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Contents

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

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Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAT	Aged Care Assessment Team
ACCHS	Aboriginal Community Controlled Health Service
ACCMIS	Aged and Community Care Management Information System
ACHS	Australian Council on Health Care Standards
ACIR	Australian Childhood Immunisation Register
ACPR	Australian Centre for Policing Research
ACSAA	Aged Care Standards and Accreditation Agency
ACSQHC	Australian Council for Safety and Quality in Health Care
ACT	Australian Capital Territory
ADR	Alternative Dispute Resolution
AFAC	Australasian Fire Authorities Council
AFP	Australian Federal Police
AGCCCS	Australian Government Census of Child Care Services
AGPAL	Australian General Practice Accreditation Limited
AGR	annual growth rate
AHCA	Australian Health Care Agreements
AHMAC	Australian Health Ministers' Advisory Council
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
AJJA	Australasian Juvenile Justice Administrators
ANTA	Australian National Training Authority
AQF	Australian Qualifications Framework

AR-DRG	Australian refined diagnosis related group
ARHP	Aboriginal Rental Housing Program
ARIA	Accessibility and Remoteness Index for Australia
ASGC	Australian Standard Geographical Classification
ASO	Ambulance Service Organisation
ATSIC	Aboriginal and Torres Strait Islander Commission
Aust	Australia
AVETMISS	Australian Vocational Education and Training Management Information Statistical Standard
BEACH	Bettering the Evaluation and Care of Health
CAA	Council of Ambulance Authorities
CACP	Community Aged Care Package (program)
CAD	computer aided dispatch
CAP	Crisis Accommodation Program
CAWG	Court Administration Working Group
CD ARIA	Census District Accessibility and Remoteness Index for Australia
CD-ROM	Compact Disc Read Only Memory
CFA	Country Fire Authority
CHINS	Community Housing and Infrastructure Needs Survey
CI	confidence interval
COAG	Council of Australian Governments
CRA	Commonwealth Rent Assistance
CRS	Commonwealth Rehabilitation Services
CSDA / CSTDA	Commonwealth State Disability Agreement / Commonwealth State/Territory Disability Agreement
CSDMAC	Community Services and Disabilities Ministers' Advisory Council
CSHA	Commonwealth State Housing Agreement
CSWG	Corrective Services Working Group
Cwlth	Commonwealth

DAC	delivery following primary caesarean
DCIS	ductal carcinoma in situ
DEA	data envelopment analysis
DEST	Department of Education, Science and Training
DEWR	Department of Employment and Workplace Relations
DoHA	Department of Health and Ageing
DOTARS	Department of Transport and Regional Services
DSE	Department of Sustainability and Environment
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home (program)
EBA	Enterprise Bargaining Agreement
EMA	Emergency Management Australia
ERP	estimated resident populations
ESL	Emergency Services Levy
ESO	emergency service organisation
FaCS	Department of Family and Community Services
FBT	Fringe Benefits Tax
FDCQA	Family Day Care Quality Assurance
FESA	Fire and Emergency Services Authority of WA
FMC	Federal Magistrates Court
FRS	Fire and Rescue Service
FSO	Fire Service Organisation
FTE	full time equivalent
FWE	full time workload equivalent
GDP	gross domestic product
GP	general practitioner
GST	goods and services tax
HACC	Home and Community Care (program)
HbA1c	glycated haemoglobin
HILDA	Household Income and Labour Dynamics Australia

HMAC	Housing Ministers' Advisory Committee
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
ICD-10-AM	Australian modification of the International Standard Classification of Diseases and Related Health Problems, version 10
IPD	Implicit Price Deflator
ITAB	Industry Training Advisory Bodies
JJNMDS	Juvenile Justice National Minimum Data Set
K10	Kessler – 10 scale
LBOTE	Language background other than English
LCL	lower confidence level
LMO	local medical officer
LSI	Likert Summation Index
MBS	Medicare Benefits Schedule
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MDS	minimum data set
MFB	Metropolitan Fire Brigade
NCAC	National Childcare Accreditation Council
NCAG	National Corrections Advisory Group
NCPASS	National Child Protection and Support Services
NCSIMG	National Community Services Information Management Group
NCVER	National Centre for Vocational Education Research
NDA	National Disability Administrators
NDCA	National Data Collection Agency
NESB	non-English speaking background
NFD	not further defined
NHCDC	National Hospital Cost Data Collection
NIDP	National Information Development Plan

NMDS	national minimum data set
NMHS	National Mental Health Strategy
no.	number
np	not published
NRCP	National Respite for Carers Program
NRF	National Reporting Framework
NSCSP	National Survey of Community Satisfaction with Policing
NSMHS	National Survey of Mental Health Services
NSW	New South Wales
NT	Northern Territory
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OECD	Organisation for Economic Co-operation and Development
OMP	other medical practitioner
OSHCQA	Outside School Hours Care Quality Assurance
PBS	Pharmaceutical Benefits Scheme
PDF	Portable Document Format
PHARIA	Accessibility/Remoteness Index of Australia modified for Pharmacies
PIP	Practice Incentives Program
PISA	Program for International Student Assessment
PSM	Population Survey Monitor
QFRS	Queensland Fire and Rescue Service
QIAS	Quality Improvement and Accreditation System
Qld	Queensland
QPA	Quality Practice Accreditation
RACGP	Royal Australian College of General Practitioners
RCS	Resident Classification Scale
RFDS	Royal Flying Doctor Service
RPBS	Repatriation Pharmaceutical Benefits Scheme
RRMA	Rural, Remote and Metropolitan Areas

RSE	relative standard error
RTO	Registered Training Organisation
SA	South Australia
SAAP	Supported Accommodation Assistance Program
SAAS	SA Ambulance Service
SAR	service activity reporting
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SCRGSP	Steering Committee for the Review of Government Service Provision
SDA	service delivery area
SDAC	Survey of Disability, Ageing and Carers
SE	standard error
SES/TES	State Emergency Service/Territory Emergency Service
SEWB Framework	National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004–2009
SEWB	Social and Emotional Wellbeing
SLA	statistical local area
SMART	SAAP Management and Reporting Tool
SOMIH	state owned and managed Indigenous housing
TAFE	technical and further education
Tas	Tasmania
UCC	user cost of capital
UCL	upper confidence level
ULN	upper limit of normal
VBAC	vaginal birth following primary caesarean
VET	vocational education and training
VHC	Veterans' Home Care
Vic	Victoria
WA	Western Australia

Glossary

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

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

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

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

PART E

HEALTH

E Health preface

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

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

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

The Australian, State, Territory and local governments spent \$33.1 billion on public (non-psychiatric) hospitals, medical services (including payments to general practitioners [GPs] and other specialist practitioners) and community and public health in 2003-04. These three areas of health care activity accounted for 65.4 per cent of government recurrent health expenditure in 2003-04 (table EA.4). There are no specific estimates of government expenditure on the detection and management of breast cancer. Government recurrent expenditure on specialist mental health services was estimated to be around \$3.4 billion in 2003-04 (tables 11A.21 and 11A.22). Some of this expenditure was on psychiatric care provided by public (non-psychiatric) hospitals (chapters 9 and 11).

Estimates of government expenditure on health care provision commonly include (by definition) high level residential aged care services and patient transport

services (ambulance services including pre-hospital care, treatment and transport services). These services are not covered in the health chapters in this Report, but are reported separately in chapters 8 ('Emergency management') and 12 ('Aged care').

Box E.1 Some common health terms

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

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

Medicare: covers Australian Government funding of private medical and optometrical services (the Medicare Benefits Schedule [MBS]). Some people use the term to include other forms of Australian Government funding — for example, funding of selected pharmaceuticals (under the Pharmaceutical Benefits Scheme [PBS]) and public hospital funding (under the Australian Health Care Agreements [AHCAs]) — aimed at providing public hospital services free of charge to public patients.

Primary health care: services that:

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

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

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

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

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

A range of government services — such as education, public housing, sanitation and water supply — also influence health outcomes. These are not formally part of Australia’s health system and are not the subject of the health chapters. Education (chapters 3 and 4) and public housing (chapter 16), however, are included in other chapters of the Report.

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

The remainder of this preface provides a summary of the nature of Australia’s health care system, an overview of Indigenous health, and data on health outcomes. It also foreshadows future directions in reporting. A list of attachment tables for this preface is provided at the end of the preface. Supporting tables are identified in references throughout the chapter by an ‘A’ suffix (for example, table EA.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report.

Profile of health services

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

Roles and responsibilities

The Australian Government’s health services activities include:

- funding public hospital services, GPs, some specialist medical services and public health programs
- funding the PBS
- funding high level residential aged care services
- funding private health insurance rebates
- funding Indigenous-specific primary health
- promulgating and coordinating health regulations

-
- undertaking health policy research and policy coordination across the Australian, State and Territory governments
 - funding hospital services and the provision of other services through the Department of Veterans' Affairs.

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

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

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

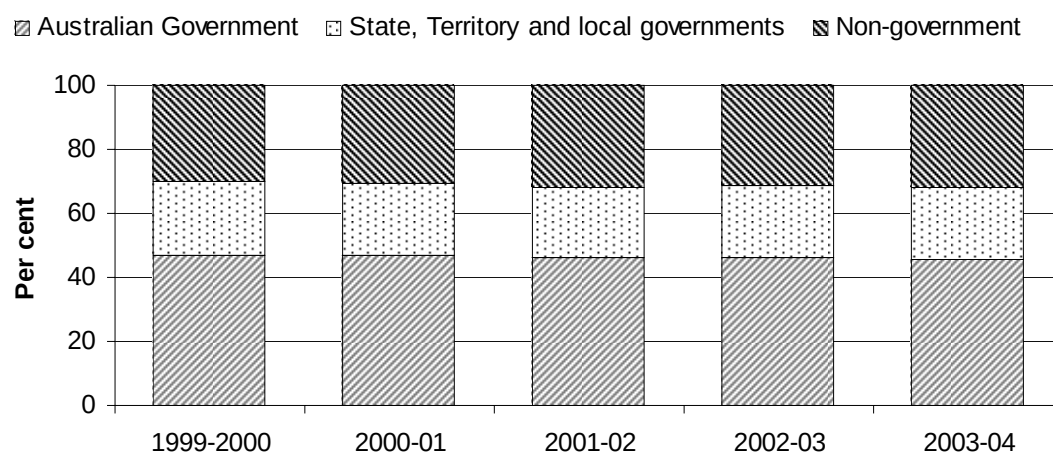
Funding

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

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

The Australian, State, Territory and local governments spent \$53.2 billion on health services (67.9 per cent of total health expenditure) in 2003-04. The Australian Government accounted for the largest proportion of health care expenditure in Australia — \$35.7 billion (or 45.6 per cent of the total) in 2003-04. State, Territory and local governments contributed \$17.5 billion (or 22.3 per cent of total health expenditure) in that year. These shares have remained relatively constant over the last five years. The remainder was paid by individuals, health insurance funds and workers compensation and compulsory motor vehicle third party insurance providers (figure E.1 and table EA.1).

Figure E.1 Total health expenditure, current prices, by source of funds^{a, b, c, d, e}



^a Includes recurrent and capital expenditure. ^b Includes expenditure on high level residential aged care (reported in chapter 12) and ambulance services (reported in chapter 8). ^c Expenditure by Australian Government and non-government sources has been adjusted for tax expenditure in relation to private health incentives claimed through the taxation system. ^d 'Non-government' includes expenditure by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurers. ^e Expenditure for 2003-04 is based on preliminary estimates by the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS).

Source: AIHW (2005b); table EA.1.

Size and scope of sector

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be \$78.6 billion in 2003-04 (table EA.1). This total was estimated to account for 9.7 per cent of gross domestic product in 2003-04, up from 9.5 per cent in 2002-03 and 8.3 per cent in 1993-94 (AIHW 2005b). This indicates that health expenditure grew faster than the whole economy over the decade to 2003-04.

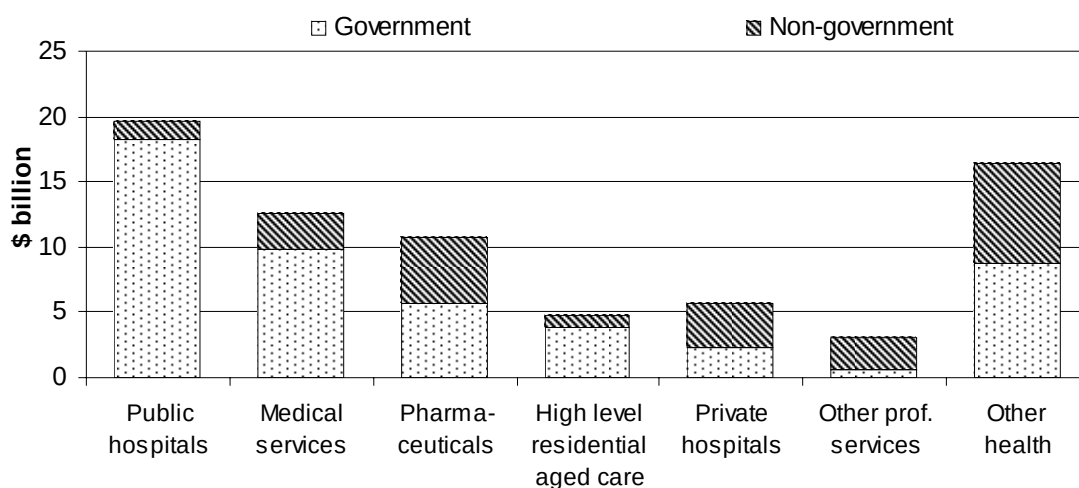
The growth of total health expenditure over the past decade was largely the result of an increase in expenditure by the Australian, State, Territory and local governments, which grew proportionally faster than expenditure by non-government sources. Between 1993-94 and 2003-04, the average annual rate of growth in real expenditure was 5.4 per cent for the Australian Government, 5.8 per cent for state, territory and local governments, and 2.8 per cent for non-government sources (AIHW 2005b).

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 \$1.6 billion in 1999-2000 to \$2.5 billion in 2003-04 (AIHW 2005b).

Public hospitals were the single largest item of recurrent health care expenditure by government and non-government sources in 2003-04. Total real expenditure on public hospitals was \$19.6 billion of which governments paid \$18.2 billion (in 2002-03 dollars)¹ (figure E.2). Public hospitals accounted for 37.0 per cent of government recurrent expenditure on health care services in 2003-04. Medical services accounted for \$9.8 billion of government expenditure (20.0 per cent of total health expenditure) and pharmaceuticals accounted for \$5.7 billion (11.6 per cent) (table EA.2).

¹ The published source data from the AIHW use 2002-03 as the base year. The same base year is used here for consistency.

Figure E.2 **Recurrent health expenditure, by area of expenditure, 2003-04**
(2002-03 dollars)^{a, b, c, d}



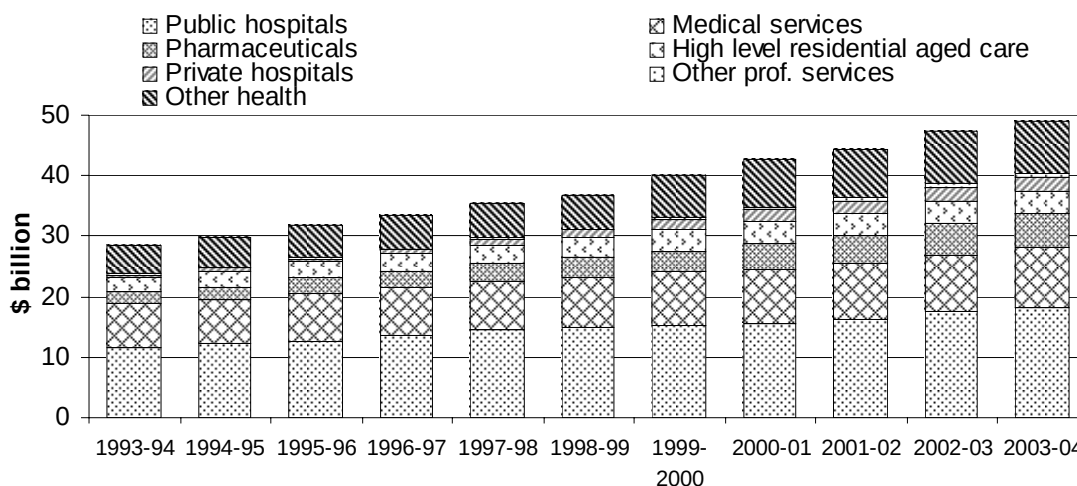
^a Almost all expenditure on medical services relates to services provided by practitioners on a fee-for-service basis, including those provided to private patients in hospitals. Excluded are the medical component of hospital care provided to public hospital inpatients and the outpatient medical services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

Source: AIHW (2005b); tables EA.2 and EA3.

The relative share of government recurrent health expenditure allocated to public hospitals has fallen since 1993-94, when it was 41.3 per cent, to 37.0 per cent in 2003-04. This decline reflects the more rapid growth over the decade of government expenditure on private hospitals and pharmaceuticals (figure E.3 and table EA.2). The average annual growth rate of government real recurrent expenditure on private hospitals was 22.4 per cent between 1993-94 and 2003-04, compared with 11.4 per cent for pharmaceuticals and 4.5 per cent for public hospitals (AIHW 2005b). 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 pharmaceutical brands, and increases in co-payments for pharmaceuticals.

The high annual growth in expenditures on pharmaceuticals and private hospitals meant they also grew as a proportion of government health care expenditure over the period 1993-94 to 2003-04. Government expenditure on pharmaceuticals increased from 6.8 per cent of government health expenditure in 1993-94 to 11.6 per cent in 2003-04, while expenditure on private hospitals increased from 1.1 per cent to 4.6 per cent over the same period (table EA.2).

Figure E.3 Government recurrent expenditure, by area of expenditure (2002-03 dollars)^{a, b, c, d, e}



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

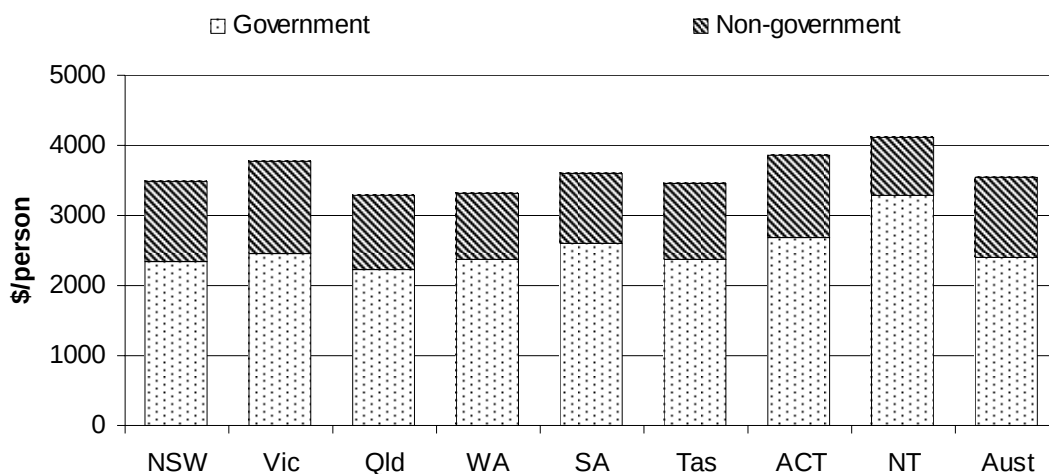
Source: AIHW (2005b); table EA.2.

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 2003-04 was \$3777 (table EA.5). The average annual growth rate in average health expenditure per person (expressed in 2002-03 dollars) from 1999-2000 to 2003-04 was 3.9 per cent (table EA.5). Average health expenditure per person in Australia increased from \$3243 in 1999-00 to \$3777 in 2003-04 (in 2002-03 dollars) (table EA.5).

Government real recurrent health expenditure per person in Australia increased from \$1988 in 1998-99 to \$2387 in 2002-03 (in 2002-03 dollars). Non-government recurrent expenditure per person in Australia rose from \$949 in 1998-99 to \$1142 in 2002-03 (in 2002-03 dollars) (figure E.4 and table EA.6). Information on expenditure per person excluding high level residential aged care is available in table EA.7.

Figure E.4 **Recurrent health expenditure per person by source of funds, 2002-03^{a, b, c}**



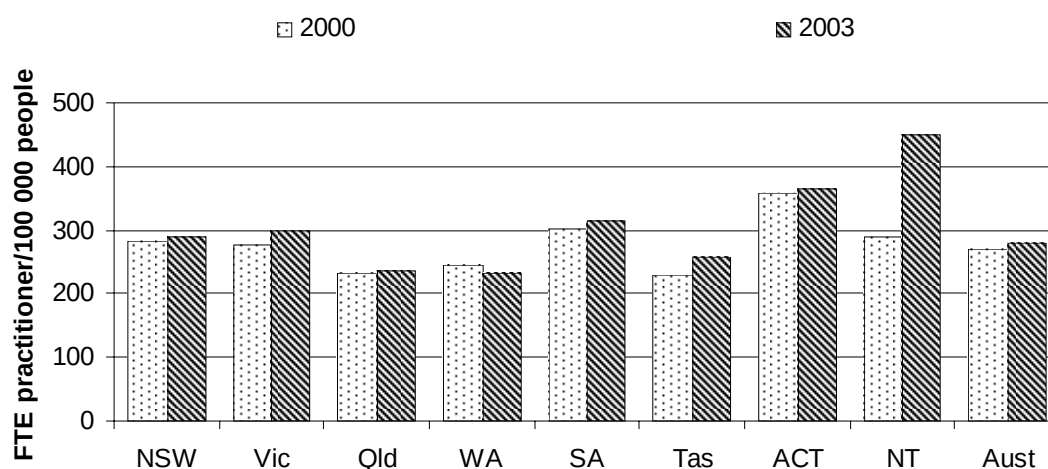
^a Preliminary data. ^b Includes expenditure on high level residential aged care (reported in chapter 12) and ambulance services (reported in chapter 8). ^c Government expenditure includes expenditure by the Australian, State, Territory and local governments.

Source: AIHW (2005b); table EA.6.

Health workforce

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

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

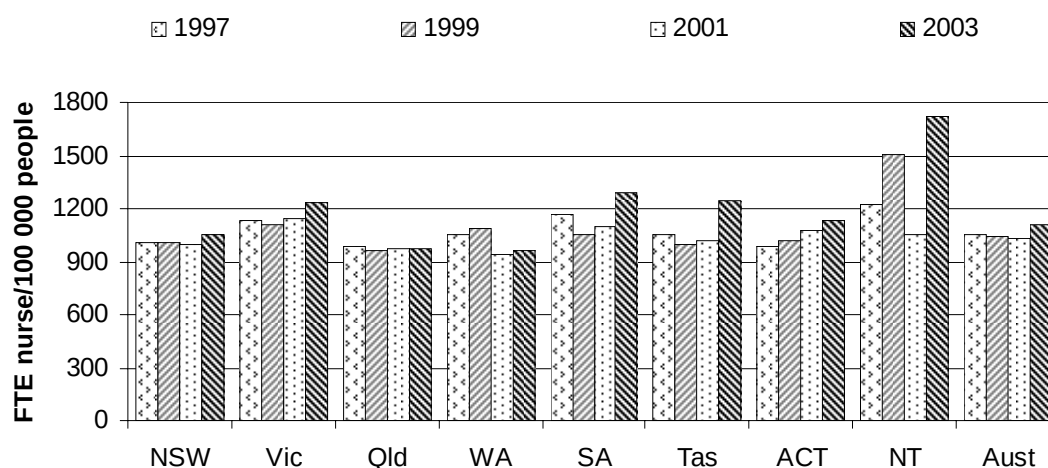


^a FTE practitioner rate (per 100 000 people) based on a 45-hour week.

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

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

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



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

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

Overview of Indigenous health

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

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

Recent publications such as *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* (ABS and AIHW 2005) and *Overcoming Indigenous Disadvantage: Key Indicators 2005* (SCRGSP 2005) include more comprehensive data on the health status of Indigenous people and Indigenous health-related factors.

Contributing factors

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

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

-
- relatively high imprisonment rates — after adjusting for age differences, Indigenous people were 11 times more likely than other Australians to be imprisoned at 30 June 2004 (SCRGSP 2005)
 - relatively high rates for health risk factors such as obesity, smoking, harmful alcohol use, substance abuse and violence — in 2002, 51 per cent of Indigenous people aged 15 years and over claimed to be cigarette smokers. Seventeen per cent of Indigenous men and 13 per cent of Indigenous women reported risky alcohol consumption. During 2002-03, Indigenous people were more than four times as likely to be in hospital for alcohol-related mental and behavioural disorders than other people (SCRGSP 2005)
 - geographic distance to health services, particularly in remote and very remote areas — in 2001, 606 discrete Indigenous communities were located 25 kilometres or more from the nearest primary health care centre, and 943 communities were 50 kilometres or more from the nearest acute care hospital (ABS and AIHW 2005)
 - inadequate and overcrowded housing, particularly in remote and very remote regions — in 2002, 26 per cent of Indigenous people aged 15 years and over (72 600 people) lived in overcrowded households (SCRGSP 2005).

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

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

Government policy and programs

The majority of government expenditure on Indigenous health is made through mainstream health programs (AIHW 2005a). In addition, the Australian, State and Territory governments fund Indigenous-specific health programs and undertake

coordination and research activities. Most Australian Government expenditure on Indigenous-specific health programs is directed to Indigenous-specific primary health. State and Territory governments fund a range of community and public health programs that specifically target Indigenous people within their jurisdictions (chapter 10).

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.

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

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

-
- resources and finances commensurate with Indigenous health needs, the cost of delivering services and community capacity to deliver health outcomes
 - accountability of health services to communities and governments.

Each State and Territory is developing an implementation plan under the framework. These plans detail information on existing and planned action by each government to improve health outcomes for Indigenous people over the next five years. The plans describe programs and policy approaches which are the primary responsibility of each government as well as their contributions to multilateral effort. Each jurisdiction will report to health ministers on progress under the plan every year and on the contribution to multilateral effort every two years.

The National Strategic Framework is complemented by a National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004–2009 (SEWB Framework), which was agreed by the Australian Health Ministers Advisory Council in March 2004. The SEWB Framework sits within the context of the National Strategic Framework for Aboriginal and Torres Strait Islander Health and the Third National Mental Health Plan. For a discussion of the Third National Mental Health Plan see chapter 11.

Expenditure

It is not always possible to make accurate estimations 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 is often unavailable for privately funded services (although it is available for many publicly funded health services). The scope and definition of health expenditures also have some limitations. Other (non-health) agency contributions to health expenditure, such as those incurred within education departments and prisons are not included. There may also be some inconsistencies across data providers resulting from limitations of financial reporting systems and different reporting mechanisms (AIHW 2005a).

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

services in public hospitals and for non-admitted patient services in hospitals. It was also higher for community health services. Expenditure per person was lower for Indigenous people than non-Indigenous people for admitted patient services in private hospitals, medical services, dental and other professional services, pharmaceuticals, aids and appliances and for services for older people (table E.1).

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

<i>Health good or service type</i>	<i>Total expenditure (\$ million)</i>			<i>Expenditure per person (\$)</i>		
	Indigenous	Non-Indigenous	Indigenous share (%)	Indigenous	Non-Indigenous	Ratio
Hospitals	849.5	21 456.9	3.8	1 852.75	1 132.01	1.64
Admitted patient services	682.5	17 927.4	3.7	1 488.38	945.80	1.57
Private hospital	11.5	5 057.1	0.2	25.08	266.80	0.09
Public hospital	671.0	12 870.2	5.0	1 463.30	679.00	2.16
Non-admitted patient services	142.4	3 116.5	4.4	310.57	164.42	1.89
Emergency departments	34.6	615.7	5.3	75.51	32.48	2.32
Other services	107.8	2 500.8	4.1	235.06	131.94	1.78
Public (psychiatric) hospitals	24.7	413.0	5.6	53.80	21.79	2.47
Medical services	99.6	11 112.5	0.9	217.19	586.27	0.37
Medicare benefit items	75.9	9 185.4	0.8	165.47	484.60	0.34
Other	23.7	1 927.2	1.2	51.72	101.67	0.51
Community health services ^{b, c}	439.9	2 810.5	13.5	959.30	148.27	6.47
Dental services ^b	21.8	3 734.2	0.6	47.59	197.01	0.24
Other professional services	16.9	2 252.4	0.7	36.76	118.83	0.31
Pharmaceuticals	66.2	9 011.6	0.7	144.36	475.43	0.30
Benefit-paid ^d	42.3	5 471.8	0.8	92.20	288.68	0.32
Other pharmaceuticals	23.9	3 539.8	0.7	52.16	186.75	0.28
Aids and appliances	15.8	2 474.0	0.6	34.51	130.52	0.26
Services for older people	49.9	4 591.6	1.1	108.83	242.24	0.45
Patient transport	62.8	892.7	6.6	136.95	47.09	2.91
Public health activities	72.5	1 029.9	6.6	158.15	54.33	2.91
Other health services (nec)	50.6	1 458.9	3.4	110.44	76.97	1.43
Health administration (nec)	43.1	1 883.6	2.2	93.99	99.37	0.95
Total	1 788.6	62 708.9	2.8	3 900.83	3 308.35	1.18

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

Source: AIHW (2005a).

In 2001-02, governments are estimated to have provided 92.7 per cent of the funding for expenditure on health goods and services for Indigenous people. States and territories contributed 49.5 per cent and the Australian Government, an estimated 43.1 per cent. Non-government sources such as injury compensation insurers, private health insurers and out-of-pocket payments supported the remaining funding by users of services (AIHW 2005a).

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

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

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

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

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

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

Source: AIHW (2005a).

Self-assessed health

In the 2002 ABS National Aboriginal and Torres Strait Islander Social Survey (NATSISS), around 42 per cent of Indigenous people aged 18 years or over reported their health as very good or excellent, 33 per cent reported their health as good and 25 per cent reported their health as fair or poor. Taking into account differences in age structure, Indigenous people were twice as likely to report their health as fair or poor, than non-Indigenous Australians (ABS and AIHW 2005).

Data quality

Good quality data are needed to assess the effectiveness of programs and to evaluate policies designed to improve health services and outcomes for Indigenous people. Despite recent improvements, the quality of the information and estimates on Indigenous health expenditures is limited by underlying data and the calculation methodology. Some of the problems associated with Indigenous health data are outlined in ABS (2004a), and ABS and AIHW (2005) including:

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

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

- The ABS has introduced a program of three yearly Indigenous household surveys with sample sizes designed to support the production of reliable state and territory level data, so every three years, some health status and health risk factors are measured. Every six years, more detailed health status information is collected, together with health service use, health actions, health related aspects of lifestyle and other health risks. Other health related surveys, which may include an Indigenous identifier, do not necessarily provide reliable data on Indigenous people, because of small sample size, geographic coverage or survey design (although considerable improvement has been made in these areas in recent years).
- Inconsistent data definitions and differences in the accuracy of identifying Indigenous status have lead to problems making comparisons between jurisdictions, and comparisons over time.
- Experimental estimates of the Indigenous population are re-based by the ABS every five years to take account of unexplained population growth (that is, other than natural increase). This requires re-estimation of various rates and rate ratios.

The Aboriginal and Torres Strait Islander Health Performance Framework has been developed to support the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (see above). It will provide the basis for measurement of the impact of the National Strategic Framework. As part of the development of the health performance framework, key priorities for data development will be identified to support an ongoing work program of data improvements.

In existing data collections, agencies such as the ABS and the AIHW have identified jurisdictions with acceptable Indigenous data quality for particular data collections. These judgments have informed the presentation of Indigenous health data in this Report.

Framework for measuring the performance of the health system

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

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

Box E.2 Overall objectives of the health system

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

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

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

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

Medical intervention strategies are implemented after a diagnosis.

As discussed in previous reports, the National Health Performance Committee has developed the National Health Performance Framework to guide the reporting and measurement of health service performance in Australia. A number of other groups involved in health performance indicator development have adopted this framework and adapted it for use within specific project areas and in publications. These groups include the National Health Priority Performance Advisory Group, the National Public Health Partnership, the Australian Council for Safety and Quality in Health Care, the National Mental Health Working Group, the Australian Council on Healthcare Standards, and the Aboriginal and Torres Strait Islander Technical

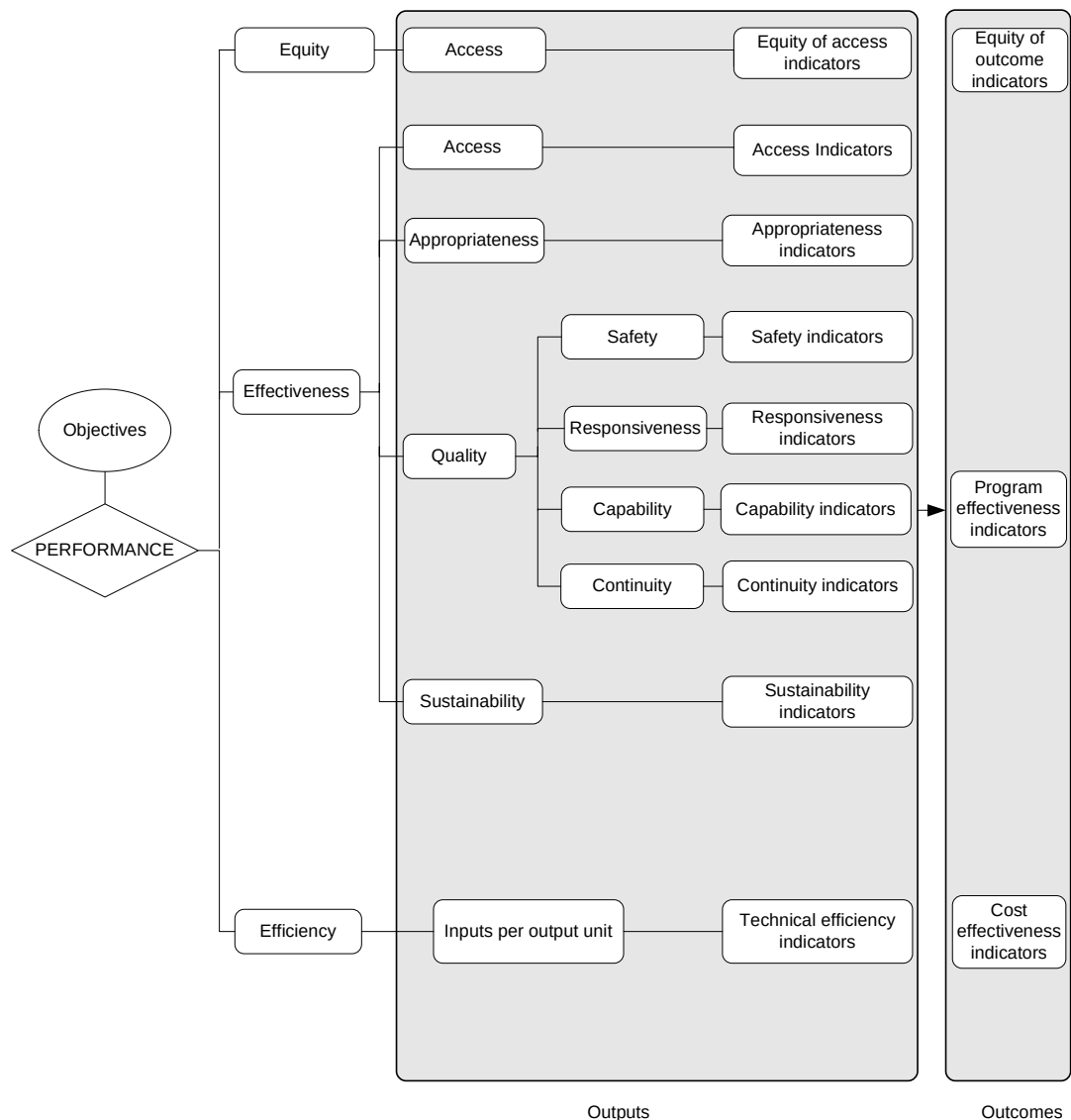
Advisory Group on Health Performance (established by the Office for Aboriginal and Torres Strait Islander Health [OATSIH]).

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

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

Other aspects and dimensions of the Steering Committee's framework of performance indicators are defined in chapter 1. The Steering Committee has applied this performance framework to health services in two ways. It has developed, first, detailed performance indicator frameworks for significant providers (public hospitals, and primary and community health services) and second, separate frameworks to examine the appropriate mix of services (including the prevention of illness and injury, and medical treatment) and the appropriate mix of service delivery mechanisms. The latter are measured by focusing on two health management issues: breast cancer and mental health. These performance indicator frameworks are discussed in chapters 9, 10 and 11.

Figure E.7 Performance indicator framework for health services



Selected indicators of health outcomes

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

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

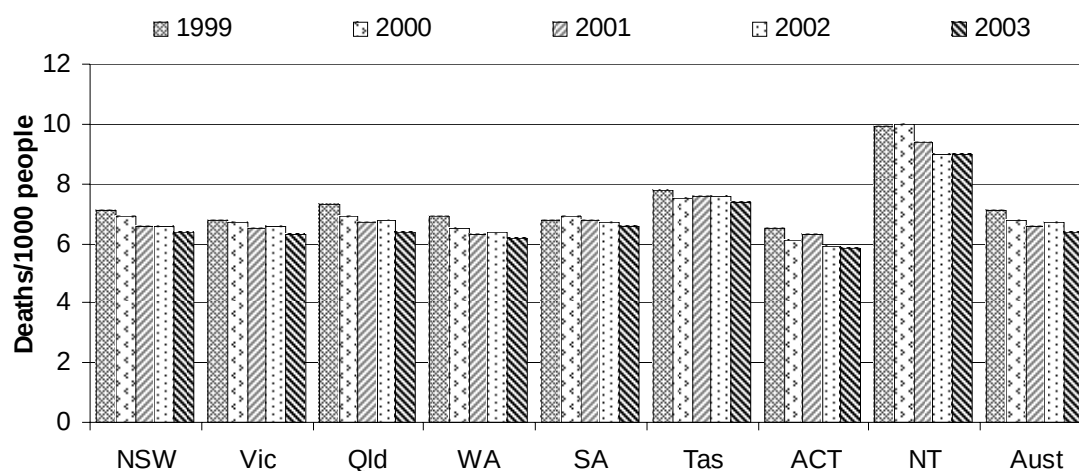
Data on health outcomes presented in this preface include self-assessed health status, mortality rates (for infants and all people), causes of death, life expectancy at birth, median age at death and birthweight. Where possible, data are presented for Indigenous people as well as the Australian population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

Mortality rates

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

There were 132 292 deaths in Australia in 2003 (ABS 2005a), which translated into an age standardised mortality rate of 6.4 per 1000 people (figure E.8). Death rates over the last 20 years have declined for all states and territories (ABS 2005a).

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



^a Calculated using direct methods of age standardisation, based on the 2001 Census standard population.

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

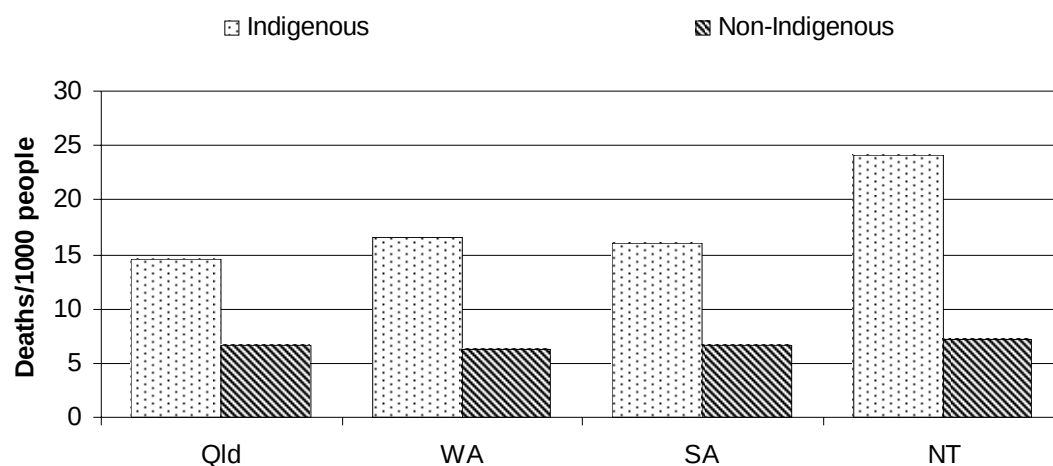
Indigenous mortality rates

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. The NT, WA, SA and Queensland in that order are generally considered to have the best coverage of death registrations for Indigenous people.² For these four jurisdictions combined, the overall rates of mortality for Indigenous people were almost three times higher than mortality rates for non-Indigenous people in 1999–2003 (figure E.9 and table EA.11). The exact magnitude of this difference cannot be established at this time due to poor identification of Indigenous Australians in death records. Reported mortality rates under estimate the true difference (ABS and AIHW 2005).

Due to the relatively small number of Indigenous deaths and the consequent volatility in annual mortality rates, the data are presented for the five year period 1999–2003. To improve the comparability of age-related mortality rates, indirect age standardisation methods have been used for both the Indigenous and total population rates.

Figure E.9 Mortality rates, age standardised, by Indigenous status, five year average, 1999–2003^{a, b, c}



^a Calculated using indirect methods of age standardisation, based on the 2001 Census, for Queensland, WA, SA and the NT. Rates are not adjusted for differences across jurisdictions in the extent of identification of Indigenous deaths. ^b Rates are calculated per 1000 Indigenous people. ^c Data for Queensland, WA, SA and the NT are considered to have the highest level of accuracy of Indigenous identification in mortality data. They do not represent a quasi-Australian figure.

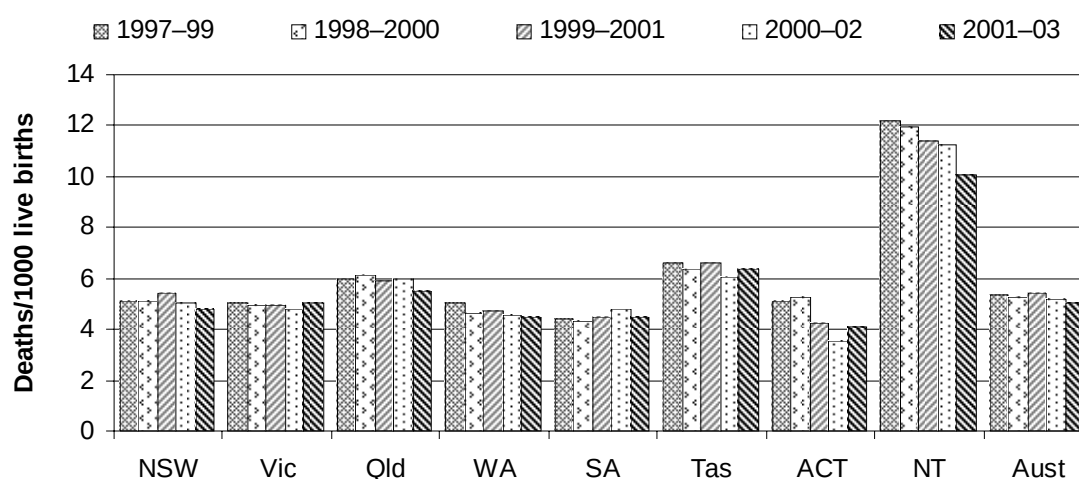
Source: ABS Deaths Australia (unpublished); table EA.11.

² The term ‘coverage’ refers to the number of Indigenous deaths registered as a percentage of the number of expected deaths based on Census population data.

Infant mortality rates

The infant mortality rate is defined as the number of deaths of children under 1 year of age in a calendar year per 1000 live births in the same year. Infant mortality rates are presented in this Report as an average over three years to reduce the volatility inherent in the annual rates due to small numbers and annual fluctuations (figure E.10). The infant mortality rate in Australia declined from 5.9 deaths per 1000 live births each year between 1993–95 to an average of 5 deaths per 1000 live births each year between 2001–03, although the rate has been relatively static in recent years (figure E.10).

Figure E.10 Infant mortality rate, three year average



Source: ABS (2004b); table EA.12.

Indigenous infant mortality rates

For the period 2001–03, the average infant mortality rate for Indigenous children is publishable for NSW, Queensland, WA, SA and the NT. The accuracy of Indigenous mortality data is variable, however, due to varying rates of coverage across jurisdictions and over time. While a high level of coverage is estimated in the NT and to a lesser extent in WA and SA, substantial undercoverage appears in NSW and Queensland. Further, the ability to detect significant changes in Indigenous infant mortality is affected by the small numbers involved. Indigenous infant mortality rates remain markedly higher than the national average for all Australians (tables EA.12 and EA.13).

Principal causes of death

The most common causes of death among Australians in 2003 were: diseases of the circulatory system (including heart disease, heart attack and stroke), cancers, and diseases of the respiratory system (including influenza, pneumonia and chronic lower respiratory diseases) (tables E.3 and EA.14). Malignant neoplasms were the main underlying cause of 28.4 per cent of all deaths in 2003 (ABS 2005a) and ischaemic heart disease was the primary cause of a further 19.5 per cent (ABS 2005a).

Table E.3 Cause of death, age standardised death rates, 2003^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	179	187	183	182	186	201	165	198
Lung cancer ^c	33	35	35	36	33	40	28	32
Diabetes mellitus	14	20	15	16	16	29	15	37
Mental and behavioural disorders	15	17	14	15	17	19	22	26
Diseases of the nervous system	21	21	19	26	16	29	25	16
Diseases of the circulatory system	243	223	242	210	247	253	213	265
Heart disease ^d	123	116	133	109	131	138	99	122
Heart attack ^e	64	62	73	58	74	63	44	56
Stroke ^f	65	53	62	52	58	51	51	55
Diseases of the respiratory system	58	54	56	55	69	63	46	97
Influenza and pneumonia	17	16	17	16	28	11	10	31
Chronic lower respiratory diseases	28	29	30	28	26	43	26	56
Diseases of the digestive system	22	22	22	20	22	28	20	41
Accidents	23	22	27	27	23	29	19	58
Transport accidents	8	8	10	11	12	12	4	28
Suicide ^g	10	11	12	12	13	15	10	24
All causes	643	627	640	623	662	739	582	892

^a Age standardised death rates per 100 000 people, based on the mid-year 2001 population. Rounded to whole numbers. ^b Malignant neoplasms. ^c Cancer of the trachea, bronchus and lung. ^d Ischaemic heart disease and heart attacks. ^e Acute myocardial infarction. ^f Cerebrovascular diseases. ^g Intentional self-harm.

Source: ABS (2005a); table EA.14.

Causes of death for Indigenous people

In the jurisdictions for which age standardised death rates are available by Indigenous status (Queensland, WA, SA and the NT), death rates were far higher for Indigenous people than for non-Indigenous people during the period 1999–2001. In particular, Indigenous people died from rheumatic heart disease at a rate that was up to 19.4 times that for non-Indigenous people. They died from diabetes at a rate that was up to 15.9 times higher than that for non-Indigenous people; from pneumonia at a rate that was up to 14.3 times that for non-Indigenous people; and from assault at a rate that was up to 12.6 times that for non-Indigenous people (tables EA.15 and E.4).³

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

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

^a Age standardised mortality rate for Indigenous people divided by the age standardised mortality rate for non-Indigenous people. Calculated from death rates per 100 000 people aged less than 75 years. ^b Indigenous deaths data reported in SIMC 2004 and quoted in this table do not reflect ABS revised Indigenous population estimates for 1999 and 2000, nor are they adjusted for differences in the extent of Indigenous identification across jurisdictions or across causes of death. ^c Excludes deaths for which Indigenous status was not stated. ^d Diabetes as an underlying cause or part of a multiple cause. ^e Includes all heart disease, acute myocardial infarction (heart attack) and cerebrovascular diseases (stroke). ^f External causes of death such as land and water transport accidents, falls, poisonings, drownings, other accidents, self-harm and assault. **np** Not published.

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

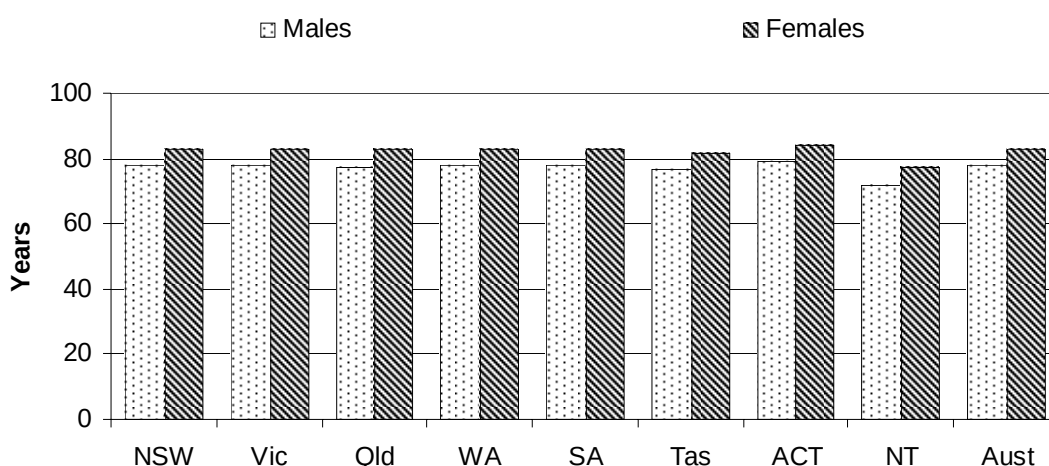
In 1999–2003, 58 per cent of deaths of Indigenous people resident in Queensland, WA, SA and the NT were caused by diseases of the circulatory system, external causes and cancer. By way of contrast these caused 78 per cent of deaths in the non-Indigenous population (ABS and AIHW 2005).

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

Life expectancy

The life expectancy of Australians improved dramatically during the twentieth century. The average life expectancy at birth in the period 1901–10 was 55.2 years for males and 58.8 years for females (ABS 2004d). It has risen steadily in each decade since, reaching 77.8 years for males and 82.8 years for females in 2001–03 (figure E.11).

Figure E.11 **Average life expectancy at birth, by sex, three year average, 2001–2003**



Source: ABS (2004b); table EA.16.

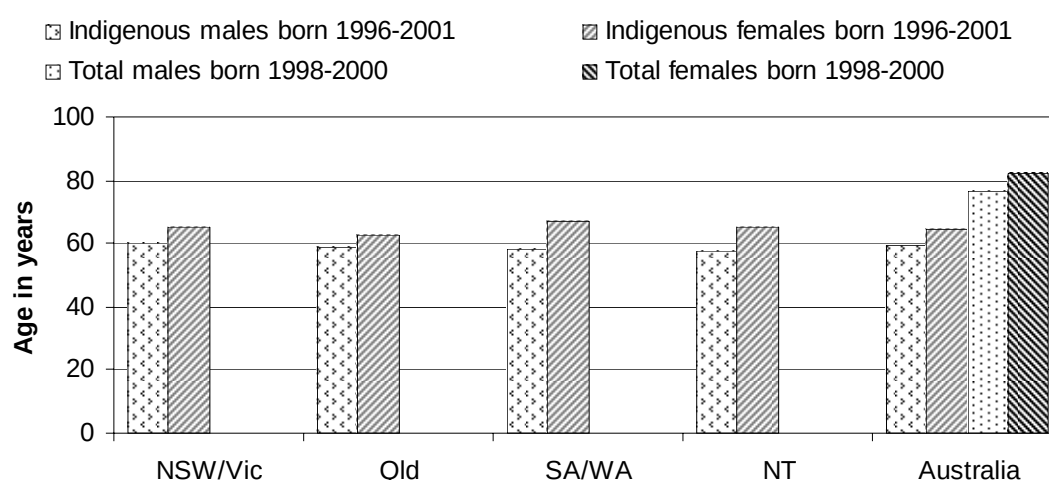
Indigenous life expectancy

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

The life expectancies of Indigenous Australians are considerably lower than those of non-Indigenous Australians. ABS experimental population estimates indicate a life expectancy at birth of 59.4 years for Indigenous males and 64.8 years for Indigenous females born from 1996 to 2001 (figure E.12 and table EA.17). In a similar, but not directly comparable time period (1998–2000) the rates for all

Australians were 76.6 years for all males and 82.0 years for females. Variations in life expectancy between Indigenous males and females and for Indigenous Australians in different states and territories should be interpreted with care as they are sensitive to the demographic assumptions and differences in data quality across jurisdictions.

Figure E.12 Life expectancy at birth, Indigenous 1996–2001, total population 1998–2000^{a, b, c}



^a Indigenous data are for the Aboriginal and Torres Strait Islander population, and include an adjustment for undercoverage of Indigenous deaths. ^b Indigenous life expectancy excludes Tasmania and the ACT. For Tasmania and the ACT, use data for Victoria and NSW respectively. ^c Life expectancy data for Indigenous males and Indigenous females are for the period 1996–2001. Data for total males and females cover the period 1998–2000, the approximate mid-point of the Indigenous data.

Source: ABS (2004a); table EA.17.

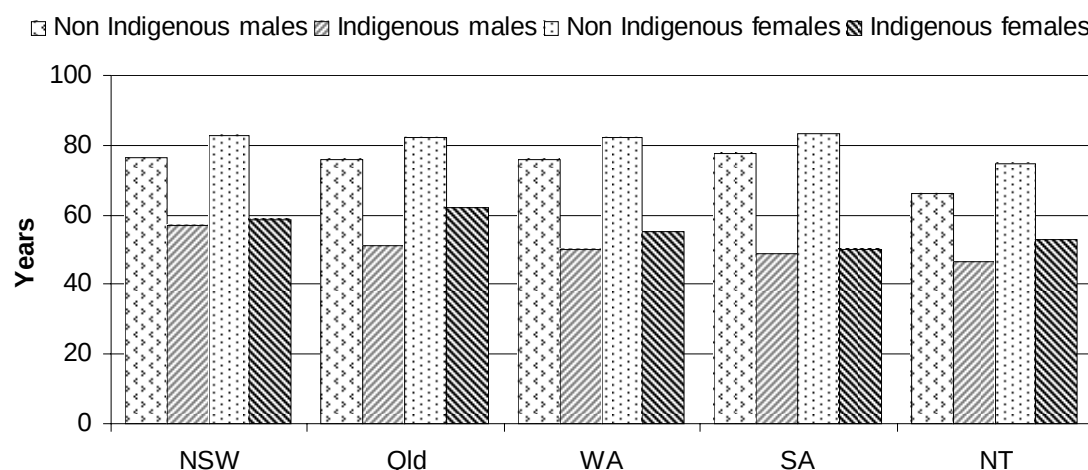
Median age at death

The median age at death is a measure of the distribution of deaths by 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 an underestimate.

For all Australian males and females in 2003, the median age at death was 76.4 years and 82.5 years respectively (figure E.13 and table EA.18). In the jurisdictions for which the data were available for Indigenous people in 2003 the median age at death for male Indigenous Australians varied between 56.8 and

46.3 years. The median age at death for female Indigenous Australians varied between 62.1 years and 50.0 years (figure E.13 and table EA.18).

Figure E.13 Median age at death, by sex and Indigenous status, 2003^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 is variable as a result of varying rates of coverage across jurisdictions and age groups, and of changes in the estimated Indigenous population caused by changing rates of identification in the Census and births data.

Source: ABS (2004c); table EA.18.

Birthweight of babies

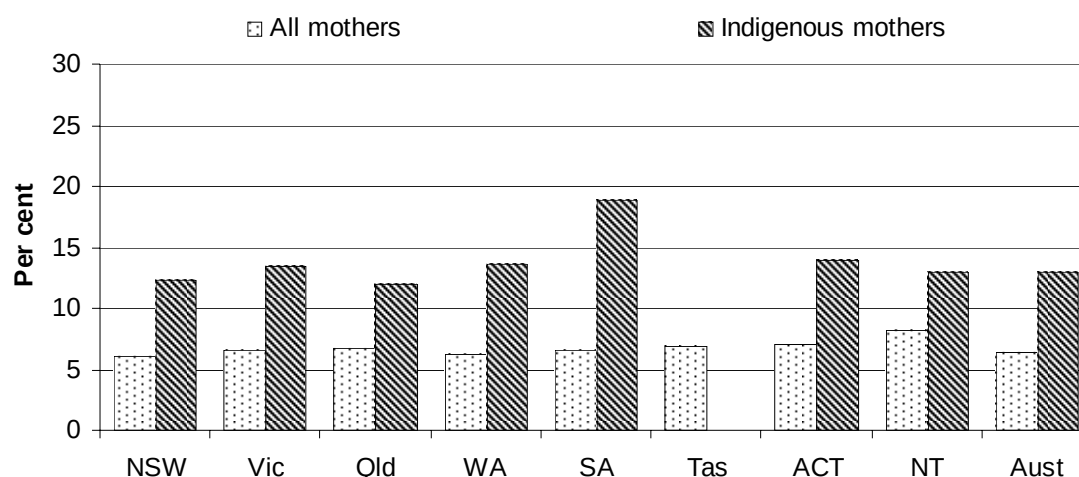
The birthweight of a baby is an important indicator of its health status and future wellbeing. In 2002, 91.8 per cent of liveborn babies in Australia weighed between 2500 and 4499 grams (Laws and Sullivan 2004). The average birthweight for all live births was 3371 grams. In 2002, the average birthweight of liveborn babies of Indigenous mothers was 3165 grams (tables EA.19 and EA.20). This was 213 grams lighter than the average of 3378 grams for liveborn babies of non-Indigenous mothers⁴ (Laws and Sullivan 2004).

Babies are defined as low birthweight if they weigh less than 2500 grams, very low birthweight if they weigh less than 1500 grams and extremely low birthweight if they weigh less than 1000 grams (Laws and Sullivan 2004). In 2002, 6.4 per cent of all liveborn babies in Australia weighed less than 2500 grams (figure E.14). They included 1.1 per cent of babies who weighed less than 1500 grams and 0.5 per cent of babies who weighed less than 1000 grams (table EA.19).

⁴ Figures for births to Indigenous mothers exclude Tasmania.

Among live babies born to Indigenous mothers in 2002, the proportions with low and very low birthweights were around twice the proportions born to all Australian mothers, with 12.9 per cent weighing less than 2500 grams and 2.2 per cent weighing less than 1500 grams (figure E.14 and table EA.20).

Figure E.14 Babies with birthweights under 2500 grams, by Indigenous status, 2002^{a, b, c, d}



^a Proportion of live births with birthweights under 2500 grams. ^b Babies with Indigenous fathers and non-Indigenous mothers are not included as Indigenous. ^c The ACT data for births to Indigenous mothers may vary from year to year as a result of small numbers. Some low birthweight babies born to Indigenous mothers in the ACT might have been born to women from NSW, so the proportion of such births may not reflect the health status of Indigenous mothers and babies who are residents of the ACT. ^d Data for births to Indigenous mothers are not available for Tasmania. Totals for Australia for Indigenous mothers exclude Tasmania.

Source: Laws and Sullivan (2004); tables EA.19 and EA.20.

Future directions

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

Improving reporting on Indigenous health is a common 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.

Supporting tables

Supporting tables are identified in references throughout this preface by an 'A' suffix (for example, table EA.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2006\AttachEA.xls and in Adobe PDF format as \Publications\Reports\2006\AttachEA.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

Table EA.1	Total health expenditure, current prices, by source of funds
Table EA.2	Government recurrent health expenditure, by area of expenditure (2002-03 dollars)
Table EA.3	Non-government recurrent health expenditure by area of expenditure (2002-03 dollars)
Table EA.4	Recurrent health expenditure, by source of funds and area of expenditure, 2003-04
Table EA.5	Total health expenditure per person (2002-03 dollars)
Table EA.6	Recurrent health expenditure per person, by source of funds (2002-03 dollars)
Table EA.7	Recurrent health expenditure per person, by source of funds, excluding high level residential aged care (2002-03 dollars)
Table EA.8	Total health price index
Table EA.9	Employed medical practitioners
Table EA.10	Employed nurses
Table EA.11	Mortality rates, age standardised for all causes (per 1000 people)
Table EA.12	Infant mortality rate, three year average (per 1000 live births)
Table EA.13	Indigenous Infant mortality rates, selected years
Table EA.14	All Australians causes of death, standardised death rates 2003
Table EA.15	Causes of death by Indigenous status, age standardised death rates, 1999–2001 (per 100 000 people)
Table EA.16	All Australians average life expectancy at birth (years)
Table EA.17	Indigenous life expectancy at birth (years)
Table EA.18	Median age at death (years)
Table EA.19	Birthweights, live births, all mothers, 2002
Table EA.20	Birthweights of babies of Indigenous mothers, live births, by state and territory 2002

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9 Public hospitals

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

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

Reporting on public hospitals has been improved this year through the inclusion of three new indicators:

- ‘Pre-anaesthetic consultation rates’ are reported as an indicator of the safety aspect of quality.
- ‘Patient satisfaction’ and ‘sentinel events’ are reported as indicators of outcomes for public hospitals.

9.1 Profile of public hospitals

Definition

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

- acute care services to admitted patients

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

This chapter focuses on acute care services provided to admitted patients and emergency services provided to non-admitted patients in public hospitals. These services comprise the bulk of public hospital activity and, in the case of acute care services to admitted patients, have the most reliable data available. Some data in the chapter include sub-acute and non-acute care services where they cannot yet be separately identified from acute care.

In some instances, stand-alone psychiatric hospitals are included in this chapter, although their role is diminishing in accordance with the National Mental Health Strategy. Under the strategy, the provision of psychiatric treatment is shifting away from specialised psychiatric hospitals to mainstream public hospitals and the community sector. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in ‘Health management issues’ (chapter 11).

Some common health terms relating to hospitals are defined in box 9.1.

Box 9.1 Some common terms relating to hospitals

Patients

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

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

(Continued on next page)

¹ Other services to non-admitted patients include community health services such as baby clinics and immunisation units, district nursing services and other outreach services (AIHW 2001a).

Box 9.1 (Continued)

Types of care

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

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

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

Hospital outputs

separation: an episode of care that 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 in the type of care for an admitted patient (for example, from acute care to rehabilitation). Admitted patients who receive same day procedures (for example, renal dialysis) are included in separation statistics.

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

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

Other common health terms

AR-DRG (Australian refined diagnosis related group): a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 4.2 is based on the ICD-10-AM classification.

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

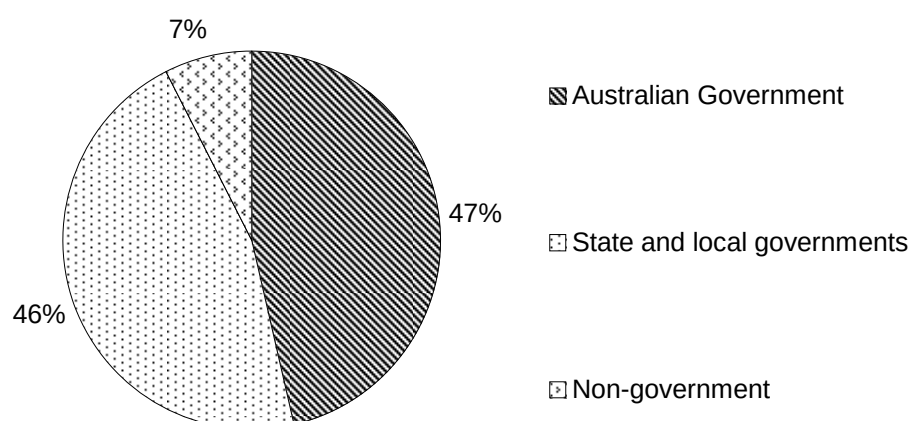
Source: AIHW (2005a); DHAC (1998, 2000); NCCH (1998); NHDC (2001, 2003).

Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was \$20.0 billion in 2003-04 (table 9A.1).² In real terms, expenditure increased by 5.4 per cent between 2002-03 and 2003-04 (AIHW 2005a).

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. Based on preliminary data, governments contributed about 92.6 per cent of funding for public (non-psychiatric) hospitals in 2003-04 (figure 9.1). Public (non-psychiatric) hospitals accounted for 36.3 per cent of government recurrent expenditure on health services in 2003-04 (AIHW 2005b).

Figure 9.1 **Recurrent expenditure, public (non-psychiatric) hospitals, by source of funds, 2003-04^a**



^a Based on preliminary Australian Institute of Health and Welfare (AIHW) and Australian Bureau of Statistics (ABS) estimates.

Source: AIHW (2005b).

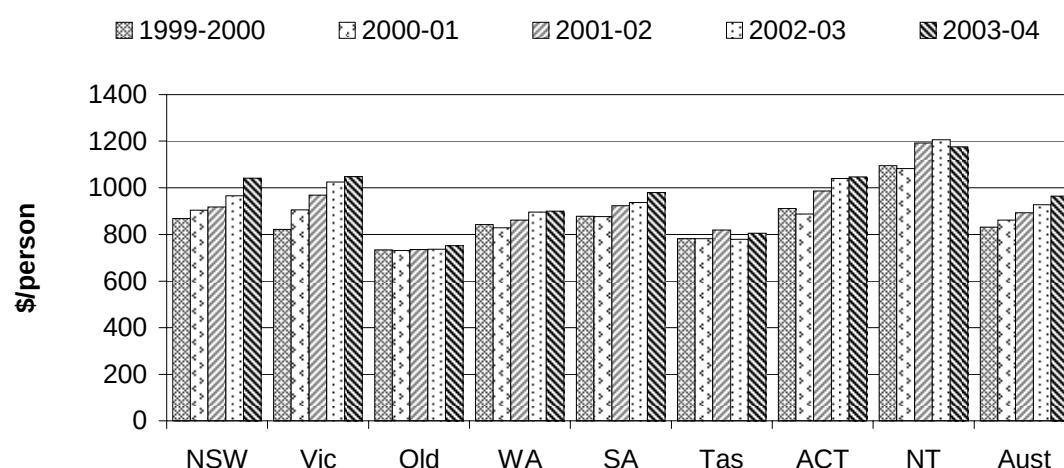
Expenditure data in figure 9.1 are from *Health Expenditure Australia* (AIHW 2005b) and are not directly comparable with other expenditure data used in this chapter, which are drawn from the *Australian Hospital Statistics* (AIHW 2005a). The data in *Health Expenditure Australia* have a broader scope than the data in the *Australian Hospital Statistics* and include some additional expenditures (such as those relating to blood transfusion services) (AIHW unpublished).

² This figure includes spending on patient transport.

For selected public hospitals, recurrent expenditure on admitted patients (based on the inpatient fraction) in 2003-04 ranged from 69.6 per cent to 77.0 per cent of total recurrent expenditure across jurisdictions (AIHW 2005a). In 2003-04, government real recurrent expenditure on public hospitals (in 2002-03 dollars) was \$964 per person for Australia, up from \$830 in 1999-2000 (figure 9.2). It is difficult to make comparisons between jurisdictions based on these recurrent expenditure data due to differences in the coverage of the data. Some of the differences are:

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

Figure 9.2 Real recurrent expenditure per person, public hospitals (including psychiatric) (2002-03 dollars)^{a, b, c, d, e, f}



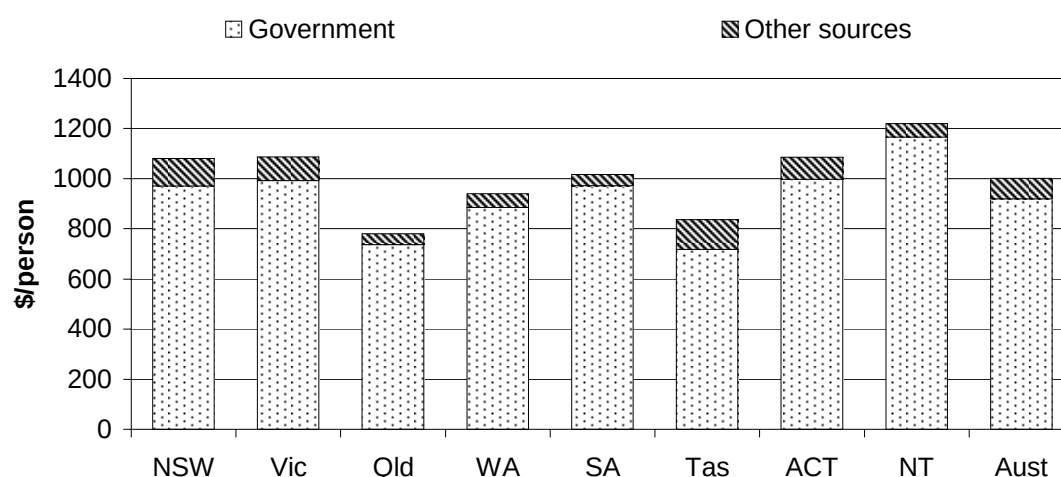
^a Expenditure data exclude depreciation and interest payments. ^b Recurrent expenditure on purchase of public hospitals services at the State, or area health service-level, from privately owned and/or operated hospitals is excluded. ^c NSW expenditure against primary and community care programs is included from 2000-01. NSW expenditure data for 2002-03 have been revised. For 2003-04, NSW hospital expenditure recorded against special purposes and trust funds is excluded. ^d Queensland expenditure on pathology services purchased from a statewide pathology service rather than being provided by hospital employees is excluded. ^e For 2000-01, data for six small Tasmanian hospitals are incomplete. For 2001-02, Tasmanian data for two small hospitals are not included and data for one small hospital are incomplete. For 2002-03, Tasmanian data for one small hospital are not included and data for five other small hospitals are incomplete. For 2003-04, Tasmanian data for five small hospitals are not included. ^f Expenditure data are deflated using the hospital/nursing home care price index from AIHW (2005b).

Source: AIHW (2005a and various years, 2005b); ABS Australian Demographic Statistics (unpublished); tables 9A.2 and A.2.

In 2003-04, public hospitals (including psychiatric hospitals) received \$1.6 billion in revenue from non-government sources — an amount that accounted for

8.2 per cent of all recurrent expenditure (excluding depreciation) (AIHW 2005a). Total revenue in each jurisdiction comprised patient revenue (including income from private and compensable patients), recoveries (including fees from private practitioners treating private patients in public hospitals, staff meals and accommodation) and other revenue (investment income, charities and bequests). Some Australian Government health insurance subsidy payments are indirectly included in non-government revenue via health insurance payments received as part of patient revenue. The proportion of hospital revenue per person funded from non-government sources varied across jurisdictions in 2003-04 (figure 9.3).

Figure 9.3 Source of public hospital funding per person, 2003-04^{a, b, c, d}



^a Expenditure excluding depreciation. ^b Includes psychiatric hospitals. ^c Tasmanian data for five small hospitals are not included. ^d Government funding is derived by subtracting other sources of funding from total expenditure on public hospitals. Other sources of funding is revenue received from non-government sources.

Source: AIHW (2005a); ABS Australian Demographic Statistics (unpublished); tables 9A.1, 9A.3 and A.2.

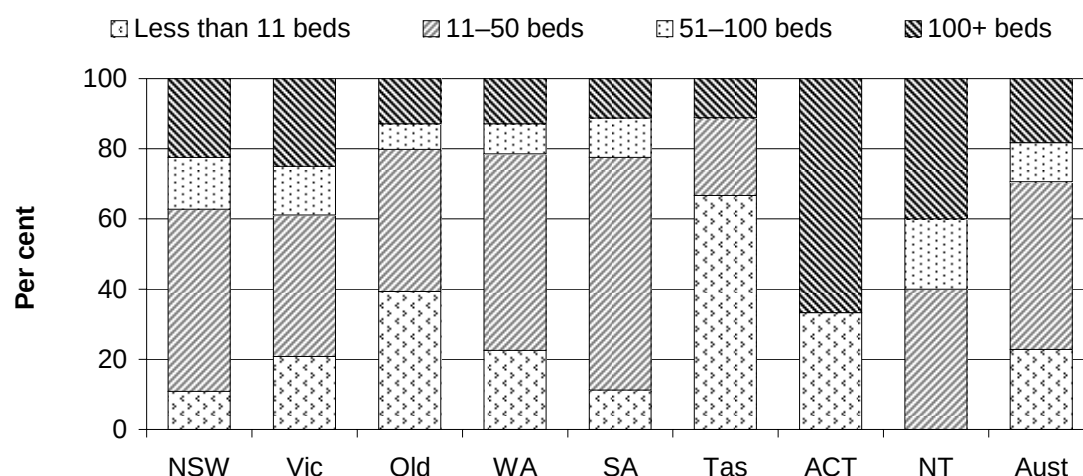
Size and scope of sector

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

Hospitals

In 2003-04, Australia had 761 public hospitals (including 20 psychiatric hospitals) (AIHW 2005a). Although 70.6 per cent of hospitals had 50 or fewer beds, these smaller hospitals represented only 18.5 per cent of total available beds (figure 9.4).

Figure 9.4 **Public hospitals, by size, 2003-04^{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 (2005a); table 9A.4.

Beds

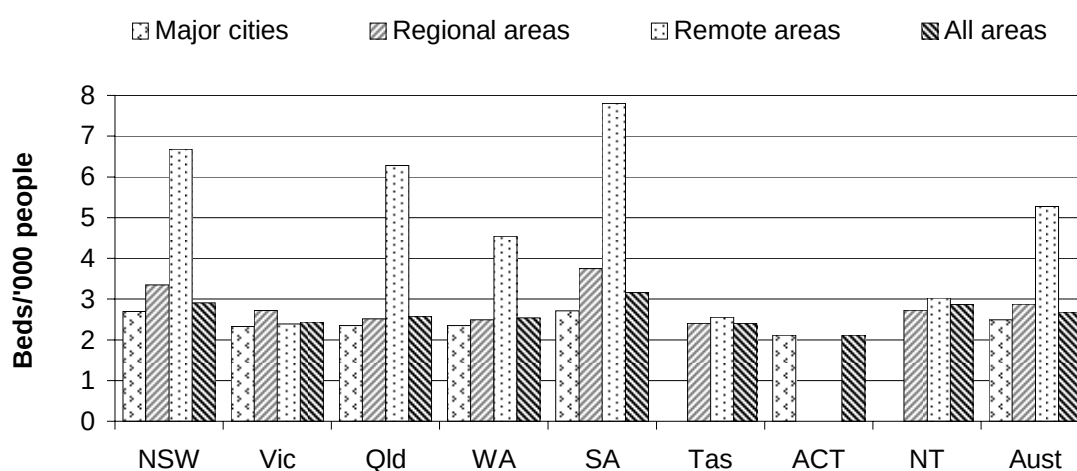
There were 53 327 available beds in public hospitals in 2003-04 (AIHW 2005a). The concept of an available bed, however, is becoming less important in the overall context of hospital activity, particularly in light of increasing same day hospitalisations and the provision of hospital-in-the-home care (AIHW 2005a).

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

Nationally, more beds were available per 1000 people in remote areas (figure 9.5), although this finding does not indicate access in remote areas to particular types of service or the distance required to travel to these services. The patterns of bed

availability may also reflect a number of factors including patterns of availability of other health care services, patterns of disease and injury and the relatively poor health of Indigenous people, who have higher population concentrations in remote areas (AIHW 2005a). These data also need to be viewed in the context of the age and sex structure (see appendix A) and the morbidity and mortality (see ‘Health preface’) of the population in each State and Territory.

Figure 9.5 Available beds, public hospitals, by location, 2003-04^{a, b, c}



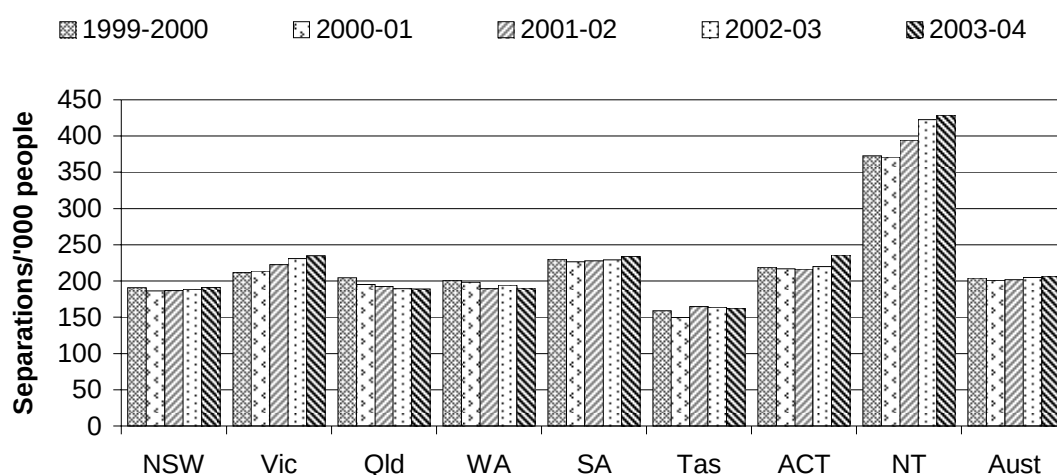
^a An 'available bed' is one that is immediately available to be used by an admitted patient. A bed is immediately available for use if it is located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period. Both occupied and unoccupied beds are included. Surgical 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 2005a). ^c Tasmania and the NT do not have major cities and the ACT does not have regional or remote areas.

Source: AIHW (2005a); table 9A.5.

Total separation rates

There were approximately 4.2 million separations from public (non-psychiatric) hospitals in 2003-04 (table 9A.6). Nationally, this translates into 206.8 separations per 1000 people (figure 9.6).

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



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

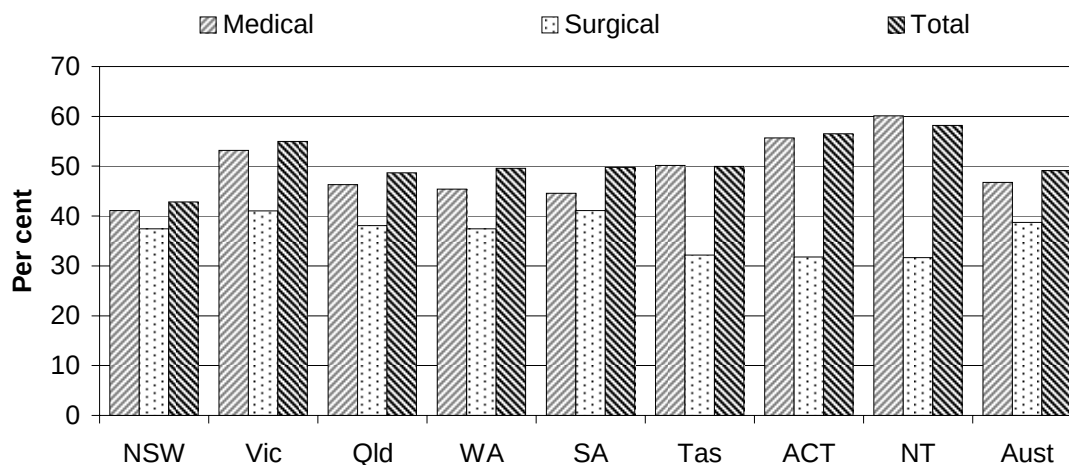
Source: AIHW (2005a and various years); table 9A.7.

Differences across jurisdictions in separation rates reflect variations in the health profiles of the people living in each State and Territory, the decisions made by medical staff about the type of care required and people's access to services other than public hospitals (for example, primary care and private hospitals). Variations in admission rates also reflect different practices in classifying patients as either admitted same day patients or outpatients.

The extent of differences in classification practices can be inferred from the variation in the proportion of same day separations across jurisdictions. Jurisdictions that have a high proportion of same day separations are likely to have a lower threshold for admitting patients, so will tend to have higher separation rates. This is particularly true of medical separations. Significant variation across jurisdictions in the proportion of same day medical separations was evident in 2003-04 (figure 9.7). Lower jurisdictional variation is likely in admission practices for surgical procedures, as reflected by the lower variability in the proportion of same day separations.

Same day separations in public (non-psychiatric) hospitals increased by 2.8 per cent between 2002-03 and 2003-04, although the proportion of same day separations remained relatively constant over this period. Overnight separations in public (non-psychiatric) hospitals increased by 2.5 per cent between 2002-03 and 2003-04 (table 9A.7).

Figure 9.7 Proportion of medical, surgical and total separations that were same day, public (non-psychiatric) hospitals, 2003-04^a



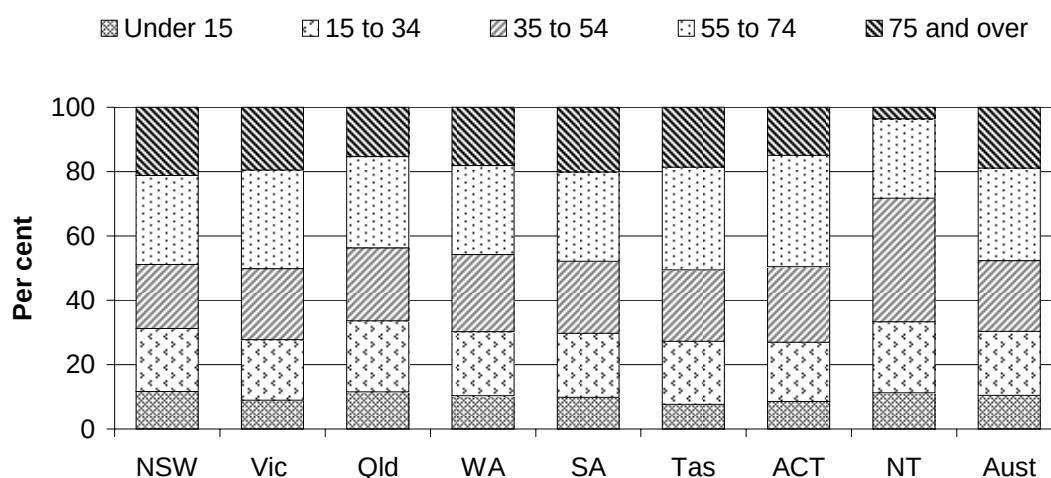
^a 'Total' includes medical, surgical, chemotherapy, radiotherapy and 'other' separations based on AR-DRG categories.

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

Separations by age group

Persons aged 55 years and over accounted for almost half of the separations in public hospitals (47.6 per cent) in 2003–04, even though they accounted for only 23.2 per cent of the estimated resident population at 31 December 2003 (figure 9.8 and AIHW 2005a). The proportion of hospital separations for this and other age groups varies across states and territories (figure 9.8). This variation largely reflects differences in the age profiles of jurisdictions (see table A.1).

Figure 9.8 Separations by age group, public hospitals, 2003-04^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 (2005a); table 9A.9.

Separation rates for Indigenous patients

Data on Indigenous patients are limited by the accuracy and extent to which Indigenous people are identified in hospital records. Identification varies across states and territories. In 1998, a pilot study in 11 hospitals found that the accuracy with which a person's Indigenous status was recorded varied greatly from hospital to hospital, ranging from 55 per cent to 100 per cent (ATSIHWIU 1999). The quality of data improved from 2000-01 because all jurisdictions used consistent definitions for Indigenous status from that year. Nevertheless, the quality of data for 2003-04 is considered acceptable only for WA, SA and the NT (AIHW 2005a). In addition, difficulties in estimating the size of the Indigenous population limit the comparability of data over time.

In 2003-04, separations for Indigenous people accounted for around 3.2 per cent of total separations in 2003-04 and 4.8 per cent of separations in public hospitals (table 9.1), but the Indigenous population made up only around 2.4 per cent of the total population. Most Indigenous separations (94 per cent) occurred in public hospitals. The low proportion of private hospital separations for Indigenous people may be due partly to a lower proportion of Indigenous patients being correctly identified in private hospitals and partly to this group's lower use of private hospitals. Data in table 9.1 need to be interpreted with care given that only data from WA, SA and the NT are considered to be of acceptable quality (AIHW 2005a).

Table 9.1 Separations, by Indigenous status and hospital sector, 2003-04^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>
Public hospital separations ('000)									
Indigenous ^b	39.6	9.2	54.0	37.3	14.5	1.8	1.5	45.1	203.0
Non-Indigenous	1 277.0	1 178.4	654.8	329.9	354.2	74.4	65.2	25.0	3 958.8
Not reported	8.9	–	12.2	–	10.5	4.7	2.3	–	38.6
Total	1 325.5	1 187.5	721.0	367.2	379.1	80.9	69.0	70.1	4 200.5
Private hospital separations ('000)									
Indigenous ^b	0.7	0.2	4.0	7.4	0.4	np	np	np	13.1
Non-Indigenous	710.7	680.6	482.4	282.8	202.9	np	np	np	2 420.2
Not reported	0.7	–	153.6	–	2.9	np	np	np	207.4
Total	712.1	680.8	640.0	290.2	206.2	np	np	np	2 640.7
Indigenous separations as proportion of total separations (%)									
Public hospitals	3.0	0.8	7.5	10.2	3.8	2.2	2.2	64.3	4.8
Private hospitals	0.1	0.0	0.6	2.5	0.2	np	np	np	0.5
All hospitals	2.0	0.5	4.3	6.8	2.5	np	np	np	3.2
Separations in public hospitals as a proportion of separations in all hospitals (%)									
Indigenous ^b	98	98	93	84	97	np	np	np	94
Non-Indigenous	64	63	58	54	64	np	np	np	62

^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 from WA, SA and the NT are considered to be of acceptable quality (AIHW 2005a). – Nil or rounded to zero. **np** Not published.

Source: AIHW (2005a); table 9A.10.

In 2003-04, on an age standardised basis, 677.6 public hospitals separations (including same day separations) for Indigenous patients were reported per 1000 Indigenous people (table 9.2). This rate was markedly higher than the corresponding rate for the total population of 207.7 per 1000 (table 9.2). Incomplete identification of Indigenous people limits the validity of comparisons over time, as well as across jurisdictions.

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

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^b</i>	<i>NT</i>	<i>Aust</i>
1999-2000									
Indigenous ^c	363.4	413.1	708.3	868.9	875.5	132.2	1 461.7	1 105.0	652.4
Total population	192.1	211.7	205.0	202.0	232.6	160.1	219.2	372.9	204.6
2000-01									
Indigenous ^c	403.8	461.4	671.6	852.2	772.6	110.6	858.0	1 031.6	637.5
Total population	187.9	213.6	195.5	199.7	228.8	150.5	217.0	370.9	201.1
2001-02									
Indigenous ^c	361.1	416.0	676.5	752.7	743.6	139.4	982.8	1 129.6	614.3
Total population	188.6	222.5	192.5	190.7	229.7	165.0	216.3	394.3	202.8
2002-03									
Indigenous ^c	406.7	476.0	685.2	809.4	788.1	173.1	1 200.0	1 223.3	657.2
Total population	190.2	231.3	189.4	195.4	231.0	164.5	219.7	422.5	205.7
2003-04									
Indigenous ^c	426.4	471.8	710.9	789.3	853.9	175.3	1 118.5	1 286.2	677.6
Total population	192.9	235.0	189.3	191.0	235.9	162.8	235.6	428.9	207.7

^a The rates are directly age standardised to the Australian population at 30 June 2001. ^b Rates reported for Indigenous people in the ACT are subject to variability, given the small Indigenous population in the jurisdiction. A high proportion of separations are for maintenance renal dialysis episodes attributable to a small number of people. ^c Identification of Indigenous patients is not considered complete and completeness varies across jurisdictions. The AIHW advised that only data from WA, SA and the NT are of acceptable quality.

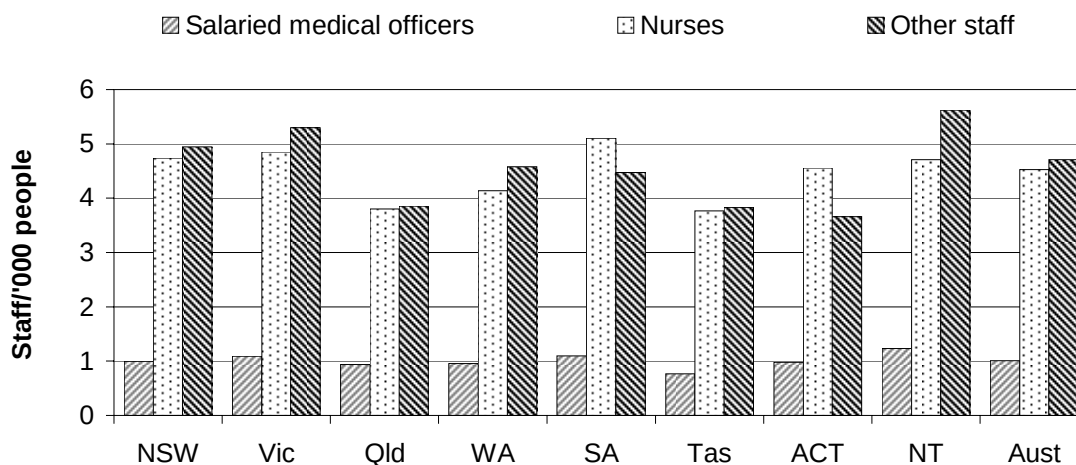
Source: AIHW (unpublished); AIHW (2005a); table 9A.11.

In previous editions of this Report, this chapter contained hospital separation ratios for Indigenous people by selected conditions such as diabetes and infectious pneumonia (see SCRGSP 2005b, pp. 9.11–9.14). Some of these data are now reported in chapter 10 against the outcome indicators ‘vaccine preventable hospitalisations’ and ‘hospitalisations for diabetes’. These data were moved as they do not signal the performance of hospitals, but do provide some indication of the outcomes of primary healthcare provided to Indigenous people.

Staff

In 2003-04, nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (4.5 per 1000 people in Australia) (figure 9.9). Comparing data on FTE staff across jurisdictions needs to be undertaken with care because these data are affected by differences across jurisdictions in the recording and classifying of staff. The outsourcing of services with a large labour related component (for example, food services and domestic services) can have a large impact on hospital staffing figures. Differences in outsourcing may explain some of the differences in FTE staff in some staffing categories and across jurisdictions (AIHW 2005a).

Figure 9.9 **Average full time equivalent staff per 1000 people, public hospitals, 2003-04**^{a, b, c, d, e, f, g}



^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 2004 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 2003 (table A.2). ^d For Victoria, FTEs may be slightly understated. ^e For Queensland, pathology services are provided by staff employed by the State pathology service and are not reported here. ^f Other personal care staff for WA excludes staff on retention who do not work regular hours. ^g Data for two small Tasmanian hospitals are not included.

Source: AIHW (2005a); ABS Australian Demographic Statistics (unpublished); tables 9A.12 and table A.2.

Activity — admitted patient care

There were around 4.2 million acute, sub-acute and non-acute separations in public hospitals in 2003-04. Of these, acute separations accounted for 95.6 per cent, newborns with some qualified days accounted for 1.1 per cent and rehabilitation care accounted for 1.7 per cent (table 9A.13).³ (Palliative care, non-acute care and other care made up the residual.) Public psychiatric hospitals accounted for around 0.4 per cent of total separations in public hospitals in 2003-04. Of the total number of separations in public (non-psychiatric) hospitals, 49.1 per cent were for same day patients (table 9A.6).

Table 9.3 shows the 10 AR-DRGs with the highest number of overnight acute separations in public hospitals for 2003-04. These 10 AR-DRGs accounted for 16.2 per cent of all overnight acute separations.

³ All babies born in hospital are admitted patients, but only qualified days for newborns are included in the patient day count under the Australian Health Care Agreements.

Table 9.3 Ten AR-DRGs (version 4.2) with the most overnight acute separations, public hospitals, 2003-04^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Separations for AR-DRGs as a proportion of all overnight acute separations (%)									
Vaginal delivery w/o complicating diagnosis	4.6	4.5	5.2	4.1	3.3	4.3	5.6	4.5	4.5
Chest pain	2.1	1.8	2.2	1.3	1.9	1.5	1.1	1.8	1.9
Oesophagitis, gastroenteritis and miscellaneous digestive system disorders age>9 w/o cat/sev cc	2.0	1.6	1.8	1.8	1.9	1.7	1.2	0.9	1.8
Cellulitis (age>59 w/o cat or sev cc) or age<60	1.2	1.2	1.6	1.6	1.0	1.0	1.4	4.3	1.3
Caesarean delivery w/o cd	1.3	1.4	1.5	1.2	1.0	1.2	1.4	1.3	1.3
Respiratory infections/inflammations w/o cc	1.3	1.1	1.3	1.2	1.0	1.1	1.5	2.2	1.2
Bronchitis and asthma age<50 w/o cc	1.1	1.0	1.0	1.3	1.3	0.6	0.8	0.8	1.1
Chronic obstructive airways disease w cat or sev cc	1.1	1.0	0.9	1.0	1.1	1.0	0.5	1.1	1.0
Abdominal pain or mesenteric adenitis w/o cc	1.1	1.0	1.0	0.9	0.8	0.9	0.8	0.5	1.0
Chronic obstructive airways disease w/o cat or sev cc	1.1	0.8	1.1	0.9	0.9	1.3	0.6	1.3	1.0
Ten AR-DRGs with the most overnight acute separations (%)	16.9	15.3	17.5	15.2	14.3	14.5	14.9	18.6	16.2
Total overnight acute separations ('000)	724	501	354	178	180	39	28	29	2 032

cat = catastrophic. cc = complications and co-morbidities. cd = complicating diagnosis. sev = severe. w/o = without. w = with. ^a Separations for which the type of episode of care was reported as 'acute' or 'newborn with qualified patient days', or was not reported. ^b Totals may not add as a result of rounding. ^c Excludes same day separations.

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

Table 9.4 lists the 10 AR-DRGs that accounted for the most patient days (17.8 per cent of all patient days recorded) in 2003-04. Schizophrenic disorders associated with involuntary mental health legal status accounted for the largest number of patient days, followed by vaginal delivery without complicating diagnosis.

Table 9.4 Ten AR-DRGs (version 4.2) with the most patient days, public hospitals, 2003-04^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Patient days for AR-DRGs as a proportion of all patient days (%)									
Schizophrenia disorders w mental health legal status	1.8	3.3	4.1	4.2	3.5	1.9	2.2	0.6	2.9
Vaginal delivery w/o complicating diagnosis	2.4	2.4	2.6	2.3	1.8	2.5	2.6	2.5	2.4
Tracheostomy any age, any condition	2.3	2.4	2.3	2.1	2.5	2.2	2.5	2.2	2.3
Major affective disorders age<70 w/o cat or sev cc	1.9	1.8	2.2	2.8	2.5	2.7	2.1	1.2	2.0
Schizophrenia disorders w/o mental health legal status	2.8	1.6	1.3	1.7	1.3	4.3	0.8	2.1	2.0
Chronic obstructive airways disease w cat or sev cc	1.7	1.5	1.4	1.6	1.7	1.6	0.8	1.4	1.6
Stroke w sev or complicating diagnosis/procedure	1.4	1.5	1.1	1.5	1.2	1.3	0.9	0.6	1.3
Heart failure and shock w/o cat cc	1.2	1.0	1.1	1.0	1.1	1.2	1.1	0.5	1.1
Caesarean delivery w/o cd	1.0	1.1	1.2	1.0	0.9	0.9	1.1	1.2	1.1
Respiratory infections/inflammations w cat cc	1.1	1.2	0.8	0.8	1.2	0.7	0.8	1.1	1.1
Ten AR-DRGs with the most patient days (%)	17.5	17.8	18.0	19.1	17.8	19.3	15.0	13.6	17.8
Total patient days ('000)	4 100	2 704	1 743	974	985	254	165	164	11 090

cat = catastrophic. cc = complications and co-morbidities. cd = complicating diagnosis. sev = severe. w/o = without. w = with. ^a Separations for which the type of episode of care was reported as 'acute' or 'newborn with qualified patient days', or was not reported. Excludes same day separations.

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

Activity — non-admitted patient services

There is no agreed classification system for services to non-admitted patients, so activity is difficult to measure and cannot be compared across jurisdictions. As well as differences in the way in which data are collected, differing admission practices lead to variation in the services reported across jurisdictions. In addition, states and territories may differ in the extent to which these types of service are provided in non-hospital settings (such as community health centres) (AIHW 2005a). Services to non-admitted patients are measured in terms of occasions of service. Differences in the complexity of the occasion of service are also not taken into account — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids (AIHW 2001a).

A total of 43.6 million individual occasions of service were provided to non-admitted patients in public hospitals in 2003-04 (table 9.5). In addition, public hospitals also delivered 440 025 group sessions during this time (a group session is

defined as a service provided to two or more patients, excluding services provided to two or more family members) (table 9A.16). In public hospitals in 2003-04, accident and emergency services comprised 13.4 per cent of all occasions of service to non-admitted patients. 'Other medical, surgical and obstetric services', 'pathology services' and 'allied health' were the most common types of outpatient care (table 9.5).

Table 9.5 Ten most common types of individual non-admitted patient care, public hospitals, 2003-04^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^b</i>	<i>Aust</i>
Occasions of service for the most common types of non-admitted patient care as a proportion of all occasions of service for non-admitted patients (%)									
Accident and emergency	10.1	18.5	14.3	13.0	21.5	11.8	22.2	27.5	13.4
Outpatient services									
Other medical/surgical/obstetric	20.7	21.4	25.2	12.7	39.9	29.6	46.8	27.0	22.3
Allied health	8.0	15.5	6.3	20.2	10.5	14.5	2.3	3.2	10.3
Pathology	12.2	10.9	27.8	14.0	..	23.1	7.8	19.7	14.9
Radiology and organ imaging	4.0	8.8	8.8	8.0	11.7	8.1	14.3	15.7	6.8
Pharmacy	4.7	5.6	7.7	3.8	..	7.4	0.1	7.0	5.1
Mental health	5.2	9.1	1.0	0.8	1.0	0.2	1.1	..	4.1
Dental	4.2	2.4	4.1	0.2	0.3	0.2	..	..	3.2
Other non-admitted services									
Community health	10.5	4.4	2.0	20.0	..	5.0	1.7	..	8.0
District nursing ^c	12.9	2.9	0.8	4.0	..	..	..	..	6.9
Ten most common types of non-admitted patient care (%)	92.5	99.6	97.9	96.8	84.8	100.0	96.2	100.0	95.0
Total occasions of service for non-admitted patients ('000)	19 661	6 951	8 742	4 460	2 142	856	438	371	43 622

^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 1 421 528 district nursing occasions of service. Their services may not be typical of district nursing. .. Not applicable

Source: AIHW (2005a); table 9A.16.

9.2 Framework of performance indicators for public hospitals

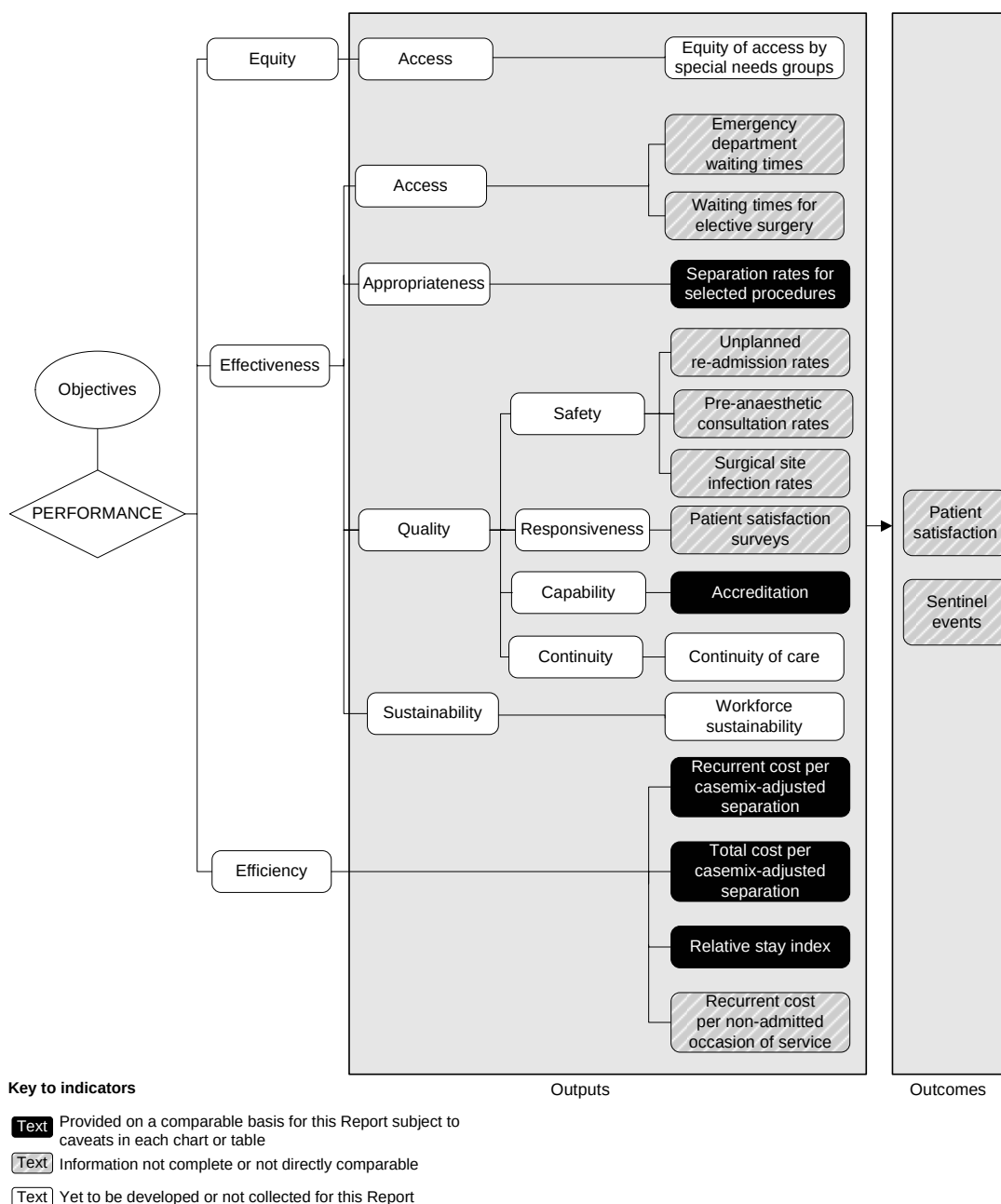
The performance indicator framework is based on the shared government objectives for public hospitals (box 9.2). The performance indicator framework shows which data are comparable in the 2006 Report (figure 9.10). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective. The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions of quality and sustainability that have been added to the standard Review framework for health services.

Box 9.2 Objectives for public hospitals

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

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

Figure 9.10 Performance indicators for public hospitals



This year, the Steering Committee has made the following revisions to the performance framework for public hospitals:

- The indicators ‘emergency department waiting times’ and ‘elective surgery waiting times’ have been moved from equity of access to effectiveness of access. Equity of access is defined in the Report in terms of access by different community groups with specific characteristics such as gender, age, disability, ethnicity or geographic location (see chapter 1). Waiting times data, therefore,

are more relevant to the ‘timeliness’ aspect of effectiveness of access, than to equity of access.

- The previously proposed equity of access indicator ‘physical access’ has been replaced with an ‘equity of access by special needs groups’ indicator. The new indicator encompasses a wider group of people who may have difficulty accessing health services, or experience poorer health outcomes, than the group covered by ‘physical access’.
- The previously proposed indicator of the safety aspect of quality ‘unplanned returns to operating theatre’ has been replaced with the ‘pre-anaesthetic consultation rates’ indicator. The ‘unplanned returns to operating theatre’ indicator was replaced as data definition problems prevented an appropriate indicator being developed. The ‘pre-anaesthetic consultation rates’ indicator was recommended for reporting by participants of a hospital quality workshop in July 2004. The workshop was organised by the Review’s Steering Committee and the Australian Council for Safety and Quality in Health Care (ACSQHC).
- The previously proposed indicator of sustainability ‘other capital quality condition’ has been replaced with the ‘workforce sustainability’ indicator. The ‘other capital quality condition’ indicator was replaced as it has not been possible to develop a meaningful data definition and identify a suitable data source.
- Two indicators of public hospital outcomes have been added to the framework. The indicators are ‘sentinel events’ and ‘patient satisfaction’. Both new indicators are reported on a non-comparable basis. This is the first edition of the Report to include indicators of public hospital outcomes (although the Report has included outcomes indicators for maternity services for some time).

9.3 Key performance indicator results for public hospitals

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

As discussed in section 9.1, public hospitals provide a range of services to admitted patients, including some non-acute services such as rehabilitation and palliative care. The extent to which these non-acute treatments can be identified and excluded as desired from the analysis of some data differs across jurisdictions. Similarly,

psychiatric treatments are provided in public (non-psychiatric) hospitals at different rates across jurisdictions.

Outputs — equity — access

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

Equity of access by special needs groups

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

Box 9.3 Equity of access by special needs groups

An indicator of equity of access by special needs groups to public hospitals is yet to be developed.

Outputs — effectiveness — access

Emergency department waiting times

‘Emergency department waiting times’ are an indicator of effectiveness of access to public hospitals (box 9.4). Nationally, in 2003-04, 99.3 per cent of patients were seen within the triage category 1 timeframe and 76.0 per cent of patients were seen within the triage category 2 timeframe. For all triage categories, 72.1 per cent of patients were seen within triage category timeframes (table 9.6). The comparability of these data across jurisdictions may be influenced by differences in data coverage.

Box 9.4 **Emergency department waiting times**

‘Emergency department waiting times’ measure 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 may vary across jurisdictions as a result of differences in clinical practices (for example, the allocation of cases to urgency categories). The proportion of patients in each triage category who were subsequently admitted may indicate the comparability of triage categorisations across jurisdictions and thus the comparability of the waiting times data (table 9A.17).

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

Table 9.6 Emergency department patients seen within triage category timeframes, public hospitals, 2003-04 (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	100.0	99.6	99.9	99.2	99.2	96.0	99.9	100.0	99.3
2 — Emergency	75.5	87.7	75.7	74.1	61.6	66.8	68.8	57.3	76.0
3 — Urgent	58.3	82.6	54.8	71.9	41.1	61.3	63.5	63.0	62.1
4 — Semi-urgent	64.7	74.6	56.4	74.7	49.0	61.3	58.2	59.3	61.3
5 — Non-urgent	85.9	89.5	84.4	97.2	87.0	92.1	77.3	85.8	81.5
Total	66.5	80.4	60.0	80.1	50.4	64.1	65.4	64.0	72.1
Data coverage: proportion of emergency department occasions of service with waiting times data ^b	72.2	81.0	61.2	100.0	65.7	80.4	94.2	92.1	74.9

^a Resuscitation patients whose waiting time for treatment was less than or equal to two minutes are considered to have been seen on time, except for SA. For that State, data on the proportion of resuscitation patients seen on time were only available calculated using a cut-off point of one minute. ^b Data coverage is estimated as the number of occasions of service with valid waiting times data divided by the number of emergency department occasions of service as a percentage. This may underestimate coverage because some occasions of service are for other than emergency presentations, for which waiting times are applicable. However, because occasions of service may have been under-enumerated for some jurisdictions and peer groups, coverage may also be overestimated.

Source: AIHW (2005a); table 9A.17.

Waiting times for elective surgery

‘Waiting times for elective surgery’ are an indicator of effectiveness of access to public hospitals (box 9.5). Two measures of this indicator are reported: ‘overall elective surgery waiting times’ and ‘elective surgery waiting times by clinical urgency category’. These two measures are affected by variations across jurisdictions in the method used to calculate waiting times for patients who:

- changed clinical urgency category while on the waiting list
- transferred from a waiting list managed by one hospital to a waiting list managed by a different hospital (AIHW 2005a).

Box 9.5 **Waiting times for elective surgery**

'Waiting times for elective surgery' is an indicator of access to hospital services. Two measures are reported:

- 'overall elective surgery waiting times'
- 'elective surgery waiting times by clinical urgency category'.

'Overall elective surgery waiting times' are calculated by comparing the date on which patients are added to a waiting list with the date on which they are admitted. Days on which the patient was not ready for care are excluded. 'Overall waiting times' is 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.

'Elective surgery waiting times by clinical urgency category' shows the proportion of patients who wait longer than the clinically desirable time before being admitted. Reporting of 'elective surgery waiting times by clinical urgency category' shows both the time waited for surgery by patients on waiting lists at particular census dates, as well as the time waited to admission. Public hospital census data reflect the proportion of patients waiting on the date of the census who had been waiting an extended period. Census data do not represent the completed waiting time of patients. 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.

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 2005a). In 2003-04, 14.4 per cent of patients were removed from waiting lists for reasons other than admission (AIHW 2005a).

'Elective surgery waiting times by clinical urgency category' cannot be compared across jurisdictions because there are systematic differences in the assignment of patients to urgency categories. This measure has the advantage, however, of aligning with the objective of providing hospital services within a clinically desirable period.

Not all elective surgery is covered by this measure. The measure does not fully cover all the in-scope procedures (87 per cent in 2003-04), and the in-scope procedures are defined as excluding a range of procedures that may be regarded as surgery, such as elective procedures involving the insertion of a stent.

For patients who changed clinical urgency category, all jurisdictions except SA counted the period in the most recent urgency category plus any time waited in more urgent categories. SA counted the total waiting time in all urgency categories. This approach has the effect of increasing the apparent waiting time for admissions in SA compared with other jurisdictions for patients who move to a list of lower urgency category.

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 2005a). NSW, Victoria, Queensland, WA and the ACT reported the total time waited on all waiting lists. This approach may have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions. SA and Queensland have indicated that patients do not commonly switch between waiting lists managed by different hospitals in their jurisdictions (AIHW 2005a).

Nationally, in 2003-04, 90 per cent of patients were admitted within 193 days and 50 per cent were admitted within 28 days (table 9.7). The proportion of patients that waited more than a year was 3.9 per cent. Nationally, waiting times at the 50th percentile changed little between 1999-2000 and 2003-04. In 1999-2000, 27 days were waited at the 50th percentile, this increased to 28 days by 2003-04. However, there were different trends in different jurisdictions over that period (figure 9.11).

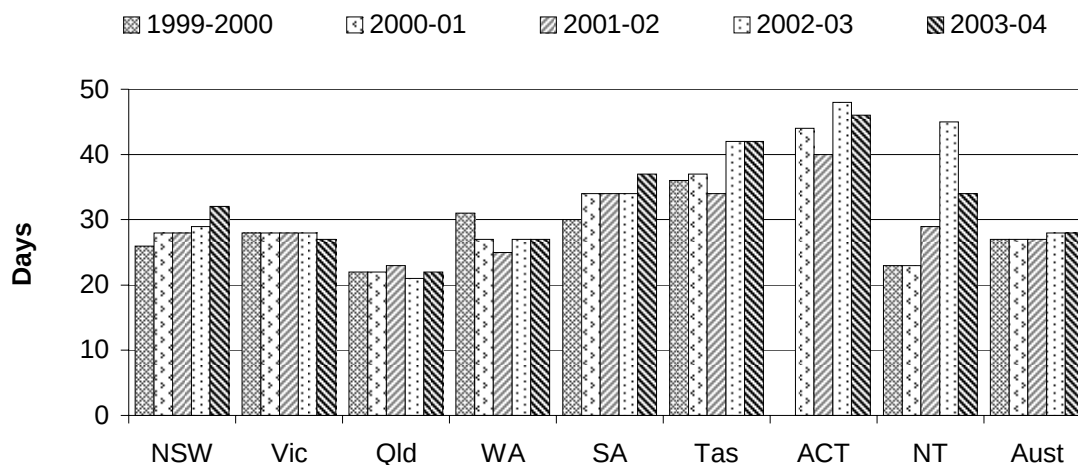
Table 9.7 Elective surgery waiting times, public hospitals, 2003-04

	<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.	32	27	22	27	37	42	46	34	28
90th percentile	no.	222	175	115	200	201	372	373	245	193
Proportion who waited more than 365 days	%	4.1	3.3	2.8	4.0	3.8	10.3	10.4	5.3	3.9
Estimated coverage of elective surgery separations ^a	%	100	78	96	76	64	100	100	100	87

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

Source: AIHW (2005a); table 9A.18.

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



^a ACT data for 1999-2000 are not available.

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

‘Elective surgery waiting times by urgency category’ are not comparable across jurisdictions because clinicians have systematically different approaches to categorisation by urgency. States and territories with lower proportions of patients in category 1 were also the states and territories that had relatively smaller proportions of patients in this category that were ‘not seen on time’. Victoria and the ACT, for example, had the lowest proportions of patients in category 1 and also had the lowest proportions of patients in category 1 that had extended waits (tables 9.8, 9A.21 and 9A.30). The apparent variation in performance thus appears to be related to the classification practices employed. Jurisdictional differences in the classification of patients by urgency category in 2003-04 are shown in table 9.8.

Table 9.8 Classification of elective surgery patients, by clinical urgency category, 2003-04 (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	na	1.9	7.4	5.8	7.2	na	3.1	6.6
Category 2	na	40.4	31.0	28.8	19.7	na	43.1	35.0
Category 3	na	57.8	61.6	65.5	73.1	na	53.8	58.4
Total^a	na	100.0	100.0	100.1	100.0	na	100.0	100.0
Patients admitted from waiting lists								
Category 1	na	20.8	35.8	33.9	33.1	na	34.2	36.9
Category 2	na	46.4	43.1	24.9	24.1	na	41.5	36.7
Category 3	na	32.8	21.1	41.2	42.8	na	24.3	26.4
Total^a	na	100.0	100.0	100.0	100.0	na	100.0	100.0

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

Source: State and Territory governments (unpublished).

Data were not available from all jurisdictions for 'elective surgery waiting times by clinical urgency category' for this Report. Jurisdictions that provided data for this Report were Victoria, Queensland, WA, SA, the ACT and the NT. No data were provided by NSW or Tasmania.

- Public hospital census data for Victoria at 30 June 2004 suggest that 0.1 per cent of category 1 patients on the waiting list were subject to extended waits, as were 43.3 per cent of category 2 patients and 24.8 per cent of category 3 patients, resulting in an overall rate of 31.8 per cent for all patients. Of patients admitted to hospital from waiting lists in 2003-04, no category 1 patients were subject to extended waits, 20.4 per cent of category 2 patients and 7.5 per cent of category 3 patients were subject to extended waits, resulting in an overall rate of 11.9 per cent for all patients (table 9A.21).
- Public hospital census data for Queensland at 1 July 2004 suggest that 1.1 per cent of category 1 patients on the waiting list were subject to extended waits, as were 2.3 per cent of category 2 patients and 34.1 per cent of category 3 patients, resulting in an overall rate of 21.8 per cent for all patients. Of patients admitted to hospital from waiting lists in 2003-04, 9.5 per cent of category 1 patients were subject to extended waits, as were 10.1 per cent of category 2 patients and 12.7 per cent of category 3 patients, resulting in an overall rate of 10.5 per cent for all patients (table 9A.23).
- Public hospital census data for WA at 30 June 2004 suggest that 37.5 per cent of category 1 patients on the waiting list were subject to extended waits, as were 47.2 per cent of category 2 patients and 23.5 per cent of category 3 patients, resulting in an overall rate of 31.1 per cent for all patients. Of patients admitted to hospital from waiting lists in 2003-04, 16.4 per cent of category 1 patients

were subject to extended waits, as were 28.7 per cent of category 2 patients and 7.4 per cent of category 3 patients, resulting in an overall rate of 15.8 per cent for all patients (table 9A.25).

- Public hospital census data for SA at 30 June 2004 suggest that 27.1 per cent of category 1 patients on the waiting list were subject to extended waits, as were 26.0 per cent of category 2 patients and 20.7 per cent of category 3 patients, resulting in an overall rate of 22.2 per cent for all patients. Of patients admitted to hospital from waiting lists in 2003-04, 17.6 per cent of category 1 patients were subject to extended waits, as were 18.6 per cent of category 2 patients and 6.2 per cent of category 3 patients, resulting in an overall rate of 13.0 per cent for all patients (table 9A.27).
- Public hospital census data for the ACT at 30 June 2004 suggest that no category 1 patients on the waiting list were subject to extended waits, whereas 57.4 per cent of category 2 patients and 42.6 per cent of category 3 patients were subject to extended waits, resulting in an overall rate of 39.1 per cent for all patients. Of patients admitted from waiting lists in 2003-04, 2.8 per cent of category 1 patients were subject to extended waits, as were 72.0 per cent of category 2 patients and 25.2 per cent of category 3 patients, resulting in an overall rate of 27.3 per cent for all patients (table 9A.30).
- Public hospital census data for the NT at 30 June 2004 suggest that 41.9 per cent of category 1 patients on the waiting list were subject to extended waits, as were 55.8 per cent of category 2 patients and 34.7 per cent of category 3 patients resulting in an overall rate of 42.6 per cent for all patients. Of patients admitted from waiting lists in 2003-04, 19.0 per cent of category 1 patients were subject to extended waits, as were 30.5 per cent of category 2 patients and 14.8 per cent of category 3 patients, resulting in an overall rate of 22.1 per cent for all patients (table 9A.32).

For more information on 'elective surgery waiting times by urgency category', see DHA (2004b). Attachment 9A also includes data on 'elective surgery waiting times' by hospital peer group, specialty of surgeon and indicator procedure (tables 9A.18, 9A.19 and 9A.20). Victoria, Queensland, WA, SA, the ACT and the NT also provided data on urgency category waiting times by clinical specialty for 2003-04 (tables 9A.22, 9A.24, 9A.26, 9A.28, 9A.31 and 9A.33).

Outputs — effectiveness — appropriateness

Separation rates for selected procedures

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

Box 9.6 Separation rates for selected procedures

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

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

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

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

The ‘separation rates for selected procedures’ reported here include all hospitals and reflect the activities of both public and private health systems.⁴ The most common procedures in 2003-04 were caesarean sections, endoscopies, lens insertions, and arthroscopic procedures (table 9.9). For all procedures, separation rates varied across jurisdictions. Statistically significant and material differences in the separation rates for these procedures may highlight variations in treatment methods across jurisdictions. Table 9A.34 presents standardised separation rate ratios —

⁴ Data include public acute, public psychiatric, private acute, private psychiatric and private free-standing day hospital facilities. Some private hospitals are not included, which may result in undercounting of some procedures, particularly procedures more likely to be performed in private hospitals (AIHW 2005a).

comparing the separation rate in each jurisdiction with the national rate — along with confidence intervals for each ratio.

Table 9.9 Separations per 1000 people, all hospitals, by selected procedure or diagnosis, 2003-04^{a, b, c, d}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total^e</i>
<i>Procedure/diagnosis</i>									
Appendectomy	1.3	1.3	1.5	1.6	1.3	1.2	1.3	1.4	1.3
Coronary artery bypass	0.8	0.8	0.8	0.5	0.7	0.7	0.4	1.1	0.7
Coronary angioplasty	1.6	1.7	1.2	1.4	1.3	1.2	1.6	1.1	1.5
Caesarean section: separation rate	3.5	3.6	4.1	4.1	3.8	3.4	3.0	4.3	3.7
separations per 100 in-hospital births ^f	27.1	29.2	30.7	32.3	30.6	26.2	25.3	29.7	29.1
Cholecystectomy	2.2	2.3	2.4	2.1	2.5	2.2	2.2	1.6	2.3
Diagnostic gastrointestinal endoscopy	25.1	32.2	29.6	25.7	24.7	19.4	14.5	19.4	27.4
Hip replacement	1.3	1.5	1.2	1.5	1.4	1.5	1.6	1.0	1.4
Revision of hip replacement	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.1	0.2
Hysterectomy ^g	1.3	1.3	1.5	1.7	1.7	1.7	1.5	1.2	1.4
Lens insertion	7.7	7.0	8.5	7.9	6.4	4.2	6.7	7.6	7.5
Tonsillectomy	1.6	1.7	1.7	1.8	2.3	0.9	1.1	0.9	1.7
Myringotomy	1.3	1.9	1.4	2.2	2.9	1.1	1.0	0.7	1.6
Knee replacement	1.5	1.2	1.4	1.5	1.4	1.2	1.9	0.8	1.4
Prostatectomy	1.1	1.5	1.1	1.2	1.1	1.4	1.1	1.3	1.2
Arthroscopic procedures ^h	4.8	5.9	4.5	7.1	8.7	4.9	6.0	8.1	5.6

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

Source: AIHW (2005a); table 9A.34.

Outputs — effectiveness — quality

There is no single definition of quality in healthcare, but the Institute of Medicine in the United States defines quality as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (Lohr and Shroeder 1990). No single indicator can measure quality across all providers. An alternative strategy is to identify and report on *aspects* of quality of care. The aspects of quality

recognised in the performance indicator framework are safety, responsiveness, capability and continuity. Data are reported against all of these aspects except continuity.

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

Various states and territories publicly report performance indicators for public hospital quality. Some have adopted the same indicators as reported here. In NSW, for example, reporting of Australian Council on Health Care Standards (ACHS) 'surgical site infection rates' is mandatory for public hospitals. Both the WA and Tasmanian health department annual reports include information on 'unplanned re-admission rates'. All Victorian hospitals are required to publish annual quality care reports that include safety and quality indicators for infection control, medication errors, falls monitoring and prevention, and pressure wound monitoring and prevention. All Australian health ministers agreed to the establishment of the ACSQHC in January 2000, with a view to taking a systematic approach to assessing and improving the quality of healthcare. The ACSQHC will be replaced in January 2006 by the Australian Commission on Safety and Quality in Health Care.

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, Brennan *et al.* 1991; Wilson *et al.* 1995; Thomas *et al.* 2000; and Davis *et al.* 2001). These adverse events can result in serious consequences for individual patients, and the associated costs can be considerable (Kohn *et al.*, 1999).

Data for the 'safety' indicators come from the ACHS Comparative Report Service (Clinical Indicators). The ACHS data are collected for internal clinical review by individual hospitals. They are predominantly used to demonstrate the potential for improvement across Australian hospitals, if all hospitals could achieve the same outcomes as the hospitals that achieve the best outcomes for patients. When interpreting results of these indicators, emphasis needs to be given to the potential for improvement. Statewide conclusions cannot be drawn because participation by public hospitals in the Comparative Report Service (Clinical Indicators) is generally voluntary, so the data are not necessarily drawn from representative samples of hospitals (box 9.7).

Box 9.7 **Reporting of ACHS clinical indicators**

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

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

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

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

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

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

Box 9.8 Unplanned re-admission rates

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

The aim is to measure unintentional additional hospital care. Patients might be re-admitted unexpectedly if the initial care or treatment was ineffective or unsatisfactory, if post-discharge planning was inadequate, or for other reasons outside the control of the hospital, for example poor post-discharge care.

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

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

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

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

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

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

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

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

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

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

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

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

stratum rate: mean rates for a particular jurisdiction.

Source: ACHS (2001).

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2004, the mean rate of ‘unplanned re-admissions’ was 2.8 per 100 admissions (table 9.10). The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th

centile, there would be 1.9 per cent (or 20 609) fewer re-admissions to these public hospitals (ACHS unpublished). National performance at the 20th centile (0.9 per cent) shows the rate which the best performing 20 per cent of ACHS reporting hospitals are performing at or below.

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 2004 are shown in table 9.10. The coverage of the ACHS data may differ across these states. For future reports, the Steering Committee will work to provide an indicative measure of what proportion of each state’s separations are covered by the data. Data for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals reported ‘unplanned re-admissions’ in each of those jurisdictions.

Table 9.10 **Unplanned re-admissions, ACHS reporting public hospitals, 2004^a**

	<i>Unit</i>	<i>Results</i>
National rate	%	2.8
National performance at 80th centile (rate)	(%)	4.8
National performance at 20th centile (rate)	(%)	0.9
<i>New South Wales</i>		
Numerator (re-admissions)	no.	12 954
Denominator (separations)	no.	395 528
Rate	%	3.3
Standard error (±)		0.2
ACHS reporting hospitals	no.	60
<i>Victoria</i>		
Numerator (re-admissions)	no.	8 910
Denominator (separations)	no.	294 183
Rate	%	3.0
Standard error (±)		0.2
ACHS reporting hospitals	no.	34
<i>Queensland</i>		
Numerator (re-admissions)	no.	3 679
Denominator (separations)	no.	111 542
Rate	%	3.3
Standard error (±)		0.3
ACHS reporting hospitals	no.	10
<i>Western Australia</i>		
Numerator (re-admissions)	no.	1 563
Denominator (separations)	no.	119 846
Rate	%	1.3
Standard error (±)		0.3
ACHS reporting hospitals	no.	25
<i>South Australia</i>		
Numerator (re-admissions)	no.	1 219
Denominator (separations)	no.	44 087
Rate	%	2.8
Standard error (±)		0.5
ACHS reporting hospitals	no.	11

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

Source: ACHS (unpublished); tables 9A.35; 9A.36, 9A.37; 9A.38 and 9A.39.

Safety — pre-anaesthetic consultation rates

‘Pre-anaesthetic consultation rates’ are an indicator of hospital safety (box 9.10). This indicator is reported for the first time this year. Pre-anaesthetic consultation rate estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are particularly unreliable. The statistical terms used to describe this indicator are explained in box 9.9.

Box 9.10 Pre-anaesthetic consultation rates

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

The ‘pre-anaesthetic consultation rate’ is the total number of procedures where there is documented evidence of a pre-anaesthetic consultation 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.

Source: ACHS (2002).

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2004, the mean rate of ‘pre-anaesthetic consultations’ was 88.2 per 100 procedures (table 9.11). The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 80th centile, there would be 11.8 per cent (or 7602) more pre-anaesthetic consultations in these public hospitals (ACHS unpublished). National performance at the 80th centile shows the rate which the best performing 20 per cent of ACHS reporting hospitals are performing at or above.

For jurisdictions with more than five hospitals reporting ‘pre-anaesthetic consultations’ to the ACHS Comparative Report Service, the mean rates in 2004 are shown in table 9.11. The coverage of the ACHS data may differ across these states. For future reports, the Steering Committee will work to provide an indicative measure of what proportion of each state’s procedures are covered by the data. Data for Queensland, WA, Tasmania, the ACT and the NT are not reported separately

because fewer than five hospitals reported ‘pre-anaesthetic consultations’ in each of those jurisdictions. Results for Queensland in 2003 are shown in table 9A.42.

Table 9.11 **Pre-anaesthetic consultation rates, ACHS reporting public hospitals, 2004^a**

	<i>Unit</i>	<i>Results</i>
National rate	%	88.2
National performance at 80th centile (rate)	(%)	100.0
National performance at 20th centile (rate)	(%)	92.1
<i>New South Wales</i>		
Numerator (pre-anaesthetic consultations)	no.	29 123
Denominator (procedures)	no.	29 175
Rate	%	99.8
Standard error ($\pm$)		2.2
ACHS reporting hospitals	no.	13
<i>Victoria</i>		
Numerator (pre-anaesthetic consultations)	no.	9 112
Denominator (procedures)	no.	9 462
Rate	%	96.3
Standard error ($\pm$)		3.9
ACHS reporting hospitals	no.	11
<i>South Australia</i>		
Numerator (pre-anaesthetic consultations)	no.	6 199
Denominator (procedures)	no.	6 290
Rate	%	98.6
Standard error ($\pm$)		4.7
ACHS reporting hospitals	no.	6

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

Source: ACHS (unpublished); tables 9A.40; 9A.41 and 9A.43.

Safety — surgical site infection rates

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

Box 9.11 Surgical site infection rates

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

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

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

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2004, the mean 'surgical site infection rate' for hip prosthesis surgery was 2.8 per 100 separations. The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 0.1 per cent (or 1) fewer infections after hip prosthesis surgery in these public hospitals (ACHS unpublished). National performance at the 20th centile shows the rate which the best performing 20 per cent of ACHS reporting hospitals are performing at or below.

The mean 'surgical site infection rate' following knee prosthesis surgery was 1.7 per 100 separations. The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 0.7 per cent (or 17) fewer infections following knee prosthesis surgery in these public hospitals (ACHS unpublished).

The mean 'surgical site infection rate' following lower segment caesarean section surgery was 1.8 per 100 separations. The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 0.8 per cent (or 62) 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 2.2 per 100 separations. The ACHS estimated that if the performance of all Australian public hospitals matched national performance at the 20th centile, there

would be 0.9 per cent (or 7) 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 2004 are shown in table 9.12. The coverage of the ACHS data may differ across these states. For future reports, the Steering Committee will work to provide an indicative measure of what proportion of each state's procedures are covered by the data. 'Surgical site infection rates' for WA, SA, Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals participated in the ACHS Comparative Report Service.

Table 9.12 Surgical site infections, ACHS reporting public hospitals, by selected procedure, 2004^{a, b}

	Unit	Hip prosthesis	Knee prosthesis	Lower segment caesarean section	Abdominal hysterectomy
National rate	%	2.8	1.7	1.8	2.2
National performance at 80th centile (rate)	(%)	2.9	2.0	2.5	3.4
National performance at 20th centile (rate)	(%)	2.8	1.0	1.0	1.2
New South Wales					
Numerator (infections)	no.	11	2	13	np
Denominator (procedures)	no.	361	357	1 071	np
Infection rate	%	3.0	0.6	1.2	np
Standard error (±)		—	0.4	0.4	np
ACHS reporting hospitals	no.	8	7	9	np
Victoria					
Numerator (infections)	no.	np	np	10	2
Denominator (procedures)	no.	np	np	877	134
Infection rate	%	np	np	1.1	1.5
Standard error (±)		np	np	0.4	0.6
ACHS reporting hospitals	no.	np	np	6	6
Queensland					
Numerator (infections)	no.	15	12	46	10
Denominator (procedures)	no.	693	729	3 333	356
Infection rate	%	2.2	1.6	1.4	2.8
Standard error (±)		—	0.3	0.2	0.4
ACHS reporting hospitals	no.	11	11	10	8

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

Source: ACHS (unpublished); tables 9A.44, 9A.45, 9A.46.

Responsiveness — patient satisfaction surveys

The use of ‘patient satisfaction surveys’ is an indicator of responsiveness in public hospitals (box 9.12). Table 9.13 lists some recent years in which patient satisfaction surveys were conducted in each State and Territory. In previous editions of this Report, *results* of patient satisfaction surveys were included under this indicator.

These data are now reported against the new outcome indicator ‘patient satisfaction’. This section now reports how jurisdictions *use* patient satisfaction surveys to improve the quality of public hospital services.

Box 9.12 Patient satisfaction surveys

‘Patient satisfaction surveys’ assist in assessing the performance of hospitals in their delivery of clinical and non-clinical services. They can be useful for obtaining information on patient views of hospital care, such as whether patients feel they were treated with respect and provided with appropriate information regarding their treatment.

This indicator provides information on whether, and when, jurisdictions have conducted patient satisfaction surveys in recent years. The more frequently patient satisfaction surveys are conducted the more responsive the public hospital system can be to the needs of patients. Information on how jurisdictions used patient satisfaction surveys to improve public hospitals quality is also provided.

Table 9.13 Patient satisfaction surveys conducted during period

	NSW ^a	Vic	Qld	WA	SA	Tas	ACT	NT
2002-03	✓	✓	✗	✓	✓	✓	✓	✗
2003-04	✓	✓	✗	✓	✓	✗	✗	✗
2004-05	✓	✓	✓	✓	✓	✓	✓	✓

^a NSW surveys are conducted during the calendar year (for example 2002-03, is 2002).

Source: State and Territory governments; SCRGSP (2004, 2005b).

This is the first edition of this Report to present information on how patient satisfaction surveys are used to improve the quality of public hospital services. Some jurisdictions have provided general information. Over time this information will be refined to identify more specific examples of how public hospital quality has improved. Jurisdictions provided the following information in relation to their most recent survey:

- In NSW, ongoing monitoring of patient satisfaction with services and understanding reasons for poor ratings provides information that assists health managers and planners to develop, implement and evaluate health services within the community (table 9A.62).
- In Victoria, each public hospital receives a detailed individual report. The reports are used by health service quality and safety managers and committees to identify areas that are most likely to benefit from quality improvement initiatives. Some hospitals also communicate data from the reports to their local community (table 9A.63).

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- In Queensland, data analysis of a survey targeting admitted patients is currently in progress. Hospital reports will be available in November and will identify areas for improvement (table 9A.64).
 - In WA, participating hospitals receive detailed information from the survey which they used to inform service improvement. Hospitals can request a workshop to assist in the interpretation of the results so that the best use can be made of them. Many hospitals also use patient satisfaction as a performance indicator (table 9A.65).
 - In SA, the survey results were used to:
 - provide a detailed report to all SA health service regions, public hospitals and mental health units, so that improvement to patient care and services can be addressed. This report included comparisons with the 2003 overnight patients survey
 - provide hospital specific feedback (where numbers permit) via presentations to individual hospitals as requested
 - present to the Mental Health Director's Forum
 - provide feedback to the Safety and Quality Council (table 9A.66).
 - In Tasmania, a report was produced for each public hospital that was broken down to the ward level. Quality Managers will undertake further qualitative research to further investigate potential areas of concern (table 9A.67).
 - In the ACT, the survey results provided input to discussions at various quality and safety committees. Elements of the results were taken up in safety programs, for example, medication received in a timely manner has been incorporated into the medication safety program and discharge issues are being addressed in various aspects of the discharge process. Additionally, the advising of patients on their rights and responsibilities, and how they can make a complaint, is ongoing (table 9A.68).
 - In the NT, surveys conducted in various hospitals were used to:
 - develop a recommendation that information to patients be provided in a culturally appropriate format to allow for the large number of patients for whom English is a second language
 - improve the quality of one hospital's menu
 - improve the quality of a hospital's pathology service — more information has been provided regarding the possibility of fainting and/or bruising after a blood sample has been taken, and blankets are now available for patients who are affected by the air conditioning (table 9A.69).

Capability — hospital accreditation

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

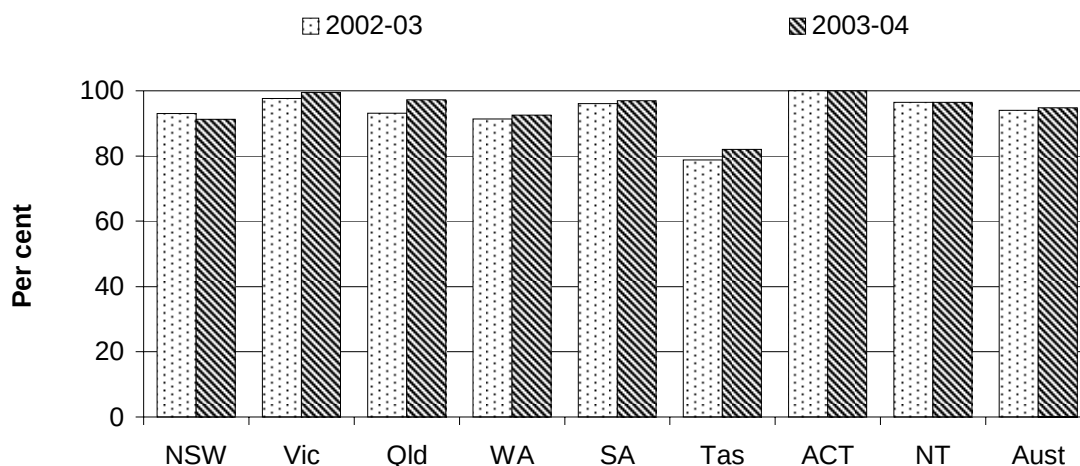
Box 9.13 Accreditation

‘Accreditation’ signifies professional and national recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals may seek accreditation through the ACHS Evaluation and Quality Improvement Program, 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. Jurisdictions apply specific criteria to determine which accreditation programs are suitable. Quality programs require hospitals to demonstrate continual adherence to quality improvement standards to gain and retain accreditation.

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

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

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



^a Where average available beds for the year were not available, bed numbers at 30 June 2004 were used.

^b Includes psychiatric hospitals.

Source: AIHW (2004, 2005a); table 9A.47.

Continuity — continuity of care

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

Box 9.14 Continuity of care

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

Outputs — effectiveness — sustainability

Workforce sustainability

The Steering Committee has identified ‘workforce sustainability’ as an indicator of public hospital sustainability (box 9.15). This indicator is for development in future reports.

Box 9.15 Workforce sustainability

The Steering Committee has agreed to develop an indicator of 'workforce sustainability' as a measure of the capacity of the public hospital workforce to respond to emerging needs.

Outputs — efficiency

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

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

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

The results reported in the study for public hospitals indicate that different methods of asset measurement could lead to quite large variations in reported capital costs. Considered in the context of total unit costs, however, the differences created by these asset measurement effects were relatively small because capital costs represent a small proportion of total cost, although the differences may affect cost rankings across jurisdictions. A key message from the study was that the adoption

of nationally uniform accounting standards across all service areas would be a desirable outcome. The results are discussed in more detail in chapter 2.

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

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

Recurrent cost per casemix-adjusted separation

‘Recurrent cost per casemix-adjusted separation’ is an indicator of the efficiency of public hospitals (box 9.16). ‘Recurrent cost per casemix-adjusted separation’ data are presented in figure 9.13.

Box 9.16 Recurrent cost per casemix-adjusted separation

The ‘recurrent cost per casemix-adjusted separation’ is a proxy indicator of efficiency in treating admitted patients. It measures the average cost of providing care for an admitted patient (overnight stay or same day) adjusted with AR-DRG cost weights for the relative complexity of the patient’s clinical condition and of the hospital services provided (AIHW 2000).

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

All admitted patient separations and their costs are included, and most separations are for acute care. Cost weights are not available for admitted patients who received non-acute care (about 3.0 per cent of total admitted patient episodes in 2003-04), so the cost weights for acute care are applied to non-acute separations also. The admitted patient cost proportion is an estimate only.

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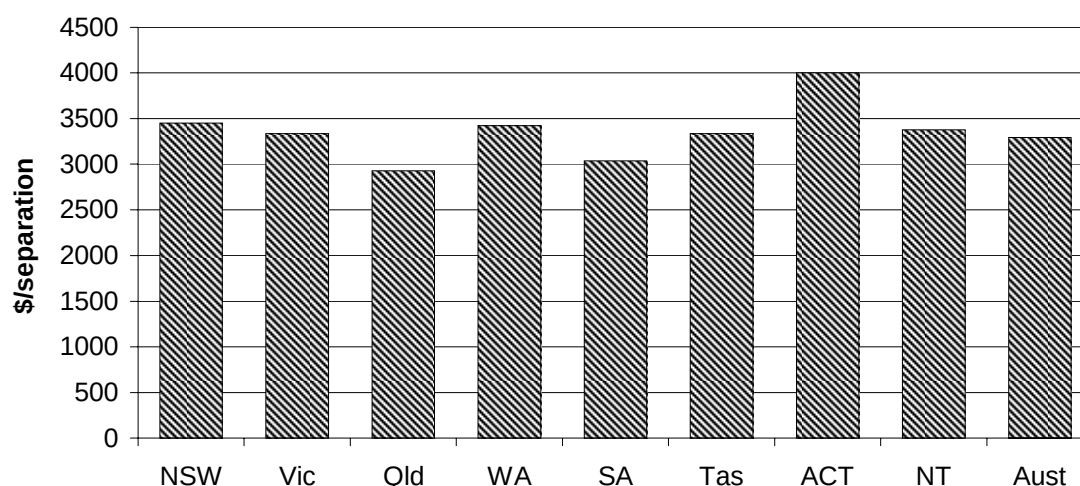
Box 9.16 (Continued)

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 the cost of psychiatric separations.

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

Hospital recurrent expenditures on Indigenous and non-Indigenous people may differ (AIHW 2001b). These differences may influence jurisdictional variation in unit costs.

Figure 9.13 **Recurrent cost per casemix-adjusted separation, 2003-04**^{a, b, c, d, e, f}

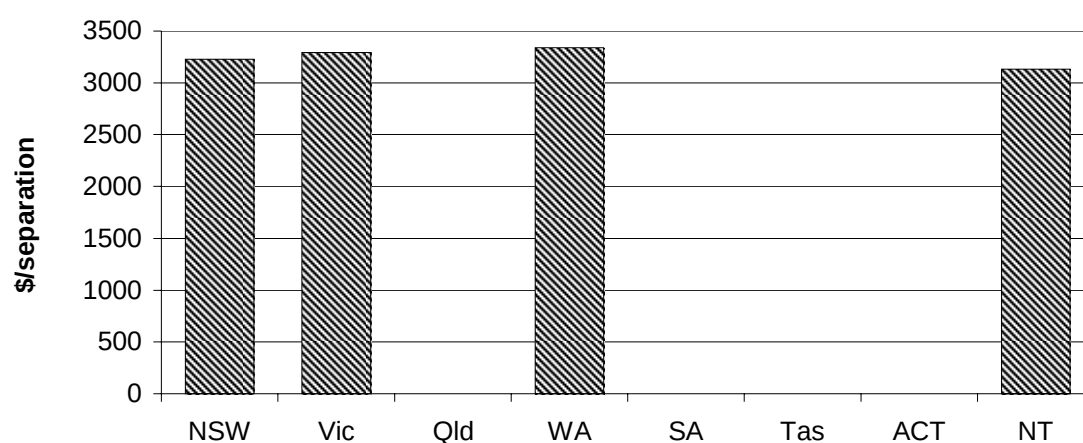


^a Excludes depreciation and the user cost of capital, spending on non-admitted patient care and research costs. ^b Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights are from the National Hospital Morbidity Database, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2002-03 AR-DRG v 4.2 cost weights (DHA 2004a). ^c Excludes separations for which the care type was reported as 'newborn with no qualified days', and records for hospital borders 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 this table. 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 NT data need to be interpreted in conjunction with the cost disabilities associated with hospital service delivery in the NT. ^f Of the selected hospitals, two small hospitals had their inpatient fraction estimated by the Health and Allied Services Advisory Council ratio (see AIHW 2005a).

Source: AIHW (2005a); table 9A.48.

Experimental estimates of ‘recurrent cost per casemix-adjusted separation’ for acute, non-psychiatric patients are reported for NSW, Victoria, WA and the NT (figure 9.14). (These estimates are not available for other jurisdictions.) The experimental estimates aim to overcome the need to apply cost weights for acute care to non-acute care separations (box 9.16). The effect of restricting the analysis to acute non-psychiatric admitted patients was to decrease the estimated recurrent cost per casemix-adjusted separation (figure 9.13) by 6.5 per cent for NSW, 1.2 per cent for Victoria, 2.5 per cent for WA and 7.3 per cent for the NT.

Figure 9.14 Recurrent cost per acute non-psychiatric casemix-adjusted separation, 2003-04 a, b, c, d, e, f



a Excludes psychiatric, mothercraft, hospices, small non-acute, un-peered and other hospitals, rehabilitation facilities, and multi-purpose services. This subset excludes hospitals where the inpatient fraction was equal to the acute inpatient fraction and more than 1000 not acute patient days were recorded. Also excludes hospitals where the apparent cost of not acute patients exceeded \$1000 per day and more than \$1 000 000 of apparent expenditure on non-acute patients days was reported. NT data restricted to the two principal referral hospitals.

b Acute separations are those where the care type is acute, newborn with qualified days, or not reported. Psychiatric separations are those with psychiatric care days. **c** Average cost weight from the National Hospital Morbidity Database, based on acute and unspecified separations and episodes of newborn care with qualified days, using the 2002-03 AR-DRG version 4.2 cost weights (DHA 2004a). **d** Cost estimates include adjustment for private patient medical costs: \$141 for New South Wales, \$88 for Victoria and \$77 for Western Australia and \$23 for the Northern Territory. **e** These estimates are not available for Queensland, SA, Tasmania, and the ACT. **f** Data are from table A3.7 in AIHW (2005a).

Source: AIHW (2005a).

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

- metropolitan hospitals with more than 20 000 acute casemix-adjusted separations per year

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

In 2003-04, these hospitals accounted for 65.6 per cent of public acute and psychiatric hospital expenditure and 66.1 per cent of separations (AIHW 2005a). The data for principal referral hospitals (excluding specialist women's and children's hospitals) are presented in table 9.14. Detailed data for all peer groups are presented in table 9A.49.

Table 9.14 Recurrent cost per casemix-adjusted separation, principal referral public hospitals, 2003-04^{a, b, c}

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Hospitals	no.	17	15	13	3	4	2	1	2	57
Average beds per hospital	no.	446	558	405	529	393	392	498	230	458
Average separations per hospital	no.	38 329	57 872	36 388	55 538	50 419	33 837	51 499	29 776	44 557
Average cost weight	no.	1.14	0.99	1.05	1.08	1.08	1.05	0.97	0.77	1.05
Cost per casemix-adjusted separation	\$	3 536	3 276	3 030	np	np	3 216	np	3 365	3 283
Recurrent expenditure on principal referral hospitals	\$m	3 676	3 954	2 012	np	np	301	np	204	12 090
Recurrent expenditure on all public hospitals	\$m	7 249	5 370	2 996	1 847	1 556	401	351	243	20 012

^a Principal referral hospitals are classified as metropolitan hospitals with more than 20 000 acute casemix-adjusted separations per year and rural hospitals with more than 16 000 acute casemix-adjusted separations per year. ^b Expenditure data exclude depreciation and the user cost of capital, spending on non-admitted patient care and research costs. ^c Average cost weight from the National Hospital Morbidity Database, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2002-03 AR-DRG v 4.2 cost weights (DHA 2004a). **np** Not published.

Source: AIHW (2005a); table 9A.49.

Total cost per casemix-adjusted separation

‘Total cost per casemix-adjusted separation’ is an indicator of the efficiency of public hospitals (box 9.17). Total cost includes both the recurrent costs (as discussed above) and capital costs associated with hospitals services. Labour costs accounted for the majority of costs per casemix adjusted separation in all jurisdictions (figure 9.15).

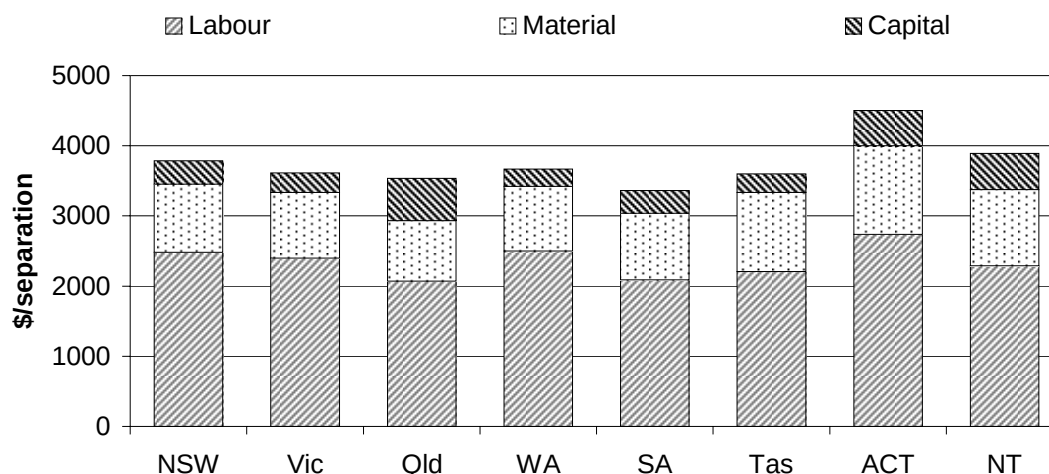
Box 9.17 Total cost per casemix-adjusted separation

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

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

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

Figure 9.15 **Total cost per casemix-adjusted separation, public hospitals, 2003-04^{a, b, c}**



^a 'Labour' includes medical and non-medical labour costs. 'Material' includes other non-labour recurrent costs, such as repairs and maintenance. ^b 'Capital cost' includes depreciation and the user cost of capital for buildings and equipment that is associated with the delivery of admitted patient services in the public hospitals as described in the data for recurrent cost per casemix-adjusted separation. 'Capital cost' excludes the user cost of capital associated with land (reported in table 9A.50). ^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 (2005a); State and Territory governments (unpublished); table 9A.48 and table 9A.50.

Relative stay index

The 'relative stay index' is an indicator of the efficiency of public hospitals (box 9.18). Data for this indicator are reported in figure 9.16. The 'relative stay index' is reported by patient election status and by medical, surgical and other AR-DRGs in tables 9A.51 and 9A.52 respectively.

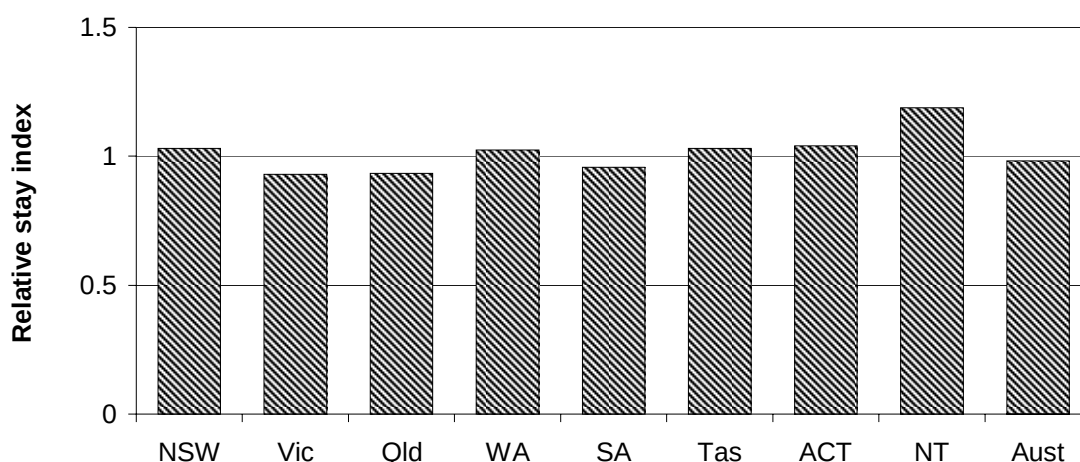
Box 9.18 Relative stay index

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 Indigenous status. Acute care separations only are included. Section 9.8 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'.

Figure 9.16 Relative stay index, public hospitals, 2003-04^{a, b}



^a Includes separations for which the care type was reported as 'acute' or 'newborn with qualified days', or was not reported. ^b Based on all hospitals using the indirect standardisation method. The indirectly standardised relative stay index is not technically comparable between cells but is a comparison of the hospital group with the national average based on the casemix of that group.

Source: AIHW (2005a); table 9A.51.

Recurrent cost per non-admitted occasion of service

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

Box 9.19 Recurrent cost per non-admitted occasion of service

Non-admitted occasions of service (including emergency department presentations and outpatient services) account for a significant proportion of hospital expenditure. This indicator is included to help assess efficiency in this part of the hospital system.

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

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

These data are not comparable across jurisdictions, given differences in practice. Reporting categories vary across jurisdictions, and further inconsistencies arise as a result of differences in outsourcing practices. In some cases, for example, outsourced occasions of service may be included in expenditure on non-admitted services, but not in the count of occasions of service. In addition, 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).

Jurisdictions able to supply 2003-04 data for this indicator reported the following results for non-admitted patient services:

- In NSW, the emergency department cost per occasion of service was \$209 for 1.8 million occasions, the outpatient cost per occasion of service was \$75 for 13.6 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was \$83 for 18.5 million occasions (table 9A.53).
- In WA, the emergency department cost per occasion of service was \$335 for 576 447 occasions, the outpatient cost per occasion of service was \$110 for 2.8 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was \$137 for 4.5 million occasions (table 9A.55).
- In SA, the emergency department cost per occasion of service was \$259 for 460 843 occasions, the outpatient cost per occasion of service was \$164 for 1.3 million occasions and the overall cost per occasion of service (emergency plus outpatient) was \$189 for 1.7 million occasions (table 9A.56).
- In Tasmania, the emergency department cost per occasion of service was \$282 for 105 783 occasions and the outpatient cost per occasion of service was \$115

for 386 245 occasions. An overall cost per occasion of service was not available (table 9A.57).

- In the ACT, the emergency department cost per occasion of service was \$382 for 97 145 occasions, the outpatient cost per occasion of service was \$75 for 507 297 occasions and the overall cost per occasion of service (emergency plus outpatient) was \$124 for 604 442 occasions (table 9A.58).

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 16 hospitals, the average cost per encounter was \$133 in 2003-04 (table 9A.54).

Given the lack of a nationally consistent non-admitted patient classification system, this Report includes national data from the Australian Government Department of Health and Ageing's National Hospital Cost Data Collection (NHCDC). The NHCDC collects data across a sample of hospitals that is expanding over time. The sample for each jurisdiction is not necessarily representative, however, because hospitals contribute data on a voluntary basis. The NHCDC data are affected by differences in costing and admission practices across jurisdictions and hospitals. 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 147 public hospitals for all types of public hospital outpatient clinics (tier 0) (table 9A.59). These data suggest that 'cost per non-admitted clinic occasions of service' for the public hospitals sector in 2003-04 was \$132 for 12.1 million occasions (table 9A.59). 'Cost per non-admitted clinic occasions of service' data are also shown for seven categories of outpatient clinics (tier 1) (table 9.15). These tier 1 outpatient clinics data were provided by 43 public hospitals. Emergency department data, provided by 156 public hospitals, show the 'cost per occasion of service for emergency departments' by triage class (table 9.16).

Table 9.15 Non-admitted clinic occasions of service for tier 1 clinics, sample results, public sector, 2003-04^{a, b, c}

	<i>Occasions of service</i>	<i>Average cost</i>
	no.	\$/occasion of service
Allied health and/or clinical nurse specialist	705 128	74
Dental	11 804	114
Medical	1 163 795	168
Obstetrics and gynaecology	267 526	168
Paediatric	106 819	220
Psychiatric	46 012	114
Surgical	547 834	138
Total	2 848 918	139

^a Includes depreciation costs. ^b Based on 43 public sector hospitals. ^c Excludes Victorian outpatient data.

Source: DHA (2005); table 9A.61.

Table 9.16 Emergency department average cost per occasion of service, public hospitals, by triage class, 2003-04 (dollars)^{a, b, c, d, e}

<i>Triage category</i>	<i>Population estimated — average cost per occasion of service^f</i>	<i>Actual — average cost per occasion of service</i>
Admitted triage 1	969	996
Admitted triage 2	473	490
Admitted triage 3	409	436
Admitted triage 4	359	389
Admitted triage 5	260	312
Non-admitted triage 1	629	591
Non-admitted triage 2	382	390
Non-admitted triage 3	325	336
Non-admitted triage 4	240	252
Non-admitted triage 5	179	191
Did not wait ^g	103	105
Total	293	312

^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 156 public sector hospitals. ^c Victorian emergency department data are not included. Victoria is working to rectify this problem. ^d Costing and admission practices vary across jurisdictions and hospitals. ^e Depreciation costs are included. ^f Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. ^g 'Did not wait' means those presentations to an emergency department who were triaged but did not wait until the completion of their treatment, at which time they would have been either admitted to hospital or discharged home.

Source: DHA (2005); table 9A.60.

Outcomes

Patient satisfaction

‘Patient satisfaction’ is an outcome indicator of public hospital quality (box 9.20). This indicator is included for the first time this year. In previous editions of this Report, the overall patient satisfaction ratings used for this indicator were reported under the responsiveness indicator ‘patient satisfaction surveys’.

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

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

Box 9.20 Patient satisfaction

‘Patient satisfaction’ with hospital services is included as an outcome indicator, because patient satisfaction provides a proxy measure of whether public hospital services are of appropriate quality and whether they meet the needs of patients. Patient satisfaction surveys are different from other sources of hospital quality data because they provide information on hospital quality from the patient’s perspective.

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

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

Jurisdictions reported the following results from patient satisfaction surveys:

- In NSW in 2004, a telephone survey of persons who had stayed for at least one night in hospital in the past 12 months was conducted. The sample size was 1485 patients and the response rate was 62 per cent. Of those surveyed, 43.8 per cent rated the care they received as 'excellent', 30.5 per cent as 'very good', 16.8 per cent rated it as 'good', 6.5 per cent rated it as 'fair', and 2.4 per cent rated it as 'poor' (table 9A.62).
- The Victorian Patient Satisfaction Monitor was conducted from 2000 to 2004, using a mailout questionnaire of adult inpatients receiving acute care in Victorian public hospitals. For September 2003 to August 2004, the sample size was 15 623 patients, which represented a response rate of 40.2 per cent. Overall, 96.0 per cent of patients surveyed across Victoria were either very satisfied or fairly satisfied with their hospital stay, and 88 per cent of patients believed they were helped a great deal or quite a bit by their stay (table 9A.63).
- In Queensland, a mailout survey was conducted of admitted patients in public hospitals from December 2004–May 2005. The total sample was 33 173, with a 52 per cent response rate for the first three months. Results of the survey are not yet available (table 9A.64).
- In WA, a telephone survey of Emergency Department patients in metropolitan public hospitals was conducted from February 2005–June 2005. The total sample was around 7500, with an 88 per cent response rate. The overall indicator of satisfaction score was 80.9 (weighted by the importance of each issue as ranked by the patient and scored from 0 to 100, where 100 is the highest possible overall satisfaction score, taking into account all of the satisfaction domains measured) (table 9A.65).
- In SA, a telephone survey was conducted with patients aged 16 to 80 years who received at least one night of designated mental health services care in the SA public hospital system in March 2004. Interviews were completed with 256 patients, which represented a response rate of 73.6 per cent. The State-wide satisfaction score was 76.2 (scored from 0 to 100, being least to most satisfied) (table 9A.66).
- In Tasmania, from September 2004 to December 2004, patients of public acute hospitals aged over 18 years were given a survey questionnaire as they were discharged. The survey was handed to 1358 patients, of whom 36.5 per cent responded. Of responding patients, 96 per cent were either very satisfied or satisfied with their experience within the hospitals, 1.3 per cent were not satisfied with the services. The majority of patients (87 per cent) thought they were helped a lot by their stay in hospital (table 9A.67).

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- In the ACT, from October 2004 to November 2004 a mailout survey of inpatients who had been discharged from one public hospital was conducted. The total sample was 384, with a 50 per cent response rate. The overall mean satisfaction score was 80.7 per cent, with 84.6 per cent of patients satisfied overall with the service they received (table 9A.68).
 - In the NT, in 2004-05, a range of client satisfaction surveys was conducted. These surveys were not coordinated across the NT hospital network, but were driven by individual hospitals and/or work units (table 9A.69). Satisfaction ratings from these surveys are not available, but the improvements hospitals have made in response to these surveys are reported under the responsiveness output indicator 'patient satisfaction surveys'.

Sentinel events

'Sentinel events' are reported as an outcome indicator of public hospital quality and safety (box 9.21). This indicator is included for the first time this year and data are available only for NSW and Victoria (table 9.17). It is anticipated that data for all jurisdictions will be available for the 2007 Report.

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

Box 9.21 **Sentinel events**

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

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

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

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

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

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

Table 9.17 Nationally agreed core sentinel events, 2003-04 (number)

<i>Sentinel event</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
1. Procedures involving the wrong patient or body part ^a	13	14	na	na	na	na	na	na	na
2. Suicide of a patient in an in-patient unit ^b	4	1	na	na	na	na	na	na	na
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure	9	8	na	na	na	na	na	na	na
4. Intravascular gas embolism resulting in death or neurological damage	–	–	na	na	na	na	na	na	na
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility	–	1	na	na	na	na	na	na	na
6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs	2	4	na	na	na	na	na	na	na
7. Maternal death or serious morbidity associated with labour or delivery ^c	3	2	na	na	na	na	na	na	na
8. Infant discharged to the wrong family	–	–	na	na	na	na	na	na	na
Total	31	30	na	na	na	na	na	na	na

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

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

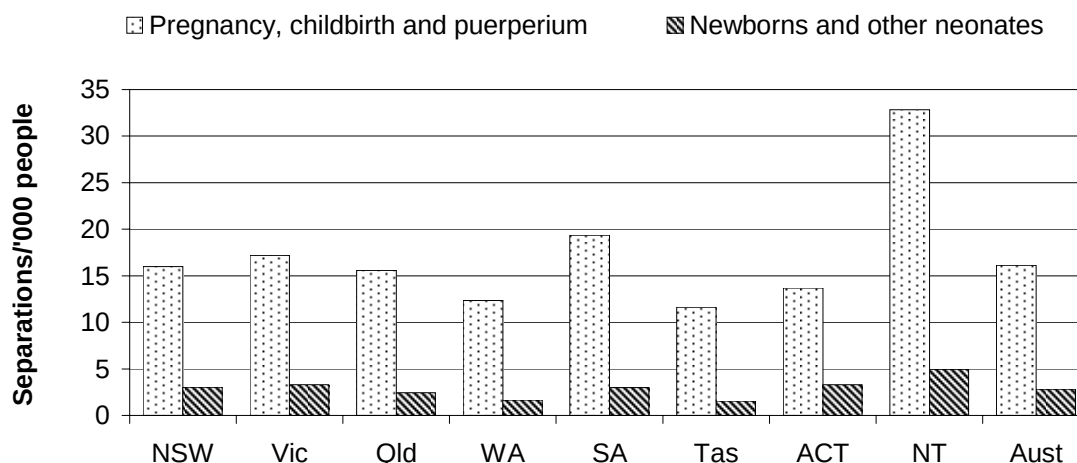
^c Excludes maternal deaths that occur prior to the onset of labour or delivery. **na** Not available. – Nil or rounded to zero.

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

9.4 Profile of maternity services

Maternity services (defined as AR-DRGs relating to pregnancy, childbirth and the puerperium, and newborns and other neonates) accounted for 9.3 per cent of total acute separations in public hospitals (table 9A.71) and around 10.8 per cent of the total cost of all acute separations in public hospitals in 2003-04 (table 9A.70). Figure 9.17 shows the rate of acute separations per 1000 people for maternity services across jurisdictions in 2003-04.

Figure 9.17 **Separation rates for maternity services, public hospitals, 2003-04^{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 (2005a); tables A.2 and 9A.71.

In Australian public hospitals in 2003-04, vaginal deliveries without complicating diagnosis accounted for a substantial proportion of the separations for pregnancy, childbirth and the puerperium (29.7 per cent) (tables 9A.71 and 9A.72). 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 9.3) and the second highest cost (\$277.7 million) (table 9A.72).

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 2002, 2003 and 2004 (table 9.18).

Table 9.18 Mean age of mothers at time of giving birth, public hospitals

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA^a</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
2002								
First birth	27.3	27.1	24.9	25.5	25.8	26.3	27.2	26.7
Second birth	29.6	29.5	27.7	28.0	28.6	28.1	29.3	27.1
Third birth	30.9	31.0	29.3	29.3	30.3	29.9	31.1	28.1
All births	29.2	29.1	27.4	27.7	28.1	28.6	28.9	27.5
2003								
First birth	27.5	27.4	25.2	25.8	26.0	26.6	27.4	24.8
Second birth	29.8	29.7	27.8	28.3	28.8	29.1	29.6	27.2
Third birth	31.1	31.2	29.6	29.8	30.5	30.2	31.2	28.2
All births	29.4	29.3	27.6	28.0	28.3	29.0	29.2	26.9
2004								
First birth	27.7	28.1	25.3	25.9	26.8	25.2	na	26.8
Second birth	29.9	30.3	27.9	28.4	29.2	27.5	na	27.1
Third birth	31.3	31.8	29.6	29.7	30.8	28.8	na	28.2
All births	29.5	29.9	27.7	28.0	28.8	27.8	na	27.0

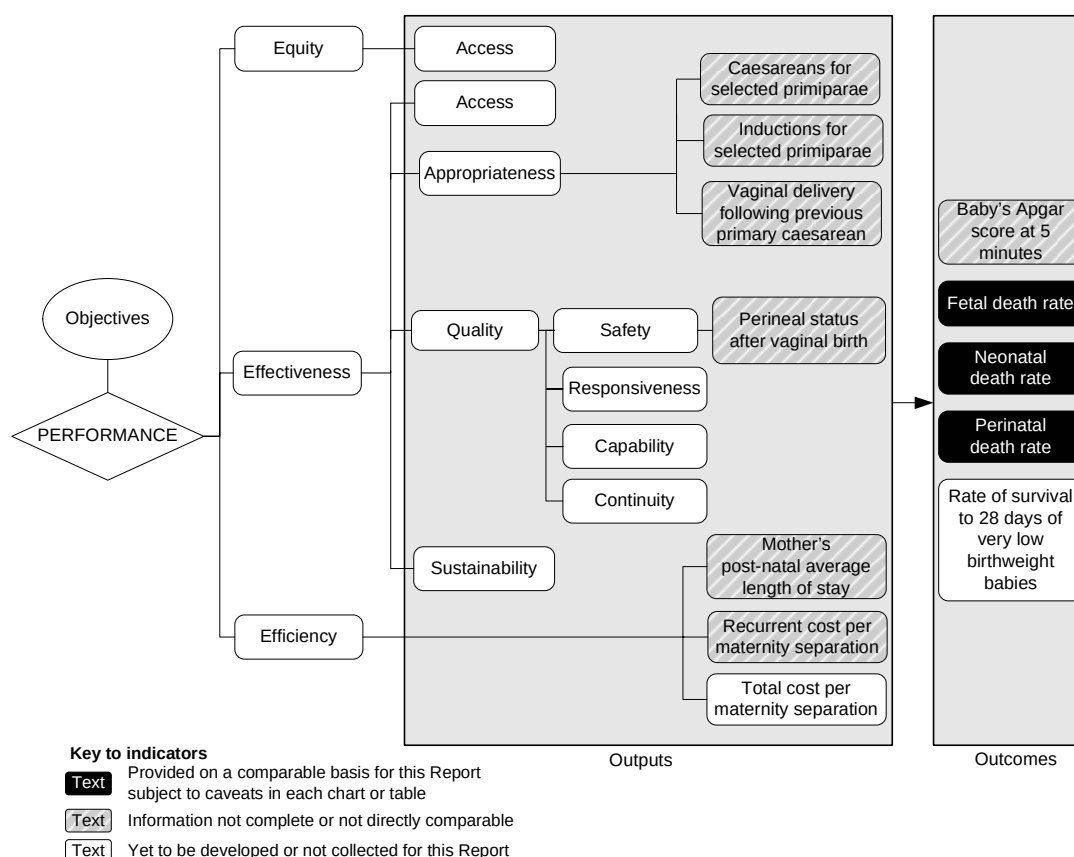
^a Age in 2004 is based on exact age (years) to 4 decimal places. In earlier years, it was based on completed years. **na** Not available.

Source: State and Territory governments (unpublished).

9.5 Framework of performance indicators for maternity services

The performance framework for maternity services is outlined in figure 9.18, 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 2006 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability that have been added to the standard Review framework for health services.

Figure 9.18 Performance indicators for maternity services



9.6 Key performance indicator results for maternity services

Outputs — equity — access

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

Outputs — effectiveness — access

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

Outputs — effectiveness — appropriateness

Caesareans and inductions for selected primiparae

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

Box 9.22 Caesareans and inductions for selected primiparae

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

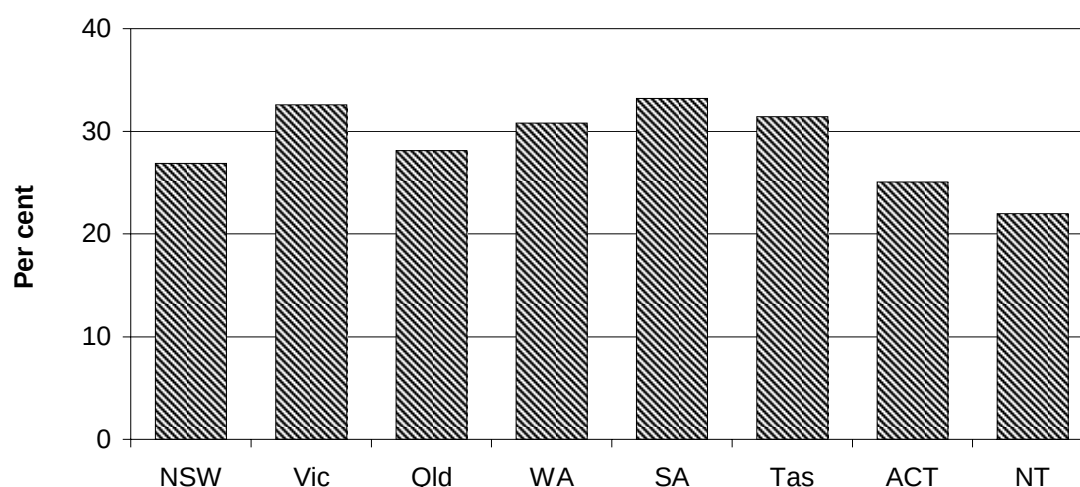
‘Caesareans and inductions for selected primiparae’ are reported for women aged between 25–29 years who have had no previous deliveries, with a vertex presentation (that is, the crown of the baby’s head is at the lower segment of the mother’s uterus) and a gestation length of 37–41 weeks. This group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

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

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

Induction rates for selected primiparae in public hospitals are reported in figure 9.19. Induction rates for private hospitals are shown in table 9A.73 for comparison. They are higher than the rate for public hospitals in all jurisdictions for which data are available. Data for all jurisdictions for earlier years are included in tables 9A.73–81.

Figure 9.19 Inductions for selected primiparae, public hospitals, 2004^a

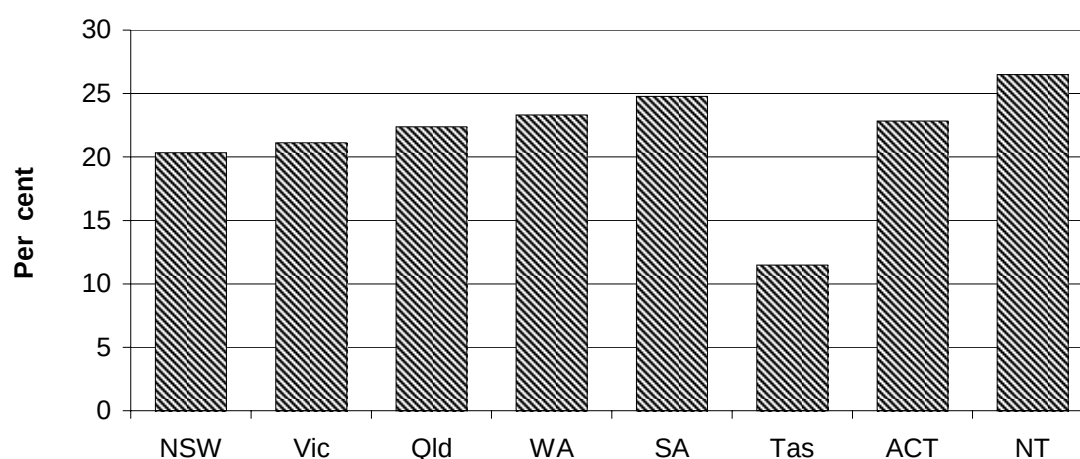


^a Data for the ACT are preliminary estimates.

