

Report on Government Services 2012

Volume 2:

*Health; Community services;
Housing and homelessness*

*Steering Committee
for the Review of
Government
Service Provision*

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Acronyms and abbreviations

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

AEDI	Australian Early Development Index
AFAC	Australasian Fire and Emergency Services Authorities Council
AFP	Australian Federal Police
AGCCCS	Australian Government Census of Child Care Services
AGCCPS	Australian Government Child Care Provider Survey
AGPAL	Australian General Practice Accreditation Limited
AGPN	Australian General Practice Network
AHCA	Australian Health Care Agreements
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHV	Aboriginal Housing Victoria
AIC	Australian Institute of Criminology
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AIJA	Australian Institute of Judicial Administration
AIPAR	Australian Institute for Population Ageing Research
AJJA	Australasian Juvenile Justice Administrators
ALLS	Adult Literacy and Life Skills
ANZPAA	Australia and New Zealand Police Advisory Agency
ANZSCO	Australian and New Zealand Standard Classification of Occupations
ANZSIC	Australian and New Zealand Standard Industrial Classification

AODTS-NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
AQF	Australian Qualifications Framework
AQTF	Australian Quality Training Framework
AR-DRG v 5.1	Australian refined diagnosis related group, version 5.1
AR-DRGs	Australian refined diagnosis related groups
ARHP	Aboriginal Rental Housing Program
ARIA	Accessibility and Remoteness Index for Australia
ARO	Authorised Review Officer
ASGC	Australian Standard Geographical Classification
ASM	Active Service Model
ASO	ambulance service organisation
ASOC	Australian Standard Offence Classification
ASSNP	core activity need for assistance
ATC	Australian Transport Commission
Aust	Australia
AVETMISS	Australian Vocational Education and Training Management Information Statistical Standard
BBF	Building a Better Future
BEACH	Bettering the Evaluation and Care of Health
BMI	Body Mass Index
C&K	Crèche and Kindergarten
CAA	Council of Ambulance Authorities
CACP	Community Aged Care Package
CAD	computer aided dispatch

CAEPR	Centre for Aboriginal Economic Policy Research
CALD	culturally and linguistically diverse
CAP	conditional adjustment payment
CAP	Crisis Accommodation Program
CAWG	Court Administration Working Group
CCB	Child Care Benefit
CCMS	Child Care Management System
CCR	Child Care Rebate
CCTR	Child Care Tax Rebate
CDC	Community Directed Care
CD-ROM	Compact Disc Read Only Memory
CDSMAC	Community and Disability Services Ministers' Advisory Council
CFA	Country Fire Authority
CFCs	Child and Family Centres
CHIP	Community Housing and Infrastructure Program
CHOS	Canadian National Occupancy Standard
CI	confidence interval
CIS	Complaints Investigation Scheme
CMHC	Community Mental Health Care
COAG	Council of Australian Governments
CPG	Court Practitioners Group
CRA	Commonwealth Rent Assistance
CRC	COAG Reform Council

CRS	Commonwealth Rehabilitation Services
CRS	Complaints Resolution Scheme
CRYPAR	Coordinated Response to Young People at Risk
CSASAW	Commonwealth-State Agreement for Skilling Australia's Workforce
CSDWG	Children's Services Data Working Group
CSHA	Commonwealth State Housing Agreement
CSMAC	Community Services Ministers' Advisory Council
CSTDA	Commonwealth State/Territory Disability Agreement
CURF	confidentialised unit record file
DDHCS	Department of Disability, Housing and Community Services
DEEWR	Department of Education, Employment and Workplace Relations
DET	Department of Education (NSW)
DGP	Divisions of General Practice
DGPP	Divisions of General Practice Program
DHAC	Department of Health and Aged Care
DHS	Department of Human Services (Vic)
DHSH	Department of Human Services and Health
DiRCS	Differences in Recorded Crime Statistics
DoCS	Department of Community Services (NSW)
DoHA	Department of Health and Ageing
DPEM	Department of Police and Emergency Management (Tas)

DPIE	Department of Primary Industries and Energy
DQI	data quality information
DSE	Department of Sustainability and Environment
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EACH-D	EACH Dementia
ECD	Early Childhood Development
ECET	Early childhood, education and training
EMA	Emergency Management Australia
EMS	emergency medical service
ERP	estimated resident population
ESO	emergency services organisation
EYL	early years learning
FaCS	Department of Family and Community Services
FaCSIA	Department of Families, Community Services and Indigenous Affairs
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FDC	family day care
FDCQA	Family Day Care Quality Assurance
FESA	Fire and Emergency Services Authority (WA)
FSO	fire services organisation
FTE	full time equivalent
FWE	full time workload equivalent
FYA	Foundation for Young Australians

GDP	gross domestic product
GFS	Government Finance Statistics
GP	general practitioner
GPA Accreditation plus	General Practice Australia ACCREDITATION plus
GPII	General Practice Immunisation Incentives Scheme
GSP	gross state product
GSS	General Social Survey
GST	goods and services tax
HACC	Home and Community Care
HAF	Housing Affordability Fund
HDSC	Health Data Standards Committee
HECS	Higher Education Contribution Scheme
HELP	Higher Education Loan Program
HILDA	Household Income and Labour Dynamic Australia
HIP	Home Independence Project
HMAC	Housing Ministers' Advisory Council
HOIST	New South Wales Population Health Survey 2007
HoTS	Heads of Treasuries
HREOC	Human Rights and Equal Opportunity Commission
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
ICD	International Classification of Diseases
ICD-10-AM	Australian modification of the International Standard Classification of Diseases and Related Health Problems, version 10

ICH	Indigenous community housing
ICHO	Indigenous Community Housing Organisation
ICT	information and communication technologies
IGA	Intergovernmental Agreement
IPD	Implicit Price Deflator
IRSD	Index of Relative Socio-economic Disadvantage
ISO	International Organisation for Standardisation
ISS	Inclusion Support Subsidy
JJNMDS	Juvenile Justice National Minimum Data Set
JJRIG	Juvenile Justice Research and Information Group
K10	Kessler Psychological Distress Scale
KPIs	key performance indicators
LBOTE	Language background other than English
LCL	lower confidence limit
LDC	long day care
LGCSA	Local Government Community Services Association of Australia
LMO	local medical officer
LOTE	Language other than English
LSAC	Longitudinal Study of Australian Children
LSAY	Longitudinal Surveys of Australian Youth
MBI	Modified Barthel Index
MBS	Medicare Benefits Schedule
MCATSIA	Ministerial Council on Aboriginal and Torres Strait Islander Affairs

MCEECDYA	Ministerial Council for Education, Early Childhood Development and Youth Affairs
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MCTEE	Ministerial Council of Tertiary Education and Employment
MCVTE	Ministerial Council on Vocational and Technical Education
MECS	Mobile Early Childhood Services
MFS	Metropolitan Fire Service
MHE	Mental Health Establishments
MHS	mental health services
MPS	multi-purpose services
NA	National Agreement
na	not available
NAHA	National Affordable Housing Agreement
NAPLAN	National Assessment Program – Literacy and Numeracy
NASWD	National Agreement for Skills and Workforce Development
NMVTRC	National Motor Vehicle Theft Reduction Council
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NBCC	National Breast Cancer Centre
NCAC	National Childcare Accreditation Council
NCAG	National Corrections Advisory Group
NCCH	National Centre for Classification in Health

NCIRS	National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases
NCJSF	National Criminal Justice Statistical Framework
NCPASS	National Child Protection and Support Services data working group
NCSIMG	National Community Services Information Management Group
NCVER	National Centre for Vocational Education Research
NDA	National Disability Agreement
NEA	National Education Agreement
NEAT	Department of Natural Resources Environment and the Arts
NEMC	National Emergency Management Committee
NESB	non-English speaking background
NGOs	non-government organisations
NHA	National Healthcare Agreement
NHIMPC	National Health Information Management Principal Committee
NHMP	National Homicide Monitoring Program
NHMRC	National Health and Medical Research Council
NHPAC	National Health Priority Action Council
NHPC	National Health Performance Committee
NHS	National Health Survey
NIA ECEC	National Information on Agreement on Early Childhood Education and Care
NIDP	National Information Development Plan

NIHEC	National Indigenous Health Equality Council
NIRA	National Indigenous Reform Agreement
NISC	National Industry Skills Committee
NMDS	national minimum data set
NMHS	National Mental Health Strategy
NNDSS	National Notifiable Diseases Surveillance System
no.	number
NOOSR	National Office of Overseas Skills Recognition
NP	National Partnership
np	not published
NPAs	National Partnership Agreements
NPC	National Preschool Census
NQC	National Quality Council
NQS	National Quality Standard
NRCP	National Respite for Carers Program
NRF	National Reporting Framework
NRSS	National Road Safety Strategy
NSCSP	National Survey of Community Satisfaction with Policing
NSOC	National Senior Officials Committee
NSSC	National Schools Statistics Collection
NSW RFS	New South Wales Rural Fire Service
NSW	New South Wales
NSWFB	New South Wales Fire Brigade

NT	Northern Territory
NTCE	Northern Territory Certificate of Education
NTES	National Territory Emergency Services
NTSC	National Training Statistics Committee
NYPR	National Youth Participation Requirement
OCYFS	Office for Children, Youth and Family Support (ACT)
OECD	Organisation for Economic Co-operation and Development
OID	Overcoming Indigenous Disadvantage
OMP	other medical practitioner
OSHC	outside school hours care
OSHCQA	Outside School Hours Care Quality Assurance
PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
PDF	Portable Document Format
PDWG	Performance and Data Working Group
PEP	Personal Enablement Program
PhARIA	Pharmacy Access/Remoteness Index of Australia
PHCRIS	Primary Health Care Research and Information Service
PIP	Practice Incentives Program
PIRP	Preschool Investment and Reform Plan
PISA	Program for International Student Assessment
PSM	ABS Population Survey Monitor
PWI	personal wellbeing index

QFRS	Queensland Fire and Rescue Service
QIAS	Quality Improvement and Accreditation System
Qld	Queensland
QMP	Quality Management Framework
RACGP	Royal Australian College of General Practitioners
RAV	Rural Ambulance Victoria
RCS	resident classification scale
RFDS	Royal Flying Doctor Service
RISS	Remote and Indigenous Service Support
ROGS	Report on Government Services
ROSC	return of spontaneous circulation
RPBS	Repatriation Pharmaceutical Benefits Scheme
RPL	recognition of prior learning
RRMA	Rural, Remote and Metropolitan Areas
RSE	relative standard error
RTO	Registered Training Organisation
S/TES	State/Territory Emergency Service
SA	South Australia
SAAP CAD	SAAP Coordination and Development Committee
SAAP NDCA	SAAP National Data Collection Agency
SAAP	Supported Accommodation Assistance Program
SAAS	SA Ambulance Service
SAR	Service Activity Reporting
SAT	school-based apprenticeships and traineeships

SCOTese	Standing Council on Tertiary Education, Skills and Employment
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SCRGSP	Steering Committee for the Review of Government Service Provision
SDAC	Survey of Disability, Ageing and Carers
SE	standard error
SEIFA	Socio Economic Indexes for Areas
SEM	standard error of the mean
SES	socioeconomic status
SES	State Emergency Services
SEWB	National Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004-05
SEWB	Social and Emotional Wellbeing
SIQ	standard Indigenous question
SLA	statistical local area
SMHWB	National Survey of Mental Health and Wellbeing
SMR	standardised mortality ratios
SOMIH	State owned and managed Indigenous housing
SPP	special purpose payment
SPRC	Social Policy Research Centre
SSAT	Social Security Appeals Tribunal
SWPE	standardised whole patient equivalent
TAFE	technical and further education

Tas	Tasmania
TAS	Tasmanian Ambulance Service
TCP	Transition Care Program
TFS	Tasmania Fire Service
TGR	total growth rate
TIMSS	Trends in International Mathematics and Science Study
TVET	technical and vocational education and training
UCC	user cost of capital
UCL	upper confidence limit
URTI	upper respiratory tract infection
USAR	Urban Search and Rescue
U-Turn	U-Turn diversionary program for young motor vehicle offenders
VCAT	Victorian Civil and Administrative Tribunal
VET	vocational education and training
VF	ventricular fibrillation
VHC	Veterans' Home Care
Vic	Victoria
VT	ventricular tachycardia
WA	Western Australia
WGIR	Working Group on Indigenous Reform
WHO	World Health Organisation
YPIRAC	Younger people in residential aged care

Glossary

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

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

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

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Attachment tables

Attachment tables are identified in references throughout this sector summary by an 'EA' prefix (for example, table EA.1). A full list of attachment tables is provided at the end of this sector summary, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

E.1 Introduction

This sector summary provides an introduction to the Public hospitals (chapter 10), Primary and community health (chapter 11), and Mental health management (chapter 12) chapters of this Report. It provides an overview of the health sector, presenting both contextual information and high level performance information.

Major improvements in reporting in health this year are identified in each of the service-specific health chapters.

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. The health system also includes a range of activities that raise awareness of health issues, thereby reducing the risk and onset of illness and injury.

Policy context

All levels of government in Australia fund, deliver and regulate health services, with most of the activity performed by the Australian, State and Territory governments. The Australian Government's health services activities include:

- funding a proportion of public hospital services through the National Health Agreement (NHA) and National Health Reform Agreement
- providing rebates to patients and regulating medical services provided by General Practitioners (GPs) and specialists, practice nurses, and some services provided by allied health professionals (such as Medicare), and delivering public health programs
- funding and regulating the Pharmaceutical Benefits Scheme (PBS)
- funding and regulating private health insurance rebates
- funding improved access to primary health care, including Indigenous-specific primary health, specialist services and infrastructure for rural and remote communities
- promulgating and coordinating health regulations
- undertaking health policy research and policy coordination across the Australian, State and Territory governments
- funding hospital services and the provision of other services through the Department of Veterans' Affairs
- funding hearing services for eligible Australians through the Australian Government Hearing Services Program
- funding the Medicare Safety Net.

State and Territory governments contribute funding for, and deliver, a range of health care services (including services specifically for Indigenous people) such as:

- public hospital services
- public health programs (such as health promotion programs and disease prevention)
- community health services

-
- public dental services
 - mental health programs
 - patient transport
 - the regulation, inspection, licensing and monitoring of premises, institutions and personnel
 - health policy research and policy development
 - specialist palliative care.

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

Sector scope

Health services in Australia are delivered by a variety of government and non-government providers in a range of service settings. This Report primarily concentrates on the performance of public hospitals (chapter 10), primary and community health services (including general practice) (chapter 11) and mental health management (chapter 12). These services are selected for reporting as they:

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

High level residential aged care services and patient transport (ambulance) services are not covered in the health chapters in this Report, but are reported separately in chapter 13 ('Aged care services') and chapter 9 ('Fire, road rescue and ambulance').

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 mental health
- funding for specialist medical practitioners.

Profile of health sector

Detailed profiles for the services within the health sector are reported in chapters 10, 11 and 12, and cover:

- size and scope of the individual service types
- funding and expenditure.

Descriptive statistics

Descriptive statistics for the health sector are included in this section. Additional descriptive data for each jurisdiction are presented in tables EA.5–EA.6.

Funding

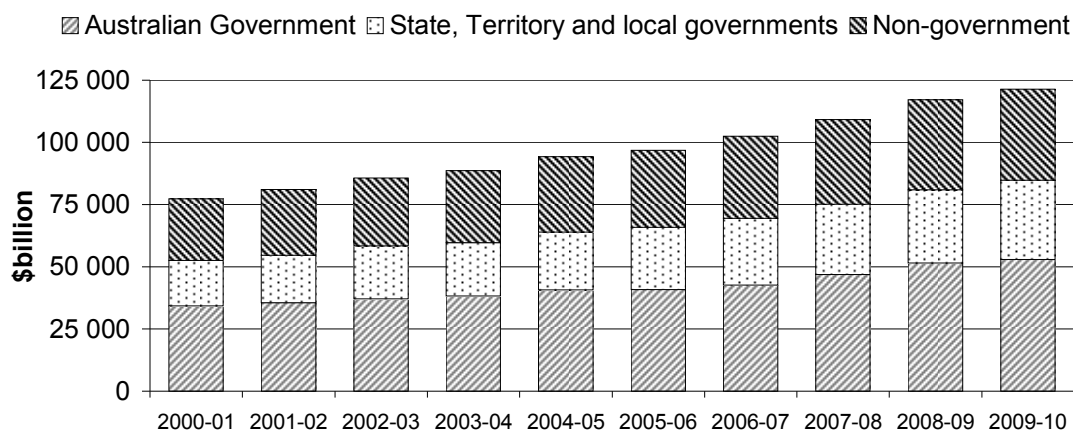
Total expenditure (recurrent and capital) on health care services in Australia was estimated to be \$121.4 billion in 2009-10 (table EA.1). This total was estimated to account for 9.4 per cent of gross domestic product in 2009-10 an increase of 1.2 percentage points from the 8.2 per cent of GDP in 2000-01 (AIHW 2011c). This indicates that health expenditure grew faster than the economy as a whole over the decade to 2009-10.

In 2009-10, the Australian, State and Territory, and local governments spent \$84.8 billion on total health services, which represented 69.9 per cent of total health expenditure. The Australian Government accounted for the largest proportion of health care expenditure — \$52.9 billion or 43.6 per cent of the total in 2009-10. State and Territory, and local governments contributed \$31.9 billion or 26.3 per cent of total health expenditure in that year (AIHW 2011c). These shares have remained relatively constant over the past 10 years. The remainder was paid by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurance providers (figure E.1 and tables EA.1 and EA.7).

The growth of total health expenditure over the past decade was largely the result of increased expenditure by Australian, State and Territory, and local governments, which grew proportionally faster than expenditure by non-government sources. Between 2000-01 and 2009-10, the average annual rate of growth in real expenditure was 4.9 per cent for the Australian Government, 6.4 per cent for State, Territory and local governments, and 4.4 per cent for non-government sources (table EA.1).¹

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

**Figure E.1 Total health expenditure, by source of funds
(2009-10 dollars)^{a, b, c, d}**



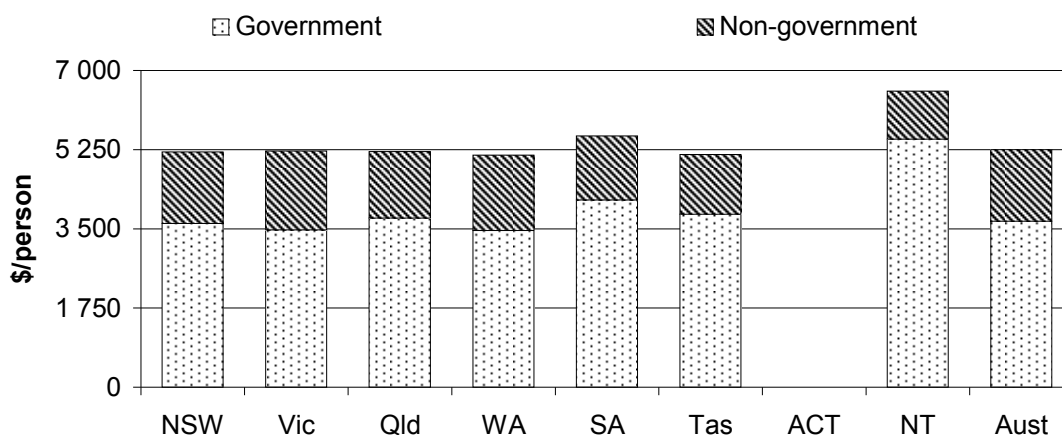
^a Includes recurrent and capital expenditure. ^b Includes expenditure on ambulance services (reported in chapter 9). ^c Expenditure by Australian Government and non-government sources has been adjusted for tax expenditure in relation to private health incentives claimed through the taxation system.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

Source: Table EA.1.

The government services reported on in this sector summary account for \$67.8 billion of the \$81.3 billion total recurrent health expenditure of the Australian, State and Territory, and local governments spent on total health services (accounting for 83.4 per cent of government recurrent health expenditure in 2009-10) (table EA.4). The health services covered include public hospitals, medical services (including payments to general practitioners [GPs] and other specialist practitioners), community and public health, medications and public dental services. Government recurrent expenditure on specialist mental health services was estimated to be around \$6.1 billion in 2009-10 (tables 12A.1 and 12A.7). Some of this expenditure was on psychiatric care provided by public (non-psychiatric) hospitals (chapters 10 and 12).

Health expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics. Nationally, total health expenditure per person in Australia increased from \$4011 in 2000-01 to \$5479 in 2009-10 (expressed in 2009-10 dollars) (table EA.5). Government real recurrent health expenditure per person in Australia increased from \$2631 in 2000-01 to \$3670 in 2009-10 (expressed in 2009-10 dollars). Non-government recurrent expenditure per person in Australia rose from \$1175 in 2000-01 to \$1580 in 2009-10 (expressed in 2009-10 dollars) (figure E.2 and table EA.6).

Figure E.2 Recurrent health expenditure per person, by source of funds, excluding high level residential aged care, 2009-10^{a, b, c}



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

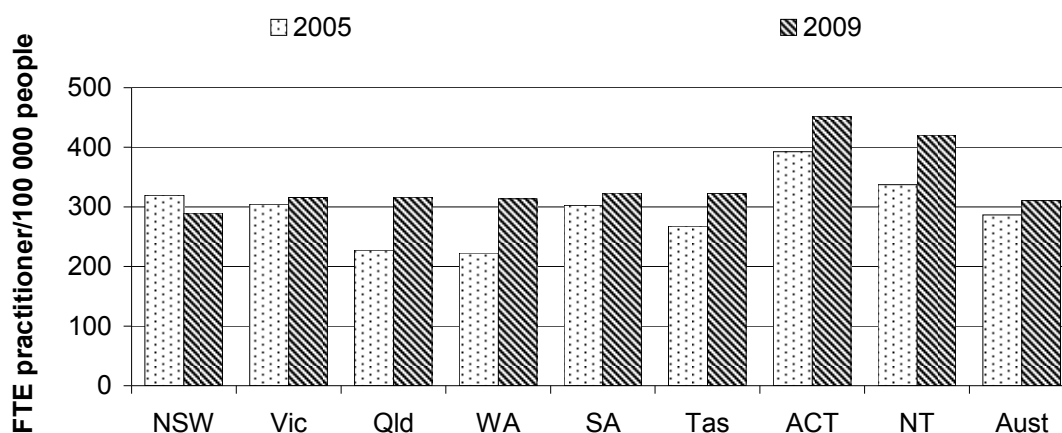
Source: Table EA.6.

Health workforce

In 2009, there were 72 739 registered medical practitioners in Australia working in medicine. A further 1520 were in the medical labour force but on extended leave or looking for work. The majority of employed practitioners working in medicine were clinicians (93.0 per cent), of whom 38.0 per cent were primary care practitioners (mainly general practitioners), 35.9 per cent were specialists, 13.5 per cent were specialists-in-training, 11.4 per cent were hospital non-specialists and 1.2 per cent were other clinicians (AIHW 2011a). The number of full time equivalent (FTE) practitioners per 100 000 people by jurisdiction is illustrated in figure E.3.

In 2009, there were an estimated 320 982 nurses identified by the Nursing and Midwifery Labour Force Survey (AIHW 2011b). The majority of nurses were employed as clinicians (90.6 per cent), of whom 32.6 per cent were working in medical and surgical areas, followed by critical care (17.3 per cent) and aged care (10.6 per cent). The number of FTE nurses per 100 000 people by jurisdiction is illustrated in figure E.4. The national increase in the FTE nurse rate in Australia between 2005 and 2009 arose from both an increase in the number of nurses employed and an increase in average hours worked (AIHW 2011b).

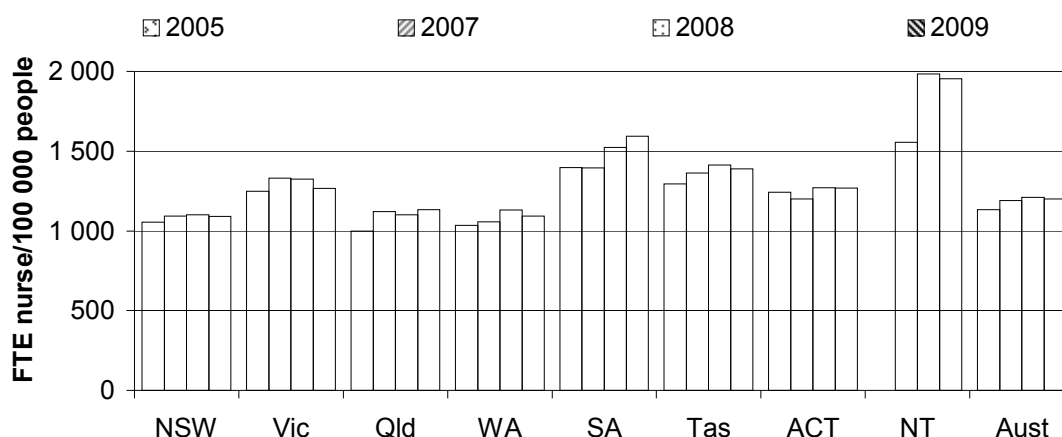
Figure E.3 **Employed medical practitioners^{a, b, c}**



a FTE rate (FTE per 100 000 people) is based on standard full-time working week of 45 hours. **b** Number of 'employed medical practitioners' does not include medical practitioners on extended leave. **c** Care must be taken when interpreting ACT's data as the ACT's medical practitioners provide a large number of services to NSW residents. This rate used the ACT resident population as the denominator, hence a high rate for the ACT. The rate will reduce if the NSW population within the catchment area of Southern NSW is included in the denominator.

Source: AIHW (2011) *Medical Labour Force 2009*, AIHW Bulletin no. 89, AIHW Cat. no. AUS 138; AIHW (2008) *Medical Labour Force 2005*, AIHW Cat. no. HWL 39, National Health Labour Force Series no. 38; table EA.8.

Figure E.4 **Employed nurses^{a, b, c}**

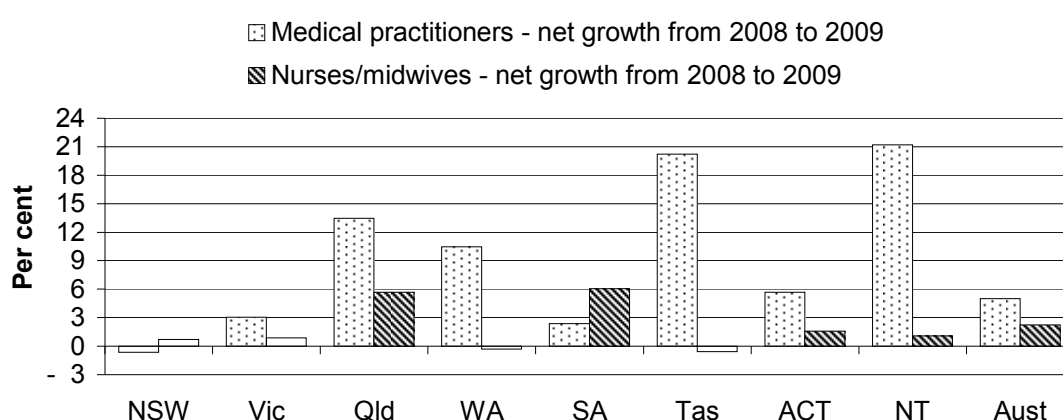


a FTE nurse rate (per 100 000 people) based on a 35-hour week. **b** Number of 'employed nurses' does not include nurses on extended leave. **c** Data for NT for 2005 are not published.

Source: AIHW (2011) *Nursing and midwifery labour force 2009*, AIHW bulletin no. 90. Cat. no. AUS 139, Canberra; AIHW (2008) *Nursing and midwifery labour force 2005*, AIHW Cat. no. HWL 40, Canberra; table EA.9.

The net growth of the health workforce can give an indication of the sustainability of the health system and its ability to respond and adapt to future needs. At the national level, the medical practitioners and nurse/midwife FTE health workforces grew from 2008 to 2009, although growth varied across states and territories. At the national level, the medical practitioner workforce grew at a faster rate than the nursing workforce (figure E.5). Health workforce growth from 2008 to 2009 by selected professions by clinical/non-clinical status are reported in table EA.11.

Figure E.5 Net growth in health workforce, selected professions, 2008 to 2009^{a, b}



^a Net growth measures the change in the FTE number in the workforce in the reference year compared to the year prior to the reference year. ^b FTEs calculated based on a 40-hour standard working week for medical practitioners and a 38-hour week for nurses/midwives.

Source: AIHW (unpublished) *Health Labour Force Surveys* (Medical (2007 and 2008)), AIHW (unpublished) *Nursing and Midwifery Labour Force Survey* (2008 and 2009); State and Territory registration board data; table EA.10.

Social and economic factors affecting demand for services

There is a complex relationship between social and economic factors and demand for health services.

It has been well documented that people who experience social and economic disadvantage are at risk of negative health outcomes. Compared with those who have social and economic advantages, disadvantaged Australians are more likely to have shorter lives (AIHW 2010). Those who are disadvantaged tend to have greater health risks such as smoking more and higher rates of obesity (SCRGSP 2009). Burden-of-disease studies indicate greater burden among people who are relatively disadvantaged in society (Begg et al. 2007). Those who are disadvantaged are more

likely to report their health as fair or poor than those that do not suffer the same disadvantage as measured by the Socio Economic Indexes for Areas (table EA.23).

While social and economic disadvantage can be linked to negative health outcomes, the effect on demand is less clear. Poor health could increase demand for health services, however, poor health could be the result of not accessing health services when required because of financial, educational or geographic barriers:

- Higher income and wealth are associated with better health. People with higher income are better able to access health services in a timely manner, and are also able to access goods and services that have health benefits such as better housing, food and other healthy pursuits (AIHW 2010).
- People with higher education levels are likely to have better health. Those with higher education levels have better prospects of employment and higher incomes, allowing greater access to health care. Higher education levels are also likely to help people gain the knowledge and confidence to look after their health and obtain the best care (AIHW 2010).
- Geographic distance to health services, particularly in remote and very remote areas, can contribute to poor health. People living in rural and remote areas tend to have higher levels of disease risk factors and illness than those in major cities (AIHW 2010). Those in remote areas are more likely to report their health as fair or poor and less likely to report their health as excellent, very good or good than those in major cities (table EA.21).

Indigenous people are generally less healthy than other Australians, die at much younger ages, and have more disability and a lower quality of life (AIHW 2010 and tables EA.40, EA.49 and EA.50). Many Indigenous Australians live in conditions of social and economic disadvantage. Indigenous people have low employment and income levels when compared to non-Indigenous people (see statistical appendix tables AA.2, AA.10, AA.11, and AA.26 to AA.27, and SCRGSP 2011). Indigenous people have relatively high rates for many health risk factors and are more likely to smoke and to consume alcohol at risky levels (ABS 2006a and SCRGSP 2011). Indigenous people are more likely to live in inadequate and overcrowded housing (SCRGSP 2011) and in remote areas with more limited access to health services. In 2006, 51 992 Indigenous people were living in discrete Indigenous communities that were 100 kilometres or more from the nearest hospital (ABS 2007).

Service-sector objectives

Government involvement in health services is predicated on the desire to improve the health of all Australians and to ensure equity of access and the sustainability of

the Australian health system. Box E.1 presents the overall objectives of the health system as summarised for this Report, which are consistent with the objectives outlined in the National Healthcare Agreement (MCFFR 2011). Governments provide a variety of services in different settings to fulfil these objectives.

Box E.1 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 ensuring Australians:

- are born and remain healthy
- receive appropriate high quality and affordable primary and community health services
- receive appropriate high quality and affordable hospital and hospital related care
- have positive health experiences that take account of individual circumstances and care needs
- have a health system that promotes social inclusion and reduces disadvantage, especially for Indigenous Australians
- have a sustainable health system.

Measuring the equity, effectiveness and efficiency of Australia's health system is a complex task. It must account for the performance of a range of services (such as prevention and medical intervention) and 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) plays an important role in determining outcomes. Other relevant factors are external to the health system, such as the socioeconomic and demographic characteristics of the population, available infrastructure and the environment.

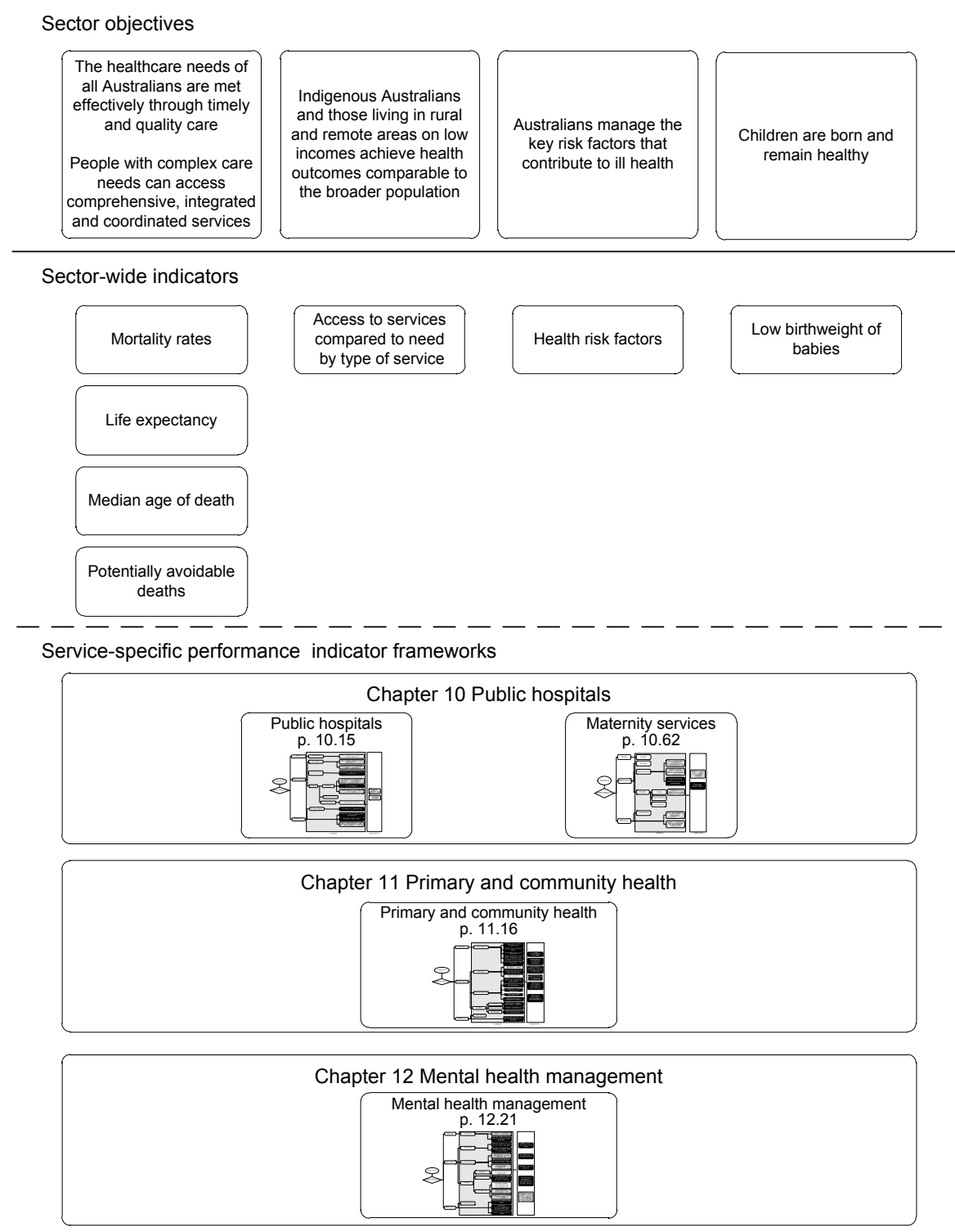
E.2 Sector performance indicator framework

This sector summary is based on a sector performance indicator framework (figure E.6). This framework is made up of the following elements:

- Sector objectives — four sector objectives are a précis of the key objectives of the health system and reflect the outcomes in the NHA (box E.1).
- Sector-wide indicators — seven sector-wide indicators relate to the overarching service sector objectives identified in the NHA.

- Information from the service-specific performance indicator frameworks that relate to health services. Discussed in more detail in chapters 10, 11 and 12, the service-specific frameworks provide comprehensive information on the equity, effectiveness and efficiency of these services.

Figure E.6 Health services sector performance indicator framework



This sector summary provides an overview of relevant performance information. Chapters 10, 11 and 12 and their associated attachment tables provide more detailed information.

Sector-wide performance indicators

This section includes high level indicators of health outcomes. Many factors are likely to influence outcomes — not solely the performance of government services. However, these outcomes inform the development of appropriate policies and delivery of government services.

Mortality rates

‘Mortality rates’ is an indicator of governments’ objective that the healthcare needs of all Australians are met effectively through timely and quality care and people with complex care needs can access comprehensive, integrated and coordinated services (box E.2).

Box E.2 Mortality rates

‘Mortality rates’ is defined by the following four measures:

- ‘mortality rate’ defined as age standardised mortality per 1000 people
- ‘infant mortality rate’ 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
- ‘child mortality rate’ defined as the number of deaths of children between one and four years of age in a calendar year per 100 000 children between one and four years of age
- ‘mortality rates by major cause of death’ age standardised per 100 000 people.

Where possible, data are presented for Indigenous people as well as the Australian population as a whole.

A low or decreasing mortality rate is desirable.

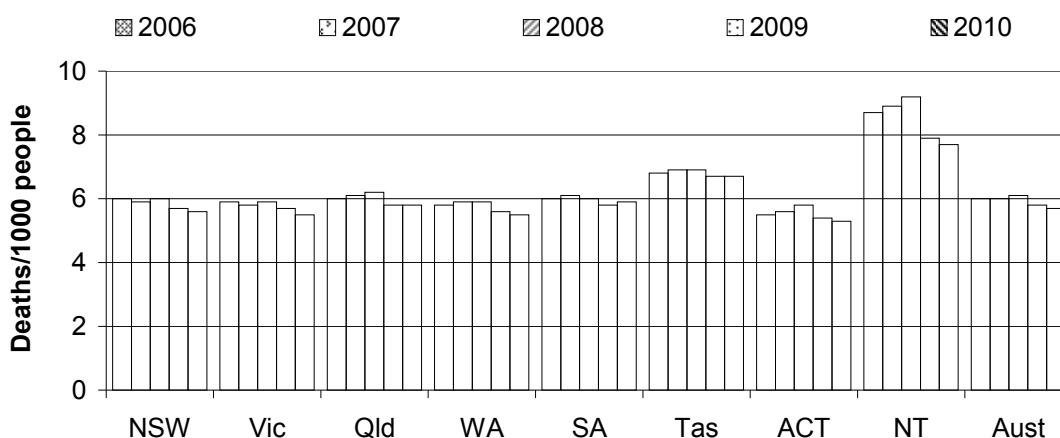
Most components of the health system can influence mortality rates, although there can be decades between the action and the effect. Factors external to the health system also have a strong influence on mortality rates.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

There were 143 500 deaths in Australia in 2010 (ABS 2011a), which translated into an age standardised mortality rate of 5.7 deaths per 1000 people (figure E.7). Death rates over the last 20 years have declined for all states and territories (ABS 2011a).

Figure E.7 Mortality rates, age standardised^{a, b, c, d}



^a Deaths are based on year of registration of death. ^b Deaths per 1000 standard population. Standardised death rates use total people in the 2001 Australian population as the standard population. ^c Death rates data for 2007 have been revised. ^d Australian totals includes all states and territories.

Source: ABS (2011) *Deaths 2010*, Australia, Cat. no. 3302.0, AusInfo, Canberra; table EA.40.

Mortality rates for Indigenous people

Data on Indigenous mortality are collected through State and Territory death registrations. The completeness of identification of Indigenous Australians in these collections varies significantly across states and territories so care is required when making comparisons.

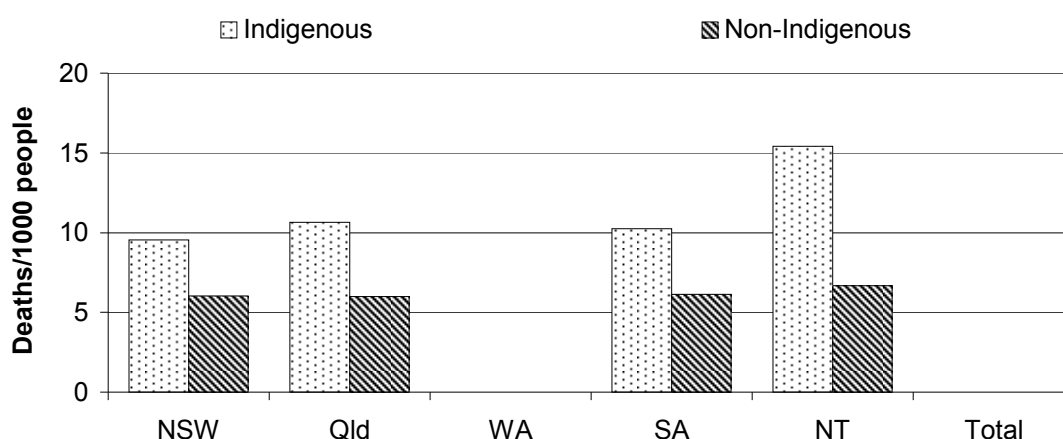
Due to the relatively small number of Indigenous deaths and the consequent volatility in annual mortality rates, data are presented for the five year period 2005–2009. To improve the comparability of age-related mortality rates, age standardisation methods have been used for both the Indigenous and total population rates.

NSW, Queensland, WA, and the NT are currently generally considered to have the best coverage of death registrations for Indigenous people (ABS 2009a).² For these four jurisdictions and SA combined, the overall rates of mortality for Indigenous

² The term ‘coverage’ refers to the number of Indigenous deaths registered as a percentage of the number of expected deaths based on experimental Indigenous population estimates and projections from the 2006 Census.

people were nearly twice as high as mortality rates for non-Indigenous people based on data for 2005–2009 (figure E.8 and table EA.40). Due to identification completeness issues, mortality rates presented here are likely to be under-estimates of the true mortality of Indigenous Australians (ABS and AIHW 2008).

Figure E.8 Mortality rates, age standardised, by Indigenous status, five year average, 2005–2009^{a, b, c, d e}



^a Deaths are based on year of registration of death. ^b Deaths per 1000 population. Standardised death rates use total people in the 2001 Australian population as the standard population. ^c Due to potential over-reporting of WA Indigenous deaths for 2007, 2008 and 2009, WA mortality data for these years (including aggregates of years and jurisdictions) are not included in this report. See data quality statements for further information. ^d Calculations of rates for the Indigenous population are based on *ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians 1991 to 2009* (ABS Cat. no. 3238.0, low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for comparison with the Indigenous population are derived by subtracting Indigenous population projections from total Estimated Resident Population and should be used with care, as these data include deaths and population units for which Indigenous status were not stated. ERP used in calculations are final ERP based on 2006 Census. ^e Total: Includes NSW, Qld, SA, WA, and NT combined, based on state or territory of usual residence. Vic, Tas and the ACT are excluded due to small numbers of registered Indigenous deaths.

Source: ABS (2010) *Deaths Australia, 2009*; table EA.40.

Infant and child mortality rates

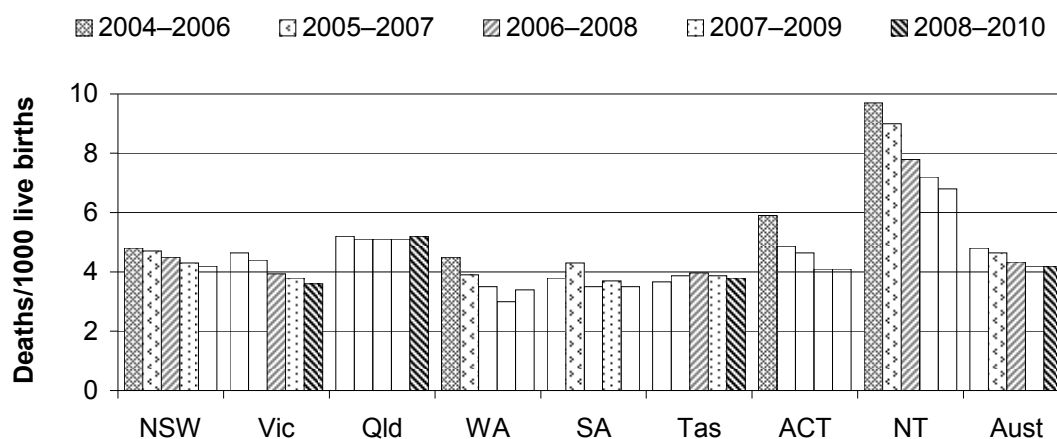
Infant and child mortality rates are presented as an average over three years to reduce the volatility inherent in the annual rates due to small numbers of deaths and annual fluctuations.

The infant mortality rate in Australia declined from an average of 5.4 deaths per 1000 live births over the period 1999–2001 to 4.2 deaths per 1000 live births over the period 2008–2010 (figure E.9 and table EA.42).

The Australian child mortality rate was 20.1 deaths per 100 000 of the child population in 2008–2010. The mortality rate for infants and children combined

(those aged 0 to 4 years) was 102.6 deaths per 100 000 of the population in 2008–2010 (table EA.42).

Figure E.9 Infant mortality rate, three year average^{a, b}



^a Infant deaths per 1000 live births. ^b Data for Australia include all states and territories.

Source: ABS (2011) *Deaths Australia, 2010, Australia*, Cat. no. 3302.0, Canberra; table EA.41.

Indigenous infant and child mortality rates

For WA, SA and the NT, longer-term trends suggest that the mortality rate for Indigenous infants decreased by 48 per cent between 1991 and 2009 (SCRGSP 2011). Despite this significant improvement, infant mortality rates for Indigenous children are still markedly higher than for non-Indigenous children in Australia.

For the period 2006–2010, the average infant mortality rate for Indigenous infants was higher than for non-Indigenous infants in the jurisdictions (NSW, Queensland, SA and NT) for which there were data available (table EA.43). For the same period, the average child mortality rate for Indigenous children was also higher for these jurisdictions (table EA.44). The combined infant and child average mortality rate for Indigenous infants and children was 157.4, 224.3, 184.1 and 322.2 deaths per 100 000 of the infant and child population in NSW, Queensland, SA and NT respectively. This compared with 100.9, 116.7, 87.4 and 95.9 deaths per 100 000 of the infant and child population for non-Indigenous infants and children (table EA.45).

Major causes of death

The most common causes of death among Australians in 2009 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.1 and EA.46).

Table E.1 Age standardised mortality rates by major cause of death (deaths per 100 000 people), 2009^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Certain infectious and parasitic diseases	8.1	7.2	6.5	7.9	7.9	7.0	6.7	13.5	7.5
Neoplasms	172.5	174.4	180.0	176.3	174.6	198.7	156.0	211.6	175.6
Diseases of the blood ^c	1.7	1.6	1.4	2.4	2.4	2.2	1.2	5.9	1.8
Endocrine, nutritional and metabolic diseases	21.0	26.1	24.4	24.4	23.1	33.6	26.0	64.7	24.0
Mental and behavioural disorders	24.7	25.6	22.9	26.2	25.4	35.1	30.1	45.7	25.2
Diseases of the:									
• nervous system	21.3	24.7	23.8	26.4	28.8	27.9	25.9	37.2	24.0
• eye and adnexa	—	—	—	—	—	—	0.3	—	—
• ear and mastoid process	—	—	—	—	—	—	—	—	—
• circulatory system	184.9	177.9	186.2	170.6	187.4	214.4	189.2	191.2	183.4
• respiratory system	46.0	43.6	46.2	39.5	43.4	54.8	30.6	70.3	44.8
• digestive system	20.8	20.7	19.1	19.5	20.7	21.0	20.3	40.5	20.5
• skin and subcutaneous tissue	1.9	1.1	1.5	1.7	1.1	1.2	0.3	1.0	1.5
• musculoskeletal system and connective tissue	4.2	4.1	4.8	4.8	3.4	6.7	4.4	5.1	4.3
• genitourinary system	13.3	15.4	11.1	12.1	14.4	11.7	13.4	19.5	13.5
Pregnancy, childbirth and the puerperium	—	—	0.1	—	—	—	—	—	—
Certain conditions originating in the perinatal period	3.2	2.8	3.8	2.0	2.3	3.0	1.1	6.1	3.0
Congenital conditions ^d	2.4	3.1	3.4	2.2	3.3	2.7	2.5	3.4	2.9
Abnormal findings nec ^e	6.4	2.4	5.2	3.7	2.8	2.0	1.5	3.5	4.4
External causes of morbidity and mortality	33.1	39.8	40.7	43.1	39.5	53.2	36.9	72.9	38.6
Total	565.7	570.7	581.0	562.9	580.6	675.2	546.5	792.1	575.1

^a Age standardised to the Australian population as at 30 June 2001. ^b Australian total includes 'Other territories'. ^c Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism. ^d Congenital malformations, deformations and chromosomal abnormalities. ^e Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified. — Nil or rounded to zero.

Source: ABS (2011) *Causes of Death Australia, 2009*, Cat. no. 3303.0; table EA.46.

Causes of death for Indigenous people

In the jurisdictions for which age standardised death rates are available by Indigenous status (NSW, Queensland, WA, SA and the NT), death rates were significantly higher for Indigenous Australians than for non-Indigenous Australians in 2005–09. For these jurisdictions the leading age-standardised cause of death for Indigenous people was circulatory diseases followed by neoplasms (cancer) (table EA.47).

Table E.2 Age standardised mortality rates by major cause of death (deaths per 100 000 people), by Indigenous status, 2005–2009^{a, b, c, d, e, f, g}

	NSW		Qld		WA		SA		NT	
Indigenous rate compared to non-Indigenous rate	Rate difference	Rate ratio	Rate difference	Rate ratio	Rate difference	Rate ratio	Rate difference	Rate ratio	Rate difference	Rate ratio
Circulatory diseases	142.6	1.7	122.3	1.6	np	np	104.0	1.5	205.7	2.2
Cancer	39.9	1.2	57.0	1.3	np	np	14.5	1.1	72.2	1.4
External causes	18.4	1.5	30.7	1.8	np	np	70.2	2.9	74.9	2.2
Endocrine, metabolic and nutritional disorders	34.2	2.7	113.1	6.0	np	np	52.6	3.2	170.7	6.7
Respiratory diseases	48.9	2.0	43.2	1.9	np	np	53.1	2.1	92.8	2.5
Digestive diseases	25.8	2.3	36.2	2.8	np	np	29.0	2.4	68.3	3.7
Conditions originating in perinatal period	11.5	2.0	22.7	3.2	np	np	np	np	65.9	5.7
Nervous system diseases	1.4	1.4	3.4	2.1	np	np	np	np	6.9	3.6
Kidney diseases	8.4	1.8	15.4	3.3	np	np	np	np	33.3	3.6
Infectious and parasitic diseases	0.1	1.0	-4.2	0.8	np	np	16.9	1.7	9.5	1.5
Other causes ^h	20.7	1.5	26.0	1.6	np	np	40.7	2.0	74.5	2.4
All causes	352.0	1.6	465.9	1.8	np	np	411.2	1.7	874.8	2.3

^a Age standardised to the Australian population as at 30 June 2001. ^b Rate ratio is the age-standardised Indigenous rate divided by the age-standardised non-Indigenous rate. ^c Although most deaths of Indigenous people are registered, it is likely that some are not accurately identified as Indigenous. Therefore, these data are likely to underestimate the Indigenous 'all causes' mortality rate. ^d Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis. ^e Data are presented in five-year groupings due to the volatility of small numbers each year. ^f Non-Indigenous estimates are available for census years only. In the intervening years, Indigenous population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the Indigenous population from the total population. Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases. ^g Due to potential over-reporting of WA Indigenous deaths for 2007, 2008 and 2009, WA mortality data for these years (including aggregates of years and jurisdictions) are not included in this report. See data quality statements for further information. ^h 'Other causes' consist of all conditions excluding the selected causes displayed in the table. **np** not published

Source: ABS (unpublished) *Causes of Death Australia, 2009*, Cat. No. 3301.0; table EA.47.

Compared to non-Indigenous people, Indigenous people died at higher rates from endocrine diseases, metabolic and nutritional disorders, kidney diseases, digestive diseases, and infectious and parasitic diseases (tables E.2 and EA.47).

Life expectancy

‘Life expectancy’ is an indicator of governments’ objective that the key healthcare needs of all Australians are met effectively through timely and quality care and people with complex care needs can access comprehensive, integrated and coordinated services (box E.3).

Box E.3 Life expectancy

‘Life expectancy’ is defined as the average number of additional years a person of a given age and sex might expect to live if the age-specific death rates of the given period continued throughout his/her lifetime.

A high or increasing life expectancy is desirable.

Most components of the health system can influence life expectancy, although there can be decades between the action and the effect. Factors external to the health system also have a strong influence on life expectancy.

Data reported for this indicator are comparable.

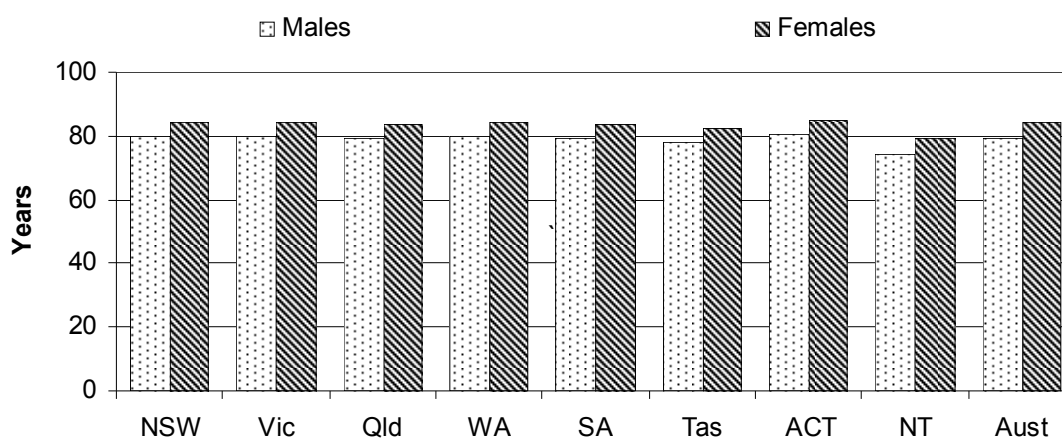
Data quality information for this indicator is under development.

The life expectancy of Australians improved dramatically during the twentieth century and so far during the twenty-first century. The average life expectancy at birth in the period 1901–1910 was 55.2 years for males and 58.8 years for females (ABS 2011a). It has risen steadily in each decade since, reaching 79.5 years for males and 84.0 years for females in 2008–2010 (figure E.10).

Indigenous life expectancy

The life expectancies of Indigenous Australians are considerably lower than those of non-Indigenous Australians. ABS experimental estimates indicate a life expectancy at birth of 67.2 years for Indigenous males and 72.9 years for Indigenous females born from 2005 to 2007. In the same time period, life expectancy at birth for non-Indigenous males was 78.7 years and for non-Indigenous females was 82.6 years (figure E.11 and table EA.49).

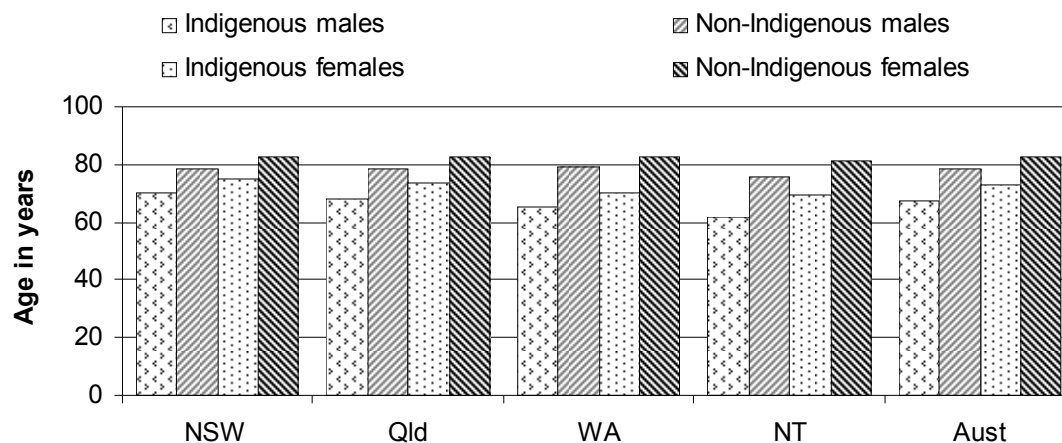
Figure E.10 **All Australians average life expectancy at birth, 2008–2010^a**



^a Figures for Australia include 'other territories'.

Source: ABS (unpublished) *Deaths, Australia*, 2009, Cat. no. 3302.0, Canberra; table EA.48.

Figure E.11 **Estimated life expectancies at birth, by Indigenous status and sex, 2005–2007 (years)^{a, b, c}**



^a Indigenous estimates of life expectancy are not available for Victoria, SA, Tasmania or the ACT due to the small number of Indigenous deaths in these jurisdictions. ^b Life tables are constructed separately for Males and Females. ^c Australian total includes all states and territories.

Source: ABS (2009) *Experimental Life Tables for Aboriginal and Torres Strait Islander Australians 2005–2007*, Australia, Cat. no. 3302, Canberra; table EA.49.

Median age at death

‘Median age at death’ is an indicator of governments’ objective that the key healthcare needs of all Australians are met effectively through timely and quality

care and people with complex care needs can access comprehensive, integrated and coordinated services (box E.4).

Box E.4 Median age at death

‘Median age at death’ is defined as the age at which exactly half the deaths registered (or occurring) in a given time period were deaths of people above that age and half were deaths below that age.

A high or increasing median age at death is desirable.

Most components of the health system can influence median age at death, although there can be decades between the action and the effect. Factors external to the health system also have a strong influence on median age at death.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

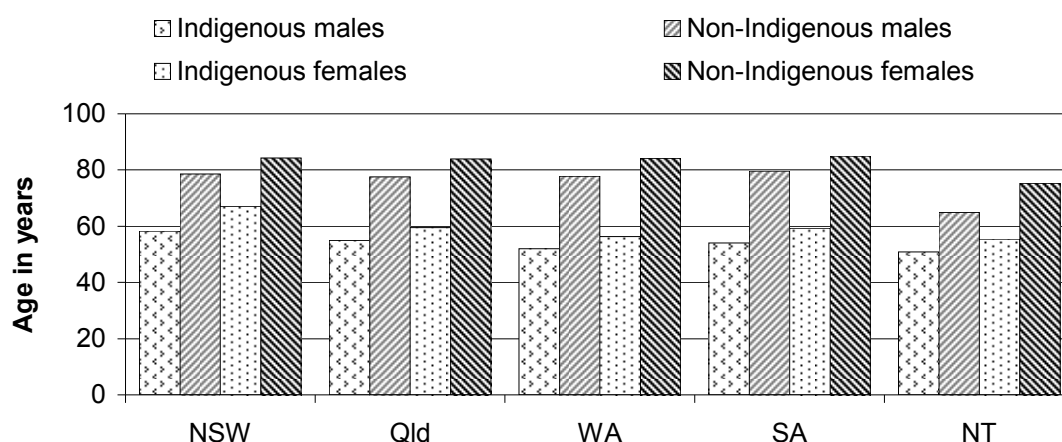
Comparisons of the median age at death for Indigenous and non-Indigenous people are affected by different age structures in the populations and by differences in the extent of identification of Indigenous deaths across jurisdictions and across age groups. Identification of Indigenous status for infant deaths is high, but falls significantly in older age groups. The median age of death for Indigenous people is, therefore, likely to be an underestimate.

Caution should be taken when comparing median age at death between Indigenous and non-Indigenous populations. Coory and Baade (2003) note that:

- the relationship between a change in median age at death and a change in death rate depends upon the baseline death rate. So comparison of trends in median age at death for Indigenous and non-Indigenous people is difficult to interpret
- changes in the median age at death of public health importance might be difficult to distinguish from statistical noise.

The median age at death in 2010 was 78.3 years of age for Australian males and 84.3 years of age for Australian females (table EA.50). In the jurisdictions for which data were available for Indigenous people, the median age at death for male Indigenous Australians was between 50.8 and 58.3 years of age. The median age at death for female Indigenous Australians was between 55.4 and 67.1 years of age (figure E.12 and table EA.50).

Figure E.12 **Median age at death, by sex and Indigenous status, 2010^{a, b}**



^a Vic, Tas and the ACT are excluded due to small numbers of registered Indigenous deaths. ^b 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 (2011a) *Deaths Australia, 2010*, Cat. no. 3302.0, Canberra; table EA.50.

Potentially avoidable deaths

‘Potentially avoidable deaths’ is an indicator of governments’ objective that the healthcare needs of all Australians are met effectively through timely and quality care and people with complex care needs can access comprehensive, integrated and coordinated services (box E.5). Avoidable deaths reflect the effectiveness of current and past preventative health activities.

Box E.5 Potentially avoidable deaths

‘Potentially avoidable deaths’ is defined as potentially preventable deaths (deaths amenable to screening and primary prevention, such as immunisation) and deaths from potentially treatable conditions (deaths amenable to therapeutic interventions) for those aged less than 75 years per 100 000 people aged less than 75 years.

A low or decreasing potentially avoidable death rate is desirable.

Most components of the health system can influence potentially avoidable death rates, although there can be decades between the action and the effect. Factors external to the health system also have a strong influence on potentially avoidable death rates.

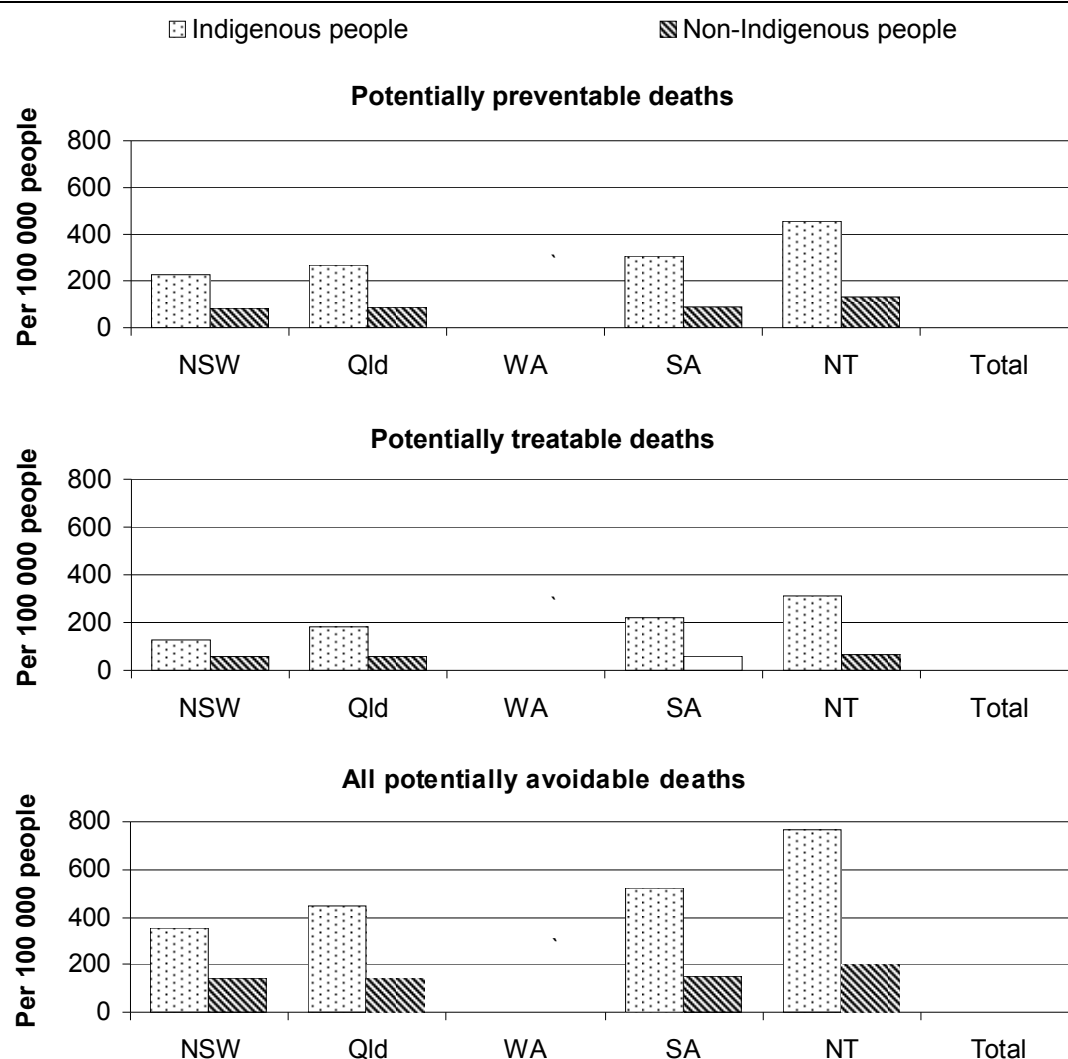
Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Indigenous people had significantly higher death rates from potentially avoidable deaths (preventable and treatable) over the period 2005–2009, comprising higher

potentially preventable deaths per 100 000 people and higher treatable deaths per 100 000 people (figure E.13 and table EA.52). Single year data are presented in table EA.51.

Figure E.13 Age standardised mortality rates of potentially avoidable deaths, under 75 years, by Indigenous status, 2005–09^{a, b, c, d, e, f, g}



^a Age standardised to the Australian population as at 30 June 2001. ^b Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis. ^c Data are presented in five-year groupings due to the volatility of small numbers each year. ^d Total includes only those five states and territories of residence that are considered to have acceptable levels of Indigenous identification in mortality data (NSW, Queensland, WA, SA and the NT). ^e Preventable deaths are those which are amenable to screening and primary prevention such as immunisation, and reflect the effectiveness of the current preventative health activities of the health sector. ^f Deaths from potentially treatable conditions are those which are amenable to therapeutic interventions, and reflect the safety and quality of the current treatment system. ^g Due to potential over-reporting of WA Indigenous deaths for 2007, 2008 and 2009, WA mortality data for these years (including aggregates of years and jurisdictions) are not included in this report. See data quality statements for further information.

Source: ABS (unpublished) *Causes of Deaths, Australia, 2009*, Cat. no. 3303.0; table EA.52.

Access to services compared to need by type of service

‘Access to services compared to need by type of service’ is an indicator of governments’ objective that Indigenous Australians and those living in rural and remote areas or on low incomes achieve health outcomes comparable to the broader population (box E.6).

Box E.6 Access to services compared to need by type of service

‘Access to services compared to need by type of service’ is defined as the number of people aged 15 years or over who accessed a particular health service in the past 12 months (for hospital admissions) or 2 weeks (for other health services) divided by the population aged 15 years or over, expressed as a percentage. Rates are age standardised and calculated separately for each type of service and by categories of self-assessed health status.

Service types are: admitted hospitalisations, casualty/outpatients, GP and/or specialist doctor consultations, consultations with other health professional and dental consultation.

Self assessed health status is categorised as excellent/very good/good and fair/poor and are reported by Indigenous status, remoteness and Socio Economic Indexes for Areas.

High or increasing rates of ‘Access to services compared to need by type of service’ are desirable, as are rates for those in disadvantaged groups being close to the rates for those who are not disadvantaged.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Results from the 2007-08 National Health Survey indicate that the majority of Australians (85 per cent) aged 15 years or over reported their health as either good, very good or excellent (ABS 2009c). In the 2008 National Aboriginal and Torres Strait Islander Social Survey, 78 per cent of Indigenous people reported their health as either good, very good or excellent (ABS 2009b).

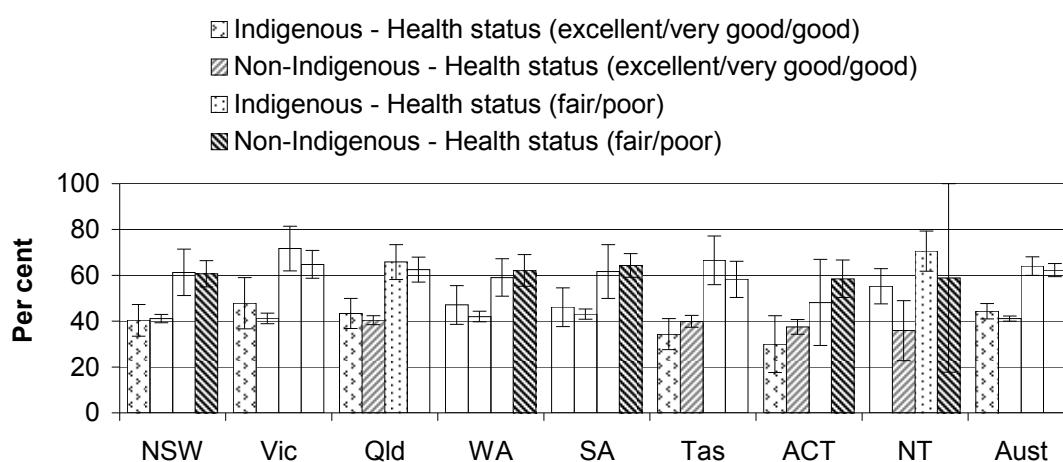
The latest available data comparing the health outcomes of Indigenous and non-Indigenous people are from the National Aboriginal and Torres Strait Islander Health Survey 2004-05 (ABS 2006a) and National Health Survey 2004-05 (ABS 2006b).

The surveys show that Indigenous people were less likely than non-Indigenous people to report very good or excellent health and the difference between the two populations was greatest in the older age groups. Taking into account differences in age structure between the Indigenous and non-Indigenous populations, Indigenous

people overall were almost twice as likely to report their health as fair or poor than non-Indigenous Australians in 2004-05.

Data from the surveys show that 41.8 per cent of Australians who reported their health status as being excellent/very good/good accessed health services in 2004-05, while health services were accessed by 62.6 per cent of people who reported their health status as being fair/poor (tables EA.17 and EA.18). There was little difference between the percentages of Indigenous and non-Indigenous people reporting excellent/very good/good health status who accessed health services or between Indigenous and non-Indigenous people reporting fair/poor health status who accessed health services in 2004-05 (figure E.14).

Figure E.14 Proportion of people who accessed health services by health status and Indigenous status, 2004-05^{a, b, c, d, e}



^a Rates are age standardised by State/Territory to the 2001 estimated resident population (5 year ranges from 15+). ^b People who accessed at least one of the health services noted in tables EA.19 and EA.20 in the last two weeks or were admitted to hospital in the last 12 months. ^c Limited to people aged 15 years or over. ^d Total people accessing any of the selected health services. Components may not add to total because people may have accessed more than one type of health service. ^e Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

Source: ABS (unpublished) *National Health Survey*, 2004-05; ABS (unpublished) *National Aboriginal and Torres Strait Islander Health Survey*, 2004-05; tables EA.19 and EA.20.

Data on the proportion of people who accessed health services by remoteness and Socio Economic Indexes for Areas and data on the types of health services people accessed are reported in tables EA.17–EA.24.

Health risk factors

‘Health risk factors’ is an indicator of governments’ objective that Australians manage the key risk factors that contribute to ill health (box E.7).

A number of behaviours create risks to health outcomes; for example, dietary habits and exercise, smoking, alcohol consumption, and sun exposure.

Health services are concerned with promoting, restoring and maintaining a healthy society. An important part of this activity is reducing health risk factors through activities that raise awareness of health issues to reduce the risk and onset of illness and injury. The incidence of cancers for 2008 are reported in tables EA.37–39.

Box E.7 Health risk factors

‘Health risk factors’ is defined by the following three measures:

- number of people aged 18 years or over who smoke tobacco every day as a percentage of the population aged 18 years or over.
- people aged 18 years or over assessed as having an alcohol consumption pattern that puts them at risk of long-term alcohol related harm, as a percentage of the population aged 18 years or over. ‘At risk of long-term alcohol related harm’ is defined according to the 2001 National Health and Medical Research Council guidelines: for males, 29 drinks or more per week; for females, 15 drinks or more per week.
- number of people aged 18 years or over with a Body Mass Index (BMI) in the categories of either underweight, normal range, overweight or obese, as a percentage of the population aged 18 years or over. BMI is calculated as weight (kg) divided by the square of height (m). BMI values are grouped according to World Health Organization and National Health and Medical Research Council guidelines. Among adults, a BMI of less than 18.5 is considered underweight, a BMI of 18.5 to less than 25 is considered normal weight, a BMI of 25 to less than 30 is considered overweight and a BMI of 30 and over is considered to be obese (WHO 2000; NHMRC 2003). Children are defined as people aged 5–17 years. For children, obesity is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years.

Rates for all three measures are age standardised.

A low or decreasing rate is desirable for each health risk factor.

Data reported for this indicator are comparable.

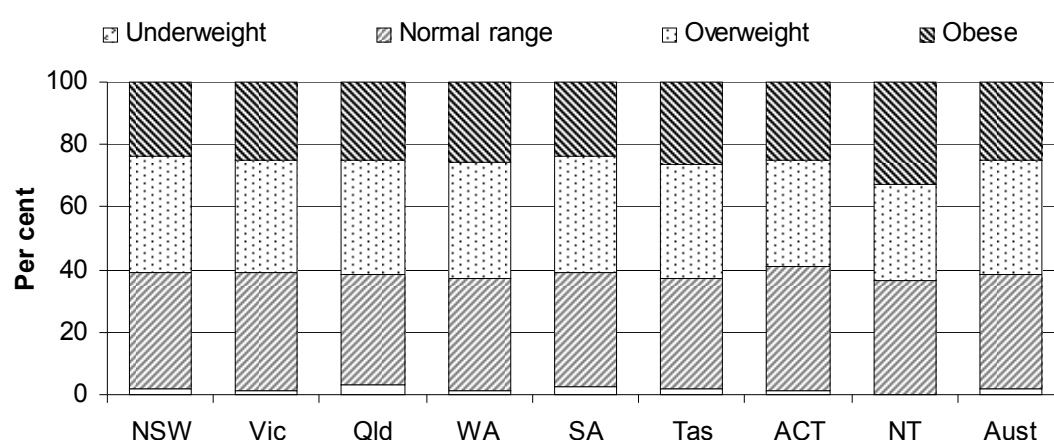
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Body mass

Being overweight or obese increases the risk of an individual developing, among other things, heart disease, stroke and Type 2 diabetes. Bowel cancer, which has been linked to diet, occurred at a rate of 61.8 new cases per 100 000 people in 2008 (tables EA.37).

In 2007-08, over a third of Australians' measured BMI was in the overweight range and almost a quarter were obese (figure E.15). The percentage of people who were obese tended to be higher in remote (35.0 per cent) and outer regional areas (31.3 per cent), than in major cities (22.5 per cent) and inner regional areas (27.6 per cent) (table EA.25). RSEs and 95 per cent confidence intervals for rates of obesity for adults and children, by remoteness, in 2007-08 are presented in table EA.26.

Figure E.15 Proportion of adults in BMI categories, 2007-08^{a, b, c, d}



^a Adults are defined as people aged 18 years and over. Children are defined as people aged 5–17 years.

^b Obesity for adults is defined as BMI equal to or greater than 30. ^c Measured people only. ^d Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population.

Source: ABS (unpublished), *National Health Survey 2007-08*; table EA.30.

The percentage of people who were obese tended to be higher in older age groups, peaking at age 55–64 for males (35.0 per cent) and at age 55–64 for females (33.4 per cent). There was a slightly higher percentage of obese males (25.6 per cent) than females (24.0 per cent) (table EA.27). RSEs and 95 per cent confidence intervals for rates of obesity for adults and children, by sex and age, in 2007-08 are presented in table EA.28.

Nationally, there were almost twice as many obese Indigenous adults (33.6 per cent) as non-Indigenous adults (17.7 per cent) (table EA.29). RSEs and 95 per cent confidence intervals for the proportion of adults and children in BMI categories, in 2007-08 are presented in table EA.31.

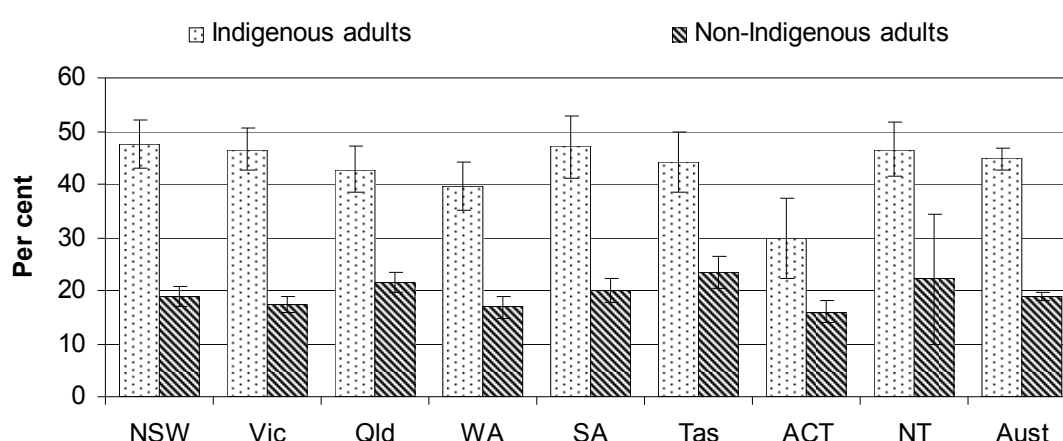
Smoking

Smoking is an important risk factor for heart disease, stroke and lung cancer. These were the three leading causes of death in Australia in 2009 (ABS 2011). Smoking is

responsible for around 80 per cent of all lung cancer deaths and 20 per cent of all cancer deaths (HealthInsite 2011). Nationally, the age standardised incidence of lung cancer was 43.3 new cases per 100 000 people in 2008.

Current daily smokers aged 18 years and over accounted for 19.1 per cent of the population in 2007-08. There were some variations in the age standardised rates of smoking across jurisdictions (figure E.16 and table EA.33). Nationally, Indigenous people had higher age standardised rates of daily smoking (44.8 per cent) than non-Indigenous people (18.9 per cent). Daily smokers accounted for 27.3 per cent of the population in remote geographical areas, gradually decreasing as remoteness of residence decreases, accounting for 25.7 per cent of the population in outer regional areas, 20.1 per cent in inner regional areas and 17.6 per cent in major cities (table EA.32).

Figure E.16 Proportion of adults who are daily smokers, by Indigenous status, 2007-08^{a, b, c, d}



^a Rates are for people aged 18 years and over who are current daily smokers, age standardised, by State and Territory, to the 2001 Estimated Resident Population (10 year ranges from 18–55 years and over). ^b Data for Indigenous people are based on the ABS *National Aboriginal and Torres Strait Islander Social Survey*, 2008. ^c Data for non-Indigenous people are based on the ABS *National Health Survey*, 2007-08. ^d Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

Source: ABS (unpublished), *National Health Survey 2007-08*; table EA.33.

Alcohol consumption

Excessive long term alcohol consumption increases the risk of heart disease, stroke, liver cirrhosis and some types of cancers. Further, it can contribute to injury and death through accidents, violence, suicide and homicide, and also to financial problems, family breakdown, and child abuse and neglect.

Nationally, 13.1 per cent of Australian adults were at risk of long term harm from alcohol in 2007-08. The age standardised rates varied among jurisdictions (table EA.34). Nationally, the age standardised proportion of adults at risk of long term harm from alcohol was slightly higher for Indigenous people (15.4 per cent) than for non-Indigenous people (13.5 per cent) in 2004-05. There were some variations in the proportion of Indigenous adults at risk of long term harm from alcohol across jurisdictions (table EA.36).

Nationally, adults who are at risk of long term harm from alcohol gradually decreased as remoteness of residence decreased in 2007-08 — although statistically significant results are not available for most jurisdictions (table EA.35).

Low birthweight of babies

‘Low birthweight of babies’ is an indicator of governments’ objective that children are born and remain healthy (box E.8). The birthweight of a baby is an important indicator of its health status and future wellbeing. Low birthweight babies have a greater risk of poor health and dying, require a longer period of hospitalisation after birth, and are more likely to develop significant disabilities (Goldenberg & Culhane 2007).

Box E.8 Low birthweight of babies

Babies’ birthweight is defined as low if they weigh less than 2500 grams, very low if they weigh less than 1500 grams and extremely low if they weigh less than 1000 grams (Li et al. 2011).

A low or decreasing number of low birthweight babies is desirable.

Factors external to the health system also have a strong influence on the birthweight of babies. Some factors contributing to low birthweight include socioeconomic status, size of parents, age of mother, number of babies previously born, mother’s nutritional status, smoking and alcohol intake, and illness during pregnancy (Li et al. 2011).

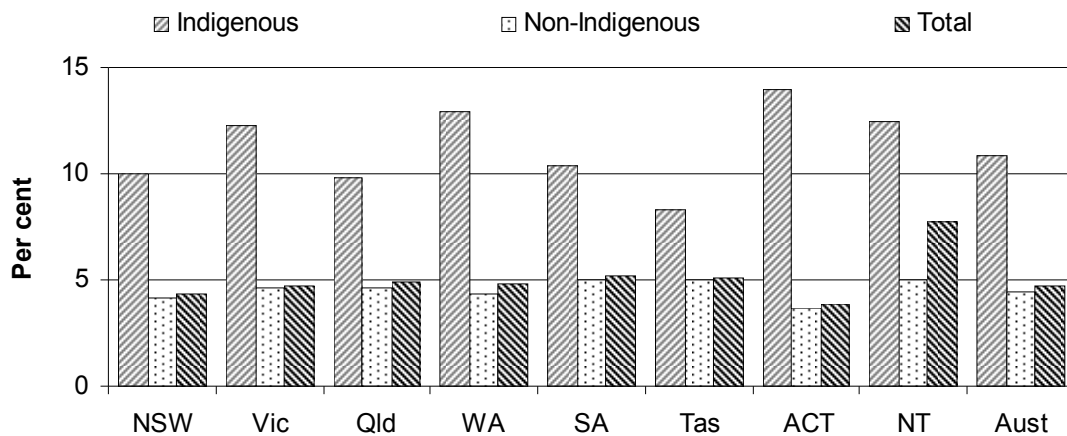
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

In 2009, 92.0 per cent of liveborn babies in Australia weighed between 2500 and 4499 grams (Li et al. 2011). The average birthweight for all live births was 3374 grams in 2009 (table EA.53). The average birthweight for liveborn babies of Indigenous mothers was 3183 grams in 2009 (table EA.54). In 2009, 1.0 per cent of all liveborn babies in Australia weighed less than 2500 grams. This included 1.0 per cent of babies with a very low birthweight (who weighed less than 1500 grams) (table EA.53).

Among live babies born to Indigenous mothers in 2009, the proportion with low birthweight was over twice that of those born to non-Indigenous mothers (figure E.17). The number and proportion of live-born singleton babies of low birthweight for the period 2007–2009 are presented in table EA.56.

Figure E.17 Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status, 2009^{a, b, c, d e}



^a Low birthweight is defined as less than 2500 grams. ^b Disaggregation by State/Territory is by place of usual residence of the mother. ^c Data excludes Australian non-residents, residents of external territories and where State/Territory of residence was not stated. ^d Excludes stillbirths and multiple births. Births were included if they were at least 20 weeks gestation or at least 400 grams birthweight. ^e Birthweight data on babies born to Indigenous mothers residing in the ACT and Tasmania should be viewed with caution as they are based on small numbers of births.

Source: AIHW (unpublished) National Perinatal Data Collection; table EA.55.

Service-specific performance indicator frameworks

The health service specific frameworks in chapters 10, 11 and 12 reflect both the general Report framework and the National Health Performance Framework.³ They differ from the general Report framework (see chapter 1) in two respects. First, they include three subdimensions of quality — safety, responsiveness and continuity — and, second, they include an extra dimension of efficiency — sustainability. These additions are intended to address the following key performance dimensions of the

³ The former National Health Performance Committee developed the National Health Performance Framework to guide the reporting and measurement of health service performance in Australia. The National Health Performance Framework was reviewed by the National Health Performance Committee and a revised framework was agreed by the National Health Information Standards and Statistics Committee in 2009. A number of groups involved in health performance indicator development have adopted this framework for use within specific project areas and in publications.

health system in the National Health Performance Framework that were not explicitly covered in the general Report 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
- *continuity*: the provision of uninterrupted, timely, coordinated healthcare interventions and actions across programs, practitioners and organisations
- *sustainability*: the capacity to provide infrastructure (such as workforce, facilities and equipment), be innovative and respond to emerging needs (NHPC 2001).

Other aspects of the Steering Committee's framework of performance indicators are defined in chapter 1.

This section summarises information from the following specific indicator frameworks:

- public hospitals (see chapter 10 for more detail)
- maternity services (see chapter 10 for more detail)
- primary and community health (see chapter 11 for more detail)
- mental health management (see chapter 12 for more detail).

Additional information is available to assist the interpretation of these results:

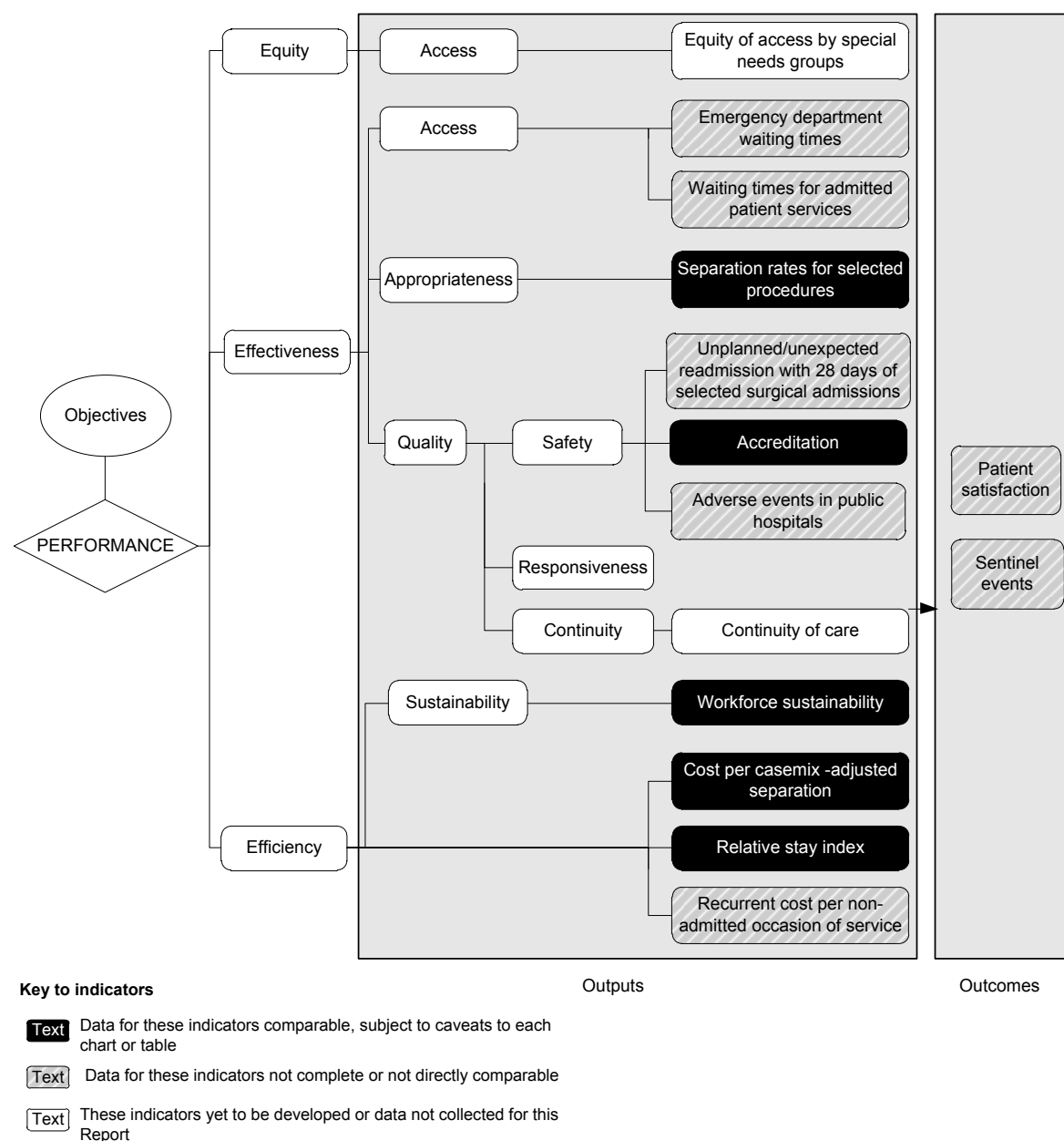
- indicator interpretation boxes, which define the measures used and indicate any significant conceptual or methodological issues with the reported information (chapters 10, 11 and 12)
- caveats and footnotes to the reported data (chapters 10, 11 and 12 and Attachments 10A, 11A and 12A)
- additional measures and further disaggregation of reported measures (for example, by Indigenous status, remoteness, disability, language background, sex) (chapters 10, 11 and 12 and Attachments 10A, 11A and 12A)
- data quality information for many indicators, based on the ABS Data Quality Framework (chapters 10, 11 and 12 Data quality information).

A full list of attachment tables and available data quality information is provided at the end of chapters 10, 11 and 12.

Public hospitals

The performance indicator framework for public hospitals is presented in figure E.18. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of public hospitals.

Figure E.18 Public hospitals performance indicator framework



An overview of the public hospital performance indicator results are presented in table E.3. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 10 and the footnotes in attachment 10A.

Table E.3 Performance indicators for public hospitals^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Effectiveness — Access indicators									
<i>Emergency department waiting times, 2010-11</i>									
Data for this indicator not complete or not directly comparable (chapter 10)									
Proportion of patients seen on time (per cent)									
Resuscitation	100	100	100	99	100	100	100	100	100
Emergency	83	81	78	71	78	72	82	65	79
Urgent	71	70	60	50	66	55	54	53	65
Semi-urgent	73	65	67	65	70	63	49	54	68
Non-urgent	88	86	90	92	88	83	76	90	88
Total	76	71	67	63	71	62	58	58	70
<i>Waiting times for elective surgery, 2010-11</i>									
Data for this indicator not complete or not directly comparable (chapter 10)									
Number of days waited									
50 th percentile	47	36	29	29	38	38	76	33	36
90 th percentile	333	182	148	159	208	359	378	223	252
Proportion who waited more than 365 days									
%	3.6	2.5	1.3	1.6	2.0	9.6	10.8	3.9	2.9

Source: tables 10A.17 and 10A.21.

Effectiveness — Appropriateness indicators

Separation rates for selected procedures, public hospitals, per 1000 people (age-standardised), 2009-10

Data for this indicator comparable, subject to caveats (chapter 10)

Cataract extraction	2.5	3.1	1.7	4.2	2.8	np	np	np	2.7
Cholecystectomy	1.3	1.4	1.2	1.1	1.4	np	np	np	1.3
Coronary angioplasty	0.9	0.8	0.7	0.8	1.0	np	np	np	0.9
Coronary artery bypass graft	0.3	0.3	0.3	0.2	0.3	np	np	np	0.3
Cystoscopy	1.5	2.7	1.8	2.9	2.4	np	np	np	2.1
Haemorrhoidectomy	0.8	0.7	0.3	0.5	0.4	np	np	np	0.6
Hip replacement	0.6	0.7	0.5	0.7	0.6	np	np	np	0.6
Hysterectomy	1.5	1.7	1.4	1.4	1.9	np	np	np	1.5
Inguinal herniorrhaphy	1.0	1.1	0.9	1.0	1.1	np	np	np	1.0
Knee replacement	0.7	0.5	0.5	0.6	0.6	np	np	np	0.6
Myringotomy	0.4	0.8	0.6	0.7	1.3	np	np	np	0.7
Prostatectomy	0.9	1.2	0.8	0.7	1.2	np	np	np	0.9
Septoplasty	0.2	0.5	0.2	0.3	0.5	np	np	np	0.3
Tonsillectomy	0.8	1.3	0.9	1.0	1.4	np	np	np	1.0
Varicose veins, stripping and ligation	0.2	0.4	0.1	0.1	0.3	np	np	np	0.2

Source: table 10A.42.

(Continued next page)

Table E.3 (continued)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Effectiveness — Quality — Safety indicators									
<i>Unplanned/unexpected readmissions within 28 days of selected surgical admissions, 2009-10</i>									
Data for this indicator not complete or not directly comparable (chapter 10)									
Surgical, procedure prior to separation, rate per 1000 separations									
Knee replacement	24.5	26.0	37.1	15.0	16.1	27.6	np	np	26.2
Hip replacement	16.0	18.0	21.9	14.6	np	26.1	np	np	16.4
Tonsillectomy and adenoidectomy	20.1	26.0	30.4	30.7	33.3	52.5	np	np	26.5
Hysterectomy	30.8	31.5	36.4	30.8	23.2	65.7	np	np	31.3
Prostatectomy	33.1	23.5	33.6	44.3	34.4	np	np	np	30.9
Cataract surgery	4.0	3.3	4.1	4.1	4.4	7.8	np	10.9	3.8
Appendicectomy	21.6	25.8	24.9	29.5	36.4	20.0	25.9	50.6	25.1
<i>Healthcare associated Staphylococcus aureus bacteraemia in acute care hospitals, 2010-11</i>									
Data for this indicator not complete or not directly comparable (chapter 10)									
Infections per 10 000 patient days									
	1.2	0.9	1.2	1.0	0.9	1.3	0.9	1.4	1.1
<i>Accreditation, proportion of accredited beds, public hospitals 2009-10</i>									
Data for this indicator comparable, subject to caveats (chapter 10)									
%	82	100	97	100	98	83	100	100	93
<i>Falls resulting in patient harm in hospitals, rate per 1000 separations, 2009-10</i>									
Data for this indicator comparable, subject to caveats (chapter 10)									
	4.1	2.8	2.7	2.8	3.0	np	np	np	3.2
<i>Intentional self harm in public hospitals, rate per 1000 separations, 2009-10</i>									
Data for this indicator comparable, subject to caveats (chapter 10)									
	0.1	0.1	0.2	0.5	0.2	np	np	np	0.2
Source: tables 10A.43–10A.48.									
Efficiency sustainability indicators									
<i>Workforce sustainability, 2009</i>									
Data for this indicator comparable, subject to caveats (chapter 10)									
Nursing workforce by age group (per cent)									
<30	14.1	13.9	13.4	12.1	12.4	10.3	12.6	16.7	na
30-39	21.4	23.3	23.0	21.2	21.7	16.0	21.2	26.7	na
40-49	26.8	28.0	31.4	30.1	30.4	31.2	28.7	27.4	na
50-59	29.2	26.3	24.7	27.8	28.4	31.8	29.7	22.8	na
60+	8.4	8.5	7.5	8.7	7.1	10.8	7.8	6.4	na
Medical practitioner workforce by age group									
<30	10.2	12.0	8.0	16.0	8.0	3.6	10.8	14.8	na
30-39	24.4	27.2	28.8	27.8	28.4	17.9	31.4	29.4	na
40-49	25.1	25.2	28.8	24.9	25.9	30.7	24.4	27.7	na
50-59	22.3	20.2	20.2	18.9	21.2	27.9	21.5	17.2	na
60+	17.9	15.3	14.3	12.4	16.5	20.0	11.9	10.9	na

Source: tables 10A.49–10A.52.

(Continued next page)

Table E.3 (continued)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Efficiency indicators									
<i>Recurrent cost per casemix adjusted separation, dollars, 2009-10</i>									
Data for this indicator comparable, subject to caveats (chapter 10)									
Total recurrent	4 550	4 525	5 093	4 722	4 372	5 363	4 989	5 517	4 684
Capital	455	576	506	534	417	334	468	663	442
<i>Relative stay index, 2009-10</i>									
Data for this indicator comparable, subject to caveats (chapter 10)									
Total	1.04	0.92	0.94	1.00	1.01	1.05	0.93	1.16	0.99
<i>Recurrent cost per non-admitted occasion of service, 2009-10</i>									
Data for this indicator not complete or not directly comparable (chapter 10). Data are available in tables 10A.58–10A.66.									
Source: tables 10A.53–10A.66.									
Outcome indicators									
<i>Patient satisfaction, 2010-11</i>									
Data for this indicator not complete or not directly comparable (chapter 10).									
Proportion (%) of persons who went to an <i>emergency department</i> in the last 12 months reporting:									
ED doctors, specialists or nurses always or often listened carefully to them									
Doctors/specialists	83.4	82.3	86.4	86.2	79.3	82.2	89.6	82.7	83.7
Nurses	85.3	84.2	90.1	88.3	86.8	87.5	89.7	90.6	86.5
ED doctors, specialists or nurses always or often showed respect to them									
Doctors/specialists	86.1	82.9	89.3	88.4	81.5	85.2	90.4	82.9	85.8
Nurses	87.1	86.5	90.7	89.2	88.8	89.7	88.7	89.7	88.1
ED doctors, specialists or nurses always or often spent enough time with them									
Doctors/specialists	79.5	74.4	82.5	82.2	76.3	77.9	83.6	80.8	78.9
Nurses	82.6	79.7	87.2	85.3	83.3	85.9	87.4	86.3	83.4
Proportion (%) of persons who were admitted to hospital in the last 12 months reporting:									
hospital doctors, specialists or nurses always or often listened carefully to them									
Doctors/specialists	90.9	89.0	90.2	89.4	89.4	86.5	95.1	88.6	90.0
Nurses	89.0	89.1	92.2	91.2	90.8	88.8	89.0	88.8	90.1
hospital doctors, specialists or nurses always or often showed respect to them									
Doctors/specialists	91.4	89.4	91.3	88.9	91.1	87.0	94.2	89.5	90.5
Nurses	90.6	90.0	93.7	90.9	93.2	91.1	90.4	92.9	91.4
hospital doctors, specialists or nurses always or often spent enough time with them									
Doctors/specialists	87.1	84.0	86.2	84.9	87.2	85.7	88.6	86.5	85.8
Nurses	87.2	87.3	88.9	88.8	85.8	85.6	92.8	89.3	87.6

Source: tables 10A.67–10A.82.

Sentinel events, 2009-10

Data for this indicator not complete or not directly comparable (chapter 10).

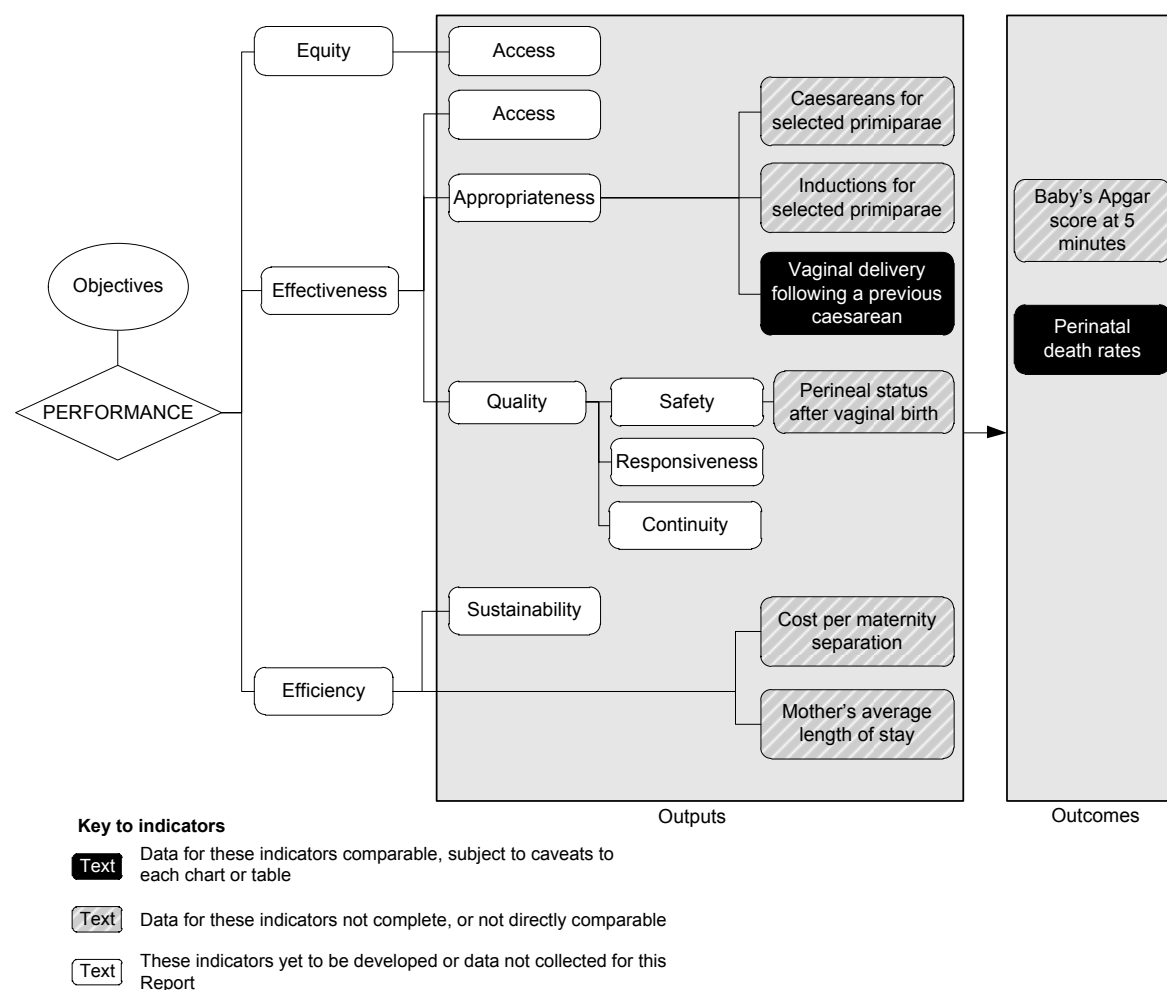
Data are available in tables 10A.83–10A.91.

^a Caveats for these data are available in chapter 10 and attachment 10A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table. – Nil or rounded to zero. **na** Not available. **np** Not published.

Maternity services

The performance indicator framework for maternity services is presented in figure E.19. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of maternity services.

Figure E.19 **Maternity services performance indicator framework**



An overview of the maternity services performance indicator results are presented in table E.4. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 10 and the footnotes in attachment 10A.

Table E.4 Performance indicators for maternity services^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Effectiveness — Appropriateness indicators									
<i>Caesareans for selected primiparae — Proportion (%) of births that were caesareans, 2010</i>									
Data for this indicator not complete or not directly comparable (chapter 10)									
Public hospitals	23.0	22.8	22.8	24.6	27.4	na	21.9	24.8	23.4
Private hospitals	31.0	30.2	36.7	34.5	28.5	na	30.2	29.6	32.6
<i>Inductions for selected primiparae — Proportion (%) of births that were induced, rate, 2010</i>									
Data for this indicator not complete or not directly comparable (chapter 10)									
Public hospitals	34.8	29.0	27.2	33.4	38.2	na	25.0	32.2	31.8
Private hospitals	36.7	34.2	32.3	38.7	39.4	na	30.8	32.1	35.5
<i>Vaginal birth following a previous caesarean, 2008</i>									
Data for this indicator comparable, subject to caveats (chapter 10)									
Vaginal delivery	17.3	16.4	15.3	12.9	17.8	17.3	21.7	28.1	16.4
Caesarean	82.6	83.4	84.7	87.1	82.1	82.6	78.3	71.8	83.5

Source: tables 10A.95–10A.104.

Effectiveness — Quality — Safety indicators

Perineal status after vaginal birth — Mothers with third or fourth degree lacerations after vaginal births, 2009

Data for this indicator not complete or not directly comparable (chapter 10)

%	1.6	1.5	1.6	2.0	2.0	1.1	3.0	1.9	1.7

Source: table 10A.105.

Efficiency indicators

Cost per maternity separation, without complications, dollars, 2008-09,

Data for this indicator not complete or not directly comparable (chapter 10)

Vaginal delivery	4 874	3 716	4 213	5 932	3 894	5 804	3 297	3 743	4 457
Caesarean	7 676	7 534	7 741	10 685	8 088	9 876	8 143	8 382	8 022

Mother's average length of stay, days, 2008-09

Data for this indicator not complete or not directly comparable (chapter 10)

Vaginal delivery	2.81	2.61	2.39	2.82	2.78	2.77	2.34	3.29	2.67
Caesarean	4.12	4.09	3.63	4.06	4.34	3.91	3.88	5.24	4.03

Source: table 10A.106.

(Continued next page)

Table E.4 (continued)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Outcome indicators									
<i>Apgar score at 5 minutes, 2010</i>									
Data for this indicator not complete or not directly comparable (chapter 10)									
Percentage of live births with an Apgar score of 3 or lower by birthweight									
<1500g	16.9	16.6	19.0	7.3	11.2	na	14.1	18.5	na
1500g–1999g	1.5	1.6	1.7	1.3	1.2	na	–	1.8	na
2000g–2499g	0.6	0.5	0.6	0.3	0.2	na	–	1.2	na
2500g+	0.2	0.2	0.2	0.1	0.1	na	0.4	0.2	na
<i>Perinatal death rates — deaths per '000 total births, 2009</i>									
Data for this indicator comparable, subject to caveats (chapter 10)									
Fetal deaths	5.3	6.1	6.7	7.0	3.8	8.6	5.1	10.2	6.0
Neonatal deaths	3.1	2.9	3.8	1.9	2.4	2.1	1.9	4.7	3.0
Perinatal deaths	8.4	8.9	10.4	8.8	6.2	10.6	7.0	14.8	9.0

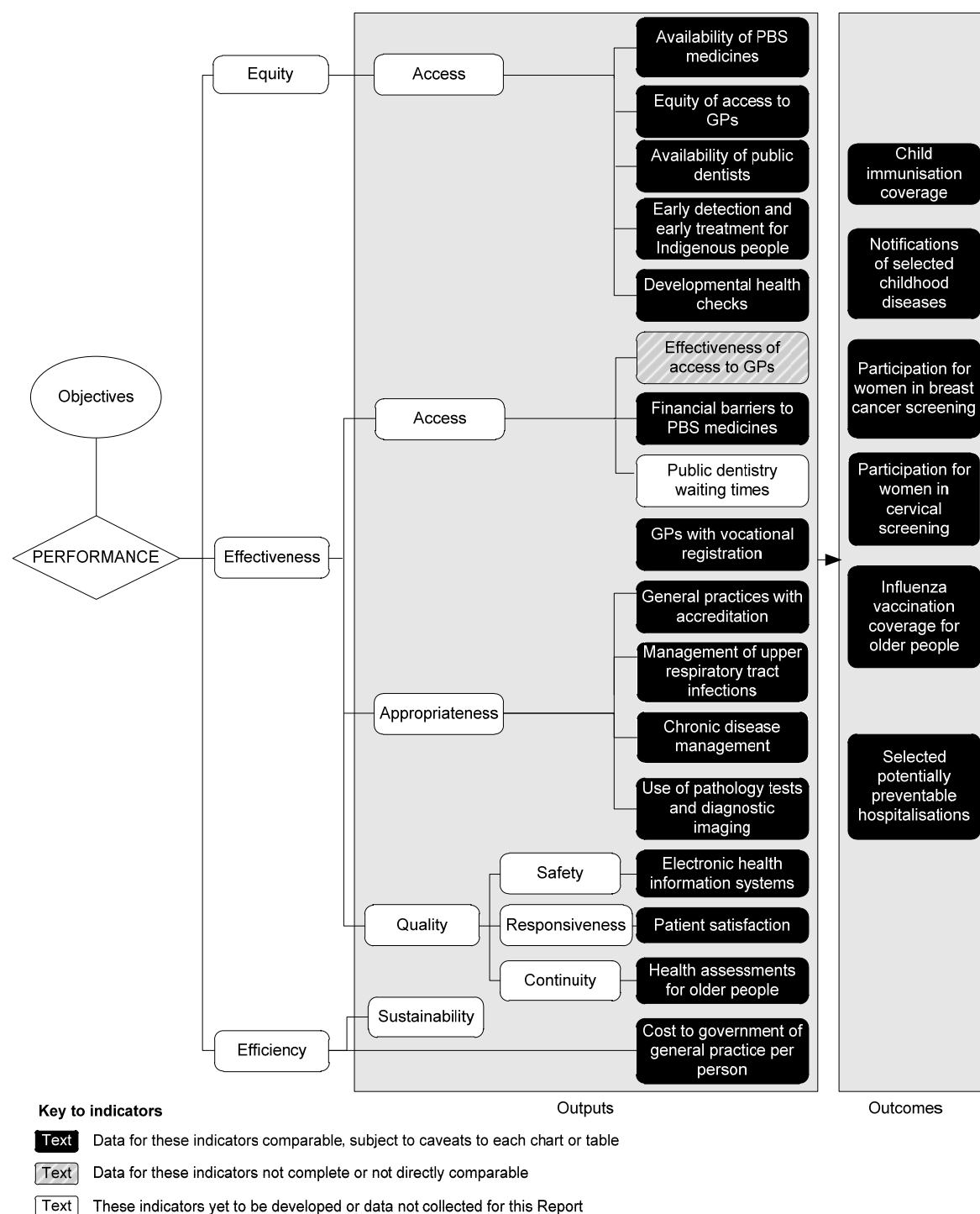
Source: tables 10A.107–10A.112.

^a Caveats for these data are available in chapter 10 and attachment 10A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table. – Nil or rounded to zero. **na** Not available.

Primary and community health

The performance indicator framework for primary and community health is presented in figure E.20. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of primary and community health.

Figure E.20 Primary and community health performance indicator framework



An overview of the primary and community health performance indicator results are presented in table E.5. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 11 and the footnotes in attachment 11A.

Table E.5 Performance indicators for Primary and community health^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Equity — Access indicators									
<i>Availability of PBS medicines — PBS prescriptions filled at concessional rate (per cent), 2010-11</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Proportion of total	86.4	86.7	85.6	82.4	88.2	89.3	72.9	75.6	86.0
<i>Equity of access to GPs, 2010-11</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Full time workload equivalent GPs by region per 100 000 people									
Urban areas, rate	99.9	91.7	90.1	71.0	95.0	89.0	65.6	66.4	91.5
Rural areas, rate	85.7	84.3	89.1	67.3	93.4	80.4	na	51.1	84.1
Availability of female GPs per 100 000 females									
Rate	60.1	54.2	56.6	43.3	51.2	56.8	52.3	50.6	55.2
<i>Availability of public dentists — per 100 000 people, 2009</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Proportion of total	6.8	6.9	9.9	7.2	9.5	5.5	9.6	12.0	7.7
<i>Early detection and early treatment for Indigenous people — Older Indigenous people who received a health assessment per 1000 older Indigenous people, 2010-11</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Rate	20.2	11.6	23.4	23.0	17.1	8.7	15.3	26.4	20.7
<i>Developmental health check — Children receiving a fourth year developmental health check, 2010-11</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Proportion	26.3	7.3	35.2	17.5	12.7	21.5	12.8	44.6	21.7
Source: tables 11A.6–11A.23.									
Effectiveness — Access indicators									
<i>Effectiveness of access to GPs</i>									
Data comparability and completeness vary for this indicator.									
Bulk billing rates for non-referred patients, 2010-11									
Proportion (%)	85.5	79.7	80.8	73.4	79.6	76.1	48.1	71.1	80.9
GP waiting times for urgent appointment, 2010 — less than 4 hours									
Proportion (%)	64.2	57.7	60.7	57.5	59.1	55.5	56.1	44.9	60.2
People deferring treatment due to cost, 2010 — deferring visits to GPs									
Proportion (%)	7.6	7.9	9.9	10.0	8.3	11.0	14.9	14.8	8.7
Selected potentially avoidable GP-type presentations to emergency departments, 2010-11									
'000	712.6	554.9	375.0	213.9	117.4	47.6	48.5	42.3	2 112.2
<i>Financial barriers to PBS medicines</i>									
People deferring treatment due to cost, 2010 — deferring purchase of medicines									
Data for this indicator comparable, subject to caveats (chapter 11)									
Proportion (%)	9.3	9.1	11.4	9.1	11.1	11.5	9.4	9.1	9.8
Source: tables 11A.23–11A.32.									

(Continued next page)

Table E.5 (continued)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Effectiveness — Appropriateness indicators									
<i>GPs with vocational registration, 2010-11</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Proportion (%)	91.8	89.4	86.6	91.1	90.3	90.9	94.8	71.8	89.9
<i>General practices with accreditation, at 30 June 2011</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Proportion (%)	62.4	71.4	78.6	74.9	69.3	78.5	72.6	47.6	69.2
<i>Management of upper respiratory tract infections, 2010-11</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Prescriptions for oral antibiotics used to treat upper respiratory tract infections, per 1000 concession card holders									
Rate	1 271.7	1 314.0	1 267.9	940.2	1 119.8	1 022.4	1 232.6	422.9	1 223.9
<i>Management of chronic disease</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
People with diabetes mellitus who have received an annual cycle of care within general practice, 2010-11									
Proportion (%)	18.3	18.8	17.9	16.7	22.4	24.8	14.0	10.9	18.6
People with asthma who have a written asthma action plan, 2007-08									
Proportion (%)	20.4	22.9	19.7	17.4	21.9	17.1	21.8	40.9	20.8
<i>Pathology tests and diagnostic imaging — Medicare benefits for pathology tests, 2010-11</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
\$ per person	64.7	59.1	64.9	55.2	61.3	58.1	58.8	52.0	61.7

Source: tables 11A.33–11A.44.

Effectiveness — Quality — Safety indicators

Electronic health information systems — general practices using electronic systems, May 2011

Data for this indicator comparable, subject to caveats (chapter 11)

Proportion (%)	84.9	89.1	89.4	89.0	88.5	88.6	93.9	80.4	87.6

Source: tables 11A.45–11A.46.

Effectiveness — Quality — Responsiveness indicators

Patient satisfaction, 2010

Data for this indicator comparable, subject to caveats (chapter 11)

Proportion (%) of people who saw a practitioner in the previous 12 months where the practitioner always or often: listened carefully to them

GP	89.8	89.4	88.0	89.3	88.0	88.6	87.6	83.3	89.1
Dental practitioner	93.6	94.5	94.7	93.8	94.9	93.3	94.8	93.1	94.2

Source: tables 11A.47–11A.50.

Effectiveness — Quality — Continuity indicators

Health assessments for older people — proportion of older people assessed, 2010-11

Data for this indicator comparable, subject to caveats (chapter 11)

Proportion (%)	26.57	24.69	29.42	25.15	24.54	29.69	19.36	20.62	26.15

Source: table 11A.51.

(Continued next page)

Table E.5 (continued)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Efficiency indicators									
<i>Cost to government of general practice per person, 2010-11</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
\$ per person	305.2	289.5	288.3	229.4	304.8	281.3	211.6	181.5	286.7
Source: table 11A.2.									
Outcome indicators									
<i>Child immunisation coverage — Children aged 60 to 63 months fully immunised, 30 June 2011</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Proportion (%)	89.7	91.1	90.3	86.0	87.0	90.3	90.6	88.1	89.6
<i>Notifications of selected childhood diseases — notifications per 100 000 children, 2010-11</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Measles	0.6	0.1	0.2	0.2	—	—	np	np	0.3
<i>Participation rates for women in breast cancer screening — Ages 50–69, 2009–10</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Rate	52.8	53.9	57.3	57.9	56.4	58.4	52.7	41.1	54.8
<i>Participation rates for women in cervical screening — Ages 20–69, 2009–10</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Rate	55.6	60.8	55.3	57.5	59.5	57.4	58.8	54.5	57.4
<i>Influenza vaccination coverage for older people — 65 years or over, 2009</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Rate	72.7	75.0	74.6	72.9	81.3	77.5	78.0	69.3	74.6
<i>Separations for selected potentially preventable hospitalisations, 2009-10, per 1000 people</i>									
Data for this indicator comparable, subject to caveats (chapter 11)									
Vaccine-preventable	0.7	0.7	0.9	0.8	0.9	0.7	0.5	2.4	0.8
Acute conditions	12.9	14.4	14.7	13.7	14.6	10.7	9.8	21.1	13.8
Chronic conditions	13.6	15.1	18.6	23.1	14.4	12.1	10.4	26.1	16.0

Source: tables 11A.55–11A80.

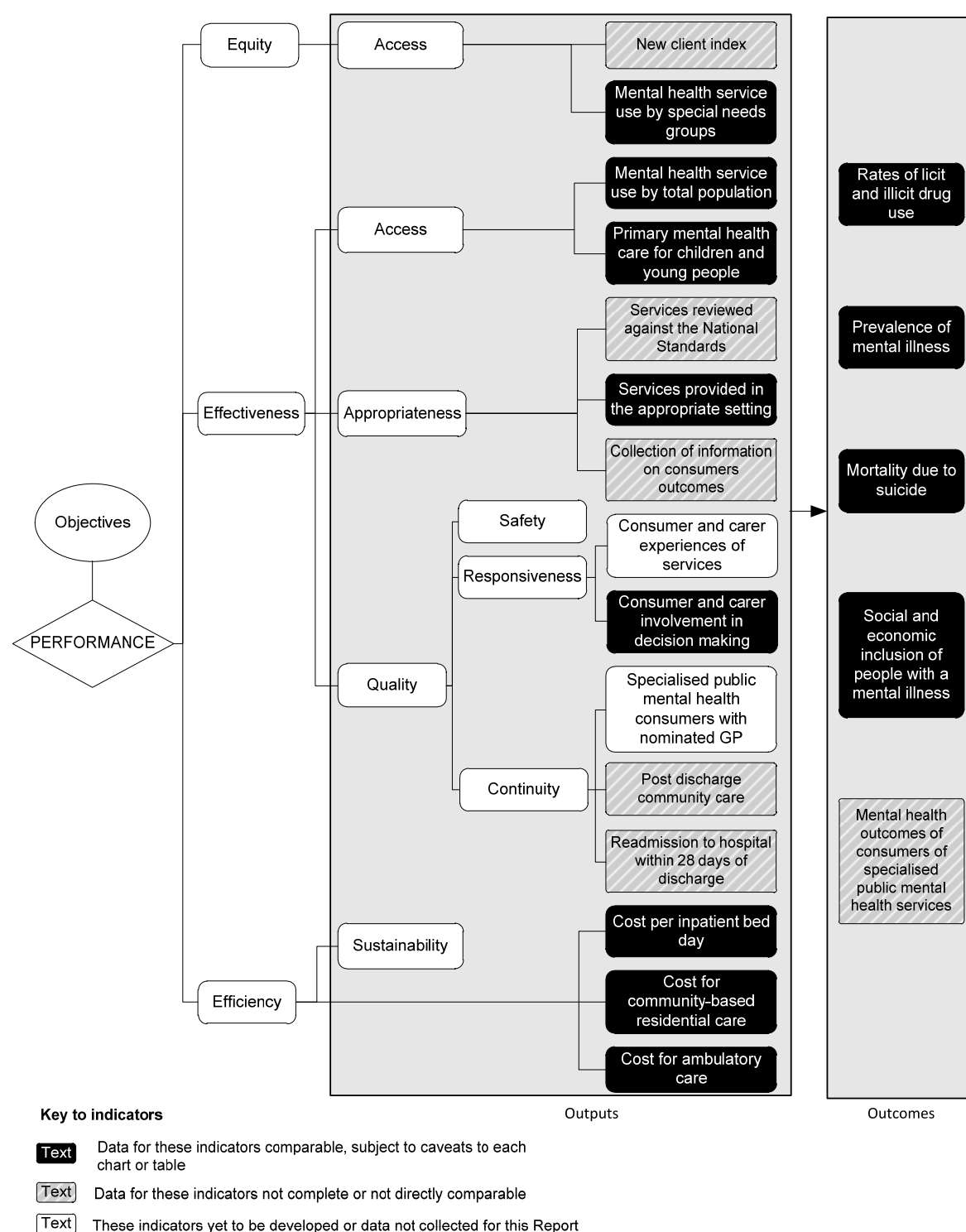
^a Caveats for these data are available in Chapter 11 and Attachment 11A. Refer to the indicator interpretation boxes in chapter 11 for information to assist with the interpretation of data presented in this table. ^b Some data are derived from detailed data in Chapter 11 and Attachment 11A. — Nil or rounded to zero. **na** Not available. **np** Not published.

Source: Chapter 11 and Attachment 11A.

Mental health management

The performance indicator framework for mental health management is presented in figure E.21. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of mental health management.

Figure E.21 Mental health management performance indicator framework



An overview of the mental health management performance indicator results are presented in table E.6. Information to assist the interpretation of these data can be

found in the indicator interpretation boxes in chapter 12 and the footnotes in attachment 12A.

Table E.6 Performance indicators for Mental health management^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Equity — Access indicators									
<i>New client index — Proportion of clients under the care of State or Territory specialised public mental health services who were new clients, 2009-10</i>									
Data for this indicator comparable, subject to caveats (chapter 12)									
Proportion (%)	43.3	24.3	45.5	41.7	42.3	46.0	52.7	47.9	40.4
<i>Mental health service use by special needs groups</i>									
Data for this indicator comparable, subject to caveats (chapter 12)									
Proportion (%) of the Indigenous population using State and Territory mental health services, compared with the proportion for non-Indigenous population, 2009-10									
Indigenous	4.9	3.2	4.0	4.2	5.7	np	5.8	3.7	4.3
Non-Indigenous	1.2	1.0	1.6	1.7	1.6	1.3	1.8	2.0	1.3
Proportion (%) of the Indigenous population using MBS and DVA funded mental health services, compared with the proportion for non-Indigenous population, 2009-10									
Indigenous	8.1	10.2	4.7	3.0	6.1	7.2	8.6	1.3	5.6
Non-Indigenous	6.3	7.0	5.9	5.3	6.3	5.6	5.1	3.2	6.2

Source: tables 12A.18–19.

Effectiveness — Access indicators

Mental health service use by total population, 2009-10

Data for this indicator comparable, subject to caveats (chapter 12)

Proportion (%) of the population in a State and Territory using a specialised public mental health service or a MBS-subsidised service

Specialised public mental health	1.6	1.1	1.7	1.9	2.0	1.5	2.1	2.5	1.6
MBS and DVA subsidised service	6.5	7.1	6.0	5.3	6.4	5.7	5.2	2.7	6.3

Primary mental health care for children and young people, 2010-11

Data for this indicator comparable, subject to caveats (chapter 12)

Proportion of young people aged under 25 years who had contact with primary mental health care services subsidised through the MBS

Proportion (%)	4.2	4.7	3.8	3.3	4.5	4.1	3.7	1.4	4.1

Source: tables 12A.28 and 12A.33.

Effectiveness — Appropriateness indicators

Services reviewed against national standards, June 2010

Data for this indicator not complete or not directly comparable (chapter 12)

Proportion of specialised public mental health services that had completed an external review against national standards and were assessed as meeting 'all Standards' (level 1)

Proportion (%)	82.1	95.6	91.0	42.7	89.1	12.0	100.0	100.0	84.1

(Continued next page)

Table E.6 (Continued)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Services provided in the appropriate setting, 2009-10</i>									
Data for this indicator comparable, subject to caveats (chapter 12)									
Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services									
Proportion (%)	44.6	62.9	54.1	54.4	52.4	54.8	74.7	65.4	53.4
<i>Collection of information on consumers outcomes, 2009-10</i>									
Data for this indicator comparable, subject to caveats (chapter 12)									
Proportion of episodes with completed consumer outcomes measures collected for people in specialised public mental health services — ongoing community care									
Proportion (%)	20.0	37.0	42.0	49.0	43.0	47.0	15.0	50.0	na

Source: tables 12A.34-35 and 12A.37.

Effectiveness — Quality — Responsiveness indicators

Consumer and carer involvement in decision making, 2009-10

Data for this indicator comparable, subject to caveats (chapter 12)

Paid consumer consultants (FTE) per 1000 paid direct care, consumer and carer staff (FTE)

no.	2.9	3.1	3.3	1.9	2.8	0.7	—	—	2.8

Source: tables 12A.36.

Effectiveness — Quality — Continuity indicators

Community follow up for people within the first 7 days of discharge from hospital, 2009-10

Data for this indicator not complete or not directly comparable (chapter 12)

Proportion of overnight separations from psychiatric inpatient services with a community mental health service contact recorded in the 7 days following separation

Proportion (%)	55.6	62.7	45.0	59.5	38.6	22.7	75.7	13.0	52.7

Readmissions to hospital within 28 days of discharge, 2009-10

Data for this indicator not complete or not directly comparable (chapter 12)

Proportion of overnight separations from psychiatric inpatient services that were followed by a readmission to a psychiatric inpatient service within 28 days of discharge

Proportion (%)	16.0	13.2	15.9	12.8	8.1	15.1	4.6	8.3	14.3

Source: tables 12A.38–39.

Efficiency indicators

Cost per inpatient bed day, 2009-10

Data for this indicator comparable, subject to caveats (chapter 12)

General mental health services

\$ per bed day	767	746	738	950	899	1 002	806	1 189	794

Public acute hospitals

\$ per bed day	839	752	756	929	886	1 130	762	1 189	821

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Table E.6 (Continued)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
<i>Average recurrent cost per patient day for community residential services, 2009-10</i>									
<i>Data for this indicator comparable, subject to caveats (chapter 12)</i>									
General adult units — 24-hour staffed units									
\$ per patient day	251	489	..	291	377	411	620	331	422
<i>Average cost of ambulatory care — Average cost per episode of ambulatory care 2009-10</i>									
<i>Data for this indicator comparable, subject to caveats (chapter 12)</i>									
\$ per episode	1 832	2 242	2 304	1 995	1 603	1 953	2 036	1 984	2 013
Source: tables 12A.40–43.									
Outcome indicators									
<i>Rates of licit and illicit drug use, 2010</i>									
<i>Data for this indicator comparable, subject to caveats (chapter 12)</i>									
Proportion of people aged 14 years or over who used any illicit drug in the preceding 12 months									
Proportion (%)	11.4	11.0	12.3	15.4	12.7	9.6	11.4	18.8	12.0
<i>Prevalence of mental illness, 2007</i>									
<i>Data for this indicator comparable, subject to caveats (chapter 12)</i>									
Proportion of people with a lifetime mental disorders among adults aged 16–85 years									
Proportion (%)	20.1	20.7	19.2	21.4	19.1	14.1	np	np	20.0
	± 2.2	± 2.3	± 2.6	± 4.1	± 3.4	± 5.4			± 1.1
<i>Mortality due to suicide — Suicide rate per 100 000 people 2005–2009</i>									
<i>Data for this indicator comparable, subject to caveats (chapter 12)</i>									
Rate	7.9	9.3	11.2	11.8	12.1	15.1	9.7	20.1	9.9
<i>Social and economic inclusion of people with a mental illness, 2007-08</i>									
<i>Data for this indicator comparable, subject to caveats (chapter 12)</i>									
Proportion of people aged 16–64 years with a mental illness who are employed									
Proportion (%)	58.4	68.4	63.6	70.5	48.2	53.9	75.1	85.0	62.9
	± 6.5	± 6.2	± 6.9	± 8.0	± 6.6	± 9.0	± 6.3	± 32.7	± 3.3
<i>Mental health outcomes of consumers of specialised public mental health services, 2009-10</i>									
<i>Data for this indicator comparable, subject to caveats (chapter 12)</i>									
Proportion of people discharged from a State or Territory public hospital psychiatric inpatient unit who had a significant improvement in their clinical mental health outcomes									
Proportion (%)	57	73	70	72	70	73	np	np	67

Source: tables 12A.45, 12A.48, 12A.53, 12A.57 and 12A.62.

^a Caveats for these data are available in chapter 12 and attachment 12A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table. — Nil or rounded to zero. .. Not applicable. np Not published.

E.3 Cross cutting and interface issues

Many determinants affect Australian's health (AIHW 2010). They include the delivery of an efficient, effective and equitable health service, but also factors such as individuals' and communities' social and economic conditions and background.

Major improvements in health outcomes therefore depend on strong partnerships between components of the health system and relationships between the health sector and other government services:

- *Early childhood, education and training services* play an important role in shaping a child's development, which has consequences for overall health and wellbeing in later life (AIHW 2011d).

Good health is critical to a child's educational development. Impaired hearing, malnutrition, poor general health, including poor eyesight, anaemia and skin diseases, and sleep deprivation have been identified as having adverse effects on the educational attainment of Indigenous children (AMA 2001).

- *Justice services* have a critical role in providing a safe and secure society, free from violence. They also enforce laws designed to improve public health such as to prevent road traffic accidents and the use of illicit drugs.

A person's health can also be a critical factor in a person's interaction with the justice system. Research shows that prisoners have significantly worse health, with generally higher levels of diseases, mental illness and illicit drug use than Australians overall (AIHW 2010).

- *Emergency management services* have an important role in the preparation and response to emergency events providing emergency first aid, protection and shelter. Ambulance services are an integral part of a jurisdiction's health service providing emergency as well as non-emergency patient care and transport.
- *Community services* and health services interact at many levels. People with disability are more likely than others to have poor physical and mental health, and higher rates of risk factors such as smoking and obesity (AIHW 2010). Aged care services can keep people living independently and healthily, without undue call on the health sector. Child protection services act to protect children and ensure their good health (while medical professionals are the source of many child protection notifications).
- *Housing and homelessness services* play an important role in ensuring the health of Australians. Living conditions (particularly poor housing and infrastructure) are a major contributor to health and well being. People with unmet housing needs tend to experience higher death rates, poor health, and are more likely to have serious chronic illnesses (Garner 2006).

E.4 Future directions in performance reporting

This health sector summary will continue to be developed in future reports.

It is anticipated that work undertaken to achieve the COAG aspirations will lead to improvements in performance reporting for the health sector. There are several important national initiatives currently underway. COAG has agreed to the National Health Reform Agreement (COAG 2011). The Agreement includes a commitment to introduce clear and transparent performance reporting against the new Performance and Accountability Framework that will include:

- a subset of the national performance indicators already agreed by COAG through the NHA
- reference to national clinical quality and safety standards developed by the Australian Commission on Safety and Quality in Health Care
- design principles for the new Hospital Performance Reports and Healthy Communities Reports.

Performance reporting will be through the establishment of the National Health Performance Authority. The Authority will:

- provide clear and transparent quarterly public reporting of the performance of every Local Hospital Network, private hospital and Medicare Local
- monitor the performance of Local Hospital Networks, Medicare Locals and hospitals
- develop additional performance indicators as appropriate
- maintain the MyHospitals website.

The COAG Reform Council will continue its role of reviewing the national performance indicators at a State and Territory level. It will report on the performance of the Australian and State and Territory governments in achieving the jurisdictional level outcomes and performance benchmarks included in the NHA.

The Public hospitals, Primary and community health and Mental health management chapters contain a service-specific section on future directions in performance reporting.

E.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this sector summary.

New South Wales Government comments

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The New South Wales Government is actively pursuing the National Health Reform initiatives and is working collaboratively with the Commonwealth in this regard. In New South Wales our focus is on implementing strategies that will improve public hospital services, build on existing strengths of our current system and deliver best-practice healthcare for public patients.

We are transforming our health system into one where patient care is seamless and integrated. Where the patient is respected, listened to and informed – where the patient is the centre of their treatment and care.

To deliver these necessary reforms we are focussing on the following key areas:

- Increasing our emphasis on health prevention to avoid unnecessary hospitalisations.
- Implementing a devolved governance structure where decisions are made as close to the patient as possible.
- Adopting the CORE values of Collaboration, Openness, Respect and Empowerment.
- Enhancing the role of our clinicians.
- Strong evidence-based policy to guide us and
- Greater transparency and public accountability.

The central plank that will deliver many of these key areas is the devolution from a highly centralised model of administration with many layers to one of local decision making. The Government's reform agenda is about getting the right structures that will deliver better health care.

The new administrative structure that we are putting in place is designed to empower local decision making and build a more responsive health system. Structurally the NSW Department of Health has become the Ministry of Health with its primary focus on the development of policy and not the delivery of services.

Local Health Districts in New South Wales will have greater authority and responsibility. They will be responsible to their local communities and they will determine the service configuration they need to meet performance targets and health outcomes.

This model of greater local control, greater local decision-making joined with a strong accountability framework will build the more flexible and resilient health system we need to deliver health services into the future.

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Victorian Government comments

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Ensuring that Victorians have optimal health and health care outcomes is essential to Victoria's economic and social future. While Victorians have one of the best health systems in the world, as measured by life expectancy and survival rates for cancer and heart disease, our health system faces considerable challenge in the near future. This comes from increasing demand and from changing health care needs as the population grows and becomes older, and as disease patterns change. The Victorian Government has developed the *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan*, with seven priority areas for the development and operation of the Victorian health system and to guide service planning and investment over the next decade. These priority areas are:

- developing a system that is responsive to people's needs
- improving every Victorian's health status and experiences
- expanding service, workforce and system capacity
- increasing the system's financial sustainability and productivity
- implementing continuous improvements and innovation
- increasing accountability and transparency
- utilising e-health and communications technology.

Important commitments have already been made, such as increasing capacity by an additional 800 new hospital beds over 4 years, and increasing the ambulance services capacity. There is also the establishment of a health infrastructure fund, training and employing more health professionals, supporting implementation of E-health and enhanced psychiatric disability rehabilitation and support services.

The Victorian Government is also committed to a range of workforce initiatives to support and sustain rural maternity services. This includes assisting rural health services to provide clinical placement, support and supervision for midwifery students, postgraduate training for specialist rural GPs and building capacity of rural midwives in clinical practice through professional support and mentorship.

The Victorian Government invests over \$1 billion in specialist mental health services and its plan for mental health reform (October 2010) improves access to hospital, community-based clinical treatment and eating disorder services, as well as focusing on improving housing, education and employment outcomes to support recovery. Strategies are also being developed to strengthen suicide prevention, reduce workplace stress, better recognise and involve carers and build a more sustainable mental health workforce.

The Victorian Government is committed to more and better information for patients, leading to informed consumers making better choices for their health care and that of their family.

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Queensland Government comments

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Queensland Health is continuing to deliver more services sooner and closer to home for patients throughout the state.

The \$7 billion hospital building program is continuing, with the Gold Coast University Hospital opening its doors in 2012 and work is well underway on the new \$2 billion Sunshine Coast University Hospital. Major hospital expansion and redevelopment projects are also ongoing in Cairns, Townsville, Ipswich, Mackay, Rockhampton and Bundaberg.

- We're also investing in innovation to deliver services in regional areas through our telehealth network. There are 960 systems across the state, allowing patients in rural and regional areas to link with specialists in major metropolitan hospitals. The increased investment in these services has resulted in a 76% increase in usage for non-admitted patients in 2010-11 compared to the previous year.

Investment in preventative health programs is also showing positive results with a decrease in adult smoking rates from 17.9% in 2007 to 14.8% in 2011; an increase in adults undertaking more physical activity from 47.6% in 2006 to 57.4% in 2011; and 92.7% of all children and 92.9% of all Aboriginal and Torres Strait Islander children aged two years being fully immunised in 2010-11.

The severe destruction to Queensland caused by the 2010-2011 summer floods and the two tropical cyclones that struck north Queensland, plunged 75% of Queensland into a state of emergency and affected 1.3 million Queenslanders.

These natural disasters triggered a comprehensive statewide public health, mental health and state emergency response, which included the provision of 17,225 tetanus/diphtheria vaccines; prompted 24,874 calls from flood affected areas to 13 HEALTH; resulted in 10,000 psychological first aid contacts; and required the rebuilding of key infrastructure to re-establish health services and facilities across the state. In addition, a public health mosquito control campaign was conducted to minimise the number of mosquito-borne infections.

Despite these challenges, and the impacts of these natural disasters on our hospitals, Queensland continues to have the shortest waiting times for elective surgery in the country, with a median wait of 27 days in 2009-10, compared to 35 days nationally. Queensland also continues to strive to reduce emergency department waiting times, with an improved median wait time of 24 minutes in 2009-10 compared with 25 minutes in 2008-09, despite a 4% increase in the number of patients presenting to emergency departments over the same period.

Queensland is also undertaking a major shake up of how health services are delivered as part of national health reform. On 14 October 2011, the Queensland Parliament passed the *National Health and Hospital Network Act 2011* which will break up Queensland Health and establish 17 Local Health and Hospital Networks from 1 July 2012. These reforms will change the face of public health and see health services delivered by the community, for the community in the community. National reform will deliver more beds, more surgery and faster emergency care to Queenslanders.

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Western Australian Government comments

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WA Health has continued to deliver high quality health services across Western Australia. Ambitious, long-term reforms to address key health priorities, drive service and productivity improvement, will meet Western Australians' future health needs. Efforts are aligned to, and given focus by, the four pillars of the *WA Health Strategic Intent 2010–2015*:

- *Caring for individuals and the community*

WA Health is working to ensure Western Australians have timely access to quality health care when they need it. Elective surgery waitlist admissions have grown (by 5.7%) since 2009-10 with a fall in the median wait time. Focus on safety and quality has seen the continued implementation of *WA Strategic Plan for Safety and Quality Care 2008-2013* including the roll out of the WA Health Surgical Safety Checklist and the paediatric National Inpatient Medication Chart.

- *Caring for those who need it most*

Improving the health of Aboriginal people remains a high priority and WA Health has rolled out new programs, and is expanding services, under the National Partnership Agreements on *Closing the Gap* and *Indigenous Early Childhood Development*.

In addition, the Four Hour Rule Program has dramatically reduced access block despite an increase in number of presentations. Services for the elderly and children in WA have also seen some significant expansion that resulted in reduced hospitalisations and wait time for child development services.

- *Making best use of funds and resources* — Activity Based Funding and Management (ABF/M) continues to extend across public health system activity with the implementation of a new Performance Management Framework. WA Health is continuing to move ahead with a massive hospital building and redevelopment program.
- *Supporting our team* — WA Health is committed to further strengthening its workforce. More medical and nursing graduates are joining the department. The department has also achieved the goal of recruiting of additional Aboriginal health workers.

The Mental Health Commission, a stand-alone public sector agency, has focused on three key strategic directions:

- Developing recovery oriented, person centred support and service for people with mental health problems and/or mental illness.
- More connected approaches across government agencies, and with community, private, primary care services and the university sector.
- Planning for a full range of services in a comprehensive and contemporary mental health system.

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South Australian Government comments

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In 2010-11, there has been a continuation of the substantial reform of the South Australian health care system, guided by South Australia's Health Care Plan 2007-16. The GP Plus Service (GPS) continues to work to alleviate the growing pressure on the acute hospital system. The GP Plus Services Fund allocates funding to programs within the community, primary prevention and subacute domains. In 2010-11 SA Health invested almost \$70 million into GPS funded programs. The investment of GPS and other wider system work has seen a continued reduction in the levels of growth in hospital inpatient separations across metropolitan Adelaide for the last three years with last year's growth for metropolitan separations below 2%.

Services have commenced at the Elizabeth GP Plus Health Care Centre. The co-located Marion GP Plus Health Care Centre and the State's first Community Mental Health Centre commenced services in May 2011. With a combined total project budget of \$38 million, both Centres were formally opened on 25 June 2011. Services commenced at the Modbury and Noarlunga GP Plus Super Clinics, in November 2010, and will be fully operational by early 2012.

2010-11 marked the first year of the Elective Surgery Strategy Four Year Plan (2010-14). As a result of State and Commonwealth Government funding, 46 433 procedures were undertaken in metropolitan hospitals, an increase of 13.9% compared with the start of the previous Elective Surgery Strategy Four Year Plan.

In 2010-11 SA Health made progress towards a number of significant capital projects. The development of the new Royal Adelaide Hospital continued, with the hospital set to open in 2016. At the Flinders Medical Centre, the Acute Medical Unit, expansion of the Intensive Care Unit, Stages 1 and 2 of the Emergency Department upgrade, Stage 1 of the Operating Theatre redevelopment, and upgrades to critical infrastructure services were completed. In the country, the Ceduna Health Service Redevelopment reached a significant milestone with the rebuilt acute hospital completed and occupied in March 2011 on time and below budget with the savings re-invested into the second stage of the project, which is the establishment of a GP Plus Health Care Centre.

Through the Primary Prevention Plan 2011-16, SA Health has continued to recognise the importance of promoting and protecting good health, preventing illness and assisting people to make healthy lifestyle choices. During 2010-11, the department invested over \$13 million (excluding the Obesity Prevention and Lifestyle (OPAL) program) into initiatives which promote healthy eating and physical activity. In 2011, the OPAL program (which aims to produce community-wide solutions to promote healthy eating and physical activity) expanded from 10 to 15 communities, each of which operates for five years.

In 2010-11, the Public Health Act 2011 was passed by State Parliament. This Act establishes a new framework for addressing contemporary public health challenges and is a significant achievement for South Australia.

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Tasmanian Government comments

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2009-2010 saw the majority of projects under *Tasmania's Health Plan* either completed or incorporated into the day-to-day business of relevant areas of the Agency. There was also significant progress with a number of new projects inspired by the principles of *Tasmania's Health Plan*, such as *Leading the Way* (Tasmania's Health Professionals Shaping Future Care); *Connecting Care* (Chronic Disease Action Framework for Tasmania 2009–2013) and *Your Care, Your Say* (Consumer and Community Engagement Strategic Framework and Action Plan).

While we have come a long way under *Tasmania's Health Plan*, there are still many challenges associated with Tasmania's decentralised and ageing population, workforce availability and other pressures. Reform of our health and human services should be an ongoing process of continuous improvement. There will always be a need to evaluate and adapt systems to suit changing environments and community needs.

Tasmania's Health Plan and the recent creation of the three area health services helped pave the way for a new national reform process agreed by the Australian, state and territory governments (except Western Australia) in April 2010.

This agreement takes health reform in Tasmania to a new level by tackling the critical issue of shared Australian and State Government responsibility for health funding and health policy. Our hospitals and other key health services will largely be funded by the Australian Government, but Tasmania will still purchase and coordinate services – according to our specific needs in each region.

The reforms will also:

- see the establishment of 'Local Hospital Networks' and 'Medicare Locals' as new structures to deliver health care
- aim to reduce hospital waiting times for patients (emergency department and elective surgery) and
- deliver changes in the areas of primary care, aged care, disability services, sub-acute care, mental health services and the health workforce.

Planning for Tasmanian implementation of these national reforms – including a process of extensive stakeholder consultation – began towards the end of 2009-2010 and continued to be a major focus of the Agency throughout 2010-2011.

Other major developments during 2009-2010 included the appointment of Tasmania's first nurse practitioners, the appointment of specialist nurses to help hospital patients quit smoking, the release of guidelines for the use of solariums, major capital works, a reduction in elective surgery waiting times, and release of a promotion, prevention and early intervention strategy to address the prevalence and severity of mental illness in the community.

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Australian Capital Territory Government comments

“ The ACT Government provides health services to local residents through two major hospitals: The Canberra Hospital and Calvary Public Hospital. These public hospitals provide the full range of acute care, including inpatient, outpatient and emergency department services. Both hospitals are teaching hospitals in cooperation with the Australian National University's Medical School and University of Canberra. The Canberra Hospital is the major trauma referral hospital for the ACT and surrounding area of NSW with a quarter of public hospital separations being residents of New South Wales.

The ACT Health Directorate continues to improve the access, efficiency, timeliness, safety and quality in relation to service delivery.

Hospital capacity continued to grow in 2009-10, with bed numbers increasing from 875 in 2008-09 to 907 in 2009-10.

One of the ACT Government-funded initiatives to address emergency department waiting times is to establish Australia's first public, nurse-led Walk-in-Centre. Since its establishment in May 2010, the Centre has managed over 17 114 presentations to the end of June 2011. The Centre provides the community with access to free treatment and care for minor illnesses.

A PET/CT scanner service began operating in November 2010. Prior to its installation, ACT residents needed to travel interstate for this service. A purpose-built neurosurgery operating theatre opened at the Canberra Hospital in September 2010 and is currently the only one of its kind in Australia. It contains an MRI machine and enables complex procedures to be undertaken while patients are anaesthetised. This improves patient outcomes and reduces rate of readmission for additional surgical procedures.

In 2008-09 the ACT Government embarked on The Capital Asset Development Program (CADP) to revitalise and ready the ACT health system for an expected increase in health care demand over the next 10 to 15 years. The CADP involves the overhaul and expansion of all aspects of the ACT health system. To date the ACT Government has committed over \$600 million to the CADP which is ultimately expected to cost over \$1 billion over 10 years.

Several projects have already been completed and construction on further projects is well underway including a new Women's and Children's Hospital; a new Adult Acute Mental Health Inpatient Unit; and a new Integrated Cancer Care Centre, all at the Canberra Hospital. Work at the Canberra Hospital has been completed on two new operating theatres; a new Mental Health Assessment Unit; the new nurse-led Walk-in Centre; a new multistorey car park, a new Neurosurgical Intra-operative Magnetic Resonance Imaging suite and a new Surgical Assessment and Planning Unit. At Calvary Hospital a new intensive care facility and an operating theatre have also been completed.

The ACT Health Directorate continues to work with the Commonwealth Government to achieve the national health reform agenda.

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Northern Territory Government comments

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The unique characteristics of the Northern Territory present both challenges and opportunities. Our challenges include a geographically dispersed population where 44 per cent of Territorians live in areas classified as remote or very remote. To add to this, 30 per cent of the Northern Territory's population are Aboriginal and/or Torres Strait Islander who present with a higher burden of disease than the non-Aboriginal population. In 2010-11, 70 per cent of hospital admissions and 72 per cent of service occasions at health centres involved Aboriginal people. With these challenges the Northern Territory Government continues to create unique ways of ensuring that the health and well being of all is of the highest standard available. Some key achievements this year include:

- In 2010-11 the NT implemented a Territory-wide 24 hour Mental Health Triage and Response Service based in Darwin. The service will facilitate improved services to consumers and carers and a stronger level of support to General Practitioners and remote clinics;
- the new Alan Walker Cancer Care Centre has completed its first full year, providing both radiation oncology and chemotherapy services. This facility is further enhanced by the provision of new self-caring patient accommodation at Barbara James House, allowing greater access and support for patients travelling from outside the greater Darwin area, particularly those travelling from Central Australia;
- elective surgery educational material for health professionals and clients has been developed and translated into 11 of the most commonly spoken Aboriginal languages. This material is intended to assist professionals to explain key points of the elective surgery process to clients and to educate hospital based health professionals; and
- the Department made good progress in its efforts to reduce smoking in the Territory including changes to the Tobacco Control Act.

These activities will make a substantial contribution to the Northern Territory Government's 2030 Plan targets and National Partnership Agreement actions around prevention of chronic disease across the life cycle for Aboriginal and non-Aboriginal Territorians and for closing the gap in life expectancy.

Significant progress in Aboriginal primary health care reform has occurred and continues to be guided by the Pathways to Community Control Framework, a tripartite framework which supports a gradual roll out of regional Aboriginal Community Controlled Health Organisations across the NT.

The NT Government has supported the National Health Reform initiatives and is working on ways to implement strategies that will take the Territory forward. Approving additional capital resources for infrastructure upgrade and development include a Palmerston hospital that will support the growth of the satellite city and rural areas south of Darwin.

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Australian Government comments

“ In August 2011, the Australian Government and states/territories signed a National Health Reform Agreement (NHRA). All states/territories have also signed a revised National Partnership Agreement on Improving Public Hospital Services, under which the Australian Government has already provided \$1 billion for improved emergency departments, more elective surgery and new sub-acute beds. Under the NHRA, governance of primary health care and hospital systems will devolve to new local institutions — Local Hospital Networks (LHNs) and Medicare Locals (MLs). Nineteen MLs have already been established around Australia, and a second and third tranche of MLs will commence operations in 2012. LHNs have been established in New South Wales, Victoria, South Australia and the Australian Capital Territory. Other states are on track to implement LHNs by 1 July 2012.

A new national aged care telephone number linking new users to Commonwealth Respite and Carelink Centres commenced on 1 July 2011. From 1 July 2011 the Australian Government assumed funding and policy responsibility for basic community care services for people aged 65 years and over (50 years and over for Indigenous Australians) under the Home and Community Care Program (except in Victoria and Western Australia).

The Australian Government also assumed funding responsibility from 1 July 2011 for specialist disability services delivered by the states in accordance with their responsibilities under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians).

The Independent Hospital Pricing Authority to determine the national efficient price of hospital services was established as a statutory agency on 15 December 2011. The National Health Performance Authority to develop public reports on the performance of hospitals and MLs was established on 21 October 2011.

The Australian Commission on Safety and Quality in Health Care has also been established as a permanent, independent authority that will develop, monitor and implement national standards for improving clinical safety and quality in hospitals and health care settings.

After an extensive period of engagement with the mental health sector the Australian Government announced the 2011-12 Delivering National Mental Health Reform Budget package which lays down the foundations for a new systematic approach to support people with mental illness. The Government will commit \$1.5 billion in investments over the next five years to build a better mental health system and develop, together with states and territories, a ten year roadmap for mental health reform.

