer rates.

Figure 12.12 presents the age standardised interval cancer rate by screening round and time since screened for women aged 50–69 years.

Figure 12.12 **Age standardised interval cancer rate, women aged 50–69 years, 2004^{a, b, c, d}**



^a Rates are expressed as the number of interval cancers per 10 000 women at risk, and age standardised to the Australian population of women attending a BreastScreen Australia service in 1998. ^b The numbers used to measure this indicator were small, resulting in large variations from year to year. It is advisable to view this indicator over time rather than from one year to the next. ^c Data were not available for NSW or Tasmania. Data for Queensland for 13–24 months for the first and subsequent screening rounds were not available. ^d No interval cancers were reported in the ACT and the NT in the first round for 0–12 and 13–24 months.

Source: State and Territory governments (unpublished); table 12A.18.

Early detection — breast cancer detection rate

The 'breast cancer detection rate' is an indicator of governments' objective to reduce morbidity and mortality attributable to breast cancer, through the provision of effective early detection services (box 12.12).

Box 12.12 Breast cancer detection rate

The 'breast cancer detection rate' is defined as the number of detected cancers per 10 000 women screened.

A higher rate of breast cancer detection is desirable in terms of the effectiveness of breast screening services (although a high incidence of breast cancer is not desirable). The breast cancer detection rate should be considered in conjunction with detection rates for invasive cancer, small invasive cancer, DCIS and interval cancer.

Data reported for this indicator are directly comparable.

Early detection of cancers that are small and localised to the breast is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality (NBOCC 2004). Changes in breast cancer detection rates may also reflect changes in the incidence of breast cancer.

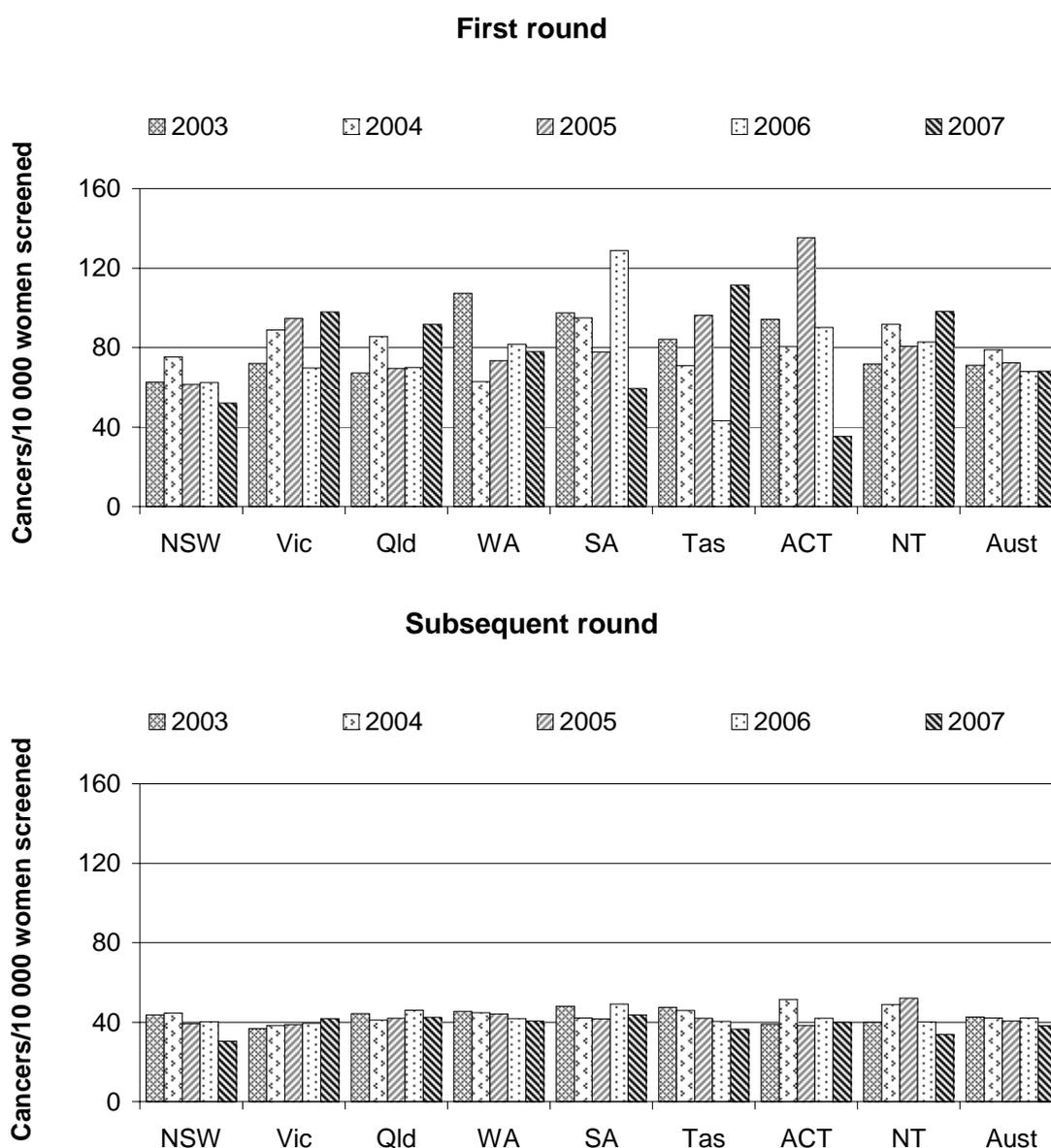
BreastScreen Australia National Accreditation Standards for detection rates are based on expected Australian rates (BreastScreen Australia 2004):

- 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.

Figure 12.13 reports the age standardised number of invasive cancers detected per 10 000 women screened aged 50–69 years, by screening round. Nationally, in 2007, the age standardised invasive breast cancer detection rate was 68.2 per 10 000 women aged 50–69 years attending their first screen. This was above the BreastScreen Australia National Accreditation Standard of greater than or equal to 50 per 10 000 women aged 50–69 years who attend for their first screen being diagnosed with invasive breast cancer. Nationally, the age standardised invasive breast cancer detection rate was 38.2 per 10 000 women aged 50–69 years attending

the second or subsequent screen. This was above the National Accreditation Standard of greater than or equal to 35 per 10 000 women aged 50–69 years who attend for their second or subsequent screen being diagnosed with invasive breast cancer. The rate of DCIS detected per 10 000 women screened is reported in table 12A.19. (Relevant definitions can be found in box 12.1 and section 12.7.)

Figure 12.13 Age standardised breast cancer detection rate for women aged 50–69 years, invasive cancers^a



^a Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen Australia service in 1998.

Source: State and Territory governments (unpublished); table 12A.19.

Early detection — small invasive cancer detection rate

The 'small invasive cancer detection rate' is an indicator of governments' objective to reduce morbidity and mortality attributable to breast cancer through the provision of effective early detection services (box 12.13).

Box 12.13 Small invasive cancer detection rate

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. The small invasive cancer detection rate should be considered in conjunction with detection rates for invasive cancer, DCIS and interval cancer.

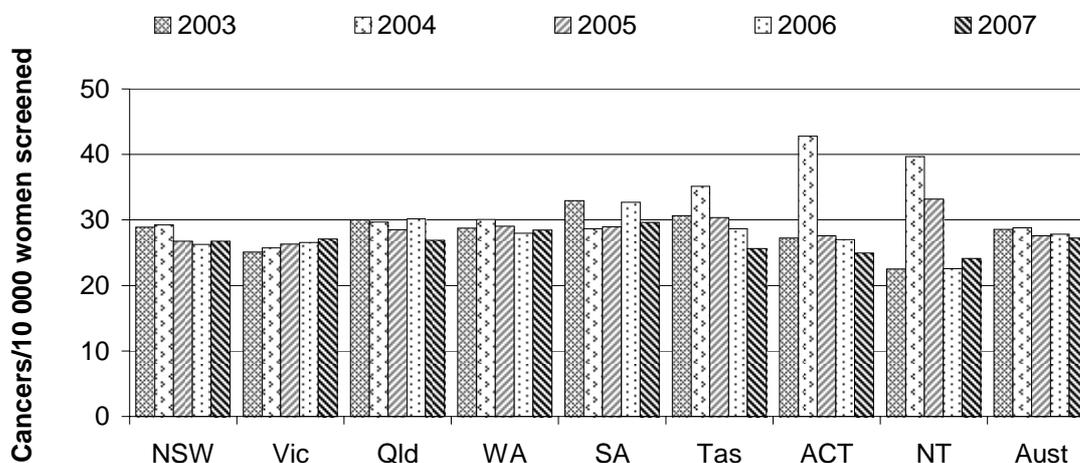
Data reported for this indicator are comparable.

Early detection of cancers that are small and localised to the breast is associated with reduced morbidity and mortality, as well as some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998).

The BreastScreen Australia National Accreditation Standards (2004) specify that 25 or more women per 10 000 women aged 50–69 years who attend screening are expected to be diagnosed with a small (15 millimetres or less) invasive breast cancer (BreastScreen Australia 2004).

Age standardised rates for small invasive cancer detection for women aged 50–69 years screened by BreastScreen Australia in 2007 are reported in figure 12.14. The rate for Australia was 27.2 cancers per 10 000 women aged 50–69 years attending screening in 2007, consistent with the National Accreditation Standard of 25 or more.

Figure 12.14 **Age standardised small diameter cancer detection rate for women aged 50–69 years, all rounds of screening^{a, b}**



^a Small diameter cancers are defined as invasive cancers up to and including 15 millimetre diameter. Prior to the 2003 Report, small diameter cancers were defined as 10 millimetre in diameter or less, so data are not comparable to data published before the 2003 Report. ^b Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen Australia service in 1998.

Source: State and Territory governments (unpublished); table 12A.20.

Early detection — size of detected cancers

The ‘size of detected cancers’ is an indicator of governments’ objective to provide effective services for the early detection of breast cancer (box 12.14).

Box 12.14 Size of detected cancers

The ‘size of detected cancers’ is defined as the number of detected invasive cancers by cancer size, as a proportion of total detected invasive cancers for women aged over 40 years.

High rates of detection of small cancers, relative to rates of detection of large cancers, are desirable.

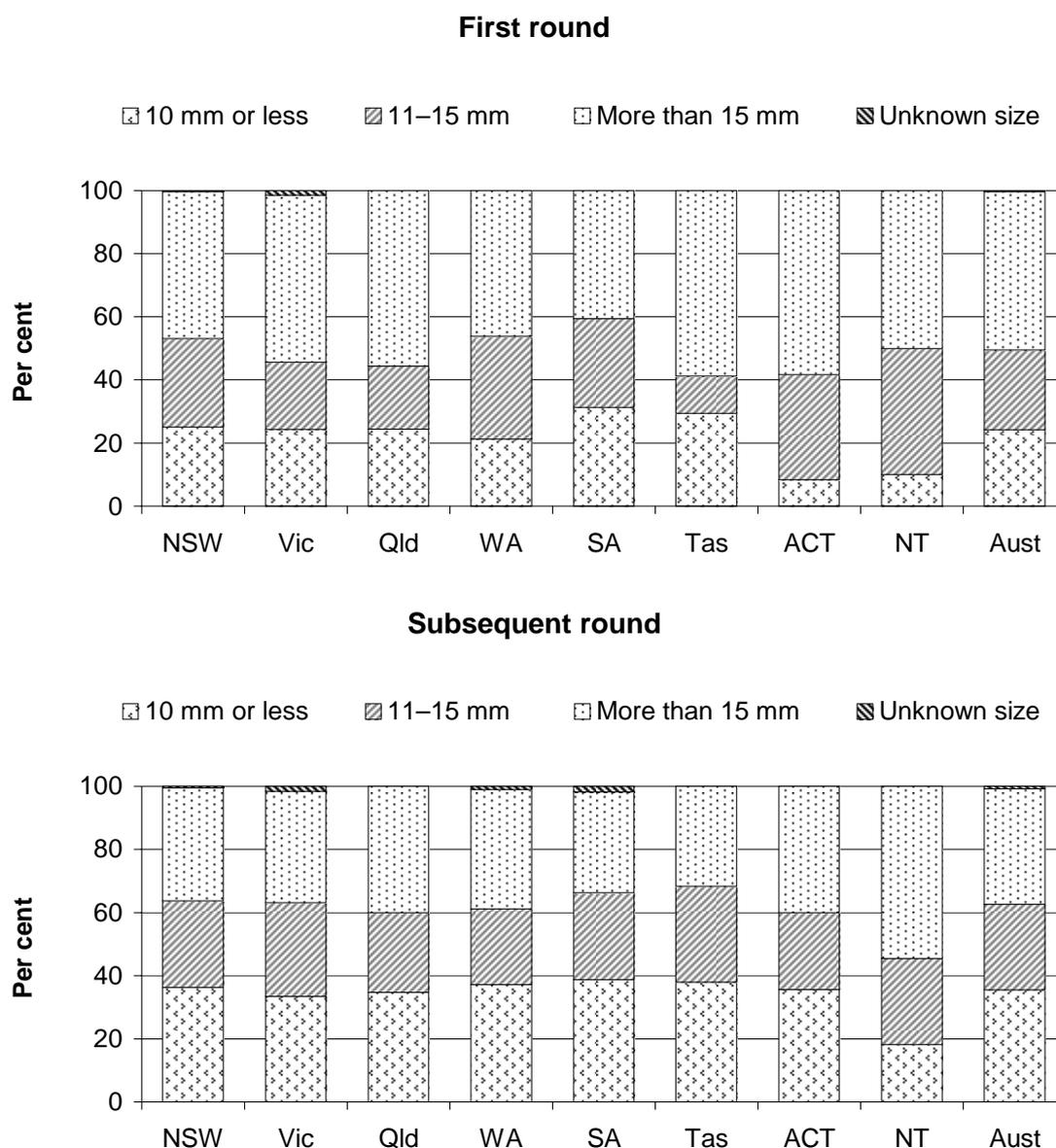
Data reported for this indicator are comparable.

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, as well as some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998).

Data are reported by round because larger cancers are expected to be found in the first round of screening. In subsequent rounds, cancers should be smaller if the program is achieving its objective (that is, early detection of small cancers through regular two yearly screening).

Figure 12.15 presents the proportion of cancers by size by screening round for 2007. The data are from BreastScreen Australia and cover only its clients.

Figure 12.15 Detected invasive cancers, women aged over 40 years, by screening round and size of cancer 2007^{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 12A.21.

Overall performance — mortality rate for breast cancer

The ‘mortality rate for breast cancer’ is an indicator of governments’ objective to reduce mortality attributable to breast cancer, through the provision of effective early detection, and treatment, services (box 12.15).

Box 12.15 Mortality rate for breast cancer

The ‘mortality rate for breast cancer’ is defined as the age standardised mortality from breast cancer per 100 000 women, expressed as a five year rolling average.

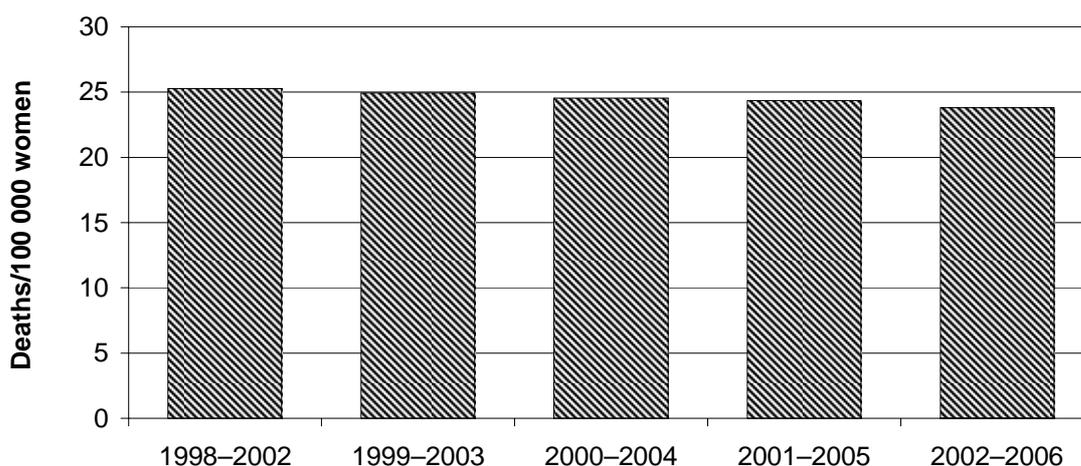
A lower mortality rate for breast cancer is desirable.

Data reported for this indicator are comparable.

Breast cancer mortality data are averaged over five year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases and relatively large variation in rates from year to year. Caution should nevertheless be used when comparing results for smaller jurisdictions (table 12A.1).

The average annual age standardised mortality rate for breast cancer declined from 25.3 per 100 000 women in the period 1998–2002 to 23.8 per 100 000 women in the period 2002–2006 (figure 12.16).

Figure 12.16 Annual average age standardised mortality rate from breast cancer, all ages^a

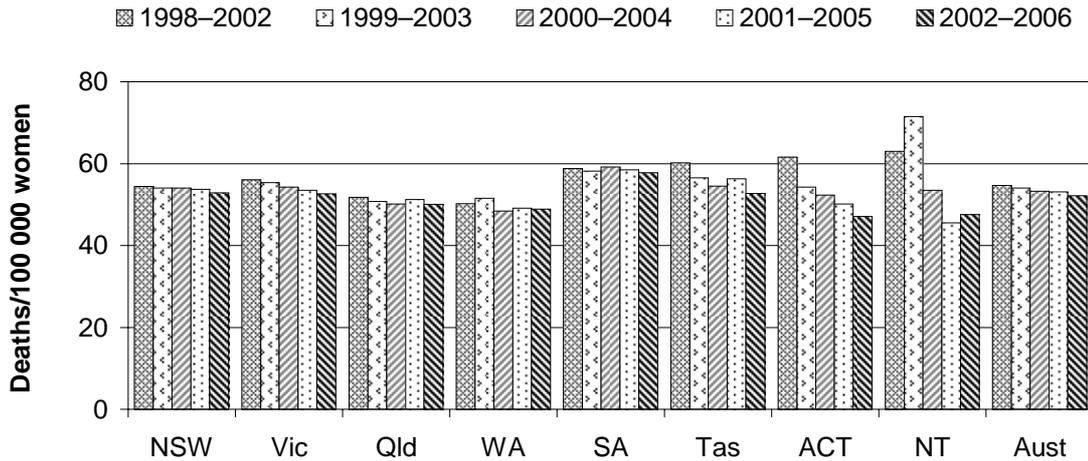


^a Age standardised to the Australian population at 30 June 2001.

Source: AIHW (unpublished), derived from the AIHW National Mortality Database; table 12A.1.

The annual average age standardised mortality rate from breast cancer for women aged 50–69 years also declined, from 54.6 per 100 000 women over the period 1998–2002 to 52.1 per 100 000 women over the period 2002–2006 (figure 12.17).

Figure 12.17 **Annual average age standardised mortality rate from breast cancer, women aged 50–69 years^a**



^a Age standardised to the Australian population at 30 June 2001.

Source: AIHW (unpublished), derived from the AIHW National Mortality Database; table 12A.1.

Overall performance — cost per life year saved

‘Cost per life year saved’ has been identified for development as an indicator of the efficiency of overall performance of services in detection and management of breast cancer (box 12.16).

Box 12.16 **Cost per life year saved**

‘Cost per life year saved’ is yet to be defined.

Data for this indicator were not available for the 2009 Report.

12.4 Mental health

Profile

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). The World Health Organization (WHO) describes mental health as:

... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

There is a wide range of mental illnesses that can affect an individual's mental health, functioning and quality of life. Each mental illness is unique in terms of its incidence across the lifespan, causal factors and treatments.

This section focuses on specialised publicly funded mental health services that treat mostly low prevalence but severe mental illnesses. Other health and related services are also important for people with a mental illness, including GPs and alcohol and drug treatment services (chapter 11), public hospitals (chapter 10), and aged care services (chapter 13). This Report does not include specific performance information on these services' treatment of people with a mental illness. Mental health patients often have complex needs that may also affect other government services they receive, such as those covered in chapter 4 ('School education'), chapter 8 ('Corrective services'), chapter 9 ('Emergency management') and chapter 14 ('Services for people with a disability').

Some common terms used in mental health management are outlined in box 12.17.

The quality of data relating to specialised publicly funded mental health services continues to improve. In previous years, data were preliminary and subject to ongoing validation. From 2005-06, these data are collected under the Mental Health Establishments National Minimum Data Set (MHE NMDS). Data collected under the MHE NMDS are further advanced in the validation process at time of publication but are subject to ongoing historical validation. Results reported in this section may therefore differ slightly to those in the upcoming Mental Health Services in Australia publication and the next National Mental Health Report.

Box 12.17 **Some common terms relating to mental health**

acute services: mental health services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. Acute episodes are characterised by the 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 is focused on the short term. Acute services may focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing mental illness 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 patients, 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: mental health services that employ mental health-trained staff on-site; provide rehabilitation, treatment or extended care to residents in a domestic-like environment and that is intended to be on an overnight basis; and encourage the resident to take responsibility for their daily living activities. These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However, all these services employ on-site mental health trained staff for some part of each day.

early intervention: actions that are appropriate for and specifically target people displaying the early signs and symptoms of a mental health problem or mental illness and people developing or experiencing a first episode of mental illness.

inpatient services: mental health services that provide admitted patient care. These are stand-alone psychiatric hospitals or specialised psychiatric units located within general (non-psychiatric) hospitals.

mental illness: a diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities. For the purposes of this chapter, it includes 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 illness are met.

(Continued on next page)

Box 12.17 (Continued)

mental health promotion: any action taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the 'coping' capacity of communities, families and individuals by giving power, knowledge, skills and the necessary resources.

mental illness prevention: interventions that occur before the initial onset of an illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and illnesses.

non-acute services: rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services focus on disability and the promotion of personal recovery. They are also characterised by an expectation of substantial improvement over the short to medium term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. Non-acute services also consist of extended care services that provide care over an indefinite period for patients who have a stable but severe level of functional impairment and inability to function independently without extensive care and support. Patients of extended care services usually show a relatively stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness. Treatment effort focuses on preventing deterioration and reducing impairment. Improvement is expected only over a long period.

non-government organisations: private not-for-profit community managed organisations that receive State and Territory government funding specifically to provide community support services for people affected by a mental illness. 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.

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 illness. This criterion is applicable regardless of the source of funds. Such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function.

Source: AIHW (2006); DoHA (2005).

Prevalence of mental illness

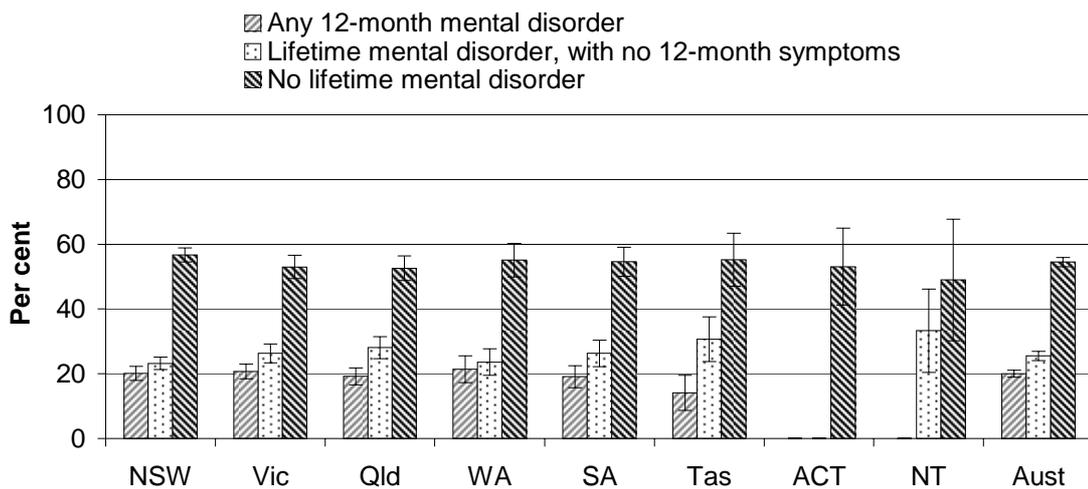
Prevalence of mental illness data are derived using the National Survey of Mental Health and Wellbeing (SMHWB). The term mental disorder is used when referring

directly to SMHWB data (as it is used in that survey). Elsewhere, the term mental illness is used to describe the illness associated with mental disorders.

The SMHWB data are reported with 95 per cent confidence intervals. These intervals assist with making comparisons between jurisdictions, and between different mental disorder status groups. Confidence intervals are a standard way of expressing the degree of uncertainty associated with survey estimates. An estimate of 80 with a confidence interval of ± 2 , for example, means that if another sample had been drawn, or if another combination of test items had been used, there is a 95 per cent chance that the result would lie between 78 and 82. Where ranges do not overlap, there is a high likelihood that there is a statistically significant difference. 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.

According to the 2007 SMHWB, 20.0 ± 1.1 per cent of adults aged 16–85 years (or approximately 3.2 million adults) met the criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months before the survey. A further 25.5 ± 1.4 per cent of adults aged 16–85 years had experienced a mental disorder at some point in their life, but did not have symptoms in the previous 12 months. These proportions were generally not statistically significantly different across jurisdictions (figure 12.18).

Figure 12.18 **Prevalence of mental disorders, 2007^{a, b}**



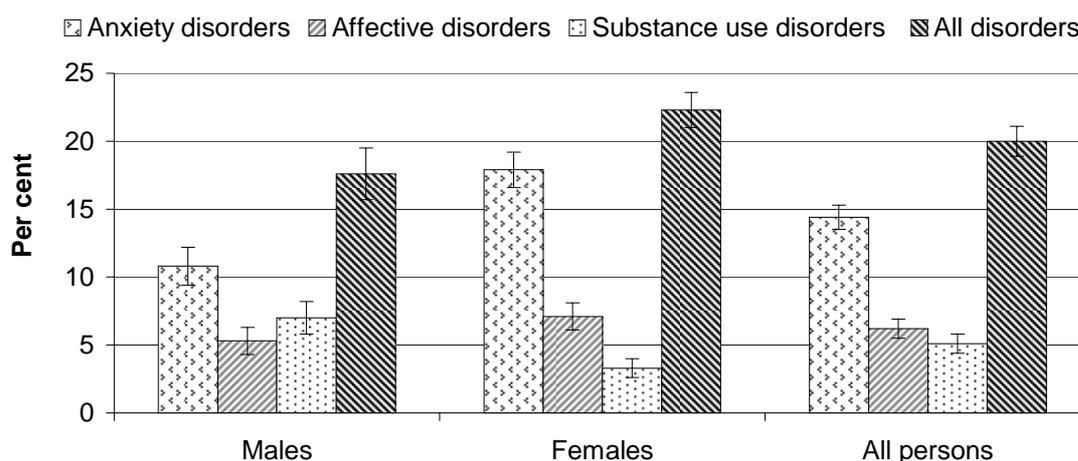
^a Error bars represent the 95 per cent confidence interval associated with each point estimate. ^b Estimates with relative standard errors (RSEs) greater than 25 per cent are not reported.

Source: ABS (unpublished), derived from the 2007 SMHWB, Cat. no. 4326.0; table 12A.22.

Overall, anxiety disorders (such as agoraphobia, post-traumatic stress disorder and social phobia) were the most common type of mental disorder reported with symptoms in the previous 12 months (14.4 ± 0.9 per cent of people). Persons with affective disorders (such as depression, mania and bipolar disorder) accounted for 6.2 ± 0.7 per cent and persons reporting substance use disorders accounted for a further 5.1 ± 0.7 per cent (figure 12.19).

There were differences in the prevalence of mental disorders between males and females (figure 12.19). Females most commonly experienced anxiety disorders (17.9 ± 1.3 per cent of all females), followed by affective disorders (7.1 ± 1.0 per cent) and substance abuse (3.3 ± 0.7 per cent). Males most commonly suffered anxiety disorders (10.8 ± 1.4 per cent of males), followed by substance use disorders (7.0 ± 1.2 per cent) and affective disorders (5.3 ± 1.0 per cent).

Figure 12.19 Prevalence of mental disorders, by gender, 2007^{a, b, c}



^a Error bars represent the 95 per cent confidence interval associated with each point estimate. ^b A person may have more than one mental disorder. Therefore the components may not add to the total of all disorders. ^c Persons who had a mental disorder with symptoms in the 12 months prior to the survey.

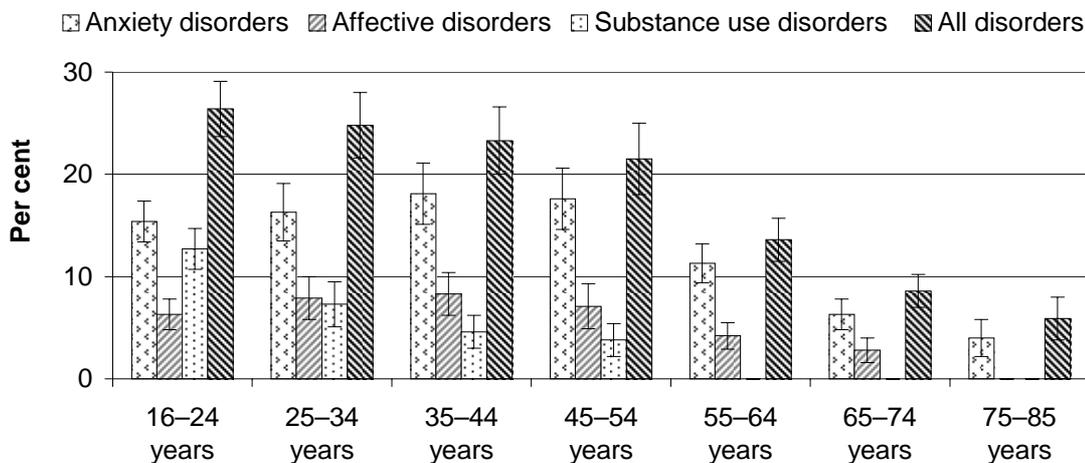
Source: ABS (unpublished), derived from the 2007 SMHWB, Cat. no. 4326.0; table 12A.23.

The prevalence of mental illness was higher for younger people than older people (figure 12.20). Of adults aged 16–24 years, 26.4 ± 2.7 per cent experienced symptoms of a mental disorder in the 12 months before the survey compared with 8.6 ± 1.6 per cent of people aged 65–74 years and 5.9 ± 2.1 per cent of people aged 75–85 years. The prevalence of anxiety disorders was highest for adults aged 35–44 years (18.1 ± 3.0 per cent), as was the prevalence of affective disorders (8.3 ± 2.1 per cent) (although the differences were not statistically significant to those of other age groups below 55–64 years). The prevalence of substance use

disorders was significantly higher in adults aged 16–24 years (12.7 ± 2.0 per cent) than other age groups.

The prevalence of mental illness did not vary with geographic location (table 12A.25). Of adults aged 16–85 years residing outside capital cities, 19.1 ± 1.9 per cent had a lifetime mental disorder and had experienced symptoms in the 12 months before the survey, compared with 20.5 ± 1.4 per cent of adults living in capital cities. A similar pattern was recorded for individual disorders.

Figure 12.20 **Prevalence of mental disorders, by age, 2007^{a, b, c, d}**



^a Error bars represent the 95 per cent confidence interval associated with each point estimate. ^b A person may have more than one mental disorder. Therefore the components may not add to the total. of all disorders. ^c Persons who had a mental disorder with symptoms in the 12 months prior to the survey. ^d Estimates with RSEs over 25 per cent are not published.

Source: ABS (unpublished), derived from the 2007 SMHWB, Cat. no. 4326.0; table 12A.24.

Impact of mental illness

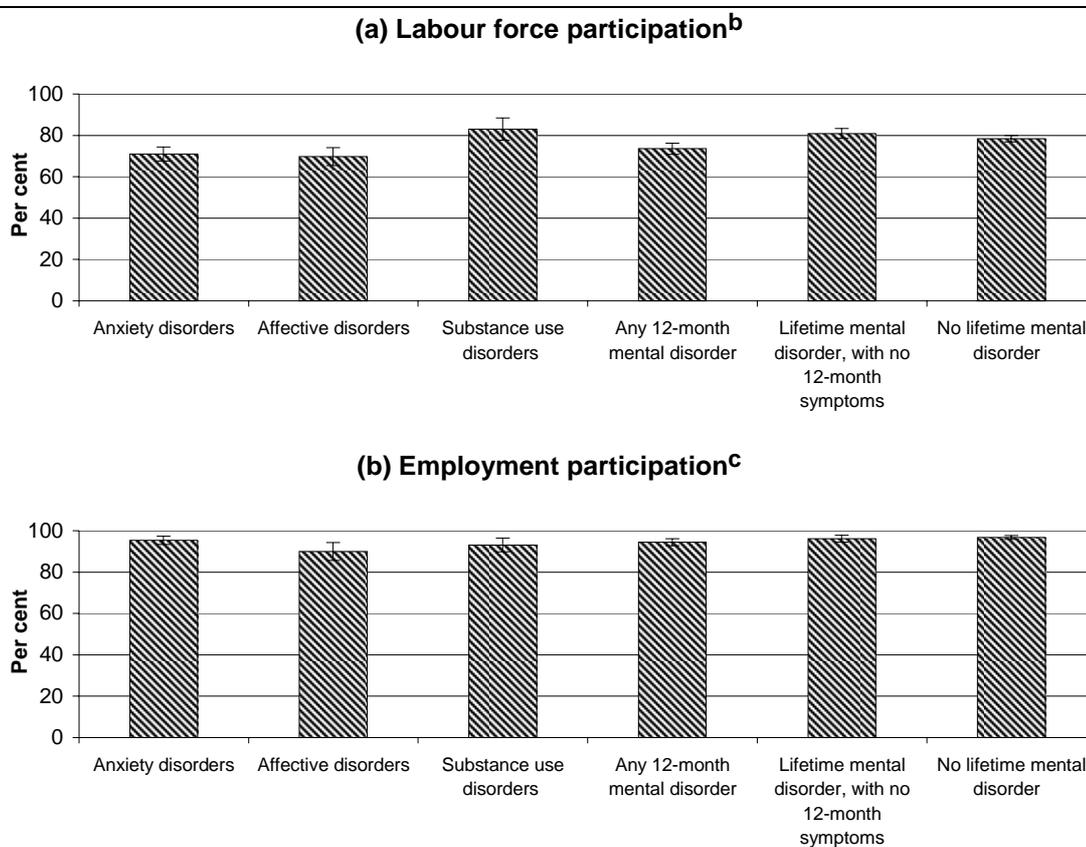
Mental illnesses contribute significantly to the total burden of disease and injury in Australia (13.3 per cent of the total burden in 2003) (AIHW: Begg et al. 2007). The total burden comprises the amount of ‘years’ lost due to fatal events (years of life lost due to premature death) and non-fatal events (years of ‘healthy’ life lost due to disability). Mental illness is also the leading cause of ‘healthy’ life years lost due to disability (24 per cent of the total non-fatal burden in 2003) (AIHW: Begg et al. 2007).

Mental illness can affect an individual’s functioning and quality of life. For example, it can act as a barrier to gaining and maintaining employment (AHMC 2008). Nationally, in 2007, the labour force participation rate for people

with a lifetime mental disorder who had symptoms in the previous 12 months was 73.6 ± 2.7 per cent, below the rate of those who did not have a mental disorder (78.4 ± 1.6 per cent). The labour force participation rate of people who had a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months was not significantly different to the rate for people who did not have a mental disorder (figure 12.21a). Of those in the labour force, 94.5 ± 1.7 per cent of people with a mental disorder who had symptoms in the previous 12 months were employed, not significantly different to the rate of those without a mental disorder (96.8 ± 0.9 per cent). People who had a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months also had employment rates that were similar to the rate of those without a mental disorder (figure 12.21b).

The labour force participation rates of those who had symptoms of a mental disorder in the previous 12 months varied across disorder type. The rates were higher for those with substance abuse disorders than for those with anxiety or affective disorders (figure 12.21a). Employment rates did not vary significantly across mental disorder type (figure 12.21b).

Figure 12.21 **Labour force and employment participation of people aged 16–64 years, by mental disorder status, 2007^a**

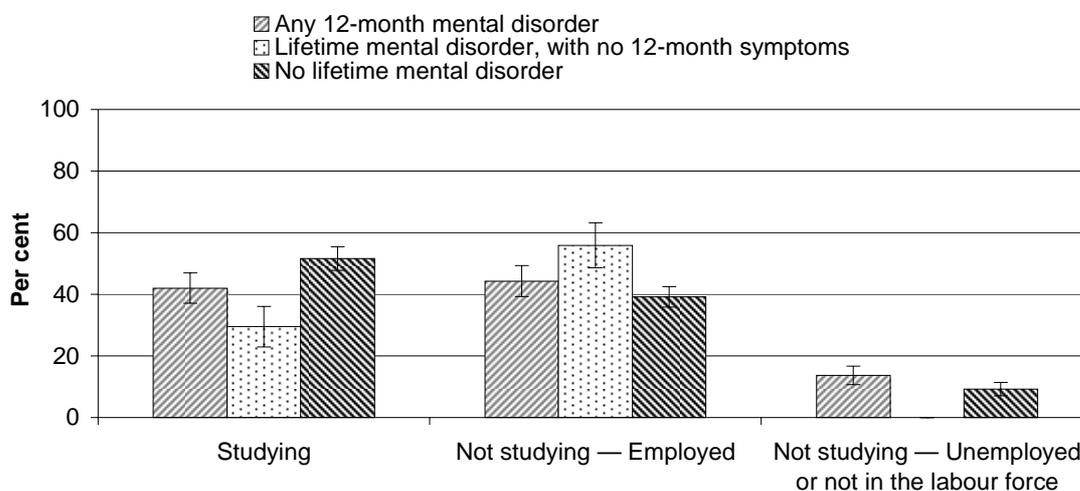


^a Error bars represent the 95 per cent confidence interval associated with each point estimate. ^b The labour force participation rate is the proportion of the total population who are employed or unemployed. ^c The employment participation rate is the proportion of the labour force who are employed.

Source: ABS (unpublished), derived from the 2007 SMHWB, Cat. no. 4326.0; table 12A.26.

Mental illness in early adult years can lead to disrupted education and premature exit from school or tertiary training, or disruptions in the transition from school to work (AHMC 2008). The impact of these disruptions can be long term, restricting the person's capacity to participate in a range of social and vocational roles over their lifetime (AHMC 2008). Nationally, in 2007, the proportion of people aged 16–30 years who had a mental disorder with symptoms in the previous 12 months who were participating in study was 42.0 ± 4.9 per cent, lower than the rate for those without a mental disorder (51.6 ± 3.8 per cent) (figure 12.22). Of people who were not studying, people with a mental disorder who had symptoms in the previous 12 months were more likely to be unemployed or not in the labour force than those without a mental disorder (although the difference was not statistically significant). Further information on the participation of people aged 16–30 years in the labour force and study is in tables 12A.27 and 12A.28.

Figure 12.22 Participation in study or the labour force of people aged 16–30 years, by mental disorder status, 2007^{a, b, c}



^a Includes persons studying full-time and part-time, persons still at school, and persons employed full-time and part-time. ^b Error bars represent the 95 per cent confidence interval associated with each point estimate. ^c Estimates with RSEs greater than 25 per cent are not published.

Source: ABS (unpublished), derived from 2007 SMHWB, Cat. no. 4326.0; table 12A.27.

The 2007 SMHWB also shows that people with a mental disorder who had symptoms in the previous 12 months are overrepresented in the homeless and incarcerated populations. While they were an estimated 20.0 per cent of the total population, they represented 53.6 per cent of the population who had ever been homeless and 41.4 per cent of the population who had ever been incarcerated (ABS 2008b). In addition, people with a mental disorder who had symptoms in the previous 12 months were more likely to have attempted suicide over the 12 months before the Survey (1.9 ± 0.8 per cent) than all people (0.4 ± 0.2 per cent) (ABS unpublished).

Roles and responsibilities

State and Territory governments are responsible for the funding, delivery and management of specialised public mental health services including admitted patient care in hospitals; ambulatory care services and community residential care (for further detail see box 12.17). As noted above, performance information in this section focuses on these mental health services.

Under the Australian Health Care Agreements, the Australian Government provides base grants and funding to states and territories to undertake reforms in the directions advocated by the NMHS, for mental health services (DoHA 2007). The Australian Government also funds health related services for people with mental

illnesses through the following mechanisms: the Medicare Benefits Schedule (MBS), which funds services provided by GPs (both general and specific mental health items), private psychiatrists and allied mental health professionals (clinical psychologists, psychologists, social workers and occupational therapists); the Pharmaceutical Benefits Scheme (PBS), which funds mental health related medications, the Medicare Safety Net, the Department of Veteran's Affairs (DVA) and the Private Hospital Insurance Premium Rebates. Other specific programs designed to increase the level of social support and community-based care for people with a mental illness and to prevent suicide are also funded by the Australian Government.

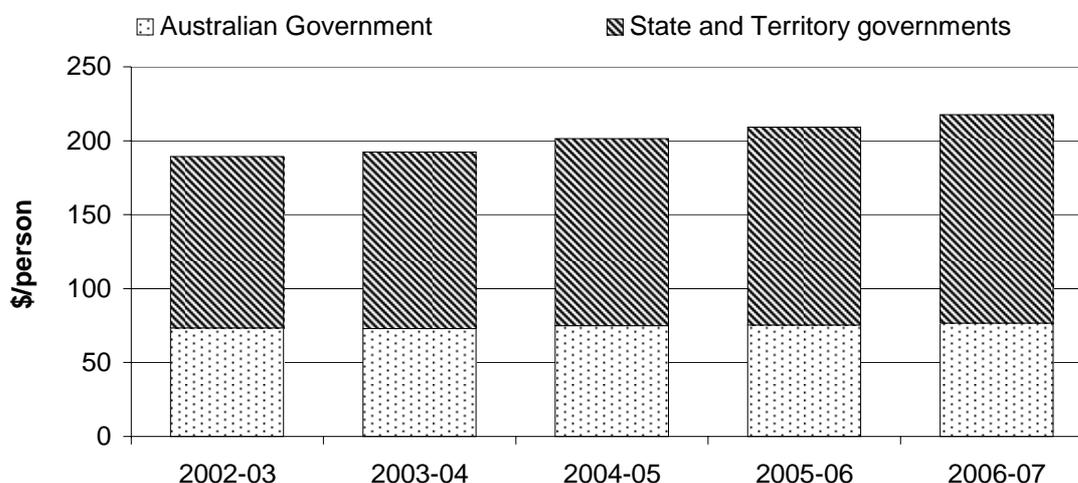
The Australian, State and Territory governments also fund/provide other services that people with mental illnesses can access, such as emergency relief, employment, accommodation, income support, rehabilitation, residential aged care and other services for older people and people with a disability (see chapters 13 and 14, respectively).

Funding

Real government recurrent expenditure of around \$4.5 billion³ was allocated to mental health services in 2006-07 (tables 12A.31 and 12A.32). State and Territory governments made the largest contribution (\$2.9 billion, or 64.8 per cent), although this included some Australian Government funds under the Australian Health Care Agreements (table 12A.32). The Australian Government spent \$1.6 billion. Real Australian Government expenditure per person rose from \$73 in 2002-03 to \$77 in 2006-07. National average State and Territory expenditure per person in 2006-07 was \$141, up from \$116 in 2002-03 (figure 12.23).

³ This includes expenditure sourced from patient fees and reimbursement by third party compensation insurers and 'other Australian Government funds'.

Figure 12.23 Real government recurrent expenditure on mental health services per person (2006-07 dollars)^{a, b}



^a Constant price expenditure for all years (2006-07 dollars), using the implicit price deflator for non-farm gross domestic product (table 12A.70) for Australian Government expenditure, and the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services for State and Territory expenditure (table 12A.69). ^b All Australian Government 2006-07 expenditure data are preliminary. Final data will be as published in the *National Mental Health Report 2008*.

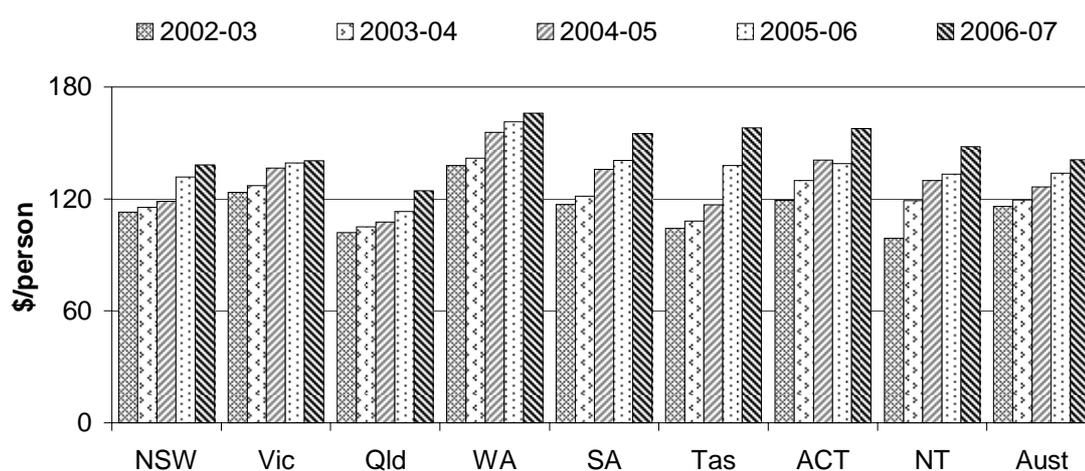
Source: Department of Health and Ageing (DoHA) (unpublished); State and Territory governments (unpublished); AIHW (unpublished), derived from the *MHE NMDS*; tables 12A.32 and 12A.33.

The largest component of Australian Government expenditure on mental health services in 2006-07 was expenditure under the Pharmaceutical Benefits Schedule for psychiatric medication (\$664 million). Expenditure on psychiatric medication increased by an annual average rate of 0.7 per cent between 2002-03 and 2006-07, but fell from 44.5 per cent of Australian Government expenditure on mental health services in 2002-03 to 41.6 per cent in 2006-07. The annual rate of growth of expenditure on psychiatric medication has declined over the reporting period (from 5.2 per cent between 2002-03 and 2003-04 to -0.7 per cent between 2005-06 and 2006-07) (table 12A.31). The reduced rate of growth in expenditure on psychiatric medication is due to a number of frequently prescribed medications coming off patent, which allowed lower cost generic medicines to be used.

In 2006-07, the next largest component of Australian Government expenditure for mental health services was MBS payments for consultant psychiatrists (15.1 per cent), followed by GPs (10.7 per cent). The residual included DVA (9.0 per cent), the NMHS (8.3 per cent), private hospital insurance premium rebates (4.2 per cent) and MBS payments for clinical psychologists and other allied health professionals (3.5 per cent) (table 12A.31).

Real expenditure per person at State and Territory discretion has increased over time (figure 12.24). Data in figure 12.24 for State and Territory government expenditure include Australian Government funds provided as part of base grants under the Australian Health Care Agreements, but exclude special purpose grants provided for mental health reform and also funding provided to states and territories by the DVA. The data are therefore referred to as expenditure 'at State and Territory discretion'. The data in figure 12.24 exclude depreciation. Estimates of depreciation are presented in table 12A.35. State and Territory government expenditure estimates excluding revenue from other sources and other Australian Government funds are presented in table 12A.34. The revenue categories are subject to minimal validation and may be inconsistently treated across jurisdictions. In addition, it is not possible to extract revenue from other sources and other Australian Government funds uniformly across time.

Figure 12.24 **Real recurrent expenditure at the discretion of State and Territory governments, per person (2006-07 dollars)^{a, b, c}**

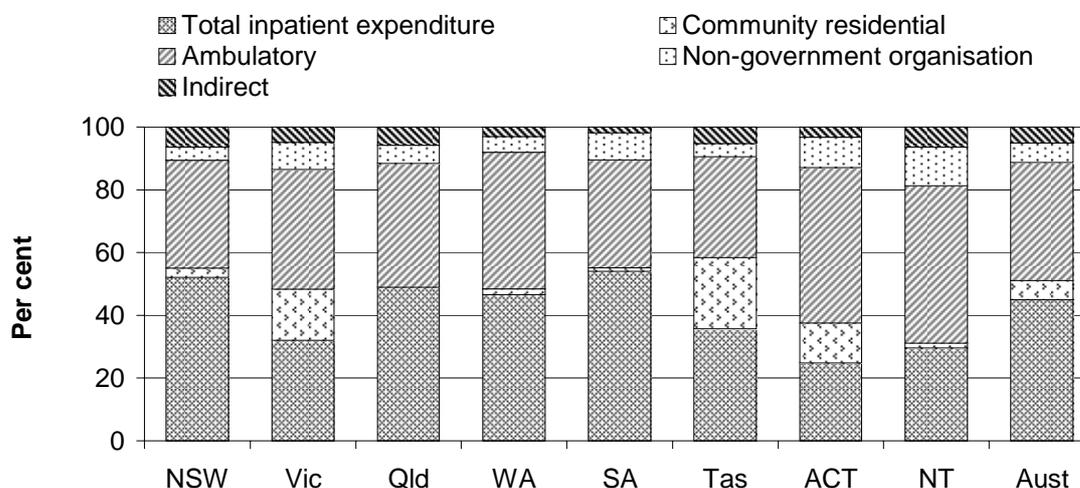


^a Constant price expenditure (2006-07 dollars), using State and Territory implicit price deflators for general government final consumption on hospital clinical services (table 12A.69). ^b Estimates of State and Territory government spending include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Australian Government funds', but exclude Australian Government funding provided under the NMHS and through the DVA. ^c Depreciation is excluded for all years. Depreciation estimates are reported in table 12A.35.

Source: DoHA (unpublished); State and Territory governments (unpublished); AIHW (unpublished), derived from the *MHE NMDS*; table 12A.32.

Figure 12.25 shows how expenditure at the discretion of State and Territory governments was distributed across the range of mental health services in 2006-07. It does not show the distribution of the Australian Government expenditure reported in figure 12.23.

Figure 12.25 **State and Territory recurrent expenditure, by service category, 2006-07^{a, b, c, d, e}**



^a Includes all State and Territory expenditure on mental health services, regardless of source of funds.

^b Depreciation is excluded. Depreciation estimates are reported in table 12A.35. ^c A community residential mental health service is a specialised mental health service that: employs mental health-trained staff on-site; provides rehabilitation, treatment or extended care to residents that is in a domestic-like environment and that is intended to be on an overnight basis; and encourages the resident to take responsibility for their daily living activities. These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However, all these services employ on-site mental health trained staff for some part of each day. ^d 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. ^e Queensland does not fund community residential services, but it funds a number of extended treatment services (both campus-based 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.

Source: AIHW (unpublished), derived from the *MHE NMDS*; table 12A.36.

Size and scope

In 2006-07, 3.1 per cent and 1.5 per cent of the total population received Medicare-funded and State and Territory clinical mental health care services, respectively (figure 12.26). These data need to be interpreted carefully. Data for some Medicare-funded mental health services were only for seven months (from November 2006). Data for state/territory mental health services are based on people who received one or more ambulatory mental health service (most people who have received a state and territory inpatient service have also received an ambulatory mental health service). Comparisons across state and territory services need to be made with caution as states and territories differ in the way they count the number of people under care (AHMC 2008).

Figure 12.26 Population receiving clinical mental health care, 2006-07^{a, b, c, d}

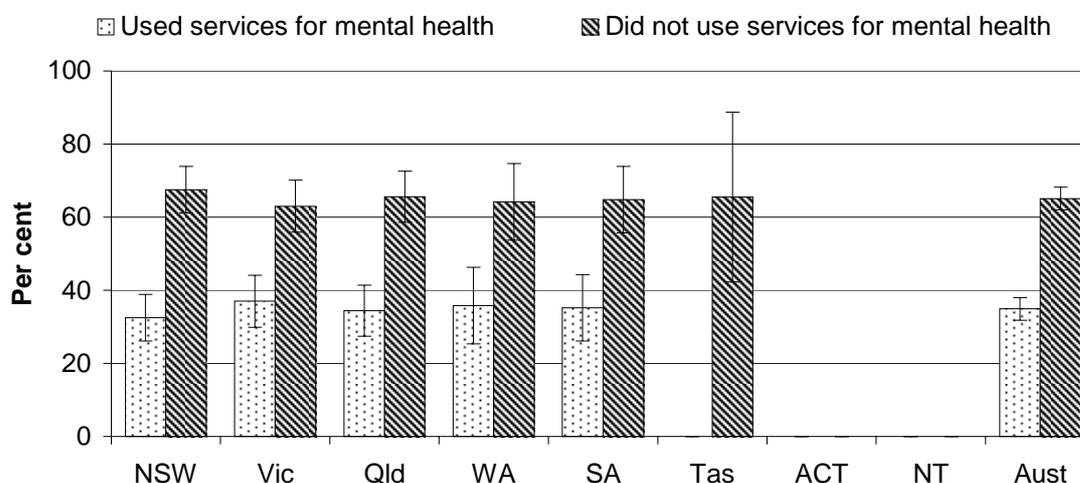


^a Estimates are preliminary only and based on unique counts of individuals receiving care from the particular services within the year. An individual is only counted once, regardless of the number of services received. An individual could have received a Medicare-funded and a State/Territory mental health service in the given year. ^b Person counts for State and Territory mental health services are confined to those receiving one or more contacts provided by ambulatory mental health services. All service contacts are counted in defining whether a person receives a service, including those delivered 'on behalf' of the consumer. ^c Jurisdictions differ in their capacity to provide accurate estimates of persons receiving services due to the lack of unique patient identifiers, or data matching systems. NSW, Tasmania and SA data are not derived using a unique patient identifier or data matching approaches. ^d All Medicare funded data are based on year of processing, as provided by the Australian Government (DoHA) and billing data maintained by Medicare Australia. A significant component of the data includes services provided under the Australian Government *Better Access to Mental Health Care* initiative, which commenced on 1 November 2006. Data related to GPs' MBS mental health related items for 2007-08 are contained in table 12.6.

Source: AHMC (2008) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-07*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council; table 12A.37.

Nationally, 34.9 ± 3.1 per cent of people with a mental disorder who had symptoms in the previous 12 months used a service for mental health (figure 12.27). Low rates of service use by people with mental illnesses may occur for a number of reasons; including the unavailability of appropriate services, lack of awareness that services are available and negative experiences associated with the previous use of services (AHMC 2008). In addition, it may not be appropriate for all people with a mental illness to use a service, for example, some may seek and receive assistance from outside the health system (AHMC 2008). Data on the proportions of people with a mental disorder with symptoms in the previous 12 months who used different types of health services are reported in table 12A.29.

Figure 12.27 People with 12-month mental disorder, use of services for mental health, 2007^{a, b, c}



^a Services used for mental health included: hospitals, GPs, psychiatrists, psychologists, other mental health professionals and other health professionals. ^b Error bars represent the 95 per cent confidence interval associated with each point estimate. ^c Estimates with RSEs over 25 per cent are not published.

Source: ABS (unpublished), derived from 2007 SMHWB, Cat. no. 4326.0; table 12A.30.

Services provided by general practitioners

Information on GP services for people with mental illnesses is available from Medicare Australia and from the BEACH (Bettering the Evaluation and Care of Health) survey data. Medicare Australia provides data on the number of services provided through the GP mental health specific MBS items. These items ‘define services for which Medicare rebates are payable where GPs undertake early intervention, assessment and management of patients with mental disorders’ (DoHA 2008a), as distinct from general surgery consultations where a mental health related problem is managed.

There were 1.2 million MBS-subsidised GP mental health services provided in 2007-08, equivalent to 57.5 per 1000 people (table 12.6). The majority (97.0 per cent) of these services were for the preparation or review of GP Mental Health Care Plans or the related surgery consultation (MBS items 2710, 2712 and 2713, respectively).

Table 12.6 Use of GP mental health MBS items, 2007-08

	<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>Total</i>
GP Mental Health Care Plans^a										
Number	'000	407.9	335.8	209.5	106.3	80.8	23.3	14.9	5.1	1 183.7
Rate	per 1000 people ^b	58.3	63.8	49.8	50.9	50.1	46.6	42.9	24.2	55.7
Focussed Psychological Strategies^c										
Number	'000	13.3	10.4	7.1	1.5	4.2	0.4	0.4	–	37.1
Rate	per 1000 people ^b	1.9	2.0	1.7	0.7	2.6	0.8	1.1	0.2	1.8
All GP mental health MBS items										
Number	'000	421.1	346.2	216.6	107.8	84.9	23.7	15.3	5.1	1 220.8
Rate	per 1000 people ^b	60.2	65.8	51.4	50.8	53.6	47.4	44.0	24.4	57.5

^a GP Mental Health Care Plans are defined under MBS items 2710, 2712 and 2713. See the Medicare Benefits Schedule for more information on these items. ^b Rates are derived from the *Medicare Item Reports* per capita counts. The Medicare per capita counts are expressed per 100 000 people and are derived by dividing the number of services processed in the financial year by the average monthly number of people enrolled in Medicare across the financial year. ^c Focussed Psychological Strategies are defined under MBS items 2721, 2723, 2725 and 2727. See the Medicare Benefits Schedule for more information on these items.

Source: Medicare Australia (2008) *Medicare Item Reports*, (www.medicareaustralia.gov.au/statistics/mbs_item.shtml); table 12A.38.

Data for the BEACH survey are collected from a sample of 1000 GPs. In 2007-08, on average 11.5 psychological/mental health problems were managed by GPs in every 100 encounters (more than one problem can be managed in a single encounter). The most frequently reported mental health related problem managed was depression (4.0 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 2007-08, depression was the fifth most frequently managed problem by a GP (Britt et al. 2008).⁴

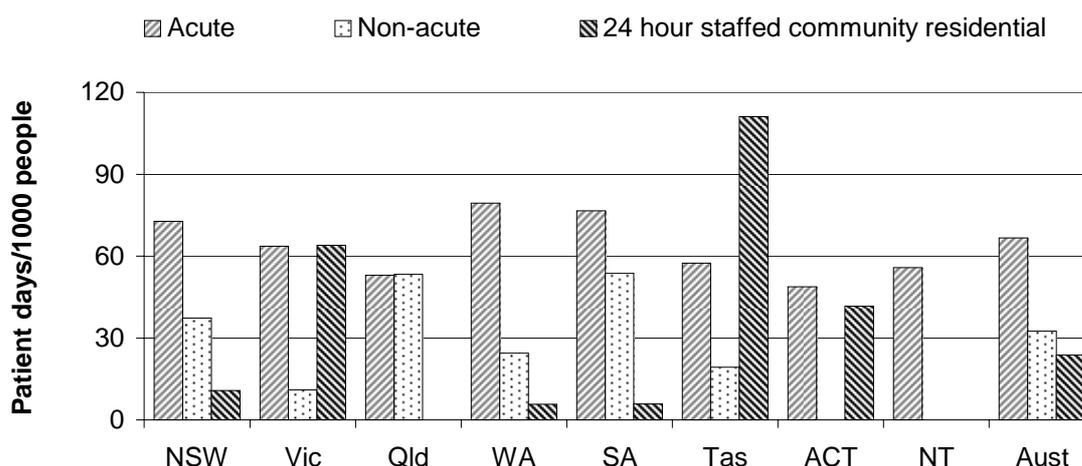
The BEACH survey asks GPs to record an MBS item for each encounter. Analysis by the AIHW of BEACH survey data for 2006-07 showed that, of encounters where a mental health related problem was managed, only 2.2 per cent of these encounters had the MBS item recorded as a specific mental health item. The large majority of these encounters (over 90 per cent) recorded the MBS item as some form of general surgery consultation (AIHW 2008b).

⁴ A GP may manage more than one problem at a single encounter. Problems managed reflect the GP's understanding of the health problem presented by the patient.

State and Territory publicly funded specialised mental health services — service activity

Estimating activity across the specialised publicly funded mental health services sector is problematic. Data for patient days are provided in figure 12.28 by acute, non-acute and 24 hour staffed community residential care (as defined in box 12.17).⁵ Hospital inpatient days and community residential patient days are included in figure 12.28, but other types of community services are not covered. Collection of data outlining community mental health care patient contacts commenced in July 2000 as part of the NMDS, but there are continuing difficulties with data quality. Queensland does not fund community residential services, but funds a number of campus-based and non-campus-based extended treatment services. Patient days in these services are included as non-acute.

Figure 12.28 Mental health patient days, 2006-07^{a, b, c}



^a Queensland does not fund community residential services, but funds a number of campus-based and non-campus-based extended treatment services. Data from these services are included as non-acute.

^b The ACT and the NT did not provide mental health care in non-acute units. ^c The NT did not provide mental health care in 24 hour staffed community residential facilities.

Source: State and Territory governments (unpublished); table 12A.42.

In 2005-06, there were 76 091 separations with specialised psychiatric care in public acute hospitals and 13 255 specialised psychiatric care separations in public psychiatric hospitals (table 12A.43). Schizophrenia accounted for a large proportion of separations with specialised psychiatric care in public hospitals (22.9 per cent in public acute hospitals and 24.4 per cent in public psychiatric hospitals) (table 12A.43).

⁵ Patient days are all days or part days for which the patient was in care during the relevant period, regardless of the original date of admission.

In 2005-06, there were 7606 ambulatory equivalent same day separations with specialised psychiatric care in public acute hospitals and 1388 in public psychiatric hospitals (AIHW 2008b). Unlike the general acute hospital sector, mental health has few procedural same day admissions. Electroconvulsive therapy treatment of people living in the community represented 6–10 per cent of all same day separations. Work for the Mental Health Classification and Service Costs Project suggested that the majority of same day hospitalisations are better described as ambulatory care and involve consumer attendance at a variety of day and group-based programs that otherwise could be provided in community settings (Buckingham *et al.* 1998).

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 and non-Indigenous people 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 illnesses. For the jurisdictions for which data are available, Indigenous people were 1.8 times more likely to receive specialised psychiatric care in hospitals than non-Indigenous people. However, the average length of stay for Indigenous people (18.5) was shorter than for non-Indigenous people (21.7) (table 12.7).

Table 12.7 Specialised psychiatric care, by Indigenous status, 2005-06^{a, b, c}

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Indigenous										
Separation rate ^d	per 1000 people	13.6	10.9	8.2	9.3	12.2	np	np	7.9	10.4
Average length of stay ^e	no.	18.0	14.5	22.5	23.3	15.0	20.1	10.6	10.3	18.5
Non-Indigenous										
Separation rate ^d	per 1000 people	5.5	5.0	6.6	5.6	6.4	np	np	4.2	5.7
Average length of stay ^e	no.	23.0	19.4	21.3	19.9	27.2	19.8	15.3	9.8	21.7
Rate ratio ^f		2.5	2.2	1.2	1.7	1.9	np	np	1.9	1.8

^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 Indigenous identification is likely to be incomplete and to vary among jurisdictions. ^d Data for NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only for the NT) are considered to be of acceptable quality for analytical purposes. ^e Includes data for overnight separations only. ^f The rate ratio is equal to the separation rate for Indigenous persons divided by the separation rate for non-Indigenous. **np** Not published.

Source: AIHW (2008) *Mental Health Services in Australia 2005-06*, Cat. no. HSE 56, Mental Health Series no. 10, www.aihw.gov.au/publications/hse/mhsa05-06/mhsia_05-06_internet.xls (accessed 2 December 2008); table 12A.44.

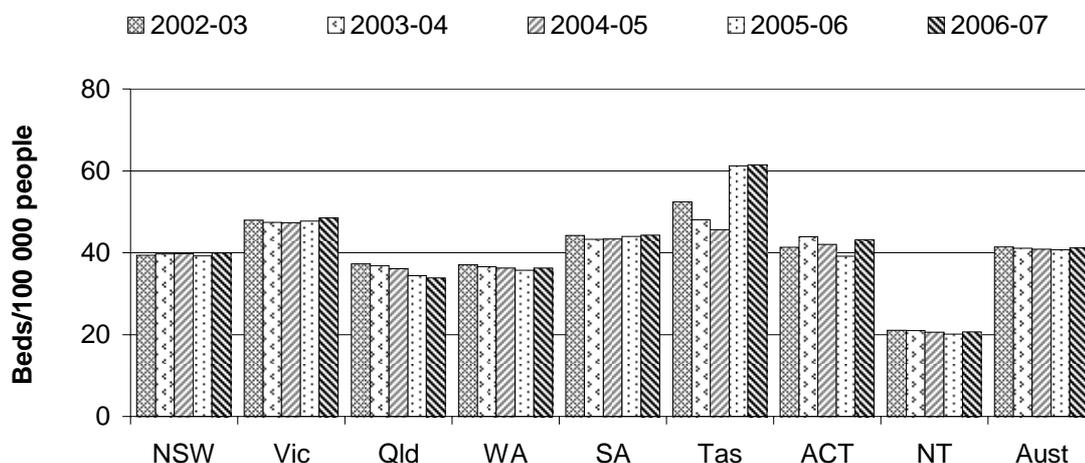
State and Territory publicly funded specialised mental health services — mental health beds

Beds are counted as those immediately available for use by admitted patients if required. They are available for use immediately — or within a reasonable period of time — if located in a suitable place for care with nursing or other auxiliary staff available.

Available beds are counted differently across years. For 2005-06 and 2006-07, available beds are counted as the average of monthly available bed numbers. For previous years, available beds are counted at 30 June. In addition, for 2005-06 and 2006-07, available beds counts excluded beds in wards that were closed for any reason (except weekend closures for beds/wards staffed and available on weekdays only). For previous years, available beds counts included wards that were temporarily closed for reasons such as renovation or strike, but that would normally be open.

Figure 12.29 presents the number of beds per 100 000 people for public hospitals and community residential facilities combined.

Figure 12.29 **Mental health beds in public hospitals and publicly funded community residential units^{a, b, c, d}**



^a Includes beds in public hospitals and publicly funded community residential units. ^b The reduction in the number of beds in Queensland is a result of a temporary closure of some acute beds in one hospital and the permanent closure of some transitional extended treatment beds. ^c Bed numbers in WA for 2005-06 include emergency department observation beds in one hospital. ^d In Tasmania, for 2005-06, non-government organisations' residential beds funded by government are included for the first time in the publicly funded community residential facilities category. This has led to a significant change in the bed numbers between 2004-05 and 2005-06.

Source: AIHW (unpublished), derived from the *MHE NMDS*; State and Territory governments (unpublished); table 12A.39.

Figure 12.30 presents the number of beds by service setting for 2006-07. These data show the differences in service mix across states and territories. As noted above, Queensland funds a number of extended treatment services (both campus- and non-campus-based) that provide longer term inpatient treatment and rehabilitation services with full clinical staffing for 24 hours a day, seven days a week. Queensland does not report these beds as community residential beds.

Figure 12.30 Available beds, by service setting, 2006-07^{a, b}



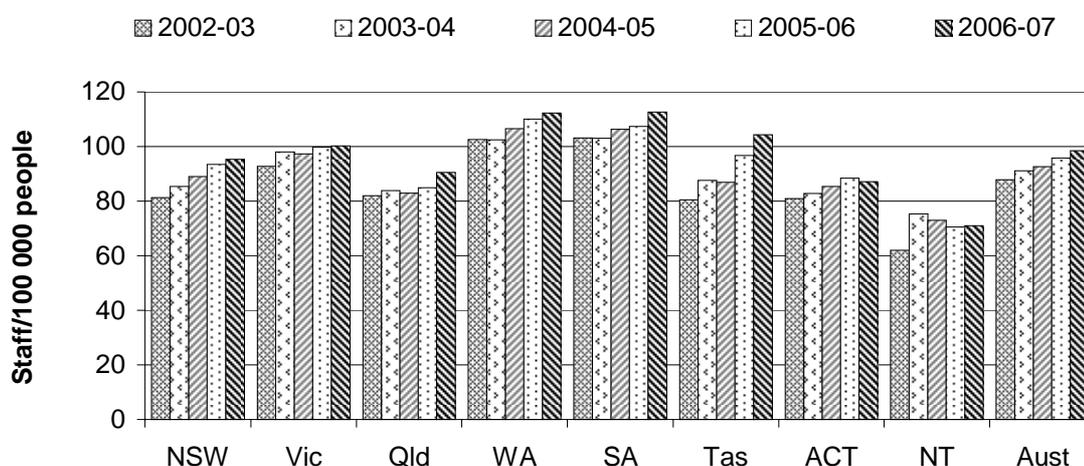
^a Queensland does not fund community residential services, but it funds a number of campus-based and non-campus-based extended treatment services. These services are reported either as beds in public acute hospitals or beds in public psychiatric hospitals. ^b Tasmania, the ACT and the NT do not have public psychiatric hospitals.

Source: AIHW (unpublished), derived from the *MHE NMDS*; State and Territory governments (unpublished); table 12A.39.

State and Territory publicly funded specialised mental health services — staff

Figure 12.31 reports full time equivalent (FTE) health professional direct care staff per 100 000 people. It includes only staff within the health professional categories of ‘medical’, ‘nursing’ and ‘allied health’. ‘Medical’ staff consist of consultant psychiatrists, psychiatry registrars, and other medical officers who are neither registered as psychiatrists within the State or Territory, nor are formal trainees of the Royal Australian and New Zealand College of Psychiatrists’ Postgraduate Training Program. ‘Nursing’ staff consist of registered and non-registered nurses. ‘Allied health’ staff consist of occupational therapists, social workers, psychologists and other allied health staff. ‘Other personal care’ direct care staff are excluded. ‘Other personal care’ staff include attendants, assistants, home companions, family aides, ward helpers, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents and who are not formally qualified or are still training in nursing or allied health professions. Definitions for staffing categories are provided in more detail in section 12.7.

Figure 12.31 FTE health professional direct care staff^a



^a Includes health professional occupational categories only.

Source: AIHW (unpublished), derived from the *MHE NMDS*; State and Territory governments (unpublished); table 12A.40.

Nursing staff comprise the largest FTE component of health care professionals employed in mental health services. Across Australia in 2006-07, 63.7 nurses per 100 000 people were working in specialised mental health services, compared with 23.4 allied health care staff and 11.4 medical staff (table 12A.40). FTE direct care staff employed in specialised mental health services, by service setting, are reported in table 12A.41.

Framework of performance indicators

Preventing the onset of mental illness is challenging, primarily because individual illnesses have many origins. Most efforts have been directed at treating mental illness when it occurs, determining the most appropriate setting for providing treatment and emphasising early intervention.

The framework of performance indicators for specialised mental health services draws on governments' broad objectives for national mental health policy, as encompassed in the NMHS and the Council of Australian Governments (COAG) National Action Plan on Mental Health (box 12.18). The framework reports on the equity, effectiveness and efficiency of specialised mental health services. It covers a number of service delivery types (admitted patient and community-based services) and includes outcome indicators of systemwide performance. Improving the framework is a priority of the Steering Committee.

Box 12.18 **Broad objectives of National Mental Health Policy**

Key broad 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 illnesses
- undertake, where appropriate, early intervention for mental health problems and mental illnesses
- reduce, where possible, the impact of mental illnesses on individuals, families and the community
- assure the rights of persons with mental illnesses
- encourage partnerships among service providers and between service providers and the community
- provide services in an equitable (including improved access to mental health services, particularly in Indigenous and rural communities) and efficient manner.

Governments also aim to improve mental health and facilitate recovery from illness through more stable accommodation and support and meaningful participation in recreational, social, employment and other activities in the community.

In 1991, Australian Health Ministers signed the Mental Health Statement of Rights and Responsibilities. This Statement of Rights and Responsibilities seeks to ensure that consumers, carers, advocates, service providers and the community are aware of their rights and responsibilities and can be confident in exercising them (Australian Health Ministers 1991). The Statement underpins the NMHS endorsed by Australian, State and Territory governments in 1992 (AIHW 2008b).

The NMHS was established to guide the reform agenda for mental health in Australia across the whole of government. The NMHS consists of the National Mental Health Policy and the National Mental Health Plan.

- The National Mental Health Policy describes the broad aims and objectives of the Strategy. The Policy has 38 objectives, including those that relate to the shift from institutional to community-based services, and the delivery of services in mainstream settings (AIHW 2008b).
- The National Mental Health Plan describes the approach to implementing the aims and objectives of the Policy. A Third Plan (2003–2008) was endorsed by all Australian Health Ministers in July 2003. This plan consolidates reforms begun under the first two plans (the first ran from 1993–1998 and the second from 1998–2003) (AIHW 2008b).

An evaluation of the third National Mental Health Plan (2003–2008) and associated Framework commenced in May 2007. On 22 July 2008, Australian Health Ministers noted the findings of the evaluation and agreed to the development of a fourth National Mental Health Plan in the context of a whole-of-government framework. Ministers further agreed to an initial Forum to inform the development of the Plan, which was convened by NSW on 11 September 2008.

The National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2004–2009 (the Social and Emotional Well Being Framework) was endorsed by the Australian Health Ministers' Advisory Council in December 2004. It aims to provide a framework for action by all governments and communities to improve the social and emotional wellbeing and mental health needs of Indigenous Australians over the next five years.

In 2006, COAG agreed to the National Action Plan on Mental Health 2006–2011 (COAG 2006). This plan involves a joint package of measures and new investments by all governments aimed at promoting better mental health and providing additional support to people with mental illness, their families and their carers. The Action Plan is designed to further promote mental health reform and focuses on areas that have not progressed sufficiently under the NMHS. The Action Plan is directed at achieving four outcomes:

- reducing the prevalence and severity of mental illness in Australia
- reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery
- increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention
- increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

A series of measures have been identified to monitor progress against these outcomes. Australian Health Ministers agreed to report annually to COAG on implementation of the Plan, and on progress against the agreed outcomes. Governments also agreed to an independent evaluation and review of the Plan after five years (COAG 2006).

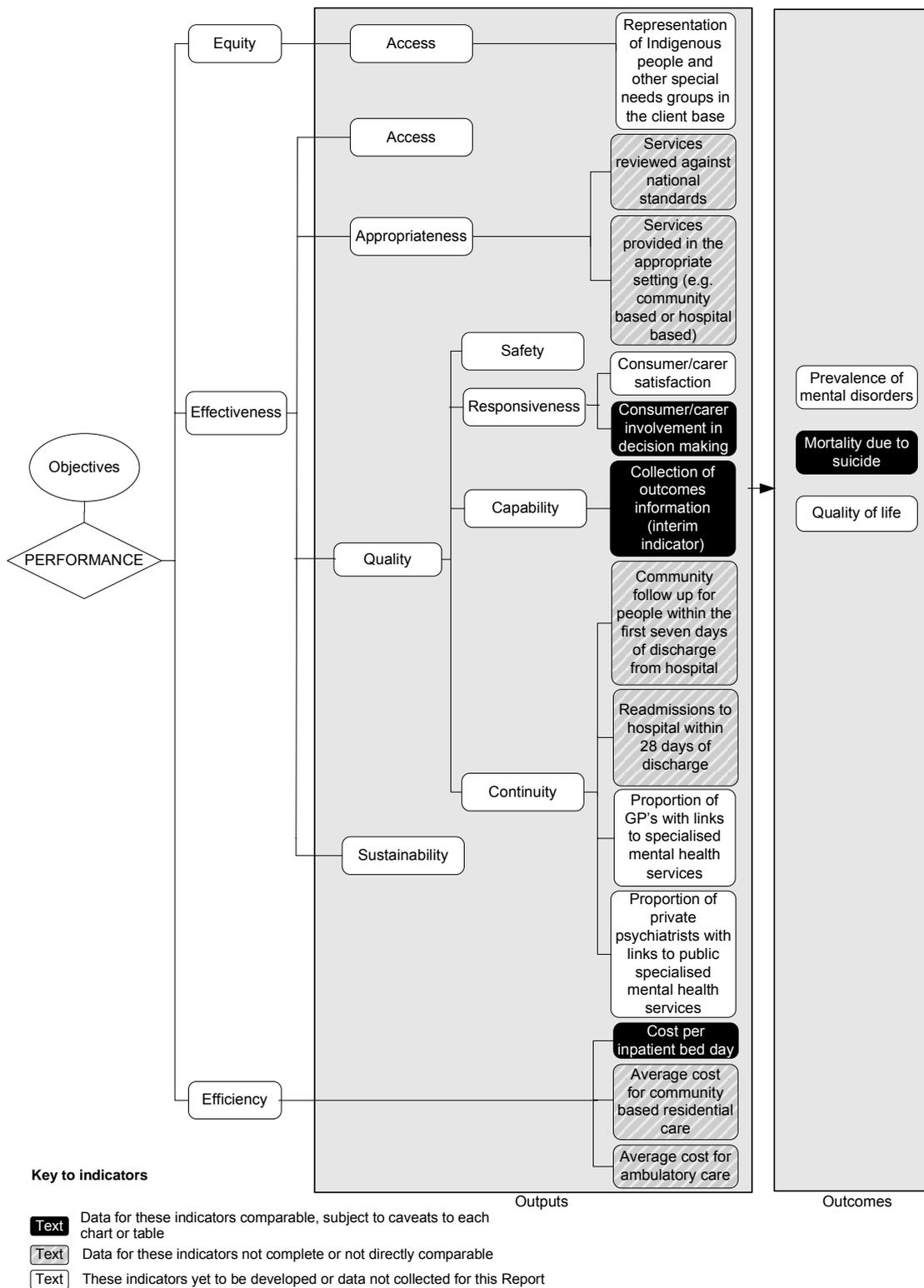
The performance indicator framework shows which data are comparable in the 2009 Report (figure 12.32). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses

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.

Some changes have been made to the mental health framework for the 2009 Report. Data for the following indicators are now included:

- ‘community follow up for people within seven days of discharge from hospital’
- ‘readmissions to hospital within 28 days of discharge’.

Figure 12.32 Performance indicators for mental health management



Key performance indicator results

Outputs

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

Equity — representation of Indigenous people and others in the client base

‘Representation of Indigenous people and other special needs groups in the client base’ is an indicator of governments’ objective to provide mental health services in an equitable manner, including access to services by special needs groups such as Indigenous people (box 12.19).

Box 12.19 Representation of Indigenous people and other special needs groups in the client base

‘Representation of Indigenous people and other special needs groups in the client base’ is yet to be defined.

Data for this indicator were not available for the 2009 Report.

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’ is an indicator of governments’ objective to provide mental health services that are appropriate (box 12.20). It is a process indicator of appropriateness, reflecting progress being made in meeting the national standards for mental health care. The National Standards are outlined in box 12.21 (these standards are currently being revised).

Box 12.20 Services reviewed against the National Standards

'Services reviewed against the National Standards' is defined as the proportion of mental health services assessed at level 1 and at level 2, where level 1 and level 2 are defined as:

- *Services assessed at level 1.* The number of specialised public mental health services that have been reviewed against the National Standards for Mental Health Services by an external accreditation agency and assessed as meeting all Standards.
- *Services assessed at level 2.* The number of specialised public mental health services that have been reviewed against the National Standards for Mental Health Services by an external accreditation agency and assessed as meeting some but not all Standards.

A higher proportion of services that have been assessed at level 1 and level 2 is desirable.

A comprehensive review of the National Standards was completed in May 2008. The review was conducted to align the Standards with developments in mental health reform, current legislation, and to assist mental health services to provide quality care that is evidence-based, integrated and recovery-focussed, for people with a mental illness (consumers). The National Standards are currently being revised.

Data reported for this indicator are not directly comparable.

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 specialised services, including mental health services. Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the national standards; rather, assessment against the National Standards must be specifically requested and involves a separate review process.

Box 12.21 The National Standards for Mental Health Services

The National Standards for Mental Health Services were developed under the First National Mental Health Plan for use in assessing service quality and as a guide for continuous quality improvement in all Australian mental health services. They comprise 11 major criteria:

1. rights
2. safety
3. consumer and carer participation
4. promoting community acceptance
5. privacy and confidentiality
6. prevention and mental health promotion
7. cultural awareness
8. integration
9. service development
10. documentation
11. delivery of care.

Source: DoHA (2002).

Table 12.8 shows the percentage of specialised public mental health services that have completed an external review process against the National Standards for Mental Health Services and have been assessed as meeting ‘all standards’ (level 1) or of meeting ‘some but not all standards’ (level 2).

Table 12.8 Specialised public mental health services reviewed against the National Standards for Mental Health Services, 30 June (per cent)^a

	<i>NSW</i>	<i>Vic^b</i>	<i>Qld</i>	<i>WA^c</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
2003								
Level 1	na	na	31.1	na	11.7	na	81.3	–
Level 2	na	na	62.2	na	14.6	na	..	–
2004								
Level 1	na	100	74.2	na	49.5	na	81.3	50.0
Level 2	na	–	8.3	na	5.6	na	..	–
2005								
Level 1	73.4	100.0	75.0	64.5	72.7	46.9	87.5	50.0
Level 2	0.6	–	6.7	12.9	2.7	–	..	50.0
2006								
Level 1	78.0	100.0	78.5	51.6	62.9	36.4	100.0	100.0
Level 2	0.9	–	1.7	9.7	3.4	15.2	–	–
2007								
Level 1	77.5	96.0	82.8	44.1	71.8	37.9	100.0	100.0
Level 2	0.9	–	0.8	41.2	1.8	6.9	–	–

^a NSW, Queensland, SA, Tasmania and the ACT report at the service unit level. Victoria, WA and the NT report at the organisation level. ^b In Victoria, two agencies did not report as at 'Level 1' for 2007. However, both agencies were in the process of being re-accredited and therefore should be deemed as having gained accreditation. ^c WA has a number of services currently involved in re-accreditation as well as internal review against the National Standards that are not included in this table. **na** Not available. **..** Not applicable – Nil or rounded to zero.

Source: AIHW (unpublished), derived from the *MHE NMDS*; State and Territory governments (unpublished); table 12A.45.

Appropriateness — services provided in the appropriate setting

'Services provided in the appropriate setting' is an indicator of governments' objective to provide mental health services in an appropriate setting (box 12.22). The development of local comprehensive mental health service systems is advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental illnesses and of providing continuity of care, so consumers can move between services as their needs change. The Strategy advocates:

- a reduced reliance on stand-alone psychiatric hospitals
- the expanded delivery of community-based care integrated with inpatient care
- mental health services being mainstreamed with other components of health care.

More appropriate treatment options can be provided by encouraging the treatment of patients in community settings and public (non-psychiatric) hospitals, rather than in stand-alone psychiatric hospitals.

One of the indicator measures in previous reports has been replaced to reflect the progress that has been made toward reforms under the Strategy: 'recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total expenditure on mental health services' has been replaced by 'recurrent expenditure on community-based services as a proportion of total expenditure on mental health services'.

Box 12.22 Services provided in the appropriate setting

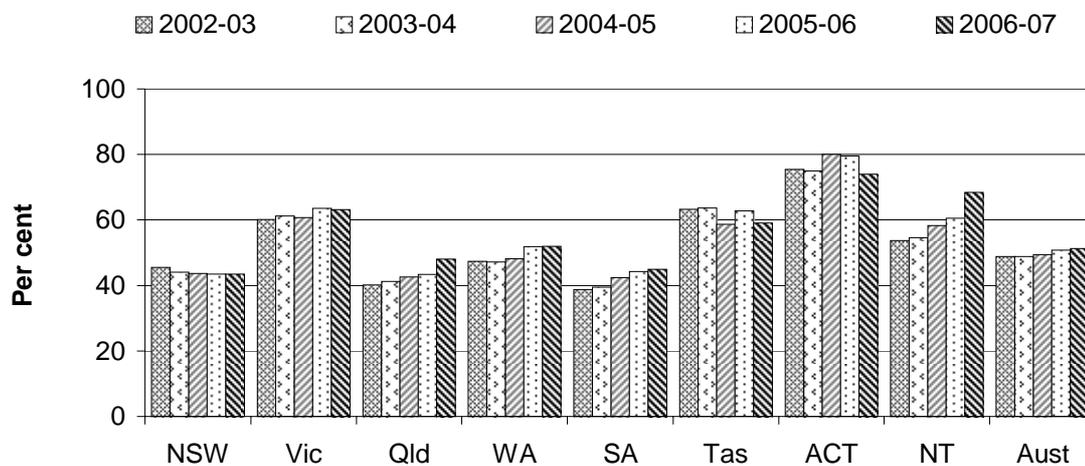
Two measures of 'services provided in the appropriate setting' are reported. These measures are defined, and results should be interpreted, as follows:

- Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services. Aged care community residential expenditure is excluded to improve comparability. A high proportion for this indicator is desirable, reflecting a greater reliance on services that are based in community settings.
- 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 a reduced reliance on stand-alone psychiatric hospitals and greater mainstreaming of mental health services.

Data reported for this indicator are not directly comparable.

Figure 12.33 shows recurrent expenditure on community-based services as a proportion of total expenditure on mental health services.

Figure 12.33 Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services^{a, b}

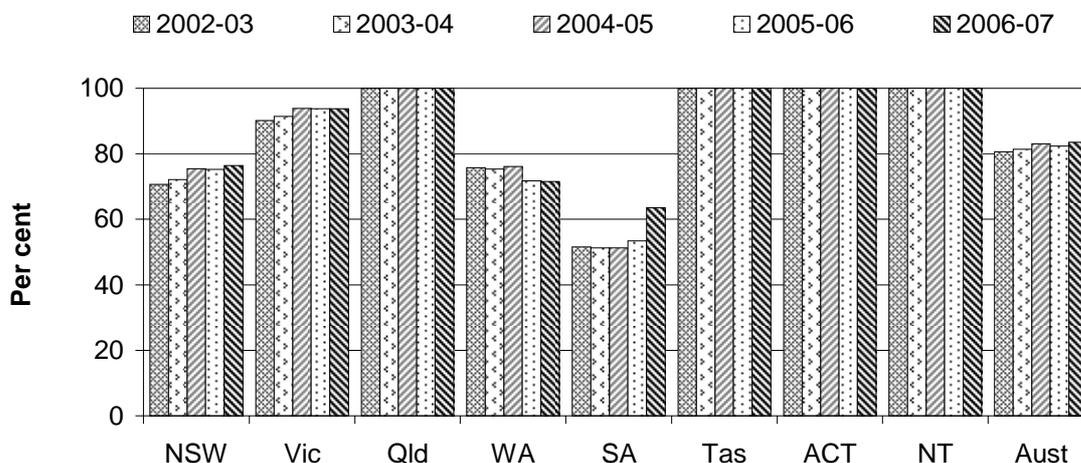


^a Community-based expenditure includes expenditure on ambulatory, non-government and adult community residential services. Aged care community residential expenditure is excluded to improve comparability.
^b Total expenditure on mental health services excludes indirect/residual expenditure that could not be apportioned directly to services and aged care community residential expenditure.

Source: AIHW (unpublished), derived from the *MHE NMDS*; State and Territory governments (unpublished); table 12A.46.

Figure 12.34 shows acute patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals. Nationally, the proportion of acute patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals has increased slightly over the period from 2002-03 to 2006-07.

Figure 12.34 Acute patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals



Source: AIHW (unpublished), derived from the *MHE NMDS*; State and Territory governments (unpublished); table 12A.46.

Quality — consumer and carer satisfaction

‘Consumer and carer satisfaction’ is an indicator of governments objective that services are responsive to the needs of consumers and their carers (box 12.23). Consumers and their carers should be satisfied with both clinicians’ responses and with services provided, in all areas of mental health. Both are important aspects of the NMHS.

Box 12.23 Consumer and carer satisfaction

‘Consumer and carer satisfaction’ is yet to be defined.

Data for this indicator were not available for the 2009 Report.

Quality — consumer and carer involvement in decision making

‘Consumer and carer involvement in decision making’ is an indicator of governments’ objective that consumers’ and carers’ are involved at the service delivery level, where they have the opportunity to influence the services they receive (box 12.24). Consumer and carer involvement is an important aspect of the NMHS.

Box 12.24 Consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' has the following two measures:

- 'Organisations with consumer participation in decision making'
- 'Paid consumer and carer consultants per 10 000 clinicians'.

'Organisations with consumer participation in decision making' is defined as the proportions of organisations that have in place certain arrangements that allow consumers to contribute to local service planning and delivery in specialised mental health services. An organisation can be classified at only one level. Arrangements are grouped into four categories:

- level 1 — organisation has a formal position for mental health consumers on the management committee or a specific mental health consumer advisory group exists to advise on all aspects of service delivery
- level 2 — organisation has a specific mental health consumer advisory group to advise on some but not all aspects of service delivery
- level 3 — organisation includes mental health consumers on a broadly based advisory committee
- level 4 — organisation has minimal/no arrangements for mental health consumer participation in planning and evaluation of services.

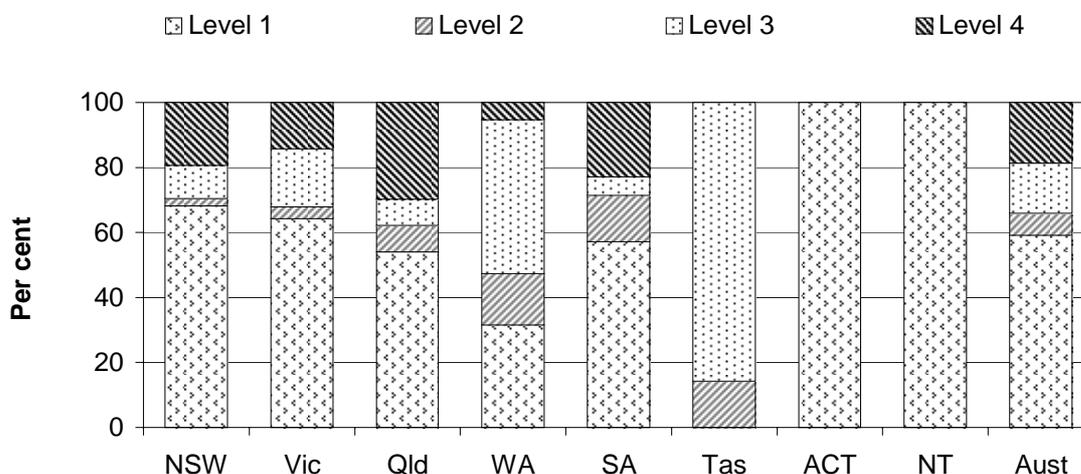
A high proportion of organisations with level 1 arrangements is desirable, while a high proportion of organisations with level 4 arrangements is undesirable.

'Paid consumer and carer consultants per 10 000 clinicians' is defined as the number of paid consumer consultants per 10 000 clinical staff and the number of paid carer consultants per 10 000 clinical staff. Higher numbers of such staff imply a greater chance that paid consumers and carers can be involved in decision making.

Data reported for this indicator are comparable.

Figure 12.35 illustrates the degree of consumer participation in decision making. As notes to figure 12.35 indicate, current categories do not match all jurisdictions' arrangements for consumer participation in decision making. The Steering Committee has identified that work to improve reporting in this area is needed.

Figure 12.35 Organisations with consumer participation in decision making, 2006-07^{a, b, c}



^a Non-government organisations are included only where they provide staffed residential services. ^b WA advised that several key consumer and carer advisory groups are supported and provided with financial assistance at a state level and, collectively, these groups provide advice and representation on consumer and carer issues. The information obtained through the MHE NMDS is restricted to the service organisation level. ^c An expanded range of indicators of consumer and carer participation for 2004-05 are reported in the *National Mental Health Report 2007*.

Source: AIHW (unpublished), derived from the *MHE NMDS*; table 12A.47.

Table 12.9 illustrates the number of paid FTE consumer and carer consultants per 10 000 FTE clinicians.

Table 12.9 Paid FTE consumer and carer consultants per 10 000 FTE clinical staff

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Paid consumer consultants per 10 000 clinicians									
2003-04	na	na	21.6	na	16.6	na	na	–	na
2004-05	26.7	na	24.4	na	23.8	na	na	–	na
2005-06	43.0	38.8	28.5	2.2	16.7	–	–	–	30.5
2006-07	37.9	36.7	27.5	3.5	11.8	–	–	–	27.9
Paid carer consultants per 10 000 clinicians									
2003-04	na	na	3.1	na	–	na	na	–	na
2004-05	na	na	3.1	na	–	na	na	–	na
2005-06	4.3	23.2	1.2	–	–	–	–	–	0.8
2006-07	13.2	27.0	2.4	–	–	–	–	–	1.1

na Not available. – Nil or rounded to zero.

Source: AIHW (unpublished), derived from the *MHE NMDS*; State and Territory governments (unpublished); table 12A.47.

Quality — collection of outcomes information (interim indicator)

The ‘collection of outcomes information’ is an indicator of governments’ objective that consumer outcomes be monitored (box 12.25). It is an interim process indicator of this objective, reflecting the capability of services in establishing systems to collect consumer outcomes information. It will be replaced by information on consumer outcomes once they become available.

Establishing a system for the routine monitoring of consumer outcomes was introduced as part of the *National Mental Health Plan 2003–2008*. States and territories have taken the following approach to introducing consumer outcomes measurement as part of day-to-day service delivery:

- measures to include ratings by clinicians and self-ratings by consumers
- all clinical staff to have undergone training in collection
- processes established to ensure uniformity in collection
- funding for information systems to store, analyse and report on the data
- a national approach to data analysis, reporting and benchmarking (DoHA 2002).

Box 12.25 Collection of outcomes information (interim indicator)

‘Collection of outcomes information (interim indicator)’ is defined as the proportion of specialised mental health services that have introduced routine collection of consumer outcomes information.

A high proportion of services that are collecting consumers outcomes information is desirable.

Data reported for this indicator are comparable.

The proportions of specialised mental health services that have introduced routine consumer outcomes measurement are shown in table 12.10.

Table 12.10 Specialised mental health services that introduced the routine collection of consumer outcomes measurement (per cent)^a

	<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
June 2006	100.0	96.9	100.0	100.0	77.6	97.0	100.0	100.0	93.0
June 2007	100.0	100.0	100.0	100.0	84.6	96.6	100.0	100.0	95.3

^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 specialised mental health services. Data are thus aggregated. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 12A.48.

Quality — community follow up for people within the first seven days of discharge from hospital

‘Community follow up for people within the first seven days of discharge from hospital’ is an indicator of governments’ objective to provide continuity of care in the delivery of mental health services (box 12.26). Continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital (AHMC 2008). A community support system for people who are discharged from hospital after an acute psychiatric episode is essential to maintain clinical and functional stability (NMHWG 2005). Patients leaving hospital with a discharge plan, involving linkages with community services and supports, are less likely to need early readmission.

Data for this indicator are reported in this chapter for the first time and are drawn from the *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-07* (figure 12.36). Data are not comparable across jurisdictions. NSW, SA and Tasmania are not able to accurately track post-discharge follow up between hospitals and community service organisations, due to the lack of unique patient identifiers or data matching systems. For these jurisdictions, post discharge follow up is regarded to have occurred only when the community mental health contact was recorded by the discharging organisation. Results for these jurisdictions could appear ‘lower’ relative to jurisdictions that are able to track utilisation across services.

Box 12.26 Community follow up for people within the first seven days of discharge from hospital

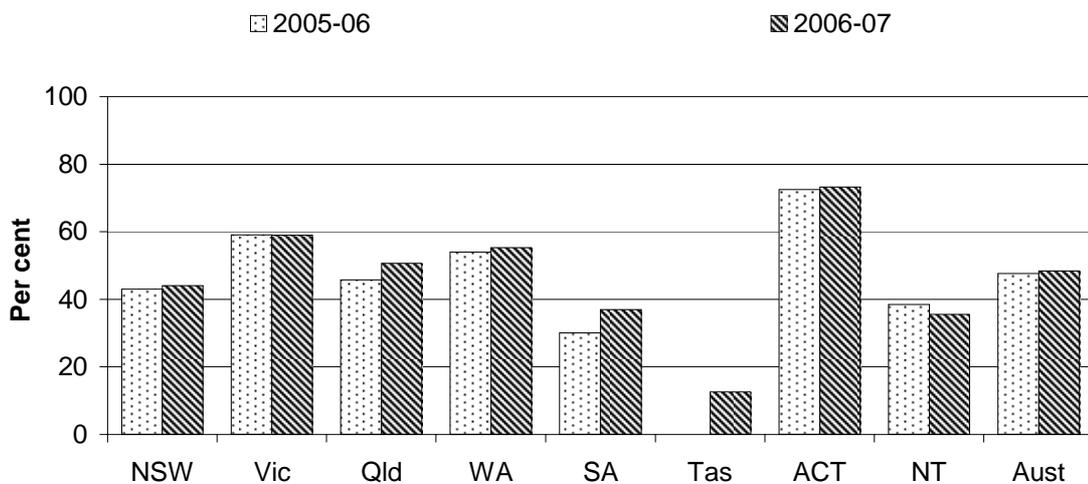
‘Community follow up for people within the first seven days of discharge from hospital’ is defined as the proportion of admitted patient overnight separations from State and Territory psychiatric inpatient services for which a community mental health contact was recorded in the seven days following separation.

A higher rate of community follow up within the first seven days of discharge from hospitals is desirable.

The indicator does not measure the frequency of contacts recorded in the seven days following separation. It also does not distinguish qualitative differences between phone and face-to-face community contacts.

Data reported for this indicator are not directly comparable.

Figure 12.36 Community follow up for people within the first seven days of discharge from hospital^{a, b, c}



^a Data for 2005-06 are for the full year, but for 2006-07, the data are based on the first 9 months of the year.

^b Community mental health contacts counted for determining whether follow up occurred are restricted to those in which the consumer participated, except for the NT where the data includes all contacts (the NT has advised that the impact on the indicator is marginal). Contacts made on the day of discharge are also excluded. ^c Data are not comparable. NSW, SA and Tasmania do not have a unique patient identifier or data matching approaches. This could contribute to lower follow up rates for these jurisdictions.

Source: AHMC (2008) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-07*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers’ Advisory Council; table 12A.49.

Quality — readmissions to hospital within 28 days of discharge

'Readmissions to hospital within 28 days of discharge' is an indicator of the governments' objective to provide effective care and continuity of care in the delivery of mental health services (box 12.27). While inpatient services aim to provide treatment that enables individuals to return to the community as soon as possible, readmissions following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow up care was inadequate to maintain the person out of hospital (AHMC 2008).

Data for this indicator are reported in this chapter for the first time and are drawn from the *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-07* (figure 12.37). Data are not comparable across jurisdictions. Due to the lack of unique patient identifiers or data matching systems, NSW, SA and Tasmania can only track readmission back to the same hospital from which the person was discharged. For these jurisdictions, readmissions are regarded to have occurred only when it is recorded by the discharging organisation. Results for these jurisdictions, could appear 'lower' relative to jurisdictions that are able to track utilisation across services.

Box 12.27 Readmissions to hospital within 28 days of discharge

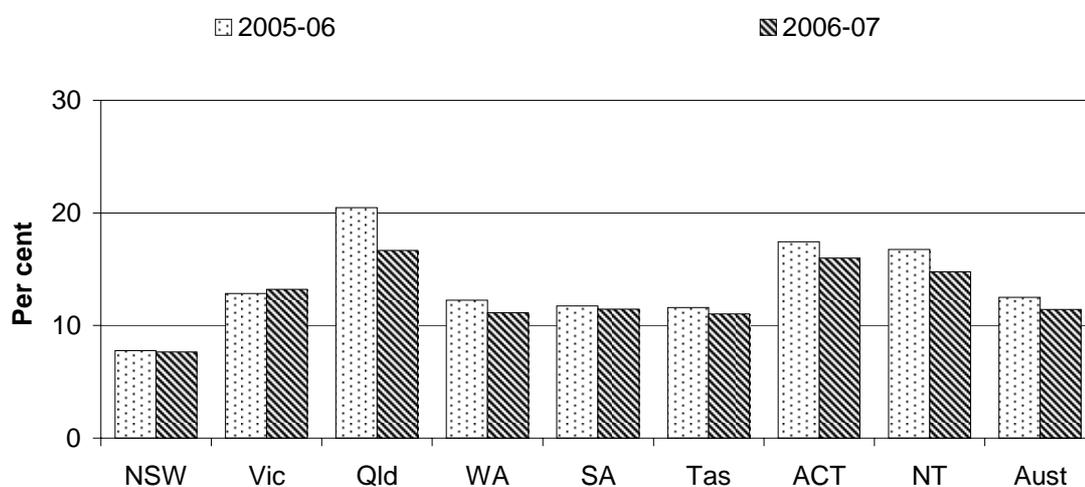
'Readmissions to hospital within 28 days of discharge' is defined as the proportion of admitted patient overnight separations from State and Territory psychiatric inpatient services that were followed by readmission to psychiatric inpatient services within 28 days of discharge.

A lower rate of readmissions to hospital within 28 days of discharge from hospitals is desirable. High rates may indicate deficiencies in hospital treatment or community follow up, or a combination of the two (NMHWG 2005).

Readmission rates are affected by other factors, such as the cyclic and episodic nature of some illnesses or other issues that are beyond the control of the mental health system (NMHWG 2005). The indicator includes all readmissions to hospital as data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission.

Data reported for this indicator are not directly comparable.

Figure 12.37 Readmissions to hospital within 28 days of discharge^{a, b, c}



^a Data for 2005-06 are for the full year, but for 2006-07, the data are based on the first 9 months of the year.

^b No distinction is made between planned and unplanned readmissions because data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission to hospital. ^c Data are not comparable. NSW, SA and Tasmania do not have a unique patient identifier or data matching approaches. This could contribute to lower re-admission rates for these jurisdictions.

Source: AHMC (2008) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-07*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council; table 12A.50.

Quality — proportion of GPs with links to specialised mental health services

The 'proportion of GPs with links to specialised public mental health services' is an indicator of governments' objective to provide continuity of care in the delivery of mental health services. GPs can be an important first point of contact for those with a mental illness (box 12.28).

Box 12.28 Proportion of GPs with links to specialised public mental health services

'Proportion of GPs with links to specialised public mental health services' is yet to be defined.

Data for this indicator were not available for the 2009 Report.

Quality — proportion of private psychiatrists with links to public specialised mental health services

The ‘proportion of private psychiatrists with links to public specialised mental health services’ is an indicator of governments’ objective to provide continuity of care in the delivery of mental health services (box 12.29).

Box 12.29 Proportion of private psychiatrists with links to public specialised mental health services

‘Proportion of private psychiatrists with links to public specialised mental health services’ is yet to be defined.

Data for this indicator were not available for the 2009 Report.

Sustainability

The Steering Committee has identified sustainability as an area for reporting but no indicators have yet been identified.

Efficiency

Efficiency — cost per inpatient bed day

‘Cost per inpatient bed day’ is an indicator of governments’ objective that mental health services be delivered in an efficient manner (box 12.30).

Box 12.30 Cost per inpatient bed day

'Cost per inpatient bed day' is defined as the cost of providing inpatient services per inpatient bed day. 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.

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.

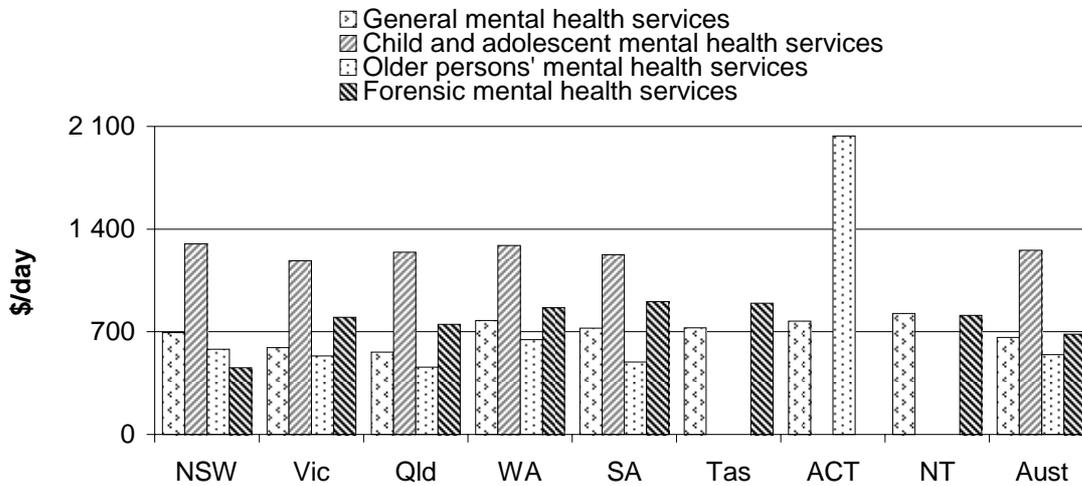
This indicator is affected by factors such as differences in the client mix and average length of stay. The client mix in inpatient settings may differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings rather than in the community. Longer lengths 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.

The most suitable indicator for mental health services would be to adjust the number of separations by the type and complexity of cases, to develop a cost per casemix adjusted separation similar to that presented for public hospitals (chapter 10), but casemix data for specialised mental health services are not available.

Data reported for this indicator are comparable.

Inpatient costs per day are presented in figures 12.38 (by inpatient target population) and 12.39 (by hospital type). Changes over time partly reflect institutional change in accordance with the NMHS (for example, a shift to the delivery of services in mainstream settings).

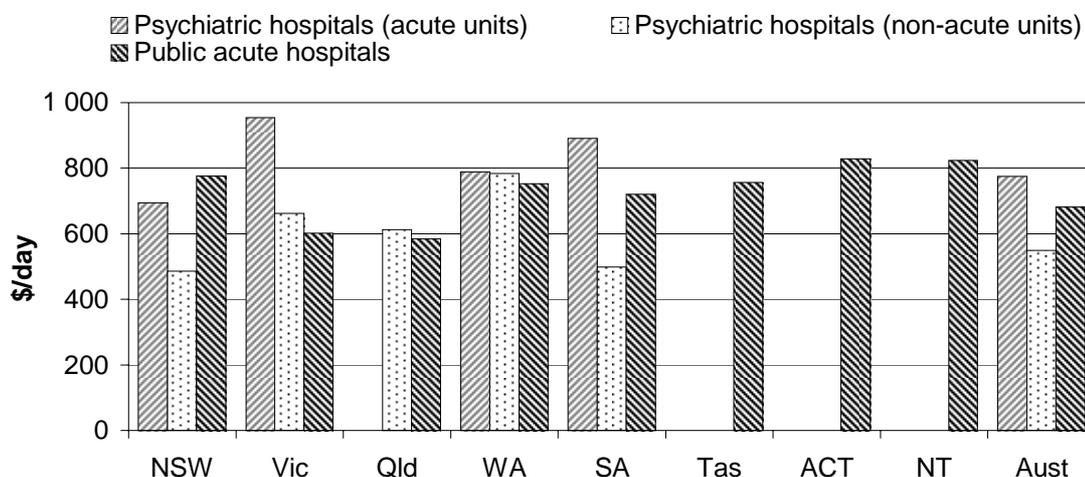
Figure 12.38 Average recurrent cost per inpatient bed day, public hospitals, by target population, 2006-07^{a, b, c, d, e}



^a Depreciation is excluded. ^b 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). ^c 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. ^d Tasmania and the NT do not provide, or cannot separately identify, child and adolescent mental health services or older persons' mental health services. ^e ACT average costs for older person's mental health services are based on a new 20 bed unit opened in March 2007. During 2006-07, only 6–10 beds operated due to issues related to staffing resources. This has artificially inflated the average cost of older persons' mental health services. The ACT does not have separate forensic or child and adolescent mental health inpatient services.

Source: AIHW (unpublished), derived from the *MHE NMDS*; table 12A.51.

Figure 12.39 Average recurrent cost per inpatient bed day, public hospitals, by hospital type, 2006-07^{a, b, c, d, e}



^a Depreciation is excluded. ^b 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). ^c 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. ^d Queensland data for general hospitals include costs associated with two extended treatment units that report through general acute hospitals. Queensland does not provide acute services in psychiatric hospitals. ^e Tasmania, the ACT and the NT do not have psychiatric hospitals.

Source: AIHW (unpublished), derived from the *MHE NMDS*; table 12A.52.

Efficiency — average cost for community-based residential care

‘Average cost for community-based residential care’ is an indicator of governments’ objective that mental health services be delivered in an efficient manner (box 12.31).

The average recurrent cost to government per patient day for community residential services is presented in table 12.11. For general adult units in 2006-07, the average cost to government per patient day for 24 hour staffed community residential services was an estimated \$368 nationally. For non-24 hour staffed community residential units, the average cost to government per patient day was \$126 nationally.

Box 12.31 Average cost for community-based residential care

'Average cost for community-based residential care' is defined as the cost of providing community-based residential care per patient day.

A low average cost can indicate efficiency, although caution must be used because the average cost does not provide any information on the quality of service provided.

These data are likely to be affected by institutional changes occurring as a result of the NMHS (for example, a shift to the delivery of services in mainstream settings). In addition, differences across jurisdictions in the types of patient admitted to community residential care affect average costs in these facilities. Average recurrent costs to government per patient day for these services are reported for both the care of adults and the care of older people. The distinction is made to reflect the differing unit costs of treating the two groups.

Data reported for this indicator are not directly comparable.

For jurisdictions that had community-based older persons' care units in 2006-07, the average recurrent cost to government per patient day for 24 hour staffed community residential services was \$297 nationally (table 12.11).

Table 12.11 Average recurrent cost to government per patient day for community residential services, 2006-07^{a, b}

	NSW	Vic	Qld ^c	WA	SA	Tas	ACT	NT	Aust
General adult units									
24 hour staffed units	269	421	..	400	203	296	499	..	368
Non-24 hour staffed units	82	151	..	130	270	..	106	242	126
Older persons' care units									
24 hour staffed units	352	280	..	..	..	437	163	..	297
Non-24 hour staffed units	280	516	..	..	..	..	..	..	345

^a Depreciation is excluded. ^b 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). ^c Queensland does not fund community residential services, although it funds a number of campus-based and non-campus-based extended treatment services. .. Not applicable.

Source: AIHW (unpublished), derived from the *MHE NMDS*; table 12A.53.

Efficiency — average cost for ambulatory care

'Average cost for ambulatory care' is an indicator of governments' objective that mental health services be delivered in an efficient manner (box 12.32).

Box 12.32 Average cost for ambulatory care

'Average cost for ambulatory care' 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.

Data reported for this indicator are not directly comparable.

Unit costs (dollars per treated patient in the community) for 2006-07 are reported for all states and territories. However, this indicator is considered to be of insufficient quality for use in any form of comparative analysis across jurisdictions for a number of reasons. First, information about service costs across jurisdictions is incomplete or inconsistent (for example, depreciation is not measured consistently across states and territories). Second, the absence of unique patient identifiers in many jurisdictions means clients who use mental health services other than their usual service may be counted twice. This double counting may artificially reduce average costs in some states or territories. Victoria, WA, the ACT and the NT have statewide systems of unique identifiers, so the potential for overcounting of patients in these jurisdictions is relatively low compared with that in other jurisdictions. Third, differences across jurisdictions in the complexity of cases treated, the service options available for treatment and the admission practices adopted reduce the comparability of data across states and territories.

- NSW reported ambulatory care unit costs of \$1552 per treated patient in the community in 2006-07, with 3.9 per cent of services (accounting for 1.4 per cent of expenditure) not reporting (table 12A.54).
- Victoria reported ambulatory care unit costs of \$4772, with 10.7 per cent of services (accounting for 1.8 per cent of expenditure) not reporting (table 12A.55).
- Queensland reported ambulatory care unit costs of \$2366, with all services reporting (table 12A.56).
- WA reported ambulatory care unit costs of \$2936, with all services reporting (table 12A.57).
- SA reported ambulatory care unit costs of \$1690, with 2.4 per cent of services (accounting for 1.4 per cent of expenditure) not reporting (table 12A.58).

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- Tasmania reported ambulatory care unit costs of \$2854 with 4.8 per cent of services (accounting for 0.7 per cent of expenditure) not reporting (table 12A.59).
 - The ACT reported ambulatory care unit costs of \$2554, with all services reporting (table 12A.60).
 - The NT reported ambulatory care unit costs of \$2715, with all services reporting (table 12A.61).
 - Across Australia, average ambulatory care unit costs per treated patient in the community were \$2308, with 4.7 per cent of services (accounting for 1.0 per cent of expenditure) not reporting (table 12A.62).

Outcomes

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

The output indicators reported above have focussed on State and Territory governments' funded specialised mental health services. The outcome indicators identified and/or reported here are not direct measures of the outcomes for people who access these services. The outcomes identified and/or reported here tend to reflect the performance of governments (including the mental health sector) against the broad objectives of the NMHS.

The *National Mental Health Plan 2003—2008* notes that most of the risk and protective factors for mental health problems, mental illness and suicide lie outside the ambit of mental health services, in sectors that impact on the daily lives of individuals and communities (Australian Health Ministers 2003). Changes to these factors usually require long-term sustained efforts across many sectors of the community and government, and cannot be achieved by the mental health sector alone. The Plan identifies that the mental health sector must form partnerships with other sectors in order to develop successful interventions that favourably shift risk and protective factors (Australian Health Ministers 2003).

Prevalence of mental illnesses

'Prevalence of mental illnesses' is an indicator of governments' objective under the NMHS to prevent and reduce mental health problems where possible (box 12.33). Not all mental illnesses are preventable and a reduction of impact of symptoms and a good quality of life will be a good outcome for many people with a mental illness.

Box 12.33 Prevalence of mental illnesses

'Prevalence of mental illnesses' is defined as the proportion of the total population who have a mental illness. Data on the prevalence of selected mental illnesses are available from the ABS 2007 Survey of Mental Health and Wellbeing and are reported in the profile section. They are not reported as an indicator as the Survey is conducted infrequently and is designed to provide reliable estimates only at the national level (for the smaller states and the territories data are subject to large standard errors). Data are available for the states with larger populations.

Data for this indicator were not available for the 2009 Report (see above paragraph).

Mortality due to suicide

'Mortality due to suicide' is an indicator of governments' objective under the NMHS to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk (box 12.34). People with a mental illness 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.)

Box 12.34 Mortality due to suicide

Mortality due to suicide' is defined as the suicide rate per 100 000 people for all people, for males and females, for people of different ages (including those aged 15–24 years), people living in capital cities, people living in other urban areas, people living in rural areas and Indigenous people.

While the performance of mental health services contributes to reducing suicides, 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 severe 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 12.34 (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.

Data reported for this indicator are comparable.

A number of factors impact on the quality of suicide data.

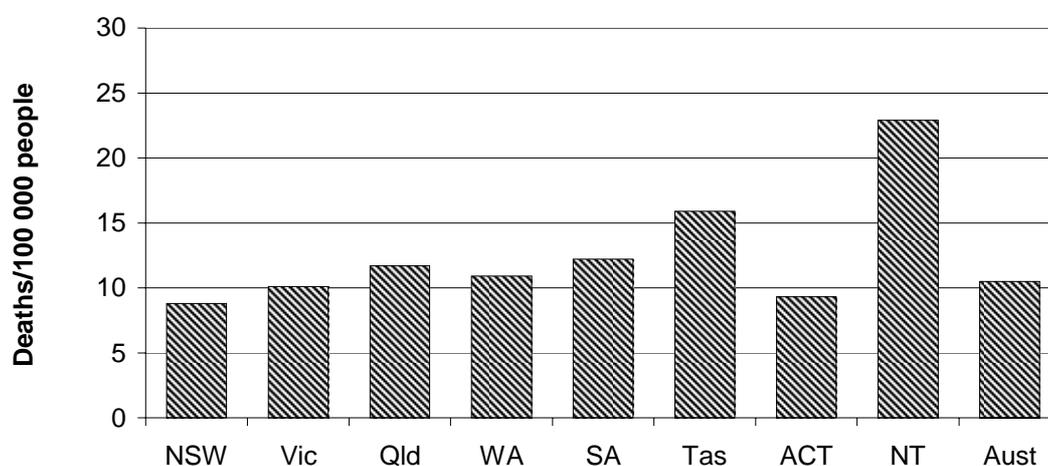
- Coroners may take different approaches to the determination of intent. Determination of intent of a death relates to whether the death results from intentional self harm, accident, homicide or undetermined intent.
 - In general, coroners may be reluctant to determine suicidal intent (particularly in children and young people). In some cases, no statement of intent will be made by a coroner (ABS 2007).
 - For deaths where it is difficult to determine suicidal intent (for example, single vehicle accidents or drownings), the burden of proof needed for the coroner to establish that the death was suicide may make a finding of suicide less likely (ABS 2007).
- Incomplete information is available on the National Coronial Information System when the ABS compiles the *Causes of Deaths* data (ABS 2007).
 - Not all coronial cases are finalised (that is, closed) when *Causes of Deaths* data are compiled. In order to classify a death as suicide (intentional self-harm) specific documentation from a medical or legal authority need to be available regarding the self-inflicted nature and suicidal intent of the incident. If this is not available, then the death must be classified as accidental. The case generally needs to be closed to code a suicide as such, unless there is conclusive information in the police report or the autopsy report to show that the death was intentional (ABS 2007). Any reported decline in the number of deaths due to suicide, therefore, may reflect an increase in open coroners' cases when the statistics were finalised.

In the period 2002–2006, 10 533 deaths by suicide were recorded in Australia (table 12A.65) — equivalent to 10.5 deaths per 100 000 people (figure 12.40). The rate for males (16.5 per 100 000 males) was almost four times that for females

(4.5 per 100 000 females) in that period — a ratio that was relatively constant over all age groups, except for those aged over 85 years where the male suicide rate was over eight times the female rate (figure 12.41). Table 12A.66 shows suicide death rates per 100 000 people aged 15–24 years for all states and territories.

Nationally the suicide rate in the period 2002–2006 was higher in rural areas. There were 9.5 suicides per 100 000 people in capital cities and 10.9 suicides per 100 000 people in other urban areas, compared with 13.5 suicides per 100 000 people in rural areas in Australia (figure 12.42).

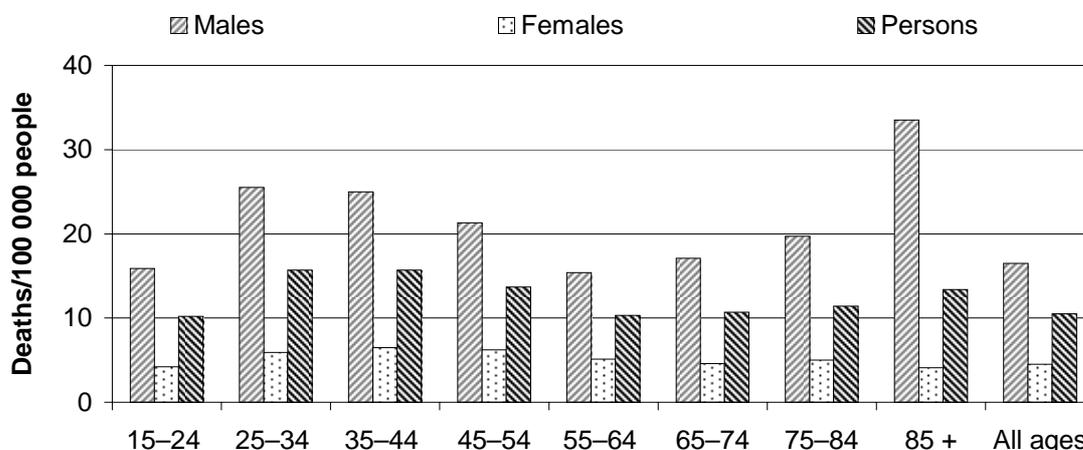
Figure 12.40 **Suicide rates, 2002–2006^{a, b}**



^a By year of registration of death. Year-to-year variation can be influenced by coronial workloads. ^b The death rate is age standardised to the mid-year 2001 population.

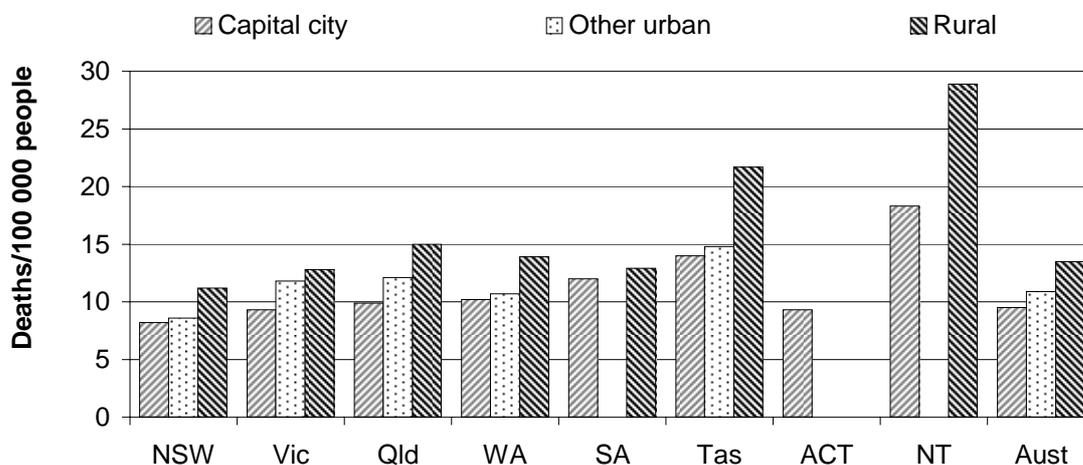
Source: ABS (unpublished), derived from *Causes of Deaths, Australia*; Cat. no. 3303.0; table 12A.65.

Figure 12.41 Suicide rates, by age and gender, 2002–2006^{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 Age specific death rates are calculated as the number of suicides for an age group per 100 000 population in the same age group, for the period 2002–2006.
 Source: ABS (unpublished), derived from *Causes of Deaths, Australia*; Cat. no. 3303.0; table 12A.64.

Figure 12.42 Suicide rates, by area, 2002–2006^{a, b, c, d}



^a Area categories are defined as follows: ‘capital cities’ — comprising capital city statistical divisions; ‘urban centres’ — based on ‘statistical districts’ that are urban centres with population >25 000 people, excluding capital city statistical divisions, (three statistical districts cross state boundaries and have to be split across the relevant states/territories — Albury–Wodonga, Canberra–Queanbeyan and Gold Coast–Tweed); ‘rural’ — balance of State, that is all areas other than capital cities and urban centres. ^b Death rate is age standardised to the mid-year 2001 population. ^c By year of registration of death. ^d SA, the ACT and the NT do not have any ‘other urban’ areas. The ACT does not have ‘rural’ areas.

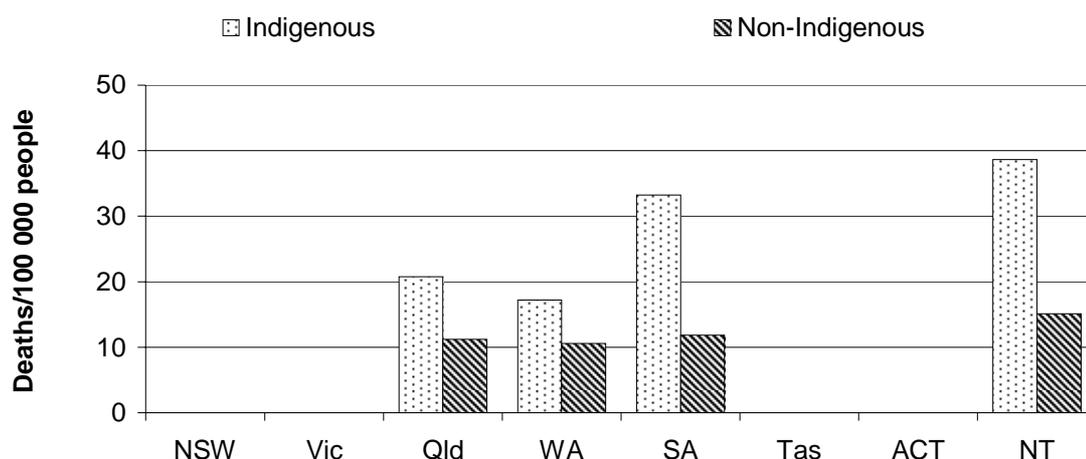
Source: ABS (unpublished), derived from *Causes of Deaths, Australia*; Cat. no. 3303.0; table 12A.67.

Tables 12A.63 and 12A.65–67 contain single year time series suicide data.

The Indigenous suicide rate is presented for the period 2002–2006 for four jurisdictions: Queensland, WA, SA and the NT (figure 12.43). After adjusting for age differences between populations, the suicide rates for Indigenous people for the period 2002–2006 in the jurisdictions for which data are presented are considerably higher than the corresponding rates for non-Indigenous people.

Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some jurisdictions are not published. Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions. The ‘Health preface’ discusses the quality of Indigenous mortality and other data.

Figure 12.43 **Suicide rates, by Indigenous status, 2002–2006^{a, b}**



^a Indigenous population figures are based on ABS *Experimental Projections, Aboriginal and Torres Strait Islander Australians* (low series, 2001 base). There are no comparable population data for the non-Indigenous population. The non-Indigenous population figures are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care. Rates are calculated on an age standardised basis. ^b Data for NSW, Victoria, Tasmania and the ACT are not reported due to varying coverage across states and territories in the identification of Indigenous deaths in death registrations.

Source: ABS (unpublished), derived from *Causes of Deaths, Australia*; Cat. no. 3303.0; table 12A.68.

Quality of life

‘Quality of life’ is an indicator of governments’ objective to prevent and reduce mental health problems so as to improve the quality of life for people with a mental illness (box 12.35).

Box 12.35 Quality of life

'Quality of life' is yet to be defined.

Data for this indicator were not available for the 2009 Report.

12.5 Future directions in performance reporting

Reform of Specific Purpose Payments

In December 2007, the Council of Australian Governments (COAG) agreed to reform Specific Purpose Payments (SPPs). SPPs are financial agreements between the Australian Government and State and Territory governments involving a contribution by the Australian Government to the funding of services which are considered a joint Australian and State and Territory government responsibility. The Australian Health Care Agreement was such an SPP.

At its 29 November 2008 meeting, COAG agreed to six new National Agreements, five of which are associated with a National SPP. In the area of Health and Ageing, there is a National Health Care Agreement associated with the National Health Care SPP (COAG November 2008). Under the reforms, the National Health Care Agreement contains the objectives, outcomes, outputs and performance indicators for Health and Ageing services. The performance of governments in achieving these mutually agreed outcomes will be assessed by the COAG Reform Council (CRC). The Steering Committee has been requested by COAG to provide the SPP performance information to the CRC (COAG July 2008).

The National Agreements/SPPs will be supplemented by a range of National Partnerships (NPs): project, facilitation and reward agreements. Funding for NPs may be conditional on states and territories meeting agreed milestones and performance benchmarks.

The Steering Committee and the Health Working Group will ensure that reporting in this chapter reflects the COAG priorities identified in the National Health Care Agreement, National Health Care SPP and relevant NPs.

Breast cancer

Key challenges for improving reporting of breast cancer include:

- expanding reporting on intervention and treatment and overall performance
- further developing indicators of outcomes
- improving the measurement and comparability of existing indicators.

Existing performance data for breast cancer management place more emphasis on the performance of State and Territory BreastScreen Australia programs than on the treatment and ongoing management of breast cancer. This emphasis is largely due to the relative availability of breast cancer screening data across jurisdictions. The Steering Committee aims to expand reporting to incorporate treatment and clinical outcomes data.

An evaluation of BreastScreen Australia is currently underway. The evaluation will address ongoing and emerging issues affecting the program, and identify opportunities for overall improvement. The evaluation is expected to be completed in 2009. The evaluation will examine benefits of the Program in terms of reduction in breast cancer death rates as well as risks associated with screening. It will consider overarching policy issues such as age range, screening interval and the appropriate management of women at higher risk of breast cancer. The evaluation will also consider the evidence for and use of new technologies, including capacity and workforce issues and will review the current governance and management structures, including the reporting and funding arrangements. The Steering Committee will draw upon this evaluation in the future development of indicators for this report.

Mental health

Key challenges for improving the reporting of mental health management are similar to those of previous years:

- improving the reporting of effectiveness and efficiency indicators for Indigenous, rural/remote and other special needs groups
- revising the performance indicator framework to 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. Further work is required to develop indicators and data collections in the areas of safety and responsiveness of services. This will then provide data covering all the domains of the National Health Performance Framework. Further information can be found in National Mental Health Working Group Information Strategy Committee Performance Indicator Drafting Group (2005).

12.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this section of the Report. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status).

Australian Government comments

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Through the Council of Australian Governments (COAG), the Commonwealth, states and territories are working together to develop initiatives in priority health reform areas. A collaborative reform agenda is being developed across a range of areas, including Indigenous health, hospital reform and the health workforce, and prevention for further COAG consideration.

COAG is overseeing major reform of Commonwealth/State financial arrangements replacing a large number of specific purpose payments with a single intergovernmental agreement and establishment of a new health agreement with a new accountability framework. The new framework will identify a number of performance indicators enabling different services across jurisdictions to be compared and to provide decision makers and administrators with better data for funding and policy decisions. COAG will consider funding arrangements for the new health agreement at the end of 2008.

Jurisdictions are reviewing roles and responsibilities of respective levels of government for aged care and disability services as well as certain mental health services.

The Australian Government has also established a National Health and Hospitals Reform Commission to develop a long-term health reform plan for a modern Australia.

Australian Government funding commitments in the 2008 Budget will contribute to further reforms of the health system. These include:

- a \$10 billion Health and Hospitals Fund to support national health infrastructure;
- \$600 million over four years to states and territories for the Elective Surgery Waiting List Reduction Plan; and
- funding of up to \$275 million, for GP Super Clinics, will be rolled out progressively over the next 5 years from 2007-08.