Source: State and Territory governments (unpublished); table 9A.73.

Caesarean rates for selected primiparae in public hospitals are reported in figure 9.20. Caesarean rates for private hospitals are shown in table 9A.73 for comparison. They are higher than the rate for public hospitals in all jurisdictions for which data are available, except Tasmania. Data for all jurisdictions for earlier years are included in tables 9A.73–81.

Figure 9.20 Caesareans for selected primiparae, public hospitals, 2004^a



^a Data for the ACT are preliminary estimates.

Source: State and Territory governments (unpublished); table 9A.73.

Vaginal birth following previous primary caesarean

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

Box 9.23 Vaginal birth following previous primary caesarean

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

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

In interpreting the results of this indicator, 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.

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

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2004, the mean rate of ‘vaginal birth following a previous primary caesarean’ was 17.8 per 100 deliveries. 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 3.1 per cent (or 273) more vaginal births following a previous primary caesarean in these public hospitals (ACHS unpublished). National performance at the 80th centile shows the rate which the

best performing 20 per cent of ACHS reporting hospitals are performing at or above.

The mean rates of ‘vaginal birth following a primary caesarean’ in 2004 are shown in table 9.19 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. For future reports, the Steering Committee will work to provide an indicative measure of what proportion of each state’s separations are covered by the data. Data for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals reported ‘vaginal birth following a primary caesarean’ in each of those jurisdictions.

Table 9.19 Vaginal births following previous primary caesarean, public hospitals, 2004^{a, b}

	<i>Unit</i>	<i>Results</i>
National rate	(%)	17.8
National performance at 80th centile (rate)	(%)	20.9
National performance at 20th centile (rate)	(%)	14.6
<i>New South Wales</i>		
Numerator (no. of VBACs)	no.	553
Denominator (no. of DACs)	no.	3 393
Rate	%	16.3
Standard error (±)		0.6
ACHS reporting hospitals	no.	39
<i>Victoria</i>		
Numerator (no. of VBACs)	no.	329
Denominator (no. of DACs)	no.	1 878
Rate	%	17.5
Standard error (±)		0.7
ACHS reporting hospitals	no.	16
<i>Queensland</i>		
Numerator (no. of VBACs)	no.	301
Denominator (no. of DACs)	no.	1 323
Rate	%	22.8
Standard error (±)		0.9
ACHS reporting hospitals	no.	10
<i>Western Australia</i>		
Numerator (no. of VBACs)	no.	179
Denominator (no. of DACs)	no.	1 139
Rate	%	15.7
Standard error (±)		1.0
ACHS reporting hospitals	no.	15
<i>South Australia</i>		
Numerator (no. of VBACs)	no.	160
Denominator (no. of DACs)	no.	807
Rate	%	19.8
Standard error (±)		1.1
ACHS reporting hospitals	no.	10

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

Source: ACHS (unpublished); tables 9A.82, 9A.83, 9A.84, 9A.85 and 9A.86.

Outputs — effectiveness — quality

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

Safety — perineal status after vaginal birth

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

Box 9.24 Perineal status after vaginal birth

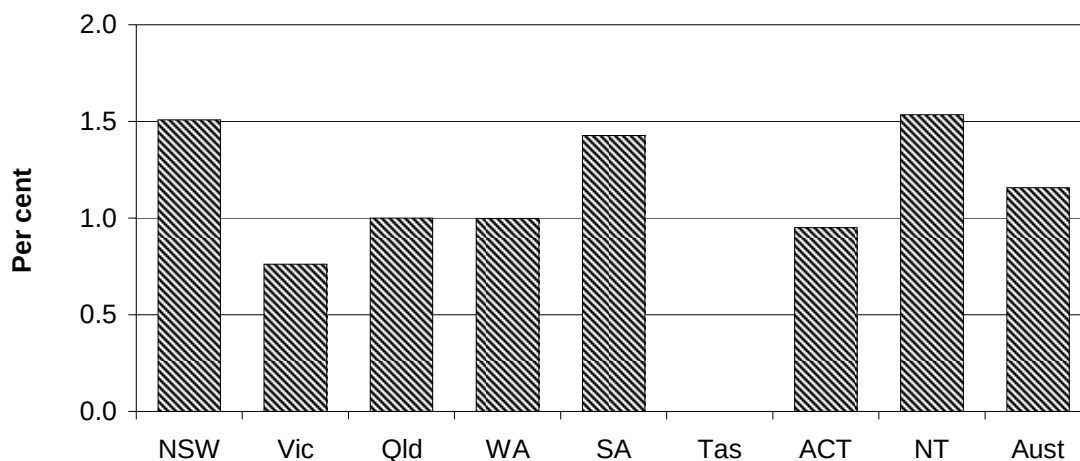
Perineal lacerations caused by childbirth are painful, take time to heal and may result in ongoing discomfort and debilitating conditions such as faecal incontinence. Maternity services staff aim to minimise lacerations, particularly more severe lacerations (third and fourth degree), through labour management practices.

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

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

The proportion of mothers with third or fourth degree lacerations to their perineums following vaginal births is shown in figure 9.21. More information on ‘perineal status after vaginal birth’ (including the proportion of mothers with intact perineums following vaginal births) is contained in attachment table 9A.87.

Figure 9.21 **Perineal status — mothers with third or fourth degree lacerations after vaginal births, 2002^{a, b, c}**



^a For multiple births, the perineal status after birth of the first child was used. ^b Data for Tasmania are not available in a form that are comparable with other jurisdictions. ^c Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths. In 2002, 2.8 per cent of all births occurred outside of hospital.

Source: Laws and Sullivan (2004); table 9A.87.

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 on earlier in this chapter generally cover maternity patients.

Capability

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

Continuity

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

Outputs — effectiveness — sustainability

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

Outputs — efficiency

Recurrent cost per maternity separation

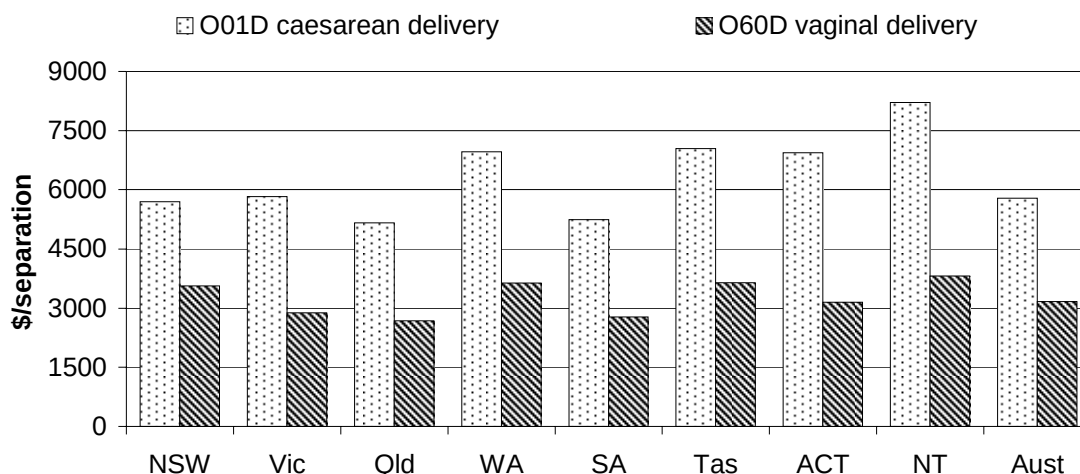
‘Recurrent cost per maternity separation’ is an indicator of the efficiency of maternity services in public hospitals (box 9.25). Data are reported for two common maternity AR-DRGs: caesarean delivery without complications; and vaginal delivery without complications (figure 9.22). Data for a number of other maternity related AR-DRGs are shown in table 9A.88. 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.

Box 9.25 Recurrent cost per maternity separation

The ‘recurrent cost per maternity separation’ is a proxy indicator of efficiency in treating admitted patients. It is presented for the two AR-DRGs that account for the largest number of maternity patient days: caesarean delivery without complicating diagnosis; and vaginal delivery without complicating diagnosis.

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

Figure 9.22 **Estimated average cost per separation for selected maternity-related AR-DRGs, public hospitals, 2003-04^{a, b}**



^a Includes AR-DRG O01D caesarean delivery without complicating diagnosis and AR-DRG O60D vaginal delivery without complicating diagnosis. ^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: DHA (2005); table 9A.88.

Total cost per maternity separation

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

Box 9.26 Total cost per maternity separation

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

Mothers average length of stay

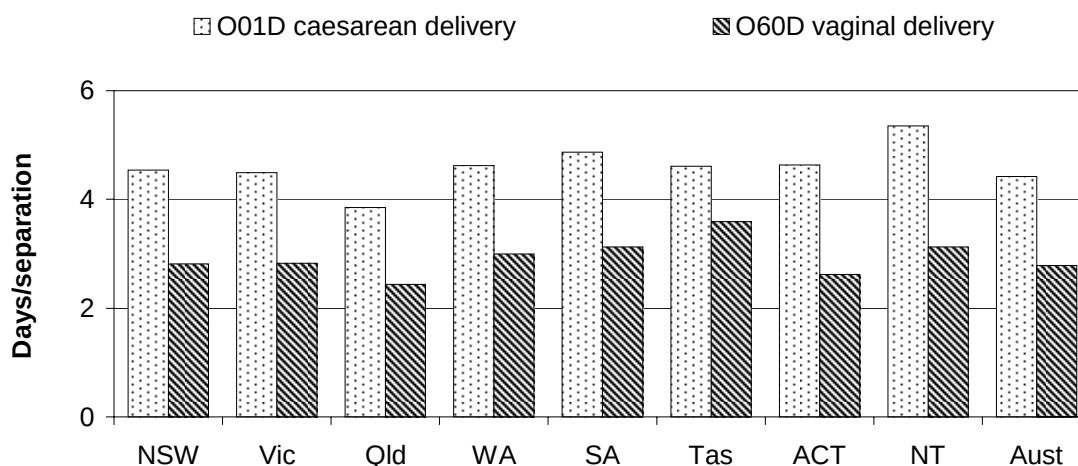
‘Mothers average length of stay in hospital’ is an indicator of the efficiency of maternity services in public hospitals (box 9.27). Data are reported for two common maternity AR-DRGs: caesarean delivery without complications; and vaginal delivery without complications (figure 9.23).

Box 9.27 Mothers average length of stay

Mother's average length of stay is defined as the total number of patient days for the selected maternity AR-DRG, divided by the number of separations for that AR-DRG.

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

Figure 9.23 Average length of stay for selected maternity-related AR-DRGs, public hospitals, 2003-04^a



^a Includes AR-DRG O01D caesarean delivery without complicating diagnosis and AR-DRG O60D vaginal delivery without complicating diagnosis.

Source: DHA (2005); table 9A.88.

Outcomes

Apgar score

'Apgar score of babies at five minutes after birth' is as an indicator of the outcomes of maternity services (box 9.28). 'Low' Apgar scores for babies by birthweight category are contained in table 9.20. The range of Apgar scores for 2000 to 2004 are reported in table 9A.89.

Box 9.28 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.

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

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

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

Table 9.20 Live births with an Apgar score of 3 or lower, five minutes post-delivery, public hospitals, 2004

Birthweight (grams)	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Less than 1500	no.	813	544	466	268	190	49	na	55
Low Apgar	%	13.8	15.6	18.0	7.1	15.8	4.1	na	25.4
1500–1999	no.	910	575	500	280	213	50	na	40
Low Apgar	%	1.0	0.9	0.8	0.7	–	–	na	2.5
2000–2499	no.	2 593	1 926	1 474	689	558	159	na	192
Low Apgar	%	0.5	0.4	0.6	0.2	0.5	–	na	1.5
2500 and over	no.	60 011	40 353	31 895	13 659	11 601	2 949	na	2 474
Low Apgar	%	0.1	0.1	0.2	0.1	0.1	0.1	na	0.6

na Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 9A.89.

Fetal death rate

The 'fetal death rate' is an indicator of the outcomes of maternity services (box 9.29). Fetal death rates are reported in figure 9.24. Nationally, fetal death rates remained stable over the period 1999–2003 although there was variation over this

period in some jurisdictions (these annual fluctuations are generally a result of the low incidence of fetal deaths). National time series for fetal death rates are included in table 9A.92. Fetal deaths rates by Indigenous status are shown in figure 9.27.

Box 9.29 Fetal death rate

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

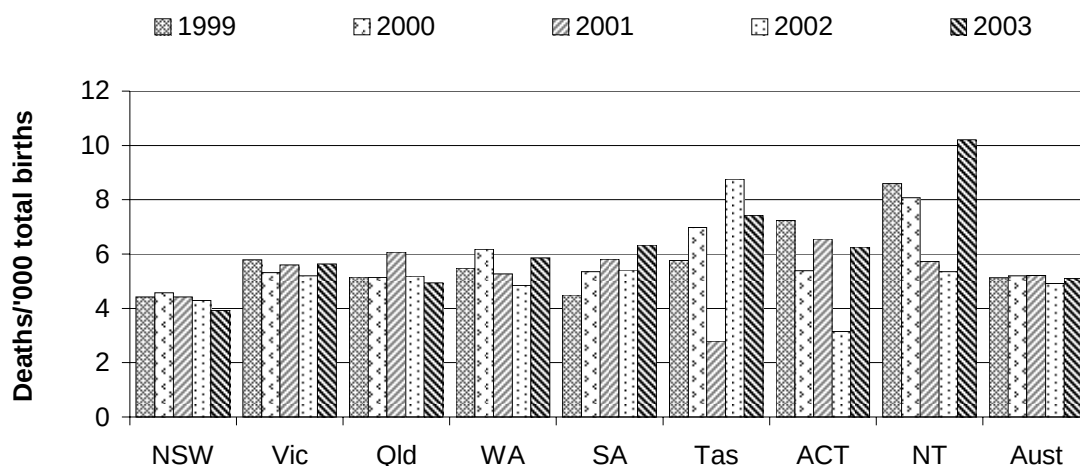
‘Fetal death rate’ is reported as an indicator because maternity services for admitted patients have some potential to reduce the likelihood of fetal deaths. This potential is limited, however, and other factors (such as the health of mothers and the progress of pregnancy before hospital admission) are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

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

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.

Figure 9.24 **Fetal death rate^{a, b}**



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

Source: ABS Deaths, Australia (unpublished); table 9A.90.

Neonatal death rate

The ‘neonatal death rate’ is an indicator of the outcomes of maternity services (box 9.30). Neonatal death rates are reported in figure 9.25. Nationally, neonatal death rates declined over the period 1999–2003, although there was variation over this period in some jurisdictions (these annual fluctuations are generally a result of the low incidence of neonatal deaths). National time series for neonatal death rates are included in table 9A.92. Neonatal death rates by Indigenous status are shown in figure 9.27.

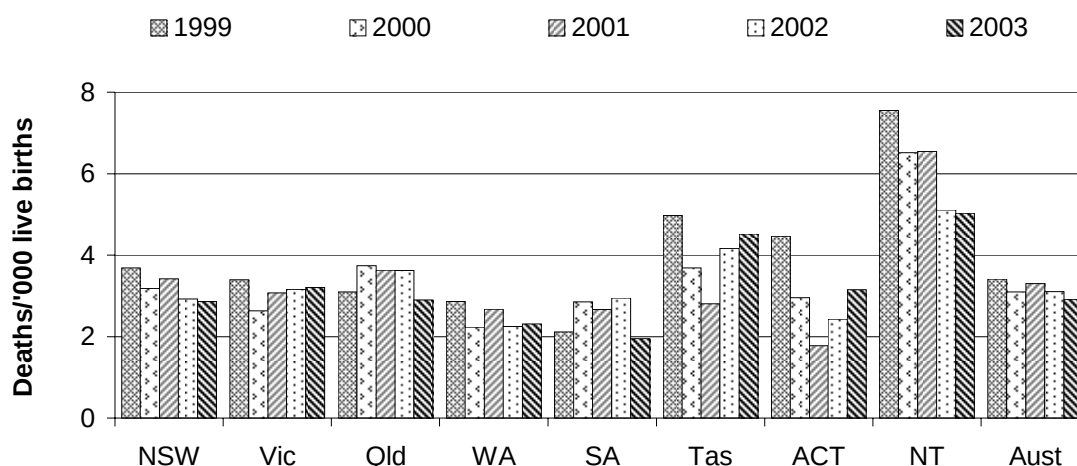
Box 9.30 Neonatal death rate

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

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

Figure 9.25 Neonatal death rate^{a, b}



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

Source: ABS Deaths, Australia (unpublished); table 9A.91.

Perinatal death rate

The 'perinatal death rate' is an indicator of the outcomes of maternity services (box 9.31). Perinatal death rates are shown in figure 9.26. Perinatal deaths rates by Indigenous status are shown in figure 9.27. National time series for perinatal death rates are included in table 9A.92.

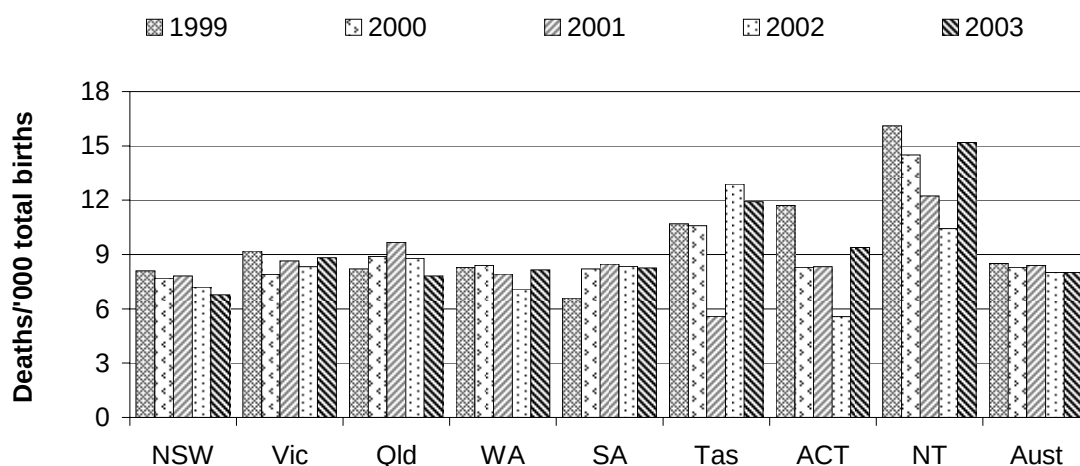
Box 9.31 Perinatal death rate

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

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

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

Figure 9.26 Perinatal death rate^{a, b}



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

Source: ABS Deaths, Australia (unpublished); table 9A.93.

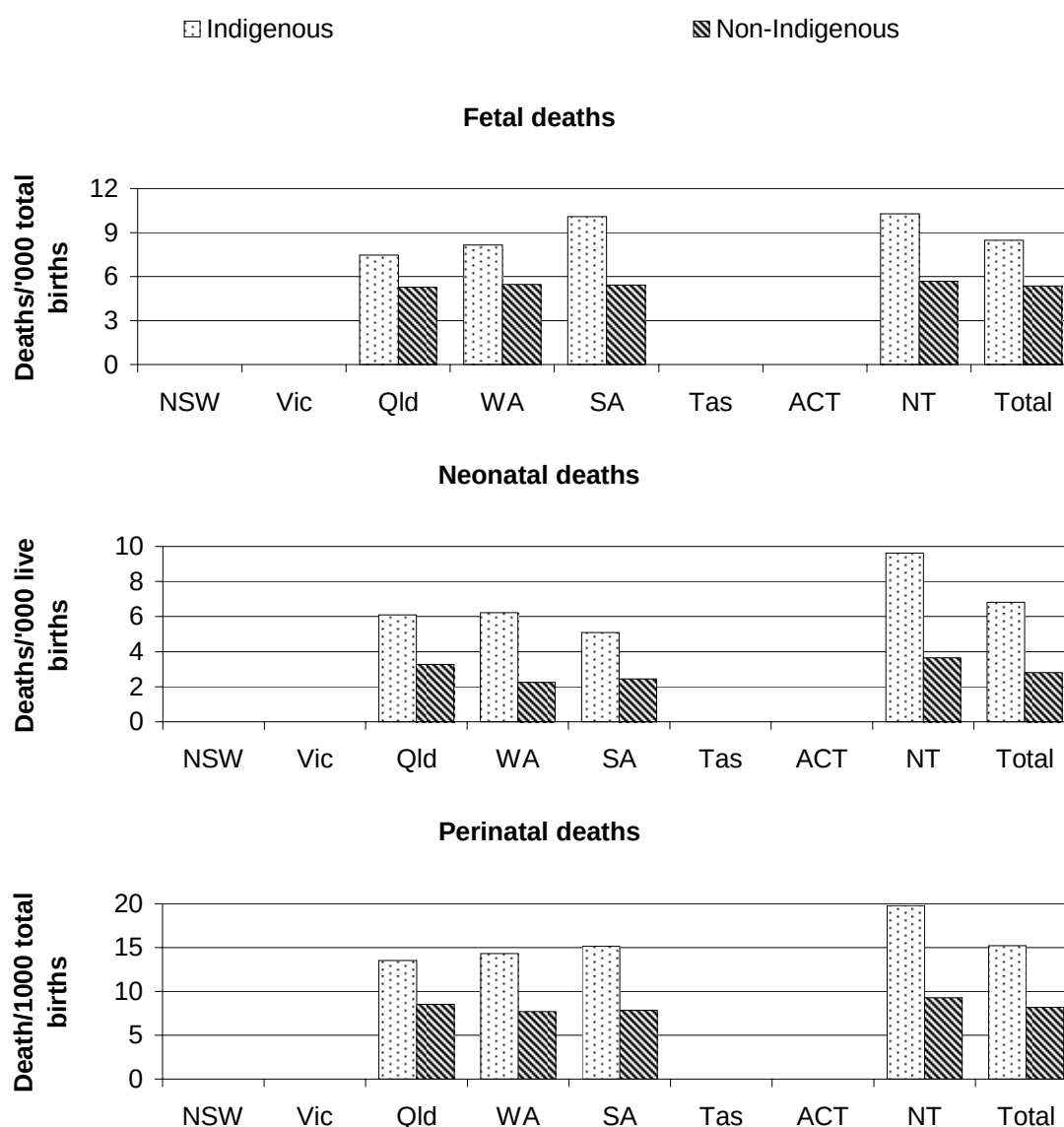
Fetal, neonatal and perinatal deaths for Indigenous people

Fetal, neonatal and perinatal deaths data by Indigenous status are available for Queensland, WA, SA and the NT only. Data are for the period 1999–2003 combined. Data for other states and the ACT are not included due to small numbers or poor coverage rates (ABS 2004).⁵ In those jurisdictions for which data are

⁵ The implied coverage of Indigenous deaths, for the period 1999 to 2003, ranges from 95 per cent in the NT, to 45 per cent and 43 per cent in NSW and Victoria respectively (SCRGSP 2005a).

available, the fetal, neonatal and perinatal death rates for Indigenous people are higher than these death rates for non-Indigenous people (figure 9.27).

Figure 9.27 **Fetal, neonatal and perinatal deaths, by Indigenous status, 1999–2003^a**



^a The total relates to those jurisdictions for which data are published.

Source: ABS Deaths, Australia (unpublished); table 9A.94.

Rate of survival to 28 days of very low birthweight babies

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

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

The ‘rate of survival to 28 days of very low birthweight babies’ is an indicator of maternity services outcomes. It would be reported by hospital type. The Steering Committee has identified this indicator for development and reporting in the future.

9.7 Future directions in performance reporting

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

- Improving the comprehensiveness of reporting by filling in gaps in the performance indicator frameworks. Important gaps in reporting for public hospitals include indicators of equity of access to services for special needs groups (particularly Indigenous people), indicators of continuity of care and indicators of sustainability. 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 will improve the comprehensiveness of reporting on public hospitals in a number of key areas by drawing on work that parallel groups are currently conducting:

- The Office for Aboriginal and Torres Strait Islander Health has recently finalised the Aboriginal and Torres Strait Islander Health Performance Framework and is now identifying data sources for its performance indicators. Data will be published in late 2006. These data will be used to develop the ‘equity of access by special needs groups’ indicator for future reports.
- The Productivity Commission is conducting a major health workforce study due for release in early 2006. The Australian Health Ministers’ Advisory Council

(AHMAC) is undertaking a range of work on health workforce issues through its workforce subcommittees and an AHMAC-funded work program. This work will be used to identify relevant contextual information and data sources for the yet-to-be-developed ‘workforce sustainability’ indicator.

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

9.8 Definitions of key terms and indicators

Accreditation	Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals may seek accreditation through the ACHS Evaluation and Quality Improvement Program, the Australian Quality Council (now known as Business Excellence Australia), the Quality Improvement Council, the International Organisation for Standardization 9000 Quality Management System or other equivalent programs.
Acute care	Clinical services provided to admitted or non-admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.
Admitted patient	A patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients may receive acute, sub-acute or non-acute care services.
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 versions 4.2 is based on the ICD-10-AM classification.
Average length of stay	The mean length of stay for all patient episodes, calculated by dividing total occupied bed days by total episodes of care.
Caesarean section	Operative birth through an abdominal incision.
Casemix adjusted	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted by AR-DRG into categories of patients with similar clinical conditions and requiring similar hospital services. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.
Casemix-adjusted separations	The number of separations adjusted to account for differences across hospitals in the complexity of episodes of care.
Catastrophic	An acute or prolonged illness usually considered to be life threatening or with the threat of serious residual disability. Treatment may be radical and is frequently costly.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Cost of capital	The return foregone on the next best investment, estimated at a rate of 8 per cent of the depreciated replacement value of buildings, equipment and land. Also called the 'opportunity cost' of capital.

Cost per casemix-adjusted separation	Recurrent expenditure multiplied by the inpatient fraction and divided by the total number of casemix-adjusted separations plus estimated private patient medical costs.
Cost per non-admitted occasion of service	Recurrent expenditure divided by the inpatient fraction and divided by the total number of non-admitted occasions of service.
Elective surgery waiting times	The time elapsed for a patient on the elective surgery waiting list, from the date on which he or she was added to the waiting list for a procedure to admission or a designated census date.
Emergency department waiting times to service delivery	The time elapsed for each patient from presentation to the emergency department (that is, the time at which the patient is clerically registered or triaged, whichever occurs earlier) to the commencement of service by a treating medical officer or nurse.
Emergency department waiting times to admission	The time elapsed for each patient from presentation to the emergency department to admission to hospital.
Episiotomy	An obstetrics procedure. A surgical incision into the perineum and vagina to prevent traumatic tearing during delivery.
Fetal death	Delivery of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Excludes infants that weigh less than 400 grams or that are of a gestational age of less than 20 weeks.
Fetal death rate	The number of fetal deaths divided by the total number of births (that is, by live births registered and fetal deaths combined).
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.
ICD-10-AM	The Australian modification of the International Standard Classification of Diseases and Related Health Problems. This is the current classification of diagnoses and procedures in Australia.
Inpatient fraction	The ratio of inpatient costs to total hospital costs.
Labour cost per casemix-adjusted separations	Salary and wages plus visiting medical officer payments, multiplied by the inpatient fraction, divided by the number of casemix-adjusted separations.
Length of stay	The period from admission to separation less any days spent away from the hospital (leave days).
Live birth	Birth of a child who, after delivery, breathes or shows any other evidence of life, such as a heartbeat. Includes all registered live births regardless of birthweight.
Medicare	Australian Government funding of private medical and optometrical services (under the Medicare Benefits Schedule). Sometimes defined to include other forms of Australian Government funding such as subsidisation of selected pharmaceuticals (under the Pharmaceutical Benefits Scheme) and public hospital funding (under the Australian Health Care Agreements), which provides public hospital services free of charge to public patients.
Mortality rate	The number of deaths per 100 000 people.
Neonatal death	Death of a live born infant within 28 days of birth. Defined in Australia as the death of an infant that weighs at least 400 grams or that is of a

	gestational age of at least 20 weeks.
Neonatal death rate	Neonatal deaths divided by the number of live births registered.
Non-acute episode of care	Clinical services provided to admitted and non-admitted patients, including planned geriatric respite, palliative care, geriatric evaluation and management and services for nursing home type patients. Clinical services delivery by designated psychiatric or psychogeriatric units, designated rehabilitation units and mothercraft services are also considered non-acute.
Non-admitted occasions of service	Occasion of examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service establishment. Services may include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.
Non-admitted patient	A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.
Perinatal death	Fetal death or neonatal death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Perinatal death rate	Perinatal deaths divided by the total number of births (that is, live births registered and fetal deaths combined).
Perineal laceration (third or fourth degree)	A 'third degree' laceration or rupture during birth (or a tear following episiotomy) involves the anal sphincter, rectovaginal septum and sphincter NOS. A 'fourth degree' laceration, rupture or tear also involves the anal mucosa and rectal mucosa (NCCH 1998).
Perineal status	The state of the perineum following a birth.
Pre-anaesthetic consultation rate	The number of procedures where there is documented evidence of a pre-anaesthetic consultation, divided by the total number of procedures with an anaesthetist in attendance during the time period under study. The suggested data collection period is 2–4 weeks (depending on throughput) (ACHS 2002).
Primary care	Essential healthcare based on practical, scientifically sound and socially acceptable methods made universally accessible to individuals and families in the community.
Primipara	Pregnant woman who has had no previous pregnancy resulting in a live birth or a still birth.
Public hospital	A hospital that provides free treatment and accommodation to eligible admitted persons who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and may provide (and charge for) treatment and accommodation services to private patients. Charges to non-admitted patients and admitted patients on discharge may be levied in accordance with the Australian Health Care Agreements (for example, aids and appliances).
Puerperium	The period or state of confinement after labour.
Real expenditure	Actual expenditure adjusted for changes in prices.
Relative stay index	The actual number of acute care patient days divided by the expected number of acute care patient days, adjusted for casemix. Includes

	acute care separations only. Excludes: separations for renal dialysis and chemotherapy (because they are overwhelmingly same day); AR-DRGs with a length of stay component in the definition; rehabilitation AR-DRGs; error AR-DRGs 960Z, 961Z, 962Z and 963Z; separations of patients who died or were transferred within two days of admission; and separations with a length of stay greater than 120 days.
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	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. 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 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: State rate = (sum of observed infections in State/sum of expected 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.

9.9 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 9A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2006\Attach9A.xls and in Adobe PDF format as \Publications\Reports\2006\Attach9A.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

Public hospitals

Table 9A.1	Recurrent expenditure, public hospitals (including psychiatric hospitals), current prices, (\$ million)
Table 9A.2	Recurrent expenditure per person, public hospitals (including psychiatric) (2002-03 dollars)
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10 Primary and community health

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

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

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

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

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

- data on the PBS are included for the first time, including the ‘availability of PBS medicines’ indicator
- the ‘availability of GPs by region’ indicator is now reported by State and Territory
- the ‘management of diabetes’ indicator, which was previously reported as an outcome has been split into ‘management of diabetes’ and ‘hospitalisations for diabetes’ indicators

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- Indigenous data are now reported for the ‘hospitalisations for vaccine preventable conditions’ and ‘hospitalisations for diabetes’ indicators.

10.1 Profile of primary and community health

Definitions, roles and responsibilities

General practitioners (GPs) are a significant part of the medical practitioner workforce. The medical practitioner workforce comprises doctors trained in a specialty (including general practice) and other medical practitioners (OMPs). The Royal Australian College of General Practitioners (RACGP) defines a GP as ‘a medical practitioner who provides primary comprehensive and continuing care to patients and their families within the community’ (Britt *et al.* 2005, p. 140). Most of the data in this chapter include two types of medical practitioner who provide GP services:

- registered GPs — medical practitioners who are vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or equivalent (Fellowship of the RACGP has been required since 1996, to achieve vocational registration) or hold a recognised training placement
- OMPs — medical practitioners who are not registered GPs and who have at least half of the schedule fee value of their Medicare billing from non-referred attendances.

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

The Australian Government provides the majority of general practice income through Medicare fee-for-service and other payments, with the remainder coming from insurance schemes, patient contributions, and State and Territory government programs. Through its funding role, the Australian Government seeks to influence the supply, regional distribution and quality of general practice services. State and

Territory governments are responsible for registering and licensing GPs in their jurisdiction. Some provide additional incentives for GPs to locate in rural and remote areas.

The Australian Government also subsidises the cost of many prescription medicines through the PBS. The PBS aims to provide all Australians affordable, reliable and timely access to prescription medicines. Around 80 per cent of prescriptions dispensed in Australia are subsidised under the PBS. Users make a co-payment with the Australian Government paying the remaining cost for drugs eligible for subsidy. For concession card holders the co-payment is currently \$4.60. For other people, or general consumers, the co-payment is currently \$28.60. These amounts are normally adjusted in line with inflation on 1 January each year. Both concession card holders and general consumers are subject to a safety net threshold. Once spending within a calendar year has reached the relevant threshold, PBS medicines will generally be cheaper or free for the rest of the calendar year for these people. The 2005 safety net threshold is \$874.90 for general patients and \$239.20 for people holding a concession card (DHA 2005).

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

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

The Australian Government and the states and territories play different roles in supporting dental services in Australia's mixed system of public and private dental health care. The Australian Government supports the provision of dental services primarily through the 30 per cent private health insurance rebate. Additionally, the Australian Government provides Medicare funding for a limited range of medical services of an oral surgical nature, and provides funding for the dental care of war

veterans and full-time and part-time members of the Australian Defence Force. It also has a role in the provision of dental services through Community Controlled Aboriginal Medical Services. The states and territories have the main responsibility for the delivery of the major public dental health care programs, primarily directed at children and disadvantaged adults. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink.

Funding

General practice

Almost all of the services provided by private GPs are at least partly funded by the Australian Government through Medicare and the DVA. This is illustrated by data from the annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia. The BEACH survey found that 93.7 per cent of all encounters with GPs in 2004-05 were for services at least partly funded by Medicare or the DVA (table 10.1). The Australian Government also provides payments to GPs through the Practice Incentives Program (PIP) and the GP Immunisation Incentives Scheme (DHAC 2000). These payments are included in the data for Australian Government expenditure presented below (figure 10.1). The Australian Government also invests in general practice through the Divisions of General Practice Program.

The Australian Government spent approximately \$4.3 billion on general practice in 2004-05, including through Medicare, non-Medicare funding, expenditure by the DVA and other funding programs. This was equivalent to expenditure of \$213 per person in 2004-05 (figure 10.1). Figure 10.1 does not give a complete picture of government expenditure on primary health because it does not include expenditure on Indigenous-specific primary health care services, other community health services, and services delivered through hospital accident and emergency departments. These types of primary healthcare are more prevalent in rural and remote areas. Accordingly, figure 10.1 understates expenditure on primary health, particularly in jurisdictions with larger proportions of Indigenous people and people living in rural and remote areas.

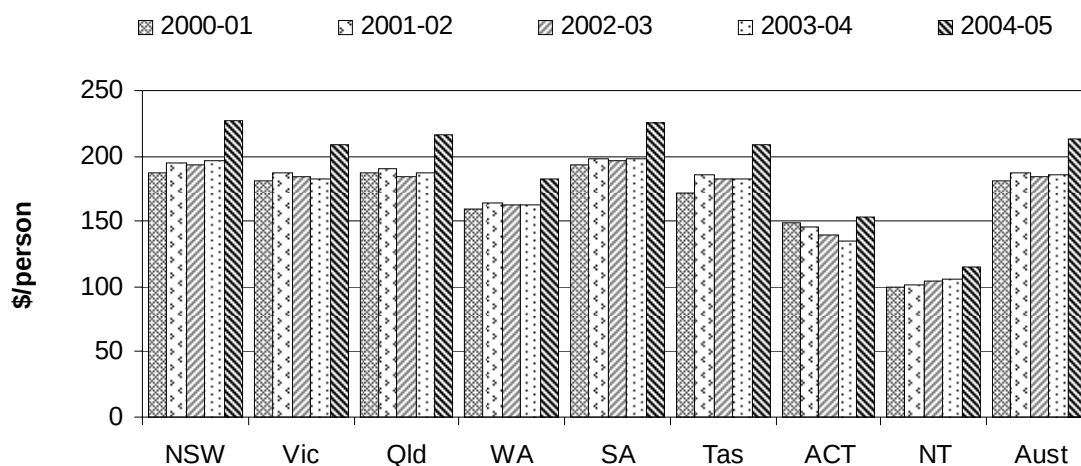
Table 10.1 GP encounters, by source of funding, 2004-05^{a, b, c}

	Number ^d	Rate ^e	95% LCL	95% UCL
	no.	no./100 encounters	no./100 encounters	no./100 encounters
GPs participating in the BEACH survey	954	..	..	..
Total encounters for which BEACH data were recorded	94 386	..	..	..
Encounters with missing data	7 355	..	..	..
Direct encounters	84 775	97.4	97.1	97.7
No charge	457	0.5	0.2	0.9
Medicare paid ^f	81 582	93.7	93.3	94.2
Workers compensation	2 132	2.5	2.1	2.8
Other paid (hospital, State, etc.)	605	0.7	0.1	1.3
Indirect encounters ^g	2 256	2.6	2.1	3.1

UCL = upper confidence limit. LCL = lower confidence limit. ^a April 2004 to March 2005. ^b An 'encounter' is any professional interchange between a patient and a GP (Britt *et al.* 2000). ^c They are usually the result of a phone call by a patient. Data from the BEACH survey may not be directly comparable with the other data on medical practitioners that are reported in this chapter. ^d Number of encounters after post-stratification weighting for GP activity and GP age and sex. ^e Missing data removed. Percentage base (N = 87 030). ^f Includes Australian Government payments made through the DVA. ^g Indirect consultations are those at which the patient is not seen by the GP but that generate a prescription, a referral, a certificate or another service. .. Not applicable.

Source: Britt *et al.* (2005); table 10A.1.

Figure 10.1 Australian Government real expenditure per person on GPs (2004-05 dollars)^a



^a The data include Medicare, PIP, DVA, Divisions of General Practice and General Practice Immunisation Incentives Scheme payments. DVA data cover consultations by local medical officers (LMOs), whether vocationally registered GPs or not. From available files, it is not possible to extract the amounts paid to LMOs (as opposed to specialists) for procedural items. It is expected, however, that the amounts for these services are small compared with payments for consultations. The Australian Government invests in general practice through the Divisions of General Practice Program.

Source: Department of Health and Ageing (DHA) (unpublished); table 10A.2.

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Expenditure on the PBS and RPBS was around \$5.8 billion, or \$285 per person, in 2004-05. Expenditure on the PBS was around \$5.3 billion in 2004-05, 79.6 per cent of which was expenditure on concessional patients (table 10.2). Data on government expenditure on pharmaceuticals is also presented in the 'Health preface.'

Table 10.2 PBS and RPBS expenditure, 2004-05 (\$ million)^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
PBS general ^b	369.3	266.6	203.7	101.2	82.0	21.5	22.7	6.2	1 073.6
PBS concessional ^c	1 471.5	1 062.5	792.2	357.2	363.0	119.1	44.4	12.6	4 222.5
PBS doctor's bag	3.4	2.4	2.0	0.6	0.7	0.2	0.1	—	9.4
PBS total	1 844.2	1 331.6	997.9	458.9	445.7	140.8	67.3	18.9	5 305.5
RPBS total ^d	na	na	na	na	na	na	na	na	465.7
Total	1 844.2	1 331.6	997.9	458.9	445.7	140.8	67.3	18.9	5 771.3
\$ per capita ^e	272.4	265.9	254.3	229.5	289.8	292.2	206.5	93.7	285.0

^a State and territory level data is 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 DHA annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements. ^b Includes PBS general ordinary and safety net. ^c Includes concessional ordinary and concessional free safety net. ^d Includes RPBS ordinary and RPBS safety net. ^e Government cost per capita for PBS groups excluding doctor's bag. **na** Not available. — Nil or rounded to zero.

Source: DHA (unpublished).

Community health services

Expenditure data are not available for all of the community health services covered in this chapter. The Australian Institute of Health and Welfare (AIHW) publishes expenditure data on community and public health, and dental services. The former category, however, includes public health activities that are not covered in this chapter, such as food safety regulation and media campaigns to promote health awareness. The dental services category includes private dental services (funded by

insurance premium rebates and non-government expenditure) that are also not reported in this chapter. In 2003-04, government expenditure on community and public health was \$4.9 billion, with State, Territory and local government providing 80.3 per cent and the Australian Government providing 19.4 per cent of this expenditure (table 10.3). Australian Government direct outlay expenditure on dental services was \$77 million in 2003-04, and State, Territory and local government expenditure was \$326 million (table 10.3).

Table 10.3 Estimated funding on community and public health, and dental services, 2003-04 (\$ million)^{a, b}

	<i>Australian Government</i>			<i>State and local govt</i>	<i>Total govt</i>	<i>Non-govt</i>	<i>Total</i>
	<i>Direct outlays</i>	<i>Premium rebates</i>	<i>Total</i>				
Community and public health ^c	941	–	941	3899	4840	17	4857
Dental services ^d	77	319	397	326	723	3971	4694

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

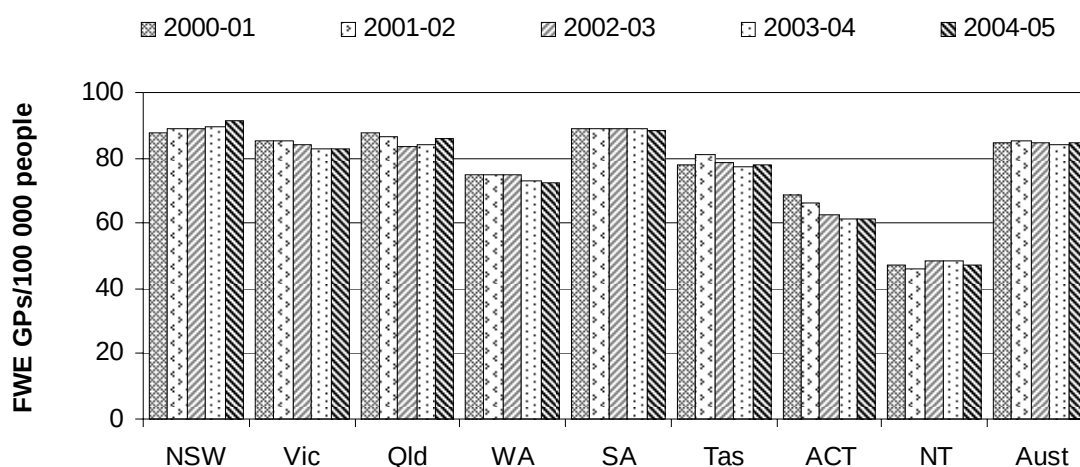
Source: AIHW (2005d).

Size and scope

General practice

There were 24 669 registered GPs and OMPs billing Medicare in Australia in 2004-05. On a full time workload equivalent (FWE) basis, there were 17 273 registered GPs and OMPs. This was equal to 84.9 registered GPs and OMPs per 100 000 people (table 10A.3). These data exclude services provided by GPs working with the Royal Flying Doctor Service and GPs working in Indigenous-specific primary health care services and public hospitals without the right of private practice. 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 number of FWE registered GPs and OMPs per 100 000 people are shown in figure 10.2.

Figure 10.2 **Availability of GPs (full time workload equivalent)^a**



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

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

There were around 186 million services provided under the PBS and RPBS in 2004-05, amounting to 9.2 scripts per person. There were around 170 million services provided under the PBS in 2004-05, of which 83.1 per cent were concessional (table 10.4).

Table 10.4 **PBS and RPBS services, 2004-05 (million services)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
PBS general ^a	9.8	7.1	5.3	2.7	2.1	0.6	0.6	0.2	28.4
PBS concessional ^b	48.8	35.7	26.7	12.1	12.2	4.2	1.4	0.4	141.5
PBS doctor's bag	0.1	0.1	0.1	—	—	—	—	—	0.4
PBS total	58.8	42.9	32.2	14.9	14.3	4.8	2.0	0.6	170.3
RPBS total ^c	na	na	na	na	na	na	na	na	15.7
Total	58.6	42.8	32.1	14.8	14.3	4.8	2.0	0.6	186.0
Services per capita ^d	8.7	8.6	8.2	7.4	9.3	9.9	6.0	2.9	9.2

^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. ^d Services per capita for PBS groups excluding doctor's bag. na Not available. — Nil or rounded to zero.

Source: DHA (unpublished).

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 10A.44–10A.52 provide information on community health programs in each jurisdiction. The more significant of these programs are described below. Other community health programs provided by some jurisdictions include:

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

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

Maternal and child health

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

Public dental services

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

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

Committee on Oral Health 2004). A number of jurisdictions indicated to the Review that they provided dental services in 2004-05.

- NSW provided basic and emergency dental care in the community (table 10A.45).
- Victoria provided emergency, general and denture services for concession card holders and their dependents. Victoria also provided specialist care for concession card holders and domiciliary services for people who find it difficult to leave their home (table 10A.46).
- Queensland provided free emergency, general, denture and specialist services to Pensioner Concession Card, Health Care Card, and State and Commonwealth Seniors card holders and their dependents. Free services were also provided to school children to Year 10 (table 10A.47).
- SA provided specialist dental services for concession card holders provided in association with students of the University of Adelaide. SA also provided emergency and general dental care (including dentures) for adult holders of concession card and their dependents in public dental clinics and through private providers (table 10A.49).
- Tasmania provided emergency, basic general dental care (such as check up, x-rays, dental health advice and referral), and dentures to holders of a Health Care or Pensioner Concession Card. Tasmania also engaged in health promotion and prevention activities to promote oral health on a population basis (table 10A.50).
- The ACT provided dental services with specific adult services such as periodontics, prosthodontics, domiciliary and oral surgery to adults (table 10A.51).
- The NT provided services to eligible adults from remote community health centres and town based clinics (table 10A.52).

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 2005a). This report excluded some treatment activities, including opioid pharmacotherapy treatment where it is the only treatment provided. The report also excluded data for the majority of Indigenous substance use services and Indigenous

community healthcare services that also provide alcohol and other drug treatment services and are funded by the Australian Government.

A total of 622 alcohol and other drug treatment services contributed 2003-04 data for the National Minimum Data Set. Of these, 300 (48.2 per cent) identified as government providers and 322 (51.7 per cent) identified as non-government providers (table 10A.8). All of the non-government providers received some government funding for 2003-04. A total of 115 163 clients were registered for treatment in 2003-04, of whom 65.9 per cent were male (AIHW 2005a). Alcohol was reported as the most common principal drug of concern for which clients sought treatment (37.5 per cent of treatment episodes). Cannabis was the next most common drug of concern (22.0 per cent of treatment episodes), followed by heroin (18.0 per cent of treatment episodes) and amphetamines (11.0 per cent of treatment episodes) (AIHW 2005a). Further information on alcohol and other drug treatment services funded by governments is included in tables 10A.44–10A.52.

Indigenous community healthcare services

Indigenous Australians utilise a range of primary health care services in Australia including private general practitioners, Indigenous-specific primary health care services and community health services. (The use of general practice services by Indigenous people is discussed separately below.) There are Indigenous-specific 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 for Indigenous-specific primary health care services is provided by Australian, State and Territory governments.

In addition to the Indigenous-specific primary health care services, specific health programs for Indigenous Australians are funded by jurisdictions. The following jurisdictions indicated to the Review that in 2004-05 they had community health programs aimed specifically at Indigenous people.

- NSW provided Indigenous health services, such as health information and education, counselling, pre and post natal programs, early childhood nursing and health promotion programs (table 10A.45).
- Queensland provided primary and community healthcare services and activities that address prevention and health management/maintenance for Indigenous communities. Services offered include: disease/illness prevention and promotion services; men's and women's health programs; child and adolescent health services; alcohol, tobacco and other drug services; sexual health services; allied

health services; and patient transport provided to increase access to healthcare (table 10A.47).

- SA provided a range of Indigenous health services provided through multidisciplinary teams from community health who work with Indigenous communities. Services provided by SA include strategies to improve Indigenous mental health, improve nutrition standards and reduce tobacco use (table 10A.49).
- Tasmania provided population and health priorities programs to prevent and manage chronic conditions such as diabetes and cardiovascular diseases, and to promote nutrition, physical activity and injury prevention in identified population groups, including the Indigenous population (table 10A.50).

All other jurisdictions treat Indigenous people through their mainstream community programs.

The Australian Government also funds Aboriginal and Torres Strait Islander primary healthcare services. Information on these services is collected through service activity reporting (SAR) surveys. Many of the surveyed 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 that are funded from all sources.

For 2003-04, SAR data are reported for 138 Indigenous primary healthcare services (table 10A.4). Of these services, 54 (39.1 per cent) were located in remote or very remote areas (table 10A.5). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 10A.6).

An episode of healthcare is defined in the SAR data collection as contact between an individual client and a service by one or more staff to provide healthcare. Over 1.6 million episodes of healthcare were provided by participating services in 2003-04 (table 10.5). Of these, around 585 000 (36.3 per cent) were in remote or very remote areas (table 10A.5).

The services included in the SAR data collection employed approximately 1713 full time equivalent health staff (as at 30 June 2004). Of these health staff, 1091 were Indigenous (63.7 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous, however, were relatively low (3.3 per cent and 12.4 per cent respectively) (table 10A.7).

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

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

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

Source: DHA SAR (unpublished).

Use of general practice services by Indigenous people

An overview of health factors and outcomes for Indigenous people is provided in the 'Health preface'. Data on national expenditure on general practice services for Indigenous people in 2001-02 (the most recent year for which expenditure data are available by Indigenous status) indicate:

- expenditure on Medicare per Indigenous person was about 39 per cent of expenditure per non-Indigenous person
- expenditure on the PBS per Indigenous person was about 33 per cent of expenditure per non-Indigenous person
- Indigenous Australians used secondary/tertiary care (such as hospitals) at a higher rate than they used primary care and at a higher rate than that used by non-Indigenous people (AIHW 2005c; see 'Health preface').

Data from the annual BEACH survey indicate the nature of encounters between Indigenous people and GPs. It is uncertain whether all patients are asked the Indigenous identification question and therefore these data may under-represent the actual number of GP encounters with Indigenous Australians. In addition, these data need to be treated with care because the BEACH survey was not designed to produce reliable results for Indigenous people and may under-identify them. For these reasons, the 2003 BEACH survey aggregated Indigenous data over a five year period to improve reliability

Over the period 1998-99 to 2002-03, 5476 encounters between Indigenous patients and GPs were recorded in the BEACH survey (table 10A.9). This represented 1.1 per cent of GP encounters in the study over this period. By comparison, the proportion of Indigenous people in the Australian population was 2.4 per cent at

June 2001 the midpoint of this period (tables A.2 and A.7). Extrapolating these results to all GP/patient encounters across Australia suggests there was an annual average of around 1.1 million encounters between Indigenous patients and GPs over the five years to 2002-03 (Britt *et al.* 2003).

The most common health problem managed in GP encounters with Indigenous people over the five years of the BEACH survey was diabetes, which accounted for 7.1 per 100 GP encounters with Indigenous people, compared with 2.8 per 100 GP encounters with all people. Other problems with significantly higher management rates in GP encounters with Indigenous people included acute otitis media/myringitis, asthma, and pre- and post-natal care (table 10.6). Further information about the location, remoteness and management activities of BEACH survey encounters between Indigenous patients and GPs is included in tables 10A.10, 10A.11 and 10A.12.

Table 10.6 Selected health problems in encounters with GPs, by Indigenous status, 1998-99 to 2002-03

<i>Problems managed</i>	<i>Indigenous people's encounters</i>			<i>All encounters</i>		
	<i>Rate (n=5476)</i>	<i>95% LCL</i>	<i>95% UCL</i>	<i>Rate (n=502 100)</i>	<i>95% LCL</i>	<i>95% UCL</i>
	no./100	no./100	no./100	no./100	no./100	no./100
Diabetes ^a	7.1	6.0	8.2	2.8	2.7	2.9
Hypertension ^a	6.7	5.7	7.7	8.8	8.6	9.0
Upper respiratory tract infection	5.7	4.8	6.5	6.0	5.9	6.2
Asthma	4.3	3.6	5.0	2.9	2.8	3.0
Acute bronchitis/bronchiolitis	3.8	3.2	4.5	2.8	2.7	2.8
Depression ^a	3.4	2.9	3.9	3.8	3.7	3.9
Immunisation (all) ^a	3.3	2.6	3.9	4.8	4.6	5.0
Acute otitis media/myringitis	3.1	2.5	3.6	1.4	1.4	1.5
Back complaint ^a	2.2	1.7	2.6	2.6	2.5	2.7
Pre- and post-natal check ^a	2.1	1.5	2.5	1.0	0.9	1.0
Subtotal	41.7	..	..	..	..	..
Total problems^b	147.7	143.7	151.6	148.1	147.3	148.9

LCL = lower confidence level. UCL = upper confidence level. ^a Includes multiple primary care classification codes. ^b Total problems managed is greater than 100, because more than one problem can be managed per encounter. .. Not applicable.

Source: Britt *et al.* (2003); table 10A.9.

10.2 Framework of performance indicators

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

Box 10.1 Objectives for primary and community health

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

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

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

The performance indicator framework shows which data are comparable in the 2006 Report (figure 10.3). 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 (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.

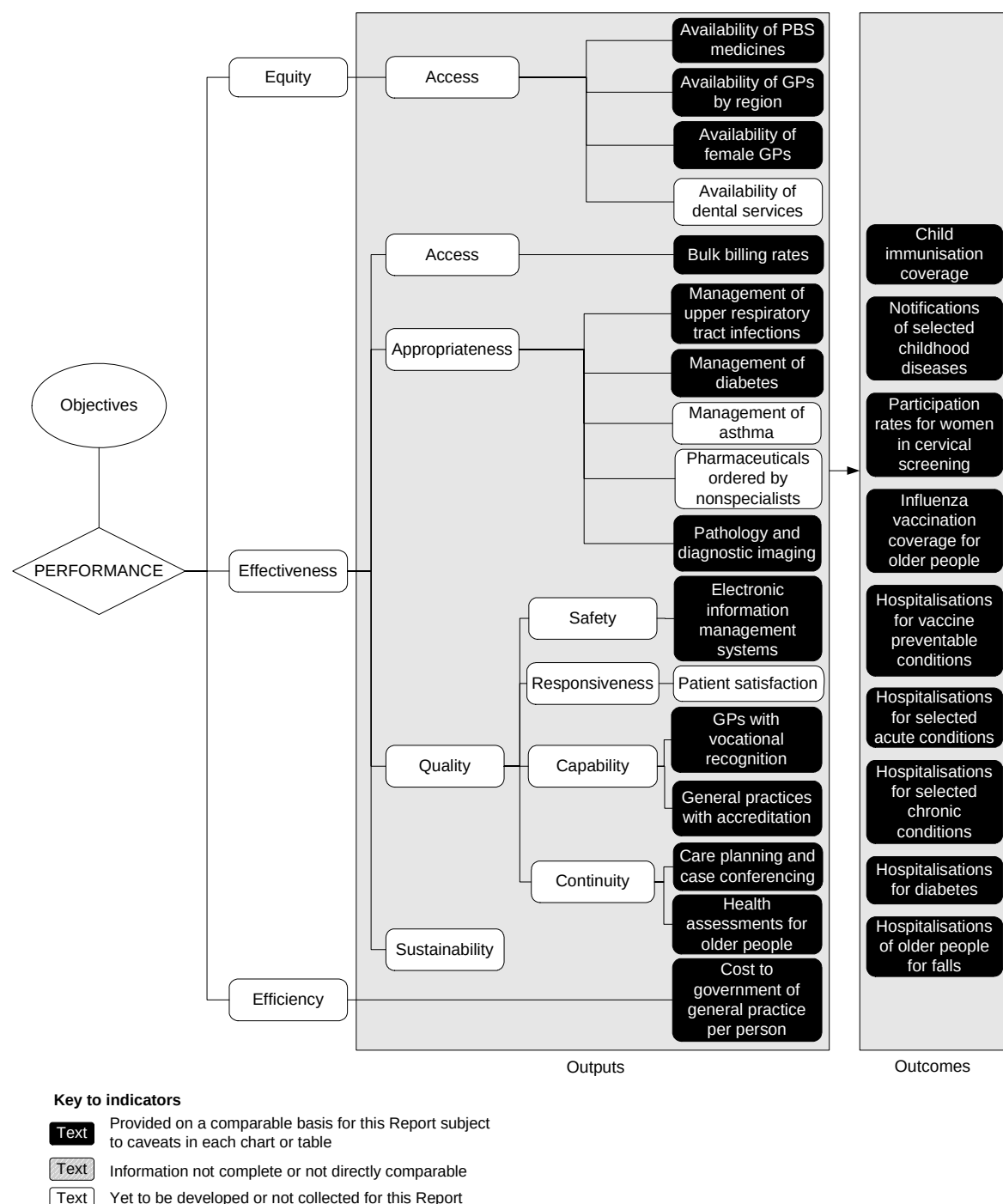
The following changes have been made to the performance indicator framework this year.

- ‘Availability of PBS medicines’ is included for the first time in line with the increase in scope of this chapter to include reporting on the PBS.
- ‘Management of diabetes’, which was previously reported as an outcome, has been split into two indicators, the first indicator ‘management of diabetes’ is reported as an indicator of appropriateness while the second indicator ‘hospitalisations for diabetes’ is reported as an outcome. The ‘management of

diabetes' indicator previously contained many pieces of data. The data on diabetes registers, glycaemic control assessments and patients at risk of complications are better classified as an output indicator of appropriateness, while the data on hospitalisations are better classified as an overall outcome indicator.

- 'Bulk billing rates' has been moved from being an indicator of equity of access to being an indicator of effectiveness of access. Equity of access relates to access by different groups such as those with a disability or from disadvantaged ethnic groups or geographic locations. The 'bulk billing rates' indicator does not report directly on these groups, but relates to timeliness and the cost of accessing GP services for all and so is better classified as an indicator of effectiveness of access. Chapter 1 contains a discussion of the distinction between equity of access and effectiveness of access.
- 'Availability of dental services' and 'management of asthma' have been included in the framework for the first time, however, specific measures have not been developed.

Figure 10.3 Performance indicators for primary and community health



10.3 Key performance indicator results

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

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

Equity

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

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

Access

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

Availability of PBS medicines

Box 10.2 Availability of PBS medicines

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

Three measures are presented for this indicator:

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

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Box 10.2 (Continued)

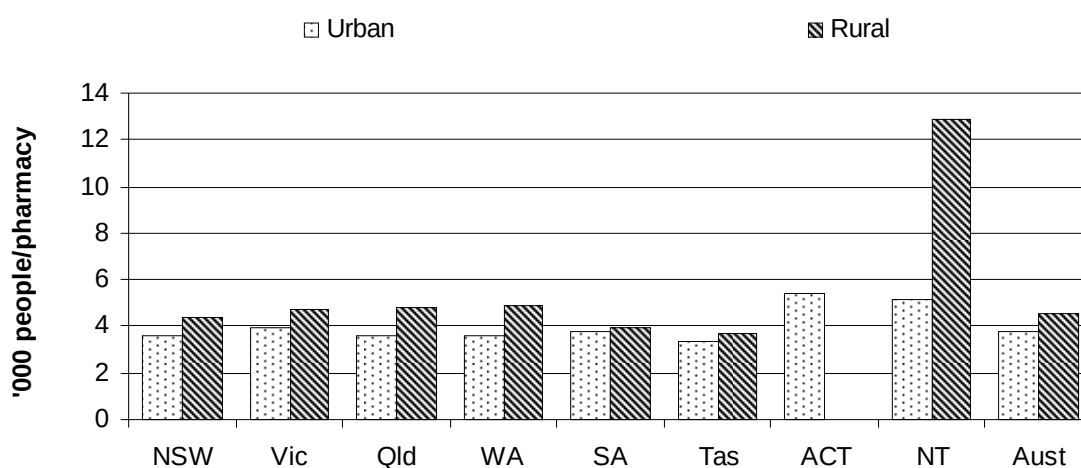
A decrease in people per pharmacy indicates improved availability of PBS medicines. An increase in PBS expenditure per person indicates improved availability of PBS medicines. An increase in the proportion of PBS prescriptions filled at a concessional rate indicates an improved access to PBS prescriptions.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

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

The distribution of pharmacies underlies access to the PBS. Across Australia, there were 3739 people per pharmacy in urban areas and 4591 people per pharmacy in rural areas in 2004-05. In all states and territories, the number of people per pharmacy was higher in rural than in urban areas (except in the ACT, which has no rural statistical areas) (figure 10.4).

In addition to pharmacies, 85 medical practitioners and 159 hospitals were approved to supply PBS medicines to the community in 2004-05. There were 83 medical practitioners and 59 hospitals located in rural areas (table 10A.14). These additional services may help to improve access to PBS medicines in some locations.

Figure 10.4 People per pharmacy, 2004-05^a



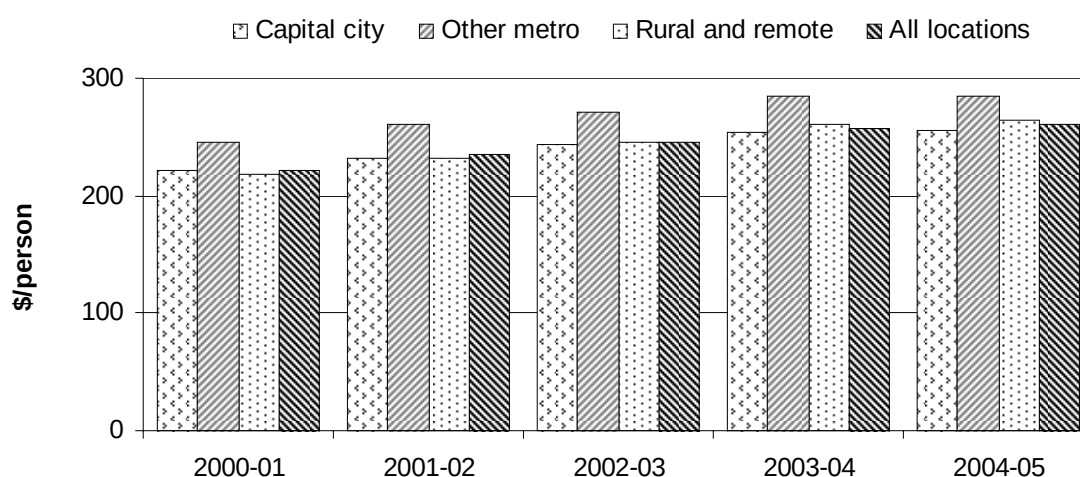
^a Pharmacies measured using the Accessibility/Remoteness Index of Australia modified for Pharmacies (PHARIA). Urban = PHARIA 1. Rural = PHARIA 2-6. The ACT has no rural statistical areas.

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

For Australia as a whole in 2004-05, PBS expenditure per person was fairly similar across regions except other metro. PBS expenditure per person has generally

increased each year over the past five years for each region in 2004-05 dollars (figure 10.5).

Figure 10.5 **PBS expenditure per person (2004-05 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 the DHA's annual report which are prepared on an accrual accounting basis and also include doctor's bag and other categories administered under special arrangements.

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

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory (although this is not available by regional location) in table 10A.13. Australia-wide, 83.1 per cent of prescriptions were concessional in 2004-05.

Availability of GPs by region

Box 10.3 Availability of GPs by region

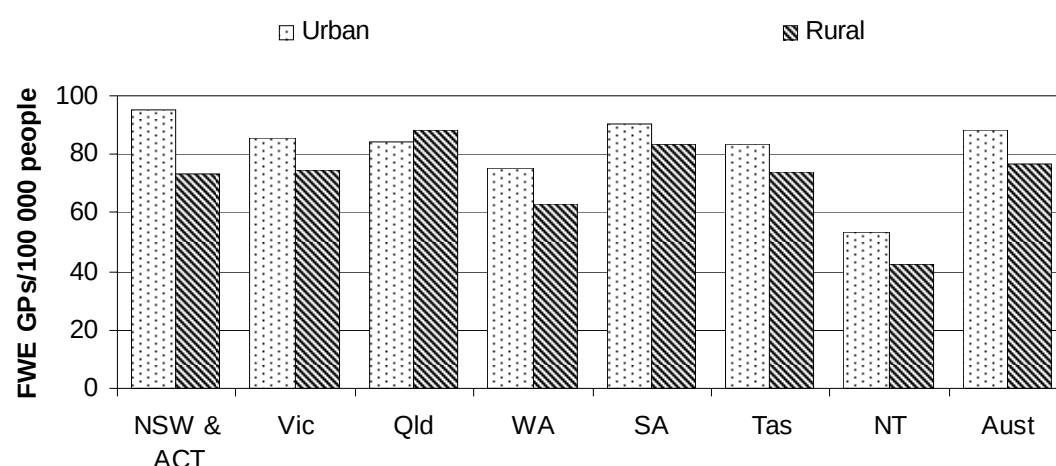
The availability (or supply) of GPs by region affects people's access to general practice services, particularly in rural and remote areas. Low availability can result in increased travel distance to a practice, increased waiting times to see a GP, and difficulty in booking long consultations. Low availability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

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

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

‘Availability of GPs by region’ is reported by State and Territory for the first time this year. In terms of FWE GPs per 100 000 people, in all states and territories there were more GPs available in urban than rural areas in 2004-05 (figure 10.6). The bulk billed proportion of non-referred attendances was generally lower in rural and remote centres, except other remote areas, than in capital cities or other metropolitan centres (table 10A.18).

Figure 10.6 **Availability of GPs (full time workload equivalent), 2004-05^{a, b, c}**



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

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

Availability of female GPs

Box 10.4 **Availability of female GPs**

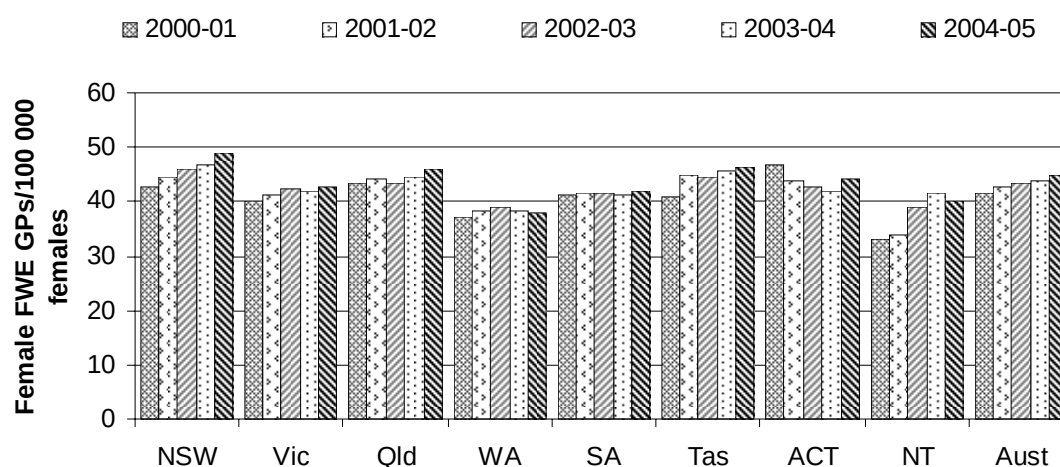
This indicator measures equity of access, recognising that some female patients prefer to discuss health matters with, and to receive primary healthcare from, a female GP.

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

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

In 2004-05, 36.8 per cent of Australia’s GPs were female. This represented 26.7 per cent of FWE GPs (tables 10A.3 and 10A.17). In 2004-05, there were 45.0 female FWE GPs per 100 000 females in Australia (figure 10.7).

Figure 10.7 **Availability of female GPs (full time workload equivalent)^a**



^a Data relate to registered GPs and OMPs.

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

Availability of dental services

The Steering Committee has identified ‘availability of dental services’ as an indicator of access to primary and community health (box 10.5). Data for this indicator, however, were not available for the 2006 Report.

Box 10.5 Availability of dental services

‘Availability of dental services’ has been identified as an indicator of access, but a specific measure has not yet been developed.

Effectiveness

Access

‘Bulk billing rates’ (box 10.6) is currently the only indicator reported against effectiveness and access. In previous years this indicator was reported against equity and access.

Bulk billing rates

Box 10.6 Bulk billing rates

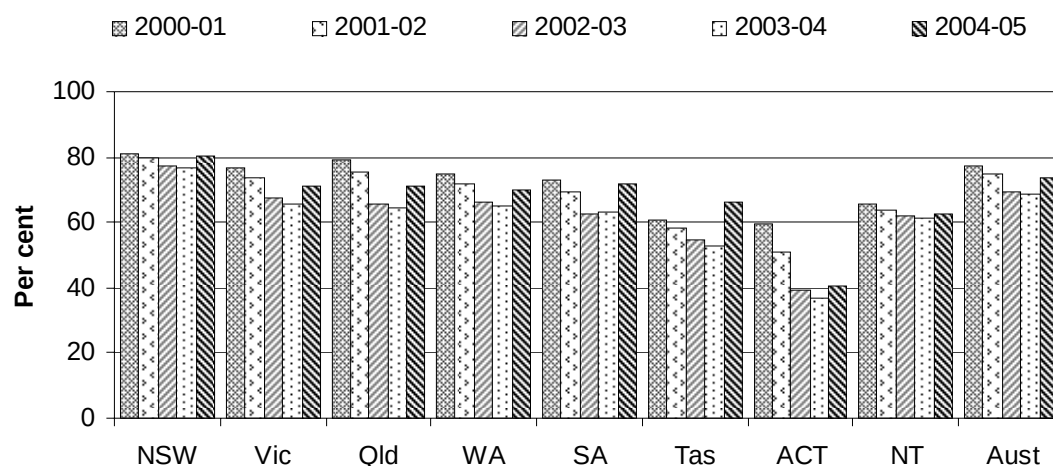
Patient visits to GPs are classed as non-referred attendances under Medicare. Patients are either bulk billed or required to pay part of the cost of the non-referred attendance. Where a patient is bulk billed, the GP bills Medicare Australia directly and since 1 January 2005 receives 100 per cent of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

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

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

Australia-wide, the bulk billed proportion of non-referred attendances was 73.8 per cent in 2004-05. This proportion varied across jurisdictions (figure 10.8).

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



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

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

Appropriateness

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

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

Management of upper respiratory tract infections

Box 10.7 Management of upper respiratory tract infections

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

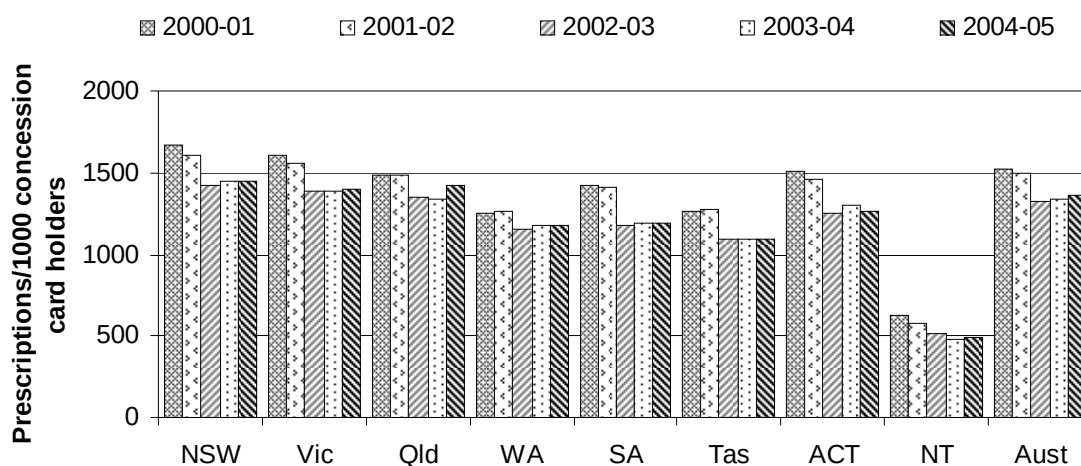
Ideally, this indicator would be based on the total population, but data restrictions mean it is based only on PBS concession card holders. The indicator is defined as the number of prescriptions for the oral antibiotics used most commonly to treat upper respiratory tract infection provided to PBS concession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

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

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

Australia-wide, the prescription rate for the oral antibiotics used most commonly to treat upper respiratory tract infection in 2004-05 was 1360.1 per 1000 PBS concession card holders. The prescription rate decreased by 10.6 per cent between 2000-01 and 2004-05 (although it had increased slightly between 2002-03 and 2004-05) (figure 10.9).

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



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

Management of diabetes

Box 10.8 Management of diabetes

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

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

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

- the proportion of adults with diabetes who have been diagnosed and placed on a Divisions of General Practice diabetes register. An increase in this proportion indicates improved patient management and monitoring
- the proportion of people on the Divisions' diabetes registers who have had a glycaemic control assessment. An increase in this proportion indicates improved patient management and monitoring

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Box 10.8 (Continued)

- the proportion of those who have had a glycaemic control assessment who are at risk of future complications — that is, they have glycated haemoglobin (HbA1c) greater than 2 per cent above the upper limit of normal (ULN). A decrease in this proportion indicates improved disease control.

While good primary and community healthcare can limit the development of diabetic complications, patient compliance with measures to maintain blood glucose levels within the near normal range (such as medication, diet and physical activity) also plays an important part.

Management of diabetes — diabetes register

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

Nationally in 2002, 17.9 per cent of adults with diabetes were on the Divisions' diabetes registers (table 10.7). These data are based on a small and not necessarily representative number of Divisions of General Practice that voluntarily took part in a national data collection.

Table 10.7 Management of adults with diabetes by participating Divisions of General Practice, 2002^{a, b, c, d, e}

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

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

Source: Centre for GP Integration Studies (2003).

Management of diabetes — glycaemic control assessments

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

In 2002, 46.0 per cent of registered adults with Type 2 diabetes with a known HbA1c measurement, had undergone a glycaemic control assessment in the previous six months (table 10.7).

Management of diabetes — patients at risk of complications

Of the people who had undergone a glycaemic control assessment in 2002, 18.7 per cent had HbA1c levels above the point at which there is an increased likelihood of complications (2 per cent above the ULN) (table 10.7). The proportion of adults with Type 2 diabetes with HbA1c levels in this range may initially reflect an increase in the impact of risk factors on changing population cohorts. Over time, however, regular testing and good management by GPs is likely to result in a decline in the proportion of people with diabetes in the category most at risk of complications.

Management of asthma

The Steering Committee has identified ‘management of asthma’ as an indicator of the appropriateness of GP services (box 10.9). Data for this indicator, however, were not available for the 2006 Report.

Box 10.9 Management of asthma

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

Pharmaceuticals ordered by non-specialists

The Steering Committee has identified ‘pharmaceuticals ordered by non-specialists’ as an indicator of the appropriateness of GP services (box 10.10). Data for this indicator, however, were not available for the 2006 Report.

Box 10.10 Pharmaceuticals ordered by non-specialists

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

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

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

Four measures are reported:

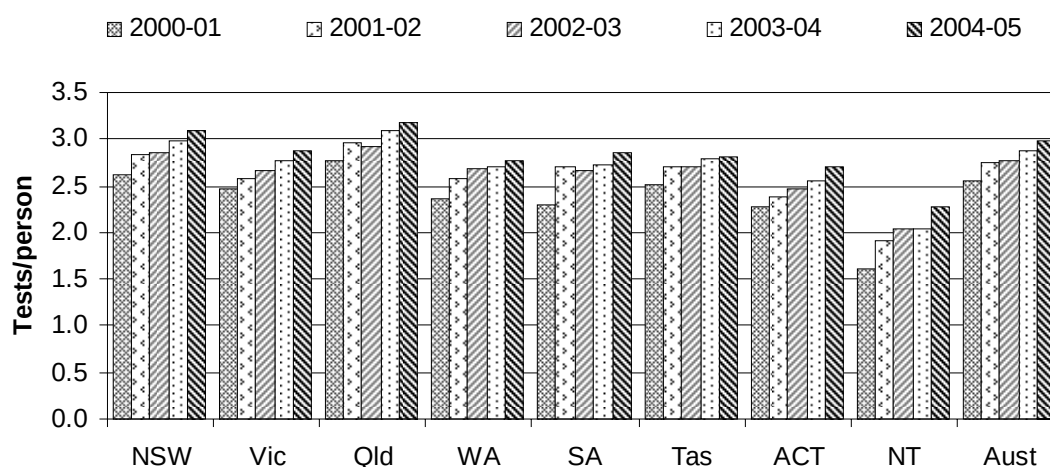
- pathology tests ordered by registered GPs and OMPs per person
- diagnostic imaging referrals from registered GPs and OMPs per person
- benefits paid per person for pathology tests
- benefits paid per person for diagnostic imaging.

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

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

Nationally, the number of pathology tests ordered per person increased from 2.5 in 2000-01 to 3.0 in 2004-05 (figure 10.10). These data represent only pathology tests paid through Medicare. In general, Medicare benefits are payable for a maximum of three tests performed on a specimen. Data on the number of tests performed but not rebated are not available. Pathology services for some areas of WA, SA, the ACT and the NT were funded by the Australian Government through health program grants until 2001-02, so these data may underestimate the number of pathology tests ordered in some jurisdictions before 2002-03 (although the amounts are relatively insignificant).

Figure 10.10 Pathology tests ordered by GPs^a

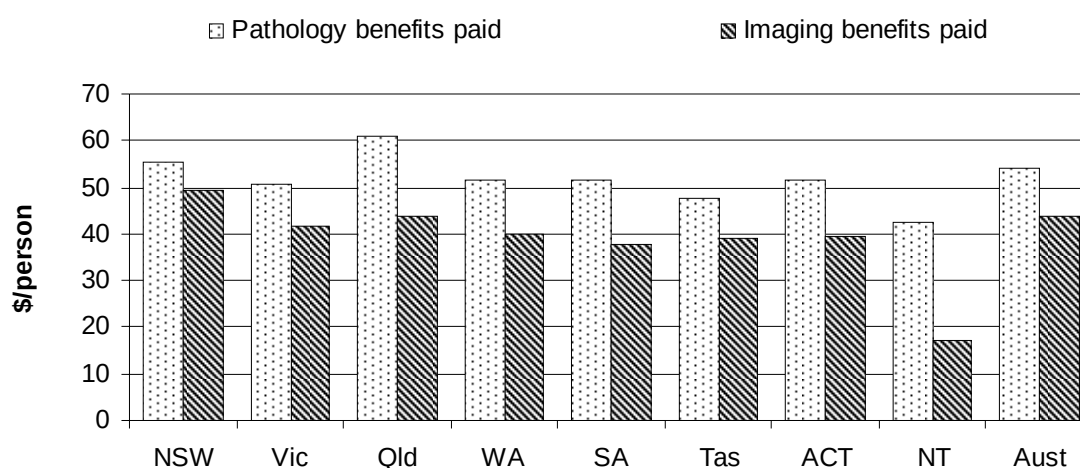


^a Data include tests ordered by registered GPs and OMPs. Data include tests ordered at the request of a patient (patient episode initiated items).

Source: DHA (unpublished); table 10A.21.

Australian Government expenditure (under Medicare) on pathology tests amounted to \$1.1 billion in 2004-05, equal to \$54 per person. Nationally, Medicare benefits worth \$892.5 million were paid for diagnostic imaging in 2003-04, equal to \$44 per person (figure 10.11).

Figure 10.11 Benefits paid for pathology tests and diagnostic imaging, 2004-05^a

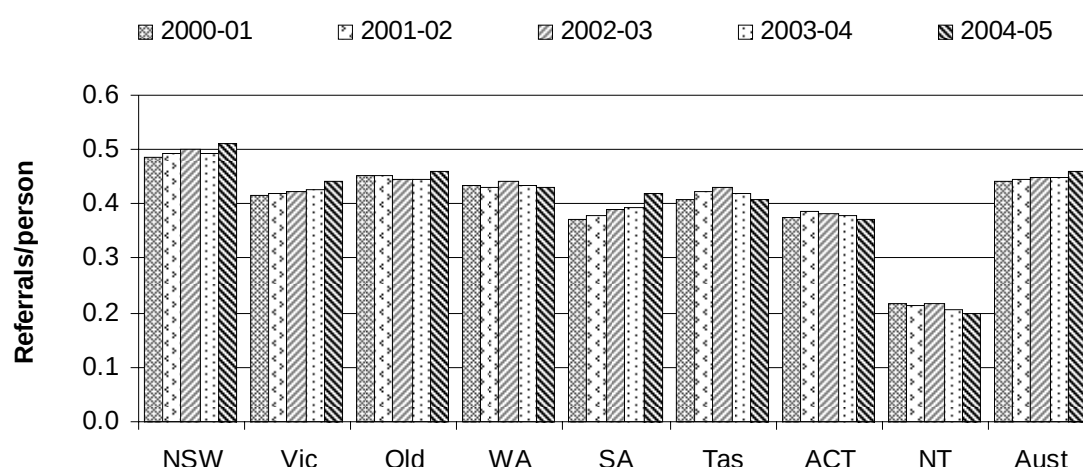


^a Includes benefits paid through Medicare (including DVA data) for pathology tests ordered, and diagnostic imaging referred, by registered GPs and OMPs.

Source: DHA (unpublished); tables 10A.21 and 10A.22.

Nationally, the number of diagnostic imaging referrals per person remained relatively constant over the five years to 2004-05 (figure 10.12). The marked difference in the number of pathology tests ordered per person and the imaging referrals per person might be because up to three tests can be ordered with one pathology specimen, whereas each imaging referral results in only one test.

Figure 10.12 **Diagnostic imaging referrals from GPs^a**



^a Data relate to registered GPs and OMPs.

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

Quality — safety

General practices with electronic information management systems

The Practice Incentives Program (PIP) provides payments to general practices based on patients' ongoing healthcare needs (rather than on service volumes), promoting activities such as: the use of electronic information management systems; after-hours care; the teaching of medical students; the employment of practice nurses; and improved chronic disease management.

Under the PIP Information Management, Information Technology program, two incentives encourage the computerisation of practices: first, the electronic prescribing incentive paid for the use of bona fide electronic prescribing software to generate the majority of prescriptions; and second, an incentive paid for the use of computer systems to send and/or receive clinical information. Computerisation of general practices can improve the safety (in terms of quality and effectiveness) of GP services (box 10.12).

Box 10.12 General practices with electronic clinical information management systems

The proportion of general practices with electronic information management systems is an indicator of safety because such systems can reduce prescribing and dispensing errors. Reductions in these types of error reduce the likelihood of harm to patients from adverse drug reactions. Electronic information management systems can also improve other aspects of quality by providing access to timely clinical data and improving the maintenance of patient health records. Use of such technology can, for example, facilitate the management of screening and other preventive health activities for patients (DHAC 2000).

Two measures of this indicator are reported:

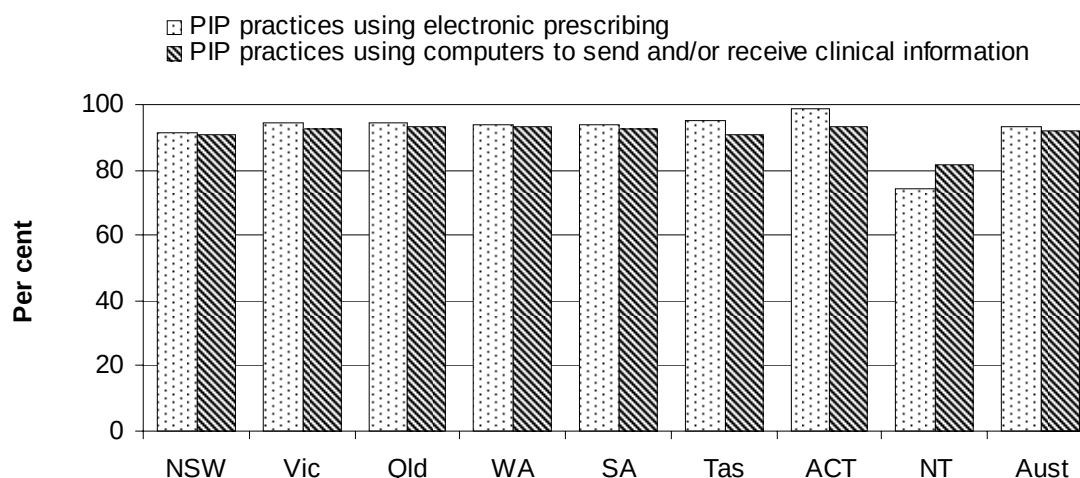
- the proportion of PIP practices that use electronic prescribing
- the proportion of PIP practices that use computers to send/or receive clinical information.

An increase in these proportions may indicate an improvement in the level of safety in patient management by general practices.

The PIP does not include all practices in Australia. PIP practices covered around 80 per cent of Australian patients (measured as standardised whole patient equivalents) in May 2004 (DHA unpublished).

Australia-wide, 93.2 per cent of PIP practices used electronic prescribing systems in May 2005. Of PIP practices, 92.0 per cent had the capacity to send and/or receive clinical information via use of computer technology in May 2005 (figure 10.13).

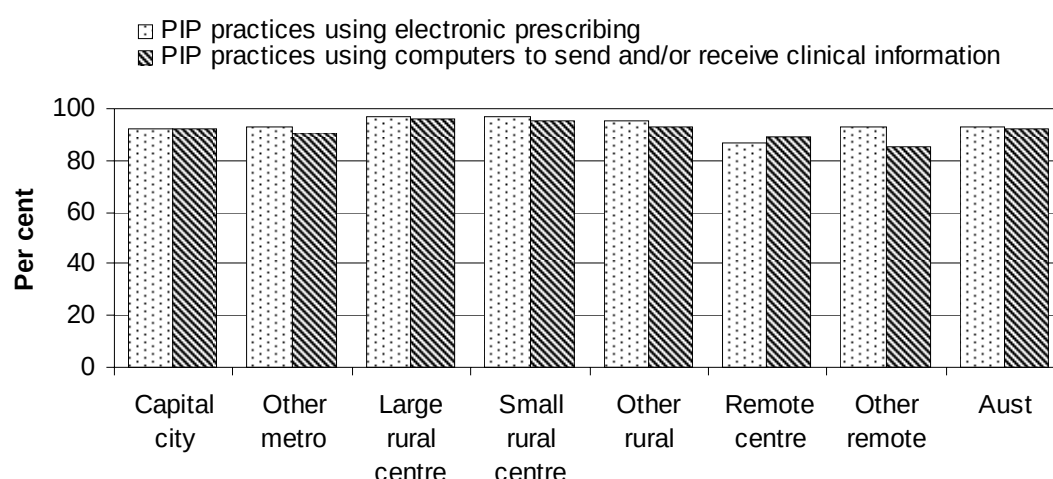
Figure 10.13 PIP practices using computers for clinical purposes, May 2005



Source: DHA (unpublished); table 10A.23.

In May 2005, PIP practices in rural areas were more likely than PIP practices in metropolitan areas or remote areas to use computers to send and/or receive clinical information and to use electronic prescribing (figure 10.14). Remote practices in the NT have difficulty meeting the accreditation requirements to qualify for the PIP, which affects the coverage of these data.

Figure 10.14 **PIP practices using computers for clinical purposes, by area, May 2005^a**



^a Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone.

Source: DHA (unpublished); table 10A.24.

Quality — responsiveness

Patient satisfaction

The Steering Committee has identified ‘patient satisfaction’ as an indicator of the quality of GP services in terms of their responsiveness to patients (box 10.13). Data for this indicator, however, were not available for the 2006 Report.

Box 10.13 Patient satisfaction

‘Patient satisfaction’ has been identified as an indicator of responsiveness, but no data are currently available.

Quality — capability

Two indicators of the quality of GP services, in terms of the GPs' capability to provide services, are reported here: first, the proportion of GPs with vocational registration (box 10.14); and second, the proportion of general practices with accreditation (box 10.15).

GPs with vocational registration

Box 10.14 GPs with vocational registration

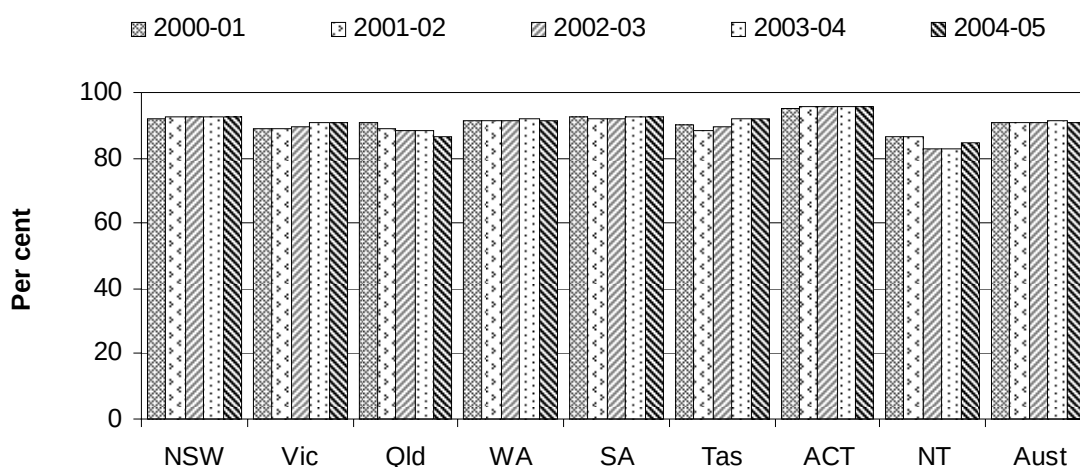
Since 1996, a GP can only achieve vocational registration by attaining Fellowship of the RACGP. GPs can attain Fellowship through the successful completion of a formal general practice training program or through the 'practice eligible' route. Once vocational registration is achieved, GPs must demonstrate ongoing involvement in continuing professional development activities in order to maintain their Fellowship status (DHA unpublished).

The measure reported is the proportion of FWE GPs with vocational registration.

An increase in the proportion of GPs with vocational registration may indicate an improvement in the ability of the GP workforce to deliver high quality services. GPs without vocational registration, however, do not necessarily deliver services of a lower quality.

The proportion of GPs with vocational registration remained relatively constant over the five years to 2004-05 (figure 10.15). The proportions of GPs with vocational registration were highest in capital cities and other metro centres and lowest in remote areas in 2004-05 (table 10A.25).

Figure 10.15 **GPs (full time workload equivalent) with vocational registration**



Source: DHA (unpublished); table 10A.26.

General practices with accreditation

Box 10.15 General practices with accreditation

Accreditation of general practice is a voluntary process of peer review that involves the assessment of general practices against a set of standards developed by the RACGP. Accredited practices, therefore, have been assessed as complying with a set of national standards.

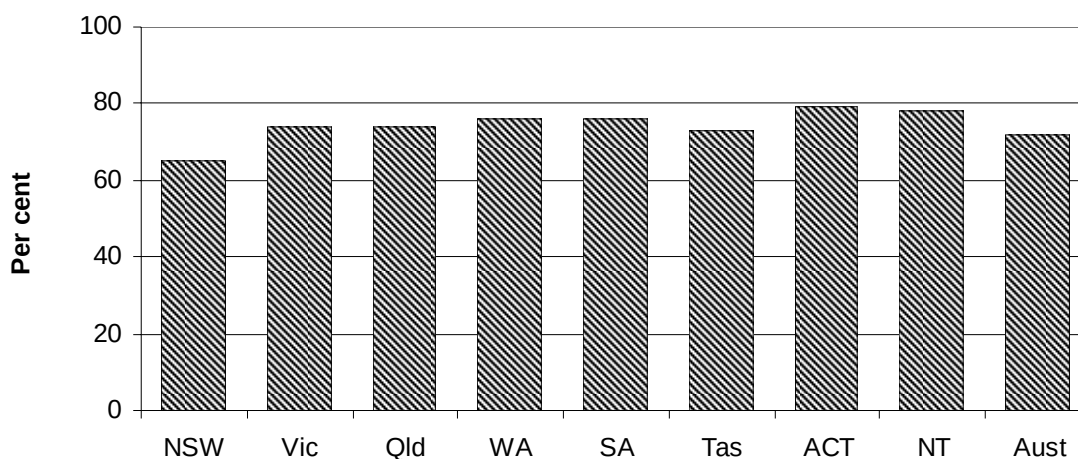
The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and Quality Practice Accreditation (QPA). This indicator is defined as the number of general practices accredited by AGPAL as a proportion of all general practices in Australia. Data on general practices accredited by QPA are not available for publication in this Report.

While an increase in the proportion of practices with accreditation may indicate an improvement in the capacity of general practices to deliver high quality services, the exclusion of QPA accredited practices from the indicator makes this interpretation uncertain.

A further caveat is that general practices without accreditation might not deliver lower quality services. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.

In June 2005, 4260 general practices (representing 72.0 per cent of general practices) were accredited with AGPAL Australia-wide (figure 10.16).

Figure 10.16 Australian general practices that are AGPAL accredited, June 2005



Source: AGPAL (unpublished); table 10A.27.

Quality — continuity

The continuity aspect of the quality of primary healthcare services relates to the sector's ability to provide uninterrupted, coordinated services across programs, practitioners, organisations and levels over time. Two indicators of this aspect of quality are reported here: first, the use of care planning and case conferencing (box 10.16); and second, the use of health assessments for older people (box 10.17).

Care planning and case conferencing

Box 10.16 Care planning and case conferencing

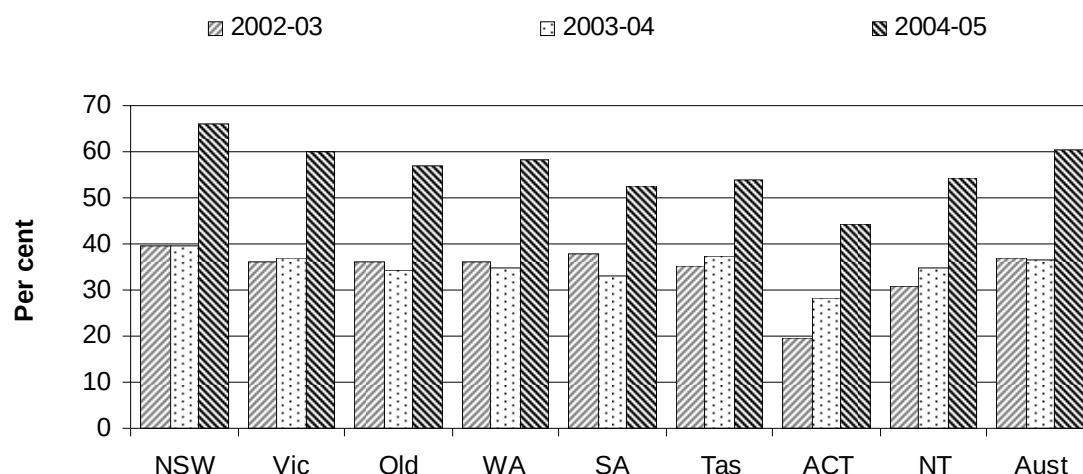
Care planning and case conferencing are chronic disease management items in the Medicare Benefits Schedule (MBS). They provide a framework for a multidisciplinary approach to healthcare for people with chronic or terminal medical conditions and complex, multidisciplinary care needs. The rationale for the indicator is that GPs with some experience using care planning and case conferencing are more likely to continue to use these options when they have the potential to improve patient care.

This indicator is defined as the proportion of GPs who used the chronic disease management items for care planning and case conferencing at least once during a 12 month period.

An increase in the proportion of GPs who used these chronic disease management items may indicate an improvement in the continuity of care provided to people with chronic or terminal medical conditions and complex, multidisciplinary care needs.

Nationally, 60.2 per cent of GPs used the chronic disease management items for care planning and case conferencing in 2004-05 (figure 10.17).

Figure 10.17 GP use of chronic disease management Medicare items for care planning and case conferencing^{a, b}



a The number of active GPs who claimed at least one of the chronic disease management items for care planning and case conferencing during the financial year, as a proportion of all active GPs. Active GPs are registered GPs or OMPs who claimed 375 or more non-referred attendances on average per quarter. **b** The increase in the proportion of general practitioners using chronic disease management MBS items for care planning and case conferencing in 2004-05 may be due to the introduction of the Strengthening Medicare allied health and dental care initiative on 1 July 2004. This initiative provides access to a range of allied health and dental care treatments for patients with chronic conditions whose complex care needs are being managed through a chronic disease management care plan.

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

Health assessments for older people

Box 10.17 Health assessments for older people

An annual voluntary assessment for older people is an MBS item that allows a GP to undertake an in-depth assessment of a patient's health. Health assessments cover the patient's health and physical, psychological and social function, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient.

(Continued on next page)

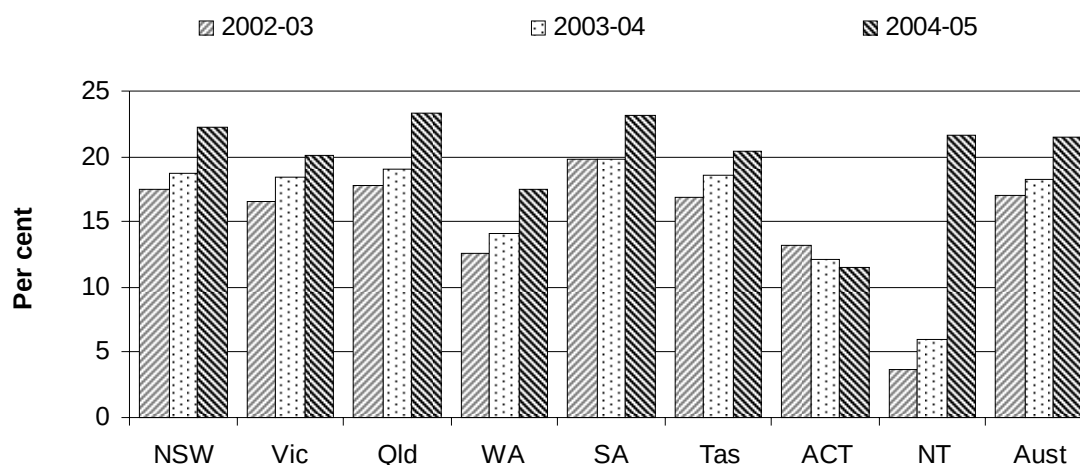
Box 10.17 (Continued)

This indicator is defined as the proportion of older people who received a voluntary health assessment. Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The lower age range for Indigenous people recognises that they face increased health risks at a much earlier age, compared with most other groups in the population. It also broadly reflects the difference in average life expectancy for the two population groups (see the 'Health preface').

An increase in the proportion of eligible older people who received a voluntary health assessment may indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.

Nationally, the proportion of older people who received a voluntary health assessment increased from 17.0 per cent in 2002-03 to 21.4 per cent in 2004-05 (figure 10.18).

Figure 10.18 **Older people who received a voluntary health assessment^a**



^a Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities.

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

Sustainability

No indicator of sustainability has been developed. The Steering Committee has identified sustainability as a key area for development in future reports.

Efficiency

Cost to government of general practice per person

The ‘cost to government of general practice per person’ is one indicator of the efficiency of general practice (box 10.18). Nationally, the recurrent cost to the Australian Government of general practice was \$213 per person in 2004-05 (figure 10.1).

Box 10.18 Cost to government of general practice per person

The ‘cost to government of general practice per person’ is an indicator of efficiency. It is defined as the cost to government of general practice (including the cost of Medicare, non-Medicare funding such as for the PIP, and expenditure by the DVA) per person in the population.

A lower cost per person may indicate higher efficiency. This is likely to be the case, however, only where the lower cost is associated with services of equal or superior effectiveness.

This indicator needs to be interpreted with care because a lower cost per person may reflect service substitution between primary healthcare and hospital services or specialist services (the latter two both being potentially higher cost than primary care). Further, the indicator also does not include costs for all primary healthcare services. Some primary healthcare services are provided by salaried GPs in community health settings, particularly in rural and remote areas through accident and emergency departments and Indigenous-specific primary health care services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, and where a salaried GP delivery model pertains.

Outcomes

Indicators of both intermediate and final primary and community health outcomes are reported here. ‘Child immunisation coverage’, for example, indicates the intermediate outcome of immunisation against disease (box 10.19). ‘Notifications of selected childhood diseases’ indicate the final outcome — the incidence of diseases — that child immunisation can prevent (box 10.20). The other reported outcome indicators relate to cervical screening (box 10.21), influenza vaccinations for older people (box 10.22) and potentially preventable hospitalisations (box 10.23).

Child immunisation coverage

Box 10.19 Child immunisation coverage

The 'child immunisation coverage' indicator is an indicator of outcomes for primary and community health services because one of the objectives of GPs and community health services is the achievement of high immunisation coverage levels for children. Many providers deliver child immunisation services (table 10.8). GPs are encouraged to achieve high immunisation coverage levels under the General Practice Immunisation Incentives Scheme, which provides incentives for the immunisation of children under seven years of age.

Two measures of this indicator are reported:

- the proportion of children aged 12 months to less than 15 months who are fully immunised. Children assessed as fully immunised at 12 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b and hepatitis B
- The proportion of children aged 24 months to less than 27 months who are fully immunised. Children assessed as fully immunised at 24 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, and measles, mumps and rubella.

An increase in the proportion of children who are fully immunised indicates a reduction in the risk of children contracting a range of diseases, including measles, whooping cough and *Haemophilus influenzae* type b.

Data on valid vaccinations supplied to children under 7 years of age from the Australian Childhood Immunisation Register (ACIR) are shown in table 10.8. Figure 10.19 shows that around 91.0 per cent of Australian children aged 12 months to less than 15 months at 30 June 2005 were assessed as fully immunised.

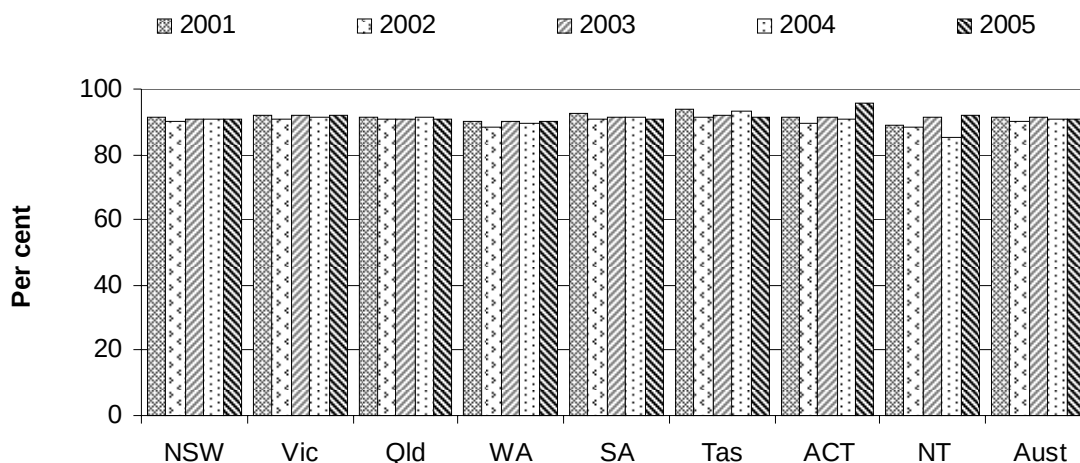
Table 10.8 Valid vaccinations supplied to children under 7 years of age, by provider type, 1996–2005 (per cent)^{a, b}

<i>Provider</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GP	83	52	83	63	69	86	37	3	70
Council	6	47	7	7	17	14	–	–	18
State or Territory health department	–	–	–	6	–	–	27	–	1
Flying doctor service	–	–	–	–	–	–	–	–	–
Public hospital	2	–	3	5	4	–	1	7	2
Private hospital	–	–	–	–	–	–	–	1	–
Indigenous health service	–	–	1	1	–	–	–	9	1
Indigenous health worker	–	–	–	–	–	–	–	–	–
Community health centre	7	1	5	18	10	1	35	79	8
Community nurse	–	–	–	–	–	–	–	–	–
Total^c	100	100	100	100	100	100	100	100	100

^a On 30 June 2005. Data collected since 1 January 1996. Data relates to the State or Territory in which the immunisation provider was located. ^b A valid vaccination is a National Health and Medical Research Council's Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. ^c Data for Australia include 4520 vaccinations (less than 0.1 per cent of the total) for which State or Territory is unknown. – Nil or rounded to zero.

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

Figure 10.19 Children aged 12 months to less than 15 months who were fully immunised^{a, b, c}

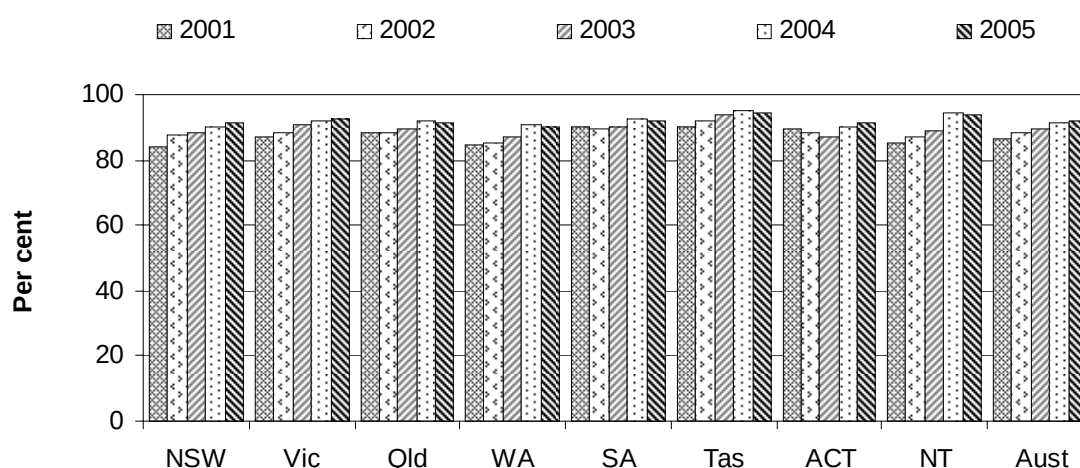


^a Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. ^b The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000). ^c There may be some under-reporting by providers, so vaccine coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

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

Nationally, 91.8 per cent of children aged 24 months to less than 27 months at 30 June 2005 were assessed as being fully immunised (figure 10.20).

Figure 10.20 **Children aged 24 months to less than 27 months who were fully immunised^{a, b, c}**



^a Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child was located. ^b The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000). ^c There may be some under-reporting by providers, so vaccine coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

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

Notifications of selected childhood diseases

Box 10.20 Notifications of selected childhood diseases

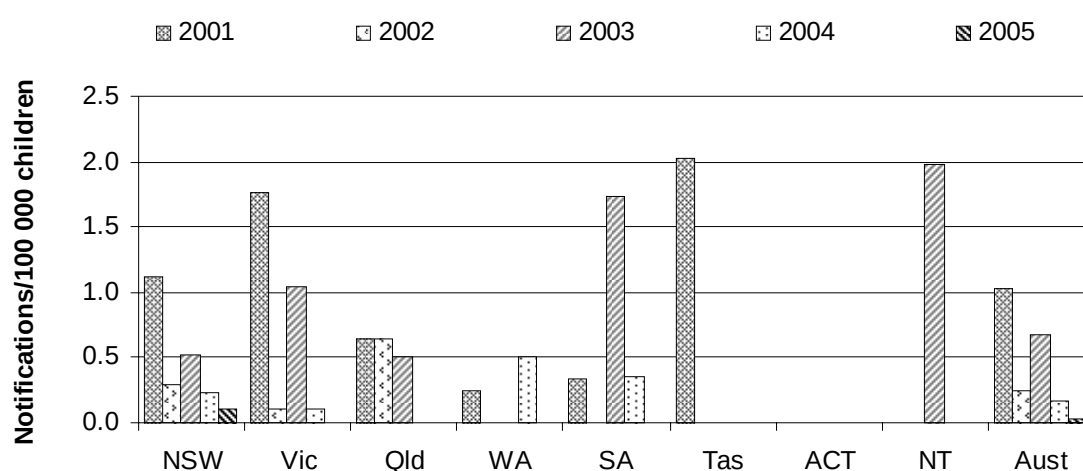
Notification rates for selected childhood vaccine preventable diseases (measles, pertussis [whooping cough] and *Haemophilus influenzae* type b) are an outcome indicator of primary and community health because the activities of GPs and community health services can influence the prevalence of these diseases through immunisation (and consequently the notification rates). These childhood diseases are nationally notifiable diseases — that is, if they are diagnosed, there is a requirement to notify the relevant State or Territory authorities. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs for one in 25 cases.

For each disease, the rate of notifications is defined as the number of notifications for children aged 0–14 years per 100 000 children in that age group.

A reduction in the notification rate for the selected diseases indicates the effectiveness of the immunisation program.

In 2005, there was only one notification of measles in Australia. This represented a national notification rate for measles of less than 0.1 per 100 000 children aged 0–14 years (figure 10.21) — a large decline from the high rates of the mid-1990s (table 10A.33). In 1994, for example, there were 3088 notifications of measles for children aged 0–14 years, representing a rate of 80.0 per 100 000 children in that age group. Since 2000, the number of annual notifications for measles in Australia has been below 100, with some jurisdictions reporting no notifications in some years.

Figure 10.21 **Notifications of measles among children aged 0–14 years^{a, b}**

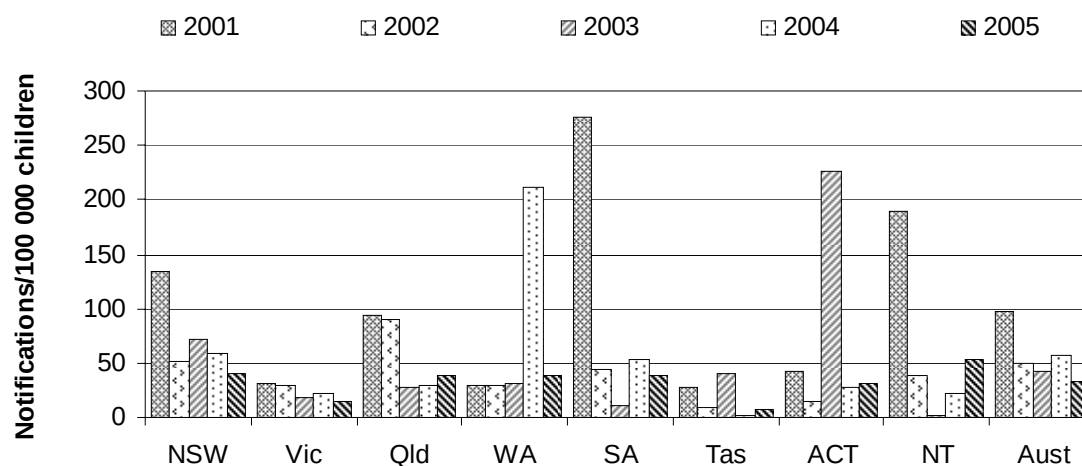


^a Notifications for 2004 are to June only and have been adjusted to annual rates for comparison. ^b Where a notification rate for a particular year is nil, no notifications were made in that jurisdiction.

Source: DHA (unpublished); table 10A.33.

In 2005, there were 982 notifications of pertussis (whooping cough) across Australia. This represented a notification rate of 33.0 per 100 000 children aged 0–14 years (figure 10.22).

Figure 10.22 Notifications of pertussis (whooping cough) among children aged 0–14 years^{a, b}

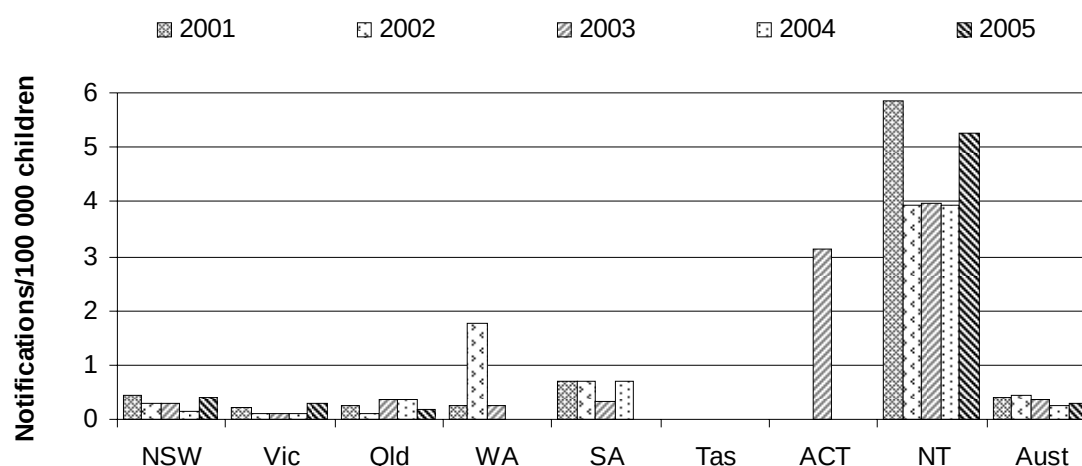


^a Notifications for 2004 are to June only and have been adjusted to annual rates for comparison. ^b Where a notification rate for a particular year is nil, no notifications were made in that jurisdiction.

Source: DHA (unpublished); table 10A.34.

In recent years, notification rates for *Haemophilus influenzae* type b have remained low. In 2005, the notification rate Australia-wide was 0.3 per 100 000 children aged 0–14 years (figure 10.23).

Figure 10.23 Notifications of *Haemophilus influenzae* type b among children aged 0–14 years^{a, b}



^a Notifications for 2004 are to June only and have been adjusted to annual rates for comparison. ^b Where a notification rate for a particular year is nil, no notifications were made in that jurisdiction.

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

Participation rates for women in cervical screening

‘Participation rates for women in cervical screening’ is an indicator of primary and community healthcare outcomes (box 10.21).

Box 10.21 Participation rates for women aged 20–69 years in cervical screening

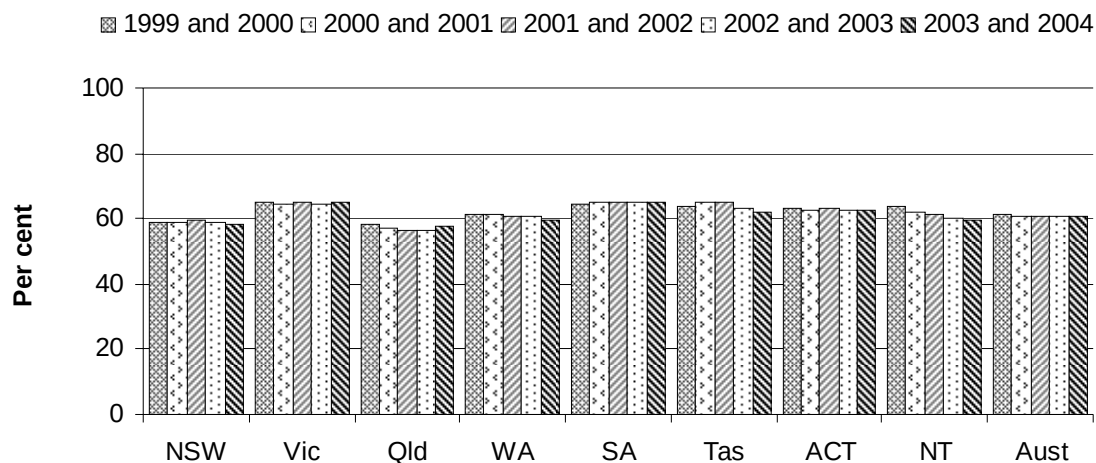
The ‘cervical screening rate for target population’ (women aged 20–69 years) is an outcome indicator for primary and community healthcare. It is estimated that up to 90 per cent of the most common type of cervical cancer (squamous cervical cancer) may be prevented if cell changes are detected and treated early. As for child immunisation, a range of healthcare providers offer cervical screening tests (Pap smears). The National Cervical Screening Program involves GPs, gynaecologists, family planning clinics and hospital outpatient clinics.

This indicator is defined as the number of women aged 20–69 years who are screened over a two year period, as a proportion of all women aged 20–69 years. Adjustments are made to account for differences in the female age distribution across states and territories, and to remove from the population of women 20–69 years old (the rate denominator) those who have had a hysterectomy.

An increase in the proportion of women aged 20–69 years who have been screened would be expected to result in a reduction in the number of women dying from this disease.

During 2003 and 2004, the national age standardised participation rate for women aged 20–69 years in cervical screening was 60.7 per cent (figure 10.24).

Figure 10.24 Age standardised participation rates for women aged 20–69 years in cervical screening^{a, b, c, d}



^a In 2001, the ABS carried out a full population Census and a National Health Survey. These led to the revision of the ABS estimated resident population (ERP) data, the introduction of a new Australian standard population for use in age standardisation, and the production of new estimates of hysterectomy status among Australian women. The denominators for participation rates for 2001 and 2002, and 2002 and 2003 have been calculated using the 2001 ABS National Health Survey hysterectomy fractions and the revised ERP values, and age adjusted using the 2001 Australian standard population. The denominators for the equivalent rates for previous years were calculated using the 1995 ABS National Health Survey hysterectomy fractions and unrevised ERP values, and age adjusted using the 1991 Australian standard population. The combined effect of these changes is that participation rates before 2001 and 2002 are on average 1–2 percentage points higher than equivalent rates for subsequent years. ^b Recent fluctuations in participation rates over time and across jurisdictions may be influenced by improvements in record linkage procedures in the State and Territory screening registers. These allow more accurate tracking of individual screening participants over time and may lead to an apparent decrease of up to 3 percentage points in recorded participation rates. ^c Some State and Territory cervical cytology registers register only women with a valid address in that State or Territory. Victoria began registering resident women from 2000–01, WA only registered resident women up to, and including, 2000–01, while the ACT has consistently only registered women with a valid ACT address. ^d All data are adjusted to exclude women who have had a hysterectomy.

Source: AIHW analysis of State and Territory Cervical Cytology Registry data (unpublished); table 10A.36.

Influenza vaccination coverage for older people

The ‘influenza vaccination coverage for older people’ is an indicator of primary and community healthcare outcomes (box 10.22). The hospitalisation rate of people for influenza and pneumonia is included as a separate indicator (box 10.24).

Box 10.22 Influenza vaccination coverage for older people

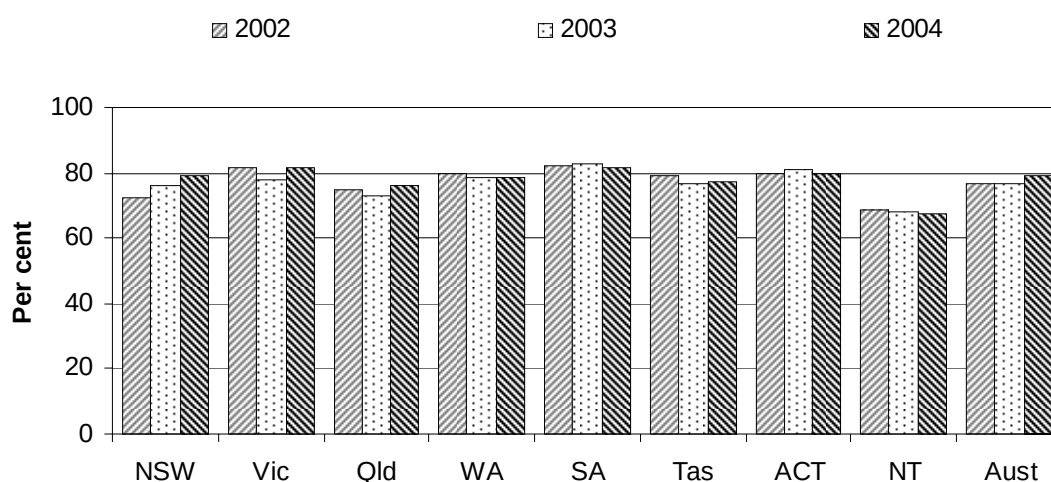
Each year, influenza and its consequences result in many older people being hospitalised, as well as a considerable number of deaths. Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (National Health Performance Committee unpublished). GPs provide the majority of influenza vaccinations for older people.

The indicator is defined as the proportion of people aged 65 years or over who have been vaccinated against influenza.

An increase in the proportion of older people vaccinated against influenza reduces the risk of older people contracting influenza and suffering consequent complications.

Through the National Influenza Vaccine Program for Older Australians, the Australian Government funds free vaccines for Australians aged 65 years or over (AIHW 2005e). In 2004, 79.1 per cent of people aged 65 years or over were vaccinated against influenza in Australia (figure 10.25).

Figure 10.25 Influenza vaccination coverage, people aged 65 years or over



Source: AIHW (2003, 2004, 2005e); table 10A.37.

Potentially preventable hospitalisations

The following five outcome indicators relate to potentially preventable hospitalisations for a range of conditions. The first three indicators — hospitalisations for vaccine preventable conditions (box 10.24), selected acute conditions (box 10.25) and selected chronic conditions (box 10.26) — were developed by the National Health Performance Committee, based on empirical

research (box 10.23). The two other outcome indicators in this category relate to hospitalisations for diabetes (box 10.27) and the hospitalisation of older people for falls (box 10.28). ‘Hospitalisations for diabetes’ was previously reported as part of the ‘management of diabetes’ indicator which was previously reported as an outcome.

Box 10.23 Development of, and rationale for, potentially preventable hospitalisation indicators

The definitions adopted for vaccine preventable conditions, acute conditions and chronic conditions indicators were based on the *Victorian Ambulatory Care Sensitive Conditions Study* (DHS 2002). This study built on research into ambulatory care sensitive conditions (for example, Billings, Anderson and Newman 1996; Bindman *et al.* 1995; Weissman, Gatsonis and Epstein 1992), which was recently the subject of systematic review and empirical analysis.

These studies show that the availability of non-hospital care explains a significant proportion of the variation between geographic areas in hospitalisation rates for the specified conditions. Other explanations for this variation include variation in the underlying prevalence of the conditions, clinical coding standards, and the likelihood that patients will be treated as an outpatient rather than an admitted patient. Potentially preventable hospitalisations will never be entirely eliminated, but the variation across geographic areas demonstrates considerable potential for strengthening the effectiveness of non-hospital care.

Source: National Health Performance Committee (unpublished).

Vaccine preventable hospitalisations

‘Vaccine preventable hospitalisations’ is an indicator of primary and community healthcare outcomes (box 10.24).

Box 10.24 Vaccine preventable hospitalisations

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for vaccine preventable conditions. This influence occurs mainly through the provision of vaccinations and the encouragement of high rates of vaccination coverage for target populations.

This indicator is defined as the number of hospital separations for influenza and pneumonia, and other vaccine preventable conditions per 100 000 people. (Adjustments are made to account for differences in the age structure of populations across states and territories.)

(Continued on next page)

Box 10.24 (Continued)

A reduction in hospitalisation rates may indicate improvements in the effectiveness of the vaccination program. Effective treatment by primary health providers may also reduce hospitalisations.

A comparison of Indigenous people and all other people is also made by presenting the ratio of age standardised hospital separation rates of Indigenous people to all people. A ratio of close to one is desirable as it implies that Indigenous people have similar separation rates to all people.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation for vaccine preventable conditions. Examples are the number and virulence of influenza strains from year to year.

Australia-wide, the age standardised hospital separation rate for all vaccine preventable conditions was 0.8 per 1000 people in 2003-04. Nationally, influenza and pneumonia accounted for 82.5 per cent of age standardised hospitalisations for vaccine preventable conditions in 2003-04 (table 10.9).

Table 10.9 **Standardised hospital separations for vaccine preventable conditions, per 1000 people^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									
Influenza and pneumonia	0.61	0.52	0.76	0.82	0.54	0.55	0.30	1.44	0.63
Other conditions	0.16	0.15	0.13	0.10	0.16	0.11	0.03	0.42	0.15
Total^b	0.78	0.67	0.89	0.92	0.69	0.65	0.33	1.86	0.78
2003-04									
Influenza and pneumonia	0.69	0.52	0.71	0.79	0.61	0.50	0.41	1.78	0.66
Other conditions	0.16	0.17	0.10	0.11	0.11	0.09	0.08	0.29	0.14
Total^b	0.85	0.70	0.81	0.90	0.72	0.59	0.49	2.06	0.80

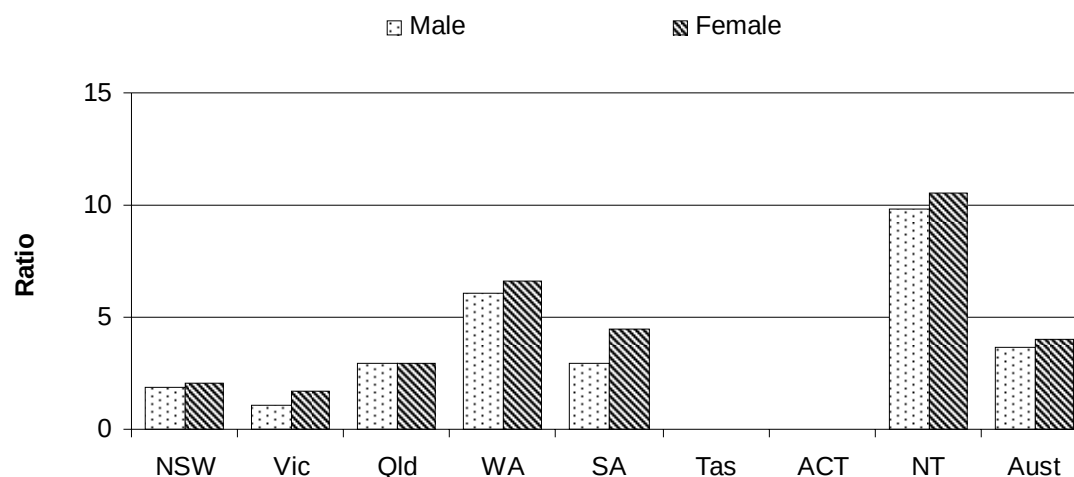
^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Totals may not equal the sum of the individual conditions due to rounding.

Source: AIHW (2005b).

Standardised hospital separation ratios for infectious pneumonia illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in age distributions. These data were previously reported in chapter 9 'Public hospitals'. For both males and females, there was a marked difference in 2003-04 between the separation rate for Indigenous people and those for the total population for infectious pneumonia diagnoses. The separation rate for Indigenous males was 3.7 times higher than those

for all Australians males. The separation rate for Indigenous females was 4.0 times the rate for all females (figure 10.26).

Figure 10.26 Ratio of age standardised hospital separation rates of Indigenous people to all people for infectious pneumonia, 2003-04^{a, b, c, d, e}



^a The ratios are indirectly age standardised using the Census based estimated resident population of Indigenous males at 30 June 2001, the hospital separation rates for Australian males aged 0–74 years for 2000-01 and the male population at 30 June 2001. ^b Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among jurisdictions. The variation in the number of Indigenous separations per 1000 Indigenous population across the states and territories suggests variation in the proportion of Indigenous persons who were identified as such in the hospital morbidity data collections and/or in the total population. The AIHW advised that only data from WA, SA and the NT are considered to be of acceptable quality. ^c Data for Tasmania and the ACT are not available, given the small size of the Indigenous population in those jurisdictions. ^d These data do not signal the performance of hospitals, but reflect a range of factors such as: the spectrum of public, primary care and post-hospital care available; Indigenous access to this care as well as hospital services; social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disease between the Indigenous and non-Indigenous populations (see appendix A). ^e NT data is for public hospitals only.

Source: AIHW (unpublished); tables 10A.38 and 10A.39.

Hospitalisations for selected acute conditions

Box 10.25 Hospitalisations for selected acute conditions

The effectiveness of primary and community healthcare services has a significant influence on the rates of hospitalisation for the following selected acute conditions: dehydration and gastroenteritis; pyelonephritis (kidney inflammation caused by bacterial infection); perforated/bleeding ulcer; cellulitis; pelvic inflammatory disease; ear, nose and throat infections; dental conditions; appendicitis; convulsions and epilepsy; and gangrene.

Hospital separation rates for the selected acute conditions are calculated per 100 000 people and adjusted to account for differences in age distributions across State and Territory populations.

A reduction in hospitalisation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation. An example is the underlying prevalence of the conditions. Public health measures not covered in this chapter may also influence the hospitalisation rates.

Of the selected acute conditions, dental conditions, and dehydration and gastroenteritis had the highest rates of hospitalisation nationally in 2003-04 (table 10.10).

Table 10.10 Standardised hospital separations for potentially preventable acute conditions, per 1000 people, 2003-04^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Dehydration and gastroenteritis	2.01	2.51	2.49	2.01	2.60	1.85	1.21	1.77	2.25
Pyelonephritis ^b	1.89	1.98	2.07	1.97	1.84	1.37	1.40	3.01	1.94
Perforated/bleeding ulcer	0.26	0.30	0.22	0.30	0.29	0.30	0.26	0.40	0.27
Cellulitis	1.41	1.49	1.54	1.40	1.33	1.14	1.23	2.79	1.45
Pelvic inflammatory disease	0.29	0.31	0.32	0.31	0.31	0.25	0.25	0.50	0.31
Ear, nose and throat infections	1.67	1.43	1.86	1.82	2.36	1.30	1.15	1.95	1.70
Dental conditions	1.83	2.74	2.64	3.40	2.54	1.67	1.63	1.52	2.41
Appendicitis	0.15	0.16	0.15	0.22	0.12	0.13	0.16	0.27	0.16
Convulsions and epilepsy	1.74	1.51	1.57	1.47	1.62	1.49	1.24	2.88	1.61
Gangrene	0.17	0.26	0.26	0.19	0.21	0.17	0.11	0.54	0.22
Total^c	11.40	12.69	13.12	13.09	13.22	9.66	8.64	15.60	12.31

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Kidney inflammation caused by bacterial infection. ^c Totals may not equal the sum of the individual conditions due to rounding.

Source: AIHW (2005b).

Hospitalisations for selected chronic conditions

Box 10.26 Hospitalisations for selected chronic conditions

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for the following selected chronic conditions: asthma; congestive cardiac failure; diabetes complications; chronic obstructive pulmonary disease; iron deficiency anaemia; hypertension; and nutritional deficiencies. (Diabetes is considered in detail in a separate indicator.)

Hospital separation rates for the selected chronic conditions are calculated per 1000 people and adjusted to account for differences in age distributions across State and Territory populations.

A reduction in hospitalisation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation. An example is the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

Of the selected chronic conditions (excluding diabetes, which is discussed below) chronic obstructive pulmonary disease and angina had the highest rates of hospitalisation nationally in 2003-04. The hospitalisation rate for diabetes complications, however, was more than two and a half times higher than the rate for either of these conditions (table 10.11).

Table 10.11 Standardised hospital separations for potentially preventable chronic conditions, per 1000 people, 2003-04^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Asthma	1.93	1.89	1.81	1.96	2.75	0.97	1.08	1.79	1.92
Congestive cardiac failure	1.92	2.23	2.08	1.96	2.09	1.71	1.77	2.21	2.05
Diabetes complications	6.33	8.93	8.10	12.93	7.92	11.25	4.80	16.58	8.25
Chronic obstructive pulmonary disease	2.78	2.66	2.93	2.80	2.78	3.04	1.66	6.24	2.79
Angina	2.06	2.18	2.85	1.72	1.91	2.10	1.47	3.57	2.20
Iron deficiency anaemia	0.75	1.25	0.80	1.17	0.87	0.86	0.82	1.03	0.94
Hypertension	0.33	0.27	0.41	0.31	0.33	0.27	0.11	0.29	0.32
Nutritional deficiencies	0.01	0.01	0.01	0.01	–	–	–	0.06	0.01
Total^b	15.23	18.39	17.97	22.08	17.59	19.43	11.02	30.53	17.53

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b The total is not the sum of the individual conditions because diabetes complications overlap other categories. – Nil or rounded to zero.

Source: AIHW (2005b).

Hospitalisations for diabetes

Box 10.27 Hospitalisations for diabetes

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for diabetes.

Hospital separation rates for patients with diabetes mellitus as the principal diagnosis, and for patients with a lower limb amputation and a principal or additional diagnosis of diabetes are reported. These rates are calculated per 100 000 people and adjusted to account for differences in the age distribution of State and Territory populations.

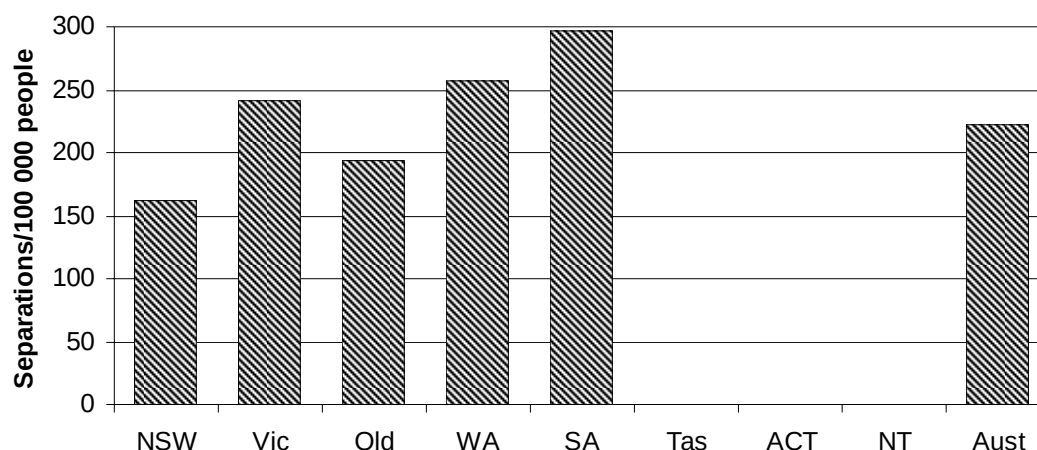
A reduction in these rates may indicate an improvement in GPs and community health providers' management of patients' diabetes.

A comparison of Indigenous and all other people is also made by presenting the ratio of age standardised hospital separation rates of Indigenous people to all people. A ratio of close to one is desirable as it implies that Indigenous people have similar separation rates to all people.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation. An example is the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

Australia-wide, the age standardised hospital separation rate in 2003-04 where the principal diagnosis was Type 2 diabetes mellitus was 222.2 separations per 100 000 people (figure 10.27).

Figure 10.27 **Standardised hospital separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2003-04**^{a, b, c, d, e}

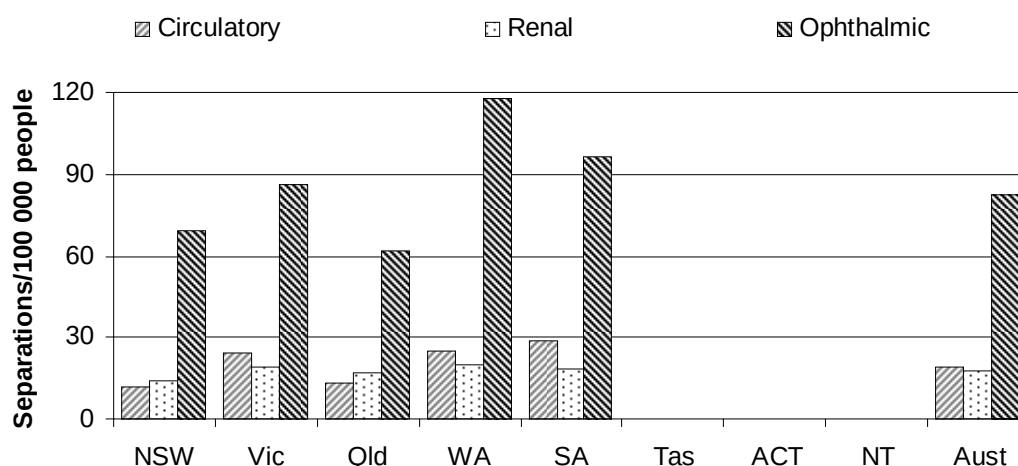


^a These data are not person-based, but episode-based. A person who is admitted to hospital, for example, three times in the year, will be counted three times. ^b Results for individual complications may be affected by small numbers, and need to be interpreted with care. ^c Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. ^d Morbidity data are coded under coding standards that may differ over time and across jurisdictions. ^e Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW unpublished; table 10A.40.

The three most common complications from Type 2 diabetes that led to hospitalisation in 2003-04 were circulatory, renal and ophthalmic complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 10.28). Each patient may have one or more complication (circulatory, renal and ophthalmic) for each diabetes hospital separation.

Figure 10.28 Standardised hospital separations for Type 2 diabetes mellitus as principal diagnosis, by selected complications, all hospitals, 2003-04^{a, b, c, d, e}



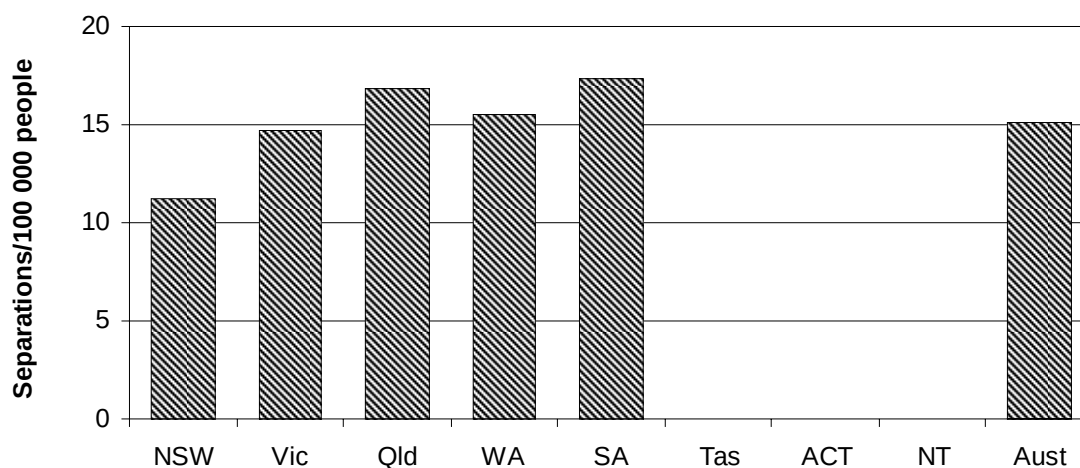
^a These data are not person-based, but episode-based. A person who is admitted to hospital, for example, three times in the year, will be counted three times. ^b Results for individual complications may be affected by small numbers, and need to be interpreted with care. ^c Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. ^d Morbidity data are coded under coding standards that may differ over time and across jurisdictions. ^e Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW unpublished; table 10A.40.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings, but the number of people accessing ambulatory services is not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect hospital separations rates. This effect is partly reflected in the substantial variation in the proportion of separations that are 'same day' across jurisdictions. Nationally, 45.7 per cent of separations for Type 2 diabetes were same day in 2003-04 (table 10A.41).

Amputation of a lower limb can be a serious outcome of diabetes-related complications. In 2003-04, there were 15.1 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 10.29).

Figure 10.29 Standardised hospital separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2003-04^{a, b, c}



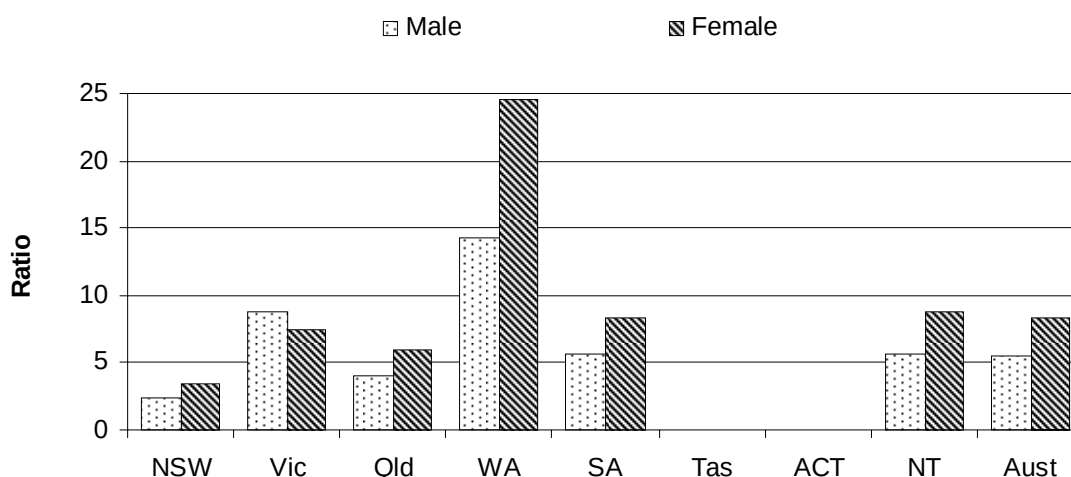
^a Includes unspecified diabetes. Separation rates are directly age standardised to the Australian population at 30 June 2001. The figures are based on the ICD-10-AM classification. The codes are E11.x and E14.x, where x=0-9 for diabetes, and Blocks 1533, 44367, 44370 and 44373 for amputations. ^b The data are not person-based, but episode-based. A person who is admitted to hospital, say, three times in the year will be counted three times. ^c Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished); table 10A.42.

Standardised hospital separation ratios for all diabetes diagnoses illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in age distributions. These data were previously reported in chapter 9 'Public hospitals'. For both males and females there was a marked difference in 2003-04 between the separation rates for Indigenous people and those for the total population for all diabetes diagnoses.¹ The separation rate for Indigenous males was 5.5 times higher than those for all Australians males. The separation rate for Indigenous females was 8.3 times the rate for all females (figure 10.30). The 'Health preface' contains data on deaths from diabetes for Indigenous people.

¹ 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes.

Figure 10.30 Ratio of age standardised hospital separation rates of Indigenous people to all people for all diabetes diagnoses, 2003-04^{a, b, c, d, e, f}



^a The ratios are indirectly age standardised using the Census based estimated resident population of Indigenous males at 30 June 2001, the hospital separation rates for Australian males aged 0–74 years for 2000-01 and the male population at 30 June 2001. ^b Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among jurisdictions. The variation in the number of Indigenous separations per 1000 Indigenous population across the states and territories suggests variation in the proportion of Indigenous persons who were identified as such in the hospital morbidity data collections and/or in the total population. The AIHW advised that only data from WA, SA and the NT are considered to be of acceptable quality. ^c Data for Tasmania and the ACT are not available, given the small size of the Indigenous population in those jurisdictions. ^d 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes. ^e These data do not signal the performance of hospitals, but reflect a range of factors such as: the spectrum of public, primary care and post-hospital care available; Indigenous access to this care as well as hospital services; social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disease between the Indigenous and non-Indigenous populations (see appendix A). ^f NT data are for public hospitals only.

Source: AIHW (unpublished); tables 10A.38 and 10A.39.

Hospitalisations of older people for falls

Box 10.28 Hospitalisation of older people for falls

The effectiveness of primary healthcare has a significant influence on the rates of hospitalisation of older people for falls.

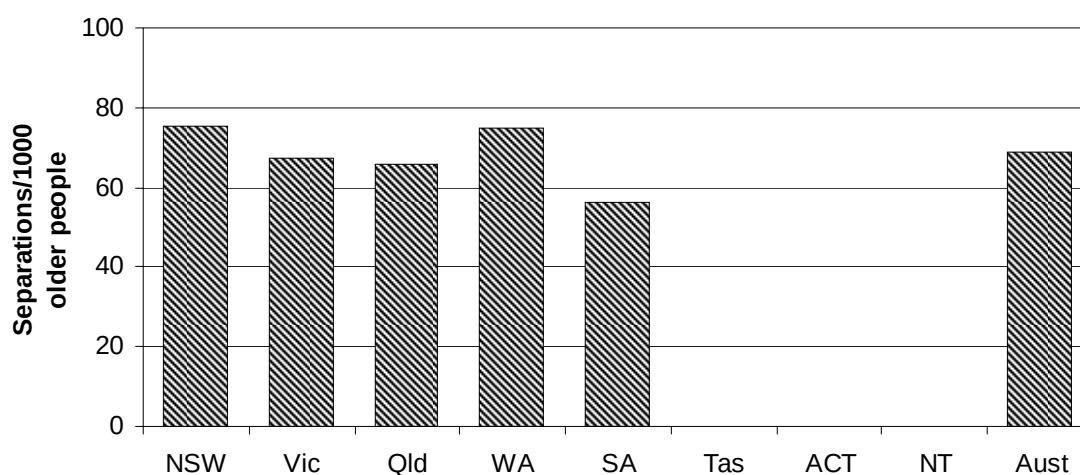
The indicator is defined as the number of hospital separations of older people for falls per 1000 older people, adjusted to take account of differences in State and Territory age distributions. Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over.

A reduction in the rate of hospitalisation due to falls may indicate improvements in the effectiveness of primary healthcare services provided to older people who are at risk of falls.

Factors outside the control of the primary healthcare system, however, also influence the rates of hospitalisation. These include the support available to older people from family and friends, and the provision of aged care services such as Home and Community Care program services and residential care.

Nationally, the age standardised hospital separation rate in 2003-04 for older people with injuries due to falls was 68.7 per 1000 older people (figure 10.31).

Figure 10.31 **Standardised hospital separations for older people for injuries due to falls, 2003-04^{a, b}**



^a Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over. ^b Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished); table 10A.43.

10.4 Future directions in performance reporting

While the topic of this chapter is all primary and community health services, the indicators still focus heavily on general practice services. This focus partly reflects the lack of data that are available on a nationally consistent basis to support reporting against indicators for other primary and community health services. The National Health Performance Committee has recognised this issue and is working to develop a broader range of primary and community health indicators. Where appropriate, these indicators will be adopted and reported in future editions of this Report.

In addition to the work undertaken by the National Health Performance Committee, the Steering Committee has identified possible areas for which indicators may be available for inclusion in the 2007 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.

The scope of this chapter may also be further refined to ensure the most appropriate reporting of primary health services against the Review's terms of reference and reporting framework (chapter 1).

Indigenous health

Barriers to accessing primary health services contribute to the poorer health status of Indigenous people compared to other Australians (see the 'Health preface'). In recognition of this issue, the Steering Committee has identified primary and community health services for Indigenous people as a priority area for future reporting. Accordingly, the Steering Committee will examine options for including indicators of the accessibility of primary and community health services to Indigenous people. The Aboriginal and Torres Strait Islander Health Performance Framework that is being developed by the Standing Committee on Aboriginal and Torres Strait Islander Health will help inform the selection of future indicators of primary and community health services to Indigenous people (see the 'Health preface').

10.5 Definitions of key terms and indicators

Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Cervical screening rates for target population	Proportion of women aged 20–69 years who are screened for cervical cancer over a two year period.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Divisions of General Practice	Geographically-based networks of GPs. Currently there are 118 Divisions of General Practice, 7 State Based Organisations and the Australian Divisions of General Practice. The Divisions of General Practice Program evolved from the former Divisions and Projects Grants Program established in 1992. The Divisions of General Practice Program aims to contribute to improved health outcomes for communities by working with GPs and other health services providers to improve the quality and accessibility of health care at the local level.
Full time workload equivalents	A measure of medical practitioner supply based on claims processed by Medicare in a given period, calculated by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that period. Full time equivalents are calculated in the same way as FWE except that full time equivalents are capped at 1 for each practitioner.
Fully immunised at 12 months	A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine and three doses of HbOC (HibTITER) (or two doses of PRP-OMP [PedvaxHIB]).
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine, four doses of HbOC (HibTITER) (or three doses of PRP-OMP [PedvaxHIB]) and one dose of measles, mumps, rubella vaccine.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.

General practitioner (GP)	Registered GPs — medical practitioners who, for the purposes of Medicare, are vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (Cwlth), hold Fellowship of the RACGP or equivalent, hold a recognised training placement or are otherwise entitled to bill Group A1 MBS items. OMPs — medical practitioners who have at least half of the schedule fee value of their Medicare billing from non-referred attendances, consisting solely or predominantly of Group A2 items.
Health management	An ongoing process beginning with initial client contact and including all actions relating to a client. Includes: assessment/evaluation; education of the person, family or carer(s); diagnosis and treatment; 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 (DHA 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	A medical practitioner other than a registered GP who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.
Per person benefits paid for GP ordered pathology	Total benefits paid for pathology tests ordered by GPs, divided by the population.

Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging tests referred by GPs, divided by the population.
Primary healthcare	The primary and community healthcare sector includes services that: • 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 registration	Number of FWE GPs who are vocationally registered, divided by the total number of FWE GPs.
Proportion of general practices registered for accreditation	Number of practices that have registered for accreditation through AGPAL, divided by the total number of practices in the Divisions of General Practice.
Proportion of general practices with electronic information management systems	Number of practices with electronic prescribing and/or electronic connectivity that are registered under the PIP, divided by the total number of practices registered.
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Reasons for encounter	The expressed demand of the patient for care, as perceived and recorded by the GP.
Registered general practitioner	Medical practitioners who are vocationally registered under s.3F of the <i>Health Insurance Act 1973</i> (Cwlth), hold Fellowship of the RACGP or equivalent or hold a recognised training placement.
Recognised immunisation provider	A provider recognised by the Medicare Australia as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist on the Medicare database earning at least half of his/her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than would otherwise be possible without the test.
Vocational registration	GPs who are registered separately for Medicare purposes and who receive higher Medicare benefits for services.

10.6 Supporting tables

Supporting tables for chapter 10 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel format as \Publications\Reports\2006\Attach10A.xls and in Adobe PDF format as \Publications\Reports\2006\Attach10A.pdf. Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 10A.3 is table 3 in the electronic files). These files can be found on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

Table 10A.1	Types of encounter, 2004-05
Table 10A.2	Australian Government real expenditure per person on GPs (2004-05 dollars)
Table 10A.3	Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs
Table 10A.4	Indigenous primary healthcare services for which service activity reporting (SAR) data is reported (number)
Table 10A.5	Services and episodes of healthcare by services for which service activity reporting (SAR) data is reported, by remoteness category (number)
Table 10A.6	Proportion of services for which service activity reporting (SAR) data is reported that undertook selected health related activities, 2003-04 (per cent)
Table 10A.7	Full time equivalent health staff employed by services for which service activity reporting (SAR) data is reported, as at 30 June 2004 (number)
Table 10A.8	Alcohol and other drug treatment services, by sector, 2003-04 (number)
Table 10A.9	Most frequent individual problems managed (in decreasing order of frequency for all encounters with Indigenous people 1998-99 to 2002-03)
Table 10A.10	Practice location of GPs who saw Indigenous people compared with total GP sample
Table 10A.11	Distribution of encounters with Indigenous and all people, by region (rural, remote and metropolitan areas [RRMA]), 1998-2003 (per cent)
Table 10A.12	Summary of patient morbidity and management at encounters with Indigenous Australians and in the total sample
Table 10A.13	PBS services, 2004-05
Table 10A.14	Approved providers of PBS medicines, by urban and rural location, 2004-05
Table 10A.15	PBS expenditure per person, by urban and rural location, (2004-05 dollars)
Table 10A.16	Availability of GPs by region
Table 10A.17	Female GPs
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11 Health management issues

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the management of breast cancer and mental health, which represent some activities of the Australian, State and Territory governments in health management.

An overview of health management and the health management performance measurement framework is provided in sections 11.1 and 11.2 respectively. Sections 11.3 and 11.4 report on the performance of breast cancer and mental health management respectively. Section 11.5 outlines the future directions for the chapter, while jurisdictions' comments relating to all the health chapters appear in section 11.6. Definitions are listed in section 11.7. Section 11.8 lists the supporting tables for this chapter and section 11.9 lists references used in the chapter.

11.1 Overview of health management

Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. This chapter examines the performance of a number of services in influencing outcomes for women with breast cancer and for people with a mental illness. Measuring performance in the management of a health problem involves measuring the performance of service providers and the overall management of a spectrum of services, including prevention, early detection and treatment programs.

Breast cancer and mental illness are significant causes of morbidity and mortality in Australia. Cancer control and mental health are identified by governments as national health priority areas, as are asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and musculoskeletal conditions. These areas represent almost 80 per cent of the total burden of disease and injury in Australia, and their management offers considerable scope for reducing this burden (AIHW 2003b).

Appropriate management of breast cancer and mental health will have a large effect on the health and wellbeing of many Australians. Both are subjects of programs

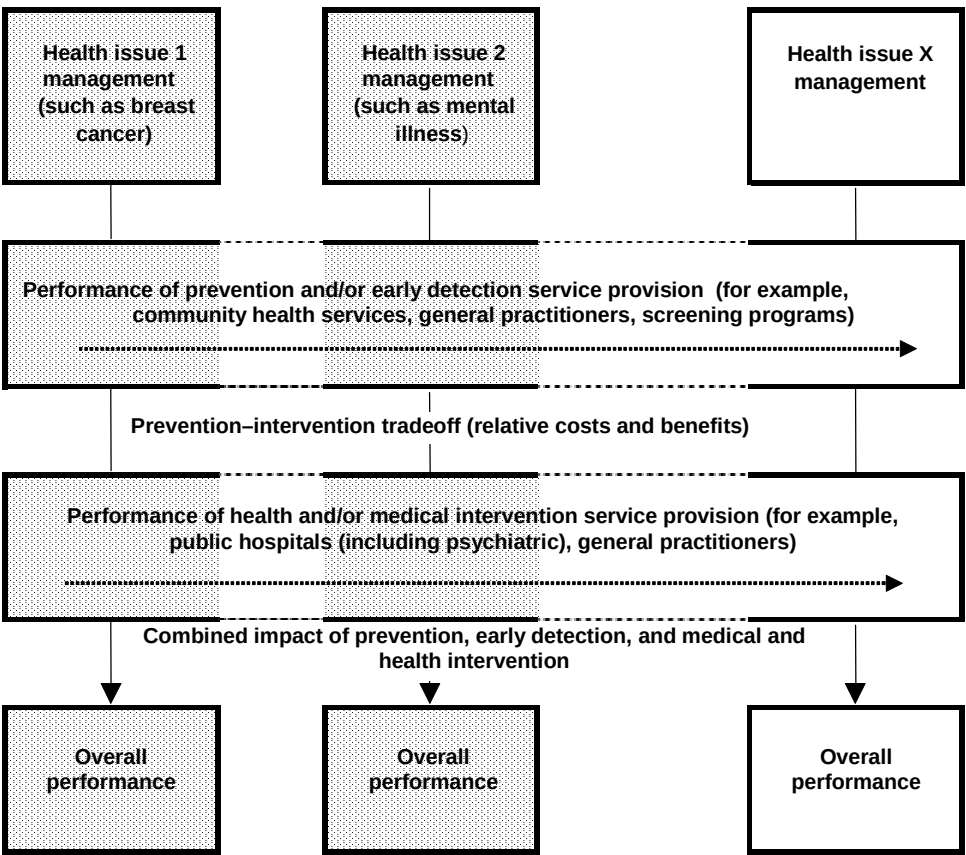
designed to improve public health. Public health programs require the participation of public hospitals, primary and community health services, and other services. The performance of public hospitals is discussed in chapter 9 and the performance of primary and community health services generally is discussed in chapter 10.

11.2 Framework for measuring the performance of health management

The ‘Health preface’ of this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and primary and community health services report the performance of particular service delivery mechanisms. The appropriateness of the mix of services (prevention versus intervention) and the appropriateness of the mix of delivery mechanisms (hospital-based versus community-based) are the focus of reporting in this chapter. The measurement approach adopted is represented diagrammatically in figure 11.1.

The appropriate mix of services — including the prevention of illness and injury, medical treatment and the appropriate mix of service delivery mechanisms — is measured by focusing on a health management issue (represented by the vertical arrows). As in previous years, the chapter covers breast cancer detection and management, and specialised mental health services. The breast cancer management framework integrates the early detection and medical intervention strategies, which should inform the tradeoffs in the allocation of resources between these two strategies. The mental health framework provides information on the interaction and integration arrangements between community-based and hospital-based providers in meeting the needs of Australians with a mental illness.

Figure 11.1 The Australian health system — measurement approach



11.3 Breast cancer

Profile

Breast cancer is a disease whereby uncontrolled or malignant cell division leads to the formation of a tumour or tumours in a woman's breast (box 11.1).¹ Tumours may expand locally by invading surrounding tissue, or they may spread via the lymphatic or vascular systems to the rest of the body. If left untreated, most malignant tumours result in the death of the affected person (AIHW 2003a). The focus of this Report is on invasive cancers, although some data are reported on *ductal carcinoma in situ* (DCIS — noninvasive tumours residing in the ducts of the breast).

¹ Breast cancer in males is very rare. It is not examined in this Report.

Box 11.1 Some common health terms used in breast cancer detection and management

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

BreastScreen Australia: a national program that undertakes nationwide breast cancer screening that targets women aged 50–69 years, although women aged 40–49 years and over 70 years are also eligible to attend. 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 pathway. 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.

health management: an ongoing process beginning with initial client contact and including all actions relating to the client: assessment/evaluation; education of the person, family or carer(s); diagnosis; and treatment. Problems associated with adherence to treatment and liaison with, or referral to, other agencies are also included.

incidence rate: the proportion of the population newly diagnosed with a particular disorder or illness during a given period (often expressed per 100 000 people).

invasive cancer: a tumour whose cells invade healthy or normal tissue.

prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

screening: the performance of tests on apparently well people to detect disease at an earlier stage than would otherwise be the case.

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

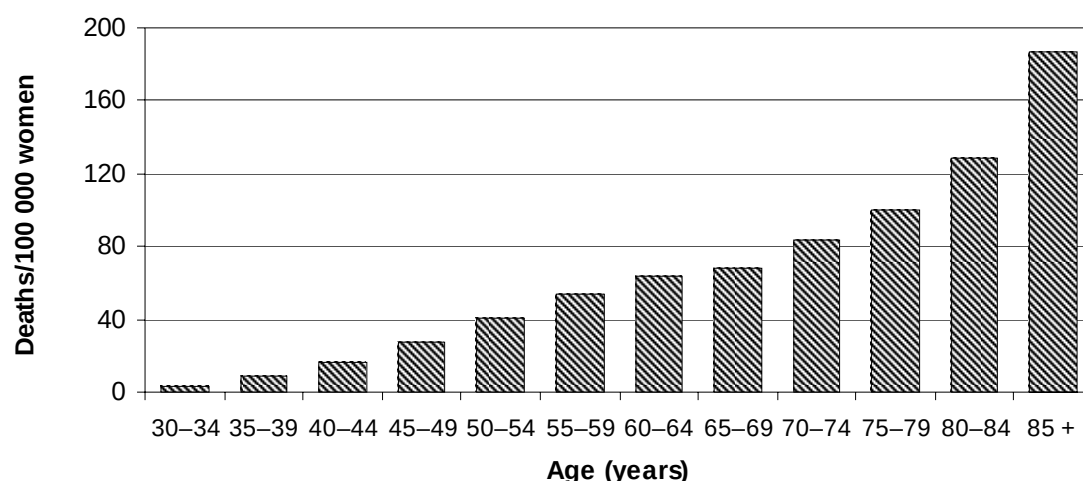
screening round (subsequent): a woman's second or subsequent visit to a BreastScreen Australia service.

total mastectomy: removal of the breast (also known as a simple mastectomy).

Breast cancer was responsible for 2713 female deaths in 2003, making it one of the most frequent causes of death from cancer for females (ABS 2005 Causes of Death). The strong relationship between age and the mortality rate from breast cancer is shown for the period 1999–2003 in figure 11.2. Women aged 40–44 years had an annual average mortality rate over this period of 16.6 per 100 000, whereas

women aged 75–79 years had an annual average mortality rate of 100.2 per 100 000.

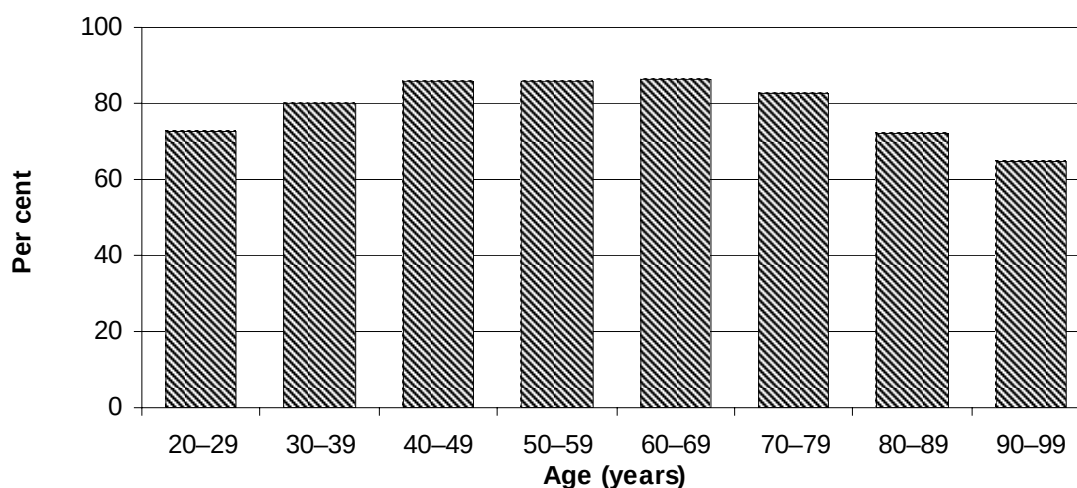
Figure 11.2 **Annual average mortality rates from breast cancer, by age group, 1999–2003**



Source: AIHW (unpublished); table 11A.19.

Relative survival after diagnosis of breast cancer in females is good compared with other cancers. Over the period 1992–97, for women of all ages in Australia, relative survival was 96.4 per cent one year after diagnosis, and 84.0 per cent five years after diagnosis. Relative survival 10 years after diagnosis was 68.3 per cent in the period 1987–91 (AIHW and AACR 2001). Five year relative survival for breast cancer in Australia at diagnosis over the period 1992–97 increased with age from the age group 20–29 years (72.4 per cent) to a peak for the age groups 40–49 years (85.8 per cent), 50–59 years (85.7 per cent) and 60–69 years (86.1 per cent). The five year relative survival rate declined with age for women over 70 years (figure 11.3).

Figure 11.3 **Breast cancer five year relative survival at diagnosis, by age group, 1992–97^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 AACR (2001); table 11A.1.

Incidence and prevalence

Breast cancer is the most prevalent type of cancer affecting Australian women. In 2001, the estimated risk of a woman in Australia developing breast cancer before the age of 75 years was one in 11 (AIHW and AACR 2004). The number of new cases of breast cancer diagnosed in Australian women increased from an annual average of 10 089 over the period 1994–98 to an annual average of 10 942 over the period 1997–2001 (table 11.1). The increase in the number of cases detected reflected both an increase in the underlying rate of breast cancer, as well as the early detection of cancers that previously would not have been discovered for some years, primarily through the activity of BreastScreen Australia (AIHW 2003a).

Annual average age standardised incidence rates of breast cancer are presented in figure 11.4. 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 but relatively large variations in rates from year to year. The Australian incidence rate increased from an annual average of 111.1 per 100 000 women for the period 1993–97 to an annual average of 114.1 for the period 1997–2001.

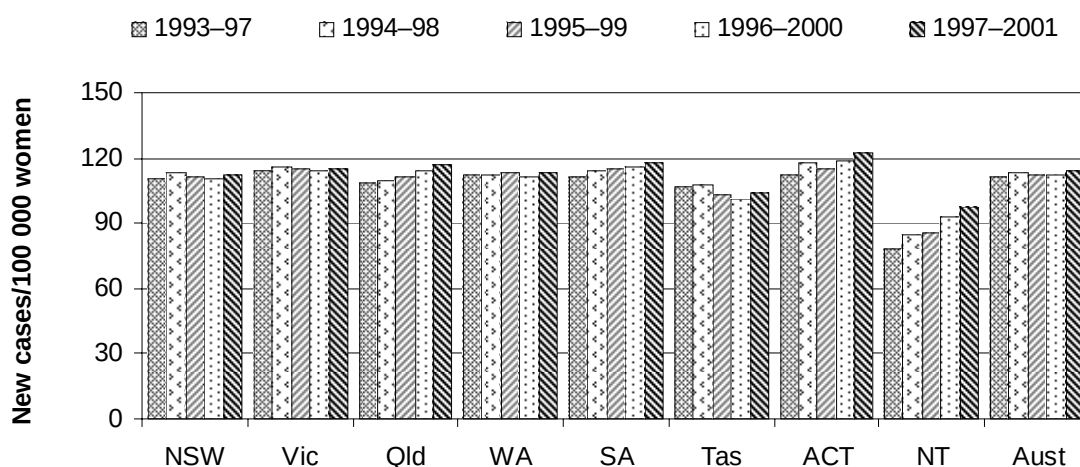
Table 11.1 Annual average new cases of breast cancer diagnosed (number)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
1994–98	3 494	2 654	1 703	902	889	255	147	45	10 089
1995–99	3 518	2 682	1 786	937	911	247	148	45	10 274
1996–2000	3 584	2 729	1 882	950	931	249	158	50	10 532
1997–2001	3 712	2 799	1 995	991	963	261	168	54	10 942

^a A new case is defined as a person who has a cancer diagnosed for the first time. One person may have more than one cancer, so may be counted twice in incidence statistics if it is decided that the two cancers are not of the same origin.

Source: AIHW (unpublished); table 11A.2.

Figure 11.4 Annual average age standardised incidence rates of breast cancer for women of all ages^{a, b}

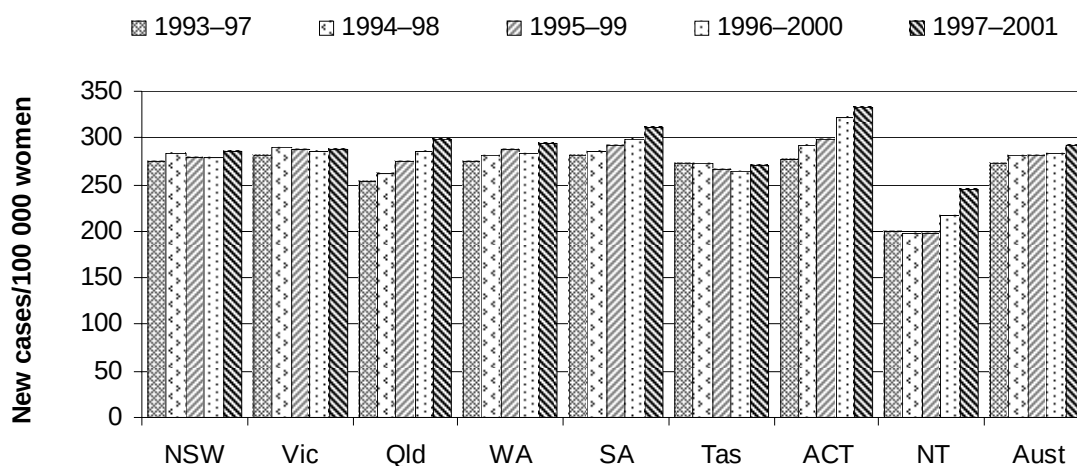


^a Incidence refers to the number of new cases of breast cancer per 100 000 women. ^b Rates are age standardised to the Australian 2001 population standard.

Source: AIHW (unpublished); table 11A.3.

Annual average age standardised incidence rates of breast cancer for women aged 50–69 years are shown in figure 11.5.

Figure 11.5 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); table 11A.3.

Size and scope of breast cancer detection and management services

Breast cancer detection and management services comprise a number of major components: primary care and community-based services, including general practitioner (GP) services and community-based women's health services; screening services; acute services based in hospitals, including both inpatient and outpatient services; private consultations for a range of disciplines; and post-acute services, including home-based and palliative care (DHS 1999).

A fundamental component of breast cancer control is the use of screening mammography to enable early detection of breast cancer. There is evidence that population-based screening of women aged 50–69 years can reduce deaths from breast cancer. According to the National Breast Cancer Centre, women whose cancer is diagnosed before it has spread outside the breast have a 90 per cent chance of surviving five years. The five year survival rate drops to 20 per cent if the cancer spreads to other parts of the body before diagnosis (NBCC 2003). It is generally argued that cancers detected early may be treated more conservatively and that these women have a higher likelihood of survival.

BreastScreen Australia, jointly funded by the Australian, State and Territory governments, undertakes nationwide breast cancer screening. It targets women aged 50–69 years for screening once every two years. The program aims to have 70 per cent or more of women aged 50–69 years participating in screening over a 24 month

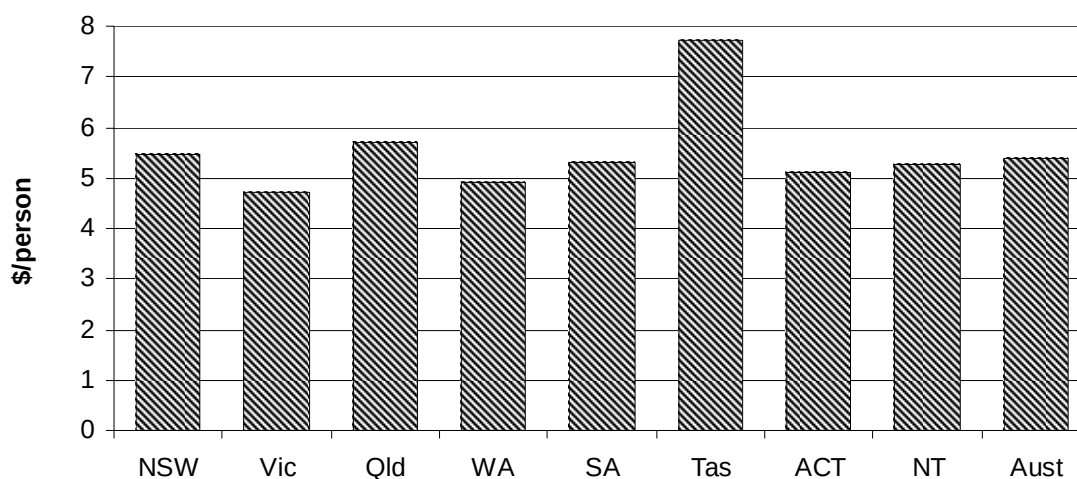
period. All recruitment activities undertaken by BreastScreen Australia specifically target women in this age group, although women aged 40–49 years and those over 70 years may also use the service.