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E.6 List of attachment tables

Attachment tables are identified in references throughout this appendix by an 'EA' prefix (for example, table EA.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

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Table EA.56	Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status, 2007–2009

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10 Public hospitals

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Attachment tables

Attachment tables are identified in references throughout this chapter by a '10A' prefix (for example, table 10A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

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

Major improvements in reporting on public hospitals this year include:

-
- combining a number of indicators with similar characteristics as separate measures under new high level indicators
 - reporting national data from the Australian Bureau of Statistics (ABS) *Patient Experience Survey 2010-11* under the 'Patient satisfaction' indicator
 - inclusion of some 'data quality information' (DQI) documentation.

10.1 Profile of public hospitals

Definition

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

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

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

In some instances, data for stand-alone psychiatric hospitals are included in this chapter. However, under the National Mental Health Strategy, the provision of psychiatric treatment is shifting away from specialised psychiatric hospitals to mainstream public hospitals and the community sector. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in the 'Mental health management' chapter (chapter 12).

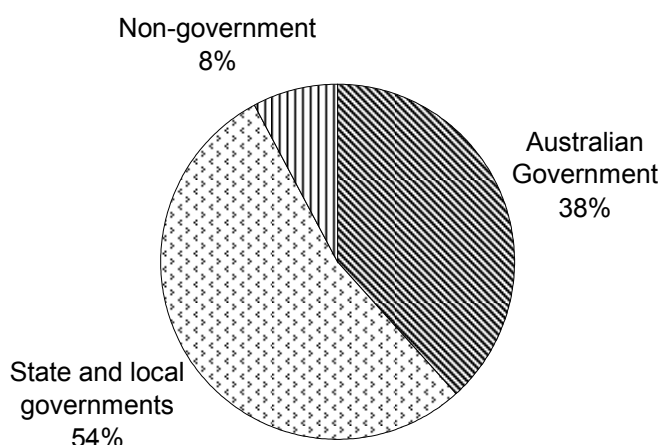
Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was \$33.7 billion in 2009-10 (table 10A.1).

The majority of total public hospital recurrent expenditure is spent on admitted patients. Non-admitted patients account for a much smaller share. For selected public hospitals, in 2009-10, the proportion of total public hospital recurrent expenditure that related to the care of admitted patients (based on the admitted patient cost proportion) was 71.0 per cent across Australia (AIHW 2011a).

Funding for public hospitals comes from a number of sources. The Australian, State and Territory governments contributed about 92.2 per cent of funding for public hospitals in 2009-10 (figure 10.1). Public hospitals accounted for 41.1 per cent of government recurrent expenditure on health services in 2009-10 (AIHW 2011b).

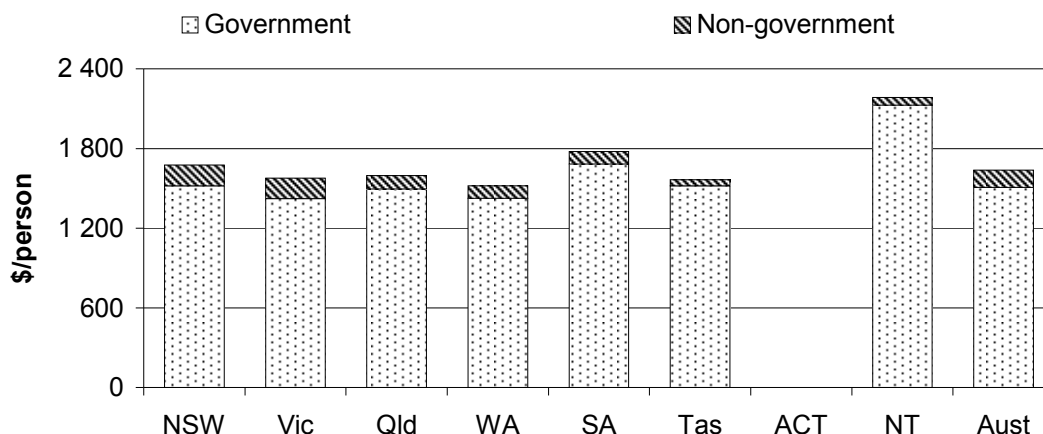
Figure 10.1 Recurrent expenditure, public hospitals, by source of funds, 2009-10



Source: AIHW (unpublished), Health expenditure database.

Non-government sources contributed 7.8 per cent of all recurrent expenditure on public hospitals in 2009-10 (figure 10.2 and table 10A.2). Non-government expenditure comprised revenue from health insurance funds, individuals and workers' compensation and compulsory third-party motor vehicle insurers as well as other sources. The proportion of hospital revenue per person funded from non-government sources varied across jurisdictions in 2009-10 (figure 10.2).

Figure 10.2 Source of public hospital recurrent expenditure, 2009-10^{a, b, c}



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

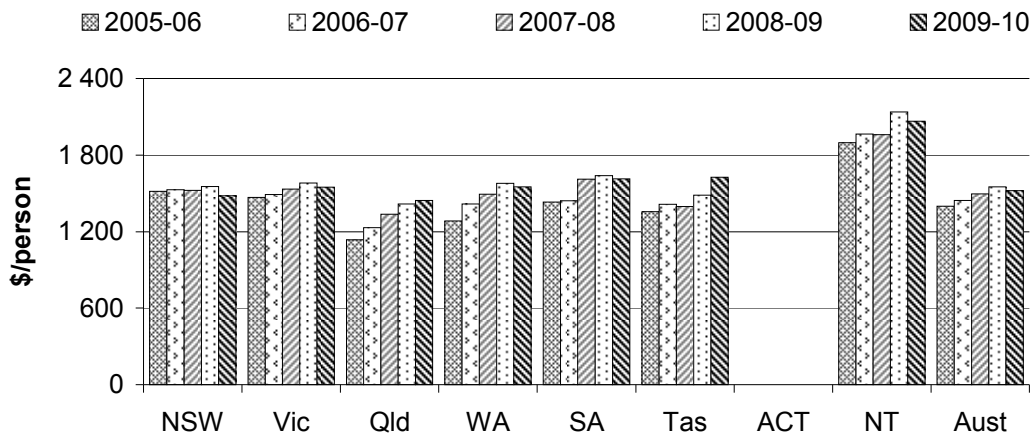
Source: AIHW (unpublished), Health expenditure database; table 10A.2.

Expenditure data in figures 10.1 and 10.2 are sourced from unpublished data from the AIHW Health Expenditure Australia database, and are not directly comparable with other expenditure data used in this chapter, which are drawn from *Australian Hospital Statistics 2009-10* (AIHW 2011a). The AIHW publication *Health Expenditure Australia 2009-10* discusses the differences in the expenditure data between the two sources (AIHW 2011b).

In 2009-10, government real recurrent expenditure on public hospitals was \$1521 per person for Australia, up from \$1400 in 2005-06 (in 2009-10 dollars) (figure 10.3). It is difficult to make comparisons between jurisdictions based on these recurrent expenditure data, due to differences in the coverage of the data. Some of the differences are:

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

Figure 10.3 Real recurrent expenditure per person, public hospitals (including psychiatric) (2009-10 dollars)^{a, b, c, d, e, f, g}



^a Expenditure data exclude depreciation and interest payments. ^b Recurrent expenditure on purchase of public hospital services at the State, or area health service level, from privately owned and/or operated hospitals is excluded. ^c Expenditure data are deflated using the hospital/nursing home care price index from AIHW (2010b). ^d Queensland pathology services were purchased from a Statewide pathology service rather than being provided by hospital employees. ^e Data for WA from 2006-07 include expenditure for public patients at Joondalup and Peel Health Campuses. Expenditures for these patients are not included in previous years. ^f For Tasmanian hospitals for 2005-06, data for one hospital are not included. ^g ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditures for NSW residents. Thus the ACT population is not the appropriate denominator.

Source: AIHW (various years), *Australian hospital statistics*, Health Services Series, Cat. nos HSE 50, 55, 71, 84 and 107; AIHW (2011), *Health expenditure Australia 2009-10*, Health and Welfare Expenditure Series No. 46, Cat. no. HWE 55. Canberra, AIHW; table 10A.3.

Size and scope of sector

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

Hospitals

In 2009-10, Australia had 753 public hospitals (table 10A.4) (including 17 psychiatric hospitals) (AIHW 2011a). Although 71.3 per cent of hospitals had 50 or fewer beds, these smaller hospitals represented only 15.8 per cent of total available beds (figure 10.4 and table 10A.4).

Figure 10.4 Public hospitals, by size, 2009-10^{a, b, c, d, e}



^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. ^e The ACT did not have hospitals with more than 10 to 50 beds or more than 50 to 100 beds. The NT did not have hospitals with 10 or fewer beds.

Source: AIHW (2011), *Australian Hospital Statistics 2009-10*, Health Services Series No. 40, Cat no. HSE 107; table 10A.4.

Beds

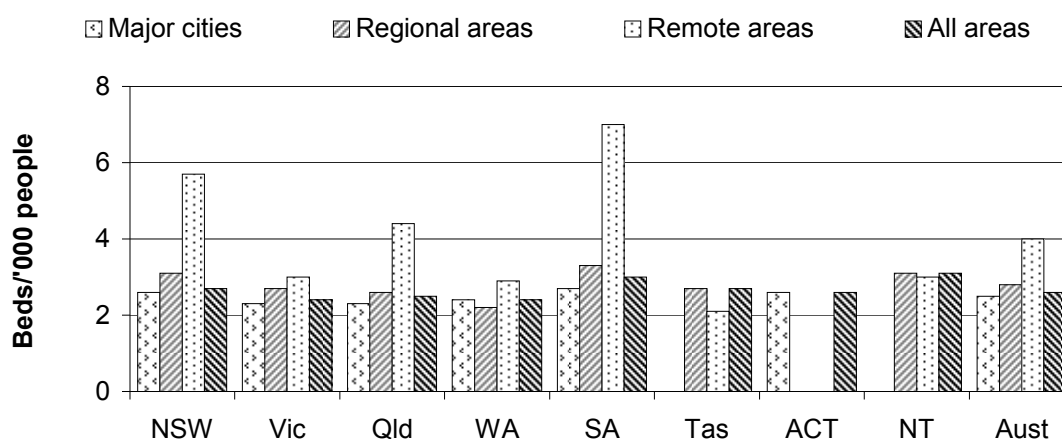
There were 56 900 available beds for admitted patients in public hospitals in 2009-10 (table 10A.4). The concept of an available bed is becoming less important in the overall context of hospital activity, particularly given the increasing significance of same day hospitalisations and hospital-in-the-home care (AIHW 2011a).

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 admission practices and how available beds are counted, both across jurisdictions and over time.

Nationally, more beds were available per 1000 people in remote areas (figure 10.5). The patterns of bed availability can reflect a number of factors, including patterns of availability of other healthcare services, patterns of disease and injury and the relatively poor health of Indigenous people, who have higher population concentrations in remote areas (AIHW 2006). These data also need to be viewed in the context of the age and sex structure (reported in appendix A) and the morbidity

and mortality (reported in the 'Health sector summary') of the population in each State and Territory.

Figure 10.5 Available beds, public hospitals, by location, 2009-10^{a, b, c, d}



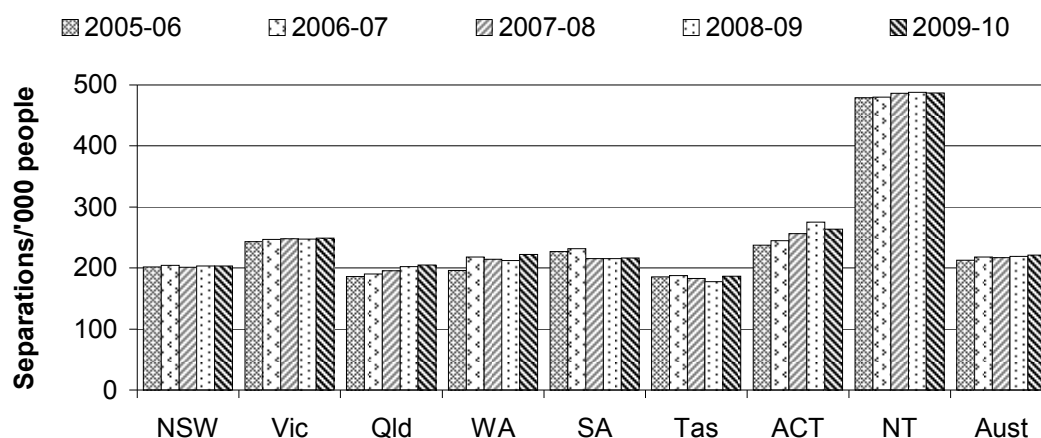
^a An 'available bed' is one that is immediately available for exclusive or predominate use by admitted patients. A bed is immediately available for use if it is located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period. Both occupied and unoccupied beds 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 (HDSC 2008). ^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 2011a). ^c Tasmania and the NT do not have major cities and the ACT does not have remote areas. ^d There were no available beds in regional areas in the ACT.

Source: AIHW (2011), *Australian Hospital Statistics 2009-10*, Health Services Series No. 40, Cat no. HSE 107; table 10A.5.

Admitted patient care

There were approximately 5.1 million separations from public (non-psychiatric) hospitals in 2009-10 (table 10A.6). Nationally, this translates into 220.9 separations per 1000 people (figure 10.6). Acute separations accounted for 95.9 per cent of separations from public hospitals, newborns with some qualified days accounted for 1.1 per cent (newborn qualification status is defined in section 10.8) and rehabilitation care accounted for 1.6 per cent (table 10A.13). Palliative care, non-acute care and other care made up the remainder. Public psychiatric hospitals accounted for around 0.2 per cent of total separations in public hospitals in 2009-10. Of the total number of separations in public (non-psychiatric) hospitals, 50.9 per cent were for same day patients (table 10A.6).

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



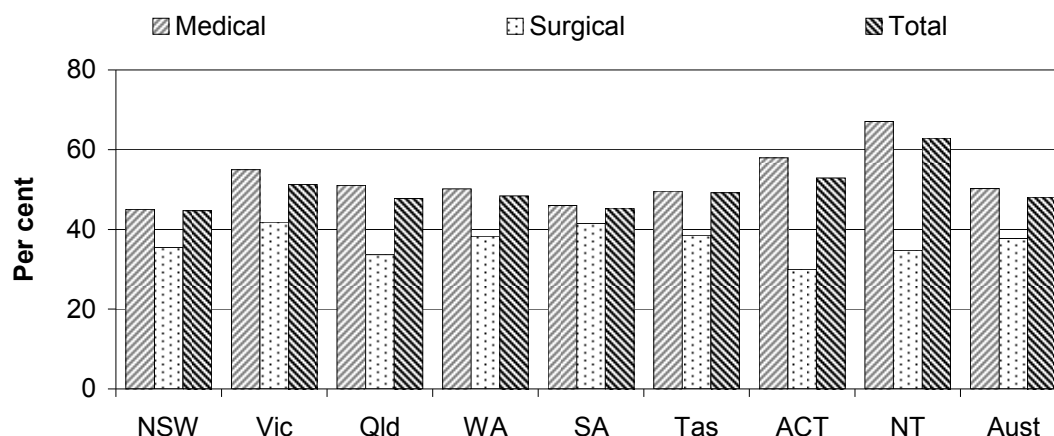
^a Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders (hospital boarder is defined in section 10.8) and posthumous organ procurement. ^b Rates are directly age standardised to the Australian population at 30 June 2001. ^c Data for WA from 2006-07 include separations for public patients at Joondalup and Peel Health Campuses. Separations for these patients are not included in previous years.

Source: AIHW (various years), *Australian Hospital Statistics*, Health Services Series, Cat. nos HSE 50, 55, 71, 84 and 107; table 10A.7.

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

Variations in admission rates can reflect different practices in classifying patients as either admitted same day patients or outpatients. The extent of differences in classification practices can be inferred from the variation in the proportion of same day separations across jurisdictions for certain conditions or treatments. This is particularly true of medical separations. Significant variation across jurisdictions in the proportion of same day medical separations was evident in 2009-10 (figure 10.7). Lower jurisdictional variation is likely in admission practices for surgical procedures, as reflected by the lower variability in the proportion of same day surgical separations.

Figure 10.7 Proportion of medical, surgical and total separations that were same day, public (non-psychiatric) hospitals, 2009-10^a



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

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

Persons aged 55 years and over accounted for half of the separations in public hospitals (51.3 per cent) in 2009-10, even though they accounted for only 24.7 per cent of the estimated resident population at 31 December 2009 (table 10A.9 and AIHW 2011a).

The 10 AR-DRGs that accounted for the most overnight acute separations in public hospitals (17.5 per cent of all overnight acute separations recorded) in 2009-10 are shown in table 10A.14. Giving birth by vaginal delivery without catastrophic or severe complications accounted for the most overnight acute separations (4.3 per cent) followed by chest pain (2.3 per cent).

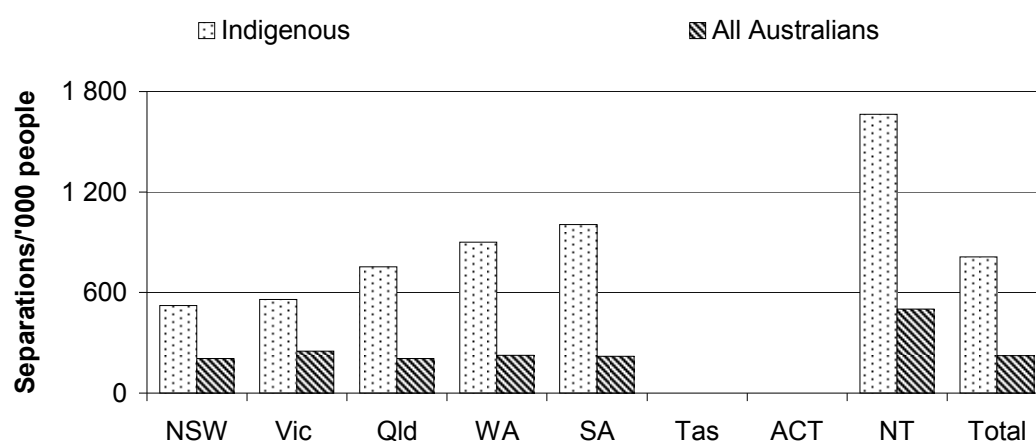
The 10 AR-DRGs that accounted for the most patient days (17.7 per cent of all patient days recorded) in 2009-10 are shown in table 10A.15. Schizophrenic disorders associated with mental health legal status accounted for the largest number of patient days (3.3 per cent), followed tracheostomy or ventilation greater than 95 hours (2.4 per cent) (table 10A.15).

Admitted patient care for Indigenous patients

The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. Efforts to improve Indigenous identification across states and territories are ongoing. In 2009-10, on an age standardised basis, 813.4 public hospital separations (including same day separations) for Indigenous

patients were reported per 1000 Indigenous people in NSW, Victoria, Queensland, WA, SA and the NT combined. This rate was markedly higher than the corresponding rate of 224.3 per 1000 for these jurisdictions' combined total population (figure 10.8).

Figure 10.8 Estimates of public hospital separations, by Indigenous status of patient, 2009-10^{a, b, c}



^a The rates are directly age standardised to the Australian population at 30 June 2001. ^b Identification of Indigenous patients is not considered complete and completeness varies across jurisdictions. ^c Data are reported for NSW, Victoria, Queensland, WA, SA and NT. These six jurisdictions are considered to have acceptable quality of Indigenous identification. The total comprises these jurisdictions only.

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

Hospital episodes of care involving dialysis accounted for 42 per cent of all hospitalisations for Indigenous people (compared with 12 per cent for other Australians) in the period July 2006 to June 2008. The Indigenous hospitalisation rate for dialysis was 11 times as high as the rate for other Australians. After adjusting for age differences, the hospitalisation rate (excluding dialysis) for Indigenous people in the two years to June 2008 was 432 per 1000 population compared with 310 per 1000 population for other Australians (1.4 times as high) (AHMAC 2011).

In 2009-10, separations for Indigenous people accounted for around 3.7 per cent of total separations and 5.8 per cent of separations in public hospitals in NSW, Victoria, Queensland, WA, SA and the NT combined (table 10A.10). Indigenous people made up only around 2.5 per cent of the population in these jurisdictions (tables AA.2 and AA.7). Most separations involving Indigenous patients (92.3 per cent) in these jurisdictions occurred in public hospitals (table 10A.10).

Non-admitted patient services

There is no agreed classification system for services to non-admitted patients, so activity is difficult to measure consistently and cannot be compared across jurisdictions. As well as differences in the way data are collected, differing admission practices lead to variation in the services reported across jurisdictions. In addition, states and territories can differ in the extent to which these types of services are provided in non-hospital settings (such as community health centres) (AIHW 2006). Services to non-admitted patients are measured in terms of occasions of service. Differences in the complexity of the occasion of service are not taken into account — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids (AIHW 2001).

A total of 49.5 million individual occasions of service were provided to non-admitted patients in public acute hospitals in 2009-10 (table 10.1). In addition, public hospitals delivered 327 855 group sessions during this time (a group session is defined as a service provided to two or more patients, excluding services provided to two or more family members) (table 10A.16). In public acute hospitals in 2009-10, accident and emergency services comprised 14.9 per cent of all individual occasions of service to non-admitted patients. ‘Other medical, surgical and obstetric services’ (24.2 per cent), ‘pathology services’ (16.9 per cent) and ‘pharmacy’ (10.0 per cent) were other common types of non-admitted patient care (table 10.1).

Table 10.1 Non-admitted patient occasions of service, by type of non-admitted patient care, public acute hospitals, 2009-10^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^b</i>	<i>Aust</i>
Occasions of service for the most common types of non-admitted patient care as a proportion of all occasions of service for non-admitted patients (%)									
Accident and emergency	11.4	20.1	14.2	16.7	25.5	20.2	16.3	26.4	14.9
Pathology	13.0	10.2	35.3	10.5	–	25.5	5.6	21.1	16.9
Radiology and organ imaging	4.3	8.2	9.2	9.4	10.7	4.0	12.8	15.4	7.1
Pharmacy ^c	16.6	5.9	5.6	4.3	–	7.7	0.2	8.0	10.0
Other medical/surgical/obstetric	24.3	20.8	24.3	16.1	42.7	28.1	52.9	26.8	24.2
Mental health	3.2	8.8	0.7	1.6	1.3	0.2	0.3	–	3.2
Dental	2.3	4.5	–	0.3	0.4	0.2	–	–	1.7
Allied health	3.2	13.7	5.8	22.3	8.1	14.1	4.6	2.3	7.8
Other non-admitted services									
Community health	6.7	3.7	1.3	13.1	0.3	–	4.0	–	5.1
District nursing ^d	6.7	2.9	1.0	3.2	0.4	–	–	–	3.9
Most common types of non-admitted patient care (%)	91.7	98.8	97.6	97.5	89.5	99.9	96.7	100.0	94.9
Total occasions of service for non-admitted patients ('000)	21 417	7 932	11 079	4 921	2 174	790	657	502	49 471

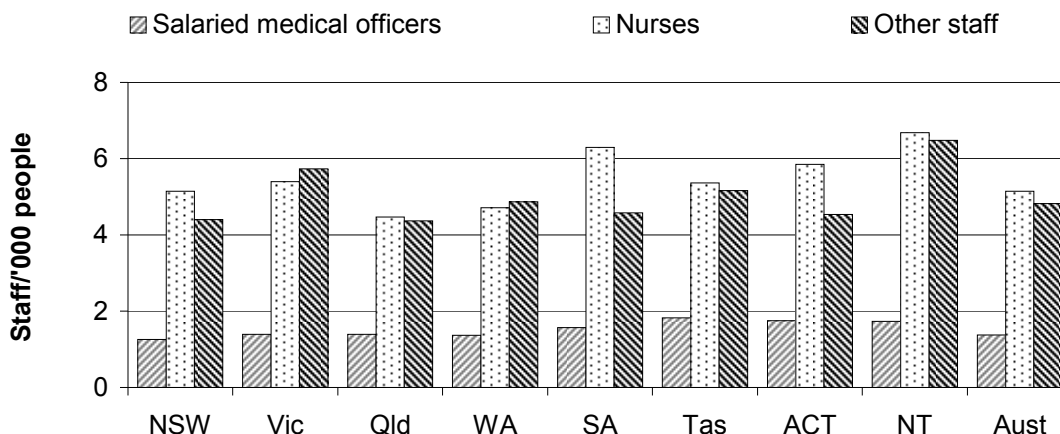
^a Individual non-admitted patient care services. Excludes group sessions. Reporting arrangements vary significantly across jurisdictions. ^b Radiology figures for the NT are underestimated and pathology figures relate to only three of the five hospitals. ^c Justice Health (formerly known as Corrections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

Source: AIHW (2011), *Australian Hospital Statistics 2009-10*, Health Services Series No. 40, Cat no. HSE 107; table 10A.16.

Staff

In 2009-10, nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (5.1 per 1000 people in Australia) (figure 10.9). 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 and can explain some of the differences in FTE staff in some staffing categories across jurisdictions (AIHW 2011a).

Figure 10.9 **Average FTE staff per 1000 people, public hospitals, 2009-10^{a, b, c, d, e}**



^a 'Other staff' include diagnostic and allied health professionals, other personal care staff, administrative and clerical staff, and domestic and other staff. ^b Staff per 1000 people are calculated from ABS population data at 31 December 2009 (table AA.2). ^c For Victoria, FTEs can be slightly understated. ^d Queensland pathology services staff employed by the State pathology service are not included. ^e Data for two small Tasmanian hospitals are not included.

Source AIHW (2011), *Australian Hospital Statistics 2009-10*, Health Services Series No. 40, Cat no. HSE 107; ABS (unpublished), *Australian Demographic Statistics*, December Quarter 2009, Cat. no. 3101.0; tables 10A.12 and AA.2.

10.2 Framework of performance indicators for public hospitals

Public hospitals performance is reported against objectives that are common to public hospitals in all jurisdictions (box 10.1). The 'Health sector summary' 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.

The Council of Australian Governments (COAG) has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations). The National Healthcare Agreement (NHA) covers the area of health, and health indicators in the National Indigenous Reform Agreement (NIRA) establish specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. Both agreements include sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance

indicators reported in this chapter are aligned with health performance indicators in the NHA.

Box 10.1 Objectives for public hospitals

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

- safe and of high quality
- appropriate and responsive to individual needs
- affordable, timely and accessible
- equitably and efficiently delivered.

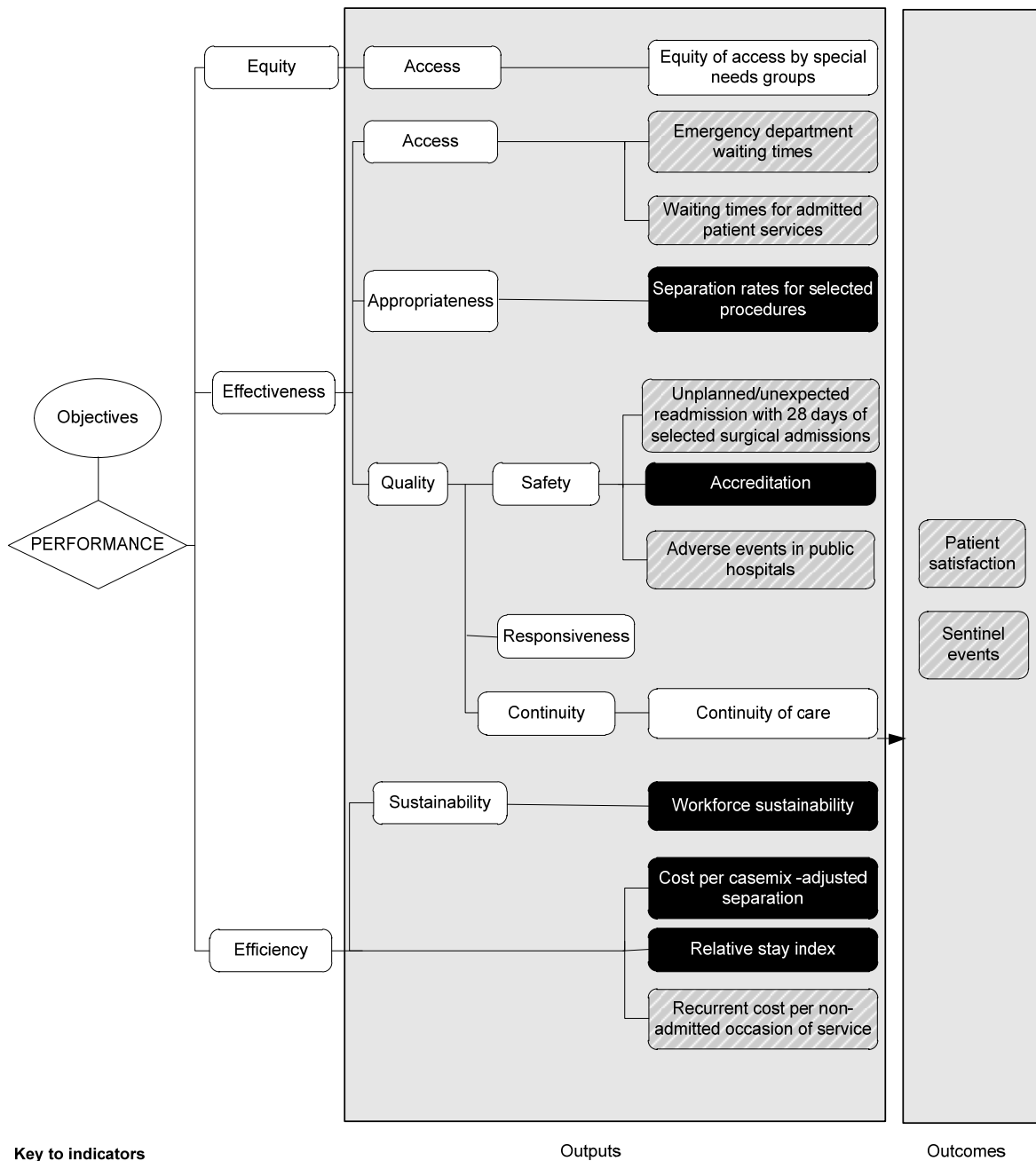
The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of public hospitals (figure 10.10). The performance indicator framework shows which data are comparable in the 2012 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

The Report's statistical appendix 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) (appendix A).

For this Report, the framework has been revised to report a number of indicators with similar characteristics as separate measures under new high level indicators:

- 'Waiting times for elective surgery' and 'Waiting times for admission following emergency department care' are reported as separate measures under the 'Waiting times for admitted patient services' indicator
- 'Healthcare associated *Staphylococcus aureus* bacteraemia in acute care hospitals', 'Falls resulting in patient harm in hospitals', 'Intentional self harm in hospitals', 'Adverse drug events in hospitals' and 'Pressure ulcers in hospitals' are reported as separate measures under the 'Adverse events in public hospitals' indicator
- 'Recurrent cost per casemix adjusted separation' and 'Total cost per casemix adjusted separation' are reported as separate measures under the 'Cost per casemix adjusted separation' indicator.

Figure 10.10 Public hospitals performance indicator framework



Key to indicators

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

10.3 Key performance indicator results for public hospitals

Different delivery contexts, locations and types of client can affect the equity, effectiveness and efficiency of health services.

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

Outputs

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

Equity — access

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

Equity of access by special needs groups

‘Equity of access by special needs groups’ is an indicator of governments’ objective to provide accessible services (box 10.2).

Box 10.2 Equity of access by special needs groups

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

‘Equity of access by special needs groups’ has been identified as a key area for development in future Reports. Data for the ‘Emergency department waiting times’ and ‘Waiting times for admitted patient services’ indicators are reported by Indigenous status and remoteness.

Effectiveness — access

Emergency department waiting times

‘Emergency department waiting times’ is an indicator of governments’ objective to provide accessible services (box 10.3).

Box 10.3 Emergency department waiting times

‘Emergency department waiting times’ measures the proportion of patients seen within the benchmarks set by the Australasian Triage Scale. The Australasian Triage Scale is a scale for rating clinical urgency, designed for use in hospital-based emergency services in Australia and New Zealand.

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, 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 (HDSC 2008).

(Continued next page)

Box 10.3 (Continued)

A high or increasing proportion of patients seen within the benchmarks set for each triage category is desirable.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage (table 10.2) and clinical practices — in particular, the allocation of cases to urgency categories. The proportion of patients in each triage category who were subsequently admitted can indicate the comparability of triage categorisations across jurisdictions and thus the comparability of the waiting times data (table 10A.17).

Nationally, in 2010-11, 100 per cent of patients in triage category 1 were seen within the clinically appropriate timeframe, and 79 per cent of patients in triage category 2 were seen within the clinically appropriate timeframe. For all triage categories combined, 70 per cent of patients were seen within triage category timeframes (table 10.2).

Emergency department waiting times by Indigenous status and remoteness, for peer group A and B hospitals are reported in the attachment (tables 10A.19 and 10A.20). Nationally, there was little difference between Indigenous and non-Indigenous people in the percentages of patients treated within national benchmarks across the triage categories, although there were variations across states and territories for some triage categories (table 10A.19). At the national level, there was variation in waiting times across triage categories by remoteness, although there was less variation for the most serious category of resuscitation (table 10A.20).

Table 10.2 Emergency department patients seen within triage category timeframes, public hospitals (per cent)^a

<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>
2009-10									
1 — Resuscitation ^b	100	100	99	99	100	99	100	100	100
2 — Emergency	82	80	77	71	78	71	83	63	78
3 — Urgent	70	71	60	55	63	52	60	49	65
4 — Semi-urgent	73	67	66	64	63	63	56	51	68
5 — Non-urgent	89	85	89	92	85	88	77	91	88
Total	75	72	66	64	67	63	63	56	70
Data coverage ^c	83	90	72	73	67	89	100	100	81
2010-11									
1 — Resuscitation ^b	100	100	100	99	100	100	100	100	100
2 — Emergency	83	81	78	71	78	72	82	65	79
3 — Urgent	71	70	60	50	66	55	54	53	65
4 — Semi-urgent	73	65	67	65	70	63	49	54	68
5 — Non-urgent	88	86	90	92	88	83	76	90	88
Total	76	71	67	63	71	62	58	58	70
Data coverage ^c	na	na	na	na	na	na	na	na	na

^a Values are derived from all hospitals that reported to the Non-admitted Patient Emergency Department Care Database, including all principal referral and specialist women's and children's hospitals, large hospitals and public hospitals that were classified to other peer groups. ^b Resuscitation patients whose waiting time for treatment was less than or equal to two minutes are considered to have been seen on time. ^c Data coverage is estimated as the number of occasions of service with waiting times data divided by the number of emergency department occasions of service. This can underestimate coverage because some occasions of service are for other than emergency presentations. For some jurisdictions, the number of emergency department occasions of service reported to the Non-admitted Patient Emergency Department Care Database exceeded the number of accident and emergency occasions of service reported to the National Public Hospital Establishments Database. For these jurisdictions the coverage has been estimated as 100 per cent.

Source: AIHW (2011), *Australian hospital statistics 2010–2011: emergency department care and elective surgery waiting times*. Health services series no. 41. Cat. no. HSE 115. Canberra; AIHW (2010), *Australian hospital statistics 2009–10: emergency department care and elective surgery waiting times*. Health services series no. 38. Cat. no. HSE 93. Canberra: AIHW; table 10A.17.

Waiting times for admitted patient services

‘Waiting times for admitted patient services’ is an indicator of governments’ objective to provide accessible services (box 10.4). Elective surgery patients who wait longer are likely to suffer discomfort and inconvenience, and more urgent patients can experience poor health outcomes as a result of extended waits.

Box 10.4 **Waiting times for admitted patient services**

‘Waiting times for admitted patient services’ is defined by three measures:

- ‘Overall elective surgery waiting times’ are calculated by comparing the date on which patients are added to a waiting list with the date on which they are admitted. Days on which the patient was not ready for care are excluded. ‘Overall waiting times’ are presented as the number of days within which 50 per cent of patients are admitted and the number of days within which 90 per cent of patients are admitted. The proportion of patients who waited more than one year is also shown.
- ‘Elective surgery waiting times by clinical urgency category’ reports the proportion of patients who were admitted from waiting lists after an extended wait. The three generally accepted clinical urgency categories for elective surgery are:
 - category 1 — 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 — admission is desirable within 90 days for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency
 - category 3 — admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency. The desirable timeframe for this category is admission within 365 days.

The term ‘extended wait’ is used for category 3 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.

- Waiting times for admission following emergency department care is currently expected to measure the percentage of patients who present to a public hospital emergency department and are admitted to the same hospital, whose time in the emergency department is less than 8 hours. This indicator is being developed as part of the NHA reporting process. Waiting times for admission following emergency department care has been identified as a key area for development in future Reports.

For ‘Overall elective surgery waiting times’ a low or decreasing number of days waited at the 50th and 90th percentiles, and a low or decreasing proportion of people waiting more than 365 days are desirable.

(Continued on next page)

Box10.4 (Continued)

For 'Elective surgery waiting times by clinical urgency category' a low or decreasing proportion of patients who have experienced extended waits at admission is desirable. However, variation in the way patients are classified to urgency categories should be taken into account. Rather than comparing jurisdictions, the results for individual jurisdictions should be viewed in the context of the proportions of patients assigned to each of the three urgency categories (table 10.4).

Data reported for this indicator are not directly comparable.

Partial data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Waiting times for elective surgery

The elective surgery waiting times data are provided for waiting lists managed by public acute hospitals. The data collection covers most public hospitals that undertake elective surgery, and in 2010-11 covered 93 per cent of separations for elective surgery in public acute hospitals (table 10.3).

Patients on waiting lists who were not subsequently admitted to hospital are excluded. Patients can 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 2011c). In 2010-11, 13.9 per cent of patients who were removed from waiting lists were removed for reasons other than elective admission (AIHW 2011c).

Comparisons between jurisdictions should be made with caution due to differences in clinical practices and classification of patients across Australia. The measures are affected by variations across jurisdictions in the method used to calculate waiting times for patients who transferred from a waiting list managed by one hospital to a waiting list managed by a different hospital. For patients who were transferred from a waiting list managed by one hospital to that managed by another, the time waited on the first list is included in the waiting time reported for some but not all states and territories (AIHW 2011c). NSW, SA and the NT reported the total time waited on all waiting lists. This approach can have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions (AIHW 2011c).

Nationally, in 2010-11, 90 per cent of patients were admitted within 252 days and 50 per cent were admitted within 36 days (table 10.3). The proportion of patients

who waited more than a year was 2.9 per cent. Nationally, waiting times at the 50th percentile increased by four days between 2006-07 and 2010-11, from 32 to 36 days. However, there were different trends for different jurisdictions and for different sized hospitals over that period (figure 10.11 and table 10A.21).

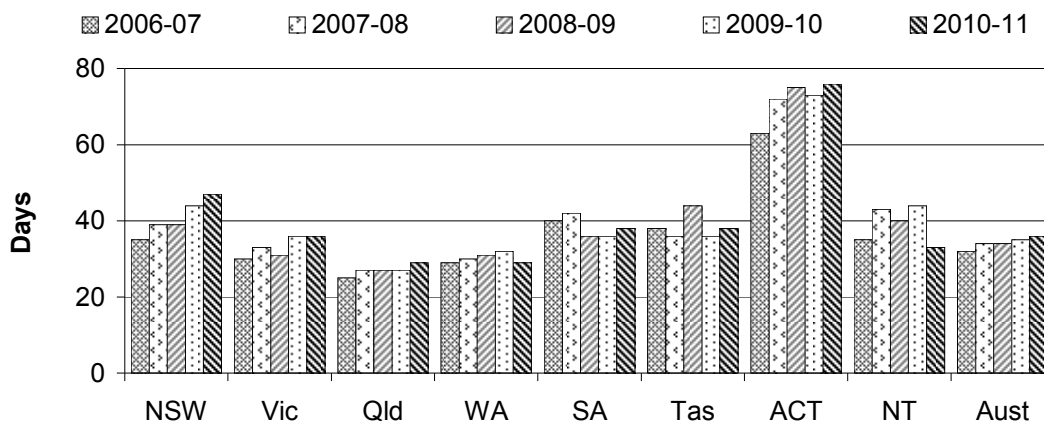
Table 10.3 Elective surgery waiting times, public hospitals

	<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>
2009-10										
Number of days waited at:										
50th percentile	no.	44	36	27	32	36	36	73	44	35
90th percentile	no.	330	197	150	161	189	332	357	271	246
Proportion who waited more than 365 days	%	4.9	2.8	2.5	1.5	1.1	8.7	9.5	5.8	3.5
Estimated coverage of elective surgery separations ^a	%	100	78	100	79	68	100	97	100	91
2010-11										
Number of days waited at:										
50th percentile	no.	47	36	29	29	38	38	76	33	36
90th percentile	no.	333	182	148	159	208	359	378	223	252
Proportion who waited more than 365 days	%	3.6	2.5	1.3	1.6	2.0	9.6	10.8	3.9	2.9
Estimated coverage of elective surgery separations ^a	%	100	78	98	92	71	100	100	100	93

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

Source: AIHW (2011), *Australian hospital statistics 2010–2011: emergency department care and elective surgery waiting times*. Health services series no. 41. Cat. no. HSE 115. Canberra; AIHW (2010), *Australian hospital statistics 2009–10: emergency department care and elective surgery waiting times*. Health services series no. 38. Cat. no. HSE 93. Canberra: AIHW; table 10A.21.

Figure 10.11 Days waited for elective surgery by the 50th percentile, public hospitals



Source: AIHW (various years), *Australian Hospital Statistics*, Health Services Series, Cat nos. HSE 50, 55, 71, 84 and 107; AIHW (2011), *Australian hospital statistics 2010–2011: emergency department care and elective surgery waiting times*. Health services series no. 41. Cat. no. HSE 115. Canberra: AIHW; table 10A.21.

Attachment 10A includes data on ‘elective surgery waiting times’ by hospital peer group, specialty of surgeon and indicator procedure. It also includes waiting times by remoteness and by Indigenous status (tables 10A.21–10A.25). Those living in regional and very remote areas had longer waiting times than those in major cities at the 50th and 90th percentiles at the national level (table 10A.24). Nationally, Indigenous people had longer waiting times for elective surgery than non-Indigenous people at the 50th percentile and 90th percentiles (table 10A.23).

‘Elective surgery waiting times by urgency category’ data not only provide an indication of the extent to which patients are seen within a clinically desirable time, but also draw attention to the variation in the way in which patients are classified across jurisdictions. Jurisdictional differences in the classification of patients by urgency category in 2009-10 are shown in table 10.4. The states and territories with lower proportions of patients in category 1 tended to have smaller proportions of patients in this category who were ‘not seen on time’. NSW, Victoria and the ACT, for example, had the lowest proportions of patients in category 1 and also had low proportions of patients in category 1 who had extended waits (tables 10.4, 10A.26, 10A.28 and 10A.38).

The system of urgency categorisation for elective surgery in public hospitals is important to ensure that priority is given to patients according to their needs. While elective surgery waiting times by urgency category are not comparable across jurisdictions, this measure has the advantage over other measures in that it provides

an indication of the extent to which patients are seen within a clinically desirable time period according to the urgency category to which they have been assigned.

Under the National Health Reform Agreement — National Partnership Agreement on Improving Public Hospital Services, following an expert panel review of the National Partnership Agreement, a review will be conducted of the elective surgery categories, focusing on safety issues and practical impediments to achieving the targets that have been set under this agreement from 2012 onwards. The review will be auspiced by Health Ministers and involve senior clinical input.

Table 10.4 Classification of elective surgery patients, by clinical urgency category, 2009-10 (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	3.0	4.0	9.2	6.2	5.1	9.5	2.8	9.4
Category 2	16.6	46.3	53.7	34.2	23.4	53.7	53.6	38.2
Category 3	80.4	49.7	37.1	59.6	71.5	36.8	43.6	52.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	27.7	26.6	39.0	28.4	31.8	39.3	29.8	42.4
Category 2	31.6	48.1	44.3	35.7	34.5	40.9	49.7	39.4
Category 3	40.7	25.3	16.7	35.9	33.6	19.8	20.4	18.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.0

Source: State and Territory governments (unpublished).

Reporting of ‘elective surgery waiting times by clinical urgency category’ includes the proportions of patients with extended waits at admission across jurisdictions. The proportions of patients on waiting lists who had already had an extended wait at the date of the census are reported in tables 10A.26, 10A.28, 10A.30, 10A.32, 10A.34, 10A.36, 10A.38 and 10A.40. Census data do not represent the completed waiting time of patients (unlike patients with extended waits at admission).

Of patients admitted from waiting lists in NSW in 2009-10, the percentage of patients classified to each category and the percentage with an extended wait were:

- 27.7 per cent were classified to category 1, of whom 7.9 per cent had an extended wait
- 31.6 per cent were classified to category 2, of whom 15.9 per cent had an extended wait
- 40.7 per cent were classified to category 3, of whom 12.1 per cent had an extended wait.

Overall in NSW, 12.1 per cent of all patients experienced extended waits (table 10.4 and table 10A.26).

Of patients admitted from waiting lists in Victoria in 2009-10, the percentage of patients classified to each category and the percentage with an extended wait were:

- 26.6 per cent were classified to category 1, of whom zero per cent had an extended wait
- 48.1 per cent were classified to category 2, of whom 27.0 per cent had an extended wait
- 25.3 per cent were classified to category 3, of whom 8.0 per cent had an extended wait.

Overall in Victoria, 15.1 per cent of all patients experienced extended waits (table 10.4 and table 10A.28).

Of patients admitted from waiting lists in Queensland in 2009-10, the percentage of patients classified to each category and the percentage with an extended wait were:

- 39.0 per cent were classified to category 1, of whom 12.8 per cent had an extended wait
- 44.3 per cent were classified to category 2, of whom 21.3 per cent had an extended wait
- 16.7 per cent were classified to category 3, of whom 11.3 per cent had an extended wait.

Overall in Queensland, 16.3 per cent of all patients experienced extended waits (table 10.4 and table 10A.30).

Of patients admitted from waiting lists in WA in 2009-10, the percentage of patients classified to each category and the percentage with an extended wait were:

- 28.4 per cent were classified to category 1, of whom 14.5 per cent had an extended wait
- 35.7 per cent were classified to category 2, of whom 24.1 per cent had an extended wait
- 35.9 per cent were classified to category 3, of whom 3.1 per cent had an extended wait.

Overall in WA, 13.8 per cent of all patients experienced extended waits (table 10.4 and table 10A.32).

Of patients admitted from waiting lists in SA in 2009-10, the percentage of patients classified to each category and the percentage with an extended wait were:

- 31.8 per cent were classified to category 1, of whom 11.2 per cent had an extended wait
- 34.5 per cent were classified to category 2, of whom 10.9 per cent had an extended wait
- 33.6 per cent were classified to category 3, of whom 3.1 per cent had an extended wait.

Overall in SA, 8.4 per cent of all patients experienced extended waits (table 10.4 and table 10A.34).

Of patients admitted from waiting lists in Tasmania in 2009-10, the percentage of patients classified to each category and the percentage with an extended wait were:

- 39.3 per cent were classified to category 1, of whom 23.3 per cent had an extended wait
- 40.9 per cent were classified to category 2, of whom 45.3 per cent had an extended wait
- 19.8 per cent were classified to category 3, of whom 19.8 per cent had an extended wait.

Overall in Tasmania, 31.6 per cent of all patients experienced extended waits (table 10.4 and table 10A.36).

Of patients admitted from waiting lists in the ACT in 2009-10, the percentage of patients classified to each category and the percentage with an extended wait were:

- 29.8 per cent were classified to category 1, of whom 6.4 per cent had an extended wait
- 49.7 per cent were classified to category 2, of whom 56.3 per cent had an extended wait
- 20.4 per cent were classified to category 3, of whom 22.0 per cent had an extended wait.

Overall in the ACT, 34.4 per cent of all patients experienced extended waits (table 10.4 and table 10A.38).

Of patients admitted from waiting lists in NT in 2009-10, the percentage of patients classified to each category and the percentage with an extended wait were:

- 42.4 per cent were classified to category 1, of whom 23.5 per cent had an extended wait
- 39.4 per cent were classified to category 2, of whom 47.8 per cent had an extended wait
- 18.2 per cent were classified to category 3, of whom 19.1 per cent had an extended wait.

Overall in the NT, 32.2 per cent of all patients experienced extended waits (table 10.4 and table 10A.40).

All jurisdictions also provided data on urgency category waiting times by clinical specialty (tables 10A.27, 10A.29, 10A.31, 10A.33, 10A.35, 10A.37, 10A.39 and 10A.41).

Effectiveness — appropriateness

Separation rates for selected procedures

‘Separation rates for selected procedures’ is an indicator of the appropriateness of public hospital services (box 10.5).

Box 10.5 Separation rates for selected procedures

‘Separation rates for selected procedures’ is defined as separations per 1000 people for certain procedures in public hospitals. The procedures are selected for their frequency, for sometimes being elective and discretionary, and because alternative treatments are sometimes available.

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

Care needs to be taken when interpreting the differences in the separation rates for the selected procedures. Variations in rates can be attributable to variations in the prevalence of the conditions being treated, or to differences in clinical practice across states and territories. Higher rates can be acceptable for certain conditions and not for others. Higher rates of angioplasties, for example, can represent appropriate levels of care, whereas higher rates of hysterectomies or tonsillectomies can represent an over-reliance on procedures. Some of the selected procedures, such as angioplasty and coronary artery bypass graft, are alternative treatment options for people diagnosed with similar conditions.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

The ‘separation rates for selected procedures’ reported here reflect the activities of the public health system. In previous Reports data for the public and private systems combined were reported. The most common procedures of those reported in 2009-10 were cataract extraction, cystoscopy, hysterectomy and cholecystectomy (table 10.5).

For all procedures, separation rates varied across jurisdictions. Statistically significant and material differences in the separation rates for these procedures can highlight variations in treatment methods across jurisdictions. Table 10A.42 reports separations for selected procedures by remoteness and Indigenous status.

Table 10.5 Separations for selected procedures per 1000 people, public hospitals, 2009-10^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
<i>Procedure/diagnosis</i>									
Cataract extraction	2.5	3.1	1.7	4.2	2.8	np	np	np	2.7
Cholecystectomy	1.3	1.4	1.2	1.1	1.4	np	np	np	1.3
Coronary angioplasty	0.9	0.8	0.7	0.8	1.0	np	np	np	0.9
Coronary artery bypass graft	0.3	0.3	0.3	0.2	0.3	np	np	np	0.3
Cystoscopy	1.5	2.7	1.8	2.9	2.4	np	np	np	2.1
Haemorrhoidectomy	0.8	0.7	0.3	0.5	0.4	np	np	np	0.6
Hip replacement	0.6	0.7	0.5	0.7	0.6	np	np	np	0.6
Hysterectomy	1.5	1.7	1.4	1.4	1.9	np	np	np	1.5
Inguinal herniorrhaphy	1.0	1.1	0.9	1.0	1.1	np	np	np	1.0
Knee replacement	0.7	0.5	0.5	0.6	0.6	np	np	np	0.6
Myringotomy (with insertion of tube)	0.4	0.8	0.6	0.7	1.3	np	np	np	0.7
Prostatectomy	0.9	1.2	0.8	0.7	1.2	np	np	np	0.9
Septoplasty	0.2	0.5	0.2	0.3	0.5	np	np	np	0.3
Tonsillectomy	0.8	1.3	0.9	1.0	1.4	np	np	np	1.0
Varicose veins, stripping and ligation	0.2	0.4	0.1	0.1	0.3	np	np	np	0.2

^a Rates are standardised to the Australian population as at 30 June 2001 and are calculated for the total population for all procedures except prostatectomy (rates calculated for the male population only) and hysterectomy (rates calculated for females aged 15–69 years). **np** Not published.

Source: AIHW (unpublished) National Hospital Morbidity Database; ABS (unpublished) Estimated Residential Population, 30 June 2009; ABS (2009) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, 30 June 2009, Series B, Cat. no. 3238.0; table 10A.42.

Effectiveness — quality

There is no single definition of quality in healthcare, but the Australian Commission on Safety and Quality in Health Care (ACSQHC) has defined quality as ‘the extent to which the properties of a service or product produces a desired outcome’ (Runciman 2006). No single indicator can measure quality across all providers. An alternative approach is to identify and report on aspects of quality of care. The aspects of quality recognised in the performance indicator framework are safety, responsiveness and continuity. This Report includes indicators of safety, but no indicators have yet been developed for responsiveness or continuity.

There has been considerable debate and research to develop suitable indicators of the quality of healthcare both in Australia and overseas. All Australian health ministers agreed to the establishment of the Australian Council for Safety and Quality in Health Care in January 2000, with a view to taking a systematic approach to assessing and improving the quality of healthcare. The Australian Council for

Safety and Quality in Health Care was replaced in January 2006 by the ACSQHC. A key objective of the ACSQHC is to achieve safe, effective and responsive care for consumers. The ACSQHC has maintained the Council's focus on improving the safety and quality in health care provided in hospitals (including private hospitals) and sought to improve the quality of primary healthcare.

Various governments publicly report performance indicators for service quality of public hospitals. Some have adopted the same indicators reported in this chapter. For example:

- The Australian Government's MyHospitals website reports *Staphylococcus aureus bacteraemia* (SAB) infections as counts and rates per 10 000 occupied bed days, and compares the rate to the national benchmark. Data are provided for most public hospitals and a number of private hospitals. This website will progressively include more hospital quality and safety indicators.
- In NSW, reporting of 'surgical site infection rates' for hip and knee surgery is mandatory for public hospitals.
- 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, pressure wound monitoring and prevention, patient satisfaction and consumer participation in health care decision making.
- Queensland Health publishes the Queensland Health annual report, which includes clinical indicator results for the largest 58 public hospitals, spanning the medical, surgical, obstetrics, gynaecology and mental health areas. Queensland Health also publishes the quarterly public hospitals performance report which, amongst other measures, includes patient satisfaction results.
- Both the WA and Tasmanian health departments' annual reports include information on 'unplanned re-admission rates' and WA also includes a section on patient satisfaction.
- SA Health publishes an annual report on patient safety, which provides a summary of the types of incidents that occurred in public hospitals, actions taken on coronial findings and progress against priority areas in the South Australian Patient Safety Framework and Strategy 2007–2011.
- The ACT Government Health Directorate publishes quarterly reports that include data on unplanned readmissions, unplanned returns to theatre and hospital acquired infection rates. Information about quality and safety activities and consumer feedback management is also included in an Annual Report.

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, Runciman et al. 2003 and Eshani et al. 2006). These adverse events can result in serious consequences for individual patients, and the associated costs to individuals and the health care system can be considerable (Eshani et al. 2006).

Safety — unplanned/unexpected readmissions within 28 days of selected surgical admissions

‘Unplanned/unexpected readmissions within 28 days of selected surgical admissions’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality (box 10.6). Patients might be re-admitted unexpectedly if the initial care or treatment was ineffective or unsatisfactory, if post discharge planning was inadequate, or for reasons outside the control of the hospital (for example poor post-discharge care).

Box 10.6 Unplanned/unexpected readmissions within 28 days of selected surgical admissions

Unplanned/unexpected readmissions within 28 days of selected surgical admissions show the rate at which patients unexpectedly return to hospital within 28 days for further treatment of the same condition.

The indicator is calculated as the number of separations that were unplanned or unexpected readmissions to the same hospital following a separation in which a selected surgical procedure was performed and which occurred within 28 days of the previous date of separation, expressed per 1000 separations in which one of the selected surgical procedures was performed.

Selected surgical procedures are knee replacement, hip replacement, tonsillectomy and adenoidectomy, hysterectomy, prostatectomy, cataract surgery and appendectomy.

‘Unexpected/unplanned’ readmissions are those having a principal diagnosis of a post-operative adverse event for which a specified ICD-10-AM diagnosis code has been assigned.

Low or decreasing rates for this indicator are desirable. Conversely, 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.

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

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

There are some difficulties in identifying re-admissions that were unplanned so the indicator is likely to be an under-estimate:

- The unplanned and/or unexpected readmissions are limited to those having a principal diagnosis of a post-operative adverse event. This does not include all possible unplanned/unexpected readmissions.
- This indicator identifies only those patients re-admitted to the same hospital, so does not include patients who go to another hospital.

Unplanned re-admission rates are not adjusted for casemix or patient risk factors, which can vary across hospitals and across jurisdictions.

Unplanned/unexpected readmissions within 28 days of selected surgical admissions in public hospitals in 2009-10 are reported in table 10.6. Unplanned/unexpected readmissions are reported by Indigenous status and remoteness in table 10A.44.

Table 10.6 Unplanned/unexpected readmissions within 28 days of selected surgical admissions in public hospitals, per 1000 separations, 2009-10

	NSW	Vic	Qld	WA ^a	SA	Tas ^a	ACT	NT	Total ^a
<i>Surgical procedure prior to separation</i>									
Knee replacement	24.5	26.0	37.1	15.0	16.1	27.6	np	np	26.2
Hip replacement	16.0	18.0	21.9	14.6	np	26.1	np	np	16.4
Tonsillectomy and Adenoidectomy	20.1	26.0	30.4	30.7	33.3	52.5	np	np	26.5
Hysterectomy	30.8	31.5	36.4	30.8	23.2	65.7	np	np	31.3
Prostatectomy	33.1	23.5	33.6	44.3	34.4	np	np	np	30.9
Cataract surgery	4.0	3.3	4.1	4.1	4.4	7.8	np	10.9	3.8
Appendicectomy	21.6	25.8	24.9	29.5	36.4	20.0	25.9	50.6	25.1

^a Total rates and numbers for Australia do not include WA and Tasmania. **np** Not published.

Source: AIHW (unpublished) Admitted Patient Care National Minimum Data Set; WA Health (unpublished); table 10A.43.

Safety — hospital accreditation

‘Accreditation’ is an indicator of governments’ objective to provide public hospital services that are of high quality (box 10.7). Data for this indicator are shown in figure 10.12.

Box 10.7 Accreditation

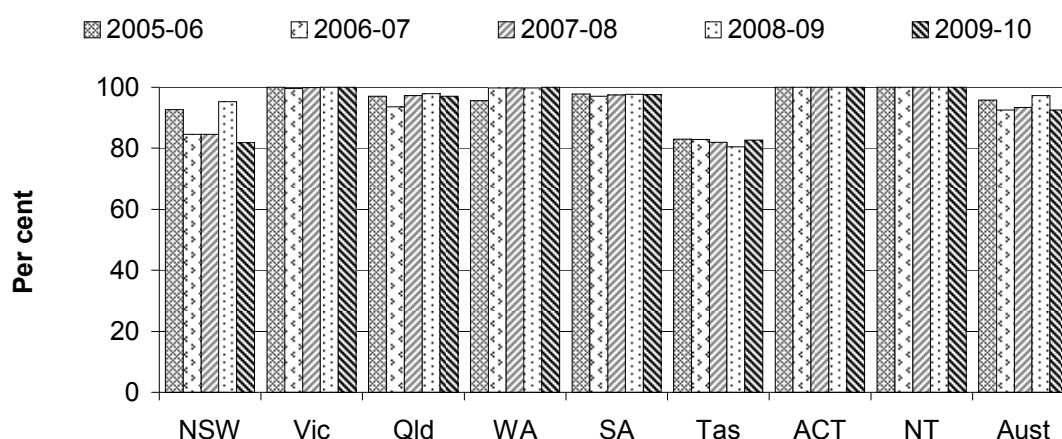
'Accreditation' is defined as the ratio of accredited beds to all beds in public hospitals. The number of beds indicates the level of hospital capacity or activity. 'Accreditation' signifies professional and national recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals can seek accreditation through the Australian Council on Health Care Standards (ACHS) Evaluation and Quality Improvement Program, Business Excellence Australia (previously known as the Australian Quality Council), the Quality Improvement Council, and through certification as compliant with the International Organisation for Standardization's (ISO) 9000 quality family or other equivalent programs. Jurisdictions apply specific criteria to determine which accreditation programs are suitable. Quality programs require hospitals to demonstrate continual adherence to quality improvement standards to gain and retain accreditation.

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

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Figure 10.12 **Proportion of accredited beds, public hospitals^{a, b}**



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

^b Includes psychiatric hospitals.

Source: AIHW (various years), *Australian Hospital Statistics*, Health Services Series, Cat nos. HSE 50, 55, 71, 84 and 107; table 10A.46.

Safety — adverse events in public hospitals

‘Adverse events in public hospitals’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality (box 10.8). Adverse events in public hospitals 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.

Box 10.8 Adverse events in public hospitals

‘Adverse events in public hospitals’ is defined by the following five measures:

- Healthcare associated *Staphylococcus aureus* bacteraemia in acute care hospitals
- Falls resulting in patient harm in hospitals
- Intentional self harm in hospitals
- Adverse drug events in hospitals
- Pressure ulcers in hospitals

Healthcare associated Staphylococcus aureus bacteraemia in acute care hospitals

‘Healthcare associated *Staphylococcus aureus* (including Methicillin-resistant *Staphylococcus aureus* [MRSA]) bacteraemia (SAB) in acute care hospitals’ is the number of SAB patient episodes associated with acute care public hospitals, expressed as a rate per 10 000 patient days for public acute care hospitals reporting for the SAB indicator.

A patient episode of SAB is defined as a positive blood culture for SAB. Only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded.

SAB is considered to be healthcare-associated if the first positive blood culture is collected more than 48 hours after hospital admission or less than 48 hours after discharge, or if the first positive blood culture is collected 48 hours or less after admission and one or more of the following key clinical criteria was met for the patient-episode of SAB:

- SAB is a complication of the presence of an indwelling medical device
- SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site
- an invasive instrumentation or incision related to the SAB was performed within 48 hours
- SAB is associated with neutropenia ($<1 \times 10^9/L$) contributed to by cytotoxic therapy.

(Continued on next page)

Box 10.8 (Continued)

Cases where a known previous blood culture has been obtained within the last 14 days are excluded.

A low or decreasing 'Healthcare associated SAB in acute care hospitals' rates is desirable.

Data reported for this measure are not directly comparable.

Falls resulting in patient harm in hospitals

Falls occurring in health care settings and resulting in patient harm is defined as the number of separations with an external cause code for fall and a place of occurrence of public health care setting, expressed as a rate per 1000 hospital separations.

A low or decreasing rate of falls resulting in patient harm in hospitals is desirable.

Data reported for this measure are comparable.

Intentional self harm in hospitals

Intentional self harm in hospitals is defined as the number of hospital separations with an external cause code for intentional self harm and a place of occurrence of public health care setting, expressed as a rate per 1000 hospital separations.

A low or decreasing rate of intentional self harm in hospitals is desirable.

Data reported for this measure are comparable.

Adverse drug events in hospitals

Adverse drug events in hospitals is currently expected to measure the number of separations with an adverse drug event occurring in hospital.

Adverse drug events in hospitals has been identified as a key area for development in future Reports. This indicator is being developed as part of the NHA reporting process.

Pressure ulcers in hospitals

Pressure ulcers in hospitals is currently expected to measure separations with a pressure ulcer in acute and subacute care settings recorded as arising during an episode of care.

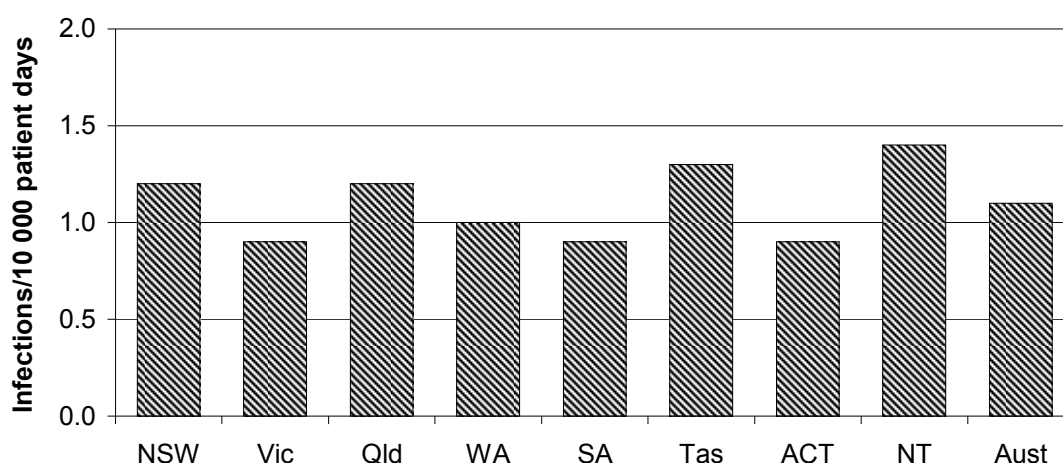
Pressure ulcers in hospitals has been identified as a key area for development in future Reports. This indicator is being developed as part of the NHA reporting process.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

*Safety — Healthcare associated *Staphylococcus aureus* bacteraemia in acute care hospitals*

Healthcare associated SAB in acute care hospitals per 10 000 patient days is reported in figure 10.13.

Figure 10.13 Healthcare associated SAB in public acute care hospitals, 2010-11^{a, b, c}



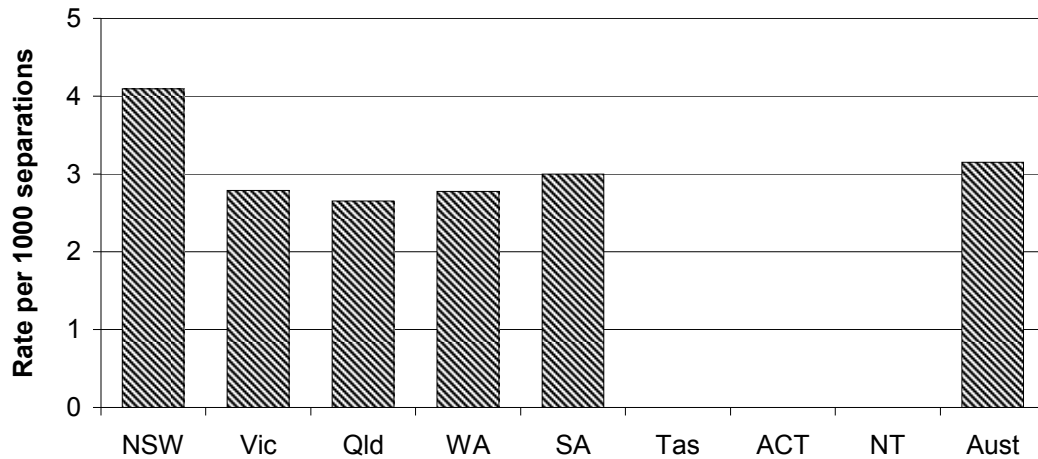
^a Comprises both Methicillin resistant *Staphylococcus aureus* and Methicillin sensitive staphylococcus aureus. ^b Queensland includes only patients 14 years of age and over. ^c The SAB patient episodes were associated with both admitted patient care and non-admitted patient care (including emergency departments and outpatient clinics). The comparability of the SAB rates among jurisdictions and over time is limited because of coverage differences and because the count of patient days reflects the amount of admitted patient activity, but does not necessarily reflect the amount of non-admitted patient activity.

Source: AIHW unpublished; table 10A.45.

Safety — falls resulting in patient harm in hospitals

The measure defines a fall in hospital as a fall for which the place of occurrence is coded as public health care setting. Public health care setting is broader in scope than hospitals, as it includes other health care settings such as day surgery centres or hospices. Data could therefore be an overestimate. Falls resulting in patient harm in public health care settings varied across states and territories in 2009-10, with a national rate of 3.2 falls per 1000 separations (figure 10.14). Data are reported by Indigenous status and remoteness in table 10A.47.

Figure 10.14 Falls resulting in patient harm in public health care settings, 2009-10^a



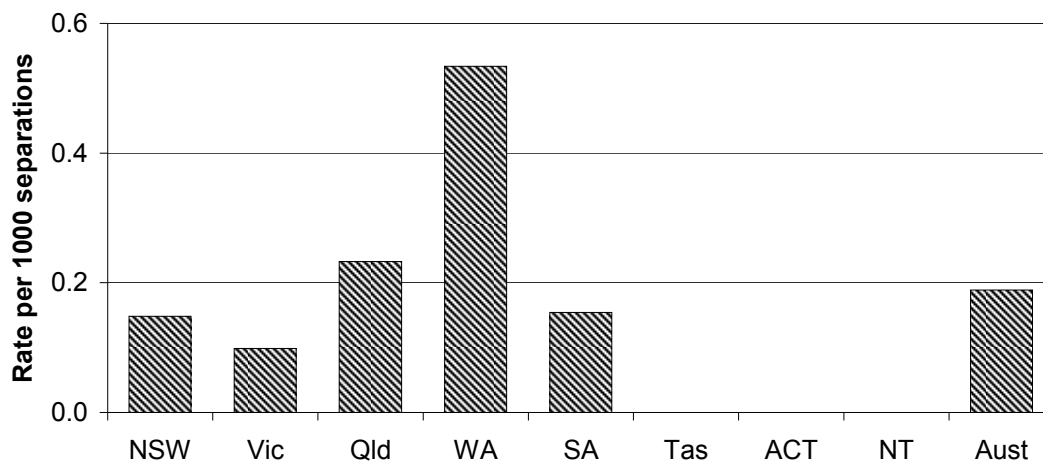
^a Data for Tasmania, the ACT and the NT are not published to protect confidentiality where the presentation could identify a patient or service provider or where rates are likely to be highly volatile.

Source: AIHW unpublished; table 10A.47.

Safety — intentional self harm in hospitals

Available data for this measure are based on the place of occurrence being a 'public health care setting'. This place of occurrence is broader in scope than hospitals, as it includes other health care settings, such as day surgery centres or hospices. Data could therefore be an overestimate. Nationally in 2009-10 occurrences of intentional self harm in public health care settings was around 0.2 per 1000 separations (figure 10.15). Data are reported by Indigenous status and remoteness in table 10A.48.

Figure 10.15 Intentional self harm in public health care settings, 2009-10^a



^a Data for Tasmania, the ACT and the NT are not published to protect confidentiality where the presentation could identify a patient or service provider or where rates are likely to be highly volatile.

Source: AIHW unpublished; table 10A.48.

Responsiveness

The Steering Committee has identified the responsiveness of public hospitals as an area for development in future Reports.

Continuity — continuity of care

‘Continuity of care’ is an indicator of governments’ objective to provide public hospital services that are of high quality (box 10.9).

Box 10.9 Continuity of care

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

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

Sustainability

Workforce sustainability

‘Workforce sustainability’ is an indicator of governments’ objective to provide sustainable public hospital services (box 10.10). Labour, particularly nurses and medical practitioners, is the most significant and costly resource used in providing public hospital services (figure 10.22), and the sustainability of the workforce helps determine whether sustainability problems might arise in the future delivery of public hospital services.

The sustainability of the public hospital workforce is affected by a number of factors, in particular, whether the number of new entrants are sufficient to maintain the existing workforce, and the proportion of the workforce who are close to retirement.

Box 10.10 Workforce sustainability

‘Workforce sustainability’ reports age profiles for nurse and medical practitioner workforces. It shows the proportions of registered nurses and medical practitioners in ten year age brackets, by jurisdiction and by region.

A high or increasing proportion of the workforce who are new entrants and/or a low or decreasing proportion of the workforce who are close to retirement is desirable.

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

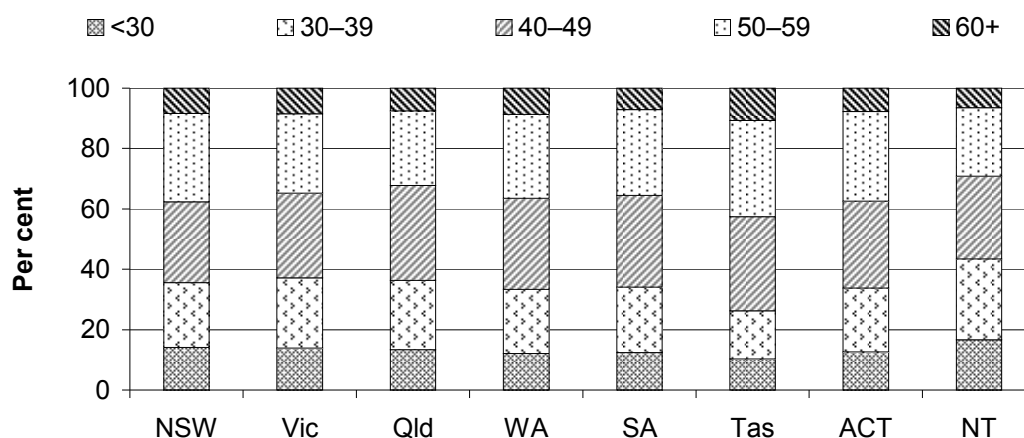
These measures are not a substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. They can, however, indicate that further attention should be given to workforce sustainability for public hospitals.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

The age profile of the nursing workforce (which includes midwives) for 2009 for each jurisdiction is shown in figure 10.16. Nursing workforce data by remoteness area for 2009 are shown in figure 10.17.

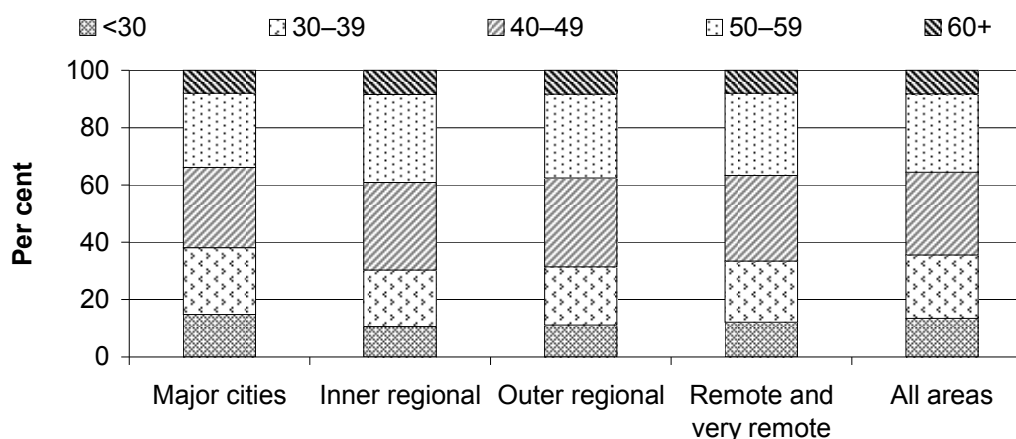
Figure 10.16 Nursing workforce, by age group, 2009^a



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

Source: AIHW (unpublished) *Nursing and Midwifery Labour Force Survey*; table 10A.50.

Figure 10.17 Nursing workforce, by age group and remoteness area, 2009^a

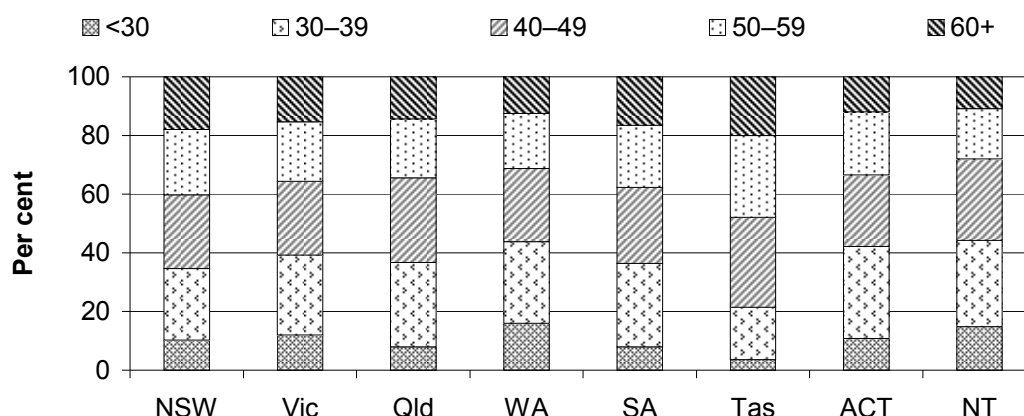


^a Includes registered and enrolled nurses (including midwives) who are employed in nursing, nurses on extended leave and nurses looking for work in nursing.

Source: AIHW (unpublished) *Nursing and Midwifery Labour Force Survey*; table 10A.49.

The age profile of the medical practitioner workforce in 2009 for each jurisdiction is shown in figure 10.18. Medical practitioner workforce data for 2009 by remoteness area are shown in figure 10.19.

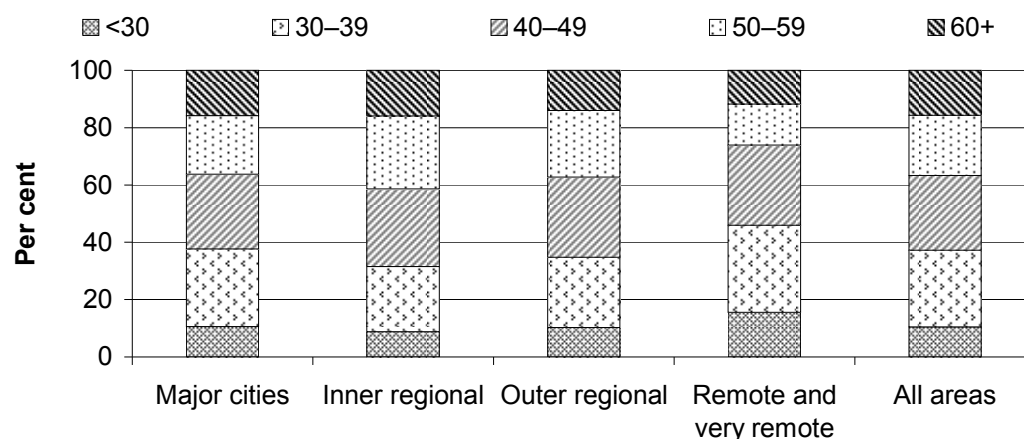
Figure 10.18 Medical practitioner workforce, by age group, 2009^a



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

Source: AIHW (unpublished) *Medical Labour Force Survey*; table 10A.52.

Figure 10.19 Medical practitioner workforce, by age group and remoteness area, 2009^a



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

Source: AIHW (unpublished) *Medical Labour Force Survey*; table 10A.51.

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'. Length of stay is correlated with costs 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) can reduce the comparability of cost estimates across jurisdictions. In response to concerns regarding data comparability, the Steering Committee initiated a study, reported in *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001). The study examined the extent to which differences in asset measurement techniques applied by participating agencies can affect the comparability of reported unit costs.

The results reported in the study for public hospitals indicate that different methods of asset measurement could lead to quite large variations in reported capital costs. However, considered in the context of total unit costs, the differences created by these asset measurement effects were relatively small, because capital costs represent a small proportion of total cost (although the differences can 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.

Care needs to be taken, therefore, in comparing unit costs across jurisdictions. Differences in counting rules, the treatment of various expenditure items (for example, superannuation) and the allocation of overhead costs have the potential to affect such comparisons. In addition, differences in the use of salary packaging can 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 can also reduce the comparability of efficiency measures. Some jurisdictions admit patients who can be treated as non-admitted patients in other jurisdictions (AIHW 2000).

Cost per casemix-adjusted separation

‘Cost per casemix-adjusted separation’ is an indicator of governments’ objective to deliver services in a cost effective manner (box 10.11).

Box 10.11 Cost per casemix-adjusted separation

‘Cost per casemix-adjusted separation’ is defined by the following two measures:

- ‘Recurrent cost per casemix-adjusted separation’ measures the average cost of providing care for an admitted patient (overnight stay or same day) adjusted with AR-DRG cost weights for the relative complexity of the patient’s clinical condition and of the hospital services provided (AIHW 2000).
 - This measure includes overnight stays, same day separations, private patient separations in public hospitals and private patient recurrent costs. It excludes non-acute hospitals, mothercraft hospitals, multipurpose hospitals, multipurpose services, hospices, rehabilitation hospitals, psychiatric hospitals and hospitals in the ‘unpeered and other’ peer groups. The data exclude expenditure on non-admitted patient care, the user cost of capital and depreciation, and research costs.
 - All admitted patient separations and their costs are included, and most separations are for acute care. Cost weights are not available for admitted patients who received non-acute care (4.1 per cent of total separations in 2009-10 (table 10A.13)), so the acute care cost weights are applied to non-acute separations. The admitted patient cost proportion is an estimate only.
 - Some jurisdictions have developed experimental cost estimates for non-psychiatric acute patients, which are reported here. Separations for non-acute patients and psychiatric acute care patients are excluded from these estimates because AR-DRG cost weights are a poor predictor of these separations.
- ‘Total cost per casemix-adjusted separation’ is defined as the recurrent cost per casemix-adjusted separation plus the capital costs per casemix-adjusted separation. Recurrent costs include labour and material costs, and capital costs include depreciation and the user cost of capital for buildings and equipment. This measure allows the full cost of hospital services to be considered. The hospitals included in this measure are the same as for recurrent cost per casemix-adjusted separation.
 - 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 services or to retire debt. Interest payments represent a user cost of capital, so are deducted from capital costs to avoid double counting.

(Continued on next page)

Box 10.11 (Continued)

A low or decreasing 'Cost per casemix-adjusted separation' can reflect more efficient service delivery in public hospitals. However, this indicator needs to be viewed in the context of the set of performance indicators as a whole as decreasing cost could also be associated with decreasing quality and effectiveness.

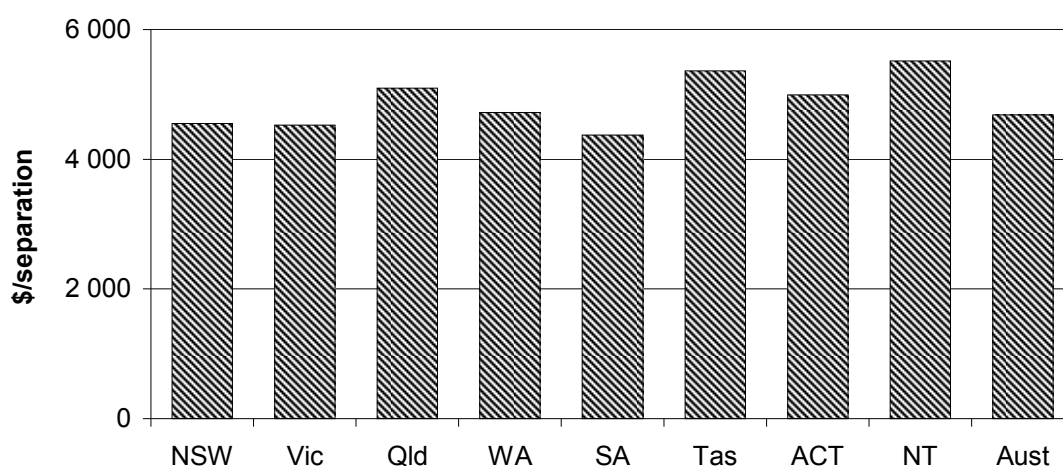
Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Recurrent cost per casemix-adjusted separation

'Recurrent cost per casemix-adjusted separation' data are presented in figure 10.20.

**Figure 10.20 Recurrent cost per casemix-adjusted separation, 2009-10^a,
b, c, d**



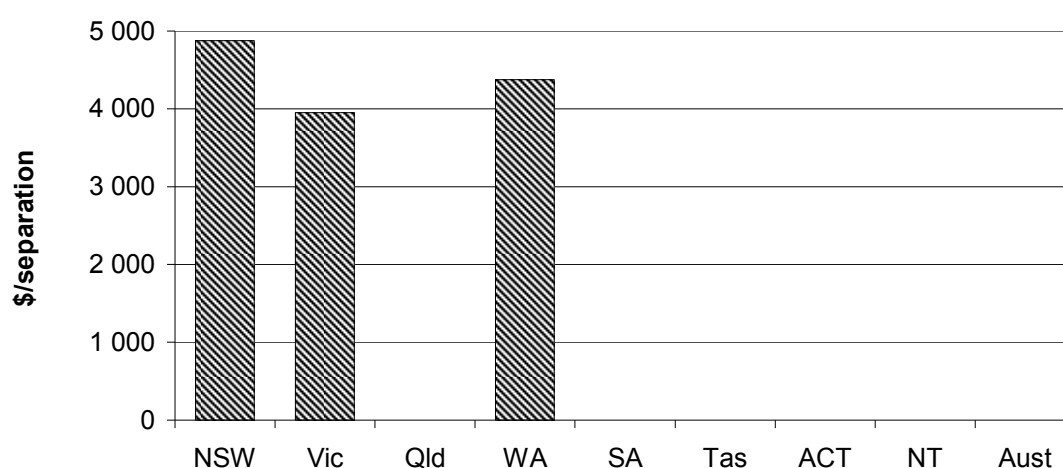
^a Excludes depreciation and the user cost of capital, spending on non-admitted patient care and research costs. ^b Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights are from the National Hospital Cost Data Collection, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2008-09 AR-DRG v 5.2 cost weights. ^c Excludes separations for which the care type was reported as 'newborn with no qualified days', and records for hospital boarders and posthumous organ procurement. ^d Psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute hospitals and multi-purpose services are excluded from these data. The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included.

Source: AIHW (2011), *Australian Hospital Statistics 2009-10*, Health Services Series No. 40, Cat no. HSE 107; table 10A.53.

Experimental estimates of 'recurrent cost per casemix-adjusted separation' for acute non-psychiatric patients are reported for NSW, Victoria and WA (figure 10.21). (These estimates relate to a subset of the selected public hospitals reported in

figure 10.20 and are not available for other jurisdictions.) The experimental estimates aim to overcome the need to apply cost weights for acute care to non-acute care separations (box 10.11). The effect of restricting the analysis to acute non psychiatric admitted patients was to increase the estimated recurrent cost per casemix adjusted separation for the subset of hospitals by 5.2 per cent for NSW and to decrease this cost by 13.9 per cent for Victoria and 7.2 per cent for WA (AIHW 2011a).

Figure 10.21 Recurrent cost per acute non-psychiatric casemix-adjusted separation, subset of hospitals, 2009-10^{a, b, c, d}



^a Excludes psychiatric hospitals, subacute, non-acute and unpeered hospitals. This subset excludes hospitals where the inpatient fraction was equal to the acute inpatient fraction and more than 1000 non-acute patient days were recorded. Also excludes hospitals where the apparent cost of non-acute patients exceeded \$1000 per day and more than \$1 million of apparent expenditure on non-acute patients days was reported. ^b Separations are those where the care type is acute, newborn with qualified days, or not reported. Psychiatric separations are those with psychiatric care days. ^c Average cost weight from the National Hospital Cost Data Collection, based on acute, newborn with at least one qualified day, or not reported, using the 2007-08 AR-DRG version 5.2 cost weights. ^d These estimates are not available for Queensland, SA, Tasmania, the ACT or the NT.

Source: AIHW (2011), *Australian Hospital Statistics 2009-10*, Health Services Series No. 40, Cat no. HSE 107; table 10A.53.

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

The dominant peer classification is the ‘Principal referral and Specialist women’s and children’s’ category. The 86 hospitals representing this group had an average of 43 099 separations each at an average cost of \$4722 per person (table 10A.54 and

table 10.7). Data for each of the hospital peer groups are presented in table 10.7. Detailed data for all peer groups are presented in table 10A.54.

Table 10.7 Recurrent cost per casemix-adjusted separation, by hospital peer group, 2009-10^{a, b, c}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Hospital peer group									
Principal referral and Specialist women's and children's	4 565	4 561	5 216	4 551	4 510	5 143	5 072	5 458	4 722
Large	4 279	4 240	3 751	4 322	4 245	6 371	4 705	..	4 291
Medium	4 647	4 178	4 681	5 292	3 909	6 548	..	..	4 593
Small acute	5 194	5 361	5 131	6 570	3 624	4 507	..	5 944	5 333
All hospitals^d	4 550	4 525	5 093	4 722	4 372	5 363	4 989	5 517	4 684

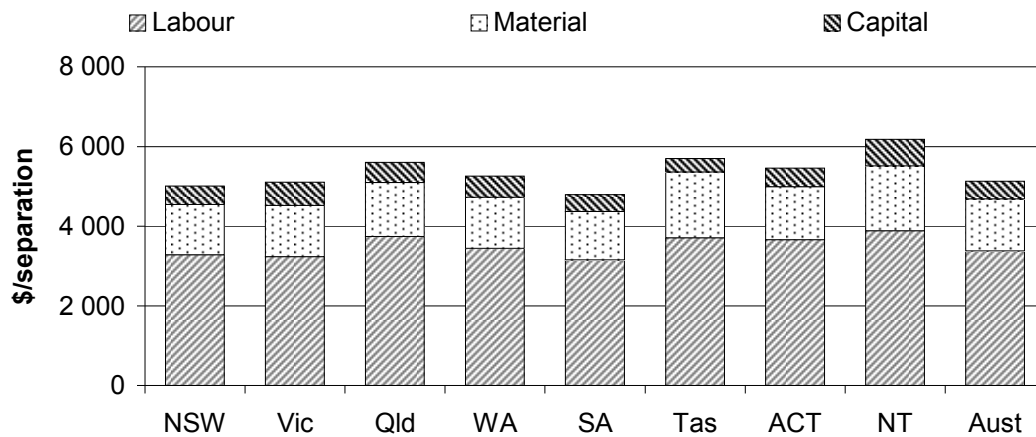
^a Data exclude depreciation and the user cost of capital, spending on non-admitted patient care and research costs. ^b The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure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

Source: AIHW (2011), *Australian Hospital Statistics 2009-10*, Health Services Series No. 40, Cat no. HSE 107; table 10A.54.

Total cost per casemix-adjusted separation

Total cost includes both the recurrent costs (as discussed above) and the capital costs associated with hospital services. Results for this indicator in 2009-10 are reported in figure 10.22. Labour costs accounted for the majority of costs in most jurisdictions. The user cost of capital for land is not included in figure 10.22 but is reported in table 10A.55.

Figure 10.22 Total cost per casemix-adjusted separation, public hospitals, 2009-10^{a, b, c}



^a Labour includes medical and non-medical labour costs. Material includes other non-labour recurrent costs, such as repairs and maintenance (table 10A.53). ^b Capital cost includes depreciation and the user cost of capital for buildings and equipment that is associated with the delivery of admitted patient services in the public hospitals as described in the data for recurrent cost per casemix-adjusted separation. Capital cost excludes the user cost of capital associated with land (reported in table 10A.55). ^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 (2011), *Australian Hospital Statistics 2009-10*, Health Services Series No. 40, Cat no. HSE 107; State and Territory governments (unpublished); tables 10A.53 and 10A.55.

Relative stay index

‘Relative stay index’ is an indicator of governments’ objective to deliver services efficiently (box 10.12).

Box 10.12 **Relative stay index**

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

‘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 or decreasing ‘relative stay index’ is desirable if it is not associated with poorer health outcomes or significant extra costs outside the hospital systems (for example, in-home care).

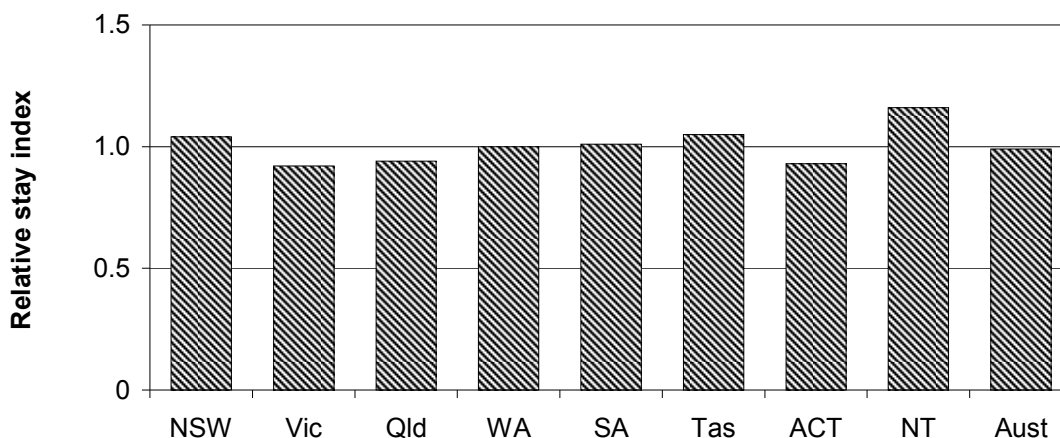
States and territories vary in their thresholds for classifying patients as either same day admitted patients or outpatients. These variations affect the ‘relative stay index’.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Data for this indicator are reported in figure 10.23. The ‘relative stay index’ is reported by patient election status and by medical, surgical and other AR-DRGs in tables 10A.56 and 10A.57 respectively.

Figure 10.23 **Relative stay index, public hospitals, 2009-10^{a, b}**



^a Separations exclude newborn with unqualified days, organ procurement posthumous and hospital boarders.

^b The relative stay index is based on all hospitals and is estimated using the indirect standardisation method and AR-DRG version 5.2. The indirectly standardised relative stay index is not strictly comparable between jurisdictions but is a comparison of the jurisdiction with the national average based on the casemix of the jurisdiction.

Source: AIHW (2011), *Australian Hospital Statistics 2009-10*, Health Services Series No. 40, Cat no. HSE 107; table 10A.56.

Recurrent cost per non-admitted occasion of service

‘Recurrent cost per non-admitted occasion of service’ is an indicator of governments’ objective to deliver services in a cost effective manner (box 10.13).

Box 10.13 Recurrent cost per non-admitted occasion of service

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

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

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

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

Data quality information for this indicator is under development.

These data are not comparable across jurisdictions. Reporting categories vary across jurisdictions, and further inconsistencies arise as a result of differences in outsourcing practices. In some cases, for example, outsourced occasions of service can be included in expenditure on non-admitted services, but not in the count of occasions of service. Jurisdictions able to supply 2009-10 data for this indicator reported the following results for non-admitted patient services:

- In NSW, the emergency department cost per occasion of service was \$210 for 2.3 million occasions, the outpatient cost per occasion of service was \$116 for 15.5 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was \$125 for 20.4 million occasions (table 10A.58).
- In WA, the emergency department cost per occasion of service was not available. The outpatient cost per occasion of service was \$222 for 3.2 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was \$253 for 4.0 million occasions (table 10A.60).
- In SA, the emergency department cost per occasion of service was \$380 for 534 000 occasions, the outpatient cost per occasion of service was \$292 for 1.5 million occasions and the overall cost per occasion of service (emergency plus outpatient) was \$315 for 2.0 million occasions (table 10A.61).
- In Tasmania, the emergency department cost per occasion of service was \$400 for 114 000 occasions. The outpatient cost per occasion of service was \$268 for

302 000 occasions. An overall cost per occasion of service was not available (table 10A.62).

- In the ACT, the emergency department cost per occasion of service was \$665 for 107 000 occasions, the outpatient cost per occasion of service was \$330 for 317 000 occasions and the overall cost per occasion of service (emergency plus outpatient) was \$371 for 424 000 occasions (table 10A.63).

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. The average cost per encounter was \$173 for 1.3 million encounters in 2009-10 (table 10A.59).

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

As NHCDC data were not available for 2009-10 at the time of Report production, 2008-09 data are discussed here. Outpatient data were contributed by 205 public hospitals for all types of public hospital outpatient clinics (tier 0). These data suggest that 'cost per non-admitted clinic occasions of service' for the public hospitals sector in 2008-09 was \$269 for 11.9 million occasions (table 10A.64). 'Cost per non-admitted clinic occasions of service' data are also shown for seven categories of outpatient clinics (tier 1) (table 10.8). These tier 1 outpatient clinics data were provided by 177 public hospitals. Emergency department data, provided by 159 public hospitals, show the 'cost per occasion of service for emergency departments' by triage class (table 10.9).

Table 10.8 Non-admitted clinic occasions of service for tier 1 clinics, sample results, public sector, 2008-09^{a, b, c, d, e}

	<i>Occasions of service</i>	<i>Average cost</i>
	no.	\$/occasion of service
Allied health and/or clinical nurse specialist	1 757 643	162
Dental	34 378	300
Medical	4 064 037	386
Obstetrics and gynaecology	1 925 889	168
Paediatric	368 498	312
Psychiatric	142 267	616
Surgical	2 988 560	220
Total	11 281 272	270

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

^b Costing and admission practices vary across jurisdictions and hospitals. ^c Includes depreciation costs.

^d Based on 177 public sector hospitals. ^e Excludes Victorian outpatient data.

Source: DoHA (2010), *National Hospital Cost Data Collection Cost Report, Round 13 (2008-09)*; table 10A.66.

Table 10.9 Emergency department average cost per occasion of service, public hospitals, by triage class, 2008-09 (dollars)^{a, b, c, d, e}

<i>Triage category</i>	<i>Population estimated — average cost per occasion of service^f</i>	<i>Actual — average cost per occasion of service</i>
Admitted triage 1	1 535	1 545
Admitted triage 2	851	861
Admitted triage 3	702	713
Admitted triage 4	585	589
Admitted triage 5	422	420
Non-admitted triage 1	815	847
Non-admitted triage 2	561	565
Non-admitted triage 3	462	472
Non-admitted triage 4	343	349
Non-admitted triage 5	221	217
Did not wait ^g	41	42
Total	438	451

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

^b Based on data from 159 public sector hospitals. ^c Victorian emergency department data are not included.

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

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

Source: DoHA (2010), *National Hospital Cost Data Collection Cost Report, Round 13 (2008-09)*; table 10A.65.

Outcomes

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

Patient satisfaction

‘Patient satisfaction’ provides a proxy measure of governments’ objective to deliver services that are high quality and responsive to individual patient needs (box 10.14). Patient satisfaction surveys are different from other sources of hospital quality data, because they provide information on hospital quality from the patient’s perspective. Surveys can be useful for obtaining information on patient views of both clinical and non-clinical hospital care (such as whether patients feel they were treated with respect and provided with appropriate information regarding their treatment).

Box 10.14 Patient satisfaction

‘Patient satisfaction’ is defined by the following six measures:

- Proportion of persons who went to an emergency department in the last 12 months reporting the emergency department doctors, specialists or nurses always or often listened carefully to them
- Proportion of persons who went to an emergency department in the last 12 months reporting the emergency department doctors, specialists or nurses always or often showed respect to them
- Proportion of persons who went to an emergency department in the last 12 months reporting the emergency department doctors, specialists or nurses always or often spent enough time with them
- Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often listened carefully to them
- Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often showed respect to them
- Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often spent enough time with them.

A high or increasing proportion of patients who were satisfied is desirable, because it suggests the hospital care received was of high quality and better met the expectations and needs of patients.

Data reported for this indicator are comparable.

This indicator also reports descriptive information on patient surveys undertaken by states and territories. The descriptive information includes the survey time period, method, sample size, response rate and a selection of results where available. This indicator also provides information on how jurisdictions have used patient satisfaction surveys to improve public hospital quality in recent years. If public hospitals respond to patient views and modify services, service quality can be improved to better meet patients’ needs.

As state and territory based surveys differ in content, timing and scope across jurisdictions, it is not possible to compare these results nationally.

Data quality information for this indicator is under development.

National data from the Australian Bureau of Statistics (ABS) *Patient Experience Survey 2010-11* are reported for the first time this year. Patient satisfaction data for emergency department and admitted hospital patients are reported in table 10.10. Relative standard errors and confidence intervals are reported in (attachment) tables 10A.67—10A.74. These tables also report patient satisfaction by remoteness.

Table 10.10 Patient satisfaction, public hospitals, 2010-11^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>
Emergency department patients									
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors, specialists or nurses always or often listened carefully to them									
Doctors or specialists	83.4	82.3	86.4	86.2	79.3	82.2	89.6	82.7	83.7
Nurses	85.3	84.2	90.1	88.3	86.8	87.5	89.7	90.6	86.5
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors, specialists or nurses always or often showed respect to them									
Doctors or specialists	86.1	82.9	89.3	88.4	81.5	85.2	90.4	82.9	85.8
Nurses	87.1	86.5	90.7	89.2	88.8	89.7	88.7	89.7	88.1
Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors, specialists or nurses always or often spent enough time with them									
Doctors or specialists	79.5	74.4	82.5	82.2	76.3	77.9	83.6	80.8	78.9
Nurses	82.6	79.7	87.2	85.3	83.3	85.9	87.4	86.3	83.4
Admitted hospital patients									
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often listened carefully to them									
Doctors or specialists	90.9	89.0	90.2	89.4	89.4	86.5	95.1	88.6	90.0
Nurses	89.0	89.1	92.2	91.2	90.8	88.8	89.0	88.8	90.1
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often showed respect to them									
Doctors or specialists	91.4	89.4	91.3	88.9	91.1	87.0	94.2	89.5	90.5
Nurses	90.6	90.0	93.7	90.9	93.2	91.1	90.4	92.9	91.4
Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often spent enough time with them									
Doctors or specialists	87.1	84.0	86.2	84.9	87.2	85.7	88.6	86.5	85.8
Nurses	87.2	87.3	88.9	88.8	85.8	85.6	92.8	89.3	87.6

^a Rates are age standardised to the 2001 estimated resident population (5 year ranges). ED=Emergency department.

Source: ABS (unpublished) *Patient Experience Survey 2010-11*, tables 10A.67–10A.74.

State and territory survey approaches differed markedly across jurisdictions:

- All jurisdictions conducted a survey in 2010 and/or 2011 with the exception of Tasmania which conducted a survey over the period 2009–2010.
- It is not possible to compare survey results between jurisdictions as survey methods and approaches differed across jurisdictions.
 - The length of time that the survey was conducted varied from a 12 month period to a two month period.

-
- Different survey methods were used by jurisdictions. Computer Assisted Telephone Interviewing was used by Queensland, WA and SA. Other jurisdictions used a combination of mail and internet surveys.
 - Most jurisdictions surveyed admitted patients, however, this also varied across jurisdictions with one jurisdiction surveying hospital inpatients and outpatients, non-admitted emergency patients, mental health inpatients and outpatients and another jurisdiction surveying emergency departments only.
 - Sample sizes varied from 220 000 to around 1500.

More information on the survey methods and results are in tables 10A.75–10A.82.

All jurisdictions reported that they use survey results in some way to improve services. All jurisdictions provide survey results or feedback to hospitals. Most jurisdictions have a formalised approach to prioritising the areas in need of improvement identified by the surveys and then implementing quality improvements. One jurisdiction reported that key performance measure results from its survey are included in its area health service performance agreements. More information on how survey results are used to improve services are in tables 10A.75–10A.82.

In 2005, the Steering Committee engaged Health Policy Analysis Pty Ltd to undertake a study reviewing patient satisfaction surveys conducted by State and Territory governments. A major objective of the study was to identify points of commonality and difference between patient satisfaction surveys and their potential for concordance and/or for forming the basis of a minimum national data set on public hospital ‘patient satisfaction’ or ‘patient experience’. The study found that, although there is some potential for harmonising approaches (as most surveys assess similar aspects of patient experience and satisfaction), different survey methodologies posed significant impediments to achieving comparable information.

Sentinel events

‘Sentinel events’ is an indicator of governments’ objective to deliver public hospital services that are safe and of high quality (box 10.15). Sentinel events can indicate hospital system and process deficiencies that compromise quality and safety.

Box 10.15 Sentinel events

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

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

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

A low or decreasing number of sentinel events is desirable.

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

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

Data quality information for this indicator is under development.

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

In 2007 the AIHW, in conjunction with the ACSQHC, published a report that included national sentinel event data for 2004-05 (AIHW and ACSQHC 2007). The

report notes that reporting practices differ across jurisdictions and, as a result, the data are not considered comparable across jurisdictions.

Numbers of sentinel events for 2009-10 are reported below. As larger states and territories will tend to have more sentinel events than smaller ones, the numbers of separations and individual occasions of service are also presented to provide context.

- In NSW, there were 3 procedures involving the wrong patient or body part, 18 suicides of patients in inpatient units, 16 cases of retained instruments or other material after surgery requiring re-operation or further surgical procedure, 1 haemolytic blood transfusion reaction resulting from ABO incompatibility, 4 medication errors leading to the death of a patient reasonably believed to be due to incorrect administration of drugs and 2 maternal deaths or serious morbidity associated with labour delivery. Sentinel events in all other categories were reported as zero (table 10A.83). In NSW public hospitals in 2009-10, there were around 1.5 million separations (table 10A.6) and around 21.4 million individual occasions of service (table 10A.16).
- In Victoria, there were 6 suicides of patients in inpatient units, 9 retained instruments or other material after surgery requiring re-operation or further surgical procedure, 1 intravascular gas embolism resulting in death or neurological damage, 2 haemolytic blood transfusion reactions resulting from ABO incompatibility, 1 medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs and 2 maternal deaths or cases of serious morbidity associated with labour or delivery. Sentinel events in all other categories were reported as zero (table 10A.84). In Victorian public hospitals in 2009-10, there were around 1.4 million separations (table 10A.6) and around 7.9 million individual occasions of service (table 10A.16).
- In Queensland, there was 1 procedure involving the wrong patient or body part, 4 suicides of patients in inpatient units, 1 retained instrument or other material after surgery requiring re-operation or further surgical procedure, 2 medication errors leading to the death of a patient reasonably believed to be due to incorrect administration of drugs and 2 maternal deaths or cases of serious morbidity associated with labour or delivery. Sentinel events in all other categories were reported as zero (table 10A.85). In Queensland public hospitals in 2009-10, there were around 923 000 separations (table 10A.6) and around 11.0 million individual occasions of service (table 10A.16).
- In WA, there was 1 procedure involving the wrong patient or body part, 3 suicides of patients in inpatient units, 1 retained instrument or other material after surgery requiring re-operation or further surgical procedure, 1 medication

error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs and 1 maternal death or serious morbidity associated with labour or delivery. Sentinel events in all other categories were reported as zero (table 10A.86). In WA public hospitals in 2009-10, there were around 506 000 separations (table 10A.6) and around 4.9 million individual occasions of service (table 10A.16).

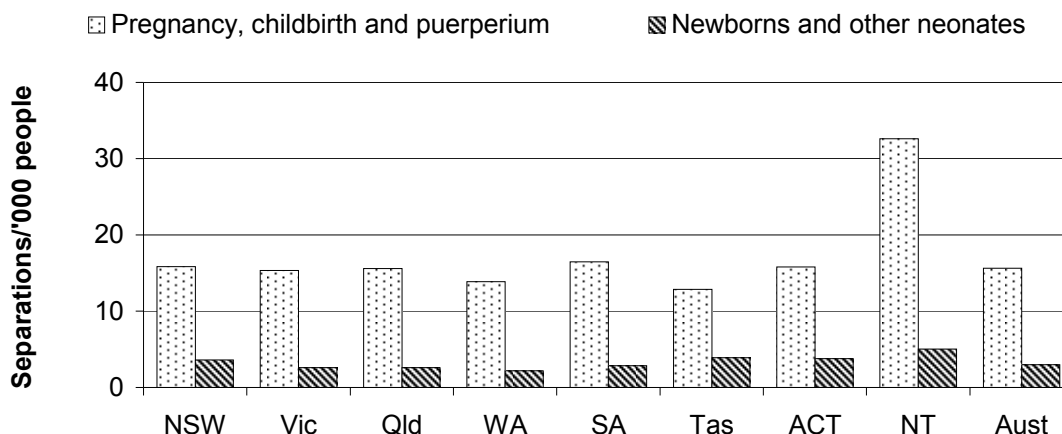
- In SA, there were 5 suicides of patients in inpatient units, 3 retained instruments or other material after surgery requiring re-operation or further surgical procedure, 1 medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs and 5 maternal deaths or serious morbidity associated with labour or delivery. Sentinel events in all other categories were reported as zero (table 10A.87). In SA public hospitals in 2009-10, there were around 383 000 separations (table 10A.6) and around 2.2 million individual occasions of service (table 10A.16).
- In Tasmania, sentinel events in all categories were reported as zero (table 10A.88). In Tasmanian public hospitals in 2009-10, there were around 102 000 separations (table 10A.6) and around 790 000 individual occasions of service (table 10A.16).
- In the ACT, there were a total of 7 sentinel events. Data for each of the nationally agreed categories have not been published (table 10A.89). In ACT public hospitals in 2009-10, there were around 88 000 separations (table 10A.6) and around 657 000 individual occasions of service (table 10A.16).
- In the NT, there was 1 maternal death or serious morbidity associated with labour or delivery. Sentinel events in all other categories were reported as zero (table 10A.90). In NT public hospitals in 2009-10, there were around 100 000 separations (table 10A.6) and around 502 000 individual occasions of service (table 10A.16).

Data for 2008-09 are reported in tables 10A.83–10A.91. Australian totals are in table 10A.91.

10.4 Profile of maternity services

Maternity services (defined as AR-DRGs relating to pregnancy, childbirth and the puerperium, and newborns and other neonates) accounted for 8.4 per cent of total acute separations in public hospitals (table 10A.93) and around 10.2 per cent of the total cost of all acute separations in public hospitals in 2009-10 (table 10A.92). Figure 10.24 shows the rate of acute separations per 1000 people for maternity services across jurisdictions in 2009-10.

Figure 10.24 **Separation rates for maternity services, public hospitals, 2009-10^{a, b, c}**



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

^b Newborns and other neonates include babies aged less than 28 days or babies aged less than one year with admission weight of less than 2500 grams. ^c Includes separations for which the type of episode of care was reported as 'acute', or 'newborn with qualified patient days'.

Source: AIHW (2011), *Australian Hospital Statistics 2009-10*, Health Services Series No. 40, Cat no. HSE 107; ABS (unpublished), *Australian Demographic Statistics*, December Quarter 2009, Cat. no. 3101.0; tables AA.2 and 10A.93.

In Australian public hospitals in 2009-10, 30.5 per cent of the separations for pregnancy, childbirth and the puerperium had a DRG of vaginal deliveries without complicating diagnosis (tables 10A.93 and 10A.94). In the context of all AR-DRGs in public hospitals, vaginal deliveries without complicating diagnosis comprised the largest number of overnight acute separations (4.3 per cent of all separations) (table 10A.14) and the third highest cost of all separation categories (\$469.8 million) (table 10A.94).

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 2008, 2009 and 2010 (table 10.11).

Table 10.11 Mean age of mothers at time of giving birth, public hospitals

	<i>NSW</i>	<i>Vic^a</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^b</i>	<i>NT</i>
2008								
First birth	27.9	27.7	25.5	26.0	26.9	27.0	28.0	24.5
Second birth	30.2	30.0	28.1	28.6	29.5	29.6	30.2	26.4
Third birth	31.5	31.5	29.7	30.1	31.0	31.7	31.9	28.5
All births	29.8	29.6	27.9	28.2	29.1	29.2	29.8	26.8
2009								
First birth	27.9	28.2	25.6	26.2	27.0	24.9	28.0	24.2
Second birth	30.4	30.7	28.3	28.6	29.6	27.7	30.4	26.8
Third birth	31.6	32.0	29.8	30.1	31.1	29.0	31.3	28.6
All births	29.9	30.1	28.0	28.3	29.1	27.3	29.8	26.9
2010								
First birth	28.2	28.2	25.6	26.3	27.1	na	27.7	24.6
Second birth	30.3	30.7	28.2	28.8	29.6	na	30.2	27.1
Third birth	31.6	32.0	29.8	30.3	31.3	na	31.6	28.9
All births	29.9	30.1	28.0	28.4	29.2	na	29.6	27.0

^a Data for Victoria for 2010 are preliminary. ^b ACT 2010 data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. **na** Not available.

Source: State and Territory governments (unpublished).

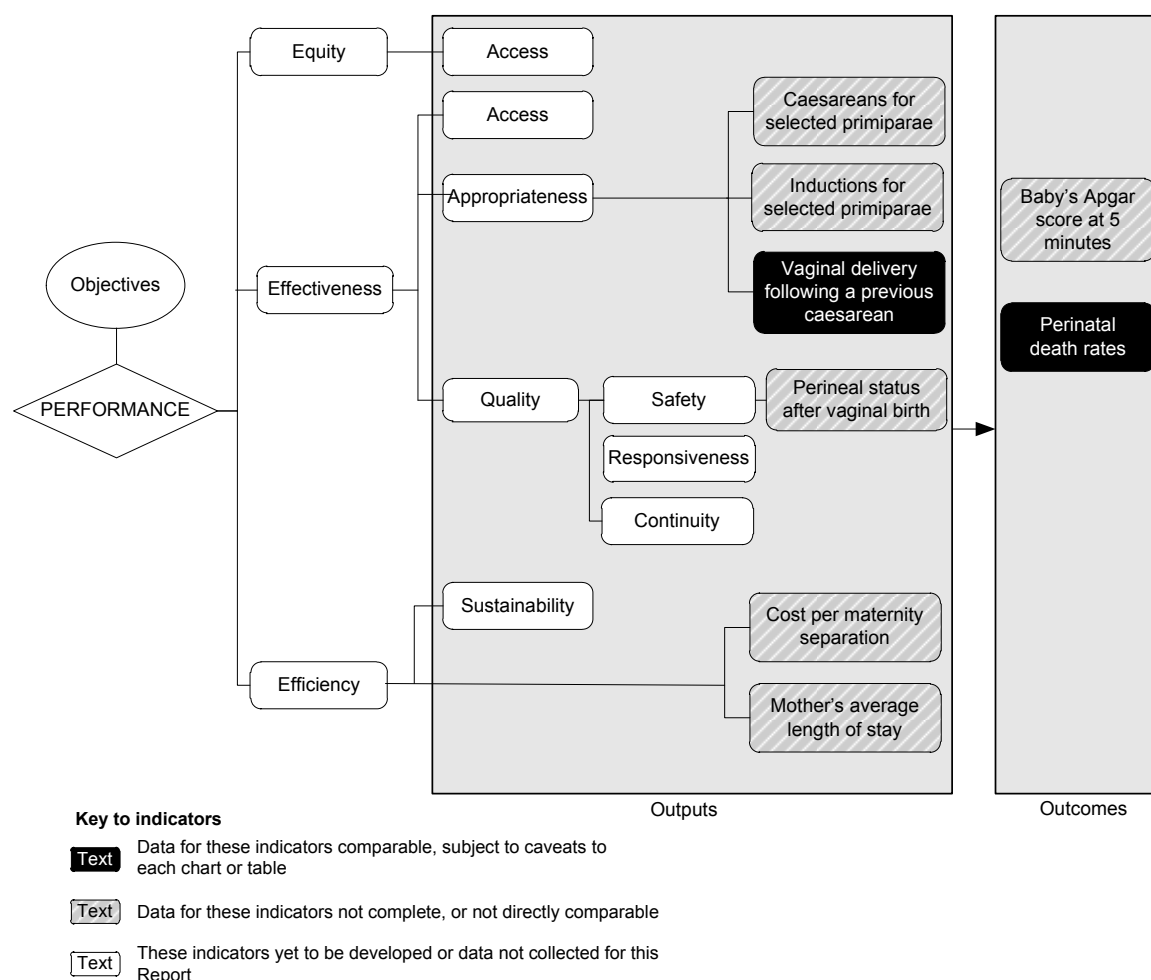
10.5 Framework of performance indicators for maternity services

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of maternity services (figure 10.25). The performance indicator framework shows which data are comparable in the 2012 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 sector summary’ 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.

The Report’s statistical appendix 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) (appendix A).

The framework has been revised to combine the previously reported indicators fetal, neonatal and perinatal deaths as separate measures under a new ‘Perinatal deaths’ indicator.

Figure 10.25 Maternity services performance indicator framework



10.6 Key performance indicator results for maternity services

Outputs

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

Equity — access

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

Effectiveness — access

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

Effectiveness — appropriateness

Caesareans and inductions for selected primiparae

‘Caesareans for selected primiparae’ and ‘Inductions for selected primiparae’ are indicators of the appropriateness of maternity services in public hospitals (box 10.16).

Box 10.16 Caesareans and inductions for selected primiparae

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

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

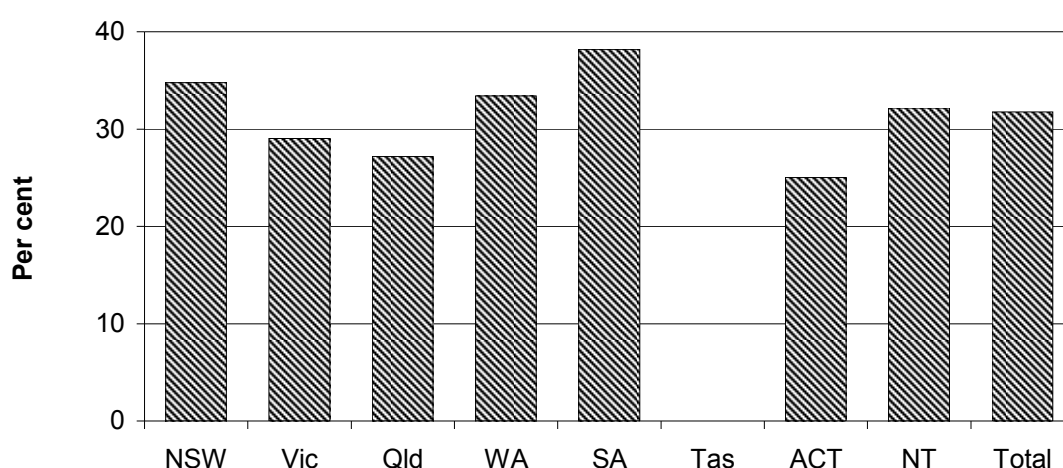
Data reported for this indicator are not complete or directly comparable.

Data quality information for this indicator is under development.

^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 Hilder 2008).

Induction rates for selected primiparae in public hospitals are reported in figure 10.26. Induction rates for private hospitals are shown in table 10A.95 for comparison. They are higher than the rate for public hospitals in all jurisdictions for which data are available, except for the NT. Data for all jurisdictions for earlier years are included in tables 10A.96–10A.103.

Figure 10.26 Inductions for selected primiparae, public hospitals, 2010^{a, b, c, d}

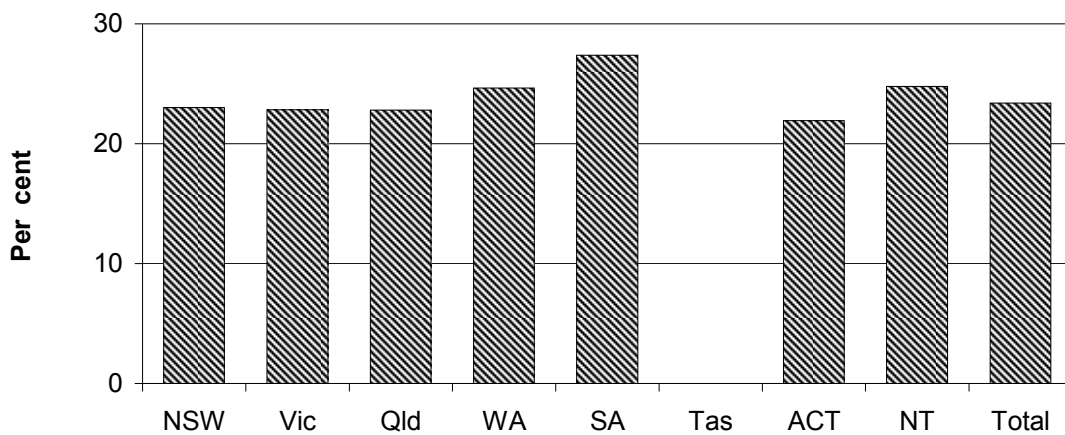


^a Data for Victoria are preliminary. ^b Data for Tasmania are not available. ^c ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. ^d Total includes only jurisdictions for which data are available.

Source: State and Territory governments (unpublished); table 10A.95.

Caesarean rates for selected primiparae in public hospitals are reported in figure 10.27. Caesarean rates for private hospitals are shown in table 10A.95 for comparison. They are higher than the rate for public hospitals in all jurisdictions for which data are available. Data for all jurisdictions for earlier years are included in tables 10A.96–10A.103.

Figure 10.27 **Caesareans for selected primiparae, public hospitals, 2010^{a, b, c, d}**



^a Data for Victoria are preliminary. ^b Data for Tasmania are not available. ^c ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. ^d Total includes only jurisdictions for which data are available.

Source: State and Territory governments (unpublished); table 10A.95.

Vaginal birth following previous caesarean

‘Vaginal birth following a previous caesarean’ is an indicator of the appropriateness of maternity services in public hospitals (box 10.17).

Box 10.17 Vaginal birth following a previous caesarean

‘Vaginal delivery following a previous caesarean’ is defined as the percentage of multiparous^a mothers who have had a previous caesarean, whose current method of birth was either an instrumental or non-instrumental vaginal delivery.

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

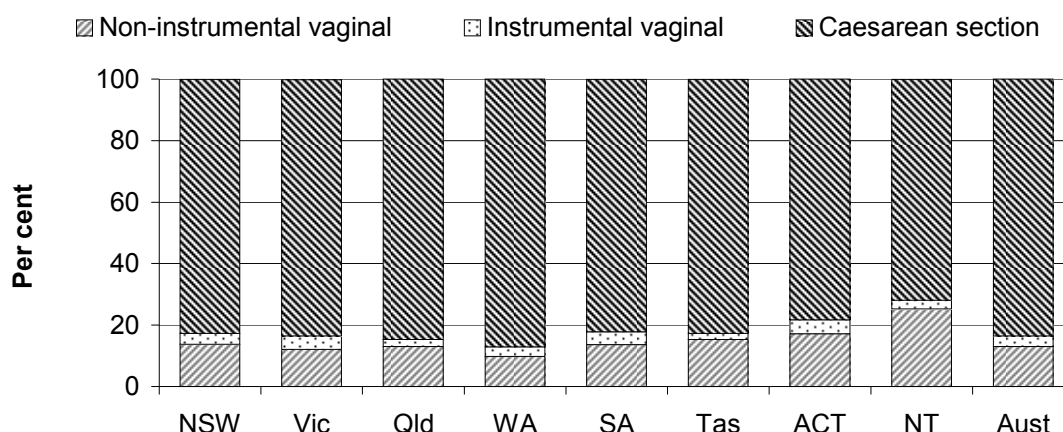
Data reported for this indicator are comparable subject to caveats.

Data quality information for this indicator is under development.

^a Multiparous means a pregnant woman who had at least one previous pregnancy resulting in a live birth or stillbirth.

Nationally, of women that had a previous caesarean section, 16.4 per cent had either an instrument or non-instrument vaginal delivery as their current method of birth, while 83.5 per cent had another caesarean section (figure 10.28).

Figure 10.28 Multiparous mothers who have had a previous caesarean section by current method of birth, 2009^{a, b, c}



^a For multiple births, the method of birth of the first born baby was used. ^b For NSW, Victoria, WA and the NT non-instrumental vaginal includes all women who had a vaginal breech birth, whether or not instruments were used. For the remaining jurisdictions, vaginal breech births are only included where instruments were not used. ^c Instrumental vaginal birth includes forceps and vacuum extraction.

Source: Li, Z., McNally, L., Hilder, L. and Sullivan, EA., 2011, *Australia's mothers and babies 2009*, Perinatal statistics series no. 25. Cat. no. PER 52, Sydney, AIHW National Perinatal Epidemiology and Statistics Unit; table 10A.104.

Effectiveness — quality

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

Safety — perineal status after vaginal birth

‘Perineal status after vaginal birth’ is an indicator of governments’ objective to provide safe and high quality services (box 10.18). Perineal lacerations caused by childbirth are painful, take time to heal and can result in ongoing discomfort and debilitating conditions such as faecal incontinence.

Box 10.18 Perineal status after vaginal birth

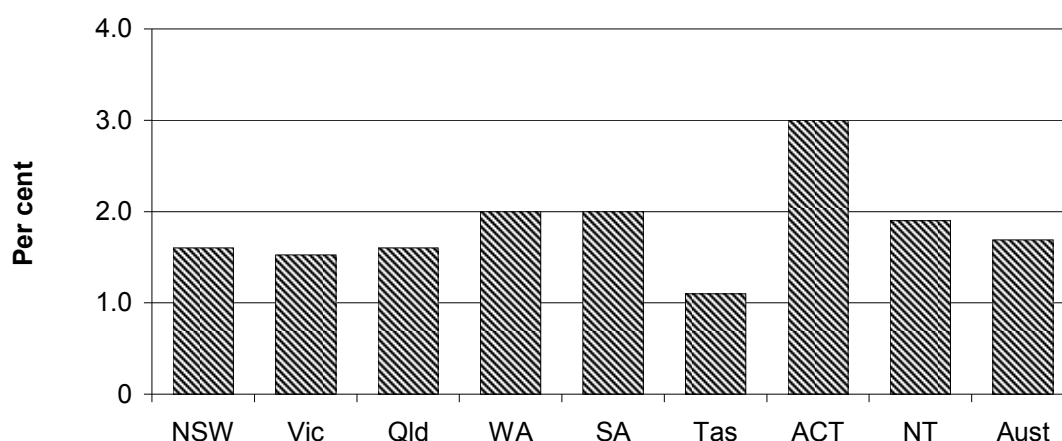
‘Perineal status after vaginal birth’ is the state of the perineum following a vaginal birth (HDSC 2008). A third or fourth degree laceration is a perineal laceration or rupture (or tear following episiotomy) extending to, or beyond, the anal sphincter (see section 10.8 for definitions) (NCCH 2008).

A low or decreasing rate of mothers with third or fourth degree lacerations after vaginal birth are desirable. Maternity services staff aim to minimise lacerations, particularly more severe lacerations (third and fourth degree), through labour management practices. Severe lacerations (third and fourth degree laceration) of the perineum are not avoidable in all cases and so safe labour management is associated with a low (rather than zero) proportion of third or fourth degree lacerations. Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

The proportion of mothers with third or fourth degree lacerations to their perineum following vaginal births is shown in figure 10.29. More information on ‘perineal status after vaginal birth’ (including the proportion of mothers with intact perineum following vaginal births) is contained in attachment table 10A.105.

Figure 10.29 **Perineal status — mothers with third or fourth degree lacerations after vaginal births, 2009^{a, b}**



^a For multiple births, the perineal status after birth of the first child was used. ^b Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths.

Source: Li, Z., McNally, L., Hilder, L. and Sullivan, EA., 2011, *Australia's mothers and babies 2009*, Perinatal statistics series no. 25. Cat. no. PER 52, Sydney, AIHW National Perinatal Epidemiology and Statistics Unit; table 10A.105.

Responsiveness, continuity

The Steering Committee has identified the responsiveness and continuity of care of maternity services as an area for development in future Reports.

Efficiency — sustainability

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

Efficiency

Recurrent cost per maternity separation

‘Recurrent cost per maternity separation’ is an indicator of governments’ objective to deliver cost effective services (box 10.19).

Box 10.19 Recurrent cost per maternity separation

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

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

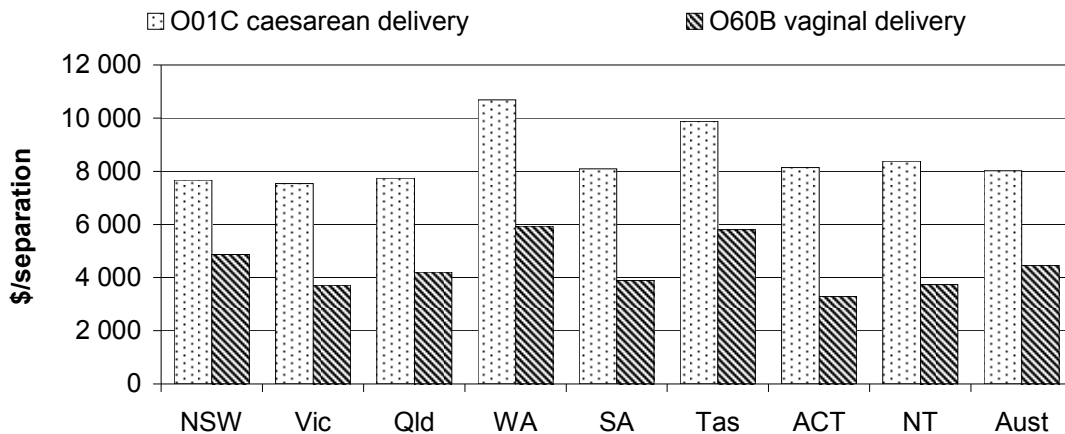
Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Data are reported for the two most common maternity AR-DRGs: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities (figure 10.30). Data for a number of other maternity related AR-DRGs are shown in table 10A.106. Data are sourced from the NHCDC. The NHCDC is a voluntary annual collection, the purpose of which is to calculate DRG cost weights. The samples are not necessarily representative of the set of hospitals in each jurisdiction. An estimation process has been carried out to create representative national activity

figures from the sample data. As NHCDC data were not available for 2009-10 at the time of Report production, 2008-09 data are discussed here.

Figure 10.30 Estimated average cost per separation for selected maternity related AR-DRGs, public hospitals, 2008-09^{a, b}



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

^b Average cost is affected by a number of factors including admission practices, sample size, remoteness and the types of hospital contributing to the collection. Caution must be used in making direct comparisons between jurisdictions, because of differences in hospital costing systems.

Source: DoHA (2010), *National Hospital Cost Data Collection Cost Report, Round 13 (2008-09)*; table 10A.106.

Mother's average length of stay

'Mother's average length of stay' is an indicator of governments' objective to deliver services efficiently (box 10.20).

Box 10.20 Mother's average length of stay

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

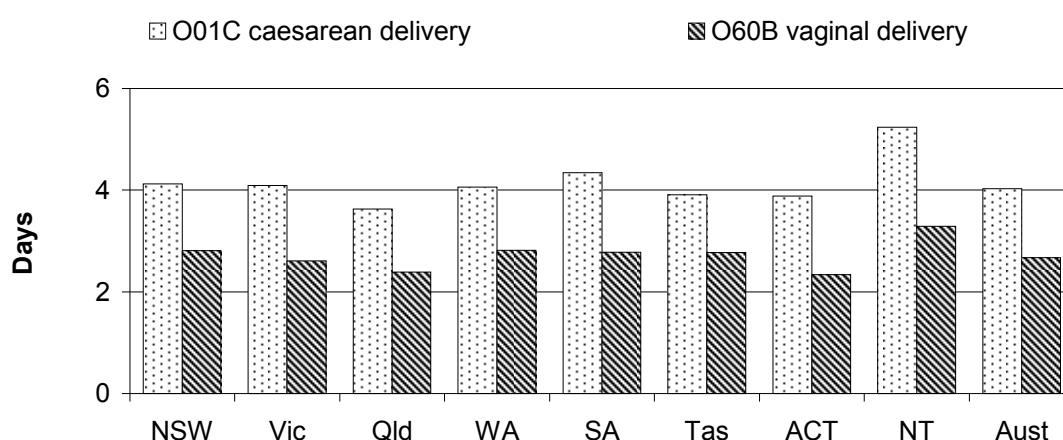
Shorter stays for mothers reduce hospital costs but whether they represent genuine efficiency improvements depends on a number of factors. Shorter stays can, for example, have an adverse effect on the health of some mothers and result in additional costs for in-home care. The indicator is not adjusted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

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Data are sourced from the NHCDC and are reported for the two most common maternity AR-DRGs: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities. As NHCDC data were not available for 2009-10 at the time of Report production, 2008-09 data are discussed here. (figure 10.31).

Figure 10.31 Average length of stay for selected maternity-related AR-DRGs, public hospitals, 2008-09^a



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

Source: DoHA (2010), *National Hospital Cost Data Collection Cost Report, Round 13 (2008-09)*; table 10A.106.

Outcomes

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

Apgar score

‘Apgar score at five minutes’ is an indicator of governments’ objective to deliver maternity services that are safe and of high quality (box 10.21). The future health of babies with lower Apgar scores is often poorer than those with higher scores.

Box 10.21 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).

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

A high or increasing Apgar score is desirable.

Low Apgar scores (defined as less than 4) are strongly associated with babies' birthweights being low. The management of labour in hospitals does not usually affect birthweights, but can affect the prevalence of low Apgar scores for babies with similar birthweights. Apgar scores can therefore indicate relative performance within birthweight categories, although factors other than hospital maternity services can influence Apgar scores within birthweight categories — for example antenatal care, multiple births and socioeconomic factors.

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

Data quality information for this indicator is under development.

'Low' Apgar scores for babies by birthweight category are contained in table 10.12. The range of Apgar scores for 2006 to 2010 are reported in table 10A.107.

Table 10.12 Live births with an Apgar score of 3 or lower, 5 minutes post-delivery, public hospitals, 2010

<i>Birthweight (grams)</i>	<i>Unit</i>	<i>NSW</i>	<i>Vic^a</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^b</i>	<i>NT</i>
Less than 1500	no.	841	668	583	273	214	na	71	54
Low Apgar	%	16.9	16.6	19.0	7.3	11.2	na	14.1	18.5
1500-1999	no.	964	792	601	299	261	na	69	55
Low Apgar	%	1.5	1.6	1.7	1.3	1.2	na	—	1.8
2000-2499	no.	2 852	2 051	1 793	796	659	na	178	163
Low Apgar	%	0.6	0.5	0.6	0.3	0.2	na	—	1.2
2500 and over	no.	66 894	47 142	39 872	16 633	13 462	na	3 667	2 758
Low Apgar	%	0.2	0.2	0.2	0.1	0.1	na	0.4	0.2

^a Data for Victoria are preliminary. ^b ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. **na** Not available. — Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 10A.107.

Perinatal death rate

‘Perinatal death rate’ is an indicator of governments’ objective to deliver maternity services that are safe and of high quality (box 10.22).

Box 10.22 Perinatal death rate

‘Perinatal death rate’ is defined by the following three measures:

- 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. 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.
- Neonatal death is the death of a live born infant within 28 days of birth (see section 10.8 for a definition of a live birth). 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.
- A perinatal death is a fetal or neonatal death. 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.

Low or decreasing death rates are desirable and can indicate high quality maternity services. The neonatal death rate tends to be higher among premature babies, so a lower neonatal death rate can also indicate a lower percentage of pre-term births.

Differences in the ‘fetal death rate’ between jurisdictions are likely to be due to factors outside the control of maternity services for admitted patients (such as the health of mothers and the progress of pregnancy before hospital admission). To the extent that the health system influences fetal death rates, the health services that can have an influence include outpatient services, general practice services and 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.

As for fetal deaths, a range of factors contribute to neonatal deaths. However, the influence of maternity services for admitted patients is greater for neonatal deaths than for fetal deaths through the management of labour and the care of sick and premature babies.

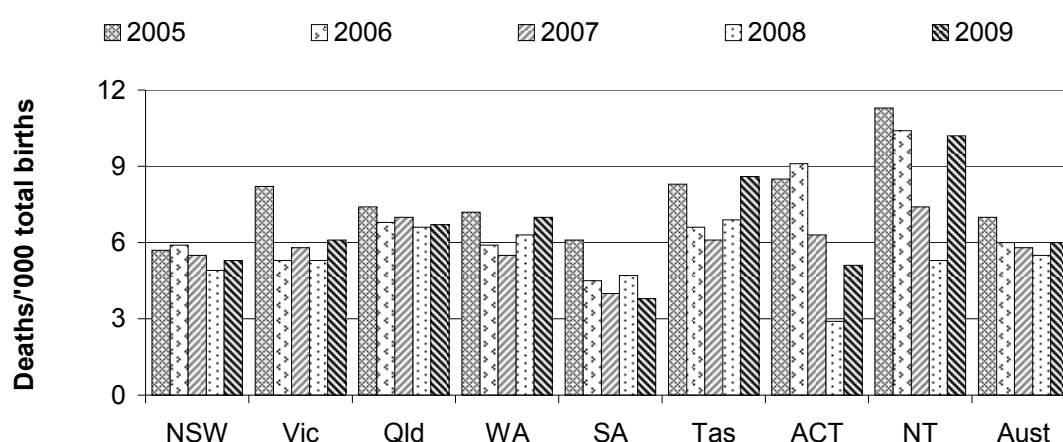
Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Fetal death rate

Fetal death rates are reported in figure 10.32. Nationally, fetal death rates have declined slightly over the period 2005–2009, although there was a slight increase in 2009. National time series for fetal death rates for the period 1997 to 2009 are included in table 10A.110. Fetal deaths rates by the Indigenous status of the mother are shown in figure 10.35.

Figure 10.32 Fetal death rate^{a, b}



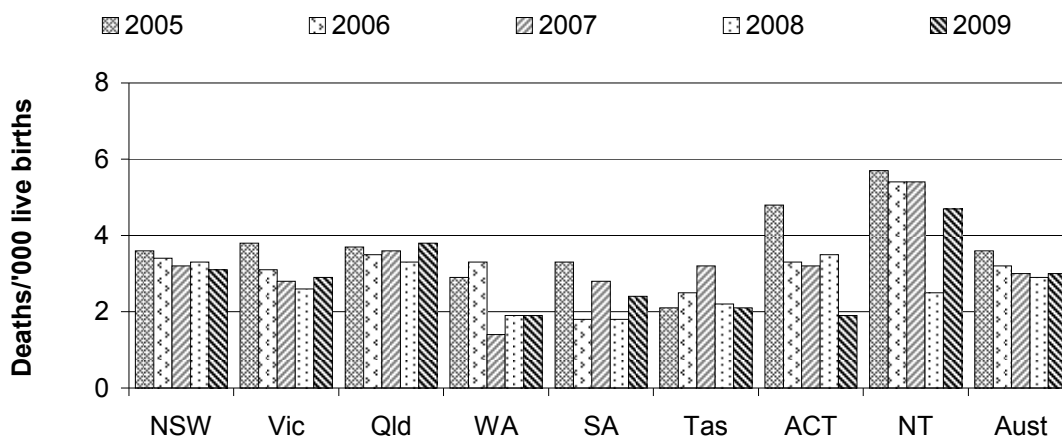
^a Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of fetal deaths and small populations. ^b The ACT and Australian total may exclude stillbirth data which were not received or processed by the ABS in time for the finalisation of the 2008 reference year. According to scope rules, these 2008 data will be included in the 2010 reference year.

Source: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.108.

Neonatal death rate

Neonatal death rates are reported in figure 10.33. Nationally, neonatal death rates have declined slightly over the period 2005–2009, although there was a slight increase in 2009. National time series for neonatal death rates for the period 1997 to 2009 are included in table 10A.110. Neonatal death rates by the Indigenous status of the mother are shown in figure 10.35.

Figure 10.33 Neonatal death rate^a



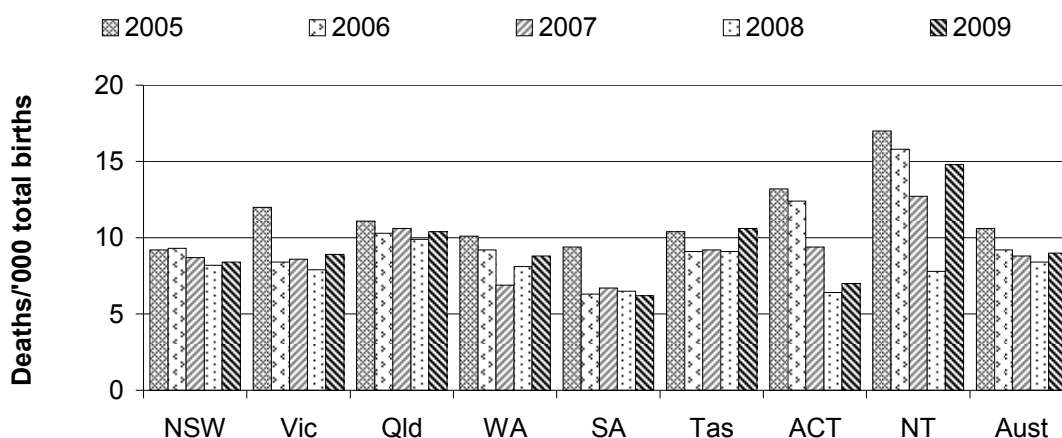
^a Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of neonatal deaths and small populations.

Source: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.109.

Perinatal death rate

Perinatal death rates are shown in figure 10.34. Perinatal death rates by the Indigenous status of the mother are shown in figure 10.35. National time series for perinatal death rates for the period 1997 to 2009 are included in table 10A.110.

Figure 10.34 Perinatal death rate^{a, b}



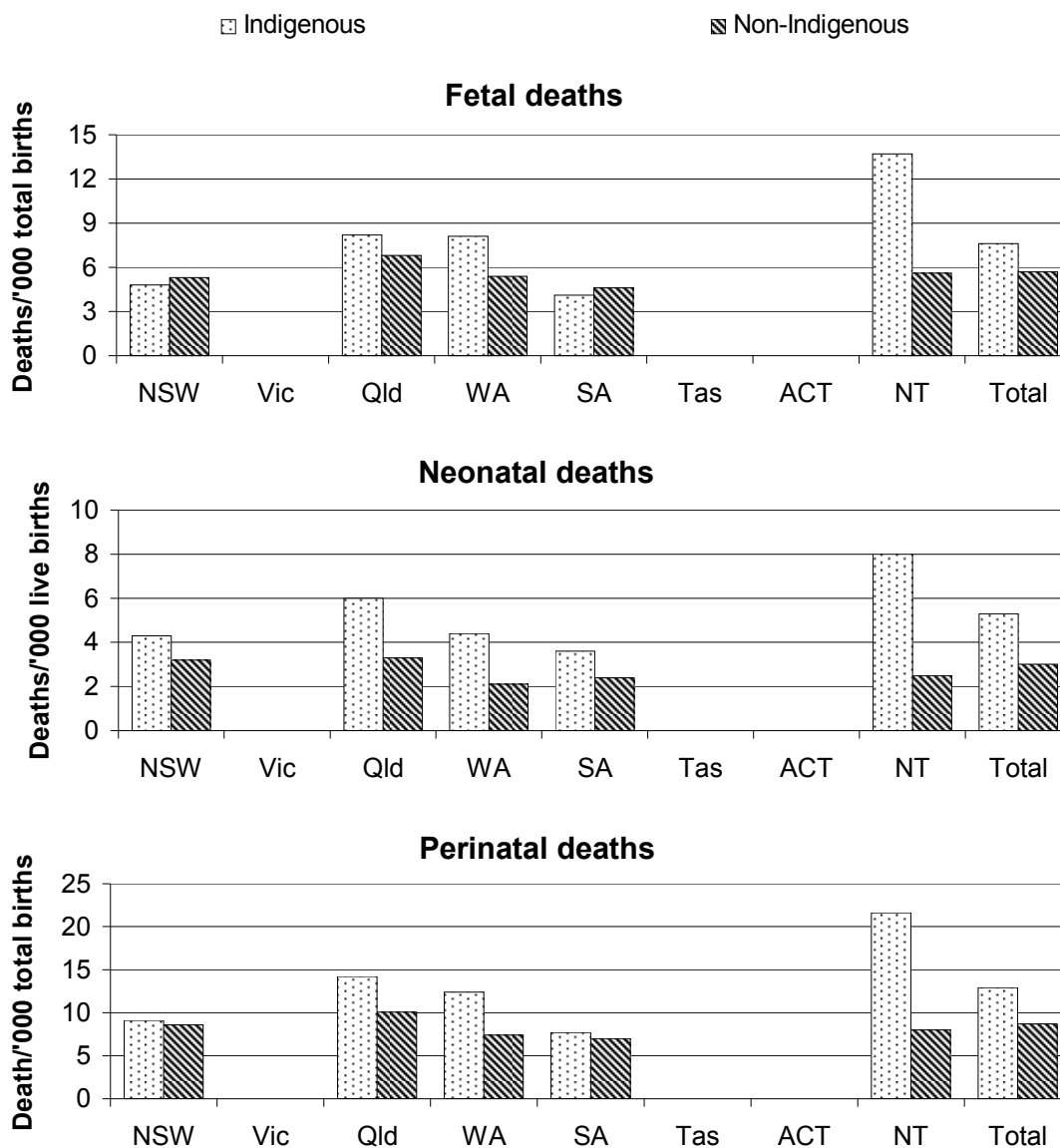
^a Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of perinatal deaths. ^b The ACT and Australian total may exclude stillbirth data which were not received or processed by the ABS in time for the finalisation of the 2008 reference year. According to scope rules, these 2008 data will be included in the 2010 reference year.

Source: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.111.

Fetal, neonatal and perinatal deaths for Indigenous people

Fetal, neonatal and perinatal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. Data for other jurisdictions are not included due to small numbers or poor coverage rates (ABS 2004). In most of the jurisdictions for which data are available, the fetal, neonatal and perinatal death rates for Indigenous people are higher than those for non-Indigenous people (figure 10.35).

Figure 10.35 **Fetal, neonatal and perinatal deaths, by Indigenous status of mother 2005–2009^a**



^a Data are reported individually by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These 5 states have evidence of sufficient levels of identification and sufficient numbers of deaths. The total relates to those jurisdictions for which data are published. Data are not available for other jurisdictions.

Source: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.112.

10.7 Future directions in performance reporting

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

-
- Improving the comprehensiveness of reporting by filling in gaps in the performance indicator frameworks. Important gaps in reporting for public hospitals include indicators of equity of access to services for special needs groups (particularly Indigenous people), and indicators of continuity of care. Gaps in the maternity services framework include equity of access, effectiveness of access, two aspects of quality — responsiveness and continuity — and the efficiency 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.
 - Improving the reporting of elective surgery waiting times by urgency category, in order to achieve greater comparability across jurisdictions in assessing the extent to which patients are seen within a clinically desirable period, and improving timeliness of the data.
 - Improving the reporting of quality and safety indicators in both the public hospitals and maternity services frameworks.
 - Improving the quality of Indigenous data. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing. The inclusion of data for Tasmania and the ACT in national totals is a priority for future Reports.

COAG developments

Outcomes from review of Report on Government Services

The COAG endorsed recommendations (December 2009) of the review of the RoGS implemented during 2010 and 2011 are reflected in this Report. Implementation of other recommendations will be reflected in future reports.

Review of National Agreements and National Partnership Agreements

COAG has agreed to progress the recommendations of the Heads of Treasuries (HoTs) Review of National Agreements, National Partnerships and Implementation Plans and reports of the COAG Reform Council (CRC). A working group, led by Senior Officials from First Ministers' and Treasury agencies, will review the performance frameworks of a limited number of agreements, including the NHA. The reviews will be concluded by June 2012. The recommendations of the review

of the NHA will be considered by the Steering Committee and may be reflected in future reports.

10.8 Definitions of key terms and indicators

Accreditation	Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals can 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 can receive acute, subacute or non-acute care services.
Admitted patient cost proportion	The ratio of admitted patient costs to total hospital costs, also known as the inpatient fraction.
Allied health (non-admitted)	Occasions of service to non-admitted patients at units/clinics providing treatment/counselling to patients. These include units providing physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy.
Apgar score	Numerical score used to evaluate a baby's condition after birth. The definition of the reported indicator is the number of babies born with an Apgar score of 3 or lower at 5 minutes post delivery, as a proportion of the total number of babies born. Excludes fetal deaths in utero before commencement of labour.
AR-DRG	Australian Refined Diagnosis Related Group - a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 5.1 is based on the ICD-10-AM classification.
Average length of stay	The mean length of stay for all patient episodes, calculated by dividing total occupied bed days by total episodes of care.
Caesarean section	Operative birth through an abdominal incision.
Casemix adjusted	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted by AR-DRG into categories of patients with similar clinical conditions and requiring similar hospital services. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.
Casemix adjusted separations	The number of separations adjusted to account for differences across hospitals in the complexity of episodes of care.
Catastrophic	An acute or prolonged illness usually considered to be life threatening or with the threat of serious residual disability. Treatment can be radical and is frequently costly.
Community health	Health services for individuals and groups delivered in a community

services	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 can 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.
Hospital boarder	A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
Inpatient fraction	The ratio of admitted patient costs to total hospital costs, also known as the admitted patient cost proportion.
Labour cost per casemix-adjusted separation	Salary and wages plus visiting medical officer payments, multiplied by the inpatient fraction, divided by the number of casemix-adjusted separations.
Length of stay	The period from admission to separation less any days spent away from the hospital (leave days).
Live birth	Birth of a child who, after delivery, breathes or shows any other evidence of life, such as a heartbeat. Includes all registered live births regardless of birthweight.
Medicare	Australian Government funding of private medical and optometrical services (under the Medicare Benefits Schedule). Sometimes

	defined to include other forms of Australian Government funding such as subsidisation of selected pharmaceuticals (under the Pharmaceutical Benefits Scheme) and public hospital funding (under the Australian Health Care Agreements), which provides public hospital services free of charge to public patients.
Mortality rate	The number of deaths per 100 000 people.
Neonatal death	Death of a live born infant within 28 days of birth. Defined in Australia as the death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Neonatal death rate	Neonatal deaths divided by the number of live births registered.
Newborn qualification status	A newborn qualification status is assigned to each patient day within a newborn episode of care. A newborn patient day is qualified if the infant meets at least one of the following criteria: • is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient, • is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care, • is admitted to, or remains in hospital without its mother. A newborn patient day is unqualified if the infant does not meet any of the above criteria. The day on which a change in qualification status occurs is counted as a day of the new qualification status. If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.
Nursing workforce	Registered and enrolled nurses who are employed in nursing, on extended leave or looking for work in nursing.
Medical practitioner workforce	Registered medical practitioners who are employed as medical practitioners, on extended leave or looking for work as a medical practitioner.
Multiparous	A pregnant women who had at least one previous pregnancy resulting in a live birth or stillbirth
Non-acute care	Includes maintenance care and newborn care.
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 can include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.
Non-admitted patient	A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.
Perinatal death	Fetal death or neonatal death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Perinatal death rate	Perinatal deaths divided by the total number of births (that is, live

	births registered and fetal deaths combined).
Perineal laceration (third or fourth degree)	A 'third degree' laceration or rupture during birth (or a tear following episiotomy) involves the anal sphincter, rectovaginal septum and sphincter NOS. A 'fourth degree' laceration, rupture or tear also involves the anal mucosa and rectal mucosa (NCCH 2008).
Perineal status	The state of the perineum following a birth.
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 can provide (and charge for) treatment and accommodation services to private patients. Charges to non-admitted patients and admitted patients on discharge can be levied in accordance with the Australian Health Care Agreements (for example, aids and appliances).
Puerperium	The period or state of confinement after labour.
Real expenditure	Actual expenditure adjusted for changes in prices.
Relative stay index	The actual number of patient days for acute care separations in selected AR-DRGs divided by the expected number of patient days adjusted for casemix. Includes acute care separations only. Excludes: patients who died or were transferred within 2 days of admission, or separations with length of stay greater than 120 days, AR-DRGs which are for 'rehabilitation', AR-DRGs which are predominantly same day (such as R63Z chemotherapy and L61Z admit for renal dialysis), AR DRGs which have a length of stay component in the definition, and error AR-DRGs.
Same day patients	A patient whose admission date is the same as the separation date.
Sentinel events	Adverse events that cause serious harm to patients and that have the potential to undermine public confidence in the healthcare system.
Separation	A total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change in the type of care for an admitted patient (for example, from acute to rehabilitation). Includes admitted patients who receive same day procedures (for example, renal dialysis).
Separation rate	Hospital separations per 1000 people or 100 000 people.
Selected primiparae	Primiparae with no previous deliveries, aged 25–29 years, singleton, vertex presentation and gestation of 37–41 weeks (inclusive).
Subacute care	Interdisciplinary therapeutic clinically-intense and goal-directed care in which the need for care depends primarily on the patient's functional status and quality of life rather than the underlying medical diagnosis or the patient's prospects of recovery from illness. Subacute care includes rehabilitation, palliative care and some mental health care, as well as geriatric evaluation and management and psychogeriatric care. Common to all is the patient no longer

	meets criteria for classification as 'acute', but still requires therapeutic, clinically-intense and goal-directed care.
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).
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 can become an emergency. Category 2 patients — admission is desirable within 90 days for a condition that is causing some pain, dysfunction or disability, but that is not likely to deteriorate quickly or become an emergency. Category 3 patients — admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, that is unlikely to deteriorate quickly and that does not have the potential to become an emergency.