A National Preventative Health Taskforce has provided the Australian Government with advice on the framework for the Preventative Health Partnerships between it and the States and Territories. The taskforce is developing a strategy to tackle the burden of disease in areas of obesity, alcohol and tobacco use.

Work is progressing on a National Primary Health Care Strategy, to be presented to the Minister for Health and Ageing in mid-2009. The Strategy is expected to deliver better frontline care to families across Australia.

Following the Prime Minister's apology to Australia's Indigenous Peoples earlier this year, particular emphasis is on reducing the 17 year gap in life expectancy between the Indigenous peoples and other Australians. The Australian Government will invest \$3.1 billion in Indigenous health over the next four years.

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New South Wales Government comments

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The NSW Health system faces many challenges in providing quality health services for the people of New South Wales, no matter where they live in the state. These challenges include an ageing population, providing care for the chronically ill, delivering a sustainable workforce, providing better services for those with mental illness, meeting the rise in demand for services and increasing costs of medical technology.

In response to these challenges, the NSW health system developed the State Health Plan — Towards 2010, which sets seven strategic directions for the future and clearly lays out the health priorities during this time. These priorities form an integral part of the NSW Government's State Plan, with NSW Health being the lead agency for achieving five of these:

- improved access to quality health care
- improved survival rates and quality of life for people with potentially fatal or chronic illness through improvements in health care
- improved health through reduced obesity, smoking, illicit drug use and risk drinking
- improved outcomes in mental health
- reduced avoidable hospital admissions.

The seven strategic directions identified in the NSW State Health Plan are:

- make prevention everybody's business
- create better experiences for people using the health system
- strengthen primary health and continuing care in the community
- build regional partnerships for health
- make smart choices about the costs and benefits of health and health support services
- build a sustainable health workforce
- be ready for new risks and opportunities.

Together these priorities and strategic directions will help guide the development and implementation of strategies to ensure the provision of high quality services to the population of NSW.

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Victorian Government comments

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The Victorian Government strives to provide high quality, accessible health services to protect the health of Victorians and continues to support the ongoing development and monitoring of performance indicators in the Report on Government Services.

Increases in demand for services comes from many factors including a growing population, its relative ageing, and the increasing variety of treatment modalities made possible by new technology.

Funding has been provided in 2008-09 to meet systemic growth in new patient demand (including maternity services) by increasing the capacity of health services. Additional funding has also been provided in 2008-09 to increase perinatal support and enable a comprehensive statewide approach to identification of and responses to mental health problems among new parents as part of a new national program.

A focus has been placed on elective surgery activity and reducing long waits for patients. A commitment to addressing demand for elective surgery has been made through substantial funding in addition to the contribution made by the Commonwealth Government as part of the Elective Surgery Waiting List Reduction Plan.

The Victorian Government released a consultation paper during 2008 on reforming the State's mental health system, *Because Mental Health Matters*. The proposals set out in the paper aim to guide the development of the State's mental health service system over the next 10 years, including improving the accessibility of services, expanding prevention and early intervention services, reforming system governance and strengthening the focus on client and service system outcomes. A commitment to develop and report on a wider range of system performance and outcome measures has also been made.

Victoria is developing its community based primary health care services with a greater emphasis on area based planning. This should facilitate better service planning and population health actions such as the delivery of integrated care for those with chronic and complex conditions, and assist in reaching vulnerable populations particularly indigenous groups, refugees and those with the poorest health status. These services will be underpinned by the self-management of health and wellbeing needs, while ensuring that tertiary services are high quality, are accessible in a timely way, and are linked with community based services at the critical stages of entry to or exit from tertiary level care. The focus is on tackling cancer and addressing the rising prevalence of chronic diseases such as diabetes.

The challenge is also to continue to deliver world-class public hospitals, to keep reducing waiting times and be innovative in the way we deliver services and connect with other health services in the community.

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Queensland Government comments

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The Queensland Government's plan for Tomorrow's Queensland — Q2 — sets long-term targets to achieve its ambition of making Queenslanders Australia's healthiest people by 2020. Through Q2, Queensland Health is implementing strategies to meet targets of cutting by one-third obesity, smoking, heavy drinking and unsafe sun exposure; and achieving the shortest public hospital waiting times in Australia.

Queensland hospital emergency department attendances have increased by 5.8 per cent and hospital admissions by 5.9 per cent over the past 12 months, in part due to an ageing population and a shortage of General Practitioners. However, Queensland has successfully reduced the waiting times for elective surgery to the best in the nation and in 2008-09 will introduce a Whole-of-Hospital Plan to further reduce Emergency Department and hospital admission waiting times.

In addition to reducing obesity, smoking, heavy drinking and unsafe sun exposure and public hospital waiting times, the Queensland Government through *Making Queenslanders Australia's Healthiest People: Advancing Health Action*, has set the following additional targets to address the key challenges impacting on the health system in Queensland:

- provide access to quality, best practice maternity and early childhood services for Queensland mothers no matter where they live
- provide accessible public health services for all Queenslanders living with a severe mental illness
- close the gap in health outcomes for Indigenous, and rural and remote Queenslanders.

The Queensland Government's \$10 billion Health Action Plan: Building a better health service for Queensland, which commenced in 2005, has laid the foundation for a better public health system. Halfway into the plan, Queensland Health now employs an extra 5834 nurses, 1675 doctors and 2030 allied health workers, including radiographers, physiotherapists, speech therapists and dieticians.

In 2008-09, the Queensland Health budget will grow to \$8.3 billion, an increase of 16.8 per cent on last year's budget, including \$114.7 million in new recurrent funding and \$330.9 million in additional capital funding.

In 2008-09, significant investment in hospital redevelopments will continue including the new Gold Coast University Hospital, Sunshine Coast Hospital, the Queensland Children's Hospital and facilities in Cairns, Mackay and Mt Isa.

In August 2008, Queensland Health announced a restructure that will remove a layer of bureaucracy and deliver more services, strengthening accountability for managers and redirecting savings of at least \$5 million to patient care.

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Western Australian Government comments

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The WA Department of Health is committed to ensuring healthier, longer and better lives for all Western Australians, through the provision of a safe, high quality, accountable and sustainable health care system. In 2007-08 significant progress has been made in our six priority areas.

Healthy Workforce — A number of initiatives to boost the skills and sustainability of the health workforce were introduced. These include attraction of experienced nurses back into the profession, training for the Assistant in Nursing role and a pilot program of community residencies for junior doctors. In 2008, a record 586 new registered nursing graduates commenced with WA Health — an increase of 110 on the 2007 recruitment year.

Healthy Hospitals, Health Services and Infrastructure — The major program of infrastructure development and improvement continued. Projects completed include the new State Major Trauma Unit at Royal Perth Hospital, Fitzroy Crossing Hospital, Morawa Health Centre and construction of supported, community-based mental health accommodation at five sites across WA.

Healthy Partnerships — Innovative partnerships are being developed with NGOs, private sector providers, community groups and other government agencies to improve service delivery, boost research and development and maximise capital investment. Significant developments were made in 2007-08 in areas including genomics and Aboriginal health.

Healthy Communities — WA Health has continued to work towards improving lifestyles, preventing ill-health and implementing long term, integrated health promotion campaigns. Initiatives have been established to combat childhood obesity, and perinatal and postnatal depression. The Department also implemented the Australian Better Health Initiative at several WA locations and established licensing infrastructure for tobacco retailers and wholesalers.

Healthy Resources — The Department continues to deliver robust resource administration, planning and management practices to oversee and support the area health services. Advances in 2007-08 included upgrades to emergency communication facilities at rural hospitals and installation of video-conferencing equipment to allow the expansion of tele-psychiatry services in an additional 58 centres across WA.

Healthy Leadership — The Institute for Healthy Leadership was established in July 2007 and has commissioned a number of programs to develop WA Health's future leaders. These include the Emerging Leaders Development Program and the Delivering the Future Leadership Development Program, which target senior managers and potential future directors and executive directors and provide high-level leadership training. Nine graduate officers were recruited and commenced with WA Health in February 2008.

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South Australian Government comments

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The South Australian Government released its Health Care Plan in June 2007, announcing a major step toward providing this State with one of the most integrated health systems in Australia. The Plan outlines the most significant single investment in health care in South Australia's history. The Government will build the 800-bed Marjorie Jackson-Nelson Hospital, a state-of-the-art facility in Adelaide's city centre, that will become Australia's most advanced hospital. The 10-year plan also proposes new investment in other major hospitals, promotes healthy lifestyles and illness prevention through new GP Plus Health Care Centres, and aims to make South Australia the best place for health professionals to work.

SA Health has progressed toward achieving a number of key objectives. These objectives relate to improvements in health infrastructure, programs and services, changes in health system governance and setting an agenda for health research as part of an integrated strategy to reform SA's health care system.

Engaging in governance reform has been a critical part of SA Health's agenda with the implementation of the *Health Care Act 2008* on 1 July 2008. This legislation has provided for a restructure of the governance arrangements of SA Health, as well as providing for the creation of South Australia's Health Performance Council and a range of Health Advisory Councils that will play an important role in providing advice to the Government of South Australia on health care needs and priorities.

In the 2007-08 financial year, \$154.4 million was spent on redeveloping hospital and health service infrastructure. This includes the development of a preliminary master plan for the Marjorie Jackson-Nelson Hospital, the Stage B Lyell McEwin Hospital Redevelopment to provide new inpatient accommodation and extend support facilities, progress on the redevelopment of both The Queen Elizabeth Hospital and Flinders Medical Centre, as well as the refurbishment of existing wards at the Royal Adelaide Hospital.

The release of the Glenside Campus Master Plan has been a significant step towards SA Health's goal of reforming mental health care in South Australia. New facilities will be integrated with public open spaces and cultural and commercial precincts.

Another significant step in the area of mental health care was the release of a draft Mental Health Bill for consultation. The Bill sets out a number of positive changes to improve the existing *Mental Health Act 1993* and reflects national and international obligations for the protection of persons with a mental illness. Feedback on the Bill was received and incorporated into the development of the Mental Health Bill 2008, which will be debated in Parliament.

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Tasmanian Government comments

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The Tasmanian Government is building a health and human services system that will withstand the heavy demands of coming decades, including the future impact of demographic change, and provide the care and assistance Tasmanians need. The Government's reform agenda is vital to the future health and wellbeing of the Tasmanian Community. It includes putting *Tasmania's Health Plan* into action and implementing evidence-based changes to children and family services, disability services and housing, with the aim of increasing social inclusion and improving health and social outcomes in the State.

Implementation of *Tasmania's Health Plan* involves more than 100 projects, many of which will be put in place during the next two years and others within five years. Information about the implementation of projects is available through the *Tasmania's Health Plan* internet site (www.dhhs.tas.gov.au/thp).

The Service Capability Framework will develop and establish standard governance, funding and accountability arrangements for regional and state-wide services. The Tasmanian Clinical Advisory Council is being established to oversee all of the Statewide Clinical Networks that are being developed.

Planning is now well underway for the new Royal Hobart Hospital which will support the sustainable delivery of contemporary acute services and be flexible in its response to future health needs. Other initiatives for 2009 include additional nurses in acute care hospitals, developing and implementing *Tasmania's Elective Surgery Improvement Plan*, improving health information technology for better patient care, implementing a series of capital investment projects and improving access and service provision for acute patient transport and medical retrieval.

Oral Health Services will continue to implement the Better Dental Care Package with the further recruitment of dentists and the construction of dental units within acute hospitals in all regions of Tasmania. There will also be further development of the client information management system enabling enhanced reporting of both service activity and health indicators.

The *Mental Health Services Strategic Plan 2006–11* continues to lead service reform, including the introduction of an assertive case management model and a focus on working in partnership with others to address the mental health needs of Tasmania's population. Better service integration will result from a realignment of services: Mental Health Services now incorporates alcohol and drug, correctional primary health and forensic mental health services. In responding to alcohol and drug use in Tasmania, the State Government has allocated significant additional funding to alcohol, tobacco and other drug service reform over the next four years.

BreastScreen Tasmania is experiencing the impact of the ageing population which increases the size of its target group. Against a background of workforce shortages, there has been a decrease in the actual number of women screened for this reporting period as well as declining participation in recent years.

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Australian Capital Territory Government comments

“ The ACT Government provides health services to local residents through two major hospitals: The Canberra Hospital and Calvary Public Hospital (via a contractual agreement with the Little Company of Mary Health Care ACT). These public hospitals provide the full range of acute care, including inpatient, outpatient and emergency department services. Both hospitals are teaching hospitals in cooperation with the Australian National University’s Medical School and University of Canberra. The Canberra Hospital is the major trauma referral hospital for the ACT and surrounding of NSW with a quarter of public hospital separations were residents of New South Wales.

In 2006, ACT Health published its *Corporate Plan 2006–2010* which covers all the areas administered by ACT Health. It brings together into one central document the portfolio’s key performance areas as well as its performance measures. The Plan clarifies the overall direction for ACT Health’s operation and facilitates a simplified reporting structure.

The year 2006-07 demonstrated that ACT public hospitals have made considerable strides in working to meet the ACT Government’s objectives of reducing the ACT’s average cost of hospital services to within 10 per cent of the national average. The ACT’s 2005-06 average cost of about 15 per cent above the national average has been reduced to 13 per cent above the national average. At the same time considerable additional investment in elective surgery has improved access to surgery for people with extended waiting times, while also ensuring that those patient with more urgent clinical needs are seen on time. The increase in the median waiting time (days waited at 50th percentile) for people admitted to surgery in 2006-07 — up to 63 days from 61 days in 2005-06 — is a further demonstration of the effectiveness of the ACT Government’s strategy to address the number of people waiting longer than standard waiting times for a surgery. As ACT Health provides additional surgery for people who are waiting long time for a surgery — the reported median waiting time for all patients will increase.

As part of ACT Health’s commitment to provide service models that improve the patient’s journey from acute care, post-acute care, rehabilitation and community-based follow up, during 2006-07 ACT Health commissioned a 60-bed Old Persons Unit at Calvary. This unit incorporates an Older Persons Mental Health Unit and sub-acute rehabilitation and geriatric medicine units.

Continuous improvement in the quality of our health services is a high priority for ACT Health. In 2006-07 each of our clinical divisions (TCH, Calvary Public Hospital, Community Health, Mental Health, the Aged Care Rehabilitation Service and the Capital Region Cancer Service) underwent its respective accreditation phase under the Australian Council on Healthcare Standards. The outcome is that all of our services remain fully accredited with ACHS. ACT Health’s corporate office also underwent accreditation and received full accreditation status. From November 2006, ACT Health is pursuing accreditation as a single entity, rather than on a division-by-division basis.”

Northern Territory Government comments

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The Department of Health and Families (DHF), is the major provider and funding source for hospital and community services as well as a substantial portion of primary care in the Territory. Service integration is integral to providing coordinated care between public hospitals and a network of 104 government and non government community health centres. The NT population is 215 000, a third of whom are Indigenous.

There are five public hospitals located in each of the major population centres of Darwin, Nhulunbuy, Katherine, Tennant Creek and Alice Springs and inpatient mental health services in Darwin and Alice Springs. The public hospitals provide 694 inpatient beds and work closely with the one private hospital in the NT to meet demand for hospital beds. Smaller regional hospitals and the larger Royal Darwin and Alice Springs Hospitals form a network to ensure the full range of medical services are available to people living across the Territory and remote areas. Each hospital retains their local identity but is able to share resources within the network. Movement of people to access medical care is supported by expansion of the Shared Electronic Health records service and specialist health access programs for travel to hospital, between hospitals and interstate when required.

‘Closing the Gap of Indigenous Disadvantage: A Generational Plan of Action’ is the NT Government’s plan of action to overcome Indigenous disadvantage. A key action to close the gap is training and employment of Aboriginal Health Workers. The Department has launched a Cultural Security policy to embed cultural competency into workplace practises.

Prevention of illness and early intervention to maintain healthy Territorians are catered for through mental health and community health services delivered across the Territory. These services include: programs for nutrition, physical activity, preventable chronic disease, women’s health, hearing, children/youth, home birth, breast screening, injury prevention, immunisation and community mental health.

The NT is faced with increasing demand on health services, a significant gap in life expectancy between indigenous people and other Territorians and health systems requiring ongoing reforms to manage finite resources. Strategies that have emerged to meet these challenges include the Rapid Admission and Planning Unit, Chronic Disease Strategy, Mental Health Action Plan and the use of electronic health records. Workforce issues related to recruitment and retention due to chronic shortages of health workers are a major challenge with strategies such as redefining roles between doctors and nurses occurring.

Legislative reform can support better provision of health services. The *Care and Protection of Children Act 2007* provides improved and better coordinated child protection services with other agencies operating in the community. In 2008-09, the Department will contribute to the reform of the *NT Liquor Act* and the *Alcohol Court Act* in partnership with other agencies.

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12.7 Definitions of key terms and indicators

AR-DRG v5.1 (Australian refined diagnosis related group, version 5.1)	A patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG v5.1 is based on the ICD-10-AM classification.
Casemix adjustment	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted into diagnosis related groups (AR-DRGs) that represent a class of patients with similar clinical conditions requiring similar hospital services.
General practice	The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients. This definition includes medical practitioners who work solely with one specific population, such as women's health or Indigenous health.
Health management	The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.
Incidence rate	Proportion of the population experiencing a disorder or illness for the first time during a given period (often expressed per 100 000 people).
Separation	An episode of care for an admitted patient, which can be a total hospital stay, or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care.
Breast cancer Breast conserving surgery	An operation to remove the breast cancer but not the breast. Types of breast conserving surgery include lumpectomy (removal of the lump), quadrantectomy (removal of one quarter of the breast) and segmental mastectomy (removal of the cancer as well as some of the breast tissue around the tumour and the lining over the chest muscles below the tumour).
Cost per woman screened	The total cost of the provision of breast screening services, divided by the number of women screened. The total cost includes the cost of providing the BreastScreen Australia program in each jurisdiction, in addition to the cost of providing the program to women.
Detection rate for small cancers	The rate of small (less than or equal to 15 millimetres) invasive breast cancers detected per 10 000 women screened.
Ductal carcinoma in situ	Abnormal cells that involve only the lining of a duct. The cells have not spread outside the duct to other tissues in the breast. Also known as intraductal carcinoma.
Invasive cancer	A tumour whose cells invade healthy or normal tissue.
Modified radical mastectomy	Surgery for breast cancer in which the breast, some of the lymph nodes under the arm, the lining over the chest muscles, and sometimes part of the chest wall muscles are removed.
Mortality rate from breast cancer	The age-specific and age standardised mortality rates of women who die as a result of breast cancer, expressed per 100 000 women in the population.

Participation	The number of women resident in the catchment area screened, divided by the number of women resident in the catchment area, expressed as a percentage. If a woman is screened more than once during the reference period, then only the first screen is counted. Catchment area is a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or statistical local area.
Radiation therapy	The use of high energy radiation from X-rays, gamma rays, neutrons, and other sources to kill cancer cells and shrink tumours. Radiation may come from a machine outside the body (external beam radiation therapy) or from materials called radioisotopes. Radioisotopes produce radiation and can be placed in or near the tumour or in the area near cancer cells. This type of radiation treatment is called internal radiation therapy, implant radiation, interstitial radiation or brachytherapy. Systemic radiation therapy uses a radioactive substance (such as a radiolabelled monoclonal antibody) that circulates throughout the body.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than otherwise would be the case.
Screening round (first)	A woman's first visit to a BreastScreen Australia mammography screening service.
Screening round (subsequent)	A woman's visit to a BreastScreen Australia mammography screening service when she has previously attended such a service.
Size of detected cancers	Invasive cancers detected, classified according to tumour size.
Total mastectomy	Removal of the breast — also known as simple mastectomy.

Mental health

Acute services	<p>Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services 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 illness for whom there has been an acute exacerbation of symptoms • target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, and forensic mental health services.
Affective disorders	A mood disturbance, including mania, hypomania, bipolar affective disorder, depression and dysthymia.
Ambulatory care services	Mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted inpatients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.

Anxiety disorders	Feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive–compulsive disorder and post-traumatic stress disorder.
Available beds	<p>The number of immediately available beds for use by admitted patients if required. Beds are immediately available for use if located in a suitable place of care with nursing or other auxiliary staff available within a reasonable period.</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. These services may include a forensic component.
Co-located services	Psychiatric inpatient services established physically and organisationally as part of a general hospital.
Community-based residential services	Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must: provide residential care to people with mental illnesses or psychiatric disability; be located in a community setting external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded.
Co-morbidity	The simultaneous occurrence of two or more illnesses such as depressive illness with anxiety disorder, or depressive disorder with anorexia.
Consumer involvement in decision making	Consumer participation arrangements in public sector mental health service organisations according to the scoring hierarchy (levels 1–4) developed for monitoring State and Territory performance under Medicare Agreements Schedule F1 indicators.
Cost per inpatient bed day	The average patient day cost according to the inpatient type.
Depression	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration may be affected.
Forensic mental health services	Services principally providing assessment, treatment and care of mentally ill individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.
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 older people. Includes, therefore, those services that cannot be described as specialised child and adolescent, older persons' or forensic services.</p> <p>General mental health services include hospital units whose principal function is to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on</p>

	specific clinical disorders within the adult population (for example, post-natal depression, anxiety disorders).
Mental illness	A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness.
Mental health promotion	Actions taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the 'coping' capacity of communities, families and individuals by giving power, knowledge, skills and necessary resources.
Mental illness prevention	Interventions that occur before the initial onset of a illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental illnesses.
Mortality rate from suicide	The percentage of the population who die as a result of suicide.
Non-acute services	<p>Non-acute services are defined in two categories:</p> <ul style="list-style-type: none"> • Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. • Extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.
Non-government organisations	Private not-for-profit community managed organisations that receive State and Territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the non-government organisation sector may include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.
Older persons' mental health services	Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged persons. These services may include a forensic component. Excludes general mental health services that may treat older people as part of a more general service.
Outpatient services — community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in

	community settings, physically separated within hospital sites. They may include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services — hospital-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They may include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Patient days (occupied bed days)	All days or part days for which patient was in hospital during the reporting year (1 July to 30 June), regardless of the original date of admission or discharge. Key definitional rules include the following: <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 illnesses.
Psychiatrist	A medical practitioner with specialist training in psychiatry.
Public health	The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional services.
Schizophrenia	A combination of signs and symptoms that may include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour.
Specialised mental health inpatient services	Services provided to admitted patients in stand-alone psychiatric hospitals or specialised psychiatric units located within general hospitals.
Specialised mental health services	Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds.
Specialised residential services	Services provided in the community that are staffed by mental health professionals on a 24 hour basis.
Staffing categories (mental health)	<i>Medical officers:</i> all medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee-for-service

basis.

Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant state or territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.

Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Other medical officers: medical officers employed or engaged by the organisation who are not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Nursing staff: all categories of registered nurses and enrolled nurses, employed or engaged by the organisation.

Registered nurses: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialised categories of registered nurses.

Enrolled nurses: Refers to persons who are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).

Diagnostic and health professionals: qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, and other diagnostic and health professionals.

Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.

Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.

Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.

Administrative and clerical staff: staff engaged in administrative and clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories. Civil engineers and computing staff are included in this category.

Domestic and other staff: staff involved in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.

Stand-alone psychiatric hospitals

Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus may also be a stand-alone hospital if the following criteria are **not** met:

- a single organisational or management structure covers the acute care hospital and the psychiatric hospital
- a single employer covers the staff of the acute care hospital and the psychiatric hospital
- the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus
- the patients of the psychiatric hospital are regarded as patients of the single integrated health service.

Substance use disorders

Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive, social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug may be psychological (as in substance misuse) or physiological (as in substance dependence).

12.8 Attachment tables

Attachment tables are identified in references throughout this chapter by an '12A' suffix (for example, table 12A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Breast cancer

Table 12A.1	Mortality rates from breast cancer for women, by age
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Table 12A.14	Real cost per woman screened (2007-08 dollars)
Table 12A.15	Scope of activities and expenditure items included in cost per woman screened calculations
Table 12A.16	Breast conserving surgery to mastectomy
Table 12A.17	Selected breast and other cancer AR-DRGs, public sector, population estimated, 2006-07
Table 12A.18	Interval cancer rate for women, by age, per 10 000 women at risk
Table 12A.19	Breast cancer detection rate, by BreastScreen Australia
Table 12A.20	Rate of detection of small diameter (15mm or less) invasive cancers, BreastScreen Australia, all rounds of screening
Table 12A.21	Number of detected invasive cancers, by size and round, women aged over 40 years

Mental health

- Table 12A.22** Prevalence of lifetime mental disorders among adults aged 16–85 years, 2007 (per cent)
- Table 12A.23** Prevalence of lifetime mental disorders among adults aged 16–85 years, by gender, 2007 (per cent)
- Table 12A.24** Prevalence of lifetime mental disorders among adults, by age, 2007 (per cent)
- Table 12A.25** Prevalence of lifetime mental disorders among adults, by region, 2007 (per cent)
- Table 12A.26** Labour force and employment participation among adults aged 16–64 years, by mental disorder status, 2007 (per cent)
- Table 12A.27** Education, training and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent)
- Table 12A.28** Labour force and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent)
- Table 12A.29** Services used for mental health problems, Australia, 2007 (per cent)
- Table 12A.30** Services used for mental health, by mental disorder status, 2007 (per cent)
- Table 12A.31** Real estimated Australian Government expenditure on mental health services (2006-07 dollars) (\$'000)
- Table 12A.32** Real estimated recurrent expenditure at the discretion of State and Territory governments (2006-07 dollars)
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PART F

COMMUNITY SERVICES

F Community services preface

CONTENTS

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Families are the principal providers of care for children, older people and people with a disability (ABS 2001). Community services aim to:

- help families to undertake these roles
- fulfil these roles when families are not in a position to provide care
- provide interventions where individual needs are not able to be met by the community without special intervention.

Community services provide support to sustain and nurture the functioning of individuals, families and groups, to maximise their potential for development and to enhance community wellbeing (LGCSA 2002). Although community services are generally targeted to the individual, they may be delivered at an institutional level. Services are typically provided by government and the not-for-profit sector, but the for-profit sector also has an important role (for example, as owners of aged care facilities). Community services also contribute to the development of community infrastructure to service needs (AIHW 2005).

What are community services?

Although there is a broad understanding of the nature of community services, the sector is complex, and consistent aggregate reporting of the sector across a range of measures is not possible at this time.

Definitions of the sector vary in their scope and can change over time. Community service activities typically include those activities ‘which assist or support members of the community in personal functioning as individuals or as members of the wider

community' (AIHW 1997). They may include financial assistance and relief to people in crisis, and housing assistance of a short term or transitional nature, such as the Supported Accommodation Assistance Program (SAAP). They exclude acute health care services, long term housing assistance and income support (such as social security pensions and allowances). Some of these interventions are included elsewhere in this Report; for example, Public hospitals (chapter 10), Health management issues (chapter 12) and Housing, including Commonwealth Rent Assistance (chapter 16).

In earlier reports, children's services and juvenile justice data were included in the community services section and preface respectively. From the 2008 Report, the Children's services chapter has been moved to the renamed 'Early childhood, education and training' section. Where possible, children's services material previously in the community services preface has been moved to the Early childhood, education and training preface. However, due to the aggregated nature of much of the statistical material used, some 'community services' data will continue to reflect some elements of child care and preschool services. Juvenile justice data have been moved from the Community services preface to the Protection and support services chapter (chapter 15).

The definition of community services activities in this preface is based on the National Classification of Community Services developed by the Australian Institute of Health and Welfare (AIHW 2003) (box F.1). The scope of the preface is therefore somewhat broader than the three service specific chapters in this section of the report (Aged care services, Services for people with a disability, and Protection and support services).

Box F.1 Community services activities

Community services activities include:

Personal and social support — activities that provide support for personal or social functioning in daily life. Such activities promote the development of personal skills for successful functioning as individuals, family members and members of the wider community. Personal and social support activities include the provision of information, advice and referral, personal advocacy, counselling, domestic assistance, provision of services that enable people to remain in their homes, disability services and other personal assistance services. The purpose of such support may be to enable individuals to live and function in their own homes or normal places of residence.

Support for children, families and carers — activities that seek to protect children from abuse and neglect or harm, through statutory intervention and support for families, are also included.

Training, vocational rehabilitation and employment — activities that assist people who are disadvantaged in the labour market by providing training, job search skills, help in finding work, placement and support in open employment or, where appropriate, supported employment.

Financial and material assistance — activities that enhance personal functioning and facilitate access to community services, through the provision of emergency or immediate financial assistance and material goods.

Residential care and supported accommodation — activities provided in special purpose residential facilities, including accommodation in conjunction with other types of support, such as assistance with necessary day-to-day living tasks and intensive forms of care such as nursing care.

Corrective services [in relation to young people and people with intellectual and psychiatric disabilities on court orders] — activities that involve correctional and rehabilitative supervision and the protection of public safety, through corrective arrangements and advice to courts and releasing authorities.^a

Service and community development and support — activities that provide support aimed at articulating and promoting improved social policies; promoting greater public awareness of social issues; developing and supporting community based activities, special interest and cultural groups; and developing and facilitating the delivery of quality community services. Activities include the development of public policy submissions, social planning and social action, the provision of expert advice, coordination, training, staff and volunteer development, and management support to service providers.

^a This Report 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); State and Territory governments (unpublished).

Other definitions of community services have broader scope. The National Community Services Information Agreement, managed by the National Community Services Information Management Group (NCSIMG), includes income support and concessions in its definition (NCSIMG 2008). Other definitions include additional activities such as advocacy, public transport, community safety and emotional support.

Profile of community services

This section examines the size and scope of the community services sector and the role of government in providing community services.

Roles and responsibilities

The Australian, State and Territory governments have a major role in the provision of community services. This role is based on a mandate to ensure basic rights and an acceptable standard of living, and a requirement to protect and support the vulnerable in society. Local governments are also important funders and providers of community services (AIHW 2005). However, community services funded solely by local government are outside the scope of this Report.

Government involvement in community services includes:

- providing services to clients directly
- funding non-government community service providers (which then provide community services to clients)
- legislating for, and regulating of, government and non-government providers
- undertaking policy development and administration
- undertaking evaluation of community services programs.

The provision of community services is complex and the roles of the various tiers of government vary from program to program. Some services are funded solely by the Australian Government, some funded solely by State and Territory governments and some are funded jointly by the Australian, State and Territory governments.

Statutory child protection and placement, and juvenile justice services are primarily provided directly by government, while residential care, accommodation support and other community services activities are primarily provided by non-government organisations.

Disability services funded by government are partially delivered by government. Most of the recurrent funding for aged care services is provided by the Australian Government, whereas for juvenile justice, child protection and disability services, State and Territory governments contribute most of the recurrent funding.

Increasingly, governments at all levels are entering partnerships with non-government organisations. Responsibilities under these partnerships vary considerably depending on the service, and mirror the complexity of the provision of services.

Effective regulation of non-government providers (through licensing, accreditation and quality assurance) enables services to be provided in response to need within an appropriate framework of agreed standards. Examples include the accreditation of residential aged care services and Australian Government quality standards for Home and Community Care (HACC).

Policy development, resource allocation, performance assessment and service provision are key roles of government in the community services context. Requirements for effective service provision in the sector include understanding and responding to changing community expectations and the needs of individuals, meeting complex needs through the development of innovative solutions and case management, and the provision of capacity to meet future demand. Increasingly, governments are working with non-government providers of services to develop and plan service provision.

Expenditure

Community services expenditure

Estimates of community services expenditure are influenced by the scope of the services to be included. The following broad estimates of community services expenditure provide context for material included in the relevant chapters of this Report.

The most recent data on the range of community services expenditures are identified in the AIHW publication *Welfare expenditure Australia 2005-06* (AIHW 2007a). It includes expenditure incurred by governments, non-government organisations and individual households in providing services to assist members of the community with special needs (limited to families and children, older people, people with a disability and other disadvantaged groups).

Welfare expenditure Australia 2005-06 identifies expenditure on welfare services in 2005-06 of \$28.9 billion (\$1404 per person), which represented 3.0 per cent of Gross Domestic Product (GDP) in that year. This expenditure excludes welfare payments. In 1998-99, this expenditure represented 2.9 per cent of GDP. Over this period, the average annual growth in expenditure on these services was similar to the average annual growth of GDP (AIHW 2007a).

Governments were the source of 70.8 per cent of all funding of welfare services in 2005-06 identified by *Welfare expenditure Australia 2005-06*, with the non-government sector providing the remaining 29.2 per cent of funding. Of this 29.2 per cent, households contributed 20.3 per cent and non-government community service organisations contributed the remaining 9.0 per cent (AIHW 2007a).

The most recent Australian Bureau of Statistics (ABS) survey of community services (ABS 2001) identified government and non-government expenditure for the sector in 1999-2000. The scope of this survey included:

- nursing homes
- child care services
- accommodation for the aged
- residential care services not elsewhere classified
- non-residential care services not elsewhere classified
- employment placement services (only organisations supporting people with a disability)
- interest groups not elsewhere classified (only organisations involved in community service advocacy services)
- government administration (only government organisations responsible for funding community services or directly involved in the provision of community services).

Some categories of government expenditure included in this Report were regarded as out-of-scope for the ABS survey. These included expenditure of \$307 million on the Residential Care Subsidy, which was paid to non-community services organisations such as hospitals and allied health organisations, Commonwealth State/Territory Disability Agreement funding of \$180 million paid to organisations providing community nursing services, \$176 million in Child Care Assistance paid to educational organisations such as primary and secondary schools and corporations providing child care in-house, and HACC Program funding of \$148 million, also paid to organisations providing community nursing services (ABS 2001).

In total, ABS identified \$12.6 billion spent on community services and related activities during 1999-2000 (\$11.5 billion excluding child care services). This expenditure included \$10.7 billion of direct community service expenditure (\$9.6 billion excluding child care services). Including direct and indirect expenditure, \$2.1 billion was expended by for-profit organisations, \$7.1 billion by not-for-profit organisations and \$3.4 billion by government organisations. Direct expenditure only, excluding child care services, was \$1.5 billion by for-profit organisations, \$5.6 billion by not-for-profit organisations and \$2.5 billion by government organisations (ABS 2001). The next ABS survey of community services is planned for 2009.

Alternative sources of information on community services expenditure, including national accounts data, will be explored in future reports.

Community services expenditure included in this Report

The following more detailed community services expenditure analysis relates only to the expenditure reported in the community services chapters of this Report (box F.2).

Box F.2 Major programs included in Community services expenditure in the Report

The major programs reported on include:

- aged care services — aged care assessment, residential care and community care programs and HACC
- services for people with a disability — services under the third Commonwealth State/Territory Disability Agreement
- protection and support services — child protection and out-of-home care services.

Each chapter includes more detailed analysis of expenditure items reported.

All recurrent expenditure included in the Report

Total government recurrent expenditure on community services covered by this Report (expenditure by State and Territory governments and the Australian Government) was estimated to be \$16.5 billion in 2007-08 (table F.1). This was equivalent to 1.5 per cent of GDP in that year, and 8.3 per cent of total government outlays (table F.1 and ABS 2008a).

Table F.1 Real government recurrent expenditure on community services (2007-08 dollars)^{a, b, c, d}

	<i>Unit</i>	<i>Aged care services</i>	<i>Services for people with a disability</i>	<i>Protection and support services</i>	<i>Total</i>
2003-04	\$m	7 556.9	3 878.8	1 687.9	13 123.6
2004-05	\$m	7 924.7	4 129.9	1 886.7	13 941.4
2005-06	\$m	8 135.5	4 251.4	2 001.3	14 388.3
2006-07	\$m	8 801.0	4 538.7	2 254.8	15 594.5
2007-08	\$m	9 242.2	4 732.8	2 514.8	16 489.7
Increase 2003-04 to 2007-08	%	22.3	22.0	49.0	25.6

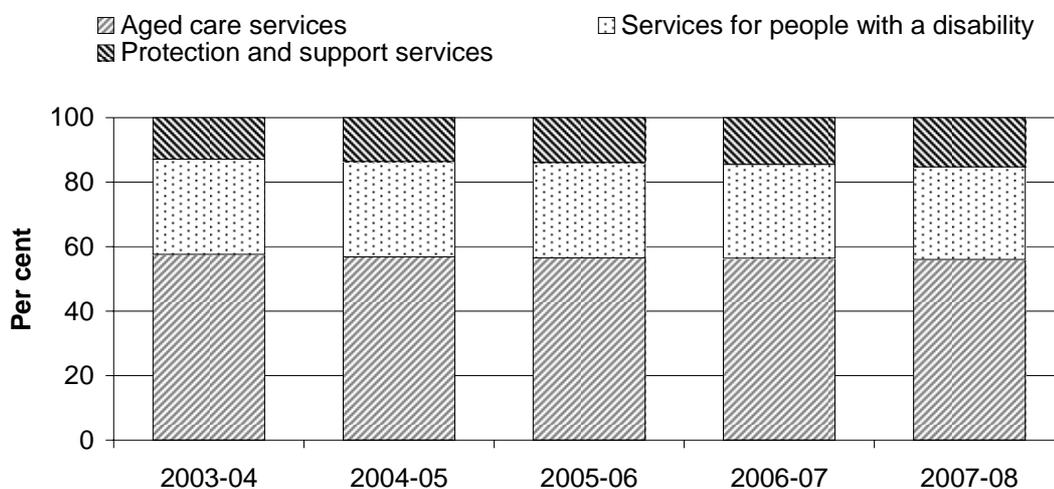
^a Data for 2003-04 to 2006-07 have been adjusted to 2007-08 dollars using the gross domestic product (GDP) price deflator in table AA.26 of appendix A. ^b Data for aged care services published in the 2008, and earlier, reports differ due to revised data and additional expenditure items collected for aged care services in the 2008 and 2009 Reports. ^c Totals may not add as a result of rounding. ^d See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report.

Source: Australian, State and Territory governments (unpublished); tables 13A.44-48, 13A.68-69, 14A.7, 15A.1, 15A.179 and AA.26.

Between 2003-04 and 2007-08, real government recurrent expenditure on community services increased by \$3.4 billion, or 25.6 per cent. The largest proportional increase in real expenditure was on protection and support services, which increased by 49.0 per cent between 2003-04 and 2007-08. The largest absolute dollar increase for a particular service between 2003-04 and 2007-08 was \$1.7 billion for aged care services (table F.1).

In 2007-08, 56.0 per cent of government recurrent expenditure on community services related to aged care services, 28.7 per cent related to services for people with a disability, and 15.3 per cent related to protection and support services. These proportions have been fairly consistent from 2003-04 to 2007-08 (figure F.1).

Figure F.1 **Government recurrent expenditure on community services^{a, b}**



^a Data for aged care published in the 2008, and earlier, reports differ due to revised data and additional expenditure items collected for aged care services in the 2008 and 2009 Reports. ^b See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report.

Source: Australian, State and Territory governments (unpublished); tables 13A.44-48, 13A.68-69, 14A.7, 15A.1 and 15A.179.

Expenditure available for reporting at a State and Territory level

Figure F.2 identifies expenditure on community services included in this Report, by jurisdiction, for 2007-08. This is expenditure by State and Territory governments and Australian Government expenditure available for reporting at the State and Territory level (table F.2 and figure F.2).

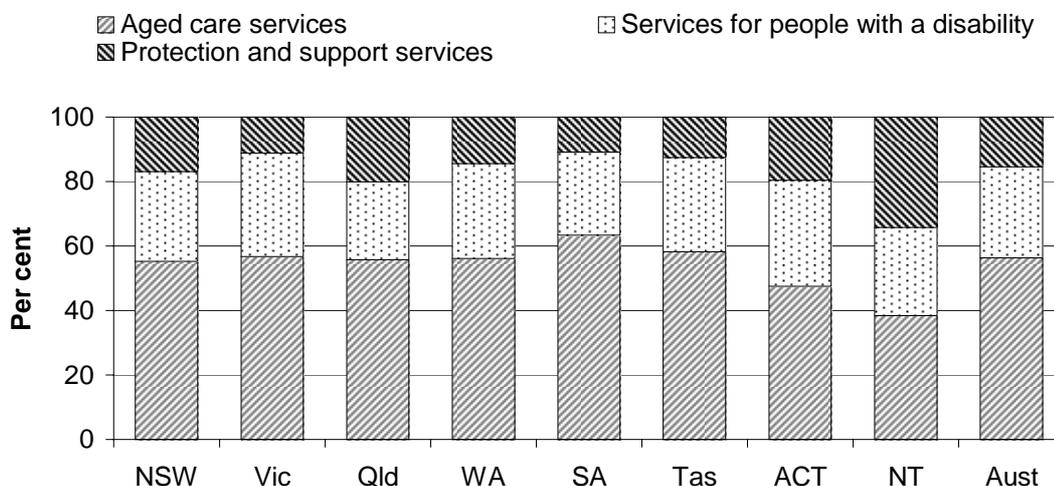
Table F.2 Government recurrent expenditure on community services, 2007-08^{a, b, c, d}

	<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>
Recurrent expenditure on community services										
Aged care services	\$m	3 055.8	2 317.2	1 696.3	790.2	914.0	265.2	104.4	54.7	9 197.6
Services for people with a disability	\$m	1 534.3	1 307.1	735.2	415.0	371.0	132.9	72.0	38.9	4 606.4
Protection and support services	\$m	937.4	457.9	610.4	203.0	156.3	57.4	43.1	48.8	2 514.8
Total	\$m	5 527.5	4 082.1	3 041.9	1 408.2	1 441.3	455.6	219.6	142.5	16 318.9
Proportion of recurrent expenditure by service										
Aged care services	%	55.3	56.8	55.8	56.1	63.4	58.2	47.6	38.4	56.4
Services for people with a disability	%	27.8	32.0	24.2	29.5	25.7	29.2	32.8	27.3	28.2
Protection and support services	%	17.0	11.2	20.1	14.4	10.8	12.6	19.6	34.3	15.4
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Recurrent expenditure on community services per person in the population^e										
Expenditure per person	\$	798.0	778.1	719.4	660.9	905.4	918.9	644.2	654.9	770.5

^a For aged care services and services for people with a disability, Australian Government expenditure available for reporting at a State and Territory level is included in the analysis for the relevant jurisdiction. Australian Government expenditure not allocated to a State or Territory is not included (\$44.8 million in aged care services and \$126.4 million in services for people with a disability). ^b Collection and reporting methods may vary across jurisdictions and services in this analysis, therefore, these data should be interpreted with care. ^c See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report. ^d Totals may not add due to rounding. ^e Population at 31 December 2007.

Source: Australian, State and Territory governments (unpublished); tables 13A.44-48, 13A.68-69, 14A.7, 15A.1, 15A.179 and AA.2.

Figure F.2 **Government recurrent expenditure on community services, 2007-08 (per cent)^{a, b, c}**

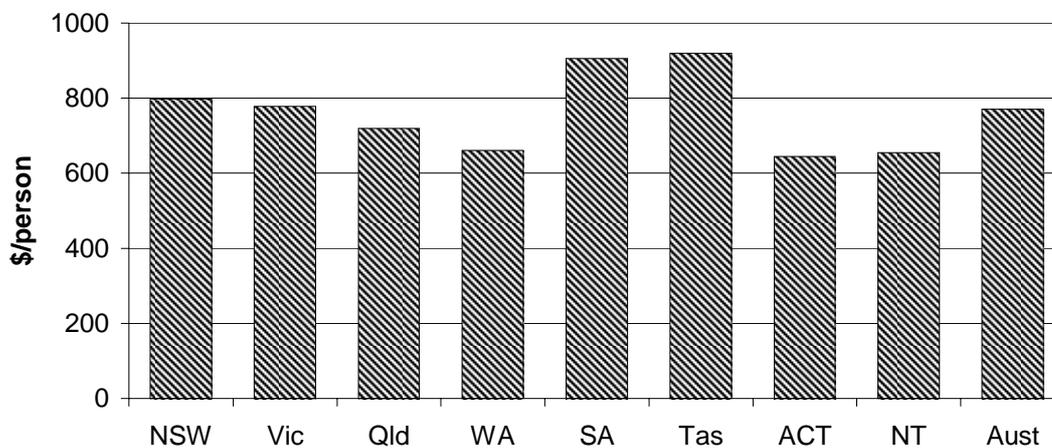


^a For aged care services and services for people with a disability, Australian Government expenditure available for reporting at a State and Territory level is included in the analysis for the relevant jurisdiction. Australian Government expenditure not allocated to a State or Territory is not included (\$44.8 million in aged care services and \$126.4 million in services for people with a disability). ^b Collection and reporting methods may vary across jurisdictions and services in this analysis, therefore, these data should be interpreted with care. ^c See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report.

Source: Australian, State and Territory governments (unpublished); table F.2.

In 2007-08, community services government recurrent expenditure was \$770 per person nationally. This expenditure (State and Territory government expenditure and Australian Government expenditure available for reporting at the State and Territory level) varied across jurisdictions (table F.2 and figure F.3).

Figure F.3 **Government recurrent expenditure on community services, per person in the population, 2007-08^{a, b, c, d}**



^a For aged care services and services for people with a disability, Australian Government expenditure available for reporting at a State and Territory level is included in the analysis for the relevant jurisdiction. Australian Government expenditure not allocated to a State or Territory is not included (\$44.8 million in aged care services and \$126.4 million in services for people with a disability). ^b Collection and reporting methods may vary across jurisdictions and services in this analysis, therefore, these data should be interpreted with care. ^c See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report. ^d Population at 31 December 2007.

Source: Australian, State and Territory governments (unpublished); table F.2.

Size and scope

Current data on size and scope of the community services sector are limited. The ABS Survey of Community Services collected data on the number of organisations that provide community services. Almost 9300 organisations were providing community services (covering the not-for-profit, government and for-profit sectors) as at 30 June 2000. Of these, 30 per cent were for-profit organisations, 63 per cent were not-for-profit organisations and 6 per cent were government organisations. If non-government sector child care services are excluded, 14 per cent were for-profit organisations, 76 per cent were not-for-profit organisations and 10 per cent were government organisations (ABS 2001). From 1995-96 to 1999-2000, the number of for-profit and not-for-profit organisations across the sector increased by 32 per cent and 10 per cent respectively.

Workforce information

The AIHW has noted difficulties identifying the true dimensions of the community services workforce. These difficulties include identifying the community services

sector and sub-sectors in data sets (the varying measurements in this preface reflect these difficulties), data gaps relating to sub-sectors of community services and the lack of regular and consistent data (AIHW 2006a).

Available information suggests increasing levels of employment within the community services sector over the past decade.

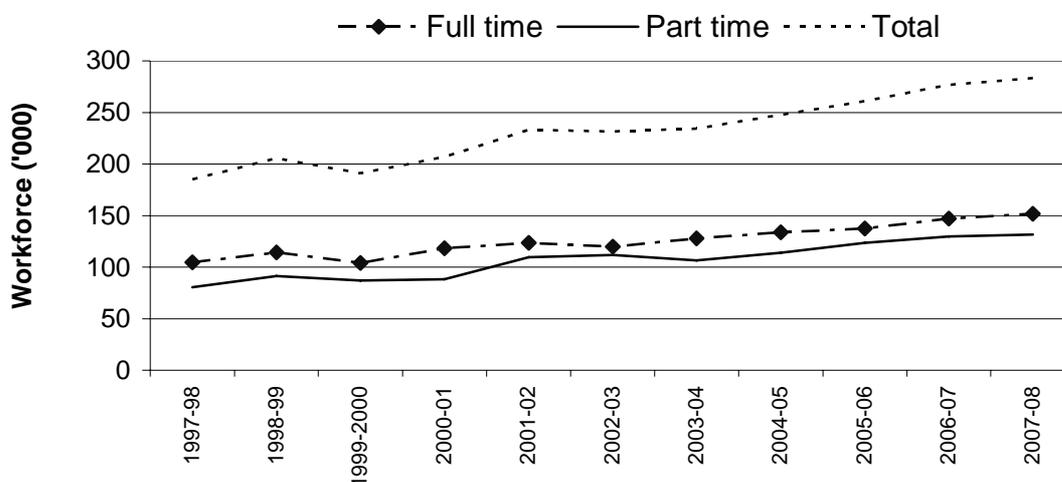
The ABS survey of community services provides a detailed description of the workforce. In 1999-2000, not-for-profit, government and for-profit organisations employed a total of 341 400 people. Of these, 59 246 were employed by government organisations, and 277 300 people were employed in direct service provision. If child care services are excluded from this analysis, 300 300 people were employed, including 238 900 in direct service provision. A further 299 400 volunteers (288 000 excluding child care services) assisted in community service activities (ABS 2001).

Subsequent developments in the community services workforce may be observed through ABS labour force survey data (ABS 2008b). These data provide a quarterly estimate of the full and part time workforce for the community services sector, within the broader industry classification 'Health and Community services'. This enables an ongoing measure of community services employment, although the 'Community services' classification is restricted to the following sub-categories of the Australian and New Zealand Standard Industrial Classification:

- nursing homes
- child care services
- accommodation for the aged
- residential care services not elsewhere classified
- non-residential care services not elsewhere classified.

Quarterly data have been averaged to provide an annual measure, which identifies that, from 1997-98 to 2007-08, the community services workforce has grown from 185 200 people (56.5 per cent full time and 43.5 per cent part time) to 283 300 people (53.5 per cent full time and 46.5 per cent part time). This represents an average annual increase in employment in the community services sector of 4.3 per cent (figure F.4).

Figure F.4 **Full time, part time and total employment in community services, 1997-98 to 2007-08**



Source: ABS 2008, *Labour Force, Australia, Detailed, Quarterly, August 2008*, Cat. no. 6291.0.55.003, Canberra.

Caution should be exercised in using these data to estimate the community services workforce. The numbers employed in a particular industry do not necessarily reflect the numbers of people in particular occupations. Employment in occupations typically associated with community services industries also occurs in other industries, for example, in education and health services. The AIHW has reported that in 2006, over 188 000 workers were employed in community services occupations in other industries (AIHW 2007b).

The Australian Community Sector Survey 2008, published by the Australian Council of Social Service (ACOSS), recorded an estimated five per cent increase in the community services workforce during 2006-07. The same survey reports that demand for a broad range of community services (measured by the number of people assisted by agencies) increased by 6.3 per cent from 2005-06 to 2006-07 (ACOSS 2008).

Volunteers

Although this Report focuses on government provision of services, it is important to recognise that volunteering provides an important contribution to the community services sector, not generally identified in workforce data. ABS data show that in 2006, 16.3 per cent of all voluntary involvement was expended in the 'community/welfare' sector (which includes community services), and that 90.4 per cent of this volunteer work occurred in the not-for-profit sector. The highest proportion of volunteers in this sector were aged 65 years and over. Just over

7 per cent of all people in the community aged 18 years and over volunteered in this sector (ABS 2007).

The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), (previously the Department of Families, Community Services and Indigenous Affairs [FaCSIA]) estimated that the total imputed dollar value of the time donated to welfare services by volunteers in 2001-02 (\$27.4 billion), was almost double the total cash amount spent by all governments and non-government sources (\$13.7 billion), in Australia. Informal help to family, friends and neighbours generates over two thirds of the imputed value of the services (FaCSIA 2006). The ABS 2003 *Survey of Disability, Ageing and Carers* (ABS 2004a) reveals that the number of people with a reported disability or with a profound or severe core activity limitation receiving assistance from informal providers (predominantly families), is significantly greater than the number of people receiving formal services (from government or non-government providers).

Community services developments

The continued growth of the community services sector is, in part, a response to changes occurring more broadly in society. Although these developments are not necessarily readily quantified, the following discussion summarises some of the movements observed in recent years.

The community services sector is influenced by changing demographic structures. For example, increases in the number and proportion of older people in the population may have an impact on the demand for aged care and disability services and the ability of the community to respond to these demands. Disability prevalence increases with age. In 2003, of the population aged 0–34 years, an estimated 9.2 per cent had a disability, whereas 21.9 per cent of the population aged 35–64 years were estimated to have a disability. Of the population aged 65 years or over in 2003, an estimated 55.7 per cent had a disability (AIHW 2006b).

The Australian Government's second Intergenerational Report (Australian Government 2007a) provides an indication of the extent to which such demographic changes may influence the sector in the future, and the impact of these changes on revenue and expenditure (box F.3).

Box F.3 **Future demographics and the Intergenerational Report 2007**

The projections in the Intergenerational Report 2007 show that over the next forty years:

- the Australian population will continue to increase in size but with a higher proportion of older people. The proportion of those over 65 is predicted to nearly double to 25 per cent of the population
- economic growth per person will slow as the proportion of the population of traditional working age falls
- substantial fiscal pressures will emerge due to projected increases in government spending, particularly in the areas of health, age pensions and aged care.

The report identifies productivity, population and participation as contributors to real GDP, which in turn, is a key factor in the ability of the economy to sustain service provision, including provision of community services.

Source: Australian Government (2007a).

In addition to an ageing population, some commentators consider that rapidly changing economic and social environments over recent years have adversely affected family and community strength and the capacity to deal with issues. Some analysis has referred to a ‘... perceived decline in social cohesion which has placed stress on family and social functioning’ (Zubrick et al. 2000, quoted in Davies and Taylor 2005). These economic and social changes can partly be attributed to:

- labour market changes, associated with growth in technology and service industries
- population movements, associated with most Australians living in, or moving to, urban settings
- changing family structures, characterised by increased family breakdown and less reliance on the extended family
- decreasing engagement in community life (Davies and Taylor 2005).

These developments may provide some background to the increasing demand for a range of community services, although the explanations for changes in demand for any given service or an individual’s demand for that service are likely to be complex.

The development of social capital (box F.4) as a result of the activities of community services and individuals is increasingly recognised as contributing to the wellbeing of society, and many government policies now explicitly aim to improve ‘social inclusion’. Although social capital is multifaceted and difficult to measure,

the ABS has identified some broad indicators of social capital, which include social participation, community support, economic participation and reciprocity (ABS 2006).

Box F.4 Community services, developing social capital and social inclusion

Social capital relates to the resources available within communities, including the not-for-profit sector, in networks of mutual support, reciprocity and trust. It is a contributor to community strength. The OECD defines social capital as ‘networks, together with shared norms, values and understandings which facilitate cooperation within or among groups’ and this is becoming a generally accepted definition.

Creation of social capital can generate benefits in a number ways:

- by reducing the costs of conducting day-to-day affairs and of doing business
- by facilitating the spread of knowledge and innovation
- by promoting cooperative and/or socially-minded behaviour in situations where narrow self-interest alone does not generate good outcomes for society
- through individual benefits — people with good access to social capital tend to be more ‘hired, housed, healthy and happy’ than those without
- through associated social spill-overs, such as lower health and welfare expenditures, and higher tax receipts.

Social capital may affect a range of areas of community and individual well being. Development of social capital may reduce the demand on community services — for example, increased social capital may result from employment, volunteering or from increased contact with family and friends, which in turn may reduce the reliance on community services. Conversely, provision of well designed accessible community services may develop social capital within society.

The development of social inclusion is of increasing interest in Australia and a range of international and Australian research and policy developments address it. Although interpretations vary, common aspects of Australian and international definitions of social inclusion (or conversely, social exclusion) are characterised by discussion of access to opportunities and limitations of the capabilities required to capitalise on these opportunities, along with reference to the social and economic dimensions of exclusion. Specific aspects of social exclusion may include locational disadvantage, jobless families, intergenerational disadvantage, children at risk, child poverty, unemployment of people with a disability, and homelessness. Policy approaches aim to move disadvantaged groups or individuals from exclusion to inclusion.

Source: ABS (2004b); Productivity Commission (2003); Australian Government (2008).

The Human Rights and Equal Opportunity Commission’s 2007 report *It’s About Time: Women, men, work and family* Final Paper 2007 (HREOC 2007) identifies a

range of possible solutions to the pressures faced by individuals managing the balance between work and family life. Many of these pressures relate to providing support in areas where community service interventions often occur, including support for people with a disability and older people. The report notes:

Demographic changes such as low birth rates mean that in future many more people will not have family members living with them as they age. Providing support and care for people outside of one's home is likely to become a larger part of what we consider to be family and carer responsibilities. This also raises the need to consider care as a community responsibility, rather than simply that of individual households. This is particularly important for elder care, as many frail older people are choosing — and are increasingly encouraged — to remain in their own homes as they age. (HREOC 2007)

Cross-cutting community services issues

Community services pathways

Although this Report discusses three areas of community services in separate chapters, it is recognised that there are many linkages between different community services. Governments are increasingly emphasising the need for integrated, client centred community services.

Many community services are linked by the provision of these services to individuals at different stages of life. Other services are not as strictly age-specific and some individuals may receive multiple services at the same time — for example, a child who is in receipt of juvenile justice services together with homelessness, child protection or disability services. Disability services may continue throughout an individual's lifetime and overlap with provision of aged care services.

The sequence of interventions or services may be referred to as 'pathways' of community service provision. However, there is limited information on the patterns of access by individuals to the range of community services, either concurrently or in succession over a lifetime. A greater understanding of the links between the use of various community services, the nature of these links, and whether interventions in one area of service provision result in reduced need for other services, will enhance the effectiveness and efficiency of the sector overall.

Examples of relevant research include:

- a cohort study carried out in Queensland, which found a correlation between contact with child protection services and the juvenile justice system. Of the 24 255 children born in 1983 or 1984 who had a contact with one or more of

child protection services, police cautioning or children's courts, 6.2 per cent had both a child protection services contact and a children's court appearance. These 1500 children represented 28.7 per cent of those with a children's court appearance and 15.7 per cent of those with a child protection history (Stewart, Dennison and Hurren 2005)

- a Community and Disability Services Ministers' Advisory Council (CDSMAC) funded project involving the linkage of three national data collections. The first phase of this project established the value and feasibility of data linkage between national data collections for SAAP, juvenile justice and child protection. The second phase involves the linkage of data for clients of juvenile justice and SAAP. The linked data will be used to analyse the pathways and characteristics of clients who are common to both juvenile justice and SAAP, to provide information for the development and monitoring of early intervention services for young people in the two sectors. Further phases of the project would extend the data linkage to include the child protection data collection when unit record data become available, and to include more years of data so that analysis can be carried out for a longer time period. It is anticipated the project will contribute to the long-term outcome of reducing the extent to which clients of child protection become clients of juvenile justice and SAAP, or to which clients of SAAP services become clients of child protection and juvenile justice
- a FaHCSIA longitudinal study of Indigenous children (*Footprints In Time*) into the links between early childhood experiences and later life outcomes for Aboriginal and Torres Strait Islander children, covering areas such as health, culture, education, housing and family relationships (FaHCSIA 2008).

There are also links between community services and other government services. Access to effective community services may influence outcomes for clients of education, health, housing and justice sector services. In turn, access to these other service areas may affect outcomes for clients of community services.

The community services and health sectors are closely related and their effective interaction assists the provision of services in both sectors. The disability sector is also strongly linked to health services by the needs of clients, as people with a disability tend to have a larger number of poor health conditions than the general population (AIHW 2006b). Other links, such as the role of medical and other health professional staff as a source of child protection notifications, also reinforce the importance of the relationship between community services and health.

HACC across the community services sector

Within the Report, HACC services are included in the Aged care services chapter, but the scope of the program is wider than aged care. The National Program Guidelines for the HACC Program note that the Program provides funding for services which support those who are frail aged people and younger people with a disability and their carers:

- who live at home and whose capacity for independent living is at risk; or
- who are at risk of premature or inappropriate admission to long term residential care (Australian Government 2007b).

Provision of HACC services is primarily to older people, but younger people including people with a disability, and their carers are also important recipients of HACC assistance.

In 2007-08, 23.3 per cent of HACC clients were aged under 65 years (up from 23.2 per cent in 2002-03). Analysis of data from the HACC program in 2007-08 indicates that clients aged under 65 years were significantly over-represented in particular assistance types, including carer counselling support (46.1 per cent), nursing care (centre) (34.5 per cent), and respite care (54.0 per cent) (DoHA 2003, DoHA unpublished).

In 2007-08, 13.6 per cent of HACC clients nationally were in receipt of a Disability Support Pension. This proportion had increased from 12.0 per cent in 2002-03. In 2007-08, 32.9 per cent of HACC clients classified as care recipients reported that they were also receiving assistance from a relative or friend/carer (DoHA 2003, DoHA unpublished).

Future directions in performance reporting

The Steering Committee intends to continue expansion of the reporting in this preface on the characteristics of the community service sector. In particular, developments which span the various community services, such as measures of social capital and social inclusion, will be considered. Ongoing investigation of cross-cutting issues may allow improved reporting of community services as a whole.

Reform of Specific Purpose Payments

In December 2007, COAG agreed to reform Specific Purpose Payments (SPPs). SPPs are financial agreements between the Australian Government and State and Territory governments involving a contribution by the Australian Government to the funding of services which are considered a joint Australian and State and Territory government responsibility. The Commonwealth State/Territory Disability Agreement and Home and Community Care payments were such SPPs.

At its 29 November 2008 meeting, COAG agreed to six new National Agreements, five of which are associated with a National SPP. In the area of Disability services, there is a National Disability Agreement associated with the National Disability Services SPP (COAG November 2008). Under the reforms, the National Disability Agreement contains the objectives, outcomes, outputs and performance indicators for disability services. The National Healthcare Agreement may also have implications for aged care services. The performance of governments in achieving these mutually agreed outcomes will be assessed by the COAG Reform Council (CRC). The Steering Committee has been requested by COAG to provide the SPP performance information to the CRC (COAG July 2008).

The National Agreements/SPPs will be supplemented by a range of National Partnerships (NPs): project, facilitation and reward agreements. Funding for NPs may be conditional on states and territories meeting agreed milestones and performance benchmarks.

The Steering Committee and the various working groups will ensure that reporting in this preface reflects the COAG priorities identified in the National Disability Agreement, the National Disability Services SPP and relevant NPs.

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13 Aged care services

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Attachment tables are identified in references throughout this chapter by a '13A' suffix (for example, table 13A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

The aged care system comprises all services specifically designed to meet the care and support needs of frail older people living in Australia. This chapter focuses on government funded residential and community care for older people and services designed for the carers of older people. Some government expenditure on aged care is not reported, but continual improvements are being made to the coverage and quality of the data. The services covered include:

- residential services, which provide high care, low care and residential respite care (box 13.1)
- community care services and flexible services, which include Home and Community Care (HACC) program services, Community Aged Care Packages

(CACPs), the Extended Aged Care at Home (EACH) program, the EACH Dementia program, the Transition Care Program (TCP), and the Department of Veterans' Affairs (DVA) Veterans' Home Care (VHC)¹ and Community Nursing programs

- respite services, which include HACC respite and centre-based day care and the National Respite for Carers Program (NRCP)
- assessment services, which are largely provided by the Aged Care Assessment Program (ACAP).

Additions and improvements made to the chapter this year include:

- inclusion of data reflecting the Aged Care Funding Instrument (ACFI), which commenced in March 2008 and which will gradually replace the Resident Classification Scale (RCS) (box 13.1). ACFI and RCS subsidy data now include the Conditional Adjustment Payment (CAP)
- inclusion of numbers of clients for key aged care programs, in addition to existing data on the numbers of operational places and rates of service provision per 1000 of target populations
- inclusion of data relating to DVA community nursing services for veterans
- inclusion of an additional category of experimental expenditure data, for state and territory expenditure on non-HACC post acute packages of care
- inclusion of the results of the most recent round of appraisals of HACC agencies, conducted in most jurisdictions between 2004-05 and 2007-08, for the indicator 'compliance with service standards for community care'
- inclusion of a new measure for the indicator 'complaints', reflecting the introduction of the new complaints system — the Complaints Investigation Scheme
- reporting for the first time the outcome indicator 'maintenance of individual functioning', with data from the TCP.

Older Australians also use other government services covered in this Report, including disability services (chapter 14), specialised mental health services (chapter 12), housing assistance (chapter 16) and services across the full spectrum of the health system (preface E and chapters 10–12). There are also interactions between these services that are likely to affect performance results in this Report, for example, the number of operational residential aged care places may affect demand for public hospital beds, and changes in service delivery in the public hospital sector may affect demand for residential and community aged care.

¹ Unless otherwise stated, HACC expenditure excludes the DVA expenditure on VHC.

Box 13.1 Transition from the RCS to ACFI and the characteristics of residents

On 20 March 2008, the ACFI was introduced and it will gradually replace the RCS.

The RCS is an eight level scheme of resident classification (RCS levels 1–8), and the level of subsidy provided varies according to the classification.

The ACFI measures each resident's need for care (high, medium, low or nil) in each of three domains (activities of daily living, behaviours and complex health care). A subsidy is provided according to a formula which takes care needs in each domain into account.

Transition arrangements include the provision that when a resident is assessed for funding using the ACFI, if the new subsidy rate is either less than the RCS rate, or not \$15 or more per day above the existing RCS rate, the RCS rate will continue to be paid. This will continue until the ACFI does provide a higher level of subsidy due to indexation, or there is an increase in the resident's care needs.

This chapter classifies residents as 'high' or 'low' care based on their RCS or ACFI classification. For this Report, under the RCS classification, high care residents have been assessed as RCS levels 1–4, and low care residents have been assessed as RCS levels 5–8. A resident assessed under ACFI is considered to be in receipt of high care (ACFI High) if they are assessed as:

- Medium or High in Activities of Daily Living; or
- High in Behaviour; or
- Medium or High in Complex Health Care.

All other residents assessed under ACFI are regarded as low care residents (ACFI Low).^a

^a This includes residents whose ACAT approval is limited to low care, but whose first ACFI appraisal rates them in a high care range. These residents are classified as 'interim low' until the ACAT low care restriction is removed, or the ACFI High status is confirmed by a subsequent assessment or review.

This chapter also describes the characteristics and performance of residential aged care in terms of residential services, places and locality (box 13.2).

Box 13.2 Interpreting residential aged care data

Residential services data

This chapter groups residential services for reporting purposes based on both the eight level RCS profile of residential services' clients and the ACFI.

- Aged care homes with 80 per cent or more residents classified as RCS 1–4 or ACFI High are described as high care services.
- Aged care homes with 80 per cent or more residents classified as RCS 5–8 or ACFI Low 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)* (the Aged Care Act). Similarly, the choice of 80 per cent as a cut-off is arbitrary but considered appropriate for descriptive purposes.

Places data

The Aged Care Act (part 2.2) 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 or ACFI High. Low care places are planned to meet the needs of residents with care needs equivalent to RCS levels 5–8 or ACFI Low.

Although a needs match is expected when residents enter vacant places (that is, for example, vacant low care places should usually be filled by low care residents), this can change over time with 'ageing in place', which allows a low care resident who becomes high care to remain within the same service until he or she is discharged.

Locality data

Geographic data are based on the Australian Bureau of Statistics (ABS) Australian Standard Geographic Classification of Remoteness Areas (ABS 2003). Data are classified according to an index of remoteness that rates each ABS Census district based on the number and size of towns, and the distance to major towns and urban centres.

13.1 Profile of aged care services

Service overview

Services for older people are provided on the basis of the frailty or functional disability of the recipients as distinct from 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. Particular 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, CACP, EACH and EACH Dementia packages.

Government funded aged care services covered in this chapter relate to the three levels of government (Australian, State and Territory, and some local) involved in service funding and delivery. The formal, publicly funded services covered represent only a small proportion of total assistance provided to frail older people. Extended family and partners are the largest source of emotional, practical and financial support for older people: more than 90 per cent of older people living in the community in 2003 who required help with self-care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 2004a). Many people receive assistance from both formal aged care services and informal sources. Older people also purchase support services in the private market, and these services are not covered in this chapter.

Roles and responsibilities

Assessment services

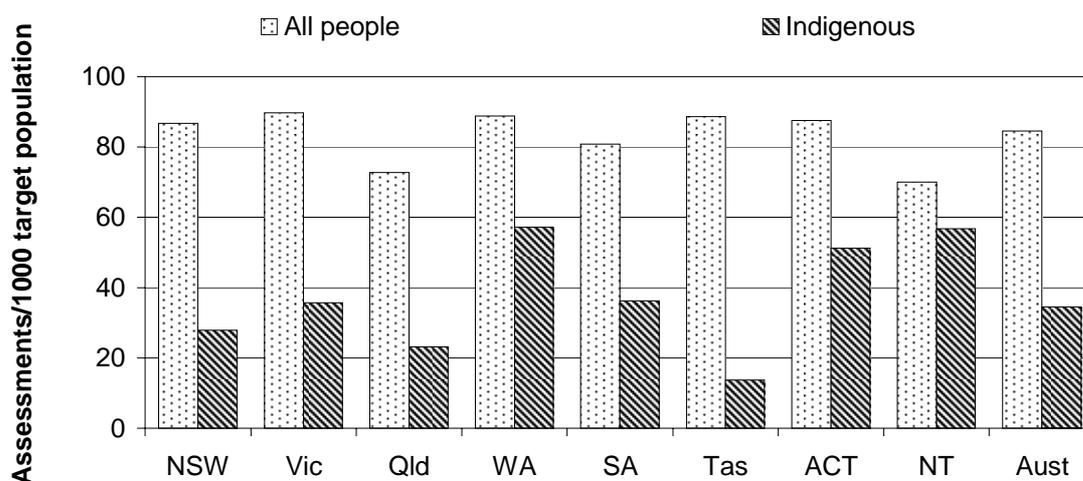
The Australian Government established the ACAP in 1984, based on the assessment processes used by State and Territory health services to determine (1) eligibility for admission into residential care and (2) the level of care required (and thus the subsidy paid to such services). The core objective of the ACAP is to assess the needs of frail older people and assist them to gain access to the most appropriate type of care. Assessment and approval by Aged Care Assessment Teams (ACATs) are mandatory for admission to Australian Government subsidised residential care or receipt of a CACP, EACH package, EACH Dementia package or TCP. People may also be referred by ACATs to other services, such as those funded by the

HACC program. An ACAT referral is not mandatory for receipt of other services, such as HACC and VHC services.

State and Territory governments are responsible for the day-to-day operation and administration of the ACAP, and for provision of the necessary accommodation and support services. The scope and practice of the teams differ across and within jurisdictions, partly reflecting the service setting and location (for example, whether the team is attached to a residential service, a hospital, or a community service). This has an effect on program outputs.

The number of assessments per 1000 target population varied across jurisdictions in 2006-07. The national rate was 84.5 assessments per 1000 people aged 70 years or over and Indigenous people aged 50 years or over and 34.5 per 1000 Indigenous people aged 50 years or over (figure 13.1).

Figure 13.1 **Aged Care Assessment Team assessment rates, 2006-07^{a b, c, d, e}**



^a Includes ACAT assessments for all services. ^b 'All people' includes all assessments of people aged 70 years or over and Indigenous people aged 50 years or over per 1000 people aged 70 years or over and Indigenous people aged 50 years or over. ^c 'Indigenous' includes all assessments of Indigenous people aged 50 years or over per 1000 Indigenous people aged 50 years or over. ^d The number of Indigenous assessments is based on self-identification of Indigenous status. ^e See table 13A.39 for further explanation of these data.

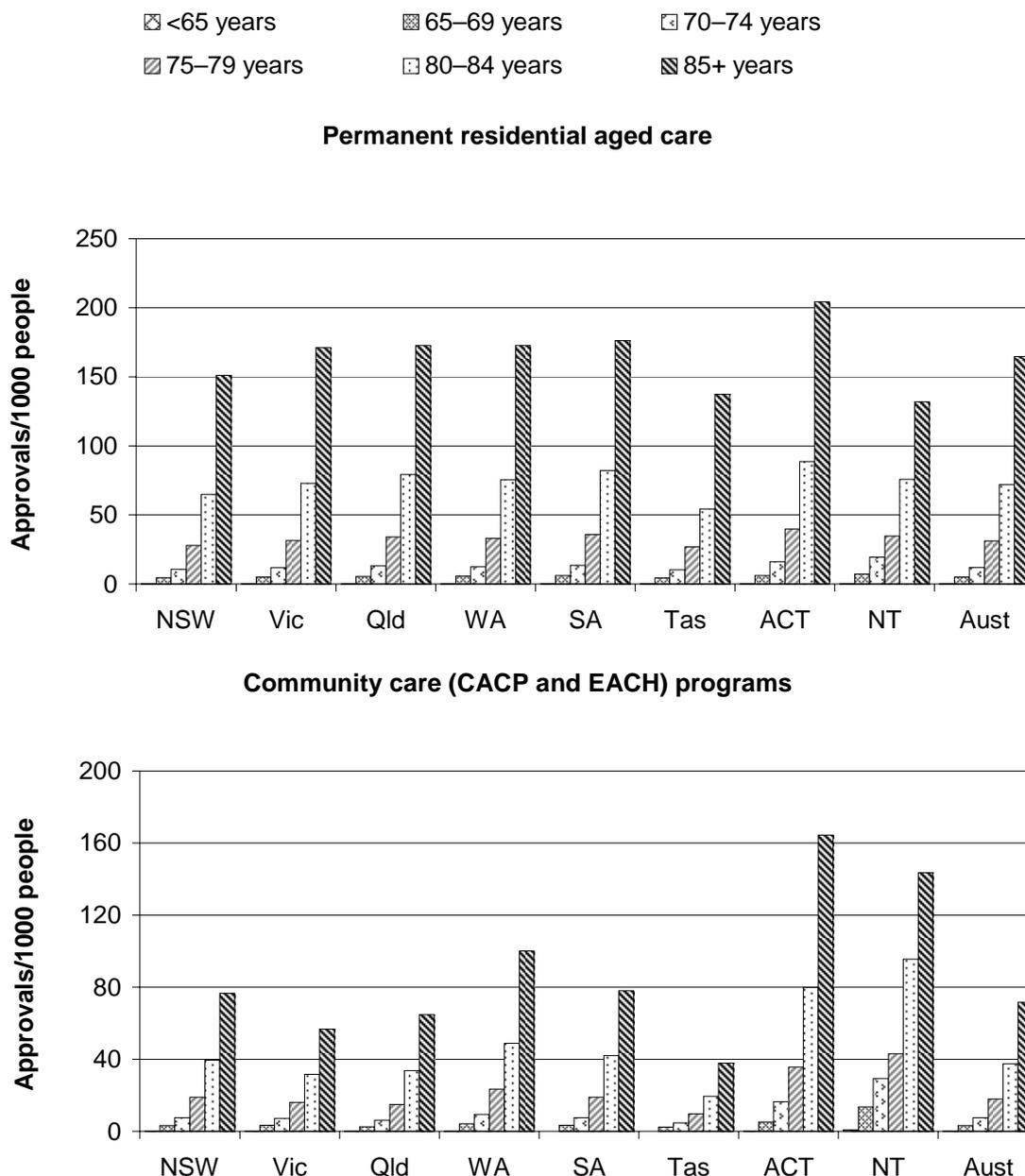
Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.39.

ACAT assessments which result in approvals of eligibility for various types of care can be shown by age-specific rates, for a series of age groups in the population. Data are provided for residential care and for community care (CACP, EACH and EACH Dementia).

These data reflect the numbers of approvals, which are a subset of assessments, as some assessments will not result in a recommendation or an approval for a particular level of care. The numbers of places accepted cannot be identified from these data (see boxes 13.12 and 13.13 in relation to waiting time for residential and community care). As practices may vary across jurisdictions, data should be interpreted with care.

The approval rates for both residential and community care services vary across jurisdictions and increase with age (figure 13.2).

Figure 13.2 **Age-specific approval rates, per 1000 people in the population, 2006-07^{a, b, c}**



^a Population numbers and the proportions of the population for older age groups in the ACT and the NT are smaller than other jurisdictions, and may show variation between years, so results should be interpreted with caution. ^b The age category population data for this table are derived from ABS estimated resident population figures as at 30 June 2007. ^c EACH packages include EACH Dementia packages.

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.40; table AA.1.

The Council of Australian Governments (COAG) has agreed to improve aged care assessment services as part of its national health agenda (box 13.3).

Box 13.3 Improved performance and streamlining of assessment processes

In February 2006, COAG agreed to establish an initiative to simplify access to care services for the elderly, people with a disability and people leaving hospital.

The initiative consists of two components:

- ACAP — more timely and consistent assessments for frail older people by ACATs
- simplified entry and assessment processes for the HACC Program.

The ACAP component provides for a range of activities to improve the timeliness, quality and consistency of ACAT recommendations, which will be implemented with the states and territories. In 2007-08, the initiatives implemented were: national and State and Territory projects undertaken to address the agreed priority areas; national training initiatives implemented under the National Training Strategy for ACATs; a project to determine the full cost of the ACAP by states and territories; release by the Minister for Ageing of the National ACAT Review Report and response paper by ACAP Officials; and improved communication to ACATs by enhancing the ACAT webpage on the Department of Health and Ageing (DoHA) internet site. States and territories continue to undertake a range of projects to improve the management and operation of ACATs.

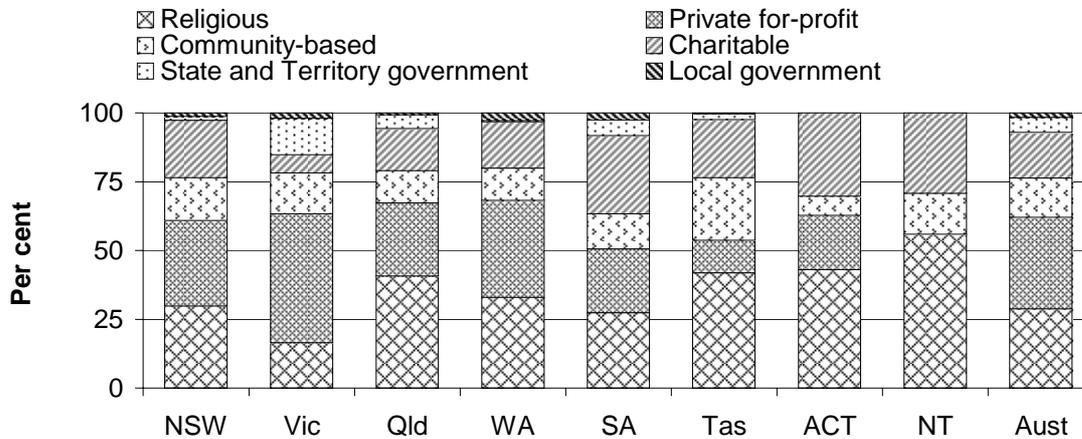
DoHA, in partnership with State and Territory governments and the community care sector has established Access Points Demonstration Projects in most states and territories. Access Points will simplify access and assessment processes for the HACC Program. Clients and carers will have their eligibility confirmed, their functional abilities and need for care assessed, and be prioritised for service referral. At the end of 2008, nine Access Point Demonstration Projects had been established in six states. They will be evaluated for approximately 12 months to inform further roll out.

Source: DoHA (unpublished).

Residential care services

Religious and private for-profit organisations were the main providers of residential care at June 2008, accounting for 28.8 per cent and 33.3 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 14.2 per cent and 16.7 per cent respectively. State, Territory and local governments provided the remaining 7.1 per cent (figure 13.3).

Figure 13.3 **Ownership of operational mainstream residential places, June 2008^{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 13A.4.

The Australian Government is responsible for most of the regulation of Australian Government subsidised residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local governments may also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 13.4).

Box 13.4 Examples of regulatory arrangements for residential services

The Australian Government controls the number of subsidised places. In February 2007, the Australian Government announced an increase in the provision ratio from 108 (adopted in 2004 following a recommendation of the Review of Pricing Arrangements in Residential Aged Care) to 113 operational places per 1000 people aged 70 years or over, to be achieved by June 2011. The proportion of places offered has been adjusted from 20 to 25 places for community care (CACP and EACH packages), with 4 of these places for every 1000 people aged 70 years or over, to be for high level care. In residential care, the provision ratio for high level care was increased from 40 to 44 places, while the ratio for low level residential care was adjusted from 48 to 44 places for every 1000 people aged 70 years or over.

Under the arrangements:

- services are expected to meet regional targets for places for concessional, assisted and supported residents. These targets range from 16 per cent to 40 per cent of places and are intended to ensure 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 the date of the resident's entry to care, home ownership and occupancy, receipt of income support and the level of assets held at entry. The criteria for being deemed a supported resident is based on the resident's entry date and level of assets held at entry)
- extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted
- to receive an Australian Government subsidy, an operator of an aged care service must be approved under the Aged Care Act as a provider of aged care
- principles (regulations) created under the Aged Care Act establish the obligations of approved providers relating to quality of care and accommodation.

Various Australian, State and Territory laws govern regulatory arrangements for residential care. State and Territory legislation may prescribe matters such as staffing, the dispensing of medication and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, and fire prevention and firefighting measures. Staff wages and conditions are generally set by jurisdiction-based awards. Local government bylaws may also apply (for example, waste disposal rules).

Source: DoHA (unpublished).

Community care services

The main community care programs reported in this chapter — the HACC, CACP and VHC programs — fund services that aim to provide practical assistance to enable frail older people (HACC and CACP), people with a disability (HACC) and

veterans (VHC) to continue living in, or return to, the community. These services also provide assistance to carers. They are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers. The number of operational places for CACP (including community care places under the National Aboriginal and Torres Strait Islander Aged Care Program, Multipurpose Services and Innovative Care) at 30 June 2008 was 40 235 (table 13A.36). There were 80 742 people approved for VHC services in 2007-08 (table 13A.47) and at least 831 472 HACC clients in 2007-08 (table 13A.33).

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 Program (MPS) and the TCP. In addition, flexible models of care are provided under the National Aboriginal and Torres Strait Islander Aged Care Strategy.

- The EACH program provides high level care to people in their own homes, complementing CACPs, which provide low level care. 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 4244 operational EACH places and 1996 operational EACH Dementia places at 30 June 2008 (table 13A.36).
- The Aged Care Innovative Pool is designed to test new approaches to providing aged care, either with time limited or ongoing flexible care allocations for innovative aged care services. It supports the development and testing of flexible models of service delivery in areas where mainstream aged care services may not appropriately meet the needs of a location or target group. For example, the TCP is built on the lessons learned from two pilot programs developed through the Innovative Pool, which addressed the interface between aged care and hospital care — the Innovative Care Rehabilitation Services and the Intermittent Care Services (DoHA unpublished).
- The MPS program supports the integration and provision of health and aged care services for small rural and remote communities. At 30 June 2008, there were 117 operational multi purpose services with a total of 2817 operational flexible aged care places. Some of the MPS serve more than one location (DoHA unpublished).

Transition care services

The TCP provides goal-oriented, time-limited and therapy-focused care to help eligible older people complete their recovery after a hospital stay. The TCP is intended to:

- enable a significant proportion of care recipients to return home, rather than prematurely enter residential care
- optimise the functional capacity of those older people who are discharged from transition care to residential care
- reduce inappropriate extended lengths of hospital stay for older people.

The TCP is jointly funded by the Australian Government and all states and territories. Its operation is overseen by the Transition Care Working Group, which includes representatives from all states and territories and the Australian Government.

Transition care can be provided in either a home-like residential setting or in the community, and targets older people who would otherwise be eligible for residential care. A person may only enter the TCP directly upon discharge from hospital. The average duration of care is 7 weeks, with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks.

Across jurisdictions, the TCP operates with some differences, including differences in service systems, local operating procedures and implementation timetables, which are reflected in national data collections. An evaluation of the impact of the Transition Care Program on clients and systems and its cost effectiveness has been undertaken. Key findings of the evaluation were that functional improvement occurred and that older people who received Transition Care had fewer readmissions to hospital and were less likely to move into permanent residential aged care (DoHA 2008).

At 30 June 2008, the Australian Government had allocated 2228 places to transition care, of which 1963 were operational, amongst 76 services across all jurisdictions. The average length of stay in 2007-08 was 50 days nationally (table 13A.69).

Long Stay Older Patient Initiative

As part of the national health and aged care agenda, COAG has funded this program since 2006-07 (box 13.5).

Box 13.5 Long Stay Older Patient Initiative

From July 2006, a new four-year program commenced to assist older public patients who no longer require acute care or rehabilitation and are in hospital waiting for residential aged care by:

- providing more appropriate care for long-stay older patients in public hospitals, particularly in rural areas
- improving the capacity of rural hospitals to provide more age friendly services, including through making capital improvements such as establishing new multi purpose services
- reducing avoidable or premature admission of older people to hospitals
- assisting older public patients requiring long-term care to take up appropriate care options.

Source: COAG (2006).

Indigenous-specific services

Aboriginal and Torres Strait Islander people access mainstream services under the Aged Care Act, including those managed by Aboriginal and Torres Strait Islander organisations, and services funded outside the Act, including those funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Some services managed by non-Indigenous approved providers also have a significant number of Aboriginal and Torres Strait Islander clients.

All aged care services that are funded under the Act are required to provide culturally appropriate care. Whether they are located in a community or residential setting, services may be subject to specific conditions of allocation in relation to the proportion of care to be provided to particular groups of people, including Aboriginal and Torres Strait Islander people.

At 30 June 2008, there were 640 flexible places for Indigenous clients allocated outside the *Aged Care Act 1997* under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. This flexible care helps to ensure that Aboriginal and Torres Strait Islander people can access culturally appropriate care services as close as possible to their communities, mainly in rural and remote locations. As part of the 1994 National Strategy, services were established to provide aged care using a flexible model. Communities are encouraged to participate in every aspect of service provision, from the very early planning stages right through to the operation of the services. These services are now funded under

the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (DoHA unpublished).

Funding

Recurrent expenditure on aged care services reported in this chapter was \$9.2 billion in 2007-08 (table 13.1). Table 13.1 does not include all State and Territory government expenditure, for example, the experimental estimates of expenditure on non-HACC post acute packages of care (table 13A.68), or any Australian Government or State and Territory government capital expenditure (table 13A.72).

Table 13.1 **Expenditure on aged care services reported in the Aged care services chapter, 2007-08^{a, b, c}**

<i>Expenditure category</i>	<i>\$ million</i>
Assessment services	65.0
Residential care services	6 206.5
Community care services	2 970.7
Total	9 242.2

^a Assessment services include only Australian Government expenditure. ^b Residential care services include DoHA, DVA (including payroll tax supplement) and State and Territory expenditure. ^c Community care services include HACC and TCP (State and Territory expenditure), VHC, DVA Community Nursing and a range of other DoHA expenditure listed in table 13A.48.

Source: tables 13A.44–48, 13A.68-69.

Assessment services

There were 116 ACATs (115 Australian Government funded) at 30 June 2008 (DoHA unpublished). In 2007-08, the Australian Government provided funding of \$65.0 million nationally for aged care assessment (table 13.1). Australian Government ACAT expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years was \$31.6 nationally during 2007-08 (table 13A.49). States and territories also contribute funding for ACATs, but this expenditure is not included in the chapter.

The Australian Government provided grants to State and Territory governments to operate 115 ACATs in 2006-07 (table 13A.56).

Residential care services

The Australian Government provides most of the recurrent funding for residential aged care services. State and Territory governments also provide some funding for

public sector beds. Residents provide most of the remaining service revenue, with some income derived from charitable sources and donations.

Australian Government expenditure

Australian Government expenditure on residential aged care was \$6.0 billion in 2007-08, comprising DoHA expenditure of \$5.1 billion (table 13A.44) and Department of Veterans' Affairs (DVA) expenditure of \$922.3 million (table 13A.46). Combined DoHA and DVA expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years was \$2923 nationally during 2007-08 (table 13A.51).

Australian Government basic subsidy (RCS or ACFI)

The Australian Government annual basic subsidy (RCS or ACFI) for each occupied place varies according to clients' levels of dependency. The CAP is included in the basic subsidy figures for the first time in this Report (box 13.6).

Box 13.6 Conditional Adjustment Payment

The CAP was introduced in 2004-05 and now constitutes a significant component of the Australian Government funding for residential aged care.

The CAP is intended to provide medium term financial assistance to residential aged care providers, while encouraging them to implement improved management practices. Consequently, providers are only eligible to receive the CAP if they meet certain reporting conditions, such as preparing general purpose financial reports. All but a few providers currently meet these conditions and receive the payment.

The amount of CAP payable is calculated as a percentage of the basic subsidy amount payable in respect of a resident. In 2004-05, the year of its introduction, this percentage was 1.75 per cent. It has risen annually and will be 8.75 per cent of the basic subsidy in 2008-09.

A review of the CAP was announced in the 2008-09 Federal Budget.

At June 2008, the average annual subsidy per residential place, including the CAP, was \$33 969 nationally (table 13.2). Variations across jurisdictions in average annual subsidies reflect differences in the dependency of residents. The rates for aged care services by the level of high and low care places provided are at table 13A.5.

Table 13.2 Average annual Australian Government basic subsidy (all RCS/ACFI levels) per occupied place at June 2008^{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>
Subsidy level	\$ 34 392	33 270	33 024	33 248	36 373	34 627	34 468	35 665	33 969

^a Includes CAP. Data in earlier reports have excluded the CAP. ^b The ACFI was introduced in March 2008 and will gradually replace the RCS as the method of determining residential aged care subsidies. See box 13.1 for further information.

Source: DoHA (unpublished); table 13A.5.

The dependency levels of all residents in both the RCS and ACFI are at table 13.3. Each resident under the ACFI scheme has a dependency level for each of three domains. These dependency levels vary across jurisdictions. These data, categorised by the proportion of high and low care places provided are included in table 13A.5.

Table 13.3 Dependency levels of permanent residents, (RCS and ACFI), June 2008^{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>
Proportions of residents										
(a) Resident classification scheme										
RCS 1-4										
(High)	%	70.3	68.7	69.2	67.7	76.7	73.8	68.1	80.6	70.2
RCS 5-8										
(Low)	%	29.7	31.3	30.8	32.3	23.3	26.2	31.9	19.4	29.8
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(b) Aged Care Funding Instrument										
Activities of Daily Living										
High	%	36.2	32.7	31.6	32.8	35.3	31.2	31.3	41.0	34.0
Medium	%	25.4	31.5	27.1	31.4	25.7	29.0	28.5	24.8	28.0
Low	%	28.9	26.8	30.6	26.8	32.6	28.7	31.6	28.6	28.8
Nil	%	9.5	9.0	10.7	9.1	6.3	11.2	8.6	5.7	9.2
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behaviours										
High	%	36.7	35.2	29.0	36.5	43.9	25.9	33.4	23.8	35.3
Medium	%	22.7	22.8	26.3	23.1	19.3	28.4	23.7	37.1	23.2
Low	%	25.0	26.6	25.1	26.2	25.8	21.8	28.8	24.8	25.6
Nil	%	15.6	15.4	19.7	14.3	11.1	23.9	14.2	14.3	15.9
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Complex Health Care										
High	%	14.4	13.9	10.9	12.7	17.5	12.8	13.5	8.6	13.8
Medium	%	38.1	38.4	41.3	40.6	38.4	39.6	38.5	41.0	39.0
Low	%	29.8	29.2	25.0	29.8	31.1	27.8	32.5	31.4	28.9
Nil	%	17.7	18.6	22.8	16.8	13.0	19.7	15.6	19.1	18.3
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Numbers of residents										
Total High	no.	38 655	27 881	19 794	9 170	11 976	3 061	1 105	305	111 947
Total Low	no.	14 554	11 927	8 209	3 915	3 303	1 082	463	67	43 520
All										
High/Low	no.	53 209	39 808	28 003	13 085	15 279	4 143	1 568	372	155 467

^a The ACFI was introduced in March 2008 and will gradually replace the RCS as the method of determining residential aged care subsidies. See box 13.1 and footnotes to table 13A.5 for further information. ^b Totals may not add as a result of rounding.

Source: DoHA (unpublished); table 13A.5.

State and Territory government recurrent expenditure

State and Territory government expenditure has been collected for three categories of residential care expenditure (adjusted subsidy reduction supplement, enterprise bargaining agreement supplement, and rural small nursing home supplement).

Reported expenditure in these three categories was \$166.1 million in 2007-08 (table 13A.68).

Capital expenditure

Although capital expenditure is not regarded as part of the total recurrent expenditure in table 13.1, it is presented here to illustrate this aspect of expenditure on aged care services. The Australian Government provided \$48.1 million in 2007-08 to fund an ongoing program of targeted capital assistance to residential aged care services. This assistance is provided to services that, as a result of their rural or remote location or because the services target financially disadvantaged people, are unable to meet the cost of necessary capital works from the income they receive through resident accommodation payments and the general capital component of Australian Government recurrent funding (table 13A.72). In addition, capital expenditure by some states and territories on residential aged care services in 2007-08 was \$90.7 million (table 13A.72).

Community care services

Following is a summary of expenditure on community care programs. More detailed data may be found in the attachment tables referenced. Data on Australian Government expenditure per head of the target population by jurisdiction are contained in table 13A.49. Recipients of community care services may also contribute towards the cost of their care.

Expenditure on HACC, CACP, NRCP and DVA programs

Total government expenditure on HACC was \$1.7 billion in 2007-08, consisting of \$1.0 billion from the Australian Government and \$645.3 million from the State and Territory governments. The Australian Government contributed 60.9 per cent, while State and Territory governments funded the remainder (table 13A.45). Recipients of HACC services may also contribute towards the cost of these services.

The Australian Government funds the CACP program, spending \$447.8 million on the program in 2007-08 (table 13A.48). CACPs are also part funded by client contributions. The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was \$173.5 million in 2007-08 (table 13.4). The NRCP assisted 125 507 people in 2007-08 (table 13A.36). A disaggregation of Australian Government expenditure on the NRCP by State and Territory is provided in table 13.4.

Table 13.4 Australian Government expenditure, National Respite for Carers Program, 2007-08 (\$million)^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	National	Aust
Commonwealth Carer Respite Centres	15.3	11.2	10.8	3.6	4.8	2.4	1.0	1.8	–	50.9
Respite services	35.4	26.5	18.3	10.1	10.7	3.2	2.8	3.0	–	110.0
National projects ^c	–	–	–	–	–	–	–	–	12.6	12.6
Total	50.7	37.7	29.1	13.7	15.5	5.6	3.8	4.8	12.6	173.5

^a Commonwealth Carer Respite Centres coordinate respite services, help carers access them, and arrange individual respite when needed. ^b Respite services reports funding for services directly providing respite care.

^c National project is for Carers Australia. – Nil or rounded to zero.

Source: DoHA (unpublished); table 13A.48.

The DVA also provided \$98.3 million for the VHC program and \$100.2 million for the Veterans Community Nursing program during 2007-08 (table 13A.47). VHC recipients may also contribute towards the cost of these services.

Flexibly funded services

The Australian Government funds the EACH and EACH Dementia programs, spending \$141.1 million and \$57.7 million respectively on these programs in 2007-08 (table 13A.48). EACH and EACH Dementia packages are also part funded by client contributions.

The Australian, State and Territory governments fund the TCP. In 2007-08 the Australian Government and the State and Territory governments spent \$52.8 million and \$59.1 million respectively (table 13A.69). The Australian Government also funds the MPS program and Indigenous specific services. In 2007-08, \$78.3 million and \$20.9 million were spent on these programs, respectively (table 13A.48).

Other aged care services

Australian Government expenditure data by jurisdiction on a range of other community care programs targeting older people are contained in table 13A.48. Australian Government expenditure on these programs was \$89.1 million in 2007-08. These programs are Community Care Grants, Assistance with Care and Housing for the Aged, Day Therapy Centres, Continence Aids Assistance Scheme, Carers Information and Support, Commonwealth Carelink Centres, the National Continence Management Strategy, Dementia Education and Support and Additional Funding for ACATs (table 13A.48). In addition, Australian Government

expenditure on the Long Stay Older Patient Initiative (see box 13.5) was \$37.5 million in 2007-08 (table 13A.44).

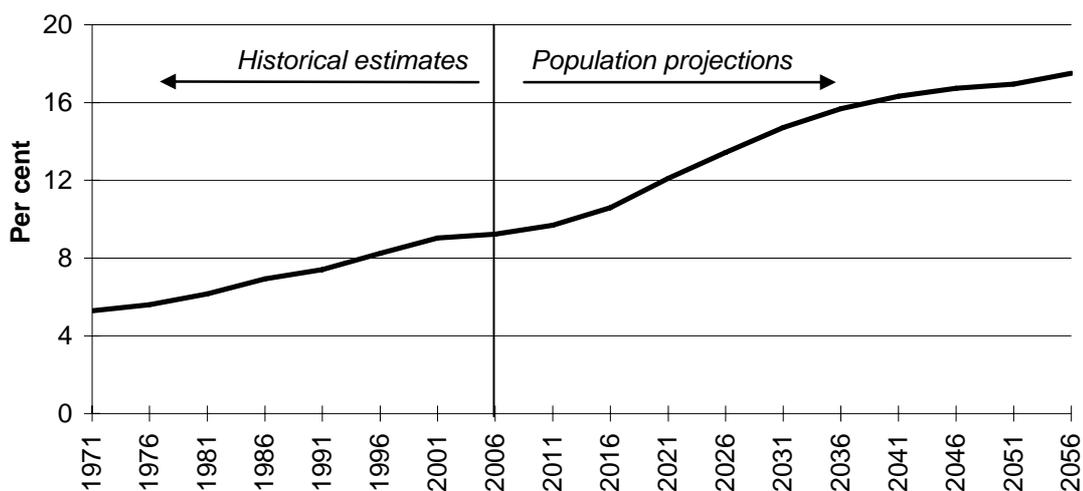
Size and scope of sector

Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of people aged 70 years or over in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically in the 21st century (figure 13.4). The proportion of older people is 9.4 per cent nationally but varies across jurisdictions (figure 13.5). A disaggregation by remoteness categorisation is provided in table 13A.3. Higher life expectancy for females resulted in all jurisdictions (except the NT, where the rate was similar) having a higher proportion of older females than older males in the total population (table 13A.1).

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 them with care.

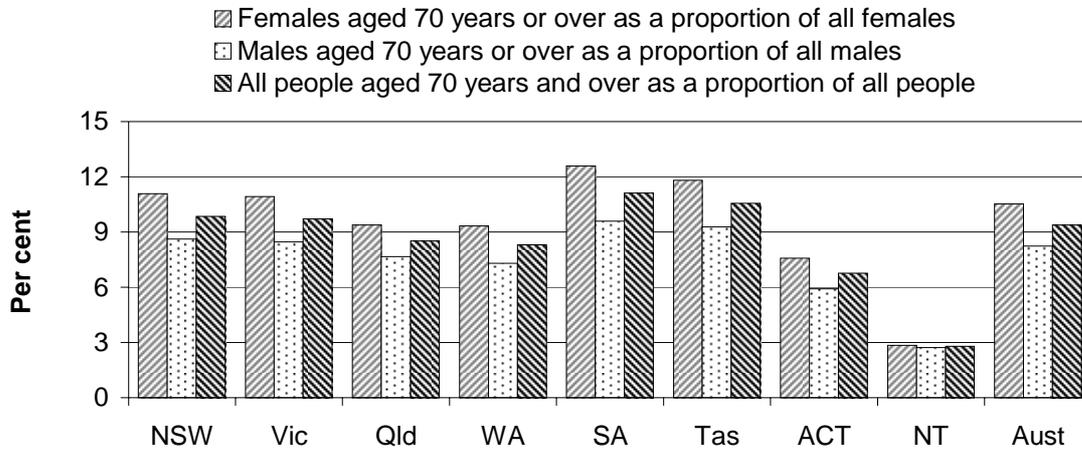
Figure 13.4 **People aged 70 years or over as a proportion of the total population^a**



^a Population projections are derived from the ABS 'B' series population projections.

Source: ABS *Australian Historical Population Statistics, 2008*, Cat. No. 3105.0.65.001, Canberra; ABS *Population Projections Australia 2006–2101*, Cat. no. 3222.0, Canberra.

Figure 13.5 Estimated proportion of population aged 70 years or over, by gender, June 2008

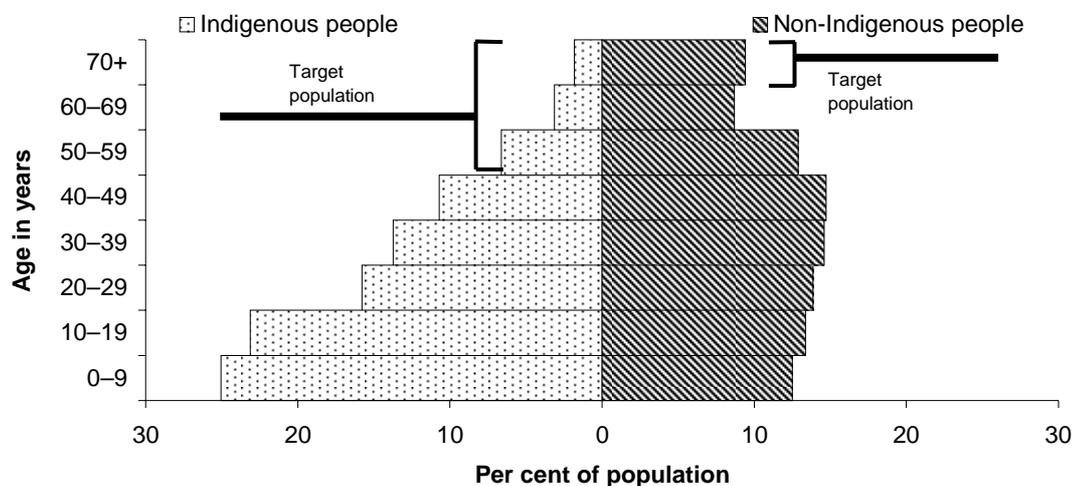


Source: Population projections prepared by the ABS in 2007, using preliminary rebased estimated resident populations based on the 2006 Census according to assumptions agreed to by the Treasury and Department of Health and Ageing (unpublished); table 13A.1.

Characteristics of older Indigenous people

DoHA estimates that about 62 800 Indigenous people were aged 50 years or over in Australia at 30 June 2008 (table 13A.2). Although the Indigenous population is also ageing, there are marked differences in the age profile of Indigenous Australians compared with non-Indigenous Australians (figure 13.6). Estimates for both males and females show life expectancy at birth in the Indigenous population is around 17 years less than in the total Australian population (ABS 2004b). These figures indicate that Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 13.6 Age profile and target population differences between Indigenous and other Australians, June 2006



Source: ABS *Experimental Estimates of Aboriginal and Torres Strait Islander Australians*, June 2006, Cat no. 3238.0.55.001, Canberra.

Residential care services

The size and location of residential services — which may influence the costs of service delivery — vary across jurisdictions. Nationally, there were up to 171 832 mainstream operational places in residential care services (71 036 in predominantly high care services, at least 10 870 in predominantly low care services and 89 866 in services with a mix of high care and low care residents) at June 2008 (tables 13A.6–9). These figures exclude flexible care places in a residential setting.

As the trend towards ‘ageing in place’ (box 13.7) 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 2004, 33.4 per cent of all places were located in services offering both high care and low care places. This proportion increased to 52.3 per cent in June 2008 (table 13A.10).

Box 13.7 Ageing in place in residential care

In its Objects, the *Aged Care Act 1997* (Commonwealth) 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 2008, 68.2 per cent of low care services had 60 or fewer places (table 13A.8), compared with 41.3 per cent of high care services (table 13A.7).

The combined number of operational high care and low care residential places per 1000 people aged 70 years or over at June 2008 was 87.3 (42.8 high care and 44.5 low care) on a national basis (table 13.5). Nationally, the proportion of low care places relative to high care places rose slightly between 2004 and 2008 (table 13A.11).

Table 13.5 Operational high care and low care residential places, 30 June 2008^{a, b, c, d}

	<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.	45.0	40.9	40.2	38.4	49.2	44.4	34.4	53.5	42.8
Low care places	no.	42.1	47.1	45.2	45.0	46.0	41.5	42.4	41.5	44.5
Total places	no.	87.2	88.0	85.4	83.4	95.2	85.9	76.8	95.0	87.3
Proportion of places										
High care places	%	51.6	46.5	47.1	46.0	51.9	51.7	44.8	56.3	49.0
Low care places	%	48.3	53.5	52.9	54.0	48.2	48.3	55.2	43.7	51.0

^a Excludes places that have been 'approved' but are not yet operational. Includes multi-purpose and flexible services attributed as high care and low care places. ^b For this Report, Australian Government planning targets are based on providing 88 residential places per 1000 people aged 70 years or over. In recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). ^c Includes residential places categorised as 'high care' or 'low care', under either the ACFI or the RCS. See box 13.1 for more information. ^d See table 13A.11 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2007-08.

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

During 2007-08, the numbers of people (of all ages) who used permanent residential care services was 208 494 nationally (including both high and low care) and 39 580 nationally for respite residential care. These figures reflect the number of individuals who utilised these services during the year, for any length of time, rather than the number of places available (table 13A.71).

Age specific usage rates for these services, by jurisdiction and remoteness, at 30 June 2008 are included at tables 13A.59 and 13A.61, and 13A.62 and 13A.64 respectively. Indigenous usage by remoteness category is identified at table 13A.65.

Community care services

Services provided under the HACC program include domestic assistance, home maintenance, personal care, food services, respite care, transport, allied health care and community nursing (box 13.8).

Box 13.8 HACC Services

HACC services are basic maintenance and support services, including allied health care, assessment, case management and client care coordination, centre-based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, personal and respite care, social support, meals, home modification, linen service, goods and equipment, and transport.

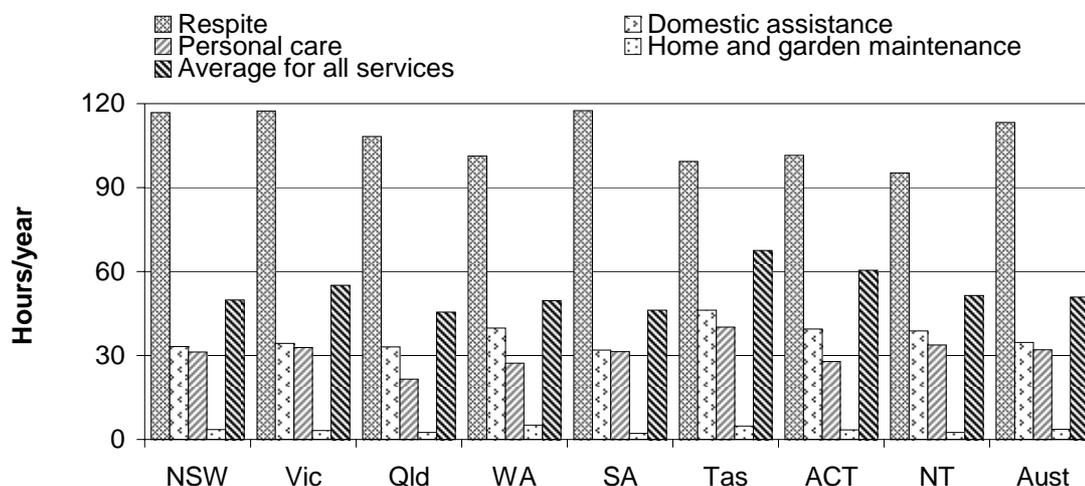
Not all HACC services are directed towards the ageing population described in this chapter. The target population is defined as people living in the community who are at risk, without these services, of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with a disability, and their carers.

Over 68 per cent of the program's recipients are aged 70 years or over, but the program is also an important source of community care for younger people with a disability and their carers, with 11.3 per cent of recipients under 50 years (table 13A.34). (Chapter 14 covers services for people with a disability, which manifests before the age of 65 years, that are provided under the Commonwealth State/Territory Disability Agreement.)

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 80 742 people approved for VHC services in 2007-08 (table 13A.47). The program offers veterans and war widows/widowers who hold a Gold or White Repatriation Health Card home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport, social support and delivered meals, are also available under the DVA's arrangements with State and Territory governments.

Eligibility for VHC services is not automatic, but based on assessed need. The average number of hours approved per year for veterans who were eligible to receive home care services was 50.9 nationally in 2007-08 (figure 13.7).

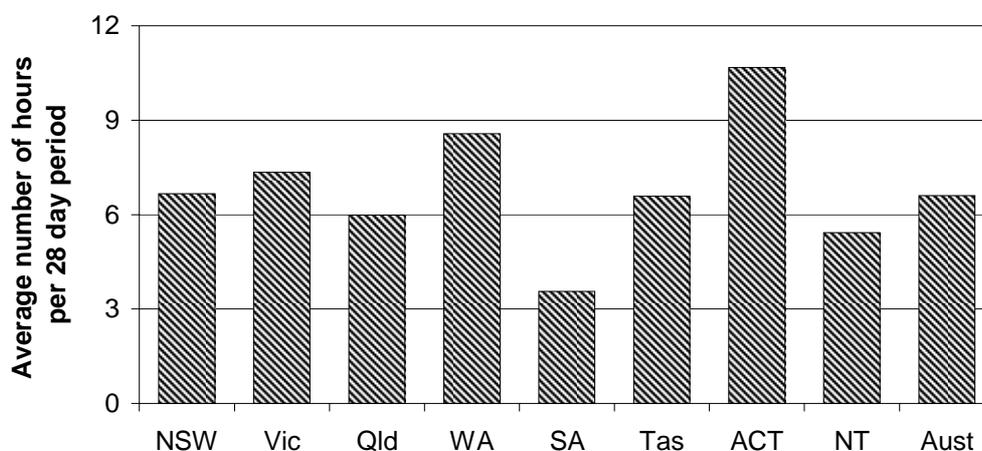
Figure 13.7 Average number of hours approved for Veterans' Home Care, 2007-08



Source: DVA (unpublished); table 13A.47.

The DVA also provides community nursing services to veterans and war widows/widowers. These services include acute/post acute, support and maintenance, personal care, medication management and palliative care. In 2007-08, 32 263 veterans received these services (table 13A.47), and the average number of hours approved for each recipient was 6.6 nationally per 28 day period (figure 13.8).

Figure 13.8 Average number of hours approved for DVA Community Nursing, 2007-08



Source: DVA (unpublished); table 13A.47.

Provision of CACPs is an alternative home-based service for older people assessed by ACATs as eligible for care equivalent to low level residential care (RCS levels 5–8 or ACFI Low). A CACP typically provides 5 to 6 hours of direct assistance per week. The EACH program is similar to the CACP program but targets people who would be eligible for high level residential aged care. An EACH package typically provides 15 to 20 hours of direct assistance each week. The main distinctions between the HACC, CACP and EACH programs are summarised in table 13.6.

Table 13.6 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	\$1.7 billion funding in 2007-08 At least 831 472 clients in 2007-08 ^c	\$447.8 million funding in 2007-08 40 235 operational places at 30 June 2008 ^d	For EACH and EACH Dementia: \$198.8 million funding in 2007-08 6 240 operational places at 30 June 2008

^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 needs that would exceed the level available under CACPs and EACH. ^c Based on 91 per cent of HACC funded agencies that submitted Minimum Data Set data for 2007-08. Consequently, the total number of clients will be higher than those reported here. ^d Includes community care places under the National Aboriginal and Torres Strait Islander Aged Care Program, Multipurpose Services and Innovative Care.

Source: DoHA (unpublished); tables 13A.33, 13A.36, 13A.45, 13A.48.

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards home-based care — have meant that the HACC, VHC, CACP and EACH programs have become increasingly important components of the aged care system. During 2007-08, the HACC program delivered approximately 19 319 hours per 1000 people aged

70 years or over plus Indigenous people aged 50–69 years (table 13A.21). The total number of CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2004 and June 2008, from 15.2 to 19.6 (table 13A.12).

The number of clients (of all ages) nationally for a range of community services are included in table 13.7. These figures reflect the number of individuals who utilised these services during the year, for any length of time, rather than the number of places available.

Table 13.7 Number of clients, aged care community care programs, 2007-08

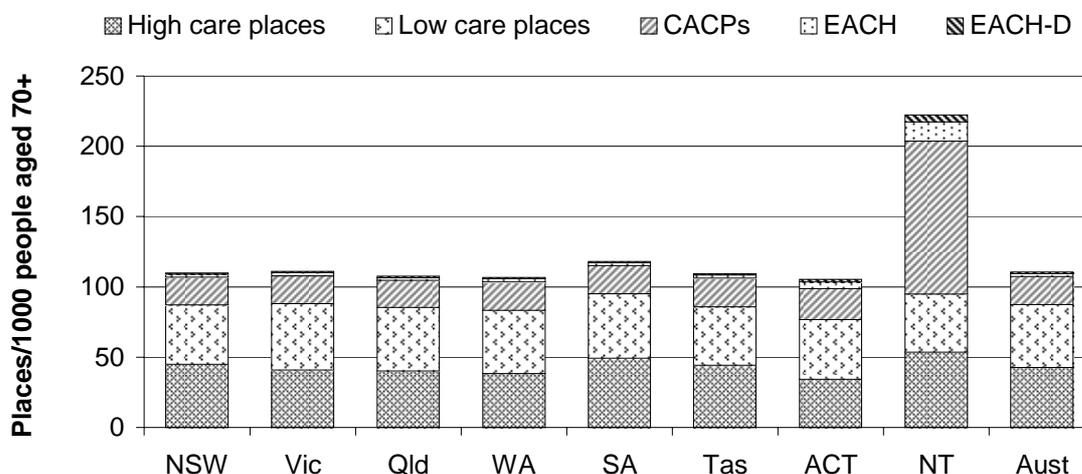
<i>Program</i>	<i>Number of clients</i>
CACP	53 224
EACH	5 907
EACH Dementia	2 659
Transition Care	10 355
Home and Community Care	831 472

Source: DoHA (unpublished); table 13A.71.

Combined residential and community care services rates

The combined number of high care residential places, low care residential places, CACPs, EACH and EACH Dementia packages, at 30 June 2008, was 110.5 per 1000 people aged 70 years or over (figure 13.9). Transition Care places add an additional 1.0 package per 1000 people aged 70 years or over (table 13A.11). The Australian Government's targets for the provision of residential and community care places were outlined previously (box 13.4).

Figure 13.9 Operational residential places, CACPs, EACH and EACH Dementia packages, 30 June 2008^{a, b, c, d, e, f, g, h}

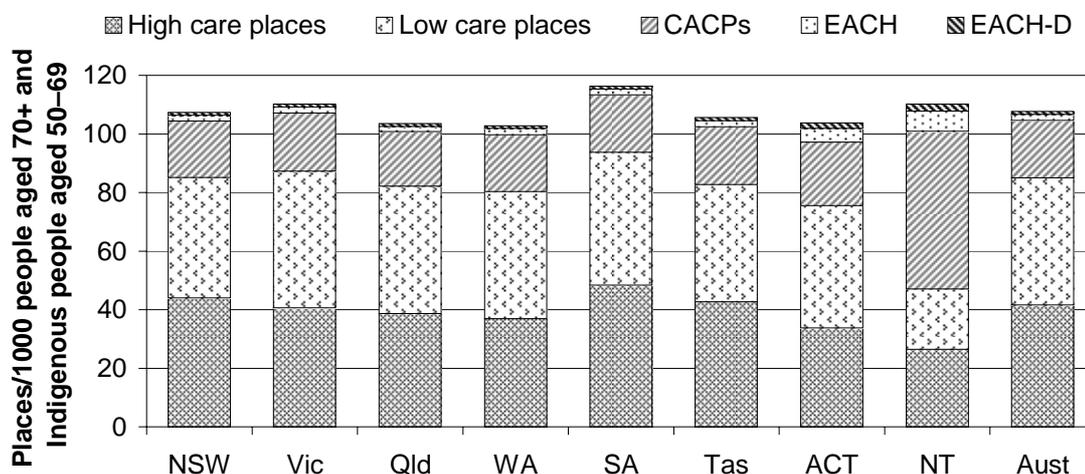


EACH-D = EACH Dementia. ^a Excludes places that have been approved but are not yet operational. ^b 'Ageing in place' may result in some low care places being filled by high care residents. ^c For this Report, Australian Government planning targets are based on providing 113 places per 1000 people aged 70 years or over by 2011. 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 Includes residential places categorised as 'high care' or 'low care', under either the ACFI or the RCS. See box 13.1 for more information. ^e CACPs, EACH and EACH Dementia packages are not residential services but are included in the Australian Government planning targets (see boxes 13.2 and 13.4 for an interpretation of residential care data and Australian Government planning targets). ^f In this figure, CACPs include community care places under the National Aboriginal and Torres Strait Islander Aged Care Program, Multipurpose Services and Innovative Care. ^g TCP are not shown (table 13A.11). ^h See table 13A.11 for further information regarding the calculation of provision ratios.

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

The number of operational places can also be shown using the target population that incorporates Indigenous people aged 50–69 years (figure 13.10). Use of this 'adjusted' target population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Figure 13.10 **Operational residential places, CACPs, EACH and EACH Dementia packages adjusted for Indigenous people aged 50–69, 30 June 2008^{a, b, c, d, e, f, g}**



EACH-D = EACH Dementia. ^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, EACH and EACH Dementia packages are not residential services but are included in the Australian Government planning targets (boxes 13.2 and 13.4 contain an interpretation of residential care data and Australian Government planning targets). ^d Includes residential places categorised as 'high care' or 'low care', under either the ACFI or the RCS. See box 13.1 for more information. ^e 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. ^f In this figure, CACPs include community care places under the National Aboriginal and Torres Strait Islander Aged Care Program, Multipurpose Services and Innovative Care. ^g TCP places are not shown (table 13A.12).

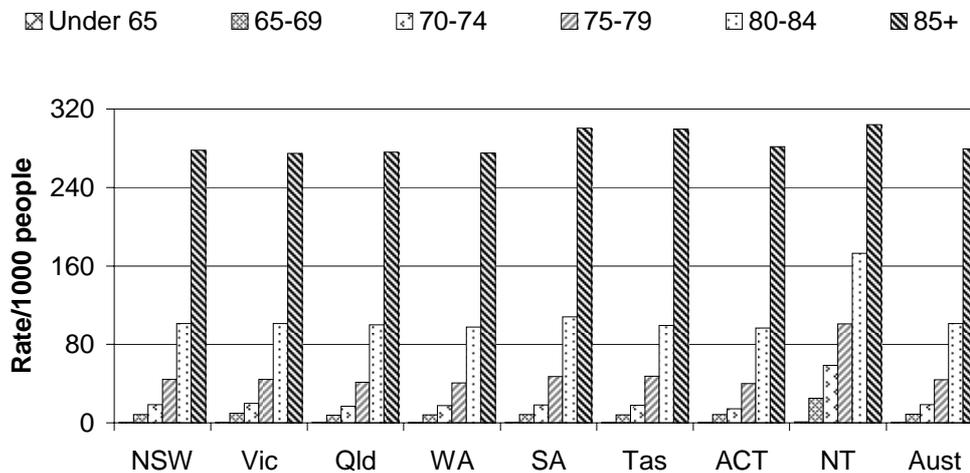
Source: DoHA (unpublished); table 13A.12.

Age-specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage, at 30 June 2008 are reported in tables 13A.59 to 13A.65.

Presentation of age-specific usage rates raises particular data issues. In particular, if the numbers of people within a particular range for a given service are small, this may lead to apparently large fluctuations in growth rates. This can be seen from some of the usage rates identified for the EACH program, which, whilst growing rapidly, are doing so from a relatively small base.

Age-specific rates in this Report are for 2007-08. The national age specific usage rates per 1000 people for high and low residential care, CACP, EACH and EACH Dementia in combination at 30 June 2008 is 0.5 for people under 65 years of age rising to 279.4 for people aged 85 years or older. These rates vary across jurisdictions (figure 13.11).

Figure 13.11 Permanent aged care residents, CACP, EACH and EACH Dementia recipients at 30 June 2008: age specific usage rates per 1000 people^{a, b, c}

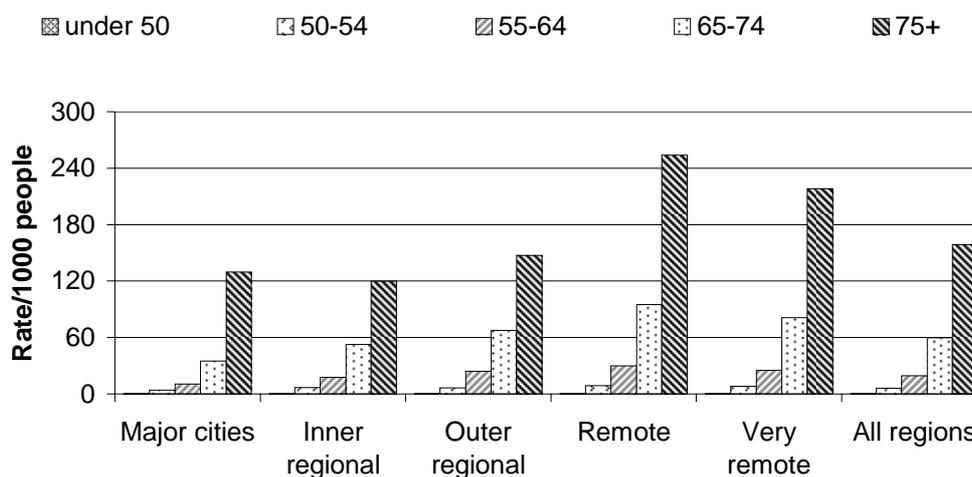


^a Population data for June 2008 are preliminary population projections by SLA for 2006–2026 based on the 2006 Census prepared by ABS according to assumptions agreed to by DoHA (see table 13A.2). ^b Residents without a recorded RCS/ACFI were omitted. ^c These figures exclude places funded by Multi-purpose services and those provided by flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy.

Source: DoHA (unpublished); table 13A.61.

The national age specific usage rates per 1000 Indigenous people for high and low residential care, CACP and EACH in combination at 30 June 2008 is 0.2 for people under 50 rising to 158.7 for people over 75. The data show that Indigenous people tend to access these services at a younger age than the population as a whole. These rates vary by remoteness category (figure 13.12).

Figure 13.12 Indigenous permanent residents classified as high or low care and Indigenous CACP and EACH at 30 June 2008: age specific usage rates per 1000 people by remoteness^{a, b, c, d, e}



^a Geographical data are based on the ABS Australian Standard Geographic Classification of Remoteness Areas 2001. Data are classified according to an index of remoteness which rates each ABS Census District based on the number and size of towns, the distance to major towns and urban centres. ^b Indigenous population data for June 2008 are determined using DoHA unpublished projections. This is a different measure from those used for these age specific usage data in previous reports. See table 13A.65 for more detail. ^c Includes residential places categorised as 'high care' or 'low care', under either the ACFI or the RCS. See box 13.1 for more information. ^d Residents without a recorded RCS/ACFI were omitted. ^e These figures exclude places and packages funded by Multi-purpose services and those provided by flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy.

Source: DoHA (unpublished); table 13A.65.

13.2 Framework of performance indicators

The framework of performance indicators aims to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the general performance indicator framework and service process diagram outlined in chapter 1 (see figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicators relate to government objectives in the aged care sector (box 13.9).

Box 13.9 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:

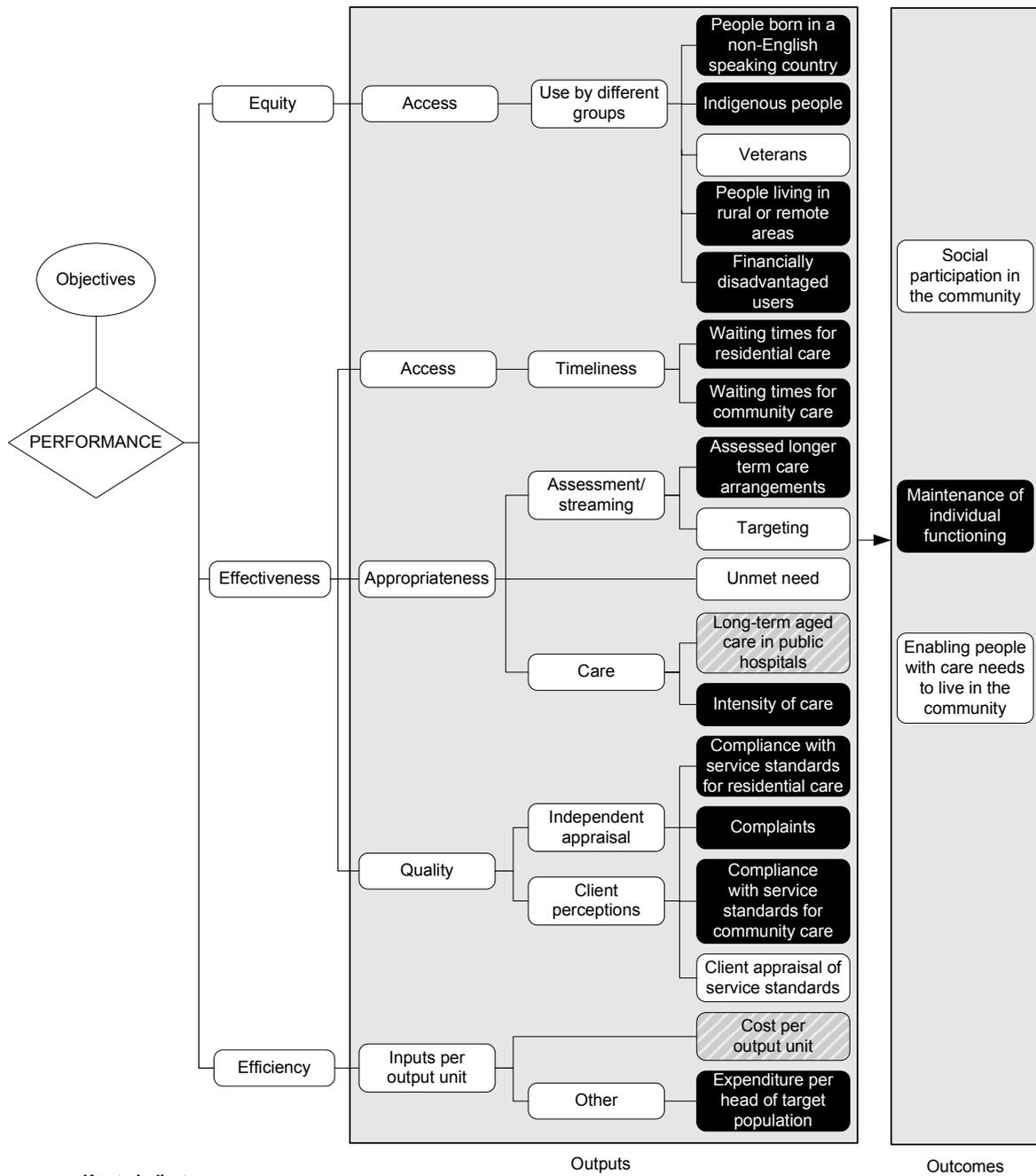
- accessible
- appropriate to needs
- high quality
- efficient.

The performance indicator framework shows which data are comparable in the 2009 Report (figure 13.13). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

13.3 Key performance indicator results

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

Figure 13.13 Performance indicators for aged care services



Key to indicators

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

Outputs

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

Equity — Access

Use by different groups

‘Use by different groups’ is an indicator of governments’ objective for the aged care system to provide equitable access to aged care services for all people who require these services (box 13.10).

Box 13.10 Use by different groups

‘Use by different groups’ is defined as:

- the number of people born in non-English speaking countries using residential services, CACPs, EACH and HACC services, divided by the number of people born in non-English speaking countries aged 70 years or over, benchmarked against the rate at which the general population accesses the service
- the number of Indigenous people using residential services, CACP, EACH and HACC services, divided by the number of Indigenous people aged 50 years or over (because Indigenous people tend to require aged care services at a younger age than the general population) benchmarked against the rate at which the general population accesses the service
- the rate of contacts with Commonwealth Carelink Centres for Indigenous people compared with all people
- access to HACC services for people living in rural or remote areas — the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 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 number of new residents classified as concessional or assisted or supported, divided by the number of new residents.

Continued on next page

Box 13.10 (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 rates than those of the general population, which suggests a greater level of need for services compared with those in the broader aged care population
- for financially disadvantaged users, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional, assisted or supported residents. These targets range from 16 per cent to 40 per cent of places, depending on the service's region. Usage rates equal to, or higher than, the minimum rates are desirable.

Use by different groups is a proxy indicator of equitable access. Various groups are identified by the *Aged Care Act (1997)* and its principles (regulations) as having special needs, including people from Indigenous communities, people born in non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans (including widows and widowers of veterans).

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.

No data were available to report on veterans for this indicator.

Data reported for this indicator are comparable.