Services provided by BreastScreen Australia in each State and Territory include all screening and assessment services to the point of diagnosis. The program includes health promotion activities, information provision, counselling and data collection across the screening pathway. Each jurisdiction manages a central BreastScreen registry to ensure women with a screen detected abnormality receive follow-up treatment and to enable women to be invited for re-screening at the appropriate interval. Data collected from the registries allow for quality assurance, monitoring and evaluation of the program. All jurisdictions perform fine needle aspiration biopsy and core biopsies as part of their assessment services, but some jurisdictions do not include open biopsies in the funded program (table 11A.4).

Information on BreastScreen Australia program performance is published by the Australian Institute of Health and Welfare (AIHW) in the BreastScreen Australia monitoring reports, the most recent of which was published in 2005 (AIHW 2005b, BreastScreen Australia Monitoring Report).

Governments spent around \$108.3 million on breast cancer screening in 2003-04 (table 11A.5). Estimates of government expenditure on breast cancer screening per person are presented by jurisdiction in figure 11.6. 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 target women living in rural and remote areas. The data therefore need to be interpreted with care.

Figure 11.6 **Public health expenditure on breast cancer screening, 2003-04^{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); ABS, Cat. no. 3101.0 (unpublished); tables A.2 and 11A.5.

The number of women aged 40 years or over screened by BreastScreen Australia indicates the size of the BreastScreen Australia program. Around 846 000 women in this age group were screened in 2004, compared with 786 000 in 2000 (table 11.2).

Table 11.2 **Number of women aged 40 years or over screened by BreastScreen Australia^a**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2000	277 459	177 232	163 731	65 593	65 493	21 344	11 463	4 147	786 462
2001	298 613	188 677	171 337	71 432	69 774	20 702	12 160	4 414	837 109
2002	294 011	187 714	177 281	69 697	68 571	22 204	11 793	4 166	835 437
2003	289 912	188 782	180 396	76 059	69 182	22 424	10 651	4 541	841 947
2004	270 598	198 743	191 084	78 773	69 882	23 107	9 995	4 016	846 198

^a First and subsequent screening rounds, for women aged 40 years or over.

Source: State and Territory governments (unpublished); table 11A.6.

Breast cancer is diagnosed outside the BreastScreen program when women elect to screen privately or when they have symptoms which make it inappropriate for the diagnosis to be made through screening. For these women, GPs are critical as the initial point of referral to specialists for diagnosis and treatment services. Relevant clinical disciplines include surgery, plastic and reconstructive surgery, pathology, radiation and medical oncology, nursing, diagnostic radiology, radiography, physiotherapy, allied health, and psychological and psychiatric services. Post-acute services include a range of further treatments, such as radiotherapy and chemotherapy (most of which take place on a same day or outpatient basis) and a range of follow-up and palliative care services (DHS 1999).

Inpatient separations in public hospitals for selected breast-cancer related Australian refined diagnosis related groups (AR-DRGs)² in 2003-04 are presented in table 11.3. Most of the data relating to breast cancer detection and management in this Report are provided by BreastScreen Australia. At present, data for breast cancer services other than screening are limited.

Table 11.3 Separations for selected AR-DRGs related to breast cancer, public hospitals, 2003-04 (per 10 000 people)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Breast cancer related conditions									
Major procedures for malignant breast conditions	2.8	3.1	2.5	2.8	2.9	2.3	3.2	1.2	2.8
Minor procedures for malignant breast conditions	1.2	1.3	1.3	1.2	1.2	1.3	0.9	0.2	1.2
Skin, subcutaneous tissue and plastic breast procedures	2.7	3.2	3.7	3.1	6.1	2.2	2.0	2.5	3.3
Other skin, subcutaneous tissue and breast procedures	12.9	22.2	23.7	18.7	34.0	14.0	8.7	11.1	19.4
Malignant breast disorders (age >69 years w CC)	0.7	1.0	0.6	0.3	0.7	1.6	0.5	0.2	0.7
Malignant breast disorders (age <70 years w CC) or (age >69 years w/o CC)	0.5	1.9	0.6	1.5	0.4	2.0	1.2	0.3	1.0
Malignant breast disorders (age <70 years w/o CC)	na	na	na	na	na	na	na	na	na
Total separations in public hospitals for all conditions	1 909.3	2 319.0	1 808.0	1 824.3	2 391.1	1 649.3	2 083.2	3 479.7	2 031.5

w/o CC = without complications and co-morbidities. w CC = with complications and co-morbidities.
^a Care needs to be taken when comparing jurisdictions because admission practices vary. ^b AR-DRG version 4.2. **na** Not available.

Source: AIHW (2005a, Australian Hospital Statistics 2003-04); table 11A.7.

² AR-DRGs are a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 4.2 is based on the ICD-10-AM classification (see chapter 9 for more detail).

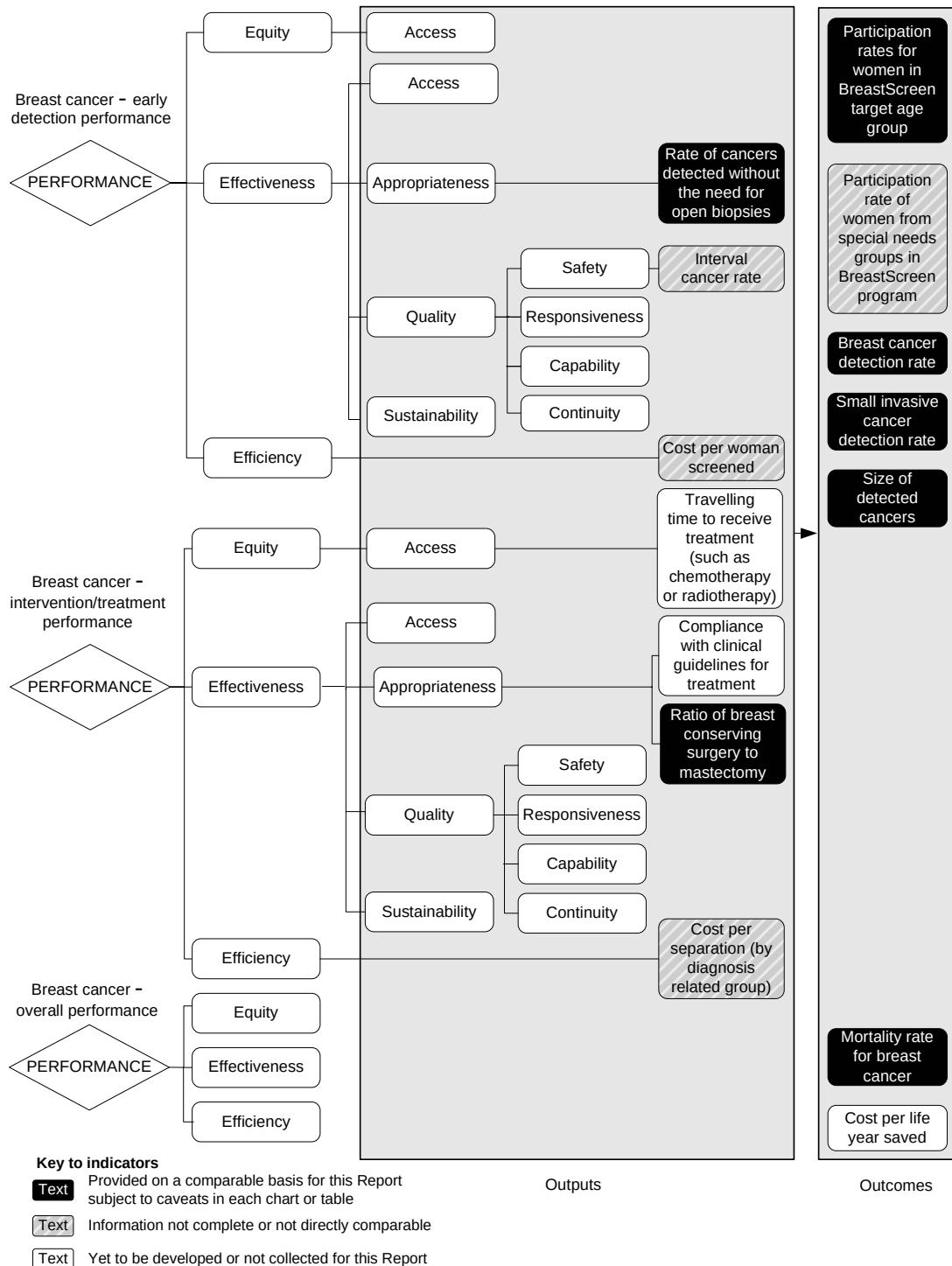
Framework of performance indicators

The indicators developed to report on the performance of breast cancer detection and management are based on the shared government objectives for managing the disease (box 11.2). The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability that have been added to the standard Review framework for health services. The performance indicator framework shows which data are comparable in the 2006 Report (figure 11.7). 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 (section 1.6).

Box 11.2 Objectives for breast cancer detection and management

The objectives for breast cancer detection and management are to reduce morbidity and mortality attributable to breast cancer, and to improve the quality and duration of life of women with breast cancer in a manner that is equitable and efficient.

Figure 11.7 Performance indicators for breast cancer detection and management



The framework for breast cancer detection and management focuses on achieving a balance between early detection of the disease and treatment. It has a tripartite

structure — that is, performance indicators presented relate to early detection, intervention and overall performance.

Key performance indicator results

Given the significant amounts of available data relating to breast cancer screening, screening is the focus of reporting. Data relating to the management and treatment of breast cancer are less readily available, and a Steering Committee priority is to extend reporting in this area in the future.

Outputs

Early detection — rate of cancers detected without the need for open biopsies

The ‘rate of cancers detected without the need for open biopsies’ is an indicator of the effectiveness of early detection performance (box 11.3).

Box 11.3 Rate of cancers detected without the need for open biopsies

The ‘rate of cancers detected without the need for open biopsies’ is an indicator of the effectiveness of BreastScreen Australia in diagnosing breast cancer without the need for invasive procedures.

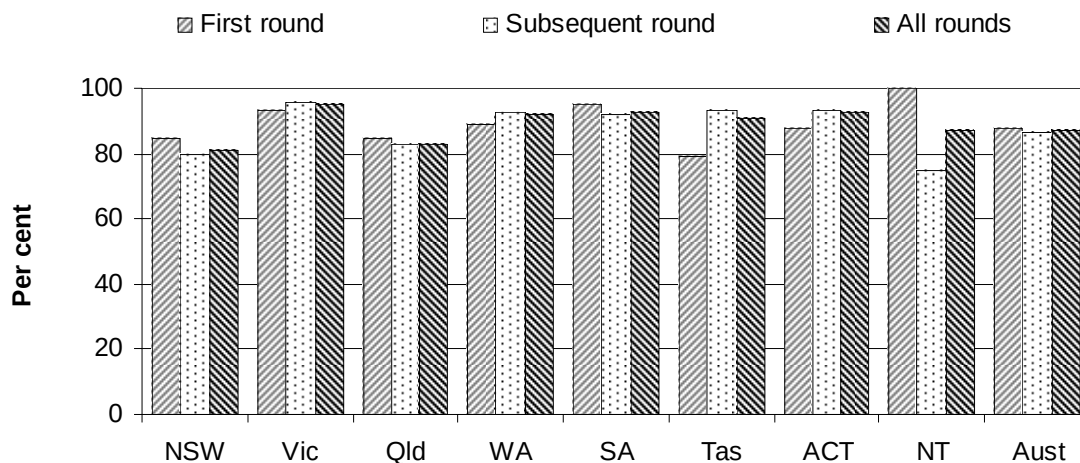
This indicator is defined as the number of diagnoses made without a diagnostic open biopsy, as a proportion of all breast cancers detected (invasive and DCIS). High rates of cancers detected without the need for open biopsies indicates effectiveness in detecting malignancies while minimising the need for invasive procedures.³

The BreastScreen Australia National Accreditation Standards (July 2002) 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 2002).

In 2004, for women attending their first screening round, the rate of cancers detected without the need for open biopsies was 87.9 per cent Australia wide. For women attending a subsequent round the rate was 86.8 per cent Australia wide (figure 11.8).

³ A breast biopsy is a procedure for obtaining a breast tissue specimen for microscopic examination to establish a diagnosis.

Figure 11.8 Rate of cancers detected without the need for open biopsies, all women, 2004



Source: State and Territory governments (unpublished); table 11A.8.

Early detection — interval cancer rate

The ‘interval cancer rate’ is an indicator of the effectiveness of early detection performance (box 11.4).

Box 11.4 Interval cancer rate

An interval cancer is an invasive breast cancer diagnosed in the interval between a negative screening result and the next scheduled screening examination. The purpose of the ‘interval cancer rate’ indicator is to help determine how effective the BreastScreen Australia program is in detecting breast cancer at an early stage. Measuring the interval cancer rate helps to obtain an early measure of the likely impact of the screening program on mortality.

The ‘interval cancer rate’ is defined as the number of interval cancers per 10 000 women screened. A low interval cancer rate is desirable because it suggests the breast screening process is effective in detecting breast cancer.

This rate needs to be interpreted in conjunction with the breast cancer detection indicators.

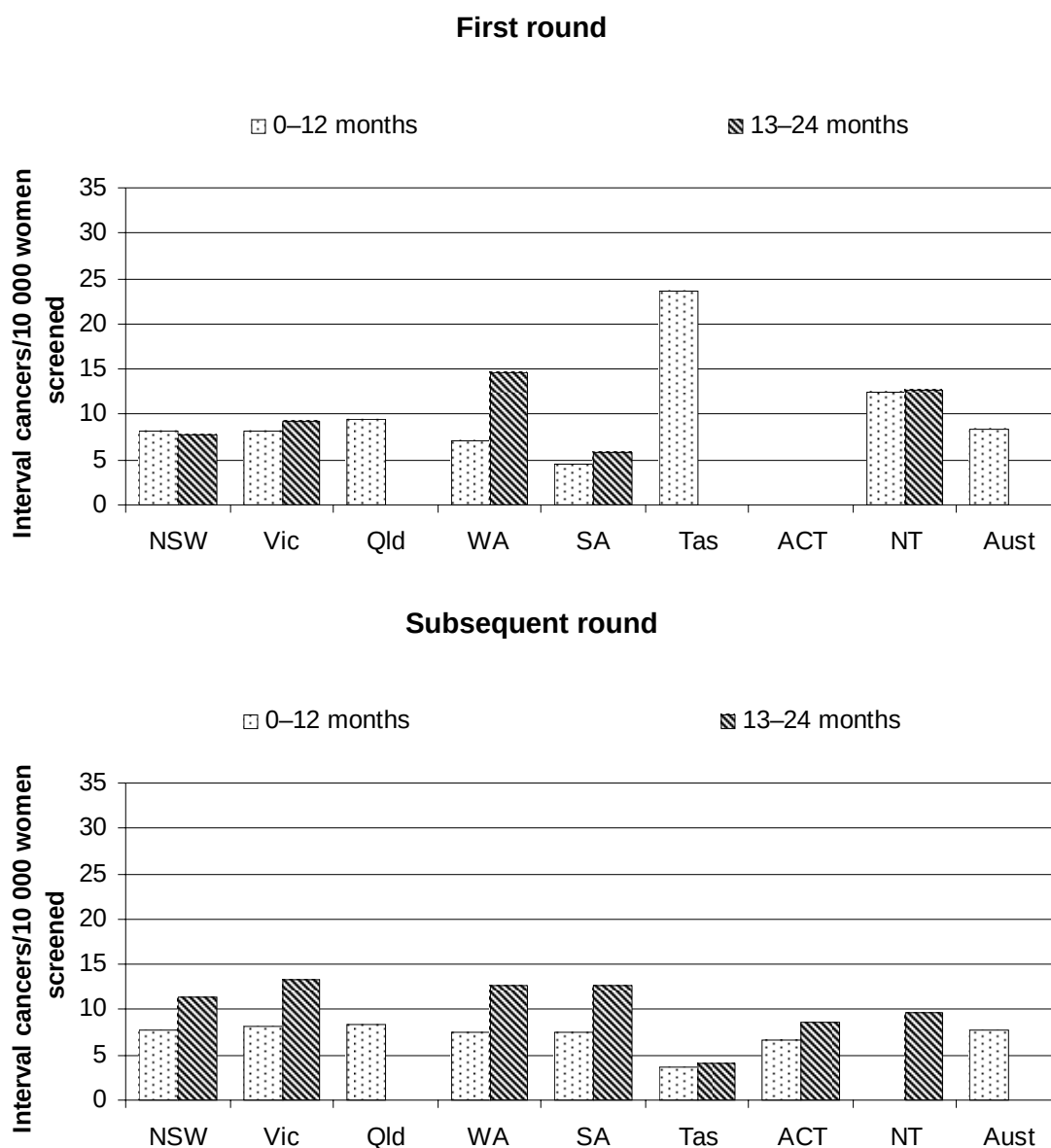
There is a time lag in obtaining data for this indicator, because the detection period falls between the last screening visit in the reference screening year and the next scheduled screening appointment. Following that period, a further time lag is required for the reporting of those cancers to the cancer registry, before a process of data matching can occur between each jurisdiction’s screening program and its

cancer registry. As a result, the most recent data available for this Report are for women screened during 2001. Stratification is by first and subsequent screening rounds to allow for expected variation in interval cancer rates between rounds.

Figure 11.9 presents the age standardised interval cancer rate by screening round for women aged 50–69 years. Differences in the rates across jurisdictions may be caused by differences in the policies of the BreastScreen services in each jurisdiction. Some jurisdictions (such as SA and some services in NSW) do not further investigate an abnormality of the breast, even when a symptom is reported, if the mammogram appears normal. These women are advised to visit their GP for a referral to a diagnostic service. This could have the effect of increasing the jurisdiction's interval cancer rate and reducing their cancer detection rate if an invasive breast cancer is subsequently diagnosed outside the breast cancer screening program. Comparisons across jurisdictions therefore need to be made with care.

In 2001, for all women aged 50–69 years in the first round of screening, the interval cancer rate 0–12 months following screening was 8.4 per 10 000 women screened. In subsequent rounds this declined to 7.7 per 10 000 women screened. Interval cancer rates 13–24 months following screening are also shown in figure 11.9.

Figure 11.9 **Age standardised interval cancer rate, women aged 50–69 years, 2001^{a, b, c, d, e, f}**



a Rates are expressed as the number of interval cancers per 10 000 women screened. **b** The numbers used to measure this indicator were small, resulting in large variations from year to year. It is reasonable to view this indicator over time rather than from one year to the next. **c** Data for Queensland for 13–24 months were not available. **d** Data for Tasmania were zero in the first round for 13–24 months. **e** Data for the ACT were zero in the first round for 0–12 months and 13–24 months. **f** Data for the NT were zero in the subsequent round for 0–12 months.

Source: State and Territory governments (unpublished); table 11A.9.

Early detection — cost per woman screened

The ‘cost per woman screened’ indicator is an indicator of the efficiency of early detection performance (box 11.5).

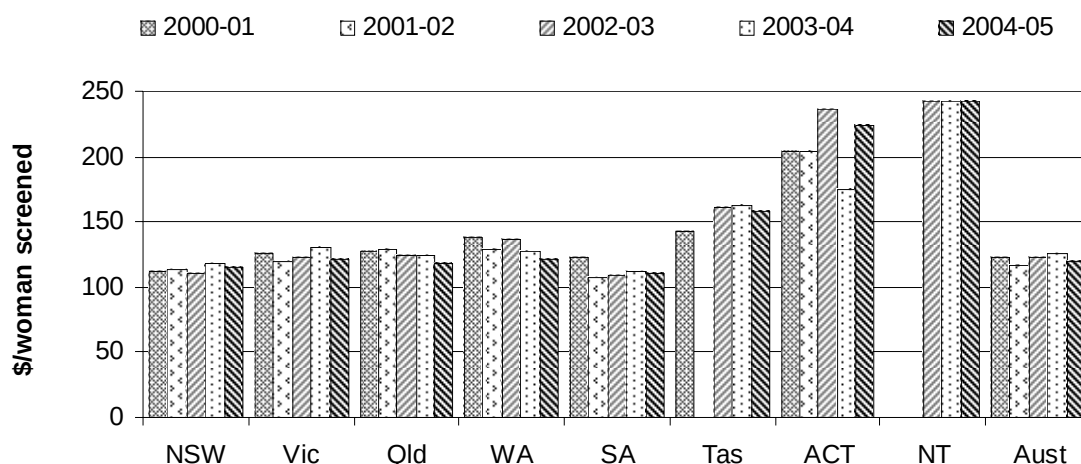
Box 11.5 Cost per woman screened

The 'cost per woman screened' is an indicator of the efficiency of the breast cancer screening program. An objective of breast cancer detection and management is that services are provided in an efficient manner.

'Cost per woman screened' measures the total cost of providing services (including screening, assessment and program management), divided by the number of women screened. A low 'cost per woman screened' can indicate efficiency, but caution must be used when interpreting indicators in this way because the cost does not provide any information on the quality of service provided.

Care needs to be taken when making comparisons across jurisdictions. There are potential differences in the items included in the measures of cost (particularly in the treatment of depreciation and capital asset charges, and the inclusion of subsidies). There may also be differences across jurisdictions in the scope of activities being costed. The Review is working to identify these differences across jurisdictions to improve data comparability in future (table 11A.11). Preliminary estimates of costs in each jurisdiction are presented in figure 11.10. The average cost per woman screened in Australia in 2004-05 was \$120.

Figure 11.10 Real cost per woman screened, BreastScreen Australia services (2004-05 dollars)^{a, b, c, d, e, f}



a Constant price expenditure (in 2004-05 dollars) using the Gross Domestic Product price deflator (table A.26). The number of women screened used to calculate the cost per woman screened is calendar year data rather than financial year. **b** Data for NSW do not include subsidies. **c** Data for Queensland include depreciation and user cost of capital for 2000-01, 2001-02 and 2002-03. **d** Data for SA are calculated on an accrual basis. **e** Data for Tasmania are not available for 2001-02. **f** Data for the NT are not available for 2000-01 and 2001-02.

Source: State and Territory governments (unpublished); ABS (unpublished) National Accounts: National Income Expenditure and Productivity; tables A.26 and 11A.10.

Intervention/treatment — travelling time to receive treatment

The Steering Committee has identified a woman's 'travelling time to receive treatment' as an indicator of the equity of intervention and treatment performance (box 11.6). Data on this indicator, however, were not available for the 2006 Report.

Box 11.6 Travelling time to receive treatment

The Steering Committee has identified the 'travelling time to receive treatment' indicator for development and reporting in future. This indicator relates to access to breast cancer intervention and treatment services such as chemotherapy or radiotherapy. A fast 'travelling time to receive treatment' suggests that intervention and treatment services are accessible in terms of distance travelled. A fast travelling time also implies that services are well located in terms of the population served.

Intervention/treatment — compliance with clinical guidelines for treatment

The Steering Committee has identified ‘compliance with clinical guidelines for treatment’ as an indicator of the effectiveness of intervention and treatment performance (box 11.7). Data on this indicator, however, were not available for the 2006 Report.

Box 11.7 Compliance with clinical guidelines for treatment

The Steering Committee has identified the ‘compliance with clinical guidelines for treatment’ indicator for development and reporting in future. This indicator relates to the appropriateness of breast cancer intervention and treatment. Compliance with clinical guidelines and treatment suggests breast cancer intervention and treatment are appropriate.

Intervention/treatment — ratio of conserving surgery to mastectomy

The ratio of ‘conserving surgery to mastectomy’ is an indicator of the effectiveness of intervention and treatment performance (box 11.8).

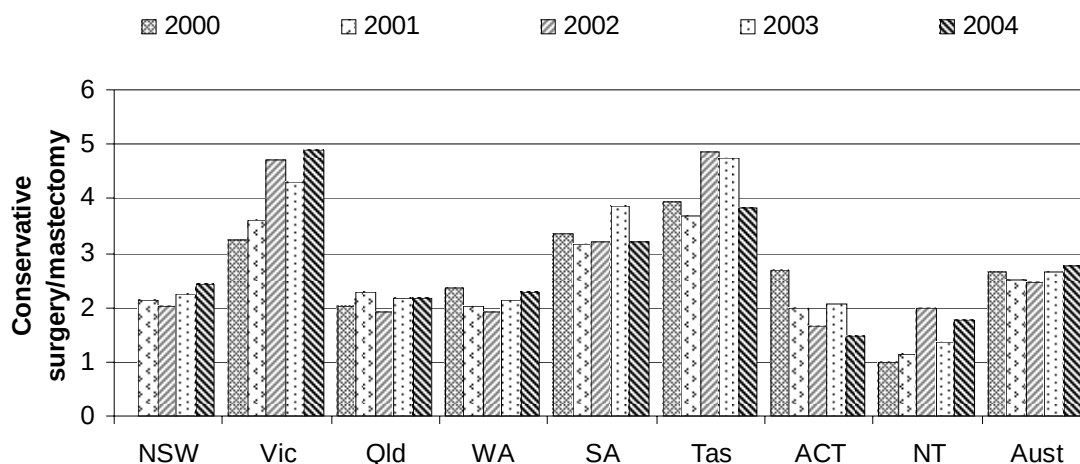
Box 11.8 Ratio of conserving surgery to mastectomy

The ratio of ‘conserving surgery to mastectomy’ is an indicator of the appropriateness of breast cancer intervention and treatment that aims to reduce morbidity and mortality. It can also reflect the early detection of breast cancer, because breast conserving surgery is more likely to be possible when cancers are detected at an early stage.

The ratio is defined as the number of cases for which no surgery or breast conserving surgery was performed, divided by the number of cases requiring mastectomy. Breast conserving surgery removes the breast cancer but not the whole breast. In terms of intervention and treatment, the ratio should reflect the appropriate mix of treatment. In terms of early detection of breast cancer, a high ratio is desirable. Other factors — such as the surgeon’s judgment as to the best treatment for the patient — can also affect the type of surgery undertaken.

Data for this indicator are derived from BreastScreen Australia and represent only a portion of the total possible treatment information available. BreastScreen Australia aims to diagnose small cancers that can be treated more effectively and with reduced morbidity for women, so these data are not necessarily a good indication of general clinical practice relating to breast cancer. Nationally in 2004 the ratio of conserving surgery to mastectomy averaged 2.8:1 (figure 11.11).

Figure 11.11 Ratio of conserving surgery to mastectomy^{a, b}



^a Data for NSW are not available for 2000. ^b Applies for women of all ages.

Source: State and Territory governments (unpublished); table 11A.12.

Intervention/treatment — cost per separation by diagnosis related group

The 'cost per separation by diagnosis related group' is an indicator of the efficiency of intervention and treatment performance (box 11.9).

Box 11.9 Cost per separation by diagnosis related group

'Cost per separation by diagnosis related group' is a proxy indicator of efficiency. An objective of breast cancer detection and management is to provide services in an efficient manner.

This indicator is defined as the cost of care per separation in public hospitals for selected breast cancer related conditions. A low cost per separation can indicate efficiency, but caution must be used when interpreting the indicator in this way, because the cost per separation does not provide any information on the quality of service provided. In addition, not all intervention strategies are reported.

Data for this indicator are sourced from the National Hospital Cost Data Collection (NHCDC) and are based on the AR-DRG classification version 4.2. The NHCDC is an annual collection of hospital cost and activity data covering the financial year before the collection period. Participation in the NHCDC is voluntary, so the samples are not necessarily representative of all hospitals in each jurisdiction (although this is improving over time). In addition, the purpose of the NHCDC is to calculate DRG cost weights, not to compare the efficiency of hospitals (DHA 2005).

Table 11.4 summarises costs per separation for selected breast cancer AR-DRGs. The average cost of major procedures for malignant breast conditions across Australia was \$5573 per separation in 2003-04; minor procedures for malignant breast conditions cost \$2724 per separation on average. Table 11A.13 summarises the average length of stay (in public hospitals) associated with each AR-DRG.

Table 11.4 Average cost per separation, public hospitals by selected breast cancer AR-DRGs, 2003-04 (dollars)^{a, b, c}

AR-DRG	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Major procedures for malignant breast conditions	5 007	6 321	4 946	5 852	5 059	8 024	6 618	8 995	5 573
Minor procedures for malignant breast conditions	2 640	2 798	2 755	2 716	2 792	2 696	2 353	np	2 724
Malignant breast disorders, age > 69 years w CC	5 832	3 562	3 050	4 029	6 126	3 756	5 314	–	4 437
Malignant breast disorders, age <70 years w CC or age >69 w/o CC	3 240	1 584	2 104	3 330	2 475	3 280	2 179	3 235	2 347
Malignant breast disorders, age <70 years w/o CC	1 454	752	1 235	342	936	778	778	np	796

w CC = with complications and co-morbidities. w/o CC = without complications and co-morbidities.

^a Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. ^b Average cost is affected by a number of factors, some of which are admission practices, sample size, remoteness and the types of hospital contributing to the collection. Direct comparison across jurisdictions is difficult because there are differences in hospital costing systems. ^c In accordance with NHCDC methodology, depreciation and some capital costs are included in these figures, except for Victoria, which does not include depreciation. **np** Not published due to low volume and privacy concerns. – Nil or rounded to zero.

Source: DHA 2005, National Hospital Cost Data Collection; table 11A.13.

Outcomes

Early detection — participation rate of women in the BreastScreen target age group

The ‘participation rate of women in the BreastScreen target age group’ is an outcome indicator of early detection performance (box 11.10).

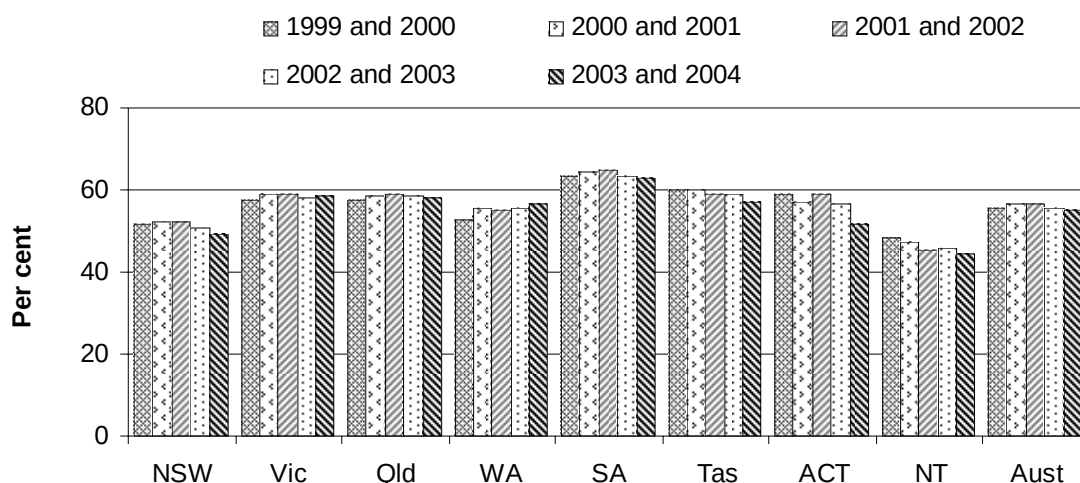
Box 11.10 Participation rate of women in the BreastScreen target age group

The 'participation rate of women in the BreastScreen target age group' of 50–69 years is included as an indicator to reflect the importance of screening to the early detection of breast cancers. Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

The participation rate measures the proportion of the eligible population attending the screening program within a 24 month period. Higher participation rates in screening are more desirable. The aim under the National Accreditation Standards (July 2002) is that at least 70 per cent of women aged 50–69 years participate in screening over a 24 month period. Recruitment activities undertaken by BreastScreen specifically target women in this age group although access to the program is also provided for women aged 40–49 years and 70 years or over (BreastScreen Australia 2002).

The participation of women aged 50–69 years in BreastScreen Australia screening programs was 55.4 per cent in the 24 month period 2003 and 2004. The participation rate has declined slightly since the 24 month period 2001 and 2002 (figure 11.12).

Figure 11.12 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 catchment area of the jurisdiction who were screened during the reference period, divided by the number of women resident in the catchment area, using the ABS estimated resident population. This value represents the estimated population at the midpoint of the reference period. It is an average of the two estimated resident populations for the two calendar years (by adding both years and dividing by two). The catchment area is a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or statistical local area. ^b Rates are standardised to the 2001 Australian population standard.

Source: State and Territory governments (unpublished); table 11A.14.

Early detection — participation rate of women from selected community groups in BreastScreen programs

The ‘participation rate of women from selected community groups in BreastScreen programs’ is an outcome indicator of early detection performance (box 11.11).

Box 11.11 Participation rate of women from selected community groups in BreastScreen programs

The ‘participation rate of women from selected community groups’ — that is, Indigenous women, women from non-English speaking backgrounds (NESB) and women living in rural and remote areas — in breast cancer screening is an indicator because screening is important in the early detection of breast cancers. Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality. Women from selected community groups may experience particular language, cultural and geographic barriers to accessing breast cancer screening. This indicator measures the performance of the BreastScreen program in overcoming these barriers.

The participation rate measures the proportion of the eligible population in the community group attending the screening program within a 24 month period. Participation rates for community groups that are at, or close to, those for the total population indicate success in overcoming group-specific barriers to access.

For the 24 month period 2003 and 2004, the national age standardised participation rate for Indigenous women aged 50–69 years (37.7 per cent) was markedly lower than the national rate for all females in that age group (55.4 per cent), although this may be influenced by problems with the identification of Indigenous status. For the same 24 month period and age group, the national participation rate for NESB women (45.8 per cent) was also lower than that of the national total female population, as was that of women living in rural and remote areas (45.9 per cent) (table 11.5). Care needs to be taken when comparing data across jurisdictions, given differences in the collection of data by Indigenous, NESB, and rural and remote status across jurisdictions.

Table 11.5 Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2003 and 2004 (24 month period) (per cent)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Indigenous ^c	35.8	45.1	49.9	34.3	35.1	38.2	36.3	18.6	37.7
Non-English Speaking Background ^d	44.6	37.7	63.9	60.9	57.8	45.1	54.3	16.1	45.8
Metropolitan or capital city ^e	59.8	58.2	76.6	57.0	62.2	54.2	52.0	41.0	61.1
Rural and remote, or rest of State ^f	34.7	59.3	43.1	54.6	65.4	58.1	–	49.2	45.9
All women aged 50–69 years	49.5	58.5	58.2	56.5	63.1	57.3	51.8	44.4	55.4

^a First and subsequent rounds. ^b Rates are standardised to the 2001 Australian population standard. ^c Those women who self-identify as being of Aboriginal or Torres Strait Islander descent. ^d Women who speak a language other than English at home. ^e Includes 'capital city' (State and Territory capital city statistical divisions) and 'other metropolitan centre' (one or more statistical subdivisions that have an urban centre with a population of 100 000 or more). ^f Includes 'large rural centre' statistical local areas where most of the population resides in urban centres with a population of 25 000 or more; 'small rural centre' (statistical local areas in rural zones containing urban centres with populations between 10 000 and 24 999); 'other rural area' (all remaining statistical local areas in the rural zone); 'remote centre' (statistical local areas in the remote zone containing populations of 5000 or more) and 'other remote area' (all remaining statistical local areas in the remote zone). – Nil or rounded to zero.

Source: State and Territory governments (unpublished); tables 11A.14 and 11A.15.

Early detection — breast cancer detection rate

The 'breast cancer detection rate' is an outcome indicator of early detection performance (box 11.12).

Box 11.12 Breast cancer detection rate

The 'breast cancer detection rate' is an indicator of the effectiveness of screening services in identifying breast cancers at an early stage. Early detection of cancers while they are still small and localised to the breast is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

The 'detection rate' is the number of detected cancers per 10 000 women screened. While a high incidence of breast cancer is not desirable, a high rate of detecting these cancers is desirable.

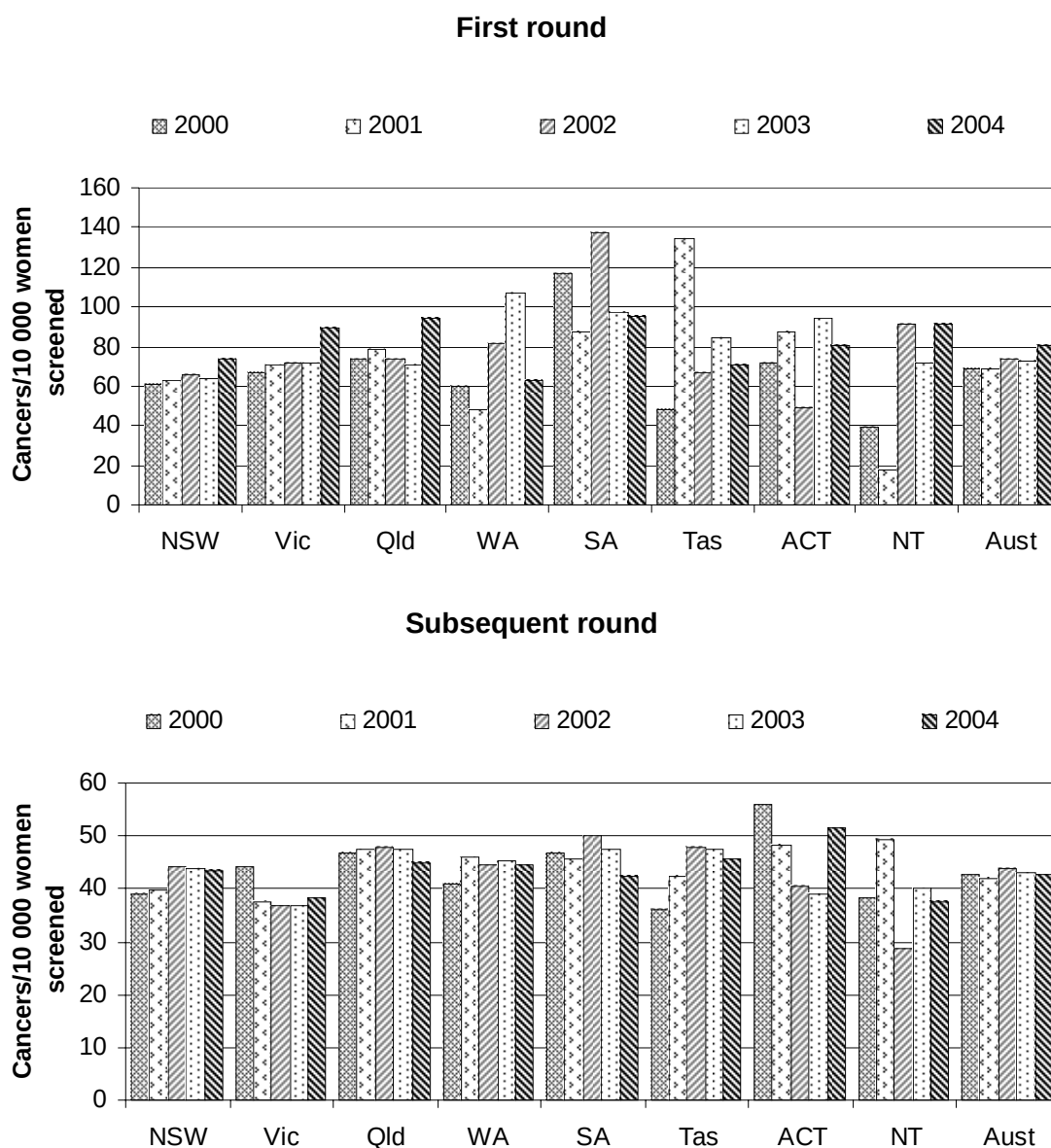
The following are the relevant BreastScreen Australia National Accreditation Standards for detection rates (BreastScreen Australia 2002):

- Greater than or equal to 50 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with invasive breast cancer.
- Greater than or equal to 35 per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with invasive breast cancer.
- Greater than or equal to 12 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with DCIS.
- Greater than or equal to seven per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with DCIS.

It is important to consider together all of the following rates: the invasive cancer detection rate, the small invasive cancer detection rate, the DCIS detection rate and the interval cancer rate.

Figure 11.13 reports the age standardised number of invasive cancers detected per 10 000 women screened aged 50–69 years, by screening round. DCIS detected per 10 000 women screened is reported in table 11A.16. (Relevant definitions can be found in box 11.1 and section 11.7.)

Figure 11.13 **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 service in 1998.

Source: State and Territory governments (unpublished); table 11A.16.

Early detection — small invasive cancer detection rate

The ‘small invasive cancer detection rate’ is an outcome indicator of early detection performance (box 11.13).

Box 11.13 Small invasive cancer detection rate

The 'small (less than 15 millimetres in diameter) invasive cancer detection rate' is an indicator of the early detection of breast cancers. Early detection of cancers while they are still small and localised to the breast is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

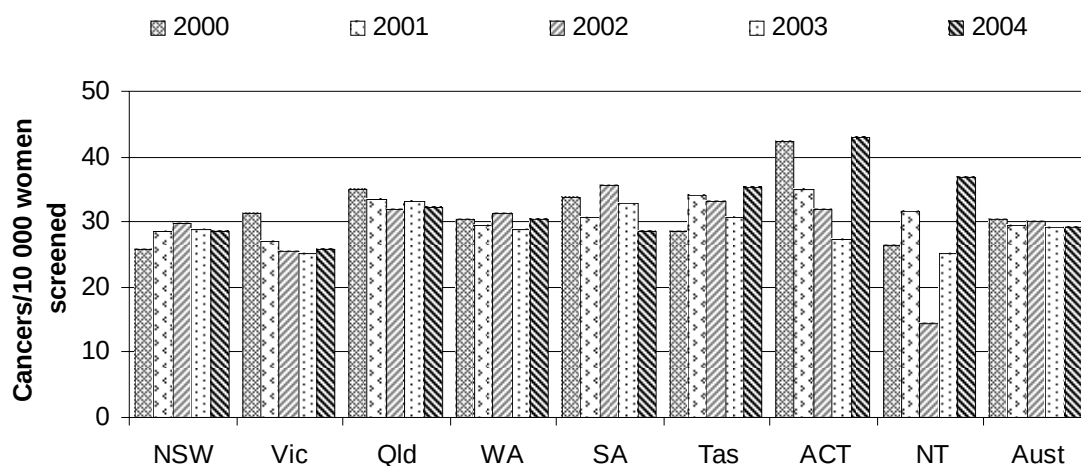
The 'small invasive cancer detection rate' is defined as the number of invasive cancers detected with a diameter of 15 millimetres or less, per 10 000 women screened. It is desirable that a high proportion of cancers detected are small cancers: detection of small cancers is generally associated with increased survival rates and reduced morbidity and mortality, leading to some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998).

The BreastScreen Australia National Accreditation Standards (2002) specify that 25 or more women per 10 000 women aged 50–69 years who attend screening are diagnosed with a small (15 millimetres or less) invasive breast cancer (BreastScreen Australia 2002).

It is important to consider together all of the following rates: the invasive cancer detection rate, the small invasive cancer detection rate, the DCIS detection rate and the interval cancer rate.

Age standardised rates for small invasive cancer detection for women aged 50–69 years screened by BreastScreen Australia in 2004 are reported in figure 11.14. This shows that the rate for Australia was 29.1 cancers per 10 000 women screened in 2004.

Figure 11.14 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 service in 1998.

Source: State and Territory governments (unpublished); table 11A.17.

Early detection — size of detected cancers

The ‘size of detected cancers’ is an outcome indicator of early detection performance (box 11.14).

Box 11.14 Size of detected cancers

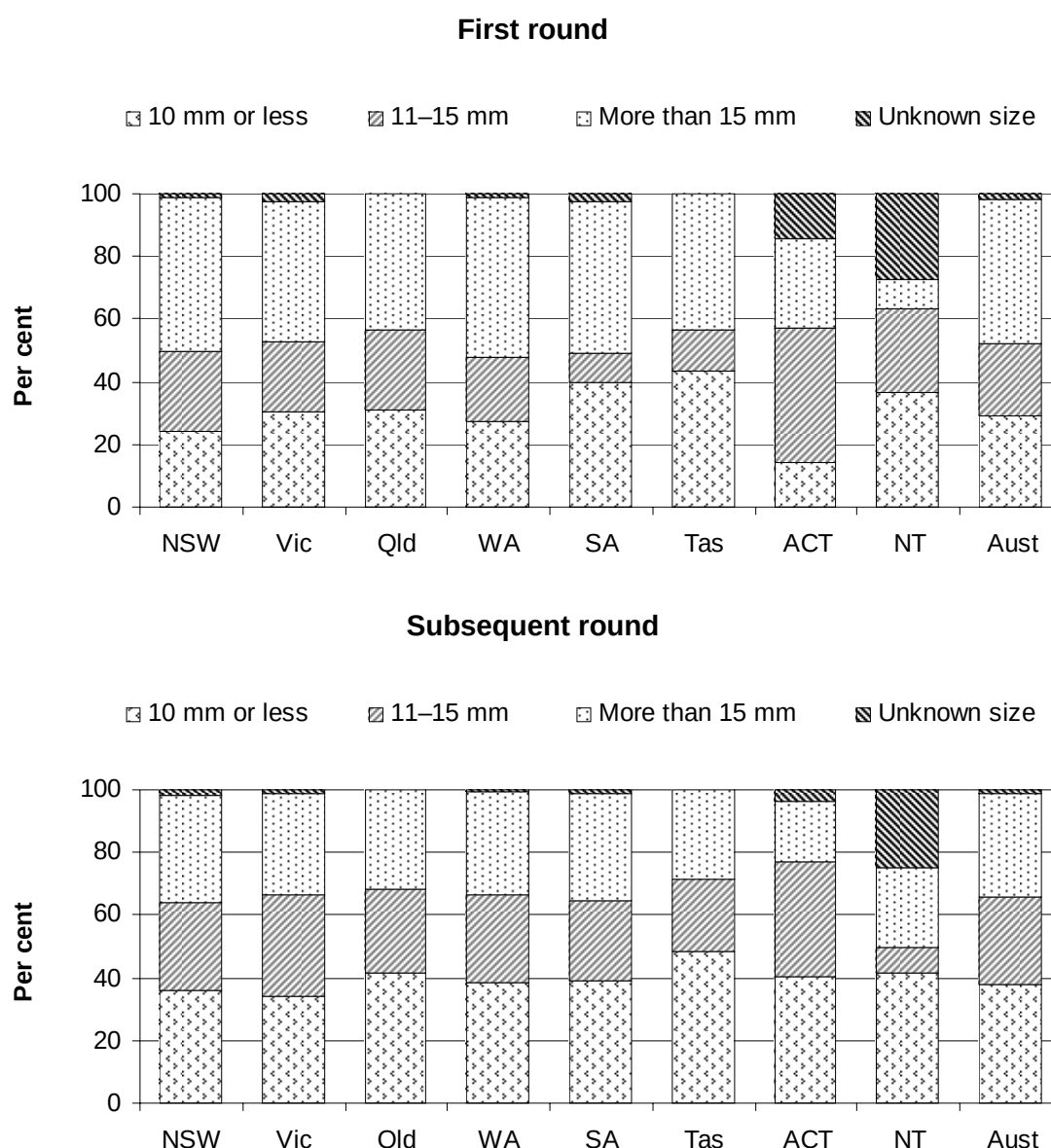
The ‘size of detected cancers’ is an indicator of the early detection of breast cancers. Detection of small cancers (those with a diameter of 15 millimetres or less) is generally associated with increased survival rates and reduced morbidity and mortality, leading to some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998).

This indicator measures detected invasive cancers by size of cancer, as a proportion of total detected invasive cancers for women aged over 40 years. High detection of small cancers relative to large cancers is desirable because it is likely to result in reduced morbidity and mortality.

Data are reported by round because larger cancers are expected to be found in the first round of screening. In subsequent rounds, cancers should be smaller if the program is achieving its objective (that is, early detection of small cancers through regular two yearly screening).

Figure 11.15 presents the proportion of cancers by size by screening round for 2004. The data are from BreastScreen Australia and cover only its clients. The data reflect that larger cancers tend to be discovered in the first round and that smaller cancers tend to be detected in subsequent rounds.

Figure 11.15 Detected invasive cancers, women aged over 40 years, by screening round and size of cancer 2004^{a, b}



^a Non-breast malignancies were not counted. ^b For small jurisdictions, fluctuations due to small numbers can make comparisons unreliable.

Source: State and Territory governments (unpublished); table 11A.18.

Overall performance — mortality rate for breast cancer

The ‘mortality rate for breast cancer’ is an outcome indicator of overall performance (box 11.15).

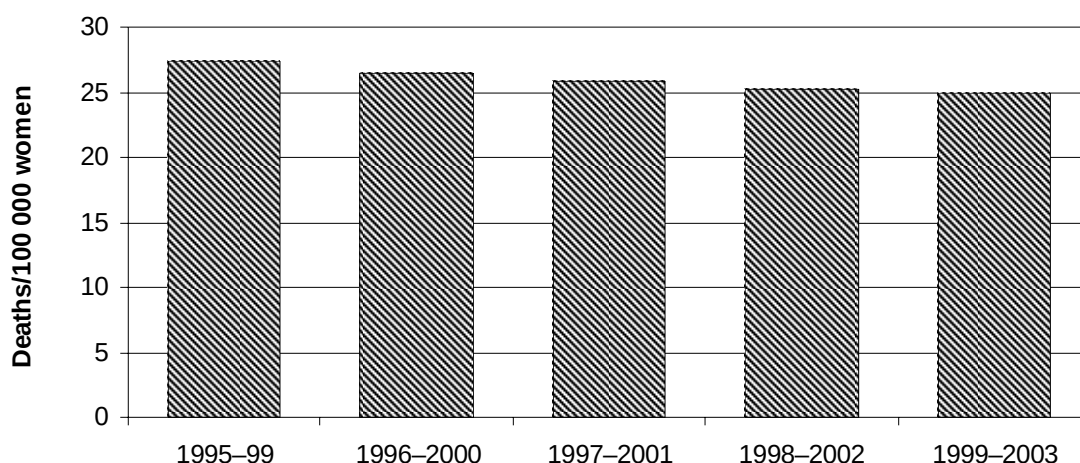
Box 11.15 Mortality rate for breast cancer

The ‘mortality rate for breast cancer’ is an outcome indicator of the effectiveness of both early detection and treatment services for breast cancer. It expresses mortality from breast cancer per 100 000 women as a five year rolling average.

Breast cancer mortality data are averaged over five year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases but relatively large variation in rates from year to year. Caution still needs to be used, however, when comparing results for smaller jurisdictions (table 11A.19).

Age standardised mortality rates are the most appropriate measure for looking at changes in mortality rates. The average annual age standardised mortality rate for breast cancer declined from 27.3 per 100 000 women over the period 1995–99 to an average of 24.9 per 100 000 women over the period 1999–2003 (figure 11.16).

Figure 11.16 **Annual average age standardised mortality rate from breast cancer, all ages^a**

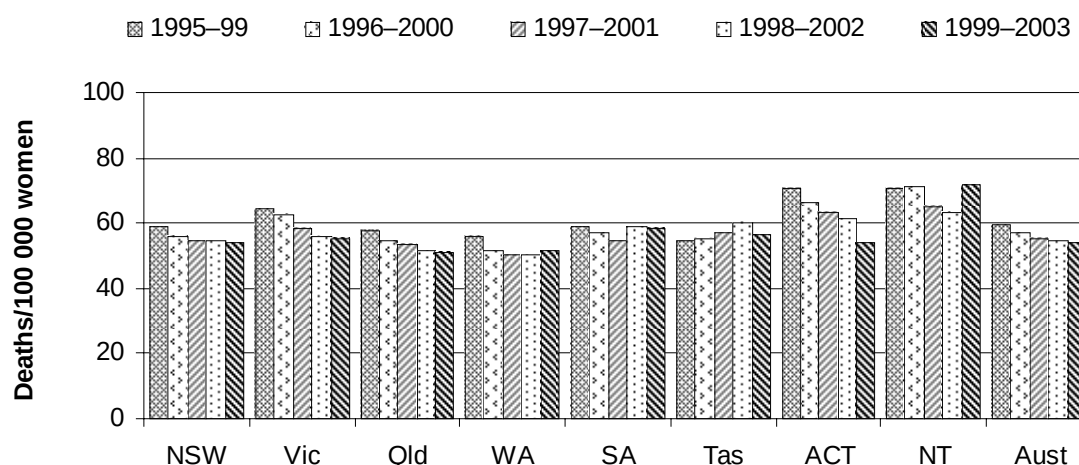


^a Age standardised to the Australian population at 30 June 2001.

Source: AIHW (unpublished); table 11A.19.

The annual average age standardised mortality rate from breast cancer for women aged 50–69 years also declined, from 59.7 per 100 000 women over the period 1995–99 to 54.0 per 100 000 women over the period 1999–2003 (figure 11.17).

Figure 11.17 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); table 11A.19.

Overall performance — cost per life year saved

The Steering Committee has identified ‘cost per life year saved’ as an outcome indicator of the efficiency of overall performance (box 11.16). Data for this indicator, however, were not available for the 2006 Report.

Box 11.16 Cost per life year saved

The Steering Committee has identified the ‘cost per life year saved’ as an indicator for development and reporting in future. The indicator is a measure of the efficiency of breast cancer detection and management services.

11.4 Mental health

Profile

This section covers specialist mental health care services that treat mostly low prevalence but severe disorders. GPs are also important service providers for people with a mental disorder (chapter 10), but this Report does not include performance information on GPs' services for people with a mental illness. Alcohol and drug treatment services are not covered here, but are briefly described in chapter 10. Some common terms used in mental health management are outlined in box 11.17.

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). Problems and disorders that interfere with this ability and diminish quality of life and productivity include cognitive, emotional and behavioural disorders. Some of the major mental disorders perceived to be public health problems are schizophrenia, depression and anxiety disorders. Each of these disorders is unique in terms of its incidence across the lifespan, causal factors and treatments.

This chapter reports on specialist mental health care services only. The performance of other health and related service providers is examined more closely in chapter 9 ('Public hospitals'), chapter 10 ('Primary and community health') and chapter 12 ('Aged care services'). Mental health patients often have complex needs and may access a number of other services, such as those covered in chapter 3 ('School education'), chapter 7 ('Corrective services'), chapter 8 ('Emergency management') and chapter 13 ('Services for people with a disability').

Box 11.17 Some common terms relating to mental health

acute services: the National Survey of Mental Health Services (NSMHS) defines acute services as specialist psychiatric care for people who present with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide short term treatment. Acute services may focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms.

ambulatory care services: mental health services dedicated to the assessment, treatment, rehabilitation and/or care of non-admitted inpatients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.

community residential services: staffed residential units established in community settings that provide specialised treatment, rehabilitation and/or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must provide residential care to people with a psychiatric illness or disability, be located in a community setting external to the campus of a general hospital or psychiatric institution, employ onsite staff for at least some part of the day, and be government funded.

inpatient services: stand-alone psychiatric hospitals or specialist psychiatric units located within non-psychiatric hospitals.

mental disorder: a diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.

mental health: the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.

mental health problem: diminished cognitive, emotional and/or social abilities, but not to the extent that the criteria for a mental disorder are met.

mental health promotion: activities designed to improve the mental health functioning of people through prevention, education and intervention activities and services.

(Continued on next page)

Box 11.17 (Continued)

mental illness prevention: interventions that occur before the initial onset of a disorder.

non-acute services: rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services focus on disability and the promotion of personal recovery. They are also characterised by an expectation of substantial improvement over the short term to medium term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. Non-acute services also consist of extended care services that provide care over an indefinite period for patients who have a stable but severe level of functional impairment and inability to function independently without extensive care and support. Patients of extended care services usually show a relatively stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness. Treatment effort focuses on preventing deterioration and reducing impairment. Improvement is expected only over a long period.

non-government organisations: private not-for-profit community managed organisations that receive State and Territory government funding specifically to provide community support services for people affected by a mental illness or psychiatric disability. Programs provided by non-government organisations may include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.

outpatient services (community-based): services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings physically separated within hospital sites. Services provided may also include outreach or domiciliary care as an adjunct to services provided from the centre base.

outpatient services (hospital-based): services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. Services provided may also include outreach or domiciliary care as an adjunct to services provided from the clinic base.

prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

specialised care service: services whose primary function is specifically to provide treatment, rehabilitation or community support targeted to people affected by a mental disorder or psychiatric disability. This criterion is applicable regardless of the source of funds. Such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function.

Source: DHA (2002).

Prevalence

As part of the National Health Survey in 2001, the ABS surveyed adults on the level of psychological distress that they had experienced in the four weeks before the survey. This survey used the Kessler-10 (K10) scale, which measures non-specific psychological distress. The scale consists of 10 questions about non-specific psychological distress and seeks to measure the level of current anxiety and depressive symptoms that a person might have experienced in the four weeks before the interview (ABS 2002b).⁴ The 2001 data showed that almost all adults aged 18 to 64 years had experienced some form of psychological distress. Nationally, 61.4 per cent of those aged 18–64 years had experienced a low level of distress, 23.5 per cent had experienced moderate distress and 13.0 per cent had experienced a high or very high level of distress. Generally, people aged 65 years or over were less likely to experience moderate and high to very high levels of distress, compared with the younger age group (table 11.6). Overall, in percentage terms, more males than females had experienced lower levels of distress, and more females than males had experienced moderate and high to very high levels of distress (table 11A.20).

In the 2003 ABS Survey of Disability, Ageing and Carers (ABS 2004), 16.1 per cent of all people with a disability (636 900 out of 3.96 million people) reported a mental or behavioural disorder as the main health condition causing their disability. Among people who had a disability that caused a profound or severe core activity limitation (around 1.2 million people or 31.4 per cent of all people with a disability), 23.4 per cent reported a mental or behavioural disorder as their main health condition (ABS 2004).

⁴ Respondents were asked whether in the previous four weeks they had felt: tired for no good reason; nervous; so nervous nothing could calm them down; hopeless; restless or fidgety; so restless they could not sit still; depressed; everything was an effort; so sad that they could not be cheered up; and worthless. For each question, there is a five level response scale based on the amount of time that the respondent reported experiencing the particular problem. Generally, each item was scored from 1 for 'none of the time', to 5 for 'all of the time'. Scores of the 10 questions were then summed, yielding a minimum possible score of 10 and a maximum possible score of 50. Low scores indicated low levels of psychological distress and high scores indicated high levels of psychological distress (ABS 2002b).

Table 11.6 K10 level of psychological distress, 2001 (per cent of population)^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>
18–64 years									
Low	61.1	62.0	62.2	61.5	60.0	61.9	62.8	na	61.4
Moderate	24.1	23.6	22.4	24.7	23.2	22.8	23.8	na	23.5
High and very high	13.4	13.2	12.4	11.1	14.8	13.8	9.8	na	13.0
Total	98.6	98.8	97.0	97.2	97.9	98.4	96.4	na	97.9
65 years or over									
Low	65.8	68.8	71.1	68.9	65.2	65.0	74.7	na	67.7
Moderate	18.4	13.8	15.8	15.1	18.3	15.7	14.3	na	16.3
High and very high	8.9	9.9	6.2	9.4	8.4	12.9	4.4 ^c	na	8.7
Total	93.1	92.6	93.1	93.3	91.9	93.7	93.3	na	92.8
Total adults									
Low	61.9	63.1	63.6	62.6	61.0	62.5	64.2	na	62.4
Moderate	23.1	22.0	21.3	23.2	22.2	21.5	22.7	na	22.3
High and very high	12.6	12.7	11.5	10.8	13.6	13.6	9.2	na	12.3
Total	97.7	97.8	96.4	96.6	96.8	97.6	96.0	na	97.1

^a Psychological distress as measured by the K10 scale. ^b Separate estimates for the NT are not available for this survey, but the NT contributed to national estimates. ^c Estimate has a relative standard error of 25–50 per cent and needs to be interpreted with caution. **na** Not available.

Source: ABS (unpublished); table 11A.20.

Roles and responsibilities

Specialist mental health care providers include a range of government and non-government service providers offering promotion, prevention, treatment and management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, public hospitals with specialist psychiatric units and stand-alone psychiatric hospitals all provide specialist mental health care. In addition, a number of health services provide care to mental health patients in a non-specialist health setting — for example, GPs, public hospital emergency departments and outpatient departments, and public hospital general wards (as opposed to specialist psychiatric wards). Some people with a mental disorder are cared for in residential aged care services.

State and Territory governments are the primary sources of funding and service delivery for specialist public mental health services. The Australian Government also provides funding to states and territories via the Australian Health Care Agreements and to private psychiatrists and GPs through the Medicare Benefits Schedule and individuals through the Pharmaceutical Benefits Scheme, Medicare

Safety Net and the Department of Veteran's Affairs (DVA). The Australian, State and Territory governments also fund other services that people with mental disorders can access, such as emergency relief, employment, accommodation, income support, rehabilitation, residential aged care and other services for older people and people with a disability (chapters 12 and 13).

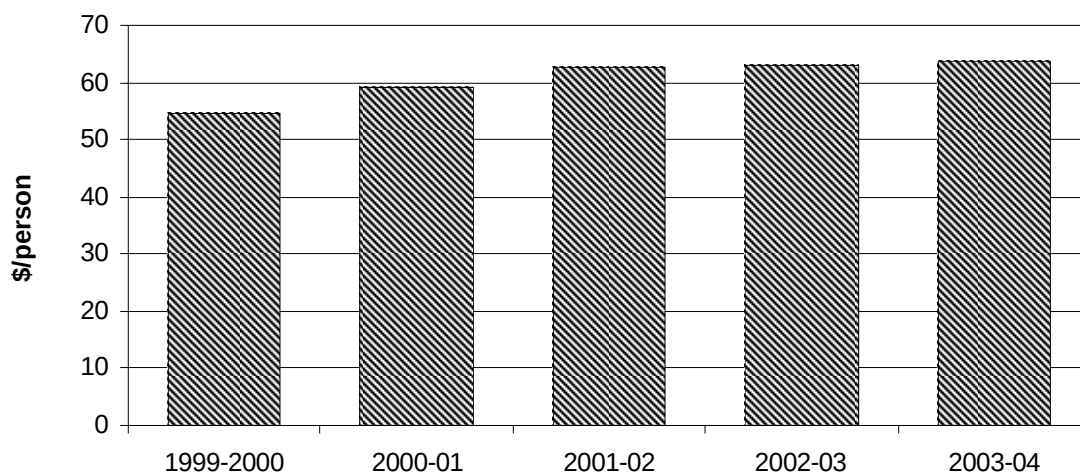
Funding

Real government recurrent expenditure of around \$3.4 billion was allocated to mental health services in 2003-04 (tables 11A.21 and 11A.22).⁵ State and Territory governments made the largest contribution (\$2.1 billion, or 63 per cent), although this included some Australian Government funds under the Australian Health Care Agreements (table 11A.22). The Australian Government spent \$1.3 billion. Real Australian Government expenditure per person in 2002-03 and 2003-04 remained steady at \$63 (figure 11.18). National average State and Territory expenditure per head was \$107 (table 11A.22).

Data in this Report relating to publicly funded mental health services come from State and Territory governments. These data for 2003-04 are preliminary (and will be further validated as part of the production of the annual National Mental Health Report), and should be interpreted with care.

⁵ The data include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Australian Government funds'.

Figure 11.18 **Real Australian Government recurrent expenditure on mental health services per person (2003-04 dollars)^{a, b}**



^a 2003-04 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2006*. ^b Constant price expenditure for all years (2003-04 dollars), using the implicit price deflator for non-farm gross domestic product (table 11A.56).

Source: Australian Government (unpublished); DHA (unpublished); tables 11A.23 and 11A.56.

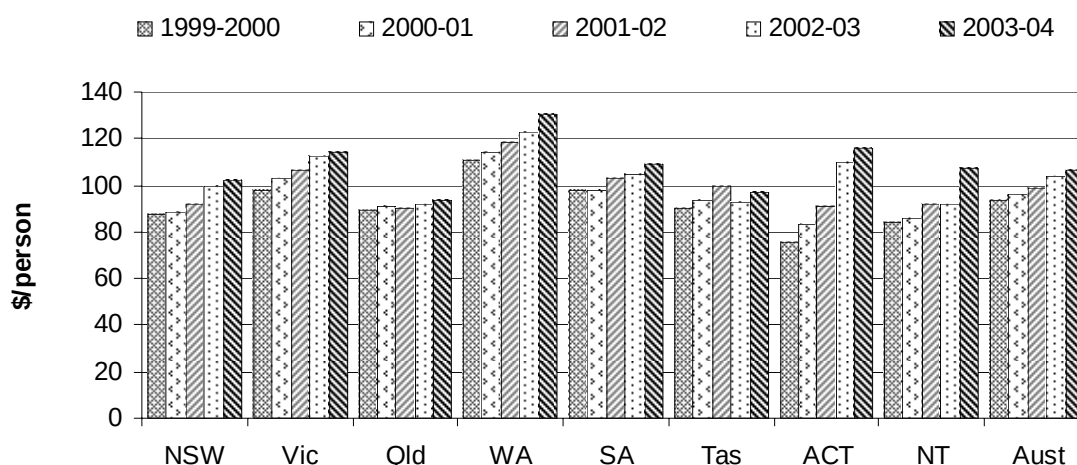
The largest component of Australian Government expenditure on mental health services in 2003-04 was expenditure under the Pharmaceutical Benefits Schedule for psychiatric medication (\$594.4 million). Expenditure on psychiatric medication increased by an annual average rate of 8.6 per cent between 1999-2000 and 2003-04 and rose from 41.1 per cent of Australian Government expenditure on mental health services in 1999-2000 to 46.7 per cent in 2003-04. The annual rate of growth of expenditure on psychiatric medication has declined over the reporting period (from 12.6 per cent from 1999-00 to 2000-2001 to 5.7 per cent from 2002-03 to 2003-04) (table 11A.21).

In 2003-04, Medicare Benefits Schedule payments for consultant psychiatrists accounted for 15.8 per cent of Australian Government expenditure on mental health services, followed by expenditure for mental health care by GPs (13.6 per cent). The residual was provided by DVA (10.3 per cent), the National Mental Health Strategy (NMHS) (7.3 per cent), private hospital insurance premium rebates (4.1 per cent), and research and other time limited program and project support (2.2 per cent) (table 11A.21).

Real expenditure per person at State and Territory discretion has increased over time (figure 11.19). Data in figure 11.19 for State and Territory government expenditure include Australian Government funds provided as part of base grants under the Australian Health Care Agreements, but exclude special purpose grants provided for mental health reform and also funding provided to states and territories

by the DVA. The data are thus referred to as expenditure ‘at State and Territory discretion’. The data in figure 11.19 exclude depreciation. Estimates of depreciation are presented in table 11A.25. State and Territory government expenditure estimates excluding revenue from other sources and other Australian Government funds are presented in table 11A.24. The revenue categories are subject to minimal validation and may be inconsistently treated across jurisdictions. In addition, it is not possible to extract revenue from other sources and other Australian Government funds uniformly across time.

Figure 11.19 Real recurrent expenditure at the discretion of State and Territory governments (2003-04 dollars)^{a, b, c, d, e}

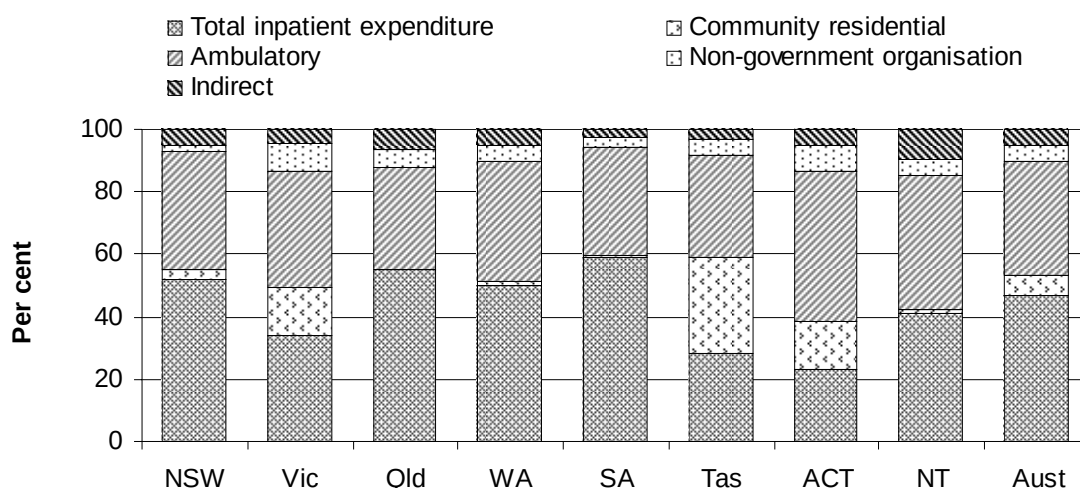


^a 2003-04 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2006*. ^b Constant price expenditure (2003-04 dollars), using State and Territory implicit price deflators for gross fixed capital expenditure on hospital clinical services (table 11A.55). ^c Estimates of State and Territory government spending include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and ‘other Australian Government funds’, but exclude Australian Government funding provided under the NMHS and through the DVA. ^d Depreciation is excluded for all years. Depreciation estimates are reported in table 11A.25. ^e Funding is a mix of Australian Government funds provided under the base grants of the Australian Health Care Agreements, funds provided by State and Territory governments and revenue from other sources noted above (footnote c).

Source: State and Territory governments (unpublished); table 11A.22; DHA (unpublished); table 11A.55.

Figure 11.20 shows how expenditure at the discretion of State and Territory governments was distributed across the range of mental health services in 2003-04. It does not show the distribution of the Australian Government expenditure discussed under figure 11.18.

Figure 11.20 **State and Territory recurrent expenditure, by service category, 2003-04^{a, b, c, d, e, f}**



^a 2003-04 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2006*. ^b Includes all spending regardless of source of funds. ^c Depreciation is excluded. Depreciation estimates are reported in table 11A.25. ^d Community residential is defined as all staffed community-based units (external to the campus of a general hospital or psychiatric institution) regardless of the number of hours that staff are present. ^e The differential reporting of clinical service providers and non-government organisations artificially segregates the mental health data. Given that the role of non-government organisations varies across jurisdictions, the level of non-government organisations resourcing does not accurately reflect the level of community support services available. ^f Queensland does not fund community residential services, but it funds a number of extended treatment services (both campus and non-campus-based), which provide longer term inpatient treatment and rehabilitation services with full clinical staffing for 24 hours a day, seven days a week.

Source: State and Territory governments (unpublished); table 11A.26.

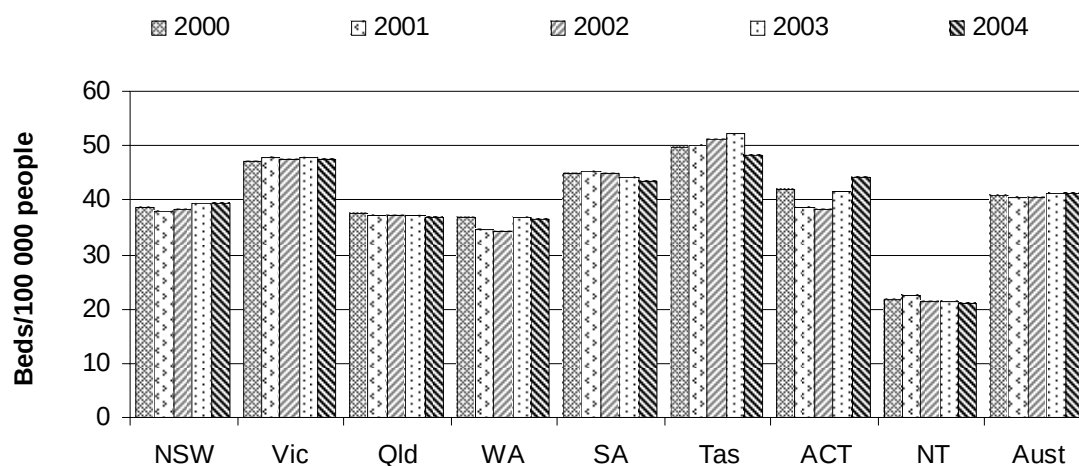
Size and scope of sector

The number of beds

Beds are counted as those immediately available for use at 30 June by admitted patients if required. They are available immediately — or within a reasonable period of time — for use if located in a suitable place for care with nursing or other auxiliary staff available. Also included are beds in wards that are temporarily closed for reasons such as renovation or strike, but that would normally be open.

Figure 11.21 presents the number of beds per 100 000 people for public hospitals and community residential facilities combined. From 1999-2000, the definition of community residential facilities has broadened to incorporate all staffed community-based units, regardless of the number of hours that staff are present.

Figure 11.21 **Beds in public hospitals and publicly funded community residential units, 30 June^{a, b}**

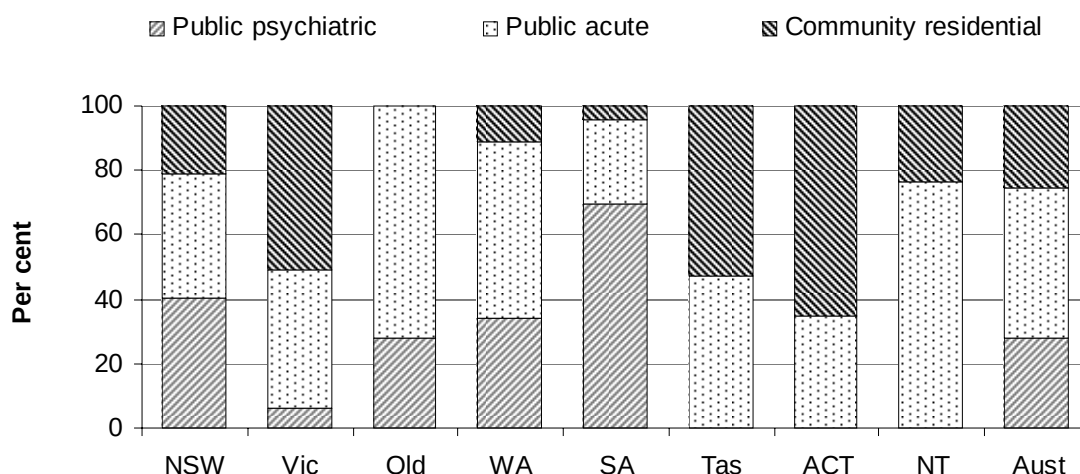


^a 2004 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2006*. ^b Includes beds in public hospitals and publicly funded community residential units.

Source: State and Territory governments (unpublished); table 11A.27.

Figure 11.22 presents the number of beds by service category for 2004. These data show the differences in service mix across states and territories. Queensland does not fund community residential services, but it funds a number of extended treatment services (both campus- and non-campus-based) that provide longer term inpatient treatment and rehabilitation services with full clinical staffing for 24 hours a day, seven days a week. Queensland does not report these beds as community residential beds because it considers them to be substantially different from beds described as such in other states and territories.

Figure 11.22 Beds, by service category, 30 June 2004^{a, b, c}



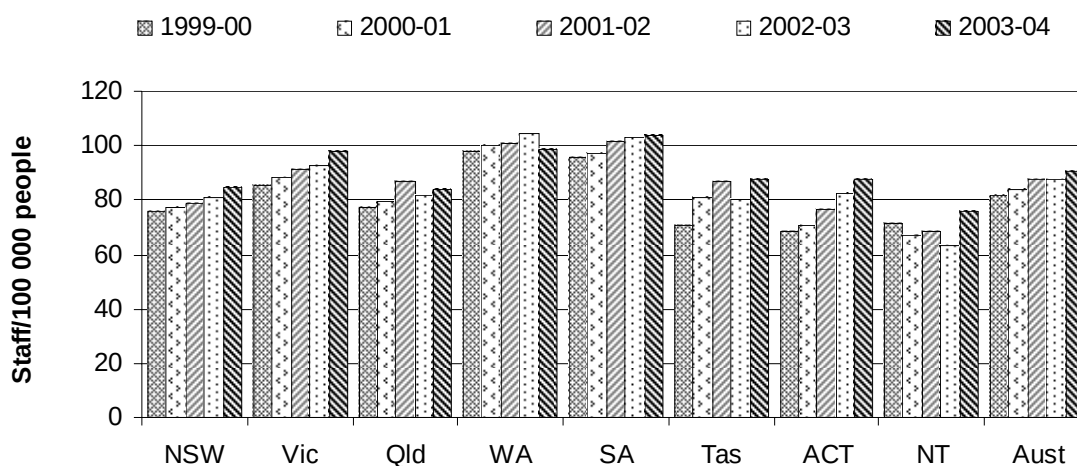
^a 2004 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2006*. ^b Queensland does not fund community residential services, but it funds a number of campus-based and non-campus-based extended treatment services. These services are reported either as beds in public acute hospitals or beds in public psychiatric hospitals. ^c Tasmania, the ACT and the NT did not have public psychiatric beds in 2004.

Source: State and Territory governments (unpublished); table 11A.27.

Staff

Figure 11.23 reports full time equivalent (FTE) direct care staff per 100 000 people and includes only staff within the health professional categories of ‘medical’, ‘nursing’ and ‘allied health’. ‘Other personal care’ direct care staff are excluded. ‘Medical’ staff consist of consultant psychiatrists, psychiatry registrars, and other medical officers who are neither registered as psychiatrists within the State or Territory, nor are formal trainees of the Royal Australian and New Zealand College of Psychiatrists’ Postgraduate Training Program. ‘Nursing’ consists of registered and non-registered nurses. ‘Allied health’ consists of occupational therapists, social workers, psychologists and other allied health staff. ‘Other personal care’ staff include attendants, assistants, home companions, family aides, ward helpers, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents and who are not formally qualified or are still training in nursing or allied health professions. Definitions for staffing categories are provided in more detail in section 11.7.

Figure 11.23 **FTE health professional direct care staff per 100 000 people^{a, b, c}**



^a 2003-04 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2006*. ^b Includes health professional occupational categories only. ^c Community residential incorporates all staffed community-based units, regardless of the number of hours that staff are present.

Source: State and Territory governments (unpublished); table 11A.28.

Nursing staff comprise the largest FTE component of health care professionals employed in mental health services. Across Australia in 2003-04, 59.5 nurses per 100 000 people were working in specialised mental health services, compared with 21.3 allied health care staff and 9.9 medical staff (table 11A.28). FTE direct care staff employed in specialised mental health services, by service setting, are reported in table 11A.29.

Services provided

Estimating activity across the specialised mental health services sector is problematic. Data for patient days are provided in figure 11.24 by acute, non-acute and 24 hour staffed community residential care (as defined in box 11.17).⁶ Hospital inpatient days and community residential patient days are included in figure 11.24, but other types of community service are not covered. Collection of data outlining community mental health care patient contacts commenced in July 2000 as part of the national minimum data set, although there are difficulties with data quality. The earlier caveat for the apparent absence of community residential beds in Queensland also applies to the data in figure 11.24.

⁶ Under the NSMHS, patient days are all days or part days for which the patient was in hospital during the survey period, regardless of the original date of admission or discharge.

Figure 11.24 Mental health patient days, 2003-04^{a, b, c, d}



^a 2003-04 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2006*. ^b Queensland does not fund community residential services, but it funds a number of campus-based and non-campus-based extended treatment services. Data from these services are included as non-acute. ^c Tasmania, the ACT and the NT did not provide mental health care in non-acute units. ^d The NT did not provide mental health care in 24 hour staffed community residential facilities.

Source: State and Territory governments (unpublished); table 11A.30.

In public psychiatric hospitals in 2002-03, there were 12 867 overnight separations and 648 same day separations with specialised psychiatric care (AIHW 2004a). In public acute hospitals there were 68 866 overnight separations and 4962 same day separations with specialised psychiatric care. Schizophrenia accounted for a large proportion of overnight separations related to mental disorders in public hospitals (23.6 per cent in public acute hospitals and 26.9 per cent in public psychiatric hospitals) (table 11A.31).

Unlike the general acute hospital sector, mental health has few procedural same day admissions, these being mainly related to electroconvulsive therapy treatment of people living in the community, which represented 6–10 per cent of all same day separations. Work for the Mental Health Classification and Service Costs Project suggested that the majority of same day hospitalisations are better described as ambulatory care and involve consumer attendance at a variety of day and group-based programs that otherwise could be provided in community settings (Buckingham *et al.* 1998).

Services by general practitioners

Limited data are available on GP care of mental health patients. The following data are collected from a sample of 1000 GPs as part of the BEACH (Bettering the Evaluation and Care of Health) survey. In 2004-05, 11.4 of every 100 encounters

with a GP involved mental health problems. The most frequently reported mental health related problem managed in GP encounters was depression (3.7 per 100 GP encounters). Anxiety and sleep disturbance and were the next most common problems managed (both 1.7 per 100 encounters). In 2004-05, depression was the fourth most frequently managed problem by a GP (Britt *et al.* 2005).⁷

Indigenous patients

Limited data are available on specialised psychiatric care of Indigenous patients in hospital. Comparisons are difficult because data on Indigenous status are incomplete and Indigenous people and other Australians may differ in their use of hospital services relative to other health services. The data reflect a range of factors, such as: the spectrum of public, primary care and post-hospital care available; Indigenous people's access to these as well as hospital services; social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disorders. Indigenous Australians were nearly twice as likely as the total population to be admitted for overnight psychiatric care. The average length of stay for Indigenous people was slightly less, however, than that for the total population (table 11.7).

Table 11.7 Specialised psychiatric care, by Indigenous status, 2002-03^{a, b}

	Same day separations	Overnight separations	Total separations	Total patient days	Total psychiatric care days	Average length of stay (overnight)	Psychiatric care days per overnight separation
No.							
Indigenous	98	3 793	3 891	78 291	77 757	20.6	20.5
Total population	8 965	104 080	113 045	2 384 159	2 346 002	22.8	22.5
Per 1000 population ^c							
Indigenous	0.3	9.6	10.0	210.6	209.0	..	..
Total population	0.5	5.3	5.8	121.5	119.5	..	..

^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 Separations per 1000 population are indirectly age standardised rates based on the projected Aboriginal and Torres Strait Islander population for 30 June 2001 and the estimated resident population for 30 June 2001. .. Not applicable.

Source: AIHW (2004a); table 11A.32.

⁷ A GP often managed more than one problem at a single encounter. Problems managed reflect the GP's understanding of the health problem presented by the patient.

Schizophrenia disorders accounted for a large proportion of overnight specialised psychiatric care separations reported for Indigenous patients in Australia in 2002-03 (28.0 per cent). They also accounted for around 47.3 per cent of patient days for Indigenous patients and a similar percentage of psychiatric care days (47.5 per cent) (table 11A.33).

Framework of performance indicators

The distinction between prevention and intervention is difficult to maintain in the case of mental illness. Preventing the onset of mental illness is challenging, primarily because individual disorders have many origins. Most efforts have been directed at treating mental illness when it occurs, determining the most appropriate setting for providing treatment, and emphasising early intervention. The indicators used in this Report focus on service delivery reforms that commenced under the First National Mental Health Plan (1993–1998) and were extended under the Second and Third Plans (1998–2003 and 2003–2008 respectively). The second plan emphasised promoting mental health and preventing mental illness. The performance indicator framework will be redeveloped in future reports to reflect these components of mental illness management and the new mental health plan.

The framework of performance indicators for mental health services builds on government objectives for mental health service delivery (box 11.18) as encompassed in the NMHS. The framework reports on the equity, effectiveness and efficiency of specialised mental health services. It covers a number of service delivery types (institutional and community-based services) and indicators of systemwide performance. Improving the framework is a priority of the Review and the Australian Health Ministers Advisory Council's National Mental Health Working Group.

Box 11.18 Objectives for mental health service delivery

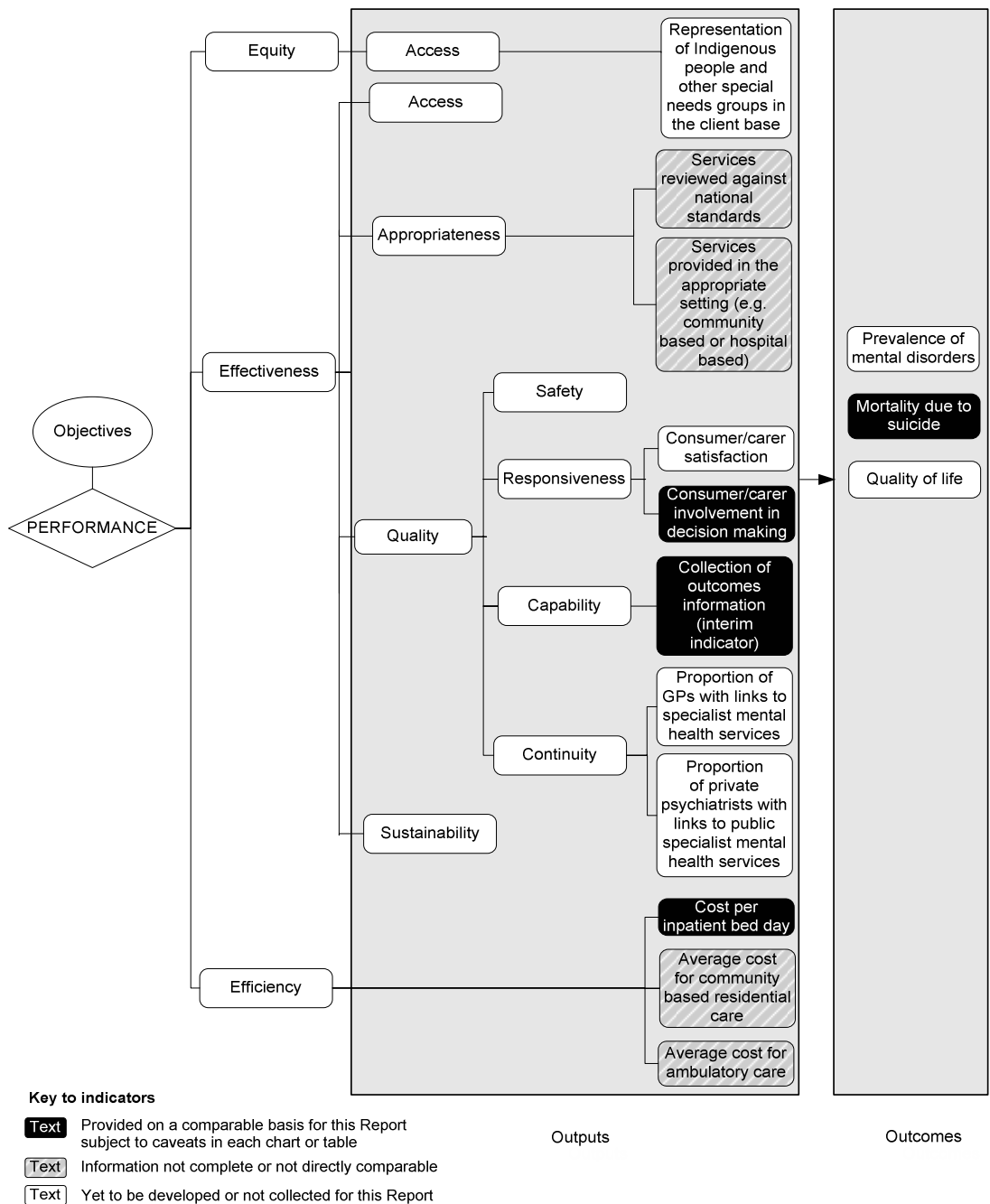
Key objectives include to:

- improve the effectiveness and quality of service delivery and outcomes
- promote, where appropriate, community awareness of mental health problems
- prevent, where possible, the development of mental health problems and mental disorders
- undertake, where appropriate, early intervention of mental health problems and mental disorders
- reduce, where possible, the impact of mental disorders on individuals, families and the community
- assure the rights of persons with mental disorders
- encourage partnerships among service providers and between service providers and the community.

Governments also aim to provide services in an equitable and efficient manner.

The performance indicator framework shows which data are comparable in the 2006 Report (figure 11.25). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (section 1.6). The ‘Health preface’ explains the performance indicator framework for health services as a whole, including the sub-dimensions for quality and sustainability that have been added to the standard Review framework for health services.

Figure 11.25 Performance indicators for mental health management



Key performance indicator results

Outputs

Equity — representation of Indigenous people and others in the client base

The Steering Committee has identified the ‘representation of Indigenous people and other special needs groups in the client base’ as a key area for development in future reports (box 11.19).

Box 11.19 Representation of Indigenous people and other special needs groups in the client base

The ‘representation of Indigenous people and other special needs groups in the client base’ is an indicator of governments’ aim to provide mental health services in an equitable manner, including access to services by special needs groups such as Indigenous people.

Access

The Steering Committee has identified access as an area for reporting, but no indicators have yet been developed.

Appropriateness — services reviewed against the national standards

‘Services reviewed against the national standards’ is an effectiveness indicator of mental health management (box 11.20).

Box 11.20 Services reviewed against the national standards

‘Services reviewed against the national standards’ is a process indicator of appropriateness, reflecting progress towards accreditation against the national standards for mental health care. The national standards are outlined in box 11.21.

This indicator is defined as the proportion of commenced and completed reviews of specialised public mental health services that are undertaken by an external accreditation agency against the National Standards for Mental Health Services. A high proportion of reviews completed by an external accreditation agency is desirable.

External accreditation agencies, such as the Australian Council on Healthcare Standards, undertake accreditation of a parent health organisation (for example, a hospital) that may cover a number of specialist services, including mental health services. Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the national standards; rather, assessment against the national standards must be specifically requested and involves a separate review process.

Data in table 11.8 show the percentage of specialised public mental health services that have participated in, or are currently participating in, an in-depth review by an external accreditation agency against the National Standards for Mental Health Services. Review against the national standards will, in some cases and in some jurisdictions, be delayed until an appropriate point is reached within the overarching accreditation cycle (for example, a mid-term review).

Box 11.21 The National Standards for Mental Health Services

The National Standards for Mental Health Services were developed under the First National Mental Health Plan for use in assessing service quality and as a guide for continuous quality improvement in all Australian mental health services. They comprise 11 major criteria:

1. rights
2. safety
3. consumer and carer participation
4. promoting community acceptance
5. privacy and confidentiality
6. prevention and mental health promotion
7. cultural awareness
8. integration
9. service development
10. documentation
11. delivery of care.

Source: DHA (2002).

At the end of June 2004, 85.5 per cent of services had commenced a review since reviews started and 61.2 per cent had completed a review. It cannot be concluded at this time whether services yet to complete a review were necessarily of poorer quality (table 11.8).

Table 11.8 Specialised public mental health services reviewed against the National Standards for Mental Health Services (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
June 2002									
Review commenced	64.2	42.9	100.0	65.6	47.5	16.7	100.0	–	61.4
Review completed	16.2	38.5	85.6	15.6	26.3	–	100.0	–	29.4
June 2003									
Review commenced	70.4	100.0	100.0	100.0	63.9	100.0	100.0	100.0	80.9
Review completed	26.6	49.7	90.2	53.1	47.4	22.2	100.0	–	41.4
June 2004									
Review commenced	73.9	100.0	100.0	100.0	100.0	100.0	100.0	50.0	85.5
Review completed	62.5	43.4	81.7	61.3	50.5	41.7	100.0	50.0	61.2

^a 'Review commenced' means the percentage of specialised public mental health services that had formally registered for review by an external accreditation agency against the National Standards for Mental Health Services; 'review completed' means the percentage of specialised public mental health services that had formally completed a review by an external accreditation agency against the National Standards for Mental Health Services. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 11A.34.

Appropriateness — services provided in the appropriate setting

'Services provided in the appropriate setting' is an effectiveness indicator of mental health management (box 11.22).

Box 11.22 Services provided in the appropriate setting

'Services provided in the appropriate setting' is an indicator of the development of local comprehensive mental health service systems advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental disorders and of providing continuity of care, so consumers can move between services as their needs change. The strategy advocates:

- a reduced reliance on stand-alone psychiatric hospitals

(Continued on next page)

Box 11.22 (Continued)

- the expanded delivery of community-based care integrated with inpatient care
- mental health services being mainstreamed with other components of health care.

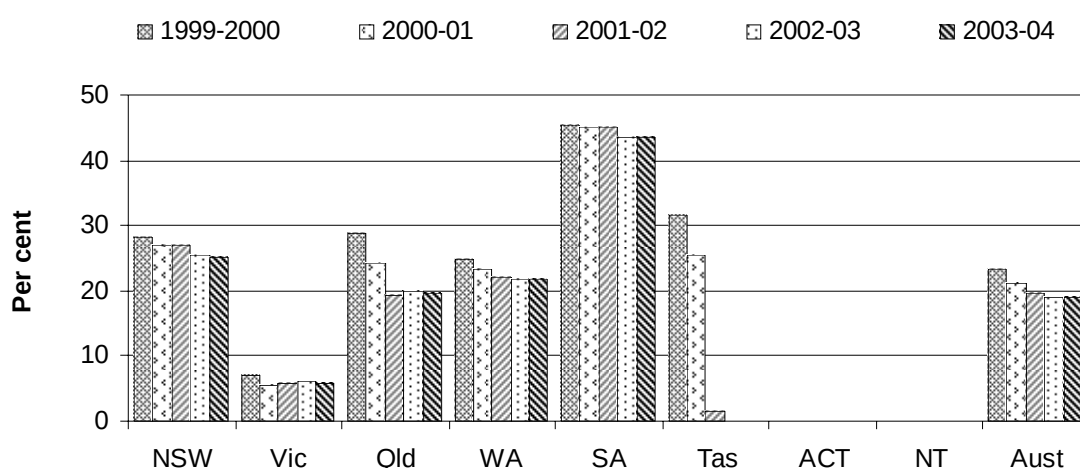
More appropriate treatment options can be provided if the service setting is substituted by encouraging the treatment of patients in community settings and public (non-psychiatric) hospitals rather than in stand-alone psychiatric hospitals.

Two measures of 'services provided in the appropriate setting' are reported.

- Recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total spending on mental health services. A low proportion for this indicator is desirable, reflecting a low reliance on stand-alone hospitals.
- Acute patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals. A high proportion for this indicator is desirable, reflecting greater mainstreaming of mental health services.

Figure 11.26 shows recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total expenditure on mental health services.

Figure 11.26 **Recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total expenditure on mental health services^{a, b}**



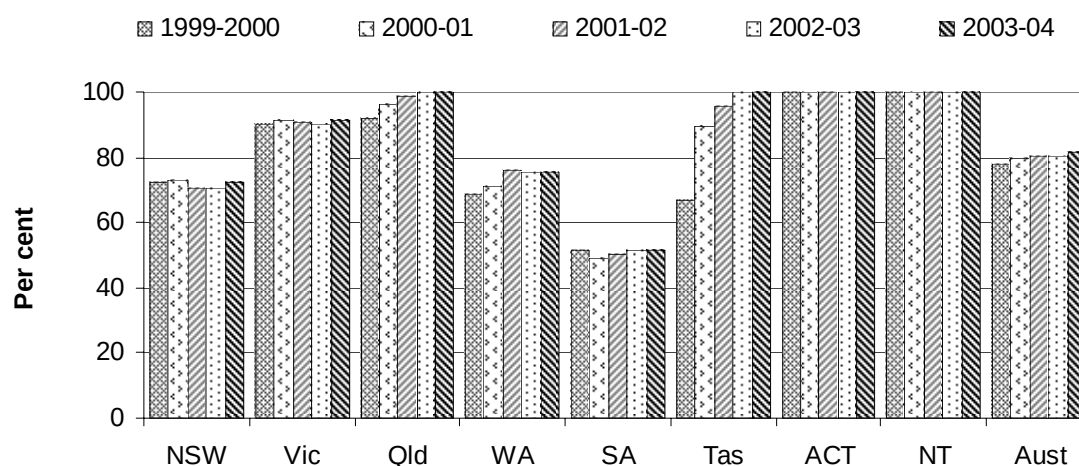
^a 2003-04 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2006*. ^b The ACT and the NT do not have public psychiatric hospitals. Tasmania did not have public psychiatric hospitals in 2002-03 or 2003-04.

Source: State and Territory governments (unpublished); table 11A.35.

Figure 11.27 shows acute patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals. The

proportion of acute patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals has increased from 78.0 per cent in 1999-2000 to 81.4 per cent in 2003-04.

Figure 11.27 Acute patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals^a



^a 2003-04 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2006*.

Source: State and Territory governments (unpublished); table 11A.35.

Quality — consumer and carer satisfaction

The Steering Committee has identified ‘consumer and carer satisfaction’ as an area for development in future reports (box 11.23).

Box 11.23 Consumer and carer satisfaction

‘Consumer and carer satisfaction’ is an indicator of satisfaction with both clinician’s responses and with services provided in all areas of mental health. Both are important aspects of the NMHS.

Quality — consumer and carer involvement in decision making

‘Consumer and carer involvement in decision making’ is an effectiveness indicator of mental health management (box 11.24).

Box 11.24 Consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' is an important aspect of the NMHS. It is an indicator of consumers' and carers' involvement at the service delivery level, where they have the opportunity to influence the services they receive.

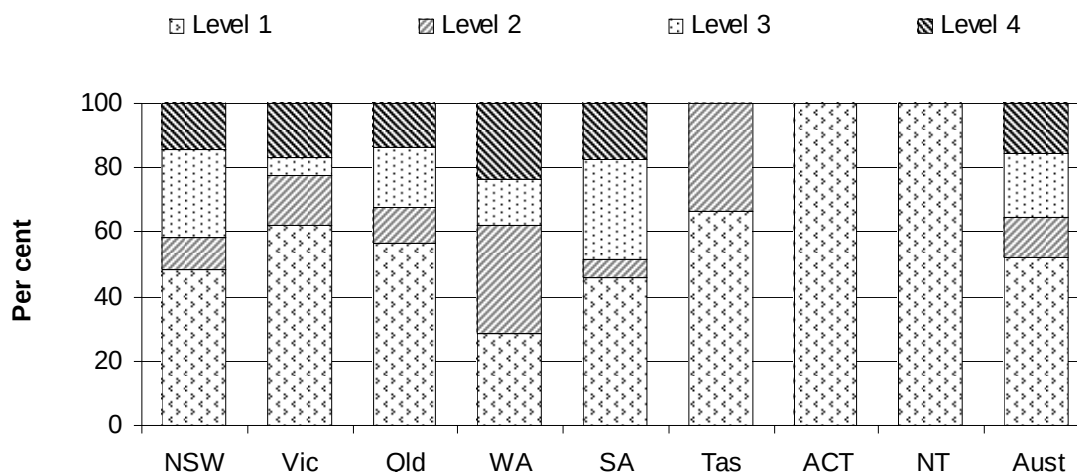
The indicator relates to the arrangements that allow consumers and carers to contribute to local service planning and delivery in specialised mental health services. Arrangements are grouped into four categories:

- level 1 — appointment of a person to represent the interests of consumers and carers on the organisation management committee, or a specific consumer and carer advisory group to advise on all aspects of service delivery
- level 2 — a specific consumer and carer advisory group to advise on some aspects of service delivery
- level 3 — participation of consumers and carers in broad-based committees
- level 4 — other/no arrangements.

An organisation can be classified at only one level. A high proportion of organisations with level 1 arrangements is desirable, while a high proportion of organisations with level 4 arrangements is undesirable.

Figure 11.28 illustrates the degree of consumer and carer participation in decision making. The *National Mental Health Report 2004* includes an expanded range of indicators on consumer and career participation in decision making (DHA 2004). These indicators cover the range of issues raised by Victoria and WA in the footnotes to table 11A.28. The Review will investigate including some or all of the new indicators in future reports.

Figure 11.28 Organisations with consumer and carer participation in decision making, 2004^{a, b, c, d, e}



^a 2004 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2006*. Non-government organisations are included only where they provide staffed residential services.

^b NSW advised that the government has no authority to require consumer participation in services delivered through the primary care program. ^c Victoria advised that its model of consumer consultants fits poorly with the Australian Health Care Agreement categories. It has paid consumer consultants working in mental health services. Many agencies report these consultants in the 'other' category, which has a low ranking and, according to Victoria, does not reflect the active role played by consumer consultants in service operation.

^d WA advised that the National Survey of Mental Health Services does not accurately represent consumer and carer participation strategies used in WA. High priority is given to the involvement of consumers and carers at a state, regional and health service level in developing a responsive mental health service. Several key consumer and carer advisory groups are supported and provided with financial assistance by the Office of Mental Health. Collectively, these groups provide advice and representation on consumer and carer issues. The Department of Health Executive has endorsed stage 1 of a comprehensive 'Consumer Participation Plan'. The Plan outlines a framework for a coordinated statewide consumer participation system. Stage 1 introduces initiatives related to education, training and advocacy, that will result in the introduction of consumer consultants in all public Mental Health Services in WA. ^e An expanded range of indicators of consumer and carer participation are reported in the National Mental Health Report.

Source: State and Territory governments (unpublished); table 11A.36.

Quality — collection of outcomes information (interim indicator)

The 'Collection of outcomes information' is an effectiveness indicator of mental health management (box 11.25).

Box 11.25 Collection of outcomes information (interim indicator)

The 'collection of outcomes information' is an interim indicator until information on client outcomes is available. Establishing a system for the routine monitoring of consumer outcomes was introduced as part of the National Mental Health Plan 2003–2008. Jurisdictions are introducing a collection that will enable reporting in future (section 11.5).

States and territories have taken the following approach to introducing consumer outcome measurement as part of day-to-day service delivery:

- measures to include ratings by clinicians and self-ratings by consumers
- all clinical staff to have undergone training
- processes established to ensure uniformity in collection
- funding for information systems to store, analyse and report on the data
- a national approach to data analysis, reporting and benchmarking (DHA 2002).

This indicator is the proportion of specialised mental health services that have introduced routine collection of consumer outcome measurement. A high proportion is desirable for this indicator.

The percentages of specialised mental health services that have introduced routine consumer outcome measurement are shown in table 11.9.

Table 11.9 Specialised mental health services that introduced the routine collection of consumer outcome measurement (per cent)^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
June 2002	55.8	11.3	–	–	–	17.6	–	–	32.2
June 2003	77.3	72.6	41.8	7.4	–	94.4	81.3	100.0	62.5
June 2004	na	100.0	100.0	71.0	49.5	94.4	81.3	100.0	84.0

^a Data are based on reports from jurisdictions. Jurisdictions report at varying levels, reflecting differences in service structure — for example, data may be reported at area health service level or at hospital level, with each level containing a number of specialist mental health services. Data are thus aggregated. – Nil or rounded to zero. **na** Not available.

Source: State and Territory governments; table 11A.37.

Quality — proportion of general practitioners with links to specialist mental health services

The Steering Committee has identified the 'proportion of GPs with links to specialist mental health services' as an indicator of the effectiveness of mental health management (box 11.26). Data for this indicator were not available for the 2006 Report.

Box 11.26 Proportion of general practitioners with links to specialist mental health services

The 'proportion of GPs with links to specialist mental health services' is an indicator of the objective of mental health service delivery to provide continuity of care. GPs can be an important first point of contact for those with a mental illness.

Quality — proportion of private psychiatrists with links to public specialist mental health services

The Steering Committee has identified the 'proportion of private psychiatrists with links to public specialist mental health services' as an indicator of the effectiveness of mental health management (box 11.27). Data for this indicator were not available for the 2006 Report.

Box 11.27 Proportion of private psychiatrists with links to public specialist mental health services

The 'proportion of private psychiatrists with links to public specialist mental health services' is an indicator of the objective of mental health service delivery to provide continuity of care.

Sustainability

The Steering Committee has identified sustainability as an area for reporting but no indicators have yet been identified.

Efficiency

As noted, the data for 2003-04 are preliminary and will be further validated as part of the production of the annual National Mental Health Report. Data for 2003-04, therefore, need to be interpreted with caution.

Efficiency — cost per inpatient bed day

'Cost per inpatient bed day' is an efficiency indicator of mental health management (box 11.28).

Box 11.28 Cost per inpatient bed day

The 'cost per inpatient bed day' is a proxy indicator of the efficiency of mental health service delivery. An aim of mental health service delivery is to provide services in an efficient manner.

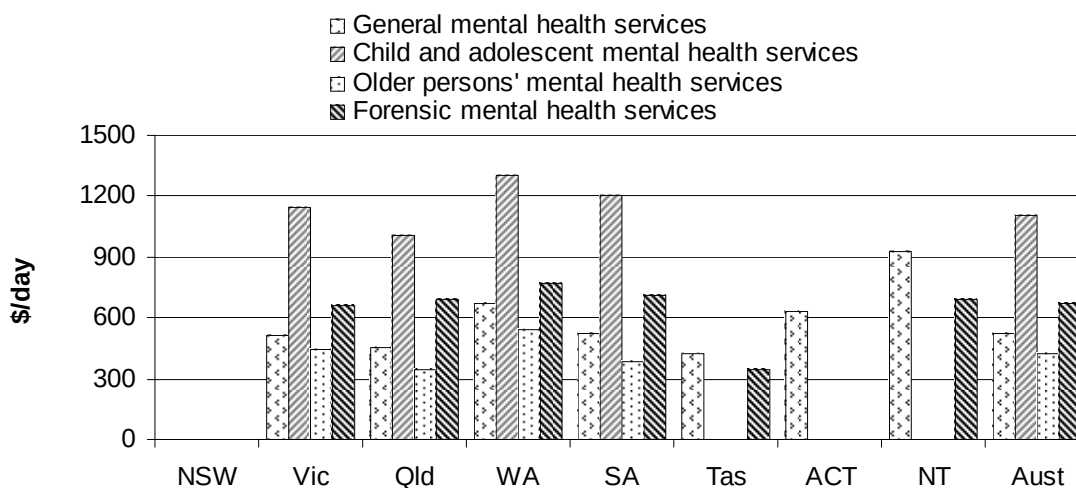
This indicator is defined as the cost of providing inpatient services per inpatient bed day. A low cost per inpatient bed day can indicate efficiency, although caution must be used because the cost per inpatient bed day does not provide any information on the quality of service provided.

This indicator is affected by factors such as differences in the client mix and average length of stay. The client mix in inpatient settings may differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings rather than in the community. Longer lengths of stay may also be associated with lower average inpatient day costs because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care.

The most suitable indicator for mental health services would be to adjust the number of separations by the type and complexity of cases, to develop a cost per casemix-adjusted separation similar to that presented for public hospitals (chapter 9), but casemix data for specialised mental health services are not available.

Reported real inpatient costs per day are disaggregated by inpatient program type (general mental health services, child and adolescent mental health services, older persons' mental health services and forensic mental health services) and hospital type (psychiatric hospitals [acute units], psychiatric hospitals [non-acute units] and general hospitals). Disaggregating these data improves comparability across jurisdictions. Real inpatient costs per day are presented in figures 11.29 (by inpatient program type) and 11.30 (by hospital type). Changes over time partly reflect institutional change in accordance with the NMHS.

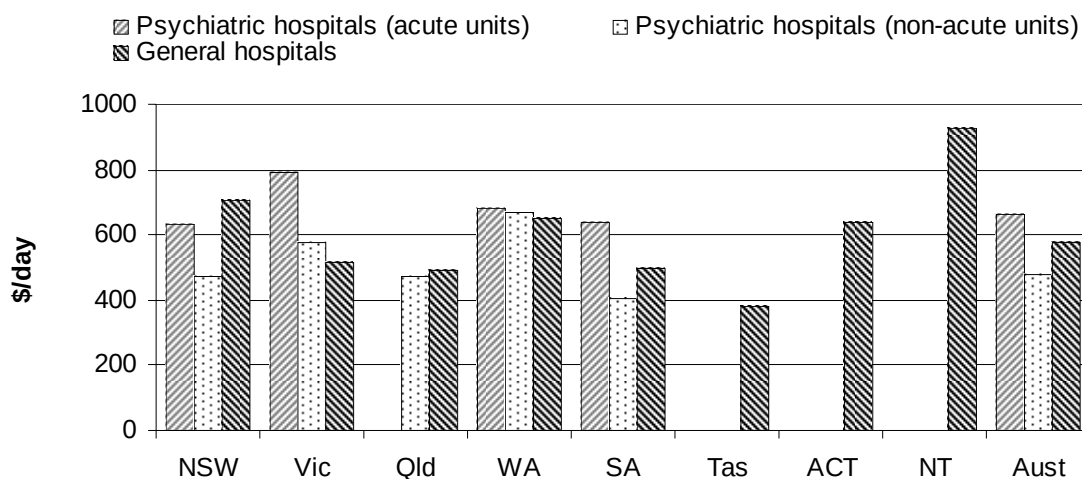
Figure 11.29 Real average recurrent cost per inpatient bed day, public hospitals, by inpatient program type, 2003-04^{a, b, c, d, e, f, g}



^a 2003-04 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2006*. ^b Depreciation is excluded. ^c Costs are not adjusted for differences in the complexity of cases across jurisdictions and may reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). ^d Constant price expenditure (in 2003-04 dollars), using State and Territory implicit price deflators for gross fixed capital expenditure on hospital clinical services (table 11A.55). ^e Queensland advised that it provides older persons' mental health services using different service models, including campus-based and non-campus-based options. All service types are reported as older persons' mental health services, which may have the effect of lowering the average patient day costs compared with the costs of jurisdictions that report older persons' care units separately. ^f Data for NSW were not available for 2003-04. ^g In 2003-04, child and adolescent mental health services were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Older persons' mental health services programs were not available, or could not be separately identified, in Tasmania the ACT and the NT. Tasmanian figures include child and adolescent mental health services within the general mental health services category. Forensic mental health services was not available, or could not be separately identified, in the ACT.

Source: State and Territory governments (unpublished); table 11A.38; DHA (unpublished).

Figure 11.30 **Real average recurrent cost per inpatient bed day, public hospitals, by hospital type, 2003-04^{a, b, c, d, e, f, g}**



^a 2003-04 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2006*. ^b Depreciation excluded. ^c Costs are not adjusted for differences in the complexity of cases across jurisdictions and may reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). ^d Constant price expenditure (in 2003-04 dollars), using State and Territory implicit price deflators for gross fixed capital expenditure on hospital clinical services (table 11A.55). ^e Mainstreaming has occurred at different rates in different jurisdictions. Victoria advised that the data for psychiatric hospitals comprise mainly forensic services, because nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means the client profile and service costs are very different from those of a jurisdiction in which general psychiatric treatment still occurs mostly in psychiatric hospitals. ^f Queensland data for general hospitals include costs associated with extended treatment units that report through general acute hospitals. ^g The ACT and the NT do not have psychiatric hospitals. Tasmania did not have any psychiatric acute or psychiatric non-acute units in 2003-04.

Source: State and Territory governments (unpublished); DHA (unpublished); tables 11A.39.

Efficiency — average cost for community-based residential care

The ‘average cost for community-based residential care’ is an efficiency indicator of mental health management (box 11.29).

Box 11.29 Average cost for community-based residential care

The 'average cost for community-based residential care' is an indicator of the efficiency of mental health service delivery. An aim of mental health service delivery is to provide services in an efficient manner.

This indicator is defined as the cost of providing community-based residential care per patient day. A low average cost can indicate efficiency, although caution must be used because the average cost does not provide any information on the quality of service provided.

These data are likely to be affected by institutional changes occurring as a result of the NMHS. In addition, differences across jurisdictions in the types of patient admitted to community residential care affect average costs in these facilities. Average recurrent costs to government per patient day for these services are reported for both the care of adults and the care of older people. The distinction is made to reflect the differing unit costs of treating the two groups.

The average recurrent cost to government per patient day for community residential services is presented in table 11.10. For general adult units in 2003-04, the average cost to government per patient day for 24 hour staffed community residential services was an estimated \$311 nationally. For non-24 hour staffed community residential units, the average cost to government per patient day was \$145 nationally.

For jurisdictions that had community-based older persons' care units in 2003-04, the average recurrent cost to government per patient day for 24 hour staffed community residential services was \$255 nationally (table 11.10).

Table 11.10 Average recurrent cost to government per patient day for community residential services, 2003-04^{a, b, c}

	NSW	Vic	Qld ^d	WA	SA	Tas	ACT	NT	Aust
General adult units									
24 hour staffed units	303.9	288.1	na	248.2	136.2	633.1	433.8	..	311.1
Non-24 hour staffed units	na	134.6	na	130.2	192.6	na	73.9	62.8	145.3
Older persons' care units									
24 hour staffed units	239.5	254.4	na	..	..	296.4	162.2	..	254.8
Non-24 hour staffed units	na	..	na	..	..	..	..	..	na

^a 2003-04 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2006*. ^b Depreciation is excluded, although treated differently across jurisdictions. ^c Costs are not adjusted for differences in the complexity of cases across jurisdictions and may reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). ^d Queensland does not fund community residential services, although it funds a number of campus-based and non-campus-based extended treatment services. **na** Not available. **..** Not applicable.

Source: State and Territory governments (unpublished); table 11A.40.

Efficiency — average cost for ambulatory care

The 'Average cost for ambulatory care' is an efficiency indicator of mental health management (box 11.30).

Box 11.30 Average cost for ambulatory care

The 'average cost for ambulatory care' is an indicator of the efficiency of mental health service delivery. An objective of mental health service delivery is to provide services in an efficient manner.

This indicator is defined as the cost of providing ambulatory care per treated patient in the community. A low average cost can indicate efficiency, although caution must be used because the average cost does not provide any information on the quality of service provided.

The provision of ambulatory treatment, rehabilitation and support to non-inpatients, and post-acute care are important components of service provision, and the Steering Committee has identified continued improvement in reporting in these areas as a priority.

Unit costs (dollars per treated patient in the community) for 2003-04 are presented here for all states and territories. The data reported for this indicator are unreliable, however, and comparisons across jurisdictions are not possible for several reasons. First, information about service costs across jurisdictions is incomplete. Second, the

absence of unique patient identifiers in many jurisdictions means clients who use mental health services other than their usual service may be counted twice. This double counting may artificially reduce average costs in some states or territories. Victoria, WA and the NT have statewide systems of unique identifiers, so the extent of overcounting of patients in these jurisdictions is relatively low compared with that in other jurisdictions. Third, differences across jurisdictions in the complexity of cases treated, the service options available for treatment and the admission practices adopted reduce the comparability of data across states and territories. Finally, cost components such as depreciation are not measured consistently across jurisdictions.

- NSW reported ambulatory care unit costs of \$978 per treated patient in the community in 2003-04, with 27.1 per cent of services (accounting for 14.1 per cent of expenditure) not reporting (table 11A.41).
- Victoria reported ambulatory care unit costs of \$2709, with 22.2 per cent of services (accounting for 2.6 per cent of expenditure) not reporting (table 11A.42).
- Queensland reported ambulatory care unit costs of \$1521, with one per cent of services (accounting for 0.1 per cent of expenditure) reporting (table 11A.43).
- WA reported ambulatory care unit costs of \$2396, with all services reporting (table 11A.44).
- SA reported ambulatory care unit costs of \$1532, with 5.7 per cent of services (accounting for 4.3 per cent of expenditure) not reporting (table 11A.45).
- Tasmania reported ambulatory care unit costs of \$1463, with 4.8 per cent of services (accounting for 7.1 per cent of expenditure) not reporting (table 11A.46).
- The ACT reported ambulatory care unit costs of \$1465, with 16.7 per cent of services (accounting for 0.5 per cent of expenditure) not reporting (table 11A.47).
- The NT reported ambulatory care unit costs of \$1846, with all services reporting (table 11A.48).
- Across Australia, average ambulatory care unit costs per treated patient in the community were \$1518, with 17.7 per cent of services (accounting for 5.9 per cent of expenditure) not reporting (table 11A.49).

Outcomes

Prevalence of mental disorders

The Steering Committee has identified the ‘prevalence of mental disorders’ as an indicator for development in future reports (box 11.31).

Box 11.31 Prevalence of mental disorders

The ‘prevalence of mental disorders’ is an outcome indicator of the objective of mental health service delivery to prevent and reduce mental health problems where possible.

There are no nationally comparable data on the prevalence of mental disorders treated by specialised mental health services, other than the data discussed in the profile for section 11.4.

Mortality due to suicide

‘Mortality due to suicide’ is an outcome indicator of mental health management (box 11.32).

Box 11.32 Mortality due to suicide

'Mortality due to suicide' is an indicator because evidence indicates that people with a mental disorder are at a higher risk of suicide than are the general population. (They are also at a higher risk of death from other causes, such as cardiovascular disease.)

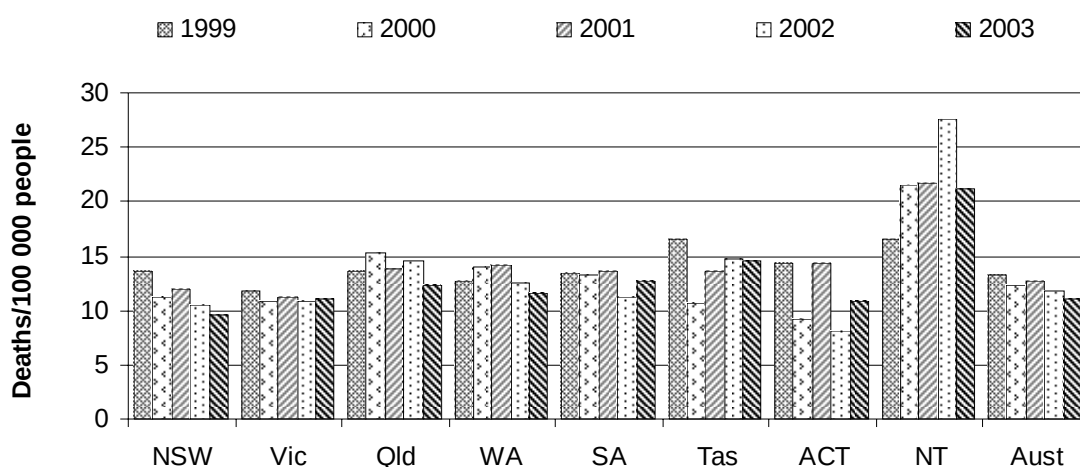
This indicator is reported as the suicide rates per 100 000 people for all people, people aged 15–24 years, people living in capital cities, people living in other urban areas, people living in rural areas and Indigenous people. While the performance of mental health services is important in reducing suicide, other government services also play a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by serious mental illness, some of whom have either attempted, or indicated the intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government departments, non-government organisations and other special interest groups. Any impact on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including police, education, housing, justice and community services agencies.

In addition, many factors outside the control of mental health services may influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often, a combination of these factors can increase the risk of suicidal behaviour.

Not all of those who commit suicide are patients of mental health services. An improved indicator would be restricted to suicide by patients of mental health services.

In 2003, 2211 deaths by suicide were recorded in Australia — equivalent to 11.1 deaths per 100 000 people. The national rate fell each year from 1997 to 2000, followed by a slight increase in 2001 and then further falls in 2002 and 2003. The rate for males (17.6 per 100 000 males) was almost four times that for females (4.8 per 100 000 females) in 2003 — a ratio that was constant over the 10 years to 2004 (figure 11.31 and table 11A.50).

Figure 11.31 Suicide rate^{a, b, c}



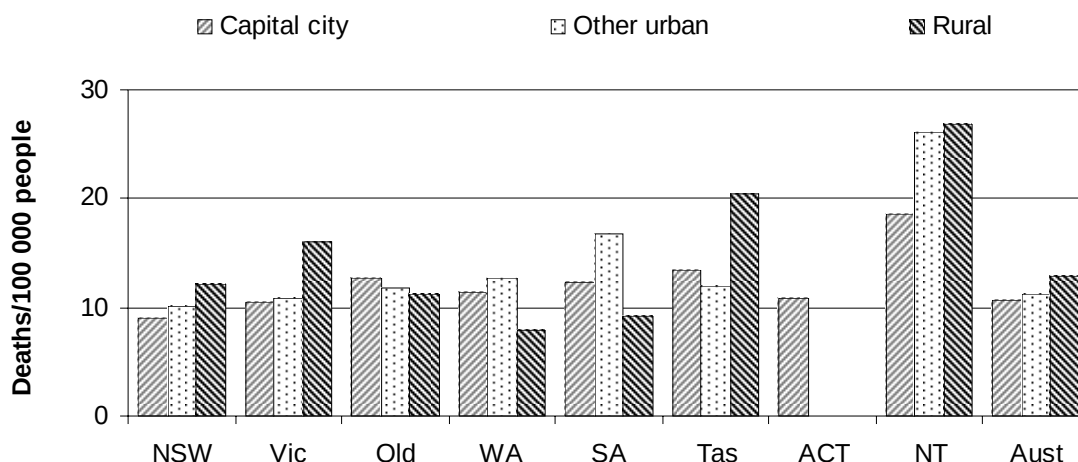
^a By year of registration of death. Year-to-year variation can be influenced by coronial workloads. ^b The death rate is age standardised to the mid-year 2001 population. ^c Low populations can result in small variations in the number of suicides appearing as large changes in rates (which are not statistically significant).

Source: ABS (various issues, Cat. no. 3303.0); table 11A.51.

In 2003, suicide was the second leading cause of death (after transport accidents) for people aged 15–24 years, accounting for 20.4 per cent of deaths in this age group (ABS 2005, Causes of Death). Suicide was the leading cause of death for 25–34 year olds in 2003, with 24.4 per cent of deaths in this age group resulting from suicide (ABS 2005).

Nationally the suicide rate in 2003 was higher in rural areas. There were 10.7 suicides per 100 000 people in capital cities and 11.3 suicides per 100 000 people in other urban areas, compared with 12.9 suicides per 100 000 people in rural areas in Australia in 2003 (figure 11.32).

Figure 11.32 Suicide rate, by area, 2003^{a, b, c, d}



^a 'Other urban' comprises centres with more than 20 000 people. 'Rural' comprises all areas except capital cities and other urban. ^b Death rate is age standardised to the mid-year 2001 population. ^c By year of registration of death. Year-to-year variation can be influenced by coronial workloads. ^d The ACT does not have any 'other urban' or 'rural' areas.

Source: ABS (unpublished); table 11A.53.

The Indigenous suicide rate is presented for the period 1999–2003 for four jurisdictions: Queensland, WA, SA and the NT. The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions. The suicide rates for Indigenous people for the period 1999–2003 in the jurisdictions for which data are presented in table 11A.54 are considerably higher than the rate for the total population in 2003.

Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some jurisdictions are not published. Estimating the Indigenous suicide rate is difficult given the low number of suicides among Indigenous people and the varying propensity of people across jurisdictions and over time to identify as Indigenous. In addition, Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The 'Health preface' discusses the quality of Indigenous mortality and other data.

Quality of life

The Steering Committee has identified 'quality of life' as an indicator for development in future reports (box 11.33).

Box 11.33 Quality of life

'Quality of life' is an outcome indicator of the objective of mental health service delivery to prevent and reduce mental health problems so as to improve the quality of life for people with a mental illness.

11.5 Future directions in performance reporting

Breast cancer

Key challenges for improving reporting of breast cancer include:

- expanding the scope of reporting to include management of breast cancer
- further developing indicators of outcomes
- improving the measurement and comparability of existing indicators.

Existing performance data for breast cancer management place relatively more emphasis on the performance of State and Territory BreastScreen Australia programs, than on the treatment and ongoing management of breast cancer. This emphasis is largely due to the relative availability of breast cancer screening data across jurisdictions. The Review aims to expand reporting to incorporate treatment and clinical outcomes data. The AIHW is working with BreastScreen Australia on a data linkage project to support the mortality feasibility study. This project could begin to broaden the emphasis of the chapter from breast screening towards overall breast cancer management. In addition, the Australian Screening Advisory Committee Monitoring and Evaluation Working Group has developed an evaluation plan and monitoring plan that will facilitate reporting of outcomes in future.⁸

Victoria has developed a set of clinical performance indicators for breast cancer management as part of a comprehensive approach to quality improvement through performance monitoring and reporting. BreastCare Victoria (Department of Human Services) commissioned the project, which a BreastScreen Victoria Inc. team is undertaking. A collaborative approach has been adopted in the development and field testing of the indicators, to maximise key stakeholder participation in, and

⁸ The Australian Screening Advisory Committee advises all Australian governments on specific policy, quality, data management, clinical and administrative issues arising out of the management of the BreastScreen Australia program.

ownership of, the project. Involvement of consumers is also a key feature of the method.

BreastScreen Victoria Inc. conducted a comprehensive review of the national and international literature in this area, and the recommended performance indicators are based on a combination of internationally accepted best practice and consensus among stakeholders. Nine rate-based indicators measure aspects of patient care across the continuum, and three ‘critical events’ are recommended for review by a breast service on a case-by-case basis. The indicators are supported by a data dictionary and framework for reporting. Further work will be undertaken to develop a phased implementation and model, and to evaluate these indicators as a quality improvement tool at the service level. Details on the recommended set of indicators are available from the Victorian Department of Human Services or BreastScreen Victoria Inc.

Mental health

Key challenges for improving the reporting of mental health management are similar to those of the past year:

- improving the reporting of effectiveness and efficiency indicators for Indigenous, rural/remote and other special needs groups
- revising the performance indicator framework to account for the Third National Mental Health Plan, to ensure reporting remains consistent with government policy objectives for mental health
- improving the reporting of effectiveness/efficiency indicators for community-based mental health care.

A set of key performance indicators for use in Australia’s public sector mental health services has been developed, based on the National Health Performance Framework and linked to the strategic directions of the National Mental Health Plan 2003–2008. Data on all indicators are currently available through existing collections. Work is proceeding on their implementation. Further work is required to develop indicators and measures for their collection in the areas of safety and responsiveness of services. This will then provide data covering all the domains of the National Health Performance Framework. Further information can be found in NMHWG Information Strategy Committee Performance Indicator Drafting Group (2005).

Information structures are being developed under the NMHS that will enable improved performance reporting in future. At present, while community-based

mental health care is expanding in accordance with the NMHS, performance reporting in this area is limited by the quality of data.

All jurisdictions have undertaken to begin collecting unit record consumer outcomes data, so as to develop the mental health casemix classification system and to collect data on the implementation of standards. Delays in the adoption of a consistent mental health casemix classification system are a particular constraint on comparable performance reporting, but all states and territories are now collecting outcomes data, and comprehensive coverage is expected in 2005.

The *National Mental Health Report 2004* includes an expanded range of indicators on consumer and carer participation in decision making. These indicators are more relevant than the indicator currently reported, and the Review will investigate including some or all of the new indicators in future reports.

11.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this section of the Report. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status).

Australian Government comments

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Through the recently negotiated third round of the Public Health Outcome Funding Agreements (PHOFAs), the Australian Government is providing State and Territory governments with \$812 million (indexed annually) over five years (2004-05 to 2008-09) for the delivery of major population health strategies and programs. These include communicable diseases (HIV/AIDS), breast cancer and cervical screening, and health risk factors, including tobacco and alcohol, sexual and reproductive health, and women's health.

Under the National Immunisation Program (NIP), free vaccines are provided to the Australian community to protect against 12 vaccine preventable diseases. In November 2004, the Australian Government concluded negotiations on the new Australian Immunisation Agreements 2004–09 (AIAs) which provide \$671 million over five years to State and Territory governments for the purchase of NIP vaccines. In addition, the Australian Government directly purchased \$161 million of childhood pneumococcal vaccine for distribution to State and Territory governments, for the first two years of this ongoing program.

The Australian Government is committed to achieving sustainable gains in the health status of Aboriginal and Torres Strait Islander Australians. The Australian Government has a commitment to collaboration between Indigenous communities, mainstream health providers and Indigenous-specific primary health care services to achieve better health outcomes. Under the changed arrangements for Indigenous Affairs collaboration across Government as well as with state/territory, local government and communities is also a high priority.

In 2005-06 the Australian Government committed \$203 million over four years for Indigenous health measures, such as continued expansion of primary health care services across Australia; commencement of a Health for Life program; funding to combat petrol sniffing and other substance use, and better access to mainstream hearing services. These funds are in addition to the funding provided through mainstream programs, such as Medicare and the Pharmaceutical Benefits Scheme, which are becoming more responsible to meeting the health needs of Indigenous Australians.

Through the 2003–08 Australian Health Care Agreements the Australian Government will maintain its commitment to the public hospital system. Assistance will be provided to the states and territories of up to \$42 billion over five years, representing a real increase of 17 per cent over the previous Agreements. This includes funding for Mental Health, Palliative Care and the Pathways Home program. State and Territory governments are responsible for ensuring the provision of public hospital services free of charge to public patients on the basis of clinical need and within clinically appropriate times. In 2003-04, \$7.5 billion was provided to States and Territories towards the provision of public hospital services.

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New South Wales Government comments

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In 2005 several key initiatives have been implemented in NSW to improve the performance of the health system.

In January, the formal implementation of the restructure of NSW Area Health Services came into effect. This reform will have the following benefits for local health services:

- additional resources for frontline clinical services, creating Area Clinical Services Plans to map future service delivery
- the partnering of population growth centres with existing centres of excellence and specialist medical expertise
- improved access to services and capacity in teaching hospitals
- enhanced linkages between hospitals to allow for greater spread of specialist services. For example Liverpool, Camden and Fairfield Hospital will have greater access to specialists from Royal Prince Alfred Hospital while Tamworth and Armidale hospitals will have greater access to specialists from Hunter hospitals
- improved academic and teaching links between hospitals. This will see funding re-directed to frontline health services across the State.

The Access Block Improvement Programme has been used in emergency departments to make significant improvements to the patient journey. This program has used a partnership between health administrators and clinicians to deliver better patient care. The success of this programme has led to the development of the Clinical Redesign Programme, a broader initiative that will look at how greater innovation, service integration and collaboration can deliver a better patient journey and improvements to the delivery of health services.

The capacity of the system has been boosted to meet the increasing needs of our aging and growing population. New permanent beds have been opened to cater for this growth in demand. There has also been an expansion and protection of surgical capacity for booked patients to reduce the number of patients waiting longer than benchmark times for their surgery.

New mental health funding has been provided to expand the Psychiatric Emergency Care unit program and new community initiatives.

The benefits of these reforms will be reflected in later versions of this Report.

NSW is pleased with the inclusion of new performance indicators in this year's report, particularly those relating to primary and community health and the quality of public hospital performance. We look forward to the continued improvement and expansion of indicators in future reports.

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Victorian Government comments

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The 2006 Report on Government Services continues to provide a valuable resource on the comparative performance of health systems across Australia.

Victoria particularly welcomes the inclusion of additional indicators on the safety and quality of care provided in public hospitals. The Victorian Department of Human Services has been reporting annually on sentinel events since 2004, with the first report covering the 2002-03 period. Reporting on sentinel events is an important component of clinical risk management, so it is pleasing to note the inclusion for the first time of data on sentinel events by two states, Victoria and New South Wales, in the Report. This also represents an important measure of progress in that the Report now includes two outcome measures in the performance indicator framework for public hospitals.

The Victorian Government's commitment to transparency and accountability on health system performance is demonstrated by its release in 2005 of the *Your Hospitals* report, a new six-monthly performance report. This report is complemented by an innovative website that allows patients seeking elective surgery to compare the median waiting times for different procedures at individual hospitals. Information on the website is updated quarterly to ensure that patients and their doctors can find hospitals with shorter waiting times and so receive their elective surgery more quickly.

Victoria supports the ongoing work of the Health Working Group in expanding the scope and range of performance indicators in the health chapters. It is a significant improvement that three measures of access to Pharmaceutical Benefits Scheme (PBS) medicines have been included in the 2006 Report. With expenditure on pharmaceuticals representing \$5.7 billion, or 11.6 per cent of total health expenditure in 2003-04, it is vitally important that additional indicators on the appropriateness, quality and efficiency of pharmaceutical services be developed and included in future editions of the Report.

Victoria has also signalled its interest in the future inclusion of reporting on private hospital performance, using comparable indicators to those currently used for public hospital performance. Finally, Victoria strongly supports the development and future inclusion of performance indicators on dental services in the Report. This would considerably improve the current scope of reporting on primary and community health programs. The work of the National Health Performance Committee in examining potential new indicators for primary care also holds promise for the future.

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Queensland Government comments

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Queensland Health provides a wide range of health services to Queensland's population of over 3.9 million people. Services include health promotion, disease prevention, acute hospital and non-admitted patient services, rehabilitation, mental health services, community-based care, and aged care.

The Report on Government Services continues to provide a valuable source of comparison on key publicly provided health services however, as in previous Reports, considerable data comparability issues across jurisdictions remain.

In this report, reflecting previous years' reports, Queensland continues to perform well across a range of health indicators however the system is under pressure. It is coping with unprecedented population growth. Along with every other state system, massive changes are needed to deal with future demand.

In October 2005, the Queensland Government launched a five-year plan, Action Plan: Building a better health service for Queensland, to further improve health services in the State. The plan followed a thorough and independent review of the health system, the Queensland Health Systems Review, led by Peter Forster. After extensive consultation, research and review process, the report found that Queensland's public health system provides a good service and that it is performing as well as any other health service in Australia.

However, the Queensland public health system is under pressure due to Queensland's rapid growth in population, an ageing population, new medicines and technologies, worldwide critical staff shortages across all health professions, shortages in critical infrastructure, insufficient community-based health infrastructure to support alternative health care arrangements, and increasing demand for services in areas such as mental health, addiction, and Indigenous health.

Under the action plan, additional funding of around \$550 million will be allocated to Queensland's public health system in 2005-06. This allocation, of which \$431.1 million is new money, will grow in the following five years to an extra \$1.5 billion in 2010-11.

The extra funding under the plan will provide immediate relief to health service staff across the State, allow investment in urgently needed new services in the future and provide for the phased implementation of reforms to ensure future sustainability. Significant numbers of additional clinical staff will be recruited for key priority health areas. This will include an extra 1200 staff in the first 18 months of the plan, comprising 300 doctors, 500 nurses and 400 allied health professionals.

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Western Australian Government comments

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The health system reform agenda in Western Australia is well underway following release in 2004 of the Health Reform Committee's (HRC) final report, which set out a clear plan for major health reform in the State. More than 110 individual projects of varying size, complexity, cost and timeframes are underway to implement the recommendations from the HRC.

Building on the vision provided by the HRC report strategic directions for the health reform agenda and the health system as a whole have been developed. The strategic directions identify six priority areas into which the activities of the health system flow. Coordinating activities into these areas (healthy workforce, healthy hospitals, healthy partnerships, healthy communities, healthy resources and healthy leadership) has provided direction to enable the health system to be more accountable and sustainable.

A major achievement following extensive consultation was the release of the Health Clinical Services Framework 2005–2015, which provides a strategic overview to map out the current and planned future of health care services throughout Western Australia over the next 10 to 15 years and beyond. The Framework includes role delineation for each health service and care facility and bed numbers planned for the metropolitan region. Subsequently, the State Government committed a further \$1 billion bringing the total capital funding to an historic \$3.6 billion to see the health reform agenda fully implemented.

Major hospital capital works to be undertaken include the relocation of Royal Perth and Fremantle Hospitals from their current sites to Murdoch in the South Metropolitan Area and moving Princess Margaret Hospital for Children to the Royal Perth Hospital north block site. The Swan District Hospital will be completely rebuilt on a new site in Midland.

There is considerable work ahead to successfully implement the Framework and develop statewide Clinical Networks to improve health system integration and the optimal delivery of clinical services to the community. The Clinical Networks will coordinate major health conditions including cancer, cardiovascular diseases and respiratory illnesses. The Cancer Network has been the first to be implemented and a comprehensive plan for improving cancer services in the State over the next five years has been released.

A major initiative to provide more ambulatory care services (Healthy @ Home) is underway. This will expand existing hospital in the home services. Chronic disease management teams will also be established to meet the growing need.

Other major health reform achievements include integration of the State's public pathology services into a single service, expected to save around \$10 million in three years. A Statewide Obstetric Support Unit has also been established to ensure the highest standard of maternity care. Other significant reform activity has focused on leadership programs for the health workforce, increased surgical training places, fast-track surgery for cataract patients, more after hours GP clinics at public hospital sites and initiatives to increase revenue and efficiencies.

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South Australian Government comments

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The Department of Health is committed to protecting and improving the health of all South Australians by providing leadership in health reform, policy development and planning. One of the challenges for the Department of Health is achieving the health targets provided in South Australia's Strategic Plan, launched in 2004. The Plan is an important focus of the SA Government which sets forward numerous challenges to improve the wellbeing of South Australians and provides some important measuring tools, targets and priority actions designed to address these challenges. The Department of Health has a role in monitoring and developing strategies for the health targets, particularly in relation to healthy life expectancy, infant mortality, psychological distress, smoking, and overweight and obesity.

In response to findings from the Generational Health Review of the SA health system, the SA Government has progressed its commitment to reform of the State's health system by increasing prevention, early intervention and health promotion; focussing on chronic disease management from early childhood to healthy ageing; improving health services for the most vulnerable populations; developing a 'healthy' workforce with the right skill balance and required training; and introducing new governance arrangements that focus on the needs of the population rather than the health institution. The SA Government has also signalled a commitment to primary health care. Key directions identified by the *Primary Health Care policy statement* are:

- increasing access to services especially for those with high need
- increasing self-management in the community
- increasing prevention and early intervention of risk factors for disease and social well being
- increasing participation in health decisions by individuals and the community;
- increasing connectivity and information sharing
- delivering continuity of health care across the hospital and primary health care system
- establishing primary health care services in a ratio of 1 service per 100 000 people.

The Health Reform Agenda also identified population health as a fundamental approach to service delivery in SA. The Department is focussing efforts on creating a population health approach through establishing a population health policy framework; establishing objectives and targets to improve population health outcomes; establishing population based funding; and enhancing community participation.

Strengthening primary health care and adopting a population health approach will be paramount in addressing inequalities, among our Indigenous population as well as other disadvantaged groups, and improving the health of the whole community.

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Tasmanian Government comments

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The Department of Health and Human Services supports the publication of information about the provision of health services and relevant performance indicators. Caution should be exercised when examining the published results as there are differences between jurisdictions in both service structure and in how the performance information is collated and reported. The reader is encouraged to note some of the qualifications in the text as well as examining original source reports where relevant.

The Department's strategic focus has three main elements — increasing the capacity of the system; service delivery reform; and meeting community expectations of the health and human services system. Following the release in 2004 of the findings of the report of the Richardson Report, the Government made a number of significant announcements to increase service capacity and reform the approach in areas of high priority.

In December 2004, the Government assumed management of the Mersey Campus of the North West Regional Hospital after a decade of private ownership and management. This was accompanied by providing additional funding for the Mersey Campus and an increase in ambulance services in the region.

The Better Hospitals Package is being implemented over three years with specific initiatives including a new transitional care unit and geriatric evaluation and management unit at the Repatriation Centre, additional high dependency/intensive care unit beds at the Royal Hobart Hospital (RHH), additional capital equipment and additional specialist staff across the state. Short, medium and long term planning of the future accommodation requirements of the RHH is being undertaken. The construction of a new Department of Emergency Medicine is due for completion during 2006.

The State Government has allocated \$47 million over four years to address recommendations arising from the Bridging the Gap review (a review of services provided to mental health consumers in Tasmania) and will be used to fund additional positions in the mental health sector and build capacity in the non-government sector. A Strategic Plan focusing on a model of care which will result in integrated and standardised service delivery; improved partnerships with consumers and all other stakeholders, including non government organisations and an interagency approach delivering holistic responses to health needs; workforce development strategies to recruit, train and retain staff; and better governance and leadership.

In terms of primary health care, the prevention, early detection, and management of chronic conditions and disease is a priority in Tasmania due to the ageing population, the increasing prevalence of prolonged illnesses. A Framework for the Prevention and Management of Chronic Conditions Framework was introduced in 2005 and provides a comprehensive set of guiding strategies to address underlying causes and common risk factors in an attempt to lift the chronic disease burden from individuals, care-givers, health services and the community.

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Australian Capital Territory Government comments

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The ACT provides a near complete range of health services to its own residents, as well as to many people living in adjoining regions of NSW. More than 95 per cent of ACT residents requiring public hospital services can be treated within the ACT. The majority of those referred interstate require very specialised high-cost, low volume services, such as organ transplantations, unable to be sustained by the population of the ACT and region.

Although the ACT continues to support the reporting of data across jurisdictions as a means of judging the performance of its own health system against other states and territories and over time, readers need to exercise caution when considering comparisons of data across jurisdictions. This is because the ACT's relatively small population can make indicators for selected services and target groups subject to large variations over time.

Published data for certain population groups in the ACT may not provide reliable insights into population health needs or service utilisation. One area where this remains of concern is the reporting of Indigenous separation rates in the ACT. For example, in 2003-04, almost 60 per cent of Indigenous separations in the ACT were for maintenance dialysis. Six patients in this group accounted for almost 60 per cent of separations, the majority of which were for dialysis.

Cost comparisons for particular services across jurisdictions should also be interpreted with caution, as accounting methods for costing services can vary considerably across the states and territories. Cost drivers will also vary and jurisdictions may have little scope to address these in the short to medium term. For example, economies and diseconomies of scale vary across the jurisdictions, as do health system structures and the ability to attract and retain skilled health workers.

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Northern Territory Government comments

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The five NT public hospitals operate as a network bringing together:

- Royal Darwin Hospital, 1440 staff with 345 beds
- Gove District Hospital, 123 staff with 30 beds
- Katherine Hospital, 178 staff with 60 beds
- Tennant Creek Hospital, 77 staff with 20 beds
- Alice Springs Hospital, 753 staff with 165 beds.

The network provides for economies of scale, shared resources, flexible workforce, clinical accountability, and for the first time, accreditation of all hospitals. While smaller hospitals are supported by the two major hospitals in Alice Springs and Darwin, they retain a local identity with close links to their communities.

The NT public hospital network faces challenges different to other jurisdictions such as:

- 50 per cent of people using NT hospital are Indigenous, the majority of whom live away from the population centres.
- Large numbers of tourist to the NT swell the population to three times the resident group at certain times of the year, people who require a medical safety net while in the Territory.
- There are limited private health services with only one private hospital.
- There are fewer general practitioners than other jurisdictions, especially in remote communities, resulting in a greater reliance on public hospital inpatient and outpatient services.
- Serious competition for health professionals with other jurisdictions increases costs for recruitment and retention.

A stated aim of Report on Government Services is to present comparable data across jurisdictions. Differences may not be due to service delivery variations but data definition and collection issues. Notwithstanding problems in comparing data, it is generally true that different demographics combine to make delivery of health and community health services more costly in the Territory than elsewhere.

Reporting on services in primary and community health and health management chapters in Report on Government Services 2006 provides some performance information to better assess the impact of oral, nutrition, cancer screening, maternal, preventable chronic disease and community mental health services on rates of hospitalisations. These indicators are largely underdeveloped for all jurisdictions. Further development of community health indicators for improving this Report are supported by the NT.

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11.7 Definitions of key terms and indicators

AR-DRG v4.2 (Australian refined diagnosis related group, version 4.2)	A patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG v4.2 is based on the ICD-10-AM classification.
Casemix adjustment	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted into diagnosis related groups (AR-DRGs) that represent a class of patients with similar clinical conditions requiring similar hospital services.
General practice	The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients. This definition includes medical practitioners who work solely with one specific population, such as women's health and Indigenous health.
Health management	The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.
Incidence rate	Proportion of the population suffering from a disorder or illness for the first time during a given period (often expressed per 100 000 people).
Separation	The process whereby an admitted patient completes an episode of care.

Breast cancer

Adjuvant therapy	Treatment given after the primary treatment to increase the chances of a cure. Adjuvant therapy may include chemotherapy, radiation therapy or hormone therapy.
Breast conserving surgery	An operation to remove the breast cancer but not the breast. Types of breast conserving surgery include lumpectomy (removal of the lump), quadrantectomy (removal of one quarter of the breast) and segmental mastectomy (removal of the cancer as well as some of the breast tissue around the tumour and the lining over the chest muscles below the tumour).
Cost per woman screened	The total cost of the provision of breast screening services, divided by the number of women screened. The total cost should include the cost of providing the BreastScreen Australia program in each jurisdiction, in addition to the cost of providing the program to women.
Detection rate for small cancers	The rate of small (less than or equal to 15 millimetres) invasive breast cancers detected per 10 000 women screened.
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 per cent. If a woman is screened more than once during the reference period, then only the first screen is counted.. Catchment area is a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or statistical local area.

Radiation therapy

The use of high energy radiation from X-rays, gamma rays, neutrons, and other sources to kill cancer cells and shrink tumours. Radiation may come from a machine outside the body (external beam radiation therapy) or from materials called radioisotopes. Radioisotopes produce radiation and can be placed in or near the tumour or in the area near cancer cells. This type of radiation treatment is called internal radiation therapy, implant radiation, interstitial radiation or brachytherapy. Systemic radiation therapy uses a radioactive substance (such as a radiolabeled monoclonal antibody) that circulates throughout the body.

Screening

The performance of tests on apparently well people to detect a medical condition at an earlier stage than otherwise would be the case.

Screening round (first)

A woman's first visit to a BreastScreen Australia mammography screening service.

Screening round (subsequent)

A woman's visit to a BreastScreen Australia mammography screening service when she has previously attended such a service.

Size of detected cancers

The percentage of invasive cancers detected, classified according to tumour size.

Total mastectomy

Removal of the breast — also known as simple mastectomy.

Mental health

Acute services

Services that provide specialist psychiatric care for people who present with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services may:

- focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms
- target the general population or be specialist in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, and forensic mental health services.

Affective disorders

A mood disturbance, including mania, hypomania, bipolar affective disorder, depression and dysthymia.

Agoraphobia	Fear of being in public places from which it may be difficult to escape. A compelling desire to avoid the phobic situation is often prominent.
Ambulatory care services	Mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted inpatients, but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.
Antidepressant	A drug that alleviates depression, usually by energising the person and thus elevating mood.
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.
Anxiolytics	Tranquillisers; drugs that reduce anxiety.
Available beds	The number of immediately available beds for use by admitted patients if required at 30 June. Beds are immediately available for use if located in a suitable place of care with nursing or other auxiliary staff available within a reasonable period. Includes beds in wards that are temporarily closed due to factors such as renovations or strikes but that would normally be open and, therefore, available for admission of patients. In many cases, available beds will be less than the number of approved beds, with the former controlled by utilisation factors and resourcing levels, while the latter refers to the maximum capacity allowed for the hospital, given sufficient resources and community demand.
Bipolar disorder	A mood disorder characterised by a history of manic (or hypomanic) episodes usually alternated with depressive episodes.
Child and adolescent mental health services	Services principally targeted at children and young people up to the age of 18 years. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on children or adolescents.
Co-located services	Psychiatric inpatient services established physically and organisationally as part of a general hospital.
Community-based residential services	Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must: provide residential care to people with psychiatric illness or disability; be located in a community setting external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded.
Co-morbidity	The simultaneous occurrence of two or more disorders such as depressive disorder with anxiety disorder, or depressive disorder with anorexia.
Consumer and carer involvement in decision making	Consumer and carer participation arrangements in public sector mental health service organisations according to the scoring hierarchy (levels 1–4) developed for monitoring State and Territory performance under Medicare Agreements Schedule F1 indicators.

Cost per inpatient bed day	The average patient day cost according to the inpatient type.
Depression	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration may be affected.
Dysthymia	Constant or constantly recurring chronic depression of mood, (lasting at least two years) that is not sufficiently severe, or whose episodes are not sufficiently prolonged, to qualify as recurrent depressive disorder. The person feels tired and depressed, sleeps badly and feels inadequate, but usually can cope with the basic demands of everyday life.
Forensic mental health services	Services principally providing assessment, treatment and care of mentally disordered individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained.
General mental health services	Services that principally target the general adult population (18–65 years old) but that may provide services to children, adolescents or the aged. Includes, therefore, those services that cannot be described as specialist child and adolescent, older persons' or forensic services. General mental health services include hospital units whose principal function is to provide of some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, post-natal depression, anxiety disorders).
Generalised anxiety disorder	Unrealistic or excessive anxiety and worry about two or more life circumstances for six months or more, during which the person has these concerns or more days than not.
Hypomania	A lesser degree of mania characterised by a persistent, mild elevation of mood and increased activity lasting for at least four days. Increased sociability, overfamiliarity and a decreased need for sleep are often present, but not to the extent that they lead to severe disruption.
Inpatient services	Stand-alone psychiatric hospitals or specialist psychiatric units located within general hospitals.
Mental disorder	A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental disorder.
Mental health promotion	Activities designed to improve the mental health functioning of persons through prevention, education and intervention activities and services.
Mental illness prevention	Interventions that occur before the initial onset of a disorder.
Mortality rate from suicide	The percentage of the population who die as a result of suicide.

Non-acute services	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 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.
Obsessive-compulsive disorder	<i>Obsessions</i>: recurrent, persistent ideas, thoughts, images or impulses that intrude into the person's consciousness against his or her will. The person experiences these as being senseless or repugnant, but cannot ignore or suppress them. <i>Compulsions</i>: recurrent, stereotyped behaviours performed according to certain rules. The person often views them as preventing some unlikely event, often involving harm to, or caused by, themselves. The person generally recognises the senselessness of the behaviour, attempts to resist it and does not derive any pleasure from carrying out the activity.
Older persons' mental health services	Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged persons. Excludes general mental health services that may treat older people as part of a more general service.
Outpatient services — community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They may include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services — hospital-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They may include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Panic disorder	Panic (anxiety) attacks that occurs suddenly and unpredictably. A panic attack is a discrete episode of intense fear or discomfort.
Patient days (occupied bed days)	All days or part days for which patient was in hospital during the reporting year (1 July to 30 June), regardless of the original data of admission or discharge. Key definitional rules include the following:

	• 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.
Post-traumatic stress disorder	A delayed and/or protracted response to a psychologically distressing event that is outside the range of usual human experience.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of disorders.
Psychiatrist	A medical practitioner with specialist training in psychiatry.
Public health	The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional services.
Schizophrenia	A combination of signs and symptoms that may include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour.
Social phobia	A persistent, irrational fear of being the focus of attention, or fear of behaving in a way that would be embarrassing or humiliating.
Specialised mental health services	Services whose the primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental disorder or psychiatric disability. This criterion applies regardless of the source of funds. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function.
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. <i>Other medical officers:</i> 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.

**Stand-alone
hospitals**

Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant state or territory medical registration board.

Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Nursing staff: all categories of registered nurses, enrolled nurses, student nurses or trainee/pupil nurses employed or engaged by the organisation.

Registered nurses: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialist categories of registered nurses.

Non-registered nurses: enrolled nurses and student nurses not included in the previous category.

Diagnostic and health professionals: qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, pharmacists, speech pathologists and dieticians.

Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.

Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.

Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, wardsmen, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.

Administrative and clerical staff: staff engaged in administrative and 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.

Domestic and other staff: staff involved in the provision of food and cleaning services. Includes all staff not elsewhere included (for example, maintenance staff, tradespersons, gardening staff).

Beds within health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under

Substance use disorders

the management control of a general hospital.

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).

11.8 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 11A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Definitions for the indicators and descriptors in this attachment are in section 4.6 of the chapter. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2006\Attach_stat_app.xls and in Adobe PDF format as \Publications\Reports\2006\Attach_stat_app.pdf. This file is available in Adobe PDF format on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (details on the inside front cover of the Report).

Breast cancer

Table 11A.1	Breast cancer five year relative survival rate in Australia at diagnosis, 1992–97
Table 11A.2	Number of new cases of breast cancer, five year averages
Table 11A.3	Incidence rates of breast cancer, five year averages
Table 11A.4	BreastScreen Australia: Scope of services provided in each jurisdiction, 2004
Table 11A.5	Expenditure on breast cancer screening (current dollars)
Table 11A.6	Number of women screened by BreastScreen Australia
Table 11A.7	Separations and separation rates for selected AR-DRGs related to breast cancer, public hospitals
Table 11A.8	Rate of cancers detected without the need for open biopsies, all women (per cent)
Table 11A.9	Interval cancer rate for women, by age, per 10 000 women screened
Table 11A.10	Real cost per woman screened (2003-04 dollars)
Table 11A.11	Scope of activities and expenditure items included in cost per woman screened calculations
Table 11A.12	Breast conserving surgery to mastectomy
Table 11A.13	Selected breast and other cancer AR-DRGs, public sector, population estimated, 2003-04
Table 11A.14	Participation rates of women in BreastScreen Australia, bi-calendar years
Table 11A.15	Participation rates of women screened by BreastScreen Australia, by special needs groups (first and subsequent rounds) (per cent)
Table 11A.16	Breast cancer detection rate, by BreastScreen Australia
Table 11A.17	Rate of detection of small diameter (15mm or less) invasive cancers, BreastScreen Australia, all rounds of screening
Table 11A.18	Detected invasive cancers, by size and round, women aged over 40 years
Table 11A.19	Mortality rates from breast cancer for women, by age

Mental health

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PART F

COMMUNITY SERVICES

F Community services preface

Families are the principal providers of care for children, older people and people with a disability (ABS 2001). Community services aim to help families to undertake this role and aim to fulfil this role when families are not in a position to provide care. Community services covered by this Report encompass aged care services (see chapter 12), services for people with a disability (see chapter 13), children's services (see chapter 14), and protection and support services (child protection, supported placements, and supported accommodation and assistance) (see chapter 15).

Community service activities (box F.1) typically include those activities 'which assist or support members of the community in personal functioning as individuals or as members of the wider community' (AIHW 1997, p. 3). They may include financial assistance and relief to people in crisis, and housing assistance of a short term or transitional nature, but they exclude acute health care services (see chapters 9–11), long term housing assistance (see chapter 16) and income support (such as social security pensions and allowances).

The definition of community service activities contained in this preface is based on the National Classification of Community Services developed by the Australian Institute of Health and Welfare (AIHW 2003) (box F.1). Community services expenditure data were aggregated for this Preface from the individual chapters in the Report.

As in previous years, this preface includes descriptive data obtained from the Australian Institute of Criminology (AIC) on the number and detention rates of young people in detention. In addition, it includes data on the number of young people on community-based orders in each jurisdiction. It is anticipated that the Report will contain performance reporting on juvenile justice in future years.

Performance information on community services as a whole is not currently reported. While there are many interactions among the various community services, the services and their funding and delivery systems are too varied to enable aggregate community services reporting.

Box F.1 **Community service activities**

Personal and social support — activities that provide support for personal or social functioning in daily life. Such activities promote the development of personal skills for successful functioning as individuals, family members and members of the wider community. Personal and social support activities include the provision of information, advice and referral, personal advocacy, counselling, domestic assistance and personal assistance. The purpose of such support may be to enable individuals to live and function in their own homes or normal places of residence.

Support for children, families and carers — the provision of care, educational, developmental and recreational activities for children (usually aged 0–12 years) by paid workers. Activities are included that seek to protect children from child abuse and neglect or harm, through statutory intervention and support for families.

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 — activities that involve correctional and rehabilitative supervision and the protection of public safety, through corrective arrangements and advice to courts and parole boards, in relation to young people and people with intellectual and psychiatric disabilities on court orders.^a

Service and community development and support — activities that provide support aimed at articulating and promoting improved social policies; promoting greater public awareness of social issues; developing and supporting community-based activities, special interest and cultural groups; and developing and facilitating the delivery of quality community services. Activities include the development of public policy submissions, social planning and social action, the provision of expert advice, coordination, training, staff and volunteer development, and management support to service providers.

^a This preface uses the term 'juvenile justice' to refer to detention and community-based supervision services for young people who have committed or allegedly committed an offence while considered by law to be a juvenile.

Source: AIHW (2003).

Profile of community services

Roles and responsibilities

Government involvement in community services includes:

- funding non-government community service organisations (which then provide community services to clients)
- providing services to clients directly
- regulating non-government providers
- undertaking policy development and administration.

The relative contribution of government to the direct provision of services varies across community service activities. Statutory protection and placement, and juvenile justice services are provided primarily by government, while residential care and accommodation support, and other community services activities are provided primarily by non-government organisations.

Expenditure

Total expenditure by governments has been calculated based on the 2004-05 expenditure totals for aged care services, services for people with a disability, children's services and protection and support services. Community services expenditure in this preface, therefore, relates only to the activities as defined in these individual chapters.

Total expenditure on community services covered by this Report was estimated to be \$14.4 billion in 2004-05 (table F.1). This was equivalent to 1.7 per cent of gross domestic product in that year, and 9.1 per cent of total government outlays (table F.1 and ABS 2005).

Between 2000-01 and 2004-05, real community services expenditure increased by \$2.9 billion, or 24.8 per cent (table F.1). The largest contributions to the increase were in aged care services and services for people with a disability, which contributed 41.3 per cent and 27.9 per cent to the increase respectively. Protection and support services contributed 16.8 per cent to the increase and the smallest contribution was made by children's services, which contributed 14.1 per cent.

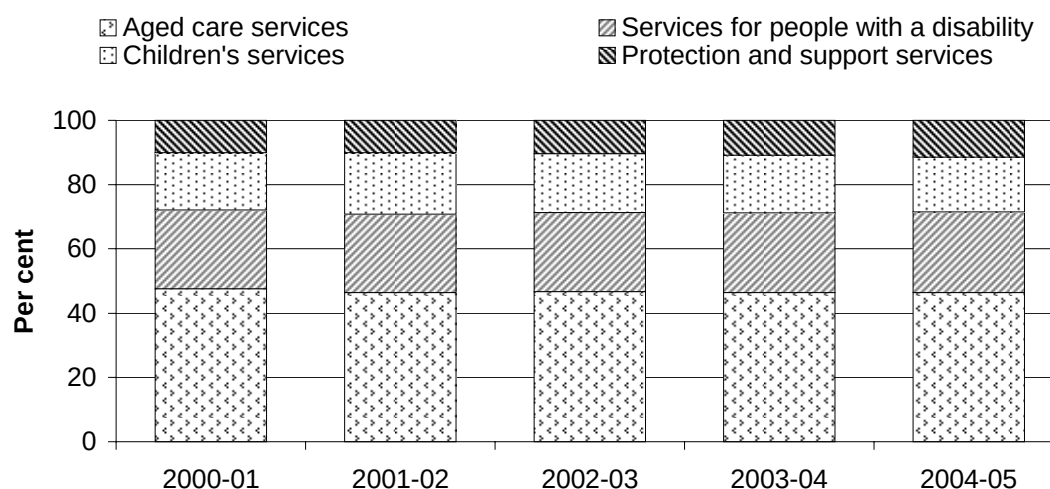
Table F.1 Government recurrent expenditure on community services covered by the Report on Government Services (2004-05 dollars) (\$ million)

	<i>Aged care services</i>	<i>Services for people with a disability</i>	<i>Children's services</i>	<i>Protection and support services</i>	Total
2000-01	5 500	2 810	2 057	1 165	11 532
2001-02	5 795	3 027	2 383	1 255	12 460
2002-03	6 098	3 189	2 388	1 356	13 031
2003-04	6 367	3 400	2 465	1 484	13 716
2004-05	6 680	3 607	2 460	1 645	14 392

Source: Australian, State and Territory governments (unpublished); tables 12A.42–12A.44, 13A.4, 14A.4, 15A.1 and 15A.167.

In 2004-05, almost half (46.4 per cent) of community services expenditure related to aged care services, 25.1 per cent related to people with a disability, 17.1 per cent to children's services, and 11.4 per cent related to protection and support services (figure F.1).

Figure F.1 Government recurrent expenditure on community services covered by the Report on Government Services



Source: Australian, State and Territory governments (unpublished); tables 12A.42–12A.44, 13A.4, 14A.4, 15A.1 and 15A.167.

Size and scope

Data on the number of organisations that provide community services are obtained from the Australian Bureau of Statistics (ABS) Community Services Survey, which was last conducted in 1999-2000. Almost 9300 organisations were providing community services (covering the not-for-profit, government and for-profit sectors)

at 30 June 2000. Across the three sectors, these organisations employed 341 400 people, including 277 300 employed in direct service provision. A further 299 400 volunteers assisted in community service activities (ABS 2001). (For information on the size and scope of the community services sector and output measures for community services in 1999-2000, see SCRGSP 2004, p. F.4.)

An important issue for governments is to determine how to assist community service clients in meeting their complex needs and how to assess performance in meeting these needs. Governments have introduced case management and policy coordination at a more central level to improve the delivery of services.

There are also links between community services and other government services. The performance of community services may influence outcomes for clients of education, health, housing and justice sector services; in turn, these other service areas affect outcomes for clients of community services. A broader discussion of these links is contained in chapters 1 and 2.

Juvenile justice

The juvenile justice system is responsible for dealing with young people (predominantly aged 10–17 years) who have committed or allegedly committed an offence while considered by law to be a juvenile. Each jurisdiction has its own legislation that dictates the policies and practices of its juvenile justice system. While this legislation varies in detail, its intent is similar across jurisdictions. Key elements of juvenile justice systems in all jurisdictions, for example, include: the diversion of young people from the more formal criminal justice system (court) where appropriate; detention as a last resort; victim's rights; the acceptance of responsibility by the young person appropriate to developmental stage for his or her behaviour; and community safety.

The juvenile justice system in each jurisdiction comprises several organisations, with each having a different primary role and responsibility in dealing with young people. These include:

- police, who are usually the young person's first point of contact with the system. Where considered appropriate, the police may administer warnings or cautions and, in some jurisdictions, use conferencing to divert the juvenile from proceeding to court.
- courts (usually a special children's or youth court), where matters relating to the charges against the young person are heard. The courts are largely responsible for decisions regarding bail (and remand) and sentencing options if the young person admits guilt or is found guilty by the court.

-
- juvenile justice agencies, which are responsible for the supervision and case management of juveniles 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 diversion. Many of the services provided by juvenile justice agencies are aimed at: rehabilitating young people; minimising the level of, and future involvement of, young people in the justice system; reducing the over-representation of Indigenous young people in the justice system; maintaining the clients' connection with family, culture and community; providing clients with an appropriate level of care and safety (duty of care); increasing client accountability to victims; and improving community safety.

Diversion of young offenders

In most jurisdictions, the majority of young people are diverted through a range of mechanisms such as police cautions, conferences and unsupervised orders, and do not become clients of juvenile justice agencies. Informal warnings, police cautions, and community, family or youth justice conferences are now part of the spectrum of legislated responses to juvenile crime. Additionally, some jurisdictions use infringement notices as a response to a wide range of regulatory, transport and environmental offences allegedly committed by young people. Responsibility for administering the options available for more minor offences — warnings (informal cautions), formal cautions, and infringement notices — falls largely on police in all jurisdictions.

Responsibility for administering the diversionary processes available for more serious offences lies with juvenile justice authorities in departments ranging from Juvenile Justice (NSW) to Courts Administration (SA). Conference referrals can originate from either police or courts in most jurisdictions. Conditions of entitlement and eligibility, along with the range and/or definition of offences that can be dealt with via conferencing, vary from jurisdiction to jurisdiction.

While comparable national data are not yet available to illustrate the level of diversion, some data have been provided by individual jurisdictions. Diverting appropriate young people from the formal court system, or minimising the involvement of young people with the justice system through a conferencing process, can take considerable resources, depending on the judicial system in the jurisdiction and the number of young people involved. The juvenile justice agencies in NSW and Queensland have provided examples of the number of young people dealt with by means of diversion (although data are not comparable across jurisdictions).

The 2003-04 data from the NSW Bureau of Crime Statistics and Research that are available to the NSW Department of Juvenile Justice show that 976 police referrals to youth justice conferences were made, 9084 cautions were given and 18 430 warnings were administered to young people. The NSW Department of Juvenile Justice data show 1232 conferences (from 1413 police and court referrals) were convened for young people in 2003-04 (Department of Juvenile Justice unpublished). In Queensland, 1752 conferences were convened for people aged 10–17 years in 2004-05, up from 1438 in 2003-04 (Department of Communities unpublished).

In addition to conferences, juvenile justice agencies in all jurisdictions provide pre-sentence reports for young people (who may or may not go on to become clients) to the courts as required.

Clients of juvenile justice agencies

At present, juvenile justice data are only available on a national comparative basis for young persons in detention, either in remand, or sentenced or both. These data are collected by the AIC and detail the number of young people aged 10–17 years held in juvenile detention centres (either on remand or sentenced), at the end of each quarter.

Detention data illustrate only one aspect of the juvenile justice system, and are not representative of the full workload or breadth of services provided by the juvenile justice system or even by juvenile justice agencies. The need for more representative national data has been one of the main factors driving the development of the Juvenile Justice National Minimum Data Set (JJ NMDS) (box F.2). The JJ NMDS is currently being implemented, with detailed reporting for the period 2000-01 to 2003-04 due to be published in 2005-06.

Box F.2 Juvenile Justice National Minimum Data Set

In 1999, the Community Services Ministers' Advisory Council funded the National Community Services Information Management Group to facilitate the establishment of a Juvenile Justice National Minimum Data Set (JJ NMDS). The development of the JJ NMDS was undertaken by the Australian Institute of Health and Welfare (AIHW) under the direction of the Australasian Juvenile Justice Administrators (AJJA).

A draft JJ NMDS was tested during 2002 and 2003 to refine data items and collection methods. The data dictionary for the JJ NMDS was finalised in early 2004 and data collected from juvenile justice agencies for the period 2000-01 to 2003-04.

The JJ NMDS provides information about young people who are supervised by juvenile justice agencies. Pre-sentence and sentenced supervision both within the community and in detention are included in the JJ NMDS. Elements of the juvenile justice system which do not require juvenile justice agency supervision (such as police and court actions) are not included in the scope of the JJ NMDS.

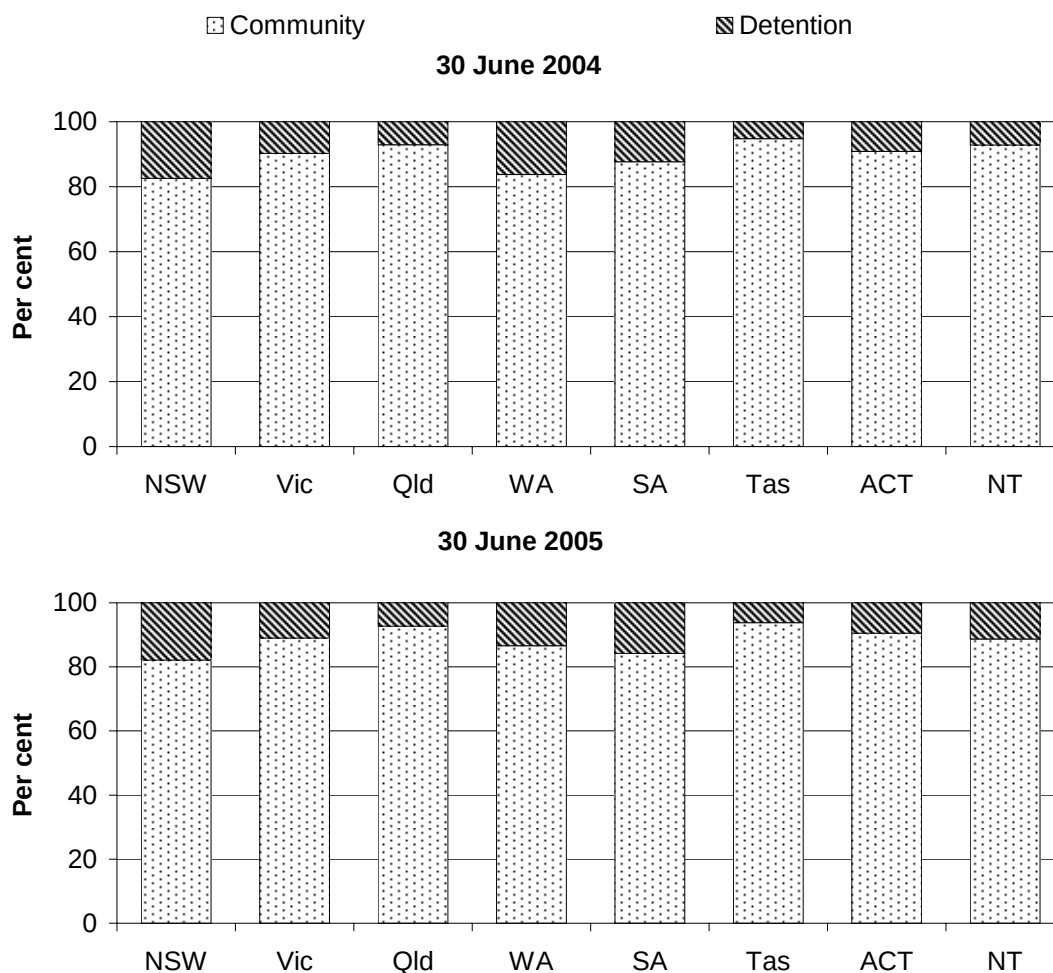
The AJJA has formed a sub-committee to develop national performance indicators from the data items included in the JJ NMDS. Two types of measures, relating to the performance of juvenile justice agencies and the performance of the broader juvenile justice system, are being considered. This performance information may be available in future reports.

Source: AIHW (2004).

Of those young people who become clients of juvenile justice agencies, most are supervised on community-based orders, including parole. Figure F.2 shows that at June 2004 the majority of young people aged 10–17 years who were supervised by juvenile justice agencies — between 82.6 per cent and 94.8 per cent — were in the community, rather than in detention. At June 2005, between 82.1 per cent and 93.8 per cent of young people supervised by juvenile justice agencies were in the community, rather than in detention.

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. Additionally, it is important to note that the proportion of juvenile justice clients aged 18 years or over varies across jurisdictions, and that data presented in figure F.2 do not include these clients.

Figure F.2 **Proportion of juvenile justice clients aged 10–17 years who were supervised in the community and in detention centres^{a, b, c, d, e, f, g, h, i}**



^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 2004 or 30 June 2005. ^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 2004 or 30 June 2005. ^d In NSW, figures for 30 June 2005 do not include young people held in the Kariong Juvenile Correctional Centre administered by the NSW Department of Corrective Services. In previous years the Kariong Centre was administered by the NSW Department of Juvenile Justice and the number of young people held at the centre was included in the information provided. ^e On 1 July 2005, Victoria enacted legislative amendments that raised the age jurisdiction of the Criminal Division of the Children's Court from 16 to include 17 year olds. ^f In Queensland, juvenile justice legislation applies to those young people who were aged 10–16 years at the time of the offence. These data, however, include 17 year olds who were still on supervision in the juvenile justice system as at 30 June 2004 and 30 June 2005. Data for 2005 are preliminary. ^g WA counts exclude persons subject to Juvenile Justice Team Referrals. ^h Tasmanian figures are based on daily roll at close of business on 30 June 2004 and 2005. ⁱ NT data for 2004 were revised to exclude persons subject to a pre-sentence report where the young person is not in custody.