10.9 List of attachment tables

Attachment tables are identified in references throughout this appendix by an ‘10A’ prefix (for example, table 10A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

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Table 10A.18	Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory
Table 10A.19	Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory
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Table 10A.21	Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals

Table 10A.22	Elective surgery waiting times, by specialty of surgeon
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Table 10A.27	NSW elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2009-10
Table 10A.28	Victorian elective surgery waiting times by clinical urgency category, public hospitals (per cent)
Table 10A.29	Victorian elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2009-10
Table 10A.30	Queensland elective surgery waiting times, by clinical urgency category, public hospitals (per cent)
Table 10A.31	Queensland elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2009-10
Table 10A.32	WA elective surgery waiting times, by clinical urgency category, public hospitals (per cent)
Table 10A.33	WA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2009-10
Table 10A.34	SA elective surgery waiting times, by clinical urgency category, public hospitals
Table 10A.35	SA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2009-10
Table 10A.36	Tasmanian elective surgery waiting times, by clinical urgency category, public hospitals
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11 Primary and community health

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Attachment tables

Attachment tables are identified in references throughout this chapter by a '11A' prefix (for example, table 11A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

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

- public hospital emergency departments and outpatient services (reported in chapter 10, 'Public hospitals')
- community mental health services (reported in chapter 12, 'Mental health management')

-
- Home and Community Care program services (reported in chapter 13, ‘Aged care’).

The primary and community health sector is the part of the healthcare system most frequently used by Australians. It is important in preventative healthcare and in the detection and management of illness and injury, through direct service provision and through referral to acute (hospital) or other healthcare services, as appropriate.

Major improvements in reporting on primary and community health this year include:

- reporting a number of indicators with similar characteristics as separate measures under new high level indicators
- publication of updated data for the equity — access indicator ‘availability of public dentists’
- reporting against the outcome indicator ‘participation for women in breast cancer screening’ for the first time in this chapter
- removal of the effectiveness — appropriateness indicator ‘pharmaceuticals ordered by non-specialists’. Data have never been reported for this indicator and it was not expected that they would become available
- data reported by financial year for the outcome indicator ‘notifications of selected childhood diseases’, increasing the timeliness of reporting
- additional ‘data quality information’ (DQI) documentation.

11.1 Profile of primary and community health

Definitions, roles and responsibilities

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

Definitions for common health terms are provided in section 11.5.

General practice

General practice is a major provider of primary healthcare in Australia. It is defined by the Royal Australian College of General Practitioners (RACGP) as providing ‘person centred, continuing, comprehensive and coordinated whole person health care to individuals and families in their communities’ (RACGP 2011). General practice is the business structure within which one or more general practitioners (GPs) and other staff, such as practice nurses, provide and supervise healthcare for patients presenting to the practice. General practices are predominantly privately owned, by GPs or corporate entities.

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

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

Services provided in general practice include:

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

The Australian Government provides the majority of general practice income through Medicare, including fee-for-service payments via the Medicare Benefits Schedule (MBS) and other payments. 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 also provide additional incentives for GPs to work in rural and remote areas.

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

The Australian Government subsidises the cost of around 80 per cent of prescription medicines through the PBS (DoHA 2010). The PBS aims to provide affordable,

reliable and timely access to prescription medicines for all Australians. Users make a co-payment, which in 2011 was \$5.60 for concession card holders and \$34.20 for general consumers (DoHA 2011). The Australian Government pays the remaining cost of medicines that are eligible for the subsidy. Co-payment amounts are normally adjusted by the rate of inflation on 1 January each year.

Co-payments are also subject to a safety net threshold. Once consumer spending within a calendar year has reached the threshold, PBS medicines are generally cheaper or fully subsidised for the rest of the calendar year. The 2011 safety net threshold was \$1317.20 for general consumers and \$336.00 for concession card holders (DoHA 2011).

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

Community health services

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

Allied health services

Allied health services include, but are not limited to, physiotherapy, psychology, occupational therapy, audiology, podiatry and osteopathy. While some allied health professionals are employed in community health services, allied health services are delivered mainly in the private sector. Governments provide some funding for private services through insurance schemes and private insurance rebates. The Australian Government also makes some allied health services available under the MBS to patients with chronic conditions and complex care needs, and improves access to allied health services in rural and remote areas.

Dental services

The Australian Government and the State and Territory governments have different roles in supporting dental services in Australia's mixed system of public and private dental healthcare. State and Territory governments have the main responsibility for the delivery of major public dental programs, primarily directed at children and disadvantaged adults. The Australian Government supports the provision of dental services primarily through the private health insurance rebate, and also provides MBS funding for dental services for patients with chronic conditions and complex care needs, and for a limited range of medical services of an oral surgical nature. In addition, the Australian Government provides funding for the dental care of war veterans and members of the Australian Defence Force. It also has a role in the provision of dental services through Indigenous Primary Health Care Services. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink.

Funding

General practice

The Australian Government funds the majority of general practice services, primarily through Medicare and the DVA. The remainder comes from insurance schemes, patient contributions, and State and Territory government programs. The annual *Bettering the Evaluation and Care of Health* (BEACH) survey of general practice activity in Australia found that 95.4 per cent of all encounters with GPs in 2010-11 were for services at least partly funded by Medicare or the DVA (Britt *et al.* 2011) (table 11.1).

Table 11.1 GP encounters, by source of funding, 2010-11^{a, b, c}

	Number ^d	Per cent of all encounters ^e	95% LCL	95% UCL
Total encounters for which BEACH data were recorded	87 953	100.0	..	..
Encounters with missing data	7 886	..	..	..
Direct encounters	86 652	98.5	98.3	98.8
No charge	370	0.4	0.3	0.5
Medicare paid ^f	83 920	95.4	95.0	95.8
Workers compensation paid	1 703	1.9	1.8	2.1
Other paid (for example, hospital, State)	659	0.8	0.6	0.9
Indirect encounters ^g	1 295	1.5	1.2	1.7

LCL = lower confidence limit. UCL = upper confidence limit. ^a April 2010 to March 2011. ^b An encounter is any professional interchange between a patient and a GP (Britt *et al.* 2011). ^c Data from the BEACH survey may not be directly comparable with other data on medical practitioners in this Report. ^d Number of encounters after post stratification weighting for GP activity and GP age and sex. ^e Missing data removed. ^f Includes Australian Government payments made through the DVA. ^g For indirect encounters, the patient is not seen by the GP but a service is provided (for example, a prescription or referral). .. Not applicable.

Source: Britt *et al.* (2011) *General practice activity in Australia 2010-11*, Sydney University; table 11A.1.

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

- the Practice Incentives Program (PIP)
- the General Practice Immunisation Incentives Scheme (GPPI)
- the Divisions of General Practice Program (DGPP) — from 30 June 2012, Medicare Locals will assume responsibility for general practice support initiatives previously funded under the DGPP.

Australian Government expenditure on general practice in 2010-11 was \$6.4 billion, or \$287 per person (figure 11.33, table 11A.2).

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

State and Territory governments provide funding for general practice through a number of programs. Generally, this funding is provided indirectly through support services for GPs (such as assistance with housing and relocation, education programs and employment assistance for spouses and family members of doctors in rural areas) or education and support services for public health issues such as

diabetes management, smoking cessation, sexual health, and mental health and counselling. Non-government sources — insurance schemes (such as, workers compensation and third party insurance) and private individuals — also provide payments to GPs.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on the PBS and RPBS was around \$7.8 billion in 2010-11. Expenditure on the PBS was around \$7.3 billion — or \$326 per person — in 2010-11, of which 77.7 per cent was for concessional patients (table 11.2). Government expenditure on pharmaceuticals data are also presented in the Health sector summary.

Table 11.2 PBS and RPBS expenditure, 2010-11 (\$ million)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS general ^b	536.0	387.6	320.8	183.4	116.6	36.4	34.0	10.1	1 624.7
PBS concessional ^c	2 001.8	1 421.6	1 081.6	467.7	487.3	165.4	56.3	16.7	5 698.4
PBS doctor's bag	4.7	3.5	3.3	1.0	1.0	0.3	0.2	0.1	14.2
PBS total	2 542.4	1 812.7	1 405.7	652.1	605.0	202.1	90.5	26.9	7 337.4
RPBS total ^d	162.3	94.0	109.1	36.0	34.2	13.7	7.2	0.9	457.3
PBS and RPBS Total	2 704.7	1 906.7	1 514.8	688.1	639.2	215.9	97.6	27.8	7 794.7
PBS \$ per person ^e	349.0	323.9	308.3	281.0	365.9	396.2	249.6	116.7	325.8

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

Source: DoHA (unpublished) PBS Statistics; table 11A.3.

Community health services

Total government expenditure data reported here includes expenditure on services that are beyond the scope of this chapter, such as, food safety regulation, media campaigns to promote health awareness and private dental services (funded by health insurance premium rebates and non-government expenditure) (table 11.3). Disaggregated expenditure data relating only to the services covered in this chapter are not available.

In 2009-10, government expenditure on community and public health was \$7.9 billion, of which State, Territory and local governments provided 76.0 per cent, and the Australian Government 24.0 per cent (table 11.3). In that year, Australian Government direct outlay expenditure on dental services, predominantly through the DVA and DoHA, was \$761 million. State, Territory and local government expenditure on dental services was \$628 million in 2009-10. Additional expenditure is incurred by some states and territories through schemes that fund the provision of dental services to eligible people by private practitioners.

Table 11.3 Estimated funding on community and public health, and dental services, 2009-10 (\$ million)

	<i>Australian Government</i>				<i>State, Territory and local government</i>	<i>Total government</i>	<i>Non-government</i>	<i>Total government and non-government</i>
	<i>DVA</i>	<i>DoHA and other^a</i>	<i>Insurance premium rebates^b</i>	<i>Total^c</i>				
Community and public health ^d	2	1792	1	1795	5673	7467	389	7856
Dental services	107	654	495	1257	628	1885	5805	7690

^a 'Other' comprises Australian Government expenditure on the NHA and health-related NPs, capital consumption, estimates of the medical expenses tax offset and health research not funded by DoHA.

^b Government expenditure on insurance premium rebates relates to private health and dental services that are not within the scope of this chapter. ^c Totals may not add due to rounding. ^d Includes expenditure on other recurrent health services (not elsewhere classified) in addition to expenditure on community and public health services.

Source: AIHW (2011) Health Expenditure Australia 2009-10, Cat. no. HWE 55.

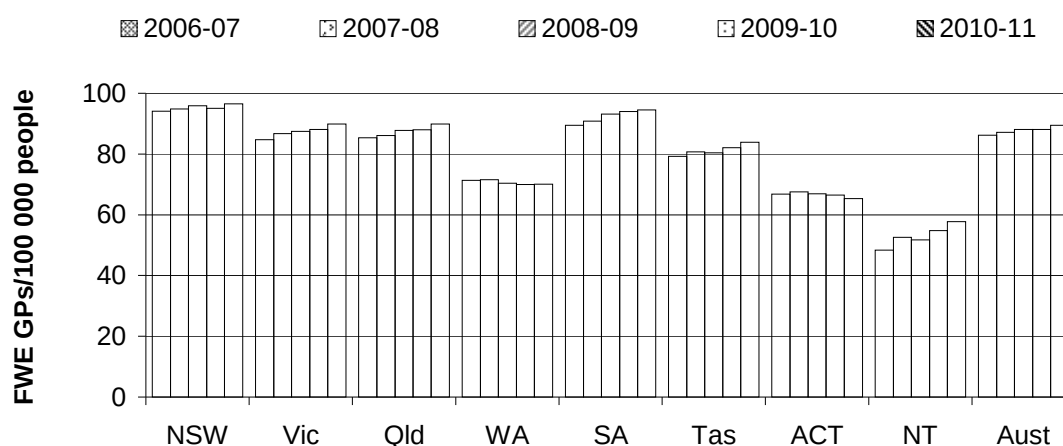
Size and scope

General practice

There were 27 639 vocationally recognised GPs and OMPs billing Medicare Australia, based on MBS claims data, in 2010-11. On a full time workload equivalent (FWE) basis, there were 20 267 vocationally recognised GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 89.5 FWE recognised GPs and OMPs per 100 000 people (table 11A.4). These data exclude services provided by GPs working with the Royal Flying Doctor Service and GPs working in Indigenous primary healthcare services and public hospitals. In addition, for some GPs — particularly in rural areas — MBS claims provide income for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid

through Medicare. The numbers of FWE vocationally recognised GPs and OMPs per 100 000 people across jurisdictions are shown in figure 11.1.

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

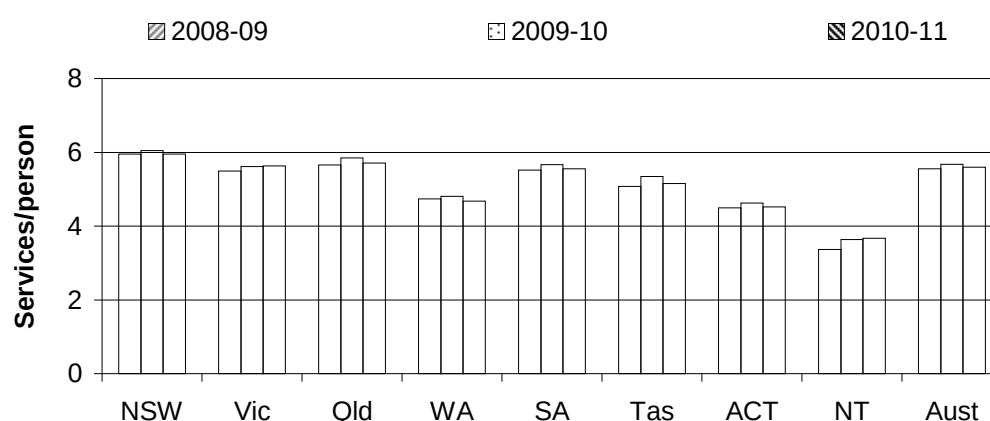


^a Data include vocationally recognised GPs and OMPs billing Medicare who are allocated to a jurisdiction based on the postcode of their major practice.

Source: DoHA (unpublished) MBS Statistics; table 11A.4.

Nationally, around 5599 general practitioner-type services were provided per 1000 population under Medicare in 2010-11 (figure 11.2).

Figure 11.2 GP-type service use^{a, b}



^a Rates are age standardised to the Australian population at 30 June 2001. ^b Includes non-referred attendances by vocationally recognised GPs and OMPs, and practice nurses.

Source: DoHA (unpublished) MBS Statistics; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 11A.5.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

There were around 201 million services provided under the PBS and RPBS in 2010-11, amounting to 9.0 prescriptions per person. There were around 188 million services provided under the PBS in 2010-11, of which 86.0 per cent were concessional (table 11.4).

Table 11.4 PBS and RPBS services, 2010-11 (million services)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
PBS general ^a	8.6	6.3	5.2	2.8	1.8	0.6	0.6	0.2	26.0
PBS concessional ^b	55.4	41.5	31.0	13.2	14.0	4.7	1.5	0.5	161.8
PBS doctor's bag	0.1	0.1	0.1	–	–	–	–	–	0.3
PBS total	64.1	47.9	36.2	16.0	15.8	5.3	2.1	0.6	188.1
RPBS total ^c	4.6	2.9	3.1	1.0	1.0	0.4	0.2	–	13.3
Total	68.7	50.8	39.4	17.0	16.9	5.7	2.3	0.7	201.4
Services per person ^d	9.4	9.1	8.7	7.3	10.2	11.2	6.4	2.9	9.0

^a Includes PBS general ordinary and safety net. ^b Includes PBS concessional ordinary and concessional free safety net. ^c Includes RPBS general ordinary and safety net. ^d Excludes RPBS and PBS doctor's bag. – Nil or rounded to zero.

Source: DoHA (unpublished) PBS Statistics; table 11A.6.

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 11A.81–11A.89 provide information on community health programs in each jurisdiction. The more significant of these programs are described below. Other community health programs provided by some jurisdictions include:

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

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

Maternal and child health

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

Public dental services

All jurisdictions provide some form of public dental service for primary school children. Some jurisdictions also provide dental services to secondary school students (tables 11A.81–11A.89).

State and Territory governments also provide some general dental services and a limited range of specialist dental services to disadvantaged adults who are holders of concession cards issued by Centrelink. In some jurisdictions, specialist dental services are provided mainly by qualified dental specialists; in others, they are provided in dental teaching hospitals as part of training programs for dental specialists (National Advisory Committee on Oral Health 2004). Most jurisdictions provided public dental services in 2010–11 targeted at disadvantaged people (tables 11A.81–11A.89).

Nationally, 74.4 public dental services were provided per 1000 people in 2010. Of these, around 19.5 per cent were emergency services (table 11.5).

Table 11.5 Use of public dental services by service type, per 1000 people, 2010^{a, b, c, d}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Emergency services ^e	9.6	10.4	26.9	12.4	13.3	29.3	14.6	25.6	14.5
General services	34.1	45.0	71.0	113.6	84.1	106.2	81.7	157.7	59.9
All services	43.7	55.4	97.9	126.0	97.3	135.4	96.3	183.3	74.4

^a Rates are age standardised to the Australian population at 30 June 2001. ^b Limited to dentate people aged 5 years or over. ^c Data are for the number of people who used a public dental service at least once in the preceding 12 months, not for the number of services provided. ^d Type of service at the most recent visit. ^e Emergency visit is a visit for relief of pain.

Source: AIHW (unpublished) National Dental Telephone Interview Survey; ABS (unpublished), *Australian Demographic Statistics*, Cat. no. 3101.0; table 11A.7.

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 2011a). Treatment activities excluded from that report include treatment with medication for dependence on opioid drugs such as heroin (opioid pharmacotherapy treatment) where no other treatment is provided, the majority of services for Indigenous people that are funded by the Australian Government, treatment services within the correctional system, and treatment units associated with acute care and psychiatric hospitals.

A total of 671 alcohol and other drug treatment agencies reported 2009-10 data to the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS). Of these, 307 (45.8 per cent) identified as government providers and 364 (54.2 per cent) identified as non-government providers (table 11A.8). All of the non-government providers received some government funding for 2009-10. There were 146 786 reported closed treatment episodes in 2009-10 (see section 11.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use, 67.8 per cent of whom were male, accounted for 140 769 closed treatment episodes (AIHW 2011a).

Alcohol was the most commonly reported principal drug of concern in closed treatment episodes for clients seeking treatment for their own substance abuse (47.9 per cent). Cannabis was the next most common drug of concern (23.2 per cent), followed by heroin (9.9 per cent) and amphetamines (7.1 per cent) (AIHW 2011a). Further information on alcohol and other drug treatment services funded by governments is included in tables 11A.81–11A.89.

Indigenous community healthcare services

Indigenous Australians use a range of primary healthcare services, including private GPs and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services in all jurisdictions. These services are planned and governed by local Indigenous communities and aim to deliver holistic and culturally appropriate health and health-related services. Funding is provided by Australian, State and Territory governments. In addition to these healthcare services, health programs for Indigenous Australians are funded by a number of jurisdictions. In 2009-10, these programs included services such as health

information, promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 11A.81–11A.89).

Data on Indigenous primary healthcare services that receive funding from the Australian Government are collected through the OATSIH Services Reporting (OSR) questionnaire (the OSR data collection replaced the previous Service Activity Reporting (SAR) data collection from the 2008-09 reporting period). Many of these services receive additional funding from State and Territory governments and other sources. The OSR data reported here represent the health-related activities, episodes and workforce funded from all sources.

For 2009-10, OSR data are reported for 223 Indigenous primary healthcare services (table 11A.9). Of these services, 91 (40.8 per cent) were located in remote or very remote areas (table 11A.10). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 11A.11). An episode of healthcare is defined in the OSR data collection as contact between an individual client and staff of a service to provide healthcare. Around 2.4 million episodes of healthcare were provided by participating services in 2009-10 (table 11.6). Of these, over 1 million (43.9 per cent) were in remote or very remote areas (table 11A.10).

Table 11.6 Estimated episodes of healthcare for Indigenous people by services for which OSR data are reported ('000)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2008-09	452.0	160.0	336.0	306.0	191.0	35.0	23.0	586.0	2 089.0
2009-10	542.4	184.8	378.8	408.8	191.6	36.2	25.7	622.4	2 390.7

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

Source: AIHW (unpublished) OSR data collection.

The services included in the OSR data collection employed 3115 full time equivalent health staff (as at 30 June 2010). Of these, 1701 were Indigenous (54.6 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous were relatively low (4.8 per cent and 10.4 per cent, respectively) (table 11A.12).

11.2 Framework of performance indicators

The performance indicator framework is based on the shared government objectives for primary and community health (box 11.1). The framework 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.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations). The *National Healthcare Agreement* (NHA) covers the areas of health and aged care services, and health indicators in the *National Indigenous Reform Agreement* establish specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. Both agreements include sets of performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with health performance indicators in the NHA.

Box 11.1 Objectives for primary and community health

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

- providing a universally accessible point of entry to the healthcare system
- promoting health and preventing illness
- providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s)
- coordinating service provision to ensure continuity of care where more than one service type, and/or ongoing service provision, is required to meet individuals' healthcare needs.

In addition, governments aim to ensure that interventions provided by primary and community health services are based on best practice evidence and delivered in an equitable and efficient manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of health services (figure 11.3). The performance indicator framework shows which data are comparable in the 2012 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).

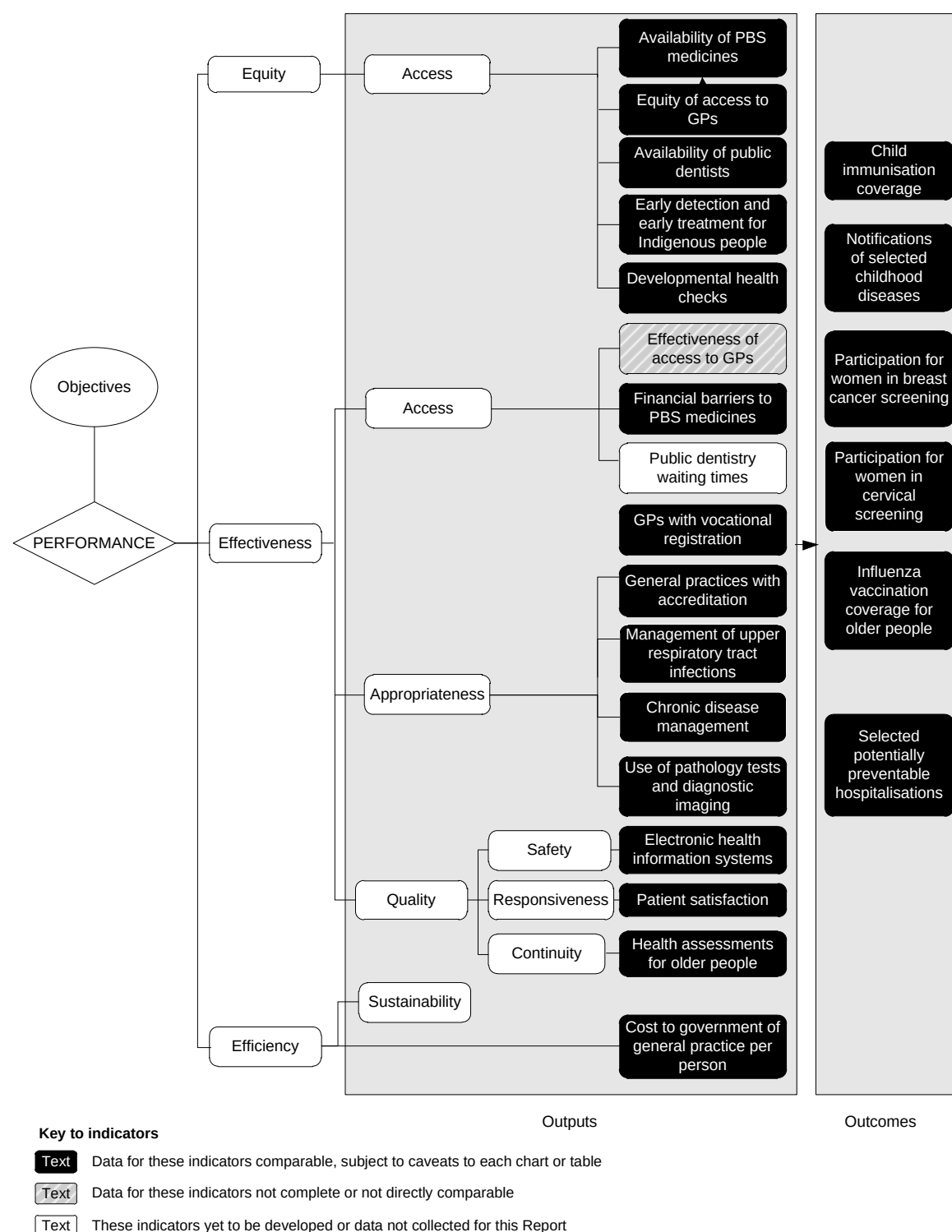
The framework has been revised to report a number of indicators with similar characteristics as separate measures under new high level indicators:

- ‘Availability of GPs by region’ and ‘availability of female GPs’ are reported as separate measures under the ‘equity of access to GPs’ indicator
- ‘Bulk billing rates’, ‘people deferring visits to GPs due to financial barriers’, ‘GP waiting times’ and ‘selected potentially avoidable GP-type presentations to emergency departments’ are reported as separate measures under the ‘effectiveness of access to GPs’ indicator
- ‘Management of diabetes’, ‘management of asthma’ and ‘care planning and case conferencing’ are reported as separate measures under the ‘chronic disease management’ indicator
- ‘Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions’, ‘potentially preventable hospitalisations for diabetes’ and ‘potentially preventable hospitalisations of older people for falls’ are reported as separate measures under the ‘selected potentially preventable hospitalisations’ indicator.

In addition, the indicator ‘participation for women in breast cancer screening’, reported in the Breast cancer framework in chapter 12 ‘Health management issues’ in previous editions of this Report, is now included in the Primary and community health performance indicator framework.

The Report’s statistical appendix 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) (appendix A).

Figure 11.3 Primary and community health performance indicator framework



11.3 Key performance indicator results

Different delivery contexts, locations and client factors may affect the equity, effectiveness and efficiency of health services.

Outputs

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

Equity

For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. Access to primary and community health services can be affected through factors such as disability, socioeconomic circumstance, age, geographic distance, cultural issues and English language proficiency (see chapter 1). Such issues have contributed to the generally poor health status of Indigenous people relative to other Australians (SCRGSP 2011).

Access

Availability of PBS medicines

‘Availability of PBS medicines’ is an indicator of governments’ objective to provide equitable access to PBS medicines (box 11.2).

Box 11.2 Availability of PBS medicines

'Availability of PBS medicines' is defined by three measures:

- 'People per pharmacy by region', defined as the estimated resident population (ERP), divided by the number of pharmacies, in urban and in rural regions.
- 'PBS expenditure per person by region', defined as expenditure on PBS medicines, divided by the ERP, in urban and in rural regions.
- 'Proportion of PBS prescriptions filled at a concessional rate', defined as the number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled.

This indicator is difficult to interpret. A low or decreasing number of people per pharmacy may indicate greater availability of PBS medicines. High or increasing PBS expenditure per person may indicate improved availability of PBS medicines. A high or increasing proportion of PBS prescriptions filled at a concessional rate may indicate improved availability of PBS prescriptions to disadvantaged people. It is also important that there are not large discrepancies in these measures by region.

Medicines are important in treating illness and can also be important in preventing illness from occurring. The availability of medicines is therefore a significant determinant of people's health and medicines should be available to those who require them, regardless of residential geolocation or socioeconomic circumstance.

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

Data for this indicator are comparable.

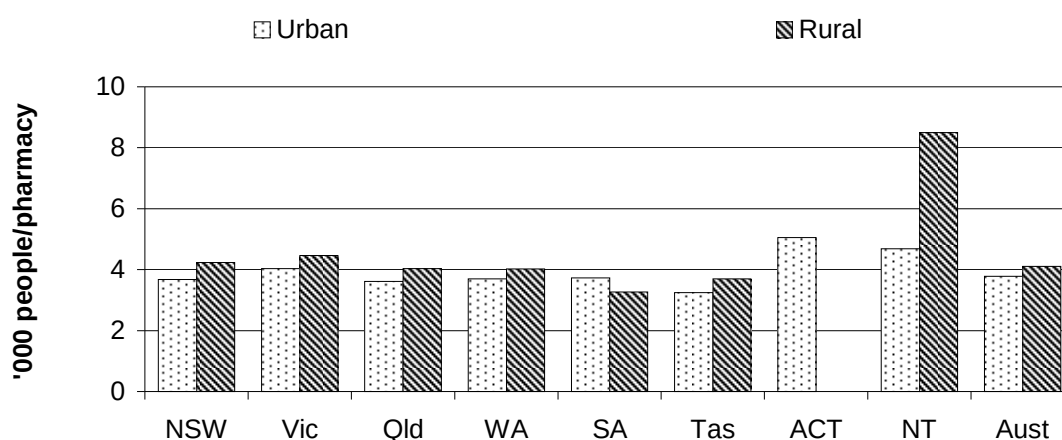
Data quality information for this indicator is under development.

Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, there were 3777 people per pharmacy in urban areas and 4108 in rural areas in 2010-11. In most states and territories, the number of people per pharmacy was higher in rural areas than in urban areas (figure 11.4, table 11A.13).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 39 medical practitioners and 238 hospitals — 89 private and 149 public¹ — approved to supply PBS medicines to the community in 2010-11. The approved medical practitioners and 47 of the approved public hospitals were located in rural areas (table 11A.13).

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

Figure 11.4 People per pharmacy, 2010-11^{a, b}

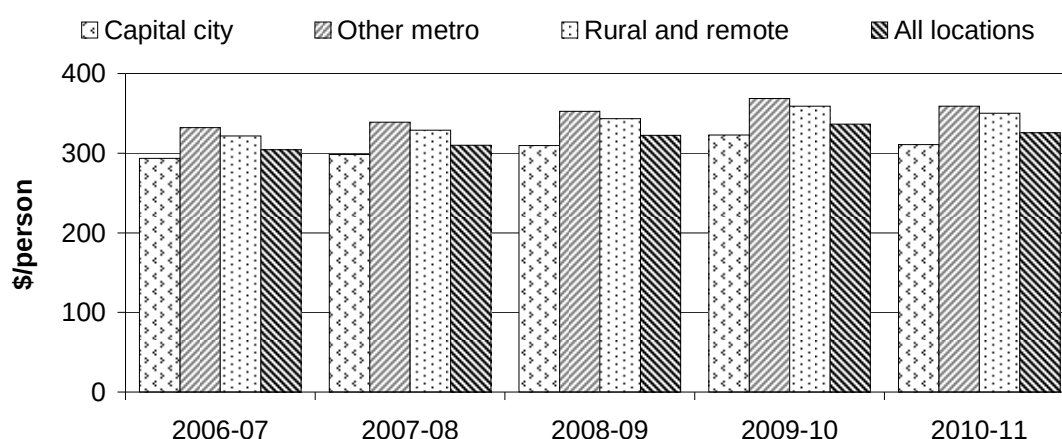


^a Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2-6. The ACT has no rural PhARIA areas. ^b Excludes RPBS and doctor's bag.

Source: DoHA (unpublished) derived from Medicare Australia, ABS 2006 Census of Population and Housing and the University of Adelaide's National Centre for Social Applications of Geographic Information Systems; table 11A.13.

Nationally, PBS expenditure per person decreased from \$337 in 2009-10 to \$326 in 2010-11 (in 2010-11 dollars) (figure 11.5). PBS expenditure per person was higher in rural and remote areas than in capital cities for the period 2006-07 to 2010-11 (in 2010-11 dollars).

Figure 11.5 PBS expenditure per person (2010-11 dollars)^a



^a Locality level data are only available on a cash basis for general and concessional categories. Data are not directly comparable to those published in DoHA's annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications dispensed under s.100 of the *National Health Act 1953* [Cwlth]).

Source: DoHA (unpublished) PBS Statistics; table 11A.14.

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 11A.6. These data are not available by regional location. Nationally, 86.0 per cent of prescriptions subsidised under the PBS were concessional in 2010-11.

Equity of access to GPs

‘Equity of access to GPs’ is an indicator of governments’ objective to provide equitable access to primary healthcare services (box 11.3).

Box 11.3 Equity of access to GPs

‘Equity of access to GPs’ is defined by two measures:

- ‘availability of GPs by region’, defined as the number of FWE GPs per 100 000 people, by region
- ‘availability of female GPs’, defined as the number of female FWE GPs, per 100 000 females.

High or increasing availability of GPs can indicate improved access to GP services. Low availability of GPs by region can be associated with an increase in distance travelled and waiting times to see a GP, and increased difficulty in booking long consultations. Reduced competition for patients can also reduce bulk billing rates. State and Territory governments seek to influence the availability of GPs through incentives to recruit and retain GPs in rural and remote areas.

High or increasing availability of female GPs means it is more likely that female patients who prefer to visit female GPs will have their preference met. Low availability of female GPs can similarly be associated with increased waiting times to see a GP, for women who prefer to discuss health matters with, and to receive primary healthcare from, a female GP.

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

Data for this indicator are comparable.

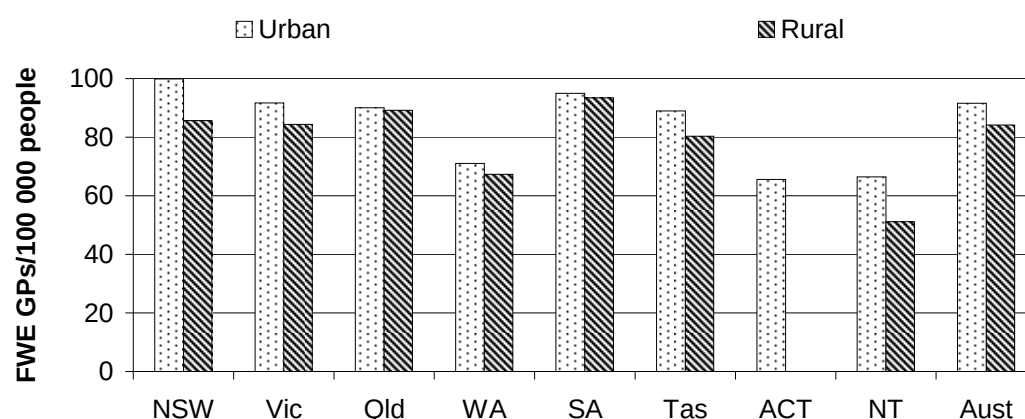
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Equity of access to GPs — availability of GPs by region

In terms of FWE GPs per 100 000 people, there were more GPs available in urban areas than in rural areas in all states and territories in 2010-11 (figure 11.6). The bulk billed proportion of non-referred attendances was generally lower in rural and

remote centres, than in capital cities, other metropolitan centres and 'other remote' areas (table 11A.24).

Figure 11.6 Availability of GPs (full time workload equivalent), 2010-11^{a, b, c}



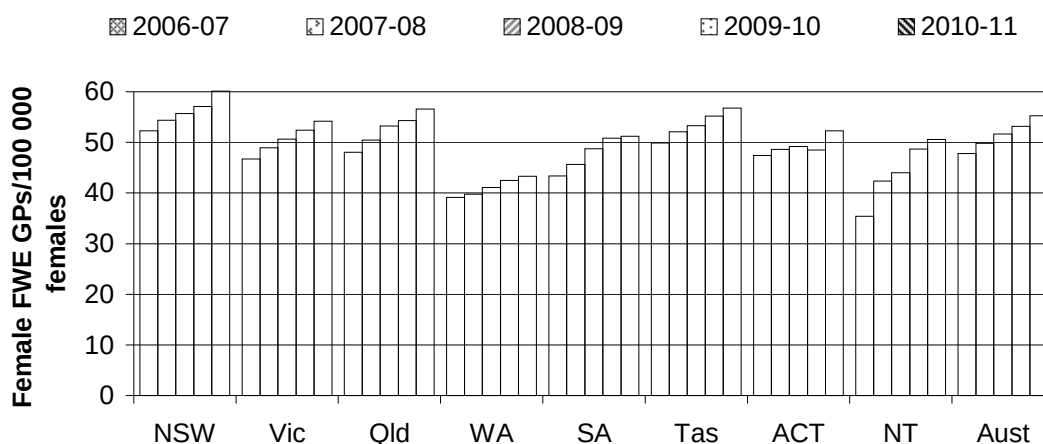
^a Geographical locations are based on the Rural, Remote and Metropolitan Areas (RRMA) classification. Urban areas consist of capital city and other metro areas. Rural areas consist of large rural centres, small rural centres, other rural areas, remote centres, other remote areas and other areas. ^b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

Source: DoHA (unpublished) MBS Statistics; table 11A.15.

Equity of access to GPs — availability of female GPs

In 2010-11, 40.8 per cent of Australia's GPs — 31.0 per cent of FWE GPs — were female (tables 11A.4 and 11A.16). The number of FWE GPs per 100 000 females increased from 47.8 to 55.2 in the period 2006-07 to 2010-11 (figure 11.7).

Figure 11.7 Availability of female GPs (full time workload equivalent)^a



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

Source: DoHA (unpublished) MBS Statistics; table 11A.16.

Availability of public dentists

‘Availability of public dentists’ is an indicator of governments’ objective to provide equitable access to dental services (box 11.4).

Box 11.4 Availability of public dentists

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

High or increasing availability of public dentists can indicate improved access to public dental services. The availability of public dentists by region affects people’s access to public dental services, particularly in rural and remote areas. Low availability can result in increased travel distance to a dentist and increased waiting times to see a dentist.

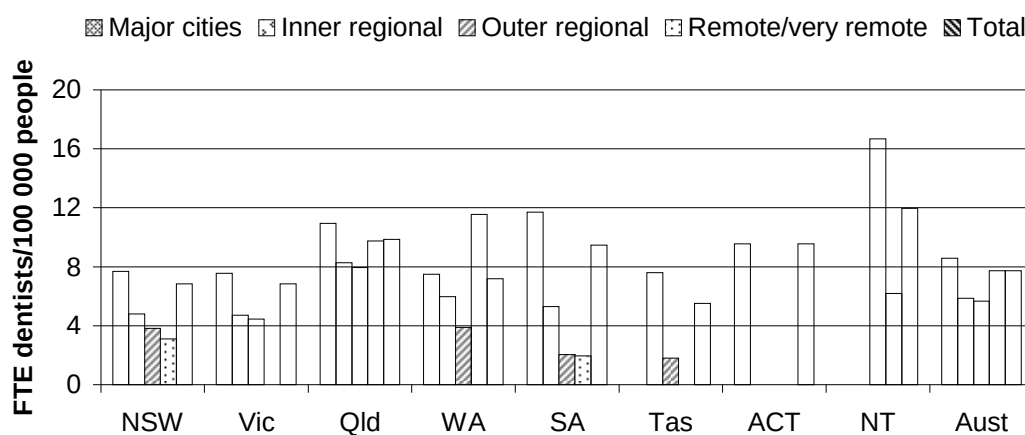
This indicator does not provide information on whether people are accessing the service or whether the services are appropriate for the needs of the people receiving them.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, there were more FTE public dentists per 100 000 people in major cities than in regional or remote areas in 2009 (figure 11.8, table 11A.17). Data for FTE dental therapists are presented in table 11A.18.

Figure 11.8 Availability of public dentists, 2009^{a, b, c, d}



^a FTE based on 40 hours per week. ^b Public dentists include those working in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and 'other public' areas. ^c There were no public dentists in remote and very remote areas in Victoria or Tasmania. There were no public dentists in inner regional areas in the ACT. ^d Tasmania has no major cities. The ACT has no outer regional, or remote and very remote, areas. The NT has no major cities or inner regional areas.

Source: AIHW (unpublished) National dental labour force collection; table 11A.17.

Early detection and early treatment for Indigenous people

'Early detection and early treatment for Indigenous people' is an indicator of governments' objective to provide equitable access to primary and community healthcare services for Indigenous people (box 11.5).

Box 11.5 Early detection and early treatment for Indigenous people

'Early detection and early treatment for Indigenous people' is defined as:

- the identification of individuals who are at high risk for, or in the early stages of, preventable and/or treatable health conditions (early detection)
- the provision of appropriate prevention and intervention measures in a timely fashion (early treatment).

Four measures of early detection and early treatment for Indigenous people are reported:

- The proportion of older people who received a health assessment by Indigenous status, where
 - 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 relatively young age at which Indigenous people become eligible for 'older' people's services recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health sector summary)
 - health assessments are MBS items that allow comprehensive examinations of patient health, including physical, psychological and social functioning. The assessments are intended to facilitate timely prevention and intervention measures to improve patient health and wellbeing.
- The proportion of older Indigenous people who received a health assessment in successive years of a five year period.
- The proportion of Indigenous people who received a health assessment or check by age group — health assessment/checks are available for Indigenous children (0–14 years), adults (15–54 years) and older people (55 years or over).
- The proportion of Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services.

A low or decreasing gap between the proportion of all older people and older Indigenous people who received a health assessment can indicate more equitable access to early detection and early treatment services for Indigenous people. An increase over time in the proportion of older Indigenous people who received a health assessment is desirable as it indicates improved access to these services. A low or decreasing gap between the proportion of Indigenous people in different age groups who received a health assessment/check can indicate more equitable access to early detection and treatment services within the Indigenous population. An increase in the proportion of Aboriginal and Torres Strait Islander primary healthcare services that included early detection activities is desirable as it indicates improved access to early detection and treatment services for Indigenous Australians.

(Continued next page)

Box 11.5 (Continued)

This indicator provides no information about the proportion of people who receive early detection and early treatment services that are not listed in the MBS. Such services are provided by salaried GPs in community health settings, hospitals and Aboriginal and Torres Strait Islander primary healthcare services, particularly in rural and remote areas. Accordingly, this indicator understates the proportion of people who received early detection and early treatment services.

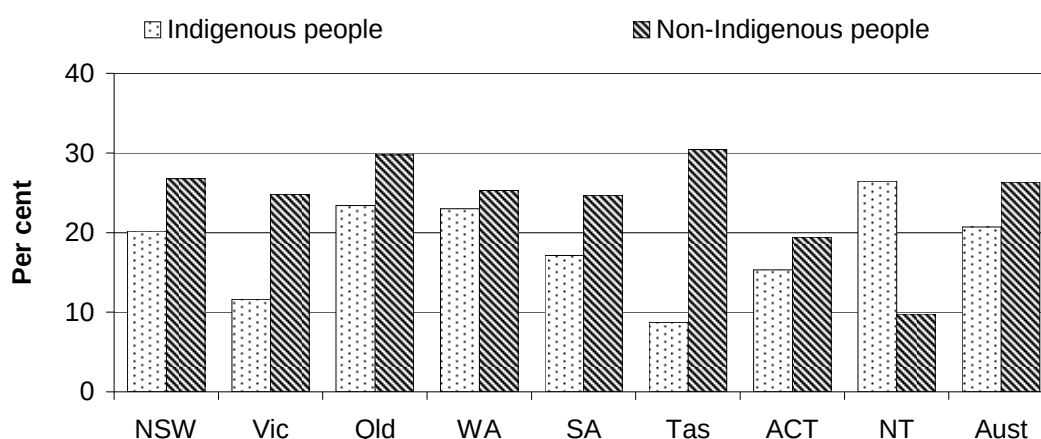
Data for this indicator are comparable.

Data quality information for this indicator is under development.

The high prevalence of preventable and/or treatable health conditions in the Indigenous population is strongly associated with relatively poor health outcomes for Indigenous people (AIHW 2008a; SCRGSP 2011). The availability and uptake of early detection and early treatment services is understood to be a significant determinant of people's health.

In 2010-11, the proportion of Indigenous older people who received an annual health assessment was lower than the proportion of non-Indigenous older people who received an annual health assessment in all jurisdictions except the NT (figure 11.9). This suggests that access to early detection and early treatment services may not be equitable.

Figure 11.9 Older people who received an annual health assessment by Indigenous status, 2010-11^{a, b}

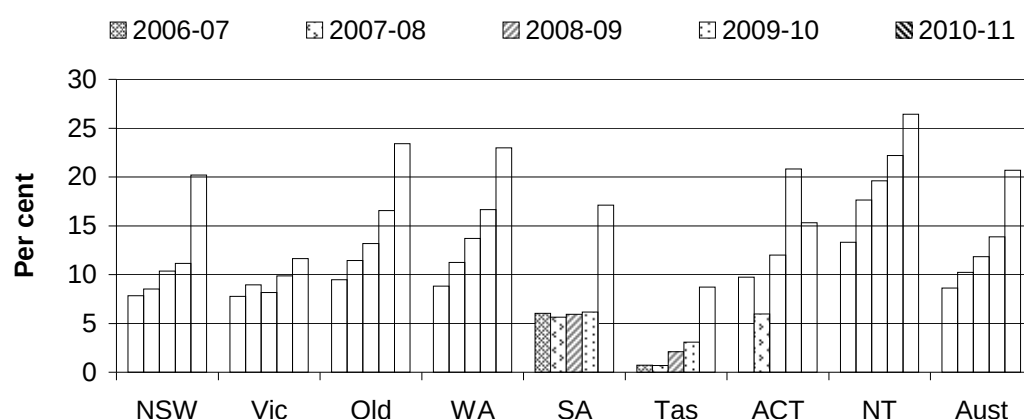


^a Older people are defined as Indigenous people aged 55 years or over and non-Indigenous people aged 75 years or over. ^b Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may receive a health assessment under the 'all older people' MBS items. This is unlikely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

Source: Derived from DoHA (unpublished) MBS Statistics, ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS (2010) *Australian demographic statistics June quarter 2010*, Cat. no. 3101.0; table 11A.19.

The proportion of older Indigenous people who received an annual health assessment increased in most jurisdictions between 2006-07 and 2010-11 (figure 11.10).

Figure 11.10 Older Indigenous people who received an annual health assessment^a



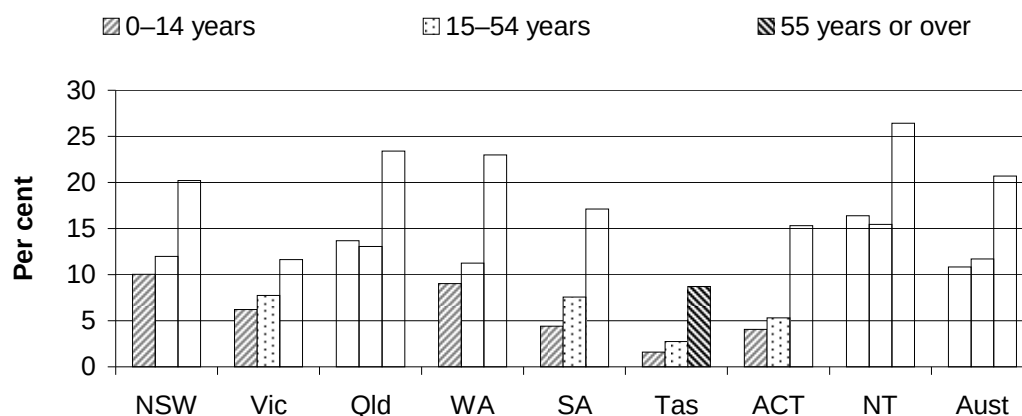
^a Older people are defined as Indigenous people aged 55 years or over. Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may receive a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect overall proportions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

Source: Derived from DoHA (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.20.

Health check MBS items were introduced for Indigenous people aged 15–54 years in May 2004. Initially available biennially, since 1 May 2010 they have been available annually. Also available annually are health checks for Indigenous children aged 0–14 years, introduced in May 2006.

The proportion of the eligible Indigenous population who received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions (figure 11.11). This can, in part, reflect differences in how long the items have been available, as factors such as awareness and administrative requirements affect the uptake of new MBS items (AIHW 2008a).

Figure 11.11 Indigenous people who received a health check or assessment by age, 2010-11^a

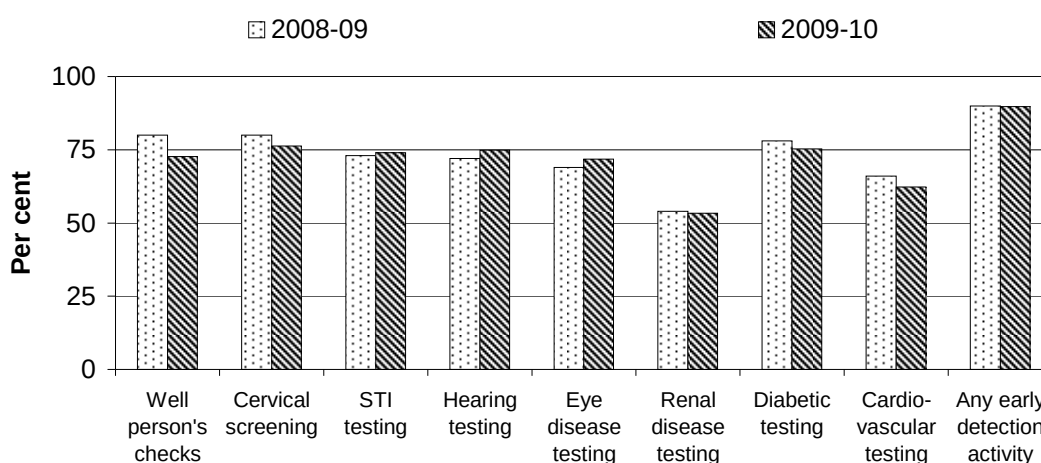


^a Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of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

Source: Derived from DoHA (unpublished) MBS Statistics and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.21.

Figure 11.12 shows the proportion of Indigenous primary healthcare services for which OSR data are reported that provided various early detection services in 2008-09 and 2009-10.

Figure 11.12 Indigenous primary healthcare services for which OSR data are reported that provided early detection services^a



^a The OSR data collection replaces the previous Service Activity Reporting (SAR) data collection from the 2008-09 reporting period. Historical SAR data are published in previous reports.

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

Developmental health checks

‘Developmental health checks’ is an indicator of governments’ objective to provide equitable access to early detection and intervention services for children (box 11.6).

Box 11.6 Developmental health checks

‘Developmental health checks’ is defined as the proportion of children who received a fourth year developmental health check under Medicare, by health check type. Health check type is considered as a proxy for Indigenous status. The ‘Healthy Kids Check’ MBS health assessment item is available to children aged 3, 4 or 5 years, while the ‘Aboriginal and Torres Strait Islander Peoples Health Assessment’ item is available to Indigenous children aged 0–14 years.

A high or increasing proportion of children receiving a fourth year developmental health check is desirable as it suggests improved access to these services.

The proportion of Indigenous children aged 3, 4 or 5 years who received the Aboriginal and Torres Strait Islander Peoples Health Assessment is considered as a proxy for the proportion of Indigenous children who received a fourth year developmental health check. This should be considered a minimum estimate as the data exclude checks received by Indigenous children under the Healthy Kids Check item.

Fourth year developmental health checks are intended to assess children’s physical health, general wellbeing and development. They enable identification of children who are at high risk for or have early signs of delayed development and/or illness. Early identification provides the opportunity for timely prevention and intervention measures that can ensure that children are healthy, fit and ready to learn when they start schooling.

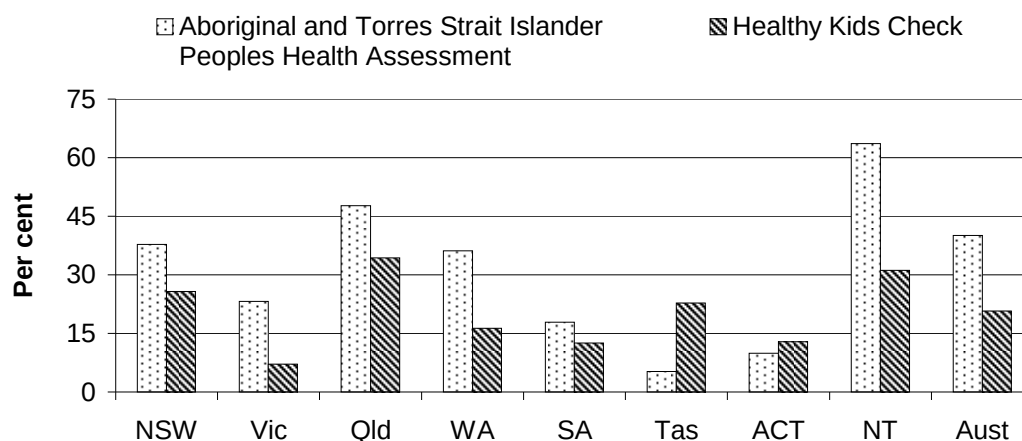
This indicator provides no information about developmental health checks for children that are provided outside Medicare, as comparable data for such services are not available for all jurisdictions. These checks are provided in the community, for example, maternal and child health services, community health centres, early childhood settings and the school education sector. Accordingly, this indicator understates the proportion of children who receive a fourth year developmental health check.

Data for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, 21.7 per cent of children received a fourth year developmental health check under Medicare in 2010–11. The proportion of Indigenous children who received an Aboriginal and Torres Strait Islander Peoples Health Assessment was higher than the proportion of children who received a Healthy Kids Check in most jurisdictions (figure 11.13).

Figure 11.13 **Children who received a fourth year developmental health check, by health check type, 2010-11^{a, b, c, d, e}**



^a Limited to health checks available under Medicare. ^b Aboriginal and Torres Strait Islander Peoples Health Assessment data include claims for MBS Item 715 for children aged 3–5 years. ^c Healthy Kids Check data include claims for MBS Items 701, 703, 705, 707 and 10 986 for children aged 3–5 years. ^d Children are counted once only; where a child received both types of health check during the reference period they are counted against the Aboriginal and Torres Strait Islander Peoples Health assessment. ^e Healthy Kids Check data include Indigenous children who received a Healthy Kids Check provided they did not also receive a Aboriginal and Torres Strait Islander Peoples Health Assessment during the reference period.

Source: DoHA (unpublished) MBS Statistics; ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS (unpublished) *Australian demographic statistics*, Cat. no. 3101.0; table 11A.23.

Effectiveness

Access

Effectiveness of access to GPs

‘Effectiveness of access to GPs’ is an indicator of governments’ objective to provide effective access to primary healthcare services (box 11.7). The effectiveness of services can vary according to the affordability and timeliness of services that people can access.

Box 11.7 Effectiveness of access to GPs

'Effectiveness of access to GPs' is defined by four measures:

- 'bulk billing rates', defined as the number of GP visits that were bulk billed as a proportion of all GP visits
- 'people deferring visits to GPs due to financial barriers', defined as the proportion of people who delayed seeing or did not see a GP due to cost
- 'GP waiting times', defined as the number of people who saw a GP for urgent medical care within specified waiting time categories in the previous 12 months, divided by the number of people who saw a GP for urgent medical care in the previous 12 months. Specified waiting time categories are:
 - less than 4 hours
 - 4 to 24 hours
 - more than 24 hours
- 'selected potentially avoidable GP-type presentations to emergency departments', defined as the number of 'GP-type presentations' to emergency departments divided by the total number of presentations to emergency departments, where GP-type presentations are those:
 - allocated to triage category 4 or 5
 - not arriving by ambulance, with police or corrections
 - not admitted or referred to another hospital
 - who did not die.

A high or increasing proportion of bulk billed attendances can indicate more affordable access to GP services. GP visits that are bulk billed do not require patients to pay part of the cost of the visit, while GP visits that are not bulk billed do. This measure does not provide information on whether the services are appropriate for the needs of the people receiving them.

A low or decreasing proportion of people deferring visits to GPs due to financial barriers indicates more widely affordable access to GPs. A high or increasing proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs. A low or decreasing proportion of GP-type presentations to emergency departments can indicate better access to primary and community health care.

Data for the first three measures of this indicator are comparable, while data for the fourth measure 'selected potentially avoidable GP-type presentations to emergency departments' are not directly comparable.

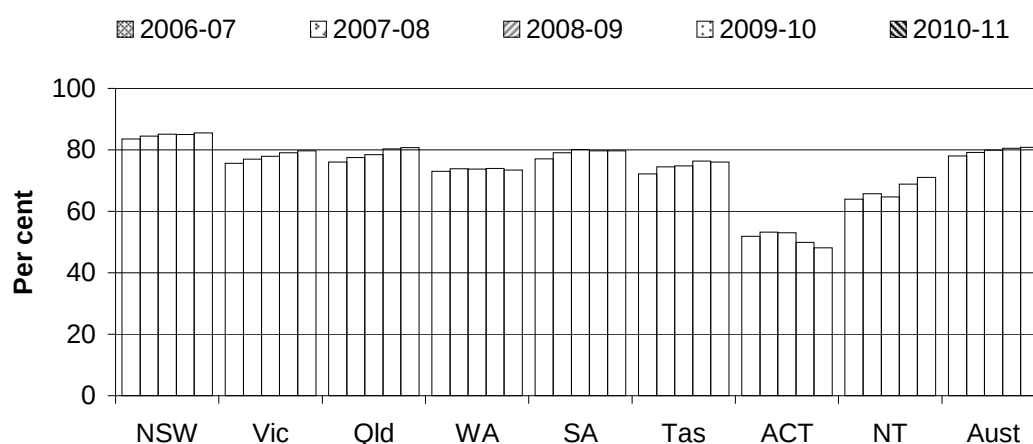
Partial data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Effectiveness of access to GPs — bulk billing rates

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

Nationally, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 80.9 per cent in 2010-11. For most jurisdictions, this proportion increased in the period 2006-07 to 2010-11 (figure 11.14). The bulk billed proportion of non-referred attendances was highest in 'other remote areas', 'capital cities' and 'other metropolitan centres' (table 11A.24). The bulk billed proportion of non-referred attendances was higher for children under 16 years and older people than for people aged 16 to 64 years (table 11A.25).

Figure 11.14 GP visits that were bulk billed^{a, b}



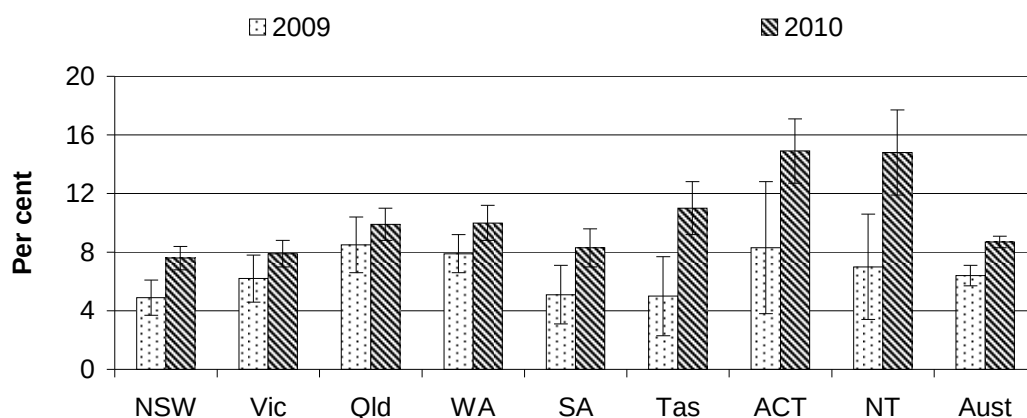
^a Includes attendances by practice nurses. ^b Allocation to State/Territory based on patients' Medicare enrolment postcode.

Source: DoHA (unpublished) MBS Statistics; table 11A.25.

Effectiveness of access to GPs — people deferring visits to GPs due to financial barriers

Timely access to healthcare services is important to people's health and wellbeing. Deferring or not visiting a GP can result in poorer health. Nationally, in 2010, 8.7 per cent of respondents reported that they delayed or did not visit a GP in the previous 12 months because of cost (figure 11.15).

Figure 11.15 People deferring visits to GPs due to cost^{a, b, c, d}



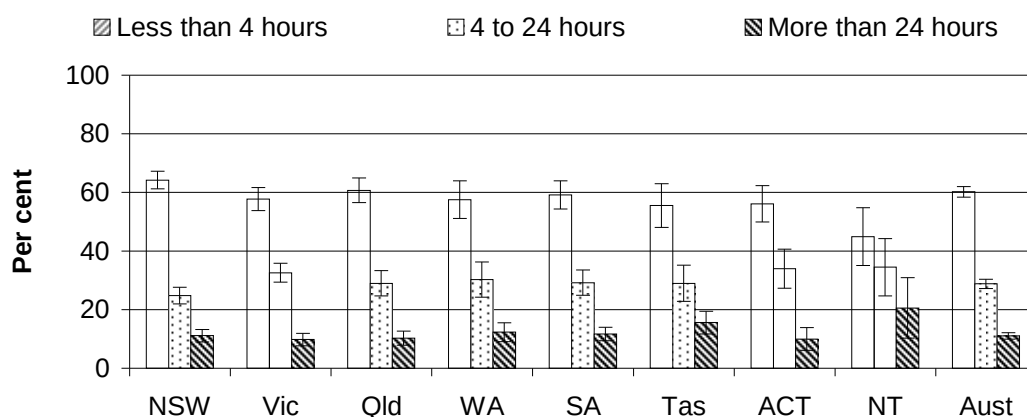
^a People aged 15 years or over. ^b Delayed visiting or did not visit a GP at any time in the previous 12 months. ^c Rates are age standardised to the Australian population at 30 June 2001. ^d Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey* 2009, 2010-11; table 11A.26.

Effectiveness of access to GPs — GP waiting times

Nationally, 60.2 per cent of people who saw a GP for urgent care waited less than 4 hours in 2010 (figure 11.16). Around 28.8 per cent waited from 4 to less than 24 hours, and 11.0 per cent waited for more than 24 hours. For visits to GPs not requiring urgent care, 15.5 per cent of people waited longer than they felt was acceptable to get an appointment (table 11A.28).

Figure 11.16 Hours waited for urgent treatment by GP, 2010^{a, b, c, d}



^a People aged 15 years or over who saw a GP for urgent medical care for their own health in the previous 12 months. ^b Time waited between making an appointment and seeing the GP for urgent medical care. ^c Rates are age standardised to the Australian population at 30 June 2001. ^d Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey* 2010-11; table 11A.27.

Effectiveness of access to GPs — GP-type presentations to emergency departments

GP-type presentations to emergency departments are presentations for conditions that could be appropriately managed in the primary and community health sector (Van Konkelenberg, Esterman and Van Konkelenberg 2003). One of several factors contributing to GP-type presentations at emergency departments is perceived or actual lack of access to GP services. Other factors include proximity of emergency departments and trust for emergency department staff.

Nationally, there were around 2.1 million GP-type presentations to public hospital emergency departments in 2010-11 (table 11.7). Data are presented by Indigenous status and remoteness in table 11A.29.

Table 11.7 GP-type presentations to emergency departments
(‘000)^{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>
2010-11	712.6	554.9	375.0	213.9	117.4	47.6	48.5	42.3	2112.2

^a GP-type emergency department presentations are defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of semi-urgent or non-urgent, and where the episode end status was not admitted to the hospital, or referred to another hospital, or died. This is an interim definition, pending development of new methodology to more closely approximate the population that could receive services in the primary care sector. ^b Data are presented by State/Territory of usual residence of the patient. ^c Data are for peer group A and B public hospitals only.

Source: AIHW (unpublished) National non-admitted emergency patient database; table 11A.30.

Financial barriers to PBS medicines

‘Financial barriers to PBS medicines’ is an indicator of governments’ objective to ensure effective access to prescribed medicines (box 11.8).

Box 11.8 Financial barriers to PBS medicines

‘Financial barriers to PBS medicines’ is defined as the proportion of people who delayed getting or did not get a prescription filled due to cost.

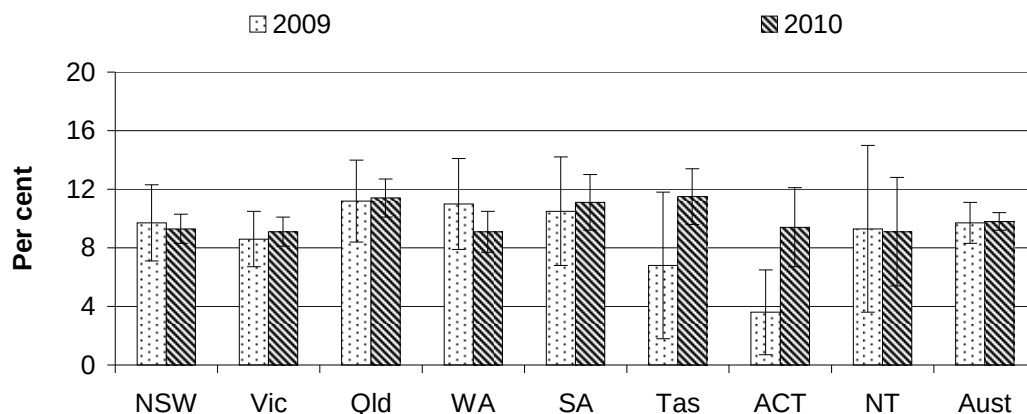
A low or decreasing proportion of people deferring treatment due to financial barriers indicates more widely affordable access to medications.

Data for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, in 2010, 9.8 per cent of respondents delayed or did not purchase prescribed medicines due to cost in the previous 12 month period (figure 11.17).

Figure 11.17 People deferring purchase of prescribed medicines due to cost^{a, b, c, d}



^a People aged 15 years or over who received a prescription for medication in the previous 12 months. ^b Delayed purchasing or did not purchase prescribed medicines at any time in the previous 12 months. ^c Rates are age standardised to the Australian population at 30 June 2001. ^d Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Patient Experience Survey 2009, 2010-11*; table 11A.32.

Public dentistry waiting times

‘Public dentistry waiting times’ is an indicator of governments’ objective to ensure timely access to public dental services for eligible people (box 11.9).

Box 11.9 Public dentistry waiting times

‘Public dentistry waiting times’ is defined as the median waiting time (in days) from being placed on a public dentistry waiting list to an offer of care for dental treatment being made.

Data for this indicator were not available for the 2012 Report.

Appropriateness

GPs with vocational registration

‘GPs with vocational registration’ is an indicator of governments’ objective to ensure the GP workforce has the capability to deliver high quality services (box 11.10).

Box 11.10 GPs with vocational registration

'GPs with vocational registration' is defined as the proportion of FWE GPs with vocational registration. Vocationally registered GPs are considered to have the values, skills and knowledge necessary for competent unsupervised general practice within Australia (RACGP 2007).

A high or increasing proportion of FWE GPs with vocational registration can indicate an improvement in the capability of the GP workforce to deliver high quality services. However, GPs without vocational registration can deliver services of equally high quality.

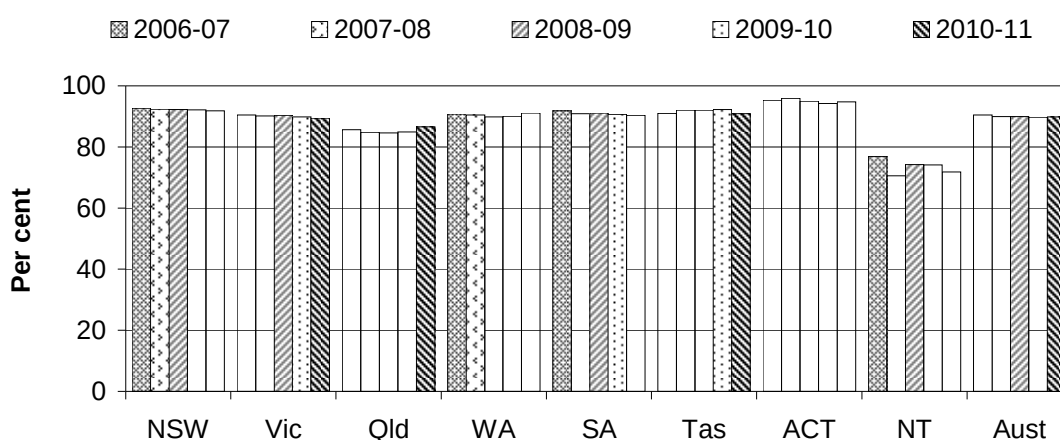
Data for this indicator are comparable.

Data quality information for this indicator is under development.

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

The proportion of FWE GPs with vocational registration remained relatively constant over the five years to 2010-11 (figure 11.18). The proportion of FWE GPs with vocational registration was highest in capital cities and other metro centres, and lowest in remote areas, in 2010-11 (table 11A.33).

Figure 11.18 **GPs (full time workload equivalent) with vocational registration^a**



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

Source: DoHA (unpublished) MBS Statistics; table 11A.34.

General practices with accreditation

‘General practices with accreditation’ is an indicator of governments’ objective to ensure the general practitioner workforce has the capability to provide high quality services (box 11.11).

Box 11.11 General practices with accreditation

‘General practices with accreditation’ is defined as the number of general practices that are accredited as a proportion of all general practices in Australia. 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.

A high or increasing proportion of practices with accreditation can indicate an improvement in the capability of general practice to deliver high quality services. However, general practices without accreditation can deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.

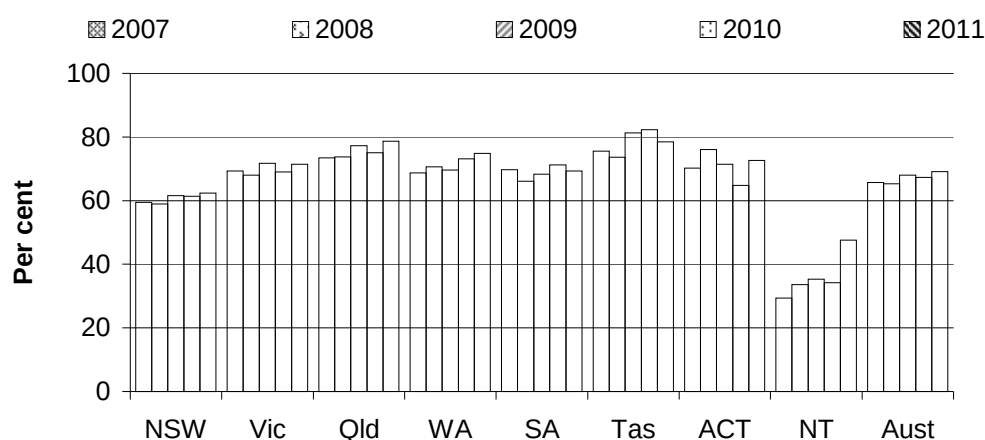
Data for this indicator are comparable.

Data quality information for this indicator is under development.

The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and General Practice Australia ACCREDITATION *plus* (GPA Accreditation *plus*).

In June 2011, 4908 general practices — representing 69.2 per cent of general practices — were accredited nationally (figure 11.19).

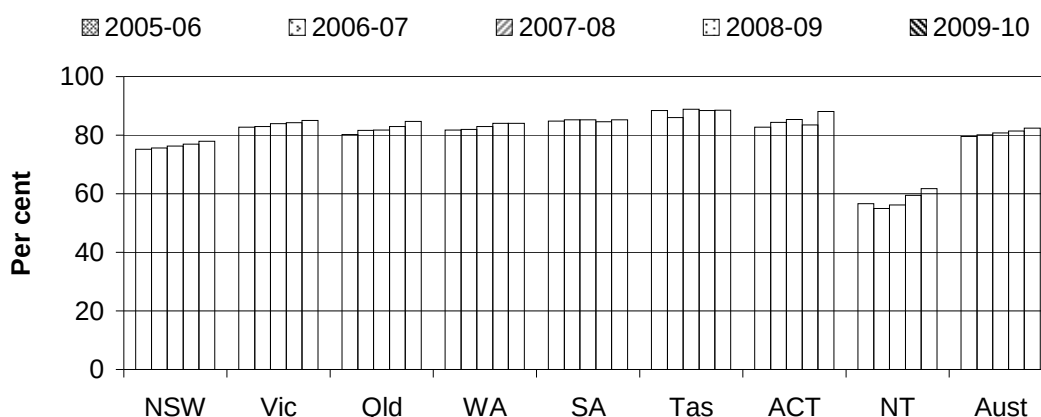
Figure 11.19 General practices with accreditation, at 30 June



Source: AGPAL (unpublished); GPA Accreditation *plus* (unpublished); Primary Health Care Research and Information Service and DoHA (unpublished) *Annual Survey of Divisions of General Practice 2010-11*; table 11A.35.

The proportion of patients attending accredited practices provides useful additional information relating to accreditation. For this measure, PIP practices provide a proxy for accredited practices, as accreditation is a requirement for PIP registration. Nationally, the proportion of general practice patient care — measured as standardised whole patient equivalents (SWPEs) — provided by PIP practices has been relatively constant in the period from 2005-06 to 2009-10 (figure 11.20).

Figure 11.20 Proportion of general practice patient care provided by PIP practices^a



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

Source: DoHA (unpublished) PIP and MBS data collections; table 11A.36.

Management of upper respiratory tract infections

‘Management of upper respiratory tract infections’ is an indicator of governments’ objective to ensure that antibiotics are used appropriately and effectively (box 11.12).

Box 11.12 Management of upper respiratory tract infections

‘Management of upper respiratory tract infections’ is defined as the number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat upper respiratory tract infection [URTI]) that are provided to PBS concession card holders, per 1000 PBS concession card holders.

A low or decreasing prescription rate can indicate that GPs’ management of URTI more closely follows guidelines.

URTI without complication is most often caused by a virus. Antibiotics have no efficacy in the treatment of viral infections, but are nevertheless frequently prescribed for viral infections. Unnecessarily high rates of antibiotic prescription for URTI have the potential to increase pharmaceutical costs and to increase antibiotic resistance in the community. The selected antibiotics are also prescribed for illnesses other than URTI; the indicator provides no information about the condition for which they were prescribed. Data are reported for PBS concession card holders because complete data are not available for prescriptions provided to non-PBS concession card holders.

Data for this indicator are comparable.

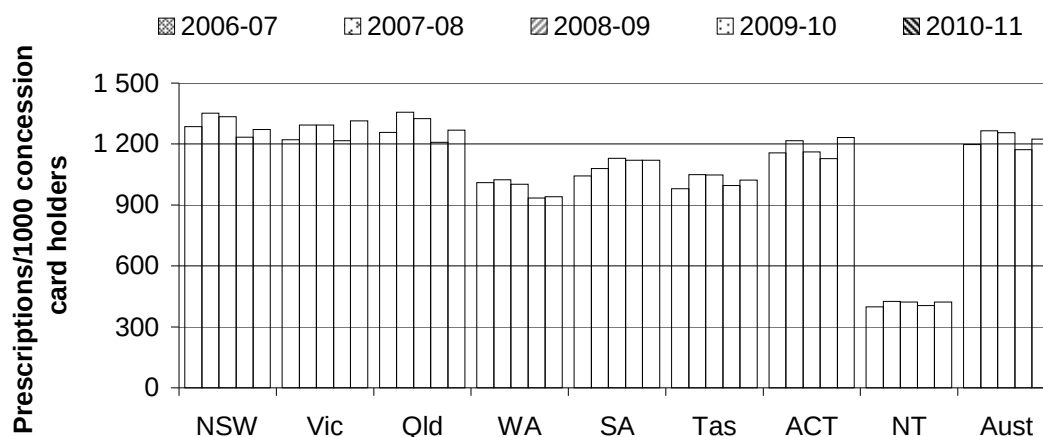
Data quality information for this indicator is under development.

Caution should be used in the interpretation of this indicator over time, as pharmaceutical needs of concession card holders can increase in complexity due to the effects of population ageing.

Nationally, the prescription rate for the oral antibiotics most commonly used to treat URTI was 1224 per 1000 PBS concession card holders in 2010-11 (figure 11.21).

Further information on GP use of antibiotics in the management of URTI is available from the annual BEACH survey of general practice activity in Australia. Nationally, the proportion of acute URTI problems for which antibiotics were prescribed dropped from 42.0 per cent in 1998-99 to 32.4 per cent in 2009-10 (Britt *et al.* 2010).

Figure 11.21 **Rate of prescription of the oral antibiotics used most commonly to treat upper respiratory tract infection^{a, b}**



^a Prescriptions ordered by vocationally recognised GPs and other medical practitioners (OMPs) and dispensed to PBS concession card holders. ^b Data are not limited to prescriptions for treatment of upper respiratory tract infection.

Source: DoHA (unpublished) PBS Statistics; table 11A.37.

Chronic disease management

‘Chronic disease management’ is an indicator of governments’ objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 11.13).

Box 11.13 Chronic disease management

‘Chronic disease management’ is defined by three measures:

- ‘Management of diabetes’, defined as:
 - the proportion of people with diabetes mellitus who have received an annual cycle of care within general practice (the number of MBS items claimed for completion of a cycle of care for patients with established diabetes mellitus, divided by the estimated number of people with diabetes mellitus)
 - the proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent (the number of people with diabetes mellitus with HbA1c below 7 per cent, divided by the estimated number of people with diabetes mellitus).

(Continued next page)

Box 11.13 (Continued)

- 'Management of asthma', defined as the proportion of people with asthma who have a written asthma action plan
- 'Care planning/case conferencing', defined as the proportion of GPs who used the MBS chronic disease management items for care planning or case conferencing at least once during a 12 month period.

A high or increasing proportion of people with diabetes mellitus who have received an annual cycle of care within general practice is desirable. The MBS annual cycle of care for patients with diabetes is generally based on RACGP clinical guidelines for the appropriate management of Type 2 diabetes in general practice. Appropriate management of diabetes in the primary and community health sector can prevent or minimise the severity of complications (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications. Data should be considered as minimum estimates as appropriate management of diabetes mellitus by GPs who do not claim the rebates is not captured. Various factors influence the uptake of MBS items by GPs.

A high or increasing proportion of people with diabetes with HbA1c below 7 per cent is desirable. HbA1c measures the level of glucose in the blood averaged over the preceding three months. Data for this measure were not available for the 2012 Report.

A high or increasing proportion of people with asthma who have a written asthma action plan is desirable. Written asthma action plans have been included in clinical guidelines for asthma management for nearly 20 years. They enable people with asthma to recognise and respond quickly and appropriately to deteriorating asthma symptoms, and thereby preventing or reducing the severity of acute asthma episodes (ACAM 2008).

A high or increasing proportion of GPs who use chronic disease management items can indicate an improvement in the continuity of care provided to people with complex, multidisciplinary care needs. Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team based care. Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.

Data reported against this indicator are comparable.

Partial data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Chronic diseases are generally long term and often progressive conditions, for example, diabetes and asthma. Chronic disease is estimated to be responsible for more than 80 per cent of the burden of disease and injury suffered by Australians (Australian Government 2010).

Appropriate and effective management in the primary and community health sector can delay the progression of many chronic diseases as well as prevent, or minimise the severity of, complications (AIHW 2008c, NHPAC 2006). Effective management requires the provision of timely, high quality healthcare to meet individual needs and provide continuity of care (Australian Government 2010). Effective management can have profound effects on individuals and on the broader health system. Individuals benefit from improved health and wellbeing, and the capacity for greater economic and social participation. Reduced demand for treatment in the acute health sector can reduce the burden on the broader health system.

Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Chronic disease management — diabetes

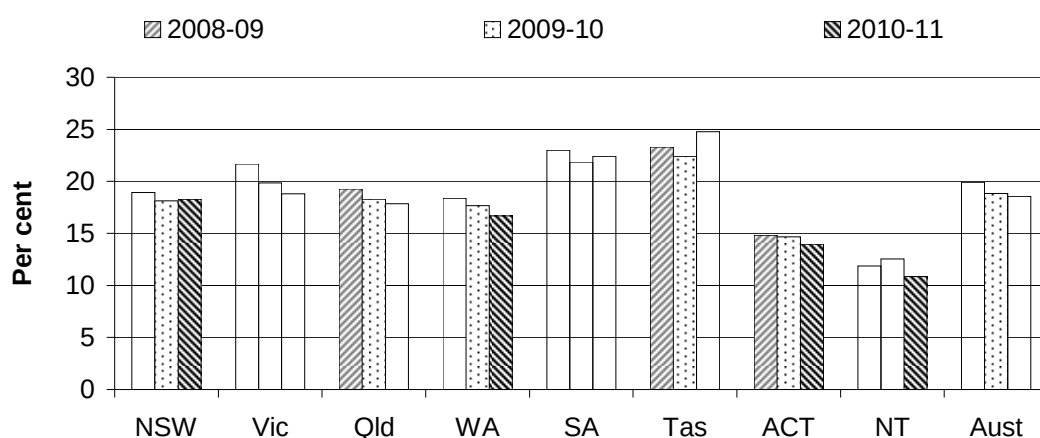
Diabetes mellitus, a chronic disease of increasing prevalence, is an identified National Health Priority Area for Australia. People with diabetes ('diabetes' refers to diabetes mellitus; this report does not consider diabetes insipidus) are at high risk of serious complications such as cardiovascular, eye and kidney disease. Type 2 diabetes is the most common form of diabetes and is largely preventable.

Appropriate management in the primary and community health sector can prevent or minimise the severity of diabetes complications (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Since 2001, rebates have been available to GPs under the MBS on completion of an annual cycle of care for diabetes. The 'required annual cycle of care' is generally based on the RACGP's clinical guidelines for the management of Type 2 diabetes in general practice (but requires less frequent testing of glycosylated haemoglobin). Clinical guidelines represent the minimum required level of care. The need for a standard definition of 'annual cycle of care' has been identified (AIHW 2007).

Nationally, 18.6 per cent of people with diabetes received the annual cycle of care in 2010-11 (figure 11.22). Data are reported by geographical region in table 11A.38.

Figure 11.22 People with diabetes mellitus who have received an annual cycle of care within general practice, 2009-10^{a, b}



^a GPs may provide the annual cycle of care but not claim the MBS rebate. Various factors influence the uptake of MBS items by GPs. ^b Historical data differ from previous reports due to the inclusion of DVA data for the first time.

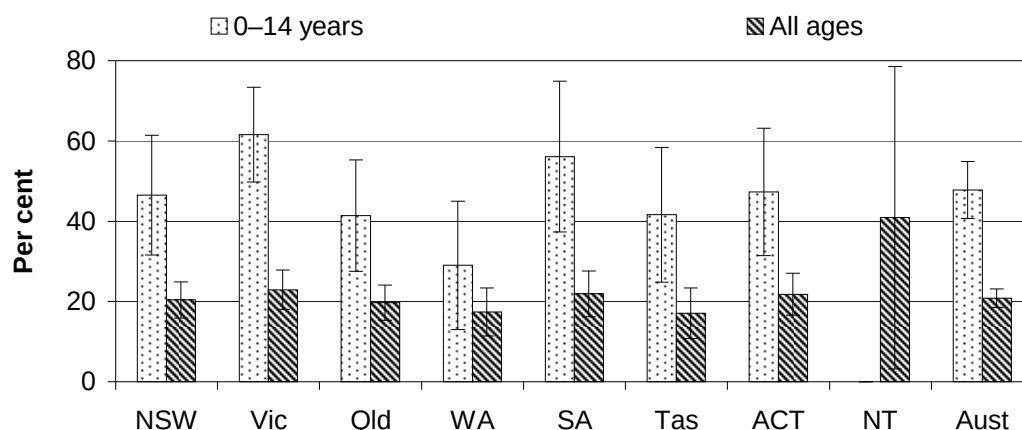
Source: DoHA (unpublished) MBS Statistics; DVA (unpublished) DVA data collection; DoHA (unpublished) National Diabetes Services Scheme (NDSS) data collection; table 11A.38.

Chronic disease management — asthma

Asthma, an identified National Health Priority Area for Australia, is a common chronic disease among Australians — particularly children — and is associated with wheezing and shortness of breath. Asthma can be intermittent or persistent, and varies in severity.

Nationally, the age standardised proportion of people with current asthma who reported having a written asthma action plan in 2007-08 was 20.8 per cent for all ages and 47.8 per cent for children aged 0–14 years (figure 11.23). Data are reported by geographical region in table 11A.40. Data for 2004-05 are reported by Indigenous status in table 11A.41.

Figure 11.23 **Proportion of people with asthma who have a written asthma action plan, 2007-08^{a, b, c}**



^a Rates for 'all ages' are age standardised to the Australian population at 30 June 2001. ^b Separate estimates for 0-14 years are not available for the NT, but the NT sample contributes to the national estimates. ^c Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *National Health Survey, 2007-2008*, Cat. No. 4364.0; table 11A.39.

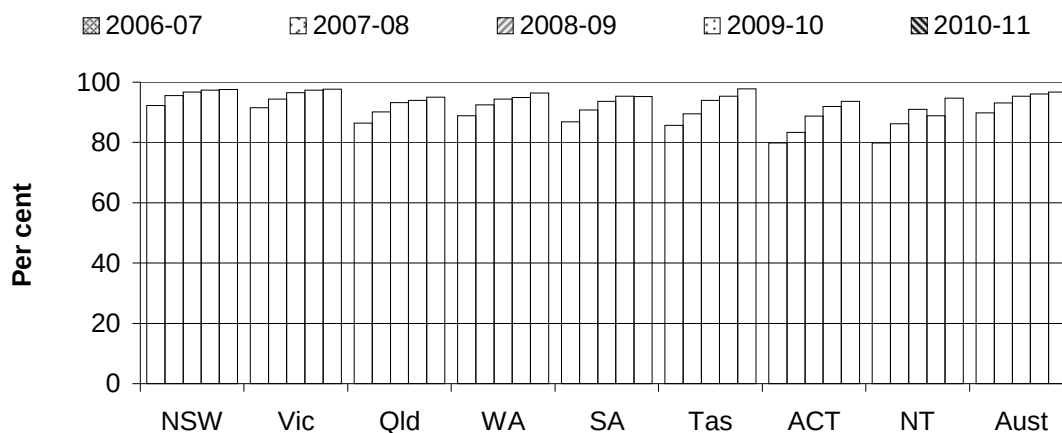
Chronic disease management — care planning and case conferencing

Individuals with chronic or terminal medical conditions commonly have complex, multidisciplinary care needs. Coordination of service provision to provide continuity of care and meet the changing needs of individuals over time is important in the effective management of such conditions. Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team based care planning and case conferencing.

Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.

Nationally, the proportion of GPs using chronic disease management MBS items for care planning or case conferencing increased from 89.8 in 2006-07 to 96.7 per cent in 2010-11 (figure 11.24). The proportion increased steadily in almost all jurisdictions in the period 2006-07 to 2010-11.

Figure 11.24 GP use of chronic disease management MBS items for care planning and case conferencing^a



^a The Strengthening Medicare initiative provides access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP. Additional chronic disease management MBS items have been introduced on several occasions since introduction of the Strengthening Medicare initiative in 2004.

Source: DoHA (unpublished) MBS Statistics; table 11A.42.

Use of pathology tests and diagnostic imaging

‘Use of pathology tests and diagnostic imaging’ is an indicator of governments’ objective to ensure that primary healthcare services are appropriate (box 11.14).

Box 11.14 Use of pathology tests and diagnostic imaging

‘Use of pathology tests and diagnostic imaging’ is defined by four measures:

- MBS items rebated through Medicare for pathology tests requested by vocationally recognised GPs and OMPs, per person
- diagnostic imaging services provided on referral from vocationally recognised GPs and OMPs and rebated through Medicare, per person
- Medicare benefits paid per person for pathology tests
- Medicare benefits paid per person for diagnostic imaging.

(Continued next page)

Box 11.14 (Continued)

This indicator cannot be interpreted as appropriate levels of use of pathology tests and diagnostic imaging cannot be determined. A high or increasing level of use can reflect overreliance on tools to support the diagnostic process. A low or decreasing level of use can contribute to misdiagnosis of disease and to relatively poor treatment decisions. Reporting differences across jurisdictions and over time contributes to consideration of these issues. Pathology tests and diagnostic imaging are important tools used by GPs in the diagnosis of many diseases, and in monitoring response to treatment.

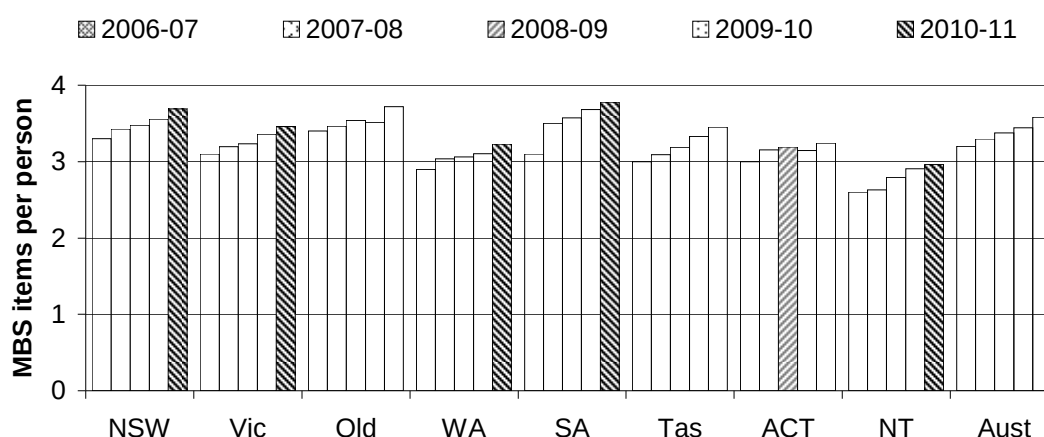
Data for this indicator are comparable.

Data quality information for this indicator is under development.

Pathology and diagnostic imaging services performed at the request of vocationally recognised GPs and OMPs and rebated through Medicare Australia is used as a proxy in reporting against this indicator. The available data do not exactly reflect the services requested and performed. For example, rebates are provided for a maximum of three MBS pathology items — additional pathology tests can be requested and performed, but are excluded from the data because rebates are not provided. A radiologist can identify the need for and perform more or different diagnostic imaging services than requested — Medicare data reflect the services provided and rebated, rather than the services requested.

Nationally, the number of rebated MBS items for pathology tests requested by GPs ranged from 3.2 to 3.6 per person in the period 2006-07 to 2010-11 (figure 11.25).

Figure 11.25 MBS items rebated through Medicare for pathology tests requested by GPs^a



^a Data include tests requested by vocationally recognised GPs and OMPs. Data include patient episode initiated items.

Source: DoHA (unpublished) MBS and DVA data collections; table 11A.43.

Australian Government expenditure (under Medicare) for pathology tests requested by vocationally recognised GPs and OMPs amounted to \$1.4 billion, or around \$62 per person, in 2010-11. Nationally, Medicare benefits worth \$1.3 billion — around \$57 per person — were paid for diagnostic imaging services provided on referral from vocationally recognised GPs and OMPs, in 2010-11 (figure 11.26).

Figure 11.26 Benefits paid for pathology tests and diagnostic imaging, 2010-11^a

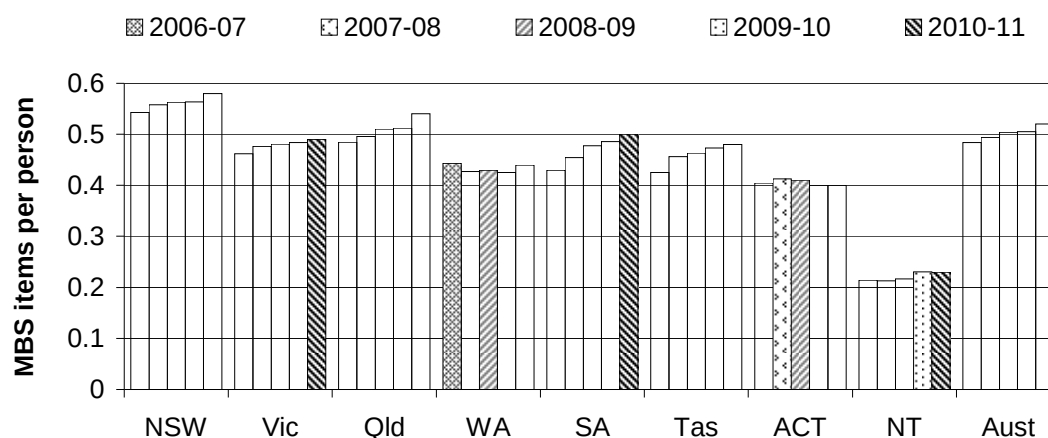


^a Includes benefits paid through Medicare (including DVA data) for MBS pathology and diagnostic imaging items, for services provided on referral from vocationally recognised GPs and OMPs.

Source: DoHA (unpublished) MBS and DVA data collections; tables 11A.43 and 11A.44.

Nationally, the number of rebated MBS items for diagnostic imaging performed on referral from GPs ranged from 0.48 to 0.52 per person in the period 2006-07 to 2010-11 (figure 11.27).

Figure 11.27 **Diagnostic imaging services referred by GPs and rebated through Medicare^a**



^a GPs include vocationally recognised GPs and OMPs.

Source: DoHA (unpublished) MBS and DVA data collections; table 11A.44.

Quality — safety

Electronic health information systems

‘Electronic health information systems’ is an indicator of governments’ objective to improve patient safety through enhanced access to patient health information at the point of care and the more efficient coordination of care across multiple providers and services (box 11.15).

Box 11.15 Electronic health information systems

‘Electronic health information systems’ is defined as the proportion of general practices enrolled in the Practice Incentives Program (PIP) that are registered for the PIP eHealth incentive.

A high or increasing proportion can indicate that patient health information at the point of care and coordination of care across multiple providers and services are desirable or are improved, minimising the likelihood of patient harm due to information gaps.

The PIP does not include all practices in Australia. PIP practices provided around 82.8 per cent of general practice patient care in Australia (measured as standardised whole patient equivalents) in 2010-11 (DoHA unpublished; table 11A.36).

Data for this indicator are comparable.

Data quality information for this indicator is under development.

The use of electronic health information systems can, for example, facilitate best practice chronic disease management as well as minimise errors of prescribing and dispensing that can cause adverse drug reactions (Hofmarcher, Oxley and Rusticelli 2007).

The PIP provides financial incentives to general practices to support quality care, and improve access and health outcomes. The PIP promotes activities such as:

- use of electronic health information systems
- the provision of after hours care
- teaching medical students
- improving management for patients with diabetes and/or asthma.

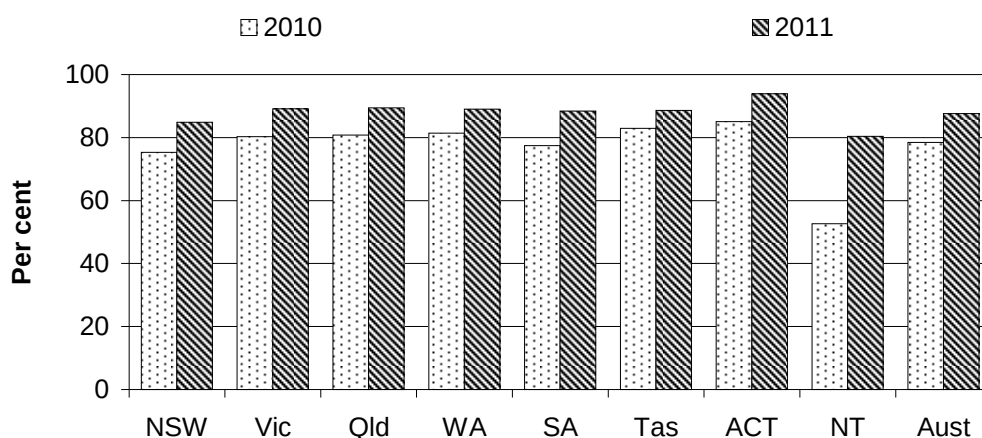
The PIP eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in electronic health information systems. It replaced, in August 2009, the PIP Information Management, Information Technology Incentive that had commenced in November 2006.

To be eligible for the PIP eHealth Incentive, practices must:

- have a secure messaging capability provided by an eligible supplier
- have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate
- provide practitioners from the practice with access to a range of key electronic clinical resources.

Nationally, 87.6 per cent of PIP practices used electronic health systems in May 2011, an increase from 78.5 per cent in May 2010 (figure 11.28).

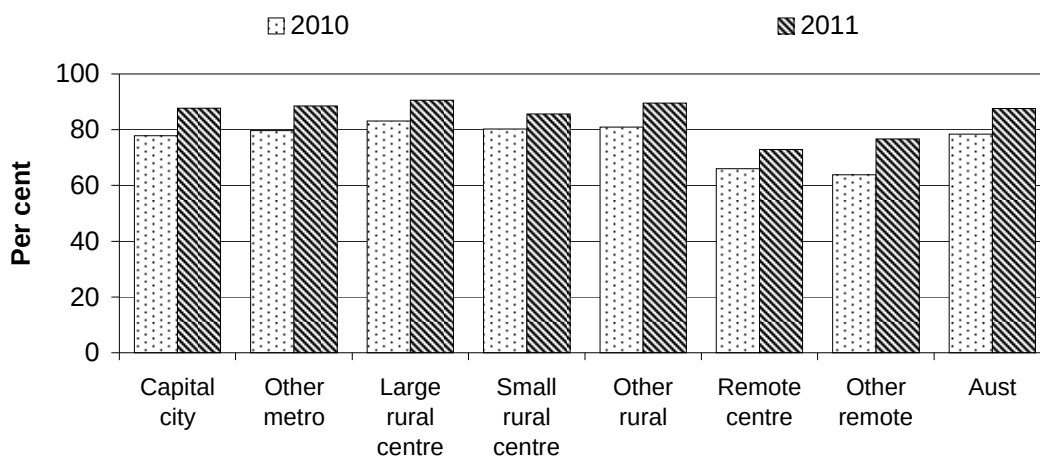
Figure 11.28 **PIP practices using electronic health systems**



Source: DoHA (unpublished) MBS and PIP data collections; table 11A.45.

The proportion of PIP practices using electronic health systems in remote areas was lower than in urban and rural areas in May 2011 (figure 11.29).

Figure 11.29 **PIP practices using electronic health systems by area^a**



^a Geographical locations are based on the Rural, Remote and Metropolitan Areas (RRMA) classification. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more SLAs that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone. SLA = statistical local area.

Source: DoHA (unpublished) MBS and PIP data collections; table 11A.46.

Quality — responsiveness

Patient satisfaction

‘Patient satisfaction’ is an indicator of governments’ objective to ensure primary and community health services are high quality and account for individual patient needs (box 11.16).

Box 11.16 Patient satisfaction

‘Patient satisfaction’ is defined as the quality of care as perceived by the patient. It is measured as patient experience of and/or satisfaction around ‘key aspects of care’ — that is, aspects of care that are key factors in patient outcomes and can be readily modified. Two measures of patient experience of communication with health professionals — a key aspect of care — are reported:

- ‘experience with selected key aspects of GP care’, defined as the number of people who saw a GP in the previous 12 months where the GP always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a GP in the previous 12 months
- ‘experience with selected key aspects of dental professional care’, defined as the number of people who saw a dental professional in the previous 12 months where the dental practitioner always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a dental practitioner in the previous 12 months.

High or increasing proportions can indicate that more patients experienced communication with health professionals as satisfactory.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Patient satisfaction — experience with selected key aspects of GP care

Nationally, the majority of respondents reported that the GP always or often (figure 11.30):

- listened carefully to them (89.1 per cent)
- showed respect (92.2 per cent)
- spent enough time with them (87.2 per cent).

Data are presented by remoteness area in tables 11A.47 and 11A.48.

Figure 11.30 Proportion of people whose GP always or often listened carefully, showed respect, spent enough time, 2010^{a, b}



^a People aged 15 years or over who or over who saw a GP in the last 12 months. ^b Rates are age standardised to the Australian population at 30 June 2001.

Source: ABS (2011) *Patient Experience Survey*; tables 11A.47, 11A.48.

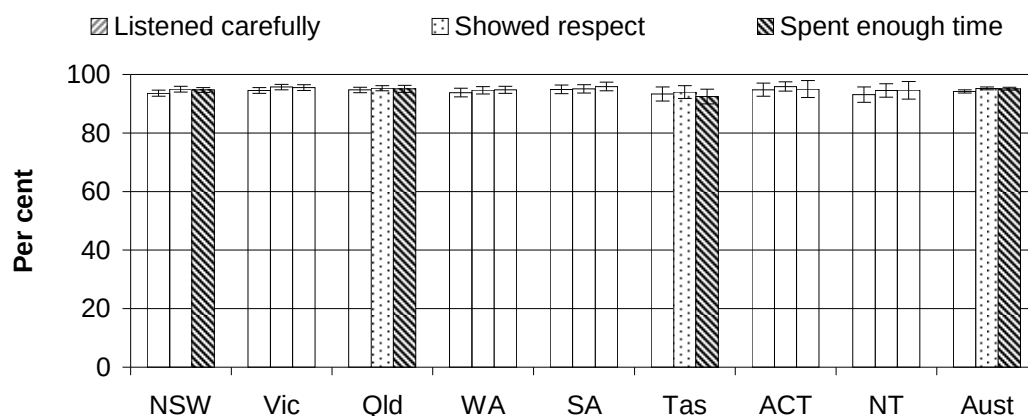
Patient satisfaction — experience with selected key aspects of dental professional care

Nationally, the majority of respondents reported that the dental professional always or often (figure 11.31):

- listened carefully to them (94.2 per cent)
- showed respect (95.2 per cent)
- spent enough time with them (95.1 per cent).

Data are presented by remoteness area in tables 11A.49 and 11A.50.

Figure 11.31 Proportion of people whose dental professional always or often listened carefully, showed respect, spent enough time, 2010^{a, b}



^a People aged 15 years or over who saw a dental professional in the last 12 months. ^b Rates are age standardised to the Australian population at 30 June 2001.

Source: ABS (2011) *Patient Experience Survey*; tables 11A.49, 11A.50.

Quality — continuity

Health assessments for older people

‘Health assessments for older people’ is an indicator of governments’ objective to improve population health outcomes through the provision of prevention as well as early detection and treatment services (box 11.17).

Box 11.17 Health assessments for older people

'Health assessments for older people' is defined as the proportion of older people who received a 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. Annual health assessments for older people are MBS items that allow a GP to undertake an in-depth assessment of a patient's health. Health assessments cover the patient's health and physical, psychological and social functioning, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient (see also box 11.5).

A high or increasing proportion of eligible older people who received a health assessment can indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.

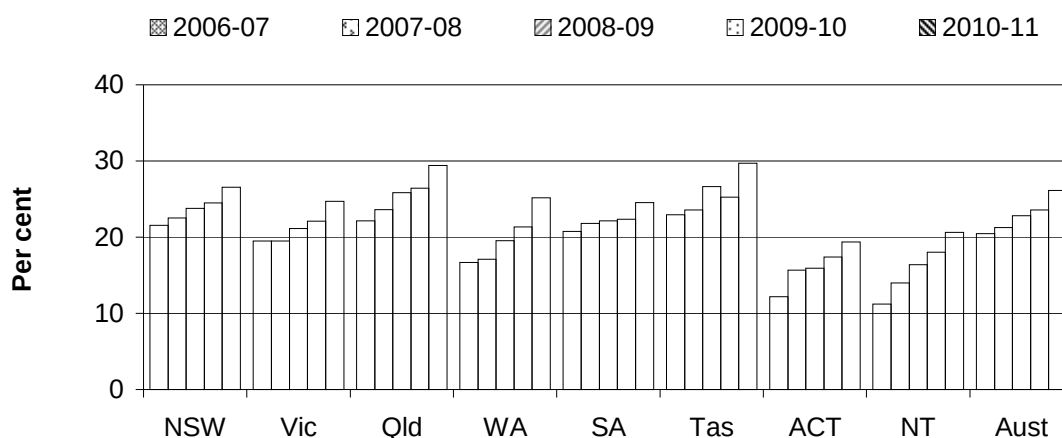
Data for this indicator are comparable.

Data quality information for this indicator is under development.

The targeted age range for Indigenous people of 55 years or over recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health sector summary). Results for Indigenous people are reported under equity indicators (box 11.5).

There has been an increase in the proportion of older people receiving a health assessment in all jurisdictions in the period 2006-07 to 2010-11. Nationally, this proportion increased from 20.5 per cent in 2006-07 to 26.2 per cent in 2010-11 (figure 11.32).

Figure 11.32 Older people who received a 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. Data may differ from previous reports due to revision of denominator data according to a change in methodology.

Source: DoHA (unpublished) MBS Statistics; ABS 2009, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; ABS 2010 *Australian Demographic Statistics*, Cat. no. 3101.0; table 11A.51.

Sustainability

The Steering Committee has identified the sustainability of primary and community health as a key area for development in future reports.

Efficiency

Cost to government of general practice per person

‘Cost to government of general practice per person’ is an indicator of governments’ objective to provide primary healthcare services in an efficient manner (box 11.18).

Box 11.18 Cost to government of general practice per person

'Cost to government of general practice per person' is defined as the cost to government of general practice per person in the population.

A lower or decreasing cost per person can indicate higher efficiency. However, this is likely to be the case only where the lower cost is associated with services of equal or superior effectiveness.

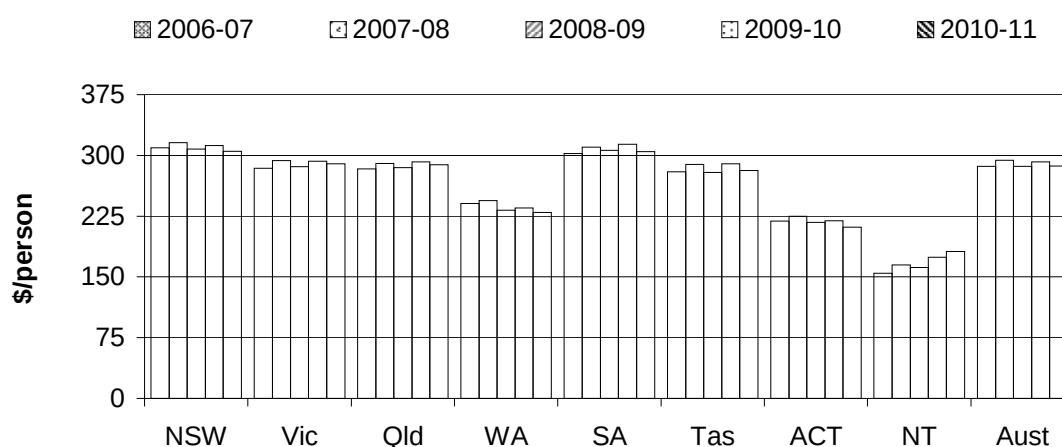
This indicator needs to be interpreted with care. A lower cost per person can reflect service substitution between primary healthcare and hospital or specialist services — potentially at greater expense. This indicator does not include costs for primary healthcare services provided by salaried GPs in community health settings, particularly in rural and remote areas, through emergency departments, and Indigenous-specific primary healthcare services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, the recurrent cost to the Australian Government of general practice was \$287 per person in 2010-11 (figure 11.33).

Figure 11.33 **Australian Government real expenditure per person on GPs (2010-11 dollars)^a**



^a Data include Medicare, DVA, PIP, DGPP and GPPII payments. DVA data cover consultations by local medical officers (LMOs), whether vocationally recognised GPs or not. From available files, it is not possible to extract the amounts paid to LMOs (distinct from specialists) for procedural items. It is expected, however, that the amounts for these services are small compared with payments for consultations.

Source: DoHA (unpublished) MBS, PIP, GPPII, DGPP and DVA data collections; table 11A.2.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the services delivered) (see chapter 1, section 1.5). Intermediate outcomes (such as vaccination coverage within a target group) moderate final outcomes (such as the incidence of vaccine preventable diseases). Both intermediate and final primary and community health outcome indicators are reported.

Child immunisation coverage

‘Child immunisation coverage’ is an indicator of governments’ objective to achieve high immunisation coverage levels for children to prevent selected vaccine preventable diseases (box 11.19).

Box 11.19 Child immunisation coverage

‘Child immunisation coverage’ is defined by three measures:

- ‘the proportion of children aged 12 months to less than 15 months who are fully immunised’, where 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’, where 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
- ‘the proportion of children aged 60 months to less than 63 months who are fully immunised’, where children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, and measles, mumps and rubella.

A high or increasing proportion of children who are fully immunised indicates a reduction in the risk of children contracting a range of vaccine preventable diseases, including measles, whooping cough and *Haemophilus influenzae* type b.

Data for this indicator are comparable.

Partial data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Many providers deliver child immunisation services (table 11.8). 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.

Table 11.8 Valid vaccinations supplied to children under 7 years of age, by provider type, 2006–2011 (per cent)^{a, b, c, d}

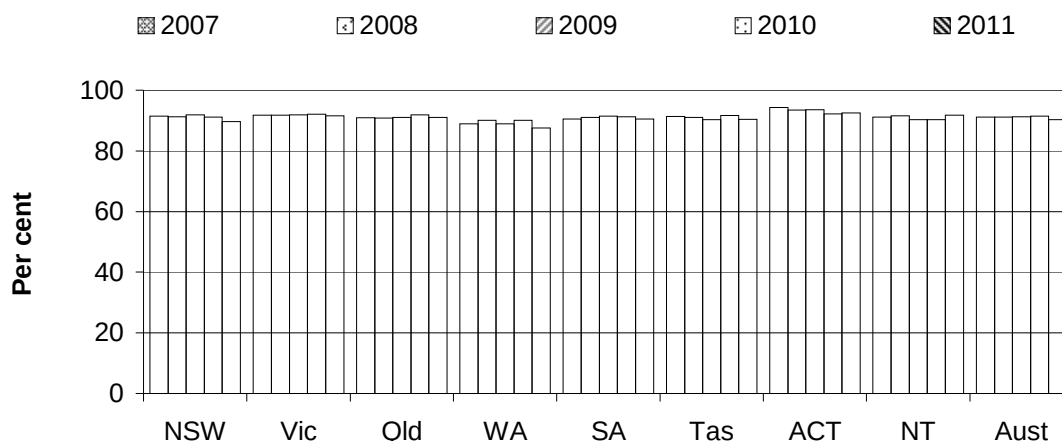
<i>Provider</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GP	84.8	53.7	82.9	65.1	69.5	87.7	44.1	5.2	71.7
Council	5.4	44.9	6.9	6.0	18.7	11.5	–	–	16.6
State or Territory health department	–	–	–	6.3	0.1	0.1	16.5	0.4	0.9
Public hospital	1.9	0.6	3.0	3.6	2.3	0.2	0.7	7.5	2.0
Private hospital	0.1	–	–	–	–	–	–	0.9	–
Indigenous health service	0.5	0.1	0.6	0.6	0.5	–	0.2	11.5	0.6
Community health centre	7.3	0.7	5.9	18.5	8.7	0.5	38.5	74.4	8.0
Other ^d	–	–	0.7	–	0.1	na	–	0.2	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

^a Data are for the period 1 July 2006 to 30 June 2011. ^b Data are based on State/Territory in which the immunisation provider was located. ^c 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. ^d Other includes Divisions of GP, Flying Doctors Services, Indigenous Health Workers, Community nurses and unknown. **na** Not available. – Nil or rounded to zero.

Source: DoHA (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 11A.52.

Around 90.3 per cent of Australian children aged 12 months to less than 15 months at 30 June 2011 were assessed as fully immunised (figure 11.34).

Figure 11.34 Children aged 12 months to less than 15 months who were fully immunised^{a, b, c, d}

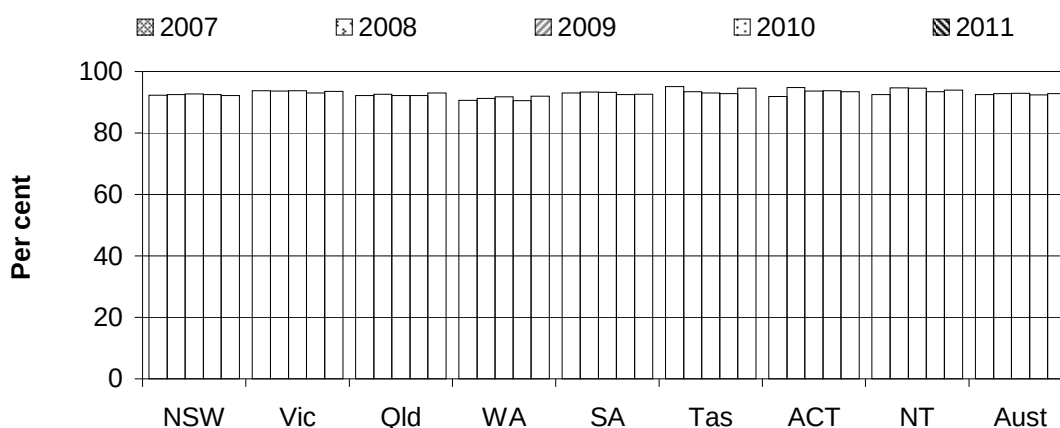


a Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. **b** The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare. **c** There can be some under-reporting by providers, so vaccination coverage estimates based on ACIR data are considered minimum estimates (NCIRS 2000). **d** Relatively low coverage rates for the June 2011 quarter are associated with parents not receiving immunisation reminders due to administrative error.

Source: DoHA (unpublished) ACIR data collection; table 11A.53.

Nationally, 92.8 per cent of children aged 24 months to less than 27 months at 30 June 2011 were assessed as being fully immunised (figure 11.35).

Figure 11.35 **Children aged 24 months to less than 27 months who were fully immunised^{a, b, c}**

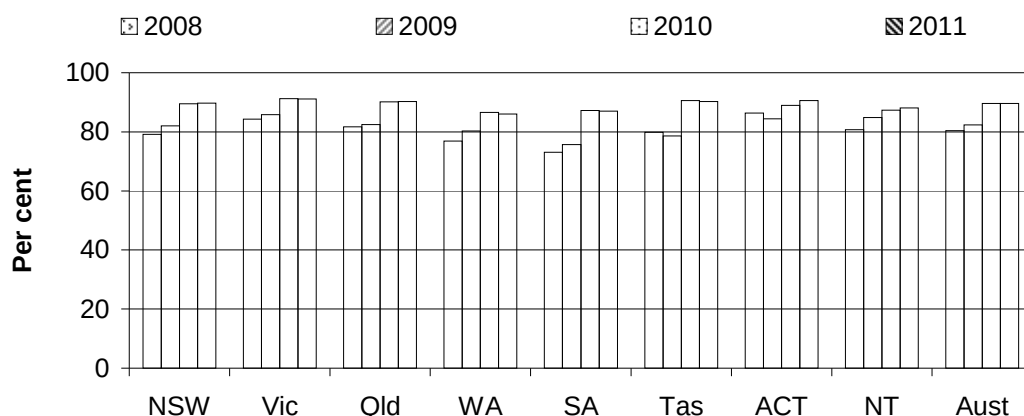


^a Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child was located. ^b The ACIR includes all children under 7 years of age who are registered with Medicare Australia. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare Australia (NCIRS 2000). ^c There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

Source: DoHA (unpublished) ACIR data collection; table 11A.54.

Nationally, 89.6 per cent of Australian children aged 60 months to less than 63 months at 30 June 2011 were assessed as fully immunised (figure 11.36). Data are presented by Indigenous status and remoteness in table 11A.56.

Figure 11.36 Children aged 60 months to less than 63 months who were fully immunised^{a, b, c, d}



^a Coverage measured at 30 June for children turning 60 months of age by 31 March, by State or Territory in which the child was located. ^b The ACIR includes all children under 7 years of age who are registered with Medicare Australia. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare Australia (NCIRS 2000). ^c There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000). ^d Data for this age group were first available in 2008.

Source: DoHA (unpublished) ACIR data collection; table 11A.55.

Notifications of selected childhood diseases

‘Notifications of selected childhood diseases’ is an indicator of governments’ objective to improve population health outcomes through the prevention of selected vaccine preventable childhood diseases (box 11.20).

Box 11.20 Notifications of selected childhood diseases

‘Notifications of selected childhood diseases’ is defined as the number of notifications of measles, pertussis and *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years, per 100 000 children in that age group.

A low or reducing notification rate for the selected diseases indicates that the immunisation program is more effective. Measles, pertussis (whooping cough) and *Haemophilus influenzae* type b are nationally notifiable vaccine preventable diseases. Notification of the relevant State or Territory authority is required when a nationally notifiable disease is diagnosed. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs in one in 25 cases. The activities of GPs and community health services can reduce the prevalence of these diseases through immunisation (and consequently the notification rates).

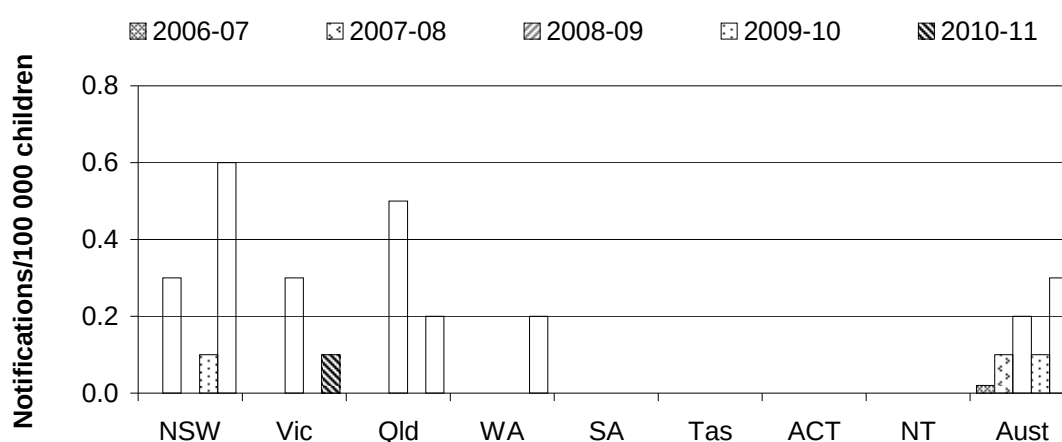
Data for this indicator are comparable.

Data quality information for this indicator is under development.

Data are presented by financial year for the first time in the 2012 Report, improving the timeliness of reporting.

In 2010-11, there were 61 notifications of measles across Australia (table 11A.57). This was the highest number of notifications in the five year period 2006-07 to 2010-11. The national notification rate was 0.3 per 100 000 children aged 0–14 years in 2010-11 (figure 11.37).

Figure 11.37 Notifications of measles per 100 000 children aged 0–14 years^a

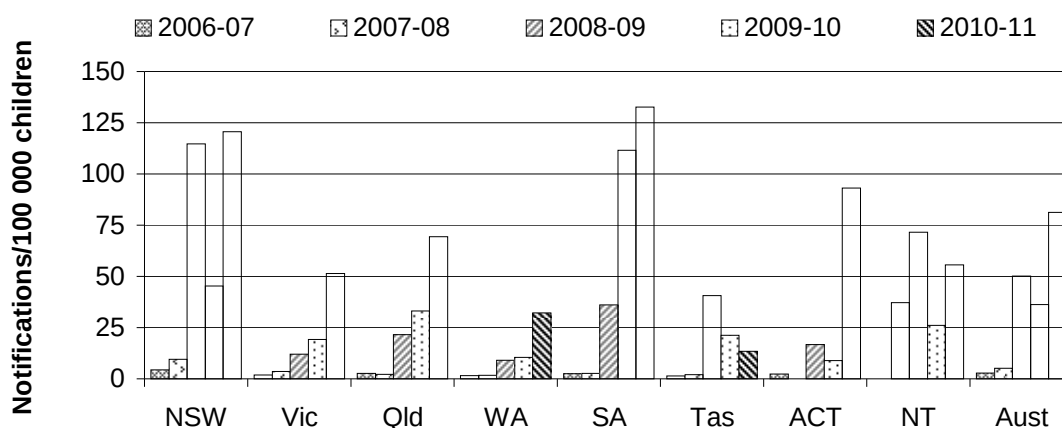


^a Data are suppressed where there are fewer than 5 notifications.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.57.

Nationally, there were over 18 000 notifications for pertussis (whooping cough) in 2010-11. The national notification rate in 2010-11 was 81.3 per 100 000 children aged 0–14 years (figure 11.38).

Figure 11.38 Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years^a

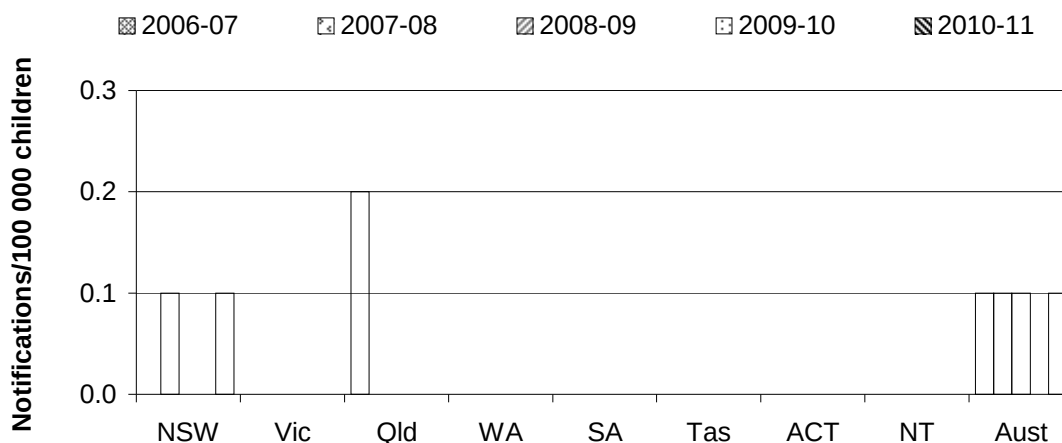


^a Data are suppressed where there are fewer than 5 notifications.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.58.

In recent years, notification rates for *Haemophilus influenzae* type b have remained low. In 2010-11, the notification rate nationally was 0.1 per 100 000 children aged 0–14 years (figure 11.39).

Figure 11.39 Notifications of *Haemophilus influenzae* type b per 100 000 children aged 0–14 years^a



^a Data are suppressed where there are fewer than 5 notifications.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.59.

Participation for women in breast cancer screening

‘Participation for women in breast cancer screening’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer through the provision of early detection services (box 11.21).

Box 11.21 Participation for women in breast cancer screening

‘Participation for women in breast cancer screening’ is defined as the number of women aged 50–69 years who are screened in the BreastScreen Australia Program over a 24 month period, divided by the estimated population of women aged 50–69 years and reported as a rate.

A high or increasing participation rate is desirable.

Data reported for this indicator are comparable.

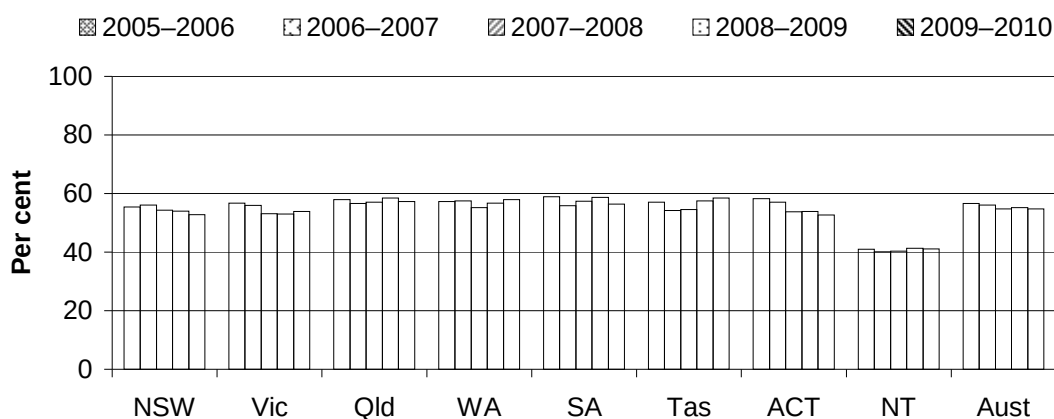
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Early detection of breast cancer is associated with improved morbidity and mortality outcomes. Early detection allows a wider range of treatment options — including less invasive procedures — and a higher likelihood of survival, than does later detection (AIHW and NBCC 2007). The BreastScreen Australia Program is jointly funded by the Australian, State and Territory governments to undertake nationwide breast cancer screening. It aims to achieve at least 70 per cent participation in screening over a period of 24 months in the target group of women aged 50–69 years. Women aged 40–49 years and 70 years or over can also access the program.

An evaluation of the BreastScreen Australia Program found that it has been successful in reducing mortality from breast cancer in the target age group (women aged 50–69 years) by approximately 21–28 per cent since screening commenced in 1991 (DoHA 2009). Further, the relatively high proportion of cancers that are detected early, and treated by breast conserving surgery, was associated with reduced treatment related morbidity for Program participants.

The national participation rate for women aged 50–69 years in BreastScreen Australia screening programs was 54.8 per cent in the 24 month period 2009 and 2010, well below the 70 per cent aim under the National Accreditation Standards (figure 11.40).

Figure 11.40 Age standardised participation rate for women aged 50–69 years in BreastScreen Australia screening programs (24 month period)^{a, b, c, d}



a The participation rate is the number of women aged 50–69 years resident in the jurisdiction who were screened during the reference period, divided by the estimated number of women aged 50–69 years resident in the jurisdiction midway through the reference period. **b** For the 2009–2010 reference period, women resident in the jurisdiction represent over 99 per cent of the women screened in each jurisdiction except the ACT (92.2 per cent). **c** The estimated resident population (ERP) is computed as the average of the ERP in each calendar year of the reference period. **d** Rates are standardised to the 2001 Australian population standard.

Source: State and Territory governments (unpublished); ABS (2008, 2009, 2010) *Population by Age and Sex, Australian States and Territories* (various years), Cat. no. 3201.0; tables 11A.60, 11A.61.

Indigenous women, women from non-English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas can experience particular language, cultural and geographic barriers to accessing breast cancer screening. Participation rates for community groups at, or close to, those for the total population indicate equitable access to early detection services.

Participation rates in the BreastScreen Australia Program for women from selected community groups are shown in table 11.9. In the 24 month period 2009 and 2010, the national age standardised participation rate for Indigenous women aged 50–69 years (36.2 per cent) was below the total participation rate in that age group (54.8 per cent), although this can in part reflect under-reporting of Indigenous status in screening program records (table 11A.62). For NESB women for the same 24 month period and age group, the national participation rate of 49.2 per cent was also lower than that of the national total female population (table 11A.63). Data for participation by remoteness are presented in table 11A.64. Care needs to be taken when comparing data across jurisdictions as there is variation in the collection of Indigenous and NESB identification data, and in the collection of residential postcodes data.

Table 11.9 Age standardised participation rate for women aged 50–69 years from selected communities in BreastScreen Australia programs, 2009 and 2010 (24 month period) (per cent)^{a, b, c}

	NSW	Vic	Qld	WA	SA	Tas	ACT ^d	NT	Aust
Indigenous ^e	35.8	27.7	47.0	30.5	33.2	53.2	49.6	23.6	36.2
NESB ^f	55.3	33.8	68.8	67.2	52.4	44.7	15.3	38.2	49.2
Major cities and inner regional ^e	52.3	54.2	56.6	58.6	56.0	59.1	52.7	..	54.6
Outer regional, remote and very remote ^g	55.8	58.0	62.0	54.2	58.7	57.2	..	41.2	57.1
All women aged 50–69 years	52.8	53.9	57.3	57.9	56.4	58.4	52.7	41.1	54.8

^a First and subsequent rounds. ^b Rates are standardised to the Australian population at 30 June 2001. ^c Data reported for this measure are not directly comparable. ^d Women resident in the jurisdiction represent over 99 per cent of women screened in each jurisdiction except the ACT (92.2 per cent). ^e Women who self-identify as being of Aboriginal and/or Torres Strait Islander descent. ^f NESB is defined as speaking a language other than English at home. ^g Remoteness areas are defined using the Australian Standard Geographical Classification (AGSC), based on the ABS 2006 *Census of population and housing*. Not all remoteness areas are represented in each State or Territory. .. Not applicable.

Source: State and Territory governments (unpublished); ABS (2010) *Population by Age and Sex, Australian States and Territories*, June 2010, Cat. no. 3201.0; ABS (unpublished) *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2021*, Cat. no. 3238.0; ABS (unpublished) 2006 *Census of Population and Housing*; AIHW (unpublished) derived from State and Territory data; tables 11A.60– 11A.64.

Participation for women in cervical screening

‘Participation for women in cervical screening’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to cervical cancer through the provision of early detection services (box 11.22).

Box 11.22 Participation for women in cervical screening

‘Participation for women in cervical screening’ is defined as the number of women aged 20–69 years who are screened over a two year period, divided by the estimated population of eligible women aged 20–69 years and reported as a rate. Eligible women are those who have not had a hysterectomy.

A high or increasing proportion of eligible women aged 20–69 years who have been screened is desirable.

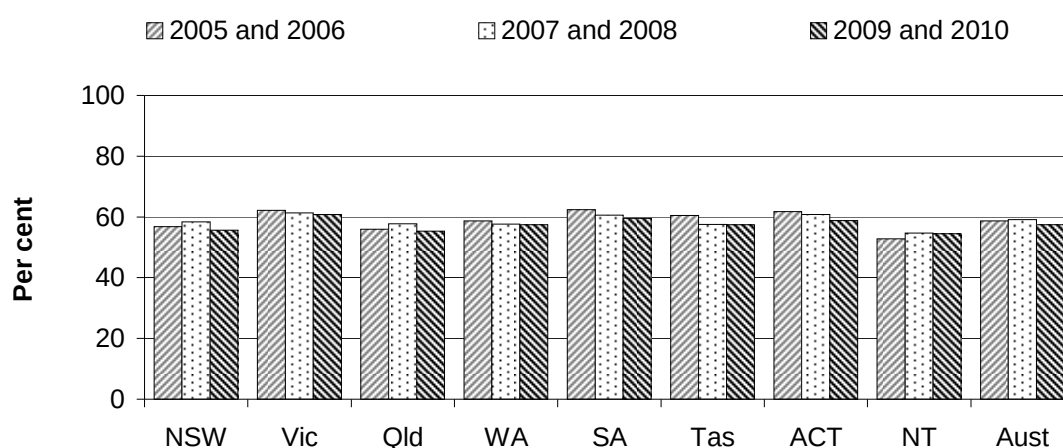
Data for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

It is estimated that up to 90 per cent of the most common type of cervical cancer (squamous cervical cancer) can be prevented if cell changes are detected and treated early (DoHA 2006; Mitchell, Hocking and Saville 2003). A range of healthcare providers offer cervical screening tests (Pap smears). The National Cervical Screening Program involves GPs, gynaecologists, family planning clinics and hospital outpatient clinics.

The national age-standardised participation rate for women aged 20–69 years in cervical screening was 57.4 per cent for the 24 month period 1 January 2009 to 31 December 2010 (figure 11.41). For most jurisdictions, participation rates have dropped slightly since the screening period of 2005 and 2006. Data for Indigenous women for 2004–05 are presented in table 11A.66. Data for women by remoteness are presented in table 11A.67.

Figure 11.41 Participation rates for women aged 20–69 years in cervical screening^{a, b, c, d}



^a Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the ABS ERP in each calendar year in the reference period and age standardised to the 2001 Australian population. ^b Eligible female population adjusted for estimated proportion who have had a hysterectomy. ^c Excludes women who have opted off the cervical cytology register. ^d Data include all women screened except for Victoria and the ACT, where data are based on residence.

Source: AIHW (2011) *Cervical screening in Australia 2008–2009*, Cat. no. CAN 57; AIHW (unpublished) State and Territory Cervical Cytology Registry data collections; table 11A.65.

Influenza vaccination coverage for older people

‘Influenza vaccination coverage for older people’ is an indicator of governments’ objective to reduce the morbidity and mortality attributable to vaccine preventable disease (box 11.23).

Box 11.23 Influenza vaccination coverage for older people

'Influenza vaccination coverage for older people' is defined as the proportion of people aged 65 years or over who have been vaccinated against seasonal influenza. This does not include pandemic influenza such as H1N1 Influenza (commonly known as 'swine flu').

A high or increasing proportion of older people vaccinated against influenza reduces the risk of older people contracting influenza and suffering consequent complications. Each year, influenza and its consequences result in the hospitalisation of many older people, as well as a considerable number of deaths.

Data for this indicator are comparable.

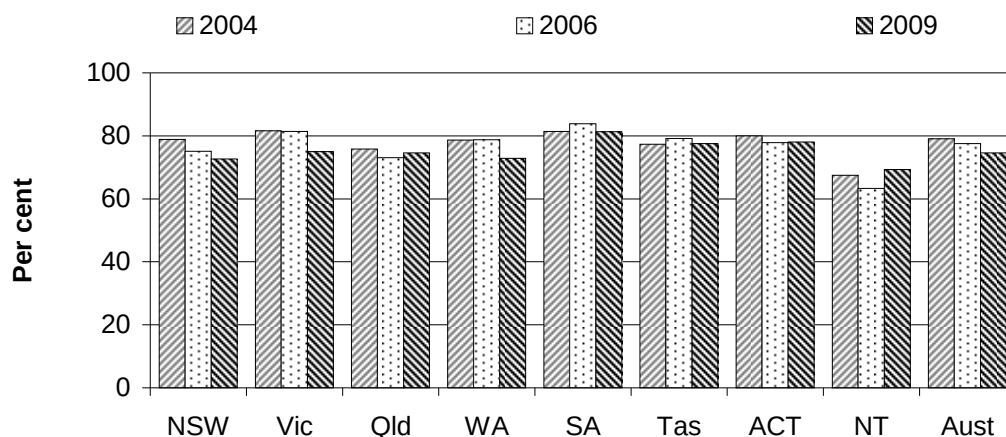
Data quality information for this indicator is under development.

Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (DoHA and NHMRC 2008). Free vaccines for Australians aged 65 years or over have been funded since 1999 by the Australian Government through the National Influenza Vaccine Program for Older Australians. GPs provide the majority of these vaccinations.

Nationally, 74.6 per cent of eligible people were fully vaccinated against influenza in 2009 (figure 11.42).

Pneumococcal disease is also a vaccine preventable disease that can result in hospitalisation and/or death. Free vaccinations against pneumococcal disease became available to older Australians in 2005. Data for older adults fully vaccinated against both influenza and pneumococcal disease are presented by remoteness in table 11A.69. Data for Indigenous people fully vaccinated against influenza and pneumococcal disease in 2004-05 are presented in table 11A.70.

Figure 11.42 People aged 65 years or over fully vaccinated against influenza^a



^a The Adult Vaccination Survey was not conducted in 2005, 2007, 2008 or 2010.

Source: AIHW 2005, 2011 *Adult Vaccination Survey: summary results*, Cat. no. PHE 56, PHE 135; DoHA (unpublished) 2006 Adult Vaccination Survey; table 11A.68.

Selected potentially preventable hospitalisations

‘Selected potentially preventable hospitalisations’ is an indicator of governments’ objective to reduce potentially preventable hospitalisations through the delivery of effective primary healthcare services (box 11.24).

Box 11.24 **Selected potentially preventable hospitalisations**

‘Selected potentially preventable hospitalisations’ is defined as hospital admissions that may be avoided by effective management of illness and injury in the primary and community healthcare sector or, in some cases, by preventing illness and injury altogether.

Three measures of selected potentially preventable hospitalisations are reported:

- potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions, as defined in the Victorian Ambulatory Care Sensitive Conditions Study (AIHW 2011b; DHS 2002)
- potentially preventable hospitalisations for diabetes
- potentially preventable hospitalisations of older people for falls.

Low or decreasing separation rates for selected potentially preventable hospitalisations can indicate improvements in the effectiveness of preventative programs and/or more effective management of selected conditions in the primary and community healthcare sector.

Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions (AIHW 2008b, 2011b). For example, the underlying prevalence of conditions, patient compliance with treatment and older people’s access to aged care services and other support.

Data for this indicator are comparable.

Partial data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions

Studies have shown that hospitalisation rates for selected vaccine preventable, acute and chronic conditions are significantly affected by the availability of care in the primary and community healthcare sector (DHS 2002). These are conditions for which hospitalisation can potentially be avoided, through prevention of the condition — for example, through vaccination — or, prevention of exacerbations or complications requiring hospitalisation — through effective management of the condition in the primary and community healthcare sector. While not all hospitalisations for the selected conditions can be prevented, strengthening the effectiveness of primary and community healthcare has considerable potential to reduce the need for hospitalisation for these conditions.

Variation in hospitalisation rates data can also be affected by differences in hospital protocols for clinical coding and admission — particularly for diagnoses of

dehydration and gastroenteritis and diabetes complications. This effect is exacerbated for diabetes hospitalisations data disaggregated by Indigenous status because of the high prevalence of diabetes in Indigenous communities. Because of improvements in data quality over time, caution also should be used in time series analysis.

Data presented by Indigenous status are adjusted to account for differences in the age structures of these populations across states and territories.

Nationally, the age standardised hospital separation rate for selected vaccine preventable, acute and chronic conditions was 30.4 per 1000 people in 2009-10 (table 11.10). Of these, 53.4 per cent were for chronic and 44.5 per cent for acute conditions (table 11A.71). Data are presented disaggregated by remoteness in table 11A.72.

Table 11.10 Separations for selected potentially preventable hospitalisations per 1000 people, 2009-10^{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^c</i>
Vaccine preventable conditions	0.7	0.7	0.9	0.8	0.9	0.7	0.5	2.4	0.8
Selected acute conditions	12.9	14.4	14.7	13.7	14.6	10.7	9.8	21.1	13.8
Selected chronic conditions	13.6	15.1	18.6	23.1	14.4	12.1	10.4	26.1	16.0
Total^d	27.1	30	34	37.5	29.7	23.4	20.7	49	30.4

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Rates are based on State/Territory of usual residence. ^c Includes other territories. Excludes overseas residents and unknown state of residence. ^d Totals may not add as more than one condition may be reported for a separation.

Source: AIHW (2011b) *Australian Hospital Statistics 2009-10*, Cat. no. HSE 107; table 11A.71.

Nationally, the age standardised hospital separation rate for all vaccine preventable conditions was 0.8 per 1000 people in 2009-10. Nationally, influenza and pneumonia accounted for 73.7 per cent of hospital separations for vaccine preventable conditions in 2009-10 (table 11.11).

Table 11.11 Separations for vaccine preventable conditions per 1000 people, 2009-10^{a, b}

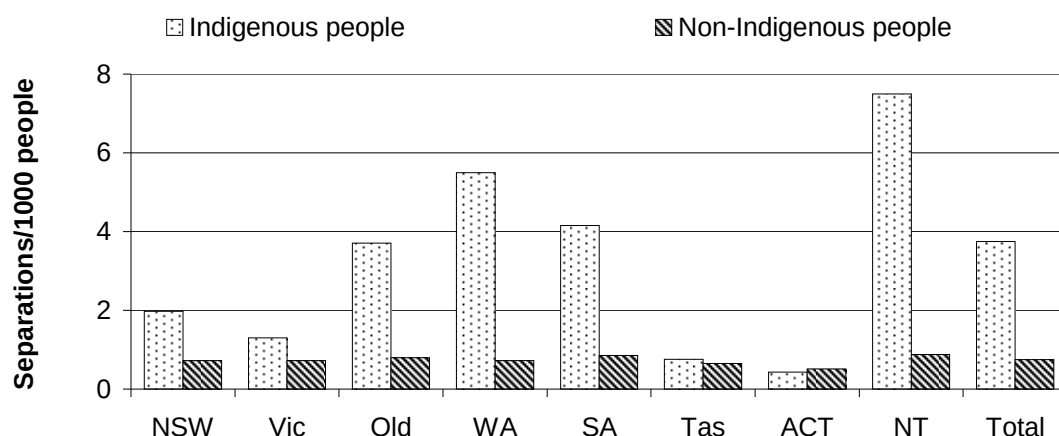
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^c</i>
Influenza and pneumonia	0.6	0.5	0.7	0.7	0.7	0.6	0.4	1.9	0.6
Other conditions	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.5	0.2
Total^d	0.7	0.7	0.9	0.8	0.9	0.7	0.5	2.4	0.8

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Rates are based on State/Territory of usual residence. ^c Includes other territories and excludes overseas residents and unknown State of residence. ^d Totals may not add due to rounding.

Source: AIHW (2011b) *Australian Hospital Statistics 2009-10*, Cat. no. HSE 107; table 11A.73.

The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous people than for non-Indigenous people in 2009-10, in most jurisdictions (figure 11.43).

Figure 11.43 Separations for vaccine preventable conditions by Indigenous status, 2009-10^{a, b, c, d, e}



^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. ^c Separation rates are based on State/Territory of usual residence. ^d NT data for Indigenous people are for public hospitals only. ^e Total comprises NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes. Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.73.

Of the selected acute conditions, dental conditions and dehydration and gastroenteritis recorded the highest rates of hospitalisation nationally in 2009-10 (table 11.12).

Table 11.12 Separations for selected acute conditions per 1000 people, 2009-10^{a, b}

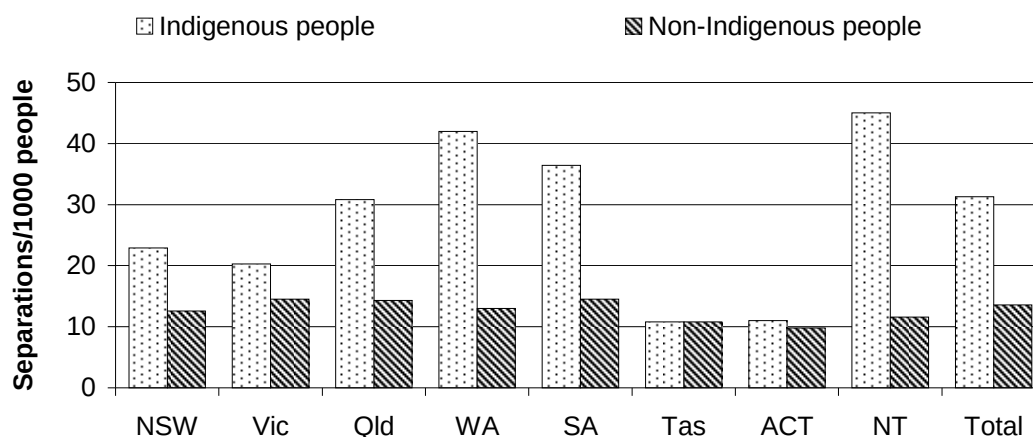
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^c</i>
Appendicitis	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Cellulitis	1.8	1.7	2.0	1.4	1.6	1.4	1.4	3.8	1.8
Convulsions and epilepsy	1.5	1.4	1.6	1.4	1.7	1.3	1.2	3.5	1.5
Dehydration and gastroenteritis	2.7	3.4	3.0	2.6	2.8	2.2	1.9	3.2	2.9
Dental conditions	2.3	3.1	2.9	3.6	3.2	2.3	1.8	2.8	2.8
Ear, nose and throat infections	1.6	1.4	1.8	1.6	2.1	1.3	1.0	2.9	1.6
Gangrene	0.1	0.3	0.2	0.2	0.2	0.3	0.1	0.7	0.2
Pelvic inflammatory disease	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.5	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Pyelonephritis ^d	2.3	2.4	2.6	2.3	2.3	1.5	1.8	3.4	2.4
Total^e	12.9	14.4	14.7	13.7	14.6	10.7	9.8	21.1	13.8

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Rates are based on State/Territory of usual residence. ^c Includes other territories and excludes overseas residents and unknown State of residence. ^d Kidney inflammation caused by bacterial infection. ^e Totals may not add as more than one acute condition may be reported for a separation.

Source: AIHW (2011b) *Australian Hospital Statistics 2009-10*, Cat. no. HSE 107; table 11A.74.

The age standardised hospital separation rate for the selected acute conditions was higher for Indigenous people than for non-Indigenous people, in 2009-10, in most jurisdictions (figure 11.44).

Figure 11.44 **Separations for selected acute conditions by Indigenous status, 2009-10**^{a, b, c, d, e}



^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. ^c Separation rates are based on State/Territory of usual residence. ^d NT data for Indigenous people are for public hospitals only. ^e Total comprises NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes. Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.74.

Of the selected chronic conditions, congestive cardiac failure, diabetes complications, asthma, hypertension and chronic obstructive pulmonary disease recorded the highest rates of hospitalisation nationally in 2009-10. The hospitalisation rates for congestive cardiac failure and diabetes complications were around two times higher than the rate for any other of the selected conditions except for asthma (table 11.13).

Table 11.13 Separations for selected chronic conditions per 1000 people, 2009-10^{a, b}

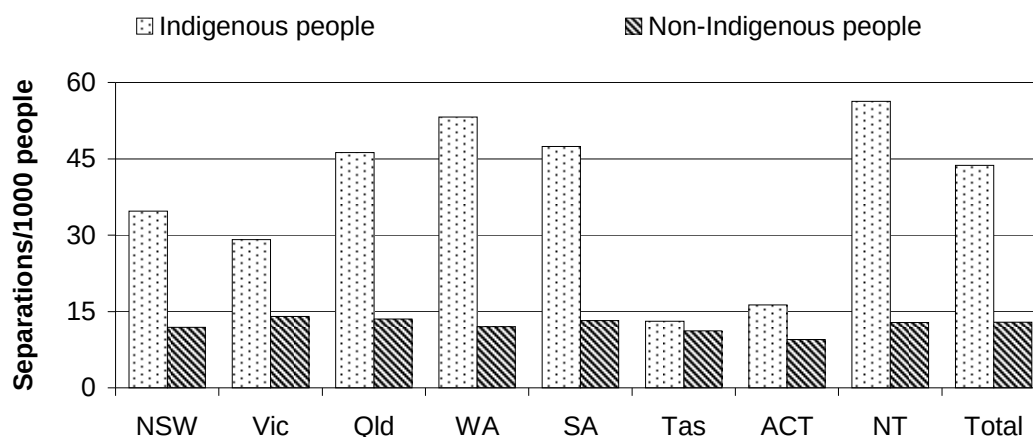
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust^c</i>
Angina	1.2	1.4	1.9	1.4	1.3	1.0	0.9	2.4	1.4
Asthma	1.9	1.9	1.8	1.3	2.5	1.2	1.1	1.9	1.8
Chronic obstructive pulmonary disease	2.6	2.5	3.0	2.2	2.7	2.5	2.0	6.3	2.6
Congestive cardiac failure	1.7	2.1	1.9	1.9	1.8	1.5	1.9	2.9	1.9
Diabetes complications	5.2	5.8	9.2	15.5	4.8	4.8	4.0	12.1	7.1
Hypertension	0.3	0.2	0.4	0.2	0.3	0.2	0.2	0.3	0.3
Iron deficiency anaemia	1.0	1.6	1.0	1.3	1.3	1.3	0.8	1.0	1.2
Nutritional deficiencies	<0.1	<0.1	<0.1	<0.1	<0.1	<0.1	<0.1	0.1	<0.1
Rheumatic heart disease ^d	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.9	0.1
Total^e	13.6	15.1	18.6	23.1	14.4	12.1	10.4	26.1	16.0

^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Rates are based on State/Territory of usual residence. ^c Includes other territories. Excludes overseas residents and unknown State of residence. ^d Includes acute rheumatic fever as well as the chronic disease. ^e Totals may not add as more than one chronic condition may be reported for a separation.