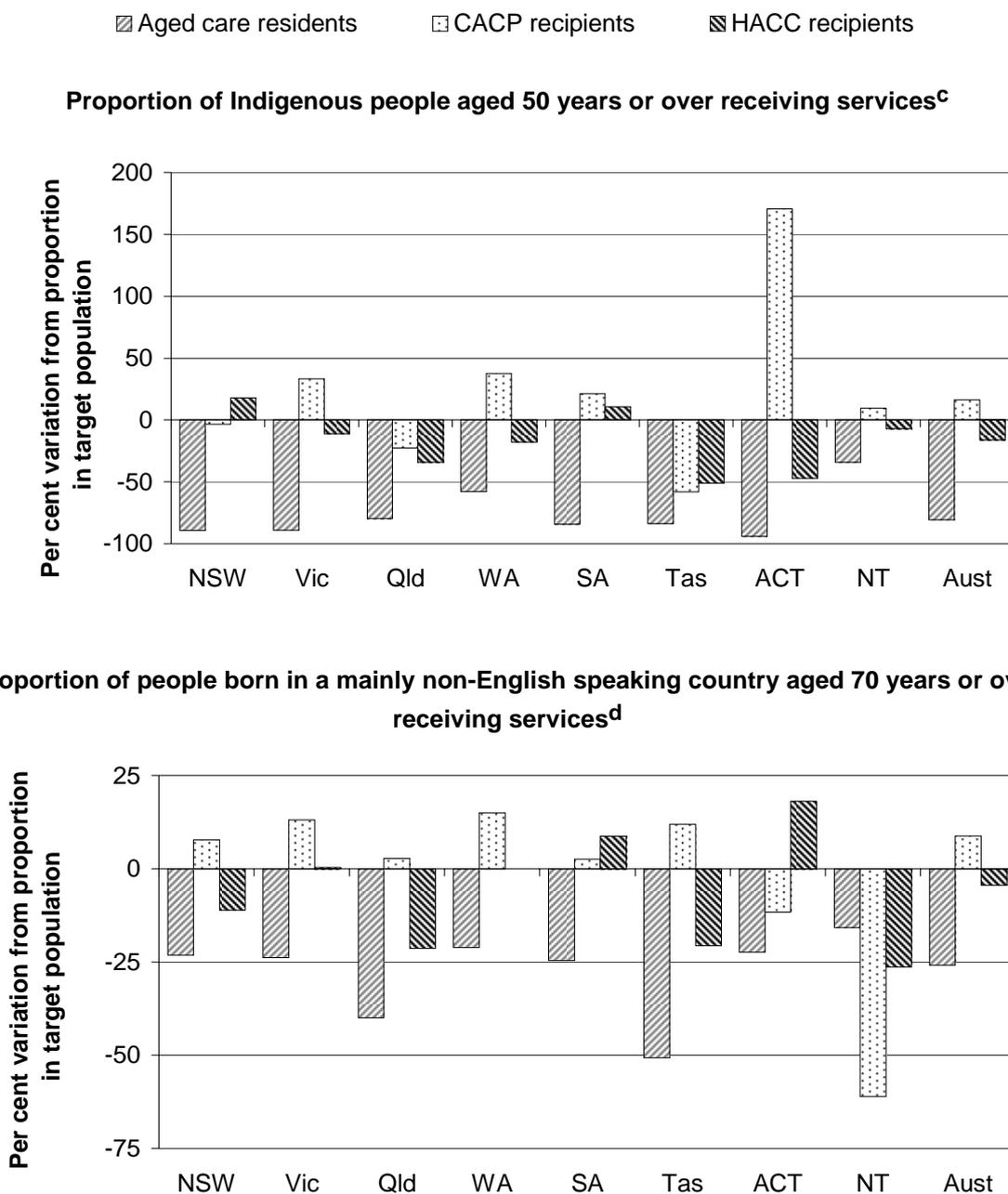
Data presented for this indicator are organised by the type of service provided, with sub-sections for the relevant special needs groups reported against that service.

Access to residential care services, CACP and HACC services by Indigenous people and people born in a mainly non-English speaking country

In general, Indigenous people and people born in a mainly non-English speaking country are under-represented in some aspects of access to residential care, CACP and HACC services in comparison to their proportion of the target population as a whole.

However, in relation to the CACP program in the majority of jurisdictions and nationally, Indigenous people and people born in a mainly non-English speaking country are over-represented, compared to the proportion of this group in the target population. Figure 13.14 demonstrates this over- and under-representation by reflecting the variation in the rate of access of the special needs target population from their proportion in the target population as a whole. If the special needs group accessed services in proportion to their general representation in the target population, no percentage variation would be observed. If they access services at a greater rate, a positive percentage from the benchmark rate will be observed, or, if services are accessed at a lower rate, the bar will be negative (figure 13.14).

Figure 13.14 Variation in the proportions of special needs target populations accessing aged care services from their proportion in the target population as a whole, June 2008 (per cent)^{a, b}



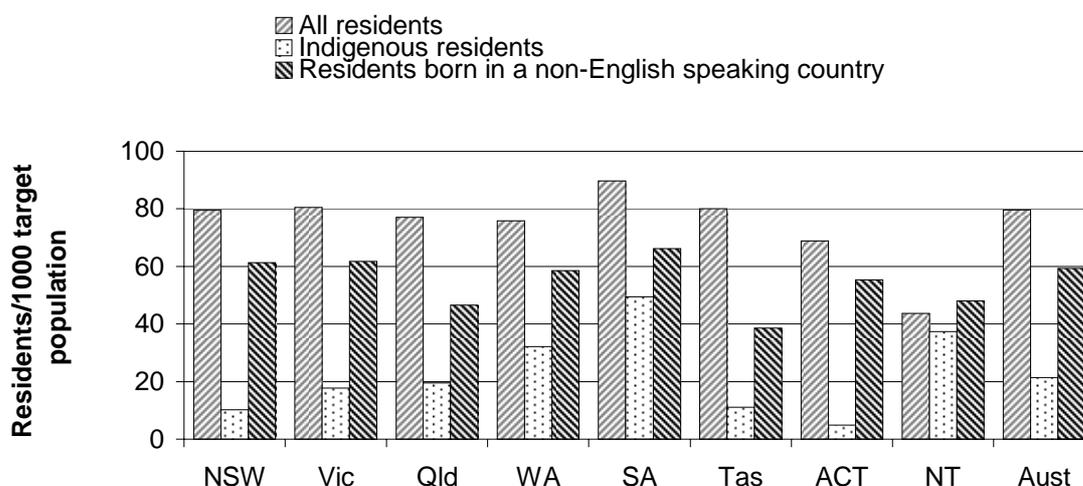
^a The proportion of HACC agencies that submitted data for the year varied between jurisdictions and actual service levels were higher than stated. ^b Reports provisional HACC data that have not been validated and may be subject to revision. ^c The ACT has a very small Indigenous population aged 50 years or over (table 13A.2) and a small number of packages result in a very high provision ratio. ^d There is no variation between the proportion of WA HACC recipients for this group and their proportion in the target population.

Source: DoHA (unpublished); table 13A.19.

Access to residential aged care services by Indigenous people and people born in a mainly non-English speaking country

In all jurisdictions at 30 June 2008, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services (21.4 and 59.3 per 1000 of the relevant target populations respectively), compared with the population as a whole (79.6 per 1000) (figure 13.15).

Figure 13.15 Residents per 1000 target population, 30 June 2008^{a, b, c}



^a All residents data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. ^b Indigenous residents data are per 1000 Indigenous people aged 50 years or over. ^c Data for residents from a non-English speaking country are per 1000 people from non-English speaking countries aged 70 years or over.

Source: DoHA (unpublished); tables 13A.13, 13A.15 and 13A.17.

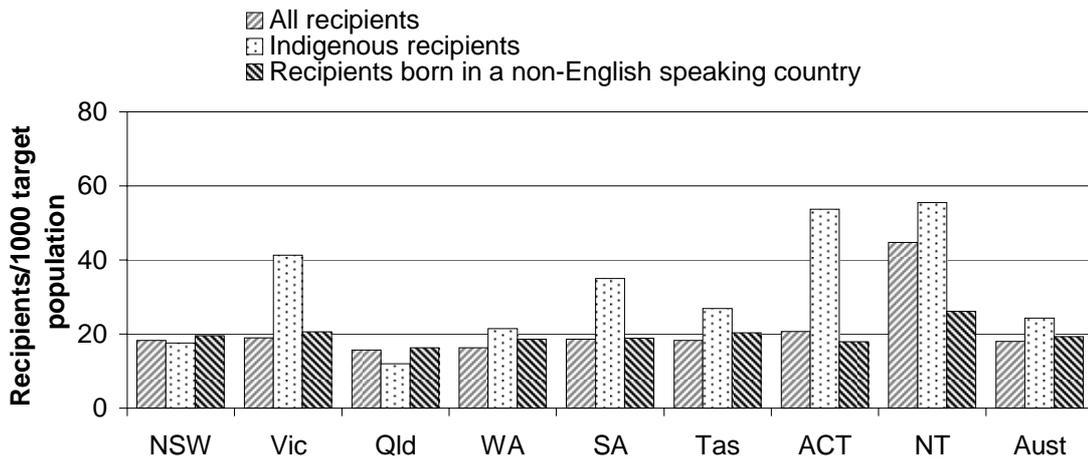
Age specific usage rates for these services, by jurisdiction and remoteness are included in the Report. These data suggest there is significant variation in usage rates by remoteness area. In general, differences amongst jurisdictions are less marked than differences between remoteness areas (tables 13A.14, 13A.16, 13A.18, 13A.59, 13A.61-62, 13A.64-65).

Access to aged care community programs by Indigenous people and people born in a mainly non-English speaking country

The number of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over was 24.3 nationally and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 19.3 nationally. These figures compare to a total of 18.0 per 1000 of the target

population (people aged 70 years or over plus Indigenous people aged 50–69 years) (figure 13.16).

Figure 13.16 Community Aged Care Package recipients per 1000 target population, 30 June 2008^{a, b, c, d, e}



^a All recipients data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. ^b Indigenous recipients data are per 1000 Indigenous people aged 50 years or over. ^c Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 70 years or over. ^d The ACT has a very small Indigenous population aged 50 years or over (table 13A.2), and a small number of packages result in a very high provision ratio. ^e CACPs provide a more flexible model of care, more suitable to remote Indigenous communities, so areas such as the NT have a higher rate of CACP recipients per 1000 people.

Source: DoHA (unpublished); tables 13A.13, 13A.15 and 13A.17.

Age–sex specific usage rates by jurisdiction, remoteness and Indigenous usage vary between jurisdictions and remoteness categories for CACP. For EACH, the differences are less marked. However, the EACH program is small and growing rapidly (tables 13A.60–61 and 13A.63–65).

Access to the HACC program by Indigenous people and by remoteness area

HACC services are provided in the client’s home or community for people with a moderate, severe or profound disability and their carers. The focus of this chapter is all people 70 years or over and Indigenous people aged 50–69 years. The proportion of HACC recipients aged 70 years or over during 2007–08 was 68.9 per cent (table 13A.33).

The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years was 19 319 nationally, and the number of meals provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 was

6202 nationally (table 13.8). The proportion of HACC agencies that submitted the data vary across jurisdictions and comparisons between jurisdictions should be made with care.

Table 13.8 HACC services received, 2007-08 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)^{a, b, c}

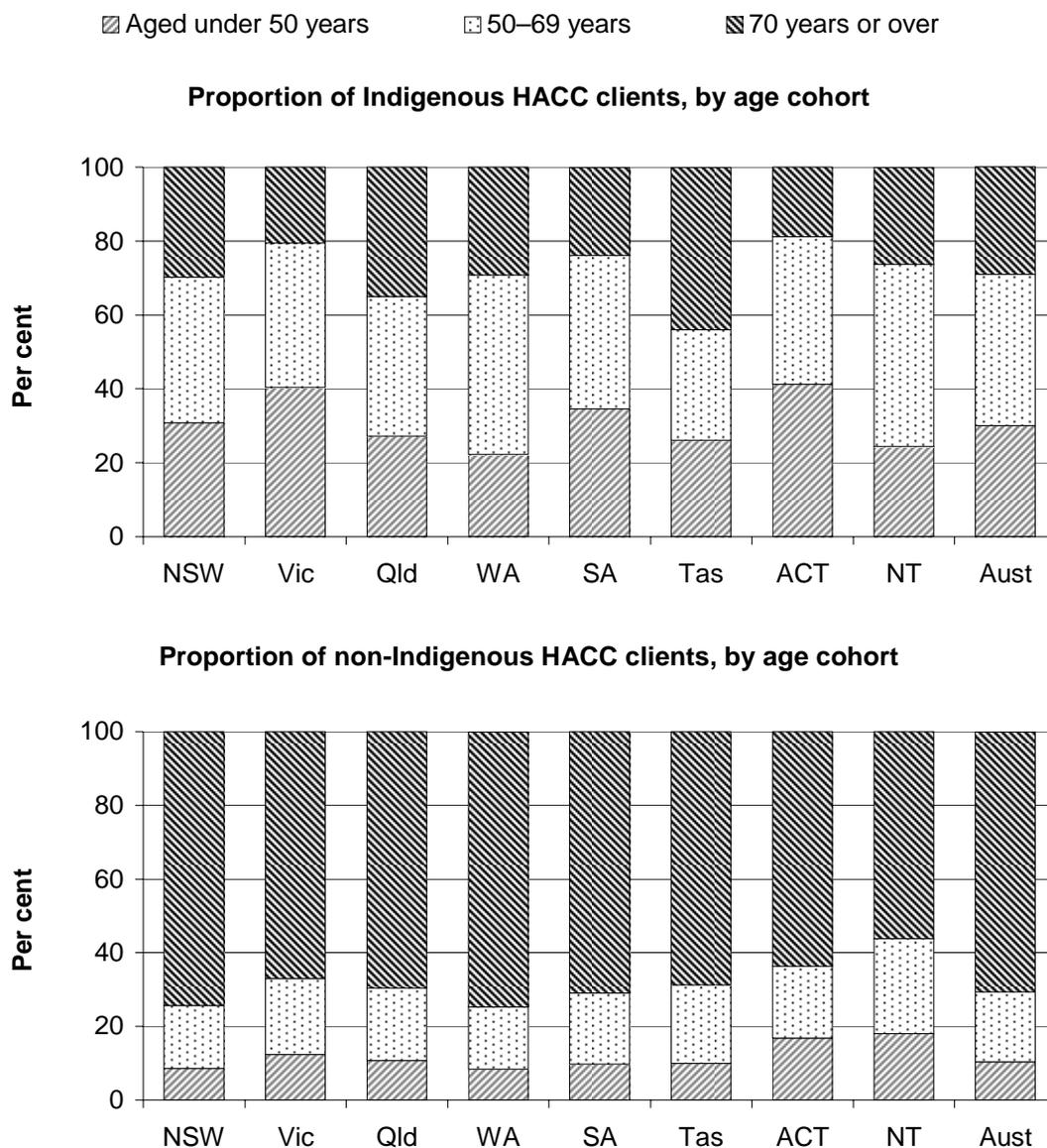
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Percentage of agencies that reported minimum data set data	88	90	94	98	95	99	100	98	91
Total hours (no.) ^d									
Major cities	14 970	20 915	19 268	22 855	17 470	..	20 805	..	18 412
Inner regional	15 180	25 577	21 326	20 381	19 225	16 637	..	..	19 606
Outer regional	19 821	32 120	22 950	26 317	21 519	16 270	..	17 014	22 954
Remote	32 002	46 793	24 839	26 580	27 310	19 743	..	19 022	26 674
Very remote	38 614	..	24 388	34 844	27 992	26 803	..	32 438	30 143
All areas	15 528	22 696	20 445	23 153	18 510	16 619	20 832	22 761	19 319
Total meals (no.) ^e									
Major cities	4 256	5 985	5 359	6 364	7 811	..	5 125	..	5 477
Inner regional	5 645	8 490	7 394	5 753	5 246	4 755	..	..	6 619
Outer regional	7 938	8 147	8 370	8 400	10 235	5 356	..	4 844	8 060
Remote	10 470	11 315	8 663	12 087	7 464	6 190	..	19 799	10 771
Very remote	17 592	..	10 200	29 165	17 839	5 760	..	46 151	25 834
All areas	4 936	6 687	6 398	7 063	7 858	4 979	5 126	22 478	6 202

^a Data represent HACC services received divided by people aged 70 years or over, plus Indigenous people aged 50–69 years (tables 13A.21–26) as distinct from HACC services received divided by HACC target population in all age groups (tables 13A.27–32). ^b The proportion of HACC agencies that submitted data for the year varied between jurisdictions and actual service levels may be higher than stated. ^c Reports provisional HACC data that have not been validated and may be subject to revision. ^d See table 13A.21 for a full list of categories. ^e Includes home meals and centre meals. .. Not applicable.

Source: DoHA Home and Community Care Minimum Data Set 2007-08 (unpublished); DoHA HACC National Data Repository (unpublished); tables 13A.21–26.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2007-08. 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 or over is 29.1 per cent and the proportion of non-Indigenous HACC clients who are aged 70 years or over is 70.5 per cent (figure 13.17).

Figure 13.17 Recipients of HACC services by age and Indigenous status, 2007-08^a



^a Reports provisional HACC data that have not been validated and may be subject to revision.

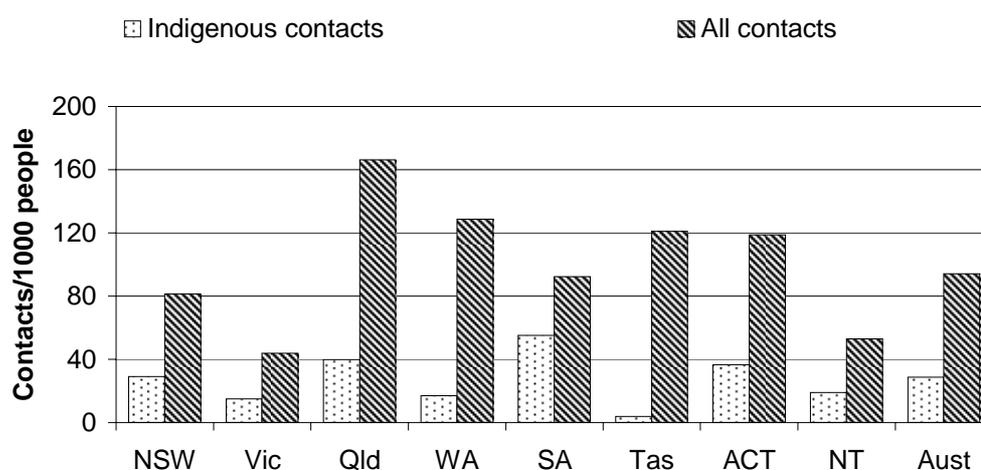
Source: DoHA (unpublished); table 13A.34.

Access by Indigenous people to Commonwealth Carelink Centres

Commonwealth Carelink Centres are information centres for older people, people with disabilities, carers and service providers. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. The national rate at which Indigenous people contacted Carelink

Centres at 30 June 2008, was 28.6 people per 1000 Indigenous people in the Indigenous target population (Indigenous people aged 50 years and over). The rate for all Australians was 94.1 per 1000 people in the target population (people aged 70 years or over plus Indigenous people aged 50–69). These figures varied across jurisdictions (figure 13.18).

Figure 13.18 Commonwealth Carelink Centres, contacts per 1000 target population, by Indigenous status, 30 June 2008^{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 13A.57.

Access to residential services by financially disadvantaged users

The financial assistance arrangements for financially disadvantaged users were changed on 20 March 2008, to include a new category known as supported residents (box 13.11).

Box 13.11 Supported residents

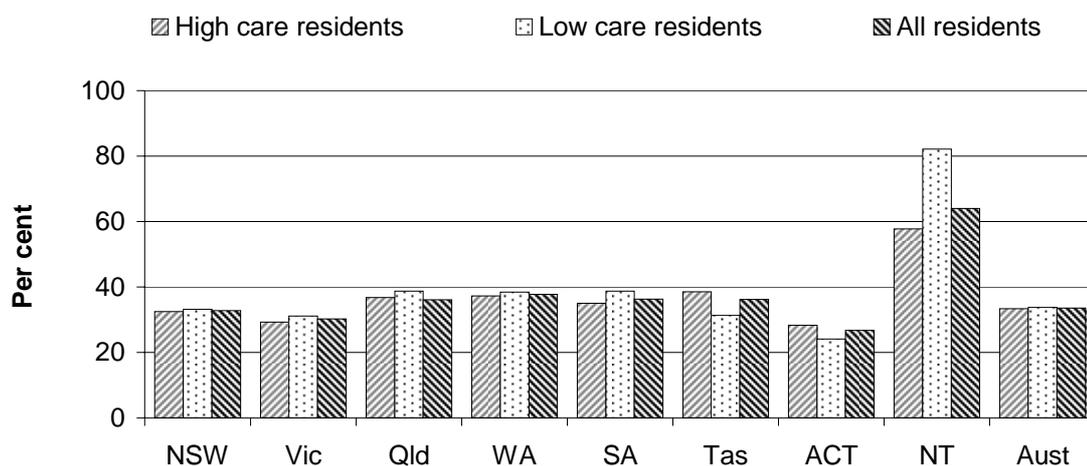
In 2008, new arrangements governing residents' contributions to their accommodation costs and the supplements the Australian Government pays for residents who cannot meet all or part of their own accommodation costs were introduced. These new arrangements only apply to residents who first enter permanent residential care on or after 20 March 2008, or who re-enter care on or after 20 March 2008, after a break in care of more than 28 days.

New residents who are assessed as eligible to receive subsidised accommodation costs are known as supported residents. Residents who entered care prior to 20 March 2008 are still subject to the eligibility criteria for 'concessional' or 'assisted' resident status. These categories have been included in previous reports.

Data incorporating the new supported residents category are reported for the first time in the 2009 Report.

The proportion of all new residents classified as concessional, assisted or supported residents during 2007-08 was 33.6 per cent nationally but varied across jurisdictions (figure 13.19). Targets for financially disadvantaged users range from 16 per cent to 40 per cent of places, depending on the service's region.

Figure 13.19 **New residents classified as concessional, assisted or supported residents, 2007-08^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 partner), 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. Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re-enter care on or after 20 March 2008 after a break in care of more than 28 days) and have assets of up to a set value (\$90 410.40 as at 30 June 2008).

Source: DoHA (unpublished); table 13A.20.

Effectiveness — timeliness of access

Waiting times for residential care

‘Waiting times for residential care’ is an indicator of governments’ objective to maximise the timeliness with which people are able to access residential care (box 13.12).

Box 13.12 Waiting times for residential care

‘Waiting times for residential care’ is defined as the percentage of people who are admitted to high care residential care within three months of their ACAT approval. The indicator measures the elapsed time between ACAT approval and entry into high care residential care service (the period between a client’s approval for high care and his or her entry into care). ACAT approval refers to the approval date of an ACAT assessment. Entry into a residential care service refers to the date of admission to a residential care service.

Shorter elapsed times (measured by higher rates of admission to high care residential care within three months of ACAT approval) are desirable.

This indicator needs to be interpreted with care. The measure of ‘elapsed time’ is utilised because the period of time between the ACAT approval and entry into residential care may be due to factors which cannot be categorised as ‘waiting’ time. These include:

- clients with ACAT approvals who do not enter residential care (for example, who die before entering care)
- residential placement offers that are not accepted
- the availability of alternative community care, informal care and respite services
- the availability and distribution of operational residential care services
- building quality and perceptions about quality of care, which influence client choice of preferred service
- delays between the date of ACAT assessments and their approval
- priority allocations (for example, special needs groups)
- hospital discharge policies and practices
- the impact on clients of programs which provide alternatives to residential care, such as EACH and EACH Dementia
- client choice not to enter residential care immediately but to take up the option later within the 12 month approval limit.

(Continued on next page)

Box 13.12 (Continued)

The measure focuses on high care services because, as a proxy for waiting time, the link between entry to residential care and elapsed time is stronger for high care residents than for low care residents. This is due to the urgency for high care residents' needs, and the greater number of alternatives for people with ACAT approvals for low care only. Waiting time measures for low care are included in the attachment tables.

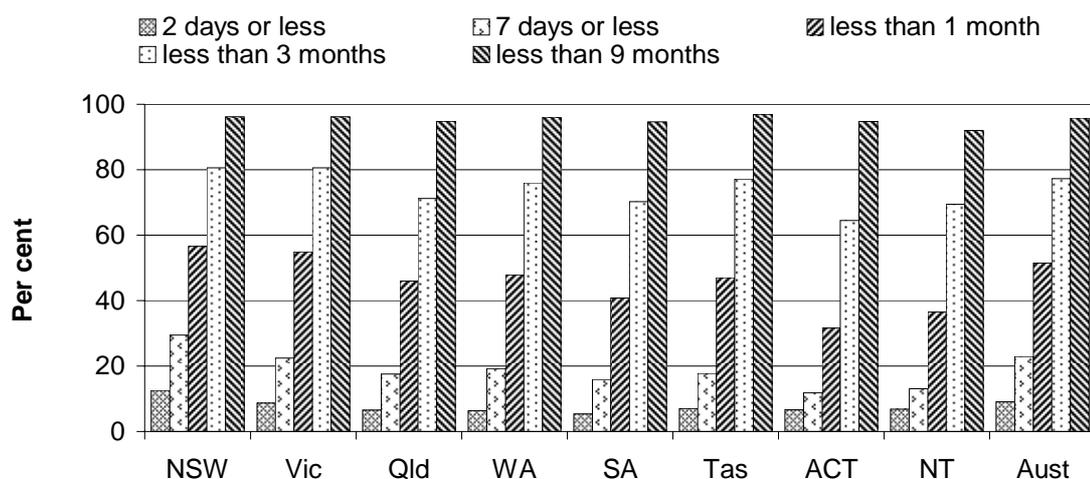
It is recognised that this indicator has limitations and work is underway to review the data. This indicator will continue to be reported until improved data are available.

Data reported for this indicator are comparable.

Overall, 22.9 per cent of all people entering high care residential care during 2007-08 did so within seven days of being approved by an ACAT, 51.5 per cent entered within one month of their ACAT approval and 77.3 per cent entered within three months of their approval. These times varied across jurisdictions (figure 13.20). In the calculation of waiting time, the most recent ACAT approval prior to entry is used. The median time for entry into high care residential care was 28 days (table 13A.37).

Nationally, a greater proportion of people entering high care residential services entered within three months of approval (77.3 per cent), compared with the proportion entering low care residential services within that time (60.9 per cent). These proportions varied across jurisdictions (table 13A.37).

Figure 13.20 People entering high care residential care within specified time periods of their ACAT approval, 2007-08^a



^a Includes residential places categorised as 'high care' under either the ACFI or the RCS. See box 13.1 for more information.

Source: DoHA (unpublished); table 13A.37.

Waiting times for community care

'Waiting times for community care' is an indicator of governments' objective to maximise the timeliness with which people are able to access community care (box 13.13).

Box 13.13 Waiting times for community care

'Waiting times for community care' is defined as the elapsed time between an ACAT approval and receipt of a CACP. The indicator measures the period between a client's approval for care and his or her receipt of care.

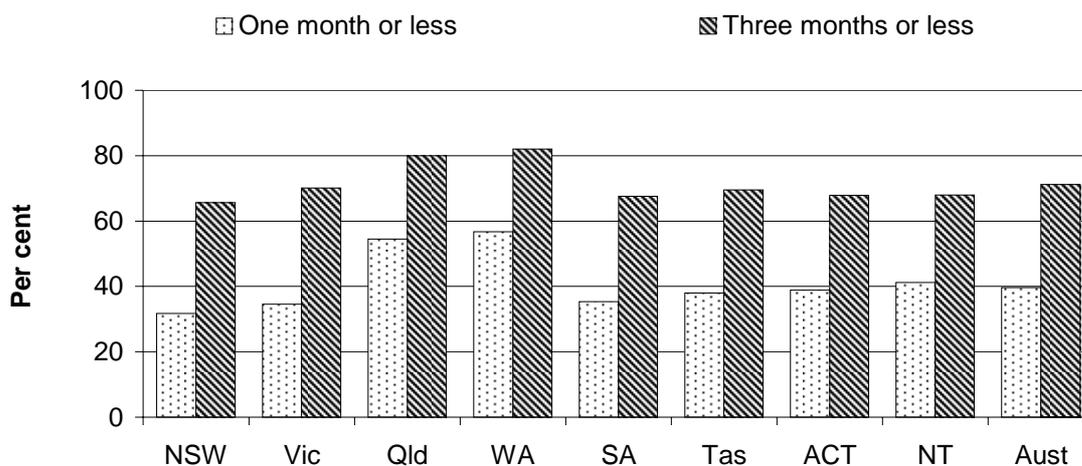
Shorter waiting times (or higher rates of receipt of a CACP within one month or within three months of an ACAT approval) are considered desirable.

This indicator needs to be interpreted with care. Some ACAT approved clients may choose not to receive a CACP, alternative community care options may be available, or varying fee regimes might influence choice.

Data reported for this indicator are comparable.

Overall, 71.2 per cent of all people receiving a CACP during 2007-08 received it within three months of being approved by an ACAT. This proportion varied across jurisdictions. On average, 39.6 per cent started receiving a CACP within one month of their ACAT approval (figure 13.21).

Figure 13.21 **People commencing a CACP within one or three months of their ACAT approval, 2007-08**



Source: DoHA (unpublished); table 13A.37.

Effectiveness — appropriateness

Assessed longer term care arrangements

‘Assessed longer term care arrangements’ is an indicator of governments’ objective to meet clients’ needs through provision of appropriate aged care services (box 13.14).

Box 13.14 Assessed longer term care arrangements

‘Assessed longer term care arrangements’ is defined as assessed longer term living arrangements, measured by the proportions of ACAT clients recommended to remain at home and in residential care (permanent or respite). Aged care assessments are mandatory for admission to Australian Government subsidised residential care or for receipt of a CACP, EACH, EACH Dementia or TCP package.

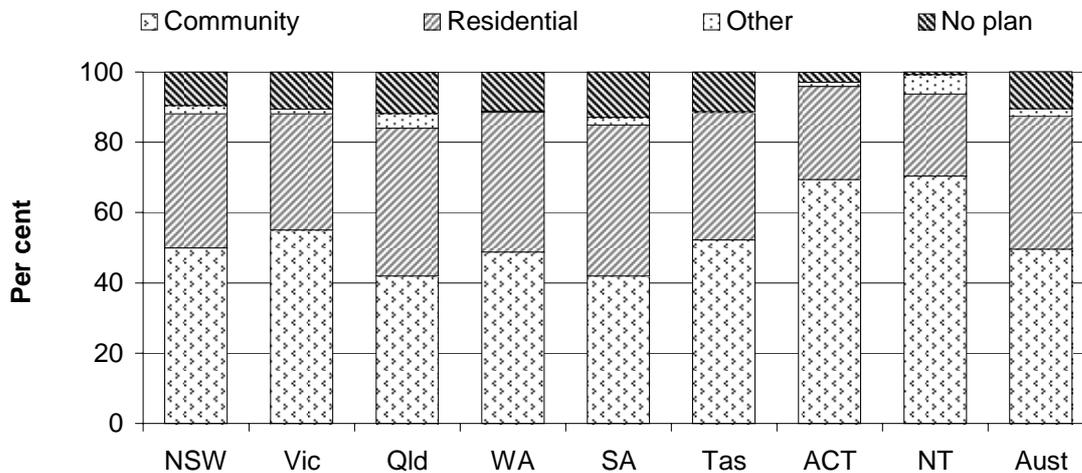
Higher proportions of clients remaining in the community are desirable.

The results for this indicator show the distribution of recommended living arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions 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.

Data reported for this indicator are comparable.

The national proportion of ACAT clients approved for residential care in 2006-07 was 37.8 per cent and the proportion recommended to remain in the community was 49.6 per cent. No long term plan was made for 10.5 per cent, which included deaths, cancellations and transfers. These proportions varied across jurisdictions (figure 13.22).

Figure 13.22 Recommended longer term living arrangements of ACAT clients, 2006-07^a



^a 'No plan' includes deaths, cancellations and transfers.

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.38.

Targeting

'Targeting' has been identified for development as an indicator of governments' objective to ensure that services are allocated to those people in greatest need (box 13.15).

Box 13.15 Targeting

'Targeting' has yet to be defined.

Data for this indicator were not available for the 2009 Report.

Unmet need

'Unmet need' is an indicator of governments' objective of ensuring aged care services are allocated to meet clients' needs (box 13.16).

Box 13.16 Unmet need

'Unmet need' is defined as the extent to which demand for services to support older people requiring assistance with daily activities is met.

While low rates of unmet need are desirable, defining and determining the level of need at an individual level, let alone at a population level, is complex. Perceptions of need and unmet need are often subjective.

Data for this indicator are drawn from the ABS 2003 Survey of Disability, Ageing and Carers. Data are for people aged 70 years or over who self-identified as having a need for assistance with at least one everyday activity, and the extent to which that need is met (fully, partly or not at all).

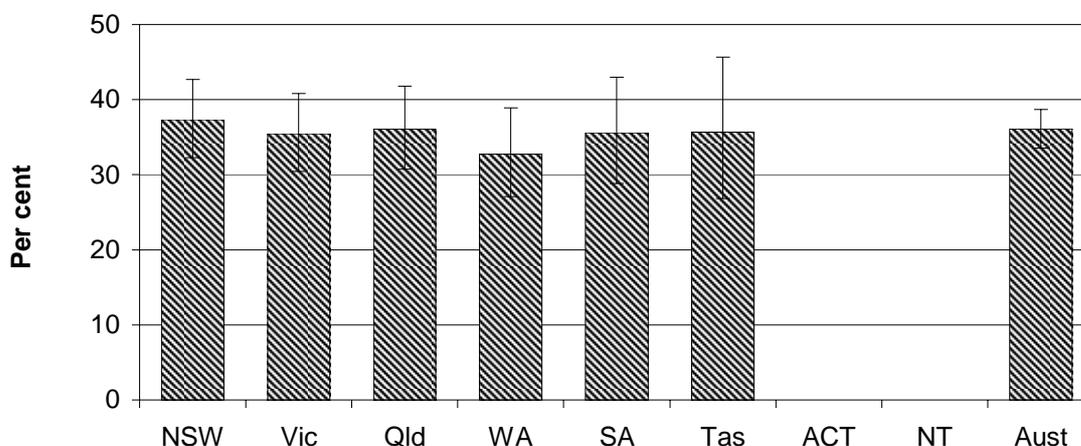
Direct inferences about the demand for services need to be made with care, because the measure used does not:

- reveal the intensity of care required by those who identify an unmet need — there is no indication of whether the need can readily be met informally or by formal home care, or whether the person may require residential care
- reflect the degree of unmet demand for a specific type of service. Differences across jurisdictions in the proportion of unmet need can reflect different policy approaches to targeting services. Some governments may choose to focus on those with the greatest degree of need for care and on fully meeting their needs. By contrast, other governments may choose to provide a lower level of service to a greater number of people, while only partly meeting the needs of those with the greatest need for care — both are valid policy approaches
- reflect the past and possible future duration of the need — that is, whether it is long term or transitory
- reflect whether the need relates to a disability support service, aged care service or health care.

Although data are included here, this indicator is regarded as yet to be developed, because of the extent of the caveats.

Of those people aged 70 years or over in 2003, who were living in households and who self-identified as having a need for assistance with at least one everyday activity, over one third (36.1 per cent) reported that their needs for assistance were not fully met (figure 13.23).

Figure 13.23 Percentage of older people needing assistance with at least one everyday activity whose need was not fully met, 2003^{a, b, c, d}



^a Aged 70 years or over, living in households. ^b Australian total includes data for the ACT and the NT. ^c Data for the ACT and the NT are not published separately. ^d Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS 2003 Survey of Disability, Ageing and Carers (unpublished); table 13A.67.

Long term aged care in public hospitals

‘Long term aged care in public hospitals’ is an indicator of governments’ objective to minimise the incidence of older people staying in public hospitals when their care needs may be met through residential or community care services (box 13.17).

Box 13.17 Long term aged care in public hospitals

‘Long term aged care in public hospitals’ is defined as the proportion of completed hospital separations for people aged 70 years or over plus Indigenous people aged 50–69 years where:

- the care type was maintenance; and
- the diagnosis (either principal or additional) was either ‘person awaiting admission to residential aged care service’ or ‘need for assistance at home and no other household member able to render care’; and
- where the length of stay was 35 days or longer

as a proportion of all such separations.

A low proportion of stays of 35 days or more is desirable.

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Box 13.17 (Continued)

Hospital inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term.

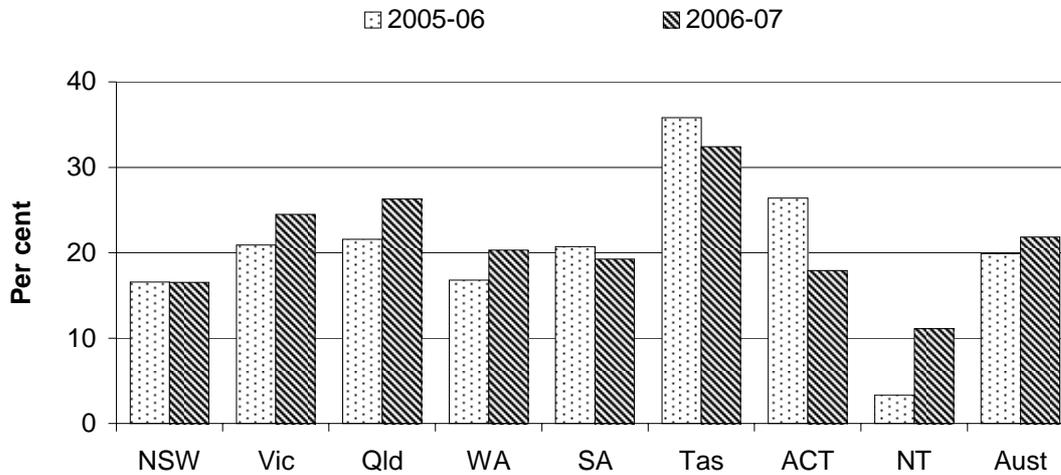
This measure should be interpreted with care.

- Patients who have not completed their hospital stay are not included.
- Although the diagnosis codes reflect a care type, they do not determine a person's eligibility for residential aged care (this is determined by an ACAT assessment) or necessarily reliably reflect access issues for residential aged care from the acute care sector.
- Diagnosis codes may not be applied consistently across jurisdictions or over time.
- Reported hospital separations do not necessarily reflect the full length of hospital stay for any individual patient. If a change in the type of care occurs during a patient's hospital stay (for example, from acute to maintenance) then two separations are reported for that patient.
- The code 'need for assistance at home and no other household member able to render care' may also be used for respite care for aged care residents or those receiving community care and some jurisdictions may have a high proportion of this type of use. This is particularly relevant in some rural areas where there are few alternative options for these clients.
- The measure does not necessarily reflect alternative strategies in place by states and territories to manage the older person into appropriate residential aged care facilities from acute care hospitals.
- The measure is regarded as a proxy, as the desired measures (utilising appropriate linked hospital separations and ACAT approvals) are not available at this time. Further development is underway to improve available data sets and associated measures for future reports.

Data reported for this indicator are not directly comparable.

The proportion of separations for patients aged 70 years or over plus Indigenous people aged 50–69 years who had a care type of maintenance with a diagnosis (either principal or additional) of either 'person awaiting admission to residential aged care service' or 'need for assistance at home and no other household member able to render care', and whose separation was 35 days or longer was 21.8 per cent nationally, in 2006-07. This proportion varied across jurisdictions (figure 13.24). These data reflect only a small proportion of all public hospital separations for patients aged 70 years or over plus Indigenous people aged 50–69 years (10 781 separations of a total of 1.4 million nationally) (table 13A.70).

Figure 13.24 **Proportion of long term separations for aged care patients, in public hospitals^{a, b, c, d, e, f, g}**



^a Data are for hospital separations with a care type of maintenance and a diagnosis (either principal or additional) of either 'person awaiting admission to residential aged care service' or 'need for assistance at home and no other household member able to render care' and where the separation lasted 35 days or longer. ^b Age of patients is 70 years or over, plus Indigenous patients 50–69 years. ^c Although the diagnosis codes reflect a care type, they do not determine a person's eligibility for residential aged care. ^d Diagnosis codes may not be applied consistently across jurisdictions or over time. ^e These data only account for completed unlinked separations. ^f The code 'need for assistance at home and no other household member able to render care' may also be used for respite care for either residential or community care patients. ^g An individual patient may have multiple hospital separations during a single hospital stay, for example, if a change in the type of care occurs during a patient's hospital stay. Data on length of stay relate to each separation and not to the whole hospital stay.

Source: AIHW (unpublished); table 13A.70.

Intensity of care

'Intensity of care' is an indicator of governments' objective to encourage 'ageing in place' to increase choice and flexibility in residential aged care service provision (box 13.18).

Box 13.18 Intensity of care

'Intensity of care' is defined by two measures:

- the proportion of people who stayed in the same residential aged care service when changing from low care to high care
- the proportion of low care places occupied by residents with high care needs, compared with the proportion of all operational places taken up by residents with high care needs.

Higher rates of ageing in place are desirable, in the context of a flexible system that also meets the need for low level care either in residential facilities or in the community.

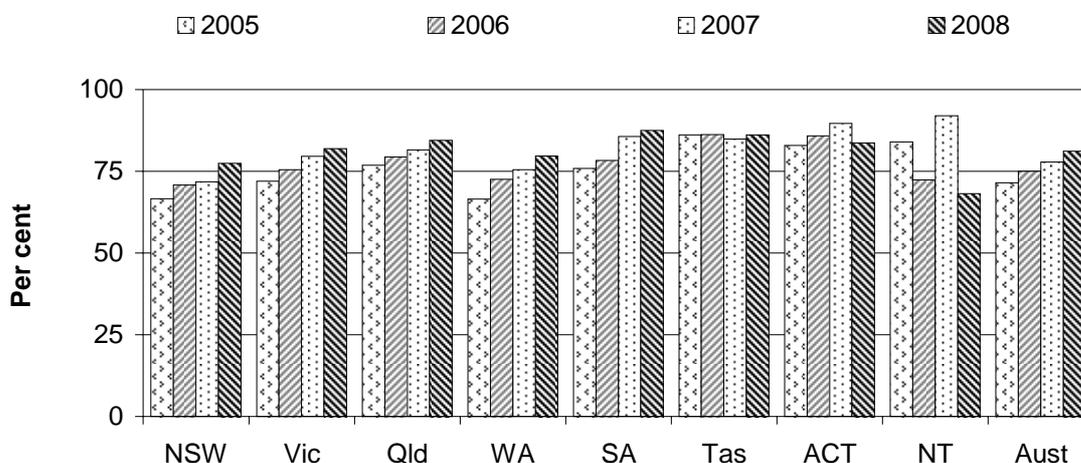
These measures reflect the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The Aged Care Act aims explicitly to encourage ageing in place to increase choice and flexibility in residential aged care service provision (box 13.7).

This indicator needs to be viewed from the perspective of the system as a whole. The implication of ageing in place is that some places that were allocated for low care will be occupied by high care residents (or, conversely, allocated for high care and occupied by low care residents). Information about the use of operational residential aged care places is provided to demonstrate the impact of ageing in place on the aged care services system over time.

Data reported for this indicator are comparable.

Nationally, from June 2005 to June 2008 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 71.5 per cent to 81.2 per cent (figure 13.25). In June 2008 the proportion was higher in inner regional areas (84.0 per cent), outer regional areas (83.5 per cent), remote areas (89.0 per cent) and very remote areas (84.0 per cent) than in major cities (79.7 per cent) (table 13A.55).

Figure 13.25 Proportion of residents who changed from low care to high care and remained in the same aged care service, June^a

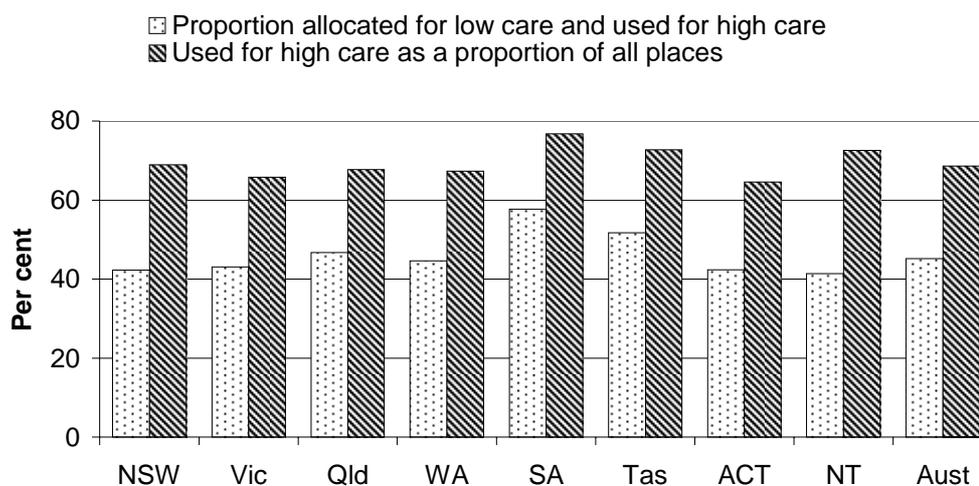


^a For June 2008, includes residential places categorised as 'high care' or 'low care', under either the ACFI or the RCS. See box 13.1 for more information.

Source: DoHA (unpublished); table 13A.55.

Nationally, 45.1 per cent of low care places in 2007-08 were occupied by residents with high care needs. The proportion of all operational places taken up by residents with high care needs was 68.6 per cent (figure 13.26). These data are provided by remoteness area in table 13A.58.

Figure 13.26 Utilisation of operational residential places, 30 June 2008^a



^a Includes residential places categorised as 'high care' or 'low care', under either the ACFI or the RCS. See box 13.1 for more information.

Source: DoHA (unpublished); table 13A.58.

Effectiveness — quality

Compliance with service standards for residential care

‘Compliance with service standards for residential care’ is an indicator of governments’ objective to ensure residential care services attain high levels of service quality, through compliance with certification and accreditation standards (box 13.19).

Box 13.19 Compliance with service standards for residential care

‘Compliance with service standards for residential care’ is defined by two measures:

- the proportion of accredited services which have received three year re-accreditation, by meeting accreditation standards
- the average number of residents per room.

The extent to which residential care services comply with service standards implies a certain level of care and service quality.

High rates of approval for three year re-accreditation are desirable.

Since 2001, each Australian Government funded residential service has been required to meet accreditation standards (which comprise 44 expected outcomes). The accreditation indicator reflects the period of accreditation granted. The accreditation process is managed by the Aged Care Standards and Accreditation Agency (ACSAA). A service must apply to ACSAA for accreditation and its application is based on a self-assessment of performance against the accreditation standards. Following a residential service applying for accreditation, a team of registered quality assessors reviews the application, conducts an onsite assessment and prepares a report based on these observations, interviews with residents, relatives, staff and management, and relevant documentation. An authorised decision maker from ACSAA then considers the report, in conjunction with any submission from the residential service and other relevant information (including information from DoHA) and decides whether to accredit and, if so, for how long. New services are generally accredited for one year.

Lower rates of residents per room are generally desirable because they imply a higher service quality of accommodation.

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Box 13.19 (Continued)

As part of the Australian Government's certification requirements for residential aged care buildings, by 31 December 2008 every service that existed prior to July 1999 will be required to have no more than four residents accommodated in any room, no more than six residents sharing each toilet and no more than seven residents sharing each shower. For new buildings planned or built since July 1999, an average for the whole service of not more than 1.5 residents per room is required. No room may accommodate more than two residents, there must be no more than three residents per toilet and no more than four residents per shower or bath.

Data reported for this indicator are comparable.

Accreditation decisions and other information relating to the accreditation standards, the aged care standards and ACSAA are publicly available via the ACSAA's web site (www.accreditation.aust.com). The accreditation process is summarised in box 13.19.

At 30 June 2008, 93.5 per cent of residential aged care services had been granted a re-accreditation approval for a period of three years or more. This proportion varied across jurisdictions (table 13.9).

Table 13.9 Re-accreditation decisions on residential aged care services, 30 June 2008^{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>
Re-accreditation period										
<2 years	%	0.4	1.7	5.2	3.2	4.6	2.3	–	13.3	2.4
2 years or more (but <3 years)	%	1.9	3.2	10.1	3.2	3.9	4.5	8.3	–	4.1
3 years or more	%	97.7	95.1	84.7	93.6	91.4	93.2	91.7	86.7	93.5
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total re-accredited services	no.	894	783	477	249	280	88	24	15	2 810

^a Excludes services being accredited for the first time, of which there were 36 in the year to June 2008. ^b NT data will be variable due to small numbers. – Nil or rounded to zero.

Source: ACSAA (unpublished); table 13A.41.

Existing services are required to meet privacy and space requirements by 2008. From 2004, the number of residents per room nationally has been gradually decreasing. The average number of residents per room at December 2006 was 1.19 nationally (table 13A.42).

Complaints

'Complaints' is an indicator of governments' objective to ensure aged care services provide a high quality of care (box 13.20).

Box 13.20 Complaints

'Complaints' is defined as the number of breaches under the *Aged Care Act 1997* per 1000 residents.

A low proportion of breaches is desirable.

This indicator is a proxy of the quality of care. It counts the number of breaches identified nationally by the Complaints Investigation Scheme (CIS), which replaced the Complaints Resolution Scheme (CRS) on 1 May 2007. Official complaints may indicate dissatisfaction about an element of the service provided, but do not always result in the finding of a breach.

The CIS investigates any potential breach of an approved provider's responsibilities in residential and community care; requires the service provider, where appropriate, to take action; and is able to refer issues that may be more appropriately dealt with by others (for example, police, nursing and medical registration boards). An independent Aged Care Commissioner has been appointed to review decisions made by the CIS in relation to the investigation of complaints, to examine complaints made about CIS processes and the conduct of the Aged Care Standards and Accreditation Agency as well as any people carrying out audits or making support contacts under the Accreditation Grant Principles 1999.

The rate at which complaints occur can be influenced by the propensity of clients and their families or service staff to complain, their knowledge of the complaints system and perceptions of the effectiveness of the complaints system.

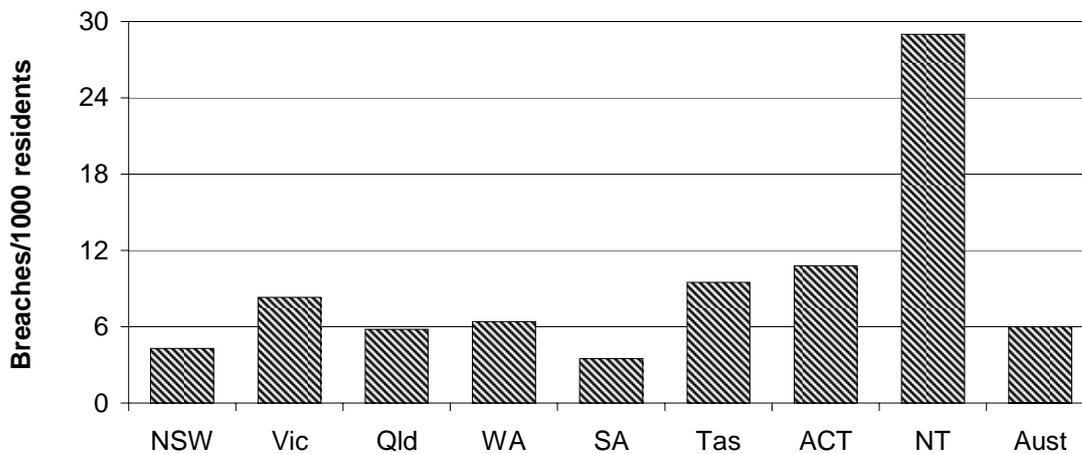
Data reported for this indicator are comparable.

From 1 July 2007 to 30 June 2008, the CIS identified 930 breaches under the Aged Care Act (table 13A.43). The number of breaches identified per 1000 residents from 1 July 2007 to 30 June 2008 was 6.0 nationally. This varied across jurisdictions (figure 13.27).

In the period 1 July 2007 to 30 June 2008, DoHA also dealt with 11 323 matters of which 7496² were within the scope of the CIS to investigate, although not all of these were complaints. The increased number of calls reflects the broader nature of the new scheme, which deals with information from a range of sources (DoHA unpublished).

² Of the 7496 in scope cases dealt with by the CIS, 89 per cent related to residential care services.

Figure 13.27 **Complaints Investigation Scheme breaches, 2007-08^{a, b}**



^a Outcomes of the CRS are included in earlier reports. ^b NT data will be variable due to small numbers.

Source: DoHA (unpublished); table 13A.43.

Compliance with service standards for community care

‘Compliance with service standards for community care’ is an indicator of governments’ objective to ensure that community aged care programs provide a high quality of service (box 13.21).

Box 13.21 Compliance with service standards for community care

'Compliance with service standards for community care' is defined by two measures:

- the number of HACC agencies appraised against the standards divided by the total number of HACC agencies
- the proportions of agencies which achieve high, good, basic, or poor ratings, and the average score in each jurisdiction.

A high proportion of agencies appraised, higher ratings and high average scores are desirable.

The indicator monitors the extent to which individual agencies are complying with service agreement standards. The HACC national service standards provide HACC funded agencies with a common reference point for internal quality control by defining aspects of service quality and expected outcomes for consumers. States and territories are required to include the standards in all service agreements. The HACC national service standards instrument has been developed to measure through a service appraisal process the extent to which individual agencies are complying with the standards. Monitoring and compliance with the standards are now a major part of service reviews. This indicator also measures the percentage of individual agencies that comply with the service standards, through the outcomes of service standard appraisals. It should be noted that the standards are not an accreditation system.

Data reported for this indicator are comparable.

A total of 3504 HACC agencies were identified for appraisal over the second appraisal cycle (the four year cycle 2004-05 to 2007-08). The number of these agencies appraised was 2915 (83.2 per cent). This proportion varied across jurisdictions (table 13.10). The outcomes of these appraisals was a national average score of 17.5 out of 20 (table 13.11).

The ACT will complete this cycle in 2008-09 and updated outcomes from the second appraisal cycle will be available for the 2010 Report.

Table 13.10 HACC National Service Standards appraisals over the four year cycle ending 2007-08^a

	<i>Unit</i>	<i>NSW^b</i>	<i>Vic^c</i>	<i>Qld^d</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^e</i>	<i>NT^f</i>	<i>Aust^d</i>
Appraisals	no.	1 411	338	963	123	179	53	..	10	2 915
HACC agencies	no.	1 785	460	801	135	179	53	..	91	3 504
Proportion of agencies assessed	%	79.0	73.5	100.0	91.1	100.0	100.0	..	11.0	83.2

^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 Validation of 343 HACC services auspiced and/or administered by NSW Health occurred from February–October 2005. Monitoring of all other NSW HACC services commenced in November 2005 under the Integrated Monitoring Framework, and is due for completion by December 2008. The total number of HACC agencies is the number of HACC services funded in 2007-08. The proportion of agencies appraised is indicative only, as agencies may equate to services or outlets. In NSW, the appraisal methodology differs slightly under the Integrated Monitoring Framework, though is closely aligned to the HACC Standards Instrument. Scores are derived from equivalent performance questions. ^c Victoria has completed appraisals for 338 agencies. The remaining 122 agencies are Quality Improvement Council or Australian Council on Healthcare Standards accredited. Victoria has contracted with the licensee of these systems to conduct appraisals against HACC standards as part of their major review. These appraisals will be finalised by mid 2010. ^d In Queensland the number of appraisals exceeds the number of agencies because some service providers were reviewed twice in the four year period. Therefore calculation of the Australian total of appraisals and the proportion of agencies assessed only includes 801 Queensland agencies. ^e Quality Assessments in the ACT will occur in 2008-09. ^f NT data are variable due to small numbers. .. Not applicable.

Source: State and Territory governments (unpublished).

Table 13.11 HACC National Service Standards results of appraisals over the four year cycle ending 2007-08 (number)^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld^d</i>	<i>WA</i>	<i>SA</i>	<i>Tas^e</i>	<i>ACT^f</i>	<i>NT</i>	<i>Aust</i>
High (17.5 – 20)	997	162	682	88	89	29	..	1	2 048
Good (15 – 17.4)	226	74	175	11	42	9	..	4	541
Basic (10 -14.9)	167	71	85	16	34	10	..	4	387
Poor (less than 10)	21	31	21	8	14	5	..	1	101
Average score	17.7	16.0	18.3	17.0	16.1	16.2	..	15.0	17.5

^a Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those listed. ^b The results of the appraisals will reflect the individual approaches adopted by each State and Territory. ^c For details about the method of determining the average score, see table 13A.66. ^d In Queensland some agencies were reviewed twice in the four year period. This table includes outcomes of all appraisals during the cycle. ^e One agency in Tasmania declined to participate in the appraisal process and was therefore scored as zero. ^f Quality Assessments in the ACT will occur in 2008-09. .. Not applicable.

Source: State and Territory governments (unpublished); table 13A.66.

Client appraisal of service standards

‘Client appraisal of service standards’ is an indicator of governments’ objective to ensure high levels of client satisfaction with aged care services (box 13.22).

Box 13.22 Client appraisal of service standards

‘Client appraisal of service standards’ is yet to be defined.

Data for this indicator were not available for the 2009 Report.

Efficiency — inputs per output unit

Cost per ACAT assessment

‘Cost per ACAT assessment’ is an indicator of governments’ objective to deliver efficient ACAT assessment services (box 13.23).

Box 13.23 Cost per ACAT assessment

‘Cost per ACAT assessment’ is defined as Australian Government expenditure on ACATs divided by the number of ACAT assessments completed.

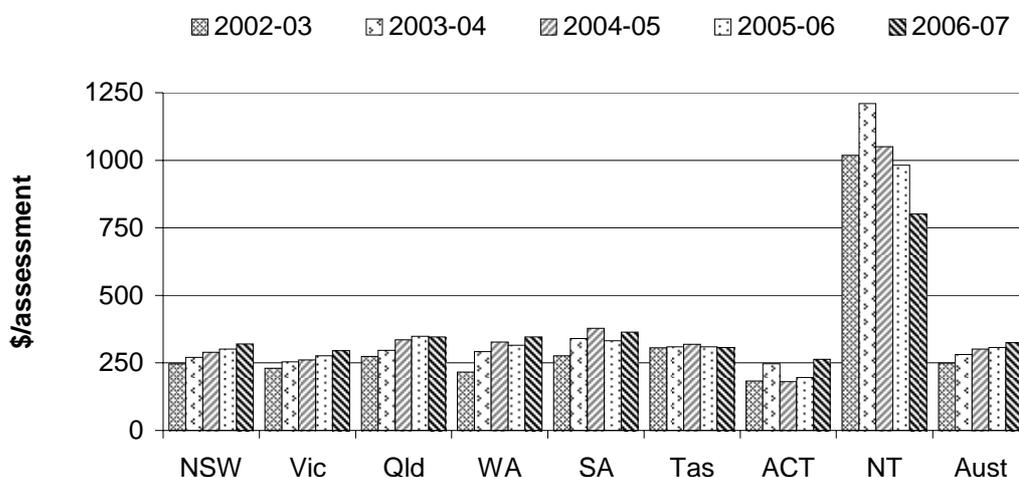
This is a proxy indicator of efficiency and needs to be interpreted with care. While high or increasing expenditure per assessment may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as greater time spent with clients) or changes in the characteristics of 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 ACAT assessment has been developed as a proxy and work is in progress to measure efficiency for ACATs.

Data reported for this indicator are not directly comparable.

Australian Government expenditure per aged care assessment during 2006-07 averaged \$325 nationally (figure 13.28). Nationally, real expenditure increased from 2002-03 to 2006-07. The cost per assessment is calculated using the total number of assessments and therefore includes clients aged less than 70 years.

Figure 13.28 **Australian Government expenditure on aged care assessments, per assessment (2006-07 dollars)^{a, b, c}**



^a Only includes Australian Government expenditure on ACATs. ^b ACAT referrals and operations vary across jurisdictions. ^c The high cost for each assessment in the NT may be influenced by the remoteness of people requiring assessments, clients having English as a second or third language, and a lack of supporting health and community services infrastructure to assist with assessments.

Source: DoHA (unpublished); table 13A.56.

Expenditure per head of target population

‘Expenditure per head of target population’ is an indicator of governments’ objective to deliver efficient aged care services (box 13.24).

Box 13.24 Expenditure per head of target population

‘Expenditure per head of target population’ 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 is a proxy indicator of efficiency and 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.

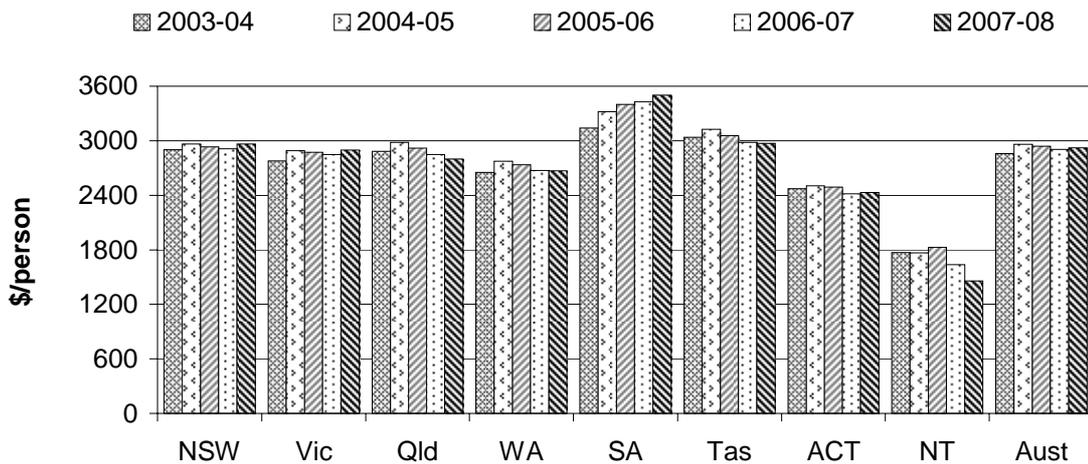
Data reported for this indicator are comparable.

Australian Government real expenditure by both DoHA and DVA on residential care services per person aged 70 years or over plus Indigenous people aged

50–69 years increased nationally from 2003-04 (\$2859) to 2007-08 (\$2923) (figure 13.29). If the payroll tax supplement paid by the Australian Government is excluded, this expenditure increased nationally from \$2819 in 2003-04 to \$2875 in 2007-08 (table 13A.51).

DoHA expenditure on residential care per person aged 70 years or over plus Indigenous people aged 50–69 years in 2007-08 was \$2474 including the payroll tax supplement and \$2434 excluding the payroll tax supplement (table 13A.50). DVA expenditure on residential care per person aged 70 years or over plus Indigenous people aged 50–69 years in 2006-07 was \$449 including the payroll tax supplement and \$441 excluding the payroll tax supplement (table 13A.46).

Figure 13.29 Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2007-08 dollars)^{a, b}

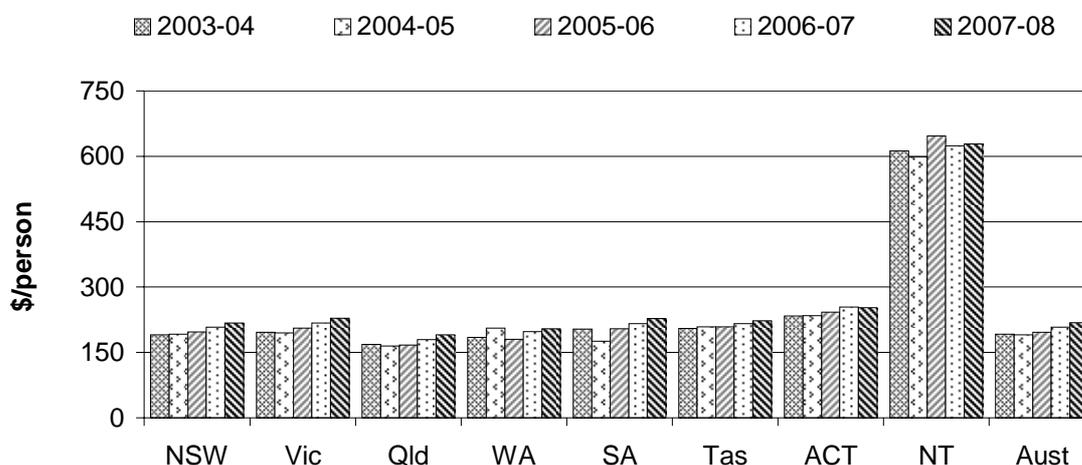


^a Includes a payroll tax supplement provided by the Australian Government. Actual payroll tax paid may differ.
^b Population data for 2007-08 are based on 2006 Census data. Population data for earlier years are based on 2001 Census data. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); DVA (unpublished); table 13A.51.

Australian Government expenditure on CACPs per person aged 70 years or over plus Indigenous people aged 50–69 years was similar in most jurisdictions except the NT in 2007-08. Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from \$192 in 2003-04 to \$218 in 2007-08 (figure 13.30).

Figure 13.30 Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2007-08 dollars)^a

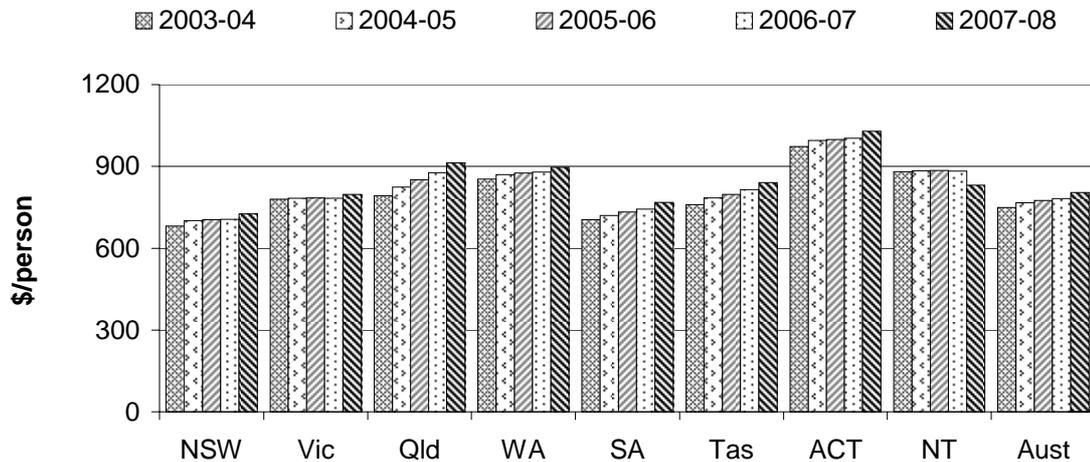


^a Population data for 2007-08 are based on 2006 Census data. Population data for earlier years are based on 2001 Census data. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); table 13A.54.

Australian, State and Territory government expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions. Nationally, real expenditure increased from \$749 in 2003-04 to \$804 in 2007-08 (figure 13.31). These figures reflect expenditure against the population used as the proxy in this chapter (see section 13.1), which is not the same as the HACC target population. Expenditure per person in the HACC target population is reported in table 13A.52.

Figure 13.31 Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2007-08 dollars)^{a, b, c, d, e}



^a People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person and the definition of the HACC target population are contained in table 13A.52. ^b This figure only represents expenditure under HACC Amending Agreements. ^c Reports provisional HACC data that have not been validated and may be subject to revision. ^d Expenditure reflects an equalisation strategy. See notes to table 13A.53 for more detail. ^e Population data for 2007-08 are based on 2006 Census data. Population data for earlier years are based on 2001 Census data. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); table 13A.53.

Outcomes

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

Social participation in the community

‘Social participation in the community’ has been identified for development as an indicator of governments’ objective to encourage the wellbeing and independence of frail older people (box 13.25).

Box 13.25 Social participation in the community

‘Social participation in the community’ is yet to be defined.

Higher rates of participation in the community are more desirable.

When developed for future reports, this indicator will show the extent to which older people participated in community, cultural or leisure activities.

Maintenance of individual functioning

‘Maintenance of individual functioning’ is an indicator of governments’ objective for aged care services to promote the health, wellbeing and independence of frail older people (box 13.26).

Box 13.26 Maintenance of individual functioning

‘Maintenance of individual functioning’ is defined as improvement in Transition Care Program (TCP) clients level of functioning, reflected in the movement from the average Modified Barthel Index (MBI) score on entry to the average MBI score on exit from the TCP. The minimum MBI score is 0 (fully dependent) and the maximum score is 100 (fully independent).

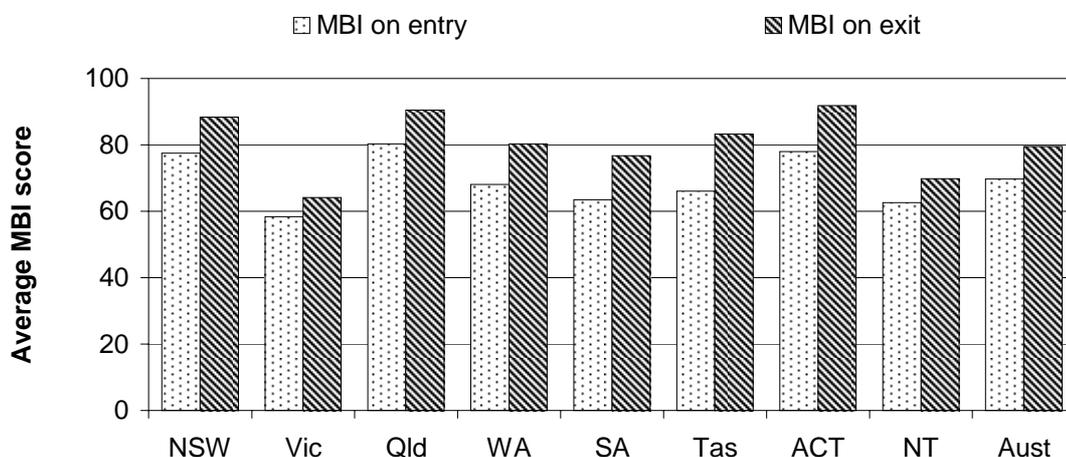
This indicator needs to be interpreted with care. The TCP is one aged care program where it is possible to measure a change in a client’s level of functioning. Variation in the average MBI scores on entry and exit from the program may reflect a range of target client groups for the program across jurisdictions.

The TCP is a small program at the interface of the health and aged care systems. It may be possible to develop measures for other aged care programs such as residential aged care and community aged care services which would be indicators of maintenance of individual functioning.

Data reported for this indicator are comparable.

The average MBI score on entry to the TCP in 2007-08 was 69.7 nationally. The average MBI score on exit from the TCP was 79.5 nationally. These results varied across jurisdictions (figure 13.32).

Figure 13.32 Transition care program — average Modified Barthel Index score on entry and exit, 2007-08^a



MBI: Modified Barthel Index. ^a The MBI is a measure of activities of daily functioning, ranging from 0 (fully dependent) to 100 (fully independent). Data are reported for Transition Care Program recipients who successfully completed a Transition Care episode.

Source: DoHA (unpublished); table 13A.69.

Enabling people with care needs to live in the community

‘Enabling people with care needs to live in the community’ has been identified for development as an indicator of governments’ objective to delay entry to residential care (box 13.27).

Box 13.27 Enabling people with care needs to live in the community

‘Enabling people with care needs to live in the community’ is yet to be defined.

Higher rates of people with care needs remaining, and participating, in the community are more desirable.

When developed for future reports, this indicator will show the extent to which older people’s entry to residential care is delayed and the extent to which older people participate in community, cultural or leisure activities.

13.4 Future directions in performance reporting

For several aspects of aged care services, indicators are not fully developed and there is little performance reporting available. Priorities for the future include:

- continued improvement of efficiency indicators, including for HACC services and assessment services
- improved reporting of waiting times for residential aged care
- improved reporting of long term aged care in public hospitals
- further development of outcome indicators.

Reform of Specific Purpose Payments

In December 2007, COAG agreed to reform Specific Purpose Payments (SPPs). SPPs are financial agreements between the Australian Government and State and Territory governments involving a contribution by the Australian Government to the funding of services which are considered a joint Australian and State and Territory government responsibility. Aged care assessment and Home and Community Care payments were such SPPs.

At its 29 November 2008 meeting, COAG agreed to six new National Agreements, (none specific to aged care services, although the National Healthcare Agreement may have implications for aged care services). Five of the new agreements are associated with a National SPP. The performance of governments in achieving these mutually agreed outcomes will be assessed by the COAG Reform Council (CRC). The Steering Committee has been requested by COAG to provide the SPP performance information to the CRC (COAG July 2008).

The National Agreements/SPPs will be supplemented by a range of National Partnerships (NPs): project, facilitation and reward agreements. Funding for NPs may be conditional on states and territories meeting agreed milestones and performance benchmarks.

The Steering Committee and the Aged Care Working Group will ensure that reporting in this chapter reflects the COAG priorities identified in the relevant NPs.

13.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data about each jurisdiction that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

“ There have been a number of changes to this year’s Report, reflecting recent policy changes. In 2007-08, the Australian Government implemented significant reforms in the funding of residential aged care. These reforms included a new, fairer income test and accommodation supplement that provide more equitable treatment for all residents, as well as a new funding instrument, the Aged Care Funding Instrument (ACFI).

On March 20 2008, new arrangements governing residents’ contributions to their accommodation costs and the supplements the Government pays for residents who cannot meet all or part of their own accommodation costs were introduced. The new arrangements combine the Concessional Resident Supplement and the Pensioner Supplement into a single Accommodation Supplement paid to the residential aged care providers on behalf of supported residents. The amount of Accommodation Supplement paid for supported residents is based on the assessed value of their assets.

The ACFI measures residents’ needs for care rather than care being provided. This is a more objective measure of resident care needs. This new system has three funded levels for personal care and includes two new funding supplements. The new supplements will better target funding towards residents with dementia and challenging behaviours, and residents who have complex health care needs, including those who need palliative care.

These changes have affected the data presented in the 2009 Report and are documented in relevant areas of the 2009 Report.

This year’s Report includes, for the first time, data on the Department of Veterans’ Affairs Community Nursing program. This is one of a suite of DVA programs to assist veterans and war widows/widowers to continue to live safely and independently in their own homes and avoid early admission to hospital or residential care.

An independent review of the Veterans’ Home Care program was completed in early 2008 and is currently under consideration.

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New South Wales Government comments

“ The NSW Government continues to be committed to providing quality services for older people and their carers which promote their health and wellbeing, optimise their independence and participation in community life, and facilitate their timely access to appropriate care and support.

NSW Health has had a busy and constructive year with the implementation and review of a range of aged and chronic care services both within NSW hospitals and at the interface between acute care and community care services.

Additional resources have been made available to assist older people across the full spectrum of acute care. This has included enhancement of specialist aged care services in Emergency Departments to better coordinate the care of older patients as well as the commissioning of Medical Assessment Units attached to Emergency Departments across NSW. New positions have been established in inpatient ward settings to assist older people access long term support services from hospital as well as the expansion of a range of short-term post-acute care options for older people after hospitalisation. A total of 674 Transition Care places were operational across NSW by 30 June 2008.

The NSW Protocols and Procedures Manual for Aged Care Assessment Teams (ACATs) in NSW was published and the ongoing review and structural reform of the Aged Care Assessment Program (ACAP) in NSW continues with the use of Australian Government COAG funds. The goal of these reforms is to improve the quality, efficiency and consistency of ACAT assessments across NSW.

Further development of services for older people with mental health issues and support for carers has also been an important focus of activity in NSW.

In 2007-08 the NSW HACC program continued to expand with the allocation of \$35 million in additional funding, bringing the total budget to \$510 million.

Planning for the HACC program in 2007-08 continued toward a more strategic approach with the identification of regional priorities and strategies over the long, medium and short term. NSW priorities for growth funding in 2007-08 included an emphasis on basic support services and improved delivery to the HACC special needs groups. Growth funding highlights include increases in social support, centre based day care, respite support and transport services to improve clients' and carers' access to the community and reduce social isolation. Initiatives were introduced to improve access for Aboriginal people, people from CALD backgrounds and people with dementia.

As part of the national Community Care reforms, the HACC Access Points Demonstration Project started in March 2008. This project streamlines and simplifies access to HACC and other community care services, using standardised intake assessment approaches and tools.

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Victorian Government comments



Victoria continued to lead innovation during 2007-08, in the development of programs and services that provide support for older people.

In February 2008, Victoria hosted the HACC National Promoting Independence Forum 2008. Almost 400 people attended the participative policy focused forum which brought key stakeholders together from amongst academics, researchers, service providers and governments to explore the evidence base and implications for more thoroughly adopting a wellness, capacity building and restorative care approach to HACC service provision, and to test whether a consensus can be developed about future directions and next steps. Invited papers were presented from Australia and elsewhere in the world, including on Victoria's *Active Service Model*.

The forum was judged to be highly successful and will undoubtedly influence future directions in Australian community care.

In April, Victoria launched the Seniors Rights Victoria, a state-wide service providing telephone support and advice to respond to the abuse, mistreatment or neglect of older people. Seniors Rights Victoria works closely with professionals who regularly deal with the financial, medical and legal affairs of older people to ensure they understand the issues and can respond appropriately. The service combines the resources and experience of the Council on the Ageing Victoria, two community legal centres and the Public Interest Law Clearing House. The service is one element of the Government's response to the 2006 report of the Elder Abuse prevention Project. Other elements are in development.

An evaluation was completed of the *Well for Life in Public Housing* program. The program takes to public housing settings, a health promotion program focussed on physical activity and nutrition among older people. Well for Life challenges established attitudes and practices about what is possible and achievable in improving functional capacity and quality of life for frail older people.

Well for Life complements other Victorian initiatives including; Older Persons High Rise Support Program, Housing Support for the Aged program, Supported Residential Services Service Coordination Program, Community Connections Service Program and Aged Care Support for Carers program.

Substantial financial support was provided during the year for a consortium of 14 local councils that is establishing a regional kitchen for the preparation of delivered meals ('Meals on Wheels'). This innovative response will provide significant economies and drive quality in a niche market not responded to by the mainstream food industry, assuring sustainable services for HACC clients.



Queensland Government comments

“ Queensland has continued to support the programs and services that improve the quality of life of older people and has worked closely with the Australian Government in implementing national programs.

The Queensland HACC Program progressed reform initiatives arising from the Common Arrangements agreed under the HACC Review Agreement 2007. The most notable initiative was the Community Care Access Point demonstration project in the Central Queensland area. The project simplifies the process for determining eligibility and priority of access for people requiring community care services, including HACC services. Extensive consultation and planning was also undertaken in the development of the first Triennial Plan for the Queensland HACC Program for the 2008–11 period.

Queensland continued to operationalise the 351 places approved under the first phase of the Transition Care Program. As at 30 June 2008, 347 of these places were operational across both residential and community settings.

With funding provided by the Australian Government through COAG, Queensland Health implemented a number of local based initiatives through the Long Stay Older Patients Program. These initiatives included continuation of existing and new capital works at the Herberton, Gordonvale, Gladstone and Boonah hospitals, interim care at Cairns, Townsville, Bundaberg, Gold Coast, Toowoomba and Princess Alexandra hospitals, and Hospital in the Nursing Home at Bundaberg and Cairns. Significant planning and capital works has also been undertaken in a number of sites across Queensland to expand the Multi-Purpose Health Service (MPHS) program.

Queensland continues to support 21 State owned and operated residential aged care facilities. In 2007-08, the State government contribution to the operations of these facilities was over \$70 million from an overall expenditure of \$146.7 million. Other revenue was received from the Australian Government, resident charges and other miscellaneous sources to supplement the Queensland Government contribution.

In addition as part of its \$120 million redevelopment program, \$6.4 million was expended on the upgrade of residential aged care facilities.

During 2007-08, 31 776 aged care assessments were undertaken in Queensland through the Aged Care Assessment Teams jointly funded by both levels of government.

In addition, in 2007-08, six projects have been progressed through COAG funding aimed at improving the consistency and timeliness of aged care assessments. These projects are the continuation of the information technology, Indigenous assessments projects commenced in 2006-07 and new projects around central coordination of the COAG initiatives, ACAT education support and coordination, the development of a locum assessment model and support for the attendance of ACATs at the national conference in 2008.

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Western Australian Government comments

“ The WA Aged Care Network has continued to promote a continuum of care approach to the planning and delivery of services for older people in WA through the development of a range of *Aged Care Models of Care* across the WA Health system. An overarching policy document: ‘Model of Care for the Older Person in WA’ has been strengthened by the development of a range of service delivery models of care endorsed by the State Health Executive Forum:

- Geriatric Evaluation and Management
- Amputees Services and Rehabilitation
- Ortho-geriatric care services
- Parkinson’s Disease Services
- Rehabilitation and Restorative Care Services.

A ‘Models of Care’ Forum attended by over 100 people from across WA provided an opportunity to bring together a diverse range of stakeholders to provide feedback on individual draft service delivery level models of care and identify practical steps to progress the implementation at the local area health service level. Progress towards the development of additional service delivery models of care including delirium and dementia will continue to support and improve the quality of care for the older person across the continuum of care.

Through the COAG, Long Stay Older Patient initiative, area health services across WA have continued to work on implementation of an eldercare pathway that has strengthened existing hospital strategies, including emergency departments’ capacity to risk screen elderly patients and facilitate further assessment of those identified at risk. All area health services now use the best practice clinical resources developed as a part of the National Action Plan.

The WA Transitional Care program has a total of 160 operational places and in 2007-08, 597 older people were assisted by the program with on average 53 per cent returning home to the community with or without the support of aged care services.

The WA ACAP has moved forward with the COAG initiatives to formalise and develop a specific ACAT training schedule which has been implemented. ACAT Education Officers have been established at various locations across the state and provide orientation and education to team members.

To support the National community care reform agenda and development of the HACC sector in WA, Access Network demonstrations commenced operating in Esperance, Derby/Broome and the Local Government Area of Swan to support the provision of information, initial eligibility screening and data collection with the goal of assisting clients/carers to access the most appropriate community care services.”

South Australian Government comments

“ The Department for Families and Communities through the Office for the Ageing (OFTA) has continued to lead the development and implementation of *'Improving with Age — Our Ageing Plan for South Australia'*. Since its launch in February 2006, OFTA has provided over \$6 million to kick-start over 60 innovative projects to implement the Ageing Plan. There are now over 135 State Government initiatives operating across the state, which are making a significant difference to the lives of older South Australians.

South Australia is a partner in the reform of Community Care Common Arrangements across Australia, including:

- the implementation of the Community Care Access Points, a COAG initiative to improve access to community care and the development and implementation of the Common Standards for Community Care
- development of Information Management and Data Collection strategies in Community Care and the development of the National Fees Framework.

The Aged Care Assessment Program projects are developed under the COAG initiative. These projects aim to improve timeliness and consistency of assessments. Specific initiatives undertaken in SA include:

- building on the earlier review of assessment practices across South Australian Aged Care Assessment Teams (ACATs) resulting in the development of Best Practice Protocols
- the Mobile Assessment Response (MAR) aims to provide support and back-up for ACAT teams, especially in unforeseen circumstances. The MAR Project has been further developed in 2007-08 with an increased range of responses, including the commencement of an annual visiting service to the Anangu Pitjantjatjara Yankunytjatjara Lands to complete assessments and provide education for suitably qualified staff on the Lands to enable them to undertake assessments between visits.

OFTA successfully developed a Triennial Plan (2008-09 to 2010-11) for the HACC Program in SA. The plan outlines the strategic directions and funding priorities for the HACC Program in SA over the next three years.

OFTA continued to implement reforms in the way that it allocates growth funding to services for frail older people, people with disabilities and carers through the HACC Program. In addition to the new funding allocation processes including direct allocation and invited submission implemented in the country regions in 2007-08, these reforms were further expanded in 2008-09 to metropolitan regions resulting in more appropriate and targeted methods of funding disadvantaged groups. The implementation of new funding allocation processes across SA has further streamlined and simplified administrative processes with benefits to both OFTA and the ageing and community services sector.

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Tasmanian Government comments

“ ‘*Tasmania’s Health Plan*’ provides a blueprint for the integrated development of primary and acute health services. It draws together the recommendations of the Primary Health Services Plan and the Clinical Services Plan, both of which were developed following comprehensive processes of stakeholder consultation and data analysis. The Plan was initially released in May 2007 and an update was released in May 2008, recognising the impact of changes resulting from the Australian Government taking control of the Mersey Community Hospital. The Plan is the cornerstone for planning for health services into the future, including aged care services.

‘*Tasmania’s Health Plan*’ recognises that health care and support for older people is increasingly being delivered in community settings rather than in acute hospitals. A need has been acknowledged in the Plan to redesign systems so that care provided across different settings is integrated seamlessly and that communities can access a comprehensive mix of services in appropriate settings.

The establishment of Clinical Networks is a key component of the Tasmanian Health Plan, mirroring the experience of most Australian states and territories. The establishment of an Aged Care and Rehabilitation Clinical Network in 2008-09 will form the basis for greater involvement of clinicians and consumers in the planning, delivery, evaluation and improvement of health services across the interface between acute and aged care in Tasmania, and enhance collaboration and coordination in the delivery of services across organisational boundaries in order to improve outcomes for older patients and clients.

The Home and Community Care (HACC) Triennial plan details funding priorities relating to service delivery, asset purchases, pilot and research projects and program development. Over the triennium the Tasmanian HACC Program will continue its current strategy of rolling priorities over a number of years, and the most significant investments will be in the provision of HACC basic services. In 2007-08, the Central Contact Point Trial (Tasmanian CAREpoint Pilot Project) tested a central, telephone-based point of contact for consumers to access selected HACC services provided in the southern region by DHHS and non-government service providers. CAREpoint provided initial contact, referral, screening and intake processes for community care services (community nursing, personal care, home help and home maintenance). The trial is now being evaluated to help inform arrangements for a wider Access Point Demonstration Project, commencing in 2008-09. The Access Point service will provide Tasmanians with easier access to information about, or referral to, community services.

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Australian Capital Territory Government comments

“ The ACT is committed to assist older people and their carers by providing better support and access to appropriate services that promote health and wellbeing and optimise independence and participation in community life. The ACT continues to pursue strategies to improve the planning and delivery of services to meet the challenge of growing care needs of frail older people.

Three ACAP projects developed under the COAG initiative of improving timeliness and consistency of aged care assessments were progressed. These projects included the development of an education and training program and the provision of infrastructure to improve the collection and quality of data.

Additional resources were allocated to the Older Persons Mental Health Unit to enhance the service delivery for older people with a mental illness. The service provides specialist mental health assessment and treatment services and also gives support and assistance to families and carers.

With funding provided by the Australian Government through the Long Stay Older Patients initiative, the ACT continued to reduce avoidable hospital admissions through the Rapid Assessment of the Deteriorating Aged at Risk (RADAR) program and improve care outcomes for older persons by providing additional support during the transition from hospital to appropriate long-term care.

During 2007-08, 157 new residential aged care places were made operational in the ACT, representing a 9.6 per cent increase. In cooperation with the Australian Government, industry and service providers, the ACT continued to review land planning and allocation processes to provide a more effective, streamlined process and significantly improve the timeliness of delivering high quality aged persons' accommodation.

The Community Partners Program, funded through the Australian Government, delivered training programs for Culturally and Linguistically Diverse volunteers on dementia and palliative care. The training enhanced their skills to support residential aged care residents and helped to ensure that older people with dementia or receiving palliative care continue to be part of their communities.

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Northern Territory Government comments

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The unique environment and socio-economic factors in the NT create specific challenges in the provision of human services including aged care services for both the NT and Australian Government. This is particularly so in the provision of appropriate, cost effective and sustainable aged care services in 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.

Enhancing Indigenous remote residents access to aged care services and equitable allocation of resources remained a priority to the NT Government.

Data quality remains an ongoing challenge for providers in the NT, given that most are small non-government agencies that receive funds from multiple sources and for multiple purposes. In addition, the relatively small numbers of aged care clients in the NT results in distorted or misleading proportions in the data analysis.

A major reform in the NT was the planning for the amalgamation of community councils to larger shire councils. From 1 July 2008, fewer and larger providers will replace the current large numbers of small and dispersed aged care providers.

In 2007-08 a number of projects were implemented with the focus of improving service planning and quality. These included a new resources allocation policy to distribute available funds to targeted services closer to home for aged people.

Transition Care services, piloted in Katherine before it was extended to Darwin and Alice Springs and planning for new common access points for aged care services was undertaken during the reporting period. The NT is trialling this approach in all areas outside Darwin and Alice Springs.

As in previous years, indicators based on the estimated number of people with severe, profound and/or core activity limitations in the NT need to be interpreted with caution. Small variations in service and population data appears in magnified proportions to the small population in the NT.

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13.6 Definitions of key terms and indicators

Adjusted subsidy reduction supplement	Payments made to equalise the recurrent funding paid by the Australian Government as adjusted subsidy reduction places to public sector residential care operators. The states and territories provide top-up funding for residential aged care places at a rate set by the Minister for Health from 1 July each year
Accreditation	<p>Accreditation is a key component of the Australian Government's quality framework for federally funded residential aged care and is a quality assurance system for residential aged care services — based on the principle of continuous improvement.</p> <p>Accreditation requires compliance with the 44 expected outcomes used for accreditation assessment — grouped into four standards: management systems and organisational development, health and personal care, residential lifestyle, and physical environment and safety systems.</p>
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. Assessment of care needs is an important component of aged care. The majority of aged care services assist in activities of daily living such as personal care (for example, bathing and dressing), housekeeping and meal provision. Other services aim to promote social participation and connectedness. These services are delivered by trained aged care workers and volunteers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists.</p> <p>Aged care services generally aim to promote wellbeing and foster function rather than to treat illness. Although some aged care services such as transition care have a specific restorative role, they are distinguished from the health services described in Part E of this Report.</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 aged 70 years or over and Indigenous people aged 50 years or over.</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 (Cwlth)</i>, s.2-1 [1j]).</p>
Capital expenditure on residential services	Expenditure on building and other capital items, specifically for the provision of Australian government funded residential aged care.
Centre day care	Respite care provided from a facility such as a day care or health centre. Respite care is usually combined with social support services

Certification	<p>to maintain the functional capabilities of the person receiving care.</p> <p>The aim of certification is to improve the physical quality of federally funded residential aged care buildings through access to ongoing streams of funding from bonds, charges and supplements to finance construction and improvement in aged care services.</p>
Complaint	<p>A complaint by the affected care recipient or his or her representative, or anyone else, to the Secretary of the Department of Health and Ageing about anything that:</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.
Dementia services program	<p>Includes flexible and innovative support, respite, counselling, information and referral services, education and leisure. The program includes meeting individual and immediate needs which cannot be met by other services, through carer respite services and other carer support agencies. Inpatient services are excluded.</p>
Disability	<p>A limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.</p>
EBA supplement	<p>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.</p>
Elapsed time between ACAT approval and entry into a residential care service	<p>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.</p>
HACC target population	<p>The HACC Target population is people in the Australian community who, without basic maintenance and support services provided under the scope of the HACC Program, would be at risk of premature or inappropriate long term residential care, including (i) older and frail people with moderate, severe or profound disabilities; (ii) younger people with moderate, severe or profound disabilities; and (iii) such other classes of people as are agreed upon, from time to time, by the Commonwealth Minister and the State Minister; and the unpaid Carers of people assessed as being within the National Program's target population. The HACC Target Population is estimated by applying the proportion of people in households with a moderate, severe, or profound disability as reported in the <i>ABS 2003 Survey of Disability, Ageing and Carers</i> to the ABS Population Projections by SLA 2002–2022.</p>
High/low care recipient	<p>This chapter classifies residents as 'high' or 'low' care based on their RCS or ACFI classification. For the purpose of this Report, under the RCS classification, high care residents have been assessed as RCS levels 1–4, and low care residents have been assessed as RCS levels 5–8. A resident assessed under ACFI is considered to be in receipt of high care (ACFI High) if they if they are assessed as:</p> <ul style="list-style-type: none"> • Medium or High in Activities of Daily Living; or • High in Behaviour; or • Medium or High in Complex Health Care <p>All other residents assessed under ACFI are regarded as low care residents (ACFI Low).</p> <p>If the person is approved as a recipient of a high level of care, that</p>

	<p>person can receive care at any care classification level (Approval of Care Recipients Principles 1997, s.5 9). A person approved as a recipient of a low level of care can be classified on entry only as RCS 5–8 (Classification Principles 1997, s.9-19).</p>
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 (Cwlth)</i>); also refers to 'beds' (<i>Aged Care (Consequential Provisions) Act 1997 (Cwlth)</i> , 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 <i>Veterans' Entitlements Act 1986 (Cwlth)</i> .

13.7 Attachment tables

Attachment tables are identified in references throughout this chapter by an ‘13A’ suffix (for example, table 13A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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13.8 References

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14 Services for people with a disability

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Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 14A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables themselves are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

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.

The Commonwealth State/Territory Disability Agreement (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. This chapter focuses on services covered by the third CSTDA, which applied to the period 1 July 2002 to 30 June 2007.

Specialist psychiatric disability services are excluded from the chapter to improve data comparability across jurisdictions.

The Australian, State and Territory governments agreed to extend the third CSTDA to 31 December 2007. It was further extended until 31 December 2008, to enable negotiations for the next National Disability Agreement to be finalised. Governments have agreed the following 8 priority areas for the new Agreement:

- better measurement of current and future need
- moving towards National Population Benchmarks for key disability services
- making older carers a priority
- quality improvement systems based on disability standards
- service planning and strategies to simplify access
- early intervention, lifelong planning and independence strategies
- increased workforce capacity
- increased access for Indigenous people with disability.

Government assistance for people with a disability can be grouped into income support, disability support services and relevant generic services provided to the community as a whole. This Report generally does not report performance information on income support. Disability support services are primarily delivered under the CSTDA, as well as through programs such as Home and Community Care (HACC) and Commonwealth Rehabilitation Services (CRS) Australia. Performance information on the HACC program for older Australians is provided in the ‘Aged care services’ chapter (chapter 13). CRS Australia’s services are not covered in this Report.

Some generic services provided to the community as a whole are covered elsewhere in this Report — for example, school education (chapter 4), vocational education and training (VET) (chapter 5), public hospital care (chapter 10), specialised mental health services (chapter 12) and public housing (chapter 16). Other generic services provided to people with a disability — such as transport and utility services at concessional rates — are outside the scope of this Report.

Results in this chapter are derived using the service user data collected under the CSTDA National Minimum Data Set (NMDS). Data quality for the CSTDA NMDS continues to improve, but the results based on this collection should be interpreted with caution. Quality issues related to these data are discussed in section 14.6.

Significant improvements in the reporting of services for people with a disability in this year's Report are the inclusion of:

- additional measures for the 'Service use by special needs groups' indicator on access to community support, community access and respite services by country of birth and geographic location
- experimental estimates for the 'Service use by special needs groups' measures that are derived using 'potential populations' to account for differences in the need for services across the relevant groups
- data on the participation of people with profound and severe core activity limitations in various social/community activities, by their perceived level of difficulty with transport
- data on access to public housing, by 'core activity need for assistance' status
- data on access to health services, by disability status.

14.1 Profile of specialist disability services

Service overview

The CSTDA defines 'specialist disability services' as 'services or initiatives specially designed from time to time to meet the needs of people with disabilities' (CSTDA 2003, p. 10). A definition of disability is provided in box 14.1.

Box 14.1 Definition of disability

The United Nation's *Convention on the Rights of Persons with Disabilities and Optional Protocol*, ratified by Australia on 17 July 2008, defines 'persons with disabilities' as including those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC) was conducted in 1981, 1988, 1993, 1998 and 2003, and was based on the International Classification of Functioning, Disability and Health and its predecessor. The 2003 survey defined a disability as a limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.

Self care, mobility and communication are defined as core activities. The ABS defines levels of core activity limitation as follows:

- mild — where a person does not need assistance and has no difficulty with self care, mobility and/or communication, but uses aids or equipment
- moderate — where a person does not need assistance, but has difficulty with self care, mobility and/or communication
- severe — where a person sometimes needs assistance with self care, mobility and/or communication tasks; has difficulty understanding or being understood by family or friends; or can communicate more easily using sign language or other non-spoken forms of communication
- profound — where a person is unable, or always needs assistance, to perform self care, mobility and/or communication tasks.

The third CSTDA (2003, p. 9) defines 'people with disabilities' as those whose disability manifests itself before the age of 65 years and for which they require significant ongoing and/or long-term episodic support. For these people, the disability will be attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is likely to be permanent and results in substantially reduced capacity in at least one of the following:

- self care/management
- mobility
- communication.

Source: ABS (2004); CSTDA (2003).

Details of the specialist disability services provided under the CSTDA are outlined in the following section on roles and responsibilities. Mechanisms for the funding and delivery of these services differ across jurisdictions as a result of policy differences. Further contextual information is provided in appendix A.

Roles and responsibilities

Australian, State and Territory governments

The CSTDA defines the roles and responsibilities of the Australian, State and Territory governments in the provision of services to people with a disability. Its agreed purposes are listed in box 14.2.

Box 14.2 The purposes of the third 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 the 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
- targeted employment support services that provide people with a disability with structured training and support to work towards social and community participation or opportunities to develop skills, or retrain, for paid employment.

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 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
- 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
- respite care services that provide relief or support (for limited periods) to families and carers of people with a disability who are living in the community.

Australian, State and Territory governments share responsibility for administering the following services:

- advocacy services that enable people with a disability to increase their control over their lives by representing their interests and views in the community
- information services that provide accessible information to people with a disability, their carers, families and related professionals about disabilities, specific and generic services and equipment; and promote the development of community awareness
- print disability services that produce alternative communication formats for people who, by reason of their disability, are unable to access information provided in a print medium
- research and development projects.

The CSTDA does not apply to the provision of:

- aids and equipment
- disability services and activities provided under the *Military Rehabilitation and Compensation Act 2004* (Cwlth)
- services with a specialist clinical focus, regardless of whether those services are provided to people eligible to receive services under the CSTDA.

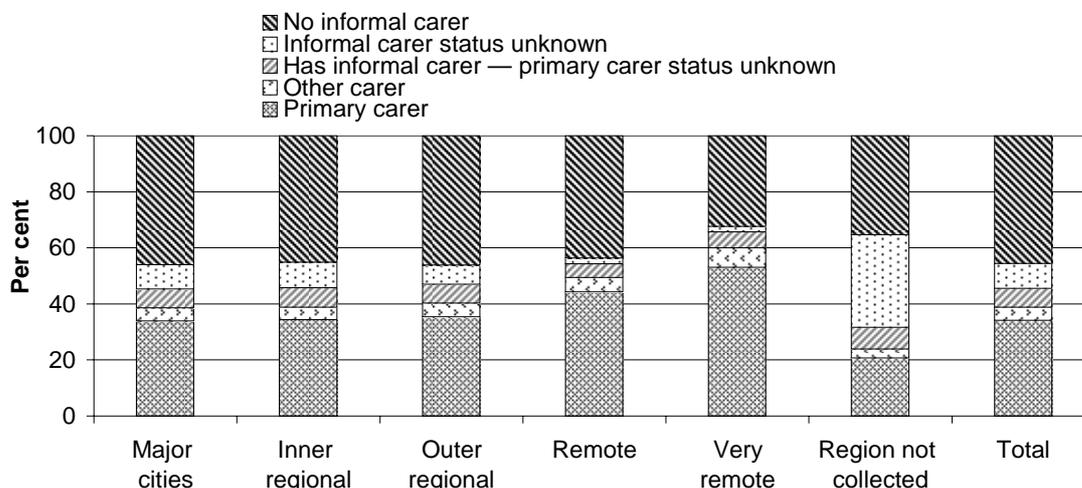
Informal carers

Family and friends provide most assistance, in terms of help or supervision, to people with a disability. Information about these informal carers enables governments to plan ahead with respect to the future demand for services that support these carers and the people they assist. Support services that assist people with a disability to live in the community, such as in-home accommodation support and community support, often rely on the availability of informal care. In turn, the provision of informal care may rely on access to formal support services including respite services and a range of other services for the person with a disability.

Information on informal carers is available from the CSTDA NMDS in relation to CSTDA service users and the ABS SDAC for carers more generally. The definition of informal carers differs slightly across these data collections (see section 14.7 for details).

In the CSTDA NMDS, an informal carer is someone such as a family member, friend or neighbour, who has been identified as providing regular and sustained care and assistance to a person with a disability. Informal carers who provide assistance with core activities (self care, mobility and communication) are defined as primary carers. Of people with a disability who accessed CSTDA funded services in 2006-07, 45.5 per cent reported having an informal carer and 34.1 per cent reported having an informal carer who was a primary carer (figure 14.1). Service users in remote or very remote locations were more likely to report having an informal carer than those in other areas. Figure 14.2 shows the proportions of informal primary carers who are in different age groups, by location.

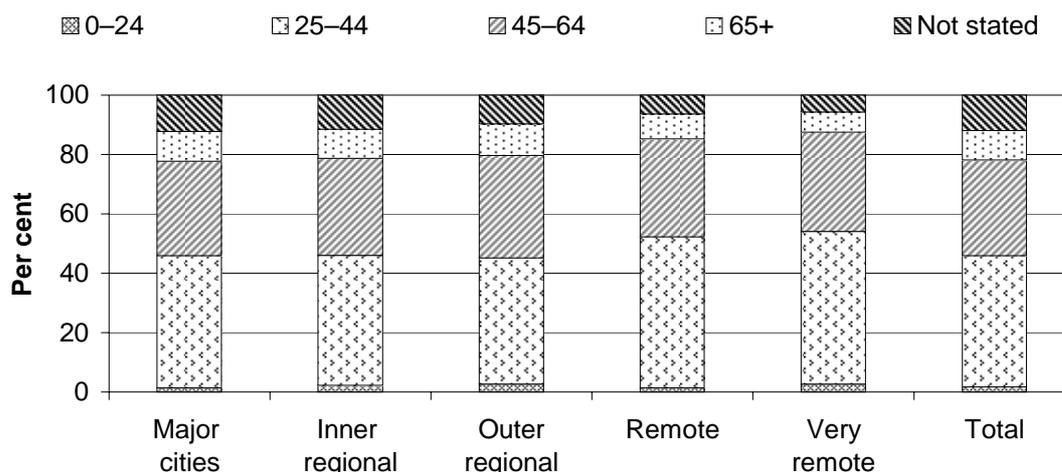
Figure 14.1 Users of CSTDA-funded services who reported having an informal carer, by primary carer status and geographic location, 2006-07^{a, b, c}



^a Total includes data for service users whose location was not collected/identified. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c Data relating to primary carers are not reported for all service users. Some service types are not required to collect all service user data items. For example, employment services are not required to collect selected informal carer information, including primary status.

Source: Australian Institute of Health and Welfare (AIHW) (unpublished), derived from the *CSTDA NMDS*; table 14A.1.

Figure 14.2 Age distribution of primary carers of people accessing CSTDA funded services, by location, 2006-07^{a, b}



^a Total includes data for service users whose location was not collected/identified. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (unpublished), derived from the *CSTDA NMDS*; table 14A.2.

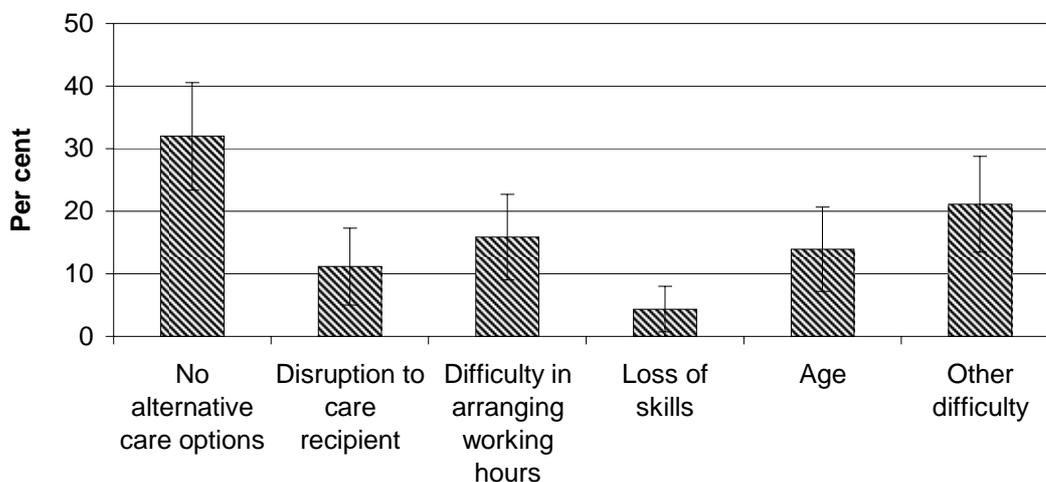
The ABS SDAC defines a primary carer as a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities (communication, mobility and self care). According to the SDAC, in 2003 an estimated 474 600 primary carers provided the majority of assistance with self care, mobility and communication for people with a disability, including older people — an increase of 5.3 per cent since 1998 (ABS 1999, 2004).

Under the human capital stream of the national reform agenda, the Council of Australian Governments (COAG) is seeking to reduce the proportion of the working age population who are not participating or who are under-participating in paid employment. One indicative progress measure identified is the proportion of people of working age who are not participating or who are under-participating in the labour force due to disability — including those providing informal care for people with a disability.

The SDAC contains information on the labour force and employment participation of people with a disability (table 14A.48). The SDAC also provides information regarding the impact that the primary caring role has on informal carers' labour force participation.

- An estimated 37.8 per cent of primary carers were employed — of these employed primary carers 23.0 per cent had reduced their working hours to take on their caring role.
- The remaining 62.2 per cent of primary carers were either unemployed or not in the labour force — of these, 30.8 per cent had worked before commencing their caring role.
- For those primary carers who were unemployed or not in the labour force and not yet retired (60.5 per cent of all primary carers), 24.1 per cent wanted to return to work. Figure 14.3 shows the most significant perceived barriers for primary carers who wanted to return to work.

Figure 14.3 Perceived barriers to returning to work for primary carers who want to return to work, 2003^a



^a Estimates for 'disruption to care recipient' and for 'loss of skills' have relative standard errors of 25–50 per cent and should be used with caution.

Source: ABS (unpublished), derived from the *Disability, Ageing and Carers, Australia, Basic Confidentialised Unit Record File (CURF) 2003*, CD-ROM, Cat. no. 4430.0.30.002.

The Australian Government provides financial assistance to eligible carers of people with a disability through the Carer Payment and the Carer Allowance (box 14.3). This financial assistance is not included under the CSTDA funding arrangements.

Box 14.3 Australian Government supplementary and income support arrangements

The Australian Government funds income support payments for people with a disability, those caring for people with a disability and those temporarily incapacitated from work as a result of illness. Payments are made only to those who meet the relevant eligibility criteria. 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 2007-08 (on an accrual basis) amounted to \$9.4 billion for the Disability Support Pension, \$1.7 billion for the Carer Payment (includes expenditure on carer bonus), \$1.6 billion for the Carer Allowance (includes expenditure on carer bonus), \$83.4 million for the Sickness Allowance and \$114.1 million for the Mobility Allowance. These income support arrangements do not constitute a CSTDA service.

(Continued on next page)

Box 14.3 (Continued)

At 30 June 2008, there were around 732 400 recipients of the Disability Support Pension, 130 700 recipients of the Carer Payment, 437 300 recipients of the Carer Allowance, 55 300 recipients of Mobility Allowance and 7 400 recipients of Sickness Allowance (table 14A.4).

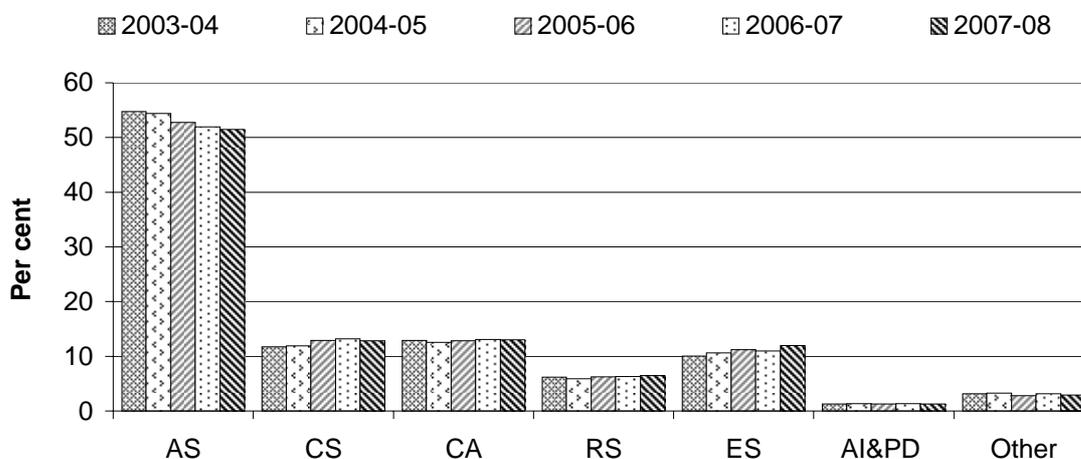
Source: Department of Families, Housing, Community Services and Indigenous Affairs (unpublished); DEEWR (2008); table 14A.4.

Funding

Under the CSTDA, Australian and State and Territory governments fund both government and non-government providers of services for people with a disability. Total government expenditure on CSTDA funded services was \$4.7 billion in 2007-08 — a real increase of 4.3 per cent on the expenditure in 2006-07 (\$4.5 billion) (table 14A.7). State and Territory governments funded the majority of this expenditure in 2007-08 (72.7 per cent, or \$3.4 billion). The Australian Government funded the remainder (27.3 per cent, or \$1.3 billion), which included \$690.7 million in transfer payments to states and territories (tables 14A.8 and 14A.9).

Direct government expenditure on CSTDA funded services (that is, excluding expenditure on administration) was \$4.3 billion in 2007-08 (table 14A.5). The distribution of direct government expenditure varied across jurisdictions. The main areas of State and Territory government expenditure were accommodation support services (51.5 per cent of total direct service expenditure), and community access (13.0 per cent of total direct service expenditure) (figure 14.4). Employment services were the main area of Australian Government expenditure in 2007-08 (12.0 per cent of total direct service expenditure and 92.5 per cent of Australian Government direct service expenditure) (table 14A.6).

Figure 14.4 Direct expenditure on CSTDA funded services, by service type^a



AS = accommodation support; CS = community support; CA = community access; RS = respite services; ES = employment services; AI&PD = advocacy, information and print disability. ^a See table 14A.5 for detailed notes accompanying expenditure data.

Source: Australian, State and Territory governments (unpublished); table 14A.6.

Size and scope

Disability prevalence

The ABS estimates that one in five people in Australia (3 958 300 or 20.0 per cent) had a reported disability (that is, a core activity limitation, a schooling or employment restriction or an impairment)¹ in 2003 (ABS 2004). Of the population aged 5–64 years in 2003, an estimated 13.0 per cent had a core activity limitation or specific restriction. This proportion comprised 4.0 per cent who had a profound or severe core activity limitation, a further 6.6 per cent who had a mild to moderate core activity limitation, and 2.4 per cent who had a schooling or employment restriction only (ABS 2004). Table 14A.11 contains additional information on disability prevalence, and table 14A.12 contains information on the estimated number of people with a profound or severe core activity limitation who received help as a proportion of those who needed help.

Aboriginal and Torres Strait Islander people

Indigenous people have significantly higher rates of profound or severe core activity limitation than non-Indigenous people. The AIHW estimates that the proportion of

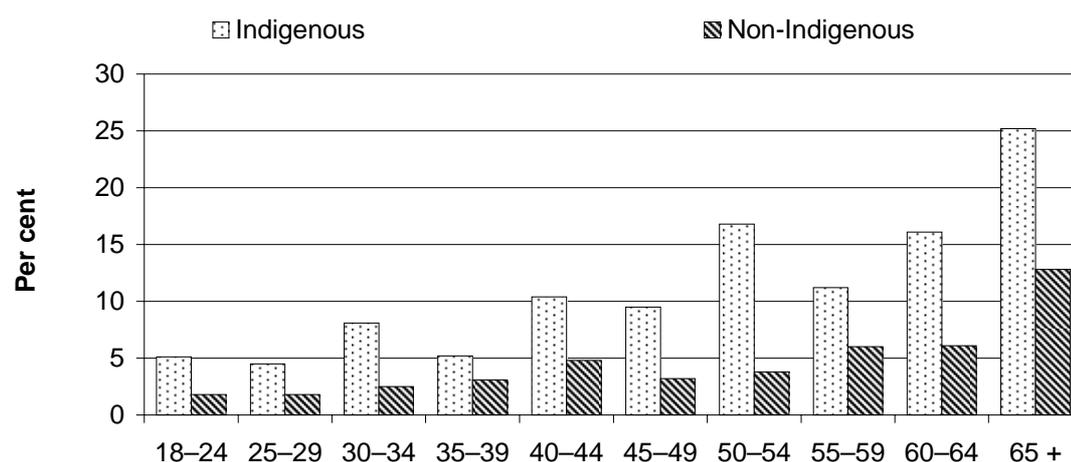
¹ Information on how disability is defined and on different disability types is in section 14.7.

Indigenous people aged over 18 years who had a profound or severe core activity limitation was approximately 2.4 times that of non-Indigenous people in 2002 (AIHW 2006b). This estimate is based on data from the ABS's General Social Survey (GSS) and National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and takes into account differences in the:

- age structure of the Indigenous and non-Indigenous populations
- method that was applied in remote areas for the two surveys (for further details on the difference in method see AIHW 2006b).

The difference (in rate ratio terms) between the populations is most marked for people aged 50–54 years and those aged 30–34 years (figure 14.5).

Figure 14.5 **Proportion of age groups who have a profound or severe core activity limitation, by Indigenous status, 2002^a**



^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.

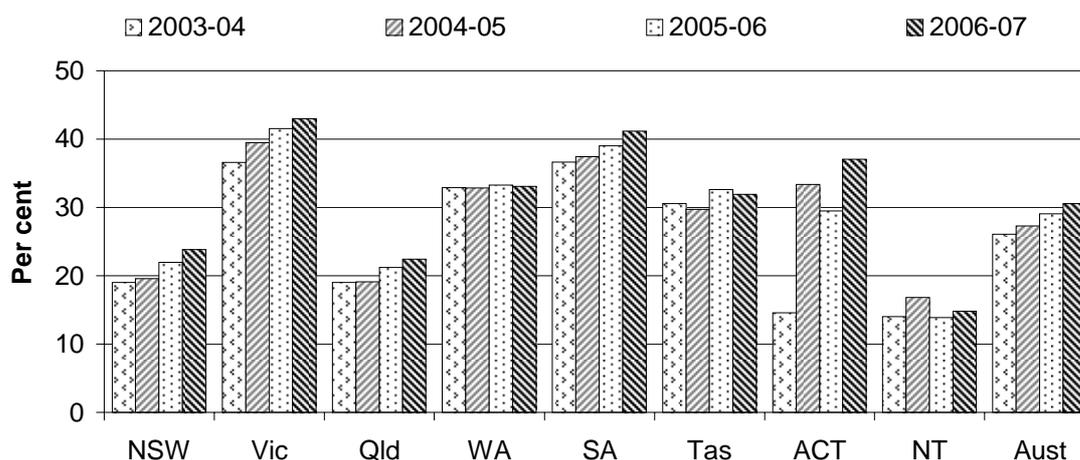
Source: AIHW (2006) 'Potential Population' — *Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Welfare Working Paper Series Number 50, Cat. no. DIS 45, Canberra.

Use of CSTDA funded services

In 2006-07, 220 419 people were reported as using services provided under the CSTDA (excluding service users who received specialist psychiatric disability services only) (table 14A.3). Nationally, this is 30.5 per cent of the estimated

potential population (see section 14.7 for information on how the potential population is defined) (figure 14.6).

Figure 14.6 Users of CSTDA funded services as a proportion of the estimated potential population^{a, b}

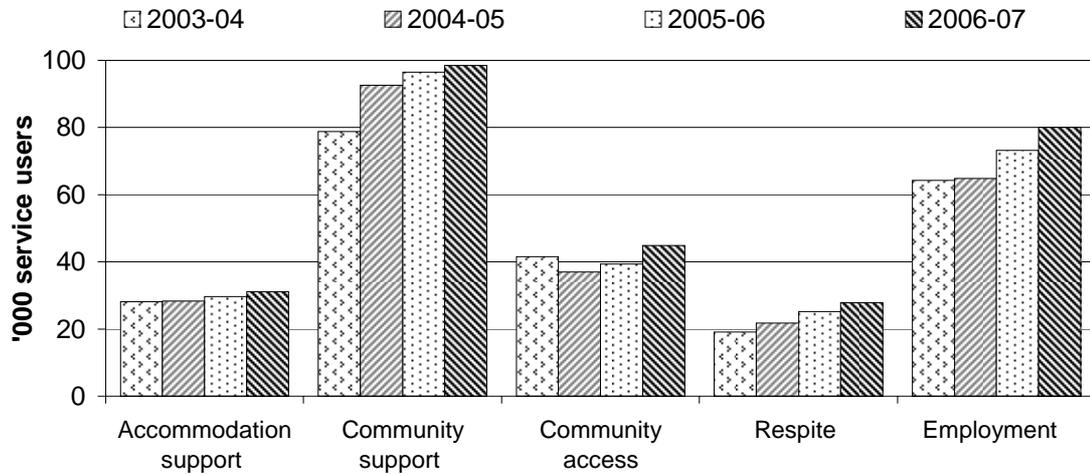


^a These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues and for service type outlet response rates across jurisdictions. ^b For the ACT, the decreased service user rate for 2005-06 was due to the data collection for therapy services being incomplete.

Source: AIHW (unpublished), derived from CSTDA NMDS; AIHW analysis of the ABS SDAC 2003; ABS *Australian Demographic Statistics*, Cat. no. 3101.0 (various issues); ABS (2004) *Experimental Projections of the Aboriginal and Torres Strait Islander Population, 30 June 2001 to 30 June 2009*, Cat. no. 3238.0, Canberra; AIHW (2006) *Potential population — Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Cat. no. DIS 45, Canberra; table 14A.3.

Service user numbers varied across service types (figure 14.7). Accommodation support, community access, community support and respite services reported 151 192 users and employment services reported 80 008 users in 2006-07.

Figure 14.7 Users of CSTDA funded services, by service type^{a, b}

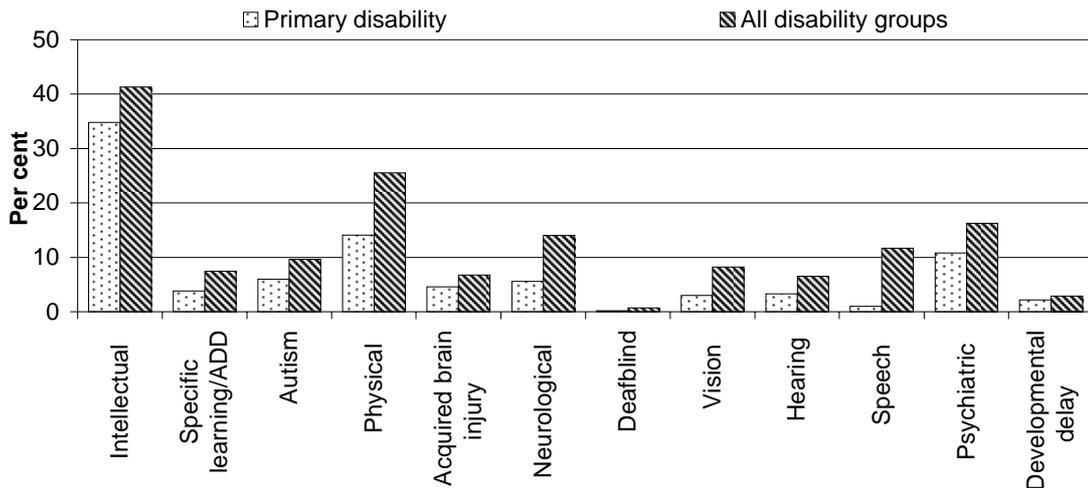


^a These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^b See table 14A.3 for detailed notes relating to these data.

Source: AIHW (unpublished), derived from CSTDA NMDS; table 14A.3.

In 2006-07, the most commonly reported disability of CSTDA service users was an intellectual disability (41.3 per cent of service users, including 34.8 per cent who reported it as their primary disability) (figure 14.8).

Figure 14.8 Service users by disability group, 2006-07^{a, b}



^a These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^b See tables 14A.13 and 14A.14 for detailed notes relating to these data.

Source: AIHW (unpublished), derived from the CSTDA NMDS; tables 14A.13 and 14A.14.

Younger people with a disability in residential aged care

At its February 2006 meeting, COAG made a commitment to reduce the number of younger people with a disability living in residential aged care, and agreed to establish a five-year program, beginning in July 2006. Funding for this program is separate and in addition to the general funding provided under the CSTDA. The cost of the program is \$244 million, to which the Australian Government and State and Territory governments have contributed equally. The Australian Government has signed bilateral agreements with all states and territories.

There are three elements to the program:

- Move younger people with a disability currently accommodated in residential aged care into appropriate supported disability accommodation, where it can be made available and if this is what clients choose.
- Divert future admission of younger people with a disability who are at risk of admission to residential aged care into more appropriate forms of accommodation.
- Enhance the delivery of specialist disability services to those younger people with a disability who choose to remain in residential aged care or for whom residential aged care remains the only available suitable supported accommodation option.

The initial priority for the program is people aged under 50, and participation is voluntary. On 30 June 2008, there were 858 people aged under 50 years living in permanent residential aged care nationally (table 14.1). This is a 15.0 per cent decrease on the number of people aged under 50 years living in permanent residential aged care on 30 June 2006 nationally.

Table 14.1 Younger people (aged under 50 years) in residential aged care, 30 June (number)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^c</i>	<i>NT</i>	<i>Aust^d</i>
2006	392	221	245	65	61	15	4	7	1 010
2007	374	210	226	63	53	12	np	5	943
2008	335	209	180	58	55	11	4	6	858

^a Data are for permanent residents in aged care. ^b These data should be interpreted with caution (particularly for the NT). There may be issues related to the age of Indigenous residents being incorrectly recorded. An assessment of the data set in the NT has previously shown that approximately half of Indigenous peoples' ages were incorrectly recorded. ^c Data are not published for 2007 due to small numbers. The number is less than 3. ^d The Australian total is for jurisdictions for which data are published only. **np** Not published.

Source: Department of Health and Ageing (unpublished).

14.2 Framework of performance indicators

The framework of performance indicators is based on the Australian, State and Territory governments' shared objectives under the third CSTDA (box 14.4).

Box 14.4 Objectives of government funded services for people with a disability

The performance data for this Report cover services provided under the third CSTDA. Through that CSTDA, governments strive to enhance the quality of life experienced by people with a disability by assisting them to live as valued and participating members of the community.

In working towards this objective, governments have five policy priorities, to:

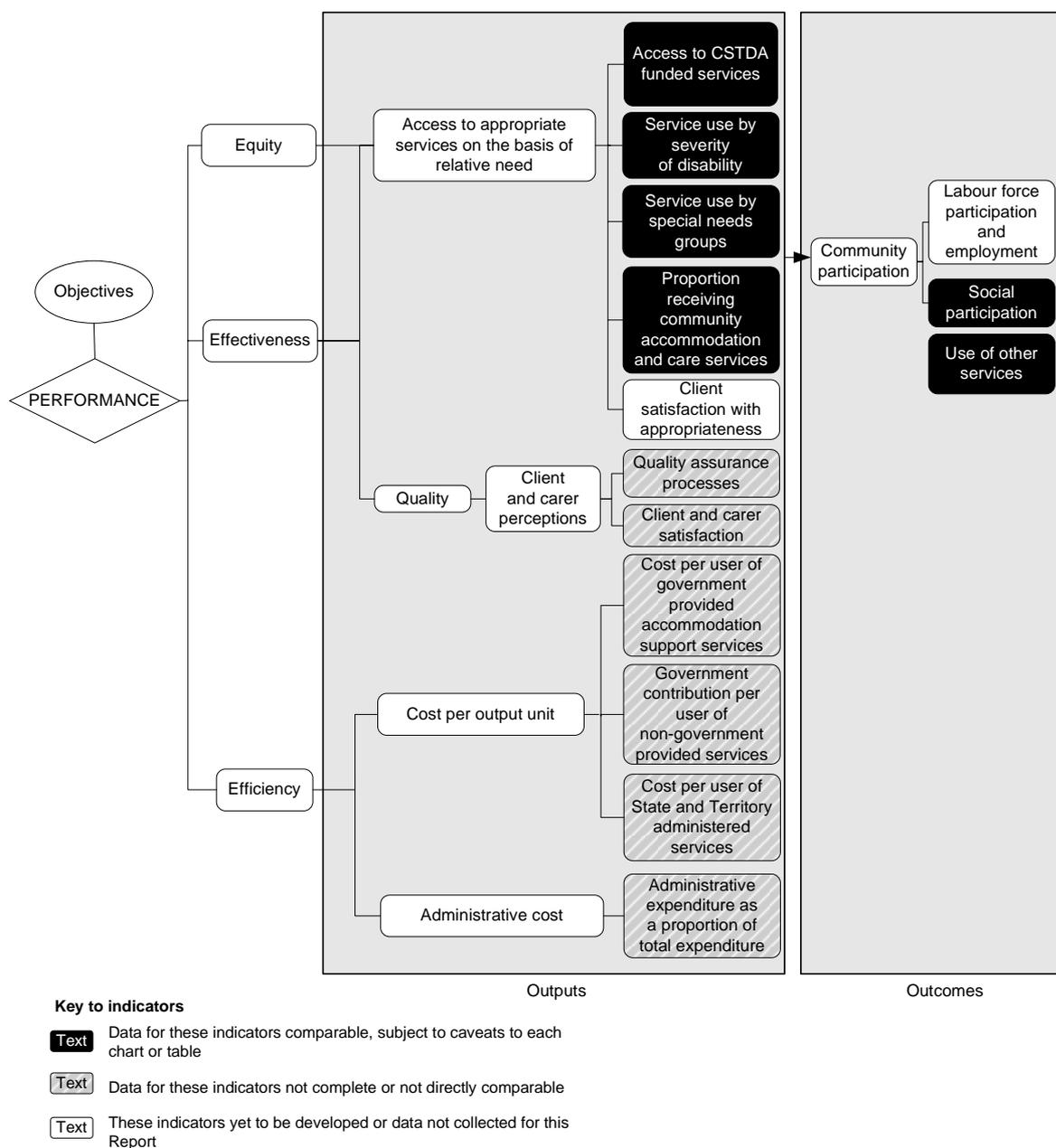
- strengthen access to generic services for people with a disability
- strengthen across government linkages — bilateral agreements between the Australian Government and each State and Territory have been negotiated to improve services
- strengthen individuals, families and carers
- improve long term strategies to respond to, and manage, demand for specialist disability services
- improve accountability, performance reporting and quality.

Source: CSTDA (2003).

The performance indicator framework shows which specialist disability services data are comparable in the 2009 Report (figure 14.9). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

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.

Figure 14.9 Performance indicators for services for people with a disability



Proxy efficiency indicators focus on unit costs and administrative costs. Effectiveness and equity indicators focus on access to appropriate services and service quality. Outcome indicators focus on the participation of people with a disability in the community.

14.3 Key performance indicator results

Different delivery contexts, locations and client characteristics may affect the equity, effectiveness and efficiency of specialist disability services. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter.

The performance indicator results reported in this chapter generally relate to CSTDA funded services. This Report includes service user data for 2006-07. These data were sourced from the CSTDA NMDS collection, which is managed by individual jurisdictions and coordinated by the AIHW. The CSTDA NMDS collection was implemented in 2002-03, with national data from the first collection available for the period 1 January 2003 to 30 June 2003. Other information on the implementation of the CSTDA NMDS is contained in box 13.6 of the 2006 Report (SCRGSP 2006) and in AIHW (2003).

When considering the performance indicator results derived from service user data, comparisons between jurisdictions and across years should be undertaken with care. While the implementation of the CSTDA NMDS continues to improve, data quality is still affected by a number of factors, including that:

- the proportion of service users and service outlets that provided data (response rates) and the ‘not stated’ rates of particular data items vary across jurisdictions and years (see section 14.6 for further details)
- the interpretation of CSTDA NMDS service definitions can differ across jurisdictions (for example, the target group for services classified as ‘early intervention’ can differ).

Outputs

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

Equity and effectiveness — access to appropriate services on the basis of relative need

The following equity and effectiveness access indicators are reported:

- ‘access to CSTDA funded services’
- ‘service use by severity of disability’
- ‘service use by special needs groups’

-
- ‘proportion of accommodation support service users receiving community accommodation and care services’.

Access to CSTDA funded services

‘Access to CSTDA funded services’ is an indicator of 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, community support, community access, respite services and employment (box 14.5).

Box 14.5 Access to CSTDA funded services

‘Access to CSTDA funded services’ is defined as the number of people using a particular CSTDA funded service divided by the ‘potential population’ for that service. The potential population is an estimate that broadly indicates the number of people with the potential to require specialist disability services at some time.

The potential population estimate for *accommodation support, community access and community support services* is the number of people aged under 65 years with profound or severe core activity limitations, multiplied by the Indigenous factor for a jurisdiction. The potential population estimate for *employment services* is the number of people aged 15–64 years with severe or profound core activity limitations, multiplied by both the Indigenous factor and the labour force participation rate for a jurisdiction. The potential population estimate for *respite services* is the number of people aged under 65 years with profound or severe core activity limitations who also reported a primary carer, multiplied by the Indigenous factor for a jurisdiction. The potential populations are further defined in section 14.7.

A higher proportion of the relevant estimated potential population using a particular CSTDA service suggests greater access to that service.

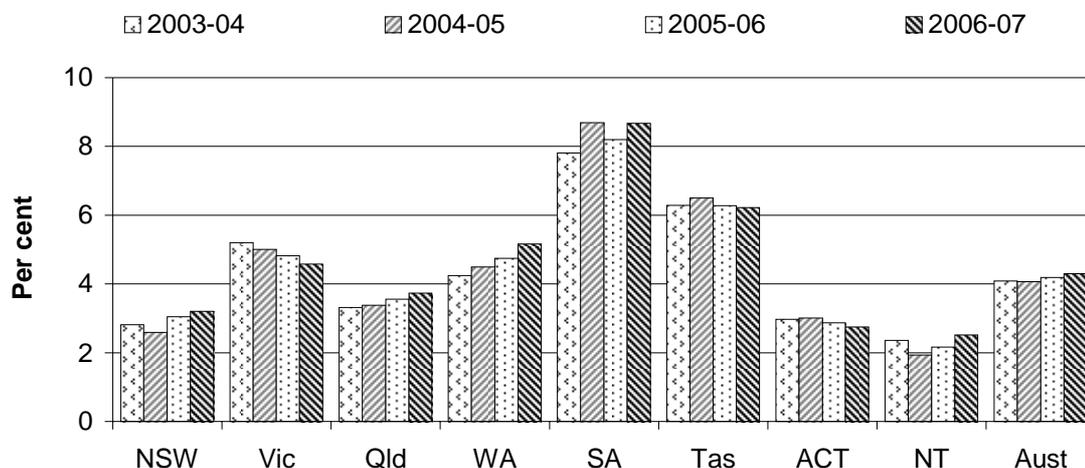
Not all people in the estimated ‘potential population’ will need the service or seek to access the service in the relevant period. In addition, this indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or accessed by those most in need.