Source: AIHW unpublished (data supplied by State and Territory governments).

Juvenile detentions

This Report includes descriptive data on the number and detention rates of juveniles in detention. The following data relate to juvenile detention only and do not describe the operation of community-based services, which supervise the majority of juvenile offenders. Jurisdictions also have different definitions of a juvenile, which may have an impact on the number and rates reported for people aged 10–17 years.

Data on the number of juveniles include those on remand as well as those sentenced. In some jurisdictions (for example, WA), juveniles who have been arrested and have not yet appeared before a court are also held in a detention centre.

The AIC uses ABS experimental projections for its estimates of the Indigenous population (ABS 2004). These data include a range of estimates (low and high). The AIC data are based on high level estimates, unlike other sections of this Report.

Nationally, the daily average number of people aged 10–17 years detained in juvenile detention centres fell from 647 to 590 between 1999-2000 and 2003-04 (table F.2).

Table F.2 Daily average population of people aged 10–17 years in juvenile detention (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>
1999-2000	251	63	112	116	47	31	11	15	647
2000-01	223	62	87	103	59	43	17	17	611
2001-02	217	62	89	108	56	27	17	16	590
2002-03	220	64	96	106	65	25	17	24	616
2003-04	209	62	91	122	50	26	18	13	590

^a Average based on population of juvenile detention centres on the last day of each quarter of the financial year.

Source: AIC (unpublished).

Nationally, the rate of detention of people aged 10–17 years per 100 000 in the relevant population fell from 30.4 per 100 000 in 1999-2000 to 26.8 per 100 000 in 2003-04, although there were substantial differences across jurisdictions (table F.3).

Table F.3 Average rate of detention of people aged 10–17 years in juvenile detention, per 100 000 relevant population^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>
1999-2000	35.5	12.4	27.2	52.8	29.1	45.7	30.2	61.2	30.4
2000-01	31.1	12.0	21.0	46.2	36.4	61.8	46.6	68.6	28.4
2001-02	30.0	11.9	20.9	47.9	34.1	48.6	47.4	63.0	27.2
2002-03	30.3	12.1	22.3	47.0	40.2	45.1	45.9	94.0	28.1
2003-04	28.7	11.6	20.7	53.5	30.5	47.8	49.8	53.0	26.8

^a Detention rates based on average population of juvenile detention centres on the last day of each quarter of the financial year.

Source: AIC (unpublished).

Nationally, females made up 7.6 per cent of the total population of juvenile detention centres at 30 June 2004. Males made up between 89.6 per cent (2001) and 92.4 per cent (2004) of the national population of juvenile detention centres (table F.4).

Table F.4 Males and females as a proportion of the total population aged 10–17 years in juvenile detention (per cent)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Males									
30 June 2000	91.6	82.7	91.2	89.6	83.1	91.9	93.3	100.0	90.0
30 June 2001	90.5	89.4	91.8	83.5	87.5	97.3	88.0	100.0	89.6
30 June 2002	92.1	93.0	84.5	89.9	85.1	96.2	80.0	100.0	90.1
30 June 2003	92.8	93.4	89.1	90.5	85.9	89.5	87.0	100.0	91.1
30 June 2004	93.4	91.9	95.6	86.4	92.2	100.0	93.8	100.0	92.4
Females									
30 June 2000	8.4	17.3	8.8	10.4	16.9	8.1	6.7	–	10.0
30 June 2001	9.5	10.6	8.2	16.5	12.5	2.7	12.0	–	10.4
30 June 2002	7.9	7.0	15.5	10.1	14.9	3.8	20.0	–	9.9
30 June 2003	7.2	6.6	10.9	9.5	14.1	10.5	13.0	–	8.9
30 June 2004	6.6	8.1	4.4	13.6	7.8	–	6.3	–	7.6

– Nil or rounded to zero.

Source: AIC (unpublished).

The daily average number of Indigenous young people aged 10–17 years detained in juvenile detention centres was 298 in 2003-04 (table F.5).

Table F.5 Daily average population of Indigenous people aged 10–17 years in juvenile detention (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>
1999-2000	91	8	60	77	13	na	2	10	261
2000-01	86	7	53	71	13	na	4	12	246
2001-02	92	7	53	71	19	na	5	12	259
2002-03	98	10	54	80	28	na	4	19	295
2003-04	98	14	54	92	18	6	4	12	298

^a Average based on population of juvenile detention centres on the last day of each quarter of the financial year. **na** Not available.

Source: AIC (unpublished).

Nationally, the daily average detention rate for Indigenous people aged 10–17 years in 2003-04 was 310.1 per 100 000 Indigenous people aged 10–17 years. This rate compared to 13.9 per 100 000 for the non-Indigenous population aged 10–17 years (table F.6). Jurisdictional comparisons need to be treated with caution, especially for those states and territories with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions.

Table F.6 Average rate of detention of Indigenous and non-Indigenous people aged 10–17 years in juvenile detention, per 100 000 people^{a, b, c}

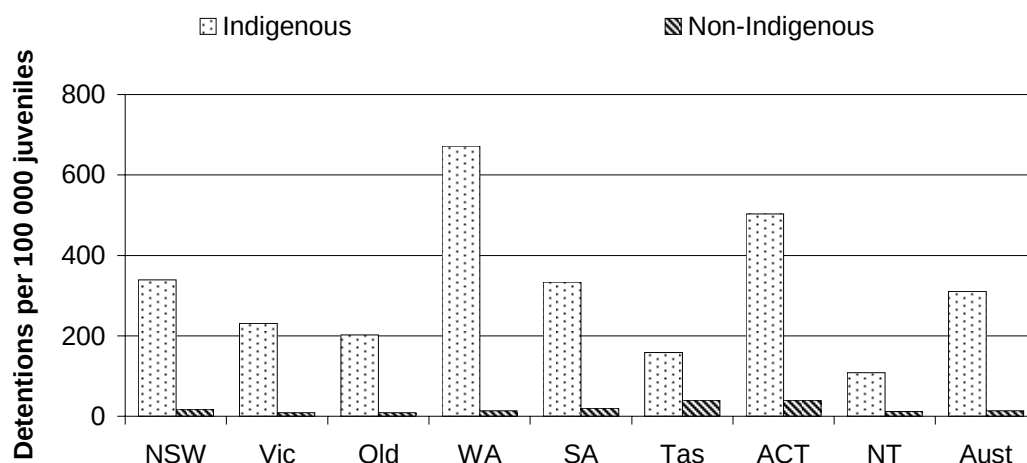
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Indigenous									
1999-2000	343.5	181.9	250.8	624.1	266.2	na	284.1	97.6	315.1
2000-01	324.9	142.4	222.2	565.4	265.9	na	524.7	121.4	294.5
2001-02	351.4	135.8	221.1	555.6	388.2	na	624.4	119.9	307.9
2002-03	353.8	173.6	212.0	604.7	538.1	na	458.6	182.6	326.6
2003-04	339.3	231.0	202.6	671.8	333.2	158.7	503.2	108.6	310.1
Non-Indigenous									
1999-2000	23.6	10.9	13.4	18.7	21.9	na	24.6	31.8	17.8
2000-01	19.9	10.7	8.7	15.1	29.3	na	36.4	26.6	16.0
2001-02	17.9	10.7	8.8	17.3	23.0	na	35.7	23.7	15.0
2002-03	17.5	10.3	10.3	12.2	23.8	na	36.9	30.9	14.9
2003-04	17.5	9.1	8.9	13.8	20.3	39.6	39.4	12.2	13.9

^a Detention rates based on average population of juvenile detention centres on the last day of each quarter of the financial year. ^b Indigenous rates for 2000-01, 2001-02, 2002-03 and 2003-04 were calculated using high series population data provided by the ABS. Any variation in derived rates may be due to the assumptions and limitations of the base population data. ^c Jurisdictional comparisons need to be treated with caution, especially for those states and territories with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions. **na** Not available.

Source: AIC (unpublished).

The overrepresentation of Indigenous young people in detention across jurisdictions in 2003-04 is shown in figure F.3.

Figure F.3 Average rate of detention of Indigenous and non-Indigenous people aged 10–17 years in juvenile detention, per 100 000 people, 2003-04^{a, b, c}



^a Detention rates based on average population of juvenile detention centres on the last day of each quarter of the financial year. ^b Indigenous rates were calculated using high series population data provided by the ABS. Any variation in derived rates may be due to the assumptions and limitations of the base population data. ^c Jurisdictional comparisons need to be treated with caution, especially for those states and territories with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions.

Source: AIC (unpublished).

Future directions in performance reporting

The juvenile justice system is part of the broader justice framework (discussed in the ‘Justice preface’) and has important links with community services such as child protection and support services.

The availability of comparable juvenile justice data as a result of the implementation of the JJ NMDS and the development of performance measures will provide an opportunity to present broader comparative data on the performance of juvenile justice systems in the Report.

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- 2004, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians 1991-2009*, Cat. no. 3238.0, Canberra.
- 2005, *Australian National Accounts: National Income, National Expenditure and Product*, Cat. no. 5206.0, Canberra.
- AIHW (Australian Institute of Health and Welfare) 1997, *National Classification of Community Services, Version 1.0*, Cat. no. HWI 7, Canberra.
- 2003, *National Classifications of Community Services, Version 2.0*, Cat. no. HWI-40, Canberra.
- 2004, *Juvenile justice: A new national collection*, Bulletin, Issue 19, Cat. no. AUS 52, Canberra.
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12 Aged care services

The aged care system comprises all services specifically designed to meet the care and support needs of frail older Australians. This chapter focuses on government funded residential and community care for older people and services designed for the carers of older people. Some government expenditure on aged care is not reported, but continual improvements are being made to the coverage and quality of the data. The services covered include:

- residential services, which provide high care, low care and residential respite care (box 12.1)
- community care services, which include Home and Community Care (HACC) program services, Community Aged Care Packages (CACPs), the Extended Aged Care at Home (EACH) program and Veterans' Home Care (VHC)¹
- respite services, which include HACC respite and centre-based day care and the National Respite for Carers Program (NRCP)
- assessment services, which are largely provided by Aged Care Assessment Teams (ACATs).

A profile of aged care services appears in section 12.1. A framework of performance indicators is outlined in section 12.2 and key performance results are discussed in section 12.3. Future directions in performance reporting are discussed in section 12.4. Jurisdictions' comments are reported in section 12.5. Section 12.6 contains a discussion of age standardisation of aged care data, and definitions for data and indicators are provided in section 12.7. Section 12.8 lists the supporting tables for this chapter. Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Section 12.9 lists references used in this chapter.

Additions and improvements made to the chapter this year include:

- provision of age-sex specific usage rates (per 1000 of the population) by jurisdiction, and by remoteness category for high and low care residential

¹ Unless otherwise stated, HACC expenditure excludes the Department of Veterans' Affairs expenditure on VHC.

services, CACP and EACH. For Indigenous populations, these data are combined for high and low care residential services and for CACP

- reporting of outcomes of appraisals of HACC agencies over the three year period to 2003-04 for the indicator 'compliance with service standards for community care'.

Older Australians also use other government services covered in this Report, including disability services (chapter 13), specialised mental health services (chapter 11), housing assistance (chapter 16) and services across the full spectrum of the health system (preface E and chapters 9–11). There are also interactions between these services that are likely to affect performance results in this Report — for example, the number of operational residential aged care places may affect demand for public hospital beds, and changes in service delivery in the public hospital sector may affect demand for residential and community aged care.

Box 12.1 Interpreting residential aged care data

This chapter describes the characteristics and performance of residential aged care in terms of residential services, residents (clients), places and locality.

- *Residential services data.* This chapter groups residential services for reporting purposes based on the eight level Resident Classification Scale (RCS) profile of residential services' clients.
 - Aged care homes with 80 per cent or more residents classified as RCS 1–4 are described as high care services.
 - Aged care homes with 80 per cent or more residents classified as RCS 5–8 are described as low care services.
 - A service that is neither high care nor low care as defined above is called a mixed service.

These categories have been used for descriptive purposes and do not have any legal foundation under the *Aged Care Act 1997* (Cwlth). Similarly, the choice of 80 per cent as a cut-off is arbitrary but considered appropriate for descriptive purposes.

- *Residents data.* This chapter classifies clients as high care or low care based on their RCS assessment. High care residents have been assessed as RCS levels 1–4, and low care residents have been assessed as RCS levels 5–8.
- *Places data.* Part 2.2 of the Aged Care Act details the processes for planning and allocating subsidised services to meet residential aged care needs and community care needs. Planning is based on a national formula for people aged 70 years or over for high and low care. High care places are planned to meet the needs of residents with care needs equivalent to RCS levels 1–4. Low care places are planned to meet the needs of residents with care needs equivalent to RCS levels 5–8.

(Continued on next page)

Box 12.1 (Continued)

Although there must be a needs match between residents entering vacant places (that is, vacant low care places should usually be filled by low care residents), this can change over time with 'ageing in place', which allows a low care resident who becomes high care to occupy a low care place within the same service until he or she is discharged.

- *Locality data.* Geographic data are based on the ABS Australian Standard Geographic Classification of Remoteness Areas (ABS 2003). Data are classified according to an index of remoteness that rates each ABS Census district based on the number and size of towns, and the distance to major towns and urban centres.

12.1 Profile of aged care services

Service overview

Services for older people are provided on the basis of the frailty or functional disability of the recipients rather than specific age criteria. Nevertheless, without more specific information, this Report uses people aged 70 years or over as a proxy for the likelihood of a person in the general population requiring these services. Certain groups (notably Indigenous people) may require various services at a younger age. For Indigenous people, those aged 50 years or over are used as a proxy for the likelihood of requiring aged care services. The Australian Government also uses these age proxies for planning the allocation of residential care, CACPs and EACH packages.

Government funded aged care services covered in this chapter relate to the three levels of government (Australian, State and Territory, and some local) involved in service funding and delivery. The formal publicly funded services covered represent only a small proportion of total assistance provided to frail older people. Extended family and partners are the largest source of emotional, practical and financial support for older people: more than 90 per cent of older people living in the community in 2003 who required help with self-care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 2004). Many people receive assistance from both formal aged care services and informal sources. Older people also purchase support services in the private market, and these services are not covered in this chapter.

Roles and responsibilities

Assessment services

The Australian Government established the Aged Care Assessment Program (ACAP) in 1984, based on the assessment processes used by State and Territory health services to determine (1) eligibility for admission into residential care and (2) the level of care required (and thus the subsidy paid to such services). The core objective of the ACAP is to assess the needs of frail older people and recommend appropriate services. Assessment and recommendation by ACATs are mandatory for admission to residential care or receipt of a CACP or an EACH package. People may also be referred by ACATs to other services, such as those funded by the HACC program. An ACAT referral is not mandatory for receipt of other services, such as HACC and VHC services.

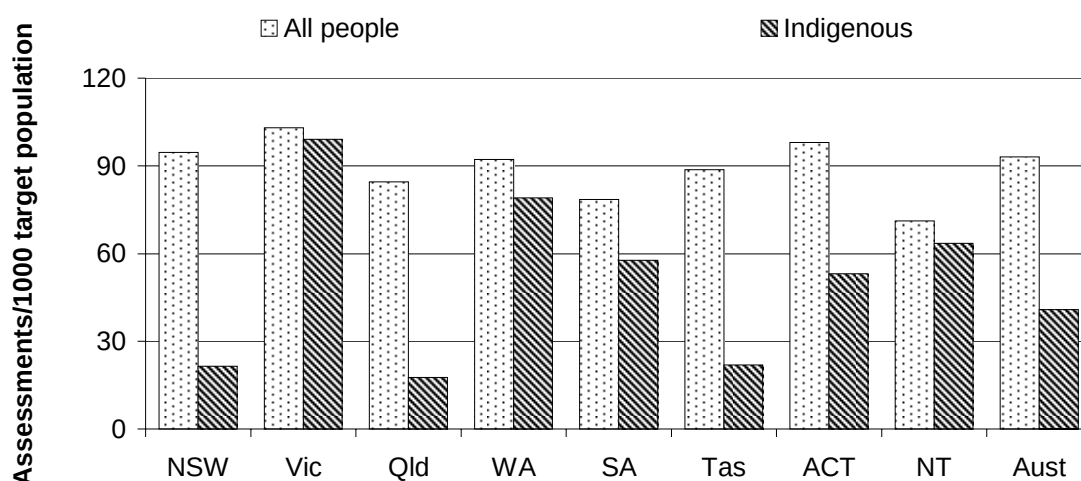
State and Territory governments are responsible for the day-to-day operation and administration of the ACAP and provide the necessary accommodation and support services. The scope and practice of the teams differ across and within jurisdictions, partly reflecting the service setting and location (for example, whether the team is attached to a residential service, a hospital, or a community service). This has an effect on program outputs.

The number of assessments per 1000 target population varied across jurisdictions in 2003-04. The national rate was 93.0 assessments per 1000 people aged 70 years or over and Indigenous people aged 50 years or over and 40.9 per 1000 Indigenous people aged 50 years or over (figure 12.1).

Residential care services

Religious and private for-profit organisations were the main providers of residential care at June 2005, accounting for 30.4 per cent and 31.2 per cent respectively of all subsidised residential aged care places. Community-based organisations and not-for-profit charitable organisations accounted for a further 14.7 per cent and 15.8 per cent respectively. State, Territory and local governments provided the remaining 7.8 per cent (figure 12.2).

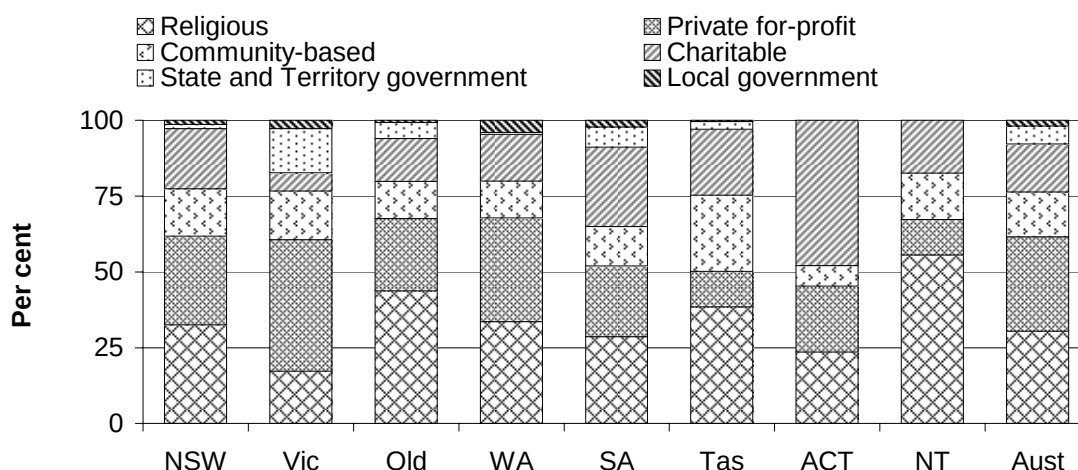
Figure 12.1 Aged Care Assessment Team assessment rates, 2003-04^{a, b, c, d}



^a Includes ACAT assessments for all services. ^b 'All people' includes all assessments of people aged 70 years or over and Indigenous people aged 50 years or over per 1000 people aged 70 years or over and Indigenous people aged 50 years or over. ^c 'Indigenous' includes all assessments of Indigenous people aged 50 or over per 1000 Indigenous people aged 50 years or over. ^d The number of Indigenous assessments is based on self-identification of Indigenous status.

Source: Lincoln Centre for Ageing and Community Care Research (unpublished); table 12A.38.

Figure 12.2 Ownership of residential places, June 2005^{a, b}



^a 'Community-based' residential services provide a service for an identifiable community based on locality or ethnicity, not for individual financial gain. ^b 'Charitable' residential services provide a service for the general community or an appreciable section of the public, not for individual financial gain.

Source: Department of Health and Ageing (DoHA) (unpublished); table 12A.4.

The Australian Government is responsible for most of the regulation of Australian Government subsidised residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local

governments also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 12.2).

Community care services

The main community care programs reported in this chapter — the HACC, CACP and VHC programs — fund services that aim to provide practical assistance to enable frail older people (HACC and CACP), people with a disability (HACC) and veterans (VHC) to continue living in the community. These services also provide assistance to carers. They are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers.

Box 12.2 Examples of regulatory arrangements for residential services

The Australian Government controls the number of subsidised places. In May 2004, following a recommendation of the Review of Pricing Arrangements in Residential Aged Care, the Australian Government adopted a new ratio of 108 places for each 1000 people in the population aged 70 years or over. Of the 108 places, 88 are residential care places (40 high care and 48 low care) and 20 are community care places (CACP and EACH packages).

- Services are expected to meet regional targets for places for concessional residents. These targets range from 16 per cent to 40 per cent of places, and aim to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care. (The criteria for being deemed a concessional resident are based on home ownership and occupancy, receipt of income support and the level of assets held at entry.)
- Extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted.
- To receive an Australian Government subsidy, an operator of an aged care service must be approved under the Aged Care Act as a provider of aged care.
- Principles (regulations) created under the Aged Care Act establish the obligations of approved providers relating to quality of care and accommodation.

Various Australian Government, State and Territory laws govern regulatory arrangements for residential care. State and Territory legislation may prescribe matters such as staffing, the dispensing of medication and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, and fire prevention and firefighting measures. Staff wages and conditions are generally set by jurisdiction-based awards. Local government by-laws may also apply (for example, waste disposal rules).

Flexibly funded services

Flexible care addresses the needs of care recipients in ways other than the care provided through mainstream residential and community care. Three types of flexible care are currently provided for under the Aged Care Act: EACH packages, Innovative Care places and Multipurpose Service program places. In addition, flexible models of care are provided under the National Aboriginal and Torres Strait Islander Aged Care Strategy.

- The Multipurpose Service program supports the integration and provision of health and aged care services for small rural and remote communities. Nationally, the number of Multipurpose Services increased from 88 in June 2004 to 92 in June 2005 (DoHA unpublished).
- The Aged Care Innovative Pool provides flexible care subsidies for alternative care options. Nationally, there were 1344 Innovative Pool places at 30 June 2005 (DoHA, unpublished). Since it began in 2001, the Innovative Pool has focused on: Innovative Care Rehabilitation Services pilots and Intermittent Care Service pilots, both of which address the interface between aged care and hospital care; Disability pilots addressing the aged care and disability services interface; Dementia pilots providing services for people with dementia in alternative settings; and High Needs pilots for areas where the provision of aged care services presents a particular challenge.
- The EACH program provides high level aged care to people in their own homes, complementing CACPs, which provide low level care. There were 1672 operational EACH places at 30 June 2005 (table 12A.35).

Indigenous-specific services

Under the Aged Care Act, 30 Indigenous aged care services are funded, providing approximately 700 places. Most of these places are available in Indigenous-specific aged care services, but some are available in aged care services catering to the broader community. In addition, approximately 600 flexibly funded aged care places were provided at 30 June 2005 through the National Aboriginal and Torres Strait Islander Aged Care Strategy, often in remote areas where no aged care services are otherwise available. Services delivered under the strategy are outside the Aged Care Act (DoHA unpublished).

The Australian Government actively targets community aged care places to Indigenous communities and contracts Aboriginal Hostels Limited to provide ongoing assistance to ensure that services in rural and remote areas remain viable.

Funding

Assessment services

The Australian Government provided grants to State and Territory governments to operate 119 ACATs (at 30 June 2005) and seven evaluation units (DoHA unpublished). In 2004-05, the Australian Government provided funding of \$51.7 million nationally for aged care assessment (table 12A.46). ACAT expenditure per person aged 70 years or over (plus per Indigenous person aged 50–69 years) was \$27 nationally during 2004-05 (table 12A.47). Some States and Territories also contribute funding for ACATs.

Residential care services

The Australian Government provides the majority of annual funding for residential aged care services — \$5.0 billion in 2004-05, comprising DoHA expenditure of \$4.3 billion (table 12A.42) and Department of Veterans' Affairs (DVA) expenditure of \$750.3 million (table 12A.44). State and Territory governments also provide some funding for public sector beds. Residents provide most of the remaining service revenue, with some income derived from charitable sources and donations.

Experimental estimates of State and Territory government expenditure have been collected for some states and territories, for three categories (table 12.1). The categories are defined in section 12.7. The data definitions need further development, so comparisons across jurisdictions need to be made with care.

Table 12.1 Experimental estimates of State and Territory government expenditure on residential aged care 2004-05 (\$ million)

	<i>NSW</i>	<i>Vic^a</i>	<i>Qld^b</i>	<i>WA</i>	<i>SA</i>	<i>Tas^c</i>	<i>ACT</i>	<i>NT^d</i>	<i>Total</i>
Adjusted subsidy reduction									
supplement	2.5	13.1	6.0	2.6	na	1.5	..	..	25.7
EBA supplement	..	41.8	24.0	..	na	..	..	..	65.8
Rural small nursing home supplement	..	5.6	na	2.4	na	10.7	..	0.5	19.2

EBA = enterprise bargaining agreement. ^a Victorian data include payments for both generic aged care places and specialist mental health services. ^b Queensland Health provided approximately \$24 million in supplementation. ^c Tasmanian data are for the adjusted subsidy reduction supplement and rural small nursing home supplement. Rural small nursing home supplement is an estimate based on the average bed day cost across all State operated small rural residential aged care services and recognises the extra cost of operating very small services in rural and remote areas, public sector EBA and staffing levels. ^d NT data are viability supplement grants given to small rural and remote residential aged care facilities. **na** Not available. **..** Not applicable.

Source: State and Territory governments (unpublished).

The Australian Government annual RCS subsidy for each occupied place varies according to the client's level of dependency. At June 2005, the average annual RCS subsidy per residential place was \$29 592 nationally (table 12.2). Variations in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents. Low care subsidy rates (RCS levels 5–8) are the same in all states and territories. High care subsidy rates (RCS levels 1–4) are being adjusted towards a uniform national rate by July 2006, under the Australian Government's Funding Equalisation and Assistance Package.

The combined number of operational high care and low care residential places per 1000 people aged 70 years or over at June 2005 was 41.8 and 43.4 respectively on a national basis (table 12.3). Nationally, the proportion of low care places relative to high care places rose between 2001 and 2004 (table 12A.10).

Table 12.2 Average annual Australian Government RCS subsidy per occupied place, and the dependency levels high care and low care residents, June 2005

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Average annual Australian Government RCS subsidy per residential place ^a										
All RCS levels	\$	29 839	29 582	28 994	28 522	30 414	30 748	29 825	30 784	29 592
Proportion of high care residents ^b										
RCS 1	%	22.4	25.2	17.9	23.7	23.7	18.1	28.7	20.8	22.5
RCS 2	%	26.7	21.6	25.3	20.6	25.7	26.5	17.8	32.6	24.5
RCS 3	%	14.3	12.7	18.3	13.2	16.1	20.4	15.6	17.1	14.9
RCS 4	%	5.4	5.3	6.1	5.8	5.4	7.2	6.3	4.2	5.6
Proportion of low care residents										
RCS 5	%	10.6	13.5	10.9	14.2	10.8	10.7	10.1	4.7	11.7
RCS 6	%	9.8	11.0	9.6	12.0	9.1	7.6	11.4	3.9	10.1
RCS 7	%	10.1	10.2	10.9	9.9	8.7	9.3	9.7	12.4	10.1
RCS 8	%	0.8	0.5	0.9	0.5	0.6	0.3	0.3	4.2	0.7

^a Includes only subsidies based on the RCS. Average Australian Government payments, including subsidies and supplements totalled \$39 336 per high care resident (RCS 1–4) and \$14 109 per low care resident (RCS 5–8). ^b Differences in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents.

Source: DoHA (unpublished); table 12A.5.

Table 12.3 Operational high care and low care residential places, 30 June 2005^{a, b}

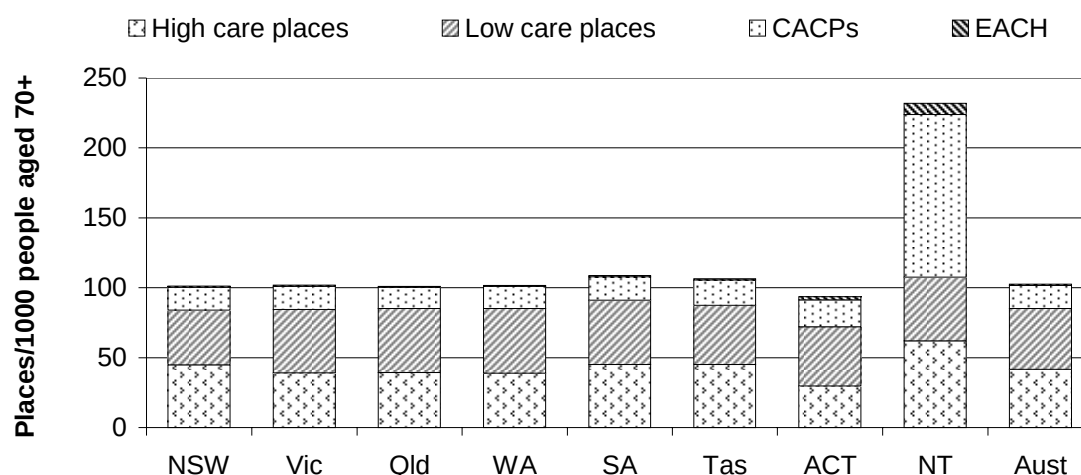
	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Number of places per 1000 people aged 70 years or over										
High care places	no.	44.9	39.1	39.3	38.7	45.2	45.3	29.6	62.2	41.8
Low care places	no.	39.2	45.4	45.9	46.5	46.0	42.1	42.5	45.3	43.4
Total places	no.	84.1	84.5	85.2	85.2	91.2	87.4	72.1	107.5	85.2
Proportion of places										
High care places	%	53.4	46.3	46.1	45.4	49.6	51.8	41.1	57.9	49.1
Low care places	%	46.6	53.7	53.9	54.6	50.4	48.2	58.9	42.1	50.9

^a Excludes places that have been 'approved' but are not yet operational. Includes multipurpose and flexible services attributed as high care and low care places. ^b For this Report, Australian Government planning targets are based on providing 88 places per 1000 people aged 70 years or over. In recognition of poorer health among Indigenous communities, however, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT).

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

The combined number of high care residential places, low care residential places, CACPs and EACH packages is 102.4 per 1000 people aged 70 years and over (figure 12.3). The Australian Government's targets for the provision of residential places, CACPs and EACH packages were outlined previously (box 12.2).

Figure 12.3 Operational residential places, CACPs and EACH packages, 30 June 2005^{a, b, c, d}



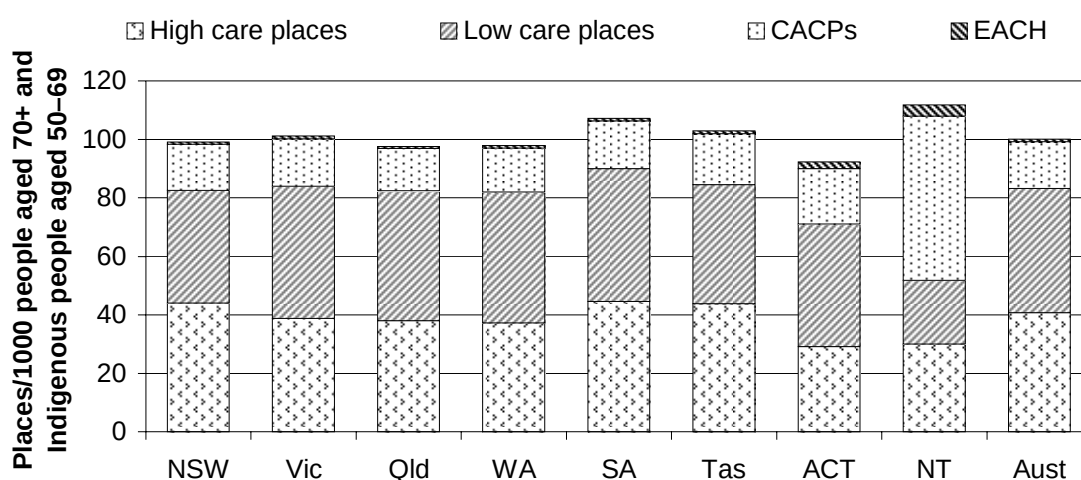
^a Excludes places that have been approved but are not yet operational. ^b 'Ageing in place' may result in some low care places being filled by high care residents. ^c For this Report, Australian Government planning targets are based on providing 108 places per 1000 people aged 70 years or over. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). ^d CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (see boxes 12.1 and 12.2 for an interpretation of residential care data and Australian Government planning targets).

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

Age specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage at 30 June 2004 are reported in tables 12A.58 to 12A.64.

The number of operational places can also be shown using the target population that incorporates Indigenous people aged 50–69 years (figure 12.4). Use of this ‘adjusted’ target population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Figure 12.4 Operational residential places, CACPs and EACH packages, 30 June 2005^{a, b, c, d}



^a Places do not include those that have been approved but are not yet operational. ^b ‘Ageing in place’ may result in some low care places being filled by high care residents. ^c CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (boxes 12.1 and 12.2 contain an interpretation of residential care data and Australian Government planning targets). ^d CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas with a high Indigenous population (such as the NT) may have a higher proportion of CACPs.

Source: DoHA (unpublished); table 12A.11.

Community care services

Total national government expenditure on HACC was \$1.3 billion in 2004-05, consisting of \$791.9 million from the Australian Government and \$509.2 million from the State and Territory governments. The Australian Government contributed 60.8 per cent, while State and Territory governments funded the remainder (table 12A.43). Recipients may also contribute towards the cost of their care.

The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was \$99.2 million in 2004-05 (table 12A.46). The DVA also provided \$80.5 million for the VHC program during

2004-05 (table 12A.45), which does not include expenditure for in-home and emergency respite home care.

The Australian Government funds the CACP and EACH programs, spending \$323.3 million and \$34.3 million respectively on the programs in 2004-05 (table 12A.46). Both CACPs and EACH packages are also part funded by client contributions. Australian Government expenditure data on a range of other community care programs targeting older people are contained in table 12A.46 and data on expenditure per head of the target population are contained in table 12A.47.

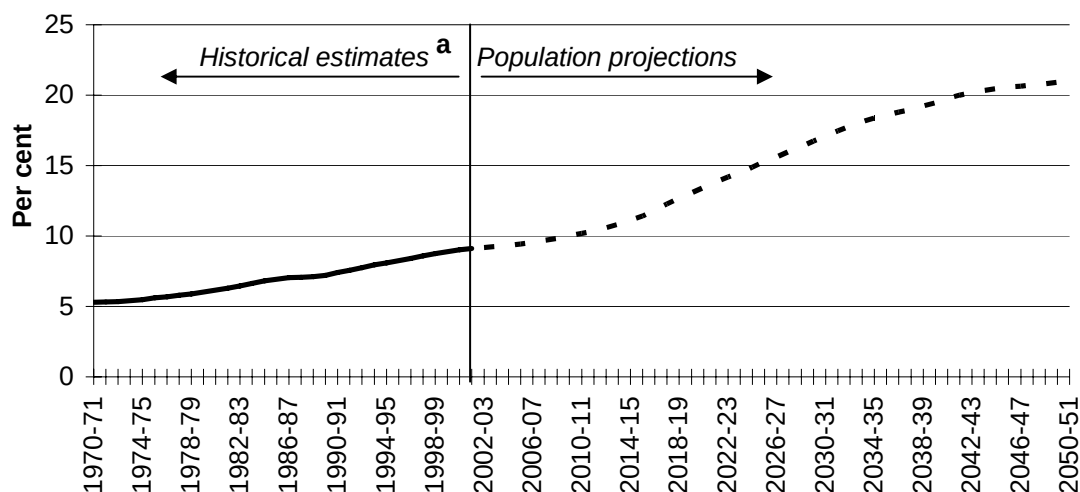
Size and scope of sector

Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of people aged 70 years or over in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically in the 21st century (figure 12.5). The proportion of older people is 9.3 per cent nationally but varies across jurisdictions (figure 12.6). Higher life expectancy for females resulted in all jurisdictions having a higher proportion of older females than older males.

Demographic profiles affect the demand for aged care services because females use aged care services (particularly residential services) more than males. Females are more likely to use residential services partly because they tend to live longer (that is, there are more women than men in the older population) and they are less likely to have a partner to provide care.

Figure 12.5 **Persons aged 70 years or over as a proportion of the total population**



^a Historical estimates are based on the ABS Census of Population and Housing that is held at five year intervals.

Source: ABS States and Population by Age and Sex (unpublished); ABS Population Projections (unpublished).

Figure 12.6 **Estimated proportion of population aged 70 years or over, by gender, June 2005**



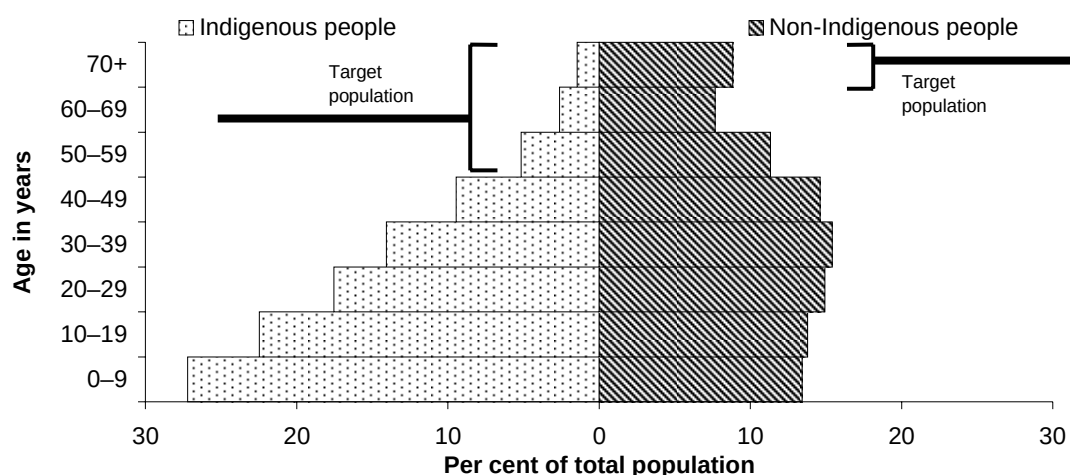
Source: ABS Population Projections by Statistical Local Area (SLA) 2002–2022 (unpublished); table 12A.1.

Characteristics of older Indigenous people

The ABS estimated that about 52 400 Indigenous people were aged 50 years or over in Australia at 30 June 2005 (table 12A.2). Although the Indigenous population is

also ageing, there are marked differences in the age profile of Indigenous Australians compared with the non-Indigenous population (figure 12.7). June 2001 ABS estimates of the life expectancy of Indigenous males and females suggested it was nearly 20 years below that recorded for the total Australian population. These figures indicate that Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 12.7 Age profile and target population differences between Indigenous and other Australians, June 2001



Source: ABS Estimated Residential Population (unpublished).

Residential care services

The size and location of residential services — which may influence the costs of service delivery — vary across jurisdictions. Nationally, there were approximately 158 901 operational places (permanent and respite) in residential care services (72 268 in predominantly high care services, 23 689 in predominantly low care services and 62 944 in services with a mix of high care and low care residents) at June 2005 (tables 12A.6–9).

As the trend towards ‘ageing in place’ (box 12.3) increases, there has been a steady increase in the number of services categorised as services providing a mix of high care and low care places. In June 2001, 25.2 per cent of all places were located in services offering both high care and low care places. This proportion increased to 30.5 per cent of places in June 2002 and 36.5 per cent of places in June 2003, then decreased to 33.4 per cent in June 2004 but increased to 39.6 per cent in June 2005 (tables 12A.6 and 12A.9; SCRCSSP 2002, 2003; SCRGSP 2004, 2005).

Box 12.3 **Ageing in place in residential care**

In its Objects, the *Aged Care Act 1997* (Cwlth) aims to:

... encourage diverse, flexible and responsive aged care services that:

- (i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and*
- (ii) facilitate the independence of, and choice available to, those recipients and carers.*

Further, the *Aged Care Act* explicitly aims to encourage and facilitate 'ageing in place'. The Act does not define 'ageing in place', but one useful definition is 'the provision of a responsive and flexible care service in line with the person's changing needs in a familiar environment'. In effect, 'ageing in place' refers to a resident remaining in the same residential aged care service as his or her care needs increase from low level to high level. This is changing the profile of people in services.

The *Aged Care Act* does not establish any 'program' or require any residential aged care service to offer ageing in place. Rather, it creates the opportunity for providers to choose to provide the full continuum of care, by removing the legislative and administrative barriers that prevented this outcome in the past.

The concept of 'ageing in place' is linked to the outcomes of increasing choice and flexibility in residential aged care service provision. These are difficult outcomes to measure. Data on 'ageing in place' is reported for the indicator 'intensity of care'.

Source: DoHA (unpublished).

The client profile of services that had predominantly low care residents in 2000 has changed over time, with low care residents staying in their current service as their dependency levels rise, and with aged care services expanding and diversifying. Low care services are generally smaller (as measured by number of places) than high care services. At June 2005, 64.2 per cent of low care services had 60 or fewer places (table 12A.8), compared with 47.3 per cent of high care services (table 12A.7).

Age specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage at 30 June 2004 are included in the Report at tables 12A.58 to 12A.64.

Community care services

Services provided under the HACC program include domestic assistance and home maintenance, personal care, food services, respite care, transport, allied health care and community nursing (box 12.4).

Box 12.4 HACC Services

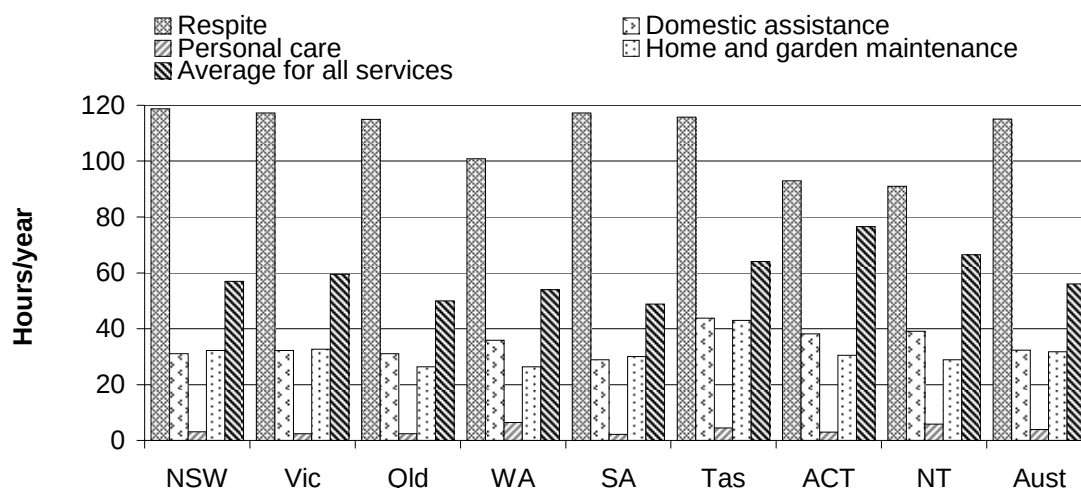
HACC services are basic maintenance and support services, including allied health care, assessment, case management and planning, centre-based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, personal and respite care, social support, meals, home modification, linen service, goods and equipment, and transportation.

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.

Not all HACC services are directed towards the ageing population described in this chapter. Figure 12.13 provides a more detailed breakdown of the age structure of HACC recipients. Approximately 68 per cent of the program's recipients are aged 70 years or over, but the program is also an important source of community care for younger people with a disability and their carers (table 12A.33). (Chapter 13 covers services for people with a disability, which manifests before the age of 65 years, that were provided under the Commonwealth State/Territory Disability Agreement.)

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 74 620 people approved for VHC services in 2004-05 (table 12A.45). The program offers veterans and war widows/widowers who hold a Gold or White Repatriation Health Card home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport, social support and delivered meals, are also available under the DVA's arrangements with State and Territory governments. Eligibility for VHC services is not automatic, but based on assessed need. The average number of hours approved per year for veterans who were eligible to receive home care services was 56.12 nationally in 2004-05 (figure 12.8).

Figure 12.8 **Average number of hours approved for Veterans' Home Care, 2004-05^a**



^a VHC recipients fall into two categories: those veterans who transferred to the VHC program from the HACC program (transitional veterans) and those that did not (non-transitional veterans). The number of hours approved per year is for non-transitional veterans and relates to services that were approved to occur in 2004-05. The average for all services takes into account relative usage of each service.

Source: DVA (unpublished); table 12A.45.

Provision of CACPs is an alternative home-based service for older people who ACATs assess as eligible for care equivalent to low level residential care (RCS levels 5–8). The EACH program is a mainstream program funded by the Australian Government. The program provides individually planned and coordinated packages of care designed to meet older people's daily care needs in the community. The EACH program differs from the CACP program in that it targets frail older people who would otherwise be eligible for high level residential aged care. An EACH package typically provides 15–20 hours of direct assistance each week. The main distinctions between the HACC, CACP and EACH programs are summarised in table 12.4.

Table 12.4 Distinctions between the HACC, CACP and EACH programs

	<i>HACC</i>	<i>CACPs</i>	<i>EACH</i>
Range of services ^a	Wide 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 a greater range of care needs	Targets people with care needs similar to low level residential care	Targets people with care needs similar to high level residential care
Size of program	\$1.3 billion funding in 2004-05 Approximately 744 197 clients in 2004-05 ^c	\$323.3 million funding in 2004-05 30 426 operational places in 2004-05	\$34.3 million funding in 2004-05 1672 operational places at 30 June 2005

^a HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. ^b Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care — for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have levels of need that would exceed the level available under CACPs and EACH. ^c Based on 82 per cent of HACC funded agencies that submitted Minimum Data Set data for 2004-05. Consequently, the total number of clients will be higher than those reported here.

Source: DoHA (unpublished); tables 12A.32, 12A.35, 12A.42 and 12A.43.

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 2004-05, the HACC program delivered approximately 10 653 hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years (table 12A.20). The total number of CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2001 and June 2005, from 14.0 to 16.0 (table 12A.11).

12.2 Framework of performance indicators

The framework of performance indicators aims to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the general performance indicator framework and service process diagram outlined in chapter 1 (figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicators relate to government objectives in the aged care sector (box 12.5). At this stage, no outcome indicators are reported for aged care services.

Box 12.5 Objectives for aged care services

The aged care system aims to promote the health, wellbeing and independence of frail older people and their carers through the funding and delivery of care services that are:

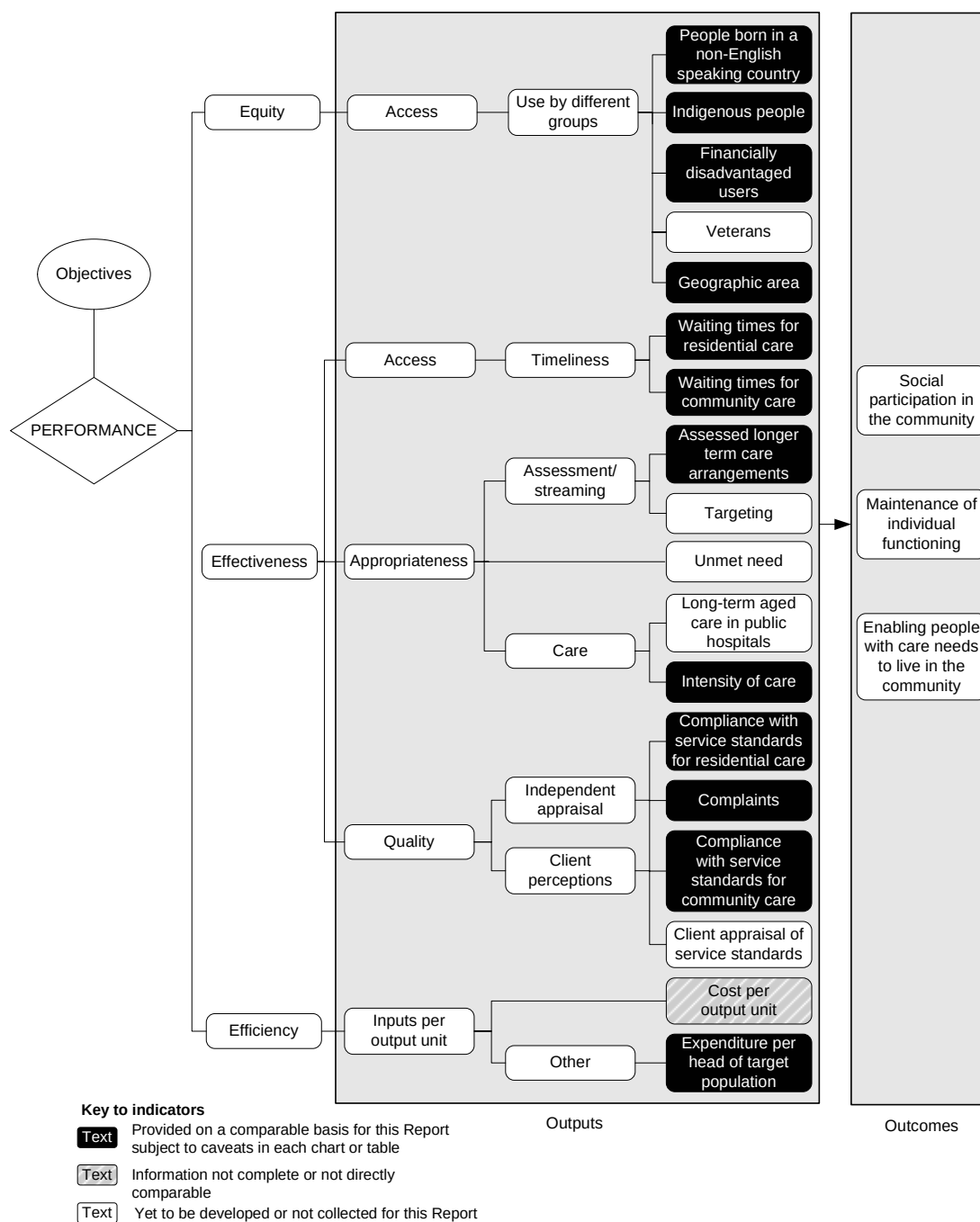
- accessible
- appropriate to needs
- high quality
- efficient.

The performance indicator framework shows which data are comparable in the 2006 Report (figure 12.9). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

12.3 Key performance indicator results

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

Figure 12.9 Performance indicators for aged care services



Outputs

Equity

Access — use by different groups

‘Use by different groups’ has been included as an output indicator of equity (box 12.6).

Box 12.6 Use by different groups

A key national objective of the aged care system is to provide equitable access to aged care services for all people who require these services. ‘Use by different groups’ is a proxy indicator of equitable access. Various groups are identified by the Aged Care Act and its principles (regulations) as having special needs, including people from Indigenous communities, people born in non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans (including widows and widowers of veterans). The indicator is reported for each special needs group except veterans, and the definitions are as follows:

- 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
- 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)
- for financially disadvantaged users — access to residential services is defined as the number of new residents classified as concessional or assisted divided by the number of new residential places
- for people living in rural and remote areas — the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 70 years or over plus Indigenous people aged 50-69 years for major cities, inner regional areas, outer regional areas, remote areas and very remote areas
- the rate of contacts with Commonwealth Carelink Centres for Indigenous people compared with all people.

(Continued on next page)

Box 12.6 (Continued)

In general, usage rates for special needs groups similar to those for the broader aged care population are desirable, but interpretation of results differs for some special needs groups because:

- there is evidence that Indigenous people have higher disability prevalence rates than those of the general population, which suggests a greater level of need for services compared with those in the broader aged care population
- for financially disadvantaged users, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional residents. These targets range from 16 per cent to 40 per cent of new places, depending on the service's region. Usage rates equal to or higher than the minimum rates are desirable.

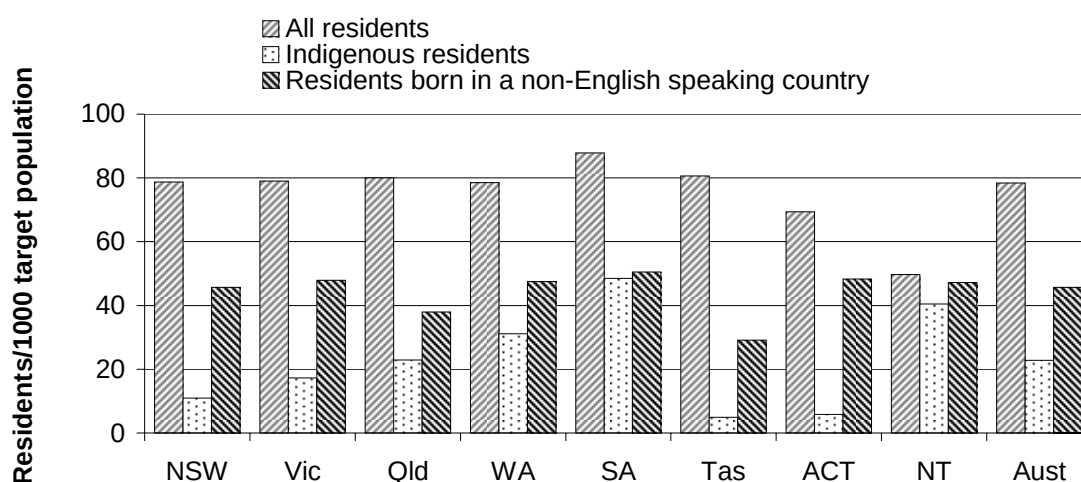
Several factors need to be considered in interpreting the results for this set of indicators:

- Cultural differences may influence the extent to which people born in non-English speaking countries use different types of services.
- Cultural differences and geographic location may influence the extent to which Indigenous people use different types of services.
- The availability of informal care and support may influence the use of aged care services in different population groups.

Access to residential services

In all jurisdictions at 30 June 2005, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services (22.8 and 45.7 per thousand of the relevant target populations respectively), compared with the population as a whole (78.4 per thousand) (figure 12.10).

Figure 12.10 Residents per 1000 target population, 30 June 2005^{a, b, c}



^a All residents data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. ^b Indigenous residents data are per 1000 Indigenous people aged 50 years or over. ^c Data for residents from a non-English speaking country are per 1000 people from non-English speaking countries aged 70 years or over.

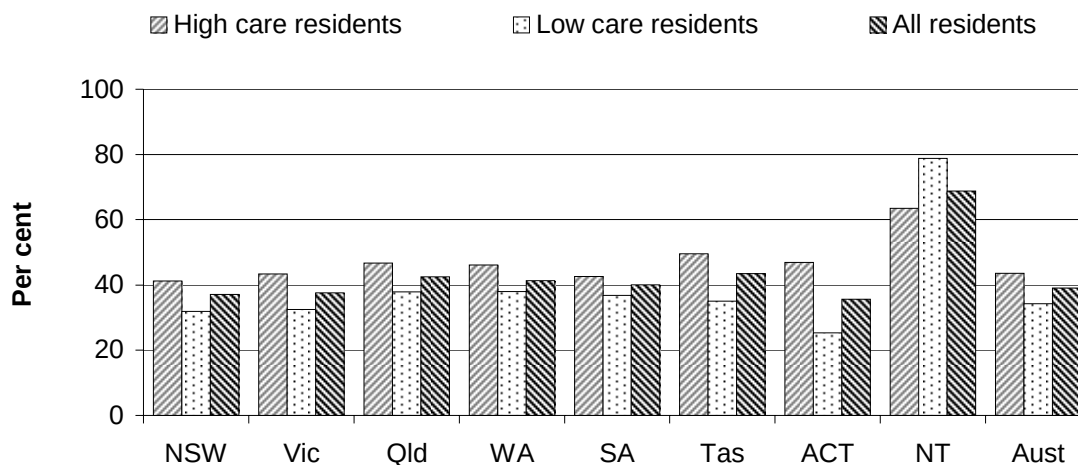
Source: DoHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Age specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage at 30 June 2004, are included in the Report. These data suggest there is significant variation in usage rates by remoteness area. In general, differences across jurisdictions are less marked than differences across remoteness areas (tables 12A.58, 12A.60, 12A.61, 12A.63 and 12A.64).

Access to services by financially disadvantaged users

The proportion of all new residents classified as concessional or assisted residents during 2004-05 was 39.1 per cent nationally but varied across jurisdictions (figure 12.11).

Figure 12.11 New residents classified as concessional or assisted residents, 30 June 2005^a



^a Concessional residents are those who receive an income support payment and have not owned a home for the previous two or more years (or whose home is occupied by a 'protected' person, such as, the care recipient's spouse or long term carer), and have assets of less than 2.5 times the annual single basic age pension. Assisted residents are those meeting the above criteria, but with assets between 2.5 and 4.0 times the annual single basic age pension.

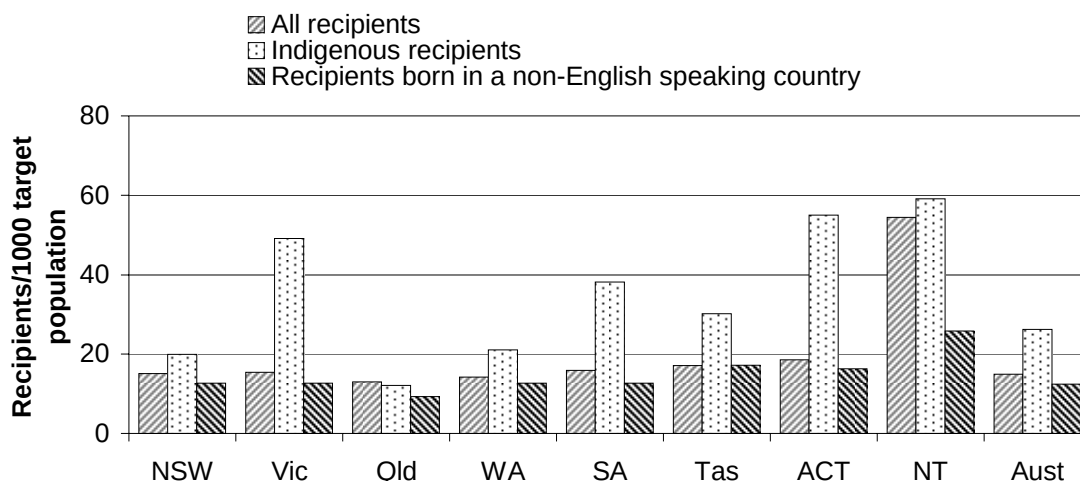
Source: DoHA (unpublished); table 12A.19.

Access to community aged care packages

The number of CACP recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years has grown in recent years, but is still small relative to the number of recipients of residential care. At June 2005, 14.9 per 1000 of the target population received CACP services compared with 78.4 recipients of residential care, although this varied across jurisdictions (table 12A.12).

The number of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over was 26.2 nationally and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 12.4 nationally (figure 12.12). The Australian Government's allocation of CACPs in every jurisdiction at June 2005 exceeded 10 CACPs per 1000 of the overall target population.

Figure 12.12 **Community Aged Care Package recipients per 1000 target population, 30 June 2005^{a, b, c, d, e}**



^a All recipients data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. ^b Indigenous recipients data are per 1000 Indigenous people aged 50 years or over. ^c Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 70 years or over. ^d The ACT has a very small Indigenous population aged 50 years or over (table 12A.2), and a small number of packages will result in a very high provision ratio. ^e CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas such as the NT have a higher rate of CACP recipients per 1000 people.

Source: DoHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Age-sex specific usage rates for CACP and EACH, by jurisdiction, and remoteness and for Indigenous usage are included in the Report. Usage rates vary between jurisdictions and remoteness categories for CACP. For EACH, the differences are less marked. However, the EACH program is small but growing rapidly (tables 12A.59, 12A.60, 12A.62-64).

Access to the Home and Community Care program

Home and Community Care services are provided in the client's home or community for frail older people with a severe, profound or moderate disability, and their carers.

The proportion of HACC recipients aged 70 years or over during 2004-05 was 67.7 per cent (table 12A.32). The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years was 10 653 nationally, and the number of meals provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 was 5269 nationally (table 12.5). HACC agencies that submitted the data as a proportion of all HACC agencies varies across jurisdictions so comparisons between jurisdictions should be made with care.

Table 12.5 HACC services received, 2004-05 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)^{a, b}

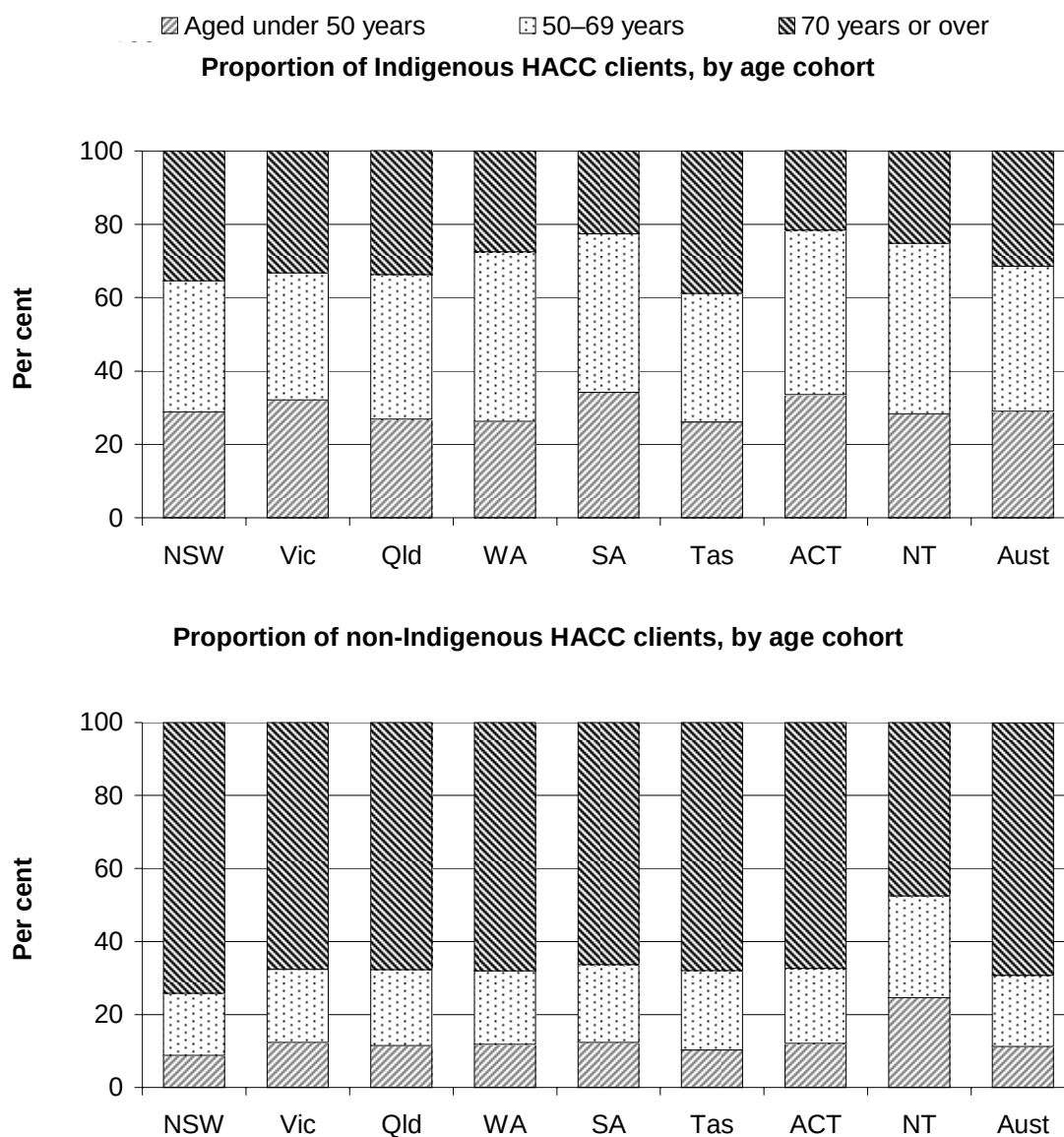
	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA^c</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Percentage of agencies that reported MDS data	%	73	89	94	98	80	86	98	65	82
Total hours ^d										
Major cities	hrs.	5 766	12 510	12 954	17 182	8 622	..	11 446	..	10 163
Inner regional	hrs.	6 048	16 022	11 308	15 816	8 522	9 791	..	..	10 615
Outer regional	hrs.	7 841	19 795	13 226	18 868	10 329	10 490	..	8 646	12 496
Remote	hrs.	11 356	19 391	14 786	15 870	11 149	12 026	..	23 033	14 497
Very remote	hrs.	6 987	..	14 144	20 213	49 077	31 348	..	22 698	20 807
All areas	hrs.	6 050	13 785	12 553	17 173	9 175	10 171	11 462	17 197	10 653
Total meals ^e	no.									
Major cities	no.	3 890	5 196	6 699	6 247	3 652	..	3 487	..	4 849
Inner regional	no.	4 996	7 334	5 784	5 571	691	5 639	..	..	5 627
Outer regional	no.	5 393	6 684	6 582	9 060	2 181	7 488	..	3 898	6 025
Remote	no.	6 416	5 127	7 921	8 293	2 066	6 109	..	12 798	6 876
Very remote	no.	1 154	..	9 452	17 227	25 352	10 973	..	23 201	16 033
All areas	no.	4 295	5 776	6 470	6 737	3 234	6 282	3 493	13 504	5 269

^a Data represent HACC services received by people aged 70 years or over plus Indigenous people aged 50–69 years (tables 12A.20–12A.25) as distinct from HACC services received by all age groups (tables 12A.26–12A.31). ^b The proportion of HACC funded agencies that submitted Minimum Data Set data for 2004-05 differed across jurisdictions, ranging from 65 per cent to 98 per cent. Consequently, actual service levels will be higher than those reported here. ^c The number of meals may be understated in SA due to slow implementation of the Minimum Data Set by Meals on Wheels. ^d See table 12A.20 for a full list of categories. ^e Includes home meals and centre meals. .. Not applicable.

Source: DoHA (unpublished); tables 12A.20–12A.25.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2004-05. This reflects the difference in morbidity and mortality trends between Indigenous people and the general population. The proportion of Indigenous HACC clients aged 70 years and over is 31.5 per cent and the proportion of non-Indigenous HACC clients aged 70 years and over is 69.1 per cent (figure 12.13).

Figure 12.13 Recipients of HACC services by age and Indigenous status, 2004-05



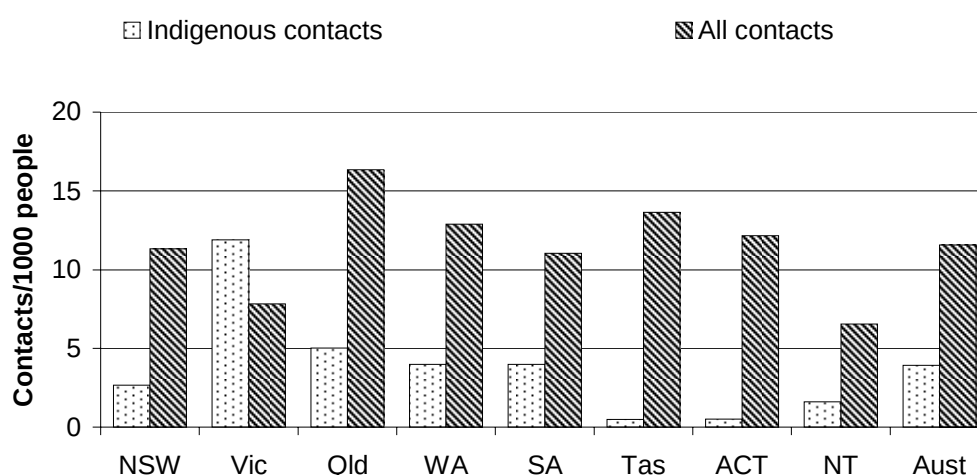
Source: DoHA (unpublished); table 12A.33.

Access by Indigenous people to Commonwealth Carelink Centres

Commonwealth Carelink Centres are information centres for older people, people with disabilities and those who provide care and services. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. The national rate at which Indigenous people contacted Carelink Centres at 30 June 2005, was 3.9 people per 1000 Indigenous

population. The rate for all Australians was 11.6 per 1000 people. These figures varied across jurisdictions (figure 12.14).

Figure 12.14 Commonwealth Carelink Centres, contacts per 1000 people, by Indigenous status, 30 June 2005^{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 population. ^c All contacts refers to contacts per 1000 total population.

Source: ABS Population Projections by SLA 2002–2022 (unpublished); table 12A.56.

Effectiveness

Timeliness of access — waiting times for residential care

The indicator ‘waiting times for residential care’ has been included as an output indicator of effectiveness (box 12.7).

Box 12.7 Waiting times for residential care

‘Waiting times for residential care’ is an output measure of effectiveness, reflecting the timeliness with which people are able to access residential care.

The indicator ‘elapsed time between ACAT approval and entry into residential care service’ measures the period between a client’s approval for care and his or her entry into care and is defined as the percentage of people who are admitted to residential care within three months of their ACAT approval. The relevant terms are defined as follows:

- ACAT approval — the approval date of an ACAT assessment
- entry into a residential care service — the date of admission to a residential care service.

Shorter waiting times (measured by higher rates of admission to residential care within three months of ACAT approval) are desirable.

This indicator needs to be interpreted with care. It may be influenced by a range of factors, such as:

- clients with ACAT assessments who do not enter residential care (for example, who die before entering care)
- residential placement offers that are not accepted
- the availability of alternative community care, informal care and respite services
- the availability and distribution of operational residential care services
- building quality and perceptions about quality of care, which influence client choice of preferred service
- delays between the date of ACAT assessments and their approval
- priority allocations (for example, special needs groups)
- hospital discharge policies and practices.

The Steering Committee acknowledges the limitations of the current indicator (box 12.8) and supports redevelopment for improvement. The current indicator will continue to be reported until improved data are available.

Box 12.8 Entry period for residential care

The Australian Institute of Health and Welfare (AIHW) conducted a detailed study of 1999-2000 ACAT assessment data and entry into residential care (AIHW 2002). The 'entry period' is the time between ACAT assessment of a person as eligible for residential aged care, and that person's entry into a residential aged care service.

The study found that one of the main determinants of a short entry period is whether the resident has an ACAT assessment performed while in hospital rather than when living at home. A longer entry period is also strongly related to whether the resident used a CACP or residential respite care before admission.

Recommendations for residential care remain active for 12 months. Some people assessed by an ACAT and recommended for residential aged care may not take up a residential place within this period. People often do not act on the recommendation immediately. They may believe they are capable of continuing to manage at home and that they do not need admission. Others receive recommendations for both residential aged care and a CACP, and take up the latter.

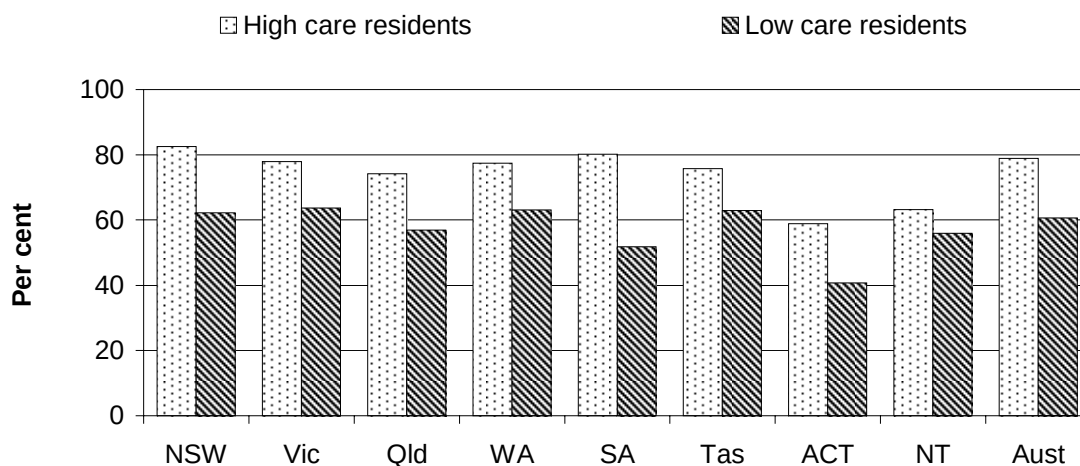
The AIHW found that many factors affect the entry period but are not linked to the performance of the aged care system. It recommended that the entry period for residential care not be used as a performance indicator.

Source: AIHW (2002).

On average, 71.7 per cent of all people entering residential care during 2004-05 did so within three months of being assessed by an ACAT, and 45.2 per cent entered within one month of their ACAT assessment (table 12A.36). In the calculation of entry period, the most recent ACAT assessment prior to entry is used.

Nationally, a greater proportion of people entering high care residential services entered within three months of assessment (78.9 per cent), compared with the proportion entering low care residential services within that time (60.6 per cent). The proportion of people entering high care residential services within three months of being assessed and the proportion of people entering low care residential services within three months of being assessed varied across jurisdictions (figure 12.15).

Figure 12.15 People entering residential care within three months of their ACAT assessment, 2004-05



Source: DoHA (unpublished); table 12A.36.

Timeliness of access — waiting times for community care

The indicator ‘waiting times for community care’ has been included as an output indicator of effectiveness (box 12.9) and reported using CACP data.

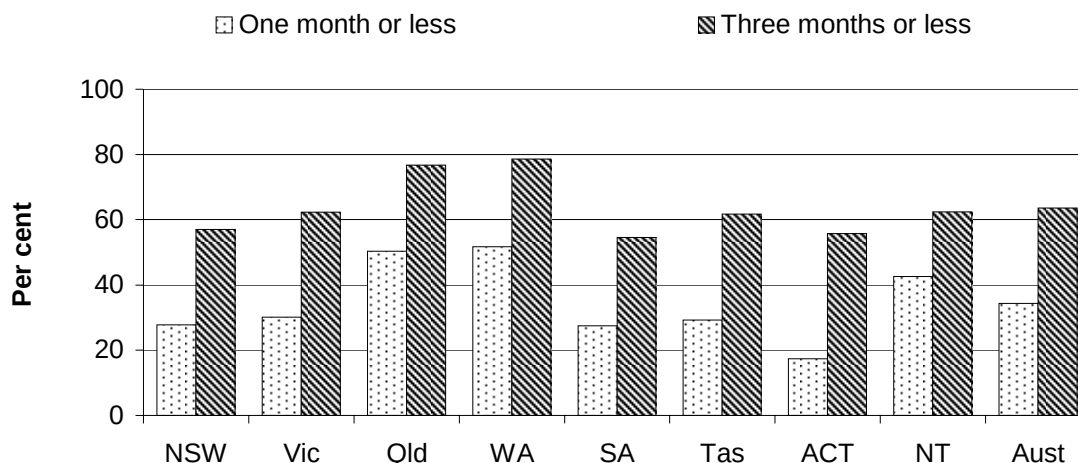
Box 12.9 Waiting times for community care

‘Waiting times for community care’ is an output measure of effectiveness and reflects the timeliness with which people are able to access CACPs. The indicator measures the period between a client’s approval for care and his or her receipt of care, and is defined as the elapsed time between an ACAT approval and receipt of a CACP. Shorter waiting times (or higher rates of receipt of a CACP within one month or within three months of an ACAT approval) are desirable.

This indicator needs to be interpreted with care. Some ACAT assessed clients may choose not to receive a CACP, alternative community care options may be available, or varying fee regimes might influence choice.

On average, 63.6 per cent of all people receiving a CACP during 2004-05 received it within three months of being assessed by an ACAT. This proportion varied across jurisdictions (figure 12.16). On average, 34.4 per cent started receiving a CACP within one month of their ACAT assessment (table 12A.36).

Figure 12.16 Elapsed time between ACAT approval and the receipt of a CACP service, 2004-05



Source: DoHA (unpublished); table 12A.36.

Appropriateness — assessed longer term care arrangements

The indicator ‘assessed longer term arrangements’ has been included as an output indicator of effectiveness (box 12.10) and measures the proportion of clients referred to community care, compared to residential care.

Box 12.10 Assessed longer term care arrangements

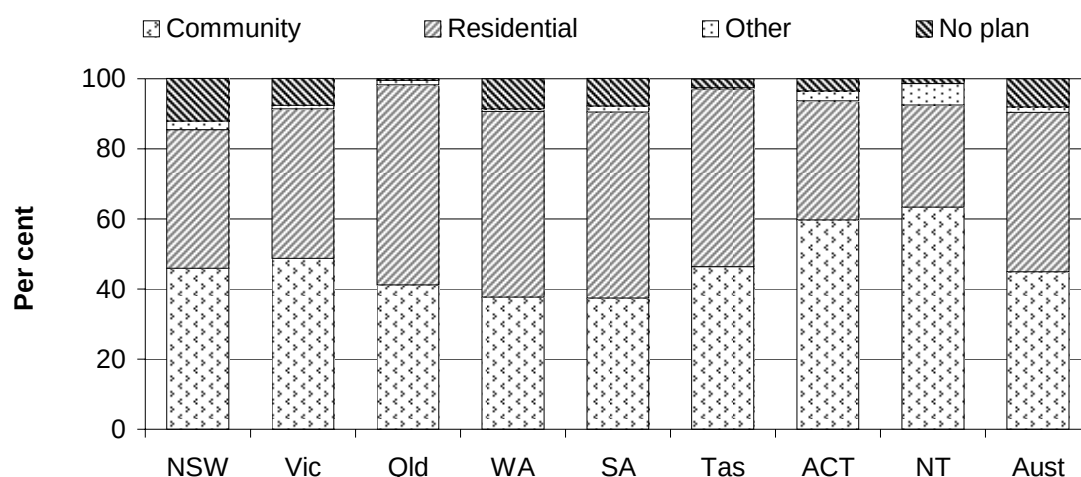
‘Assessed longer term care arrangements’ is an indicator of appropriateness. The purpose is to measure how effectively clients are allocated to the services that best meet their needs.

This indicator is defined as the number of ACAT clients referred to community care (CACPs or EACH packages) or residential care (permanent or respite). (Aged care assessments are mandatory for admission to residential care or for receipt of a CACP or an EACH package.)

The results for this indicator show the distribution of recommended living arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions may reflect external factors such as geographic dispersion of clients and service availability, but also client preferences and views on the types of client best served by community-based services. The distribution of ACAT recommendations for various living arrangements are influenced by the degree to which any pre-selection process refers people requiring residential care to ACATs for assessment. Jurisdictions with lower overall assessment rates may operate a filtering process to focus assessments on individuals who are more likely to require residential care.

The national proportion of ACAT clients referred to residential care in 2003-04 was 45.5 per cent and the proportion referred to community care was 44.9 per cent. No long term plan was made for 8.0 per cent, which included deaths, cancellations and transfers. These proportions vary across jurisdictions (figure 12.17).

Figure 12.17 **Recommended longer term care arrangements of ACAT clients, 2003-04^a**



^a 'No plan' includes deaths, cancellations and transfers.

Source: Lincoln Centre for Ageing and Community Care Research (unpublished); table 12A.37.

Appropriateness — targeting

The 'targeting' indicator has not yet been developed (box 12.11).

Box 12.11 Targeting

The Steering Committee has identified 'targeting' as an indicator of appropriateness. It will be developed for reporting in the future.

Appropriateness — unmet need

The indicator 'unmet need' has been included as an output indicator of effectiveness (box 12.12).

Box 12.12 **Unmet need**

'Unmet need' is an appropriateness indicator. The purpose of the indicator is to measure the extent to which demand for services to support older people requiring assistance with daily activities is met.

Defining and determining the level of need at an individual level, let alone at a population level, are complex tasks. Perceptions of need and unmet need are often subjective. Data for this indicator are drawn from the ABS 2003 Survey of Disability, Ageing and Carers and reflect people aged over 65 years who self-identified as having a need for assistance with at least one everyday activity, and the extent to which that need was met (fully, partly or not at all).

While low rates of unmet need are theoretically desirable, direct inferences about the demand for services from these data need to be made with care, because the data do not:

- reveal the intensity of care required by those who identify an unmet need — there is no indication of whether the need can readily be met informally or by formal home care, or whether the person may require residential care
- reflect the degree of unmet demand for a specific type of service. Differences across jurisdictions in the proportion of unmet need can reflect different policy approaches to targeting services. Some governments may choose to focus on those with the greatest degree of need for care and on fully meeting their needs. By contrast, other governments may choose to provide a lower level of service to a greater number of people, while only partly meeting the needs of those with the greatest need for care. Both policy approaches to the targeting of services are valid.
- reflect the past and possible future duration of the need — that is, whether it is long term or transitory
- reflect whether the need relates to a disability support service, aged care service or medical care, and thus whether it is a State, Territory or Australian Government responsibility.

The total number of persons aged 65 years or over living in households who needed assistance with at least one everyday activity in 2003 and whose needs for assistance were not met comprised over one third (35.7 per cent) of all those needing assistance (table 12.6).

Table 12.6 Older persons needing assistance with at least one everyday activity: extent to which need was met, 2003^a

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^b</i>
Persons with a need not fully met	'000	108.0	98.8	76.3	29.0	30.1	9.6	na	na	358.6
All persons needing assistance	'000	306.9	269.8	214.7	80.8	92.2	27.8	na	na	1 005.2
Self-reported total or partial unmet need	%	35.2	36.6	35.5	35.9	32.6	34.5	na	na	35.7

^a Aged 65 years or over, living in households. ^b Australian total includes data for the ACT and the NT. **na** Not available.

Source: ABS Survey of Disability, Ageing and Carers (unpublished).

Appropriateness — long term aged care in public hospitals

An indicator 'long term aged care in public hospitals' has not yet been developed (box 12.13).

Box 12.13 Long term aged care in public hospitals

'Long-term aged care in public hospitals' is an indicator of the appropriateness of care. Acute inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term. Low incidence is desirable.

The Steering Committee has identified this indicator for development and reporting in future.

Appropriateness — intensity of care

The indicator 'intensity of care' has been included as an output indicator of effectiveness (box 12.14).

Box 12.14 Intensity of care

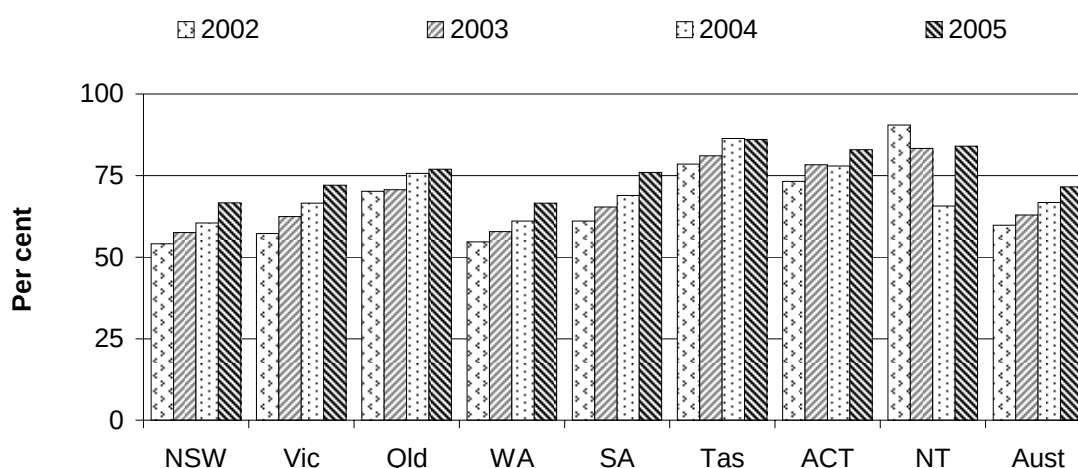
'Intensity of care' is an indicator of appropriateness, reflecting the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The Aged Care Act aims explicitly to encourage 'ageing in place' to increase choice and flexibility in residential aged care service provision (box 12.3).

This indicator needs to be viewed from the perspective of the system as a whole. The implication of ageing in place is that some places that were allocated for low care will be occupied by high care residents (or, conversely, allocated for high care and occupied by low care residents). Information about the use of operational residential aged care places is provided to demonstrate the impact of ageing in place on the aged care service system over time (figure 12.19).

Higher rates of ageing in place are desirable, in the context of a flexible system that meets the need for low level care either in residential facilities or in the community.

From June 2002 to June 2005, 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 59.7 per cent to 71.5 per cent nationally (figure 12.18). In June 2005, the proportion was higher in inner regional areas (76.3 per cent), outer regional areas (74.3 per cent) and remote areas (90.3 per cent) than in major cities (69.4 per cent) and very remote areas (59.1 per cent) (table 12A.53).

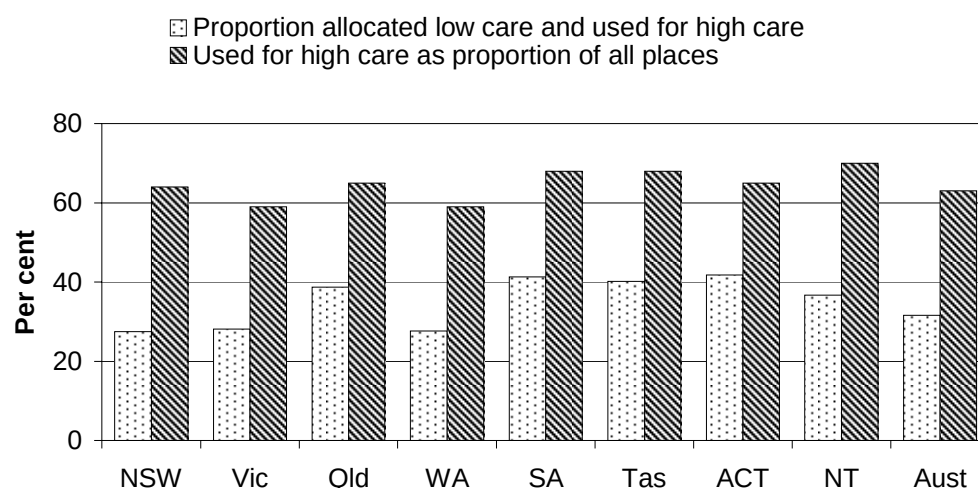
Figure 12.18 **Proportion of residents who changed from low care to high care and remained in the same aged care service, June**



Source: DoHA (unpublished); table 12A.53.

Nationally, 31.6 per cent of low care places in 2004-05 were occupied by residents with high care needs (figure 12.19). These data are provided by remoteness area in table 12A.57.

Figure 12.19 Utilisation of operational residential places, 30 June 2005



Source: DoHA (unpublished); table 12A.57.

Quality — compliance with service standards for residential care

The indicator ‘compliance with service standards for residential care’ has been included as an output indicator of effectiveness (box 12.15).

Box 12.15 Compliance with service standards for residential care

‘Compliance with service standards for residential care’ is an indicator of the quality of care. The purpose of the indicator is to monitor the extent to which residential care facilities are complying with accreditation or certification standards. The extent to which they comply implies a certain level of care and service quality.

Since 2001, Australian Government funded residential services have been required to meet accreditation standards (which comprise 44 expected outcomes), against which each residential service is assessed. The accreditation indicator reflects the period of accreditation granted. High rates of approval for accreditation for three years or more are desirable.

(Continued on next page)

Box 12.15 (Continued)

Residents per room and average certification safety scores are also output indicators of quality. Lower rates of residents per room are generally desirable because they imply a higher service quality of accommodation. Higher rates of safety certification are desirable because they imply a higher level of care and service quality. Average safety certification scores have been presented in previous Reports but are not included in the 2006 Report. This is because the data frequently do not represent the true condition of the buildings under consideration and in many cases are out of date. A replacement reporting regime is expected to arise from an evaluation of the accreditation process and changes in process in relation to reporting of fire safety.

There are three steps in the accreditation process.

- First, residential services apply for accreditation by completing a self-assessment of their performance against the accreditation standards, and submitting this with other relevant information to the Aged Care Standards and Accreditation Agency (ACSAA).
- Second, a team of registered quality assessors reviews the application (the ‘desk audit’) and then conducts an onsite assessment of the residential service (the ‘site audit’). During the site audit, the team observes the living environment and practices of the residential service, reviews relevant documentation such as care plans, and interviews residents, relatives, staff and management. The team gives a draft report to the residential service at the end of the site audit, and a final ‘site audit report’ is prepared and submitted to the ACSAA within two weeks. During that two week period, the residential service has the opportunity to comment on the draft report or provide additional information.
- Third, an authorised decision maker from ACSAA (not the team) considers the site audit report, in conjunction with submissions from the residential service and any other relevant information (including information from DoHA), and decides whether to accredit and, if so, for how long.

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).

At 30 June 2005, 92.3 per cent of residential aged care services had been granted an accreditation approval for a period of three years. This proportion varied across jurisdictions (table 12.7).

Table 12.7 Accreditation decisions on residential aged care services, 30 June 2005

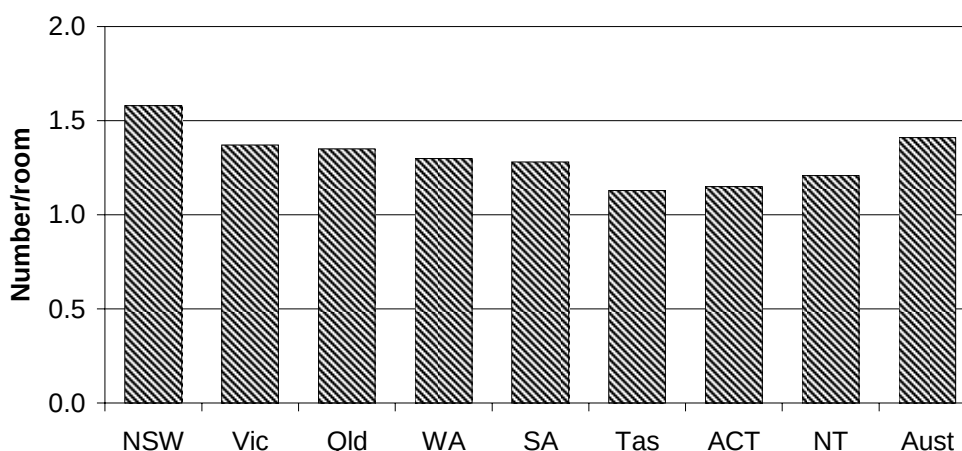
	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Accreditation period										
One year	%	1.4	2.6	1.4	1.9	0.7	–	–	–	1.6
Two years	%	4.7	4.4	12.6	4.7	6.0	5.4	4.3	6.7	6.1
Three years	%	93.9	93.1	86.0	93.4	93.3	94.6	95.7	93.3	92.3
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Accredited services										
	no.	935	821	494	257	298	92	23	15	2 935

– Nil or rounded to zero.

Source: ACSAA (unpublished); table 12A.39.

Existing services are required to meet privacy and space requirements by 2008. All new services must meet these targets from the time of construction. The average number of residents per room at July 2005 was 1.41 nationally (figure 12.20).

Figure 12.20 Average residents per room, July 2005



Source: DoHA (unpublished); table 12A.40.

Quality — complaints

The indicator ‘complaints’ is an output indicator of effectiveness (box 12.16).

Box 12.16 Complaints

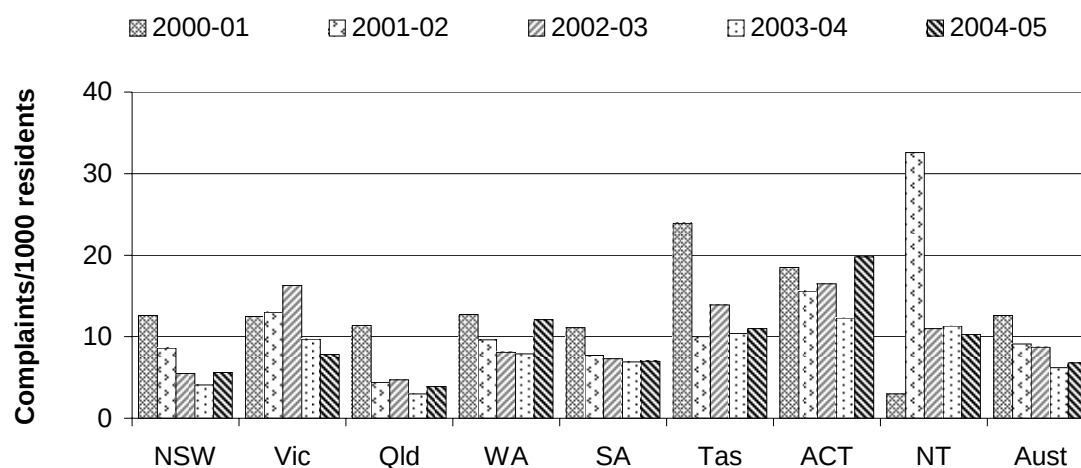
'Complaints' is an indicator of the quality of care. The purpose of the indicator is to monitor the level of complaints received by the Complaints Resolution Scheme in each State and Territory. If service recipients make official complaints, they may be dissatisfied with an element of the service provided and, therefore, dissatisfied with service quality.

All aged care services are required to have an internal complaints system. The Aged Care Complaints Resolution Scheme is a free complaints system run by the DoHA and overseen by an independent Commissioner for Complaints. The scheme is available to anyone who wishes to make a complaint about an Australian Government funded aged care service, including residents of aged care facilities and their families, staff and people receiving CACPs and EACH packages. The indicator measures the number of complaints per 1000 residents. A low rate of complaints is desirable.

The rate at which complaints occur is influenced by the propensity of clients and their families or service staff to complain, their knowledge of the complaints system, and perceptions of the effectiveness of the complaints system. In many cases, complaints may be resolved without the need to involve the Complaints Resolution Scheme.

In 2004-05, the Complaints Resolution Scheme received approximately 1004 new complaints, compared with 967 in 2003-04 (table 12A.41). Of these, 84 per cent were lodged as open complaints, 13 per cent as confidential and 3 per cent as anonymous. Of all complaints handled by the Scheme, 96 per cent related to residential aged care services (DoHA unpublished). The number of complaints registered per 1000 residents in 2004-05 was 6.8 nationally. This varied across jurisdictions (figure 12.21).

Figure 12.21 **Aged Care Complaints Resolution Scheme complaints per 1000 residents**



Source: DoHA (unpublished); table 12A.41.

Quality — compliance with service standards for community care

The indicator ‘compliance with service standards for community care’ has been included as an output indicator of effectiveness (box 12.17).

Box 12.17 Compliance with service standards for community care

‘Compliance with service standards for community care’ is an output indicator of quality. The purpose of the indicator is to monitor the extent to which individual agencies are complying with service agreement standards.

The HACC national service standards provide HACC funded agencies with a common reference point for internal quality control, by defining aspects of service quality and expected outcomes for consumers. States and territories are required to include the standards in all service agreements. The HACC national service standards instrument has been developed to measure through a service appraisal process the extent to which individual agencies are complying with the standards. Monitoring and compliance with the standards are now a major part of service reviews.

The indicator measures the number of HACC agencies appraised against the standards divided by the total number of HACC agencies. This indicator also measures the percentage of individual agencies that comply with the service standards, through data on the outcomes of service standard appraisals. It should be noted that the standards are not an accreditation system.

The total number of HACC agencies identified for appraisal operating over the three year cycle 2001-02 to 2003-04 was 3207. The number of these agencies appraised was 2711 (85 per cent). This proportion varied across jurisdictions (table 12.8). The outcomes of these appraisals was a national average score of 16.0 out of 20 (table 12.9). In the course of the initial three year appraisal process, in the absence of detailed implementation guidelines, each State and Territory adopted individual approaches when assessing agencies against the National Service Standards Instrument (State and Territory governments unpublished).

Table 12.8 HACC National Service Standards appraisals over the three year cycle ending 2003-04^a

	<i>Unit</i>	<i>NSW^b</i>	<i>Vic</i>	<i>Qld^c</i>	<i>WA^d</i>	<i>SA^e</i>	<i>Tas^f</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Appraisals	no.	1 095	481	706	168	161	58	31	11	2 711
HACC agencies	no.	1 487	481	730	178	161	58	31	81	3 207
Proportion of agencies assessed	%	74	100	97	94	100	100	100	14	85

^a Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those reported. ^b The total number of agencies identified for NSW are those targeted in the appraisal plan as at 2001-02. The Integrated Monitoring Framework implemented by NSW in 2005-06 will cover new agencies since that time. NSW has completed all remaining appraisals in 2004-05. ^c Reviews in Queensland are conducted by an external agency on a three year contract. In Queensland, 730 is the number of agencies at the beginning of the contract period. There were 808 agencies in Queensland at the commencement of the 2004-05 contract. ^d The number of WA agencies appraised is lower than expected because some agencies amalgamated. ^e SA has an additional 21 exempt agencies. ^f Two agencies were exempt from the appraisal process in Tasmania.

Source: State and Territory governments (unpublished).

Table 12.9 HACC National Service Standards results of appraisals over the three year cycle ending 2003-04^{a, b, c}

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
High (17.5 – 20)	no.	607	157	276	108	51	12	25	na	1 236
Good (15 – 17.4)	no.	337	168	191	28	37	11	2	na	774
Basic (10 -14.9)	no.	132	123	142	34	50	24	3	na	508
Poor (less than 10)	no.	19	33	97	4	23	11	1	na	188
Average score	no.	17.2	15.5	14.8	17.0	14.5	13.2	17.9	na	16.0

^a Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those listed. ^b The results of the appraisals will reflect different methodologies applied across each State and Territory. ^c For details about the method of determining the average score, see table 12A.65.

Source: State and Territory governments (unpublished); table 12A.65.

Quality — client appraisal of service standards

The indicator ‘client appraisal of service standards’ has not yet been developed (box 12.18).

Box 12.18 Client appraisal of service standards

'Client appraisal of service standards' is an output indicator of quality. This indicator aims to monitor client satisfaction with services received. The Steering Committee has identified this indicator for development and reporting in future.

Efficiency***Inputs per output unit — cost per output unit***

The indicator 'cost per output unit' is an output indicator of efficiency (box 12.19).

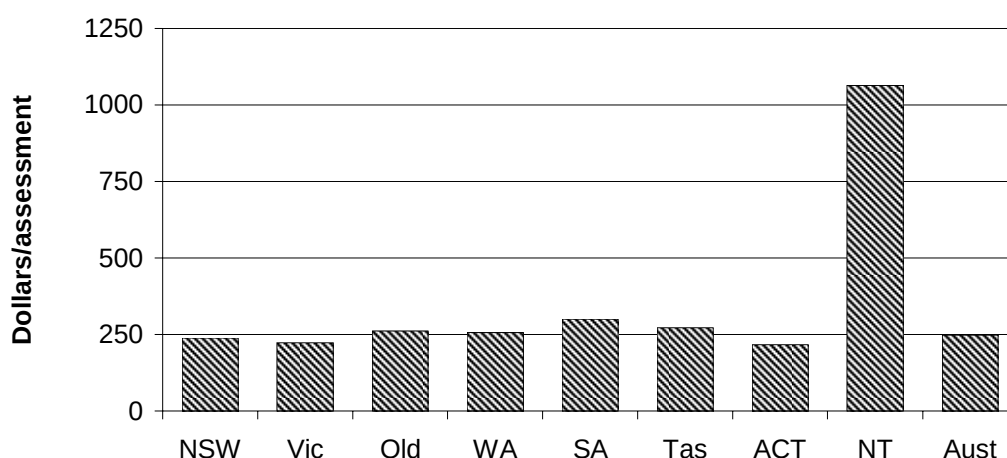
Box 12.19 Cost per output unit

A proxy efficiency indicator, 'cost per assessment', has been developed as work in progress in measuring efficiency for ACATs. It is defined as expenditure on ACATs divided by the number of ACAT assessments completed.

This indicator needs to be interpreted with care. While high or increasing expenditure per assessment may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as greater time spent with clients) or changes in the characteristics of clients (such as their geographic location). Similarly, low or declining expenditure per assessment may reflect improving efficiency or less time spent with clients (for example). States and territories also contribute to the cost of ACAT assessments and relative costs between jurisdictions may also reflect the impact of undertaking assessments in rural and remote areas.

Cost per aged care assessment during 2003-04 averaged \$248 nationally. The cost per assessment is calculated using the total number of assessments and also includes clients aged less than 70 years (figure 12.22).

Figure 12.22 Aged care assessment unit costs, 2003-04 (dollars)^{a, b, c}



^a Only includes Australian Government expenditure on ACAT. ^b ACAT referrals and operations vary across jurisdictions. ^c The high cost for each assessment in the NT may be influenced by the remoteness of people requiring assessments, clients having English as a second or third language, and a lack of supporting health and community services infrastructure to assist with assessments.

Source: DoHA (unpublished); Lincoln Centre for Ageing and Community Care Research (unpublished); table 12A.54.

Inputs per output unit — expenditure per head of target population

The indicator ‘expenditure per head of target population’ is included as an output indicator of efficiency (box 12.20).

Box 12.20 Expenditure per head of target population

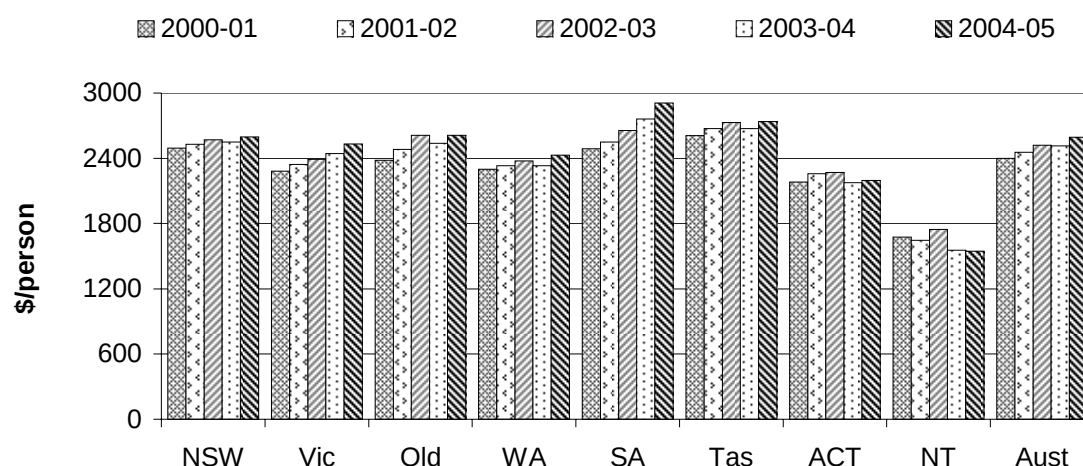
A proxy indicator of efficiency is ‘expenditure per head of target population’. It reflects the objective to ensure services for frail older people are provided efficiently. The indicator is defined as government inputs (expenditure) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years. Expenditure per person in the target population is reported for three main service types: residential services, CACP and HACC services.

This indicator needs to be interpreted with care. While high or increasing expenditure per person may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as better quality of services) or in the characteristics of clients receiving the service (such as their geographic location or level of care need). Similarly, low or declining expenditure per assessment may reflect improving efficiency or a decrease in service standards.

Australian Government expenditure (including expenditure by the DVA) on residential care services per person aged 70 years or over plus Indigenous people

aged 50–69 years increased nationally from \$2399 (in 2004-05 dollars) in 2000-01 to \$2593 in 2004-05. This figure varied across jurisdictions (figure 12.23).

Figure 12.23 Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2004-05 dollars)^{a, b}

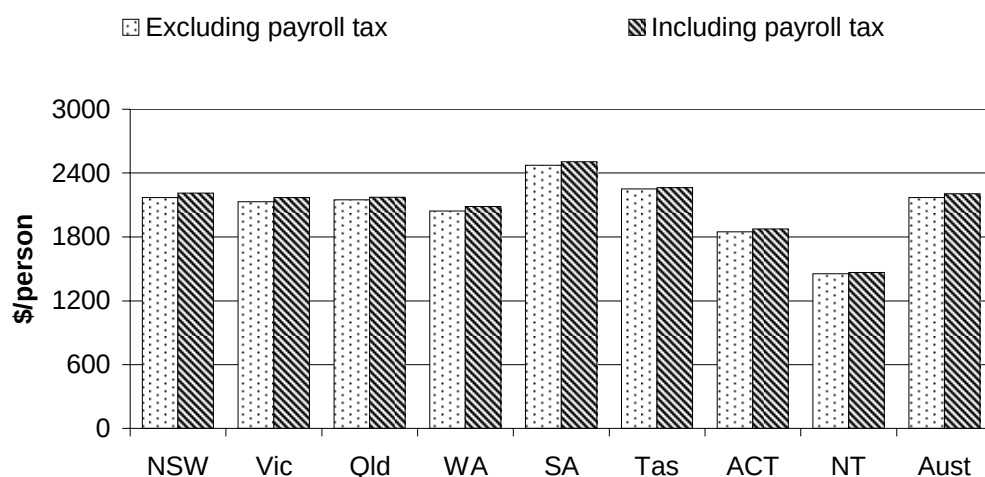


^a Includes payroll tax. ^b Includes expenditure by DVA.

Source: DoHA (unpublished); DVA (unpublished); table 12A.49.

Payroll tax has been separately identified in Australian Government expenditure. DoHA expenditure on residential aged care per person aged 70 or over plus Indigenous people aged 50–69 years was \$2206 nationally (including payroll tax) and \$2170 nationally (excluding payroll tax) in 2004-05. These rates varied across jurisdictions (figure 12.24). DVA expenditure on residential aged care in 2004-05 was \$750.3 million nationally (including payroll tax) and \$737.8 million (excluding payroll tax) (table 12A.44).

Figure 12.24 Australian Government (DoHA) expenditure on residential aged care, per person aged 70 years or over plus Indigenous people aged 50–69 years, 2004-05 (dollars)^a

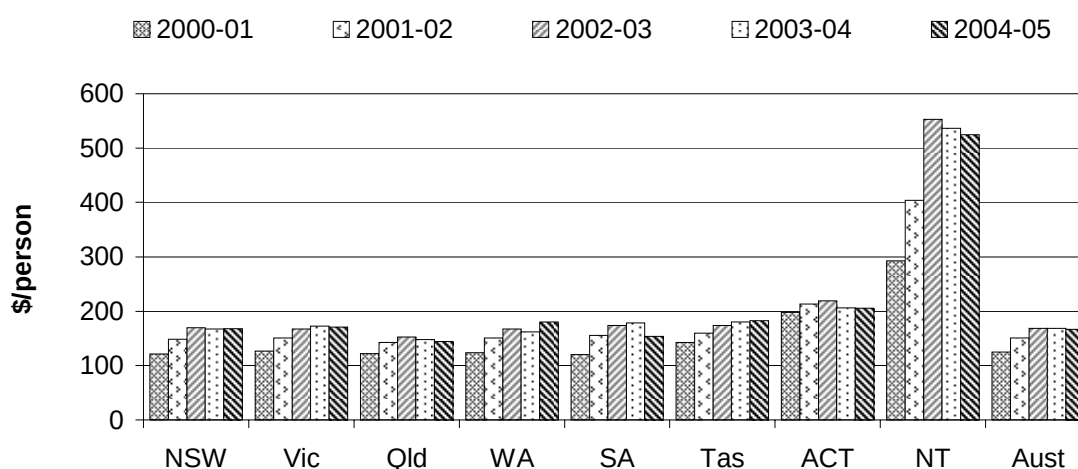


^a Data in this table exclude DVA expenditure on residential aged care.

Source: DoHA (unpublished); table 12A.48.

Australian Government expenditure on CACPs per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions in 2004-05. Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from \$125 (in 2004-05 dollars) in 2000-01 to \$167 in 2004-05 (figure 12.25).

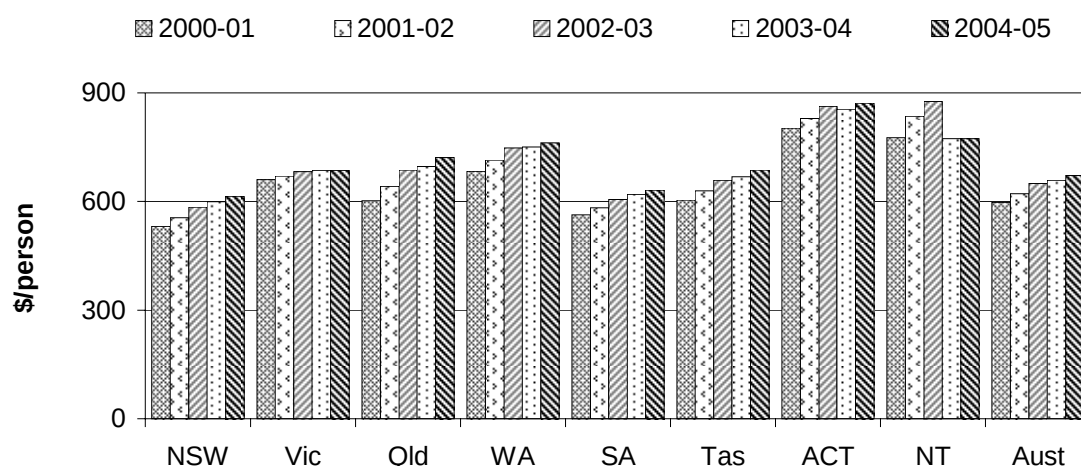
Figure 12.25 Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2004-05 dollars)



Source: DoHA (unpublished); table 12A.52.

Australian, State and Territory government expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions. Nationally, real expenditure increased from \$598 (in 2004-05 dollars) in 2000-01 to \$672 in 2004-05 (figure 12.26). These figures reflect expenditure against the population regarded as the proxy for this chapter (see page 12.3), which is not the same as the HACC target population. Expenditure per person in the HACC target population is reported in table 12A.50.

Figure 12.26 Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2004-05 dollars)^{a, b}



^a People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person and definition of the HACC target population is contained in table 12A.50.

^b This figure only represents expenditure under HACC Amending Agreements.

Source: DoHA (unpublished); table 12A.51.

Outcomes

Outcomes indicators have been identified this year for development and reporting in future (boxes 12.21, 12.22 and 12.23).

Social participation in the community

Box 12.21 Social participation in the community

'Social participation in the community' is an outcome indicator that measures the wellbeing and independence of frail older people. An indicator will be developed to show the extent to which older people participated in community, cultural or leisure activities. Higher rates of participation in the community are more desirable.

The Steering Committee has identified this indicator for development and reporting in future.

Maintenance of individual functioning

Box 12.22 Maintenance of individual functioning

'Maintenance of individual functioning' is an outcome indicator that reflects the objective for aged care services to promote the health, wellbeing and independence of frail older people. The indicator is defined as:

- maintenance of, or minimised decline in, residents' level of functioning reflected by a movement of clients to a higher level of need as indicated by a change in classification on the resident classification scale
- length of stay in residential care for a given level of frailty or age at entry.

The Steering Committee has identified this indicator for development and reporting in future.

Enabling people with care needs to live in the community

Box 12.23 Enabling people with care needs to live in the community

'Enabling people with care needs to live in the community' is an outcome indicator that reflects the objective of community care to delay entry to residential care and will measure levels of dependency on entry to residential care for those who have been receiving community care.

The Steering Committee has identified this indicator for development and reporting in future.

12.4 Future directions in performance reporting

For several aspects of aged care services, indicators are not fully developed and there is little performance reporting. Priorities for the future include:

- continued improvement of efficiency indicators, including for HACC services and assessment services
- further development of reporting of outcome indicators
- improved reporting of waiting times for residential aged care
- further work on reporting the indicator ‘long term aged care in public hospitals’
- improved reporting of State and Territory expenditure on residential aged care.

12.5 Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data about each jurisdiction that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

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In the 2004-05 Budget, the Australian Government responded to the report of Professor Warren Hogan's Review of Pricing Arrangements in Residential Aged Care by announcing the \$2.2 billion Investing in Australia's Aged Care: More Places, Better Care package. Of the 31 new measures, 24 were implemented by the end of 2004-05 and three more by 1 July 2005. Implementation of the remaining four is well advanced. The package is providing for expanded provision of care; additional recurrent and capital funding for aged care services; improved quality of care; workforce initiatives; streamlined administration; more support in rural and remote areas; and improvements to the hospital/aged care interface through Transition Care.

In consultation with the states and territories, the Australian Government is also implementing The Way Forward, a blueprint announced in May 2004 for the future of community care.

The 2005-06 Budget provided \$320.6 million over five years to make dementia an Australian Government National Health Priority and \$207.6 million over four years to provide carers with more access to respite services. It provides for important new initiatives to help improve the quality of care.

The 2005-06 Budget established a framework for consultation with the community and the aged care industry on the long-term future of aged care, in particular the remaining medium term recommendations and long term options from the Review of Pricing Arrangements in Residential Aged Care.

The views of the community and the aged care sector will help the Government consider the best options to increase care recipients' choice of services that will meet their needs and to strengthen the sector's long-term sustainability.

The Department of Veterans' Affairs held its second Veteran's Home Care (VHC) program Assessment Agency Forum in Melbourne on 17-18 May 2005. The Forum provided an opportunity for contracted VHC assessment agencies and representatives from other organisations to review the first four years of the program, share experiences and provide directions and improvements for the future.

The Forum proved to be an outstanding success, with the overwhelming majority of the 80 delegates expressing enthusiasm and appreciation for the significant achievements that the VHC program has made to date.

The Australian Government provided an additional \$52.4 million over four years during 2004-05 to enhance the VHC program. The funds have enabled the Department of Veterans' Affairs to increase the number of eligible Veterans and War Widowers/s receiving services from around 60 000 to 66 000 during 2004-05.

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New South Wales Government comments

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The NSW Government remains committed to assisting older people and their carers to maximise their independence and participation in community life, to promote their health and wellbeing, and to provide information and support to enable them to access appropriate services.

In 2004-05 NSW continued to expand the Home and Community Care (HACC) Program with the allocation of \$32 million in additional funding, bringing the total HACC budget to more than \$414 million. HACC services were expanded throughout NSW through the selection of providers to deliver \$23 million of additional services, with a continuing emphasis on basic support including domestic assistance, personal care, transport, social support and respite care. The NSW Government continues its commitment to examining and addressing the needs of older people in disadvantaged communities, including Aboriginal and Torres Strait Islander peoples, rural, culturally diverse and public housing communities.

To meet the needs of the rapidly increasing numbers of people living with dementia, NSW Health has allocated \$11 million over four years through its Future Directions for Dementia Care and Support in NSW (2001–2006). NSW Health is also the lead agency developing the National Framework for Action on Dementia (NFAD) as agreed by the Australian Health Ministers in January 2005. NSW Health has also committed \$12.9 million to a four-year NSW Carers Program in 2004 to provide practical information, training and support for carers, many of whom are older people. Area Health Service Carer Support Officers are increasing the responsiveness of health services to meet the needs of carers.

An ‘Older People Framework Forum: Celebrating Improvements’ Forum is being held on 30 November 2005 to enable NSW Area Health Services to report on improved practices and systems change under the umbrella of the NSW Health Framework for Integrated Support and Management of Older People in the NSW Health Care System (2004–2006).

NSW is implementing the Transitional Aged Care program on a jointly funded basis with the Australian Government. The transition care model for older people aims to help reduce hospital length of stay and readmission rates and the premature admission to long-term residential aged care. Another evolving initiative is the Sub-Acute Fast Track Elderly Care (SAFTE Care) program designed to provide interventions for frail older people with emerging crisis and acute care needs in the community, thereby avoiding hospital presentation and admission. NSW funding of \$4 million has been earmarked for this program to help meet the challenge of better integrating hospital aged care services, the hospital-community interface, general practice and community health services, so that older people receive the right care at the right time.

NSW has been actively engaged in COAG reforms during 2005 and continues to work with the Australian Government and other states and territories in activities associated with the Community Care Review.

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Victorian Government comments

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During 2004-05 Victoria emphasised innovation in responding to the aged care challenges particular to the context in the State. Victoria has long had an emphasis on community-based care with a comprehensive sub-acute and rehabilitation system supported by an especially strong community care sector. However, with people delaying entry to residential care for as long as possible, there is pressure to both improve community care responses and to support the provision of higher levels of residential care.

Victoria is adopting an 'active service model'; aiming to bring a more capacity focused and person centred approach to service delivery. It takes as its premise that the starting point needs to be promoting people's independence rather than expecting them to continue to be dependent. A number of elements support this approach including pilot projects that are being conducted and documented in support of the model.

The 'Well For Life' program has been introduced to assist residential care and HACC Planned Activity Group workers implement change aimed at improving physical activity and nutrition of frail older people. It is hoped that people will achieve greater independence in activities of daily living such as eating, personal care, and personal mobility. Forty-eight projects have been funded across Victoria and an independent support and evaluation program is being conducted.

An Innovation Fund has also been introduced to support HACC service providers to develop innovation in service delivery and explore ways to do business more efficiently.

Measures are also being introduced to bolster residential aged care provision — both in terms of facilitating the development of services and in supporting quality care.

Development and redevelopment of residential aged care in inner and middle ring suburbs of Melbourne is being limited by economic factors including the price of suitable land. The Government announced in the 'A Fairer Victoria' social policy statement that it would explore options to assist not-for-profit residential aged care operators to develop new services in areas of high need.

Initiatives to further develop quality residential care include a business performance improvement project, development of quality of care indicators and a resource kit to assist services in the implementation of the Australian Pharmaceutical Advisory Council (APAC) 'Guidelines for medication management in residential aged care facilities'.

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Queensland Government comments

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Queensland recognises that the preference for many older people and their carers is to live independently for as long as practicable and considers enabling people to act on that preference to be a key objective. Consumer and provider organisations support the need for a continuum of community care that enables older people to age in place with support increasing in direct proportion to need.

The Queensland Government achieves this through the HACC program, which is at the beginning of the aged care continuum, and is instrumental in helping older people to remain in their own homes. HACC is jointly funded by the Australian and Queensland Governments.

Planning for current and future generations has become essential as the Queensland population ages, with the number of older people expected to increase from 11.5 per cent in 2001 to more than 23 per cent in 2051.

Queensland has commenced implementation of Queensland Health's Directions for Aged Care 2004–2011. This document provides a clear vision to guide Queensland Health and its partners towards providing even better health and support services to older people. Funding has recently been provided to support a number of one-off initiatives based around improving care for older people, ranging from improved discharge planning, training for staff at aged care facilities through the Hospital in the Nursing Home program, to trialling aged assessments in regional areas through telehealth facilities.

Queensland Health presently owns and operates 21 aged care facilities. In line with the recommendations of the Action Plan: Building a better health service for Queensland, a 'case by case' review will determine Queensland Health's future involvement in each of these residential aged care homes.

Queensland Health has worked in close collaboration with the Australian Government to jointly fund and implement the new national Transition Care Program. This is a unique Program at the interface of the hospital and aged care sectors that will provide an opportunity for older people who are eligible to further improve their level of independence with therapy services and support services, for a period of up to 12 weeks. Transition care will also provide this group of clients additional time to consider their longer term care options.

Queensland welcomes the opportunity to work with the Australian Government and all State and Territory jurisdictions to continue the development of a new HACC Amending Agreement and to improve the delivery of aged care services in Australia through the review of the Community Care Sector.

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Western Australian Government comments

“ Western Australia’s approach to programs and services for older people continues to be predicated on the vision of ‘independence, well-being and quality of life for older people through responsive health and aged care services and supports’ as articulated in the State Aged Care Plan for Western Australia 2003–2008. In line with the preference of older people to remain in their own homes for as long as possible, independence-promoting service models are a continuing focus for the Home and Community Care (HACC) program. These service models utilise multidisciplinary teams to deliver short-term packages of therapy-based care for clients assessed as being able and willing to improve/maintain their health status and functioning.

The *Carers’ Recognition Act 2004 (WA)*, formally recognising carers as key partners in the delivery of care, came into effect on 1 January 2005. The Act establishes a Carers’ Charter and provides a framework for involving carers in the assessment, planning and delivery of services. The HACC program will be promoting the Carers’ Charter across all HACC provider organisations and assisting them in fulfilling the requirements of the charter.

In a collaborative initiative with Carers WA, the HACC program is supporting a ‘Prepare to Care’ project run by Carers WA, which operates at the acute and community care interface. Carer Support officers work with hospital staff and family members to ensure ‘new’ carers are equipped to care for family members after discharge and have access to appropriate community-based services. Another recent focus of the HACC program is support for the establishment of the Alliance for the Prevention of Elder Abuse: WA to promote a whole-of-government policy framework that supports the rights of older people.

Western Australia continues to develop and refine its model of transition care for older people. The Transitional Care Service (TCS), providing a flexible model of care for older people at risk of premature admission to long-term services, provides short-term rehabilitation and support services either in the client’s home/hostel or temporarily in a residential aged care facility. Since the service began in November 2002, until 30 September 2005, 60 per cent of discharged clients returned home, with or without aged care support services. In February 2005, the Intermittent Care Service (ICS), a joint Australian Government and State program similar to the TCS, commenced. With a rehabilitative focus, the ICS provides short-term, flexible care options at the acute/subacute and residential care interface. It aims to reduce inappropriate extended hospital length of stay and premature admission to residential care.

In response to the national Transition Care Program announced by the Australian Government in the 2004-05 budget, Western Australia has developed a Transition Care Program Implementation Plan, which proposes to mainstream both the TCS and the recently commenced ICS pilot programs. Using efficiencies in the system, the intention is to further expand the community aspects of the program into selected rural areas.

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South Australian Government comments

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The South Australian Government again fully matched the Australian Government growth offer for HACC in 2004-05, and has demonstrated its commitment to community care in planning for growth in HACC in the forward estimates.

Although the South Australian population is ageing more rapidly than the Australian population as a whole, HACC expenditure per person aged 70 years and over has been lower than the national average. The outcome of targeting HACC growth to frail older people over the last years is starting to be reflected in the data. Priority has been for people requiring low levels of care, especially those who live alone or are otherwise isolated, and for those people who have unstable accommodation arrangements, who age prematurely, or are in other ways vulnerable.

HACC services for people from culturally and linguistically diverse backgrounds continue to be fostered. Each year there have been more ethnic community organisations supported to provide services to their senior members.

Funding for Indigenous specific services has been maintained following concerted endeavours to establish services from the mid 1990s. The emphasis is increasingly on skills development for Aboriginal staff, and improving service delivery arrangements as required. Each year, two Indigenous HACC Workforce Forums are held for staff to network, share information and pursue training identified as needed across agencies.

In 2005, a Carer Support Project was conducted to better understand the current distribution and models of service. This will inform future developments for carer support, including in 2005-06.

The pilot Home Rehabilitation and Support Service was completed in June 2005. An on-going Transition Care Program is now jointly funded by the South Australian and Australian Governments to facilitate the transition of older people from acute care to more appropriate community options.

As the general population in South Australia has aged more quickly than for the nation as a whole, so too has the disabled population. This has provided an opportunity for the State and Australian Governments to explore innovative ways of supporting this group. Disability and aged care providers have come together to develop an 'Interlink' approach. The projects aim to support the increasing needs of people with disabilities which are due to their ageing. HACC and Innovative Pool funding are used respectively to top-up CSTDA funding, for people with lower and higher needs.

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Tasmanian Government comments

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The State Government has recognised the challenges facing the State's health and community services, which include the need to maintain the highest standards of client care in the face of the ageing of the population and increasing costs of new health technologies and recruiting and retaining specialist staff. The Government also acknowledges that pressures may be greater in Tasmania because the State's population is ageing more rapidly than the rest of Australia, and because of the difficulties in servicing a dispersed population with the resulting diseconomies of scale.

Under the Better Hospitals Package a new 42 bed Transitional Care Unit is being established to complement the State's Extended Rehabilitation Service. Additional investment has also been made in mental health; rural health; disability services; elective surgery; health workforce; ambulance services; and social housing.

The Tasmanian Department of Health and Human Services has identified Caring for Ageing Tasmanians as a high priority and will continue to invest significant effort in developing and improving a service system that deals with aged care needs in a flexible, fair and coordinated way.

Following a review of Community Options Services in the State, the service has been restructured and expanded. It is anticipated that a tripartite partnership agreement on population ageing, involving the Australian, Tasmanian and Local Governments, and aimed at addressing a range of specific aged care issues, will be implemented in 2006.

Tasmania is currently reviewing its Dementia Care Plan, with the aim that the updated plan will be consistent with and complement the National Framework for Action on Dementia 2006–2010. The State's Seniors Bureau is also reviewing and updating the Tasmanian Plan for Positive Ageing.

The State Government is keen to work with the Australian Government on programs that address the needs of an ageing population, particularly in those areas at the interface between health services and aged care services.

The Pathways Home Program, Community Care Reforms, Transition Care Program and the new Home and Community Care Agreement will have significant implications for the State. Implementation of these programs needs to complement the State Government's health service reforms to ensure continuing and appropriate support and care are provided to Tasmania's ageing and regionally dispersed population.

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Australian Capital Territory Government comments

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The ACT Government has undertaken a number of initiatives to support older Canberrans. Under the Transition Care Program, ACT Health has successfully applied to the Australian Government to receive 10 transition care places in 2005-06. These places will be jointly funded by the ACT and Australian Government and will provide additional support for older people leaving hospital to increase their level of physical functioning. In July 2006, the 25 Intermittent Care Service pilot places, which began in January 2005, will also become part of the Transition Care Program, resulting in 35 transition care places.

The ACT Government has also committed to construct a 40 bed rehabilitation/convalescent service and 20 bed psychogeriatric facility at Calvary Hospital. This service will provide improved sub acute care for patients in need and where appropriate aid their transition back to independent living. Initially proposed construction dates have been extended. Architectural plans are now being finalised and construction will commence in early 2006.

In an Australian first, the ACT and Australian Governments collaborated to allocate aged care beds to a particular site. This will result in the establishment of a further 100-bed aged care complex that will also include 150 self-care/independent living units, and will be developed on the banks of Lake Ginninderra in Belconnen. This proposal will include 40 high and 60 low aged care places. Illawarra Retirement Trust has been selected to purchase and develop the site.

The ACT Government has approved an application from Calvary Hospital for an aged care complex consisting of a 100-bed aged care facility providing low, high and dementia care and 78 independent living units, 30 of which will be apartment style dwellings. The ACT Government has also approved the redevelopment of the Goodwin Aged Care facility in Ainslie, which includes a 108-bed residential aged care facility and 148 aged persons units.

The Elder Abuse Prevention Information Line has been actively promoted in the media and is receiving general enquiries as well as requests for assistance or referral to appropriate supports.

To improve the coordination and investigation of complaints, relating to older people in aged care homes in particular, a Memorandum of Understanding was signed on 28 June 2005 between the Secretary of the Department of Health and Ageing and the ACT Community and Health Services Complaints Commissioner.

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Northern Territory Government comments

“ Compared to other jurisdictions, the Northern Territory has unique socio-economic and environmental factors that necessitate flexible and creative ways of delivering specialist aged and community care services. These factors include relatively a younger population, a high proportion (30 per cent) of Aboriginal and Torres Strait Islander population, many of whom live in remote or very remote communities, and an environment as diverse as desert and wet tropics.

Free-standing, mainstream and traditional aged care service models are often not suitable, or viable or sustainable in remote Indigenous communities. It is for these reasons that the Northern Territory continued to provide aged care services through pooled resources across a range of health and community services sources.

The ‘trans-disciplinary’ approach to Allied Health service delivery was further expanded to assist more remote residents. Regular scheduled and agreed service visits by Allied Health and other Aged and Disability teams to rural and remote communities throughout the NT were conducted. These initiatives arose from the NT Government’s policy of supporting people in their home communities and strong commitment to also increasing the level of services available to remote communities.

Other initiatives maximise community participation and independence of senior Territorians, including the provision of concessions and subsidies related to costs associated with essential services and utilities; professional support services such as assessment, case management and community support for frail older people; expansion of HACC services to more Indigenous remote communities; the roll out of new respite services for older carers; a Darwin-based transitional care service; and the Aged Care Innovative Pool pilot. The Northern Territory Government is also planning to implement a ‘Return To Home’ Project, which coordinates the return of older people to their homes and community from hospital, through the provision of an intensive short term care package.

As noted in earlier reports, the NT potential population estimates need to be interpreted with caution. The small NT population yields a small sample size, and subsequently a high standard error.

The NT is committed to support national strategies to improve data collection and reporting particularly in relation Indigenous and rural and remote residents.

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12.6 Appendix: Age standardisation of aged care data

How age profiles can distort observed service usage patterns

The age profile of Australians varies across jurisdictions and across different cultural and linguistic backgrounds (see for example the different age profiles of Indigenous and non-Indigenous Australians — figure 12.7). Variations in age profiles are important because the likelihood of needing aged care services increases with age (figure 12.13). As a result, observed differences in service usage rates by different cohorts within the community may arise from different age profiles, rather than from different usage patterns. One method of eliminating this distortion from the data is to standardise for the age profiles of different groups.

Method of standardisation

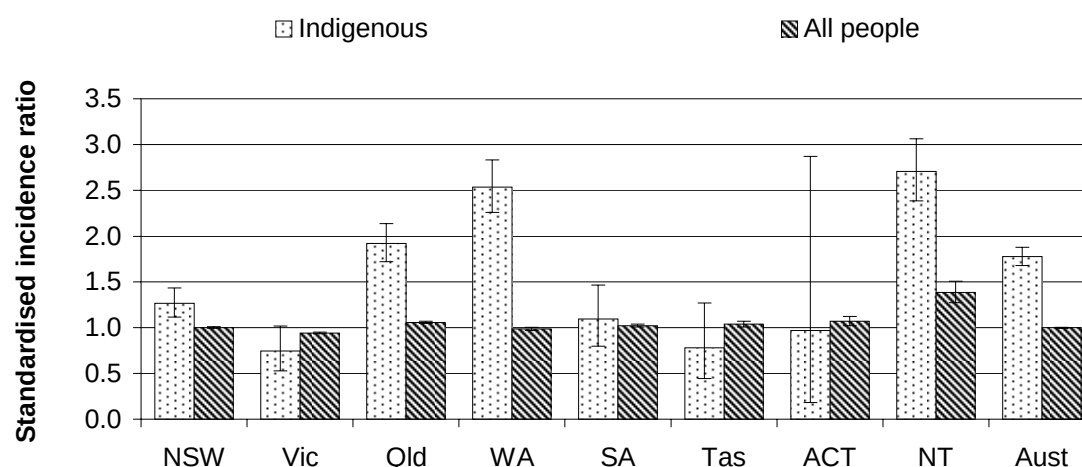
Either direct or indirect standardisation can be used. Indirect standardisation is presented here because it is more appropriate when comparing small populations. This method applies standard age-specific usage rates (in this case, average Australian rates) to actual populations (different groups within states and territories), and compares observed numbers of clients with the numbers that would have been expected if average rates had applied. Comparisons are made via the standardised incidence ratio. A value greater than 1.0 in this ratio means that use is higher than would be expected if the particular group had the same usage rate as that of the Australian population as a whole. A value below 1.0 means use is lower than expected. Age standardisation generally covers use by all age groups, so the resulting standardised incidence ratios compare use by complete population groups, not just by those aged 70 years or over.

Application of indirect standardisation

In the following illustration, 2001 data are used. Within each State and Territory, the combined use of permanent residential aged care and CACPs by Indigenous people is compared with average service use by all Australians. The resulting standardised incidence ratios are presented in figure 12.27. The error bars in the figure show how accurate the comparisons are—if an error bar goes across the value of 1.0, then the usage rate by that population group is not significantly different from the average use by all Australians. People (Indigenous people in particular) also use long stay hospital beds, flexible places and other services not covered in the analysis, and consequently, these results do not represent all the available services.

Figure 12.27 shows that Indigenous people had a higher than average combined use of CACPs and permanent residential aged care — nationally, about 80 per cent higher. This result reflects the higher age-specific usage rates of CACPs for Indigenous people at all ages, and of permanent residential aged care for those Indigenous people aged under 75 years (table 12.10). Results vary across jurisdictions. The combined use of the services is not significantly different from the national average for Indigenous people in Victoria, SA, Tasmania and the ACT, but is higher than the average in other jurisdictions.

Figure 12.27 **Standardised incidence ratio for use of CACP and permanent residential aged care (combined), 30 June 2001^{a, b, c}**



^a The Indigenous ratio is per 1000 Indigenous people aged 50 or over, the all people ratio is per 1000 Indigenous people aged 50 or over and non-Indigenous people aged 70 or over ^b The calculations use indirect age standardisation against use by all people Australia-wide. ^c ACT data are based on a very small Indigenous population and have high standard errors.

Source: AIHW (unpublished); table 12A.55.

Table 12.10 **Age-specific usage rates of CACPs and permanent residential aged care (per 1000 people), 30 June 2001^{a, b}**

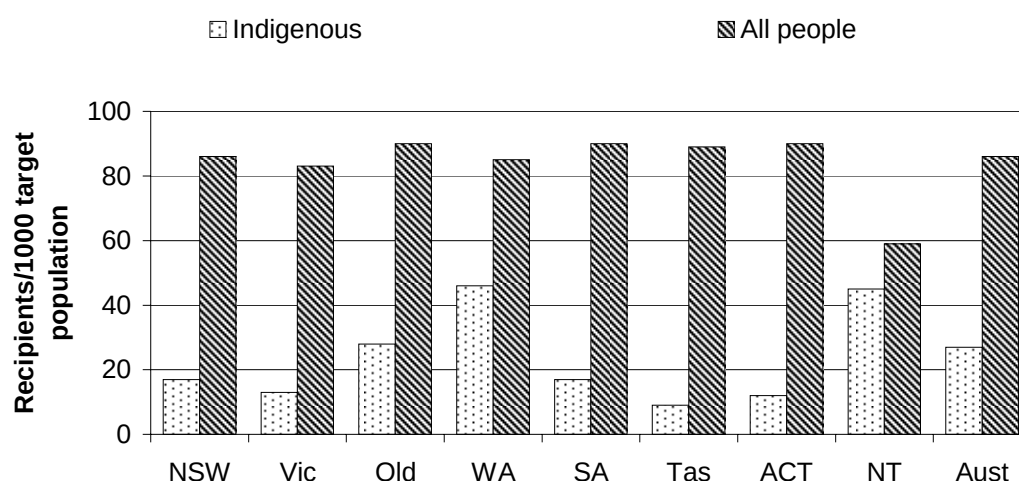
Age (years)	CACP recipients		Permanent aged care residents	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
50–54	1.7	0.1	3.3	0.7
55–59	4.1	0.3	4.2	1.4
60–64	8.6	0.7	9.5	2.9
65–69	16.3	1.5	11.4	6.1
70–74	30.1	3.2	25.2	14.5
75–79	33.7	7.1	66.3	35.3
80+	36.7	20.7	116.3	160.8

^a Excludes clients of multipurpose and flexible services. ^b Cases with missing data on Indigenous status have been pro rated within gender/age groups.

Source: AIHW (unpublished).

The age standardised rates are quite different from those that will result from comparing use with the target group population (clients per 1000 in the target group). The target group measure (figure 12.28) suggest that combined use of CACPs and permanent residential aged care is much lower for Indigenous people than for all people in all jurisdictions. Figure 12.28 also suggests that combined use of the two services is generally much lower in the NT than in other jurisdictions; this difference is not apparent after age standardisation (figure 12.28), indicating that the difference in this measure is the result of the relatively young age structure of the NT (even within the two subgroups of people 70 years and over and Indigenous people 50 years and over).

Figure 12.28 **Ratio of CACP recipients and permanent residents (combined) to 1000 persons in target population, 30 June 2001^a**



^a Indigenous ratio is per 1000 Indigenous people aged 50 years or over, 'all people' ratio is per 1000 Indigenous people aged 50 years or over and non-Indigenous people aged 70 years or over.

Source: AIHW (unpublished); table 12A.55.

Age-specific usage rates prepared for the 2006 Report

Preparation of age-specific usage rates is a necessary requirement before any age standardisation, either direct or indirect, can be undertaken. The 2006 Report includes some age specific usage rates per 1000 persons, against the following categories of data for 30 June 2004:

- permanent aged care residents, (both high care and low care); CACP; and EACH, by jurisdiction and by remoteness. These are also provided as total figures for the three services. These are each broken down into male, female and all persons across six age ranges.

- the total of Indigenous permanent aged care residents (both high and low care) and CACP, by remoteness. These data are broken down into male, female and all persons across five age ranges.

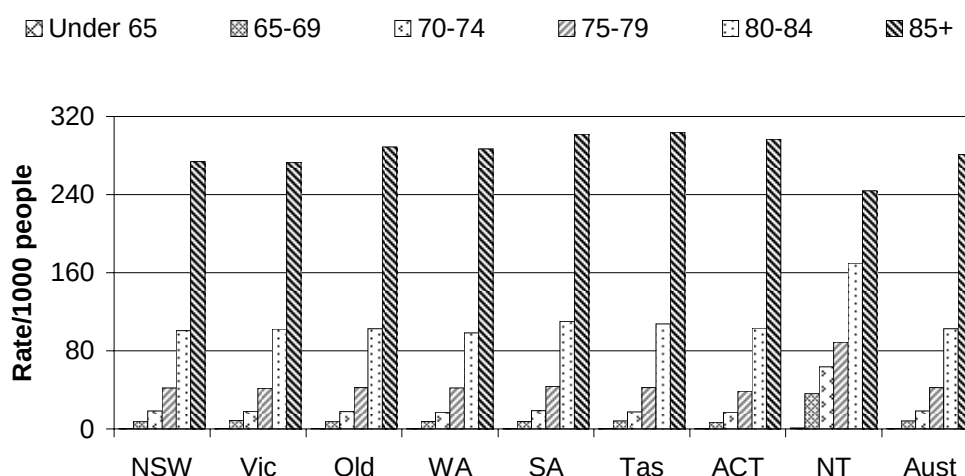
These data are included in tables 12A.58–12A.64.

Presentation of age-specific usage rates raises particular data issues which would have further implications for age standardisation, if undertaken. In particular, if the numbers of people within a particular range for a given service are small, this may lead to instability in the data and the possibility of data which do not provide meaningful information. This can be seen from some of the usage rates identified for the EACH program, which, whilst growing rapidly, is doing so from a relatively small base and is likely to fluctuate in future before stabilising.

The development of age-specific usage rates has intrinsic value, as a snapshot or when mapped over time. The data included in the 2006 Report provide some insights into these issues and identify some significant variations in rates between jurisdictions and remoteness areas.

The national age specific usage rates per 1000 persons for high and low residential care, CACP and EACH in combination at 30 June 2004 is 0.5 for people under 65 rising to 280.9 for people over 85. These rates vary across jurisdictions (figure 12.29).

Figure 12.29 Permanent aged care residents, CACP and EACH recipients at 30 June 2004: age specific usage rates per 1000 persons by jurisdiction a, b

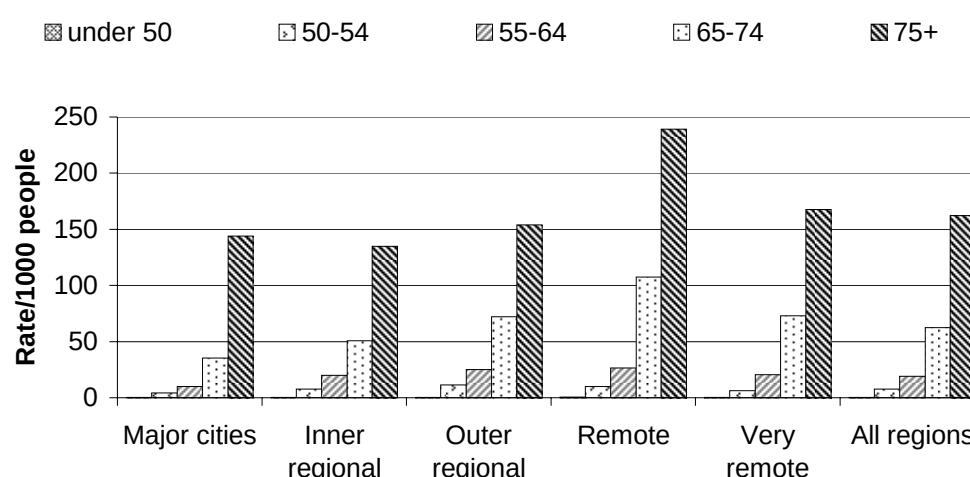


a Data based on AIHW analysis of the DoHA Australian Community Care Management Information System (ACCMIS) database and ABS population data. **b** Residents without a recorded RCS were omitted.

Source: AIHW (unpublished); table 12A.60.

The national age specific usage rates per 1000 Indigenous persons for high and low residential care and CACP in combination at 30 June 2004 is 0.3 for people under 50 rising to 162.3 for people over 75. These rates vary by remoteness category (figure 12.30).

Figure 12.30 Indigenous permanent residents classified as high or low care and Indigenous CACP at 30 June 2004: age specific usage rates per 1000 persons by remoteness^{a, b}



^a Data based on AIHW analysis of the DoHA ACCMIS database and ABS data. The Australian Standard Geographical Classification (ASGC) population figures for the Indigenous population at 30 June 2004 were derived by the AIHW from the 2001 Census ASGC data and the experimental estimates and projections of the Indigenous population which includes age and sex breakdowns by states and territories. ^b Residents without a recorded RCS were omitted.

Source: AIHW (unpublished); table 12A.64.

12.7 Definitions of key terms and indicators

Adjusted subsidy reduction supplement	Payments made to equalise the recurrent funding paid by the Australian Government as adjusted subsidy reduction places to public sector residential care operators. The states and territories provide top-up funding for residential aged care places at a rate set by the Department of Health and Ageing from 1 July each year.
Aged care	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. The majority of aged care services assist in activities of daily living such as personal care (for example, bathing and dressing), housekeeping and meal provision, and are delivered by trained aged care workers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists. These services generally aim to maintain function rather than treat illness or rehabilitate, and are distinguished from the health services described in Part E of this Report. Assessment of care needs is also an important component of aged care. Aged care services may be funded through programs specifically or mainly directed to older people, or through programs that address the needs of people of different ages. Generally, the target groups of aged care services are people over the age of 70 years and Indigenous people aged over 50 years.
Ageing in place in residential care	An approach that aims to provide residents with appropriate care and increased choice by allowing them to remain in the same facility regardless of changes in their level of care needs. It also allows couples with different levels of care needs to be cared for in the same facility. The main facet of 'ageing in place' is that funding is tied to the assessed care needs of the client rather than to the services provided by the facility. One of the objectives of Australian Government aged care legislation is 'to promote ageing in place through the linking of care and support services to the places where older people prefer to live' (<i>Aged Care Act 1997</i> (Cwlth), s.2-1 [1j]).
Centre day care	Respite care provided from a facility such as a day care or health centre. Respite care is usually combined with social support services to maintain the functional capabilities of the person receiving care.
Complaint	A complaint by the affected care recipient or his or her representative, or anyone else, to the Secretary about anything that: • may be a breach of the relevant approved provider's responsibilities under the <i>Aged Care Act 1997</i> or the Aged Care Principles • the complainant thinks is unfair or makes the affected care recipient dissatisfied with the service.

Disability	A limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.
EBA supplement	Payments made to supplement services for the extra costs associated with public sector enterprise bargaining agreements over and above those required by other wage Awards.
Elapsed time between ACAT approval and entry into a residential care service	The measure of the elapsed time between ACAT approval and entry into a residential care service. It has been used in past years as an indicator of access to residential care.
High/low care recipient	Recipient of a high level of residential care (that is, a level to RCS levels 1–4) or a recipient of a low level of residential care (that is, a level corresponding to RCS levels 5–8). If the person is approved as a recipient of a high level of care, that person can receive care at any care classification level (<i>Approval of Care Recipients Principles 1997</i> , s.5-9). A person approved as a recipient of a low level of care can be classified only as RCS 5–8 (<i>Classification Principles 1997</i> , s.9-19).
In-home respite	A short term alternative for usual care.
People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Where a person does not need assistance, but has difficulty with self care, mobility or communication.
People with a profound disability	Where a person is unable to perform self-care, mobility and/or communication tasks, or always needs assistance.
People with a severe disability	Where a person sometimes needs assistance with self-care, mobility or communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing).
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (<i>Aged Care Act 1997</i> (Cwlth)); also refers to 'beds' (<i>Aged Care (Consequential Provisions) Act 1997</i> (Cwlth), s.16).
Real expenditure	Actual expenditure adjusted for changes in prices, using the GDP(E) price deflator and expressed in terms of final year prices.
Resident	For the purposes of the <i>Aged Care Act 1997</i> , a person who is being provided with residential care through an aged care service conducted by an approved provider under the Act.
Respite care	Alternative care arrangements for dependent people living in the community, with the primary purpose of giving their carer a short term break from their usual caring commitments.
Rural small nursing home supplement	Payments made by states and territories to small sized high care public sector residential aged care facilities (up to 30 places) that are located in rural areas. Three levels of supplement are paid to facilities varying in size from 10 to 20 and 30 places.
Special needs groups	Section 11-3 of the <i>Aged Care Act</i> , specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from non-English speaking countries; people who live in rural or remote areas; and people who are financially or socially disadvantaged. Principles (Regulations) made under s. 11-3 also specify veterans as a special needs group.

Veterans

Veterans, their war widows, widowers and dependents who are eligible for treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlements Act 1986* (Cwlth).

12.8 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2006\Attach12A.xls and in Adobe PDF format as \Publications\Reports\2006\Attach12A.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

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Table 12A.65	HACC National Service Standards appraisals - results of appraisals

12.9 References

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13 Services for people with a disability

The Australian, State and Territory governments aim to maximise opportunities for people with a disability to participate actively in the community, by providing services and support for people with a disability, their families and carers. A definition of disability is provided in box 13.1.

The Commonwealth State/Territory Disability Agreement (CSTDA), which applies to the period 1 July 2002 to 30 June 2007, forms the basis for the provision and funding of specialist services for people with a disability who require ongoing or long term episodic support.

This chapter focuses on services covered by the CSTDA, examining the performance of the Australian, State and Territory governments in providing services and supports for people with a disability where the disability manifests before the age of 65 years. Specialist psychiatric disability services are excluded to improve data comparability.

Services for people with a disability can be grouped into income support, disability support services and relevant generic services provided to the community as a whole. The Review of Government Service Provision generally does not report information on income support. Disability support services are primarily delivered under the CSTDA, as well as through programs such as Home and Community Care (HACC). The HACC program aims to prevent inappropriate or premature admission to residential care by providing basic maintenance and support services to frail older people, younger people with a disability, and their carers. An estimated 68.2 per cent of HACC clients in 2004-05 were aged 70 years or over, while 31.8 per cent were aged under 70 years (table 12A.33). Performance information on the HACC program is provided in the 'Aged care services' chapter (chapter 12).

Box 13.1 Definition of disability

Disability is conceptualised as being a multidimensional experience for the person involved, relating to body functions and structures, activities, and the life areas in which the person participates (WHO 2001). The International Classification of Functioning, Disability and Health also recognises the role of physical and social environmental factors in affecting disability.

The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers was conducted in 1981, 1988, 1993, 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 CSTDA (2003, p. 9) defines people with disabilities who are eligible for CSTDA funded services:

People with disabilities attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is likely to be permanent and results in substantially reduced capacity in at least one of the following:

- self-care/management
- mobility
- communication

requiring significant ongoing and/or long term episodic support and which manifests itself before the age of 65.

Source: ABS (2004a); WHO (2001); CSTDA (2003).

Some mainstream services provided to the community as a whole — for example, vocational education and training (VET), school education, public hospital care, specialised mental health services and public housing — are covered elsewhere in this Report (box 13.2). Other mainstream services provided to people with a

disability — such as transport and utility services at concessional rates — are outside the scope of this Report.

Box 13.2 Other disability reporting in the 2006 Report

‘School education’ (chapter 3) reports data on students with a disability in the student body mix.

‘Vocational education and training’ (chapter 4) reports the proportion of government funded VET students who are identified as having a disability, and the load pass rates of VET students who are identified as having a disability.

‘Health management issues’ (chapter 11) reports performance data on specialised mental health services.

The ‘Community services preface’ (section F) reports data on recurrent expenditure on services for people with a disability.

‘Aged care services’ (chapter 12) reports data on HACC services received, including those received by people with a profound, severe or moderate core activity limitation, disaggregated by jurisdiction and geographic location.

‘Children’s services’ (chapter 14) reports data on the representation of children with a disability in Australian Government approved child care and in State and Territory government funded and/or provided preschool.

‘Housing’ (chapter 16) reports data on access to public, community and State owned and managed Indigenous housing by special needs households, which include households that have at least one member with a disability. Also reported are Disability Support Pension recipients by the proportion of their income spent on rent with and without Commonwealth Rent Assistance.

Significant improvements in the reporting of services for people with a disability in this Report are:

- reporting data on community access services against the ‘service use by severity of disability’ indicator
- reporting data by special needs groups against the ‘labour force participation and employment’ outcome indicator
- inclusion of CSTDA National Minimum Data Set (NMDS) service user data collected over a whole year (2003-04 data) — this is an improvement over the six months of data (from 1 January 2003 to 30 June 2003) for 2002-03 included in last year’s report and the data for previous reports sourced from the Commonwealth/State Disability Agreement (CSDA) Minimum Data Set (MDS) snapshot day collections.

This Report also includes 2004-05 expenditure data provided by jurisdictions. However, efficiency indicators (cost per service user) are reported for 2003-04, because 2004-05 service user data from the CSTDA NMDS collection were not available for this Report. Service user data from the CSTDA NMDS collection are also published in the following Australian Institute of Health and Welfare (AIHW) reports: *Disability Support Services 2003-04: National Data on Services Provided under the Commonwealth State/Territory Disability Agreement* (2005a) and *CSTDA NMDS Tables Prepared for the CSTDA Annual Public Report 2003-04* (2005b). There are also other reports that include these data for example, the National Disability Administrators' (NDA) *CSTDA Annual Public Report 2003-04*.

Social participation, labour force participation and employment rate data for 2003 are reported for all jurisdictions (except the NT). For WA, 2004 social participation and client/carer satisfaction data are also included. Information on quality assurance processes for providers of specialist disability services in 2004-05 are available for four jurisdictions — the Australian Government, Victoria, WA and Tasmania.

A profile of services for people with a disability provided under the CSTDA appears in section 13.1. All jurisdictions have developed and agreed to report against comparable performance indicators. A framework of performance indicators is outlined in section 13.2. The performance of jurisdictions is discussed in section 13.3 and future directions for performance reporting are discussed in section 13.4. Section 13.5 contains jurisdictions' comments and section 13.6 provides definitions of the data descriptors and indicators. Section 13.7 lists the supporting tables for this chapter. Supporting tables are identified in references throughout the chapter by an 'A' suffix (for example, table 13A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Section 13.8 lists references used in this chapter.

13.1 Profile of specialist disability services

Service overview

The Australian, State and Territory governments fund both government provided and non-government provided services for people with a disability. Mechanisms for the funding and delivery of specialist disability services differ across jurisdictions as a result of policy differences and other factors described in the statistical appendix (see appendix A). Under the CSTDA, the Australian Government administers employment services, and the State and Territory governments administer accommodation support, community access, community support and respite care

services. Advocacy, information, print disability and research and development services are jointly administered by the Australian, State and Territory governments. Details of these services are outlined below.

Roles and responsibilities

The CSTDA defines the roles and responsibilities of the Australian, State and Territory governments in the provision of specialist disability services to people with a disability. Specialist disability services are defined under the CSTDA as services that are specially designed from time to time to meet the needs of people with a disability. The third national agreement, the CSTDA, is effective from 1 July 2002 to 30 June 2007. Its agreed purposes are listed in box 13.3.

Box 13.3 The purposes of the CSTDA

The purposes of the CSTDA are to:

- provide a national framework to underpin the provision of specialist disability services across Australia, and outline a means for measuring and publicising the progress of governments towards achieving this national framework
- outline the respective and collective roles and responsibilities of governments in the planning, policy setting and management of specialist disability services
- provide for accountability to funders in respect of funds contributed by one government which are expended by another government
- establish the financial arrangements for making funds available for the provision of specialist disability services
- define the persons eligible for services under this Agreement and acknowledge they may require services provided outside the Agreement
- provide for a nationally consistent approach to quality across specialist disability services
- provide for funds to address key national and strategic research, development and innovation priorities.

Source: CSTDA (2003).

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

-
- open and supported employment services that provide 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 (attendant care and in-home support)
- 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. They include learning and life skills development and recreation/holiday programs
- community support services that help people with a disability to integrate and participate in the community, and include case management, counselling, early intervention therapy and other therapy services
- respite care services that provide relief or support (for limited periods) to families and carers of people with a disability who are living in the community.

Australian, State and Territory governments share administration of 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 services that undertake research projects relating to:
 - the provision of services funded under the CSTDA
 - the achievement of the national framework, under the CSTDA for people with a disability.

The CSTDA does not apply to the provision of:

- disability services and activities provided under the *Veterans' Entitlements Act 1986* (Cwlth)
- services with a specialist clinical focus, regardless of whether those services are provided to people eligible to receive other services under this agreement.

Family and friends meet most needs of people with a disability. In 2003, an estimated 474 600 primary carers provided the majority of informal help with self-care, mobility and communication for people with a disability — an increase of 5.3 per cent on the number in 1998 (ABS 1999, 2004a). Recognising the cost of providing such informal support, the Australian Government provides income support in the form of the Carer Payment and other financial assistance through the Carer Allowance to carers of people with a disability (box 13.4). This financial assistance is not included under the CSTDA funding arrangements.

Accommodation support, community access, community support and respite services provided under the CSTDA in 2003-04 had 125 709 service users (excluding users who received specialist psychiatric disability services only) (table 13A.1). Employment services provided under the CSTDA in 2003-04 had 64 281 service users (table 13A.1).

Box 13.4 Australian Government supplementary and income support arrangements

The Australian Government funds payments for people with a disability, those caring for people with a disability and those temporarily incapacitated from work as a result of illness. These payments include the Disability Support Pension, the Carer Payment, the Carer Allowance, the Sickness Allowance and the Mobility Allowance. Outlays on payments to people with a disability in 2004-05 (on an accrual basis) amounted to \$7.9 billion for the Disability Support Pension, \$1.1 billion for the Carer Payment (includes expenditure on carer bonus), \$1.1 billion for the Carer Allowance (includes expenditure on carer bonus), \$89.4 million for the Sickness Allowance and \$85.6 million for the Mobility Allowance (Department of Family and Community Services [DFaCS] [unpublished] and Department of Employment and Workplace Relations [DEWR] [unpublished]). These income support arrangements do not constitute a CSTDA service.

At 30 June 2005, there were 706 782 recipients of the Disability Support Pension, 95 446 recipients of the Carer Payment, 357 078 recipients of the Carer Allowance, and 49 215 recipients of the Mobility Allowance. There were also 8367 recipients of the Sickness Allowance (table 13A.2).

Source: DFaCS (unpublished); DEWR (unpublished); table 13A.2.

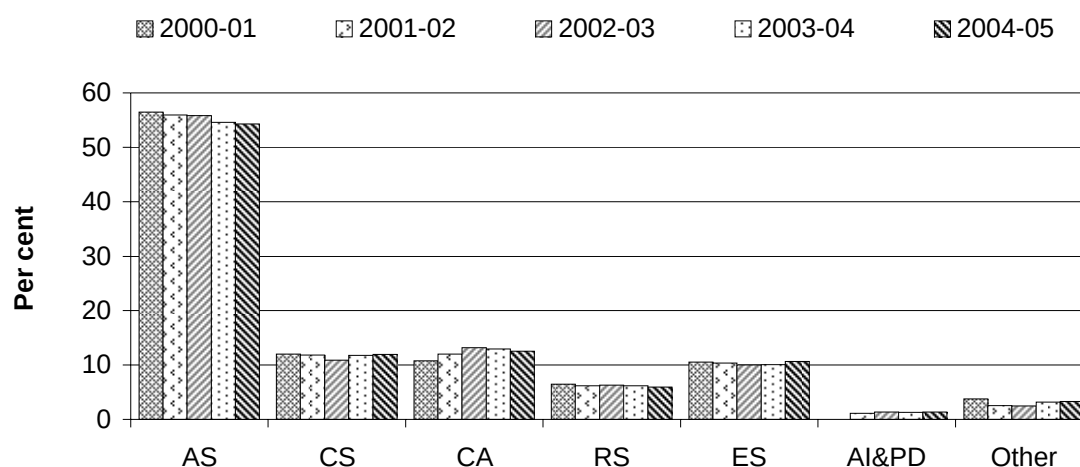
Funding

Both government and non-government providers of services for people with a disability are funded under the CSTDA, the HACC program and Commonwealth Rehabilitation Services (CRS) Australia. HACC services are reported in chapter 12 ('Aged care services') but CRS Australia's services are not covered in this Report.

Total government expenditure on CSTDA services was \$3.6 billion in 2004-05 — a real increase of 6.2 per cent on the expenditure in 2003-04 (\$3.4 billion) (table 13A.4). State and Territory governments funded the majority of this expenditure in 2004-05 (72.1 per cent, or \$2.6 billion). The Australian Government funded the remainder (27.9 per cent, or \$1.0 billion), which included \$563.7 million in transfer payments to the states and territories (tables 13A.3 and 13A.5).

Direct government expenditure on CSTDA services, which excludes expenditure on administration, was \$3.3 billion in 2004-05 (table 13A.3). The distribution of direct government expenditure varied across jurisdictions in 2004-05. The main areas of State and Territory government expenditure were accommodation support services (54.3 per cent of direct service expenditure) and community access services (12.6 per cent of direct service expenditure). Employment services were the main area of Australian Government expenditure in 2004-05 (86.0 per cent of Australian Government direct service expenditure and 10.7 per cent of total direct service expenditure) (figure 13.1).

Figure 13.1 Distribution of expenditure, by disability service type^{a, b}



AS = accommodation support; CS = community support; CA = community access; RS = respite services; ES = employment services; AI&PD = advocacy, information and print disability. ^a See table 13A.3 for detailed notes accompanying expenditure data. ^b Data for advocacy, information and print disability are not available for 2000-01.

Source: Australian, State and Territory governments (unpublished); table 13A.5.

Governments have increased funding over time for accommodation support services provided in community settings to enable people with a disability to participate more fully in the community. In addition, some jurisdictions have developed programs that provide funding directly to service users. These programs allow service users to choose a customised package of services that better reflects their needs.

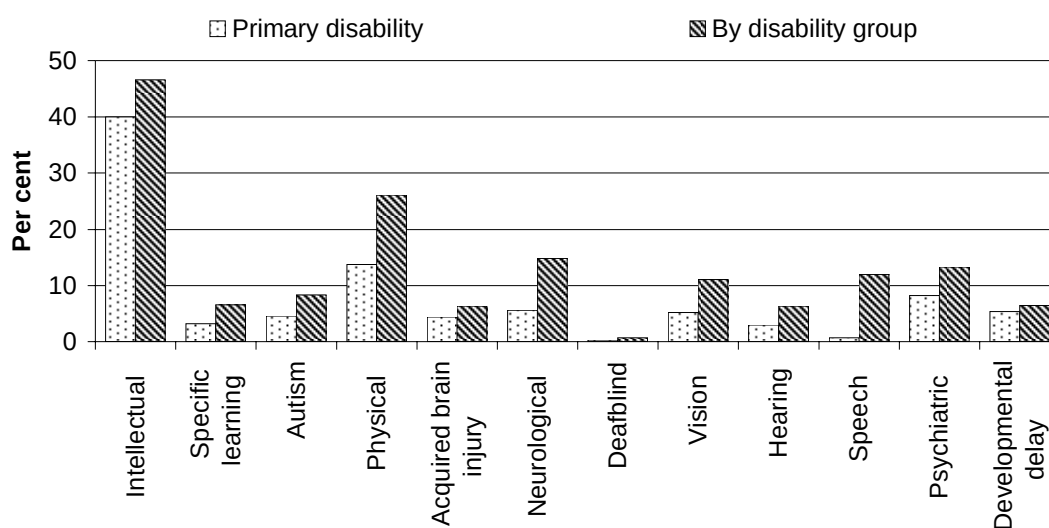
Size and scope

Performance indicators for services provided under the CSTDA in 2003-04 are reported in this chapter. These indicators focus mainly on accommodation support and employment services, which accounted for 64.7 per cent of total government direct expenditure on services provided under the CSTDA in 2003-04 (table 13A.5).

The ABS Survey of Disability, Ageing and Carers (SDAC) estimated that people with a core activity limitation, schooling or employment restriction accounted for 13.0 per cent of the total Australian population aged 5–64 years in 2003 (ABS 2004a). Tables 13A.6 and 13A.7 contain additional information from the SDAC on people with a disability.

Data provided by the AIHW for 2003-04 indicate that 46.6 per cent of CSTDA service users had an intellectual disability and 40.0 per cent of CSTDA service users had an intellectual disability as their primary disability (figure 13.2).

Figure 13.2 Service users by disability group, 2003-04^{a, b}



^a Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet during the relevant period. Individuals might have accessed services from more than one State or Territory during the relevant period. ^b Data for users of CSTDA services funded by the states and territories exclude specialist psychiatric disability services identified by the jurisdiction.

Source: AIHW (2005a, 2005b); tables 13A.8 and 13A.9.

13.2 Framework of performance indicators

The framework of performance indicators is based on the Australian, State and Territory governments' shared objectives under the CSTDA (box 13.5).

Box 13.5 Objectives of government funded services for people with a disability

The performance data for this Report cover services provided under the CSTDA. Through this agreement, 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.

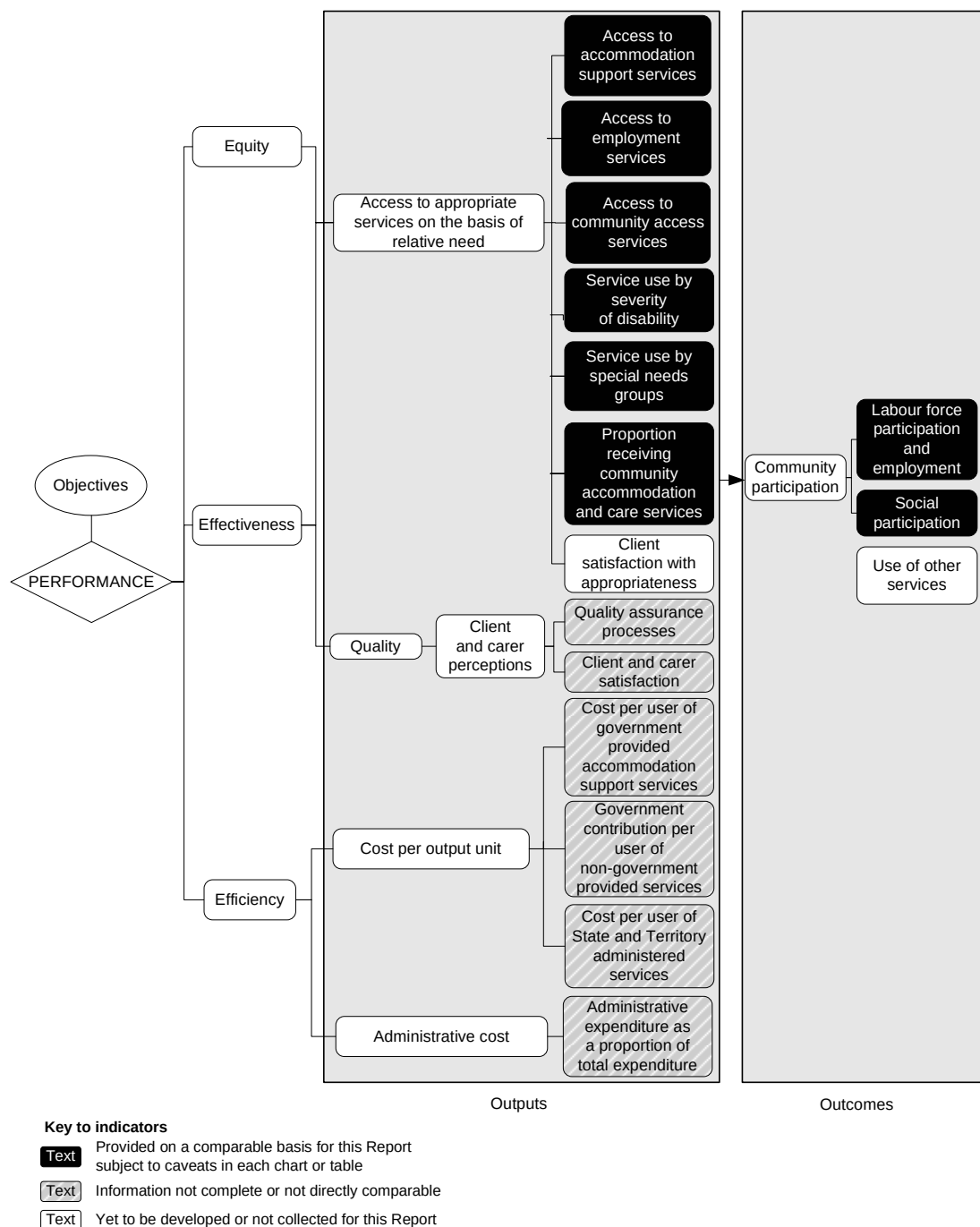
Source: CSTDA (2003).

The performance indicator framework shows which specialist disability services data are comparable in the 2006 Report (figure 13.3). 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).

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of government funded services for people with a disability. This is consistent with the general performance indicator framework and service process diagram (figures 1.2 and 1.3, chapter 1) on which the Steering Committee has agreed.

Proxy efficiency indicators focus on unit costs and administrative costs. Effectiveness and equity indicators focus on service quality and appropriateness. Outcome indicators focus on the participation of people with a disability in the community.

Figure 13.3 Performance indicators for specialist disability services



13.3 Key performance indicator results

Different delivery contexts, locations and client characteristics may affect the equity, effectiveness and efficiency of specialist disability services. Appendix A

contains data that may assist in interpreting the performance indicators presented in this chapter.

The performance indicator results reported in this chapter relate to CSTDA services. Expenditure data were provided by Australian, State and Territory governments. These 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.

Service user data were sourced from the CSTDA NMDS collection, which is coordinated by the AIHW. The CSTDA NMDS collection was implemented in 2002-03, with national data from the first collection available for the period 1 January 2003 to 30 June 2003. Before its implementation, service user data for this chapter were sourced mainly from the CSDA MDS. The CSDA MDS was based on a snapshot day collection (see the 2005 Report for data from this collection). The main differences between the CSTDA and the CSDA data sets are discussed in box 13.6.

When considering the indicator results derived using service user data, comparisons between jurisdictions and between the 2002-03 and 2003-04 data should be undertaken with care because:

- the collection period for the 2003-04 data was 12 months, whereas, the collection period for the 2002-03 data was six months
- the implementation of the CSTDA NMDS has led to some data quality issues. In particular, the proportion of service users and service outlets that provided data (response rates) and the 'not stated' rates of particular data items vary across jurisdictions.

The 2002-03 expenditure data used to calculate some of the efficiency indicators were adjusted to account for these factors. The efficiency results using these adjustments provide only indicative estimates of jurisdictional efficiency. The 2005 Report contains further detail on these adjustments.

Box 13.6 **Implementation of the CSTDA NMDS**

From 1994, the CSDA MDS collections provided funding bodies, funded agencies (service providers), service users and other stakeholders with information about services delivered under the CSDA and the people receiving those services. This information was collected on one snapshot day in the year. In 1999, the NDA and the AIHW began to review and redevelop the CSDA MDS collection. The redeveloped collection was fully implemented nationally in October 2002 and is now referred to as the CSTDA NMDS. The first national collection period for the CSTDA NMDS commenced on 1 January 2003 and ended on 30 June 2003.

As with its predecessor, the CSTDA NMDS has an agreed set of data items of national significance, and an agreed framework for collection and national collation. Data items relate to the equity, efficiency and effectiveness of services.

The most significant change from the CSDA MDS to the CSTDA NMDS collection is that, for most service types, funded agencies are required to provide information about all service users throughout the year (rather than just those who received a service on a snapshot day). Less detail, however, is asked about service users for some service types than others. Accommodation and community support services, for example, provide all data items relating to service users, whereas recreation or holiday program providers provide minimal information (for example, sex and date of birth). As with the previous collection, services such as advocacy and print services are not required to provide service user details.

A small number of new data items have been introduced into the CSTDA NMDS, including items on informal carers. This is in recognition of the mutual support among people with a disability, informal carers and formal services, and the fact that program goals are recognising, in particular, the importance of ageing carers.

In specifying revised core data items for ongoing collection by all service providers funded under the CSTDA, the CSTDA NMDS:

- aims to meet critical data needs across the disability field, and to be consistent with other major data developments, such as the HACC MDS
- integrates data collation with the operations of agencies and funding departments
- uses statistical linkage keys to enable data from various sources to be related and collated without duplication of effort
- uses statistical linkage keys to account for double counting of service users.

Source: AIHW (2003).

Outputs — equity and effectiveness — access to appropriate services on the basis of relative need

Indicators relating to access to specialist disability services on the basis of relative need are reported for accommodation support services, employment services and community access services. One indicator of access to services on the basis of relative need is the proportion of the estimated potential population using the service. The potential populations for accommodation support, employment and community access services are defined in section 13.6. Data are also reported on ‘service use by severity of disability’ and ‘service use by special needs groups’ for these services.

Results for the access to accommodation support, employment and community access service indicators should be considered in conjunction with the ‘service use by severity of disability’ indicator. The numerator of an access indicator includes service users who have moderate to no core activity limitations and/or who are aged over 64 years. The denominator includes only people who have a severe or profound core activity limitation and who are aged under 65 years. This denominator is the estimated potential population and matches the population who the CSTDA states are eligible for funded services (box 13.1).

The ‘service use by severity of disability’ indicator provides information in relation to the numerator of each access indicator. This indicator reports the proportion of service users who have profound, severe or moderate to no core activity limitations. Under the CSTDA, people eligible for services are those with substantially reduced capacity in at least one of the core activities (self care, mobility or communication), and as a result of which they require significant ongoing and/or long term episodic support. This indicator, therefore, shows the extent to which services are accessed by people eligible under the CSTDA.

Access to accommodation support services

‘Access to accommodation support services’ is an indicator of access to specialist disability services on the basis of relative need (box 13.7).

Box 13.7 Access to accommodation support services

The proportion of the estimated potential population using accommodation support services is an output (access) indicator of governments' objective to provide access to government funded or provided specialist disability services on the basis of relative need and available resources.