Source: AIHW (2011b) *Australian Hospital Statistics 2009-10*, Cat. no. HSE 107; table 11A.75.

The age standardised hospital separation rate for the selected chronic conditions was higher for Indigenous people than for non-Indigenous people, in 2009-10, in all jurisdictions (figure 11.45).

Figure 11.45 **Separations for selected chronic conditions by Indigenous status, 2009-10^{a, b, c, d, e, f}**



^a Excludes separations with diabetes complications as an additional diagnosis. ^b Separation rates are directly age standardised to the Australian population at 30 June 2001. ^c Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. ^d Separation rates are based on State/Territory of usual residence. ^e Total comprises NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes. ^f Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.75.

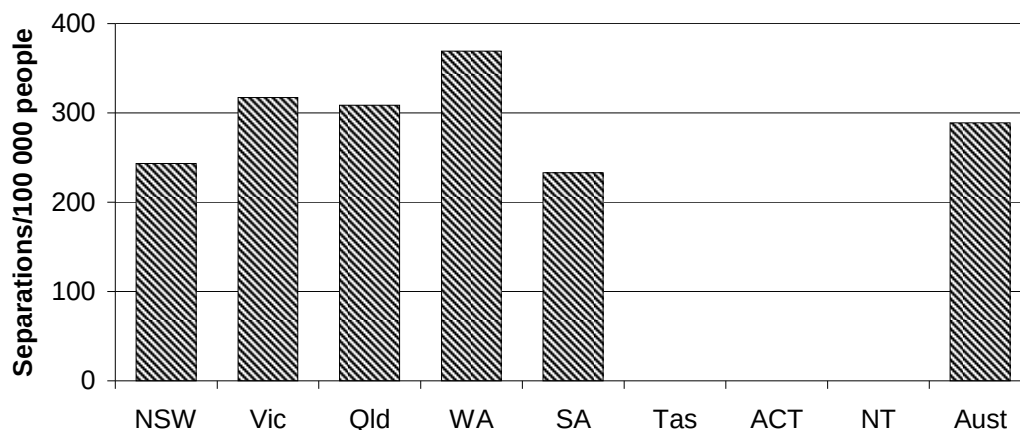
Potentially preventable hospitalisations for diabetes

Diabetes is a chronic disease of increasing prevalence, and is an identified National Health Priority Area for Australia. People with diabetes are at high risk of serious complications such as cardiovascular, eye and kidney disease. Type 2 diabetes is the most common form of diabetes and is largely preventable.

The provision of high quality, appropriate and effective management of diabetes in the primary and community health sector can prevent or minimise the severity of diabetes complications, thereby reducing demand for hospitalisation (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Nationally, the age standardised hospital separation rate for Type 2 diabetes mellitus as principal diagnosis was 288.8 separations per 100 000 people in 2009-10 (figure 11.46).

Figure 11.46 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2009-10^{a, b, c}**

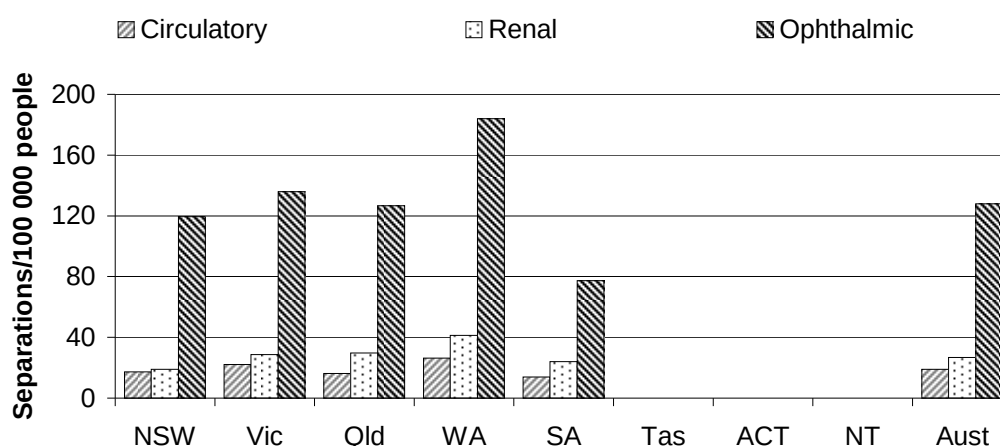


^a Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. ^b Morbidity data are coded under coding standards that can differ over time and across jurisdictions. ^c Data for Tasmania, the ACT and the NT are not published separately (due to hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.77.

The three complications of Type 2 diabetes most commonly leading to hospitalisation in 2009-10 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.47).

Figure 11.47 Separations for principal diagnosis of Type 2 diabetes mellitus by selected complication, all hospitals, 2009-10^{a, b, c, d, e}



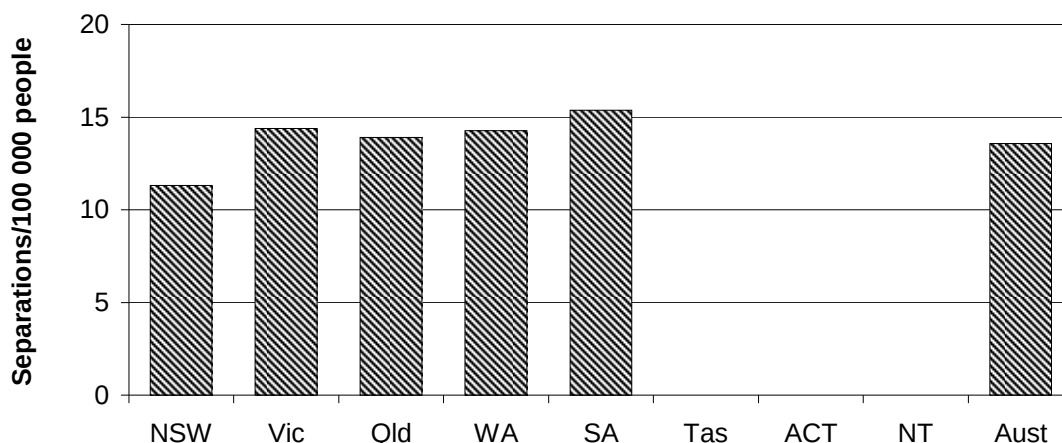
^a Results for individual complications can be affected by small numbers, and need to be interpreted with care. ^b Patients can have one or more complication(s) for each separation. ^c Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient 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 can 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) National Hospital Morbidity Database; table 11A.77.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but these data are not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients affect hospital separation rates. This effect is partly reflected in the variation in the proportion of separations that are 'same day' across jurisdictions. Nationally, 51.6 per cent of separations for Type 2 diabetes were same day separations in 2009-10 (table 11A.78).

Serious circulatory complications of diabetes can necessitate amputation of a lower limb. In 2009-10, there were 13.6 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 11.48).

Figure 11.48 Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2009-10^{a, b, c}



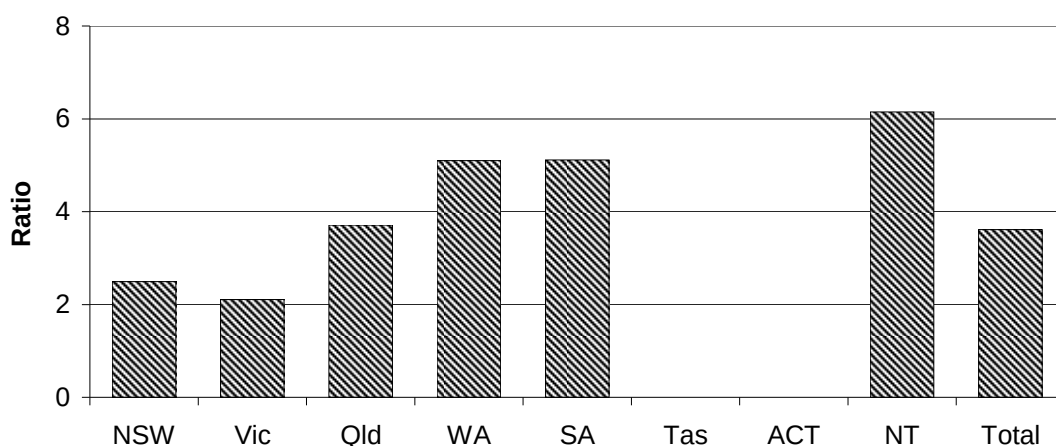
^a Separation rates are directly age standardised to the Australian population at 30 June 2001. ^b Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation. ^c Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.79.

Age standardised hospital separation ratios for diabetes (excluding separations for diabetes complications as an additional diagnosis) illustrate differences between the rate of hospital admissions for Indigenous people and that for all Australians, taking into account differences in the age structures of the two populations. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. A reduction in the gap in hospital separation rates between Indigenous and all people can indicate greater equity of access to primary healthcare services.

There was a marked difference in 2009-10 between the separation rates for Indigenous people and those for the total population for diabetes diagnoses. The quality of Indigenous identification is considered acceptable for analysis only for NSW, Victoria, Queensland, WA, SA and the NT. For these jurisdictions combined, the separation rate for Indigenous people was 3.6 times higher than the separation rate for all Australian people (figure 11.49).

Figure 11.49 **Ratio of separation rates of Indigenous people to all people for diabetes, 2009-10**^{a, b, c, d, e, f, g}



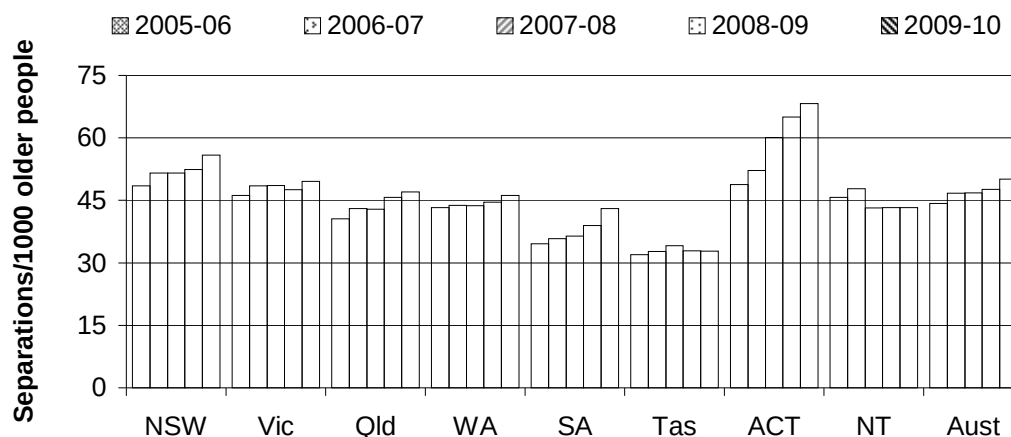
^a Excludes separations with diabetes complications as an additional diagnosis. ^b Ratios are directly age standardised to the Australian population at 30 June 2001. ^c Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. ^d Patients aged 75 years or over are excluded. ^e Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. ^f NT data are for public hospitals only. ^g Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT.

Source: AIHW (unpublished) National Hospital Morbidity Database; tables 11A.76.

Potentially preventable hospitalisations of older people for falls

The number of hospital separations for older people with a reported external cause of falls per 1000 older people, adjusted to take account of differences in State and Territory age distributions, increased in the period 2005-06 to 2009-10 in most jurisdictions (figure 11.50). Nationally, the separation rate per 1000 older people increased from 44.3 in 2005-06 to 50.1 in 2009-10.

Figure 11.50 Separations for older people with a reported external cause of falls^{a, b, c}



^a Older people are defined as people aged 65 years or over. ^b Separation rates are age standardised to the Australian population aged 65 years or over at 30 June 2001. ^c Excludes separations records for hospital boarders and posthumous organ procurement.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.80.

11.4 Future directions in performance reporting

The topic of this chapter is all primary and community health services. However, the indicators remain heavily focused on general practice services. This partly reflects the lack of nationally consistent data available to report potential indicators for other primary and community health services. Priorities for future reporting on primary and community health services include:

- improving the reporting of public dental health services
- reporting of community-based drug and alcohol treatment services
- reporting of additional indicators relating to the use of the MBS chronic disease management items
- improving the quality of Indigenous data, particularly Indigenous identification and completeness. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing, with the inclusion of data for Tasmania and the ACT in national totals a priority.

The scope of this chapter can also be further refined to ensure the most appropriate reporting of primary health services against the Review's terms of reference and reporting framework (see chapter 1).

Indigenous health

Barriers to accessing primary health services contribute to the poorer health status of Indigenous people compared to other Australians (see the Health sector summary). The Steering Committee has identified primary and community health services for Indigenous people as a priority area for future reporting and will continue to examine options for the inclusion of further such indicators. The Aboriginal and Torres Strait Islander Health Performance Framework developed under the auspices of the Australian Health Ministers' Advisory Council will inform the selection of future indicators of primary and community health services to Indigenous people.

Continued efforts to improve Indigenous identification are necessary to better measure the performance of primary and community health services in relation to the health of Indigenous Australians. Work being undertaken by the ABS and AIHW includes an ongoing program to improve identification of Indigenous status in Australian, State and Territory government administrative systems.

COAG developments

Outcomes from review of Report on Government Services

COAG endorsed recommendations (December 2009) of the review of the RoGS implemented during 2010 and 2011 are reflected in this Report. Implementation of other recommendations will be reflected in future reports.

Review of National Agreements and National Partnership Agreements

COAG has agreed to progress the recommendations of the Heads of Treasuries Review of National Agreements, National Partnerships and Implementation Plans and reports of the COAG Reform Council. A working group, led by Senior Officials from First Ministers' and Treasury agencies, will review the performance frameworks of a limited number of agreements, including the NHA. The reviews will be concluded by June 2012. The recommendations of the review of the NHA will be considered by the Steering Committee and may be reflected in future reports.

11.5 Definitions of key terms and indicators

Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Annual cycle of care for people with diabetes mellitus within general practice	The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice, based on RACGP guidelines. MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines.
Asthma Action Plan	An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional. <i>Source:</i> ACAM (Australian Centre for Asthma Monitoring) 2007, Australian asthma indicators: Five-year review of asthma monitoring in Australia. Cat. no. ACM 12, AIHW, Canberra.
Cervical screening rates for target population	Proportion of eligible women aged 20–69 years who are screened for cervical cancer over a 2 year period. Eligible women are those who have not had a hysterectomy.
Closed treatment episode	A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for three months or more. Clients may be involved in more than one closed treatment episode in a data collection period.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Divisions of General Practice	Geographically-based networks of GPs. There are 109 Divisions of General Practice (DGP), 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN). The DGP Program (DGPP) evolved from the former Divisions and Projects Grants Program established in 1992. The DGPP 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 healthcare at the local level.
Full time workload equivalents (FWE)	A measure of medical practitioner supply based on claims processed by Medicare in a given period, calculated by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that period. Full time equivalents (FTE) are calculated in the same way as FWE except that FTE are capped at 1 per practitioner.

Fully immunised at 12 months	A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine and three doses of Hepatitis B vaccine and three doses of <i>Haemophilus influenzae</i> type B vaccine.
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine, three doses of Hepatitis B vaccine, four doses of <i>Haemophilus influenzae</i> type B and one dose of measles, mumps and rubella vaccine.
Fully immunised at 60 months	A child who has received the necessary doses of diphtheria, tetanus, whooping cough, polio, <i>Haemophilus influenzae</i> type b, hepatitis B, and measles, mumps and rubella vaccines.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.
General practitioner (GP)	Vocationally recognised GPs — medical practitioners who are vocationally recognised under s.3F of the <i>Health Insurance Act 1973</i> (Cwlth), hold Fellowship of the RACGP, Australian College of Rural and Remote Medicine (ACRRM), or equivalent (from 1996 vocational registration was available only to GPs who attained Fellowship of the RACGP; since April 2007, it has also been available to Fellows of the ACRRM), or hold a recognised training placement. Other medical practitioners (OMP) — medical practitioners who are not vocationally recognised GPs.
GP-type services	Non-referred attendances by vocationally recognised GPs and OMPs, and practice nurses.
<i>Haemophilus influenzae</i> type b	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (DoHA 2008).
Immunisation coverage	The proportion of a target population fully immunised with National Immunisation Program specified vaccines for that age group.
Management of upper respiratory tract infections	Number of prescriptions ordered by GPs for the oral antibiotics most commonly used in the treatment of upper respiratory tract infections per 1000 people with PBS concession cards.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive Medicare reimbursement.
Non-referred attendances that are bulk billed	Number of non-referred attendances that are bulk billed and provided by medical practitioners, divided by the total number of non-referred non-specialist attendances.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (DoHA 2004). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.
Notifications of selected childhood diseases	Number of cases of measles, pertussis and <i>Haemophilus influenzae</i> type b reported to the National Notifiable Diseases Surveillance System by State and Territory health authorities.

Other medical practitioner (OMP)	A medical practitioner other than a vocationally recognised GP who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.
Per person benefits paid for GP ordered pathology	Total benefits paid under Medicare for pathology tests requested by GPs, divided by the population.
Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging services performed on referral 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 given period (period prevalence).
Proportion of GPs who are female	Number of all FWE GPs who are female, divided by the total number of FWE GPs.
Proportion of GPs with vocational recognition	Number of FWE GPs who are vocationally recognised, divided by the total number of FWE GPs.
Proportion of general practices registered for accreditation	Number of practices registered for accreditation through either of the two accreditation bodies (AGPAL and GPA ACCREDITATION plus), divided by the total number of practices in the DGP.
Proportion of general practices with electronic health information systems	Number of PIP-registered practices that have taken up the eHealth PIP incentive, 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.
Recognised immunisation provider	A provider recognised by Medicare Australia as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist on the Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition earlier than would otherwise be possible.

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).
Vocationally recognised general practitioner	A medical practitioner who is vocationally recognised under s.3F of the <i>Health Insurance Act 1973</i> (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances.

11.6 List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘11A’ prefix (for example, table 11A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

Table 11A.1	Types of encounter, 2010-11
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12 Mental health management

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Attachment tables

Attachment tables are identified in references throughout this chapter by a '12A' prefix (for example, table 12A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the management of mental health, which represents one activity of the Australian, State and Territory governments in health management.

12.1 Overview of health management

Health management is the ongoing process beginning with initial client contact and including all actions relating to the client: assessment/evaluation; education of the person, family or carer(s); diagnosis; and treatment. Problems associated with adherence to treatment and liaison with, or referral to, other agencies are also included.

This chapter examines the performance of a number of service types in influencing outcomes for people with a mental illness. Mental illness is a significant cause of morbidity and mortality in Australia. Mental health is identified by governments as a national health priority area as are cancer, asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and musculoskeletal conditions and obesity. The national health priority areas represented over 70 per cent of the total burden of disease and injury in Australia in 2003, and their management offers considerable scope for reducing this burden (Begg et al. 2007).

Specialised mental health management services offered by a range of government and non-government service providers include promotion, prevention, treatment, management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, Aboriginal health workers, Aboriginal mental health workers, public hospitals with specialised psychiatric units and stand-alone psychiatric hospitals all provide specialised mental health care. In addition, a number of health services provide care to mental health patients in a non-specialised health setting — for example, general practitioners (GPs), Aboriginal community controlled health services, public hospital emergency departments and outpatient departments, and public hospital general wards (as distinct from specialist psychiatric wards). Some people with a mental illness are cared for in residential aged care services.

Mental health is also the subject of programs designed to improve public health. Public health programs require the participation of public hospitals, primary and community health services, and other services. The performance of public hospitals is reported in chapter 10 and the performance of primary and community health services generally is reported in chapter 11.

Previously this chapter also reported on breast cancer screening and management. Some performance data on the management of breast cancer are now included in the 'Primary and community health' chapter. Future versions of this chapter might include performance reporting on other national health priority areas that need to be managed through a range of health services.

The following improvements have been made to the chapter this year:

- inclusion of the following five new indicators:
 - equity — access indicator ‘new client index’
 - effectiveness — access indicators ‘mental health service use by total population’ and ‘primary mental health care for children and young people’ (this is the first time that this chapter has included any effectiveness — access indicators)
 - outcome indicators ‘rates of use of licit and illicit drugs that contribute to mental illness in young people’ and ‘mental health outcomes of consumers of specialised public mental health services’
- replacement of the outcome indicator ‘quality of life’ with the indicator ‘social and economic inclusion of people with a mental illness’. While data have never been reported for the ‘quality of life’ indicator, data are reported for the replacement indicator
- removal of the following measures, as they no longer reflect the National Mental Health Policy, or are not effective in terms of encouraging improved performance:
 - acute mental health inpatient bed days in public acute hospitals as a proportion of the total acute mental health inpatient bed days in public acute and psychiatric hospitals
 - the proportion of specialised mental health services that have introduced routine collection of consumer outcomes information
 - the proportion of organisations that have in place arrangements that allow consumers to contribute to local service planning and delivery in specialised mental health services
- removal of the effectiveness — quality — continuity indicator ‘private psychiatrists with links to public specialised mental health services’. Data have never been reported for this indicator and it was not expected that they would become available
- inclusion for the first time of data quality information (DQI) on the indicators ‘prevalence of mental illness’, ‘mortality due to suicide’ and ‘social and economic participation of people with a mental illness’.

Framework for measuring health management performance

Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. Measuring performance in the

management of a health problem involves measuring the performance of service providers, and the overall management of a spectrum of services, including prevention, early detection and treatment programs.

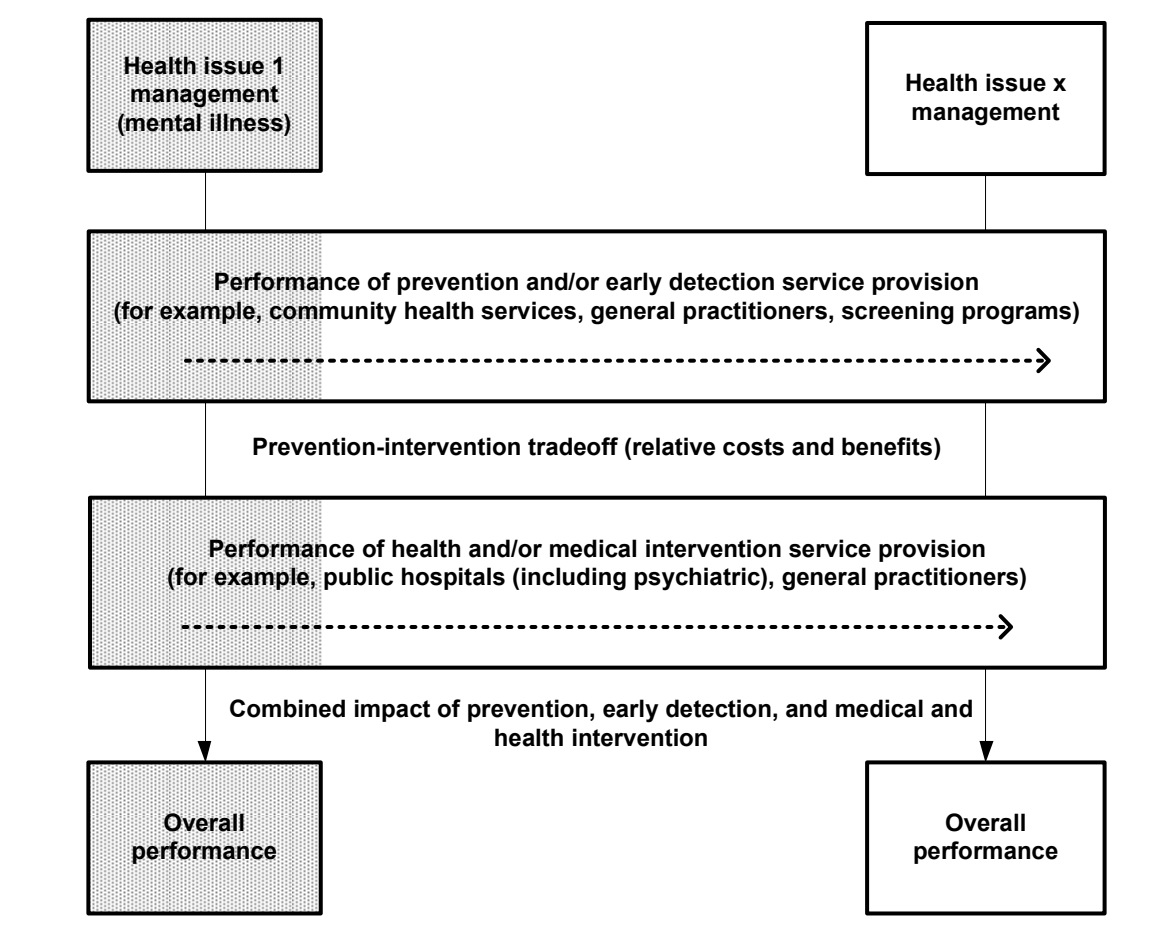
The ‘Health sector summary’ in this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and primary and community health services report the performance of particular service delivery mechanisms. The appropriateness of the mix of services (prevention versus intervention) and the appropriateness of the mix of delivery mechanisms (hospital-based versus community-based) are the focus of reporting in this chapter. The measurement approach is summarised in figure 12.1.

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 specific health management issue (represented by the vertical arrows). Of these this chapter covers mental health services. The mental health management performance framework provides information on the interaction and integration arrangements between GPs (as the key providers of primary health), community-based and hospital-based providers in meeting the needs of people with a mental illness.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (see chapter 1 for more detail on reforms to federal financial relations).

The National Healthcare Agreement (NHA) covers the areas of health and aged care services. The NHA includes sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with the mental health-related performance indicators in the NHA.

Figure 12.1 The Australian health system — measurement approach



12.2 Profile of mental health management

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). The World Health Organization (WHO) describes positive mental health as:

... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

'Mental illness' is a term that describes a diverse range of behavioural and psychological conditions. These conditions can affect an individual's mental health, functioning and quality of life. Each mental illness is unique in its incidence across the lifespan, causal factors and treatments. The most common illnesses are anxiety, affective (mood) and substance use disorders. Mental illness also includes 'low prevalence' conditions such as schizophrenia, bipolar disorder and other psychoses, and severe personality disorder (DoHA 2010).

This chapter focuses on the performance of State and Territory specialised public mental health services that treat mostly low prevalence but severe mental illnesses. It also includes performance data on the services provided by GPs, psychiatrists and other allied health professionals under the Medicare Benefits Schedule (MBS).

The quality of data relating to specialised public mental health services, collected under the *Mental Health Establishments National Minimum Data Set* (MHE NMDS) or the *Community Mental Health Care National Minimum Data Set* (CMHC NMDS) continues to improve. However, these data are subject to ongoing historical validation. Results reported in this section might therefore differ slightly to those in the *Mental Health Services in Australia* and *National Mental Health Report* publications.

Other health and related services are also important for people with a mental illness, including alcohol and drug treatment services (chapter 11), public hospitals (chapter 10) and aged care services (chapter 13). This Report does not include specific performance information on these services' treatment of people with a mental illness. Mental health patients often have complex needs that can also affect other government services they receive, such as those covered in chapter 4 ('School education'), chapter 8 ('Corrective services'), chapter 9 ('Fire, road rescue and ambulance'), chapter 14 ('Services for people with disability') and chapter 17 ('Homelessness services').

Some common terms used in mental health management are outlined in section 12.6.

Roles and responsibilities

State and Territory governments are responsible for the funding, delivery and management of specialised public mental health services including admitted patient care in hospitals, community-based ambulatory care services and community-based residential care (for further details see the sector scope section later in this chapter). State and Territory governments also fund not-for-profit, non-government organisations (NGOs) to provide a range of support services for people with psychiatric disability arising from a mental illness.

The Australian Government is responsible for the funding of the following mental health services and related programs:

- MBS-subsidised services provided by GPs (both general and specific mental health items), private psychiatrists and allied mental health professionals (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers)

-
- Pharmaceutical Benefits Scheme (PBS) funded mental health-related medications
 - other specific programs designed to increase the level of social support and community-based care for people with a mental illness and to prevent suicide.

In addition, the Australian Government provides funding for mental health-related services through the Medicare Safety Net, the Department of Veterans' Affairs (DVA) and the Private Health Insurance Premium Rebates.

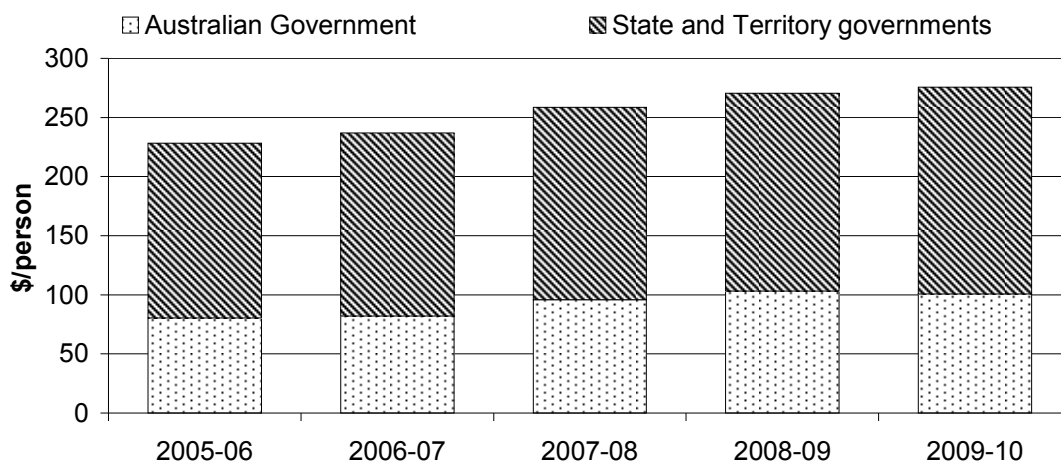
Until 1 July 2009, the Australian Government provided State and Territory governments with base grants and specific funding to undertake reforms in the directions advocated by the *National Mental Health Strategy* (NMHS) for mental health services under the Australian Health Care Agreements (AHCA) (DoHA 2007). The Australian Government now provides a special purpose payment (SPP) to State and Territory governments under the NHA that does not dictate the amount to be spent on mental health or any other health area. According to the *Intergovernmental Agreement on Federal Financial Relations*, under which this SPP is provided, State and Territory governments must expend the SPP on the health sector, but they have budget flexibility to allocate funds within that sector as they deem appropriate. As a consequence of these changes, specific mental health funding cannot be identified in the Australian Government funding provided to State and Territory governments under the NHA.

The Australian, State and Territory governments also fund and/or provide other services that people with mental illnesses can access, such as employment, accommodation, income support, rehabilitation, residential aged care and other services for older people and people with disability (see chapters 13 and 14, respectively).

Funding

Real government recurrent expenditure of around \$6.1 billion was allocated to mental health services in 2009-10 (tables 12A.1 and 12A.2). State and Territory governments made the largest contribution (\$3.9 billion, or 63.5 per cent), although this included some Australian Government funds provided under the NHA SPP (table 12A.2). The Australian Government spent \$2.2 billion or 36.5 per cent of total mental health services' government recurrent expenditure (table 12A.1). Real Australian Government expenditure per person increased from an average of \$80 in 2005-06 to \$101 in 2009-10. Nationally, average State and Territory governments' expenditure per person in 2009-10 was \$175, an increase from \$148 in 2005-06 (figure 12.2).

Figure 12.2 Real government recurrent expenditure on mental health services per person (2009-10 dollars)^{a, b}



a Real expenditure for all years (2009-10 dollars), using the all goods Consumer Price Index for Australian Government expenditure (table 12A.64), and the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services for State and Territory governments' expenditure (table 12A.63). **b** Includes expenditure sourced from patient fees and reimbursement by third party compensation insurers and 'other Australian Government funds'.

Source: Department of Health and Ageing (DoHA) (unpublished); State and Territory governments (unpublished); Australian Institute of Health and Welfare (AIHW) (unpublished) MHE NMDS; tables 12A.2 and 12A.3.

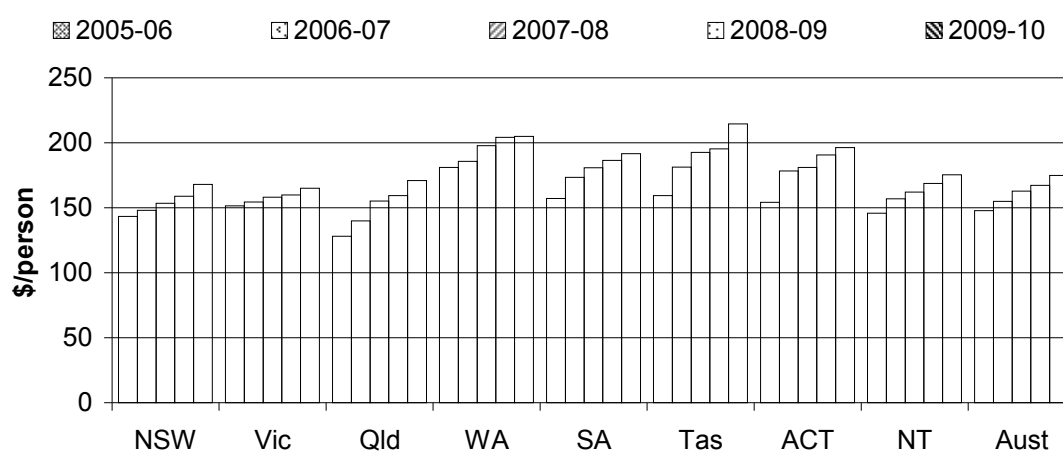
The largest component of Australian Government expenditure on mental health services in 2009-10 was expenditure under the PBS for mental health-related medications (\$771.5 million) (table 12A.1). Real expenditure on PBS mental health-related medications increased by an annual average rate of 2.2 per cent between 2005-06 and 2009-10. This average annual growth rate was lower than the overall Australian Government mental health services average annual expenditure growth rate of 7.8 per cent. Expenditure on PBS mental health-related medications decreased as a share of real expenditure from 42.8 per cent in 2005-06 to 34.6 per cent in 2009-10 (table 12A.1).

In 2009-10, the next largest component of Australian Government expenditure for mental health services was MBS payments for psychologists and other allied health professionals (social workers and occupational therapists) (13.6 per cent), followed by expenditure on consultant psychiatrists (11.6 per cent). The residual included DoHA managed programs and initiatives (9.9 per cent), GPs (8.7 per cent), DVA managed programs and initiatives (7.1 per cent), Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) managed programs and initiatives (6.3 per cent), private health insurance premium rebates (4.0 per cent), research (3.1 per cent), the National Suicide Prevention Program (1.0 per cent) and mental health specific payments to states and territories (0.2 per cent) (table 12A.1).

Australian Government expenditure on mental health specific payments to State and Territory governments has decreased as a share of expenditure for 2009-10 compared with previous years. Until 2008-09, it included specific payments to State and Territory governments for undertaking mental health reform. From 2009-10 onwards, this category only includes the National Perinatal Depression Plan — payment to states. Additional categories of payments are expected to be added to reporting in future years.

Real expenditure per person at State and Territory governments' discretion has increased over time (figure 12.3). Data in figure 12.3 for State and Territory governments' expenditure include Australian Government funds from base grants or SPPs provided under the AHCA/NHA, but exclude Australian Government mental health specific payments and also funding provided to State and Territory governments by the DVA. The data are referred to as expenditure 'at State and Territory governments' discretion'.

Figure 12.3 Real recurrent expenditure at the discretion of State and Territory governments (2009-10 dollars)^{a, b, c, d}

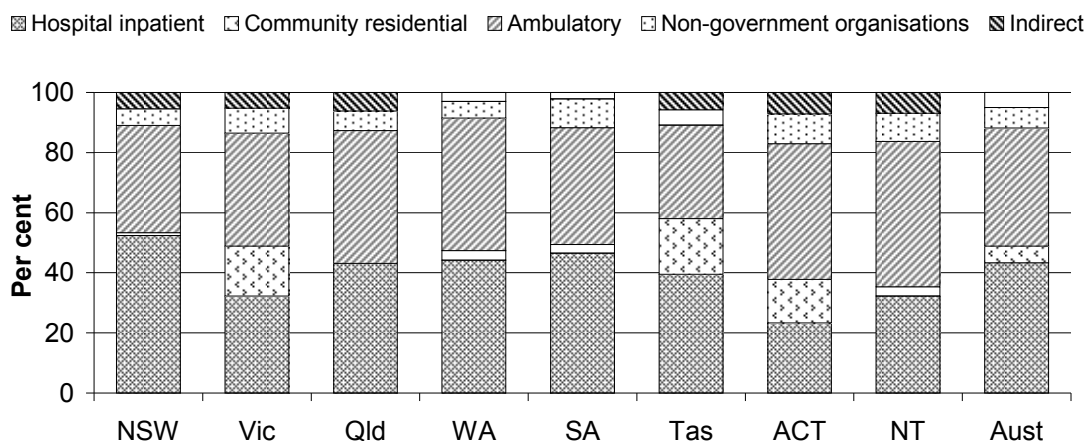


^a Real expenditure (2009-10 dollars), using State and Territory implicit price deflators for general government final consumption on hospital clinical services (table 12A.63). ^b Estimates of State and Territory governments' spending include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Australian Government funds', but exclude Australian Government mental health specific payments and DVA funding. Mental health specific payments and DVA funding data are reported in table 12A.6. ^c Depreciation is excluded for all years. Depreciation estimates are reported in table 12A.5. ^d Data on expenditure 'at State and Territory governments' discretion' excluding revenue from other sources (including patient fees and reimbursement by third party compensation insurers) are presented in table 12A.4.

Source: DoHA (unpublished); State and Territory governments (unpublished); AIHW (unpublished) MHE NMDS; table 12A.2.

Figure 12.4 shows how State and Territory governments' recurrent expenditure was distributed across the range of mental health services in 2009-10.

Figure 12.4 State and Territory governments' recurrent expenditure, by service category, 2009-10^{a, b, c, d}



^a Includes all State and Territory governments' expenditure on mental health services, regardless of source of funds. ^b Depreciation is excluded. Depreciation estimates are reported in table 12A.5. ^c The differential reporting of clinical service providers and NGOs artificially segregates the mental health data. Given that the role of NGOs varies across states and territories, the level of expenditure on NGOs does not necessarily reflect the level of community support services available. ^d Queensland does not fund community-based residential services, but it funds a number of extended treatment services (both campus-based and non-campus-based) that provide longer term inpatient treatment and rehabilitation services with full clinical staffing for 24 hours a day, 7 days a week.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.7.

Size and scope of sector

Prevalence and impact of mental illness

According to the National Survey of Mental Health and Wellbeing (SMHWB), in 2007, 20.0 ± 1.1 per cent of adults aged 16–85 years (or approximately 3.2 million adults) met the criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months before the survey. A further 25.5 ± 1.4 per cent of adults aged 16–85 years had experienced a mental disorder at some point in their life, but did not have symptoms in the previous 12 months (table 12A.49). Additional data on the prevalence of selected mental illnesses are reported under the indicator 'prevalence of mental illness'.

Mental illnesses contribute significantly to the total burden of disease and injury in Australia (13.3 per cent of the total burden in 2003) (Begg et al. 2007). The total burden comprises the amount of 'years' lost due to fatal events (years of life lost due to premature death) and non-fatal events (years of 'healthy' life lost due to

disability). Mental illness is also the leading cause of 'healthy' life years lost due to disability (24 per cent of the total non-fatal burden in 2003) (Begg et al. 2007).

Mental illness can affect an individual's functioning and quality of life. According to the SMHWB, in 2007, people with a lifetime mental disorder who had symptoms in the previous 12 months (20.0 ± 1.1 per cent of the total population), were significantly overrepresented in the populations who had high or very high levels of psychological distress — 57.1 ± 5.1 per cent and 79.6 ± 7.2 per cent of these populations respectively (table 12A.8). Data collected under the SMHWB on the impact of mental illness on an individual's functioning and quality of life relating to level of disability, days out of role and suicidal behaviours are also included in table 12A.8.

According to the National Health Survey (NHS), a significantly higher proportion of females reported high/very high levels of psychological distress than males in 2007-08 (14.4 ± 1.1 per cent compared with 9.6 ± 0.9 per cent) (table 12A.9). The proportion of high/very high levels of psychological distress was also higher for people aged 18–64 years, than for people aged 65 years or over (table 12A.9). In 2008, 32 per cent of Indigenous Australians aged 18 years or over reported high levels of psychological distress. After adjusting for age, this was 2.5 times the rate for non-Indigenous adults (AHMAC 2011).

Mental health services

There are a range of government provided or funded mental health services; the key services are the following:

- MBS-subsidised mental health services — services provided by a GP, psychiatrist or an allied health professional on a fee-for-service basis that are partially or fully funded under Medicare. GPs provide mental health-related services under specific mental health MBS items (GP Mental Health Care and Focussed Psychological Strategies) and through other mental health-related encounters, such as through a standard surgery consultation.
- Admitted patient care in hospitals — services provided to admitted patients in stand-alone psychiatric hospitals or specialised psychiatric units located within general hospitals.
- Community-based mental health services, comprising the following:
 - ambulatory care services provided by outpatient clinics (hospital and clinic based), mobile assessment and treatment teams, day programs and other services dedicated to the assessment, treatment, rehabilitation and care of

people with a mental illness or psychiatric disability who live in the community

- specialised residential services that provide beds in the community, staffed on-site (24 hour and non-24 hour) by mental health professionals that are designed for people with significant disability or sub-acute disorders (these services replace some of the functions previously performed by long stay psychiatric hospitals)
- not-for-profit, NGO services, funded by State and Territory governments to provide support for people with a psychiatric disability arising from a mental illness, including accommodation, outreach to support people living in their own homes, residential rehabilitation units, recreational programs, self-help and mutual support groups, carer respite services and system-wide advocacy (DoHA 2010).

MBS-subsidised mental health services

In 2009-10, there were 3.0 million MBS-subsidised services provided by psychologists, 2.0 million services provided by psychiatrists, 1.8 million services provided by GPs (under specific mental health MBS items) and 200 000 services provided by other allied health professionals (table 12A.10). This was equivalent to 134.1 psychologist services, 89.5 psychiatrist services, 81.7 GP services and 9.0 other allied health services per 1000 people in the population (table 12A.10).

Information on GP mental health-related encounters is also available from the *Bettering the Evaluation and Care of Health* (BEACH) survey data. Data for the BEACH survey are collected from a sample of 1000 GPs.

A GP can manage more than one problem at a single encounter. Problems managed reflect the GP's understanding of the health problem presented by the patient. Under the BEACH, a mental health-related encounter is defined as one at which a mental health-related problem is managed. In 2009-10, on average 12.1 psychological or mental health problems were managed by GPs in every 100 encounters (more than one problem can be managed in a single encounter). Depression was the most frequently reported mental health-related problem managed (4.3 per 100 GP encounters) and of all problems was the fifth most frequently managed (Britt et al. 2010). Anxiety (1.8 per 100 GP encounters) and sleep disturbance (1.5 per 100 GP encounters) were the next most common psychological or mental health-related problems.

These encounters are most often recorded as standard surgery consultations. The GP mental health-specific MBS items were recorded at a rate of 1.2 per 100 GP encounters in the 2009–10 BEACH survey (Britt et al. 2010).

Admitted patient care and community-based mental health services — service use

Estimating activity across the publicly funded specialised mental health services sector, which comprises admitted patient care and community-based mental health services, is problematic as the service types differ. Service activity is reported by separations for admitted patient care, episodes for community-based residential care and contacts for community-based ambulatory care. Service use data for the NGO sector are not available.

There were 87 797 separations with specialised psychiatric care in public acute hospitals and 10 562 specialised psychiatric care separations in public psychiatric hospitals in 2008-09 (table 12A.12). Schizophrenia accounted for a large proportion of separations with specialised psychiatric care in public hospitals (20.6 per cent in public acute hospitals and 21.5 per cent in public psychiatric hospitals) (table 12A.12). There were a further 4798 ambulatory equivalent same day separations with specialised psychiatric care in public acute hospitals and 61 in public psychiatric hospitals (AIHW 2011b).

There were 3497 episodes of community-based residential care in 2008-09 (table 12A.14). Schizophrenia, schizotypal and other delusional disorders as a principal diagnosis accounted for the largest proportion of these episodes (61.1 per cent) (AIHW 2011b). There were 6.6 million community-based ambulatory care patient contacts, equivalent to 300.3 contacts per 1000 people, in 2009-10 (table 12A.24). Data on the rate of contacts by Indigenous status, Socio-Economic Indexes for Areas (SEIFA) and remoteness are in table 12A.23. Data on the number and rate of contacts for 2008-09 by sex and age are in table 12A.13. For those contacts in 2008-09 where a principal diagnosis was available, the largest proportion was for schizophrenia (31.0 per cent) (AIHW 2011b).

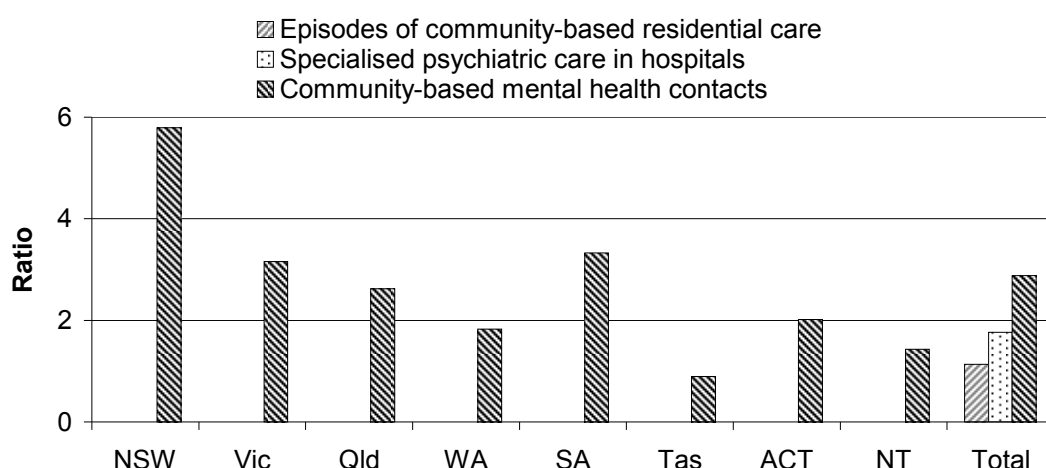
Data on service use by the Indigenous status of patients are available, but comparisons not necessarily accurate because Indigenous patients are not always correctly identified. Differences in rates of service use could also reflect other factors, including the range of social and physical infrastructure services available to Indigenous people, and differences in the complexity, incidence and prevalence of illnesses.

Combined data for the jurisdictions for which data are available, show that Indigenous people were 1.1 times more likely to have an episode of

community-based residential care and 2.9 times more likely to have a community-based ambulatory mental health contact than were non-Indigenous people in 2008-09 (figure 12.5). For specialised psychiatric care in hospitals, Indigenous people were 1.8 times more likely to receive admitted (non-ambulatory) specialised psychiatric care in hospitals than were non-Indigenous people in 2008-09 (figure 12.5). However, this pattern of service use is not necessarily reflected for ambulatory-equivalent specialised psychiatric care in hospitals. Data for July 2006 to June 2008, show that Indigenous people were less likely than non-Indigenous people (rate ratio of 0.2) to receive this type of care (AIHW 2011a).

Table 12A.14 contains further information on use of these services by Indigenous status. Data for episodes of community-based residential care and specialised psychiatric care in hospitals are not available by Indigenous status across jurisdictions for 2008-09.

Figure 12.5 Ratio of Indigenous to non-Indigenous specialised mental health service use, 2008-09^{a, b, c, d, e}



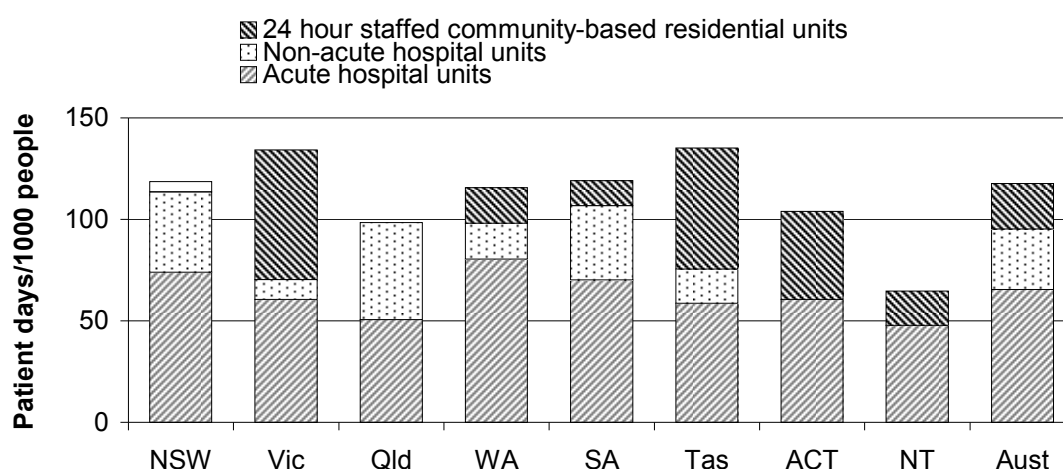
^a Data for episodes of community-based residential care and specialised psychiatric care in hospitals are not available by Indigenous status across jurisdictions for 2008-09. National data should be interpreted with caution due to the varying quality and completeness of Indigenous identification across jurisdictions. ^b Data for community-based mental health contacts should be interpreted with caution. Across jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown. Data were reported by the following states and territories to be of acceptable quality: NSW, Queensland, WA Tasmania, the ACT and the NT. ^c The ratio is equal to the service use rate (episodes, contacts or separations) for Indigenous people divided by the service use rate for non-Indigenous people. ^d Specialised psychiatric care in hospital data for non-Indigenous people include those whose Indigenous status was 'not stated'. For the community-based data, people whose Indigenous status was 'not stated' are excluded. ^e Data for specialised psychiatric care in hospitals includes both public and private hospitals (except for the NT that are for public hospitals only).

Source: AIHW 2011, *Mental Health Services in Australia Online*, tables 4.14, 7.4 and 8.4, mhsa.aihw.gov.au/home/ (accessed 13 October 2011); table 12A.14.

Admitted patient care and community-based mental health services patient days, beds and staffing

Activity can be measured across specialised public mental health services by accrued mental health patient days, mental health beds and full time equivalent (FTE) direct care staff. Admitted patient care and community-based residential (24 hour staffed) accrued patient days per 1000 people are included in figure 12.6.

Figure 12.6 Accrued mental health patient days, 2009-10^{a, b}



^a Queensland does not fund community-based residential services, but funds a number of campus-based and non-campus-based extended treatment services. Data from these services are included as non-acute.

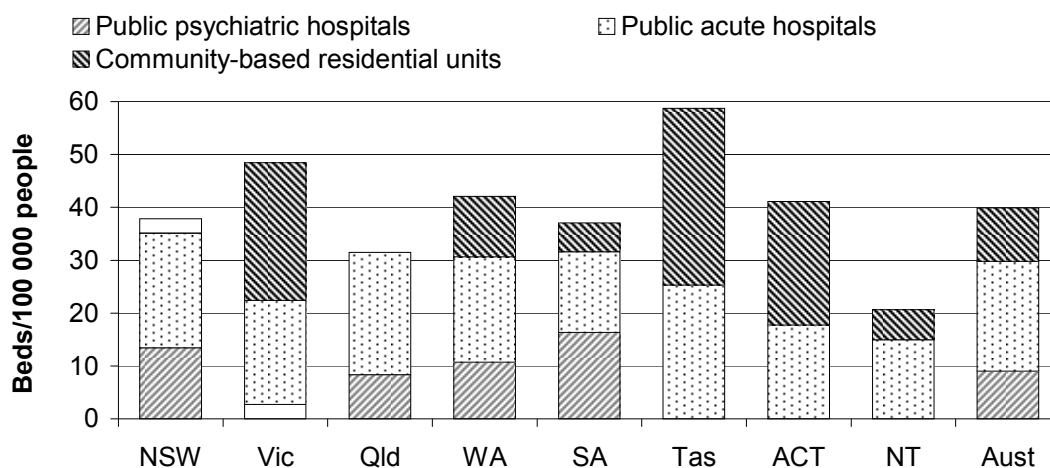
^b The ACT and the NT did not provide mental health care in non-acute hospital units.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.11.

Beds are counted as those immediately available for use by admitted patients if required. They are available for use immediately — or within a reasonable period of time — if located in a suitable place for care with nursing or other auxiliary staff available. Figure 12.7 presents the number of beds per 100 000 people by service setting, in 2009-10. These data show the differences in service mix across states and territories.

Figure 12.8 reports FTE direct care staff per 100 000 people employed across the admitted patient and community-based services (ambulatory and residential). Nursing staff comprise the largest FTE component of direct care staff employed in specialised public mental health services. Across Australia in 2009-10, there were 64.6 nurses per 100 000 people, compared with 23.7 allied health care staff, 12.4 medical staff and 4.4 other personal care staff (table 12A.16). FTE direct care staff employed in specialised mental health services, by service setting, are reported in table 12A.17.

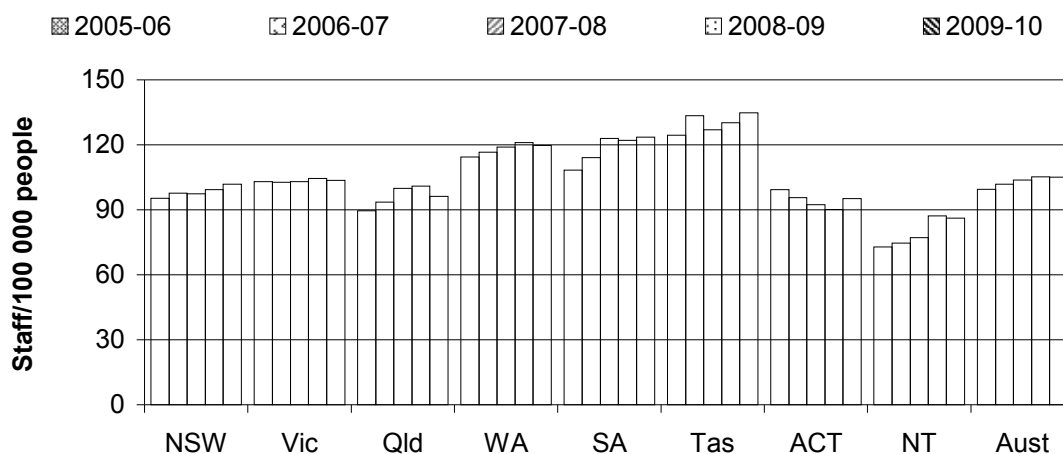
Figure 12.7 Mental health beds in public hospitals and community-based residential units, 2009-10^{a, b, c, d}



^a Includes beds in public hospitals and publicly funded community-based residential units. ^b Queensland does not fund community-based residential services, but funds campus-based and non-campus-based extended treatment services. ^c Beds data in WA include publicly funded mental health beds in private hospitals. ^d Tasmania, the ACT and the NT do not have public psychiatric hospitals.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.15.

Figure 12.8 FTE health professional direct care staff^a



^a Includes staff within the health professional categories of 'medical', 'nursing', 'allied health' and 'other personal care'. Section 12.6 provides detailed definitions for these staffing categories.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.16.

12.3 Framework of performance indicators for mental health management

Preventing the onset of mental illness is challenging, primarily because individual illnesses have many origins. Most efforts have been directed at treating mental illness when it occurs, determining the most appropriate setting for providing treatment and emphasising early intervention.

The framework of performance indicators for mental health services draws on governments' broad objectives for national mental health policy, as encompassed in the NMHS and the COAG National Action Plan on Mental Health (box 12.1). The performance indicator framework reports on the equity, effectiveness and efficiency of mental health services. It covers a number of service delivery types (MBS-subsidised, admitted patient and community-based services) and includes outcome indicators of system-wide performance.

Box 12.1 Broad objectives of National Mental Health Policy^a

Key broad objectives include to:

- improve the effectiveness and quality of service delivery and outcomes
- promote community awareness of mental health problems
- prevent, where possible, the development of mental health problems and mental illness
- undertake early intervention for mental health problems and mental illness
- promote recovery from mental health problems and mental illness
- reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community
- assure the rights of people with mental illness
- encourage partnerships among service providers and between service providers and the community
- provide services in an equitable (including improved access to mental health services, particularly in Indigenous and rural communities) and efficient manner
- improve mental health and facilitate recovery from illness through more stable accommodation and support and meaningful participation in recreational, social, employment and other activities in the community.

^a These objectives represent a paraphrased interpretation of aspects of the National Mental Health Policy 2008.

National Mental Health Strategy

In 1991, Australian Health Ministers signed the *Mental Health Statement of Rights and Responsibilities*. This Statement seeks to ensure that consumers, carers, advocates, service providers and the community are aware of their rights and responsibilities and can be confident in exercising them (Australian Health Ministers 1991). The Statement underpins the NMHS endorsed by Australian, State and Territory governments in 1992 (AIHW 2008). In 2011, the Statement was updated to align with the *National Mental Health Policy 2008* and Australia's international obligations with respect to the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Convention on the Rights of the Child.

The NMHS was established to guide the reform agenda for mental health in Australia across the whole-of-government. The NMHS consists of the National Mental Health Policy and the National Mental Health Plan.

- The National Mental Health Policy describes the broad aims and objectives of the NMHS. The revised *National Mental Health Policy 2008* includes a renewed emphasis on whole-of-government mental health reform and commits the Australian, State and Territory governments to the continual improvement of Australia's mental health system. Under the Policy, these governments will seek to ensure people with a mental illness have access to services that detect and intervene early in illness, promote recovery and provide effective and appropriate treatment and community supports to enable them to fully participate in the community.
- The National Mental Health Plan describes the approach to implementing the aims and objectives of the Policy. A fourth plan (2009–2014) was endorsed by all Australian Health Ministers in September 2009. This plan consolidates and builds on reforms begun under the first three plans (the first operated from 1993–1998, the second from 1998–2003 and the third from 2003–2008). The fourth plan aims to strengthen the accountability framework with Australian, State and Territory governments by developing targets and data sources for a set of indicators and to provide annual progress reports to COAG (AHMC 2009). These indicators will be the primary vehicle for monitoring the progress of these governments in achieving national mental health reform under the fourth plan.

COAG National Action Plan on Mental Health

In 2006, COAG agreed to the *National Action Plan on Mental Health 2006–2011* (COAG 2006). This plan involved a joint package of measures and new investments by all governments aimed at promoting improved mental health and

providing additional support to people with mental illness, their families and their carers. The Action Plan was designed to further promote mental health reform and focuses on areas that have not progressed sufficiently under the NMHS. A series of measures had been identified to monitor progress under the Action Plan. Australian Health Ministers agreed to report annually to COAG on implementation of the Plan, and on progress against the agreed outcomes. Governments also agreed to an independent evaluation and review of the Plan after five years (COAG 2006).

Performance indicator framework

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of mental health management services (figure 12.9). The performance indicator framework shows which data are comparable in the 2012 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).

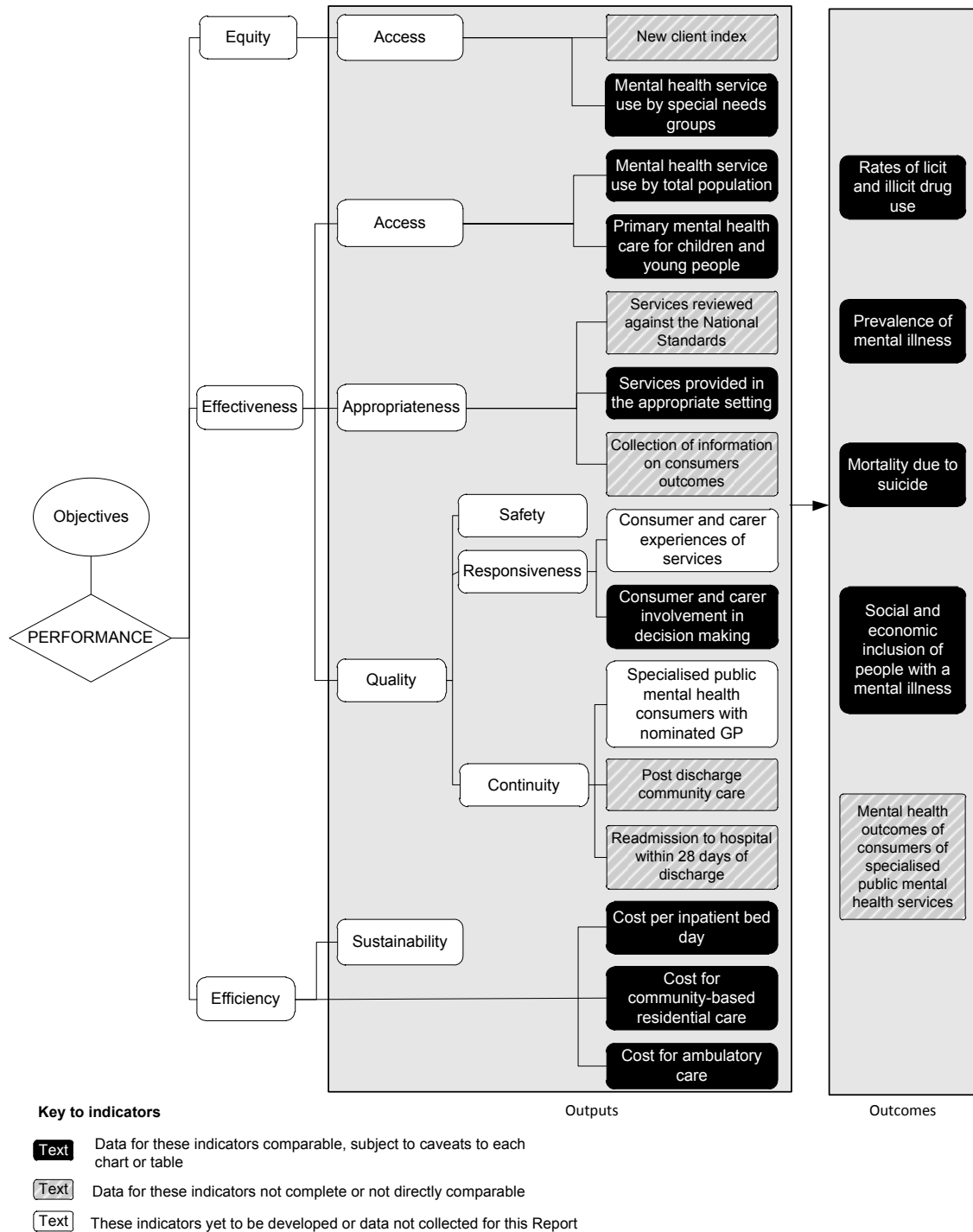
The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Some changes have been made to the mental health management framework for the 2012 Report:

- Five new indicators have been added to the framework, all for which data are reported:
 - equity — access indicator 'new client index'
 - effectiveness — access indicators 'mental health service use by total population' and 'primary mental health care for children and young people'
 - outcome indicators 'rates of use of licit and illicit drugs that contribute to mental illness in young people' and 'mental health outcomes of consumers of specialised public mental health services'.
- The outcome indicator 'social and economic inclusion of people with a mental illness' has replaced the 'quality of life' indicator.
- The effectiveness — quality — continuity indicator 'private psychiatrists with links to public specialised mental health services' has been removed.

-
- The names of two ‘white’ indicators have been revised to better reflect the nationally agreed indicators under the Fourth National Mental Health Plan:
 - the effectiveness — quality — responsiveness indicator ‘consumer and carer satisfaction’ has been changed to ‘consumer and carer experiences of services’
 - effectiveness — quality — continuity indicator ‘GP’s with links to specialised mental health services’ has been changed to ‘specialised public mental health consumers with nominated GP’.

Figure 12.9 Mental health management performance indicator framework



12.4 Key performance indicators for mental health management

Outputs

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

Equity — new client index

‘New client index’ is an indicator of governments’ objective to provide mental health services in an equitable manner (box 12.2). Population treatment rates are relatively low and it might be difficult for a new client to access specialised public mental health services if resources are already utilised by existing clients.

Box 12.2 New client index

‘New client index’ is defined as the proportion of total clients under the care of State or Territory specialised public mental health services who were new clients. A new client is a consumer who has not been seen by a specialised public mental health service in the five years preceding the initial contact with a service in the relevant reference period.

A high or increasing proportion of total clients who are new might be desirable, as it suggests it is easier for new clients to access specialised public mental health services. However, results are difficult to interpret. The appropriate balance between providing ongoing care to existing clients who have continuing needs and meeting the needs of new clients is unknown.

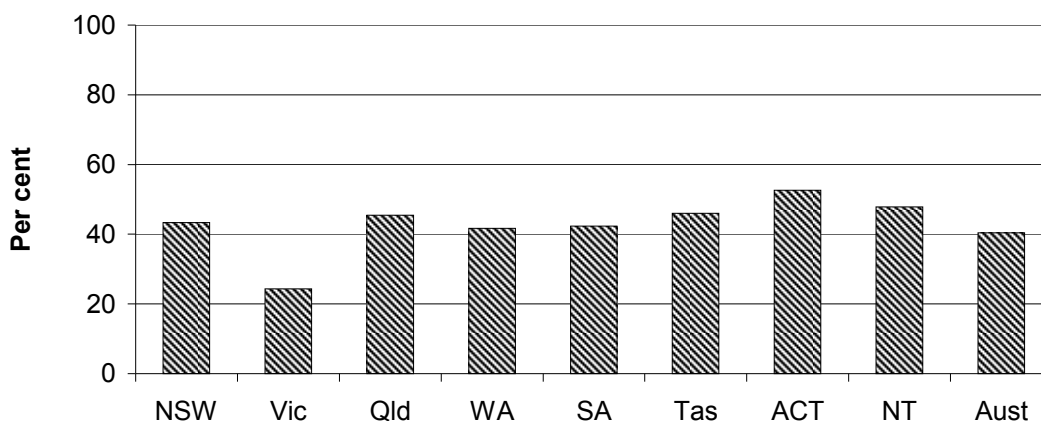
This indicator does not provide information on whether the services are appropriate or adequate for the needs of the people receiving them (new or existing clients), or correctly targeted to those clients who are most in need.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

The proportions of total clients of specialised public mental health services who are new are reported in figure 12.10.

Figure 12.10 Proportion of total clients of specialised public mental health services who are new, 2009-10^{a, b, c}



^a Clients in receipt of services include all people who received one or more community-based ambulatory service contact or had one or more day of inpatient or community-based residential care in the data period.

^b A new client is a consumer who had not been seen in the five years preceding the first contact with a State or Territory specialised public mental health service during 2009-10. ^c The approach to identifying unique clients differs across jurisdictions. Some have a State-wide unique patient identifier, others use a statistical linkage key. For SA, the client counts are not unique, but are an aggregation of three separate databases.

Source: State and Territory governments (unpublished); table 12A.18.

Equity — mental health service use by special needs groups

‘Mental health service use by special needs groups’ is an indicator of governments’ objective to provide mental health services in an equitable manner, including access to services by special needs groups such as Indigenous people (box 12.3).

Box 12.3 Mental health service use by special needs groups

'Mental health service use by special needs groups' is defined by two measures:

- proportion of the population in a special needs group using State and Territory specialised public mental health services, compared with the proportion of the population outside the special needs group using State and Territory specialised public mental health services
- proportion of the population in a special needs group using MBS-subsidised ambulatory mental health services provided by private psychiatrists, GPs and allied health providers (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers), compared with the proportion of the population outside the special needs group using MBS-subsidised ambulatory mental health services.

The special needs groups reported are Indigenous people, people from outer regional, remote and very remote locations and people residing in low socio-economic areas.

This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across special needs groups. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness. It also does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

The proportions of the population using State and Territory specialised public mental health services in 2009-10, by special needs group are reported in figure 12.11. The results at the national level show that the proportion of the population using these services is higher:

- for Indigenous people, than for non-Indigenous people (figure 12.11a)
- in very remote locations, than in other locations (figure 12.11b)
- for people in the three most disadvantaged SEIFA quintiles (1, 2 and 3), than the more advantaged quintiles (figure 12.11c).

These results, which are derived using community-based ambulatory care data, should be interpreted with care, as:

- people receiving only admitted and/or community-based residential services are not included in the proportion of people accessing services or in rates of service use

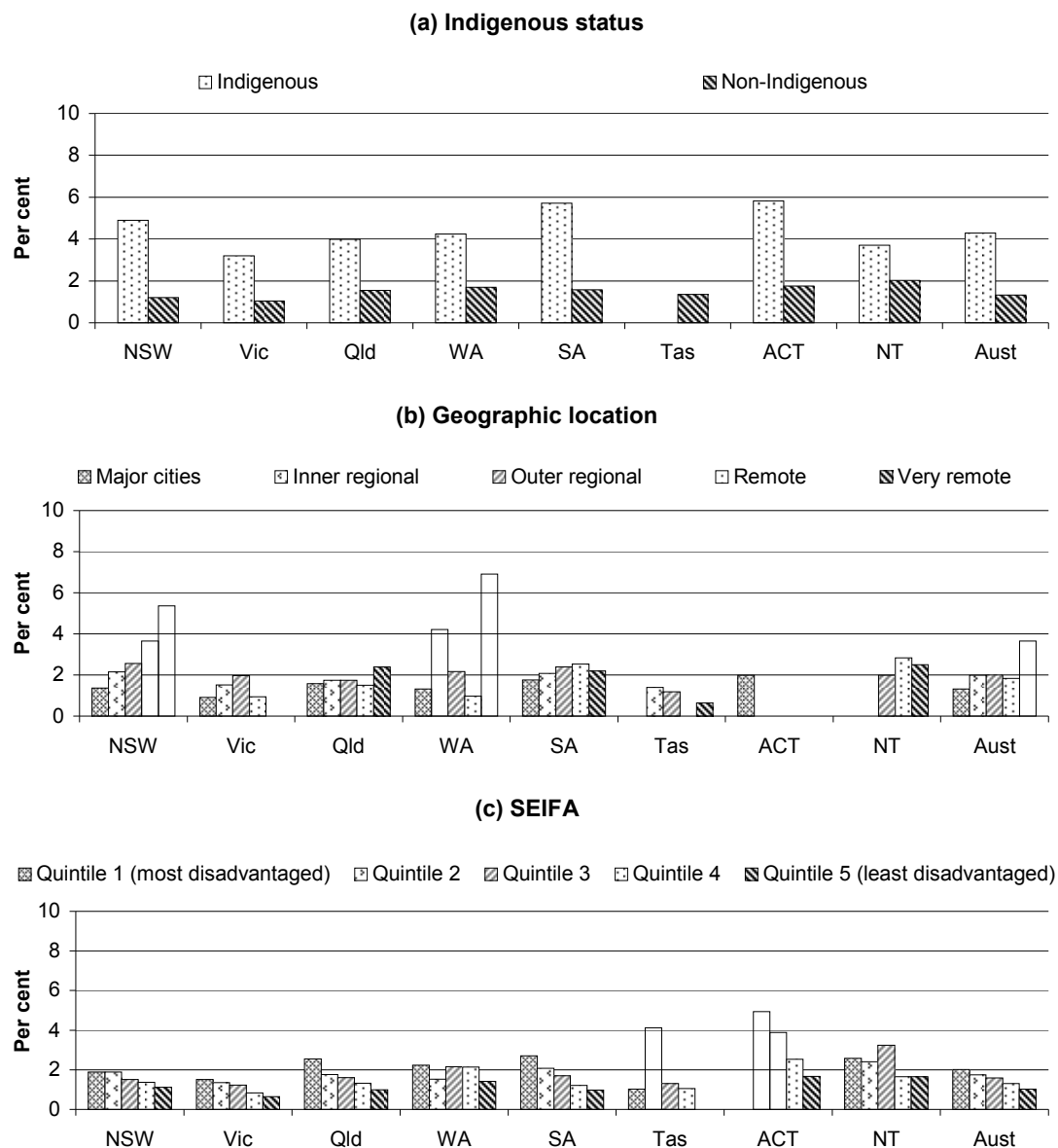
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- there is no identifier to distinguish ‘treatment’ versus ‘non-treatment’ service contacts in the community mental health care data set
 - jurisdictions differ in their collection and reporting of community-based ambulatory care data — there are variations in local business rules and in the interpretation of the national definitions.

The proportions of the population using MBS-subsidised ambulatory mental health services, by special needs group are reported in figure 12.12. The results at the national level show that the proportion of the population using MBS-subsidised ambulatory mental health services is lower:

- for Indigenous people, than for non-Indigenous people (figure 12.12a)
- in remote and very remote locations than in other locations (figure 12.12b)
- for those in the most disadvantaged SEIFA quintile 1, than for those in the more advantaged quintiles (figure 12.12c).

Further data on the use of State and Territory community-based specialised mental health services and MBS-subsidised ambulatory mental health services are in tables 12A.22–27. Data on the use of private hospital mental health services are also contained in tables 12A.28 and 12A.19–21.

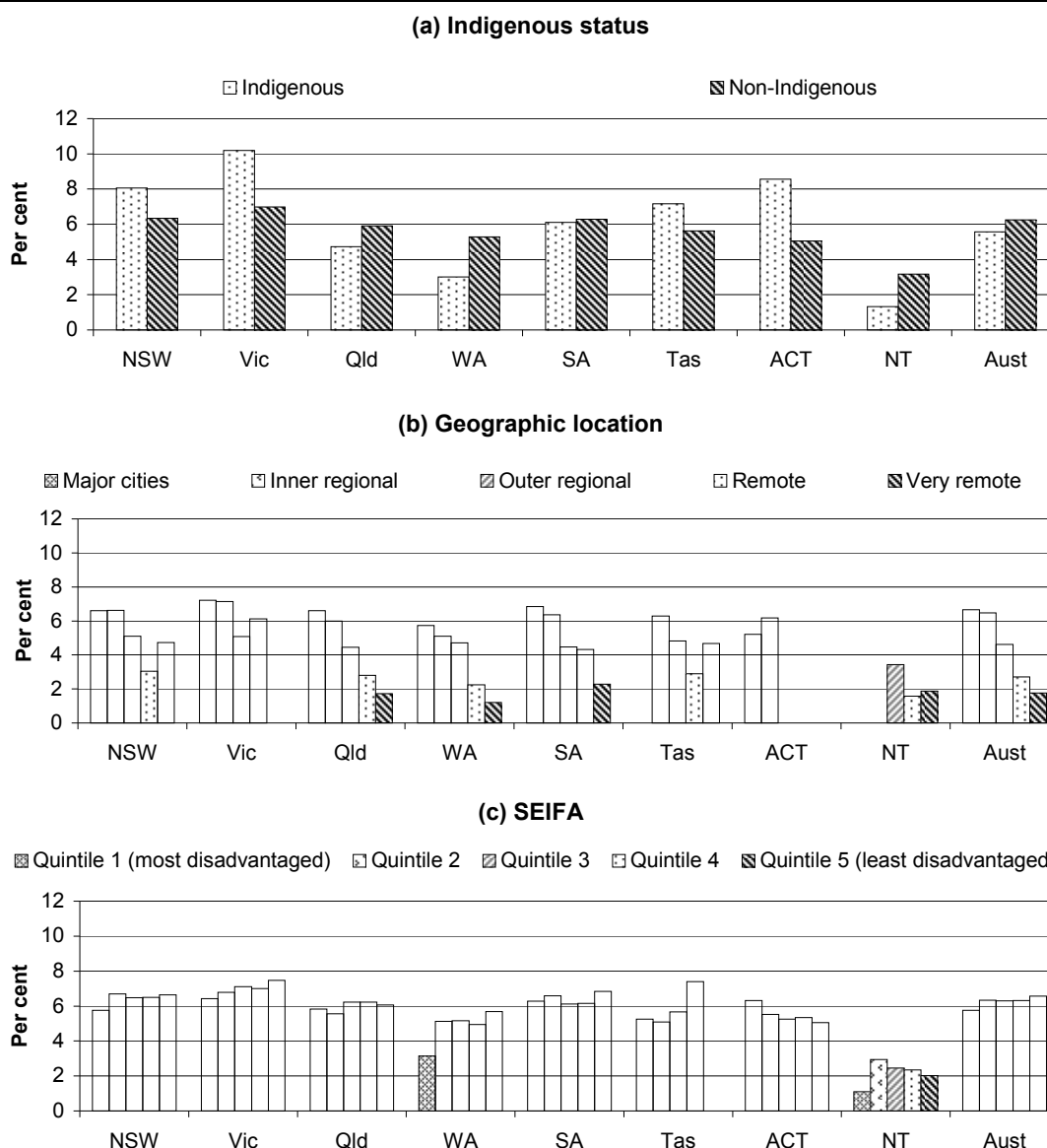
Figure 12.11 Population using State and Territory specialised public mental health services, by special needs groups, 2009-10^{a, b, c, d, e, f, g}



SEIFA = Socio-Economic Indexes for Areas. ^a Proportions are age-standardised to the Australian population as at 30 June 2001. ^b Counts for State and Territory specialised public mental health services are counts of people receiving one or more service contacts provided by community-based ambulatory services. ^c SA submitted data that were not based on unique patient identifiers or data matching approaches. Therefore, caution needs to be taken when making jurisdictional comparisons. ^d Victoria does not have very remote locations. ^e Tasmanian data for Indigenous people are not published. Tasmania does not have major cities and the contact rate in remote areas is zero. SEIFA Quintile 5 is not applicable for Tasmania. ^f The ACT does not have outer regional, remote or very remote locations. ACT data are not published for inner regional areas. Data for quintile 1 are not published for the ACT. ^g The NT does not have major cities or inner regional locations.

Source: State and Territory governments (unpublished) CMHC data; tables 12A.19–21.

Figure 12.12 Population using MBS-subsidised ambulatory mental health services, by special needs groups, 2009-10^{a, b, c, d}



SEIFA = Socio-Economic Indexes for Areas. ^a Proportions are age-standardised to the Australian population as at 30 June 2001. ^b MBS-subsidised services are those mental health-specific services provided under the general MBS and by DVA. The specific Medicare items included are detailed in table 12A.28. ^c Victoria does not have very remote areas. Tasmania does not have major cities. ACT does not have outer regional, remote or very remote locations. The NT does not have major cities or inner regional locations. ^d SEIFA Quintile 5 is not applicable for Tasmania.

Source: DoHA (unpublished) Medicare Statistics data; DVA (unpublished); tables 12A.19–21.

Effectiveness — access — mental health service use by total population

‘Mental health service use by total population’ is an indicator of governments’ objective to provide equitable access to mental health services for all people who need them (box 12.4). An estimate of the population who need mental health services is not available, so the indicator is reported as a proportion of the total population.

Box 12.4 Mental health service use by total population

‘Mental health service use by total population’ is defined as the proportion of the population in a State and Territory using a specialised public mental health service or a MBS-subsidised service. Data are reported separately for State and Territory specialised public mental health services and MBS-subsidised services. Data from the 2007 SMHWB on the proportion of people who had a lifetime mental disorder with symptoms in the 12 months before the survey who used any service for mental health are also reported.

This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across jurisdictions. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.

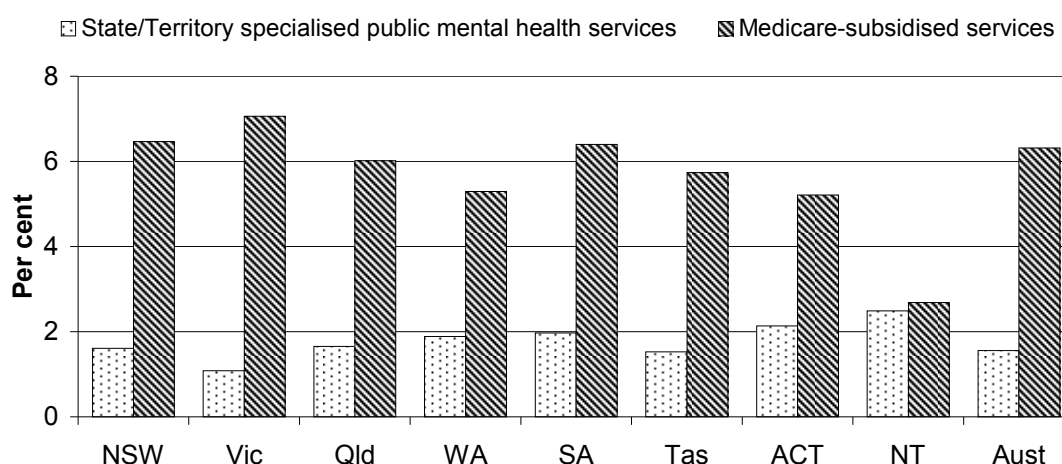
This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. People with a mental illness can have low rates of service use due to them choosing not to access services, unavailability of appropriate services, lack of awareness that services are available and negative experiences associated with the previous use of services (AHMC 2008). In addition, it might not be appropriate for all people with a mental illness to use a service, for example, some can seek and receive assistance from outside the health system (AHMC 2008).

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

In 2009-10, 6.3 per cent and 1.6 per cent of the total population received MBS-subsidised (MBS general and DVA) and State and Territory specialised public mental health services, respectively (figure 12.13).

Figure 12.13 Population receiving mental health services, by service type, 2009-10^{a, b, c}



a Rates are age-standardised to the Australian population as at 30 June 2001. **b** Counts for State and Territory specialised public mental health services are counts of people receiving one or more service contacts provided by community-based ambulatory services (most people who have received an inpatient service or residential care service have also received a service contact with a community-based ambulatory service). **c** MBS-subsidised services are those specific mental health services provided under Medicare by psychiatrists, clinical psychologists, GPs and other allied health services. The specific MBS items included are detailed in table 12A.28. People seen by more than one provider type are counted only once.

Source: State and Territory governments (unpublished) CMHC data; DoHA (unpublished) Medicare Statistics data; DVA (unpublished); table 12A.28.

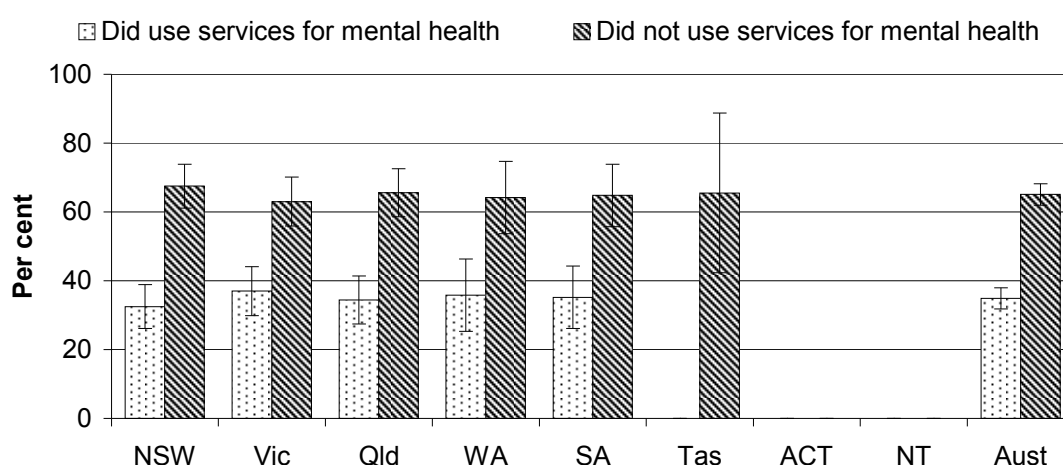
According to the SMHWB, 34.9 ± 3.1 per cent of people with a lifetime mental disorder who had symptoms in the previous 12 months used services for mental health in 2007 (figure 12.14). Service use was more common among people with severe disorders. Almost two thirds (64.8 per cent) of people with severe mental disorders used services, compared with 40.2 per cent of those with moderate mental disorders and 17.9 per cent of people with mild mental disorders (Slade et al. 2009).

For people with a lifetime mental disorder who had symptoms in the previous 12 months who did not use services, the SMHWB examined whether there were services or types of help that they thought they needed, but had not received. For these people, 85.7 per cent reported that they had no need for any of the types of help asked about in the survey (information, medication, talking therapy, social intervention, or skills training) (Slade et al. 2009). Data for 2007 on the use of different types of health services by people with a mental disorder who had symptoms in the previous 12 months are reported in table 12A.31.

The SMHWB estimates for 2007 are unlikely to reflect current access to mental health services as the survey captured only the early impact of the Australian Government's *Better Access to Mental Health Care* initiative commencing in November 2006. The *Better Access* program expanded the role of the primary

health sector in providing mental health care through MBS-subsidised services. Recent analysis undertaken by DoHA, as part of a national evaluation of the *Better Access* program that incorporates the growth in the number of people treated by *Better Access* program services and estimates from other service utilisation data, suggests that the proportion of people with a current mental illness who received care in 2009-10 was 46.1 per cent (Pirkis et al. 2012).

Figure 12.14 Use of services for mental health for people with a lifetime mental disorder who had symptoms in the previous 12 months, 2007^{a, b, c}



^a Services used for mental health included hospitals, GPs, psychiatrists, psychologists, other mental health professionals and other health professionals. ^b Error bars represent the 95 per cent confidence interval associated with each point estimate. ^c Estimates with relative standard errors (RSEs) over 25 per cent are not published. This is the case for Tasmanian data for the category 'did use services for mental health', the ACT and the NT.

Source: ABS (unpublished) 2007 SMHWB, Cat. no. 4326.0; table 12A.32.

Effectiveness — access — primary mental health care for children and young people

'Primary mental health care for children and young people' is an indicator of governments' objective to prevent, where possible, the development of mental health problems and mental illness and undertake early intervention for mental health problems and mental illness (box 12.5). Early identification of and intervention in mental illnesses for children and young people can result in better outcomes.

Box 12.5 Primary mental health care for children and young people

‘Primary mental health care for children and young people’ is defined as the proportion of young people aged under 25 years who had contact with primary mental health care services subsidised through the MBS. Data are also reported by four age cohorts: pre-school (0-<5 years), primary school (5-<12 years), secondary school (12-<18 years) and youth/young adult (18- <25 years).

High or increasing proportions of young people who had contact with primary mental health care services subsidised through the MBS is desirable.

This indicator does not provide information on whether the services are appropriate for the needs of the young people receiving them, or correctly targeted to those young people most in need. It also does not measure access according to need, that is, according to the prevalence of mental illness across jurisdictions. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.

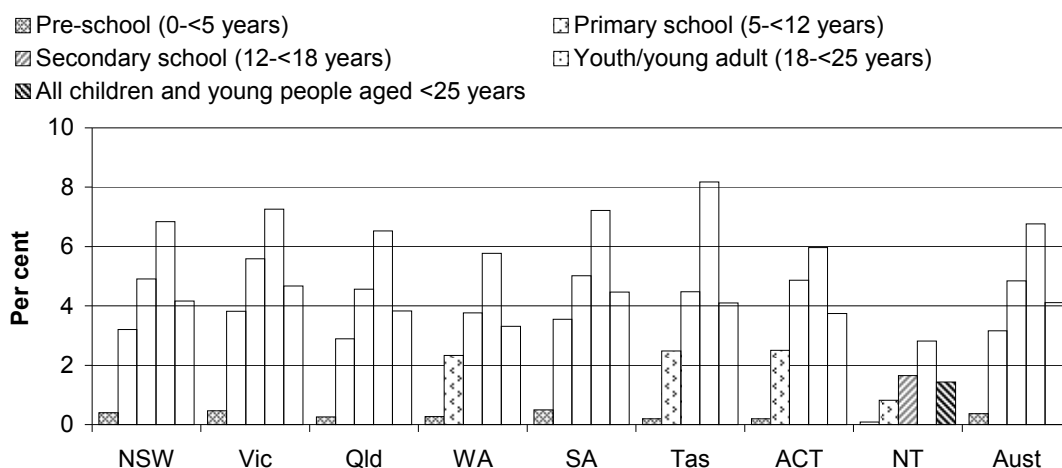
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Results for this indicator should be interpreted with caution. Primary mental health care for children and young people can be accessed from services other than those that are MBS subsidised. Other providers of primary mental health care to young people include community health centres, school counsellors and school health nurses, university and Technical and Further Education counselling services. A component of the mental health care provided by State and Territory specialised public mental health services could also be considered primary mental health care for young people, but this cannot be reliably differentiated from other care types (NMHPSC 2011).

In 2010-11, 4.1 per cent of all children and young people aged under 25 years had contact with MBS-subsidised primary mental health care services (figure 12.15).

Figure 12.15 Children and young people who received MBS-subsidised primary mental health care, 2010-11



Source: DoHA (unpublished); table 12A.33.

Appropriateness — services reviewed against the National Standards

‘Services reviewed against the National Standards’ is an indicator of governments’ objective to provide mental health services that are appropriate (box 12.6). It is a process indicator of appropriateness, reflecting progress made in meeting the national standards for mental health care (see box 12.7 for details on the relevant standards).

Box 12.6 Services reviewed against the National Standards

‘Services reviewed against the National Standards’ is defined as the proportion of specialised public mental health services that had completed a review by an external accreditation agency against the *National Standards for Mental Health Services* (NSMHS). Services were assessed as level 1, level 2, level 3, or level 4 where these levels are defined as:

- *Services at level 1* — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met all National Standards.
- *Services at level 2* — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met some but not all National Standards.
- *Services at level 3* — the number of specialised public mental health services that are (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) booked for review by an external accreditation agency.
- *Services at level 4* — the number of specialised public mental health services that do not meet criteria detailed under levels 1 to 3.

A high or increasing proportion of specialised public mental health services that had completed a review by an external accreditation agency against the NSMHS and that had been assessed as level 1 or level 2 is desirable. It suggests an improvement in the quality of services.

The indicator does not provide information on whether the standards or assessment process are appropriate. In addition, services that had not been assessed do not necessarily deliver services of lower quality. Some services that had not completed an external review included those that were undergoing a review and those that had booked for review and were engaged in self-assessment preparation.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Revised *National Standards for Mental Health Services* (NSMHS) were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. A National Standards Implementation Strategy and Plan will provide guidance for jurisdictional implementation. The standards have been broadened to include non-government community mental health services and private office-based services as well as specialised mental health services.

Box 12.7 outlines the previous NSMHS against which services were reviewed for the latest available results reported in table 12.1. External accreditation agencies,

such as the Australian Council on Healthcare Standards, undertake accreditation of a parent health organisation (for example, a hospital) that can cover a number of specialised services, including mental health services. Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the National Standards; rather, assessment against the National Standards must be specifically requested and involves a separate review process.

Box 12.7 The National Standards for Mental Health Services

The NSMHS were developed under the *First National Mental Health Plan* for use in assessing service quality and as a guide for continuous quality improvement in all Australian mental health services. They comprise 11 major criteria:

1. Rights.
2. Safety.
3. Consumer and carer participation.
4. Promoting community acceptance.
5. Privacy and confidentiality.
6. Prevention and mental health promotion.
7. Cultural awareness.
8. Integration.
9. Service development.
10. Documentation.
11. Delivery of care.

Source: DoHA (2002).

Table 12.1 shows the percentage of specialised public mental health services that had completed an external review against the NSMHS and were assessed as meeting ‘all standards’ (level 1) or as meeting ‘some but not all standards’ (level 2). Table 12.1 also shows the number of specialised public mental health services that are either in the process of being reviewed by an external accreditation agency but the outcomes are not known, or booked for review by an external accreditation agency (level 3) and those that do not meet criteria detailed under levels 1 to 3 (level 4).

Table 12.1 Specialised public mental health services reviewed against the NSMHS, 30 June 2010 (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>
Level 1	82.1	95.6	91.0	42.7	89.1	12.0	100.0	100.0	84.1
Level 2	16.4	0.6	2.6	33.3	—	—	—	—	9.8
Level 3	0.1	3.2	5.3	16.0	3.4	88.0	—	—	4.1
Level 4	1.3	0.6	1.1	8.0	7.6	—	—	—	1.9

^a Data are based on counts of individual service units within mental health organisations, not at whole organisation level. However, there is variation across jurisdictions in the method used to assign an assessment level (1, 2, 3 or 4) to a service unit. In some jurisdictions, if an organisation with multiple service units is assessed at a particular level all the organisation's units are 'counted' at that assessment level. In other jurisdictions, service units are 'counted' individually at assessment levels and assessment levels may or may not be consistent across the units within an organisation. The approach can also vary across organisations within a single jurisdiction.

— Nil or rounded to zero.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.34.

Appropriateness — services provided in the appropriate setting

'Services provided in the appropriate setting' is an indicator of governments' objective to provide mental health services in mainstream or community-based settings wherever possible (box 12.8).

Box 12.8 Services provided in the appropriate setting

'Services provided in the appropriate setting' is defined as recurrent expenditure on community-based services as a proportion of State and Territory expenditure on specialised mental health services (excluding aged care community residential expenditure). Community-based services are defined as ambulatory care, non-government organisations and adult residential services. Aged residential care is excluded to improve comparability.

A high or increasing proportion of recurrent expenditure spent on community-based services is desirable, reflecting a greater reliance on services that are based in community settings.

Data reported for this indicator are comparable.

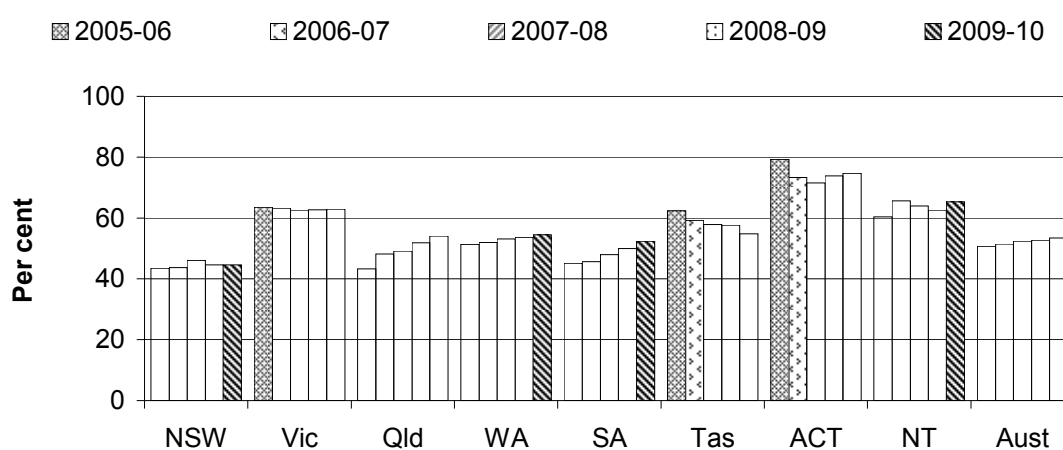
Data quality information for this indicator is under development.

The development of local, comprehensive mental health service systems is advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental illnesses and of providing continuity of care to enable consumers to move between services as their needs change. More appropriate mental health treatment options can be provided by encouraging the

treatment of patients in community-based settings, rather than in stand-alone psychiatric hospitals and public (non-psychiatric) hospitals.

Figure 12.16 shows recurrent expenditure on community-based services as a proportion of total expenditure on specialised public mental health services.

Figure 12.16 Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services^{a, b, c}



^a Community-based expenditure includes expenditure on ambulatory, NGO and adult residential services. Aged care residential expenditure is excluded to improve comparability. ^b Total expenditure on mental health services excludes indirect/residual expenditure that could not be apportioned directly to services and aged care community residential expenditure. ^c Queensland does not fund community-based residential services, but funds extended treatment (campus-based and non-campus-based) services that provide longer term inpatient treatment and rehabilitation services with clinical staffing for 24 hours a day, 7 days a week.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.35.

Appropriateness — collection of information on consumers' outcomes

'Collection of information on consumers' outcomes' is an indicator of governments' objective that consumer outcomes be monitored (box 12.9). It is a process indicator, reflecting the capability of services in establishing systems to collect information on consumers' mental health outcomes.

Box 12.9 Collection of information on consumers' outcomes

'Collection of information on consumers' outcomes' is defined as the proportion of specialised public mental health service episodes with completed clinical mental health outcome measures data, by client type (people in ongoing community-based care, people discharged from community-based care and people discharged from hospital).

High or increasing proportions of episodes for which information on consumers' mental health outcomes is collected is desirable.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

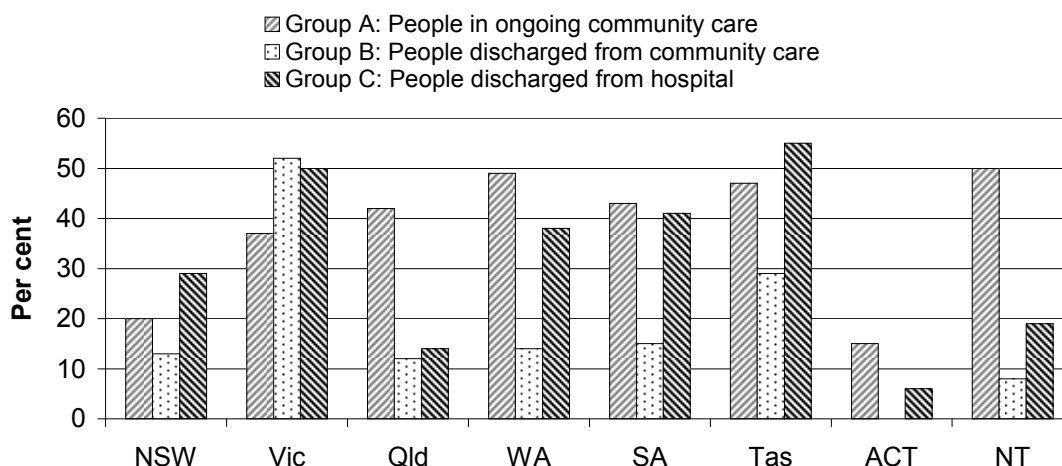
Establishing a system for the routine monitoring of consumer outcomes was first foreshadowed as part of the original *1992 National Mental Health Policy*. Implementation commenced under the *Second National Mental Health Plan 1998–2003*, with Australian Government funding provided to State and Territory governments to establish the necessary information infrastructure and undertake workforce training.

State and Territory governments have taken the following approach to introduce consumer outcomes measurement as part of day-to-day service delivery:

- Introduced measures to include ratings by clinicians and self-ratings by consumers.
- Ensured that all clinical staff have undergone training in data collection.
- Established processes to ensure uniformity in data collection.
- Funded information systems to store, analyse and report on the data.
- Taken a national approach to data analysis, reporting and benchmarking (DoHA 2002).

The estimated proportions of specialised public mental health service episodes for which information on consumers' mental health outcomes is collected are shown in figure 12.17.

Figure 12.17 Estimated proportion of episodes for which ‘complete’ consumer outcome measures were collected, 2009-10^{a, b, c}



^a These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government (DoHA). To be counted as an episode for which consumer outcome measures are collected, data need to be completed correctly (a specified minimum number of items completed) and have a ‘matching pair’ — that is, a beginning and end rating are needed to enable an outcome score to be determined. ^b For the ACT, due to a technical issue, the proportion of matched pairs for people discharged from a community episode of care was below the statistical threshold for a meaningful comparison. ^c Estimates of coverage for State and Territory services are crude and made by DoHA based on available data.

Source: AHMC (2012) *Council of Australian Governments National Action Plan for Mental Health 2006–2011: Progress Report 2009-10*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers’ Advisory Council (forthcoming); table 12A.37.

Quality — consumer and carer experiences of services

‘Consumer and carer experiences of services’ is an indicator of governments’ objective that services are of a high quality and responsive to the needs of consumers and their carers (box 12.10). Consumers and their carers should have positive experiences in all mental health service areas with clinicians and services provided. Both are important aspects of the NMHS.

Box 12.10 Consumer and carer experiences of services

‘Consumer and carer experiences of services’ is yet to be defined.

Data for this indicator were not available for the 2012 Report.

Quality — consumer and carer involvement in decision making

‘Consumer and carer involvement in decision making’ is an indicator of governments’ objective that consumers and carers are involved at the service delivery level, where they have the opportunity to influence the services they receive (box 12.11). Consumer and carer involvement is an important aspect of the NMHS.

Box 12.11 Consumer and carer involvement in decision making

‘Consumer and carer involvement in decision making’ is defined by two measures:

- the number of paid FTE consumer staff per 1000 FTE direct care, consumer and carer staff
- the number of paid FTE carer staff per 1000 FTE direct care, consumer and carer staff.

High or increasing proportions of paid FTE direct care, consumer and carer staff who are consumer/carer staff implies better opportunities for consumers and carers to be involved at the service delivery level, where they can influence the services received.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Table 12.2 reports the number of paid FTE consumer and carer staff per 1000 paid FTE direct care, consumer and carer staff. Results will differ from previous reports as the specifications for this indicator have changed (for details of the previous specifications see the 2011 Report).

Table 12.2 Number of paid FTE consumer and carer staff per 1000 FTE direct care, consumer and carer staff

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Paid FTE consumer staff per 1000 paid FTE direct care, consumer and carer staff									
2005-06	4.2	3.7	2.7	0.2	1.7	–	3.9	–	3.0
2006-07	3.7	3.6	2.7	0.3	1.2	–	–	–	2.7
2007-08	4.1	3.7	2.3	0.5	2.4	–	–	–	2.9
2008-09	3.3	3.0	3.1	1.4	3.2	0.8	–	–	2.8
2009-10	2.9	3.1	3.3	1.9	2.8	0.7	–	–	2.8
Paid FTE carer staff per 1000 paid FTE direct care, consumer and carer staff									
2005-06	0.4	2.2	0.1	–	–	–	–	–	0.7
2006-07	1.3	2.5	0.2	–	–	–	–	–	1.1
2007-08	1.0	2.9	0.4	0.3	0.9	–	–	–	1.2
2008-09	1.5	2.5	0.6	0.2	1.2	0.8	–	–	1.3
2009-10	1.9	2.8	1.1	0.4	0.8	0.7	–	–	1.6

– Nil or rounded to zero.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.36.

Quality — specialised public mental health service consumers with nominated GP

‘Specialised public mental health service consumers with nominated GP’ is an indicator of governments’ objective to provide continuity of care in the delivery of mental health services. GPs can be an important point of contact for those with a mental illness (box 12.12).

Box 12.12 Specialised public mental health service consumers with nominated GP

‘Proportion of specialised public mental health service consumers with nominated GP’ is yet to be defined.

Data for this indicator were not available for the 2012 Report.

Quality — post discharge community care

‘Post discharge community care’ is an indicator of governments’ objective to provide continuity of care in the delivery of mental health services (box 12.13).

Box 12.13 Post discharge community care

‘Post discharge community care’ is defined as the proportion of admitted patient overnight separations from psychiatric inpatient services for which a community-based ambulatory mental health care contact was recorded in the seven days following separation.

A high or increasing rate of community follow up within the first seven days of discharge from hospitals is desirable.

This indicator does not measure the frequency of contacts recorded in the seven days following separation. It also does not distinguish qualitative differences between phone and face-to-face community contacts. Only community-based ambulatory contact made by State and Territory specialised public mental health services are included. Where clinical follow up is managed outside these services (for example, by private psychiatrists or GPs), these contacts are not included.

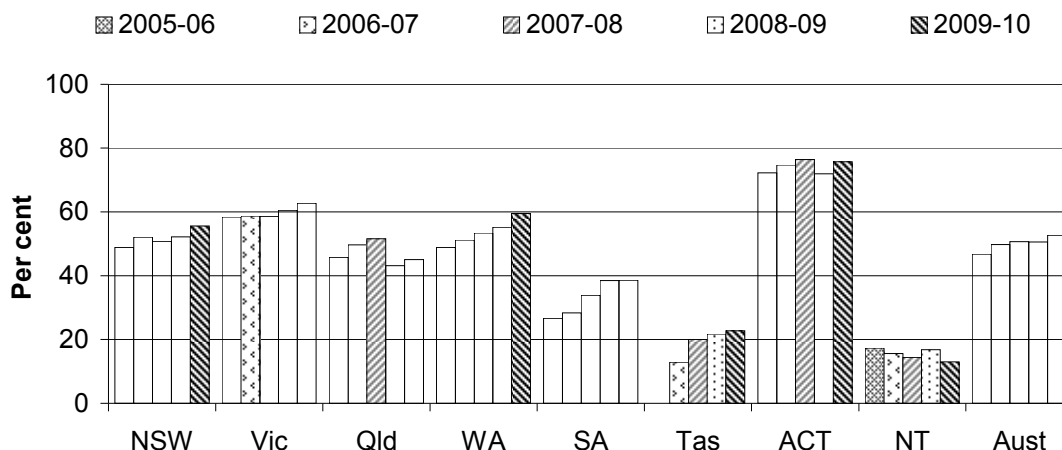
Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital (AHMC 2012). A community support system for people who are discharged from hospital after an acute psychiatric episode is essential to maintain clinical and functional stability and to minimise the need for hospital readmission (NMHPSC 2011).

Data on the rates of community follow up for people within the first seven days of discharge from hospital are reported in figure 12.18.

Figure 12.18 Community follow up for people within the first seven days of discharge from hospital^{a, b, c, d}



^a Data for 2006-07 to 2008-09 are for the full year, but data for 2009-10 are based on the first nine months of the year. Data for 2008-09 have been revised and will differ from those in the 2011 Report. ^b Community-based ambulatory mental health contacts counted for determining whether follow up occurred are restricted to those in which the consumer participated, except for the NT where the data include all contacts (the NT has advised that the impact on the indicator is immaterial). Contacts made on the day of discharge are also excluded. ^c Data are not comparable across jurisdictions. SA and Tasmania are not able to accurately track post discharge follow up between hospitals and community service organisations, due to the lack of unique patient identifiers or data matching systems. Results for these jurisdictions could appear 'lower' relative to jurisdictions that are able to track utilisation across services. ^d Tasmanian data for 2005-06 are not available.

Source: AHMC (2012) *Council of Australian Governments National Action Plan for Mental Health 2006–2011: Progress Report 2009-10*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (forthcoming); table 12A.38.

Quality — readmissions to hospital within 28 days of discharge

'Readmissions to hospital within 28 days of discharge' is an indicator of the governments' objective to provide effective care and continuity of care in the delivery of mental health services (box 12.14).

Box 12.14 Readmissions to hospital within 28 days of discharge

'Readmissions to hospital within 28 days of discharge' is defined as the proportion of admitted patient overnight separations from public psychiatric inpatient services that were followed by readmission to public psychiatric inpatient services within 28 days of discharge.

A low or decreasing rate of readmissions to hospital within 28 days of discharge from hospitals is desirable. Readmissions following a recent discharge can indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain people out of hospital (NMHPSC 2011).

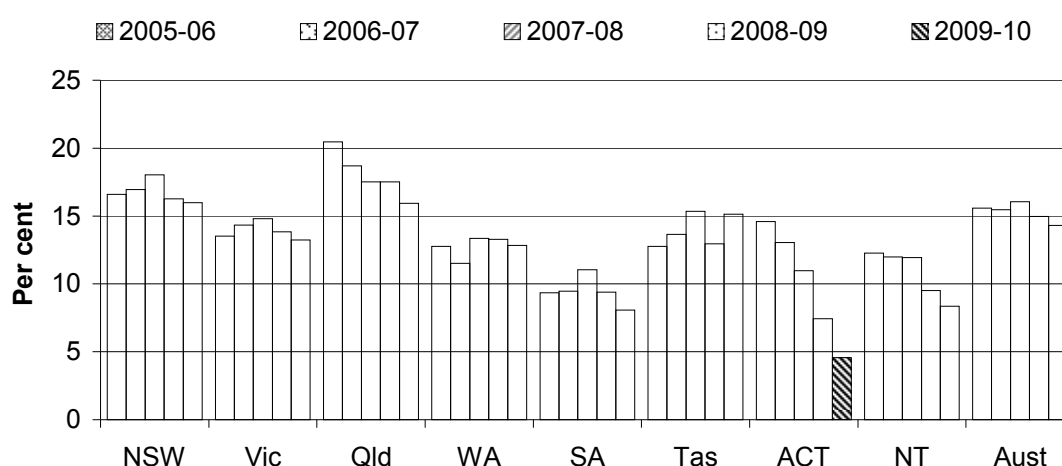
Readmission rates are affected by factors other than deficiencies in specialised mental health services, such as the cyclic and episodic nature of some illnesses or other issues that are beyond the control of the mental health system (NMHWG 2005).

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Data on the rates of readmission to hospital within 28 days of discharge are reported in figure 12.19.

Figure 12.19 Readmissions to hospital within 28 days of discharge^{a, b, c}



^a Data for 2006-07 to 2008-09 are for the full year, but data for 2009-10 are based on the first 9 months of the year. Data for 2008-09 have been revised and will differ from those in the 2011 Report. ^b No distinction is made between planned and unplanned readmissions because data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission to hospital. ^c Data are not comparable across jurisdictions. SA and Tasmania can only track readmission back to the same hospital from which the person was discharged. For these states, readmissions are regarded to have occurred only when it is recorded by the discharging organisation. Results for these states could appear 'lower' relative to jurisdictions that are able to track utilisation across services.

Source: AHMC (2012) *Council of Australian Governments National Action Plan for Mental Health 2006–2011: Progress Report 2009–10*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (forthcoming); table 12A.39.

Sustainability

The Steering Committee has identified sustainability as an area for reporting but no indicators have yet been identified.

Efficiency — cost per inpatient bed day

‘Cost per inpatient bed day’ is an indicator of governments’ objective that mental health services be delivered in an efficient manner (box 12.15).

Box 12.15 Cost per inpatient bed day

‘Cost per inpatient bed day’ is defined as the cost of providing inpatient services per inpatient bed day in public hospitals. Reported real inpatient costs per day are disaggregated by inpatient program type (general mental health services, child and adolescent mental health services, older peoples’ mental health services and forensic mental health services) and hospital type (psychiatric hospitals (acute units), psychiatric hospitals (non-acute units) and general hospitals).

A low or decreasing cost per inpatient bed day can indicate efficiency, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

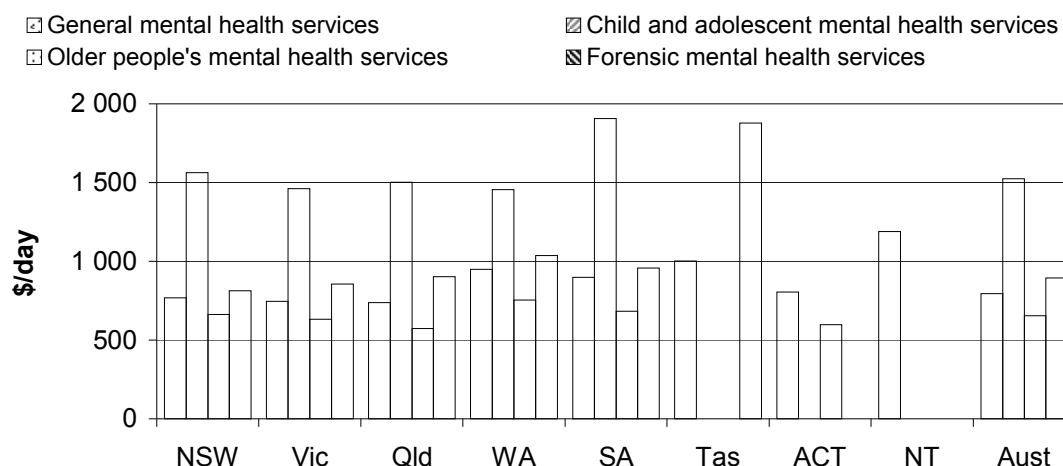
This indicator does not account for differences in the client mix and average length of stay. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. Longer lengths of stay can 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. A more suitable indicator for mental health services would be to adjust the number of separations by the type and complexity of cases, to develop a cost per casemix adjusted separation similar to that presented for public hospitals (chapter 10), but as casemix funding has not been applied to specialised mental health services, data for this are not available.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Inpatient costs per day are presented in figures 12.20 (by inpatient target population) and 12.21 (by hospital type). Changes over time partly reflect institutional change in accordance with the NMHS (for example, a shift to the delivery of services in mainstream settings).

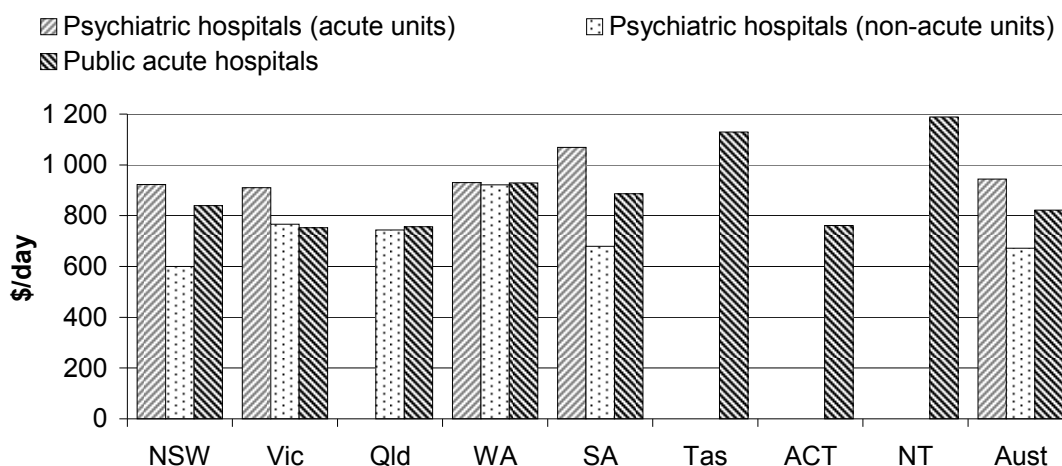
Figure 12.20 Average recurrent cost per inpatient bed day, public hospitals, by target population, 2009-10^{a, b, c, d, e, f}



^a Depreciation is excluded. ^b Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). ^c Queensland provides older people's mental health services using a variety of different service models, including extended treatment services co-located with other services. These different service models are all reported as older people's mental health services, which lowers the average patient day costs, and limits comparability with the costs of jurisdictions that report these services differently. ^d Tasmania does not provide, or cannot separately identify, child and adolescent mental health services or older people's mental health services. ^e The ACT does not have separate forensic or child and adolescent mental health inpatient services. ^f The NT has general mental health services only.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.40.

Figure 12.21 Average recurrent cost per inpatient bed day, public hospitals, by hospital type, 2009-10^{a, b, c, d, e}



^a Depreciation is excluded. ^b Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). ^c Mainstreaming has occurred at different rates across jurisdictions. Victorian data for psychiatric hospitals comprise mainly forensic services, because nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means the client profile and service costs are very different from those of a jurisdiction in which general psychiatric treatment still occurs mostly in psychiatric hospitals. ^d Queensland data for public acute hospitals include costs associated with extended treatment services (campus-based and non-campus-based) that report through general acute hospitals. Queensland does not provide acute services in psychiatric hospitals. ^e Tasmania, the ACT and the NT do not have psychiatric hospitals.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.41.

Efficiency — cost for community-based residential care

‘Cost for community-based residential care’ is an indicator of governments’ objective that mental health services be delivered in an efficient manner (box 12.16).

Box 12.16 Cost for community-based residential care

‘Cost for community-based residential care’ is defined as the average cost per day for specialised public mental health services of providing community-based residential care.

A low or decreasing average cost can indicate efficiency, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

The indicator does not account for differences in the client mix. The client mix in community-based services can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of more complex patients in community-based residential settings.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

These data are likely to be affected by institutional changes occurring as a result of the NMHS (for example, a shift to the delivery of services in mainstream settings). Differences across jurisdictions in the types of patient admitted to community-based 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 per patient day for community-based residential care services is presented in table 12.3. For general adult units in 2009-10, the average cost per patient day for 24 hour staffed community-based residential care was an estimated \$422 nationally. For non-24 hour staffed community-based residential units, the average cost per patient day was \$160 nationally. For State or Territory governments that had community-based older people’s residential care units in 2009-10, the average recurrent cost per patient day for 24 hour staffed services was \$340 nationally (table 12.3).

Table 12.3 Average recurrent cost per inpatient day for community-based residential services, by target population and staffing provided, 2009-10^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld^c</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
General adult units									
24 hour staffed	251	489	..	291	377	411	620	331	422
Non-24 hour staffed	190	148	..	143	255	227	113	..	160
Older people's care units									
24 hour staffed	211	327	..	..	..	731	190	..	340
Non-24 hour staffed	209	..	..	..	..	..	..	..	209

^a Depreciation is excluded. ^b Costs are not adjusted for differences in the complexity of cases across states and territories and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). ^c Queensland does not fund community-based residential services, although it funds a number of campus-based and non-campus-based extended treatment services. .. Not applicable.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.42.

Efficiency — Cost for ambulatory care

‘Cost for ambulatory care’ is an indicator of governments’ objective that mental health services be delivered in an efficient manner (box 12.17).

Box 12.17 Cost for ambulatory care

‘Cost for ambulatory care’ indicator is defined by two measures:

- average cost per episode of ambulatory care provided by community-based specialised public mental health services
- average number of community treatment days per episode of ambulatory care provided by community-based specialised public mental health services. This measure is provided along with average costs as frequency of servicing is the main driver of variation in care costs. It is equivalent to the ‘length of stay’ efficiency measure for public hospitals.

An episode of ambulatory care is a three month period of ambulatory care for an individual registered patient where the patient was under ‘active care’ (one or more *treatment* days in the period). Community-based periods relate to the following four fixed three monthly periods: January to March, April to June, July to September, and October to December. Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode.

(Continued next page)

Box 12.17 (Continued)

A low or decreasing average cost or fewer community treatment days can indicate greater efficiency although, efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

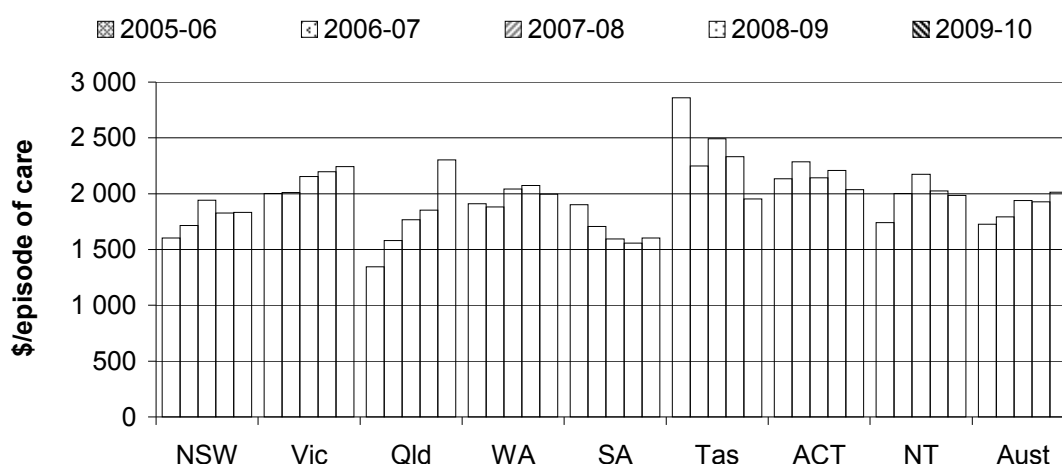
The measures do not account for differences in the client mix. The client mix in community-based services can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of more complex patients in community-based ambulatory settings.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Average recurrent cost per episode of ambulatory care data are shown in figure 12.22 and average treatment days per episode of ambulatory care data are shown in figure 12.23.

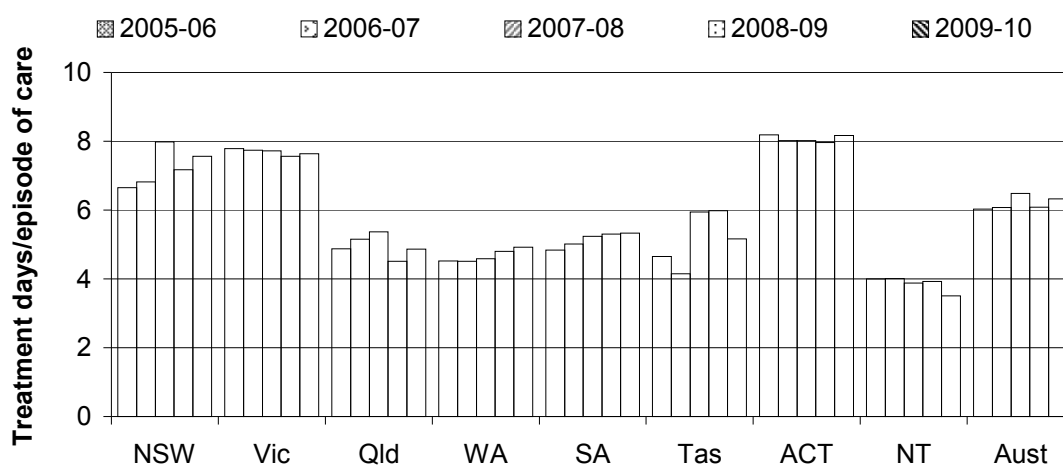
Figure 12.22 **Average recurrent cost per episode of ambulatory care (2009-10 dollars)^{a, b, c}**



^a Real expenditure (2009-10 dollars), using State and Territory implicit price deflators for general government final consumption on hospital clinical services (table 12A.63). ^b Recurrent expenditure data used to derive this measure have been adjusted (that is, reduced) to account for the proportion of clients in the *CMHC NMDS* that were defined as 'non-uniquely identifiable consumers'. Therefore, it does not match recurrent expenditure on ambulatory care reported elsewhere. ^c 'Non-uniquely identifiable consumers' have been excluded from the episodes of ambulatory care.

Source: AIHW (unpublished) *CMHC NMDS*; AIHW (unpublished) *MHE NMDS*; table 12A.43.

Figure 12.23 **Average treatment days per episode of ambulatory care^{a, b}**



^a Real expenditure (2009-10 dollars), using State and Territory implicit price deflators for general government final consumption on hospital clinical services (table 12A.63). ^b 'Non-uniquely identifiable consumers' have been excluded from the episodes of ambulatory care and treatment days data.

Source: AIHW (unpublished) *CMHC NMDS*; AIHW (unpublished) *MHE NMDS*; table 12A.43.

Outcomes

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

The output indicators reported above focus on specialised public mental health services provided by State and Territory governments (although the indicators 'client use of services by special needs groups', 'mental health service use by total population' and 'primary mental health care for children and young people' include measures of access to MBS-subsidised services). The outcome indicators identified and/or reported here are generally not direct measures of the outcomes for people who access these services and tend to reflect the performance of governments (including the mental health sector) against the broad objectives of the NMHS.

The whole-of-government approach within the *Fourth National Mental Health Plan 2009–2014* acknowledges that many of the determinants of good mental health, and of mental illness, are influenced by factors beyond the health system. The fourth plan identifies that the mental health sector must form partnerships with other sectors in order to develop successful interventions (AHMC 2009).

Rates of licit and illicit drug use

‘Rates of licit and illicit drug use’ is an indicator of governments’ objective under the NMHS to prevent the development of mental health problems and mental illness where possible, by reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery (box 12.18). High rates of substance use and abuse in young people can contribute to the onset of, and poor recovery from, mental illness (NMHPSC 2011).

Box 12.18 Rates of licit and illicit drug use

‘Rates of licit and illicit drug use’ is defined as the proportion of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months. The specific drugs are: alcohol, cannabis, ecstasy, cocaine, meth/amphetamine, hallucinogens, Gamma-hydroxybutyrate (GHB), inhalants, and heroin.

A low or decreasing proportion of people aged 14 years or over using specific licit and illicit drugs is desirable. It suggests a reduction in the risk factors that contribute to the onset of mental illness and prevent longer term recovery.

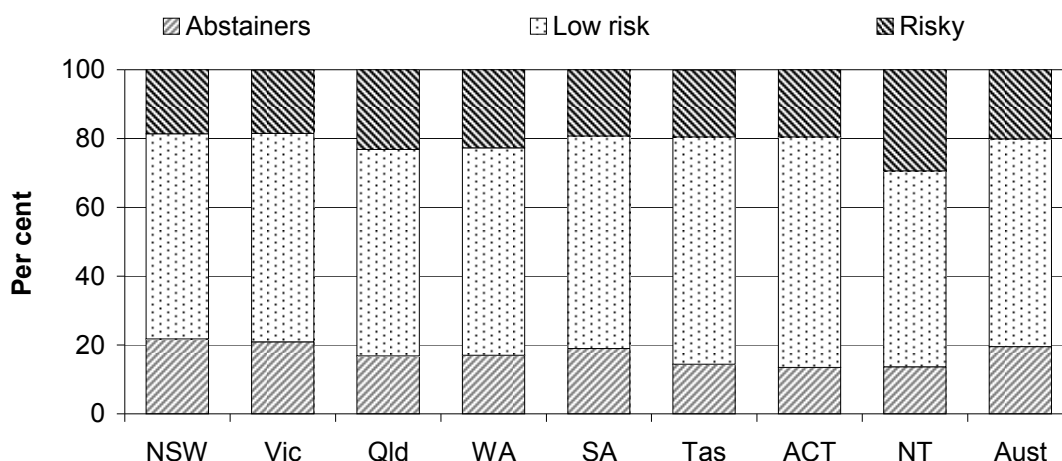
Many of the risk and protective factors that impact on a person’s propensity to use licit or illicit drugs lie outside the ambit of the mental health system. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of substance abuse. A reduction in the prevalence of drugs use, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Alcohol is the substance most commonly used and abused, and is a major cause of death, injury and illness in Australia (AHMC 2011). In 2010, of people aged 14 years or over, 80.5 per cent drank alcohol over the last 12 months (table 12A.45) and 20.1 per cent drank alcohol at levels considered ‘risky’ for developing long-term health problems (figure 12.24).

Figure 12.24 Recent use of alcohol by people aged 14 years or over, life time risk status, 2010^{a, b, c}



^a Abstainers — people who did not consume alcohol in the previous 12 months. ^b Low risk — people who on average, had no more than two standard drinks per day. ^c Risky — people who on average, had more than two standard drinks per day.

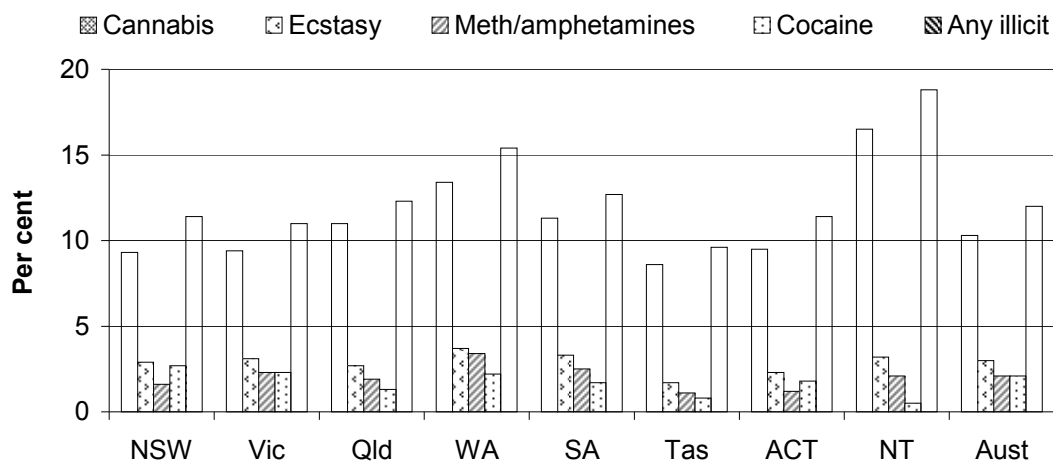
Source: AIHW (2011) *2010 National Drug Strategy Household Survey Report*, Drug statistics series no. 25, Cat. no. PHE 145, Canberra; table 12A.44.

Cannabis, ecstasy, cocaine and meth/amphetamines are the most widely used illicit drugs in Australia (figure 12.25). Younger people's usage rates of cannabis and meth/amphetamines are of particular concern for their associated mental health problems (AHMC 2011). Cannabis use can precipitate schizophrenia in people who have a family history of the disorder, increase the risk of symptoms for those vulnerable to psychosis and also exacerbate the symptoms of schizophrenia. Cannabis use also poses a moderate risk for later depression, with heavy cannabis use possibly posing a small additional risk of suicide (AHMC 2011).

Symptoms of psychosis are also one of the consequences of meth/amphetamine use and dependent meth/amphetamine users can also suffer from a range of co-morbid mental health problems. Among methamphetamine users who take the drug monthly or more often, the prevalence of psychosis is 11 times higher than among the general population (AHMC 2011). Figure 12.26 shows the rates of use of cannabis and meth/amphetamines by young people.

Data on self-reported health conditions including mental illness and level of psychological distress by whether a person had used an illicit drug in the previous 12 months are included in table 12A.47.

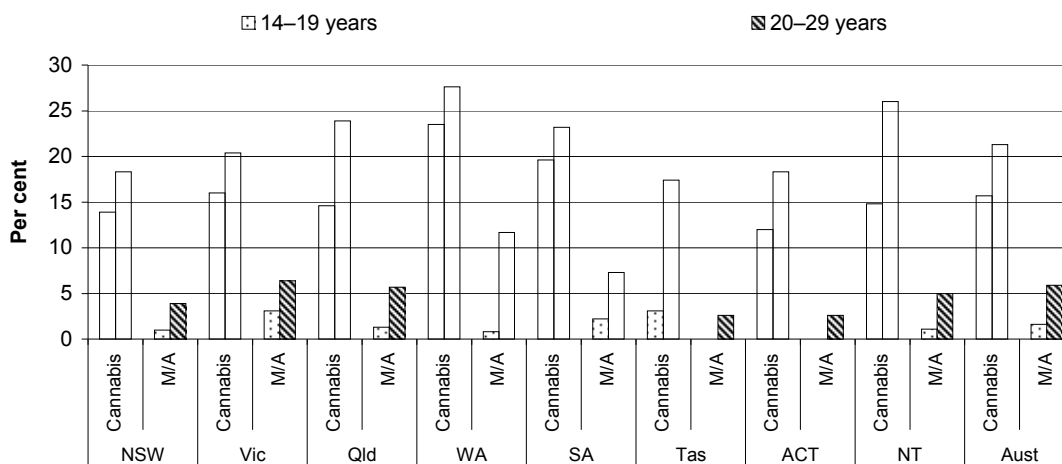
Figure 12.25 Recent use of selected illicit drugs by people aged 14 years or over, 2010^a



^a The following estimates have RSEs of between 25 per cent and 50 per cent and should be considered with caution: use of ecstasy, meth/amphetamine and cocaine for Tasmania and the ACT, and for the NT the use of meth/amphetamine. The use of cocaine in the NT is subject to an RSE greater than 50 per cent and is considered too unreliable for general use.

Source: AIHW (2011) *2010 National Drug Strategy Household Survey Report*, Drug statistics series no. 25, Cat. no. PHE 145, Canberra; table 12A.45

Figure 12.26 Recent use of cannabis and meth/amphetamines by young people, 2010^{a, b}



M/A = meth/amphetamine. ^a The following estimates have RSEs of between 25 per cent and 50 per cent and should be considered with caution: for people aged 14–19 years, cannabis use in SA, the ACT and the NT and meth/amphetamine use in Victoria and Queensland; and for people aged 20–29 years, meth/amphetamine use in SA and the NT. The following estimates are subject to RSEs greater than 50 per cent and are considered too unreliable for general use: for people aged 14–19 years, meth/amphetamine use in NSW, WA, SA and the NT, and cannabis use in Tasmania; and for people aged 20–29 years, meth/amphetamine use in the Tasmania and the NT. ^b The proportion of people aged 14–19 years in Tasmania and the ACT who used meth/amphetamine was zero.

Source: AIHW (2011) *2010 National Drug Strategy Household Survey Report*, Drug statistics series no. 25, Cat. no. PHE 145, Canberra; table 12A.46.

Prevalence of mental illness

‘Prevalence of mental illness’ is an indicator of governments’ objective under the NMHS to prevent the development of mental health problems and mental illness where possible (box 12.19).

Box 12.19 Prevalence of mental illness

‘Prevalence of mental illness’ is defined as the proportion of the total population who have a mental illness. Proportions are reported for all people, for males and females and for people of different ages, by disorder type.

A low or decreasing prevalence of mental illness can indicate that measures to prevent mental illness have been effective.

Reduction in prevalence can be brought about by preventative efforts to stop an illness occurring, or by increasing access to effective treatments for those in whom the illness has begun (AHMC 2008). Many of the risk and protective factors that impact on the development of mental health problems and mental illness lie outside the ambit of the mental health system, in sectors that impact on the daily lives of individuals and communities. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of mental illness, whereas employment is recognised as important in supporting good mental health. A reduction in the prevalence of mental illness, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services. Not all mental illnesses are preventable and a reduction of the impact of symptoms and an improved quality of life will be a positive outcome for many people with a mental illness.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

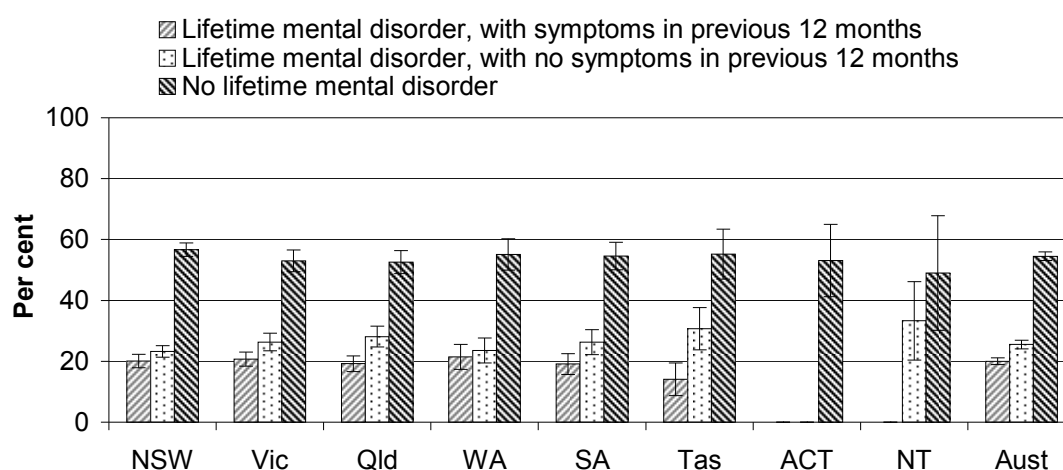
Prevalence of mental illness data are from the 2007 SMHWB. The term mental disorder is used when referring directly to SMHWB data (as it is used in that survey). Elsewhere, the term mental illness is used to describe the illness associated with mental disorders.

The SMHWB data are reported with 95 per cent confidence intervals. These intervals assist with making comparisons between jurisdictions, and between different mental disorder status groups. Confidence intervals are a standard way of expressing the degree of uncertainty associated with survey estimates. An estimate of 80 (for example, mean age 80 years) with a confidence interval of ± 4 means that if another sample had been drawn there is a 95 per cent chance that the result would lie between 76 and 84. Where ranges do not overlap, there is a statistically

significant difference. A statistically significant difference means there is a high probability that there is an actual difference — it does not imply that the difference is necessarily large or important.

The 2007 SMHWB was designed to provide reliable estimates at the national level, not at the State and Territory level, however, some jurisdictional data are available and are reported in figure 12.27. The survey was designed to provide prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders (such as social phobia), affective disorders (such as depression) and substance use disorders (such as harmful alcohol use). The survey does not measure the prevalence of some severe mental disorders, such as schizophrenia and bipolar disorder.

Figure 12.27 Prevalence of mental disorders, 2007^{a, b}



^a Error bars represent the 95 per cent confidence interval associated with each point estimate. ^b Estimates with RSEs greater than 25 per cent are not published.

Source: ABS (unpublished) 2007 SMHWB, Cat. no. 4326.0; table 12A.48.

There were differences in the prevalence of lifetime mental disorders with symptoms in the previous 12 months between males and females. Females most commonly experienced anxiety disorders (17.9 ± 1.3 per cent), followed by affective disorders (7.1 ± 1.0 per cent) and substance abuse (3.3 ± 0.7 per cent) (table 12A.49). Males most commonly suffered anxiety disorders (10.8 ± 1.4 per cent), followed by substance use disorders (7.0 ± 1.2 per cent) and affective disorders (5.3 ± 1.0 per cent) (table 12A.49).

The prevalence of mental illness was higher among younger people than older people. Of adults aged 16–24 years, 26.4 ± 2.7 per cent experienced a mental disorder with symptoms in the previous 12 months, compared with 8.6 ± 1.6 per

cent of people aged 65–74 years and 5.9 ± 2.1 per cent of people aged 75–85 years (table 12A.50).

Mortality due to suicide

‘Mortality due to suicide’ is an indicator of governments’ objective under the NMHS to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk (box 12.20).

Box 12.20 Mortality due to suicide

‘Mortality due to suicide’ is defined as the suicide rate per 100 000 people. The suicide rate is reported for all people, for males and females, for people of different ages (including those aged 15–24 years), people living in capital cities, people living in other urban areas, people living in rural areas, Indigenous and non-Indigenous people.

A low or decreasing suicide rate per 100 000 people is desirable.

While mental health services contribute to reducing suicides, other government services also have a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by severe mental illness, some of whom have either attempted, or indicated an intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government agencies, 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 education, housing, justice and community services.

Many factors outside the control of mental health services can influence a person’s decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often a combination of these factors can increase the risk of suicidal behaviour.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

People with a mental illness are at higher risk of suicide than are the general population. They are also at higher risk of death from other causes, such as cardiovascular disease (Coghlan et al. 2001; Joukamaa et al. 2001; Sartorius 2007).

Australian Bureau of Statistics’ causes of death data are the source of suicide statistics in this chapter (ABS 2011). Developments that have improved the quality

of ABS' causes of death data for the three most recent years of data are processing improvements and a revisions process.

Two processing improvements, relating to the way the ABS codes Coroner certified deaths, have been introduced to the causes of death collection for the release of the preliminary data. 'Cause of death' codes are now better assigned to Coroner certified cases and all causes of death data have been positively impacted by these improvements (ABS 2010).

All Coroner certified deaths registered after 1 January 2007 are subject to a revisions process. The revisions process enables the use of additional information relating to Coroner certified deaths either 12 or 24 months after initial processing. This increases the specificity of the assigned ICD-10 codes over time (ABS 2010). Each year of data will be released as preliminary, revised and final, respectively.

Table 12.4 compares the preliminary, revised and final suicides data for 2007 across jurisdictions.

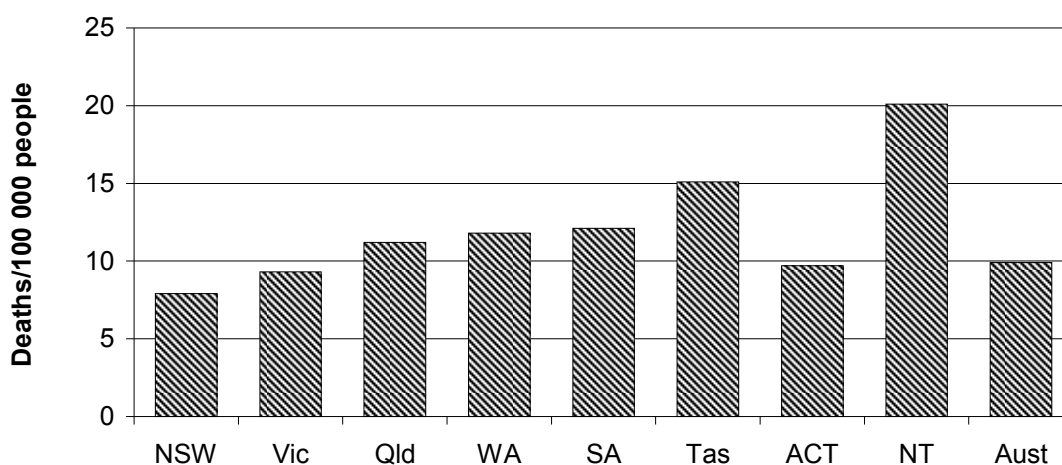
Table 12.4 Number of suicides, preliminary, revised and final

	<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>
2007									
Preliminary	551	438	285	254	202	66	31	54	1 881
Revised	553	443	445	257	202	67	31	56	2 054
Final	611	474	520	266	205	66	32	55	2 229
2008									
Preliminary	553	505	507	297	176	75	35	42	2 190
Revised	587	534	538	300	175	73	36	38	2 281
2009									
Preliminary	515	512	488	276	187	83	32	38	2 131

Source: ABS (various issues), *Causes of Deaths, Australia (various years)*, Cat. no. 3303.0, Canberra.

In the period 2005–2009, 10 544 deaths by suicide were recorded in Australia (table 12A.53) — equivalent to 9.9 deaths per 100 000 people (figure 12.28). The rate for males (15.6 per 100 000 males) was around three times that for females (5.5 per 100 000 females) in that period — a ratio that was relatively constant over all age groups, except for those aged over 85 years where the male suicide rate was over seven times the female rate (figure 12.29). Table 12A.54 shows suicide death rates per 100 000 people aged 15–24 years for all jurisdictions.

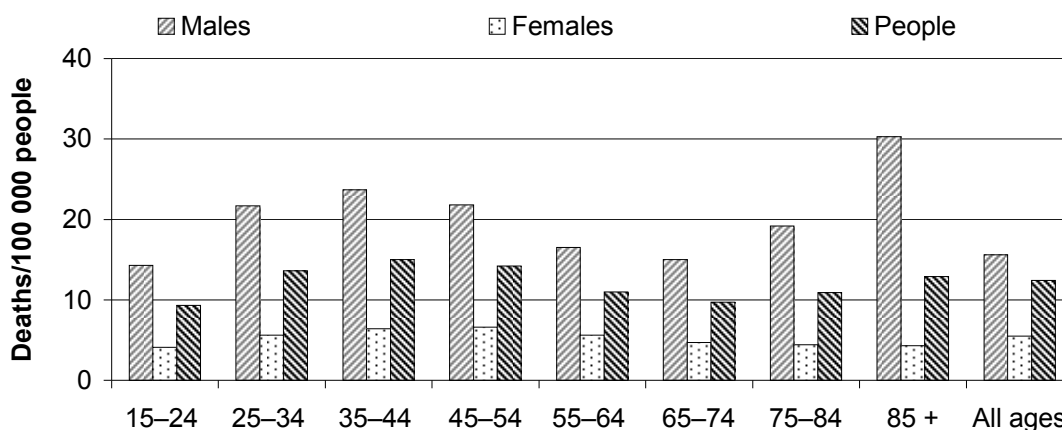
Figure 12.28 Suicide rates, 5 year average, 2005–2009^{a, b, c}



^a Suicide deaths include ICD-10 codes X60-X84 and Y87.0. ^b The death rate is age standardised to the mid-year 2001 population. ^c Causes of death data for 2007 have undergone two years of revisions. Causes of death data for 2008 have been revised and are subject to further revisions. Causes of death data for 2009 are preliminary and subject to a revisions process.

Source: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.53.

Figure 12.29 Suicide rates, by age and sex, 2005–2009^{a, b, c}



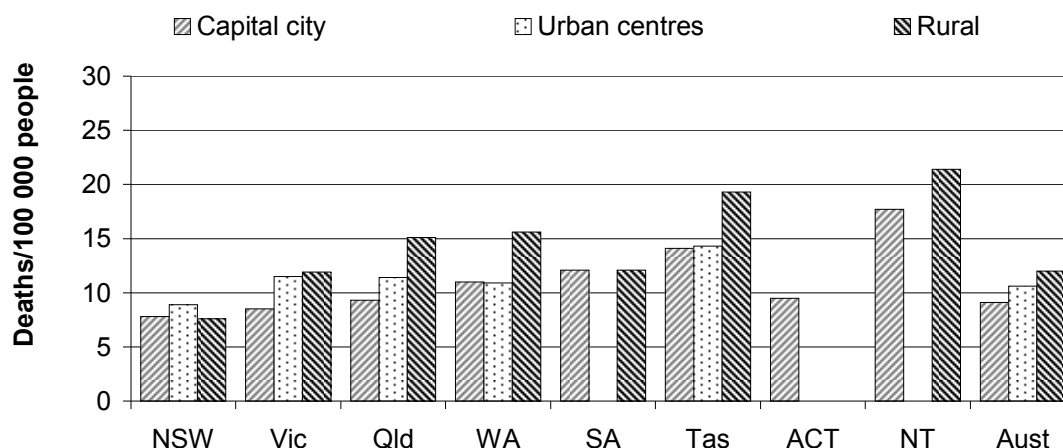
^a Suicide deaths include ICD-10 codes X60-X84 and Y87.0. ^b Age specific death rates are calculated as the number of suicides for an age group per 100 000 population in the same age group, for the period 2005–2009. ^c Causes of death data for 2007 have undergone two years of revisions. Causes of death data for 2008 have been revised and are subject to further revisions. Causes of death data for 2009 are preliminary and subject to a revisions process.

Source: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.52.

Nationally the suicide rate in the period 2005–2009 was higher in rural areas. There were 9.1 suicides per 100 000 people in capital cities and 10.6 suicides

per 100 000 people in urban centres, compared with 12.0 suicides per 100 000 people in rural areas in Australia (figure 12.30).

Figure 12.30 **Suicide rates, by area, 2005–2009**^{a, b, c, d, e}



^a Area categories are defined as follows: 'capital cities' — comprising capital city statistical divisions; 'urban centres' — based on 'statistical districts' that are urban centres with population >25 000 people, excluding capital city statistical divisions, (three statistical districts cross State boundaries and have to be split across the relevant states or territories — Albury–Wodonga, Canberra–Queanbeyan and Gold Coast–Tweed); 'rural' — balance of State (or Territory), that is all areas other than capital cities and urban centres. ^b The suicide rate is indirectly age standardised to the mid-year 2001 population. ^c Suicides are reported by year of registration of death. ^d Causes of death data for 2007 have undergone two years of revisions. Causes of death data for 2008 have been revised and are subject to further revisions. Causes of death data for 2009 are preliminary and subject to a revisions process. ^e SA, the ACT and the NT do not have any 'urban centres'. The ACT did not have any recorded suicide deaths in 'rural' areas.

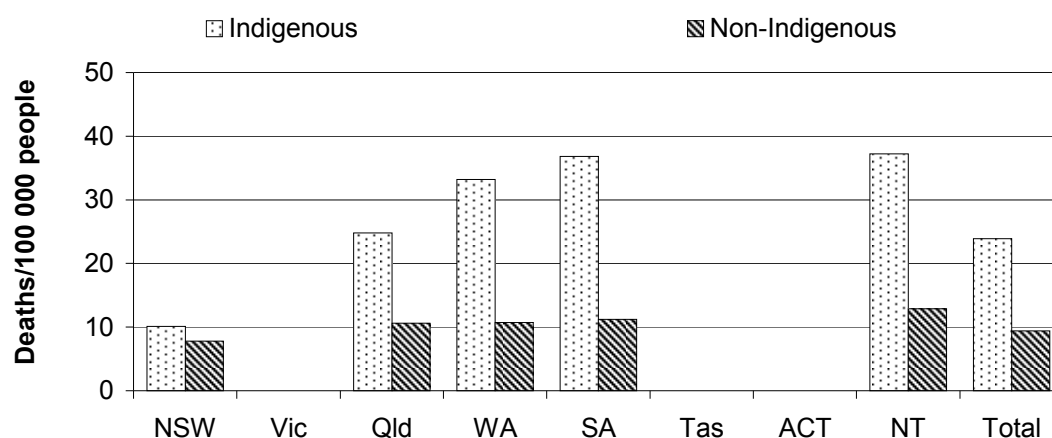
Source: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.55.

Tables 12A.51, and 12A.53–55 contain single year time series suicide data.

Indigenous suicide rates are presented for NSW, Queensland, WA, SA and the NT (figure 12.31). After adjusting for differences in the age structure of the two populations, the suicide rate for Indigenous people during the period 2005–2009, for the reported jurisdictions, was higher than the corresponding rate for non-Indigenous people.

Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some jurisdictions are not published. Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions.

Figure 12.31 **Suicide rates, by Indigenous status, 2005–2009**^{a, b, c, d, e, f, g}



^a Deaths from suicides are deaths with ICD-10 codes X60–X84 and Y87.0. ^b Suicide rate is indirectly age-standardised. ^c Denominators used in the calculation of rates for the Indigenous population are from ABS *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0 (series B, 2006 base). Non-Indigenous estimates are available for Census years only. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the Indigenous population from the total population. Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the Indigenous projection series increases. ^d Data on deaths of Indigenous people are affected by differing levels of coverage of deaths identified as Indigenous across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Indigenous and non-Indigenous data. ^e Deaths with a 'not stated' Indigenous status are excluded. ^f Causes of death data for 2007 have undergone two years of revisions. Causes of death data for 2008 have been revised and are subject to further revisions. Causes of death data for 2009 are preliminary and subject to a revisions process. ^g Total data are for NSW, Queensland, WA, SA, and the NT combined, based on State or Territory of usual residence. Victoria, Tasmania and the ACT are excluded due to small numbers of registered Indigenous deaths.