Data reported for this indicator are comparable.

The numerators and denominators of the access measures do not match fully in terms of age scope. The numerator of an access measure includes service users of all ages. The denominator includes people who are aged under 65 years only.

Nationally, 4.3 per cent of the estimated potential population were using CSTDA funded accommodation support services in 2006-07 (figure 14.10).

Figure 14.10 Users of CSTDA funded accommodation support services as a proportion of the estimated potential population^{a, b}

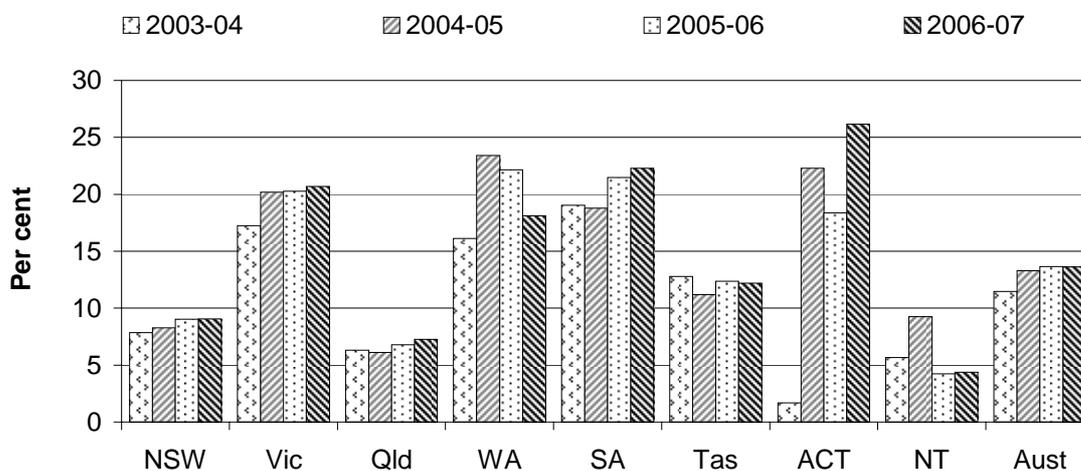


^a See table 14A.15 for detailed notes relating to service user data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (unpublished), derived from the CSTDA NMDS; AIHW analysis of the ABS SDAC 2003; ABS *Australian Demographic Statistics*, Cat. no. 3101.0 (various issues); ABS (2004) *Experimental Projections of the Aboriginal and Torres Strait Islander Population, 30 June 2001 to 30 June 2009*, Cat. no. 3238.0, Canberra; AIHW (2006) *'Potential population' — Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Cat. no. DIS 45, Canberra; table 14A.15.

Nationally, 13.6 per cent of the estimated potential population were using CSTDA funded community support in 2006-07 (figure 14.11).

Figure 14.11 Users of CSTDA funded community support services as a proportion of the estimated potential population^{a, b, c, d}

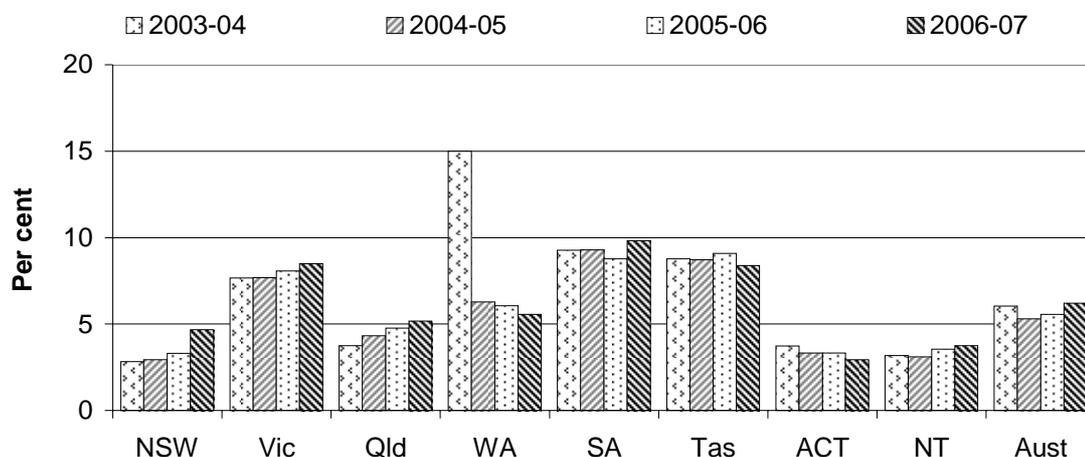


^a See table 14A.16 for detailed notes relating to service user data. ^b These results need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c The increase in the number of WA service users between 2003-04 and 2004-05 is due to the inclusion of data from a new electronic database for the first time. ^d For the ACT, the decreased community support services rate for 2005-06 was due to the data collection for therapy services being incomplete.

Source: AIHW (unpublished), derived from the *CSTDA NMDS*; AIHW analysis of the ABS SDAC 2003; ABS *Australian Demographic Statistics*, Cat. no. 3101.0 (various issues); ABS (2004) *Experimental Projections of the Aboriginal and Torres Strait Islander Population, 30 June 2001 to 30 June 2009*, Cat. no. 3238.0, Canberra; AIHW (2006) *Potential population — Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Cat. no. DIS 45, Canberra; table 14A.16.

Nationally, 6.2 per cent of the estimated potential population were using CSTDA funded community access services in 2006-07 (figure 14.12).

Figure 14.12 Users of CSTDA funded community access services as a proportion of the estimated potential population^{a, b, c}

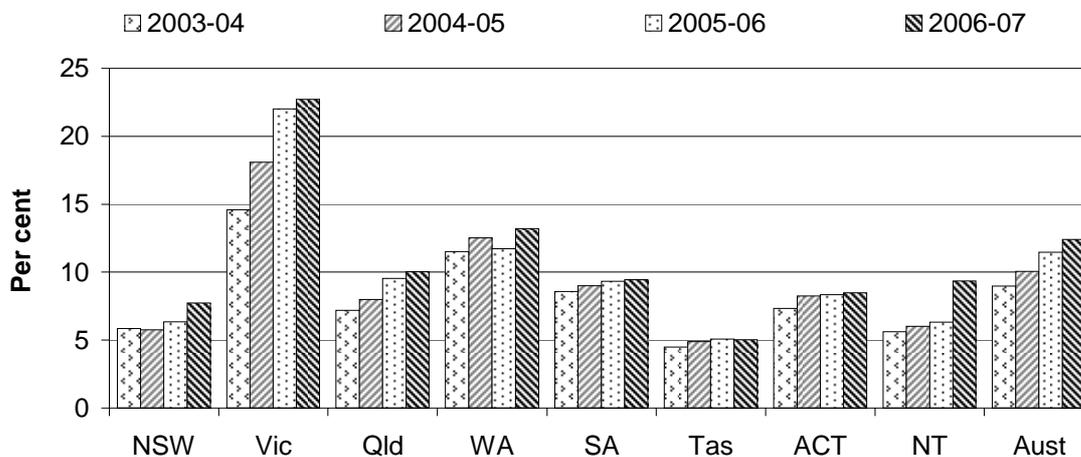


^a See table 14A.17 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c The decrease in the number of WA service users between 2003-04 and 2004-05 is due to a change in reporting by one recreation agency.

Source: AIHW (unpublished), derived from the CSTDA NMDS; AIHW analysis of the ABS SDAC 2003; ABS *Australian Demographic Statistics*, Cat. no. 3101.0 (various issues); ABS (2004) *Experimental Projections of the Aboriginal and Torres Strait Islander Population, 30 June 2001 to 30 June 2009*, Cat. no. 3238.0, Canberra; AIHW (2006) *Potential population — Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Cat. no. DIS 45, Canberra; table 14A.17.

Nationally, 12.4 per cent of the estimated potential population (who reported having a primary carer) were using CSTDA funded respite services in 2006-07 (figure 14.13).

Figure 14.13 Users of CSTDA funded respite services as a proportion of the estimated potential population for respite services^{a, b}

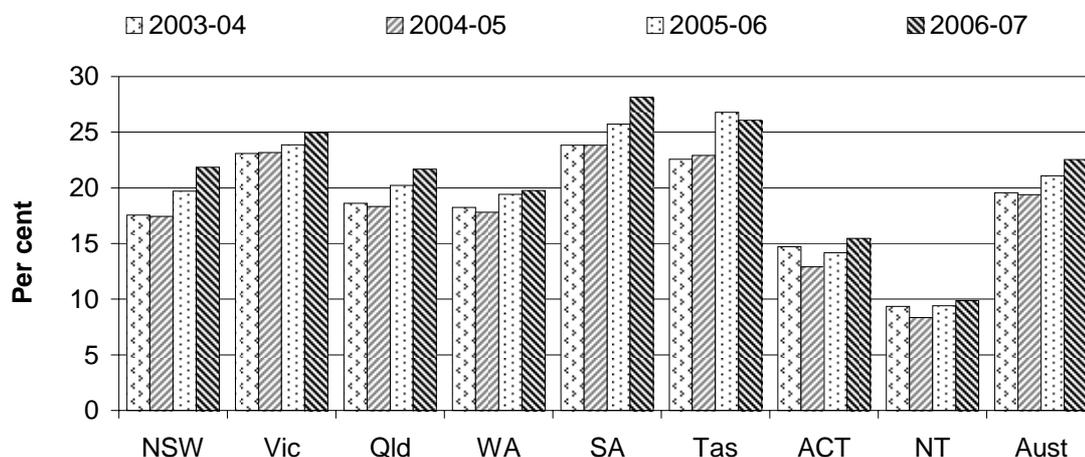


^a See table 14A.18 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (unpublished), derived from the *CSTDA NMDS*; AIHW analysis of the *ABS SDAC 2003*; *ABS Australian Demographic Statistics*, Cat. no. 3101.0 (various issues); *ABS (2004) Experimental Projections of the Aboriginal and Torres Strait Islander Population, 30 June 2001 to 30 June 2009*, Cat. no. 3238.0, Canberra; AIHW (2006) *'Potential population' — Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Cat. no. DIS 45, Canberra; table 14A.18.

During the reporting period, the Australian Government had responsibility for employment services under the CSTDA and provided most employment services (over 99 per cent) by funding non-government organisations. Nationally, 22.6 per cent of the estimated potential population for CSTDA funded employment services were using these services in 2006-07 (figure 14.14).

Figure 14.14 **Users of CSTDA funded employment services as a proportion of the estimated potential population for employment services^a**



^a See table 14A.19 for detailed notes relating to these data.

Source: AIHW (various issues), *Disability Support Services* (various years): *National Data on Services Provided under the CSTDA*; AIHW analysis of the ABS SDAC 2003; ABS *Australian Demographic Statistics*, Cat. no. 3101.0 (various issues); ABS (2004) *Experimental Projections of the Aboriginal and Torres Strait Islander Population, 30 June 2001 to 30 June 2009*, Cat. no. 3238.0, Canberra; AIHW (2006) 'Potential population' — *Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Cat. no. DIS 45, Canberra; ABS *Labour Force Australia*, Cat. no. 6203.0 (various issues); table 14A.19.

Service use by severity of disability

'Service use by severity of disability' is an indicator of governments' objective to use available resources to target services to people with the greatest level of need, where the level of core activity limitation is used as a proxy for relative need (box 14.6). This indicator provides additional information for interpreting the access to CSTDA funded accommodation support, employment, community access, community support and respite services measures reported above.

Severity of disability (core activity limitation) is derived using data on the level of support needed in one or more of the core 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 moderate to no core activity limitations reported needing no support in all the core activity support areas. For these people, other factors may be important in determining relative need, such as the complexity of need for support in other activity areas, for example, cognition or emotional support and transport.

Box 14.6 Service use by severity of disability

'Service use by severity of disability' is defined as the proportion of people who access CSTDA funded services, by severity of core activity limitation. Three categories of core activity limitation are reported: profound, severe, and moderate to no core activity limitation. Measures are reported for accommodation support, employment, community access, community support and respite services.

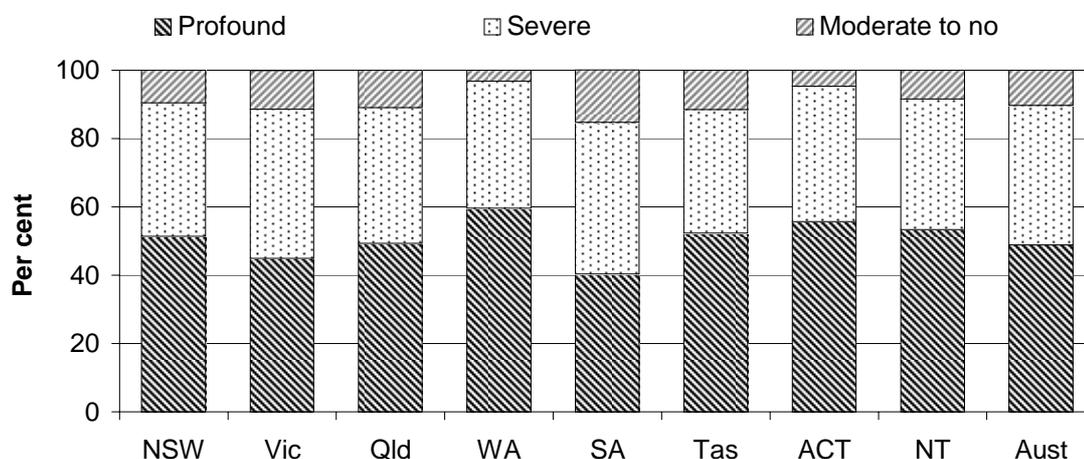
A higher proportion of people with a profound or severe core activity limitation using a particular service type suggests greater access to this service type for those with the greatest level of need.

This indicator does not provide information on whether services are appropriate for the needs of the people receiving them or appropriately targeted to those with the greatest level of need in terms of access to other formal and informal support. The need for services is assumed to vary according to the level of core activity limitation and so core activity limitation is used as one proxy for relative need. Core activity limitation data are self/carer identified, not based on formal clinical assessments of individual limitations. In addition, there are other factors that may also be important in determining relative need, such as the complexity of a service user's needs.

Data reported for this indicator are comparable.

Nationally, 48.9 per cent of users of CSTDA funded accommodation support services in 2006-07 had a profound core activity limitation, 40.8 per cent had a severe core activity limitation and 10.3 per cent had moderate to no core activity limitations (figure 14.15).

Figure 14.15 Users of CSTDA funded accommodation support services, by severity of core activity limitation, 2006-07^{a, b}



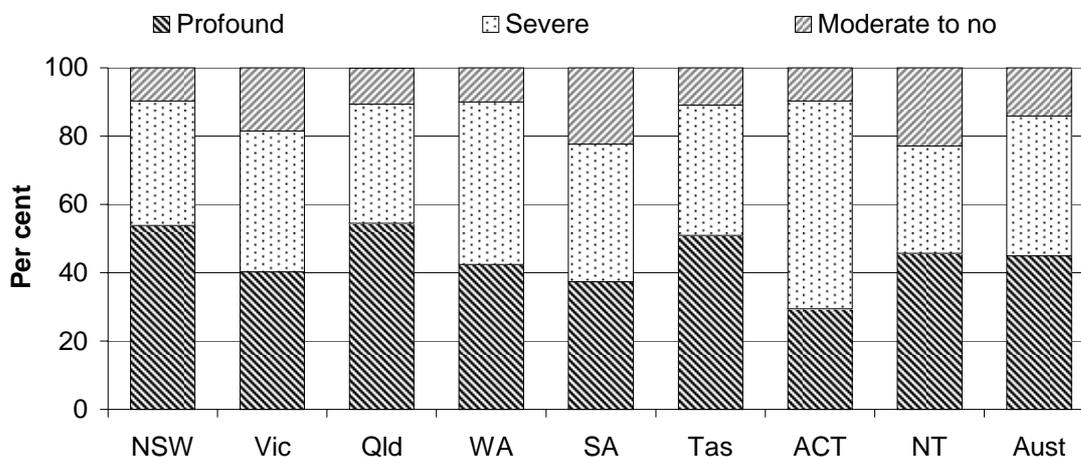
^a See table 14A.20 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (unpublished), derived from the CSTDA NMDS; table 14A.20.

Nationally, 45.0 per cent of users of CSTDA funded community support services in 2006-07 had a profound core activity limitation, 40.9 per cent had a severe core activity limitation and 14.1 per cent had moderate to no core activity limitations (figure 14.16). Care should be taken when interpreting this measure due to the high rate of missing data. Data exclude 23 613 community support service users (out of a total of 98 432) who did not report on their level of need for support with any of the areas: self care; mobility; or communication.

Nationally, 41.2 per cent of users of CSTDA funded community access services in 2006-07 had a profound core activity limitation, 44.3 per cent had a severe core activity limitation and 14.5 per cent had moderate to no core activity limitations (figure 14.17).

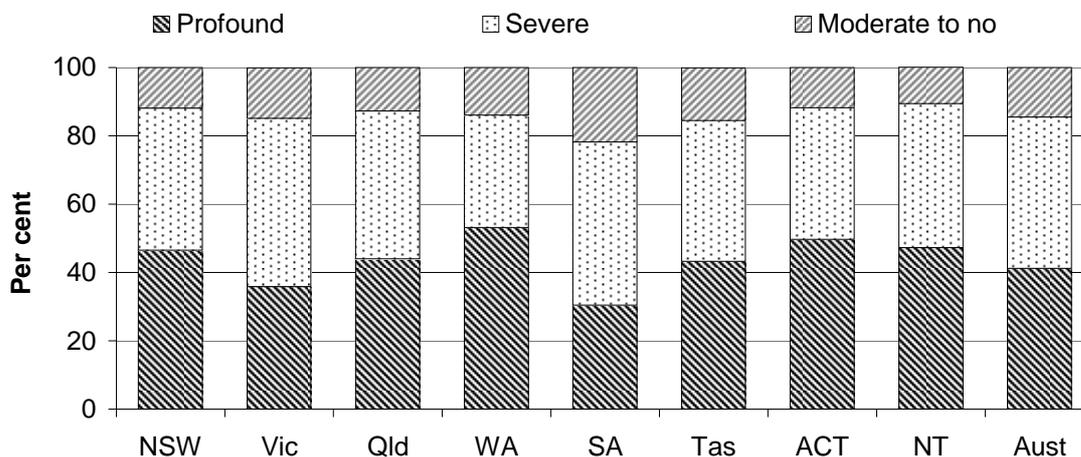
Figure 14.16 Users of CSTDA funded community support services, by severity of core activity limitation, 2006-07^{a, b}



^a See table 14A.21 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (unpublished), derived from the CSTDA NMDS; table 14A.21.

Figure 14.17 Users of CSTDA funded community access services, by severity of core activity limitation, 2006-07^{a, b}



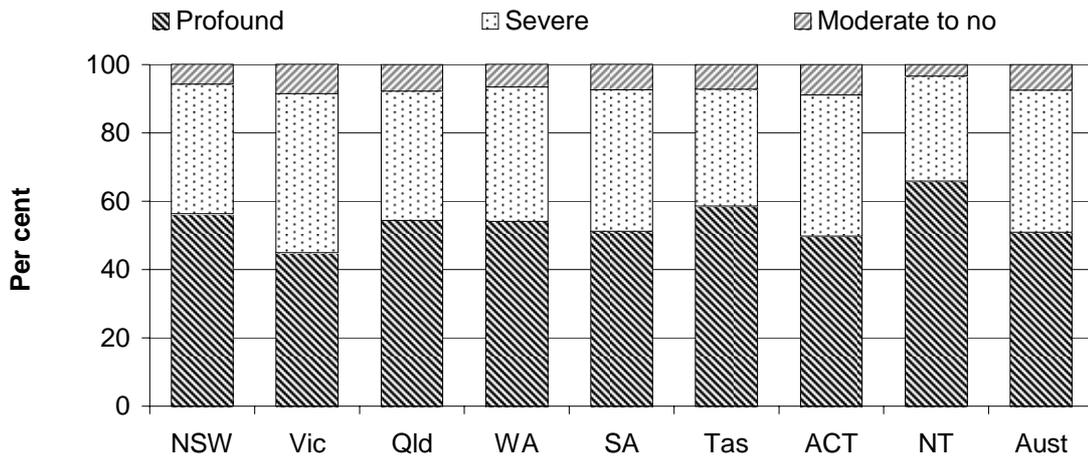
^a See table 14A.22 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (unpublished), derived from the CSTDA NMDS; table 14A.22.

Nationally, 50.9 per cent of users of CSTDA funded respite services in 2006-07 had a profound core activity limitation, 41.6 per cent had a severe core activity

limitation and 7.5 per cent had moderate to no core activity limitations (figure 14.18).

Figure 14.18 Users of CSTDA funded respite services, by severity of core activity limitation, 2006-07^{a, b, c}

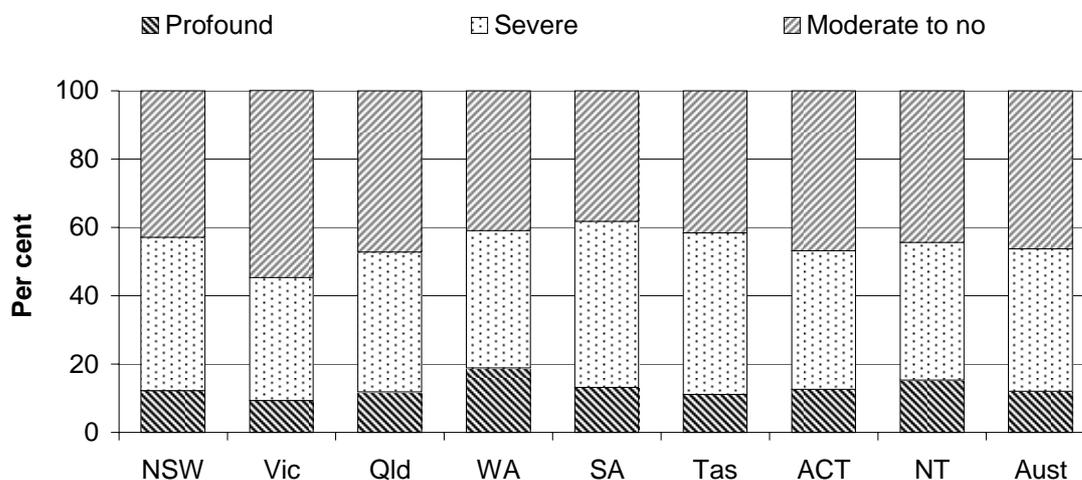


^a See table 14A.23 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c These data relate to severity of core activity limitations for people with a disability, not their carers. Carers may also be thought of as 'users' of respite services.

Source: AIHW (unpublished), derived from the *CSTDA NMDS*; table 14A.23.

Nationally, 12.1 per cent of users of CSTDA funded employment services in 2006-07 had a profound core activity limitation, 41.6 per cent had a severe core activity limitation and 46.3 per cent had moderate to no core activity limitations (figure 14.19).

Figure 14.19 Users of CSTDA funded employment services, by severity of core activity limitation, 2006-07^{a, b, c}



^a Severity of core activity limitation relates to the level of support needed in the areas of self care, mobility and communication. It does not necessarily relate to the level of support needed to find or maintain employment. ^b See table 14A.24 for detailed notes relating to these data. ^c These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (2008) *Disability Support Services 2006-07: National Data on Services Provided under the CSTDA*, Cat. no. DIS 52, Canberra; table 14A.24.

Service use by special needs groups

‘Service use by special needs groups’ is an indicator of governments’ objective that access to services should be equitable for all members of the community and provided on the basis of relative need (box 14.7). For the first time, this Report compares access for people from special needs groups with access for people from outside the special needs group in terms of the ‘potential population’ (that is, people in the relevant groups who have the potential to need services). These new results are *experimental estimates* and are presented for illustrative purposes only (they will be further refined in future reports). They have been developed to account for differences in the prevalence of disability between people in the special needs group and people outside the special needs group. As in previous reports, the indicator also compares access in terms of the whole population in the relevant groups. For information on how the potential populations for the special needs groups were derived see section 14.6.

Box 14.7 **Service use by special needs groups**

The 'service use by special needs groups' indicator compares the proportion of service users per 1000 people (or per 1000 potential population) in a particular special needs group with the proportion of service users per 1000 people (or per 1000 potential population) outside the special needs group. The three special needs groups reported are:

- people from outer regional and remote/very remote locations
- people identified as Indigenous Australians
- people who were born in a non-English speaking country (that is, not born in Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland, the United States or Zimbabwe).

The disability service types reported are accommodation support, employment, community access, community support and respite services.

Holding other factors constant, the proportion of service users per 1000 people (or per 1000 potential population) in a special needs group should not differ significantly from the proportion of service users per 1000 people (or per 1000 potential population) outside the special needs group.

For both measures, while a markedly lower proportion may indicate reduced access for a special needs group, it may also represent strong alternative support networks (and thus a lower level of need), or a lower tendency of people with a disability in a special needs group to choose to access CSTDA funded services. Similarly, a higher proportion may suggest poor service targeting, the lack of alternative support networks or a greater tendency of people with a disability in a special needs group to choose to access CSTDA funded services. For the measure that compares the proportions of service users per 1000 population, significant differences in access may also reflect the special needs group having a higher/lower prevalence of disability.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. The indicator does not take into account differences in the level of informal assistance that is available for people in special needs groups and outside the special needs groups. Results for outer regional and remote/very remote users of 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.

Data reported for this indicator are comparable.

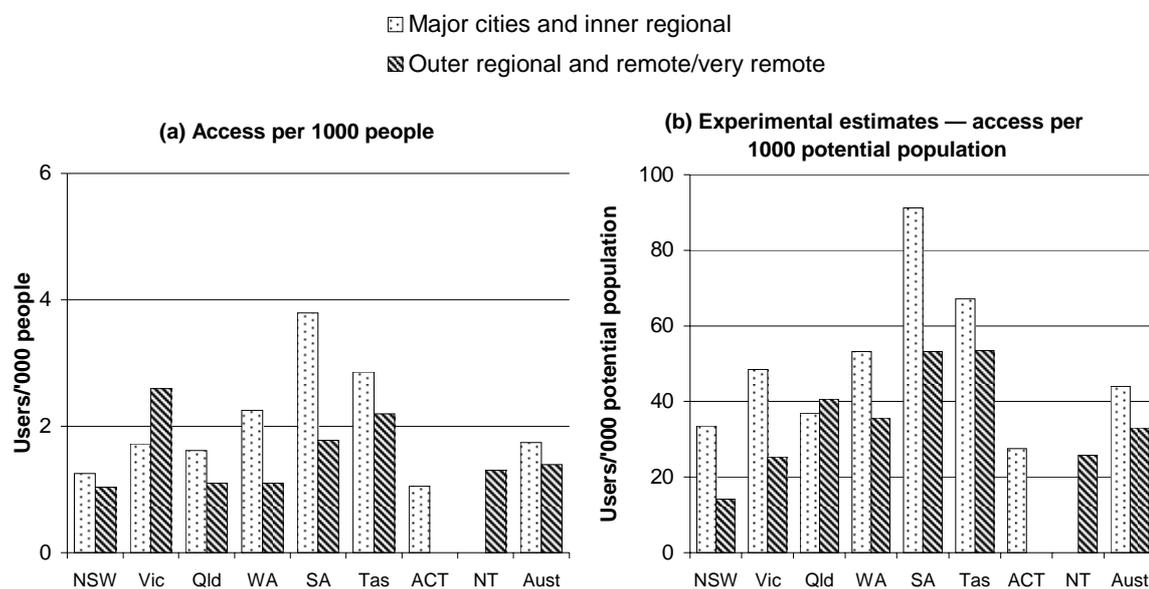
The numerators and denominators of the ‘service use by special needs groups’ measures do not match fully. The numerators of the measures include service users of all ages whereas the denominators (populations/potential populations) include people aged under 65 years only.

Service use by special needs groups — people in outer regional and remote/very remote areas

Data on service use for people in outer regional and remote/very remote areas are reported for the first time for community support, community access and respite services.

Nationally, the proportion of the outer regional and remote/very remote population who used CSTDA funded accommodation support services in 2006-07 (1.4 service users per 1000 people aged under 65 years) was lower than that of the major cities and inner regional populations (1.7 service users per 1000 people aged under 65 years) (figure 14.20a). Similarly, the proportion of the outer regional and remote/very remote potential population who used CSTDA funded accommodation support services (33.0 service users per 1000 potential population) was lower than that of the major cities and inner regional potential population (44.0 service users per 1000 potential population) (figure 14.20b).

Figure 14.20 Users of CSTDA funded accommodation support services, by geographic location, 2006-07^{a, b, c, d, e, f}

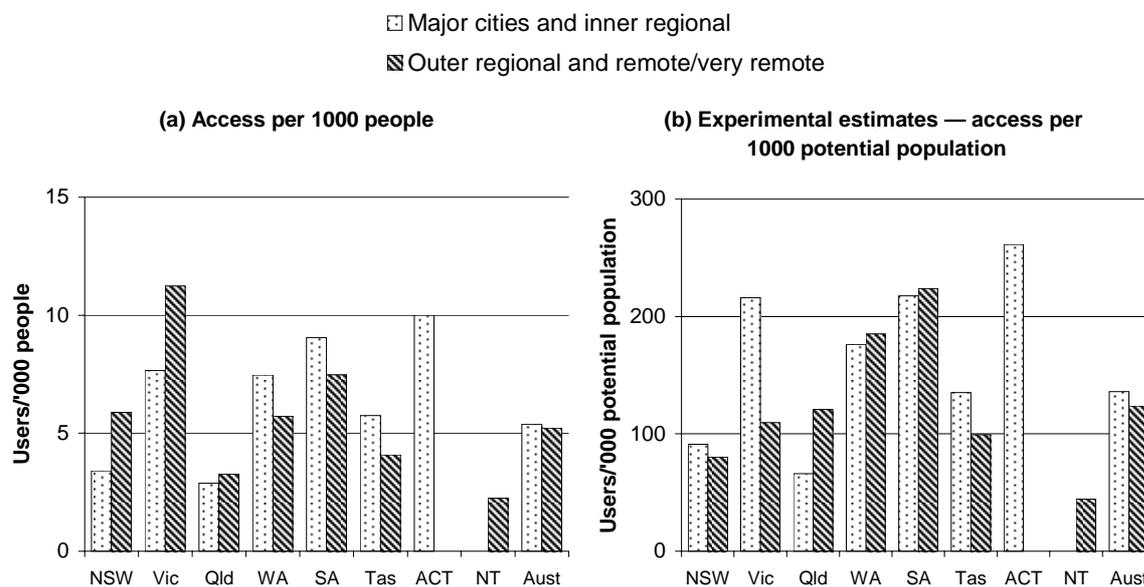


^a See table 14A.25 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c Tasmania does not have major cities. ^d The ACT does not have outer regional and remote/very remote areas. ^e The NT does not have major cities and inner regional areas. ^f Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the CSTDA NMDS; ABS (unpublished), derived from the 2006 Census of Population and Housing; AIHW analysis of ABS Statistical Local Area (SLA) population estimates for June 2006; table 14A.25.

Nationally, the proportion of the outer regional and remote/very remote population who used CSTDA funded community support services in 2006-07 (5.2 service users per 1000 people aged under 65 years) was lower than that of the major cities and inner regional population (5.4 service users per 1000 people aged under 65 years) (figure 14.21a). Similarly, the proportion of the outer regional and remote/very remote potential population who used CSTDA funded community support services (123.8 service users per 1000 potential population) was lower than that of the major cities and inner regional potential population (135.9 service users per 1000 potential population) (figure 14.21b).

Figure 14.21 Users of CSTDA funded community support services, by geographic location, 2006-07^{a, b, c, d, e, f}

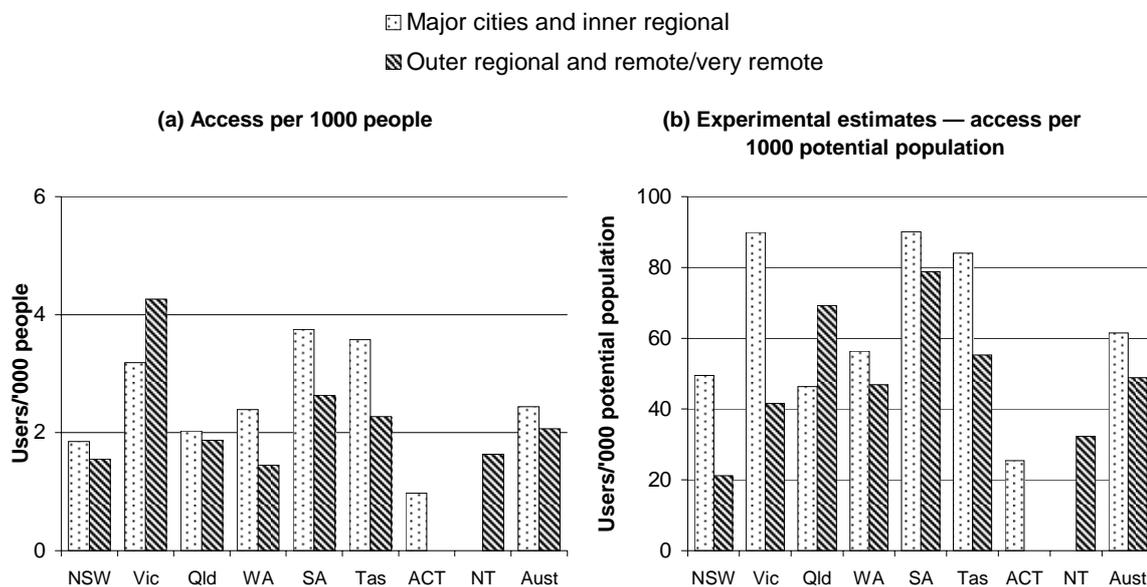


^a See table 14A.26 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c Tasmania does not have major cities. ^d The ACT does not have outer regional and remote/very remote areas. ^e The NT does not have major cities and inner regional areas. ^f Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the *CSTDA NMDS*; ABS (unpublished), derived from the *2006 Census of Population and Housing*; AIHW analysis of ABS SLA population estimates for June 2006; table 14A.26.

Nationally, the proportion of the outer regional and remote/very remote population who used CSTDA funded community access services in 2006-07 (2.1 service users per 1000 people aged under 65 years) was lower than that of the major cities and inner regional populations (2.4 service users per 1000 people aged under 65 years) (figure 14.22a). Similarly, the proportion of the outer regional and remote/very remote potential population who used CSTDA funded community access services (48.9 service users per 1000 potential population) was lower than that of the major cities and inner regional potential population (61.5 service users per 1000 potential population) (figure 14.22b).

Figure 14.22 Users of CSTDA funded community access services, by geographic location, 2006-07^{a, b, c, d, e, f}

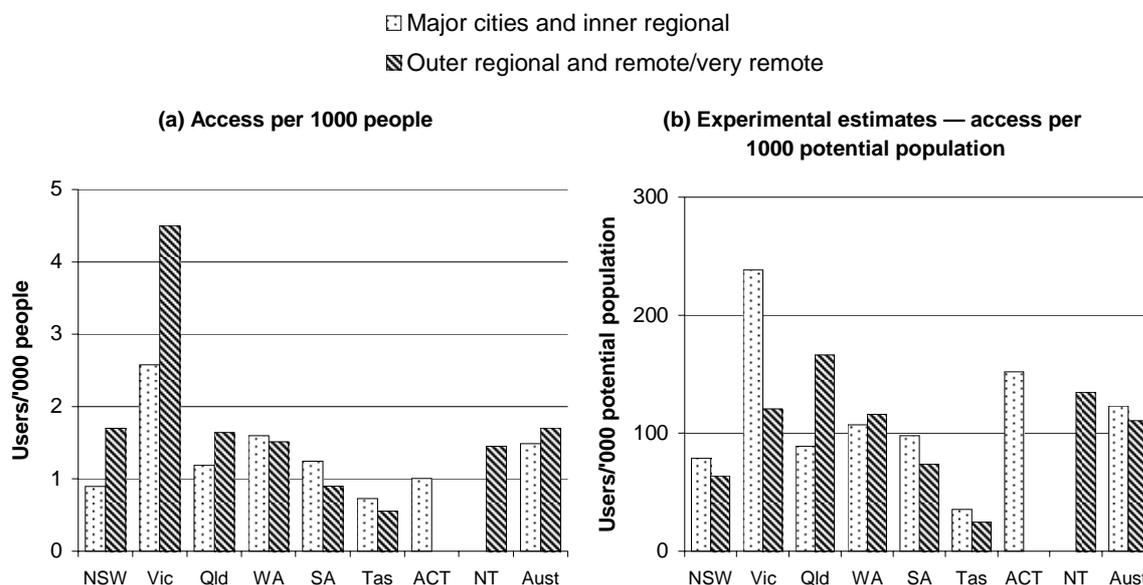


^a See table 14A.27 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c Tasmania does not have major cities. ^d The ACT does not have outer regional and remote/very remote areas. ^e The NT does not have major cities and inner regional areas. ^f Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the CSTDA NMDS; ABS (unpublished), derived from the 2006 Census of Population and Housing; AIHW analysis of ABS SLA population estimates for June 2006; table 14A.27.

Nationally, the proportion of the outer regional and remote/very remote population who used CSTDA funded respite services in 2006-07 (1.7 service users per 1000 people aged under 65 years) was higher than that of the major cities and inner regional population (1.5 service users per 1000 people aged under 65 years) (figure 14.23a). In contrast, the proportion of the outer regional and remote/very remote potential population who used CSTDA funded respite services (110.8 service users per 1000 potential population) was lower than that of the major cities and inner regional potential population (123.1 service users per 1000 potential population) (figure 14.23b).

Figure 14.23 Users of CSTDA funded respite services, by geographic location, 2006-07^{a, b, c, d, e, f}

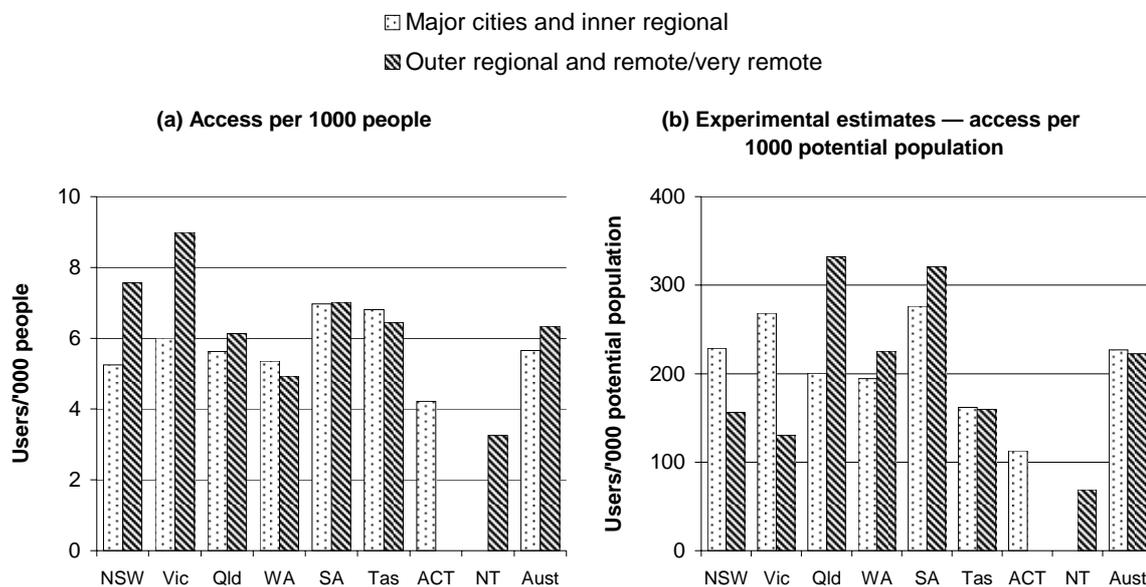


^a See table 14A.28 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c Tasmania does not have major cities. ^d The ACT does not have outer regional and remote/very remote areas. ^e The NT does not have major cities and inner regional areas. ^f Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the CSTDA NMDS; ABS (unpublished), derived from the 2006 Census of Population and Housing; AIHW analysis of ABS SLA population estimates for June 2006; table 14A.28.

Nationally, the proportion of the outer regional and remote/very remote population who used CSTDA funded employment services in 2006-07 (6.3 service users per 1000 people aged 15–64 years) was higher than that of the major cities and inner regional population (5.6 service users per 1000 people aged 15–64 years) (figure 14.24a). In contrast, the proportion of the outer regional and remote/very remote potential population who used CSTDA funded employment services (222.5 service users per 1000 potential population) was lower than that of the major cities and inner regional potential population (226.9 service users per 1000 potential population) (figure 14.24b).

Figure 14.24 **Users of CSTDA funded employment services, by geographic location, 2006-07^{a, b, c, d, e}**



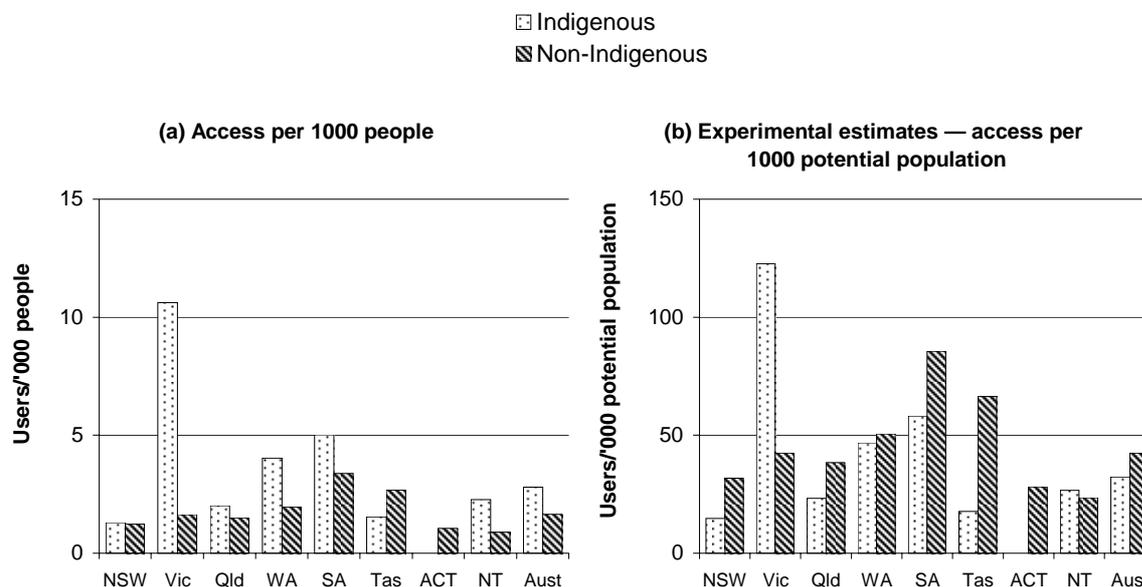
a See table 14A.29 for detailed notes relating to these data. **b** Tasmania does not have major cities. **c** The ACT does not have outer regional and remote/very remote areas. **d** The NT does not have major cities and inner regional areas. **e** Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the CSTDA NMDS; ABS (unpublished), derived from the 2006 Census of Population and Housing; AIHW analysis of ABS SLA population estimates for June 2006; table 14A.29.

Service use by special needs groups — Indigenous people

Nationally, the proportion of the Indigenous population who used CSTDA funded accommodation support services in 2006-07 (2.8 service users per 1000 people aged under 65 years) was higher than the proportion of the non-Indigenous population who used these services (1.6 service users per 1000 people aged under 65 years) (figure 14.25a). In contrast, the proportion of the Indigenous potential population who used CSTDA funded accommodation support services in 2006-07 (32.3 service users per 1000 potential population) was lower than the proportion of the non-Indigenous population who used these services (42.4 service users per 1000 potential population) (figure 14.25b).

Figure 14.25 Users of CSTDA funded accommodation support services, by Indigenous status, 2006-07^{a, b, c, d}

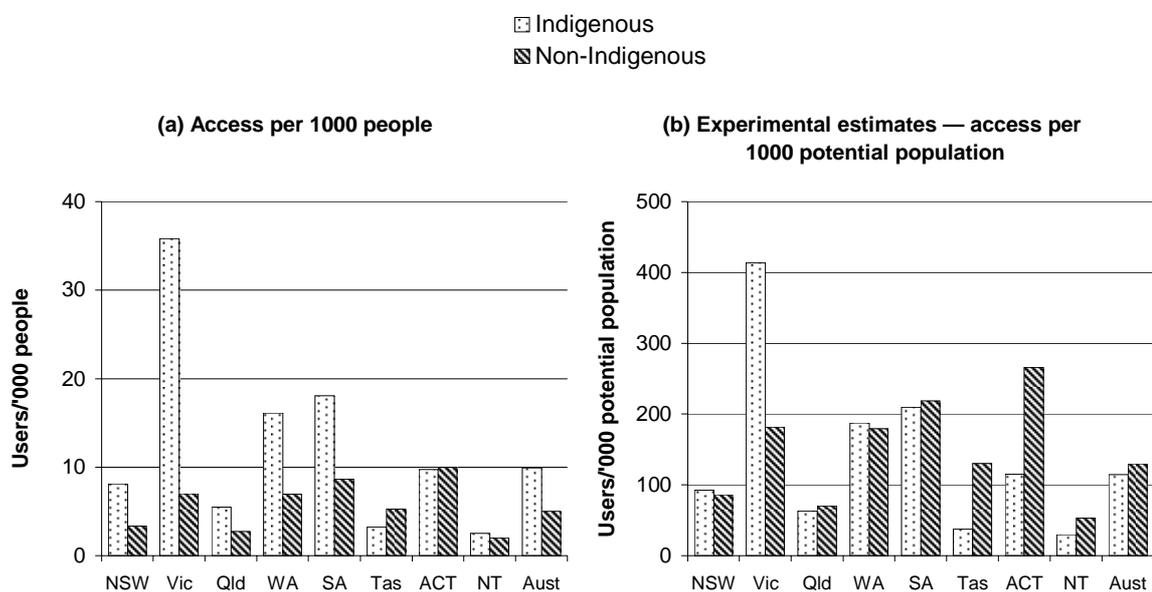


^a See table 14A.30 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c ACT data for service users per 1000 Indigenous people or Indigenous potential population are not published as they are based on a small number of service users. ^d Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the CSTDA NMDS; ABS *Australian Demographic Statistics 2006* Cat. no. 3101.0; ABS (2004) *Experimental Projections of the Aboriginal and Torres Strait Islander Population, 30 June 2001 to 30 June 2009*, Cat. no. 3238.0; AIHW (2006) *Potential population' — Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Cat. no. DIS 45, Canberra; table 14A.30.

Nationally, the proportion of the Indigenous population who used CSTDA funded community support services in 2006-07 (9.9 service users per 1000 people aged under 65 years) was higher than the proportion of the non-Indigenous population who used these services (5.0 service users per 1000 non-Indigenous people aged under 65 years) (figure 14.26a). In contrast, the proportion of the Indigenous potential population who used CSTDA funded community support services in 2006-07 (114.6 service users per 1000 potential population) was lower than the proportion of the non-Indigenous potential population who used these services (129.7 service users per 1000 potential population) (figure 14.26b).

Figure 14.26 Users of CSTDA funded community support services, by Indigenous status, 2006-07^{a, b, c}

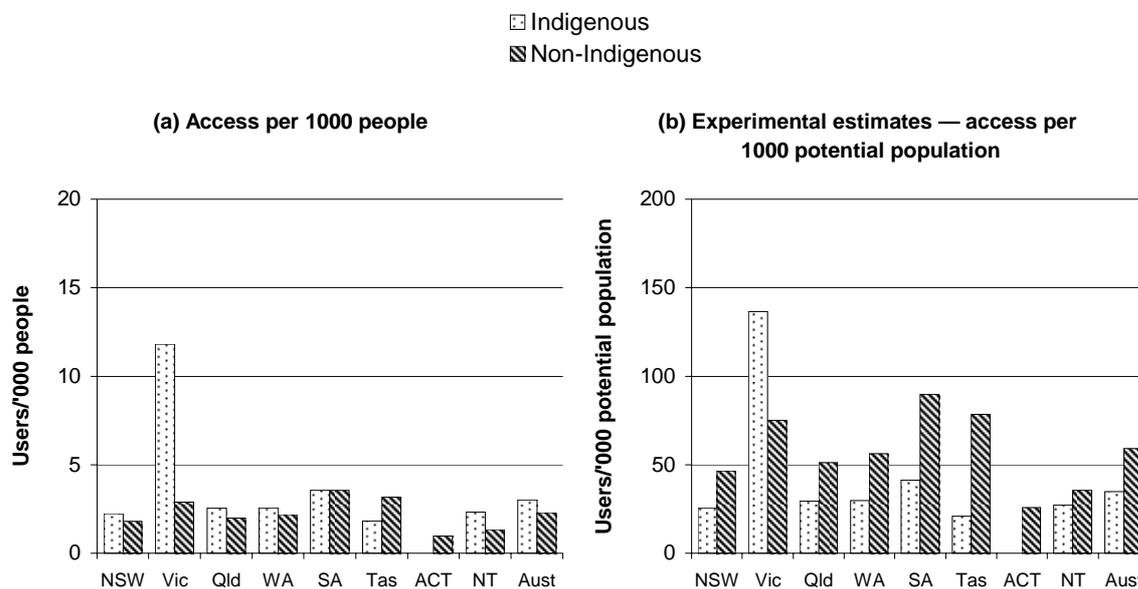


^a See table 14A.31 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the CSTDA NMDS; ABS *Australian Demographic Statistics 2006* Cat. no. 3101.0; ABS (2004) *Experimental Projections of the Aboriginal and Torres Strait Islander Population, 30 June 2001 to 30 June 2009*, Cat. no. 3238.0; AIHW (2006) *Potential population* — *Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Cat. no. DIS 45, Canberra; table 14A.31.

Nationally, the proportion of the Indigenous population who used CSTDA funded community access services in 2006-07 (3.0 service users per 1000 people aged under 65 years) was higher than the proportion of the non-Indigenous population who used these services (2.3 service users per 1000 people aged under 65 years) (figure 14.27a). In contrast, the proportion of the Indigenous potential population who used CSTDA funded community access services in 2006-07 (34.8 service users per 1000 potential population) was lower than the proportion of the non-Indigenous population who used these services (59.1 service users per 1000 potential population) (figure 14.27b).

Figure 14.27 Users of CSTDA funded community access services, by Indigenous status, 2006-07^{a, b, c, d}

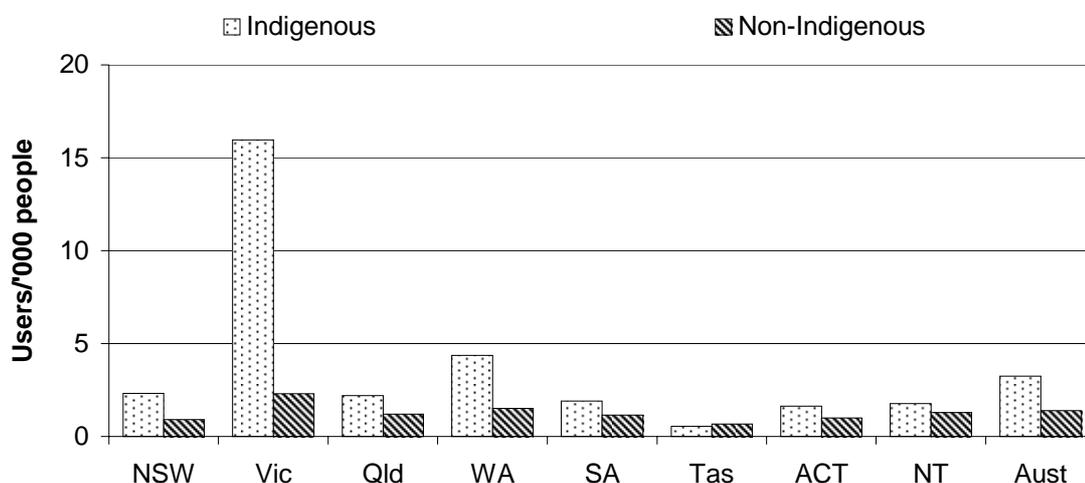


^a See table 14A.32 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c ACT data for service users per 1000 Indigenous people are not published as they are based on a small number of service users. ^d Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the CSTDA NMDS; ABS *Australian Demographic Statistics 2006* Cat. no. 3101.0; ABS (2004) *Experimental Projections of the Aboriginal and Torres Strait Islander Population, 30 June 2001 to 30 June 2009*, Cat. no. 3238.0; AIHW (2006) *Potential population* — *Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Cat. no. DIS 45, Canberra; table 14A.32.

Nationally, the proportion of the Indigenous population who used CSTDA funded respite services in 2006-07 (3.3 service users per 1000 people aged under 65 years) was higher than the proportion of the non-Indigenous population who used these services (1.4 service users per 1000 people aged under 65 years) (figure 14.28). Access to respite as a proportion of the potential population is not reported by Indigenous status as data to estimate the potential populations are not available.

Figure 14.28 Users of CSTDA funded respite services per 1000 people, by Indigenous status, 2006-07^{a, b, c}

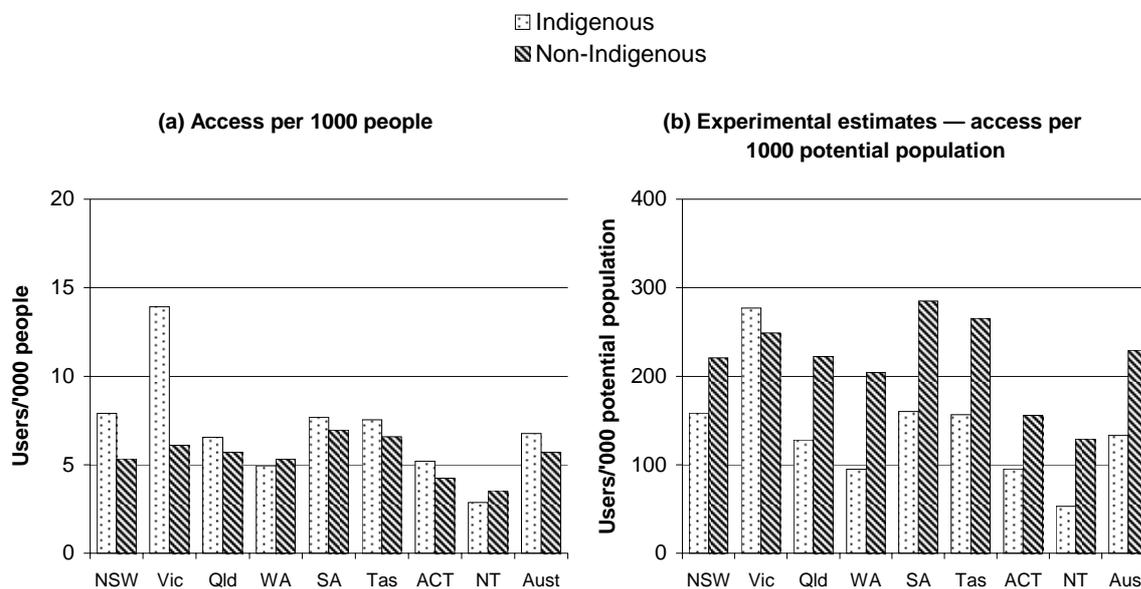


^a See table 14A.33 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c ACT data for service users per 1000 Indigenous people are not published as they are based on a small number of service users.

Source: AIHW (unpublished), derived from the CSTDA NMDS; ABS *Australian Demographic Statistics 2006* Cat. no. 3101.0; ABS (2004) *Experimental Projections of the Aboriginal and Torres Strait Islander Population, 30 June 2001 to 30 June 2009*, Cat. no. 3238.0; AIHW (2006) *Potential population* — *Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Cat. no. DIS 45, Canberra; table 14A.33.

Nationally, the proportion of the Indigenous population who used CSTDA funded employment services in 2006-07 (6.8 service users per 1000 people aged 15–64 years) was higher than the proportion of the non-Indigenous population who used these services (5.7 service users per 1000 people aged 15–64 years) (figure 14.29a). In contrast, the proportion of the Indigenous potential population who used CSTDA funded employment services in 2006-07 (133.0 service users per 1000 potential population) was lower than the proportion of the non-Indigenous population who used these services (229.5 service users per 1000 potential population) (figure 14.29b).

Figure 14.29 Users of CSTDA funded employment services, by Indigenous status, 2006-07^{a, b}



^a See table 14A.34 for detailed notes relating to these data. ^b Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the CSTDA NMDS; ABS *Australian Demographic Statistics 2006*, Cat. no. 3101.0; ABS (2004) *Experimental Projections of the Aboriginal and Torres Strait Islander Population, 30 June 2001 to 30 June 2009*, Cat. no. 3238.0; AIHW (2006) 'Potential population' — *Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Cat. no. DIS 45, Canberra; table 14A.34.

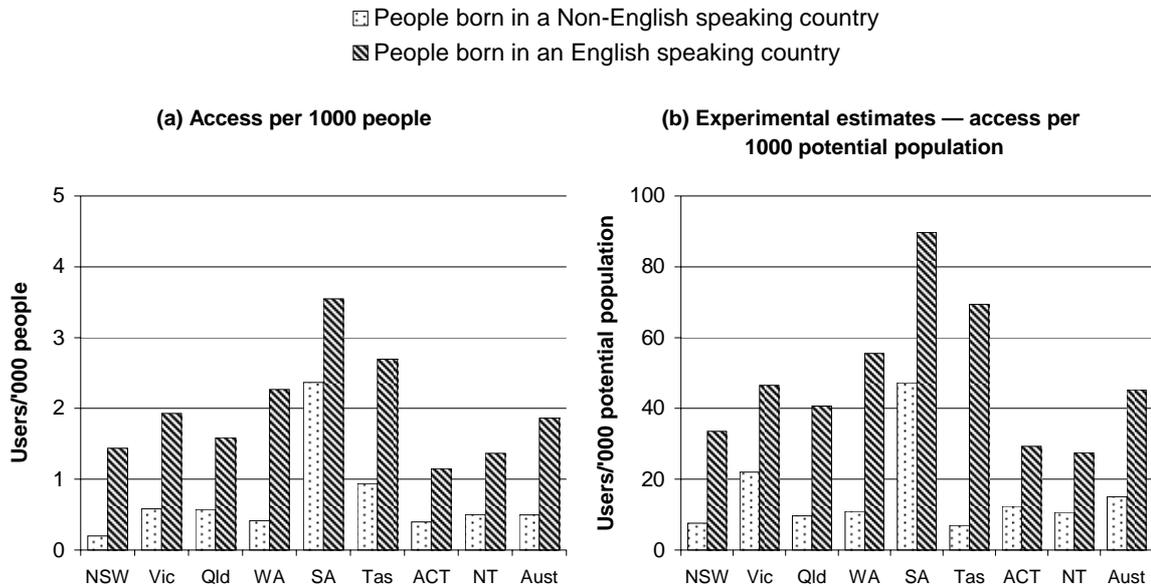
Service use by special needs groups — people born in a non-English speaking country

Data on service use for people born in a non-English speaking country are reported for the first time for community support, community access and respite services.

Nationally, the proportion of people born in a non-English speaking country who used CSTDA funded accommodation support services in 2006-07 (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 (1.9 service users per 1000 people aged under 65 years) (figure 14.30a). Similarly, the proportion of the potential population born in a non-English speaking country who used CSTDA funded accommodation support services in 2006-07 (15.1 service users per 1000 potential population) was lower than the proportion of the potential

population born in an English speaking country who used these services (45.2 service users per 1000 potential population) (figure 14.30b).

Figure 14.30 Users of CSTDA funded accommodation support services, by country of birth, 2006-07^{a, b, c}

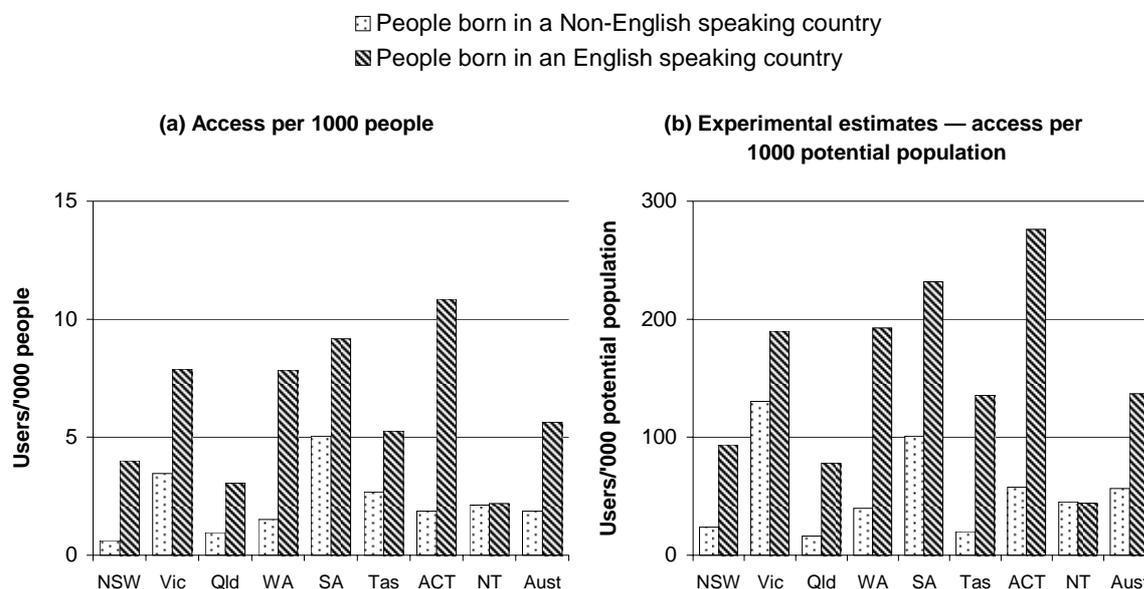


a See table 14A.35 for detailed notes relating to these data. **b** These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. **c** Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the CSTDA NMDS; ABS *Australian Demographic Statistics 2006*, Cat. no. 3101.0; ABS (2005) *Migration Australia 2003-04*, Cat. no. 3412.0, Canberra; ABS (unpublished), derived from the 2001 *Census of Population and Housing*; ABS (unpublished), derived from the 2003 *Survey of Disability, Ageing and Carers*, Cat. no. 4430.0; table 14A.35.

Nationally, the proportion of people born in a non-English speaking country who used CSTDA funded community support services in 2006-07 (1.9 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 (5.6 service users per 1000 people aged under 65 years) (figure 14.31a). Similarly, the proportion of the potential population born in a non-English speaking country who used CSTDA funded community support services in 2006-07 (56.6 service users per 1000 potential population) was lower than the proportion of the potential population born in an English speaking country who used these services (136.9 service users per 1000 potential population) (figure 14.31b).

Figure 14.31 Users of CSTDA funded community support services, by country of birth, 2006-07^{a, b, c}

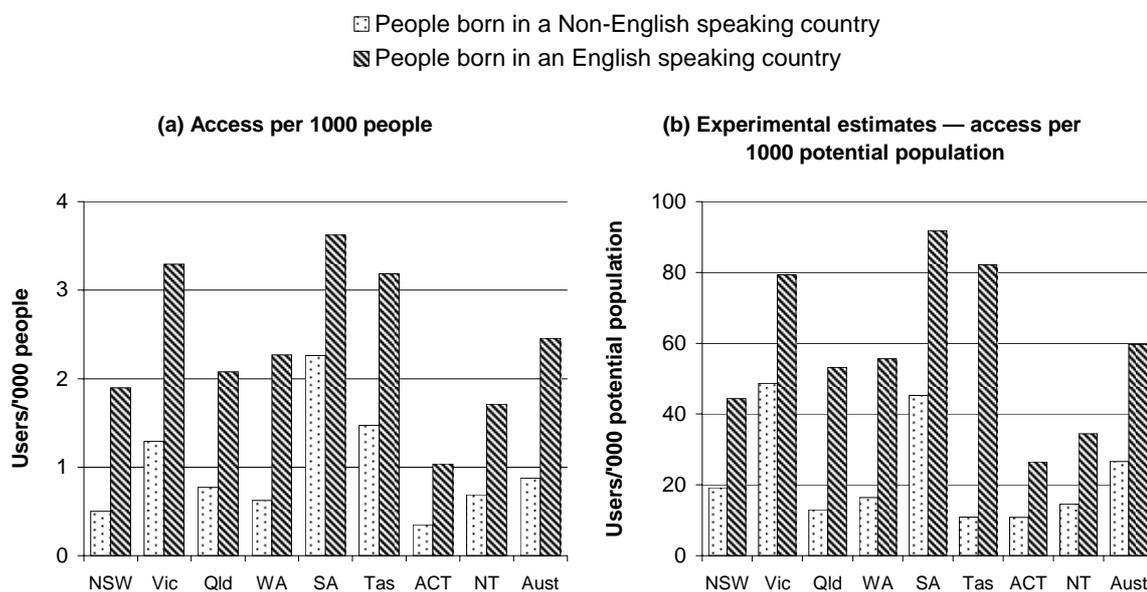


^a See table 14A.36 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. ^c Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the *CSTDA NMDS*; ABS *Australian Demographic Statistics 2006*, Cat. no. 3101.0; ABS (2005) *Migration Australia 2003-04*, Cat. no. 3412.0, Canberra; ABS (unpublished), derived from the *2001 Census of Population and Housing*; ABS (unpublished), derived from the *2003 Survey of Disability, Ageing and Carers*, Cat. no. 4430.0; table 14A.36.

Nationally, the proportion of people born in a non-English speaking country who used CSTDA funded community access services in 2006-07 (0.9 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 (2.5 service users per 1000 people aged under 65 years) (figure 14.32a). Similarly, the proportion of the potential population born in a non-English speaking country who used CSTDA funded community access services in 2006-07 (26.6 service users per 1000 potential population) was lower than the proportion of the potential population born in an English speaking country who used these services (59.7 service users per 1000 potential population) (figure 14.32b).

Figure 14.32 Users of CSTDA funded community access services, by country of birth, 2006-07^{a, b, c}

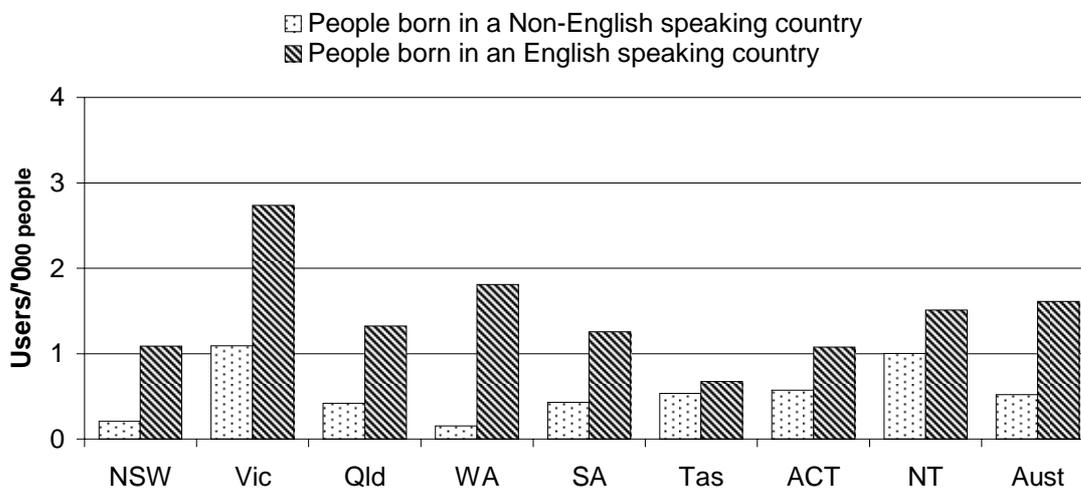


a See table 14A.37 for detailed notes relating to these data. **b** These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. **c** Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the CSTDA NMDS; ABS *Australian Demographic Statistics 2006*, Cat. no. 3101.0; ABS (2005) *Migration Australia 2003-04*, Cat. no. 3412.0, Canberra; ABS (unpublished), derived from the 2001 *Census of Population and Housing*; ABS (unpublished), derived from the 2003 *Survey of Disability, Ageing and Carers*, Cat. no. 4430.0; table 14A.37.

Nationally, the proportion of people born in a non-English speaking country who used CSTDA funded respite services in 2006-07 (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 (1.6 service users per 1000 people aged under 65 years) (figure 14.33). Access to respite as a proportion of the potential population is not reported by country of birth as data to estimate the potential populations are not available.

Figure 14.33 Users of CSTDA funded respite services per 1000, by country of birth, 2006-07^{a, b}

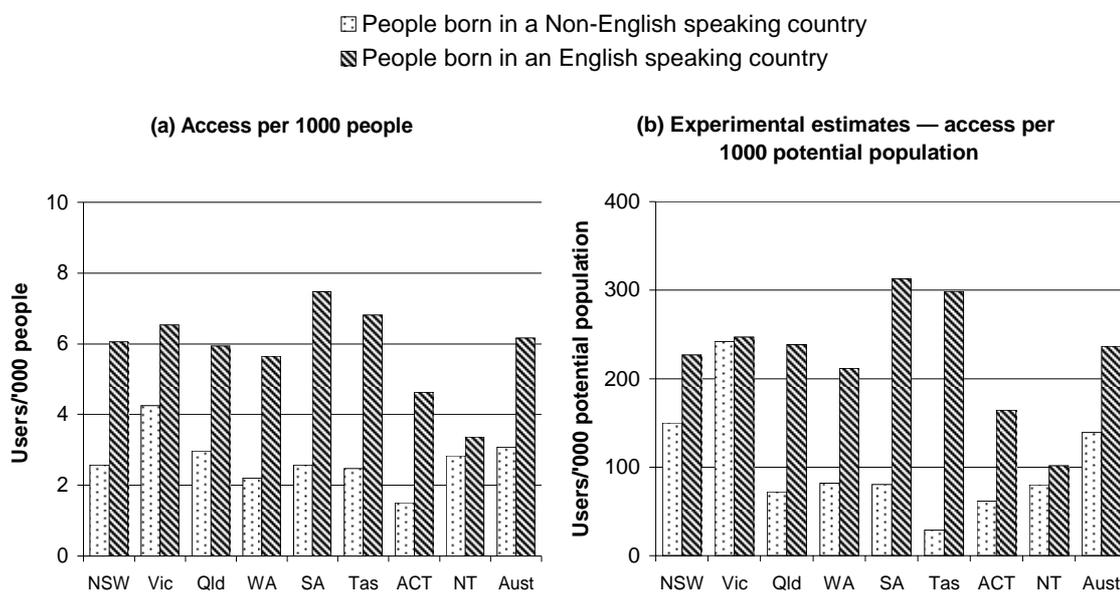


^a See table 14A.38 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (unpublished), derived from the *CSTDA NMDS*; ABS *Australian Demographic Statistics 2006*, Cat. no. 3101.0; ABS (2005) *Migration Australia 2003-04*, Cat. no. 3412.0, Canberra; ABS (unpublished), derived from the *2001 Census of Population and Housing*; ABS (unpublished), derived from the *2003 Survey of Disability, Ageing and Carers*, Cat. no. 4430.0; table 14A.38.

Nationally, the proportion of people born in a non-English speaking country who used CSTDA funded employment services in 2006-07 (3.1 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 (6.2 service users per 1000 people aged under 65 years) (figure 14.34a). Similarly, the proportion of the potential population born in a non-English speaking country who used CSTDA funded employment services in 2006-07 (139.1 service users per 1000 potential population) was lower than the proportion of the potential population born in an English speaking country who used these services (236.8 service users per 1000 potential population) (figure 14.34b).

Figure 14.34 **Users of CSTDA funded employment services, by country of birth, 2006-07^{a, b, c}**



a See table 14A.39 for detailed notes relating to these data. **b** These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues. **c** Results for the per 1000 potential population are *experimental estimates* and are presented for illustrative purposes only. They will be further refined in future reports. Results can differ significantly for these estimates and those calculated per 1000 population, including that access for the special needs group may be higher in one measure and lower in the other. These estimates seek to adjust for the prevalence of disability across special needs groups.

Source: AIHW (unpublished), derived from the CSTDA NMDS; ABS (unpublished), derived from the 2003 Survey of Disability, Ageing and Carers, Cat. no. 4430.0; ABS Australian Demographic Statistics 2006, Cat. no. 3101.0; ABS (2005) Migration Australia 2003-04, Cat. no. 3412.0, Canberra; ABS (unpublished), derived from the 2001 Census of Population and Housing; table 14A.39.

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 governments’ objective to assist people with a disability to live as valued and participating members of the community (box 14.8). Governments provide or fund accommodation support services to people with a disability in institutional/residential settings and through community accommodation and care services. Institutional or residential accommodation support services are provided in both institutions and hostels. Community accommodation and care services are provided in group homes and other community settings. The services provided in other community settings are attendant care/personal care, in-home accommodation support, alternative family placement and other accommodation support.

State and Territory governments generally seek, if possible, to provide accommodation support services to people with 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.

Box 14.8 Proportion of CSTDA funded accommodation support service users receiving community accommodation and care services

'Proportion of CSTDA funded accommodation support service users receiving community accommodation and care services' 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).

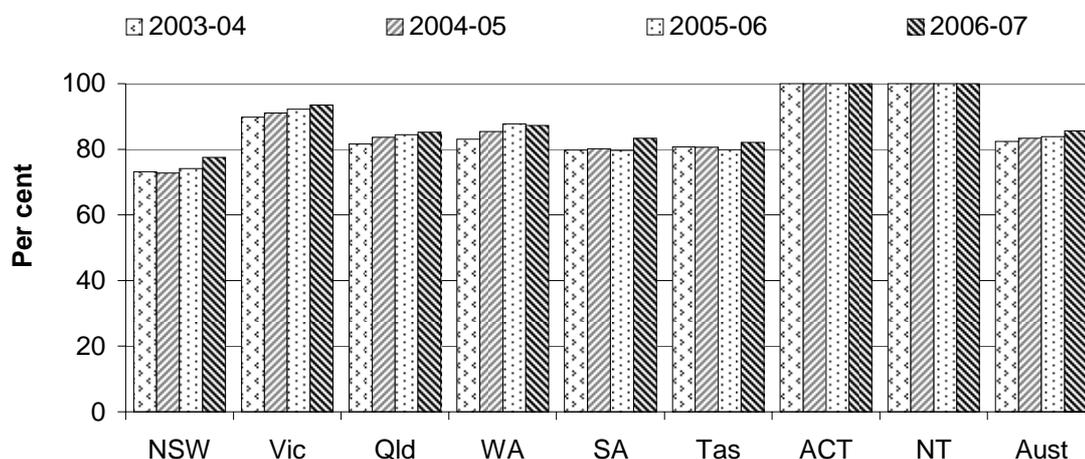
A higher proportion of people accessing CSTDA funded community accommodation and care services is likely to provide better opportunities for people with a disability (who need accommodation support) to be involved in their community.

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.

Data reported for this indicator are comparable.

Nationally, 85.6 per cent of users of CSTDA funded accommodation support service received community accommodation and care services in 2006-07 (figure 14.35).

Figure 14.35 **Users of community accommodation and care services as a proportion of all CSTDA funded accommodation support service users^{a, b}**



^a See table 14A.40 for detailed notes relating to these data. ^b These data need to be interpreted with caution due to a number of factors affecting data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (unpublished), derived from the *CSTDA NMDS*; table 14A.40.

Client satisfaction with appropriateness

‘Client satisfaction with appropriateness’ has been identified for development as an indicator of governments’ objective to provide services to people with a disability that are appropriate to their needs (box 14.9). This indicator will seek to measure the appropriateness of these services relative to the service user’s need, from the service user’s perspective.

Box 14.9 Client satisfaction with appropriateness

‘Client satisfaction with appropriateness’ is yet to be defined.

Data for this indicator were not available for the 2009 Report.

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 2007-08 are available for seven jurisdictions — the Australian Government, NSW, Victoria, Queensland, WA, SA and the ACT. Client and/or carer satisfaction data are included for Victoria (2007-08 data), Queensland (2006 data), WA (2008 data), Tasmania (2007-08 data) and the ACT (2007 data).

Quality assurance processes

‘Quality assurance processes’ are an indicator related to governments’ objective to deliver and fund services for people with a disability that meet a certain standard of quality (box 14.10). All services funded under the CSTDA are required to comply with national standards, and most jurisdictions have been examining ways of implementing quality assurance monitoring systems for these services.

Box 14.10 Quality assurance processes

‘Quality assurance processes’ is defined as the proportion/number 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/number 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 reported for this indicator are neither complete nor directly comparable.

Data on quality assurance processes in 2007-08 are reported in box 14.11. These quality assurance processes data relate to service providers from all disability service types provided under the CSTDA. Data come from service quality reviews and self-assessment processes. The jurisdictions implementing monitoring of quality assurance processes expect to review all service providers in a rolling process over several years.

Box 14.11 Quality assurance processes for specialist disability services

The quality assurance processes data reported below relate to CSTDA funded services.

Australian Government

Australian Government funded disability employment assistance organisations are required to meet 12 quality standards and 26 Key Performance Indicators, as a prerequisite for continued funding. In order to verify that the standards have been met, independent accredited certification bodies perform initial certification as well as annual surveillance audits for each organisation. From 15 September 2008, certification bodies must engage auditors and consumer technical experts who themselves are certified by the Disability Services Audit Personnel Scheme. In 2007-08, around 380 organisations funded to provide disability employment assistance (100 per cent) were audited by independent certification bodies.

NSW, Victoria, Queensland, WA, SA and the ACT

In 2007-08, different quality assurance processes were in place in NSW, Victoria, Queensland, WA, SA 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 (although in some jurisdictions the requirements are different across service sectors).

NSW

In NSW, the Integrated Monitoring Framework (IMF) provides an integrated approach to compliance, quality and performance reporting for all funded services. Each year service providers are required to report their compliance with contractual obligations including adherence to legislation, policy and program guidelines. The quality component of the IMF includes a provider self assessment and a desk top review, followed by an on-site service review of the provider's outlets. As part of the on-site review, service providers are required to demonstrate adherence to 23 Key Performance Indicators (KPIs). By June 2008, 1678 outlets had been assessed through an on-site review.

Victoria

As part of the Quality Framework for Disability Services in Victoria (2007), standards for disability services have been developed that shift the accountability focus from processes to outcomes. The standards allow the quality of services for people with a disability to be measured, monitored, confirmed and improved. Since September 2007, over 2000 staff from community service organisations and the department staff have participated in formal training in relation to the standards. As at October 2008, 312 service providers had attended training.

(Continued on next page)

Box 14.11 (Continued)

Queensland

In Queensland, the Disability Sector Quality System was introduced in 2004. Disability services that are recurrently funded or provided by Disability Services Queensland were given four years from 1 July 2004 to become certified against service standards. As at 30 June 2008, 99.1 per cent of services recurrently funded or delivered by the department underwent external assessment under the Disability Sector Quality System, and 94.5 per cent achieved certification.

WA

In WA, 27.7 per cent (205 of 741) of total service outlets had been independently monitored (comprehensive and abridged monitoring) against the service standards, and 83.4 per cent (171 of 205) 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 620 (this includes some service outlets that were also independently monitored).

SA

In SA, non-government service providers are required to meet quality assurance criteria before they can provide CSTDA funded services. From 2006-07 this included participation in an independently audited quality assurance system. As at June 2008, 68 per cent (99 of 145) of agencies are engaged in the Service Excellence Framework, with a further 16 per cent (23 of 145) involved in other independently assessed quality assurance programs. Disability SA, the government disability services provider, self-assesses against the Business Excellence Framework adopted across all areas of the Department for Families and Communities. In addition, some Disability SA outlets meet specific quality assurance system requirements in relation to catering, aged care and Home and Community Care services, where applicable.

ACT

In 2007-08, Disability ACT continued implementation of a new quality improvement system for all funded agencies. Individual agencies undertook a baseline self-assessment against the National Disability Service Standards, with quality improvement action plans being developed and implemented on the basis of any identified issues. Disability ACT engaged an external consultant to undertake an independent quality audit of 10 per cent of service providers with action plans developed, monitored and implemented to address identified issues.

Source: Australian, NSW, Victoria, Queensland, WA, SA and the ACT governments (unpublished).

Client and carer satisfaction

‘Client and carer satisfaction’ 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 (box 14.12). Data are available for reporting for Victoria, Queensland, WA, Tasmania and the ACT only. It is anticipated that data for other jurisdictions will be included in future reports.

Box 14.12 Client and carer satisfaction

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).

Data reported for this indicator are neither complete nor directly comparable.

In Victoria, a satisfaction survey was conducted to measure carers’ satisfaction with the respite services they received in 2007-08. The results showed that 82 per cent of the households surveyed were satisfied with the services they received.

Queensland conducted a consumer satisfaction survey and carer satisfaction survey of specialist disability services during November and December 2006. Overall, of the 2450 consumers, proxies and carers who were surveyed, 83 per cent of consumers and proxies and 72 per cent of carers identified that they were satisfied with the services they received. The survey provided results according to the type of disability services received and showed the following:

- 89 per cent of consumers and their proxies and 72 per cent of carers were satisfied with accommodation support services
- 79 per cent of consumers and their proxies and 67 per cent of carers were satisfied with community support services
- 83 per cent of consumers and their proxies and 78 per cent of carers were satisfied with community access services
- 80 per cent of consumers and their proxies and 70 per cent of carers were satisfied with respite services (Queensland Government (unpublished)).

The survey also contained three qualitative questions. The questions and associated responses are as follows:

-
- ‘How do disability services make a difference in life?’ — respondents expressed very strong recognition that disability services add value and enrich the lives of people with a disability and their carers.
 - ‘What factors are considered important about the services received?’ — respondents consistently considered ‘improved social connection and interaction’ as the most important factor about the disability services they received.
 - ‘How could the disability services be improved?’ — the most common response was there was ‘no need’ to improve disability services; however, a strong secondary theme indicated a need for ‘more’ disability services followed by a ‘need for greater personalisation of services’ (Queensland Government (unpublished)).

In 2008, WA conducted a carer and client satisfaction study. In this study, 1020 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, 76 per cent of respondents were happy with their quality of life. The following results show the proportions of clients/carers who were satisfied with individual services:

- residential services — 95 per cent
- supported community living — 79 per cent
- community support — 75 per cent
- respite — 85 per cent
- recreation/day option — 77 per cent
- local area coordination — 53 per cent (WA Government (unpublished)).

In the WA carer and client satisfaction study, questions were also included in relation to the personal wellbeing of service users. Each respondent was asked to rate their level of satisfaction with seven key wellbeing domains (standard of living, personal health, achieving in life, personal relationships, personal safety, community connectedness and future security). The results of the seven domains were averaged to give an overall personal wellbeing index (PWI). For the first time in 2008, the PWI for carers was measured and it was found that the overall score was 71 per cent. The overall PWI score for clients across the seven domains was 72 per cent. The PWI scores for clients across the six CSTDA service types were as follows:

- hostel/community residential — 74 per cent
- supported community living — 68 per cent

-
- community support — 71 per cent
 - respite — 66 per cent
 - recreation/day option — 71 per cent
 - local area coordination — 73 per cent (WA Government (unpublished)).

Tasmania conducted client and family satisfaction surveys across a total of 8 service outlets within the CSTDA defined service types of hostel, small residential/institutional and large residential/institution services during 2007-08. Surveys were conducted with:

- 21 clients and 49 family members/significant others of people residing in hostel accommodation
- 31 clients and 131 family members/significant others of people residing in small and large residential/institutional accommodation options.

Overall, 78 per cent of clients and 100 per cent of family members/significant others were satisfied with the hostel services. Similarly, 86 per cent of clients and 99 per cent of responding family members/significant others were satisfied with the small and large residential/institution services. ‘Hostel’ service type results included:

- 89 per cent of clients felt safe in their residence and surrounding area and 97 per cent of family members/significant others perceived the hostel to be safe
- 84 per cent of clients indicated that they are free from abuse and 72 per cent of family members/significant others indicated that they felt that their family member is free from abuse
- 82 per cent of clients and 87 per cent of family members/significant others indicated that staff communicate effectively
- 83 per cent of clients indicated that they are free from restrictive practices and 52 per cent of family members/significant others indicated that they feel their family member is free from restrictive practices
- 84 per cent of clients indicated that they feel comfortable reporting complaints
- 63 per cent of clients indicated that they are able to make choices about important life decisions and 96 per cent of family members/significant others indicated that the service respects their family member’s choices and preferences (Department of Health and Human Services 2008a).

Results for ‘small and large residential/institution’ service type included:

- 79 per cent of clients felt safe in their residence and surrounding area and 98 per cent of family members/significant others perceived the residence to be safe
- 82 per cent of clients indicated that they are free from abuse and 77 per cent of family members/significant others indicated that they felt that their family member is free from abuse
- 75 per cent of clients and 86 per cent of family members/significant others indicated that staff communicate effectively
- 71 per cent of clients indicated that they are free from restrictive practices and 62 per cent of family members/significant others indicated that they feel their family member is free from restrictive practices
- 68 per cent of clients indicated that they feel comfortable reporting complaints
- 55 per cent of clients indicated that they are able to make choices about important life decisions and 94 per cent of family members/significant others indicated that the service respects their family member’s choices and preferences (Department of Health and Human Services 2008b).

The ACT conducted a client satisfaction survey in 2007 regarding government provided CSTDA services. Both these surveys asked clients to rate their overall satisfaction levels with a range of programs. These satisfaction levels ranged from 75–100 per cent and for reporting purposes have been combined into the four main CSTDA service types. Each satisfaction level has been weighted according to the number of respondents commenting on each service and are as follows:

- for accommodation services, 90.2 per cent of service users were satisfied
- for respite services, 84.8 per cent of service users were satisfied
- for community access services, 78.9 per cent of service users were satisfied
- for community support services, 89.7 per cent of service users were satisfied with the services that they received (ACT Government (unpublished)).

Efficiency — cost per output unit

The following cost per output unit efficiency indicators are reported:

- ‘Cost per user of government provided accommodation support services’
- ‘Government contribution per user of non-government provided services’
- ‘Cost per user of State and Territory administered services’.

This Report includes 2007-08 expenditure data provided by Australian, State and Territory governments. However, as 2007-08 service user data from the CSTDA NMDS collection were not available for this Report, the cost per service user efficiency indicators are reported for 2006-07. Expenditure data might differ from information reported elsewhere (such as in departmental annual reports) because the financial counting rules and definitions used to calculate expenditure may differ. Data in this Report may also differ from information reported elsewhere because the data here exclude users of specialist psychiatric disability services.

It is an objective of the Review to report comparable estimates of costs. Ideally, such comparisons would include the full range of costs to government. Where the full costs cannot be counted, costs are estimated on a consistent basis. The jurisdictional expenditure data included in this chapter do not yet include the user cost of capital, and so do not reflect the full costs of government funded services. (User cost of capital is defined in chapter 2.)

Considerable effort has been made to document any differences in calculating the reported efficiency indicators. Concerns remain over the comparability of the results, because jurisdictions use different methods of data collection (table 14.2).

Table 14.2 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	Accrual	Cash	Accrual	Accrual	Accrual
Workers compensation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Payroll tax ^a									
Actual	✓	✓	✓	X	✓	✓	X	✓	..
Imputed	X	✓	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	Accrual	Cash	Accrual	Accrual	Accrual
Depreciation	✓	✓	✓	✓	✓	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).

Financial data — expenditure items included/excluded

Financial data reported in this chapter include/exclude various expenditure items depending on the context in which the data are reported. When specific service types are being discussed, only direct recurrent expenditure on those specific services are included (this may include administrative costs that can be directly attributed to a specific service/s). When the disability services system as a whole is being discussed, expenditure includes general administrative overheads that cannot be allocated to a specific service/s and major capital grants to non-government service providers. Capital grants to non-government service providers are excluded from total recurrent expenditure for the indicator 'administrative expenditure as a proportion of total recurrent expenditure', as they are not strictly a 'recurrent' expense. Exclusion of these grants improves the comparability of the indicator across jurisdictions and over time.

Government and non-government provided services

Efficiency indicators are reported for both government and non-government provided services. Government provision means that a service is both funded and directly provided by a government department, agency or local government. Non-government provision is a service purchased or part-funded by a government department or agency, but provided by a non-government organisation. Non-government service providers may receive funds from the private sector and the general public in addition to funding, grants and input tax concessions (such as payroll tax exemptions) from governments. Data on funds that non-government service providers received from the private sector and the general public are not included in this Report.

Accommodation support services

Governments provide or contribute funding to accommodation support services for people with a disability in institutional/residential settings and through community accommodation and care. In recent years, there has been an ongoing process of relocating people with a disability from institutional/residential accommodation to community accommodation (including group homes and other community accommodation). As a result, total government expenditure on accommodation support services in institutional/residential settings has decreased, with a corresponding increase in expenditure on community accommodation and care services.

Cost per user of government provided accommodation support services

‘Cost per user of government provided accommodation support services’ is an indicator of governments’ objective to provide specialist disability services in an efficient manner (box 14.13). The data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Box 14.13 Cost per user of government provided accommodation support services

‘Cost per user of government provided accommodation support services’ is 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.

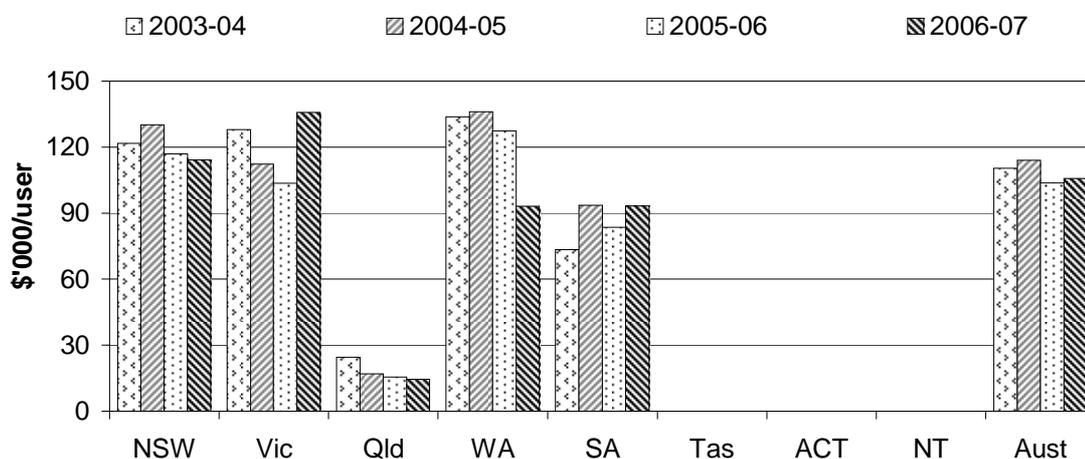
Efficiency data are difficult to interpret. While high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided. Increasing expenditure may also reflect the changing needs of service users — 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.

Data reported for this indicator are not directly comparable.

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 \$105 693 per service user in 2006-07 (figure 14.36).

Figure 14.36 **Estimated annual government expenditure per user of government provided accommodation support services in institutional/residential settings (2006-07 dollars)^{a, b, c}**



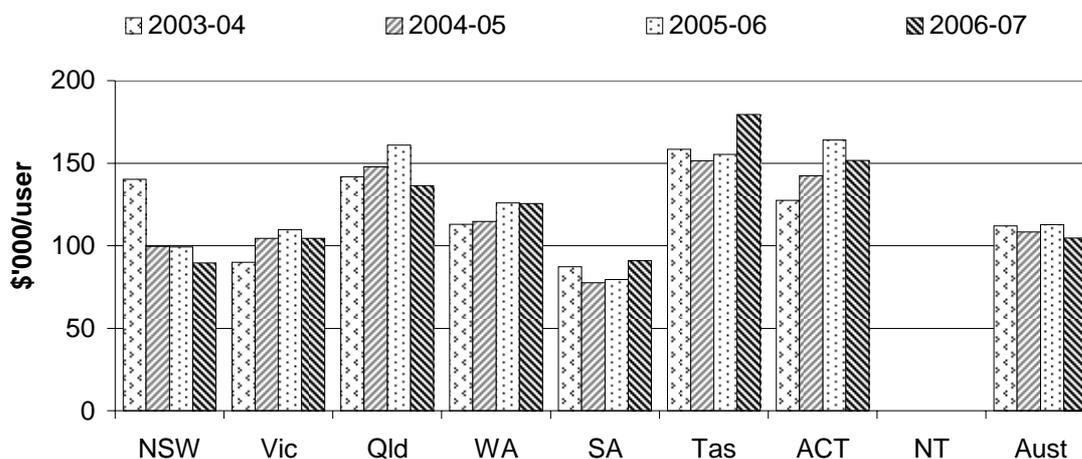
^a See table 14A.41 for detailed notes relating to these data. ^b The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. See section 14.6 for further information on these quality issues. ^c There were no government provided accommodation support services in institutional/residential settings in Tasmania, the ACT or the NT.

Source: State and Territory governments (unpublished); AIHW (unpublished), derived from the *CSTDA NMDS*; table 14A.41.

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 \$104 729 per service user in 2006-07 (figure 14.37). For 2003-04 and 2004-05, the denominators and the numerators used to derive this measure do not match for NSW, Victorian, WA and SA, as the service user data include services provided by local governments and the expenditure data exclude services provided by local governments. Thus, historical data for this measure need to be interpreted with care.

Figure 14.37 Estimated annual government expenditure per user of government provided accommodation support services in group homes (2006-07 dollars)^{a, b, c, d}



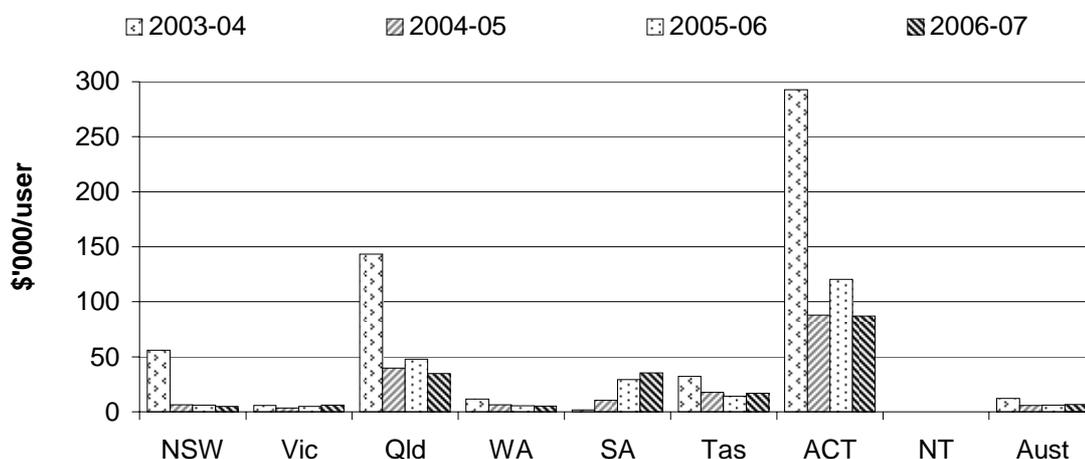
^a See table 14A.41 for detailed notes relating to these data. ^b The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. See section 14.6 for further information on these quality issues. ^c In the ACT, the increase in expenditure between 2004-05 to 2005-06 was the result of a combination of factors including service user information being excluded as a result of data cleansing analyses of the NMDS forms or being reclassified to 'other community settings'. ^d There were no government providers of accommodation support services in group homes in the NT.

Source: State and Territory governments (unpublished); AIHW (unpublished), derived from the CSTDA NMDS; table 14A.41.

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 \$6631 per service user in 2006-07 (figure 14.38). For 2003-04 and 2004-05, the denominators and the numerators used to derive this measure do not match for NSW, Victorian, WA and SA, as the service user data include services provided by local governments and the expenditure data exclude services provided by local governments. Thus, historical data for this measure need to be interpreted with care.

Figure 14.38 **Estimated annual government expenditure per user of government provided accommodation support services in other community settings (2006-07 dollars)^{a, b, c, d}**



a See table 14A.41 for detailed notes relating to these data. **b** The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. See section 14.6 for further information on these quality issues. **c** In the ACT, the increase in cost per user between 2004-05 and 2005-06 was the result of data cleansing as some services users were not counted. **d** There were no government providers of accommodation support services in other community settings in the NT.

Source: State and Territory governments (unpublished); AIHW (unpublished), derived from the *CSTDA NMDS*; table 14A.41.

Government contribution per user of non-government provided services

‘Government contribution per user of non-government provided services’ is an indicator of governments’ objective to provide specialist disability services in an efficient manner (box 14.14). Governments directly provide services to users and also fund non-government service providers to deliver services. The focus on the contribution of governments to non-government service providers reflects the Steering Committee’s terms of reference, which require it to report on services funded and/or delivered by government. The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Box 14.14 Government contribution per user of non-government provided services

‘Government contribution per user of non-government provided services’ is defined as the net government expenditure per user. Measures are reported for the following non-government provided services:

- accommodation support services in:
 - institutional/residential settings
 - group homes
 - other community settings
- employment services (reported per employment service user assisted).

Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service.

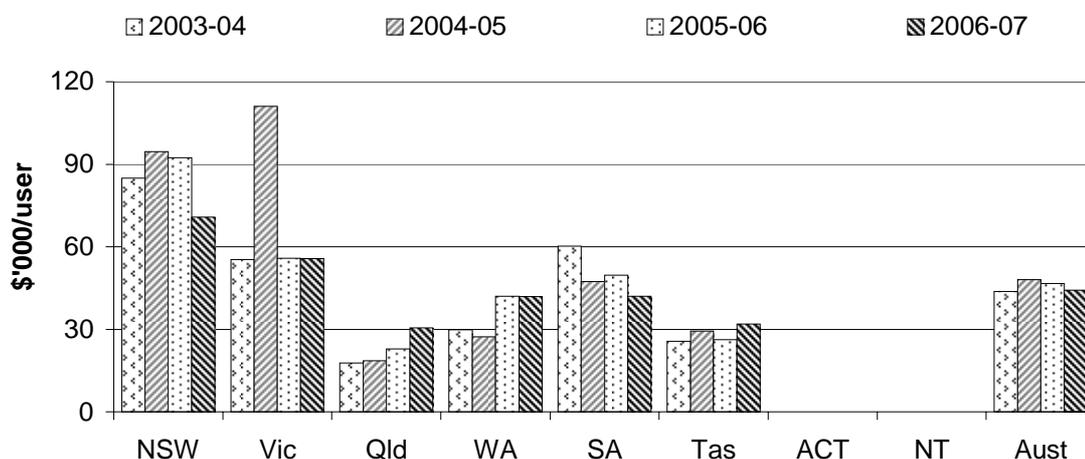
Efficiency data are difficult to interpret. Although high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of users. Similarly, low or declining expenditure per unit of output may reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Data reported for this indicator are not directly comparable.

Government contribution per user of non-government provided services — accommodation support services in institutional/residential settings

Nationally, estimated annual government funding of non-government provided accommodation support services in institutional/residential settings was \$44 167 per service user in 2006-07 (figure 14.39).

Figure 14.39 **Estimated annual government funding per user of non-government provided accommodation support services in institutional/residential settings (2006-07 dollars)^{a, b, c, d}**



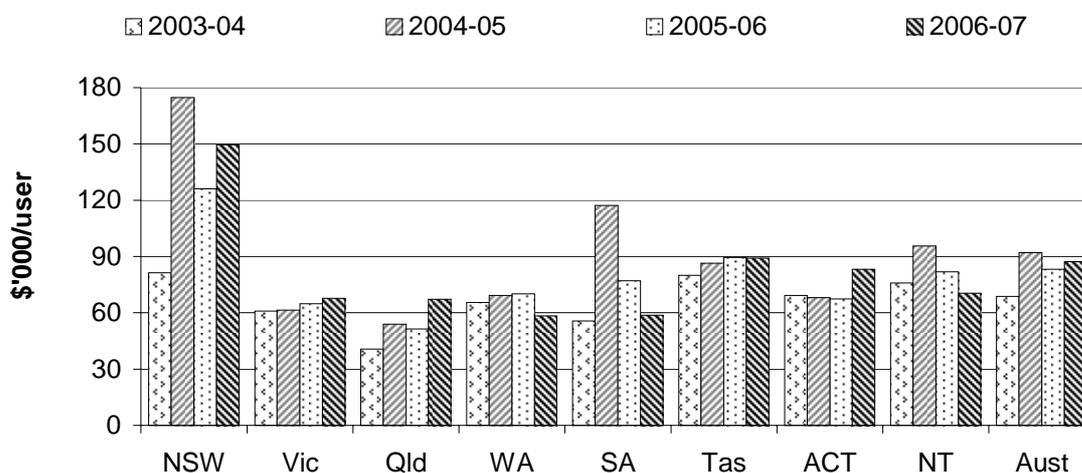
^a See table 14A.41 for detailed notes relating to these data. ^b The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. See section 14.6 for further information on these quality issues. ^c The Victorian cost per service user for 2004-05 is overstated due to a move towards community based and individualised settings, which was not reflected in the expenditure data. ^d There were no non-government provided accommodation support services in institutional/residential settings in the ACT and the NT.

Source: State and Territory governments (unpublished); AIHW (unpublished), derived from the *CSTDA NMDS*; table 14A.41.

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 \$87 258 per service user in 2006-07 (figure 14.40). For 2003-04 and 2004-05, the denominators and the numerators used to derive this measure do not match for NSW, Victorian, WA and SA, as the service user data exclude services provided by local governments and the expenditure data include services provided by local governments. Thus historical data for this measure need to be interpreted with care.

Figure 14.40 Estimated annual government funding per user of non-government provided accommodation support services in group homes (2006-07 dollars)^{a, b}



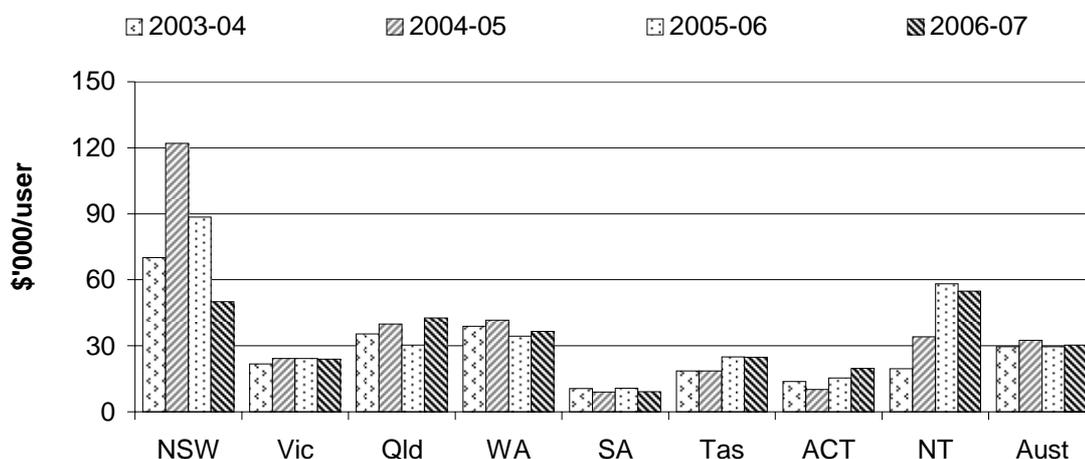
^a See table 14A.41 for detailed notes relating to these data. ^b The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. See section 14.6 for further information on these quality issues.

Source: State and Territory governments (unpublished); AIHW (unpublished), derived from the CSTDA NMDS; table 14A.41.

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 \$30 391 per service user in 2006-07 (figure 14.41). For 2003-04 and 2004-05, the denominators and the numerators used to derive this measure do not match for NSW, Victorian, WA and SA, as the service user data exclude services provided by local governments and the expenditure data include services provided by local governments. Thus historical data for this measure need to be interpreted with care.

Figure 14.41 **Estimated annual government funding per user of non-government provided accommodation support services in other community settings (2006-07 dollars)^{a, b}**



^a See table 14A.41 for detailed notes relating to these data. ^b The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. See section 14.6 for further information on these quality issues.

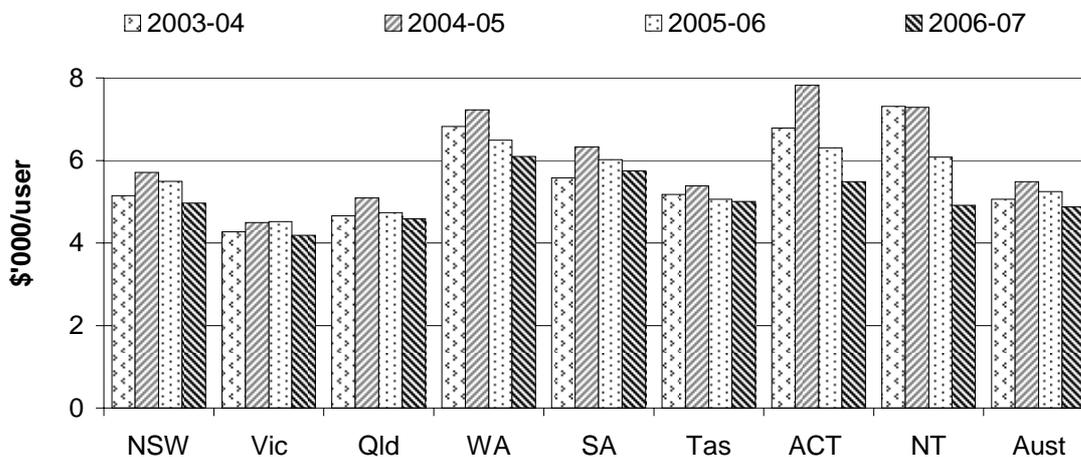
Source: State and Territory governments (unpublished); AIHW (unpublished), derived from the *CSTDA NMDS*; table 14A.41.

Government contribution per employment service user assisted

Assistance with employment for people with a disability is the responsibility of the Australian Government under the *CSTDA*. Nationally, for all employment services, estimated government expenditure per service user assisted was \$4878 in 2006-07 (figure 14.42).

Nationally, estimated annual government expenditure per service user in 2006-07, by employment service type, was \$3678 on open services (employed or seeking employment in the open labour market) and \$8111 on supported services (employed by the service provider) (table 14A.43).

Figure 14.42 **Government contribution per employment service user assisted (2006-07 dollars)^{a, b}**



^a See tables 14A.42 and 14A.43 for detailed notes relating to these data. ^b This indicator is derived using service user data provided by the AIHW. Cost per employment service user data may differ from those reported in the Australian Government's annual report, as the Australian Government and the AIHW use different rules to count the number of employment service users. Where a person has used more than one service outlet during the reporting period, the person is counted more than once by the Australian Government, whereas the AIHW counts each person only once. In addition, the Australian Government includes independent workers (1004 persons in 2003-04, 804 persons in 2004-05, 266 persons in 2005-06 and 6 persons in 2006-07) in calculating service user numbers, whereas the AIHW does not.

Source: Australian Government (unpublished); AIHW (unpublished), derived from the *CSTDA NMDS*; table 14A.42.

Cost per user of State and Territory administered services

'Cost per user of State and Territory administered services' is an indicator of governments' objective to provide specialist disability services in an efficient manner (box 14.15).

Box 14.15 Cost per user of State and Territory administered services

'Cost per user of State and Territory administered services' 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.

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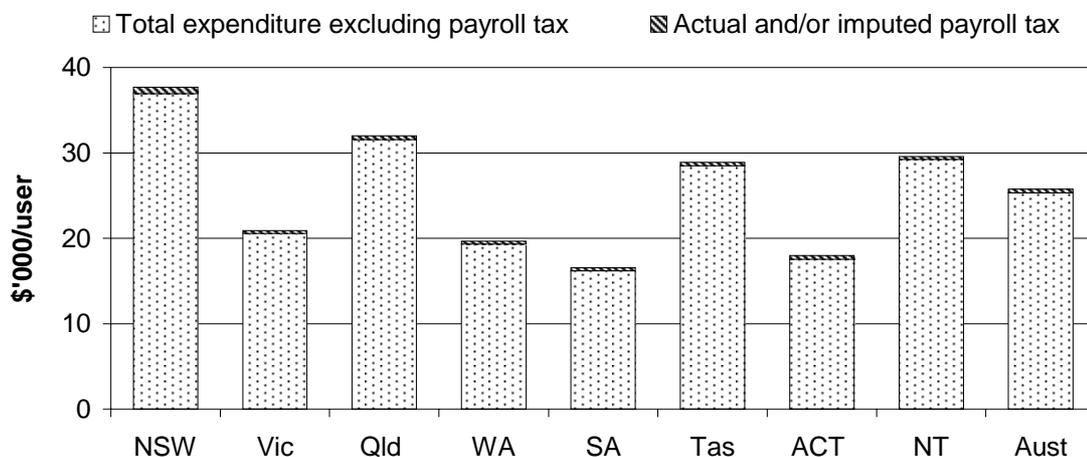
Box 14.15 (Continued)

Efficiency data are difficult to interpret. Although high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of service users. Similarly, low or declining expenditure per unit of output may reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Data reported for this indicator are not directly comparable.

Total estimated government expenditure per user of CSTDA State and Territory administered specialist disability services in 2006-07 is reported both net of payroll tax and including actual and/or imputed payroll tax. Nationally, estimated expenditure per service user was \$25 299 excluding payroll tax and \$25 755 including actual and/or imputed payroll tax (figure 14.43).

Figure 14.43 Estimated annual government expenditure per user of CSTDA State and Territory administered services, 2006-07^{a, b, c, d}



^a In some jurisdictions (NSW, Victoria and SA in part, Queensland, Tasmania and the NT), payroll tax data is actual; in other jurisdictions (Victoria and SA in part, WA, and the ACT), payroll tax data is imputed. ^b Government expenditure per service user for Australia excludes Australian Government expenditure on State and Territory administered services that was not provided as transfer payments. ^c Payroll tax data for Queensland includes paid payroll tax and accrued payroll tax. ^d In the NT, payroll tax relates to government service provision and excludes expenditure for program management and administration.

Source: State and Territory governments (unpublished); AIHW (unpublished), derived from the *CSTDA NMDS*; table 14A.44.

Efficiency — administrative cost

Administrative expenditure as a proportion of total recurrent expenditure

‘Administrative expenditure as a proportion of total recurrent expenditure’ is an indicator of governments’ objective to provide specialist disability services in an efficient manner (box 14.16). The proportion of total expenditure on administration is not yet comparable across jurisdictions because it is apportioned by jurisdictions using different methods (table 14.2). However, administrative expenditure data can indicate trends within jurisdictions over time.

Box 14.16 Administrative expenditure as a proportion of total recurrent expenditure

‘Administrative expenditure as a proportion of total recurrent expenditure’ is defined as government expenditure on administration as a proportion of total recurrent CSTDA expenditure. Major capital grants to non-government service providers are excluded to improve comparability across jurisdictions and over time.

Holding other factors constant (such as service quality and accessibility), a decrease in administrative expenditure as a proportion of total recurrent CSTDA expenditure may reflect an increase in administrative efficiency.

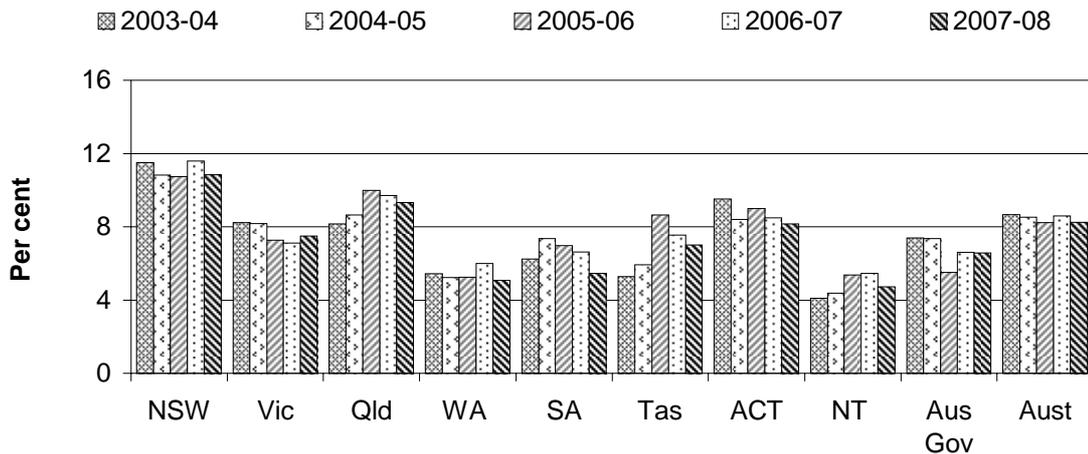
Efficiency data are difficult to interpret. Although high or increasing administrative expenditure as a proportion of total expenditure may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the administrative services provided. Similarly, low or declining administrative expenditure as a proportion of total expenditure may reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Data reported for this indicator are not directly comparable.

Nationally, administrative expenditure as a proportion of total government expenditure on specialist disability services (excluding payroll tax) decreased from 8.6 per cent in 2006-07 to 8.2 per cent in 2007-08 (figure 14.44). When actual or imputed payroll tax is included, the average national administrative expenditure as a proportion of total CSTDA expenditure was 8.1 per cent in 2007-08 (table 14A.45). Payroll tax data need to be interpreted with caution because some jurisdictions (NSW, Victoria (in part), Queensland, SA, Tasmania and the NT) have provided payroll or payroll tax data on the basis of direct service delivery expenditure for government provided services, and others (WA and the ACT) have provided the data on the basis of total expenditure for government provided services. Real total

CSTDA expenditure is reported in table 14A.10, both excluding and including actual or imputed payroll tax amounts.

Figure 14.44 **Administrative expenditure as a proportion of total recurrent expenditure^{a, b, c, d, e}**



^a See table 14.2 for an explanation of different methods of apportioning departmental costs. ^b Data exclude payroll tax. ^c Australian Government administrative expenditure is an estimate, based on average staffing levels. ^d The decrease in WA administrative expenditure in 2007-08 mainly reflects the abolition of the capital user charge by the Department of Treasury and Finance. ^e In Tasmania, the Department administering Disability Services underwent a restructure in 2006-07. Disability Services now falls under the umbrella of a smaller management team. This resulted in a reduction in administration expenditure in 2006-07.

Source: Australian, State and Territory governments (unpublished); table 14A.45.

Outcomes

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

The following outcome indicators are included in the performance framework:

- ‘Labour force participation and employment of people with a disability’
- ‘Social participation of people with a disability’
- ‘Use of other services’.

The ‘labour force participation and employment of people with a disability’ indicator is not reported in the 2009 Report as data to update the indicator are not available.

The measures and data sources for the ‘social participation’ and ‘use of other services’ indicators differ across report years.

- Social participation data from the GSS 2006 are reported for all jurisdictions. These data relate to participation in various social/community activities. National data are also included on the participation in these activities for people with severe and profound core activity limitations who had different levels of perceived difficulty with transport. National data from the ABS 2007 *Survey of Mental Health and Wellbeing* (SMHWB) on social networks are also included.
- For the ‘use of other services’ indicator, the representation of people by ‘core activity need for assistance’ in public housing are reported for all jurisdictions. These data are sourced from the ABS 2006 Census. National data from the 2007 *SMHWB* on access to health services by disability status are also reported.

Interpreting data for some outcome indicators

For the outcome indicators derived using survey data, 95 per cent confidence intervals are presented. These intervals assist with making comparisons between jurisdictions, and between different disability status groups. Confidence intervals are a standard way of expressing the degree of uncertainty associated with survey estimates. An estimate of 80 with a confidence interval of ± 2 , for example, means that if another sample had been drawn, or if another combination of test items had been used, there is a 95 per cent chance that the result would lie between 78 and 82. If one jurisdiction’s results ranges from 78–82 and another’s from 77–81, then it is not possible to say with confidence that one differs from the other (because there is unlikely to be a statistically significant difference). Where ranges do not overlap, there is a high likelihood that there is a statistically significant difference. To say that there is a statistically significant difference means there is a high probability that there is an actual difference — it does not imply that the difference is necessarily large or important.

Labour force participation and employment of people with a disability

‘Labour force participation and employment of people with a disability’ is an indicator of governments’ objective of assisting people with a disability to participate fully in the community (box 14.17). Participation in the labour force and employment is important to the overall wellbeing of people with a disability, particularly in terms of the opportunity for self-development, interaction with people outside the home, occupying a valued role and financial independence. Data are not available to update this indicator for the 2009 Report.

Box 14.17 Labour force participation and employment of people with a disability

‘Labour force participation and employment of people with a disability’ is defined as the labour force participation and employment rates of people aged 15–64 years with a profound or severe core activity limitation. Labour force participation rates and employment rates of people aged 15–64 years without a profound or severe core activity limitation are also reported.

A higher labour force participation or employment rate for people with a profound or severe core activity limitation is likely to increase the quality of life of people by providing greater opportunities for self-development and interaction with people outside the home.

This indicator does not provide information on why people choose not to participate in the labour force and why people are not employed. It also does not provide information on whether the jobs that people find are appropriate or fulfilling.

Data collection for this indicator is under development. Data for this indicator were not available for the 2009 Report and are anticipated to be available for the 2010 Report.

According to the ABS’s SDAC the labour force participation rate for people with a profound or severe core activity restriction in 2003 was 30.0 per cent — 34.4 percentage points below the rate for the general population in all jurisdictions (74.4 per cent). The employment rate for people with a profound or severe core activity limitation was 89.9 per cent — 4.0 percentage points below the rate for the general population (93.9 per cent) (table 14A.48). Additional data on labour force participation and employment rates of people with a disability are shown in tables 14A.46, 14A.47 and 14A.49–51.

Social participation of people with a disability

‘Social participation of people with a disability’ is an indicator of governments’ objective to assist people with a disability to live as valued and participating members of the community (box 14.18).

Box 14.18 Social participation of people with a disability

This indicator is defined as the proportion of people aged 18–64 years with a limitation or restriction who participate in selected social or community activities. The proportion of people without a limitation or restriction who participate in these activities is also reported. The selected social or community activities are:

- had face-to-face contact with non-household family and friends at least once a month
- attended selected cultural venues/events in the last 12 months
- attended a sporting event in the last 12 months
- were actively involved in a social or support group in the last 12 months
- did unpaid voluntary work in the last 12 months through an organisation.

National data are included on the proportions of people with severe or profound core activity limitations who participated in these activities, by their level of perceived difficulty with transport. National data are also reported on the proportions of people who had friends and family in whom they could confide or on whom they can rely, by limitation or restriction status.

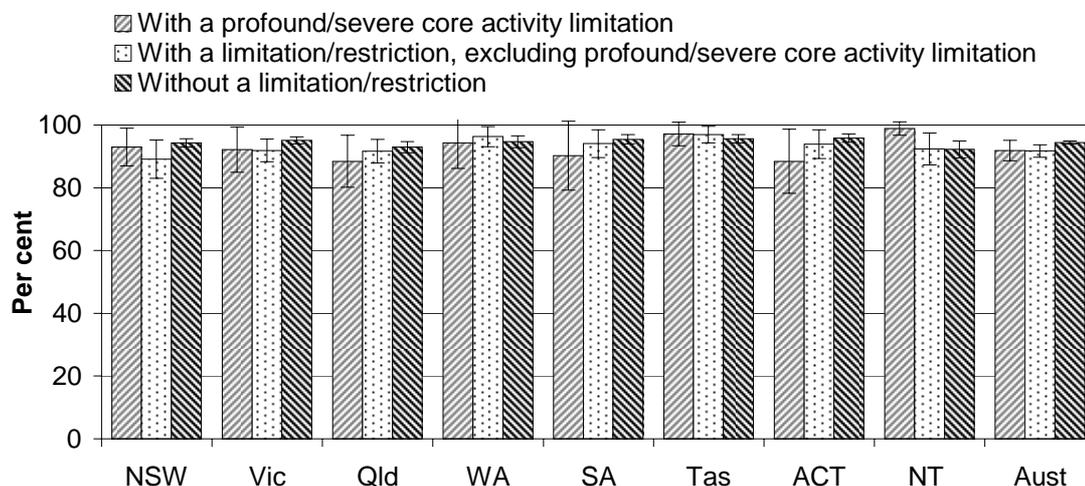
A higher proportion of people with a limitation or restriction who participate in social or community activities reflects their greater integration in the community.

This indicator does not provide information on the degree to which the identified types of social or community activities contribute to people's quality of life. It also does not provide information on why some people did not participate (although the national data on participation in various activities by perceived level of difficulty with transport could help inform why some people do not participate).

Data reported for this indicator are comparable.

Nationally, in 2006, the estimated proportions of people with a profound or severe core activity limitation aged 18–64 years who had face-to-face contact with family and friends at least once a month was 91.9 ± 3.2 per cent, not significantly different to the proportion for other people with a limitation or restriction, excluding profound or severe core activity limitation (91.7 ± 2.0 per cent) or the proportion for people without a limitation or restriction (94.4 ± 0.6 per cent) (figure 14.45).

Figure 14.45 **Estimated proportion of people aged 18–64 years who had contact with non-household family and friends at least once a month, by disability status, 2006^{a, b, c}**



^a Due to different collection methodologies, in particular those used to identify disability, these estimates may not be consistent with those that could be obtained from the SDAC or other ABS 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.

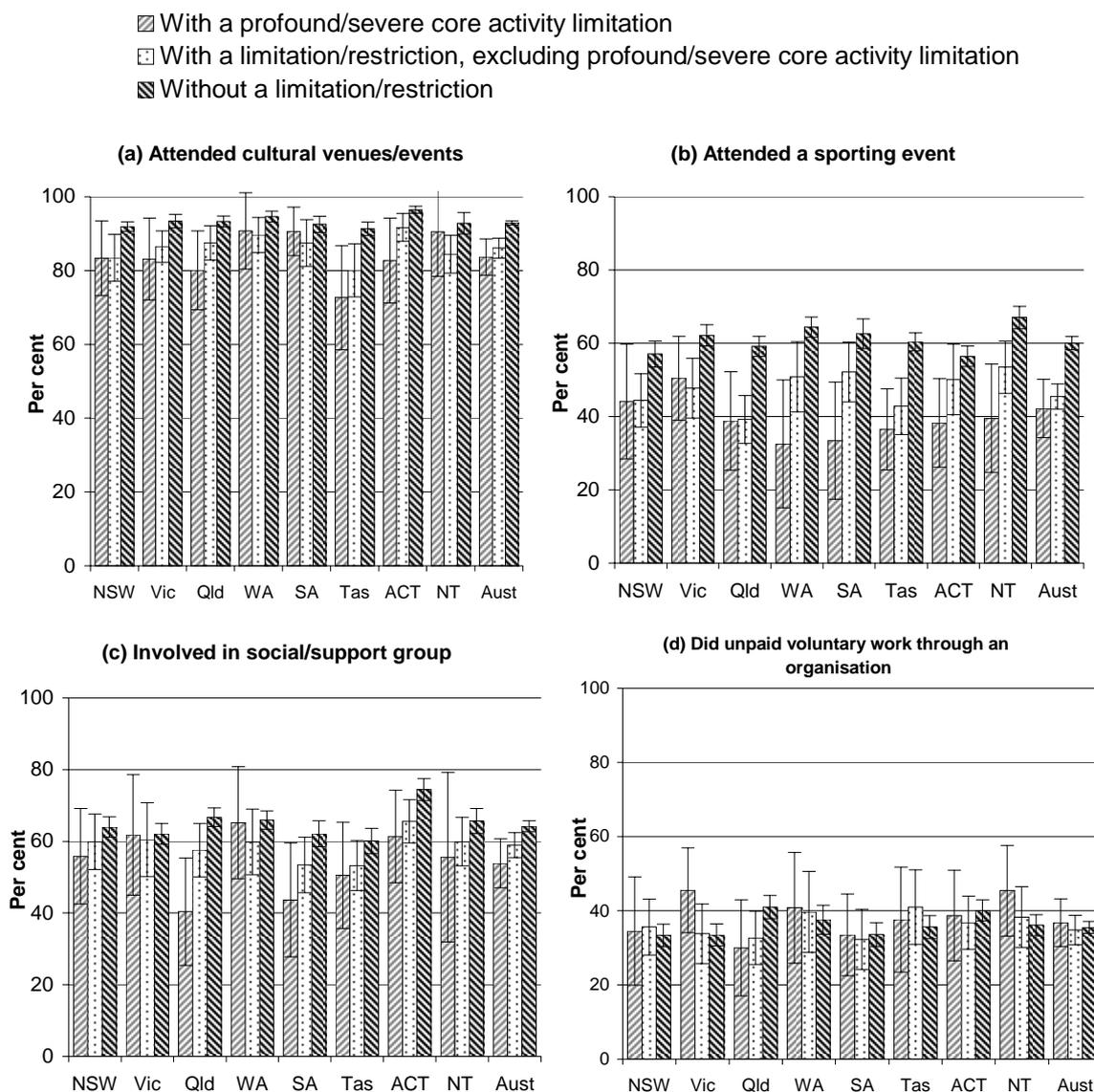
Source: ABS (unpublished), derived from the GSS 2006, Expanded CURF, remote access data laboratory, Cat. no. 4159.0.30.002; table 14A.52.

Nationally, in 2006, the estimated proportions of people with a profound or severe core activity limitation aged 18–64 years who participated in selected social and community activities in the last 12 months were:

- 83.7 ± 4.9 per cent attended selected cultural venues/events, not significantly different to the proportion for other people with a limitation or restriction, excluding profound or severe core activity limitation (86.1 ± 2.7 per cent), but below the proportion for people without a limitation or restriction (92.9 ± 0.5 per cent) (figure 14.46a)
- 42.2 ± 7.9 per cent attended a sporting event, not significantly different to the proportion for other people with a limitation or restriction, excluding profound or severe core activity limitation (45.5 ± 3.5 per cent), but below the proportion for people without a limitation or restriction (60.0 ± 1.8 per cent) (figure 14.46b)
- 53.9 ± 6.9 per cent were involved in a social/support group, not significantly different to the proportion for other people with a limitation or restriction, excluding profound or severe core activity limitation (58.9 ± 3.5 per cent), but below the proportion for people without a limitation or restriction (64.2 ± 1.5 per cent) (figure 14.46c)

- 36.8 ± 6.4 per cent did unpaid voluntary work through an organisation, not significantly different to the proportion for other people with a limitation or restriction, excluding profound or severe core activity limitation (34.8 ± 4.0 per cent), or the proportion for people without a limitation or restriction (35.5 ± 1.6 per cent) (figure 14.46d).

Figure 14.46 Estimated proportion of people aged 18–64 years who participated in selected social and community activities in the last 12 months, by disability status, 2006^{a, b, c}

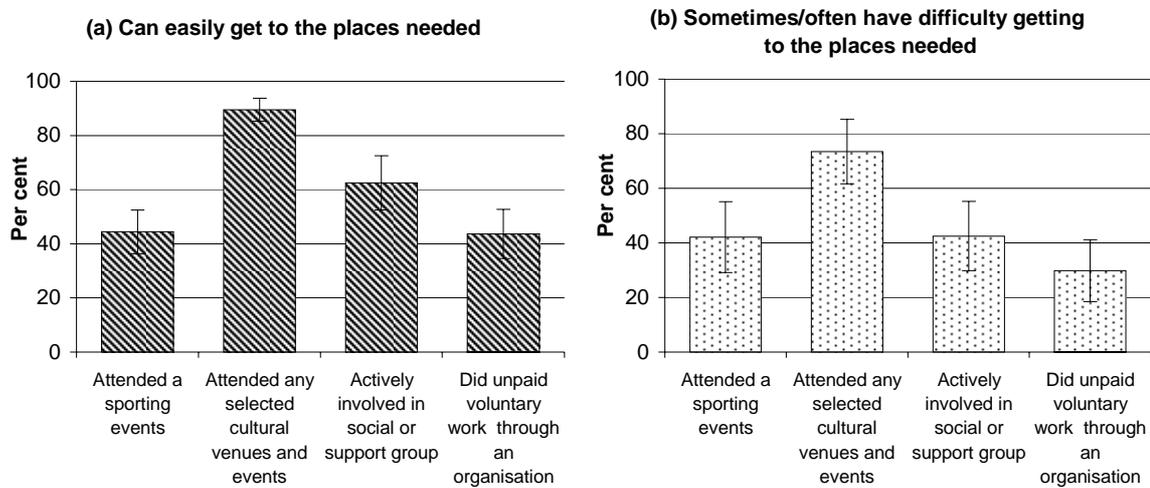


^a Due to different collection methodologies, in particular those used to identify disability, these estimates may not be consistent with those that could be obtained from the SDAC or other ABS surveys. ^b Profound or severe core activity limitation refers to always or sometimes needing assistance with 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 (unpublished), derived from the GSS 2006, Expanded CURF, remote access data laboratory, Cat. no. 4159.0.30.002; table 14A.52.