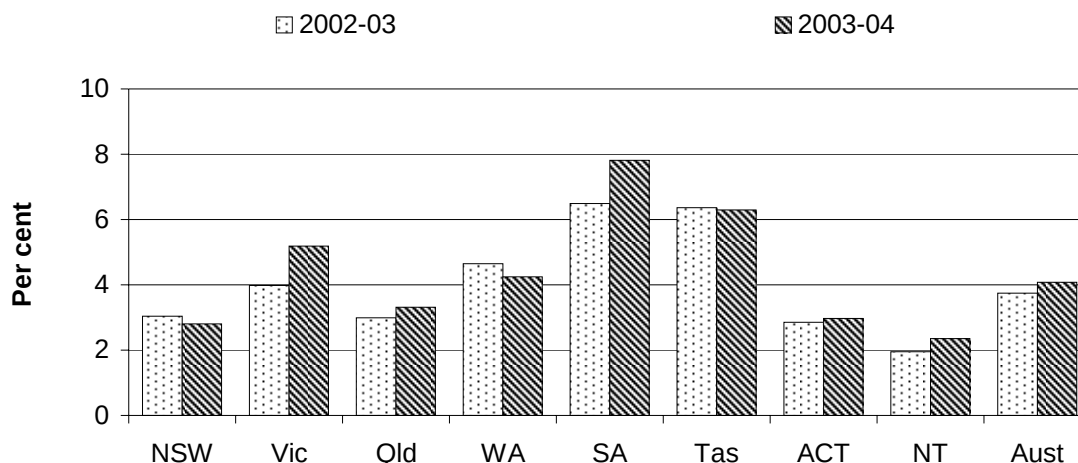
This indicator is defined as the number of people using CSTDA funded accommodation support services divided by the estimated potential population for accommodation support services. The potential population estimates for accommodation support services are the number of people aged under 65 years, with profound or severe core activity limitations, multiplied by the Indigenous factor for that jurisdiction. See section 13.6 for detailed information on the estimated potential population and the Indigenous factor.

A higher proportion of the estimated potential population using accommodation support services suggests greater access to these services.

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 need for services is assumed to vary according to the level of core activity limitation, so core activity limitation is used as a proxy for relative need. Not all people in the estimated potential population, however, will need the service in the relevant period.

Nationally, 4.1 per cent of the estimated potential population were using CSTDA funded accommodation support services in 2003-04 (figure 13.4). Results for this indicator need to be considered in conjunction with the 'service use by severity of disability' indicator.

Figure 13.4 Users of accommodation support services as a proportion of the estimated potential population^{a, b, c, d, e, f, g, h, i}



^a Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. The NT has population estimates of less than 9000. ^b Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet during the relevant period. Individuals might have accessed services from more than one State or Territory during the relevant period. ^c The potential population estimates (national age- and sex-specific rates applied to each jurisdiction) for accommodation support services are the number of people aged under 65 years, with profound or severe core activity limitations, multiplied by the Indigenous factor for that jurisdiction. See section 13.6 for detailed information on the estimated potential population and the Indigenous factor. ^d Data for users of CSTDA funded accommodation support services exclude specialist psychiatric disability services identified by the jurisdiction. ^e The 2002-03 service user data used to derive this indicator are for the period 1 January 2003 to 30 June 2003 only. ^f Data used for this indicator have quality issues related to the development of the new CSTDA NMDS. This indicator thus needs to be interpreted with care. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^g The number of NSW service users is underreported for 2002-03 and 2003-04 because of low response rates. ^h Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users. ⁱ The WA 2003-04 service data reflect an improved and more accurate method of data collection for one agency and are not comparable with 2002-03 data. The counting variance exceeds the reported variance between the two years, indicating a likely real increase.

Source: ABS (2002a, 2003a, 2004b); AIHW (2004a, 2004b, 2005a, 2005b); AIHW analysis of the 2003 ABS Survey of Disability, Ageing and Carers data; table 13A.10.

Access to employment services

During the reporting period, the Australian Government had responsibility for employment services under the CSTDA and provided most services through funding non-government organisations. 'Access to employment services' is an indicator of access to specialist disability services on the basis of relative need (box 13.8).

Box 13.8 Access to employment services

The proportion of the estimated potential labour force using employment services is an output (access) indicator of governments' objective to provide access to government funded or provided specialist disability services on the basis of relative need and available resources.

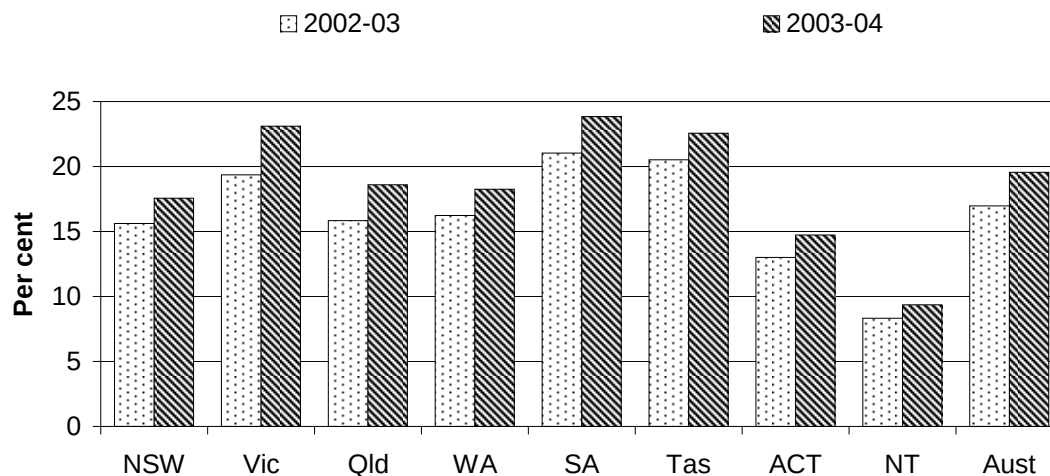
This indicator is defined as the number of people using CSTDA funded employment services divided by the estimated potential population for employment services. The potential population estimates for employment services are the number of people aged 15–64 years with severe or profound core activity limitations, multiplied by both the Indigenous factor and the labour force participation rate for that jurisdiction. See section 13.6 for detailed information on the estimated potential population and the Indigenous factor.

A higher proportion of the estimated potential population using employment services suggests greater access to these services.

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 need for services is assumed to vary according to the level of core activity limitation, so core activity limitation is used as a proxy for relative need. Not all people in the estimated potential population, however, will need the service in the relevant period.

Nationally, 19.6 per cent of the estimated potential population were using employment services in 2003-04 (figure 13.5). Results for this indicator need to be considered in conjunction with the 'service use by severity of disability' indicator.

Figure 13.5 Users of employment services as a proportion of the estimated potential population for employment services^{a, b, c, d}



^a Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. Tasmania, the ACT and the NT have population estimates of less than 9000. ^b Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet during the relevant period. Individuals might have accessed services from more than one State or Territory during the relevant period. ^c The potential population estimates (national age- and sex-specific rates applied to each jurisdiction) for employment services are the number of people aged 15–64 years with severe or profound core activity limitations, multiplied by both the Indigenous factor and the labour force participation rate for that jurisdiction. See section 13.6 for detailed information on the estimated potential population and the Indigenous factor. ^d Data for 2002-03 are for the period 1 January 2003 to 30 June 2003 only.

Source: ABS (2002a, 2002b, 2003a, 2003b, 2004b); AIHW (2004a, 2004b, 2005a, 2005b); AIHW analysis of the 2003 ABS Survey of Disability, Ageing and Carers data; table 13A.11.

Access to community access services

‘Access to community access services’ is an indicator of access to specialist disability services on the basis of relative need (box 13.9).

Box 13.9 Access to community access services

The proportion of the estimated potential population using community access services is an output (access) indicator of governments' objective to provide access to government funded or provided specialist disability services on the basis of relative need and available resources.

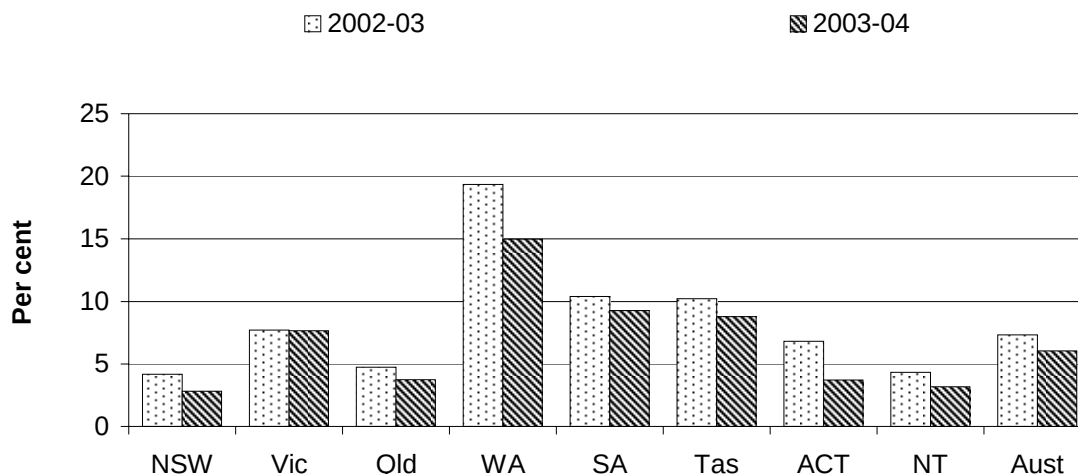
This indicator is defined as the number of people using CSTDA funded community access services (such as learning and life skills development) divided by the estimated potential population for community access services. For 2003-04 data, the potential population estimates for community access services are the number of people aged under 65 years, who have a profound or severe core activity limitation, multiplied by the Indigenous factor for each jurisdiction. For 2002-03 data, the potential population is derived using the same method but includes only people aged 15–64 years. See section 13.6 for detailed information on the estimated potential population and the Indigenous factor.

A higher proportion of the estimated potential people using community access services suggests greater access to these services.

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 need for services is assumed to vary according to the level of core activity limitation, so core activity limitation is used as a proxy for relative need. Not all people in the estimated potential population, however, will need the service in the relevant period.

Nationally, 6.0 per cent of the estimated potential population were using a community access service in 2003-04 (figure 13.6). Results for this indicator need to be considered in conjunction with the 'service use by severity of disability' indicator.

Figure 13.6 Users of community access services as a proportion of the estimated potential population^{a, b, c, d, e, f, g, h}



^a The 2002-03 and 2003-04 indicator results are not comparable due to a difference in the age groups included in the estimated potential population. For 2003-04 data, the potential population estimates for community access services are the number of people aged under 65 years, who have a profound or severe core activity limitation, multiplied by the Indigenous factor for each jurisdiction. For 2002-03 data, the potential population is derived using the same method but includes only people aged 15–64 years. (As a result, the 2003-04 estimated potential population is larger than the 2002-03 estimated potential population.) See section 13.6 for detailed information on the estimated potential population and the Indigenous factor. ^b Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. The ACT in 2002-03 and the NT have population estimates of less than 9000. ^c Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet during the relevant period. Individuals might have accessed services from more than one State or Territory during the relevant period. ^d Data for users of CSTDA funded community access services exclude specialist psychiatric disability services specifically identified by the jurisdiction. ^e The 2002-03 service user data used to derive this indicator are for the period 1 January 2003 to 30 June 2003 only. ^f Data used for this indicator have quality issues related to the development of the new CSTDA NMDS. This indicator thus needs to be interpreted with care. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^g The number of NSW service users is underreported for 2002-03 and 2003-04 because of low response rates. ^h Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users.

Source: ABS (2002a, 2003a, 2004b); AIHW (2004a, 2004b, 2005a, 2005b); AIHW analysis of the 2003 ABS Survey of Disability, Ageing and Carers data; table 13A.12.

Service use by severity of disability

'Service use by severity of disability' is an indicator of access to specialist disability services on the basis of relative need (box 13.10). This indicator provides information for understanding the access to accommodation support, employment and community access indicators reported above.

Box 13.10 Service use by severity of disability

The proportion of people accessing CSTDA funded services by severity of core activity limitation is an output indicator of governments' objective to use available resources to target services to people with the greatest level of need.

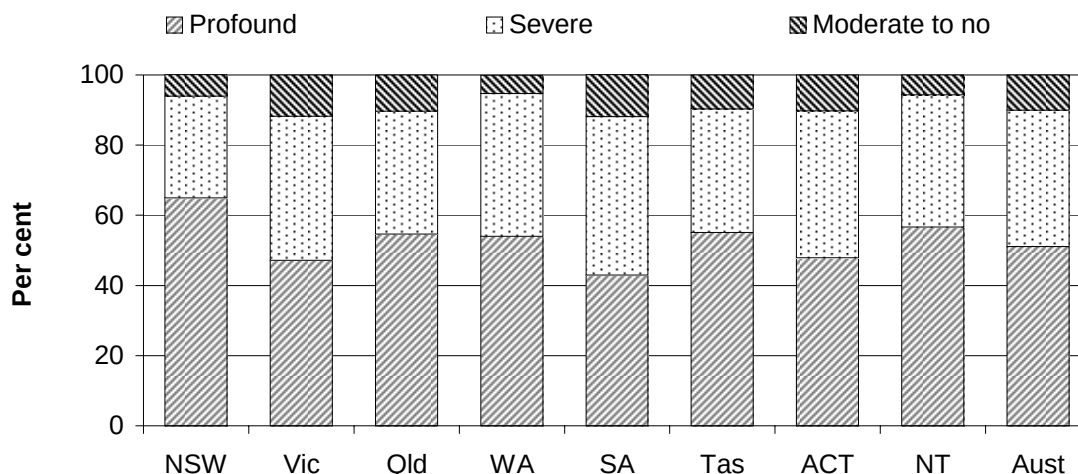
This indicator is defined as the proportion of people, by level of core activity limitation, accessing CSTDA funded services. Data are reported for people with a profound, severe and moderate to no core activity limitation, and are reported for accommodation support, employment and community access services.

A higher proportion of people with a profound or severe core activity limitation using accommodation support or employment services suggests greater access to these services 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, so core activity limitation is used as one proxy for relative need. It is important to note that core activity limitation data are not based on formal clinical assessments of individual limitations. In addition, there are other factors that may also be important in determining relative need including service users with complex needs.

Nationally, 51.1 per cent of users of accommodation support services in 2003-04 had a profound core activity limitation, 38.9 per cent had a severe core activity limitation and 10.0 per cent had moderate to no core activity limitations (figure 13.7).

Figure 13.7 Users of accommodation support services, by severity of core activity limitation, 2003-04^{a, b, c, d, e, f}

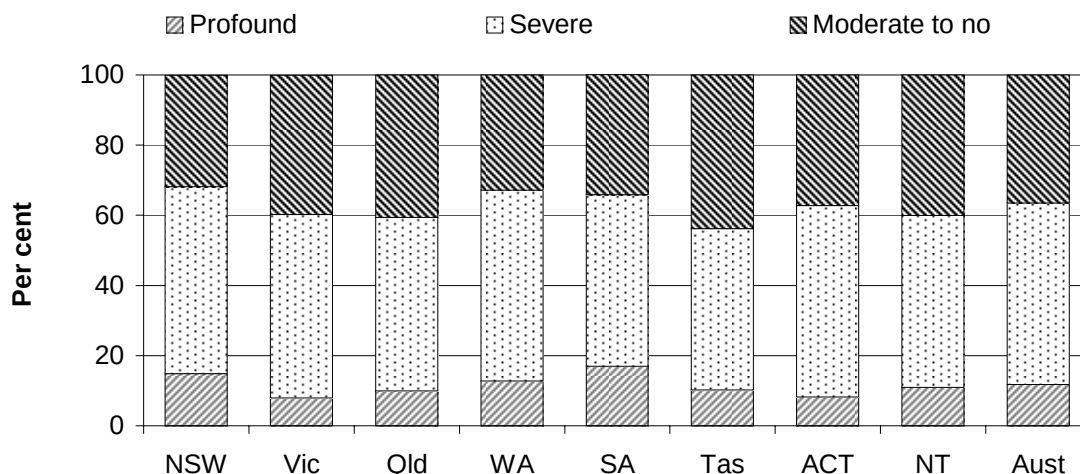


^a Severity of core activity limitation is derived using data on level of support needed in one or more of the support areas: self-care, mobility, and communication. Service users with a profound core activity limitation reported always needing support in one or more of these areas. Service users with a severe core activity limitation reported sometimes needing support in one or more of these areas. Service users with a moderate to no core activity limitation reported needing no support in all of these areas. ^b Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet in 2003-04. Individuals might have accessed services from more than one State or Territory during that period. ^c Data exclude 4899 service users who did not report on a need for support with any of the areas: self-care, mobility, or communication. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Data for service users of CSTDA funded accommodation support services exclude specialist psychiatric disability services identified by the jurisdiction. ^e Data used for this indicator have quality issues related to the development of the new CSTDA NMDS. This indicator thus needs to be interpreted with care. ^f Victorian data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users.

Source: AIHW (2005a, 2005b); table 13A.13.

Nationally, 11.8 per cent of users of employment services in 2003-04 had a profound core activity limitation, 51.7 per cent had a severe core activity limitation and 36.5 per cent had moderate to no core activity limitations (figure 13.8).

Figure 13.8 Users of employment services, by severity of core activity limitation, 2003-04^{a, b, c, d}

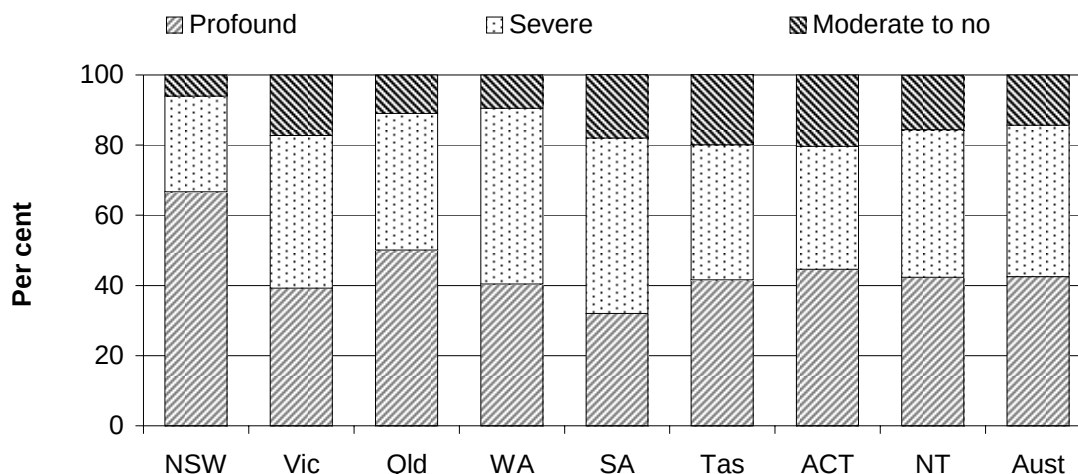


^a Severity of core activity limitation was derived using data on the level of support needed in one or more of the support areas: self-care, mobility, and communication. Service users with a profound core activity limitation reported always needing support in one or more of these areas. Service users with a severe core activity limitation reported sometimes needing support in one or more of these areas. Service users with a moderate or no core activity limitation reported needing no support in all of these areas. ^b Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet in 2003-04. Individuals might have accessed services from more than one State or Territory during that period. ^c Data exclude 2044 service users who did not report on a need for support with any of the areas: self-care, mobility, or communication. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Severity of core activity limitation relates to the level of support needed in the areas of self care, mobility and communication. It does not necessarily relate to the level of support needed to find or maintain employment.

Source: AIHW (2005a, 2005b); table 13A.14.

Nationally, 42.6 per cent of users of community access services in 2003-04 had a profound core activity limitation, 43.1 per cent had a severe core activity limitation and 14.3 per cent had moderate to no core activity limitations (figure 13.9).

Figure 13.9 Users of community access services, by severity of core activity limitation, 2003-04^{a, b, c, d, e, f, g}



^a Severity of core activity limitation was derived using data on the level of support needed in one or more of the support areas: self-care, mobility, and communication. Service users with a profound core activity limitation reported always needing support in one or more of these areas. Service users with a severe core activity limitation reported sometimes needing support in one or more of these areas. Service users with a moderate or no core activity limitation reported needing no support in all of these areas. ^b Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet in 2003-04. Individuals might have accessed services from more than one State or Territory during that period. ^c Data exclude 13 417 service users who did not report on a need for support with any of the areas: self-care, mobility, or communication. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Data for service users of CSTDA funded community access services exclude specialist psychiatric disability services specifically identified by the jurisdiction. ^e Service users who accessed the service type 'recreation/holiday programs' (service type 3.02) were not required to complete the item on support needs; however, those who did provide a response are included in the data. ^f Data used for this indicator have quality issues related to the development of the new CSTDA NMDS. This indicator thus needs to be interpreted with care. ^g Victorian data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users.

Source: AIHW (2005a, 2005b); table 13A.15.

Service use by special needs groups

An additional indicator of access is the comparison between the representation of all people with a disability who use CSTDA funded services and the representation of people with a disability from special needs groups (box 13.11).

Box 13.11 Service use by special needs groups

The proportion of people from special needs groups accessing CSTDA funded services is an output (access) indicator of governments' objective that access to appropriate services should be equitable for all members of the community. The three special needs groups reported here are:

- people from outer regional and remote/very remote locations
- people who have an Indigenous background
- people who were not born in Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland or the United States — that is, people born in a non-English speaking country.

This indicator compares the proportion of service users per 1000 people from a particular special needs group with the proportion of all service users per 1000 people in the Australian population or with the proportion of service users per 1000 people outside the special needs group. The disability service types reported are accommodation support, employment and community access services. For accommodation support and community access services, people aged under 65 years are included in the population counts for both the special needs groups and the Australian population/people outside the special needs groups. For employment, only people aged 15–64 years are included in these population counts.

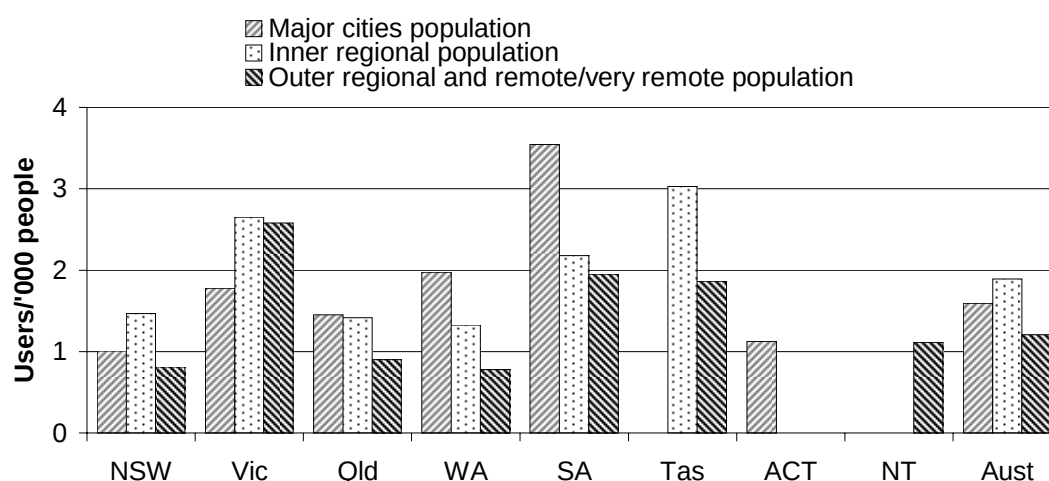
Holding other factors constant, the proportion of service users per 1000 people from a special needs group should not vary significantly from the proportion of all service users per 1000 people in the Australian population. While a markedly lower proportion may represent reduced access for a special needs group, it may also represent strong alternative support networks (and thus a lower level of need), or the individual choice of people with a disability not to access CSTDA funded services. Similarly, while a higher proportion may suggest poor service targeting or the lack of alternate support networks, it may also reflect the special needs group having a greater prevalence of disability.

The CSTDA funded services are provided on the basis of need and available resources. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. The indicator also does not take account of informal assistance that may be significant for 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 are available in these areas. Specifically, accommodation support services in outer regional and remote/very remote areas are largely provided informally, making use of local area coordinators and local community resources.

Service use by special needs groups — people in outer regional and remote/very remote areas

Nationally, the proportion of the outer regional and remote/very remote population who used accommodation support services in 2003-04 (1.2 service users per 1000 people aged under 65 years) was lower than that of the major cities and inner regional populations (1.6 and 1.9 service users per 1000 people aged under 65 years, respectively) (figure 13.10).

Figure 13.10 Users of accommodation support services per 1000 people, by geographic location, 2003-04^{a, b, c, d, e, f, g, h, i, j, k}

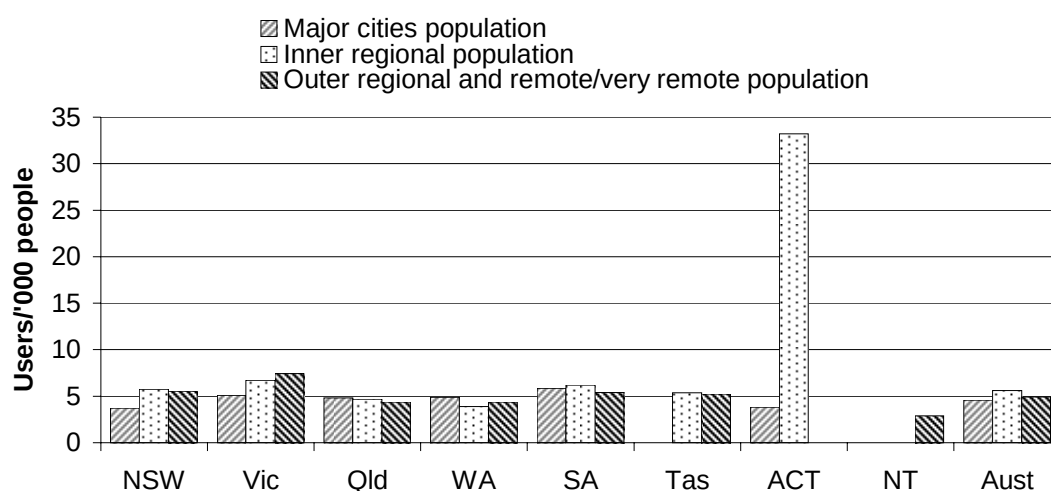


^a Data on outer regional and remote/very remote users per 1000 people were derived by dividing the number of outer regional and remote/very remote service users by the number of outer regional and remote/very remote people aged under 65 years, multiplied by 1000. The 'outer regional and remote/very remote' classification was derived by adding outer regional, remote and very remote data. ^b The State and Territory data on the Australian population were derived by the AIHW from ABS statistical local area (SLA) population estimates for June 2003. ^c The number of service users in each geographic location was estimated based on service users' residential postcodes. Some postcode areas were split between two or more geographic locations; in this case, the data were weighted according to the proportion of the population of the postcode area in each geographic location. ^d Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet in 2003-04. Individuals might have accessed services from more than one State or Territory during that period. ^e Data exclude 283 service users whose postcode was not reported. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^f Data for service users of CSTDA funded accommodation support services exclude specialist psychiatric disability services identified by the jurisdiction. ^g Data used for this indicator have quality issues related to the development of the new CSTDA NMDS. This indicator thus needs to be interpreted with care. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^h The number of NSW service users is underreported because of low response rates. ⁱ Tasmania does not have major cities. ^j The ACT does not have outer regional and remote/very remote areas. ACT data for service users per 1000 people in inner regional areas are not published as they are based on a small number of service users. ^k The NT does not have major cities or inner regional areas.

Source: AIHW analysis of ABS SLA population estimates for June 2003; AIHW (unpublished); table 13A.16.

Nationally, the proportion of the outer regional and remote/very remote population who used employment services in 2003-04 (4.9 service users per 1000 people aged 15–64 years) was higher than the proportion of the major cities population (4.6 service users per 1000 people aged 15–64 years) and less than the proportion of the inner regional population (5.6 service users per 1000 people aged 15–64 years) (figure 13.11).

Figure 13.11 Users of employment services per 1000 people, by geographic location, 2003-04^{a, b, c, d, e, f}



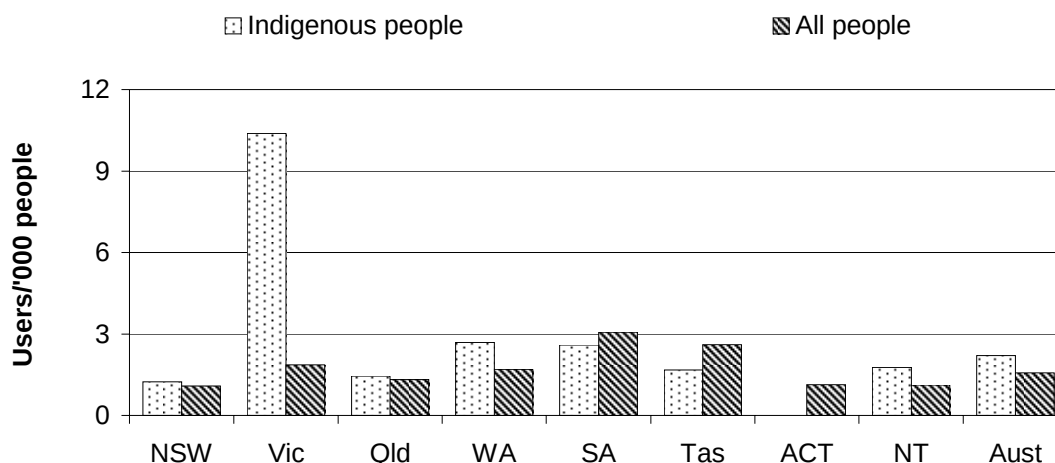
^a Data on outer regional and remote/very remote users per 1000 people were derived by dividing the number of outer regional and remote/very remote service users by the number of outer regional and remote/very remote people aged 15–64 years, multiplied by 1000. The 'outer regional and remote/very remote' classification was derived by adding outer regional, remote and very remote data. ^b The State and Territory data on the Australian population were derived by the AIHW from ABS SLA population estimates for June 2003. ^c The number of service users in each geographic location was estimated based on service users' residential postcodes. Some postcode areas were split between two or more geographic locations; in this case, the data were weighted according to the proportion of the population of the postcode area in each geographic location. ^d Data exclude six service users whose postcode was not reported. ^e Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet in 2003-04. Individuals might have accessed services from more than one State or Territory during that period. ^f Tasmania does not have major cities. The ACT does not have outer regional and remote/very remote areas. The NT does not have major cities or inner regional areas.

Source: AIHW analysis of ABS SLA population estimates for June 2003; AIHW (unpublished); table 13A.17.

Service use by special needs groups — Indigenous people

Nationally, the proportion of the Indigenous population who used accommodation support services in 2003-04 (2.2 Indigenous service users per 1000 Indigenous people aged under 65 years) was higher than the proportion of the total population who used these services (1.6 service users per 1000 people aged under 65 years in the total population) (figure 13.12).

Figure 13.12 Users of accommodation support services per 1000 people, by Indigenous status, 2003-04^{a, b, c, d, e, f, g, h}

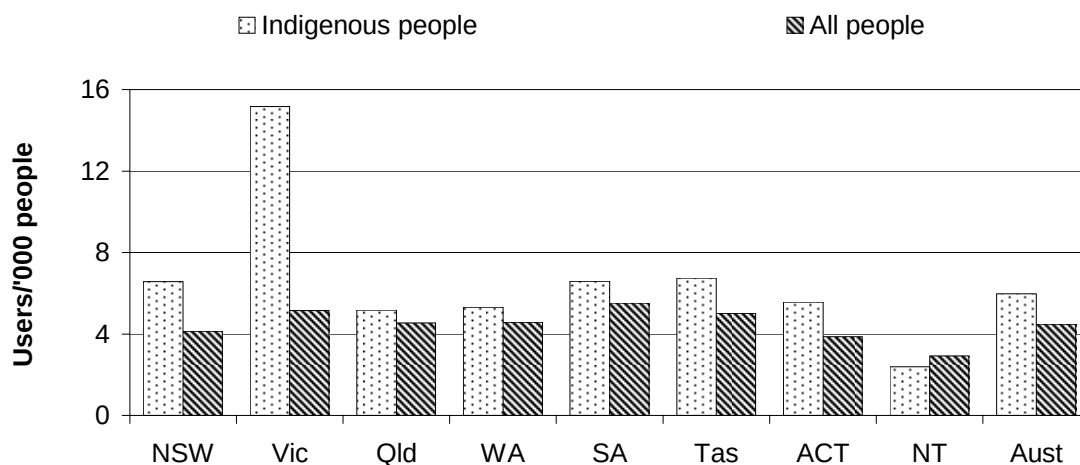


^a Data for Indigenous users per 1000 people were derived by dividing the number of Indigenous service users by the number of Indigenous Australians aged under 65 years, multiplied by 1000. ^b Where Indigenous status was inconsistently recorded for the same user, the user was counted as an Indigenous Australian. ^c Data for all service users exclude 954 service users whose Indigenous status was not reported, so accommodation support service users per 1000 total population aged under 65 years may differ from other figures. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Data for users of CSTDA funded accommodation support services exclude specialist psychiatric disability services identified by the jurisdiction. ^e Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet in 2003-04. Individuals might have accessed services from more than one State or Territory during that period. ^f Data used for this indicator have quality issues related to the development of the new CSTDA NMDS. This indicator thus needs to be interpreted with care. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^g The number of NSW service users is underreported because of low response rates. ^h ACT data for service users per 1000 Indigenous people are not published as they are based on a small number of service users.

Source: ABS (2003a, 2004b); AIHW (unpublished); table 13A.18.

Nationally, the proportion of the Indigenous population who used employment services in 2003-04 (6.0 Indigenous service users per 1000 Indigenous people aged 15–64 years) was higher than the proportion of the total population who used these services (4.5 service users per 1000 people aged 15–64 years) (figure 13.13).

Figure 13.13 Users of employment services per 1000 people, by Indigenous status, 2003-04^{a, b, c, d}

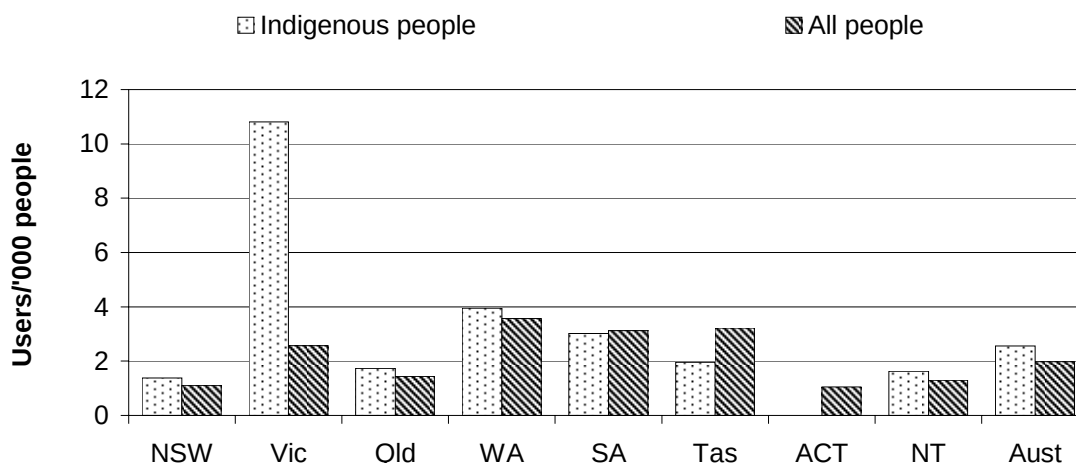


^a Data for Indigenous users per 1000 people were derived by dividing the number of Indigenous service users by the number of Indigenous Australians aged 15–64 years, multiplied by 1000. ^b Where Indigenous status was inconsistently recorded for the same user, the user was counted as an Indigenous Australian. ^c Data for all service users exclude 4498 service users whose Indigenous status was not reported, so employment service users per 1000 total population aged 15–64 years may differ from other figures. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet in 2003-04. Individuals might have accessed services from more than one State or Territory during that period.

Source: ABS (2003a, 2004b); AIHW (unpublished); table 13A.19.

Nationally, the proportion of the Indigenous population who used community access services in 2003-04 (2.6 Indigenous service users per 1000 Indigenous people aged under 65 years) was higher than the proportion of the total population who used these services (2.0 service users per 1000 people aged under 65 years) (figure 13.14).

Figure 13.14 Users of community access services per 1000 people, by Indigenous status, 2003-04^{a, b, c, d, e, f, g, h, i}



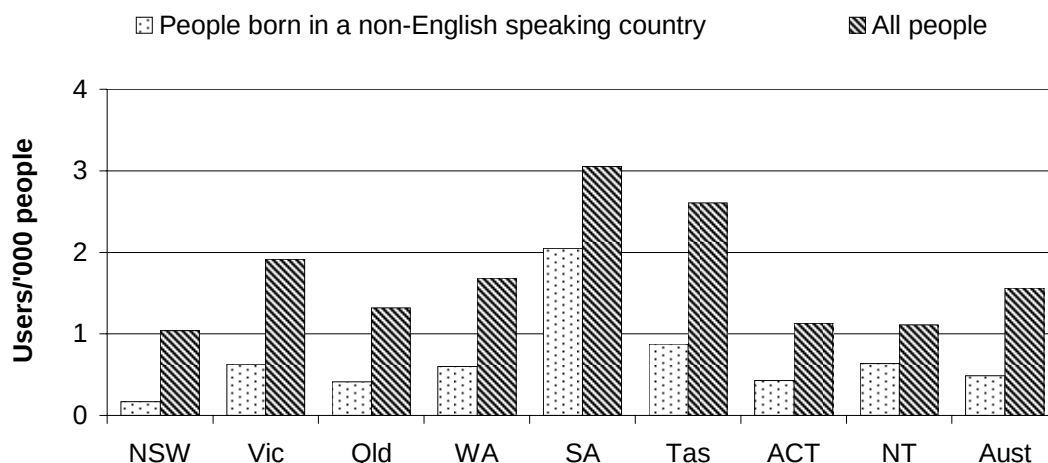
^a Data for Indigenous users per 1000 people were derived by dividing the number of Indigenous service users by the number of Indigenous Australians aged under 65 years, multiplied by 1000. ^b Where Indigenous status was inconsistently recorded for the same user, the user was counted as an Indigenous Australian. ^c Data for all service users exclude 7283 service users whose Indigenous status was not reported, so community access service users per 1000 total population aged under 65 years may differ from other figures. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^d Service users who accessed the service type 'recreation/holiday programs' (service type 3.02) were not required to complete the item on Indigenous status; however, those who did provide a response are included in the data. ^e Data for users of CSTDA funded community access services exclude specialist psychiatric disability services specifically identified by the jurisdiction. ^f Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet in 2003-04. Individuals might have accessed services from more than one State or Territory during that period. ^g Data used for this indicator have quality issues related to the development of the new CSTDA NMDS. This indicator thus needs to be interpreted with care. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^h The number of NSW service users is underreported because of low response rates. ⁱ ACT data for service users per 1000 Indigenous people are not published as they are based on a small number of service users.

Source: ABS (2003a, 2004b); AIHW (unpublished); table 13A.20.

Service use by special needs groups — people born in a non-English speaking country

Nationally, the proportion of people born in a non-English speaking country who used accommodation support services in 2003-04 (0.5 service users per 1000 people aged under 65 years) was lower than the proportion of the total population who used these services (1.6 service users per 1000 people aged under 65 years) (figure 13.15).

Figure 13.15 Users of accommodation support services per 1000 people, by country of birth, 2003-04^{a, b, c, d, e, f, g, h}

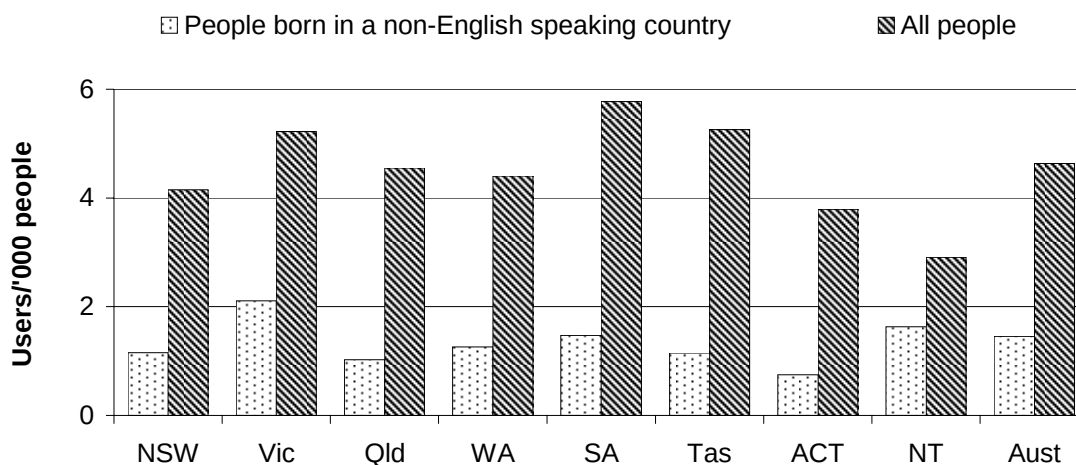


^a Data for service users born in a non-English speaking country per 1000 people were derived by dividing the number of service users born in a non-English speaking country by the number of Australians aged under 65 years who were born in a non-English speaking country, multiplied by 1000. ^b Data for service users born in a non-English speaking country were based on responses for country of birth in English Proficiency Groups 2–4 (which includes all countries except Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States). ^c The State and Territory data on people born in a non-English speaking country were derived from country of birth data for the corresponding 2001 Australian Census proportional distribution of the population of states and territories. Estimates exclude people whose country of birth was not stated or who were visitors to Australia from overseas. ^d Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet in 2003-04. Individuals might have accessed services from more than one State or Territory during that period. Where country of birth was inconsistently recorded for the same service user, the service user was counted as having been born in a non-English speaking country. ^e Data for all service users exclude 1023 service users whose country of birth was not reported, so accommodation support service users per 1000 total population aged under 65 years may differ from other figures. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator. ^f Data for service users of CSTDA funded accommodation support services exclude specialist psychiatric disability services identified by the jurisdiction. ^g Data used for this indicator have quality issues related to the development of the new CSTDA NMDS. This indicator thus needs to be interpreted with care. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^h The number of NSW service users is underreported because of low response rates.

Source: ABS (2003a); ABS Australian Census of Population and Housing (unpublished); AIHW (unpublished); table 13A.21.

Nationally, the proportion of people born in a non-English speaking country who used employment services in 2003-04 (1.5 service users per 1000 people aged 15–64 years) was lower than the proportion of the total population who used these services (4.6 service users per 1000 people aged 15–64 years) (figure 13.16).

Figure 13.16 Users of employment services per 1000 people, by country of birth, 2003-04^{a, b, c, d, e}



^a Data for service users born in a non-English speaking country per 1000 people were derived by dividing the number of service users born in a non-English speaking country by the number of Australians aged 15–64 years who were born in a non-English speaking country, multiplied by 1000. ^b Data for service users born in a non-English speaking country were based on responses for a country of birth in English Proficiency Groups 2–4 (which includes all countries except Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States). ^c The State and Territory data on people born in a non-English speaking country were derived from country of birth data for the corresponding 2001 Australian Census proportional distribution of the population of states and territories. Estimates exclude people whose country of birth was not stated or who were visitors to Australia from overseas. ^d Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet in 2003-04. Individuals might have accessed services from more than one State or Territory during that period. Where country of birth was inconsistently recorded for the same service user, the service user was counted as having been born in a non-English speaking country. ^e Data for all service users exclude 2481 service users whose country of birth was not reported, thus employment service users per 1000 total population aged 15–64 years might differ from other figures. Due to the relatively high rate of missing data, care should be taken when interpreting this indicator.

Source: ABS (2003a); ABS Australian Census of Population and Housing (unpublished); AIHW (unpublished); table 13A.22.

Proportion of accommodation support service users receiving community accommodation and care services

The ‘proportion of accommodation support service users receiving community accommodation and care services’ is an indicator of access to appropriate services (box 13.12).

Box 13.12 Proportion of accommodation support service users receiving community accommodation and care services

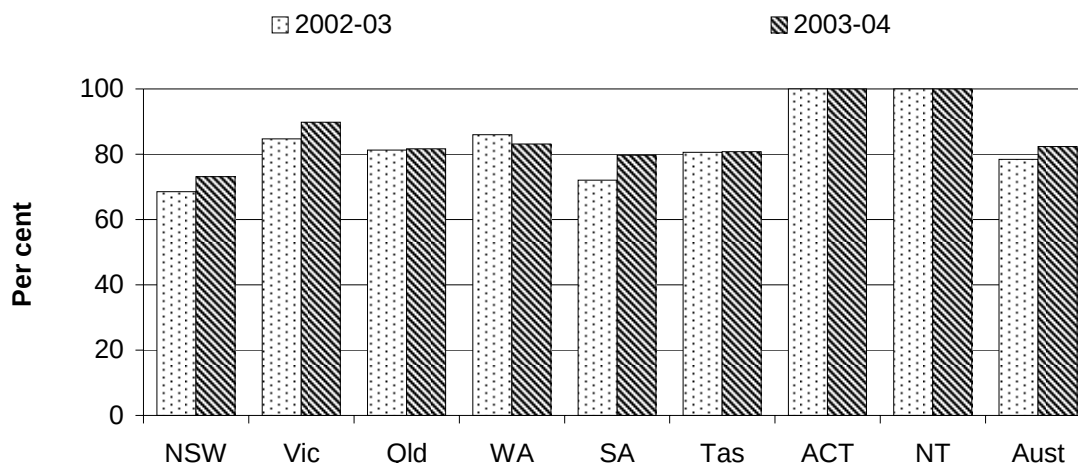
It is an objective of governments to assist people with a disability to live as valued and participating members of the community. State and Territory governments generally seek, if possible, to provide accommodation support services to people with a disability that are outside of institutional/residential settings. Community accommodation and care services are considered to provide better opportunities for people with a disability to be involved in their community.

This indicator is defined as the number of people using a CSTDA funded community accommodation and care service divided by the total number of people using CSTDA funded accommodation support services (excluding people who use specialist psychiatric disability services only). An increase in the proportion of people accessing community accommodation and care services is likely to increase the ability of these people to integrate and be involved in the community.

The CSTDA funded services are provided on the basis of need and available resources. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

Nationally, 82.4 per cent of accommodation support service users received community accommodation and care services in 2003-04 (figure 13.17).

Figure 13.17 Users of community accommodation and care services as a proportion of all accommodation support service users^{a, b, c, d, e, f}



^a Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet during each period. Individuals might have accessed services from more than one State or Territory. Individuals might have accessed services from both accommodation service type categories (institutional/large residential or community accommodation and care services). ^b Data for service users of CSTDA funded accommodation support services exclude specialist psychiatric disability services identified by the jurisdiction. ^c Community accommodation and care services include group homes, attendant care/personal care, in-home accommodation support, alternative family placement and other accommodation support. ^d Data used for this indicator have quality issues related to the development of the new CSTDA NMDS. This indicator thus needs to be interpreted with care. Differences in service type outlet response rates between jurisdictions, for example, should be considered when comparing jurisdictional data. ^e Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users. ^f The WA 2003-04 service data reflect an improved and more accurate method of data collection for one agency and are not comparable with 2002-03 data. The counting variance exceeds the reported variance between the two years, indicating a likely real increase.

Source: AIHW (2004a, 2004b, 2005a, 2005b); table 13A.23.

Client satisfaction with appropriateness

The Steering Committee has identified 'client satisfaction with appropriateness' as an indicator of access to services that are appropriate to client needs (box 13.13). This indicator is for development in future reports. Data for this indicator are currently not available.

Box 13.13 Client satisfaction with appropriateness

‘Client satisfaction with appropriateness’ will provide an output indicator of government’s objective to provide services to people with a disability that are appropriate to their needs and goals. This indicator will measure the appropriateness of these services relative to the service user’s need, from the service user’s perspective.

Outputs — equity and effectiveness — quality of services

Quality assurance processes

‘Quality assurance processes’ are an indicator of the quality of specialist disability services (box 13.14). All services funded under the CSTDA are required to comply with national standards, so most jurisdictions have been examining ways of implementing quality assurance monitoring systems for specialist disability services programs.

Box 13.14 Quality assurance processes

‘Quality assurance processes’ are an indicator of quality related to governments’ objective to deliver and fund services for people with a disability that meet a certain standard of quality.

This indicator is defined as the proportion of government and non-government disability service outlets that have been assessed (either by an assessing agency or through a self-assessment process) against service standards or performance indicators.

A higher proportion of disability service outlets that have been accredited against service standards or performance indicators suggests an improvement in the quality of specialist disability services delivered or funded by government.

This indicator does not provide information on whether the standards and performance indicators of the quality assurance processes are appropriate. In addition, service outlets that are not quality assessed do not necessarily deliver services of lower quality.

Data on quality assurance processes in 2004-05 are reported for the Australian Government, Victoria, WA and Tasmania (box 13.15). 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 four jurisdictions implementing monitoring of quality assurance

processes expect to review all service providers in a rolling process over several years.

Box 13.15 Quality assurance processes for specialist disability services

The quality assurance processes data reported below relate to CSTDA funded services.

Australian Government

Australian Government funded disability employment assistance organisations are required to meet quality standards as a prerequisite for continued funding. In July 2002, revised disability services standards were introduced, comprising 12 standards and 26 key performance indicators. All organisations (390) were assessed by independent accredited certification bodies and achieved certification against the revised standards by 31 December 2004. Organisations' compliance with the quality standards will continue to be monitored by certification bodies through a programme of surveillance audits.

Victoria, WA and Tasmania

In 2004-05, different quality assurance processes were in place in Victoria, WA and Tasmania, but these jurisdictions collect data on similar indicators. Specialist disability services providers (outlets and organisations) refer to providers of accommodation support; community support; community access; respite; advocacy, information and print disability; and other support services. The evaluation processes relate to both government and non-government service outlets.

In Victoria, by December 2004, 56 (of a possible 389) government and non-government disability service organisations (which operate at least one service outlet) had participated in an independent strategic review. In addition, 97 per cent of eligible service outlets (those receiving more than \$20 000 in disability funding) had undertaken a self-assessment against the Victorian Standards for Disability Services and implemented a quality plan.

In WA, 32.2 per cent (215 of 668) of total service outlets had been independently monitored (comprehensive and abridged monitoring) against the service standards, and 80.9 per cent (155 of 215) 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 546.

In Tasmania, 11.1 per cent of total service outlets (23 out of 207) were comprehensively evaluated against the service standards. Of the total number of service outlets that have undergone an evaluation (to June 30 2005) 100 per cent (43 out of 43) are being monitored through a Service Development Plan. Service development plans were also provided by 36.6 per cent of all non-evaluated service outlets (52 out of 142).

Source: Australian, Victorian, WA and Tasmanian governments (unpublished).

Client and carer satisfaction

‘Client and carer satisfaction’ is an indicator of the quality of specialist disability services (box 13.16). Data are available for reporting for WA only. It is anticipated that data for other jurisdictions will be included in future reports.

Box 13.16 Client and carer satisfaction

‘Client and carer satisfaction’ is an output (quality) indicator designed to provide information on satisfaction with the quality of services received. It is an indicator of governments’ objective to deliver and fund quality services for people with a disability that meet the needs and goals of the client (or carer of the client) receiving them.

Overall client and carer satisfaction ratings and satisfaction with individual services are reported. Results are taken from a client and carer satisfaction survey and are expressed in percentage terms. A higher proportion of clients and carers satisfied is desirable because it suggests the service received was of a high quality and better met the needs and goals of the client (or carer).

This indicator will be further developed over time as data become available from more jurisdictions.

WA conducted a carer and client satisfaction study in 2004. In this study, 688 disability services clients 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 people responded that the services had enhanced their quality of life. The following results show the proportions of clients/carers that were satisfied with individual services:

- residential services — 87 per cent
- supported community living — 84 per cent
- community support — 95 per cent
- respite — 77 per cent
- recreation/day option — 81 per cent
- local area coordination — 81 per cent (Disability Services Commission, WA Government [unpublished]).

Outputs — efficiency — cost per output unit

It is an objective of the Review to report comparable estimates of costs. Ideally, such comparisons would include the full range of costs to government. Where the full costs cannot be counted, costs are estimated on a consistent basis. The

jurisdictional expenditure data included in this Report do not yet include the user cost of capital, so do not reflect the full costs of government funded services.

Considerable effort has been made to document any differences in calculating the reported efficiency indicators. Some concerns remain over the comparability of the results, because jurisdictions use somewhat different methods of data collection (table 13.1). Expenditure data reported in this section are from individual jurisdictions' collections and may differ from cost per service user data reported elsewhere.

Table 13.1 Comparability of expenditure estimates for government provided specialist disability services, by items included, 2003-04

<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^a</i>	<i>Aus Gov</i>
Superannuation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basis of estimate	Accrual	Accrual	Accrual	Accrual	Cash	Accrual	Accrual	Accrual	Accrual
Workers compensation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Payroll tax ^b									
Actual	✓	✓	✓			✓		✓	
Imputed		✓		✓	✓		✓		..
Apportioned umbrella department costs	✓	✓	✓	..	✓	✓	✓	✓	✓
Basis of apportioning									
Departmental formula	✓	✓	✓	..	✓	✓	x	✓	✓
% of FTE employees	x	x	x	..	x	✓	✓	x	x
Long service leave									
Entitlements	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basis of estimate	Accrual	Accrual	Accrual	Accrual	Cash	Accrual	Accrual	Accrual	Accrual
Depreciation	✓	✓	✓	✓	x	x	x	x	✓

FTE = full time equivalent. ^a In 2003-04, the NT changed the apportioning of umbrella departmental costs from the percentage of FTE employees to a departmental formula. ^b Actual payroll tax amounts are included in cost (expenditure) per user data for NSW, Victoria, Queensland, 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: State and Territory governments (unpublished).

Government and non-government provided services

Efficiency indicators are reported for both government and non-government provided services. Government provision means that a service is both funded and directly provided by a government department or agency. Non-government provision is a service purchased or part-funded by a government department or agency, but provided by a non-government organisation. Non-government service providers may receive funds from the private sector and the general public in addition to funding, grants and input tax concessions (such as payroll tax exemptions) from governments. Data on funds received by non-government service providers from the private sector and the general public are not included in this Report.

When considering the results of the efficiency indicators it is important to note the following, that for the:

- service user data, services provided by local governments are counted as government
- expenditure data, services provided by local governments are counted by most states as non-government.

This discrepancy between service user data and expenditure data for local government services only applies to accommodation support services provided in group homes and other community settings. In addition, it is not relevant for Tasmania, the ACT and the NT.

For the 2007 Report, the classifying of services provided by local governments will be reviewed. Consideration will be given to whether services provided by local governments are more appropriately grouped with non-government organisations or the government sector. Local government provided services will be classified consistently for service user and expenditure data in future reports.

Accommodation support services

Governments provide, purchase or part-fund accommodation support services to people with a disability in institutional/residential settings, group homes and other community settings. Institutional or residential accommodation support services are provided in both institutions and hostels. Community accommodation and care services are provided in group homes and other community settings. The accommodation support services provided in other community settings are attendant care/personal care, in-home accommodation support, alternative family placement and other accommodation support. In recent years, there has been an ongoing process of relocating people with a disability from institutional/residential

accommodation to community accommodation. As a result, total government expenditure on accommodation support services in institutional/residential settings has decreased, with a corresponding increase in expenditure on community accommodation and care services.

Cost per user of government provided accommodation support services

‘Cost per user of government provided accommodation support services’ is an indicator of the efficiency of specialist disability services (box 13.17).

Box 13.17 Cost per user of government provided accommodation support services

‘Cost per user of government provided accommodation support services’ is included as an output (efficiency) indicator of governments’ objective to provide specialist disability services in an efficient manner. A set of indicators are reported under this heading for a range of service types.

This indicator is defined as the net government expenditure per user of government provided accommodation support services in institutional/residential settings, group homes and other community settings.

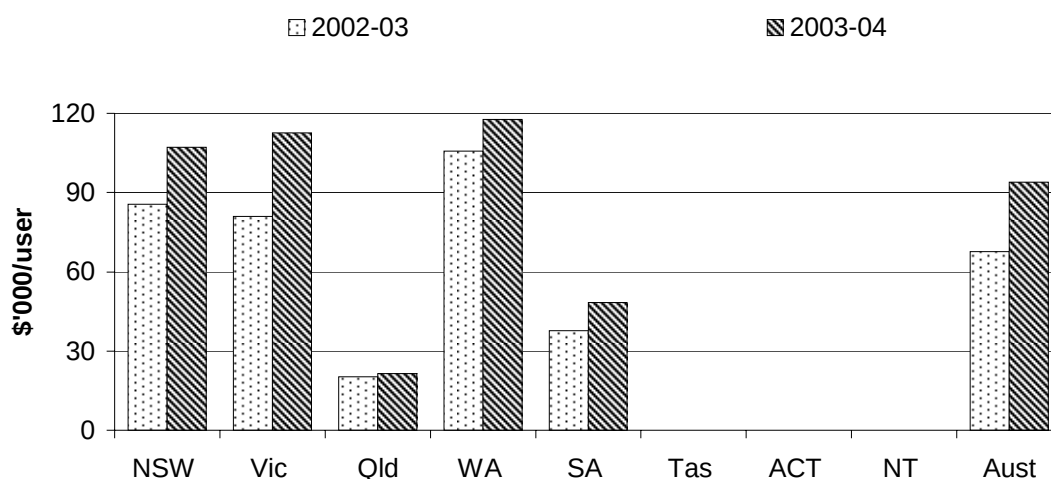
Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service.

Efficiency data are difficult to interpret. While high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided. Increasing expenditure may also reflect the changing needs of service users — for example, as the population of accommodation support service users ages, their support needs are also likely to increase. Similarly, low or declining expenditure per unit of output may reflect improving efficiency, or lower quality less effective services. Efficiency data thus always need to be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Cost per user of government provided accommodation support services — institutional/residential settings

Nationally, estimated annual government expenditure on accommodation support services in institutional/residential settings was \$93 908 per service user in 2003-04. There were no government provided accommodation support services in institutional/residential settings in Tasmania, the ACT or the NT (figure 13.18).

Figure 13.18 **Estimated annual government expenditure per user of government provided accommodation support services in institutional/residential settings (2003-04 dollars)^{a, b, c, d, e}**



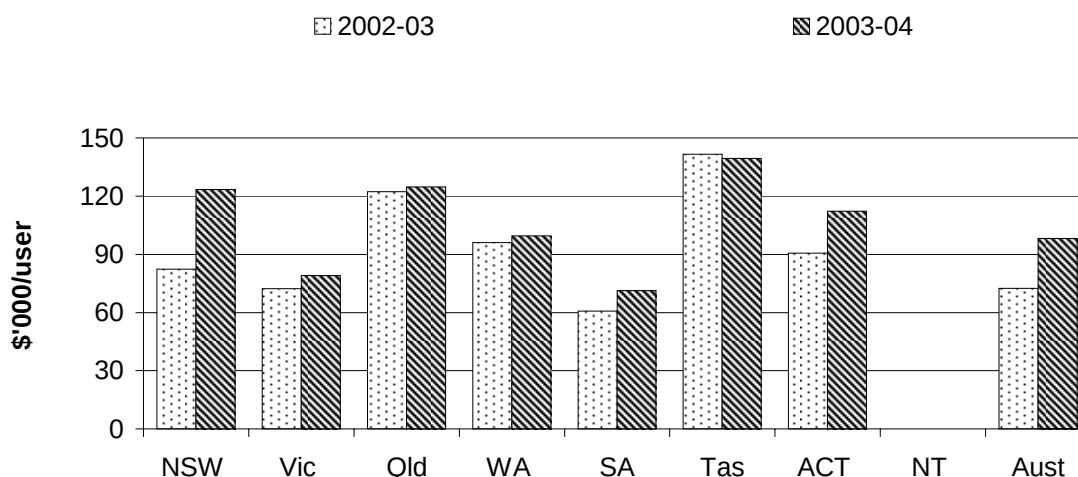
^a For 2002-03 data, estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. ^b The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. ^c Nominal expenditure in 2002-03 is shown in table 13A.24. ^d The number of NSW service users is underreported for 2002-03 and 2003-04 because of low response rates. ^e Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users.

Source: State and Territory governments (unpublished); AIHW (unpublished); table 13A.25.

Cost per user of government provided accommodation support services — group homes

Nationally, estimated annual government expenditure on government provided accommodation support services in group homes was \$98 289 per service user in 2003-04. There were no government providers of accommodation support services in group homes in the NT (figure 13.19).

Figure 13.19 Estimated annual government expenditure per user of government provided accommodation support services in group homes (2003-04 dollars)^{a, b, c, d, e, f, g}



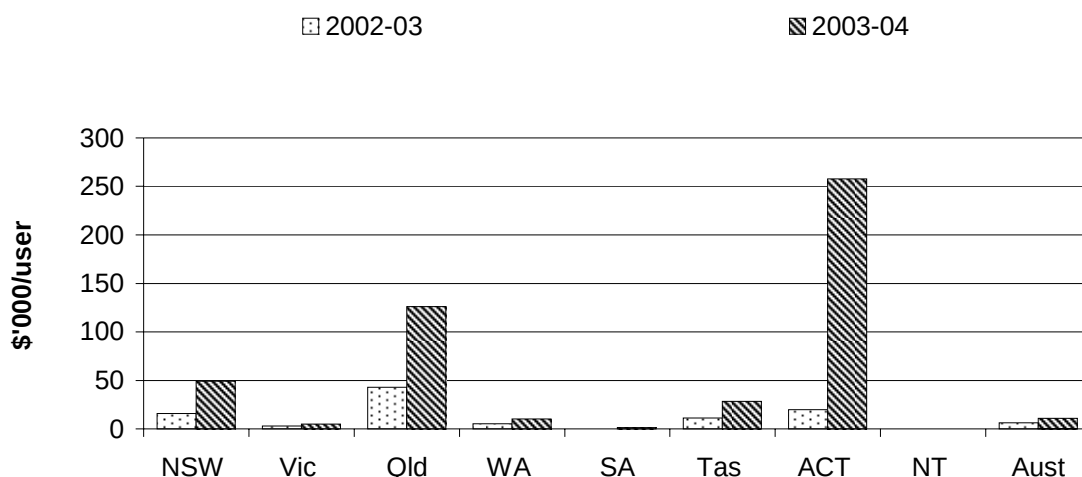
^a For 2002-03 data, estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. ^b The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. ^c Service user data used to derive this indicator include users of services provided by local government, while states' expenditure data exclude services provided by local governments (except Tasmania). The ACT does not have services provided by local governments. Thus this indicator needs to be interpreted with care. ^d Nominal expenditure in 2002-03 is shown in table 13A.24. ^e The number of NSW service users is underreported for 2002-03 and 2003-04 because of low response rates. ^f Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users. ^g Data for 2002-03, exclude three service users in WA whose agency sector (government/non-government) was not stated.

Source: State and Territory governments (unpublished); AIHW (unpublished); table 13A.25.

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 \$10 836 per service user in 2003-04. There were no government providers of accommodation support services in other community settings in the NT (figure 13.20).

Figure 13.20 Estimated annual government expenditure per user of government provided accommodation support services in other community settings (2003-04 dollars)^{a, b, c, d, e, f}



^a For 2002-03 data, estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. ^b The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. ^c Service user data used to derive this indicator include users of services provided by local government, while states' expenditure data exclude services provided by local governments (except Tasmania). The ACT does not have services provided by local governments. Thus this indicator needs to be interpreted with care. ^d Nominal expenditure in 2002-03 is shown in table 13A.24. ^e The number of NSW service users is underreported for 2002-03 and 2003-04 because of low response rates. ^f Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users. Data for 2002-03 exclude 44 service users in Victoria whose agency sector (government/non-government) was not stated.

Source: State and Territory governments (unpublished); AIHW (unpublished); table 13A.25.

Government contribution per user of non-government provided services

'Government contribution per user of non-government provided services' is reported as an indicator of the efficiency of specialist disability services (box 13.18).

Box 13.18 Government contribution per user of non-government provided services

Governments directly provide services to service users and also fund non-government service providers to deliver these services. The government contribution per user of non-government provided services is included as an output (efficiency) indicator of governments' objective to provide specialist disability services in an efficient manner. The focus on the contribution of governments reflects the Steering Committee's terms of reference, which require it to report on services funded and/or delivered by government.

A set of indicators are reported under this heading for a range of government funded service types. This indicator is defined as the net government expenditure per user of the following non-government provided services:

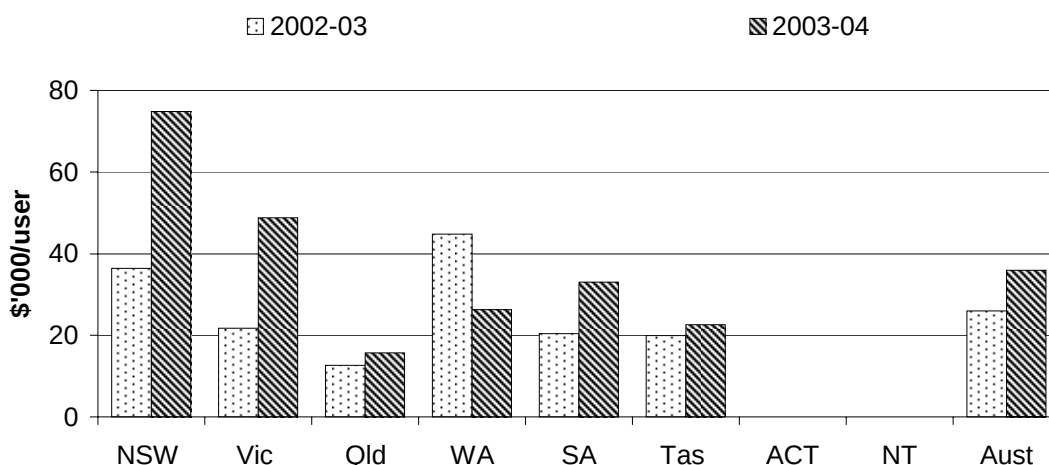
- accommodation support services in:
 - institutional/residential settings
 - group homes
 - other community settings
- employment services (reported per employment service user assisted).

Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service. Efficiency data, however, are difficult to interpret. While high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of service users. Similarly, low or declining expenditure per unit of output may reflect improving efficiency, or lower quality less effective services. Efficiency data thus always need to be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

*Government contribution per user of non-government provided services —
accommodation support services in institutional/residential settings*

Nationally, estimated annual government funding of non-government provided accommodation support services in institutional/residential settings was \$35 971 per service user in 2003-04 (figure 13.21). There were no non-government provided accommodation support services in institutional/residential settings in the ACT and the NT.

Figure 13.21 Estimated annual government funding per user of non-government provided accommodation support services in institutional/residential settings (2003-04 dollars)^{a, b, c, d, e}



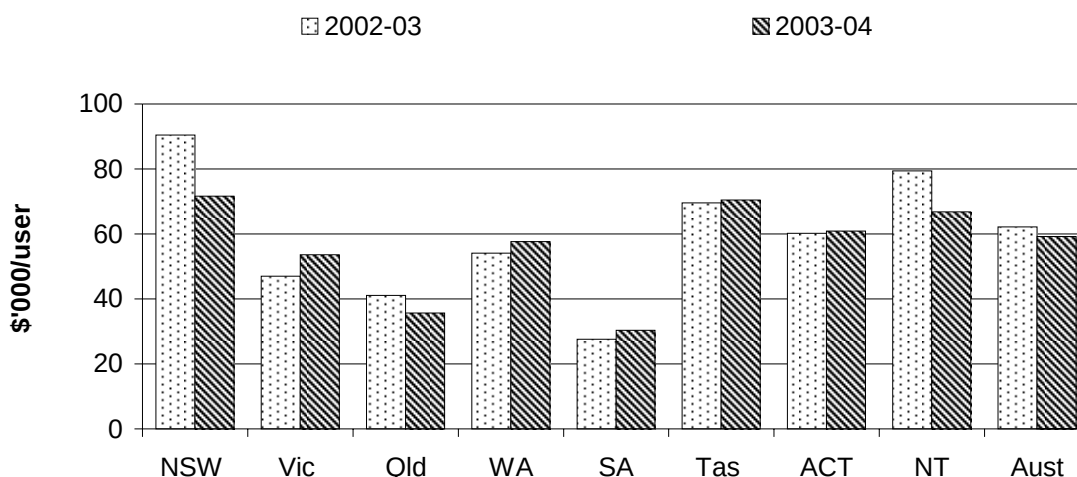
^a For 2002-03 data, estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. ^b The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. ^c Nominal expenditure in 2002-03 is shown in table 13A.24. ^d The number of NSW service users is underreported for 2002-03 and 2003-04 because of low response rates. ^e Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users.

Source: State and Territory governments (unpublished); table 13A.25.

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 \$59 213 per service user in 2003-04 (figure 13.22).

Figure 13.22 Estimated annual government funding per user of non-government provided accommodation support services in group homes (2003-04 dollars)^{a, b, c, d, e, f, g}



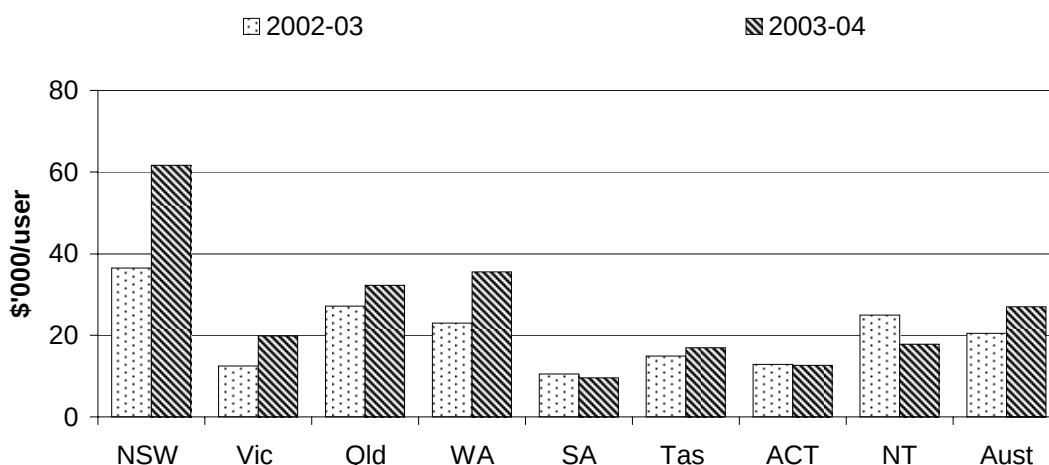
^a For 2002-03 data, estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. ^b The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. ^c Service user data used to derive this indicator exclude users of services provided by local government, while states' expenditure data include services provided by local governments (except Tasmania). The ACT and the NT do not have services provided by local governments. Thus this indicator needs to be interpreted with care. ^d Nominal expenditure in 2002-03 is shown in table 13A.24. ^e The number of NSW service users is underreported for 2002-03 and 2003-04 because of low response rates. ^f Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users. ^g Data for 2002-03 exclude three service users in WA whose agency sector (government/non-government) was not stated.

Source: State and Territory governments (unpublished); AIHW (unpublished); table 13A.25.

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 \$26 977 per service user in 2003-04 (figure 13.23).

Figure 13.23 Estimated annual government funding per user of non-government provided accommodation support services in other community settings (2003-04 dollars)^{a, b, c, d, e, f}



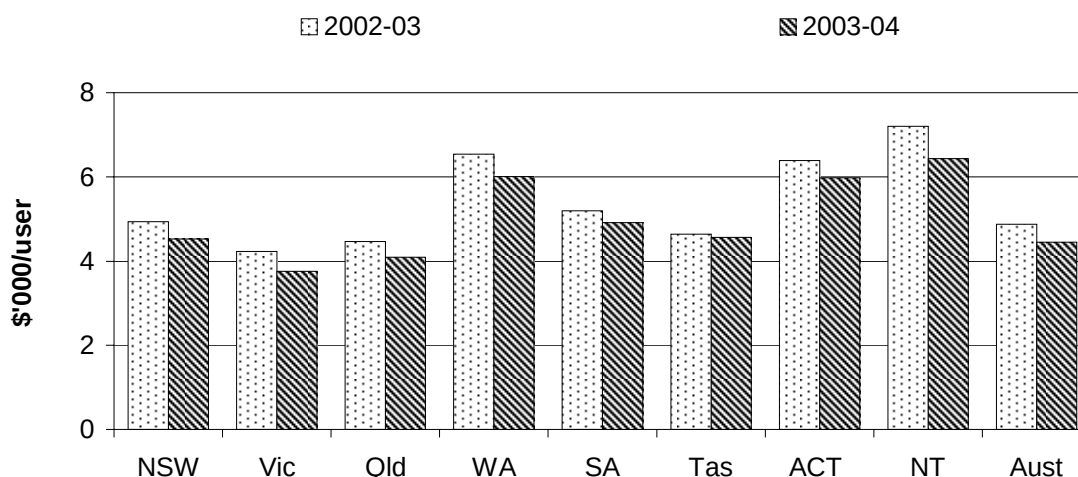
^a For 2002-03 data, estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. ^b The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. ^c Service user data used to derive this indicator exclude users of services provided by local government, while states' expenditure data include services provided by local governments (except Tasmania). The ACT and the NT do not have services provided by local governments. Thus this indicator needs to be interpreted with care. ^d Nominal expenditure in 2002-03 is shown in table 13A.24. ^e The number of NSW service users is underreported for 2002-03 and 2003-04 because of low response rates. ^f Victorian 2003-04 data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting of service users. Data for 2002-03 exclude 44 service users in Victoria whose agency sector (government/non-government) was not stated.

Source: State and Territory governments (unpublished); AIHW (unpublished); table 13A.25.

Government contribution per user of non-government provided services — per employment service user assisted

Assistance with employment for people with a disability was the responsibility of the Australian Government under the CSTDA in 2003-04. Nationally, for all employment services, government expenditure per service user assisted was \$4450 in 2003-04 (figure 13.24).

Figure 13.24 **Government funding per user of non-government provided employment services (2003-04 dollars)^{a, b}**



^a This indicator is derived using service user data provided by the AIHW. Cost per employment service user data may differ from those reported in the Australian Government's annual report, as the Australian Government and the AIHW use different rules to count the number of employment service users. The Australian Government focuses on the total number of service outlets used, whereas the AIHW focuses on the number of service users, irrespective of the number of service outlets the individual accesses. In addition, the Australian Government includes independent workers (1004 persons in the 2003-04 financial year) in calculating service user numbers, whereas the AIHW does not. ^b The 2002-03 service user data used to derive this indicator are for the period 1 January 2003 to 30 June 2003 only. Therefore, for 2002-03 the cost per employment service user for Australia differs from the cost per employment service user that would be derived using data in table 13A.28, which uses 12 month data.

Source: DFACS (unpublished); AIHW (unpublished); table 13A.27.

Nationally, estimated annual government expenditure per service user in 2003-04, by employment service type, was \$3401 on open programs (employment in the open labour market), \$6613 on supported programs (employment within the service provider) and \$3997 on open and supported mixed programs (table 13A.28). Table 13A.29 compares real expenditure by employment service type for 2002-03 and 2003-04.

Cost per user of State and Territory administered services

'Cost per user of State and Territory administered services' is an indicator of the efficiency of specialist disability services (box 13.19).

Box 13.19 Cost per user of State and Territory administered services

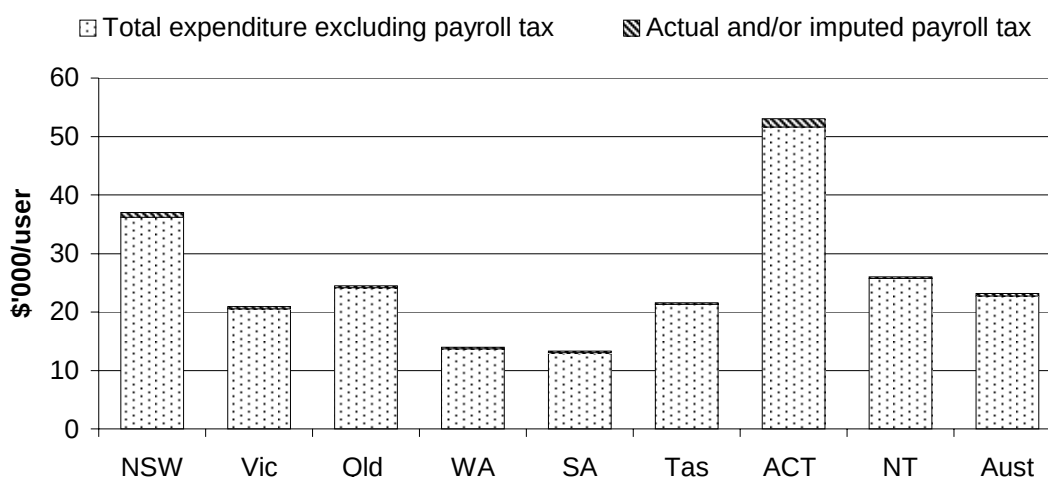
'Cost per user of State and Territory administered services' is an output (efficiency) indicator of governments' objective to provide specialist disability services in an efficient manner.

This indicator is defined as government expenditure on CSTDA State and Territory administered services per service user. Data are reported separately for government expenditure net of payroll tax and for government expenditure including actual and/or imputed payroll tax.

Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service. Efficiency data, however, are difficult to interpret. While high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of service users. Similarly, low or declining expenditure per unit of output may reflect improving efficiency, or lower quality less effective services. Efficiency data need to be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Total estimated government expenditure per user of CSTDA State and Territory administered specialist disability services in 2003-04 is reported both net of payroll tax and including actual and/or imputed payroll tax. Nationally, estimated expenditure per service user was \$22 719 excluding payroll tax and \$23 173 including actual and/or imputed payroll tax (figure 13.25).

Figure 13.25 Estimated annual government expenditure per service user of CSTDA State and Territory administered services, 2003-04^{a, b, c, d, e, f}



^a In some jurisdictions (NSW, Victoria in part, Queensland, Tasmania and the NT), payroll tax is paid directly by the service; in other jurisdictions (Victoria in part, WA, SA and the ACT), payroll tax is not paid directly by the service. ^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 The number of NSW service users is underreported because of low response rates. ^d Victorian service user data are reported to be significantly understated because errors in the 'date of last service received' and lower than expected response rates have led to undercounting. ^e Payroll tax data for Queensland includes paid payroll tax and accrued payroll tax. ^f In the NT, payroll tax relates to government service provision and excludes expenditure for program management and administration.

Source: AIHW (2005a, 2005b); State and Territory governments (unpublished); table 13A.30.

Output — efficiency — administrative cost

Administrative expenditure as a proportion of total expenditure

'Administrative expenditure as a proportion of total expenditure' is an indicator of the efficiency of the administration of specialist disability services (box 13.20). The proportion of total expenditure on administration is not yet comparable across jurisdictions because they apportion it using different methods. Administrative expenditure data are useful, however, for indicating trends within jurisdictions over time.

Nationally, administrative expenditure as a proportion of total government expenditure on specialist disability services (excluding payroll tax) decreased from 8.7 per cent in 2003-04 to 8.6 per cent in 2004-05 (figure 13.26).

Box 13.20 Administrative expenditure as a proportion of total expenditure

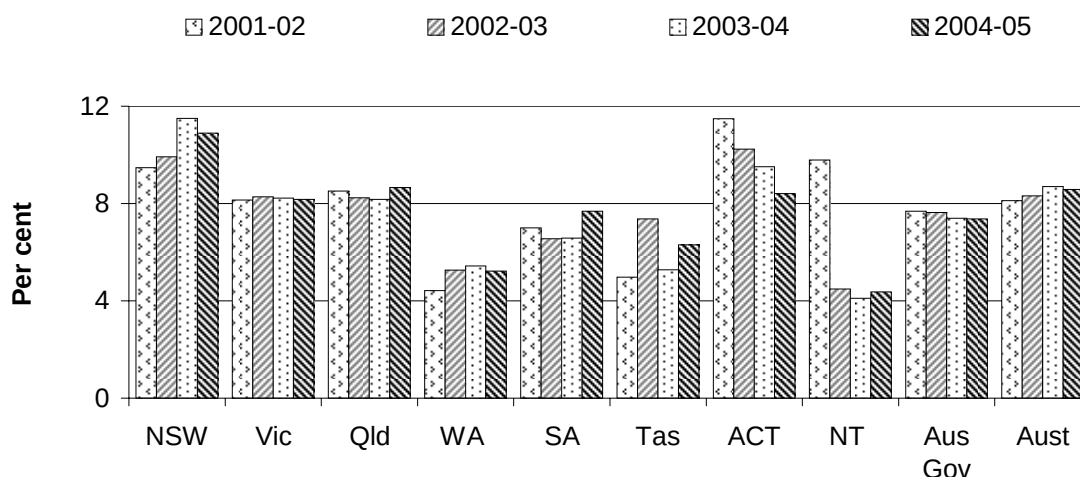
Administrative expenditure as a proportion of total expenditure is an output (efficiency) indicator of governments' objective to provide specialist disability services in an efficient manner. Administrative expenditure in this context represents the costs incurred by government agencies in administering CSTDA funded services.

This indicator is defined as government expenditure on administration as a proportion of total CSTDA expenditure.

Holding other factors constant (such as service quality and accessibility), a decrease in administrative expenditure as a proportion of total CSTDA expenditure may reflect an increase in administrative efficiency.

Efficiency data are difficult to interpret. While high or increasing administrative expenditure as a proportion of total expenditure may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the administrative services provided. Similarly, low or declining administrative expenditure as a proportion of total expenditure may reflect improving efficiency, or lower quality less effective services. Efficiency data thus always need to be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Figure 13.26 Administrative expenditure as a proportion of total expenditure^{a, b, c, d}



^a See table 13.1 for an explanation of different methods of apportioning departmental costs. ^b Data exclude payroll tax. ^c Australian Government administrative expenditure is an estimate, based on average staffing levels. ^d NT expenditure is underreported in 2001-02. For 2002-03, the method of apportioning administrative expenditure changed, resulting from a re-alignment of some costs previously reported under this category to direct service delivery. The NT changed from cash to accrual accounting in 2002-03, limiting the comparability of expenditure with previous years.

Source: Australian, State and Territory governments (unpublished); table 13A.31.

When actual or imputed payroll tax is included, the average national administrative expenditure as a proportion of total CSTDA expenditure was 8.4 per cent in 2004-05 (table 13A.31). Payroll tax data need to be interpreted with caution, however, because some jurisdictions (NSW, Victoria [in part], Queensland, Tasmania and the NT) have provided payroll or payroll tax data on the basis of direct service delivery expenditure for government provided services, and others (WA, SA and the ACT) have provided the data on the basis of total expenditure for government provided services. Nominal and real total CSTDA expenditure is reported in tables 13A.3 and 13A.4, both excluding and including actual or imputed payroll tax amounts.

Outcomes

Labour force participation and employment of people with a disability

‘Labour force participation and employment of people with a disability’ is an indicator of outcomes for specialist disability services (box 13.21). Detailed definitions and calculations of labour force participation and employment rates are provided in section 13.6.

Box 13.21 Labour force participation and employment of people with a disability

‘Labour force participation and employment of people with a disability’ is an outcome indicator of governments’ objective of assisting people with a disability to participate fully in the community. Participation in the labour force and employment is important to the overall well being of people with a disability, particularly in terms of the opportunity for self-development and interaction with people outside the home.

This indicator is defined as the labour force participation rates and employment rates of people aged 15–64 years with a profound or severe core activity limitation compared with the rates of people aged 15–64 years in the general population.

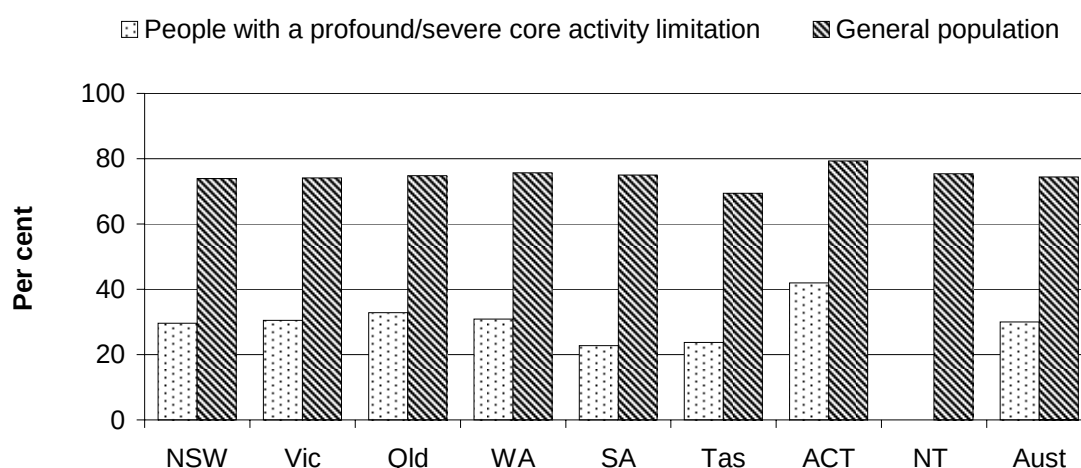
A higher labour force participation or employment rate for people with a disability is likely to increase the quality of life for these people by providing greater opportunities for self-development and interaction with people outside the home.

This indicator does not provide information on why people cannot find the work they are looking for. It also does not provide information on why people choose not to participate in the labour force. Finally, it does not provide information on whether the jobs that people find are appropriate or fulfilling.

Labour force participation

Nationally, the estimated labour force participation rate of people aged 15–64 years with a profound or severe core activity limitation in 2003 (30.0 per cent) was below that of the general population aged 15–64 years (74.4 per cent) (figure 13.27).

Figure 13.27 Estimated labour force participation rates of people aged 15–64 years, 2003^a

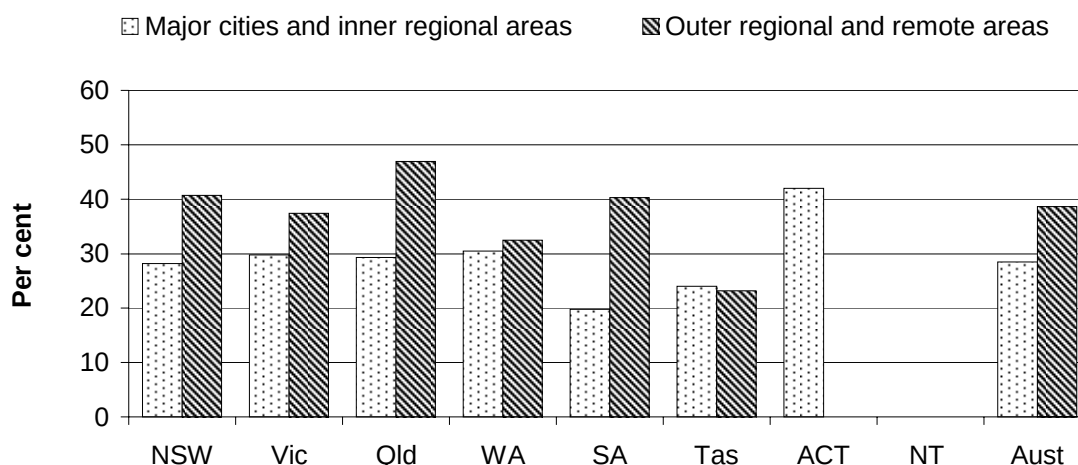


^a Data for people with a disability in the NT are not reported separately due to small numbers, but contribute to the national estimates.

Source: ABS (Labour Force Survey Cat. no. 6291.0.55.001 [Supertable LM8], Disability, Ageing and Carers Survey [unpublished]); table 13A.32.

The labour force participation rate of people aged 15–64 years with a profound or severe core activity limitation varied across geographic locations and by country of birth, in 2003. Nationally, the estimated participation rate of people with a profound or severe core activity limitation living in outer regional and remote areas (38.6 per cent) was above that of those living in major cities and inner regional areas (28.5 per cent) (figure 13.28).

Figure 13.28 Estimated labour force participation rates of people aged 15–64 years with a profound/severe core activity limitation, by geographic location, 2003^{a, b}

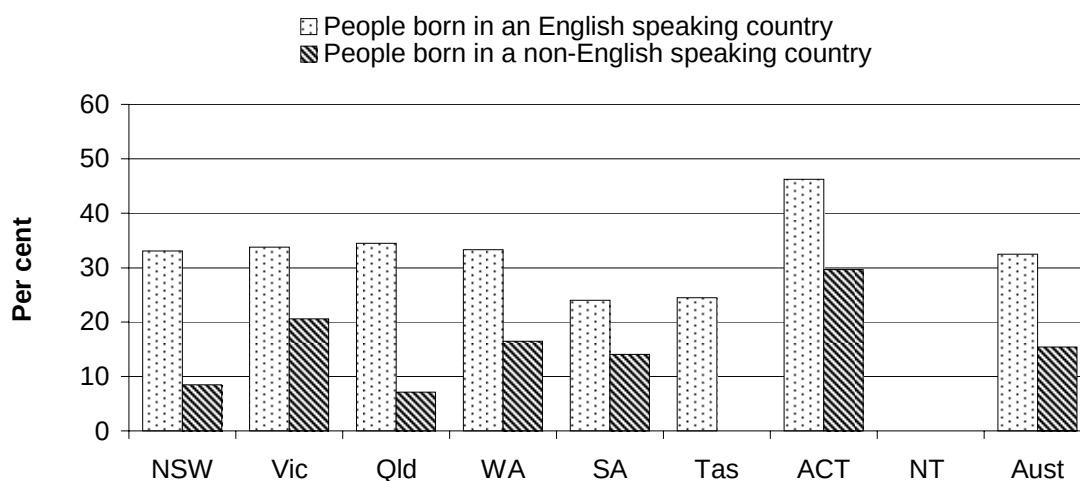


^a The ACT does not have outer regional and remote areas. ^b Data for people with a disability in the NT are not reported separately due to small numbers, but contribute to the national estimates.

Source: ABS Disability, Ageing and Carers Survey (unpublished); table 13A.33.

Nationally, the estimated labour force participation rate of people aged 15–64 years with a profound or severe core activity limitation who were born in a non-English speaking country (15.4 per cent) was below that of those born in an English speaking country (32.5 per cent) (figure 13.29).

Figure 13.29 **Estimated labour force participation rates of people aged 15–64 years with a profound/severe core activity limitation, by country of birth, 2003^{a, b}**



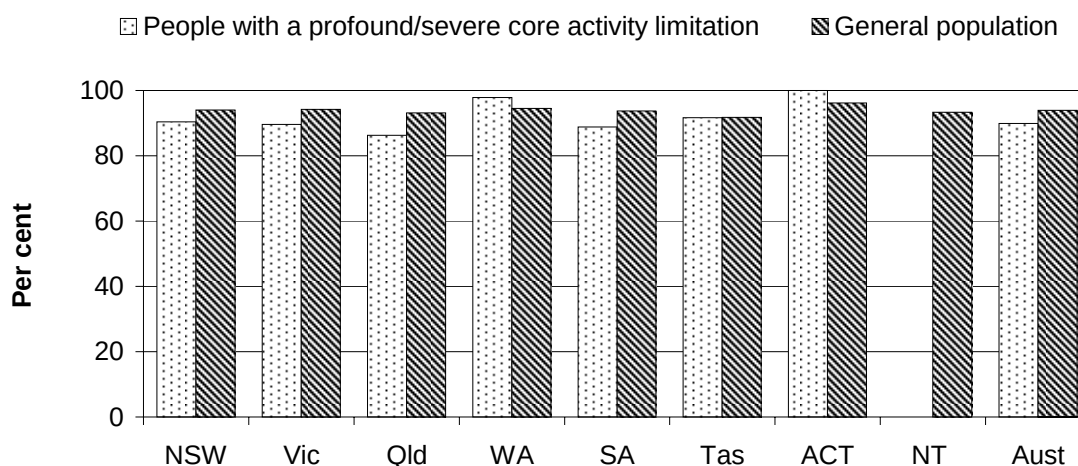
^a The data for Tasmanian people born in a non-English speaking country are not reported as the relative standard error was greater than 50 per cent. ^b Data for people with a disability in the NT are not reported separately due to small numbers, but contribute to the national estimates.

Source: ABS Disability, Ageing and Carers Survey (unpublished); table 13A.33.

Employment

Nationally, the estimated employment rate of people aged 15–64 years with a profound or severe core activity limitation in 2003 (89.9 per cent) was below that of the general population aged 15–64 years (93.9 per cent) (figure 13.30).

Figure 13.30 **Estimated employment rates of people aged 15–64 years, 2003^a**



^a Data for people with a disability in the NT are not reported separately due to small numbers, but contribute to the national estimates.

Source: ABS (Labour Force Survey Cat. no. 6291.0.55.001 [Supertable LM8], Disability, Ageing and Carers Survey [unpublished]); table 13A.32.

The employment rates in 2003 of people aged 15–64 years with a profound or severe core activity limitation across geographic locations and by country of birth are shown in table 13A.33. Nationally, the estimated employment rate of people with a profound or severe core activity limitation living in outer regional and remote areas (90.0 per cent) was similar to that of people living in major cities and inner regional areas (89.9 per cent) (table 13A.33). Nationally, the estimated employment rate of people with a profound or severe core activity limitation who were born in a non-English speaking country (89.2 per cent) was similar to that of people who were born in an English speaking country (90.0 per cent) (table 13A.33).

Social participation of people with a disability

‘Social participation of people with a disability’ is an indicator of outcomes for specialist disability services (box 13.22).

Box 13.22 Social participation of people with a disability

'Social participation of people with a disability' is an outcome indicator of governments' objective to assist people with a disability to live as valued and participating members of the community.

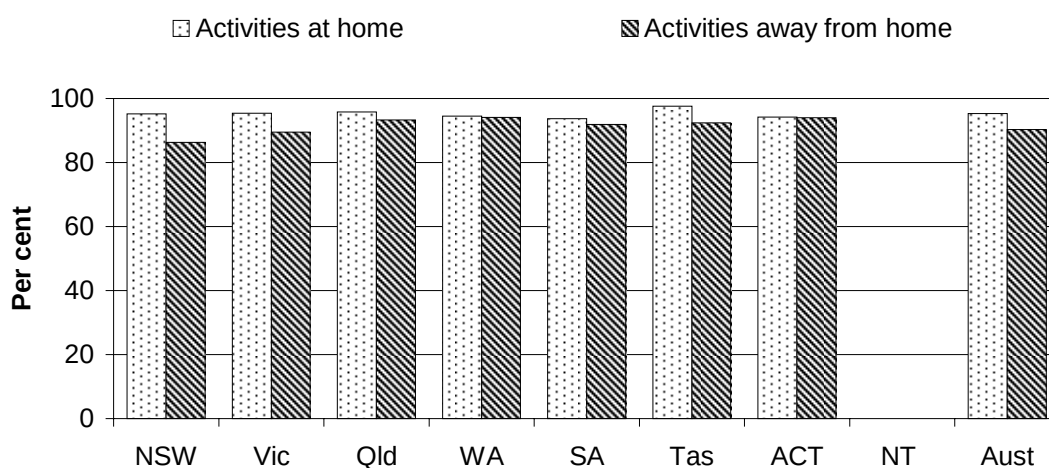
This indicator is defined as the proportion of people aged 5–64 years with a profound or severe core activity limitation who participate in social or community activities both in and away from home.

A higher proportion of people aged 5–64 years with a profound or severe core activity limitation who participate in social activities reflects their greater integration in the community.

This indicator does not provide information on the degree to which the identified types of social participation contribute to people's quality of life. It also does not provide information on why some people did not participate.

Nationally, the estimated proportion of people aged 5–64 years with a profound or severe core activity limitation who participated in social activities at home was 95.3 per cent in 2003, and the estimated proportion who participated in social activities away from home was 90.3 per cent (figure 13.31). Table 13A.34 includes detail of the types of activity in which people with a profound or severe core activity limitation participated.

Figure 13.31 **Estimated proportion of people aged 5–64 years with a severe or profound core activity limitation who participated in social activities, 2003^{a, b}**



^a Data for the ACT contain relative standard errors over 25 per cent. ^b Data for the NT are not reported separately due to small numbers, but contribute to the national estimates.

Source: ABS Disability, Ageing and Carers Survey (unpublished); table 13A.34.

In 2004, WA conducted a survey of users of disability services (or their carers) on their participation in various social activities. Results of this survey are provided in box 13.23.

Box 13.23 Social participation of people with a disability in WA

In 2004, 688 randomly selected users of disability services (or their carers) were surveyed on their participation in a range of social activities. The questions used in the survey were based largely on previous surveys but were modified to align with the International Classification of Functioning categorisation of functions.

The surveyed service users (or carers) were asked if they participated in the activities 'often', 'sometimes', 'rarely' or 'never'. The 'often' and 'sometimes' categories were combined to indicate participation in these activities. Surveyed service users were also asked whether they wanted to participate in the activities 'more often', 'less often' or 'not change'.

The following are the reported results of service users' participation, where:

- 67 per cent reported going out to entertainment (for example, movies, restaurants and concerts), 15 per cent reported never going out to entertainment and 45 per cent reported wanting to participate in these activities more often
- 56 per cent reported being involved in group leisure or sport, 35 per cent reported never being involved in group leisure or sport and 34 per cent reported wanting to participate in these activities more often
- 77 per cent reported being involved in individual activities such as going to the park, walking or swimming, 9 per cent reported never being involved in individual activities and 41 per cent reported wanting to participate in these activities more often
- 33 per cent reported attending cultural, religious or community events, 57 per cent reported never being involved in these events and 11 per cent reported wanting to participate in these activities more often
- 62 per cent reported communicating with people other than carers, friends or family members, 24 per cent reported never communicating with these people and 24 per cent reported wanting to communicate with these people more often.

Source: WA Government (unpublished).

Use of other services

'Use of other services' is an indicator of outcomes for specialist disability services (box 13.24).

Box 13.24 Use of other services

‘Use of other services’ is an outcome indicator of governments’ objective of enhancing the quality of life experienced by people with a disability by assisting them to gain access to mainstream government and community services and facilities.

Data on the participation by people with a disability in various services are incorporated in the performance indicator frameworks for other chapters of this Report. Participation is reported for VET (see chapter 4), children’s services (see chapter 14) and public, community and State owned and managed Indigenous housing (see chapter 16).

13.4 Future directions in performance reporting

There is scope for further improvements in reporting against the current framework, including improving the data on service quality. The Steering Committee intends to address limitations over time by:

- considering whether the most recent year’s service user data are available for reporting
- examining reporting on younger people with a disability in residential aged care facilities
- reporting additional indicators on CSTDA services for which performance data are currently not included (in particular, respite and community support services)
- reporting additional indicators on services for Indigenous people with a disability where possible
- reviewing the classification of services provided by local governments to ensure consistency across data sources
- reporting national client and carer satisfaction with service quality
- reporting more complete, current, ongoing quality assurance processes data.

Under the umbrella of the multilateral CSTDA, the Australian Government has signed individual agreements with each State and Territory government. In these agreements, the governments (with the exception of the NT) have agreed to work in partnership to improve the access of younger people with a disability in residential aged care facilities to appropriate specialist disability services and supports, and to explore alternative support models that meet the individual needs of young people in residential aged care facilities.

The importance of the issue of younger people with a disability in residential aged care facilities is highlighted by the Council of Australian Government's Working Group in Health placing the issue on its agenda in 2005.

The Steering Committee will consider the need for an indicator on younger people with a disability in residential aged care facilities for the 2007 Report. Recent work on this issue (listed below) will inform the Steering Committee's decision:

- a Senate inquiry into aged care, which included in its terms of reference an examination of the appropriateness of younger people with a disability being accommodated in residential aged care facilities. The inquiry report was released in June 2005.
- NDA projects on disability and ageing; and people with high clinical/medical support needs. Reports on these projects are scheduled for release by mid-2006.

The Steering Committee intends to include performance data for respite and community support services in the 2007 Report. Reporting on quality assurance processes is expected to become more complete and comparable over time, with refinements to performance indicators and data collections.

13.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

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This is the first Report where all jurisdictions have supplied full financial year data, thereby providing a more comprehensive picture of the disability services sector, and likely better service provision to people with a disability.

The Australian Government has collected full financial year data through its annual Disability Services Census since 2000. Data are collected for all Australian Government funded disability services under the Commonwealth State/Territory Disability Agreement (CSTDA), including staff hours and hours of service provider operation. More detailed information is collected on disability employment services, namely demographic and outcome measures on consumers of these services.

The data derived from the Disability Services Census are used by government and non-government agencies and researchers, and allow a better understanding of consumers and providers of Australian Government funded disability services.

Additional information on the Disability Services Census is available on the FaCS website at <http://www.facs.gov.au/dscensus>.

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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 Department of Ageing Disability and Home Care during 2004-05 focused its attention on challenges such as the ageing of people with a disability and their carers, growing demand for services and the changing needs of clients.

Expenditure on disability services in NSW increased by 6 per cent in 2004-05 to \$1.052 billion. Additional resources have been used to meet growing demand for disability services and ensure that existing levels of access to services are maintained. Significant resources were also invested in more assistance for children and families, improved support for school leavers, and assisting non-government organisations facing sustainability pressures.

Initiatives focusing on children and young people with a disability included increasing services through a broader range of support options and funding additional children's case managers.

NSW initiated wide-ranging discussion with the supported accommodation sector on accommodation models for people with a disability, looking to expand the current models available to better meet the needs of people with a disability.

Expenditure on post school services increased to \$61 million, with additional funding in 2004-05 provided to implement reforms to increase long-term security for school leavers with a disability. Two new programs, Community Participation and Transition to Work, were introduced to provide alternatives to work, and to improve the work readiness of school leavers.

NSW developed an Integrated Monitoring Framework (IMF) to monitor service providers' performance in accordance with Funding Agreements, including agreed outputs and quality standards. In 2004-05 a successful trial of the service review component of the IMF was undertaken. The IMF draws together a consistent and improved approach that will provide Government with information necessary to ensure program funds are spent appropriately and that service providers are performing well. It will also enable the Government and providers to engage in improvement activities focused on achieving better outcomes and quality of services for clients.

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Victorian Government comments

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The Victorian Government, through its social policy statement, *A Fairer Victoria*, is committed to reforming the way people with a disability are supported to ensure that services give people maximum choice and opportunity in the way they live their lives. There is an emphasis on individual choice, carer support and early intervention to enable people to live independently in the community.

In 2004-05, some key achievements included:

- the ongoing redevelopment of Kew Residential Services, with a total of 192 residents having now moved to 38 community houses
- the continued focus on the Individual Planning and Support approach and the provision of an additional 360 *Support and Choice* packages
- the development of alternative accommodation options through the Accommodation Innovation Grants program and individualised support packages. Over the past two years, 100 people have moved (or are now preparing to move) to a more independent option that suits their individual needs and lifestyle
- the further rollout of *MetroAccess*, which, together with *RuralAccess*, is effectively building community capacity (social capital) to support people with a disability, thereby reducing the requirement for formal services, and increasing access to local community infrastructure and services
- the completion of phase two of the review of disability services legislation, including developing recommendations, releasing a report and conducting public consultation.

Victoria continues to invest heavily in the implementation of the National Minimum Dataset (NMDS) by providing ongoing training and support to assist disability agencies to collect data through the Quarterly Data Collection (QDC). For quarter four in 2004-05 the response rate was almost 98 per cent.

Despite the significant increase in response rates there are still a number of data quality issues, which impact on our ability to accurately reflect the level of support provided to people with a disability. Some key data items collected, such as consent, date of birth (DOB), sex, postcode, start date and individual program plans (IPPs), are often either missing or inaccurate. Victoria is committed to a number of activities to maintain response rates and improve data quality.

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Queensland Government comments

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During 2004-05 Queensland continued, in partnership with other stakeholders, to implement the *Future Directions for Disability Services* to advance the achievement of the five strategic policy priorities that underpin the CSTDA and to support an efficient and responsive disability services system that delivers quality outcomes for people with a disability.

Providing support for more adults and young people with a disability, increasing support for families who care for a child, children or adult family member with a disability and creating opportunities to improve and strengthen disability services were a high priority for Queensland.

Support was provided to an additional 177 adults with a disability, through the Adult Lifestyle Support Program, to enable them to maintain living arrangements, build and strengthen social relationships and increase participation in the community, bringing the total number of people supported through this program to 1319.

The Post School Services Program provided support to plan for the transition from school to an independent adult life to an extra 162 school leavers with a disability and their families.

Through the Local Area Coordination Program 1716 people with a disability and their families were provided assistance to access services and information in their local area, an increase of 366 from 2003-04. The Family Support Program provided support to more than 950 families who care for a child, children or adult with a disability whose high and complex support needs are not being met through the existing disability services system. This represents an increase of more than 250 families supported from 2003-04.

Queensland continued implementation of the Disability Sector Quality System through the provision of financial and other assistance to service providers to establish their internal quality management systems and undertake initial external assessment.

Queensland continues to progress legislative reform including the review of the *Disability Services Act 1992*. Through consultation, the disability sector has made an important contribution to defining the ways this legislation can be strengthened. The new disability legislation is scheduled for introduction in late 2005, with implementation starting from mid-2006.

Extensive consultation has been undertaken on the proposed reforms to the current approaches to assessment, prioritisation, service delivery and funding for people who seek services from the specialist disability support system. There were over 1800 responses to the consultation paper 'Have Your Say: On improving disability services in Queensland'. Implementation options will be considered by the Queensland Government in 2005-06.

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Western Australian Government comments

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The WA Government has continued to build upon the work of previous years in developing and sustaining services for people with disabilities and their carers and has continued to collect whole-of-year data for the NMDS.

This year, emphasis has been placed on strengthening and forging partnerships with the disability sector. An outcome of this collaboration is the development of the inaugural Disability Industry Plan, a five-year plan aimed at assisting the sector to achieve the highest outcomes for people with disabilities and their families within current resources.

Work has also focussed on increasing community awareness and enhancing community responsiveness to people with disabilities and their families. A range of community awareness strategies were implemented including a community awareness campaign, ‘Open Your Mind and Count Us In’, to promote the inclusion of people with disabilities in all aspects of community life.

In addition, work has continued on developing accessible and appropriate services for people with disabilities in regional areas of Western Australia and the Indian Ocean Territories.

Targeted strategies were implemented to support Indigenous Australians and people from culturally and linguistically diverse backgrounds including the development of an Indigenous Policy Framework, a more relevant and responsive Local Area Coordination Program, increased accessibility of advocacy services and the translation of brochures into seven languages.

Support to individuals, families and carers has continued with increased provision of community-based accommodation support, family support, therapy and a steady increase in the number of people who were supported through Local Area Coordination. Day options have increased, particularly for school leavers and those aged over 54 years of age. A two-year pilot program, Learning for Work, was introduced to assist school leavers who require further skill development to successfully maintain employment.

Improving service quality has been a focus this year with the development of the Ninth Disability Services Standard, ‘Protection of Human Rights and Freedom from Abuse and Neglect’. A number of sector training sessions have been held in regional and metropolitan areas.

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South Australian Government comments

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The Disability Services Office of the Department for Families and Communities (DFC) in SA continued its focus on improved service delivery, deinstitutionalisation, and a greater commitment to the needs of special groups such as children, Aboriginal people and ageing carers. A business plan, aligned with the DFC Strategic Plan and the Disability Services Framework 2004–2007 was completed. Following are some of the achievements of 2004–05:

- consolidation of plans to relocate 400 people with a disability from institutional accommodation into community accommodation
- the development of a Health Support Training and Competency Based Assessment of Care Workers policy
- the introduction and roll out of joint Commonwealth and State Ageing Carer Funding for respite for ageing carers of people with a disability
- cabinet endorsement of the Companion Card which will enable carers of people with a disability to accompany them on public transport and access entertainment and other venues for free
- initiation of a project to review the needs of children with a disability under the Guardianship of the Minister in conjunction with Child, Youth and Family Services
- the development of a programme to move 15 younger people with disabilities out of Aged Care Facilities utilising Australian Government Innovative Pool Funding
- work to establish a protocol between agencies in the disability sector and Commonwealth Aged Care Assessment Teams to prevent younger people from being admitted to Aged Care Facilities
- the signing of a Tri-State Agreement between South Australia, Western Australia and the Northern Territory to improve services to Aboriginal people with a disability in the Anangu Pitjantjatjara Yankunytjatjara Lands
- the opening of an Options Coordination Office based at the Ceduna Koonibba Aboriginal Health Service to increase access to case management services for Aboriginal people
- governance training for Aboriginal community leaders and the establishment of physiotherapy services and day services in the Amata and Pukatja Communities
- a proposal to establish the Centre for Intellectual Disability Health in collaboration with the health, disability and education sectors
- the introduction of new arrangements in Day Options to provide a five day a week service for people with intellectual disability within current funding benchmarks, including improved assessment to ensure a smooth transition for children with a disability from school to day options.

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Tasmanian Government comments

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The 2004-05 State Budget provided additional funding of \$3.8 million for disability services. Supplementary funding of \$2.6 million was also delivered in November 2004. The additional funding allowed service expansion in the areas of individual funding, day support, accommodation and intensive support services.

Disability Services' Individual Funding Unit was formally established during 2004-05. Over 90 new recurrent support and respite packages and 34 one-off individual support packages were created. This allowed more people to receive flexible support in their own homes and local communities.

Growth funding enabled the provision of additional support for 22 people with high and complex support needs, 85 new day support packages and 35 support packages for school leavers through the Supporting Individual Pathways program. Significant work was also undertaken to plan and develop new accommodation services and facilities due to come on line in the next two years.

The development of quality improvement strategies and processes was another focus area during 2004-05. Initiatives include:

- an independent review of Disability Services' evaluation process. Recommendations from the review will form the basis of a revised and improved service evaluation system
- development of a workforce learning and development strategy. The Strategy aims to increase understanding about ways to support people with a disability, their families and carers, increase the skills of workers to provide this support, and create a culture which supports and encourages ongoing learning and development.

Other achievements include the development of pilot projects to provide flexible day support services for working parents and people living in remote areas, to provide support for new parents with a disability, and to establish an innovative and flexible respite model in a rural area.

The Tasmanian Government continued to work with members of the community to develop the Disability Framework for Action. The Framework aims to promote leadership across all State Government Agencies to institute a whole of Government approach to policy, planning and service delivery for Tasmanians with a disability. The Framework also sets out what the Tasmanian Government is doing to promote a society in which people with disability are able to enjoy the same rights and opportunities as all other citizens and participate fully in the life of the community.

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Australian Capital Territory Government comments

“ The Department of Disability, Housing and Community Services continues to work towards developing a range of support models to meet the different requirements of individuals with disabilities, their families and carers and to achieving equitable access, eligibility and funding arrangements across the sector. The availability of more accurate data in improved small area estimates will better inform the Department's planning processes.

The Future Directions: a framework for the ACT 2004–2008 sets out four strategic directions to support people with disabilities in the ACT:

- promote an inclusive society
- strengthen the capacity of individuals and families to maximise control over their lives
- improve planning and use of available funding
- in partnership with the Community Sector, strengthen the sustainability and responsiveness of the Service Delivery Sector.

Initiatives targeted to meeting these challenges include:

- the development of an Intensive Treatment and Support Program for people who have a dual disability, high and complex needs and who are at risk of entering or re-entering the criminal justice system. The aim of the program is to provide a transitional system of treatment and support that will enable clients to integrate back into the community. It is anticipated that this program will result in significantly more cost-efficient and effective services to this client group
- working with the service delivery sector to develop and implement a comprehensive workforce strategy. Work to date includes a sector-wide survey of the ACT disability workforce identifying characteristics and working patterns, implementation of a program of events for disability support workers and the establishment of a Certificate IV in Disability Work
- Disability ACT and the Australian Government jointly sponsored a project to evaluate the participation of people with disabilities in post-school opportunities and identify barriers to achieving meaningful employment and vocational opportunities. Disability ACT will continue to work with the Australian Government to develop future directions that will maximise the effectiveness of service delivery and co-ordination in this area
- in the 2004-05 budget the ACT Government provided funding for the introduction of a Local Area Coordination program (LAC). The LAC will allow a single point of entry in the community for people with disabilities, their families and carers. The program will provide information, referral and assistance to access formal and informal supports and services. The LAC has been developed with significant input from the disability community and service sector to maximise its effectiveness.

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Northern Territory Government comments

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Compared to other jurisdictions, the NT has unique socio-economic and environmental factors that necessitate flexible and creative ways of delivering specialist disability services. These factors include a relatively young population, a high proportion of Aboriginal and Torres Strait Islander (30 per cent) population who live in remote or very remote communities, and an environment as diverse as desert and wet tropics.

Free-standing, mainstream and traditional disability services are often not suitable, viable or sustainable in remote Indigenous communities. It is for these reasons that the Northern Territory has continued to provide disability services through pooled resources across a range of health and community services sources.

The ‘trans-disciplinary’ approach to Allied Health and Positive Behaviour Support Initiatives first implemented in 2003-04 have further expanded to assist more remote residents. These initiatives arise from the NT Government’s policy of supporting people in their home communities and a strong commitment to increasing the level of services to remote communities.

Other initiatives focused on services to families, including the development of a joint protocol with the NT Family and Children’s Services program to deliver coordinated support to children with disabilities and their families. A new family based alternative care service has been developed, commencing in Central Australia in 2005, with plans to be rolled out in the Top End in 2006.

At the National level, the NT jointly developed a four year Tri-State Disability Strategic Framework with SA and WA for people with disabilities living in the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Lands of central Australia. A joint MOU, with a commitment to work collaboratively through joint planning and providing services through a single contract, was signed by the Ministers of the three jurisdictions in July 2005.

The Department of Health and Community Services, as part of its services reform agenda, is for the first time undertaking a comprehensive review of disability services. The Review will commence in early 2006, with the aim of enhancing opportunities and outcomes for people with disabilities, their carers and families.

As was noted in earlier reports, NT potential population estimates need to be interpreted with caution. The small NT population yields small sample size, and subsequently, a high standard error.

The NT is committed to support national strategies to improve data collection and reporting, particularly in relation Indigenous and rural and remote residents.

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13.6 Definitions of key terms and indicators

Accommodation support service users receiving community accommodation and care services	People using CSTDA NMDS accommodation support service types 1.04–1.08, as a proportion of all people using CSTDA accommodation support services (excludes specialist psychiatric disability services). See AIHW (2005a) for more information on service types 1.04–1.08.
Administration expenditure as a proportion of total expenditure	The numerator — expenditure (accrual) by jurisdictions on administering the disability service system as a whole (including the regional program management and administration, the central policy and program management and administration, and the disability program share of corporate administration costs under the umbrella department, but excluding administration expenditure on a service that has been already counted in the direct expenditure on the service) — divided by the denominator — total government expenditure on services for people with a disability (including expenditure on both programs and administration, direct expenditure and grants to government service providers, and government grants to non-government service providers).
Core activities as per the 2003 ABS Survey of Disability, Ageing and Carers	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 (2005a) 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 2003 Survey of Disability, Ageing and Carers 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], 5.02 [supported], 5.03 [combined open and supported]) — divided by the denominator — number of service users who received assistance. See AIHW (2005a) 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 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. As Indigenous people have significantly higher disability prevalence rates and greater representation in CSTDA 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 two and adding the data for non-Indigenous Australians. Hence Indigenous Australians are weighted at two 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 2005a).

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 Survey of Disability, Ageing and Carers).
Moderate core activity limitation	Not needing assistance but having difficulty performing a core activity task (as per the ABS 2003 Survey of Disability, Ageing and Carers).
Non-English speaking country of birth	People with a country of birth other than Australia and classified in English proficiency groups 2, 3 or 4 (DIMA 1999). These countries include countries other than New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States.
Potential population	Potential population estimates are used as the denominators for performance indicators on access to accommodation support services, access to employment services, and access to community access services. The term 'potential population' is not the same as the population needing the services. Rather, it indicates those with the potential to require disability support services, which include individuals who meet the service eligibility criteria but who do not demand the services. The potential population for CSTDA funded accommodation support services is the number of people aged under 65 years who have a profound or severe core activity limitation, adjusted for the Indigenous factor. The potential population for CSTDA funded employment services is the number of people aged 15–64 years with a profound or severe core activity limitation, adjusted for the Indigenous factor and the labour force participation rate. The potential population for CSTDA funded community access services for 2003-04 data is the number of people under 65 years with a profound or severe core activity limitation, adjusted for the Indigenous factor. For 2002-03 data, the potential population is derived using the same method but includes only people aged 15–64 years. The ABS concept of a 'profound or severe' core activity limitation that relates to the need for assistance with everyday activities of self-care, mobility and communication was argued to be the most relevant population for specialist disability services. The relatively high standard errors in the prevalence rates for smaller jurisdictions, as well as the need to adjust for the Indigenous population necessitated the preparation of special estimates of the 'potential population' for specialist disability services. Briefly, the potential population was estimated by applying the 2003

	national age- and sex- specific rates of profound or severe core activity limitation to the age and sex structure of each jurisdiction in the current year, to give an 'expected current estimate' of people with a profound or severe core activity limitation in that jurisdiction. These estimates were adjusted by the Indigenous factor to account for differences in the proportion of jurisdictions' populations who are Indigenous. Indigenous people have been given a weighting of 2 in these estimates, in recognition of their greater prevalence rates of disability and their relatively greater representation in CSTDA services (AIHW 2000).
Primary carer	A primary carer is a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities (communication, mobility and self-care) (ABS 2004a).
Primary disability group	Disability group that most clearly expresses the experience of disability by a person. The primary disability group can also be considered as the disability group causing the most difficulty to the person (overall difficulty in daily life, not just within the context of the support offered by a particular service).
Profound core activity limitation	Unable to, or always needing assistance to, perform a core activity task (as per the ABS 2003 Survey of Disability, Ageing and Carers).
Real expenditure	Actual expenditure (accrual) adjusted for changes in prices, using the GDP(E) price deflator, and expressed in terms of current year dollars.
Schooling or employment restriction	<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. <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.
Service	A service is a support activity provided to a service user, in accord with the CSTDA. Services within the scope of the collection are those for which funding has been provided during the specified period by a government organisation operating under the CSTDA.
Service type	The support activity that the service type outlet has been funded to provide under the CSTDA. The NMDS classifies services according to 'service type'. The service type classification groups services into seven categories: accommodation support; community support; community access; respite; employment; advocacy, information and print disability; and other support services. Each of these categories has subcategories.
Service type outlet	A service type outlet is the unit of the funded agency that delivers a particular CSTDA service type at or from a discrete location. If a funded agency provides, for example, both accommodation support and respite services, it is counted as two service type outlets. Similarly, if an agency is funded to provide more than one accommodation support service type (for example, group homes and

	attendant care), then it is providing (and is usually separately funded for) two different service types — that is, there are two service type outlets for the funded agency.
Service user	A service user is a person with a disability who receives a CSTDA funded service. A service user may receive more than one service over a period of time or on a single day.
Service users with different levels of severity of core activity limitation	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: • 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' in all of these areas.
Severe core activity limitation	Sometimes needing assistance to perform a core activity task (as per the ABS 2003 Survey of Disability, Ageing and Carers).
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 (2005a) 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 (2005a) for more information on service types 2.01–2.07.
Users of CSTDA employment services	People using one or more services that correspond to the following CSTDA NMDS service types: 5.01 open employment; 5.02 supported employment; and 5.03 combined open and supported employment.
Users of CSTDA respite services	People using one or more services that correspond to the following CSTDA NMDS service types: 4.01 own home respite; 4.02 centre-based respite/respite homes; 4.03 host family respite/peer support respite; 4.04 flexible/combination respite; and 4.05 other respite. See AIHW (2005a) for more information on service types 4.01–4.05.

13.7 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 13A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2006\Attach13A.xls and in Adobe PDF format as \Publications\Reports\2006\Attach13A.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

Table 13A.1	Users of Commonwealth State/Territory Disability Agreement (CSTDA) government and non-government provided services, by service type
Table 13A.2	Recipients of Disability Support Pension, Mobility Allowance, Carer Payment, Carer Allowance and Sickness Allowance ('000)
Table 13A.3	Nominal government expenditure, by service type (\$'000)
Table 13A.4	Real government expenditure, by service type (2004-05 dollars) (\$'000)
Table 13A.5	Government expenditure, by service type (per cent)
Table 13A.6	People aged 5–64 years with a disability, 2003
Table 13A.7	People aged 0–64 years with a profound or severe core activity limitation who received help as a proportion of those who needed help, 2003 (per cent)
Table 13A.8	Users of CSTDA services, by primary disability group
Table 13A.9	Users of CSTDA services, by disability group (all disability groups reported) as a proportion of total users
Table 13A.10	Users of CSTDA accommodation support services, as a proportion of the total estimated potential population for accommodation support services
Table 13A.11	Users of CSTDA employment services, as a proportion of the total potential population for employment services
Table 13A.12	Users of CSTDA community access services, as a proportion of the total potential population for community access services
Table 13A.13	Users of CSTDA accommodation support services, by severity of core activity limitation
Table 13A.14	Users of CSTDA employment services, by severity of core activity limitation
Table 13A.15	Users of CSTDA community access services, by severity of core activity limitation
Table 13A.16	Users of CSTDA accommodation support services, by geographic location, per 1000 people
Table 13A.17	Users of CSTDA employment services, by geographic location, per 1000 people
Table 13A.18	Users of CSTDA accommodation support services, per 1000 people, by Indigenous status

Table 13A.19	Users of CSTDA employment services, per 1000 people, by Indigenous status
Table 13A.20	Users of CSTDA community access services, per 1000 people, by Indigenous status
Table 13A.21	Users of CSTDA accommodation support services, per 1000 people, by country of birth
Table 13A.22	Users of CSTDA employment services, per 1000 people, by country of birth
Table 13A.23	Users of CSTDA community accommodation and care services as a proportion of all accommodation support service users (per cent)
Table 13A.24	Nominal government expenditure per user of CSTDA accommodation support services (dollars)
Table 13A.25	Real government expenditure per user of CSTDA accommodation support services (2003-04 dollars)
Table 13A.26	Accommodation support services expenditure adjustment factors (2002-03)
Table 13A.27	Australian Government funding per user of non-government provided employment services
Table 13A.28	Nominal Australian Government funding per user of non-government provided employment services
Table 13A.29	Real Australian Government funding per user of non-government provided employment services
Table 13A.30	Total estimated expenditure per service user, State and Territory government administered programs, 2003-04
Table 13A.31	Government administration expenditure as a proportion of total expenditure on services (per cent)
Table 13A.32	Labour force and employment participation, 2003 (per cent)
Table 13A.33	Labour force and employment participation of people with a profound or severe core activity limitation, by special needs groups, 2003 (per cent)
Table 13A.34	Social activities participated in by people with a profound or severe core activity limitation, 2003 (per cent)

13.8 References

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14 Children's services

This chapter presents performance and descriptive information for government funded and/or delivered child care and preschool services. Children's services aim to meet the care, education and development needs of children, although the emphasis on these broad objectives may differ across the services. Child care services reported in this chapter include those provided to children aged less than 13 years, usually by someone other than the child's parents or guardian. Preschool services reported in this chapter are provided to children mainly in the year or two before they commence full time schooling.

Unless otherwise stated, the data relate to services that are supported by the Australian, State and Territory governments and provided for children aged less than 13 years. Local governments also plan, fund and deliver children's services. Given data limitations, however, this chapter records data on local government activities only where Australian, State and Territory government funding and licensing are involved. The chapter does not include services that do not receive government funding (unless otherwise noted).

A profile of children's services is presented in section 14.1. This provides a context for assessing the performance indicators presented later in the chapter. All jurisdictions have agreed to develop, and aim to report, comparable indicators; a framework of performance indicators is outlined in section 14.2. The data on performance are discussed in section 14.3 and future directions for performance reporting are discussed in section 14.4. The chapter concludes with jurisdictions' comments in section 14.5. Definitions of terms specific to children's services are found in section 14.6. Section 14.7 lists the supporting tables for this chapter. Supporting tables are identified in references throughout the chapter by an 'A' suffix (for example, table 14A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Section 14.8 lists the references used in this chapter.

Major changes to reporting on children's services this year include reporting data for the first time on preschool service costs, and hospital admissions resulting from injuries sustained in children's services. There are also improvements to data quality and comparability.

14.1 Profile of children's services

Service overview

Children's services are provided using a variety of service delivery types that can be grouped into the following six broad categories:

- *Centre-based long day care* — comprises services aimed primarily at 0–5 year olds, provided in a centre, usually by a mix of qualified and other staff. Educational, care and recreational programs are provided based on the developmental needs, interests and experience of each child. In some jurisdictions, primary school children may also receive care before and after school, and during school vacations. Centres typically operate for at least eight hours per day on normal working days, for a minimum of 48 weeks per year.
- *Family day care* — comprises services provided in the carer's home. The care is largely aimed at 0–5 year olds, but primary school children may also receive care before and after school, and during school vacations. Central coordination units in all states and territories organise and support a network of carers, often with the help of local governments.¹
- *Occasional care* — comprises services usually provided at a centre on an hourly or sessional basis for short periods or at irregular intervals for parents who need time to attend appointments, take care of personal matters, undertake casual and part time employment, study or have temporary respite from full time parenting. These services provide developmental activities for children and are aimed primarily at 0–5 year olds. Centres providing these services usually employ a mix of qualified and other staff.
- *Preschool* — comprises services usually provided by a qualified teacher on a sessional basis in dedicated preschools. Preschool programs or curricula may also be provided in long day care centres and other settings. These services are primarily aimed at children in the year before they commence full time schooling (that is, when children are 4 years old in all jurisdictions), although younger children may also attend in all jurisdictions except Victoria.²

¹ In WA, family day care licences can be issued for the 0–5 and 5–12 age groups, allowing for licence holders to provide vacation care, and before and after school hours care, as well as long day care.

² In Tasmania, the flexibility to enrol children of pre-kindergarten age is permitted only under limited circumstances (such as for gifted children or children previously enrolled in another State or Territory who now reside in Tasmania). In the NT, younger children may attend with approval under certain circumstances, and younger Indigenous children may attend from 3 years of age if accompanied by an adult.

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- *Outside school hours care* — comprises services provided for school aged children (5–12 year olds) outside school hours during term and vacations. Care may be provided on student free days and when school finishes early.
 - *Other services* — comprise government funded services to support children with additional needs or in particular situations (including children from Indigenous or non-English speaking backgrounds, children with a disability or of parents with a disability, and children living in regional and remote areas).

Roles and responsibilities

The Australian Government and the State and Territory governments have different but complementary roles in supporting children's services. Both levels of government help fund services, provide information and advice to parents and service providers, and help plan, set and maintain operating standards.

The Australian Government's roles and responsibilities for child care include:

- assisting families to participate in the social and economic life of the community by providing financial support to families, principally through payment of Child Care Benefit. The benefit is payable to families using approved child care services or registered informal carers
- administering a planning system to allocate child care places to those areas that need more places, in conjunction with other levels of government. There is no Australian Government limit on the allocation of centre-based long day care places
- providing information and advice to parents and providers about the availability of Australian Government funded services and some State and Territory funded services
- helping to enhance the quality of child care by funding the National Childcare Accreditation Council (NCAC) to administer the following quality assurance systems for children's services:³
 - the Quality Improvement and Accreditation System (QIAS) for centre-based long day care centres
 - Family Day Care Quality Assurance (FDCQA) for family day care schemes
 - Outside School Hours Care Quality Assurance (OSHCQA) for outside school hours care services

³ Participation in the quality assurance systems is required to remain eligible for continued Child Care Benefit funding approval from the Australian Government.

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- funding organisations to provide information, support and training to service providers
 - providing operational and capital funding to some providers.

State and Territory governments' roles and responsibilities vary across jurisdictions and may include:

- providing operational and capital funding to non-government service providers
- delivering some services directly (especially preschool services)
- developing new child care and preschool services
- licensing and setting standards for children's services providers
- monitoring and resourcing licensed and/or funded children's services providers
- providing information, support, training and development opportunities for children's services providers
- assisting services in enhancing quality by providing curriculum and policy support and advice, as well as training and development for management and staff
- planning to ensure the appropriate mix of services is available to meet the needs of the community
- providing information and advice to parents and others about operating standards and the availability of services
- providing dispute resolution and complaints management processes.

Currently, it is generally the case that State and Territory governments are responsible for providing educational and developmental opportunities, such as preschool services.

Quality of care

Both levels of government are committed to supporting quality children's services. The mechanisms used include licensing, quality assurance, the measurement of performance against standards, and outcomes linked to funding. These mechanisms are used in addition to the provision of curriculum and policy support and advice, and the training and development of management and staff.

Licensing

State and Territory governments set legislative and regulatory requirements for the licensing of children's services and monitor adherence to these requirements. These regulations include safety standards, staff qualifications, child/staff ratios and health and safety requirements.

The Australian, State and Territory governments have jointly developed national standards for centre-based long day care, family day care and outside school hours care services. These standards express a national view about the level of care all Australians should expect from the different types of child care service available to them. The types of service covered, the standards that apply, and the extent of implementation of these standards vary across jurisdictions.

Quality assurance

The Australian Government has implemented quality assurance systems for Australian Government funded centre-based long day care services, family day care services and outside school hours care services. The broad objective of the quality assurance system is to ensure that children in care have stimulating, positive experiences and interactions that nurture all aspects of their development. The quality assurance systems do this by defining quality child care, providing a way to measure the quality of care provided by the service and identifying areas for ongoing quality improvement. Services participating in the quality assurance system are required to progress through the five step process as outlined in box 14.1.

To be eligible for Child Care Benefit and other funding support, child care services are required to register and satisfactorily participate in quality assurance. Quality assurance is designed to build on and complement the State and Territory government licensing requirements (where they exist).

Box 14.1 Accreditation under National Childcare Accreditation Council quality assurance systems

There are several stages that service providers must progress through prior to National Childcare Accreditation Council (NCAC) making an accreditation decision.

- Registration — all family day care schemes, outside school hours care services and long day care centres are required to register with NCAC to participate in quality assurance in order to be eligible to receive Child Care Benefit from the Australian Government on behalf of parents and families.
- Self assessment — Each registered provider is required to undertake a self assessment for each of the quality areas against the service delivery standards. The provider is also required to develop and implement a quality improvement plan. The results of the self assessment are submitted to NCAC.
- Validation — Providers are reviewed by a third party 'validator' (a child care professional or peer who is selected and trained by NCAC), who visits to assess quality practices. The validator observes the provider's care practices and completes a report for NCAC. The validator also collects surveys completed by service's director/coordinator, staff/carers and the parents of children using the service, who provide a rating against the quality standards.
- Moderation — A moderator assesses the providers practices, guided by information from the self assessment, the validator's report and completed surveys. A 'quality profile' is compiled by NCAC showing these various perspectives of the provider's performance across the quality areas. Indicative weightings for these perspectives are self assessment (20 per cent), staff validation survey (10 per cent), family validation survey (10 per cent), child validation survey (10 per cent), validator's report (40 per cent), moderator's rating (10 per cent). Moderators also write a guide for the provider that focuses on quality improvement.
- Accreditation decision — NCAC makes the accreditation decision. To be accredited a provider must achieve a rating of 'satisfactory' or higher on all quality areas as detailed in the quality profile.

Accredited providers are required to submit a self assessment to NCAC every 2.5 years. During this period service providers are expected to continuously monitor performance against the quality standards. Services that do not meet accreditation standards are required to submit a new self assessment within six months of the accreditation decision.

Source: adapted from NCAC (2004a, 2004b and 2005).

Funding performance standards and outcomes

State and Territory governments impose varying performance requirements for funding children's services. These requirements may include: the employment of higher qualified staff than required by licensing or minimum standards;

self-assessment of quality; and a demonstration of the delivery of quality educational and recreational programs.

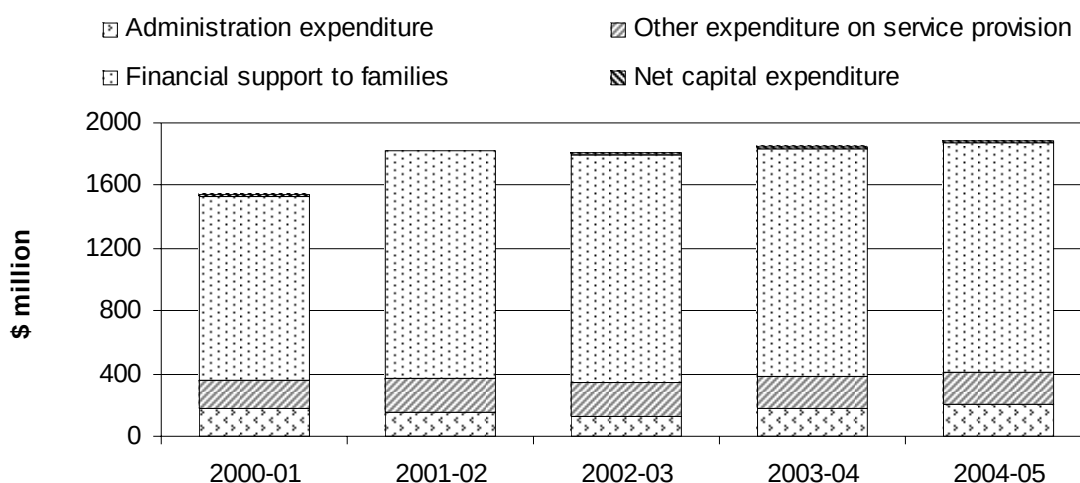
Funding

Total Australian, State and Territory government expenditure on children's services was approximately \$2487 million in 2004-05, compared with \$2482 million (in real terms) in 2003-04 (table 14A.4).

Australian Government expenditure accounted for 75.9 per cent (\$1886 million) of total government expenditure on children's services in 2004-05. The major component of Australian Government expenditure was financial support to families through assistance with fees, which accounted for 77.8 per cent (\$1468 million) of Australian Government expenditure on children's services. Other expenditure on service provision accounted for a further 10.7 per cent (\$202.3 million), and administration expenditure and net capital expenditure accounted for the remaining 10.7 per cent (\$200.9 million) and 0.8 per cent (\$15.4 million) respectively (figure 14.1).

State and Territory government expenditure on children's services in 2004-05 was approximately \$600.3 million, of which other expenditure on service provision comprised around 52.3 per cent (\$313.7 million). Administration expenditure, financial support to families and net capital expenditure accounted for 42.6 per cent (\$255.8 million), 3.2 per cent (\$19.3 million) and 1.9 per cent (\$11.6 million) respectively (table 14A.4).

Figure 14.1 **Australian Government real expenditure on children's services (2004-05 dollars)**



Source: Department of Family and Community Services (FaCS) (unpublished); table 14A.4.

In the distribution of total State and Territory government expenditure across all children's service types, the provision of preschool services accounted for the largest proportion (around 83.8 per cent, or \$503.2 million) in 2004-05 (table 14A.5).

The Australian Government provides supplementary funding to support the participation of Indigenous children in preschool programs. In 2003, an estimated \$11.2 million was provided to education providers for 7644 full time equivalent Indigenous preschool enrolments (DEST 2005).

Size and scope

Child care services

The Australian Government supported 561 876 child care places in 2004 — an increase of 8.5 per cent on the number in 2003 (table 14A.8). The majority of Australian Government supported child care places were outside school hours care places (45.2 per cent), followed by centre-based long day care places (40.9 per cent), family day care places (13.3 per cent), occasional care places (0.5 per cent) and other care places (0.2 per cent).

State and Territory governments supported at least 204 000 preschool places in 2004-05 (tables 14A.29, 14A.38, 14A.47, 14A.56, 14A.65, 14A.74, 14A.83 and 14A.92).

In 2004-05, around 115 700 children aged 12 years or younger attended State and Territory government funded and/or provided child care and 748 900 children aged 12 years or younger attended Australian Government approved child care services (tables 14A.10, 14A.30, 14A.39, 14A.48, 14A.57, 14A.66, 14A.75, 14A.84, 14A.93). Some children may attend both Australian and State/Territory funded child care and some services may receive funding from both Australian and State/Territory governments.

Table 14.1 shows the proportion of children in the relevant age groups attending Australian, State and Territory government funded and/or provided child care. Different data collection approaches and the exclusion of certain services funded by some jurisdictions reduce the comparability of these data across jurisdictions.

Table 14.1 Proportion of children using Australian, State and Territory government funded and/or provided child care, 2004-05^{a, b}

<i>Age</i>	<i>NSW^c</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA^d</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
0–5 years	50.1	27.9	40.8	25.2	32.6	34.3	39.4	22.0	38.3
6–12 years	13.3	13.8	17.3	8.8	22.6	15.0	22.8	13.9	14.6
0–12 years	29.9	20.1	27.7	16.0	27.0	23.6	30.3	17.8	25.2

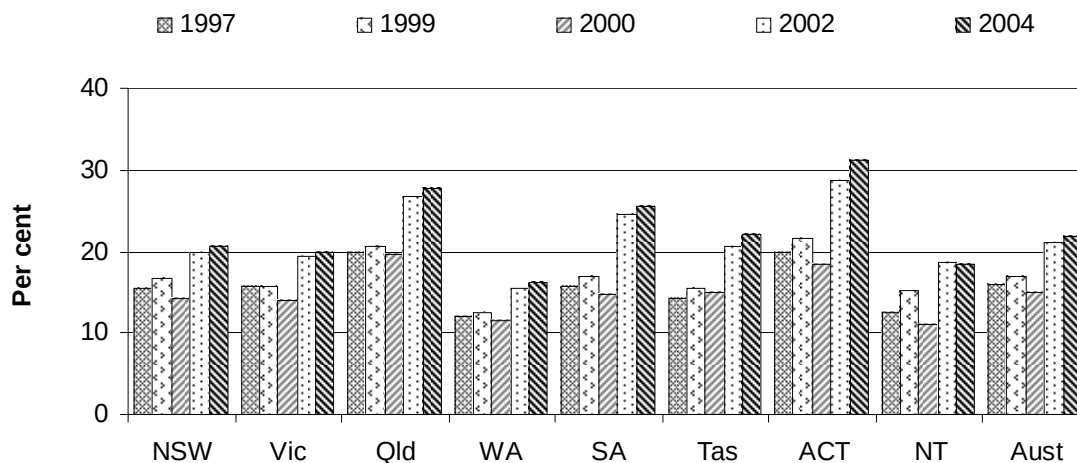
^a Australian Government data are drawn from the March 2004 Australian Government Census of Child Care Services (AGCCCS). ^b Population as at June 2005. ^c NSW used a revised method of calculating the number of children receiving child care and preschool services. This new method of calculation will provide clear trend data for each age group for child care and preschool. The data include estimates based on the rate of survey return for each year. NSW data are not comparable with data for other states and territories. ^d SA excludes children in non-government preschools.

Source: AGCCCS, March 2004 (unpublished); State and Territory governments (unpublished); Australian Bureau of Statistics (ABS) Australian Demographic Statistics (unpublished); ABS (2002), *Population Projections, Australia*, Cat. no. 3222.0, Canberra; tables 14A.1, 14A.10, 14A.30, 14A.39, 14A.48, 14A.57, 14A.66, 14A.75, 14A.84 and 14A.93.

The majority of children attending Australian Government approved child care in 2004 (approximately 490 600, or 65.5 per cent) were aged 0–5 years (table 14A.10). Nationally, 21.9 per cent of children aged 0–12 years attended Australian Government approved child care services in 2004 (figure 14.2).

The average hours of attendance in child care in 2004 varied considerably across jurisdictions, for all types of service. Nationally, attendance per child at centre-based long day care centres was 19.1 hours per week, while the average attendance per child at family day care was 18.0 hours per week. The national average attendance per child at occasional care was 9.3 hours per week and the national average attendance at vacation care during school holidays was 2.8 days per week (table 14A.9).

Figure 14.2 Proportion of children aged 0–12 years using Australian Government approved child care^{a, b, c, d}



^a Excludes children cared for in neighbourhood model services. ^b Data for 1997, 1999, 2002 and 2004 are drawn from the respective AGCCCS, while data for 2000 are drawn from Centrelink administrative data. The AGCCCS and Centrelink data are not fully comparable and such comparisons need to be treated with care. ^c Data for WA exclude children attending Department of Education provided kindergartens for 4 year olds, who would otherwise be in child care. ^d Australian total includes children in other Territories.

Source: AGCCCS, August 1997, May 1999, May 2002 and March 2004 (unpublished); Centrelink administrative data, August 2000 (unpublished); ABS Australian Demographic Statistics (unpublished); ABS (2002), Population Projections, Australia, Cat. no. 3222.0, Canberra; table 14A.10.

Preschool services

Preschools provide a range of educational and developmental programs (generally on a sessional basis) to children in the year immediately before they commence full time schooling and also, in some jurisdictions, to younger children. The age from which children may attend preschools varies across jurisdictions. Victoria contributes funding towards a preschool program for all 4-year-old children, which is the year before they commence schooling. Children in the NT are funded by government to attend preschool in the year before they commence schooling. Younger children in NSW, Queensland, WA, SA, Tasmania and the ACT may also access government funded preschool services.⁴

Younger Indigenous children living in remote areas in the NT and Queensland also may attend preschools. In SA, a pre-entry program provides one session of preschool a week for 10 weeks in the term before preschool, and children from Indigenous backgrounds may attend preschool at 3 years of age. In the ACT, children from Indigenous backgrounds, children with English as a second language,

⁴ See footnote 2.

and children with a hearing impairment and/or whose parents have a hearing impairment may be eligible for early entry into preschool (for 5.25 hours per week) at 3 years of age.

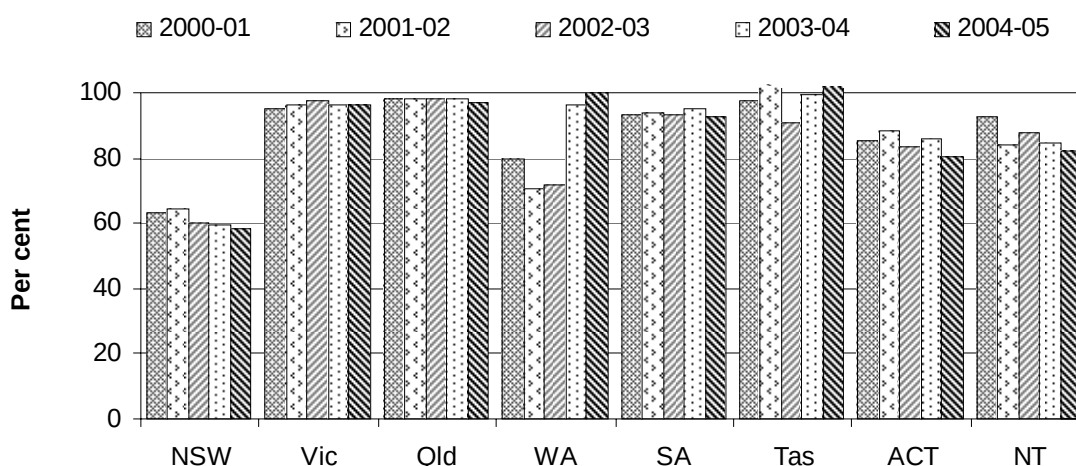
This disparity in the age from which children may access preschool services reduces the comparability of preschool data across jurisdictions. Preschool data are presented for two categories to improve comparability:

- children attending preschool in the year immediately before they commence full time schooling (data that are largely presented on a comparable basis for all jurisdictions)
- younger children attending preschool services.

Approximately 244 200 children attended State and Territory funded and/or provided preschool services in 2004-05. The majority (88.5 per cent, or approximately 216 100 children) were to begin full time schooling the following year (table 14A.11).

Nationally in 2004-05, 83.4 per cent of children of 4 years of age attended funded and/or provided preschool in the year immediately before they commenced school. There is some double counting in several jurisdictions, as well as issues with synchronisation of data collection times, leading to overestimation of the attendance rates being reported (figure 14.3).

Figure 14.3 Proportion of children attending State and Territory government funded and/or provided preschool services immediately before the commencement of full time schooling^{a, b, c, d, e, f}



^a The denominator — the population of preschool aged children — is defined as persons aged 4 years in all states and territories. Data for estimated resident population are six months out of sequence with the data for children using State or Territory government funded and/or provided preschool services in year before full time school. 'Year before full time school' includes a number of non-4 year olds. ^b There is some double counting of children in jurisdictions (except in Victoria, SA, Tasmania and the ACT) because some children moved in and out of the preschool system throughout the year and, as a result, the number of children reported in preschool exceeds the number of children in the target population. There is no double counting for Victoria, SA, Tasmania and the ACT because a snapshot is used for each year's data collection. ^c NSW used a revised method of calculating the number of children receiving child care and preschool services. NSW data are not comparable with data for other states and territories. ^d Victorian data include some children attending funded preschool services conducted in centre-based long day care centres and independent schools. ^e WA data for 2000-01 to 2002-03 exclude the non-government sector. Data for 2003-04 include the non-government sector for the first time, resulting in a significant jump in the time series. Changes to the school entry age (and the associated move to full time schooling for pre-year 1 children) have resulted in changes in the reporting of data from 2001-02. From 2002, pre-year 1 students in non-compulsory schooling are not included. ^f Data for SA exclude children in non-government preschools.

Source: State and Territory governments (unpublished); ABS Australian Demographic Statistics (unpublished); ABS (2002), Population Projections, Australia, Cat. no. 3222.0, Canberra; table 14A.11.

Younger children in NSW, Queensland, SA, the ACT and the NT were able to attend government funded preschool services in 2004-05. Nationally, around 11.2 per cent of children aged 3 years attended preschool services in that year (approximately 28 100 children). Participation in 2004-05 differed across jurisdictions, reflecting variation in policies on access to funded preschool services (table 14A.11).

All jurisdictions except NSW, Victoria and the NT provided data on the average hours of attendance for government funded and/or provided preschool services in 2004-05. The average attendance of children in the year immediately before they commenced full time schooling was at least 11 hours per week (tables 14A.47, 14A.56, 14A.65, 14A.74 and 14A.83).

Employment status of parents

Access to children's services differs according to the service type. The workforce and employment status of parents may influence children's access to services. Those services eligible for Child Care Benefit, for example, give a high priority to children at risk and children of parents with work-related child care needs. Occasional care services give priority to parents requiring care to meet other needs (such as to attend appointments, take care of personal matters or have temporary respite from full time parenting). Details of the labour force and employment status of parents whose children use these services are shown in table 14A.15.

Services by management type

Children's services are managed by the government (State, Territory and local), community and private sectors. The management structure of services indicates the involvement of these sectors in the direct delivery of children's services. The limited data on the management type of child care need to be interpreted with care because the scope of data collection varies across jurisdictions. Available data on the management type of preschool services in 2004-05, is more complete than that for child care services, and indicate considerable variation across jurisdictions (table 14.2).

Table 14.2 **Proportion of State and Territory licensed and/or registered children's services, by management type, 2004-05 (per cent)^a**

	NSW	Vic ^b	Qld	WA	SA	Tas ^c	ACT	NT ^d
Child care								
Community managed ^e	31.7	38.9	26.1	18.2	39.7	55.3	82.6	73.8
Private ^f	65.0	46.2	70.6	80.0	34.5	20.5	17.4	26.2
Government managed	3.2	14.9	3.3	1.9	25.9	24.2	–	–
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Preschool								
Community managed ^e	90.1	73.9	23.1	na	4.7	..	8.0	4.2
Private ^f	9.9	8.2	21.6	na	–	24.2	na	na
Government managed	na	17.9	55.3	100.0	95.3	75.8	92.0	95.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

^a Includes all Australian, State and Territory government supported services. ^b All government managed preschools in Victoria are managed by local government. ^c Preschools include funded non-government preschools. ^d Preschool services are provided by the Department of Education directly, but a range of management functions are devolved to school councils and parent management committees. ^e Community managed services include not-for-profit services provided or managed by parents, churches or co-operatives. ^f Private for-profit services provided or managed by a company, private individual or non-government school. **na** Not available. **..** Not applicable. **–** Nil or rounded to zero.

Source: State and Territory governments (unpublished); tables 14A.33, 14A.42, 14A.51, 14A.60, 14A.69, 14A.78, 14A.87 and 14A.96.

14.2 Framework of performance indicators

The framework of performance indicators is based on common objectives for children's services endorsed by the Community Services and Disabilities Ministers' Advisory Council (CSDMAC) (box 14.2). The relative emphasis placed on each objective varies across jurisdictions.

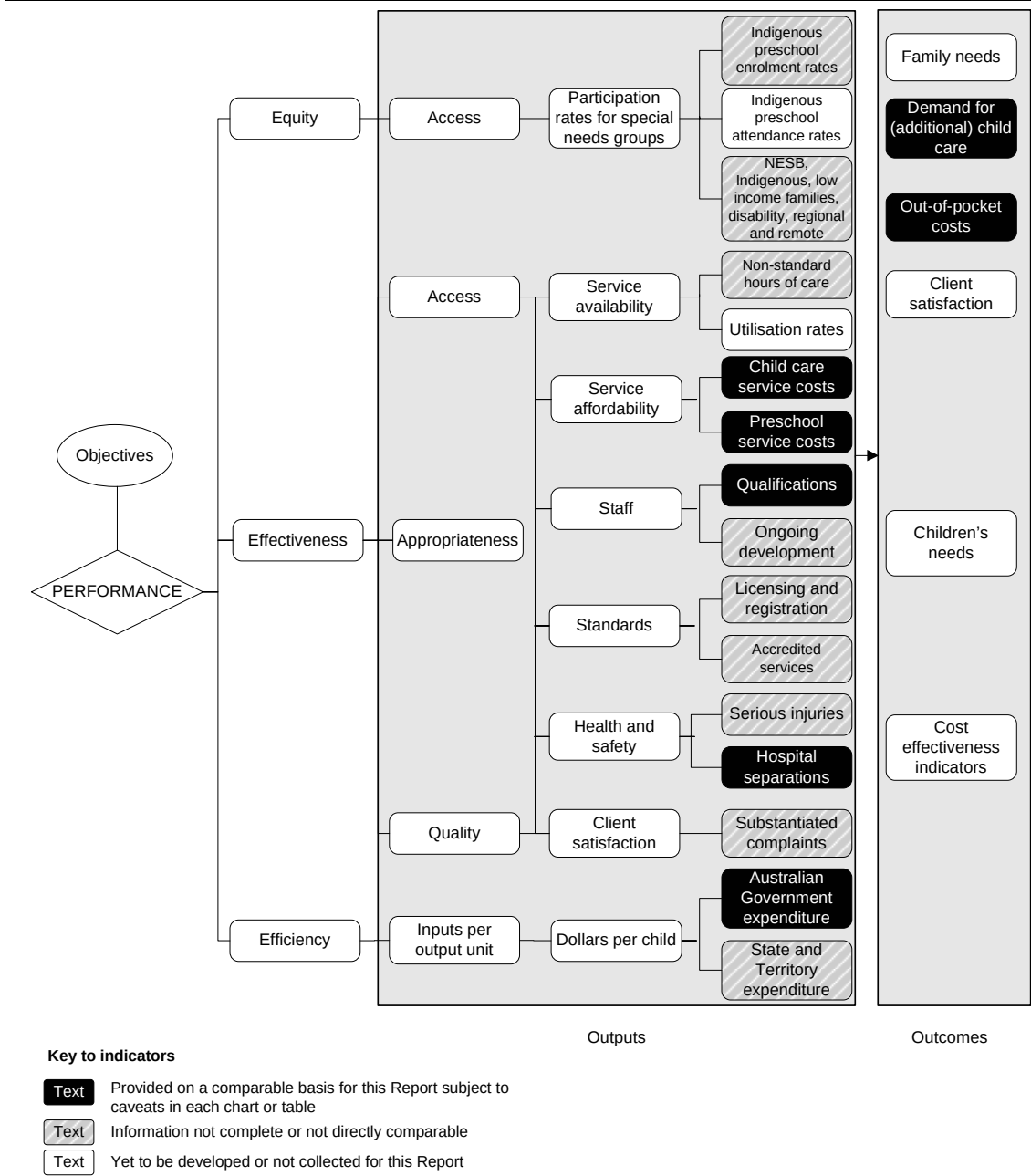
Box 14.2 Objectives for children's services

Children's services aim to:

- meet the care, education and development needs of children in a safe and nurturing environment
- provide support for families in caring for their children
- provide these services in an equitable and efficient manner.

A performance indicator framework consistent with these objectives is summarised in figure 14.4. The framework shows which data are provided on a comparable basis in the 2006 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 14.4 Performance indicators for children's services



14.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the equity, effectiveness and efficiency of children's services. Much of the data available for reporting in this chapter are not comparable across jurisdictions. Appendix A contains contextual information, which may assist in interpreting the performance indicators presented in this chapter. Definitions of key terms and indicators are in section 14.6.

Outputs

Equity

Access — participation rates for special needs groups

The ‘participation rates for special needs groups’ indicator is explained in box 14.3.

Box 14.3 Participation rates for special needs groups

‘Participation rates for special needs groups’ is an output (equity — access) indicator of governments’ objective to ensure that all Australian families have equitable access to child care and preschool services, that there is no discrimination between groups, and that there is consideration of the needs of those groups who may have special difficulty accessing services.

This indicator is defined as the proportion of children using child care services who are from targeted special needs groups, compared with the representation of these groups in the community. Data are reported separately for child care and preschool services. Targeted special needs groups include children from a non-English speaking background, children from an Indigenous background, children from low income families, children with a disability, and children from regional and remote areas.

The representation of special needs groups among children’s services users would be expected to be broadly similar to their representation in the community.

The data indicate that the representation of children in special needs groups among users of Australian Government supported child care is sometimes substantially different across jurisdictions (table 14.3). It is important to note that due to the unavailability of certain data items, the Australian Government data exclude flexible and innovative services and other services such as mobile and toy libraries, Indigenous play groups and enrichment programs, which are targeted towards children from these groups. However, there is a general pattern across jurisdictions for children from each special needs group. In almost all jurisdictions:

- children from a non-English speaking background participated in child care at a higher rate than this group’s representation in the community
- the representation of children from an Indigenous background among child care users was lower than this group’s overall representation in the community
- children from low income families participated in child care at a higher rate than this group’s representation in the community

- the representation of children with a disability among child care users was lower than their overall representation in the community
- the proportion of children in regional areas attending child care was generally lower than the proportion of children who live in regional areas
- the proportion of children in remote areas attending child care was lower than the proportion of children who live in remote areas.

Table 14.3 Proportion of children (aged 0–12 years) from special needs groups attending Australian Government approved child care services, 2004 (per cent)

<i>Representation</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Children from non-English speaking backgrounds									
In child care services	17.4	13.5	6.3	7.9	6.9	3.4	12.1	8.1	11.6
In the community ^{a, b}	8.8	8.0	2.7	3.6	3.0	1.1	2.1	4.1	6.1
Children from Indigenous backgrounds									
In child care services	1.6	0.6	2.5	1.8	1.3	1.0	0.7	10.7	1.6
In the community ^{c, d}	3.6	1.0	5.9	5.8	3.1	6.4	2.1	36.7	4.1
Children from low-income families									
In child care services	28.0	28.3	33.8	32.6	33.0	31.5	12.4	18.8	29.9
In the community ^e	16.7	16.1	15.0	17.3	18.6	19.9	8.0	18.8	16.4
Children with a disability									
In child care services	2.1	2.0	2.0	1.7	3.5	2.2	2.1	2.4	2.1
In the community ^f	8.6	7.2	7.9	9.2	9.9	7.3	7.2	na	8.2
Children from regional and remote areas									
Children from regional areas									
In child care services	25.9	22.5	38.9	18.2	16.2	99.6	–	74.0	28.8
In the community ^{c, d}	30.0	29.1	45.6	24.0	26.9	97.6	0.3	48.9	33.4
Children from remote areas									
In child care services	0.4	0.1	1.6	5.0	2.0	0.4	–	26.0	1.4
In the community ^{c, d}	0.8	0.1	4.7	9.2	4.8	2.4	–	51.1	3.2

^a Data relate to children aged 0–11 years and were obtained from the ABS 2002 Survey of Child Care. These data are not strictly comparable to the proportion of children from a non-English speaking background using the services. ^b Data for Tasmania have a relative standard error of between 25 per cent and 50 per cent and should be used with caution. ^c Data relate to children aged 0–14 years at June 2001 and were obtained from the ABS 2001 Census of Population and Housing. ^d These numbers do not include innovative or flexible services that receive direct funding from the Australian Government and are targeted towards children from these groups. ^e Data relate to children aged 0–12 years and were obtained from the ABS 2003-04 Survey of Household Income and Expenditure. ^f Data are estimated from the ABS 2003 Survey of Disability, Ageing and Carers and relate to children aged 0–14 years, and are thus not strictly comparable to the proportion of child care service users with a disability. **na** Not available. – Nil or rounded to zero.

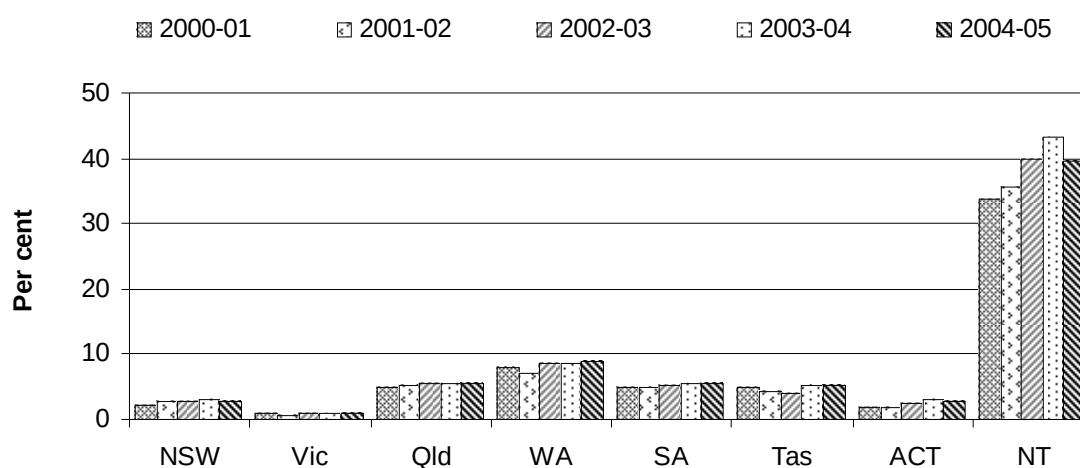
Source: AGCCCS (unpublished); ABS 2001 Census of Population and Housing (unpublished); ABS 2003-04 Survey of Household Income and Expenditure (unpublished); ABS 2003 Survey of Disability, Ageing and Carers (unpublished); ABS 2002 Child Care Survey (unpublished); table 14A.19.

Estimates for the representation of special needs groups in the community are based on data that may not match the age range used for the participation of special needs groups in preschools. Although the participation of special needs groups in preschools and the representation of special needs groups in the community are not directly comparable, they provide a broad indication of the relative access to preschool for special needs groups.

Data on the representation of special needs groups among government funded preschool attendees are provided in table 14.4. The proportion of preschool attendees in 2004-05 who were from special needs groups display no clear pattern, with some groups overrepresented in several jurisdictions and underrepresented in others.

The proportion of preschool enrolments from Indigenous backgrounds has been relatively constant over time within jurisdictions, except in the NT, where it increased between 2000-01 and 2004-05 (figure 14.5). The proportion of Indigenous enrolments largely reflects the proportion of the population in each jurisdiction from Indigenous backgrounds.

Figure 14.5 Proportion of preschool enrolments from Indigenous backgrounds



Source: State and Territory governments (unpublished); tables 14A.34, 14A.43, 14A.52, 14A.61, 14A.70, 14A.79, 14A.88 and 14A.97.

Table 14.4 Proportion of children (aged 0–12 years) from special needs groups attending State and Territory funded or provided preschools, 2004-05 (per cent)

<i>Representation</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Children from non-English speaking backgrounds									
In preschool services	7.4	13.6	1.0	na	9.5	na	7.7	na	6.4
In the community ^{a, b}	8.8	8.0	2.7	3.6	3.0	1.1	2.1	4.1	6.1
Children from Indigenous backgrounds									
In preschool services	2.9	0.8	5.6	8.9	5.5	5.2	2.7	39.6	4.5
In the community ^{c, d}	3.6	1.0	5.9	5.8	3.1	6.4	2.1	36.7	4.1
Children with a disability									
In preschool services ^e	6.4	8.8	1.3	3.1	16.0	na	5.2	na	5.9
In the community ^f	8.6	7.2	7.9	9.2	9.9	7.3	7.2	na	8.2
Children from regional and remote areas									
Children from regional areas									
In preschool services	68.6	31.8	50.2	24.2	28.4	98.1	na	na	45.6
In the community ^{c, d}	30.0	29.1	45.6	24.0	26.9	97.6	0.3	48.9	33.4
Children from remote areas									
In preschool services	1.4	0.1	8.5	3.8	5.9	1.9	na	na	3.5
In the community ^{c, d}	0.8	0.1	4.7	9.2	4.8	2.4	..	51.1	3.2

^a Data relate to children aged 0–11 years and were obtained from the ABS 2002 Survey of Child Care. These data are not strictly comparable to the proportion of children from a non-English speaking background using the services. ^b Data for Tasmania has a relative standard error of between 25 per cent and 50 per cent and should be used with caution. ^c Data relate to children aged 0–14 years at June 2001 and were obtained from the ABS 2001 Census of Population and Housing. ^d These numbers do not include innovative or flexible services that receive direct funding from the Australian Government and are targeted towards children from these groups. ^e Data are not directly comparable between jurisdictions because there is no national definition or standard on children with a disability. ^f Data are estimated from the ABS 2003 Survey of Disability, Ageing and Carers and relate to children aged 0–14 years, and are thus not strictly comparable to the proportion of preschool users with a disability. **na** Not available. **..** Not applicable.

Source: State and Territory governments (unpublished); ABS 2001 Census of Population and Housing (unpublished); ABS 2003 Survey of Disability, Ageing and Carers (unpublished); ABS 2002 Child Care Survey (unpublished); tables 14A.34, 14A.43, 14A.52, 14A.61, 14A.70, 14A.79, 14A.88 and 14A.97.

Effectiveness

Service availability — non-standard hours of care

An indicator of the appropriateness of, and community access to, children's services is the proportion of services offering 'non-standard hours of care' (box 14.4). The definition of 'non-standard hours' varies across service types, and a full explanation can be found in section 14.6, which provides definitions for various terms used in this chapter.

Box 14.4 Non-standard hours of care

The prevalence of services providing 'non-standard hours of care' is an output (service availability) indicator of governments' objective to ensure government funded and/or provided children's services meet the needs of all users.

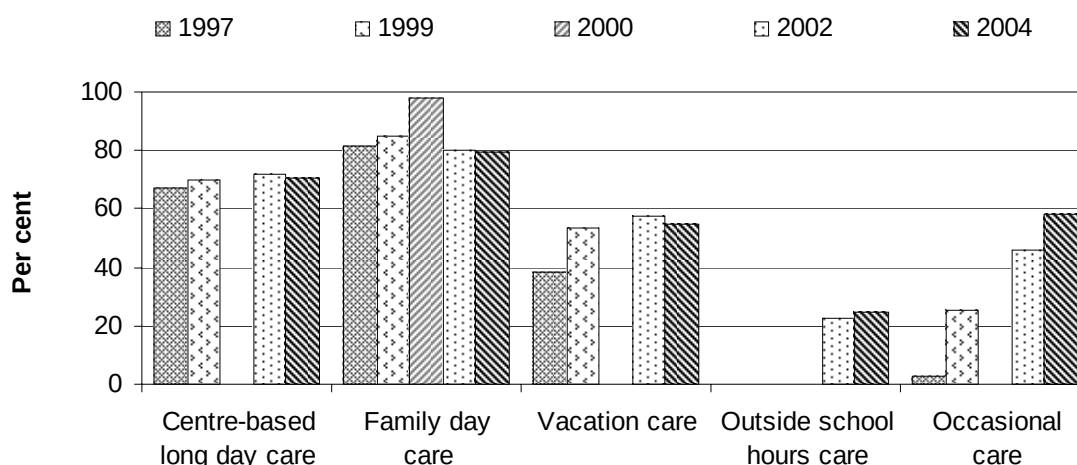
This indicator is defined as the number of services providing non-standard hours of care divided by the total number of services. Data are reported by service type.

A higher proportion of services providing non-standard hours of care may suggest a greater flexibility of services to meet the needs of families.

This indicator does not provide information on the demand for non-standard hours of care. It also provides no information on how closely available non-standard hours services match the needs of users.

Provision of non-standard hours of care may be influenced by a range of factors such as costs to services and parents, demand for care, availability of carers, and compliance with occupational and health and safety requirements. Figure 14.6 shows the proportion of services that provided non-standard hours of care by service type.

Figure 14.6 Australian Government approved child care services providing non-standard hours of care, by service type^{a, b, c}



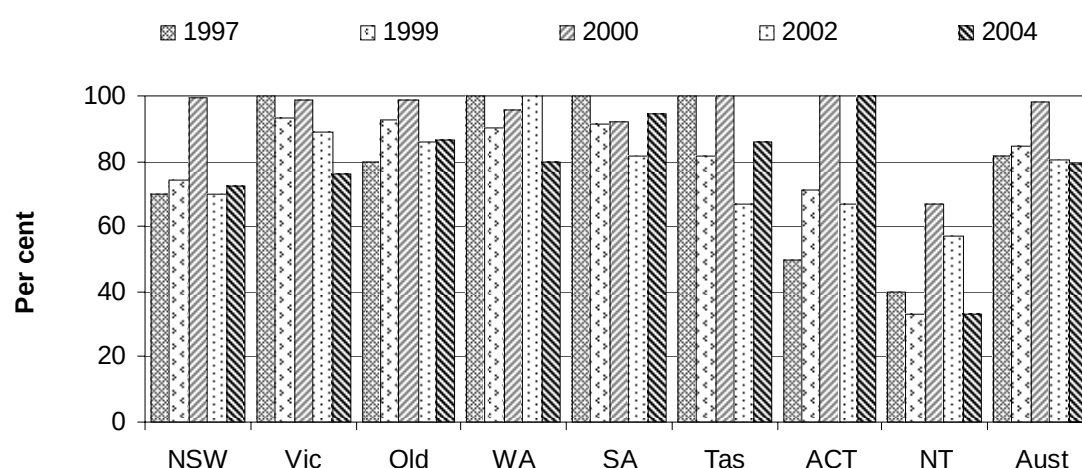
^a Only family day care data can be reported for 2000. ^b Comparison between 2000 data and data for other years is not possible, given different data collection methods and time frames. ^c An outside school hours care category combined data reported on before school hours care and after school hours care in 2002. Data for the combined category are not available for previous years.

Source: AGCCCS, August 1997, May 1999, May 2002 and March 2004 (unpublished); Centrelink administrative data, August 2000 (unpublished); table 14A.16.

The provision of non-standard hours of care by Australian Government approved family day care schemes in different jurisdictions is shown in figure 14.7.

Limited data are available on services not included in the Australian Government Census of Child Care Services (AGCCCS) that were offering non-standard hours of care. New South Wales and SA were able to provide data on the proportion of their preschools that offered non-standard hours in 2004-05 (tables 14A.34 and 14A.70).⁵

Figure 14.7 Australian Government approved family day care services providing non-standard hours of care^a



^a Comparison between 2000 data and data for other years is not possible, given different data collection methods and time frames.

Source: AGCCCS, August 1997, May 1999, May 2002 and March 2004 (unpublished); Centrelink administrative data, August 2000 (unpublished); table 14A.16.

Service availability — utilisation rates

The Steering Committee has identified ‘utilisation rates’ as an indicator of the effectiveness of children’s services (box 14.5). Data for this indicator, however, were not available for the 2006 Report.

⁵ In SA, preschools are encouraged to offer back-to-back preschool services to assist parents, particularly in country regions where the need to travel long distances makes it impractical for children to attend preschool more frequently (see footnotes to table 14A.70).

Box 14.5 Utilisation rates

This indicator will provide an output (service availability) indicator of governments' objective to ensure all Australian families have equitable and adequate access to children's services.

Utilisation refers to the level of usage of a service and can be measured in a number of ways, including vacancy levels and capacity to take on more children. Utilisation rates can also measure how efficiently existing assets are being used. Although governments do not always directly own or operate children's services, the level of utilisation may be relevant where governments provide targeted capital or operational funding to establish or maintain services.

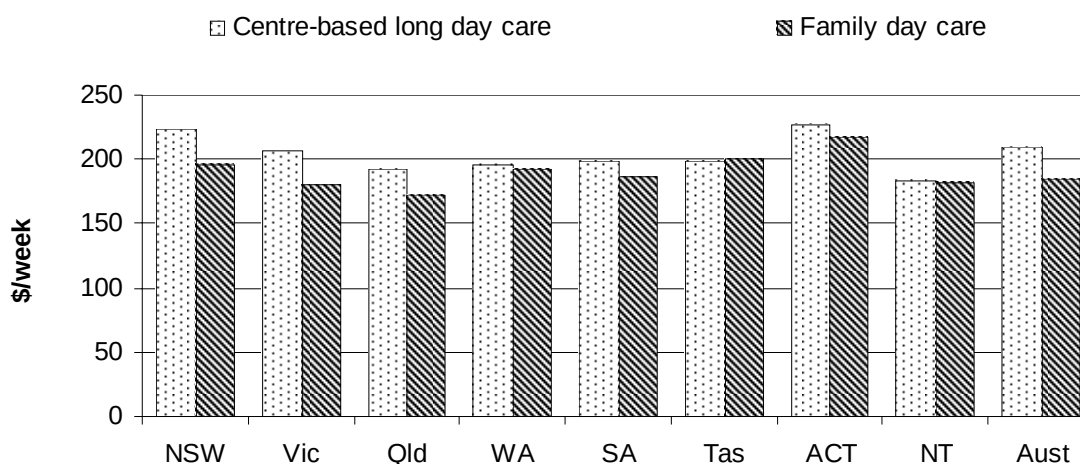
The desirable level of utilisation will depend on a number of factors. High levels of utilisation may be desirable as a measure of efficiency in situations where a community does not require additional services. An alternative view of high utilisation rates is that services are less accessible as there are fewer unused places available.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Service affordability — child care service costs

An indicator of the affordability (and thus accessibility) of children's services is the 'child care service cost', represented by average weekly fees for child care services (box 14.6). Nationally, average weekly fees for 50 hours of care in 2004 were higher for centre-based long day care services than for family day care (figure 14.8).