Source: SCRGSP (2011) *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra; table 12A.56.

Social and economic inclusion of people with a mental illness

‘Social and economic inclusion of people with a mental illness’ is an indicator of governments’ objective to improve mental health and facilitate recovery from illness through encouraging meaningful participation in recreational, social, employment and other activities in the community (box 12.21).

Box 12.21 Social and economic inclusion of people with a mental illness

‘Social and economic inclusion of people with a mental illness’ is defined by two measures:

- proportion of people aged 16–64 years with a mental illness who are employed, compared with the equivalent proportion for people without a mental illness
- proportion of people aged 16–30 years with a mental illness who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (studying full or part-time), compared with the equivalent proportion for people without a mental illness.

A high or increasing proportion of people with a mental illness aged 16–64 years who are employed is desirable. A high or increasing proportion of people aged 16–30 years with a mental illness who are employed and/or are enrolled for study is also desirable.

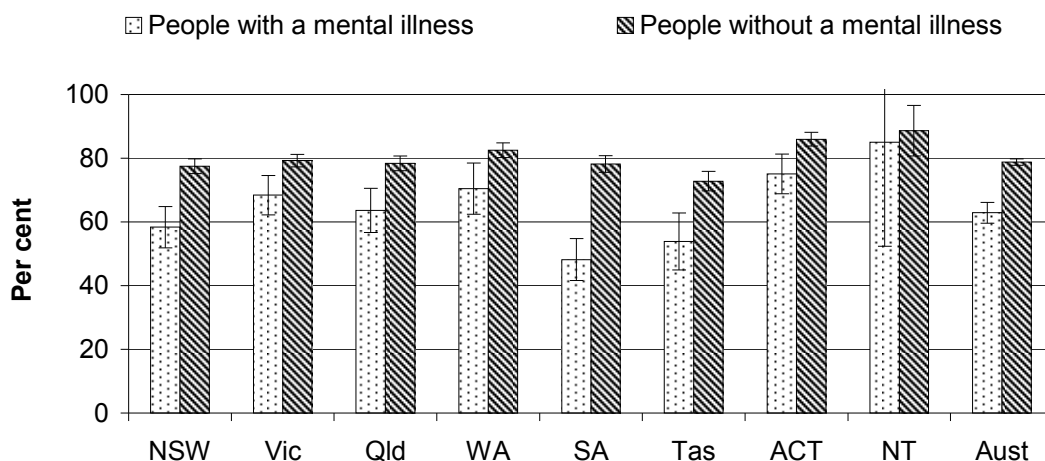
This indicator measures employment participation relative to the total population aged 16–64 years, as distinct from the labour force (that is, people who are employed or unemployed, but actively looking for work). Some people can choose not to participate in the labour force (that is, they are not working or actively looking for work). It also does not provide information on whether for those employed or enrolled for study, their jobs/studies are appropriate or meaningful.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Mental illness can act as a barrier to gaining and maintaining employment (AHMC 2008). Nationally, in 2007-08, the proportion of people with a mental illness who were employed was 62.9 ± 3.3 per cent, compared to 78.8 ± 1.0 per cent for those without a mental illness (figure 12.32).

Figure 12.32 People aged 16–64 years who are employed, by mental illness status, 2007-08^a



^a In the *National Health Survey*, people with a mental illness are defined as those who self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more.

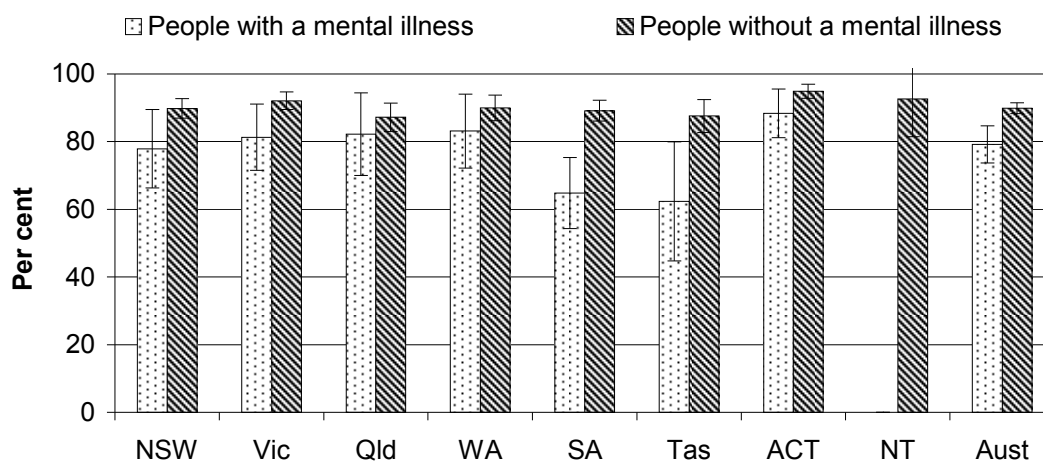
Source: ABS (unpublished) 2007-08 *National Health Survey*, Cat. no. 4364.0; table 12A.57.

Data from the 2007 SMHWB on the labour force and employment participation of people who had a mental disorder with symptoms in the previous 12 months are in table 12A.59.

Mental illness in early adult years can lead to disrupted education and premature exit from school or tertiary training, or disruptions in the transition from school to work. The impact of these disruptions can be long term, restricting the person's capacity to participate in a range of social and vocational roles over their lifetime (AHMC 2008). Nationally, in 2007-08, the proportion of people aged 16-30 years with a mental illness who were employed and/or are enrolled for study in a formal secondary or tertiary qualification was 79.2 ± 5.5 per cent, compared to 89.9 ± 1.6 per cent for those without a mental illness (figure 12.33).

Data from the 2007 SMHWB on the participation of people aged 16–30 years in the labour force and/or in education or training are in tables 12A.60-61.

Figure 12.33 People aged 16-30 years who were employed and/or are enrolled for study in a formal secondary or tertiary qualification, by mental illness status, 2007-08^{a, b}



^a In the *National Health Survey*, people with a mental illness are defined as those who self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. ^b The proportion of people with a mental illness aged 16-30 years who were employed and/or are enrolled for study in a formal secondary or tertiary qualification is zero in the NT.

Source: ABS (unpublished) 2007-08 *National Health Survey*, Cat. no. 4364.0; table 12A.58.

Mental health outcomes of consumers of specialised public mental health services

‘Mental health outcomes of consumers of specialised public mental health services’ is an indicator of governments’ objective to improve the effectiveness and quality of service delivery and outcomes and promote recovery from mental health problems and mental illness (box 12.22).

Box 12.22 Mental health outcomes of consumers of specialised public mental health services

‘Mental health outcomes of consumers of specialised public mental health services’ is defined as the proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes. Data are also reported on the proportion who experienced no significant change or a significant deterioration in their mental health outcomes. Data are reported by three service user types: people in ongoing community-based care, people discharged from community-based care and people discharged from a hospital psychiatric inpatient unit.

Results are difficult to interpret as there are a range of mental health clinical outcomes for people treated in specialised public mental health services and ‘best practice’ outcomes are unknown (AHMC 2011). A high or increasing proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes is desirable.

The assessment of a consumer’s clinical mental health outcomes is based on the changes reported in a consumer’s ‘score’ on a rating scale known as the Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Outcome scores are classified based on effect size. Effect size is a statistic used to assess the magnitude of a treatment effect. It is based on the ratio of the difference between pre- and post- scores to the standard deviation of the pre- score. Individual episodes are classified as ‘significant improvement’ if the effect size index is greater than or equal to positive 0.5; ‘no change’ if the index is between -0.5 and zero; and ‘significant deterioration’ if the effect size index is less than or equal to -0.5 (AHMC 2012).

This indicator has many technical and conceptual issues. The outcome measurement tool is imprecise. A single ‘average score’ does not reflect the complex service system in which services are delivered across multiple settings (inpatient, community and residential) and provided as both discrete, short term episodes of care and prolonged care over indefinite periods. The approach separates a consumer’s care into segments (hospital versus the community) rather than tracking the person’s overall outcomes across treatment settings. In addition, consumers’ outcomes are measured from the clinician’s perspective and not as the ‘lived experience’ from the consumer’s viewpoint (AHMC 2012).

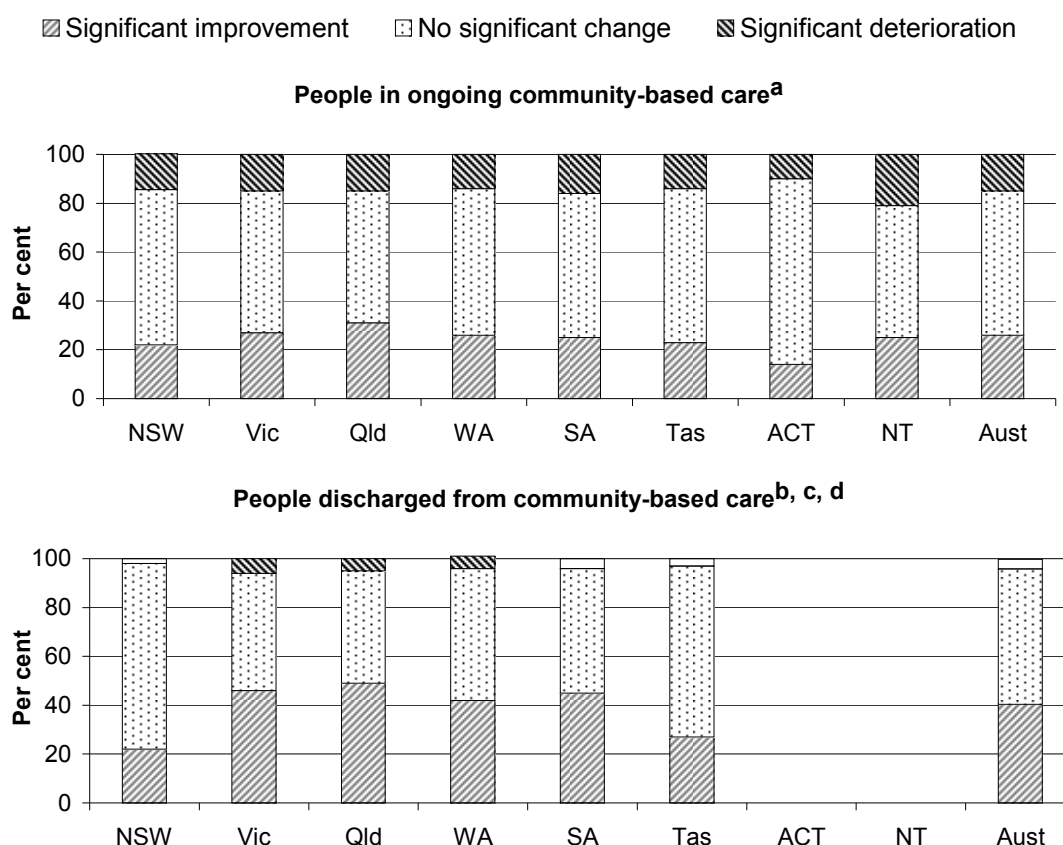
Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Nationally, in 2009-10, 26 per cent of people in ongoing community-based care, 40 per cent of people discharged from community-based care and 67 per cent of people discharged from a hospital psychiatric inpatient unit showed a significant improvement in their mental health clinical outcomes (figures 12.34-35). Caution is required in interpreting results across states and territories. Data are of variable

quality and there are different levels of coverage across states and territories (AHMC 2012).

Figure 12.34 Mental health outcomes of consumers of State or Territory community-based specialised public mental health services, 2009-10



^a Data comprise people receiving relatively long term community-based care. Data include people who were receiving care for the whole of 2009-10, and those who commenced community-based care sometime after 1 July 2009 who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June 2010). Outcome scores were calculated as the difference between the total score recorded on the first occasion rated and the last occasion rated in the year.

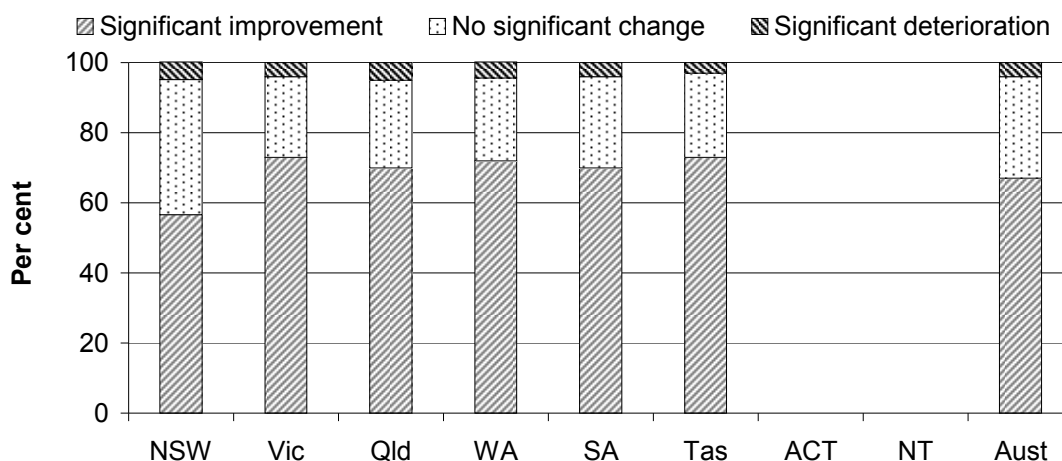
^b Data comprise people who received relatively short term community-based care. The defining characteristic of the group is that the episode of community-based care commenced, and was completed, within 2009-10. Outcome scores were calculated as the difference between the total score recorded at admission to, and discharge, from community-based care. People whose episode of community-based care was completed because they were admitted to hospital are not included.

^c The ACT data are not published due to a technical issue with the correct assignment of the service setting for the observations.

^d The NT data are not published due to insufficient observations.

Source: AHMC (2012) *Council of Australian Governments National Action Plan for Mental Health 2006–2011: Progress Report 2009-10*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (forthcoming); table 12A.62.

Figure 12.35 Mental health outcomes of consumers discharged from State or Territory inpatient mental health services, 2009-10^{a, b}



^a The ACT and the NT data are not published due to insufficient observations. ^b Data comprise people who received a discrete episode of inpatient care within a psychiatric unit. The defining characteristic of the group is that the episode of inpatient care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission and discharge. The analysis excludes episodes where the length of stay was three days or less because it is not meaningful to compare admission and discharge ratings for short duration episodes.

Source: AHMC (2012) *Council of Australian Governments National Action Plan for Mental Health 2006–2011: Progress Report 2009-10*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (forthcoming); table 12A.62.

12.5 Future directions in performance reporting

Key challenges for improving the reporting on mental health include:

- improving the reporting of effectiveness and efficiency indicators for Indigenous, rural/remote and other special needs groups
- developing an estimate of the number of people who need mental health services so that access to services can be measured in terms of need
- identifying indicators that relate to the performance framework dimensions of quality — safety and sustainability
- improving reporting on outcomes to include indicators that relate to the participation of people with a mental illness in meaningful social and recreational activities
- further developing the measurement and reporting on the clinical mental health outcomes of consumers of specialised public mental health services.

COAG developments

Outcomes from review of Report on Government Services

The COAG endorsed recommendations (December 2009) of the review of the RoGS implemented during 2010 and 2011 are reflected in this Report. Implementation of other recommendations will be reflected in future reports.

Review of National Agreements and National Partnership Agreements

COAG has agreed to progress the recommendations of the Heads of Treasuries (HoTs) Review of National Agreements, National Partnerships and Implementation Plans and reports of the CRC. A working group, led by Senior Officials from First Ministers' and Treasury agencies, will review the performance frameworks of a limited number of agreements, including the NHA. The reviews will be concluded by June 2012. The recommendations of the review of the NHA will be considered by the Steering Committee and may be reflected in future reports.

12.6 Definitions of key terms and indicators

General terms

General practice

The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients. This definition includes medical practitioners who work solely with one specific population, such as women's health or Indigenous health.

Health management

The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.

Incidence rate

Proportion of the population experiencing a disorder or illness for the first time during a given period (often expressed per 100 000 people).

Separation

An episode of care for an admitted patient, which can be a total hospital stay, or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care.

Mental health

Acute services

Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services can:

- focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric illness for whom there has been an acute exacerbation of symptoms
- target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, and forensic mental health services.

Affective disorders

A mood disturbance, including mania, hypomania, bipolar affective disorder, depression and dysthymia.

Ambulatory care services

Mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted inpatients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.

Anxiety disorders

Feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder.

Available beds	The number of immediately available beds for use by admitted patients if required. Beds are immediately available for use if located in a suitable place of care with nursing or other auxiliary staff available within a reasonable period. 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.
Child and adolescent mental health services	Services principally targeted at children and young people up to the age of 18 years. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on children or adolescents. These services can include a forensic component.
Co-located services	Psychiatric inpatient services established physically and organisationally as part of a general hospital.
Community-based residential services	Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must: provide residential care to people with mental illnesses or psychiatric disability; be located in a community setting external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded.
Co-morbidity	The simultaneous occurrence of two or more illnesses such as depressive illness with anxiety disorder, or depressive disorder with anorexia.
Consumer involvement in decision making	Consumer participation arrangements in public sector mental health service organisations according to the scoring hierarchy (levels 1–4) developed for monitoring State and Territory performance under Medicare Agreements Schedule F1 indicators.
Cost per inpatient bed day	The average patient day cost according to the inpatient type.
Depression	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration can be affected.
Forensic mental health services	Services principally providing assessment, treatment and care of mentally ill individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.
General mental health services	Services that principally target the general adult population (18–65 years old) but that can provide services to children, adolescents or older people. Includes, therefore, those services that cannot be described as specialised child and adolescent, older people's or forensic services. General mental health services include hospital units whose principal function is to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, post-natal depression, anxiety disorders).

Mental illness	A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness.
Mental health promotion	Actions taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the 'coping' capacity of communities, families and individuals by giving power, knowledge, skills and necessary resources.
Mental illness prevention	Interventions that occur before the initial onset of a illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental illnesses.
Mortality rate from suicide	The proportion of the population who die as a result of suicide.
Non-acute services	Non-acute services are defined by two categories: • Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. • Extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which can include high levels of severe unremitting symptoms of mental illness. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.
Non-government organisations	Private not-for-profit community managed organisations that receive State and Territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the non-government organisation sector can include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.
Older people's 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 people. These services can include a forensic component. Excludes general mental health services that may treat older people as part of a more general service.

Outpatient services — community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They can 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 can include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Patient days (occupied bed days)	All days or part days for which patient was in hospital during the reporting year (1 July to 30 June), regardless of the original date of admission or discharge. Key definitional rules include the following: • For a patient admitted and discharged on different days, only the day of admission is counted as a patient day. • Admission and discharge on the same day are equal to one patient day. • Leave days are not included when they involve an overnight absence. • A patient day is recorded on the day of return from leave.
Percentage of facilities accredited	The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of illnesses.
Psychiatrist	A medical practitioner with specialist training in psychiatry.
Public health	The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional services.
Schizophrenia	A combination of signs and symptoms that can include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour.
Specialised mental health inpatient services	Services provided to admitted patients in stand-alone psychiatric hospitals or specialised psychiatric units located within general hospitals.
Specialised mental health services	Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds.
Specialised residential services	Services provided in the community that are staffed by mental health professionals on a 24 hour basis.

**Staffing categories
(mental health)**

Medical officers: all medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee-for-service basis.

Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant State or Territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.

Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Other medical officers: medical officers employed or engaged by the organisation who are not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Nursing staff: all categories of registered nurses and enrolled nurses, employed or engaged by the organisation.

Registered nurses: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialised categories of registered nurses.

Enrolled nurses: Refers to people who are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).

Diagnostic and health professionals: qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, and other diagnostic and health professionals.

Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.

Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.

Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.

Administrative and clerical staff: staff engaged in administrative and clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories. Civil engineers and computing staff are included in this category.

Domestic and other staff: staff involved in the provision of food and

Stand-alone psychiatric hospitals

cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.

Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus can also be a stand-alone hospital if the following criteria are not met:

- a single organisational or management structure covers the acute care hospital and the psychiatric hospital
- a single employer covers the staff of the acute care hospital and the psychiatric hospital
- the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus
- the patients of the psychiatric hospital are regarded as patients of the single integrated health service.

Substance use disorders

Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive, social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug can be psychological (as in substance misuse) or physiological (as in substance dependence).

12.7 List of attachment tables

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12.8 References

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PART F

COMMUNITY SERVICES



F Community services sector summary

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Attachment tables

Attachment tables are identified in references throughout this sector summary by a 'FA' prefix (for example, table FA.1). A full list of attachment tables is provided at the end of this sector summary, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

F.1 Introduction

This sector summary provides an introduction to the Aged care services (chapter 13), Services for people with disability (chapter 14) and Protection and support services (chapter 15) chapters of this Report. It provides an overview of the community services sector, presenting both contextual information and high level performance information.

Major improvements in reporting on community services this year are identified in each of the service-specific community services chapters.

Policy context

Families are the principal providers of care for children, older people and people with disability (ABS 2010; Australian Government 2008). Community services aim to:

- support families to fulfil their caring roles
- provide care when families are unable to
- provide interventions when a person's needs are not able to be met within the community without special intervention.

Community services provide support to sustain and nurture the functioning of individuals, families and groups, to maximise their potential and to enhance community well being (Australian Council of Social Service 2009). Although community services generally target individuals, they can be delivered at an institutional level. Services are typically provided by government and the not-for-profit sector, but the for-profit sector also has an important role (for example, as owners of aged care facilities). Community services also contribute to the development of community infrastructure to service needs (AIHW 2005).

Sector scope

Although there is a broad understanding of the nature of community services, the sector is complex, and consistent aggregate reporting across the community services sector is not possible at this time.

Definitions of the sector vary in their scope and can change over time. Community service activities typically include activities that support individual and family functioning. They can include financial assistance and relief to people in crisis but exclude acute health care services and long term housing assistance. Some of these interventions are included elsewhere in this Report; for example, Public hospitals (chapter 10), Health management issues (chapter 12), Housing (chapter 16), and Homelessness services (chapter 17).

The definition of community services activities in this sector summary is based on the National Classification of Community Services developed by the Australian Institute of Health and Welfare (AIHW 2003) (box F.1). The scope of the sector summary is therefore somewhat broader than the three service specific chapters in this section of the Report (Aged care services, Services for people with disability, and Protection and support services).

Box F.1 **Community services activities**

Community services activities include:

Personal and social support — activities that provide support for personal or social functioning in daily life. Such activities promote the development of personal skills for successful functioning as individuals, family members and members of the wider community. Personal and social support activities include the provision of information, advice and referral, personal, social and systemic advocacy, counselling, domestic assistance, provision of services that enable people to remain in their homes, disability services and other personal assistance services. The purpose of such support is to enable individuals to live and function in their own homes or normal places of residence.

Support for children, families and carers — activities that seek to promote child and family welfare by supporting families and protecting children from abuse and neglect or harm through statutory intervention.

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 that are 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 in relation to young people and people with intellectual and psychiatric disabilities on court orders that involve correctional and rehabilitative supervision and the protection of public safety, through corrective arrangements and advice to courts and releasing authorities.^a

Service and community development and support — activities that provide support aimed at articulating and promoting improved social policies; promoting greater public awareness of social issues; developing and supporting community based activities, special interest and cultural groups; and developing and facilitating the delivery of quality community services. Activities include the development of public policy submissions, social planning and social action, the provision of expert advice, coordination, training, staff and volunteer development, and management support to service providers.

^a This Report uses the term ‘juvenile justice’ to refer to detention and community based supervision services for young people who have committed or allegedly committed an offence while considered by law to be a juvenile (chapter 15).

Source: AIHW (2003); State and Territory governments (unpublished).

Other definitions of community services have even broader scope. The National Community Services Information Agreement, managed by the National Community Services Information Management Group (NCSIMG), includes income support and concessions in its definition (NCSIMG 2008). Alternative definitions include activities such as advocacy, public transport, community safety and emotional support.

Profile of the community services sector

This section examines the size and scope of the community services sector and the role of government in providing community services. Detailed profiles for the services within the community services sector are reported in chapters 13, 14 and 15, and cover:

- size and scope of the individual service types
- funding and expenditure.

Roles and responsibilities

The Australian, State and Territory governments have a major role in the provision of community services. This role is based on a mandate to ensure basic rights and an acceptable standard of living, and a requirement to protect and support vulnerable people in society.

Local governments are also funders and providers of community services (AIHW 2005). However, community services funded solely by local government are not included in this Report.

Roles and responsibilities for the health sector were confirmed by COAG under the National Health Reform Agreement 2011.

Government involvement in community services includes:

- providing services directly to clients
- funding non-government community service providers (which then provide services to clients)
- legislating for, and regulating, government and non-government providers
- undertaking policy development and administration
- undertaking monitoring and evaluation of community services programs.

The roles and funding arrangements for community services vary across service areas and programs:

- statutory child protection, out-of-home care services, intensive family support services and juvenile justice services are funded and delivered primarily by State and Territory governments, with some non-government sector involvement, particularly in the delivery of out-of-home care services. Family support and early intervention (assessment and referral) services are funded by State and Territory governments and services are delivered primarily by non-government organisations
- specialist disability services, excluding employment services, are funded primarily by State and Territory governments (with some Australian Government contribution) and are delivered primarily by State and Territory governments and the non-government sector
- residential aged care is funded primarily by the Australian Government and services are delivered primarily by State and Territory governments and the non-government sector
- Home and Community Care (HACC) services are jointly funded by the Australian Government and States and Territories and delivered primarily by local government, non-government community organisations, religious or charitable bodies, State and Territory government agencies, and private (for profit) organisations — under the National Health Reform changes in roles and responsibilities for the HACC came into effect on 1 July 2011 (for more detail see section F.3 and box 13.1).

Effective regulation of non-government agencies (through licensing, accreditation and quality assurance) enables agencies to provide services within a framework of agreed standards. Examples include the accreditation of residential aged care services and the new Community Care Common Standards that came into effect on 1 March 2011. The Common Standards apply for the HACC program, Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH), EACH-Dementia (EACH-D) and National Respite for Carers Program (NRCP).

Expenditure

Community services expenditure

Estimates of community services expenditure are influenced by the scope of the services to be included. The following broad estimates of community services

expenditure provide context for material included in the relevant chapters of this Report.

Australia's welfare 2011 (AIHW 2011) analyses community services expenditure incurred by governments, non-government organisations and individual households in providing services to assist members of the community with special needs (limited to families and children, older people, people with disability and other disadvantaged groups). It estimates that:

- Welfare expenditure broadly comprises spending on welfare services and cash payments. In 2008–09, welfare expenditure was estimated to be \$136.6 billion, \$94.4 billion of this was for cash payments while \$42.2 billion was for welfare services (AIHW 2011)
- expenditure on welfare services, excluding welfare payments (\$42.2 billion) in 2008–09 represented 3.4 per cent of Gross Domestic Product (GDP) in that year. The amount spent on welfare services between 1998–99 and 2008–09 increased on average each year by 4.9 per cent, much higher than GDP growth of 3.2 per cent (AIHW 2011)
- governments were the source of 73.0 per cent (\$30.9 billion) of all funding of welfare services in 2008–09, with the non-government sector providing the remaining 27.0 per cent (\$11.2 billion) (AIHW 2011).

Community Services Australia, 2008–09 (ABS 2010) provides data on community services expenditure incurred by governments and non-government organisations (for-profit and not-for-profit) in providing services to assist members of the community with special needs, including personal and social support, residential care and other social assistance services. These data apply to organisations engaged in providing a wide variety of social support services directly to clients including (but not limited to), welfare services, disabilities assistance and adult day care centre operation.

It estimates that during 2008–09 \$25.2 billion was spent on direct community services activities and a further \$4.0 billion on non-direct and related community services activities. The majority of services are provided by the not-for-profit sector which receives most of its funding from government. Total expenditure on direct activities comprised \$13.8 billion by not-for-profit organisations, \$6.7 billion by for-profit organisations, \$3.8 billion by Australian, State and Territory governments and \$0.9 billion by local government. In addition, Australian, State and Territory governments provided funding of \$9.5 billion to other private organisations and self-employed contractors for the direct provision of community services:

-
- Personal and social support comprises activities relating to information, advice and referral, individual and family support, independent and community living support, and support in the home. During 2008–09, total expenditure on personal and social support was \$5.9 billion which accounted for 24 per cent of all direct community services expenditure. Not-for-profit organisations delivered the majority of this with \$4.3 billion. The main components of personal and social support expenditure were \$1.6 billion for individual and family support, \$1.5 billion for support in the home, and \$1.5 billion for other personal and social support
 - Direct expenditure on residential care across the community services sector was \$12.6 billion in 2008–09. Not-for-profit organisations had the largest allocation with \$7.2 billion, followed by for-profit organisations with \$3.3 billion, and government organisations with \$2.0 billion. Aged and disability care was the most significant activity within residential care, contributing \$10.3 billion to total expenditure. The main components of this were high level care contributing \$6.8 billion (66 per cent), and low level care contributing \$3.5 billion (34 per cent), of which not-for-profit organisations accounted for \$3.3 billion (48 per cent) and \$2.5 billion (73 per cent) respectively.

Community services expenditure included in this Report

The following community services expenditure analysis relates only to expenditure on programs reported in the community services chapters of this Report (box F.2).

Box F.2 Major programs included in community services expenditure in the Report

The major programs reported on include:

- aged care services — aged care assessment, residential care, community care and HACC
- services for people with disability — services as outlined in the National Disability Agreement
- protection and support services — child protection, out-of-home care services, and intensive family support services.

Each chapter includes more detailed analysis of expenditure items reported.

Recurrent expenditure included in the Report

Total Australian, State and Territory government recurrent expenditure on community services covered by this Report was estimated to be \$21.5 billion in 2010-11 (table F.1). This was equivalent to 1.5 per cent of GDP in that year, and 8.6 per cent of total government outlays (table F.1 and ABS 2011).

Between 2006-07 and 2010-11, real government recurrent expenditure on community services increased by \$4.6 billion or 27.0 per cent. The largest proportional increase in real expenditure was on protection and support services, which increased by 52.6 per cent between 2006-07 and 2010-11. The largest absolute dollar increase for a particular service between 2006-07 and 2010-11 was \$2.4 billion for aged care services (table F.1).

Table F.1 Real government recurrent expenditure on community services (2010-11 dollars)^{a, b, c, d e}

	<i>Unit</i>	<i>Aged care services</i>	<i>Services for people with disability</i>	<i>Protection and support services</i>	<i>Total</i>
2006-07	\$m	9 813.5	5 060.5	2 041.6	16 915.6
2007-08	\$m	10 268.9	5 258.7	2 324.7	17 852.3
2008-09	\$m	10 722.6	5 582.7	2 640.0	18 945.3
2009-10	\$m	11 704.1	6 108.1	2 996.9	20 809.1
2010-11	\$m	12 173.3	6 201.0	3 114.5	21 488.8
Increase 2006-07 to 2010-11	%	24.0	22.5	52.6	27.0

^a Data for 2006-07 to 2009-10 have been adjusted to 2010-11 dollars using the gross domestic product (GDP) price deflator in table AA.39 of appendix A. ^b Data for aged care services published in the 2008, and earlier, reports differ due to revised data and the inclusion of additional expenditure items in the 2008 and later reports. The 2010, 2011 and 2012 reports included new expenditure data for the Community Visitors Scheme, the Innovative Care Pool, CALD programs and Specific Purpose Payments. ^c Totals may not add as a result of rounding. ^d See box F.2 for the major programs included in expenditure for each service. ^e More detailed expenditure data can be found in the relevant chapters of the Report.

Source: Australian, State and Territory governments (unpublished); tables 13A.6, 14A.4, 15A.1 and AA.39.

Expenditure available for reporting at a State and Territory level

Table F.2 identifies expenditure by State and Territory governments and Australian Government expenditure available for reporting at the State and Territory level on community services included in this Report, by jurisdiction, for 2010-11.

Table F.2 **Government recurrent expenditure on community services, 2010-11^{a, b, c, d, e}**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Recurrent expenditure on community services										
ACS	\$m	3 972.9	3 057.0	2 296.6	1 073.1	1 160.8	329.9	140.3	70.2	12 173.3
SPWD	\$m	1 787.6	1 454.2	903.6	539.1	387.6	148.8	79.2	57.2	6 201.0
PSS	\$m	1 223.4	558.2	694.8	279.5	176.5	63.4	39.5	79.3	3 114.5
Total	\$m	6 983.9	5 069.3	3 894.9	1 891.6	1 725.0	542.1	259.0	206.7	21 488.9
Proportion of recurrent expenditure by service										
ACS	%	56.9	60.3	59.0	56.7	67.3	60.9	54.2	34.0	56.6
SPWD	%	25.6	28.7	23.2	28.5	22.5	27.5	30.6	27.7	28.9
PSS	%	17.5	11.0	17.8	14.8	10.2	11.7	15.3	38.4	14.5
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Recurrent expenditure on community services per person in the population^f										
ACS	\$	546.3	547.3	504.9	463.1	703.4	647.8	387.5	305.4	541.6
SPWD	\$	245.8	260.4	198.6	232.7	234.9	292.2	218.9	248.8	275.9
PSS	\$	168.2	99.9	152.7	120.6	107.0	124.5	109.2	345.0	138.6
Total	\$	960.4	907.6	856.3	816.4	1045.2	1064.5	715.6	899.2	956.0

ACS = Aged care services. **SPWD** = Services for people with disability. **PSS** = Protection and support services.

^a For aged care services and services for people with disability, Australian Government expenditure not allocated to a State or Territory is included in the totals (\$72.6 million in aged care services and \$843.6 million in services for people with disability). ^b Collection and reporting methods may vary across jurisdictions and services in this analysis, therefore, these data should be interpreted with care. ^c See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report. ^d Totals may not add due to rounding. ^e Expenditure for aged care does not include capital expenditure. ^f Population at 31 December 2010.

Source: Australian, State and Territory governments (unpublished); tables 13A.5, 14A.4, 15A.1 and AA.39.

Size and scope

Current data on the size and scope of the community services sector are limited. The ABS survey of community services collected data on the number of organisations that provided community services in 2009. Almost 11 000 organisations were providing community services. These included 5809 not-for-profit organisations, 4638 for-profit organisations and 520 government organisations (ABS 2010).

Social and economic factors affecting demand for services

In general, relatively disadvantaged members of the community live shorter lives and have higher rates of illness and disability than those whose circumstances are advantageous. Disadvantage limits the extent to which individuals and families can participate in society. Economic participation conveys financial, health and social benefits to individuals, households and families and as such is central to population

welfare. For example, higher levels of education and income are associated with lower prevalence of risk factors to health such as smoking and obesity, and better health outcomes generally (AIHW 2010). Economic participation can be described as a person's engagement in education and employment, and access to economic resources including income and wealth. The various aspects of economic participation are inter-related, and are also associated with positive social and health outcomes (AIHW 2011).

There is no one factor that can predict whether a child will experience maltreatment though low income families, particularly families reliant on pensions and benefits, are overrepresented in the child protection system (Allen Consulting Group 2003). Other factors commonly associated with child maltreatment include: early child bearing, parental alcohol and drug use, family violence, adult mental illness, social isolation, and children with health, disability or behavioural problems (Bromfield and Holzer 2008).

The Productivity Commission (PC 2011a) report into the disability care and support sector describes the sector as underfunded, unfair, fragmented, and inefficient, and gives people with a disability little choice and no certainty of access to appropriate supports. The disability sector reflects social barriers, such as prejudice, out-of date practices, and poorly designed infrastructure.

The National Disability Strategy focuses on increasing access to employment opportunities for people with disability, their families and carers; ensuring income support and tax systems provide adequate support; and improving access to secure and affordable housing options (COAG 2011).

The National Health and Hospitals Reform Commission noted a number of challenges facing the aged care sector including significant shifts in the type of care demanded due to reduced access to carers and family support due to changes in social and economic circumstances (NHHRC 2009). The Productivity Commission report (PC 2011b) into caring for older Australians highlighted the increasing numbers of older people who are likely to require care (by 2050 it is estimated the 3.5 million Australians will use aged care services), along with their increasing expectations of care and the relative fall in the number of informal carers as significant future challenges for the aged care sector.

Service-sector objectives

The overarching service sector objectives in box F.2 draw together the objectives from each of the specific services detailed in this Report. More detailed objectives

can be found in chapters 13 (Aged care services), 14 (Services for people with disability) and 15 (Protection and support services).

Box F.2 Objectives for community services

The overarching objective of the community services sector is to ensure that older people, people with disability and vulnerable children are supported or assisted and have the opportunity to fully participate in the community.

The specific objectives of the services that comprise the community services sector are summarised below:

- *Aged care services* (chapter 13) aim to promote the wellbeing and independence of frail older people and their carers through the funding and delivery of care services that are accessible, appropriate to needs, high quality, efficient, and person-centred. These objectives are consistent with the Australian, State and Territory governments' long-term aged care objectives articulated under the NHA: that 'older Australians receive appropriate high quality and affordable health and aged care services' (COAG 2009).
- *Services for people with disability* (chapter 14) aim to enhance the quality of life experienced by people with disability by assisting them to live as valued and participating members of the community.
- *Protection and support services* (chapter 15) aim to support families to care for their children and to protect children who are at risk of harm. Juvenile justice services aim to contribute to a reduction in the frequency or severity of youth offending, recognise the rights of victims, and promote community safety.

Source: Chapters 13, 14 and 15.

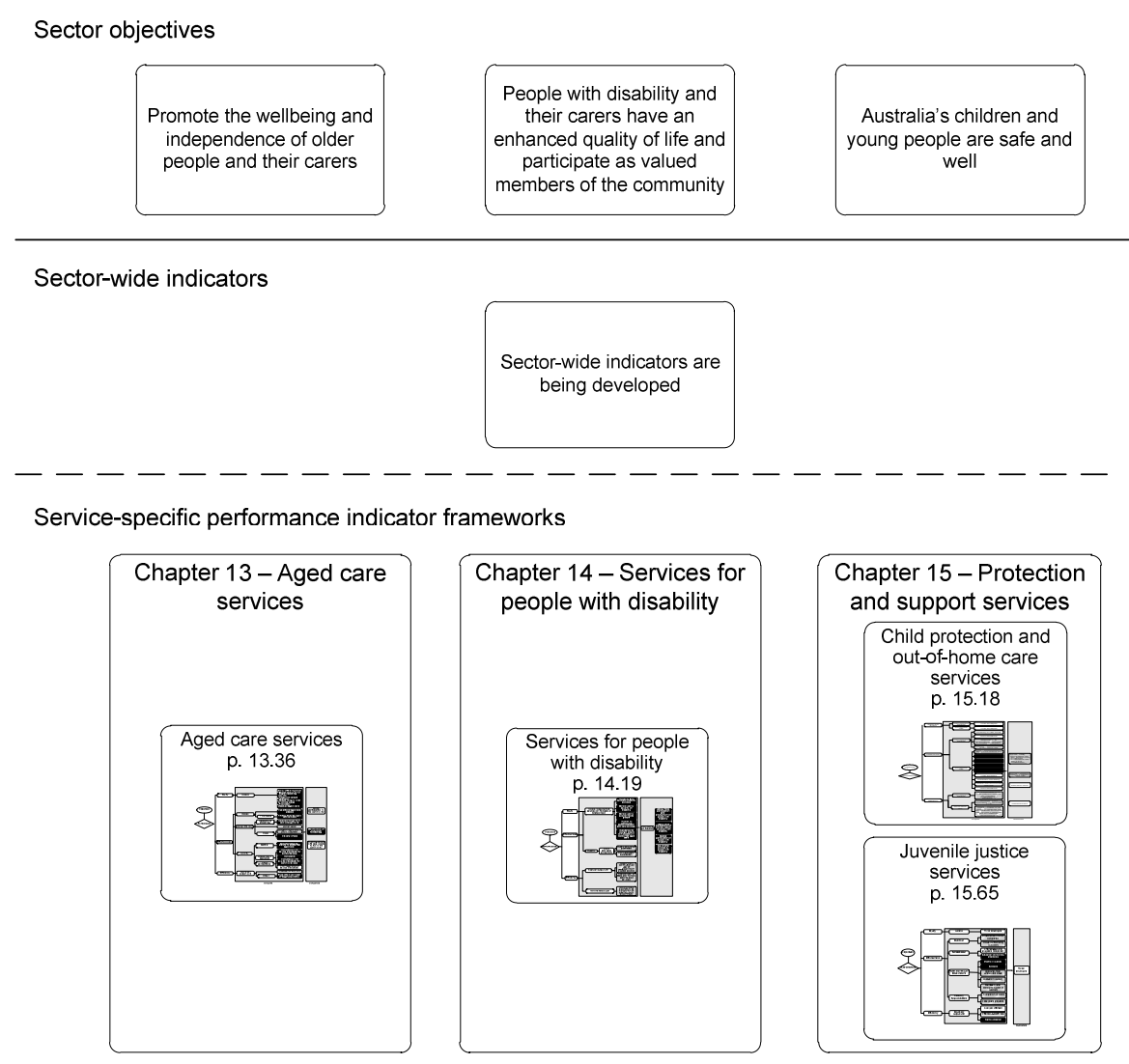
F.2 Sector performance indicator framework

This sector summary is based on a sector performance indicator framework (figure F.1). This framework is made up of the following elements:

- Sector objectives — three sector objectives are a précis of the key objectives of the community services sector (box F.2)
- Sector-wide indicators — sector-wide indicators are high level indicators which cut across community services
- Service specific indicators — information from the service-specific performance indicator frameworks that relate to community services. Discussed in more detail in chapters 13, 14 and 15, the service-specific frameworks provide comprehensive information on the equity, effectiveness and efficiency of these services.

This sector summary provides an overview of relevant performance information. Chapters 13, 14 and 15 and their associated attachment tables provide more detailed information.

Figure F.1 Community services performance indicator framework



Sector-wide indicators

This section will include high level indicators of community services outcomes. Many factors are likely to influence these outcomes — not solely the performance of government services. However, these outcomes will inform the development of appropriate policies and the delivery of government services.

These indicators are currently under development and will be reported in future publications.

Service-specific performance indicator frameworks

This section summarises information from the Aged care services' service-specific indicator framework in chapter 13, the Services for people with disability service-specific indicator framework in chapter 14 and the Protection and support services' service-specific indicator framework in chapter 15.

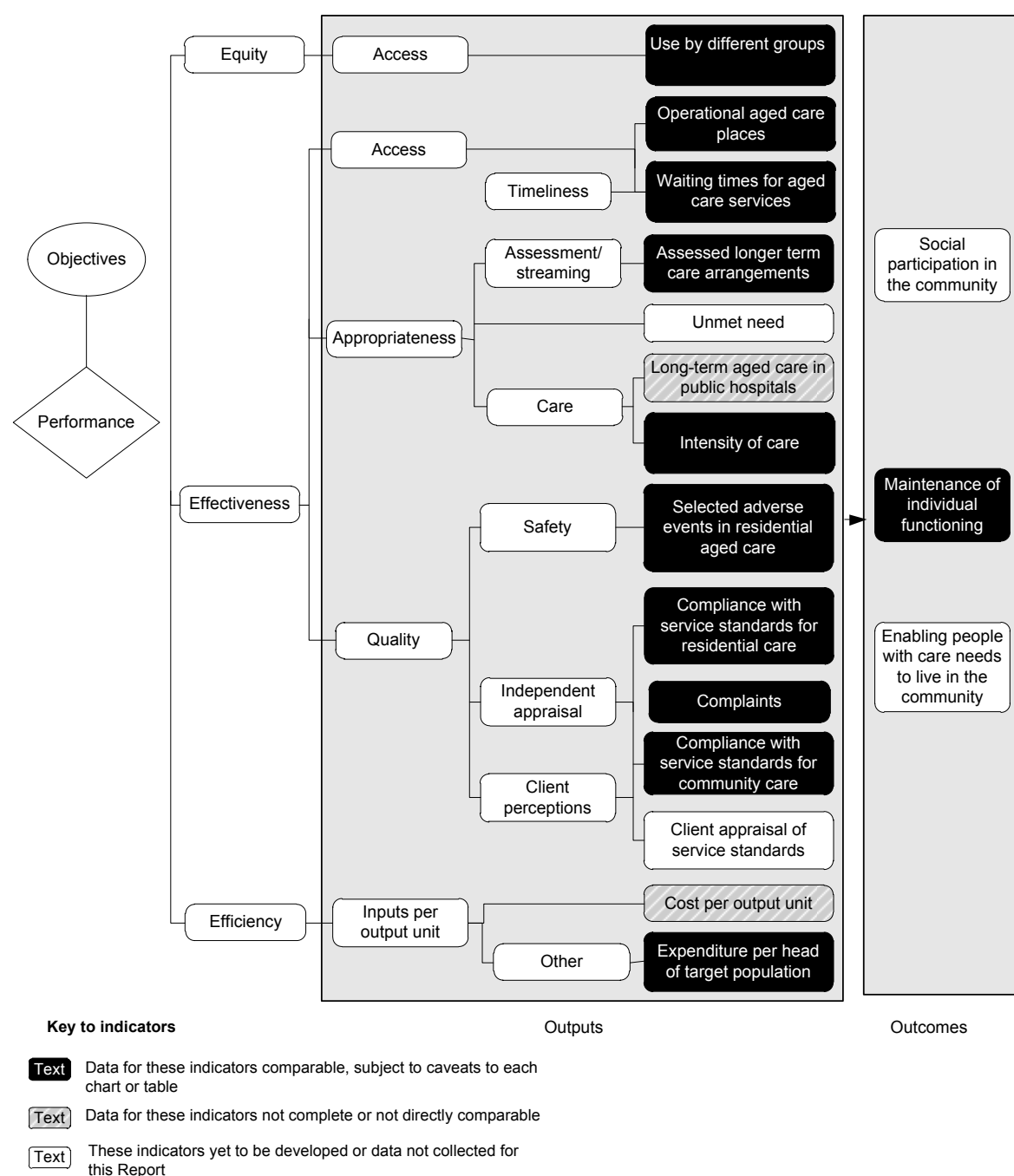
Additional information is available to assist the interpretation of these results:

- indicator interpretation boxes, which define the measures used and indicate any significant conceptual or methodological issues with the reported information (chapters 13, 14 and 15)
- caveats and footnotes to the reported data (chapters 13, 14 and 15 and attachments 13A, 14A and 15A)
- additional measures and further disaggregation of reported measures (for example, by Indigenous status, remoteness, language background, sex and age (chapters 13, 14 and 15 and attachments 13A, 14A and 15A)
- data quality information for many indicators (Chapters 13, 14 and 15 Data Quality Information).

Aged care services

The performance indicator framework for aged care services is presented in figure F2. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of aged care services.

Figure F.2

Aged care services performance indicator framework

An overview of aged care performance indicator results are presented in table F.3. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 13 and the footnotes in attachment 13A.

Table F.3 Performance indicators for aged care services^{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>	<i>Source</i>
Equity — access indicators										
Use by different groups										
Access to residential aged care services by all people — aged care recipients per 1000 in the target population, 2010-11										
Data for this indicator are comparable, subject to caveats (chapter 13)										
no.	78.7	79.2	73.3	71.7	86.7	75.4	70.9	41.0	77.4	13A.28
Access to residential aged care services by Indigenous people — Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over, 2010-11										
Data for this indicator are comparable, subject to caveats (chapter 13)										
no.	11.8	20.7	19.5	29.7	41.3	8.0	15.1	34.7	21.0	13A.34
Veterans in residential care per 1000 eligible veterans 70 years or over, 2010-11										
Data for this indicator are comparable, subject to caveats (chapter 13)										
no.	165.4	171.3	151.6	145.0	181.1	144.6	120.2	85.5	162.0	13A.14
Access to the HACC program — service hours per 1000 people aged 70 years or over and Indigenous people aged 50–69 years, 2010-11 (no.)										
Major cities	10 666	13 759	14 644	14 792	13 654	..	13 157	..	12 916	13A.48
Inner regional	9 021	16 078	11 607	12 599	11 677	13 311	...	..	11 963	13A.49
Outer regional	11 722	20 783	13 801	17 258	13 162	10 837	...	8 227	14 137	13A.50
Remote	15 688	32 623	18 093	14 468	18 200	14 215	...	9 561	16 181	13A.51
Very remote	15 030	..	22 408	23 331	51 138	24 053	...	12 758	21 923	13A.52
All areas	10 381	14 757	13 925	14 834	13 744	12 549	13 157	10 063	12 930	13A.47
Effectiveness — access indicators										
Total operational aged care places per 1000 people aged 70 years or over (excluding transition care), 2010-11										
Data for this indicator are comparable, subject to caveats (chapter 13)										
no.	112.1	111.2	111.4	115.6	115.5	111.2	120.8	218.6	112.8	13A.24
Waiting times for aged care services — proportion of people entering high care residential services entered within 3 months of approval, 2010-11										
Data for this indicator are comparable, subject to caveats (chapter 13)										
%	74.8	78.9	69.7	68.0	72.5	76.0	69.6	42.9	74.0	13A.67
Effectiveness — appropriateness indicators										
Assessed longer term care arrangements — proportion of clients recommended to remain in the community, 2009-10										
Data for this indicator are comparable, subject to caveats (chapter 13)										
%	49.3	59.5	38.8	50.9	41.9	56.5	68.0	66.8	50.0	13A.68
Long term aged care in public hospitals — proportion of separations for 'aged care type' public hospitals patients that were 35 days or longer, 2009-10										
Data for this indicator not complete or not directly comparable (chapter 13)										
%	8.1	34.7	21.6	14.4	11.6	22.9	14.1	7.3	14.6	13A.70

(continued on next page)

Table F.3 (continued)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	Source
Intensity of care — proportion of people who stayed in the same residential aged care service when changing from low care to high care, 2010-11										
Data for this indicator are comparable, subject to caveats (chapter 13)										
%	88.1	92.0	92.8	89.0	93.2	95.5	94.9	93.9	90.9	13A.38
Effectiveness — quality indicators										
Selected adverse events in residential aged care — hospital separations for falls in residential aged care services per 10 000 resident occupied place days, 2009-10										
Data for this indicator are comparable, subject to caveats (chapter 13)										
no.	3.4	3.7	3.2	3.3	2.5	1.7	5.7	2.5	3.4	13A.72
Compliance with service standards for residential care — proportion of re-accredited residential aged care services that were granted a re-accreditation approval for a period of three years, 2010-11										
Data for this indicator are comparable, subject to caveats (chapter 13)										
%	88.1	86.2	70.5	82.0	82.1	100.0	42.9	25.0	81.7	13A.73
Complaints — number of breaches under the Aged Care Act 1997 identified per 1000 residents, 2010-11										
Data for this indicator are comparable, subject to caveats (chapter 13)										
no.	7.0	6.5	7.1	5.7	7.2	6.8	22.1	19.3	7.0	13A.74
Compliance with service standards for community care — average score of HACC appraisals, 2007-08–2010-11										
Data for this indicator are comparable, subject to caveats (chapter 13)										
no.	17.6	16.5	18.8	15.1	17.3	13.7	17.6	14.3	17.6	13A.77
Efficiency indicators										
Cost per ACAT assessment — Australian Government expenditure on aged care assessments, per assessment, 2009-10										
Data for this indicator not complete or not directly comparable (chapter 13)										
\$	423	370	457	391	412	398	373	1 018	412	13A.78
Expenditure per head of target population — Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over and Indigenous people aged 50–69 years (including payroll tax), 2010-11										
Data for this indicator are comparable, subject to caveats (chapter 13)										
\$	3 625	3 659	3 352	3 233	4 180	3 339	3 043	1 689	3 569	13A.80
Outcome indicators										
Maintenance of individual functioning — improvement in Transition Care Program (TCP) client's level of functioning, reflected in the movement from the average Modified Barthel Index (MBI) score on entry to the average MBI score on exit, 2010-11										
Data for this indicator are comparable, subject to caveats (chapter 13)										
Average MBI on entry										
no.	79.7	64.4	76.7	61.1	66.8	68.0	77.7	72.9	71.7	13A.84
Average MBI on exit										
no.	88.8	70.3	89.1	67.8	84.4	83.5	93.6	84.3	81.3	13A.84

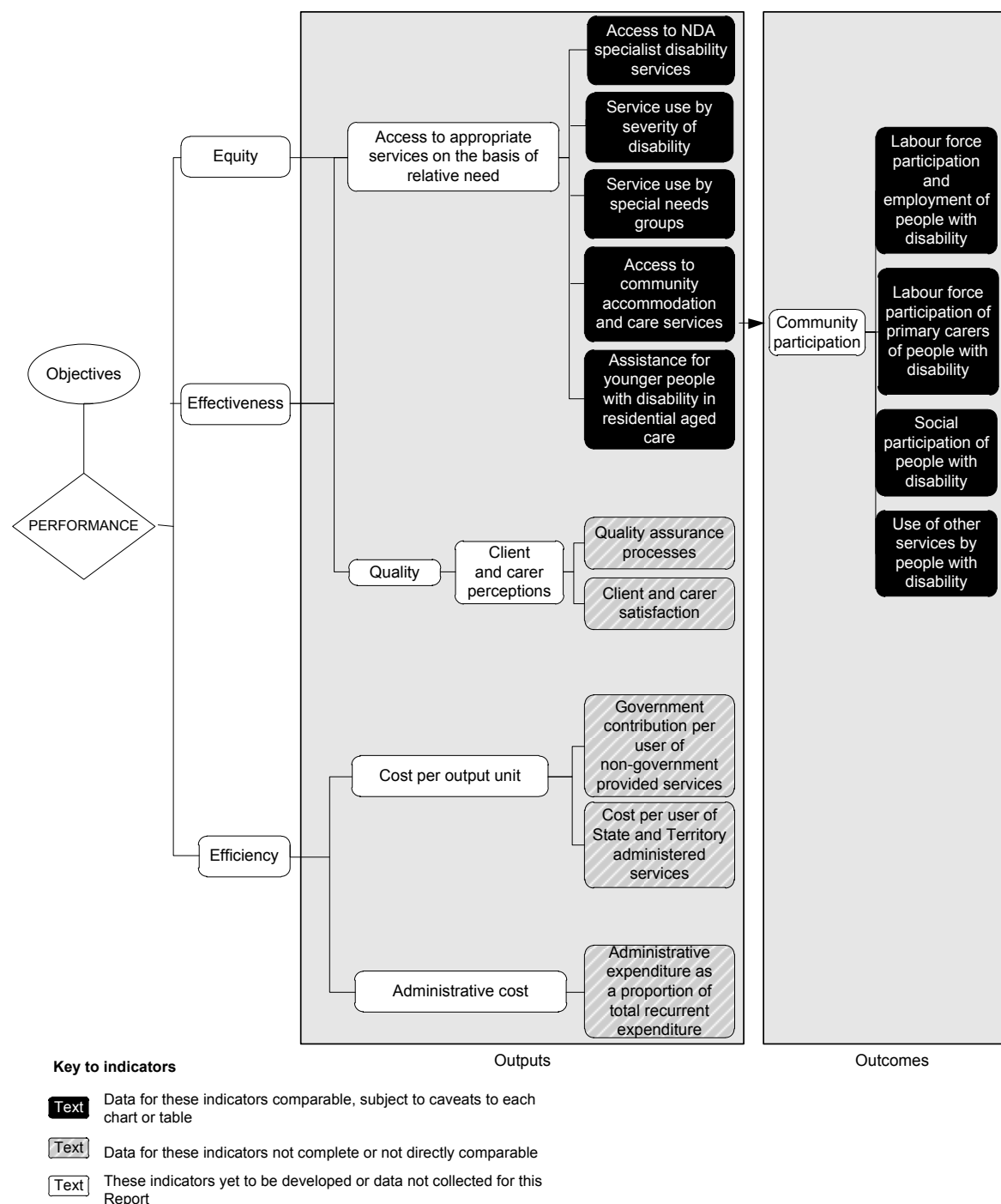
^a Caveats for these data are available in Chapter 13 and Attachment 13A. Refer to the indicator interpretation boxes in chapter 13 for information to assist with the interpretation of data presented in this table. ^b Some data are derived from detailed data in Chapter 13 and Attachment 13A. **na** Not available. – Nil or rounded to zero.

Source: Chapter 13 and Attachment 13A.

Services for people with disability

The performance indicator framework for services for people with disability is presented in figure F.3. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of disability services.

Figure F.3 **Services for people with disability performance indicator framework**



An overview of services for people with disability performance indicator results for 2009-10 are presented in table F.4. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 14 and the footnotes in attachment 14A.

Table F.4 Performance indicators for services for people with disability, 2009-10^{a, b, c, d}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	Source
Equity — access indicators										
Access to NDA specialist disability services										
Data for this indicator are comparable, subject to caveats (chapter 14)										
<i>Proportion of potential population (revised method) accessing State and Territory delivered disability support services</i>										
%	20.8	31.1	15.4	21.4	34.4	35.9	36.3	12.4	23.7	14A.16
Service use by severity of disability										
Data for this indicator are comparable, subject to caveats (chapter 14)										
<i>Proportion of users of NDA State and Territory delivered services (aged 0-64 years), by severity of disability who need help with Assisted Daily Living</i>										
Data for this indicator are comparable, subject to caveats (chapter 14)										
%	71.2	49.0	86.6	88.1	81.3	82.2	77.7	83.2	69.3	14A.28
Service use by special needs groups										
<i>Proportion of Indigenous potential population who use State and Territory delivered disability support services</i>										
Data for this indicator are comparable, subject to caveats (chapter 14)										
%	24.6	62.1	18.8	36.1	46.1	12.2	42.9	16.1	27.6	14A.45
Access to community accommodation and care services										
<i>Users of NDA community accommodation and care services as a proportion of all accommodation support service users</i>										
Data for this indicator are comparable, subject to caveats (chapter 14)										
%	82.2	96.2	86.9	89.9	87.5	83.9	100.0	100.0	88.2	14A.65
Assistance for younger people with disability in residential aged care										
<i>Rate of younger people admitted to permanent residential aged care per 10 000 potential population</i>										
Data for this indicator are comparable, subject to caveats (chapter 14)										
%	30.0	27.0	24.1	25.2	35.6	37.0	14.2	32.3	27.9	14A.69
Efficiency indicators										
Government contribution per user of non-government provided services										
<i>Government funding per user of non-government provided accommodation support services in institutional/residential setting</i>										
Data for this indicator not complete or not directly comparable (chapter 14)										
\$	44 065	44 105	49 739	69 151	53 436	39 523	..	..	49 122	14A.82

(continued on next page)

Table F.4 (continued)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	Source
Cost per user of State and territory administered services										
<i>Total estimated expenditure per service user, State and Territory government administered programs</i>										
Data for this indicator not complete or not directly comparable (chapter 14)										
\$	35 105	22 182	39 481	31 551	17 341	22 148	18 518	49 591	28 216	14A.85
Administrative expenditure as a proportion of total recurrent expenditure										
<i>Administration expenditure as a proportion of total expenditure (excluding actual and imputed payroll tax)</i>										
Data for this indicator not complete or not directly comparable (chapter 14)										
%	8.3	9.2	8.2	4.3	4.9	4.6	8.3	3.7	7.5	14A.86
Outcome indicators										
Labour force participation and employment of people with disability										
<i>Employment rate for people with a profound/severe core activity limitation</i>										
Data for this indicator are comparable, subject to caveats (chapter 14)										
%	90.4	89.0	87.9	88.1	89.3	89.7	96.6	96.3	89.4	14A.87
	±0.9	±0.9	±0.9	±1.0	±0.9	±0.9	±1.0	±1.0	±0.9	
Labour force participation of primary carers of people with disability										
<i>Labour force participation rate for primary carers aged 15-64 years</i>										
Data for this indicator are comparable, subject to caveats (chapter 14)										
%	55.4	52.2	52.5	53.4	50.8	52.7	67.7	62.5	53.6	14A.105
	±7.0	±5.5	±6.5	±10.5	±3.6	±10.3	±13.5	±19.3	±3.6	
Social participation of people with disability										
<i>People with a profound/severe disability aged 5-64 years who have had face to face contact with ex-household family or friends in the previous week</i>										
Data for this indicator are comparable, subject to caveats (chapter 14)										
%	69.5	76.0	71.5	76.9	71.1	70.1	77.8	78.6	72.5	14A.110
	±5.1	±5.1	±6.4	±3.5	±4.2	±9.2	±11.8	±20.4	±3.4	
Use of other services by people with disability										
<i>Data for this indicator were not available for the 2012 Report</i>										

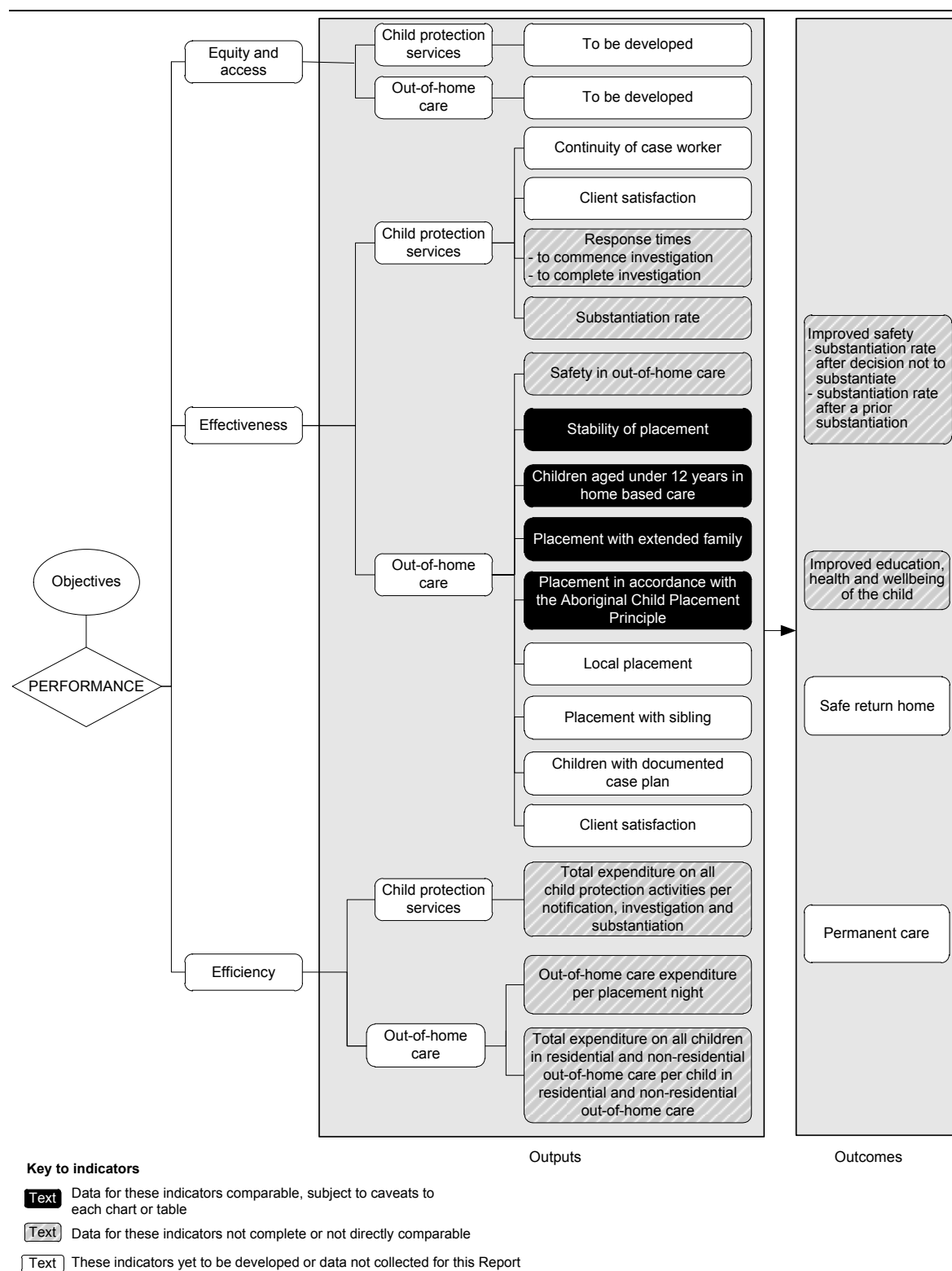
^a Caveats for these data are available in Chapter 14 and Attachment 14A. Refer to the indicator interpretation boxes in chapter 14 for information to assist with the interpretation of data presented in this table. ^b Some data are derived from detailed data in Chapter 14 and Attachment 14A. ^c Data are for 2009. ^d Data are as at 30 June 2009. ^{na} Not available. – Nil or rounded to zero.

Source: Chapter 14 and Attachment 14A.

Protection and support services

The performance indicator framework for child protection and out-of-home care services is presented in figure F.4. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of protection and support services.

Figure F.4 Child protection and out-of-home care services performance indicator framework



An overview of child protection and out-of-home care services performance indicator results for 2010-11 are presented in table F.5. Information to assist the

interpretation of these data can be found in the indicator interpretation boxes in chapter 15 and the footnotes in attachment 15A.

Table F.5 Performance indicators for child protection and out of home care services, 2010-11^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	Source
Effectiveness — child protection indicators										
Response times										
Data for this indicator are not complete or not directly comparable (chapter 15)										
<i>Proportion of investigations completed within 28 days of notification</i>										
%	na	29.0	23.7	29.5	37.0	29.9	69.8	56.0	..	15A.15
<i>Proportion of investigations completed in more than 90 days from notification</i>										
%	na	31.1	37.0	38.0	20.7	21.5	1.1	20.2	..	15A.15
Substantiation rate										
Data for this indicator are not complete or not directly comparable (chapter 15)										
<i>Proportion of finalised child protection investigations that were substantiated</i>										
%	35.3	58.9	38.8	32.5	48.3	64.3	43.4	51.9	..	Fig.15.7
Effectiveness — out-of-home care indicators										
Safety in out-of-home care										
Data for this indicator are not complete or not directly comparable (chapter 15)										
<i>Children in care who were the subject of a substantiation as a proportion of all children in care</i>										
%	0.5	0.9	2.3	0.1	0.3	2.3	1.2	na	..	15A.25
Stability of placement										
Data for this indicator are comparable, subject to caveats (chapter 15)										
<i>Proportion of children on a care and protection order exiting care after less than 12 months in 1 or 2 placements</i>										
%	86.4	75.6	89.9	na	79.6	72.2	82.5	89.0	83.2	15A.24
<i>Proportion of children on a care and protection order exiting care after 12 months or more in 1 or 2 placements</i>										
%	55.6	47.8	44.7	na	45.5	33.3	47.5	44.3	48.7	15A.24
Children aged under 12 years in home-based care										
Data for this indicator are comparable, subject to caveats (chapter 15)										
<i>Proportion of children aged under 12 years in out-of-home care who were in a home-based placement at 30 June</i>										
%	99.7	97.6	97.8	91.2	90.6	96.7	98.1	90.4	97.4	15A.23
Placement with extended family										
Data for this indicator are comparable, subject to caveats (chapter 15)										
<i>Proportion of children in out-of-home care placed with relatives/kin at 30 June</i>										
%	56.0	42.0	32.3	43.8	41.6	33.5	51.9	16.7	45.9	15A.21

(continued on next page)

Table F.5 (continued)

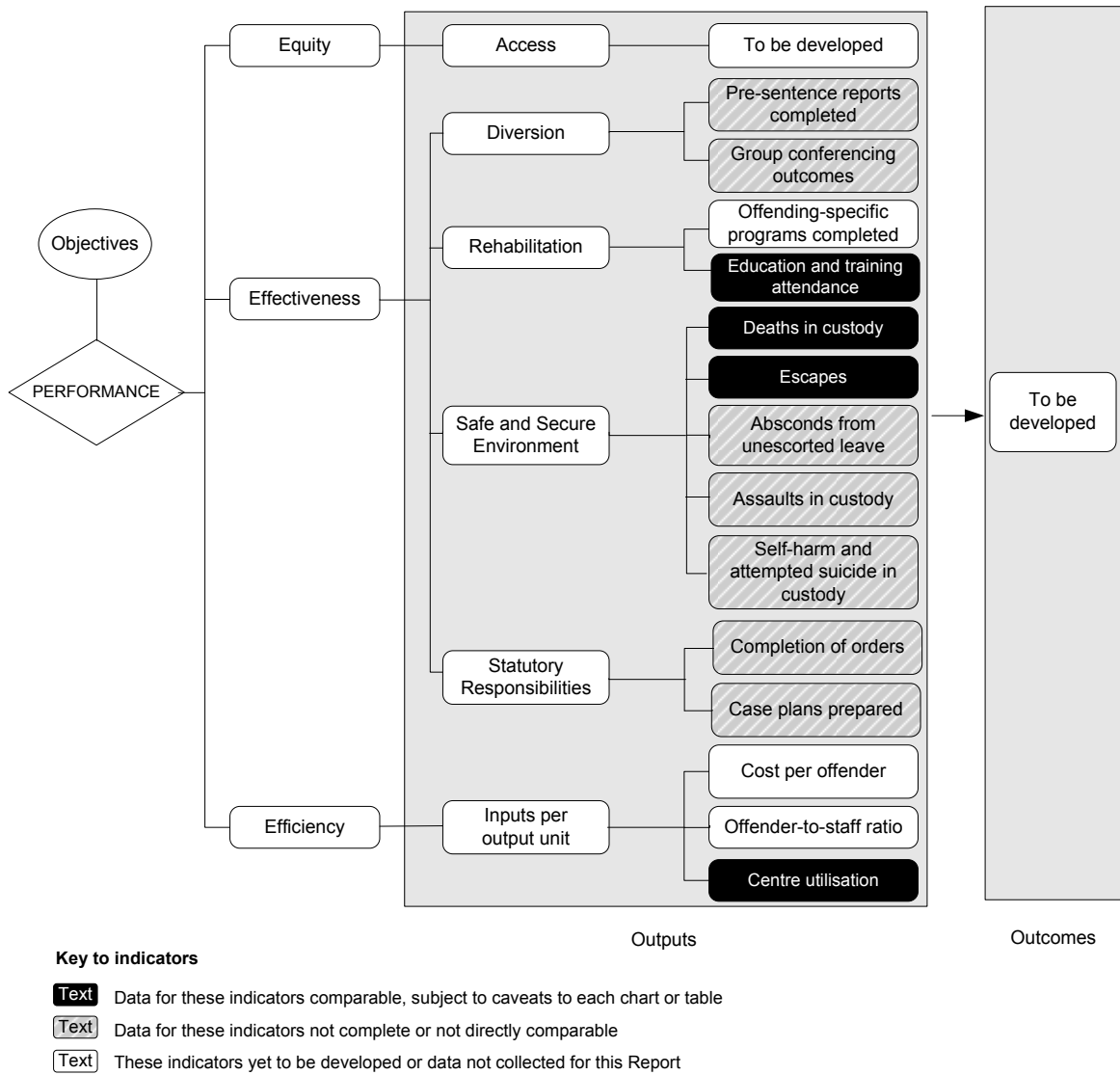
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>	<i>Source</i>
Placement in accordance with Aboriginal Child Placement Principle										
Data for this indicator are comparable, subject to caveats (chapter 15)										
<i>Proportion of Indigenous children placed in accordance with the Aboriginal Child Placement Principle</i>										
%	82.4	57.5	52.5	71.2	74.8	42.9	63.9	33.5	69.2	15A.22
Efficiency – child protection services										
Total expenditure on all child protection activities, per notification, investigation and substantiation										
Data for this indicator are not complete or not directly comparable (chapter 15)										
<i>Expenditure per notification</i>										
\$	3633	3114	13634	6097	1897	1834	871	4743	..	15A.2
<i>Expenditure per investigation</i>										
\$	5031	12447	13634	9539	6899	8604	6105	7758	..	15A.2
<i>Expenditure per substantiation</i>										
\$	19312	22704	44748	35090	18072	16001	16049	18881	..	15A.2
Efficiency – out-of-home care services										
Total expenditure on all out-of-home care divided by the number of children in all out-of-home care at 30 June										
Data for this indicator are not complete or not directly comparable (chapter 15)										
\$	41850	56617	48600	65831	56060	40517	51635	75395	..	15A.3
Out-of-home care expenditure per placement night										
Data for this indicator are not complete or not directly comparable (chapter 15)										
\$	116.7	143.9	137.5	184.3	156.0	116.2	145.0	221.8	135.3	15A.32
Outcomes										
Improved safety										
Data for this indicator are not complete or not directly comparable (chapter 15)										
<i>Substantiation rate after decision not to substantiate, 3 months</i>										
%	3.8	3.2	3.2	0.5	3.4	6.5	10.5	5.2	..	15A.9
<i>Substantiation rate after decision not to substantiate, 12 months</i>										
%	10.7	10.1	8.7	1.8	12.0	18.3	24.2	15.0	..	15A.9
<i>Substantiation rate after a prior substantiation, 3 months</i>										
%	8.8	3.0	8.0	1.1	6.5	8.1	11.9	8.9	..	15A.10
<i>Substantiation rate after a prior substantiation, 12 months</i>										
%	19.5	20.3	17.7	3.1	15.8	20.1	25.1	21.2	..	15A.10

^a Caveats for these data are available in Chapter 15 and Attachment 15A. Refer to the indicator interpretation boxes in chapter 15 for information to assist with the interpretation of data presented in this table. ^b Some data are derived from detailed data in Chapter 15 and Attachment 15A. .. Not applicable. **na** Not available. – Nil or rounded to zero.

Source: Chapter 15 and Attachment 15A.

The performance indicator framework for juvenile justice services is presented in figure F.5. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of juvenile justice services.

Figure F.5 Juvenile justice services performance indicator framework



An overview of juvenile justice services performance indicator results for 2010-11 are presented in table F.6. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 15 and the footnotes in attachment 15A.

Table F.6 Performance indicators for juvenile justice services, 2010-11^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	Source
Effectiveness — diversion										
Pre-sentence reports completed										
Data for this indicator are not complete or not directly comparable (chapter 15)										
<i>Proportion of pre-sentence reports completed by juvenile justice agencies</i>										
%	100.0	99.9	na	98.6	na	100.0	95.5	100.0	99.4	15A.178
Group conferencing outcomes										
Data for this indicator are not complete or not directly comparable (chapter 15)										
<i>Proportion of group conferences resulting in an agreement</i>										
%	99.0	100.0	95.4	na	87.8	91.9	99.1	na	94.2	15A.179
Effectiveness — rehabilitation										
Education and training attendance										
Data for this indicator are comparable, subject to caveats (chapter 15)										
<i>Proportion of young people in detention of compulsory school age attending an education course</i>										
%	100.0	63.6	100.0	92.1	100.0	100.0	100.0	100.0	97.4	15A.181
Effectiveness – safe and secure environment										
Deaths in custody										
Data for this indicator are comparable, subject to caveats (chapter 15)										
no.	—	—	—	—	—	1.0	—	—	1.0	15A.180
Escapes										
Data for this indicator are comparable, subject to caveats (chapter 15)										
<i>Rate of escapes from detention per 10 000 custody nights</i>										
%	—	—	—	0.2	—	1.1	1.2	—	0.1	15A.182
<i>Rate of escapes from escorted movement per 10 000 custody nights</i>										
%	3.4	—	—	—	—	13.4	—	na	2.9	15A.182
Absconds from unescorted leave										
Data for this indicator are not complete or not directly comparable (chapter 15)										
<i>Rate of absconds per 1000 periods of unescorted leave</i>										
%	—	—	—	—	—	—	—	—	—	15A.183
Assaults in custody										
Data for this indicator are not complete or not directly comparable (chapter 15)										
<i>Rate of young people and staff injured as a result of a serious assault per 10 000 custody nights</i>										
%	—	—	0.4	na	na	—	—	—	..	15A.184
<i>Rate of young people and staff injured as a result of an assault per 10 000 custody nights</i>										
%	4.3	na	3.4	na	na	na	np	12.0	..	15A.185

(continued on next page)

Table F.6 (continued)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	Source
<i>Self-harm and attempted suicide in custody</i>										
Data for this indicator are not complete or not directly comparable (chapter 15)										
<i>Rate of incidents of self-harm in custody requiring hospitalisation per 10 000 custody nights</i>										
%	0.1	0.2	–	na	na	–	np	–	..	15A.186
<i>Rate of incidents of self-harm in custody that did <u>not</u> require hospitalisation per 10 000 custody nights</i>										
%	2.2	2.6	0.6	na	na	11.7	np	1.4	..	15A.186
<i>Completion of orders</i>										
Data for this indicator are not complete or not directly comparable (chapter 15)										
<i>Proportion of community-based orders successfully completed</i>										
%	85.8	86.3	75.8	63.4	65.2	90.3	69.6	na	79.0	15A.187
<i>Case plans prepared</i>										
Data for this indicator are not complete or not directly comparable (chapter 15)										
<i>Proportion of case plans prepared or reviewed within 6 weeks of commencing a sentenced detention order</i>										
%	100.0	91.4	85.6	100.0	na	na	76.9	na	93.0	15A.188
<i>Proportion of case plans prepared or reviewed within 6 weeks of commencing a sentenced community-based order</i>										
%	97.3	96.3	75.3	90.4	na	na	98.9	na	86.4	15A.188
Efficiency indicators										
<i>Centre utilisation</i>										
Data for this indicator are comparable, subject to caveats (chapter 15)										
%	81.0	82.6	76.7	79.5	64.1	70.7	59.4	60.6	77.5	15A.189

^a Caveats for these data are available in Chapter 15 and Attachment 15A. Refer to the indicator interpretation boxes in chapter 15 for information to assist with the interpretation of data presented in this table. ^b Some data are derived from detailed data in Chapter 15 and Attachment 15A. .. Not applicable. na Not available. np Not published. – Nil or rounded to zero.

Source: Chapter 15 and Attachment 15A.

F.3 Cross-cutting and interface issues

Community services pathways

Although this Report discusses three areas of community services in separate chapters, it is recognised that there are many linkages between different community services. Governments are increasingly emphasising the need for integrated, client centred community services.

Many community services are linked by the provision of different services to individuals at different stages of life. Other services are not as strictly age-specific and some individuals may receive multiple services at the same time — for example, a child who is in receipt of juvenile justice services together with homelessness, child protection or disability services. Disability services can continue throughout an individual's lifetime and overlap with the provision of aged care services.

The sequence of interventions or services can be referred to as 'pathways' of community service provision. However, there is limited information on the patterns of access by individuals to the range of community services, either concurrently or in succession over a lifetime. A greater understanding of the links between the use of various community services, the nature of these links, and whether interventions in one area of service provision result in reduced need for other services, will help to inform government social policy agendas.

Examples of relevant research include:

- a cohort study carried out in Queensland, which found a correlation between contact with child protection services and the juvenile justice system. Of the 24 255 children born in 1983 or 1984 who had a contact with one or more of child protection services, police cautioning or children's courts, 6.2 per cent had both a child protection services contact and a children's court appearance. These 1500 children represented 28.7 per cent of those with a children's court appearance and 15.7 per cent of those with a child protection history (Stewart, Dennison and Hurren 2005)
- a Community and Disability Services Ministers' Advisory Council (CDSMAC) funded project being undertaken by the AIHW involving the linkage of available Supported Accommodation Assistance Program data, juvenile justice data and child protection data. This project involves analysing the characteristics and pathways of children and young people who are involved in these sectors
- a FaHCSIA longitudinal study of Indigenous children (*Footprints In Time*) into the links between early childhood experiences and later life outcomes for Aboriginal and Torres Strait Islander children, covering areas such as health, culture, education, housing and family relationships (FaHCSIA 2008)
- The Australian Community Sector Survey (ACSS) was undertaken from 1 July 2009 – 30 June 2010. The ACSS is an annual national survey which collects data about the non-government, non-profit community services and welfare sector (Australian Council of Social Service 2011).

In September 2009, the Australian Government launched the Australian Institute for Population Ageing Research (AIPAR), based at the University of New South Wales. The AIPAR will bring together cross-disciplinary research on the issue of population ageing to inform economic and social policy. The AIPAR will also maintain a 'Longevity Index' to track the extent to which Australians are able to maintain their living standards over their lifetime (UNSW 2009).

On 30 April 2009, COAG endorsed *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020* ("the National Framework"). The National Framework argues that Australia needs to think more broadly about the notion of 'protecting children'. Rather than defining 'protecting children' as a statutory response to abuse and neglect, the National Framework contends protecting children should be seen as a community and cross-sector responsibility. The National Framework is intended to deliver a more integrated response to protecting Australia's children and emphasises the role of government, the non-government sector, and the community in achieving these aims. As reporting for the National Framework progresses, the Steering Committee will consider the suitability of some of the high-level, cross-sector performance indicators in the National Framework for inclusion in the Community services sector summary in the 2012 Report.

There are also links between community services and other government services. Access to effective community services can influence outcomes for clients of education, health, housing and justice sector services. In turn, access to these other service areas can affect community services outcomes.

The community services and health sectors are closely related and their effective interaction assists the provision of services in both sectors. The disability sector is also strongly linked to health services by the needs of clients, as people with disability tend to have a larger number of poor health conditions than the general population (AIHW 2006). Other links, such as the role of medical and other health professional staff as a source of child protection notifications, also reinforce the importance of the relationship between community services and health.

HACC across the community services sector

Within the Report, HACC services are included in the Aged care services chapter, but the scope of the program is wider than aged care. Provision of HACC services is primarily to older people, but younger people with disability and carers are also important recipients of HACC assistance. The HACC National Program Guidelines

note that the Program provides funding for services that support both frail aged people and younger people with disability and their carers:

- who live at home and whose capacity for independent living is at risk
- who are at risk of premature or inappropriate admission to long term residential care (Australian Government 2007).

The HACC program is jointly funded by the Australian Government and State and Territory governments under the HACC Review Agreement. In 2010-11, government expenditure on the HACC program was around \$2.1 billion. The Australian Government provided approximately 60 per cent of funding and the State and Territory governments approximately 40 per cent (table 13A.9). The HACC Review Agreement and the associated Special Purpose Payment (SPP) ceased on 30 June 2011. From 1 July 2011, the Australian Government has assumed funding and program responsibility for aged care including HACC services (now called basic community care) provided to people aged 65 years or over (aged 50 years or over for Indigenous Australians) for states and territories (with the exception of Victoria and WA). States and territories will assume responsibility for funding and regulating HACC services delivered to people aged under 65 years (aged 50 years or under for Indigenous Australians) (COAG 2010a; COAG 2010b).

In 2010-11, 23 per cent of HACC clients were aged under 65 years (no change from 2009-10). Analysis of data from the HACC program in 2010-11 indicates that clients aged under 65 years were significantly over-represented in particular assistance types, including respite care (67 per cent), case management (49 per cent), carer counselling support (47 per cent) and personal care (42 per cent) (DoHA unpublished). In 2010-11, 15 per cent of HACC clients nationally were in receipt of a Disability Support Pension. This proportion had increased from 14 per cent in 2009-10. In 2010-11, 28 per cent of HACC clients classified as care recipients reported that they were also receiving assistance from a relative or friend/carer (DoHA unpublished).

F.4 Future directions in performance reporting

This community services sector summary will continue to be developed in future reports.

The Aged care services, Service for people with disability, and Protection and support services chapters contain a service-specific section on future directions in performance reporting.

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13 Aged care services

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13.1 Profile of aged care services	13.2
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Attachment tables

Attachment tables are identified in references throughout this chapter by a '13A' prefix (for example, table 13A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

The aged care system comprises all services specifically designed to meet the care and support needs of older people living in Australia. This chapter focuses on government funded residential and community care for older people and services designed for the carers of older people. Some government expenditure on aged care is not reported, but continual improvements are being made to the coverage and quality of the data.

Major improvements in reporting on aged care services this year include:

- reporting of the following new measures:
 - the proportion of all eligible resident care days that are for all supported, concessional or assisted residents under the ‘use by different groups’ indicator
 - the cost per hour of Home and Community Care (HACC) service for domestic assistance, personal care, nursing and allied health under the ‘cost per unit of output’ indicator
 - Australian Government expenditure on residential aged care, selected community aged care programs, multipurpose services and Indigenous specific services under the ‘expenditure per head of target population’ indicator
- expansion of time series data reporting in some attachment tables, in particular six years of data are now reported for most aged care expenditure and HACC data
- inclusion of new data quality information (DQI) documentation.

Older Australians are also users of other government services covered in this Report, including specialised mental health services (chapter 12), disability services (chapter 14), and housing assistance (chapter 16). Understanding the relationship between the health system and the aged care system is of particular importance (sector summary E and chapters 10–12), given that people aged 65 years or over account for around 50 per cent of all patient days in public hospitals (AIHW 2010). Interactions between health and aged care services are critical for the performance of both systems, for example, the number of operational residential aged care places can affect demand for public hospital beds, and throughput of older patients in acute and sub-acute care has a substantial effect on the demand for residential and community aged care.

13.1 Profile of aged care services

Service overview

Services for older people are provided on the basis of the frailty or functional disability of the recipients, as distinct from specific age criteria. Nevertheless, in the absence of more specific information, this Report uses people aged 70 years or over as a proxy for the likelihood of a person in the general population requiring these services. Particular groups (notably Indigenous people) can 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. People aged 70 years or over and Indigenous people aged 50–69 years are used as a proxy ‘target’ population for aged care services in this Report. The Australian Government uses this population as a ‘planning population’ to allocate aged care places under the *Aged Care Act 1997*. Nationally, in 2010-11, the proportion of the population who are in this category was 10.0 per cent, although the proportion varies across jurisdictions (tables 13A.1 and 13A.2).

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 services covered include:

- assessment and information services, which are largely provided by the Aged Care Assessment Program (ACAP)
- residential care services, which provide permanent high and low level care, and respite high and low level care
- community care services, including home-based care and assistance to help older people remain, or return to, living independently in the community as long as possible. These services include:
 - HACC program services
 - Community Aged Care Packages (CACP)
 - flexible care services provided under the Extended Aged Care at Home (EACH) and the EACH-Dementia (EACH-D) programs
 - services provided by the Department of Veterans’ Affairs (DVA) under the Veterans’ Home Care (VHC)¹ and Community Nursing programs
- community care respite services, which include HACC respite and centre-based day care services and services provided under the National Respite for Carers Program (NRCP)
- services provided in mixed delivery settings, which are designed to provide flexible care or specific support:
 - flexible care services, which address the needs of care recipients in ways other than that provided through mainstream residential and community care — services are provided under the Transition Care Program (TCP), Multi-purpose Service Program (MPS), Innovative Care Pool and National Aboriginal and Torres Strait Islander Flexible Aged Care Program

¹ Unless otherwise stated, HACC expenditure excludes the DVA expenditure on VHC.

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- specific support services, which are provided to address particular needs such as those under the Long Stay Older Patients initiative and in Day Therapy Centres.

The formal publicly funded services covered represent only a small proportion of total assistance provided to 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 2009 who required help with self-care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 2011). 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

The funding and regulation of aged care services are predominantly the role of the Australian Government (although all three levels of government are involved). The *Aged Care Act 1997*, together with the accompanying *Aged Care Principles*, are the main regulatory instruments establishing the aged care framework. Key provisions covered include service planning, user rights, eligibility for care, funding, quality assurance and accountability (Productivity Commission 2010).

The roles and responsibilities outlined in this section apply up until 30 June 2011, which is the end of the period to which most of the reported data apply. From 1 July 2011, the roles and responsibilities that apply to aged care and disability services changed under the *Heads of Agreement — National Health Reform* (box 13.1). This could affect reporting for future editions of the Report.

Box 13.1 National Health Reform Agreement

The Australian, State and Territory governments committed to the National Health Reform Agreement on 2 August 2011 and will see all governments working together to reform the health and aged care systems. The Agreement reaffirmed previous commitments on aged care made at Council of Australian Governments (COAG) meetings on 13 February 2011 under the *Heads of Agreement — National Health Reform* and on 10 April 2010 under the *National Health and Hospitals Network Agreement*.

Under the *National Health Reform Agreement* the agreed policy and funding responsibilities of Australian, State and Territory governments (other than for Victoria and WA) are as follows:

- The Australian Government is responsible for:
 - regulating packaged community (CACP, EACH and EACH-D) and residential aged care
 - funding packaged community and residential aged care for people aged 65 years or over (50 years or over for Indigenous people)
 - funding and regulating basic community care services (previously delivered under the HACC program) for people aged 65 years or over (50 years or over for Indigenous people)
 - funding specialist disability services delivered by the State and Territory governments under the *National Disability Agreement* (NDA) for people aged 65 years or over (50 years or over for Indigenous people).
- State and Territory governments are responsible for:
 - regulating specialist disability services delivered under the NDA
 - funding and regulating basic community care services (previously delivered under the HACC program) for people aged under 65 years, except for Indigenous people aged 50 years or over
 - funding packaged community (CACP, EACH and EACH-D) and residential aged care for people aged under 65 years, except Indigenous people aged 50 years or over.

The basic community care reforms for aged care will occur over two phases (except in Victoria and WA). From 1 July 2011, the Australia Government will assume funding and policy responsibility for basic community care services for people aged 65 years or over (50 years or over for Indigenous people), and from 1 July 2012, will also assume operational responsibility for these services.

Unless otherwise agreed, the changes to roles and responsibilities for basic community care, aged care and specialist disability services and the reconciliation arrangements do not apply to Victoria and WA. In these States, basic community care will continue to be delivered under HACC as a joint Australian and State governments' funded program. The Australian Government and these State governments will maintain bilateral agreements for that purpose.

(Continued next page)

Box 13.1 (Continued)

A key objective in implementing the new arrangements will be to minimise disruption for care recipients and providers in both the aged care and disability support systems. In 2011-12, for aged care the Australian Government will develop and implement the program framework and information technology systems needed to support these changes. During the transition, care recipients will continue to receive services from their current providers.

Other Australian Government aged care initiatives that will be implemented from 1 July 2011 include:

- the introduction of a single entry point for aged care, beginning with a new national telephone number and improved website, with the aim of making it easier for older people and their carers to access information about aged care
- effective from 1 October 2011, enhanced prudential regulations to better protect the bonds paid by older people to residential aged care providers
- 2010-11 Budget funding to State and Territory governments to contribute to ensuring that Long Stay Older Patients receive appropriate care while they remain in hospital for longer than would otherwise be necessary while they secure an appropriate community or residential aged care place.

Aged Care Assessment Program

The Australian Government established the ACAP in 1984. Under the ACAP, assessments are undertaken by an Aged Care Assessment Team (ACAT) and an approval is mandatory to be eligible for admission to Australian Government subsidised residential care (including respite) or to receive a CACP, EACH package, EACH-D package or enter the TCP. People can also be referred by an ACAT to other services, such as those funded by the HACC program (although an ACAT referral is not mandatory for receipt of these other services).

The Australian Government has oversight of policy and guidelines, and provides funding to State and Territory governments specifically to operate ACATs. State and Territory governments are responsible for the day to day operation and administration of the ACAP, including the provision of the necessary accommodation and some support services. The scope and practice of the ACATs differ across and within jurisdictions, partly reflecting the service setting and location (for example, whether the team is attached to a hospital or a community service) and this has an effect on program outputs.

In 2010-11, Australian Government funding for the ACAP was provided to the State and Territory governments under the ACAP Implementation Plan 2010–2012 of the National Partnership Agreement on Health Services. The Implementation

Plan sets Key Performance Indicators for the State and Territory governments, and allows for payments to be made to the State and Territory governments on achievement of program milestones up until June 2012. The Implementation Plan continues the approach adopted under the February 2006 Council of Australian Governments (COAG) measure (an initiative to simplify access to care services for the elderly, people with disability and people leaving hospital) to improve the timeliness, consistency and quality of ACAT assessments. The Australian Government is also continuing a range of activities commenced under the measure, including:

- the implementation of a set of validated assessment tools
- the continued provision of national training resources for the ACAP.

Residential care services

The Australian Government is responsible for most of the regulation of Australian Government subsidised residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local governments may also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 13.2).

Box 13.2 Examples of regulatory arrangements for residential services

The Australian Government controls the number of subsidised residential care places. The current provision ratio for residential aged care is 88 operational places per 1000 people aged 70 years or over. More detail on the provision ratios across aged care services is provided in box 13.11.

Under the arrangements:

- services are expected to meet regional targets for places for concessional, assisted and supported residents. These targets range from 16 per cent to 40 per cent of places and are intended to ensure that residents who cannot afford to pay an accommodation bond or charge have equal access to care. (The criteria for being deemed a concessional or assisted resident are based on the date of the resident's entry to care, home ownership and occupancy, receipt of income support and the level of assets held at entry. The criteria for being deemed a supported resident are based on the resident's entry date and level of assets held at entry)
- extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted

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Box 13.2 (Continued)

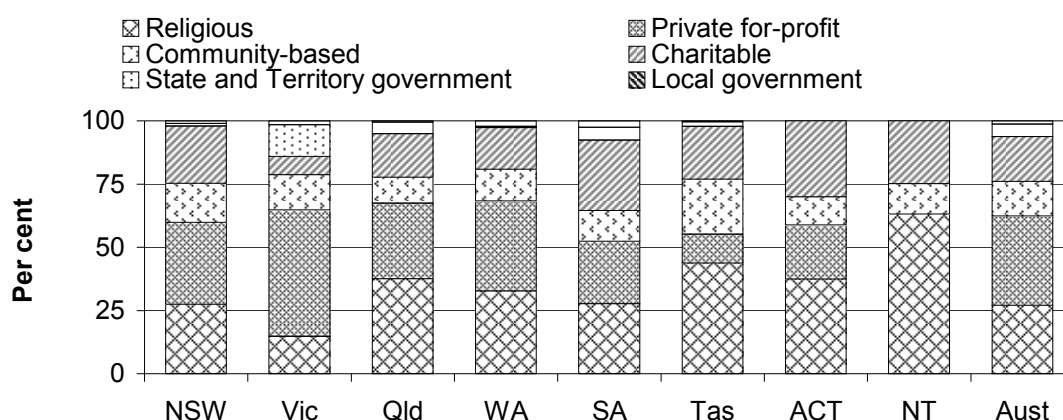
- to receive an Australian Government subsidy, an operator of an aged care service must be approved under the Aged Care Act 1997 as a provider of aged care
- principles (regulations) created under the Aged Care Act 1997 establish the obligations of approved providers relating to quality of care and accommodation.

Various Australian, State and Territory laws govern regulatory arrangements for residential care. State and Territory legislation may prescribe matters such as staffing, the administration of medicines and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, and fire prevention and firefighting measures. Industrial relations arrangements and outcomes vary between and within jurisdictions.

Source: DoHA (unpublished).

Religious and private for-profit organisations were the main providers of residential care at June 2011, accounting for 27.1 per cent and 35.3 per cent respectively of all Australian Government subsidised residential aged care places. Community-based organisations and charitable organisations accounted for a further 13.7 per cent and 17.7 per cent respectively. State, Territory and local governments provided the remaining 6.2 per cent (figure 13.1).

Figure 13.1 Ownership of operational residential places, June 2011^{a, b, c}



^a Community-based residential services provide a service for an identifiable community based on locality or ethnicity, not for financial gain. ^b Charitable residential services provide a service for the general community or an appreciable section of the public, not for financial gain. ^c Data exclude the flexible places provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Innovative Pool programs and care provided by Multi-purpose Services.

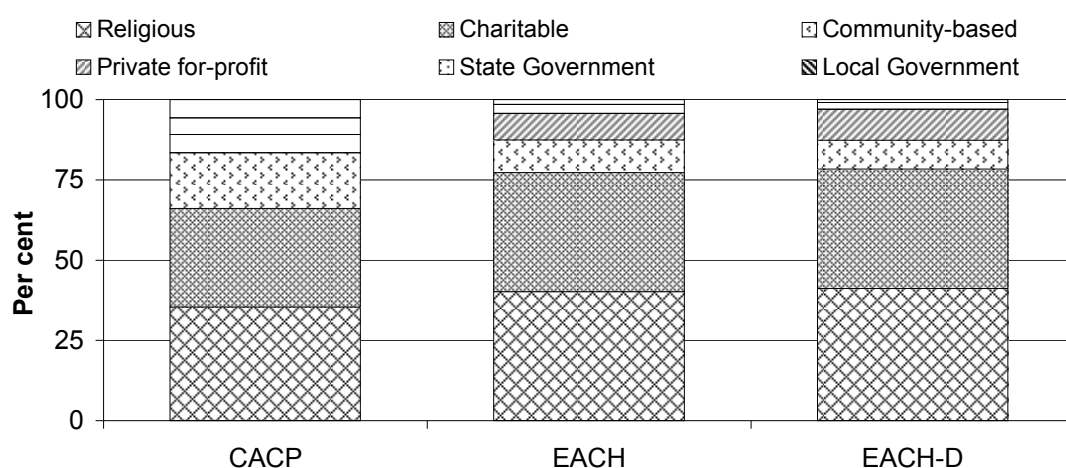
Source: Department of Health and Ageing (DoHA) (unpublished); table 13A.16.

Community care services

The main community care programs reported in this chapter are the HACC, CACP, EACH, EACH-D and the DVA VHC and community nursing programs. The HACC program is a joint Australian Government, and State and Territory governments' initiative administered under the *Home and Community Care Act 1985* (DoHA 2011). The State and Territory governments provide the day to day management and the Australian Government provides national oversight for the program. HACC service providers vary from small community-based groups to large charitable and public sector organisations.

The Australian Government (Department of Health and Ageing [DoHA]) is responsible for the policy oversight and regulation of the CACP, EACH and EACH-D programs. Religious and charitable organisations were the main providers of Australian Government subsidised community care places across the three programs at June 2011 (figure 13.2). EACH and EACH-D services are considered flexible care under the *Aged Care Act 1997*, but because of their nature are classified in this chapter as community care.

Figure 13.2 Operational CACP, EACH and EACH-D places, by provider type, June 2011^{a, b}



^a Community-based organisations provide a service for an identifiable community based on locality or ethnicity, not for financial gain. ^b Charitable organisations provide a service for the general community or an appreciable section of the public, not for financial gain.

Source: DoHA (unpublished).

The Australian Government (DVA) is primarily responsible for policy oversight and regulation of the VHC programs and community nursing services for veterans and war widows/widowers. These services are delivered primarily by organisations contracted by DVA. There were 75 341 people approved for VHC services in

2010-11 and 31 857 people receiving community nursing services (table 13A.13), including services provided to assist carers.

Services provided in mixed delivery setting

Two categories of services are defined in this Report as being provided in mixed delivery settings:

- flexible care services provided under the:
 - *Aged Care Act 1997*
 - National Aboriginal and Torres Strait Islander Flexible Aged Care Program
- specific support services.

Flexible care services under the Aged Care Act 1997

Flexible care services provided in mixed delivery settings that are included under the *Aged Care Act 1997* comprise the TCP, MPS and innovative care places.

- The TCP is jointly funded by the Australian, State and Territory governments. Its operation is overseen by the Transition Care Working Group, which includes representatives from all State and Territory governments and the Australian Government. Within the framework of the program, State and Territory governments, as the approved providers, develop their own service delivery models.
- MPS are a joint initiative between the Australian Government and State and Territory governments. Australian Government aged care funding is combined with State and Territory governments funding for health and aged care to bring a flexible mix and range of aged care and health services together under one management structure. State and local governments are the major providers of MPS, which are primarily located in small rural hospital settings (DoHA 2011).
- The Aged Care Innovative Pool is designed to test new approaches to providing aged care. At the beginning of each financial year, the Australian Government's Minister for Ageing determines the flexible care subsidy rates for the Innovative Pool pilots. Further information on the TCP, MPS, and innovative care pool is provided in box 13.3.

Box 13.3 Flexible care programs provided under the *Aged Care Act*

Transition care

The TCP provides goal-oriented, time-limited and therapy-focused care to help eligible older people complete their recovery after a hospital stay. The TCP is intended to:

- enable a significant proportion of care recipients to return home, rather than prematurely enter residential care
- optimise the functional capacity of those older people who are discharged from transition care to residential care
- reduce inappropriate extended lengths of hospital stay for older people.

Transition care can be provided either in a home-like residential setting or in the community, and targets older people who would otherwise be eligible for residential care. A person may only enter the TCP directly upon discharge from hospital. The average duration of care is around 8 weeks (61 days for completed episodes), with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks.

The TCP operates with some differences across jurisdictions including differences in service systems, local operating procedures and implementation timetables, which are reflected in national data collections. An early evaluation of the impact of the TCP on clients and systems and its cost effectiveness has been undertaken. Key findings of the evaluation were that functional improvement occurred and that older people who received transition care had fewer readmissions to hospital and were less likely to move into permanent residential aged care (DoHA 2008).

Multi-purpose services (MPS)

The MPS Program supports the integration and provision of health and aged care services for small rural and remote communities. Some health, aged and community care services may not be viable in a small community if provided separately. By bringing the services together, economies of scale are achieved to support the services.

Innovative pool

The Aged Care Innovative Pool supports the development and testing of flexible models of service delivery in areas where mainstream aged care services might not appropriately meet the needs of a location or target group. For example, the TCP is built on the lessons learned from two pilot programs developed through the Innovative Pool, which addressed the interface between aged care and hospital care — the Innovative Care Rehabilitation Services and the Intermittent Care Services.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Flexible models of care are also provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. These services are funded and operate outside the regulatory framework of the *Aged Care Act 1997*. Aboriginal and Torres Strait Islander people also access mainstream services under the *Aged Care Act 1997*, including those managed by Aboriginal and Torres Strait Islander organisations.

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program aims to provide quality, flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and community. Flexible Aged Care services can deliver a mix of residential and community aged care services to meet the needs of the community.

Some services managed by non-Indigenous approved providers also have significant numbers of Aboriginal and Torres Strait Islander clients. All aged care services that are funded under the *Aged Care Act 1997* are required to provide culturally appropriate care. Whether they are located in a community or residential setting, services can be subject to specific conditions of allocation in relation to the proportion of care to be provided to particular groups of people, including Aboriginal and Torres Strait Islander people.

Specific support services

A range of programs designed to meet the specific support needs of older people across care settings are funded and operate outside the regulatory framework of the *Aged Care Act 1997*. The Day Therapy Centre Program, for example, provides a wide range of therapy services to older people living in the community and to low care residents of Australian Government funded residential aged care facilities.

The Australian Government established, funds and oversees most of these programs. The Long Stay Older Patient Initiative is one exception. This program was established as part of the COAG national health and aged care agenda. The Australian Government has funded State and Territory governments to provide services under this initiative since 2006-07 (box 13.4).

Box 13.4 Long Stay Older Patient Initiative

From July 2006, a four-year program commenced to improve care for older patients in public hospitals, and particularly those who no longer required hospital care and were awaiting alternative/long term care. This initiative was continued for a further two years in the 2010-11 Budget (to June 2012) and operates under the National Partnership Agreement on Health Services.

States and territories are currently undertaking a range of activities under the program to ensure that older Australians at risk of unnecessary and prolonged hospital stays receive appropriate and quality health care that better meets their needs, through:

- reduction in unnecessary admissions
- improvement in hospital services for older people
- improved transition to appropriate long term care
- improvement in the flexibility and capacity of rural hospitals to provide more age-appropriate services.

Source: COAG (2006); Federal Budget (2010-11).

Funding

Recurrent expenditure on aged care services reported in this chapter was \$12.2 billion in 2010-11 (table 13.1). Table 13.1 does not include all State and Territory government expenditure, for example, the experimental estimates of expenditure on non-HACC post acute packages of care (table 13A.11), and Australian, State or Territory government capital expenditure are excluded (table 13A.12). Data on Australian, State and Territory governments' expenditure per person in the target population by program, jurisdiction and over time are in table 13A.6.

Table 13.1 Recurrent expenditure on aged care services, 2010-11

<i>Expenditure category</i>	<i>\$ million</i>
Assessment and information services ^a	89.1
Residential care services ^b	8 143.3
Community care services ^c	3 423.4
Services provided in mixed delivery settings ^d	517.4
Total	12 173.3

^a Assessment and information services include only Australian Government expenditure. ^b Residential care services include DoHA and DVA (including payroll tax supplement) and State and Territory governments' expenditure. ^c Community care services include HACC, CACP, EACH, EACH-D, NRCP, Community care grants, VHC, DVA Community Nursing and Assistance with Care and Housing for the Aged. ^d Services provided in mixed delivery settings include MPS, TCP, National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Day Therapy Centres, Continence Aids Payment Scheme, National Continence Program, Innovative Care Pool and Dementia Education and Support, Long Stay Older Patient Initiative, Community Visitors Scheme and Culturally and Linguistically Diverse expenditure.

Source: DoHA (unpublished); State and Territory governments (unpublished); table 13A.5.

Assessment services

There were 108 ACATs (107 Australian Government funded) at 30 June 2011 (DoHA unpublished). In 2010-11, the Australian Government provided funding of \$69.1 million nationally for the aged care assessment program (table 13A.7). Australian Government ACAT expenditure per person aged 70 years or over and Indigenous people aged 50–69 years was \$31 nationally during 2010-11 (table 13A.7). State and Territory governments also contribute funding for ACATs, but this expenditure is not included in the chapter.

Aged care assessment program activities and costs for 2009-10 are reported in table 13A.78.

Residential care services

The Australian Government provides most of the recurrent funding for residential aged care services. State and Territory governments provide some funding for public sector beds. Residents provide most of the remaining service revenue, with some income derived from charitable sources and donations.

Australian Government expenditure

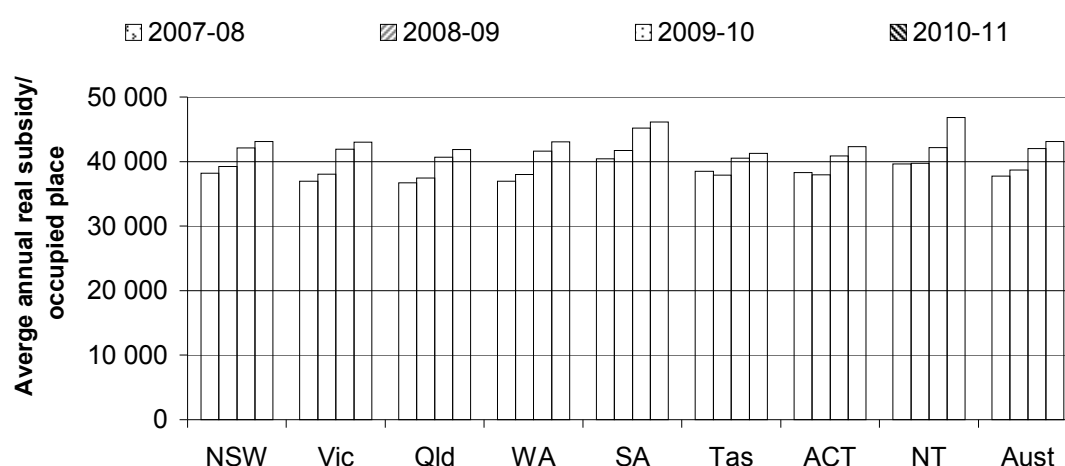
Australian Government expenditure on residential aged care was \$8.0 billion in 2010-11, comprising DoHA expenditure of \$6.7 billion (table 13A.8) and DVA expenditure of \$1.2 billion (table 13A.8).

Australian Government basic subsidy

The Australian Government annual basic subsidy for each occupied place varies according to clients' levels of dependency and includes the Conditional Adjustment Payment (CAP). The CAP was introduced in 2004-05 as part of the Australian Government's initial response to the Review of Pricing Arrangements in Residential Aged Care. The amount of CAP payable in respect of a resident is calculated as a percentage of the basic subsidy amount. Since 2008-09, the percentage has been set at 8.75 per cent.

At June 2011, the average annual subsidy per residential place, including the CAP, was \$43 100 nationally (figure 13.3). Variations across jurisdictions in average annual subsidies reflect differences in the dependency of residents. Rates for aged care services by the level of high and low care places are in table 13A.17.

Figure 13.3 Average annual Australian Government real basic subsidy (all levels) per occupied place, at June (2010-11 dollars)^a



^a See footnotes to table 13A.17 for further information.

Source: DoHA (unpublished); table 13A.17.

The dependency levels of permanent residents are shown in table 13.2. Each permanent resident has a dependency level for each of three domains. These dependency levels vary across jurisdictions. These data, categorised by the proportion of high and low care places provided, are included in table 13A.17.

Table 13.2 Dependency levels of permanent residents, June 2011^{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>
Proportions of residents										
Aged Care Funding Instrument										
Activities of daily living										
High	%	41.0	40.9	41.1	38.2	40.4	36.9	36.7	47.7	40.6
Medium	%	28.9	28.7	30.1	30.2	34.9	30.6	28.7	31.8	29.8
Low	%	25.8	26.8	24.5	28.8	21.8	27.9	29.8	18.2	25.8
Nil	%	4.3	3.6	4.3	2.8	2.9	4.6	4.7	2.3	3.9
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Behaviours										
High	%	49.3	49.4	44.5	48.6	51.9	38.9	52.8	47.5	48.4
Medium	%	23.8	24.5	24.5	23.9	25.6	24.5	25.2	26.0	24.3
Low	%	17.0	17.8	19.0	18.4	16.5	21.4	14.4	18.7	17.7
Nil	%	9.9	8.3	11.9	9.1	6.0	15.1	7.6	7.8	9.5
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Complex health care										
High	%	22.4	23.9	19.4	20.0	32.2	23.2	19.4	32.5	23.0
Medium	%	32.5	33.4	30.8	35.6	33.0	27.7	35.9	29.7	32.7
Low	%	33.0	32.1	35.9	33.6	27.3	34.6	32.1	23.5	32.8
Nil	%	12.1	10.6	13.9	10.8	7.5	14.5	12.5	14.3	11.6
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Numbers of permanent residents										
Total High	no.	42 504	31 846	22 322	10 228	12 537	3 047	1 346	365	124 195
Total Low	no.	14 151	10 889	7 560	3 703	3 012	1 196	488	82	41 081
All										
High/Low	no.	56 655	42 735	29 882	13 931	15 549	4 243	1 834	447	165 276

^a See footnotes to table 13A.17 for further information. ^b Totals may not add as a result of rounding.

^c Information on the Aged Care Funding Instrument (ACFI) and the characteristics of residents is provided in box 13.5.

Source: DoHA (unpublished); table 13A.17.

State and Territory government recurrent expenditure

State and Territory government expenditure has been collected for three categories of residential care expenditure (adjusted subsidy reduction supplement, enterprise bargaining agreement supplement, and rural small nursing home supplement). Reported expenditure in these three categories was \$189.0 million in 2010-11 (table 13A.8).

Capital expenditure

The Australian Government provided \$22.6 million in 2010-11 to fund the ongoing Rural and Regional Building Fund and Targeted Capital Assistance programs (table 13A.12). These programs offer financial assistance, on a competitive basis, to

approved providers of residential aged care services that, as a result of their rural or remote location or because the services target people with special needs as defined by the *Aged Care Act 1997*, are unable to meet the total cost of necessary capital works from the income they receive through all other funding sources including debt finance, resident accommodation payments and the general capital component of Australian Government recurrent funding (table 13A.12). The Australian Government also provided \$7.9 million in 2010-11 to fund the Remote and Indigenous Service Support (RISS) Initiative. In 2010-11, the RISS initiative provided funding to undertake essential maintenance and repairs and upgrades to a range of aged care services providing care in remote communities and to Aboriginal and Torres Strait Islander people. In addition, the Zero Real Interest Loans initiative provides zero real interest loans to residential care providers to build or expand residential and respite facilities in areas of high need. Expenditure on this initiative in 2010-11 was \$7.8 million.

State and Territory governments also provided \$31.6 million in 2010-11 for capital expenditure on residential aged care services (table 13A.12). Capital expenditure on aged care services in 2010-11 is summarised in table 13A.12. These capital funds are in addition to the total recurrent expenditure reported in table 13.1.

Community care services

Following is a summary of expenditure on community care programs (table 13.3). More detailed data are in the attachment tables referenced. Recipients of community care services can also contribute towards the cost of their care.

Total government expenditure on HACC under the HACC Review Agreement was \$2.1 billion in 2010-11, consisting of \$1.3 billion from the Australian Government and \$815.9 million from the State and Territory governments. The Australian Government contributed 61.3 per cent, while State and Territory governments funded the remainder (table 13A.9). Recipients of HACC services also contribute towards the cost of these services.

The Australian Government funds the CACP program, spending \$531.7 million on the program in 2010-11 (table 13.3). CACPs are also partly funded by client contributions. The Australian Government also funds flexible care services under the EACH and EACH-D programs, spending \$246.9 million and \$117.9 million respectively on these programs in 2010-11 (table 13.3). EACH and EACH-D packages are also partly funded by client contributions.

The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was \$202.9 million in 2010-11 (table 13.3). The NRCP assisted 130 477 people in 2010-11 (table 13A.15).

Table 13.3 Governments' expenditure on selected community care programs, 2010-11 (\$million)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
<i>HACC expenditure by the Australian, State and Territory governments under the HACC Review Agreement</i>									
	626.6	506.4	479.3	214.4	176.3	59.7	31.1	13.0	2 106.8
<i>Australian Government expenditure</i>									
CACP	181.7	137.5	88.3	47.4	46.5	14.4	6.8	9.1	531.7
EACH	75.6	61.0	44.4	31.8	17.4	6.4	6.1	4.1	246.9
EACH-D	37.6	27.8	21.7	14.2	9.2	4.0	2.2	1.2	117.9
NRCP	61.2	43.4	33.8	17.3	18.1	6.7	4.0	5.6	202.9

Source: DoHA (unpublished); table 13A.5.

The DVA also provided \$89.6 million for the VHC program and \$120.7 million for veterans community nursing services during 2010-11 (table 13A.9). VHC recipients also contribute towards the cost of these services.

Services provided in mixed delivery settings

Five types of flexible care are provided under the *Aged Care Act 1997* (EACH and EACH-D packages, TCP, MPS and innovative care places). Expenditure relating to EACH and EACH-D is reported in table 13.3. The Australian, State and Territory governments fund the TCP. In 2010-11, the Australian Government spent \$147.9 million and the State and Territory governments spent \$93.8 million on the TCP (table 13A.10). The Australian Government also funds the MPS program (in conjunction with State and Territory governments) and the Innovative Care Pool. In 2010-11, the Australian Government spent \$108.2 million and \$7.4 million on these programs, respectively (table 13A.10). In addition to expenditure on these flexible care programs, the Australian Government spent \$25.3 million on Indigenous specific services delivered under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

Australian Government expenditure data by jurisdiction on a range of other services provided in mixed delivery settings targeting older people are in table 13A.10. Australian Government expenditure was \$97.6 million in 2010-11 on these programs which comprise Day Therapy Centres, Continence Aids Payment Scheme, National Continence Program, Dementia Education and Support, Community Visitors Scheme and support for people from Culturally and Linguistically Diverse (CALD) backgrounds (table 13A.10). In addition, Australian Government

expenditure on the 2006 Long Stay Older Patient Initiative (see box 13.4) was \$37.2 million in 2010-11 (table 13A.5).

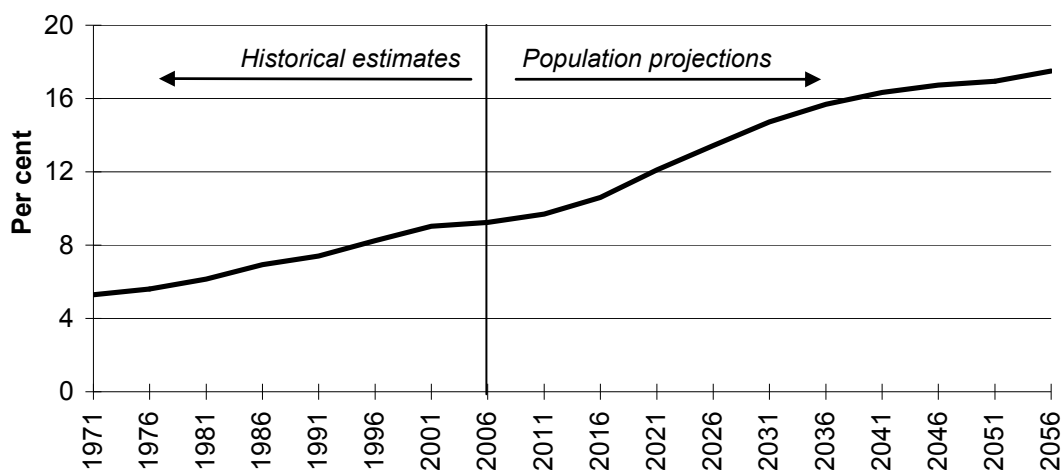
Size and scope of sector

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 during this century (figure 13.4). The proportion of older people is 9.7 per cent nationally but varies across jurisdictions (figure 13.5). A disaggregation by remoteness categorisation is provided in table 13A.3. Higher life expectancy for females resulted in all jurisdictions having a higher proportion of older females than older males in the total population (except the NT) (table 13A.1).

The demand for aged care services is driven by the size and health of the older population. Females comprise a larger proportion of the older population and are more likely to utilise aged care services than males (partly because they are more likely to live alone). Based on the current age-sex specific utilisation rates for residential aged care and packaged community care combined, and projected growth in the size of the older population, it is estimated that the demand for aged care services for people aged 70 years or over will more than treble by 2056 (DoHA unpublished estimate, based on ABS population projections series B in Cat. no. 3222.0).

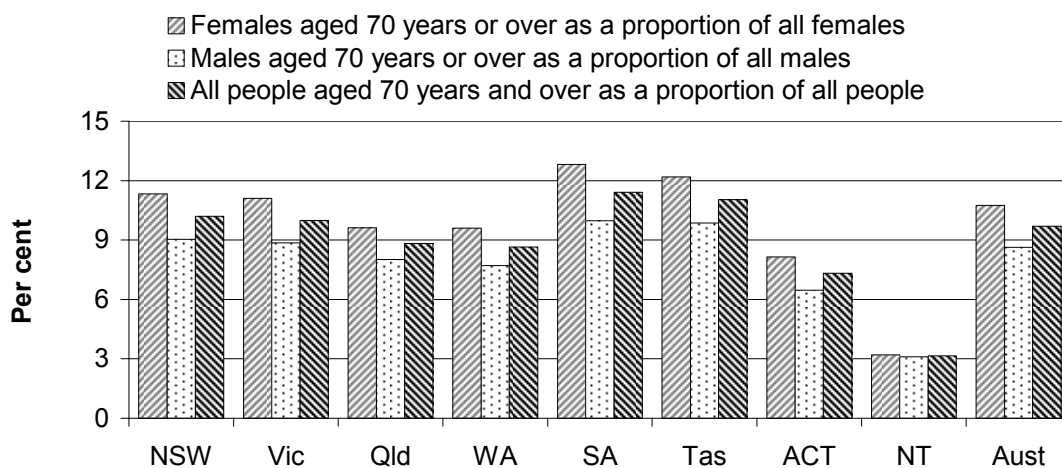
Figure 13.4 People aged 70 years or over as a proportion of the total population^a



^a Population projections are derived from the ABS 'B' series population projections.

Source: ABS (2008) *Australian Historical Population Statistics, 2008*, Cat. no. 3105.0.65.001, Canberra; ABS (2008) *Population Projections Australia 2006–2101*, Cat. no. 3222.0, Canberra.

Figure 13.5 Estimated proportion of population aged 70 years or over, by sex, June 2011



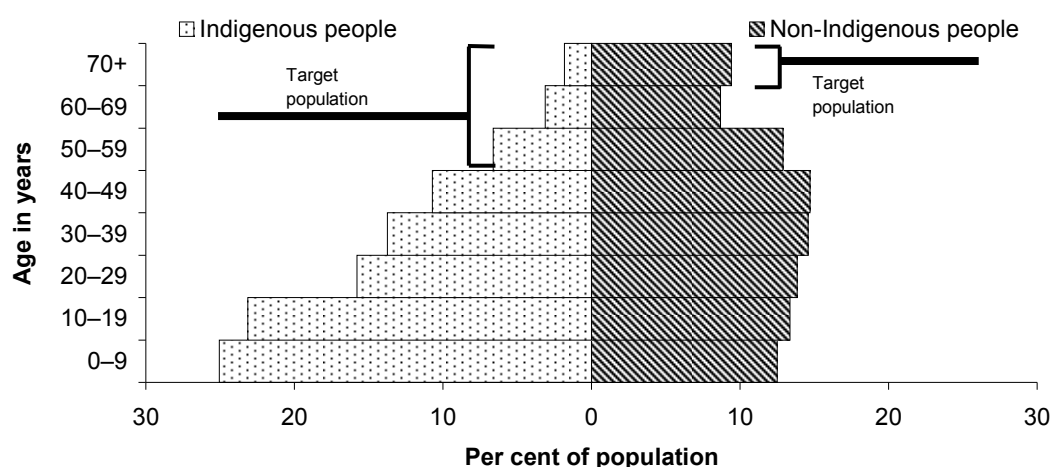
Source: Population projections prepared by the ABS using preliminary rebased estimated resident populations based on the 2006 Census according to assumptions agreed to by the Treasury and DoHA (unpublished); table 13A.1.

Characteristics of older Indigenous people

The DoHA estimates that about 76 324 Indigenous people were aged 50 years or over in Australia at 30 June 2011 (table 13A.2). Although the Indigenous population is also ageing, there are marked differences in the age profile of

Indigenous Australians compared with non-Indigenous Australians (figure 13.6). Estimates show life expectancy at birth in the Indigenous population is around 11.5 years less for males and 9.7 years less for females when compared with the total Australian population (ABS 2009). Indigenous people aged 50 years or over are used in this Report as a proxy for the likelihood of requiring aged care services, compared to 70 years or over for the general population.

Figure 13.6 Age profile and target population differences between Indigenous and other Australians, June 2006



Source: ABS (2008) *Experimental Estimates of Aboriginal and Torres Strait Islander Australians*, June 2006, Cat. no. 3238.0.55.001, Canberra.

Aged Care Assessments

Aged care assessments are designed to assess the care needs of older people and assist them to gain access to the most appropriate type of care. The number of assessments of people aged 70 years or over and Indigenous people aged 50–69 years per 1000 target population varied across jurisdictions in 2009–10. The national rate was 78.1 assessments per 1000 people aged 70 years or over and Indigenous people aged 50–69 years. The rate for Indigenous people was 32.9 per 1000 Indigenous people aged 50 years or over (figure 13.7). Data on the numbers and rates of assessment for people of all ages by age group, Indigenous status, remoteness of residence and Socio-Economic Indexes for Areas (SEIFA) are in table 13A.66.

Figure 13.7 **Aged Care Assessment Team assessment rates, 2009-10**^{a, b, c, d, e}

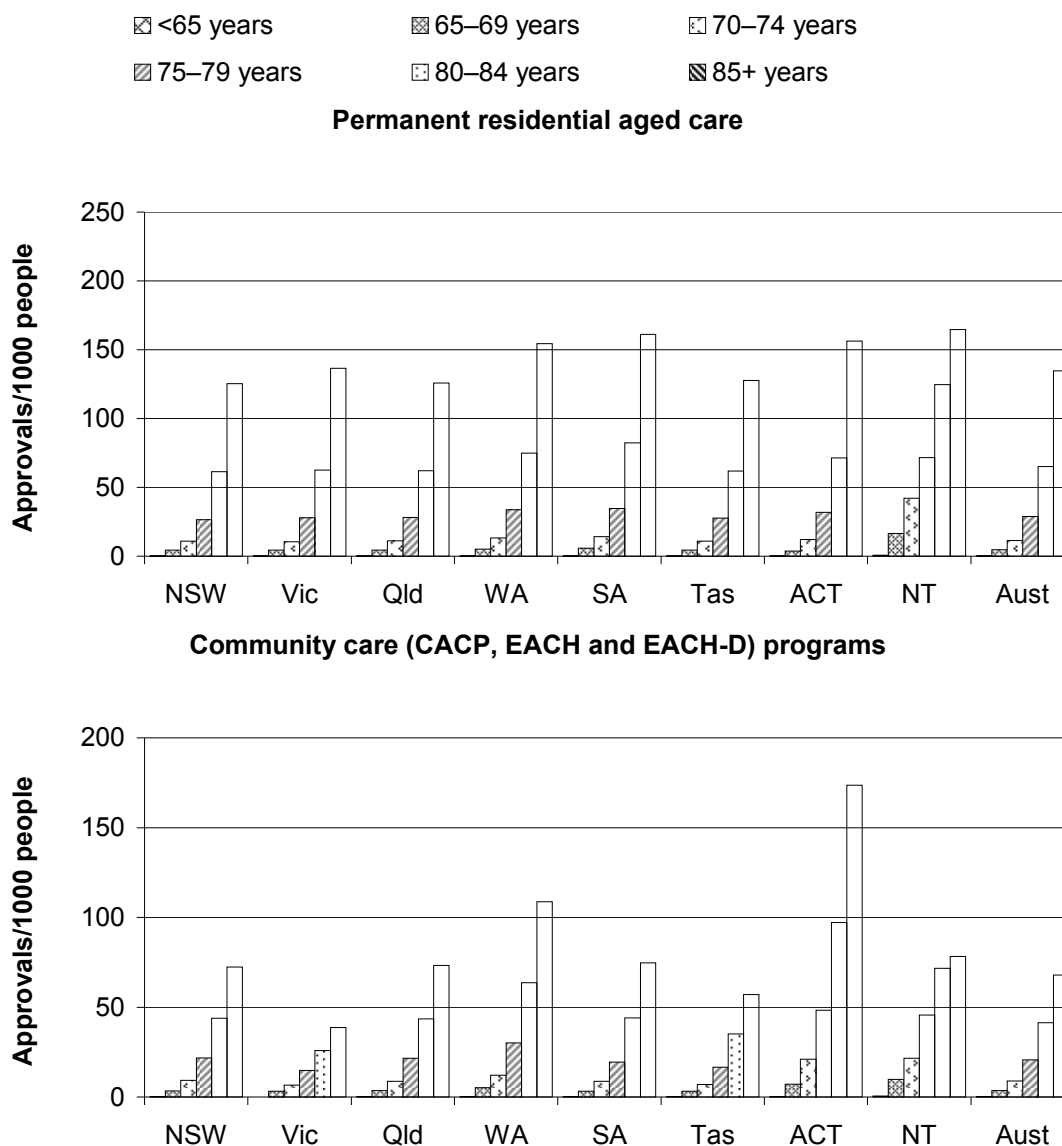


^a Includes ACAT assessments for all services. ^b All people includes all assessments of people aged 70 years or over and Indigenous people aged 50 years or over per 1000 people aged 70 years or over and Indigenous people aged 50 years or over. ^c Indigenous includes all assessments of Indigenous people aged 50 years or over per 1000 Indigenous people aged 50 years or over. ^d The number of Indigenous assessments is based on self-identification of Indigenous status. ^e See table 13A.64 for further explanation of these data.

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.64.

ACAT assessments that result in approvals of eligibility for various types of care can be shown by age-specific rates, for a series of age groups in the population. Data are provided for residential care and for community care (CACP, EACH and EACH-D). The approval rates for both residential and community care services vary across jurisdictions and increase with age (table 13A.65 and figure 13.8). These data reflect the numbers of approvals, which are a subset of assessments, as some assessments will not result in a recommendation or an approval for a particular level of care.

Figure 13.8 Age-specific approval rates, per 1000 people in the population, 2009-10^{a, b}



^a Population numbers and the proportions of the population for older age groups in the ACT and the NT are smaller than other jurisdictions, and may show variation between years, so results should be interpreted with caution. ^b The age category population data for this figure are derived from ABS estimated resident population figures as at 30 June 2010.

Source: DoHA (unpublished); table 13A.65.

Residential care services

Residential care services provide permanent high level and low level care and respite high/low level care:

- high care combines services such as nursing care, continence aids, basic medical and pharmaceutical supplies and therapy services with the types of services provided in low care such as accommodation, support services (cleaning, laundry and meals) and personal care services
- low care focuses on personal care services, accommodation, support services (cleaning, laundry and meals) and some allied health services such as physiotherapy — nursing care can be given when required
- respite provides short term residential high/low care on a planned or emergency basis (DoHA 2011).

At June 2011, there were 2760 residential aged care services (table 13A.18). Low care services are generally smaller (as measured by number of places) than high care services. At June 2011, 87.5 per cent of low care services had 60 or fewer places (table 13A.20), compared with 32.0 per cent of high care services (table 13A.19).

The size and location of residential services — which can influence the costs of service delivery — vary across jurisdictions. Nationally, there were 182 302 mainstream operational places (excluding flexible care places) in residential care services (83 963 in predominantly high care services, 3975 in predominantly low care services and 94 364 in services with a mix of high care and low care residents) at June 2011 (tables 13A.18–21). Box 13.5 contains information on the planning and allocation of residential aged care places and how the Aged Care Funding Instrument (ACFI) is used to appraise a resident's needs as high or low care.

Box 13.5 Planning and allocation of residential aged care places and the Aged Care Funding Instrument

Planning and allocating of places

The *Aged Care Act 1997* (part 2.2) details the processes for planning and allocating Australian Government subsidised services to meet residential aged care needs and community care needs. Planning for residential aged care is based on a national ratio of places per 1000 people aged 70 years or over (see box 13.11). High care places are planned to meet the needs of residents equivalent to high care. Low care places are planned to meet the needs of residents equivalent to low care.

(Continued next page)

Box 13.5 (Continued)

Although a needs match is expected when residents enter vacant places (that is, for example, vacant low care places should usually be filled by low care residents) this can change over time with 'ageing in place', which allows a low care resident who becomes high care to remain within the same service.

Aged Care Funding Instrument and the characteristics of residents

Aged Care Assessment Teams (ACATs) assess and approve clients for residential and community care. ACAT approvals for residential care can limit the approval for some residents to low care. Following this, approved providers of aged care homes appraise the level of a resident's care needs using the ACFI.

The ACFI measures each resident's need for care (high, medium, low or nil) in each of three domains: Activities of Daily Living, Behaviours and Complex Health Care. The ACFI was introduced on 20 March 2008 and replaced the Resident Classification Scale (RCS).

Residents are classified as high or low care based on the resident's level of approval for care (determined by an ACAT) and on the approved provider's appraisal of the resident's care needs against the ACFI, in the following manner:

- Residents who have not yet received an ACFI appraisal are classified using their ACAT assessment.
- Residents whose ACAT approval is not limited to low care, are classified as high care^a if they are appraised under the ACFI as:
 - High in Activities of Daily Living, or
 - High in Complex Health Care, or
 - High in Behaviour, together with low or medium in at least one of the Activities of Daily Living or Complex Health Care domains; or
 - Medium in at least two of the three domains.
- All other residents appraised under the ACFI are classified as low care residents.
- In addition, residents whose ACAT approval is limited to low care, but whose first ACFI appraisal rates them in a high care range are classified as 'interim low' until the ACAT low care restriction is removed, or the ACFI High status is confirmed by a subsequent assessment or review.

Residents care needs may change over time. Under 'ageing-in-place', a low care resident who becomes high care at a later date is able to remain within the same service.

^a From 1 January 2010, the definition for high care under the ACFI has changed to make it similar to what it was before the ACFI was introduced (see www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-factsheets.htm).

The combined number of all operational high care and low care residential places per 1000 people aged 70 years or over at June 2011 was 85.8 (42.5 high care and

43.3 low care) on a national basis (table 13.4). Nationally, the proportion of low care places relative to high care places has remained relatively constant between 2006 and 2011 (table 13A.24).

Table 13.4 Operational high care and low care residential places, 30 June 2011^{a, b, c, d, e}

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Number of places per 1000 people aged 70 years or over										
High care places	no.	45.0	41.3	39.5	36.7	48.9	45.2	33.9	52.0	42.5
Low care places	no.	42.2	45.2	43.7	42.9	42.8	39.5	44.1	42.2	43.3
Total places	no.	87.1	86.4	83.1	79.6	91.8	84.6	77.9	94.2	85.8
Proportion of places										
High care places	%	51.6	47.7	47.5	46.1	53.3	53.3	43.5	55.2	49.5
Low care places	%	48.4	52.3	52.5	53.9	46.7	46.7	56.5	44.8	50.5

^a Excludes places that have been 'approved' but are not yet operational. Includes multi-purpose and flexible services attributed as high care and low care places. ^b For this Report, Australian Government planning targets are based on providing 88 residential places per 1000 people aged 70 years or over. In recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as in the NT). ^c Includes residential places categorised as high care or low care. ^d See table 13A.24 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2010-11. ^e Data in this table may not add due to rounding.

Source: DoHA (unpublished); table 13A.24.

Age specific usage rates for permanent residential aged care services, by jurisdiction and remoteness, at 30 June 2011 are included in tables 13A.36 and 13A.43, respectively. Age specific usage rates for these permanent residential services combined with community care program services (CACP, EACH and EACH-D) are reported in tables 13A.41 and 13A.45. Indigenous age specific usage rates for all these services by remoteness category are in table 13A.46.

During 2010-11, the number of older clients (aged 70 years or over and Indigenous people aged 50–69 years) who received either high or low care in a residential aged care facility was 205 530 nationally for permanent care and 43 041 nationally for respite care (table 13A.4). These figures reflect the number of older individuals who utilised these services during the year, for any length of time. Data on the number of younger people aged under 65 years who used permanent residential care during 2010-11 are in table 13A.42.

Community care services

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards community-based care — have meant that the HACC, CACP, EACH, EACH-D and DVA VHC and

community nursing programs have become increasingly important components of the aged care system.

HACC, CACP, EACH and EACH-D programs

The distinctions between the HACC, CACP, EACH and EACH-D programs are summarised in table 13.5. DVA VHC and community nursing program services are described below.

Table 13.5 Distinctions between the HACC, CACP, EACH and EACH-D programs

	<i>HACC</i>	<i>CACPs</i>	<i>EACH and EACH-D</i>
Type of services ^a	Maintenance and support services for people in the community whose independence is at risk	Package of low level care tailored to client needs	Package of high level care tailored to client needs (including those with dementia)
Relationship to residential care	Aims to prevent premature or inappropriate admission	Substitutes for a low care residential place	Substitutes for a high care residential place
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory	ACAT assessment mandatory
Funding	Cost shared by the Australian, State and Territory governments and client contributions	Funded by the Australian Government and client contributions	Funded by the Australian Government and client contributions
Target client groups ^b	Available to people with profound, severe and moderate disability and their carers. Not age specific	Targets older people with care needs similar to low level residential care	Targets older people with care needs similar to high level residential care
Size of program	\$2.1 billion funding in 2010-11 At least 930 087 clients in 2010-11 ^c	\$531.7 million funding in 2010-11 46 126 operational places ^d in 2010-11	\$364.8 million funding in 2010-11 12 345 operational places ^e in 2010-11

^a HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. ^b Most HACC clients at the lower end of the scale would not be assessed as eligible for residential care, for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have needs that would exceed the level available under CACPs and EACH. ^c The proportion of HACC funded agencies that submitted Minimum Data Set data for 2010-11 differed across jurisdictions and ranged from 94 per cent to 100 per cent. Consequently, the total number of clients will be higher than those reported. ^d The number of operational places includes CACPs and flexible community places. See note (d) to table 13A.15. ^e The number of operational places includes EACH and EACH-D and high level consumer directed care (CDC) places.

Source: DoHA (unpublished); tables 13A.4, 13A.5 and 13A.15.

Services provided under the HACC program include domestic assistance, home maintenance, personal care, food services, respite care, transport, allied health care and community nursing (box 13.6). During 2010-11, the HACC program delivered

approximately 12 930 hours per 1000 people aged 70 years or over and Indigenous people aged 50–69 years (table 13A.47). Some further information on HACC services is contained in box 13.6.

Box 13.6 Home and Community Care Services

Home and Community Care (HACC) services are basic maintenance and support services, including allied health care, assessment, case management and client care coordination, centre-based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, personal care and respite care, social support, meals, home modification, linen service, goods and equipment, and transport.

Not all HACC services are directed towards the ageing population described in this chapter. The HACC 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 older people and younger people with disability. Carers may also receive HACC services.

In 2010-11, 69.2 per cent of the program's recipients were aged 70 years or over, but the program was also an important source of community care for younger people with disability and their carers, with 10.7 per cent of recipients aged under 50 years (table 13A.60). (Chapter 14 reports on the services for people with disability, which manifests before the age of 65 years, that were provided under the *Commonwealth State/Territory Disability Agreement* and the *National Disability Agreement* from 1 January 2009.)

CACPs provide community-based low level care to older people who are assessed by ACATs as having complex low care needs, but who are able to live at home with assistance. The total number of CACPs per 1000 people aged 70 years or over and Indigenous people aged 50–69 years increased between June 2006 and June 2011, from 17.8 to 20.7 (table 13A.25).

EACH and EACH-D provide community-based high level care to older people who are assessed by ACATs as having complex high care needs, but who have expressed a preference to live at home and are able to do so with assistance (EACH-D provides this care to people with the complex care needs associated with dementia). The total combined number of EACH and EACH-D packages per 1000 people aged 70 years or over and Indigenous people aged 50–69 years increased between June 2006 and June 2011, from 1.6 to 5.5 (table 13A.25).

Age specific usage rates for CACP, EACH and EACH-D, by jurisdiction and remoteness, at 30 June 2011 are included in tables 13A.40 and 13A.44 respectively. Age specific usage rates for these community care program services (CACP, EACH and EACH-D) combined with permanent residential services are in tables 13A.41

and 13A.45. Indigenous age specific usage rates for all these services by remoteness category are in table 13A.46.

Presentation of age-specific usage rates raises particular data issues. In particular, if the numbers of people within a particular range for a given service are small, this can lead to apparently large fluctuations in growth rates. This can be seen from some of the usage rates identified for the EACH and EACH-D programs, which, whilst growing rapidly, are doing so from a relatively small base.

Data on the number of older clients (aged 70 years or over and Indigenous people aged 50–69 years) who received HACC, CACP, EACH and EACH-D services in 2010-11 are included in table 13.6. These data reflect the number of individuals who utilised these services during the year, for any length of time, as distinct from the number of places available. Data on the number of younger people aged under 65 years who used CACP, EACH and EACH-D services during 2010-11 are in table 13A.42.

Table 13.6 Number of community aged care older clients, by program, 2010-11

<i>Program</i>	<i>Number of clients</i>
HACC	652 451
CACP	55 904
EACH	9 028
EACH-D	4 443

Source: DoHA (unpublished); table 13A.4.

Veterans' Home Care and Community Nursing programs

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 75 341 people approved for VHC services in 2010-11 (table 13A.13)². 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.

Eligibility for VHC services is not automatic, but based on assessed need. The average number of hours provided per year for veterans who were eligible to receive home care services was 51.2 nationally in 2010-11 (figure 13.9).

² DVA data include veterans of all ages.

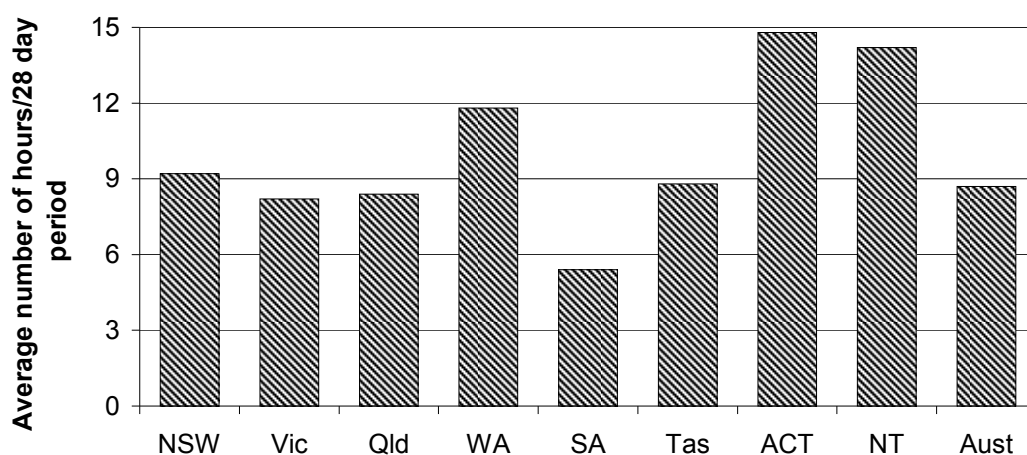
Figure 13.9 Average number of hours approved for Veterans' Home Care, 2010-11



Source: DVA (unpublished); table 13A.13.

The DVA also provides community nursing services to veterans and war widows/widowers. These services include acute/post acute, support and maintenance, personal care, medication management and palliative care. In 2010-11, 31 857 veterans received these services (table 13A.13) and the average number of hours provided for each recipient was 8.7 per 28 day period (figure 13.10).

Figure 13.10 Average number of hours provided for DVA Community Nursing, 2010-11



Source: DVA (unpublished); table 13A.13.

Services provided in mixed delivery setting

Information on the size/scope of a selection of the programs delivering services in mixed delivery settings is outlined below:

- At 30 June 2011, the Australian Government had allocated 4000 places to transition care, of which 3349 were operational, amongst 93 services across all jurisdictions. The average length of stay in 2010-11 was 61 days nationally for completed episodes (table 13A.84). Transition care will expand to up to 4000 operational places by 30 June 2012.
- At 30 June 2011, there were 134 operational MPS services with a total of 3216 operational flexible aged care places. Some of the MPS services serve more than one location (DoHA unpublished).
- At 30 June 2011, there were 28 aged care services funded to deliver 645 flexible aged care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (DoHA unpublished).
- During 2010-11, 86 376 people were assisted through the Continence Aids Payment Scheme (DoHA unpublished).
- During 2010-11, 73 902 people received Day Therapy Centre Program services from 139 centres (DoHA unpublished).

Case study

Box 13.7 contains a case study of the performance and evaluation of Wellness and reablement approaches in HACC.

Box 13.7 Case study — Wellness and reablement approaches in HACC: the Victorian and WA experience

Wellness and reablement approaches in HACC seek to support older people to maintain or regain their capacity to live as independently as possible at home and in the community. The overall aim is to improve functional and psychosocial independence, quality of life and social participation. Wellness and reablement approaches involve redesigning the service delivery model so that services work with clients in ways that serve to:

- prevent loss of independence by focusing on the retention of existing skills
- minimise the negative impact of service support by avoiding an emphasis on task completion and instead support the client to do as much as possible for themselves
- where appropriate, focus on regaining skills and a subsequent increased stage of independence and well-being as opposed to a continuing or increasing dependence on services being provided by others
- actively involve clients in setting goals and making decisions about their care and provide timely and flexible services that support people to reach their goals
- promote active participation in society, social connections and family-centred care.

The foundation for the development of this approach in Australia has been two reablement projects. The Home Independence Project (HIP) targets older home care clients (without dementia), when first referred for assistance or when referred for additional services because of increased need. The Personal Enablement Program (PEP) is designed to meet the needs of eligible clients who are exiting an acute episode of care in hospital.

Evaluation of these programs has focused on the HIP. Findings from a pilot study (1999) and an operation trial (2001) showed the HIP to be effective in increasing functionality and reducing the need for services. Under the pilot study, 32 per cent of those completing the program did not need ongoing services and 39 per cent had reduced service requirements. Participants also demonstrated gains in their everyday functioning, mobility, confidence and morale. For the operational trial, 70 per cent of participants did not require ongoing services after completing the program.

A non-randomised controlled trial conducted between 2001 and 2003, compared the outcomes for HIP clients with clients of 'usual' HACC services. Results of the study suggest that HIP clients had better individual and service outcomes and they demonstrated gains in functioning. The below table shows a comparison of the service outcomes for HIP clients and 'usual' HACC service clients after 3 and 12 months.

Service outcome	3 months		12 months	
	HIP	HACC	HIP	HACC
	%	%	%	%
Discharged — no longer required a service	63	11	57	19
Service requirement remained unchanged	18	67	19	58
Required a lower level of service	3	—	8	7
Required an increased level of service	—	13	3	1
Deceased	4	4	11	11
Entered residential care	1	2	2	4
Service cancelled or on hold	9	3	—	—
Total	100	100	100	100

(Continued next page)

Box 13.7 (Continued)

A randomised controlled trial conducted between 2005 and 2009, similarly compared the outcomes for HIP clients and 'usual' HACC service clients. Results show that at:

- 3, 12 and 24 months, HIP clients are less likely to be receiving home care and more likely to be independent in showering
- 12 months, HIP clients show greater improvement in Independent Activities of Daily Living
- 12 and 24 months, HIP clients are less likely to have visited an emergency department or be Aged Care Assessment Team assessed as high care and have lower health and aged care costs.

An increase in people's independence that reduces the need for ongoing aged care services could mean that the wellness and reablement approaches are cost effective. Results from some of the research cited above, show that HIP is as cost effective in the short term as 'usual' HACC services, when HIP services are provided prior to usual home care (if clients still need it). Although it is very likely, there is currently not sufficient evidence to conclude that it results in cost savings in the longer term. An evaluation of the long term outcomes of HIP and PEP is being conducted during 2011.

Developed from the outcomes of the HIP model, and informed by parallel work in New Zealand and the UK, wellness and reablement approaches have been adopted as core policy positions within WA and Victoria since 2006. An evaluation of WA HACC agencies implementation of the Wellness approach was conducted in 2009. Findings suggest that agencies associate Wellness with maximising client independence and believe it provides a sound philosophical basis for service delivery. HACC agencies that have progressed with implementation of the Wellness approach, generally cited multiple benefits of the change process, including client benefits and greater equity in service delivery, and increased staff satisfaction.

In Victoria, the approach has been developed as the Active Service Model (ASM). After significant developmental work, all HACC funded agencies developed an initial ASM implementation plan in 2010 which focused on assessing their readiness to take on this approach and have just completed a review and implementation plan documenting their achievements to date and proposed next steps. The reviews demonstrate, where this approach is in place, evidence of improved client satisfaction, more flexible and focussed service responses with higher rates of episodic rather than ongoing care; higher staff satisfaction and greater coordination and partnership with other agencies to produce better client outcomes and use of resources (Victorian Government unpublished).

Source: Lewin, Vandermeulen and Coster (2006); Lewin et. al. (2008); Lewin and Vandermeulen (2010); Skinner, Clark and Cukrov (2009); Victorian and WA governments (unpublished).

13.2 Framework of performance indicators

The framework of performance indicators aims to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the general performance indicator framework and service process diagram outlined in chapter 1 (see figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicator framework for aged care services is based on a set of shared government objectives in the aged care sector (box 13.8).

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations).

The NHA covers the area of health and aged care. The Agreement includes sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with the aged care performance indicators in the NHA.

Box 13.8 Objectives for aged care services

The aged care system aims to promote the wellbeing and independence of older people and their carers through the funding and delivery of care services that are:

- accessible
- appropriate to needs
- high quality
- efficient
- person-centred.

These objectives are consistent with the Australian, State and Territory governments' long term aged care objectives articulated under the NHA that 'older Australians receive appropriate high quality and affordable health and aged care services' (COAG 2009).

The performance indicator framework shows which data are comparable in the 2012 Report (figure 13.11). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

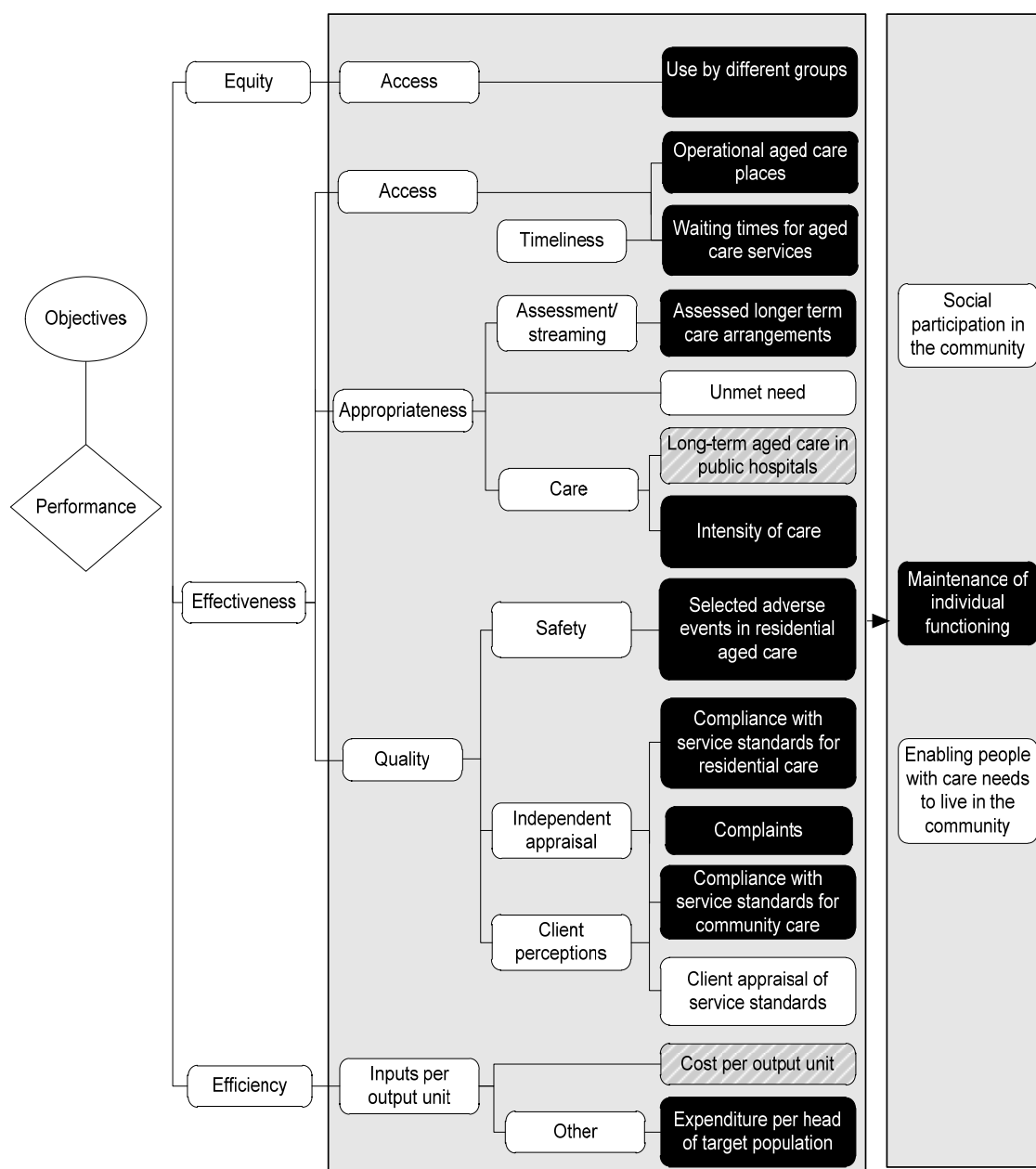
Some changes have been made to the aged care framework for the 2012 Report.