Figure 14.47 compares the estimated proportions of people with a profound or severe core activity limitation aged 18–64 years who participated in selected social/community activities and who had difficulties getting to places that they needed to go, with the proportions for those who could easily get to places that they needed to go.

Figure 14.47 Estimated proportion of people aged 18–64 years with a profound/severe core activity limitation who participated in/attended selected social/community activities in the last 12 months, by level of perceived difficulty with transport, 2006^{a, b}



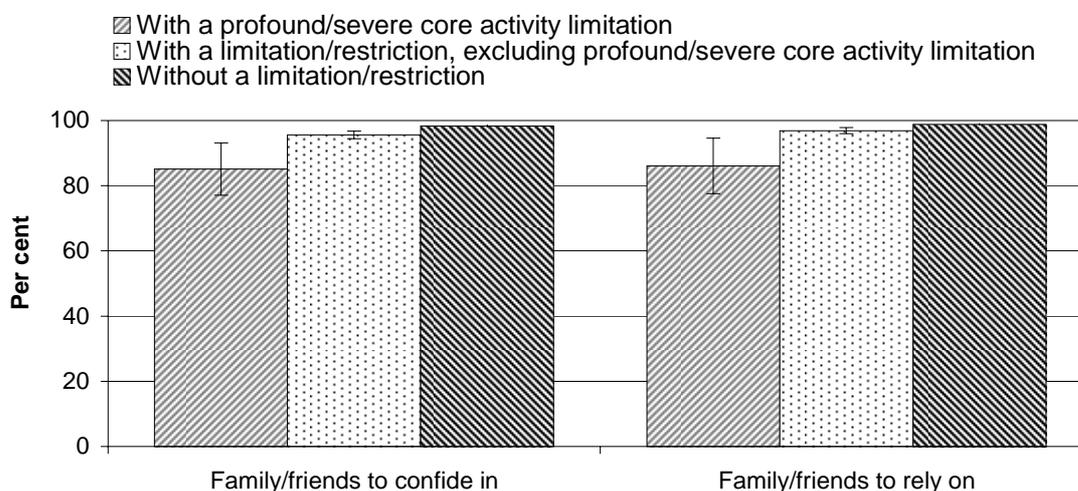
^a Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self care. ^b Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished), derived from the GSS 2006, Expanded CURF, remote access data laboratory, Cat. no. 4159.0.30.002; table 14A.53.

Nationally, the estimated proportions of people with a profound or severe core activity limitation aged 16–64 years who had friends and family in whom they can confide or on whom they can rely were:

- 85.1 ± 8.0 per cent had family or friends in whom they can confide, below the proportion for other people with a limitation or restriction, excluding profound or severe core activity limitation (95.6 ± 1.2 per cent) and the proportion for people without a limitation or restriction (98.3 ± 0.5 per cent) (figure 14.48)
- 86.1 ± 8.5 per cent had family or friends on whom they can rely, below the proportion for other people with a limitation or restriction, excluding profound or severe core activity limitation (96.9 ± 0.9 per cent) and the proportion for people without a limitation or restriction (98.8 ± 0.4 per cent) (figure 14.48).

Figure 14.48 Estimated proportion of people aged 16–64 years who had family or friends in whom they can confide or on whom they can rely, by disability status, 2007^{a, b, c}



^a Due to different collection methodologies, in particular those used to identify disability, these estimates may not be consistent with those that could be obtained from the SDAC or other ABS 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 (unpublished), derived from the 2007 SMHWB, Cat. no. 4326.0; table 14A.54.

Additional data on the social participation of people with a disability are in tables 14A.55–57.

Use of other services

‘Use of other services’ is an indicator of governments’ objective of enhancing the quality of life experienced by people with a disability by assisting them to gain access to generic government and community services and facilities (box 14.19).

Box 14.19 Use of other services

The 'Use of other services' indicator has three measures that are defined as follows:

- the proportion of public housing dwellings in which one or more people aged 0–64 years who had a 'core activity need for assistance' reside. The proportion of other rental housing dwellings in which one or more of these people reside is provided for comparison.
- the proportion of people residing in public housing dwellings who were aged 0–64 years and who had a 'core activity need for assistance'. The proportion of these people residing in other rental housing dwellings is provided for comparison.
- the proportion of people aged 16–64 years with a limitation or restriction who accessed selected health services. The proportion of people without a limitation or restriction who access these health services is also reported.

Higher proportions of State or Territory housing authority dwellings in which one or more people who have a 'core activity need for assistance' resides, or higher proportions of people in State or Territory housing who have a 'core activity need for assistance' aged 16–64 years, suggests greater access to these generic government housing services.

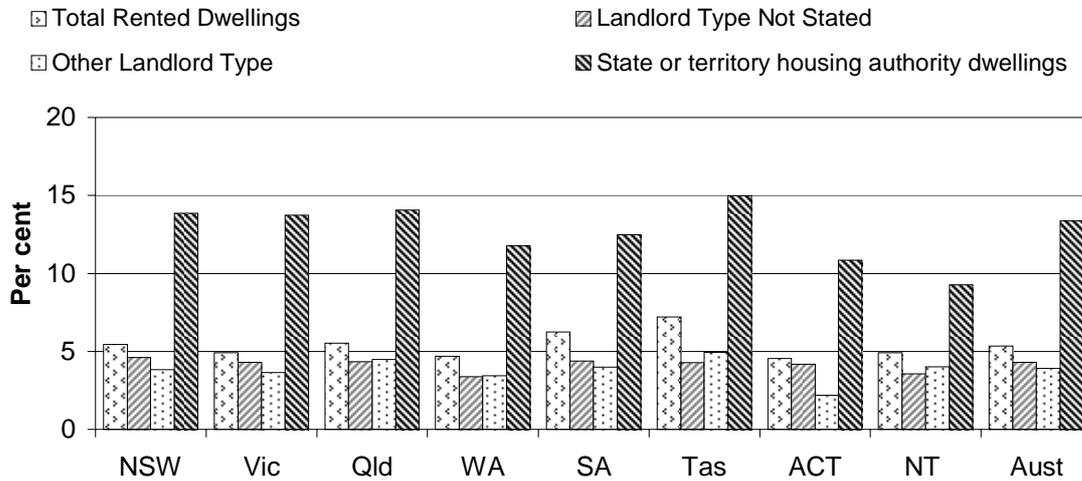
Higher proportions of people aged 16–64 years with a limitation or restriction who access selected health services suggests greater access to generic health services.

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.

Data reported for this indicator are comparable.

Nationally, the proportion of State or Territory housing dwellings that had one or more people aged 0–64 years with a 'core activity need for assistance' was 13.4 per cent, higher than the proportion of other rental dwellings that had one or more of these people (3.9 per cent) (figure 14.49). Nationally, the proportion of people in State or Territory housing dwellings who were aged 0–64 years and who had a core activity need for assistance was 7.4 per cent, higher than the proportion of these people in other rental dwellings (1.9 per cent) (figure 14.50).

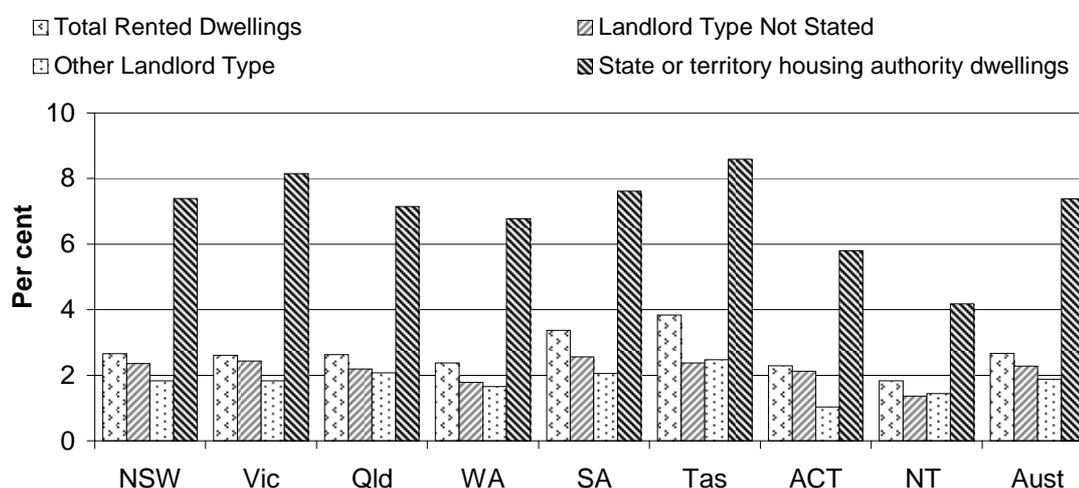
Figure 14.49 Proportion of rented dwellings that had one or more persons aged 0–64 years with a core activity need for assistance, by dwelling type, 2006^{a, b}



^a The ABS 2006 Census module, used to source these data, was designed to measure 'Core Activity Need for Assistance' (ASSNP). The ASSNP is conceptually comparable with the SDAC and ABS disability module population of people who have a profound or severe core activity limitation, but due to the different collection methodology and shortening of the question set used, the population identified is smaller (but displays very similar characteristics). ^b Only the characteristics of persons who usually reside in the dwelling and who were present on Census night were taken into consideration when determining the results. Those persons who were visitors and those persons who were not present in the household were not taken into account. Those dwellings that contained only visitors or were unable to be classified were also excluded from the count.

Source: ABS (unpublished), derived from the *2006 Census of Population and Housing*; table 14A.58.

Figure 14.50 Proportion of people residing in rented dwelling types who were aged 0–64 years and who had a core activity need for assistance, by dwelling type, 2006^{a, b}



^a The ABS 2006 Census module, used to source these data, was designed to measure 'Core Activity Need for Assistance' (ASSNP). The ASSNP is conceptually comparable with the SDAC and ABS disability module population of people who have a profound or severe core activity limitation, but due to the different collection methodology and shortening of the question set used, the population identified is smaller (but displays very similar characteristics). ^b Only the characteristics of persons who usually reside in the dwelling and who were present on Census night were taken into consideration when determining the number results. Those persons who were visitors and those persons who were not present in the household were not taken into account. Those dwellings that contained only visitors or were unable to be classified were also excluded from the count.

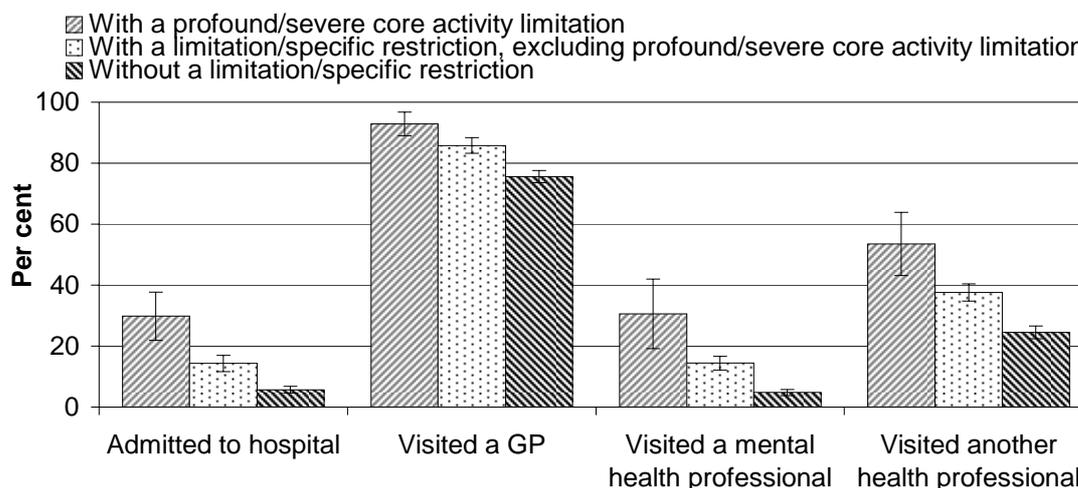
Source: ABS (unpublished), derived from the 2006 Census of Population and Housing; table 14A.59.

Nationally, the estimated proportions of people with a profound or severe core activity limitation aged 16–64 years who used various health services were:

- 29.8 ± 7.9 per cent were admitted to hospital, greater than the proportion for other people with a limitation or restriction, excluding profound or severe core activity limitation (14.3 ± 2.7 per cent) and the proportion for people without a limitation or restriction (5.7 ± 1.1 per cent) (figure 14.51)
- 92.9 ± 3.9 per cent visited a GP, greater than the proportion for other people with a limitation or restriction, excluding profound or severe core activity limitation (85.8 ± 2.6 per cent) and the proportion for people without a limitation or restriction (75.6 ± 2.0 per cent) (figure 14.51)
- 30.6 ± 11.4 per cent visited a mental health professional, greater than the proportion for other people with a limitation or restriction, excluding profound or severe core activity limitation (14.4 ± 2.3 per cent) and the proportion for people without a limitation or restriction (4.8 ± 1.0 per cent) (figure 14.51)
- 53.5 ± 10.4 per cent visited another health professional, greater than the proportion for other people with a limitation or restriction, excluding profound

or severe core activity limitation (37.6 ± 2.8 per cent) and the proportion for people without a limitation or restriction (24.5 ± 2.1 per cent) (figure 14.51).

Figure 14.51 Estimated proportion of people aged 16–64 years who accessed particular health services, by disability status, 2007^{a, b, c}



^a Due to different collection methodologies, in particular those used to identify disability, these estimates may not be consistent with those that could be obtained from the SDAC or other ABS 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 (unpublished), derived from the 2007 SMHWB, Cat. no. 4326.0; table 14A.60.

Other data

Data on the participation of people with a disability in various government services are incorporated in the performance indicator frameworks for other chapters of this Report. Participation is reported for children’s services (see chapter 3), VET (see chapter 5), public, community and State owned and managed Indigenous housing and for Commonwealth Rent Assistance (CRA) (see chapter 16). In addition, the following chapters include data on services provided to people with a disability:

- ‘School education’ (see chapter 4) reports data on students with a disability in the student body mix
- ‘Health management issues’ (see chapter 12) reports performance data on specialised mental health services
- ‘Aged care services’ (see chapter 13) reports data on HACC services received, including those received by people with a profound, severe or moderate core activity limitation, disaggregated by jurisdiction and geographic location.

14.4 Future directions in performance reporting

Scope for further improvements to current framework

There is scope for further improvements in reporting against the current framework, including improvements to the data on service quality. The Steering Committee intends to address limitations over time by:

- considering the development of an indicator on quality of life
- considering complementing the descriptive data on younger people with a disability in residential aged care facilities with a performance indicator
- reporting of improved service user data, as a result of anticipated improvements in data quality and comparability
- reporting more comprehensive social and community participation data, when available
- reporting 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.

Reform of Specific Purpose Payments

In December 2007, COAG agreed to reform Specific Purpose Payments (SPPs). SPPs are financial agreements between the Australian Government and State and Territory governments involving a contribution by the Australian Government to the funding of services which are considered a joint Australian and State and Territory government responsibility. The CSTDA, under which disability services are funded, is such an SPP.

At its 29 November 2008 meeting, COAG agreed to six new National Agreements, five of which are associated with a National SPP. In the area of disability services, there is a National Disability Agreement associated with the National Disability Services SPP (COAG November 2008). Under the reforms, the National Disability Agreement contains the objectives, outcomes, outputs and performance indicators for disability services. The performance of governments in achieving these mutually agreed outcomes will be assessed by the COAG Reform Council (CRC). The Steering Committee has been requested by COAG to provide the SPP performance information to the CRC (COAG July 2008).

The National Agreements/SPPs will be supplemented by a range of National Partnerships (NPs): project, facilitation and reward agreements. Funding for NPs may be conditional on states and territories meeting agreed milestones and performance benchmarks.

The Steering Committee and the Disability Services Working Group will ensure that reporting in this chapter reflects the COAG priorities identified in the National Disability Agreement and relevant NPs.

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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- In 2007-08, the Australian Government provided funding for over 20 000 supported employment places in 354 business service outlets across Australia.
- In 2007-08, the Australian Government Allocated \$112 million over 5 years as part of its enhanced Disability Assistance Package (DAP). As part of the DAP, \$33.7 million was allocated for the creation of 750 new Business Service employment places. In January 2008, 500 of these places were allocated to existing high performing disability business services. In June 2008, a selection process was completed allocating the remaining 250 places to new services for areas of high demand.
- In 2007-08, \$21.8 million has been made available over five years for temporary viability support to disability business services facing short-term financial difficulties.
- In 2007–2008, a suite of 74 training resources and information products were developed and were completed and distributed to all business service outlets and advocacy services by June 2008.
- In June 2008, the Australian government provided each business service with an extra payment of \$2500 (\$525 000 nationally) to assist with the marketing of their products and services. A Quality Strategy Toolkit was also designed and trialled in the early part of 2008.
- During 2007-08, the Disability Employment Network (DEN) capped stream provided employment assistance to approximately 51 000 clients. The demand-driven (uncapped) DEN stream assisted approximately 18 000 clients in 2007-08. The proportion of DEN job seekers who received assistance during 2007-08 that achieve a sustainable employment outcome (8 hours of work per week for 26 weeks) in the capped stream was 39 per cent.
- The DEN capped stream has a fixed capacity of approximately 39 000 places. It assists eligible job seekers who are unable to work at full award wages or are able to work a minimum of eight hours a week in the open labour market who are likely to require ongoing support to retain employment once they have found a job. In 2007-08, 201 organisations delivered the capped stream from 371 sites, assisting approximately 51 000 clients.
- The demand driven DEN uncapped stream guarantees assistance to job seekers receiving income support who are required to look for work to meet part-time participation requirements. Introduced in July 2006, it provides up to two years of employment assistance to job seekers assessed as able to work 15–29 hours per week independently at full award wages. In 2007-08, 106 organisations delivered uncapped services from 497 sites, assisting approximately 18 000 job seekers.

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New South Wales Government comments

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The NSW Government continued its commitment to providing services to people with a disability and their carers to assist them to live independently and participate in community life. The total expenditure for the disability services reported in this chapter has reached nearly \$1.4 billion in 2007-08.

In 2007-08, the NSW Government continued expansion of services under the NSW Government's historic ten-year plan to boost disability services — *Stronger Together: a new direction for disability services: 2006–2016*. NSW has invested an additional \$350 million in the past two years to deliver a wide range of additional services.

Much of this funding has targeted the areas of greatest need. These include 1000 new therapy places; 95 new attendant care places; 1900 family and children's services places; 345 specialist accommodation places; and 2800 respite places.

New programs have been developed to support groups of people for whom access has been an issue, for example younger people in or at risk of entering residential aged care, Aboriginal people and people from culturally and linguistically diverse (CALD) backgrounds, people with an acquired brain injury, people with degenerative conditions and people who have severely challenging behaviours.

Over 500 school leavers were accepted into a *Transition To Work* program and 314 school leavers into a *Community Participation* program. Sixteen *Intensive Family Support* services are now operating across the state, including three services for people from CALD backgrounds and four for Aboriginal people. Over 600 additional respite places were allocated under *Teen Time* to parents of teenagers with a disability to enable them to pursue their workforce ambitions and *Leisure Link* to foster interests and goals of people with disabilities to build their capacity and confidence. An *Innovative Accommodation Framework* has been developed to guide the establishment of over 660 new accommodation support places over the next three years.

The NSW Government is committing a \$6 million package over four years to boost services for young children with autism and their families. This is in addition to other initiatives announced during the year. An additional \$48 million will provide additional early intervention services.

The NSW Companion Card scheme was announced in 2008. The scheme will enable people in NSW who have a profound or severe disability, and who need the support of an attendant carer, to use public transport and attend some events for the price of a single ticket. The card is still in its early planning stages, but it is estimated that 17 000 people will benefit when it is introduced in 2009.

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Victorian Government comments

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The *Disability Act 2006* came into operation on 1 July 2007. The new Act has substantially reformed the law for people with a disability in Victoria and is guided by the principles of human rights and citizenship. The Act provides a framework for a whole-of-government and community approach and facilitates the delivery of more flexible support, based on people's individual requirements. The Victorian Government continues the implementation of the *Victorian State Disability Plan 2002–2012*, which emphasises that people with a disability have the same rights, responsibilities and opportunities to participate in the life of the community as other citizens in Victoria.

2007-08 saw the first full year of operation of the Office of the Senior Practitioner and the Office of the Disability Services Commissioner (ODSC). The role of the Senior Practitioner was established to protect the rights of people subject to restrictive interventions and compulsory treatment, and to lead best practice in supporting people with behaviours of concern. The ODSC was established to provide an independent process for dealing with complaints raised by and on behalf of people with a disability, their families and carers.

Key achievements for 2007-08 included:

- completion of the redevelopment of Kew Residential Services. Over 460 residents of the former Kew Cottages are now living in new houses, integrated into their communities and enjoying an improved quality of life
- continuation of the expansion of individual support packages and consolidation into streamlined packages with a consistent set of guidelines which provide people with greater control and choice over their support arrangements
- expansion of the *Aids and Equipment Program*, including implementation of the *Vehicle Modification Subsidy Scheme* to assist people with a disability modify their vehicles
- continuation of the implementation of *my future, my choice* initiative to establish more appropriate housing and support for younger people who are living in Residential Aged Care. Individualised packages were also allocated to assist younger people to return to, or remain in their homes or other community based accommodation
- provision of improved standards of direct support for people with a disability living in residential care, through the *Promoting Better Practice* initiative to review and improve the quality and safety of service delivery in department managed supported accommodation
- establishment of working groups to facilitate implementation of *Partnering for the future: The Victorian industry development plan for the provision of support for people with a disability*. Key priorities include workforce development, strengthening sector governance and capacity building to develop contemporary approaches to support provision.

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Queensland Government comments

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The Queensland Government has moved forward with implementing key reforms to improve the integrity and responsiveness of the State's disability service system.

In 2007-08, Queensland began its four-year program of reforms under the *Growing Stronger* initiative. The release of a single application form is part of simplifying access to specialist disability services. It supports a timely and consistent response for people with a disability seeking services, and supports responses that are tailored to an individual's needs across a mix of service types. The new streamlined process also aims to reduce unnecessary administrative burden.

Queensland also maintained its focus on delivering quality services, with \$6.3 million in recurrent funding allocated to support the Queensland disability sector to implement and maintain the Disability Sector Quality System. To further safeguard the rights of adults with an intellectual or cognitive disability who exhibit challenging behaviour, Queensland has progressed amendments to the *Disability Services Act 2006* and *Guardianship Administration Act 2000*. From 1 July 2008, new provisions commence to regulate the use of restrictive practices in services provided and funded by Disability Services Queensland, and promote a positive behaviour support system and improved outcomes for these individuals.

Whilst pursuing these reforms, Queensland has continued to invest in service delivery, with additional recurrent funding of \$33.3 million in 2007-08 to deliver additional specialist disability services; though demand also continues from a growing and ageing population.

To improve service access for people from culturally and linguistically diverse backgrounds, Queensland has developed an Interpreting and Translating Assistance Strategy. Through this strategy, funded non-government service providers have access to interpreting and translating services to meet the different communication needs of people who require their services and to provide information in appropriate languages and formats.

Queensland also continued efforts to build capacity in the community and non-government sector to increase support for people with a disability. Queensland has introduced the Carer Business Discount Card scheme to provide carers with discounts and other offers at participating businesses. Queensland has also continued to build the workforce and organisational capability and infrastructure of non-government service providers through the Strengthening Non-Government Organisations Strategy. For example, over \$6 million in capital funding was allocated to increase the infrastructure capacity of 16 services that deliver developmental day services for adults with a disability.

Queensland continues to focus on enhancing the service system in a way that strengthens both the formal and informal supports that assist people with a disability, and their families and carers.

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Western Australian Government comments

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A major focus for Western Australia in 2007-08 has been implementing the 67 recommendations of the Sector Health Check report, which was launched in May 2007. These include the commencement of an innovative statewide pilot program to facilitate more timely access to community based support for people with rapidly degenerating neurological conditions; the development of the Community Living Plan; and the conduct of sector wide consultations on the development of a long term plan for disability.

The Community Living Plan draws from innovative national and international community living models, and promotes a broad range of ‘person centred’, sustainable, alternative community living arrangements that can be tailored to the needs of individuals with disabilities.

The Disability Services Commission has undertaken a leadership role in the development of a visionary plan for the Western Australian community which will set long term future directions for the benefit of all Western Australians with disabilities, their families and carers. To be known as ‘Disability Future Directions 2025’, the plan will serve as a guide for a wide range of government and community organisations into the future. Stage one has included extensive engagement with people with disabilities, families, carers, community members, other government agencies and university and research organisations to conduct an environmental scan to gather information about what life in WA will be like in 2025.

In line with recommendations from the Sector Health Check to facilitate a stronger relationship between government and the disability sector, the inaugural Chief Executive Officer Roundtable was held in March 2008, with over 70 CEOs and the Disability Services Commission’s Director General attending the full day forum. This important body enables an exchange of information between the Commission and the non government sector and provides a forum for discussion and debate about broad strategic issues facing the WA disability sector.

There continues to be a focus on making local communities more accessible and inclusive for people with disabilities, in line with the legislative requirement under WA’s Disability Services Act which requires State Government agencies and Local Government to implement Disability Access and Inclusion Plans to improve access to their services, buildings and information for people with disabilities. Key achievements include working with representatives from the business sector to develop a resource kit promoting the employment of people with disabilities; launch of the WA Accessible Tourism Strategic Directions plan; and further expansion of the You’re Welcome initiative across local governments throughout the State to assist businesses and community organisations make their services accessible and to provide people with disabilities the information they need on the accessibility of venues and services.

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South Australian Government comments

“ Disability SA continues to deliver improved services to people with a disability to assist them to live independently and participate in their community. Highlights for 2007-08 include significant enhancements to consumer advisory mechanisms and further progress in transitioning people with a disability from institutional care to community settings.

Some key achievements for 2007-08 include the following:

- The *Companion Card* program was introduced to promote fairer ticketing for people with a disability who require a companion to attend community venues and activities.
 - Disability policy development in South Australia has been supported by a new *Minister's Disability Advisory Council* comprising people with a lived experience of disability.
 - 40 new community based group homes have been developed through the *Strathmont Centre Community Living and Sustainment Project*.
 - A new target relating to employment outcomes for people with disabilities has been agreed for agencies reporting progress under the *Promoting Independence Strategy*.
 - Further enhancements have been made to performance reporting requirements for funded agencies, including the roll-out of the Department for Families and Communities' quality performance monitoring framework.
 - Early intervention services for children with autism have been expanded.
 - The quality of supported accommodation services in Disability SA has been enhanced through implementation of the *Active Support* model.
 - Service Co-ordination has been streamlined to facilitate access to services for people with a disability requiring short term assistance.
 - Regionalisation of Aboriginal Service Coordinators has been achieved to support access to services by Aboriginal people.
 - A new consumer consultation group, the *Disability Advisory Network of South Australia*, has been developed to inform Disability SA regarding service delivery, development and future planning.
 - Streamlined access to accommodation vacancies across the disability sector has been facilitated through the introduction of the *Accommodation Placement Panel* process.
 - Allied health services have been enhanced, with the development of three regional teams, known as *ASSIST* teams.
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Tasmanian Government comments

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A Review of Tasmanian Disability Services was announced by the Minister for Health and Human Services in July 2007, and was conducted by KPMG. The Final Report provided advice to the Tasmanian Government on the strategic direction and best practice service models needed in order to use available resources in an equitable, cost effective and sustainable way.

In June 2008, the Government announced it had accepted all recommendations of the Review. Implementation of the recommendations will result in significant changes to Disability Services with a focus on:

- the Implementation of clear shared governance arrangements to oversee disability services at a statewide and at a regional level
- responsibility for all direct service delivery to be devolved to the NGO sector over a three-year period
- development of a resource allocation and funding model which considers relative population need and risk, historic inequities in service access, reasonable costs of service delivery, and consistency in funding amongst the providers within a region
- 'planning by location' processes to ensure services are better targeted to community needs
- establishing appropriate outcomes and measures of effectiveness which are meaningful to individuals
- refining the existing quality systems
- enhancing the capacity of the workforce
- implementation of consistent and transparent eligibility determination and prioritisation procedures for accessing disability services
- visible entry points to disability services to enable improved access to specialist disability supports for people with disabilities and a centralised approach to the management of demand at the regional level.

Other notable achievements during 2007-08 include:

- continued implementation of the Disability Services Quality Review and Improvement System. Client and family satisfaction surveys were undertaken within all large and small residential services and hostels in Tasmania
- finalisation of the transfer of the management of all group homes managed by the Government to the non-government sector under the Living Independently project
- completion of the Disability Services Accommodation Options Project 2008 which identified current and future issues in the provision of accommodation supports for people with a disability.

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Australian Capital Territory Government comments

“ In 2007-08 the Department of Disability, Housing and Community Services, through Disability ACT, continued to advance its strategic plan as outlined in *Future Directions: a framework for the ACT 2004–2008*. Activity in 2007-08 included:

- responding to known priority need through the delivery of additional ACT Government funding allocated in the 2007-08 Budget to build service capacity to meet increased demand for a range of services for young people and adults with high level intellectual and physical disabilities
- finalisation of the Review of the Role of Government as a Disability Service Provider. A small think tank of stakeholders developed the practical elements of the consultation into 12 in-principle recommendations that broadly cover areas of service delivery, access and information, establishing priorities and making decisions, service relationships and sector development
- continued support for Local Area Coordination (LAC) in working directly with people with disability and their families to help them tailor supports and services in their local communities. An evaluation of the program in late 2007 identified that one of the keys to the program's success is the wealth of local knowledge and contacts that the LAC has built up to assist individuals and their families
- the Business Leaders Innovative Thoughts and Solutions group continued its program to raise awareness of people with disability in the ACT. Activities included undertaking a scoping project for a disability awareness program; auspice of the 2007 Chief Minister's Inclusion Awards and International Day of People with a Disability activities. Disability ACT in partnership with Live Experience Access Develop (LEAD) and ArtsACT commenced development of a Performing Arts Alliance to assist performing artists with disability to develop their profile and collaborate on significant events
- the fourth annual Post Schools Options Expo was held in June 2008. 450 students attended. Disability ACT also continued to work closely with other ACT Government agencies in implementing the Access to Government Strategy
- continued support for a number of family governed networks to plan and manage the current and future support of families including Planning Alternative Tomorrows with Hope, Family Leadership and You, Stepping Stones for Life
- further development of the Intensive Treatment and Support program including the opening of a respite facility to assist in the provision of ITAS services.”

Northern Territory Government comments

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The unique environment and socio-economic factors in the NT create specific challenges in the provision of human services including specialist disability services. This is particularly so in the provision of appropriate, cost effective and sustainable specialist disability services in remote Indigenous communities. Enhancing Indigenous remote residents access to specialist disability services and equitable allocation of resources remained a priority to the NT Government.

The high proportion of people living in remote settings and lack of a major metropolitan centre creates increase cost structures for all services in the NT.

Data quality remains an ongoing challenge for providers in the NT, given that most are small non-government agencies that receive funds from multiple sources and for multiple purposes. In addition, the relatively small numbers of disability services clients in the NT results in distorted or misleading proportions in the data analysis.

A major reform in the NT was the planning for the amalgamation of community councils to larger shire councils. From 1 July 2008, fewer and larger providers will replace the current large numbers of small and dispersed disability providers.

In 2007-08, a number of projects were implemented with the focus of improving service planning and quality. These included a new resources allocation policy to distribute available funds to targeted services closer to home for people with a disability.

As in previous years, indicators based on the estimated number of people with severe, profound and/or core activity limitations in the NT need to be interpreted with caution. Small variations in service and population data appears in magnified proportions to the small population in the NT.

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14.6 Service user data quality and other issues

Data quality

Data quality considerations should be taken into account when interpreting the CSTDA NMDS service user data used in this chapter. In particular, data quality should be considered when making comparisons across jurisdictions and across years.

There are three aspects of quality that affect the accuracy and reliability of the data reported in this chapter:

- service type outlet response rates
- service user response rates
- ‘not stated’ rates for individual data items.

The first two of these affect the service user counts — nationally, by jurisdiction and service type — and all three affect the accuracy of analyses of individual data items (AIHW 2006a).

Service type outlet response rates

Response rates are based on the number of service type outlets responding divided by the total number of outlets in the jurisdiction. Service user data are collected quarterly from service type outlets. A service type outlet is considered a responding outlet even if they provide service use data for one quarter only.

The overall national service type outlet response rate for the 2006-07 collection was 94 per cent (table 14.3). This was the same as for the 2005-06 collection.

Table 14.3 Service type outlet response rates

	<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>	<i>Aust</i>
2003-04	80	94	97	100	100	100	93	95	100	93
2004-05	85	92	99	100	100	96	98	70	100	94
2005-06	89	90	99	100	100	100	100	100	100	94
2006-07	89	90	100	100	100	100	100	100	100	94

Source: AIHW *Disability Support Services* (various years): *National Data on Services Provided under the CSTDA* (various issues).

Service user response rates

Service user information may be missing from the data set for a number of reasons. There are outlets that do not respond (table 14.3) and outlets that, through administrative or other error, neglect to report on all of their service users (AIHW 2006a). Estimates of the total number of service users who may be missing from the data set are not available.

Response rates based on the number of service type outlets responding who provided service user data are available for accommodation support services by type and government sector for 2003-04, 2004-05, 2005-06 and 2006-07 (table 14.4). While helpful, these response rates do not account for service users who received services from:

- responding outlets, but whose data were not included
- non-responding outlets.

Table 14.4 Service user data response rates for CSTDA funded accommodation support service type outlets (per cent)^a

	<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>
2003-04									
Institutions/large residential or hostel									
Government	92	86	67	100	80	–	–	–	89
Non-government	83	84	99	100	100	100	–	–	94
Group homes									
Government	98	99	100	100	94	100	98	–	98
Non-government	96	98	100	100	96	100	100	100	98
Community based									
Government	100	82	100	100	100	75	100	–	89
Non-government	96	85	94	100	95	98	100	100	93
2004-05									
Institutions/large residential or hostel									
Government	100	100	100	100	100	–	–	–	100
Non-government	100	100	100	100	100	100	–	–	100
Group homes									
Government	100	100	100	100	100	100	98	100	100
Non-government	100	100	100	100	100	100	100	100	100
Community based									
Government	100	100	100	100	50	100	–	100	99
Non-government	100	100	100	100	100	100	88	100	100

(Continued on next page)

Table 14.4 (Continued)

	<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>
2005-06									
Institutions/large residential or hostel									
Government	100	100	100	100	100	–	–	–	100
Non-government	100	100	100	100	100	100	–	–	100
Group homes									
Government	100	100	100	100	100	100	98	100	100
Non-government	100	100	100	100	100	100	100	100	100
Community based									
Government	100	100	100	100	50	100	–	100	99
Non-government	100	100	100	100	100	100	88	100	100
2006-07									
Institutions/large residential or hostel									
Government	100	100	100	100	100	100	100	100	100
Non-government	100	100	100	100	100	100	100	100	100
Group homes									
Government	100	100	100	100	100	100	100	100	100
Non-government	100	100	99	92	100	97	100	100	99
Community based									
Government	100	100	100	100	75	100	100	100	99
Non-government	100	100	99	94	100	98	100	100	99

^a Percentages are based on the number of service type outlets providing service user data. The denominator is the total number of outlets that provided service type outlet data; the numerator is the number of outlets that provided service user data. – Nil or rounded to zero.

Source: AIHW (unpublished), derived from the *CSTDA NMDS*.

'Not stated' rates

'Not stated' rates for individual data items vary between jurisdictions (AIHW 2006a). One reason for the higher level of 'not stated' responses to some data items may be the increased efforts to improve the coverage and completeness of the *CSTDA NMDS* collection overall. For example, therapy services (a community support service) in the ACT participated for the first time in the 2004-05 collection. In an effort to include all users of these services, provisional data collection processes were used that meant minimal data were provided for each user (AIHW 2006a).

Table 14.5 shows the total 'not stated' rates for the relevant individual data items used in this chapter. Results reported in this chapter are not adjusted to account for these 'not stated' rates.

Table 14.5 'Not stated' rates for individual data items (per cent)

<i>Data item</i>	<i>Accommodation support</i>	<i>Employment</i>	<i>Community access</i>	<i>Community support</i>	<i>Respite</i>
2003-04					
Severity of core activity limitation	17.4	3.2	32.3	..	..
Indigenous status	3.4	7.0	17.5	..	..
Country of birth	3.6	3.9	..	..	..
Geographic location	1.0	0.0	..	..	..
2004-05					
Severity of core activity limitation	5.1	3.1	12.2	32.7	13.0
Indigenous status	8.6	4.1	14.1	29.5	16.8
Country of birth	3.1	3.5	..	..	..
Geographic location	1.0	–	..	..	..
2005-06					
Severity of core activity limitation	3.9	14.5	11.8	28.4	12.8
Indigenous status	2.3	1.8	7.8	15.6	7.1
Country of birth	2.8	6.8	..	..	..
Geographic location	0.7	0.3	..	..	..
2006-07					
Severity of core activity limitation	3.2	7.0	13.0	24.0	11.6
Indigenous status	2.8	–	7.2	5.5	6.7
Country of birth	2.7	1.3	9.9	6.2	5.6
Geographic location	1.2	–	3.9	1.7	1.9

.. Not applicable. – Nil or rounded to zero.

Source: AIHW (unpublished), derived from the *CSTDA NMDS*.

Other issues

Service user data/data items not collected

Service user data are not collected for the following CSTDA funded service types: advocacy, information/referral, combined information/advocacy, mutual support/self-help groups, print disability/alternative formats of communication, research and evaluation, training and development, peak bodies and other support services. In addition, some service types are not required to collect all service user data items. In particular:

- 'recreation/holiday programs' (service type 3.02) are required to collect only information related to the statistical linkage key (selected letters of name, date of birth and sex)

-
- employment services (service types 5.01 and 5.02) are not required to collect selected informal carer information, including primary status (AIHW 2007).

Specialist psychiatric disability services

Data for specialist psychiatric disability services are excluded to improve the comparability of data across jurisdictions. People with psychiatric disability may use a range of CSTDA-funded service types. In some jurisdictions (Victoria, Queensland and WA), specialist psychiatric disability services are funded specifically to provide such support (AIHW 2006a). Nationally, there were 11 834 users of specialist psychiatric disability services in 2006-07.

Data for these services are included in other publications on the CSTDA NMDS, such as AIHW 2008. Therefore, service user data for Victoria, Queensland and WA in this chapter will differ to other publications.

Statistical linkage key

A statistical linkage key is used to derive the service user counts in this chapter. The statistical linkage key enables the number of service users to be estimated from data collected from different service outlets and agencies (AIHW 2006a). Using the linkage key minimises double counting of service users who use more than one service outlet during the reporting period.

The statistical linkage key components of each service record are compared with the statistical linkage key components of all other records. Records that have matching statistical linkage keys are assumed to belong to the same service user.

- As the statistical linkage key is not a unique identifier, some degree of false linking is expected. A small probability exists that some of the linked records do not actually belong to the same service user and, conversely, that some records that did not link do belong to the same service user. The statistical linkage key does not enable the linking of records to the extent needed to be certain that a 'service user' is one individual person.
- Missing or invalid statistical linkage keys cannot be linked to other records and so must be treated as belonging to separate service users. This may result in the number of service users being overestimated (AIHW 2006a).

Deriving potential populations for the special needs groups

Potential populations have been estimated for each of the special needs groups (outer regional and remote/very remote areas, Indigenous, and people born in a non-English speaking country) and for those outside of the special needs groups (major cities and inner regional areas, non-Indigenous and people born in an English speaking country). These ‘potential populations’ are estimates of the number of people with the potential to require disability support services in the relevant group, including individuals who meet the service eligibility criteria but who do not demand the services.

The approach used to derive the potential population estimates by country of birth and geographic location involved the following steps:

- Derive national five-year age specific proportions of people with severe/profound core activity limitations by geographic location and country of birth.
 - The ABS 2006 Census was used to derive the proportions by geographic location. The geographic location categories are major cities, inner regional areas, outer regional areas and remote/very remote areas. (These proportions were used for all services except respite.)
 - The ABS 2003 SDAC was used to derive the proportions by geographic location for respite services. The SDAC categorises geographic locations to three levels: major cities, inner regional areas, and other areas (outer regional, remote and very remote). The SDAC was used in this context as data on the presence of a ‘primary carer’ are available (whereas they are not in the Census).
 - The ABS 2003 SDAC was used to derive the proportions by country of birth. The country of birth categories are: people born in Australia, people born in another English speaking country and people born in a non-English speaking country. These proportions were used to derive the ‘potential population’ estimates for all services except respite. It was not possible to use the SDAC to derive the proportions by country of birth for respite services due to small cell sizes (and associated high relative standard errors).
- Multiply the proportions of people born in Australia and each of the geographic locations by the five-year age specific ‘potential populations’ for each state/territory. Multiply the proportions for people born in another English speaking country or a non-English speaking country by the five-year age-specific estimates of people with severe/profound core activity limitations for each state/territory. Indigenous people are given a weight of 2.4 in the ‘potential population’ and as most are born in Australia, it is inappropriate to

multiply the proportions of people born in another English speaking country or a non-English speaking country by the ‘potential population’.

- Sum the resultant five-year age group counts to derive the total ‘potential populations’ for the geographic locations, people born in Australia, people born in another English speaking country and people born in a non-English speaking country. Sum the potential populations for people born in Australia and people born in another English speaking country to derive the total ‘potential population’ for people born in an English speaking country.
- For employment, repeat the above steps, but restrict to people aged 15–64 years, then multiply each State/Territory total by state/territory specific labour force participation rates for people aged 15 years and over.

The approach used to derive the potential populations by Indigenous status involved the following steps:

- Multiply the national five-year rates of severe/profound core activity limitation by the Indigenous population for people aged 0–64 years. The Indigenous counts for each five-year age group are then multiplied by the Indigenous factor (2.4) to obtain an ‘Indigenous potential population’ within each age group. The non-Indigenous counts are derived by subtracting the Indigenous counts from the total ‘potential population in each age group.
- Sum the five-year age group counts to derive a total Indigenous and non-Indigenous ‘potential population’ for each state/territory.
- For employment, repeat the above steps, but restrict to people aged 15–64 years, then multiply each State/Territory total by state/territory specific labour force participation rates for people aged 15 years and over.

14.7 Definitions of key terms and indicators

Accommodation support service users receiving community accommodation and care services

People using the following CSTDA accommodation support services: group homes; attendant care/personal care; in-home accommodation support; alternative family placement and other accommodation support (types 1.04–1.08), as a proportion of all people using CSTDA accommodation support services (excludes specialist psychiatric disability services). See AIHW (2008) 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 (except major capital grants)).

Core activities as per the 2003 ABS SDAC

Self care — showering or bathing, dressing, eating, toileting and bladder or bowel control; mobility — getting into or out of a bed or chair, moving about the usual place of residence, going to or getting around a place away from the usual residence, walking 200 metres, walking up and down stairs without a handrail, bending and picking up an object from the floor, using public transport (the first three tasks contribute to the definitions of profound and severe core-activity limitation); and communication — understanding and being understood by strangers, family and friends.

Cost per user of government provided accommodation support services — group homes

The numerator — government expenditure (accrual) on government provided accommodation support services in group homes (as defined by CSTDA NMDS service type 1.04) — divided by the denominator — the number of users of government provided accommodation support services in group homes.

Cost per user of government provided accommodation support services — institutional/residential settings

The numerator — government expenditure (accrual) on government provided accommodation support services in institutional/residential settings (as defined by CSTDA NMDS service types 1.01, 1.02 and 1.03) — divided by the denominator — the number of users of accommodation support services in institutional/residential settings. See AIHW (2007) for more information on service types 1.01–1.03.

Cost per user of government provided accommodation support services — other community settings

The numerator — government expenditure (accrual) on government provided accommodation support services in other community settings (as defined by CSTDA NMDS service types 1.05–1.08) divided by the denominator — the number of users of government provided accommodation support services in other community settings.

Disability

A multidimensional experience that may involve effects on organs or body parts, and effects on a person's participation in areas of life. Correspondingly, three dimensions of disability are recognised in the International Classification of Functioning, Disability and Health: body structure and function (and impairment thereof), activity (and activity limitations) and participation (and participation restriction)(WHO 2001). The classification also recognises the role of physical and social environmental factors in affecting disability outcomes.

The ABS SDAC 2003 defined 'disability' as the presence of one or more of 17 limitations, restrictions or impairments, which have lasted, or are likely to last, for a period of six months or more: loss of sight (not corrected by glasses or contact lenses); loss of hearing where communication is restricted; or an aid to assist with, or substitute for, hearing is used; speech difficulties; shortness of breath or breathing difficulties causing restriction; chronic or recurrent pain or discomfort causing restriction; blackouts, fits or loss of consciousness; difficulty learning or understanding; incomplete use of arms or fingers; difficulty gripping or holding things; incomplete use of feet or legs; nervous or emotional condition causing restriction; restriction in physical activities or in doing physical work; disfigurement or deformity; mental illness or condition requiring help or supervision; long-term effects of head injury; stroke or other brain damage causing restriction; receiving treatment or medication for any other long-term conditions or ailments and still restricted; any other long-term conditions resulting in a restriction.

Employment rate for people with a profound or severe core activity limitation

Total estimated number of people aged 15–64 years with a profound or severe core activity limitation who are employed, divided by the total estimated number of people aged 15–64 years with a profound or severe core activity limitation in the labour force, multiplied by 100.

Employment rate for total population

Total estimated number of people aged 15–64 years who are employed, divided by the total number of people aged 15–64 years in the labour force, multiplied by 100.

Funded agency

An organisation that delivers one or more CSTDA service types (service type outlets). Funded agencies are usually legal entities. They are generally responsible for providing CSTDA NMDS data to jurisdictions. Where a funded agency operates only one service type outlet, the service type outlet and the funded agency are the same entity.

Geographic location

Geographic location is based on the ABS's Australian Standard Geographical Classification of Remoteness Areas, which categorises areas as 'major cities', 'inner regional', 'outer regional', 'remote', 'very remote' and 'migratory'. The criteria for Remoteness Areas are based on the Accessibility/Remoteness Index of Australia, which measures the remoteness of a point based on the physical road distance to the nearest urban centre in each of five size classes (ABS 2001).

The 'outer regional and remote/very remote' classification used in this Report was derived by adding outer regional, remote and very remote data.

Government contribution per user of non-government provided employment services

The numerator — Australian Government grant and case based funding expenditure (accrual) on specialist disability employment services (as defined by CSTDA NMDS service types 5.01 (open) and 5.02 (supported)) — divided by the denominator — number of service users who received assistance. (For data prior to 2005-06, service type 5.03 (combined open and supported) is also included.) See AIHW (2008) for more information on service types 5.01–5.03.

Government contribution per user of non-government provided services — accommodation support in group homes

The numerator — government expenditure (accrual) on non-government provided accommodation support services in group homes (as defined by CSTDA NMDS service type 1.04) — divided by the denominator — the number of users of non-government provided accommodation support services in group homes.

Government contribution per user of non-government provided services — accommodation support in institutional/residential settings

The numerator — government expenditure (accrual) on non-government provided accommodation support services in institutional/residential settings (as defined by CSTDA NMDS service types 1.01, 1.02 and 1.03) — divided by the denominator — the number of users of non-government provided accommodation support services in institutional/residential settings.

Government contribution per user of non-government provided services — accommodation support in other community settings

The numerator — government expenditure (accrual) on non-government provided accommodation support services in other community settings (as defined by CSTDA NMDS service types 1.05–1.08) — divided by the denominator — the number of users of non-government provided accommodation support services in other community settings.

Indigenous factor

The potential populations were estimated by applying the 2003 national age- and sex- specific rates of profound or severe core activity limitation to the age and sex structure of each jurisdiction in the current year. As Indigenous people have significantly higher disability prevalence rates and greater representation in some CSTDA funded services than non-Indigenous people, and there are differences in the share of different jurisdictions' populations who are Indigenous, a further Indigenous factor adjustment was undertaken. The Indigenous factor was multiplied by the 'expected current population estimate' of people with a profound or severe core activity limitation in each jurisdiction to derive the 'potential population'.

The following steps were undertaken to estimate the Indigenous factors.

- Data for all people (weighted) were calculated by multiplying the data for Indigenous Australians by 2.4 and adding the data for non-Indigenous Australians. Hence Indigenous Australians are weighted at 2.4 and non-Indigenous Australians at one.
- Data for all people (weighted per person) were calculated by dividing the all people (weighted) data by the sum of the Indigenous Australians data and the non-Indigenous Australians data.
- The Indigenous factors were then calculated by multiplying the all people (weighted per person) data by 100 and dividing by the all people (weighted per person) total for Australia (AIHW 2008).

Informal carer

ABS informal carer: A person of any age who provides any informal assistance, in terms of help or supervision, to persons with disabilities or long-term conditions, or older persons (that is, aged 60 years and over). This assistance has to be ongoing, or likely to be ongoing, for at least six months. Assistance to a person in a different household relates to 'everyday types of activities', without specific information on the activities. Where the care recipient lives in the same household, the assistance is for one or more of the following activities: cognition or emotion, communication, health care, housework, meal preparation, mobility, paperwork, property maintenance, self care and transport (ABS 2004).

CSTDA NMDS informal carer: an informal carer is someone such as a family member, friend or neighbour, who has been identified as providing regular and sustained care and assistance to the person. Each service user can only record one informal carer (it is expected that the carer recorded will be the one who provides the most significant care and assistance related to the service user's capacity to remain living in their current environment). Informal carers include those people who receive a pension or benefit for their caring role but do not include paid or volunteer carers organised by formal services. See also primary carer.

Labour force participation rate for people with a profound or severe core activity limitation

The total number of people with a profound or severe core activity limitation in the labour force (where the labour force includes employed and unemployed people), divided by the total number of people with a profound or severe core activity limitation who are aged 15–64 years, multiplied by 100.

An employed person is a person who, in his or her main job during the remuneration period (reference week):

- worked one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (including employees, employers and self-employed persons)
- worked one hour or more without pay in a family business, or on a farm (excluding persons undertaking other unpaid voluntary work), or
- was an employer, employee or self-employed person or unpaid family helper who had a job, business or farm, but was not at work.

An unemployed person is a person aged 15–64 years who was not employed during the remuneration period, but was looking for work.

Labour force participation rate for the total population

Total number of people aged 15–64 years in the labour force (where the labour force includes both employed and unemployed people) divided by the total number of people aged 15–64 years, multiplied by 100.

Mild core activity limitation

Not needing assistance with, and has no difficulty performing, core activity tasks, but uses aids and equipment (as per the ABS 2003 SDAC).

Moderate core activity limitation

Not needing assistance but having difficulty performing a core activity task (as per the ABS 2003 SDAC).

Non-English speaking country of birth	<p>People with a country of birth other than Australia and classified in English proficiency groups 2, 3 or 4 (DIMA 1999, 2003). For 2003-04 and 2004-04 data these countries include countries other than New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States. For 2005-06 onwards, data include Zimbabwe as an 'English-speaking country'.</p>
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 'potential population' is the number of people with the potential to require disability support services, including individuals who meet the service eligibility criteria but who do not demand the services. In practice, the number of people with profound or severe core activity limitation is used as the basis to measure the potential population (see definition of core activities above).</p> <p>The potential population for CSTDA funded accommodation support, community access and community support services is measured by 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 measured by the number of people aged 15–64 years with a profound or severe core activity limitation, adjusted for the Indigenous factor and the labour force participation rate. The potential population for CSTDA funded respite services data is measured by 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.</p> <p>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 currently underpins the measurement of the population in need of 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.</p> <p>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</p>

	<p>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 2006).</p>
Primary carer	<p><i>ABS SDAC primary carer:</i> 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). In the SDAC, primary carers only include persons aged 15 years and over for whom a personal interview was conducted. Persons aged 15 to 17 years were only interviewed personally if parental permission was granted (ABS 2004).</p> <p><i>CSTDA NMDS primary carer:</i> an informal carer who assists the person requiring support, in one or more of the following activities of daily living: self care, mobility or communication.</p> <p>See also informal carer.</p>
Primary disability group	<p>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).</p>
Profound core activity limitation	<p>Unable to, or always needing assistance to, perform a core activity task (as per the ABS 2003 SDAC).</p>
Real expenditure	<p>Actual expenditure (accrual) adjusted for changes in prices, using the Gross Domestic P(E) price deflator, and expressed in terms of current year dollars.</p>
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	<p>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.</p>

Service type	The support activity that the service type outlet has been funded to provide under the CSTDA. The NMDS classifies services according to 'service type'. The service type classification groups services into seven categories: accommodation support; community support; community access; respite; employment; advocacy, information and print disability; and other support services. Each of these categories has subcategories.
Service type outlet	A service type outlet is the unit of the funded agency that delivers a particular CSTDA service type at or from a discrete location. If a funded agency provides, for example, both accommodation support and respite services, it is counted as two service type outlets. Similarly, if an agency is funded to provide more than one accommodation support service type (for example, group homes and attendant care), then it is providing (and is usually separately funded for) two different service types — that is, there are two service type outlets for the funded agency.
Service user	A service user is a person with a disability who receives a CSTDA funded service. A service user may receive more than one service over a period of time or on a single day.
Service users with different levels of severity of core activity limitation	Data on service users with different levels of severity of core activity limitation are derived by the AIHW based on the level of support needed in one or more of the three areas of daily living: self care, mobility and communication. Service users with: <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 SDAC 2003).
Users of CSTDA accommodation support services	People using one or more accommodation support services that correspond to the following CSTDA NMDS service types: 1.01 large 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 (2007) for more information on service types 3.01–3.03.
Users of CSTDA community support services	People using one or more services that correspond to the following CSTDA NMDS service types: 2.01 therapy support for individuals; 2.02 early childhood intervention; 2.03 behaviour/specialist intervention; 2.04 counselling; 2.05 regional resource and support teams; 2.06 case management, local coordination and development; and 2.07 other community support. See AIHW (2008) for more information on service types 2.01–2.07.

**Users of CSTDA
employment services**

People using one or more services that correspond to the following CSTDA NMDS service types: 5.01 open employment and 5.02 supported employment. (For data prior to 2005-06, people using service type 5.03 [combined open and supported] are also included.)

**Users of CSTDA respite
services**

People using one or more services that correspond to the following CSTDA NMDS service types: 4.01 own home respite; 4.02 centre-based respite/respite homes; 4.03 host family respite/peer support respite; 4.04 flexible/combo respite; and 4.05 other respite. See AIHW (2008) for more information on service types 4.01–4.05.

14.8 Attachment tables

Attachment tables are identified in references throughout this chapter by an '14A' suffix (for example, table 14A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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15 Protection and support services

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Attachment tables

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Protection and support services aim to assist individuals and families who are in crisis or experiencing difficulties that hinder personal or family functioning. These services assist by alleviating the difficulties and reducing the potential for their recurrence.

This chapter reports on:

- *child protection services*: the functions of government that receive and assess allegations of child abuse and neglect, and/or harm to children and young people, provide and refer clients to family support and other relevant services, and intervene to protect children
- *out-of-home care services*: care for children placed away from their parents for protective or other family welfare reasons
- *juvenile justice services*: services that aim to promote community safety and reduce youth offending by assisting young people to address their offending behaviour
- *supported accommodation and assistance services*: services to assist young people, adults and families who are homeless or at imminent risk of becoming homeless.

Several improvements to the chapter have been made this year including:

- two new 'response time' indicators of the effectiveness of child protection services are now reported
- seven jurisdictions are now reporting indicative unit costs (program dollars per placement day) for out-of-home care services
- a national performance indicator framework for juvenile justice services is reported for the first time and the juvenile justice section has been redeveloped.

A number of government agencies are responsible for the provision of protection and support services. A matrix listing the State or Territory department responsible for funding and/or administering child protection and out-of-home care services, juvenile justice and supported accommodation and assistance services is provided (table 15.1).

Table 15.1 Department responsible for funding and/or administering protection and support services, 2007-08

<i>State</i>	<i>Child protection and out-of-home care services</i>	<i>Juvenile justice services</i>	<i>Supported Accommodation and Assistance Services</i>
Aust			Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)
NSW	Department of Community Services (DOCS)	Department of Juvenile Justice (DJJ)	Department of Community Services (DOCS)
Vic	Department of Human Services (DHS)	Department of Human Services (DHS)	Department of Human Services (DHS)
Qld	Department of Child Safety (DCS)	Department of Communities (DOC)	Department of Communities (DOC)
WA	Department for Child Protection (DCP)	Department of Corrective Services (DCS)	Department for Child Protection (DCP)
SA	Department for Families and Communities (DFC)	Department for Families and Communities (DFC)	Department for Families and Communities (DFC)
Tas	Department of Health and Human Services (DHHS)	Department of Health and Human Services (DHHS)	Department of Health and Human Services (DHHS)
ACT	Department of Disability, Housing and Community Services (DDHCS)	Department of Disability, Housing and Community Services (DDHCS)	Department of Disability, Housing and Community Services (DDHCS)
NT	Department of Health and Community Services (DHCS)	Department of Justice (DOJ)	Department of Health and Community Services (DHCS)

15.1 Profile of child protection and out-of-home care services

Service overview

Child protection services

Child protection services are provided to protect children and/or young people aged 0–17 years who are at risk of harm within their families, or whose families do not have the capacity to protect them. These services include:

- receiving and responding to reports of concern about children or young people, including investigation and assessment where appropriate
- providing support services (directly or through referral), where harm or a risk of significant harm is identified, to strengthen the capacity of families to care safely for children
- initiating intervention where necessary, including applying for a care and protection order through a court and, in some situations, placing children or young people in out-of-home care to secure their safety
- ensuring the ongoing safety of children and young people by working with families to resolve protective concerns
- working with families to reunite children (who were removed for safety reasons) with their parents as soon as possible (in some jurisdictions, restoration may occur in voluntary placements as well)
- securing permanent out-of-home/alternative care when it is determined that a child is unable to be returned to the care of his or her parents, and working with young people to identify alternative supported living arrangements where family reunification is not possible.

Research suggests that children and families who come into contact with the protection and support services system often share common social and demographic characteristics. Families with low incomes or that are reliant on pensions and benefits, those that experience alcohol and substance abuse, or a psychiatric disability, and those that have a family history of domestic violence are over-represented in the families that came into contact with the protection and support services system (Department of Human Services 2002).

Child protection concerns and Indigenous communities

Studies have highlighted the high incidence of child abuse and neglect within some Indigenous communities, compared with non-Indigenous communities. Indigenous families across Australia have been found to experience high levels of violence, compared with non-Indigenous families (AIHW 2006a). ‘Little Children are Sacred’, the final report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse (2007), identified child sexual abuse as a significant issue for many of the remote NT Aboriginal communities consulted as part of the Inquiry. The final report of the WA Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities (Gordon Report 2002), also found high levels of violence and child abuse within Aboriginal communities in WA.

Out-of-home care services

Out-of-home care services provide care for children and young people aged 0–17 years who are placed away from their parents or family home for reasons of safety or family crisis. These reasons include abuse, neglect or harm, illness of a parent and the inability of parents to provide adequate care. The placements may be voluntary or made in conjunction with care and protection orders.

Out-of-home care services are either home-based care (for example, foster care, care with the child’s extended family or other home-based arrangements), facility-based care (for example, community residential care) or independent living (which is often intensively supported) as a transition to full independence or supported placements. Across jurisdictions, there has been a shift away from the use of facility-based (or residential) care towards foster care and other forms of home-based care, including relative/kinship care.

Intensive family support services are increasingly perceived as an alternative to the removal of the child from his or her home for child protection reasons (box 15.1).

Box 15.1 Intensive family support services

Intensive family support services are specialist services, established in each jurisdiction, that aim to:

- prevent the imminent separation of children from their primary caregivers as a result of child protection concerns
- reunify families where separation has already occurred.

Intensive family support services differ from other types of child protection and family support services referred to in this chapter, in that they:

- are funded or established explicitly to prevent the separation of, or to reunify, families
- provide a range of services as part of an integrated strategy focusing on improving family functioning and skills, rather than providing a single type of service
- are intensive in nature, averaging at least four hours of service provision per week for a specified short term period (usually less than six months)
- generally receive referrals from a child protection service.

Intensive family support services may use some or all of the following strategies: assessment and case planning; parent education and skill development; individual and family counselling; anger management; respite and emergency care; practical and financial support; mediation, brokerage and referral services; and training in problem solving.

Expenditure on intensive family support services

Recurrent expenditure on intensive family support services across all jurisdictions was \$179.2 million in 2007-08. This expenditure has increased in real terms each year from \$95.9 million in 2003-04 (table 15A.26). This represents an average annual increase in expenditure of 16.9 per cent over this four year period. Tables 15A.26–29 provide additional information about families and children who were involved with intensive family support services, including the cost of providing these services per child commencing intensive family support services.

Child protection treatment and support services

A complementary suite of services not currently included in this Report, but intended for inclusion in future Reports, are known as child protection treatment and support services. These are targeted to at-risk families where there are concerns about the safety and wellbeing of children. They may be less intensive in nature and include services that strengthen family relationships in response to concerns about the welfare of a child and may focus on either early intervention or reunification support.

(Continued on next page)

Box 15.1 (Continued)

Child protection treatment and support services provide educational services, clinical services including counselling, group work and other therapeutic interventions, and domestic violence services, where the child is the direct recipient of the service and s/he is, has, or is likely to become, a client of child protection.

The Australian Institute of Health and Welfare (AIHW), with the support of the States and Territories, is studying the feasibility of a national data collection for child protection treatment and support services.

Source: AIHW (unpublished).

Roles and responsibilities

State and Territory governments fund child protection, out-of-home care, family support (including intensive family support) and other relevant services (see box 15.2 for responsible State/Territory departments during 2007-08). These services may be delivered by the government or the non-government sector. State and Territory departments responsible for child protection are responsible for investigating and assessing reports to the department, providing, or referring families to, support services, and intervening where necessary (including making court applications when an order is required to protect a child, and placing children in out-of-home care).

Box 15.2 Child protection and out-of-home care services

<i>NSW</i>	Department of Community Services (DOCS)
<i>VIC</i>	Department of Human Services (DHS)
<i>QLD</i>	Department of Child Safety (DCS)
<i>WA</i>	Department for Child Protection (DCP)
<i>SA</i>	Department for Families and Communities (DFC)
<i>TAS</i>	Department of Health and Human Services (DHHS)
<i>ACT</i>	Department of Disability, Housing and Community Services (DDHCS)
<i>NT</i>	Department of Health and Community Services (DHCS)

Other areas of government also have roles in child protection and provide services for children who have come into contact with relevant departments for protective reasons. These include:

- police services, which investigate serious allegations of child abuse and neglect, particularly criminal matters, and may also work on child protection assessments with State and Territory departments responsible for child protection
- courts, which decide whether a child will be placed on an order
- education and child care services, which provide services for these children and also conduct mandatory reporting and protective behaviours education in some jurisdictions
- health services, which support the assessment of child protection matters and deliver therapeutic, counselling and other services.

A range of appointments, schemes and charters have been introduced by jurisdictions in recent years, to enable additional protection for clients of the child protection system. Examples of these are listed in box 15.3.

Box 15.3 Initiatives 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 the Commissioner's role is to monitor the quality of out-of-home care services. A charter of rights for children in care was launched on 28 November 2007. |
| <i>QLD</i> | The Commission for Children and Young People and Child Guardian has a range of legislated functions designed to oversee children's wellbeing in the child protection system. One of these enables Community Visitors to regularly visit children in out-of-home care to independently assess their safety and wellbeing. The DCS has a complaints management system so that clients, family members, advocates and members of the Queensland public can raise enquiries, concerns, or complaints about their contact and interactions with the Department. |

(Continued on next page)

Box 15.3 (Continued)

WA The Advocate for Children in Care provides advocacy and complaints management services for children and young people in care. The Department's general Consumer Advocacy Service has been redesignated as a Complaints Management Unit from January 2008 and is available to all customers.

Formal monitoring of protection and care service standards by a Standards Monitoring Unit began on 1 July 2007. Seventeen Districts are monitored on a two-year cycle and the monitoring regime will be extended across all care providers in due course.

SA The Office of the Guardian monitors and assesses care, advocates for, and advises on, the circumstances and needs of children and systemic issues affecting the quality of out-of-home care.

TAS The Commissioner for Children's functions include promoting the rights and wellbeing of children, examining the policies, practices and services provided for children and any laws affecting the health, welfare, care, protection and development of children.

ACT The ACT Public Advocate's functions include monitoring the provision of services, and protecting and advocating for the rights of children and young people. Systemic issues are referred by the Public Advocate to the Commissioner for Children and Young People, appointed in 2007. The Commissioner consults and listens to the views of children and young people and promotes their participation in decision making. In addition, the Commissioner investigates and seeks to resolve complaints involving children and young people. The Official Visitor's role is to visit and inspect places of care, of detention or therapeutic protection, and receive and inquire about complaints made concerning the care provided to children and young people at these locations.

NT A review of the *NT Community Welfare Act* has resulted in the development of a new *Care and Protection of Children Act* — which was introduced in late 2007. The Act includes provisions for a Children's Commissioner and a child death review committee.

Source: State and Territory governments (unpublished).

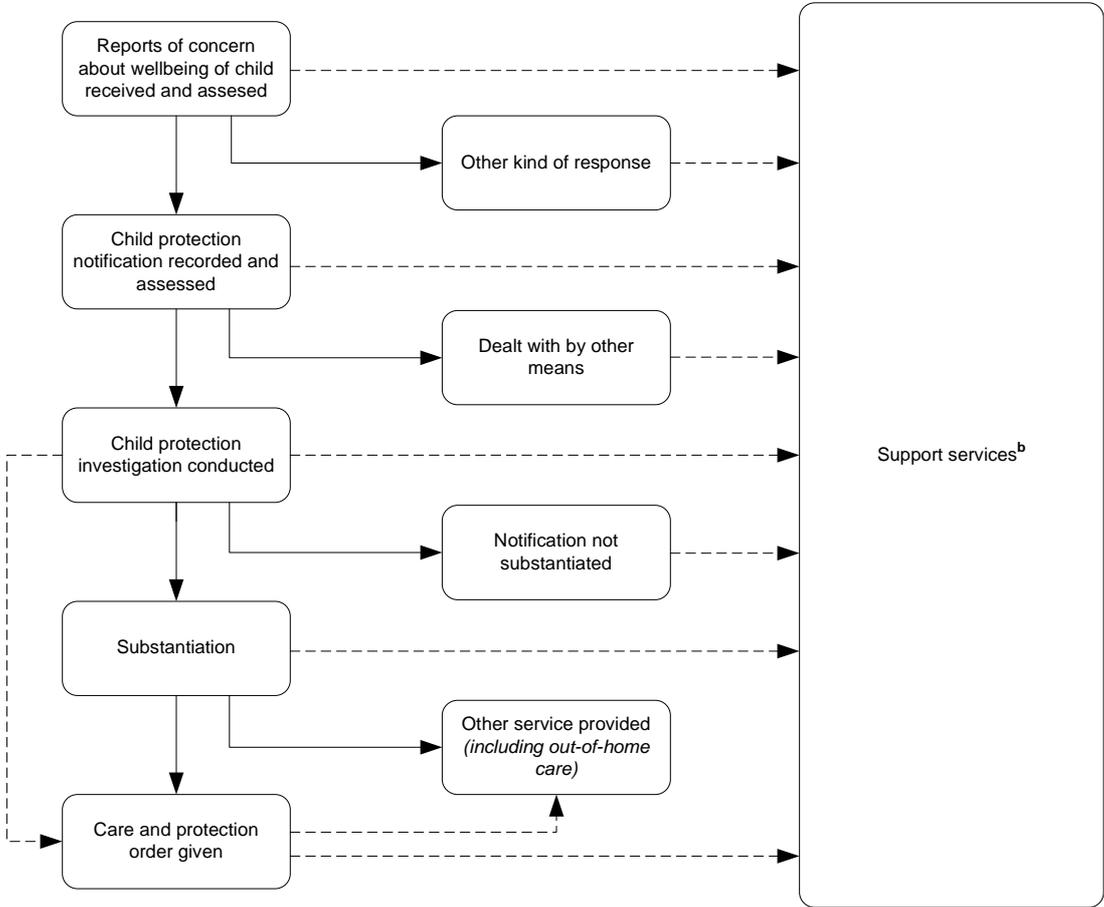
Size and scope

The child protection system

Child protection legislation, policies and practices vary across jurisdictions, but the broad processes in child protection systems are similar (figure 15.1).

State and Territory departments with responsibility for child protection are advised of concerns about the wellbeing of children through reports to these departments. Reports may be made by people mandated to report or by other members of the community. Individuals and organisations mandated to report vary across the states and territories, and may include medical practitioners, police services, school teachers and principals. These reports are assessed and classified as child protection notifications, child concern reports, or matters requiring some other kind of response. The most common sources of notification for finalised investigations in 2007-08 were police, school personnel, hospitals and other sources (AIHW 2009).

Figure 15.1 The child protection system^a



^a Dashed lines indicate that clients may or may not receive these services, depending on need. ^b Support services include family support or family preservation services provided by departments responsible for child protection and referrals to other agencies.

Notification

Jurisdictions count notifications at different points in the response to a report, ranging from the point of initial contact with the source of the report to the end of a

screening and decision making process. This means the number of notifications is not strictly comparable across jurisdictions.¹

All jurisdictions except Tasmania and the ACT screen incoming reports before deciding whether they will be counted as a notification, thus reducing the proportion of reports that become notifications.

In all jurisdictions, notifications are investigated, based on the policies and practices in that jurisdiction. Once it has been decided that an investigation is required, the investigation process is similar across jurisdictions. The department responsible for child protection may obtain further information about the child and his or her family by checking information systems for any previous history, undertaking discussion/case planning with agencies and individuals, interviewing/sighting the child and/or interviewing the caregivers/parents. At a minimum, the child is sighted whenever practicable, and the child's circumstances and needs are assessed. This investigation process determines whether the notification is substantiated or not substantiated (figure 15.1).

Nationally, 192 804 children aged 0–16 years were the subject of child protection notifications in 2007-08. The rate of notifications per 1000 children in the population aged 0–16 years was 41.3 in 2007-08 (table 15A.8). The total number of notifications for each jurisdiction for 2007-08 (including cases where a child is the subject of more than one child protection notification) by Indigenous status of the child is reported in table 15A.5.

Data on the number of notifications are collected early in the child protection process and often before the agency has full knowledge of the child's family circumstances. This lack of information and the inherent difficulties in identifying Indigenous status mean that data on the number of notifications by Indigenous status need to be interpreted with care.

Substantiation

The criteria for substantiation vary across jurisdictions. In the past, child protection legislation and policy focused on the identification and investigation of narrowly defined incidents that were broadly grouped as types of abuse or neglect. Across all jurisdictions, the focus is now shifting away from the actions of parents and

¹ Child protection services, care and protection orders and out-of-home care relate to children aged 0–17 years. However, rates of children subject to notifications, investigations and substantiations, are calculated for children aged 0–16 years, given differences in jurisdictions' legislation, policies and practices regarding children aged 17 years. Rates of children on care and protection orders and in out-of-home care are calculated for children aged 0–17 years.

guardians, toward the desired outcomes for the child, the identification and investigation of actual and/or likely harm to the child, and the child's needs.

If an investigation results in substantiation, intervention by the relevant department may be needed to protect the child. This intervention can take a number of forms, including one or more of: referral to other services; supervision and support; an application to court; and a placement in out-of-home care.

Nationally, 31 915 children aged 0–16 years were the subject of a substantiation in 2007-08. The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–16 years was 6.8 (table 15A.8). The number and rate of children aged 0–16 years who were the subject of a substantiation has increased since 2003-04. Nationally, 23 862 children were the subject of a substantiation in 2003-04. This represented a rate of 5.3 per 1000 children in the population aged 0–16 years (SCRGSP 2005, based on revised population data for children aged 0–16 years).

Nationally, 7313 Indigenous and 24 602 non-Indigenous children were the subject of a substantiation in 2007-08. The rate of children who were the subject of a substantiation per 1000 children in the target population aged 0–16 years was 35.3 for Indigenous children and 5.5 for non-Indigenous children (table 15A.8).

Care and protection orders

Although child protection substantiations are often resolved without the need for a court order (which is usually a last resort), recourse to the court may take place at any point in the child protection investigation process. The types of order available vary across jurisdictions and may include guardianship or custody orders, supervisory orders, and interim and temporary orders.

Nationally, 34 279 children aged 0–17 years were on care and protection orders at 30 June 2008. The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 6.9 (table 15A.8). The number and rate of children aged 0–17 years who were the subject of a care and protection order has increased since 2003-04. At 30 June 2004, 14 627 children were the subject of a care and protection order, which represented a rate of 4.6 per 1000 children in the population aged 0–17 years (SCRGSP 2005).

Nationally, 9011 Indigenous and 25 268 non-Indigenous children were on care and protection orders at 30 June 2008. The rate of children on care and protection orders per 1000 children in the target population aged 0–17 years was 41.0 for Indigenous children and 5.3 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, 2007-08. Table 15A.7 identifies the number of children on care and protection orders by type of order and Indigenous status at 30 June 2008.

Out-of-home care

Out-of-home care is one of a range of services provided to families and children where there is a need to provide safe care for a child. The services are intended to place a child in out-of-home care only if this will improve the outcome for the child and only when it is not possible to maintain the child within their family. If it is necessary to remove the child from his or her home, then placement with the wider family or community is sought where possible, particularly in the case of Indigenous children (AIHW 2006b). Continued emphasis is placed on improving case planning and case management processes to facilitate the safe return home of children in out-of-home care and to maximise case workers' contact time with children and families.

Nationally, 31 166 children were in out-of-home care at 30 June 2008. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 6.3 (table 15A.16). The number and rate of children aged 0–17 years in out-of-home care has increased since 2003-04. At 30 June 2004, 21 795 children were in out-of-home care. This represented a rate of 4.5 per 1000 children in the population aged 0–17 years (SCRGSP 2005).

Nationally, 9070 Indigenous children and 22 096 non-Indigenous children were in out-of-home care at 30 June 2008. The rate of children in out-of-home care per 1000 children in the target population aged 0–17 years was 41.3 for Indigenous children and 4.6 for non-Indigenous children (table 15A.16).

Further information on children in out-of-home care is included in the attachment tables to this Report. Table 15A.17 identifies the number of children in out-of-home care by Indigenous status and placement type at 30 June 2008. Table 15A.18 identifies the number of children in out-of-home care by Indigenous status and whether they were on a care and protection order at 30 June 2008. Table 15A.19 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 2008. Table 15A.20 identifies the number of children who exited care during 2007-08, by Indigenous status and length of time spent in care.

Funding

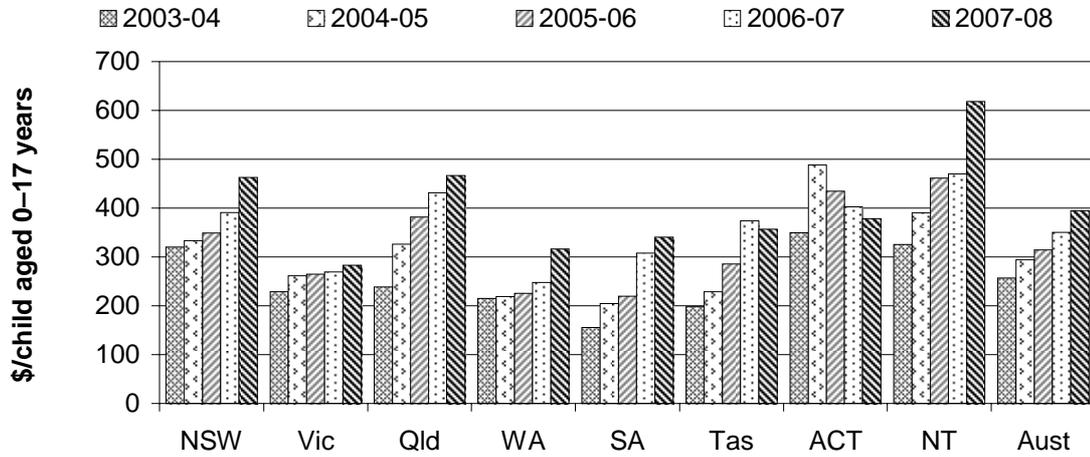
Recurrent expenditure on child protection and out-of-home care services was approximately \$2.0 billion across Australia in 2007-08 — a real increase of \$235.3 million (13.6 per cent) from 2006-07. Of this expenditure, out-of-home care services accounted for the majority (64.0 per cent, or \$1.3 billion). Nationally, annual real expenditure on child protection and out-of-home care services has increased by \$730.3 million from \$1.2 billion since 2003-04, an average annual increase over the four year period of 12.3 per cent (table 15A.1).

In 2007-08, real recurrent expenditure per child aged 0–17 years in child protection and out-of-home care services was \$395 nationally (figure 15.2). Real recurrent expenditure per child aged 0–17 years increased in all jurisdictions between 2003-04 and 2007-08 and has increased nationally each year since 2003-04. In 2003-04 the real recurrent expenditure per child aged 0–17 years was \$257 (table 15A.1). This represents an average annual increase over the four year period of 11.3 per cent.

It is an objective of the Review to report comparable estimates of costs. Ideally, the full range of costs to government would be determined on a comparable basis across jurisdictions. Where full costs cannot be counted, costs should be estimated on a consistent basis across jurisdictions. However, in the area of child protection, there are differences across jurisdictions in the calculation of expenditure.

Table 15A.4 identifies the level of consistency across jurisdictions for a number of expenditure items. The scope of child protection systems also varies across jurisdictions, and expenditure on some services may be included for some jurisdictions, but not for others.

Figure 15.2 Real recurrent expenditure on child protection and out-of-home care services per child (2007-08 dollars)^a



^a Refer to table 15A.1 for detailed jurisdiction-specific footnotes on expenditure data and table 15.A4 for information on the comparability of expenditure data.

Source: State and Territory governments (unpublished); table 15A.1.

15.2 Framework of performance indicators for child protection and out-of-home care services

The framework of performance indicators for child protection and out-of-home care services is based on shared government objectives (box 15.4).

Box 15.4 Objectives for child protection and out-of-home care services

The aims of child protection services are to:

- protect children and young people 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.

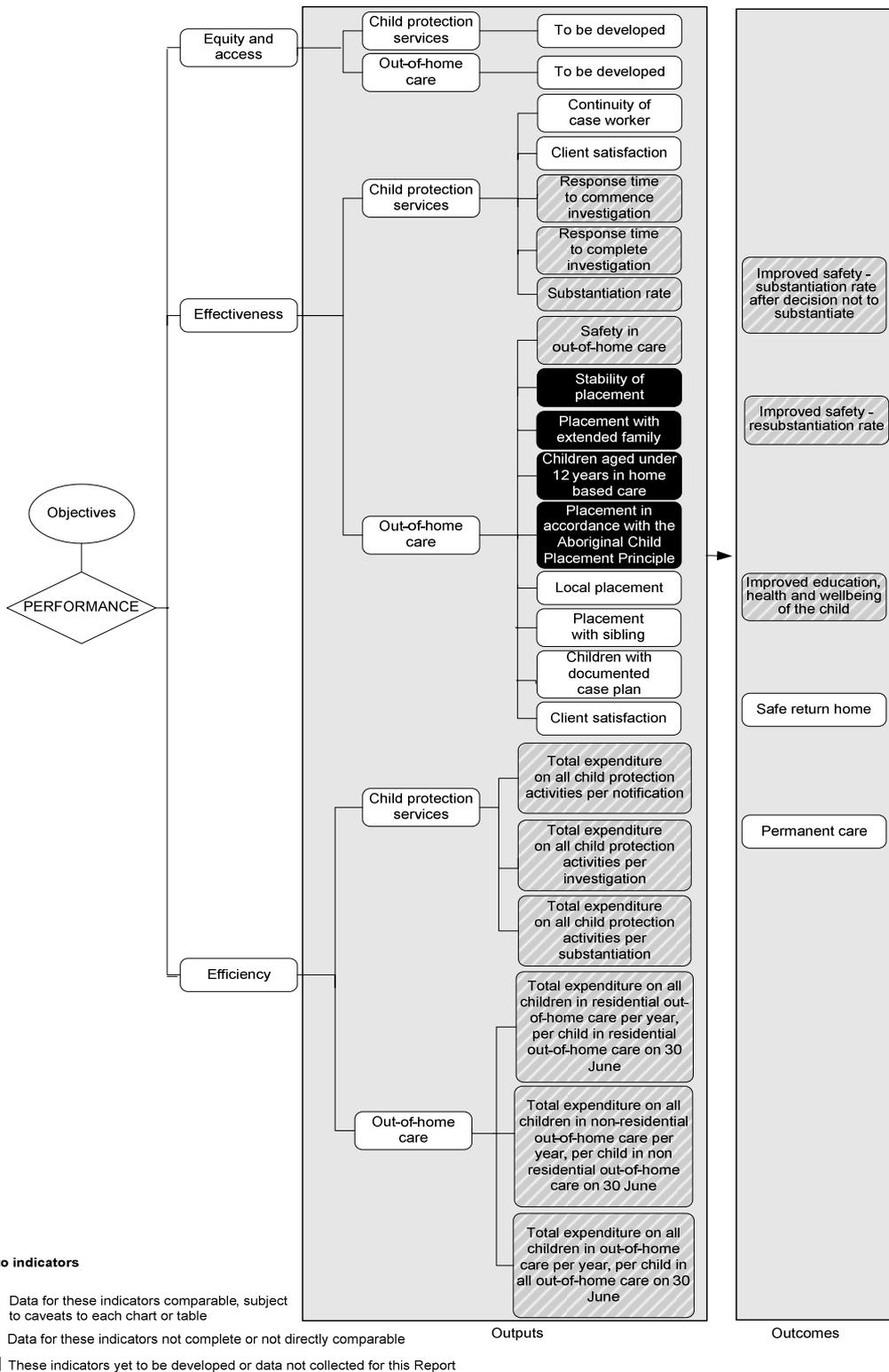
Child protection and out-of-home care services should be provided in an efficient and effective manner.

The performance indicator framework shows which data are comparable in the 2009 Report (figure 15.3). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

15.3 Key child protection and out-of-home care services performance indicator results

Different delivery contexts, locations and types of client may affect the equity/access, effectiveness and efficiency of child protection services. Appendix A contains detailed statistics that may assist in interpreting the performance indicators.

Figure 15.3 Performance indicators for child protection and out-of-home care services



Outputs

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

Equity and access

Equity and access indicators are indicators of governments' objective to ensure that all clients have fair and equitable access to services on the basis of relative need and available resources (box 15.5).

Box 15.5 Access to child protection and out-of-home care services by equity groups

'Access to child protection and out-of-home care services by equity groups' are yet to be defined.

These indicators have been identified for development in future reports.

Effectiveness

Child protection services — continuity of case worker

'Continuity of case worker' is an indicator of governments' objective to ensure child protection services are delivered in an effective manner (box 15.6).

Box 15.6 Continuity of case worker

'Continuity of case worker' is yet to be defined.

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.

Child protection services — client satisfaction

'Client satisfaction' is an indicator of governments' objective to provide high quality services that meet the needs of recipients (box 15.7).

Box 15.7 Client satisfaction

'Client satisfaction' is yet to be defined.

This indicator has been identified for development and reporting in future.

Box 15.8 provides examples of steps taken in seven jurisdictions to monitor, assess and promote client satisfaction in relation to child protection and out-of-home care.

Box 15.8 Developments in client satisfaction

NSW A large scale evaluation is being undertaken of the Brighter Futures early intervention program, which targets vulnerable families with children under 9 years of age. As part of the evaluation, a sample of 168 families participated in a survey assessing satisfaction with the services provided. In summary, 92 per cent stated that they were satisfied or completely satisfied with case management; nearly all (97 per cent) stated that they were satisfied or completely satisfied with home visits. More than half (59 per cent) stated that they were satisfied with the child care service (with 35 per cent stating that it was not applicable); and nearly half (48 per cent) stated that they were satisfied with parenting programs (with 46 per cent stating that it was not applicable).

VIC A survey of child protection clients and families was undertaken in 2001 on their experience of child protection. The survey findings identified areas for practice improvement and a range of strengths in child protection practice, including that in the majority of cases, child protection intervention improved the safety and life circumstances of young people. A further survey of clients is anticipated in 2009 based on the Victorian Outcomes Framework. Client feedback is also routinely sought by Community Services Organisations as part of meeting Victorian out-of-home care service registration standards.

Qld The views of children in care are regularly sought through surveys undertaken by the Commission for Children and Young People and Child Guardian. The surveys inform systems monitoring indicators and contribute to policy and practice development. In addition the Department continues to support the 'Be Heard' programs, delivered through the CREATE Foundation. These programs gather information from children and young people in care at a local level and provide feedback and training to the relevant child safety service centre. This includes recommendations to staff about how they can overcome barriers and address issues that have been raised by children and young people.

(Continued on next page)

Box 15.8 (Continued)

- WA** The Department for Child Protection undertook an on-line survey of foster carers in early 2008 and is responding to the feedback obtained from this important stakeholder group. The Department introduced new complaints policy and procedures in March 2008. Formal monitoring of service standards has continued and all districts will have been assessed by June 2009. A pilot standards monitoring regime for residential and non-government placement services will be completed by June 2009. Western Australia's first Commissioner for Children and Young People was appointed in December 2007. The Commissioner has legislative powers to consult, investigate, research, advise and report independently to the Parliament about issues that concern children and young people and those supporting them.
- TAS** Tasmania has engaged the CREATE Foundation to consult with between 160 and 200 children and young people as part of the Be Heard project. The consultations will explore the circumstances of children and young people in care and their views on key matters including the degree of satisfaction with contact with family members, reactions to changes in placement, satisfaction with current placement, and involvement in case and care planning. Tasmania has also established a system of investigating and responding to complaints relating to child protection services and out-of-home care as well as developing structured processes to address identified issues.
- ACT** CREATE released a report in July 2004 based on qualitative interviews of children and young people in out-of-home care in the ACT. This report recommended the development of a charter of rights for children and young people in care in the ACT. The Government will develop a charter in consultation with children and young people.
- NT** A participation survey of children and young people in care was funded in 2005 and an evaluation of case work attitudes was also undertaken. As a result, out-of-home care core training for staff has been restructured to incorporate the participation of young people in care planning.

Source: State and Territory governments (unpublished).

Child protection services — response time to commence investigation

'Response time to commence investigation' is an indicator of 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 (box 15.9).

Box 15.9 Response time to commence investigation

'Response time to commence investigation' is defined as the length of time (measured in days) between a child protection notification being received by a statutory department and the department commencing an investigation.

The length of time between notification and the commencement of an investigation by the department indicates the promptness of the department in effectively responding to child protection concerns.

It should be noted that an assessment of a notification takes place at the time that the notification has been received.

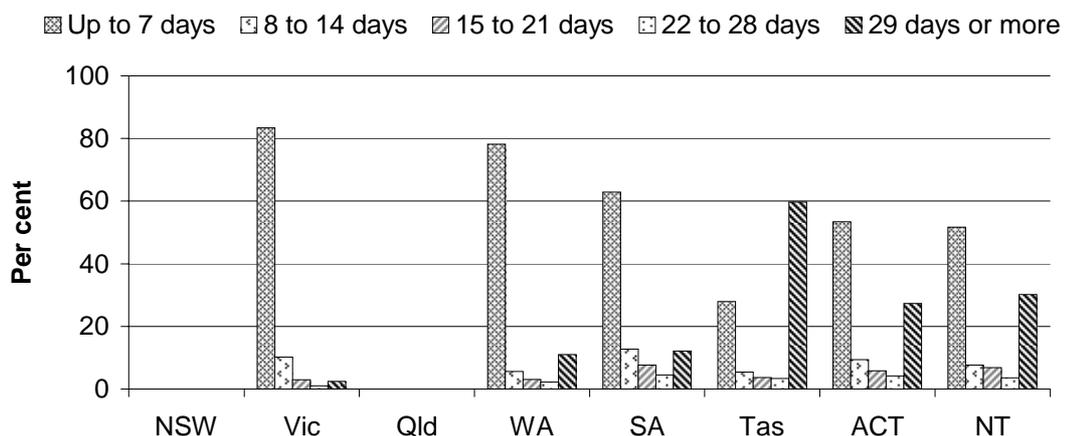
This indicator needs to be interpreted with care as jurisdictions count notifications at different stages in response to a report, and most states and territories have policy or legislation outlining the time recommended for investigations to be commenced, based on the seriousness of the child protection concern.

A shorter response time to commence an investigation is desirable.

Data reported for this indicator are not complete.

For most jurisdictions, the majority of investigations were commenced within seven days of notification in 2007-08 (figure 15.4).

Figure 15.4 Proportion of investigations commenced, by time taken to commence investigation (2007-08)^{a, b}



^a Caution should be used when interpreting results as jurisdictions count notifications at different points in response to a report, and have different policies and protocols governing the type of response to a notification.

^b Data for NSW and Queensland were not available.

Source: AIHW data collection (unpublished); table 15A.14.

Child protection services — response time to complete investigation

‘Response time to complete investigation’ is an indicator of governments’ objective to minimise the risk of harm to the child by responding to notifications of possible child protection incidents and completing investigations in a timely manner (box 15.10).

Box 15.10 Response time to complete investigation

‘Response time to complete investigation’ is defined as the length of time (measured in days) between the date a child protection notification is received by a statutory department and the date when an investigation outcome is recorded by the department (a determination is made regarding whether to substantiate the notification or not).

The length of time between the point of notification and the completion of an investigation indicates the effectiveness of the department in conducting investigations in a timely manner.

It should be noted that an assessment of a notification takes place at the time that the notification has been received.

This indicator needs to be interpreted with care as jurisdictions count notifications at different points in response to a report, and most states and territories have policy or legislation outlining the time recommended for investigations to be commenced, based on the seriousness of the child protection concern. Furthermore, while investigations should be conducted in a timely manner, it is important that expediency does not undermine a thorough and accurate assessment of the case. In addition, a number of factors outside the control of a department may affect the timeliness of investigations, including involvement by external parties (for example, police, schools), and the inability to locate the child and/or family.

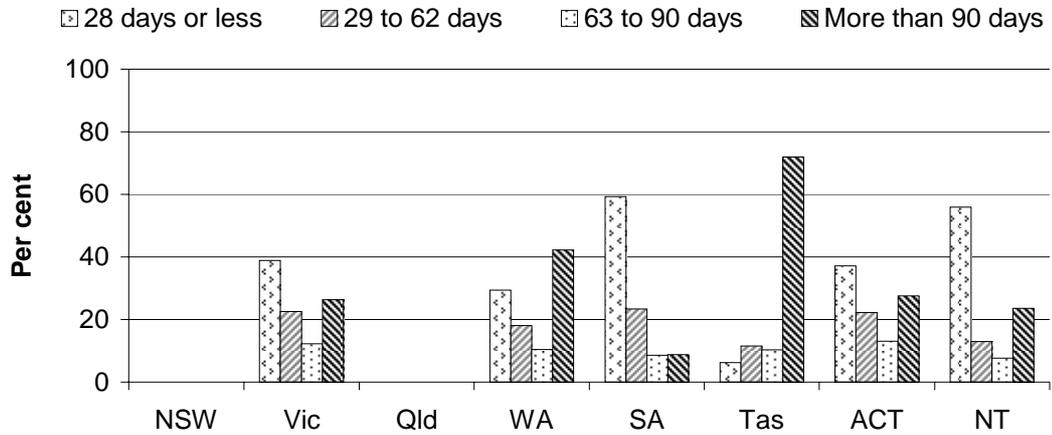
A shorter response time to complete an investigation is desirable.

Data reported for this indicator are not complete.

Investigation is the process whereby the relevant department obtains more detailed information about a child who is the subject of a notification received (for the 2009 Report this is between 1 July 2007 and 30 June 2008), and makes an assessment about the harm or degree of harm to the child, and his or her protective needs. An investigation includes the sighting or interviewing of the subject child where it is practical to do so.

The response time to complete investigation varied across jurisdictions in 2007-08, with the majority of investigations completed in either less than 28 days or more than 90 days (figure 15.5).

Figure 15.5 Proportion of investigations finalised, by time taken to complete investigation (2007-08)^{a, b}



^a Caution should be used when interpreting results as jurisdictions count notifications at different points in response to a report, and have different policies and protocols governing the type of response to a notification.

^b Data for NSW and Queensland were not available.

Source: AIHW data collection (unpublished); table 15A.15.

Child protection services — substantiation rate

‘Substantiation rate’ is an indicator of governments’ objective to target investigations to those notifications where a substantive child abuse/neglect incident has occurred (box 15.11).

Box 15.11 Substantiation rate

The 'substantiation rate' is defined as the proportion of finalised investigations where harm or risk of harm was substantiated.

The 'substantiation rate' provides an indication of the extent to which government has avoided the human and financial costs of an investigation where no harm has occurred.

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.

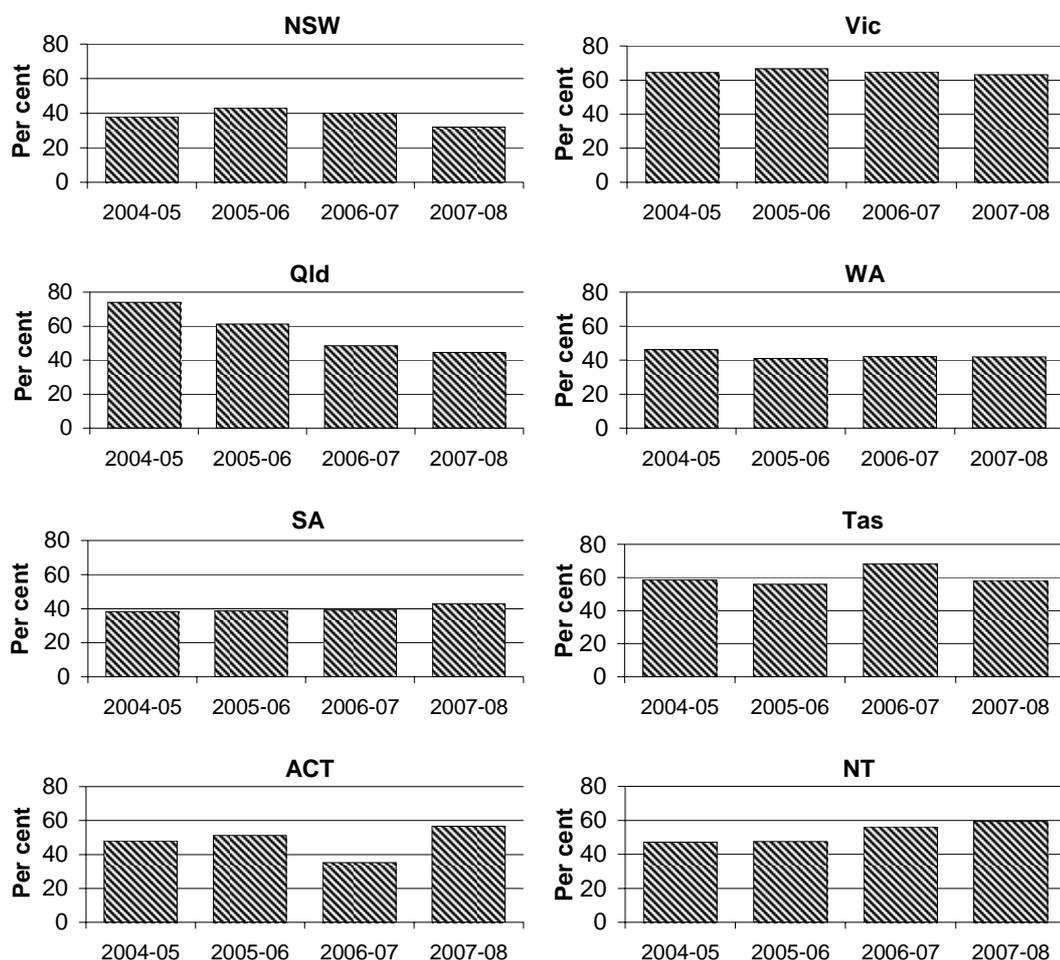
Finalised investigations that were substantiated may fluctuate because of policy, funding and practice change, such as better targeting of investigative resources, the impact of mandatory reporting or other factors such as increased community awareness and willingness to notify suspected instances of child abuse, neglect or harm.

Data reported for this indicator are not directly comparable.

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 15.6).

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 15.6 Proportion of finalised child protection investigations that were substantiated^{a, b}



^a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates should not be compared across jurisdictions. ^b Refer to footnotes in the source tables for information about what each jurisdiction's data include.

Source: AIHW (unpublished), derived from *Child protection notifications, investigations and substantiations, Australia* data collection; tables 15A.39, 15A.56, 15A.73, 15A.90, 15A.107, 15A.124, 15A.141 and 15A.158.

Out-of-home care — safety in out-of-home care

‘Safety in out-of-home care’ is an indicator of governments’ objective to provide children who are under the care of the State with a safe home environment (box 15.12).

Box 15.12 Safety in out-of-home care

‘Safety in out-of-home care’ 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.

The indicator reflects the safety of clients in care situations.

A low proportion of substantiations is desirable.

Data reported for this indicator are not complete.

Two jurisdictions (WA and ACT) provided 2007-08 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. These data are reported in table 15A.25.

Out-of-home care — stability of placement

‘Stability of placement’ is an indicator of governments’ objective to provide high quality services that meet the needs of recipients on the basis of relative need and available resources (box 15.13).

Box 15.13 Stability of placement

‘Stability of placement’ is defined as the proportion of children who had 1 or 2 placements during a period of continuous out-of-home care.

A low number of child placements (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 15.13 (Continued)

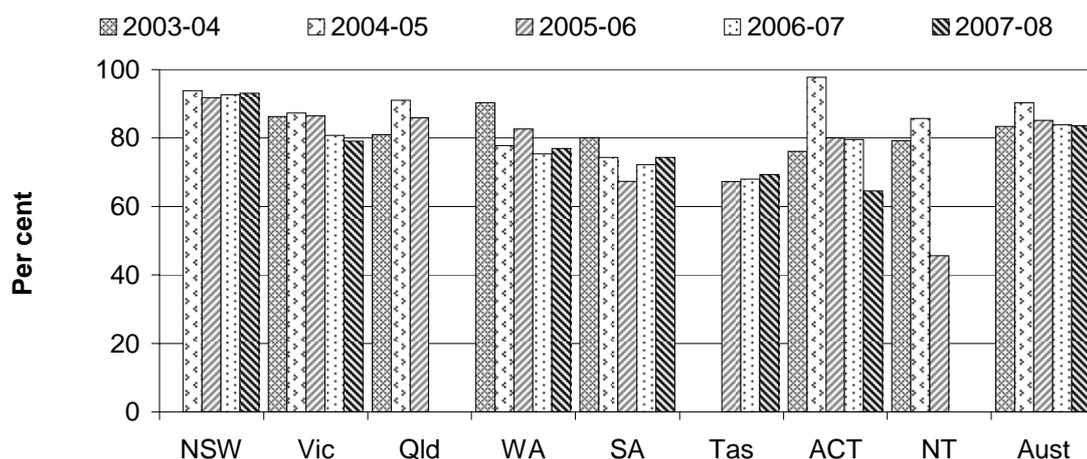
Data are collected only for children who are on orders and who exit care during the reporting period. There are limitations to counting placement stability using an exit cohort rather than entry cohort longitudinal data, because the sample is biased to children from recent entry cohorts with relatively short stays in care, and these children are likely to have experienced fewer placements.

Data reported for this indicator are comparable.

For children placed away from their family for protective reasons, stability of placement is an important indicator of service quality, particularly for those children who require long term placements. Data are collected on the number of different placements for children on a care and protection order who exited out-of-home care in 2007-08. Data are grouped according to the length of time in care (less than 12 months and 12 months or more).

Nationally, 83.6 per cent of the children on a care and protection order who exited care after less than 12 months in 2007-08 experienced only one or two placements. This proportion varied across jurisdictions (figure 15.7).

Figure 15.7 Proportion of children on a care and protection order exiting care after less than 12 months, who had 1 or 2 placements^{a, b, c, d, e, f, g}

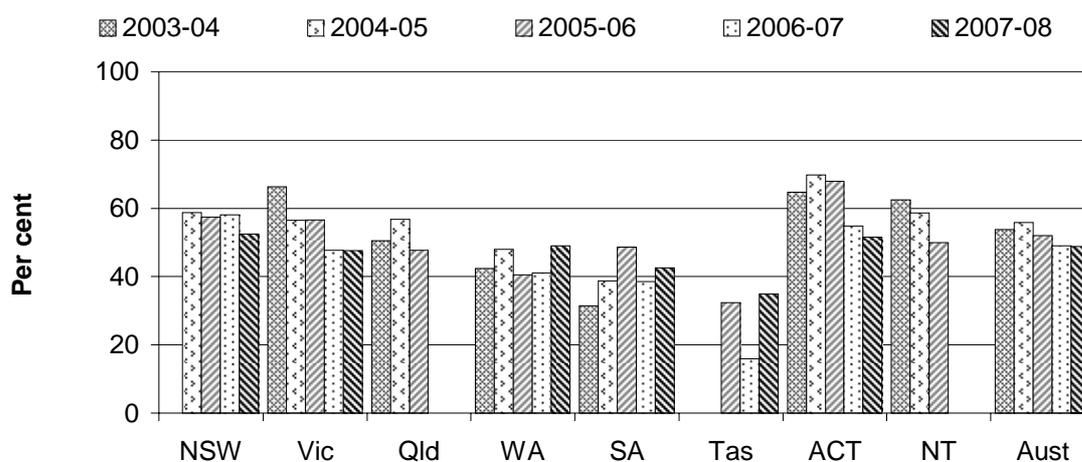


^a Data refer to children exiting care during the relevant financial year. ^b Refer to footnotes in the source tables for information about what each jurisdiction's data include. ^c NSW was unable to provide data for 2003-04 due to the introduction of a new client information system. ^d During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 onwards may not be fully comparable to previous years' data. ^e Queensland and NT data for 2006-07 and 2007-08 are not available. ^f Data for Tasmania were not available prior to 2005-06. ^g The apparent decline in the proportion for the ACT is impacted by the small number of children involved and the placement of large sibling groups.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* collection; table 15A.24.

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 2007-08 after 12 months or more who had experienced one or two placements was 48.8 per cent nationally but varied across jurisdictions (figure 15.8).

Figure 15.8 Proportion of children on a care and protection order exiting care after 12 months or more, who had 1 or 2 placements^{a, b, c, d, e, f, g}



^a Data refer to children exiting care during the relevant financial year. ^b Refer to footnotes in the source table for information about what each jurisdiction's data include. ^c NSW was unable to provide data for 2003-04 due to the introduction of a new client information system. ^d During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 onwards may not be fully comparable to previous years' data. ^e Queensland data for 2006-07 and 2007-08 are not available. ^f Data for Tasmania were not available prior to 2005-06. ^g NT data for 2006-07 and 2007-08 were not available.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* data collection; table 15A.24.

Out-of-home care — placement with extended family

'Placement with extended family' is an indicator of governments' objective to provide services that meet the needs of the recipients on the basis of relative need and available resources (box 15.14).

Box 15.14 Placement with extended family

'Placement with extended family' is defined as the proportion of all children in out-of-home care who are placed with relatives or kin who receive government financial assistance to care for that child.

A reasonably high rate for this indicator is considered desirable.

'Placement with extended family' needs to be considered with other factors in the placement decision.

Placing children with their relatives or kin is generally the preferred out-of-home care placement option. This option is generally associated with better long term outcomes due to increased continuity, familiarity and stability for the child. Relatives are more likely to have or form long term emotional bonds with the child. Placement with familiar people can help to overcome the loss of attachment and belonging that can occur when children are placed in out-of-home care.

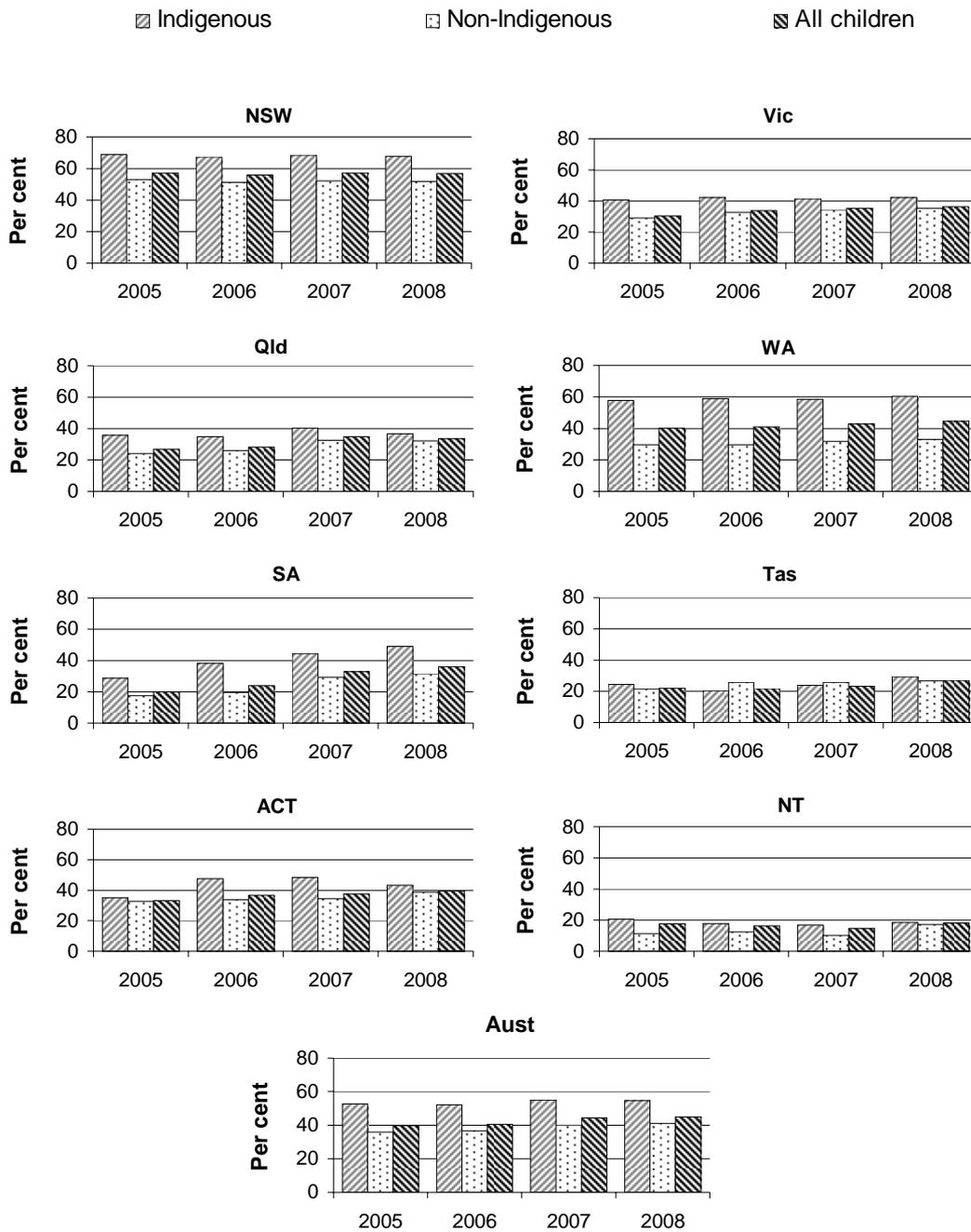
Placements with extended family may not always be the best option. Long standing family dynamics may undermine the pursuit of case goals such as reunification, and the possibility of intergenerational abuse needs to be considered. In addition, depending on the individual circumstances of children, it may be more important to have a local placement that enables continuity at school, for example, rather than a distant placement with relatives.

Data reported for this indicator are comparable.

Figure 15.9 shows the proportion of children placed with relatives or kin by Indigenous status for the past four years. Although these data are comparable, each jurisdiction is shown separately for simpler presentation. The proportion of children placed with relatives or kin at 30 June 2008 was greater for Indigenous children than for non-Indigenous children in all jurisdictions and nationally (figure 15.9).

In addition, the Aboriginal Child Placement Principle places additional emphasis on the placement of Indigenous children with extended family. This principle is discussed in box 15.16.

Figure 15.9 Proportion of children in out-of-home care placed with relatives/kin, by Indigenous status, 30 June^a



^a Non-Indigenous status includes children whose Indigenous status is unknown or not stated.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* data collection; table 15A.21.

Out-of-home care — children aged under 12 years in home-based care

‘Children aged under 12 years in home-based care’ is an indicator of governments’ objective to provide services which meet the needs of the recipients (box 15.15).

Box 15.15 Children aged under 12 years in home-based care

‘Children aged under 12 years in home-based care’ is defined as the number of children 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.

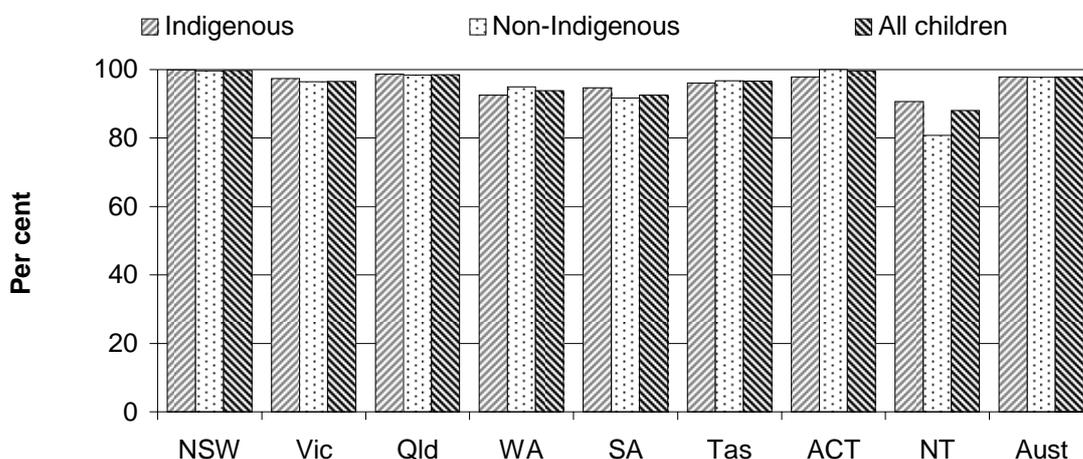
Placing children in home-based care is generally considered to be in their best interests, particularly for younger children. Children will generally make better developmental progress (and have more ready access to normal childhood experiences) in family settings rather than in residential care.

This indicator should be interpreted in conjunction with other placement indicators.

Data reported for this indicator are comparable.

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 2008 was 97.8 per cent nationally. In most jurisdictions the proportion of Indigenous children aged under 12 years who were placed in home-based care was similar to that of non-Indigenous children (figure 15.10).

Figure 15.10 Proportion of children aged under 12 years in out-of-home care and in a home-based placement, by Indigenous status, 30 June 2008^{a, b}



^a Family group homes are not classified as being home-based care. ^b Non-Indigenous status includes children whose Indigenous status is unknown or not stated.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* data collection; table 15A.23.

Out-of-home care — placement in accordance with the Aboriginal Child Placement Principle

‘Placement in accordance with the Aboriginal Child Placement Principle’ is an indicator of governments’ objective to protect the safety and welfare of Indigenous children while maintaining the cultural ties and identity of Indigenous children in out-of-home care (box 15.16). Subject to an over-riding concern for the safety and wellbeing of Indigenous children, the principle supports the maintenance of the Indigenous child’s cultural ties and identity while in out-of-home care.

According to the Aboriginal Child Placement Principle (NSW Law Reform Commission 1997), the following hierarchy or placement preference should be pursued in protecting the safety and welfare of Indigenous children:

- placement with the child’s extended family (which includes Indigenous and non-Indigenous relatives/kin)
- placement within the child’s Indigenous community
- placement with other Indigenous people.

All jurisdictions have now adopted this principle in both legislation and policy.

Box 15.16 Placement in accordance with the Aboriginal Child Placement Principle

'Placement in accordance with the Aboriginal Child Placement Principle' is defined as the number of Indigenous children placed with the child's extended family, Indigenous community or other Indigenous people, divided by the total number of Indigenous children in out-of-home care. Data are reported separately for children placed (i) with relative/kin, (ii) with other Indigenous carer or Indigenous residential care, and (iii) not placed with relative/kin, other Indigenous carer or Indigenous residential care.

Placing Indigenous children in circumstances consistent with the Aboriginal Child Placement Principle is considered to be in their best interests. However, it is one factor among many considerations for the child's safety and wellbeing that must be carefully considered in the placement decision. In the application of this principle, consultation with and involvement of appropriate Indigenous individuals or organisations occurs in the placement decision.

If the preferred options are not available, the child may be placed (after appropriate consultation) with a non-Indigenous family or residential setting. The principle does not preclude the possibility that in some instances, placement in a non-Indigenous setting, where arrangements are in place for the child's cultural identity to be preserved, may be the most appropriate placement for the child.

A high proportion of children placed in accordance with the principle is desirable.

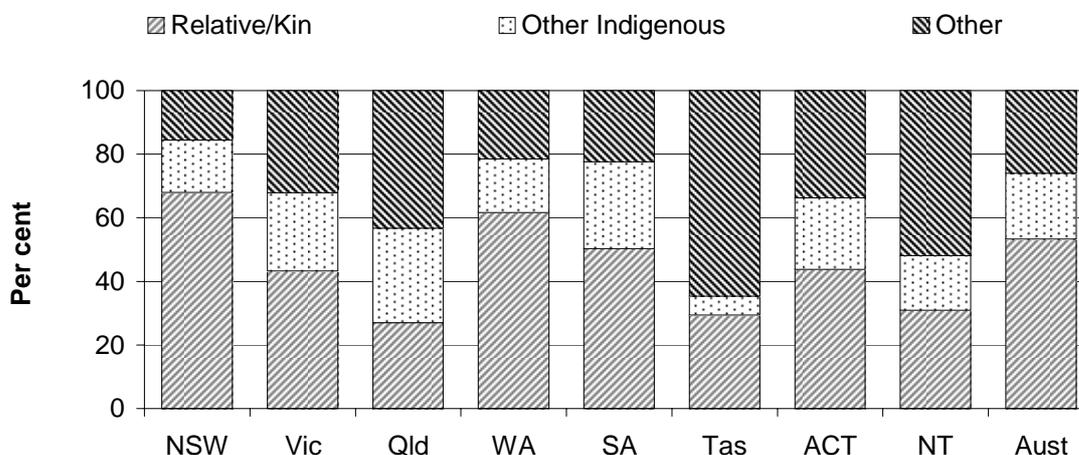
This indicator needs to be interpreted with care as the current measure is a proxy measure for compliance with the principle, as it reports the placement outcome of the Indigenous child rather than compliance with the principle. The indicator does not report whether the hierarchy was followed in the consideration of the best placement for the child, nor whether consultation was held with appropriate Indigenous individuals or organisations.

Data reported for this indicator are comparable.

Nationally, at 30 June 2008, 53.3 per cent of Indigenous children in out-of-home care were placed with a relative/kin, 20.6 per cent placed with other Indigenous carer or Indigenous residential care, and 26.0 per cent were not placed with relative/kin, other Indigenous carer or other Indigenous residential care (figure 15.11).

The proportion of Indigenous children in out-of-home care at 30 June 2008 who were placed with Indigenous or non-Indigenous relatives or kin or with another Indigenous carer or in Indigenous residential care varied across jurisdictions (figure 15.11).

Figure 15.11 Placement of Indigenous children in out-of-home care, 30 June 2008^{a, b}



Relative/Kin = Placed with relative/kin. Other Indigenous = Placed with other Indigenous carer or Indigenous residential care. Other = Not placed with relative/kin, other Indigenous carer or Indigenous residential care. ^a Excludes Indigenous children living independently and those whose living arrangements were unknown. ^b Data for Tasmania and the ACT relate to a small number of Indigenous children (102 and 81 respectively) in care at 30 June 2008.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* data collection; table 15A.22.

Out-of-home care — local placement

‘Local placement’ is an indicator of governments’ objective to provide services which meet the needs of the recipients (box 15.17).

Box 15.17 Local placement

Local placement is defined as the proportion of children attending the same school after entering out-of-home 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 considered to enhance the stability, familiarity and security of the child. It enables some elements of the child’s life to remain unchanged (for example, they can continue attending the same school and retain their friendship network). It may also facilitate family contact if the child’s parents continue to live nearby.

(Continued on next page)

Box 15.17 (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 school to a secondary school.

Data will be provided for 3 and 12 months after entering care. Data collection for this indicator is under development. Data were not available for the 2009 Report.

Out-of-home care — placement with sibling

‘Placement with sibling’ is an indicator of governments’ objective to provide services which meet the needs of the recipients (box 15.18).

Box 15.18 Placement with sibling

‘Placement with sibling’ is defined as the proportion of children who are on orders and in out-of-home care at 30 June who have siblings also on orders and in out-of-home care, who are placed with at least one of their siblings.

A high rate of placement with siblings is desirable.

Placement of siblings together promotes stability and continuity. It is a long standing placement principle that siblings should be placed together, where possible, in the interests of their emotional wellbeing. Children are likely to be more secure and have a sense of belonging within their family when placed with siblings.

This is one factor among many that must be considered in the placement decision. In circumstances of sibling abuse, or when a particular child in a family has been singled out as the target for abuse or neglect, keeping siblings together may not be appropriate.

Data collection for this indicator is under development. Data were not available for the 2009 Report.

Out-of-home care — children with documented case plan

‘Children with documented case plan’ is an indicator of governments’ objective to provide services that meet the needs of the recipients (box 15.19).

Box 15.19 Children with documented case plan

‘Children with documented case plan’ 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 collection for this indicator is under development. Data were not available for the 2009 Report.

Out-of-home care — client satisfaction

‘Client satisfaction’ is an indicator of governments’ objective to provide high quality services that meet the needs of recipients (box 15.20).

Box 15.20 Client satisfaction

‘Client satisfaction’ is yet to be defined.

This indicator has been identified for development and reporting in future.

Some information on jurisdictions’ development of initiatives which may assist to measure client satisfaction in the future is included in box 15.8.

Efficiency

Understanding the efficiency of the child protection systems that they administer helps State and Territory governments to identify the key cost drivers of their systems and to weigh the efficacy of options for addressing child protection issues.

Challenges in reporting efficiency for child protection systems

Current efficiency data for child protection services has several limitations, including:

- *different systems and priorities across jurisdictions* — child protection systems in Australia have evolved independently under the auspices of State and Territory governments. This has resulted in variations in the processes and emphases placed on different service delivery paradigms, such as different approaches to diversionary options
- *limitations of current information systems* — in most jurisdictions, it is difficult to identify explicit resources expended on child protection services, out-of-home care services and other support services for families. This is due in part to the historic structure of information systems and the embedding of the government agencies responsible for child protection issues within larger community services departments. Table 15A.4 identifies the level of consistency in expenditure data across jurisdictions.

As a result of these limitations, cost allocations reflect the historic nature of information systems and do not necessarily provide an accurate reflection of the costs involved in provision of various child protection and out-of-home care services.

In April 2002, the Review initiated a project to improve efficiency data for a national framework of protection and support pathways (box 15.21). Until this can be fully implemented, reporting on efficiency has been limited to relatively poor proxy indicators (box 15.22 and box 15.23).

Box 15.21 The pathways project

The pathways project developed and tested a model that will ultimately allow jurisdictions to calculate more meaningful, comparable and robust efficiency measures (the 'pathways method'). The model is based on a top-down application of the activity-based costing method. A set of eight national pathways has been developed as a high level representation of the services that a protection and support client could receive in any jurisdiction. Each pathway consists of common activity groups which act as the 'building blocks' for each of the pathways. The aggregate cost of each activity group within the pathway will allow for the unit cost of an individual pathway to be determined.

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Box 15.21 (Continued)

These activity groups and pathways will provide additional utility for jurisdictions in managing the business of child protection services. Implementation of the model has the potential to improve the quality of national reporting of protection and support services efficiency measures. Activity-based data can also result, over time, in measures of the cost savings associated with early intervention strategies.

The activity groups are:

- Activity Group 1 Receipt and assessment of initial information about a potential protection and support issue
- Activity Group 2 Provision of generic/non-intensive family support services
- Activity Group 3 Provision of intensive family support services
- Activity Group 4 Secondary information gathering and assessment
- Activity Group 5 Provision of short term protective intervention and coordination services for children not on an order
- Activity Group 6 Seeking an order
- Activity Group 7 Provision of protective intervention, support and coordination services for children on an order
- Activity Group 8 Provision of out-of-home care services.

Detailed definitions of activity groups are included in section 15.13.

Before jurisdictional reporting against the activity groups can be undertaken with confidence, further refinement of activity group definitions and counting rules is required. Development work, including further data testing in these areas will continue.

Source: SCRCCSP (2003) and SCRGSP (unpublished).

Experimental results from the Pathways model, provided by four jurisdictions, are included in table 15.2. These data are preliminary and are subject to further analysis and refinement for future Reports. The data do not represent unit costs and should be interpreted with caution. Due to differing internal management systems across jurisdictions, there may be significant variation between jurisdictions in relation to specific activities or expenditures that are included in each activity group.

The data reflect a combination of allocation of direct costs (those costs which can be clearly identified by a jurisdiction to a particular activity group) and indirect costs (which form part of the overall expenditure base, but which cannot be identified in a specific activity group and hence have been allocated amongst the activity groups). These indirect allocations have been approximated by each jurisdiction amongst the eight activity groups.

Table 15.2 provides an approximation of the proportionate allocation of expenditure amongst the eight activity groups for each participating jurisdiction. The expenditure base used for the pathways project differs from the expenditure base used to calculate the existing proxy efficiency indicators for child protection and out-of-home care services (box 15.22 and box 15.23).

The proportion of expenditure allocated to Activity group 8 (Out-of-home care) is the most significant and varies from 39 per cent to 46 per cent across reporting jurisdictions. The proportions allocated to Activity groups 1 (Receipt and assessment of initial information about a potential protection and support issue), 6 (Seeking an order) and 7 (Provision of protective intervention, support and coordination services for children on an order) each accounted for less than 10 per cent across all reporting jurisdictions.

Table 15.2 Proportion of expenditure by activity group – experimental estimates (per cent)^{a, b, c, d}

	AG1	AG2 ^e	AG3	AG4	AG5	AG6	AG7	AG8	Total
NSW (2005-06)	7	17	18	6	2	3	2	46	100
Vic (2005-06)	3	24	4	5	4	7	8	44	100
SA (2005-06)	4	8	4	13	10	8	7	45	100
Tas (2004-05)	5	9	3	11	15	8	9	39	100

AG = Activity Group (see box 15.21 for information). ^a Includes direct and indirect expenditure. ^b These experimental data have been derived from expenditure allocations in different years by the various participating jurisdictions. ^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, for example the inclusion/exclusion of expenditure on services outsourced to non-government organisations.

Source: NSW, Victorian, SA and Tasmanian governments (unpublished).

Out-of-home care services unit costs – program expenditure per placement day

Indicative unit costs for out-of-home care services are provided in table 15.3. Out-of-home care program expenditure per placement day varied across jurisdictions (table 15.3).

Table 15.3 Indicative unit costs of out-of-home care services, 2007-08^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas^c</i>	<i>ACT</i>	<i>NT</i>
Real expenditure on out-of-home care services (\$m)	463.9	221.6	291.0	121.9	85.4	25.9	19.3	27.1
Placement days in out-of-home care (no. '000) ^d	4625.4	2013.8	na	903.6	664.7	248.7	150.1	141.7
Out-of-home care program expenditure per placement day (\$)	100.3	110.0	na	134.9	128.5	104.3	128.9	190.9

^a These data should not be interpreted as unit costs for Activity Group 8 as they are derived using reported program expenditure and not activity group expenditure. ^b Caution should be used when interpreting results due to the variability of activities that are included in out-of-home care services. ^c Children in facility-based care placements contribute to a significant proportion of out-of-home care expenditure and may inflate the average unit cost. ^d A placement day in out-of-home care only counts children who stay overnight in an out-of-home care placement. **na** Not available.

Source: State and Territory Governments (unpublished); table 15A.32.

These indicative costs are derived using total real recurrent program expenditure on out-of-home care services (table 15A.1) and not expenditure allocated to an activity group. It is anticipated that unit costs on out-of-home care services derived from Activity group 8 expenditure will be available in future Reports, as development work continues on definitions, counting rules and a pilot data collection for the pathways project.

Child protection services proxy efficiency indicators

Three child protection efficiency measures are reported as proxy indicators of governments' objective to maximise the benefit to the community through the efficient use of taxpayer resources: 'total expenditure on all child protection activities, per notification', 'total expenditure on all child protection activities, per investigation', and 'total expenditure on all child protection activities, per substantiation' (box 15.22).

Box 15.22 Child protection services proxy efficiency indicators

There are three 'Child protection services proxy efficiency indicators', defined as:

- total expenditure on all child protection activities divided by the number of notifications
- total expenditure on all child protection activities divided by the number of investigations
- total expenditure on all child protection activities divided by the number of substantiations.

These indicators are imperfect proxy indicators and need to be interpreted with care.

Because each of these proxy indicators is based on total expenditure on child protection activities, they do not represent, and cannot be interpreted as, unit costs for notifications, investigations or substantiations.

These proxy indicators cannot be added together to determine overall cost of child protection services.

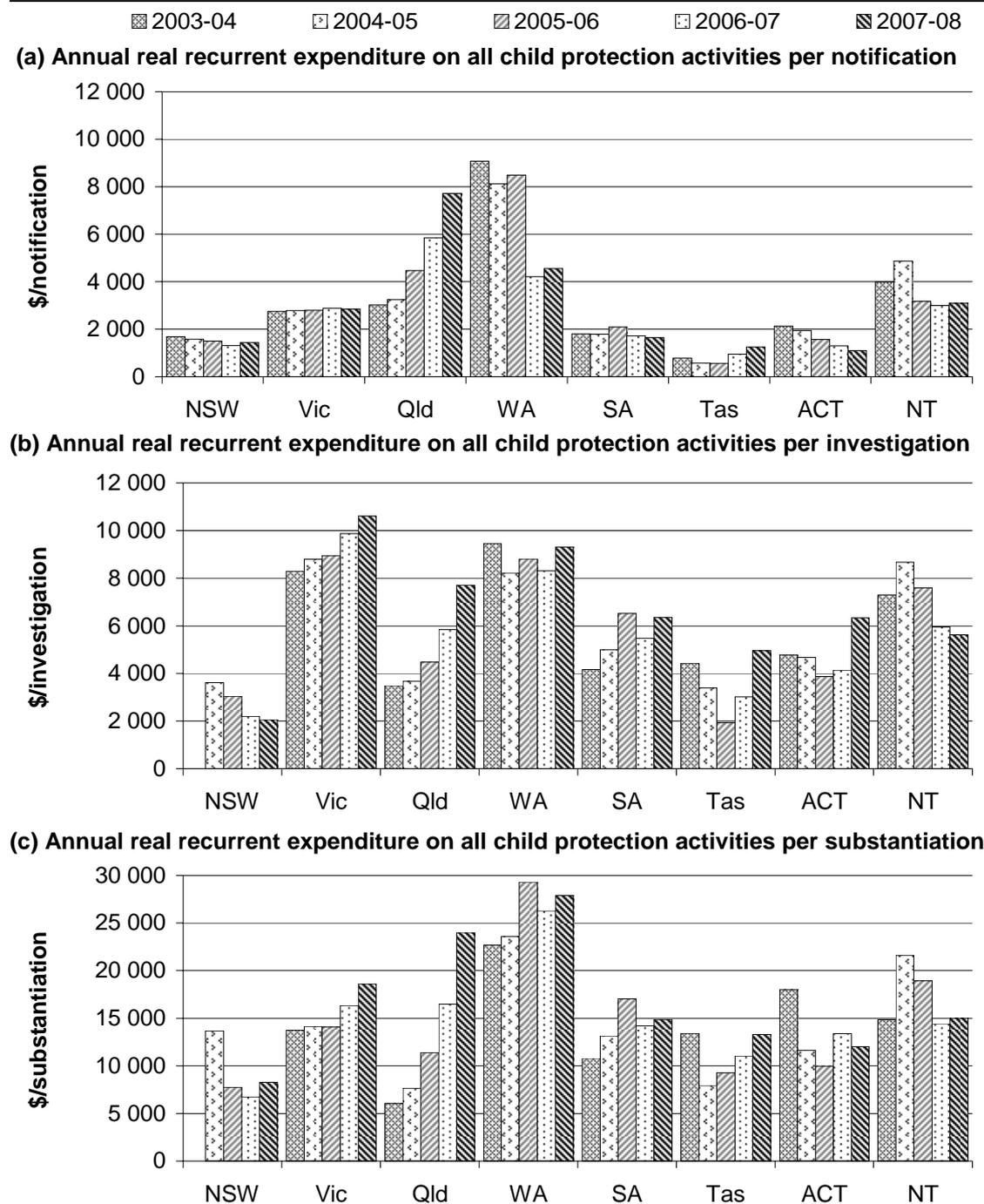
Lower expenditure per notification/investigation/substantiation may suggest more efficient services but may indicate lower quality or different service delivery models.

Better efficiency indicators would relate expenditure on particular child protection activities to a measure of output of those activities. Work is in progress to develop an activity-based costing method that will allow this type of reporting from existing information systems (box 15.21).