Figure 14.8 Average fees charged by Australian Government funded child care services, 2004^a



^a Average fees based on 50 hours of care in the Census reference week.

Source: AGCCCS, March 2004 (unpublished); table 14A.25.

Box 14.6 Child care service costs

This indicator is an output (service affordability) indicator of governments' objective to ensure all Australian families have equitable access to children's services regardless of their financial circumstances.

This indicator is defined as average weekly fees for 50 hours of care by service type.

Provided the service quality is held constant, lower service costs are more desirable.

Fee data need to be interpreted with care because fees are independently set by service providers. Charging practices, including fees, are commercial decisions made by individual services, so there is significant variation in the fees charged by services. Fee variation occurs as a result of factors including State and Territory licensing requirements, award wages, and whether fees include charges for additional services such as nappies and meals.

Service affordability — Preschool service costs

'Preschool service costs' is an indicator of the affordability and accessibility of preschool services (box 14.7).

Preschool services are delivered by a different mix of community managed, privately managed and government managed service providers across jurisdictions (tables 14A.33, 14A.42, 14A.51, 14A.60, 14A.69, 14A.78, 14A.87 and 14A.96). Differences in fees charged by service providers may reflect commercial decisions (for privately managed services), the extent of cost recovery (for community and government managed services) and whether fees include charges for additional services such as meals and materials.

Preschool service costs per child may also depend on the time spent in preschool. Of the 239 100 children attending preschool in 2002, 9.9 per cent attended preschool for less than five hours per week, 30.5 per cent attended for between five and nine hours per week, 53.8 per cent attended for between 10 and 19 hours per week and 5.8 per cent attended preschool for more than 20 hours per week (ABS 2003).

Box 14.7 Preschool service costs

Preschool service costs is an indicator of governments' objective that all Australian families have equitable access to children's services regardless of their financial circumstances.

This indicator is defined as the weekly cost of preschool per child (after subsidies received by families). Data are reported as the average and median weekly cost per child.

Provided the service quality and quantity is held constant, lower weekly costs represents more affordable preschool.

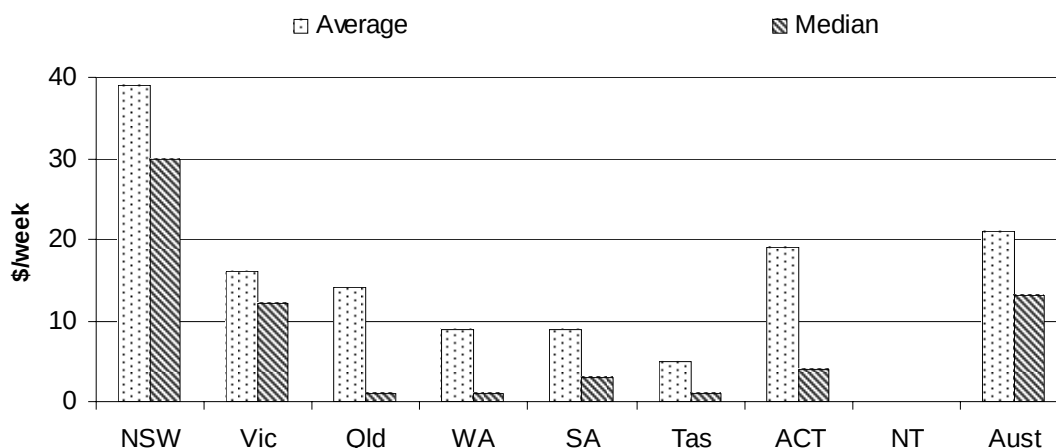
A variety of factors influences preschool costs and care needs to be exercised when interpreting results.

- There may be differences between jurisdictions in the number of hours and sessions attended by children each week.
- Preschool services are provided by a different mix of providers (community, private and government). Differences in charging practices, including fees, may be due to commercial or cost recovery decisions made by individual services. Fee variation can also occur as a result of charges for additional services such as meals and materials.
- Some jurisdictions provide targeted fee relief that lowers fees for some children.

Data for this indicator were obtained from the ABS 2002 Child Care Survey. Given that estimates from the 2002 survey are based on information obtained from a sample of dwellings, they are subject to sampling variability. They may differ from those estimates that would have been produced by a census. Estimates for the smaller jurisdictions are based on small sample sizes and, consequently, are subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution. Box 14.18 includes further information about the 2002 survey.

Nationally, the average cost of preschool per child in 2002 was \$21 per week and the median cost (the middle value in the distribution of fees paid per child) was \$13 per week (figure 14.9). Data for Tasmania and the ACT need to be interpreted with caution. Data for the NT are statistically unreliable and are not published. Table 14A.26 provides additional information on the preschool service costs for children by cost range for selected jurisdictions.

Figure 14.9 **Children who attended preschool, weekly cost per child (after subsidies), 2002^{a, b, c, d, e}**



^a Net costs per child after subsidies have been received. Some children attending preschool services may be eligible for the minimum rate of the Child Care Benefit. ^b The estimates are not based on standardised measures of child age, hours of service provided or preschool service delivery mechanisms. ^c In Victoria and NSW, a fee subsidy is paid directly to services to reduce fees paid by eligible families such as those holding approved concession cards or meeting specified income thresholds. ^d The estimates for Tasmania and the ACT have a relative standard error between 25 per cent and 50 per cent and should be used with caution. ^e The estimate for the NT has a relative standard error greater than 50 per cent and is unreliable for general use.

Source: ABS 2002 Child Care Survey (unpublished); table 14A.26.

Quality

An important focus of Australian, State and Territory governments is to set and maintain appropriate quality standards in child care and preschool services. Indicators of the quality of children's services are the proportion of qualified staff, the rate of ongoing staff development, the extent of licensing and registration, the proportion of services that have achieved quality accreditation, the number of serious injuries, and the number of substantiated breaches arising from complaints per registered or licensed service, by service type. These data need to be treated with caution because there are differences in reporting across jurisdictions.

Staff — qualifications

Staff qualifications are an indicator of staff quality (box 14.8).

Box 14.8 Qualifications

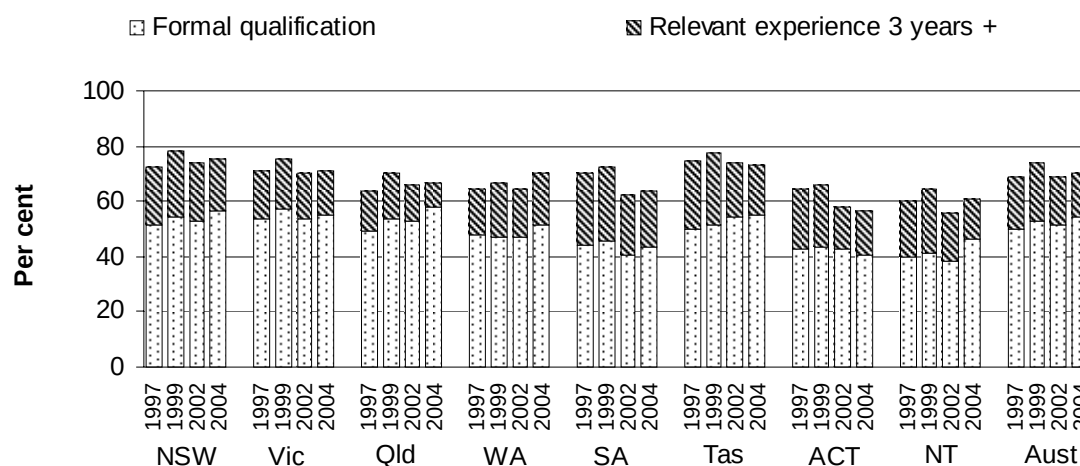
The qualifications of staff in children's services is an output (staff) indicator of governments' objective to ensure staff in government funded or provided children's services are able to provide services which meet the needs of children. In particular, this means ensuring staff have the training and experience to provide a safe and nurturing environment that fulfils the educational and development needs of children.

This indicator is defined as the proportion of primary contact staff with relevant formal qualifications or three or more years of relevant experience.

Some studies and research have shown a link between a higher proportion of qualified and experienced primary contact staff and a higher quality service.

Nationally, there were more than 68 500 primary contact staff employed in Australian Government approved child care in 2004, an increase of 59.2 per cent since 1997 (table 14A.13). The proportion of primary contact staff with relevant formal qualifications or three or more years of relevant experience across jurisdictions over this period is reported in figure 14.10.

Figure 14.10 **Paid primary contact staff employed by Australian Government approved child care services, by qualification^{a, b}**

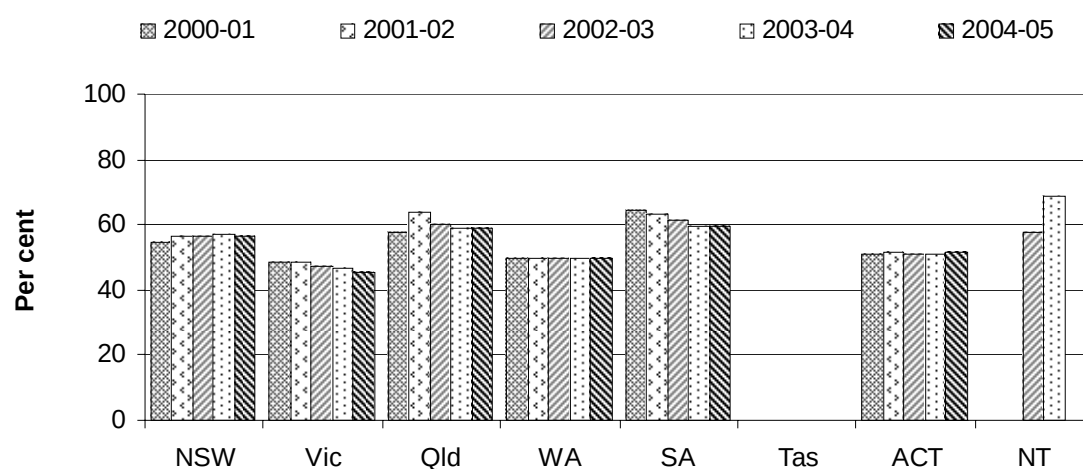


^a Excludes Aboriginal play groups, mobile and toy libraries, and in-home care. ^b 'Three or more years relevant experience' category excludes staff with a relevant formal qualification.

Source: AGCCCS, August 1997, May 1999, May 2002 and March 2004 (unpublished); table 14A.13.

Some data are available on the qualifications of staff employed by preschool services that received funding from State and Territory governments. The proportion of preschool primary contact staff with a relevant formal qualification is reported in figure 14.11. The comparability of these data is limited, however, by the different licensing and funding arrangements across jurisdictions.

Figure 14.11 Paid primary contact staff with a relevant formal qualification employed by State and Territory funded and/or managed preschools^{a, b, c}



^a All funded preschool services in Victoria must have at least two staff but only the preschool teacher must be qualified. ^b Preschools in Queensland must have at least two staff, of whom one must have a relevant formal qualification. ^c Data for Tasmania and some years in the NT are not available.

Source: State and Territory governments (unpublished); tables 14A.32, 14A.41, 14A.50, 14A.59, 14A.68, 14A.77, 14A.86 and 14A.95.

Staff — ongoing development

Ongoing development of the skills and competencies of child care and preschool staff is an indicator of staff quality (box 14.9).

Box 14.9 Ongoing development

The ongoing development of staff in children's services is an output (staff) indicator of governments' objective to ensure staff in government funded or provided children's services are able to provide services that meet the needs of children. In particular, this means ensuring staff have the training and experience to provide a safe and nurturing environment that fulfils the educational and development needs of children.

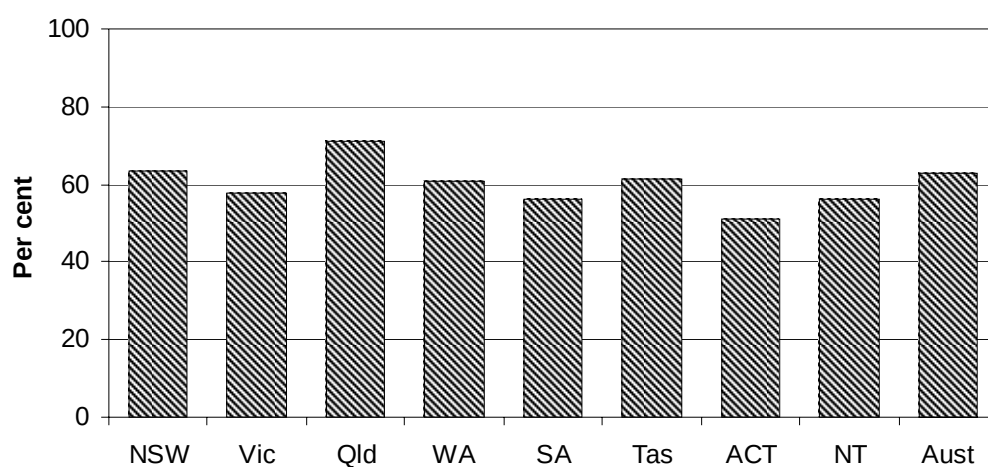
This indicator is defined as the proportion of staff who undertook relevant in-service training in the previous 12 months.

A high rate of in-service training suggests a relatively high quality of service.

This indicator does not provide information on whether the ongoing development undertaken by staff is adequate or sufficiently relevant to improve the quality of the service provided.

Nationally, more than 60 per cent of paid staff working in Australian Government child care services in 2004 undertook relevant in-service training in the previous 12 months (figure 14.12). Limited data are available on training by paid child care and preschool staff employed by State and Territory funded and/or managed service providers. New South Wales, Victoria, Queensland and the ACT were able to provide data on the proportion of preschool staff undertaking training in 2004-05 (tables 14A.32, 14A.41, 14A.50 and 14A.86)

Figure 14.12 **Staff in Australian Government child care services who undertook relevant in-service training in previous 12 months, 2004^a**



^a Excludes Aboriginal play groups, mobile and toy libraries, and in-home care.

Source: AGCCCS, March 2004 (unpublished); table 14A.14.

Standards

The Australian Government and the State and Territory governments are committed to supporting the quality of care provided by children's services. The mechanisms used to support quality are accreditation and licensing. These mechanisms are used in addition to the provision of curriculum and policy support and advice, and the training and development of management and staff.

Standards — licensing and registration

State and Territory governments are responsible for licensing children's services in their jurisdiction (box 14.10).

Box 14.10 Licensing and registration

'Licensing and registration' is an output (standards) indicator of governments' objective to ensure government funded or provided children's services meet the minimum standards considered necessary to provide a safe and nurturing environment, and to meet the educational and development needs of children.

Data are currently not reported on this indicator. The Steering Committee has identified this indicator for development and reporting in future. Descriptive information is reported for some jurisdictions as an interim measure. This information includes the number of licensed services.

A higher proportion of licensed services is desirable.

This indicator does not provide information on the degree to which licensing and registration translates into higher quality service outcomes above the minimum standards of care.

State and Territory governments also undertake activities aimed at the promotion of quality, such as publishing curriculum materials and other resources, and undertaking consumer education.

The types of service covered by legislation vary across jurisdictions (table 14.5).

Table 14.5 State and Territory licensing and registration of child care services, 2005

<i>Service type</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>
Long day care ^a	✓	✓	✓	✓	✓	✓	✓	✓
Occasional care ^a	✓	✓	✓	✓	✓	✓	✓	✓
Family day care schemes ^b	✓	x	✓	x	✓	✓	✓	x
Family day care carers ^c	✓	x	x	✓	x	x	x	x
Outside school-hours care	x	x	✓	✓	x	✓	✓	x
Other/home-based care ^d	✓	x	x	x	✓	✓	✓	x

^a In the ACT, licensed as centre-based children's services. ^b In WA, the carers, not the schemes, are licensed. ^c Family day care providers in NSW and WA are individually licensed. Family day carers in Queensland, SA and Tasmania are not required to be licensed, provided they are registered through a family day care scheme. ^d Includes baby sitting agencies in SA. Includes playschools and independent preschools in the ACT.

Source: State and Territory governments (unpublished).

State and Territory licensing requirements establish the foundations for quality of care by stipulating enforceable standards to support the health, safety, welfare and development needs of children in formal child care settings. Accreditation of services is built on this platform.

Licensed children's services may include centre-based long day care, occasional care, preschools, family day care services and outside school hours care. Australian, State and Territory governments have developed national standards for centre-based long day care, family day care services and outside school hours care. Jurisdictions refer to these standards when writing regulations. The extent of implementation of these standards varies across Australia.

Standards — accredited services

The NCAC administers quality assurance systems for long day care centres, family day care schemes and outside school hours care services across Australia (box 14.11).

Box 14.11 Accredited services

‘Accredited services’ is an output (standards) indicator of governments’ objective to ensure government funded or provided children’s services meet the standards considered necessary to provide a safe and nurturing environment, and to meet the educational and development needs of children. Accredited services have been independently evaluated against a series of national quality standards for the specific child care service type.

This indicator is defined as the number of child care services that are accredited by NCAC expressed as a proportion of services fully assessed. Data are reported for centre-based long day care services, family day care schemes and outside school hours care services.

A higher proportion of centres that have been accredited is more desirable.

This indicator does not provide information on the degree to which accreditation translates into higher quality service outcomes.

The Australian Government also funds professional support services across Australia to assist services participating in the quality assurance systems. State and Territory government initiatives include quality and improvement systems for government preschools (SA and Victoria) and non-government preschools (Queensland). Some other jurisdictions are exploring similar systems.

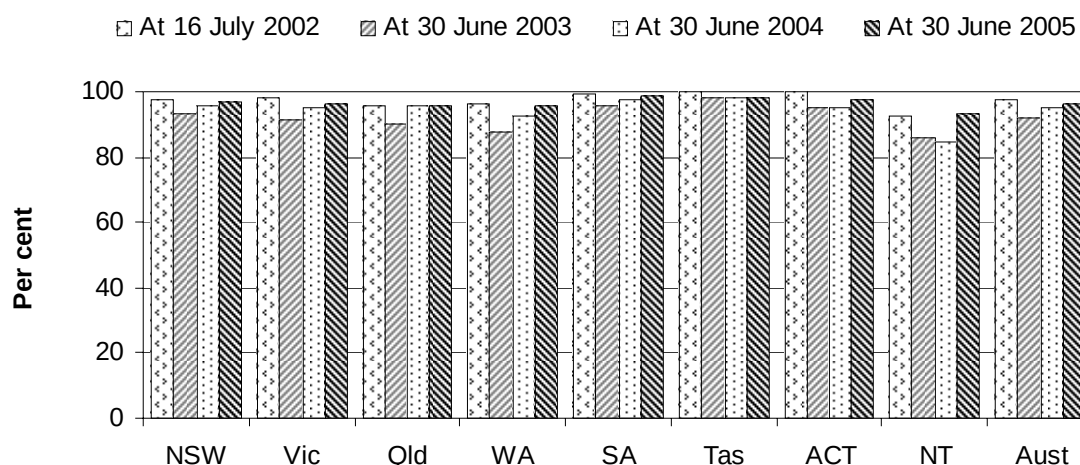
The QIAS for long day child care centres commenced in 1994 and was revised in January 2002. Family Day Care Quality Assurance was introduced on 1 July 2001 and OSHCQA commenced on 1 July 2003. To become accredited under NCAC quality assurance systems service providers are required to achieve and maintain the quality standards set out for each service type. Long day child care services participating in the QIAS receive a ‘quality profile’ as part of their accreditation decision, which details their performance against the following ten ‘quality areas’:

- relationships with children
- respect for children
- partnerships with families
- staff interactions
- planning and evaluation
- learning and development
- protective care
- health
- safety
- managing to support quality.

The NCAC accreditation systems are Australian Government initiatives linked to Child Care Benefit funding. All centre-based long day child care services are required to participate in the QIAS to be eligible for approval for Child Care Benefit purposes, and the majority of centre-based long day child care services participate.

Nationally, of the 4747 centres registered to participate in the QIAS at 30 June 2005, 4147 centres had received an accreditation decision (table 14A.2). Of the centres assessed, 96.5 per cent (4001 centres) were successful in achieving accreditation (figure 14.13). The centres that do not meet accreditation standards (146 centres) are required to submit another self study report to NCAC within six months of the date of NCAC's accreditation decision. At 30 June 2005, a further 600 centres (12.6 per cent of those registered to participate in QIAS) were in self study, review or moderation, or awaiting an accreditation decision (table 14A.2).

Figure 14.13 Accredited centres as a proportion of centres fully assessed under the Quality Improvement and Accreditation System^{a, b}



^a Figures may change daily and are updated every six weeks following an NCAC meeting. ^b Results for Tasmania, the ACT and the NT may be unduly influenced by the relatively small number of services (76, 92 and 53 respectively at 30 June 2005) participating in the process.

Source: NCAC (unpublished); table 14A.2.

Self-study reports from family day care schemes have been submitted from July 2002, with 311 out of 312 schemes accredited at 30 June 2005. One scheme was not accredited and seven were in self study, validation or moderation, or awaiting an accreditation decision (table 14A.2). Family day care schemes also receive a quality profile, which details their performance against the following six quality areas:

- interactions
- physical environments
- children's experiences, learning and development
- health, hygiene, nutrition, safety and wellbeing
- carers and coordination unit staff
- management and administration.

The family day care quality standards (detailed in NCAC 2001) were revised in 2004 based on feedback and consultation with family day care schemes. The revised standards (detailed in NCAC 2004c) came into effect from 1 January 2005.

All services providing before school, after school and vacation care were required to register with NCAC by 30 September 2003. Each registered outside school hours care service is required to submit a self-study report to NCAC between July 2004 and December 2006. Outside school hours care services receive a quality profile, which details their performance against the following eight quality areas:

- respect for children
- staff interactions and relationships with children
- managing to support quality
- programming and evaluation
- play and development
- health, nutrition and wellbeing
- protective care and safety
- partnerships with families and community links.

There were 2908 outside school hours care services registered at 30 June 2005 to participate in OSHCQA (table 14A.2). Of the 279 services that had received an accreditation decision at 30 June 2005, 74.2 per cent (207 services) were successful in achieving accreditation. A further 2629 services had not yet completed the accreditation process.

Health and safety — serious injuries

‘Serious injuries’ is an indicator of child care services’ success in providing a safe environment (box 14.12).

Box 14.12 Serious injuries

‘Serious injuries’ is an output (health and safety) indicator of governments’ objective to ensure children’s services meet the care, educational and development needs of children in a safe and nurturing environment.

This indicator is defined as the number of serious injuries per registered or licensed service provider. A serious injury is defined as an injury requiring hospitalisation or a visit to, or by, a doctor.

Comparable data are not available for this Report. A higher rate of injury does not provide information on whether a jurisdiction has lower service safety and quality, or a more effective reporting and monitoring regime. All else being equal, a low injury rate may indicate a high level of safety.

Data on the number of serious injuries and the number of serious injuries per registered or licensed service provider were limited for 2004-05. Although most jurisdictions could provide some information, the small incident numbers, different approaches to defining serious injuries and differences in data collection approaches mean that jurisdictions cannot be directly compared. Tables 14A.35, 14A.44, 14A.53, 14A.62, 14A.89 and 14A.98 provide a breakdown of the available

information for each jurisdiction. South Australia and Tasmania did not report on serious injuries.

Health and safety — hospitalisations for external causes of injury occurring in children's services

At present, jurisdictions do not have comparable administrative collections on serious injuries occurring in children's services. One source of comparable information is hospitalisations data. 'Hospital separations for external causes of injury' is an indicator of children's services' success in providing a safe environment (box 14.13).

In 2003-04, there were 28 448 injuries to children aged 0-4 years that resulted in a hospital admission in Australia (table 14A.27). Boys accounted for approximately 57.8 per cent of these admissions. In total, the most common causes of injury to children aged 0-4 years were falls (27.7 per cent), exposure to mechanical forces (20.7 per cent) and complications of medical and surgical care (18.5 per cent) (Australian Institute of Health and Welfare unpublished). Boys and girls generally experienced similar causes of injury.

Place of occurrence was recorded for 68.7 per cent of hospitalisations for children aged 0-4 years in 2003-04 (table 14A.27). Of those injuries for which a place of occurrence was recorded in 2003-04, 60.6 per cent occurred in the child's home. This reflects the fact that children in this age group spend the majority of their time in the home and about half do not attend formal care. Nationally, 576 injuries (2.0 per cent) were reported as occurring at a 'school' (which includes day nursery, centre-based child care, and public or private kindergartens and preschools) (figure 14.14).

Box 14.13 Hospital separations for external causes of injury

'Hospital separations for external causes of injury' is an output (health and safety) indicator of governments' objective to ensure that children's services meet the care, educational and developmental needs of children in a safe and nurturing environment.

This indicator is defined as the number of hospital separations for children aged 0–4 years resulting from an external cause of injury occurring in 'school' expressed as a proportion of total hospital separations for children aged 0–4 years resulting from an external cause of injury.

Limiting the data to children aged 0–4 reduces the likelihood that the 'school' place of occurrence includes children in full time compulsory schooling, which children generally attend when they are 5 years old or more. For children in the older age group it is not possible to separate injuries that occur in a children's service from those that occur in a full time formal school setting, and so they are excluded from the indicator.

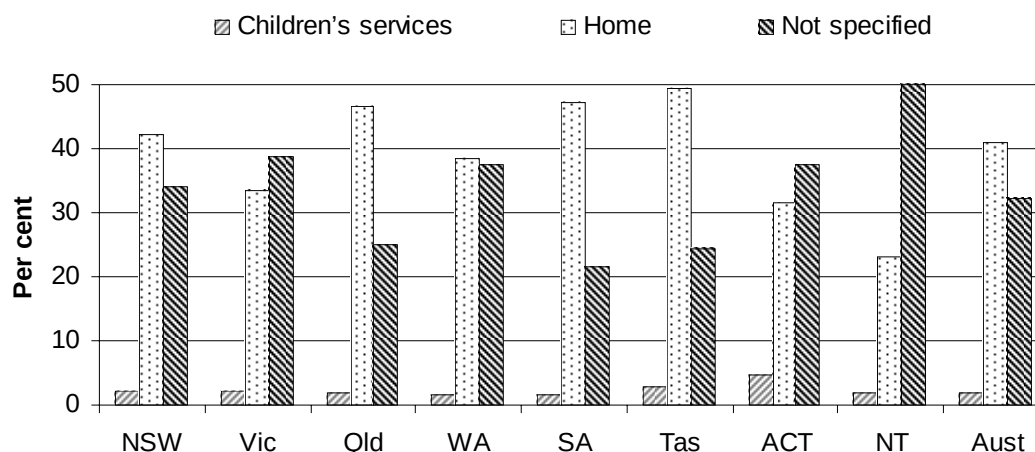
For children aged 0–4 years, the term 'school' incorporates a range of formal children's services settings including kindergarten, preschool and centre-based child care services. Family day care services, which are typically provided in the carer's home, are not likely to be covered by this term. External cause refers to the environmental event, circumstance or condition that causes the injury. Persons admitted to hospital as a result of a pre-existing existing illness or condition (such as asthma), are excluded.

A hospital separation is an episode of care for a person admitted to a hospital. It can be a total hospital stay (from admission to discharge, transfer or death) or portions of hospital stays beginning or ending in a change of type of care (for example from acute to rehabilitation) that cease during a reference period. Injuries resulting in a hospital separation are generally more serious than those requiring treatment at a hospital emergency department or by a general practitioner.

Low or decreasing hospitalisations for external causes of injury for children aged 0–4 years occurring in a 'school' indicates better performance towards achieving the objective of providing the care, educational and development needs of children in a safe and nurturing environment.

All hospital separation data need to be interpreted with care. Nationally, no place of occurrence was reported for 32.3 per cent of hospitalisations of children aged 0–4 years in 2003-04. As a result, this indicator should be interpreted as the minimum proportion of hospital separations for an external cause of injury that occurred in children's services.

Figure 14.14 Hospital separations for external causes of injury for children aged 0–4 years, by place of occurrence (proportion of total), 2003-04^{a, b, c, d, e}



^a The definition of school includes a range of formal children's services settings such as kindergarten, preschool and child care services. ^b External cause refers to the environmental event, circumstance or condition that causes the injury. Persons admitted to hospital as a result of a pre-existing existing illness or condition, such as asthma, are excluded. ^c A hospital separation is an episode of care for a person admitted to a hospital. ^d Separations without an external cause and those for which care type was reported as newborn with no qualified days, and records for hospital boarders or posthumous organ procurement are excluded. ^e Injuries occurring in other specified places — covering the remaining places where injuries occurred — are not shown in the figure, but are included in table 14A.27.

Source: Australian Institute of Health and Welfare Australian Hospital Statistics 2003-04 (unpublished); table 14A.27.

Client satisfaction — substantiated breaches arising from complaints

‘Substantiated breaches arising from complaints’ is an indicator of community satisfaction with child care services (box 14.14). Breaches identified as a result of normal monitoring and inspection visits are excluded from these data.

Breaches of legislation, regulations or conditions can relate to a broad range of requirements. Some requirements have serious implications for the quality of care provided to children (such as requirements to undertake criminal record checks for staff and requirements to install smoke detectors). Other requirements do not necessarily directly affect the quality of care (such as requirements to display licensing information). Similarly, action taken by regulatory authorities in response to a breach can range from a requirement to comply within a specified time frame through to deregistration or prosecution.

Box 14.14 Substantiated breaches arising from complaints

'Substantiated breaches arising from complaints' is an output (client satisfaction) indicator of governments' objective to ensure government funded or provided children's services meet the needs and expectations of users.

This indicator is defined as the number of substantiated breaches arising from complaints divided by the total number of registered or licensed services. Results are presented by service type. Data on the proportion of substantiated breaches arising from complaints against which action was taken are also reported.

A substantiated breach is defined as a finding by the regulatory body that a service has failed to abide by the State or Territory legislation, regulations or conditions. A complaint is an expression of concern, whether made orally, in writing or in person to the relevant government authority. It does not include complaints made to service management and dealt with at that level.

Complaints data need to be interpreted with care.

- Some jurisdictions give priority to developing client groups who are well informed, as part of improving their service delivery. Clients who are well informed may be more likely to make a complaint than are clients without access to this information.
- The number of approved care providers or parent users per service differs in each service across states and territories.
- Complaints management systems vary across jurisdictions. In SA, for example, the Department of Education and Children's Services is the sole sponsor of family day care. Similar complaints in other states and territories may be managed at a service level and, as such, may not be reported.
- A higher rate of complaints does not provide information on whether a jurisdiction has lower service safety and quality, or a more effective reporting and monitoring regime. All else being equal, a higher rate of breaches arising from complaints may suggest a lower quality service.

Victoria, WA, Tasmania, the ACT and the NT provided data on the number of substantiated breaches arising from complaints and allegations of regulation breaches made to the State and Territory government regulatory bodies in 2004-05 (tables 14A.45, 14A.63, 14A.81, 14A.90 and 14A.99 respectively).

Efficiency

Differences in reported efficiency results across jurisdictions may reflect differences in counting and reporting rules for financial data and in reported expenditure, which are partly due to different treatments of various expenditure items. Information on the comparability of the expenditure is shown in table 14A.6.

The level of government input per unit of output(s) (unit costs) is a proxy indicator of efficiency. The indicators reported here are:

- Australian Government total expenditure on children's services per child aged 0–12 years in Australia (box 14.15)
- State and Territory government total expenditure on children's services per child aged 0–12 years in the relevant jurisdiction (box 14.16).

Data were sought from all governments on their expenditure by service type. Incomplete data and changes in collection method, however, make it difficult to compare expenditure across jurisdictions and over time. Unit cost data for children's services do not yet contain an estimate of user cost of capital.

Inputs per output unit — Australian Government expenditure (dollars per child)

Box 14.15 Australian Government expenditure per child

'Australian Government expenditure per child' is an output (efficiency) indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources.

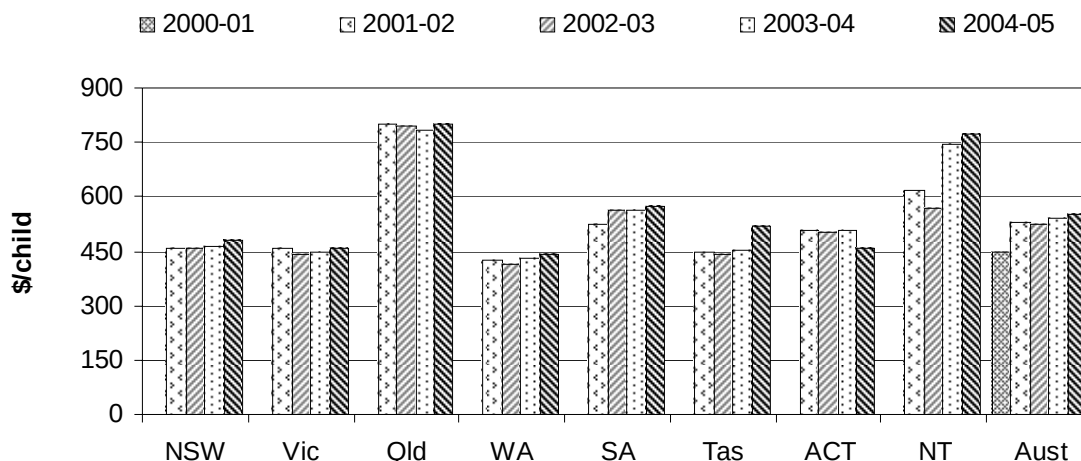
This indicator is defined as Australian Government expenditure on children's services per child aged 0–12 years in Australia.

Provided the level and quality of, and access to, services remains unchanged, lower expenditure per child can indicate greater efficiency of government expenditure.

All efficiency data need to be interpreted with care. Changes in expenditure per child could represent changes in government funding policy. While high or increasing unit costs may reflect deteriorating efficiency, they may also reflect increases in the quality or quantity of service provided. Similarly, low or declining expenditure per child may reflect improving efficiency or lower quality or quantity.

After adjusting for inflation to calculate the 'real' value of expenditure in previous years, Australian Government expenditure on children's services at a national level increased between 2000-01 and 2004-05 (figure 14.15).

Figure 14.15 **Australian Government real expenditure on children's services per child aged 0–12 in the jurisdiction (2004-05 dollars)^{a, b, c}**



^a Includes administration expenditure, other expenditure on service provision, financial support to families and net capital expenditure on child care and preschool services. ^b Data by State and Territory were not available for 2000-01. ^c The Australian total includes a component of expenditure that cannot be disaggregated by State and Territory.

Source: FaCS (unpublished); ABS Australian Demographic Statistics (unpublished); ABS (2002), *Population Projections, Australia*, Cat. no. 3222.0, Canberra; table 14A.20.

Inputs per output unit — State and Territory government expenditure (dollars per child)

Box 14.16 **State and Territory government expenditure per child**

'State and Territory government expenditure per child' is an output (efficiency) indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources.

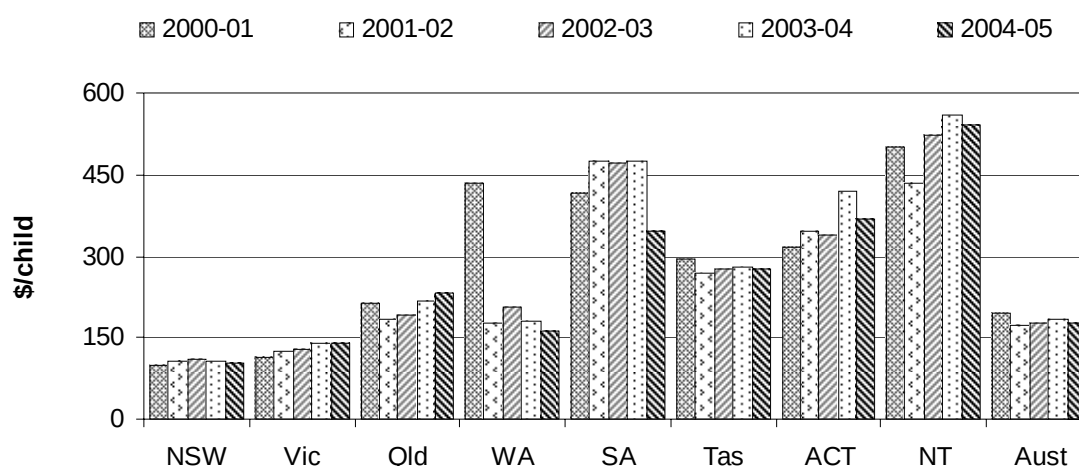
This indicator is defined as State or Territory government expenditure on children's services per child aged 0–12 years in the relevant jurisdiction.

Lower expenditure per child represents greater efficiency of government expenditure, provided the level and quality of, and access to, services remains unchanged.

All efficiency data need to be interpreted with care. Changes in expenditure per child could represent changes in government funding policy. While high or increasing unit costs may reflect deteriorating efficiency, they may also reflect increases in the quality or quantity of service provided. Similarly, low or declining expenditure per child may reflect improving efficiency or lower quality or quantity provided.

Figure 14.16 shows the variation in total real expenditure per child aged 0–12 years by State and Territory governments over the period 2000-01 to 2004-05.

Figure 14.16 State and Territory real expenditure on children's services per child aged 0–12 in the jurisdiction (2004-05 dollars)^{a, b, c, d, e}



^a Includes administration expenditure, other expenditure on service provision, financial support to families, and net capital expenditure on child care and preschool services. ^b The increase in Queensland expenditure for 2004-05 is the result of improved reporting processes. This specifically captures information relating to a newly developed output of Child Care Policy and Services, and includes previously unreported information, namely indirect costs, head office overheads and expenditure on policy advice and development. ^c WA expenditure for 2001-02 declined in response to the changes in the school entry age and the associated move to full time schooling for pre-year 1 children. ^d Data for 2003-04 and 2004-05 exclude expenditure on the non-government sector. ^e The drop in SA expenditure per child aged 0–12 years in 2004-05 was due to the exclusion of all Australian Government contributions, which the state currently administers, from the total state/territory real expenditure on children's services.

Source: State and Territory governments (unpublished); ABS Australian Demographic Statistics (unpublished); ABS (2002), *Population Projections, Australia*, Cat. no. 3222.0, Canberra; table 14A.21.

Outcomes

Demand for (additional) child care

Data on the 'demand for additional child care services' provides an indicator of the success of children's services in meeting the needs of the community (box 14.17).

Box 14.17 Demand for (additional) child care

This indicator provides an outcome indicator of governments' objective to ensure children's services meet the requirements of all Australian families. Expressed need for child care indicates the extent to which children's services are meeting demand by families.

The indicator is defined as the proportion of children aged under 12 years for whom additional services were required in the four weeks before the survey interview.

A lower proportion of children for whom additional services were required indicates demand by families is being met to a greater extent.

One available indicator is the expressed need for additional child care services, collected in the ABS Child Care Survey (box 14.18).

Box 14.18 ABS Child Care Survey

The 2002 ABS Child Care Survey was conducted throughout Australia in June 2002, as a supplement to the Labour Force Survey.

Information was obtained from a sample of dwellings through interviews conducted over a two week period with usual residents with children under 12 years of age. In each selected household, detailed information about each child's child care was collected for a maximum of two children. Data were collected for a sample of approximately 10 000 children in total.

The survey included information about whether parents' needs for child care were met. Those families not already using child care or preschool services were asked whether there was any time in the previous four weeks when they wanted to use any child care or preschool services for their child but did not. Those families already using child care or preschool services were asked a similar question to determine whether they had wanted to use any more services in the previous four weeks.

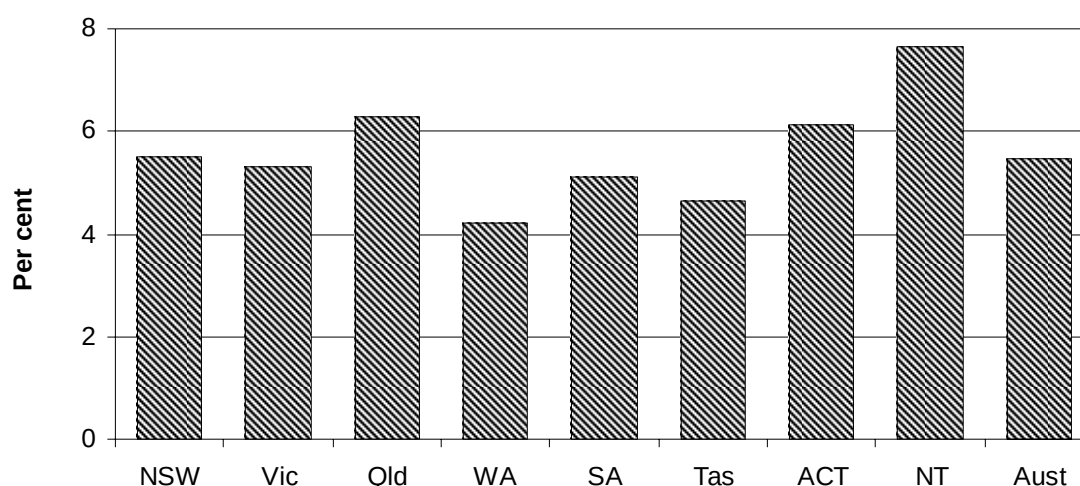
Given that estimates from the 2002 survey are based on information obtained from a sample of dwellings, they are subject to sampling variability. They may differ from those estimates that would have been produced by a census. Estimates for the smaller jurisdictions are based on small sample sizes and, consequently, are subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution.

Aggregated survey data need to be interpreted with care, because over and undersupply of child care places can be specific to particular areas, including small and remote communities. Further, the data will not reflect changes in population in some areas since June 2002.

The most recent ABS Child Care Survey was conducted over a two week period in June 2005. Results are expected to be available in the first half of 2006.

Nationally, no additional child care or preschool services were required for the majority (94.4 per cent) of children aged under 12 years in 2002 (figure 14.17). Additional child care services were required, however, for approximately 169 400 children aged under 12 years (table 14A.23). A further 5100 children aged under 12 years required additional preschool services (table 14A.23).

Figure 14.17 Proportion of children aged under 12 years for whom additional formal child care was required, 2002^a

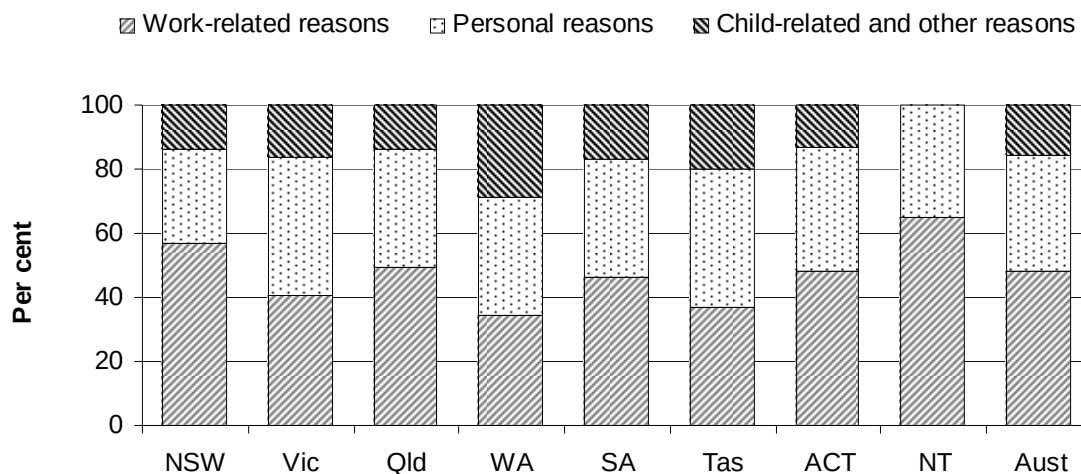


^a Estimates for the smaller jurisdictions are based on small sample sizes and, consequently, are subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution. Source: ABS 2002 Child Care Survey (unpublished); table 14A.22.

The reasons given for additional services being required varied between those requiring additional child care services and those requiring additional preschool services. The needs of the parent, including the need to work, was the major reason for desiring additional child care services. Nationally, work-related reasons were cited in 48.4 per cent of circumstances, with personal reasons accounting for an additional 35.8 per cent of cases (figure 14.18). Child-related and other reasons were cited in the remaining 15.8 per cent of cases (table 14A.23).

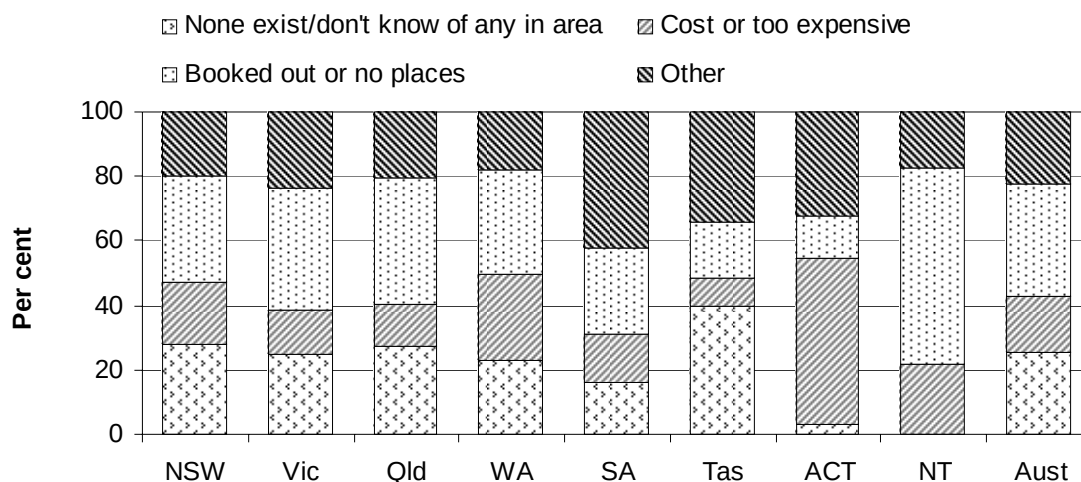
The most common reason given for not being able to access additional child care services was lack of available places ('booked out or no places', table 14A.24), accounting for 34.8 per cent of the national total. No services being available (or known of) in the area, and the cost of services were also significant reasons, accounting for 25.3 per cent and 17.3 per cent respectively of the number of children requiring additional child care services (figure 14.19).

Figure 14.18 Children aged under 12 years who required additional child care services by main reason required, 2002^a



^a Estimates for the smaller jurisdictions are based on small sample sizes and, consequently, are subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution. Source: ABS 2002 Child Care Survey (unpublished); table 14A.23.

Figure 14.19 Children aged under 12 years by main reason additional child care services not used, 2002^{a, b}



^a 'None exist/don't know of any in area' includes 'not known whether care available'. 'Other' includes 'other service related', 'child-related' and 'other'. ^b Estimates for the smaller jurisdictions are based on small sample sizes and, consequently, are subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution.

Source: ABS 2002 Child Care Survey (unpublished); table 14A.24.

Out-of-pocket costs

‘Out-of-pocket costs’ of child care is an indicator of the affordability and accessibility of child care services (box 14.19).

Box 14.19 Out-of-pocket costs

‘Out-of-pocket costs’ is an outcome indicator of governments’ objective that all Australian families have equitable access to children’s services regardless of their financial circumstances.

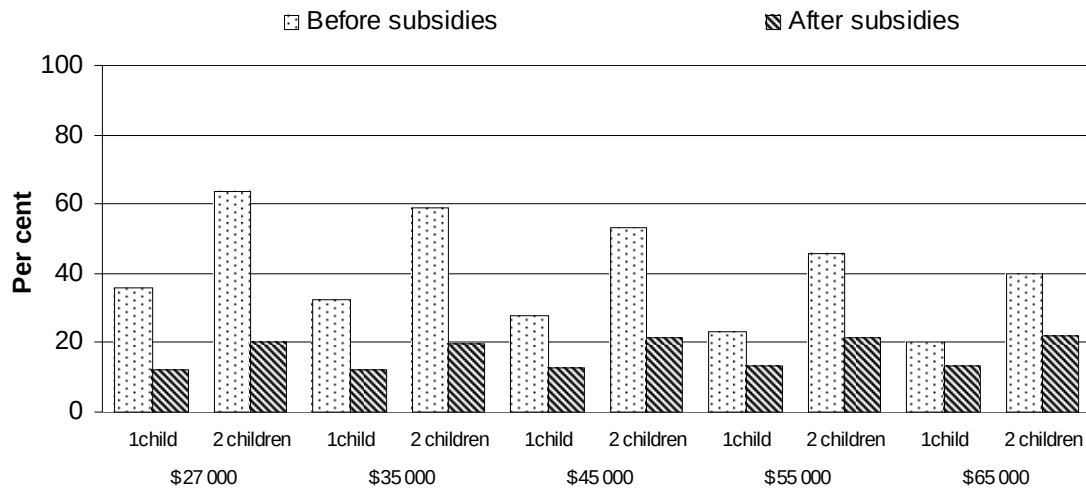
This indicator is defined as the proportion of weekly disposable income that representative families spend on child care services before and after the payment of child care subsidies. Data are estimated for families with a 60:40 income split and gross annual income of \$27 000, \$35 000, \$45 000, \$55 000 and \$65 000. Families are assumed to have either one or two children who attend full time care (equal to 50 hours per child per week) in centre-based long day care and family day care.

Lower out-of-pocket costs for child care as a proportion of weekly disposable income (after child care subsidies) represents more affordable child care. Similar percentages across income groups suggest a more equitable outcome.

Care needs to be exercised when interpreting results, however, because a variety of factors may influence child care fees.

After the payment of child care subsidies, out-of-pocket costs as a proportion of weekly family income in 2004 was generally similar across income bands compared to the case before subsidies were paid (figure 14.20).

Figure 14.20 **Out-of-pocket costs of child care for families with children in full time centre-based long day care, as a proportion of weekly disposable income, by gross annual family income, 2004^{a, b}**

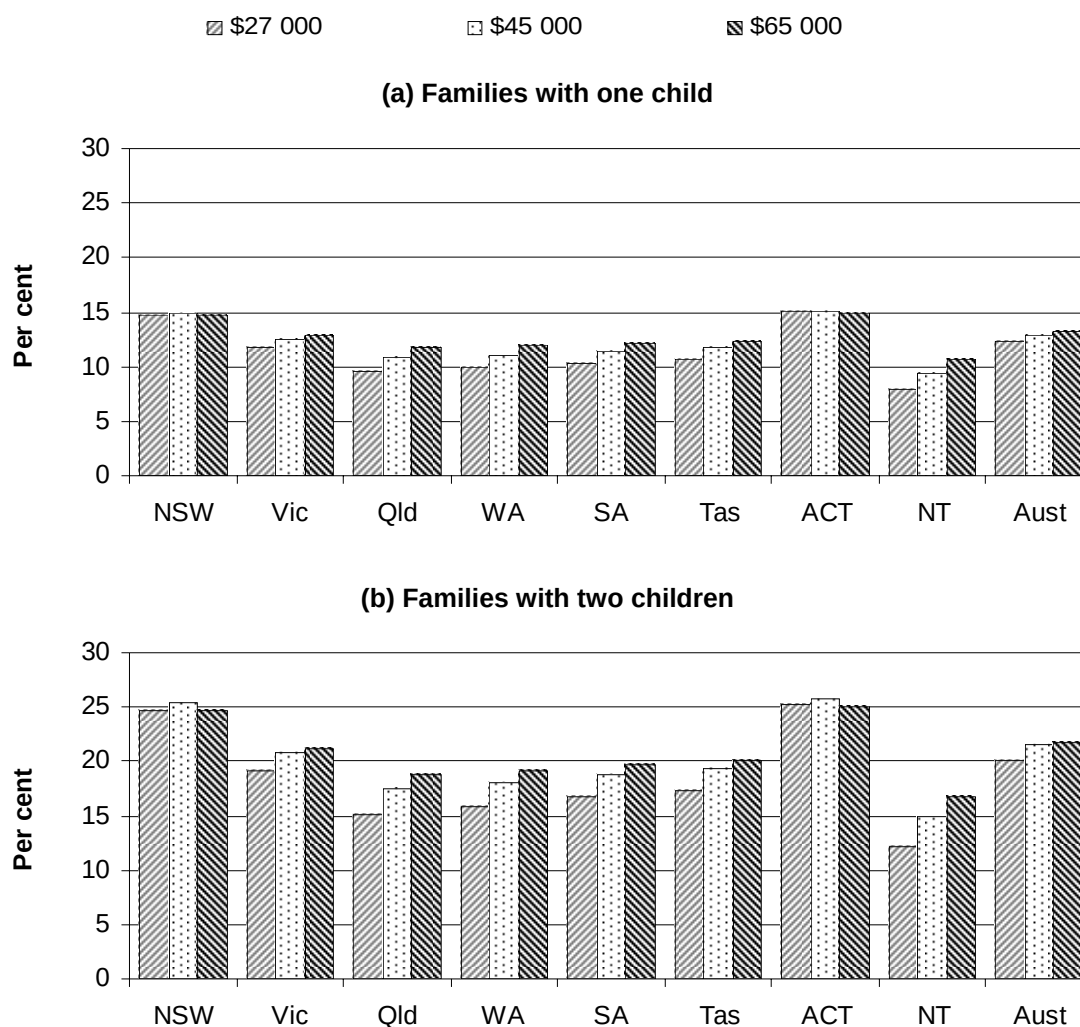


^a Disposable income calculations are based on 20 March 2004 tax and payment parameters. Calculations are modelled on couple families with dual incomes (60:40 income split) with one or two dependent children aged under 5 years. ^b Out-of-pocket cost calculations are based on June 2004 average fees.

Source: AGCCCS March 2004 (unpublished); table 14A.17.

Figure 14.21 shows out-of-pocket costs (after subsidies) in 2004 for centre-based long day care for families with one child and with two children in care across jurisdictions. Out-of-pocket costs (after subsidies) for family day care in 2004 are shown in figure 14.22.

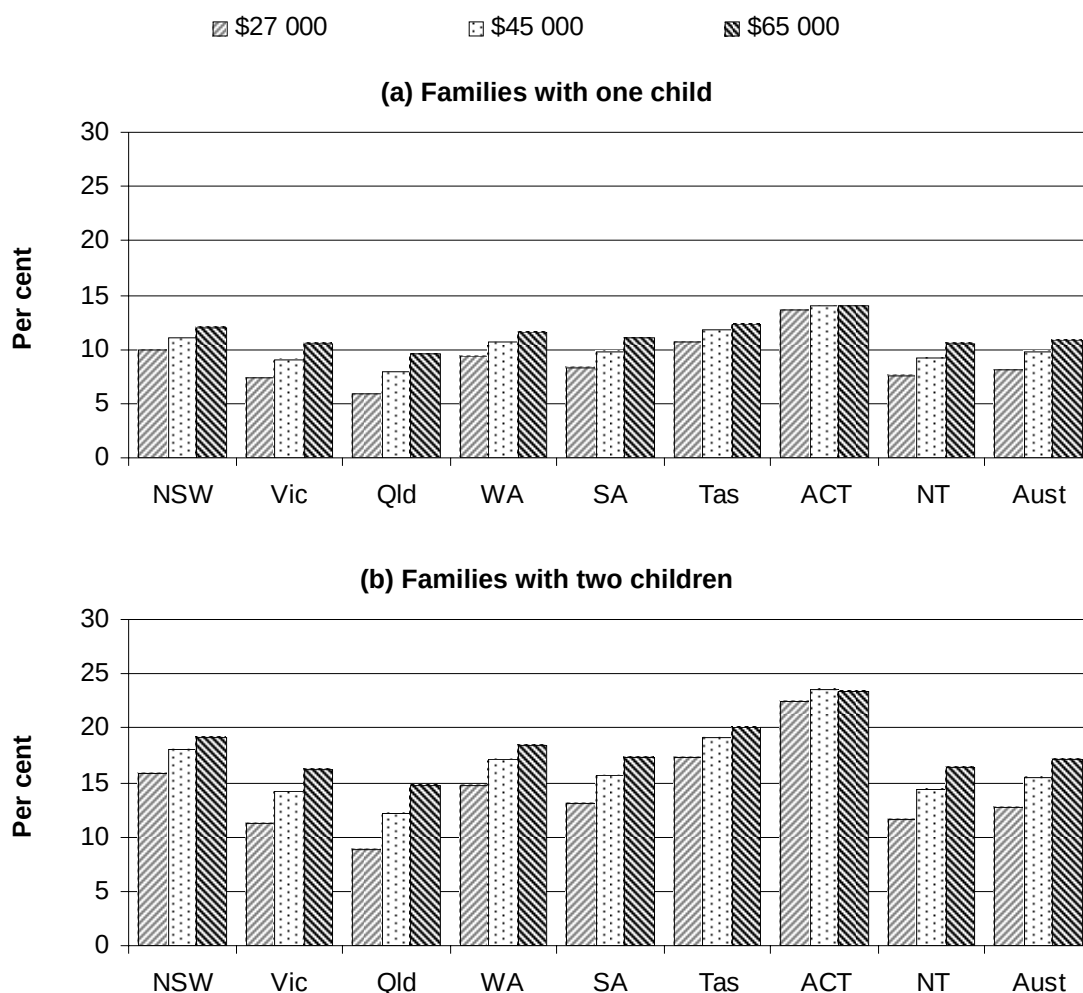
Figure 14.21 **Out-of-pocket costs for centre-based long day care (after subsidies), as a proportion of weekly disposable income, by gross annual family income, 2004^{a, b}**



^a Disposable income calculations are based on 20 March 2004 tax and payment parameters. Calculations are modelled on couple families with dual incomes (60:40 income split) with one or two dependent children aged under 5 years. ^b Out-of-pocket cost calculations are based on June 2004 average fees, after subsidies.

Source: AGCCCS March 2004 (unpublished); table 14A.17.

Figure 14.22 **Out-of-pocket costs for family day care (after subsidies), as a proportion of weekly disposable income, by gross annual family income, 2004^{a, b}**



^a Disposable income calculations are based on 20 March 2004 tax and payment parameters. Calculations are modelled on couple families with dual incomes (60:40 income split) with one or two dependent children aged under 5 years. ^b Out-of-pocket cost calculations are based on June 2004 average fees, after subsidies.

Source: AGCCCS March 2004 (unpublished); table 14A.18.

Client satisfaction

The Steering Committee has identified 'client satisfaction' as an outcome indicator of children's services meeting family needs (box 14.20). Data for this indicator, however, were not available for the 2006 Report.

Box 14.20 Client satisfaction

‘Client satisfaction’ has been identified as an outcome indicator of governments’ objective to ensure children’s services meet the needs and expectations of all users.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

14.4 Future directions in performance reporting

The Steering Committee is committed to improving the comparability, completeness and overall quality of reported data for all indicators included within the performance indicator framework.

Improving reporting of existing indicators

Processes for refining definitions, estimation methods and counting rules are continuing. Further work is planned to improve the consistency and comparability of performance information across jurisdictions. Changes in the children’s services industry have required jurisdictions to revise collection methods, and these revisions have reduced the comparability of historical data across years and across jurisdictions. It will take some time before the improvements are reflected in the chapter.

Future indicator development

The Review will continue to improve the appropriateness and completeness of the performance indicator framework. Future work on indicators will focus on:

- developing an access indicator for Indigenous preschool attendance
- developing a service availability indicator for utilisation rates
- revising the quality indicators for health and safety, and substantiated breaches arising from complaints
- developing indicators to measure the extent to which children’s services meet family needs, including investigating an outcome indicator of client satisfaction
- developing indicators to measure the extent to which children’s services meet children’s needs
- completing the quality indicators for licensing, accreditation and registration

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- improving the government expenditure efficiency indicators
 - conducting a rolling revision of all indicators within the framework.

While these areas have been identified as requiring further work, improvements to the chapter and progress on performance reporting will not be limited to these indicators.

Improving the completeness and comparability of data

National Minimum Data Set

The National Community Services Information Management Group (NCSIMG) is developing a National Minimum Data Set (NMDS) for children's services. When completed, this data set will provide a framework for collecting a minimum set of nationally comparable data and assist the development of measurable performance indicators and descriptors.

The collection covers information about the organisations that provide child care and preschool services, the characteristics of workers delivering these services and the characteristics of the children who attend them. The data items in the NMDS were pilot tested in two phases, the first in 2002 and the second in 2004.

In September 2005, the data items were endorsed by NCSIMG, completing the development phase. A full report of the development process was due to be released at the end of 2005. The project is now moving to the implementation phase. Outstanding issues to be addressed are agreement about the best mechanism for data collection, funding arrangements, and the creation and maintenance of a register of service providers.

ABS Child Care Survey

The ABS conducted its Child Care Survey over a two week period in June 2005. It is expected that the results of the 2005 survey will be published in the first half of 2006. The Children's Services Working Group will examine additional published and unpublished data from the survey for inclusion in the 2007 Report.

Following a request by the Children's Services Working Group, the ABS changed the age scope of the 2005 Child Care Survey from children aged under 12 years to children aged under 13 years. This change will more closely align statistics from the Child Care Survey with other data collected by jurisdictions published in the Report.

Data collection

Consistency in the data collected by State and Territory governments is an important goal to improve data comparability. There is still room for improvement in the data collection process. One way of improving comparability is to collect data in a (preferably common) sample week that is representative of a typical standard week (and does not include any public holidays) in each State and Territory.

Another way to improve the consistency of data is to use common definitions. Although the children's service NMDS is yet to be implemented, several jurisdictions are reviewing their statistical collections and incorporating definitions from the NMDS where possible. As the NMDS definitions are more widely adopted in jurisdictions' separate collections, there will be better comparability of data across jurisdictions.

14.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

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The Australian Government is currently finalising the National Agenda for Early Childhood with state and territory governments. The National Agenda will provide the overarching policy framework for national activity which promotes optimal child development during the first eight years of life. It is intended to guide current and future Australian Government early childhood investment, and that made by a wide range of stakeholders, as well as serve as a vehicle for collaboration with state and territory governments in support of young children and their families. It is anticipated that the National Agenda will be publicly released in early 2006.

New measures are being implemented to improve the affordability of child care. The Child Care Tax Rebate will provide families receiving Child Care Benefit and who use approved child care with a 30 per cent tax rebate for out-of-pocket expenses from 1 January 2005. Increased assistance has also been provided to grandparents with primary care of their grandchildren. From November 2004, the work test was waived for eligible grandparent carers, allowing access to up to 50 hours of Child Care Benefit. From January 2005, grandparents who are the primary carers of their grandchildren and who receive an income support payment, have been eligible for a special rate of Child Care Benefit which covers the full cost of approved child care for up to 50 hours per child per week.

The 2005-06 Budget saw further investment in child care including an increase of 84 300 Outside School Hours Care places, 2500 Family Day Care places and 1000 In-Home Care places over the next four years. Increased funding will also be made available through the Jobs Education Training Child Care program to support 52 000 low income families to meet the cost of child care, ensuring that child care costs are not a barrier for parents making the transition from income support to employment.

The implementation of the new Child Care Support program in 2004-05 has resulted in the development of the new Inclusion and Professional Support Program. Professional Support Co-ordinators are in place to provide a national focus on the delivery of professional support to child care services throughout Australia. From January 2006, 67 Inclusion Support Agencies will be established on a regional basis to co-ordinate assistance to child care services to build their skill base and capacity to include children with additional needs into child care.

Attracting and retaining staff is a widely recognised challenge facing the child care sector, with shortages in rural and remote areas of particular concern. The Australian Government is committed to building capacity and skills in the workforce through collaborative research projects across all jurisdictions, and through funding of the Inclusion and Professional Support Program, which aims to increase the skill level of child care workers and service staff in line with nationally consistent principles.

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New South Wales Government comments

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The central feature of the NSW Government's Early Childhood Services Policy is its focus on the importance of the early years of life through a system of good quality children's services that are responsive to the needs of children, regardless of their age or service type attended, and in the context of their families and the communities in which they live.

The NSW Government supports a wide range of children's services, including preschools, long day care, occasional care, mobile services, family day care, home based care and vacation care. This support is provided through initiatives including funding, licensing, training and research.

Children's services have been recognised for the benefits they provide for children's healthy development, and for early intervention benefits. Early childhood experiences crucially affect the health and wellbeing of children, and the attainment of further competence at later ages. NSW continues to implement strategies to improve access to and participation in children's services for all children, especially those with additional needs.

The NSW regulatory framework recognises the integrated nature of early childhood education and care. All licensed early childhood services are required by regulation to provide an education program tailored to each child's intellectual, physical, social and emotional development and employ appropriately qualified teaching staff.

For this reason, the structure of the children's services chapter continues to pose difficulties in comparing the performance of NSW with that of other jurisdictions, and in accurately reporting NSW data. The chapter is based on distinguishing preschool from child care, which does not reflect the integrated delivery of early childhood education in NSW. NSW urges caution in any use or interpretation of this data in relation to the number of children that access a preschool program.

A number of strategies have supported the implementation of the new Children's Services Regulation 2004. These include 81 service provider briefings in locations across NSW. The briefing presentation and frequently asked questions are available on DoCS (Department of Community Services) website, along with a comprehensive new Guide to Children's Services Licensing for use by licensees and prospective licensees.

DoCS Regional staff have undergone training on new licensing processes and resources have been developed to support staff including a new Licensing and Monitoring Manual and Operational Guide.

The report of the Stage Two Review of Preschool Affordability has been delivered. Continuing work focuses on reform of the policy, planning and funding framework for NSW children's services with the goal of enhanced and equitable access for disadvantaged families to preschool services, sector reconfiguration and administrative reforms.

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Victorian Government comments

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The Victorian Government's vision for children is to provide them with the best possible start in life and to give parents the help they need to achieve this. In December 2004 the Government released *Putting Children First ... the next steps* in response to the recommendations of the Premier's Children's Advisory Committee. Structural changes have been introduced including the appointment of a Minister for Children, the establishment of an Office for Children and a new Victorian Children's Council to provide independent ongoing expert advice to Government.

Putting Children First also outlines the Government's intention to develop a Plan for Victoria's children. The Plan will define the desired outcomes for children and the best ways for these to be measured and monitored. It will also build on the strong partnership between State and Local Government and the work that Local Government has undertaken to prepare Municipal Early Years Plans.

In 2005 the Government commenced a process to regulate family day care schemes and outside school hours care services. The first step is establishing a register of all existing family day care schemes and outside school hours care services.

In 2004-05 the Government provided funding of \$500 000 to assist organisations plan for new outside school hours care services or additional service types.

In 2005-06, the third year of the three year Children's First capital project, a further 21 projects have been funded, bringing the total to 50 across the State. This initiative provides contributory funding to bring together services such as kindergarten, child care, maternal and child health, and early intervention in new or extended facilities. It is supported by a new web based design guide that provides information about the planning and design of children's services.

The provision of kindergarten programs by long day care settings is being promoted through the allocation of an additional \$19.3 million over four years in the 2005-06 State Budget. This funding will increase the kindergarten per capita rate available to long day care services that provide a kindergarten program.

Kindergarten cluster management continues to strengthen the delivery of kindergarten programs in the state. To support this initiative, mentoring and leadership training has been provided to staff in the clusters.

Kindergarten affordability for low-income families is being improved through a 25 per cent increase in the kindergarten fee subsidy from 1 January 2006, an increase from \$255 to \$320 per year. Approximately 27 per cent of children attending kindergarten benefit from the fee subsidy.

A new kit, *Supporting Aboriginal and Torres Strait Islander children in kindergarten*, promotes participation of Indigenous children in kindergarten programs. The kit contains practical tools to assist teachers to develop culturally inclusive programs and to promote the importance of kindergarten to the Indigenous community.

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Queensland Government comments

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The Queensland Government promotes high quality children's services that are responsive to children and flexible in addressing contemporary family needs. The *Queensland Child Care Strategic Plan 2000–2005* and *Education and Training Reforms for the Future* package provide a strong foundation for the development of quality services, innovative practice and life-long learning.

By June 2005, Queensland Government child care training initiatives assisted 2572 child care staff to complete awards and gain the qualification they require to work in licensed services, 87 of these were achieved by Indigenous child care professionals in Far North Queensland. The Queensland training initiatives support legislative requirements for increased qualifications in centre-based child care services and acknowledge the link between staff qualifications and quality child care.

The Queensland Government has introduced legislation that requires school age care services to be licensed. As part of an ongoing program to assist school age care services meet licensing requirements, \$1 million was distributed to 32 services during 2004-05. The funding assisted with the upgrade of facilities and was in addition to \$370 000 provided in equipment grants to not-for-profit services.

From 2007, the Queensland Government will implement a full-time, non-compulsory preparatory year, delivered in schools, for all Queensland children of eligible age. The preparatory year, which will replace the current sessional preschool program, will be acknowledged as the first year of school in Queensland. The Queensland Studies Authority has developed the *Early Years Curriculum Guidelines* for use by teachers when planning, implementing and monitoring preparatory programs. The Queensland Government will continue to support preschool education through the provision of targeted funding for the community kindergarten sector.

In April 2005, the Queensland Department of Communities established the Office for Children to strengthen the department's approach to prevention and early intervention and place greater emphasis on child care and family support.

The Queensland Government continues to explore new models of integrated children's services through the Child Care and Family Support Hub Strategy. Research to investigate the impact of child care and family support hubs in rural, remote and disadvantaged areas was extended during 2004-05. Additional funding of almost \$500 000 was allocated in 2004-05, bringing the total number of child care and family support hubs to 26.

The Queensland Government remains committed to using data and research to inform planning and decision making and is working to enhance the availability, integrity and comparability of data for future Reports.

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Western Australian Government comments

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The Department for Community Development is developing child care regulations, required due to the proclamation of the new *Children and Community Services Act 2004* from March 2006.

Sector wide consultations by the Department has given the child care sector and other stakeholders, the opportunity to contribute to the regulatory framework, resulting in recommendations for improved licensing standards.

The implementation of the new regulations will be completed in two stages: improvements of a more minor nature will take effect from the commencement of the *Children and Community Services Act 2004*; and as soon as practicable after the commencement of the new regulations, more complex issues such as staffing, group sizes, transport and building and premises will be incorporated.

Training for licensing staff in Certificate IV in Government: Statutory Compliance has contributed to the Department's improved ability to impose sanctions for breaches of the regulations.

The Child Care Advisory Committee reports to the Minister for Community Development and had its inaugural meeting in November 2004. The Department completed its 2004-05 contract with the Australian Government to provide training for the outside school hours care sector to implement the Child Care Services Quality Assurance Program. A further contract of \$253 060 was awarded for July 2005 to November 2006.

The Western Australian Department of Education and Training provides access to an eleven hour per week, free, universal kindergarten program for eligible children. The kindergarten year is the first of two non compulsory years of schooling, with the majority of children attending both years. Twenty eight Aboriginal kindergartens support student learning and development, by providing culturally appropriate programs with an emphasis on literacy, numeracy and family and community involvement.

The Western Australian Curriculum Framework defines the outcomes of schooling for all students from kindergarten to Year 12 and is mandated for all schools. For government schools, the Outcomes and Standards Framework is the tool that will be used to monitor children's progress and achievement and to plan for improvement in relation to Curriculum Framework outcomes. In the pre-compulsory years, the curriculum emphasis is on social, emotional, physical, literacy and numeracy development and learning within an integrated, interactive program.

A number of programs supporting early childhood teachers are underway. These include the Home-Schools Links strategy that aims to support teachers in building positive relationships with parents/caregivers, the Pre-primary Profile project that supports continuity of education between home, pre-compulsory and compulsory schooling and the Fundamental Movement Skills project, that aims to build children's skills and confidence to participate in physical activity as a way of supporting their well being, including combating obesity.

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South Australian Government comments

“ In 2004-05, South Australia took significant steps to position its system to accept the challenges that a new generation of young children and their families present.

A Ministerial Inquiry into Early Childhood Services in South Australia was initiated in 2004 reflecting the State Government's commitment to develop South Australia as the nation's leading 'family friendly' state. A review of this nature had not been undertaken in 20 years. The Inquiry took into account the views of parents, carers, early childhood services staff, the community and government agencies across the State and considered the latest early childhood research and practice locally, nationally and internationally. The Minister for Education and Children's Services, launched the Inquiry report *The Virtual Village: Raising a Child in the New Millennium* on 16 June 2005.

The structures for the delivery of early childhood services have been reviewed and realigned. The Department of Education and Children's Services (DECS) has established the Office of Early Childhood Services, to drive the development of long-term directions of early childhood services in South Australia. In addition, ten pilot early childhood service centres will be established as part of an \$8.1 million package to improve services for young children. These centres will create extra childcare places in disadvantaged areas and will be configured to meet the needs of their local communities, providing childcare and education, family support and health services for children aged from before birth to eight years.

The Early Years Literacy Program began in earnest as a proactive, intervention measure focussing on improving the literacy skills and outcomes of young children. Specialised literacy professional learning is being provided to all preschool to year 3 teachers, whilst additional teachers have been provided in preschools to support Aboriginal and Torres Strait Islander three year olds.

South Australia's first public specialised early learning programs, designed specifically to cater for children with high support needs and disabilities, opened as part of a \$1.43 million State Government initiative in 2004 and 2005. The six programs in metropolitan and country areas provide educational programs for children with a wide range of disabilities, including children with autism.

The state's commitment to special needs groups continued with the launch of the DECS Aboriginal Strategy 2005–2010. The strategy actively seeks to accelerate the educational outcomes of all Aboriginal children and students across South Australia. The 'Learning Together' project has a specific focus to support Aboriginal families to access and participate in health and education services. Twenty two percent of the total number of families accessing this community-linked program were Aboriginal.

Increasing access to child care for families in high-need locations continued as a priority. The first of four new child care centres opened in February 2005. Services include child care, out of school hours care, crisis care advocacy, play groups, breakfast club, counselling, family mediation, youth mentoring and community arts.

Tasmanian Government comments

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The Tasmanian Government continues to be committed to the importance of the early years and is currently involved in the development of a whole of government policy framework, and a number of community based initiatives with non-government agencies. This will improve collaboration and integration, and enhance early learning opportunities for young children and their families.

The Department of Education provides education and library services to children in this age group, and is also responsible for the regulation of child care services.

The Child Care Act 2001 has now been implemented for the last two years. Approved Registration Bodies—Class 1 (Family Day Care Schemes), and Centre Based Care—Class 2 (OSHC) have been licensed for the first time, although standards for the latter are being implemented in a staggered approach, with the expectation that services will be licensed against the full set by 2007. Work is also continuing on the development of standards for Approved Registration Bodies—Class 2 (In-Home Care).

Minor amendments to the Child Care Act 2001 will be made in 2005-06. The main purpose of this is to ensure that persons who have the authority to give directions and make decisions in respect of the management of a child care service (but who do not operate the service, or are not the licensee or an employee, eg external managers, franchisees) are able to be assessed for fitness and propriety and may be subject to disciplinary action, as appropriate. The amendments also enable some administrative processes to be streamlined and to better reflect practice.

All six services funded through the State Government's child care in schools program have been established. This has increased the number of child care places by more than 300.

The major work around the development of the new Essential Learnings curriculum has been completed. It is not mandatory for child care services, however many are choosing to implement it. All schools have begun to assess and report against this, including kindergartens (preschools).

From the beginning of the 2004 school year, enrolment in preparatory became compulsory and children are now expected to attend school on a full time basis from the beginning of the school year, although exceptions may be granted.

The Department of Health and Human Services also has a significant role in the delivery of services to young children. The Our Kids Bureau within this agency, works with a number of agencies to progress issues focussing on child health and wellbeing, in particular facilitating the provision of Family Partnership Training across government and non-government organisations. The Agency has also developed a strategic plan for early childhood for 2005–2008 which focuses on early childhood health issues provided within the Family, Child and Youth Health Service division.

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Australian Capital Territory Government comments

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The ACT Government has a vision for the children of Canberra that encourages and supports them to reach their full potential, a place where children are active citizens and a great and safe place for children.

The Department of Education and Training is responsible for providing preschool services for all eligible children in the year immediately prior to their entry to school. In 2004 the ACT Government committed \$8 million over three years to increase the number of hours children are eligible to attend preschool from 10.5 to 12 hours a week. This initiative will be fully implemented by 2006.

The ACT Department of Education and Training is undertaking a renewal of the curriculum. The new curriculum will cover Preschool to Year Ten and will be based on a framework of thirty 'essential learning' achievements for children in the twenty-first century.

The Office for Children, Youth and Family Support was integrated within the Department of Disability, Housing and Community Services in November 2004 to create a comprehensive human service delivery agency for the ACT Government.

Children's Services within the Office for Children, Youth and Family Support is responsible for the licensing of and monitoring of children's services in the ACT to ensure they meet the requirements of the Children and Young People Act 1999.

Children's Services provides ongoing professional support and advice to stakeholders involved with children's services in the ACT through the delivery of licensing presentations to services, management committees and training providers. Regular meetings and newsletters provide the opportunities for information sharing and networking throughout the sector.

The ongoing implementation of the Children's Plan launched in 2004 builds on the ACT Government's commitment to strengthening communities in the development and delivery of services for children in the Territory.

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Northern Territory Government comments

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Increasing attention is being given to ensuring that children in the Northern Territory get the best start in life. The focus of effort is on improving the health and wellbeing of Indigenous children, supporting families and communities to care for and protect children, strengthening early learning and promoting service integration, quality and viability.

The Territory has a small and young population of dispersed across one-sixth of the national landmass. About 40 per cent of the 0–12 population are Indigenous children, some 75 per cent of whom live in small remote communities and towns. Diseconomies of scale, an environment ranging from desert to tropical climates, and the particular interests, needs and priorities of the population have resulted in unique approaches to providing children’s services in the Northern Territory.

Comparability for reporting purposes therefore continues to be difficult. For example, this and previous Reports indicate a considerably lower participation level of Indigenous children in child care services, however the data do not include participation in other services and activities such as innovative child care centres, JET creches, mobile services, playgroups and informal care services, which are preferred service models in a number of communities.

In 2004-05, new legislation was drafted, including provision for regulation of a broader scope of children’s services. This legislation gives emphasis to prevention and early intervention measures, alongside investigation and response to child maltreatment.

The Northern Territory Government provides access to universal preschool education for four year old children, and for some three year olds. At five years of age, children commonly attend all-day universally available transition education, which supports their successful inclusion in primary school. In 2004-05, a trial of earlier age of entry to transition and preschool education continued in nine locations, enabling children turning four by 30 June to enrol in these trial sites in term one.

Access to child health services and parent information and support has improved through expanded programs in several remote Indigenous communities. Work continues to strengthen integrated planning approaches and to promote child and family-centred service delivery.

A Five-Year Aboriginal Health and Families framework for action from 2005–2010 places a strong emphasis on the early years and on building better core services to reduce risks for young Aboriginal children and to promote their health and wellbeing. Children’s services will be working to make a significant contribution to this priority.

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14.6 Definitions of key terms and indicators

Administration expenditure	All expenditure by the departments responsible for the provision of licensing, advice, policy development, grants administration and training services. Responsible departments include those that administer policy for, fund and license/accredit child care and preschool services in each jurisdiction.
Centre-based long day care	Services aimed primarily at 0–5 year olds that are provided in a centre, usually by a mix of qualified and other staff. Educational, care and recreational programs are provided based on the developmental needs, interests and experience of each child. In some jurisdictions, primary school children may also receive care before and after school, and during school vacations. Centres typically operate for at least eight hours per day on normal working days, for a minimum of 48 weeks per year.
Child care	The meeting of a child's care, education and developmental needs by a person other than the child's parent or guardian. The main types of service are centre-based long day care, family day care, outside school hours care (vacation, before/after school hours and 'pupil free days' care), occasional care and other care.
Children	All resident male and female Australians aged 12 years or younger at 30 June of each year.
Children from Indigenous backgrounds	Children of Indigenous descent who identify as being Indigenous and are accepted as such by the community in which they live.
Children from low income families	Families who are receiving the maximum rate of Child Care Benefit.
Children from non-English speaking backgrounds	Children living in situations where the main language spoken is not English.
Children's services	All government funded and/or provided child care and preschool services (unless otherwise stated).
Counting rules	Prescribed standards, definitions and mathematical methods for determining descriptors and performance indicators for monitoring government services.
Disability related care	Care of children who have a developmental delay or disability (including a intellectual, sensory or physical impairment), or who have parent(s) with a disability.
External cause (of injury)	The environmental event, circumstance or condition that causes an injury.
Family day care	Services provided in the carer's home. The care is largely aimed at 0–5 year olds, but primary school children may also receive care before and after school, and during school vacations. Central coordination units in all states and territories organise and support a network of carers, often with the help of local governments.
Financial support to families	Any form of fee relief paid by governments to the users of children's services (for example, Child Care Benefit).

Formal child care	Organised care provided by a person other than the child's parent or guardian, usually outside of the child's home — for example, centre-based long day care, family day care, outside school hours care, vacation care and occasional care (excluding babysitting).
Formal qualifications	Early childhood-related teaching degree (three or four years), a child care certificate or associate diploma (two years) and/or other relevant qualifications (for example, a diploma or degree in child care [three years or more], primary teaching, other teaching, nursing [including mothercraft nursing], psychology and social work). Some jurisdictions do not recognise one year certificates.
Full time equivalent staff numbers	A measure of the total level of staff resources used. A full time staff member is employed full time and engaged solely in activities that fall within the scope of children's services covered in the chapter. The full time equivalent of part time staff is calculated on the basis of the proportion of time spent on activities within the scope of the data collection compared with that spent by a full time staff member solely occupied by the same activities.
Government funded or/and provided	All government financed services — that is, services that receive government contributions towards providing a specified service (including private services eligible for Child Care Benefit) and/or services for which the government has primary responsibility for delivery.
Hospital separation	An episode of care for a person admitted to a hospital. It can be a total hospital stay (from admission to discharge, transfer or death) or portions of hospital stays beginning or ending in a change of type of care (for example from acute to rehabilitation) that cease during a reference period.
Informal child care	Child care arrangements provided privately (for example, by friends, relatives, nannies) for which no government assistance (other than the minimum rate of Child Care Benefit for Registered Care) is provided. Such care is unregulated in most states and territories.
In-home care	Care provided by an approved carer in the child's home. Families eligible for in-home care include those where the parent(s) or child has an illness/disability, those in regional or remote areas, those where the parents are working shift work or non-standard hours, those with multiple births (more than two) and/or more than two children under school age, and those with a breastfeeding mother working from home.
In-service training	Formal training only (that is, structured training sessions that may be conducted in-house or externally), including training in work or own time but not training towards qualifications included in obtaining formal qualifications. It includes: • management or financial training • training for additional needs children (such as children with a disability, Aboriginal or Torres Strait Islander children and children from a culturally diverse background) • other child care-related training • other relevant courses (such as a first aid certificate).
Licensed services	Those services that comply with the relevant State or Territory licensing regulations. These regulations cover matters such as the number of children whom the service can care for, safety requirements and the required qualifications of carers.

Net capital expenditure	Expenditure on the acquisition or enhancement of fixed assets, less trade-in values and/or receipts from the sale of replaced or otherwise disposed of items. Capital expenditure does not include expenditure on fixed assets which falls below threshold capitalisation levels, depreciation or costs associated maintaining, renting or leasing equipment.
Non-standard hours of care	Defined by service type as: • centre-based long day care — providers of service for more than 10 hours per day on Monday to Friday and/or service on weekends • preschool — providers of service for more than six hours per day • family day care — providers of service for more than 50 hours per week and/or service overnight and/or on weekends • vacation care — providers of service for more than 10 hours per day • before school hours care — providers of service for more than two hours before school • after school care — providers of service for more than three hours after school • occasional care — providers of service for more than eight hours per day • other — providers of service for more than 10 hours per day.
Occasional care	Services usually provided at a centre on an hourly or sessional basis for short periods or at irregular intervals for parents who need time to attend appointments, take care of personal matters, undertake casual and part time employment, study or have temporary respite from full time parenting. These services provide developmental activities for children and are aimed primarily at 0–5 year olds. Centres providing these services usually employ a mix of qualified and other staff.
Other expenditure on service provision	Includes all recurrent expenditure on government funded and/or provided child care and preschool services except administration and financial support to families. It includes one-off, non-capital payments to peak agencies that support child care and preschool service providers.
Other services	Government funded services to support children with additional needs or in particular situations (including children from an Indigenous or non-English speaking background, children with a disability or of parents with a disability, and children living in regional and remote areas).
Outside school hours care	Services provided for school aged children (5–12 year olds) outside school hours during term and vacations. Care may be provided on student free days and when school finishes early.
Preschools	Services usually provided by a qualified teacher on a sessional basis in dedicated preschools. Preschool programs or curricula may also be provided in long day care centres and other settings. These services are primarily aimed at children in the year before they commence full time schooling (that is, when children are 4 years old in all jurisdictions), although younger children may also attend in most jurisdictions.
Primary contact staff	Staff whose primary function is to provide care and/or preschool services to children.

Real expenditure	Actual expenditure adjusted for changes in prices. Adjustments were made using the GDP price deflator and expressed in terms of final year prices.
Recurrent expenditure	Expenditure that does not result in the creation or acquisition of fixed assets (new or second hand). It consists mainly of expenditure on wages, salaries and supplements, purchases of goods and services, and the consumption of fixed capital (depreciation).
Regional and remote areas	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 'regional' classification used in this chapter was derived by adding data for inner regional and outer regional areas. The 'remote' classification was derived by adding data for remote, very remote and migratory areas. In previous reports, geographic location data was based on the rural, remote and metropolitan areas classification (DPIE and DSHS 1994).
Serious injury	Injury requiring hospitalisation or a visit to (or by) a doctor.
Service	The type of service provided. Preschool service, for example, is a package of educational and developmental services received by a child in the year or two before full time schooling. Preschool services may be provided by either a preschool service provider or a child care service provider.
Service type	The categories for which data were collected, namely: • centre-based long day care • family day care • outside school hours care – vacation care – before/after school care • occasional care • 'other' care • preschool services.
Special needs group	An identifiable group within the general population who may have special difficulty accessing services. Special needs groups for which data are reported in this chapter include: children from a non-English speaking background, children from an Indigenous background, children from low income families (Australian Government child care only), children with a disability, and children from regional or remote areas.
Substantiated breach arising from a complaint	An expression of concern about a child care or preschool service, made orally, in writing or in person to the regulatory authority, which constitutes a failure by the service to abide by the State or Territory legislation, regulations or conditions. This concern is investigated and subsequently considered to have substance by the regulatory body.
Vacation care	Care and developmental activities provided for school age children during school vacation periods.

14.7 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 14A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2006\Attach_stat_app.xls and in Adobe PDF format as \Publications\Reports\2006\Attach_stat_app.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

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Table 14A.55	State Government real expenditure on child care and preschool services, Western Australia (2004-05 dollars) (\$'000)
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14.8 References

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- 2003, *Child Care Australia*, Cat. nos 4402.0, 4402.1.40.001–4402.8.40.001, Canberra.
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15 Protection and support services

Protection and support services aim to assist individuals and families who are in crisis or experiencing difficulties that hinder personal or family functioning. These services assist by alleviating the difficulties and reducing the potential for their recurrence.

This chapter reports on:

- *child protection services*: the functions of government that receive and assess allegations of child abuse and neglect, and/or harm to children and young people, provide and refer clients to family support and other relevant services, and intervene to protect children
- *out-of-home care services*: care for children placed away from their parents for protective or other family welfare reasons
- *supported accommodation and assistance services*: services to assist young people, adults and families who are homeless or at imminent risk of becoming homeless.

A profile of child protection and out-of-home care services appears in section 15.1. A framework of performance indicators is outlined in section 15.2 and data are discussed in section 15.3. Future directions in child protection and out-of-home care performance reporting are outlined in section 15.4.

A profile of supported accommodation and assistance services funded under the Supported Accommodation Assistance Program (SAAP) appears in section 15.5. A framework of performance indicators for these services is outlined in section 15.6 and data are discussed in section 15.7. Future directions in SAAP performance reporting are discussed in section 15.8.

Jurisdictions' comments on both child protection and out-of-home care services, and supported accommodation and assistance services are reported in section 15.9. Definitions of data descriptors and indicators are provided in section 15.10. A list of supporting tables is provided in section 15.11. Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 15A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. Section 15.12 lists references used in this chapter.

15.1 Profile of child protection and out-of-home care services

Service overview

Child protection services

Child protection services are provided to protect children and/or young people aged 0–17 years who are at risk of harm within their families, or whose families do not have the capacity to protect them. These services include:

- receiving and responding to reports of concern about children or young people, including investigation and assessment where appropriate
- providing support services (directly or through referral), where harm or a risk of significant harm is identified, to strengthen the capacity of families to care safely for children
- initiating intervention where necessary, including applying for a care and protection order through a court and, in some situations, placing children or young people in out-of-home care to secure their safety
- ensuring the ongoing safety of children and young people by working with families to resolve protective concerns
- working with families to reunite children (who were removed for safety reasons) with their parents as soon as possible (in some jurisdictions, restoration may occur in voluntary placements as well)
- securing permanent out-of-home/alternative care when it is determined that a child is unable to be returned to the care of his or her parents, and working with young people to identify alternative supported living arrangements where family reunification is not possible.

Research suggests that children and families who come into contact with the protection and support system often share common social and demographic characteristics. Families with low incomes or that are reliant on pensions and benefits, those that experienced alcohol and substance abuse, or a psychiatric disability, and those that have a family history of domestic violence are over-represented in the families that came into contact with the protection and support system (Department of Human Services 2002). Studies have also highlighted the high incidence of child abuse and neglect within Indigenous communities, compared with non-Indigenous communities. These studies include the final report of the WA Inquiry into Response by Government Agencies to

Complaints of Family Violence and Child Abuse in Aboriginal Communities (Gordon Report 2002), which found high levels of violence and child abuse within Aboriginal communities in WA. The report also found that the incidence of child abuse and family violence in Aboriginal communities was significantly under-reported and that a lack of trust between Aboriginal communities and government agencies was a significant barrier to complaints of violence and abuse being lodged. The report found that greater coordination across government agencies, more training for staff and more and better resources and services were required. The WA government is implementing recommendations arising from the Inquiry.

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

(Continued on next page)

Box 15.1 (Continued)

- 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 data indicate that recurrent expenditure on intensive family support services across all jurisdictions was at least \$104.3 million in 2004-05 (table 15A.21). Tables 15A.21–24 provide additional information about families and children who were involved with intensive family support services during 2004-05.

A complementary suite of services not currently included in this Report, but intended for inclusion in future Reports, are known as child protection treatment and support services. These are targeted to at-risk families where there are concerns about the safety and wellbeing of children. They may be less intensive in nature and include services that strengthen family relationships in response to concerns about the welfare of a child and may have either an early intervention or support reunification orientation.

Child protection treatment and support services provide educational services, clinical services including counselling, group work and other therapeutic interventions, and domestic violence services, where the child is the direct recipient of the service and s/he is, has, or is likely to become, a client of child protection.

Source: Australian Institute of Health and Welfare (AIHW) (unpublished).

Roles and responsibilities

State and Territory governments fund child protection, out-of-home care, family support (including intensive family support) and other relevant services. These services may be delivered by the government or the non-government sector. State and Territory community services departments are responsible for investigating and assessing reports to the department, providing or referring families to support services, and intervening where necessary (including making court applications when an order is required to protect a child and placing children in out-of-home care).

Other areas of government also have a role in child protection and provide services for children who have come into contact with community services departments for protective reasons. Examples include:

- police services, which investigate serious allegations of child abuse and neglect, particularly criminal matters, and may also work on child protection assessments with State and Territory community services departments
- courts, which decide whether a child will be placed on an order
- education and child care services, which provide services for these children and also conduct mandatory reporting and protective behaviours education in some jurisdictions
- health services, which support the assessment of child protection matters and deliver therapeutic, counselling and other services.

A range of appointments, schemes and charters have been introduced by jurisdictions in recent years, to enable additional protection for clients of the child protection system. Examples of these are listed in box 15.2.

Box 15.2 Initiatives in place to enable additional protection for clients

<i>NSW</i>	The Commission for Children and Young People initiates and influences broad and positive change for children and young people. The Office of the Children's Guardian promotes the best interests and rights of all children in out-of-home care, through accreditation and monitoring of out-of-home care agencies to ensure services are of the highest standard.
<i>Vic</i>	The Child Safety Commissioner promotes child safe practices and environments across the community. The Advocate for Children in Care works within the Commissioner's office and monitors the quality of out-of-home care services. A charter of rights for children in care is being developed.
<i>Qld</i>	The Commission for Children and Young People and the Child Guardian provides a Community Visitor Scheme, investigates complaints and undertakes systemic monitoring and auditing of services. A Departmental complaints system has also been established in the Department of Child Safety.
<i>WA</i>	A charter of rights for children and young people is under development in partnership between government and non-government organisations.
<i>SA</i>	The Office of the Guardian monitors and assesses care, and advocates for, and advises on, the circumstances and needs of children and systemic issues affecting the quality of out-of-home care.

(Continued on next page)

Box 15.2 (Continued)

<i>Tas</i>	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.
<i>ACT</i>	The Office of the Community Advocate's functions include monitoring the provision of services, and protecting and acting as an advocate for the rights of children and young people. The Official Visitors' role is to investigate complaints made by or on behalf of children and young people in institutions or shelters concerning their care. The Commissioner for Human Rights and Discrimination ensures the rights of children and young people are upheld.

Source: State and Territory governments (unpublished).

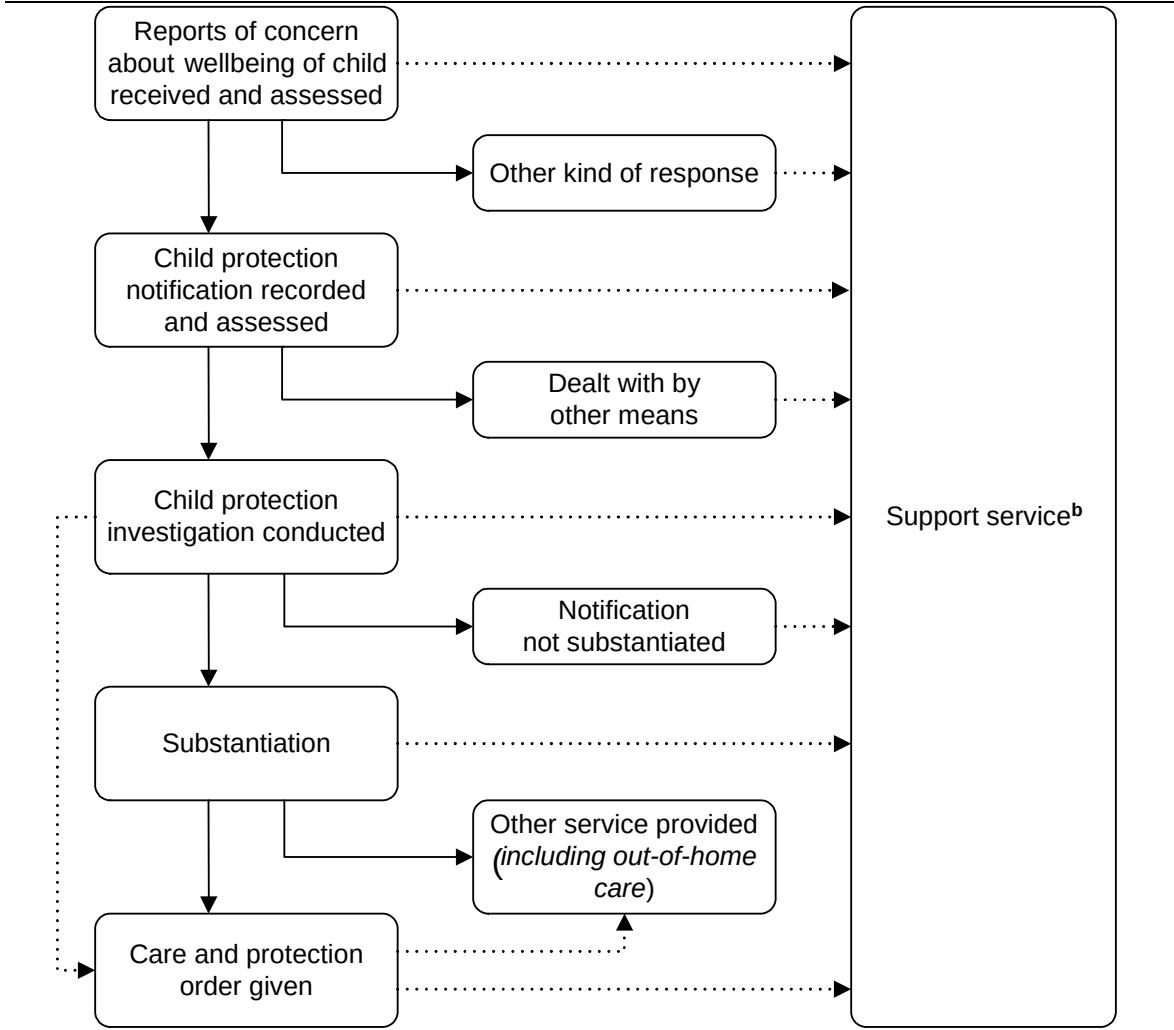
Size and scope

The child protection system

Child protection legislation, policies and practices vary across jurisdictions, but the broad processes in child protection systems are similar (figure 15.1).

State and Territory community services departments are advised of concerns about the wellbeing of children through reports to these departments. Reports may be made by people mandated to report (such as medical practitioners, police services and school teachers and principals) or by other members of the community. These reports are assessed and classified as child protection notifications, child concern reports, or matters requiring some other kind of response. The most common sources of notification for finalised investigations in 2004-05 were police, school personnel, hospital/health centres, parents and guardians, other relatives, non-government organisations and friends/neighbours (AIHW 2006).

Figure 15.1 The child protection system^a



^a Dashed lines indicate that clients may or may not receive these services, depending on need. ^b Support services include family support or family preservation services provided by community service departments and referrals to other agencies.

Notification

Jurisdictions count notifications at different points in the response to a report, ranging from the point of initial contact with the source of the report to the end of a screening and decision making process. This means the number of notifications is not strictly comparable across jurisdictions.¹

All jurisdictions except Victoria, Tasmania, the ACT and the NT screen incoming reports before deciding whether they will be designated and counted as a notification, thus reducing the proportion of reports that become notifications. WA undertakes a further screening process designed to differentiate between reports about harm/maltreatment and child and family concerns. This reduces the number of notifications, as only reports about child harm/maltreatment are included in this Report.

In all jurisdictions, notifications are investigated when deemed appropriate, based on the policies and practices in that jurisdiction. Once it has been decided that an investigation is required, the investigation process is similar across jurisdictions. The community services department 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).

Although notifications are defined differently across jurisdictions, 160 021 children aged 0–16 years were the subject of child protection notifications in 2004-05. Nationally, the rate of notifications per 1000 children in the population aged 0–16 years was 35.3 in 2004-05 (table 15A.8).

Data on the number of notifications are collected very early in the child protection process and often before the agency has full knowledge of the child's family circumstances. This lack of full knowledge and the inherent difficulties in identifying Indigenous status mean it is not possible to report reliable data on the number of notifications by Indigenous status.

¹ Child protection services, care and protection orders and out-of-home care relate to children aged 0–17 years. Rates of children subject to notifications, investigations and substantiations, however, are calculated for children aged 0–16 years, given differences in jurisdictions' legislation, policies and practices regarding children aged 17 years.

Substantiation

The criteria for substantiation vary across jurisdictions. In the past, child protection legislation and policy focused on the identification and investigation of narrowly defined incidents that were broadly grouped as types of abuse or neglect. Across all jurisdictions, however, the focus is shifting away from the actions of parents and guardians, toward the desired outcomes for the child, the identification and investigation of actual and/or likely harm to the child, and the child's needs.

If an investigation results in substantiation, intervention by the relevant community services department may be needed to protect the child. This intervention can take a number of forms, including one or more of referral to other services, supervision and support, an application to court, and a placement in out-of-home care.

Nationally, 33 871 children aged 0–16 years were the subject of a substantiation in 2004-05. The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–16 years was 7.5 (table 15A.8).

Nationally, 4887 Indigenous and 28 984 non-Indigenous children were the subject of a substantiation in 2004-05. The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–16 years was 24.0 for Indigenous children and 6.7 for non-Indigenous children (table 15A.8).

Care and protection orders

Although child protection substantiations are often resolved without the need for a court order (which is usually a last resort), recourse to the court may take place at any point in the child protection investigation process (figure 15.1). The types of order available vary across jurisdictions.

Nationally, 25 065 children aged 0–17 years were on care and protection orders at 30 June 2005. The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 5.2 (table 15A.8).

Nationally, 5564 Indigenous and 19 501 non-Indigenous children were on care and protection orders at 30 June 2005. The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 25.8 for Indigenous children and 4.3 for non-Indigenous children (table 15A.8).

Out-of-home care

Out-of-home care is one of a range of services provided to families and children where there is a need to provide safe care for a child. The services are intended to maintain the child within the family if possible, and to place a child in out-of-home care only if this will improve the outcome for the child. If it is necessary to remove the child from his or her home, then placement with the wider family or community is sought where possible, particularly in the case of Indigenous children (AIHW 2006). Continued emphasis is being placed on improving case planning and case management processes to facilitate the safe return home of children in out-of-home care and to maximise case workers' contact time with children and families.

Nationally, 23 695 children were in out-of-home care at 30 June 2005. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 4.9 (table 15A.11).

Nationally, 5678 Indigenous children and 18 017 non-Indigenous children were in out-of-home care at 30 June 2005. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 26.4 for Indigenous children and 3.9 for non-Indigenous children (table 15A.11).

Funding

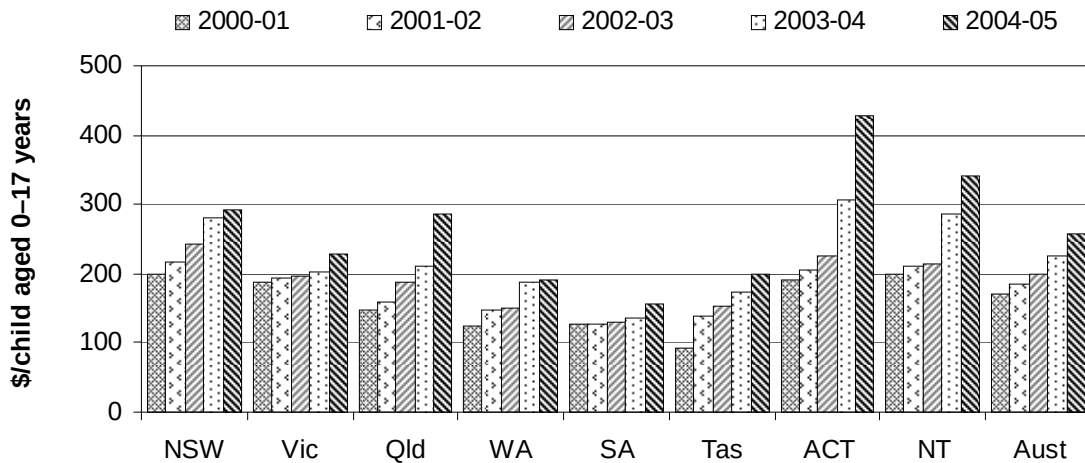
Recurrent expenditure on child protection and out-of-home care services was at least \$1230.8 million across Australia in 2004-05 — a real increase of \$147.1 million (13.6 per cent) from 2003-04. Nationally, out-of-home care services accounted for the majority (61.9 per cent, or \$762.0 million) of this expenditure. Some jurisdictions have difficulty in separating expenditure on child protection from expenditure on out-of-home care services (table 15A.1).

Nationally, real recurrent expenditure per child aged 0–17 years on child protection and out-of-home care services was \$256 in 2004-05 (figure 15.2). Real recurrent expenditure per child aged 0–17 years increased in all jurisdictions between 2003-04 and 2004-05.

It is an objective of the Review to report comparable estimates of costs. Ideally, the full range of costs to government would be determined on a comparable basis across jurisdictions. Where full costs cannot be counted, costs should be estimated on a consistent basis across jurisdictions. In the area of child protection, however, there are differences across jurisdictions in the expenditure reported. Table 15A.4 identifies the level of consistency across jurisdictions for a number of expenditure items. The scope of child protection systems also varies across jurisdictions, and

expenditure on some services may be included for some jurisdictions, but not for others.

Figure 15.2 Real recurrent expenditure on child protection and out-of-home care services (2004-05 dollars)



Source: State and Territory governments (unpublished); table 15A.1.

15.2 Framework of child protection and out-of-home care services performance indicators

The framework of performance indicators for child protection and out-of-home care services is based on shared government objectives (box 15.3).

Box 15.3 Objectives for child protection and out-of-home care services

The aims of child protection services are to:

- protect children and young people at risk of harm within their family or in circumstances in which the family of the child or young person does not have the capacity to protect them
- 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 2006 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The performance indicator framework and those indicators that are comparable in the 2006 Report are shown in figure 15.3.

15.3 Key child protection and out-of-home care services performance indicator results

Different delivery contexts, locations and types of client may affect the equity/access, effectiveness and efficiency of child protection services. Appendix A contains detailed statistics that may assist in interpreting the performance indicators.

Outputs

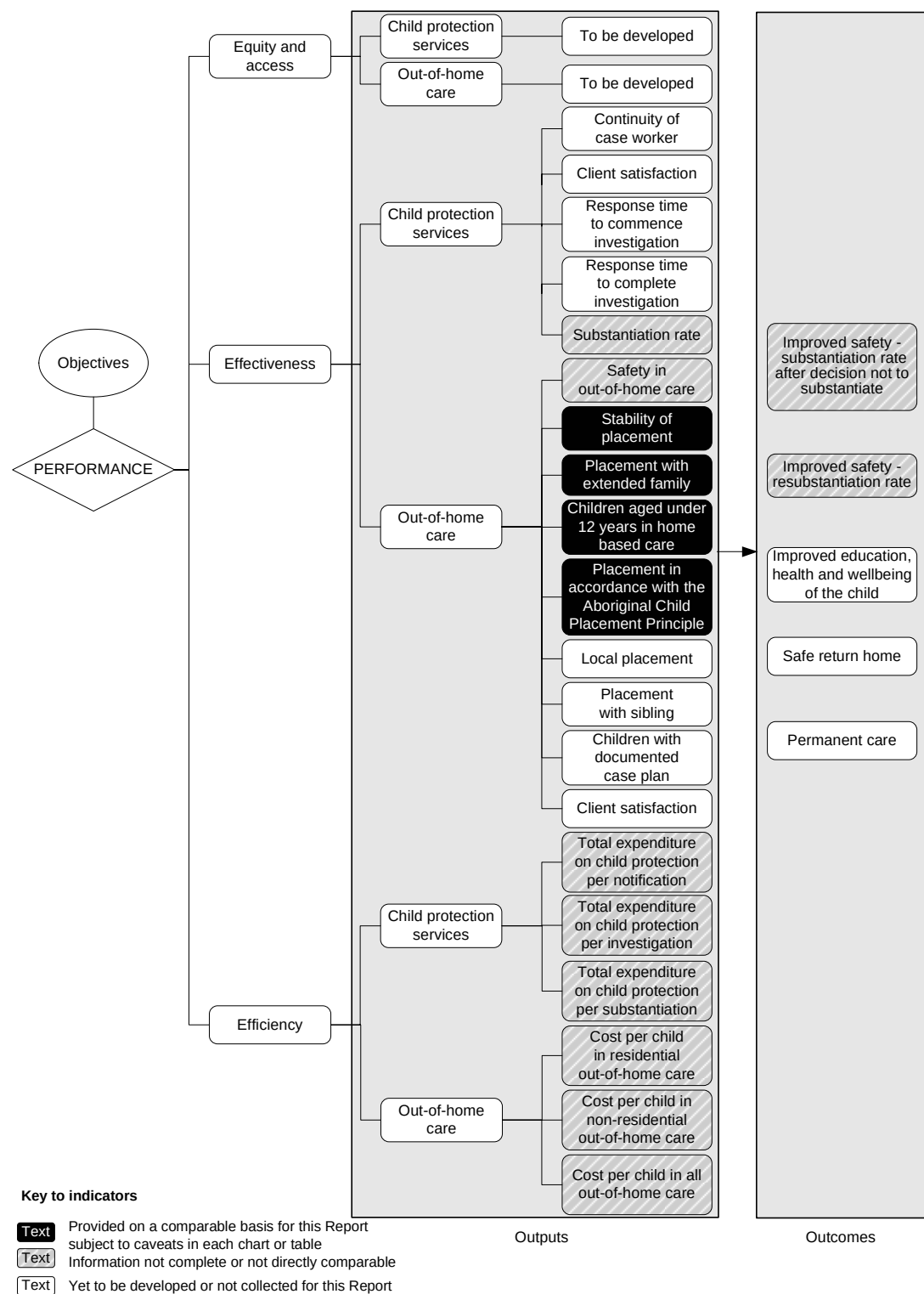
Equity and access

The Steering Committee has identified equity and access as a key area for further development in future reports (box 15.4).

Box 15.4 Access to child protection and out-of-home care services by different groups

These will be output 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 and data are currently not collected.

Figure 15.3 Performance indicators for child protection and out-of-home care services



Effectiveness

Child protection services — continuity of case worker

The Steering Committee has identified ‘continuity of case worker’ as an output indicator of the effectiveness of child protection services (box 15.5). No data on this indicator were available for the 2006 Report.

Box 15.5 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. 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.

Data are currently not collected for this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Child protection services — client satisfaction

The Steering Committee has identified ‘client satisfaction’ as an output indicator of the effectiveness of child protection services (box 15.6).

Box 15.6 Client satisfaction

Client satisfaction is an indicator of governments’ objective to provide high quality services that meet the needs of recipients.

Data are currently not collected for this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Box 15.7 provides examples of steps taken in seven jurisdictions to monitor, assess and promote client satisfaction in relation to child protection and out-of-home care.

Box 15.7 **Developments in client satisfaction**

<i>NSW</i>	An evaluation of the Early Intervention Program is planned. This program targets vulnerable families with children aged 0–8 years. A sample of families and children receiving services will be surveyed during the evaluation to ascertain whether they are satisfied the program is meeting their needs.
<i>Vic</i>	A survey of child protection clients and families in 2001 was designed to gather information on the clients' and families' experience of child protection, in order to enhance future service delivery, and to improve client and family outcomes. The survey findings identified a range of specific strengths in child protection practice, including that in the majority of cases, child protection intervention improved the safety and life circumstances of young people. The survey also identified a range of areas for practice improvement.
<i>Qld</i>	CREATE is currently funded to engage a sample of children and young people through surveys and activities to assess how child protection practices are affecting them. The results of these will be followed by workshops that present findings to staff and suggest strategies for improvement. New practices are also being introduced that more actively involve children in case planning, for example, seeking feedback from children and young people on their satisfaction with family group meetings process and outcomes.
<i>WA</i>	Children and young people provided with leaving care services are surveyed on a range of matters including their service plan, satisfaction with the service, satisfaction with the time it took to provide the service and the extent to which the young person and his/her family were provided with care and safety.
<i>Tas</i>	A 2004 survey targeted at children, young people, and families involved in Family Group Conferencing determined that this program is valued by clients of all ages and supported the continued use of external facilitators to ensure independence in the conferencing process. An out-of-home care consultation process found feedback from young people with out-of-home care experience to be critical in identifying focal points for service and system improvements.
<i>ACT</i>	CREATE released a report in July 2004 based on qualitative interviews of children and young people in out-of-home care in the ACT. This report recommended the development of a charter of rights for children and young people in care in the ACT. The Government will develop a charter in consultation with children and young people.
<i>NT</i>	A participation survey of children and young people in care was funded in 2005 and an evaluation of case worker attitudes was also undertaken. As a result, it is expected that future out-of-home care training for staff will be undertaken in order to increase the participation of young people in care planning.

Source: State and Territory governments (unpublished).

Child protection services — response time to commence investigation

The Steering Committee has identified ‘response time to commence investigation’ as an output indicator of the effectiveness of child protection services (box 15.8).

Box 15.8 Response time to commence investigation

‘Response time to commence investigation’ is an 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.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Child protection services — response time to complete investigation

The Steering Committee has identified ‘response time to complete investigation’ as an output indicator of the effectiveness of child protection services (box 15.9).

Box 15.9 Response time to complete investigation

‘Response time to complete investigation’ is an 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.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Child protection services — substantiation rate

‘Substantiation rate’ is included as an output indicator of effectiveness of child protection services (box 15.10).

Box 15.10 Substantiation rate

The 'substantiation rate' is included as an indicator of governments' objective to target investigations to those notifications where a substantive child abuse/neglect incident has occurred. It also provides an indication of the extent to which government has avoided the human and financial costs of an investigation where no harm has occurred.

This indicator is defined as the proportion of finalised investigations where harm or risk of harm was substantiated.

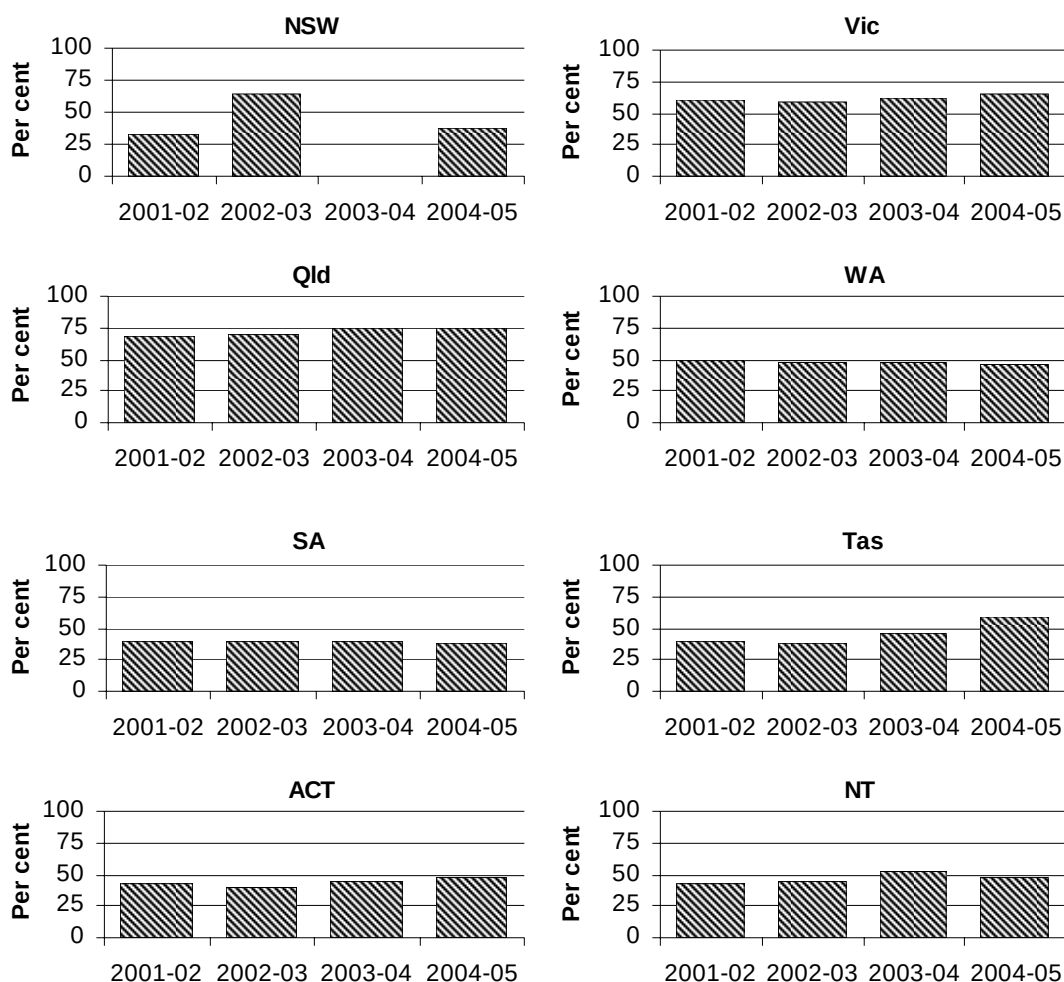
The substantiation rate should be neither 'very high' nor 'very low'. A very low substantiation rate may suggest that notifications and investigations are not accurately targeted at appropriate cases, with the undesirable consequence of distress to families and undermining the chances that families will voluntarily seek support. Very low substantiation rates may also indicate that the scarce resources of the child protection system are being overwhelmed and that screening should be tightened. A very high substantiation rate may indicate that either some appropriate cases are being overlooked at notification and investigation or that the criteria for substantiation are bringing 'lower risk' families into the statutory system.

Finalised investigations that were substantiated may fluctuate because of policy, funding and practice change, such as better targeting of investigative resources, the impact of mandatory reporting or other factors such as increased community awareness and willingness to notify suspected instances of child abuse, neglect or harm.

Data that are comparable across jurisdictions are not available for this indicator because definitions of substantiation vary across jurisdictions, but data are comparable within each jurisdiction over time unless otherwise stated (figure 15.4).

Due to the difficulties in identifying the source of annual fluctuations in substantiation rates, changes over time within jurisdictions are more appropriately used to prompt further analysis, rather than used as definitive performance information.

Figure 15.4 Proportion of finalised child protection investigations that were substantiated^{a, b}



^a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates should not be compared across jurisdictions. ^b NSW child protection data are not comparable over time because of computer system changes in 2002-03 and 2003-04. NSW was able to provide limited data for 2003-04 due to the introduction of its current new client information system.

Sources: AIHW Child protection notifications, investigations and substantiations, Australia data collection (unpublished); tables 15A.33, 15A.50, 15A.67, 15A.84, 15A.101, 15A.118, 15A.135 and 15A.152.

Out-of-home care — safety in out-of-home care

‘Safety in out-of-home care’ is included as an output indicator of effectiveness. (box 15.11).

Box 15.11 Safety in out-of-home care

‘Safety in out-of-home care’ is included as an indicator of governments’ objective to provide children who are under the care of the State with a safe home environment. The indicator reflects the safety of clients in care situations.

This indicator is defined as the proportion of substantiations where those responsible for harm or risk were carers or other people living in households providing out-of-home care.

A low proportion of substantiations is desirable.

Five jurisdictions (Qld, WA, SA, Tas and ACT) provided 2004-05 data on the incidence of child protection substantiations where the person believed responsible for harm or risk to the child was either the carer or another person living in the household providing out-of-home care. WA provided data on abuse by foster carers or workers in placement services, but not abuse by others living in the household (table 15A.20).

Out-of-home care — stability of placement

‘Stability of placement’ is included as an output indicator of effectiveness (box 15.12).

Box 15.12 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.

This indicator is defined as the number of placements that a child has had during a period of continuous out-of-home care.

A low number of child placements (one or two) per period of care is desirable, but must be balanced against other placement quality indicators, such as placements in compliance with the Aboriginal Child Placement Principle, local placements and placements with siblings.

Children may have multiple placements for good reasons, (for example, an initial placement followed by a longer term placement) or it may be desirable to change placements to achieve better child–family compatibility. It is not desirable for a child to stay in an unsatisfactory or unsupportive placement. Also, older children are more likely to have multiple placements as they move towards independence and voluntarily seek alternate placements.

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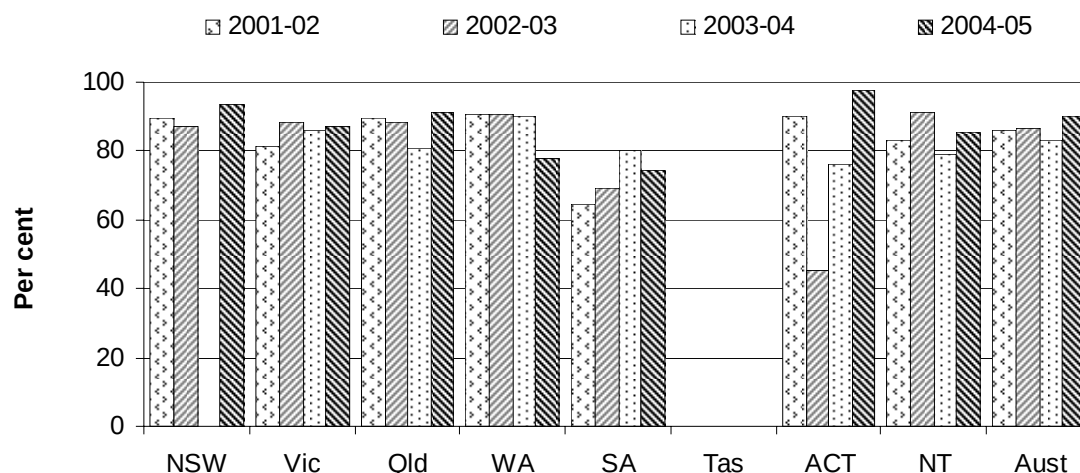
Box 15.12 (Continued)

Data are collected only for children who are on orders and who exit care during the reporting period. There are limitations to counting placement stability using an exit cohort rather than entry cohort longitudinal data, because the sample is biased to children from recent entry cohorts with relatively short stays in care, and these children are likely to have experienced fewer placements.

For children placed away from their family for protective reasons, stability of placement is an important indicator of service quality, particularly for those children who require long term placements. Data were collected on the number of different placements for children on a care and protection order who exited out-of-home care in 2004-05. Data were grouped according to the length of time in care (less than 12 months and 12 months or more).

Nationally, for all jurisdictions able to provide data, 90.3 per cent of the children on a care and protection order who exited care after less than 12 months experienced only one or two placements in 2004-05. This proportion varied across jurisdictions (figure 15.5).

Figure 15.5 **Proportion of children on a care and protection order exiting care after less than 12 months, who had 1 or 2 placements^{a, b, c, d}**

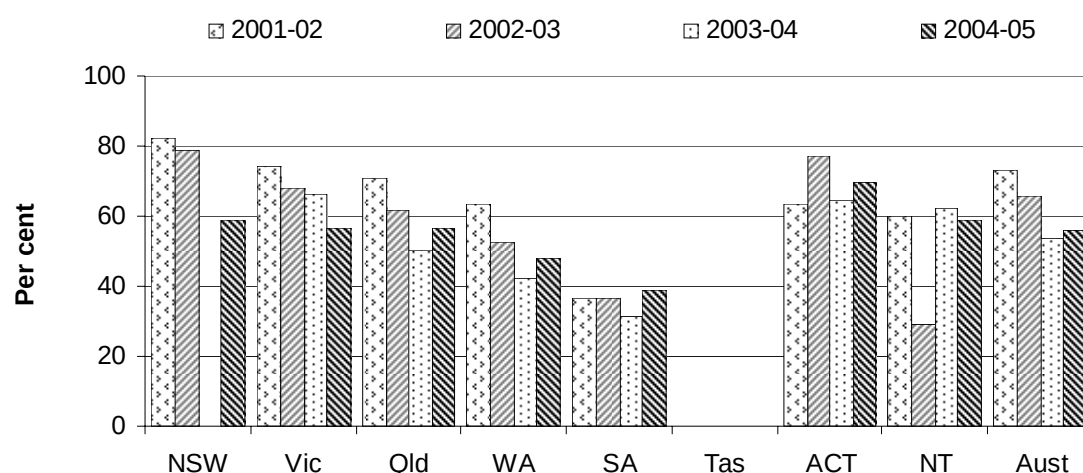


^a Data refer to children exiting care during the relevant financial year. ^b Refer to footnotes in the source tables for information about what each jurisdiction's data include. ^c NSW child protection data from 2002-03 onwards are not comparable with data for previous years. NSW was able to provide limited data for 2003-04 due to the introduction of a new client information system. ^d Data for Tasmania were not available.

Source: AIHW Children in out-of-home care, Australia data collection (unpublished); tables 15A.19, 15A.42, 15A.59, 15A.76, 15A.93, 15A.110, 15A.127, 15A.144 and 15A.161.

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 2004-05 after 12 months or more who had experienced one or two placements (for all jurisdictions where these data were available) was 55.9 per cent nationally but varied across jurisdictions (figure 15.6).

Figure 15.6 **Proportion of children on a care and protection order exiting care after 12 months or more, who had 1 or 2 placements^{a, b, c, d}**



^a Data refer to children exiting care during the relevant financial year. ^b Refer to footnotes in the source table for information about what each jurisdiction's data include. ^c NSW child protection data from 2002-03 are not comparable with data for previous years. NSW was able to provide limited data for 2003-04 due to the introduction of a new client information system. ^d Data for Tasmania were not available.

Source: AIHW Children in out-of-home care, Australia data collection (unpublished); tables 15A.19, 15A.42, 15A.59, 15A.76, 15A.93, 15A.110, 15A.127, 15A.144 and 15A.161.

Out-of-home care — placement with extended family

'Placement with extended family' is an output indicator of effectiveness. (box 15.13).

Box 15.13 Placement with extended family

'Placement with extended family' is an indicator of governments' objective to provide services that meet the needs of the recipients on the basis of relative need and available resources. Placing children with their relatives or kin is generally the preferred out-of-home care placement option. This option is generally associated with better long term outcomes due to increased continuity, familiarity and stability for the child. Relatives are more likely to have or form long term emotional bonds with the child. Placement with familiar people can help to overcome the loss of attachment and belonging that can occur when children are in placed out-of-home care.

This indicator is defined as the proportion of all children in out-of-home care who are placed with relatives or kin who receive government financial assistance to care for that child.

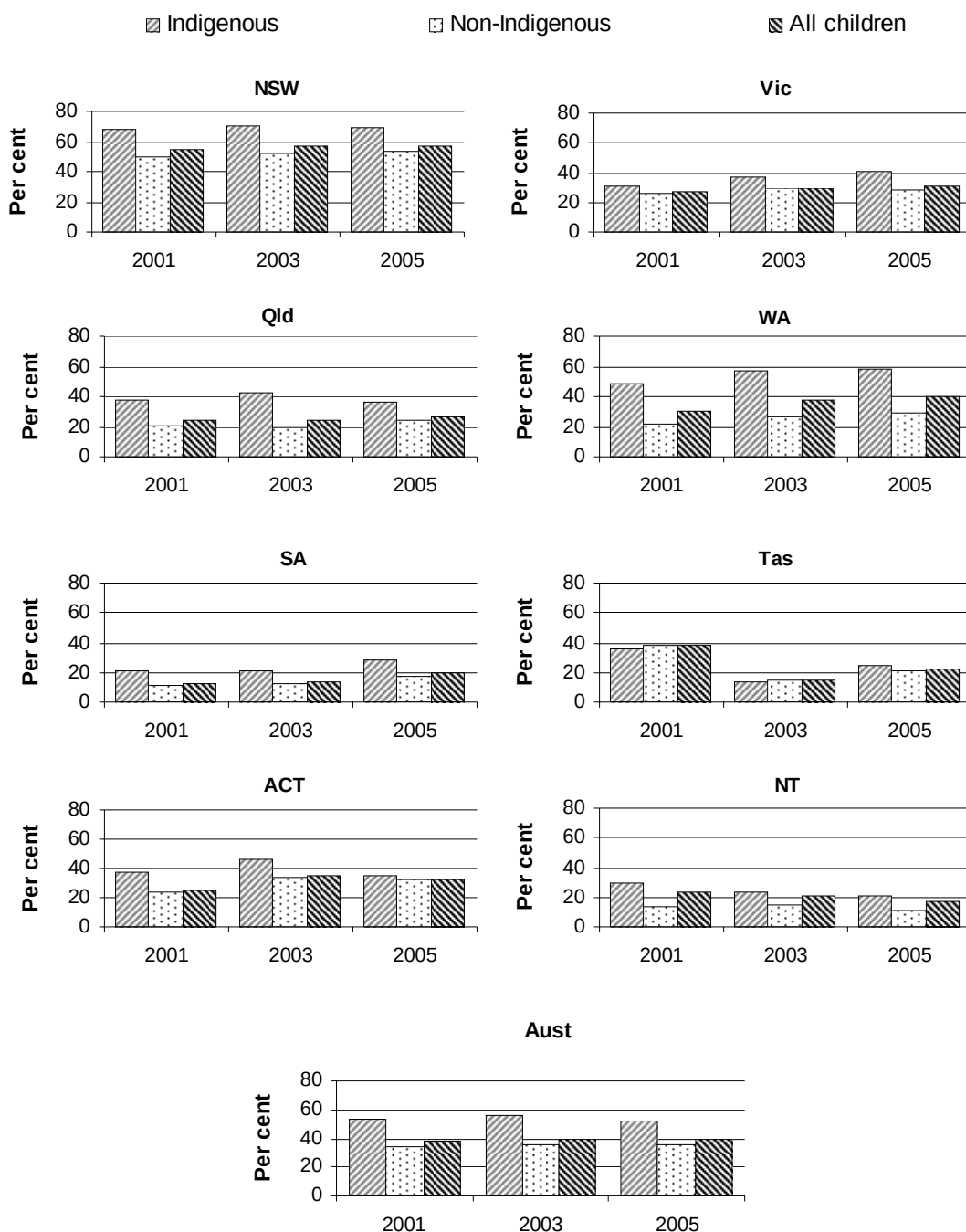
A reasonably high rate for this indicator is considered desirable.

This needs to be considered with other factors in the placement decision.

Placements with extended family may not always be the best option. Long standing family dynamics may undermine the pursuit of case goals such as reunification, and the possibility of intergenerational abuse needs to be considered. In addition, depending on the individual circumstances of children, it may be more important to have a local placement that enables continuity at school, for example, rather than a distant placement with relatives.

The proportion of children placed with relatives or kin at 30 June 2005 was greater for Indigenous children than for non-Indigenous children in all jurisdictions (figure 15.7).

Figure 15.7 Proportion of children in out-of-home care placed with relatives/kin, by Indigenous status, 30 June 2005



Source: AIHW Children in out-of-home care, Australia data collection (unpublished); tables 15A.16, 15A.39, 15A.56, 15A.73, 15A.90, 15A.107, 15A.124, 15A.141 and 15A.158.

Out-of-home care — children aged under 12 years in home-based care

‘Children aged under 12 years in home-based care’ is an output indicator of effectiveness (box 15.14).

Box 15.14 Children aged under 12 years in home-based care

'Children aged under 12 years in home-based care' is an indicator of governments' objective to provide services which meet the needs of the recipients. 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.

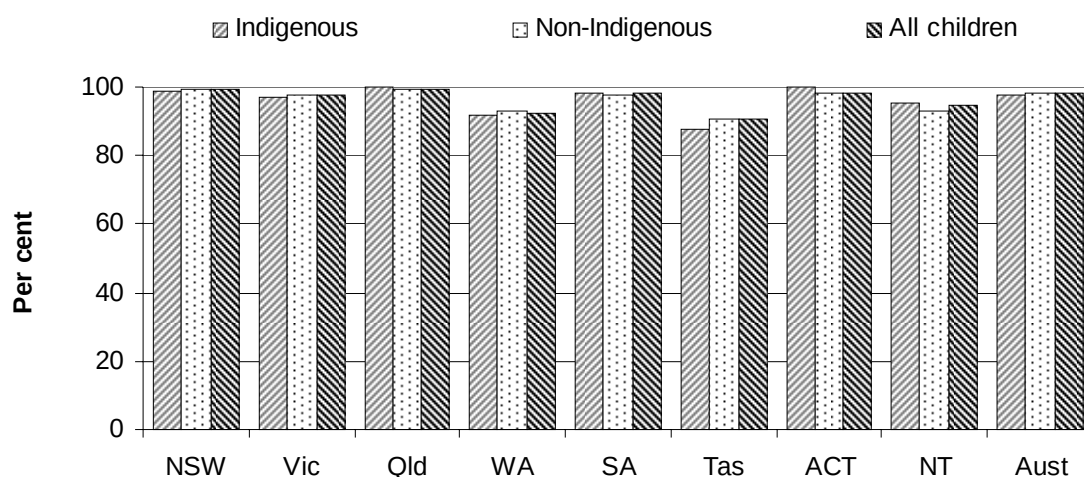
This indicator is defined as the number of children less than 12 years of age placed in home-based care divided by the total number of children under 12 years in out-of-home care.

A high rate for this indicator is considered desirable.

This indicator should be interpreted in conjunction with other placement indicators.

The proportion of all children aged under 12 years in care who were placed in home-based care (excluding family group homes) at 30 June 2005 was 98.2 per cent nationally and exceeded 90 per cent in all jurisdictions. In all jurisdictions the proportion of Indigenous children aged under 12 years who were placed in home-based care was broadly similar to that of non-Indigenous children (figure 15.8).

Figure 15.8 Proportion of children aged under 12 years in out-of-home care and in a home based placement, by Indigenous status, 30 June 2005^a



^a Family group homes are not classified as being home based care.

Source: AIHW (unpublished) Children in out-of-home care, Australia data collection; table 15A.18.

Out-of-home care — placement in accordance with the Aboriginal Child Placement Principle

‘Placement in accordance with the Aboriginal Child Placement Principle’ is an output indicator of effectiveness (box 15.15).

According to the Aboriginal Child Placement Principle (NSW Law Reform Commission 1997), the following hierarchy or placement preference should be pursued in protecting the safety and welfare of Indigenous children:

- placement with the child’s extended family (which includes Indigenous and non-Indigenous relatives/kin)
- placement within the child’s Indigenous community
- placement with other Indigenous people.

All jurisdictions have adopted this principle, either in legislation or policy.

Box 15.15 Placement in accordance with the Aboriginal Child Placement Principle

‘Placement in accordance with the Aboriginal Child Placement Principle’ is included as 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. Placing Indigenous children in circumstances consistent with the Aboriginal Child Placement Principle is generally considered to be in their best interests.

This indicator is defined as the number of Indigenous children placed with the child’s extended family, Indigenous community or other Indigenous people, divided by the total number of Indigenous children in out-of-home care. Data are reported separately for children placed (i) with extended family, (ii) with other Indigenous carer, and (iii) not placed with extended family or other Indigenous carer.

A high proportion of children placed in accordance with the principle is desirable.

This is one factor among many that must be considered in the placement decision.

The proportion of Indigenous children in out-of-home care at 30 June 2005 who were placed in accordance with the principle varies across jurisdictions (figure 15.9).

Figure 15.9 Placement of Indigenous children in out-of-home care, 30 June 2005^{a, b, c}



^a Excludes Indigenous children living independently and those whose living arrangements were unknown.

^b 'Placed with other Indigenous carer' includes those living in Indigenous residential care. ^c Data for Tasmania and the ACT relate to a small number of Indigenous children (78 and 60 respectively) in care at 30 June 2005.

Source: AIHW Children in out-of-home care, Australia data collection (unpublished); table 15A.17.

Out-of-home care — local placement

The Steering Committee has identified 'local placement' as an output indicator of the effectiveness of out-of-home care services (box 15.16).

Box 15.16 Local placement

Local placement is an indicator of governments' objective to provide services which meet the needs of the recipients.

This indicator is defined as the proportion of children attending the same school after entering care. Data will be provided for 3 and 12 months after entering care.

A placement close to where a child lived prior to entering out-of-home care is believed to enhance the stability, familiarity and security of the child. It enables some elements of the child's life to remain unchanged (for example, they can continue attending the same school and retain their friendship network). It may also facilitate family contact if the child's parents continue to live nearby.

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Box 15.16 (Continued)

This indicator should be balanced against other quality indicators. This is one factor among many that must be considered in the placement decision. For example, placement with a sibling or relative might preclude a local placement. Also, a child might move from a primary to a secondary school.

A high rate of 'local placement' is desirable.

Data on this indicator were not available for the 2006 Report.

Out-of-home care — placement with sibling

The Steering Committee has identified 'placement with sibling' as an output indicator of the effectiveness of out-of-home care services (box 15.17).

Box 15.17 Placement with sibling

'Placement with sibling' is an indicator of governments' objective to provide services which meet the needs of the recipients.

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 indicator is defined as the proportion of children who are on finalised 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.

This is one factor among many that must be considered in the placement decision. In circumstances of sibling abuse, or when a particular child in a family has been singled out as the target for abuse or neglect, keeping siblings together might not be appropriate.

Data on this indicator were not available for the 2006 Report.

Out-of-home care — children with documented case plan

The Steering Committee has identified 'children with documented case plan' as an output indicator of the effectiveness of out-of-home care services (box 15.18).

Box 15.18 Children with documented case plan

‘Children with documented case plan’ is an indicator of governments’ objective to provide services that meet the needs of the recipients.

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.

This indicator is defined as the proportion of children on a finalised guardianship or custody 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. The mere existence of a case plan does not guarantee that appropriate case work is occurring that meets the child’s needs.

Data on this indicator were not available for the 2006 Report.

Out-of-home care — client satisfaction

The Steering Committee has identified ‘client satisfaction’ as an output indicator of the effectiveness of out-of-home care services (box 15.19).

Box 15.19 Client satisfaction

Client satisfaction is an output indicator of governments’ objective to provide high quality services that meet the needs of recipients.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Some information on jurisdictions’ development of initiatives which may assist to measure client satisfaction in the future are included on pages 15.14-15.

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

Reporting comparable and meaningful efficiency data for child protection services is problematic for a number of reasons, including:

- *different systems and priorities across jurisdictions* — child protection systems in Australia have evolved independently under the auspices of State and Territory governments (section 15.1). This has resulted in variations in the processes and emphases placed on different service delivery paradigms (the different approaches to diversionary options, for example, see figure 15.1)
- *limitations of current information systems* — in most jurisdictions, it is difficult to identify explicit resources expended on child protection services, out-of-home care services and other support services for families. This is due in part to the historic structure of information systems and the embedding of the government agencies responsible for child protection issues within larger community services departments. Table 15A.4 identifies the level of consistency in expenditure data across jurisdictions.

In response to these difficulties, in April 2002, the Review initiated a project to develop a method for annual reporting of efficiency data for a national framework of protection and support pathways (box 15.20).

Box 15.20 The pathways project

The pathways project developed and tested a model that will ultimately allow jurisdictions to calculate more meaningful, comparable and robust efficiency measures (the 'pathways method'). The model is based on a top-down application of the activity-based costing method. A set of eight national pathways has been developed as a high level representation of the services that a protection and support client could receive in any jurisdiction. Each pathway consists of common activity groups for which an operational and non-operational resource allocation can be made. These activity groups 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. The activity groups are:

- receipt and assessment of initial information about a potential protection and support issue
- provision of generic/non-intensive family support services
- provision of intensive family support services
- secondary information gathering and assessment
- provision of short term protective intervention and coordination services

(Continued on next page)

Box 15.20 (Continued)

- seeking a court order
- provision of longer term protective intervention, support and coordination services
- provision of out-of-home care services.

Before 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. Implementation of the model has the potential to significantly improve the quality of national reporting of protection and support services efficiency measures.

Source: SCRCSSP (2003).

Refinement of counting rules, data testing and changes to information systems will be necessary before full reporting is possible for all jurisdictions. Partial reporting against the framework is anticipated for the 2007 Report.

Child protection services proxy efficiency indicators

Proxy indicators are included as output indicators of efficiency for child protection services (box 15.21).

Box 15.21 Child protection services efficiency indicators

Three child protection efficiency measures are included as output (efficiency) indicators of governments' objective to maximise the benefit to the community through the efficient use of taxpayer resources: 'total expenditure on child protection per notification', 'total expenditure on child protection per investigation', and 'total expenditure on child protection per substantiation'.

These indicators are defined, respectively, as:

- the total expenditure on all child protection activities divided by the number of notifications
- the total expenditure on all child protection activities divided by the number of investigations
- the total expenditure on all child protection activities divided by the number of substantiations.

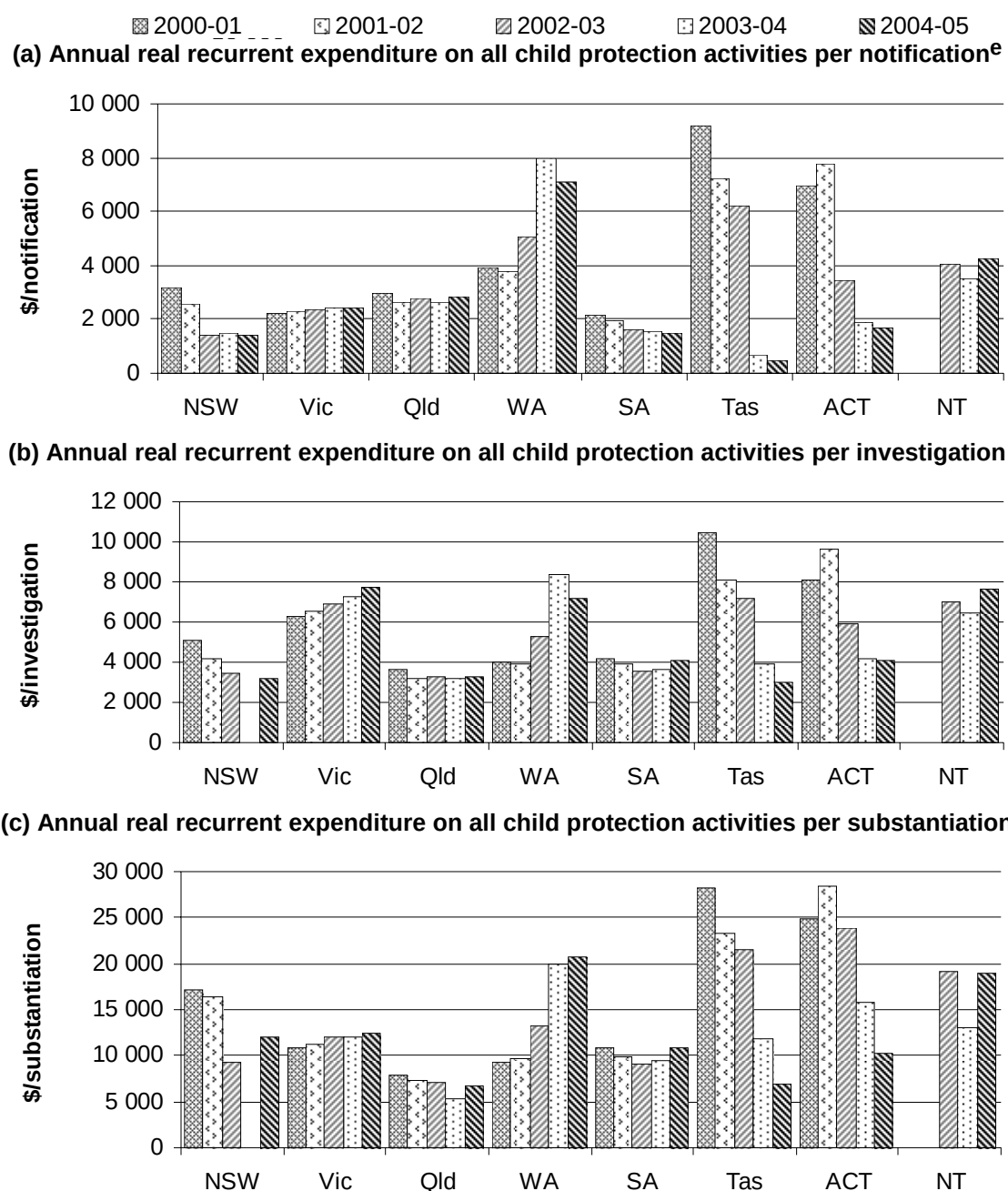
Lower expenditure per notification/investigation/substantiation suggests more efficient services but may indicate lower quality or different service delivery models.

These indicators do not represent unit costs and need to be interpreted with care. Also, they cannot be added together to determine overall child protection efficiency indicators.

These measures are imperfect proxy indicators. They are included as interim measures only, and will be replaced by a more robust method under development. Better efficiency indicators would relate expenditure on particular child protection activities to a measure of output of those activities. Work is in progress to develop an activity-based costing method that will allow this type of reporting from existing information systems.

Total expenditure on child protection per notification, child protection per investigation and child protection per substantiation from 2000-01 to 2004-05 varied between jurisdictions. Some jurisdictions were unable to provide data for all years (figure 15.10).

Figure 15.10 Child protection efficiency indicators (2004-05 dollars)^{a, b, c, d}



^a Real expenditure based on ABS gross domestic product price deflator (2004-05 = 100) (table A.26).

^b These data cannot be interpreted as the 'expenditure per notification', 'expenditure per investigation' or 'expenditure per substantiation' because each is based on the total expenditure of all child protection activities. Differences across jurisdictions reflect the quantity of the three activities rather than a difference in unit costs. ^c NSW child protection data from 2002-03 onwards are not comparable with data for previous years. NSW was able to provide limited data for 2003-04 due to the introduction of a new client information system. ^d NT was unable to provide data for 2000-01 and 2001-02. ^e Information for Tasmania from 2003-04 should not be compared with previous years because of a change in recording practices that has been adopted as a result of centralisation of the intake service. Now every call regarding a child is recorded as a notification, whereas previously, child protection workers made the decision locally about whether the call was a notification based on the risk to the child.

Source: State and Territory governments (unpublished); table 15A.2.

Out-of-home care proxy efficiency indicators

Proxy indicators are included as output indicators of efficiency for out-of-home care efficiency (box 15.22).

Box 15.22 Out-of-home care efficiency indicators

Three out-of-home care efficiency measures are included as output (efficiency) indicators of governments' objective to maximise the benefit to the community through the efficient use of taxpayer resources: 'cost per child in residential out-of-home care', 'cost per child in non-residential out-of-home care', and 'cost per child in all out-of-home care'.

These indicators are defined respectively as:

- the total annual expenditure on residential out-of-home care divided by the number of children in residential out-of-home care at 30 June
- the total annual expenditure on non-residential out-of-home care divided by the number of children in non-residential out-of-home care at 30 June
- the total annual expenditure on all out-of-home care divided by the number of children in all out-of-home care at 30 June

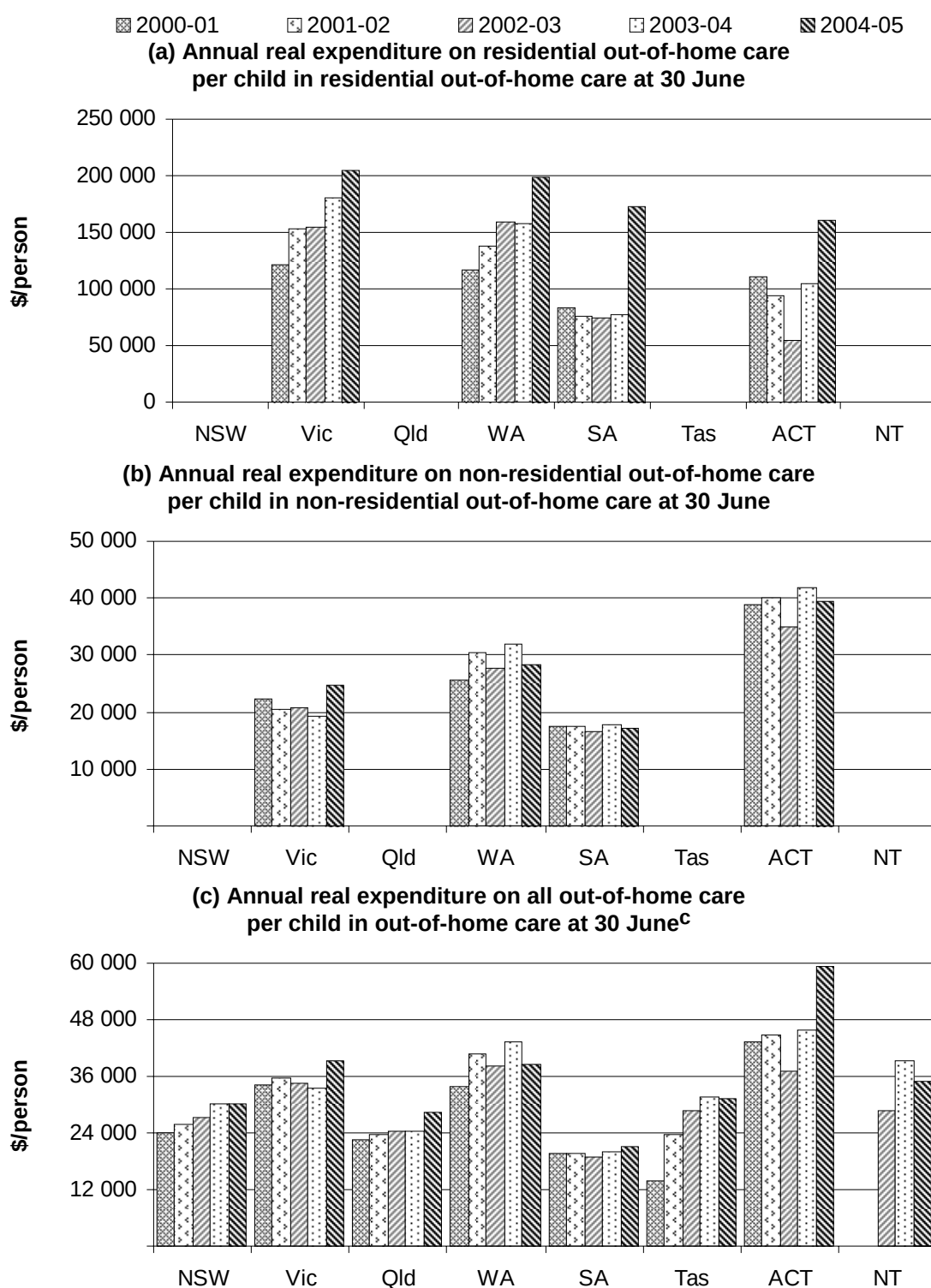
Low expenditure per child in care suggests more efficient services but may also indicate lower service quality.

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.

Victoria, WA, SA and the ACT were able to separate expenditure on out-of-home care into residential care and non-residential care and this annual expenditure to 30 June for 2000-01 to 2004-05 varied across jurisdictions (figures 15.11a and 15.11b). All jurisdictions provided data on total expenditure on out-of-home care per child in care to 30 June for 2000-01 to 2004-05, which varied across jurisdictions (figure 15.11c).

Figure 15.11 Out-of-home care efficiency indicators (2004-05 dollars)^{a, b}



^a Real expenditure based on ABS gross domestic product price deflator (2004-05 = 100) (table A.26). ^b ACT data are affected by the higher subsidy levels for carers, higher award costs in the ACT due to a more recently negotiated agreement, and the effect of a small number of children in care with special high support needs.

^c NT were unable to provide data for 2000-01 and 2001-02.

Source: State and Territory governments (unpublished); table 15A.3.

Outcomes

Improved safety — substantiation rate after decision not to substantiate

‘Substantiation rate after decision not to substantiate’ is an outcome indicator of child protection and out-of-home care services (box 15.23). 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.

Box 15.23 Improved safety — substantiation rate after decision not to substantiate

‘Improved safety — substantiation after decision not to substantiate’ is an outcome indicator of governments’ objective to reduce the risk of harm to children by appropriately assessing notifications of possible child protection incidents. It also provides a measure of the adequacy of intervention offered to children in terms of protecting them from further harm.

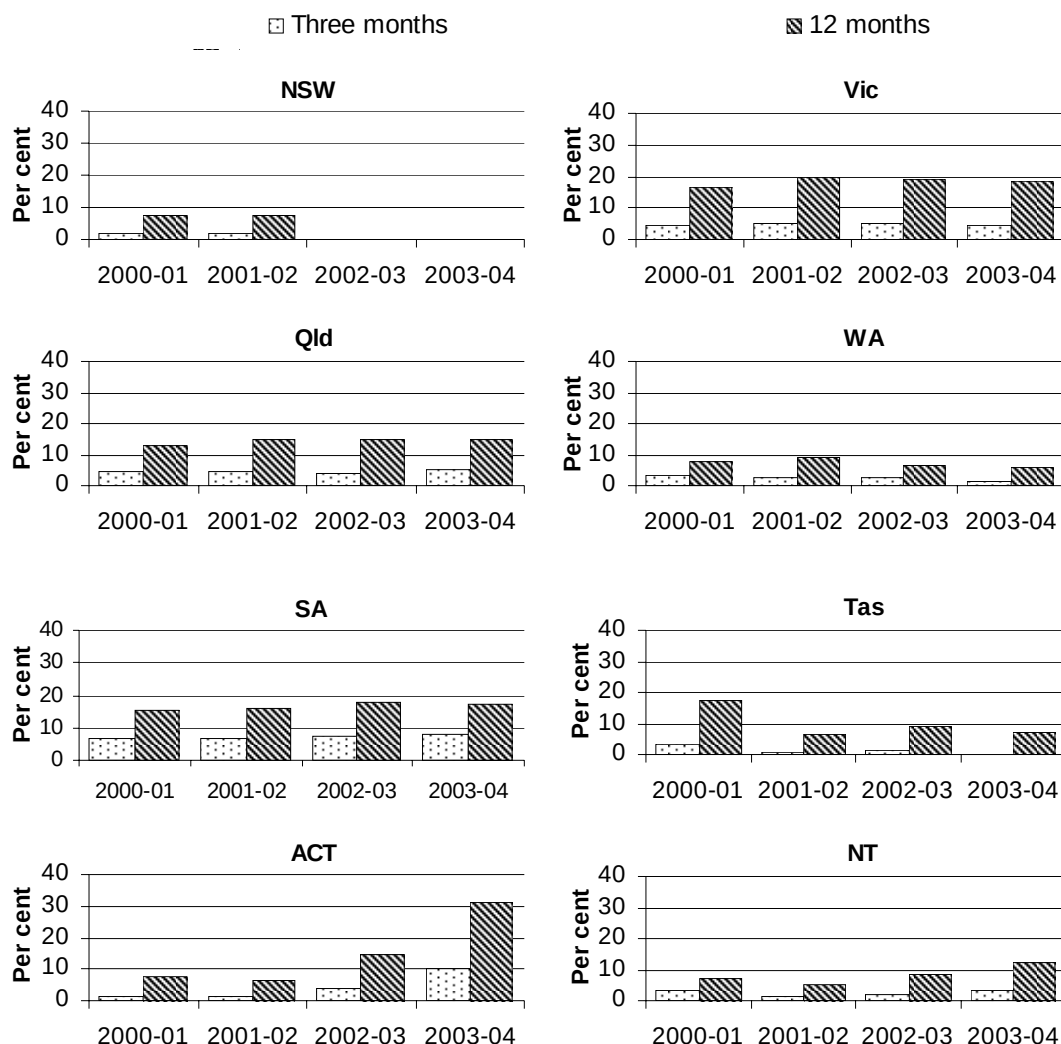
This indicator is defined as the proportion of children who were the subject of an investigation in the previous financial year that led to a decision not to substantiate, and who were later the subject of a substantiation within three or 12 months of the initial decision not to substantiate.

A low rate for this indicator is desirable.

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).

Data that are comparable across jurisdictions are not available for this indicator because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time until 2002-03. Data for 2003-04 are based on a different counting rule to previous years (figure 15.12).

Figure 15.12 Improved safety — resubstantiation rate within 3 and/or 12 months after a decision not to substantiate^{a, b, c}



^a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. ^b NSW was able to provide limited data for 2003-04 due to the introduction of a new client information system. As this indicator is calculated using two years of data, 2002-03 rates are also not available for NSW. ^c The counting rule for this indicator has been changed since previous Reports, which may have resulted in a lowering of the rate for some jurisdictions in 2003-04. Therefore care should be taken when comparing 2003-04 with previous years.

Source: AIHW Child protection notifications, investigations and substantiations, Australia (unpublished); tables 15A.31, 15A.48, 15A.65, 15A.82, 15A.99, 15A.116, 15A.133 and 15A.150.

Improved safety — resubstantiation rate

The ‘resubstantiation rate’ is an outcome indicator of child protection and out-of-home care services (box 15.24).

Box 15.24 Improved safety — resubstantiation rate

‘Resubstantiation rate’ is an indicator of governments’ objective to reduce the risk of harm and to prevent the recurrence of abuse and neglect or harm to children. This indicator also partly reveals the extent to which intervention by child protection services has succeeded in preventing further harm.

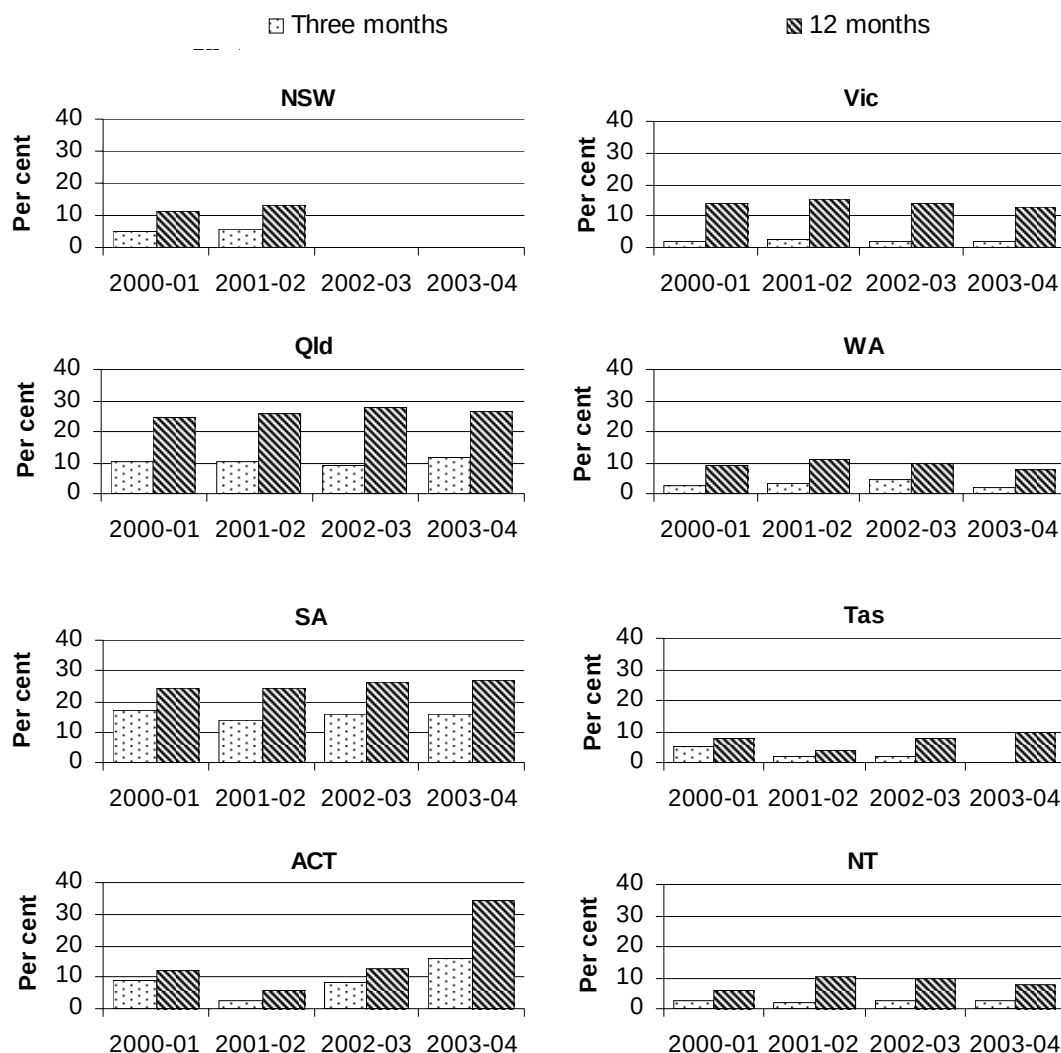
This indicator is defined as the proportion of children who were the subject of a substantiation in the previous financial year, who were subsequently the subject of a further substantiation within the following three or 12 months.

A low rate for this indicator is desirable.

Reported results may be affected by the finalisation of investigations, factors beyond the control of child protection services, such as changes in the family situation (for example, illness, unemployment or a new partner). In addition, this indicator does not distinguish between subsequent substantiations that are related to the initial notification (that is, the same source of risk of harm) and those that are unrelated to the initial notification (that is, a different source of risk of harm).

Data that are comparable across jurisdictions are not available for this indicator because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time until 2002-03. Data for 2003-04 are based on a different counting rule to previous years (figure 15.13).

Figure 15.13 Improved safety — resubstantiation rate within 3 and/or 12 months after a substantiation^{a, b, c}



^a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. ^b NSW was able to provide limited data for 2003-04 due to the introduction of a new client information system. As this indicator is calculated using two years of data, 2002-03 rates are also not available for NSW. ^c The counting rule for this indicator has been changed since previous Reports, which may have resulted in a lowering of the rate for some jurisdictions in 2003-04. Therefore care should be taken when comparing 2003-04 with previous years.

Source: AIHW Child protection notifications, investigations and substantiations, Australia data collection (unpublished); tables 15A.32, 15A.49, 15A.66, 15A.83, 15A.100, 15A.117, 15A.134 and 15A.151.

Improved education, health and wellbeing of the child

‘Improved education, health and wellbeing of the child’ has been identified as an outcome indicator for development for future Reports (box 15.25).

Box 15.25 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.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Safe return home

‘Safe return home’ has been identified as an outcome indicator for further development for future Reports (box 15.26).

Box 15.26 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. 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.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Permanent care

‘Permanent care’ has been identified as an outcome indicator for further development for future Reports (box 15.27).

Box 15.27 Permanent care

‘Permanent care’ is an indicator of governments’ objective to provide appropriate care for children who cannot be safely reunified with their families. Appropriate services are those that minimise the length of time before stable, permanent placement is achieved.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator 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

Between 2000 and 2003, the National Child Protection and Support Services (NCPASS) Data Working Group, under the auspices of the National Community Services Information Management Group, reviewed the reporting framework used to collect the national child protection data. The review aimed to establish the feasibility of updating the national reporting framework so the national data:

- more accurately reflect the current responses of states and territories to child protection and child concern reports
- are more comprehensive
- have increased consistency and comparability.

The review resulted in the development of a broader framework to count responses to calls received by community services departments about the safety and wellbeing of children. The responses include those that occur outside the formal child protection system. The new framework incorporates data elements such as the provision of advice and information, the assessment of needs, and the provision of general and intensive family support services.

The AIHW, in conjunction with the NCPASS, has developed data dictionaries to support the new reporting framework. These dictionaries have undergone initial data testing and it is envisaged that they will be used by jurisdictions to provide unit record data. This will provide more detailed child protection and out-of-home care data than is currently available with aggregated data. It is anticipated that the outcomes of the new framework will provide additional data for the 2007 and 2008 Reports.

15.5 Profile of supported accommodation and assistance services

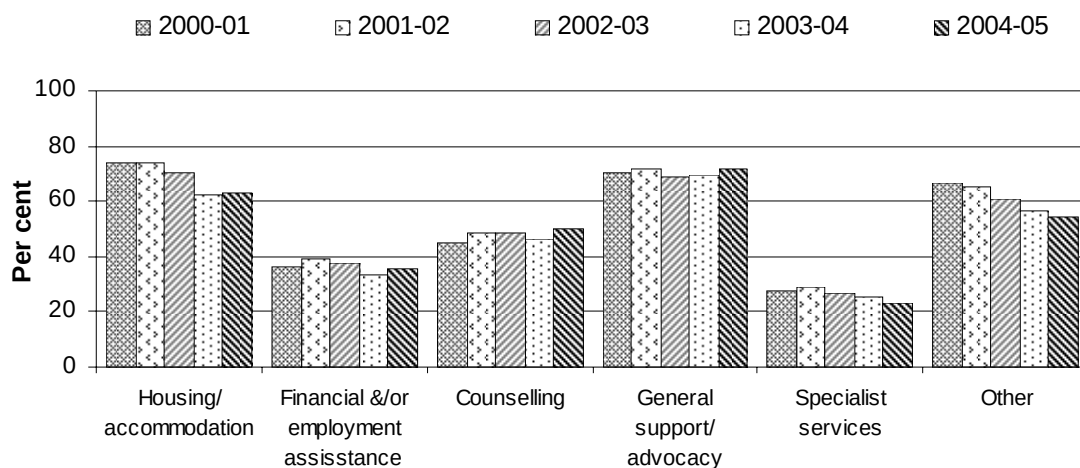
Service overview

Supported accommodation and assistance services aim to assist people who are homeless or at imminent risk of becoming homeless as a result of a crisis, including women and children escaping domestic violence.

The primary focus of SAAP is to use a case management approach to support homeless people, and adults and children escaping domestic violence. Through this process, clients are offered a range of services, including supported accommodation, counselling, advocacy, links to housing, health, education and employment services, outreach support, brokerage and meals services.

Nationally, in 2004-05, housing and accommodation services were provided in 62.7 per cent of support periods. Financial and employment assistance (35.6 per cent), counselling (50.0 per cent), general support and advocacy (72.0 per cent), and specialist services (23.2 per cent) were also commonly provided. Agencies may provide more than one type of service during a single support period (figure 15.14).

Figure 15.14 **Services received during a SAAP support period^a**



^a Totals may not add to 100 per cent because agencies may provide more than one type of service during a single support period.

Source: SAAP National Data Collection Agency (NDCA) Administrative Data and Client Collections (unpublished); table 15A.163.

Size and scope

Support services funded by SAAP are provided by agencies to a range of groups, such as homeless families, single men, single women, young people, and adults and children escaping domestic violence. At least 1291 agencies are funded under the SAAP program, and most target principally one client group. Services were delivered in 2004-05 by agencies targeting:

- young people (36.4 per cent of agencies)
- women escaping domestic violence (22.5 per cent)
- families (9.3 per cent)
- single men (7.1 per cent)
- single women (3.8 per cent)
- multiple client groups (20.9 per cent) (table 15A.164).

Agencies also vary in their service delivery model. The most common models in 2004-05 were the provision of medium term to long term supported accommodation (36.3 per cent) and the provision of crisis or short term supported accommodation (34.8 per cent). Agencies also provided services other than accommodation, such as outreach support (5.0 per cent of agencies), day support (1.9 per cent), and telephone information and referral (1.3 per cent). A further 13.2 per cent of agencies provided multiple services and 1.9 per cent provided agency support (table 15A.165).

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 have also had contact with child protection and out-of-home care services or have been subject to a current or past order. In 2003-04, it is estimated that 33 per cent of SAAP clients were women escaping domestic violence. Of the 52 700 accompanying children accessing SAAP, 66 per cent were children who accompanied a female parent or guardian escaping domestic violence (AIHW 2005).

Close links also exist between SAAP services and other forms of housing assistance reported in the Housing chapter (chapter 16), which focuses on the performance of government in providing public, Indigenous and community housing under the Commonwealth State Housing Agreement (CSHA) and the Commonwealth Rent Assistance (CRA) program. In particular, the Housing chapter includes data on accommodation funded under the Crisis Accommodation Program. This is a special purpose program under the CSHA which provides funding to State and Territory

housing authorities to support SAAP agencies, by providing accommodation to SAAP clients (figure 16.2 and table 16.2). Some individuals and families utilise both SAAP services and services described in the Housing chapter, as people tend to move from homelessness to social housing.² In 2004-05, for example, approximately 18.1 per cent of former SAAP clients had moved to public housing (figure 15.29).

Roles and responsibilities

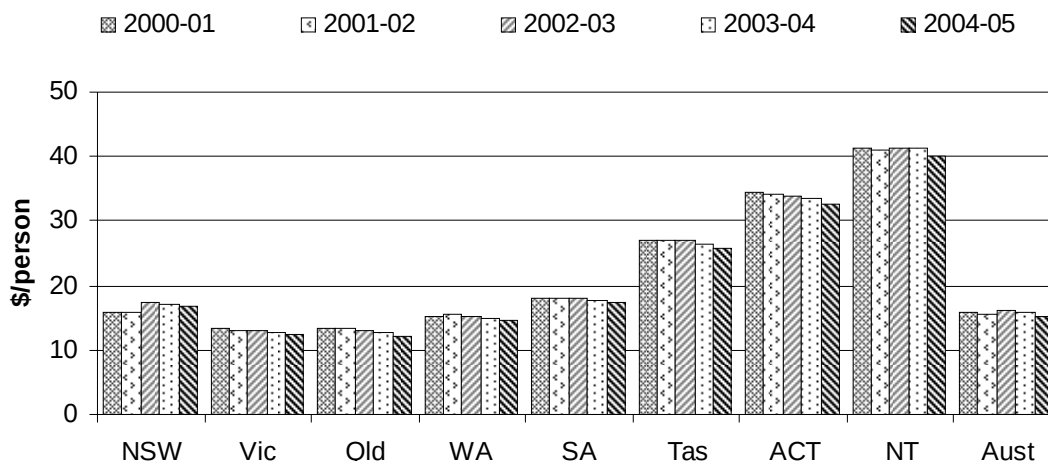
The Australian, State and Territory governments jointly fund SAAP, which was established in 1985 to consolidate a number of existing programs. The State and Territory governments have responsibility for the day-to-day management of SAAP, including the distribution of funding to SAAP funded agencies. Non-government agencies, with some local government participation, deliver most SAAP services. Research, strategy, and other planning and development activities are coordinated at the national level by the SAAP National Coordination and Development Committee (which includes representatives of the Australian Government and each State and Territory government).

Funding

Recurrent funding of SAAP services was \$309.9 million in 2004-05, of which the Australian Government contributed 56.4 per cent and the states and territories contributed 43.6 per cent (table 15A.166). Recurrent SAAP funding per person in the total population in 2004-05 was \$15 nationally. This figure varied across jurisdictions (figure 15.15).

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.

Figure 15.15 **Real recurrent SAAP funding per person in the residential population (2004-05 dollars)^{a, b, c}**



^a Includes total recurrent allocations (including State and Territory level allocations for program administration). ^b The total population figure is not indicative of the demand for these services. ^c Real expenditure is based on the ABS gross domestic product price deflator 2004-05 = 100 (table A.26).

Source: Department of Family and Community Services (DFaCS) (unpublished); table 15A.168.

15.6 Performance indicator framework of supported accommodation and assistance services

The performance indicator framework is based on the shared government objectives for SAAP services (box 15.28).