- The performance framework diagram has been amended so that ‘use by different groups’ is portrayed as one indicator.
- ‘Waiting times for resident care’ and ‘waiting times for community care’ are now reported as separate measures under the ‘waiting times for aged care services’ indicator.
- The indicator ‘targeting’ has been deleted. No data have been reported for this indicator as it has not been possible to define relevant measures.

Other changes to performance reporting for the 2012 Report include the following:

- Inclusion of data on the variation in the proportion of people aged 50 years or over accessing residential services, HACC, CACPs, EACH and EACH-D services who are Indigenous, from the proportion of people aged 50 years or over who are Indigenous, to provide additional analysis under the ‘Use by different groups’ indicator.
- Three new measures are reported under the following indicators:
 - ‘use by different groups’ indicator — the proportion of all eligible resident care days that are for all supported, concessional or assisted residents
 - ‘cost per unit of output’ indicator — the cost per hour of HACC service for domestic assistance, personal care, nursing and allied health
 - ‘expenditure per head of target population’ indicator — Australian Government expenditure on residential aged care, selected community aged care programs, multipurpose services and Indigenous specific services.

Figure 13.11 Aged care services performance indicator framework



Key to indicators

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

13.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of aged care services.

Appendix A contains 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).

Outputs

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

Equity — Access

Use by different groups

‘Use by different groups’ is an indicator of governments’ objective for the aged care system to provide equitable access to aged care services for all people who require these services (box 13.9).

Box 13.9 Use by different groups

‘Use by different groups’ is defined by the following measures:

- variation in the proportion of people aged 70 years or over accessing residential services, HACC, CACPs, EACH and EACH-D services who are born in a non-English speaking country, from the proportion of people in the target population (aged 70 years or over) who are born in a non-English speaking country
- variation in the proportion of people aged 70 years or over and Indigenous people aged 50–69 years accessing residential services, HACC, CACPs, EACH and EACH-D services who are Indigenous, from the proportion of people in the target population who are Indigenous (similar analysis using data for all people aged over 50 years is reported for information)
- the number of people born in non-English speaking countries using residential services, CACPs, EACH and EACH-D, divided by the number of people born in non-English speaking countries aged 70 years or over, compared with the rate at which the general population (number of people aged 70 years or over and Indigenous people aged 50–69 years) accesses the service
- the number of Indigenous people using residential services, CACP, EACH, and EACH-D 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) compared with the rate at which the general population (number of people aged 70 years or over and Indigenous people aged 50–69 years) accesses the service
- the number of veterans aged 70 years or over in residential care divided by the total number of eligible veterans aged 70 years or over, where a veteran is defined as a DVA Gold or White card holder
- access to HACC services for people living in rural or remote areas — the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 70 years or over and 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 Respite and Carelink Centres for Indigenous people compared with the rate for all people
- access to residential aged care services for financially disadvantaged people
 - the proportion of new residents classified as supported
 - the proportion of permanent resident care days classified as concessional, assisted or supported

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Box 13.9 (Continued)

In general, usage rates for special needs groups similar to those for the broader aged care population are desirable, but interpretation of results differs for some special needs groups because:

- there is evidence that Indigenous people have higher disability rates than those of the general population, which suggests a greater level of need for services compared with those in the broader aged care population
- for financially disadvantaged users, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional, assisted or supported residents. These targets range from 16 per cent to 40 per cent of places, depending on the service's region. Usage rates equal to, or higher than, the minimum rates are desirable.

Use by different groups is a proxy indicator of equitable access. Various groups are identified by the *Aged Care Act 1997* and its principles (regulations) as having special needs, including people from Indigenous communities, people born in non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, veterans (including widows and widowers of veterans), people who are homeless or at risk of becoming homeless, or who are care leavers. A care leaver is a person who was in institutional care (such as an orphanage or mental health facility) or other form of out-of-home care, including foster care, as a child or youth (or both), at some time during their lifetime (DoHA 2011).

Several factors need to be considered in interpreting the results for this set of measures:

- Cultural differences can influence the extent to which people born in non-English speaking countries use different types of services.
- Cultural differences and geographic location can influence the extent to which Indigenous people use different types of services.
- The availability of informal care and support can influence the use of aged care services in different population groups.

Data reported for this indicator are comparable.

Data quality information for five measures defined for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012. Data quality information for the other measures is under development.

Data presented for this indicator are organised by the type of service provided, with sub-sections for the relevant special needs groups reported against that service.

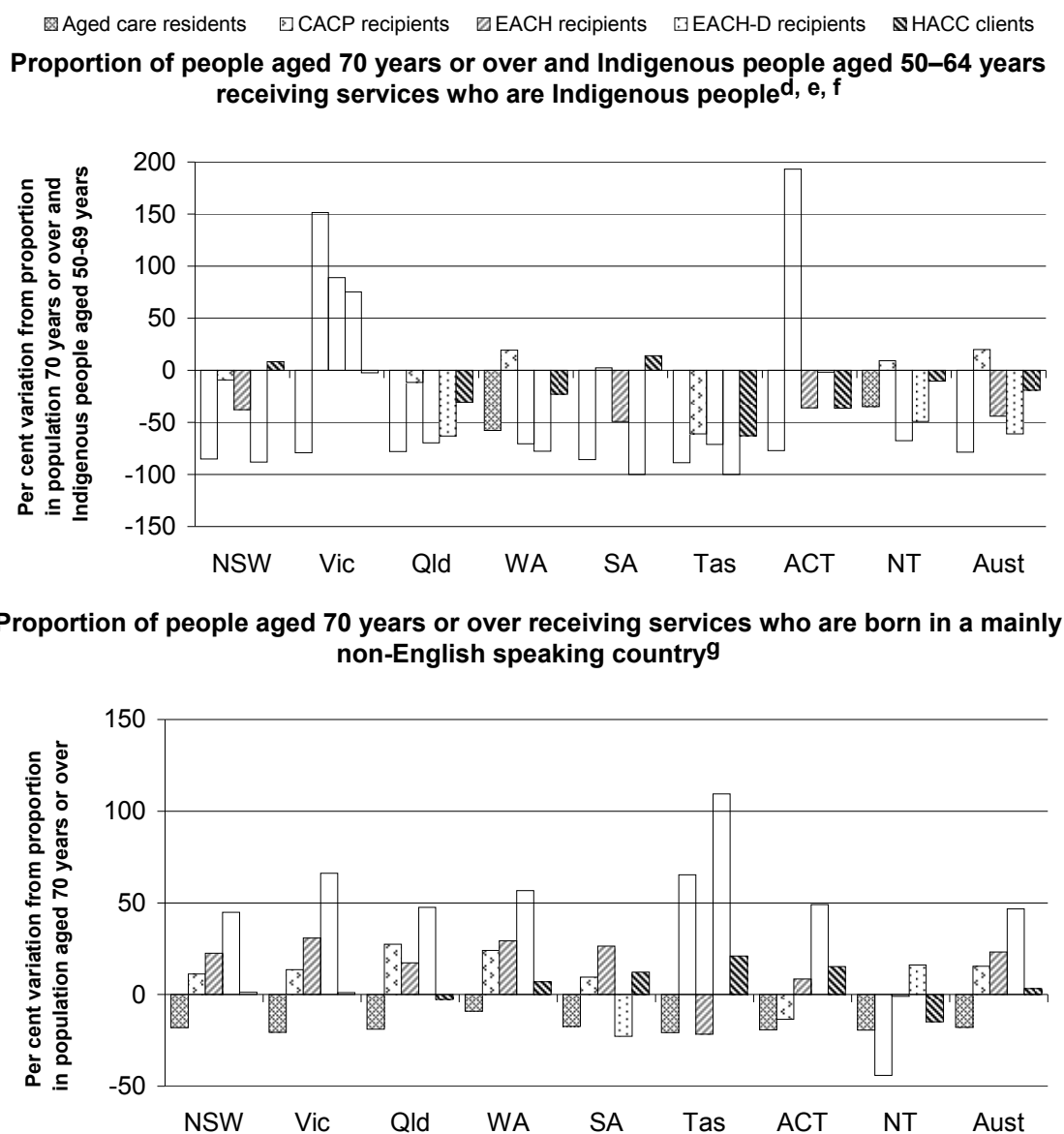
Access to residential care services, HACC, CACP, EACH and EACH-D services by Indigenous people and people born in a mainly non-English speaking country

Nationally, in comparison to their proportion of the target population as a whole, Indigenous people are under-represented in access to residential care, HACC, EACH and EACH-D services, whereas people born in a mainly non-English speaking country are under-represented in access to residential care only (figure 13.12). However, in relation to the CACP program, Indigenous people are over-represented, compared with the proportion of this group in the target population.

Results for Indigenous people should be considered with caution. While Indigenous recipients are under-represented when compared to the general target population (people aged 70 years or over and Indigenous people aged 50–69 years), if the analysis is done separately for all people aged 50 years or over; nationally, Indigenous clients are over-represented compared to the total Australian population in this age group for all services, except residential care (figure 13.13). However, this might not be an over-representation in terms of the need for services if the higher disability/morbidity rates of Indigenous people are taken into account.

In addition, if access to HACC services were measured in terms of the HACC target population the results would also differ to those reported in figure 13.12. The HACC target population is based on the proportion of people in households with moderate, severe or profound disability rather than the population of people aged 70 years or over and Indigenous people aged 50–65 years. For further details on the HACC target population see section 13.6.

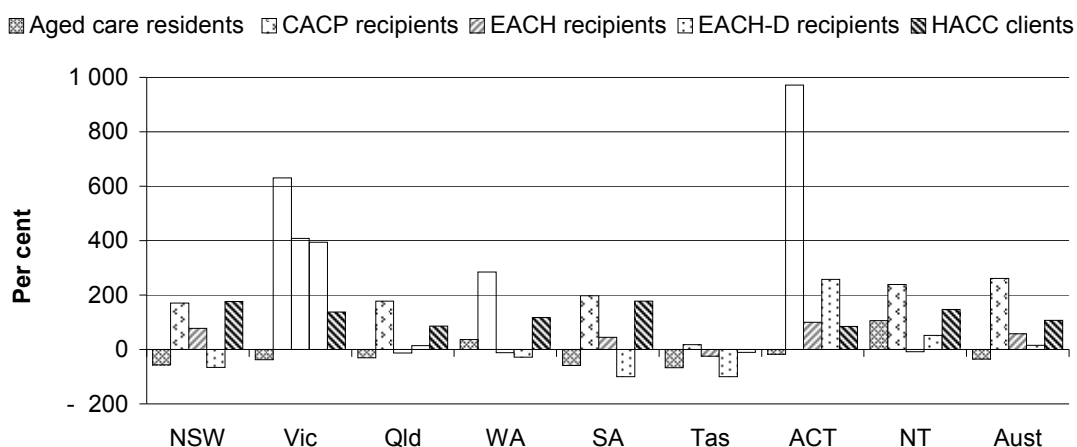
Figure 13.12 Variation in the proportion of people accessing services who are in a special needs group, from their proportion in the relevant target population as a whole, June 2011^{a, b, c}



^a The proportion of HACC funded agencies that submitted Minimum Data Set data for 2010-11 differed across jurisdictions and ranged from 94 per cent to 100 per cent. Consequently, actual service levels were higher than stated. ^b Reports provisional HACC data that have not been validated and may be subject to revision. ^c Some of these proportions are calculated using small numbers. In particular, this applies to the proportions for EACH and EACH-D. See table 13A.30 for more details. ^d The numerator of the proportion comprises service users who are Indigenous people aged 50 years or over. The denominator of the proportion comprises service users who are people aged 70 years or over and Indigenous people aged 50–64 years. ^e The ACT has a very small Indigenous population aged 50 years or over (table 13A.2) and a small number of CACP recipients results in a very high provision ratio. ^f Excludes National Aboriginal and Torres Strait Islander Flexible Aged Care Program recipients. ^g The numerator of the proportion comprises service users born in a mainly non-English speaking country who are aged 70 years or over. The denominator of the proportion comprises the number of people aged 70 years who receive services.

Source: DoHA (unpublished); table 13A.30.

Figure 13.13 Variation in the proportion of people aged 50 years or over accessing aged care services who are Indigenous, from their proportion in the population aged 50 years or over, June 2011^{a, b, c, d, e}



^a The proportion of HACC funded agencies that submitted Minimum Data Set data for 2010-11 differed across jurisdictions and ranged from 94 per cent to 100 per cent. Consequently, actual service levels were higher than stated. ^b Reports provisional HACC data that have not been validated and may be subject to revision. ^c Some of these proportions are calculated using small numbers. In particular, this applies to the proportions for EACH and EACH-D. See table 13A.31 for more details. ^d The ACT has a very small Indigenous population aged 50 years or over (table 13A.2) and a small number of CACP recipients results in a very high provision ratio. ^e Excludes National Aboriginal and Torres Strait Islander Flexible Aged Care Program recipients.

Source: DoHA (unpublished); table 13A.31.

Access to residential aged care services by Indigenous people and people born in a mainly non-English speaking country

In all jurisdictions at 30 June 2011, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services (21.0 and 63.4 per 1000 of the relevant target populations respectively), compared with the population as a whole (77.4 per 1000) (figure 13.14).

Figure 13.14 Residents per 1000 target population, 30 June 2011^{a, b, c}



^a All residents data are per 1000 people aged 70 years or over and Indigenous people aged 50–69 years. ^b Indigenous residents data are per 1000 Indigenous people aged 50 years or over. ^c Data for residents from a non-English speaking country are per 1000 people from non-English speaking countries aged 70 years or over.

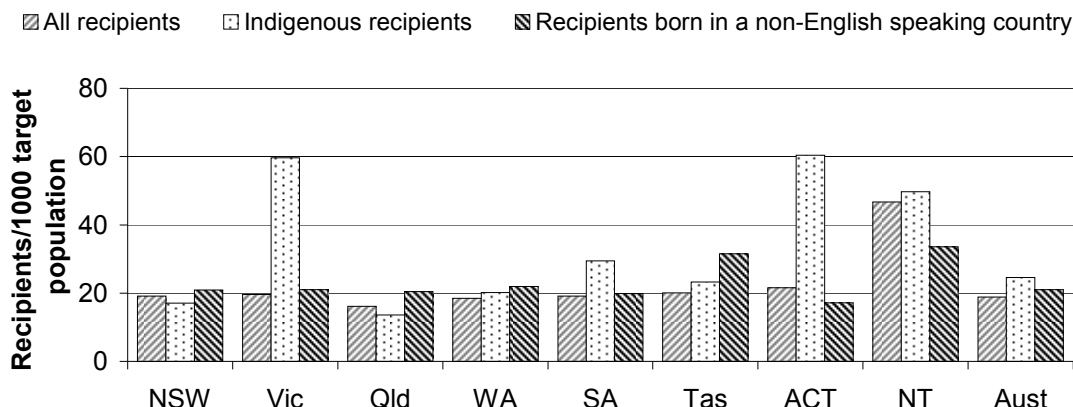
Source: DoHA (unpublished); tables 13A.28, 13A.32 and 13A.34.

Age specific usage rates for these services, by jurisdiction and remoteness, suggest there is greater variation in usage rates by remoteness area than amongst jurisdictions (tables 13A.36, 13A.41, 13A.43, 13A.45-46).

Access to aged care community programs by Indigenous people and people born in a mainly non-English speaking country

Nationally, the number of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over was 24.6 and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 21.0. These numbers compare to a total of 18.8 per 1000 of the target population (people aged 70 years or over and Indigenous people aged 50–69 years) (figure 13.15).

Figure 13.15 Community Aged Care Package recipients per 1000 target population, 30 June 2011^{a, b, c, d, e}



^a All recipients data are per 1000 people aged 70 years or over and Indigenous people aged 50–69 years. ^b Indigenous recipients data are per 1000 Indigenous people aged 50 years or over. ^c Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 70 years or over. ^d The ACT has a very small Indigenous population aged 50 years or over (table 13A.2), and a small number of packages result in a very high provision ratio. ^e CACPs provide a more flexible model of care, more suitable to remote Indigenous communities, so areas such as the NT have a higher rate of CACP recipients per 1000 people.

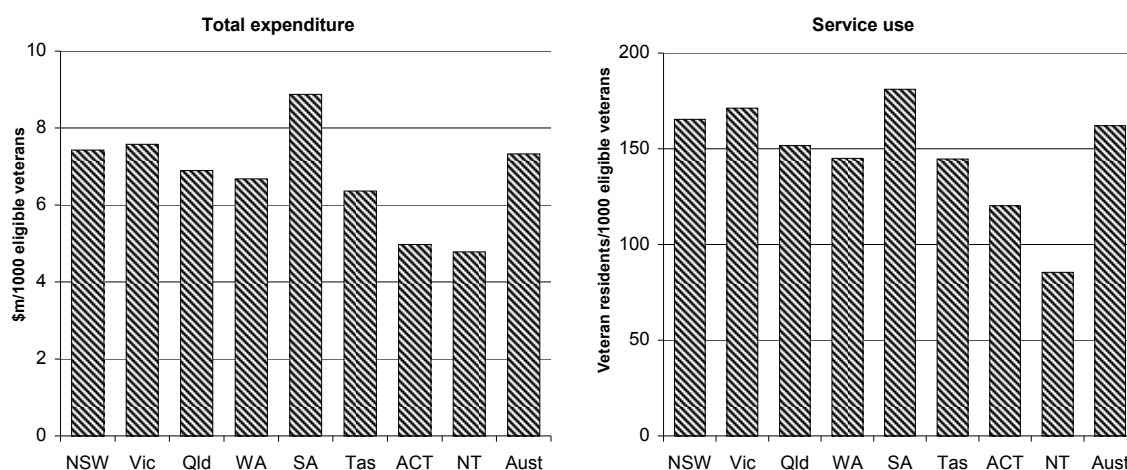
Source: DoHA (unpublished); tables 13A.28, 13A.32 and 13A.34.

Age–sex specific usage rates vary between jurisdictions and remoteness categories for CACP, EACH and EACH-D (tables 13A.40–41 and 13A.44–45).

Access by veterans

The total number of veterans 70 years or over who were in the DVA treatment population (that is, eligible veterans) at 30 June 2011 was 168 182 (table 13A.14). The number of veterans in residential care per 1000 eligible veterans aged 70 years or over at 30 June 2011 was 162.0 (figure 13.16). Nationally, total DVA expenditure on residential aged care subsidy per person aged 70 years or over was \$570 in 2010–11 (table 13A.14).

Figure 13.16 Number of veterans aged 70 years or over in residential care and total DVA expenditure on residential aged care subsidy, per 1000 eligible veterans aged 70 years or over, 2010-11^{a, b, c}



^a Data are subject to a time lag and may be subject to revision. ^b The number of eligible veterans are veterans with a DVA Gold and White card holder residents as at June 2011. ^c Veterans 70 years or over includes those whose age is unknown.

Source: DVA (unpublished); DoHA (unpublished); table 13A.14.

Access to the HACC program

HACC services are provided in the client's home or community for people with moderate, severe or profound disability and their carers. The focus of this chapter is all people 70 years or over and Indigenous people aged 50–69 years. The proportion of HACC clients aged 70 years or over during 2010-11 was 69.2 per cent (table 13A.60).

Nationally, the number of service hours per 1000 people aged 70 years or over and Indigenous people aged 50–69 years was 12 930 and the number of meals provided per 1000 people aged 70 years or over and Indigenous people aged 50–69 was 4382 (table 13.7). The proportion of HACC agencies that submitted data vary across jurisdictions so comparisons between jurisdictions should be made with care.

Table 13.7 HACC services received, 2010-11 (per 1000 people aged 70 years or over and Indigenous people aged 50–69 years)

a, b, c

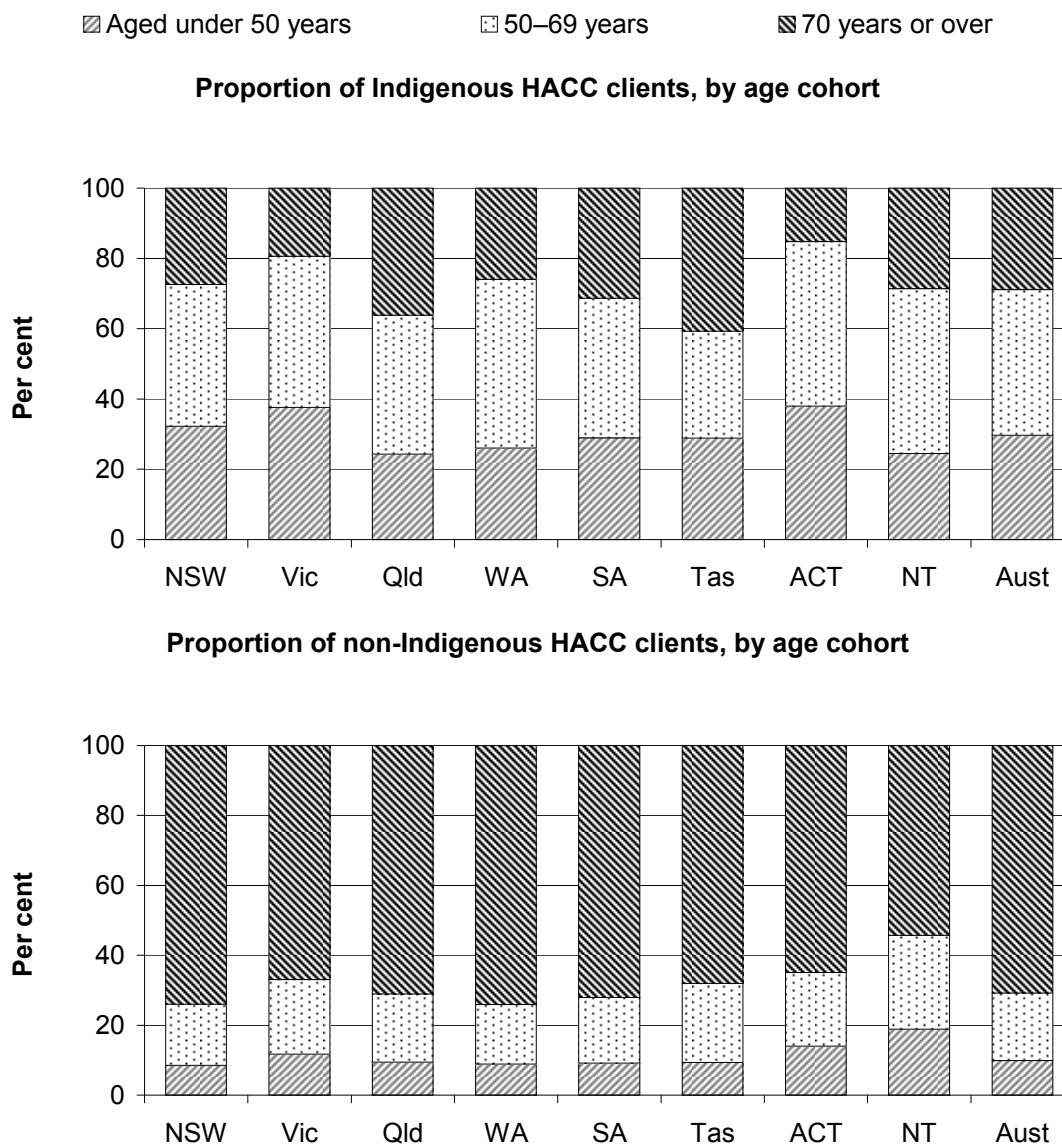
	NSW ^d	Vic	Qld	WA	SA ^e	Tas	ACT	NT	Aust
Percentage of agencies that reported Minimum Data Set data	96	97	97	99	99	97	100	94	97
Total hours (no.) ^f									
Major cities	10 666	13 759	14 644	14 792	13 654	..	13 157	..	12 916
Inner regional	9 021	16 078	11 607	12 599	11 677	13 311	..	..	11 963
Outer regional	11 722	20 783	13 801	17 258	13 162	10 837	..	8 227	14 137
Remote	15 688	32 623	18 093	14 468	18 200	14 215	..	9 561	16 181
Very remote	15 030	..	22 408	23 331	51 138	24 053	..	12 758	21 923
All areas	10 381	14 757	13 925	14 834	13 744	12 549	13 157	10 063	12 930
Total meals (no.) ^g									
Major cities	3 111	4 109	4 445	3 041	6 180	..	2 169	..	3 874
Inner regional	4 177	4 962	4 955	3 676	3 737	4 204	..	..	4 481
Outer regional	6 461	5 792	4 703	5 349	7 289	4 485	..	5 010	5 677
Remote	10 272	8 953	8 102	7 391	7 740	5 668	..	12 914	8 701
Very remote	16 051	..	10 690	19 709	42 584	7 075	..	27 367	20 546
All areas	3 698	4 416	4 757	3 811	6 322	4 336	2 169	14 357	4 382

^a Data represent HACC services received by people aged 70 years or over and Indigenous people aged 50-69 years, divided by people aged 70 years or over and Indigenous people aged 50–69 years (tables 13A.47–52) as distinct from HACC services received divided by HACC target population in all age groups (tables 13A.54–59). ^b The proportion of HACC funded agencies that submitted Minimum Data Set data for 2010-11 differed across jurisdictions and ranged from 94 per cent to 100 per cent. Consequently, actual service levels were higher than stated. ^c Reports provisional HACC data that have not been validated and may be subject to revision. ^d The NSW data are provisional. Consequently, some assistance types are underreported for NSW and the level of underreporting may be substantial. ^e Validation processes for SA and the HACC Minimum Data Set differ. As a result, actual service levels may be up to 5 per cent higher or lower than stated. ^f See table 13A.47 for a full list of categories. ^g Includes home meals and centre meals. .. Not applicable.

Source: DoHA (unpublished) *HACC Minimum Data Set 2010-11*; DoHA (unpublished) *HACC National Data Repository*; tables 13A.47–52.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2010-11. This reflects the difference in morbidity and mortality trends between Indigenous people and the general population. The proportion of Indigenous HACC clients who are aged 70 years or over is 28.9 per cent and the proportion of non-Indigenous HACC clients who are aged 70 years or over is 70.8 per cent (figure 13.17).

Figure 13.17 Recipients of HACC services by age and Indigenous status, 2010-11^{a, b}



^a Reports provisional HACC data that have not been validated and may be subject to revision. ^b The proportion of HACC clients with unknown Indigenous status differed across jurisdictions. Nationally, the proportion of HACC clients with unknown or null Indigenous status was 7.1 per cent (table 13A.60).

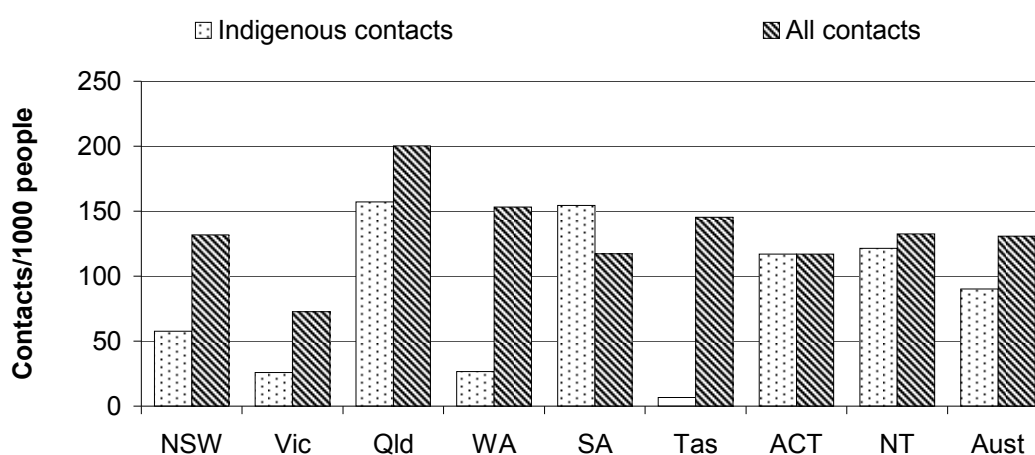
Source: DoHA (unpublished); table 13A.61.

Access by Indigenous people to Commonwealth Respite and Carelink Centres

Commonwealth Respite and Carelink Centres are information centres for older people, people with disabilities, carers and service providers. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment

processes and eligibility criteria. The national rate at which Indigenous people contacted Respite and Carelink Centres at 30 June 2011, was 90.1 people per 1000 Indigenous people in the Indigenous target population (Indigenous people aged 50 years or over). The rate for all Australians was 130.9 per 1000 people in the target population (people aged 70 years or over and Indigenous people aged 50–69 years). These figures varied across jurisdictions (figure 13.18).

Figure 13.18 Commonwealth Respite and Carelink Centres, contacts per 1000 target population, by Indigenous status, 30 June 2011^{a, b, c, d}



^a Contacts include phone calls, visits, emails and facsimiles. ^b Indigenous contacts refer to contacts by Indigenous people per 1000 Indigenous people in the target population. ^c All contacts refers to contacts per 1000 target population. ^d Indigenous status is determined through people making contact self identifying themselves as Indigenous. Therefore, there is likely to be substantial under-reporting of Indigenous status.

Source: DoHA (unpublished); table 13A.63.

Access to residential services by financially disadvantaged users

The financial assistance arrangements for financially disadvantaged users were changed on 20 March 2008, to include a new category known as supported residents (box 13.10).

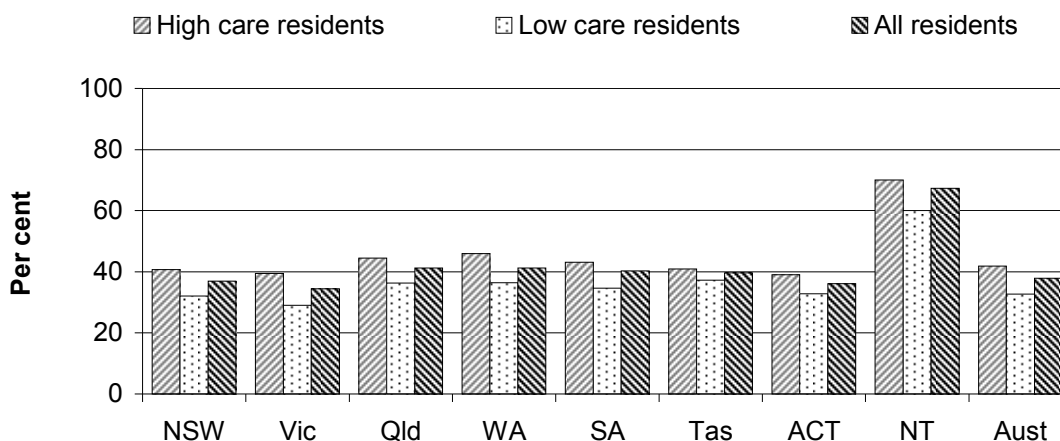
Box 13.10 Concessional, assisted or supported residents

In 2008, new arrangements governing residents' contributions to their accommodation costs and the supplements the Australian Government pays for residents who cannot meet all or part of their own accommodation costs were introduced. These new arrangements only apply to residents who first entered permanent residential care on or after 20 March 2008, or who re-entered care on or after 20 March 2008, after a break in care of more than 28 days.

New residents who are assessed as eligible to receive subsidised accommodation costs are known as supported residents. Residents who entered care prior to 20 March 2008 are still subject to the eligibility criteria for 'concessional' or 'assisted' resident status.

The proportion of all new residents classified as supported residents during 2010-11 was 37.9 per cent nationally but varied across jurisdictions (figure 13.19). Targets for financially disadvantaged users range from 16 per cent to 40 per cent of places, depending on the service's region.

Figure 13.19 New residents classified as supported residents, 2010-11^a

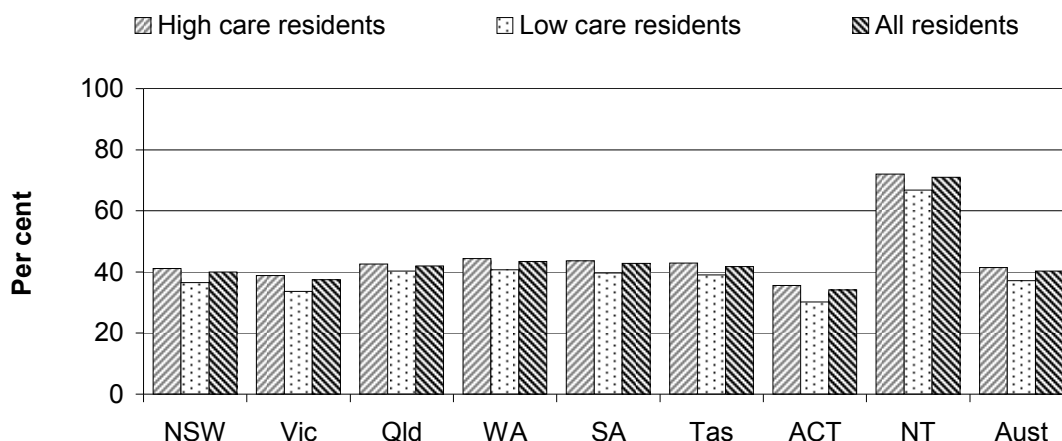


^a Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re-entered care on or after 20 March 2008 after a break in care of more than 28 days) and have assets of up to a set value (from 20 March 2010 to 19 September 2010 — \$93 410.40, from 20 September 2010 to 19 March 2011 — \$98 237.60 and from 20 March 2011 — \$102 544.00).

Source: DoHA (unpublished); table 13A.37.

The proportion of all permanent resident care days classified as concessional, assisted or supported during 2010-11 was 40.3 per cent nationally, but varied across jurisdictions (figure 13.20).

Figure 13.20 Permanent residents care days classified as concessional, assisted or supported, 2010-11^a



^a Concessional residents are those who entered permanent residential care before 20 March 2008, receive an income support payment and have not owned a home for the last two or more years (or whose home is occupied by a protected person, for example, the care recipient's partner), and have assets of less than 2.5 times the annual single basic age pension (or for a transfer from 20 September 2009 less than 2.25). Assisted residents are those meeting the above criteria, but with assets between 2.5 and 4.0 times the annual single basic age pension (or for a transfer from 20 September 2009 between 2.25 and 3.61). Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re-enter care on or after 20 March 2008 after a break in care of more than 28 days) and have assets of up to a set value (from 20 March 2010 to 19 September 2010 — \$93 410.40, from 20 September 2010 to 19 March 2011 — \$98 237.60 and from 20 March 2011 to 19 September 2011 — \$102 544.00).

Source: DoHA (unpublished); table 13A.37.

Effectiveness — level of access

Operational aged care places

'Operational aged care places' is an indicator of governments' objective to provide older Australians with access to a range of aged care services that can meet their care needs (box 13.11). This indicator does not include places that have been approved, but are not yet operational.

Box 13.11 Operational aged care places

‘Operational aged care places’ is defined by two measures, the number of operational places (by type) per 1000 people:

- aged 70 years or over
- aged 70 years or over and Indigenous people aged 50–69 years.

The planning framework for services provided under the *Aged Care Act 1997* aims to keep the growth in the number of Australian Government subsidised aged care places in line with growth in the aged population, and to ensure a balance of services across Australia, including services for people with lower levels of need and in rural and remote areas. The framework aims to achieve and maintain a national provision ratio of 113 operational aged care places per 1000 of the population aged 70 years or over by June 2011. Within this overall target provision ratio of the 113 places per 1000 people aged 70 years or over:

- 44 places (39 per cent) should be residential high care — designed to meet the needs of residents equivalent to high care^a
- 44 places (39 per cent) should be residential low care — designed to meet the needs of residents equivalent to low care
- 25 places (22 per cent) should be community care, with 4 of these places (around 3.5 per cent of total places) being for high level community care — designed to enable those with high/low care needs to continue living in, or return to, the community (DoHA unpublished)^a.

In recognition of poorer health among Indigenous communities and that planning in some cases also takes account of the Indigenous population aged 50–69 years, the provision ratio is also reported for operational places per 1000 people aged 70 years or over and Indigenous people aged 50–69 years. A 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).

In general, provision ratios across state and territories, and across regions, that are broadly similar to the overall target provision ratios are desirable as it indicates that older Australians have access to a similar level and mix of services to meet their care needs.

This indicator does not provide information on whether the overall target provision ratios are adequate or provide an appropriate mix of services relative to need.

Data reported for this indicator are comparable.

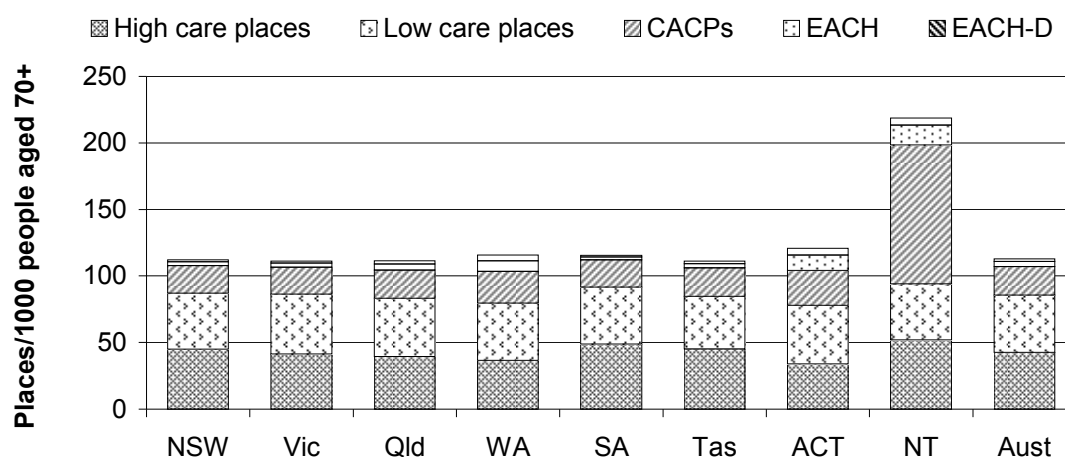
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

^a In 2010, the target for high level community care was temporarily increased from 4 to 6 places per 1000 people aged 70 years or over, while the target for high level residential care was temporarily adjusted from 44 to 42 places per 1000 people aged 70 years or over. This was to ensure that the overall target ratio was achieved in 2011, together with the balance of 48 high care and 65 low care places (DoHA 2011).

Nationally, the combined number of high care residential places, low care residential places, CACPs, flexible care places (including EACH and EACH-D, but excluding Transition Care places) and places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program at 30 June 2011, was 112.8 per 1000 people aged 70 years or over (figure 13.21). Transition Care places add an additional 1.5 per 1000 people aged 70 years or over, however, these places are not included in the target of 113 places (table 13A.24). The number of operational aged care places per 1000 people aged 70 years or over by care type was:

- 42.5 places (37.7 per cent of total) for residential high care
- 43.3 places (38.4 per cent of total) for residential low care
- 27.0 places (24.0 per cent of total) for community care — 21.3 places for CACPs and 5.7 places for EACH and EACH-D combined (5.1 per cent of total places) (figure 13.21).

Figure 13.21 Operational residential places, CACPs, EACH and EACH-D packages per 1000 people aged 70 years or over, 30 June 2011^{a, b, c, d, e, f, g}

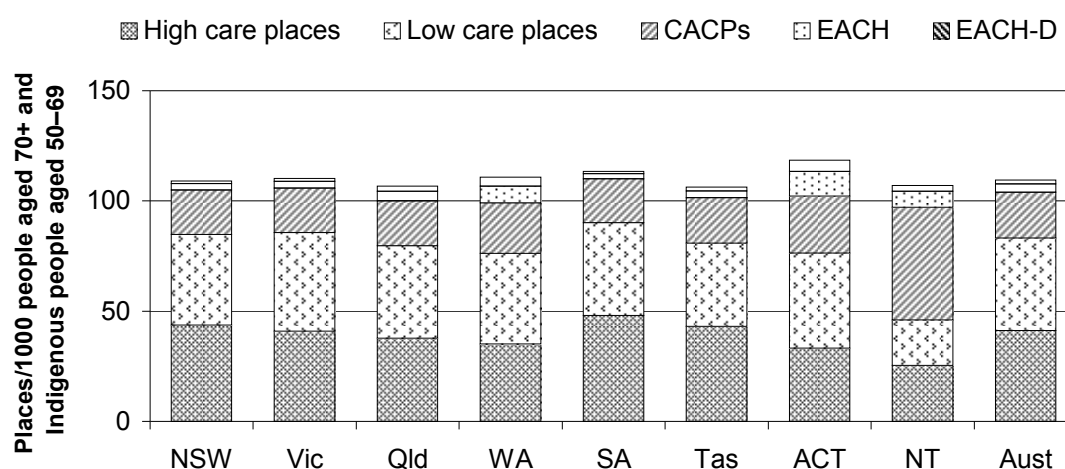


^a Excludes places that have been approved but are not yet operational. ^b Ageing in place may result in some low care places being filled by high care residents. ^c For this Report, Australian Government planning targets are based on providing 113 places per 1000 people aged 70 years or over by June 2011. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). ^d Includes residential places categorised as high care or low care. ^e CACPs, EACH and EACH-D packages are included in the Australian Government planning targets. ^f CACP data include flexible community low care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Multi-Purpose Service Program and Innovative Pool Program (including Community Directed Care (CDC) low care places). ^g See table 13A.24 for further information regarding the calculation of provision ratios.

Source: DoHA (unpublished); table 13A.24.

The number of operational aged care places can also be shown using a population that incorporates Indigenous people aged 50–69 years (figure 13.22). Use of this ‘adjusted’ population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Figure 13.22 Operational residential places, CACPs, EACH and EACH-D packages per 1000 people aged 70 years or over and Indigenous people aged 50–69 years, 30 June 2011^{a, b, c, d, e, f, g}



^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 CACPs, EACH and EACH-D packages are included in the Australian Government planning targets. ^d Includes residential places categorised as high care or low care. ^e CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas with a high Indigenous population (such as the NT) may have a higher proportion of CACPs. ^f CACP data include flexible community low care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Multi-Purpose Service Program and Innovative Pool Program (including CDC low care places). EACH data includes CDC high care places and EACH-D data includes CDC high care dementia places. ^g TCP places are not shown, see table 13A.25.

Source: DoHA (unpublished); table 13A.25.

Data on the number of residential and community care operational aged care places per 1000 people aged 70 years or over and Indigenous people aged 50–69 years by planning region and remoteness are in tables 13A.26-27.

Effectiveness — timeliness of access

Waiting times for aged care services

‘Waiting times for aged care services’ is an indicator of governments’ objective to maximise the timeliness with which people are able to access residential care (box 13.12).

Box 13.12 **Waiting times for aged care services**

‘Waiting times for aged care services’ is defined by two measures.

- The proportion of people who entered residential high care within three months of their ACAT approval. Entry into a residential care service refers to the date of admission to a residential aged care service. ACAT approval refers to the approval date of the most recent ACAT assessment prior to admission into care.
- The proportion of people who commenced a CACP who did so within one month or within three months of their ACAT approval. ACAT approval refers to the approval date of the most recent ACAT assessment prior to commencement of care.

Shorter waiting times (measured by higher rates of admission to high residential care within three months of ACAT approval or of commencement of a CACP service within one or three months of ACAT approval) are desirable.

This indicator needs to be interpreted with care. The measure of ‘elapsed time’ is utilised because the period of time between the ACAT approval and entry into residential care or commencement of a CACP may be influenced by factors that cannot be categorised as time spent ‘waiting’ and not all ‘waiting’ time is included. Some examples include:

- clients with ACAT approvals who do not enter residential care or commence a CACP (for example, who die before entering care)
- residential placement offers that are not accepted
- the availability of alternative community care, informal care and respite services
- the availability and distribution of operational residential care services
- building quality and perceptions about quality of care, which influence client choice of preferred service
- delays between the date of ACAT assessments and their approval
- priority allocations (for example, special needs groups)
- hospital discharge policies and practices
- the impact on clients of programs that provide alternatives to residential care, such as EACH and EACH-D
- client choice not to enter residential care immediately but to take up the option at a later time
- client choice not to receive a CACP but to take up an alternative community care options due to, for example, varying fee regimes.

(Continued next page)

Box 13.12 (Continued)

For residential aged care, this indicator focuses on high care services because, as a proxy for waiting time, the link between entry to residential care and elapsed time is stronger for high care residents than for low care residents. This is due to the urgency for high care residents' needs, and the greater number of alternatives for people with ACAT approvals for low care only.

It is recognised that this indicator has limitations and work is underway to review the data. This indicator will continue to be reported until improved data are available.

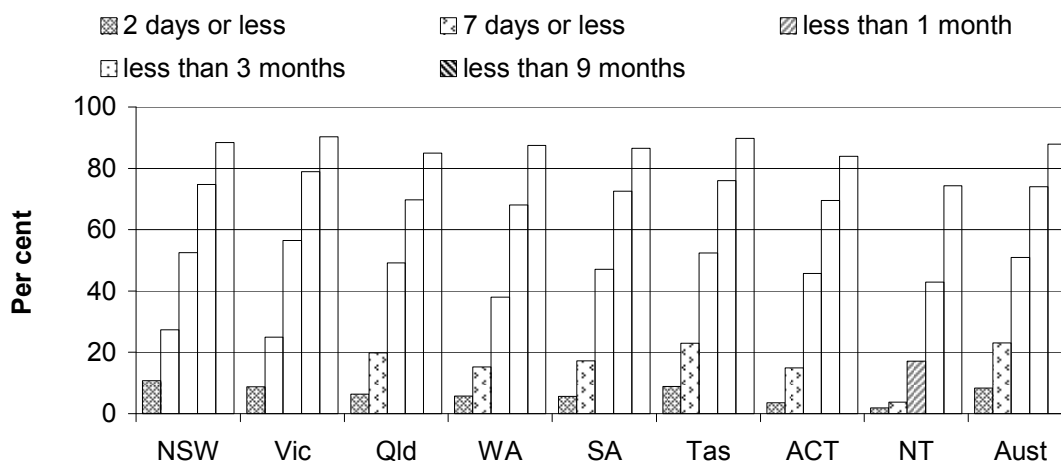
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Overall, 23.0 per cent of all people entering residential high care during 2010-11 did so within 7 days of being approved by an ACAT compared with 25.2 per cent in 2009-10. In 2010-11, 51.0 per cent entered within one month of their ACAT approval and 74.0 per cent entered within 3 months of their approval (figure 13.23), compared with 53.7 per cent and 77.2 per cent respectively in 2009-10 (table 13A.67). The median time for entry into high care residential services was 28 days in 2010-11 compared with 26 days in 2009-10 (table 13A.67).

Nationally in 2010-11, a greater proportion of people entering high care residential services entered within 3 months of approval (74.0 per cent), compared with the proportion entering low care residential services within that time (59.8 per cent). Further data on waiting time measures for low care are included table 13A.67.

Figure 13.23 People entering high care residential care within specified time periods of their ACAT approval, 2010-11^a

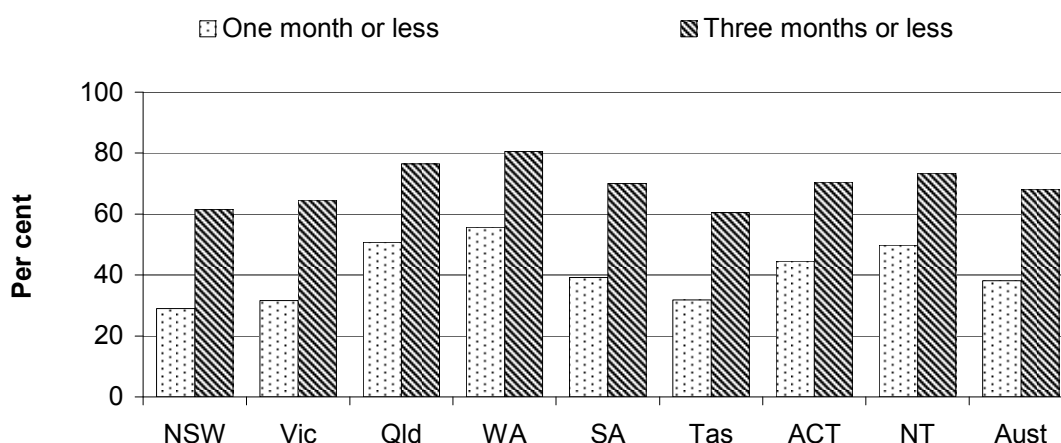


^a Includes residential places categorised as high care.

Source: DoHA (unpublished); table 13A.67.

Overall, 68.2 per cent of all people receiving a CACP during 2010-11 received it within three months of being approved by an ACAT. This proportion varied across jurisdictions. On average, 38.1 per cent started receiving a CACP within one month of their ACAT approval (figure 13.24).

Figure 13.24 People commencing a CACP within one or three months of their ACAT approval, 2010-11



Source: DoHA (unpublished); table 13A.67.

Effectiveness — appropriateness

Assessed longer term care arrangements

‘Assessed longer term care arrangements’ is an indicator of governments’ objective to meet clients’ needs through provision of appropriate aged care services (box 13.13).

Box 13.13 ACAT recommended longer term living arrangements

‘Assessed longer term care arrangements’ is defined as the proportions of ACAT clients recommended to reside in the community (private residence or other community), or in residential care (high or low level), or in another location (such as, hospital) or to have no plan in the reporting year. A recommendation does not mean that the person will be approved for the care recommended, and an approval does not mean that the person will take up the care approved. Aged care assessments are mandatory for admission to Australian Government subsidised residential care or for receipt of a CACP, EACH, EACH-D or TCP package.

High or increasing proportions of clients recommended to remain in the community (assuming this is appropriate) are desirable.

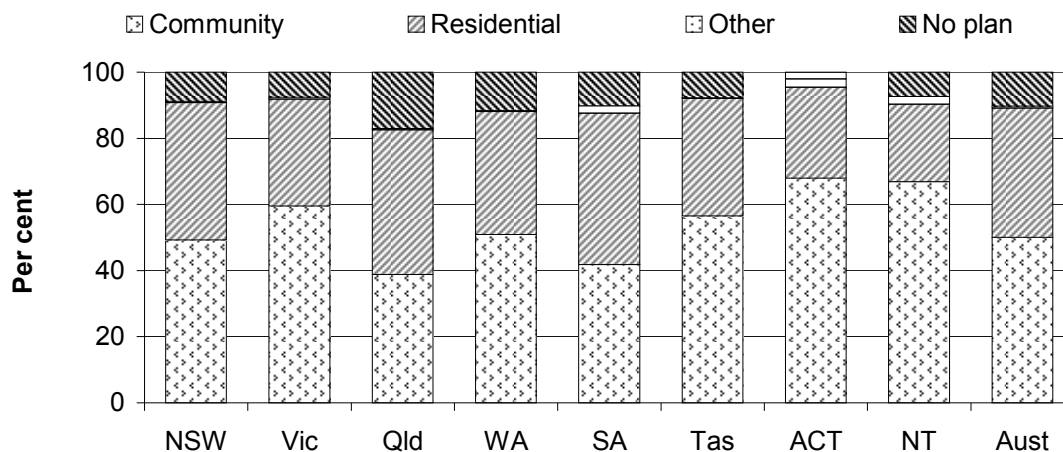
The results for this indicator show the distribution of recommended living arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions can reflect external factors such as geographic dispersion of clients and service availability, but also client preferences and views on the types of client best served by community-based services. The distribution of ACAT recommendations for various living arrangements are influenced by the degree to which any pre-selection process refers people requiring residential care to ACATs for assessment. Jurisdictions with lower overall assessment rates may operate a filtering process to focus assessments on individuals who are more likely to require residential care.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

The national proportion of ACAT clients approved for residential care in 2009-10 was 39.1 per cent and the proportion recommended to remain in the community was 50.0 per cent (figure 13.25). No long term plan was made for 10.2 per cent, which included deaths, cancellations and transfers.

Figure 13.25 Recommended longer term living arrangements of ACAT clients, 2009-10^a



^a No plan includes deaths, cancellations and transfers.

Source: DoHA (unpublished) *Ageing and Aged Care Data Warehouse* from *Aged Care Assessment Program Minimum Data Set*; table 13A.68.

Unmet need

‘Unmet need’ is an indicator of governments’ objective of ensuring aged care services are allocated to meet clients’ needs (box 13.14).

Box 13.14 Unmet need

‘Unmet need’ is defined as the extent to which demand for services to support older people requiring assistance with daily activities is not met.

Low rates of unmet need are desirable, however, defining and determining the level of need at an individual level is complex and at a population level is highly complex. Perceptions of need and unmet need are often subjective.

Data for this indicator are drawn from the ABS *2009 Survey of Disability, Ageing and Carers*. Data are for people aged 70 years or over who self-identified as having a need for assistance with at least one everyday activity, and the extent to which that need was being met (fully, partly or not at all).

Direct inferences about the demand for services need to be made with care, because the measure used does not:

- reveal the intensity of care required by those who identify an unmet need — there is no indication of whether the need can readily be met informally or by formal home care, or whether the person may require residential care
- reflect the degree of unmet demand for a specific type of service. Differences across jurisdictions in the proportion of unmet need can reflect different policy approaches to targeting services. Some governments may choose to focus on those with the greatest degree of need for care and on fully meeting their needs. By contrast, other governments may choose to provide a lower level of service to a greater number of people, while only partly meeting the needs of those with the greatest need for care — both are valid policy approaches
- reflect the past and possible future duration of the need — that is, whether it is long term or transitory
- reflect whether the need relates to a disability support service, aged care service or health care.

Although data are included, this indicator is regarded as yet to be developed, because of the extent of the caveats.

Of those people aged 70 years or over in 2009, who were living in households and who self-identified as having a need for assistance with at least one everyday activity, 29.9 per cent reported that their need for assistance was not fully met (table 13A.69).

Long term aged care in public hospitals

‘Long term aged care in public hospitals’ is an indicator of governments’ objective to minimise the incidence of older people staying in public hospitals when their care needs may be met more appropriately through residential or community care services (box 13.15).

Box 13.15 Long term aged care in public hospitals

'Long term aged care in public hospitals' is defined by two measures:

- the proportion of completed 'aged care type' hospital separations for people aged 70 years or over and Indigenous people aged 50–69 years for which the length of stay was 35 days or longer, where 'aged care type' hospital separations are defined as:
 - the care type was maintenance, and
 - the diagnosis (either principal or additional) was either person awaiting admission to residential aged care service or need for assistance at home and no other household member able to render care
- the proportion of all patient days (for overnight separations only) used by patients who are waiting for residential aged care, where the:
 - care type was maintenance, and
 - diagnosis (either principal or additional) was person awaiting admission to residential aged care service, and
 - separation mode was discharge/transfer to another acute hospital or to residential aged care (unless this is usual place of residence); statistical discharge, that is a change in care type; the patient died; discharge/transfer to other health care accommodation (including mother craft hospitals and another psychiatric hospital); left against medical advice/discharge at own risk or statistical discharge from leave.

Low or decreasing proportions of hospital stays of 35 days or more and low or decreasing proportions of patient days used by people waiting for residential aged care are desirable.

Hospital inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term.

These measures should be interpreted with care, because:

- patients who have not completed their period of acute care in a hospital are not included
- although the diagnosis codes reflect a care type, they do not determine a person's eligibility for residential aged care (this is determined by an ACAT assessment) or necessarily reliably reflect access issues for residential aged care from the acute care sector
- diagnosis codes may not be applied consistently across jurisdictions or over time

(Continued next page)

Box 13.15 (Continued)

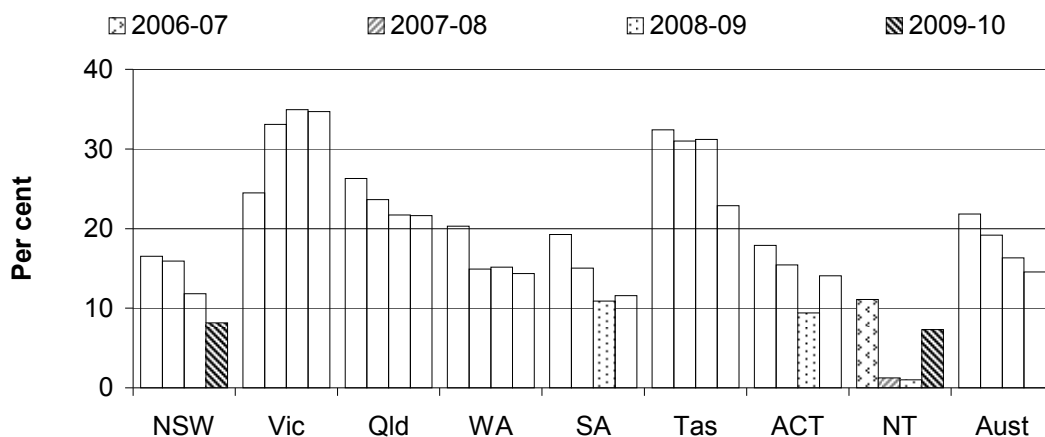
- reported hospital separations and patient days do not necessarily reflect the full length of hospital stay for an individual patient. If a change in the type of care occurs during a patient's hospital stay (for example, from acute to maintenance) then two separations are reported for that patient
- for the first measure, the code 'need for assistance at home and no other household member able to render care' may also be used for respite care for aged care residents or those receiving community care, and some jurisdictions may have a high proportion of this type of use. This is particularly relevant in some rural areas where there are few alternative options for these clients
- the measures do not necessarily reflect alternative strategies in place by states and territories to manage the older person into appropriate residential aged care facilities from acute care hospitals
- the measures are regarded as proxies, as the desired measures (utilising appropriate linked hospital separations and ACAT approvals) are not available at this time. Further development is underway to improve available data sets and associated measures for future reports.

Data reported for this indicator are not directly comparable.

Data quality information for one measure (proportion of all patient days used by patients who are waiting for residential aged care) is at www.pc.gov.au/gsp/reports/rogs/2012. Data quality information for the other measure is under development.

The proportion of separations for 'aged care type' patients (as defined in box 13.15) aged 70 years or over and Indigenous people aged 50–69 years whose separation was 35 days or longer was 14.6 per cent nationally in 2009-10 (figure 13.26). These data reflect only a small proportion of all public hospital separations for patients aged 70 years or over and Indigenous people aged 50–69 years (10 669 separations of a total of 1.6 million nationally) (table 13A.70).

Figure 13.26 Proportion of separations for ‘aged care type’ public hospitals patients that were 35 days or longer^{a, b, c, d, e, f, g}

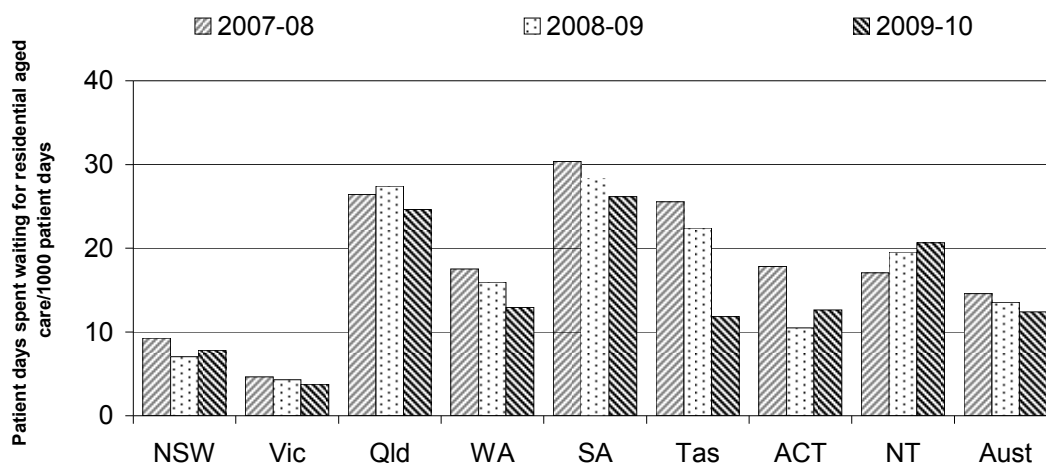


^a Data are for hospital separations with a care type of maintenance and a diagnosis (either principal or additional) of either ‘person awaiting admission to residential aged care service’ or ‘need for assistance at home and no other household member able to render care’ and where the separation lasted 35 days or longer. ^b Age of patients is 70 years or over and Indigenous patients 50–69 years. ^c Although the diagnosis codes reflect a care type, they do not determine a person’s eligibility for residential aged care. ^d Diagnosis codes may not be applied consistently across jurisdictions or over time. ^e These data only account for completed unlinked separations. ^f The code ‘need for assistance at home and no other household member able to render care’ may also be used for respite care for either residential or community care patients. ^g An individual patient may have multiple hospital separations during a single hospital stay, for example, if a change in the type of care occurs during a patient’s hospital stay. Data on length of stay relate to each separation and not to the whole hospital stay.

Source: AIHW (unpublished); table 13A.70.

The proportion of all hospital patient days (for overnight separations only) used by patients who are waiting for residential aged care (as defined in box 13.15) was 12.4 per 1000 patient days nationally in 2009-10 (figure 13.27).

Figure 13.27 Hospital patient days used by patients waiting for residential aged care^{a, b, c, d, e, f}



^a Data include overnight hospital separations only. ^b Numerator data include patients with a care type of maintenance, and diagnosis (either principal or additional) was 'person awaiting admission to residential aged care service', and separation mode was 'discharge/transfer to another acute hospital'; 'discharge, transfer to residential aged care (unless this is usual place of residence)'; 'statistical discharge—type change'; 'died'; 'discharge/transfer to other health care accommodation (including mother craft hospitals)' or 'left against medical advice/discharge at own risk; statistical discharge from leave; discharge/transfer to (an)other psychiatric hospital'. ^c Includes patients of all ages. ^d Although the diagnosis codes reflect a care type, they do not determine a person's eligibility for residential aged care. ^e Diagnosis codes may not be applied consistently across jurisdictions or over time. ^f These data only account for completed unlinked separations. An individual patient may have multiple hospital separations during a single hospital stay, for example, if a change in the type of care occurs during a patient's hospital stay. Data on patient days relate to the defined separations and not to the whole hospital stay.

Source: AIHW (unpublished); table 13A.71.

Intensity of care

'Intensity of care' is an indicator of governments' objective to encourage 'ageing in place' to increase choice and flexibility in residential aged care service provision (box 13.16). (See box 13.17 for background information on the 'ageing in place' policy.)

Box 13.16 Intensity of care

'Intensity of care' is defined by two measures:

- the proportion of people who stayed in the same residential aged care service when changing from low care to high care
- the proportion of low care places occupied by residents with high care needs, compared with the proportion of all operational places taken up by residents with high care needs.

High or increasing rates of ageing in place are desirable, in the context of a flexible system that also meets the need for low level care either in residential facilities or in the community.

These measures reflect the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The *Aged Care Act 1997* aims explicitly to encourage ageing in place to increase choice and flexibility in residential aged care service provision (box 13.17).

This indicator needs to be viewed from the perspective of the system as a whole. The implication of ageing in place is that some places that were allocated for low care will be occupied by high care residents (or, conversely, allocated for high care and occupied by low care residents). Information about the use of operational residential aged care places is provided to demonstrate the impact of ageing in place on the aged care services system over time.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, from June 2003 to June 2011, there was a steady increase in the proportion of people who stayed in the same residential aged care service when changing from low care to high care, from 62.9 per cent to 90.9 per cent (figure 13.28). In June 2011, the proportion was highest in remote areas (96.3 per cent), compared to other areas where it was similar: major cities (91.0 per cent), inner regional areas (90.9 per cent), outer regional areas (89.2 per cent) and very remote areas (89.7 per cent) (table 13A.38).

Box 13.17 Ageing in place in residential care

In its Objects, the *Aged Care Act 1997* 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.

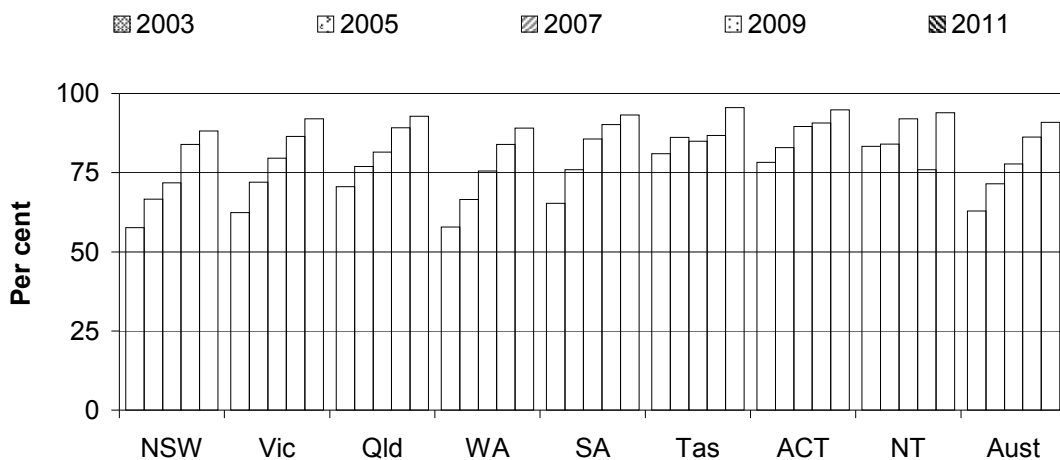
Further, the *Aged Care Act 1997* explicitly aims to encourage and facilitate 'ageing in place'. The Act does not define 'ageing in place', but one useful definition is 'the provision of a responsive and flexible care service in line with the person's changing needs in a familiar environment'. In effect, '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 1997* 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.

Source: DoHA (unpublished).

Figure 13.28 **Proportion of residents who changed from low care to high care and remained in the same aged care service, June^a**

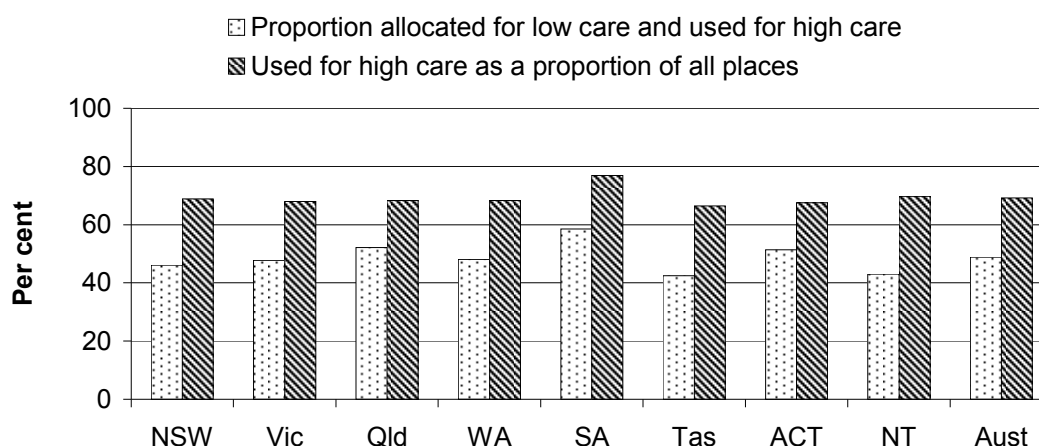


^a Ten years of annual data for this indicator are in attachment 13A.38.

Source: DoHA (unpublished); table 13A.38.

Nationally, 48.9 per cent of low care places in 2010-11 were occupied by residents with high care needs. The proportion of all operational places taken up by residents with high care needs was 69.2 per cent (figure 13.29). These data are provided by remoteness area in table 13A.39.

Figure 13.29 Utilisation of operational residential places, 30 June 2011^a



^a Includes residential places categorised as high care or low care.

Source: DoHA (unpublished); table 13A.39.

Effectiveness — quality

Selected adverse events in residential aged care

‘Selected adverse events in residential aged care’ is an indicator of governments’ objective to provide residential care services that are safe and of high quality by preventing and minimising the harm associated with adverse events in residential aged care (box 13.18).

Box 13.18 Selected adverse events in residential aged care

‘Selected adverse events in residential aged care’ is defined by the number of hospital separations for falls in residential aged care services per 10 000 resident occupied place days. Falls that occurred in residential aged care, but did not result in hospitalisation are not included.

Low or decreasing rates of hospital separations for falls in residential aged care services per 10 000 resident occupied place days are desirable.

Not all falls are preventable. An excessively custodial and risk-averse approach to preventing falls that infringes on a older person’s autonomy and limits rehabilitation is also not appropriate. Interventions that prevent falls or mitigate harm from falls, but do not limit autonomy or rehabilitation are most desirable.

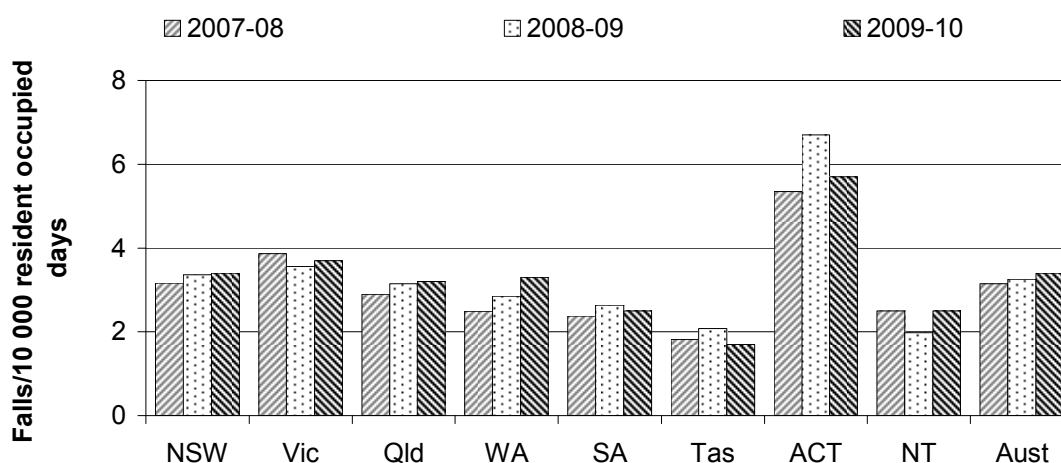
Falls in residential aged care that resulted in a hospital admission are the only adverse events reported on for the 2012 Report. As data for other adverse events (such as pressure ulcers) become available they will also be included.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, in 2009-10 there were 3.4 hospital separations for falls in residential aged care services per 10 000 resident occupied place days (figure 13.30). These data are provided by Indigenous status, remoteness area and SEIFA in table 13A.72. See box 13.19 for background information on falls in residential aged care.

Figure 13.30 Hospitalisations for falls in residential aged care^a



^a Number of hospital separations involving one or more falls in an aged care facility, not the number of falls.

Source: AIHW (unpublished); table 13A.72.

Box 13.19 Falls in residential aged care

Falls are the most common cause of serious injury among older Australians and the most common reason for injuries that result in hospital admission (Pointer, Harrison and Bradley 2003; AIHW 2007). For older people who are hospitalised, the largest proportion of injuries are to the hip and thigh. Of these hip and thigh injuries, a significant proportion are fractures. The second most common injuries are to the head (Bradley and Pointer 2009).

Analysis of data for 2005-06 on hospitalisations for falls of people aged 65 years or over shows that the rate was more than five times higher for people in aged care facilities than for those who lived in the community (Bradley and Pointer 2009). There were differences and similarities in the types of falls experienced by older people in these settings. A high proportion of falls for both groups were from slipping, tripping, stumbling and other falls on the same level. However, the proportion of falls from beds in aged care facilities was twice that of falls from beds in the home. In comparison, the proportion of falls in the home attributed to falls on and from stairs or steps was nearly ten times the proportion for those living in aged care facilities (Bradley and Pointer 2009).

There are a number of risk factors for residents falling in aged care facilities (many of these risks will also apply in other settings). A person's risk of falling increases as their number of risk factors accumulate. Risk factors can be related to:

- a person's behaviour or condition — some examples include wandering behaviour, cognitive impairment and multiple drug use
- the environment or a person's interaction with the environment — relocation between settings and environmental hazards (ACSQHC 2009).

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has identified four components for best practice for fall prevention and harm minimisation in residential aged care: (1) implementing standard falls prevention strategies; (2) identifying falls risks; (3) implementing interventions targeting these risks to prevent falls and (4) preventing injury to those people who do fall (ACSQHC 2009). According to the ACSQHC, knowledge about the risk of falls and how to reduce these falls is growing and a combination of interventions tailored to the individual appear to be effective for reducing the risk of falls. In the residential aged care setting, there is also evidence that certain single interventions, such as hip protectors, vitamin D and calcium supplementation, or medication reviews, prevent fractures or reduce the risk of falls in some residents (ACSQHC 2009).

Source: ACSQHC (2009); Pointer, Harrison and Bradley (2003); AIHW (2007); Bradley and Pointer (2009).

Compliance with service standards for residential care

‘Compliance with service standards for residential care’ is an indicator of governments’ objective to ensure residential care services attain high levels of

service quality, through compliance with certification and accreditation standards (box 13.20).

Box 13.20 Compliance with service standards for residential care

‘Compliance with service standards for residential care’ is defined by two measures:

- the proportion of accredited services which have received three year re-accreditation, by meeting accreditation standards
- the proportion of aged care services that are compliant with building certification, fire safety and privacy and space requirements.

High or increasing proportions of approval for three year re-accreditation and services that are compliant with building certification, fire safety and privacy and space requirements are desirable. The extent to which residential care services comply with service standards and other requirements implies a certain level of care and service quality.

Since 2001, each Australian Government funded residential service has been required to meet accreditation standards (which comprise 44 expected outcomes). The accreditation indicator reflects the period of accreditation granted. The accreditation process is managed by the Aged Care Standards and Accreditation Agency Ltd (ACSAA). A service must apply to ACSAA for accreditation and its application is based on a self-assessment of performance against the accreditation standards. Following an existing residential service applying for accreditation, a team of registered quality assessors reviews the application, conducts an onsite assessment and prepares a report based on these observations, interviews with residents, relatives, staff and management, and relevant documentation. An authorised decision maker from ACSAA then considers the report, in conjunction with any submission from the residential service and other relevant information (including information from DoHA) and decides whether to accredit and, if so, for how long. Commencing services are subject to a desk audit only, and are accredited for one year.

A home must be certified to be able to receive accommodation payments and extra service charges. Residents expect high quality and safe accommodation in return for their direct and indirect contributions, therefore all aged care homes are required to meet fire safety and privacy and space requirements to be eligible to receive the maximum level of the accommodation supplement.

While certification is not time limited, it is based on the principle of continuous improvement and an agreed 10-year plan, introduced in 1999, provided homes with a clear framework for improving safety, privacy and space requirements. Every aged care home that was constructed prior to July 1999 is required to have no more than four residents accommodated in any room, no more than six residents sharing each toilet and no more than seven residents sharing each shower or bath.

(Continued next page)

Box 13.20 (Continued)

Under the privacy and space requirements, all new buildings constructed since July 1999, are required to have an average, for the whole aged care home, of no more than 1.5 residents per room. No room may accommodate more than two residents. There is also a mandatory standard of no more than three residents per toilet, including those off common areas, and no more than four residents per shower or bath.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Accreditation decisions and further information relating to the accreditation standards and ACSAA are publicly available (ACSAA 2009). The accreditation process is summarised in box 13.20.

At 30 June 2011, of residential aged care services that were re-accredited during 2010-11, 81.7 per cent were granted re-accreditation approval for a period of three years (table 13.8).

Table 13.8 Re-accreditation decisions on residential aged care services, 30 June 2011^{a, b}

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Re-accreditation period										
<2 years	%	5.9	9.9	16.2	6.0	7.7	–	14.3	50.0	9.9
2 years or more (but <3 years)	%	5.9	3.9	13.3	12.0	10.3	–	42.9	25.0	8.4
3 years	%	88.1	86.2	70.5	82.0	82.1	100.0	42.9	25.0	81.7
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total re-accredited services										
	no.	118	152	105	50	39	12	7	4	487
Total services	no.	888	761	483	245	263	79	26	15	2 760

^a Data at 30 June 2011 relate only to re-accreditations, and do not include accreditation periods for 24 commencing services. Earlier reports (up to June 2007 data) included both initial accreditations and re-accreditations. ^b Note that 'accreditation period' shows the decision in effect at 30 June 2011. Data in this table will not necessarily be consistent with the accreditation decisions made in 2010-11, because those decisions may not yet have taken effect, or may have been superseded. – Nil or rounded to zero.

Source: ACSAA (unpublished); tables 13A.18 and 13A.73.

Nationally, as at 30 June 2011, 99.7 per cent of residential aged care services were compliant with building certification, fire safety, and privacy and space requirements (table 13.9).

Table 13.9 Residential aged care services compliant with building certification, fire safety and privacy and space requirements, at 30 June 2011

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^a</i>	<i>Aust</i>
Total residential services	no	888	761	483	245	263	79	26	15	2 760
Total compliant services	no	884	761	480	245	263	79	26	15	2 753
Proportion of compliant services	%	99.5	100.0	99.4	100.0	100.0	100.0	100.0	100.0	99.7

^a NT data are variable due to small numbers.

Source: DoHA (2011).

Complaints

‘Complaints’ is an indicator of governments’ objective to ensure aged care services provide a high quality of care (box 13.21).

Box 13.21 Complaints

‘Complaints’ is defined as the number of breaches of an approved provider’s responsibilities in residential and community care under the *Aged Care Act 1997* identified by the Complaints Investigation Scheme (CIS) per 1000 residents.

A low or decreasing rate of breaches is desirable.

This indicator is a proxy of the quality of care. It counts the number of breaches identified by the CIS. Official complaints may indicate dissatisfaction about an element of the service provided, but do not always result in the finding of a breach.

The CIS investigates any potential breach of an approved provider’s responsibilities in residential and community care; requires the service provider, where appropriate, to take action; and is able to refer issues that may be more appropriately dealt with by others (for example, the Aged Care Standards and Accreditation Agency, police, nursing and medical registration boards). The CIS is able to issue Notices of Required Action where an approved provider is found to be in breach of their responsibilities under the *Aged Care Act 1997* and where the breach has not been rectified immediately.

The rate at which complaints occur can be influenced by the propensity of clients and their families or service staff to complain, their knowledge of the complaints system and perceptions of the effectiveness of the complaints system.

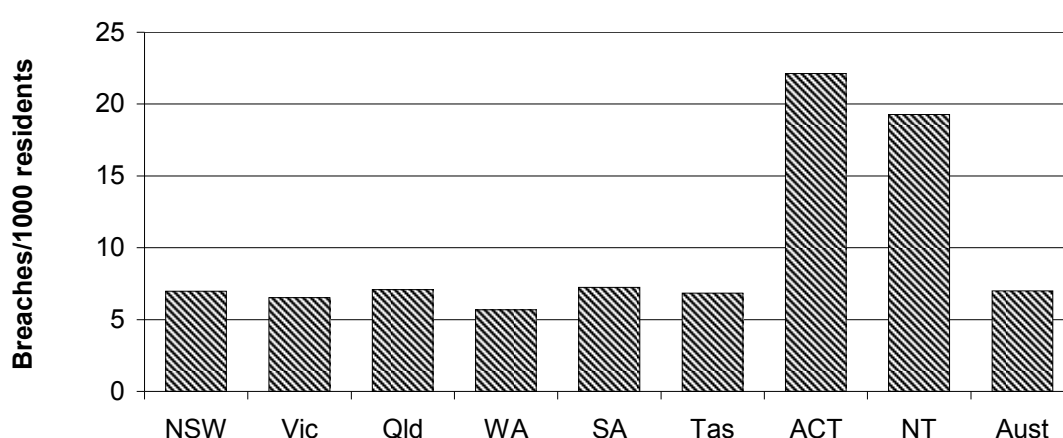
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

From 1 July 2010 to 30 June 2011, the CIS identified 1148 breaches under the *Aged Care Act 1997* (table 13A.74). The number of breaches identified per 1000 residents from 1 July 2010 to 30 June 2011 was 7.0 nationally (figure 13.31).

In the period 1 July 2010 to 30 June 2011, DoHA received 13 606 contacts of which 8468 were within the scope of the Scheme to investigate, although not all of these were complaints. Of the 8468 in-scope cases dealt with by the Scheme, 96 per cent related to residential care services (DoHA unpublished).

Figure 13.31 Complaints Investigation Scheme breaches, 2010-11^{a, b}



^a Data for NT and ACT are variable due to small numbers. ^b Data relate to permanent residents as at 31 December 2010.

Source: DoHA (unpublished); table 13A.74.

Compliance with service standards for community care

‘Compliance with service standards for community care’ is an indicator of governments’ objective to ensure that community aged care programs provide a high quality of service (box 13.22).

Box 13.22 Compliance with service standards for community care

‘Compliance with service standards for community care’ is defined by four measures:

- the number of HACC agencies appraised against the standards as a percentage of the total number of HACC agencies
- the proportions of HACC agencies which achieve high, good, basic, or poor ratings, and the average score in each jurisdiction
- the number of reviews against program standards for community aged care services (CACP, EACH, EACH-D and NRCP) as a proportion of total services to be reviewed
- the proportion of community aged care services (CACP, EACH, EACH-D and NRCP) which received ratings for:
 - Outcome 1 — effective process and systems in place
 - Outcome 2 — some concerns about effectiveness of processes and systems in place
 - Outcome 3 — significant concerns about effectiveness of processes and systems in place.

A high or increasing proportion of HACC agencies having been appraised, and having achieved good or higher ratings and a high average score are desirable. A high or increasing proportion of community aged care services reviewed and a high or increasing proportion reviewed who achieved an outcome 1 (effective processes and systems in place) are desirable.

The indicator monitors the extent to which individual agencies are complying with service agreement standards/program standards. The HACC National Service Standards provide HACC funded agencies with a common reference point for internal quality control by defining aspects of service quality and expected outcomes for consumers. States and territories are required to include the standards in all service agreements. The HACC National Service Standards Instrument has been developed to measure, through a service appraisal process, the extent to which individual agencies are complying with the standards. Monitoring and compliance with the standards are now a major part of service reviews. This indicator also measures the percentage of individual agencies that comply with the service standards, through the outcomes of service standard appraisals. It should be noted that the standards are not an accreditation system.

New Community Care Common Standards came into effect on 1 March 2011. The Common Standards apply for the HACC program, CACP, EACH, EACH-D and NRCP. Quality reporting for 2010-11 for the HACC Program will include a mix of reporting against the HACC National Service Standards for reviews completed prior to March 2011 and against the Community Care Common Standards for any reviews completed after 1 March 2011.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

A total of 3462 HACC agencies were identified for appraisal over the four year period 2007-08 to 2010-11. The number of these agencies appraised was 2630 (76.0 per cent) (table 13.10). The outcomes of these appraisals was a national average score of 17.6 out of 20 (table 13.11).

Table 13.10 HACC National Service Standards appraisals over the four year period ending 2010-11^{a, b}

	<i>Unit</i>	<i>NSW^c</i>	<i>Vic</i>	<i>Qld^d</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^e</i>	<i>NT^f</i>	<i>Aust^d</i>
Appraisals	no.	974	306	1028	280	160	46	30	16	2 630
HACC agencies	no.	1 754	306	820	280	160	72	30	40	3 462
Proportion of agencies assessed	%	55.5	100.0	100.0	100.0	100.0	63.9	100.0	40.0	76.0

^a Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those reported. ^b New Community Care Common Standards came into effect on 1 March 2011. Quality reporting for 2010-11 will include a mix of reporting against the HACC National Service Standards for reviews completed prior to March 2011 and against the Community Care Common Standards for any reviews completed after 1 March 2011. Some jurisdictions delayed undertaking HACC appraisals in the latter part of the four year period pending the introduction of the new standards and the changes in governments roles and responsibilities for HACC (box 13.1). ^c All HACC services were reviewed using a comprehensive monitoring tool between November 2005 and June 2009. That monitoring activity verified NGO self assessment against the HACC instrument. Over 84 per cent of appraisals undertaken indicated scores above 15 across NSW and with 70 per cent above 17.5. ^d In Queensland the number of appraisals exceeds the number of agencies because some service providers were reviewed twice in the four year period. Therefore, calculation of the Australian total of appraisals and the proportion of agencies assessed only includes 820 Queensland agencies. ^e Quality Assessments in the ACT occurred in 2008-09 only. ^f NT data are variable due to small numbers.

Source: State and Territory governments (unpublished).

Table 13.11 HACC National Service Standards results of appraisals over the four year period ending 2010-11 (number)^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld^d</i>	<i>WA</i>	<i>SA</i>	<i>Tas^e</i>	<i>ACT^f</i>	<i>NT</i>	<i>Aust</i>
High (17.5 – 20)	663	169	867	100	102	12	18	3	1 934
Good (15 – 17.4)	150	55	113	79	24	7	9	4	441
Basic (10 – 14.9)	139	60	41	91	20	13	3	7	374
Poor (less than 10)	22	22	7	10	6	14	–	2	83
Average score	17.6	16.5	18.8	15.1	17.3	13.7	17.6	14.3	17.6

^a Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those listed. ^b The results of the appraisals will reflect the individual approaches adopted by each State and Territory. ^c For details about the method of determining the average score, see table 13A.77. ^d In Queensland, some agencies were reviewed twice in the four year period. This table includes outcomes of all appraisals during the cycle. ^e One agency in Tasmania declined to participate in the appraisal process and was therefore scored as zero. ^f Quality Assessments in the ACT occurred in 2008-09 only. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 13A.77.

Nationally, a total of 679 community aged care organisations providing CACP, EACH, EACH-D and NRCP services were to be reviewed in 2010-11 (table 13A.75). Of these services, 78.5 per cent were reviewed (table 13.12). The proportion of the reviews for which an outcome 1 — effective processes and systems in place — was achieved was 80.3 per cent (table 13.12).

Table 13.12 Compliance with service standards for community aged care services — CACP, EACH, EACH-D and NRCP, 2010-11 (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^a</i>	<i>Aust</i>
<i>Proportion of services reviewed</i>	91.2	80.4	67.5	62.9	69.4	73.3	87.5	135.0	78.5
<i>Proportion of reviews achieving relevant outcomes</i>									
Outcome 1 ^b	81.8	87.8	71.5	72.7	85.3	100.0	85.7	70.4	80.3
Outcome 2 ^c	9.7	8.1	18.2	22.7	7.4	—	14.3	29.6	12.6
Outcome 3 ^d	8.5	4.1	10.2	4.5	7.4	—	—	—	7.1

^a In the NT, more services were reviewed than the annual target. ^b Outcome 1 is effective processes and systems in place. ^c Outcome 2 is some concerns about effectiveness of processes and systems in place. ^d Outcome 3 is significant concerns about effectiveness of processes and systems in place. — Nil or rounded to zero.

Source: DoHA (unpublished); tables 13A.75-76.

Client appraisal of service standards

‘Client appraisal of service standards’ is an indicator of governments’ objective to ensure high levels of client satisfaction with aged care services (box 13.23).

Box 13.23 Client appraisal of service standards

‘Client appraisal of service standards’ is yet to be defined.

Data for this indicator were not available for the 2012 Report.

Efficiency — inputs per output unit

Cost per output unit

‘Cost per output unit’ is an indicator of governments’ objective to deliver efficient aged care services (box 13.24).

Box 13.24 Cost per output unit

‘Cost per output unit’ is defined by two measures:

- cost per ACAT assessment — Australian Government expenditure on ACATs divided by the number of ACAT assessments completed
- cost per hour of service for HACC — State and Territory governments expenditure on services, divided by the number of hours of service provided (by service type domestic assistance, personal care, nursing and allied health service).

This is a proxy indicator of efficiency and needs to be interpreted with care. While high or increasing expenditure per assessment or hour of service 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 or hour of service may reflect improving efficiency or less time spent with clients, for example.

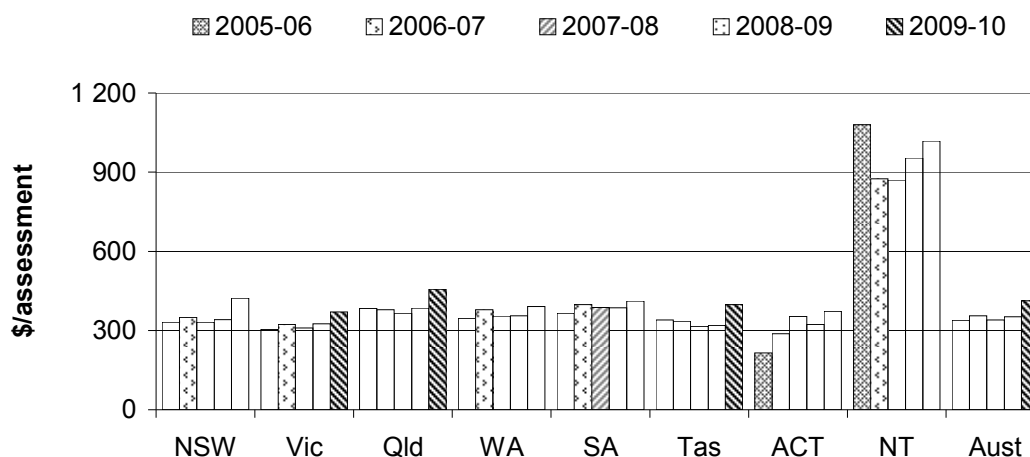
Cost per ACAT assessment and cost per hour of HACC service have been developed as proxies. For cost per ACAT assessment, only Australian Government expenditure is included, although State and Territory governments also contribute to the cost of ACAT assessments. Similarly only State and Territory governments’ expenditure on HACC services is included and expenditure funded by non-government sources is excluded.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Australian Government expenditure per aged care assessment during 2009-10 averaged \$412 nationally (figure 13.32). Nationally, real expenditure increased between 2005-06 to 2009-10. The cost per assessment is calculated using the total number of assessments and therefore includes clients aged less than 70 years.

Figure 13.32 **Australian Government expenditure on aged care assessments, per assessment (2009-10 dollars)^{a, b, c}**

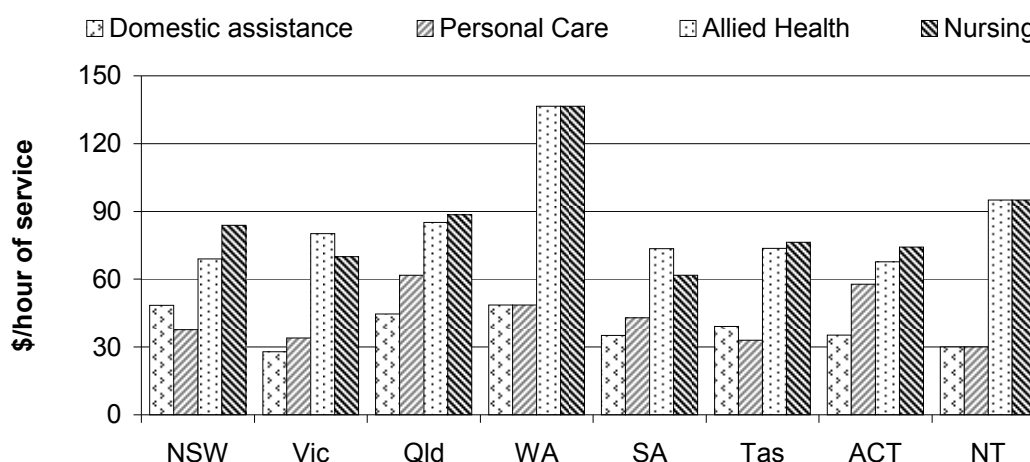


^a Only includes Australian Government expenditure on ACATs. ^b ACAT referrals and operations vary across jurisdictions. ^c The high cost for each assessment in the NT may be influenced by the remoteness of people requiring assessments, clients having English as a second or third language, and a lack of supporting health and community services infrastructure to assist with assessments.

Source: DoHA (unpublished); table 13A.78.

State and Territory governments' expenditure per hour of HACC service during 2009-10 was higher for nursing and allied health than for domestic assistance and personal care across all states and territories (figure 13.33).

Figure 13.33 **State and Territory governments' expenditure per hour of HACC service, by service type, 2009-10^a**



^a WA and the NT contract by service group. Unit costs reported are an average across all services in the group.

Source: DoHA (unpublished), from State and Territory governments *HACC 2009-10 Annual Business Reports*; table 13A.79.

Expenditure per head of target population

‘Expenditure per head of target population’ is an indicator of governments’ objective to deliver efficient aged care services (box 13.25).

Box 13.25 Expenditure per head of target population

‘Expenditure per head of target population’ is defined as government inputs (expenditure) divided by the number of people aged 70 years or over and Indigenous people aged 50–69 years. Expenditure per person in the target population is reported for residential care, selected community aged care programs (CACP, EACH and EACH-D) and multi-purpose and Indigenous specific services combined and reported separately for the three main service types: residential care services, HACC and CACP services.

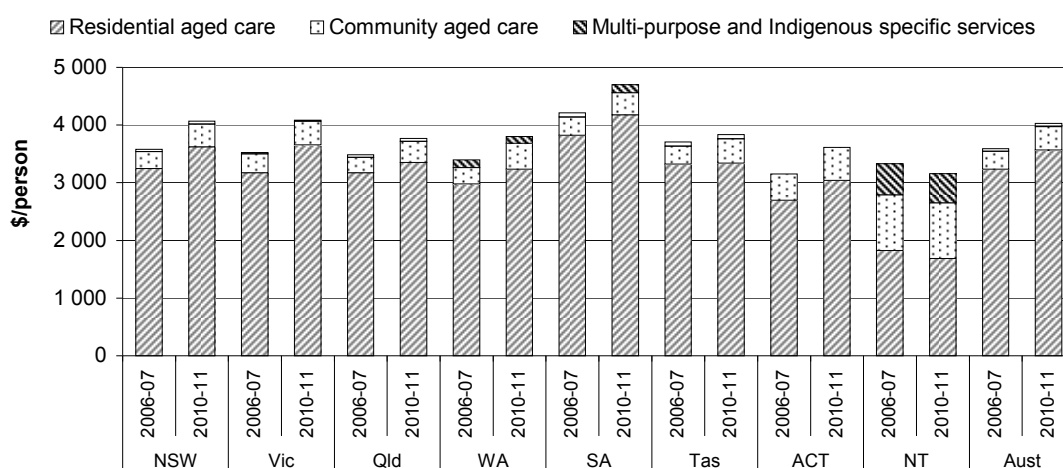
This is a proxy indicator of efficiency and needs to be interpreted with care as it measures cost per target population, not cost per unit of service. While high or increasing expenditure per person can reflect deteriorating efficiency, it can also reflect changes in aspects of the service (such as better 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 can reflect improving efficiency or a decrease in service standards.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Australian Government real expenditure on residential care, selected community care programs (CACP, EACH, EACH-D), and on multipurpose and Indigenous specific services combined per person aged 70 years or over and Indigenous people aged 50–69 years increased from \$3593 in 2006-07 to \$4032 nationally in 2010-11 (figure 13.34).

Figure 13.34 Australian Government (DoHA and DVA) real expenditure on selected programs, per person in the target population (2010-11 dollars)^{a, b}



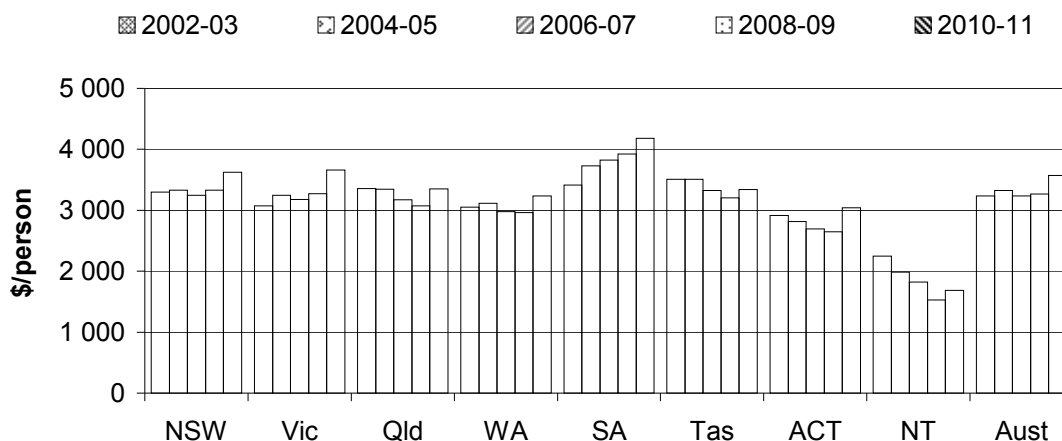
^a Population data for years prior to 2008 are from population projections by statistical local area (SLA) for 2002–2022 based on the 2001 Census prepared for DoHA by the ABS according to assumptions agreed by DoHA. Population data for June 2008 are from preliminary population projections by SLA for 2006–2026 based on the 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. Population data for years from June 2009 are from population projections by SLA for 2007–2027 based on the 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information. ^b Recent ABS published population estimates (for Indigenous people and the total population) show that the aged care target population in the NT was substantially underestimated in 2006-07. This explains the apparent decrease in expenditure per head of target population for the NT from 2006-07 to 2010-11.

Source: DoHA (unpublished); tables 13A.8-10.

Nationally, Australian Government real expenditure by both DoHA and DVA on residential care services per person aged 70 years or over and Indigenous people aged 50–69 years increased from \$3237 in 2002-03 to \$3569 in 2010-11 (figure 13.35). If the payroll tax supplement paid by the Australian Government is excluded, this expenditure nationally was \$3513 in 2010-11 (table 13A.80).

Nationally, DoHA expenditure on residential care per person aged 70 years or over and Indigenous people aged 50–69 years in 2010-11 was \$3016 including the payroll tax supplement and \$2969 excluding the payroll tax supplement (table 13A.8). DVA expenditure on residential care per person aged 70 years or over was \$570 including the payroll tax supplement and \$561 excluding the payroll tax supplement in 2010-11 (table 13A.14).

Figure 13.35 Australian Government (DoHA and DVA) real expenditure on residential services per person in the target population (2010-11 dollars)^{a, b, c}



^a Includes a payroll tax supplement provided by the Australian Government. Actual payroll tax paid may differ.

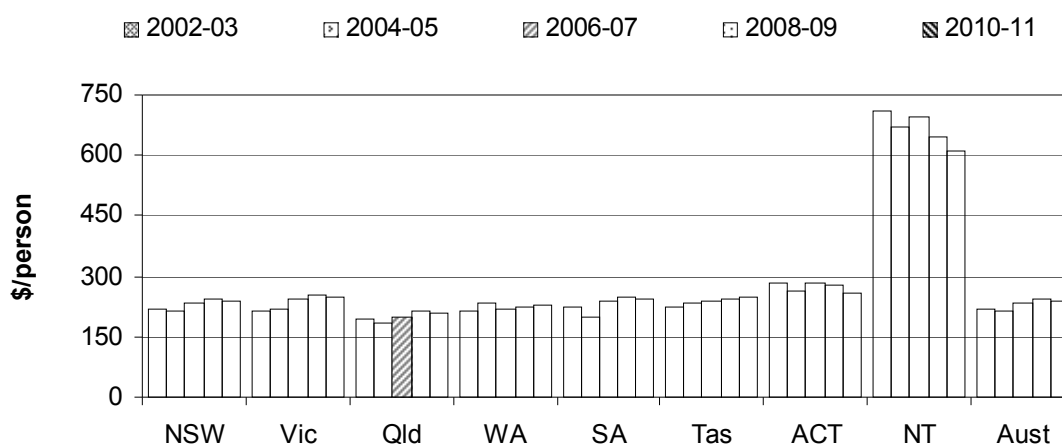
^b Population data for years prior to 2008 are from population projections by SLA for 2002–2022 based on the 2001 Census prepared for DoHA by the ABS according to assumptions agreed by DoHA. Population data for June 2008 are from preliminary population projections by SLA for 2006–2026 based on the 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. Population data for years from June 2009 are from population projections by SLA for 2007–2027 based on the 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information.

^c Full ten years of data for this indicator are in attachment 13A.80.

Source: DoHA (unpublished); DVA (unpublished); table 13A.80.

Australian Government expenditure on CACPs per person aged 70 years or over and Indigenous people aged 50–69 years was similar in most jurisdictions except the NT. Nationally, real expenditure per person aged 70 years or over and Indigenous people aged 50–69 years increased from \$217 in 2002-03 to \$239 in 2010-11 (figure 13.36).

Figure 13.36 Australian Government real expenditure on CACP services per person in the target population (2010-11 dollars)^{a, b}



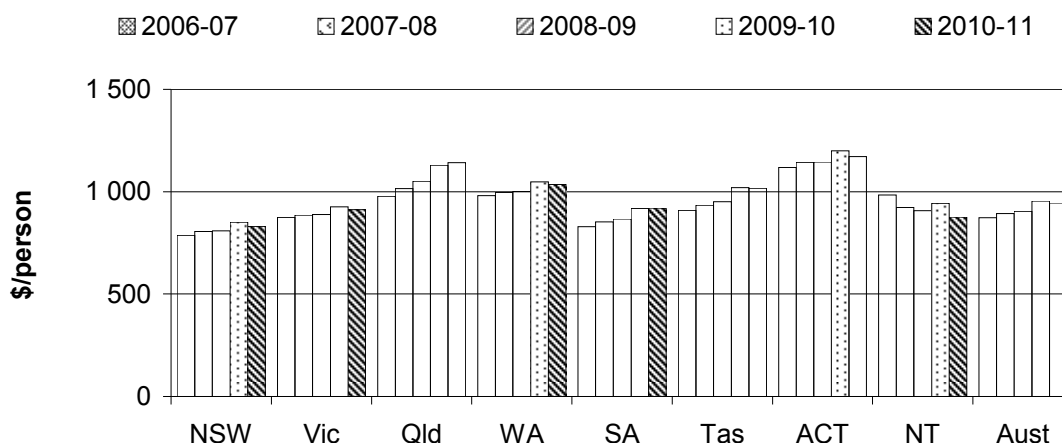
^a Population data for years prior to 2008 are from population projections by SLA for 2002–2022 based on the 2001 Census prepared for DoHA by the ABS according to assumptions agreed by DoHA. Population data for June 2008 are from preliminary population projections by SLA for 2006–2026 based on the 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. Population data for years from June 2009 are from population projections by SLA for 2007–2027 based on the 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information.

^b Full ten years of data for this indicator are in attachment 13A.83.

Source: DoHA (unpublished); table 13A.83.

Australian, State and Territory governments' real expenditure on HACC services per person aged 70 years or over and Indigenous people aged 50–69 years was \$945 nationally in 2010-11, higher than expenditure in 2006-07 which was \$873 (figure 13.37). These data reflect expenditure against the population used as the proxy in this chapter (see section 13.1), which is not the same as the HACC target population. Expenditure per person in the HACC target population is reported in table 13A.81.

Figure 13.37 Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over and Indigenous people aged 50–69 years (2010-11 dollars)^{a, b, c, d, e}



^a People aged 70 years or over and Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person in the HACC target population is contained in table 13A.81. HACC target population data are in table 13A.53. ^b These data represent expenditure under the HACC Review Agreement only. ^c Reports provisional HACC data that have not been validated and may be subject to revision. ^d Expenditure reflects an equalisation strategy. ^e Population data for years prior to 2008 are from population projections by SLA for 2002–2022 based on the 2001 Census prepared for DoHA by the ABS according to assumptions agreed by DoHA. Population data for June 2008 are from preliminary population projections by SLA for 2006–2026 based on the 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. Population data for years from June 2009 are from population projections by SLA for 2007–2027 based on the 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); table 13A.82.

Outcomes

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

Social participation in the community

‘Social participation in the community’ has been identified for development as an indicator of governments’ objective to encourage the wellbeing and independence of older people (box 13.26).

Box 13.26 Social participation in the community

‘Social participation in the community’ is yet to be defined.

High or increasing rates of participation in the community are desirable.

When developed for future reports, this indicator will show the extent to which older people participated in community, cultural or leisure activities.

Maintenance of individual functioning

‘Maintenance of individual functioning’ is an indicator of governments’ objective for aged care services to promote the health, wellbeing and independence of older people (box 13.27).

Box 13.27 Maintenance of individual functioning

‘Maintenance of individual functioning’ is defined as improvement in the TCP client’s level of functioning, reflected in the movement from the average Modified Barthel Index (MBI) score on entry to the TCP to the average MBI score on exit from the TCP. The minimum MBI score is 0 (fully dependent) and the maximum score is 100 (fully independent).

This indicator needs to be interpreted with care. The TCP is one aged care program where it is possible to measure a change in a client’s level of functioning. Variation in the average MBI scores on entry and exit from the program may reflect a range of target client groups for the program across jurisdictions. An increase in score from entry to exit is desirable.

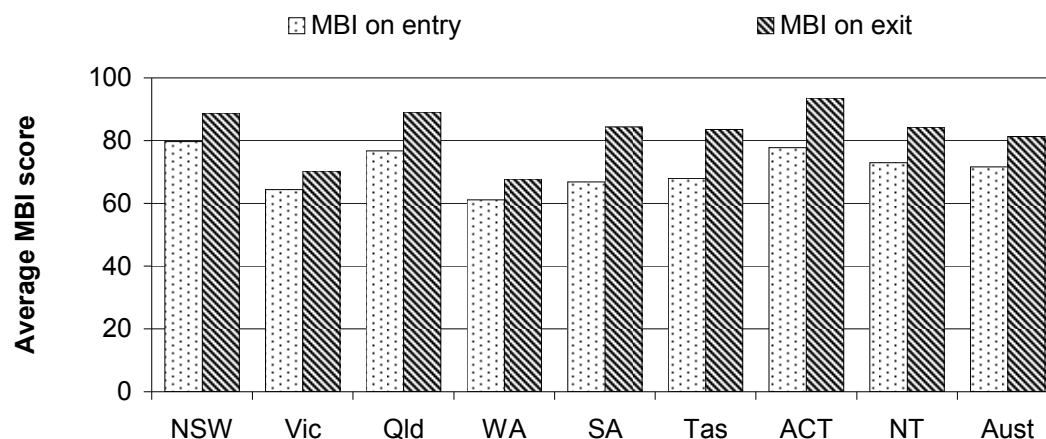
The TCP is a small program at the interface of the health and aged care systems. It may be possible to develop measures for other aged care programs such as residential aged care and community aged care services which would be indicators of maintenance of individual functioning.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

The average MBI score on entry to the TCP in 2010-11 was 71.7 nationally. The average MBI score on exit from the TCP was 81.3 nationally (figure 13.38).

Figure 13.38 Transition Care Program — average Modified Barthel Index score on entry and exit, 2010-11^a



MBI = Modified Barthel Index. ^a The MBI is a measure of functioning in the activities of daily living, ranging from 0 (fully dependent) to 100 (fully independent). Data are reported for TCP recipients who completed a transition care episode.

Source: DoHA (unpublished); table 13A.84.

Enabling people with care needs to live in the community

‘Enabling people with care needs to live in the community’ has been identified for development as an indicator of governments’ objective to delay entry to residential care (box 13.28).

Box 13.28 Enabling people with care needs to live in the community

‘Enabling people with care needs to live in the community’ is yet to be defined.

High or increasing rates of people with care needs remaining and participating in the community are desirable.

When developed for future reports, this indicator will show the extent to which older people’s entry to residential care is delayed.

13.4 Future directions in performance reporting

For several aspects of aged care services, indicators are not fully developed and there is little performance reporting available. Priorities for the future include:

- continued improvement of efficiency indicators
- improved reporting of waiting times for aged care
- improved reporting of long term aged care in public hospitals
- inclusion of additional data on adverse events in residential aged care as they become available
- further development of outcome indicators.

COAG Developments

Outcomes from review of Report on Government Services

The COAG endorsed recommendations (December 2009) of the review of the RoGS implemented during 2010 and 2011 are reflected in this Report. Implementation of other recommendations will be reflected in future reports.

Review of National Agreements and National Partnership Agreements

COAG has agreed to progress the recommendations of the Heads of Treasuries (HoTs) Review of National Agreements, National Partnerships and Implementation Plans and reports of the CRC. A working group, led by Senior Officials from First Ministers' and Treasury agencies, will review the performance frameworks of a limited number of agreements, including the NHA. The reviews will be concluded by June 2012. The recommendations of the review of the NHA will be considered by the Steering Committee and may be reflected in future reports.

13.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter.

Australian Government comments

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A new National Partnership (NP) Agreement was negotiated during 2010-11 to implement the Council of Australian Governments agreement that from 1 July 2011 the Australian Government will assume full funding and policy responsibility for aged care services for people 65 years of age and over, and Indigenous people 50 years and over. This includes responsibility for basic community care services for older people under the HACC Program, except in Victoria and Western Australia where existing arrangements for the HACC Program will continue.

From 1 July 2012, the Australian Government will assume full operational responsibility for all aged care services for non-Indigenous people aged 65 years and over and for Aboriginal and Torres Strait Islander people aged 50 years and over covering basic home care through to residential care in most states and territories. While service delivery mechanisms for basic home care will not be substantially altered before 1 July 2015, these reforms will enable the Australian Government to build a consistent and unified aged care system that delivers high quality, accessible and affordable care.

It has been agreed that the Home and Community Care (HACC) Program reforms will occur in two phases (except in Victoria and WA):

- *Phase 1: from 1 July 2011 until 30 June 2012* — the Australian Government will continue to fund State and Territory governments to manage the HACC program, but the Australian Government will fully fund HACC services for all people aged 65 years and Indigenous people aged 50–64 years.
- *Phase 2: from July 2012* — the Australian Government will fund and manage the HACC program services for clients aged 65 years and over and for Indigenous Australians clients aged 50–64 years and Indigenous clients aged under 50 years.

This shift in responsibility will enable the development of a consistent aged care system covering basic care at home through to high level care in aged care homes. It will enable the Australian Government to drive increased integration between acute care, public hospitals, GPs, primary health care and aged care.

In 2010 the Australian Government announced it would invest over \$800 million in aged care, including more than \$530 million in additional funding, and would direct almost \$300 million to the states and territories to support older people eligible for aged care in public hospitals.

A major inquiry into aged care by the Productivity Commission was set up in April 2010 and the subsequent report was released by the Australian Government in August 2011. In developing its response to the Productivity Commission's report, the Australian Government will be meeting with key stakeholders and has also started a national conversation with older Australians, their families and carers on the ageing reform agenda at forums across the country.

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New South Wales Government comments

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In 2010-11, the NSW Home and Community Care (HACC) program budget grew by \$38.3 million, an increase of 6.5 per cent over the previous year.

Overall, the HACC Program provided services to around 270 000 people in NSW. Over 12.6 million hours of support was provided, in addition to 3.5 million meals and over 2 million community transport trips. Over 600 organisations provided services, the majority of these being locally based with volunteer management committees. A key strength of the NSW HACC Program is its strong community base.

In response to the need for specialised services for people with dementia, the HACC Capital Strategy delivered twelve new dementia-specific day care centres by 30 June 2011. Two of the remaining four centres will be operational in late 2011 and the final two will open in 2012.

The NSW Department of Health, together with the Department of Family and Community Services, worked closely with a range of agencies, including Alzheimer's Australia, to implement the *NSW Dementia Services Framework 2010-15*. The HACC program is a major contributor to the provision of dementia supports in NSW.

NSW Health continues to work with the Commonwealth on opportunities to improve integration of specialist health services for older people within the national aged care system. An Integrated Services Framework is currently being developed to articulate links between primary care, health care and aged care; to improve the capacity of NSW health system to respond to the often complex care and support needs of frail older people and their carers; to better integrate with services for people with chronic and complex disease; and to improve access of frail older people to local specialist health aged care services.

The NSW Government has agreed to the Commonwealth's proposal that NSW Health will continue to provide Aged Care Assessment Team (ACAT) services through an extended transition period 2012-14. A total of 33 of the 39 ACATs in NSW now submit Aged Care Client Records electronically to Medicare Australia.

The Transition Care Program, jointly funded by the Commonwealth and the State, is increasingly becoming an important component of specialist aged care services delivered by NSW Health. In 2010-11, 5575 clients accessed this Program, an increase of 864 clients over 2009-10 admissions. Approximately 57 per cent (3195) were able to return home or remain at home following Transition Care. Some 74 per cent (4128) maintained or improved their functional capacity.

Three key specialist health services for older people are provided under the Long Stay Older Patients (LSOP) Implementation Plan 2010-2012: (i) AgedCare Services in Emergency Teams which aim to improve the clinical management of older people in Emergency Departments; (ii) Acute to Aged-Related Care Services which target early and appropriate identification of the discharge support needs of older people admitted to hospital; (iii) Hospital-to-Home short-term post hospitalisation support packages for people aged 75 years or over.

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Victorian Government comments

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In 2010–11, Victoria strengthened its work in promoting the health, wellbeing and participation of older people by:

- improving the way HACC is delivered, including implementation of the Active Service Model
- extending the Well for Life program by promoting activities that enhance emotional wellbeing
- developing initiatives that aim to improve the nutrition of older Victorians living in supported accommodation
- developing a new website, Seniors Online, which will provide a platform for the Victorian Government to communicate directly with older people.

The former Office of Senior Victorians moved from the Department of Planning and Community Development to the Department of Health strengthening the department's role in celebrating the contribution of older people and promoting the health, wellbeing and participation of Victorian seniors.

In 2010-11, Victoria continued its strong engagement with COAG and the Commonwealth on issues in health and ageing. This included implementing agreed COAG priorities through the National Healthcare Agreement and National Partnership Arrangements. The National Health Reform Agreement was signed in early 2011.

In Victoria, HACC remains a joint responsibility and Victoria will continue to present the case for continued integration between aged care assessment and health services' role in assessing and supporting older people needing health and aged care services. These reflect Victoria's views in relation to health reform and aged care, and the important recognition that the effectiveness of the aged care system impacts directly on the health care system, including on its efficiency. Structured, deliberate links between health and aged care also aid the effectiveness of the aged care system and the care delivered to older people.

The Victorian government has a vision for the future, and a plan to get there. There are seven priority areas for the development and operation of the Victorian health and aged care system, as part of the *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan*:

- developing a system that is responsive to people's needs
- improving every Victorian's health status and experiences
- expanding service, workforce and system capacity
- increasing the system's financial sustainability and productivity
- implementing continuous improvements and innovation
- increasing accountability and transparency
- utilising e-health and communications technology.

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Queensland Government comments

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The Department of Communities, is leading the *Positively Ageless, Queensland Seniors Strategy 2010-20*. The initial 2010-12 Action Plan containing 138 initiatives across 17 State Government agencies, with an investment of approximately \$1.6 billion in services and programs.

In 2010-11, Queensland continued to address priorities identified in the HACC Triennial Plan 2008-11. The high level of program growth over the triennium aimed to bring Queensland into parity with other states and territories in terms of per capita expenditure. Other key HACC achievements in 2010-11 included:

- Promoting and embedding the use of assistive technologies to enhance the safety and independence of HACC eligible service users and expand service delivery through funding five demonstration projects.
- Commencing independent evaluations of the Continence Management Strategy and the delivery of Major Home Modifications services.
- Building on the positive evaluation of the pilot program Nutrition for One or Two and commenced expanding program to over 20 locations state-wide.
- The Community Services Skilling Plan conducted a state-wide project, working closely with service providers, workers and volunteers to identify training needs and building links with registered training providers.

Queensland Health is helping people get well in their communities by continuing to implement places approved under the Transition Care Program. As at 30 June 2011, 606 places were operational. During 2010-11, Queensland Health contributed over \$16 million towards the cost of Transition Care.

Queensland Health is delivering more services sooner and closer to home through local based initiatives under the Long Stay Older Patients' Program. Initiatives include Hospital in the Home and Nursing Home, Interim Care, Early Intervention and Hospital Avoidance across metropolitan and major provincial sites.

Queensland has implemented new technology to improve services for Queenslanders. In 2010-11, 28 747 aged care assessments were completed and submitted via the electronic lodgement process.

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Western Australian Government comments

“ The State continues to monitor the effects that the ageing population has on the demand for aged care services and work continues on the streamlining of a range of client pathways across the continuum of care.

The WA Assessment Framework (WAAF) commenced from 1 January 2011 in the Perth metropolitan area and aims to streamline entry into the aged care system by linking the Home and Community Care (HACC) and Aged Care Assessment Team (ACAT) assessment processes, sharing client information and ensuring that the client and/or carer are at the centre of decision making. The WAAF is being evaluated and will continue to evolve based on the outcomes of the evaluation and in line with a continued improvement approach.

In 2008 the Department of Health (DOH) developed an overarching ‘Model of Care for Older People in WA’ that was supported by a number of service specific service delivery models of care. This year the focus had been on the finalisation of the Dementia Model of Care to complete the suite of service specific delivery models. The Dementia Model of Care builds on the National Framework for Action on Dementia 2006-10.

The Friend in Need- Emergency (FINE) scheme continues to support a range of services that support the interface between the community, residential care and hospital systems for aged people and people with complex health problems.

Two of the services operating within the FINE scheme include:

- The Residential Care Line (RCL) that provides clinical and technical support to staff in residential care facilities. The RCL includes a 24 hour 7 day a week telephone triage service and an outreach nursing team.
- Complex Needs Coordination Team’s (CoNECT) that aim to maintain and improve the quality of life for “at risk” clients and their family/carers with a focus on preventing functional decline and improving ‘outcomes’ for clients and family/carers, reducing avoidable public hospital emergency department presentations, and preventing avoidable public hospital admission.

Growth in sub acute services continues to support an ageing population with a focused on expanding Geriatric Evaluation and Management in day therapy units, Rehabilitation in the Home (RITH), rural visiting geriatrician and psychogeriatrician professional services, specialist community rehabilitation services and State-wide Clinical Training for specialist rehabilitation, geriatrician, psychogeriatrician physicians and allied health staff.

In order to make effective use of resources, WA has where possible supported existing services with additional resources. There has been a particular focus across rural and remote WA Country Health Service (WACHS) regions.

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South Australian Government comments

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In 2010-11, the Department for Families and Communities realigned administration of the ageing and disability sectors in South Australia through the establishment of the Community and Home Support SA Division. Under this structure the Disability, Ageing and Carers Branch (DAC) lead the development and implementation of ‘Improving with Age — Our Ageing Plan for South Australia’.

The Aged Care Assessment Program projects (ACAP) have been developed in line with the ACAP Implementation Plan outcomes and Key Performance Indicators to improve improving data quality and the consistency and timeliness of ACAT assessments by streamlining ACAT business processes across South Australia through a state-wide approach to change management and working towards an electronic environment for the submission of the Aged Care Client Record to Medicare Australia.

South Australia has continued to build the interface between Access to Home Care (A2HC) and the ACATs. A high proportion of people seeking an ACAT assessment do not progress to an ACAT referral following screening and discussion at A2HC. With this model, clients not requiring community packages or residential aged care in the near future are linked to more appropriate and lower level services such as Home and Community Care (HACC).

With the expansion of A2HC across the metropolitan region it is expected that this will have a significant impact on the client experience with improved service linkages and the timeliness of effective referral as well as improved referrer knowledge regarding access to the aged care sector. Current figures indicate between 41–46 per cent of current referrals for an ACAT assessment are actually linked to more appropriate services, typically HACC.

The SA Home and Community Care (HACC) program continues to take a strategic approach to funding allocation with emphasis on regional consultations aimed at improving the evidence base for funding planning and allocations that were established in the Triennial Plan (2008-09 to 2010-11). The SA HACC program continued to expand, with \$12.1 million in additional funding bringing the total budget to \$174.3 million in 2010-11.

Additional funding was allocated for services for Aboriginal people and people from Cultural and Linguistically Diverse (CALD) backgrounds, with CALD-specific funding increasing from \$2.5 million in 2001-02 to \$10.4 million in 2010-11.

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Tasmanian Government comments

“ Tasmania has the oldest population in Australia with Tasmania’s Demographic Change Advisory Council forecasting that the proportion of the population aged 65 years or over will rise from 16 per cent in 2011 to around 25 per cent by 2030.

While demand for aged care services will increase with that demographic change, evidence confirms better outcomes for older people and lower costs to governments through enabling older people to live independently and as long as possible in their own homes.

The Tasmanian Government has been committed to that principle and in 2011 it has matched the Australian Government’s offer of growth in the Home and Community Care (HACC) Program. Growth has been focussed towards strengthening the sustainability of existing services, particularly social support, personal care, transport and respite. A continuing priority has been the expansion of the very successful health-promoting Home Independence Program.

While under National Health Reform Agreement, the Australian Government is moving to assume full funding and management responsibility for the provision of aged care services to people over 65 years of age, the Tasmanian Government retains a strong interest in the planning and provision of those services and their impact on those parts of the broader health and human services system for which it retains whole or partial responsibility.

Tasmania considers it to be critical that national aged care planning into the future be particularly mindful of the circumstances of regional and rural communities and people with special needs, with reasonable protection for effective locality-based aged care service models that have developed over years in response to the challenges presented by economies-of-scale issues.

While longer term aged care reform planning is essential, older people are also substantial consumers of broader health and hospital services and Tasmania has continued to make a considerable investment in 2010-2011 with both the jointly-funded Transition Care and the Long Stay Older Patients programs, continuing to successfully divert older people away from, or reduce their stay, in acute care.

Hospitals have also continued to utilise strategies, such as the purchase of temporary beds in private aged care facilities, to facilitate the transition for older people from hospital to home or into residential care.

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Australian Capital Territory Government comments

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- Canberrans' enjoy one of the highest standards of health and healthcare in Australia, but our population is increasing and our community is getting older. The ACT Government in partnership with the ACT Ministerial Advisory Council on Ageing has developed a Strategic Plan for Positive Ageing (2010–2014) to address the future needs of our ageing population.
- It aims to provide a blueprint for a coordinated approach across Government and the community to support positive ageing and an age-friendly city where older people are respected, valued and supported to actively participate.
- The regional population growth projections have influenced planning and infrastructure through the Capital Asset Development Project *Your health — our priority* is a \$1 billion plus redevelopment of the Health Directorate infrastructure. Plans are underway to develop critical care, cancer services, mental health services, diabetes, corrections health and surgical services plans.
- The Transition Care Program is jointly funded between the States, Territories and the Commonwealth and aims to provide short term care to optimise the functioning and independence of older people after a hospital stay. The ACT Transitional Therapy Care Program provides a mix of community and residential based care with the demand for community based transition care greater than residential based care. The total allocation for 2010-11 was 49 places comprising 34 community places and 15 residential with additional places to be effective in 2011-2012.
- In recognition of the General Practitioner (GP) access difficulties, a GP in-hours locum service to support GPs and residents of residential aged care facilities has commenced. The GP Aged Day Service (GPADS) provides an in-hours locum service to support people who are homebound or in residential aged care facilities and their regular GP is unable to make a house call. The service aims to support ACT GPs by providing care to frail and/or aged patients who need prompt attention and might otherwise have required hospital admission.
- The service hours are 8am to 6pm Monday – Friday (excluding public holidays) and referrals are received from GPs to the locum service who will then provide primary care to patients.
- Over the last four years under the Long Stay Older Patients (LSOP) initiative, Health Directorate have employed a Community Geriatrician and a Nurse Practitioner to assist with the issue of long stay older patients in public hospitals and their access to appropriate long-term care options.

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Northern Territory Government comments

“ The NT continues to support people as they age and encourage them to take responsibility for their own health and financial wellbeing. As part of this commitment, the NT has continued to progress issues of ageing under the Active Ageing Framework (the Framework). The Framework focuses on providing people with mechanisms to maintain their good health, continue to remain mentally and physically active and retain their capacity for independent living for as long as possible regardless of their age and to ensure people's quality of life is sustained. The Framework will be reviewed in 2012.

The NT population profile is distinctly different when compared with other parts of Australia. People aged 65 and over comprise approximately 5.4 per cent of the NT population, very low compared to the Australian average of 12.2 per cent. Over the next 25 years this population group is projected to triple, but the Territory will continue to have the lowest age profile of all Australian jurisdictions.

During 2010-11 the Home and Community Care (HACC) Program provided services to 3615 frail aged and younger people with disabilities. In 2010/11 total funding for the NT HACC Program was \$12 962 000. The program received \$4 056 000 from the NT Government, \$8 906 000 from the Australian Government.

There are 29 allocated places under the Transition Care Program (TCP). Thirteen are community based places and 16 residential based. In 2010-11, there were 92 admissions to TCP across the NT with 85 resulting in successful discharge; 49 from residential care settings and 36 from the community. Work commenced on improving the uptake of TCP in the NT.

From 1 July 2012, the Australian Government will take full funding and administration responsibility for the HACC Program as part of the national health reforms. The Australian Government will be responsible for all aged care services for people aged 65 years and over and Indigenous people aged over 50 years. State and territory governments will continue to fund HACC type services for younger people with a disability. The NT commenced working with the Australian Government on the transition of the HACC Program to ensure this transition has minimal impact on service providers and clients.

The NT has continued to provide comprehensive aged care assessment under the Aged Care Assessment Program (ACAP) Implementation Plan (IP). The current IP is for the period 1 July 2010 through to 30 June 2012 and was developed in response to the National Health Reforms that included major reforms to aged care.

As in previous years, indicators based on the estimated number of people with severe, profound and/or core activity limitations in the NT need to be interpreted with caution. Small variations in service and population data appears in magnified proportions to the small population of the NT.

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13.6 Definitions of key terms and indicators

Adjusted subsidy reduction supplement	An adjusted subsidy reduction supplement is a payment made by State governments to some public sector residential care operators to offset the effect of the Australian Government's adjusted subsidy reduction. The adjusted subsidy reduction reduces the daily rate of Residential Care Subsidy paid by the Australian Government in respect of certain residential aged care places owned by State governments or State public sector organisations. The rate of the reduction is determined by the relevant Commonwealth Minister from 1 July each year, in accordance with section 44-19 of the <i>Aged Care Act 1997</i>.
Accreditation	Accreditation is a key component of the Australian Government's quality framework for federally funded residential aged care and is a quality assurance system for residential aged care services — based on the principle of continuous improvement. Accreditation requires assessment against the 44 expected outcomes used for accreditation assessment — grouped into four standards: management systems, staffing and organisational development; health and personal care; residential lifestyle; and physical environment and safety systems.
Aged care	Formal services funded and/or provided by governments that respond to the functional and social needs of older people, and the needs of their carers. Community aged care services aim to optimise independence and to assist older people to stay in their own homes, while residential care services provide accommodation and care for those who can no longer be assisted to stay at home. Assessment of care needs is an important component of aged care. The majority of aged care services assist in activities of daily living such as personal care (for example, bathing and dressing), housekeeping and meal provision. Other services aim to promote social participation and connectedness. These services are delivered by trained aged care workers and volunteers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists. Aged care services generally aim to promote wellbeing and foster function rather than to treat illness. Although some aged care services such as transition care have a specific restorative role, they are distinguished from the health services described in Part E of this Report. Aged care services may be funded through programs specifically or mainly directed to older people, or through programs that address the needs of people of different ages. Generally, the target groups of aged care services are people aged 70 years or over and Indigenous people aged 50 years or over.
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]).

Capital expenditure on residential services	Expenditure on building and other capital items, specifically for the provision of Australian government funded residential aged care.
Care leaver	A care leaver is a person who was in institutional care (such as an orphanage or mental health facility) or other form of out-of-home care, including foster care, as a child or youth (or both) at sometime during their lifetime (DoHA 2011).
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 of the Department of Health and Ageing 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.
Dementia services program	Includes flexible and innovative support, respite, counselling, information and referral services, education and leisure. The program includes meeting individual and immediate needs which cannot be met by other services, through carer respite services and other carer support agencies. Inpatient services are excluded.
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.
HACC target population	The HACC Target population is people in the Australian community who, without basic maintenance and support services provided under the scope of the HACC Program, would be at risk of premature or inappropriate long term residential care, including (i) older and frail people with moderate, severe or profound disabilities; (ii) younger people with moderate, severe or profound disabilities; and (iii) such other classes of people as are agreed upon, from time to time, by the Commonwealth Minister and the State Minister. The HACC Target Population is estimated by applying the proportion of people in households with a moderate, severe, or profound disability as reported in the ABS 2003 <i>Survey of Disability, Ageing and Carers</i> to the ABS Population Projections by SLA 2002–2022.
High/low care recipient	On entry, a resident is classified as high or low care based on their ACAT assessment and their approved provider's appraisal of their care needs under the ACFI. Residents whose ACAT approval is not limited to low care are classified as high care if they have an ACFI appraisal of: • high in Activities of Daily Living, or • high in Complex Health Care, or • high in Behaviour, together with low or medium in at least one of the Activities of Daily Living or Complex Health Care domain, or • medium in at least two of the three domains. All other ACAT approval and ACFI appraisal combinations result in a classification of low level care. A resident's care needs may change over time resulting in a change in classification from low to high level care (ageing in place).
In-home respite	A short term alternative for usual care.

People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Where a person does not need assistance, but has difficulty with self-care, mobility or communication.
People with a profound disability	Where a person is unable to perform self-care, mobility and/or communication tasks, or always needs assistance.
People with a severe disability	Where a person sometimes needs assistance with self-care, mobility or communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing).
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (<i>Aged Care Act 1997 (Cwlth)</i>); also refers to 'beds' (<i>Aged Care (Consequential Provisions) Act 1997 (Cwlth)</i> , s.16).
Real expenditure	Actual expenditure adjusted for changes in prices, using the GDP(E) price deflator and expressed in terms of final year prices.
Resident	For the purposes of the <i>Aged Care Act 1997</i> , a person who is being provided with residential care through an aged care service conducted by an approved provider under the Act.
Respite care	Alternative care arrangements for dependent people living in the community, with the primary purpose of giving their carer a short term break from their usual caring commitments.
Rural small nursing home supplement	Payments made by states and territories to small sized high care public sector residential aged care facilities (up to 30 places) that are located in rural areas. Three levels of supplement are paid to facilities varying in size from 10 to 20 and 30 places.
Special needs groups	Section 11-3 of the <i>Aged Care Act</i> , specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from non-English speaking countries; people who live in rural or remote areas; and people who are financially or socially disadvantaged. Principles (Regulations) made under s. 11-3 also specify veterans, people who are homeless or at risk of becoming homeless, and care leavers as special needs groups
Veterans	Veterans, their war widows, widowers and dependents who are eligible for treatment through the Department of Veterans' Affairs under the provisions of the <i>Veterans' Entitlements Act 1986 (Cwlth)</i> .
Waiting times	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.

13.7 List of attachment tables

Attachment tables are identified in references throughout this chapter by a '13A' prefix (for example, table 13A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

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14 Services for people with disability

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Attachment tables

Attachment tables are identified in references throughout this chapter by a '14A' prefix (for example, table 14A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

The Australian, State and Territory governments aim to ensure that people with disability and their carers have an enhanced quality of life and participate as valued members of the community. The *National Disability Agreement* (NDA), effective from 1 January 2009, provides the national framework and key areas of reform for the provision of government support and services for people with disability. Box 14.1 provides an overview of the NDA. The NDA replaced the third *Commonwealth State Territory Disability Agreement* (CSTDA), which was due to expire on 30 June 2007 but was extended to 31 December 2008. Funding to the State and Territory governments is provided through the National Disability Services Specific Purpose Payment (ND SPP), not the NDA.

Box 14.1 *National Disability Agreement and the National Disability Services Specific Purpose Payment*

Funding to the State and Territory governments is provided through the National Disability Services Specific Purpose Payment (ND SPP), associated with the *National Disability Agreement* (NDA). The focus of the NDA is on the provision of specialist disability services. However, the NDA acknowledges that specialist disability services are complemented by mainstream services and income support measures.

Reforms under the NDA are directed at creating a disability services system that is effective, efficient and equitable, and has a focus on: early intervention; timely, person-centred approaches; and lifelong planning. Ten priority areas have been identified to underpin the policy directions and achieve these reforms:

- better measurement of need
- population benchmarking for disability services
- making older carers a priority
- quality improvement systems based on disability standards
- service planning and strategies to simplify access
- early intervention and prevention, lifelong planning and increasing independence and social participation strategies
- increased workforce capacity
- increased access for Indigenous Australians
- access to aids and equipment
- improved access to disability care.

Other specific details relating to the NDA (such as roles and responsibilities of different governments) are provided throughout the chapter.

Source: COAG (2009).

This chapter provides information on the assistance provided by governments to people with disability and their carers, focusing on specialist disability services provided under the NDA and funded by the ND SPP. The chapter reports NDA and ND SPP data for 2009-10, a combination of NDA and CSTDA data for 2008-09 and CSTDA data for earlier years:

- Specialist psychiatric disability services are excluded to improve data comparability across jurisdictions. Disability support services are also provided by programs such as Home and Community Care (HACC) and Commonwealth Rehabilitation Services (CRS) Australia. Information on the HACC program is provided in ‘Aged care services’ (chapter 13). CRS Australia’s services are not covered in this Report

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- Performance information on access by people with disability to mainstream services is excluded. Further information on access by people with disability to mainstream services is included elsewhere in this Report — for example, School education (chapter 4), Vocational education and training (VET) (chapter 5), Public hospitals (chapter 10), Mental health management (chapter 12) and Public housing (chapter 16). Other mainstream services and supports provided to people with disability — such as transport and utility services at concessional rates — are outside the scope of this Report.
 - Descriptive information on income support to people with disability and their carers is included, for context. This Report generally does not include performance information on income support.

Major improvements in the reporting of services for people with disability this year include:

- reporting a new indicator ‘Labour force participation of primary carers of people with disability’ and associated data for the first time
- updating data from the Survey of Disability, Ageing and Carers (SDAC) 2009 for the following indicators:
 - ‘Access to NDA specialist disability services’
 - ‘Service use by severity of disability’
 - ‘Service use by special needs groups’
 - ‘Labour force participation and employment of people with disability’
 - ‘Labour force participation of primary carers of people with disability’
 - ‘Social participation of people with disability’ including data reporting unmet need reported for the first time
- reporting Tasmanian data for the ‘Quality assurance’ indicator for the first time
- removal of the indicator ‘Client satisfaction with appropriateness’. Data have never been reported for this indicator and it is not expected that they would become available
- removal of the indicator ‘Cost per user of government provided accommodation support services’, now incorporated as a measure under the indicator ‘Cost per user of State and Territory administered services’
- continued alignment with relevant NDA indicators incorporating time series data where available
- continued expansion of time series in all attachment tables where data are available

-
- Data quality information (DQI) for the following indicators:
 - ‘Labour force participation and employment of people with disability’
 - ‘Labour force participation of primary carers of people with disability’
 - ‘Social participation of people with disability’.

14.1 Profile of disability services

Service overview

Government assistance for people with disability and their carers comprises provision of specialist disability services, access to mainstream services and provision of income support. Definitions of disability are provided in box 14.2.

Box 14.2 Definitions of disability

The United Nation’s *Convention on the Rights of Persons with Disabilities*, ratified by Australia on 17 July 2008, defines ‘persons with disabilities’ as those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The World Health Organisation (WHO) defines ‘disabilities’ as impairments, activity limitations, and participation restrictions: an impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; and a participation restriction is a problem experienced by an individual in involvement in life situations. Disability is a complex phenomenon, reflecting an interaction between features of a person’s body and features of the society in which he or she lives (WHO 2009).

The third Commonwealth State and Territory Disability Agreement ([CSTDA] 2003, p 9) defines ‘people with disabilities’ as those whose disability manifests itself before the age of 65 years and for which they require significant ongoing and/or long-term episodic support. For these people, the disability will be attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is likely to be permanent and results in substantially reduced capacity in at least one of the following:

- self care/management
- mobility
- communication.

(Continued on next page)

Box 14.2 (Continued)

The NDA does not report a specific definition of 'people with disability'.

The Australian Bureau of Statistics (ABS) *Survey of Disability, Ageing and Carers* (SDAC) 2009 defines 'disability' as a limitation, restriction or impairment, which has lasted, or is likely to last, for at least 6 months and restricts everyday activities. Examples range from hearing loss that requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision. The SDAC reports on the spectrum of disability experiences using three main 'categories' of disability:

- with a specific core activity limitation (mild, moderate, severe and profound)
- with a schooling or employment restriction
- with a disability, but without a specific limitation or restriction — includes people who need assistance with health care, cognition and emotion, paperwork, transport, housework, property maintenance or meal preparation.

Self care, mobility and communication are defined as core activities. The ABS defines levels of core activity limitation as:

- mild — where a person does not need assistance and has no difficulty with self care, mobility and/or communication, but uses aids or equipment. They may also not be able to easily walk 200m, walk up and down stairs without a handrail, bend to pick up objects from the floor or use public transport easily or without help or supervision
- 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.

Source: ABS (2011); WHO (2009); CSTDA (2003).

Specialist disability services

Specialist disability services are services specially designed to meet the needs of people with disability. These services tend to be targeted at those who have profound or severe core activity limitations. There are seven broad categories of specialist disability services outlined below. These categories underpin the collection of the Disability Services National Minimum Data Set (DS NMDS) and expenditure data on specialist disability services:

-
- *accommodation support services* that provide support to people with disability in accommodation settings (hostels, institutions and group homes), and in their own home (including attendant/personal care, in home support and alternative family placements)
 - *community support services* that provide the support needed for a person with disability to live in a non-institutional setting — including therapy support, counselling and early childhood intervention
 - *community access services* that provide opportunities for people with disability to gain and use their abilities to enjoy their full potential for social independence — including learning and life skills development and recreation/holiday programs
 - *respite care services* that provide a short-term and time-limited break for families and other voluntary caregivers of people with disability, to assist in supporting and maintaining the primary care-giving relationship, while providing a positive experience for the person with disability
 - *employment services* for people with disability that provide:
 - open employment services — assistance in obtaining and/or retaining paid employment in the open labour market
 - supported employment services — support and employment within the same organisation
 - *advocacy, information and alternative forms of communication*
 - advocacy services enable people with disability to increase their control over their lives by representing their interests and views in the community
 - information services provide accessible information to people with disability, their carers, families and related professionals about disabilities, specific and mainstream services and equipment; and promote the development of community awareness
 - alternative forms of communication for people who are by reason of their disability, unable to access information provided in a print medium
 - *other support services* that include research and evaluation, and training and development projects.

Mainstream services

Mainstream services are services provided to the community as a whole. Governments acknowledge that specialist disability services are complemented by mainstream services. Under the NDA, all Australian governments have agreed to

‘strive’ to ensure that all people with disability have access to mainstream government services within their jurisdictions. It is recognised that improved outcomes for people with disability, their families and their carers, are contingent upon the effective coordination of efforts across government services. Some mainstream services give priority to people with disability (for example, public housing) or have programs to meet the special needs of people with disability (for example, school education).

Income support and allowances

Income support for people with disability and their carers contributes to the outcomes of the NDA. The Australian Government is responsible for the provision of income support targeted to the needs of people with disability, their families and carers (box 14.3). Income support is provided to those who meet the relevant eligibility criteria. Income support payments and allowances include the Disability Support Pension, Carer Payment, Carer Allowance, Sickness Allowance, Mobility Allowance, Child Disability Assistance Payment and Carer Supplement.

Details of the roles and responsibilities of the Australian, State and Territory governments in relation to assistance for people with disability are outlined in the following section.

Box 14.3 Australian Government supplementary and income support arrangements

Under the NDA, provision of income support for people with disability, their families and carers is a key responsibility of the Australian Government (see ‘roles and responsibilities’ section). Outlays on income support payments and allowances to people with disability and their carers in 2010-11 (on an accrual basis) amounted to \$13.4 billion for the Disability Support Pension, \$2.7 billion for the Carer Payment, \$1.6 billion for the Carer Allowance, \$85.2 million for the Sickness Allowance, \$130.0 million for the Mobility Allowance, \$160.2 million for the Child Disability Assistance Payment and \$451.8 million for Carer Supplement (Australian Government unpublished).

At 30 June 2011, there were around 818 900 recipients of the Disability Support Pension, 186 100 recipients of the Carer Payment, 539 600 recipients of the Carer Allowance (including Health Care Card only recipients), 58 800 recipients of the Mobility Allowance, 6700 recipients of the Sickness Allowance, 141 500 recipients of the Child Disability Assistance Payment and 525 200 recipients of Carer Supplement (table 14A.1).

Source: Australian Government (unpublished); table 14A.1.

Roles and responsibilities

Australian, State and Territory governments

The NDA defines the roles and responsibilities of the Australian, State and Territory governments in the provision of services and supports to people with disability and their carers.

The Australian Government is responsible for:

- provision of employment services for people with disability (which includes regulation, service quality and assurance, assessment, policy development service planning, and workforce and sector development) in a manner that most effectively meets the needs of people with disability consistent with local needs and priorities
- provision of income support targeted to the needs of people with disability, their families and carers
- provision of funds to states and territories to contribute to the achievement of the NDA objective and outcomes
- where appropriate, investing in initiatives to support nationally agreed policy priorities, in consultation with State and Territory governments
- ensuring that Commonwealth legislation and regulations are aligned with the national policy reform directions and the *United Nations Convention on the Rights of Persons with Disabilities*.

State and Territory governments are responsible for:

- the provision of specialist disability services, except disability employment services (which includes regulation, service quality and assurance, assessment, policy development, service planning, and workforce and sector development) in a manner which most effectively meets the needs of people with disability, their families and carers, consistent with local needs and priorities
- ensuring that State and Territory legislation and regulations are aligned with the national policy and reform directions
- where appropriate, investing in initiatives to support nationally agreed policy priorities, in consultation with the Australian Government.

Australian, State and Territory governments are jointly responsible for:

- development of national policy and reform directions to meet the agreed objectives and outcomes of the NDA

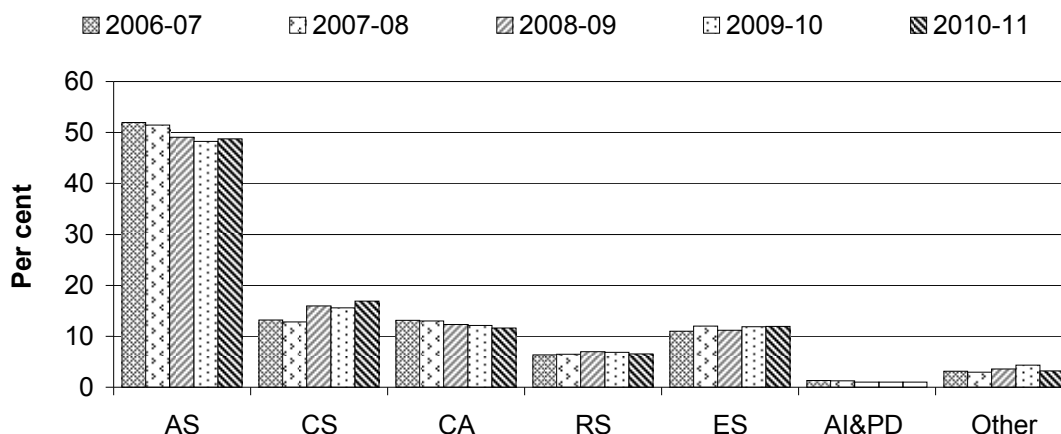
-
- funding and pursuing research that provides an evidence base for national policy and reform directions
 - developing and implementing reforms to improve outcomes for Indigenous people with disability
 - the provision of data, including a commitment to providing data for the DS NMDS and a commitment to the improvement of data.

Funding

Australian and State and Territory governments funded both government and non-government providers of specialist disability services under the NDA. Total government expenditure on these services was \$6.2 billion in 2010-11 — a real increase of 1.5 per cent on the expenditure in 2009-10 (\$6.1 billion) (table 14A.4). State and Territory governments funded the majority of this expenditure in 2010-11 (69.4 per cent, or \$4.3 billion). The Australian Government funded the remainder (30.6 per cent, or \$1.9 billion), which included \$1.1 billion in transfer payments to states and territories (tables 14A.5 and 14A.6). Table 14A.7 provides data on total government expenditure including and excluding payroll tax.

Direct government expenditure on specialist disability services (excluding expenditure on administration) under the NDA was \$5.7 billion in 2010-11 (table 14A.8). The distribution of direct government expenditure varied across jurisdictions. The main areas of State and Territory government expenditure were accommodation support services (48.8 per cent of total direct service expenditure) and community support (16.9 per cent of total direct service expenditure) (figure 14.1). Employment services were the main area of Australian Government expenditure in 2010-11 (11.9 per cent of total direct service expenditure and 86.2 per cent of Australian Government direct service expenditure) (table 14A.9).

Figure 14.1 Direct expenditure on NDA specialist disability services, by service type^a



AS = accommodation support; CS = community support; CA = community access; RS = respite services; ES = employment services; AI&PD = advocacy, information and print disability. ^a See table 14A.8 for detailed notes accompanying expenditure data.

Source: Australian, State and Territory governments (unpublished); table 14A.9.

Size and scope

Disability prevalence

The ABS estimates that 1 in 5 people in the Australian population (4 026 213) had one or more disabilities (that is, a core activity limitation, a schooling or employment restriction or an impairment) in 2009 (ABS 2011), compared with 3 958 300 in 2003 (ABS 2004). Of the population aged 5–64 years in 2009 (ABS 2011), an estimated 16.0 per cent had a core activity limitation or specific restriction compared with 13.0 per cent in 2003 (ABS 2004). This proportion comprised 5.8 per cent who had a profound or severe core activity limitation, 8.6 per cent who had a mild to moderate core activity limitation and 1.6 per cent who had a schooling or employment restriction only (ABS 2011). Tables 14A.10 and 14A.11 contain additional information on disability prevalence, and table 14A.12 contains information on the estimated number of people with a profound or severe core activity limitation who received help as a proportion of those who needed help.

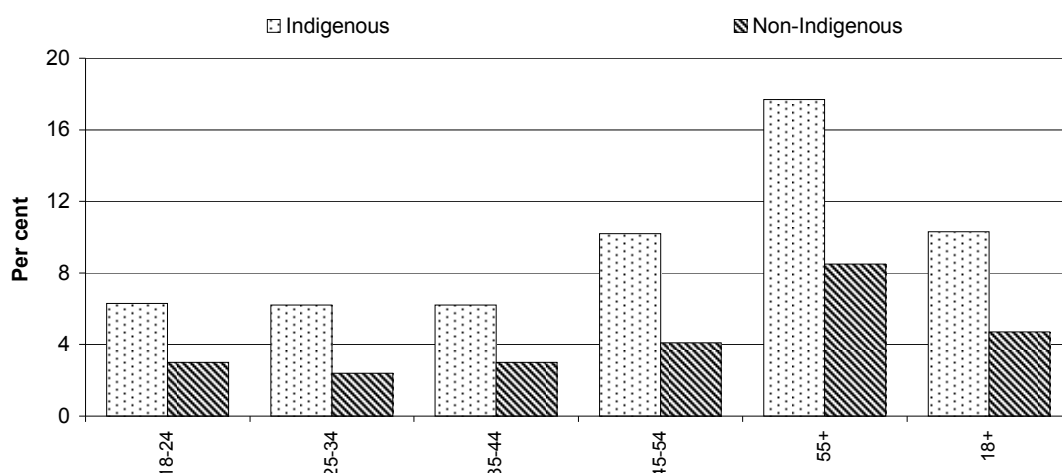
Aboriginal and Torres Strait Islander people

Indigenous people have significantly higher rates of profound or severe core activity limitation than non-Indigenous people. Disability data on ‘core activity need for assistance’ are available from the ABS 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS). The concept of ‘core activity need for assistance’ (ASSNP¹) is similar to the concept of profound or severe core activity limitations, but the relevant data are not suitable for direct comparison due to differences in the questions asked and the methods of data collection.