Data reported for this indicator are not directly comparable.

Total expenditure on all child protection activities per notification, per investigation and per substantiation from 2003-04 to 2007-08 varied between jurisdictions (figure 15.12).

Figure 15.12 **Child protection efficiency indicators (2007-08 dollars)^{a, b, c, d}**



^a Real expenditure based on ABS gross domestic product price deflator (2007-08 = 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 2007-08 data for some jurisdictions for 'annual real expenditure per notification' and 'annual real expenditure per investigation' may not be strictly comparable with previous years, due to the introduction of a new investigation category 'Investigation closed—no outcome possible'. ^d See table 15A.2 for detailed jurisdiction-specific footnotes.

Source: State and Territory governments (unpublished); table 15A.2.

Out-of-home care proxy efficiency indicators

Three out-of-home care efficiency measures are reported as proxy indicators of governments' objective to maximise the benefit to the community through the efficient use of taxpayer resources: 'total expenditure on all children in residential out-of-home care per year, per child in residential out-of-home care on 30 June', 'total expenditure on all children in non-residential out-of-home care per year, per child in non-residential out-of-home care on 30 June', and 'total expenditure on all children in out-of-home care per year, per child in all out-of-home care on 30 June' (box 15.23).

Box 15.23 Out-of-home care proxy efficiency indicators

There are three 'Out-of-home care proxy efficiency' indicators, defined as:

- total annual expenditure on residential out-of-home care divided by the number of children in residential out-of-home care at 30 June
- total annual expenditure on non-residential out-of-home care divided by the number of children in non-residential out-of-home care at 30 June
- total annual expenditure on all out-of-home care divided by the number of children in all out-of-home care at 30 June.

These indicators are imperfect proxy indicators and need to be interpreted with care. Low expenditure per child in care may suggest more efficient services but may also indicate lower service quality.

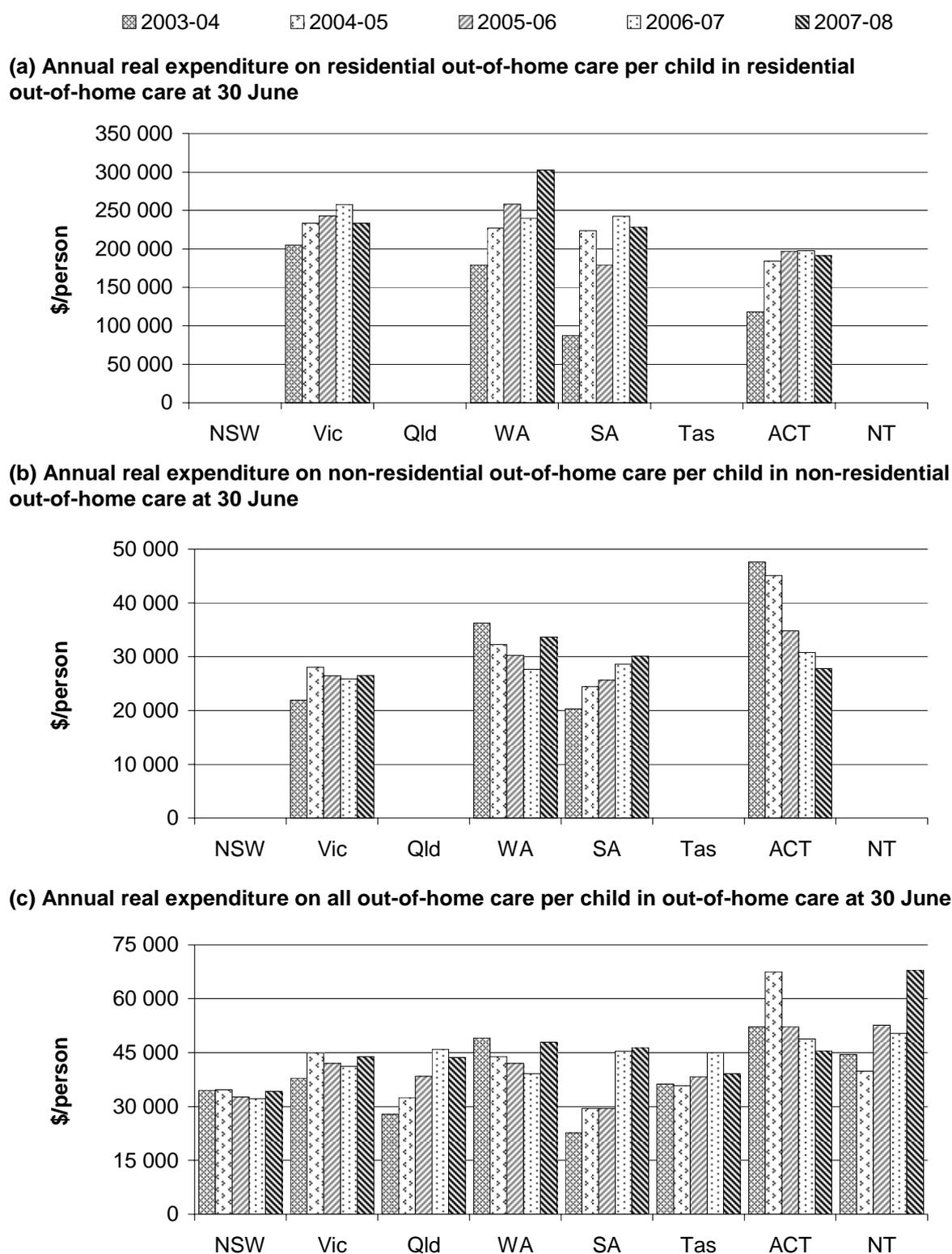
These indicators should be interpreted with care because they do not represent unit cost measures. Expenditure per child in care at 30 June overstates the cost per child because significantly more children are in care during a year than at a point in time. In addition, the indicator does not reflect the length of time that a child spends in care.

Better efficiency indicators would relate expenditure on particular out-of-home care activities to a measure of output of those activities. Work is currently in progress to develop an activity-based costing method which will allow this type of reporting from existing information systems (box 15.21).

Data reported for this indicator are not directly comparable.

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 2003-04 to 2007-08, per child in residential care and non-residential care at 30 June, varied across these jurisdictions (figures 15.13(a) and figure 15.13(b)). All jurisdictions provided data on total expenditure on out-of-home care per child in care at 30 June for 2003-04 to 2007-08, which varied across jurisdictions (figure 15.13(c)).

Figure 15.13 Out-of-home care efficiency indicators (2007-08 dollars)^{a, b, c}



^a Real expenditure based on ABS gross domestic product price deflator (2007-08 = 100) (table AA.26).

^b These data do not represent unit costs of providing out-of-home care services. ^c NSW, Qld, Tasmania and the NT could not disaggregate expenditure on out-of-home care into residential care and non-residential care.

Source: State and Territory governments (unpublished); table 15A.3.

Outcomes

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

Improved safety — substantiation rate after decision not to substantiate

‘Substantiation rate after decision not to substantiate’ is an indicator of governments’ objective to reduce the risk of harm to children by appropriately assessing notifications of possible child protection incidents (box 15.24).

Box 15.24 Improved safety — substantiation rate after decision not to substantiate

‘Improved safety — substantiation rate after decision not to substantiate’ 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.

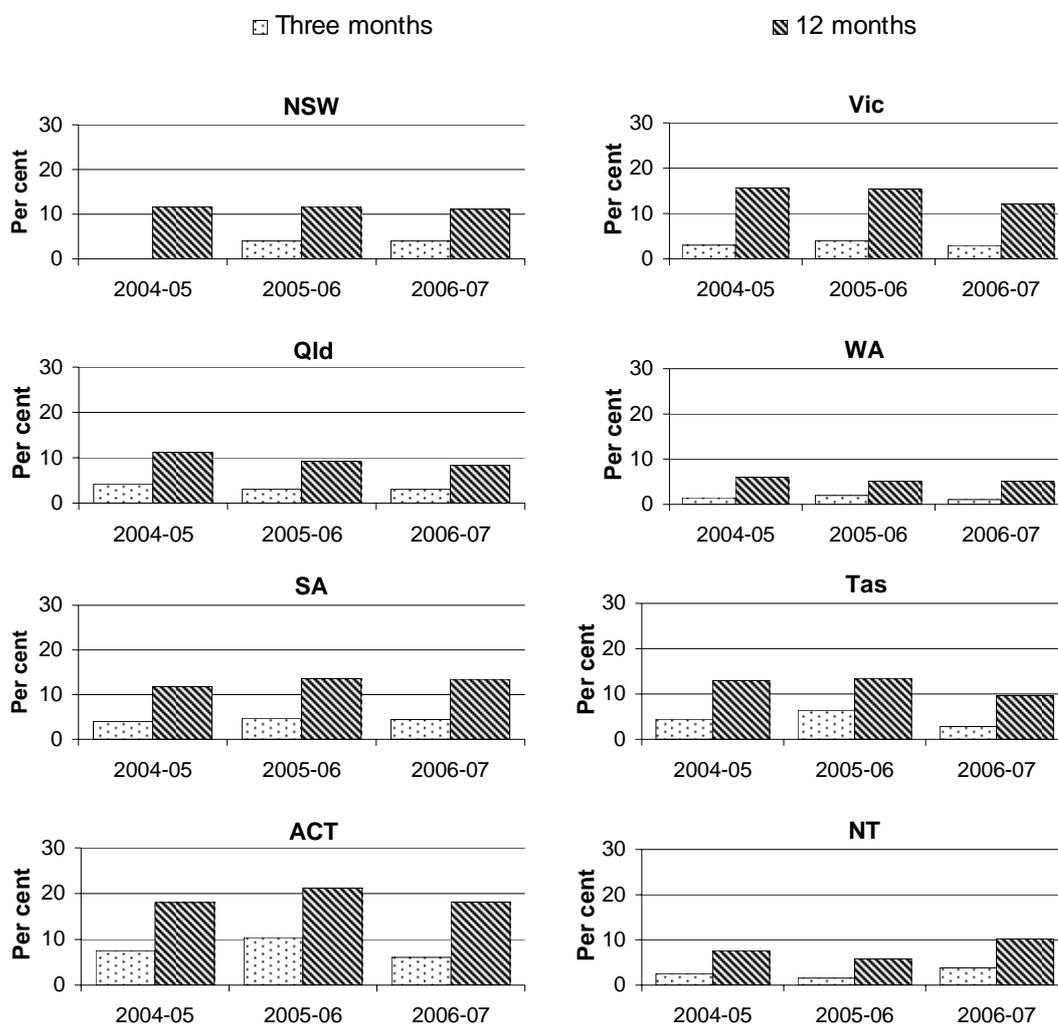
A low rate for this indicator is generally desirable. However, reported results may be affected by the finalisation of investigations, factors beyond the control of child protection services, or a change in circumstances after the initial decision not to substantiate was made. A demonstrable risk of 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 reported for this indicator are not directly comparable.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.14).

Figure 15.14 Improved safety — substantiation rate within 3 and/or 12 months after a decision not to substantiate^{a, b, c, d}



^a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. ^b Jurisdictions have provided the denominator for this indicator for this Report. In previous Reports the denominator was derived by the AIHW. Data in this Report may therefore differ from previous Reports. ^c During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 may not be fully comparable to previous years' data. See source table 15A.54 for more details on these arrangements. ^d Data relating to substantiations after a decision not to substantiate in Tasmania for 2006-07 should be interpreted carefully due to the high proportion of investigations in process at 31 August 2007.

Source: AIHW (unpublished), derived from *Child protection notifications, investigations and substantiations, Australia* data collection; tables 15A.9, 15A.37, 15A.54, 15A.71, 15A.88, 15A.105, 15A.122, 15A.139 and 15A.156.

Improved safety — resubstantiation rate

The ‘resubstantiation rate’ is an indicator of governments’ objective to reduce the risk of harm and to prevent the recurrence of abuse and neglect or harm to children. This indicator also partly reveals the extent to which intervention by child protection services has succeeded in preventing further harm (box 15.25).

Box 15.25 Improved safety — resubstantiation rate

‘Resubstantiation rate’ 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.

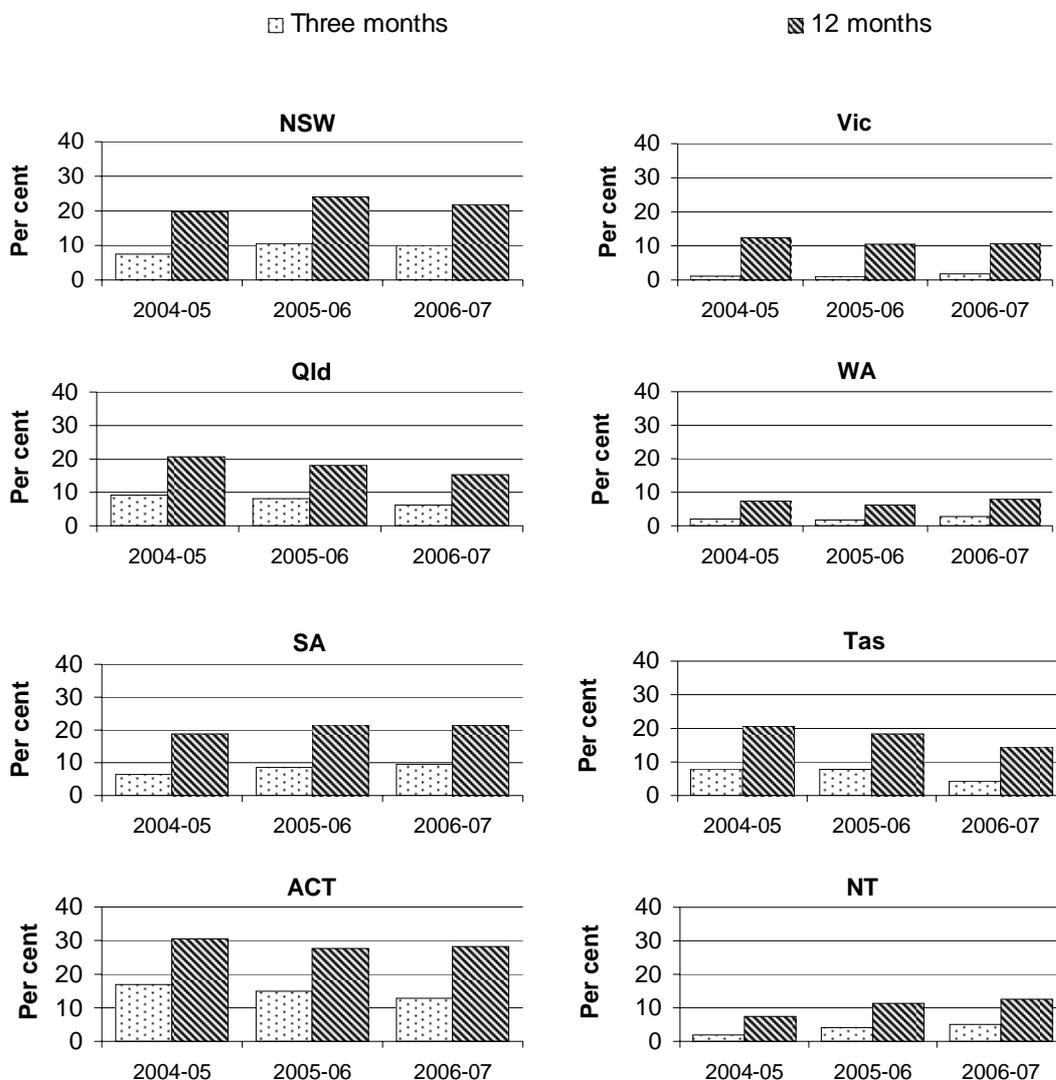
A low rate for this indicator is generally desirable. However, reported results may be affected by the finalisation of investigations or factors beyond the control of child protection services, such as changes in the family situation (for example, illness, unemployment or a new partner). In addition, 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 reported for this indicator are not directly comparable.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.15).

Figure 15.15 Improved safety — resubstantiation rate within 3 and/or 12 months after a substantiation^{a, b, c, d}



^a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. ^b Jurisdictions have provided the denominator for this indicator for this Report. In previous Reports the denominator was derived by the AIHW. Data in this Report may therefore differ from previous Reports. ^c During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 may not be fully comparable to previous years' data. See source table 15A.55 for more details on these arrangements. ^d Data relating to resubstantiations in Tasmania for 2006-07 should be interpreted carefully due to the high proportion of investigations in process at 31 August 2007.

Source: AIHW (unpublished), derived from *Child protection notifications, investigations and substantiations, Australia* data collection; tables 15A.10, 15A.38, 15A.55, 15A.72, 15A.89, 15A.106, 15A.123, 15A.140 and 15A.157.

Improved education, health and wellbeing of the child

‘Improved education, health and wellbeing of the child’ is an indicator of governments’ objective to maximise children’s life chances by ensuring children in care have their educational, health and wellbeing needs met (box 15.26).

Box 15.26 Improved education, health and wellbeing of the child

‘Improved education, health and wellbeing of the child’ is defined as the change over time in learning outcomes for children on guardianship or custody orders. This is a partial measure of this outcome indicator.

An increase in learning outcomes over time for children on guardianship or custody orders indicates that their educational outcomes are improving.

However, factors outside the control of protection and support services may also influence the educational outcomes of children on guardianship or custody orders, and care needs to be exercised when interpreting results.

Data reported for this indicator are not complete.

For the 2009 Report, data were reported on the proportion of children in years 3, 5 and 7 on guardianship or custody orders (attending government schools) achieving the national reading and numeracy benchmarks in 2003, relative to all children (attending government and non-government schools) achieving these benchmarks over the same period (see tables 15A.11–15A.13). Until information on the learning outcomes for these children is available at a later point in time, changes over time are not able to be presented.

Additional data on educational outcomes will be collected for children on guardianship or custody orders in 2004, 2005 and 2006. The longitudinal component of this study will assess any change in academic performance over time for children who were continuously on guardianship or custody orders for a two-year period (between 2003–2005 and 2004–2006). These data are anticipated to be available for the 2011 Report.

Safe return home

‘Safe return home’ is an indicator of governments’ objective to remove the risk of harm to the child while maintaining family cohesion (box 15.27).

Box 15.27 Safe return home

'Safe return home' is yet to be defined.

For children who cannot be protected within their family and are removed from home, often the best outcome is when effective intervention to improve their parents' skills or capacity to care for them enables them to return home.

This indicator has been identified as a key area for development in future reports.

Permanent care

'Permanent care' is an indicator of governments' objective to provide appropriate care for children who cannot be safely reunified with their families (box 15.28).

Box 15.28 Permanent care

'Permanent care' is yet to be defined.

Appropriate services are those that minimise the length of time before stable, permanent placement is achieved.

This indicator has been identified for development and reporting in future.

15.4 Future directions in child protection and out-of-home care services performance reporting

Improving national child protection data

The National Child Protection and Support Services (NCPASS) working group has identified a number of gaps in national data reporting for child protection. NCPASS also has responsibility for monitoring the comparability of child protection data. A series of projects, approved by the National Community Services Information Management Group (NCSIMG) and funded by the Community and Disability Services Ministerial Council (CDSMC), have been initiated to address these issues. These projects are: *Educational Outcomes for Children on Orders*; *Treatment and Support Services*; *National Foster Carers Data Collection*; and, *National Data Comparability*. The project work for these initiatives has in most cases been undertaken by the AIHW working closely with states and territories. It is expected that these projects will enable improved reporting on child protection.

Further development of the pathways activity-based costing project will reduce the reliance on proxy efficiency indicators for child protection and out-of-home care and enable more detailed and comparative analysis of efficiency indicators. Developments planned for the 2010 Report include the implementation of a common survey tool (developed in 2008 and due to be piloted in 2009) to facilitate greater consistency across jurisdictions in reporting on the 'Pathways' project, and the inclusion of reporting unit costs for some activity groups.

The development of the *National Framework for Protecting Australia's Children* during 2008 is intended to improve child protection outcomes, through the inclusion of actions designed to:

- improve connection and coordination across various parts of the system and across jurisdictional boundaries
- where a national approach would ensure better use of resources
- where the Australian Government could make use of its policies and programs to ensure children are better protected (FaHCSIA 2008c).

The Council of Australian Governments (COAG) has noted the work underway (COAG 2008a), and it is anticipated that the Framework will be released in early 2009.

15.5 Profile of juvenile justice services

Service overview

Juvenile justice services aim to promote community safety and reduce youth offending by assisting young people to address their offending behaviour and take responsibility for the effect their behaviour has on victims and the wider community. In doing this, juvenile justice services recognise the importance of the families and communities of young offenders, particularly Indigenous communities, in the provision of services. Consequently, services are designed to maximise opportunities to maintain offending free lifestyles by rehabilitating young people who commit offences and reintegrating them into their community.

The juvenile justice system is responsible for dealing with young people (predominantly aged 10–17 years) who have committed or allegedly committed an offence while considered by law to be a juvenile. Key elements of juvenile justice systems in all jurisdictions include:

- the diversion of young people from the more formal criminal justice system (courts) where appropriate
- detention as a last resort
- victims' rights
- ensuring a young person fulfils their sentencing obligations
- responsibility appropriate to the developmental stage of the young person
- community safety.

The juvenile justice information in the Report is sourced from the Juvenile Justice National Minimum Data Set (JJ NMDS) managed by the AIHW on behalf of the States and Territories, the Australian Institute of Criminology (AIC) and the AIHW.

Roles and responsibilities

The responsibility for juvenile justice in Australia resides with State and Territory governments. The relevant department within each state and territory in 2007-08 responsible for funding and/or providing juvenile justice services is listed in box 15.29. Each jurisdiction has its own legislation that determines the policies and practices of its juvenile justice system. While this legislation varies in detail, its intent is similar across jurisdictions. National coordination takes place through the Australasian Juvenile Justice Administrators (AJJA). AJJA is a Standing Committee of the Community and Disability Services Ministerial Advisory Council.

Box 15.29 Juvenile justice services

<i>NSW</i>	Department of Juvenile Justice (DJJ)
<i>VIC</i>	Department of Human Services (DHS)
<i>QLD</i>	Department of Communities (DOC)
<i>WA</i>	Department of Corrective Services (DCS)
<i>SA</i>	Department for Families and Communities (DFC)
<i>TAS</i>	Department of Health and Human Services (DHHS)
<i>ACT</i>	Department of Disability, Housing and Community Services (DDHCS)
<i>NT</i>	Department of Justice (DOJ)

The juvenile justice system in each jurisdiction comprises several organisations, each with a different primary role and responsibility in dealing with young people. These include:

- police, who are usually the young person's first point of contact with the system
- courts (usually a special children's or youth court), where matters relating to the charges against the young person are heard. The courts are largely responsible for decisions regarding bail (and remand) and sentencing options
- juvenile justice agencies, which are responsible for the supervision and case management of young people on a range of community-based legal arrangements and in detention, and for the provision of a wide range of services aimed at crime prevention and reduction. Many of the services provided by juvenile justice agencies are aimed at: rehabilitating young people; minimising the level and future involvement of young people in the juvenile justice system; reducing the over representation of Indigenous young people in the justice system; maintaining the young person's connection with family, culture and community; providing young people with an appropriate level of care and safety (duty of care); increasing young people's accountability to victims; improving community safety; and providing pre-sentence reports for young people to the courts as required.

Diversion of young offenders

In most jurisdictions, the majority of young people who come into contact with the juvenile justice system are diverted through a range of mechanisms such as police cautions, conferences and unsupervised orders, and do not generally become clients of juvenile justice agencies. These mechanisms are now part of the spectrum of legislated responses to juvenile crime.

Responsibility for administering the options available for more minor offences — warnings (informal cautions), formal cautions, and infringement notices — rests mainly with police in all jurisdictions. Responsibility for administering the diversionary processes available for more serious offences lies with juvenile justice authorities and courts in each jurisdiction. Comparable national data are not yet available to illustrate the nature or level of diversion undertaken by different jurisdictions.

Funding

Data on Australian, State and Territory government expenditure on juvenile justice services are not currently available. This information is anticipated to be available for future reports.

Size and scope

Clients of juvenile justice agencies

The fourth report of the JJ NMDS covers the period 2006-07 and was released in August 2008 (AIHW 2008a). The JJ NMDS provides information about young people who are supervised by juvenile justice agencies. Pre-sentenced and sentenced supervision both within the community and in detention are included in the JJ NMDS. Elements of the juvenile justice system which do not require juvenile justice agency supervision (such as police and court actions) are not within the scope of the JJ NMDS.

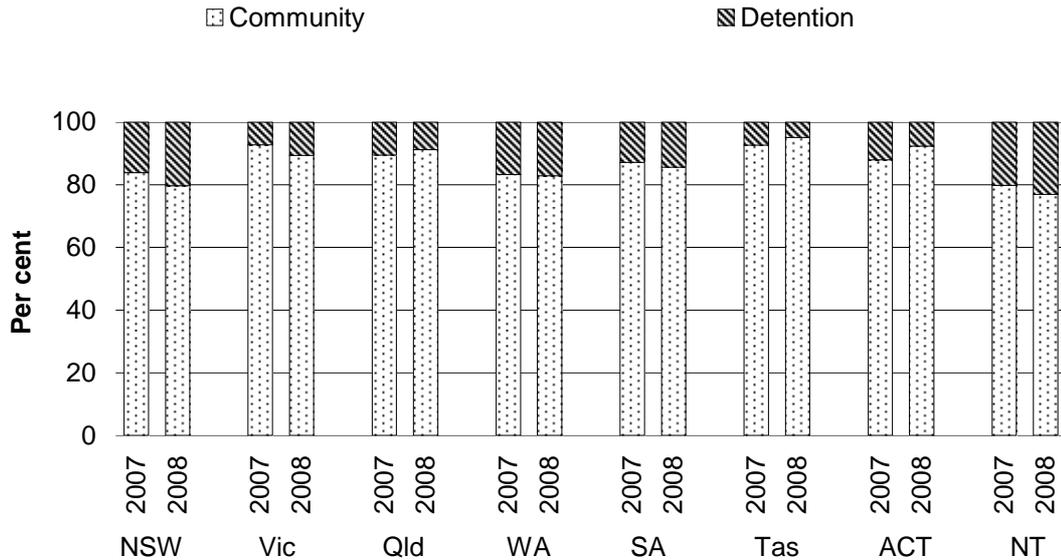
Of those young people who become clients of juvenile justice agencies, most are supervised on community-based orders, including parole. The JJ NMDS shows that, during 2006-07, 12 765 young people experienced juvenile justice supervision in Australia. Of these young people, 10 697 had community-based supervision, 5487 had detention-based supervision, with some young people experiencing both (AIHW 2008a).

Across jurisdictions, the majority of young people aged 10–17 years supervised by juvenile justice jurisdictions (between 76.9 per cent and 95.1 per cent) were in the community, rather than in detention (figure 15.16). These figures do not include any juveniles aged 10–17 years who were supervised in the adult correctional system.

These data were collected at a point in time, so they need to be interpreted with care, particularly for jurisdictions with smaller populations where a small change to

the number of young people in detention can make a significant difference to their relative proportion.

Figure 15.16 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}



^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. ^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. ^d Refer to source table 15A.169 for detailed footnotes.

Source: AIHW unpublished (data supplied by State and Territory governments); table 15A.169.

Juvenile detention

As outlined above, the majority of juvenile offenders are supervised in community-based services. The following data from the AIC relate to juvenile detention only (both on remand or sentenced). As jurisdictions have different definitions of a juvenile, this may affect the number and rates reported for young people aged 10–17 years.

Nationally, the daily average number of people aged 10–17 years detained in juvenile detention centres increased from 616 to 696 between 2002-03 and 2006-07 (table 15.3).

Table 15.3 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>
2002-03	220	64	96	106	65	25	17	24	616
2003-04	209	62	91	122	50	26	18	13	590
2004-05	218	53	89	110	58	33	15	22	596
2005-06	244	53	127	115	39	27	13	17	634
2006-07	277	48	138	132	42	19	14	26	696

^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. Numbers for NSW in the quarters commencing from 31 March 2005 include young people in the care of both the NSW Department of Juvenile Justice and the Department of Corrective Services.

Source: AIC (unpublished); table 15A.170.

The average rate of detention of young people aged 10–17 years per 100 000 in the population aged 10–17 years increased from 28.1 per 100 000 in 2002-03 to 30.8 per 100 000 in 2006-07, although rates varied across jurisdictions (table 15A.171).

Nationally, females made up 9.3 per cent of the total population of juvenile detention centres at 30 June 2007. Males made up 90.7 per cent of the national population of juvenile detention centres at 30 June 2007 (table 15A.172).

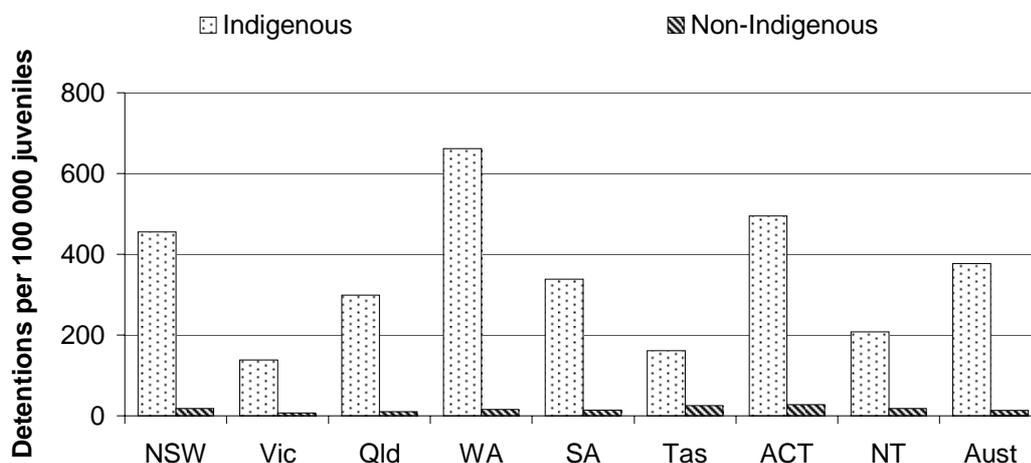
Numbers and rates of Indigenous young people placed in detention

The daily average number of Indigenous young people aged 10–17 years detained in juvenile detention centres was 400 in 2006-07 (table 15A.173). Nationally, the daily average detention rate for Indigenous people aged 10–17 years in 2006-07 was 376.9 per 100 000 Indigenous people aged 10–17 years. The rate for the non-Indigenous population aged 10–17 years in 2006-07 was 13.7 per 100 000 non-Indigenous people aged 10-17 years (table 15A.174).

Jurisdictional comparisons need to be treated with caution, especially for those states and territories with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions. The AIC uses ABS experimental projections for its estimates of the Indigenous population (ABS 2004). These data include a range of estimates (low and high). The AIC data are based on high level estimates, unlike other sections of this Report, which use the low level estimates.

The over-representation of Indigenous young people in detention across jurisdictions in 2006-07 is shown in figure 15.17.

Figure 15.17 **Average rate of detention of Indigenous and non-Indigenous people aged 10–17 years in juvenile detention, per 100 000 people, 2006-07^{a, b}**



^a Rates of detention for Indigenous and non-Indigenous people in NSW in each quarter in 2006-07 include young people in the care of both the NSW Department of Juvenile Justice and the Department of Corrective Services. ^b The rate for Indigenous young people should be treated with caution due to the small Indigenous population in the ACT. The rate ratio at table 15A.174 should also be taken into account.

Source: AIC (unpublished); table 15A.174.

15.6 Framework of performance indicators for juvenile justice services

The framework of performance indicators for juvenile justice is based on a set of shared government objectives (box 15.30). However, juvenile justice services in each state and territory operate under their own legislation. Consequently there are different emphases with respect to aims and objectives.

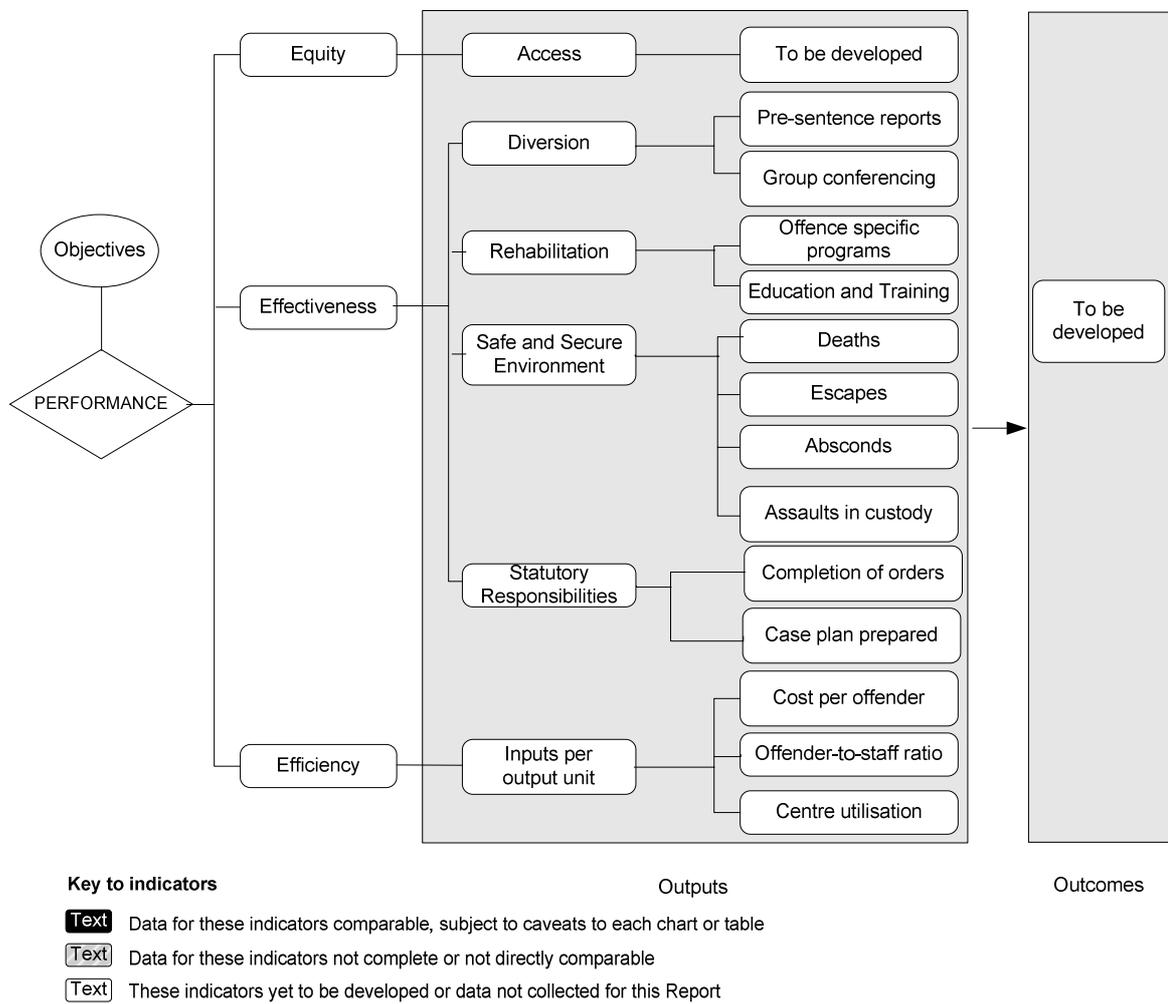
Box 15.30 Objectives for juvenile justice services

Juvenile justice services aim to contribute to the reduction in frequency or severity of youth offending, recognise the rights of victims and promote community safety. Juvenile justice services seek to achieve these aims by:

- assisting young people to address their offending behaviour and take responsibility for the effect their behaviour has on victims and the wider community
- enabling the interests and views of victims to be heard
- contributing to the diversion of young offenders to alternative services
- recognising the importance of the families and communities of young offenders, particularly Indigenous communities, in the provision of services and programmes
- providing services that are designed to rehabilitate young offenders and reintegrate them into their community.

The performance indicator framework for juvenile justice services is included for the first time in the 2009 Report (figure 15.18).

Figure 15.18 Performance indicators for juvenile justice services



Outputs

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

Equity and access

Equity and access indicators are a key area for further development in future reports. These will be indicators of governments' objective to ensure that all clients have fair and equitable access to services on the basis of relative need and available resources. These indicators are under development.

Effectiveness

Diversion — pre-sentence reports

Box 15.31 Pre-sentence reports

'Pre-sentence reports' (Pre-sentence reports completion rate) is an indicator of governments' objective to ensure that accurate and timely advice is provided to the court to inform decision-making.

The pre-sentence reports completion rate is defined as the number of written reports provided by juvenile justice agencies to a court in response to a request for pre-sentence reports, as a proportion of all court requests to juvenile justice agencies for written pre-sentence reports.

A pre-sentence report provides a court with relevant information about the assessed factors that contributed to a young person's offence and explores programs and services that could be provided to address the offending behaviour. A pre-sentence report is prepared when ordered by a court after a young person has pleaded, or has been found, guilty of an offence

A high rate for this indicator is desirable.

Diversion — group conferencing

Box 15.32 Group conferencing

This indicator and associated measures are currently under development.

Rehabilitation — offence specific programs

Box 15.33 Offence specific programs

This indicator and associated measures are currently under development.

Box 15.34 Education and training

‘Education and training’ (education and training rate) is an indicator of governments’ objectives of providing program interventions in education or training to increase the chances of successful re-integration into the community.

The education and training indicator has two measures:

- the number of young people of compulsory school age in custody participating in education and/or training, as a percentage of all young people of compulsory school age in custody
- the number of young people not of compulsory school age in custody participating in education and/or training, as a percentage of all young people not of compulsory school age in custody.

Compulsory school age refers to individual state/territory requirements for a young person to participate in school which are based primarily on age (see chapter 4 of the Report for further information).

Education and/or training refers to school education or an accredited education or training course under the Australian Qualifications Framework.

Exclusions include young people not under juvenile justice supervision (for example, in police custody) and young people whose situation may exclude their participation in education programs (including those on temporary leave or work release; who are medically unable to participate; in isolation; and, on remand or sentence for less than 7 days).

A high ‘education and training’ participation rate is desirable.

Box 15.35 Deaths

‘Deaths (detainees)’ is an indicator of governments’ objective to ensure that juvenile justice agencies provide a safe and secure environment for young people in custody.

‘Deaths (detainees)’ is defined as the number of young people who died while in custody, as a proportion of all young people in custody.

The scope of this indicator is restricted to those young people who died while in the legal and/or physical custody of a juvenile justice agency, but does include those who died in, or en route to, an external medical facility as a result of becoming ill or being injured in custody (even if not escorted by juvenile justice agency workers).

A zero rate for this indicator is desirable.

Box 15.36 Escapes

'Escapes' is an indicator of governments' objective to ensure that juvenile justice agencies provide a safe and secure environment for young people in custody, and the community.

'Escapes' has two measures, defined as:

- the number of escapes from a juvenile justice detention centre, as a proportion of all young people in custody
- the number of escapes during periods of escorted movements, as a proportion of all periods of escorted movements.

An escape from a juvenile justice detention centre is defined as the breach of a secure perimeter or defined boundary of a juvenile justice detention centre by a young person under the supervision of the centre.

A period of escorted movement is defined as a period of time in which a young person is in the custody of the juvenile justice agency while outside a detention centre. The period of escorted movement ends when the young person is returned to the detention centre, or is no longer in the legal or physical custody of the juvenile justice agency. An escape from an escorted movement is defined as the failure of a young person to remain in the custody of a supervising juvenile justice worker or approved service provider during a period of escorted movement.

An escape is counted each time a young person escapes. For example, if a young person escapes three times in the counting period, three escapes are recorded; if three young people escape at the same time, this is counted as three escapes.

A zero rate for this indicator is desirable.

Safe and secure environment — absconds

Box 15.37 Absconds

'Absconds' (absconds from unescorted leave) is an indicator of governments' objectives to appropriately manage young people while they are in the legal custody of a juvenile justice detention centre. This includes the provision of appropriate assessment, planning and supervision to enable young people to undertake unescorted temporary leave from detention centres. Unescorted leave may be undertaken for the purposes of providing opportunities for rehabilitation and reintegration through activities such as education, training, employment, accommodation as well as counselling/treatment.

This indicator is defined as the number of young people who have unescorted temporary leave and fail to return to custody, as a proportion of all young people who have unescorted temporary leave .

A zero or low rate is desirable and indicates that appropriate assessment, planning and supervision are in place during the temporary leave.

Safe and secure environment — assaults in custody

Box 15.38 Assaults in custody

This indicator and associated measures are currently under development.

Statutory responsibilities — completion of orders

Box 15.39 Completion of orders

This indicator and associated measures are currently under development.

Statutory responsibilities — case plan prepared

Box 15.40 Case plan prepared

'Case plan prepared' is an indicator of governments' objective to ensure that juvenile justice agencies support young people to minimise the likelihood of re-offending by addressing their offending-related needs.

'Case plan prepared' is defined as the number of eligible young people who had a documented case plan prepared within six weeks of commencing a sentenced order, as a proportion of all eligible young people.

An eligible young person is one who:

- is serving a sentenced order that requires case management
- does not have a current and valid case plan already in place when the sentenced order commences.

A high rate for this indicator is desirable.

Efficiency

Cost per offender

Box 15.41 Cost per offender

This indicator and associated measures are currently under development.

Offender-to-staff ratio

Box 15.42 Offender-to-staff ratio

This indicator and associated measures are currently under development.

Centre utilisation

Box 15.43 Centre utilisation

This indicator and associated measures are currently under development.

Outcomes

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

Outcome indicators for juvenile justice services are yet to be developed. The Steering Committee has identified outcome indicators as an important element of the performance indicator framework to develop for future reports.

15.7 Future directions in juvenile justice reporting

The AJJA has formed a working group to develop national performance indicators for juvenile justice. The indicators are being developed in three stages:

- Stage 1 indicators are included in detail in the performance indicator boxes within section 15.6
- Stage 2 indicators (all remaining indicators of equity and effectiveness) are currently under development
- Stage 3 involves the development of the efficiency and outcome indicators. Development of these indicators will follow the completion of stages 1 and 2.

15.8 Profile of supported accommodation and assistance services

Service overview

Supported accommodation and assistance services aim to assist people who are homeless or at imminent risk of becoming homeless as a result of a crisis, including women and children escaping domestic violence.

The Supported Accommodation Assistance Program (SAAP) was established in 1985 to bring homelessness programs funded by individual State and Territory governments and the Australian Government under one nationally coordinated program. The current program (SAAP V) is governed by the *Supported Accommodation Assistance Act 1994*. This specifies that the overall aim of SAAP is to provide transitional supported accommodation and related support services to assist homeless people achieve the maximum degree of self-reliance and independence (AIHW 2008b).

Clients are offered a range of services through SAAP. These include:

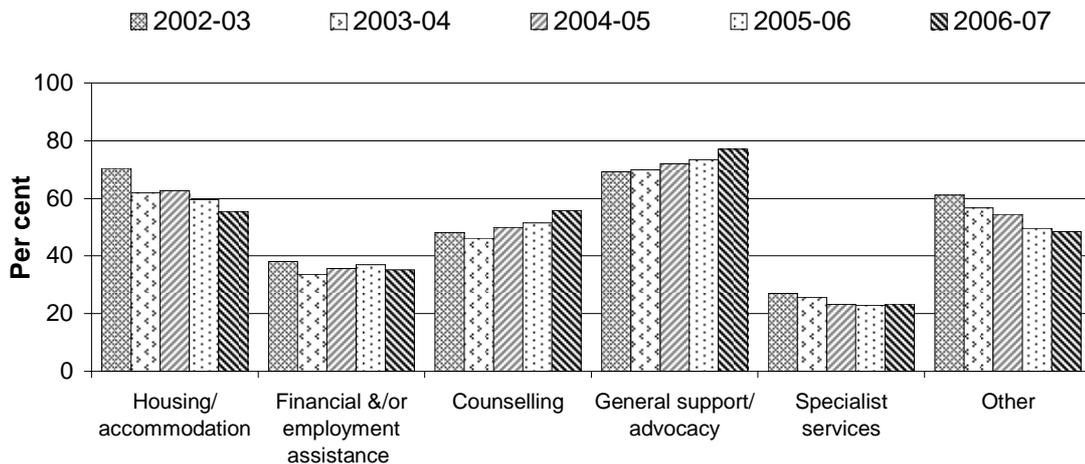
- supported accommodation
- counselling
- advocacy
- links to housing
- health, education and employment services
- outreach support
- brokerage and meals services
- financial and employment assistance.

The main source of SAAP information in this report is the SAAP National Data Collection (NDC). SAAP data for 2006-07 are available for this report, with selected financial data available for 2007-08.

Nationally, in 2006-07, housing and accommodation services were provided in 55.5 per cent of support periods. Financial and employment assistance (35.2 per cent), personal support (55.9 per cent), general support and advocacy (77.1 per cent), and specialist services (23.3 per cent) were also commonly provided. There has been some change in the proportions of types of service provided by SAAP agencies over time (figure 15.19). For example, in 2002-03,

housing and accommodation constituted 70.5 per cent of support periods and counselling constituted 48.2 per cent.

Figure 15.19 **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.175.

Size and scope

Support services funded by SAAP are provided by agencies to a range of groups. These include homeless families, single men and women, young people and adults and children escaping domestic violence.

At least 1539 agencies were funded under the SAAP program in 2006-07 and included non-government, community or local government agencies (AIHW 2008b) (table 15A.176). Services were delivered in 2006-07 by agencies targeting:

- young people (35.4 per cent of agencies)
- women escaping domestic violence (24.0 per cent)
- families (8.4 per cent)
- single men (6.4 per cent)
- single women (3.0 per cent)
- multiple client groups (22.7 per cent) (table 15A.176).

SAAP agencies also vary in their service delivery model. The most common models in 2006-07 were the provision of medium term to long term supported

accommodation (40.0 per cent) and the provision of crisis or short term supported accommodation (31.1 per cent). Agencies also provide services other than accommodation, such as outreach support, day support, and telephone information and referral. Agencies might also provide multiple types of services and agency support. The proportions of agencies delivering particular service models have remained relatively stable since 2002-03 (table 15A.177).

SAAP and the link with other services

Families and children in crisis (such as those escaping domestic violence or experiencing homelessness) are often subject to considerable stress, violence and transience, all of which have a negative impact on children. As a result, some children assisted by SAAP may have also had contact with child protection and out-of-home care services, or may have been subject to a current or past care and protection order. In 2006-07, 69 100 children were accompanying a parent or guardian who received substantial SAAP support (AIHW 2008b). Research using 2004-05 data indicates that 49.5 per cent of these children were accompanying a female parent or guardian escaping domestic violence (AIHW 2006b).

Close links also exist with other forms of housing assistance reported in the Housing chapter of the Report (chapter 16), which focuses on the performance of government in providing public, Indigenous and community housing under the Commonwealth State Housing Agreement (CSHA) and financial assistance under the Commonwealth Rent Assistance (CRA) program. The Crisis Accommodation Program (CAP) is a special purpose program funded under the CSHA which provides funding to State and Territory housing authorities to support SAAP agencies, by providing infrastructure funding for SAAP accommodation.

Some individuals and families utilise both SAAP services and services described in the Housing chapter, as people tend to move from homelessness to social housing, or may be in receipt of SAAP services and accommodated in social housing.² In 2006-07, approximately 17.4 per cent of former SAAP clients, who requested assistance with obtaining or maintaining independent housing, had moved to public housing (table 15A.195).

Roles and responsibilities

SAAP is jointly funded by the Australian, State and Territory governments. The Coordination and Development Committee (CAD) of senior Australian, State 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).

Territory government officials oversees the development and implementation of the program at the national level, including coordination at the national level of research, strategy, and other planning and development activities. The State and Territory governments are responsible for the day-to-day management of the program including the distribution of funding to SAAP funded agencies (see box 15.44 for list of relevant departments in 2007-08). Non-government agencies, with some local government participation, deliver most SAAP services.

Box 15.44 Supported Accommodation and Assistance Services

<i>NSW</i>	Department of Community Services (DOCS)
<i>VIC</i>	Department of Human Services (DHS)
<i>QLD</i>	Department of Communities (DOC)
<i>WA</i>	Department for Child Protection (DCP)
<i>SA</i>	Department for Families and Communities (DFC)
<i>TAS</i>	Department of Health and Human Services (DHHS)
<i>ACT</i>	Department of Disability, Housing and Community Services (DDHCS)
<i>NT</i>	Department of Health and Community Services (DHCS)
<i>Aust</i>	Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)

Funding

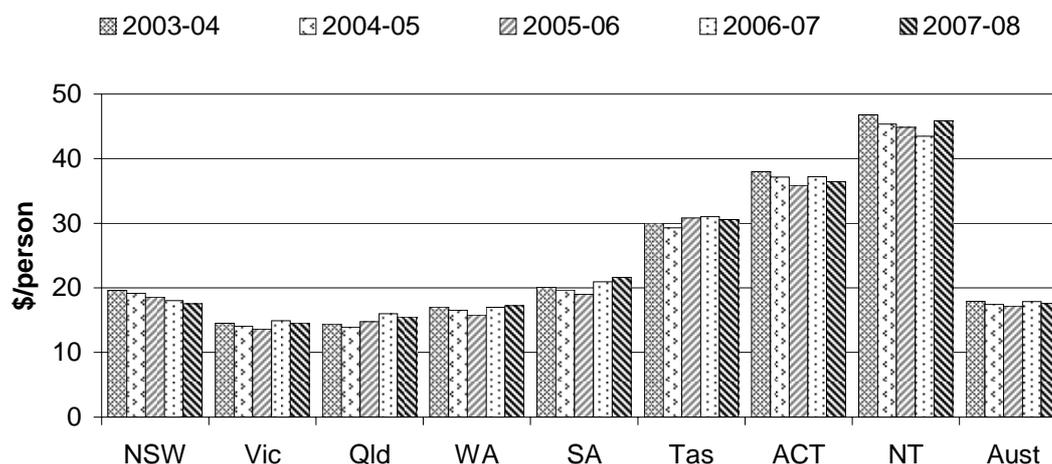
Recurrent funding of SAAP services was approximately \$372.9 million in 2007-08 (table 15A.179), of which the Australian Government contributed 49.8 per cent and the State and Territory governments contributed 50.1 per cent (table 15A.178). The Australian Government expenditure includes funding for Innovation and Investment pilot projects and \$500 000 allocated to national priorities funding. Since 2005-06, the State and Territory governments contribution has been increasing as a proportion of the overall recurrent SAAP funding (table 15A.178).

Nationally, real recurrent SAAP funding per head of population has remained relatively stable from 2003-04 to 2007-08 (table 15A.180). These figures varied across jurisdictions (figure 15.20).

In 2007-08, in addition to the amounts determined in agreements between jurisdictions and the Australian Government, some jurisdictions made recurrent allocations to SAAP services or SAAP-like activities (for example, to assist service

viability). These additional funds are not included in the above figures, but may be included in future Reports.

Figure 15.20 Real recurrent SAAP funding per person in the residential population (2007-08 dollars)^{a, b, c}



^a Includes total recurrent allocations (including State and Territory level allocations for program administration). ^b Historical population rates used in this figure may differ from those in previous Reports, as historical population data have been revised using Final Rebased Estimated Resident Population (ERP) data following the 2006 Census of Population and Housing (for 31 December 2003 to 2005). The total population figure is not indicative of the demand for SAAP services. ^c Real recurrent funding is calculated using ABS gross domestic product expenditure implicit price deflator (2007-08=100) (table AA.26).

Source: FaHCSIA (unpublished); table 15A.180; table AA2.

15.9 Framework of performance indicators for supported accommodation and assistance services

The framework of performance indicators for supported accommodation and assistance services is based on the shared government objectives for SAAP services (box 15.45).

Box 15.45 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:

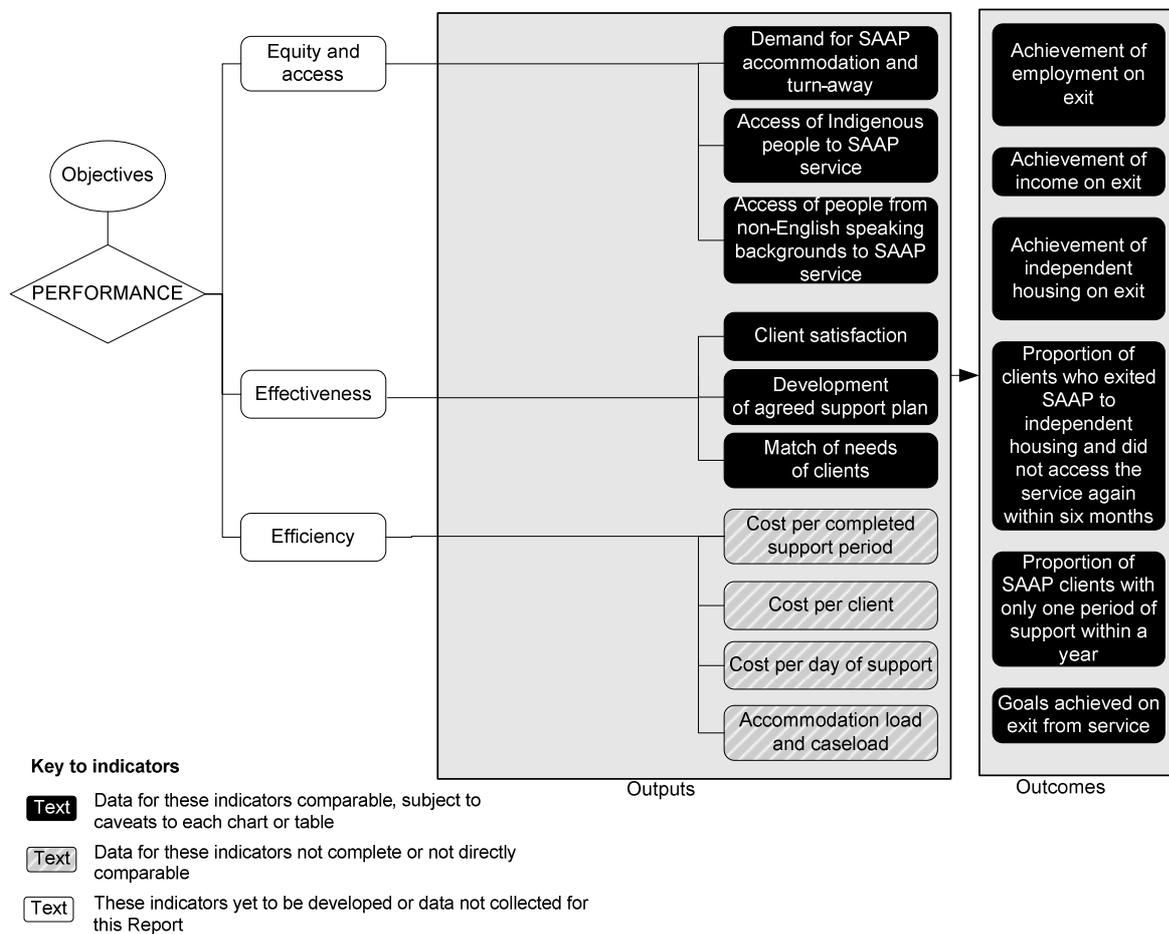
- resolve crises
- re-establish family links where appropriate
- re-establish the capacity of clients to live independently of SAAP.

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 15.21).

The performance indicator framework shows which data are comparable in the 2009 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 15.21 Performance indicators for SAAP services



15.10 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 15.46).

Box 15.46 Information to be considered when analysing SAAP data

The following information needs to be considered when analysing SAAP data.

- Informed consent is an essential component of the integrity of the data. The principle of client/consumer rights (which underpins informed consent) recognises that clients do not receive services under a mandatory order. They have the right to accept or reject the services offered and they have the right to provide or not provide information while receiving SAAP services.
- Clients consented to provide personal details for the SAAP client collection for 81.1 per cent of support periods in 2006-07. A weighting system has been developed to adjust for agency non-participation (87.2 per cent of agencies participated in the client collection) and non-consent (AIHW 2008b).
- Agency participation is essential to ensure accurate reflection of the work done under the SAAP program. While the majority of jurisdictions had participation rates of 90 per cent or more in 2006-07, the ACT and Victoria had participation rates of 76 per cent and 78 per cent respectively. These lower participation rates were the result of restructuring and consolidation of services in the ACT and creation of new agencies in Victoria. A number of services affected by these changes did not submit data. Weighting for participation assumes that agencies operated a full year. Partial year participation will result in a variation in the number of support periods and clients. This assumption has a more significant impact on smaller jurisdictions.

Outputs

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

Equity and access

Demand for SAAP accommodation and turn-away

‘Demand for SAAP accommodation and turn-away’ is an indicator of governments’ objective to ensure all Australians have equitable access to SAAP services on the basis of relative need (box 15.47).

Box 15.47 Demand for SAAP accommodation and turn-away

‘Demand for SAAP accommodation and turn-away’ is defined as the extent to which the demand for accommodation is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation cannot be provided with that assistance (although one-off assistance may be provided). Two measures of the proportion of people whose valid request for immediate SAAP accommodation cannot be met are reported:

- turn-away as the proportion of people requiring new SAAP accommodation, defined as the average daily percentage of people who could not be accommodated relative to all people making valid requests for immediate SAAP accommodation. This provides an indication of a person’s likelihood of obtaining SAAP accommodation.
- turn-away as the proportion of total demand for SAAP accommodation, defined as the average daily percentage of people who could not be accommodated relative to all people who required new and immediate SAAP accommodation or who were continuing their accommodation from the previous day. This provides a measure of the overall ability of SAAP to meet the demand for accommodation on an average day during the Demand for Accommodation Collection period.

A higher or increasing proportion of valid requests receiving accommodation is desirable.

Data reported for this indicator are comparable across jurisdictions. However, these data are not necessarily comparable over time due to different collection periods in different years.

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.

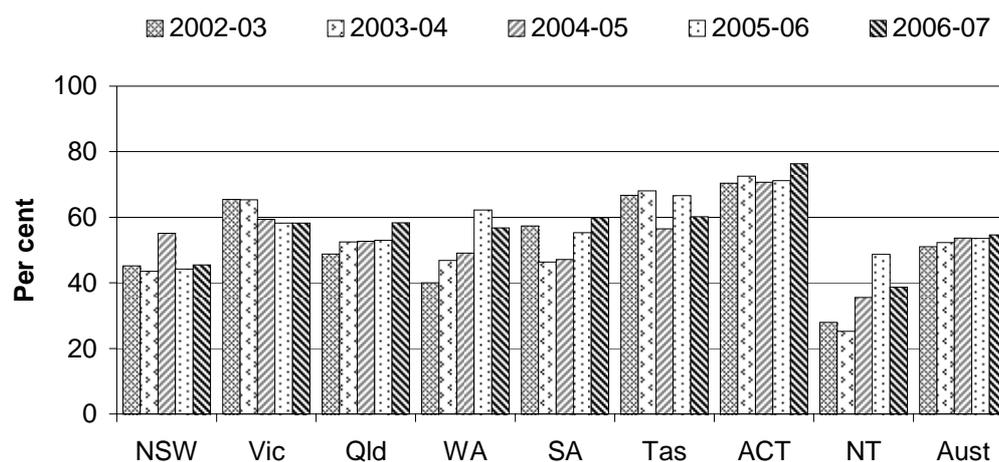
The Demand for Accommodation Collection collects data on ‘valid unmet requests’ for immediate accommodation. ‘Valid unmet requests’ excludes requests made at an agency, where the person or group is determined to be inappropriate for the targeting of the agency, where there is no fee-free accommodation available at that time³, or where offered assistance is refused. For the Client Collection, the accommodation status of a client on a particular day is based on the reported periods of accommodation within a support period.

³ ‘No fee-free accommodation available’ refers to situations where the person/group is not given accommodation because they cannot meet the financial requirements (for example, fees) for that accommodation.

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 one-week sample periods 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.181-182).

Data on the proportion of people with valid requests for SAAP accommodation who were turned away are reported for the years 2002-03 to 2006-07. Nationally, 54.6 per cent of adults and unaccompanied children requesting immediate new SAAP accommodation on a given day were turned away in 2006-07. This proportion varied across jurisdictions (figure 15.22).

Figure 15.22 Turn-away of adults and unaccompanied children as a proportion of people requiring new SAAP accommodation^{a, b, c, d}



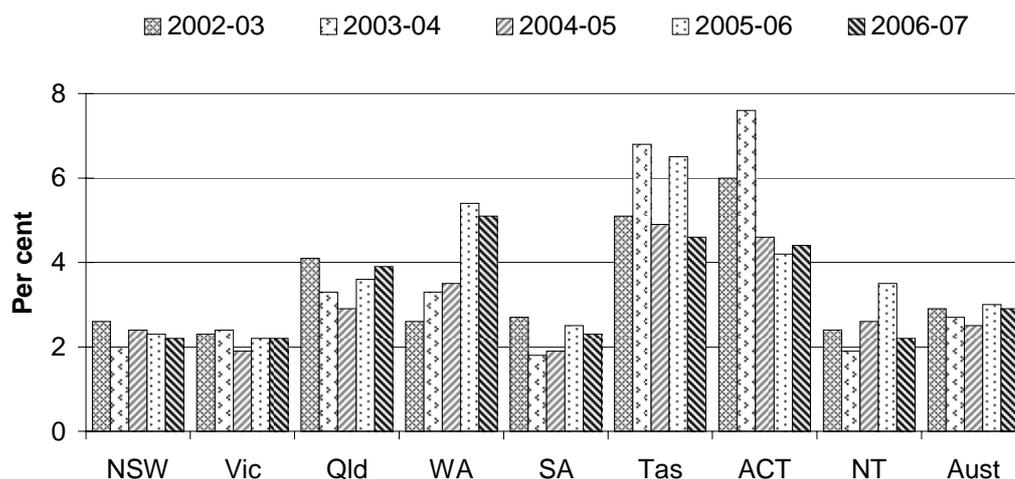
^a A two-week Demand for Accommodation Collection is conducted annually to gather information about homeless people whose requests for accommodation were unable to be met by SAAP agencies. The collections were held in December and May, or August and May, of each financial year. ^b Comparisons between 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 The denominator for this indicator refers to adults and unaccompanied children. ^d See notes to table 15A.181 for more detailed data caveats.

Source: AIHW (2008) *Demand for SAAP accommodation by Homeless People 2006-07: A report from the SAAP national data collection*. SAAP NDCA report series 12. Cat. No. HOU 186; table 15A.181.

Nationally, the number of adults and unaccompanied children who made valid requests for SAAP accommodation but could not be accommodated accounted for 2.9 per cent of the total demand for SAAP accommodation in 2006-07 (total demand includes adults and unaccompanied children). 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 15.23).

Figure 15.23 Turn-away of adults and unaccompanied children as the proportion of total demand for SAAP accommodation^{a, b, c, d}



^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, or August 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 The denominator for this indicator refers to adults and unaccompanied children. ^d See notes to table 15A.182 for more detailed data caveats.

Source: AIHW (2008) *Demand for SAAP accommodation by Homeless People 2006-07: A report from the SAAP national data collection*. SAAP NDCA report series 12. Cat. No. HOU 186; table 15A.182.

Requests for SAAP accommodation were not met for a number of reasons in 2006-07, including lack of available accommodation (59.7 per cent), no vacancies at the referral agency (21.8 per cent), type of accommodation requested is not provided (6.8 per cent) and insufficient staff (2.0 per cent) (table 15A.190).

Access of Indigenous people to SAAP service

‘Access of Indigenous people to SAAP service’ is an indicator of governments’ objective to ensure all Australians have equitable access to SAAP services on the basis of relative need (box 15.48).

Box 15.48 Access of Indigenous people to SAAP service

'Access of Indigenous people to SAAP service' 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.

A high and equivalent proportion of valid requests receiving assistance is desirable.

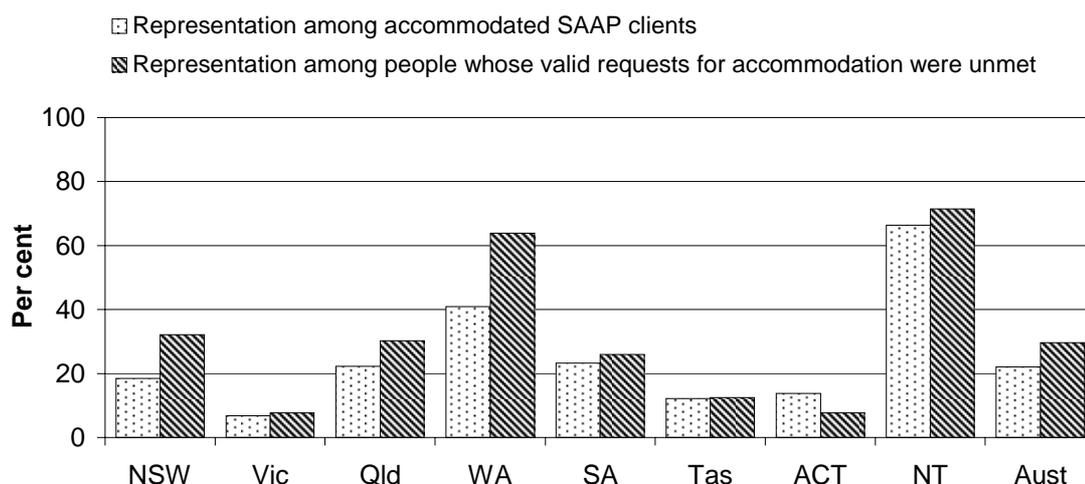
The indicator measures the extent to which the demand for assistance from Indigenous people is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation, or support, cannot be provided with that assistance (although one-off assistance may be provided).

Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as Indigenous people) is particularly important.

Data reported for this indicator are comparable.

Nationally, Indigenous people made up 29.7 per cent of all people whose valid requests for accommodation did not result in accommodation assistance in 2006-07 — a proportion greater than Indigenous clients among all accommodated SAAP clients (22.1 per cent). This result varied across jurisdictions (figure 15.24).

Figure 15.24 **Proportion of Indigenous people among all accommodated SAAP clients and among people whose valid requests for accommodation were unmet, 2006-07^a**



^a See notes to table 15A.183 for details of data definitions.

Source: SAAP NDCA *Client and Demand for Accommodation Collections* (unpublished); AIHW (2008) *Demand for SAAP accommodation by Homeless People 2006-07: A report from the SAAP national data collection*. SAAP NDCA report series 12. Cat. No. HOU 186; table 15A.183.

Access of people from non-English speaking backgrounds to SAAP service

‘Access of people from non-English speaking backgrounds to SAAP service’ is an indicator of governments’ objective to ensure all Australians have equitable access to SAAP services on the basis of relative need (box 15.49).

Box 15.49 Access of people from non-English speaking backgrounds to SAAP service

‘Access of people from non-English speaking backgrounds to SAAP service’ 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.

A high and equivalent proportion of valid requests receiving assistance is desirable.

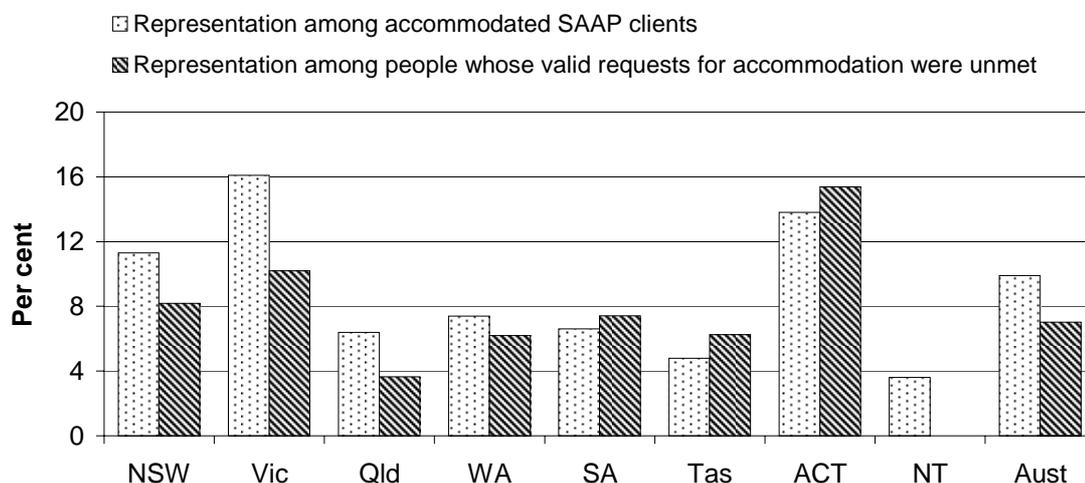
The indicator measures the extent to which the demand for assistance from people from non-English speaking backgrounds is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation, or support, cannot be provided with that assistance (although one-off assistance may be provided).

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.

Data reported for this indicator are comparable.

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 7.0 per cent in 2006-07 — 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 15.25).

Figure 15.25 Proportion of people from non-English speaking backgrounds among all accommodated SAAP clients and among people whose valid requests for accommodation were unmet, 2006-07^a



^a See notes to table 15A.184 for details of data definitions.

Source: SAAP NDCA *Client and Demand for Accommodation Collections* (unpublished); AIHW (2008) *Demand for SAAP accommodation by Homeless People 2006-07: A report from the SAAP national data collection*. SAAP NDCA report series 12. Cat. No. HOU 186; table 15A.184.

Effectiveness

Client satisfaction

'Client satisfaction' is an indicator of governments' objective to provide high quality services that meet the needs of SAAP recipients (box 15.50).

Box 15.50 Client satisfaction

'Client satisfaction' 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 reported for this indicator are comparable.

Data for the client satisfaction indicator are sourced from the national SAAP client satisfaction survey, which was conducted in 2003. As a result, new data for this indicator are not available for this Report. Data on client satisfaction relating to a

four week period beginning 11 November 2003 were included in the 2005 Report (SCRGSP 2005, pp. 15.47-48; CBSR 2004).

Development of agreed support plan

‘Development of agreed support plan’ is an indicator of governments’ objective to provide high quality services that are appropriately targeted to meet the needs of SAAP clients (box 15.51).

Box 15.51 Development of agreed support plan

‘Development of agreed support plan’ is defined as the number of closed support periods with an agreed support plan divided by the total number of closed support periods. Data are reported for all SAAP clients, and separately for Indigenous clients.

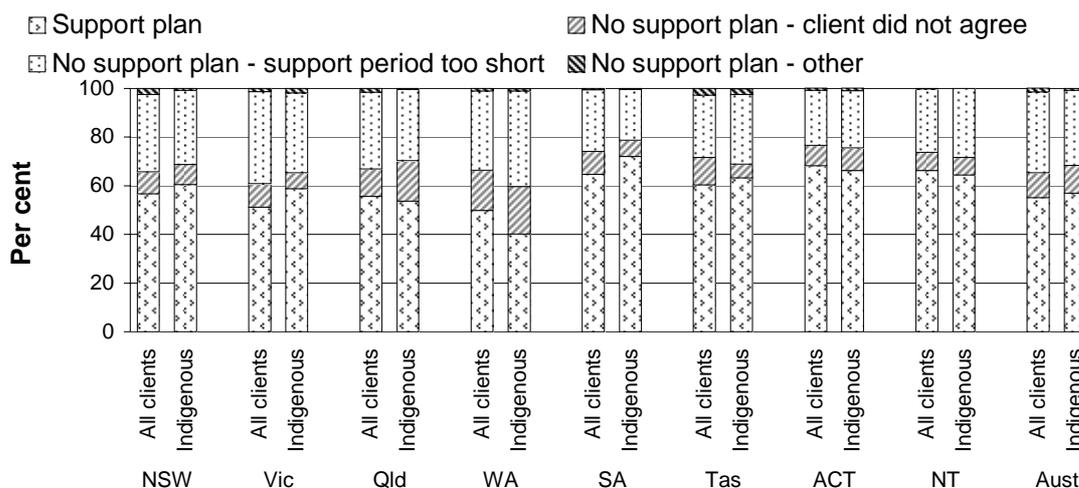
A higher proportion of support periods with agreed support plans is desirable.

However, in some instances, a support plan may be judged to be inappropriate (such as when a support period is short term).

Data reported for this indicator are comparable.

Nationally, there was an agreed support plan for 55.1 per cent of closed support periods for all clients in 2006-07 (compared to 57.0 per cent for Indigenous clients). These proportions varied across jurisdictions (figure 15.26).

Figure 15.26 Support periods, by the existence of a support plan, 2006-07^a



^a See notes to tables 15A.185-186 for more details of data definitions.

Source: SAAP NDCA Client Collection (unpublished); tables 15A.185-186.

Match of needs of clients

'Match of needs of clients' is an indicator of governments' objective to ensure that SAAP services meet their client's individual needs (box 15.52).

Box 15.52 Match of needs of clients

'Match of needs of clients' is defined as the number of distinct services required by the clients that are provided as well as those referred to another agency, divided by the total number of distinct services required by SAAP clients.

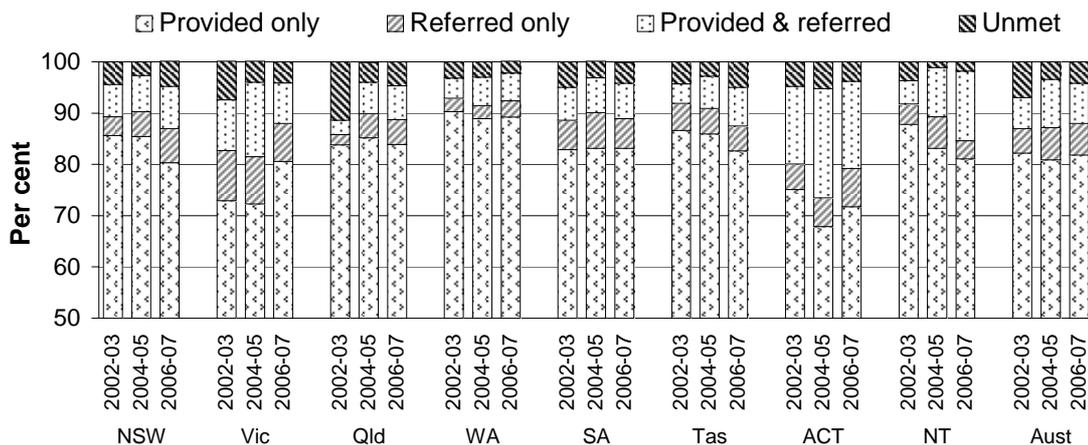
A higher proportion of clients who received services they needed, or who were referred to another agency, is desirable.

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. Data are reported for all SAAP clients, and separately for Indigenous people and people from non-English speaking backgrounds.

Data reported for this indicator are comparable.

Nationally, the proportion of clients who received needed services (including services provided by the initially approached agencies and/or referrals to another agency) was 95.8 per cent in 2006-07 (figure 15.27).

Figure 15.27 SAAP clients, by met and unmet support needs

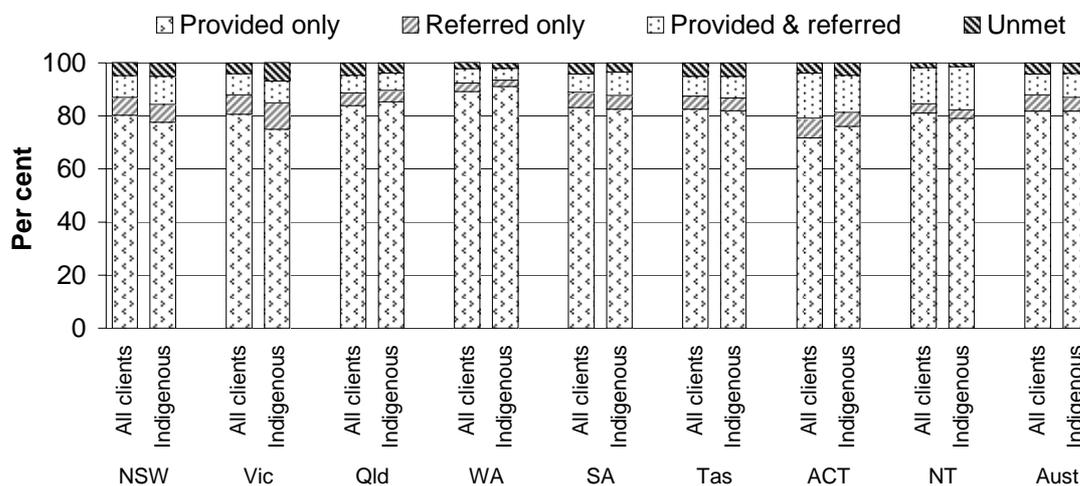


Source: SAAP NDCA Client Collection (unpublished); table 15A.187.

The proportions for Indigenous clients (96.0 per cent) and clients from a non-English speaking background (96.4 per cent) who received services in 2006-07

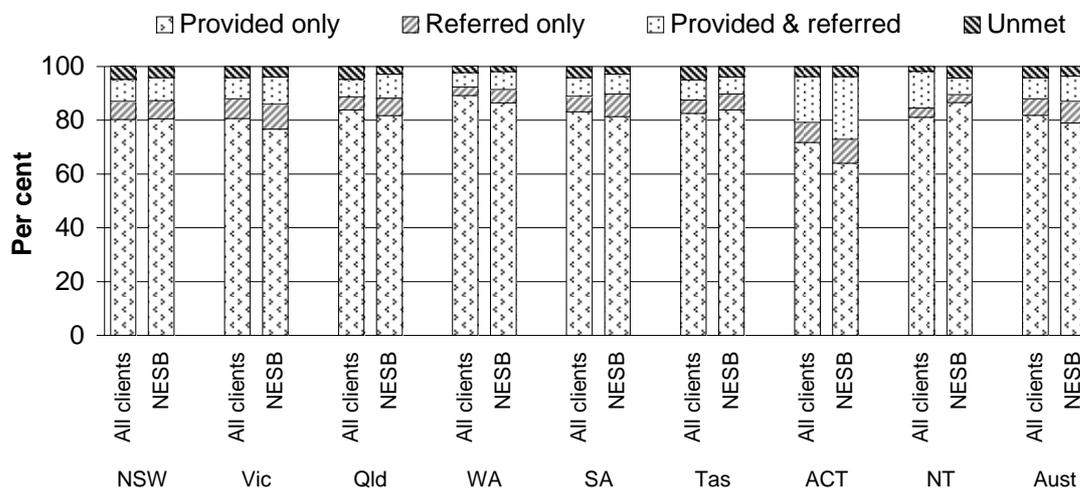
were similar to that for all clients. These proportions varied across jurisdictions (figures 15.28-29).

Figure 15.28 Indigenous clients, by met and unmet support needs, 2006-07



Source: SAAP NDCA Client Collection (unpublished); tables 15A.187-188.

Figure 15.29 Clients from non-English speaking backgrounds, by met and unmet support needs, 2006-07



NESB = Non-English speaking background.

Source: SAAP NDCA Client Collection (unpublished); tables 15A.187 and 15A.189.

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 for efficiency indicators may reflect these differences.

The funding figures used to calculate the following efficiency indicators include recurrent allocations to agencies provided by some jurisdictions in addition to the amounts determined in the agreements between these jurisdictions and the Australian Government.

Cost per completed support period

‘Cost per completed support period’ is an indicator of the governments’ objective to maximise the availability and quality of services through the efficient use of taxpayer resources (box 15.53).

Box 15.53 Cost per completed support period

‘Cost per completed support period’ is defined as total expenditure on SAAP services divided by the number of completed support periods (excluding casual clients, and adults and accompanying children with a valid unmet request for accommodation).

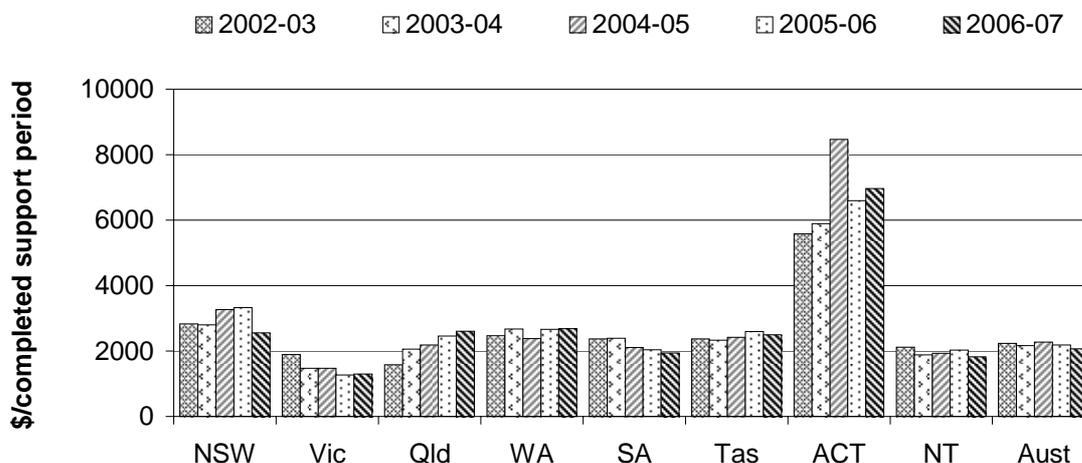
A lower cost per completed support period is desirable, but may also indicate lesser service quality.

This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost), including only expenditure by service delivery providers. Unit cost indicators ideally include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the CSHA through a special purpose program (the CAP).

Data reported for this indicator are not directly comparable.

The recurrent cost per completed support period (excluding potential clients and accompanying children) averaged \$2060 nationally and varied across jurisdictions in 2006-07 (figure 15.30).

Figure 15.30 **Real recurrent cost per completed support period (2006-07 dollars)^a**



^a See notes to table 15A.191 for detailed data caveats.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.191.

Cost per client

‘Cost per client’ is an indicator of governments’ objective to maximise the availability and quality of services through the efficient use of taxpayer resources (box 15.54).

Box 15.54 **Cost per client**

‘Cost per client’ is defined as total expenditure on SAAP services divided by the number of clients accessing a bed or place over the year.

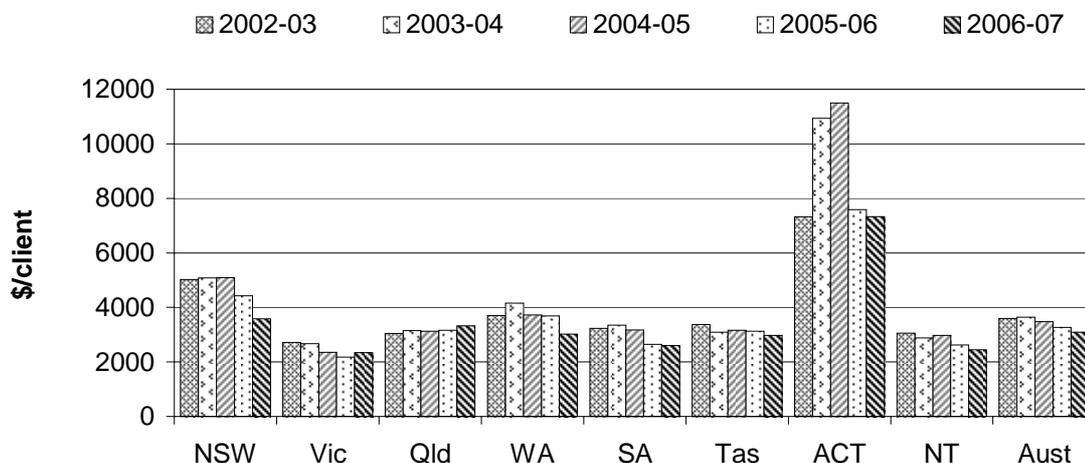
A lower cost per client is desirable, but may also indicate lesser service quality.

This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost), including only expenditure by service delivery providers. Unit cost indicators ideally include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the CSHA through a special purpose program (the CAP).

Data reported for this indicator are not directly comparable.

Nationally, the recurrent cost per client accessing SAAP services was \$3090 and varied across jurisdictions in 2006-07 (figure 15.31).

Figure 15.31 Real recurrent cost per client accessing SAAP services (2006-07 dollars)^a



^a See notes to table 15A.192 for detailed data caveats.

Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); table 15A.192.

Cost per day of support

‘Cost per day of support’ is an indicator of governments’ objective to maximise the availability and quality of services through the efficient use of taxpayer resources (box 15.55).

Box 15.55 Cost per day of support

‘Cost per day of support’ is defined as total expenditure on SAAP services divided by the number of days of support for SAAP clients receiving support and/or supported accommodation (excluding casual clients, and adults and accompanying children with a valid unmet request for accommodation).

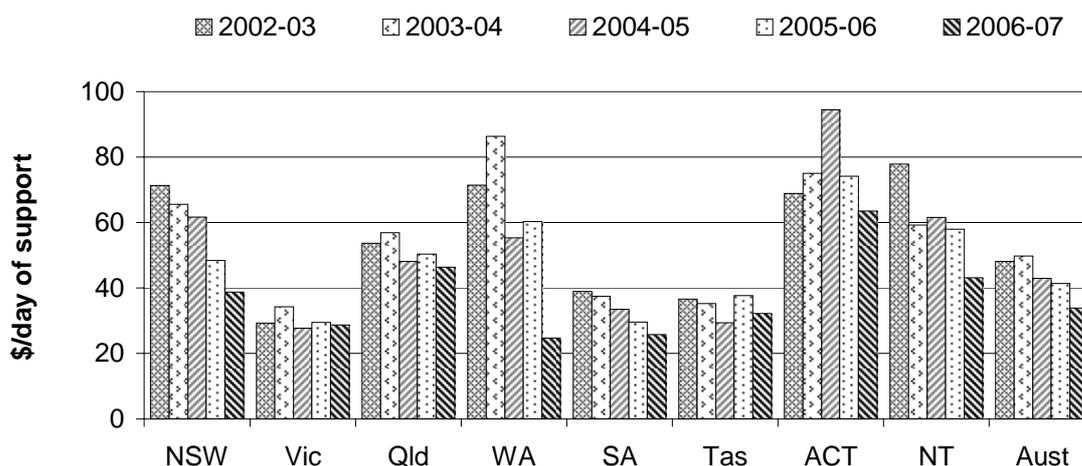
A lower cost per day of support is desirable, but may also indicate lesser service quality.

This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost), including only expenditure by service delivery providers. Unit cost indicators ideally include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the CSHA through a special purpose program (the CAP).

Data reported for this indicator are not directly comparable.

The recurrent cost per day of support for SAAP clients averaged \$34 nationally and varied across jurisdictions in 2006-07 (figure 15.32).

Figure 15.32 **Real recurrent cost per day of support for clients (2006-07 dollars)^a**



^a See notes to table 15A.193 for detailed data caveats.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.193.

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 (box 15.56).

Box 15.56 Accommodation load and caseload

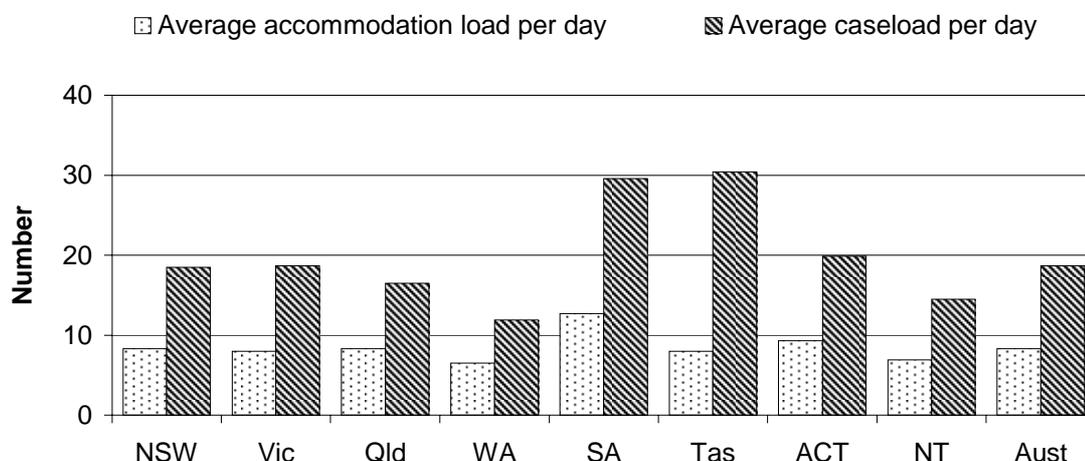
The average accommodation load is defined as the average number of people accommodated per day per agency. The average caseload is defined as the average number of people being supported per day per agency.

Average accommodation load and caseload are indicators of efficiency as they indicate levels of output by agencies. Accommodation load and caseload are likely to be affected by the size of the agencies funded under the SAAP Program.

Data reported for this indicator are not directly comparable.

The national average daily accommodation load and caseload per agency were 8.3 and 18.7 respectively, and this varied across jurisdictions in 2006-07 (figure 15.33).

Figure 15.33 Average accommodation load and caseload per day, 2006-07^a



^a See notes to table 15A.194 for descriptions of how accommodation load and caseload were estimated.
 Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.194.

Outcomes

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

An important outcome of SAAP services is clients' achievement of self-reliance and independence. Characteristics that may indicate whether clients can live independently include their income, housing status and workforce status. These characteristics are recorded at the end of a client's support period.

In 2006, the SAAP CAD commissioned a research project on SAAP Impact on Client Self-reliance. The research was undertaken by the Social Policy Research Centre (SPRC) of the University of New South Wales. The study involved a survey of 630 SAAP clients who had received support for at least four weeks and had a case plan in place. These 630 clients came from 75 agencies that were broadly representative of all SAAP agencies.

In its report *Measuring the Impact of SAAP-funded Homelessness Services on Client Self-reliance* (FaHCSIA 2008a) the SPRC found that, on a ten-point scale representing the concept of 'getting back on my feet', two-thirds of respondents perceived they were at point eight or beyond. Only five per cent of respondents perceived they had made no progress at all. The factor that most influenced how respondents perceived their self-reliance was the length of time they had been accessing the service. There were no significant differences in outcomes at the

average level between Indigenous and non-Indigenous clients, or between clients from culturally or linguistically diverse background (CALD) and non-CALD clients. The report showed that SAAP clients perceive that SAAP is effective in helping them move towards self-reliance but also that many of the problems and barriers that led clients into homelessness are not susceptible to quick and easy solutions and may take considerable time, effort and resources to overcome.

Achievement of employment on exit

‘Achievement of employment on exit’ is an indicator of governments’ objective to enable clients to participate as productive and self-reliant members of society at the end of their support period (box 15.57).

Box 15.57 Achievement of employment on exit

‘Achievement of employment on exit’ is defined as the number of closed support periods for SAAP clients who sought assistance to obtain or maintain employment and training, and achieved employment after SAAP support, divided by the total number of closed support periods for clients who sought assistance to obtain or maintain employment. Support periods reported relate to these clients only.

Higher proportions of achievement of employment are desirable.

This indicator compares these clients’ employment status before and after they requested SAAP support. Data are reported for all SAAP clients, and separately for Indigenous clients.

This indicator relates to relatively short term outcomes — that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but more difficult to measure.

Data reported for this indicator are comparable.

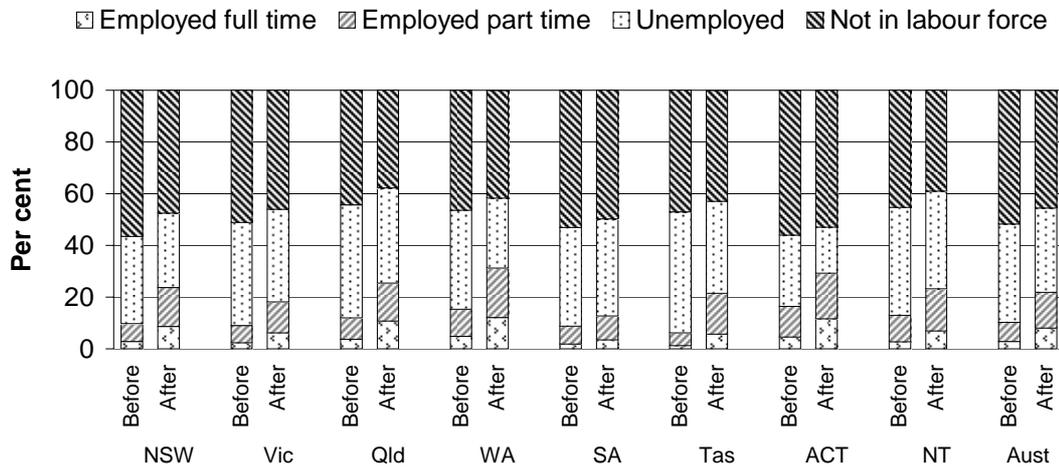
Nationally, of those clients who sought assistance to obtain or maintain employment and training when entering SAAP in 2006-07, the proportion of clients who were employed either full time or part time increased from 10.3 per cent before support to 21.9 per cent after support (8.0 per cent full time and 13.9 per cent part time). The proportions of clients who were unemployed decreased from 38.0 per cent before support to 32.5 per cent after support. The proportions of clients who were not in the labour force decreased from 51.8 per cent before support to 45.5 per cent after support. These proportions varied across jurisdictions (figure 15.34(a), table 15A.197).

Nationally, of those Indigenous clients who sought assistance to obtain or maintain employment and training when entering SAAP in 2006-07, the proportion of clients

who were employed either full time or part time increased from 7.0 per cent before support to 15.7 per cent after support (6.7 per cent full time and 9.0 per cent part time). The proportion of clients who were unemployed decreased from 34.1 per cent before support to 31.0 per cent after support. The proportion of clients who were not in the labour force decreased from 59.0 per cent before support to 53.3 per cent after support. These proportions varied across jurisdictions (figure 15.34(b) and table 15A.198).

Figure 15.34 Changes in labour force status of clients who needed assistance to obtain/maintain employment and training before/after SAAP support, 2006-07^a

(a) All SAAP clients



(b) Indigenous SAAP clients



^a Data are for people who requested assistance with obtaining or maintaining employment when entering SAAP services.

Source: SAAP NDCA Client Collection (unpublished); tables 15A.197-198.

Achievement of income on exit

‘Achievement of income on exit’ is an indicator of governments’ objective to enable clients to participate independently in society at the end of their support period (box 15.58).

Box 15.58 Achievement of income on exit

‘Achievement of income on exit’ is defined as the number of closed support periods for SAAP 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 closed support periods for clients who sought assistance to obtain or maintain a pension or benefit. Data are reported for all SAAP clients, and separately for Indigenous clients.

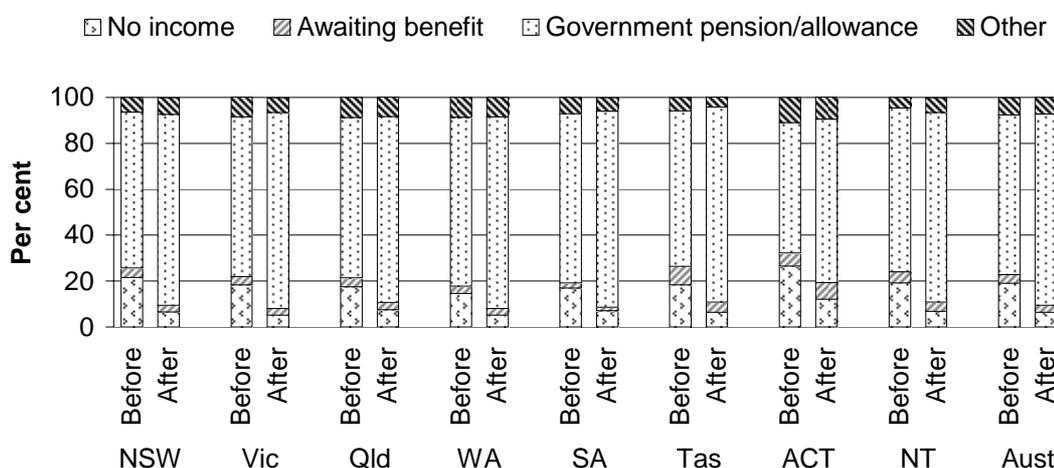
A high proportion of clients who requested income assistance and exited SAAP with an income source is desirable.

This indicator compares these clients’ income status before and after they received SAAP support. A client’s independence and self-reliance is enhanced when the client experiences a positive change in income source (for example, from having no income support to obtaining some income, including wages and/or benefits) on exit from SAAP services.

Data reported for this indicator are comparable.

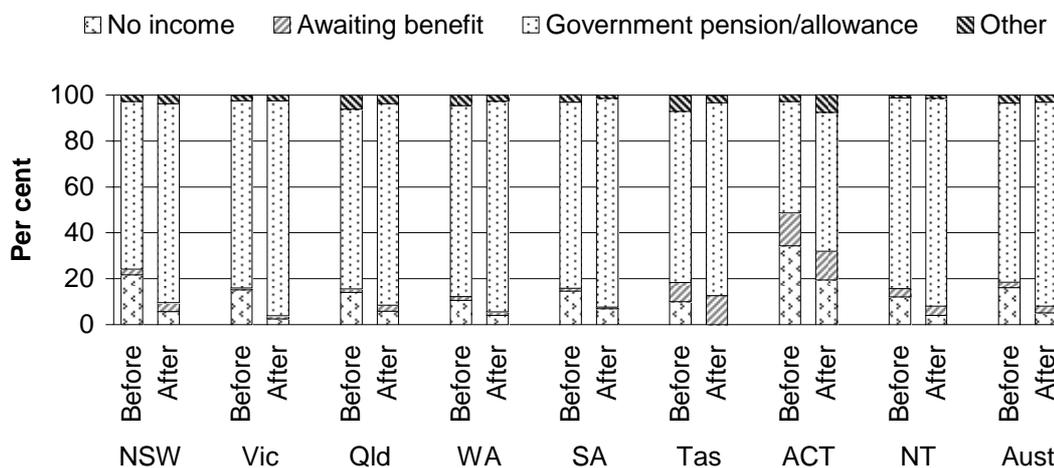
Nationally, in 2006-07 19.0 per cent of SAAP clients who requested income assistance did not have income prior to SAAP assistance. After SAAP assistance, the proportion of clients who had requested income assistance and had no income fell to 6.4 per cent (figure 15.35). The proportion of Indigenous clients who did not have income and requested income assistance also decreased after SAAP assistance (from 16.2 per cent to 5.1 per cent nationally) (figure 15.36). Both before and after the SAAP assistance, the income source for the majority of SAAP clients is a government pension/allowance (figures 15.35 and 15.36).

Figure 15.35 **Source of income immediately before/after SAAP support of clients who needed assistance to obtain/maintain a pension or benefit, 2006-07**



Source: SAAP NDCA Client Collection (unpublished); table 15A.202.

Figure 15.36 **Source of income immediately before/after SAAP support of Indigenous clients who needed assistance to obtain/maintain a pension or benefit, 2006-07**



Source: SAAP NDCA Client Collection (unpublished); table 15A.203.

Achievement of independent housing on exit

‘Achievement of independent housing on exit’ is an indicator of governments’ objective to enable clients to participate as productive and self-reliant members of society at the end of their support period (box 15.59).

Box 15.59 Achievement of independent housing on exit

'Achievement of independent housing on exit' 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 of completed support periods of clients who requested assistance with obtaining or maintaining independent housing.

Higher proportions of clients who are in independent housing are desirable.

This indicator compares the proportion of clients who were in independent housing before and after they received SAAP support. It relates to relatively short term outcomes — that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but more difficult to measure. Data are reported for all SAAP clients, and separately for Indigenous clients.

Data reported for this indicator are comparable.

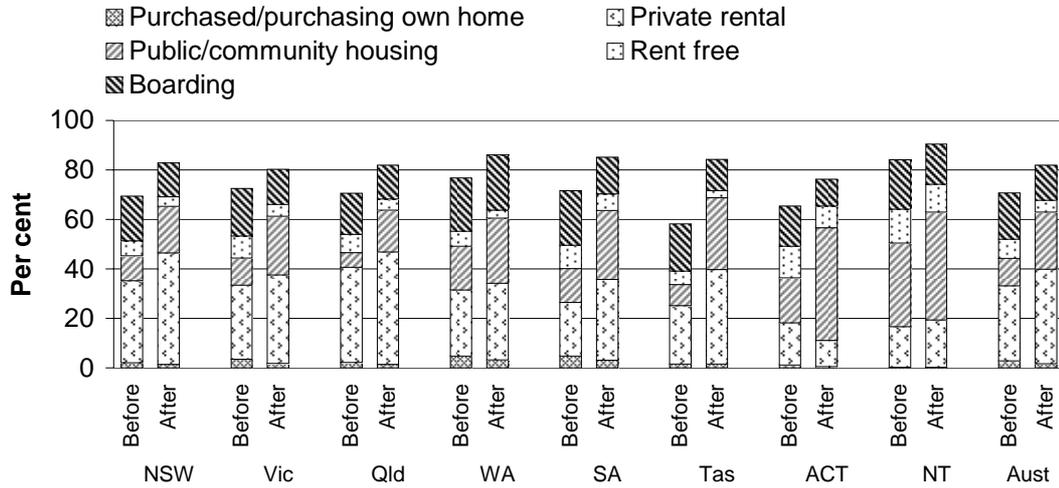
Nationally, 81.9 per cent of clients who requested assistance with obtaining or maintaining independent housing achieved independent housing at the end of a support period in 2006-07. This included clients who moved or returned to private rental housing (38.2 per cent), to public rental housing (17.4 per cent), and those who were boarding (14.2 per cent) (figure 15.37(a)).

Among Indigenous clients, on a national basis, 83.9 per cent of clients who requested assistance with obtaining or maintaining independent housing achieved independent housing at the end of a support period in 2006-07, including those who moved or returned to private rental housing (29.4 per cent), to public rental housing (25.5 per cent), and who were boarding (16.9 per cent) (figure 15.37(c)).

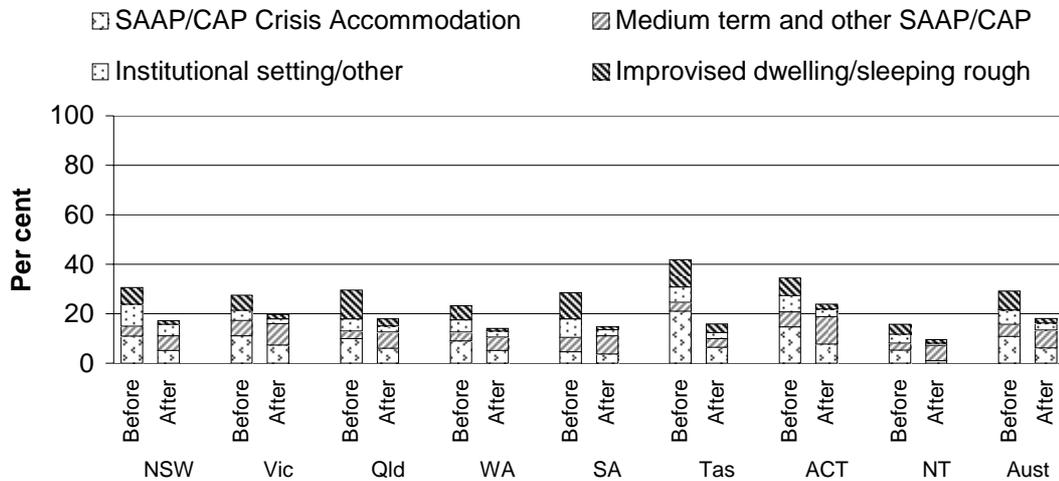
Clients who did not achieve independent housing at the end of a support period in 2006-07 included those who moved to, or continued to live in, short to medium term SAAP accommodation and other forms of non-independent accommodation (figure 15.37(b) and 15.37(d)).

Figure 15.37 Accommodation type before and after SAAP support, for clients who requested assistance with obtaining or maintaining housing, 2006-07

(a) All SAAP clients, Independent housing

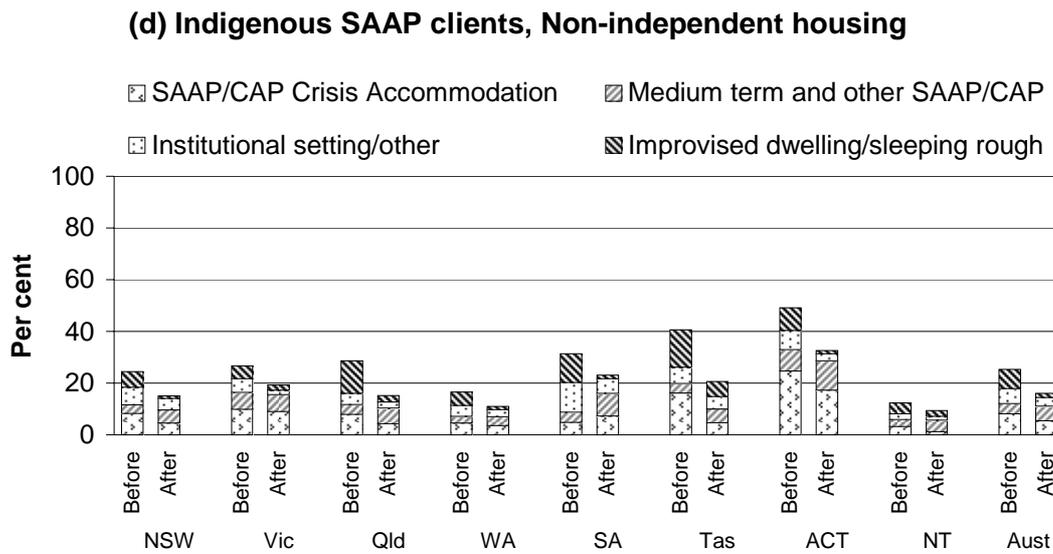
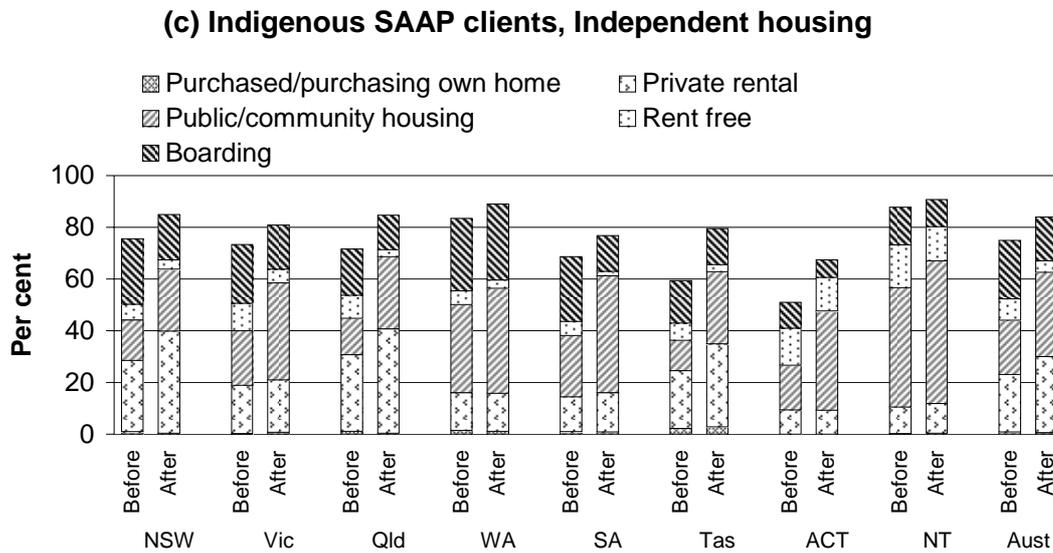


(b) All SAAP clients, Non-independent housing



(Continued on next page)

Figure 15.37 (Continued)



Source: SAAP NDCA Administrative Data and Client Collections (unpublished); tables 15A.195-196.

Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months

‘Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months’ is an indicator of governments’ objective to enable clients to participate independently in society at the end of their support period (box 15.60).

Box 15.60 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 defined as the number of clients who exit to independent housing and do not return to SAAP within six months, divided by the total number of SAAP clients.

A higher proportion of clients not returning to the program within six months is desirable.

A number of SAAP clients who need long term assistance may access SAAP services a number of times before their needs are met on a permanent basis. Ongoing contact with SAAP agencies may also lead to an improvement in living skills and self-reliance.

Data reported for this indicator are comparable.

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 15.46. The most recent data available are from 2004-05 and may not represent all clients (table 15A.201). Given the potential for data bias, these estimates should be interpreted with care.

Proportion of SAAP clients with only one period of support within a year

‘Proportion of SAAP clients with only one period of support within a year’ is an indicator of governments’ objective to enable clients to participate independently in society at the end of their support period (box 15.61).

Box 15.61 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 defined as the number of clients with only one support period during the year, divided by the total number of SAAP clients. Data are reported for all SAAP clients, and separately for Indigenous clients.

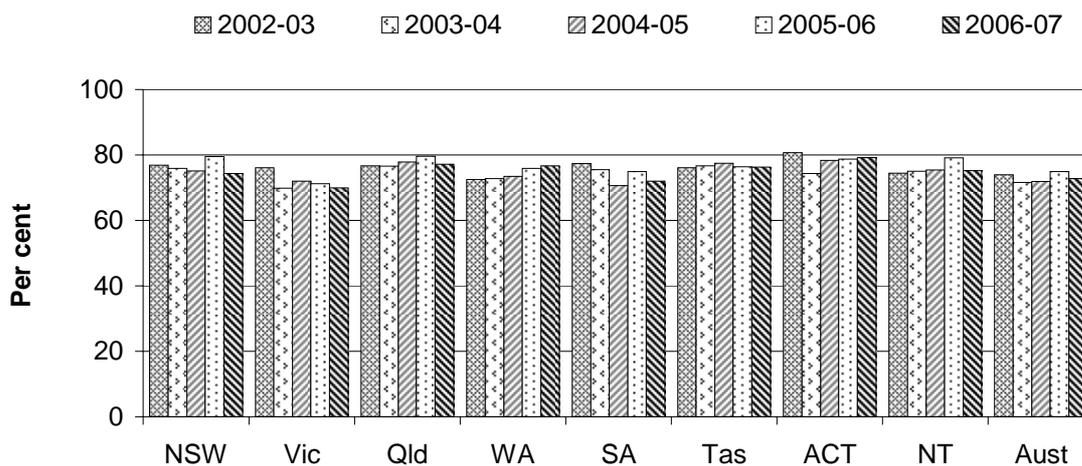
A higher proportion of clients with only one support period during the year is desirable.

It may be appropriate for some clients to receive more than one support period in a given period of time (for example, moving from crisis accommodation to medium term accommodation). One group that makes multiple use of SAAP is single adults, especially older single men. A number of SAAP clients who need long term assistance may access SAAP services a number of times before their needs are met on a permanent basis. Ongoing contact with SAAP agencies may also lead to an improvement in living skills and self-reliance.

Data reported for this indicator are comparable.

Nationally, 72.8 per cent of SAAP clients had only one support period in 2006-07 (figure 15.38). The proportion for Indigenous clients was similar (72.1 per cent) (table 15A.200).

Figure 15.38 Proportion of SAAP clients with only one period of support within a year



Source: SAAP NDCA Client Collection (unpublished); table 15A.199.

Goals achieved on exit from service

‘Goals achieved on exit from service’ is an indicator of governments’ objective to ensure SAAP services meet the needs and expectations of clients (box 15.62).

Box 15.62 Goals achieved on exit from service

‘Goals achieved on exit from service’ 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.

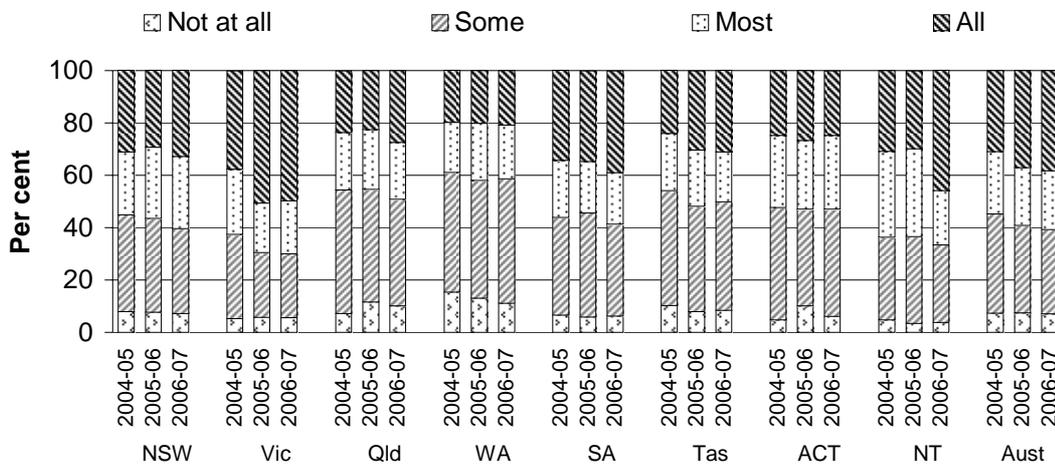
A high proportion of achieved goals is desirable.

The data are identified from a questionnaire completed by clients.

Data reported for this indicator are comparable.

Nationally, case management goals were fully or mostly achieved by the end of the support period for 60.7 per cent of clients in 2006-07 (figure 15.39).

Figure 15.39 Goals achieved on exit from SAAP service



Source: SAAP NDCA Client Collection (unpublished); table 15A.204.

15.11 Future directions in supported accommodation and assistance performance reporting

Reforms to Specific Purpose Payments

In December 2007, COAG agreed to reform Specific Purpose Payments (SPPs). SPPs are financial agreements between the Australian Government and State and Territory governments involving a contribution by the Australian Government to the funding of services which are considered a joint Australian and State and Territory government responsibility. *SAAP V (2005–2010)* was such an SPP.

At its 29 November 2008 meeting, COAG agreed to six new National Agreements, five of which are associated with a National SPP. In the area of supported accommodation and assistance services, there is a National Affordable Housing Agreement (NAHA) associated with the National Affordable Housing SPP (COAG 2008b). Under the reforms, the NAHA contains the objectives, outcomes, outputs and performance indicators for supported accommodation and assistance services. The performance of governments in achieving these mutually agreed outcomes will be assessed by the COAG Reform Council (CRC). The Steering Committee has been requested by COAG to provide the SPP performance information to the CRC (COAG 2008a).

The National Agreements/SPPs will be supplemented by a range of National Partnerships (NPs): project, facilitation and reward agreements. Funding for NPs may be conditional on states and territories meeting agreed milestones and performance benchmarks.

The Steering Committee and the Protection and Support Services Working Group will ensure that reporting in this chapter reflects the COAG priorities identified in the NAHA, National Affordable Housing SPP and relevant NPs.

SAAP V

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 were placed on client outcome information. Four levels of client outcomes are identified in the SAAP V Program Logic developed by a working group of the CAD.

Information on some client outcome indicators can be obtained from the SAAP National Data Collection and reported on a regular basis, but information on some higher level client outcome indicators can only be obtained from targeted research. Two specific research projects will be carried out under SAAP V to obtain this information. These projects are: SAAP Impact on client self-reliance (report published in January 2008, with descriptive material included under the outcomes section of this chapter); and, measuring the number of clients with high and complex needs (data from this project are anticipated to be published in late 2008).

SAAP V is anticipated to end on 31 December 2008, as a result of the new SPP reporting arrangements discussed above.

Homelessness reforms

In May 2008, the Australian Government released a green paper, dealing with the issue of homelessness. The Green Paper proposed three reform options, each of which would have an impact on future SAAP reporting:

- transform SAAP to build a national homelessness response focused on distinct streams
- improve the current SAAP response
- improve the mainstream service response to homelessness and restrict SAAP to responding to crisis interventions (FaHCSIA 2008b).

A White Paper and National Action Plan were anticipated to be released in late 2008.

15.12 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

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Child protection and supported placements

The Government currently invests around \$78 million in programs and projects that assist in the prevention of child abuse and neglect through ensuring better outcomes for vulnerable children and families. This includes programs such as Invest to Grow and Communities for Children that provide parenting education and a range of early intervention services. Other projects funded that specifically address child protection include the National Child Protection Clearinghouse and National Child Protection Week.

The Australian Government contributes to the wellbeing of children and young people in foster and grandparent/relative care, mainly through the provision of Commonwealth payments for eligible carers and a Health Care concession card.

The Australian Government committed \$2.64 million over three years (2008–2011) to lead the development and implementation of a *National Framework for Protecting Australia's Children*. The development of the *National Framework for Protecting Australia's Children* is being progressed by the Commonwealth in close consultation with the Community and Disability Services Ministers' Conference and will be released in early 2009.

Supported Accommodation Assistance Program (SAAP)

In 2007-2008 the Australian Government spent approximately \$277 million on programs for homeless persons and people at risk of homelessness. In addition to SAAP, these programs include the Household Organisational Management Expenses (HOME) Advice Program, the National Homelessness Strategy, Reconnect, and other related programs.

The HOME Advice Program provides support to families experiencing difficulties maintaining their tenancies or home ownership to prevent homelessness. The National Homelessness Strategy includes demonstration projects which trial innovative models to prevent or respond to homelessness and communication activities to disseminate best practices to prevent homelessness. Reconnect is an Australian Government program which assists young people who are homeless or at risk of being homeless to stop homelessness and improve participation.

The Australian Government is reforming homelessness and housing assistance through the development of a National Affordable Housing Agreement (NAHA) with State and Territory governments and the development of a White Paper on Homelessness. The NAHA will bring together funding for affordable housing, the Commonwealth-State Housing Agreement, the SAAP and Commonwealth Rent Assistance and other housing measures into a single, overarching agreement. Funding for homelessness programs will continue under the NAHA supplemented by specific National Partnership Agreements with state and territory governments including one on Homelessness.

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New South Wales Government comments

Child protection and supported placements

NSW Brighter Futures program is a voluntary, targeted program that supports vulnerable children and families to prevent them from escalating in the child protection system. This program will deliver \$150 million over five years for early intervention services in addition to employing 350 new dedicated early intervention caseworkers. Families in the Brighter Futures Program can access funded services, which include parenting programs and quality childcare.

Of the reviewable child deaths in NSW in 2006, 59 per cent were children aged less than 12 months. Research suggests that many of these children were affected by their mothers' drug and/or alcohol dependence while pregnant. In response, the NSW Department of Community Services (DoCS) has developed the *Responding to Prenatal Reports Policy* in conjunction with NSW Health. This provides guidance for caseworkers at DoCS Helpline and at Community Services Centres (CSCs) in responding to prenatal reports. Prenatal reports may arise from concerns that include mental illness, homelessness, domestic violence and drug and/or alcohol abuse during pregnancy.

DoCS is collaborating with NSW Health to reinforce the primary role of the Health sector in providing support and antenatal care to pregnant women. Close collaboration maximises preventative and early intervention strategies to reduce the risk of harm to unborn children. A six month trial of the policy began in June 2008 at three CSCs. Early indicators from the trial, are that substance abuse and transience are the biggest risk factors for mothers in the trial, followed by mental health and domestic violence.

Juvenile justice

The NSW Government is committed to providing restorative justice services to young offenders, victims and the community through administering youth justice conferences. The Department of Juvenile Justice supervises juvenile offenders on community-based or custodial orders or young people remanded into custody pending finalisation of their court matters. The Government's commitment to reducing re-offending is reflected in programs including Community Interventions such as the Intensive Supervision Program and Intensive Bail Supervision Program.

Supported Accommodation Assistance Program (SAAP)

During the second year of the SAAP V Agreement in NSW each of the seven DoCS regions developed a regional plan in line with the SAAP V strategic priorities to improve early intervention and post crisis strategies. These plans also identified priorities for funding under the national Innovation and Investment Fund. DoCS began the implementation of funding reforms with increased accountability. This involves service agreements that reflect Program priorities; results-based service specifications, and implementation of a performance monitoring framework.

Victorian Government comments

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Child protection and supported placements

The *every child every chance* reform process supported by the *Children, Youth and Families Act 2005*, has continued during 2008. The reforms promote prevention and support services for at-risk families, strengthen child protection and out-of-home care services and assist the delivery of culturally appropriate services to Aboriginal children and families. There has been further expansion across the state of Child FIRST with statewide provision planned for early 2009. A Best Interests Case Practice Model has been developed and is being implemented across Child Protection, Placement Services and Family Services to further promote and support good practice. A comprehensive review of out-of-home care services was commenced with the aim of developing a strategy to further improve the placement system and improve the outcomes for children.

Juvenile Justice

During 2007-08 the Department of Human Services Youth Services and Youth Justice program has been developing a Vulnerable Youth Framework for those aged between 10 and 25 years. The purpose of the Framework is to guide and strengthen action across State and local government and communities, including schools, to better respond to the needs of vulnerable young people who, through a combination of their circumstances and adolescent risk taking behaviour, are at risk of not realising their potential.

The Youth Justice Service Delivery Model (YJSDM) has been developed as an integrated approach to the provision of intensive support to Youth Justice clients. Through the YJSDM, Community Service Organisations have formed partnerships/consortia to collaboratively provide intensive support and a referral pathway to the broader youth service system to enhance outcomes for clients.

Supported Accommodation Assistance Program (SAAP)

In 2007-08, Victoria made significant progress in assisting people who are homeless or at risk of homelessness to transition to more stable living arrangements and active participation in the community.

A framework for a coordinated entry point system designed to provide the basis for a more responsive and less stressful process for people in crisis was successfully piloted in five sites across the state.

Implementation of the Integrated Response to Family Violence has continued in Victoria with significant reform and strengthening of the service system.

The Intensive Case Management Model has seen excellent outcomes in people re-establishing their lives and maintaining accommodation. The model provides a longer period of more intensive support for people with complex needs including young people, people with mental health issues, single adults and women experiencing family violence. All of these initiatives delivered through SAAP are helping to break the cycle of economic and social disadvantage by helping homeless people to develop skills and community connections.

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Queensland Government comments

Child protection and supported placements

Key achievements in 2007-08 included: employing 23 staff as part of the *One Chance at Childhood* initiative to provide specialist services to high-risk families with babies and toddlers; launching the Foster and Kinship Carer Recruitment Campaign, a five-year campaign to recruit, train and increase support for foster carers; establishing placement support units across the state to improve the quality, diversity and cost effectiveness of out-of-home placements; funding the establishment of four therapeutic residential facilities; and improving services to remote communities at Thursday Island, Weipa, Cooktown and Palm Island and establishing outreach services in Doomadgee, Normanton and Mornington Island.

Juvenile justice

The Queensland Government is continuing to implement and explore initiatives to reduce the rates of young people on remand and reduce the over-representation of Aboriginal and Torres Strait Islander young people in the criminal justice system. In 2007-08, recurrent funding was allocated for a Young Offender Community Response Service and Bail Support Service in Far North Queensland. A not-for-profit organisation — ACT for Kids — has been funded \$1.175 million per annum to deliver what is called the Youth Opportunity Program which will commence receiving clients in July 2008. Further work will be undertaken to reduce crime and recidivist behaviour among Indigenous young people through the implementation of an Aboriginal and Torres Strait Islander Youth Justice Strategy over the next year. Other key initiatives delivered to young people in Queensland over the course of the year include the introduction of two new evidence-based therapeutic programs to address some key factors contributing to offending behaviour—Aggression Replacement Therapy and Changing Habits And Reaching Targets. These two programs are being rolled out in youth justice service centres and detention centres across Queensland with extensive training and supervision being provided to staff involved in the programs' delivery.

Supported Accommodation Assistance Program (SAAP)

In 2007-08, the Queensland Government continued to address homelessness through the implementation of the 'Responding to Homelessness 2005–2009' initiative – under which the Queensland Government has committed \$235.52 million over four years to provide a continuum of integrated responses to the needs of homeless people. This includes \$56.5 million committed to SAAP. In August 2008, the Premier of Queensland announced that the Department of Communities would take lead responsibility for homelessness policy as of 1 January 2009. In addition, a number of elements of the Crisis Accommodation Program will transition from the Department of Housing to the Department of Communities. The new arrangements aim to improve client pathways to long-term housing through improved linkages between homelessness responses and the social housing system.

Western Australian Government comments

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Child protection and supported placements

2007-08 is the first year of operation of the Department for Child Protection, which was created in May 2007 following the outcomes of the *Ford Review*. The Department has completed a number of recommendations from the Review and is implementing 36 reform projects. During 2007-08 the Department adopted *Signs of Safety* as its child protection practice framework and established the Aboriginal Reference Group. Legislation for the mandatory reporting of child sexual abuse by doctors, nurses and midwives, teachers and police was passed in State Parliament and is expected to be operational from 1 January 2009. Key initiatives to improve services for children in the CEO's care include: introducing health and education plans; increasing the number and range of accommodation and care options; providing improved leaving care services and providing more support to foster carers, including additional respite.

Juvenile justice

Significant achievements during the year saw the continued expansion of the Intensive Supervision Program, the further development of the Regional Youth Justice Strategy, the trialling of the Pilot Youth Justice Initiative, a multi-agency initiative based on collaborative co-case management, and sustained participation in interagency discussions to address the increasing number of young people held in custody on remand and an ongoing focus on staff development to ensure a better delivery of services to young people. A range of group and individual development and therapeutic programs was delivered to young people in detention and in the community throughout the year. Work has also continued on the development of an integrated juvenile justice service delivery model to ensure the system is able to meet future demand.

Supported Accommodation Assistance Program (SAAP)

SAAP continues to operate under the SAAP V Multilateral Agreement, signed on 30 September 2005 and the Western Australian Bilateral Agreement, signed on 25 January 2006. It is anticipated the SAAP V Agreement will be shortened in preparation for the commencement of the new National Affordable Housing Agreement (NAHA). In the 2008-09 State Budget an allocation of \$3.2 million over four years was provided to 20 youth accommodation services facing the greatest cost pressures. In addition new recurrent funding was allocated to establish a safe house for teenage mothers aged 14–18 years escaping domestic violence. The SAAP V Innovation and Investment Fund pilots' evaluation indicates extremely positive outcomes for clients. Service viability, housing affordability and lack of exit point housing continue to challenge the sector. ”

South Australian Government comments

Child protection and supported placements

The *Keeping Them Safe* reform program emphasises shared responsibility across Government and the whole community to ensure that all children are safe from harm. Partnerships with government agencies and key non-government agencies have been a foundation for implementing the reform program. An across Government information sharing guideline will allow all agencies who work with vulnerable families and children to share information and coordinate service provision. The *Keeping them Safe – In Our Care* reforms place emphasis on specialist family support services; improving assessment processes; implementing ‘wrap around’ care packages tailored to each child; expanding therapeutic foster care placements to children with complex needs; and changing the Children’s Payment system to support efficiency and equity.

Juvenile justice

The *To Break the Cycle* reform program lead by the South Australian Attorney-General’s Department is taking an all-of-government approach to tackling serious offending and preventing early entry of children and young people into the justice system. Emphasis has been placed on strengthening delivery of case management, including intensive case management services for serious repeat offenders and an expansion of home detention services. The SA Government has engaged Professor David Kennedy, Director Crime Prevention and Control at John Jay College, New York to work a cross-government community engagement and problem solving approach with a group of serious and persistent offenders.

Supported Accommodation Assistance Program (SAAP)

While the 2007-08 SAAP data was not available for this Report, the available 2006-07 data indicates that South Australian SAAP services are achieving positive results for people who are homeless or at imminent risk of homelessness on a number of effectiveness and efficiency indicators.

South Australian SAAP services compared well nationally on measures of efficiency, with a higher than average recurrent SAAP program funding per person/population, a much lower than average recurrent cost per client accessing services, the second lowest real recurrent cost per day of support, the second highest of an existence of a support plan for all clients at 64.7 per cent, the highest average accommodation load per day of 12.7, and the second highest average caseload per day of 29.6 (compared with the national average of 18.7). South Australia also ranks the highest nationally for the existence of a support plan for Indigenous clients; at 72 per cent compared with 57 per cent. This signifies a positive direction for improved planning and assessment responses to meet Indigenous client needs. South Australia in 2006-07 recorded a higher than average turn away rate for new accommodation at 59.9 per cent. It is prioritising this issue for improvement in 2008-09.

Tasmanian Government comments

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Child protection and supported placements

The Tasmanian Government continues to be engaged in the implementation of a wide range of reforms of the child protection service system as outlined in the report *New Directions for Child Protection in Tasmania: An Integrated Strategic Framework, January 2008*. Key aspects of the reform agenda involve the establishment of a new family services system and the development of a more responsive out-of-home care program. These reforms are designed to occur over a period of five years and during 2007-08 detailed implementation plans were completed. To date, area teams have been established, new child protection systems have been implemented and a new practice framework introduced. In addition, a new structure incorporating Children and Family Services, Disability and Youth Justice Services has been formed to provide for improved collaboration and better integration of services for children, young people and their families.

Juvenile justice

As part of the continuing reform of Human Services in Tasmania, Youth Justice Services now forms part of the larger 'Disability, Child, Youth and Family Services'. Whilst Youth Justice Services continues to operate as a separate business unit, the joining together of Human Services allows for coordinated and integrated case management practices to meet assessed client needs as early in the service pathway as possible. The intention is to provide sustainable service support for children, young people, families and service providers within the community. Where appropriate, funding will be pooled to ensure care and client-service provider relationships are not disrupted by gate keeping barriers at service entry points. The system improvements are consistent with current diversion, evidence based practice and social inclusion policy. The *Youth Justice Act 1997* will be reviewed in 2008-09.