Box 15.28 Objectives for SAAP services

The overall aim of SAAP is to provide transitional supported accommodation and a range of related support services, to help people who are homeless or at imminent risk of homelessness to achieve the maximum possible degree of self-reliance and independence. Within this aim, the goals are to:

- resolve crises
- re-establish family links where appropriate
- re-establish the capacity of clients to live independently of SAAP.

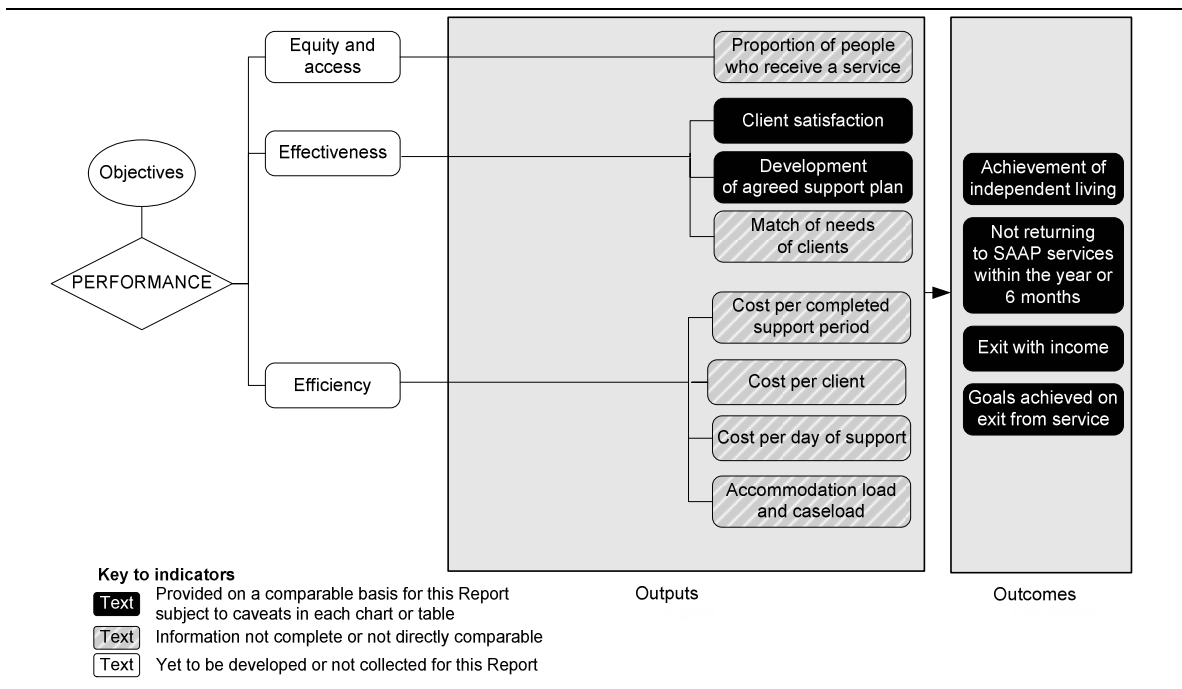
SAAP services should be provided in an equitable and efficient manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of SAAP services (figure 15.16). 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.

The performance indicator framework shows which data are comparable in the 2006 Report (figure 15.16). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 15.16 Performance indicators for SAAP services



In the 2006 Report, there are a number of improvements in reporting performance of SAAP services. New data with improved quality and comparability have been introduced for the outcome indicator ‘proportion of people who receive a service’. This includes new data on daily turn-away rate of adults and unaccompanied children requesting immediate SAAP accommodation, and directly comparable data for the equity measure of access to SAAP accommodation services by special needs groups of people. New data for the outcome indicator ‘exit with income’ are also introduced to report the income status of SAAP clients who specially requested assistance with obtaining/maintaining their source of income. Data for the outcome indicator ‘goals achieved on exit from service’ are also included in the Report for the first time.

15.7 Key supported accommodation and assistance performance indicator results

The data collection for SAAP allows for the measurement of the number of clients and of the number and types of services provided to clients, but is subject to some limitations (box 15.29).

Box 15.29 Information needs to be considered when analysing SAAP data

The following information needs to be considered when analysing SAAP data.

- Informed consent is an essential component of the integrity of the data. The principle of client/consumer rights (which underpins informed consent) recognises that clients do not receive services under a mandatory order. They have the right to accept or reject the services offered, as they have the right to provide or not provide information while receiving SAAP services.
- Clients consented to provide personal details for the SAAP client collection for 87 per cent of support periods in 2004-05. A weighting system has been developed to adjust for agency non-participation (93 per cent of agencies participated in the client collection) and non-consent.

Outputs

Equity and access

Proportion of people who receive a service

‘Proportion of people who receive a service’ is an output (equity and access) indicator of SAAP services (box 15.30).

Box 15.30 Proportion of people who receive a service

‘Proportion of people who receive a service’ is an indicator of governments’ objective to ensure all Australians have equitable access to SAAP services on the basis of relative need. The indicator measures the extent to which the demand for assistance is met or unmet. Unmet demand occurs when a homeless person seeking supported accommodation, or support, cannot be provided with that assistance (although one-off assistance may be provided).

Two measures of the proportion of people who receive services are reported for all SAAP clients: daily turn-away rate of requests for accommodation and total unmet demand for accommodation.

Daily turn-away rate of requests for accommodation is defined as the daily average number of people whose valid requests for immediate accommodation were unmet, divided by the daily average total number of people who made valid requests for immediate accommodation.

Total unmet demand for accommodation is defined as the daily average total number of people whose requests for immediate accommodation were unmet, divided by the daily average number of people who made requests for immediate accommodation, and those who were continuing their accommodation from the previous day.

A measure of equity in providing access to SAAP accommodation is reported for two special needs groups of people, Indigenous people and people from non-English speaking backgrounds. This measure compares the representation of people from these two groups among all people whose valid requests for SAAP accommodation were unmet with their representation among people whose requests for SAAP accommodation were met.

A higher proportion of valid requests receiving assistance is desirable.

Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as Indigenous people and people from non-English speaking backgrounds) is particularly important.

Data for assessing access to SAAP services are sourced from the Demand for Accommodation Collection and the Client Collection. The Demand for Accommodation Collection measures the levels of met and unmet demand for SAAP accommodation by collecting information about requests for accommodation by individuals or groups over two weeks each year. These data are used in conjunction with Client Collection data to calculate the ‘turn-away’ rate for demand for SAAP accommodation.

The Demand for Accommodation Collection collects data on ‘valid unmet requests’ for immediate accommodation. ‘Valid unmet requests’ excludes requests made at an agency, where the person or group is determined to be inappropriate for the agency,

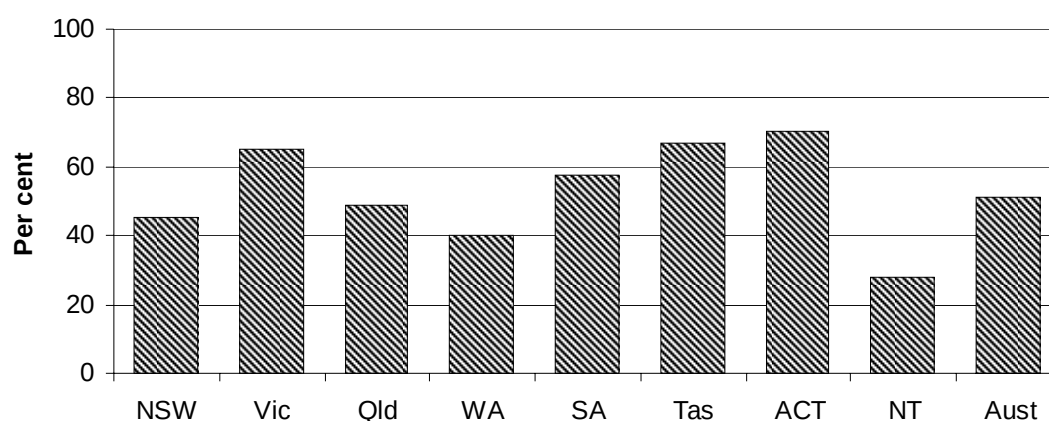
where there is no fee-free accommodation available, or where proffered assistance is refused. For the Client Collection, the accommodation status of a client on a particular day is based on the reported periods of accommodation within a support period.

As only data from agencies that participated in both the Client Collection and the Demand for Accommodation Collection are used for the calculations, data included in this Report may understate activities of SAAP agencies. Additionally, the two week sample period over which data are collected may not be representative of the eventual success of clients accessing SAAP services over the full year (see notes to tables 15A.169-170).

Data for 'proportion of people who receive a service' in this Report are not comparable with those in previous Reports as they are based on different data collections.

Data on proportions of people with valid requests for SAAP accommodation who were turned away are included for the first time in this Report. Nationally, in 2002-03, 51.0 per cent of adults and unaccompanied children requesting immediate SAAP accommodation were turned away. The proportion varied across jurisdictions (figure 15.17).

Figure 15.17 Daily turn away rate of adults and unaccompanied children requesting immediate SAAP accommodation, December 2002 and May 2003^{a, b, c}

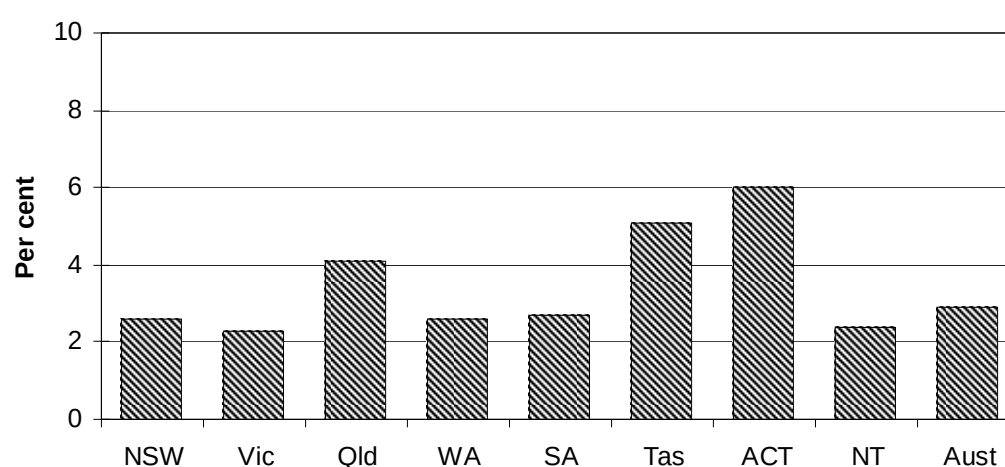


^a Data are sourced from new collections and are only available for 2002-03. ^b A two-week Demand for Accommodation Collection is conducted annually to gather information about homeless people who are not accepted as clients of SAAP agencies. The collection for 2002-03 data was held between 9–15 December 2002 and 7–13 May 2003. ^c See notes to table 15A.169 for more detailed data caveats.

Source: AIHW (2004); table 15A.169.

Nationally, the number of adults and unaccompanied children who made valid requests for SAAP accommodation but could not be accommodated accounted for 2.9 per cent of the total demand for SAAP accommodation in 2002-03. This proportion varied across jurisdictions. Total demand for SAAP accommodation is measured by the total number of people who made requests for immediate SAAP accommodation, and those who were continuing their accommodation from the previous day (figure 15.18).

Figure 15.18 Total unmet demand for SAAP accommodation by adults and unaccompanied children, December 2002 and May 2003^{a, b, c}



^a Data are sourced from new collections and are only available for 2002-03. ^b A two-week Demand for Accommodation Collection is conducted annually to gather information about homeless people who are not accepted as clients of SAAP agencies. The collection for 2002-03 data was held between 9–15 December 2002 and 7–13 May 2003. ^c See notes to table 15A.170 for more detailed data caveats.

Source: AIHW (2004); table 15A.170.

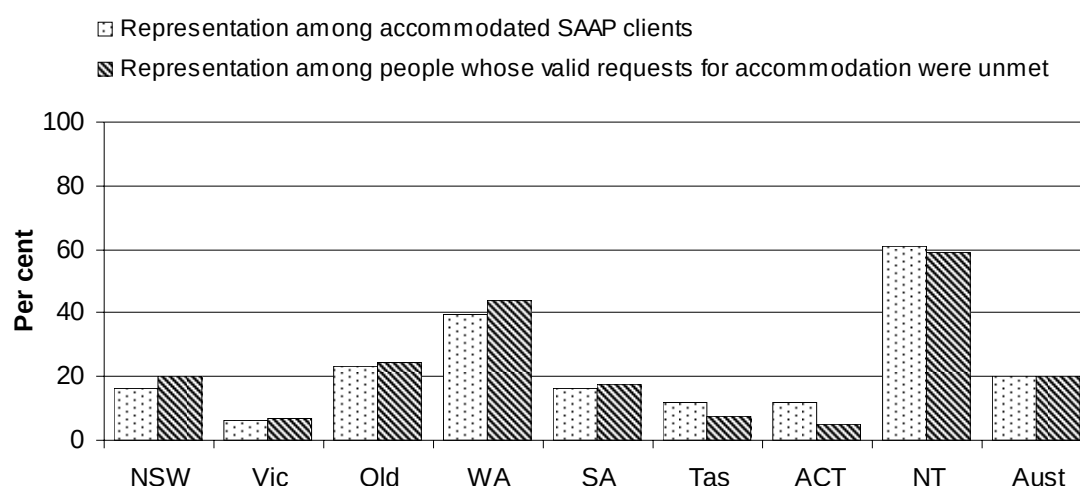
A measure of equity in access to SAAP services by special needs groups of people is reported respectively for Indigenous people and people from non-English speaking backgrounds. This measure compares the representation of people from these two groups among all people whose valid requests for SAAP accommodation were unmet with their representation among all people whose requests had been met (accommodated SAAP clients).³

Nationally, Indigenous people made up 20.1 per cent of all people whose valid requests for accommodation did not result in accommodation assistance in 2004-05

³ In previous Reports, this measure compared the proportion of people from these two groups who could not be accommodated with their representation among all SAAP clients (including accommodated and not accommodated). This Report presents, for the first time, data for a direct comparison focusing on accommodation. Therefore, these data are not comparable to those in previous Reports.

— a proportion similar to that of Indigenous clients among all accommodated SAAP clients (20.4 per cent). This result varied across jurisdictions (figure 15.19).

Figure 15.19 Proportion of Indigenous people among all accommodated SAAP clients and among people whose valid requests for accommodation were unmet, 2004-05^a

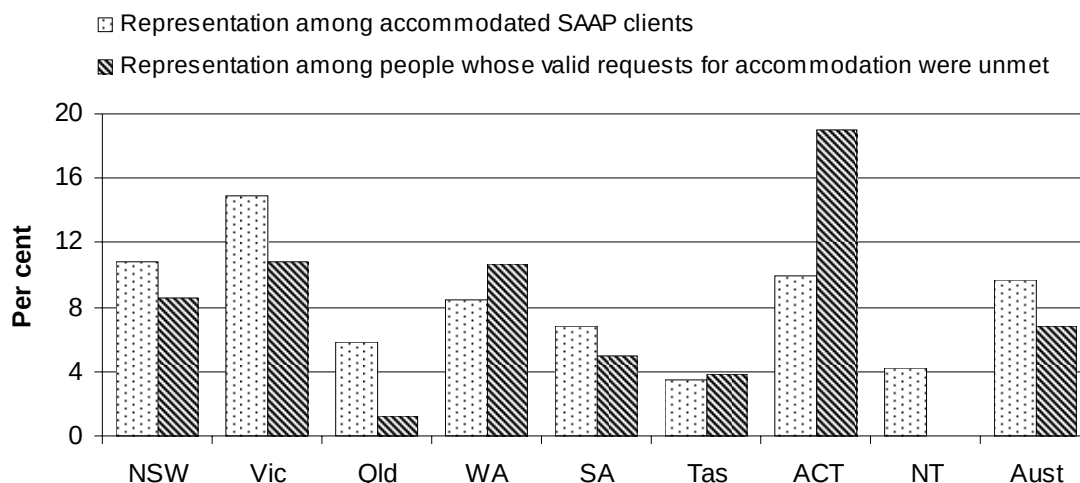


^a See notes to table 15A.171 for details of data definitions.

Source: SAAP NDCA Client and Demand for Accommodation Collections (unpublished); table 15A.171.

Nationally, the proportion of people from non-English speaking backgrounds among all people whose valid requests for accommodation did not result in accommodation assistance was 6.8 per cent in 2004-05 — lower than that of people from non-English speaking backgrounds among all accommodated SAAP clients (9.7 per cent). This result varied across jurisdictions (figure 15.20).

Figure 15.20 Proportion of people from non-English speaking backgrounds among all accommodated SAAP clients and among people whose valid requests for accommodation were unmet, 2004-05^a



^a See notes to table 15A.172 for details of data definitions.

Source: SAAP NDCA Client and Demand for Accommodation Collections (unpublished); table 15A.172.

Requests for SAAP services were not met for a number of reasons in 2004-05, including a lack of available accommodation (the main reason that 63.6 per cent of potential clients were not provided with services), no vacancies at the referral agency (22.2 per cent), and insufficient staff (1.2 per cent) (table 15A.178).

Effectiveness

Client satisfaction

'Client satisfaction' is an output (effectiveness) indicator of SAAP services (box 15.31).

Box 15.31 Client satisfaction

'Client satisfaction' is an indicator of governments' objective to provide high quality services that meet the needs of SAAP recipients.

The indicator is defined as the proportion of clients whose overall satisfaction with the assistance they had received from the SAAP service was either 'good' or 'really good'.

A higher proportion suggests greater client satisfaction with the overall SAAP service.

Data for the client satisfaction indicator are sourced from the national SAAP client satisfaction survey, which is scheduled to be conducted periodically. As a result,

new data for this indicator are not available for this Report. Data on client satisfaction relating to a four week period beginning 11 November 2003 were included in the 2005 Report (pp. 15.47-48; Colmar Brunton Social Research 2004).

Development of agreed support plan

‘Development of agreed support plan’ is an output (effectiveness) indicator of SAAP services (box 15.32).

Box 15.32 Development of agreed support plan

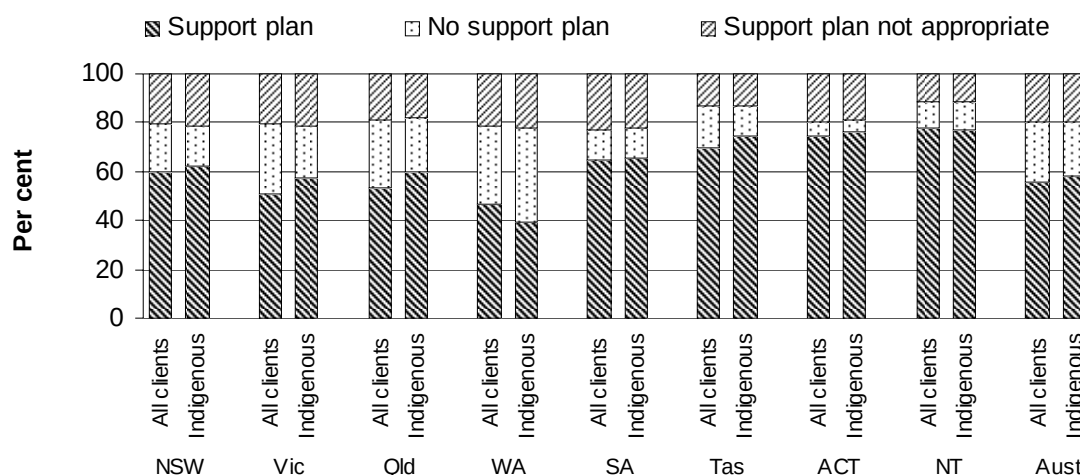
‘Development of agreed support plan’ is an indicator of governments’ objective to provide high quality services that are appropriately targeted to meet the needs of SAAP clients.

This indicator is defined as the number of support periods with an agreed support plan divided by the total number of support periods. Data are reported for all SAAP clients, and separately for Indigenous people.

A higher proportion of support periods with agreed support plans is desirable. In some instances, however, a support plan may be judged to be inappropriate (such as when a support period is short term).

Nationally, there was an agreed support plan for 55.8 per cent of support periods for all clients in 2004-05 (compared with 58.6 per cent for Indigenous clients). This proportion varied across jurisdictions (figure 15.21).

Figure 15.21 Support periods, by the existence of a support plan, 2004-05^a



^a See notes to tables 15A.173-174 for more details.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); tables 15A.173-174.

Match of needs of clients

‘Match of needs of clients’ is an output (effectiveness) indicator of SAAP services (box 15.33).

Box 15.33 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. This is a measure of appropriateness. The range of services needed is broad (ranging from meals to laundry facilities to long-term accommodation), so the effect of not providing these services varies.

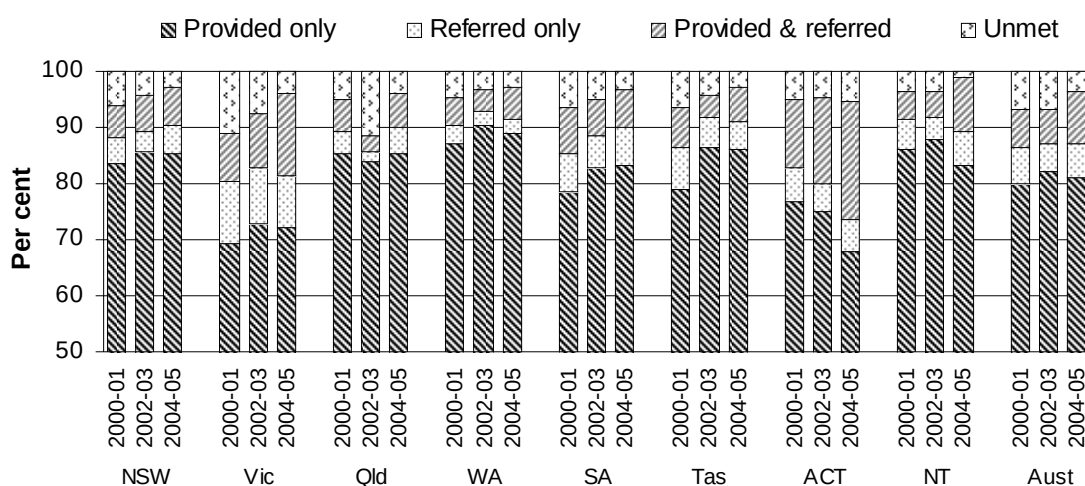
This indicator is defined as the number of clients who were provided with the services they needed and clients who were referred to another agency, divided by the total number of SAAP clients.

Data are reported for all SAAP clients, and separately for Indigenous people and people from non-English speaking backgrounds.

A higher proportion of clients who received services they needed, or who were referred to another agency, is desirable.

Nationally, the proportion of clients who received needed services (including services provided by the agencies and/or who were referred to another agency) was 96.6 per cent in 2004-05 (figure 15.22).

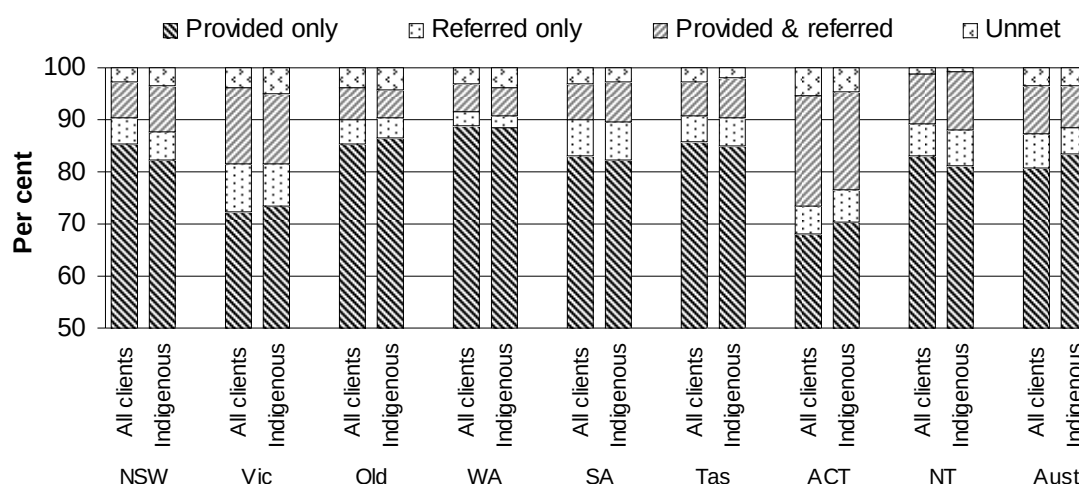
Figure 15.22 SAAP clients, by met and unmet support needs



Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.175.

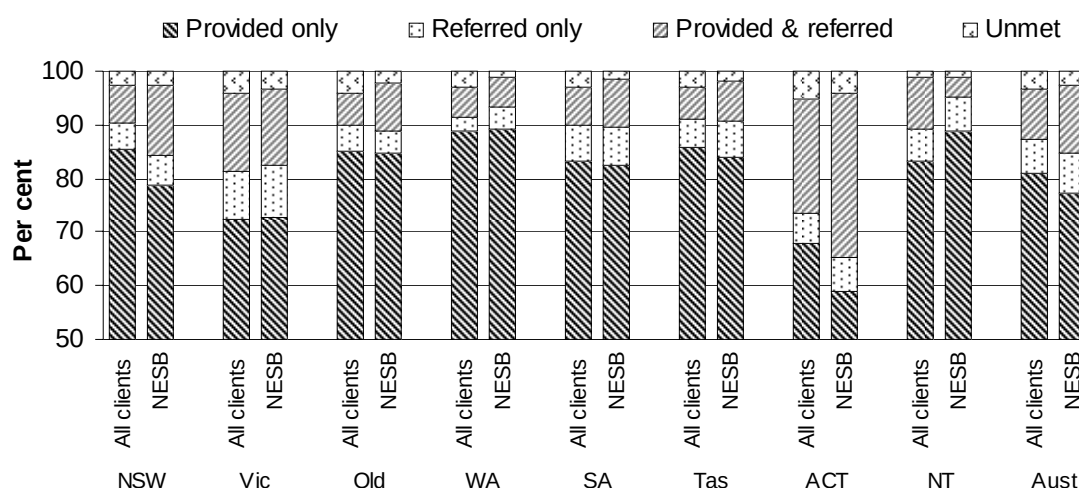
The proportions for Indigenous clients (96.7 per cent) and clients from a non-English speaking background (97.3 per cent) who received needed services in 2004-05 were similar to that for all clients. This proportion varied across jurisdictions (figures 15.23 and 15.24).

Figure 15.23 Indigenous clients, by met and unmet support needs, 2004-05



Source: SAAP NDCA Administrative Data and Client Collections (unpublished); tables 15A.175-176.

Figure 15.24 Clients from non-English speaking backgrounds, by met and unmet support needs, 2004-05



NESB = Non-English speaking background.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); tables 15A.175 and 15A.177.

Efficiency

Across jurisdictions, there are varying treatments of expenditure items (for example, superannuation) and different counting and reporting rules for generating financial data. Results reported on efficiency indicators may reflect these differences.

Cost per completed support period

‘Cost per completed support period’ is an output (efficiency) indicator of SAAP services (box 15.34).

Box 15.34 Cost per completed support period

‘Cost per completed support period’ is an indicator of governments’ objective to maximise the availability and quality of services through the efficient use of taxpayer resources. This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost).

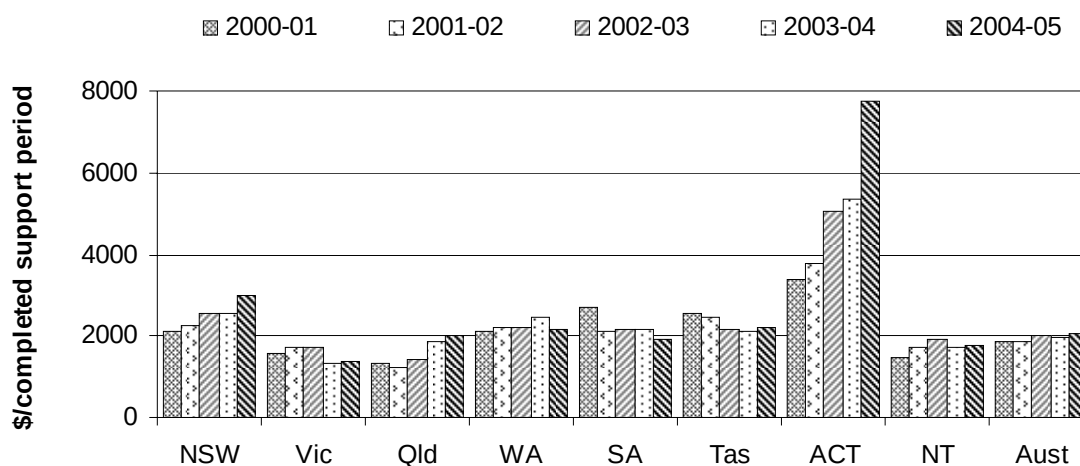
This indicator is defined as total expenditure on SAAP services divided by the number of completed support periods (excluding casual and potential clients, and accompanying children).

A lower cost per completed support period is desirable, but may also indicate lesser service quality.

Unit cost analyses include only expenditure by service delivery providers. Unit cost indicators should also include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the Commonwealth State Housing Agreement through a special purpose program (the Crisis Accommodation Program).

The recurrent cost per completed support period (excluding casual and potential clients, and accompanying children) averaged \$2080 nationally and varied across jurisdictions in 2004-05 (figure 15.25).

Figure 15.25 **Real recurrent cost per completed support period
(2004-05 dollars)^a**



^a See notes to table 15A.179 for detailed data caveats.

Source: SAAP NDCA Administrative Data and Client Collections(unpublished); table 15A.179.

Cost per client

‘Cost per client’ is an output (efficiency) indicator of SAAP services (box 15.35).

Box 15.35 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. This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost).

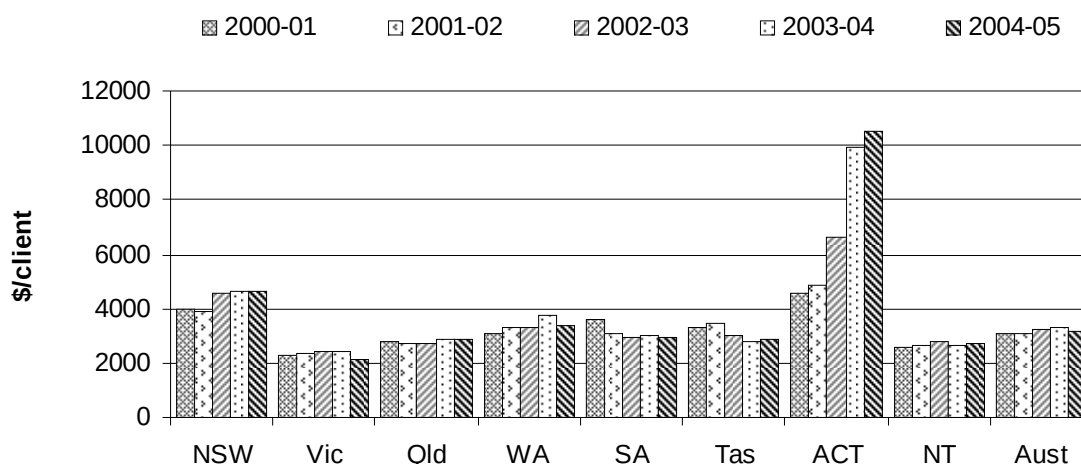
This indicator is defined as total expenditure on SAAP services divided by the number of clients accessing a bed or place over the year.

A lower cost per client is desirable, but may also indicate lesser service quality.

Unit cost analyses include only expenditure by service delivery providers. Unit cost indicators should also include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the Commonwealth State Housing Agreement through a special purpose program (the Crisis Accommodation Program).

Nationally, the recurrent cost per client accessing SAAP services was \$3190 and varied across jurisdictions in 2004-05 (figure 15.26).

Figure 15.26 **Real recurrent cost per client accessing SAAP services (2004-05 dollars)^a**



^a See notes to table 15A.180 for detailed data caveats.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.180.

Cost per day of support

‘Cost per day of support’ is an output (efficiency) indicator of SAAP services (box 15.36).

Box 15.36 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. This indicator provides a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost).

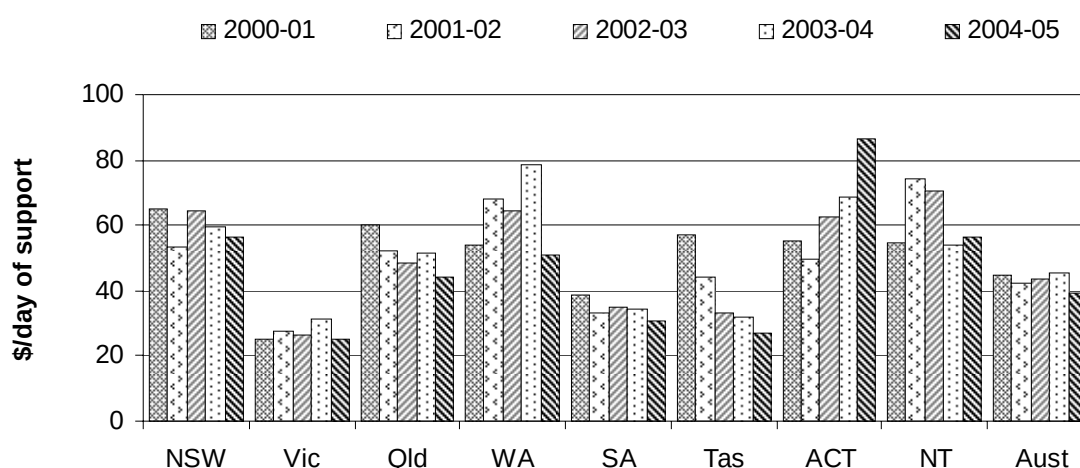
This indicator is defined as total expenditure on SAAP services divided by the number of days of support for SAAP clients receiving support and/or supported accommodation (excluding casual and potential clients, and accompanying children).

A lower ‘cost per day of support’ is desirable, but may also indicate lesser service quality.

Unit cost analyses include only expenditure by service delivery providers. Unit cost indicators should include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the Commonwealth State Housing Agreement through a special purpose program (the Crisis Accommodation Program).

The recurrent cost per day of support for SAAP clients averaged \$39 nationally and varied across jurisdictions in 2004-05 (figure 15.27).

Figure 15.27 Real recurrent cost per day of support for homeless clients (2004-05 dollars)^a



^a See notes to table 15A.181 for detailed data caveats.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.181.

Accommodation load and caseload

‘Accommodation load’ and ‘caseload’ are output (efficiency) indicators of SAAP services (box 15.37).

Box 15.37 Accommodation load and caseload

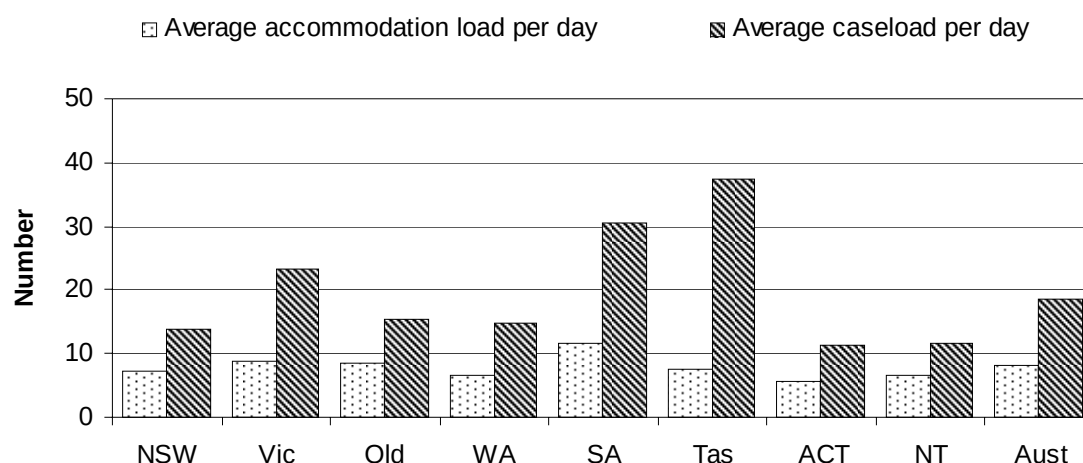
‘Accommodation load’ and ‘caseload’ are indicators of governments’ objective to maximise the availability and quality of services through the efficient use of taxpayer resources. Average accommodation load and caseload are output indicators of efficiency, and they indicate levels of output by agencies.

The average accommodation load is defined as the average number of people accommodated per day per agency. The average caseload is defined as the average number of people being supported per day per agency.

Higher loads may mean greater efficiency or, alternatively, a lesser quality service. Accommodation load and caseload are likely to be affected by the size of the agencies funded under the SAAP Program.

In 2004-05, the national average daily accommodation load and caseload per agency were 8.1 and 18.5 respectively, and this efficiency output varied across jurisdictions (figure 15.28).

Figure 15.28 Average accommodation load and caseload per day, 2004-05^a



^a See notes to table 15A.182 for descriptions of how accommodation load and caseload were estimated.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.182.

Outcomes

An important outcome of SAAP services is clients' achievement of self-reliance and independence. Characteristics that may indicate whether clients can live independently include their income, housing status and workforce status. These characteristics are recorded at the end of a client's support period.

Achievement of independent living

'Achievement of independent living' is an outcome indicator of SAAP services. Data are reported separately for clients' success in achieving independent housing and employment (box 15.38).

Box 15.38 Achievement of independent living

'Achievement of independent living' 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. Two indicators of independent living are reported: achievement of independent housing and achievement of employment.

Achievement of independent housing is defined as the number of clients achieving independent housing at the end of a support period, divided by the total number of completed support periods.

Achievement of employment is defined as the number of SAAP clients who were unemployed before SAAP support, but achieved employment after SAAP support, divided by the total number of clients who were unemployed before SAAP support.

These two indicators relate to relatively short term outcomes — that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but more difficult to measure.

Higher proportions of these achievements are desirable.

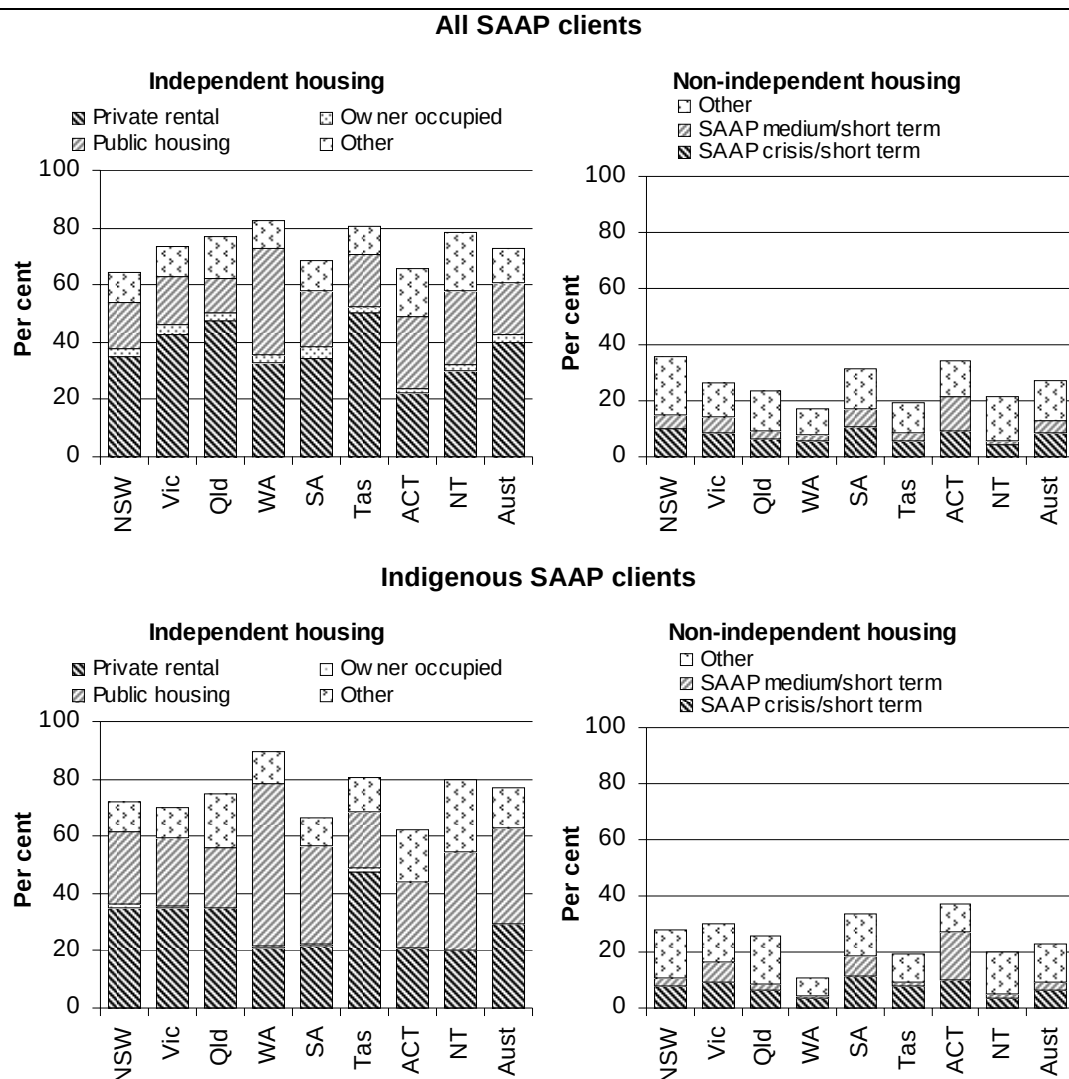
Independent living — housing

Nationally, 72.6 per cent of clients achieved independent housing at the end of a support period in 2004-05. This included clients who moved or returned to private rental housing (40.0 per cent), to public housing (18.1 per cent), and those in owner occupied housing (3.0 per cent) (figure 15.29).

Among Indigenous clients, on a national basis, 77.0 per cent achieved independent housing at the end of a support period in 2004-05, including those who moved or returned to private rental housing (29.1 per cent), to public housing (33.4 per cent), and to owner occupied housing (0.6 per cent) (figure 15.29).

Clients who did not achieve independent housing at the end of a support period in 2004-05 included those who moved to, or continued to live in, short to medium term SAAP accommodation and other forms of non-independent accommodation (figure 15.29).

Figure 15.29 Accommodation type on exit from SAAP support, 2004-05^a



^a 'Other' independent housing may include living rent free in a house or flat. 'Other' non-independent housing may include: SAAP funded accommodation at hostels, hotels or community placements; non-SAAP emergency accommodation; car, tent or squat; and an institutional setting.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); tables 15A.183-184.

Independent living — employment

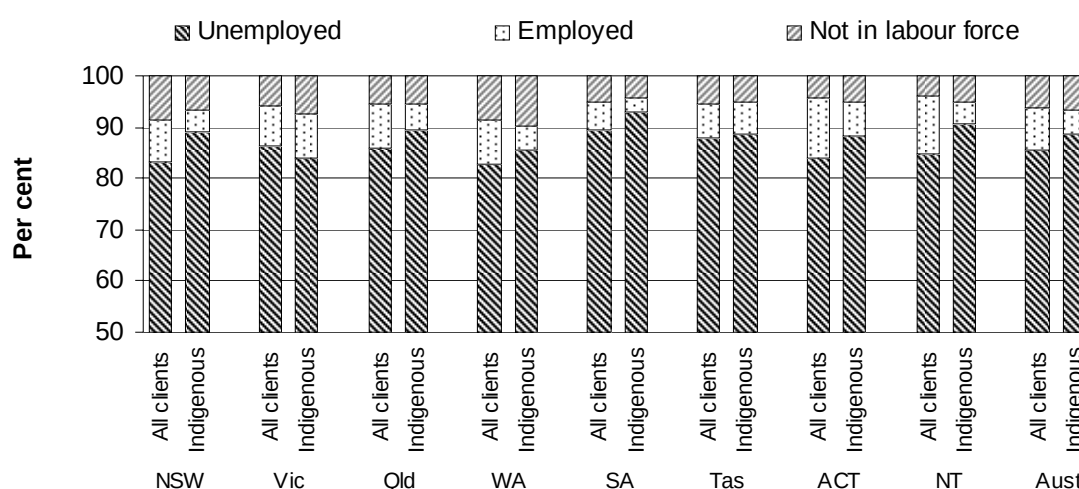
Nationally, 9.0 per cent of support periods in 2004-05 involved clients who were employed before support, while 26.6 per cent involved clients who were previously unemployed. These proportions varied across jurisdictions (table 15A.185).

Of the clients who were unemployed when entering SAAP, approximately 8.1 per cent were employed at the end of the support period (2.7 per cent full time, 1.7 per cent part time and 3.8 per cent on a casual basis), 85.5 per cent remained

unemployed and 6.4 per cent were not in the labour force (figure 15.30 and table 15A.186).

Among Indigenous clients who were unemployed when entering SAAP in 2004-05, about 4.8 per cent were employed at the end of the support period (1.4 per cent full time, 1.1 per cent part time and 2.2 per cent on a casual basis), 88.7 per cent remained unemployed and 6.5 per cent were not in the labour force (figure 15.30 and table 15A.187).

Figure 15.30 Changes in labour force status after SAAP support, by Indigenous status 2004-05^a



^a Data are for people who were unemployed when entering SAAP services.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); tables 15A.186-187.

Not returning to SAAP services within the year or six months

‘Not returning to SAAP services within the year or six months’ is an outcome indicator of SAAP services (box 15.39).

Box 15.39 Not returning to SAAP services within the year or six months

'Not returning to SAAP services within the year or six months' is an indicator of governments' objective to enable clients to participate independently in society at the end of their support period.

Two indicators of not returning to SAAP services are reported: achieving long term self-reliance and independence and achieving medium term independence.

Achieving long term self-reliance and independence is defined as the number of clients not returning to SAAP services within the year, divided by the total number of SAAP clients.

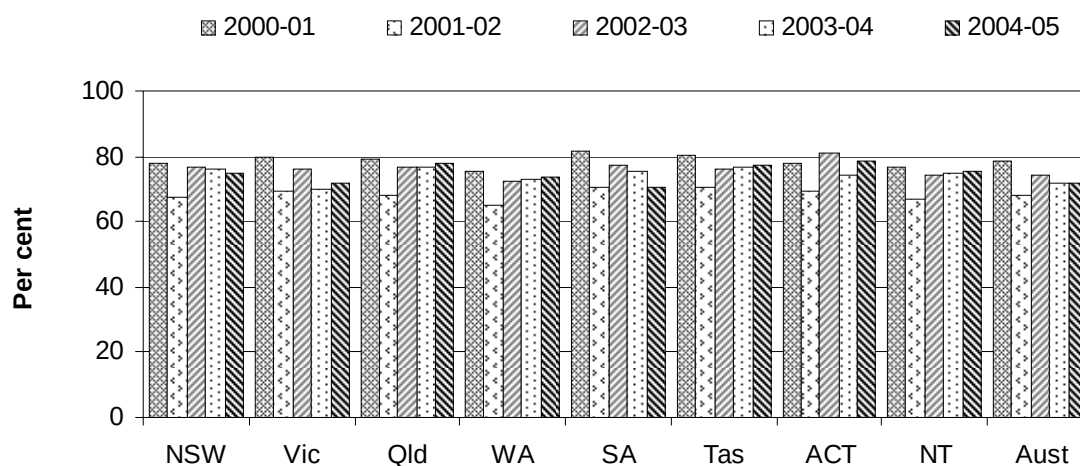
Achieving medium term independence is defined as the number of clients who exit to independent housing and do not return to SAAP within six months, divided by the total number of SAAP clients.

A higher proportion of clients not returning to the program within the year or six months 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.

Nationally, 71.9 per cent of SAAP clients who exited a SAAP service during 2004-05 did not return to a SAAP agency within the year (figure 15.31). The proportion for Indigenous clients was similar (70.8 per cent) (table 15A.189).

Figure 15.31 Proportion of former clients who did not return to a SAAP service within 12 months of exiting the program^a



^a Data from 2001-02 are based on estimated support periods per client, rather than on observed support periods per client as reported in previous Reports.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.188.

Estimates of clients exiting SAAP support to independent housing and not returning to SAAP within six months are affected by the data issues discussed in box 15.29. Current estimates may not represent all clients — for example, at the national level, only 62.3 per cent of clients provided information on their accommodation after exiting at least one support period in 2004-05 (table 15.1). Given the potential for data bias, these estimates should be interpreted with care.

Table 15.1 Indicative estimates of clients who exited SAAP to independent housing and did not return within six months, 2004-05^a

Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Clients who provided information on accommodation after exit from support									
no.	13 100	25 300	9 000	5 200	4 800	2 200	900	1 900	62 500
As a proportion of total clients									
%	57.0	72.5	54.2	61.2	53.9	51.2	64.3	67.9	62.3
Clients recorded as exiting to independent accommodation and not returning within six months									
no.	5 300	12 500	3 700	2 500	1 700	1 200	400	1 100	28 400
Indicative estimates of clients exiting to independent housing and not returning within six months									
%	40.5	49.4	41.1	48.1	35.4	54.5	44.4	57.9	45.4

^a See notes to table 15A.190 for more details of how the estimates were calculated and data caveats.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.190.

Strategies are being implemented to improve the quality of these data, including improving client consent rates and the collection of exit information. It is

anticipated that eventually data will be sufficiently robust to allow comparative performance assessment.

Exit with income

‘Exit with income’ is an outcome indicator of SAAP services (box 15.40).

Box 15.40 Exit with income

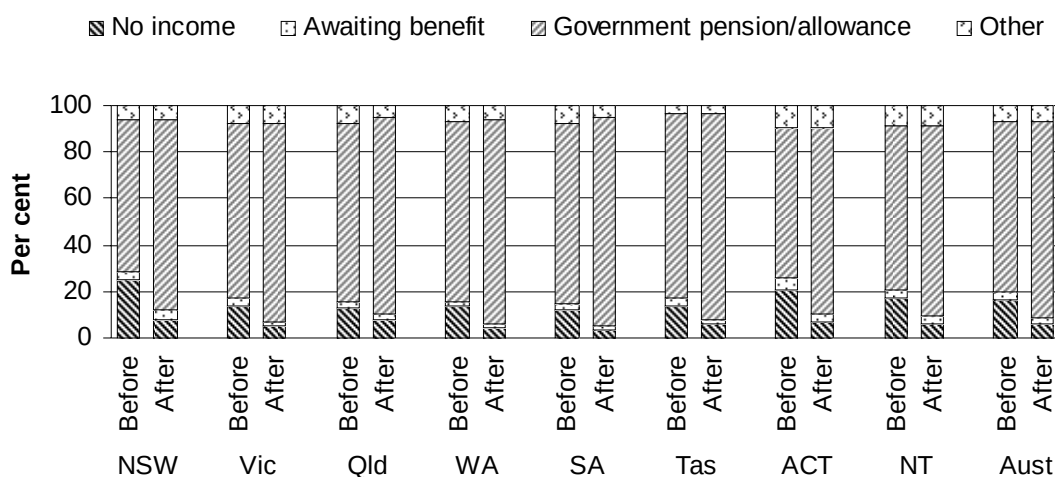
‘Exit with income’ is an indicator of governments’ objective to enable clients to participate independently in society at the end of their support period. A client’s independence and self-reliance is enhanced when the client experiences a positive change in income source (for example, from having no income support to obtaining some income, including wages and/or benefits) on exit from SAAP services.

This indicator is defined as the number of clients who requested income assistance and exited SAAP with an income source, divided by the total number of clients who requested income assistance.

A higher proportion of clients who requested income assistance and exited SAAP with an income source is desirable.

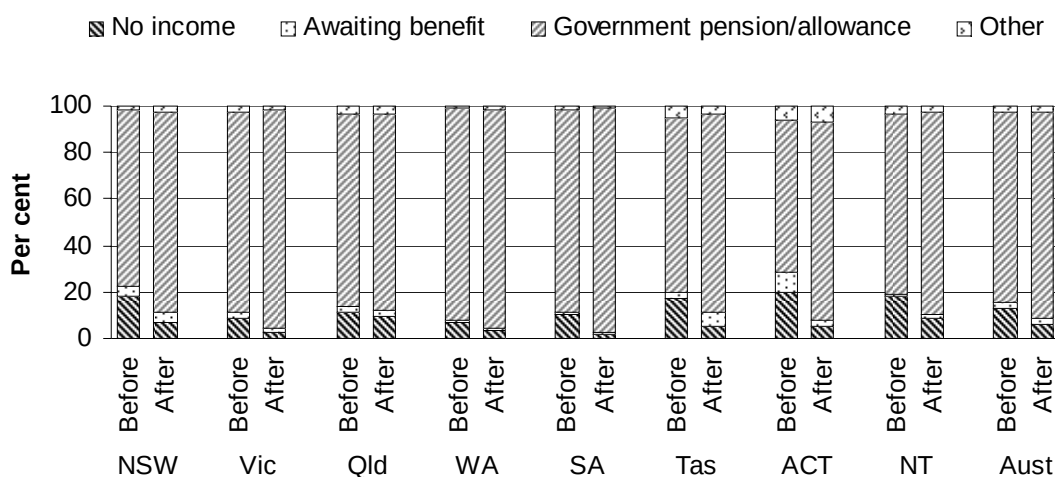
Nationally, the proportion of clients who did not have income and requested income assistance was 6.1 per cent after SAAP assistance in 2004-05 — a 10.1 per cent decrease from 16.2 per cent before SAAP assistance (figure 15.32). The proportion of Indigenous clients who did not have income and requested income assistance also decreased after SAAP assistance nationally (5.9 per cent compared with 12.6 per cent before SAAP assistance) (figure 15.33). Both before and after the SAAP assistance, the income source for the majority of SAAP clients is a government pension/allowance (figures 15.32 and 15.33).

Figure 15.32 Source of income immediately before/after SAAP support of clients who needed assistance to obtain/maintain a pension or benefit, 2004-05



Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.191.

Figure 15.33 Source of income immediately before/after SAAP support of Indigenous clients who needed assistance to obtain/maintain a pension or benefit, 2004-05



Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.192.

Goals achieved on exit from service

‘Goals achieved on exit from service’ is an outcome indicator of SAAP services (box 15.41). Data for this indicator are included for the first time in this Report.

Box 15.41 Goals achieved on exit from service

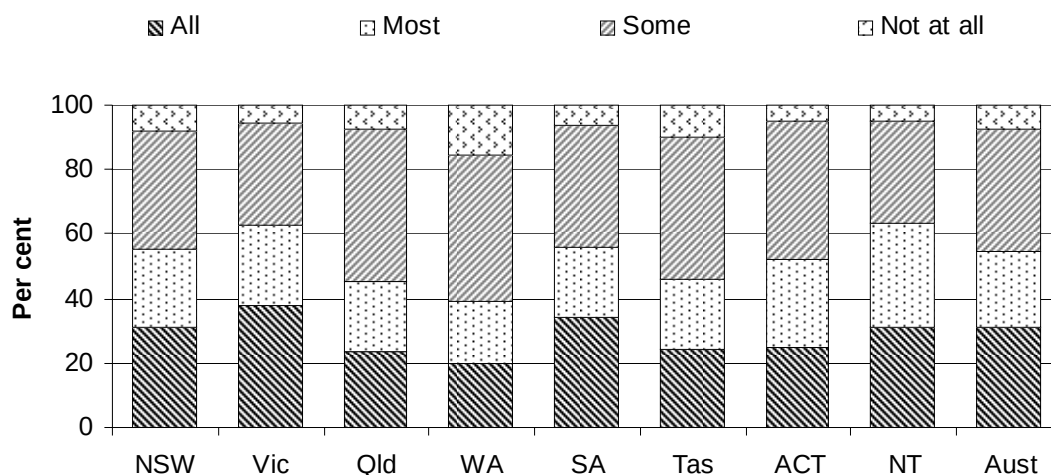
'Goals achieved on exit from service' is an indicator of governments' objective to ensure SAAP services meet the needs and expectations of users.

This indicator is defined as the number of clients whose case management goals are fully or mostly achieved by the end of the support period, divided by the total number of clients with case management goals in a given period.

A high proportion of achieved goals is desirable.

Nationally, case management goals were fully or mostly achieved by the end of the supported period for 54.8 per cent of clients in 2004-05 (figure 15.34).

Figure 15.34 Goals achieved on exit from SAAP services, 2004-05



Source: SAAP NDCA Client and Administrative Data Collections (unpublished); table 15A.193.

15.8 Future directions in supported accommodation and assistance performance reporting

Developing measures for client satisfaction and SAAP outcomes

'Client satisfaction' is an important indicator of quality. A national SAAP client satisfaction survey was conducted in 2003, and results from the survey were first used for SAAP performance reporting in the 2005 Report. Similar surveys to measure the level of SAAP client satisfaction are expected to be conducted in future and results will be reported when available.

Further development of outcome measures for SAAP services, in particular measuring self-reliance and independence of SAAP clients, is also in progress. This will provide opportunities for further reporting of outcome indicators for SAAP services in future Reports.

Improving data and information collection

A new SAAP core data set (CDS) was introduced on 1 July 2005. The new CDS contains revised questions to improve data quality and a new statistical linkage key which is used in a number of other national data sets. The statistical linkage key will facilitate linkage with other national data, particularly for longitudinal data analyses.

The SAAP Management and Reporting Tool (SMART) was upgraded at the same time as the new CDS. The SMART is currently used by over 55 per cent of SAAP agencies for electronic data collection. With built-in data collection and security settings as well as customised functions for users, the upgraded software will enable agencies to manage activities more efficiently and improve the coverage and quality of SAAP data for future Reports. The software will be further developed and expanded to be a full case management tool for SAAP agencies.

Enhanced SAAP performance reporting

SAAP performance reporting has been progressively streamlined and improved over the life of the SAAP IV agreement. Enhanced performance reporting will be incorporated in the SAAP V agreement and will be an important source of information on SAAP performance for future Reports.

15.9 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

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2004-05 was the last year of the fourth Supported Accommodation Assistance Program Agreement (SAAP) between the Australian Government and the states and territories. The Australian Government has provided \$175 million to SAAP in 2004-05 and \$833 million over the five years of SAAP IV to 2004-05. Total Australian and State and Territory funding under SAAP IV was \$1.4 billion.

During 2004-05 the report of the evaluation of SAAP IV was presented to the Community Services ministers. The evaluation found SAAP IV to be an effective, appropriate and efficient program. Subsequently, the Australian Government in partnership with the States and Territories worked on the development of the next iteration of SAAP, the SAAP V Agreement. The SAAP V multilateral agreement was signed in October 2005 and it incorporates a new performance framework. Development work in 2004-05 led to the determination of three priorities under SAAP V: pre-crisis intervention, improved linkages, and better post-crisis transition support.

Work was also undertaken to introduce a new SAAP data set including the Statistical Linkage Key, and improved information systems for agency data reporting and performance and outcome measurement. During the year, a number of large research projects were completed which shed light on major issues facing agencies such as measurement of client satisfaction and measurement and assessment of the complex needs of SAAP clients. A number of other small research projects have informed SAAP of the characteristics, needs of clients and agency practice at regional and local level.

In 2004-05 the Australian Government committed \$10.4 million in new funding for the Household Organisational Management Expenses (HOME) Advice Program. This program builds on the success of the Family Homelessness Prevention Pilots. This pilot has delivered very strong results for families at risk of becoming homeless.

In 2004-05, almost 4700 young people were assisted through Reconnect services. Reconnect is an Australian Government program which assist young people who are homeless or at risk of being homeless. The aim of this early intervention program is to improve the level of engagement of homeless young people aged between 12 and 18, or those at risk of homelessness, with their family, with work, with education or training and with the community.

Also in 2004-05, almost 800 young people received the Transition to Independent Living Allowance (TILA). TILA is a one-off allowance of up to \$1000 in goods and services for young people exiting care, exiting juvenile justice, Indigenous kinship care, or other informal out-of-home care arrangements and who are moving to independent living.

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New South Wales Government comments

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Child protection and supported placements

In 2004, the Department of Community Services (DoCS) commenced a review of the Interagency Guidelines for Child Protection Intervention under the auspices of a Child Protection Senior Officers Group. The Guidelines form a foundation for good cross-agency practice in child protection in NSW and are well recognised and embedded in the practitioner community. The new Guidelines which are scheduled for completion in mid-2006 will take account of the new focus on prevention and early intervention as well as the significant growth in demand for child protection services.

In 2004-05 DoCS continued its program of research and development and design of improved models of care and support to better address the needs of children and young people in out-of-home care (OOHC). Enhancements include funding of additional intensive foster and residential care placements for children and young people with high needs, and recruitment of additional caseworkers and psychologists for Intensive Support teams for children and young people with high needs. Additional funds were allocated this year to expand foster care services for Aboriginal children and young people. Funding was provided to the Social Policy Research Centre for their Availability of Foster Carers report, and My Life Story Book was published and distributed for use with children in OOHC.

The business process for the inter-country adoption program was streamlined and cost recovery was introduced. The accreditation provision for inter-country and local adoption providers was put in place.

Supported Accommodation Assistance Program (SAAP)

In 2004-05 the key focus in NSW was on completing initiatives identified in the SAAP IV Agreement. These included a review of the Parramatta Men's Coalition and the Reconfiguration of Inner City of Sydney SAAP Services. The ongoing SAAP reform project in NSW accomplished new models of service, moving away from institutionalised care and placing stronger emphasis on retaining skills and encouraging self reliance through an independent living model at Campbell House.

SAAP provided funding for the commencement of the Domestic Violence Intervention Court Model strategy, in South West Sydney and Wagga. The funding was used to employ advocates to support and work with victims referred by Police. An evaluation of four safe houses in Orana Far West and Bourke Women's Refuge commenced in partnership with the Aboriginal community.

Negotiation of the SAAP V Multi-lateral Agreement has been a high priority. The new Agreement requires focus on the core issues of financial viability in the service system, and improved pre and post crisis support and service linkages. The Multilateral Agreement commenced on 30 November 2005. Focus will now shift to negotiating a Bilateral Agreement to be implemented by the end of January 2006.

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Victorian Government comments

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Child protection and supported placements

Legislation is currently passing through the Victorian Parliament that continues the child and family reform process commenced in 2002. This reform process has three aims: First to provide more assistance to families earlier so that the need for subsequent child protection involvement is diminished. Second, where children cannot remain in their parent's care, to put in place concerted efforts to reunite them safely with their family. Finally, where children cannot safely return home, to work to maximise stability for the child. The proposed legislation places children's best interests at its core and puts in place a range of measures designed to improve outcomes for children. These include:

- mechanisms to support strengthened earlier intervention
- stability planning requirements and timelines
- mechanisms to promote Aboriginal children's cultural and spiritual identity and development by, wherever possible, maintaining and building their connections to their Aboriginal family and community.

Informed by contemporary research on the child's development, Victoria's reform process is producing pleasing results with demand for front-end child protection services (notifications, investigations and substantiations) stabilising in recent years.

Supported Accommodation Assistance Program (SAAP)

Victoria has continued to implement new directions for the provision of homelessness assistance under the Victorian Homelessness Strategy during 2004-05. 34 900 people were provided with assistance through SAAP services. In addition, Housing Information and Referral services, accommodation through over 3500 transitional properties and Housing Establishment Funds (\$6.7 million), were also provided to people who are homeless or at risk of homelessness. A number of homelessness agencies undertook a trial of the Homelessness Assistance Standards prior to their finalisation for implementation across the sector during 2005-06.

Activities under the Youth Homelessness Action Plan continued to be implemented including four demonstration projects aimed at addressing the needs of young people who are homeless and parenting, same sex attracted young people, young people who self harm and accommodation models for young Indigenous people. The support for young Indigenous people leaving care was also implemented.

The Housing and Community Building Division in conjunction with Department of Victorian Communities, Department of Justice, Victoria Police and Office for Children were successful in gaining funding (\$35.1 million over four years) to implement the Integrated response to family violence from 2005-06.

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Queensland Government comments

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Child protection and supported placements

Since the establishment of the new Department of Child Safety in September 2004, 85 of the 110 Crime and Misconduct Commission recommendations and 14 of the Foster Care Audit recommendations have been fully implemented.

Greater access to support for carers and children in care with complex and extreme needs has been provided through enhanced therapeutic and support services with funding allocated for 140 and 220 new or enhanced alternative care places in 2004-05 and 2005-06 respectively. A suite of Structured Decision Making tools and an accompanying Child Safety Practice Manual have been introduced to promote consistent practice and improve child safety outcomes in Queensland. Further legislative reforms were passed by Parliament in August 2005 with these amendments due to commence no later than April 2006. Key amendments relate to regulation of voluntary placements and carers, refinement of the Indigenous child placement principle, and Indigenous entity consultation.

The Suspected Child Abuse and Neglect (SCAN) team system has been strengthened with membership now including core representation from the Departments of Child Safety (Lead agency), Queensland Health, Education and the Arts, Queensland Police Service and a recognised Aboriginal and Torres Strait Islander entity. Twenty SCAN teams are now operational around the State.

Supported Accommodation Assistance Program (SAAP)

Data in the 2006 Report reflect a general picture in Queensland of population growth, and increased demand for SAAP services. They also reflect the lack of additional SAAP funding to meet this need. Queensland's small share of Commonwealth SAAP funding has meant that Queensland's SAAP expenditure per person in the residential population is the lowest of any jurisdiction. The Queensland Government has responded by increasing its commitment to SAAP by more than 50 per cent (\$55 million in new funding for SAAP over the course of SAAP V).

This includes funding for a statewide information and referral service, integrated service hubs, early intervention services and additional accommodation for homeless families, young people and clients with complex needs — consistent with the new strategic directions for SAAP. Queensland will work with the Australian government and jurisdictions on indicator development, evaluation and reporting frameworks for these new services and strategic directions.

The Report also indicates continued high levels of access of SAAP services by Indigenous people and people from Culturally and Linguistically Diverse communities. It also shows that the SAAP services system is responding to this increased demand. Responsiveness by Queensland SAAP services to client need will be further enhanced through SAAP V through the implementation of Community Service Standards and Accreditation system.

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Western Australian Government comments

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Child protection and supported placements

The Department for Community Development is planning for the implementation of the *Children and Community Services Act 2004* and the *Working with Children (Criminal Record Checking) Act 2004* in 2006.

The *Children and Community Services Act 2004* supports a model that recognises the capacity of families to care safely for their children and provides a strong framework of intervention for children who are in need of protection.

The Department is currently exploring with indigenous communities a capacity building approach to child protection, a central element of which is the valuing of relationship based practice.

The implementation of a Central Carer Register ensures Department and funded agency carers are appropriately screened, assessed and registered. Mandatory preparation training for all general and relative foster carers was introduced.

Independent consultants were engaged to quality assure the systems, processes and practices aimed at protecting children in care. The report highlighted significant strengths as well as areas where improvements were required. The Government's response *Protecting Children in Care: A Way Forward* identifies the actions taken to enhance the safety and well being of children in care.

Supported Accommodation Assistance Program (SAAP)

2004-05 was the final year of the SAAP IV Agreement. The negotiation of the SAAP V Multilateral Agreement between the State and Australian Government was a significant process in 2004-05.

The Department initiated a number of projects during 2004-05 including:

- SAAP V Project to better understand cost pressures and sector trends affecting existing SAAP services over an extended period
- a project to investigate the use of support plans and extent of implementation of SAAP Service Standards
- a project to improve access for people with diverse sexuality and gender identity in SAAP services is providing training, support, resources and coaching and will be visiting a number of metropolitan and country locations across WA
- a review of four funded services for young people in the Perth inner city area to ensure the most appropriate mix of services is available to meet the needs of at risk young people, resulting in changes to ensure services are delivered effectively to young people who are homeless or at risk of homelessness.

The SAAP State Advisory Committee conducted four regional forums to better understand issues and service delivery needs across the State and completed two major reports on services for children in SAAP and how services meet the needs of clients with high and complex needs.

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South Australian Government comments

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Child protection and supported placements

South Australia's Keeping them Safe child protection reform agenda has facilitated an across-government commitment to supporting children, young people and their families, and to providing effective, appropriate interventions, reforming work practices and culture, establishing collaborative partnerships and improved accountability across government.

In 2004-05, significant progress on the reform agenda has been achieved through strengthening collaboration and cooperation across government departments. Amongst the new initiatives are the 'Strong Families, Safe Babies' intervention project for high risk infants, therapeutic and counselling treatment services for children, an additional ten emergency care houses, and a process of ensuring timely responses to the needs of children under the Guardianship of the Minister (the Rapid Response across-government agreement).

Amendments to the *Children's Protection Act, 1993* (the Keeping them Safe Bill) have been drafted. The proposed amendments contain new objects and principles to reflect a stronger focus on the child. The Bill provides for building community capacity to protect children through child safe environments, and extends the interpretation of 'at risk' to more truly reflect the extent of harm to a child. The Bill formalises mechanisms for independent monitoring and review of the care and protection system to help safeguard the interests of children.

Supported Accommodation Assistance Program (SAAP)

A comparative evaluation of transitional accommodation property management models was completed in June 2005. Consideration of the recommendations and appropriate service response is being undertaken by the Housing Management Council.

With the changes to the SAAP National Data Collection and the introduction of a core data set and a more robust statistical linkage key effective from 1 July 2005, a number of Familiarisation Sessions were conducted by the SAAP National Data Collection Agency (NDCA) in Adelaide. Ongoing discussions are being held with assessment and referral agencies in order to maximise their participation in the data collection.

South Australia has been involved in the SAAP NDCA's efforts to enhance the usefulness of electronic data collection instrument for agencies.

In conjunction with the University of South Australia a research project on 'Getting out and staying out: Pathways to independent living: best practice, critical interventions and strategies for addressing homelessness in South Australia' was completed and funded by the Department through AHURI Southern. Detailed analysis of SAAP data complemented this research.

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Tasmanian Government comments

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Child protection and supported placements

On 31 March 2005 Tasmania proclaimed the *Family Violence Act 2004*. The introduction of the legislation has significantly increased notifications from Tasmania Police as it has amended the definition of a child at risk of abuse and neglect to include a child affected by family violence.

A number of initiatives have been progressed during the financial year. These include further development of an information management system to record details of notifications and investigations; the introduction of Step by Step, the NSW assessment framework, and Shared Stories, Shared Lives, a complementary training package for carers, the development of a formal kinship care program, introduction of cottage care, the development of an information kit for young people leaving care, and ongoing implementation of Looking After Children.

These initiatives were informed by a report that was published by the Ombudsman's Office in November 2004 on a review of claims made by adults that they were abused while in State care as children. The purpose of the review was to acknowledge the experiences of claimants in State care. This involved an assessment of claims as well as the provision of support, counselling services, access to personal files and in some instances provision of ex gratia payments.

Supported Accommodation Assistance Program (SAAP)

During 2004-05, the final year of the initial SAAP IV agreement, Tasmania commissioned a consultant to undertake a Tasmanian Evaluation of SAAP IV. The evaluation will both review what has been achieved over the term of SAAP IV, what remains outstanding, what requires further development, and what were the unanticipated outcomes, and will help position Tasmania to address homelessness in this state in the post SAAP-IV environment. The final report from the consultant was provided in November 2005.

The State commenced work on a Homelessness Pathways project. This has brought together extensive information from Australian and international literature regarding how people become homeless. The project has identified common pressure points where people are likely to become homeless and has involved consultations with a wide range of service systems to establish whether the identified pressure points are valid in the Tasmanian context, to confirm the extent of the activity in this regard, and to identify any significant gaps in the existing service systems within the State.

In continuing to improve the standard of service delivery Tasmania is undertaking a project to implement the Quality Improvement Council's core organisational standards within SAAP services.

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Australian Capital Territory Government comments

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Child protection and supported placements

The 2004-05 period has seen a significant increase in the number of child protection reports received, as well as an increase in the demand for out-of-home care placements. To meet this increased demand, new funding agreements for foster care agencies have been established, and a greater range of residential services for children have been developed.

During the period, the ACT Government continued with implementation of the recommendations and reforms agreed to in the Government response to The Territory as Parent – Review of the Safety of Children in Care in the ACT and of ACT Child Protection Management (25 May 2004). Some of the achievements of the implementation to date include:

- establishment of a new Office for Children Youth and Family Support (Office) structure (within the Department of Disability, Housing and Community Services) that aligns functions and client groups. This new Office has been centralised into one metropolitan location.
- the Office has recruited a number of experienced, professional child protection workers, more than doubling the number of frontline workers.
- on 3 January 2005, the Department established the Institute for Child Protection Studies – a partnership between the Office and the Australian Catholic University to promote best practice in the care and protection of children and young people in the ACT.

Supported Accommodation Assistance Program (SAAP)

The ACT Government continued to strengthen its response to homelessness in 2004-05, providing a recurrent funding allocation of \$381 000 (indexed over three years) to the Canberra Emergency Accommodation Service. This initiative, in addition to ACT Government funding of \$3.1 million (from the 2003-04 allocation of \$13.4 million over four years), increased ACT Government funding to the SAAP by 86 per cent.

Innovation and sector reform were ongoing features of the period, as the implementation of Breaking the Cycle — the ACT Homelessness Strategy facilitated cross-sectoral links and service collaboration. Reform of Ainslie Village, the ACT's largest and most expensive SAAP provider continues, with the site transitioning to a community housing model which better reflects the site's provision of longer-term accommodation.

Housing affordability in the ACT places particular pressures on the public housing system, with lengthy waiting periods for priority allocation impacting on people's transition from SAAP. Length of support periods are affected accordingly, although a longer period of support contributes to a more effective outcome for clients, as they are supported to resolve the causal and consequential factors of their homelessness.

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Northern Territory Government comments

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Child protection and supported placements

The Northern Territory Government continued the development of the Family and Children's Services Reform Agenda in 2005. Increased funding commenced in December 2003 with the intent of improving child protection services and systems over a period of 5 years. Parts of the increased funds have been used to build on the child protection workforce and to ensure quality of care for children in out-of-home care. The tailoring of services to some of the highest needs children in out-of-home care by means of a specialist carer model has also commenced.

Other initiatives resulted in the employment of additional Indigenous apprentices and cadets to further strengthen the Indigenous Family and Children's Services workforce.

A new Intensive Family Preservation service commenced in July 2005, providing intensive family support to 30 families annually. It will provide a strengths based model as a strategy to keep families together and prevent admissions to the Out of Home care system.

Supported Accommodation Assistance Program (SAAP)

This year saw the continuing consolidation of SAAP IV and integration with other Northern Territory cross government initiatives including the Community Harmony Project and the Northern Territory Domestic and Aboriginal Family Violence Strategy.

The trend of Indigenous people being over represented in SAAP in the Northern Territory has not changed. More than 80 per cent of clients receiving assistance from refuges for women and children escaping family violence were Indigenous women with the exception of one service in Darwin where more than 50 per cent were Indigenous.

In recognition of the damage caused to children who witness family violence Women's refuges are increasingly developing programs for children.

Interestingly one youth service in Darwin has identified an increase in the number of young families presenting with only 58 per cent of their clients presenting as single people. The rest were either couples with or without children, sole parents or other family structures.

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15.10 Definitions of key terms and indicators

Child protection and out-of-home care services

Care and protection orders

Legal orders or administrative/voluntary arrangements involving the community services department, issued in respect of an individual child who is deemed to be in need of care and/or protection. Community services department involvement may include:

- total responsibility for the welfare of the child (for example, guardianship)
- responsibility for overseeing the actions of the person or authority caring for the child
- responsibility for providing or arranging accommodation, or reporting or considering the child's welfare.

The order may have been from a court, children's panel, minister of the Crown, authorised community services department officer or similar tribunal or officer.

Care and protection orders are categorised as:

- finalised guardianship and finalised custody orders sought through a court
- finalised supervision and other finalised court orders that give the department some responsibility for the child's welfare (excluding interim orders)
- interim and temporary orders (including orders that are not finalised)
- administrative or voluntary arrangements with the community services department, for the purpose of child protection.

Children are counted only once, even if they are on more than one care and protection order.

Child

A person aged 0–17 years.

Child at risk

A child for whom no abuse or neglect can be substantiated but where there are reasonable grounds to suspect the possibility of prior or future abuse or neglect, and for whom continued departmental involvement is considered warranted.

Child concern reports

Reports to community services departments regarding concerns about a child, as distinct from notifications of child abuse and neglect. The distinction between the two differs across and within jurisdictions.

Children in out-of-home care during the year

The total number of children who are in at least one out-of-home care placement at any time during the year. A child who is in more than one placement is counted only once.

Exited out-of-home care

Where a child does not return to care within two months.

Family based care

Home-based care (see 'placement types').

Family group homes	Residential child care single dwelling establishments that have as their main purpose the provision of substitute care to children. They are typically run like family homes, with a limited number of children who eat together as a family group and are cared for around the clock by resident substitute parents.
Foster care	Care of a child who is living apart from his or her natural or adoptive parents in a private household, by one or more adults who act as 'foster parents' and are paid a regular allowance by a government authority or non-government organisation for the child's support. The authorised department or non-government organisation provides continuing supervision or support while the child remains in the care of foster parents.
Foster parent	Any person (or such a person's spouse) who is being paid a foster allowance by a government or non-government organisation for the care of a child (excluding children in family group homes).
Guardian	Any person who has the legal and ongoing care and responsibility for the protection of a child.
Indigenous person	Person of Aboriginal or Torres Strait Islander descent who identifies as being an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he or she is associated. If Indigenous status is unknown, then a person is considered to be non-Indigenous.
Investigation	An investigation of child abuse and neglect that involves identifying harm or risk of harm to the child, determining an outcome and assessing protective needs. It includes the interviewing or sighting of the subject child where practicable.
Investigation finalised	Where an investigation is completed and an outcome is recorded by 31 August.
Investigation not finalised	Where an investigation is commenced but an outcome is not recorded by 31 August.
Length of time in continuous out-of-home care	The length of time for which a child is in out-of-home care on a continuous basis. A return home of less than seven days is not considered to break the continuity of placement.
Non-respite care	Out-of-home care for children for child protection reasons.
Notification	Contact with an authorised department by persons or other bodies making allegations of child abuse or neglect, or harm to a child.
Other relative	A grandparent, aunt, uncle or cousin, whether the relationship is half, full, step or through adoption, and can be traced through or to a person whose parents were not married to each other at the time of the child's birth. This category includes members of Aboriginal communities who are accepted by that community as being related to the child.
Out-of-home care	Overnight care, including placement with relatives (other than parents) where the government makes a financial payment. Includes care of children in legal and voluntary placements (that is, children on and not on a legal order) but excludes placements made in disability services, psychiatric services, juvenile justice facilities and overnight child care services.

Placement types	Four main categories: • facility-based care (placement in a residential building where the purpose is to provide placement for children and where there are paid staff, including placements in family group homes) • home-based care (placement in the home of a carer who is reimbursed for expenses for the care of the child). The three subcategories of home-based care are foster care/community care, relative/kinship care and other • independent living (including private board) • other (including unknown).
Relatives/kin	Family members other than parents, or a person well known to the child and/or family (based on an existing relationship).
Respite care	Out-of-home care on a temporary basis for reasons other than child protection — for example, when parents are ill. Excludes emergency care provided to children who are removed from their homes for protective reasons.
Safety in out-of-home care	The proportion of children in out-of-home care who are the subject of a child protection substantiation, where the person believed responsible for the child abuse, neglect or harm is living in the household (or was a worker in a residential care facility).
Stability of placement	Number of placements for children who have exited out-of-home care and do not return within two months. Placements exclude respite or temporary placements lasting less than seven days. Placements are counted separately where there is: • a change in the placement type — for example, from a home-based to a facility-based placement • within placement type, a change in venue or a change from one home-based placement to a different home-based placement. A particular placement is counted only once, so a return to a previous placement is another placement.
Substantiation	Notification for which an investigation concludes there is reasonable cause to believe that the child has been, is being or is likely to be abused, neglected or otherwise harmed. It does not necessarily require sufficient evidence for a successful prosecution and does not imply that treatment or case management is, or is to be, provided.

Supported accommodation and assistance

Accommodation	Crisis or short term accommodation, medium term to long term accommodation, and other SAAP funded accommodation (which comprises accommodation at hostels, motels and hotels, accommodation in caravans, community placements and other SAAP funded arrangements).

Accommodation load (of agencies)	The number of accommodation days divided by the number of days for which the agency is operational during the reporting period, where the number of accommodation days equals the sum of accommodation days for all clients of an agency who are supported during the reporting period. The average accommodation load is the mean value of all agencies' accommodation loads. Support periods without valid accommodation dates are assigned the interquartile modal duration of accommodation for agencies of the same service delivery model in the same jurisdiction.
Agency	The body or establishment with which the State or Territory government or its representative agrees to provide a SAAP service. The legal entity has to be incorporated. Funding from the State or Territory government could be allocated directly (that is, from the government department) or indirectly (that is, from the auspice of the agency). The SAAP service could be provided at the agency's location or through an outlet at a different location.
Caseload (of agencies)	The number of support days (the sum of support days for all clients of the agency who are supported during the reporting period) divided by the number of days for which the agency is operational during the reporting period. The average caseload is the mean value of all agencies' caseloads. Support periods without valid support dates are assigned the interquartile modal duration of support for agencies of the same service delivery model in the same jurisdiction.
Casual client	A person who is in contact with a SAAP agency and receives one-off assistance for generally not more than one hour, and who does not establish an ongoing relationship with an agency.
Client	A person who receives supported accommodation or support.
Crisis or short term supported accommodation	Supported accommodation for periods of generally not more than three months (short term), and for persons needing immediate short term accommodation (crisis).
Cross-target/multiple/general services	SAAP services targeted at more than one primary client group category — for example, SAAP services for single persons regardless of their gender.
Day support	Support provided only on a walk-in basis — for example, an agency that provides a drop-in centre, showering facilities and a meals service at the location of the SAAP agency.
Homeless person	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: • 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. A person is also considered homeless if living in accommodation provided by a SAAP agency or some other form of emergency accommodation.

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.
Non-recurrent funds	SAAP funds received for non-recurrent purposes, such as funds for research, a special one-off project or replacement of capital items (for example, furniture and motor vehicles).
Non-SAAP accommodation places	Accommodation places in the form of permanent beds (owned or managed by the agency) that use funds other than SAAP funds.
One-off assistance	Assistance provided to a person who is not a client, such as the provision of a meal, a shower, transport, money, clothing, telephone advice, information or a referral.
Ongoing support period	A support period for which, at the end of the reporting period, no support end date and no after-support information are provided.
Other special characteristics	Primary or secondary characteristics that are not included in those of a service's primary client or group, or in other categories of the secondary client group — for example, a service specifically targeted at homeless persons with a disability.
Outlet	A premise owned/managed/leased by an agency at which SAAP services are delivered. Excludes accommodation purchased using SAAP funds (for example, at a motel).
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	The period that commences when a SAAP client establishes or re-establishes (after the cessation of a previous support period) an ongoing relationship with a SAAP agency. The support period ends when: • support ceases because the SAAP client terminates the relationship with the SAAP agency • 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. A support period is relevant to the provision of supported accommodation or support, not the provision of one-off assistance.
Supported accommodation	Accommodation provided by a SAAP agency in conjunction with support. The accommodation component of supported accommodation is provided in the form of beds in particular locations or accommodation purchased using SAAP funds (for example, at a motel). Agencies that provide accommodation without providing support are considered to provide supported accommodation.
Telephone information and referral	Support delivered via telephone without face-to-face contact. Support provided may include information and/or referral.
Total funding	Funding for allocation to agencies (not available at the individual client group level) for training, equipment and other administration costs.
Unmet demand	A homeless person who seeks supported accommodation or support, but is not provided with that supported accommodation or support. The person may receive one-off assistance.

**Women escaping
domestic violence
services**

Services specifically designed to assist women and women accompanied by their children, who are homeless or at imminent risk of becoming homeless as a result of violence and/or abuse.

**Youth/young
people services**

Services provided for people who are independent and above the school leaving age for the State or Territory concerned, and who present to the SAAP agency unaccompanied by a parent/guardian.

15.11 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 15A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2006\Attach15A.xls and in Adobe PDF format as \Publications\Reports\2006\Attach15A.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

All jurisdictions data

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PART G

HOUSING

16 Housing

Government plays a significant role in the Australian housing market, directly through housing assistance and indirectly through policies associated with land planning and taxation. The Australian, State and Territory governments share responsibility for housing assistance. Direct assistance includes public and community housing, home purchase and home ownership assistance, Indigenous housing, State and Territory rental assistance (such as State and Territory provided bond loans, guarantees and assistance with rent payments and advance rent payments, relocation expenses and other one-off grants) and Commonwealth Rent Assistance (CRA).

This chapter focuses on the performance of governments in providing public, Indigenous and community housing under the Commonwealth State Housing Agreement (CSHA) (box 16.1) and CRA. Close links exist between public and community housing services and other government programs and support services discussed elsewhere in the Report, such as:

- the Supported Accommodation Assistance Program (SAAP), which provides accommodation and other services for homeless people or those at imminent risk of becoming homeless (chapter 15)
- services delivered by the Australian, State and Territory governments and community organisations to promote independent living, including services for people with a disability (chapter 13), mental health services (chapter 11) and aged care services, such as the Home and Community Care program (chapter 12).

A profile of housing and housing assistance is presented in section 16.1. This provides the context for assessing the performance indicators presented later in the chapter. All jurisdictions have agreed to develop and report comparable indicators, and a framework of performance indicators is outlined in section 16.2. The data are discussed in section 16.3, and future directions for performance reporting are discussed in section 16.4. Jurisdictions' comments are reported in section 16.5 and definitions are listed in section 16.6. Section 16.7 lists the supporting tables for this chapter and section 16.8 lists references used in this chapter.

Box 16.1 Commonwealth State Housing Agreement

The CSHA is an agreement made between the Australian, State and Territory governments under the *Housing Assistance Act 1996* (Cwlth) to provide strategic direction and funding certainty for the provision of housing assistance. The aim of this agreement is to provide appropriate, affordable and secure housing assistance for those who most need it, for the duration of their need.

The 2003 CSHA came into effect on 1 July 2003 and will run until 30 June 2008, and includes bilateral agreements between the Australian Government and each State and Territory government and an overarching multilateral agreement. There are generally separate bilateral agreements for mainstream and Indigenous housing in each jurisdiction. Bilateral agreements are intended to provide greater flexibility for states and territories to respond to their particular housing needs.

A national ten year strategy to improve Indigenous housing, Building a Better Future, was agreed in 2001 by Australian, State and Territory ministers. State Indigenous Bilateral Agreements are the primary vehicle for implementing the national Building a Better Future strategy. The desired strategy outcomes are better housing and housing services, more housing, improved partnerships, greater effectiveness and efficiency, and improved performance linked to accountability and coordination of services.

Funding arrangements

The majority of funding under the 2003 CSHA is provided by the Australian Government, taking the form of general assistance funding (public housing, home purchase assistance and private rental assistance) and specified funding for identified programs: the Aboriginal Rental Housing Program (ARHP), the Crisis Accommodation Program (CAP) and the Community Housing Program. The majority of CSHA funding is distributed to State and Territory governments on a modified per person basis, with the State and Territory governments contributing additional funding from their own resources to partly 'match' Australian Government funding allocations.

Roles and responsibilities

Under the CSHA, the Australian Government has responsibility for:

- ensuring the outcomes pursued through the agreement are consistent with broader national objectives, particularly in relation to support for individuals and communities
- advising State and Territory governments of Australian Government objectives to be achieved under the agreement
- reporting to the Commonwealth Parliament on performance against agreed outcomes and targets of housing assistance provided under the agreement.

State and Territory governments have responsibility for:

- developing housing assistance strategies that are consistent with Australian, State and Territory government objectives and that best meet the circumstances of the state or territory
- developing, implementing and managing services and programs to deliver agreed outcomes
- reporting on a basis that enables performance assessment by the Australian, State or Territory governments, based on agreed performance indicators.

Source: CSHA (2003).

Public, community and State owned and managed Indigenous housing information has been obtained from the State and Territory governments, except where otherwise indicated. The Australian Institute of Health and Welfare (AIHW) collects and collates these data and produces annual data collection manuals and reports. The data manuals and data reports are available from the AIHW web site at www.aihw.gov.au (AIHW 2005d, 2005e and 2005f). Most non-financial data items for public rental housing and for State owned and managed Indigenous housing were compiled from unit record data under the National Housing Data Repository at the AIHW. CRA data were obtained from the Department of Family and Community Services (FaCS). Data on satisfaction, location and amenity were obtained from national social housing surveys of public housing, community housing and State owned and managed Indigenous housing (SOMIH) 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, Science and Training (DEST)
- the First Home Owners Grant, provided by the Australian Government and delivered through State and Territory governments
- some Indigenous housing and infrastructure assistance provided by Australian, State and Territory governments, land councils and Indigenous community organisations
- non-Indigenous community housing not funded under the CSHA
- home purchase assistance.

16.1 Profile of housing and housing assistance

Service overview

The Australian Bureau of Statistics (ABS) 2001 Census of Population and Housing (ABS 2002a) identified just under 7.1 million households in Australia, where 'household' is classified as a person living alone or as a group of related or unrelated people who usually reside and eat together. Of these households, 66.2 per cent owned or were purchasing their own home, 21.8 per cent rented in the private sector, 4.5 per cent were in public rental accommodation, and 2.8 per cent resided in other tenure types (table 16A.68). Due to non-response, Census data are likely to underestimate the number of tenants in public housing.¹ Approximately 0.4 per cent of Australian households live in community housing.²

The composition of Australian households is changing. There is an increasing number of smaller households, including a rising number of single person households. The average Australian household size fell from 3.3 people to 2.6 people between 1971 and 2001, while the proportion of single person households increased from 18.1 per cent to 22.9 per cent over this period (ABS 2002a).

The average Indigenous household is larger than the average non-Indigenous household. In 2001, the average non-Indigenous Australian household size was 2.6 people, whereas the average household with at least one Indigenous person was 3.5 people (ABS and AIHW 2003).

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.

¹ Public housing tenants appear to be undercounted in the 2001 Census (and in previous censuses).

² This estimate is based on data received from jurisdictions regarding the number of community housing dwellings in each jurisdiction, combined with data from the ABS 2001 Census on the total number of dwellings in each jurisdiction.

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). The Australian Government also influences the housing market through other direct and indirect means, including taxation and home purchase assistance.
- State and Territory governments provide housing assistance under the CSHA, such as assistance for the homeless, public housing, community housing, Indigenous rental housing, private rental assistance and home purchase assistance. Some also contribute to the delivery of housing assistance through mechanisms such as home lending programs and joint ventures with the private sector. State and Territory governments are also responsible for land taxes, stamp duties and residential tenancy legislation.
- Local governments implement planning regulations and are sometimes involved in providing community housing.

In Australia, the major types of housing assistance to the private rental market are:

- government budget outlays, including financial assistance to households to pay rent, bond and relocation costs
- government guarantees of private rental bonds
- taxation expenditure, providing incentives for investors and landlords through negative gearing and concessional taxation of capital gains
- government regulations and standards for tenants and landlords, including residential tenancy legislation and ‘affordable housing’ planning regulations
- other services, such as tenant advice services and automatic rent deductions for income support recipients.

Public rental housing provides a range of assistance to public housing tenants through:

- outlays covering rebated/subsidised rent, repairs, maintenance and upgrades, housing modification, construction and purchase
- security of tenure
- government regulations and standards including appeals mechanisms, and regulations aimed at ensuring only low-income households access low-income rental housing, allocations policy and rent policy
- priority allocation and relocation, and coordination of support services.

Government assistance to community housing providers and tenants takes many forms:

- rebated/subsidised rent and CRA for tenants, recurrent funding of organisations and the undertaking of repairs, maintenance and upgrades, and capital funding for dwelling and infrastructure construction
- taxation benefits, including charitable tax status for organisations
- government regulations and standards that provide skills development, accreditation, development of specific building guidelines, and regulations aimed at ensuring only low-income households access low-income rental housing
- other activities of government, including sector coordination, partnerships and incentives, and coordination of support services and transition paths to long-term accommodation.

Two major types of community housing are available in Australia:

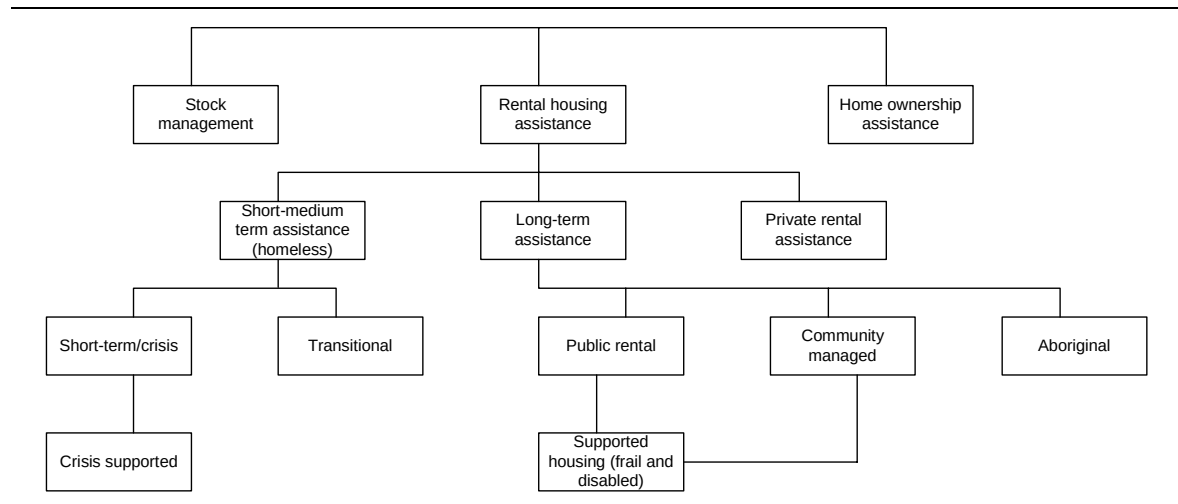
- long term housing, such as that provided under the CSHA mainstream community housing programs and the Indigenous Community Housing and Infrastructure Program
- transitional or crisis housing, which provides accommodation to people in need in the short to medium term.

Assistance for home purchase or ownership includes:

- government outlays, such as for the First Home Owner Grant, home purchase assistance and the Aboriginal and Torres Strait Islander Home Ownership Program
- taxation expenditures, including the non-taxation of imputed rent from owner occupation, rates and land tax concessions, and capital gain and stamp duty exemptions
- government regulations and standards in housing and financial markets
- other assistance, such as home purchase advisory and counselling services.

A snapshot presenting different forms of CSHA housing assistance for low income people is presented through the example for Victoria (figure 16.1).

Figure 16.1 Forms of CSHA housing assistance for low income Victorians

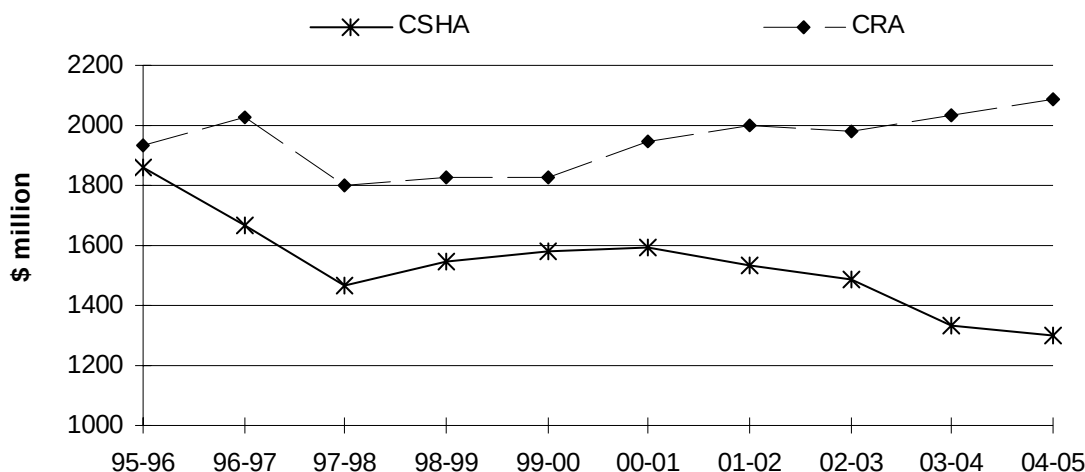


Source: Victorian Department of Human Services (2001, p. 4).

Funding

The Australian, State and Territory governments provided \$1.3 billion (contributing 72.4 per cent and 27.6 per cent respectively) for housing programs under the CSHA in 2004-05 (FaCS 2005). Public and community housing accounted for the majority of CSHA funding in 2004-05. The Australian Government also provided almost \$2.1 billion for CRA in 2004-05. Real expenditure on CSHA assistance declined by 30.0 per cent between 1995-96 and 2004-05 (figure 16.2). Real expenditure on CRA increased by 7.8 per cent over the same period (table 16A.75).

Figure 16.2 Real government expenditure on CSHA assistance and CRA (2004-05 dollars)^{a, b, c}



^a Care needs to be taken in interpreting these data because CRA is a demand driven recurrent expenditure program, whereas CSHA expenditure includes a component for capital investment that has resulted in around \$63 billion of public housing assets that are continually used for housing assistance. ^b CSHA data are not comparable to data published before the 2001 Report. The data for 1995-96 have been adjusted to enable comparability (see source document for further explanation). Australian Government CSHA expenditure differed from Australian Government budgetary allocations for the three years from 1996-97 to 1998-99 as some State and Territory governments chose CSHA funds as the source to offset their State Fiscal Contributions to the Australian Government's debt reduction program, which was agreed at the 1996 Premiers' Conference. ^c CSHA expenditure in 2000-01 and 2001-02 contained \$89.7 million of goods and services tax (GST) compensation paid to State and Territory governments. No GST compensation is included in 2003-04 and 2004-05 expenditure.

Source: CSHA (1999); FaCS (1999); FaCS (2005); FaCS (various years); FaCS (unpublished); table 16A.75.

Public housing is the largest form of assistance provided under the CSHA. Given the capital intensive nature of public housing, additional assistance to annual funding is provided through the use of \$63 billion of housing stock owned by housing authorities in 2003-04 (calculated from 2003-04 State and Territory financial statements).

Nationally, total government recurrent expenditure on public housing per capita in the population was approximately \$81 in 2004-05. Including annualised capital costs, average total government expenditure on public housing per capita nationally was \$340 (table 16.1).

It is important to note the differences in housing assistance operations across jurisdictions when discussing expenditure per capita on public housing. It is also important to note that the per capita data could have been influenced by historic arrangements (such as previous years' investment) that might have influenced the overall size of the public housing sector relative to the size of the population. Recurrent expenditure per dwelling can be used to overcome these data issues.

Table 16.1 is a summary table that presents recurrent government expenditure including and excluding capital costs, on a per capita and per dwelling basis. It also includes the CRA per capita expenditure and per income unit figures to present the overall level of government housing assistance covered in this chapter. More detailed analysis of the cost components for public housing are presented in table 16.13.

Table 16.1 Government housing assistance, 2004-05

	<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 ^a									
<i>Per capita</i>									
Recurrent	87	48	56	81	144	148	270	261	81
Recurrent including capital costs ^b	423	239	239	270	431	432	1 028	642	340
<i>Per dwelling</i>									
Recurrent	4 704	3 686	4 444	5 080	4 836	6 116	8 066	9 423	4 757
Recurrent including capital costs ^b	22 925	18 346	18 883	16 983	14 495	17 873	30 703	23 174	19 895
CRA expenditure ^c									
<i>Per capita</i>	105	89	136	96	92	102	52	62	104
<i>Per income unit</i>	2 211	2 136	2 251	2 190	2 105	2 063	2 012	2 236	2 189

^a Differences in the extent to which jurisdictions have separated public housing expenditure from other housing expenditure may affect these results. All public housing data exclude payroll tax. ^b Data are not comparable to data published prior to the 2003 Report due to the exclusion of interest payments from capital costs. ^c Actual expenditure on CRA is monitored only at a national level. Expenditure has been apportioned between states and territories based on available records for regular fortnightly instalments.

Source: FaCS (unpublished); State and Territory governments (unpublished); table 16A.82.

Size and scope

Housing assistance is provided in various forms, and models for delivering assistance can vary within and across jurisdictions. The main forms of assistance are outlined in box 16.2. This chapter focuses on four forms of assistance: public housing, community housing, State owned and managed Indigenous housing, and CRA.

Box 16.2 **Forms of housing assistance**

There are several main forms of CSHA housing assistance.

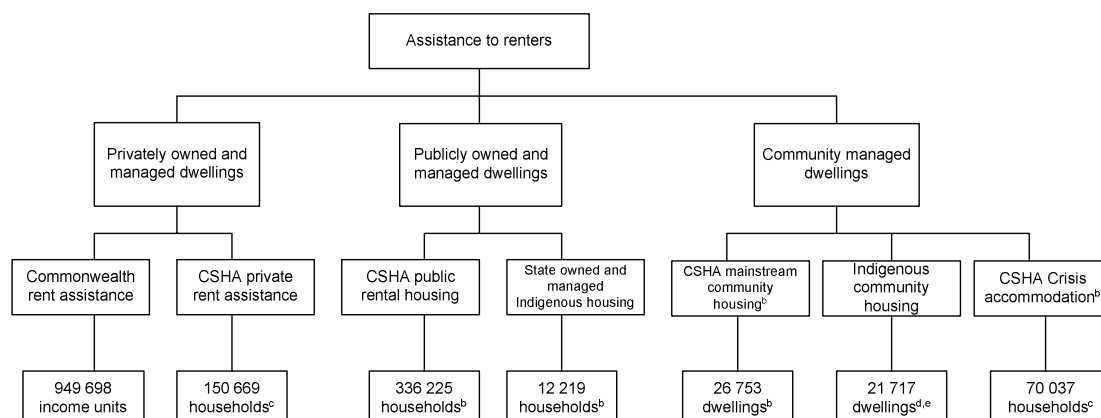
- *Public housing*: dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation. The CSHA is the main source of funding for public housing along with internally generated rental revenues and the proceeds of asset sales.
- *Community housing*: rental housing provided for low to moderate income or special needs households, managed by community-based organisations that are at least partly subsidised by government. Community housing models vary across jurisdictions.
- *Indigenous housing*: State owned housing targeted at Indigenous households (referred to as 'State owned and managed Indigenous housing' in this report) and houses owned or leased and managed by Indigenous community housing organisations and community councils in major cities, regional and remote areas.
- *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 to moderate income households to help with first home purchases or mortgage repayments.
- *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).

Types of Government housing assistance

Figure 16.3 illustrates the range of government assistance to renters.

Figure 16.3 Recipients of rental assistance across rental sector, 2005^a



^a CSHA crisis accommodation 2003-04 data for NSW and Victoria have significantly increased since AUSWelfare 03 due to changes in coverage. ^b Additional dwellings are funded under programs other than CSHA; however, data about these dwellings are not available. ^c At 30 June 2004. Figures are not consistent with those reported in the *Report on Government Service Provision 2003* as they are from a different data set. ^d At 30 June 2004. ^e The scope of the Indigenous community housing data collection is dwellings managed by funded or registered Indigenous community housing organisations. 18 735 of these dwellings were managed by organisations funded by state governments and 2982 were managed by organisations funded by the Australian Government through FaCS.

Source: AIHW (2005a, 2005b, 2005c, 2005d, 2005e, 2005f, 2005h).

In addition to CRA and the CSHA programs presented in this report, the CSHA also provides private rental assistance, home purchase assistance and crisis accommodation.

In 2003-04, CSHA private rent assistance was provided to just over 150 000 households across Australia. Of the \$78 million spent, about \$50 million was provided in bond loans and guarantees, and \$24 million in rental grants and subsidies. This assistance often supplements the assistance provided to households by the CRA program as part of Centrelink payments (FaCS 2005).

CSHA home purchase assistance in 2003-04 was approximately \$830 million, compared to \$606 million the previous year, an increase of 37 per cent. These funds were mainly provided as loans by the states and territories under the agreement. Most of this funding (\$813 million) was given in direct lending, up from \$588 million the previous year, with the majority of it going to home purchasers in WA (65 per cent) and SA (30 per cent). Other home purchase assistance funding included \$1.4 million in deposit assistance, \$13 million in interest rate assistance and \$882 000 in mortgage relief (FaCS 2005).

Also in 2003-04, the CSHA provided 7129 dwellings for emergency accommodation under its CAP. Approximately \$30.5 million was spent on additional dwellings or new constructions. CAP-funded dwellings are used by governments, churches and other welfare organisations to assist people in situations

of actual or impending crisis or homelessness. Support services to these households are provided directly by health and community service organisations, and the national SAAP. In Victoria, in addition to crisis housing, CAP funds have been used in conjunction with CSHA funds to develop a Transitional Housing program which provides medium term accommodation for homeless clients. SAAP is covered in the Protection and support services chapter (chapter 15). CSHA funding data for 2002-03 and 2003-04 financial years are presented in table 16.2.

Table 16.2 CSHA funding, 2002-03 and 2003-04 (\$ million)

Funding arrangements	2002-03	2003-04
Base funding grants ^a	824.2	725.2
Aboriginal Rental Housing Program	100.0	100.7
Crisis Accommodation Program	39.7	39.7
Community Housing Program	64.0	64.0
State matching grants	359.5	355.0
	1 387.4	1 284.5

^a Includes Public Housing, Home Purchase Assistance and Private Rental Assistance Programs.

Source: FaCS (2004, 2005).

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 335 259 public housing dwellings were occupied at 30 June 2005 (table 16A.1). Public housing is available to people on low incomes and those with special needs. Although people with a disability represented 19 per cent of the total population in 2003, 40.6 per cent of public housing tenants were people with a disability (ABS 2004).³

Public housing rents are generally set at market levels, and rebates are granted to low income tenants (so they generally pay no more than 25 per cent of their assessable income in rent), to provide affordable housing. Public housing allocations are constrained by the amount of housing stock available and are income tested. The proportion of total households residing in public housing in 2001 (4.5 per cent nationally) is presented for all jurisdictions in table 16A.71. Information on the proportion of income paid in rent by public housing tenants is contained in table 16A.76.

³ Disability is defined as any restriction or lack of ability (resulting from an impairment) to perform an action in the manner or within the range considered normal for a human being.

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.72 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

(Continued on next page)

Box 16.3 (Continued)

- *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 6.9 per cent (\$64.7 million) of total CSHA funding provided by the Australian Government in 2004-05 (FaCS unpublished). There were 29 269 CSHA community housing dwellings in Australia at June 2005,⁴ or 8.1 per cent of the total public and community housing stock supported under the CSHA (table 16.7).

Indigenous housing

Government funded Indigenous housing includes both State managed and community managed housing. The State managed component is generally funded by ARHP and may be supplemented by untied CSHA funds and State matching funds. Community managed Indigenous housing may be financed from ARHP funds, supplementary State funds, untied CSHA funds, and funds from other sources.

State owned and managed Indigenous housing⁵

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 2005d). They include dwellings managed by government Indigenous housing agencies for allocation to Indigenous tenants. There were 12 860 dwellings identified in the 2004-05 State owned and managed Indigenous housing collection (table 16A.28).

⁴ Data are based on survey results except for Queensland and the NT. Results, therefore, are affected by survey non-response.

⁵ The territories are not included in the data collection for this program, so are not included in the section heading.

State owned and managed Indigenous housing is only one of a number of programs designed to provide housing assistance to Indigenous people. Indigenous Australians are eligible for assistance under Indigenous community managed housing (where community agencies carry out tenancy management functions), the mainstream public and community housing programs, CRA and other government housing programs (both Indigenous-specific and mainstream).

The ACT and the NT are not included in the State owned and managed Indigenous housing data collection. The ACT does not receive funding for, or administer, any Territory owned and managed Indigenous housing programs; in the NT, ARHP funding is directed to community managed Indigenous housing. All Indigenous housing programs in the NT are community managed and administered, and specific management issues (such as eligibility and waiting lists) are the responsibility of Indigenous housing organisations that manage permanent dwellings for people in discrete Indigenous communities. The approaches of these organisations may differ significantly, depending on the size of the organisations, the socioeconomic circumstances of particular communities, and cultural considerations. The Indigenous Housing Authority of the NT allocates funds to the seven regional councils in the NT, which in turn allocate funds to those communities most in need. The NT government cannot differentiate between the various funding sources, given its commitment under the CSHA Indigenous Agreement to ‘pool’ all funds earmarked for Indigenous housing and associated infrastructure in the NT.

In NSW, a separate statutory organisation — the Aboriginal Housing Office — is responsible for planning, administering and expanding policies, programs and the asset base for Aboriginal housing in that State. Funding for the office comes from the CSHA and the State Government (in addition to its CSHA commitments).

Some other jurisdictions are increasingly pooling funding but currently report State owned and managed Indigenous housing data separately. Queensland administers a separate Aboriginal and Torres Strait Islander Housing Program, which includes ARHP funds, untied CSHA funds and State funds, and does not report separately against the ARHP component of the program funds (which forms more than one third of total expenditure).

Indigenous community housing

In August 2003, the Housing Ministers Advisory Committee (HMAC) endorsed the National Reporting Framework (NRF) as the performance indicator framework that would be used to report against both Indigenous community housing and State

owned and managed Indigenous housing. The framework includes the State owned and managed Indigenous housing indicators used in this Report.

A national report against a subset of the NRF was produced in 2003-04. It was based on data from the 2001 Census, the 2001 Aboriginal and Torres Strait Islander Commission (ATSIC)/ABS CHINS, CSHA administrative data and additional administrative data on the Indigenous community housing sector provided by states and territories (AIHW 2005h).

As at 30 June 2004, there were a total of 551 Indigenous community housing organisations in all states and territories excluding WA, which did not provide data. These organisations owned and managed a total of 20 932 permanent dwellings (table 16A.40). The average occupancy rate for these dwellings was 94.5 per cent (table 16A.41) and the average rent collected as a proportion of rent charged was 94.2 per cent (AIHW 2005h).

Data from the 2001 ATSIC/ABS CHINS are reported for dwelling condition (table 16A.42). Seventy percent of dwellings were in need of minor or no repair, 18.9 per cent were in need of major repair and 8.4 per cent were in need of replacement.

Commonwealth Rent Assistance

CRA is a non-taxable supplementary payment provided by the Australian Government to help with the cost of private rental housing. It is available to recipients of income support payments, including those who receive more than the base rate of the Family Tax Benefit Part A and who pay private rent above minimum thresholds. Private rent includes rent paid under both formal tenancy agreements and informal arrangements, such as board and lodging paid to a family member. It also includes mooring and site fees (for boats and caravans) and payments for retirement village services. Community housing tenants may also be eligible for CRA.

CRA is paid at 75 cents for every dollar above the threshold until a maximum rate is reached. The maximum rates and thresholds vary according to a client's family situation and number of children (table 16.3). For single people without dependent children, the maximum rate may also vary according to whether accommodation is shared with others. Rent thresholds and maximum rates are indexed twice per year (March and September) to reflect changes in the consumer price index.

Because CRA is a national payment, FaCS seeks to ensure CRA clients who have the same income unit characteristics and who pay the same amount of rent receive the same amount of assistance wherever they live. There were 941 120 income units

(where an income unit is defined as either a single person or a couple with or without dependents)⁶ receiving CRA at 4 March 2005 (table 16A.46). The maximum rate of assistance was received by 65 per cent of CRA recipients at 4 March 2005 (table 16A.61). There was little variation in the average level of assistance across locations at 4 March 2005 (table 16A.60), even though rents varied considerably by location. At 4 March 2005, the average payment across Australia was \$80 per fortnight (approximately \$2086 per year) (table 16A.60).

Table 16.3 Eligibility and payment scales for CRA, 2005 (\$ per fortnight)^{a, b}

<i>Income unit type^c</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	87.00	217.67	98.00
Single, no children, sharer ^d	87.00	174.11	65.33
Couple, no dependent children	141.80	265.00	92.40
Single, one or two dependent children	114.66	268.10	115.08
Single, three or more dependent children	114.66	288.07	130.06
Partnered, one or two dependent children	169.68	323.12	115.08
Partnered, three or more dependent children	169.68	343.09	130.06
Partnered, illness separated, no dependent children	87.00	217.67	98.00
Partnered, temporarily separated, no dependent children	87.00	210.20	92.40

^a At 4 March. Rates apply to period 20 March 2005 to 19 September 2005. ^b Income units are analogous to family units except that non-dependent children and other adults are treated as separate income units (see section 16.6 for more detail). Rates of assistance depend on the number of dependent children aged under 16 years for whom the Family Tax Benefit is paid at more than the basic rate. ^c A child is regarded as dependent on an adult only if the adult receives the Family Tax Benefit for the care of the child. ^d The maximum rate of assistance is lower for some single persons without dependent children who share accommodation, but there are several exceptions. Those not subject to this lower rate are classified as single no dependent children even if they share accommodation. (For a definition of 'sharer' see section 16.6.)

Source: FaCS (unpublished); table 16A.45.

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

⁶ Dependents are defined as young persons for whom the person or partner receives the Family Tax Benefit. The benefit is not payable for children receiving Youth Allowance or any other income security payment. Children aged over 16 years for whom the Family Tax Benefit is not payable are regarded as separate income units.

objectives depending on their historical precedents and ways of interacting with community sector providers. Jurisdictions also face differing private housing markets. These differences lead to a variety of policy responses and associated assistance products. It is important to be aware of all the housing assistance operations in each State and Territory when analysing performance information.

Appendix A contains information on each State and Territory that may help in interpreting the performance indicators presented in this chapter. State and Territory governments have provided the following additional information on the key operating parameters characterising housing assistance provision in their jurisdictions.

Public housing

Eligibility criteria for access to public housing, such as income and asset definitions and limits, vary across jurisdictions. In most cases, jurisdictions require that applicants be Australian citizens or permanent residents and not own or part-own residential property. All jurisdictions require eligible applicants to be resident in the respective State or Territory. All State and Territory governments prioritise access to public housing by segmenting their waiting lists in some way. Segments are defined differently across jurisdictions, but generally reflect urgent need/homelessness and an inability to access appropriate private market accommodation. Most jurisdictions provide security of tenure after an initial probationary period. Most jurisdictions also have periodic reviews of eligibility to ensure that tenants are meeting the other terms of their tenancy agreement. Rebated rents result in the majority of households paying no more than 25 per cent of their assessable income in rent (the rent-to-income ratio). Definitions of assessable income vary across jurisdictions (table 16.4).

Table 16.4 Public housing policy context, 2005^a

Eligibility	NSW ^b	Vic ^c	Qld ^d	WA ^e	SA ^f	Tas ^g	ACT	N ^h
Income limit per week (\$) ⁱ	395	347	582	390	608	336	483	529
'Other' asset limits (\$) ⁱ	None	30 000	None	36 400 cash	263 500	34 473	40 000 liquid assets	38 100
Minimum age	18	15	18	18	None	16	16	None
Waiting listⁱ								
	Wait turn and priority (five segments)	Priority (four segments)	Priority (two segments)	Priority (three segments)	Need (four segments)	Need (four segments)	Priority (five segments)	Priority (two segments)
Tenure								
Probationary period	1 year then 3 years then 3 years	None	None	None	6 months	3–6 months	None	3–6 months 2 year then 5 year
Fixed term	3 or 6 months	5 years	6 months	3 months	None	1–3 years	None	
Ongoing	Ongoing after probation	Lifetime after age 65 To	Yes	Ongoing	Ongoing after probation	In some cases, particularly older persons	Lifetime tenure	None
Tenancy review	Reviewed at end of each term	commence in 2008	None	Annual	None	Fixed term leases reviewed at end of each term	None	Prior to each new lease

(Continued on next page)

Table 16.4 Continued

	NSW ^b	Vic ^c	Qld ^d	WA ^e	SA ^f	Tas ^g	ACT	NT ^h
Rebated rent setting								
Rent-to-income ratio	25	25	25	23 or 25	25	23–25	25	18 or 23

^a At 30 June. ^b Interest accrued from cash assets is assessed as income. Applicants under the age of 18 years must demonstrate living skills to be eligible for housing. Following announcement of the Reshaping Public Housing Reforms, NSW commenced action to phase out existing one and three year renewable tenancy agreements from 1 July 2005. New tenants housed after 1 July 2005 will be subject to the new tenure policy in July 2006. For rebated rents, varied concessional rates are applicable to certain sources of income. ^c Public housing tenancies in Victoria are ongoing tenancies (not fixed term) that are subject to review after 5 years. For households that require major disability modifications, discretion may be applied to extend the asset limit to \$60 000. ^d Age criteria may be waived in situations where the applicant is not yet 18 but is currently responsible for their own household. While no formal eligibility review exists, it is an ongoing requirement for clients to meet property ownership limitations. ^e Income limit for those in north west remote areas is \$550 per week. Those aged over 60 years are subject to a cash asset limit of \$80 000. A rent-to-income ratio of 23 per cent can apply for groups such as seniors, people with disabilities and people living in remote locations. ^f The same definition as the Centrelink asset test threshold for a single person who does not own their own home is used. Most households pay a rent-to-income ratio of 25 per cent of assessable income in rent, except aged residents in cottage flat and bedsitter flat accommodation (for whom the ratio is 19 per cent and 17 per cent respectively) and households receiving less than the single Newstart Allowance (for whom the ratio is 19.5 per cent). ^g For people aged over 55 years, the asset limit is \$35 000. ^h While the NT does not have a minimum age, people must be over 16 years to enter into a tenancy agreement under the *Residential Tenancies Act*. The rent-to-income ratio is 18 per cent for aged pension recipients. ⁱ Limits are for a single person. ^j Two segment lists generally consist of 'priority' and 'wait turn'.

Source: State and Territory governments (unpublished).

The proportion of public housing tenants in receipt of a rental rebate at 30 June is shown in table 16.5.

Table 16.5 Public housing — rebated rents, 2005 (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>
Tenants in receipt of rebated rent	88.4	87.9	84.9	86.0	86.4	78.1	86.0	88.1	86.9

^a At 30 June.

Source: AIHW (2005c); table 16A.1.

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 16.6.

Table 16.6 Public housing — regional and remote area concentrations, 2005 (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>
Major cities	80.5	72.0	61.6	70.4	77.1	–	99.8	–	71.4
Inner regional	15.3	22.4	19.5	9.6	6.8	72.7	0.2	–	16.8
Outer regional	3.8	5.5	16.6	9.6	14.2	26.4	–	68.7	9.6
Remote	0.3	–	1.8	7.1	1.8	0.6	–	27.2	1.7
Very remote	0.1	–	0.6	3.3	0.1	0.3	–	4.1	0.5

^a At 30 June. ^b Under ASGC remoteness areas. – Nil or rounded to zero.

Source: AIHW (2005c); table 16A.1.

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. Community housing dwellings as a proportion of total public and community housing dwellings at June 2005 are shown in table 16.7.

Table 16.7 Community housing dwellings as a proportion of all public and community housing dwellings, 2005 (per cent)^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
	8.7	6.9	9.7	9.4	8.2	3.9	5.0	2.0	8.1

^a At 30 June. ^b Based on survey data provided for all but the NT (which is based on administrative data), these results are affected by survey non-response. ^c Excluding Crisis Accommodation Program dwellings and the Victorian Transitional Housing Management program.

Source: AIHW (2005b; 2005e); tables 16A.1 and 16A.15.

For the data that are available, the proportions of community housing located in regional and remote areas using (ASGC remoteness areas) are shown in table 16.8.

Table 16.8 Community housing — regional and remote area concentrations, 2005 (per cent)^{a, b}

	<i>NSW</i>	<i>Vic^c</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Major cities	68.4	76.3	36.7	68.0	87.5	—	100.0	—	65.9
Inner regional	23.4	19.7	25.3	12.7	7.5	60.1	—	—	19.9
Outer regional	8.0	3.8	26.8	11.6	3.8	38.0	—	55.7	10.9
Remote	0.2	0.2	4.3	5.6	1.2	1.9	—	41.7	1.8
Very remote	0.1	—	6.9	2.1	—	—	—	2.6	1.5

^a At 30 June. ^b Under the ASGC remoteness areas. ^c In Victoria, the interpretation of the definition of a 'dwelling' varied for providers. Some larger agencies also advised that they were unable to provide tenancy units by postcode. For consistency and accuracy, properties have been counted by postcode from the internal administrative system, so the dwelling postcode count will not match the number of tenancy units because group housing program arrangements have multiple tenancies per property. — Nil or rounded to zero.

Source: AIHW (2005b); table 16A.15.

State owned and managed Indigenous housing

Eligibility criteria for access to State owned and managed Indigenous housing are generally consistent with those for public housing once an applicant has been confirmed as Indigenous. Queensland is an exception, having no income or age eligibility limits on State owned and managed Indigenous housing. The management of waiting lists varies across jurisdictions — for example, a number of jurisdictions use the same list for both State owned and managed Indigenous housing and public housing. Terms of tenure are the same as those for public housing for a number of jurisdictions (table 16.9).

Table 16.9 State owned and managed Indigenous housing policy context, 2005^a

	NSW ^b	Vic ^c	Qld ^d	WA ^e	SA ^f	Tas ^g
Eligibility						
Income limit per week (\$) ^h	395	347	None	390	608	336
'Other' asset limits (\$) ^h	None	30 000	None	36 400 in cash	263 500	34 473
Minimum age	18	15	None	18	None	16
Waiting list						
Details	Combined with public housing	Combined with public housing	Wait turn	Combined with public housing	Need (Four segment)	Priority, similar to public housing
Tenure						
Probationary period	None	None	None	None	6 months	3–6 months
Fixed term	3 or 6 months	5 years	None	3 months	None	1–3 years
Ongoing	Yes	Lifetime after age 65	Yes	Ongoing	Ongoing after probation	Dependant on housing history
Tenancy review	Not regularly	To commence in 2008	None	Annual	None	Fixed term leases reviewed at end of each term

^a At 30 June. ^b Interest accrued from cash assets is assessed as income. Applicants under the age of 18 years must demonstrate living skills to be eligible for housing. Following announcement of the Reshaping Public Housing Reforms, NSW commenced action to phase out existing one and three year renewable tenancy agreements from 1 July 2005. New tenants housed after 1 July 2005 will be subject to new tenure policy in July 2006. ^c Tenancies in Victoria are ongoing tenancies (not fixed term) that are subject to review after 5 years. For households that require major disability modifications, discretion may be applied to extend the asset limit to \$60 000. Indigenous households generally access long term accommodation through the General Rental program or housing managed by the Aboriginal Housing Board of Victoria. ^d Ten per cent of applicants can be housed ahead of turn in urgent circumstances. While no formal eligibility review exists, it is an ongoing requirement for clients to meet property ownership limitations. ^e The income limit for those in north west remote areas is \$550 per week. Those aged over 60 years are subject to a cash asset limit of \$80 000. ^f The same definition as the Centrelink asset test threshold at 30 June 2004 for a single person who does not own their own home is used. Includes 21 Indigenous households with other special needs (including youth, disability, aged etc.). ^g For people aged over 55 years the asset limit is \$35 000. Applications outside the guidelines may be considered where there are extenuating circumstances in relation to income, asset and age criteria. ^h Limits are for a single person.

Source: State and Territory governments (unpublished).

The proportions of State owned and managed Indigenous housing located by ASGC remoteness areas are shown in table 16.10.

Table 16.10 State owned and managed Indigenous housing — regional and remote area concentrations, 2005 (per cent)^{a, b}

	<i>NSW</i>	<i>Vic^c</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Aust</i>
Major cities	40.6	38.3	12.7	28.8	60.3	—	33.8
Inner regional	31.8	37.0	14.3	7.8	7.8	82.4	21.9
Outer regional	20.4	24.4	45.2	22.0	18.0	17.6	26.2
Remote	5.6	0.4	10.5	20.2	6.0	—	8.7
Very remote	1.6	—	17.3	21.2	7.8	—	9.4

^a At 30 June. ^b Under the ASGC remoteness areas. ^c In Victoria, the interpretation of the definition of a 'dwelling' varied for providers. Some larger agencies also advised they were unable to provide tenancy units by postcode. For consistency and accuracy, properties have been counted by postcode from the internal administrative system, so the dwelling postcode count will not match the number of tenancy units because group housing program arrangements have multiple tenancies per property. — Nil or rounded to zero.

Source: AIHW (2005a); table 16A.28.

Private rental markets

Tight private rental markets (vacancy rates below 3.0 per cent) were evident in all states in June 2005. Capital city vacancy rates in the private rental market for all jurisdictions are reported in table 16A.69. Capital city median rents varied across jurisdictions. Median rents for three bedroom houses and two bedroom flats or units are reported in table 16A.70.

16.2 Framework of performance indicators

Public, community and State owned and managed Indigenous housing adopt a common performance indicator framework based on the framework developed for the 1999 CSHA (which ran from 1 July 1999 to 30 June 2003) (figures 16.4, 16.5 and 16.6). The CSHA framework reflects the national objectives of the agreement to improve the quality of national performance information and to recognise the need for balanced reporting at the national and bilateral levels as outlined in a number of guiding principles (CSHA 1999).

The new CSHA took effect on 1 July 2003 and will run until 30 June 2008 (box 16.4). Many aspects of this agreement, including the aims and objectives, are similar to those of the previous agreement. The new CSHA places greater emphasis on Australian, State and Territory governments improving housing outcomes for Indigenous people, and governments have committed to improving access to mainstream housing options for Indigenous people living in urban and rural areas.

This is the second year that data are reported under the new agreement. Work is being undertaken on the performance indicators to improve the quality and scope of national performance information.

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, rural 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).

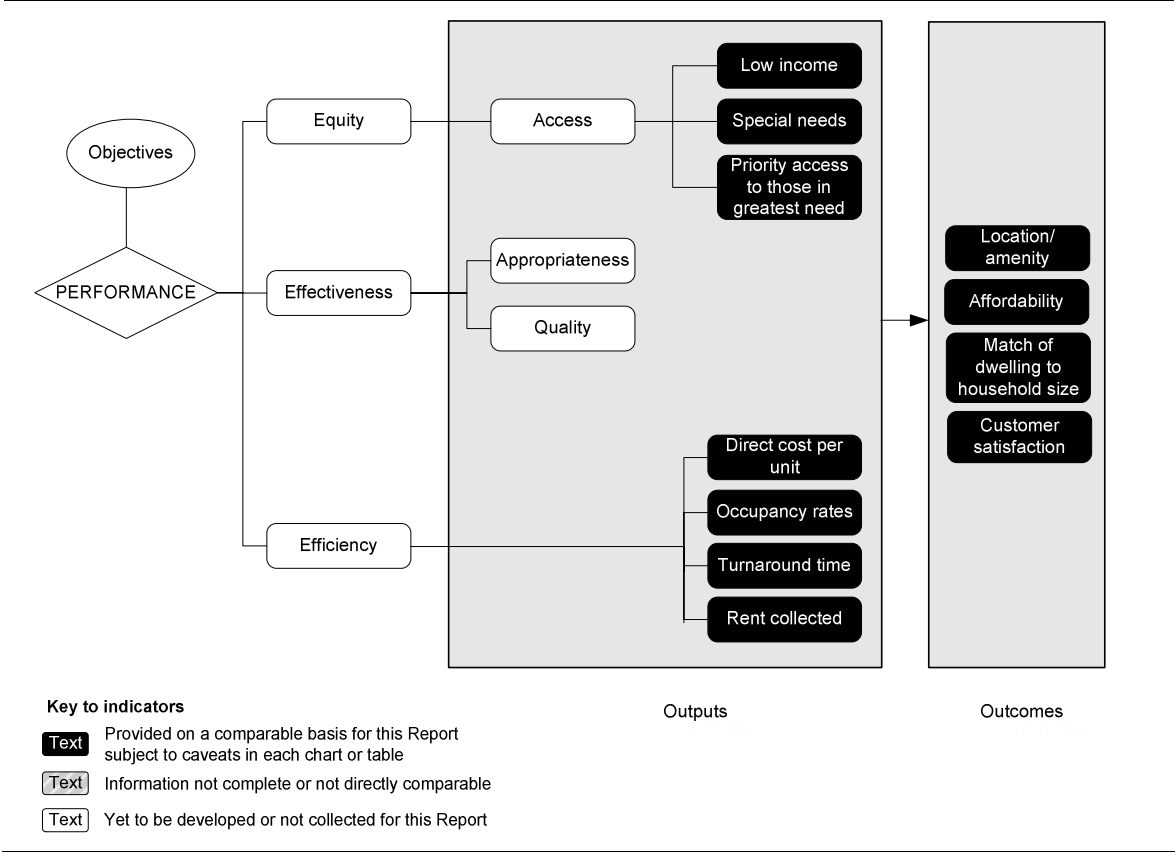
A slightly modified performance indicator framework is used for reporting on CRA (figure 16.7). The performance indicator frameworks show which data are comparable in the 2006 Report (figures 16.4, 16.5, 16.6 and 16.7). For data that are not considered directly comparable, the text includes relevant caveats and

supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

The frameworks reflect the adoption by governments of accrual accounting and depict the Review’s focus on outcomes, consistent with demand by governments for outcome oriented performance information. The frameworks also accentuate the importance of equity. More detail on the general report framework, along with the differences between outputs and outcomes, can be found in chapter 1.

Comparable public housing data are presented for the full range of indicators in the performance measurement framework (figure 16.4). It has not been possible, however, to obtain nationally comparable performance information for community housing given current data standards and data collection capacity (figure 16.5).

Figure 16.4 Performance indicators for public housing



While public, community and State owned and managed Indigenous housing use a common framework, the delivery method for community housing differs from that for public and State owned and managed Indigenous housing. Community organisations and sometimes local government deliver community housing, while State and Territory governments deliver public and State owned and managed

Indigenous housing. The performance indicator framework for State owned and managed Indigenous housing is shown in figure 16.6.

Figure 16.5 Performance indicators for community housing

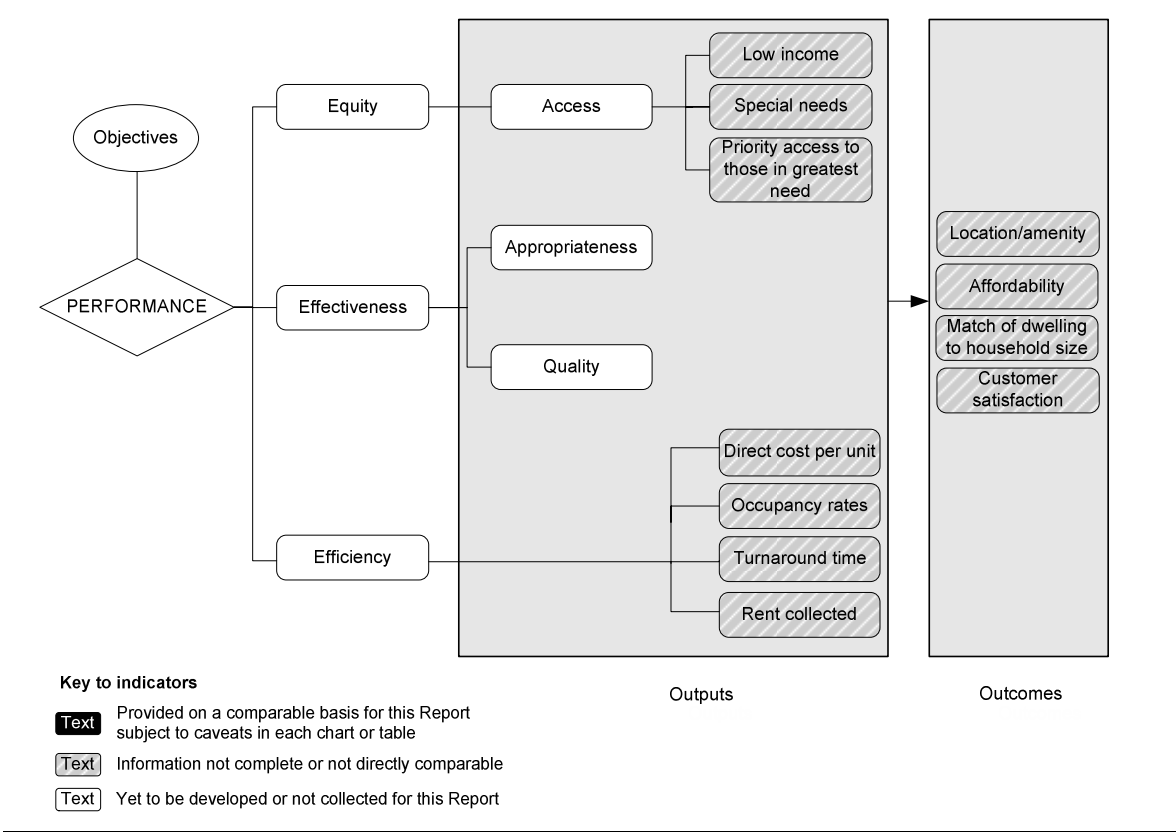
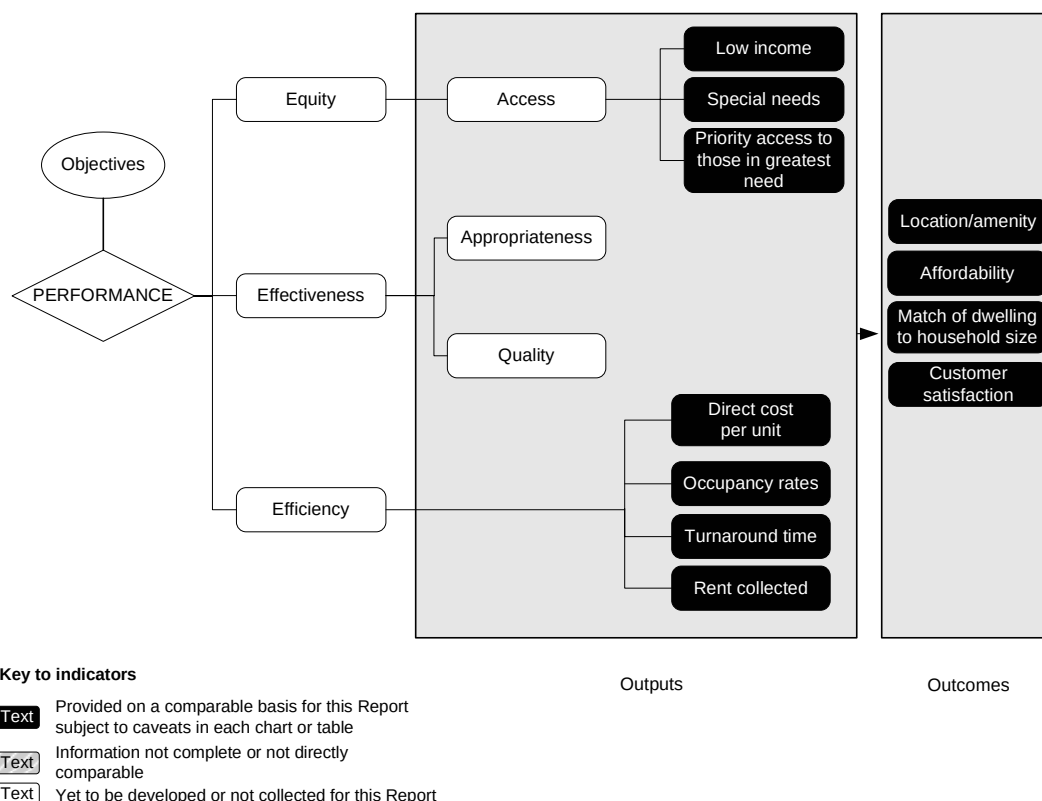


Figure 16.6 Performance indicators for State owned and managed Indigenous housing

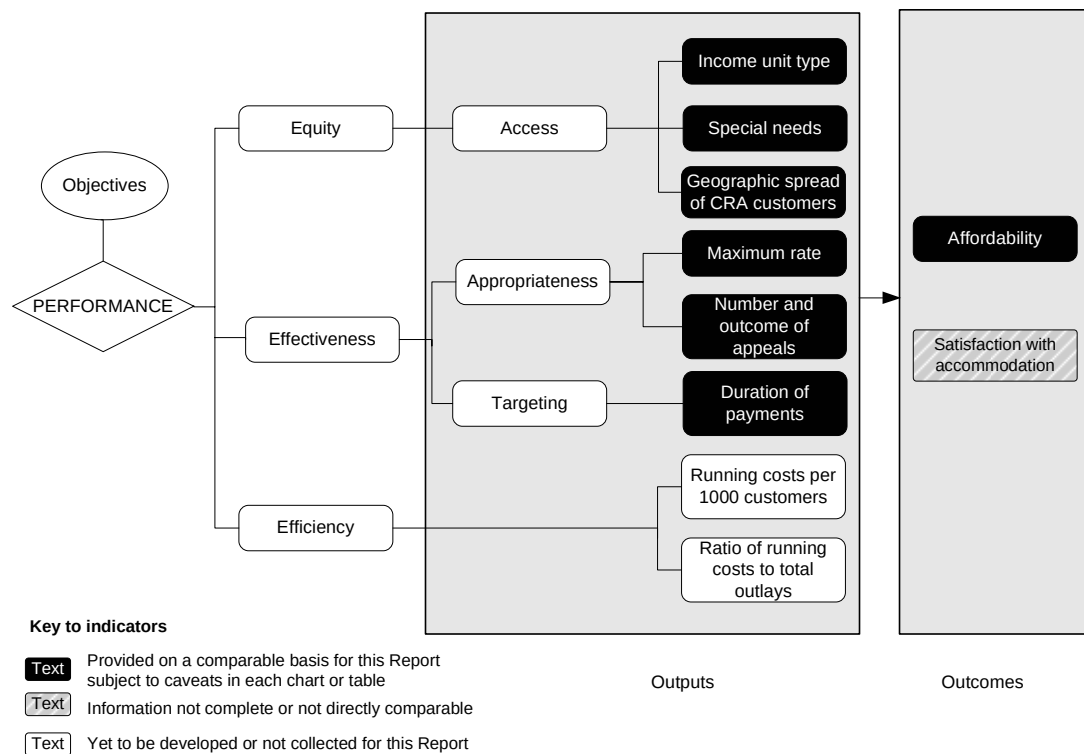


The performance indicators for CRA differ from those for public, community and State owned and managed Indigenous housing because CRA has different objectives and delivery methods. Reporting for CRA uses a performance indicator framework (figure 16.7) based on the CRA objective outlined in box 16.5. All indicators are defined in section 16.6.

Box 16.5 Objective of CRA

The objective of CRA is to provide income support recipients and low income families in the private rental market with additional financial assistance, in recognition of the housing costs that they face (Newman 1998). This assistance should be delivered in an equitable and efficient manner. CRA is also governed by other objectives relating to the primary income support payment.

Figure 16.7 Performance indicators for CRA



16.3 Key performance indicator results

Performance indicator results are not comparable across the public, community and State owned and managed Indigenous housing sections because data quality and coverage can differ. More information on indicator definitions are provided in each indicator section.

Public housing

Different delivery contexts, locations and types of client may affect the performance of public housing reported in this chapter. Care therefore needs to be taken in interpreting performance indicator results, and the qualifications presented with the data need to be considered. Some descriptive information on public housing can be found in table 16A.1.

Outputs

Equity — low income and special needs

The first two equity indicators reported for public housing are ‘low income’ and ‘special needs’ (box 16.6).

Box 16.6 Low income and special needs

‘Low income’ is an output indicator of the CSHA’s aim to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing.

It measures three low income components:

- new low income households as a proportion of all new households
- new low income households plus special needs (not low income) households, as a proportion of all new households
- households paying less than market rent and special needs households paying market rent, as a proportion of all households (new and existing).

(Continued on next page)

Box 16.6 (Continued)

'Special needs' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures the proportion of new tenancies allocated to special needs households. New tenancies are reported as a proxy for all households receiving assistance. Special needs households are those that have either a household member with a disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members. A high proportion indicates a high degree of targeting of the special needs households.

The two household income measures for the purpose of this indicator are:

- low income A households — 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)
- low income B households — 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.

Households with incomes below these levels are included in the measure, although they may not necessarily receive income support benefits.

High values for the three measures indicate high degrees of access for low income (and special needs) households.

The proportion of new tenancies allocated to low income A and low income B households is presented in tables 16.11 and 16A.2.

Table 16.11 Public housing — low income and special needs households as a proportion of all new households (per cent)^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA^d</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^d</i>	<i>NT^d</i>	<i>Aust</i>
New low income A households									
2000-01	94.1	86.1	90.0	85.8	89.3	84.6	np	83.6	89.5
2001-02	94.6	93.0	90.4	83.8	89.7	93.1	92.0	87.0	91.4
2002-03	92.9	90.4	90.3	86.8	89.6	90.6	88.9	87.4	90.4
2003-04	94.7	92.4	90.5	87.9	87.5	89.1	87.7	87.6	91.2
2004-05	94.0	92.5	88.1	85.8	87.1	80.8	89.4	85.6	90.0
New low income A households plus special needs (not low income) households									
2000-01	97.3	90.6	93.4	89.7	94.6	85.9	np	np	93.3
2001-02	97.4	95.6	93.7	89.5	94.2	96.2	94.3	93.4	94.9
2002-03	96.1	94.0	93.3	91.9	94.1	94.2	84.0	92.1	93.9
2003-04	97.0	95.6	94.5	92.7	93.5	94.4	91.3	93.9	95.0
2004-05	96.8	95.6	93.8	93.3	97.5	94.9	93.9	90.8	95.4

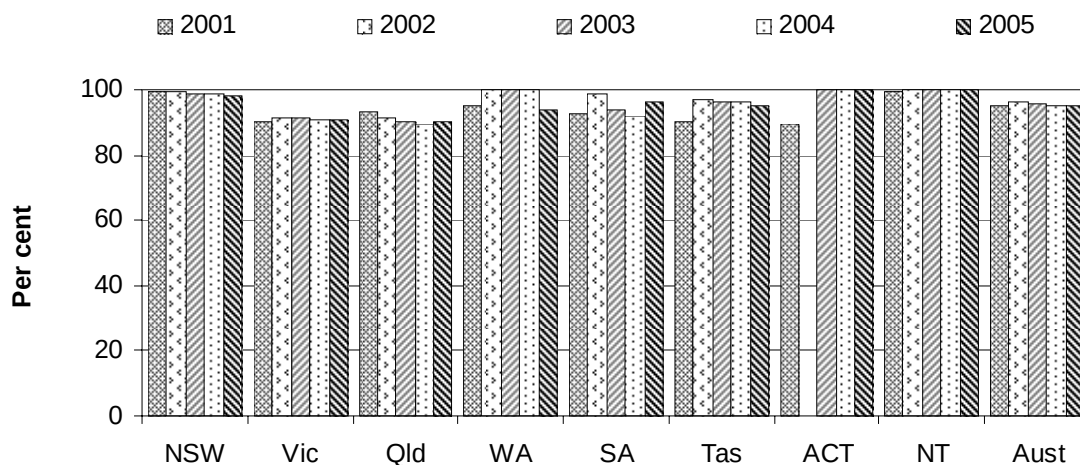
^a For details of: mixed composition, non-rebated and other households excluded, see table 16A.83. ^b Data for 2004-05 are not directly comparable to the previous years' data and any direct comparison of 2004-05 data with previous years should be done with caution. For details of these changes see footnotes in table 16A.2.

^c Data are not comparable across all jurisdictions due to each using different methodology. For this reason data should not be directly compared across jurisdictions. For details of non-comparability see footnotes in table 16A.2. ^d Data for WA, ACT and NT are based on different methodology from that used for their previous years' data and a direct comparison of 2004-05 data with previous years for WA, ACT and NT cannot be made. For details of these changes see WA, ACT and NT footnotes in table 16A.2. **np** Not published.

Source: AIHW (various years) CSHA National Data Reports: Public Rental Housing; table 16A.2.

All households paying less than market rent and special needs households paying market rent as a proportion of all households (new and existing), at 30 June 2005, are reported in figure 16.8.

Figure 16.8 **Public housing — households paying less than market rent and special needs households paying market rent, at 30 June, as a proportion of all households (new and existing)^{a, b, c}**

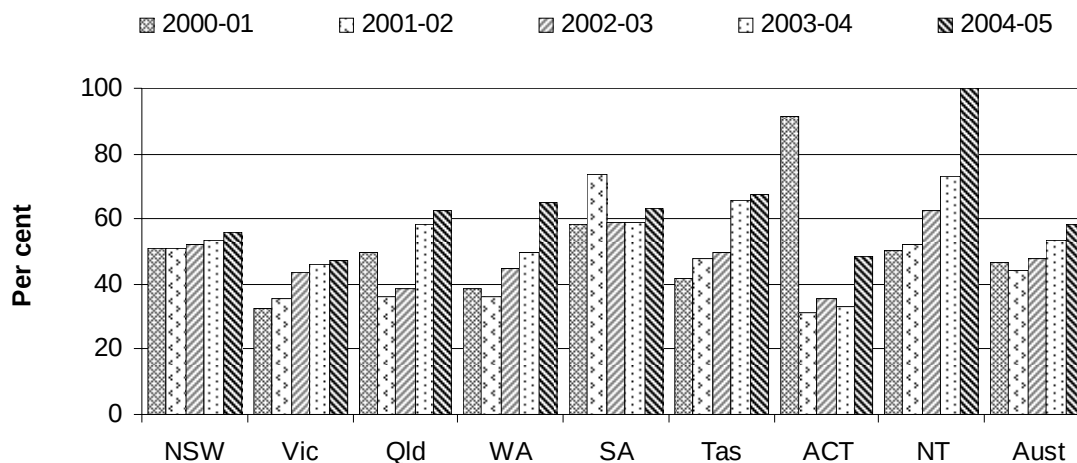


a Data for NSW and SA for 2004-05 are not directly comparable to the previous years' data and any direct comparison of 2004-05 data with previous years for NSW and SA should be done with caution. For details of these changes see NSW and SA footnotes in table 16A.3. **b** Data for WA and the NT are based on different methodology from that used for their previous years' data and a direct comparison of 2004-05 data with previous years for WA and the NT cannot be made. For details of these changes see WA and the NT footnotes in table 16A.3. **c** Data for Queensland, WA and the ACT for 2004-05 are not comparable with the other data presented and should not be directly compared with other jurisdictions' data. For details of non-comparability see Queensland, WA and the ACT footnotes in table 16A.3.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.3.

New public housing tenancies allocated to households with special needs are presented in figure 16.9.

Figure 16.9 **Public housing — new tenancies allocated to households with special needs^{a, b}**



^a Data for WA and ACT for 2004-05 are based on different methodology from that used for their previous years' data and a direct comparison of 2004-05 data with previous years for WA and ACT cannot be made. For details of these changes see WA and ACT footnotes in table 16A.4. ^b Data for the Queensland, WA, ACT and the NT for 2004-05 are not comparable with the other data presented and should not be directly compared with other jurisdictions' data. For details of non-comparability see Queensland, WA, ACT and the NT footnotes in table 16A.4.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.4.

Equity — priority access to those in greatest need

The final equity indicator reported for public housing is 'priority access to those in greatest need' (box 16.7). The proportion of new allocations to those in greatest need in 2004-05 is presented in table 16.12. Differences in State and Territory housing allocation policies can influence comparability.

Box 16.7 Priority access to those in greatest need

'Priority access to those in greatest need' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes are such that those in greatest need have first access to housing. It measures the proportion of new allocations to those in greatest need. Greatest need households are defined as low income households that at the time of allocation are homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs.

Table 16.12 shows the proportion of new allocations to those in greatest need by time to allocation. Data are provided for tenants waiting for less than three months to more than two years. These numbers are not cumulative. A high value for this indicator, particularly for short time frames, represents a high degree of access of those in greatest need.

Table 16.12 **Public housing — proportion of new allocations to those in greatest need, 2004-05 (per cent)**

	NSW ^a	Vic	Qld ^a	WA	SA ^a	Tas	ACT	NT ^a	Aust
Total for year ending									
30 June	22.8	67.4	16.9	26.2	40.1	93.5	87.9	19.4	37.7
Proportion of new allocations to those in greatest need, by time to allocation									
<3 months	47.6	78.1	49.2	43.9	58.4	87.9	87.8	23.7	59.5
3–<6 months	43.7	68.7	46.2	55.1	66.2	95.1	93.5	31.3	59.6
6 months–<1 year	27.1	71.8	30.8	21.9	55.5	97.5	91.6	16.0	48.4
1–<2 years	12.7	65.2	12.5	2.1	28.5	96.6	79.7	10.1	26.8
2+ years	3.0	24.6	2.9	–	2.5	94.5	54.3	6.8	5.6

^a For a more detailed explanation of data for these jurisdictions, see table 16A.5. – Nil or rounded to zero.

Source: AIHW (2005c); table 16A.5.

Efficiency — direct cost per unit

The efficiency indicator identified for public housing is 'direct cost per unit' (outputs) (box 16.8).

Box 16.8 Direct cost per unit

'Direct cost per unit' has been identified as an output indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It measures the cost of providing assistance per dwelling. 'Direct cost per unit' can be defined as the total administration costs and the costs of maintaining the operation of dwellings. Two related measures are also reported:

- gross cost per unit — gross cost to government (administration and operating costs plus capital costs)
- net cost per unit — net cost to government (cost excluding rents received from tenants).

Due to a high level of capital expenditure in housing, gross and net cost per unit are predominantly driven by the user cost of capital (see box 16.9). Caution must therefore be used when interpreting the indicator because the user cost of capital and service delivery models differ across the jurisdictions. The cost per dwelling indicators also do not provide any information on the quality of service provided (for example, the standard of dwellings).

The costs incurred by jurisdictions in providing public housing 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). Box 16.9 provides a discussion of the user cost of capital.

In 2001, the Steering Committee completed a research project to assess the impact of asset measurement factors (such as depreciation and asset valuation methods) on the comparability of cost data in the Report. The results of this study are summarised in chapter 2. Box 16.10 summarises the results relating to housing.

Box 16.9 **The user cost of capital**

The ‘user cost of capital’ for government services is the cost of having funds tied up in the capital used to deliver services (for example, houses and land in public housing). It makes explicit the opportunity cost of using the funds to deliver services rather than investing them elsewhere or using them to retire debt. It is calculated by applying a jurisdictional cost of capital rate to the value of government assets (see chapter 2 for details of the determination of a cost of capital rate). The costs of capital for land and other assets are shown separately, to allow users to consider any differences in land values across jurisdictions when assessing the results. Land values make up a large part of the user cost of capital and are largely beyond the control of jurisdictions.

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

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

The Steering Committee accepts that asset valuation data are imperfect. It also recognises that non-recognition of the cost of capital used by departments to deliver services can result in 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.

Box 16.10 **Asset measurement in the costing of government services**

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

The relative capital intensity associated with the provision of public housing increases the potential for differences in asset measurement techniques to have a material impact on total unit costs. The results of this study suggest, however, that the adoption under the CSHA of a uniform accounting framework has largely avoided this impact. The results are discussed in more detail in chapter 2.

Source: SCRCSSP (2001).

The direct, gross and net costs to government per dwelling in 2004-05 are presented in table 16.13.

Interest payments have been subtracted from other capital costs (depreciation and the indicative user cost of capital) to obtain the total capital cost, gross cost and net cost to government, rendering these data not comparable with those published before the 2002 Report. Interest payments are included in recurrent costs, and reported capital costs must be reduced by the amount of interest payments to avoid double counting of capital costs once the indicative user cost of capital is included. Prior to the 2002 Report, it had not been possible to avoid this double counting.

Payroll tax is excluded from total recurrent cost for public housing. This was done for the first time in the 2004 Report, making the cost data not comparable with the data published in prior reports. (Chapter 2 elaborates on the reasons for excluding payroll tax from the cost calculations.)

Care needs to be taken in interpreting the cost of delivering public housing. Cost data for some jurisdictions are either more complete than other cost data or collected on a more consistent basis. Administration costs and operating costs, for example, may not capture all costs incurred by government, so could understate the total costs of public housing. In addition, some jurisdictions had difficulty separating costs for public housing from those for other housing assistance activities. There may also be double counting of some expenditure items in the cost calculations for some jurisdictions. The user cost of capital, for example, is intended to capture all the costs of funding assets used to produce the services, but reported operating costs (apart from interest payments, which have been adjusted for) may already include some of these costs.

Table 16.13 **Public housing — costs per dwelling, 2004-05 (dollars)^a**

	NSW ^b	Vic ^b	Qld	WA	SA	Tas	ACT	NT	Aust
Total direct costs	4 743	3 735	4 476	5 119	4 885	6 175	8 153	9 475	4 801
Total direct costs (excluding payroll tax)	4 704	3 686	4 444	5 080	4 836	6 116	8 066	9 423	4 757
Depreciation	1 871	1 819	1 375	1 481	1 227	2 103	1 114	2 551	1 664
Indicative user cost of capital ^c									
Land	10 541	5 938	7 428	5 501	4 356	2 554	15 128	5 443	7 734
Other assets	6 191	6 903	5 996	5 662	5 018	8 083	6 908	7 889	6 207
Total assets	16 731	12 841	13 424	11 163	9 373	10 637	22 036	13 332	13 941
Interest payments ^d	381	—	360	740	941	983	513	2 132	467
Total capital costs	18 221	14 660	14 439	11 903	9 659	11 757	22 637	13 751	15 138
Full gross costs (excluding payroll tax)	22 925	18 346	18 883	16 983	14 495	17 873	30 703	23 174	19 895
Rent collected from tenants	4 442	4 329	4 239	3 962	4 458	3 704	5 653	4 612	4 366
Full net costs (excluding payroll tax)	18 483	14 017	14 644	13 021	10 038	14 169	25 050	18 563	15 530
Dwellings (no.)	124 247	64 727	49 137	31 510	45 648	11 644	10 846	5 542	343 301

^a Issues surrounding the comparability of capital cost data are discussed in the Steering Committee research paper, *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001). ^b For a more detailed description of data method, please see table 16A.6 notes. ^c The rate used to calculate the user cost of capital is currently 8 per cent. See chapter 2 for a discussion of capital costs. ^d Interest payments are included in total recurrent costs, but they must be excluded from total capital costs, full gross costs and full net costs to avoid double counting of capital costs once the indicative user cost of capital is included. Before the 2002 Report, it had not been possible to avoid this double counting. — Nil or rounded to zero.

Source: AIHW (2005c); State and Territory governments (unpublished); table 16A.6.

Efficiency — occupancy rate

The third efficiency indicator reported for public housing is the ‘occupancy rate’ (box 16.11).

The national average proportion of public rental stock occupied at 30 June 2005 was 97.7 per cent. There was only slight variation across jurisdictions (table 16.14).

Box 16.11 Occupancy rate

The 'occupancy rate' is an output indicator of the efficiency of housing utilisation. It represents the proportion of dwellings occupied. The term 'occupied dwelling' refers to dwellings occupied by tenants who have a tenancy agreement with the relevant housing authority. Occupancy is influenced by both turnover and housing supply and demand.

Table 16.14 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>
2000-01	98.2	96.2	96.6	95.6	94.4	94.3	95.7	95.2	96.6
2001-02	98.1	96.4	97.5	95.4	94.2	95.7	98.7	95.0	96.8
2002-03	98.3	96.5	97.9	95.7	94.9	96.8	98.7	93.9	97.1
2003-04	98.7	96.6	98.7	95.3	95.4	97.4	97.2	93.8	97.4
2004-05	98.7	97.3	98.6	95.6	96.1	98.0	98.1	94.1	97.7

^a Data for SA for 2004-05 are not directly comparable to the previous years' data and any direct comparison of 2004-05 data with previous years should be done with caution. For details of these changes see footnotes in table 16A.7.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.7.

Efficiency — turnaround time

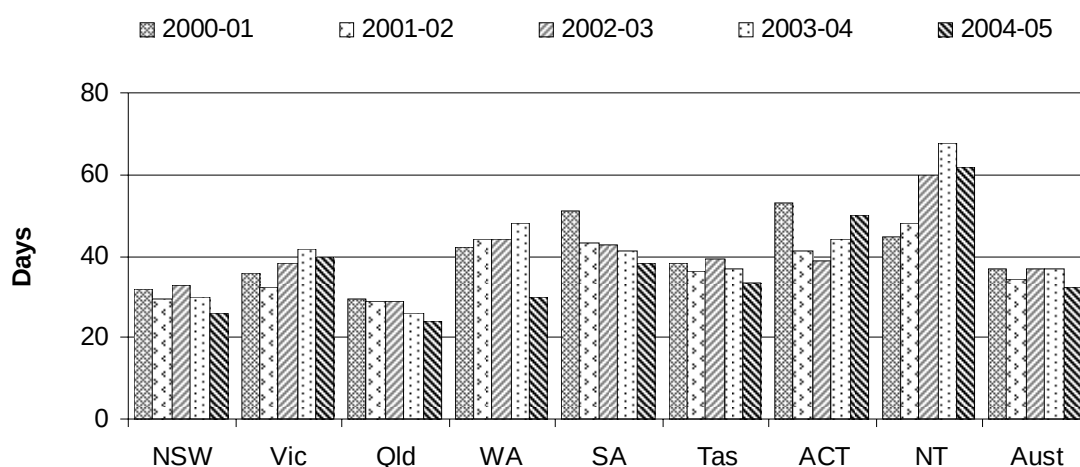
The fourth efficiency indicator reported for public housing is 'turnaround time' (box 16.12).

Box 16.12 Turnaround time

'Turnaround time' is an output indicator of the time taken to reallocate vacant properties after they have been vacated, acquired or newly constructed. The indicator measures the average time taken in days for vacant dwellings to be occupied. The length of time taken to rent untenanted dwellings affects allocations of housing, waiting times, the length of waiting lists and rent foregone. A low turnaround time suggests efficient housing allocation and asset management. All jurisdictions aim to minimise turnaround times.

The average number of days for vacant stock to be allocated in 2004-05 is presented in figure 16.10. The indicator may be affected by changes in maintenance programs and allocation policies, and some jurisdictions may have difficulty excluding stock which is out-of-scope.

Figure 16.10 Public housing — average turnaround times^{a, b}



^a Data for WA and Tasmania for 2004-05 are based on different methodology from that used for their previous years' data and a direct comparison of 2004-05 data with previous years for WA and Tasmania cannot be made. For details of these changes see WA and Tasmania footnotes in table 16A.8. Data for Queensland for 2003-04 and 2004-05 are based on different methodology from that used for their previous years' comparison of 2003-04 and 2004-05 data with previous years for Queensland cannot be made. ^b Data are not comparable across all jurisdictions due to each using different methodology. For this reason the data presented should be interpreted with caution. For details of these variations see footnotes in table 16A.8.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.8.

Efficiency — rent collected

The final efficiency indicator reported for public housing is 'rent collected' (box 16.13).

Box 16.13 Rent collected

'Rent collected' is an output indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It is the total rent collected as a proportion of the rent charged. A high proportion suggests efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a proportion of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of this indicator's reported results. Further, payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

Rent collected as a proportion of the rent charged in 2004-05 is presented in table 16.15.

Table 16.15 Public housing — total rent collected as a proportion of total rent charged (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>
2000-01	100.0	99.6	99.4	101.4	98.6	101.4	98.2	97.4	99.7
2001-02	99.2	99.8	98.8	101.0	97.8	100.7	100.0	97.9	99.3
2002-03	100.5	99.8	99.3	101.0	98.3	99.7	99.9	97.5	99.8
2003-04	99.7	99.3	99.8	101.9	100.0	102.2	99.3	99.9	99.9
2004-05	101.2	101.1	100.6	103.2	100.5	99.7	100.0	102.8	101.1

^a Not calculated via the data repository. Figures supplied by jurisdictions. ^b Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.9.

Outcomes

Location/amenity

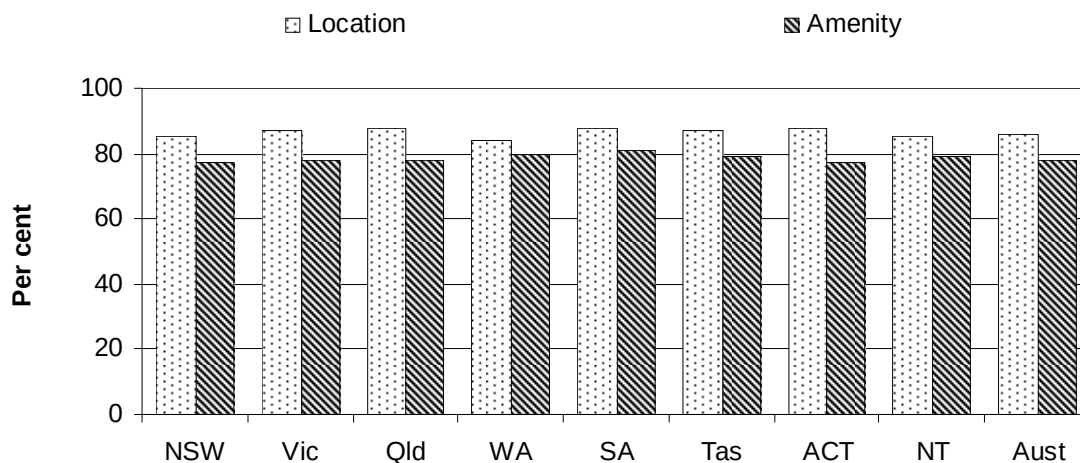
‘Location/amenity’ is an outcome indicator of success in meeting tenants’ needs (box 16.14).

Box 16.14 Location/amenity

‘Location/amenity’ is an outcome indicator of the CSHA’s aim to provide housing assistance that is appropriate to the needs of different households. The location/amenity indicator is a survey-based measure of the proportion of tenants rating location and amenity aspects as important and as meeting their needs.

The data are taken from the 2005 National Social Housing Survey for public rental housing. Public housing tenants were asked whether particular aspects of the location and amenity of their dwellings were important to them and, if so, whether they felt their needs were met. The precision of survey estimates depends on the respondent sample size and the size of the sample estimate. Larger sample sizes with high response rates result in higher precision, as do larger sample estimates for a given or similar sample size. If, for example, 90 per cent of surveyed respondents chose an answer, then there would be more certainty about the actual population’s views than if 50 per cent of respondents chose it. Care thus needs to be taken in interpreting small differences in results (figure 16.11). Further information on the sample size is provided in tables 16A.10 and 16A.11.

Figure 16.11 **Public housing — proportion of tenants rating their current home as meeting their location and amenity needs, 2005^{a, b}**



^a 2005 data are not comparable with 2003 and earlier survey data due to significant changes in survey methodology including question changes and changes to the way performance indicators are derived. ^b Care needs to be taken in interpreting small differences in the results that are affected by various sampling issues.

Source: AIHW (2005i); tables 16A.10 and 16A.11.

Affordability

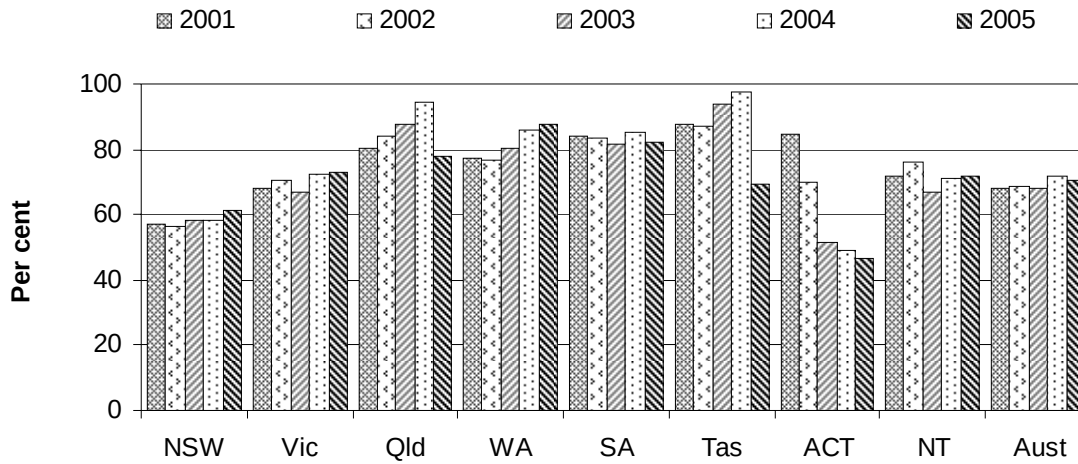
‘Affordability’ is an outcome indicator of ability to access suitable housing (box 16.15).

Box 16.15 Affordability

‘Affordability’ is an outcome indicator of the CSHA’s aim to assist people who are unable to access suitable housing. It measures the rent charged to tenants as a proportion of the market rent for each dwelling, adjusted for CRA. A low proportion implies a high level of subsidy from the State or Territory housing authority after adjusting for imputed CRA. This largely reflects the differing levels of market rent across jurisdictions.

The rent charged at 30 June 2005 as a proportion of the market rent for each dwelling (adjusted for CRA) is presented in figure 16.12. Related information on affordability, measured as the proportion of household income spent on housing costs, can be found at tables 16A.63–16A.66.

Figure 16.12 **Public housing — rent charged as a proportion of market rent, adjusted for CRA^{a, b, c}**



a At 30 June. **b** For details of mixed composition, non-rebated and other households excluded, see table 16A.83. **c** Data for NSW and SA for 2004-05 are not directly comparable to the previous years' data and any direct comparison of 2004-05 data with previous years for NSW and SA should be done with caution. For details of these changes see NSW and SA footnotes in table 16A.12.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.12.

Match of dwelling to household size

'Match of dwelling to household size' is an outcome indicator (box 16.16).

Box 16.16 Match of dwelling to household size

'Match of dwelling to household size' is an outcome indicator of the CSHA's aim to provide housing assistance that is appropriate to the needs of different households, such as household size. It measures the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

Proxy occupancy standard for appropriate sized dwelling, by household structure

<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

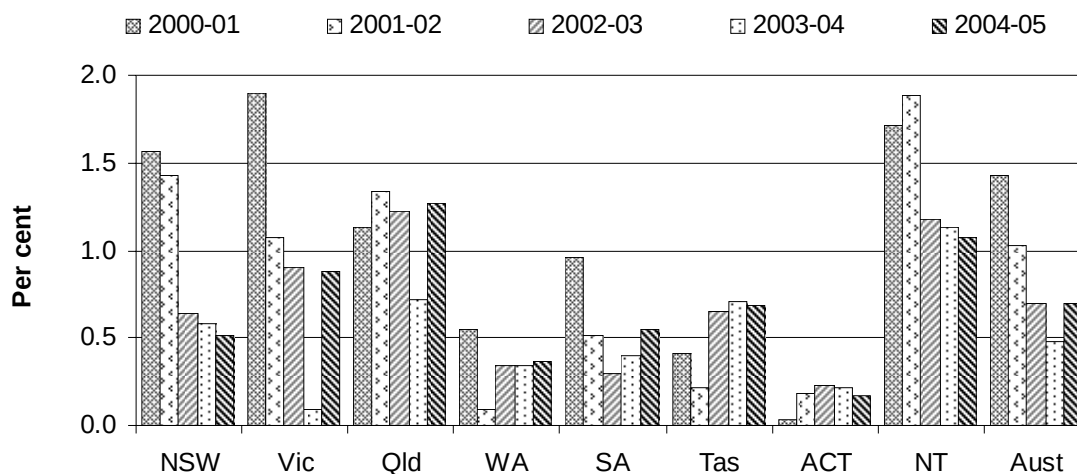
Source: AIHW (2003g).

A low proportion indicates a low proportion of overcrowded households.

The proxy occupancy standard shown above may differ from the specific criteria used by State and Territory housing authorities to match households to dwelling types, affecting interpretation of this indicator. These data are included in AIHW Data Collection reports.

The proportion of households with overcrowding is illustrated in figure 16.13. Information on moderate overcrowding and underuse can be found in table 16A.79.

Figure 16.13 Public housing — proportion of households with overcrowding^{a, b, c, d, e}



^a For details of mixed composition, non-rebated and other households excluded, see table 16A.83. ^b Data for Victoria and Queensland for 2004-05 are based on different methodology from that used for their previous years' data and a direct comparison of 2004-05 data with previous years for Victoria and Queensland cannot be made. For details of these changes see Victoria and Queensland footnotes in table 16A.13. ^d Data for NSW and SA for 2004-05 are not directly comparable to the previous years' data and any direct comparison of 2004-05 data with previous years for NSW and SA should be done with caution. For details of these changes see NSW and SA footnotes in table 16A.13. ^e Data for Victoria and Queensland for 2004-05 are not comparable with the other data presented and should not be directly compared with other jurisdictions' data. For details of non-comparability see Victoria and Queensland footnotes in table 16A.13.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.13.

Customer satisfaction

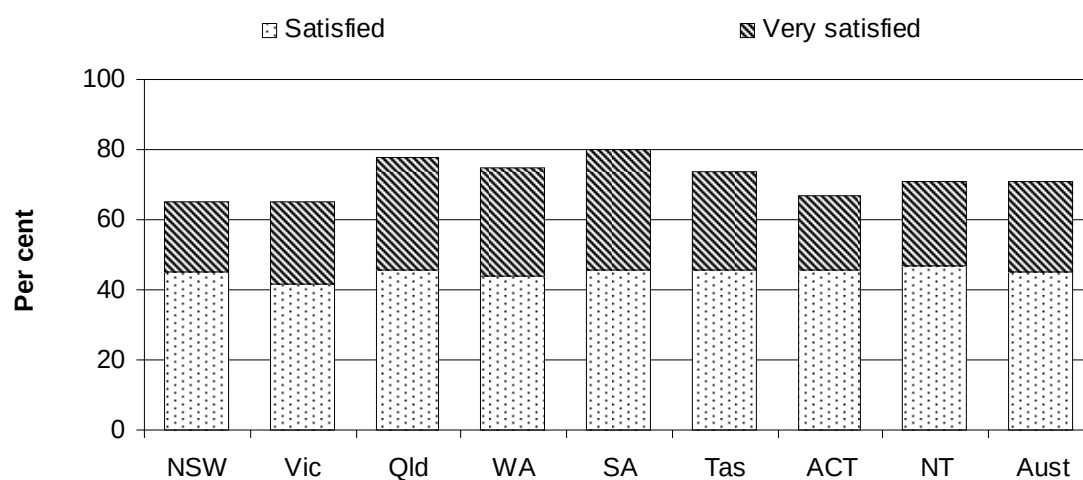
'Customer satisfaction' is an outcome indicator (box 16.17).