Nationally, 10.3 per cent of Indigenous people aged 18 years and over reported a profound or severe core activity restriction in 2008, around twice the rate for non-Indigenous people (4.7 per cent) (ABS 2009). The disparity between Indigenous and non-Indigenous people is consistent across ages or age groups (as applicable) (figure 14.2).

¹ The acronym ASSNP is the variable name used by the ABS to define ‘core activity need for assistance’. It appears to incorporate a shortened version of ‘assistance need’ and the letter ‘P’ indicates that the classification describes a characteristic of a person. This acronym is used throughout the chapter to denote ‘core activity need for assistance’.

Figure 14.2 People with profound or severe core activity restrictions by age group and Indigenous status, non-remote areas of Australia, 2008



Source: SCRGSP (2011) *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission.

Informal carers

Family and friends provide the most help and/or care assistance to people with disability. Information about informal carers enables governments to plan ahead for the future demand for services that support carers and the people they assist. Support services that assist people with disability to live in the community, such as in-home accommodation support and community support, often complement and are contingent upon the availability of informal care. In turn, the provision of informal care may rely on access to formal support services including respite services and a range of other services for the person with disability.

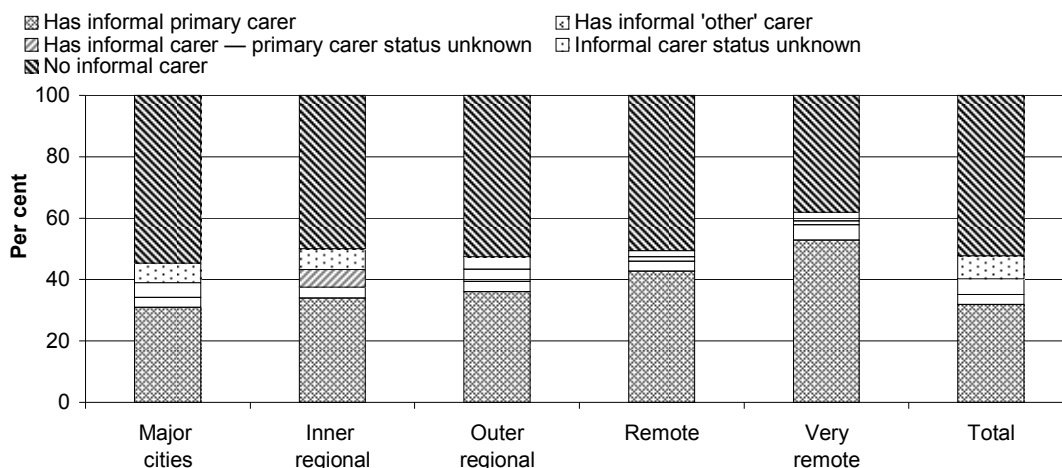
Information on informal carers is available from the ABS SDAC and for NDA service users from the DS NMDS. The definition of informal carers differs slightly across these data collections:

- The ABS SDAC defines an informal primary carer as a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities (communication, mobility and self care)
- The DS NMDS defines an informal carer as someone such as a family member, friend or neighbour, who is identified as providing regular and sustained care and assistance to a person with disability (see section 14.7 for further details).

Informal carers who provide assistance with core activities (self care, mobility and communication) are defined as primary carers.

An estimated 575 500 informal primary carers aged 15-64 years provided the majority of assistance with self care, mobility and communication for people with disability, including older people in 2009 (ABS 2011). Of people with disability who accessed NDA specialist disability services in 2009-10, 40.2 per cent reported having an informal carer and 31.9 per cent reported having an informal carer who was a primary carer (figure 14.3). Service users in remote or very remote locations were more likely to report having an informal carer than those in other areas. Figure 14.4 shows the proportions of informal primary carers who are in different age groups, by location.

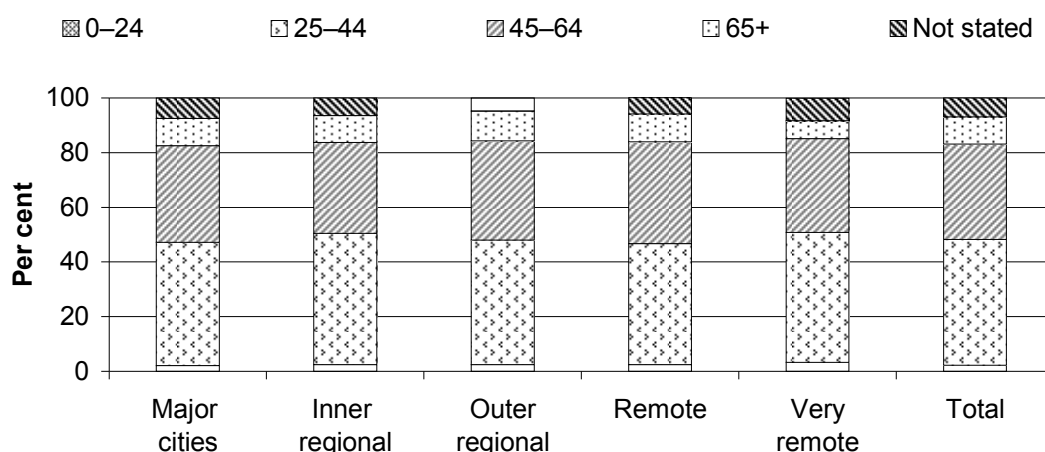
Figure 14.3 Users of NDA specialist disability services, by whether they had an informal carer and geographic location, 2009-10^{a, b, c}



^a Total includes data for service users whose location was not collected/identified. ^b Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. ^c Data relating to primary carers are not reported for all service users. Some service types are not required to collect all service user data items. For example, employment services are not required to collect selected informal carer information, including primary status.

Source: Australian Institute of Health and Welfare (AIHW) (unpublished) *DS NMDS*; table 14A.2.

Figure 14.4 Age distribution of primary carers of people accessing NDA specialist disability services, by location, 2009-10^{a, b}



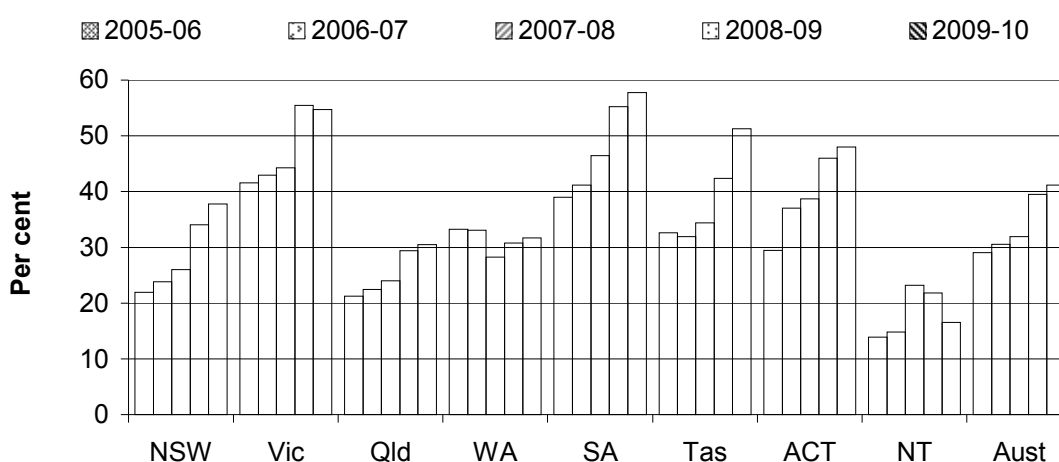
^a Total includes data for service users whose location was not collected/identified. ^b Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *DS NMDS*; table 14A.3.

Use of NDA specialist disability services

In 2009-10 282 293 people were reported as using specialist disability services provided under the NDA (excluding service users who received specialist psychiatric disability services only) (table 14A.13). Nationally, this is 41.2 per cent of the estimated potential population (see section 14.7 for information on how the potential population is defined) (figure 14.5).

Figure 14.5 Users of NDA specialist disability services as a proportion of the estimated potential population^{a, b, c}

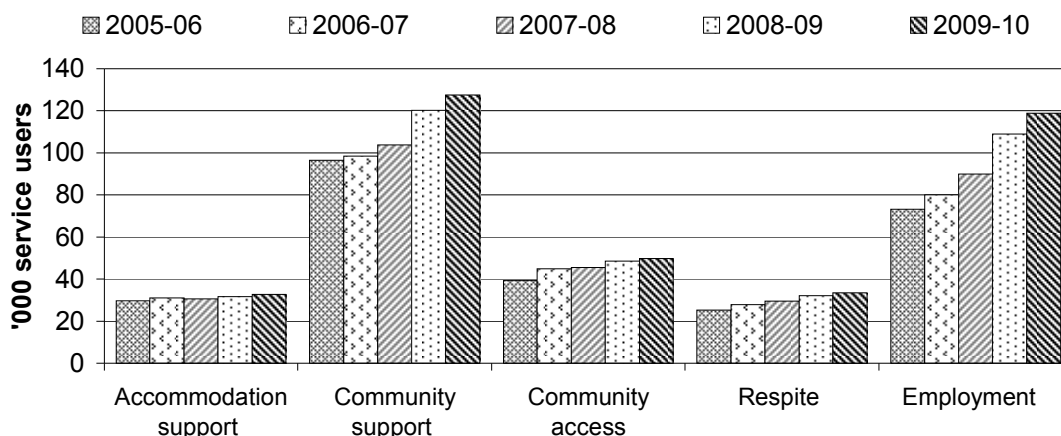


^a Potential population is calculated using the unrevised method. See section 14.7 for information on how the potential population is defined. ^b Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. ^c For the ACT, the decreased service user rate for 2005-06 was due to incomplete data collection for therapy services.

Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW (2011b) *Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreement*, Cat. no. DIS 58; AIHW (2010) *2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA* Cat. no. DIS (56 and previous publications); table 14A.13.

Service user numbers varied across service types. Accommodation support, community access, community support and respite services reported a total of 179 013 users and employment services reported a total of 118 801 users, in 2009-10 (figure 14.6).

Figure 14.6 Users of NDA specialist disability services, by service type^{a, b}

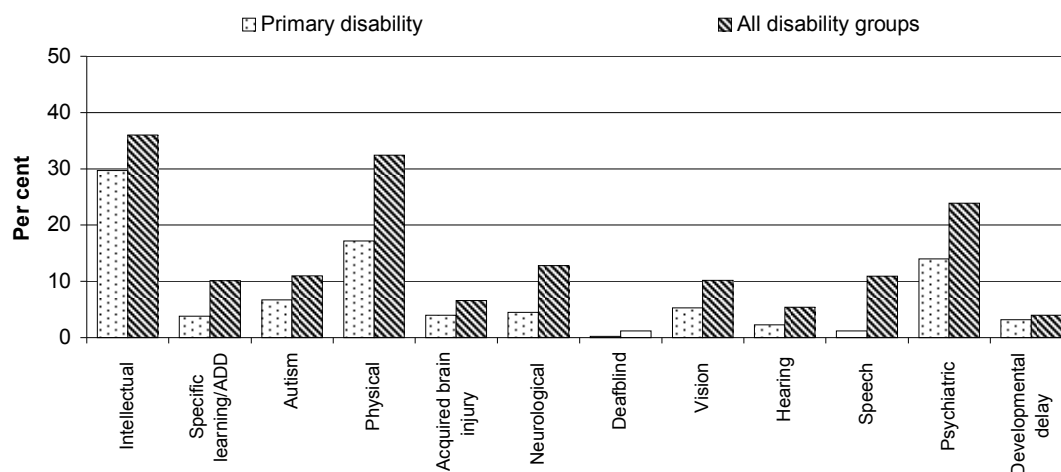


^a Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. ^b See table 14A.13 for detailed notes relating to these data.

Source: AIHW (unpublished) *DS NMDS*; table 14A.13.

In 2009-10, the most commonly reported disability of NDA service users was an intellectual disability (36.0 per cent of service users, including 29.7 per cent who reported it as their primary disability) (figure 14.7).

Figure 14.7 NDA specialist disability service users, by disability group, 2009-10^{a, b}



^a Data need to be interpreted with care due to a number of factors affecting data quality. ^b See tables 14A.14 and 14A.15 for detailed notes relating to these data.

Source: AIHW (unpublished) *DS NMDS*; tables 14A.14 and 14A.15.

14.2 Framework of performance indicators

The performance framework and related indicators reflect governments' shared objectives and priorities under the NDA (box 14.4).

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations). The NDA covers the area of disability services. The agreement includes sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with performance indicators in the NDA.

Box 14.4 Objective of government funded services for people with disability

Performance data for this year's Report cover services provided under the NDA.

The following long-term objective under the NDA is similar to the previous broad objective under the third CSTDA:

People with disability and their carers have an enhanced quality of life and participate as valued members of the community.

All aspects of the NDA contribute to or measure progress towards this objective. The objective is enhanced by three specific outcomes as well as a set of revised priority reform areas (outlined in box 14.1). The outcomes are that:

- people with disability achieve economic participation and social inclusion
- people with disability enjoy choice, wellbeing and the opportunity to live as independently as possible
- families and carers are well supported.

In support of the agreed NDA outcomes, governments will contribute to the following outputs:

- services that provide skills and support to people with disability to enable them to live as independently as possible
- services that assist people with disability to live in stable and sustainable living arrangements
- income support for people with disability and their carers
- services that assist families and carers in their caring role.

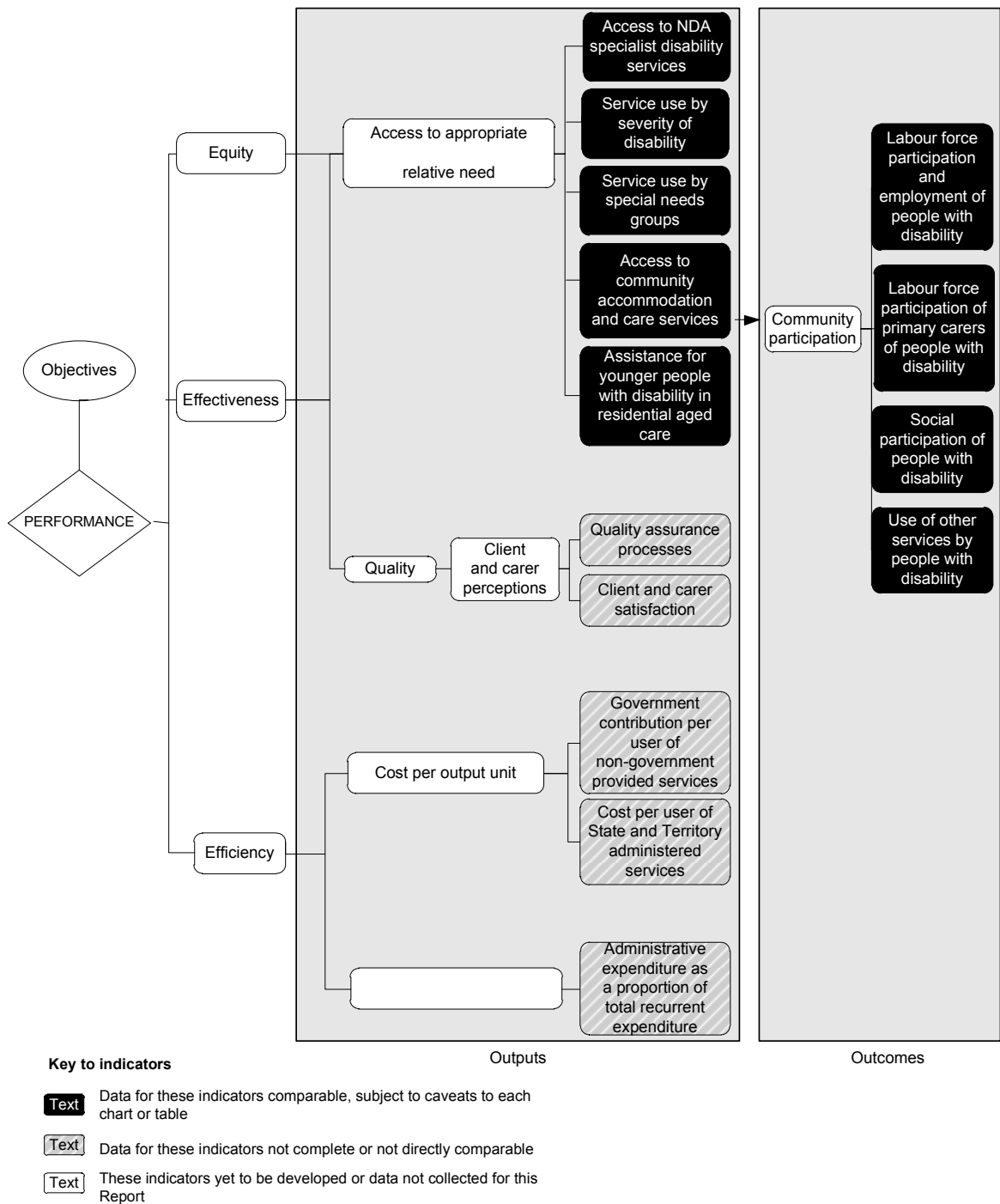
Source: COAG (2009)

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes outputs and outcomes of government funded

services for people with disability (figure 14.8). The performance indicator framework shows which data are comparable in the 2012 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 Report's statistical appendix 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) (appendix A).

Figure 14.8 Services for people with disability performance indicator framework



14.3 Key performance indicator results

The performance indicator results reported in this chapter relate to NDA specialist disability services. These data were sourced from the DS NMDS collection which is managed by Australian, State and Territory governments at the service and jurisdictional level and by the AIHW at the national level. Under the NDA, governments have committed to the ongoing improvement of and the ongoing provision of data for the DS NMDS.

When considering the performance indicator results derived from service user data, comparisons between jurisdictions and across years should be undertaken with care. While the implementation of the DS NMDS continues to improve, data quality is still affected by a number of factors, including:

- differences across jurisdictions and over time in the proportions of service users and service outlets that provided data (response rates) and in the ‘not stated’ rates of particular data items (see section 14.6 for further details)
- differences across jurisdictions in the interpretation of DS NMDS service definitions (for example, the target group for services classified as ‘early intervention’ can differ)
- differences across jurisdictions in whether particular activities are defined as specialist disability services or are funded under other programs or sectors.

Outputs

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

Equity and effectiveness — access to appropriate services on the basis of relative need

The following equity and effectiveness access indicators are reported:

- ‘Access to NDA specialist disability services’
- ‘Service use by severity of disability’
- ‘Service use by special needs groups’
- ‘Access to community accommodation and care services’
- ‘Assistance for younger people with disability in residential aged care’.

Access to NDA specialist disability services

‘Access to NDA specialist disability services’ (renamed in this Report) is an indicator of governments’ objective to provide access to government funded services including specialist disability services on the basis of relative need and available resources. Measures are reported for accommodation support, community support, community access, respite services and employment (box 14.5).

Box 14.5 Access to *National Disability Agreement* specialist disability services

‘Access to NDA specialist disability services’ is defined as the number of people using a particular NDA specialist disability service divided by the ‘potential population’ for that service. The potential population is an estimate that broadly indicates the number of people with the potential to require specialist disability services at some time.

This Report includes two methods for calculating the potential population — the ‘unrevised’ method and the ‘revised’ method. The unrevised method is the original method used until the 2011 Report. The revised method was introduced in the 2011 report to align with the method used in the NDA Performance Reports. Further definitions of the two methods are in section 14.7.

Unless otherwise stated, all references to the potential population are to the unrevised method.

The potential population estimate for accommodation support, community access and community support services is the number of people aged under 65 years with profound or severe core activity limitations, multiplied by the Indigenous factor for a jurisdiction. The potential population estimate for employment services is the number of people aged 15–64 years with severe or profound core activity limitations, multiplied by both the Indigenous factor and the labour force participation rate for a jurisdiction. The potential population estimate for respite services is the number of people aged under 65 years with profound or severe core activity limitations who also reported a primary carer, multiplied by the Indigenous factor for a jurisdiction. The potential population has been recalculated based on available data from the 2009 SDAC. The potential population has been backcast to the 2008-09 year. Data published in the 2011 Report have been recalculated for this Report.

A higher or increasing proportion of the relevant estimated potential population using a particular NDA service suggests greater access to that service.

Not all people in the estimated potential population will need the service or seek to access the service in the relevant period. In addition, this indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or accessed by those most in need.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

The numerators and denominators of this access measure apply to different age groups. The numerator of an access measure is service users of all ages. The denominator is the estimated potential population:

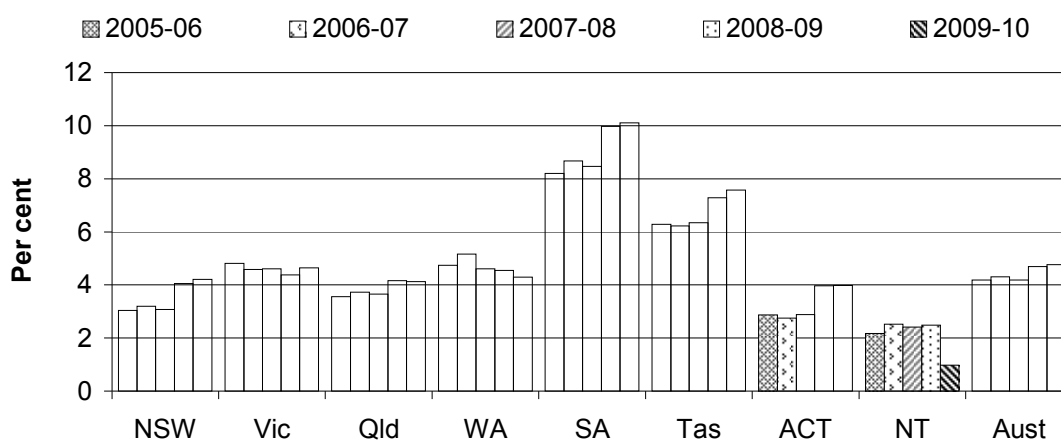
- for people aged under 65 years for accommodation support, community support, community access and respite services
- for people aged 15–64 years for employment services.

Data on users of NDA specialist disability services as a proportion of the estimated potential population (revised method) are also available disaggregated by service group, age and sex (table 14A.16).

Nationally, 4.8 per cent of the estimated potential population were using NDA accommodation support services in 2009-10 (figure 14.9).

Data on users of NDA accommodation support services as a proportion of the estimated potential population (revised method) are also available disaggregated by service group, age and sex (table 14A.18).

Figure 14.9 Users of NDA accommodation support services as a proportion of the estimated potential population^{a, b, c}



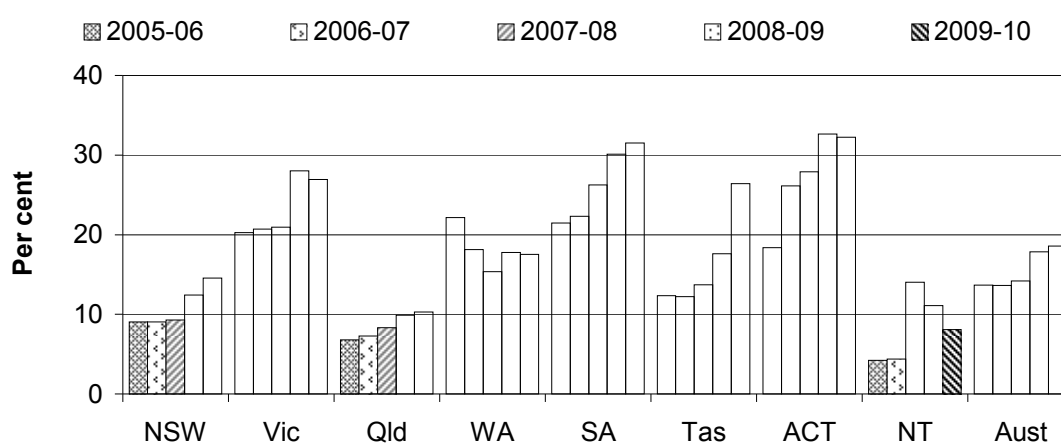
^a See table 14A.17 for detailed notes relating to service user data. ^b Potential population is calculated using the unrevised method. See section 14.7 for information on how the potential population is defined. ^c Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW (2011b) *Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreement*, Cat. no. DIS 58; AIHW (2010) *2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA* Cat. no. DIS (56 and previous publications); table 14A.17.

Nationally, 18.6 per cent of the estimated potential population were using NDA community support in 2009-10 (figure 14.10).

Data on users of NDA community support as a proportion of the estimated potential population (revised method) are also available disaggregated by service group, age and sex (table 14A.20).

Figure 14.10 Users of NDA community support services as a proportion of the estimated potential population^{a, b, c, d, e, f}



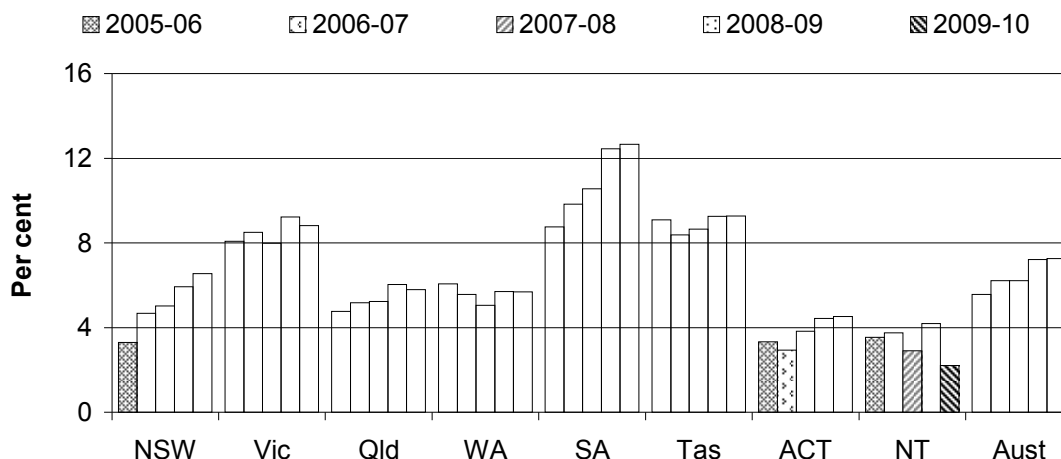
^a See table 14A.19 for detailed notes relating to service user data. ^b Potential population is calculated using the unrevised method. See section 14.7 for information on how the potential population is defined. ^c Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. ^d For WA, the decrease in the number between 2006-07 and 2007-08 is due to a refining of the counting rules that has led to the exclusion of some data. ^e For the ACT, the decrease in the community support services rate for 2005-06 was due to the incomplete data collection for therapy services. ^f For Victoria, additional agencies reporting clients and the change of data capturing for the Individualised Support Packages under the Community Support category resulted in an increase in the count of service users in 2008-09.

Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW (2011b) *Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreement*, Cat. no. DIS 58; AIHW (2010) *2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA* Cat. no. DIS (56 and previous publications); table 14A.19.

Nationally, 7.3 per cent of the estimated potential population were using NDA community access services in 2009-10 (figure 14.11).

Data on users of NDA community access services as a proportion of the estimated potential population (revised method) are also available disaggregated by service group, age and sex (table 14A.22).

Figure 14.11 Users of NDA community access services as a proportion of the estimated potential population^{a, b, c}



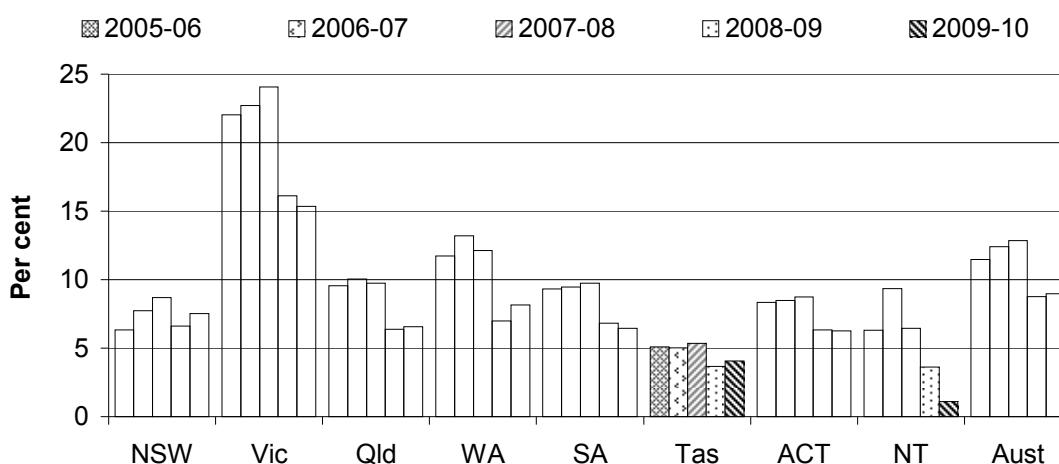
^a See table 14A.21 for detailed notes relating to these data. ^b Potential population is calculated using the unrevised method. See section 14.7 for information on how the potential population is defined. ^c Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW (2011b) *Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreement*, Cat. no. DIS 58; AIHW (2010) *2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA* Cat. no. DIS (56 and previous publications); table 14A.21.

Nationally, 9.0 per cent of the estimated potential population who reported having a primary carer were using NDA respite services in 2009-10 (figure 14.12).

Data on users of NDA respite services as a proportion of the estimated potential population (revised method) are also available disaggregated by service group, age and sex (table 14A.24).

Figure 14.12 **Users of NDA respite services as a proportion of the estimated potential population for respite services^{a, b, c, d}**



^a See table 14A.23 for detailed notes relating to these data. ^b Potential population is calculated using the unrevised method. See section 14.7 for information on how the potential population is defined. ^c Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. ^d The potential population for 2008-09 and 2009-10 has been calculated using data from the 2009 SDAC and is higher than in previous years. Data for 2008-09 and 2009-10 is not comparable to previous years.

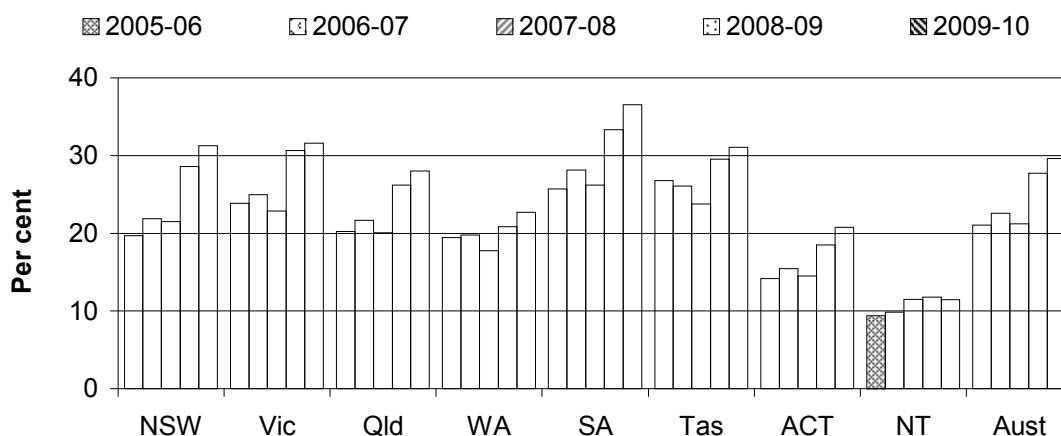
Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW (2011b) *Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreement*, Cat. no. DIS 58; AIHW (2010) *2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA* Cat. no. DIS (56 and previous publications); table 14A.23.

Nationally, 29.6 per cent of the estimated potential population for NDA employment services were using these services in 2009-10 (figure 14.13).

Data on users of NDA open employment services as a proportion of the estimated potential population (revised method) are also available disaggregated by age and sex (table 14A.26).

Data on users of NDA supported employment services as a proportion of the estimated potential population (revised method) are also available disaggregated by age and sex (table 14A.27).

Figure 14.13 Users of NDA employment services as a proportion of the estimated potential population for employment services^{a, b, c}



^a See table 14A.25 for detailed notes relating to these data. ^b Potential population is calculated using the unrevised method. See section 14.7 for information on how the potential population is defined. ^c Data for 2007-08 and 2008-09 are not comparable with previous years as the potential populations for that year were derived using labour force participation rates for people aged 15–64 years, not the participation rate for people aged 15 years and over that was used in previous years. Applying the participation rate for people aged 15–64 years to derive the 2007-08 and 2008-09 data increased the number of people in the estimated potential population relative to previous years (by around 15 per cent).

Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series. Cat. no. DIS 59.* Canberra; AIHW (2011b) *Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreement, Cat. no. DIS 58*; AIHW (2010) *2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA Cat. no. DIS (56 and previous publications); table 14A.25.*

Service use by severity of disability

‘Service use by severity of disability’ is an indicator of governments’ objective to use available resources to provide services to people on the basis of relative need, where need for services is assumed to vary according to the need for help with the activities of daily living (ADL) and for help with activities of independent living (AIL) or activities of work, education and community living (AWEC) (box 14.6). This indicator provides additional information for interpreting the access to NDA accommodation support, community support, community access, employment and respite services measures reported above.

Data on the need for assistance are derived using information on the level of support needed in one or more of the following support areas for:

- ADL – self care, mobility, and communication (the core support areas)

-
- AIL – interpersonal interactions and relationships, learning, applying knowledge and general tasks and demands; and domestic life
 - AWEC – education, community (civic) and economic life; and work.

Service users who need help with ADL, or AIL, or AWEC reported always/sometimes needing help in one or more of these, however, only people who need help with ADL are ‘conceptually comparable’ with people who have a profound or severe core activity limitation. Service users who did not need help with ADL, or AIL, or AWEC, reported needing no support in the major life areas.

Box 14.6 Service use by severity of disability

‘Service use by severity of disability’ is defined as the proportion of people who access NDA specialist disability services, by need for help with ADL, or AIL, or AWEC. Four categories are reported:

- need help with ADL
- need help with AIL, or AWEC but not ADL
- does not need assistance and information on ADL, AIL or AWEC
- not stated/collected.

Measures are reported for accommodation support, community support, community access, employment and respite services.

A higher or increasing proportion of people using a particular service type who need help with ADL suggests greater access to this service type for those with the greatest level of need.

This indicator does not provide information on whether services are appropriate for the needs of the people receiving them or appropriately targeted based on relative need taking into account access to other formal support and access to informal support networks. The need for services is assumed to vary according to the need for help with ADL, or AIL, or AWEC. Data on ADL, AIL and AWEC are self/carer identified, not based on formal clinical assessments of individual limitations. There are other factors that may also be important in determining relative need, such as the complexity of a service user’s needs in other activity areas.

Data reported for this indicator are comparable.

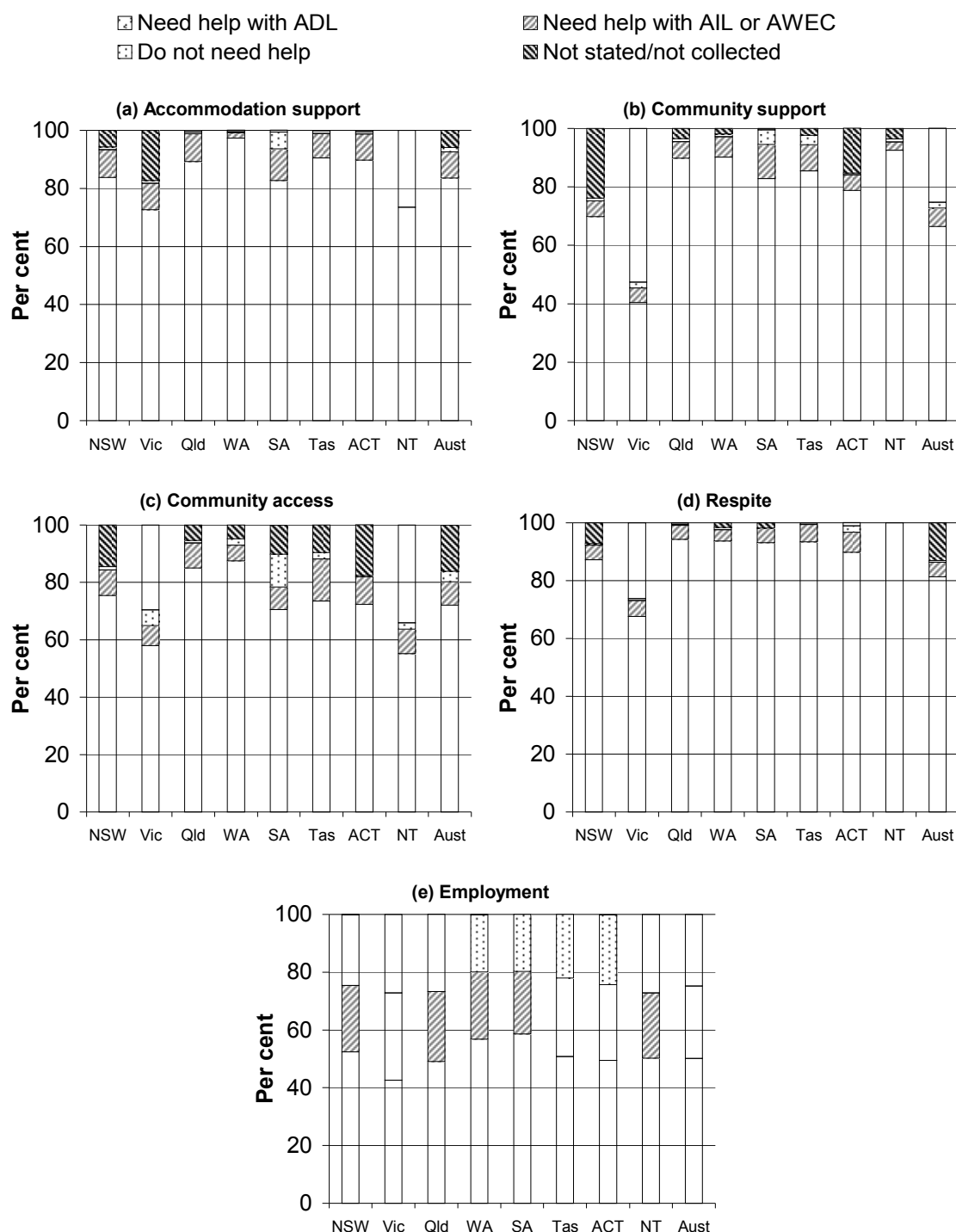
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, in 2009-10:

- 83.6 per cent of users of NDA accommodation support services needed help with ADL, 9.0 per cent required assistance with AIL or AWEC but not with ADL, 1.5 per cent did not report need for any assistance in major life areas and for 5.9 per cent information on need for assistance was not collected/not stated (figure 14.14a)
- 66.4 per cent of users of NDA community support services needed help with ADL, 6.4 per cent required assistance with AIL or AWEC, but not with ADL, 1.9 per cent did not report need for any assistance in major life areas and for 25.4 per cent information on need for assistance was not collected/not stated (figure 14.14b)
- 72.1 per cent of users of NDA community access services needed help with ADL, 8.1 per cent required assistance with AIL or AWEC, but not with ADL, 3.7 per cent did not report need for any assistance in major life areas and for 16.0 per cent information on need for assistance was not collected/not stated (figure 14.14c)
- 81.3 per cent of users of NDA respite services needed help with ADL, 5.1 per cent required assistance with AIL or AWEC, but not with ADL, 0.6 per cent did not report need for any assistance in major life areas and for 13.0 per cent information on need for assistance was not collected/not stated (figure 14.14d)
- 50.1 per cent of users of NDA employment services needed help with ADL, 25.1 per cent required assistance with AIL or AWEC, but not with ADL and 24.8 per cent did not report need for any assistance in major life areas. (figure 14.14e).

Data on users of NDA specialist disability services as a proportion of the estimated potential population (revised method) are also available (tables 14A.28, 14A.30, 14A.32, 14A.34, 14A.36, 14A.38 and 14A.39).

Figure 14.14 Users of NDA specialist disability services, by need for help with Activities of Daily Living, 2009-10^{a, b, c, d}



^a Need for help with ADL relates to the level of support needed in self care, mobility and communication. It does not necessarily relate to the level of support needed to find or maintain employment or with other activities. ^b See tables 14A.29, 14A.31, 14A.33, 14A.35 and 14A.37 for detailed notes about these data. ^c Data need to be interpreted with care due to factors affecting data quality. Section 14.6 contains further information on these quality issues. ^d Need help with AIL or AWEC does not include people who also need help with ADL.

Source: AIHW (unpublished) *DS NMDS*; tables 14A.29, 14A.31, 14A.33, 14A.35 and 14A.37.

Service use by special needs groups

‘Service use by special needs groups’ is an indicator of governments’ objective that access to services should be equitable for all members of the community and provided on the basis of relative need (box 14.7). The Report compares access for people from special needs groups with access for people from outside the special needs group of the total population and the potential population. The potential population is an estimate, derived using a range of data sources, of the number of people with the potential to require disability support services, including individuals who meet the service eligibility criteria but who do not demand the services. Results are reported on the basis of the potential population to account for differences in the prevalence of disability between people in the special needs group and people outside the special needs group. For information on how the potential populations for the special needs groups were derived see section 14.6.

Box 14.7 Service use by special needs groups

‘Service use by special needs groups’ is defined by two measures:

- the proportion of service users per 1000 total population in a particular special needs group, compared to the proportion of service users per 1000 total population outside the special needs group
- the proportion of service users per 1000 potential population in a particular special needs group, compared to the proportion of service users per 1000 potential population outside the special needs group.

Both measures are reported for accommodation support, community support, community access and employment services. For respite services, data are reported per 1000 total population only due to data limitations.

Data are reported for three special needs groups:

- people from outer regional and remote/very remote locations
- people identified as Indigenous Australians
- people who were born in a non-English speaking country (that is, not born in Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland, the United States or Zimbabwe).

Holding other factors constant, the proportion of service users per 1000 people (or per 1000 potential population in a special needs group) should not differ significantly from the proportion of service users per 1000 people (or per 1000 potential population outside the special needs group).

(Continued on next page)

Box 14.7 (Continued)

For both measures, while a lower proportion can indicate reduced access for a special needs group, it can also represent strong alternative informal support networks (and a consequent lower level of otherwise unmet need), or a lower tendency of people with disability in a special needs group to choose to access NDA specialist disability services. Similarly, a higher proportion can suggest poor service targeting, the lack of alternative informal support networks or a greater tendency of people with disability in a special needs group to choose to access NDA specialist disability services. For the measure that compares access per 1000 population, significant differences in access can also reflect the special needs group having a higher/lower prevalence of disability.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted on the basis of relative need. The indicator does not take into account differences in the level of informal assistance that is available for people in special needs groups and outside the special needs groups. Results for outer regional and remote/very remote users of accommodation support services, for example, need to be considered with care because alternatives to government funded accommodation support services are likely to be more readily available in these areas. Specifically, accommodation support services in outer regional and remote/very remote areas are largely provided informally, making use of local area coordinators and local community resources.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

The numerators and denominators of this access measure apply to different age groups. The numerator of an access measure is service users of all ages. The denominator is the estimated population/potential population:

- for people aged under 65 years for accommodation support, community support, community access and respite services
- for people aged 15–64 years for employment services.

Data for access per 1000 potential population need to be interpreted with care due to a number of factors affecting data quality. Potential sources of error include:

- that there are service users for whom ‘special needs group’ status (for example, Indigenous status) is not stated or not collected — poor and/or inconsistent levels of Indigenous identification between states and territories would affect comparisons
- the assumptions underlying the method used to derive the potential populations

-
- for the Indigenous estimates, differential Census undercount between states and territories might also introduce bias in the results that could affect the comparability of estimates across jurisdictions.

Section 14.6 contains more detailed information on these quality issues.

Service use by special needs groups — people in outer regional and remote/very remote areas

Nationally, in 2009-10, the proportion of the outer regional and remote/very remote population who used NDA accommodation support services was 1.3 service users per 1000 population, lower than the proportion of the major cities and inner regional population who used these services (1.8 service users per 1000 population) (figure 14.15a). The proportion of the outer regional and remote/very remote potential population who used NDA accommodation support services (33.3 service users per 1000 potential population) was lower than that of the major cities and inner regional potential population who used these services (49.1 service users per 1000 potential population) (figure 14.16a).

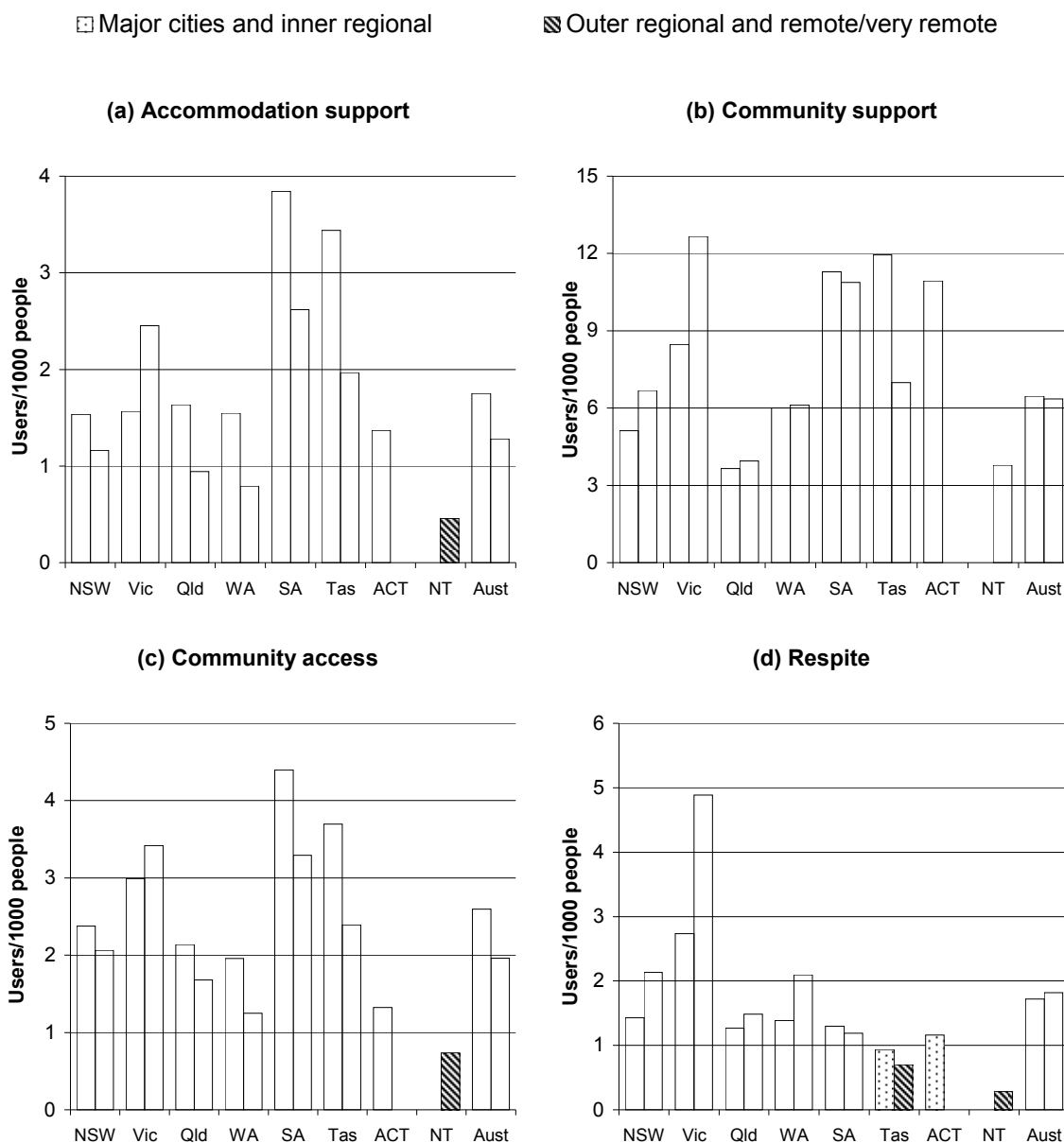
Nationally, in 2009-10, the proportion of the outer regional and remote/very remote population who used NDA community support services was 6.4 service users per 1000 population, lower than the proportion of the major cities and inner regional population who used these services (6.5 service users per 1000 population) (figure 14.15b). The proportion of the outer regional and remote/very remote potential population who used NDA community support services (164.9 service users per 1000 potential population) was lower than the proportion of the major cities and inner regional potential population who used these services (181.0 service users per 1000 potential population) (figure 14.16b).

Nationally, in 2009-10, the proportion of the outer regional and remote/very remote population who used NDA community access services was 2.0 service users per 1000 population, lower than the proportion of the major cities and inner regional population who used these services (2.6 service users per 1000 population) (figure 14.15c). The proportion of the outer regional and remote/very remote potential population who used NDA community access services (50.8 service users per 1000 potential population) was lower than the proportion of the major cities and inner regional potential population who used these services (72.7 service users per 1000 potential population) (figure 14.16c).

Nationally, in 2009-10, the proportion of the outer regional and remote/very remote population who used NDA respite services was 1.8 service users per 1000 population, higher than the proportion of the major cities and inner regional population who used these services (1.7 service users per 1000 population)

(figure 14.15d). Access to respite as a proportion of the potential population is not reported. To derive an estimate of the respite potential populations across the relevant groups Census data on people with a ASSNP who had a primary carer are needed. Potential population data for respite services is not calculated at these levels because of conceptual, definitional and quality issues with carer data from the 2006 Census for the special needs groups.

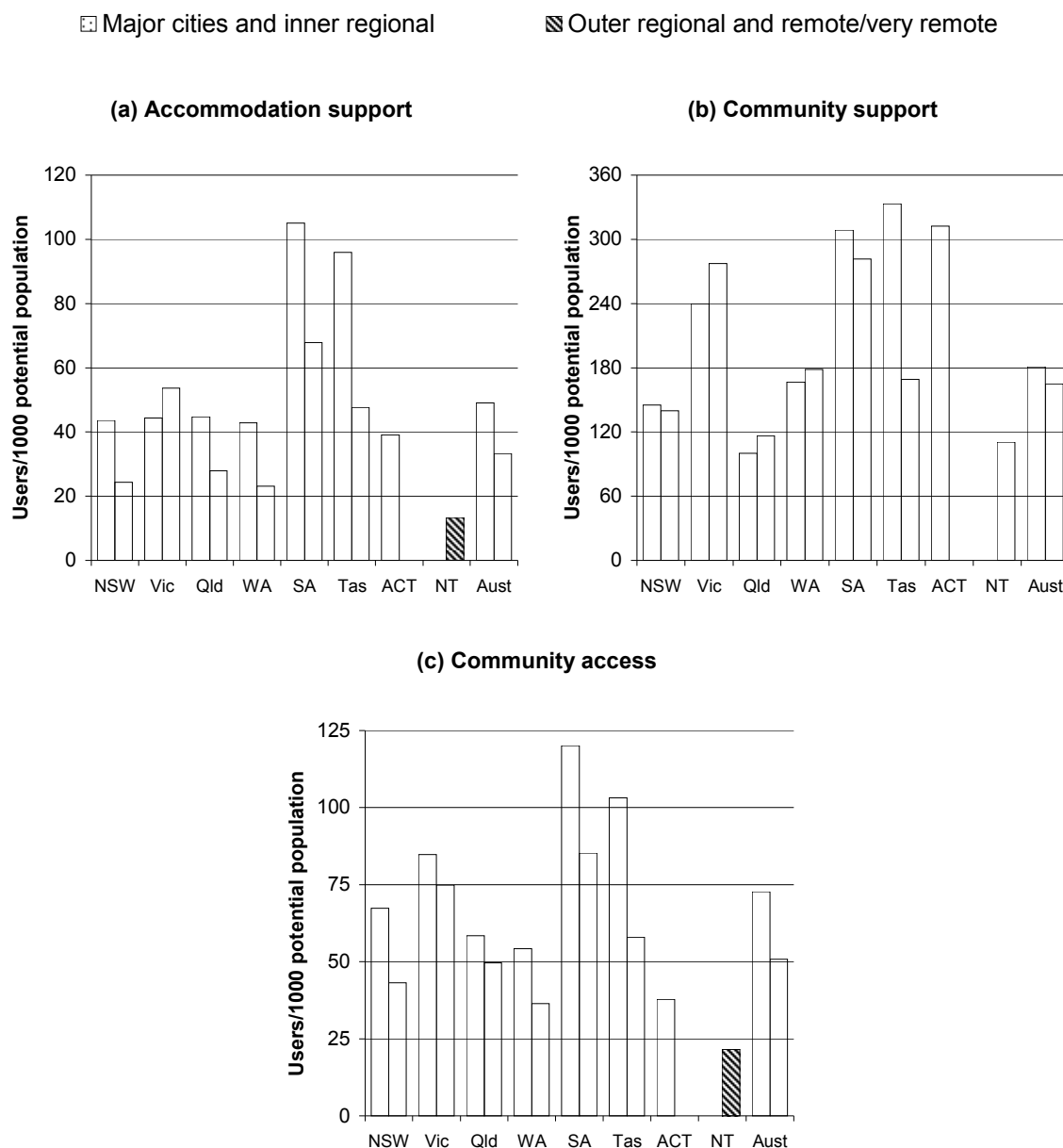
Figure 14.15 Users of State and Territory administered NDA specialist disability services per 1000 people, by geographic location, 2009-10^{a, b, c, d}



^a See tables 14A.40, 14A.41, 14A.42 and 14A.43 for detailed notes relating to these data. ^b Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. ^c The ACT does not have outer regional and remote/very remote areas. ^d The NT does not have major cities and inner regional areas.

Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW; AIHW (unpublished), derived from ABS 2011, 2009 Survey of Disability, Ageing and Carers, Cat. no. 4430.0; tables 14A.40, 14A.41, 14A.42 and 14A.43.

Figure 14.16 Users of State and Territory administered NDA specialist disability services per 1000 potential population, by geographic location, 2009-10^{a, b, c, d, e, f}

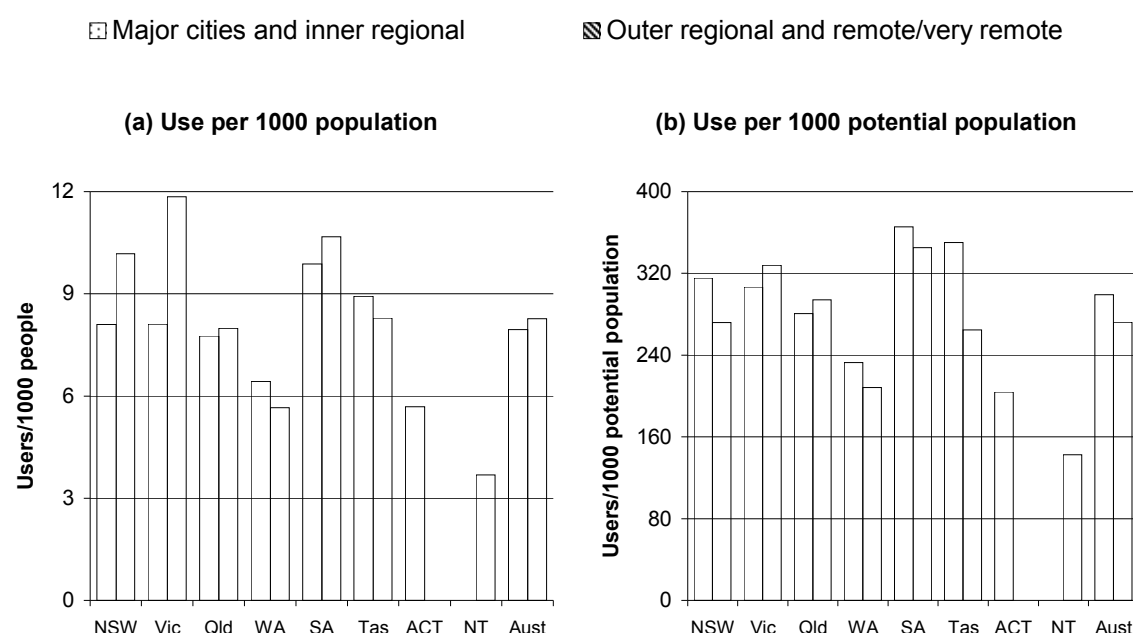


^a See tables 14A.40, 14A.41 and 14A.42 for detailed notes relating to these data. ^b Potential population is calculated using the unrevised method. See section 14.7 for information on how the potential population is defined. ^c Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. ^d The ACT does not have outer regional and remote/very remote areas. ^e The NT does not have major cities and inner regional areas. ^f ACT data for service users per 1000 Indigenous potential population are not published as they are based on a small number of service users.

Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW; AIHW (unpublished), derived from ABS 2011, 2009 Survey of Disability, Ageing and Carers, Cat. no. 4430.0; tables 14A.40, 14A.41 and 14A.42.

Nationally, in 2009-10, the proportion of the outer regional and remote/very remote population who used NDA employment services (8.3 service users per 1000 population) was higher than that of the major cities and inner regional population (8.0 service users per 1000 population) (figure 14.17a). The proportion of the outer regional and remote/very remote potential population who used NDA employment services (272.1 service users per 1000 potential population) was lower than that of the major cities and inner regional potential population (299.3 service users per 1000 potential population) (figure 14.17b).

Figure 14.17 Users of NDA employment services, by geographic location, 2009-10^{a, b, c, d}



^a See table 14A.44 for detailed notes relating to these data. ^b Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. ^c The ACT does not have outer regional and remote/very remote areas. ^d The NT does not have major cities and inner regional areas.

Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW; AIHW (unpublished), derived from ABS 2011, 2009 Survey of Disability, Ageing and Carers, Cat. no. 4430.0; table 14A.44.

Service use by special needs groups — Indigenous people

Nationally, in 2009-10, the proportion of the Indigenous population who used NDA accommodation support services was 2.8 service users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (1.6 service users per 1000 population) (figure 14.18a). The proportion of the Indigenous

potential population who used NDA accommodation support services (45.1 service users per 1000 potential population) was lower than the non-Indigenous potential population who used these services (46.3 service users per 1000 potential population) (figure 14.19a).

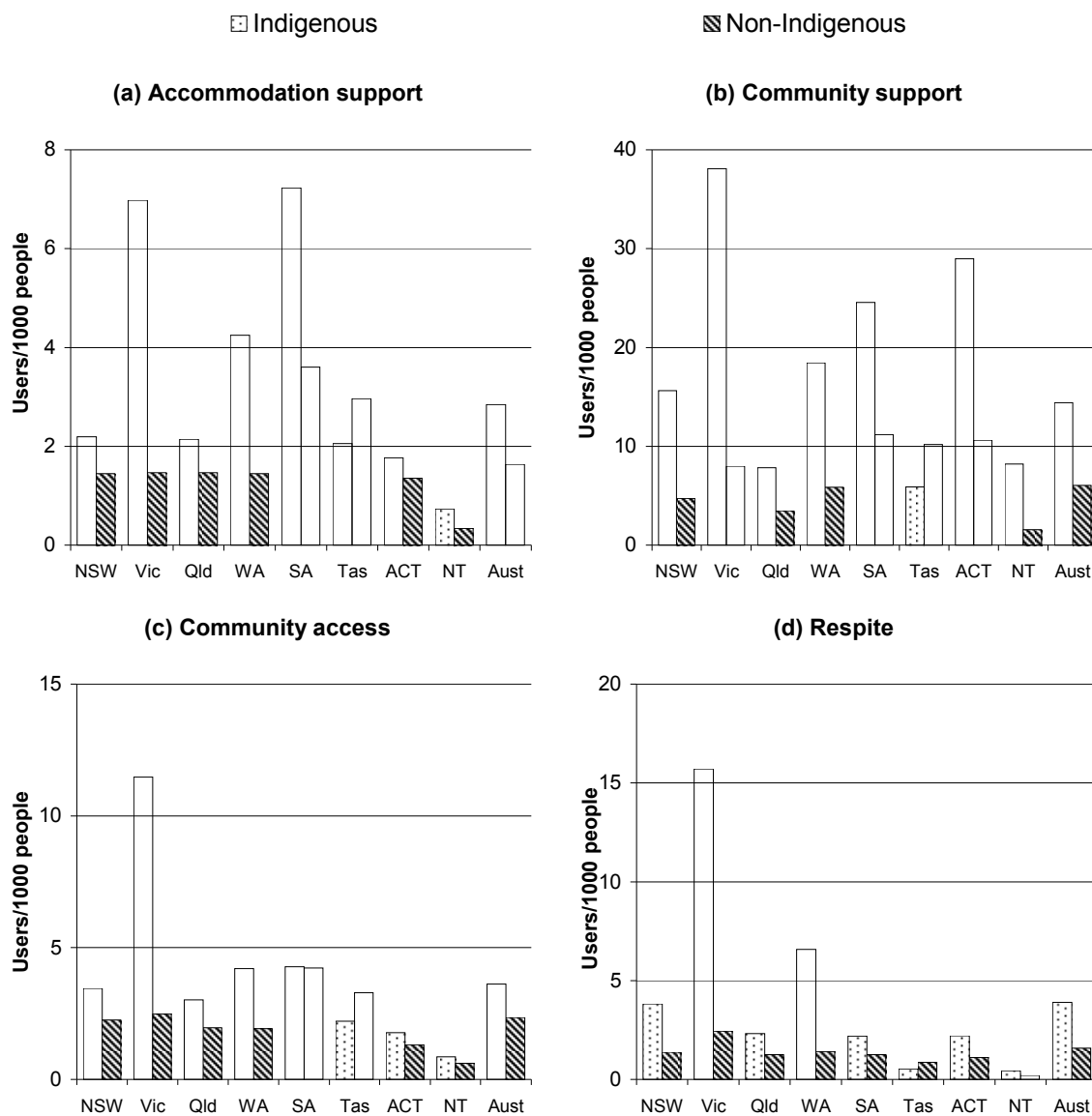
Nationally, in 2009-10, the proportion of the Indigenous population who used NDA community support services was 14.4 service users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (6.1 service users per 1000 population) (figure 14.18b). The proportion of the Indigenous potential population who used NDA community support services (228.9 service users per 1000 potential population) was higher than the proportion of the non-indigenous potential population who used these services (171.6 service users per 1000 potential population) (figure 14.19b).

Nationally, in 2009-10, the proportion of the Indigenous population who used NDA community access services was 3.6 service users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (2.4 service users per 1000 population) (figure 14.18c). The proportion of the Indigenous potential population who used NDA community access services (57.4 service users per 1000 potential population) was lower than the proportion of the non-Indigenous potential population who used these services (66.6 service users per 1000 potential population) (figure 14.19c).

Nationally, in 2009-10, the proportion of the Indigenous population who used NDA respite service was 3.9 users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (1.6 service users per 1000 population) (figure 14.18d). Access to respite as a proportion of the potential population is not reported. To derive an estimate of the respite potential populations across the relevant groups, data on people with a ASSNP who had a primary carer are needed. Potential population data for respite services is not calculated at these levels because of conceptual, definitional and quality issues with carer data from the 2006 Census for the special needs groups.

Data on users of NDA disability support services as a proportion of the Indigenous estimated potential population (revised method) are also available disaggregated by age (table 14A.45).

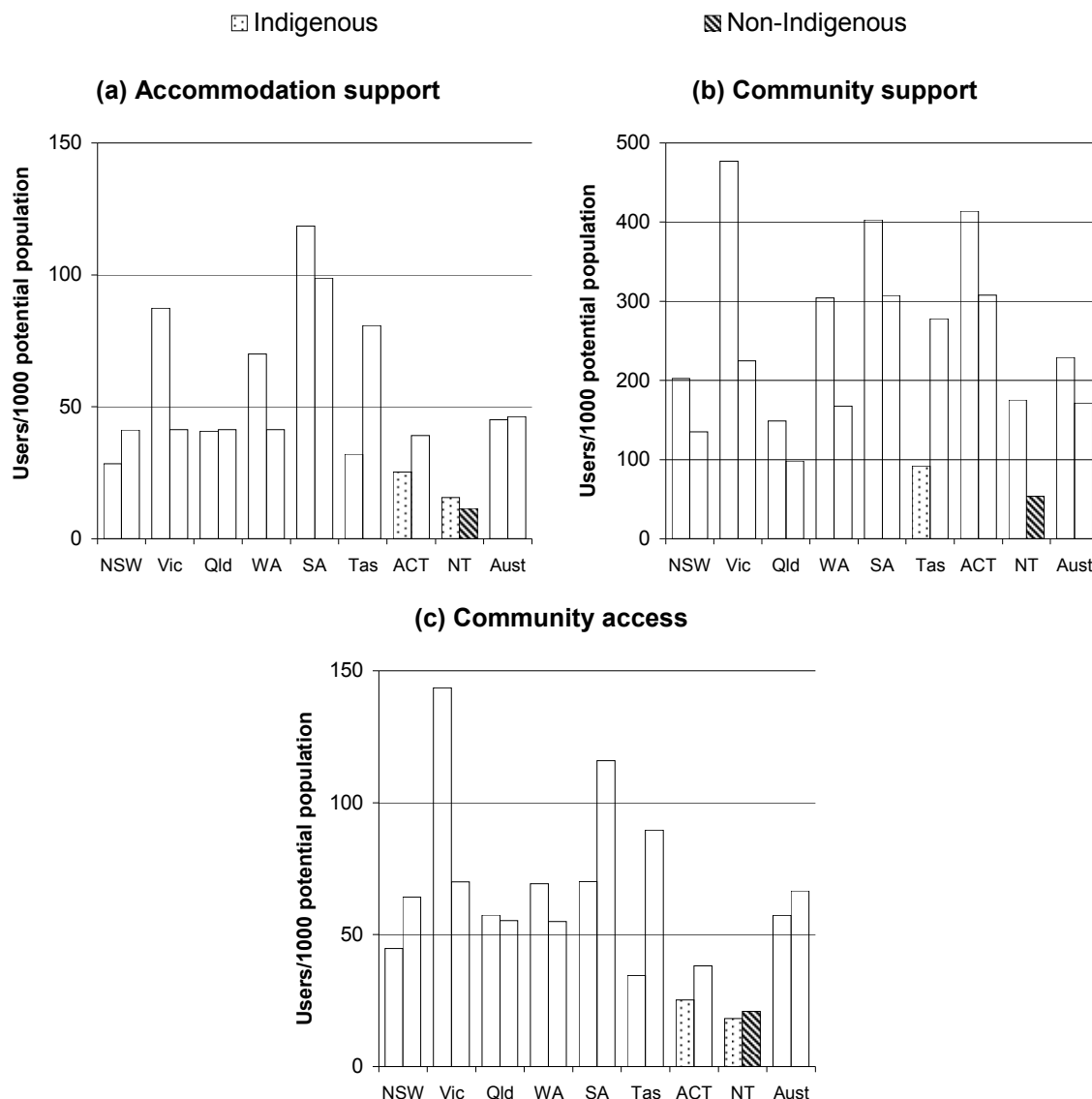
Figure 14.18 Users of State and Territory administered NDA specialist disability services per 1000 people, by Indigenous status, 2009-10^{a, b}



^a See tables 14A.46, 14A.47, 14A.48 and 14A.49 for detailed notes relating to these data. ^b Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW; AIHW (unpublished), derived from ABS 2011, 2009 Survey of Disability, Ageing and Carers, Cat. no. 4430.0; tables 14A.46, 14A.47, 14A.48 and 14A.49.

Figure 14.19 Users of State and Territory administered NDA specialist disability services per 1000 potential population, by Indigenous status, 2009-10^{a, b, c, d}



^a See tables 14A.46, 14A.47 and 14A.48 for detailed notes relating to these data. ^b Potential population is calculated using the unrevised method. See section 14.7 for information on how the potential population is defined. ^c Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. ^d ACT data for service users per 1000 Indigenous potential population are not published for accommodation support and community access as they are based on a small number of service users.

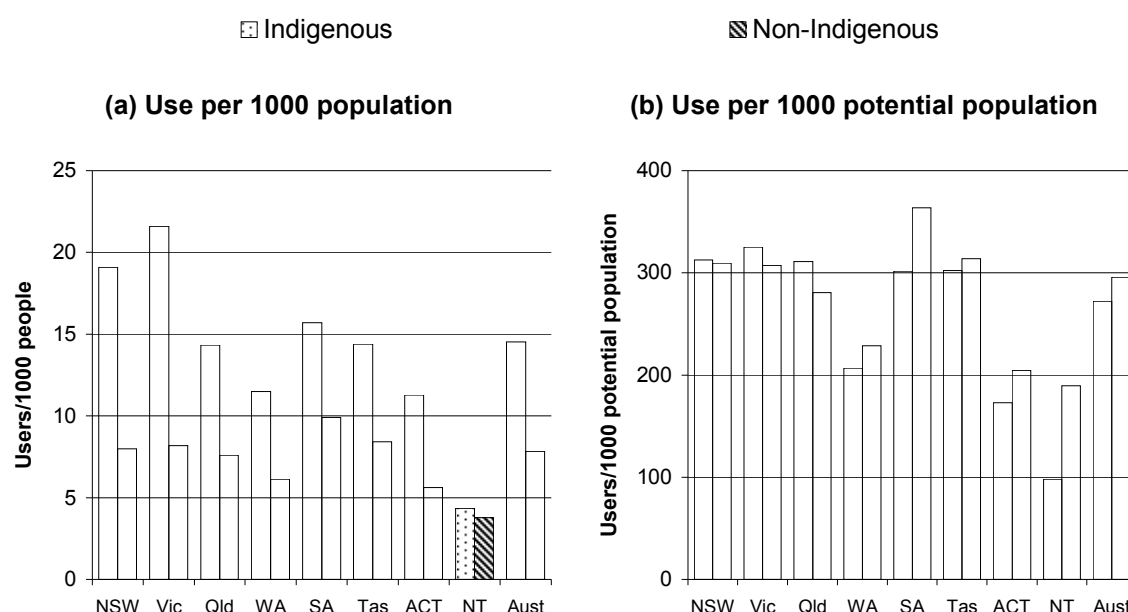
Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW; AIHW (unpublished), derived from ABS 2011, 2009 Survey of Disability, Ageing and Carers, Cat. no. 4430.0; tables 14A.46, 14A.47, 14A.48.

Nationally, in 2009-10, the proportion of the Indigenous population who used NDA employment services (14.5 service users per 1000 population) was higher than that

of the non-Indigenous population (7.8 service users per 1000 population) (figure 14.20a). The proportion of the Indigenous potential population who used NDA employment services (272.1 service users per 1000 potential population) was lower than that of the non-Indigenous potential population (295.7 service users per 1000 potential population) (figure 14.20b).

Data on users of NDA open employment services as a proportion of the Indigenous estimated potential population (revised method) are also available disaggregated by age (table 14A.51). Data on users of NDA supported employment services as a proportion of the Indigenous estimated potential population (revised method) are also available disaggregated by age (table 14A.52).

Figure 14.20 Users of NDA employment services, by Indigenous status, 2009-10^{a, b, c}



^a See table 14A.50 for detailed notes relating to these data. ^b Potential population is calculated using the unrevised method. See section 14.7 for information on how the potential population is defined. ^c Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement*. Disability series. Cat. no. DIS 59. Canberra; AIHW (unpublished) derived from ABS (2011) *2009 SDAC*, Cat. no. 4430.0, ABS *2006 Census of Population and Housing (CDATA Online)*, ABS (2007) *Labour Force Australia, Detailed Electronic Delivery*, June 2008, Cat. no. 6291.0.55.001, ABS (2009) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, Cat. no. 3238.0, *Australian Demographic Statistics, 2008*, Cat. no. 3101.0 and ABS (2007) *Population by Age and Sex, Australian States and Territories, Jun 2007*, Cat. no. 3201.0; table 14A.50.

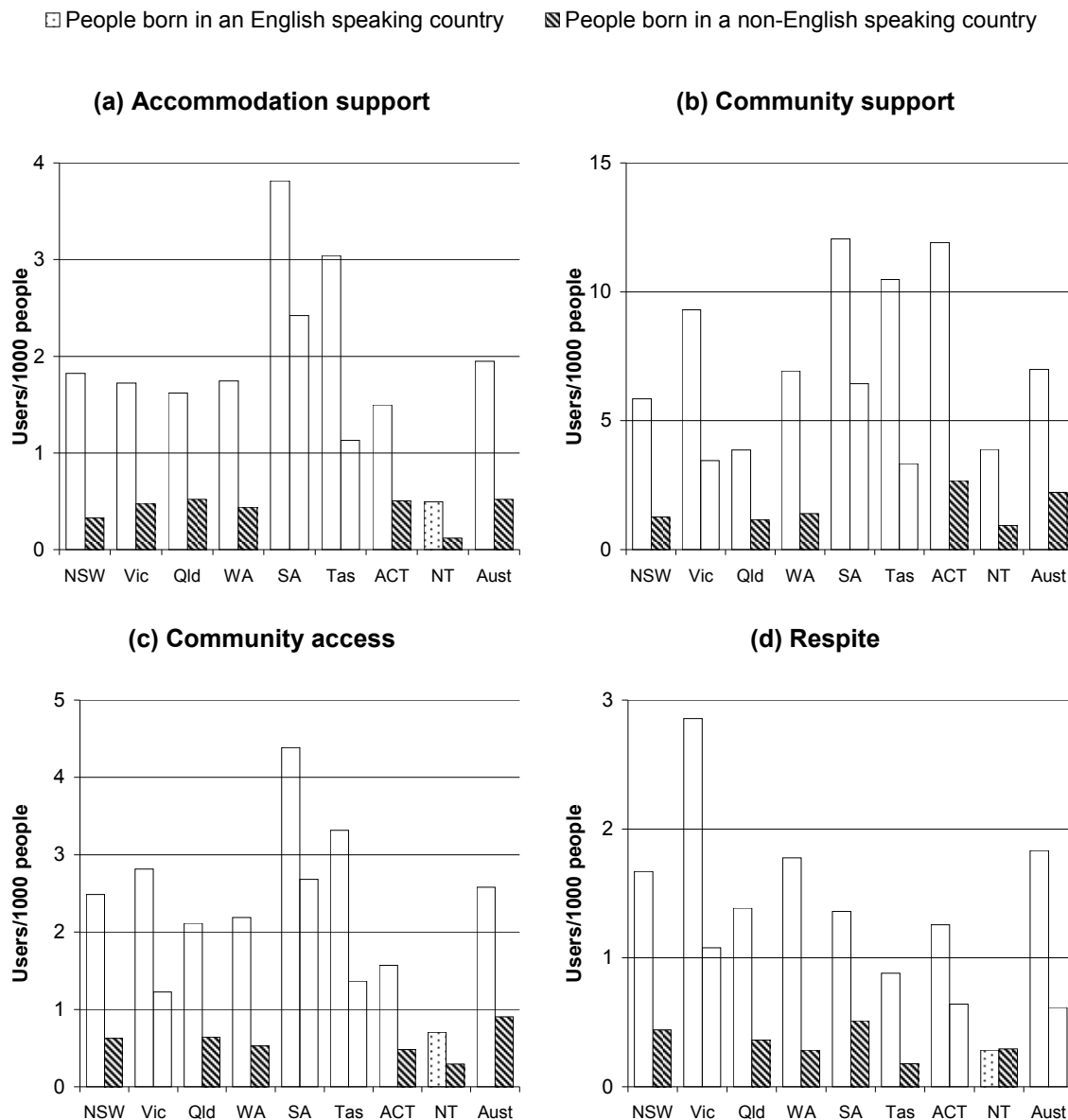
Service use by special needs groups — people born in a non-English speaking country

Nationally, in 2009-10, the proportion of people born in a non-English speaking country who used NDA:

- accommodation support services was 0.5 users per 1000 population, lower than the proportion of people born in an English speaking country (1.9 service users per 1000 population) (figure 14.21a). The proportion of the potential population born in a non-English speaking country who used NDA accommodation support services (14.7 users per 1000 potential population) was lower than the proportion of people born in an English speaking country who used these services (54.0 service users per 1000 potential population) (figure 14.22a)
- community support services was 2.2 service users per 1000 population, lower than the proportion of people born in an English speaking country who used these services (7.0 service users per 1000 population) (figure 14.21b). The proportion of the potential population born in a non-English speaking country who used community support services (62.8 service users per 1000 potential population) was lower than the proportion of people born in an English speaking country who used these services (193.5 service users per 1000 potential population) (figure 14.22b)
- community access services was 0.9 users per 1000 population, lower than the proportion of people born in an English speaking country who used these services (2.6 service users per 1000 population) (figure 14.21c). The proportion of the potential population born in a non-English speaking country who used community access services (25.6 service users per 1000 potential population) was lower than the proportion of people born in an English speaking country who used these services (71.3 service users per 1000 population) (figure 14.22c)
- respite services was 0.6 service users per 1000 population, lower than the proportion of people born in an English speaking country who used these services (1.8 service users per 1000 population) (figure 14.21d). Access to respite as a proportion of the potential population is not reported. To derive an estimate of the respite potential populations across the relevant groups Census data on people with a ASSNP who had a primary carer are needed. Potential population data for respite services is not calculated at these levels because of conceptual, definitional and quality issues with carer data from the 2006 Census for the special needs groups.

Data for users of disability support services as a proportion of estimated potential population (revised method) are also available disaggregated by country of birth and remoteness (tables 14A.53, 14A.55, 14A.57, 14A.59 and 14A.61).

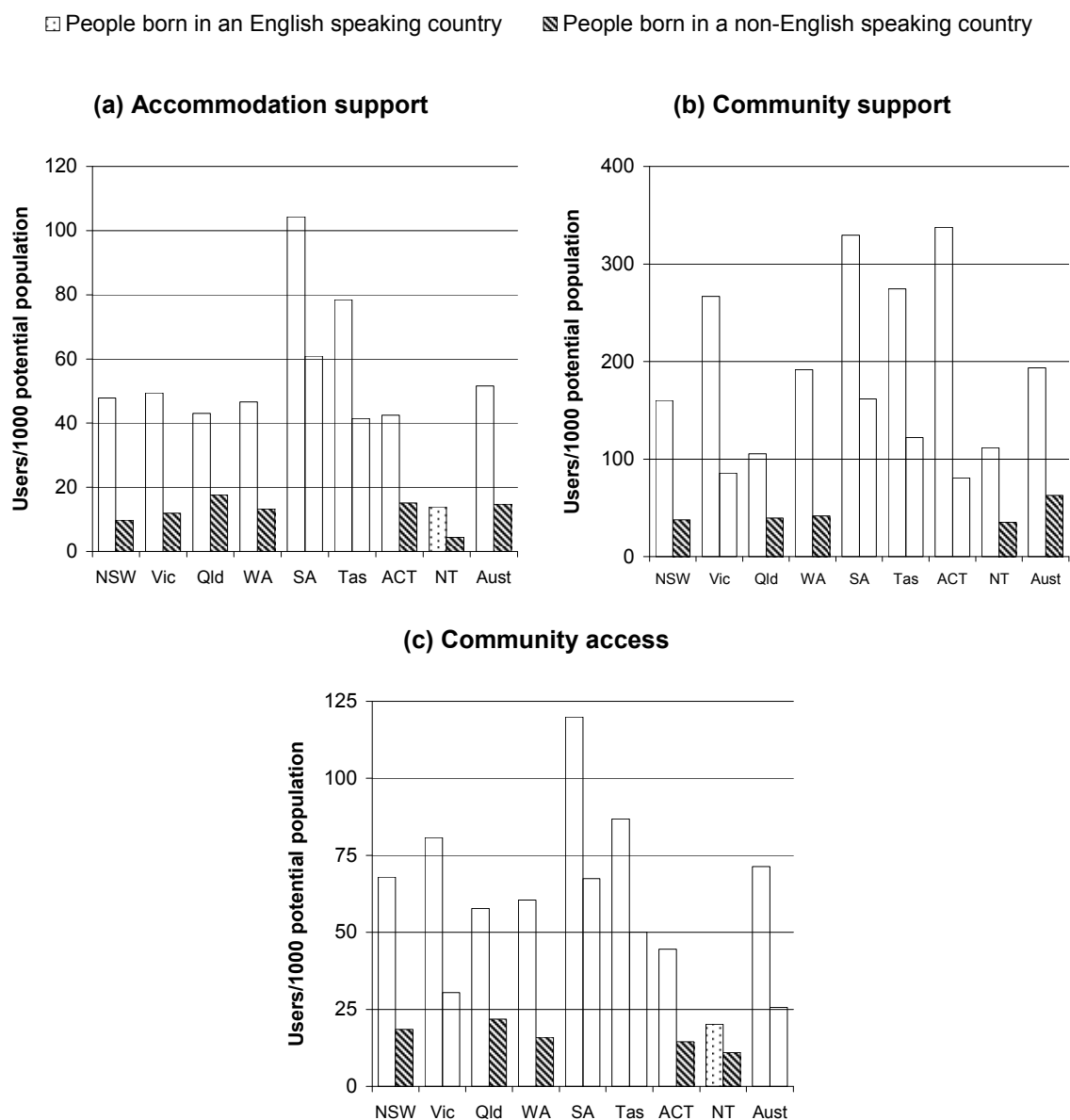
Figure 14.21 Users of State and Territory administered NDA specialist disability services per 1000 people (aged 0–64), by country of birth, 2009–10^{a, b}



^a See tables 14A.54, 14A.56, 14A.58 and 14A.60 for detailed notes relating to these data. ^b Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009–10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW (unpublished) derived from ABS 2006 *Census of Population and Housing (CDATA Online)* and ABS (2007) *Population by Age and Sex, Australian States and Territories, Jun 2008*, Cat. no. 3201.0, *Australian Demographic Statistics, 2008*, Cat. no. 3101.0, ABS (2007) *Labour Force Australia, Detailed Electronic Delivery, June 2008*, Cat. no. 6291.0.55.001; tables 14A.54, 14A.56, 14A.58 and 14A.60.

Figure 14.22 Users of State and Territory administered NDA specialist disability services per 1000 potential population, by country of birth, 2009-10^{a, b, c}

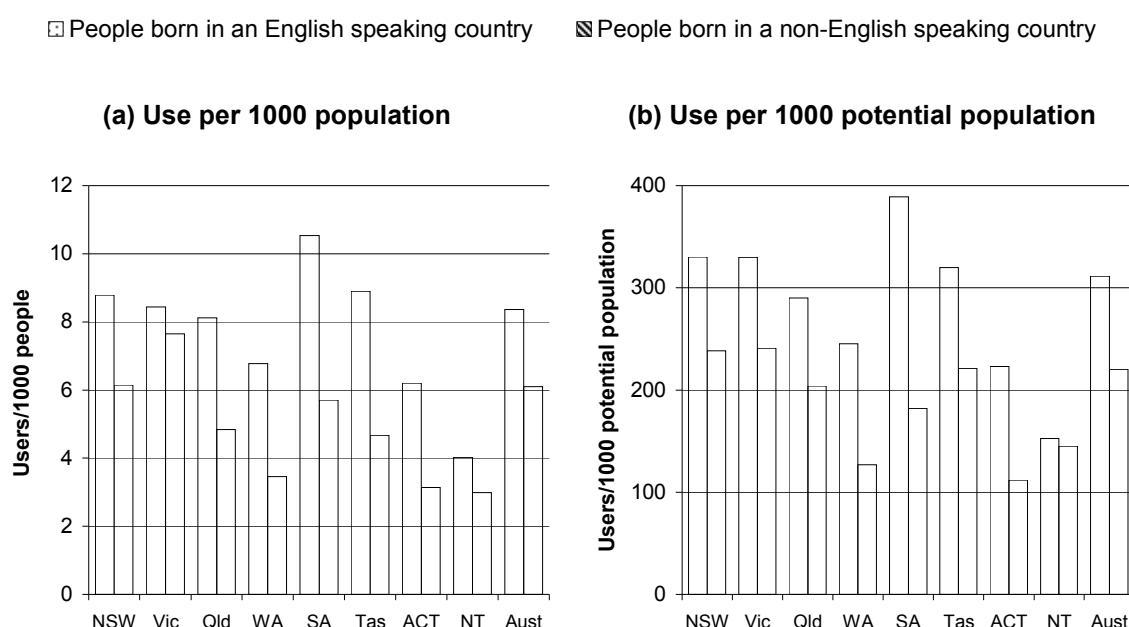


^a See tables 14A.54, 14A.56 and 14A.58 for detailed notes relating to these data. ^b Potential population is calculated using the unrevised method. See section 14.7 for information on how the potential population is defined. ^c Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW (unpublished) derived from ABS 2006 *Census of Population and Housing (CDATA Online)* and ABS (2007) *Population by Age and Sex, Australian States and Territories, Jun 2008*, Cat. no. 3201.0, *Australian Demographic Statistics, 2008*, Cat. no. 3101.0, ABS (2007) *Labour Force Australia, Detailed Electronic Delivery, June 2008*, Cat. no. 6291.0.55.001; tables 14A.54, 14A.56 and 14A.58.

Nationally, in 2009-10, the proportion of people born in a non-English speaking country who used NDA employment services (6.1 service users per 1000 population) was lower than that of people born in an English speaking country (8.4 service users per 1000 population) (figure 14.23a). The proportion of the potential population of people born in a non-English speaking country who used NDA employment services (220.3 service users per 1000 potential population) was lower than that of the potential population of people born in an English speaking country (311.4 service users per 1000 potential population) (figure 14.23b).

Figure 14.23 Users of NDA employment services, by country of birth, 2009-10^{a, b, c}



a See table 14A.62 for detailed notes relating to these data. **b** Potential population is calculated using the unrevised method. See section 14.7 for information on how the potential population is defined. **c** Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *DS NMDS*; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series*. Cat. no. DIS 59. Canberra; AIHW (unpublished) derived from ABS (2011) *2009 SDAC*, Cat. no. 4430.0, ABS *2006 Census of Population and Housing*, ABS (2007) *Labour Force Australia, Detailed Electronic Delivery, June 2008*, Cat. no. 6291.0.55.001, *Australian Demographic Statistics, 2008*, Cat. no. 3101.0 and ABS (2007) *Population by Age and Sex, Australian States and Territories, Jun 2007*, Cat. no. 3201.0; table 14A.62.

Data on users of NDA open employment services are also available disaggregated by country of birth and remoteness (table 14A.63). Data on users of NDA supported employment services are also available disaggregated by country of birth and remoteness (table 14A.64).

Access to community accommodation and care services

‘Access to community accommodation and care services’ is an indicator of governments’ objective to assist people with disability to live as valued and participating members of the community (box 14.8). Governments provide or fund accommodation support services to people with disability in institutional/residential settings and through community accommodation and care services. Institutional or residential accommodation support services are provided in both institutions and hostels. Community accommodation and care services are provided in group homes and other community settings. The services provided in other community settings are attendant care/personal care, in home accommodation support, alternative family placement and other accommodation support.

State and Territory governments generally seek, if possible, to provide accommodation support services to people with disability outside of institutional/residential settings. Community accommodation and care services are considered to provide better opportunities for people with disability to be involved in their community.

Box 14.8 Access to community accommodation and care services

‘Access to community accommodation and care services’ is defined as the number of people using a NDA community accommodation and care service divided by the total number of people using NDA accommodation support services (excluding people who use specialist psychiatric disability services only).

A higher proportion of people accessing NDA community accommodation and care services might provide better opportunities for people with disability (who need accommodation support) to be involved in their community.

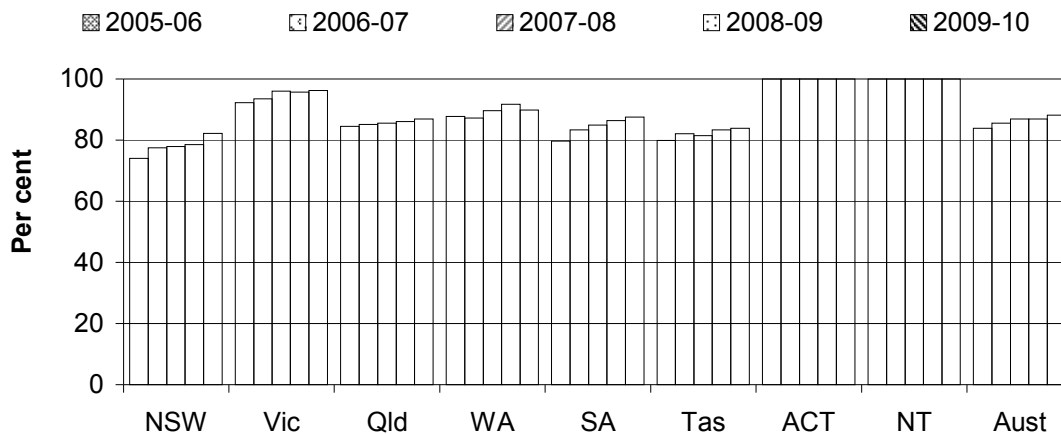
NDA specialist disability services are provided on the basis of need and available resources. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted on the basis of relative need.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, 88.2 per cent of users of NDA accommodation support services received community accommodation and care services in 2009-10 (figure 14.24).

Figure 14.24 Users of community accommodation and care services as a proportion of all NDA accommodation support service users^{a, b}



^a See table 14A.65 for detailed notes relating to these data. ^b Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *DS NMDS*; table 14A.65.

Assistance for younger people with disability in residential aged care

‘Assistance for younger people with disability in residential aged care’ (renamed in this Report) is an indicator of governments’ objective to provide access to services to people with disability that are appropriate to their needs (box 14.9).

Box 14.9 Assistance for younger people with disability in residential aged care

Assistance for younger people in residential aged care' is defined by two measures:

- the percentage change in numbers of younger people in residential aged care
- the proportion of service users in the Younger People in Residential Aged Care program (YPIRAC) who have achieved program objectives since its inception.

At its February 2006 meeting, COAG made a commitment to reduce the number of younger people with disability living in residential aged care, and agreed to establish a 5 year initiative — YPIRAC. The initial priority group is younger people with disability aged less than 50 years. Individuals participate in the YPIRAC initiative voluntarily.

The YPIRAC initiative has three main objectives:

- Objective 1 — People moving out of residential aged care to more appropriate supported disability accommodation.
- Objective 2 — People at risk, diverted from inappropriate admission to residential aged care.
- Objective 3 — People provided with enhanced services within a residential aged care setting, for whom residential aged care is the only available, suitable supported accommodation option.

To meet these objectives, the YPIRAC initiative provides three broad categories of services:

- YPIRAC assessment, individual care planning and/or client monitoring
- Alternative accommodation
- Support services packages.

On 1 January 2009, the NDA replaced the CSTDA. The NDA provides the framework for the provision of government support for people with disability. Australian Government funding for the YPIRAC initiative was rolled into funding provided to the State and Territory governments for the NDA. However, the YPIRAC initiative targets remain as agreed in the previous bilateral agreements.

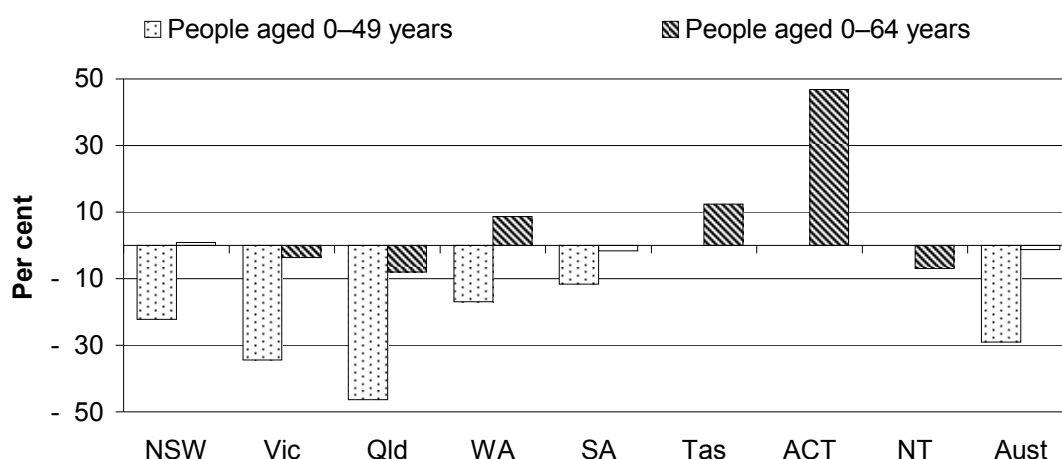
Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

On 30 June 2010, there were 715 people aged under 50 years living in permanent residential aged care nationally (table 14A.66). This is a 29.0 per cent decrease on the number of people aged under 50 years living in permanent residential aged care on 30 June 2006 (figure 14.25). These data need to be interpreted with care as some younger people choose to remain in residential aged care for a variety of reasons such as:

- their physical and nursing needs can be best met in residential aged care
- they are satisfied with their current living situation (that is, it is the preferred facility)
- the facility is located close to family and friends
- it is a familiar home environment.

Figure 14.25 Younger people in residential aged care, percentage change in numbers between 2006 and 2010, by age group^a, ^{b, c}

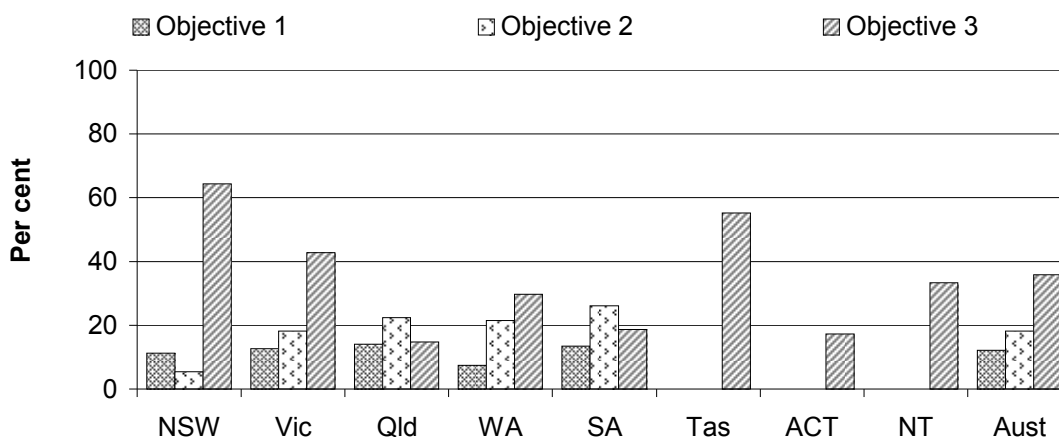


^a Data are for permanent residents in aged care. ^b These data should be interpreted with care (particularly for the NT). There may be issues related to the age of Indigenous residents being incorrectly recorded. An assessment of the data set in the NT has previously shown that approximately half of Indigenous people's ages were incorrectly recorded. ^c The percentage change for the number of people aged 0–49 years in the ACT is not reported due to confidentiality.

Source: Derived from AIHW (2011c), *Younger People with Disability in Residential Aged Care: update from the 2009–10 Minimum Data Set*. Bulletin no. AUS 135. Canberra; table 14A.66.

An estimated 1141 younger people with disability have been assisted with YPIRAC services since its inception in 2006. Objectives of the YPIRAC program are listed in box 14.9. A total of 12.2 per cent (139 service users) have achieved objective 1, 18.1 per cent (207 service users) have achieved objective 2 and 35.8 per cent (409 service users) have achieved objective 3 (figure 14.26, table 14A.68).

Figure 14.26 Proportion YPIRAC service users who have achieved program objectives since its inception to June 2010^{a, b, c}



^a Services user numbers are adjusted for individuals who received services in more than one jurisdiction therefore State and Territory totals may not add to the Australian total. ^b Service users may have received services in more than one collection period and may have had different target groups and residential settings recorded in different years. The most recently provided target group and residential setting were used to determine whether services users have achieved program objectives. ^c Box 14.9 contains definitions of Objectives 1-3.

Source: Derived from AIHW (2011c), *Younger People with Disability in Residential Aged Care: update from the 2009–10 Minimum Data Set*. Bulletin no. 86. Cat. no. AUS 135. Canberra; table 14A.68.

Data on younger people admitted to residential aged care, younger people who separated from permanent residential aged care and the number of younger people with disability receiving residential aged care are also available (tables 14A.69–71).

Equity and effectiveness — quality of services

The following equity and effectiveness quality indicators are reported:

- ‘Quality assurance processes’
- ‘Client and carer satisfaction’.

Quality assurance processes

‘Quality assurance processes’ are an indicator related to governments’ objective to deliver and fund services for people with disability that meet a particular standard of quality (box 14.10).

Box 14.10 Quality assurance processes

‘Quality assurance processes’ is defined as the proportion of NDA disability service outlets that have been assessed (either by an external agency or through a self-assessment process) against service standards.

A higher or increasing proportion of disability service outlets that have been assessed against the standards (and are found to be compliant) suggests an improvement in the quality of government delivered or funded specialist disability services.

This indicator does not provide information on whether the standards or the quality assurance processes are appropriate. In addition, service outlets that are not quality assessed do not necessarily deliver services of lower quality.

Data reported for this indicator are neither complete nor directly comparable.

Data quality information for this indicator is under development.

A set of eight minimum National Disability Service Standards were developed in 1992 in the context of the first Commonwealth State Disability Agreement (box 14.11). Under that Agreement, the Australian Government and all State and Territory governments agreed to implement these minimum standards:

- The Australian Government has implemented a quality assurance system for funded disability employment and rehabilitation services that requires service providers to be certified as compliant against 12 standards (which include the eight minimum standards). Each standard has a least one key performance indicator (table 14A.80)
- Most State and Territory governments have undertaken work to interpret the standards (such as developing supporting standards) and to develop related performance indicators and/or guidance on how to meet the standards. Most State and Territory governments have adopted additional standards to the eight minimum National Standards. Five jurisdictions have adopted a specific standard relating to ‘Protection of human rights and freedom from abuse’, for example. Some have also introduced specific outcome standards for service users or generic standards that apply to all community sector organisations including disability services (tables 14A.72–79)
- All State and Territory governments have also developed, or are in the process of developing/re-developing, mechanisms for assessing compliance with standards (tables 14A.72–79).

Box 14.11 National Disability Service Standards

Standard 1 Service access

Each consumer seeking a service has access to a service on the basis of relative need and available resources.

Standard 2 Individual needs

Each person with a disability receives a service which is designed to meet, in the least restrictive way, his or her individual needs and personal goals.

Standard 3 Decision making and choice

Each person with a disability has the opportunity to participate as fully as possible in making decisions about the events and activities of his or her daily life in relation to the services he or she receives.

Standard 4 Privacy, dignity and confidentiality

Each consumer's right to privacy, dignity and confidentiality in all aspects of his or her life is recognised and respected.

Standard 5 Participation and integration

Each person with a disability is supported and encouraged to participate and be involved in the life of the community.

Standard 6 Valued status

Each person with a disability has the opportunity to develop and maintain skills and to participate in activities that enable him or her to achieve valued roles in the community.

Standard 7 Complaints and disputes

Each consumer is free to raise and have resolved, any complaints or disputes he or she may have regarding the agency or the service.

Standard 8 Service management

Each agency adopts sound management practices which maximise outcomes for consumers.

The quality assurance processes differ across jurisdictions. Most processes include some form of self-assessment. Many expect, or are working toward implementing, an external third party audit/certification process.

Data on quality assurance processes in 2009-10 are reported in box 14.12. These results should be interpreted with reference to tables 14A.72–80 that contain information on the legislation under which jurisdictions' implement standards, the relevant disability service standards and how quality is monitored.

Box 14.12 Quality assurance processes for specialist disability services 2010-11

Quality assurance processes data reported relate to NDA specialist disability services.

Australian Government

The Australian Government funded a total of 414 disability employment organisations, comprising 1829 outlets, operating across Australia at 30 June 2011. Of these:

- Disability Employment Services (DES) funded by the Department of Education, Employment and Work Place Relations (DEEWR) made up 215 (51.0 per cent) of the 414 organisations. DES also accounted for 1508 (88.5 per cent) of total outlets. Of the 212, 67 (31.6 per cent) DES organisations operated as dual (both DEEWR and The Department of Families, Housing, Community Services and Indigenous Affairs [FaHCSIA]) funded employment services.
- Australian Disability Enterprises (ADEs) funded by FaHCSIA made up 202 (49.0 per cent) of the 414 disability employment organisations, with 321 (11.5 per cent) outlets. Of the 202, 67 (33.1 per cent) ADE organisations operated as dual funded employment services.
- As at June 30 2011, there were a total of 368 quality assurance audits performed at 75 dual organisations, 139 ADE organisations and 154 DES organisations. FaHCSIA paid a total of \$2.5 million in contributions towards the cost of these audits, 6 per cent below estimated budget expenditure.

Of the 154 audits performed at DES organisations, 44 were certification audits and 110 were surveillance audits. FaHCSIA paid a total of \$1.4 million in contribution payments. Auditors identified non-conformities during visits to five DES services this quarter, two out of the three were dual funded organisations.

Of the 143 audits conducted at ADE organisations, 69 were certification audits and 70 were surveillance audits. FaHCSIA paid a total of \$1.1 million in contribution payments.

NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT

Different quality assurance processes were in place in NSW, Victoria, Queensland, WA, SA and the ACT in 2009-10. The evaluation processes relate to both government and non-government service outlets, although in some jurisdictions the requirements are different across service sectors.

NSW — All NSW non-government organisation providers are required annually to revalidate ongoing compliance with Standards. In 2009-10 96 per cent of providers reported compliance with Standards. An action plan is developed for any required remedial action. The information return provided is assessed using a risk monitoring tool to determine the level of intervention required to support the provider. The extent of intervention required to support a provider is based on a range of factors including output and financial reporting, complaints, self assessments and implementation of agreed plans for improvement.

(Continued on next page)

Box 14.12 (Continued)

To complement and strengthen this approach, NSW is implementing a Quality Framework to ensure a consistent approach to measuring outcomes so that service providers can demonstrate their application of, and performance against standards. Service providers are being supported to build their understanding of quality improvement and outcomes measurement to enhance their organisation capacity and achieve real outcomes for people receiving services.

Victoria — In a survey of quality plans conducted in 2010-11, 98 per cent of residential accommodation support services outlets reported a minimum of two planned quality improvement activities in the forthcoming year.

Queensland — The Disability Sector Quality System introduced on 1 July 2004, requires all disability service providers recurrently funded by the Department of Communities, to achieve certification through an external certification body accredited by the Joint Accreditation System of Australia and New Zealand (JAS-ANZ). Each year service providers undergo annual surveillance audits to ensure that certification is maintained and that a continuous improvement plan has been developed. The quality system also provides a framework to support service providers to develop, implement and maintain their own quality management system. The assessment process relates to both government and non-government service providers.

Of the established 245 recurrently funded service providers, 100 per cent have achieved certification and undergo annual surveillance audits to ensure that certification is maintained and that a continuous improvement plan has been developed. Currently there are 22 new service providers who are in the process of implementing their quality management systems in preparation for external audit. Evaluation processes relate to both government and non-government service outlets.

WA — In July 2010, a new Quality Management Framework (QMF) replaced the previous standards monitoring approach. The new framework is based on outcomes and the evaluation of service points that comprise a number of service outlets. Previous to 2010, Standards Monitoring was based on monitoring outputs. The QMF provides a more rigorous process for evaluating whether quality standards are being met and cannot be compared against previous years' performances. For 2010-11, 76 per cent of service points met independently assessed quality assurance standards.

SA — In SA, non-government service providers are required to meet quality assurance criteria before they can provide NDA specialist disability services. From 2006-07 this included participation in an independently audited quality assurance system. Currently 98 per cent of grant-funded organisations are required to be engaged in an approved quality improvement program, with a further 2 per cent exempt from quality improvement requirements. It is anticipated that 93 per cent of organisations will have met quality improvement requirements by December 2011.

(Continued on next page)

Box 14.12 (Continued)

Tasmania — During 2010-11 Tasmania continued implementation of a Quality and Safety Standards Framework across all Department of Health and Human Services funded community sector organisations, including specialist services for people with disability. The requirement to adhere to, and engage with the Standards Framework is included in the contractual arrangement between the Agency and the community sector organisation.

Engagement with the Standards Framework requires community sector organisations to demonstrate continuous quality improvement, on a six monthly basis, or continue with their current accreditation framework or, if seeking accreditation, select an appropriate framework that is inclusive of relevant national standards. To date, 100 per cent of funded community sector organisations delivering specialist disability services have engaged with the Standards Framework.

The Standards Framework is currently under evaluation and this evaluation will assist to position the Standards Framework post 2012. The evaluation process has included face-to-face forums across the State and the opportunity for community sector organisations to have further input on-line.

ACT — In 2010-11 the ACT continued the implementation of the quality improvement framework for all services delivered by Government and Community Sector service providers. All individual organisations are required to undertake an annual baseline self-assessment against the National Disability Service Standards, with quality improvement action plans being developed and implemented on the basis of any identified issues.

Further, as part of a regular process in the quality improvement framework, the ACT has engaged an external contractor to conduct an independent compliance, quality assurance and financial audit on 15 Disability ACT funded non-government organisations. This audit has been completed and Disability ACT will be conducting a further three more funded non-government organisations' audits from July 2011. These on-going audits will involved at least 42 funded non-government organisations over a period of three years.

Source: Australian, NSW, Victorian, Queensland, WA, SA, Tasmanian and the ACT governments (unpublished).

Under the NDA, there is a performance benchmark that all services be subject to quality improvement systems consistent with National Standards by 2010. Quality improvement systems are an identified priority area on which parties have agreed to concentrate initial national efforts (box 14.1). In September 2009, the Community and Disability Services Ministers' Conference endorsed an interim National Quality Framework for Disability Services, including revising the National Standards for Disability Services. Under this Framework, a national approach to quality assurance and the continuous improvement of disability services were introduced.

Client and carer satisfaction

‘Client and carer satisfaction’ is an indicator of governments’ objective to deliver and fund quality services for people with disability that meet the needs and goals of the client (or carer of the client) receiving them (box 14.13).

Box 14.13 Client and carer satisfaction

‘Client and carer satisfaction’ are defined as reported overall ratings and satisfaction with individual services. Results are taken from a client and carer satisfaction survey and are expressed in percentage terms.

A higher or increasing proportion of clients and carers satisfied is desirable, as it suggests the service received was of a higher quality and better met the needs and goals of the client (or carer).

Data reported for this indicator are neither complete nor directly comparable.

Data quality information for this indicator is under development.

Data are available for reporting for Victoria, Queensland, WA, SA, Tasmania and the ACT only (box 14.14). It is anticipated that data for other jurisdictions will be included in future reports

Box 14.14 Client and carer satisfaction with specialist disability services

Client and carer satisfaction processes data reported relate to NDA specialist disability services.

Victoria

In Victoria, the Department of Human Services (DHS), under the Disability Services Respite activity specification, has a quality measure requirement to complete an annual Carer Satisfaction Survey. The result of this survey is used to inform program directions and is reported to the Department of Treasury and Finance.

The Respite Carer Satisfaction Survey 2010-11 sought feedback from carers on the range of respite services available, provided by both the Department of Human Services and Community Service Organisations and identified:

- 67 per cent of carers were satisfied with respite services
- 13 per cent of carers were dissatisfied with respite services
- 20 per cent of carers reported neither being satisfied nor dissatisfied.

(Continued on next page)

Box 14.14 (Continued)

DHS has committed to undertake a range of projects aimed at improving respite supports in Victoria, including the development of a plan to ensure that a wide range of supports are able to meet the diversity of families/carers needs into the future.

Queensland

No survey was conducted in Queensland in 2010-11. Queensland's most recent *Disability and Mental Health Service Users and Carers Satisfaction Survey* was conducted during February to April 2009. Overall, of the 2147 service users, service users' proxies, and carers who were surveyed, 73 per cent of service users and proxies and 66 per cent of carers reported that they were satisfied with the services they received. The survey provides results according to the type of disability and mental health services received and shows:

- 80 per cent of service users and their proxies and 74 per cent of carers were satisfied with accommodation support services
- 66 per cent of service users and their proxies and 61 per cent of carers were satisfied with community support services
- 76 per cent of service users and their proxies and 65 per cent of carers were satisfied with community access services
- 81 per cent of service users and their proxies and 77 per cent of carers were satisfied with respite services.

WA

Western Australia conducted a carer and client satisfaction survey in May 2011. In this survey, a total of 736 structured telephone interviews were completed from a sample of 1882 individuals with a disability or their carers, which was stratified to ensure that it contained individuals representing users across all services funded by the Disability Services Commission. Of the 736 respondents, 75 (10.0 per cent) were service users and 661 (90.0 per cent) were carers responding on behalf of service users. This survey was previously undertaken biennially but from 2011 will be undertaken annually.

Overall service user satisfaction is 81 per cent. For individual services, reported satisfaction is:

- 82 per cent for accommodation
- 82 per cent for individual support (includes Disability Professional Services and Day Options)
- 72 per cent for local area coordination.

(Continued on next page)

Box 14.14 (Continued)

SA

The Disability SA component of the Department for Families and Communities Customer Satisfaction Survey was conducted in February 2010. From 2011 the survey will be undertaken annually and it was in process in late 2011.

A total of 172 people responded to the February 2010 survey, of which 34 per cent were clients of Disability SA and 66 per cent were family carers or advocates. Results of the customer satisfaction survey indicate:

- 74 per cent of respondents reported they were satisfied with the overall quality of the service delivery and of those 36 per cent were very satisfied
- 76 per cent of respondents reported they were satisfied overall with accessing the service
- 69 per cent reported they were satisfied with the amount of time it took to get the service/product they needed
- 97 per cent reported that it was important that they are treated fairly, while 84 per cent agreed they were treated fairly.

Tasmania

No survey was conducted in Tasmania in 2010-11. In 2008-09, Tasmania conducted client and family satisfaction surveys across a range of group homes and community access services. For group homes, 117 clients and 272 families were surveyed and for community access services, 63 clients and 153 families were surveyed:

- The proportion of clients who were satisfied with the quality of services was 91 per cent for group homes and 96 per cent for community access services
- Families indicated similar levels of satisfaction with the quality of services with 98 per cent satisfied in group homes and 95 per cent satisfied in community access services.

ACT

In 2011 the ACT conducted client satisfaction surveys of government provided disability services including NDA services. These surveys asked clients to rate their overall satisfaction levels with the quality of the services they had received. The proportion of service users reporting that they were satisfied or very satisfied was:

- 60 per cent for accommodation support services
- 62 per cent for respite service users
- 94 per cent for community support users.

Source: Victorian, Queensland, WA, SA, Tasmanian and the ACT governments (unpublished).

Efficiency — cost per output unit

The following cost per output unit efficiency indicators are reported:

- ‘Government contribution per user of non-government provided services’
- ‘Cost per user of State and Territory administered services’.

This Report includes 2010-11 expenditure data provided by Australian, State and Territory governments. However, as 2010-11 service user data from the DS NMDS collection were not available for this Report, the cost per service user efficiency indicators are reported for 2009-10. 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 can differ. Data in this Report might also differ from information reported elsewhere because the data here exclude users of specialist psychiatric disability services.

It is an objective of the Review to report comparable estimates of costs. Ideally, such comparisons would include the full range of costs to government. Where the full costs cannot be counted, costs are estimated on a consistent basis. The jurisdictional expenditure data included in this chapter do not yet include the user cost of capital, and so do not reflect the full costs of government funded services (User cost of capital is defined in chapter 2).

Considerable effort has been made to document any differences in calculating the reported efficiency indicators. Concerns remain over the comparability of the results, because jurisdictions use different methods of data collection (table 14A.81).

Financial data — expenditure items included/excluded

Financial data reported in this chapter include/exclude various expenditure items depending on the context in which the data are reported. When specific service types are discussed, only direct recurrent expenditure on those specific services is included (this may include administrative costs that can be directly attributed to a specific service/s). When the disability services system as a whole is discussed, expenditure includes general administrative overheads that cannot be allocated to a specific service/s and major capital grants to non-government service providers. Capital grants to non-government service providers are excluded from total recurrent expenditure for the indicator ‘administrative expenditure as a proportion of total recurrent expenditure’, as they are not strictly a ‘recurrent’ expense. Exclusion of these grants improves the comparability of the indicator across jurisdictions and over time.

Government and non-government provided services

Efficiency indicators are reported for both government and non-government provided services. Government provision means that a service is both funded and directly provided by a government department, agency or local government. Non-government provision is a service purchased or part-funded by a government department or agency, but provided by a non-government organisation. Non-government service providers may receive funds from the private sector and the general public in addition to funding, grants and input tax concessions (such as payroll tax exemptions) from governments. Data on funds that non-government service providers received from the private sector and the general public are outside the scope of this Report.

Government contribution per user of non-government provided services

‘Government contribution per user of non-government provided services’ is an indicator of governments’ objective to provide specialist disability services in an efficient manner (box 14.15).

Box 14.15 Government contribution per user of non-government provided services

‘Government contribution per user of non-government provided services’ is defined as the net government expenditure per NDA service user. Measures are reported for the following non-government provided services:

- accommodation support services in:
 - institutional/residential settings
 - group homes
 - other community settings
- employment services (reported per employment service user assisted).

Holding other factors constant (such as service quality and accessibility), a low or decreasing government expenditure per service user reflects a more efficient provision of this service.

Efficiency data are difficult to interpret. Although high or increasing expenditure per unit of output can reflect deteriorating efficiency, it can also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of users. Similarly, low or declining expenditure per unit of output can reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Data reported for this indicator are not directly comparable.

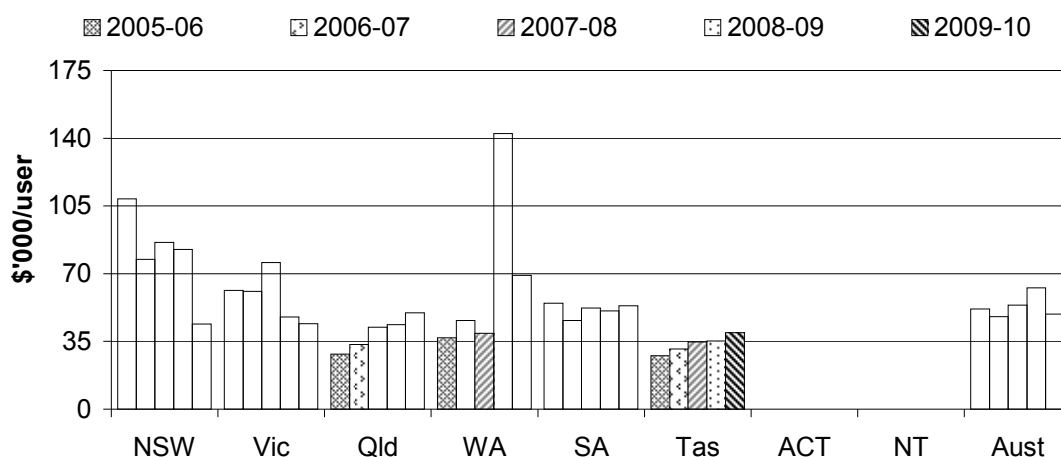
Data quality information for this indicator is under development.

The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

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 \$49 122 per service user in 2009-10 (figure 14.27).

Figure 14.27 Estimated annual government funding per user of non-government provided accommodation support services in institutional/residential settings (2009-10 dollars)^{a, b, c, d, e, f}



^a See table 14A.82 for detailed notes relating to these data. ^b Service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. ^c Government and non-government sectors have not been accurately recorded in the NSW DS MDS over the years. Some non-government providers have been coded as government and this will affect the comparability of the number of service users from government and non-government sectors over time. ^d The Victorian cost per service user for 2004-05 is overstated due to a significant proportion of service users having moved from institutional settings to community based and individualised settings, while expenditure continued to be similar to previous years. ^e There were no non-government provided accommodation support services in institutional/residential settings in the ACT and the NT. ^f Real dollars are previous years' expenditure in current year's dollars after basing expenditure on the ABS GDP price deflator 2009-10 =100 (table AA.39).

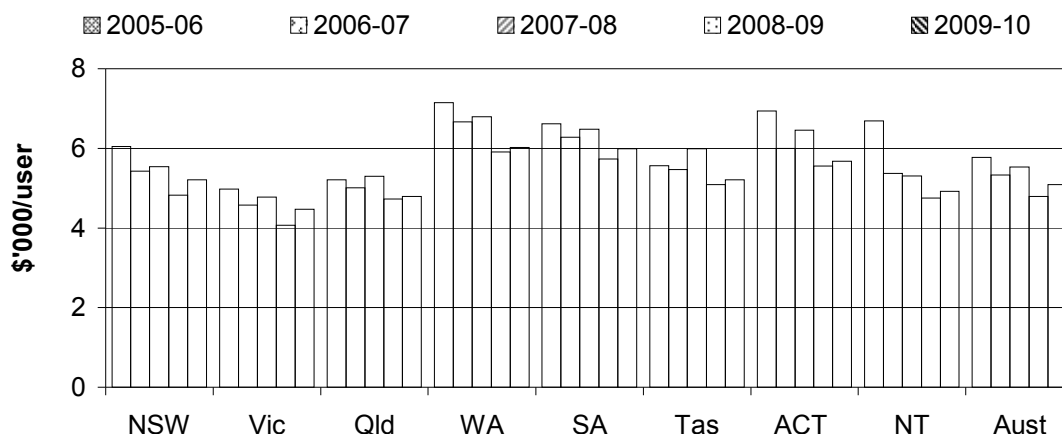
Source: AIHW (unpublished) DS NMDS; State and Territory governments (unpublished); table 14A.82.

Estimated annual government funding per user of non-government provided accommodation support services in group homes and other community settings for 2009-10 are reported in table 14A.82.

Government contribution per user of non-government provided services — government contribution per employment service user assisted

Nationally, for all employment services, estimated government expenditure per service user assisted was \$5088 in 2009-10 (figure 14.28). Nationally, estimated annual government expenditure per service user in 2009-10, by employment service type, was \$4545 on open services (employed or seeking employment in the open labour market) and \$9352 on supported services (employed by the service provider) (table 14A.84).

Figure 14.28 Government contribution per employment service user assisted (2009-10 dollars)^{a, b, c}



^a See table 14A.83 for detailed notes relating to these data. ^b Cost per employment service user data reported here might differ from those reported in the Australian Government's annual report, where different rules are used to count the number of employment service users. ^c Real dollars are previous years' expenditure in current year's dollars after basing expenditure on the ABS GDP price deflator 2009-10 =100 (table AA.39).

Source: Australian Government (unpublished); AIHW (unpublished) *DS NMDS*; table 14A.83.

Cost per user of State and Territory administered services

'Cost per user of State and Territory administered services' is an indicator of governments' objective to provide specialist disability services in an efficient manner (box 14.16).

Box 14.16 Cost per user of State and Territory administered services

‘Cost per user of State and Territory administered services’ is defined as government expenditure on NDA State and Territory administered services per service user. The following two measures are reported:

- estimated government expenditure per user of NDA State and Territory administered services (data are reported separately for government expenditure net of payroll tax and for government expenditure including actual and/or imputed payroll tax)
- cost per user of government provided accommodation support services in:
 - institutional/residential settings
 - group homes
 - other community settings.

Holding other factors constant (such as service quality and accessibility), a low or decreasing government expenditure per service user reflects a more efficient provision of this service.

Efficiency data are difficult to interpret. Although high or increasing expenditure per unit of output can reflect deteriorating efficiency, it can 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 can reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Total estimated government expenditure per user of NDA State and Territory administered specialist disability services in 2009-10 is reported both net of payroll tax and including actual and/or imputed payroll tax. Nationally, estimated expenditure per service user was \$27 781 excluding payroll tax and \$28 216 including actual and/or imputed payroll tax (figure 14.29).

Figure 14.29 Estimated annual government expenditure per user of NDA State and Territory administered services, 2009-10^{a, b, c, d}



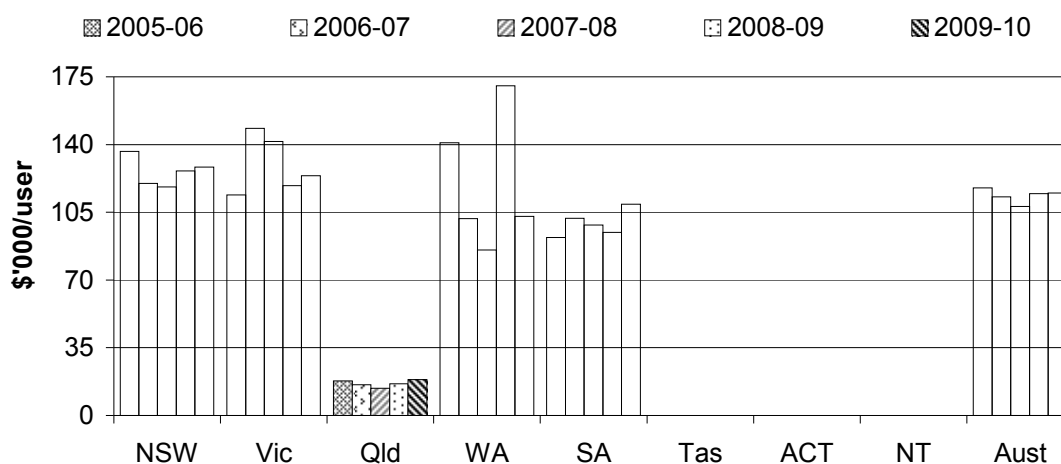
^a In some jurisdictions (NSW, Victoria, SA, Queensland, Tasmania and the NT), payroll tax data are actual; in other jurisdictions (WA and ACT), payroll tax data are imputed. ^b Government expenditure per service user for Australia excludes Australian Government expenditure on State and Territory administered services that was not provided as transfer payments. ^c Payroll tax data for Queensland includes paid payroll tax and accrued payroll tax. ^d In the NT, payroll tax relates to government service provision and excludes expenditure for program management and administration.

Source: AIHW (unpublished) *DS NMDS*; State and Territory governments (unpublished); table 14A.85.

Cost per user of State and Territory administered services — government provided accommodation support services – institutional/residential settings

Nationally, estimated annual government expenditure on accommodation support services in institutional/residential settings was \$114 937 per service user in 2009-10 (figure 14.30).

Figure 14.30 Estimated annual government expenditure per user of government provided accommodation support services in institutional/residential settings (2009-10 dollars)^{a, b, c, d, e, f}



^a See table 14A.82 for detailed notes relating to these data. ^b Service user data used to derive this measure have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. ^c Government and non-government sectors have not been accurately recorded in the NSW DS MDS over the years. Some non-government providers have been coded as government and this will affect the comparability of the number of service users from government and non-government sectors over time. ^d Queensland data include funding provided by the Department of Communities only. ^e There were no government provided accommodation support services in institutional/residential settings in Tasmania, the ACT or the NT. ^f Real dollars are previous years' expenditure in current year's dollars after basing expenditure on the ABS GDP price deflator 2009-10 =100 (table AA.39).

Source: AIHW (unpublished) *DS NMDS*; State and Territory governments (unpublished); table 14A.82.

Estimated annual government expenditure per user of government provided accommodation support services in group homes and other community settings for 2009-10 are reported in table 14A.82.

Efficiency — administrative cost

Administrative expenditure as a proportion of total recurrent expenditure

'Administrative expenditure as a proportion of total recurrent expenditure' is an indicator of governments' objective to provide specialist disability services in an efficient manner (box 14.17). The proportion of total expenditure on administration is not yet comparable across jurisdictions as it is apportioned by jurisdictions using different methods (table 14A.81). However, administrative expenditure data can indicate trends within jurisdictions over time.

Box 14.17 Administrative expenditure as a proportion of total recurrent expenditure

‘Administrative expenditure as a proportion of total recurrent expenditure’ is defined as government expenditure on administration as a proportion of total recurrent NDA expenditure. Major capital grants to non-government service providers are excluded to improve comparability across jurisdictions and over time.

Holding other factors constant (such as service quality and accessibility), lower or decreasing administrative expenditure as a proportion of total recurrent NDA expenditure might reflect an increase in administrative efficiency.

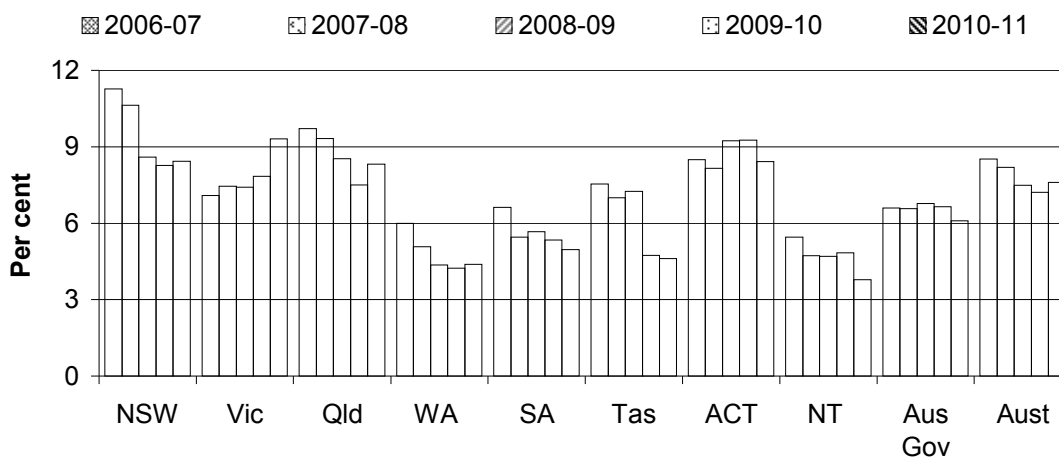
Efficiency data are difficult to interpret. Although high or increasing administrative expenditure as a proportion of total expenditure may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the administrative services provided. Similarly, low or declining administrative expenditure as a proportion of total expenditure may reflect improving efficiency, or lower quality and less effective administrative services. This may in turn affect service delivery effectiveness. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Nationally, administrative expenditure as a proportion of total government expenditure on specialist disability services (excluding payroll tax) increased from 7.2 per cent in 2009-10 to 7.6 per cent in 2010-11 (figure 14.31). When actual or imputed payroll tax is included, the average national administrative expenditure as a proportion of total NDA expenditure was 7.5 per cent in 2010-11 (table 14A.86). Real total NDA expenditure is reported in table 14A.7, both excluding and including actual or imputed payroll tax amounts.

Figure 14.31 Administrative expenditure as a proportion of total recurrent expenditure^{a, b, c, d, e, f}



^a See table 14A.81 for an explanation of different methods of apportioning departmental costs. ^b Data exclude payroll tax. ^c Australian Government administrative expenditure is an estimate, based on average staffing levels. ^d The decrease in NSW administrative expenditure as a proportion of total recurrent expenditure on services in 2008-09 reflects an improved overhead allocation model which results in better allocation of funding to direct and non-direct service expenditures. ^e The decrease in WA administrative expenditure in 2007-08 mainly reflects the abolition of the capital user charge by the Department of Treasury and Finance. ^f In Tasmania, reduction in administrative expenditure for 2009-10 was due to improved processes for aligning administrative and direct service delivery expenditure.

Source: Australian, State and Territory governments (unpublished); table 14A.86.

Outcomes

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

The following outcome indicators are included in the performance framework:

- ‘Labour force participation and employment of people with disability’
- ‘Labour force participation of primary carers of people with disability’
- ‘Social participation of people with disability’
- ‘Use of other services by people with disability’.

The measures and data sources for the ‘labour force participation and employment of people with disability’, ‘social participation of people with disability’ and ‘use of other services’ indicators differ across report editions. Data for these indicators for this Report are from the 2009 SDAC. ‘Labour force participation of primary carers of people with disability’ is reported for the first time.

Interpreting data for some outcome indicators

For the outcome indicators derived using survey data, 95 per cent confidence intervals are presented. These intervals assist with making comparisons across jurisdictions, and across different disability status groups. Confidence intervals are a standard way of expressing the degree of uncertainty associated with survey estimates. An estimate of 80 with a confidence interval of ± 4 , for example, means that if another sample had been drawn there is a 95 per cent chance that the result would lie between 76 and 84. Where ranges do not overlap, there is a statistically significant difference. If one jurisdiction's results range from 78–80 and another's from 82–89, then it is possible to say that one differs from the other (because there is a statistically significant difference). To say that there is a statistically significant difference means there is a high probability that there is an actual difference — it does not imply that the difference is necessarily large or important.

Labour force participation and employment of people with disability

'Labour force participation and employment of people with disability' is an indicator of governments' objective of assisting people with disability to participate fully in the community (box 14.18). Participation in the labour force and employment is important to the overall wellbeing of people with disability, providing opportunities for self development and financial independence.

Box 14.18 Labour force participation and employment of people with disability

‘Labour force participation and employment of people with disability’ is defined as the labour force participation and employment rates of people aged 15–64 years by disability status:

- Profound or severe core activity limitation
- Other disability
- No disability.

Higher or increasing labour force participation and employment rates for people with disability are desirable. Higher rates are likely to increase the quality of life of people with disability by providing greater opportunities for self-development and for economic and social participation.

This indicator does not provide information on why people choose not to participate in the labour force and why people are not employed. It also does not provide information on whether the employment positions are appropriate or fulfilling.

Data reported for this indicator are comparable.

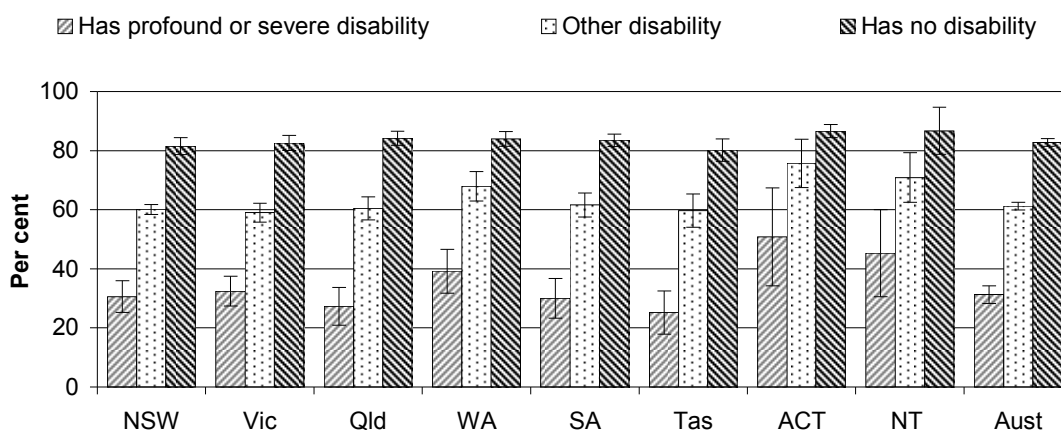
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Labour force participation

Nationally, in 2009, the estimated labour force participation rate of people with a profound or severe core activity limitation aged 15–64 years (31.3 ± 5.0 per cent) was statistically significantly lower than the rate for people with other disability (but without a profound or severe core activity limitation) (61.2 ± 8.4 per cent) and the rate for people without disability (82.8 ± 0.4 per cent) (figure 14.32).

Detailed definitions of the labour force participation rate and its calculation method are provided in section 14.7. Other data on the labour force participation of people with disability are reported in tables 14A.87–104.

Figure 14.32 Estimated labour force participation rates of people aged 15–64 years, by disability status, 2009^{a, b}



^a Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self care. ^b Error bars represent the 95 per cent confidence interval associated with each point estimate.

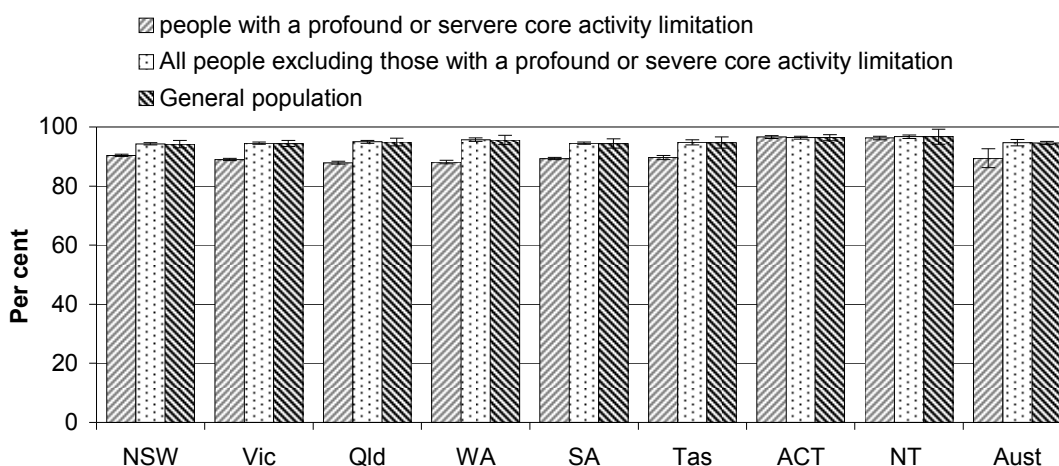
Source: ABS (unpublished) *Survey of Disability, Ageing and Carers, 2009*; table 14A.88.

Employment

Nationally, in 2009, the estimated employment rate of people aged 15–64 years with a profound or severe core activity limitation (89.4 ± 0.9 per cent) was lower than the rate for all people excluding those with a profound or severe core activity limitation (94.7 ± 1.1 per cent) and the rate for the general population (94.6 ± 3.2 per cent) (figure 14.33).

Detailed definitions of the employment rate and its calculation method are provided in section 14.7. Employment rates should be interpreted in conjunction with labour force participation rates. Other data on the employment of people with disability are reported in tables 14A.87–104.

Figure 14.33 Estimated employment rates of people aged 15–64 years, by disability status, 2009^{a, b}



^a Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self care. ^b Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Survey of Disability, Ageing and Carers, 2009*; table 14A.87.

Labour force participation of primary carers of people with disability

‘Labour force participation of primary carers of people with disability’ is an indicator of governments’ objective of assisting primary carers of people with disability to participate fully in the community (box 14.19). Participation in the labour force is important to the overall wellbeing of carers, providing opportunities for self development and financial independence.

Box 14.19 Labour force participation of primary carers of people with disability

‘Labour force participation of primary carers of people with disability’ is defined as labour force participation rate for primary carers aged 15–64 years of people with disability.

Primary carer is defined as a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. A detailed definition is provided in section 14.7.

Higher or increasing labour force participation rates for primary carers of people with disability are desirable. Higher rates are likely to increase the quality of life of primary carers of people with disability by providing greater opportunities for self-development.

This indicator does not provide information on why people choose not to participate in the labour force. It also does not provide information on whether the participation in the labour force is fulfilling.

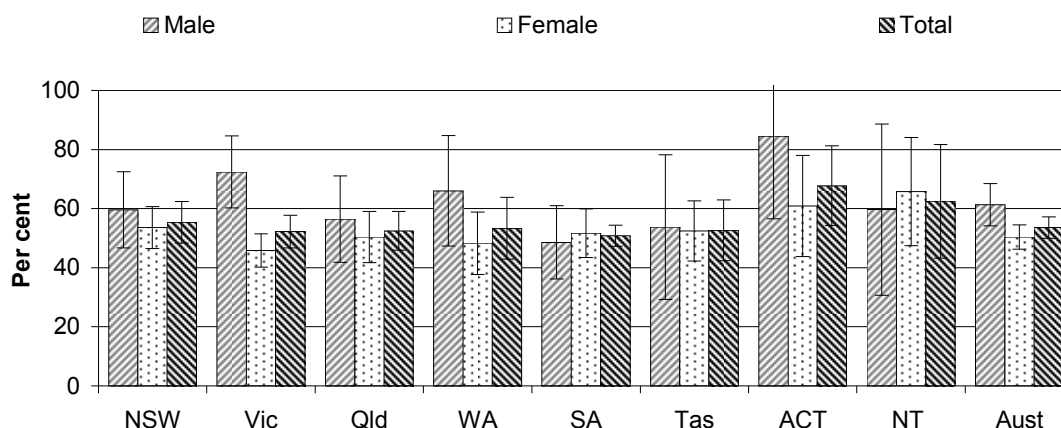
Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, in 2009, the estimated labour force participation rate of primary carers aged 15–64 years for people with disability was 53.6 ± 3.6 per cent. Male primary carers were more likely to participate in the labour force (61.4 ± 7.2 per cent) than female primary carers (50.4 ± 4.1 per cent) (figure 14.34). The number of female primary carers (approximately 417 100) was significantly higher than male primary carers (approximately 158 400).

Detailed definitions of the labour force participation rate and its calculation method are provided in section 14.7. Other data on the labour force participation for primary carers of people with disability are reported in tables 14A.105–108.

Figure 14.34 Labour force participation rate for primary carers (carers of people with disability) aged 15–64 years, by carer sex, by State/Territory, 2009^a



^a Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Survey of Disability, Ageing and Carers, 2009*; table 14A.105.

Social participation of people with disability

‘Social participation of people with disability’ is an indicator of governments’ objective to assist people with disability to live as valued and participating members of the community (box 14.20).

Box 14.20 Social participation of people with disability

‘Social participation of people with disability’ is defined as the proportion of people who participate in selected social or community activities by disability status:

- Profound or severe core activity limitation
- Other disability
- No disability.

A higher or increasing proportion of people with disability who participate in social or community activities reflects their greater inclusion in the community.

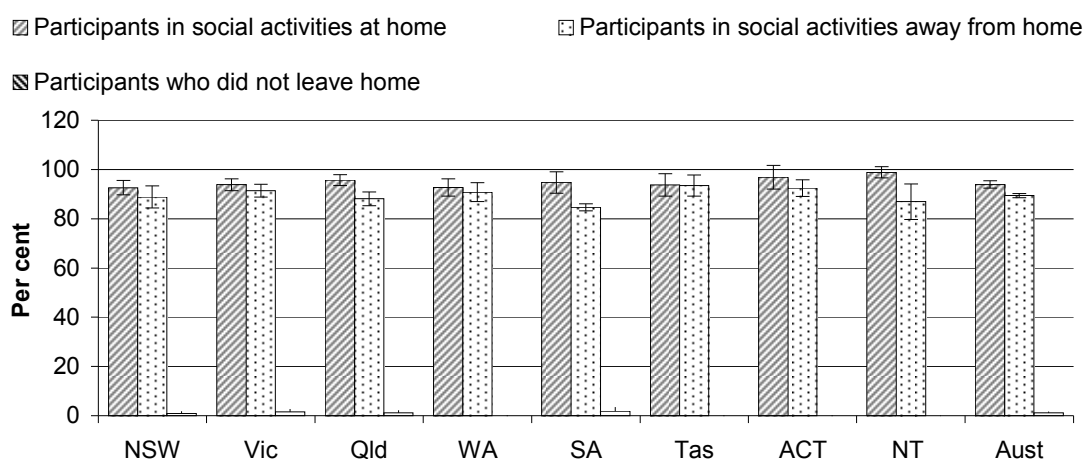
This indicator does not provide information on the degree to which the identified types of social or community activities contribute to people’s quality of life. It also does not provide information on why some people did not participate.

Updated data for this indicator were not available for the 2012 Report.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, in 2009, similar proportions of people with a profound or severe core activity limitation aged 5–64 years participated in a social activity at home in the past 3 months (93.9 per cent) and away from home in the past 3 months (89.4 per cent). An estimated 1.1 per cent of people with a profound or severe core activity limitation aged 5–64 years did not leave home in the past 3 months (figure 14.35).

Figure 14.35 Social activities participated in by people with a profound or severe core activity limitation, 2009^{a, b, c}

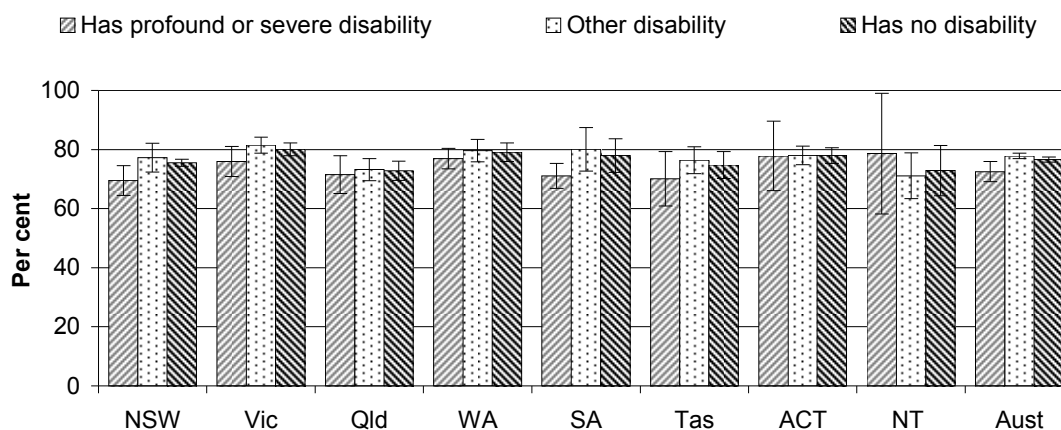


^a For people aged 5–64 years, living in households. ^b Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self care. ^c These questions gathered social activity information from the respondent about the three months prior to interview.

Source: ABS (unpublished) *Survey of Disability, Ageing and Carers, 2009*; table 14A.109.

Nationally, in 2009, the estimated proportion of people with disability aged 5–64 years with a profound or severe disability who had face-to-face contact with ex-household family or friends in the previous week (72.5 ± 3.4 per cent) was lower than the rate for other people with disability (without a profound or severe core activity limitation) (77.8 ± 0.9 per cent) and the rate for people without disability (76.6 ± 0.9 per cent) (figure 14.36).

Figure 14.36 People with disability aged 5-64 years who had face-to-face contact with ex-household family or friends in the previous week, 2009^{a, b, c}



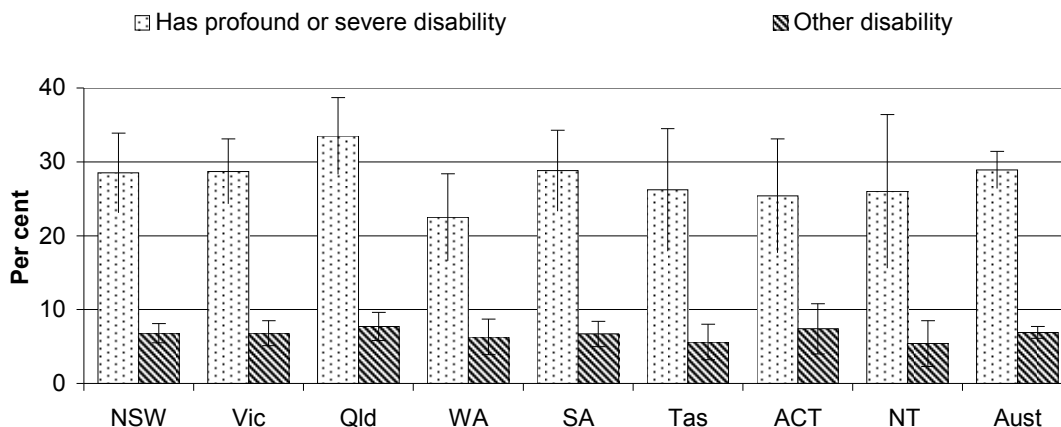
^a For people aged 5–64 years, living in households. ^b Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self care. ^c Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Survey of Disability, Ageing and Carers, 2009*; table 14A.110.

Nationally, in 2009, the estimated proportion of people with disability aged 5–64 years with a profound or severe disability who reported their disability condition as the main reason for not leaving home as often as they would like (28.9 ± 2.5 per cent) was significantly higher than the rate for other people with disability (without a profound or severe core activity limitation) (6.9 ± 0.8 per cent) (figure 14.37).

Other data on participation of people with disability in selected social and community activities are reported in tables 14A.109–138.

Figure 14.37 People with disability aged 5–64 years who report the main reason for not leaving home as often as they would like is their disability or condition, by disability status, 2009^{a, b, c}



^a For people aged 5–64 years, living in households. ^b Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self care. ^c Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *Survey of Disability, Ageing and Carers, 2009* ; table 14A.119.

Use of other services by people with disability

‘Use of other services by people with disability’ is an indicator of governments’ objective of enhancing the quality of life experienced by people with disability by assisting them to gain access to mainstream government services (box 14.21).

Box 14.21 Use of other services by people with disability

‘Use of other services by people with disability’ is defined by two measures:

- the proportion of people aged 0–64 years with a ASSNP who lived in State or Territory housing authority dwellings (data are also reported for people without ASSNP and the proportions of both groups living in other dwelling tenure types)
- the proportion of people aged 15–64 years with disability who visited a GP at least once in the last 6 months (data are also reported for people without disability).

A higher or increasing proportion of people with disability who use the selected mainstream government services suggests greater access to these services.

This indicator does not provide information on whether the service accessed is the most appropriate, or the degree to which the service contributes to people’s quality of life. It also does not provide information on why some people do not access these services.

Data for this indicator were not available for the 2012 Report.

Data quality information for this indicator is under development.

‘Use of other services’ data reported elsewhere in this Report

Data on the participation of people with disability in various government services are incorporated in the performance indicator frameworks for other chapters of this Report. Participation is reported for children’s services (chapter 3); VET (chapter 5); public, community and State owned and managed Indigenous housing and Commonwealth Rent Assistance (chapter 16). In addition, the following chapters include data on services provided to people with disability:

- ‘School education’ (chapter 4) reports data on students with disability in the student body mix
- ‘Mental health management’ (chapter 12) reports performance data on specialised mental health services
- ‘Aged care services’ (chapter 13) reports data on HACC services received, including those received by people with a profound, severe or moderate core activity limitation, disaggregated by jurisdiction and geographic location.

14.4 Future directions in performance reporting

Scope for further improvements to current framework

There is scope for further improvements in reporting against the current framework, including improvements to the data on service quality. The Steering Committee intends to address limitations over time by:

- considering the development of an indicator on quality of life
- reporting of improved service user data, as a result of anticipated improvements in data quality and comparability
- reporting more comprehensive social and community participation data, when available
- reporting national client and carer satisfaction with service quality
- reporting more complete, current, ongoing quality assurance processes data, which are expected to become more complete and comparable under the NDA.

Further alignment between the Report and NDA indicators will occur in future reports as a result of developments in NDA reporting.

COAG developments

Outcomes from review of Report on Government Services

The COAG endorsed recommendations (December 2009) of the review of the RoGS implemented during 2010 and 2011 are reflected in this Report. Further recommendations will be reflected in future Reports.

Review of National Agreements and National Partnership Agreements

COAG has agreed to progress the recommendations of the Heads of Treasuries (HoTs) Review of National Agreements, National Partnerships and Implementation Plans and reports of the COAG Reform Council (CRC). A working group, led by Senior Officials from First Ministers' and Treasury agencies, will review the performance frameworks of a limited number of agreements, including the NDA. (COAG 2011). The recommendations of the review of the NDA will be considered by the Steering Committee and may be reflected in future reports.

National Disability Strategy

The National Disability Strategy 2010-2020 was formally endorsed by COAG on 13 February 2011 and launched by the Australian Government on 18 March 2011. This represents the first time in Australia's history that all governments have committed to a unified, national approach to improving the lives of people with disability, their families and carers.

The Strategy will guide public policy across governments and aims to bring about changes to all mainstream services and programs, as well as community infrastructure, to ensure they are accessible and responsive to the needs of people with disability.

The Strategy will also be an important mechanism to ensure that the principles underpinning the United Nations Convention on the Rights of Persons with Disabilities are incorporated into policies, services and programs affecting people with disability, their families and carers.

The Strategy will be implemented in collaboration with people with disability, their families and carers, and other key stakeholders, and will be reviewed and amended as necessary to ensure it continues to drive better outcomes for people with disability.

A first year report on the Strategy will be presented to COAG in February 2012. Every two years, a high level progress report will track achievements under the Strategy and provide a picture of how people with disability are faring. The first biennial progress report will be presented to COAG in February 2014.

14.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter.

Australian Government comments

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- During 2010-11 the Australian Government funded supported employment for over 22 500 people with disability in 321 Australian Disability Enterprise (ADE) outlets across Australia.
- In July 2010, the Australian Government released a discussion paper, Inclusion for People with Disability through Sustainable Supported Employment. Public consultations were held and an Advisory Group was appointed to provide strategic advice to the Australian Government in the development of a Vision. Submission of their final report to the Parliamentary Secretary for Disabilities and Carers, Senator the Hon. Jan McLucas took place in September 2011.
- The Australian Government has been working with state and territory jurisdictions to test retirement planning options for ageing workers in ADEs.
- A draft report on the review of costs the Australian Government pays to services providers to deliver supported employment has been received by Government and is currently being considered.
- The Australian Government implemented a red tape reduction trial for ADEs. A pause on Disability Maintenance Instrument reassessments, which determine funding levels for a worker with disability for a two year period, is underway.
- The Disability Employment Services (DES) – Employment Support Service (ESS) program was in operation during the entire 2010-11 year. ESS assists job seekers with permanent disability and an assessed need for long-term, regular support in the workplace. Job seekers receive tailored services that are flexible and responsive to both their needs and those of employers.
- As at 30 June 2011 there were 211 organisations delivering ESS from 1095 sites and for the 2010-11 financial year there were 115 379 participants serviced in the program.
- The proportion of ESS job seekers who achieved a sustainable employment outcome (at their assessed benchmark hours of 8, 15 or 30 hours of work per week for 26 weeks) was 16.7 per cent as at 30 June 2011. This outcome rate is expected to improve, as the program matures.
- It should be noted that comparisons to Disability Employment Network (DEN was the previous program) outcome rates should be done with care. The requirements regarding the payment of outcome fees have been tightened under DES to reward genuine sustainable employment at the participants work capacity with assistance.