Supported Accommodation Assistance Program (SAAP)

Tasmania has been implementing a culture of continuous improvement within the SAAP service sector through the Quality Development Project. All funded services have undertaken self assessment and participated in peer reviews, and a significant number have completed their external assessments. The project is fostering an organisational context within each service for ongoing review cycles. Tasmania also examined *Exclusionary Practices in SAAP* and found that the recent reforms have maximised equitable provision of services for clients. Some barriers still persist, however, notably across service system boundaries in relation to mental health, drug and alcohol and other drug issues, and people with co-morbidities and disabilities, requiring greater levels of collaboration. In 2007-08, Tasmania also commenced a transitional support service for ex-prisoners. Support commences whilst the client is in prison and streamlines the release and reintegration process through intensive support.

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Australian Capital Territory Government comments

Child protection and supported placements

During 2007-08 the ACT continued to have an increased focus on earlier intervention with children and families at risk and working with vulnerable children and young people.

In 2007, Care and Protection Services introduced a new Risk Assessment Framework which has broadened the focus of a family assessment from an episodic analysis (which looks only at immediate risk and safety), towards an assessment of cumulative risk, focussing on the developmental wellbeing of children and families over time.

Also in 2007, Care and Protection Services introduced a differential response at Intake which has allowed workers to actively engage with families through assessment and referral, before children meet the statutory threshold for a response (i.e., before they are in need of care and protection).

Juvenile justice

A realignment of operational and business units which provide Youth service provision came into effect in November 2007. The new Youth Directorate brings together all the key youth service and policy areas, including youth justice, building stronger links and improving services to vulnerable young people.

Construction of Bimberi Youth Justice Centre continued throughout 2007-08 and improvements to the data system used by ACT Youth Justice were introduced which have improved electronic data entry. Substantial youth justice policy development continues to occur with the introduction of the *Children and Young People Act 2008*.

Community Youth Justice have also commenced a program of work to introduce a new service delivery and policy framework which includes the development of alternative ways to manage offending behaviours.

Supported Accommodation Assistance Program (SAAP)

The ACT has undertaken a significant reform process, guided by *Breaking the Cycle- the ACT Homelessness Strategy (2004–2008)*. The evaluation of the Strategy was finalised during 2007-08.

Key achievements of the Strategy have been: more equal availability of services to a range of client groups experiencing homelessness; more targeted responses; support from the moment of contact; and better support for children and young people.

There are significant moves towards a system where clients are not required to change services or accommodation sites as their needs change along the continuum of need from crisis to long term housing.

Reforms to refocus the role of Housing ACT as a post crisis service have assisted in creating an integrated service system.

Northern Territory Government comments

Child protection and supported placements

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The Northern Territory Government continued its significant child protection reform agenda in 2008, establishing a new Families and Children Division within the Department of Health and Families, and beginning the implementation of the new *Care and Protection of Children Act 2007* (the Act). The Act provided the legislative base for the appointment of the Northern Territory Children's Commissioner in June 2008, and encompassed provisions for other reforms in the areas of Care Plans, support for young people leaving care until the age of 25 years, and development of mediation conferences.

A particular focus of reform activities in 2008 has been the strengthening of place-based service responses in regional and remote areas of the Northern Territory. A mobile child protection team was established, and remote Aboriginal Family and Children Workers employed. Cross-government Community Action Planning has broadened responses available in locations such as Katherine, and significant progress made on major reforms to boost family support services as an early intervention response to vulnerable families notified to the Department.

The *Out of Home Care Capacity Report* was completed, providing a blueprint for development of the Northern Territory's Out of Home Care system. A new training package for foster carers – *Our Carers Our Kids* – provides appropriate cultural training for carers of Indigenous children.

Juvenile justice services

The *Youth Justice Amendment (Family Responsibility) Act 2008* commenced on 1 July 2008 and legislated for a Youth Justice Strategy (the Strategy) in the Northern Territory to tackle youth antisocial behaviour. The three key elements of the Strategy are the Family Responsibility Program, Youth Camps and the Youth Justice Advisory Committee. Initiatives flowing from the Strategy include two family support centres to provide assistance and referrals for families; a system of Family Responsibility Agreements and/or Orders; and three Youth Camps to provide safe places for young Territorians to undertake cultural healing and personal development.

Supported Accommodation Assistance Program (SAAP)

Services in the Northern Territory have continued to experience cost pressures, an increase in clients with complex needs, increased length of accommodation and support periods and few affordable exit options from homelessness.

Nevertheless agencies have remained optimistic and provided a high level of quality service to clients. The innovation occurring in services is demonstrated by projects such as the 'Chefs of Hard Knocks' program operated by St Vincent de Paul's Vincentcare, where Work for the Dole and Department of Education and Training funding has been used to train people in catering and also to provide the 200 meals per day that the agency requires.

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15.13 Definitions of key terms and indicators

Child protection and out-of-home care services

Activity Group 1 (pathways)

Receipt and assessment of initial information about a potential protection or support issue

Activities that are typically associated with receipt and assessment of initial information including receipt and recording of information, review of department databases, initial assessment of information and decisions about the appropriate response. This activity can also include consultation, with possible provision of advice. Activities by non-government organisations (NGO) may be included if appropriate.

Activity Group 2 (pathways)

Provision of generic/non-intensive family support services

Activities that are typically associated with provision of lower level family support services at various stages including identification of family needs, provision of support services and diversionary services, some counselling and active linking of the family to support networks. Services are funded by government but can be delivered by either the relevant agency or a NGO. This bundle of services does not involve planned follow-up by the relevant agency after initial service delivery. The services will be delivered under voluntary arrangements between the relevant agency and family. Clients may receive these services more than once.

Activity Group 3 (pathways)

Provision of intensive family support services

Activities that are typically associated with provision of complex or intensive family support services including provision of therapeutic and in-home supports such as counselling and mediation, modelling of positive parenting strategies, referrals to intensive support services that may be provided by NGOs, advocacy on behalf of clients and intensive support for a family in a residential setting. This includes protection and treatment support services. These activities services may be provided if diversionary services are inappropriate to the case and may lead to statutory services being provided to the client.

Activity Group 4 (pathways)

Secondary information gathering and assessment

Activities that are typically associated with secondary information gathering and assessment are currently counted as 'investigations' in the Report on Government Services. As part of this activity group a decision may be made to substantiate or not substantiate. Information gathering activities include:

- sighting the child
- contacting people with relevant information about the child or family (for example, teachers, police, support services)
- interviewing the child, sibling(s) and parents
- observing family interactions
- obtaining assessments of the child and/or family
- conducting family group conferences
- liaising with agencies providing services to the child and family
- recording a substantiation or non-substantiation decision
- case conferences with partners and contributors in the investigation and assessment process.

Activity Group 5 (pathways)

Provision of short-term protective intervention and coordination services for children

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

not on an order

goals

- case conferences with agencies providing services to the child and/or family, internal discussions and reviews
- specialist child-focused therapeutic support.

Activity Group 6 (pathways)

Seeking an order

Activities that are typically associated with seeking orders (court orders or voluntary/administrative orders) including:

- preparing applications for the order
- preparing reports for the court
- obtaining assessment reports to submit to the court
- informing parties to the court proceedings, including parents, the child, and lawyers
- informing and briefing legal counsel or internal court groups
- going through internal pre-court review processes
- attending court
- conducting family group conferences.

Activity Group 7 (pathways)

Provision of protective intervention, support and coordination services for children on an order

Activities that are typically associated with provision of longer-term protective intervention and coordination services including:

- monitoring the child or young person's progress and development (for example, social development and education progress) and undertaking activities that facilitate progress and development
- meeting any specific requirements of any court order
- reviewing appropriateness of the order for the circumstances of the child or young person. This usually occurs at intervals established by the court or in legislation
- reporting back to court
- long term cases involving out-of-home care.

Activity Group 8 (pathways)

Provision of out-of-home care services

Activities that are typically associated with provision of out-of-home care services including:

- finding suitable placement(s) for the child
- assisting the child or young person to maintain contact with his/her family
- in some cases, staff payments for recruiting and training carers
- assessing suitability of potential kinship carers
- assisting the child or young person to maintain contact with their family
- working to return the child home
- assisting the child or young person as they prepare to leave care as the end of the order approaches.

Care and protection orders

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:

	<ul style="list-style-type: none"> • finalised guardianship and finalised custody orders sought through a court • third party parental responsibility orders • 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. <p>Children are counted only once, even if they are on more than one care and protection order.</p>
Child	A person aged 0–17 years.
Child at risk	A child for whom no abuse or neglect can be substantiated but where there are reasonable grounds to suspect the possibility of prior or future abuse or neglect, and for whom continued departmental involvement is considered warranted.
Child concern reports	Reports to departments responsible for child protection regarding concerns about a child, as distinct from notifications of child abuse and neglect. The distinction between the two differs across and within jurisdictions.
Children in out-of-home care during the year	The total number of children who are in at least one out-of-home care placement at any time during the year. A child who is in more than one placement is counted only once.
Dealt with by other means	A notification that is responded to by means other than an investigation, such as the provision of advice or referral to services.
Exited out-of-home care	Where a child does not return to care within two months.
Family based care	Home-based care (see 'placement types').
Family group homes	Residential child care single dwelling establishments that have as their main purpose the provision of substitute care to children. They are typically run like family homes, with a limited number of children who eat together as a family group and are cared for around the clock by resident substitute parents.
Foster care	Care of a child who is living apart from his or her natural or adoptive parents in a private household, by one or more adults who act as 'foster parents' and are paid a regular allowance by a government authority or non-government organisation for the child's support. The authorised department or non-government organisation provides continuing supervision or support while the child remains in the care of foster parents.
Foster parent	Any person (or such a person's spouse) who is being paid a foster allowance by a government or non-government organisation for the care of a child (excluding children in family group homes).
Guardian	Any person who has the legal and ongoing care and responsibility for the protection of a child.
Indigenous person	Person of Aboriginal or Torres Strait Islander descent who identifies as being an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he or she is associated. If Indigenous status is unknown, then a person is considered to be non-Indigenous.

Investigation	An investigation of child abuse and neglect that involves identifying harm or risk of harm to the child, determining an outcome and assessing protective needs. It includes the interviewing or sighting of the subject child where practicable.
Investigation finalised	Where an investigation is completed and an outcome of 'substantiated' or 'not substantiated' is recorded by 31 August.
Investigation in process	Where an investigation is commenced but an outcome is not recorded by 31 August.
Investigation closed – no outcome possible	Where an investigation is commenced but is not able to be finalised in order to reach the outcome of 'substantiated' or 'not substantiated'. These files would be closed for administrative purposes. This may happen in instances where the family have relocated.
Length of time in continuous out-of-home care	The length of time for which a child is in out-of-home care on a continuous basis. A return home of less than seven days is not considered to break the continuity of placement.
Non-respite care	Out-of-home care for children for child protection reasons.
Notification	Contact with an authorised department by persons or other bodies making allegations of child abuse or neglect, or harm to a child. Notifications can be counted at different points in the response to a report, ranging from the point of initial contact with the source of the report to the end of a screening and decision making process.
Other relative	A grandparent, aunt, uncle or cousin, whether the relationship is half, full, step or through adoption, and can be traced through or to a person whose parents were not married to each other at the time of the child's birth. This category includes members of Aboriginal communities who are accepted by that community as being related to the child.
Out-of-home care	Overnight care, including placement with relatives (other than parents) where the government makes a financial payment. Includes care of children in legal and voluntary placements (that is, children on and not on a legal order) but excludes placements made in disability services, psychiatric services, juvenile justice facilities and overnight child care services.
Placement types	Four main categories: <ul style="list-style-type: none"> • residential 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) • non-residential care (placement in the home of a carer who is reimbursed for expenses for the care of the child). The three subcategories of non-residential 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	The proportion of children in out-of-home care who are the subject

out-of-home care	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	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>A particular placement is counted only once, so a return to a previous placement is another placement.</p>
Substantiation	Notification for which an investigation concludes there is reasonable cause to believe that the child has been, is being or is likely to be abused, neglected or otherwise harmed. It does not necessarily require sufficient evidence for a successful prosecution and does not imply that treatment or case management is, or is to be, provided.

Juvenile justice services

Juvenile justice centre	A place administered and operated by a juvenile justice department, where young people are detained whilst under the supervision of the relevant juvenile justice department on a remand or sentenced detention episode.
Juvenile justice department	Refers to those departments in each State and Territory that are responsible for juvenile justice matters.
Supervision period	A period of time during which a young person is continuously under juvenile justice supervision of one type or another. A supervision period is made up of one or more contiguous episodes.
Police caution	Refers to when a police officer administers a caution to the child instead of bringing the child before a court for the offence.
Pre-sentence community	Pre-sentence arrangements where the juvenile justice department is responsible for the case management or supervision of a young person (such as supervised or conditional bail where the juvenile justice department is involved with monitoring or supervising a young person).
Pre-sentence detention	Remanded or held in a juvenile justice centre or police watch house prior to appearing in court or to being sentenced.
Sentenced community-based supervision	Includes probation, recognisance and community service orders which are supervised or case managed by the juvenile justice department. May be supervision with or without additional mandated requirements, requiring some form of obligation or additional element that a young person is required to meet. This obligation could be community work such as in a community service order, a developmental activity or program attendance. The juvenile justice department may or may not directly supervise any additional mandated requirements, but remains responsible for the overall case management of a young person.
Youth justice conference	A youth justice conference is a facilitated meeting resulting in a formal agreement to repair the harm caused by the offence.

Participants can include the victim, offender, convenor, police and other key stakeholders. Referrals may be initiated by the police or the courts.

Supported accommodation and assistance services

Accommodation	Crisis or short term accommodation, medium term to long term accommodation, and other SAAP funded accommodation (which comprises accommodation at hostels, motels and hotels, accommodation in caravans, community placements and other SAAP funded arrangements).
Accommodation load (of agencies)	The number of accommodation days divided by the number of days for which the agency is operational during the reporting period, where the number of accommodation days equals the sum of accommodation days for all clients of an agency who are supported during the reporting period. The average accommodation load is the mean value of all agencies' accommodation loads. Support periods without valid accommodation dates are assigned the interquartile modal duration of accommodation for agencies of the same service delivery model in the same jurisdiction.
Agency	The body or establishment with which the State or Territory government or its representative agrees to provide a SAAP service. The legal entity has to be incorporated. Funding from the State or Territory government could be allocated directly (that is, from the government department) or indirectly (that is, from the auspice of the agency). The SAAP service could be provided at the agency's location or through an outlet at a different location.
Caseload (of agencies)	The number of support days (the sum of support days for all clients of the agency who are supported during the reporting period) divided by the number of days for which the agency is operational during the reporting period. The average caseload is the mean value of all agencies' caseloads. Support periods without valid support dates are assigned the interquartile modal duration of support for agencies of the same service delivery model in the same jurisdiction.
Casual client	A person who is in contact with a SAAP agency and receives one-off assistance for generally not more than one hour, and who does not establish an ongoing relationship with an agency.
Client	A person who receives supported accommodation or support.
Crisis or short term supported accommodation	Supported accommodation for periods of generally not more than three months (short term), and for persons needing immediate short term accommodation (crisis).
Cross target/multiple/general services	SAAP services targeted at more than one primary client group category — for example, SAAP services for single persons regardless of their gender.
Day support	Support provided only on a walk-in basis — for example, an agency that provides a drop-in centre, showering facilities and a meals service at the location of the SAAP agency.
Homeless person	A person who does not have access to safe, secure and adequate housing. A person is considered to not have such access if the only housing to which he or she has access:

	<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

**Women escaping
domestic violence
services**

support. The person may receive one-off assistance.

Services specifically designed to assist women and women accompanied by their children, who are homeless or at imminent risk of becoming homeless as a result of violence and/or abuse.

**Youth/young people
services**

Services provided for people who are independent and above the school leaving age for the State or Territory concerned, and who present to the SAAP agency unaccompanied by a parent/guardian.

15.14 Attachment tables

Attachment tables are identified in references throughout this chapter by an '15A' suffix (for example, table 15A.3 is table 3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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PART G

HOUSING

16 Housing

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Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 16A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables themselves are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

Governments play a significant role in the Australian housing market, directly through housing assistance and indirectly through policies associated with land planning and taxation. The Australian, State and Territory governments share responsibility for housing assistance. Direct assistance includes public and community housing, home purchase and home ownership assistance, Indigenous housing, State and Territory private rental assistance (such as State and Territory provided bond loans, guarantees and assistance with rent payments and advance rent payments, relocation expenses and other one-off grants) and Commonwealth Rent Assistance (CRA).

This chapter focuses on the performance of governments in providing public, State owned and managed Indigenous housing (SOMIH) and community housing under the Commonwealth State Housing Agreement (CSHA) (box 16.1), Indigenous community housing (ICH) and CRA. Close links exist between the housing services covered in this chapter and other government programs and support services discussed elsewhere in the Report, such as:

- the Supported Accommodation Assistance Program (SAAP), which provides accommodation and other services for homeless people or those at imminent risk of becoming homeless (chapter 15)
- services delivered by the Australian, State and Territory governments and community organisations to promote independent living, including services for people with a disability (chapter 14), mental health services (chapter 12) and aged care services, such as the Home and Community Care program (chapter 13).

Improvements in the chapter this year include:

- restructuring of the performance indicator framework sections of the chapter for each service area
- complete unit record data sourced from all jurisdictions' administrative systems for the first time for a number of data items. This increases the quality and comparability of data and includes dwelling counts in major cities, inner regional, outer regional, remote and very remote areas at 30 June 2008. The number of community housing providers at 30 June 2008 was also sourced from jurisdictions' administrative systems.

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 was to run until 30 June 2008 (extended pending negotiation of the new agreement), 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.

(Continued on next page)

Box 16.1 (Continued)

A national ten year strategy to improve Indigenous housing, *Building a Better Future*, was agreed in 2001 by Australian, State and Territory Housing 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 Australian Parliament on performance against agreed outcomes and targets of housing assistance provided under the agreement.

State and Territory governments have responsibility for:

- developing housing assistance strategies that are consistent with Australian, State and Territory government objectives and that best meet the circumstances of the State or Territory
- developing, implementing and managing services and programs to deliver agreed outcomes
- reporting on a basis that enables performance assessment by the Australian, State or Territory governments, based on agreed performance indicators.

Source: CSHA (2003).

Public housing, SOMIH, community housing and ICH information has been obtained from the State and Territory governments, except where otherwise indicated. The Australian Institute of Health and Welfare (AIHW) collects and collates these data and produces annual data collection manuals and reports. The data reports are available from the AIHW web site at www.aihw.gov.au. CRA data were obtained from the Department of Families, Housing, Community Services and

Indigenous Affairs (FaHCSIA). Data on satisfaction, amenity and location were obtained from national social housing surveys of public housing, SOMIH and community housing tenants.

Housing assistance not covered

This chapter does not cover a number of government funded and provided housing services, including:

- the CAP, including the Victorian Transitional Housing Management Program under the CSHA, which provides capital funding for accommodation for homeless people
- non-CSHA programs, including those provided by the Department of Veterans' Affairs (DVA)
- CRA paid by the DVA or paid to Abstudy recipients on behalf of the Department of Education, Employment and Workplace Relations (DEEWR)
- some Indigenous housing and infrastructure assistance
- non-Indigenous community housing not funded under the CSHA
- home purchase assistance, including the First Home Owners Grant, a Commonwealth initiative administered by State and Territory governments
- private rent assistance funded by states and territories.

16.1 Profile of housing and housing assistance

Service overview

The Australian Bureau of Statistics (ABS) 2006 Census of Population and Housing (ABS 2007) identified just under 7.1 million households in Australia, where 'household' is classified as 'a person living alone' or as 'a group of related or unrelated people who usually reside and eat together'. Of these households, 68.1 per cent owned or were purchasing their own home, 19.0 per cent rented in the private sector, 3.6 per cent were in public rental accommodation, 0.7 per cent lived in community housing,¹ 2.6 per cent resided in other tenure types and 6.0 per cent did not state their tenure type (table 16A.72). For a number of reasons, including

¹ This estimate is based on data received from jurisdictions regarding the number of community housing dwellings in each jurisdiction, combined with data from the ABS 2006 Census on the total number of dwellings in each jurisdiction.

non-response and misunderstanding, Census data are likely to underestimate the number of tenants in public housing.²

The composition of Australian households is changing. There is an increasing number of smaller households, including a rising number of single person households. The average Australian household size fell from 3.3 people to 2.8 people between 1971 and 2006, while the proportion of single person households increased from 18.1 per cent to 24.4 per cent over this period (ABS 2007).

The average Indigenous household is larger than the average non-Indigenous household. In 2006, the average non-Indigenous Australian household size was 2.6 people, whereas the average household with at least one Indigenous person was 3.4 people (ABS 2007).

Why government provides housing assistance

Australia's private housing stock houses the majority of the population. Most Australian households can access accommodation either through owner occupation or by renting from a private landlord. Many households, however, face problems in acquiring or accessing suitable private accommodation, for reasons of cost, discrimination, availability, location and/or adequacy. The price of rental dwellings can be prohibitive for people on lower incomes. Further, stock may not be available in the private rental market for households with special accommodation needs. Housing assistance from the Australian, State and Territory governments can help these households.

Roles and responsibilities

Each level of government has different roles and responsibilities in housing and housing assistance:

- The Australian Government provides CRA and shares responsibility with State and Territory governments for housing assistance provided under the CSHA (box 16.1). It also provides funding for the Community Housing and Infrastructure Program (CHIP). The Australian Government also influences the housing market through other direct and indirect means, including taxation and home purchase assistance.
- State and Territory governments provide housing assistance, such as homeless assistance, public housing, community housing, SOMIH, private rental

² Public housing tenants appear to be undercounted in the 2006 Census (and in previous censuses).

assistance and home purchase assistance. Some jurisdictions also contribute to the delivery of housing assistance through mechanisms such as home lending programs and joint ventures with the private sector. State and Territory governments are also responsible for land taxes, stamp duties and residential tenancy legislation.

- Local governments implement planning regulations and are sometimes involved in providing community housing.

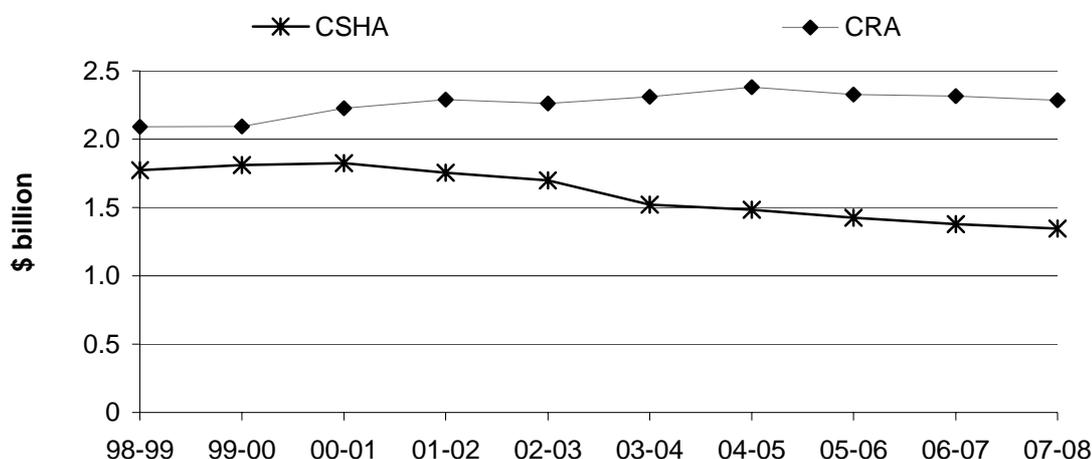
Funding

The Australian, State and Territory governments provided \$1.3 billion for housing programs under the CSHA in 2007-08 (figure 16.1). Of this, the Australian Government provided \$970.6 million or 72.2 per cent, and State and Territory governments were collectively required to provide minimum matching funds of \$374.6 million or 27.8 per cent (FaHCSIA 2008). In addition, most jurisdictions provided additional funding above the minimum matching requirements. Public and community housing accounted for the majority of CSHA funding in 2007-08. Real expenditure on CSHA assistance declined by 24.1 per cent between 1998-99 and 2007-08 (figure 16.1).

Some of the funding for ICH comes through the CSHA and some comes through the CHIP. Indigenous community housing is also funded by the Australian, State and Territory governments.

The Australian Government also provided \$2.3 billion for CRA in 2007-08 (figure 16.1). Real expenditure on CRA increased by 9.3 per cent over the 10 year time period (table 16A.79).

Figure 16.1 Real government expenditure on CSHA assistance and CRA (2007-08 dollars)^a



^a Data may not be comparable over time and comparisons could be misleading. Reasons for this are provided in table 16A.79.

Source: CSHA (1999) *Commonwealth State Housing Agreement*, Australian Government, Department of Family and Community Services, Canberra; FaCS/FaCSIA (Department of Family and Community Services and Indigenous Affairs)/FaHCSIA (various years), *Housing Assistance Act 1996 Annual Report 2007-08*, Australian Government, Canberra; FaHCSIA (unpublished); table 16A.79.

Public housing is the largest form of assistance provided under the CSHA. Given the capital intensive nature of provision of social housing, additional assistance to annual funding is provided through the use of \$74 billion of housing stock owned by housing authorities in 2006-07 (calculated from 2006-07 State and Territory CSHA national financial statements).

Table 16.1 is a summary table that presents government expenditure including and excluding capital costs, on a per capita and per dwelling basis. It also includes CRA expenditure per capita and per income unit to present the overall level of government housing assistance covered in this chapter. More detailed analysis of the cost components for public housing is presented in table 16.15. Nationally, net recurrent cost per capita on public housing was approximately \$97 in 2007-08. Cost including capital costs per capita on public housing was \$398 (table 16.1). Nationally, net recurrent cost per dwelling on public housing was approximately \$6064 in 2007-08. Average cost including capital cost per dwelling on public housing was \$24 733 (table 16.1).

It is important to note the differences in housing assistance operations across jurisdictions when analysing expenditure per capita on public housing. 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 net recurrent cost per public housing dwelling addresses some of these issues.

Table 16.1 Government housing assistance, 2007-08 (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>
Government expenditure on public housing									
<i>Per capita^b</i>									
Net recurrent cost	105	60	64	122	171	172	225	268	97
Cost including capital cost	417	276	304	568	511	473	1 136	694	398
<i>Per dwelling</i>									
Net recurrent cost	6 010	4 798	5 286	8 173	6 256	6 947	7 086	10 918	6 064
Cost including capital cost	23 938	22 190	25 073	37 977	18 755	20 075	35 747	28 301	24 733
CRA expenditure									
<i>Per capita^b</i>									
	115	96	134	87	103	121	49	56	109
<i>Per income unit</i>									
	2 427	2 402	2 468	2 391	2 354	2 413	2 257	2 353	2 421

^a Data may not be comparable across jurisdictions and comparisons could be misleading. Reasons for this are provided in tables 16A.5 and 16A.86. ^b Data are expressed as per capita of Australian population.

Source: FaHCSIA (unpublished); State and Territory governments (unpublished); table 16A.86.

CSHA funding data for 2006-07 and 2007-08 are presented in table 16.2.

Table 16.2 CSHA funding, 2006-07 and 2007-08 (\$ million)^{a, b}

Funding arrangements	2006-07	2007-08
Base funding grants	752.5	765.2
Aboriginal Rental Housing Program	94.4	96.0
Crisis Accommodation Program	41.2	41.8
Community Housing Program	66.4	67.5
State matching grants — minimum funding required	368.4	374.6
Total^c	1 323.0	1 345.2

^a Includes Public Housing, Home Purchase Assistance and Private Rental Assistance Programs. ^b Expressed in nominal dollars (that is not adjusted for inflation). ^c Due to rounding, the total may not equal the sum of the individual program funding allocations.

Source: FaHCSIA (2008) *Housing Assistance Act 1996 Annual Report 2007-08*, Australian Government, Canberra; FaHCSIA (unpublished).

Size and scope

Housing assistance is provided in various forms, and models for delivering assistance can vary within and across jurisdictions. The main forms of assistance are outlined in box 16.2. This chapter focuses on five forms of assistance: public housing, SOMIH, community housing, ICH and CRA.

Box 16.2 Forms of housing assistance

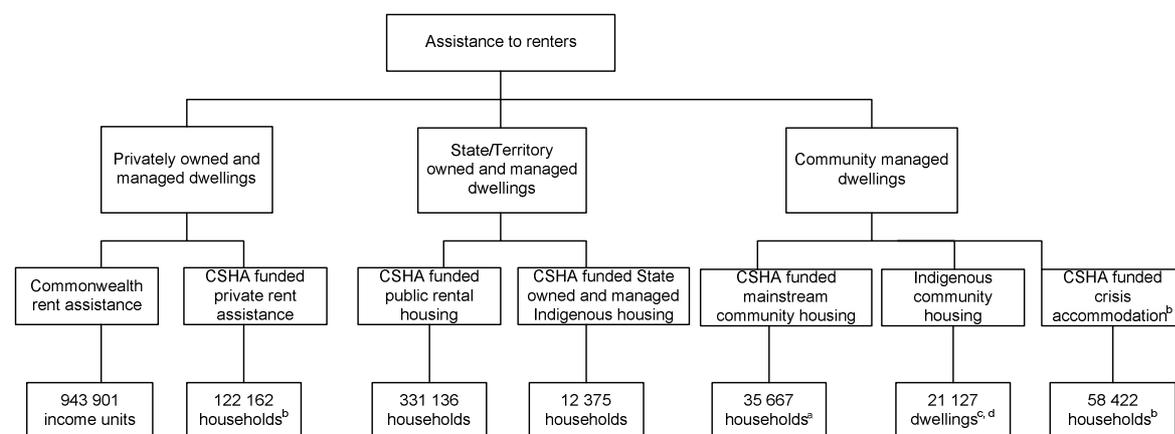
There are several significant forms of housing assistance.

- *Public housing*: dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation. The CSHA is the main source of funding for public housing along with internally generated rental revenues and the proceeds of asset sales.
- *Community housing*: rental housing provided for low to moderate income or special needs households, managed by community-based organisations that have received capital or recurrent subsidy from government. Community housing models vary across jurisdictions, and the housing stock may be owned by a variety of groups including government.
- *State owned and managed Indigenous housing (SOMIH)*: State owned houses targeted at Indigenous households.
- *Indigenous community housing (ICH)*: houses owned or leased and managed by ICH organisations and community councils in major cities, regional and remote areas.
- *Crisis accommodation*: accommodation services to help people who are homeless or in crisis. Services are generally provided by non-government organisations and many are linked to support services funded through SAAP. Sources of government funding include CAP through the CSHA, which provides funding for accommodation, and SAAP funding for live-in staff, counselling and other support services.
- *Home purchase assistance*: assistance provided by State and Territory governments to low income households to help with home purchases or mortgage repayments; for example, the grant provided under the First Home Owner's Scheme, a Commonwealth initiative administered by State and Territory governments.
- *Private rental assistance*: assistance funded by State and Territory governments to low income households experiencing difficulty in securing or maintaining private rental accommodation. This assistance may include ongoing or one-off payments to help households meet rent payments, one-off payments for relocation costs, guarantees or loans to cover the cost of bonds and housing assistance advice and information services. Assistance may be provided by community-based organisations funded by government.
- The chapter also reports on CRA, which is a non-taxable income support supplement paid by the Australian Government to income support recipients or people who receive more than the base rate of the Family Tax Benefit Part A and who rent in the private rental market.

Source: CSHA (2003); FaCS (2003).

Figure 16.2 illustrates the range of government assistance to renters.

Figure 16.2 Assistance across the rental sector, 2008^a



^a Additional dwellings are funded under programs other than CSHA. Data about these dwellings are not available. ^b For year ending 30 June 2007. ^c At 30 June 2007. ^d Includes permanent dwellings managed by funded/actively registered and unfunded ICH organisations. Of these dwellings 18 897 were managed by organisations administered by the State Governments and 2230 managed by organisations administered by the Australian Government.

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 331 136 public housing dwellings were occupied at 30 June 2008 (table 16A.1). Public housing is available to people on low incomes and those with special needs. In 2006-07, 29.1 per cent of public housing tenants were people with a disability (AIHW 2007c).

Public housing rents are generally set at market levels, and rebates are granted to low income tenants (so they generally pay no more than 25 per cent of their assessable income in rent), to provide affordable housing. Public housing allocations are constrained by the amount of housing stock available and are income tested. The proportion of total households residing in public housing in 2006 (4.3 per cent nationally) is presented for all jurisdictions in table 16A.75. Information on the proportion of income paid in rent by public housing tenants is contained in table 16A.80. Details of multiple family composition, non-rebated and other public households excluded from data in this chapter are presented in table 16A.87.

State owned and managed Indigenous housing

State owned and managed Indigenous housing dwellings are defined as those rental housing dwellings owned and managed by government and allocated only to

Indigenous Australians (AIHW 2006). They include dwellings managed by government Indigenous housing agencies for allocation to Indigenous tenants. There were 12 778 dwellings identified in the 2007-08 SOMIH collection (table 16A.14).

In Victoria, Aboriginal Housing Victoria (AHV) — a non-government community housing organisation — assists the government in the administration of SOMIH. Under the transition to independence strategy for AHV, tenancy management for some SOMIH properties was transferred to AHV in 2007-08. This has reduced the number of properties reported in Victoria as SOMIH by 348, and will lead to a corresponding increase in the number of properties reported as state managed ICH for 2007-08. It should be noted that while SOMIH stock is reported for the year 2007-08, ICH is reported for the year 2006-07. Accordingly, data relating to 348 formerly SOMIH properties, now managed by AHV, will not appear in this Report.

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 ICH.

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).

Details of multiple family composition, non-rebated and other public households excluded from SOMIH data in this chapter are presented in table 16A.88.

Community housing

Community housing is generally managed by not-for-profit organisations or local governments, which perform asset and tenancy management functions. A major objective of community housing is to increase social capital by encouraging local communities to take a more active role in planning and managing appropriate and affordable transitional and long term rental accommodation. Community housing is also intended to provide a choice of housing location, physical type and management arrangements. Some forms of community housing also allow tenants to participate in the management of their housing.

Community housing programs aim to achieve links between housing and services that are best managed at the community level, including services for people with a disability, and home and community care. Notwithstanding their common

objectives, community housing programs vary within and across jurisdictions in their administration and types of accommodation (box 16.3).

Box 16.3 Models of community housing

Community housing models vary across jurisdictions in terms of their scale, organisational structure and financing arrangements, and the extent to which the community or government has management responsibility and ownership of the housing stock. Table 16A.76 lists the relevant community housing programs in each jurisdiction.

Some community housing models are:

- *regional or local housing associations*, whereby the associations provide property and tenancy management services, and community groups provide support services to tenants
- *joint ventures and housing partnerships*, whereby a range of church, welfare, local government agencies and other organisations provide resources in cooperation with State and Territory governments
- *housing cooperatives*, which are responsible for tenant management and maintenance, while government, a central finance company or an individual cooperative owns the housing stock
- *community management and ownership*, whereby not-for-profit or community housing associations both own and manage housing
- *local government housing associations*, which provide low cost housing within a particular municipality, are closely involved in policy, planning, funding and/or monitoring roles, and may directly manage the housing stock
- *equity share rental housing*, whereby housing cooperatives wholly own the housing stock and lease it to tenants (who are shareholders in the cooperative and, therefore, have the rights and responsibilities of cooperative management).

Source: State and Territory governments (unpublished).

Funding for community housing is typically either fully or partly provided by governments to not-for-profit organisations or local governments. Australian Government funding for community housing amounted to 7.0 per cent (\$67.5 million) of total CSHA funding provided by the Australian Government in 2007-08 (FaHCSIA unpublished). There were 36 079 mainstream community housing tenancy rental units in Australia at 30 June 2008 (table 16A.25).³

³ Data are based on a combination of survey and administrative data. Results, therefore, are affected by survey non-response. Details of community housing survey response rates and associated information are presented in table 16A.89.

Table 16A.77 presents the proportion of all households residing in community housing in each jurisdiction in 2006 (0.7 per cent nationally).

Indigenous community housing

ICH is delivered by ICH organisations that perform asset and tenancy management functions. The funding and administrative arrangements for ICH vary across jurisdictions. In some jurisdictions, only the states are involved in the administration of ICH; in some only the Australian Government is involved; and in others both the State or Territory and the Australian governments are involved.

The Australian Government, through FaHCSIA, formerly through Aboriginal and Torres Strait Islander Services, is directly responsible for the funding and administration of ICH in three jurisdictions — Victoria, Queensland and Tasmania. At the time data for this Report were collected (2006-07), in Victoria and Tasmania there was only Australian Government administered ICH housing, while in Queensland, some ICH housing was administered by the Australian Government and some by the State government. In the five remaining jurisdictions — NSW, WA, SA, the ACT and the NT — funding from the relevant State or Territory and the Australian Government is pooled and the State or Territory government has sole responsibility for the administration of ICH (AIHW 2007b).

There has been considerable progress in the development of national ICH data to report against the National Reporting Framework (NRF) for Indigenous housing. This Report includes a performance indicator framework and data for ICH and additional descriptive data on ICH are contained in table 16A.37.

CRA

Commonwealth Rent Assistance 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.

Commonwealth Rent Assistance 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.

Table 16.3 Eligibility and payment scales for CRA, 20 March to 19 September 2008 (\$ 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	95.40	238.33	107.20
Single, no children, sharer	95.40	190.69	71.47
Couple, no dependent children	155.20	289.87	101.00
Single, one or two dependent children	125.44	293.25	125.86
Single, three or more dependent children	125.44	315.28	142.38
Partnered, one or two dependent children	185.64	353.45	125.86
Partnered, three or more dependent children	185.64	375.48	142.38
Partnered, illness separated, no dependent children	95.40	238.33	107.20
Partnered, temporarily separated, no dependent children	95.40	230.07	101.00

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.47.

Source: FaHCSIA (unpublished); table 16A.47.

Because CRA is a national payment, FaHCSIA seeks to ensure that CRA recipients who have the same income unit characteristics and who pay the same amount of rent receive the same amount of assistance wherever they live. There were 946 641 income units (where an income unit is defined as either a single person or a couple with or without dependents)⁴ entitled to receive CRA at 6 June 2008 (table 16A.48). The proportion of CRA recipients by income unit type is presented in table 16A.49. Data on the number and proportion of Indigenous income units receiving CRA by income unit type are presented in tables 16A.50 and 16A.51, respectively.

The maximum rate of assistance was received by 70.9 per cent of CRA recipients at 6 June 2008 (table 16A.63). There was relatively little variation in the average level of assistance across locations at 6 June 2008 (table 16A.62), even though rents

⁴ Dependents are defined as young persons for whom the person or partner receives the Family Tax Benefit. The benefit is not payable for children receiving Youth Allowance or any other income security payment. Children aged over 16 years for whom the Family Tax Benefit is not payable are regarded as separate income units.

varied considerably by location. At 6 June 2008, the average payment across Australia was \$90.53 per fortnight (approximately \$2354 per year) (table 16A.62).

Diversity of State and Territory housing assistance operations

State and Territory governments have similar broad objectives for providing housing assistance. Individual jurisdictions, however, emphasise different objectives depending on their historical precedents and ways of interacting with community sector providers. Jurisdictions also have different private housing markets. These differences lead to a variety of policy responses and associated forms of assistance. It is important to be aware of all the housing assistance operations in each State and Territory when analysing performance information.

Appendix A contains information on each State and Territory that may help in interpreting the performance indicators presented in this chapter.

Public housing and State owned and managed Indigenous housing

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 16.4.

Table 16.4 Public housing — regional and remote area concentrations, at 30 June 2008 (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	81.9	72.3	67.4	70.7	77.4	–	99.9	–	72.8
Inner regional	14.5	22.4	16.3	9.4	6.7	73.3	0.1	–	16.1
Outer regional	3.3	5.2	14.1	9.6	13.9	25.9	–	70.4	9.0
Remote	0.3	–	1.7	7.2	1.8	0.6	–	25.5	1.7
Very remote	–	–	0.5	3.0	0.2	0.3	–	4.1	0.5

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.1. – Nil or rounded to zero.

Source: AIHW (2009) *Public rental housing 2007-08: CSHA national data report*, Canberra; table 16A.1.

The proportions of SOMIH located by ASGC remoteness areas are shown in table 16.5.

Table 16.5 SOMIH — regional and remote area concentrations, at 30 June 2008 (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	41.0	29.5	14.8	27.9	60.6	–	33.2
Inner regional	33.1	41.1	19.4	7.7	7.5	83.3	23.5
Outer regional	20.2	28.9	39.8	20.7	17.9	16.7	25.2
Remote	4.9	0.5	9.9	20.2	5.4	–	8.4
Very remote	0.7	–	16.1	23.6	8.6	–	9.6

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.14. – Nil or rounded to zero.

Source: AIHW (2009) *State owned and managed Indigenous housing 2007-08: CSHA national data report*, Canberra; table 16A.14.

Eligibility criteria for access to public housing, such as income and asset definitions and limits, vary across jurisdictions (table 16.6). In most cases, jurisdictions require that applicants be Australian citizens or permanent residents and not own or part-own residential property. All jurisdictions require eligible applicants to be resident in the respective State or Territory. All State and Territory governments prioritise access to public housing by segmenting their waiting lists in some way. Segments are defined differently across jurisdictions, but generally reflect urgent need/homelessness and an inability to access appropriate private market accommodation. Most jurisdictions provide security of tenure after an initial probationary period. Most jurisdictions also have periodic reviews of eligibility. Rebated rents result in the majority of households paying no more than 25 per cent of their assessable income in rent (the rent-to-income ratio). Definitions of assessable income vary across jurisdictions.

Eligibility criteria for access to SOMIH are generally consistent with those for public housing once an applicant has been confirmed as Indigenous (table 16.7). 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 Public housing policy context, 2008^a

	NSW ^b	Vic ^c	Qld	WA ^d	SA ^e	Tas ^f	ACT ^g	N ^h
Eligibility								
Income limit per week (\$) ⁱ	410	435	609	430	718	429	528	619
'Other' asset limits (\$) ⁱ	None	30 000	None	41 000 cash	287 750	35 000	40 000	43 400
Minimum age (years)	18	16	None	18	None	16	16	16
Waiting list								
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	12 months	3–6 months	None	3–6 months
Fixed term	3, 6, 12 or 18 months	None	None	3 or 6 months	None	1–3 years	None	2 then 5 years
	2, 5 and 10 years							
Ongoing	Yes	Reviewable for tenancies (except 65 years plus) commenced after November 1997.	Subject to review	Ongoing	Ongoing after probation	In some cases, particularly older persons	Lifetime tenure	Leases extended
		Lifetime for pre November 1997 tenancies						

(Continued on next page)

Table 16.6 (Continued)

	NSW ^b	Vic ^c	Qld	WAd	SAe	Tas ^f	ACT ^g	N ^h
Tenancy review	Prior to the end of the tenancy	Periodic review	Review at 4 or 10 years	Annual	None	Fixed term leases reviewed at end of each term with each property visited at least annually	None	Prior to each lease extension and rebate review
Rebated rent setting								
Rent-to-income ratio	25–30	25	25	23 or 25	25	23–25	25	14–23

^a At 30 June. ^b Interest accrued from cash assets is assessed as income less the first \$5000 of each person's savings. Applicants under the age of 18 years must demonstrate living skills to be eligible for housing. Tenants housed prior to 1 July 2005 were generally provided with a continuous lease. New tenants housed since 1 July 2005 are generally provided with a fixed term lease. New tenancies from 1 July 2005 to 22 October 2006 were signed as 18 month interim tenancies. Tenants on an 18 month fixed term lease are reviewed prior to the end of lease, and if eligible, are offered a 2, 5 or 10 year lease. If ineligible, they are offered a 12 month fixed term lease. From 23 October 2006 the Department began to offer 2, 5 or 10 year leases to new tenants and ceased to offer the 18 month interim leases. From 5 December 2005 new thresholds and rules determine whether a tenant is eligible for a rent subsidy and the percentage of income they will pay as rent. Their household's gross assessable income, household size and age of household members are used when assessing the household's eligibility for a rent subsidy. For rebated rents, varied concessional rates are applicable to certain age groups and some pensioners. For households whose tenancy commenced on or after 5 December 2005, the Family Tax Benefit Part A and Part B received are assessed at 15 per cent. Where the tenancy commenced prior to 5 December 2005 the Family Tax Benefit Part A and Part B received was assessed at 12 per cent from 5 December 2005, with an increase of 1 per cent every 6 months until the assessment rate reaches 15 per cent. ^c Public housing tenancies in Victoria are ongoing tenancies that are subject to review after 5 years for tenancies which commenced after November 1997 (exemption for 65 years plus). 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 \$610 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 bed-sitter flat accommodation (for whom the ratio is 19 per cent and 17 per cent respectively) and households receiving less than the single Newstart Allowance (for whom the ratio is 19.5 per cent). ^f The rent-to-income ratio is indicative only. The majority of households pay amounts within this range, but some pay lesser or higher amounts, depending on household composition and the relationship of household members to the tenant, for example, boarder, parent, independent child. ^g The revised Public housing policy context Program provides for a review where a tenant's income exceeds \$80 000 for three consecutive years. ^h There is discretion to accept applications for people under 16 years. The rent-to-income ratio is 14 per cent for aged pension recipients housed prior to 2003. ⁱ Limits are for a single person. ^j Two segment lists generally consist of 'priority' and 'wait turn'.

Source: State and Territory governments (unpublished).

Table 16.7 SOMIH housing policy context, 2008^a

	NSW ^b	Vic ^c	Q/d	WAd	SA ^e	Tas ^f
Eligibility						
Income limit per week (\$)g	410	435	609	430	718	429
'Other' asset limits (\$)g	None	30 000	None	41 000 in cash	287 750	35 000
Minimum age (years)	18	16	None	18	None	16
Waiting list						
Details	Combined with public housing	Combined with public housing	Combined with public housing	Combined with public housing	Need (four segments)	Priority, similar to public housing
Tenure						
Probationary period	None	None	None	None	12 months	3–6 months
Fixed term	3, 6, 12 or 18 months	None	None	3 or 6 months	None	1–3 years
Ongoing	2, 5 and 10 years					
	Yes	Reviewable for tenancies (except 65 years plus) commenced after November 1997. Lifetime for pre November 1997 tenancies	Subject to review	Ongoing	Ongoing after probation	Dependant on housing history
Tenancy review	Prior to the end of the tenancy	Periodic review	Review at 4 or 10 years	Annual	None	Fixed term leases reviewed at end of each term
Rebated rent setting						
Rent-to-income ratio	25–30	25	25	23 or 25	25	23–25

(Continued on next page)

Table 16.7 (Continued)

a At 30 June. **b** Interest accrued from cash assets is assessed as income less the first \$5000 of each person's savings. Applicants under the age of 18 years must demonstrate living skills to be eligible for housing. Tenants housed prior to 1 July 2005 were generally provided with a continuous lease. New tenants housed since 1 July 2005 are generally provided with a fixed term lease. New tenancies from 1 July 2005 to 22 October 2006 were signed to 18 month interim tenancies. Tenants on an 18 month fixed term lease are reviewed prior to the end of lease, and if eligible, are offered a 2, 5 or 10 year lease. If ineligible, they are offered a 12 month fixed term lease. From 23 October 2006 the Department began to offer 2, 5 or 10 year leases to new tenants and ceased to offer the 18 month interim leases. From 5 December 2005 new thresholds and rules determine whether a tenant is eligible for a rent subsidy and the percentage of income they will pay as rent. Their household's gross assessable income, household size and age of household members are used when assessing the household's eligibility for a rent subsidy. For rebated rents, varied 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 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 \$610 per week. Those aged over 60 years are subject to a cash asset limit of \$80 000. **e** The same definition as the Centrelink asset test threshold for a single person who does not own their own home is used. Most households pay a rent-to-income ratio of 25 per cent of assessable income in rent. However, households receiving less than the single Newstart Allowance pay rent-to-income ratio is indicative only. The majority of households pay amounts within this range, but some pay lesser or higher amounts, depending on household composition and the relationship of household members to the tenant, for example, boarder, parent, independent child. **g** Limits are for a single person.

Source: State and Territory governments (unpublished).

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.

The proportions of community housing located by ASGC remoteness areas are shown in table 16.8.

Table 16.8 Community housing — regional and remote area concentrations, at 30 June 2008 (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	69.6	76.1	45.8	61.5	85.7	..	100.0	..	67.0
Inner regional	22.6	20.4	23.2	12.1	8.1	65.8	..	..	19.6
Outer regional	7.6	3.3	21.1	14.6	4.7	31.0	..	72.0	10.0
Remote	0.2	0.2	4.0	8.9	1.4	3.2	..	21.5	2.1
Very remote	–	..	5.8	2.9	0.1	–	..	6.5	1.3

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.25. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2008) *Community housing 2007-08: CSHA national data report*, Canberra; table 16A.25.

Private rental markets

Tight private rental markets (vacancy rates well below 3.0 per cent) were evident in all states in June 2008. Capital city vacancy rates in the private rental market for all jurisdictions are reported in table 16A.73. Capital city median rents varied across jurisdictions. Median rents for three bedroom houses and two bedroom flats or units are reported in table 16A.74.

16.2 Framework of performance indicators

The performance indicator frameworks show which data are comparable in the 2009 Report (figures 16.3, 16.12, 16.19 and 16.20). 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.

While public, SOMIH, community and ICH use a common framework, the delivery method for public housing and SOMIH differs from that for community and ICH. State and Territory governments deliver public housing and SOMIH, while community organisations and sometimes local governments deliver community and ICH.

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 current CSHA that took effect in 2003 [box 16.4]). The current 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 fifth year that data are reported under the current agreement. Work is being undertaken on the performance indicators to improve the quality and scope of national performance information.

Box 16.4 Objectives for public and community housing under the 2003 CSHA

The principles guiding the 2003 CSHA are to:

1. maintain a core Social Housing sector to assist people unable to access alternative suitable housing options
2. develop and deliver affordable, appropriate, flexible and diverse housing assistance responses that provide people with choice and are tailored to their needs, local conditions and opportunities
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.

Indigenous housing aims to achieve the outcomes listed in box 16.5 as part of the *Building a Better Future: Indigenous Housing to 2010* strategy. The aims also relate to ICH.

Box 16.5 Indigenous housing

The guiding principles and objectives for achieving better Indigenous housing are to:

1. provide better housing that meets agreed standards, is appropriate to the needs of Aboriginal and Torres Strait Islander people, and contributes to their health and well being
2. provide better housing services that are well managed and sustainable
3. ensure housing growth in the number of houses to address both the backlog of Indigenous housing need and emerging needs of a growing Indigenous population
4. ensure improved partnerships in a way that Indigenous people are fully involved in the planning, decision making and delivery of services by governments
5. ensure greater effectiveness and efficiency in a way that assistance is properly directed to meeting objectives, and that resources are being used to best advantage
6. commit to improved performance linked to accountability for the program performance reporting based on national data collection systems and good information management
7. promote the a 'whole of government' coordination of services approach that ensures greater coordination of housing and housing-related services linked to improved health and well being outcomes.

Source: FaCSIA (2001).

The performance indicators for CRA differ from those for public, SOMIH, mainstream and ICH because CRA has different objectives and delivery methods. The CRA performance indicator framework in figure 16.20 is based on the CRA objective outlined in box 16.6.

Box 16.6 Objective of CRA

The objective of CRA is to provide income support recipients and low income families in the private rental market with additional financial assistance, in recognition of the housing costs that they face (Newman 1998). This assistance should be delivered in an equitable and efficient manner. CRA is also governed by other objectives relating to the primary income support payment.

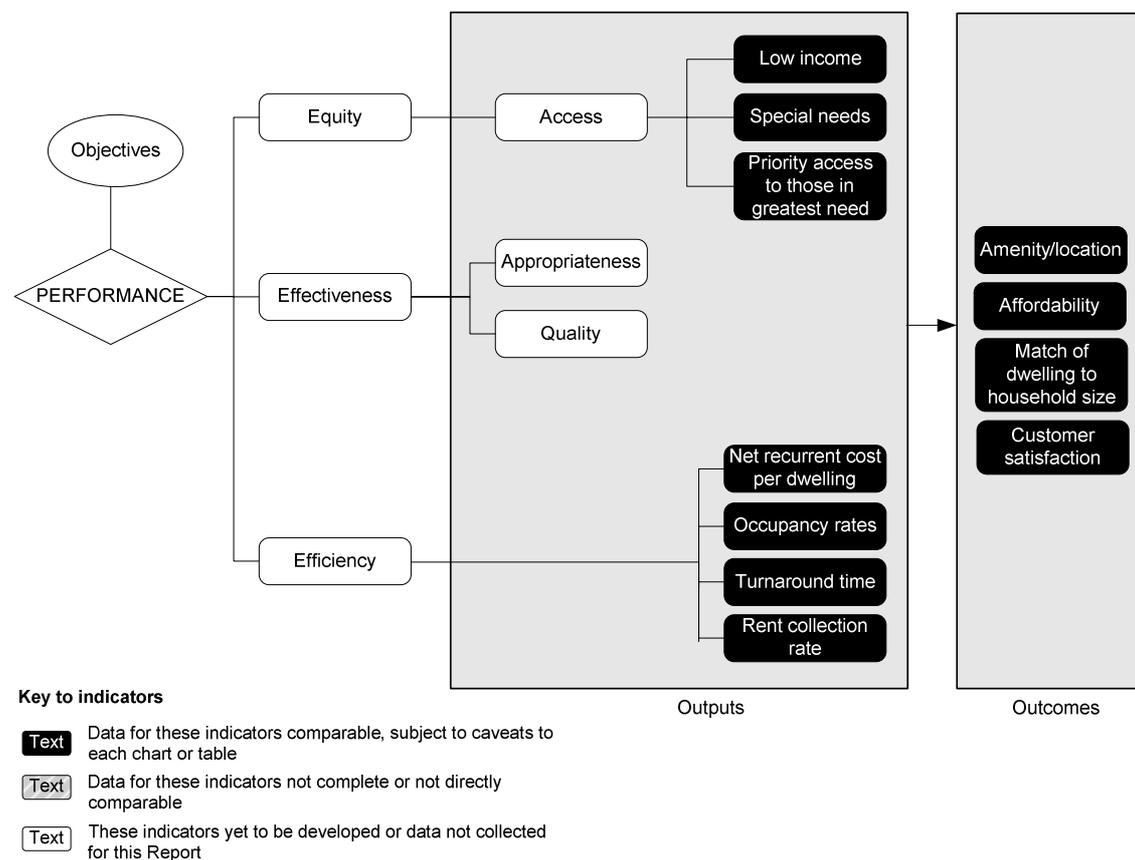
16.3 Key performance indicator results

Generally, performance indicator results are comparable between public housing and SOMIH, but are not comparable to mainstream community housing and ICH because data quality and coverage can differ. More information on definitions is provided in a box for each indicator.

Public housing and SOMIH

The performance indicator framework for public housing and SOMIH is presented in figure 16.3.

Figure 16.3 Performance indicators for public housing and SOMIH



Different delivery contexts, locations and types of tenant may affect the performance of public housing and SOMIH reported in this chapter. For example, SOMIH housing dwellings are slightly more likely than mainstream public or community housing dwellings to be located in regional or remote areas (tables 16.4, 16.5 and 16.8). Care therefore needs to be taken in comparing performance

indicator results, and the qualifications presented with the data need to be considered.

Some descriptive information on public housing can be found in table 16A.1. Some descriptive data on SOMIH are included in table 16A.14. As outlined in section 16.1, the ACT and the NT are not included in the SOMIH data collection.

Outputs

The following indicators measure the outputs of public housing and SOMIH. Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity

Low income

'Low income' is an indicator of the CSHA guiding principle to assist people unable to access alternative suitable housing options (box 16.7).

Box 16.7 Low income

'Low income' is defined as the number of new low income households as a proportion of all new households. Two measures 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 or increasing values for these measures indicate a high degree of access for low income households.

Data reported for this indicator are comparable.

The proportion of new tenancies allocated to low income A households for public housing in 2007-08 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 — new 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>									
2003-04	94.7	92.4	90.5	87.9	87.5	89.1	87.7	87.6	91.2
2004-05	94.0	92.5	88.1	85.8	87.1	80.8	89.4	85.6	90.0
2005-06	94.5	93.3	87.3	88.2	87.6	89.8	87.1	85.3	90.9
2006-07	93.6	92.5	72.9	83.6	89.5	88.9	90.2	85.2	87.7
2007-08	95.0	90.8	79.3	85.6	87.2	84.3	87.3	88.2	88.5

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.2.

Source: AIHW (2004, 2005) *CSHA national data reports: public rental housing*, Canberra; AIHW (2006, 2008, 2009) *Public rental housing: CSHA national data report*, Canberra; table 16A.2.

The proportion of new tenancies allocated to low income A households for SOMIH in 2007-08 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 — new 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>							
2003-04	94.4	90.5	83.3	93.5	89.2	89.5	90.6
2004-05	94.2	87.7	76.1	92.9	86.0	86.0	88.0
2005-06	95.9	88.2	89.2	88.6	86.5	93.3	90.4
2006-07	95.5	89.9	76.5	87.9	88.7	100.0	87.7
2007-08	95.0	82.4	75.4	86.4	85.5	82.4	85.7

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.15.

Source: AIHW (2004, 2005) *CSHA national data reports: Aboriginal rental housing program: State and Territory owned and managed Indigenous housing*, Canberra; AIHW (2006, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*, Canberra; table 16A.15.

The ratio of low income households to all new households was similar for public housing and SOMIH. There were some variations across jurisdictions.

Special needs

‘Special needs’ is an indicator of the CSHA guiding principle to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing (box 16.8).

Box 16.8 Special needs

'Special needs' is defined as the proportion of new tenancies allocated to special needs households. The proportion of new tenancies with special needs are reported as a proxy for measuring all households with special needs. Special needs households are defined as those households that have either a household member with a disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members. Special needs households for SOMIH are defined as those households that have either a household member with a disability or a principal tenant aged 24 years or under, or 50 years or over.

A high or increasing proportion indicates a high degree of access by these special needs households.

Data for public housing cannot be compared with those of SOMIH.

Data reported for this indicator are comparable.

New public housing tenancies allocated to households with special needs are presented in table 16.11.

Table 16.11 Public housing — new tenancies allocated to households with special needs (per cent)^a

	<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>
2003-04	53.6	45.9	58.2	49.9	58.9	65.7	33.0	73.0	53.5
2004-05	55.7	47.1	62.7	64.8	63.2	67.6	48.4	100.0	58.2
2005-06	55.7	58.9	61.9	67.7	61.1	66.1	52.7	63.1	59.8
2006-07	52.3	54.5	64.6	56.2	65.8	63.9	48.5	66.0	57.8
2007-08	50.3	53.2	68.6	69.4	66.4	68.0	50.7	63.0	59.5

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.3.

Source: AIHW (2004, 2005) *CSHA national data reports: public rental housing*, Canberra; AIHW (2006, 2008, 2009) *Public rental housing: CSHA national data report*, Canberra; 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>
2003-04	44.6	44.2	46.3	40.8	39.5	60.3	43.6
2004-05	51.5	45.4	45.2	49.2	42.1	66.7	48.1
2005-06	48.8	42.8	46.8	53.2	45.3	62.3	48.8
2006-07	47.6	52.9	47.0	44.6	45.6	65.6	47.4
2007-08	46.0	44.7	50.6	47.7	42.9	61.9	47.5

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.16.

Source: AIHW (2004, 2005) *CSHA national data reports: Aboriginal rental housing program: State and Territory owned and managed Indigenous housing*, Canberra; AIHW (2006, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*, Canberra; table 16A.16.

The proportion of new tenancies allocated to households with special needs increased between 2006-07 and 2007-08 at the national level for both public housing and SOMIH, but there were variations among the jurisdictions.

Priority access to those in greatest need

‘Priority access to those in greatest need’ is an indicator of the CSHA guiding principle to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes are such that those in greatest need have first access to housing (box 16.9).

Box 16.9 Priority access to those in greatest need

‘Priority access to those in greatest need’ is defined as the proportion of new allocations of housing to those in greatest need. Greatest need households are defined as households that at the time of allocation were either homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs.

High or increasing values for these measures, particularly for short time frames, indicate a high degree of access for those households in greatest need.

Reported measures reflect the percentages of new allocations to greatest need households overall, and for greatest need households waiting for periods of less than three months, three months to less than six months, six months to less than one year, one year to less than two years, and two years or more. As time to allocation reflects greatest need allocations as a percentage of all new allocations for the time period, these percentages are not cumulative.

Data reported for this indicator are comparable.

Differences in State and Territory housing assessment policies can influence comparability for this indicator. The proportion of new allocations to those in greatest need in 2007-08 for public housing is presented in table 16.13.

Table 16.13 Public housing — proportion of new allocations to those in greatest need, 2007-08 (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	38.9	67.3	44.5	46.8	53.0	92.8	87.0	39.5	51.0
Proportion of new allocations to those in greatest need, by time to allocation									
<3 months	68.6	75.8	81.6	53.2	76.2	91.8	92.9	21.5	71.7
3–<6 months	55.2	67.2	88.1	77.8	73.6	96.6	89.0	53.3	70.8
6 months–<1 year	41.8	73.0	75.1	64.3	58.3	92.3	90.6	58.9	62.5
1–<2 years	24.2	66.8	33.4	31.1	48.3	94.4	83.9	47.0	40.9
2+ years	5.0	25.5	4.5	3.6	5.9	83.3	52.5	14.3	7.4

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.4.

Source: AIHW (2009) *Public rental housing 2007-08: CSHA national data report*, Canberra; table 16A.4.

The proportion of new allocations to those in greatest need for 2007-08 for SOMIH is presented in table 16.14.

Table 16.14 SOMIH — proportion of new allocations to those in greatest need, 2007-08 (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	12.9	17.0	29.9	34.9	69.3	na	30.6
Proportion of greatest need allocations to new allocations, by time to allocation							
<3 months	23.6	35.7	50.0	30.4	83.0	na	40.2
3–<6 months	11.7	11.1	50.0	60.8	70.0	na	37.1
6 months–<1 year	12.7	50.0	53.8	62.9	66.7	na	39.8
1–<2 years	–	12.5	18.8	25.6	70.4	na	23.3
2+ years	–	–	5.4	3.1	39.5	na	8.1

^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 (2009) *State owned and managed Indigenous housing 2007-08: CSHA national data report*, Canberra; table 16A.17.

Efficiency

Net recurrent cost per dwelling

‘Net recurrent cost per dwelling’ is an indicator of the CSHA guiding principle to undertake efficient and cost-effective management (box 16.10).

Box 16.10 Net recurrent cost per dwelling

‘Net recurrent cost per dwelling’ is defined as total recurrent expenses, including administration and operational costs, divided by the total number of dwellings. It measures the average cost of providing assistance per dwelling. Cost of providing assistance (including capital) per dwelling is also reported.

Holding other factors equal, a lower or decreasing net recurrent cost per dwelling suggests an improvement in efficiency.

The cost per dwelling indicators do not provide any information on the quality of service provided (for example, the standard of dwellings).

Data reported for this indicator are comparable.

Due to a high level of capital expenditure in housing, cost per dwelling is predominantly driven by the user cost of capital (box 16.11). Caution must therefore be used when interpreting the indicator because the user cost of capital and service delivery models differ across jurisdictions.

The cost incurred by jurisdictions in providing public housing and SOMIH include:

- administration costs (the cost of the administration offices of the property manager and tenancy manager)
- operating costs (the costs of maintaining the operation of the dwelling, including repairs and maintenance, rates, the costs of disposals, market rent paid and interest expenses)
- depreciation costs
- the user cost of capital (the cost of the funds tied up in the capital used to provide public housing and SOMIH). Box 16.11 provides a discussion of the user cost of capital in general and how it relates to housing.

Treatment of assets by housing agencies for each jurisdiction is presented in table 16A.78.

Box 16.11 The user cost of capital

The 'user cost of capital' for government services is the cost of having funds tied up in the capital used to deliver services (for example, houses and land in public housing). It makes explicit the opportunity cost of using the funds to deliver services rather than investing them elsewhere or using them to retire debt. It is calculated by applying a national cost of capital rate to the value of government assets (see chapter 2 for details of the determination of a cost of capital rate). The costs of capital for land and other assets are shown separately, to allow users to consider any differences in land values across jurisdictions when assessing the results. Land values make up a large part of the user cost of capital and are largely beyond the control of jurisdictions.

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

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

The Steering Committee accepts that asset valuation data are imperfect. It also considers that non-recognition of the cost of capital used by departments to deliver services can result in a significant underestimation of costs for those services for which government capital is a major input. While the measurement of capital costs in this Report is not perfect, using an imputed costing is preferable to not costing government capital at all. The rate used for the user cost of capital is based on a weighted average of rates nominated by jurisdictions (currently 8 per cent).

Differences in the techniques for measuring non-current physical assets (such as valuation methods) may reduce the comparability of capital cost estimates across jurisdictions. The Steering Committee initiated the study, *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001). The aim of the study was to examine the extent to which differences in asset measurement techniques applied by participating agencies affect the comparability of reported unit costs.

The relative capital intensity associated with the provision of public housing increases the potential for differences in asset measurement techniques to have a material impact on total unit costs. However, the results of this study suggest that the adoption under the CSHA of a uniform accounting framework has largely avoided this impact. The results are discussed in more detail in chapter 2.

Source: SCRCSSP (2001).

Care needs to be taken in interpreting the cost of delivering public housing. Cost data for some jurisdictions are either more complete than for other jurisdictions or collected on a more consistent basis. Administration costs and operating costs, for example, may not capture all costs incurred by government, so could understate the total cost of public housing. In addition, some jurisdictions have difficulty

separating costs for public housing from those for other housing assistance activities. There may also be double counting of some expenditure items in the cost calculations for some jurisdictions. The user cost of capital, for example, is intended to capture all the costs of funding assets used to produce the services, but reported operating costs (apart from interest payments, which have been adjusted for) may already include some of these costs.

Payroll tax is excluded from total recurrent cost for public housing. This was done for the first time in the 2004 Report, making the cost data not comparable with the data published in past reports. (Chapter 2 elaborates on the reasons for excluding payroll tax from the cost calculations.)

Nationally, net recurrent cost per dwelling (excluding the cost of capital) was \$6064 in 2007-08. Direct cost per dwelling including capital costs was \$24 733 in 2007-08 (table 16.15).

Table 16.15 Public housing — cost of providing assistance per dwelling (2007-08 dollars)^{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>
Net recurrent cost of providing assistance (excluding the cost of capital) per dwelling									
2003-04	5 706	4 160	5 200	5 554	5 454	7 125	9 167	11 897	5 556
2004-05	5 414	4 264	5 109	5 843	5 576	7 049	9 307	10 817	5 480
2005-06	5 585	4 616	5 146	5 869	5 762	7 430	8 381	10 146	5 611
2006-07	6 019	4 731	5 377	7 868	6 240	7 033	7 127	9 898	6 204
2007-08	6 010	4 798	5 286	8 173	6 256	6 947	7 086	10 918	6 064
Cost of providing assistance (including the cost of capital) per dwelling									
2003-04	27 694	20 966	21 426	17 884	14 238	14 573	34 426	24 804	22 552
2004-05	26 170	20 891	21 556	19 387	16 547	20 403	34 568	27 417	22 702
2005-06	24 778	20 719	22 249	21 217	17 545	19 815	33 236	26 362	22 492
2006-07	24 476	20 400	23 014	31 841	18 268	19 087	32 934	26 053	23 663
2007-08	23 938	22 190	25 073	37 977	18 755	20 075	35 747	28 301	24 733

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.5. ^b Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2007-08 = 100) table AA.26.

Source: AIHW (2004, 2005) *CSHA national data reports: public rental housing*, Canberra; AIHW (2006, 2008, 2009) *Public rental housing: CSHA national data report*, Canberra; State and Territory governments (unpublished); table 16A.5.

The net recurrent cost of providing assistance (excluding the cost of capital) per dwelling for SOMIH is presented in table 16.16. Capital cost data for SOMIH are not available for this Report. As with other indicators, it is not appropriate to compare the net recurrent cost of providing assistance per dwelling for public housing with the net recurrent cost of providing assistance per dwelling for SOMIH, because there is greater scope for economies of scale in administration costs with public housing, which is a much larger program overall.

SOMIH dwellings are also slightly more concentrated in regional and remote areas, where the cost of providing housing assistance is potentially greater. The need to construct culturally appropriate housing (possibly requiring different amenities) may also affect the cost per dwelling. Finally, different cost structures may apply to the programs. Construction of dwellings under SOMIH, for example, may involve a skills development element to allow for training of Indigenous apprentices in regional areas.

Table 16.16 **SOMIH — net recurrent cost of providing assistance per dwelling (2007-08 dollars)^{a, b}**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Total</i>
Net recurrent cost of providing assistance (excluding the cost of capital) per dwelling							
2003-04	6 727	5 606	7 451	7 171	6 472	4 054	6 747
2004-05	5 772	5 473	7 003	7 828	4 699	5 578	6 223
2005-06	5 849	6 770	7 178	8 276	7 558	6 054	6 929
2006-07	6 060	4 247	7 782	7 944	6 952	6 698	6 746
2007-08	6 229	4 929	8 139	10 726	9 513	6 504	8 014

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.18. ^b Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2007-08 = 100) table AA.26.

Source: AIHW (2004, 2005) *CSHA national data reports: Aboriginal rental housing program: State and Territory owned and managed Indigenous housing*, Canberra; AIHW (2006, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*, Canberra; table 16A.18.

Occupancy rate

‘Occupancy rate’ is an indicator of the CSHA guiding principle to measure the efficiency of housing utilisation (box 16.12).

Box 16.12 Occupancy rate

‘Occupancy rate’ is defined as the proportion of rental housing stock occupied by households. The term ‘occupied’ refers to rental housing stock occupied by tenants who have a tenancy agreement with the relevant housing authority.

A high or increasing value for this indicator suggests higher efficiency of housing utilisation.

Occupancy is influenced by both turnover and housing supply and demand.

Data reported for this indicator are comparable.

The national average proportion of public rental stock occupied at 30 June 2008 was 98.0 per cent. There were only slight variations across jurisdictions or over time (table 16.17).

Table 16.17 Public housing — occupancy rates (per cent)^a

	<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>
2004	98.7	96.6	98.7	95.3	95.4	97.4	97.2	93.8	97.4
2005	98.7	97.3	98.6	95.6	96.1	98.0	98.1	94.1	97.7
2006	98.6	97.5	98.9	96.2	96.2	98.4	98.7	95.6	97.8
2007	98.6	97.6	99.1	96.5	97.1	98.7	98.6	95.7	98.0
2008	99.0	97.3	99.1	96.1	96.4	98.9	98.6	95.4	98.0

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.6.

Source: AIHW (2004, 2005) *CSHA national data reports: public rental housing*, Canberra; AIHW (2006, 2008, 2009) *Public rental housing: CSHA national data report*, Canberra; table 16A.6.

The proportion of total SOMIH stock occupied at 30 June 2008 is presented in table 16.18. The national average proportion of SOMIH stock occupied at 30 June 2008 was 96.8 per cent.

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>
2004	98.0	96.7	96.8	94.1	92.2	98.2	96.0
2005	97.4	95.8	96.1	94.2	91.8	97.7	95.5
2006	97.4	96.7	96.8	94.1	93.5	98.3	96.1
2007	97.7	96.4	97.2	94.5	94.1	97.7	96.4
2008	98.4	97.9	97.7	94.1	94.6	97.7	96.8

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.19.

Source: AIHW (2004, 2005) *CSHA national data reports: Aboriginal rental housing program: State and Territory owned and managed Indigenous housing*, Canberra; AIHW (2006, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*, Canberra; table 16A.19.

Turnaround time

‘Turnaround time’ is an indicator of the CSHA guiding principle to undertake efficient and cost-effective management (box 16.13).

Box 16.13 Turnaround time

'Turnaround time' is defined as the average time taken for occupancy of available dwelling stock to rent through normal processes.

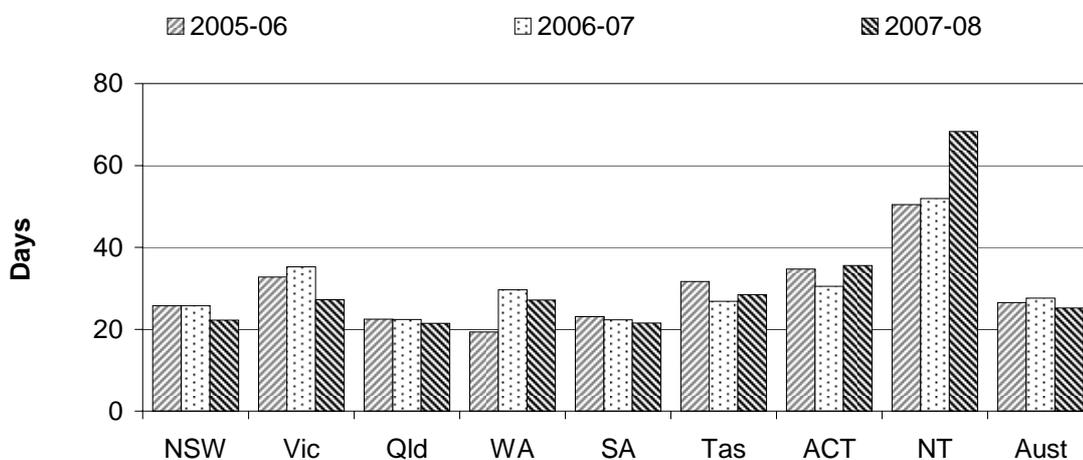
A low or decreasing turnaround time suggests efficient housing allocation.

'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.

Data reported for this indicator are comparable.

The average number of days for vacant stock to remain unallocated in 2007-08 is presented in figure 16.4 for public housing and figure 16.5 for SOMIH.

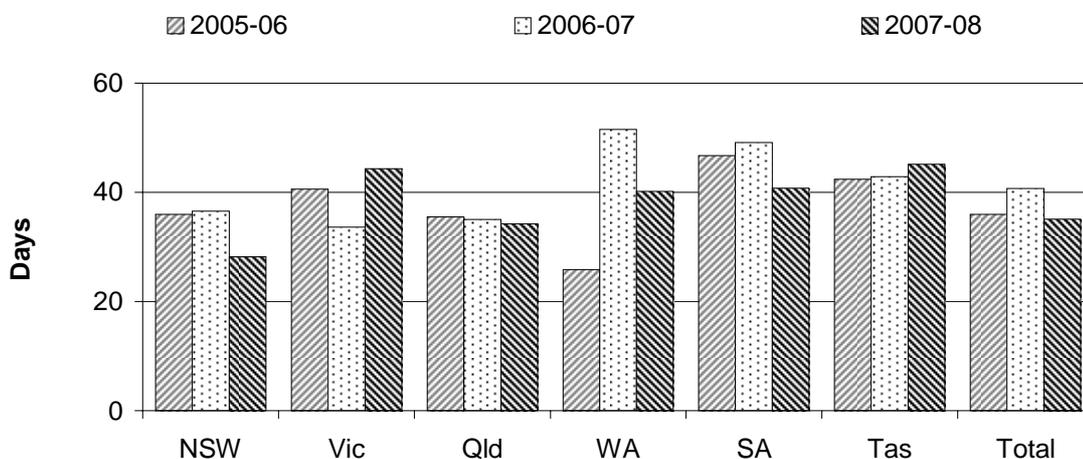
Figure 16.4 **Public housing — average turnaround time^a**



^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.7.

Source: AIHW (2009) *Public rental housing 2007-08: CSHA national data report*, Canberra; table 16A.7.

Figure 16.5 **SOMIH — average turnaround time^a**



^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.20.

Source: AIHW (2009) *State owned and managed Indigenous housing 2007-08: CSHA national data report*, Canberra; table 16A.20.

Rent collection rate

‘Rent collection rate’ is an indicator of the CSHA guiding principle to undertake efficient and cost-effective management (box 16.14).

Box 16.14 Rent collection rate

'Rent collection rate' is defined as the total rent actually collected as a percentage of the total rent charged.

A high or increasing percentage suggests efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a percentage of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of this indicator's reported results. Further, payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

Data reported for this indicator are comparable.

The rent collection rate in 2007-08 is presented in table 16.19 for public housing and table 16.20 for SOMIH.

Table 16.19 Public housing — rent collection rate (per cent)^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2003-04	99.7	99.3	99.8	101.9	100.0	102.2	99.3	99.9	99.9
2004-05	101.2	101.1	100.6	103.2	100.5	99.7	100.0	102.8	101.1
2005-06	100.1	100.1	100.2	101.7	100.8	103.8	99.8	100.7	100.4
2006-07	97.8	97.0	99.4	102.1	100.3	101.5	100.1	100.9	98.8
2007-08	100.0	97.2	98.9	101.0	99.6	101.9	99.9	101.7	99.5

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.8.

Source: AIHW (2004, 2005) *CSHA national data reports: public rental housing*, Canberra; AIHW (2006, 2008, 2009) *Public rental housing: CSHA national data report*, Canberra; table 16A.8.

Table 16.20 SOMIH — rent collection rate (per cent)^a

	NSW	Vic	Qld	WA	SA	Tas	Total
2003-04	104.1	99.8	101.3	103.1	97.0	102.2	101.8
2004-05	97.7	100.6	100.4	103.9	93.8	99.6	99.2
2005-06	100.5	99.0	99.7	104.3	94.7	103.8	100.0
2006-07	101.8	92.8	97.3	105.3	103.0	102.1	100.6
2007-08	96.8	89.2	99.6	104.3	103.7	99.8	99.0

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.21.

Source: AIHW (2004, 2005) *CSHA national data reports: Aboriginal rental housing program: State and Territory owned and managed Indigenous housing*, Canberra; AIHW (2006, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*, Canberra; table 16A.21.

Outcomes

The following indicators measure the outcomes of public housing and SOMIH. Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Amenity/location

‘Amenity/location’ is an indicator of the CSHA guiding principle to provide housing assistance that is appropriate to the needs of different households (box 16.15).

Box 16.15 Amenity/location

‘Amenity/location’ is defined as the percentage of tenants rating amenity/location aspects of their dwelling as important and as meeting their needs.

A higher or increasing level of satisfaction with amenity and location suggests the provision of housing assistance satisfies household needs.

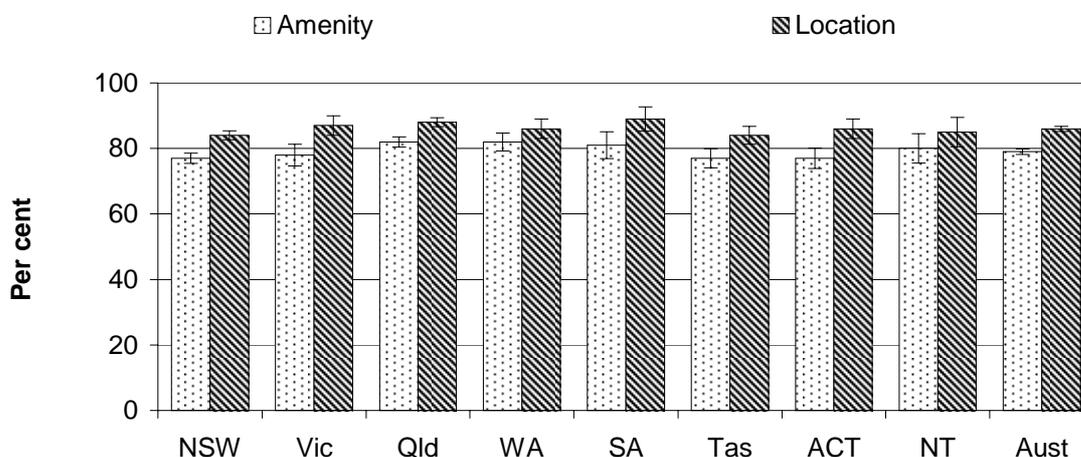
Amenity/location is reported using a survey-based measure.

Data reported for this indicator are comparable.

The data for public housing are taken from the *2007 National Social Housing Survey* for public rental housing. Tenants were asked whether particular aspects of the amenity and location of their dwellings were important to them and, if so, whether they felt their needs were met. The error bars in the figures show the range of potential values that might be expected, based on the sample size. Further information on the sample size is provided in tables 16A.9 and 16A.10.

The proportion of public housing tenants rating their current home as meeting their needs is reported in figure 16.6.

Figure 16.6 Public housing — proportion of tenants rating their current home as meeting their amenity and location needs, 2007^a



^a Further information pertinent to the data included in this table and/or its interpretation is provided in tables 16A.9 and 16A.10.

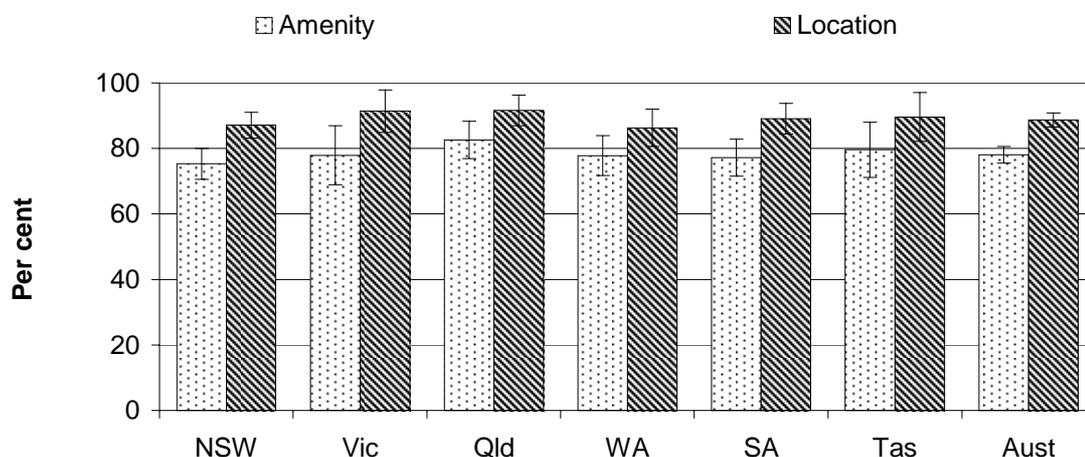
Source: AIHW (2009) *Public rental housing 2006-07: CSHA national data report*, Canberra; tables 16A.9 and 16A.10.

Nationally, 70.0 per cent of Indigenous and 79.0 per cent of non-Indigenous public housing tenants rated amenity aspects as important and meeting their needs. Similarly, at the national level, 80.0 per cent of Indigenous and 86.0 per cent of non-Indigenous public housing tenants rated location aspects as important and meeting their needs (AIHW 2007a).

During 2006-07, all states participated in the *National Social Housing Survey of SOMIH*. As for the National Social Housing Survey undertaken biennially for public and community housing, the survey seeks to determine tenants' level of satisfaction with various aspects of service and measure housing outcomes.

SOMIH tenants were asked whether particular aspects of the amenity and location of their dwellings were important to them and, if so, whether they felt their needs were met. Nationally, 78.1 per cent of tenants for whom amenity was important felt that their needs were met, and of those tenants for whom location was important, 88.7 per cent felt that their needs were met (figure 16.7). Caution should be used when comparing the SOMIH survey results with the public housing survey results, due to the different demographic profile of Indigenous tenants and the different survey methods used. A mail-out survey is used for the public housing survey and interviews for the SOMIH survey. These differences may affect the comparability of the results.

Figure 16.7 **SOMIH — proportion of tenants rating their current home as meeting their amenity and location needs, 2007^a**



^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.22.

Source: AIHW (2009) *State owned and managed Indigenous housing 2006-07: CSHA national data report*, Canberra; table 16A.22.

Affordability

‘Affordability’ is an indicator of the CSHA guiding principle to provide affordable housing to assist people who are unable to access suitable housing (box 16.16).

Box 16.16 Affordability

‘Affordability’ is defined as tenants’ ability to access suitable housing. Two measures of affordability are reported:

- average weekly rental subsidy per rebated household, derived by dividing the total rental rebate amount by the total number of rebated households
- the proportion of rebated households spending less than 30 per cent of their income in rent.

A high or increasing value implies greater housing affordability.

This affordability measure differs from that reported for community housing.

Data reported for this indicator are comparable.

The average weekly subsidy per rebated household and the proportion of rebated households spending less than 30 per cent of their income in rent for public housing

at 30 June 2008 are presented in table 16.21. Information on the amount of income paid in rent by households as a proportion of income can be found in table 16A.80.

Table 16.21 Public housing — average weekly subsidy per rebated household and proportion of households spending 30 per cent or less of their income in rent, 2008^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>
Average weekly subsidy per rebated household (\$)									
2008	129.8	81.6	121.4	78.1	82.6	66.1	179.6	126.2	108.6
Proportion of rebated households spending 30 per cent or less of their income in rent									
2008	100.0	100.0	100.0	99.2	99.7	100.0	99.2	98.9	99.8

^a Data may not be comparable across jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.11.

Source: AIHW (2009) *Public rental housing 2007-08: CSHA national data report*, Canberra; table 16A.11.

The average weekly subsidy per rebated household and the proportion of rebated households spending less than 30 per cent of their income in rent for SOMIH at 30 June 2008 are presented in table 16.22. Information on the amount of income paid in rent by SOMIH tenants as a proportion of income can be found in table 16A.81.

Table 16.22 SOMIH — average weekly subsidy per rebated household 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>Total</i>
Average weekly subsidy per rebated household (\$)							
2008	118.9	96.5	131.5	98.0	96.7	73.6	111.8
Proportion of rebated households spending 30 per cent or less of their income in rent							
2008	100.0	100.0	99.8	98.4	98.7	100.0	98.8

^a Data may not be comparable across jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.23.

Source: AIHW (2009) *State owned and managed Indigenous housing 2007-08: CSHA national data report*, Canberra; table 16A.23.

Match of dwelling to household size

‘Match of dwelling to household size’ is an indicator of the CSHA guiding principle to provide housing assistance that is appropriate to the needs of different households, such as household size (box 16.17).

Box 16.17 Match of dwelling to household size

'Match of dwelling to household size' is defined as the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

Proxy occupancy standard for appropriate sized dwelling, by household structure

<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 (2006).

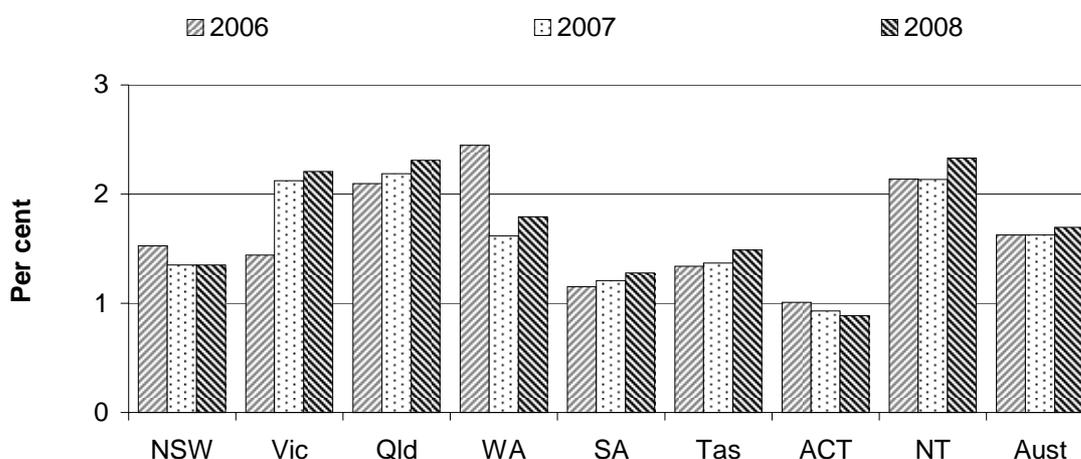
A low or decreasing proportion indicates less overcrowded households.

The proxy occupancy standard was revised in 2005-06 to remove the four bedroom cap. Data prior to 2005-06 should not be compared with data from later years.

Data reported for this indicator are comparable.

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 16.8. Information on moderate overcrowding and underutilisation for public housing can be found in table 16A.83.

Figure 16.8 Public housing — proportion of households with overcrowding^a

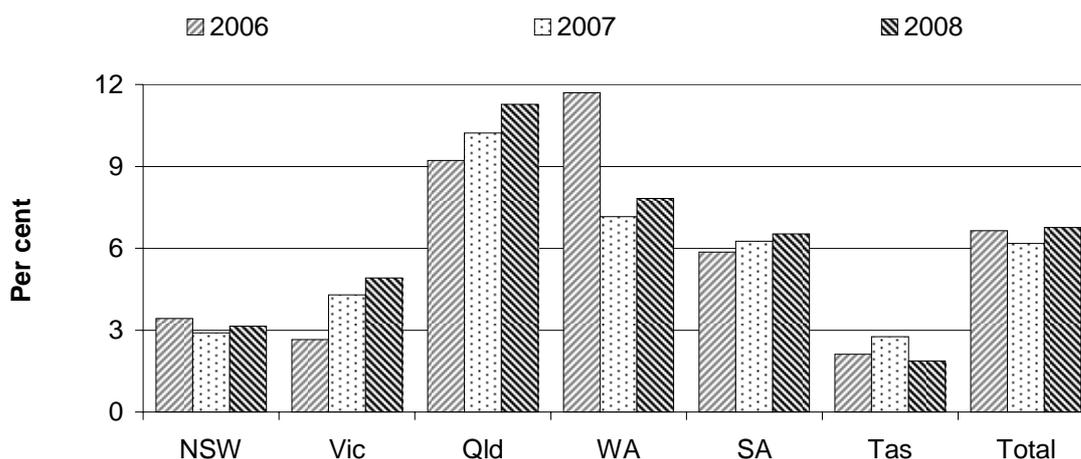


^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.12.

Source: AIHW (2006, 2008, 2009) *Public rental housing: CSHA national data report*, Canberra; table 16A.12.

The proportion of households with overcrowding for SOMIH is illustrated in figure 16.9. Information on moderate overcrowding and underutilisation for SOMIH can be found in table 16A.84.

Figure 16.9 SOMIH — proportion of households with overcrowding^a



^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.24.

AIHW (2006, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*, Canberra; table 16A.24.

Customer satisfaction

‘Customer satisfaction’ is an indicator of the CSHA guiding principle to provide housing assistance that is appropriate for different households (box 16.18).

Box 16.18 Customer satisfaction

‘Customer satisfaction’ is defined as tenants’ satisfaction with the overall service provided by the State or Territory housing authority.

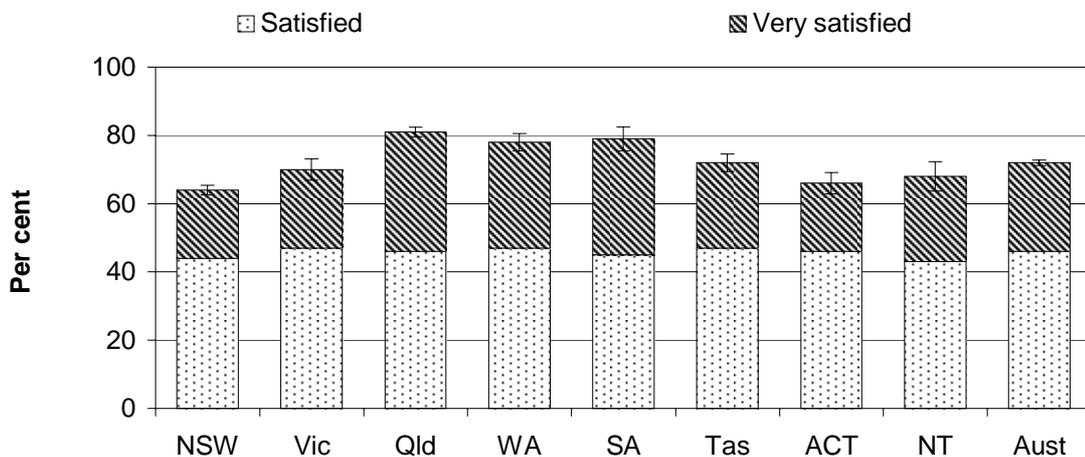
A higher or increasing percentage for customer satisfaction may imply better housing assistance provision.

Customer satisfaction is a survey-based measure.

Data reported for this indicator are comparable.

Data for public housing are sourced from the *2007 National Social Housing Survey* for public rental housing. Nationally in 2007, 71.0 per cent of tenants were either satisfied or very satisfied with the service provided (figure 16.10).

Figure 16.10 **Public housing — customer satisfaction, 2007^a**



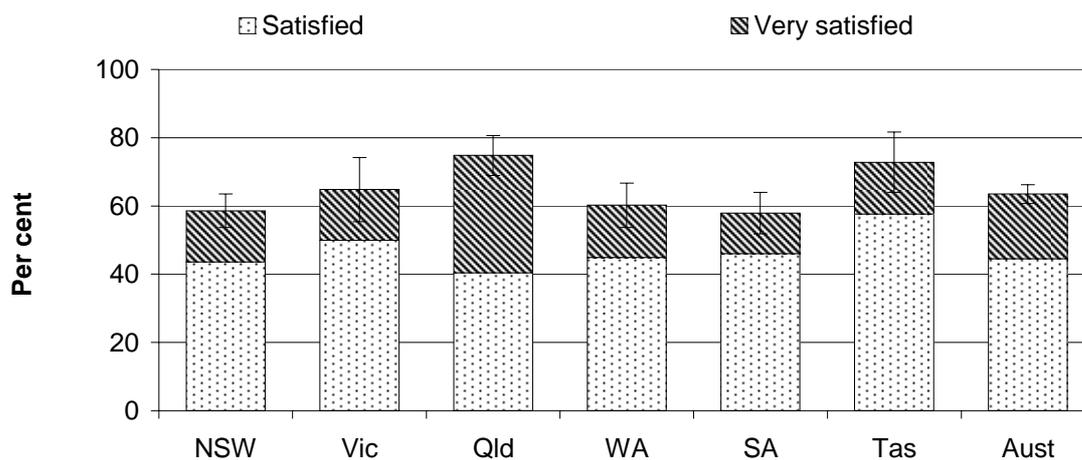
^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.13.

Source: AIHW (2009) *Public rental housing 2006-07: CSHA national data report*, Canberra; table 16A.13.

Nationally, 57 per cent of Indigenous and 72 per cent of non-Indigenous public housing tenants were either satisfied or very satisfied with the overall service provided by their State housing authority in 2007 (AIHW 2007a).

Results for SOMIH are taken from the *2007 National Social Housing Survey* for SOMIH. Nationally, 64 per cent of respondents were either satisfied or very satisfied with the overall service provided by their State housing authority (figure 16.11).

Figure 16.11 **SOMIH — customer satisfaction, 2007^a**



^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.22.

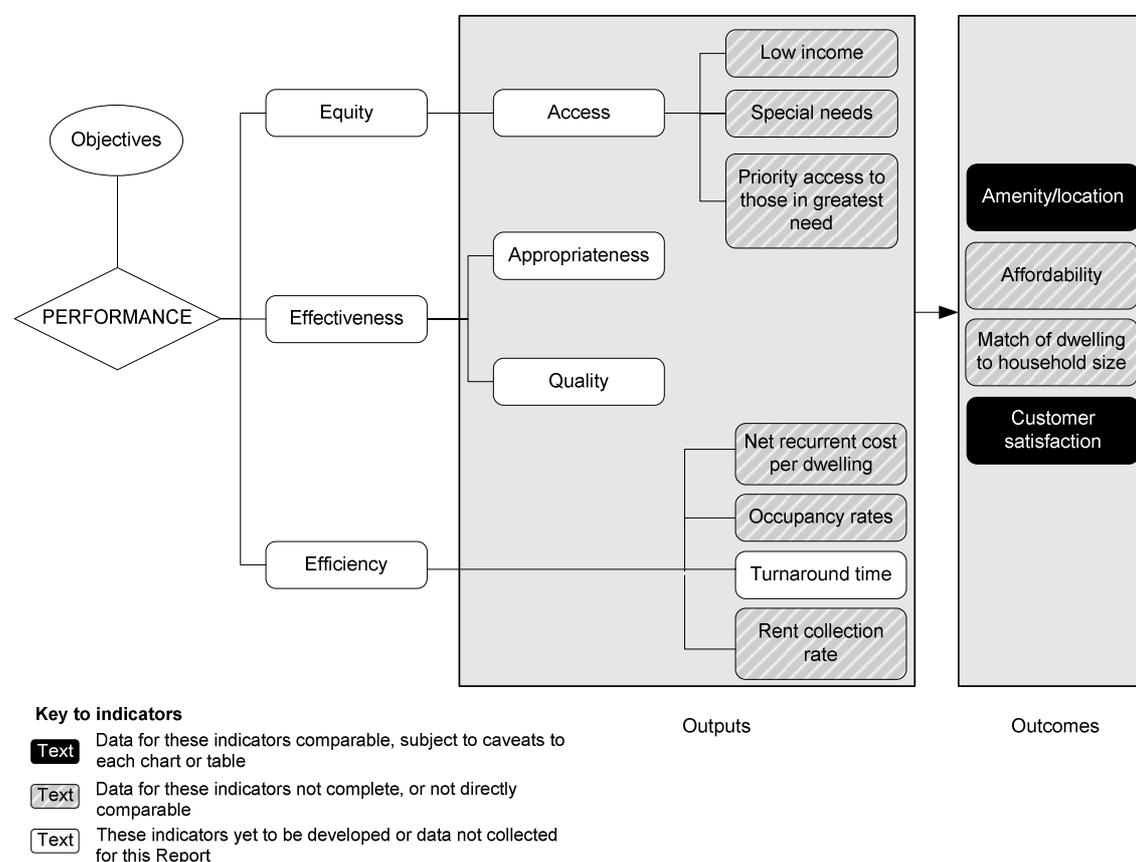
Source: AIHW (2009) *State owned and managed Indigenous housing 2006-07: CSHA national data report*, Canberra; table 16A.22.

Mainstream community housing

The performance indicator framework for mainstream community housing is presented in figure 16.12. Performance indicator results are not comparable between public, SOMIH community housing, and ICH sections.

The turnaround time performance indicator has been removed from the CSHA community housing data collection by the National Housing Data Agreement Management Group following its review of the national performance reporting framework, and so no data were available for this Report.

Figure 16.12 Performance indicators for mainstream community housing



Mainstream community housing data have three sources:

- jurisdictions' administrative data, provided by the State or Territory government body with responsibility for administering the community housing program in the jurisdiction. The NT provided only administrative data, as it currently does not survey its providers
- community housing provider survey data, collected from the community organisations (providers) that manage the service delivery

-
- survey data collected via the National Social Housing Survey.

For the mainstream community housing provider survey data, response rates, along with changes to the definitions and counting rules used over time, can influence the comparability of the data. Comparisons over time therefore need to be made with care. Table 16A.89 outlines the survey response rates and associated information for each jurisdiction for each year from 2002-03 to 2007-08.

Some descriptive data on community housing are contained in table 16A.25. Table 16A.76 lists State and Territory programs included in the mainstream community housing data collection.

Outputs

The following indicators measure the outputs of mainstream community housing. Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity

Low income

‘Low income’ is an indicator of the CSHA guiding principle to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It assesses the low income need status of all households receiving assistance (box 16.19).

Box 16.19 Low income

‘Low income’ is defined as the number of low income households as a proportion of all households (new and existing).

A high or increasing proportion indicates a high degree of access by low income households.

The low income indicator is measured differently for mainstream community housing than for public housing. The mainstream 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.

Data reported for this indicator are not directly comparable.

At 30 June 2008, 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>
2004	96.6	99.5	93.3	95.7	94.0	72.2	95.6	na	95.6
2005	88.9	98.5	98.2	87.5	91.6	93.5	97.5	na	91.8
2006	89.8	93.8	81.9	97.8	97.3	95.1	97.7	na	90.3
2007	89.2	98.2	95.3	99.6	99.7	91.5	97.9	na	93.6
2008	88.5	99.0	93.1	99.9	99.8	96.5	98.9	na	92.9

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.26. **na** Not available.

Source: AIHW (2005, 2006) *CSHA national data reports: CSHA community housing*, Canberra; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*, Canberra; table 16A.26.

Special needs

‘Special needs’ is an indicator of the CSHA guiding principle to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing (box 16.20).

Box 16.20 Special needs

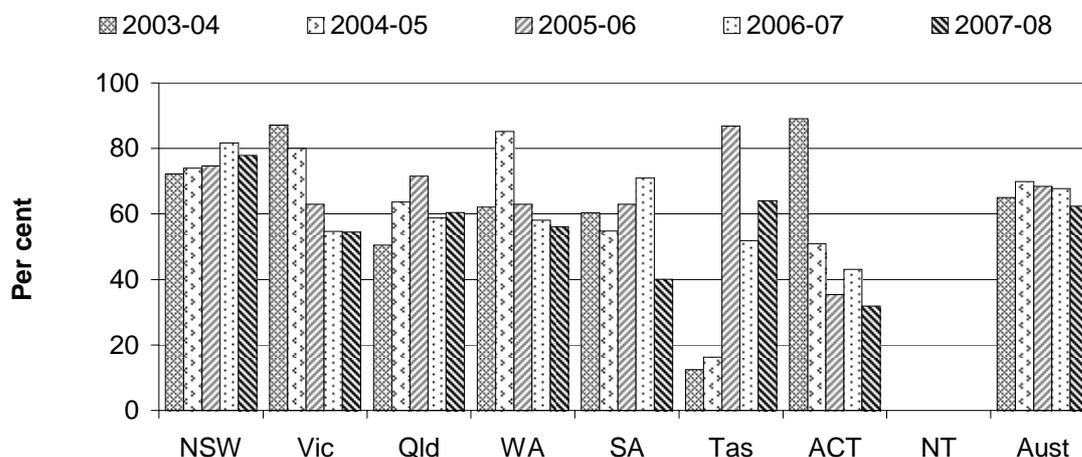
‘Special needs’ is defined as the proportion of new tenancies allocated to special needs households. The proportion of new tenancies with special needs are reported as a proxy for measuring all households with special needs. Special needs households are defined as those households that have either a household member with a disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members.

A high or increasing proportion indicates a high degree of access by these special needs households.

Data reported for this indicator are not directly comparable.

The proportion of new tenancies allocated to special needs households in 2007-08 is presented in figure 16.13.

Figure 16.13 **Community housing — new tenancies allocated to households with special needs^{a, b}**



^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.27. ^b Data for the NT are not available.

Source: AIHW (2005, 2006) *CSHA national data reports: CSHA community housing*, Canberra; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*, Canberra; table 16A.27.

Priority access to those in greatest need

‘Priority access to those in greatest need’ is an indicator of the CSHA guiding principle to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing (box 16.21).

Box 16.21 Priority access to those in greatest need

‘Priority access to those in greatest need’ is defined as 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:

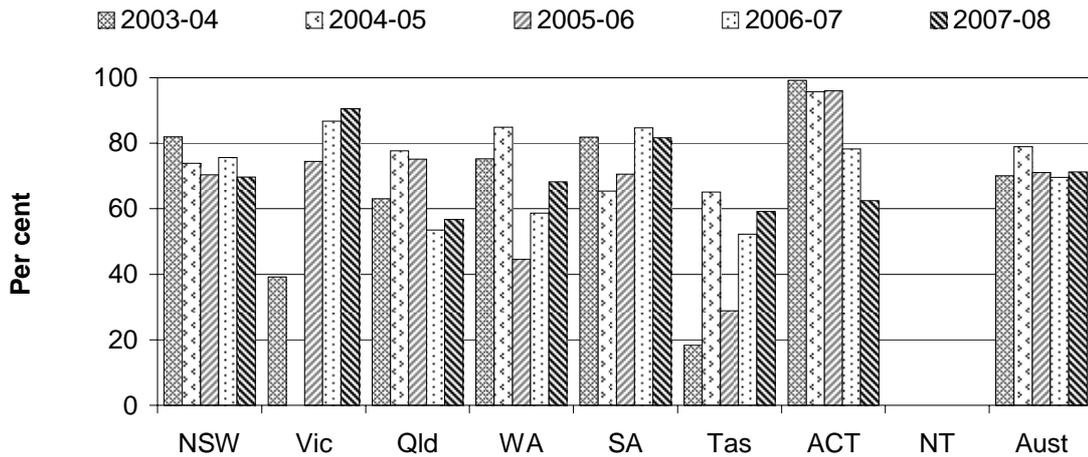
- low income households that at the time of allocation are homeless, or
- in housing inappropriate to their needs, or
- in housing that is adversely affecting their health or placing their life and safety at risk, or
- that have very high rental housing costs.

High or increasing values for this indicator represent a high degree of access by those in greatest need.

Data reported for this indicator are not directly comparable.

The proportion of new allocations to those in greatest need is presented in figure 16.14. Differences in community housing allocation policies can influence comparability for this indicator across jurisdictions.

Figure 16.14 **Community housing — proportion of new allocations to those in greatest need^{a, b}**



^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.28. ^b Data for Victoria for 2004-05 and the NT are not available.

Source: AIHW (2005, 2006) *CSHA national data reports: CSHA community housing*, Canberra; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*, Canberra; table 16A.28.

Efficiency

Net recurrent cost per dwelling

‘Net recurrent cost per dwelling’ is an indicator of the CSHA guiding principle to undertake efficient and cost-effective management (box 16.22).

Box 16.22 Net recurrent cost per dwelling

'Net recurrent cost per dwelling' is defined as the average cost of providing assistance per dwelling. It includes the total administration costs and the costs of maintaining operation of dwellings. It excludes cost of capital.

Holding other factors equal, a lower or decreasing net recurrent cost per dwelling suggests higher efficiency.

The cost per dwelling indicators do not provide any information on the quality of service provided (for example, the standard of dwellings).

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

Capital cost data for mainstream community housing are not included in the 2009 Report as no data on value of assets are available.

The net recurrent cost per dwelling at 30 June 2007 is presented in table 16.24. For community housing, data on net recurrent cost per dwelling are reported with a one year lag to allow community housing providers an extra year to collate financial data.

Table 16.24 **Community housing — net recurrent cost per dwelling (2006-07 dollars)^{a, b}**

	<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>
Net recurrent cost of providing assistance (excluding the cost capital) per dwelling									
2002-03	9 443	4 323	4 920	5 932	5 125	6 079	na	na	6 622
2003-04	10 482	5 871	4 876	8 933	4 263	8 764	na	na	7 420
2004-05	10 296	7 302	6 033	8 776	7 662	12 448	na	na	8 482
2005-06	8 709	7 075	4 664	9 848	7 858	9 986	na	na	7 752
2006-07	8 580	7 963	3 787	6 591	6 999	9 832	6 690	na	7 100

^a Data may not be comparable across jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.29. ^b Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2006-07 = 100) table AA.26. **na** Not available.

Source: AIHW (2005, 2006) *CSHA national data reports: CSHA community housing*, Canberra; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*, Canberra; table 16A.29.

Occupancy rate

'Occupancy rate' is an indicator of the CSHA guiding principle to measure the efficiency of housing utilisation (box 16.23).

Box 16.23 Occupancy rate

'Occupancy rate' is defined as the proportion of dwellings occupied. The term 'occupied dwelling' refers to dwellings occupied by tenants who have a tenancy agreement with the relevant mainstream community housing organisation.

A higher or increasing occupancy rate suggests higher efficiency of housing utilisation.

Occupancy is influenced by both turnover and housing supply.

Data reported for this indicator are not directly comparable.

The proportion of community housing dwellings occupied at 30 June 2008 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>
2004	98.6	98.1	95.0	99.8	95.4	99.8	95.8	100.0	97.5
2005	98.2	94.5	95.7	98.0	95.1	98.9	89.8	100.0	96.5
2006	98.4	93.7	97.2	94.1	96.5	99.8	89.8	100.0	96.6
2007	97.2	96.6	96.6	96.1	96.8	98.5	90.4	100.0	96.7
2008	98.4	95.4	97.0	95.8	96.1	100.0	93.9	100.0	97.1

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.30.

Source: AIHW (2005, 2006) *CSHA national data reports: CSHA community housing*, Canberra; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*, Canberra; table 16A.30.

Turnaround time

'Turnaround time' is an indicator of the CSHA guiding principle to undertake efficient and cost-effective management (box 16.24). Current data for turnaround time are not available for community housing due to data quality issues. Data for this indicator were last reported in the 2006 Report.

Box 16.24 Turnaround time

'Turnaround time' is defined as the average time taken in days for normal vacant dwellings to be occupied.

A low or reducing turnaround time suggests efficient housing allocation.

The length of time taken to rent untenanted dwellings affects allocations of housing, waiting times, the length of waiting lists and rent foregone.

'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 this indicator were not available for the 2009 Report.

Rent collection rate

'Rent collection rate' is an indicator of the CSHA guiding principle to undertake efficient and cost-effective management (box 16.25).

Box 16.25 Rent collection rate

'Rent collection rate' is defined as the total rent actually collected as a proportion of the rent charged.

A high or increasing proportion suggests efficiency in collecting rent.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of 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.

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

For mainstream community housing, data on the rent collection rate are reported with a one year lag to allow mainstream community housing providers an extra year to collate financial data (table 16.26). As with public housing, payment arrangements for rent in some jurisdictions mean the rent collected over a 12 month period may be higher than rent charged over that period.

Table 16.26 Community housing — rent collection rate (per cent)^a

	<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>
2002-03	98.8	98.6	83.8	100.5	97.3	98.9	99.7	na	95.7
2003-04	99.4	96.1	98.6	98.0	97.8	101.2	92.6	na	98.3
2004-05	99.5	96.3	98.3	102.6	97.8	100.4	100.3	na	99.0
2005-06	98.8	99.6	99.6	100.5	98.0	98.5	97.3	na	99.1
2006-07	99.8	99.5	100.3	100.3	98.4	95.7	98.1	na	99.6

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.31. **na** Not available.

Source: AIHW (2005, 2006) *CSHA national data reports: CSHA community housing*, Canberra; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*, Canberra; table 16A.31.

Outcomes

The following indicators measure the outcomes of mainstream community housing. Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Amenity/location

‘Amenity/location’ is an indicator of the CSHA guiding principle to provide housing assistance that is appropriate to the needs of different households (box 16.26).

Box 16.26 Amenity/location

‘Amenity/location’ is defined as the percentage of tenants rating amenity/location aspects of their dwelling as important and as meeting their needs.

A higher or increasing level of satisfaction with amenity and location suggests the provision of housing assistance satisfies household needs.

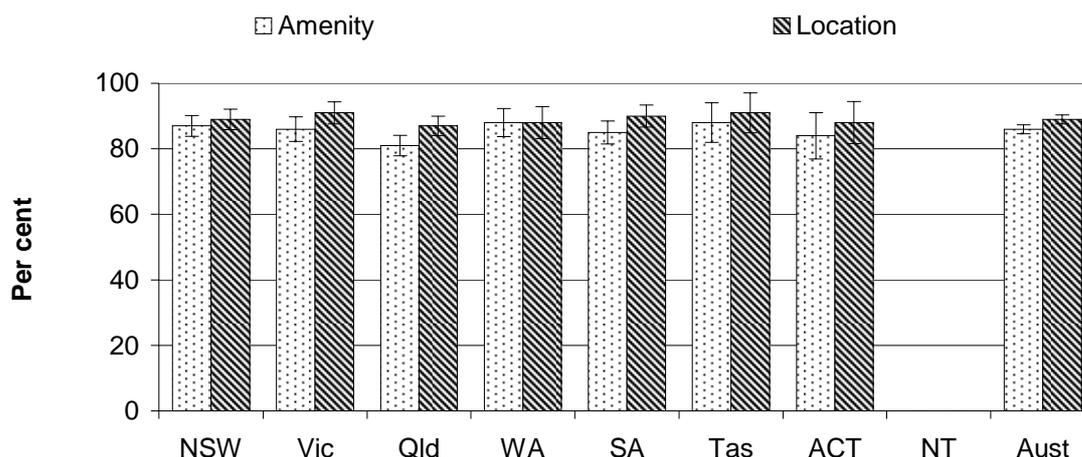
Amenity/location is reported using a survey-based measure.

Data reported for this indicator are comparable.

The data for this indicator are from the *2007 Community Housing National Social Housing Survey*. Mainstream community housing tenants were asked whether particular aspects of the amenity and location of their dwellings were important to them and, if so, whether they felt their needs were met. The proportions of tenants satisfied with the amenity and location of their dwelling in March/April 2007 are presented in figure 16.15. As with public housing, the precision of survey estimates depends on the survey sample size (see the discussion of amenity/location for public

housing). More information on the sample size and standard error is provided in tables 16A.32 and 16A.33.

Figure 16.15 Community housing — proportion of tenants rating their current home as meeting their amenity and location needs, 2007^{a, b}



^a Further information pertinent to the data included in this table and/or its interpretation is provided in tables 16A.32 and 16A.33. ^b Data for the NT are not available.

Source: AIHW (2009) *Community housing 2006-07: CSHA national data report*, Canberra; tables 16A.32 and 16A.33.

Affordability

‘Affordability’ is an indicator of the CSHA guiding principle to provide affordable housing to assist people who are unable to access suitable housing (box 16.27).

Box 16.27 Affordability

‘Affordability’ is defined as the proportion of household income left after paying rent.

A high or increasing proportion indicates that housing is affordable.

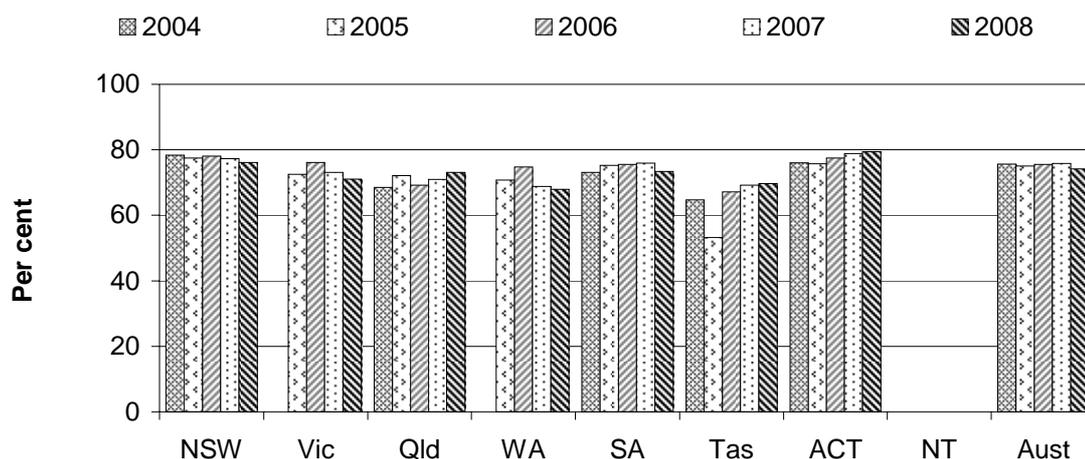
This affordability measure differs from that reported for public housing and SOMIH.

Data reported for this indicator are not directly comparable.

The proportion of household income left after paying rent is presented in figure 16.16. Differences in the definition of assessable income, including the treatment of CRA in rent assessment, may affect the comparability of this

indicator's reported result. More information on affordability for community housing can be found in table 16A.82.

Figure 16.16 **Community housing — proportion of income left after paying rent^{a, b, c}**



^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.34. ^b Data for Victoria (for 2004) and the NT are not available. ^c Data for WA for 2004 are not published.

Source: AIHW (2005, 2006) *CSHA national data reports: CSHA community housing*, Canberra; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*, Canberra; table 16A.34.

Match of dwelling to household size

‘Match of dwelling to household size’ is an indicator of the CSHA guiding principle to provide housing assistance that is appropriate to the needs of different households, such as household size (box 16.28).

Box 16.28 Match of dwelling to household size

'Match of dwelling to household size' is defined as the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

Proxy occupancy standard for appropriate sized dwelling, by household structure

<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 (2006).

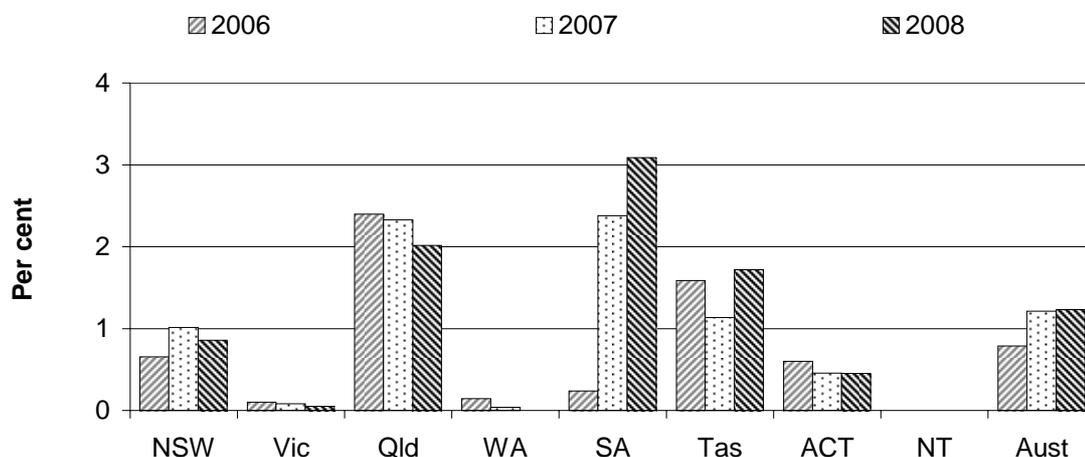
A low or decreasing proportion indicates less overcrowded households.

The proxy occupancy standard was revised in 2005-06 to remove the four bedroom cap. Data prior to 2005-06 should not be compared with data from later years.

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

The proportion of mainstream community housing households with overcrowding is illustrated in figure 16.17. Information on moderate overcrowding and underutilisation for mainstream community housing can be found in table 16A.85.

Figure 16.17 **Community housing — proportion of households with overcrowding^{a, b}**



^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.35. ^b Data for the NT are not available.

Source: AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*, Canberra; table 16A.35.

Customer satisfaction

‘Customer satisfaction’ is an indicator of the CSHA guiding principle to provide housing assistance that is appropriate to different households (box 16.29).

Box 16.29 Customer satisfaction

‘Customer satisfaction’ is defined as satisfaction with the overall service provided by the State or Territory housing authority.

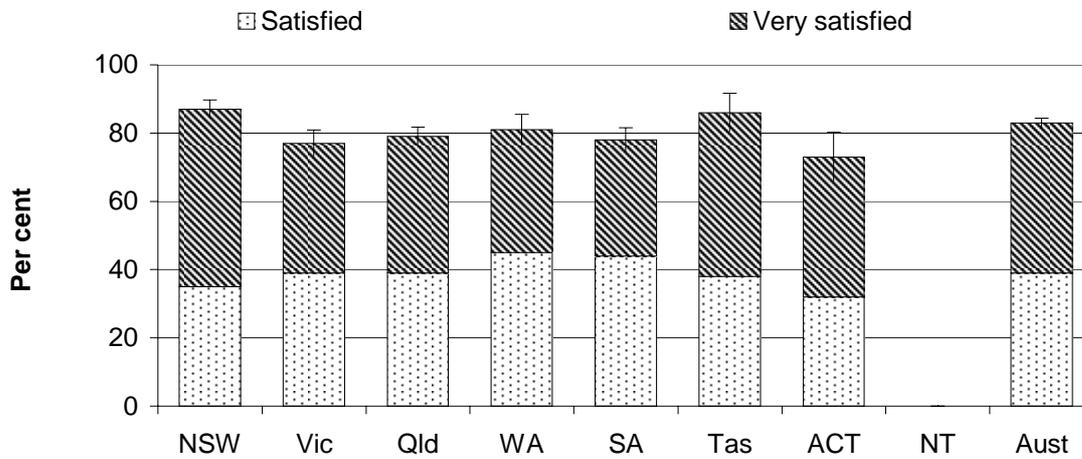
A higher or increasing proportion of satisfied customers may imply better housing assistance provision.

Customer satisfaction is a survey-based measure.

Data reported for this indicator are comparable.

Data for this indicator are from the *2007 Community Housing National Social Housing Survey*. Nationally, in March/April 2007, 82.0 per cent of tenants were satisfied or very satisfied with the services provided by their community housing organisation (figure 16.18).

Figure 16.18 Community housing — customer satisfaction, 2007^{a, b, c}



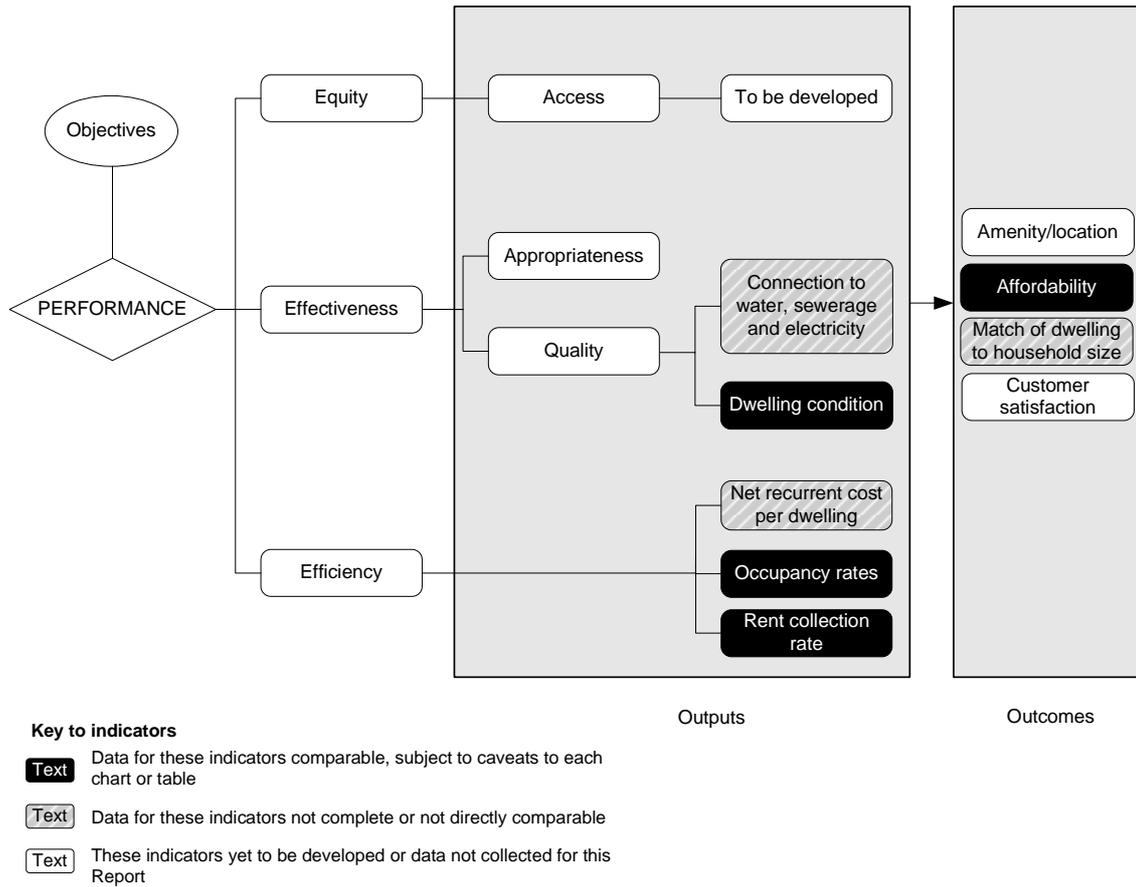
^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.36. ^b Totals may not add due to rounding. ^c Data for the NT are not available.

Source: AIHW (2009) *Community housing 2006-07: CSHA national data report*, Canberra; table 16A.36.

Indigenous community housing

The performance indicator framework for ICH is presented in figure 16.19.

Figure 16.19 Performance indicators for ICH



The definition of ICH is presented in box 16.30.

Box 16.30 Indigenous community housing

Indigenous community housing refers to housing funded by State or Federal governments that is managed and delivered by ICH organisations. These organisations are responsible for asset and tenancy management functions.

Funding for ICH comes through Australian Government programs such as the ARHP, CHIP and the National Aboriginal Health Strategy. State and Territory governments also provide funding for ICH. In most jurisdictions (NSW, SA, WA, the ACT and the NT), State and Territory and Federal funding is pooled and administered by the State governments. At the time data for this Report were collected (2006-07), the Australian Government was involved in the administration of ICH in Victoria and Tasmania only. In Queensland, some ICH is administered by the State government and some by the Australian Government.

In May 2001, housing ministers endorsed a 10-year statement of new directions for Indigenous housing, *Building a Better Future: Indigenous Housing to 2010* (BBF). BBF recognised that Indigenous housing was a major national issue requiring priority action and sought to improve housing and environmental health outcomes for Indigenous Australians. The focus of BBF was on: identifying and addressing outstanding need; improving the viability of ICH organisations; establishing safe, healthy and sustainable housing for Indigenous Australians, especially in rural and remote communities; and establishing a national framework for the development and delivery of improved housing outcomes for Indigenous Australians by State, Territory and community housing providers.

The National Reporting Framework (NRF) for Indigenous Housing was developed to provide a framework for reporting across all Indigenous housing programs and on the implementation and outcomes of BBF. The NRF comprises a set of 38 performance indicators for national reporting and the AIHW collects annual data for reporting on these indicators.

Source: AIHW (2007b).

Outputs

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

Equity — access

Access indicators measure equitable access to ICH (box 16.31).

Box 16.31 Performance indicator — access

‘Access’ indicators are output indicators of the ICH guiding principle to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing.

Access has been identified as a key area for development in future reports.

Effectiveness — quality

Connection to water, sewerage and electricity

‘Connection to water, sewerage and electricity’ is an indicator of the ICH guiding principle to provide quality housing (box 16.32).

Box 16.32 Connection to water, sewerage and electricity

‘Connection to water, sewerage and electricity’ is defined as the proportion of ICH dwellings not connected to essential services. Specifically, it is measured as the number of permanent ICH dwellings not connected to an organised water, sewerage and electricity system as a percentage of the total number of permanent dwellings.

A lower or decreasing percentage suggests higher housing quality.

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

The percentage of Indigenous community houses not connected to water, sewerage and electricity at 30 June 2007 is presented in table 16.27.

Table 16.27 ICH — proportion of permanent dwelling not connected to water, sewerage and electricity (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>Aus Gov</i>	<i>Aust</i>
Water										
2005-06	–	..	–	–	–	..	–	4.7	0.1	1.7
2006-07	–	..	–	–	–	..	–	4.7	0.1	1.5
Sewerage										
2005-06	–	..	–	–	–	..	–	6.4	0.5	2.4
2006-07	–	..	–	–	–	..	–	6.4	0.1	2.1
Electricity										
2005-06	–	..	–	–	–	..	–	5.4	0.1	2.0
2006-07	–	..	–	–	–	..	–	5.4	0.3	1.8

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in tables 16A.38, 16A.39 and 16A.40. .. Not applicable. – Nil or rounded to zero.

Source: AIHW, *Indigenous housing indicators 2006-07 collection* (unpublished); AIHW (2007) *Indigenous housing indicators 2005-06*, Indigenous housing series no. 2, Cat. no. HOU 168. Canberra; tables 16A.38, 16A.39 and 16A.40.

Dwelling condition

‘Dwelling condition’ is an indicator of the ICH guiding principle to provide quality housing (box 16.33).

Box 16.33 Dwelling condition

‘Dwelling condition’ is defined as the proportion of ICH dwellings in poor condition and in need of major repair or replacement. It is measured as the number of permanent ICH dwellings in need of either major repair or replacement as a percentage of the total number of permanent dwellings.

A lower or decreasing proportion suggests higher housing quality.

Data reported for this indicator are comparable.

The dwelling condition indicator for ICH in 2006 is presented in table 16.28.

Table 16.28 **ICH — dwelling condition, (per cent), 2006^a**

	NSW (includes ACT) ^b	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Dwellings in need of major repair	18.8	24.7	26.3	27.9	22.4	30.6	..	21.0	23.4
Dwellings in need of replacement	2.7	4.5	5.9	10.1	5.8	–	..	10.2	7.2

^a Data may not be comparable across jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.41. ^b Data for the ACT has been included with NSW due to low numbers. .. Not applicable. – Nil or rounded to zero.

Source: ABS (2007) *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities 2006*; table 16A.41.

Efficiency

Net recurrent cost per dwelling

‘Net recurrent cost per dwelling’ is an output indicator of the ICH guiding principle to provide efficient and cost-effective management of housing (box 16.34).

Box 16.34 Net recurrent cost per dwelling

‘Net recurrent cost per dwelling’ is defined as total recurrent costs for ICH divided by the total number of permanent dwellings. It includes the recurrent cost of delivering ICH. It excludes cost of capital.

Holding other factors equal, a lower or decreasing proportion suggests higher efficiency.

The cost per dwelling indicators do not provide any information on the quality of service provided (for example, the standard of dwellings).

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

The net recurrent cost per dwelling for 2006-07 is presented in table 16.29.

Table 16.29 ICH — net recurrent cost per dwelling (2006-07 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>Aus Gov^b</i>	<i>Aust</i>
2005-06	7 285	..	na	na	6 724	..	23 422	593	7 196	na
2006-07	7 938	..	3 272	na	3 251	..	na	na	na	4 977

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.42. ^b Contains data from Victoria, Tasmania and Queensland and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey. **na** Not available. .. Not applicable.

Source: AIHW, *Indigenous housing indicators 2006-07 collection* (unpublished); AIHW (2007) *Indigenous housing indicators 2005-06*, Indigenous housing series no. 2, Cat. no. HOU 168. Canberra; table 16A.42.

Occupancy rate

‘Occupancy rate’ is an indicator of the ICH guiding principle to provide efficient housing utilisation (box 16.35).