Box 16.17 Customer satisfaction

'Customer satisfaction' is an outcome indicator because one aim of the CSHA is to provide housing assistance that is appropriate for different households. Customer satisfaction is a survey measure of satisfaction with the overall service provided by the State or Territory housing authority. Results are expressed in percentage terms.

Data are sourced from the 2005 National Social Housing Survey for public rental housing. Nationally in 2005, 71 per cent of tenants were either satisfied or very satisfied with the service provided (figure 16.14 and table 16A.14).

Figure 16.14 **Public housing — customer satisfaction, 2005^{a, b, c}**



^a At July-August. ^b Caution should be used when interpreting small differences in the results, which are affected by sample and estimate size. Data do not add to 100 per cent as a result of non-responses. ^c Calculated as simple numerical averages due to a lack of raw data.

Source: AIHW 2005 (unpublished); table 16A.14.

Community housing

Community housing data have three sources:

- administrative data, collected by the State or Territory government body with responsibility for administering the community housing program in the jurisdiction
- survey data, collected from the community organisations (providers) that manage the service delivery
- survey data, collected via the National Social Housing Survey.

This section includes data on 10 of the 12 performance indicators in the community housing framework (figure 16.5). Community housing data are largely obtained by surveying community providers, and survey response rates, along with changes to the definitions and counting rules used over time, can influence the comparability of the data. Comparisons over time using community housing data thus need to be made with care. Table 16A.84 outlines the survey response rates and associated information for each jurisdiction for each year from 2000-01 to 2004-05. Performance indicator results are not comparable across the public, community and State owned and managed Indigenous housing sections. The NT provided only administrative data.

Some descriptive data on community housing are contained in table 16A.15. Table 16A.72 lists State and Territory programs included in the community housing data collected.

Outputs

Equity — low income

The first equity indicator reported for community housing is ‘low income’ (box 16.18).

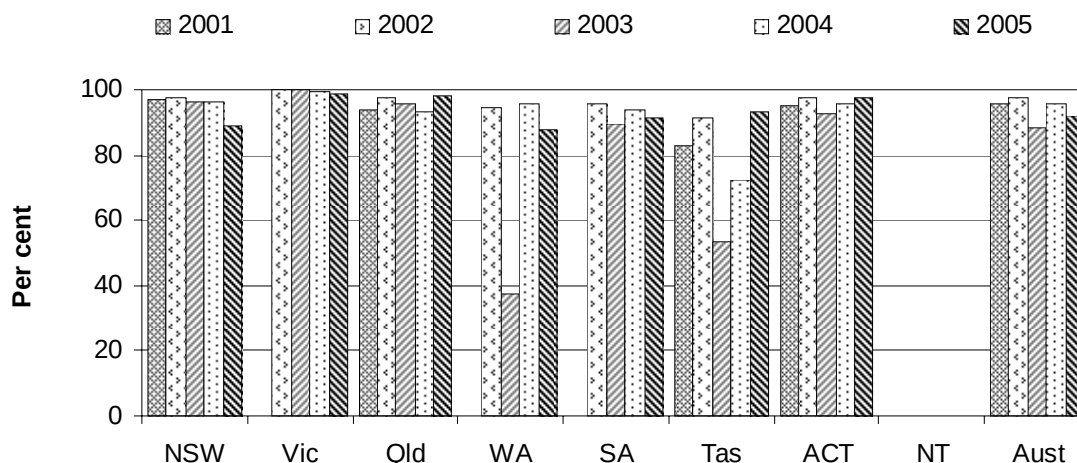
Box 16.18 Low income

'Low income' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures the number of low income households as a proportion of all households (new and existing). A high proportion indicates a high degree of access of low income (and special needs) households.

The low income indicator is measured differently for community housing than for public housing, however, the community housing indicator is based on the low income B cut-offs used in the public rental housing data collection. All households, rather than just new households with low income, are reported.

At 30 June 2005, across those jurisdictions able to provide data, the number of low income households as a proportion of all households (new and existing) is presented in figure 16.15.

Figure 16.15 Community housing — the number of low income households as a proportion of all households (new and existing)^{a, b, c, d, e, f, g, h}



a At 30 June. **b** Data for 2004-05 is not comparable to previous years' due to changes in the definition of a low income household as well as variation in response rates and the community housing organisations who respond to the survey. Data may not be comparable across jurisdictions due to the considerable variation in the way community housing operates in each jurisdiction. Organisation and tenant data may vary considerably due to the policy and program environment and the nature of the sector. **c** Data for Victoria are not comparable to previous years' due to changes in the survey methodology. Data for WA and Tasmania for 2004-05 are based on different methodology from that used for other data reported and also differs to the methodology used in previous years' data. A direct comparison of 2004-05 with previous years for WA and Tasmania may not be made and data should be interpreted with caution. **d** For NSW, data underestimates the number of low income households, as the Data Collection data can only identify households where the main source of assessable income is either 1) a government pension or allowance; or 2) child support of maintenance; or 3) no income. **e** For Victoria, the total number of low income and all households for which income and household composition details are known at 30 June 2005 does not include the Common Equity Rental Cooperation (CERC) program (32 per cent of long term community tenancies in Victoria) due to data collection issues associated with the new survey methodology. **f** For WA and Tasmania, the total number of households has been used as the default value for this item due to inconsistencies in survey data. **g** For ACT, low income households excludes households which contained multiple families, groups of unrelated adults or for which the household composition was unknown as the relationships between household members could not be determined. Households for which income details and/or age of children were unknown were also excluded. **h** For further details refer to footnotes in table 16A.16.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.16.

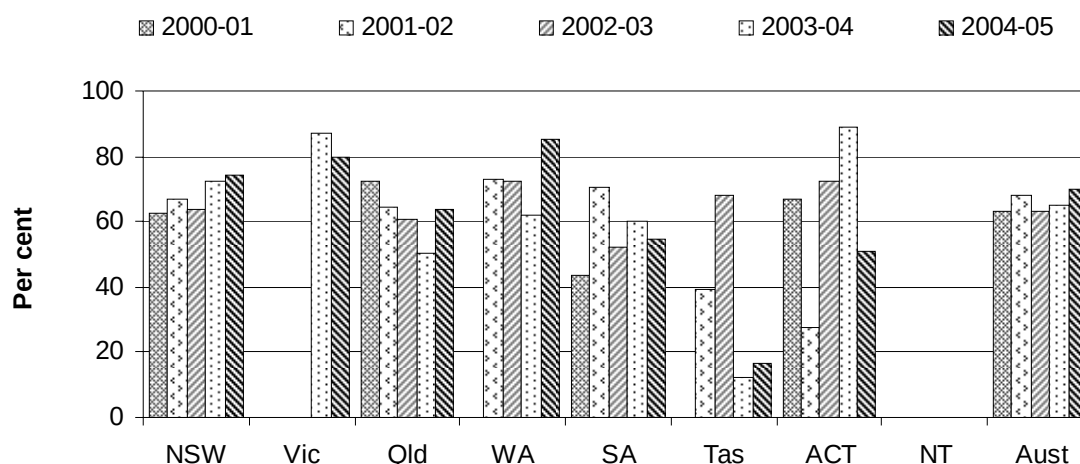
Equity — special needs

The second equity indicator reported for community housing is 'special needs' (box 16.19). The proportion of new tenancies allocated to special needs households in 2004-05 is presented in figure 16.16.

Box 16.19 Special needs

'Special needs' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures the proportion of new tenancies allocated to special needs households. New tenancies are reported as a proxy for all households receiving assistance. Special needs households are those that have either a household member with a disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members. A high proportion indicates a high degree of access of these special needs households.

Figure 16.16 Community housing — new tenancies allocated to households with special needs^{a, b, c, d, e, f, g, h, i, j}



a Year ending 30 June. **b** Data within a jurisdiction may not be comparable to previous years' due to variation in response rates and the community housing organisations who respond to the survey. Data may not be comparable across jurisdictions due to the considerable variation in the way community housing operates in each jurisdiction. Organisation and tenant data may vary considerably due to the policy and program environment and the nature of the sector. **c** Data for Victoria are not comparable to previous years' due to changes in the survey methodology. NSW data definitions differ from national definitions and are based on different methodology from the other data reported. As such, data should be interpreted with caution. Data for Tasmania for 2004-05 are based on different methodology from that used for other data reported and also differs to the methodology used in previous years. A direct comparison of 2004-05 with previous years for Tasmania may not be made and data should be interpreted with caution. For details of the variation, see the Tasmania footnote below. **d** For NSW, the total number of new households with special needs for year ending 30 June 2005 may include households previously housed by another community housing provider. **e** For NSW, household types reported with special needs include 1) Indigenous households, 2) Non-English speaking households, 3) Disability households, 4) Households with support needs, 5) Older person households (principal resident over 75), 6) Young person households (principal resident less than 24 years old), 7) Newly arrived migrants, refugees or asylum seekers, and 8) Other special needs. **f** For NSW, disability is defined in the NSW Community Housing Data Collection as follows: includes anything which restricts the person's everyday activities or otherwise limits their ability to function within the range considered normal for a human being. Disability includes; intellectual, physical, sensory and psychiatric. **g** For Victoria, special needs households do not include CERC program (32 per cent of long term community tenancies in Victoria) due to data collection issues associated with the new survey methodology. **h** For Tasmania, due to inconsistencies in survey data the total number of new households has been used as the default value for this item. **i** For the ACT, the total number of households for which special needs details are known has increased from 92 to 238 – this has resulted in a decrease in the special needs indicator (from 89.1 per cent to 50.8 per cent). **j** For further details refer to footnotes in table 16A.17. See table 16A.84 for response rates and other relevant information).

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.17.

Equity — priority access to those in greatest need

The final equity indicator reported for community housing is 'priority access to those in greatest need' (box 16.20).

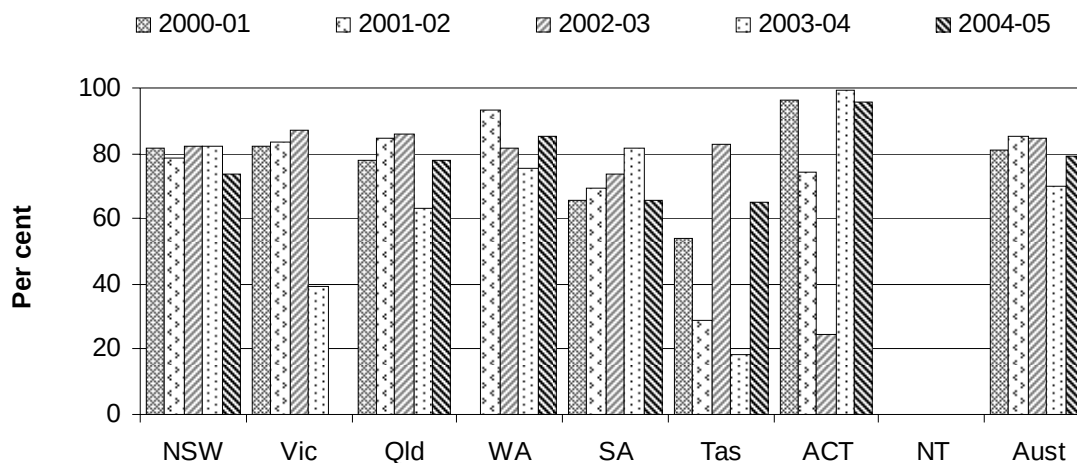
Box 16.20 Priority access to those in greatest need

'Priority access to those in greatest need' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes are such that those in greatest need have first access to housing. It measures the proportion of new allocations to those in greatest need.

Greatest need households are defined as low income households that at the time of allocation are homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs. High values for this indicator represent a high degree of access of those in greatest need.

This is an abbreviated version of the indicator used in the public housing and State owned and managed Indigenous housing collections because only data for the overall total are presented and there is no breakdown into time periods. The proportion of new allocations to those in greatest need is presented in figure 16.17. Differences in State and Territory housing allocation policies can influence comparability for this indicator, because the majority of jurisdictions do not require community housing organisations to segment waiting lists.

Figure 16.17 Community housing — proportion of new allocations to those in greatest need^{a, b, c, d, e, f, g, h}



a Year ending 30 June. **b** Data within a jurisdiction may not be comparable to previous years' due to variation in response rates and the community housing organisations who respond to the survey. Data may not be comparable across jurisdictions due to the considerable variation in the way community housing operates in each jurisdiction. Organisation and tenant data may vary considerably due to the policy and program environment and the nature of the sector. For example, the diverse nature of waiting list and allocation processes in the sector may result in organisations allocating tenants using factors other than priority. Community housing organisations may need to house a mix of tenants (e.g. market rent payers, those who can participate) to remain viable; or may need to obtain the right mix of tenants in a share house (e.g. the current tenant may choose the person with whom they will be sharing). **c** For NSW, data may include households previously housed by another community housing provider. Includes needy households who were imminently homeless or living in crisis accommodation. **d** For Victoria, priority access to those in greatest need is not reported for 2004-05 due to data collection issues associated with the new survey methodology. **e** Data for Victoria do not include CERC program (32 per cent of long term community tenancies in Victoria) due to data collection issues associated with the new survey methodology. **f** National average excludes Victoria (total number of new households for year ending 30 June 2005) as they were not able to provide a complete data set for the priority access to those in greatest need. **g** For SA, the total number of new greatest need allocations for year ending 30 June 2005 is defined as Category 1 applicants. **h** For further details refer to footnotes in table 16A.18.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.18.

Efficiency — direct cost per unit

The efficiency indicator identified for community housing is 'direct cost per unit' (outputs) (box 16.21).

Box 16.21 Direct cost per unit

‘Direct cost per unit’ has been identified as an output indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It measures the cost of providing assistance per dwelling. ‘Direct cost per unit’ can be defined as the total administration costs and the costs of maintaining the operation of dwellings. Two related measures have also been identified:

- gross cost per unit — gross cost to government and community housing providers (administration and operating costs plus capital costs)
- net cost per unit — net cost to government and community housing providers (cost excluding rents received from tenants).

Due to a high level of capital expenditure in housing, gross and net cost per unit are predominantly driven by the user cost of capital (see box 16.10). Caution must therefore be used when interpreting the indicator because the user cost of capital and service delivery models differ across the jurisdictions. The cost per dwelling indicators also do not provide any information on the quality of service provided (for example, the standard of dwellings).

Only ‘direct cost per unit’ is reported for community housing in this Report. The Steering Committee has identified gross and net cost per output unit for development and reporting in future. Data were not available for this Report.

The ‘direct cost per unit’ for 2003-04 is presented in table 16.16. Caution must be used when interpreting this indicator because service delivery models differ across jurisdictions.

Table 16.16 Community housing — direct cost per unit (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>
2003-04	9 224.2	5 166.9	4 291.2	7 861.3	3 751.5	7 712.5	na	na	6 529.4

^a Year ending 30 June. ^b For further details refer to footnotes in table 16A.19. **na** Not available.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.19.

Efficiency — occupancy rate

A second efficiency indicator reported for community housing is the ‘occupancy rate’ (box 16.22).

Box 16.22 Occupancy rate

The 'occupancy rate' is an output indicator of the efficiency of housing utilisation. It is the proportion of dwellings occupied. The term 'occupied dwelling' refers to dwellings occupied by tenants who have a tenancy agreement with the relevant community housing organisation. Occupancy is influenced by both turnover and housing supply.

The proportion of community housing occupied at 30 June 2005 is presented in table 16.17. The NT occupancy rates are based on the assumption that all dwellings are occupied due to many organisations turning away people seeking accommodation.

Table 16.17 Community housing — occupancy rates (per cent)^{a, b}

	NSW	Vic ^{c, d, e}	Qld ^f	WA	SA	Tas	ACT ^g	NT ^h	Aust
2000-01	97.9	94.6	95.8	na	94.7	90.4	94.3	100.0	95.9
2001-02	98.2	95.6	94.8	97.2	95.8	100.0	94.7	100.0	96.5
2002-03	97.8	96.3	96.1	100.4	95.6	98.3	97.4	100.0	97.0
2003-04	98.6	98.1	95.0	99.8	95.4	99.8	95.8	100.0	97.5
2004-05	98.2	94.5	95.7	98.0	95.1	98.9	89.8	100.0	96.5

^a At 30 June. ^b Data within a jurisdiction may not be comparable to previous years' due to variation in response rates and the community housing organisations who respond to the survey. Data may not be comparable across jurisdictions due to the considerable variation in the way community housing operates in each jurisdiction. Organisation and tenant data may vary considerably due to the policy and program environment and the nature of the sector. ^c Data for Victoria are not comparable to previous years' due to changes in the survey methodology. For details of the variation, see the footnote for Victoria. ^d Due to changes in survey response rates and methodology, results for 2004-05 are not comparable with results in earlier years. Vacancy rates in some community housing programs such as Group Housing for people with disabilities may be affected by the program model which provides multiple tenancy arrangements in the same dwelling. In these cases the agency is required to match disabled clients in shared accommodation, which can increase the number of vacancy units at a point in time and turnaround times. ^e Includes some accommodation for disabled which has been allocated for a carer or equipment aids for disabled. ^f Based on administrative data apportioned according to the percentage of occupied dwellings indicated in the survey data (4769 out of 4981). This approach was taken to ensure consistency with reporting all dwelling information from administrative data. ^g For the total community housing providers data are extracted from the unit record file of 5286 dwellings provided to the AIHW. Through the 2004-05 Trial Collection of Unit Record Data it has been identified that that the dwelling count is undercounted due to tenancy units not being counted separately in some cases. The total number of tenancy (rental) units at 30 June 2005 is reported from administrative data. The total number of tenancy (rental) units at 30 June 2005 from survey data are 4981. ^h It is assumed that all dwellings are occupied due to many organisations turning away people seeking accommodation. **na** Not available.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.20.

Efficiency — turnaround time

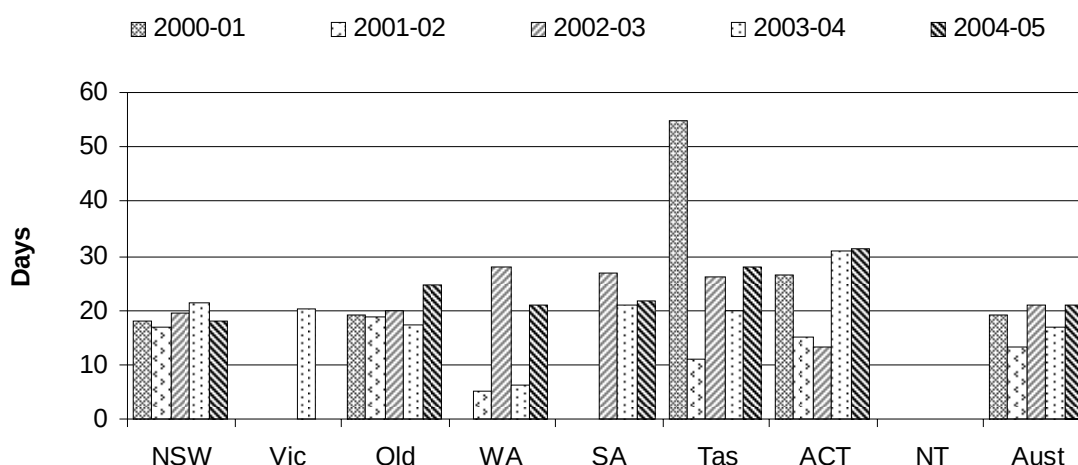
The third efficiency indicator reported for community housing is 'turnaround time' (box 16.23).

Box 16.23 Turnaround time

'Turnaround time' is an output indicator of the time taken to reallocate vacant properties after they have been vacated, acquired or newly constructed. The indicator measures the average time taken in days for vacant dwellings to be occupied. The length of time taken to rent untenanted dwellings affects allocations of housing, waiting times, the length of waiting lists and rent foregone. A low turnaround time suggests efficient housing allocation and asset management. All jurisdictions aim to minimise turnaround times.

The average number of days for vacant stock to be allocated in 2004-05 for the jurisdictions able to provide data are presented in figure 16.18.

Figure 16.18 Community housing — average turnaround times^{a, b, c, d, e}



^a Year ending 30 June. ^b NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT data are based on surveys. See table 16A.84 for response rates and other relevant information. ^c Data within a jurisdiction may not be comparable to previous years' due to variation in response rates and the community housing organisations who respond to the survey. Data may not be comparable across jurisdictions due to the considerable variation in the way community housing operates in each jurisdiction. Organisation and tenant data may vary considerably due to the policy and program environment and the nature of the sector. For example, variation in tenancy management procedures across the sector may result in the count of days vacant commencing from the date the keys are handed in, a nominated day of the week (e.g. Sunday), the date abandonment is discovered etc. The need to obtain the right mix of tenants can also inflate vacancy days (e.g. a tenancy (rental) unit may be vacant in a share house/complex/community until an appropriate tenant is chosen). ^d Not reported for Victoria for 2004-05 due to data collection issues associated with the new survey methodology. NSW data definitions differ from national definitions and are based on different methodology from the other data reported. As such, data should be interpreted with caution. For details of the variation, see the NSW footnote below. Data for the ACT are based on a different methodology from the other data reported and as such data should be interpreted with caution. For details of the variation, see the ACT footnote below. ^e For NSW, providers reported on the number of dwellings occupied at 30 June 2005 which were vacant at any time during the year. If a property was vacant more than once, they reported a single consolidated 'episode' comprising the property and the total number of days vacant for all episodes. They did not separately count multiple episodes for each property. 'Average time taken for occupancy of vacant stock' calculated using these data are therefore overstated. ^e For the ACT, the calculation of average time taken for occupancy of vacant stock excludes boarding houses and other dwellings containing multiple tenancies. Vacancies that commenced prior to 1 July 2004 are also excluded as the vacancy start date for these vacancies were not collected in the survey.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.21.

Efficiency — rent collected

The fourth efficiency indicator reported for community housing is 'rent collected' (box 16.24).

Box 16.24 Rent collected

'Rent collected' is an output indicator of the CSHA's guiding principle to undertake efficient and cost-effective management. It is the total rent collected as a proportion of the rent charged. A high proportion suggests efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a proportion of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of this indicator's reported results. Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

For community housing, data on rent collected are reported with a one year lag to allow community housing providers an extra year to collate financial data (table 16.18). 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 16.18 Community housing — total rent collected as a proportion of total rent charged (per cent)^{a, b, c, d}

	NSW	Vic	Qld	WA ^e	SA	Tas	ACT	NT	Aust
1999-2000	92.5	98.5	97.5	na	na	99.0	96.7	na	94.9
2000-01	92.5	na	98.6	99.2	97.8	na	97.6	na	95.5
2001-02	98.5	na	92.6	97.5	97.9	98.7	98.9	na	97.1
2002-03	98.8	98.6	83.8	100.5	97.3	98.9	99.7	na	95.7
2003-04	99.4	96.1	98.6	98.0	97.8	101.2	92.6	na	98.3

^a At 30 June. ^b Data for the 2003-04 financial year are reported to provide additional time to collate financial data. Therefore it relates to a different number of providers and tenant households. ^c Data within a jurisdiction may not be comparable to previous years' due to variation in response rates and the community housing organisations who respond to the survey. Data may not be comparable across jurisdictions due to the considerable variation in the way community housing operates in each jurisdiction. Organisation and tenant data may vary considerably due to the policy and program environment and the nature of the sector. ^d Data for Victoria are not comparable to previous years' due to changes in the survey methodology. ^e The reported result for this indicator is based on survey responses from organisations which provided data on both total rent charged and total rent collected for the year ending 30 June 2004. **na** Not available.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.22.

Outcomes

Location/amenity

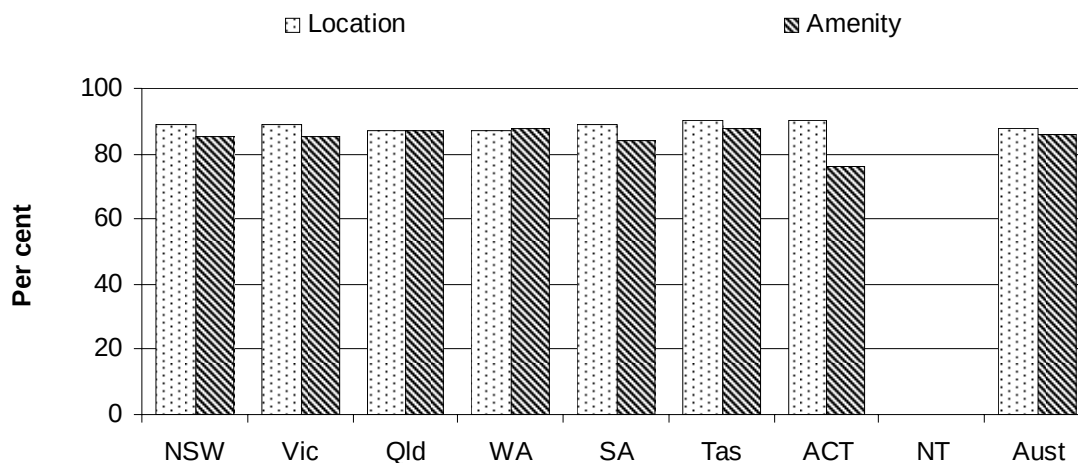
'Location/amenity' is an outcome indicator (box 16.25).

Box 16.25 Location/amenity

'Location/amenity' is an outcome indicator of the CSHA's aim to provide housing assistance that is appropriate to the needs of different households. The location/amenity indicator is a survey-based measure of the proportion of tenants rating location and amenity aspects as important and as meeting their needs. Results are expressed as percentages.

The data for this indicator are from the 2005 Community Housing National Social Housing Survey. Community housing tenants were asked whether particular aspects of the location and amenity of their dwellings were important to them and, if so, whether they felt their needs were met. The proportions of tenants satisfied with the location and amenity of their dwelling in February/March 2005 are presented in figure 16.19. As with public housing, the precision of survey estimates depends on the survey sample size (see the discussion of location/amenity for public housing). More information on the sample size is provided in tables 16A.23 and 16A.24.

Figure 16.19 **Community housing — tenants satisfied with location and amenity aspects of their dwelling, 2005^{a, b, c}**



^a At April/May. ^b Care needs to be taken in interpreting small differences in the results that are affected by various sampling issues. ^c May not represent national total due to data not being available from all jurisdictions.

Source: AIHW (2005j); tables 16A.23 and 16A.24.

Affordability

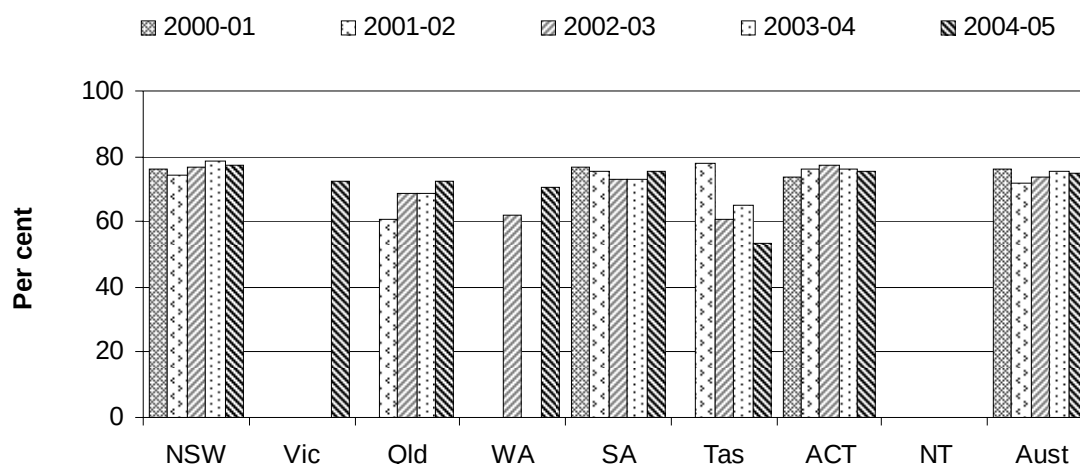
'Affordability' is an outcome indicator (box 16.26).

Box 16.26 Affordability

'Affordability' is an outcome indicator of the CSHA's aim to provide affordable housing to assist people who are unable to access suitable housing. It measures the proportion of household income left after paying rent. A high proportion indicates that housing is affordable. This affordability measure differs from that reported for public housing and State owned and managed Indigenous housing, which measures the rent charged to tenants as a proportion of the market rent for each dwelling, adjusted for CRA.

The proportion of household income left after paying rent in 2004-05 is presented in figure 16.20. 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.77.

Figure 16.20 Community housing — proportion of income left after paying rent^{a, b, c, d, e, f, g, h, i, j, k, l, m, n, o}



^a At 30 June. ^b NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT data are based on surveys. See table 16A.84 for response rates and other relevant information. ^c Data within a jurisdiction may not be comparable to previous years' due to variation in response rates and the community housing organisations who respond to the survey. Data may not be comparable across jurisdictions due to the considerable variation in the way community housing operates in each jurisdiction. Organisation and tenant data may vary considerably due to the policy and program environment and the nature of the sector. ^d Data for Victoria are not comparable to previous years' due to changes in the survey methodology. Data for Tasmania for 2004-05 are based on different methodology from that used in previous years' data and a direct comparison of 2004-05 with previous years for Tasmania may not be made. For Tasmania, the reported result for this indicator is based on survey responses from organisations which provided data on both total rents charged for the week ending 30 June 2005 and total household assessable income for that week. There are significant data quality issues which have impacted on this indicator and results should be interpreted with caution. ^e For Victoria, funding arrangements for some community managed programs do not allow full transparency of rental information. Some rent includes share of cost for utilities and board. ^f Data for Victoria do not include CERC program (32 per cent of long term community tenancies in Victoria) due to data collection issues associated with the new survey methodology. ^g For Queensland, the total rents charged for week of 30 June 2005 includes CRA as listed in the Community Housing Rent Policy. ^h For Queensland, the total household assessable income for week of 30 June 2005, does not include CRA as listed in the Community Housing Rent Policy. ⁱ For WA, the reported result for the proportion of household income left after paying rent indicator is based on survey responses from organisations which provided data on both total rents charged for the week ending 30 June 2005 and total household assessable income for that week. ^j For SA, the total rents charged for week of 30 June 2005 does not include 25 households for which rent details are not known. and the total household assessable income for week of 30 June 2005 does not include 432 households for which income details are not known. ^k For Tasmania, the reported result for this indicator is based on survey responses from organisations which provided data on both total rents charged for the week ending 30 June 2005 and total household assessable income for that week. There are significant data quality issues which have impacted on this indicator and results should be interpreted with caution. ^l For the ACT, rent charged in boarding houses may include utilities costs. ^m For the ACT, the reported result for this indicator is based on survey responses from organisations which provided data on both total rents charged for the week ending 30 June 2005 and total household assessable income for that week. Rent charged in boarding houses may include utilities costs. ⁿ National average excludes NT (total rents charged for week of 30 June 2005) as they were not able to provide a complete data set for affordability. ^o For further details refer to footnotes in table 16A.25.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.25.

Match of dwelling to household size

‘Match of dwelling to household size’ is an outcome indicator (box 16.27).

Box 16.27 Match of dwelling to household size

‘Match of dwelling to household size’ is an outcome indicator of the CSHA’s aim to provide housing assistance that is appropriate to the needs of different households, such as household size. It measures the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

Proxy occupancy standard for appropriate sized dwelling, by household structure

<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

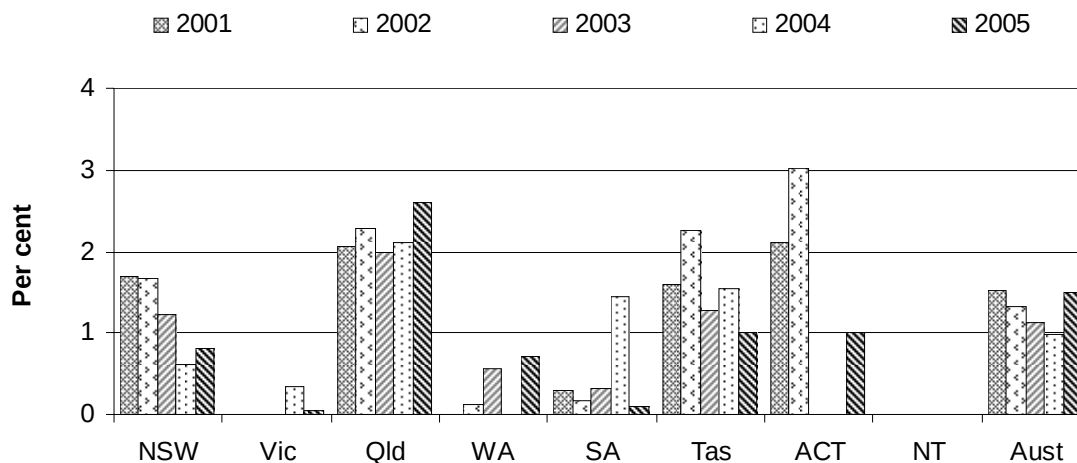
Source: AIHW (2003a).

A low proportion indicates a low proportion of overcrowded households.

The proxy occupancy standard above may differ from the specific criteria used by community housing organisations to match households to dwelling types, affecting interpretation of this indicator.

The proportion of households with overcrowding is illustrated in figure 16.21. More information on moderate overcrowding and underutilisation for community housing can be found in table 16A.80.

Figure 16.21 **Community housing — proportion of households with overcrowding**^{a, b, c, d, e, f}



^a At 30 June. ^b NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT data are based on surveys. See table 16A.84 for response rates and other relevant information. ^c Data within a jurisdiction may not be comparable to previous years' due to variation in response rates and the community housing organisations who respond to the survey. Data may not be comparable across jurisdictions due to the considerable variation in the way community housing operates in each jurisdiction. Organisation and tenant data may vary considerably due to the policy and program environment and the nature of the sector. ^d Data for Victoria are not comparable to previous years' due to changes in the survey methodology. Data for Queensland for 2004-05 are based on different methodology from that used for previous years' data and a direct comparison of 2004-05 with previous years' for Queensland cannot be made. Changes to the structure of the survey question resulted in an increase in the number of households being identified as overcrowded. ^e Data for Victoria do not include CERC program (32 per cent of long term community tenancies in Victoria) due to data collection issues associated with the new survey methodology. ^f Data for the ACT excludes households which contained multiple families, groups of unrelated adults or for which the household composition was unknown as the relationships between household members could not be determined.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.26.

Customer satisfaction

'Customer satisfaction' is an outcome indicator (box 16.28).

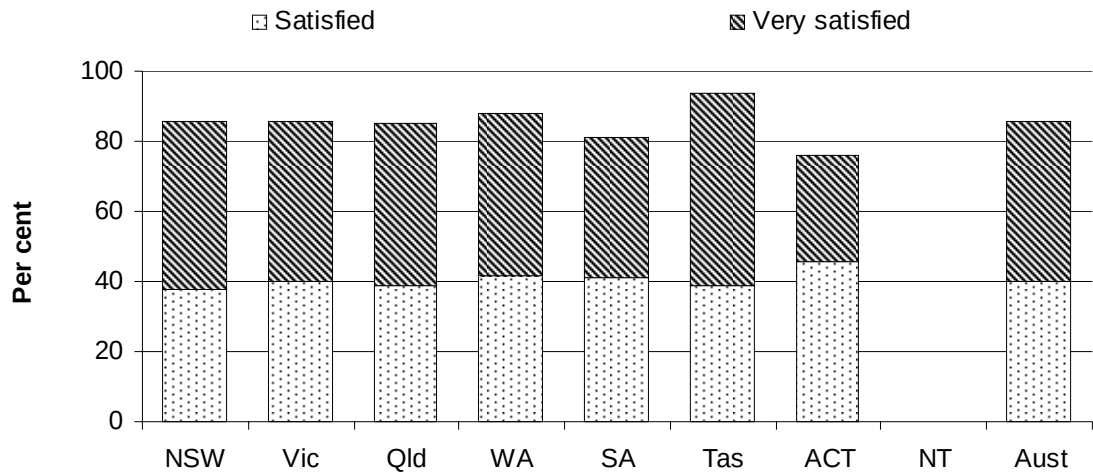
Box 16.28 Customer satisfaction

'Customer satisfaction' is an outcome indicator because one aim of the CSHA is to provide housing assistance that is appropriate for different households. Customer satisfaction is a survey measure of satisfaction with the overall service provided by the community housing organisation. Results are expressed in percentage terms.

The data for this indicator are from the 2005 Community Housing National Social Housing Survey. Nationally, in February/March 2005, 86.0 per cent of tenants were

satisfied or very satisfied with the services provided by their community housing organisation (figure 16.22).

Figure 16.22 **Community housing — customer satisfaction, 2005**^{a, b, c, d, e, f}



^a At April/May. ^b Care needs to be undertaken in interpreting small differences in the results that are affected by sample and estimate size. ^c Categories do not add to 100 per cent because non-responses and neutral responses are not included. ^d Comparisons may be influenced by a range of factors beyond quality of service, such as the age profile of tenants. ^e May not represent national total due to data not being available from all jurisdictions. Data are not available for NT as it chose not to participate in the survey due to its small community housing tenant population. ^f Data for WA are based on different methodology from the other jurisdictions and should be interpreted with caution. For details of these variations including sample size and survey response rate see NFO Donovan Research (2002).

Source: AIHW (unpublished); table 16A.27.

State owned and managed Indigenous housing

Different delivery contexts, locations and types of client may affect the performance reported in this section. Care therefore needs to be taken in interpreting performance indicator results, and the qualifications presented with the data need to be considered. Variations in the funding and administration of State owned and managed Indigenous housing across jurisdictions may also influence the comparability of data. As outlined in section 16.1, the ACT and the NT are not included in the State owned and managed Indigenous housing data collection.

In addition, performance indicator results are not comparable across the public, community and State owned and managed Indigenous housing sections. Some descriptive data on State owned and managed Indigenous housing are included in table 16A.28. State owned and managed Indigenous housing dwellings are more likely than public or community housing dwellings to be located in rural or remote areas (table 16.10).

Outputs

Equity — low income and special needs

The first two equity indicators reported are ‘low income’ and ‘special needs’ (box 16.29).

Box 16.29 Low income and special needs

‘Low income’ is an output indicator of the CSHA’s aim to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures three low income components:

- new low income households as a proportion of all new households
- new low income households plus special needs (not low income) households, as a proportion of all new households
- households paying less than market rent and special needs households paying market rent, as a proportion of all households (new and existing).

High values for these measures indicate high degrees of targeting of low income (and special needs) households.

(Continued on next page)

Box 16.29 (Continued)

The two household income measures for this indicator are:

- low income A households — 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).
- low income B households — 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.

Households with incomes below these levels are included in the measure, although they may not necessarily receive income support benefits.

It is not appropriate to use this indicator to compare the performance of public, community and State owned and managed Indigenous housing. State owned and managed Indigenous housing uses a definition of special needs more appropriate to the program. The special needs indicator for public housing includes Indigenous households in the definition of special needs households, so using this definition for State owned and managed Indigenous housing would result in 100 per cent of State owned and managed Indigenous housing households being regarded as having special needs.

'The definition also differs for 'aged' households: households with a principal tenant aged 50 years or over are considered special needs households for State owned and managed Indigenous housing, while households with a principal tenant aged 75 years or over are considered special needs households for mainstream public and community housing. This difference reflects the lower life expectancy and higher level of illness among Indigenous Australians.

'Special needs' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures the proportion of new tenancies allocated to special needs households. New tenancies are reported as a proxy for all households receiving assistance. Special needs households are those 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 proportion indicates a high degree of access of special needs households.

It is not appropriate to use this indicator to compare the performance of public, community and State owned and managed Indigenous housing because the special needs category includes Indigenous people for public and community housing.

The proportion of new tenancies allocated to low income A and low income A plus special needs (not low income) households in 2004-05 is presented in table 16.19. Table 16A.29 contains information on both low income A households and low income B households.

Table 16.19 State owned and managed Indigenous housing — low income and special needs households, as a proportion of all new households (per cent)^{a, b, c}

	NSW	Vic	Qld	WA ^d	SA	Tas	Total
<i>New low income A households as proportion of all new households</i>							
2000-01	91.3	80.0	81.4	89.3	88.9	76.8	86.5
2001-02	89.6	88.1	83.1	81.3	87.3	95.5	85.8
2002-03	91.5	87.8	89.7	89.1	86.5	87.2	89.2
2003-04	94.4	90.5	83.3	93.5	89.2	89.5	90.6
2004-05	94.2	87.7	76.1	92.9	86.0	86.0	88.0
<i>New low income A households plus special needs (not low income) households, as proportion of all new households</i>							
2000-01	96.9	83.3	87.0	92.0	97.9	81.7	91.4
2001-02	92.6	91.7	89.5	84.4	90.1	97.0	89.6
2002-03	92.9	92.9	94.6	92.1	93.2	92.3	93.0
2003-04	96.7	96.8	87.5	95.5	92.4	98.1	94.0
2004-05	96.6	93.1	84.2	95.9	91.3	100.0	92.9

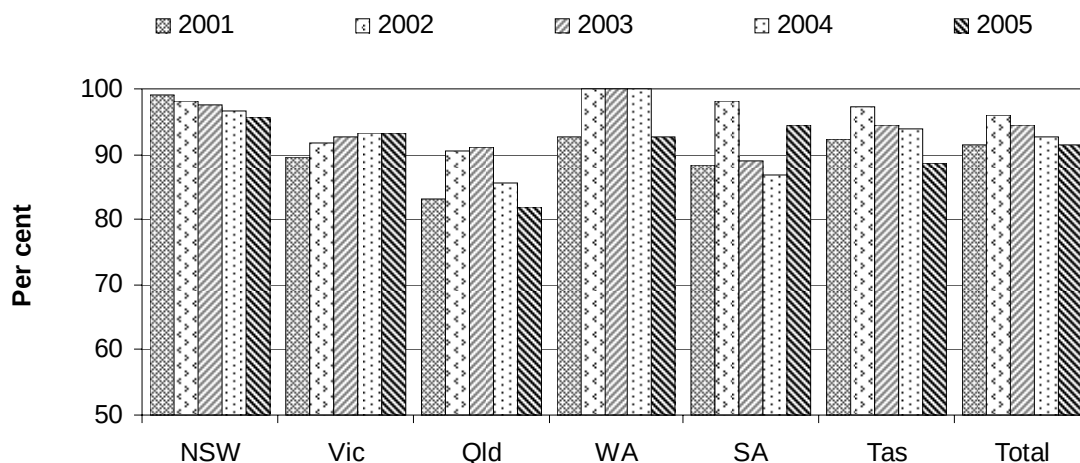
^a For details of mixed composition, non-rebated and other households excluded, see table 16A.85. ^b Data for 2004-05 are not directly comparable to the previous years' data and any direct comparison of 2004-05 data with previous years should be done with caution. For details of these changes see footnotes in table 16A.29.

^c Data are not comparable across all jurisdictions due to each using different methodology. For this reason data should not be directly compared across jurisdictions. For details of non-comparability see footnotes in table 16A.29. ^d Data for WA are based on different methodology from that used for their previous years' data and a direct comparison of 2004-05 data with previous years for WA cannot be made. For details of these changes see WA footnotes in table 16A.29.

Source: AIHW (various years); CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.29.

The proportion of households paying less than market rent and special needs households paying market rent, as a proportion of all households (new and existing) at 30 June 2005 is presented in figure 16.23.

Figure 16.23 State owned and managed Indigenous housing — households paying less than market rent and special needs households paying market rent as a proportion of all households (new and existing)^{a, b, c, d}

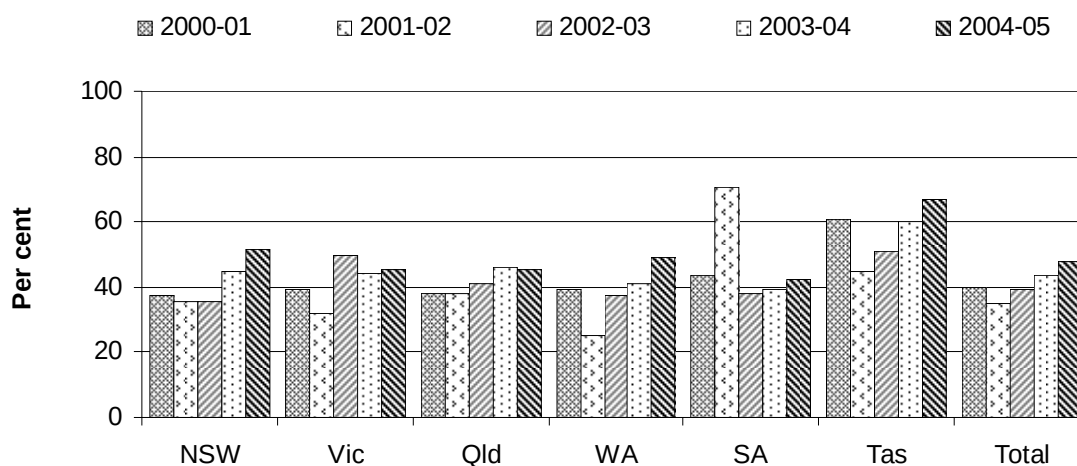


a At 30 June. **b** Data for NSW and SA for 2004-05 are not directly comparable to the previous years' data and any direct comparison of 2004-05 data with previous years for NSW and SA should be done with caution. For details of these changes see NSW and SA footnote in table 16A.30. **c** Data for WA are based on different methodology from that used for their previous years' data and a direct comparison of 2004-05 data with previous years for WA cannot be made. For details of these changes see WA footnotes in table 16A.30. **d** Data for Queensland and WA for 2004-05 are not comparable with the other data presented and should not be directly compared with other jurisdictions data. For details of non-comparability see Queensland and WA footnotes in table 16A.30.

Source: AIHW (various years); CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.30.

The proportion of new tenancies allocated to special needs households is presented in figure 16.24.

Figure 16.24 **State owned and managed Indigenous housing — new tenancies allocated to households with special needs^{a, b}**



^a Data for WA for 2004-05 are based on different methodology from that used for their previous years' data and a direct comparison of 2004-05 data with previous years for WA cannot be made. For details of these changes see WA footnotes in table 16A.31. ^b Data for Queensland and WA for 2004-05 are not comparable with the other data presented and should not be directly compared with other jurisdictions data. For details of non-comparability see Queensland and WA footnotes in table 16A.31.

Source: AIHW (various years); CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.31.

Equity — priority access to those in greatest need

The final equity indicator reported for State owned and managed Indigenous housing is 'priority access to those in greatest need' (box 16.30).

The proportion of new allocations to those in greatest need for 2004-05 is presented in table 16.20. Differences in State housing allocation policies can influence comparability for this indicator. The relatively low level of priority allocations in NSW and Victoria were partly because Indigenous tenants in greatest need are likely to be housed under the State's general public housing programs.

Box 16.30 Priority access to those in greatest need

'Priority access to those in greatest need' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes are such that those in greatest need have first access to housing. It measures the proportion of new allocations to those in greatest need. Greatest need households are defined as low income households that at the time of allocation are homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs.

Table 16.20 shows the proportion of new allocations to those in greatest need by time on the waiting list. Data are provided for tenants waiting less than three months to more than two years. These numbers are not cumulative. A high value for this indicator, particularly for short time frames, represents a high degree of access of those in greatest need without these people waiting long periods of time.

It may not be appropriate to compare the performance of public, community and State owned and managed Indigenous housing in relation to this indicator. In some jurisdictions, different priority allocation guidelines may be used to allocate targeted housing. Priority access for Indigenous people is given through mainstream housing. Further, where allocation is made at the community level, reasons for allocation may not be recorded in information management systems.

Table 16.20 State owned and managed Indigenous housing — proportion of new allocations to those in greatest need (per cent)

	NSW ^{a, b}	Vic	Qld ^c	WA	SA	Tas	Total
Total for year ending							
30 June 2005	10.1	20.9	7.5	26.2	83.4	na	27.5
Proportion of greatest need allocations to new allocations, by time to allocation							
<3 months	20.5	26.6	10.6	36.3	77.3	na	38.7
3–<6 months	21.7	23.1	9.5	55.3	97.3	na	47.0
6 months–<1 year	3.0	32.1	3.7	11.1	97.0	na	24.0
1–<2 years	3.9	11.5	9.8	–	93.1	na	19.0
2+ years	1.8	–	5.3	–	56.3	na	5.4

^a The 'priority access to those in greatest need' excludes households with 'very high rental costs', and hence the 'greatest need' data represent an undercount. The cost of housing at the time of allocation is not collected in NSW, as very high rental costs do not constitute a reason for 'priority' housing. This is because most applicants in NSW face high private rental costs, particularly in Sydney, and if this were deemed a reason for 'priority' housing nearly all applicants would be classified as 'priority'. ^b For further details refer to footnotes in table 16A.32. ^c The total number of new households allocated housing for year ending 30 June 2005 excludes 7 households for which allocation time could not be determined. **na** Not available. – Nil or rounded to zero.

Source: AIHW (2005a); table 16A.32.

Efficiency — direct cost per unit

The efficiency indicator identified for State owned and managed Indigenous housing is 'direct cost per unit' (outputs) (box 16.31).

Box 16.31 Direct cost per unit

'Direct cost per unit' has been identified as an output indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It measures the cost of providing assistance per dwelling. 'Direct cost per unit' can be defined as the total administration costs and the costs of maintaining the operation of dwellings. Two related measures have also been identified:

- gross cost per unit — gross cost to government (administration and operating costs plus capital costs)
- net cost per unit — net cost to government (cost excluding rents received from tenants).

Due to a high level of capital expenditure in housing, gross and net cost per unit are predominantly driven by the user cost of capital (see box 16.10). Caution must therefore be used when interpreting the indicator because the user cost of capital and service delivery models differ across the jurisdictions. The cost per dwelling indicators also do not provide any information on the quality of service provided (for example, the standard of dwellings).

The costs incurred by jurisdictions in providing State owned and managed Indigenous housing include:

- administration costs (the cost of the administration offices of the property manager and tenancy manager)
- operating costs (the costs of maintaining the operation of the dwelling, including repairs and maintenance, rates, the costs of disposals, market rent paid and interest expenses)
- depreciation costs
- the user cost of capital (the cost of the funds tied up in the capital used to provide State owned and managed housing).

Payroll tax has been excluded from gross cost per output unit calculations for State owned and managed Indigenous housing. Further, depreciation costs and the user cost of capital (capital costs) are not available for reporting on State owned and managed Indigenous housing. The cost per dwelling shown in figure 16.25 represents gross recurrent expenditure (that is, administration and operating costs) per dwelling. Rent received from tenants has not been deducted. In 2004-05, the

gross cost per Indigenous dwelling (excluding capital costs and payroll tax) was \$5423, nationally (figure 16.25).

The gross cost per dwelling is presented in figure 16.25. A low cost per dwelling can indicate greater efficiency. Caution must be used, however, when interpreting indicators in this way because the cost per dwelling indicator does not provide any information on the quality of service provided (for example, the standard of dwellings). Caution must also be used when interpreting this indicator because service delivery models differ across jurisdictions.

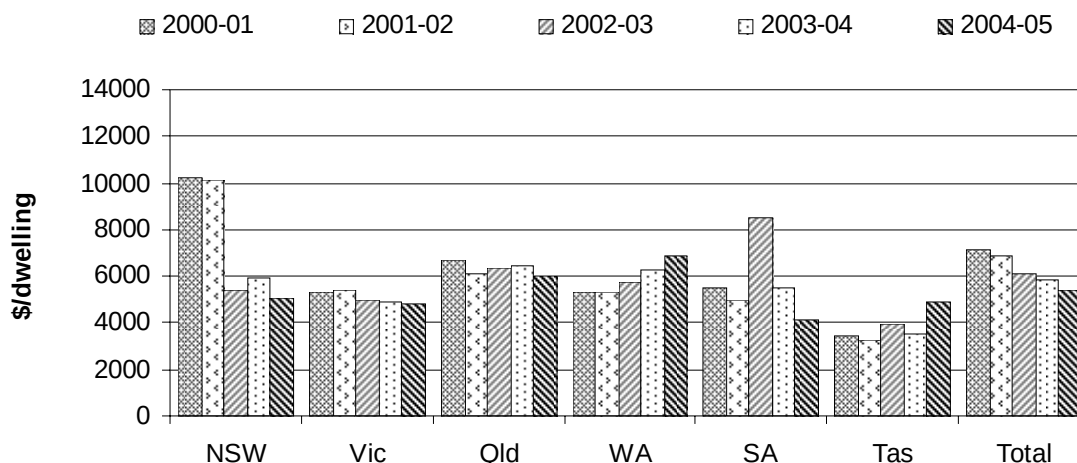
Only gross cost per output unit is reported for State owned and managed Indigenous housing in this Report. The Steering Committee has identified direct cost per unit and net cost per output unit for development and reporting in future.

As with other indicators, it is not appropriate to compare the gross cost per State owned and managed Indigenous housing dwelling with the gross cost per dwelling for public housing (which would be the public housing equivalent of this indicator) because there is greater scope for economies of scale in administration costs with public housing, which is a much larger program overall.

State owned and managed Indigenous housing dwellings are also more highly concentrated in rural and remote areas where the cost of providing housing assistance is potentially greater. The need to construct culturally appropriate housing (possibly requiring a higher standard of amenities) may also affect the cost per dwelling. Finally, different cost structures may apply to the programs. Construction of dwellings, for example, under State owned and managed Indigenous housing may involve a skills development element to allow for training of apprentices in rural areas.

Care needs to be taken in interpreting the total cost of delivering housing. Administration costs and operating costs, for example, may not capture all costs incurred by government, so the total costs of housing provision could be understated.

Figure 16.25 State owned and managed Indigenous housing — gross cost per dwelling, excluding capital costs (2004-05 dollars)^{a, b, c, d, e, f, g}



^a For further details refer to footnotes in table 16A.33. ^b The total direct costs for year ending 30 June 2005 is not calculated via the data repository. Figures supplied by jurisdictions. ^c The total number of dwellings at 30 June 2005 result is reported. ^d In NSW, costs have decreased since last year due to the completion of several upgrading programs in 2003-04. ^e For Victoria, the property data for this collection are unreconciled and may not match published jurisdictional annual data. ^f Data for WA includes the costs for those dwellings (around 160 dwellings leased to other organisations) that are excluded in the total number of dwellings. ^g For WA, the total number of dwellings at 30 June 2005 data are derived through the repository process are unreconciled with jurisdictional data and may not match published jurisdictional annual data.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.33.

Efficiency — occupancy rate

The second efficiency indicator reported for State owned and managed Indigenous housing is the 'occupancy rate' (box 16.32).

Box 16.32 Occupancy rate

The 'occupancy rate' is an output indicator of the efficiency of housing utilisation. It is the proportion of dwellings occupied. The term 'occupied dwelling' refers to dwellings occupied by tenants who have a tenancy agreement with the relevant housing authority. Occupancy is influenced by both turnover and housing supply and demand.

The proportion of State owned and managed Indigenous housing stock (including untenable dwellings) occupied at 30 June 2005 is presented in table 16.21.

Table 16.21 State owned and managed Indigenous housing — occupancy rates

	<i>NSW</i>	<i>Vic^a</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Total</i>
2000-01	98.0	95.4	94.0	96.0	94.3	93.1	95.8
2001-02	97.9	96.6	94.6	95.2	91.2	92.7	95.4
2002-03	97.6	96.1	94.2	94.4	91.8	95.8	95.2
2003-04	98.0	96.7	96.8	94.1	92.2	98.2	96.0
2004-05	97.4	95.8	96.1	94.2	91.8	97.7	95.5

^a Property data for this collection are unreconciled and may not match published jurisdictional annual data.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.34.

Efficiency — turnaround time

The third efficiency indicator reported for State owned and managed Indigenous housing is ‘turnaround time’ (box 16.33).

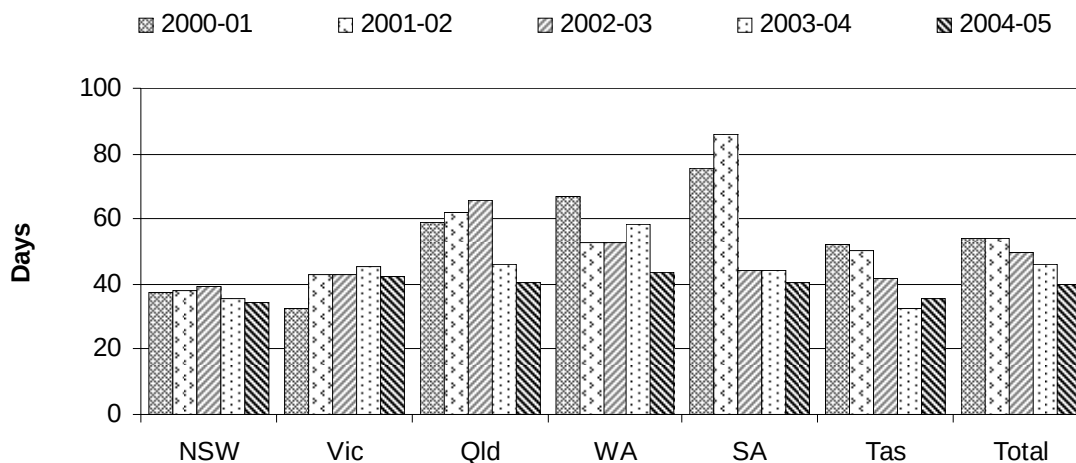
Box 16.33 Turnaround time

‘Turnaround time’ is an output indicator of the time taken to reallocate vacant properties after they have been vacated, acquired or newly constructed. The indicator measures the average time taken in days for vacant dwellings to be occupied. The length of time taken to rent untenanted dwellings affects allocations of housing, waiting times, the length of waiting lists and rent foregone. A low turnaround time suggests efficient housing allocation and asset management. All jurisdictions aim to minimise turnaround times.

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 State owned and managed Indigenous housing dwellings relative to public housing dwellings. Following the death of a significant person, for example, a dwelling may need to be vacant for a longer period of time (Morel and Ross 1993). The higher proportion of dwellings in rural and remote areas may also contribute to delays in completing administrative tasks and maintenance before dwellings can be re-tenanted.

The average number of days for vacant stock to be allocated in 2004-05 is presented in figure 16.26.

Figure 16.26 **State owned and managed Indigenous housing — average turnaround time^{a, b}**



^a Data for WA for 2004-05 are based on different methodology from that used for their previous years' data and a direct comparison of 2004-05 data with previous years for WA cannot be made. For details of these changes see WA footnotes in table 16A.35. ^b Data are not comparable across all jurisdictions due to each using different methodology. For this reason the data presented should be interpreted with caution. For details of these variations see footnotes in table 16A.35.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.35.

Efficiency — rent collected

The final efficiency indicator reported for State owned and managed Indigenous housing is 'rent collected' (box 16.34).

Box 16.34 Rent collected

'Rent collected' is an output indicator of the CSHA's guiding principle to undertake efficient and cost-effective management. It is the total rent collected as a proportion of the rent charged. A high proportion suggests efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a proportion of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of this indicator's reported results. Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

Rent collected as a proportion of the rent charged in 2004-05 is presented in table 16.22.

Table 16.22 State owned and managed Indigenous housing — total rent collected as a proportion of total rent charged (per cent)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Total</i>
2000-01	99.3	99.5	99.1	101.1	95.0	94.8	98.8
2001-02	99.9	98.8	97.3	103.0	92.6	99.1	98.5
2002-03	102.3	98.1	97.2	101.9	107.9	98.8	101.4
2003-04	104.1	99.8	101.3	103.1	97.0	102.2	101.8
2004-05	97.7	100.6	100.4	103.9	93.8	99.6	99.2

^a The total rent collected from and charged to tenants for year ending 30 June 2005, and the total rent actually collected as a percentage of total rent charged are not calculated via the data repository. Figures supplied by jurisdictions. ^b Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.36.

Outcomes

Location/amenity

‘Location/amenity’ is an outcome indicator (box 16.35).

Box 16.35 Location/amenity

‘Location/amenity’ is an outcome indicator of the CSHA’s aim to provide housing assistance that is appropriate to the needs of different households. The location/amenity indicator is a survey-based measure of the proportion of tenants rating location and amenity aspects as important and as meeting their needs.

During 2004-05, all states participated in the first National Housing Survey of State owned and managed Indigenous housing. As for the National Social Housing Survey undertaken bi-annually for Public and Community Housing, the survey seeks to determine tenants’ level of satisfaction with various parameters of service and gauge housing outcomes. Further, the survey informs reporting of two indicators developed as part of the CSHA performance indicator framework: location/amenity and customer satisfaction.

State owned and managed Indigenous housing tenants were asked whether particular aspects of the location and amenity of their dwellings were important to them and, if so, whether they felt their needs were met. The methodology for the survey was face to face interviews with a clustered sample of tenants. This Report includes national weighted survey results. State results will be available from the

National Social Housing Survey reports which will be available on the AIHW website in early 2006.

Survey results indicate that for those tenants for whom amenity was important 74 per cent felt that their needs were met and of those tenants for whom location was important 87 per cent felt that their needs were met (table 16A.37). Caution should be taken when comparing the State owned and managed Indigenous housing survey results with the public housing survey results, due to the different demographic profile of Indigenous clients, which may affect results.

Customer satisfaction

‘Customer satisfaction’ is an outcome indicator (box 16.36).

Box 16.36 Customer satisfaction

‘Customer satisfaction’ is an outcome indicator because one aim of the CSHA is to provide housing assistance that is appropriate for different households. Customer satisfaction is a survey measure of satisfaction with the overall service provided by the State housing authority. Results are expressed in percentage terms.

Results are taken from the 2005 National Social Housing Survey of State owned and managed Indigenous housing. Survey data indicate that, of 897 respondents, 63 per cent were either satisfied or very satisfied with the overall service provided by their State housing authority.

Affordability

‘Affordability’ is an outcome indicator (box 16.37).

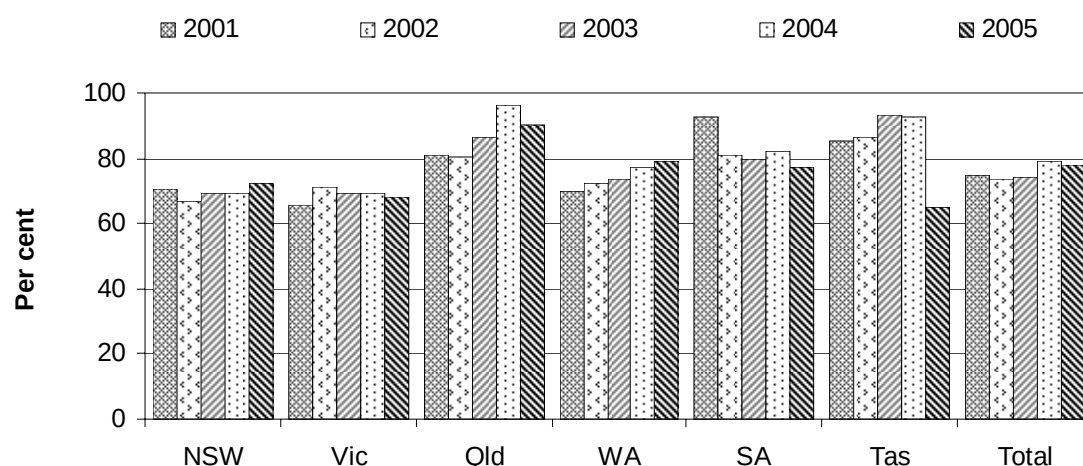
Box 16.37 Affordability

‘Affordability’ is an outcome indicator of the CSHA’s aim to provide affordable housing to assist people who are unable to access suitable housing. It measures the rent charged to tenants as a proportion of the market rent for each dwelling, adjusted for CRA. A low proportion indicates a high level of subsidy from the State or Territory housing authority over and above CRA. This largely reflects the differing levels of market rent across jurisdictions.

Rent charged at 30 June 2005 as a proportion of the market rent for each dwelling (adjusted for CRA) is presented in figure 16.27. Information on the amount of

income paid in rent by State owned and managed Indigenous housing tenants as a proportion of income, can be found in table 16A.78.

Figure 16.27 State owned and managed Indigenous housing — rent charged as a proportion of market rent, adjusted for CRA^{a, b, c}



^a At 30 June. ^b For details of mixed composition, non-rebated and other households excluded, see table 16A.85. ^c Data for NSW and SA for 2004-05 are not directly comparable to the previous years' data and any direct comparison of 2004-05 data with previous years for NSW and SA should be done with caution. For details of these changes see NSW and SA footnotes in table 16A.38.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.38.

Match of dwelling to household size

‘Match of dwelling to household size’ is an outcome indicator (box 16.38).

Box 16.38 Match of dwelling to household size

'Match of dwelling to household size' is an outcome indicator of the CSHA's aim to provide housing assistance that is appropriate to the needs of different households, such as household size. It measures the proportion of households where allocated 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
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

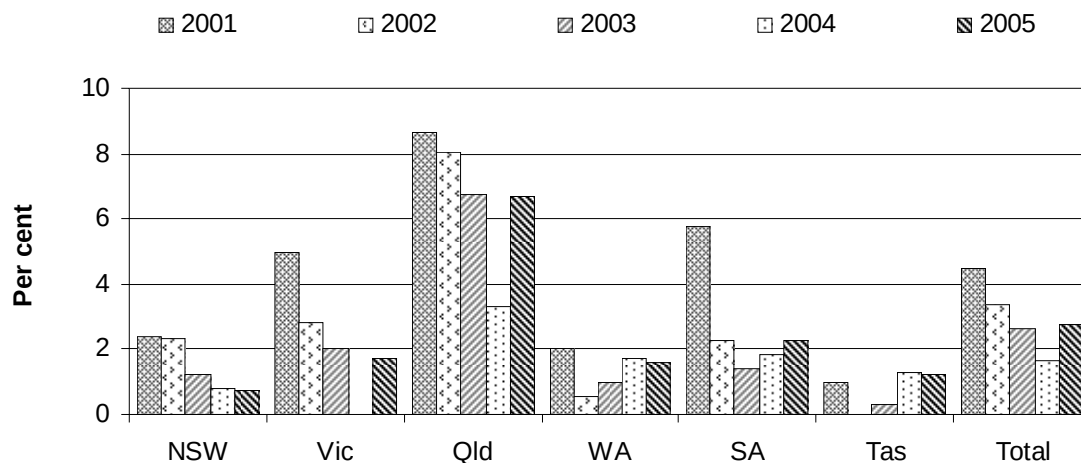
Source: AIHW (2003g).

A low proportion indicates a low proportion of overcrowded households.

The proxy occupancy standard above may differ from the specific criteria used by State housing authorities to match households to dwelling types, affecting interpretation of this indicator.

The proportion of households with overcrowding is illustrated in figure 16.28. More information on overcrowding and underuse for State owned and managed Indigenous housing can be found in table 16A.81.

Figure 16.28 State owned and managed Indigenous housing — proportion of households with overcrowding^{a, b, c, d, e}



^a At 30 June. ^b For details of mixed composition, non-rebated and other households excluded, see table 16A.85. ^c Data for Victoria and Queensland for 2004-05 are based on different methodology from that used for their previous years' data and a direct comparison of 2004-05 data with previous years for Victoria and Queensland cannot be made. For details of these changes see Victoria and Queensland footnotes in table 16A.39. ^d Data for NSW and SA for 2004-05 are not directly comparable to the previous years' data and any direct comparison of 2004-05 data with previous years for NSW and SA should be done with caution. For details of these changes see NSW and SA footnote in table 16A.39. ^e Data for Victoria and Queensland for 2004-05 are not comparable with the other data presented and should not be directly compared with other jurisdictions' data. For details of non-comparability see Victoria and Queensland footnotes in table 16A.39.

Source: AIHW (various years) CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.39.

Commonwealth Rent Assistance

Data for CRA recipients are only for individuals and families paid CRA by Centerlink under the *Social Security Act 1991* or family assistance law. It includes amounts paid under the Social Security Act with payments now administered by the Department of Employment and Workplace Relations (DEWR) and DEST. It does not include equivalent payments made by the Department of Veterans Affairs, or payments made with Abstudy on behalf of DEST.

Data are generally for those entitled to CRA for 4 March 2005. Approximately 948 000 individuals or families were paid Rent Assistance with a regular social security or family assistance payment during the proceeding fortnight but in some cases this was for a past period only.

Important eligibility requirements for CRA (which is paid automatically once eligibility has been established) are (1) the receipt of an income support payment or more than the base rate of the Family Tax Benefit Part A, and (2) liability to pay rent.

Outputs

Equity — access — income unit type

The first access indicator is ‘income unit type’ (box 16.39).

Box 16.39 Income unit type

Access to CRA by ‘income unit type’ is an output indicator of the objective of CRA to provide financial assistance in an equitable manner. This indicator measures the number and proportion of eligible income support recipients receiving CRA by income unit type. The level of access experienced by different income unit types is influenced by a number of factors, including (but not restricted to) the size of their respective base populations and the levels of home ownership. CRA is a demand driven payment that has no benchmark in terms of the mix of customers. This indicator provides descriptive information only.

There were 941 120 income units receiving CRA at 4 March 2005. Of these, 27 927 (approximately 3.0 per cent) self-identified as Indigenous. Single people with no children represented approximately 52.3 per cent of income units receiving CRA and 39.2 per cent of Indigenous income units receiving CRA (table 16.23). The figures for the total number and proportion of income units by the income unit type disaggregated at the jurisdiction level are presented in table 16A.44.

Table 16.23 Income units receiving CRA, by income unit type, 2005^{a, b, c}

<i>Type of income unit^d</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.	%
Single, no dependent children	363 089	38.6	8 242	29.4
Single, no children, sharer ^e	129 300	13.7	2 761	9.8
Single, one or two dependent children	193 414	20.6	7 596	27.1
Single, three or more dependent children	33 476	3.6	2 207	7.9
Partnered, no dependent children	78 477	8.3	1 537	5.5
Partnered, one or two dependent children	100 619	10.7	3 518	12.6
Partnered, three or more dependent children	40 043	4.3	2 066	7.4
Partnered, illness or temporarily separated, no dependant children	2 524	0.3	na	0.3
Partnered, temporarily separated, no children	178	–	na	–
Unknown income unit	na	na	na	na
Total	941 120	100.0	27 927	100.0

^a At 4 March. ^b Includes only income units entitled to a daily rate of CRA under the *Social Security Act 1991* or with Family Tax Benefit in respect of 4 March 2005. ^c Income units are classified as Indigenous if recipient or partner have voluntarily self-identified as being of Aboriginal, Torres Strait Islander or South Sea Islander descent. ^d Income units are analogous to family units except that non-dependent children and other adults are treated as separate income units (see section 16.6 for more detail). A child is regarded as dependent on an adult only if the adult receives the Family Tax Benefit for the care of the child. ^e The maximum rate of assistance is lower for some single persons without dependent children who share accommodation (see the definition of 'sharer' in section 16.6). **na** Not available. – Nil or rounded to zero.

Source: FaCS (unpublished); table 16A.44.

The second access indicator is 'special needs' (box 16.40).

Box 16.40 Special needs

'Special needs' access to CRA is an output indicator of the objective of CRA to provide income support recipients and low income families with financial assistance. This indicator provides the proportions of special needs income units receiving CRA, including Indigenous income units and those with a member receiving a Disability Support Pension. It 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 clients. Additional measures of special need, which include a geographic dimension, are reported under 'affordability'.

Table 16.24 illustrates number and the proportion of income units receiving CRA at 4 March 2005 by jurisdiction, Indigenous status and geographic location.

Overall, 58.9 per cent of total income units receiving CRA at 4 March 2005 were located in capital cities, while 41.1 per cent were in the rest of the State/Territory. There were 35.4 per cent of Indigenous income units receiving CRA who were located in capital cities and 64.6 per cent of income units receiving CRA who lived in the rest of the State/Territory. For non-Indigenous income units receiving CRA, 59.6 per cent were located in capital cities, while 40.4 per cent lived in the rest of the State/Territory (table 16.24).

People who own their own home are not entitled to CRA. Indigenous people receiving social security benefits are less likely to own their own home, and therefore are more likely to receive CRA. Nationally, 6 per cent of Indigenous income units are home owners receiving social security benefits, while 44 per cent of non-Indigenous income units are home owners receiving social security benefits (FaCS unpublished).

Table 16.24 Income units receiving CRA, by Indigenous status and geographic location, 2005^{a, b, c, d}

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust ^b	
Non-Indigenous											
	Income units	no.	305 728	202 544	221 883	82 570	65 746	22 850	7 864	4 304	913 805
	In capital city	%	55.0	70.4	44.1	77.0	77.7	43.1	99.6	79.5	59.6
	In rest of State	%	45.0	29.6	55.9	23.0	22.3	56.9	0.4	20.5	40.4
	Share of all recipients	%	96.9	99.1	95.7	97.0	98.1	96.3	98.7	79.9	97.1
	Non-Indigenous population, as a proportion of total population	%	99.9	100.0	99.7	99.9	99.9	99.8	..	99.5	99.9
Indigenous											
	Income units	no.	9 686	1 765	9 937	2 552	1 294	876	105	1 081	27 315
	In capital city	%	28.4	48.4	28.1	55.6	62.8	35.7	100.0	57.4	35.4
	In rest of State	%	71.6	51.6	71.9	44.4	37.2	64.3	..	42.6	64.6
	Share of all recipients	%	3.1	0.9	4.3	3.0	1.9	3.7	1.3	20.1	2.9
	Indigenous population, as a proportion of total population	%	0.1	—	0.3	0.1	0.1	0.2	..	0.5	0.1
Total income units		no.	315 414	204 309	231 820	85 122	67 040	23 726	7 969	5 385	941 120

^a At 4 March. ^b Rest of State includes unidentified localities, Australia includes other territories and unknown address. ^c Includes only income units entitled to a daily rate of CRA under the *Social Security Act 1991* or with Family Tax Benefit in respect of the 4 March 2005. ^d Income units are classified as Indigenous if recipient or partner have voluntarily self-identified as being of Aboriginal or Torres Strait Islander descent. – Nil or rounded to zero. .. Not applicable.

Source: FaCS (unpublished); table 16A.50.

Equity — access — geographic spread of CRA customers

The third access indicator is the ‘geographic spread of CRA customers’ (box 16.41).

Box 16.41 Geographic spread of CRA customers

The ‘geographic spread of CRA customers’ provides descriptive information about rents, average levels of assistance, and the proportion of private rental stock occupied by CRA recipients within regions. This information is useful in examining differences across states and territories, and capital cities/rest of State. The indicator can provide some insight into the responsiveness of CRA to regional variations in rent and the extent to which recipients are able to exercise choice in where to live.

Two measures are presented:

- maps showing CRA recipients as a proportion of private rental stock (from 2001 Census) across Australia and within each capital city.
- the average CRA entitlement across locations.

Additional measures of geographic spread are reported under ‘affordability’.

Results for income units receiving CRA as a proportion of income units in each capital city receiving a social security income support benefit or more than the base rate of the Family Tax Benefit are mapped in tables 16A.51–16A.59. Information on the average CRA entitlement across locations is contained in table 16A.60.

The ratio of CRA recipients to private rental stock between and within capital cities varies but the patterns are complex. The maps should be interpreted with caution because they compare CRA recipients in March 2005 with 2001 Census data and make no allowance for changes in private rental stock (FaCS unpublished).

Effectiveness — appropriateness — maximum rate

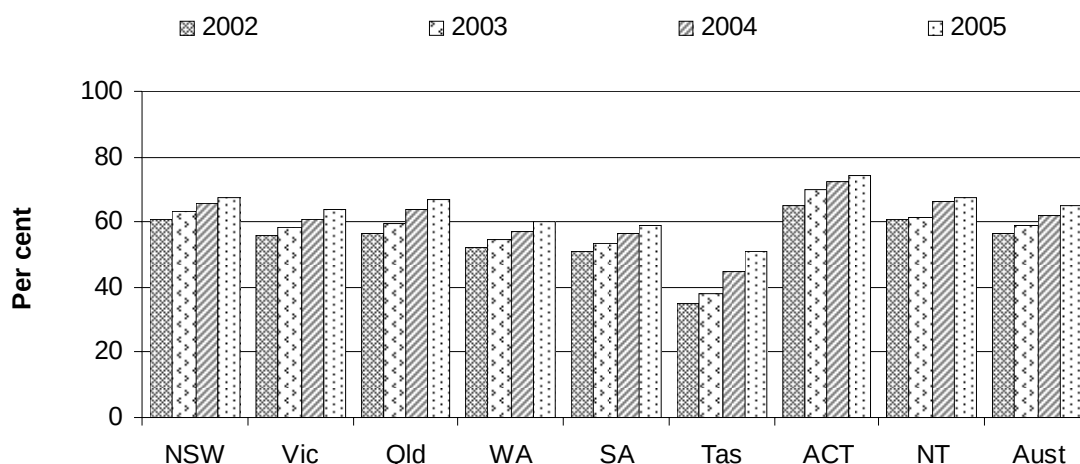
The first effectiveness indicator is the proportion of income units receiving the ‘maximum rate of CRA’, by jurisdiction and payment type (box 16.42).

Box 16.42 Maximum rate of CRA

The 'maximum rate of CRA' indicator is an output indicator of the appropriateness of CRA. It measures the proportion of income units receiving the maximum rate of CRA, and can be used to monitor the adequacy of CRA over time. The effectiveness of the payment against rents is reflected in increasing/decreasing proportions on the maximum rates of assistance. An increasing proportion of the maximum rate of payment suggests that CRA is decreasing in its effectiveness against rental increases, while a decreasing proportion suggests that CRA is increasing at a rate above that of rental increases.

At 4 March 2005, 65 per cent of income units receiving CRA across Australia qualified for the maximum rate of CRA payments (figure 16.29).

Figure 16.29 Proportion of income units receiving CRA paying enough rent to receive maximum assistance^{a, b, c}



^a Data for 2005 as at 4 March. Data for other years are for various dates near the end of the financial year.

^b Income units are analogous to family units except that non-dependent children and other adults are treated as separate income units. See section 16.6 for more detail. ^c Includes only income units entitled to a daily rate of CRA under the *Social Security Act 1991* or with Family Tax Benefit in respect of the 4 March 2005.

Source: FaCS (unpublished); table 16A.61.

Effectiveness — appropriateness — number and outcome of appeals

The second effectiveness indicator is the 'number and outcome of appeals' (box 16.43).

Box 16.43 Number and outcome of appeals

The 'number and outcome of appeals' is an output indicator that measures the appropriateness of decisions related to the payment of CRA. There is a formal review process for decisions related to the payment of CRA. Clients who are dissatisfied with a decision are encouraged to discuss the matter with the original decision maker before taking the matter further, although this is not a necessary step. Authorised review officers conduct a quick and informal internal review of the decision. Generally, customers who are dissatisfied with the authorised review officer's decision can appeal to the Social Security Appeals Tribunal, which is an independent body with decision making powers. Either the customer or FaCS, DEWR or DEST can seek an Administrative Appeals Tribunal review of the Social Security Appeals Tribunal's decisions. The indicator measures the outcomes of all CRA appeals finalised. A high proportion of original decisions affirmed would imply that the original decisions were appropriate.

There were 376 finalised appeals to an authorised review officer in 2004-05, which represented approximately 0.04 per cent of income units receiving CRA. Approximately 58 per cent of finalised appeals to an authorised review officer, 50 per cent of appeals to the Social Security Appeals Tribunal and 25 per cent of appeals to the Administrative Tribunal resulted in the original decision being affirmed or appeal dismissed (table 16.25).

Table 16.25 Outcome of all CRA appeals finalised in 2004-05^a

Outcome	Appeals to ARO		Appeals to SSAT		Appeals to AAT	
	no.	%	no.	%	no.	%
Original decision affirmed or appeal dismissed	218	58.0	32	50.0	4	25.0
Original decision set aside	99	26.3	23	35.9	4	25.0
Original decision varied	53	14.1	4	6.3	—	—
Appeal withdrawn	6	1.6	5	7.8	8	50.0
Total finalised^a	376	100.0	64	100.0	16	100.0

ARO = authorised review officer. SSAT = Social Security Appeals Tribunal. AAT = Administrative Appeals Tribunal. ^a Totals may not add to 100 as a result of rounding. — Nil or rounded to zero.

Source: FaCS (unpublished); table 16A.62.

Efficiency — running costs per 1000 customers

The Steering Committee has identified 'running costs per 1000 customers' as an indicator of efficiency (box 16.44). Data for this indicator, however, were not available for the 2006 Report.

Box 16.44 Running costs per 1000 customers

'Running costs per 1000 customers' is an output indicator of CRA's aim to provide financial assistance in an efficient manner. Low running costs per 1000 customers would imply high efficiency for a given service level. The Steering Committee has identified this indicator for development and reporting in future.

Efficiency — ratio of running costs to total outlays

The Steering Committee has identified the 'ratio of running costs to total outlays' as an indicator of efficiency (box 16.45). Data for this indicator, however, were not available for the 2006 Report.

Box 16.45 Ratio of running costs to total outlays

The 'ratio of running costs to total outlays' is an output indicator of CRA's aim to provide financial assistance in an efficient manner. A low ratio would imply high efficiency for a given service level. The Steering Committee has identified this indicator for development and reporting in future.

*Outcomes**Affordability*

'Affordability' is one of two outcome indicators reported for CRA (box 16.46).

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.63–16A.65.

Nationally, 35 per cent of income units receiving CRA paid more than 30 per cent of their income on rent. The proportion of income units paying more than 30 per cent of their income in rent if there were no CRA would be 67.7 per cent (figure 16.30).

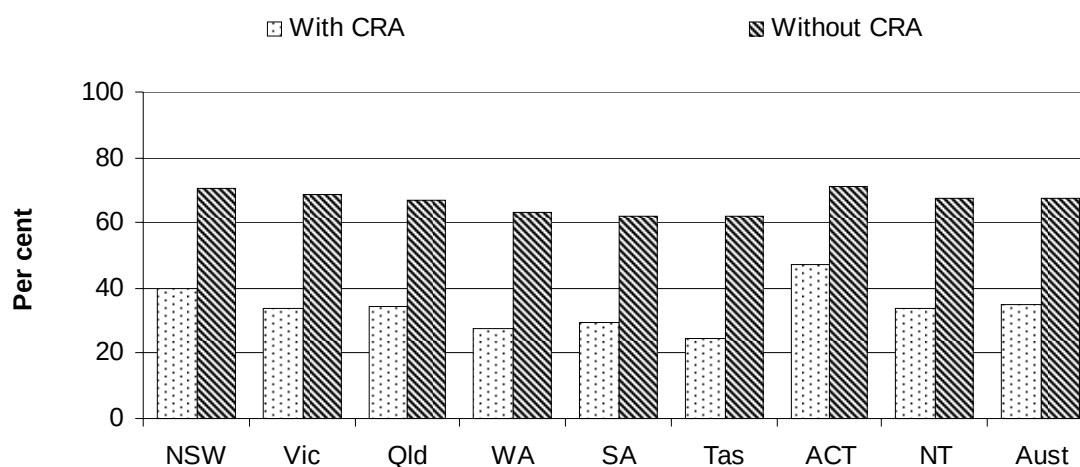
Furthermore, without CRA, 27.5 per cent of recipients across Australia would have spent more than 50 per cent of their income on rent, while with CRA the proportion is 9.0 per cent (table 16A.66).

Box 16.46 Affordability

'Affordability' is an outcome indicator of the CRA objective to provide income support recipients and low income families in the private rental market with financial assistance. CRA is intended to improve affordability not to achieve a particular benchmark. Program performance is best judged by trends over a number of years. This indicator measures the proportions of income units spending more than 30 per cent and 50 per cent of their income on rent with and without CRA since June 2000, and the latest information about those spending over 50 per cent of their income on rent. A low proportion implies high affordability for recipients spending both 30 per cent and 50 per cent of income on rent with and without CRA.

Affordability outcomes (with and without CRA) have been provided for all income units receiving CRA, Indigenous income units receiving CRA, and Disability Support Pension income units receiving CRA.

Figure 16.30 Income units paying more than 30 per cent of income on rent, with and without CRA, 2005^{a, b, c}



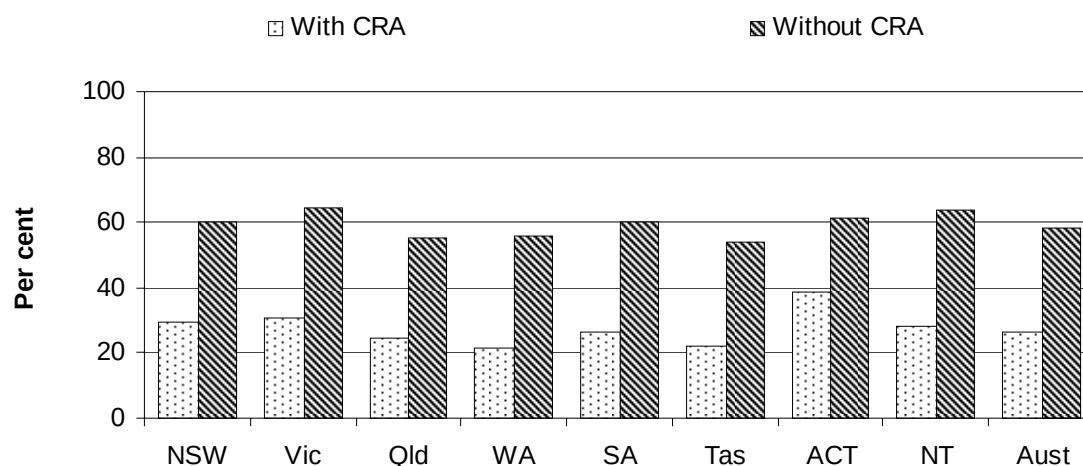
^a At 4 March. ^b Includes only income units paid CRA under the *Social Security Act 1991* or with Family Tax Benefit in the proceeding fortnight who were still entitled to assistance at the end of that fortnight. Excludes a small number of income units paid where income details are incomplete. ^c See Section 16.6 for explanation of how proportion of income spent on rent is calculated.

Source: FaCS (unpublished); table 16A.63.

Nationally, if CRA were not payable, then 58.2 per cent of those Indigenous income units receiving CRA would have spent more than 30 per cent of income on rent at 4 March 2005. Accounting for CRA payments (thereby reducing the rent paid by the amount of the assistance), the national proportion of Indigenous income units who spent more than 30 per cent of income on rent at 4 March 2005 decreases to 26.5 per cent (figure 16.31). Similarly, if CRA were not payable, then 21.2 per cent

of Indigenous income units across Australia would have spent more than 50 per cent of income on rent at 4 March 2005. Accounting for CRA payments this proportion decreases to 5.9 per cent (table 16A.66).

Figure 16.31 Indigenous income units receiving CRA paying more than 30 per cent of income on rent, with and without CRA, 2005^{a, b, c, d}

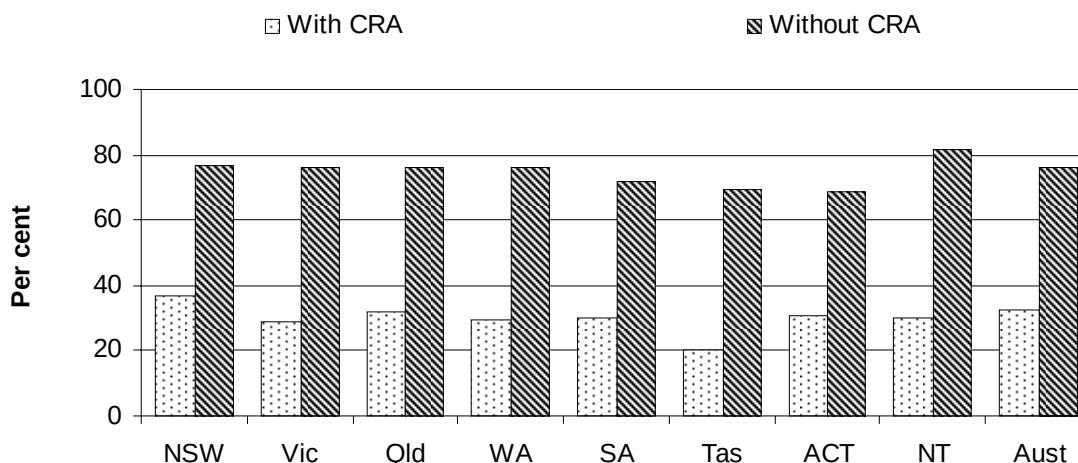


^a At 4 March. ^b Income units classified as Indigenous if either partner self-identifies as an Aboriginal or Torres Strait Islander. ^c Includes only income units paid CRA under the *Social Security Act 1991* or with Family Tax Benefit in the proceeding fortnight who were still entitled to assistance at the end of that fortnight. Excludes a small number of income units paid where income details are incomplete. ^d See Section 16.6 for explanation of how proportion of income spent on rent is calculated.

Source: FaCS (unpublished); table 16A.64.

If CRA were not payable, then 75.8 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 4 March 2005. Accounting for CRA payments (thereby reducing the rent paid by the amount of the assistance), the proportion of income units receiving a Disability Support Pension who spent more than 30 per cent of income on rent at 4 March 2005 decreases to 32.2 per cent (figure 16.32). Similarly, if CRA were not payable, then 29.6 per cent of all income units receiving a Disability Support Pension would have spent more than 50 per cent of income on rent at 4 March 2005. Accounting for CRA payments, this proportion decreases to 6.0 per cent (table 16A.66).

Figure 16.32 Income units receiving a Disability Support Pension paying more than 30 per cent of income on rent, with and without CRA, 2005^{a, b, c, d}



^a At 4 March. ^b Income units are included if either the recipient or partner receive Disability Support Pension. ^c Includes only income units paid CRA under the *Social Security Act 1991* or with Family Tax Benefit in the proceeding fortnight who were still entitled to assistance at the end of that fortnight. Excludes a small number of income units paid where income details are incomplete. ^d See Section 16.6 for explanation of how proportion of income spent on rent is calculated.

Source: FaCS (unpublished); table 16A.65.

Targeting

Duration of payments

‘Duration of CRA payments’ is a targeting indicator (box 16.47).

Box 16.47 Duration of CRA payments

‘Duration of CRA payments’ is a targeting indicator whose objective is to provide information on the level of long-term and short-term dependence on CRA payments. The indicator presents the number customers receiving CRA benefits at the beginning and at the end of the year, as well as the number of CRA recipients who were in receipt of CRA benefits at the beginning of the year and still in receipt a year later.

Nationally, 927 895 income units were receiving CRA payments at March 2004, and 941 120 income units were receiving CRA at the end of March 2005. Out of those, 653 747 income units were receiving CRA at both times, implying a high degree of dependence on CRA (table 16.26).

Table 16.26 shows that, nationally, over 287 000 individuals and families 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 FaCS data show that while CRA was paid on average to just over one million individuals each fortnight in 2004-05, over 1.4 million individuals were entitled to assistance during the financial year (FaCS unpublished).

Table 16.26 Duration of Payments, 2005^a

<i>State</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 Income units at the beginning and the end of the year</i>
	no.	no.	no.
NSW	309 371	315 414	224 512
Victoria	199 728	204 309	141 117
Queensland	231 580	231 820	161 551
WA	85 090	85 122	57 647
SA	65 371	67 040	45 999
Tasmania	23 162	23 726	15 872
ACT	7 588	7 969	4 252
NT	5 587	5 385	2 634
Total	927 895	941 120	653 747

^a Counts are for income units entitled to receive CRA in respect of the 4 March 2005 and 5 March 2004 respectively. Income units are taken to receive CRA at both dates provided either member of an income unit receiving CRA for 4 March 2005 benefited from CRA in March 2004.

Source: FaCS (unpublished); table 16A.67.

Satisfaction with location and quality

The remaining two outcome indicators are ‘satisfaction with location’ and ‘satisfaction with quality’ (box 16.48). The survey used for this indicator in previous reports has ended and data for these indicators were not available for the 2006 Report.

Box 16.48 Satisfaction with location and quality

‘Satisfaction with location’ and ‘satisfaction with quality’ are included as outcome indicators, because customer satisfaction is an important outcome and a proxy measure of whether the housing is appropriate to the needs of the CRA recipient.

Data for these indicators were not available for this Report.

Some information about satisfaction with accommodation has been derived from the Household Income and Labour Dynamics Australia (HILDA) survey. The

survey does not reliably identify all CRA recipients but can be used to identify social security recipients who reside in private rental accommodation and are potentially eligible for CRA.

Data on satisfaction with location and adequacy of housing extracted from the HILDA survey are presented in table 16.27.

Overall, 63 per cent of social security recipients living in private rental properties expressed a preference to stay in the area in which they live, while 15 per cent expressed a preference to leave the area. When asked about the adequacy of their home in meeting housing needs in general, 11 per cent considered their housing to be either less than adequate or much less than adequate, while 27 per cent considered it to be more than adequate or much more than adequate.

Table 16.27 Satisfaction with location and adequacy of housing (per cent)^a

	Strong preference to stay	Moderate preference to stay	Unsure/no strong preference to stay or leave	Moderate preference to leave	Strong preference to leave
Location ^b	41.0	22.0	21.5	8.0	7.0
	Much less than adequate	Less than adequate	Adequate	More than adequate	Much more than adequate
Adequacy ^c	2.3	9.1	61.5	23.4	3.6

^a Respondents getting income support and living in private rental accommodation. ^b Based on 861 valid responses by social security recipients living in private rental accommodation. ^c Based on 847 valid responses by social security recipients living in private rental accommodation.

Source: FaCS (unpublished).

16.4 Future directions in performance reporting

Further developing indicators and data

A new CSHA took effect on 1 July 2003 and will run until 30 June 2008. The Policy Research Working Group of HMAc is undertaking a review of the performance indicator framework to reflect the objectives of the new CSHA and to improve the quality and scope of the national performance indicators in some areas.

Improved reporting on housing provision to Indigenous Australians continues to be a priority, with work to be done by the National Housing Data Agreement Management Group, the National Indigenous Housing Information Implementation Committee and the National Housing Data Development Committee over the next

year to improve the availability and reliability of data on Indigenous Australians accessing public and community housing.

16.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

“ The 2003 Commonwealth State Housing Agreement (CSHA) aims to maintain a core Social Housing sector to assist people unable to access alternative suitable housing options. It is recognised that states are implementing wide-ranging reforms to the management and delivery of housing assistance and that these reforms will continue. The performance framework introduced under the 1999 CSHA continues to support the measurement of the guiding principles of the 2003 CSHA. The 2003 CSHA has a particular emphasis on timely reporting and demonstrated progress in achieving performance objectives.

A total of around \$4.75 billion over five years to 2007-08 provides strategic direction and funding certainty. Programs funded include public housing, Aboriginal rental housing program (ARHP) community housing program (CHP) and crisis accommodation program (CAP).

The Australian Government has allocated \$93 million in 2005-06 with indexation applying in subsequent years through the ARHP. ARHP funding is allocated to states and territories to address Indigenous housing need in rural and remote areas.

Over \$280 million has also been allocated in the 2005-06 Budget through the Community Housing and Infrastructure Program (CHIP) to increase access to safe, healthy and sustainable housing and related services for Indigenous families and communities. CHIP provides for community housing and housing related environmental health infrastructure in rural and remote areas, and for community housing in urban areas. This funding is either directed through state and territory governments or to specific community housing organisations. CHIP funding was formerly appropriated to the Aboriginal and Torres Strait Islander Services (ATSIS).

In the 2005 Budget, the Australian Government committed \$102.8 million over four years for the *Healthy Indigenous Housing* measure which will focus on progressing the principles and objectives of *Building a Better Future — Indigenous Housing to 2010*, with an emphasis on the delivery of sustainable outcomes, and contributing to sustainable Indigenous communities.

Rent Assistance is provided as a financial supplement and has the flexibility to cope with changing demand and provide customers with more choice about where they live and the quality of their housing. This choice can involve a trade-off with other expenses and with the consumer's after-housing income.

The Rent Assistance program has no specific benchmark for affordability. The adoption of an affordability benchmark would fail to recognise the element of choice exercised by customers who place a higher value on housing than others in comparable circumstances. Customers may, for example, choose to pay higher rent for a property that is well-located, thus trading off housing and transport costs.

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New South Wales Government comments

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In NSW, the Department of Housing and the Aboriginal Housing Office operate in a challenging environment characterised by the growing incidence of housing stress due to reduced housing affordability for low to moderate income households and the increasingly complex needs of social housing clients. These pressures exacerbate the demand for social housing and are further compounded by rising operational and maintenance costs and financial constraints.

The *Reshaping Public Housing Reforms* announced in April 2005 by the NSW Government are a major initiative to support the long-term viability of the social housing sector. The reform package is designed to provide a sustainable and fair public housing system that will help those in greatest need. Changes will be made to the way eligibility and tenure length are determined. Public housing will be more targeted to assist those on low-incomes who need support services to live independently and vulnerable households with housing affordability problems. The length of new public housing tenancies will be determined by the extent and duration of client need so that the social housing sector in NSW will be able to assist a greater number of people in the longer term.

Projected savings from the implementation of new maintenance arrangements as well as changes to water usage charges and rents will contribute to the long-term sustainability of public housing.

In recognition of the changing client needs, the reforms also involve the implementation of a Housing and Human Services Accord to facilitate the coordinated provision of support services from relevant key agencies. A major public housing asset reconfiguration program will also address the changing housing and locational needs of the client base. The \$500 million Bonnyrigg development is an example of a public private partnership to address renewal of a large public housing estate in Western Sydney.

One of the key contributing components to Sydney's high cost of living has been the escalating price of housing over the past ten years. In June 2005 the average home loan in NSW was \$257 000, which was nearly \$66 000 more than the national average. The cost of private rental in Sydney is also higher than in other capital cities and rents outside Sydney are high in comparison to rural and regional centres in other states.

Despite these challenges, the NSW social housing sector continues to play a vital role in the provision of affordable housing solutions for low income and special needs clients. In 2004-05 the Department of Housing managed over 128 000 public housing properties and allocated funding to not-for-profit organisations to provide property and tenancy management for 13 500 properties. The Aboriginal Housing Office currently owns 4200 properties and Aboriginal community housing organisations manage a further 4900 properties. The sector also developed and implemented a range of innovative products, initiatives and services to respond to changing mainstream and indigenous housing needs and priorities.

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Victorian Government comments

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Victoria continues to provide innovative solutions to address demand for social housing in an environment characterised by diminishing housing affordability in the private sector, increasing complexity of client needs, declining capital funding through the Commonwealth State Housing Agreement and the ageing of social housing properties.

A key focus for Victoria is the expansion of social housing for low-income households. In 2004-05, Victoria funded the acquisition of over 850 new social housing units, including 33 properties for the Aboriginal Rental Housing Program. Acquisition strategies employed by Victoria ensure that clients are housed in locations with accessibility to employment opportunities, transport and amenities.

In 2004-05, Victoria established a legislative framework for the registration and regulation of housing associations and registered community housing providers. This will support the development of financially viable, non-government, not-for-profit housing agencies and encourage private sector investment in social housing. In 2004-05 partnership approaches to housing acquisition led to the purchase of 171 units.

An environment of strong demand for public housing and declining capital funding has necessitated a highly targeted approach to housing allocations in Victoria, ensuring that priority is given to people who are homeless, those with specific medical or support needs and those experiencing family violence. The high level of targeting has contributed to a growing level of complexity in client need to which the Office of Housing is continuing to respond with a range of tailored programs that integrate homelessness services with long-term housing and support.

To improve areas experiencing economic and social disadvantage, Victoria is undertaking community renewal and improving economic participation through the Neighbourhood Renewal program. One of the program's most important outcomes is providing employment opportunities through specific job creation programs. Work experience and accredited training has been provided to 851 neighbourhood renewal residents, 60 per cent of which proceeded into further employment and/or training.

Recognising the importance of maintaining the asset in line with community standards, in 2004-05, Victoria has upgraded 2666 properties, 598 of which were in Neighbourhood Renewal areas.

Overall the Victorian government has provided an additional \$363 million above its matching obligations, under the Commonwealth State Housing Agreement, since it came to Government, to improve services and grow social housing.

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Queensland Government comments

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The Department continues to operate in an environment characterised by growing housing stress, where home ownership and private rental are increasingly less affordable for low income earners. An increase in housing prices and the continuing loss of affordable private rental housing, including the decline in boarding houses and caravan park accommodation, has exacerbated the demand for government-funded housing assistance.

During 2004-05, the Department assisted around 240 000 households with a diverse range of products and services including:

- providing approximately 55 000 households with Public Rental Housing and Aboriginal and Torres Strait Islander Housing
- funding community organisations to provide around 131 000 households with accommodation, tenancy advice, home maintenance and minor home modifications
- providing 18 400 households with loans or grants to enable them to access private rental housing.

As well as investment in the Aboriginal and Torres Strait Islander Housing rental program, the Department provided funding of \$27.9 million to Aboriginal Shire Councils and Torres Strait Island Councils to commence construction of 74 dwellings and upgrade 229 dwellings in discrete Indigenous communities.

The Department also assisted households with a person with a disability or mental illness in a number of ways, including modifying 578 homes through the Home and Community Care Home Modification Service, to allow older people and people with a disability to stay living in their own homes.

The Department promoted environmentally, socially and economically sustainable housing to government, the building industry, home-owners and renovators through its Smart Housing program.

The Kelvin Grove Urban Village project demonstrated how partnerships with the private sector and other agencies can realize common objectives. This project creates a model for future development which is more sustainable, at less cost to the environment. The Department negotiated arrangements for the private sector development of 108 units of student accommodation and 107 units of seniors accommodation in the Village and completed the transfer of land assets, infrastructure and community establishments to the value of \$4.55 million.

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Western Australian Government comments

“ During the 2004-05 financial year the State Housing Commission continued to assist Western Australians into home ownership through low deposit, affordable home ownership schemes. Through its home lending arm, Keystart, 5417 new loans were approved. The Commission also assisted 228 additional families with home purchase loans via its other loan schemes.

Rental Housing manages 34 870 properties of the 39 200 properties in the total housing portfolio. Under the Rental Sales Scheme 109 rental properties were sold to tenants and 314 were refurbished for sale across the state under the New Living Program. The Regional Upgrade Strategy commenced to replace 800 properties and refurbish a further 200 properties in regional areas over the next four years. During the year the Commission:

- introduced the Good Neighbour Policy which aims at curbing the incidence of antisocial behaviour
- reviewed its key customer service provision roles, with a view to providing tighter property management and a higher level of service
- enhanced customer service through the provision of additional staff
- reviewed and updated fire and emergency procedures in its rental complexes, and
- commenced the Residual Current Devices (Safety Switches) project. There are 23 000 existing homes that require these switches to be installed.

The Commission actively acquires and develops land to assist in the delivery of affordable residential land, including the provision of sites to meet its housing construction programs. The Commission acquired a total of 30 group housing development sites, 18 in the Perth region and 12 in country regional centres. Approximately 53 single residential allotments were purchased — 7 in the Perth Region and 46 in country centres. The Commission also acquired sites in established areas offering potential for approximately 135 dwellings from agencies such as the Police, Landcorp, Main Roads WA and the Public Asset Rationalisation Committee. In addition two inner city properties have been acquired that offer potential for around 150 units.

In regional Western Australia, 20 per cent of Indigenous people live in 230 discrete communities, mainly in the Kimberley region. Delivery of sustainable housing and infrastructure is therefore a priority. The Commission aims to ensure that communities have access to essential service infrastructure (such as water and power); that essential services are maintained; community infrastructure is improved; new housing provided and existing housing upgraded, renovated and maintained. Many strategies have been developed to address the particular issues in providing housing and infrastructure to regional and remote Aboriginal towns and communities.

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South Australian Government comments

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The past year has been one of significant change for housing in South Australia. In March 2005 the Housing Plan for South Australia was launched with an emphasis on new investment and working with the private sector, Local Government, the not-for-profit sector and communities to achieve affordable and high need housing solutions. The Plan and information about the Plan can be viewed at <http://www.familiesandcommunities.sa.gov.au/housingplan>.

In addition, the Department for Families and Communities was created on 1 July 2004 and the Affordable Housing Innovations Unit launched to facilitate innovative and affordable housing investments for low to moderate income South Australians with, and without, additional needs. Information about the associated program is available at <http://www.housing.sa.gov.au/affordable>.

During the year a number of major initiatives were undertaken including:

- A variety of major urban renewal projects were continued, including Westwood (The Parks), Hawksbury Park (Salisbury North), Mapleton Grove (Kilburn), Risdon Grove (Port Pirie), Myall Place (Whyalla) and Royal Park.
- The construction of 401 South Australian Housing Trust dwellings.
- Managing a number of initiatives to address homelessness including projects funded by the Social Inclusion Unit.
- Contributing to the establishment of a Recovery Centre to provide assistance to approximately eighty families in need of alternative housing following the Eyre Peninsula bushfires in January 2005.
- The launch of EquityStart to support the sale of social housing to existing tenants and to reinvest in new affordable and high need accommodation opportunities.
- Increasing the stock of Aboriginal housing to 1903 dwellings.
- Development and integration of an AHA Integrated Database together with the development of Community Management Software for implementation within AHA funded communities and homelands. This software will streamline reporting and allow Indigenous Community Housing Organisations to provide timely information for reporting against the National Reporting Framework (NRF).
- Stock numbers for community housing increased by 4.7 per cent in 2004-05 to 4414 properties managed by 121 community housing organisations.
- Development of a new Funding Agreement for Community Housing which includes simplified reporting arrangements and increased funding levels for organisations. Additionally, SACHA released its Asset Management Plan to ensure ongoing stock viability.
- Community housing rents are being brought into parity with other social housing rents through a market policy, to be implemented in late 2006.

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Tasmanian Government comments

“Housing Tasmania, a division of the Tasmanian Department of Health and Human Services, provides a range of affordable housing options, including public, community and Aboriginal housing, home ownership assistance, and ongoing support for private renters on low incomes. Housing Tasmania works from the premise that affordable, appropriately located housing plays a vital role in enabling Tasmanians to access social and economic opportunities, the support networks they need and improving health and well-being outcomes for people on low incomes.

During the year, Housing Tasmania continued to implement initiatives under the Affordable Housing Strategy. The Strategy realised the construction or purchase of 321 public rental homes, upgrades to 315 homes, and the purchase of three supported residential facilities to house an additional 90 to 110 people. Further upgrades or purchases commenced for six disability group homes, 28 community groups successfully applied for grants for urban renewal and community capacity building and direct employment and training opportunities were created for 34 individuals within the building and construction industry. Strategies were also implemented to supplement Private Rental Assistance programs and to support low income earners in their efforts to purchase a home.

Housing Tasmania has also focused on an Integrated Planning Framework to provide the best possible housing outcomes through the strategic allocation of resources to assets and services. The Framework reflects a five stage ‘bottom up’ approach, which draws together a range of social and housing data at a local level, to inform the development of an Asset and Service Plan for each precinct.

A Service Delivery Review commenced in 2004-05 as a means of increasing service delivery flexibility to respond to the constantly changing needs and expectations of clients and communities. The Review will seek to achieve consistent practice, high quality service delivery and build capacity to manage the growing proportion of clients who have complex needs. As a result, staff will be better supported in their increasingly diverse roles and be more able to participate in the development of an evolving social housing system.

To extend available Community Housing grant funds, applications for this year’s funding round were weighted toward organisations contributing their own resources to projects, rather than relying solely on public funds. Priority was given to new models of delivery, including regional/rural models linked to support for older people, people with mental health problems and people with disabilities and refugee accommodation including transitional and longer term models that are linked to cultural support.

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Australian Capital Territory Government comments

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The ACT Government strives to meet public and community housing objectives under the 2003 Commonwealth State Housing Agreement through organisational development initiatives and innovative partnership arrangements. These include the appointment of a new contractor to manage the delivery of repairs and maintenance services to the combined north and south regions from 1 July 2005. The new contract, which builds upon the experience of delivering maintenance under the total facility management model introduced on 1 July 2001, contains a number of enhancements including a performance management system with measures for client satisfaction with maintenance delivery as well as cost and quality. The contract also emphasises moving from a reactive to a proactive management of maintenance and is being accompanied by administrative changes including property standards training for all staff and improvements to the IT system to better manage information about the status of maintenance works.

To help ensure that housing assistance is appropriate and tailored to people's needs, the ACT ensures that tenants receive at least one annual client service visit during which the property is inspected and tenancy issues are discussed. The meeting of 2004-05 targets for these visits is directly reflected in the significant increase in ACT tenants' overall satisfaction with service reported in the National Social Housing Survey 2005 with the ACT achieving its highest satisfaction rating since the survey commenced.

The introduction of the Complaints Management Unit, which commenced operations on 1 July 2005, provides for greater recognition of consumer rights and responsibilities. The new unit, established in line with Australian Standard AS 4269-1995, will ensure that complaint-handling processes are consistent, responsive and fair; and, that complaint trends can be identified and addressed to improve client services.

Other organisational improvements include the amalgamation of the management of the SAAP Program, Community Housing and public housing (from 1 July 2005) which has enabled the ACT to make the links with service provision between homelessness and its prevention, and the provision of safe, secure affordable housing through public and community housing.

The ACT Government continues to support the development of the community housing sector through capital funding for a range of programs to meet emerging housing needs, including purchase of properties for Aboriginal and Torres Strait Islander people, people with disabilities, people living with HIV/AIDS, young people, and people with mental health issues. The ACT Government also progressed its boarding house program to increase affordable housing options with the opening of an eight-room boarding house for older women and the construction of a 20-unit complex, which will be completed in late 2005.

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Northern Territory Government comments

“ The Territory has continued to consolidate new directions in housing policy since the launch of the Home Territory 2010 Strategy in 2004, with particular focus on increasing the accessibility and availability of affordable housing options within the overall housing system.

Expansion of home ownership continues to be an area of key focus for the Northern Territory, and the HomeNorth scheme remains the Northern Territory Government's principle mechanism by which to provide low income earners with an affordable pathway into home ownership. Growth in this sector was strongly stimulated during the year by the release of new loan products in the HomeNorth portfolio and the introduction of HomeNorth Extra, which has significantly expanded the accessibility of the scheme. Increasing the uptake of home ownership by Indigenous Territorians has been identified as a priority.

There continues to be increases in the number of Indigenous people accessing mainstream public housing, with the proportion of Indigenous public housing tenants jumping from 25 per cent in June 2003 to 30 per cent in June 2005. In some localities Indigenous households comprise over 50 per cent of public housing tenancies.

Improving the condition of stock in the mainstream public housing portfolio is an area of ongoing effort, and during 2004-05 there were 116 dwellings upgraded at a total cost of \$8.8 million.

The Overarching Agreement on Indigenous Affairs between the Commonwealth of Australia and the Northern Territory of Australia was signed by the Prime Minister and NT Chief Minister on 6 April 2005. The Agreement sets out the priority areas for action in Indigenous affairs in the Northern Territory, and includes a Sustainable Indigenous Housing Schedule. The new Agreement builds on previous arrangements between the Northern Territory and Australian Government, and will provide a policy framework under which existing Indigenous housing program funds can be more effectively integrated.

Other initiatives being pursued under the auspices of Home Territory 2010 include:

- the establishment of a Housing Minister's Round Table to improve communication and co-ordination between Government, NGO's and other stakeholders involved in housing provision
- development of a Homelessness Strategy
- improvement in the management and maintenance of housing in remote Indigenous communities across the Northern Territory, through more effective policy and program responses and increased service delivery capacity within Indigenous Community Housing Organisations.

16.6 Definitions of key terms and indicators

Public, community and State owned and managed Indigenous housing

Administration costs	Those costs associated with the administration offices of the property manager and tenancy manager. They include the general accounting and personnel function costs relating to: • employee expenses (for example, superannuation, compensation, accrued leave and training) • supplies and services expenses (including stationery, postage, telephone, office equipment, information systems and vehicle expenses) • rent • grants and subsidies (excluding rental subsidies) • expenditure incurred by other government agencies on behalf of the public housing agency • contracted public housing management services.
Affordability	The proportions of recipients spending more than 30 per cent and 50 per cent of their income on rent with and without CRA.
Location/amenity	A survey-based measure of the proportion of tenants rating location and amenity aspects as important and meeting their needs.
Assessable income	The income used to assess eligibility for housing assistance and to calculate the rental housing rebate that allows a household to pay a rent lower than the market rent. Definition may vary across jurisdictions.
Community housing rental dwelling	Includes properties covered by the CSHA. Excludes properties for which the tenancy management functions are undertaken and administered under the Public Rental Housing Program, the ARHP or transitional/emergency accommodation for people who are homeless and in crisis (the Crisis Accommodation Program).
Customer satisfaction	A survey measure of the proportion of customers expressing different degrees of satisfaction with the overall service provided.
Depreciation costs (as per the Australian Accounting Standards 13–17)	Depreciation calculated on a straight-line basis at a rate that realistically represents the useful life of the asset.
Direct costs	Total administration costs and the costs of maintaining the operation of dwellings.
Disability (as per the ABS Survey of Disability Ageing and Carers)	Any restriction or lack of ability (resulting from an impairment) to perform an action in the manner or within the range considered normal for a human being.
Dwelling	For the purpose of the public, community and State owned and managed Indigenous housing collections, counting the number of tenancy agreements is the proxy for continuing the number of households. A tenancy (rental) unit is defined as the unit of accommodation on which a tenancy agreement can be made. It is a way of counting the maximum number of distinct rentable units that a dwelling structure can contain.
Greatest need	Low income households that at the time of allocation were subject to one or more of the following circumstances:

	• homelessness • their life or safety being at risk in their accommodation • their health condition being aggravated by their housing • their housing being inappropriate to their needs • their rental housing costs being very high.
Household	For the purpose of the public, community and State owned and managed Indigenous housing collections, a tenancy agreement. 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. Counting the number of tenancy agreements is the proxy for counting the number of households.
Income unit	One person or a group of related people within a household who share command over income. The allowable relationships in the definition of income unit are restricted to (1) marriage (registered or <i>de facto</i>) and (2) parent and dependent child who usually reside in the same household. Operationally, an income unit is: • a married couple (registered or <i>de facto</i>) or sole parent, and dependent children only • a married couple only (registered or <i>de facto</i>) with no dependent children present • a person in a private dwelling who is not related to any other household member either by marriage (registered or <i>de facto</i>) or by a parent/dependent child relationship. It is defined differently for CRA.
Indigenous household	A household with one or more members (including children) who identify as Aboriginal and/or Torres Strait Islander.
Low income household	A household whose members are assessed as having a low income according to the following definitions. Households are assigned an income status based on total household gross income and the composition of the household: • low income A households are those in public housing in which all household members have incomes at or below the maximum pension rate • low income B households are those in public housing that have incomes that would enable them to receive government income support benefits below the maximum pension.
Maintenance costs	Costs incurred to maintain the value of the asset or to restore an asset to its original condition. The definition includes day-to-day maintenance reflecting general wear and tear, cyclical maintenance, performed as part of a planned maintenance program and other maintenance, such as repairs as a result of vandalism.
Market rent	Aggregate market rent that would be collected if the public rental housing properties were available in the private market.
Match of dwelling to household size	The proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure. Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.
Moderate Overcrowding	Where one additional bedroom is required to satisfy the proxy

	occupancy standard.
New household	Households that commence receiving assistance for the financial year and are waitlist type 'new applicant/household'.
Occupancy rate	The proportion of dwellings occupied. The term 'occupied dwelling' refers to dwellings occupied by tenants who have a tenancy agreement with the relevant housing authority.
Occupied dwelling	Any structure that people live in, regardless of its intended purpose. The structure may or may not be tenantable.
Overcrowding	Where two or more additional bedrooms are required to meet the proxy occupancy standard.
Priority access to those in greatest need	Allocation processes to ensure those in greatest need have first access to housing. This is measured as the proportion of new allocations to those in greatest need in the following timeframes: • under three months • three months to under six months • six months to under one year • one year to less than two years • two years or more • total.
Principal tenant	The person or principal 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	The standard used to determine overcrowding/underuse. The standard used in the public and community housing collections is based on the Canadian model. (For further discussion on measuring household bedroom requirements, see Foard <i>et al.</i> 1994).
Public rental dwelling	Public rental properties covered by the CSHA. Excludes properties administered under Community Rental Housing, the ARHP or transitional/emergency accommodation for people who are homeless and in crisis (the Crisis Accommodation Program).
Relocated household	A household, either rebated or market renting, that relocates (transfers) from one public or community rental dwelling to another.
Rent charged	The amount in dollars that households are charged based on the rents they are expected to pay. The rents charged to tenants may or may not have been received.
Rent collected	The total rent collected as a proportion of the 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 State owned and managed Indigenous housing), or (except for State owned and managed Indigenous housing) is Indigenous.
Special needs but not low income household	A household with a member who has a special need, but where the household income is assessed as not being low income according to a household income cut-off value.
Tenant or tenant household	The usual members of a household occupying a public, community or State owned and managed Indigenous housing dwelling where there is a tenancy agreement with the housing authority. A tenant household either receives rebated assistance or pays the market rent as determined by the agency.

Tenantable dwelling	A dwelling where maintenance has been completed, whether occupied or unoccupied at 30 June. All occupied dwellings are tenantable.
Total gross household income	The value of gross weekly income from all sources (before deductions for income tax, superannuation etc.) for all household members, expressed as dollars per week. The main components of gross income are current usual wages and salary; income derived from self-employment, government pensions, benefits and allowances; and other income comprising investments and other regular income.
Turnaround time	The average time taken in days for vacant dwellings to be occupied.
Underuse	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

Control of incorrect payment	The proportion of CRA payment adjustments resulting from a risk-based review.
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.
Eligible income support clients	Clients 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 clients who are not paid are those affected by Centrelink errors in recording information or by program errors.
Geographic spread of CRA customers	Two measures are presented: • CRA recipients as a proportion of income units in each capital city receiving a social security income support benefit or more than the base rate of the Family Tax Benefit • the average CRA entitlement across locations.

Income unit	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.
Low income	Income of CRA recipients, by quintiles of family income received per week.
Maximum rate	Proportion of CRA recipients receiving the maximum rate of CRA.
Number and outcome of appeals	The outcomes of all CRA appeals finalised: (1) the number of customers who appealed to an authorised review officer, and (2) the proportions of appeals where the decision was affirmed, set aside or varied, or the appeal was withdrawn.
Number and proportion of CRA recipients, by income unit type	A point-in-time indicator showing the number of CRA recipients by income unit type, and the proportion of recipients within each income unit category. Includes data on Indigenous recipients.
Number and proportion of CRA recipients, by payment type	A point-in-time indicator showing the number of CRA recipients by the type of primary payments received, and the proportion of recipients within each payment type category.
Payment type	The number and proportion of income support recipients receiving CRA, by the primary payment type received.
Primary payment type	Each income unit receiving CRA is assigned a primary payment type, based on the payment(s) received by each member. This is used to monitor the extent to which assistance is provided to families and individuals that primarily depend on different forms of assistance. The primary payment is determined using a hierarchy of payment types, precedence being given to pensions, then other social security payments that attract CRA, and then the Family Tax Benefit. Within this overall structure a lower precedence is given to payments that are made only to the partners of a social security payment. If both members of a couple receive a payment of the same rating, the male is regarded as the primary member of the couple. No extra weight is given to the payment type with which CRA is paid.
Proportion of income spent on rent with and without CRA	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: • with CRA: rent (minus CRA) divided by total income from all sources, excluding CRA • without CRA: rent divided by total income from all sources, excluding CRA.

Ratio of running costs to total outlay for CRA	Total running costs for the CRA program as a proportion of total outlay.
Rent	Amount payable as a condition of occupancy of a person's home. Includes site fees for a caravan, mooring fees and payment for services provided in a retirement village. Rent encompasses not only a formal tenancy agreement, but also informal agreements between family members, including the payment of board or board and lodgings. Where a person pays board and lodgings and cannot separately identify the amount paid for lodgings, two thirds of the payment is deemed to be for rent. There is no requirement that rent be paid; a person whose rent is in arrears may remain eligible for assistance, provided Centrelink is satisfied that the liability is genuine.
Running costs per 1000 CRA customers	Total running costs for the CRA program per 1000 CRA customers.
Sharer	Some single people are subject to a lower maximum (sharer) rate of CRA. The lower rate may apply to only a single person (with no dependent child) who shares a major area of accommodation. The lower rate does not apply to those receiving the Disability Support Pension or Carer Payment, those in nursing homes or boarding house accommodation, or those paying for both board and lodgings. A person is not regarded as a sharer solely because he or shares with a child (of any age) if the child does not receive CRA.
Satisfaction with location of housing	Satisfaction with the location of housing rather than with the CRA payment, as measured by the FaCS General Customer Survey. The indicator measures the proportion of respondents satisfied with the quality of their housing, broken down into categories of 'poor', 'just okay', 'good' and 'great'.
Satisfaction with quality of housing	Satisfaction with the quality of housing rather than with the CRA payment, as measured by the FaCS General Customer Survey. The indicator measures the proportion of respondents satisfied with the quality of their housing, broken down into categories of 'poor', 'just okay', 'good' and 'great'.
Special needs	The proportions of special needs income units receiving CRA, such as rural and remote Australians and Indigenous recipients, by benefit type.
Total income from all sources	Income received by the customer or partner, excluding income received by a dependent. Includes regular social security payments and any maintenance and other private income taken into account for income testing purposes. Excludes: • one-time payments • arrears payments • advances • Employment or Education Entry Payments • 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 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 16A.3 is table 3 in the attachment). Section 16.7 contains a complete list of the supporting tables. Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2006\Attach_stat_app.xls and in Adobe PDF format as \Publications\Reports\2006\Attach_stat_app.pdf. The files containing the supporting tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the CD-ROM or Internet can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

Public housing

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A Statistical appendix

A.1 Introduction

This appendix contains contextual information to assist the interpretation of the performance indicators presented in the Report. The following six key factors in interpreting the performance data are addressed:

- *Australia's population.* Section A.2 presents data on population characteristics, including size, age and sex, ethnicity, geographic location and a profile of Indigenous Australians.
- *Family and household.* Section A.3 provides an overview of the family and household environment within which Australians live.
- *Income, education and employment.* Section A.4 summarises the income and employment characteristics of Australians, including educational attainment and workforce participation.
- *Statistical concepts used in the Report.* Section A.5 provides technical information on the key statistical concepts used in the Report.
- *List of source tables.* Section A.6 lists the supporting tables for this chapter. Supporting tables are identified in references throughout the chapter by an 'A' suffix (for example, table A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report.
- *References.* Section A.7 lists references used in this chapter.

A.2 Population

The Australian people are the principal recipients of the government funded and/or provided services covered by this Report. The size, trends and characteristics of the population can have a significant influence on the demand for government services and the cost of their delivery. This section provides a limited exposition of the Australian population to support the analysis of government services provided in the Report. A more detailed exposition is provided in the Australian Bureau of Statistics (ABS) annual publication *Australian Social Trends* (ABS 2005). In the statistical

appendix and attachment tables, population totals for the same year can vary because they are drawn from different ABS sources depending on the information required — for example, some data are from the Census (ABS 2002a) and others from the Australian Demographic Statistics.

Most of the service areas covered by the Report use population data from tables A.1 and A.2 for descriptive information (such as expenditure per person in the population) or performance indicators (such as participation rates for vocational education and training [VET]).

Population size and trends

More than three quarters of Australia's 20.1 million people lived in the eastern states as at 30 June 2004, with NSW, Victoria and Queensland accounting for 33.5 per cent, 24.7 per cent and 19.3 per cent respectively of the nation's population. Western Australia and SA accounted for a further 9.9 per cent and 7.6 per cent respectively of the population, while Tasmania, the ACT and the NT accounted for the remaining 2.4 per cent, 1.6 per cent and 1.0 per cent respectively (table A.1).

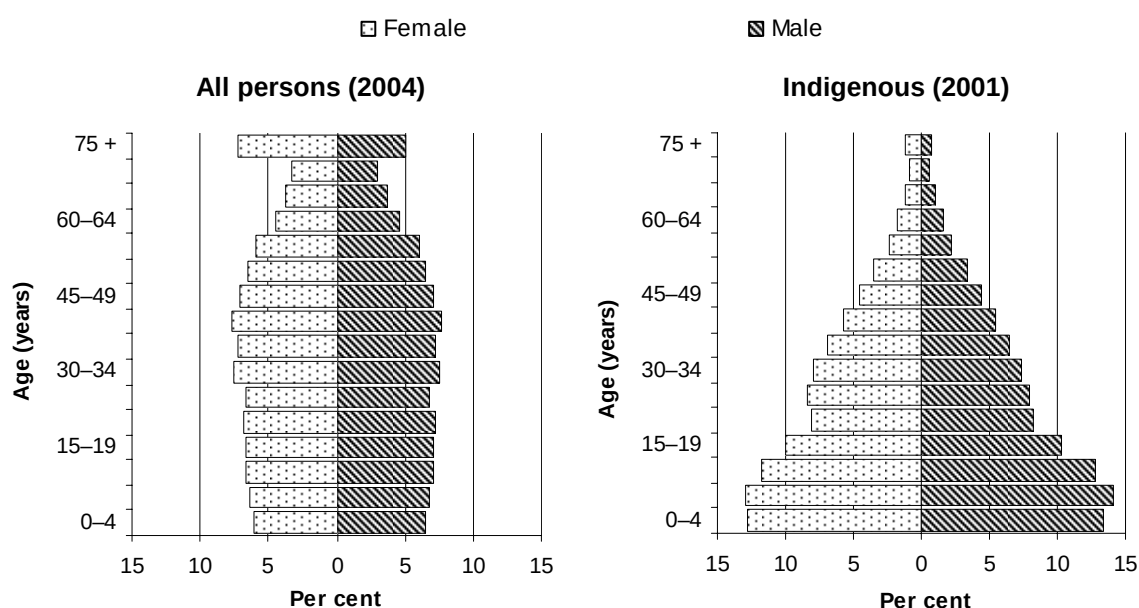
Nationally, the average annual growth rate of the population between 2000 and 2004 was approximately 1.2 per cent. The growth across jurisdictions ranged from 2.2 per cent in Queensland to 0.5 per cent in SA (table A.2, calendar year estimates).

Population, by age and sex

As in most other developed economies, greater life expectancy and declining fertility have contributed to an 'ageing' of Australia's population. The experiences of Indigenous Australians, however, are markedly different (figure A.1). At 30 June 2004, 9.2 per cent of Australia's population was aged 70 years or over, in contrast to 1.6 per cent of Australia's Indigenous population at 30 June 2001 (table A.7). Across jurisdictions, the proportion of people aged 70 years or over ranged from 11.0 per cent in SA to 2.6 per cent in the NT (table A.1).

Approximately half (50.3 per cent) of the population at June 2004 was female. This distribution was similar across all jurisdictions except the NT, which had a relatively low representation of women in its population (47.4 per cent) (table A.1). The proportion of women in the population varies noticeably by age. Nationally, approximately 57.1 per cent of people aged 70 or over were female, compared with 48.7 per cent of people aged 14 years or younger (table A.1).

Figure A.1 Population distribution, Australia, by age and sex, 30 June^{a, b}



^a Totals may not add as a result of rounding. ^b Includes other territories.

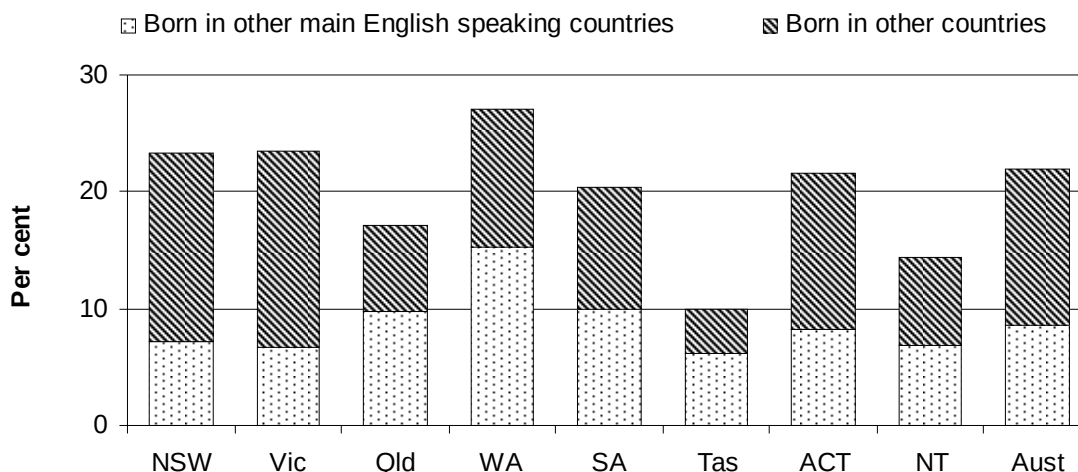
Source: ABS (2001); ABS Australian Demographic Statistics (unpublished); tables A.1 and A.7.

Population, by ethnicity

New Australians face specific problems when accessing government services. Language and culture can be formidable barriers for otherwise capable people. Cultural backgrounds can also have a significant influence on the support networks offered by extended families. People born outside Australia accounted for 21.9 per cent of the population in August 2001 (8.5 per cent from the main English speaking countries and 13.3 per cent from other countries).¹ Across jurisdictions, the proportion of people born outside Australia ranged from 27.0 per cent in WA to 10.0 per cent in Tasmania. The proportion from countries other than the main English speaking countries ranged from 16.8 per cent in Victoria to 3.9 per cent in Tasmania (figure A.2).

¹ The ABS defines the main English speaking countries as the United Kingdom, Ireland, New Zealand, Canada, the United States and South Africa.

Figure A.2 People born outside Australia, by country of birth, August 2001^{a, b, c}



^a Born outside Australia excludes overseas visitors. ^b The ABS defines other main English speaking countries as the United Kingdom, Ireland, New Zealand, Canada, the United States and South Africa. ^c Born in other countries includes inadequately described, at sea and not elsewhere classified.

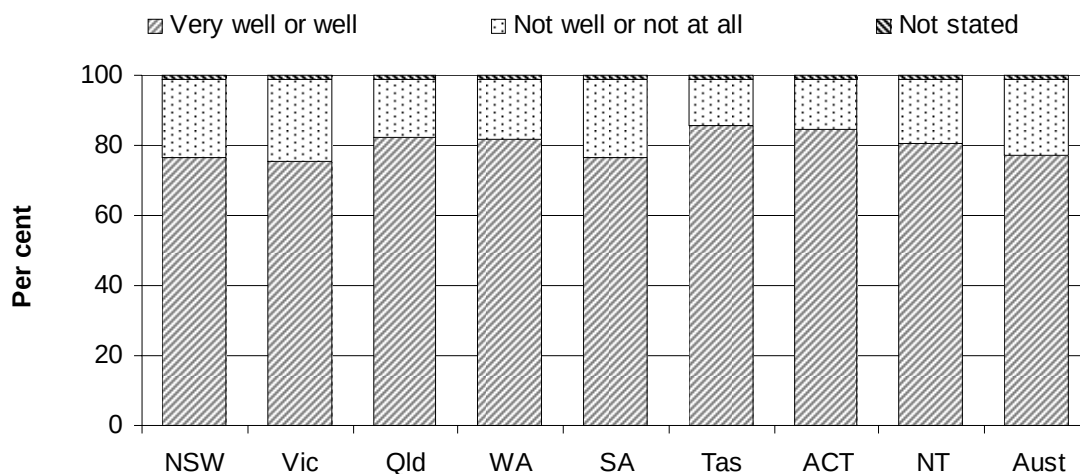
Source: ABS (2002a); table A.4.

People who speak a language other than English accounted for 47.9 per cent of the population born outside Australia in August 2001 (table A.3). Of these, 21.6 per cent did not speak English well or at all. Nationally, 21.2 per cent of the total population did not speak English well or at all. The proportion of people who did not speak English well or at all across jurisdictions, ranged from 29.6 per cent in Victoria to 2.7 per cent in Tasmania (tables A.1 and A.3).

Across jurisdictions in August 2001, the proportion of the population who were born outside Australia and who spoke a language other than English ranged from 58.0 per cent in Victoria to 22.0 per cent in Tasmania. The proportion who were born outside Australia and who did not speak English well or at all ranged from 13.6 per cent in Victoria to 2.9 per cent in Tasmania (figure A.3).

Approximately 15.2 per cent of Australians spoke a language other than English at home in August 2001. Across jurisdictions, this proportion ranged from 22.8 per cent in the NT to 3.1 per cent in Tasmania (table A.5). The most common languages spoken were Chinese languages, Italian, Greek and Arabic.

Figure A.3 **People born overseas who spoke English and another language, by proficiency in spoken English, August 2001^{a, b, c}**



^a Excludes overseas visitors and people who did not state their birthplace. ^b Includes other territories. ^c 'Not stated' includes cases where language spoken at home was stated but proficiency in English was not stated, and cases where both language spoken at home and proficiency in English were not stated.

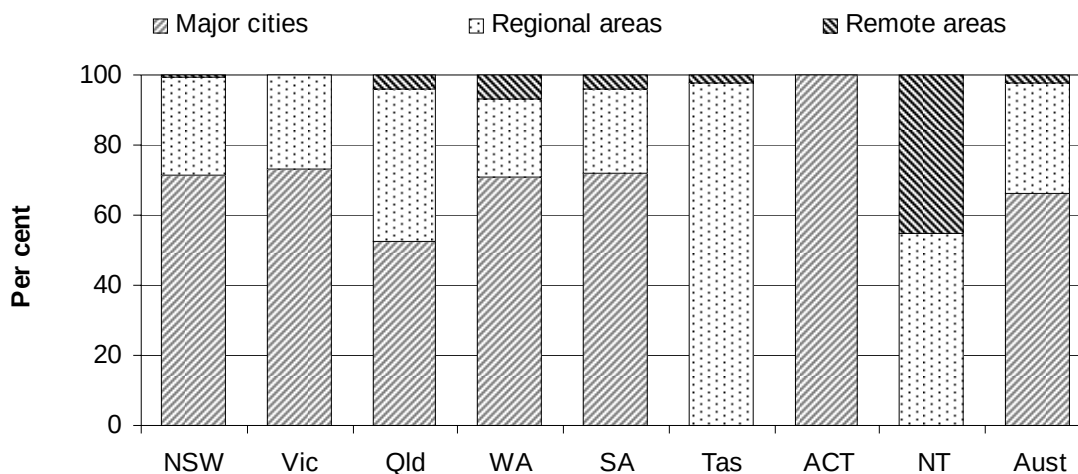
Source: ABS (2002a); table A.3.

The most and least common languages other than English spoken in people's homes varied across jurisdictions in August 2001. The most extreme variation was in the NT, where 15.4 per cent of people spoke an Australian Indigenous language (67.6 per cent of the total persons who spoke a language other than English in their homes) (table A.5).

Population, by geographic location

The Australian population is highly urbanised, with 66.3 per cent of the population located in major cities as at 30 June 2004 (figure A.4). Across jurisdictions, this proportion ranged from 99.8 per cent in the ACT to 52.7 per cent in Queensland (table A.6). Tasmania and the NT by definition have no major cities. In Tasmania, 97.7 per cent of the population lived in regional areas. Australia-wide, 2.5 per cent of people lived in remote areas. The NT was markedly above this average, with 45.2 per cent of people living in remote areas.

Figure A.4 **Estimated residential population, by geographic location, June 2004^{a, b, c}**



^a Preliminary data. ^b Geographic location is based on the Remoteness Structure outlined in the 2001 Australian Standard Geographic Classification (ASGC). ^c 'Australia' includes other territories.

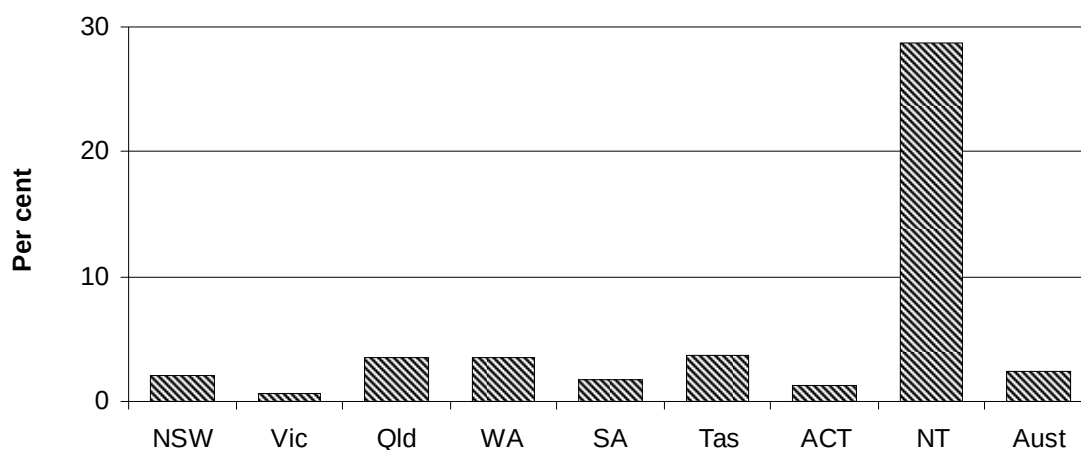
Source: ABS Australian Demographic Statistics (unpublished); table A.6.

Indigenous population profile

There were 458 520 (230 994 female and 227 526 male) Indigenous people in Australia at 30 June 2001, accounting for approximately 2.4 per cent of the population (tables A.2 and A.7). The proportion of people who were Indigenous was significantly higher in the NT (28.8 per cent) than in any other jurisdiction. Across the other jurisdictions, the proportion ranged from 3.7 per cent in Tasmania to 0.6 per cent in Victoria (figure A.5). Nationally, the Indigenous population is projected to grow to 528 645 people in 2009 (table A.8).

The majority of Indigenous people (79.8 per cent) at August 2001 spoke only English at home, while 12.1 per cent spoke an Indigenous language and English, and 2.5 per cent spoke another language. At that time, 5.6 per cent did not state any specific language (table A.9).

Figure A.5 **Indigenous people as a proportion of the population, 30 June 2001^a**



^a 'Australia' includes other territories.

Source: ABS (2001); ABS Australian Demographic Statistics (unpublished); tables A.2 and A.7.

A.3 Family and household

Family structure

There were 5.5 million families in Australia in 2004. Across jurisdictions, the number of families ranged from 1.8 million in NSW to 39 000 in the NT. The average family size across Australia was 3.0 people (the same as in 2003). Across jurisdictions, the average in all states was 3.0 people except for SA and the NT, which averaged 2.9 people (table A.10).

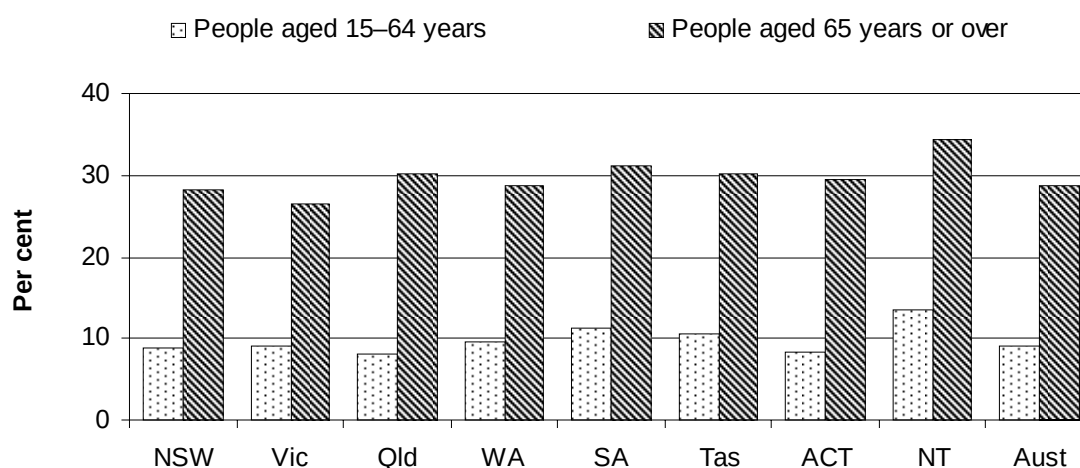
Lone parent families may have a greater need for government support and particular types of government services (such as child care for respite reasons). Nationally, 20.8 per cent of children aged under 15 years lived in one parent families in 2004; 20.3 per cent of families with children aged under 15 years were lone mother families and 2.8 per cent had a father only. Across jurisdictions, the proportion of children aged under 15 years living in one parent families ranged from 31.9 per cent in the NT to 18.6 per cent in Victoria (table A.11).

Employment status also has implications for the financial independence of families. Nationally, 16.2 per cent of children aged under 15 years in 2002-03 lived in families where no parent was employed. Across jurisdictions, the proportion ranged from 21.1 per cent in Tasmania to 12.7 per cent in SA (table A.12).

Household profile

There were 7.4 million households in Australia in 2001 (table A.14). Close to one quarter (24.5 per cent) of these were lone person households. Across jurisdictions, the proportion of lone person households ranged from 28.0 per cent in SA to 21.3 per cent in the NT. The proportion of people aged 65 years or over who lived alone in June 2004 was considerably higher than that for people aged 15–64 years — nationally, 28.6 per cent compared with 9.1 per cent respectively. Across jurisdictions, the proportion of people aged 65 years or over who lived alone ranged from 34.3 per cent in the NT to 26.5 per cent in Victoria (figure A.6).

Figure A.6 Proportion of population who lived alone, by age group, 2004



Source: ABS (2005); table A.14.

Nationally, the majority of occupied private dwellings (66.2 per cent, or 4.7 million dwellings) in August 2001 were owned or were being purchased. Home ownership was highest in Victoria (70.7 per cent) and lowest in the NT (42.5 per cent). Australians rented 26.3 per cent of dwellings (21.5 per cent from private rental sources, 4.5 per cent from government and 0.3 per cent from unspecified sources) (table A.15). Across jurisdictions, the proportion of dwellings that were rented was highest in the NT (41.5 per cent) and lowest in Victoria (22.1 per cent) (figure A.7).

Figure A.7 **Occupied private dwellings, by tenure type and landlord type, August 2001^{a, b}**



^a 'Rented' includes rented dwellings where the landlord type was not stated. ^b 'Other' includes dwellings being occupied rent free or under a life tenure scheme.

Source: ABS (2002a); table A.15.

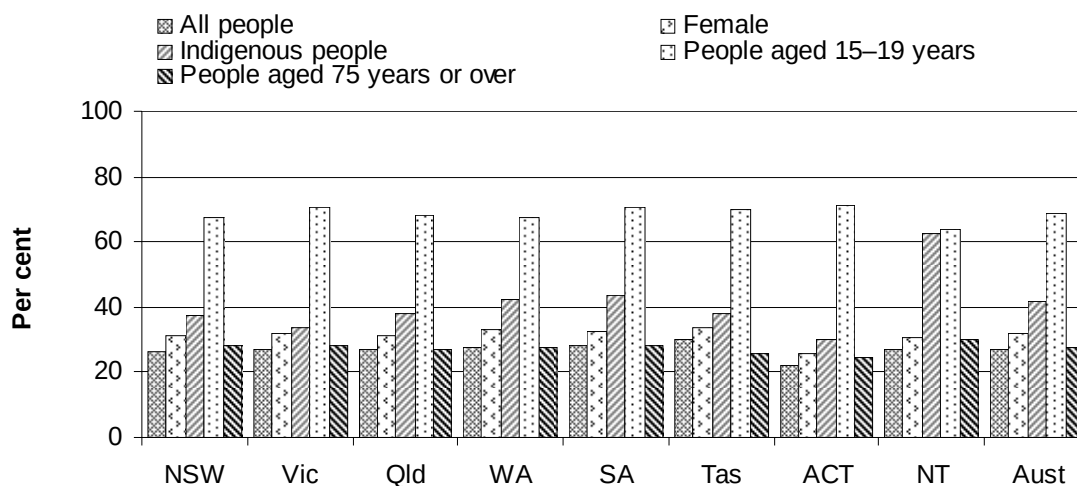
A.4 Income, education and employment

Income

Nationally, 27.1 per cent of people aged 15 years or over in August 2001 had a weekly individual income of \$199 or less (table A.16). The proportion was considerably higher for younger people (68.8 per cent for people aged 15–19 years), Indigenous people (41.6 per cent), females (31.8 per cent) and older people (27.7 per cent for people aged 75 years or over) (figure A.8).

Nationally, the proportion of the total population receiving income support was 18.1 per cent in 2004. The age pension was received by 9.3 per cent of the population, while 3.5 per cent received a disability support pension and 2.3 per cent received a single parent payment. A further 3.0 per cent of the population received some form of labour market allowance in 2004 (figure A.9).

Figure A.8 Weekly individual income of \$199 or less, by sex, Indigenous status and age, August 2001^a



^a 'Australia' includes other territories.

Source: ABS (2002a); ABS (2002b); tables A.16–A.18.

Figure A.9 Proportion of total population on income support, June 2004^{a, b}



^a Jurisdictions do not add to total because data for Australia include pensions paid to people living overseas.

^b Data for the labour market allowance are for a point in time that does not match the average of weekly data, which include people who receive a nil rate of payment.

Source: ABS (2005); table A.19.

The proportion of the population receiving the age pension in 2004 ranged from 11.2 per cent in SA to 3.1 per cent in the NT; the proportion receiving a disability support pension ranged from 6.9 per cent in Tasmania to 1.8 per cent in the ACT; and the proportion receiving a single parent payment ranged from 3.1 per cent in the

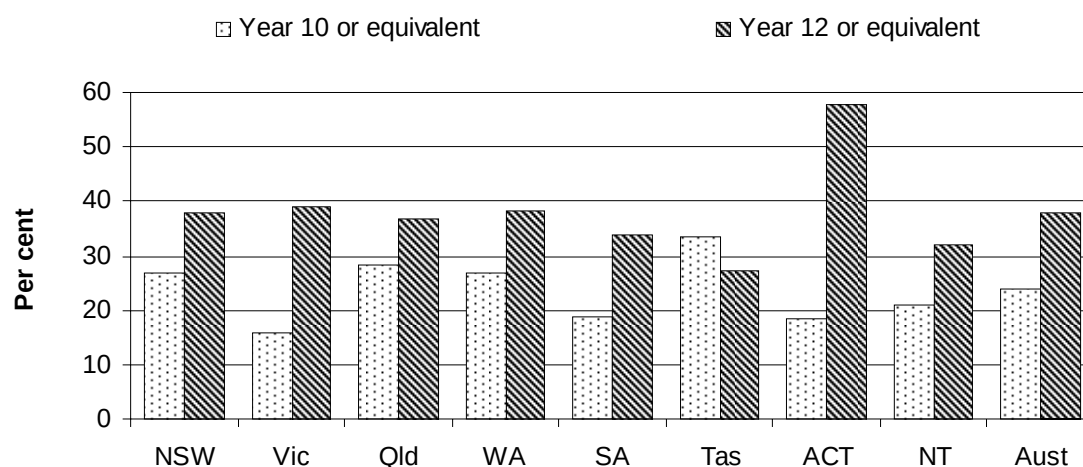
NT to 1.6 per cent in the ACT. The proportion receiving a labour market allowance in 2004 ranged from 8.5 per cent in the NT to 1.7 per cent in the ACT.

Educational attainment

Employment outcomes and income are closely linked to the education and skill levels of individuals. At August 2001, 37.7 per cent of people aged 15 years and over (approximately 5.6 million people) had completed year 12 or equivalent as the highest level of schooling. A further 23.8 per cent (3.5 million people) had completed year 10 or equivalent schooling, excluding the 3.4 per cent (503 200 people) who were still at school (many of whom were studying in year 11 or 12, and had completed year 10). Across jurisdictions, the proportion of people aged 15 years and over who had completed year 12 or equivalent schooling ranged from 57.8 per cent in the ACT to 27.2 per cent in Tasmania (figure A.10).

The proportion of non-Indigenous people aged 15 years or over who had completed year 12 or equivalent schooling was considerably higher than the proportion of Indigenous people (39.5 per cent and 16.8 per cent respectively) in August 2001. Across jurisdictions, the proportion of Indigenous people aged 15 years or over who had completed year 12 or equivalent schooling ranged from 36.4 per cent in the ACT to 7.1 per cent in the NT. The proportion of non-Indigenous people was highest in the ACT (59.8 per cent) and lowest in Tasmania (28.4 per cent) (figure A.11).

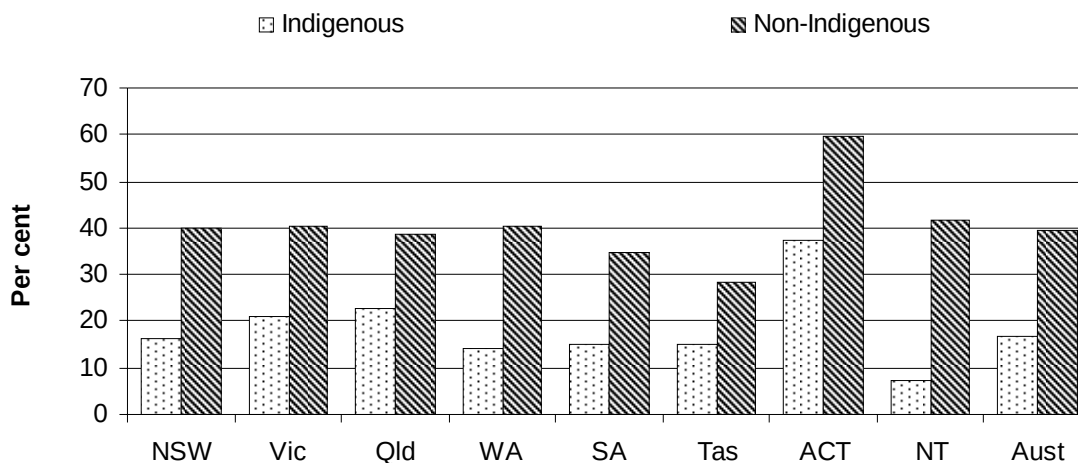
Figure A.10 **People aged 15 years or over, by highest year of school completed, August 2001^{a, b, c}**



^a Refers to primary or secondary schooling. ^b 'Australia' includes other territories. ^c 'All persons' includes Indigenous status not stated.

Source: ABS (2002b); table A.20.

Figure A.11 People aged 15 years or over who had completed year 12 or equivalent, by Indigenous status, August 2001^{a, b}

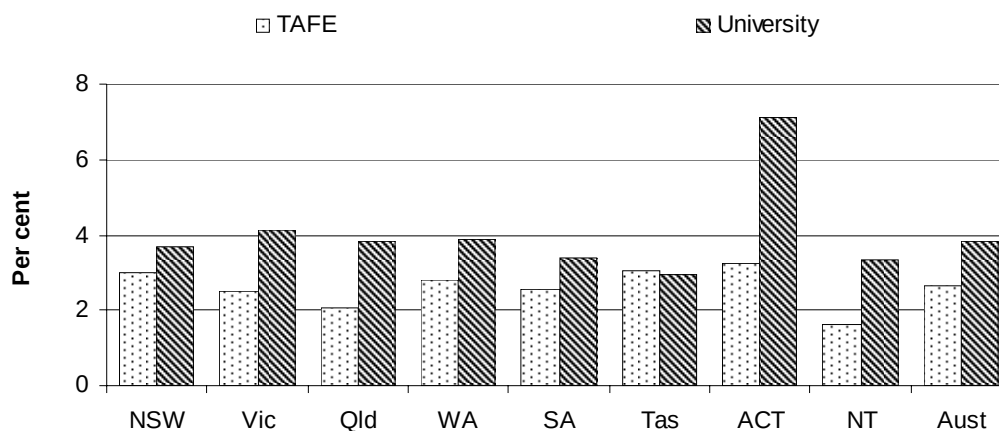


^a Refers to primary and secondary schooling. ^b 'Australia' includes other territories.

Source: ABS (2002b); table A.20.

Tertiary education in Australia is principally provided by universities and technical and further education (TAFE) institutes. Nationally, 6.5 per cent of the population were attending university or TAFE in August 2001 (3.8 per cent at university and 2.6 per cent at TAFE). Across jurisdictions, the proportion of people attending TAFE ranged from 3.2 per cent in the ACT to 1.6 per cent in the NT; the proportion attending university ranged from 7.1 per cent in the ACT to 3.0 per cent in Tasmania (figure A.12).

Figure A.12 Proportion of population attending higher education institutions, August 2001^{a, b}

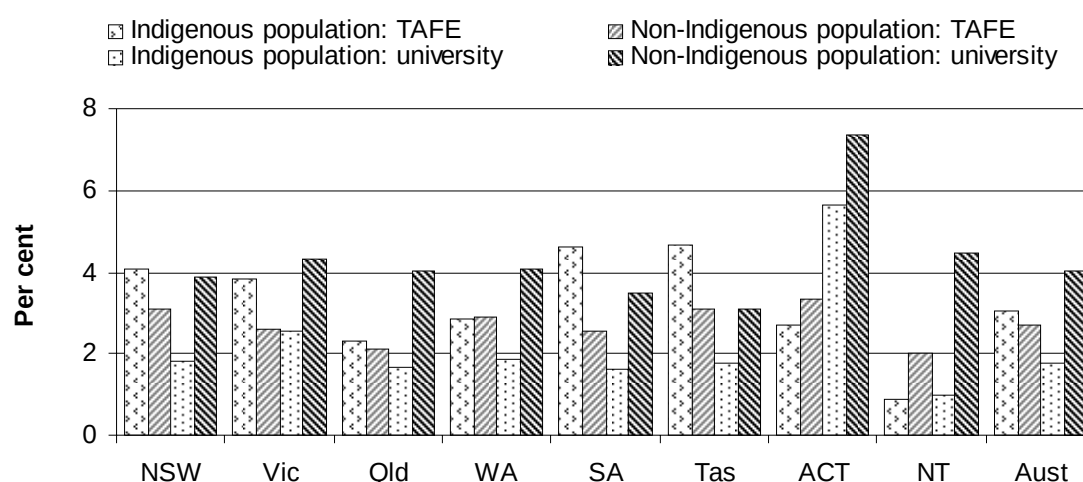


^a 'Australia' includes other territories. ^b 'University' includes other tertiary institutions.

Source: ABS (2002b); table A.21.

The proportion of the Indigenous population who were attending TAFE in August 2001 was greater than the proportion of the non-Indigenous population in all jurisdictions except WA, the ACT and the NT. Conversely, the proportion of the Indigenous population attending university was less than that of the non-Indigenous population in all jurisdictions (figure A.13).

Figure A.13 Proportion of population attending higher education, by Indigenous status, August 2001^{a, b}



^a 'Australia' includes other territories. ^b 'University' includes other tertiary institutions.

Source: ABS (2002b); table A.21.

Employment and workforce participation

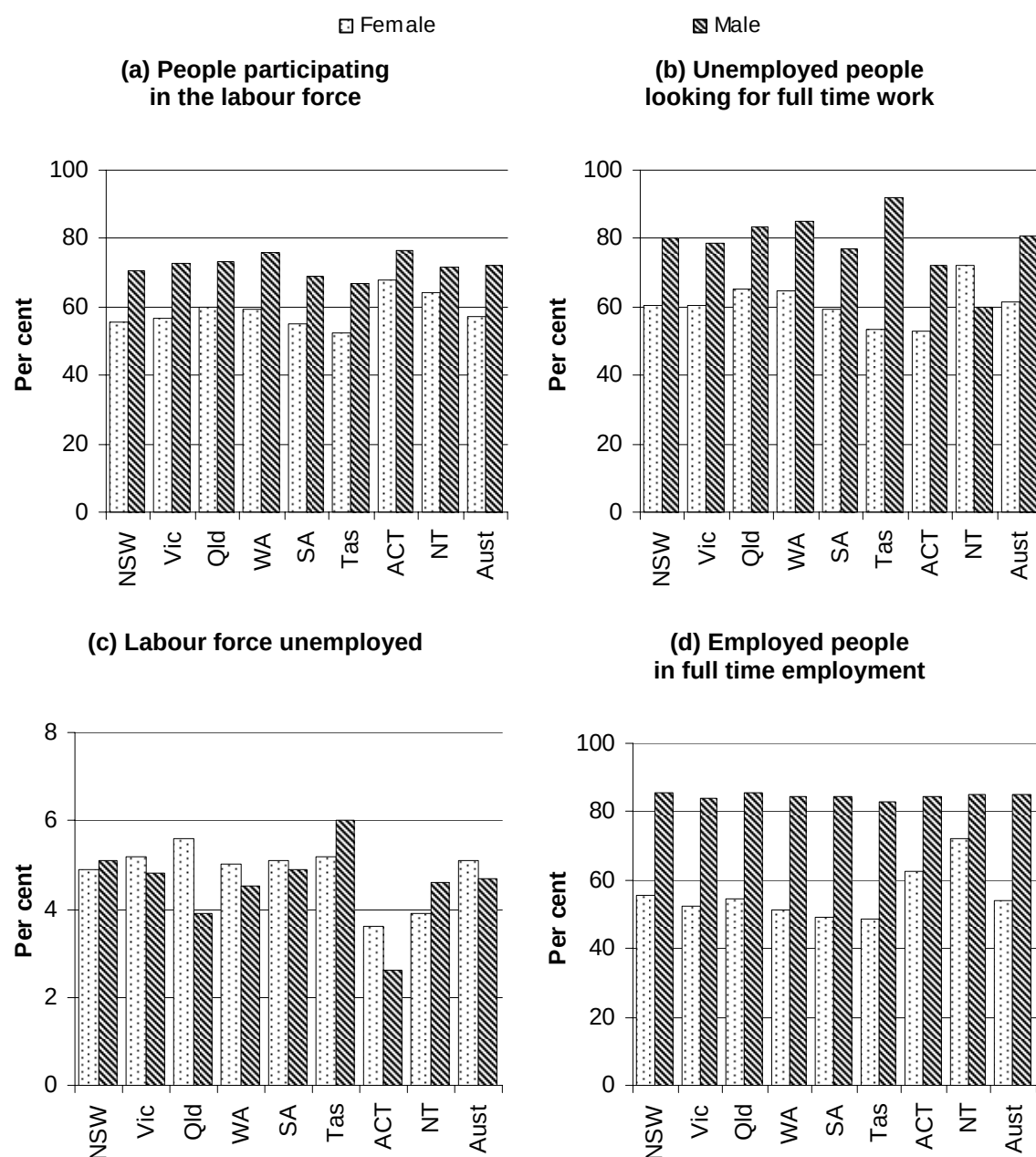
There were 10.5 million people aged 15 years or over in the labour force in Australia in June 2005. The majority of employed persons (71.0 per cent) were in full time employment. A further 514 000 people were looking for either full time work (71.6 per cent of those looking for work) or part time work (28.4 per cent). This means 4.9 per cent of the participating labour force were unemployed at June 2005 (table A.22).

Across jurisdictions, the proportion of employed people in full time employment in June 2005 ranged from 79.2 per cent in NT to 67.4 per cent in Tasmania. The unemployment rate ranged from 5.7 per cent in Tasmania to 3.1 per cent in the ACT (tables A.22 and A.24). The proportion of unemployed people looking for full time work ranged from 76.3 per cent in Tasmania to 60.3 per cent in the ACT.

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, 61.6 per cent and 80.5 per cent respectively (figure A.14b).

Figure A.14 Labour force outcomes for people aged 15 years or over, by sex, June 2005



Source: ABS Labour Force Survey (unpublished); tables A.22–A.24.

The unemployment rate for females was higher than that for males in all jurisdictions except NSW, Tasmania and the NT (figure A.14c). A greater proportion of employed males than of employed females had full time employment.

The difference between male and female full time employment ranged from 35.3 percentage points in SA to 12.9 percentage points in the NT (figure A.14d).

General economic indicators

The proportion of national gross product varied widely across the states and territories in 2003-04. The Gross State Product for NSW accounted for 34.8 per cent of national gross product, compared with 1.2 per cent for the NT. Growth from the previous year's Gross State Product (in current prices) was highest for Queensland (7.9 per cent) and lowest for the NT (1.8 per cent). Across Australia, the Gross State Product per person was \$40 647 in 2003-04 (table A.25).

A.5 Statistical concepts used in the Report

Reliability of estimates

Outcome and quality indicators are reported from surveys (including surveys of client and community perception) for a number of services covered in this Report. Police services, for example, use a survey to obtain an indicative level of community satisfaction with the services that police agencies provide. The potential for sampling error — that is, the error that occurs by chance because the data are obtained from only a sample and not the entire population — means that the reported responses may not indicate the true responses.

Standard error

The standard error (SE) is one measure of the variability that occurs as a result of surveying a sample of the population. There are two chances in three (67 per cent) that a survey estimate is within one standard error of the figure that would have been obtained if the population had been surveyed, and about 19 chances in 20 (95 per cent) that it is within approximately two standard errors. There is a 95 per cent probability that the true value of x lies within:

$$x - 1.96 SE(x) \text{ and } x + 1.96 SE(x)$$

where x is the estimate (for example, the number of persons responding either 'satisfied' or 'very satisfied'). The standard error of an estimate can be obtained from either (1) the tables in chapters reporting the estimates and relative standard errors or (2) the relative standard error tables produced at the end of each of the

relevant attachments. Linear interpolation needs to be used to calculate the standard errors of estimates falling between the sizes of estimates listed in these tables.

Relative standard error

The standard error can be expressed as a proportion of the estimate — known as the relative standard error (RSE), which is determined by dividing the standard error of the estimate $SE(x)$ by the estimate x and expressing it as a percentage:

$$RSE(x) = \frac{SE(x)}{x}$$

If, for example, 4.3 million people in NSW were estimated to be satisfied with a service, and the standard error was approximately $\pm 34\ 100$ people, then the $RSE(x)$ would be equal to 0.0078, or 0.78 per cent. The relative standard error is a useful measure in that it provides an immediate indication of the percentage errors likely to have occurred as a result of sampling.

Proportions and percentages formed from the ratio of two estimates are also subject to sampling error, as when estimating the proportion of a population that is ‘satisfied’ or ‘very satisfied’ with a service. The size of the error depends on the accuracy of both the numerator (the estimated number of persons responding as ‘satisfied’ or ‘very satisfied’) and the denominator (the estimated size of the population). The formula for the RSE of a proportion is:

$$RSE\left(\frac{x_1}{X}\right) = \sqrt{[RSE(x_1)]^2 - [RSE(X)]^2}$$

where x_1 is estimated as the number of persons from jurisdiction x responding as ‘satisfied’ or ‘very satisfied’, and X is the estimated population of jurisdiction x .

Testing for statistical differences

The chance that an estimate falls within a certain range of the true value is known as the *confidence* of the estimate. For any particular survey, there is a tradeoff between the confidence of the estimate and the range of error (in terms of standard errors) attached to the estimate. The appropriate level of reliability chosen depends on the purpose of obtaining the estimate. The lower the level of confidence required, the more precise the estimate will be.

Confidence intervals — the value ranges within which estimates are likely to fall — can be used to test whether the results reported for two jurisdictions are statistically

different. If the confidence intervals for the results overlap, then there can be little confidence that the estimated results differ from each other.

For example, assume survey data estimated a result of 60 per cent for NSW, with a 95 per cent confidence interval of ± 3.2 per cent, and a result of 58 per cent for Queensland, with a 95 per cent confidence interval of ± 1.15 per cent.

These results imply that we can be 95 per cent sure the true result for NSW lies between 56.8–62.3 per cent, and the true result for Queensland lies between 56.5–59.5 per cent. As these two ranges overlap, we cannot be sure that the true result for NSW and Queensland are statistically different.

Expressed mathematically, the estimated response is within the 95 per cent confidence interval:

$$\left(\frac{x_1}{X} - \frac{y_1}{Y}\right) - 1.96 \sqrt{\text{RSE}\left(\frac{x_1}{X}\right) \times \frac{x_1}{X} + \text{RSE}\left(\frac{y_1}{Y}\right) \times \frac{y_1}{Y}}$$

and

$$\left(\frac{x_1}{X} - \frac{y_1}{Y}\right) + 1.96 \sqrt{\text{RSE}\left(\frac{x_1}{X}\right) \times \frac{x_1}{X} + \text{RSE}\left(\frac{y_1}{Y}\right) \times \frac{y_1}{Y}}$$

where x_1 , X , y_1 and Y represent the estimated number of respondents and estimated populations of jurisdictions x and y respectively. If none of the values in this interval is zero, then the difference between jurisdiction x 's response and jurisdiction y 's response is statistically significant.

Growth rates

Average annual growth rates

Given that data in the Report cover different periods, compound annual averages have been used to facilitate more meaningful comparisons of changes over time.

The formula for calculating a compound annual growth rate is:

$$\text{AGR} = \left[\left(\frac{P_v}{P_0} \right)^{\left(\frac{1}{n-1} \right)} - 1 \right] \times 100$$

where AGR is the annual growth rate
 P_v is the present value
 P_0 is the beginning value
 n is the number of periods

Summing and taking averages of growth rates

Total growth rate

The formula for calculating a total growth rate from annual growth rates is:

$$\text{TGR} = \Pi_t (1+r)_t - 1$$

that is, the total growth over the period, TGR, is found by taking the product (Π) of each $(1+r)_i$ and deducting 1. If, for example, the sample ranges of growth rates are:

6 per cent in 2001-02 to 2002-03
6 per cent in 2002-03 to 2003-04
8 per cent in 2003-04 to 2004-05

where TGR is the total growth rate
 t is the year (2000, 2001, 2002... n)
 n is the final period

then the total growth over the period 2001-02 to 2004-05 can be calculated as:

$$\begin{aligned} r_T &= [\Pi_i (1+r)_i - 1] \times 100 \\ &= [(1.06) \times (1.06) \times (1.08) - 1] \times 100 \\ &= (1.213488 - 1) \times 100 \\ &= 21.3 \text{ per cent} \end{aligned}$$

Average growth rates

The formula for the average of growth rates is:

$$r_A = \left\{ \left[\prod_i (1 + r_i) \right]^{\frac{1}{t}} - 1 \right\} \times 100$$

This involves first finding the total growth over the period, then finding the average. Note that t is the count of growth rates being averaged, not the years. For example:

$$\begin{aligned} r_A &= \{ [(1.06 \times 1.06 \times 1.08)^{\frac{1}{3}} - 1] \times 100 \} \\ &= \{ [(1.213488)^{\frac{1}{3}} - 1] \times 100 \} \\ &= [(1.066625) - 1] \times 100 \\ &= 6.66 \text{ per cent.} \end{aligned}$$

Gross domestic product deflators

Table A.26 in the attachment contains GDP deflators for 1995–1996 to 2004–05. Financial data are often deflated by the gross domestic product (GDP) deflator data from table A.26 (except in some health chapters and chapter 4 on VET, which use service-specific deflators) to calculate real dollars.

The general formula used to re-base GDP deflators is as follows:

$$N_t 100 \times \frac{O_t}{B}$$

where N_t is the new index based in year t

O_t is the current index for year t

B is the current index for the year that will be the new base.

A.6 Supporting tables

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table A.3 is table 3 in the attachment). Supporting tables are provided on the CD-ROM enclosed with the Report. The files containing the supporting tables are provided in Microsoft Excel format as \Publications\Reports\2006\Attach_stat_app.xls and in Adobe PDF format as \Publications\Reports\2006\Attach_stat_app.pdf. The files containing the supporting tables can also be found on the Review web pages (www.pc.gov.au/gsp). Users without access to the CD-ROM can contact the Secretariat to obtain the supporting tables (see contact details on the inside front cover of the Report).

Population

Table A.1	Estimated resident population by age and sex, 30 June 2004 ('000)
Table A.2	Estimated resident population by calendar and financial year
Table A.3	Proficiency in spoken English of people born overseas, August 2001 ('000)
Table A.4	Persons by country of birth, August 2001 ('000)
Table A.5	Persons by language spoken at home, August 2001 ('000)
Table A.6	Estimated resident population by geographic location, 30 June 2004
Table A.7	Preliminary estimated resident Indigenous population by age and sex, 30 June 2001 ('000)
Table A.8	Experimental projection of the Indigenous population, 2000 to 2009 (number)
Table A.9	Language spoken at home by Indigenous people and proficiency in spoken English, by sex, August 2001 (number)

Family

Table A.10	Family structure, 2000–2004
Table A.11	Family structure: lone parents, 2000–2004 (per cent)
Table A.12	Families and work (per cent)
Table A.13	Families and persons in families in occupied private dwellings by Indigenous status and family type, August 2001
Table A.14	Household structure, 2000–2004
Table A.15	Occupied private dwellings by tenure type and landlord type, August 2001 ('000)

Income and employment

Table A.16	Persons aged 15 years and over, by weekly individual income and sex, August 2001

Table A.17	Persons aged 15 years and over by weekly individual income and Indigenous status, August 2001
Table A.18	Persons aged 15 years and over, by weekly individual income and age, August 2001
Table A.19	Income support, 30 June, 2000–2004
Table A.20	People aged 15 years or over, by highest level of schooling completed and Indigenous status, August 2001 ('000)
Table A.21	Type of educational institution attending by Indigenous status, August 2001 ('000)
Table A.22	Labour force profile of the civilian population aged 15 years or over by sex, June 2005
Table A.23	Labour force participation rate of the civilian population aged 15 years or over by sex, (per cent)
Table A.24	Unemployment rate of labour force participants aged 15 years or over by sex, (per cent)

General economic indicators

Table A.25	Gross State Product, 1999–00 to 2003–04
Table A.26	Gross Domestic Product price deflator (index)

A.7 References

- ABS (Australian Bureau of Statistics) 2001, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0, Canberra.
- 2002a, *Census of Population and Housing: Basic Community Profiles*, Australia, Cat. no. 2002.0, DX Database, viewed 18 July 2002, unpublished.
- 2002b, *Census of Population and Housing: Indigenous Community Profiles*, Australia, Cat. no. 2002.0, DX Database, viewed 18 July 2002, unpublished.
- 2005, *Australian Social Trends*, Cat. no. 4102.0, Canberra.

Related publications

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Overcoming Indigenous Disadvantage

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Other

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cat. no. 9927071

RRP \$8.95

Asset Measurement in the Costing of Government Services

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