Box 16.35 Occupancy rate

‘Occupancy rate’ is defined as the proportion of dwellings occupied. ‘Occupied dwelling’ refers to dwellings occupied by tenants who have a tenancy agreement with the relevant ICH organisation.

A higher or increasing occupancy rate suggests higher efficiency of housing utilisation.

Occupancy is influenced by both turnover and housing supply.

Data reported for this indicator are comparable.

The proportion of ICH occupied at 30 June is presented in table 16.30.

Table 16.30 ICH — occupancy rates (per cent)^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus Gov ^b	Aust
2006	96.6	..	95.7	77.9	88.3	..	95.7	87.0	94.1	89.6
2007	98.3	..	100.0	91.0	89.0	..	100.0	na	94.9	96.2

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.43. ^b Contains data from Victoria, Queensland and Tasmania and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey. **na** Not available. .. Not applicable.

Source: AIHW, *Indigenous housing indicators 2006-07 collection* (unpublished); AIHW (2007) *Indigenous housing indicators 2005-06*, Indigenous housing series no. 2, Cat. no. HOU 168. Canberra; table 16A.43.

Rent collection rate

‘Rent collection rate’ is an indicator of the ICH guiding principle to provide efficient and cost-effective management of housing (box 16.36).

Box 16.36 Rent collection rate

‘Rent collection rate’ is defined as the total rent actually collected as a proportion of the rent charged.

A high or increasing proportion suggests efficiency in collecting rent.

As with mainstream community housing, payment arrangements for rent in some jurisdictions mean the rent collected over a 12 month period may be higher than rent charged over that period.

Data reported for this indicator are comparable.

Rent collection rate in 2006-07 is presented in table 16.31.

Table 16.31 ICH — rent collection rate (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>Aus Gov^b</i>	<i>Aust</i>
2005-06	89.4	..	97.4	94.1	102.7	..	100.0	103.8	84.7	94.2
2006-07	90.0	..	96.6	96.8	65.5	..	100.0	111.5	92.0	96.2

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.44. ^b Contains data from Victoria, Queensland and Tasmania and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey. .. Not applicable.

Source: AIHW, *Indigenous housing indicators 2006-07 collection* (unpublished); AIHW (2007) *Indigenous housing indicators 2005-06*, Indigenous housing series no. 2, Cat. no. HOU 168. Canberra; table 16A.44.

Outcomes

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

Amenity/location

‘Amenity/location’ is an indicator of the ICH guiding principle to provide housing assistance that is appropriate to the needs of different households (box 16.37).

Box 16.37 Amenity/location

‘Amenity/location’ is defined as the proportion of tenants rating amenity and location aspects as important and as meeting their needs.

Higher levels of satisfaction with amenity and location imply the provision of housing assistance that satisfies household needs.

The amenity/location indicator is a survey-based measure.

Data for this indicator were not available for the 2009 Report.

Affordability

‘Affordability’ is an indicator of the ICH guiding principle to provide affordable housing to assist people who are unable to access suitable housing (box 16.38).

Box 16.38 Affordability

'Affordability' is defined as the extent to which low income households are paying a large share of their income in rent. It is measured as the number of ICH households in the bottom 40 per cent of equivalised incomes paying 25 per cent or more of their income in rent, divided by the total number of Indigenous community households.

A low or decreasing proportion indicates that housing is more affordable.

No administrative data are currently collected for this indicator, so ABS survey data from 2006 are reported. This affordability measure differs from that reported for public housing, SOMIH and community housing.

Data reported for this indicator are comparable.

The proportion of Indigenous community households in the bottom 40 per cent of equivalised incomes paying 25 per cent or more of their income on rent is presented in table 16.32.

Table 16.32 ICH — proportion of low income households paying 25 per cent or more of their income on rent (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>
2001	28.9	31.1	20.2	12.4	12.3	20.9	..	5.2	15.8
2006	31.3	41.6	19.9	7.4	15.9	42.6	..	3.9	15.1

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.45. ^b Low income households refer to those in the bottom 40 per cent of equalised gross household income. .. Not applicable. – Nil or rounded to zero.

Source: ABS (2002) *2001 Census of Population and Housing*, Canberra; ABS (2007) *2006 Census of Population and Housing*, Canberra; table 16A.45.

Match of dwelling to household size

'Match of dwelling to household size' is an indicator of the ICH guiding principle to provide housing assistance that is appropriate to the needs of different households, such as household size (box 16.39).

Box 16.39 Match of dwelling to household size

'Match of dwelling to household size' is defined as the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

Proxy occupancy standard for appropriate sized dwelling, by household structure

<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 (2006).

A low proportion indicates less overcrowded households.

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

The proportion of Indigenous community households with overcrowding at 30 June is illustrated in table 16.33.

Table 16.33 ICH — proportion of households with overcrowding (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>Aus Gov^b</i>	<i>Aust</i>
2006	na	..	36.6	na	5.6	..	4.5	na	19.3	na
2007	na	..	27.2	na	24.1	..	na	na	24.5	30.8

^a Data may not be comparable across jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.46. ^b Contains all data from Victoria and Tasmania and some data from Queensland and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey. **na** Not available. **..** Not applicable.

Source: AIHW, *Indigenous housing indicators 2006-07 collection* (unpublished); AIHW (2007) *Indigenous housing indicators 2005-06*, Indigenous housing series no. 2, Cat. no. HOU 168. Canberra; table 16A.46.

Customer satisfaction

'Customer satisfaction' is an indicator of the ICH guiding principle to provide housing assistance that is appropriate to different households (box 16.40).

Box 16.40 Customer satisfaction

'Customer satisfaction' is defined as satisfaction with the overall quality of service provided.

A higher proportion of satisfied tenants may imply better housing assistance provision.

Data for this indicator were not available for the 2009 Report.

Commonwealth Rent Assistance

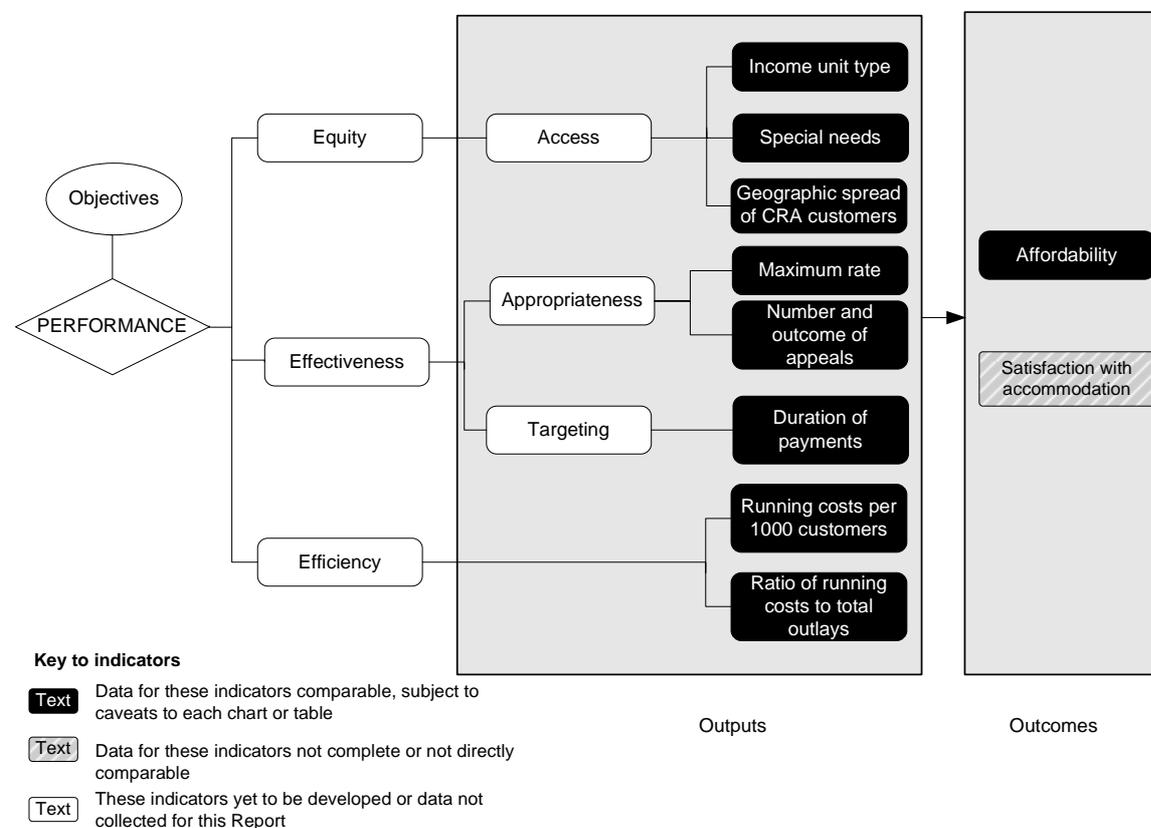
The performance indicator framework for CRA is presented in figure 16.20.

Data for CRA recipients are for individuals and families paid CRA by Centrelink under the *Social Security Act 1991* or family assistance law. CRA data do not include equivalent payments made by the Department of Veterans Affairs, or payments made with Abstudy on behalf of DEEWR.

Data are generally for those entitled to CRA at 6 June 2008. Centrelink recorded 946 641 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.

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.

Figure 16.20 Performance indicators for CRA



Outputs

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

Equity — access

Income unit type

‘Income unit type’ is an indicator of the CRA’s guiding principle to provide financial assistance in an equitable manner (box 16.41).

Box 16.41 Income unit type

‘Income unit type’ is defined as the number and proportion of eligible income support recipients receiving CRA by income unit type.

Data for this indicator are difficult to interpret. CRA is a demand driven payment that has no benchmarks in terms of the mix of customers.

The number of CRA recipients in each State and Territory is influenced by a number of factors, including the size of the base population, dependence on welfare and levels of home ownership. This indicator provides descriptive information only.

Data reported for this indicator are comparable.

Of the 946 641 income units entitled to receive CRA at 6 June 2008, 31 494 (approximately 3.3 per cent) self-identified as Indigenous. Single people with no children represented approximately 51.1 per cent of income units receiving CRA and 37.3 per cent of Indigenous income units receiving CRA (table 16.34). Data for the total number and proportion of income units by the income unit type disaggregated at the jurisdiction level are presented in tables 16A.48, 16A.49, 16A.50 and 16A.51.

Table 16.34 Income units receiving CRA, by income unit type, 2008^a

<i>Type of income unit</i>	<i>Income units</i>		<i>Proportion of CRA recipients</i>		<i>Indigenous income units</i>		<i>Proportion of Indigenous CRA recipients</i>	
	no.	%	no.	%	no.	%	no.	%
Single, no dependent children aged under 16	365 087	38.6	9 199	29.2				
Single, no children, sharer	118 172	12.5	2 553	8.1				
Single, one or two dependent children aged under 16	182 808	19.3	8 142	25.9				
Single, three or more dependent children aged under 16	36 804	3.9	2 727	8.7				
Partnered, no dependent children aged under 16	83 966	8.9	1 793	5.7				
Partnered, one or two dependent children aged under 16	107 614	11.4	4 122	13.1				
Partnered, three or more dependent children aged under 16	49 293	5.2	2 816	8.9				
Partnered, illness or temporarily separated	2 897	0.3	142	0.5				
Unknown income unit	..	..	..	..
Total	946 641	100.0	31 494	100.0				

^a Further information pertinent to the data included in this table and/or its interpretation is provided in tables 16A.48, 16A.49, 16A.50 and 16A.51. .. Not applicable.

Source: FaHCSIA (unpublished); tables 16A.48, 16A.49, 16A.50 and 16A.51.

Special needs

‘Special needs’ is an indicator of the CRA’s guiding principle to provide income support recipients and low income families with financial assistance (box 16.42).

Box 16.42 Special needs

'Special needs' is defined as the proportion of income units receiving CRA that include an Indigenous person or a person receiving a Disability Support Pension.

Data for this indicator are difficult to interpret. The number of CRA recipients in each State and Territory is influenced by a number of factors, including the size of the base populations and levels of home ownership.

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.

Data reported for this indicator are comparable.

Table 16.35 illustrates the number and proportion of income units receiving CRA at 6 June 2008 by jurisdiction, Indigenous status and geographic location.

Overall, 57.4 per cent of all income units receiving CRA at 6 June 2008 were in capital cities, while 42.6 per cent were in the rest of the State or Territory (FaHCSIA unpublished). For Indigenous income units receiving CRA, 33.0 per cent were located in capital cities, while 67.0 per cent lived in the rest of the State or Territory. For non-Indigenous income units receiving CRA, 58.3 per cent were located in capital cities, while 41.7 per cent lived in the rest of the State or Territory (table 16.35).

People who own their home are not entitled to CRA. Indigenous people receiving social security benefits are less likely to own their home and therefore are more likely to receive CRA. Nationally, 6.8 per cent of Indigenous income units receiving social security or family payments were homeowners, while 45.0 per cent of non-Indigenous income units receiving benefits were home owners, in 2008 (FaHCSIA unpublished).⁵

⁵ Home ownership rate refers to the proportion of income units receiving a social security payment or more than the base rate Family Tax Benefit Part A recorded as owning or purchasing a home. It excludes those identified as living in special residences such as nursing homes, aged care and retirement villages, those residing overseas or living in caravan parks.

Table 16.35 Income units receiving CRA, by Indigenous status, disability support pension and geographic location, 2008^a

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
<i>Non-Indigenous</i>										
	Income units	no. 313 851	208 287	216 169	72 822	68 393	23 744	na	3 933	914 574
	In capital city	% 54.7	68.7	42.2	74.8	76.5	42.7	na	79.5	58.3
	In rest of State/Territory	% 45.3	31.3	57.8	25.2	23.5	57.3	na	20.5	41.7
	Non-Indigenous income units as proportion of all CRA recipient income units	% 96.1	98.8	95.4	96.7	97.7	95.4	na	80.3	96.6
	Non-Indigenous population, as proportion of total population	% 97.9	99.4	96.7	96.6	98.2	96.2	98.7	71.5	97.6
<i>Indigenous</i>										
	Income units	no. 12 541	2 372	10 321	2 454	1 581	1 136	133	927	31 473
	In capital city	% 25.3	45.7	27.3	53.9	59.4	37.4	100.0	53.1	33.0
	In rest of State/Territory	% 74.7	54.3	72.7	46.1	40.6	62.6	–	46.9	67.0
	Indigenous income units as proportion of all CRA recipient income units	% 3.8	1.1	4.6	3.3	2.3	4.6	1.8	18.9	3.3
	Indigenous population, as proportion of total population	% 2.1	0.6	3.3	3.4	1.8	3.8	1.3	28.5	2.4
	Total income units	no. 326 525	210 740	226 673	75 311	69 996	24 882	7 495	4 895	946 641
<i>Disability Support Pension</i>										
	In capital city	% 46.9	66.3	40.9	73.6	76.1	42.7	99.4	70.3	54.7
	In rest of State/Territory	% 53.0	33.7	59.0	26.4	23.8	57.3	na	29.4	45.3
	Total income units	no. 63 915	44 746	44 929	14 771	14 911	5 354	1 041	1 069	190 754

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.52. na Not available. – Nil or rounded to zero.

Source: FaHCSIA (unpublished); ABS population by age and sex, Australian States and Territories, Cat. no. 3201.0, (unpublished). ABS (2007) 2006 Census of Population and Housing, Canberra; ABS (2004) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islanders*, Cat. no. 3238.0; table 16A.52.

Geographic spread of CRA customers

‘Geographic spread of CRA customers’ is an indicator of the CRA’s guiding principle to ensure equitable spread of CRA customers within geographic regions (box 16.43).

Box 16.43 Geographic spread of CRA customers

‘Geographic spread of CRA customers’ is defined by two measures:

- CRA recipients as a proportion of private rental stock (from 2006 Census) across Australia and within each capital city (in map form)
- the average CRA entitlement across locations.

Descriptive information is provided about rents, average levels of assistance, and the proportion of private rental stock occupied by CRA recipients within regions.

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. This information is useful in examining differences across states and territories, and capital cities/rest of State.

Additional measures of geographic spread are reported under ‘affordability’.

Data reported for this indicator are comparable.

Results for income units receiving CRA as a proportion of income units in each capital city receiving a social security income support benefit or more than the base rate of the Family Tax Benefit are mapped in tables 16A.53–16A.61. Information on the average CRA entitlement across locations is contained in table 16A.62.

The ratio of CRA recipients to private rental stock between and within capital cities varies but the patterns are complex. The maps should be interpreted with caution because they compare CRA recipients at 6 June 2008 with 2006 Census data and make no allowance for changes in private rental stock over that period (FaHCSIA unpublished).

Effectiveness — appropriateness

Maximum rate

‘Maximum rate’ is an indicator of the CRA’s guiding principle to provide appropriate financial assistance (box 16.44).

Box 16.44 Maximum rate

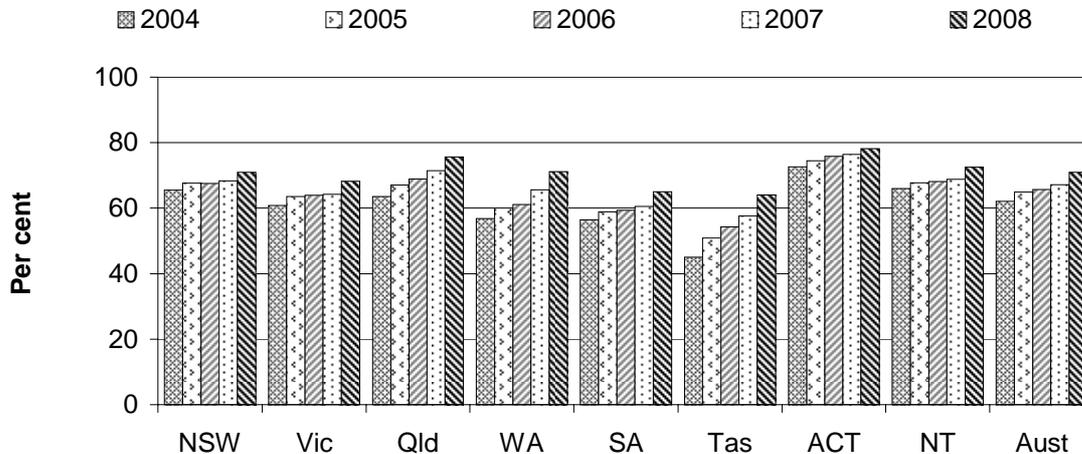
'Maximum rate' is defined as the proportion of income units receiving the maximum rate of CRA.

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. Maximum rate can be used to monitor the adequacy of CRA over time.

Data reported for this indicator are comparable.

At 6 June 2008, 70.9 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 over recent years.

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.63.

Source: FaHCSIA (unpublished); table 16A.63.

Number and outcome of appeals

'Number and outcome of appeals' is an indicator of the CRA's guiding principle to ensure appropriateness of decisions related to the payment of CRA (box 16.45).

Box 16.45 Number and outcome of appeals

'Number and outcome of appeals' is defined as the outcome of all CRA appeals finalised.

A high or increasing proportion of original decisions affirmed implies that the original decisions were appropriate.

There is a formal review process for decisions related to the payment of CRA. Recipients who are dissatisfied with a decision are encouraged to discuss the matter with the original decision maker before taking the matter further, although this is not a necessary step. Authorised review officers conduct a quick and informal internal review of the decision. Generally, recipients who are dissatisfied with the authorised review officer's decision can appeal to the Social Security Appeals Tribunal, which is an independent body with decision making powers. Either the recipients, FaHCSIA or the DEEWR can seek an Administrative Appeals Tribunal review of the Social Security Appeals Tribunal's decisions.

Data reported for this indicator are comparable.

There were 441 finalised appeals to an authorised review officer in 2007-08, which represented approximately 0.05 per cent of income units receiving CRA. The original decision was affirmed, or appeal dismissed, for approximately 57.6 per cent of finalised appeals to an authorised review officer, 45.9 per cent of appeals to the Social Security Appeals Tribunal and 45.5 per cent of appeals to the Administrative Appeals Tribunal (table 16.36).

Table 16.36 Outcome of all CRA appeals finalised in 2007-08^a

Outcome	Appeals to ARO		Appeals to SSAT		Appeals to AAT	
	no.	%	no.	%	no.	%
Original decision affirmed or appeal dismissed	254	57.6	28	45.9	5	45.5
Original decision set aside	112	25.4	20	32.8	1	9.1
Original decision varied	63	14.3	5	8.2	2	18.2
Appeal withdrawn	12	2.7	8	13.1	3	27.3
Total finalised	441	100.0	61	100.0	11	100.0

ARO = Authorised Review Officer. SSAT = Social Security Appeals Tribunal. AAT = Administrative Appeals Tribunal. ^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.64.

Source: FaHCSIA (unpublished); table 16A.64.

Duration of payments

'Duration of payments' is an indicator of the CRA's guiding principle to measure targeting of the CRA payments in an efficient manner (box 16.46).

Box 16.46 Duration of payments

'Duration of payments' is defined as the level of long-term and short-term dependence on CRA payments. The indicator is measured by the number of recipients receiving CRA benefits at the beginning and at the end of the year, as well as the number of CRA recipients who were in receipt of CRA benefits at the beginning of the year and still in receipt a year later.

A low or decreasing level of payment duration reflects less dependence on CRA.

Data reported for this indicator are comparable.

Nationally, 943 718 income units were entitled to receive CRA payments at June 2007, and 946 641 income units were entitled to receive CRA at 8 June 2008. Out of those, 679 026 income units were receiving CRA at both times, implying a high degree of dependence on CRA (table 16.37). The remaining 267 615 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 FaHCSIA data show that while CRA was paid on average to just over 1 million individuals each fortnight in 2007-08, over 1.4 million individuals were entitled to assistance during the financial year (FaHCSIA unpublished).

Table 16.37 Duration of CRA payments, by State and Territory (number), 2008^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>
NSW	324 528	326 525	239 692
Victoria	208 289	210 740	150 126
Queensland	227 511	226 673	161 933
WA	77 051	75 311	53 529
SA	68 634	69 996	49 648
Tasmania	24 668	24 882	17 211
ACT	7 615	7 495	4 253
NT	5 260	4 895	2 607
Total	943 718	946 641	679 026

^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.65.

Source: FaHCSIA (unpublished); table 16A.65.

Running costs per 1000 customers

'Running costs per 1000 customers' is an indicator of CRA's guiding principle to provide financial assistance in an efficient manner (box 16.47).

Box 16.47 Running costs per 1000 customers

'Running costs per 1000 customers' is defined as total CRA running costs divided by total CRA customers, expressed as a rate per 1000 customers.

Low or decreasing running costs per 1000 customers implies high or increasing efficiency for a given service level.

Data reported for this indicator are comparable.

Nationally, the running costs per 1000 customers were \$50 900 for 2007-08, \$59 688 for 2006-07 and \$58 888 for 2005-06 (2007-08 dollars) (table 16A.66).

Ratio of running costs to total outlays

'Ratio of running costs to total outlays' is an indicator of CRA's guiding principle to provide financial assistance in an efficient manner (box 16.48).

Box 16.48 Ratio of running costs to total outlays

'Ratio of running costs to total outlays' is defined as total CRA running costs as a proportion of total CRA outlays.

A low or decreasing ratio implies high or increasing efficiency for a given service level.

Data reported for this indicator are comparable.

Nationally, the ratio of running costs to total outlays was 2.10 per cent for 2007-08, 2.46 per cent for 2006-07 and 2.42 per cent for 2005-06 (table 16A.67).

Outcomes

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

Affordability

‘Affordability’ is an indicator of the CRA objective to provide income support recipients and low income families in the private rental market with financial assistance (box 16.49).

Box 16.49 Affordability

‘Affordability’ is defined as the proportions of income units spending more than 30 per cent and 50 per cent of their income on rent with and without CRA. Affordability outcomes (with and without CRA) are reported for all income units receiving CRA, Indigenous income units receiving CRA, and Disability Support Pension income units receiving CRA.

A lower proportion of recipients spending 30 per cent and 50 per cent of income on rent with CRA implies improved affordability.

CRA is intended to improve affordability, not to achieve a particular benchmark. Program performance is best judged by trends over a number of years.

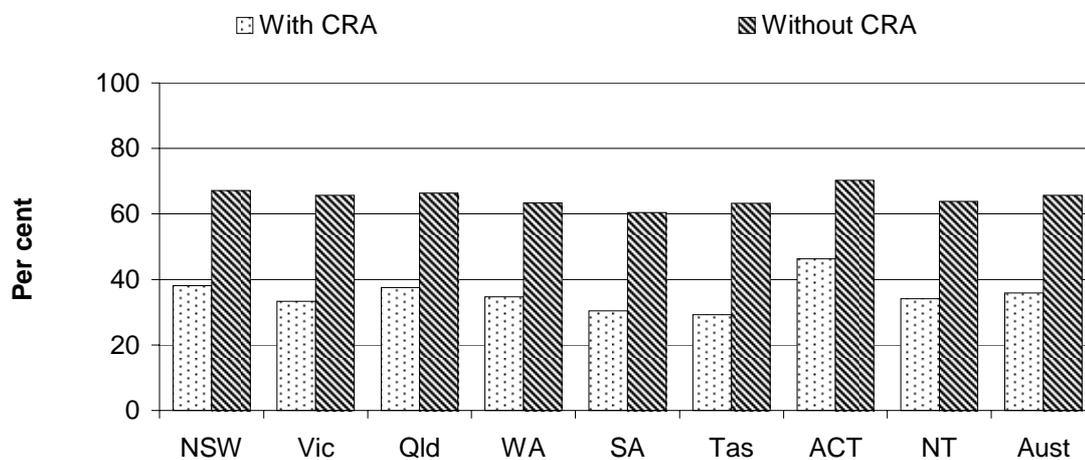
Data reported for this indicator are comparable.

Information on the proportion of income spent on rent (with and without CRA) by Australians living in State capital cities and rest of State regions, income units where one or more members’ self-identify as Indigenous Australians and income units where one or more members receive a Disability Support Pension is presented in tables 16A.68–16A.71.

Nationally, if CRA were not payable, then at 6 June 2008, 65.7 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 35.9 per cent (figure 16.22).

Without CRA, 26.7 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 10.0 per cent (table 16A.71).

Figure 16.22 **Income units paying more than 30 per cent of income on rent, with and without CRA, 2008^a**

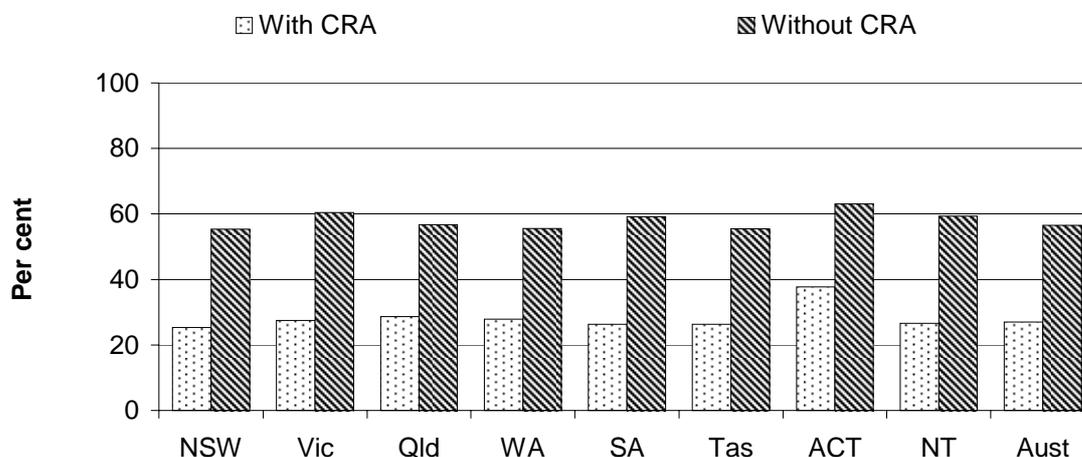


^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.68.

Source: FaHCSIA (unpublished); table 16A.68.

Nationally, if CRA were not payable, then 56.6 per cent of the Indigenous income units receiving CRA would have spent more than 30 per cent of income on rent at 6 June 2008. Taking CRA into account, this proportion falls to 27.0 per cent (figure 16.23). Similarly, if CRA were not payable, then 20.1 per cent of Indigenous income units across Australia would have spent more than 50 per cent of income on rent at 6 June 2008. Accounting for CRA payments this proportion decreases to 6.6 per cent (table 16A.71).

Figure 16.23 Indigenous income units receiving CRA paying more than 30 per cent of income on rent, with and without CRA, 2008^a

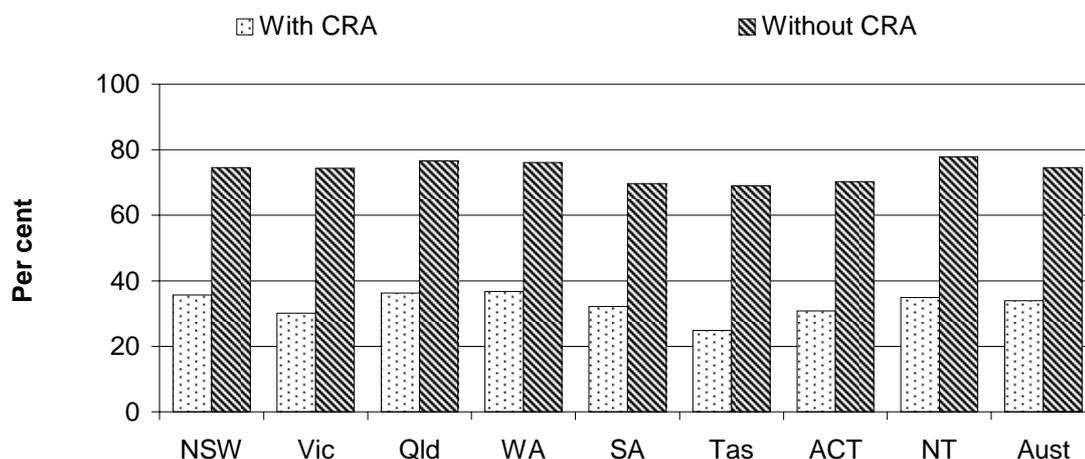


^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.69.

Source: FaHCSIA (unpublished); table 16A.69.

Nationally, if CRA were not payable, then 74.6 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 6 June 2008. Accounting for CRA payments this proportion decreases to 34.0 per cent (figure 16.24). Similarly, if CRA were not payable, then 28.2 per cent of income units receiving a Disability Support Pension would have spent more than 50 per cent of income on rent at 6 June 2008. Accounting for CRA payments, this proportion decreases to 6.9 per cent (table 16A.71).

Figure 16.24 **Income units receiving a Disability Support Pension paying more than 30 per cent of income on rent, with and without CRA, 2008^a**



^a Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.70.

Source: FaHCSIA (unpublished); table 16A.70.

Satisfaction with accommodation

‘Satisfaction with accommodation’ is an indicator of the CRA’s guiding principle to ensure that housing is appropriate to the needs of CRA recipients (box 16.50).

Box 16.50 Satisfaction with accommodation

‘Satisfaction with accommodation’ is defined by two measures:

- ‘satisfaction with location’, defined as the proportion of the social security recipients’ preferences to either stay or leave current location
- ‘satisfaction with quality’, defined as the proportion of the social security recipients who are satisfied with the home in which they live.

A high or increasing proportion of satisfied customers may imply better or improving accommodation provision.

Data reported for this indicator are not directly comparable.

No recent surveys have been conducted to determine CRA recipients’ satisfaction with the quality and location of their home.

However, the Household Income and Labour Dynamic Australia (HILDA) Survey identifies social security recipients living in private rental accommodation who are potentially eligible for CRA. Data on satisfaction with location and the adequacy of housing derived from the HILDA survey conducted in 2006-07 are presented in table 16.38.

Overall, 67.5 per cent of social security recipients living in private rental properties expressed a preference to stay in the area in which they live, while 12.6 per cent expressed a preference to leave the area. When asked to rate their satisfaction with the home in which they live, 77.7 per cent expressed some level of satisfaction (with 20.4 per cent totally satisfied), while 12 per cent expressed some dissatisfaction with their home.

Table 16.38 Satisfaction with location and quality of housing (per cent)

	<i>Strong preference to leave</i>		<i>Preference to leave</i>		<i>Unsure/no preference to stay or leave</i>		<i>Preference to stay</i>		<i>Strong preference to stay</i>		
Satisfaction with location ^a	4.2		8.4		19.8		29.7		37.8		
	<i>Totally dissatisfied</i>			<i>Neither satisfied nor dissatisfied</i>				<i>Totally satisfied</i>			
	0	1	2	3	4	5	6	7	8	9	10
Satisfaction with home in which they live ^b	1.3	0.7	2.1	3.2	5.1	9.9	8.3	16.0	19.3	13.7	20.4

^a Satisfaction with location of housing data were based on 571 valid responses. ^b Satisfaction with quality of housing data were based on 766 valid responses.

Source: FaHCSIA (unpublished).

16.4 Future directions in performance reporting

Reform of Specific Purpose Payments

In December 2007, Council of Australian Governments (COAG) agreed to reform Specific Purpose Payments (SPPs). SPPs are financial agreements between the Australian Government and State and Territory governments involving a contribution by the Australian Government to the funding of services which are considered a joint Australian and State and Territory government responsibility. The CSHA was such an SPP.

At its 29 November 2008 meeting, COAG agreed to six new National Agreements, five of which are associated with a National SPP. In the area of housing, there is a National Affordable Housing Agreement (NAHA) associated with the affordable housing SPP (COAG November 2008). Under the reforms, the NAHA contains the objectives, outcomes, outputs and performance indicators for housing. The performance of governments in achieving these mutually agreed outcomes will be assessed by the COAG Reform Council (CRC). The Steering Committee has been requested by COAG to provide the SPP performance information to the CRC (COAG July 2008).

The National Agreements/SPPs will be supplemented by a range of National Partnerships (NPs): project, facilitation and reward agreements. Funding for NPs may be conditional on states and territories meeting agreed milestones and performance benchmarks.

The Steering Committee and the Housing Working Group will ensure that reporting in this chapter reflects the COAG priorities identified in the NAHA, affordable housing SPP and relevant NPs.

Further developing indicators and data

Improved reporting on housing provision to Indigenous Australians continues to be a priority. All states, territories and the Australian Government have committed to improve reporting against the NRF, the nationally endorsed performance indicator framework for Indigenous housing. Jurisdictions have implemented action plans to improve the availability and reliability of data on Indigenous Australians accessing mainstream housing assistance.

The Housing Working Group will continue to improve the quality of mainstream community housing and financial data that are published in the report.

16.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

“ The 2003 CSHA assists people whose housing needs can not be met in the private rental sector to access appropriate and affordable housing. The 2003 CSHA has delivered around \$4.75 billion over five years (approximately \$930 million each year) to state and territory governments to provide housing assistance such as public and community housing, Indigenous housing, crisis accommodation, home purchase assistance and private rental assistance.

The guiding principles of the 2003 CSHA are measured through a strong performance framework that has evolved from the 1999 CSHA. The 2003 CSHA has a particular emphasis on timely reporting and demonstrated progress in achieving performance objectives.

The Australian Government is negotiating a new NAHA with the states and territories, to commence in 2009. The new Agreement will encompass housing assistance provided at all levels of government — including all programs funded by State and Territory Governments through the CSHA, the SAAP, as well as other measures aimed at making housing more affordable for renters and purchasers.

Over \$372 million was also allocated in the 2007-08 Budget through the CHIP and the Australian Remote Indigenous Accommodation (ARIA) program to increase access to safe, healthy and sustainable housing and related services for Indigenous families and communities. ARIA replaces CHIP from 1 January 2009. The purpose of ARIA is to reform Indigenous housing and infrastructure delivery arrangements through bilateral agreements with state and territory governments.

Commonwealth Rent Assistance is a non-taxable income supplement payable to eligible Australian residents who rent accommodation in the private rental market. It is designed to help individuals and families on a low to moderate income to pay for safe and secure housing in the private rental market. The CRA program has no specific benchmark for affordability.

The Australian Government is implementing a number of new initiatives to improve housing affordability, particularly for low to moderate income earners. These new initiatives include: a Housing Affordability Fund; a National Rental Affordability Scheme; First Home Savers Accounts; releasing surplus Commonwealth land; a National Housing Supply Council; and increases to the First Home Owners Grant, the Commonwealth Financial Counselling Program and Centrelink's Financial Information Service.

These initiatives tackle the critical issue of a low supply of affordable housing, by subsidising the cost of building new homes, and by increasing the available stock of land. Financial incentives and savings for first home buyers, and additional financial counselling and support services for people experiencing financial stress will further improve housing affordability.

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New South Wales Government comments

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- Housing NSW manages the largest portfolio of public housing in Australia with over 126 000 properties. The community housing sector's role in the provision of social housing continues to grow with over 15 000 properties now being managed in this sector. The Aboriginal Housing Office currently owns over 4200 properties, and Aboriginal housing providers manage about 5000 properties.
- The Reshaping Public Housing reforms have been progressively implemented since being announced in 2005. In alignment with these reforms, Housing NSW is continuing a major reconfiguration of public housing assets in terms of size, location and condition to meet the housing need of the projected profile of social housing clients.
- The new Maintenance Service Contract, which commenced in October 2008, is a responsive and preventive approach to maintenance and includes the annual servicing of all Housing NSW properties. Housing NSW as part of its commitment to environmentally sustainable housing design is incorporating energy saving measures in new homes, retrofitting homes with water saving devices and encouraging tenants to use water and power efficiently.
- A five year strategy, *Planning for the Future: New Directions for Community Housing in NSW*, released in 2007 sets out key actions to ensure that community housing continues as a viable and diversified component of the NSW social housing system. The actions focus on the growth and sustainability of the sector to offer more housing for people, tailored to their needs, with a target set to grow the sector to 30 000 homes by 2016.
- Improving the financial viability, asset and tenancy management and governance of Aboriginal community housing is a key focus of the NSW Aboriginal Housing Office, which continues to implement a range of reforms.
- In 2007, the Housing and Human Services Accord was launched to improve the sustainability of tenancies for people with complex needs. It is a formal partnership agreement between government and non-government agencies.
- Affordable housing is a social policy priority for the NSW Government. The NSW Government is working with the Australian Government to improve the supply of affordable housing through the Housing Affordability Fund and the National Rental Affordability Scheme.
- NSW is also working with the Australian Government and other states and territories to develop a NAHA encompassing a range of government policies that impact on the housing system.

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Victorian Government comments

“ Victoria continued to grow the supply of social housing for low income earners in 2007-08 with the acquisition of 1357 social housing dwellings (including leases). Of these, 1321 properties were for long-term housing, and 36 properties were for short-term housing delivered through the Crisis and Supported Accommodation and Transitional Housing Management programs. In addition, 2346 major renovations were undertaken on existing public housing properties, further improving quality of living for many Victorian tenants.

Victoria has also delivered greater diversity and growth capacity in social housing through partnerships with the not-for-profit housing sector. In 2007-08 more than 750 social housing acquisitions were delivered in partnership with not-for-profit housing associations. To further strengthen the not-for-profit sector, in June 2008, the Government provided freehold ownership to not-for-profit housing associations of 1152 properties (which were previously leased to housing associations). Freehold ownership will provide additional financial capacity for the not-for-profit sector to grow social housing.

Victoria is also improving housing choices for Indigenous Victorians. In 2007-08, many ARHP tenants were provided the opportunity to transfer management of their tenancy to Aboriginal Housing Victoria (AHV), a not-for-profit community housing provider. As at 30 June 2008, AHV was managing tenancies for 348 households. Data for these households is reported as ICH, rather than SOMIH.

In April 2008, the Premier announced the establishment of a supportive housing facility that will provide long term accommodation and assistance to up to 50 chronically homeless people in the Melbourne CBD. Based on the successful New York model called Common Ground, this facility will offer on-site support including mental health services, living skills training and employment services.

In 2007-08, the *Support for High Risk Tenancies* initiative was rolled-out across the State to assist around 300 people in social housing who are at risk of losing their long-term housing by providing them with a better safety-net of support.

To promote economic participation in disadvantaged communities, the State government continues to fund the Neighborhood Renewal program which has created more than 5000 jobs since its inception. To encourage public housing tenants to find paid employment, in May 2008, 26-weeks fixed rents were introduced. Rents will remain unchanged between review periods, regardless of increases in household income in the intervening period. This change will allow public housing tenants to earn extra income without an immediate increase in rent.

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Queensland Government comments

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High rents and property prices, record low vacancy rates in the private sector, and housing demand exceeding supply of new constructions in the private market are significantly affecting housing affordability in Queensland.

In this environment, it is critical that Government-funded housing assistance is provided to Queenslanders in greatest need for the duration of their need. During 2007-08, Queensland assisted almost 259 600 Queenslanders by providing 78 108 households with social rental housing and helping 181 489 households access or sustain private market tenure.

During 2008 all applications on the department's wait list were reviewed to understand the extent and nature of applicants' housing need. A state-wide register for Queenslanders seeking housing assistance was developed, together with referral mechanisms to all social housing providers in the State. The development and growth of community-based housing providers was also supported through the provision of information and grants to assist with amalgamations and mergers.

A flexible approach has been taken to acquiring accommodation types that have not previously existed in the department's portfolio of assets. For example buying and renovating older-style motels has proven to be an effective way to rapidly deliver both transitional and long-term social housing. To date, 102 units have been added to the portfolio through this style of accommodation.

The range of housing assistance has been expanded through the development of additional products and housing options. RentConnect, a service to assist people to access and maintain private market accommodation, has been introduced in two locations as trial sites.

Through the Housing Improvement Program for Indigenous communities, in 2007-08 the department provided tenancy management to four Indigenous communities with approximately 400 rental properties. During the year, payment of rent by tenants in these communities has increased by 20 per cent. This has meant more funds available to expend on new housing or upgrades to existing housing. Together, council members, residents and the department have worked hard to achieve noticeable improvements to the quality of houses in the communities.

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Western Australian Government comments

“ The year 2007-08 saw a difficult environment in which to maximise the availability of social housing, and the emphasis is now on building partnerships with the non-government community housing sector to leverage and increase stock.

Within the community housing sector a three-tiered registration system has been developed, requiring community housing providers to meet strict business, governance, management and service delivery standards. Three ‘first tier’ growth providers have been registered. A regulation and compliance unit was established within the Department of Housing and Works to assess and reduce risk and to ensure the ongoing compliance of funded organisations. A new funding program, the State Community Housing Investment Program (SCHIP) was introduced. The role of the SCHIP is to support sector capacity building and encourage greater integration of community housing within the social housing system. Tenancy allocations from the public rental housing waiting list into community housing managed options have commenced. By June 2008, 34 per cent of public housing applicants in the metropolitan area had indicated an interest in being housed by registered community housing providers.

The Department continued to progress the Indigenous housing reform agenda to ensure that Indigenous housing is managed to a high standard with more accountability. This includes engaging eight regional service providers to manage more than 2200 Indigenous houses, located in 120 communities, throughout the State. The regional service providers are located in Kununurra, Halls Creek, Fitzroy Crossing, Derby, Broome, Port Hedland, Geraldton, Kalgoorlie and the Ngaanyatjarra lands.

In 2007-08, the Department procured 762 new properties through construction and spot purchases adding to the 861 new properties from 2006-07. The Department also undertook refurbishment and bed-sitter conversions on 408 existing dwellings as it did for 536 dwellings during 2006-07.

The Alternative Home Construction Initiative promoting factory-built houses and innovative forms of construction was announced during 2007-08. This initiative aims to test the market to see if transportables can substantially reduce delivery times and cost. The homes will be used to meet the housing needs of government regional officers and people in remote Indigenous communities.

During 2007-08 the development of new initiatives to assist more people into housing resulted in a 100 per cent increase in the Bond Assistance Loan Scheme budget, up from \$5.7 million to \$11.5 million.

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South Australian Government comments

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The ongoing viability of the social housing sector continued to be in the forefront of Housing SA's strategic planning during 2007-08. Implemented in March 2007, the Affordable Homes Program involves the sale of 8000 properties over 10 years and aims to restore social housing viability through the repayment of housing related debt; to open up home ownership opportunities for low to moderate income South Australians; and to create programs that encourage not-for-profit and institutional investment in affordable rental.

South Australia became the first state in Australia to set a target for affordable housing in new housing developments. New legislation now requires the inclusion of 15 per cent affordable housing within significant developments.

Housing SA implemented a new service delivery model in 2007-08 based on offering the full continuum of housing options and coordinating effective packages of support for customers with high needs. Aboriginal Housing Services staff relocated into Housing SA offices which enabled the greater sharing of culturally specific knowledge and experience. The move has been well received by customers and has seen an overall increase in Aboriginal customers accessing services. Other significant achievements include:

- providing affordable housing to over 45 800 SA households and allocating over 2200 properties to new tenants
- providing over 11 400 bond guarantees to assist customers secure private rental accommodation and providing emergency assistance to over 600 customers to escape domestic violence
- approving 15 capital projects for funding involving partnering organisations to deliver 222 affordable rental housing outcomes
- securing commitments for over 720 affordable housing opportunities in residential government land releases to achieve 15 per cent affordable housing
- launching the home ownership initiative, Property Locator, in August 2007 to provide exclusive listing access of affordable housing for sale to eligible customers, resulting in 171 sales during 2007-08
- providing 51 additional dwellings to the community housing sector and increasing Aboriginal stock in remote areas by 22 housing outcomes
- completing 316 new energy efficient homes with over 95 per cent meeting accessibility standards
- completing development of 39 units for use by Common Ground Adelaide to assist homeless and low income people into stable housing
- completing Port Pirie and Whyalla urban renewal projects
- implementing a new Disruptive Behaviour Strategy to further improve the management of tenancy disruption.

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Tasmanian Government comments

“ Relative to other states and territories, Tasmania has a higher proportion of low-income and single person households, long-term unemployment, and welfare dependence, and the lowest labour force participation rate in the country. Tasmania also has the fastest rate of population ageing in the nation. The housing market has therefore become increasingly unaffordable for a growing number of Tasmanians on low incomes.

Housing Tasmania continues to work collaboratively with program areas of the Department of Health and Human Services (DHHS) and external providers to deliver and support the delivery of housing assistance to low income renters. The Housing Improvement Project Stage 2 is now complete and sees Housing Tasmania intervening earlier, coordinating support and improving linkages with health and human services in the provision of public housing and SOMIH.

A new 'head contract' model for maintenance services was successfully introduced during 2007-08. The introduction of a new performance auditing regime has seen improvements across the board in the quality of services provided to Housing Tasmania by maintenance contractors.

The Affordable Housing Strategy (AHS) wound up in June 2008, having assisted over 8000 households with home purchase and private rental assistance, the establishment of supported residential facilities and property upgrades. Some recurrent support initiatives will continue, despite cessation of AHS funding. One of these initiatives is the 'About Housing' website launched in January 2008, providing a central information resource relating to all tenure types, and including information and contact details for non-government service providers.

2007-08 was the first full year of operation by Tasmanian Affordable Housing Limited (TAHL), with a total of 53 properties completed and occupied. TAHL continues to negotiate with developers for the provision of affordable housing, and has 620 potential properties either contracted or under negotiation. Further, three supported residential facilities became operational during the year, providing communal supported accommodation for up to 80 people on low incomes.

The administration of SAAP in Tasmania and the policy responsibility for homelessness has been relocated to Housing Tasmania, providing an opportunity for better linkages and support between social housing and homelessness services and a more integrated response to clients with high levels of need.

This integrated response is further supported by the establishment of a new unit within Housing Tasmania early in 2008-09. The Accommodation Options Team will bring together the various strands of capital management for supported accommodation that currently exist within DHHS programs, and improve the integration of Government and non-Government services.

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Australian Capital Territory Government comments

“ During 2007-08 Housing ACT has consolidated the reforms introduced by the ACT Government in the previous year to improve service delivery.

Reform of Housing ACT and homelessness services is creating an integrated service system that addresses clients needs along their pathway from homelessness to independent living within the community.

The reforms have developed a continuum of housing responses from crisis accommodation to long-term, sustainable housing through public housing as the provider to those in greatest need, and through community housing as provider to those who are on low to moderate incomes.

These reforms are reflected in this Report through a significant reduction in public housing waiting times, especially to house those clients most in need and the consequent change in the demographic of those allocated community housing.

The Transitional Housing Program (THP) commenced in 2006 and utilises vacant Housing ACT stock to provide transitional accommodation for people exiting crisis accommodation. This enables better utilisation of Housing ACT stock, which may be vacant for a period of time because it is awaiting redevelopment or is hard to let. This innovative program contributes the equivalent of an additional \$6 million of capital funding into homelessness service provision.

On 30 April 2008 the Refugee Transitional Housing Program was launched. The program is a joint initiative between Housing ACT, Companion House and Centacare and assists up to eight refugee families at a time by offering them six-month temporary housing whilst they seek permanent accommodation. Companion House provides outreach support services while Centacare provides tenancy management and funded support services. Housing ACT makes up to eight properties available for the program.

The implementation of additional housing options and service responses for Indigenous clients, who remain over-represented amongst the ACT's homelessness population, remains a priority. The Indigenous Supported Accommodation Service (ISAS) continues to provide crisis and transitional supported accommodation and outreach support. The number of Indigenous households in public housing has increased from 204 in 2006-07 to 260 in 2007-08.

The ACT Government will provide \$20 million over the next 10 years to improve energy efficiency, commencing in 2007-08 and \$0.5 million over two years to improve water efficiency in public housing properties. Housing ACT has developed a 10 year plan to deliver the energy efficiency program. Water efficiency measures primarily focus on water saving devices.

A priority for Housing ACT during 2007-08 was the negotiation of a new NAHA to replace the existing CSHA which expired on 31 December 2008.

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Northern Territory Government comments

“ The Northern Territory is currently experiencing an era of historic prosperity, with unprecedented growth in employment and the economy overall. The benefits of continued growth in the economy are widespread — however, it presents some challenges in the area of housing where demand is outstripping supply. The Northern Territory Government (NTG) has increased investment in housing and related infrastructure by 55 per cent to \$176 million for the 2008-09 financial year. The most significant focus is housing for Indigenous Australians living in remote areas, securing the affordability of housing for Territorians, and improving housing and support services for households with special needs.

Work under the Commonwealth and NT governments' joint investment in the Strategic Indigenous Housing and Infrastructure Program (SIHIP) ramped up in 2008. The \$647 million program will deliver 750 new and 230 replacement homes and over 2500 major refurbishments over the next four years. \$103 million will be invested in fixing town camps under SIHIP with Julalikari Council Aboriginal Corporation and the NTG reaching a landmark lease agreement that will see \$30 million of that sum invested in housing and infrastructure at Tennant Creek town camps. The Australian Government has since committed a further \$6.5 million for housing at those camps under SIHIP. SIHIP is geared to deliver significant training, employment and economic development outcomes for local Indigenous people in remote communities — specific targets for these areas will be set in the latter part of 2008.

The NTG has assisted over 2400 households into homeownership through HomeNorth and similar home purchase assistance schemes since 1999. Significant work to secure the affordability of housing for Territorians continued through 2008, with the NTG committing to provide an affordable housing component — equalling 15 per cent of all allotments — in all new NTG land releases. The NTG has expedited the release of approximately 4000 residential allotments over the next few years, committed to renovating 16 units of accommodation for purchase by low to middle income households, and has also limited the sale of public housing assets almost exclusively to public tenants (greater than 80 per cent of total sales).

The NTG's increased investment in short term managed accommodation has been well justified, with Stuart Lodge, Boulter Road and Ayiparinya Hostels averaging over 90 per cent occupancy rates. Changing demographics and increased uptake overall have necessitated a revamp of the NTG's life skills and tenancy support programs — Territory Housing is preparing to roll out a new Tenancy Sustainability Program through the latter part of 2008. The NTG has experienced some success in this area, where intensive tenancy support and the use of Indigenous Community Liaison Officers has seen a nearly 30 per cent increase since 2005 in the number of Indigenous households that sustain their public housing tenancies beyond two years. A new living skills and case management program will be rolled out in remote communities as part of the new public housing framework that will support investment under SIHIP.

”

16.6 Definitions of key terms and indicators

Public, community, ICH 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 rebated household derived by dividing the total rebated amount by the total number of rebated households• the proportion of households spending less than 30 per cent of their income in rent.
Amenity/location (satisfaction)	<p>A survey-based measure of the proportion of tenants rating amenity and location aspects as important and meeting their needs.</p>
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	<p>Depreciation calculated on a straight-line basis at a rate that realistically represents the useful life of the asset (as per the Australian Accounting Standards 13–17).</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• their rental housing costs being very high.

Household	For the purpose of the public, community, SOMIH and ICH collections, the number of tenancy agreements is the proxy for counting the number of households. A tenancy agreement is defined as a formal written agreement between a household (a person or group of people) and a housing provider, specifying details of a tenancy for a particular dwelling.
Indigenous household	A household with one or more members (including children) who identify as Aboriginal and/or Torres Strait Islander.
Low income household	<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 is classified as low income. 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.
Net recurrent cost	The average cost of providing assistance (excluding the cost of capital) per dwelling. The formula is 'total net recurrent costs for the year ending 30 June' divided by 'total number of dwellings at 30 June'.
New household	Households that commence receiving assistance for the financial year.
Occupancy rate	The proportion of dwellings occupied.
Occupied dwelling	Dwellings occupied by tenants who have a tenancy agreement with the relevant housing authority.

Overcrowding	Where two or more additional bedrooms are required to meet the proxy occupancy standard.														
Priority access to those in greatest need	Allocation processes to ensure those in greatest need have first access to housing. This is measured as the proportion of new allocations to those in greatest need.														
Principal tenant	The person whose name appears on the tenancy agreement. Where this is not clear, it should be the person who is responsible for rental payments.														
Proxy occupancy standard	A measure of the appropriateness of housing related to the household size and tenancy composition. The measure specifies the bedroom requirements of a household. <table border="0" style="margin-left: 40px;"> <thead> <tr> <th style="text-align: left;"><i>Household structure</i></th> <th style="text-align: left;"><i>Bedrooms required</i></th> </tr> </thead> <tbody> <tr> <td>Single adult only</td> <td>1</td> </tr> <tr> <td>Single adult (group)</td> <td>1 (per adult)</td> </tr> <tr> <td>Couple with no children</td> <td>2</td> </tr> <tr> <td>Sole parent or couple with one child</td> <td>2</td> </tr> <tr> <td>Sole parent or couple with two or three children</td> <td>3</td> </tr> <tr> <td>Sole parent or couple with four children</td> <td>4</td> </tr> </tbody> </table> <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														
Rent charged	The amount in dollars that households are charged based on the rents they are expected to pay. The rents charged to tenants may or may not have been received.														
Rent collection rate	The total rent actually collected as a proportion of the total rent charged.														
Special needs household	A household with a member(s) who has a disability or is aged 24 years or under, or 75 years or over (50 years or over for SOMIH), or (except for SOMIH) is Indigenous.														
Tenancy rental unit	A tenancy (rental) unit is defined as the unit of accommodation on which a tenancy agreement can be made. It is a way of counting the maximum number of distinct rentable units that a dwelling structure can contain.														
Tenantable dwelling	A dwelling where maintenance has been completed, whether occupied or unoccupied at 30 June. All occupied dwellings are tenantable.														
Total gross household income	The value of gross weekly income from all sources (before deductions for income tax, superannuation etc.) for all household members, expressed as dollars per week. The main components of gross income are current usual wages and salary; income derived from self-employment, government pensions, benefits and allowances; and other income comprising investments and other regular income.														
Transfer household	A household, either rebated or market renting, that relocates (transfers) from one public or community rental dwelling to another.														
Turnaround time	The average time taken in days for normally vacant dwellings to be occupied.														
Underutilisation	Where there are two or more bedrooms additional to the number required in the dwelling to satisfy the proxy occupancy standard.														
Untenantable dwelling	A dwelling not currently occupied by a tenant, where maintenance has been either deferred or not completed at 30 June.														

Commonwealth Rent Assistance

Affordability The proportions of recipients spending more than 30 per cent and 50 per cent of their income on rent with and without CRA.

Dependent child A person under 18 years who is the dependant of another person (an adult) if the adult is legally responsible for the day-to-day care, welfare and development of the child, if the child is not a dependent child of another person, and if the child is wholly or substantially in the adult's care.

A young person aged 18–24 years may be regarded as the dependant of another person if he or she is wholly or substantially dependent on that other person. A young person aged 21 years or over cannot be regarded as a dependant unless undertaking full time study. A young person cannot be regarded as a dependant if he or she receives an income support payment.

Operationally, a child is regarded as a dependant of another person (the parent) if the parent receives the Family Tax Benefit for the care of the child. A dependent child is regarded as a member of the parental income unit.

The maximum rate of CRA depends on the number of children for whom the recipient or partner receives more than the base rate of the Family Tax Benefit Part A. Although the Family Tax Benefit may be paid for a child aged 16 years or over, it cannot be paid at more than the base rate. It may also be paid at not more than the base rate if a parent has not taken appropriate steps to obtain maintenance from a child's other parent.

Duration of payments Broadly presents dependence on CRA by showing the percentage of people who are in receipt of CRA payments at a given point in time and who are still dependent on the CRA payments a year later.

Eligible income support recipient Recipients in receipt of an income support payment or more than the base rate of the Family Tax Benefit Part A. CRA is automatically paid once eligibility is established. The only eligible recipients who are not paid are those affected by Centrelink errors in recording information or by program errors.

Geographic spread of CRA recipients Two measures are presented. Maps show the number of individuals and families entitled to CRA at 6 June 2008 as a proportion of private rental stock in the same area. Private rental stock is taken from the 2006 Census with no adjustment for subsequent changes in the number of dwellings. The number of CRA recipients and their average rent and average CRA payments are provided for each capital city and the rest of the state.

Income unit One person or a group of related people within a household who share command over income. The only recognised relationships are (1) marriage (registered or defacto) and (2) adult and dependent child. Operationally, an income unit may consist of:

- a single person with no dependent child
- a sole parent with a dependent child
- a couple (registered or defacto) with no dependent child
- a couple (registered or defacto) and any dependent children.

A non-dependent child, including any child receiving Youth Allowance or some other income support payment, is not regarded as part of the parental income unit. Rather, he or she is regarded as a separate income unit.

Income unit type	The number and proportion of eligible income support recipients receiving CRA, by income unit type.
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.
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

A survey-based measure of CRA recipients' preference to stay in the area in which they live. The measure has been derived from the Household Income and Labour Dynamics (HILDA) survey conducted in 2006-07 which asked respondents about their preference to remain in the area in which they live. Respondents receiving social security payments who live in private rental dwellings have been used as a proxy for those eligible for CRA.

Satisfaction with quality of housing

A survey-based measure of CRA recipients' satisfaction with the home in which they live. The measure has been derived from the Household Income and Labour Dynamics (HILDA) survey conducted in 2006-07 which asked respondents to rate their level of satisfaction with the home in which they live. Respondents receiving social security payments who live in private rental dwellings have been used as a proxy for those eligible for CRA.

Special needs

Individuals and families with at least one member who either self-identifies as Indigenous or receives a Disability Support Pension.

Total income from all sources

Income received by the recipients or partner, excluding income received by a dependent. Includes regular social security payments and any maintenance and other private income taken into account for income testing purposes. Excludes:

- one-time payments
- arrears payments
- advances
- Employment or Education Entry Payments
- the Mobility Allowance
- the Maternity Allowance
- the Child Care Assistance Rebate.

In most cases, private income reflects the person's current circumstances. Taxable income for a past financial year or an estimate of taxable income for the current financial year is used where the income unit receives more than the minimum rate of the Family Tax Benefit but no other income support payment.

16.7 Attachment tables

Attachment tables are identified in references throughout this chapter by an '16A' suffix (for example, table 16A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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A Statistical appendix

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Attachment tables

Attachment tables are identified in references throughout this appendix by an 'AA' suffix (for example, table AA.3). A full list of attachment tables is provided at the end of this appendix, and the attachment tables themselves are available on the CD-ROM enclosed with the Report or from the Review website at www.pc.gov.au/qsp.

A.1 Introduction

This appendix contains contextual information to assist the interpretation of the performance indicators presented in the Report. The following key factors in interpreting the performance data are addressed:

- Australia's population
- family and household
- income, education and employment
- statistical concepts used in the Report.

A.2 Population

The Australian people are the principal recipients of the government services covered by this Report. The size, trends and characteristics of the population can have a significant influence on the demand for government services and the cost of delivery. This section provides a limited description of the Australian population to support the interpretation of performance data provided in the Report. More detail is provided in the Australian Bureau of Statistics (ABS) annual publication *Australian Social Trends* (ABS 2008b).

In this appendix and associated attachment tables, population totals for the same year can vary because they are drawn from different ABS sources depending on the information required — for example, some data are from the *Census of Population and Housing* (ABS 2006b) and others from the *Australian Demographic Statistics* (ABS 2008a).

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) and performance indicators (such as participation rates for vocational education and training).

Population size and trends

More than three quarters of Australia's 21.0 million people lived in the eastern mainland states as at 30 June 2007, with NSW, Victoria and Queensland accounting for 32.8 per cent, 24.8 per cent and 19.9 per cent, respectively, of the nation's population. Western Australia and SA accounted for a further 10.0 per cent and 7.5 per cent, respectively, of the population, while Tasmania, the ACT and the NT accounted for the remaining 2.3 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 2003 and 2007 was approximately 1.4 per cent. The growth across jurisdictions ranged from 2.3 per cent in Queensland to 0.8 per cent in Tasmania (table AA.2, 31 December estimates).

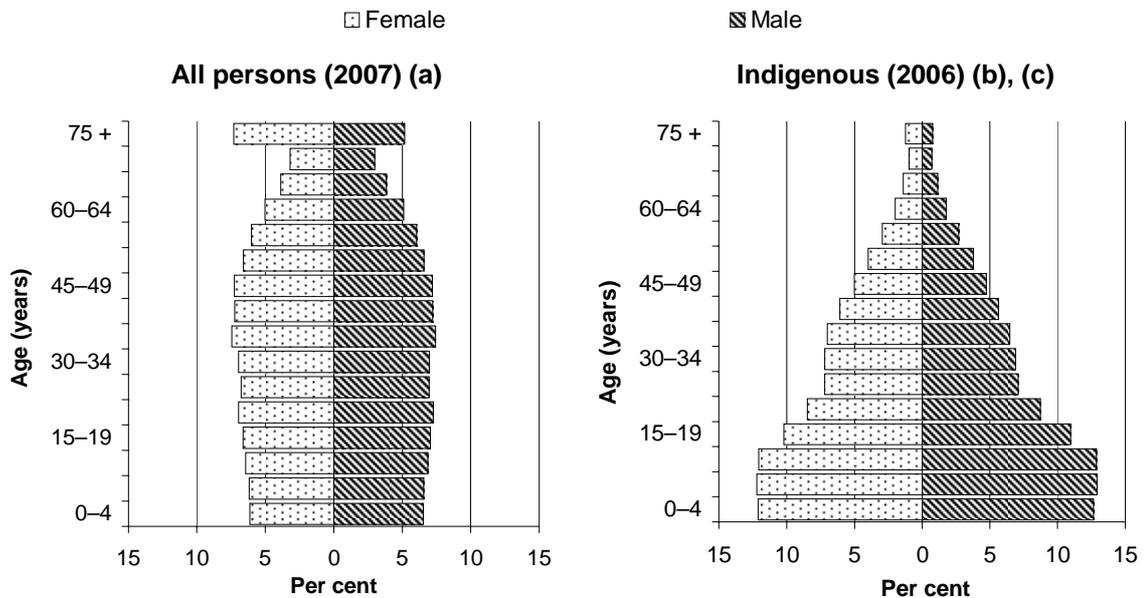
Population, by age and sex

As in most other developed economies, greater life expectancy and declining fertility have contributed to an 'ageing' of Australia's population. However, the age distribution of Indigenous Australians is markedly different (figure A.1). At

30 June 2007, 9.3 per cent of Australia's population was aged 70 years or over, in contrast to 1.8 per cent of Australia's Indigenous population, as at 30 June 2006 (tables AA.1 and AA.7). Across jurisdictions, the proportion of all 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).

Half of the population at June 2007 was female (50.3 per cent). This distribution was similar across all jurisdictions except the NT, which had a lower representation of women in its population (48.1 per cent) (table AA.1). The proportion of women in the population varies noticeably by age. Nationally, approximately 56.5 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 Totals may not add as a result of rounding. **b** Includes other territories. **c** Experimental estimates at 30 June 2006 are preliminary rebased estimates and are based on the 2006 Census of Population and Housing.

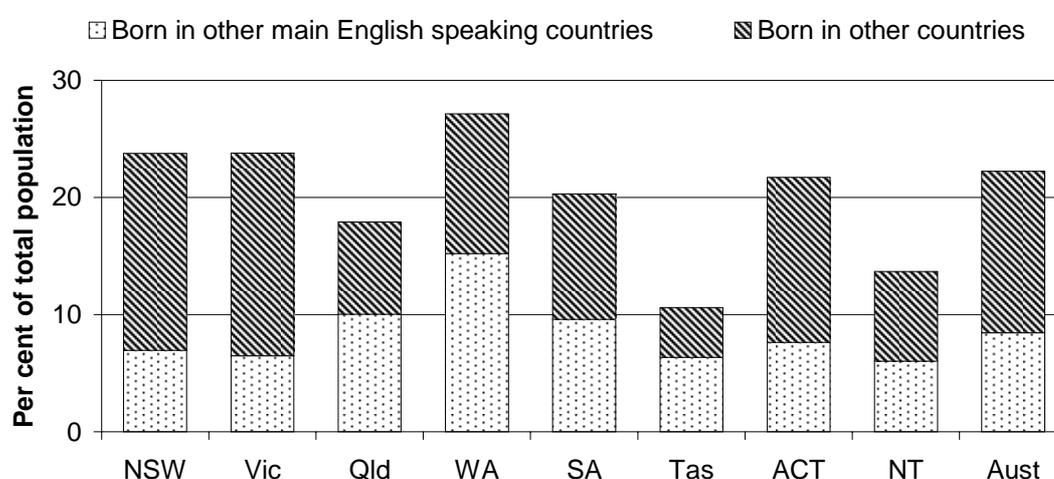
Source: ABS (2008), *Population by Age and Sex, Australian States and Territories, June 2002-2007*, Cat. no. 3201.0; ABS (2007), *Australian Demographic Statistics, March Quarter 2007*, Cat. no. 3101.0; tables AA.1 and AA.7.

Population, by ethnicity and proficiency in English

New Australians face specific problems when accessing government services. Language and culture can be formidable barriers for otherwise capable people. Cultural backgrounds can also have a significant influence on the support networks

offered by extended families. People born outside Australia accounted for 22.2 per cent of the population in August 2006 (8.4 per cent from the main English speaking countries and 13.8 per cent from other countries).¹ Across jurisdictions, the proportion of people born outside Australia ranged from 27.1 per cent in WA to 10.6 per cent in Tasmania. The proportion from countries other than the main English speaking countries ranged from 17.3 per cent in Victoria to 4.2 per cent in Tasmania (figure A.2).

Figure A.2 **People born outside Australia, by country of birth, August 2006^{a, b}**



^a 'Australia' includes other territories. ^b The ABS defines the other main English speaking countries as Canada, Ireland, New Zealand, South Africa, the United States of America and the United Kingdom.

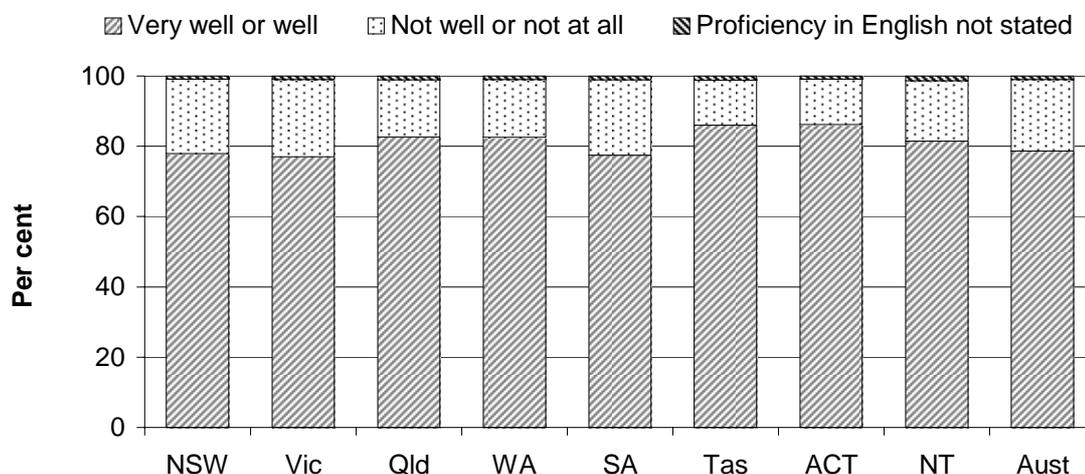
Source: ABS (unpublished), derived from 2006 Census of Population and Housing, table AA.4.

Of the population born outside Australia, in August 2006, 89.0 per cent spoke only English, or spoke another language as well as speaking English very well or well. Figure A.3 shows proficiency in English of people born overseas who speak another language. Of those people born overseas who spoke another language, 78.6 per cent also spoke English very well or well. The proportion of people born overseas who spoke another language, who did not speak English well or at all, ranged from 21.9 per cent in Victoria to 12.8 per cent in Tasmania (table AA.3).

The proportion of all people born overseas who did not speak English well or at all was 10.0 per cent nationally, and ranged from 12.9 per cent in Victoria to 3.1 per cent in Tasmania (table AA.3).

¹ The ABS defines the other main English speaking countries as Canada, Ireland, New Zealand, South Africa, the United States of America and the United Kingdom.

Figure A.3 People born overseas who spoke another language, by proficiency in English, August 2006^a



^a Excludes persons who did not state their country of birth.

Source: ABS (2007), *2006 Census of Population and Housing*, Cat. no. 2068.0; table AA.3.

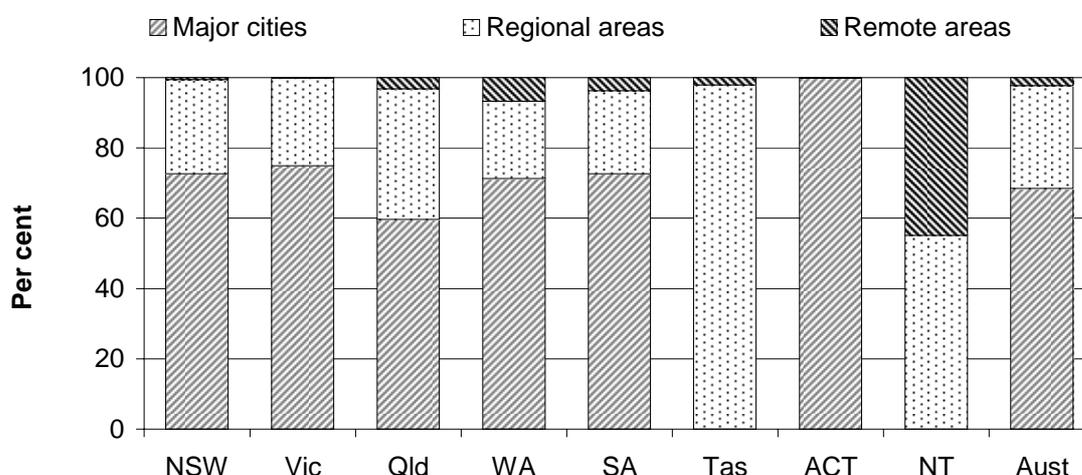
Approximately 15.8 per cent of Australians spoke a language other than English at home in August 2006. Across jurisdictions, this proportion ranged from 23.2 per cent in the NT to 3.5 per cent in Tasmania (table AA.5). The most common languages spoken were Chinese languages, Italian, Greek and Arabic.

The most and least common languages other than English spoken in people's homes varied across jurisdictions in August 2006. The most extreme variation was in the NT, where 15.1 per cent of people spoke an Australian Indigenous language (65.3 per cent of the total persons in the NT who spoke a language other than English in their homes) (table AA.5).

Population, by geographic location

The Australian population is highly urbanised, with 68.5 per cent of the population located in major cities as at 30 June 2007 (figure A.4). Across jurisdictions, this proportion ranged from 99.9 per cent in the ACT to 59.7 per cent in Queensland (table AA.6). Tasmania and the NT by definition have no major cities. In Tasmania, 97.9 per cent of the population lived in regional areas. Australia-wide, 2.3 per cent of people lived in remote areas. The NT was markedly above this average, with 44.9 per cent of people living in remote areas.

Figure A.4 Population, by remoteness area, June 2007^{a, b}



^a Preliminary estimated resident population based on the *Australian Standard Geographical Classification 2006*. ^b 'Australia' includes other territories.

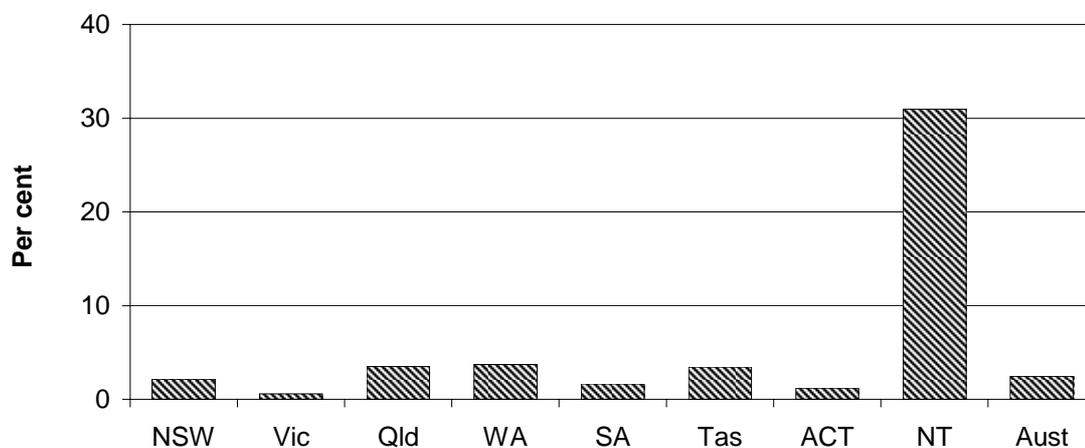
Source: ABS (unpublished), derived from *Regional Population Growth, Australia, 2006-07*, Cat. no. 3218.0; table AA.6.

Indigenous population profile

There were an estimated 517 174 Indigenous people (259 693 female and 257 481 male) in Australia at 30 June 2006, accounting for approximately 2.5 per cent of the total population (tables AA.2 and AA.7). The proportion of people who were Indigenous was significantly higher in the NT (31.0 per cent) than in any other jurisdiction. Across the other jurisdictions, the proportion ranged from 3.7 per cent in WA to 0.6 per cent in Victoria (figure A.5). Nationally, the Indigenous population is projected to grow to 528 645 people in 2009 (table AA.8).

The majority of Indigenous people (81.8 per cent) at August 2006 spoke only English at home, while a further 9.0 per cent spoke an Indigenous language and English very well or well. However, 2.2 per cent spoke English not well or not at all (up to 12.2 per cent in the NT). Nationally, 5.2 per cent of Indigenous people did not state their language proficiency (table AA.9).

Figure A.5 **Indigenous people as a proportion of the population, 30 June^{a, b, c}**



^a 'Australia' includes other territories. ^b Experimental estimates of the Australian Indigenous population at 30 June 2006 are preliminary rebased estimates and are based on the 2006 *Census of Population and Housing*. ^c The estimated resident population at 30 June 2007 is preliminary.

Source: ABS (2008), *Australian Demographic Statistics, December Quarter 2007*, Cat. no. 3101.0; ABS (2007), *Australian Demographic Statistics, March Quarter 2007*, Cat. no. 3101.0; tables AA.2 and AA.7.

A.3 Family and household

Family structure

There were 5.8 million families in Australia in 2007.² Across jurisdictions, the number of families ranged from 1.9 million in NSW to 41 000 in the NT. The average family size across Australia was 3.0 people. Across jurisdictions, the average family size was the same as the national average except for SA, Tasmania and the NT, where the average family size was 2.9 people. Nationally, 38.9 per cent of families had at least one child under 15 years, and 17.6 per cent of families had at least one child under 5 years (table AA.10).

Lone parent families may have a greater need for government support and particular types of government services (such as child care for respite reasons). Nationally, 19.5 per cent of children aged under 15 years lived in one parent families in 2007.

² The ABS *Census Dictionary* (ABS 2006a) defines a family as two or more persons, one of whom is aged 15 years or over, who are related by blood, marriage (registered or de facto), adoption, step or fostering; and who are usually resident in the same household. The basis of a family is formed by identifying the presence of a couple relationship, lone parent-child relationship or other blood relationship. Some households contain more than one family.

Lone mother families made up 18.8 per cent of families with children aged under 15 years. Lone father families made up 2.9 per cent of families with children under 15 years. Across jurisdictions, the proportion of children aged under 15 years living in lone parent families ranged from 25.7 per cent in the NT to 17.0 per cent in Victoria (table AA.11).

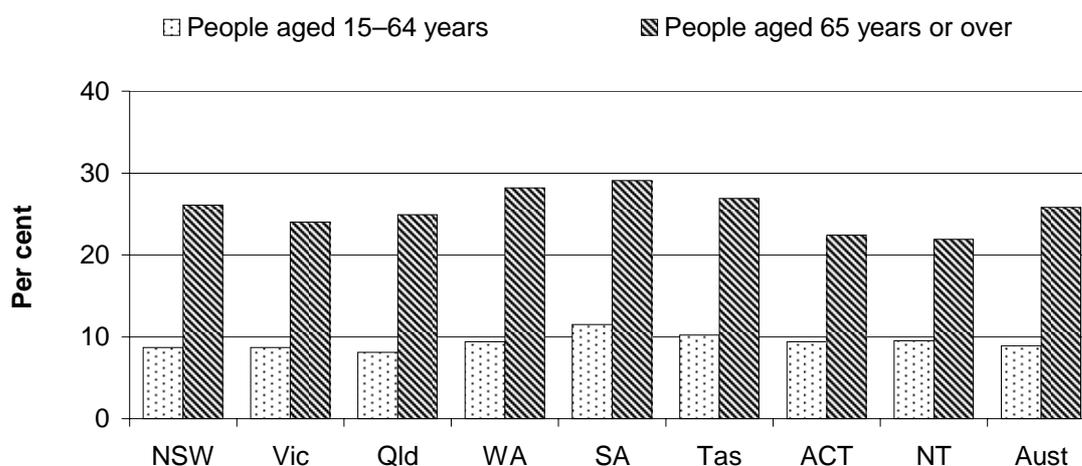
Employment status also has implications for the financial independence of families. Nationally, 15.8 per cent of children aged under 15 years in 2005-06 lived in families where no parent was employed (table AA.12).

Household profile

There were 8.2 million households in Australia in 2007 (some households may contain more than one family) (table AA.14). Over one quarter (26.7 per cent) of these were lone person households. Across jurisdictions, the proportion of lone person households ranged from 31.1 per cent in Tasmania to 23.8 per cent in the NT.

In June 2007, the proportion of people aged 65 years or over who lived alone (25.8 per cent) was considerably higher than that for people aged 15–64 years (8.9 per cent). Across jurisdictions, the proportion of people aged 65 years or over who lived alone ranged from 29.1 per cent in SA to 21.9 per cent in the NT (figure A.6).

Figure A.6 **Proportion of population who lived alone, by age group, June 2007**

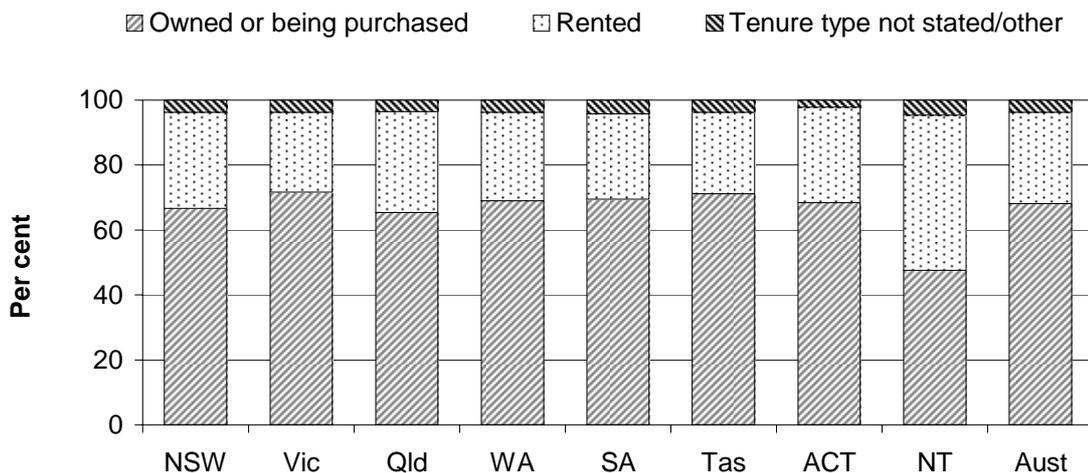


Source: ABS (2008), *Australian Social Trends 2008*, Cat. no. 4102.0; table AA.14.

Approximately 15.4 million people in families lived in private dwellings in August 2006 (table AA.13).³ Home ownership can reflect on a family's wealth and savings, and is often positively related to employment and income.

Nationally, the majority of occupied private dwellings (68.1 per cent, or 4.9 million dwellings) in August 2006 were owned or were being purchased. Home ownership was highest in Victoria (71.6 per cent) and lowest in the NT (47.6 per cent). Australians rented 2.0 million dwellings, or 28.1 per cent of dwellings (of these, 50.9 per cent were from real estate agents and 15.1 per cent from state or territory housing authorities) (table AA.15). Across jurisdictions, the proportion of dwellings that were rented was highest in the NT (47.8 per cent) and lowest in Victoria (24.6 per cent) (figure A.7).

Figure A.7 **Occupied private dwellings, by tenure type, August 2006^{a, b, c}**



^a 'Australia' includes other territories. ^b 'Owned or being purchased' includes dwellings being purchased under a rent/buy scheme. ^c 'Other tenure type' includes dwellings being occupied under a life tenure scheme.

Source: ABS (2007), *2006 Census of Population and Housing*, Cat. no. 2068.0; table AA.15.

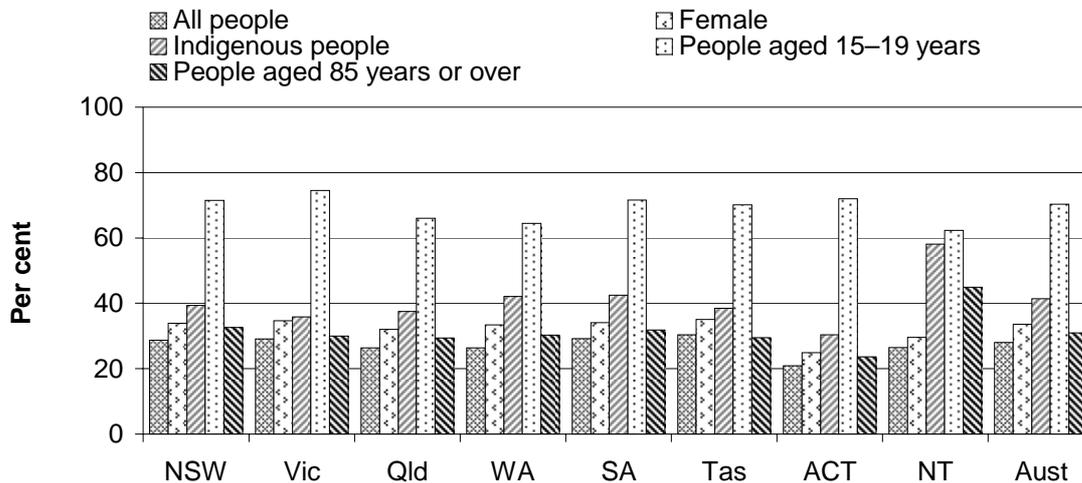
³ The ABS *Census Dictionary* (ABS 2006a) defines an occupied private dwelling as a private dwelling occupied by one or more people. A private dwelling is normally a house, flat, or even a room. It can also be a caravan, houseboat, tent or a house attached to an office, or rooms above a shop.

A.4 Income, education and employment

Income

Nationally, 28.0 per cent of people aged 15 years or over in August 2006 had a relatively low weekly individual income of \$249 or less (table AA.16). The proportion was considerably higher for younger people (70.3 per cent for people aged 15–19 years), Indigenous people (41.4 per cent), females (33.5 per cent) but similar for older people (30.9 per cent for people aged 85 years or over) (figure A.8).

Figure A.8 **Weekly individual income of \$249 or less, by sex, Indigenous status and age, August 2006^a**



^a 'Australia' includes other territories.

Source: ABS (2007), *2006 Census of Population and Housing*, Cat. no. 2068.0; ABS (unpublished), derived from *2006 Census of Population and Housing*; tables AA.16–AA.18.

Nationally, 16.9 per cent of the total population was receiving income support in 2007. The age pension was received by 9.3 per cent of the population, while 3.4 per cent received a disability support pension and 1.9 per cent received a single parent payment. A further 2.3 per cent of the population received some form of labour market allowance in 2007 (figure A.9).

Figure A.9 Proportion of total population on income support, June 2007^a



^a Components do not add to Australian total because total for Australia includes payments to people living overseas and where valid geographic data were not available. ^b Data include current Newstart and Youth Allowance (other) customers. Newstart component of data excludes CDEP participants and those who did not receive a payment.

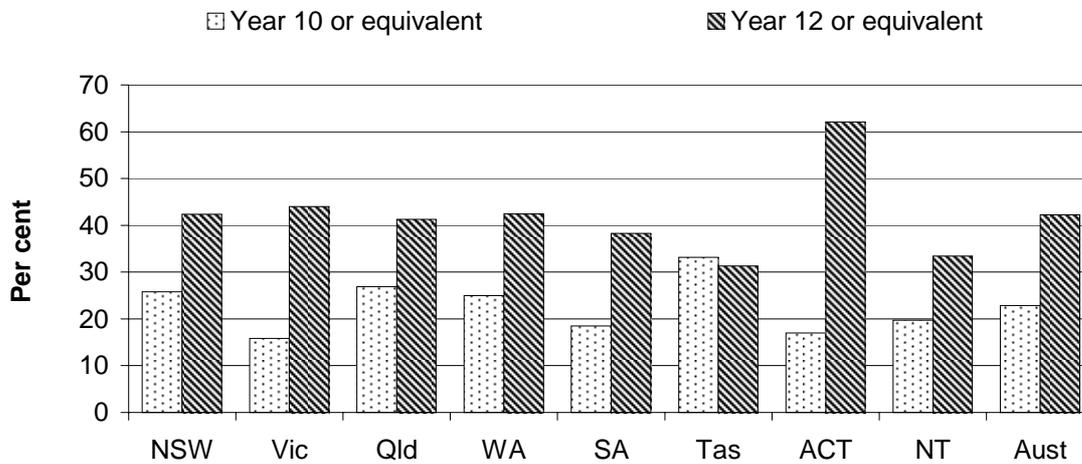
Source: ABS (2008), *Australian Social Trends 2008*, Cat. no. 4102.0; table AA.19.

The proportion of the population receiving the age pension in 2007 ranged from 11.2 per cent in SA to 3.3 per cent in the NT; the proportion receiving a disability support pension ranged from 5.0 per cent in Tasmania to 2.0 per cent in the ACT; and the proportion receiving a single parent payment ranged from 2.5 per cent in the NT to 1.2 per cent in the ACT. The proportion receiving a labour market allowance in 2007 ranged from 5.2 per cent in the NT to 1.1 per cent in the ACT.

Educational attainment

Employment outcomes and income are closely linked to the education and skill levels of individuals. At August 2006, 42.2 per cent of people aged 15 years and over (approximately 6.7 million people) had completed year 12 or equivalent. A further 22.9 per cent (3.6 million people) had a highest level of schooling of year 10 or equivalent. Across jurisdictions, the proportion of people aged 15 years and over who had year 12 or equivalent schooling ranged from 62.1 per cent in the ACT to 31.3 per cent in Tasmania (figure A.10).

Figure A.10 People aged 15 years or over, by highest year of school completed, August 2006^a

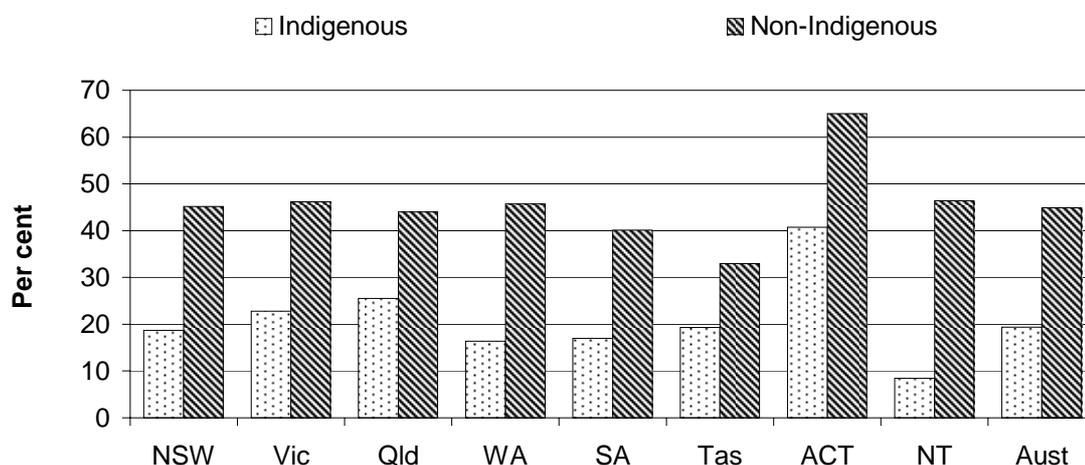


^a 'Australia' includes other territories.

Source: ABS (2007), *2006 Census of Population and Housing*, Cat. no. 2068.0; table AA.20.

At August 2006, a much higher proportion of non-Indigenous people (44.9 per cent) aged 15 years or over had completed year 12 or equivalent as their highest year of school (this is the highest level of primary or secondary school a person has completed) than Indigenous people (19.4 per cent). Across jurisdictions, the proportion of Indigenous people aged 15 years or over who had completed year 12 or equivalent schooling ranged from 40.7 per cent in the ACT to 8.5 per cent in the NT. The proportion of non-Indigenous people who had completed year 12 or equivalent schooling was highest in the ACT (65.0 per cent) and lowest in Tasmania (33.0 per cent) (figure A.11).

Figure A.11 **People aged 15 years or over who had completed year 12 or equivalent as highest year of school, by Indigenous status, August 2006^a**



^a 'Australia' includes other territories.

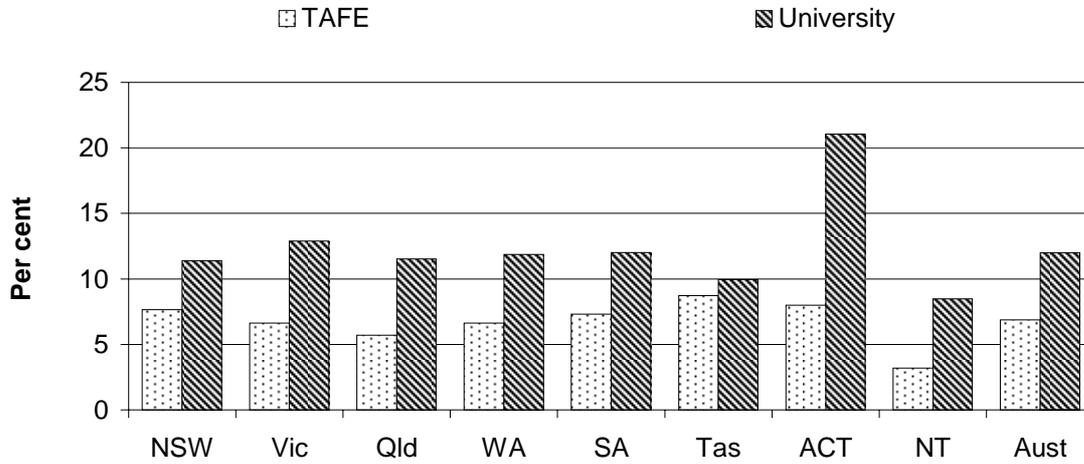
Source: ABS (2007), derived from *2006 Census of Population and Housing*, Cat. no. 2068.0; table AA.20.

Tertiary education in Australia is principally provided by universities and technical and further education (TAFE) institutes. Nationally, 18.9 per cent of those attending an educational institution⁴ were attending university or TAFE in August 2006 (12.0 per cent at university and 6.9 per cent at TAFE). Across jurisdictions, the proportion of students attending TAFE ranged from 8.7 per cent in Tasmania to 3.2 per cent in the NT; the proportion attending university ranged from 21.1 per cent in the ACT to 8.5 per cent in the NT (figure A.12).

In August 2006, the proportion of the Indigenous tertiary students who were attending TAFE was highest in Tasmania (9.5 per cent) and lowest in the NT (2.0 per cent). At August 2006, the proportion of non-Indigenous students (14.4 per cent) attending university was considerably higher than the proportion of Indigenous students (3.7 per cent). Across jurisdictions, the proportion of non-Indigenous students attending university ranged from 24.0 per cent in the ACT to 11.7 per cent in Tasmania. For Indigenous students the proportion ranged from 10.0 per cent in the ACT to 2.2 per cent in the NT (figure A.13).

⁴ Educational institutions include pre-school, infants/primary school, secondary school, tertiary institutions and other educational institutions.

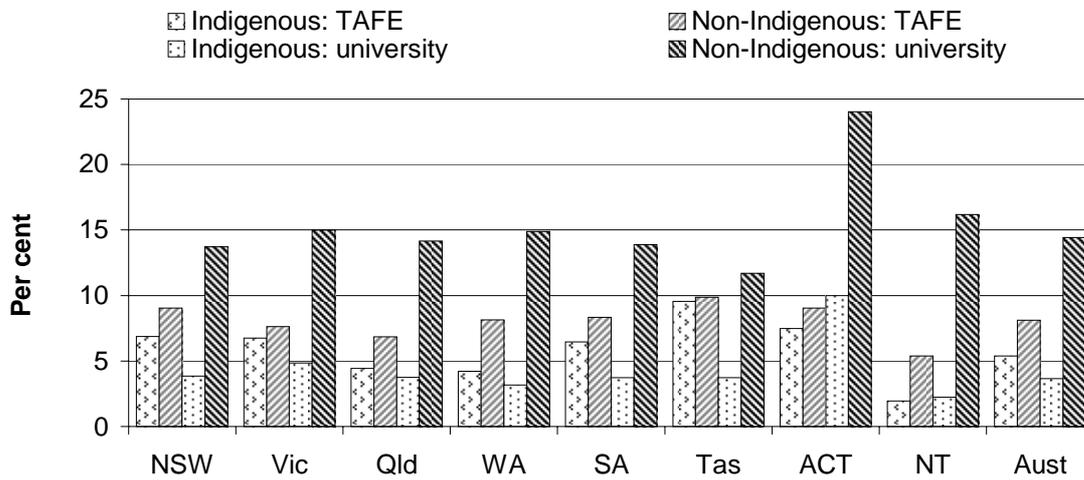
Figure A.12 Proportion of students attending tertiary education institutions, August 2006^{a, b, c}



^a 'Australia' includes other territories. ^b Includes 'technical and further educational institution (including TAFE colleges)'. ^c Totals may not add as a result of rounding.

Source: ABS (2007), 2006 Census of Population and Housing, Cat. no. 2068.0; table AA.21.

Figure A.13 Proportion of students attending tertiary education institutions, by Indigenous status, August 2006^{a, b, c}



^a 'Australia' includes other territories. ^b Includes 'technical and further educational institution (including TAFE colleges)'. ^c Totals may not add as a result of rounding.

Source: ABS (2007), 2006 Census of Population and Housing, Cat. no. 2068.0; table AA.21.

Employment and workforce participation

There were 11.2 million people aged 15 years or over in the labour force in Australia in June 2008. Of these, 95.9 per cent were employed. This means 4.1 per cent of the participating labour force were unemployed at June 2008. The majority of employed persons (71.0 per cent) were in full time employment. Of the 461 000 people looking for work, 67.9 per cent were seeking full time work and 32.1 per cent were seeking part time work (table AA.22).

Across jurisdictions, the proportion of employed people in full time employment in June 2008 ranged from 76.6 per cent in the NT to 67.3 per cent in Tasmania. The unemployment rate ranged from 4.5 per cent in NSW and SA to 2.3 per cent in the ACT. The proportion of unemployed people looking for full time work ranged from 74.2 per cent in Tasmania to 62.2 per cent in Victoria (tables AA.22 and AA.24).

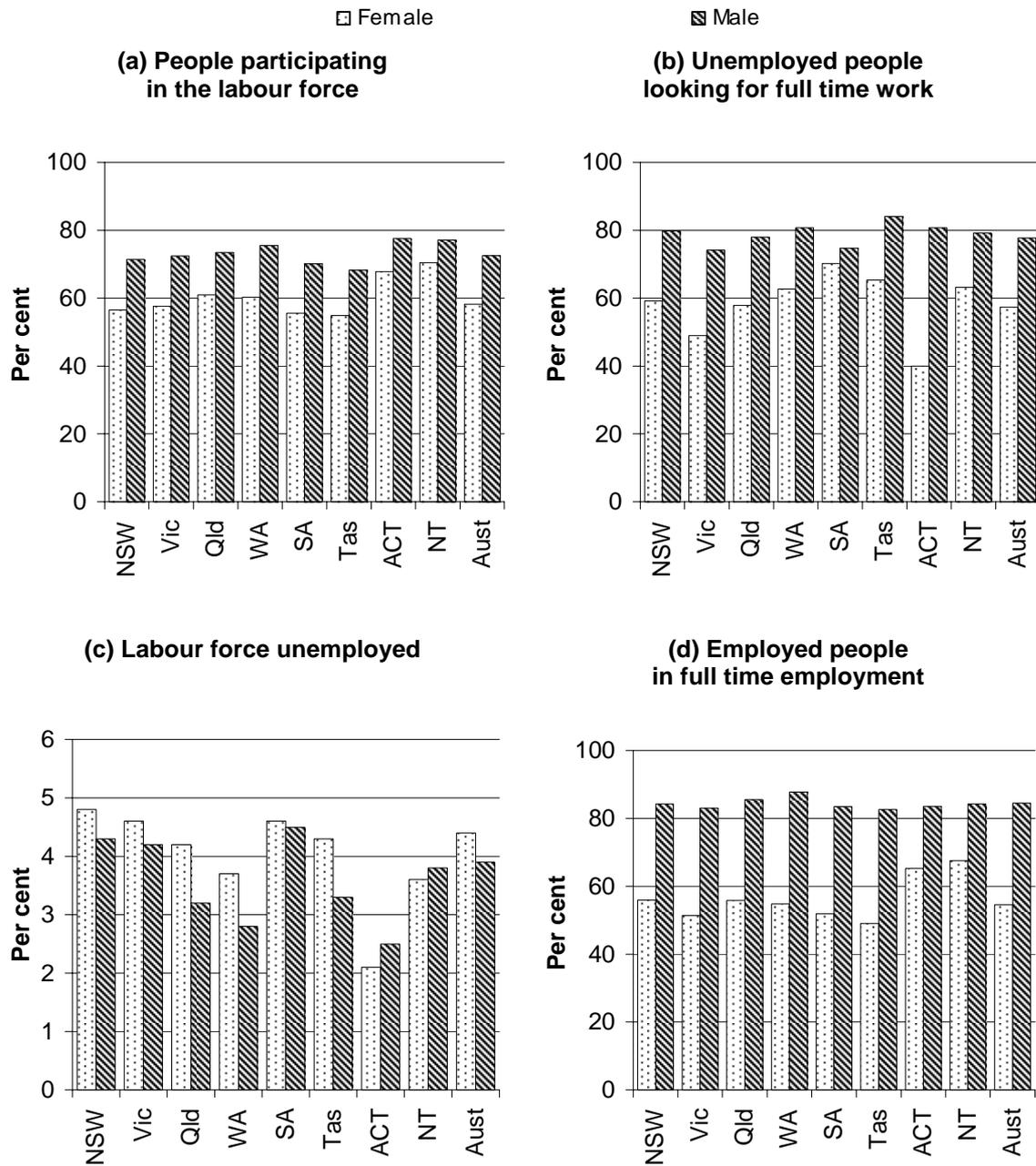
The unemployment rate needs to be interpreted within the context of labour force participation rates, which were higher for males than for females in all jurisdictions (figure A.14a). Nationally, fewer unemployed females were looking for full time work than males (57.4 per cent and 77.7 per cent respectively) (figure A.14b).

The unemployment rate for females was higher than that for males in all jurisdictions except for the ACT and the NT (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 33.6 percentage points in Tasmania to 16.7 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). In 2006-07, the GSP for NSW accounted for 32.0 per cent of national gross product, compared with 1.4 per cent for the NT. Growth from the previous year's GSP (in 2006-07 dollars) was highest for WA (12.4 per cent) and lowest for Victoria (0.1 per cent). Across Australia, the GSP per person was \$50 264 in 2006-07 (table AA.25).

Figure A.14 Labour force outcomes for people aged 15 years or over, by sex, June 2008



Source: ABS (2008), *Labour Force, Australia, Detailed – Electronic Delivery*, Cat. no. 6291.0; tables AA.22–AA.24.

A.5 Statistical concepts used in the Report

Reliability of estimates

Data for some outcome and quality indicators in this Report are based on samples, either from surveys or from a selection of observations from, for example, administrative databases. The potential for sampling error — that is, the error that occurs by chance because the data are obtained from a sample and not the entire population — means that the reported estimates may not accurately reflect the true value.

This Report indicates the reliability of estimates based on samples, by reporting either relative standard errors (RSE) or confidence intervals (CIs). RSE and CIs are calculated based on the standard error (SE). The larger the SE, RSE or CIs, the less reliable is the estimate as an indicator for the whole population (ABS 2008d, 2008c).

Standard error

The SE measures the sampling error of an estimate (box A.1). (There can also be non-sampling error, or systematic biases, in the data.) There are several types of SE. A commonly used type of SE in this Report is the SE of the mean (average). Sampling error results from using a sample of the population to derive an estimate of the whole population mean — the SE measures how much the estimated mean value may differ from the true population mean value.

Box A.1 Technical concepts and formulas — standard error

The SE of a method of measurement or estimation is the estimated standard deviation of the error in that method. Specifically, it estimates the standard deviation of the difference between the measured or estimated values and the true values. Standard deviation is a measure of how spread out the data are, that is, a measure of variability.

The SE of the mean (SEM), an unbiased estimate of expected error in the sample estimate of a population mean, is the sample estimate of the population standard deviation (sample standard deviation) divided by the square root of the sample size (assuming statistical independence of the values in the sample):

$$SE_x = \frac{s}{\sqrt{n}} \quad (\text{equation A.1})$$

Where:

SE_x is the SE of the sample estimate of a population mean

s is the sample's standard deviation (the sample based estimate of the standard deviation of the population)

n is the size (number of items) of the sample.

Decreasing the uncertainty of a mean value estimate by a factor of two requires the sample size to increase fourfold. Decreasing SE by a factor of ten requires the sample size to increase hundredfold.

Relative standard error

The RSE is used to indicate the reliability of an estimate (box A.2). The RSE shows the size of the error, relative to the estimate, and is derived by dividing the SE of the estimate, by the estimate.

The RSE is useful for comparing the size of the SE across different sample estimates. As with the SE, the higher the RSE, the less confidence there is that the estimate from the sample is close to the true value of the population mean.

Box A.2 Technical concepts and formulas — reliability of estimates

Relative standard error

The SE can be expressed as a proportion of the estimate — known as the RSE. The formula for the RSE of an estimate is:

$$\text{RSE}(x) = \frac{\text{SE}(x)}{x} \quad (\text{equation A.2})$$

Where:

x is the estimate

$\text{SE}(x)$ is the SE of the estimate.

The resultant RSEs are generally multiplied by 100 and expressed as a percentage.

Proportions and percentages formed from the ratio of two estimates are also subject to sampling error. The size of the error depends on the accuracy of both the numerator and the denominator. One method for calculating the RSE of a proportion is expressed through the following formula:

$$\text{RSE}\left(\frac{x}{y}\right) = \sqrt{[\text{RSE}(x)]^2 - [\text{RSE}(y)]^2} \quad (\text{equation A.3})$$

Where:

x is the numerator of the estimated proportion

y is the denominator of the estimated proportion.

Confidence intervals

The formula for calculating CIs is:

$$\text{LCL} = x - z_i \text{SE}(x) \quad (\text{equation A.4})$$

$$\text{UCL} = x + z_i \text{SE}(x)$$

Where:

LCL is the lower confidence limit

UCL is the upper confidence limit

x is the estimate

$\text{SE}(x)$ is the SE of the estimate

z_i is the factor used to determine the CI (the factor varies according the level of confidence required).

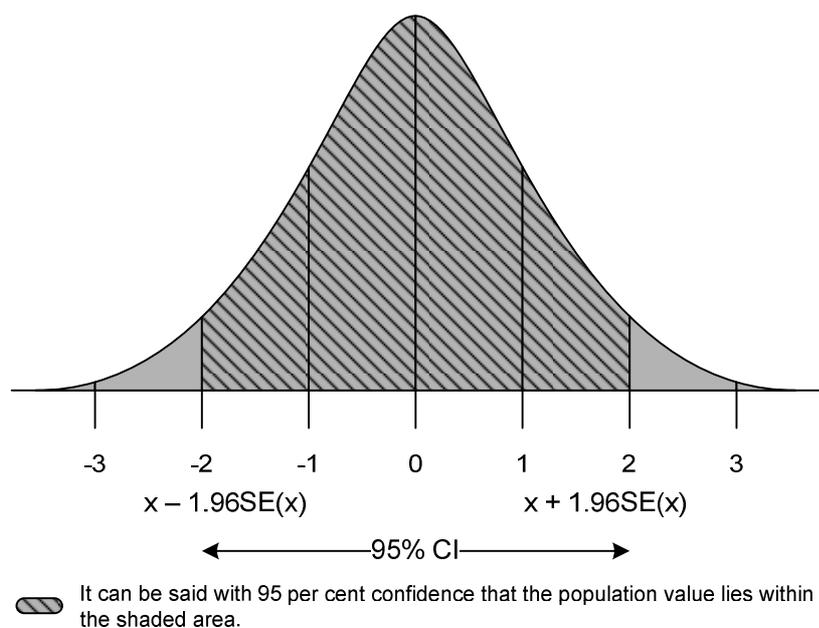
The most commonly used CIs are calculated for the 95 per cent ($p = 0.05$; $z = 1.96$) level of probability. That is, there is a 95 per cent likelihood that the true value lies within the estimate confidence interval.

A rule of thumb adopted in this Report is that estimates with an RSE between 25-50 per cent are to be used with caution and estimates with an RSE greater than 50 per cent are unreliable for general use.

Confidence intervals

Confidence intervals are used to indicate the reliability of an estimate (box A.2). A CI is a specified interval, with the sample statistic at the centre, within which the corresponding population value can be said to lie with a given level of confidence (ABS 2008c). Increasing the desired confidence level will widen the CIs (figure A.15). CIs are useful because a range, rather than a single estimate, is more likely to encompass the real figure for the population value being estimated.

Figure A.15 Normal distribution with 95 per cent confidence intervals



CIs are calculated from the population estimate and its associated SE. The most commonly used CI is calculated for 95 per cent levels of probability (where 95 per cent reflects the estimate plus and minus approximately two times the SE). For example, if the estimate from a survey was that 628 300 people report having their needs fully met by a government service, and the associated SE of the estimate was 10 600 people, then the 95 per cent CI would be calculated by:

$$\text{lower confidence limit} = 628\,300 - (2 \times 10\,600) = 628\,300 - 21\,200 = 607\,100$$

$$\text{upper confidence limit} = 628\,300 + (2 \times 10\,600) = 628\,300 + 21\,200 = 649\,500$$

This indicates that, at the 95 per cent confidence level, the true number of people who perceive that their needs are met by a government service is between 607 100 and 649 500.

The smaller the SE of the estimate, the narrower the CIs and the closer the estimate can be expected to be to the true value.

Confidence intervals also test for statistical differences between sample results (box A.3) (ABS 2008c). For example, assume survey data estimated a result of 30 per cent of people for jurisdiction A perceived that their needs were met by government services, with a 95 per cent CI of ± 5 per cent, and a result of 25 per cent for jurisdiction B, with a 95 per cent CI of ± 10 per cent (figure A.16). These results imply that we can be 95 per cent sure the true result for jurisdiction A lies between 25 and 35 per cent, and the true result for jurisdiction B people lies between 15 and 35 per cent. As these two ranges overlap, it cannot be said with confidence that the results for jurisdiction A and jurisdiction B are statistically different.

Box A.3 Technical concepts and formulas — statistical significance

Using confidence intervals to test for statistical significance

The CIs — the value ranges within which estimates are likely to fall — can be used to test whether the results reported for two estimated proportions are statistically different. If the CIs for the results overlap, then there can be little confidence that the estimated proportions differ from each other. To test whether the 95 per cent CIs of two estimates overlap, a range is derived using the following formulas.

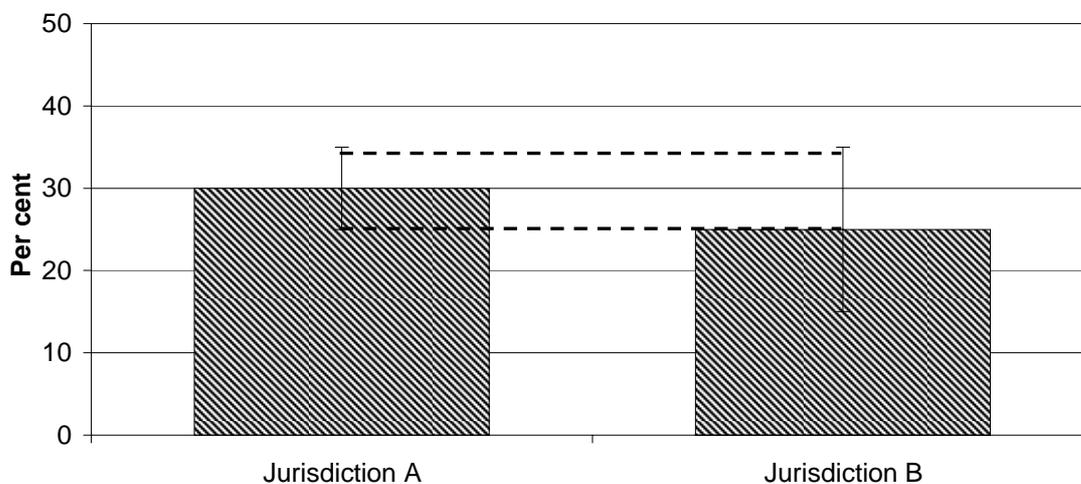
$$R_1 = \left(\frac{x_2}{y_2} - \frac{x_1}{y_1} \right) - 1.96 \sqrt{\left(\text{RSE} \left(\frac{x_2}{y_2} \right) \times \left(\frac{x_2}{y_2} \right) \right)^2 + \left(\text{RSE} \left(\frac{x_1}{y_1} \right) \times \left(\frac{x_1}{y_1} \right) \right)^2} \quad (\text{equation A.5})$$

and

$$R_2 = \left(\frac{x_2}{y_2} - \frac{x_1}{y_1} \right) + 1.96 \sqrt{\left(\text{RSE} \left(\frac{x_2}{y_2} \right) \times \left(\frac{x_2}{y_2} \right) \right)^2 + \left(\text{RSE} \left(\frac{x_1}{y_1} \right) \times \left(\frac{x_1}{y_1} \right) \right)^2} \quad (\text{equation A.6})$$

If none of the values in this range is zero, then the difference between the two estimated proportions is statistically significant.

Figure A.16 Using confidence intervals to test for statistical significance



Confidence intervals overlap so no statistically significant differences.

Population measures

Measures expressed per person (that is, as a proportion of the population) are often presented in this Report. This is to make it easier to compare relative numbers, essentially standardised by size of population, as distinct from absolute numbers.

This Report typically includes annual data. Population data are available quarterly. As the population changes over time, an issue arises as to which population figure to use — that at the start of the period, at the end of the period, or some average level.

This Report uses mid point population data — using the mid point (second quarter) population level as a proxy for the average population level. These estimates are available in time for this Report.

Three other options were considered but not preferred.

1. *Average population data.* The most statistically robust approach would be to use the average population level across the four quarters. However, while this is possible for calendar year data, estimates for the fourth quarter of the financial year are not available in time for this Report.
2. *End point population data.* This approach would use the population level at the end of the period. However, this is not a good proxy for the average population level, and again, estimates for the end point of the financial year are not available in time for this Report.

-
3. *Use of population projections.* This approach would use population projections (rather than estimates) for the fourth quarter population level. Population projections are not as accurate as estimates.

Growth rates

The Review uses growth rates to facilitate meaningful comparisons of data movements over time (box A.4). Two growth rates methods are generally used:

1. *Average annual growth rates (AAGR).* The AAGR is the uniform growth rate that would need to have applied each year for the value in the first year to grow to the value in the final year of the period of analysis. This method is also called a compound annual growth rate, as it allows for the ‘cumulative’ effect of growth in later periods ‘compounding’ growth in earlier periods.
2. *Total growth rates (TGR).* The TGR is the growth rate between two periods/years. Two methods can be used to calculate TGR.

The first and most commonly used method calculates TGR by subtracting the value in the first period from the value in the last period then dividing the result by the value in the first period. This is generally multiplied by 100 to express the growth rate as a percentage (equation A.8).

The second method uses a composite of the growth rates between each of the sub-periods within the overall period of analysis. For example, for the period 2004-05 to 2007-08, a composite of the growth rates between 2004-05 to 2005-06, 2005-06 to 2006-07 and 2006-07 to 2007-08 would be used. Box A.4 includes an example of how sub-period growth rates can be used to derive the TGR.

Box A.4 Technical concepts and formulas — growth rates

Growth rate formulas

Average annual growth rate

The formula for calculating a compound annual growth rate (AAGR) is:

$$\text{AAGR}(t_0, t_n) = \left[\left(\frac{P(t_n)}{P(t_0)} \right)^{\frac{1}{t_n - t_0}} - 1 \right] \times 100 \quad (\text{equation A.7})$$

Where:

$P(t_0)$ is the value in the initial period

$P(t_n)$ is the value in the last period

$t_n - t_0$ is the number of periods.

Total growth rate

The formula for calculating the total growth rate (TGR) is:

$$\text{TGR} = \frac{P(t_n) - P(t_0)}{P(t_0)} \times 100 \quad (\text{equation A.8})$$

Where:

$P(t_0)$ is the value in the initial period

$P(t_n)$ is the value in the last period

The formula for calculating a total growth rate (TGR) using a composite of growth rates between sub-periods within the overall period of analysis is:

$$\text{TGR} = \left(\prod_t (1 + r_t) - 1 \right) \times 100 \quad (\text{equation A.9})$$

That is, the TGR over the period is found by taking the product (\prod_t) of each $(1 + r_t)$ and deducting 1. This is multiplied by 100 so the growth rate is expressed as a percentage. If, for example, the sample ranges of growth rates are:

6 per cent in 2004-05 to 2005-06

6 per cent in 2005-06 to 2006-07

8 per cent in 2006-07 to 2007-08

then the total growth over the period 2004-05 to 2007-08 can be calculated as:

$$\begin{aligned} \text{TGR} &= [(1.06) \times (1.06) \times (1.08) - 1] \times 100 \\ &= (1.213488 - 1) \times 100 \\ &= 21.3 \text{ per cent.} \end{aligned}$$

Gross domestic product deflators

The GDP deflator is used to convert raw financial data into constant (real) dollars (box A.5). ‘Nominal’ financial data are converted to ‘real’ dollars so that comparisons over time are not affected by inflation. (Not all financial data in the Report are deflated using the GDP Implicit Price Deflator (IPD). The exceptions include some health chapters and the chapter on VET, which use service-specific deflators to calculate real dollars.)

The calculations to achieve constant (real) dollars are in two steps:

Step 1. Re-referencing of GDP deflators.

The Review re-references the period where the GDP IPD (published by the ABS) is 100 as this Report requires a current year deflator (2007-08 = 100). The ABS publishes the GDP IPD to the third most current year only (for example, if the current year is 2007-08, the available deflator is 2005-06 = 100). Table A.1 shows how the GDP deflator is re-based.

Table A.1 **Re-basing the GDP deflator**

<i>Financial year</i>	<i>ABS index value (2005-06 = 100)^a</i>	<i>Calculation</i>	<i>Re-based GDP deflator (2007-08=100)</i>
2003-04	92.1	92.1/109.0*100	84.5
2004-05	95.5	95.5/109.0*100	87.6
2005-06	100.0	100.0/109.0*100	91.7
2006-07	104.6	104.6/109.0*100	96.0
2007-08	109.0	109.0/109.0*100	100.0

^a Index values from ABS (2008), *Australian National Accounts: National Income, Expenditure and Product, June Quarter 2008*, Cat. no. 5206.0, table 32, Expenditure on Gross Domestic Product (GDP), Chain volume measures and Current prices, Annual (Series ID. A2304682C).

Source: ABS (2008), *Australian National Accounts: National Income, Expenditure and Product, June Quarter 2008*, Cat. no. 5206.0; table AA.26.

Table AA.26 in the attachment contains GDP deflators for 1998-99 to 2007-08. Five GDP deflator series are published, from 2003-04 = 100 through to the latest year, where 2007-08 = 100.

Step 2. Transforming nominal dollars into constant dollars.

Nominal dollars are transformed into constant (or real) dollars by dividing the nominal dollars with the GDP deflator for the applicable financial year and multiplying by 100. The deflator used may vary according to the most current year for which the particular financial data are available. For example, if the most current year for the data is 2006-07 then the data are deflated using the deflator series for

2006-07 = 100. If the most current year is 2007-08 then the data are deflated using the deflator series for 2007-08 = 100. Table A.2 shows how the GDP deflator for 2007-08 = 100 is applied.

Table A.2 Applying the GDP IDP to derive constant (real) dollars

<i>Financial year</i>	<i>Nominal data</i>	<i>GDP deflator (2007-08 = 100)</i>	<i>Calculation</i>	<i>Real data</i>
2003-04	6 200	84.5	(6 200/84.5)*100	7 337
2004-05	6 300	87.6	(6 300/87.6)*100	7 192
2005-06	6 350	91.7	(6 350/91.7)*100	6 925
2006-07	6 485	96.0	(6 485/96.0)*100	6 755
2007-08	7 020	100.0	(7 020/100.0)*100	7 020

Box A.5 Technical concepts and formulas — GDP deflator formulas

Gross Domestic Product deflator re-base

The general formula used to re-base GDP deflators is:

$$N_t = 100 \times \frac{O_t}{B} \quad (\text{equation A.10})$$

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.

GDP deflator application

The general formula for applying the deflator to convert nominal dollars to real dollars is:

$$R_t = \frac{D_t}{N_t} \times 100 \quad (\text{equation A.11})$$

Where:

R_t is real dollars in year t

D_t is nominal dollars in year t

N_t is the new index based in year t .

Age standardisation of data

Rationale for age standardisation of data

The age profile of Australians varies across jurisdictions, periods of time, geographic areas and/or population sub-groups (for example, between Indigenous and non-Indigenous populations). Variations in age profiles are important because they can affect the likelihood of using a particular service (such as a public hospital) or particular ‘events’ occurring (such as death, incidence of disease or incarceration). Using ‘crude’ (or unadjusted) rates across populations with different age profiles can lead to drawing erroneous conclusions about variables that are correlated with age. Age standardisation adjusts for the effect of variations in age profiles when comparing service usage, or rates, of particular events across different populations.

Calculating age standardised rates

Age standardisation adjusts each of the comparison/study populations (for example, Indigenous or non-Indigenous) against a standard population (box A.6). The standard population generally used is the final 30 June estimated Australian resident total population for the most recent year ending in ‘1’ (for example, 1991 and 2001) (AIHW 2008). The result is a standardised estimate for each of the comparison/study populations.

The Review generally reports age-standardised rates that have been calculated using either one of two methods, as appropriate. The direct method is generally used for comparisons between study groups. The indirect method is recommended when the age-specific rates for the population being studied are not known (or are unreliable), but the total number of events is known (AIHW 2008).

- The *direct method* has three steps:
 - Step 1: Calculate the age-specific rate for each age group for the study/comparison group.
 - Step 2: Calculate the expected number of ‘events’ in each age group by multiplying the age-specific rates by the corresponding standard population.
 - Step 3: Sum the expected number of cases in each age group and divide by the total of the standard population (box A.6, equation A.12).
- The *indirect method* has four steps:
 - Step 1: Calculate the age-specific rates for each age group in the standard population.

Step 2: Apply the age-specific rates resulting from step 1 to the number in each age group of the study population and sum to derive the total ‘expected’ number of cases for the study population.

Step 3: Divide the observed number of events in the study population by the ‘expected’ number of cases for the study population derived in step 2.

Step 4: Multiply the result of step 3 by the crude rate in the standard population (box A.6, equation A.13).

Box A.6 Technical concepts and formulas — direct and indirect age standardisation

The formula for deriving the age standardised rate using the direct method is:

$$SR = \frac{\sum (r_i P_i)}{\sum P_i} \quad (\text{equation A.12})$$

The formula for deriving the age standardised rate using the indirect method is:

$$SR = \frac{C}{\sum (R_i p_i)} \times R \quad (\text{equation A.13})$$

The formula for deriving the age standardised ratio using the indirect method is:

$$SR_a = \frac{C}{\sum (R_i p_i)} \quad (\text{equation A.14})$$

Where:

SR is the age-standardised rate for the population being studied

SR_a is the standardised ratio for the population being studied

r_i is the age-group specific rate for age group i in the population being studied

P_i is the population of age group i in the standard population

C is the observed number of events in the population being studied

$\sum (R_i p_i)$ is the expected number of events in the population being studied

R_i is the age-group specific rate for age group i in the standard population

p_i is the population for age group i in the population being studied

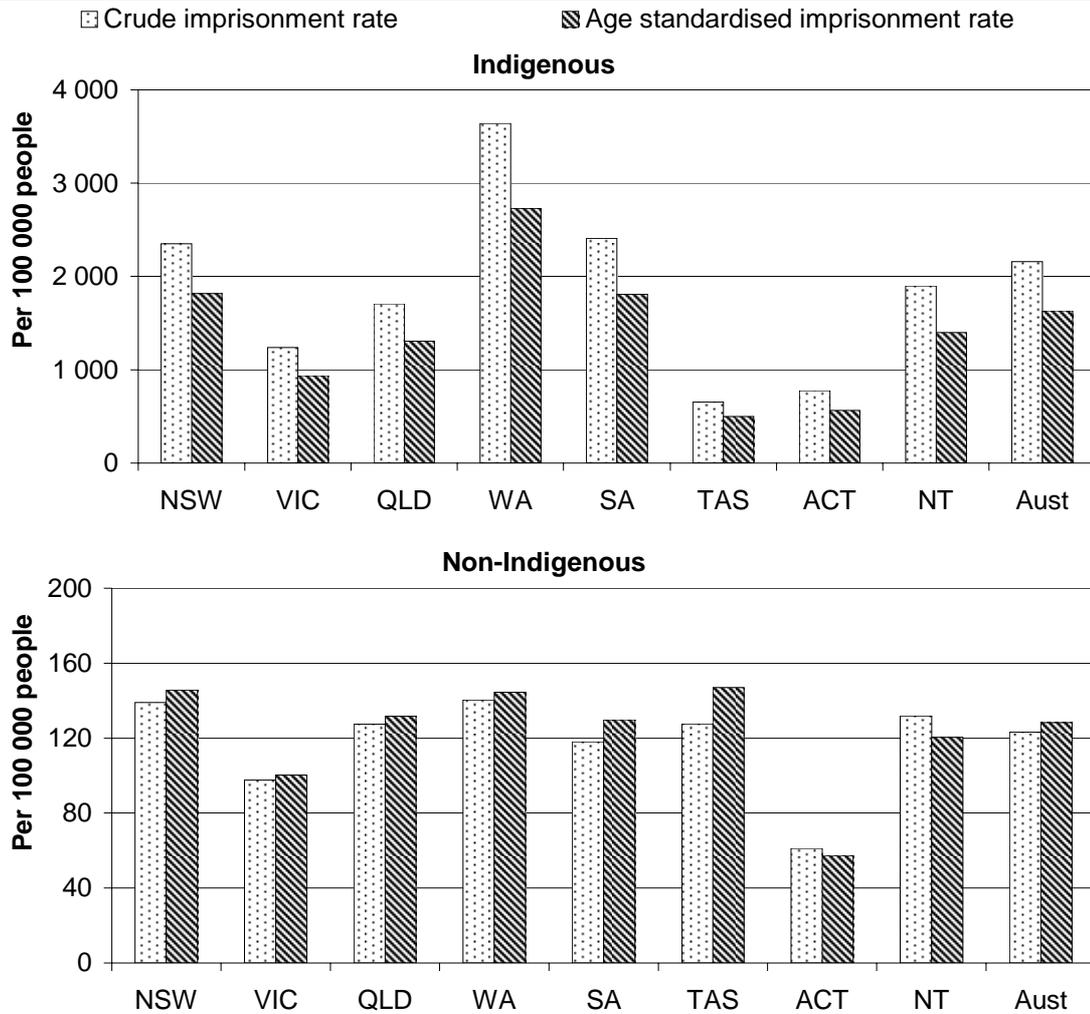
R is the crude rate in the standard population.

Source: AIHW (2008).

Tables AA.27 and AA.28 in the attachment contain examples of the application of direct and indirect age standardisation, respectively. Standardised rates are generally multiplied by 1000 or 100 000 to avoid small decimal fractions. They are then reported as age standardised rates per 1000 or 100 000 population (AIHW 2008).

Figure A.17 compares crude imprisonment rates and imprisonment rates standardised against the age profile of the total Australian prisoner population for Indigenous and non-Indigenous people.

Figure A.17 **Indigenous and non-Indigenous crude and age standardised imprisonment rates, 2007-08^{a, b}**



^a For detailed notes relating to these figures, please see table 8A.4. ^b Rates are based on the indirect standardisation method, applying age-group imprisonment rates derived from Prison Census data.

Source: ABS (unpublished), derived from *Australian Demographic Statistics, December Quarter 2007*, Cat. no. 3101.0; ABS (unpublished), derived from *Experimental Projections Aboriginal and Torres Strait Islander Population*, Cat. no. 3231.0; ABS (unpublished), derived from *Prisoners in Australia*, Cat. no. 4517.0; State and Territory governments (unpublished); table 8A.4; table AA.28.

Calculating age standardised ratios

A variation of the *indirect method* is used to calculate age standardised ratios (box A.6). These ratios express the overall experience of a study population in terms

of a standard population, where the standard population is the population to which the study population is being compared.

Application of age standardised ratios

Standardised Mortality Ratios (SMRs) have been used to compare death rates between the Indigenous and non-Indigenous populations (table A.3). The SMR is the ratio between the observed number of deaths in the Indigenous population and the expected number of deaths that would have occurred if the Indigenous population experienced the same age-specific death rates as the non-Indigenous population. If the SMR is greater than 1.0, there were more deaths than expected; if the ratio is less than 1.0, there were fewer deaths than expected (ABS and AIHW 2008).

Table A.3 Indigenous deaths, main causes and standardised mortality ratios, 2001–2005^{a, b}

	<i>Male</i>			<i>Female</i>		
	<i>Observed</i>	<i>Expected</i>	<i>SMR</i>	<i>Observed</i>	<i>Expected</i>	<i>SMR</i>
Diseases of the circulatory system	1 150	360	3.2	856	320	2.7
External causes	851	292	2.9	369	105	3.5
Neoplasms	592	406	1.5	547	351	1.6
Endocrine, nutritional and metabolic diseases	315	42	7.5	367	36	10.1
Diabetes	281	26	10.8	319	22	14.5
Diseases of the respiratory system	378	88	4.3	281	77	3.6
Diseases of the digestive system	251	43	5.8	182	36	5.1
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	169	28	6.0	85	19	4.6
Certain conditions originating in the perinatal period	126	44	2.9	82	36	2.3
Diseases of the genitourinary system	79	16	4.8	119	20	6.0
Diseases of the nervous system	122	42	2.9	69	44	1.6
Certain infectious and parasitic diseases	102	20	5.1	72	14	5.0
Mental and behavioural disorders	101	17	5.8	72	23	3.1
All causes	4329	1438	3.0	3215	1123	2.9

SMR = Standardised Mortality Ratio. ^a Data for Qld, WA, SA and NT combined. Deaths are based on year of registration of death. Disease groupings are based on ICD-10 chapter. ^b Standardised mortality ratio is the observed Indigenous deaths divided by expected Indigenous deaths, based on the age, sex and cause-specific rates for non-Indigenous persons.

Source: ABS and AIHW (2008), *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Cat. no. 4704.0, Canberra.

A.6 Attachment tables

Attachment tables are identified in references throughout this appendix by an 'AA' suffix (for example, table AA.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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Table AA.27	Age standardisation of data using the direct method
Table AA.28	Age standardisation of data using the indirect method

A.7 References

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AIHW 2008, *Age-standardised rate*, METeOR,
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10 September 2008.

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