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New South Wales Government comments

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In 2010-11, NSW continued the implementation of Stronger Together, the NSW Government's 10 year plan to make the specialist disability service system more responsive to the needs of people with a disability, their families and carers.

The NSW Government increased funding for disability services by \$1.5 billion over the five years to 2010-11 under Stronger Together. An estimated 20 000 additional people with disability and their families throughout NSW have been supported through the creation of 33 000 specialist service places, exceeding the initial target by around 15 000 places.

The NSW Government has committed a further \$2.0 billion in growth funding for disability services over the next five years to 2015-16 under Stronger Together. This will provide an additional 47 200 places. By 2013-14, anyone receiving services will have the option of using an individualised and portable funding arrangement. Key reforms will be implemented to shape the disability service system into a truly person-centred system that takes account of people's life stages and their circumstances. Extensive consultation will ensure that the voices of people with a disability, their families and carers are the ones that shape the new system.

In 2010-11, disability funding in NSW increased by 7.9 per cent over the previous year, reaching \$1.8 billion. More than 26 000 therapy and fixed term intervention services were delivered and approximately 10 300 children accessed early childhood intervention. Over 6800 individuals enrolled in post school programs and 8 000 people participated in community engagement programs. An estimated 7 800 people received community living support from government provided and funded organisations.

NSW also made significant investment in 2011 in the capacity of staff and funded service providers to deliver person centred support with an extensive consultation process. About 370 places were allocated to four individualised support models which were piloted and evaluated through a participatory action research project. These pilot projects tested new models of support across a range of target groups and generated evidence of the requirements, impact, and outcomes of individualised support.

The NSW Government is working in partnership with community care and service providers to ensure the service system is integrated, sustainable and has the capacity to deliver improved flexible services which respond to a broader range of individual choices. A Sector Planning Framework had been developed to shift sector planning from a focus on resource allocation to a community partnership approach. This will devolve decision making to local communities and place people with a disability at the centre of the planning process.

During 2010-11, a Memorandum of Understanding was signed between Ageing, Disability and Home Care NSW and NSW Health for the provision of services to people with an intellectual disability and mental illness, representing a significant milestone in interagency collaboration.

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Victorian Government comments

“ In 2010-11, Victoria has continued to extend its disability reform and increase the availability of disability support services. Notable achievements in 2010-11 included:

- The completion of the transition to a new statewide service provider for the Aids and Equipment Program. People with a disability can apply for aids and equipment through a single point of access supported by a website and information resources.
- Delivery of 114 new accommodation beds, including 35 places for younger people with disability who are living in or at risk of entering residential aged care (the my future my choice initiative) and a further 57 places for people with disability who have ageing carers.
- The Office of the Senior Practitioner undertook a comprehensive consultation process with a diverse range of stakeholders including people with disability, their families and service providers. As a result the Senior Practitioner made their first direction under the Victorian Disability Act 2006 to protect the rights of people with disability who are subject to restrictive interventions and compulsory treatment and to ensure compliance with appropriate standards designed to prevent actions that could result in harm or ill-health.
- Improving the Disability Support register to improve the experience of people registering for supports. Improvements included a new application form and help guide, revised guidelines and practices, enhanced recording systems, information sheets and revised web information.
- Continued the transition to self-directed approaches, giving people with a disability, their families and carers more choice and controls over their supports. The expansion of Individual Support Packages has been a key mechanism to enable more flexible and responsive disability supports.
- The statewide financial intermediary service was launched in July 2010 and has now been operable for a full year. Just under 2000 people are being supported to manage their Individual Support Package funding.
- The number of people on direct payments continued with over 300 using this funding administration arrangement by June 2011. A trial of people directly employing their support workers was also conducted with the evaluation showing promising outcomes for respondents.

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Queensland Government comments

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The Queensland Government is continuing to coordinate disability policy across government, providing and leading services to support people with a disability, and their families and carers, and promoting their participation in society.

In 2010-11, Queensland provided information and support to people with a disability with the launch of Disability Online offering disability-related information from Australian, state and local governments through a single online entry point. During the Queensland flood crisis the website was a key communication tool providing information for people with a disability on what preparations should be taken, including links to other relevant websites.

To help deliver better outcomes for people with a disability, their families and carers in Queensland, consultations were held across the state on the draft 10-year plan for supporting Queenslanders. The plan details how all levels of government, business and community can work together to make the vision a reality by 2021.

Amendments to legislation in 2010-11 saw Queensland become the first state in Australia to legislatively recognise grandparents providing full-time care for grandchildren to ensure they grow up in safe, supportive and caring environments.

Following feedback from disability service providers about the complexity and costs involved in complying with the restrictive practices regime, the Department of Communities undertook to conduct the review of the *Disability Services Act 2006* (DSA) in two stages. Stage 1, which commenced in late 2010, is analysing ways to simplify processes and reduce unnecessary legislative burden in relation to the legislative provisions around restrictive practices, whilst maintaining safeguards for clients. Stage 2, which is proposed to commence in 2012, will review all remaining provisions within the DSA.

Additionally, the *Forensic Disability Act 2011* was enacted on 19 May 2011 and will come into effect on 1 July 2011. The establishment of the Act will regulate the completed Forensic Disability Service to provide secure accommodation for people who are subject to a forensic order, have an intellectual or cognitive disability and do not require specialist in-patient care.

Growing Stronger reforms have continued to be implemented to Queensland's specialist disability service system in 2010-11. With the release of Phase 1 of the reforms in all 18 Disability and Community Care Service Centres across the department's seven regions, clients only need to provide their information once via a single application form which is a significant reduction from the 27 pages of documentation required previously.

Early intervention strategies have continued to be a key priority for Queensland to assist young people with a disability. The Children with a Physical Disability Initiative, the Early Intervention for Children with Autism Initiative, Child Connect Initiative, respite services, and intensive family support are key examples how Queensland is assisting children with a disability, their families and carers.

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Western Australian Government comments

“ The WA Government’s ongoing commitment towards providing support to individuals and families with disabilities was acknowledged when the Commission was presented with a Premier’s Award for the Local Area Coordination Program in the category of strengthening families and communities. This innovative and people-focused program is helping individuals, families and local communities to work together and support good lives for everyone.

The allocation of substantial additional growth funding (\$80.8 million over four years) continues to reflect the WA Government’s commitment to disability services.

Key initiatives for 2009-2010 include:

- Implementation of a long-term disability strategy Count Me In: Disability Future Directions, which has underpinned the development of the Commission’s 2011-2016 strategic plan
- Implementation of the new Community Living initiative, an innovative approach to create low cost options tailored to the individual needs and aspirations of people with disability, to enable them to live good lives in their local community
- Providing alternative accommodation and support for 42 younger people with disability deemed at risk of entering residential care by the end of 2010-2011, through the Young People in Residential Aged Care program
- The first of five new respite centres to be built across the state opened in Broome
- \$1.32 million allocated through the Equipment for Living grants to fund specialist equipment outside the state Community Aids and Equipment Program
- Consolidation of the Commission’s metropolitan and regional service teams into one directorate to ensure seamless provision of services to all Western Australians with disability, their families and carers
- Implementation of a Quality Management Framework that uses individual focussed outcomes and performance indicators to ensure services achieve positive outcomes for people with disability, their families and carers
- Agreement and support for the Australian Disability Parking Scheme including a national permit design and minimum standards for eligibility time concessions
- The awarding of \$250 000 in grants to 16 local governments to implement the You’re Welcome Access initiative.

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South Australian Government comments

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During 2010 to 2011 a state-wide community services support system was established to provide a single access point to services for people with disability, older people and their carers. This new Division, known as Community and Home Support SA, encompasses the former Disability SA; promotes and develops opportunities for people with disability to actively engage in the community; and delivers services, both directly and through partnership with non-government organisations. A strong focus on choice, enhanced options and community inclusion for people with disability has been part of the South Australian Government's commitment for 2010 to 2011.

Highlights for 2010-11 include:

- Commencement of Self-managed Funding to improve service choices and active participation in the community for people with disability
- The release of the Social Inclusion Board's discussion paper entitled *Activating Citizenship, A social Inclusion Approach to Disability in South Australia*
- A two-part review of the South Australian Disability Services Act 1993. Part one presented a case for new legislation and part two identified the structure and functions of the new legislation
- Expanding the range of accommodation models available to ensure people with disability are appropriately housed and supported in the community. This has included the development of a co-tenant model aimed at building in natural supports and the use of technology in housing to meet high support needs
- Completion of Stage One of the Strathmont Centre Redevelopment and Community Living Project, which moved 144 residents into community living over five years
- Improvements in the way individual packages of community support are funded and allocated that will ensure fairness, transparency and best use of resources
- The development of a report by the Minister's Disability Advisory Council, 'inclusion & protection – a dynamic safeguarding scheme for South Australians with disability who are also vulnerable to neglect and abuse'
- Increased funding to expand supports for children with Autism Spectrum Disorder. This includes an expansion of diagnostic services, with a focus on servicing country areas, and the establishment of a 'State-wide Autism Project' to develop a framework to improve services
- A review of the Promoting Independence Strategy, which has been driving improvements in access and inclusion for people with disability across state government portfolios for the last 10 years.

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Tasmanian Government comments

“ In 2010-2011 Tasmania continued to implement recommendations from the Operational Framework for Disability Services (2009) which provides the strategic direction for disability services into the future. Ongoing reforms across the disability sector are significantly changing the delivery of services to Tasmanian people with disability, their families and carers.

There is now an increase in the flexibility and range of services available, services are available to more people and there is a greater focus on person and family focussed service delivery.

The Tasmania government no longer delivers any specialist disability support services as all services have now been outsourced to the community sector. This was completed in March 2011.

Adult centre based respite services were transitioned to Community Sector providers in the south, north and north west of the state together with additional respite options for children and young people which include non-centre based respite options such as recreational and holiday programs.

New community access service programs have been developed following a project to identify innovative service delivery for community access. Alternatives to Work which places an emphasis on skill acquisition, recreational opportunities and promotes social networking and Preparation for Retirement which provides recreational opportunities focusing on skills maintenance and social networking for older people with disability.

The Resource Allocation and Unit Pricing Framework project which has developed a framework to promote equity between the regions and define payments to service providers for the delivery of services was finalised and implementation of the transition to a unit price has begun.

The Disability Services Bill 2011 was passed by Parliament and will be proclaimed on 1 January 2012

Work began on the implementation of a new state-wide program TasEquip to be implemented by 2013 following the completion of the review of the provision of equipment and assistive technology in Tasmania.

There has been a continuing focus on Community Partnership Teams established in each regional area to build and strengthen partnerships between Disability and Community Services and the community sector.

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Australian Capital Territory Government comments

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In 2010-2011, the Community Services Directorate's Disability ACT division continued to work collaboratively across government to implement policy priorities under the Future Directions: Towards Challenge 2014 to improve outcomes and opportunities for Canberrans with disability. In particular, disability services were strategically advanced in the ACT through the following activities:

- Disability ACT continued to align and deliver services under the National Disability Agreement with a focus on the following funding priorities: young people transitioning from school; respite services for mature carers; people without existing formal support; people moving inter-state; and people in emergency need
- Disability ACT broadened its engagement with people with disability and their families, introducing a case coordination service for Aboriginal and Torres Strait families who were identified by the community as potentially benefiting from support related to the disability of one or more family members
- Another initiative was the co-location government and community services providing a range of information, planning, and community development services. The co-location is intended to build capacity and extend the reach of these services across the ACT
- Disability ACT commissioned a scoping study to inform our understanding of after-school care and holiday program needs for children and young people with complex behaviours. New afterschool and vacation care programs will commence in 2012
- Continued planning and support for young people with high and complex needs related to their disability to achieve their vocational, social and recreational goal has been made available when they leave school and move into their adult lives. In particular, Disability ACT worked with new social enterprises to provide genuine ways for people with disability to contribute to the economic life of the ACT community
- With a focus on developing leadership and participation, Disability ACT funded community organisations to build capacity among people with disability to be self-advocates
- Disability ACT has been responsive to the unique accommodation needs of people with disability. In 2011, Disability ACT employed a Housing Options Facilitator and supported eight families to plan for their future housing, tenancy and support needs. A particular focus was to provide individualised planning for people with disability with mature carers

The mobile on-call attendant care service feasibility study was undertaken to provide advice on how best to provide overnight flexible support to people who live in the community and have limited in home support.

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Northern Territory Government comments

“ The Northern Territory Government’s vision is for a society where people with disabilities have productive and fulfilling lives as valued members of their communities. Disability support provision is based on contemporary practice underpinned by partnerships and collaborative approaches. The Territory Government also aims to continue to improve access to support for Territorians with a disability, and ensure the Territory is a community where carers also enjoy good health, wellbeing, resilience and financial security.

Initiatives undertaken towards these aims during 2010-11 include:

- Implementation of a pilot Remote Intensive Therapy Program, to provide specialised and intensive allied health treatment and support for children and young adults with a significant disability living in a remote location, designed to maximise function, participation and quality of life.
- Progress of the review of the Territory Independence and Mobility Equipment Scheme with a Clinical Reference Group to oversee the implementation of review recommendations. This has included new arrangements to ensure clients are being prescribed the most appropriate equipment by the most appropriate allied health professional, and work towards the finalisation of equipment that will be included under the new scheme. These developments will help people with a disability in addressing their independence and mobility needs.
- The number of disability supported accommodation places in the Territory increased by nine to 164, providing care and support to people with a disability with high support needs.
- Work towards an update of the Northern Territory Adult Guardianship Act is supporting progression towards a new system; ensuring families can make decisions regarding everyday matters on someone’s behalf without long and complex legal processes, providing advice and support services for community guardians, and systemic advocacy and community education in terms of decision-making and guardianship.
- Ongoing work in Darwin and Alice Springs on the development of secure care facilities, to provide a community-based therapeutic model of care and support within a safe environment, for those clients with more complex needs who find community living difficult to manage.

Most services for people with a disability in remote areas are provided under the jointly Northern Territory and Australian Government funded Home and Community Care (HACC) Program.

As in previous years, indicators based on the estimated number of people with severe, profound and/or core activity limitations in the Northern Territory need to be interpreted with caution. Small variations in service and population data appears in magnified proportions to the small population in the Territory.

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14.6 Service user data quality and other issues

Data quality

Data quality considerations should be taken into account when interpreting the DS NMDS service user data used in this chapter. In particular, data quality should be considered when making comparisons across jurisdictions and across years.

There are three aspects of quality that affect the accuracy and reliability of the data reported in this chapter:

- service type outlet response rates
- service user response rates
- ‘not stated’ rates for individual data items.

The first two of these affect the service user counts — nationally, by jurisdiction and service type — and all three affect the accuracy of analyses of individual data items (AIHW 2011a).

‘Not stated’ rates for individual data items vary between jurisdictions (AIHW 2011a). One reason for the higher level of ‘not stated’ responses to some data items may be the increased efforts to improve the coverage and completeness of the DS NMDS collection overall. For example, therapy services (a community support service) in the ACT participated for the first time in the 2004-05 collection. In an effort to include all users of these services, provisional data collection processes were used that meant minimal data were provided for each user (AIHW 2011a).

Other issues

Service user data/data items not collected

Service user data are not collected for the following NDA specialist disability service types: advocacy, information/referral, combined information/advocacy, mutual support/self-help groups, print disability/alternative formats of communication, research and evaluation, training and development, peak bodies and other support services. In addition, some service types are not required to collect all service user data items. In particular:

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- ‘recreation/holiday programs’ (service type 3.02) are required to collect only information related to the statistical linkage key (selected letters of name, date of birth, sex, commencement date and date of last service)
 - employment services (service types 5.01 and 5.02) are not required to collect selected informal carer information, including primary status (AIHW 2007).

Specialist psychiatric disability services

Data for specialist psychiatric disability services are excluded to improve the comparability of data across jurisdictions. People with psychiatric disability may use a range of NDA specialist disability service types. In some jurisdictions (Victoria, Queensland and WA), specialist psychiatric disability services are funded specifically to provide such support (AIHW 2011a). Nationally, in 2009-10, 12 731 people used only specialist psychiatric disability services (AIHW unpublished). Data for these services are included in other publications on the DS NMDS, such as AIHW (2011a). Therefore, service user data for Victoria, Queensland and WA in this chapter will differ to other publications.

Statistical linkage key

A statistical linkage key is used to derive the service user counts in this chapter. The statistical linkage key enables the number of service users to be estimated from data collected from different service outlets and agencies (AIHW 2011a). Using the linkage key minimises double counting of service users who use more than one service outlet during the reporting period.

The statistical linkage key components of each service record are compared with the statistical linkage key components of all other records. Records that have matching statistical linkage keys are assumed to belong to the same service user.

As the statistical linkage key is not a unique identifier, some degree of false linking is expected. A small probability exists that some of the linked records do not actually belong to the same service user and, conversely, that some records that did not link do belong to the same service user. The statistical linkage key does not enable the linking of records to the extent needed to be certain that a ‘service user’ is one individual person.

Missing or invalid statistical linkage keys cannot be linked to other records and so must be treated as belonging to separate service users. This may result in the number of service users being overestimated (AIHW 2011a).

Deriving potential populations for the special needs groups

Potential populations have been estimated for each of the special needs groups (outer regional and remote/very remote areas, Indigenous and people born in a non-English speaking country) and for those outside of the special needs groups (major cities and inner regional areas, non-Indigenous and people born in an English speaking country). These potential populations are estimates of the number of people with the potential to require disability support services in the relevant group, including individuals who meet the service eligibility criteria but who do not demand the services.

The approach used to derive the potential population estimates by country of birth and geographic location involved the following steps:

- Deriving State/Territory based 10-year age and sex specific proportions of people with ASSNP by geographic location and country of birth using the 2006 Census
- Multiplying these State/Territory based 10-year age and sex specific proportions by the 10-year age specific estimates of the number of people with severe/profound core activity limitations in each State/Territory
- Summing the resultant 10-year age and sex group counts to derive the total potential populations for the geographic locations, people born in Australia, people born in another English speaking country and people born in a non-English speaking country. Summing the potential populations for people born in Australia and people born in another English speaking country to derive the total potential population for people born in an English speaking country
- For employment, repeating the above steps, but restricting the calculations to those people aged 15–64 years, then multiplying each State/Territory total by State/Territory specific labour force participation rates for people aged 15–64 years.

The approach used to derive the potential populations by Indigenous status involved the following steps:

- Deriving current State/Territory based 10-year age and sex specific rate ratios of people with ASSNP by Indigenous status using the 2006 Census
- Multiplying the current State/Territory Indigenous and non-Indigenous 10-year age and sex population estimates by national 10-year age and sex specific rates of severe/profound core activity limitation from the 2009 SDAC. Then multiplying the Indigenous and non-Indigenous counts for each 10-year age and sex group by the 10-year age and sex specific rate ratios of people with ASSNP

to obtain an Indigenous/non-Indigenous potential population within each age and sex group

- Summing the 10-year age and sex group counts to derive a total Indigenous and non-Indigenous potential population for each State/Territory
- For employment, repeating the above steps, but restricting the calculations to those people aged 15–64 years, then multiplying each State/Territory total by State/Territory specific labour force participation rates for people aged 15–64 years.

Data quality issues

Data measuring the potential populations of the special needs groups are not explicitly available for the required time periods and have been estimated using several different data sources (as noted above), under several key assumptions. Some issues with this approach are outlined below:

- The method used to estimate the potential populations assumes:
 - that disability rates vary only by age and sex, and there is no effect of remoteness, disadvantage, or any other variable — this is likely to affect the reliability of comparisons across states and territories, however, it is currently not possible to detect the size or direction of any potential bias
 - that age- and sex- specific disability rates do not change significantly over time.
- The rate ratio/proportion adjustments (that is, multiplication) assumes consistency between the rate ratio/proportion as calculated from the 2006 Census and the corresponding information if it were collected from the 2009 SDAC. Two particular points to note with this assumption are that:
 - information about people with ASSNP is based on the self-enumeration (interview in Indigenous communities) of four questions under the 2006 Census, whereas in SDAC 2009 people are defined as having a severe/profound core activity limitation on the basis of a comprehensive interviewer administered module of questions — the two populations are different, but are conceptually related
 - the special needs groups identification may not be the same between the 2006 Census and the 2009 SDAC (ABS research indicates, for example, that the Indigenous identification rate differs across the Census and interviewer administered surveys)
- It is not known if the data collection instruments are culturally appropriate for all special needs groups; nor is it known how this, combined with different data

collection methods, impacts on the accuracy of the estimated potential population

- There are a number of potential sources of error related to the Census that stem from failure to return a Census form or failure to answer every applicable question. Information calculated from 2006 Census data exclude people for whom data item information is not available. As with any collection, should the characteristics of interest (for example, ASSNP and/or special needs group status) of the people excluded differ from those people included, a potential for bias is introduced. In particular, for Indigenous estimates, differential undercount of Indigenous Australians across states and territories may introduce bias into the results that would affect the comparability of estimates across jurisdictions, if those missed by the Census had a different rate of disability status to those included.

14.7 Definitions of key terms and indicators

Accommodation support service users receiving community accommodation and care services

People using the following NDA accommodation support services: group homes; attendant care/personal care; in-home accommodation support; alternative family placement and other accommodation support (types 1.04–1.08), as a proportion of all people using NDA accommodation support services (excludes service users of specialist psychiatric disability services only). See AIHW (2009) 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 disability (including expenditure on both programs and administration, direct expenditure and grants to government service providers, and government grants to non-government service providers (except major capital grants)).

Core activities as per the 2009 ABS SDAC

Self care — showering or bathing, dressing, eating, toileting and bladder or bowel control; mobility — getting into or out of a bed or chair, moving about the usual place of residence, going to or getting around a place away from the usual residence, walking 200 metres, walking up and down stairs without a handrail, bending and picking up an object from the floor, using public transport (the first three tasks contribute to the definitions of profound and severe core-activity limitation); and communication — understanding and being understood by strangers, family and friends.

Cost per user of government provided accommodation support services — group homes

The numerator — government expenditure (accrual) on government provided accommodation support services in group homes (as defined by DS 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 DS 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 (2009) 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 DS 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

The United Nation's *Convention on the Rights of Persons with Disabilities*, ratified by Australia on 17 July 2008, defines 'persons with disabilities' as those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The WHO defines 'disabilities' as impairments, activity limitations, and participation restrictions: an impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; and a participation restriction is a problem experienced by an individual in involvement in life situations. Disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives (WHO 2009).

The ABS SDAC 2009 defined 'disability' as the presence of at least one of 17 limitations, restrictions or impairments, which have lasted or are likely to last for a period of 6 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.

The third CSTDA (2003, p. 9) defined 'people with disabilities' as those whose disability manifests itself before the age of 65 years and for which they require significant ongoing and/or long-term episodic support. For these people, the disability will be attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is likely to be permanent and results in substantially reduced capacity in at least one of the following: self care/management, mobility and communication.

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 NDA service types (service type outlets). Funded agencies are usually legal entities. They are generally responsible for providing DS 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 DS NMDS service types 5.01 (open) and 5.02 (supported)) — divided by the denominator — number of service users who received assistance. (For data prior to 2005-06, service type 5.03 (combined open and supported) is also included.) See AIHW (2009) 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 DS 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 DS 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 DS NMDS service types 1.05–1.08) — divided by the denominator — the number of users of non-government provided accommodation support services in other community settings.
Indigenous factor	The potential populations were estimated by applying the 2009 national age- and sex- specific rates of profound or severe core activity limitation to the age and sex structure of each jurisdiction in the current year. As Indigenous people have significantly higher disability prevalence rates and greater representation in some NDA specialist disability services than non-Indigenous people, and there are differences in the share of different jurisdictions' populations who are Indigenous, a further Indigenous factor adjustment was undertaken. The Indigenous factor was multiplied by the 'expected current population estimate' of people with a profound or severe core activity limitation in each jurisdiction to derive the 'potential population'. The following steps were undertaken to estimate the Indigenous factors: • Data for all people (weighted) were calculated by multiplying the

	data for Indigenous Australians by 2.4 and adding the data for non-Indigenous Australians. Hence Indigenous Australians are weighted at 2.4 and non-Indigenous Australians at one • Data for all people (weighted per person) were calculated by dividing the all people (weighted) data by the sum of the Indigenous Australians data and the non-Indigenous Australians data • The Indigenous factors were then calculated by multiplying the all people (weighted per person) data by 100 and dividing by the all people (weighted per person) total for Australia (AIHW 2011a).
Informal carer	<i>ABS informal carer:</i> A person of any age who provides any informal assistance, in terms of help or supervision, to persons with disabilities or long-term conditions, or older persons (that is, aged 60 years and over). This assistance has to be ongoing, or likely to be ongoing, for at least 6 months. Assistance to a person in a different household relates to 'everyday types of activities', without specific information on the activities. Where the care recipient lives in the same household, the assistance is for one or more of the following activities: cognition or emotion, communication, health care, housework, meal preparation, mobility, paperwork, property maintenance, self care and transport (ABS 2011a). <i>DS NMDS informal carer:</i> an informal carer is someone such as a family member, friend or neighbour, who has been identified as providing regular and sustained care and assistance to the person. Each service user can only record one informal carer (it is expected that the carer recorded will be the one who provides the most significant care and assistance related to the service user's capacity to remain living in their current environment). Informal carers include those people who receive a pension or benefit for their caring role but do not include paid or volunteer carers organised by formal services. See also primary carer.
Labour force participation rate for people with a profound or severe core activity limitation	The total number of people with a profound or severe core activity limitation in the labour force (where the labour force includes employed and unemployed people), divided by the total number of people with a profound or severe core activity limitation who are aged 15–64 years, multiplied by 100. An employed person is a person who, in his or her main job during the remuneration period (reference week): • worked one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (including employees, employers and self-employed persons) • worked one hour or more without pay in a family business, or on a farm (excluding persons undertaking other unpaid voluntary work), or • was an employer, employee or self-employed person or unpaid family helper who had a job, business or farm, but was not at work. An unemployed person is a person aged 15–64 years who was not employed during the remuneration period, but was looking for work.
Labour force participation rate for the total population	Total number of people aged 15–64 years in the labour force (where the labour force includes both employed and unemployed people) divided by the total number of people aged 15–64 years, multiplied by 100.
Mild core activity limitation	Not needing assistance with, and has no difficulty performing, core activity tasks, but uses aids and equipment (as per the 2009 SDAC).

Moderate core activity limitation	Not needing assistance but having difficulty performing a core activity task (as per the 2009 SDAC).
Non-English speaking country of birth	People with a country of birth other than Australia and classified in English proficiency groups 2, 3 or 4 (DIMA 1999, 2003). For 2003-04 and 2004-05 data these countries include countries other than New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States. For 2005-06 onwards, data include Zimbabwe as an 'English-speaking country'.
Payroll tax	A tax levied on employers based on the value of wages and certain supplements paid or payable to, or on behalf of, their employees (SCRCSSP 1999). Payroll tax arrangements for government funded and delivered services differ across jurisdictions. Differences in the treatment of payroll tax can affect the comparability of unit costs across jurisdictions and services. These differences include payroll tax exemptions, marginal tax rates, tax-free thresholds and clawback arrangements (see SCRCSSP 1999). There are two forms of payroll tax reported: • <i>actual</i> — payroll tax actually paid by non-exempt services • <i>imputed</i> — a hypothetical payroll tax amount estimated for exempt services. A jurisdiction's estimate is based on the cost of salaries and salary related expenses, the payroll tax threshold and the tax rate.
Potential population (unrevised method)	Potential population estimates are used as the denominators for the performance measures reported under the indicator 'access to NDA specialist disability services'. The 'potential population' is the number of people with the potential to require disability support services, including individuals who meet the service eligibility criteria but who do not demand the services. In practice, the number of people with profound or severe core activity limitation is used as the basis to measure the potential population (see definition of core activities above). The potential population for NDA accommodation support, community access and community support services is measured by the number of people aged under 65 years who have a profound or severe core activity limitation, adjusted for the Indigenous factor. The potential population for NDA employment services is measured by the number of people aged 15–64 years with a profound or severe core activity limitation, adjusted for the Indigenous factor and the labour force participation rate. The ABS concept of a 'profound or severe' core activity limitation that relates to the need for assistance with everyday activities of self care, mobility and communication currently underpins the measurement of the population in need of specialist disability services. The relatively high standard errors in the prevalence rates for smaller jurisdictions, as well as the need to adjust for the Indigenous population necessitated the preparation of special estimates of the 'potential population' for specialist disability services. Briefly, the potential population was estimated by applying the 2009 national age- and sex- specific rates of profound or severe core activity limitation to the age and sex structure of each jurisdiction in the current year, to give an 'expected current estimate' of people with a profound or severe core activity limitation in that jurisdiction. These

estimates were adjusted by the Indigenous factor to account for differences in the proportion of jurisdictions' populations who are Indigenous. Indigenous people have been given a weighting of 2.4 in these estimates, in recognition of their greater prevalence rates of disability and their relatively greater representation in NDA specialist disability services (AIHW 2006).

The potential populations for 2004-05 to 2008-09 were calculated using national age- and sex-specific rates of severe or profound core activity limitation from the ABS Survey of Disability, Ageing and Carers (SDAC) conducted in 2003. In 2011, the 2009 SDAC was released, resulting in a break in series between the 2003 and 2009 surveys. For comparison purposes, the potential population for 2008-09 has also been recalculated using 2009 SDAC.

Potential Population (revised method)

Potential population estimates are used as the denominators for the performance measures reported to COAG under the NDA.

The 'potential population' is the number of people aged under 65 with the potential to require disability support services, including individuals who meet the service eligibility criteria but who do not demand the services. In practice, the number of people with profound or severe core activity limitation is used as the basis to measure the potential population (see definition of core activities above).

The potential population for State/Territory delivered disability support services is measured by the number of people aged under 65 years who have a profound or severe core activity limitation. Briefly, the 2009 national age- and sex- specific rates of profound or severe core activity limitation are applied 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. No Indigenous weight or scaling factor is used. The potential population for NDA employment services is measured by the number of people aged 15-64 years with a profound or severe core activity limitation, and is calculated using the same method. No Indigenous weight or scaling factor is used. There is no adjustment for labour force participation.

The method used to calculate the Indigenous potential population is to apply adjusted national age- and sex- specific rates of profound or severe core activity limitation to the age and sex structure of the Indigenous population of each jurisdiction in the current year. The national age- and sex- specific rates of profound or severe core activity limitation are adjusted by the rate ratio of the Indigenous rate need for assistance to the all persons rate of need for assistance with core activities, as calculated from the Census. Estimates of potential population by country of birth and Remoteness Area are calculated by applying Census distributions of country of birth and Remoteness Area for people who need assistance with core activities to the age and sex structure of the jurisdictional potential population.

The potential populations for 2004-05 to 2008-09 were calculated using national age- and sex-specific rates of severe or profound core activity limitation from the ABS Survey of Disability, Ageing and Carers (SDAC) conducted in 2003. In 2011, the 2009 SDAC was released, resulting in a break in series between the 2003 and 2009 surveys. For comparison purposes, the potential population for 2008-09 has also been recalculated using 2009 SDAC.

Primary carer

ABS SDAC 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 6 months and be provided for one or more of the core activities (communication, mobility and self care). In the SDAC, primary carers only include persons aged 15 years and over for whom a personal interview was conducted. Persons aged 15 to 17 years were only interviewed personally if parental permission was granted (ABS 2011a).

DS NMDS primary carer: an informal carer who assists the person requiring support, in one or more of the following ADL: self care, mobility or communication.

See also informal carer.

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 2009 SDAC).
Real expenditure	Actual expenditure (accrual) adjusted for changes in prices, using the Gross Domestic P(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 NDA. 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 NDA.
Service type	The support activity that the service type outlet has been funded to provide under the NDA. The DS 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 NDA 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 disability who receives a NDA specialist disability 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 need for assistance with ADL	Data on service users with different levels of need for assistance with ADL are derived using information on the level of support needed in one or more of the core support areas: self care, mobility, and communication. Service users who need help with ADL reported always/sometimes needing help in one or more of these areas (people who need help with ADL are ‘conceptually comparable’ with people who have a profound or severe core activity limitation). Service users who did not need with ADL reported needing no support in all the core activity support areas.
Severe core activity limitation	Sometimes needing assistance to perform a core activity task (as per the SDAC 2009).
Users of NDA accommodation support services	People using one or more accommodation support services that correspond to the following DS 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 NDA community access services	People using one or more services that correspond to the following DS NMDS service types: 3.01 learning and life skills development; 3.02 recreation/holiday programs; and 3.03 other community access. See AIHW (2009) for more information on service types 3.01–3.03.
Users of NDA community support services	People using one or more services that correspond to the following DS 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 (2009) for more information on service types 2.01–2.07.
Users of NDA employment services	People using one or more services that correspond to the following DS NMDS service types: 5.01 open employment and 5.02 supported employment. (For data prior to 2005-06, people using service type 5.03 [combined open and supported] are also included.)
Users of NDA respite services	People using one or more services that correspond to the following DS NMDS service types: 4.01 own home respite; 4.02 centre-based respite/respite homes; 4.03 host family respite/peer support respite; 4.04 flexible/combo respite; and 4.05 other respite. See AIHW (2009) for more information on service types 4.01–4.05.

14.8 List of attachment tables

Attachment tables are identified in references throughout this chapter by a '14A' prefix (for example, table 14.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

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15 Protection and support services

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Attachment tables

Attachment tables are identified in references throughout this chapter by a '15A' prefix (for example, table 15A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

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* — 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
- *intensive family support services* — specialist services that aim to prevent the imminent separation of children from their primary caregivers as a result of child protection concerns and to reunify families where separation has already occurred (performance data for intensive family support services are not yet available, therefore, reporting for intensive family support services is limited to expenditure data and information on the numbers of children commencing intensive family support services)
- *juvenile justice services* — services to promote community safety and reduce youth offending by assisting young people to address their offending behaviour.

Improvements to the reporting of protection and support services this year include:

- all jurisdictions reporting proportions of expenditure across child protection Pathway activity groups, compared with seven previously
- seven jurisdictions reporting experimental unit cost data for selected Pathways activity groups, compared with five previously
- with the exception of data from WA and the NT, all juvenile justice profile data were sourced from the Juvenile Justice National Minimum Data Set (JJ NMDS) in which daily averages are derived on the basis of data from each day of the year (in previous reports, daily averages were derived on the basis of the average of four end of quarter counts) (AIHW 2011). Daily average numbers equivalent to the JJ NMDS were sourced directly from WA and the NT, which do not currently participate in the JJ NMDS. There has been some impact on the length of time series reported for juvenile justice profile data, however, at least two years of trend data are reported using the new data source and calculation method for all juvenile justice profile data and for all jurisdictions
- some data quality information (DQI) documentation.

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 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 and young people, including investigation and assessment where appropriate
- providing support services (directly or through referral) 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 care when it is determined that a child is unable to be returned to the care of his or her parents, and working with young people to identify alternative supported living arrangements where family reunification is not possible.

Research suggests that children and families who come into contact with the protection and support services system often share common social and demographic characteristics. Families with low incomes or that are reliant on pensions and benefits, those that experience alcohol and substance abuse, or a psychiatric disability, and those that have a family history of domestic violence are over-represented in the families that come into contact with the protection and support services system (Department of Human Services 2002; The Allen Consulting Group 2008).

Child protection concerns and Indigenous communities

Studies have highlighted the high incidence of child abuse and neglect within some Indigenous communities, compared with non-Indigenous communities. Indigenous families across Australia have been found to experience high levels of violence, compared with non-Indigenous families (AIHW 2006). The final report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse (2007), identified child sexual abuse as a significant issue for many of the remote NT Aboriginal communities consulted as part of the Inquiry. The final report of the WA Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities (Gordon Report 2002), also found high levels of violence and child abuse within Aboriginal communities in WA.

The Report of the Board of Inquiry into the Child Protection System in the NT *Growing them strong, together* also observed the presence of multiple risk factors in Aboriginal communities, including lack of adequate housing, financial security and education. However, Aboriginal communities also possessed protective factors which can safeguard children and families from psychological distress, such as spirituality and connection to land, family and culture (Bamblett, Bath and Roseby 2010).

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/or the inability of parents to provide adequate care. Placements may be voluntary or made in conjunction with care and protection orders.

Out-of-home care services comprise home-based care (for example, foster care, care with a 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

Intensive family support services are increasingly perceived as an alternative to the removal of a child from his or her home for child protection reasons (box 15.1).

Box 15.1 Intensive family support services

Intensive family support services are specialist services, established in each jurisdiction, that aim to:

- prevent the imminent separation of children from their primary caregivers as a result of child protection concerns
- reunify families where separation has already occurred.

Intensive family support services differ from other types of child protection and family support services referred to in this chapter, in that they:

- are funded or established explicitly to prevent the separation of, or to reunify, families
- provide a range of services as part of an integrated strategy focusing on improving family functioning and skills, rather than providing a single type of service
- are intensive in nature, averaging at least four hours of service provision per week for a specified short term period (usually less than six months)
- generally receive referrals from a child protection service.

Intensive family support services may use some or all of the following strategies: assessment and case planning; parent education and skill development; individual and family counselling; anger management; respite and emergency care; practical and financial support; mediation, brokerage and referral services; and training in problem solving.

Child protection treatment and support services

A complementary suite of services not included in this Report, but intended for inclusion in future editions, are known as child protection treatment and support services. These services target at-risk families where there are concerns about the safety and wellbeing of children. They may be less intensive in nature and include services that strengthen family relationships in response to concerns about the welfare of a child and may focus on either early intervention or reunification support.

Child protection treatment and support services provide educational services, clinical services including counselling, group work and other therapeutic interventions, and domestic violence services.

The Australian Institute of Health and Welfare (AIHW), with the support of State and Territory governments, is studying the feasibility of a national data collection for child protection treatment and support services.

Source: AIHW (unpublished).

Roles and responsibilities

State and Territory governments fund child protection, out-of-home care, family support (including intensive family support) and other relevant services (box 15.2 identifies responsible State and Territory government departments during 2010-11). These services may be delivered by the government, non-government organisations, and in some cases, by for-profit providers. State and Territory governments, responsible for child protection, investigate and assess reports, provide or refer families to support services, and intervene where necessary (including making court applications when an order is required to protect a child, and placing children in out-of-home care).

Box 15.2 Child protection and out-of-home care services

<i>NSW</i>	Department of Family and Community
<i>Vic</i>	Department of Human Services
<i>Qld</i>	Department of Communities
<i>WA</i>	Department for Child Protection
<i>SA</i>	Department for Education and Child Development
<i>Tas</i>	Department of Health and Human Services
<i>ACT</i>	Community Services Directorate
<i>NT</i>	Department of Children and Families

Other areas of government also have roles in child protection and provide services for children who have come into contact with relevant departments for protective reasons. These include:

- education and child care services, which provide services for 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
- police, which investigate serious allegations of child abuse and neglect, particularly criminal matters, and may also work on child protection assessments with State and Territory departments responsible for child protection
- courts, which decide whether a child will be placed on an order.

A range of appointments, schemes and charters have been introduced by jurisdictions in recent years, to enable additional protection for clients of child protection systems. Examples of these are listed in box 15.3.

Box 15.3 Initiatives to enable additional protection for clients

<i>NSW</i>	The Commission for Children and Young People initiates and influences broad and positive change for children and young people. The Office of the Children's Guardian promotes the best interests and rights of all children in out-of-home care, through accreditation and monitoring of out-of-home care agencies to ensure services are of the highest standard.
<i>Vic</i>	The Child Safety Commissioner promotes child safe practices and environments across the community through a charter of rights for children in care. Part of the Commissioner's role is to monitor the quality of out-of-home care services.
<i>Qld</i>	The Commission for Children and Young People and Child Guardian has a range of legislated monitoring and oversighting functions for children in the child protection system, including regular visits to children in out-of-home care, receiving and investigating complaints and monitoring child outcomes. The Department of Communities (Child Safety Services) has a complaints management system to which clients, family members, advocates and members of the Queensland public can raise enquiries, concerns, or complaints about their contact and interactions with the department.
<i>WA</i>	The Advocate for Children in Care provides advocacy and complaints management services for children and young people in care. The Department's Complaints Management Unit is available to all customers. Formal monitoring of protection and care service standards by a Standards Monitoring Unit began on 1 July 2007. Seventeen Districts are monitored on a two-year cycle and the monitoring regime has been extended across all placement service providers.
<i>SA</i>	The Office of the Guardian monitors and assesses care, advocates for, and advises on, the circumstances and needs of children and systemic issues affecting the quality of out-of-home care.
<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.

(Continued on next page)

Box 15.3 (Continued)

- ACT** The Public Advocate of the ACT monitors the provision of services, and protects and advocates for the rights of children and young people. Systemic issues are referred by the Public Advocate to the Commissioner for Children and Young People. The Commissioner consults with and promotes the interests of children. The Official Visitor's role is to visit and inspect places of care, of detention or therapeutic protection, and receive and inquire about complaints made concerning the care provided to children and young people at these locations. In addition, an ACT Charter of Rights for children and young people in out-of-home care was launched in November 2009. The Charter is consistent with the United Nations Convention on the Rights of the Child, the ACT Human Rights Act 2004, and the Children and Young People Act 2008, all of which emphasise the basic human rights to which children and young people are entitled.
- NT** The Office of the Children's Commissioner was established in 2008 to independently monitor the child protection system through the investigation of complaints and reporting against the Department's administration of the Care and Protection of Children Act. In July 2011, the powers of the Children's Commissioner were extended to allow the initiation of investigations without receiving a formal complaint. The scope of the Children's Commissioner's powers was expanded beyond children involved in the child protection system: "protected children" to "vulnerable children". An Aboriginal Peak body (Stronger Aboriginal Families, Together) has been established for the purpose of creating Aboriginal Child Care Agencies (ACCA). The establishment of ACCAs will provide a robust focus on the safety and wellbeing of Aboriginal and Torres Strait Islander children within the child protection system.

Source: State and Territory governments (unpublished).

Size and scope

The child protection system

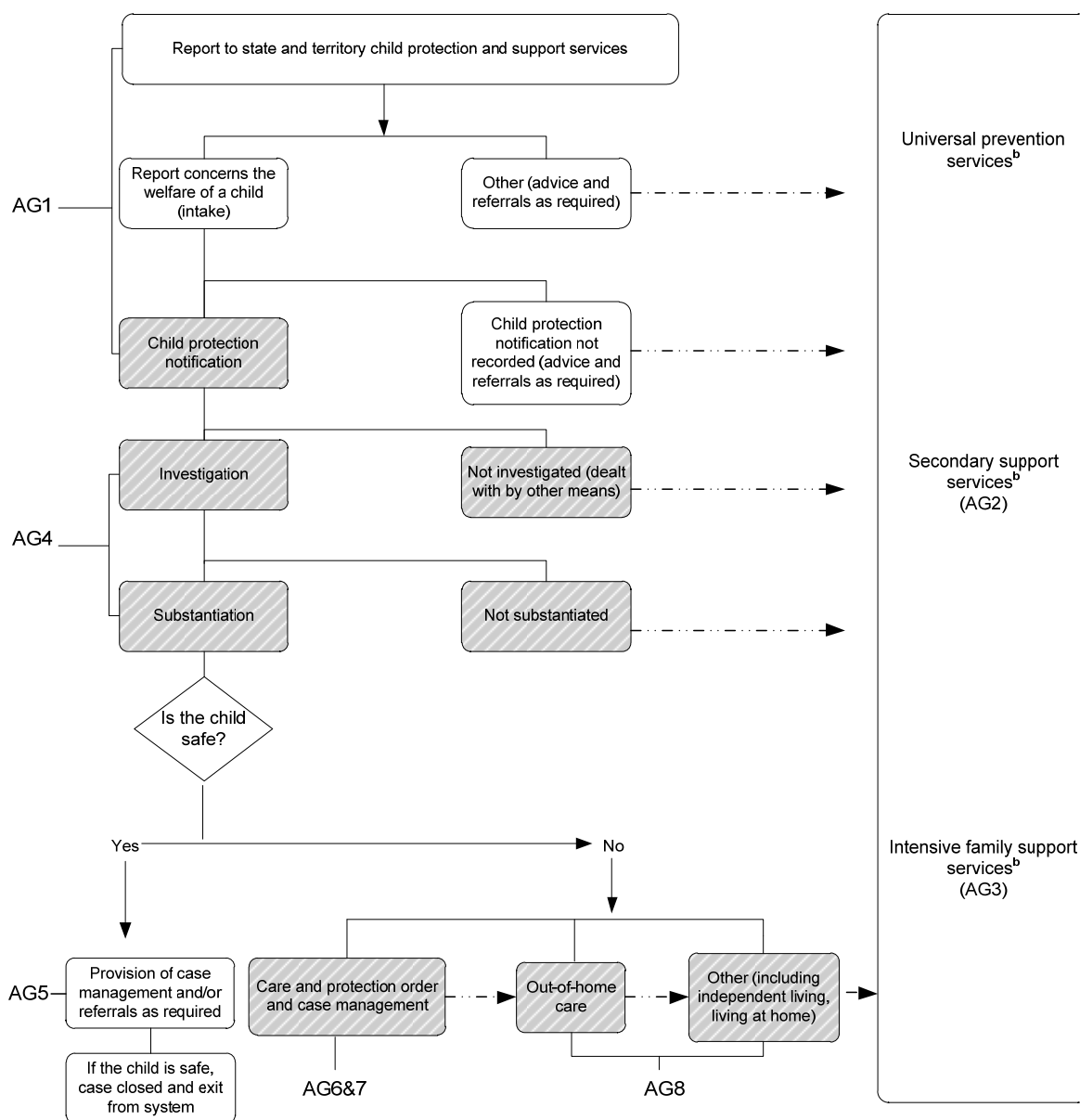
Child protection legislation, policies and practices vary across jurisdictions, which has some implications for the comparability of child protection data (Holzer and Bromfield 2008). However, the broad processes in child protection systems are similar (figure 15.1).

State and Territory departments with responsibility for child protection are advised of concerns about the wellbeing of children through reports to these departments. Reports may be made by people mandated to report or by other members of the community. Individuals and organisations mandated to report vary across states and territories, and may include medical practitioners, police services, school teachers

and principals. These reports are assessed and classified as child protection notifications, child concern reports, or matters requiring some other kind of response. Nationally, police were the most common source of notifications in 2010-11 (AIHW 2012).

Figure 15.1 is a simplified representation of the statutory child protection system. It depicts the common pathways through the statutory system and referrals to support services, which can take place at any point along the statutory service system. Children might or might not move sequentially along these pathways and in some instances children might move through these pathways quite rapidly (for example, on the same day). There are a range of other services and programs which work to meet the needs of children and families which are not depicted in this diagram, including health, education and early childhood services.

Figure 15.1 The child protection service^{a, b, c, d, e}



^a Dashed lines indicate that clients may or may not receive these services, depending on need, service availability, and client willingness to participate in what are voluntary services. ^b Support services include family preservation and reunification services provided by government departments responsible for child protection and other agencies. Children and families move in and out of these services and the statutory child protection system, and might also be in the statutory child protection system while receiving support services. ^c Shaded boxes are those for which data are available. ^d AG = Activity Group. ^e AG1 = Receipt and assessment of initial information about a potential protection and support issue; AG2 = Provision of generic/non-intensive family support services; AG3 = Provision of intensive family support services; AG4 = Secondary information gathering and assessment; AG5 = Provision of short term protective intervention and coordination services for children not on an order; AG6 = Seeking an order; AG7 = Provision of protective intervention, support and coordination services for children on an order; AG8 = Provision of out-of-home care services.

Source: State and Territory governments (unpublished).

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.

Most jurisdictions assess incoming reports to determine whether they meet the threshold for recording a notification. Notifications are subsequently investigated based on the policies and practices in each jurisdiction (figure 15.1).

Prior to 2009-10, the rates of children subject to notifications, investigations and substantiations were calculated for children aged 0–16 years, while the rates of children on care and protection orders and in out-of-home care were calculated for children aged 0-17 years. From the 2009-10 period onwards, all child protection data are reported for the age range 0-17 years.

Nationally, 163 767 children aged 0–17 years were the subject of child protection notifications in 2010-11. The rate of notifications per 1000 children in the population aged 0–17 years was 31.9 in 2010-11 (table 15A.8). The total number of notifications for each jurisdiction for 2010-11 (including cases where a child is the subject of more than one child protection notification) by Indigenous status of the child is reported in table 15A.5.

Notifications data are collected early in the child protection process and often before an agency has full knowledge of a child's circumstances. This lack of information and the inherent difficulties in identifying Indigenous status mean that data on the number of notifications by Indigenous status need to be interpreted with care.

Investigation

An investigation is the process whereby the relevant department obtains more detailed information about a child who is the subject of a notification and makes an assessment about the harm or risk of harm to the child, and his or her protective needs. Once it has been decided that an investigation is required, the investigation process is similar across jurisdictions.

The department responsible for child protection may obtain further information about the child and his or her family by checking information systems for any previous history, undertaking discussion 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. Where possible, an investigation determines whether a notification is substantiated or not substantiated.

Nationally, 76 552 children aged 0-17 years who were the subject of a notification in 2010-11 were subsequently the subject of an investigation in 2010-11 (table 15A.8). The rate per 1000 children in the population aged 0–17 years was 14.9 in 2010-11 (table 15A.8). The total number of notifications investigated for each jurisdiction in 2010-11, by Indigenous status, is reported in table 15A.5.

Substantiation

The legal definition of harm or risk of harm, abuse or risk of abuse are similar across jurisdictions. Traditionally, child protection legislation and policy focused on the identification and investigation of narrowly defined incidents that were broadly grouped as types of abuse or neglect. Across all jurisdictions, the focus has now shifted 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 or risk to the child, and the child's needs. While the legal criteria for substantiating such matters are now similar across jurisdictions, there remain some differences in practice, including different thresholds for recording a substantiation related to risk of harm.

If an investigation results in a substantiation, intervention by child protection services might be needed to protect the child. This intervention can take a number of forms, including one or more of: referral to other services; supervision and support; an application to court; and a placement in out-of-home care.

Nationally, 31 527 children aged 0–17 years were the subject of a substantiation in 2010-11. The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–17 years was 6.1 (table 15A.8). The number and rate of children who were the subject of a substantiation has fluctuated within jurisdictions since 2006-07. Nationally, 33 860 children aged 0-16 were the subject of a substantiation in 2006-07. This represented a rate of 7.3 per 1000 children in the population aged 0–16 years (prior to 2009-10, substantiations data were collected for children aged 0–16 years) (table 15A.8).

Nationally, 8231 Indigenous, 22 144 non-Indigenous children and 1152 children of unknown Indigenous status were the subject of substantiations in 2010-11. The rate of children who were the subject of a substantiation per 1000 children in the target population aged 0–17 years was 34.6 for Indigenous children and 4.5 for non-Indigenous children (table 15A.8).

Care and protection orders

Although child protection substantiations are often resolved without the need for a court order (which is usually a last resort) recourse to a court may take place at any point in the child protection investigation process. The types of orders available vary across jurisdictions and may include guardianship or custody orders, supervisory orders, and interim and temporary orders.

Nationally, 39 058 children aged 0–17 years were on care and protection orders at 30 June 2011. The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 7.6 (table 15A.8). The number and rate of children aged 0–17 years who were the subject of a care and protection order has increased since 2007. At 30 June 2007, 28 954 children were the subject of a care and protection order, which represented a rate of 5.9 per 1000 children in the population aged 0–17 years (table 15A.8).

Nationally, 12 280 Indigenous, 26 531 non-Indigenous and 247 children of unknown Indigenous status were on care and protection orders at 30 June 2011. The rate of children on care and protection orders per 1000 children in the target population aged 0–17 years was 51.4 for Indigenous children and 5.4 for non-Indigenous children (table 15A.8).

Further information regarding children on care and protection orders is included in the attachment tables. Table 15A.6 identifies the number of children admitted to and discharged from care and protection orders by Indigenous status in 2010–11. Table 15A.7 identifies the number of children on care and protection orders by type of order and Indigenous status at 30 June 2011.

Out-of-home care

Out-of-home care is one of a range of services provided to children and families where there is a need to provide safe care for a child. Children are placed in out-of-home care as a last resort when it is not in their best interests to remain with their family (for example, because they are not safe or because no one is able or willing to provide care). Where children are placed in out-of-home care, placement with the extended family or community is sought where possible, particularly in the case of Indigenous children (AIHW 2006). Continued emphasis is placed on improving case planning and case management processes to facilitate the safe return home of children in out-of-home care and to maximise case workers' contact time with children and families.

Nationally, 37 648 children were in out-of-home care at 30 June 2011. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years

was 7.3 (table 15A.16). The number and rate of children aged 0–17 years in out-of-home care has increased since 2007. At 30 June 2007, 28 379 children were in out-of-home care. This represented a rate of 5.8 per 1000 children in the population aged 0–17 years (table 15A.16).

Nationally, 12 358 Indigenous children and 24 929 non-Indigenous children were in out-of-home care at 30 June 2011. The rate of children in out-of-home care per 1000 children in the target population aged 0–17 years was 51.7 for Indigenous children and 5.1 for non-Indigenous children (table 15A.16).

Further information on children in out-of-home care is included in the attachment tables. Table 15A.17 identifies the number of children in out-of-home care by Indigenous status and placement type at 30 June 2011. Table 15A.18 identifies the number of children in out-of-home care by Indigenous status and whether they were on a care and protection order at 30 June 2011. Table 15A.19 identifies the number of children in out-of-home care by Indigenous status and length of time in continuous out-of-home care as at 30 June 2011. Table 15A.20 identifies the number of children who exited care during 2010-11, by Indigenous status and length of time spent in care.

Funding

Recurrent expenditure on child protection and out-of-home care services was approximately \$2.8 billion across Australia in 2010-11 — a real increase of \$137.7 million (5.1 per cent) from 2009-10. Of this expenditure, out-of-home care services accounted for the majority (64.9 per cent, or \$1.8 billion). Nationally, annual real expenditure on child protection and out-of-home care services has increased by \$914.1 million from \$1.9 billion since 2006-07, an average annual increase over the 4 year period of 10.2 per cent (table 15A.1).

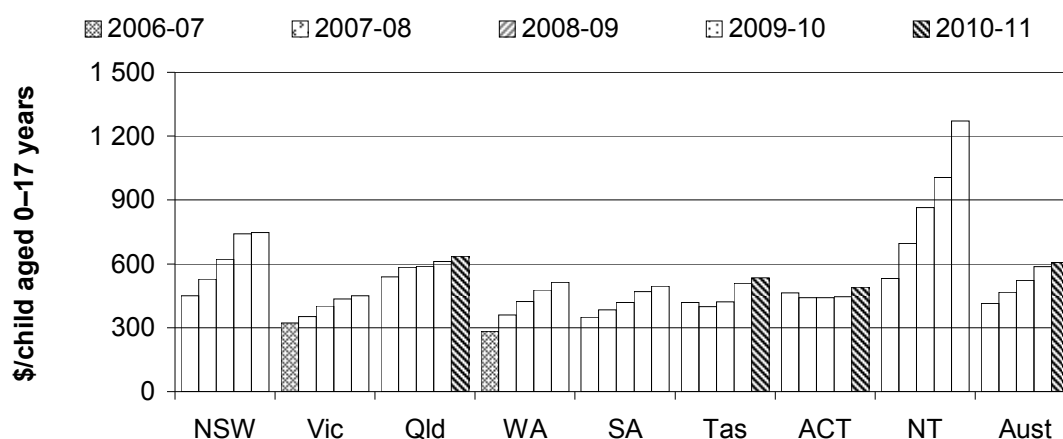
Recurrent expenditure on intensive family support services across all jurisdictions was \$274.4 million in 2010-11. This expenditure has increased in real terms each year from \$115.5 million in 2006-07 (table 15A.26). This represents an average annual increase in expenditure of 24.1 per cent over this period. Table 15A.1 and Tables 15A.26–29 provide additional information about families and children who were involved with intensive family support services, including the cost of providing these services per child commencing intensive family support services.

In 2010-11, real recurrent expenditure on child protection, out-of-home care and intensive family support services per child aged 0–17 years in the population was \$607 nationally. Real recurrent expenditure per child aged 0–17 years increased in most jurisdictions between 2006-07 and 2010-11 and has increased nationally each

year since 2006-07. In 2006-07 the real recurrent expenditure per child aged 0–17 years was \$414 (table 15A.1). This represents an average annual increase over the 4 year period of 10.0 per cent.

Figure 15.2 depicts total real recurrent expenditure per child aged 0-17 years in the population for the period 2006-07 to 2010-11. Figure 15.3 depicts expenditure on child protection services, out-of-home care services, and intensive family support services per child aged 0-17 years in the population in 2010-11.

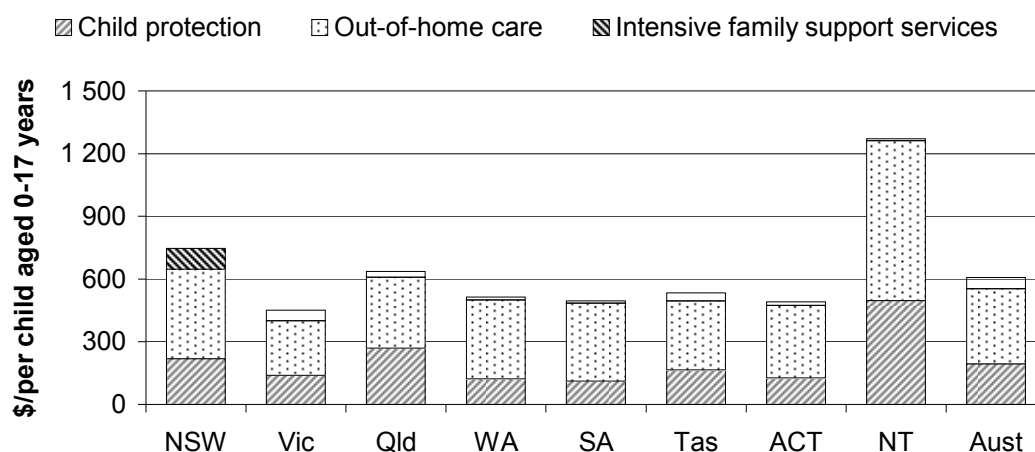
Figure 15.2 Real recurrent expenditure on child protection, out-of-home care, and intensive family support services per child (total) (2010-11 dollars)^a



^a Refer to table 15A.1 for detailed jurisdiction-specific footnotes on expenditure data and table 15A.4 for information on the comparability of expenditure data.

Source: State and Territory governments (unpublished); table 15A.1.

Figure 15.3 Real recurrent expenditure on child protection, out-of-home care, and intensive family support services per child, 2010-11^a



^a Refer to table 15A.1 for detailed jurisdiction-specific footnotes on expenditure data and table 15A.4 for information on the comparability of expenditure data.

Source: State and Territory governments (unpublished); table 15A.1.

It is an objective of the Review to report comparable estimates of costs. Ideally, the full range of costs to government would be determined on a comparable basis across jurisdictions. Where full costs cannot be calculated, costs should be estimated on a consistent basis across jurisdictions. However, in the area of child protection, there are differences across jurisdictions in the calculation of expenditure.

Table 15A.4 identifies the level of consistency across jurisdictions for a number of expenditure items. The scope of child protection systems also varies across jurisdictions, and expenditure on some services are included for some jurisdictions, but not for others.

15.2 Framework of performance indicators for child protection and out-of-home care services

The framework of performance indicators for child protection and out-of-home care services is based on shared government objectives (box 15.4).

Box 15.4 Objectives for child protection and out-of-home care services

The aims of child protection services are to:

- protect children and young people who are at risk of harm within their families or whose families do not have the capacity to provide care and protection
- 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.

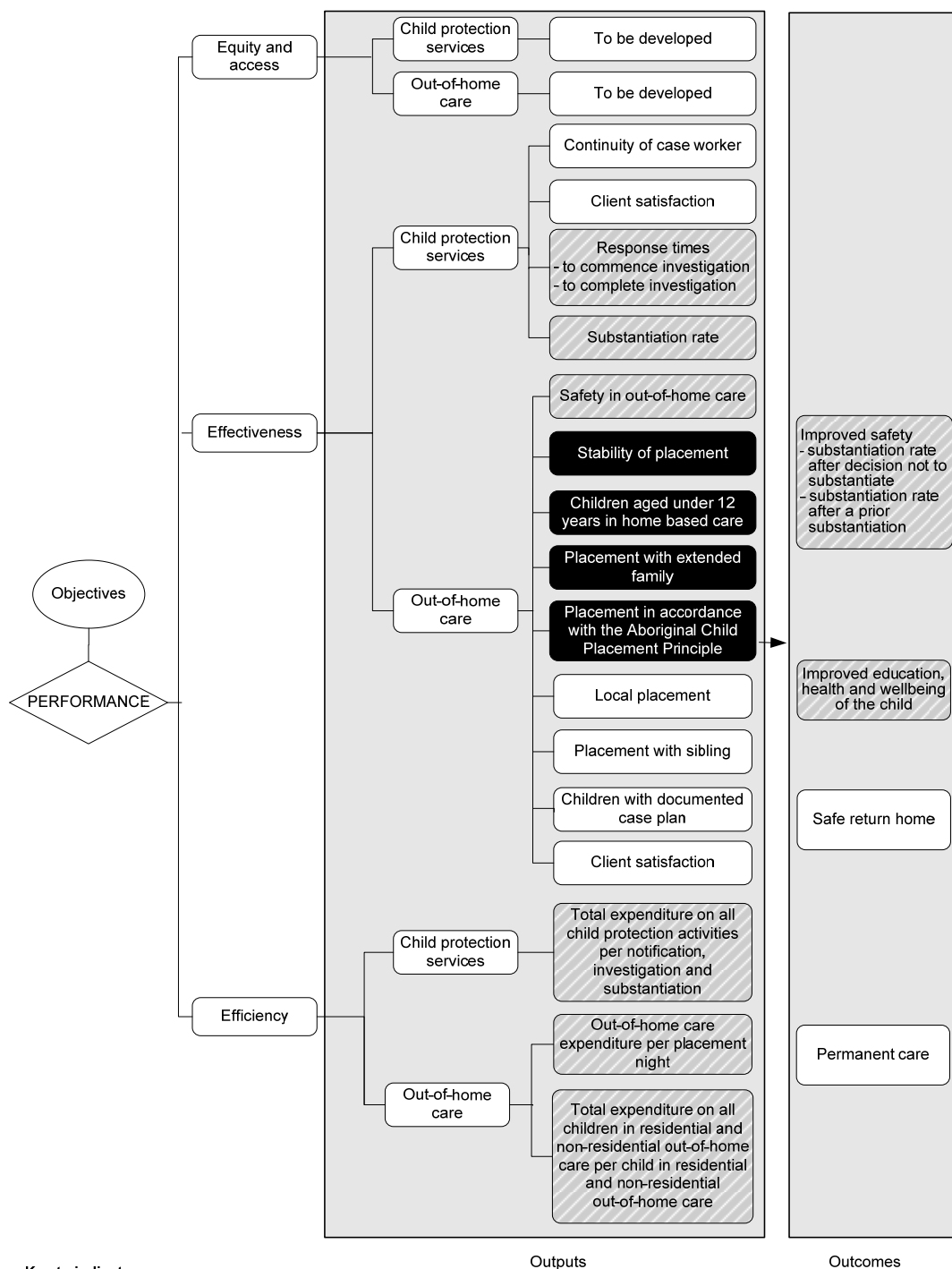
The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of child protection and out-of-home care services (figure 15.4). The performance indicator framework shows which data are comparable in the 2012 Report. For data 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 Report's statistical appendix 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) (appendix A). The statistical appendix also notes that the large populations of the eastern mainland states — NSW, Victoria and Queensland — have a significant effect on national averages, as approximately three quarters of Australia's population live in these states.

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 and out-of-home care services.

Figure 15.4 Child protection and out-of-home care services performance indicator framework



Outputs

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

Equity and access

Equity and access indicators are indicators of governments' objective to ensure that all clients have fair and equitable access to services on the basis of relative need and available resources (box 15.5).

Box 15.5 Access to child protection and out-of-home care services by equity groups

'Access to child protection and out-of-home care services by equity groups' are yet to be defined.

These indicators have been identified for development and reporting in future.

Effectiveness

Child protection services — continuity of case worker

'Continuity of case worker' is an indicator of governments' objective to ensure child protection services are delivered in an effective manner (box 15.6).

Box 15.6 Continuity of case worker

'Continuity of case worker' is yet to be defined.

The turnover of workers is a frequent criticism of the quality of child protection services. Effective intervention requires a productive working relationship between the worker and the child and family.

This indicator has been identified for development and reporting in future.

Child protection services — client satisfaction

'Client satisfaction' is an indicator of governments' objective to provide high quality services that meet the needs of recipients (box 15.7).

Box 15.7 Client satisfaction

'Client satisfaction' is yet to be defined.

This indicator has been identified for development and reporting in future.

Box 15.8 provides examples of steps taken across jurisdictions to monitor, assess and promote client satisfaction with child protection and out-of-home care services.

Box 15.8 Developments in client satisfaction

NSW A large scale evaluation is being undertaken of the Brighter Futures early intervention program, which targets vulnerable families with children under 9 years of age. As part of the evaluation, a sample of 2484 families participated in the family survey, which assessed satisfaction with the services provided. The survey was conducted from August 2007 to 30 June 2009. Interviewed families were overwhelmingly positive about the Brighter Futures program, and generally satisfied with the services they received. Respondents were asked (using a scale from 1 to 5, with 1 being 'completely dissatisfied' and 5 'completely satisfied'), their degree of service satisfaction. Respondents consistently reported a high level of satisfaction (on average, 5 or 'completely satisfied') with the quality of services and the amount of help they received from Brighter Futures, which was sustained over the three waves of surveys.

Vic Survey findings of child protection clients and families in 2001 on their experience of child protection identified areas for practice improvement and a range of strengths in child protection practice, including that in the majority of cases, child protection intervention improved the safety and life circumstances of young people. A further survey of child protection, out-of-home care and intensive family support services clients is to take place in 2012. Client feedback is also routinely sought by Community Services Organisations as part of meeting Victorian out-of-home care service registration standards.

Q/d Children in State care are visited regularly by the Commission for Children and Young People and Child Guardian's Community Visitors (CVs) to independently assess their safety and wellbeing. CVs work to resolve issues locally and are able to escalate more serious concerns. Children are surveyed every two years by the Commission. Several age-appropriate questionnaires are used to determine satisfaction with current placements, case workers and the child protection system. Information is also gathered on placement histories, education and health needs, participation in decision-making, and planning for transition to independent living for those aged 16 and over. The last survey of children and young people in foster care was undertaken in 2009, with a report of results published in 2010: www.ccypcg.qld.gov.au/resources/publications/views/ViewsChildrenYoungPeopleinFosterCare10.html.

(Continued on next page)

Box 15.8 (Continued)

- WA** WA's first Commissioner for Children and Young People was appointed in December 2007 and has legislative powers to consult, investigate, research, advise and report independently to the Parliament about issues that concern children and young people and those supporting them. The Department for Child Protection undertook an on-line survey of foster carers in early 2008 and is responding to the feedback obtained from this stakeholder group. In summary, 63 per cent of carers reported that the department met their needs as a carer in the previous 12 months, while 66 per cent of carers reported that they were confident to manage as a carer in the future. New carers indicated that the most useful additional support they could have received was 'mentoring by an experienced carer'. Where children were new to care, carers indicated that the most useful assistance they could have received was 'better access to caseworkers'. The Department introduced new complaints policy and procedures in March 2008. Formal monitoring of service standards has continued and all districts were assessed by June 2009. A pilot standards monitoring regime for residential and non-government placement services was completed in June 2009. As a result of a positive outcome for 2009-10, residential and placement services completed a self assessment. External on-site monitoring commenced in July 2010.
- SA** The Office of the Guardian for Children and Young People conducted interviews with 28 children and young people in care to identify what they want from their case workers. Overwhelmingly, children and young people value a positive relationship with their case worker. The Office of the Guardian has developed a Charter of Rights for Children and Young People in Care which has been tabled in Parliament. Amendments have been made to the Children's Protection Act 1993 to provide for a Youth Advisory Committee, established and appointed by the Guardian for Children and Young People. A second Foster Carers' Relation Survey was conducted in 2009: a total of 322 carers completed a mail-out survey. Of this total, 60 per cent were satisfied with their interactions with Families SA, 70 per cent were happy with the service from their support agencies and 81 per cent were confident of still being carers in 12 months time.

(Continued on next page)

Box 15.8 (Continued)

- Tas** In March 2010, the Commissioner for Children commenced a child visitor's pilot. The Commissioner recruited and trained 12 volunteers who visited 18 children in care on a monthly basis. Each visitor asked the child a series of questions based on the Charter of Rights for Tasmanian children and young people in out-of-home care. The visitor also spent time with the child participating in an activity of the child's choice. The pilot was undertaken for a period of one year and, as well as proposing some changes to the model, an independent evaluation confirmed the overall benefit of the pilot. During 2010-11, Children and Youth Services (CYS) commenced development of a quality and safety framework to support delivery of safe, high quality, and client centred services. As part of this framework, CYS is aiming to provide services that are more easily accessible and which respect choice and learn from client experiences. Models of Care outlining actions by which CYS can build on strengths and opportunities to become more client centred will provide a reference for the way forward.
- ACT** The ACT Government, Community Services Directorate entered into a research partnership *Community Capacity Building in Child Protection Through Responsive Regulation*. This research, which commenced in 2006, seeks to develop a regulatory framework for child protection that effectively manages escalating notification rates and addresses the challenge of how and when governments can intervene in individuals' lives without undermining the goodwill essential for such interventions to be successful. One of the studies undertaken as part of this research partnership examines parents' experiences of their encounters with the child protection system. Descriptive analysis from the parent study has been completed and further results are expected to be published in 2012.
- NT** With the establishment of the new Department of Children and Families on 1 January 2011, the Practice Integrity and Complaints Management Branch has recently been created. This Branch will provide a clear point of contact for clients wishing to provide feedback or raise concerns. The Children's Commissioner's powers have also been strengthened to allow the Commissioner to investigate concerns relating to vulnerable children without having to receive a formal complaint. The Department is in the early stages of establishing effective mechanisms for listening to children, including the development of a community visitor model for children in out-of-home care.

Source: State and Territory governments (unpublished).

Child protection services — response time to commence investigation

'Response time to commence investigation' is an indicator of governments' objective to minimise the risk of harm to children by responding to notifications of

possible child protection incidents and commencing investigations in a timely manner (box 15.9).

Box 15.9 Response time to commence investigation

‘Response time to commence investigation’ is defined as the length of time (measured in days) between the date a child protection department records a notification and the date an investigation is subsequently commenced.

A short or decreasing length of time between recording a notification and commencing an investigation is desirable. The length of time between recording a notification and commencing an investigation indicates a department’s promptness in effectively responding to child protection concerns.

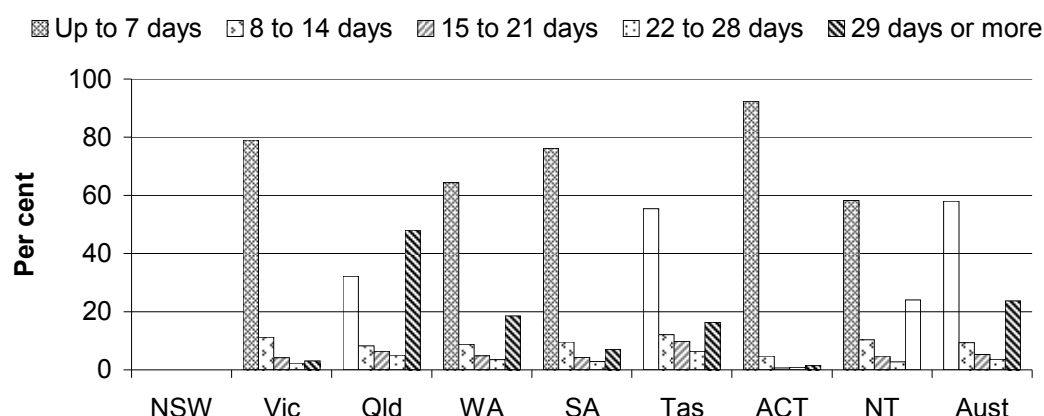
This indicator needs to be interpreted with care as jurisdictions record notifications at different stages in response to a report, and jurisdictions have policy and legislation outlining the time recommended for commencing investigations, based on the seriousness of the child protection concern.

Data reported for this indicator are neither directly comparable nor complete.

Data quality information for this indicator is under development.

For most jurisdictions, the majority of investigations were commenced within seven days of notification in 2010-11 (figure 15.5).

Figure 15.5 Proportion of investigations commenced, by time taken to commence investigation (2010-11)^{a, b}



^a Data for NSW are not available due to information system limitations. ^b See source table for detailed footnotes.

Source: AIHW data collection (unpublished); table 15A.14.

Child protection services — response time to complete investigation

‘Response time to complete investigation’ is an indicator of governments’ objective to minimise the risk of harm to the child by responding to notifications of possible child protection incidents and completing investigations in a timely manner (box 15.10).

Box 15.10 Response time to complete investigation

‘Response time to complete investigation’ is defined as the length of time (measured in days) between the date a child protection department records a notification and the date an investigation is completed (that is, the date an investigation outcome is determined by a department).

A short or decreasing length of time between recording a notification and completing an investigation is desirable. The length of time between recording a notification and completing an investigation indicates the effectiveness of a department in conducting investigations in a timely manner.

This indicator needs to be interpreted with care as jurisdictions record notifications at different stages in response to a report, and jurisdictions have policy and legislation outlining the time recommended for commencing investigations, based on the seriousness of the child protection concern. Furthermore, while investigations should be conducted in a timely manner, it is important that expediency does not undermine a thorough and accurate assessment of the case. In addition, a number of factors outside the control of a department can affect the timeliness of investigations, including involvement by external parties (for example, police, schools) and an inability to locate a child and/or family.

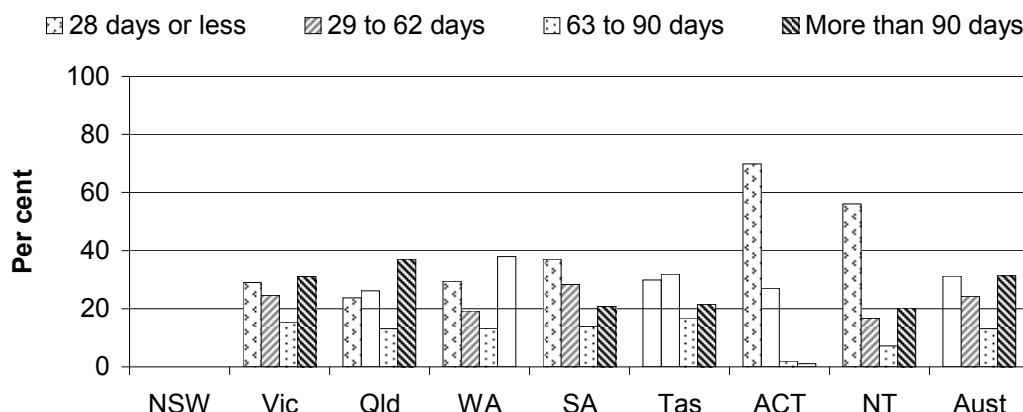
Data reported for this indicator are neither directly comparable nor complete.

Data quality information for this indicator is under development.

Investigation is the process whereby the relevant department obtains more detailed information about a child who is the subject of a notification and makes an assessment about the harm or degree of harm to the child, and his or her protective needs. An investigation includes sighting or interviewing the subject child where it is practical to do so.

Response times to complete investigations varied across jurisdictions in 2010-11. Nationally, 31.3 per cent of investigations were completed in 28 days or less, 24.3 per cent were completed in 29 to 62 days, 13.1 per cent were completed in 63 to 90 days, and 31.3 per cent were completed in 90 days or more (figure 15.6).

Figure 15.6 **Proportion of investigations finalised, by time taken to complete investigation (2010-11)^{a, b, c}**



^a Data for NSW are not available due to information system limitations. ^b The NT's data supply differs from the national counting rule — the NT counts the number of days from the start of investigations to the completion of investigations, as distinct from the number of days from recording notifications to the completion of investigations. ^c See source table for detailed footnotes.

Source: AIHW data collection (unpublished); table 15A.15.

Child protection services — substantiation rate

'Substantiation rate' is an indicator of governments' objective to target investigations to those notifications where a substantive child abuse/neglect incident has occurred or is at risk of occurring (box 15.11).

Box 15.11 Substantiation rate

'Substantiation rate' is defined as the proportion of finalised investigations where harm or risk of harm was confirmed.

The substantiation rate provides an indication of the extent to which government avoided the human and financial costs of an investigation where no harm had occurred or was at risk of occurring. Neither a very high nor very low substantiation rate is desirable. A very low substantiation rate might indicate that notifications and investigations are not accurately targeted to appropriate cases, with the undesirable consequence of distress to families and undermining the likelihood that families will voluntarily seek support. It might also reflect a greater propensity to substantiate abuse incidents rather than situations of risk. A very high substantiation rate might indicate that either some appropriate cases are being overlooked at notification and/or investigation, or that the criteria for substantiation are unnecessarily bringing 'lower risk' families into the statutory system.

Box 15.11 (Continued)

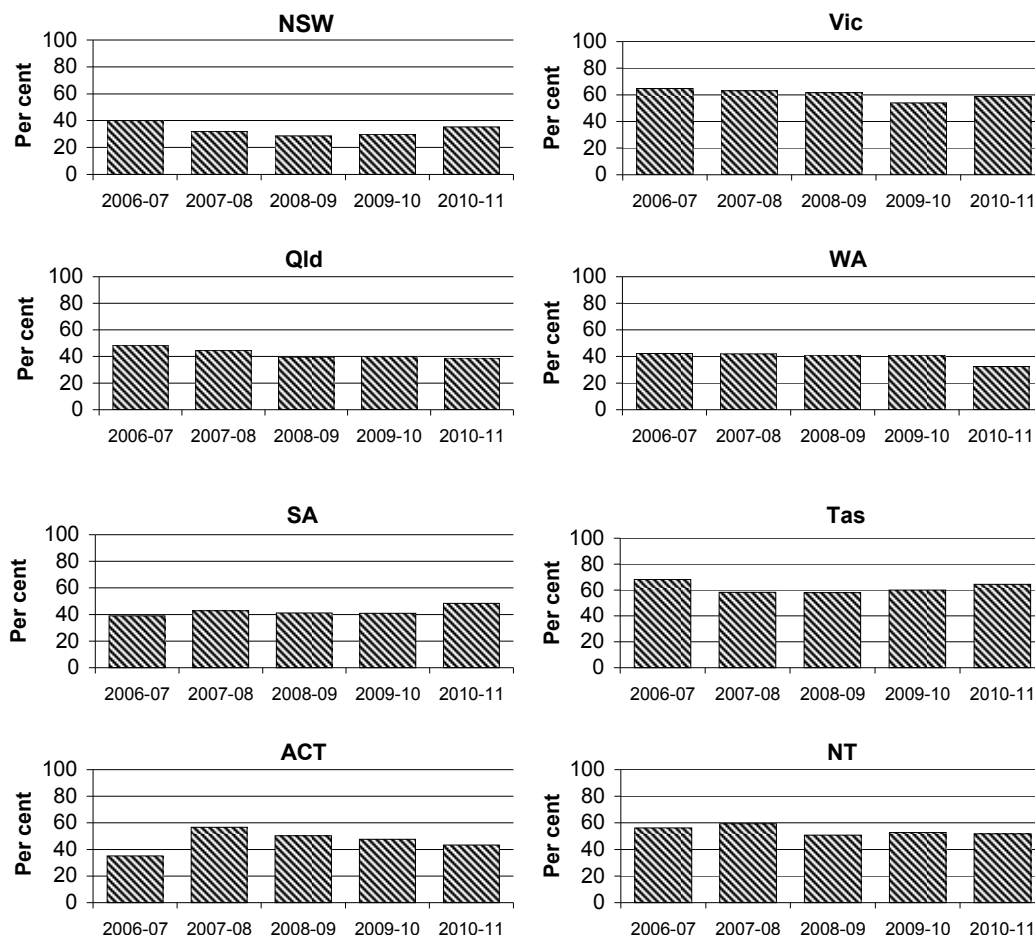
The rate of finalised investigations that were substantiated is influenced by a range of factors and might fluctuate because of policy, funding and practice changes, such as better targeting of investigative resources, the impact of mandatory reporting or other factors such as increased community awareness and willingness to notify suspected instances of child abuse, neglect or harm.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.7).

Figure 15.7 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 See source tables for detailed footnotes.

Source: AIHW data collection (unpublished); tables 15A.39, 15A.56, 15A.73, 15A.90, 15A.107, 15A.124, 15A.141 and 15A.158.

Out-of-home care — safety in out-of-home care

‘Safety in out-of-home care’ is an indicator of governments’ objective to provide children who are under the care of the State with a safe home environment (box 15.12).

Box 15.12 **Safety in out-of-home care**

‘Safety in out-of-home care’ is defined as the proportion of children in out-of-home care who were the subject of a substantiation where the person responsible was living in the household providing out-of-home care.

A low or decreasing proportion of substantiations is desirable.

This indicator reflects the safety of children in care situations. Care should be taken when interpreting this indicator as the threshold for substantiating harm or risk involving children in care is generally lower than that for substantiating harm or risk involving a child in the care of his or her own parents. This is because governments assume a duty of care for children removed from the care of their parents for protective reasons. In addition, care should be taken when interpreting these data as the scope of information captured by jurisdictions differs. Some jurisdictions include substantiations concerning visitors to the home and substantiations where abuse was perpetrated by someone outside the care setting but a carer’s action or inaction contributed to the harm.

Data reported for this indicator are neither complete nor directly comparable.

Data quality information for this indicator is under development.

The proportion of children in out-of-home care who were the subject of a substantiation where the person responsible was living in the household varied across jurisdictions (table 15.1).

Table 15.1 Rate and number of children in out-of-home care who were the subject of a substantiation and the person responsible was living in the household, 2010-11^{a, b}

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld^c</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
Children in care who were the subject of a substantiation	no.	93	78	194	4	9	27	9	na
Children aged 0-17 in at least one care placement during the year	no.	19 590	8 473	8 265	3 839	2 822	1 167	779	897
Children in care who were the subject of a substantiation as a proportion of all children in care	%	0.5	0.9	2.3	0.1	0.3	2.3	1.2	na

^a Data reported for this indicator are not comparable due to differences in policies, practices and reporting methods. ^b See source table for detailed footnotes. ^c Queensland's data comprise matter of concern substantiations, which refer to children in the custody or guardianship of the Chief Executive only. Queensland's consideration of the 'person believed responsible' relates to the overall safety and risk experienced by a child in care. It includes not only allegations of actual harm inflicted by members of a household but also whether the carer's action or inaction contributed to the risk or harm even if the person believed responsible did not reside in the household. Therefore, Queensland's data are broader than the scope of the national counting rule and should not be compared to other jurisdictions' data. **na** Not available.

Source: AIHW data collection (unpublished); table 15A.25.

Out-of-home care — stability of placement

'Stability of placement' is an indicator of governments' objective to provide high quality services that meet the needs of recipients on the basis of relative need and available resources (box 15.13).

For children placed away from their family for protective reasons, stability of placement is an important indicator of service quality, particularly for those children who require long term placements. Data are collected on the number of different placements for children on a care and protection order who exited out-of-home care in 2010-11. Data are grouped according to the length of time in care (less than 12 months and 12 months or more).

Box 15.13 Stability of placement

‘Stability of placement’ is defined as the proportion of children who had 1 or 2 placements during a period of continuous out-of-home care.

A low number of child placements (1 or 2) 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 can have multiple short term placements for appropriate reasons (for example, an initial placement followed by a longer term placement) or it may be desirable to change placements to achieve better compatibility between a child and family. 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.

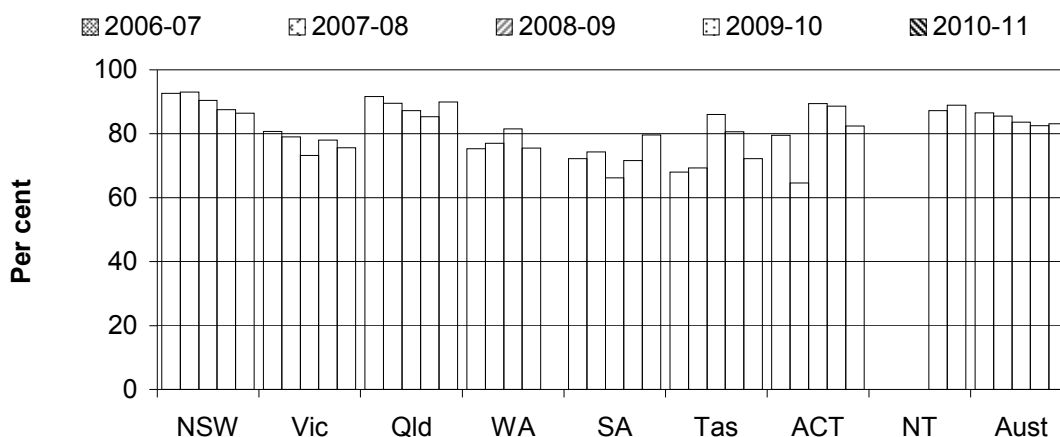
Data are collected only for children who are on orders and who exit care during the reporting period. There are limitations to counting placement stability using a cohort of children on exit from care rather than longitudinally tracking a cohort of children on their entry into care: an exit cohort is biased to children who stayed a relatively short time in care and thus were more likely to have experienced fewer placements.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, 83.2 per cent of the children on a care and protection order who exited care after less than 12 months in 2010-11 experienced 1 or 2 placements. Proportions varied across jurisdictions (figure 15.8).

Figure 15.8 Proportion of children on a care and protection order exiting care after less than 12 months, who had 1 or 2 placements^{a, b, c, d, e}

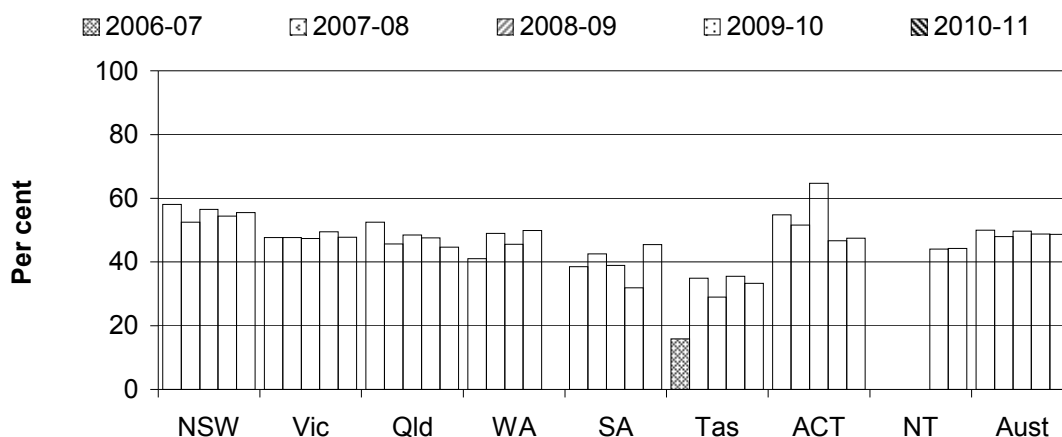


^a Data refer to children exiting care during the relevant financial year. ^b See source table for detailed footnotes. ^c During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 onwards may not be fully comparable to previous years' data. ^d The apparent decline in the proportion for the ACT in 2007-08 was impacted on by the small number of children involved and the placement of large sibling groups. ^e NT data for 2006-07 to 2008-09 were not available. WA data for 2010-11 were not available.

Source: AIHW data collection (unpublished); table 15A.24.

Across jurisdictions, children who had been in out-of-home care longer tended to have had more placements. The proportion of children exiting care in 2010-11 after 12 months or more who had experienced 1 or 2 placements was 48.7 per cent nationally but varied across jurisdictions (figure 15.9).

Figure 15.9 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 See source table for detailed footnotes. ^c During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 onwards may not be comparable with previous years' data. ^d NT data for 2006-07 to 2008-09 are not available. WA data for 2010-11 were not available.

Source: AIHW data collection (unpublished); table 15A.24.

Out-of-home care — children aged under 12 years in home-based care

'Children aged under 12 years in home-based care' is an indicator of governments' objective to provide services which meet the needs of recipients (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 defined as the number of children aged under 12 years placed in home-based care divided by the total number of children aged under 12 years in out-of-home care.

A high or increasing rate for this indicator is desirable. This indicator should be interpreted in conjunction with other placement indicators.

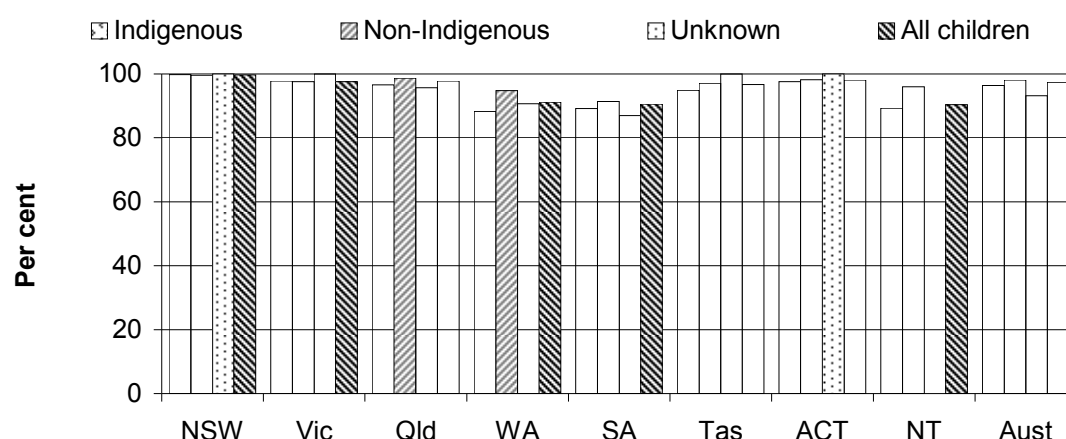
Placing children in home-based care is generally considered to be in their best interests, particularly for younger children. Children will generally make better developmental progress (and have more ready access to normal childhood experiences) in family settings rather than in residential or institutional care environments.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, the proportion of all children aged under 12 years in care who were placed in home-based care at 30 June 2011 was 97.4 per cent. In most jurisdictions the proportion of Indigenous children aged under 12 years who were placed in home-based care was similar to that of non-Indigenous children (figure 15.10).

Figure 15.10 Proportion of children aged under 12 years in out-of-home care who were in a home-based placement, by Indigenous status, 30 June 2011^a



^a See source table for detailed footnotes.

Source: AIHW data collection (unpublished); table 15A.23.

Out-of-home care — placement with extended family

‘Placement with extended family’ is an indicator of governments’ objective to provide services that meet the needs of recipients on the basis of relative need and available resources (box 15.15).

Box 15.15 Placement with extended family

‘Placement with extended family’ is defined as the proportion of all children in out-of-home care who are placed with relatives or kin who receive government financial assistance to care for that child.

A high or increasing rate for this indicator is desirable. Placement with extended family needs to be considered with other factors in the placement decision. Placing children with their relatives or kin is generally the preferred out-of-home care placement option. This option is generally associated with better long term outcomes due to increased continuity, familiarity and stability for the child. Relatives are more likely to have or form long term emotional bonds with the child. Placement with familiar people can help to overcome the loss of attachment and belonging that can occur when children are placed in out-of-home care.

Placements with extended family may not always be the best option. Long standing family dynamics can 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 the child, it may be more important to have a local placement that enables continuity at school, for example, rather than a distant placement with relatives.

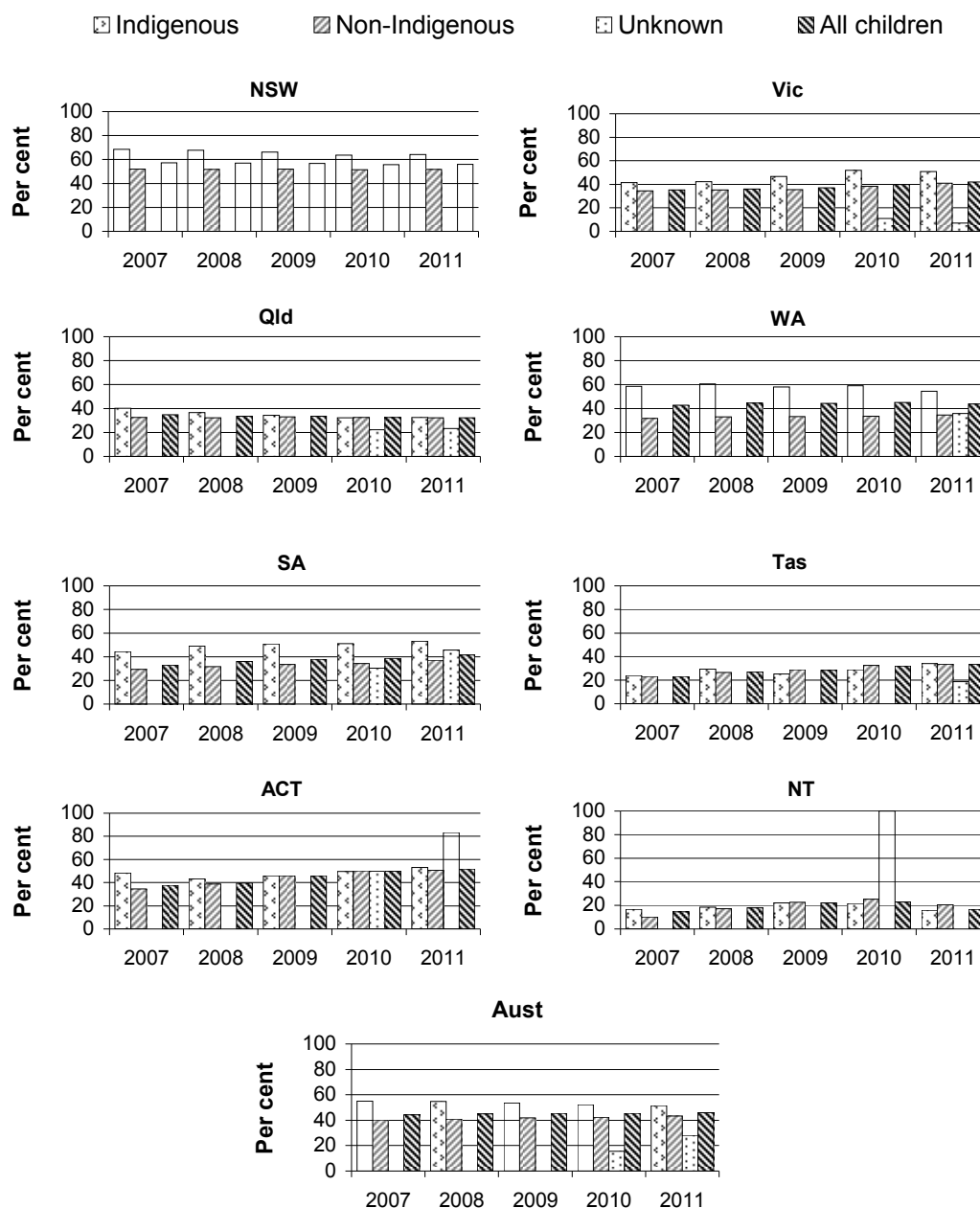
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Figure 15.11 shows the proportion of children placed with relatives or kin by Indigenous status. Although these data are comparable, each jurisdiction is shown separately for simpler presentation. The proportion of children placed with relatives or kin at 30 June 2011 was greater for Indigenous children than for non-Indigenous children in most jurisdictions (figure 15.11).

The Aboriginal Child Placement Principle places considerable emphasis on the placement of Indigenous children with extended family. This principle is discussed in box 15.16.

Figure 15.11 Proportion of children in out-of-home care placed with relatives/kin, by Indigenous status, 30 June^{a, b, c}



^a Prior to 2009-10, non-Indigenous status included children whose Indigenous status was unknown or not stated. From 2009-10 onwards, the category unknown Indigenous status is reported separately. ^b See source table for detailed footnotes. ^c The NT figure of 100 per cent of children of 'unknown' Indigenous status in home-based care at 30 June 2010 is for two children who were in care at that time.

Source: AIHW data collection (unpublished); table 15A.21.

Out-of-home care — placement in accordance with the Aboriginal Child Placement Principle

‘Placement in accordance with the Aboriginal Child Placement Principle’ is an indicator of governments’ objective to protect the safety and welfare of Indigenous children while maintaining their cultural ties and identity (box 15.16).

Box 15.16 Placement in accordance with the Aboriginal Child Placement Principle

‘Placement in accordance with the Aboriginal Child Placement Principle’ is defined as the number of Indigenous children placed with the child’s extended family, Indigenous community or other Indigenous people, divided by the total number of Indigenous children in out-of-home care. Data are reported separately for children placed (i) with relative/kin, (ii) with a non-relative Indigenous carer or in Indigenous residential care, and (iii) not placed with relative/kin, a non-relative Indigenous carer or in Indigenous residential care.

A high or increasing proportion of children placed in accordance with the principle is desirable. This indicator needs to be interpreted with care as it is a proxy for compliance with the principle. This indicator reports the placement outcomes of Indigenous children rather than compliance with the principle. The indicator does not reflect whether the hierarchy was followed in the consideration of the best placement for the child, nor whether consultation was had with appropriate Indigenous individuals or organisations.

Placing Indigenous children in circumstances consistent with the Aboriginal Child Placement Principle is considered to be in their best interests. However, it is one factor among many considerations for the child’s safety and wellbeing that must be carefully considered in the placement decision. In the application of this principle, departments consult with and involve appropriate Indigenous individuals and/or organisations. If the preferred options are not available, the child may be placed (after appropriate consultation) with a non-Indigenous family or in a residential setting. The principle does not preclude the possibility that in some instances, placement in a non-Indigenous setting, where arrangements are in place for the child’s cultural identity to be preserved, might be the most appropriate placement for the child.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

According to the Aboriginal Child Placement Principle (NSW Law Reform Commission 1997) the following hierarchy of placement options should be pursued in protecting the safety and welfare of Indigenous children:

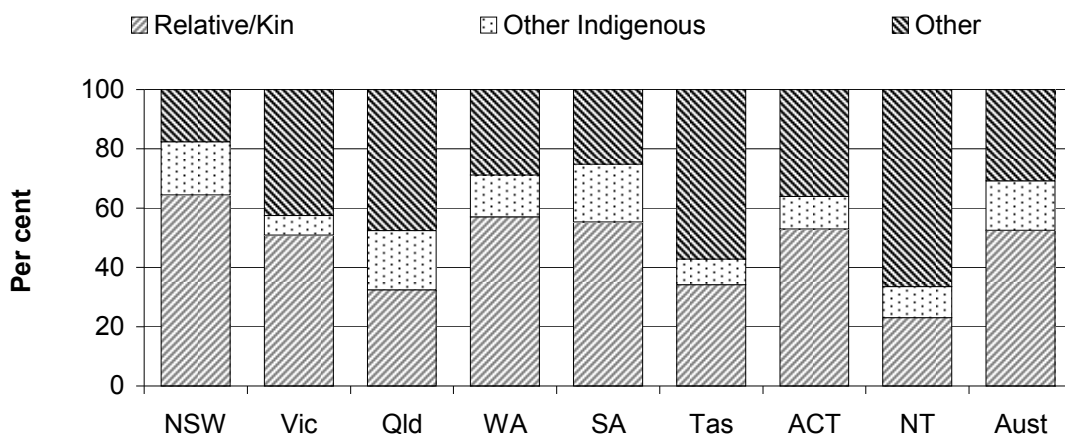
- placement with the child's extended family (which includes Indigenous and non-Indigenous relatives/kin)
- placement within the child's Indigenous community
- placement with other Indigenous people.

All jurisdictions have adopted this principle in both legislation and policy.

Nationally, at 30 June 2011, 52.5 per cent of Indigenous children in out-of-home care were placed with relatives/kin (39.0 per cent with Indigenous relatives/kin and 13.5 per cent with non-Indigenous relatives/kin). A further 16.7 per cent of Indigenous children in out-of-home care were placed with other Indigenous carers or in Indigenous residential care (figure 15.12).

The proportion of Indigenous children in out-of-home care at 30 June 2011 who were placed with Indigenous or non-Indigenous relatives or kin or with another Indigenous carer or in Indigenous residential care varied across jurisdictions (figure 15.12).

Figure 15.12 Placement of Indigenous children in out-of-home care, 30 June 2011^{a, b, c}



Relative/Kin = Placed with relative/kin. Other Indigenous = Placed with other Indigenous carer or Indigenous residential care. Other = Not placed with relative/kin, other Indigenous carer or Indigenous residential care. ^a Excludes Indigenous children living independently and those whose living arrangements were unknown. ^b Data for Tasmania and the ACT relate to a small number of Indigenous children. ^c See source table for detailed footnotes.

Source: AIHW data collection (unpublished); table 15A.22.

Out-of-home care — local placement

‘Local placement’ is an indicator of governments’ objective to provide services which meet the needs of the recipients (box 15.17).

Box 15.17 Local placement

‘Local placement’ is defined as the proportion of children attending the same school that they were attending before entering out-of-home care as after entering out-of-home care.

A high or increasing rate of local placement is desirable.

A placement close to where a child lived prior to entering out-of-home care is considered to enhance the stability, familiarity and security of the child. It enables some elements of the child’s life to remain unchanged (for example, they can continue attending the same school and retain their friendship network). It may also facilitate family contact if the child’s parents continue to live nearby.

This indicator should be balanced against other quality indicators. This is one factor among many that must be considered in the placement decision. For example, placement with a sibling or relative might preclude a local placement. Also, a child might move from a primary school to a secondary school or to a different local school at the same level.

Data will be provided for 3 and 12 months after entering care. Data collection for this indicator is under development. Data were not available for the 2012 Report.

Data quality information for this indicator is under development.

Out-of-home care — placement with sibling

‘Placement with sibling’ is an indicator of governments’ objective to provide services which meet the needs of the recipients (box 15.18).

Box 15.18 Placement with sibling

‘Placement with sibling’ is defined as the proportion of children who are on orders and in out-of-home care at 30 June who have siblings also on orders and in out-of-home care, who are placed with at least one of their siblings.

A high or increasing rate of placement with siblings is desirable. Placement of siblings together promotes stability and continuity. It is a long standing placement principle that siblings should be placed together, where possible, in the interests of their emotional wellbeing. Children are likely to be more secure and have a sense of belonging within their family when placed with siblings.

This is one factor among many that must be considered in the placement decision. In circumstances of sibling abuse, or when a particular child in a family has been singled out as the target for abuse or neglect, keeping siblings together may not be appropriate.

Data collection for this indicator is under development. Data were not available for the 2012 Report.

Data quality information for this indicator is under development.

Out-of-home care — children with documented case plan

‘Children with documented case plan’ is an indicator of governments’ objective to provide services that meet the needs of the recipients (box 15.19).

Box 15.19 Children with documented case plan

‘Children with documented case plan’ is defined as the proportion of children on an order and in out-of-home care who have a documented case plan.

A high or increasing rate is desirable because all children should have a case plan. The quality of a case plan must also be considered as the existence of a case plan does not guarantee that appropriate case work to meet a child’s needs is occurring.

Case planning is essential to structured and purposeful work to support children’s optimal development. Case plans outline intervention goals such as improved parent-child attachments, reunification or other forms of permanency, and set out the means to achieve these goals, such as frequency of family contact and any remedial or special services considered appropriate for the individual child. Case plans also allow for the monitoring of a child’s time in care.

Data collection for this indicator is under development. Data were not available for the 2012 Report.

Data quality information for this indicator is under development.

Out-of-home care — client satisfaction

‘Client satisfaction’ is an indicator of governments’ objective to provide high quality services that meet the needs of recipients (box 15.20).

Box 15.20 Client satisfaction

‘Client satisfaction’ is yet to be defined.

This indicator has been identified for development and reporting in future.

Some information on jurisdictions’ development of initiatives which may assist to measure client satisfaction in the future is included in box 15.8.

Efficiency

Understanding the efficiency of child protection systems broadly — and the different components of child protection systems, such as early intervention and out-of-home care services — enables State and Territory governments to identify key service cost drivers. Efficiency measures coupled with outcome measures ultimately enable State and Territory governments to compare the relative cost effectiveness of broad system approaches and the cost effectiveness of different components of child protection systems.

Challenges in reporting efficiency for child protection systems

Current efficiency data for child protection services have several limitations, including:

- *different systems and priorities across jurisdictions* — child protection systems in Australia have evolved independently under the auspices of State and Territory governments. This has resulted in variations in the processes and emphases placed on different service delivery paradigms, such as different approaches to diversionary options
- *limitations of current information systems* — in most jurisdictions, it is difficult to identify resources directed specifically to 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 government agencies responsible for child protection services within larger community services departments. Table 15A.4 identifies the level of consistency in expenditure data across jurisdictions.

As a result of these limitations, cost allocations reflect the historic nature of information systems and do not necessarily provide an accurate reflection of the costs involved in provision of various child protection and out-of-home care services.

In April 2002, the Review initiated a project to improve efficiency data for a national framework of protection and support pathways (the ‘Pathways’ project) (box 15.21). Until this can be fully implemented, reporting on efficiency has been limited to proxy indicators (boxes 15.22 and 15.24).

Experimental data relating to the proportion of expenditure across each Pathways activity group are included in table 15.2. These data are preliminary and are subject to further analysis and refinement for future Reports. Due to different internal management systems, there can be significant variation across jurisdictions in relation to specific activities or expenditures that are included in each activity group. However, for all jurisdictions, the proportion of expenditure allocated to Activity group 8 (out-of-home care) is the most significant and varies from 42.7 per cent to 70.2 per cent across jurisdictions.

These data reflect a combination of allocation of direct costs (those costs which can be clearly identified by a jurisdiction to a particular activity group) and indirect costs (which form part of the overall expenditure base, but which cannot be identified in a specific activity group). Indirect allocations have been approximated by jurisdictions across the eight activity groups.

Box 15.21 The 'Pathways' project

The Pathways project developed and tested a model that will ultimately allow jurisdictions to calculate more meaningful, comparable and robust efficiency measures (the 'pathways method'). The model is based on a top-down application of the activity-based costing method. Eight national pathways have been developed as a high level representation of the services that a protection and support client could receive in any jurisdiction. Each pathway consists of common activity groups which act as the 'building blocks' for each of the pathways. The aggregate cost of each activity group within the pathway will allow the unit cost (including direct and indirect expenditure) of an individual pathway to be determined.

These activity groups and pathways will provide additional utility for jurisdictions in managing the business of child protection services. Implementation of the model has the potential to improve the quality of national reporting of protection and support services efficiency measures. Activity-based data can also result, over time, in measures of the cost savings associated with early intervention strategies.

The activity groups are:

- Activity Group 1 Receipt and assessment of initial information about a potential protection and support issue.
- Activity Group 2 Provision of generic/non-intensive family support services.
- Activity Group 3 Provision of intensive family support services.
- Activity Group 4 Secondary information gathering and assessment.
- Activity Group 5 Provision of short term protective intervention and coordination services for children not on an order.
- Activity Group 6 Seeking an order.
- Activity Group 7 Provision of protective intervention, support and coordination services for children on an order.
- Activity Group 8 Provision of out-of-home care services.

Detailed definitions of activity groups are included in section 15.13.

Before jurisdictional reporting against the activity groups can be undertaken with confidence, further refinement of activity group definitions and counting rules is required. Development work, including further data testing in these areas will continue.

Source: SCRCSSP (2003).

Table 15.2 Proportion of expenditure by activity group — experimental estimates (per cent), 2010-11^{a, b, c}

	<i>AG1</i>	<i>AG2</i>	<i>AG3</i>	<i>AG4</i>	<i>AG5</i>	<i>AG6</i>	<i>AG7</i>	<i>AG8</i>	<i>Total</i>
NSW	4.0	16.8	11.1	4.6	5.4	5.9	4.8	47.4	100
Vic ^d	3.0	24.0	4.0	5.0	4.0	7.0	8.0	44.0	100
Qld	2.9	4.4	4.1	7.6	4.7	4.5	20.9	50.8	100
WA	3.1	5.0	7.5	3.8	5.4	3.3	12.1	59.8	100
SA	6.8	4.4	2.9	4.0	1.6	1.5	8.5	70.2	100
Tas	8.6	12.4	6.7	5.5	3.6	9.0	11.3	42.7	100
ACT	5.6	6.8	4.0	3.3	2.6	4.2	6.1	67.4	100
NT ^e	12.0	9.3	0.6	18.9	1.7	3.4	0.9	53.1	100

AG = Activity Group (box 15.21). ^a Totals may not add to 100 due to rounding. ^b Experimental percentage allocations are derived from total expenditure allocations which vary from totals used to derive costs presented elsewhere in the chapter. ^c Expenditure items included in calculating proportional expenditure for AG2 can vary across jurisdictions, for example the inclusion/exclusion of expenditure on services outsourced to non-government organisations. ^d Proportions for Victoria were derived on the basis of 2005-06 expenditure. For all other jurisdictions, proportions were derived on the basis of 2010-11 expenditure. ^e Data for the NT should be considered indicative only. The NT Department of Children and Families is reviewing its output splits and working toward providing complete, robust data for the 2011-12 financial year.

Source: State and Territory governments (unpublished).

Table 15.3 presents experimental unit cost data for five activity groups for participating jurisdictions. Unit cost data will be provided for remaining activity groups and for remaining jurisdictions once jurisdictions are able to report appropriate denominators (that is, activity counts).

Table 15.3 Activity group unit costs — experimental data, 2010-11^{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^c</i>
AG1-Cost per notification ^d	\$	596	na	962	1 112	632	568	200	1 660
AG2-Cost per child commencing non-intensive family support services ^e	\$	na	na	na	na	na	na	na	na
AG3-Cost per child commencing intensive family support services	\$	25 925	na	10 148	28 969	11 075	na	8 188	6 932
AG4-Cost per notification investigated ^f	\$	960	na	2 554	2 153	1 352	1 719	829	4 267
AG5-Cost per child commencing protective intervention and coordination services who are not on an order	\$	na	na	na	na	na	na	na	na
AG6-Cost per order issued	\$	17 561	na	4 640	8 548	1 082	5 877	3 208	1 649
AG7-Cost per child commencing protective intervention and coordination services who is on an order	\$	na	na	na	na	na	na	na	na
AG8-Cost per placement night ^g	\$	117	na	138	213	163	90	147	222

AG = Activity Group (box 15.21). ^a Data are rounded to the nearest whole number. ^b Experimental unit costs are based on jurisdictions' total expenditure for each activity group, including direct and indirect costs such as staffing and other overheads. ^c Data for the NT should be considered indicative only. The NT Department of Children and Families is reviewing its output splits and working toward providing complete, robust data for the 2011-12 financial year. ^d Jurisdictions count notifications at different points in 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 and hence the unit cost for notifications are not comparable across jurisdictions. ^e Unit costs for AG 2 will be included once jurisdictions are able to report appropriate denominators. ^f Jurisdictions differ in the way notifications and investigations are defined and the requirements for conducting an investigation. ^g Cost per placement night should be interpreted with caution due to the effect of different proportions of children in residential out-of-home care across jurisdictions. **na** Not available.

Source: State and Territory governments (unpublished).

Total expenditure on all child protection activities per notification, investigation and substantiation

‘Total expenditure on all child protection activities, per notification’, ‘total expenditure on all child protection activities, per investigation’, and ‘total expenditure on all child protection activities, per substantiation’ are reported as proxy indicators of governments’ objective to maximise the benefit to the community through the efficient use of public resources (box 15.22).

Box 15.22 Total expenditure on all child protection activities per notification, investigation and substantiation

‘Total expenditure on all child protection activities per notification, investigation and substantiation’ is defined as:

- total expenditure on all child protection activities divided by the number of notifications
- total expenditure on all child protection activities divided by the number of investigations
- total expenditure on all child protection activities divided by the number of substantiations.

Low or decreasing expenditure per notification/investigation/substantiation can suggest more efficient services but may indicate lower quality or different service delivery models. These indicators are proxy indicators and need to be interpreted with care. Because each of these proxy indicators is based on total expenditure on child protection activities, they do not represent, and cannot be interpreted as, unit costs for notifications, investigations or substantiations. These proxy indicators cannot be added together to determine overall cost of child protection services.

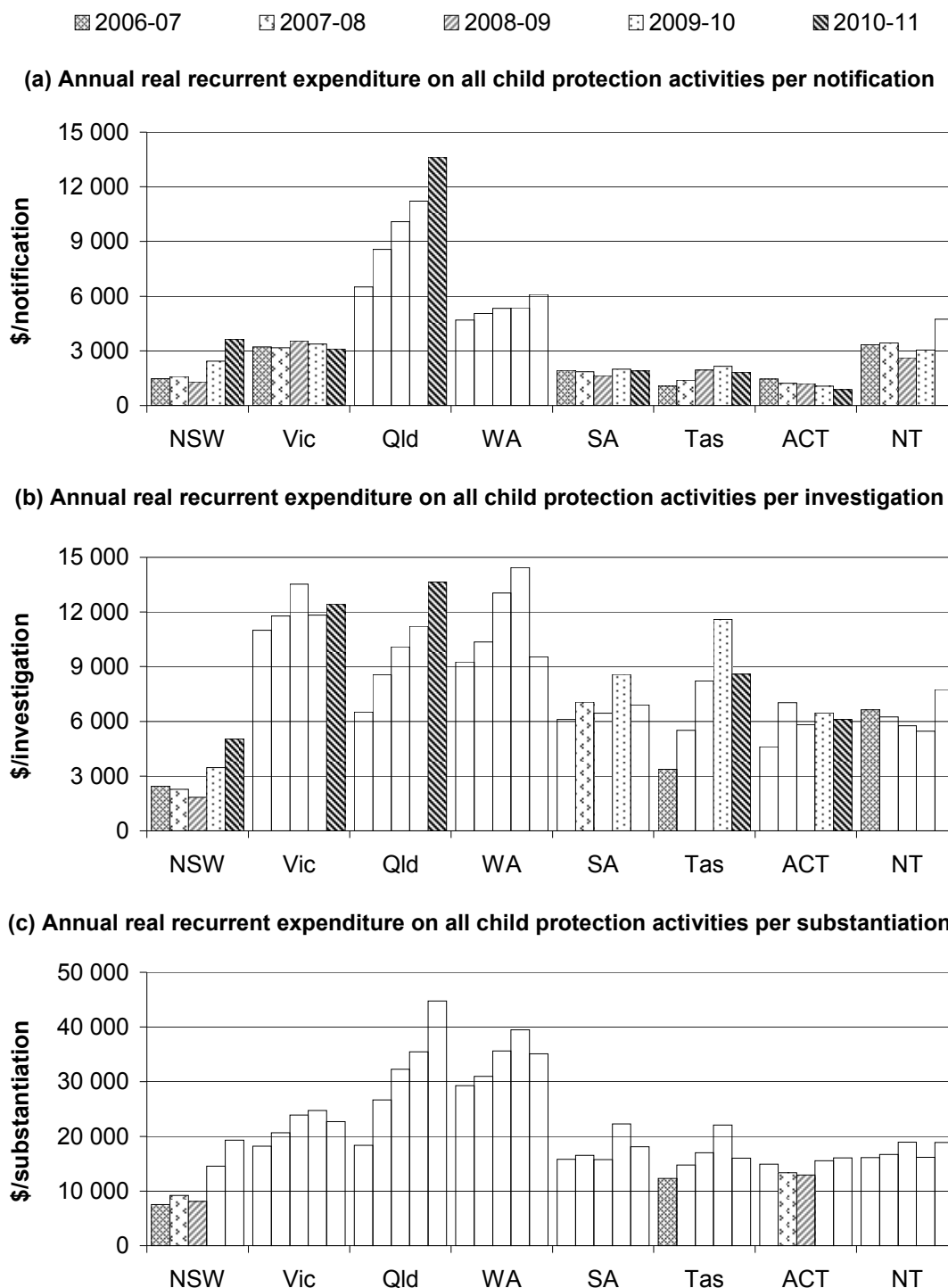
More comprehensive and accurate efficiency indicators would relate expenditure on particular child protection activities to a measure of output of those activities. Work is underway to develop a national activity-based costing method, the Pathways project, that will allow this type of reporting from existing information systems (box 15.21). Experimental data using the Pathways method are included in Table 15.3. The following proxy data will be replaced by Pathways unit cost data once the Pathways method is refined and implemented nationally.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Total expenditure on all child protection activities per notification, per investigation and per substantiation from 2006-07 to 2010-11 varied across jurisdictions (figure 15.13).

Figure 15.13 Child protection efficiency indicators (2010-11 dollars)
a, b, c



a Real expenditure based on ABS gross domestic product price deflator (2010-11 = 100) (table AA.26). **b** See source table for detailed footnotes. **c** In Queensland, all notifications are required to be investigated. As such, the annual real recurrent expenditure on all child protection activities per notification is equivalent to the annual real recurrent expenditure on all child protection activities per investigation.

Source: AIHW data collection (unpublished); State and Territory governments (unpublished); table 15A.2.

Out-of-home care expenditure per placement night

‘Out-of-home care expenditure per placement night’ is an indicator of governments’ objective to maximise the availability and quality of services through the efficient use of public resources (box 15.23).

Box 15.23 Out-of-home care expenditure per placement night

‘Out-of-home care expenditure per placement night’ is defined as total real recurrent expenditure on out-of-home care services divided by the total number of placement nights in out-of-home care.

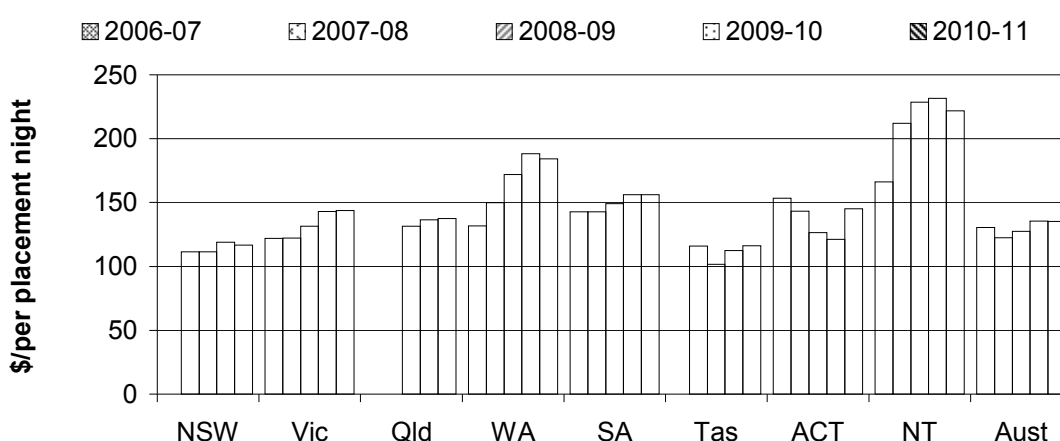
Low or decreasing expenditure per placement night can suggest more efficient services but may indicate lower service quality or different service delivery models. Further, in some cases, efficiencies may not be able to be realised due to remote geographic locations that limit opportunities to reduce overheads through economies of scale.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Out-of-home care expenditure per placement night varied across jurisdictions (figure 15.14).

Figure 15.14 Out-of-home care expenditure per placement night (2010-11 dollars)^{a, b, c}



^a These data should not be interpreted as unit costs for Activity Group 8 as they are derived using reported program expenditure and not activity group expenditure. ^b Caution should be used when interpreting results due to the variety of activities included in out-of-home care services. ^c See source table for detailed footnotes.

Source: AIHW data collection (unpublished); State and Territory governments (unpublished); table 15A.32.

These indicative unit costs are derived using total real recurrent program expenditure on out-of-home care services (table 15A.1) and not expenditure allocated to an activity group.

Total expenditure on all children in residential and non-residential out-of-home care per child in residential and non-residential out-of-home care

‘Total expenditure on all out-of-home care services per child in out-of-home care, by residential and non-residential care’ are reported as proxy indicators of governments’ objective to maximise the benefit to the community through the efficient use of public resources (box 15.24).

Box 15.24 Total expenditure on children in residential and non-residential out-of-home care per child in residential and non-residential out-of-home care

Total expenditure on children in residential and non-residential out-of-home care per child in residential and non-residential out-of-home care is defined as:

- total expenditure on residential out-of-home care divided by the number of children in residential out-of-home care at 30 June
- total expenditure on non-residential out-of-home care divided by the number of children in non-residential out-of-home care at 30 June
- total expenditure on all out-of-home care divided by the number of children in all out-of-home care at 30 June.

Low or decreasing expenditure per child in care can suggest more efficient services but may indicate lower quality or different service delivery models. These indicators are proxy indicators and need to be interpreted with care as they do not represent a measure of unit costs. 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.

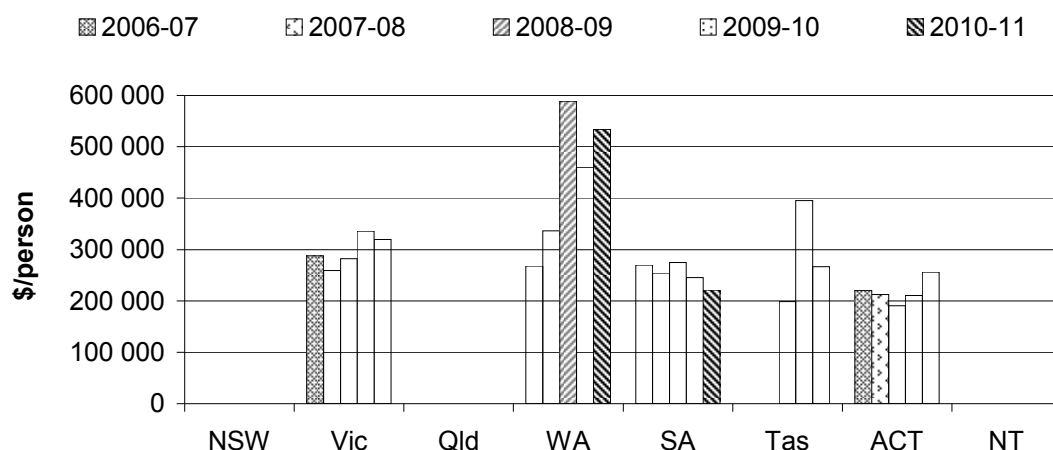
Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

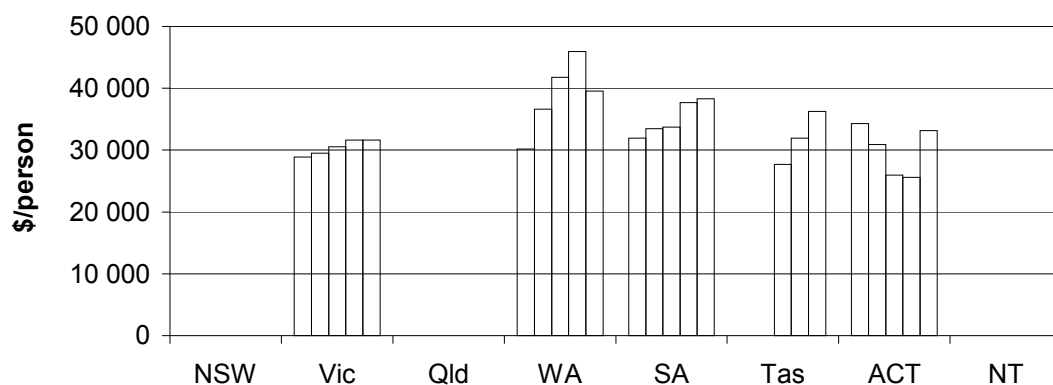
Total expenditure on residential care and non-residential care for the period 2006-07 to 2010-11, per child in residential care and non-residential care at 30 June, varied across jurisdictions (figures 15.15(a) and figure 15.15(b)). Total expenditure on all out-of-home care per child in care at 30 June for 2006-07 to 2010-11 also varied across jurisdictions (figure 15.15(c)).

Figure 15.15 Out-of-home care efficiency indicators (2010-11 dollars)
a, b, c

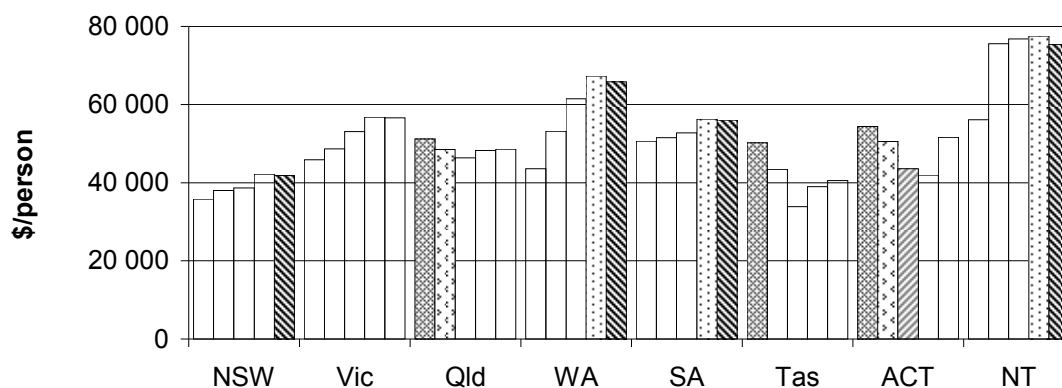
(a) Annual real recurrent expenditure on residential out-of-home care per child in residential out-of-home care at 30 June



(b) Annual real expenditure on non-residential out-of-home care per child in non-residential out-of-home care at 30 June



(c) Annual real expenditure on all out-of-home care per child in out-of-home care at 30 June



^a Real expenditure based on ABS gross domestic product price deflator (2010-11 = 100) (table AA.26).

^b NSW, Queensland, and the NT could not disaggregate expenditure on out-of-home care. Tasmania could only disaggregate these data from 2008-09 onwards. ^c See source table for detailed footnotes.

Source: AIHW data collection (unpublished); State and Territory governments (unpublished); table 15A.3.

Outcomes

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

Improved safety — substantiation rate after decision not to substantiate

‘Improved safety’ is an indicator of governments’ objective to reduce the risk of harm to children by appropriately assessing notifications of possible child protection incidents (box 15.25).

Box 15.25 Improved safety

‘Improved safety’ comprises two measures:

- substantiation rate after decision not to substantiate (figure 15.16)
- substantiation rate after a prior substantiation (figure 15.17).

The measure ‘Substantiation rate after decision not to substantiate’ is defined as the proportion of children who were the subject of an investigation in the previous financial year that led to a decision not to substantiate, and who were later the subject of a substantiation within 3 or 12 months of the initial decision not to substantiate. The year reported relates to the year of the initial decision not to substantiate.

A low or decreasing rate for this indicator is desirable. However, reported results can be affected by the finalisation of investigations, factors beyond the control of child protection services, or a change in circumstances after the initial decision not to substantiate was made. A demonstrable risk of harm might not have existed in the first instance. In addition, this indicator does not distinguish between subsequent substantiations which are related to the initial notification (that is, the same source of risk of harm) and those which are unrelated to the initial notification (that is, a different source of risk of harm). This indicator partly reveals the extent to which an investigation has not succeeded in identifying the risk of harm to a child who is subsequently the subject of substantiated harm. It also provides a measure of the adequacy of interventions offered to children to protect them from further harm. This indicator should be considered with other outcome indicators.

(Continued on next page)

Box 15.25 (Continued)

The measure 'Resubstantiation rate after a prior substantiation' 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 3 or 12 months. The year reported relates to the year of the original substantiation.

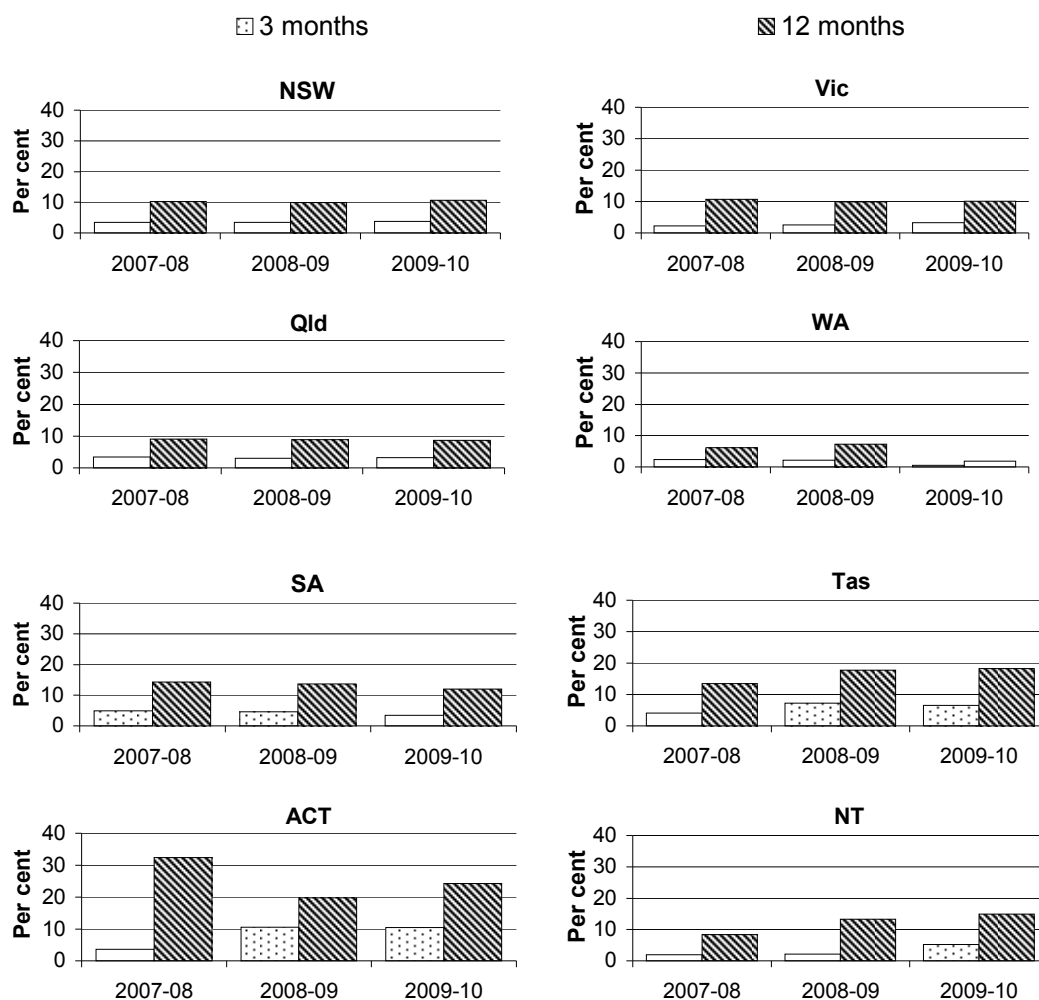
A low or decreasing rate for this indicator is desirable. This indicator partly reveals the extent to which intervention by child protection services has succeeded in preventing further harm. However, reported results can be affected by the finalisation of investigations or factors beyond the control of child protection services, such as changes in the family situation (for example, illness, unemployment or a new partner). In addition, this indicator does not distinguish between subsequent substantiations that are related to the initial notification (that is, the same source of risk of harm) and those that are unrelated to the initial notification (that is, a different source of risk of harm). This indicator should be considered with other outcome indicators.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.16).

Figure 15.16 Improved safety — substantiation rate within 3 and/or 12 months after a decision not to substantiate^{a, b}

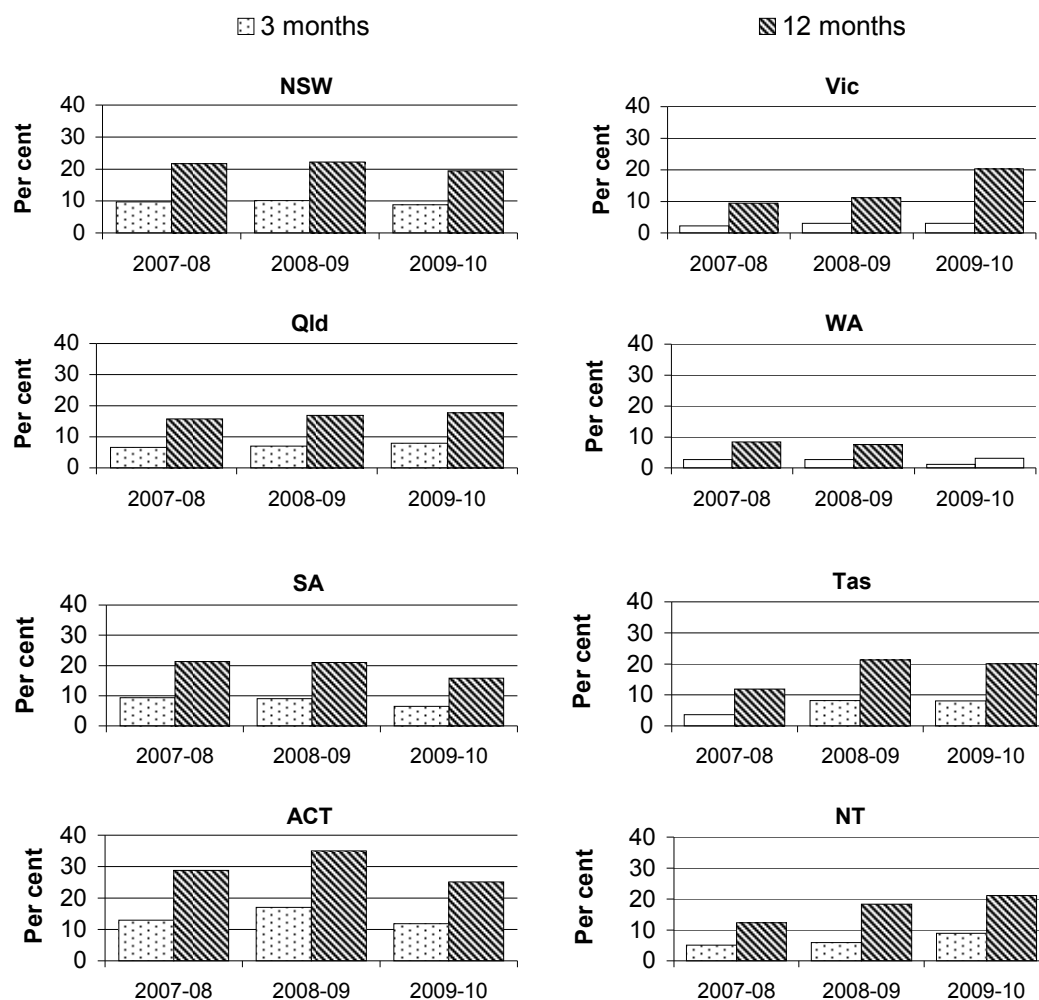


^a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. ^b See source tables for detailed footnotes.

Source: AIHW data collection (unpublished); tables 15A.9, 15A.37, 15A.54, 15A.71, 15A.88, 15A.105, 15A.122, 15A.139 and 15A.156.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.17).

Figure 15.17 **Improved safety — resubstantiation rate within 3 or 12 months of a prior 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 See source table for detailed footnotes.

^c Victorian data for 2009-10 are likely to overstate the true resubstantiation rate due to an information processing error. This issue will be reviewed in 2012 and data revisions included in the 2013 Report.

Source: AIHW data collection (unpublished); tables 15A.10, 15A.38, 15A.55, 15A.72, 15A.89, 15A.106, 15A.123, 15A.140 and 15A.157.

Improved education, health and wellbeing of the child

‘Improved education, health and wellbeing of the child’ is an indicator of governments’ objective to maximise children’s life chances by ensuring children in care have their educational, health and wellbeing needs met (box 15.26).

Box 15.26 Improved education, health and wellbeing of the child

‘Improved education, health and wellbeing of the child’ is defined as the change over time in the learning outcomes of children on guardianship or custody orders.

A high or increasing rate at which children’s educational outcomes are improving is desirable.

Factors outside the control of protection and support services can also influence the educational outcomes of children on guardianship or custody orders, and care needs to be exercised when interpreting results. Further, the change over time in the learning outcomes for children on guardianship or custody orders is a partial measure of this outcome indicator.

Data reported for this indicator are not complete.

Data quality information for this indicator is under development.

Tables 15A.11 to 15A.13 provide data on the proportion of children in years 3, 5 and 7 on guardianship or custody orders (attending government schools) achieving national reading and numeracy benchmarks in 2003, 2004, 2005 and 2006 relative to all children (attending government and non-government schools). These data are sourced from a pilot study conducted by the AIHW. Data are not available for all jurisdictions.

The proportion of children on guardianship or custody orders achieving national reading and numeracy benchmarks in 2003, 2004, 2005 and 2006 varied significantly across jurisdictions. However, with few exceptions, the proportion of children on orders achieving national reading and numeracy benchmarks was less — at times significantly less — than all students.

Safe return home

‘Safe return home’ is an indicator of governments’ objective to remove the risk of harm to the child while maintaining family cohesion (box 15.27).

Box 15.27 Safe return home

‘Safe return home’ is yet to be defined.

For children who cannot be protected within their family and are removed from home, often the best outcome is when effective intervention to improve their parents’ skills or capacity to care for them enables them to return home.

This indicator has been identified for development and reporting in future.

Permanent care

‘Permanent care’ is an indicator of governments’ objective to provide appropriate care for children who cannot be safely reunified with their families (box 15.28).

Box 15.28 Permanent care

‘Permanent care’ is yet to be defined.

Appropriate services are those that minimise the length of time before stable, permanent placement is achieved.

This indicator has been identified for development and reporting in future.

15.4 Future directions in child protection and out-of-home care services performance reporting

Improving national child protection data

The Performance and Data Working Group has initiated a number of national projects to improve the gaps in child protection reporting and to monitor the comparability of child protection data. Such projects, approved by the National Community Services Information Management Group (NCSIMG) and funded by the Community and Disability Services Ministerial Council (CDSMC), include: Educational Outcomes for Children on Orders; Scoping of a Treatment and Support Services data collection; and the development of a unit-record based Carer data module. It is expected that these projects, along with the development of a child based unit-record data collection, will improve child protection reporting.

COAG developments

National framework for protecting Australia’s children 2009—2020

On 30 April 2009, COAG endorsed *Protecting Children is Everyone’s Business: National Framework for Protecting Australia’s Children 2009-2020* (“the National Framework”). The National Framework argues that Australia needs to move from seeing ‘protecting children’ as a response to abuse and neglect to one of promoting the safety and wellbeing of children. The National Framework is intended to deliver a more integrated response to protecting Australia’s children and emphasises the role of government, the non-government sector, and the community in promoting

the safety and wellbeing of children. The National Framework's main goal is to ensure that Australia's children and young people are safe and well. As such, the National Framework contains a broad suite of indicators ("indicators of change"), which will be reported on annually in order to measure progress over the life of the National Framework (2009–2020).

The Report's child protection and out-of-home care performance indicator framework already includes and reports upon several National Framework performance indicators. In addition, the Steering Committee has previously identified developments for the Report's child protection and out-of-home care performance indicator framework which are complementary to many of the measures in the National Framework. In further developing the Report's child protection and out-of-home care performance indicator framework, the Steering Committee will reflect and report consistently with applicable National Framework developments.

National standards for out-of-home care

Under the National Framework, Australian governments have committed to implementing National Standards for Out-of-Home Care ("the National Standards"). The National Standards relate to areas impacting on the outcomes and experiences of children in out-of-home care, including health, education, case planning, connection to family, transitioning from care, training and support for carers, belonging and identity, and stability and safety. The Steering Committee will keep a watching brief on the development of performance indicators pursuant to the National Standards, particularly insofar as identifying ways in which the Report's child protection and out-of-home care performance indicator framework can reflect and report consistently with the National Standards.

Outcomes from review of Report on Government Services

The COAG endorsed recommendations (December 2009) of the review of the RoGS implemented during 2010 and 2011 are reflected in this Report. Further recommendations will be reflected in future reports.

15.5 Profile of juvenile justice services

Service overview

Juvenile justice systems are responsible for attending to young people (predominantly aged 10–17 years) who have committed or allegedly committed an offence while considered by law to be a juvenile. In so doing, juvenile justice systems aim to promote community safety and reduce youth offending by assisting young people to address their offending behaviour and take responsibility for the effect their behaviour has on victims and the wider community.

The juvenile justice system in each State and Territory comprises:

- police, who are usually a young person's first point of contact with the system, and are typically responsible for administering the options available for diverting young people from further involvement in the juvenile justice system
- courts (usually a special children's or youth court), where matters relating to the charges against young people are heard. The courts are largely responsible for decisions regarding bail, remand and sentencing
- statutory juvenile justice agencies, which are responsible for the supervision and case management of young people on a range of legal and administrative orders, and for the provision of a wide range of services intended to reduce and prevent crime
- non-government and community service providers who may work with juvenile justice agencies to provide services and programs for young people under supervision.

The majority of young people who come into contact with the juvenile justice system do not become clients of statutory juvenile justice agencies. Instead, young people are diverted through a range of mechanisms including contact with police (who have the authority to issue warnings, formal cautions and infringement notices for minor offences) and the courts (which can issue non-supervised orders for minor offences).

This chapter reports on services provided by statutory juvenile justice agencies that are responsible for the supervision and case management of young people who have committed or allegedly committed an offence.

Most of the juvenile justice information contained in the 'size and scope' section of this chapter is sourced from the Juvenile Justice National Minimum Data Set (JJ NMDS), which is maintained by the Australian Institute of Health and Welfare (AIHW). Remaining information is sourced directly from State and Territory

governments. The performance indicator data contained in section 15.6 are sourced directly from State and Territory governments (box 15.30).

Roles and responsibilities

Responsibility for the provision of juvenile justice services in Australia resides with State and Territory governments. The relevant department in each State and Territory responsible for funding and/or providing juvenile justice services in 2010-11 is listed in box 15.29. Each jurisdiction has its own legislation that determines the policies and practices of its juvenile justice system. While this legislation varies in detail, its intent is similar across jurisdictions. The Australasian Juvenile Justice Administrators (AJJA) is responsible for national coordination of juvenile justice services and is a Standing Committee of the Community and Disability Services Ministerial Advisory Council (CDSMAC).

Box 15.29 Government departments responsible for the delivery of juvenile justice services	
NSW	Department of Attorney General and Justice
Vic	Department of Human Services
Qld	Department of Communities
WA	Department of Corrective Services
SA	Department for Communities and Social Inclusion
Tas	Department of Health and Human Services
ACT	Community Services Directorate
NT	Department of Justice and Department of Children and Families

Diversion of young offenders

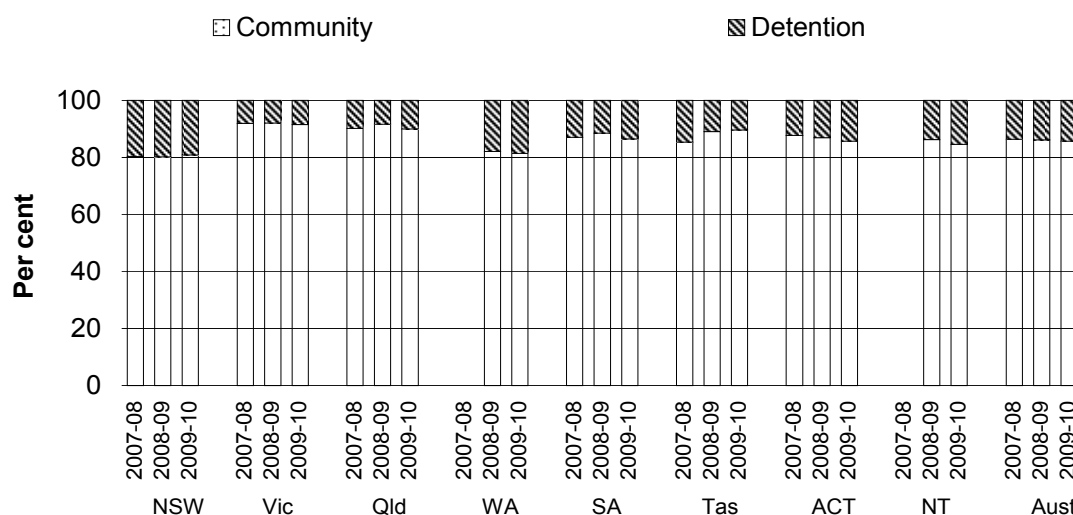
In all jurisdictions, police have responsibility for administering options for diverting young people who have committed (or allegedly committed) relatively minor offences from further involvement in the juvenile justice system. Diversionary options include warnings (informal cautions), formal cautions, and infringement notices. Responsibility for administering the diversionary processes available for more serious offences lies with juvenile justice authorities and courts. Comparable and extensive national data are not yet available to illustrate the nature or level of diversion undertaken by Australian jurisdictions. However, Police services (chapter 6) provides data on the number of juveniles who are diverted by police, as a proportion of all juvenile offenders formally dealt with by police (table 6.2).

Size and scope

Clients of juvenile justice agencies

Most young people who are supervised by juvenile justice agencies are on community-based orders, which include supervised bail, probation and parole. During 2009-10, 15 090 young people experienced juvenile justice supervision in Australia (AIHW 2011). Nationally, 85.7 per cent of young people aged 10–17 years who were supervised by juvenile justice services on an average day during 2009-10 were in the community (figure 15.18). These data do not include juveniles aged 10–17 years who were supervised in the adult correctional system.

Figure 15.18 Daily average proportion of juvenile justice clients aged 10–17 years supervised in the community and in detention centres^{a, b, c}



^a Data for 2007-08 were not available for WA or the NT. ^b In Tasmania, there are regional inconsistencies in the recording of some community supervision orders, which may result in a slight over-count of young people supervised in the community in 2009-10. ^c Refer to table 15A.169 for detailed footnotes.

Source: AIHW 2011, *Juvenile justice in Australia 2009–10*, Juvenile justice series no. 8, Cat. no. JUV 8. Canberra: AIHW; WA and NT governments (unpublished); table 15A.169.

Juvenile detention

Nationally, the daily average number of young people aged 10–17 years in juvenile detention centres increased from 829 to 875 between 2008-09 and 2009-10 (table 15.4).

Table 15.4 Daily average population of young people aged 10–17 years in juvenile detention (number)^{a, b, c, d}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2009-10	371	86	133	156	58	27	15	29	875
2008-09	382	73	112	137	55	28	14	27	829
2007-08	343	68	144	na	59	29	18	na	661
2006-07	289	53	135	na	49	29	15	na	570

^a Data for 2006-07 and 2007-08 were not available for WA or the NT. ^b In Tasmania, there are regional inconsistencies in the recording of some community supervision orders, which may result in a slight over-count of young people supervised in the community in 2009-10. ^c Due to rounding, the Australian total may differ from the combined total of all jurisdictions. ^d Refer to table 15A.169 for detailed footnotes. **na** Not available.

Source: AIHW 2011, *Juvenile justice in Australia 2009–10*, Juvenile justice series no. 8, Cat. no. JUV 8. Canberra: AIHW; WA and NT governments (unpublished); table 15A.169.

The daily average rate of detention of young people aged 10–17 years per 100 000 in the population aged 10–17 years increased from 36.4 per 100 000 in 2008-09 to 38.3 per 100 000 in 2009-10, with rates varying across jurisdictions (table 15A.169).

Nationally, on an average day, females comprised 8.4 per cent of the total population of juvenile detention centres during 2009-10, while males comprised 91.5 per cent of the juvenile detention population (table 15A.172).

Community-based supervision

As outlined above, the majority of juvenile offenders are supervised in the community. Nationally, the daily average number of young people aged 10–17 years supervised in the community increased from 5172 to 5242 between 2008-09 and 2009-10 (table 15.5).

Table 15.5 Daily average population of young people aged 10–17 years supervised in the community (number)^{a, b, c}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2009-10	1567	934	1201	685	372	235	90	157	5242
2008-09	1543	845	1238	629	424	228	93	172	5172
2007-08	1398	777	1320	na	398	169	129	na	4192
2006-07	1232	696	1276	na	360	167	103	na	3835

^a Data for 2006-07 and 2007-08 were not available for WA or the NT. ^b Due to rounding, the Australian total may differ from the combined total of all jurisdictions. ^c Refer to table 15A.169 for detailed footnotes. **na** Not available.

Source: AIHW 2011, *Juvenile justice in Australia 2009–10*, Juvenile justice series no. 8, Cat. no. JUV 8. Canberra: AIHW; WA and NT governments (unpublished); table 15A.169.

The daily average rate of young people aged 10–17 years supervised in the community per 100 000 in the population aged 10–17 years increased from 226.9 per 100 000 in 2008-09 to 229.3 per 100 000 in 2009-10, with rates varying across jurisdictions (table 15A.169).

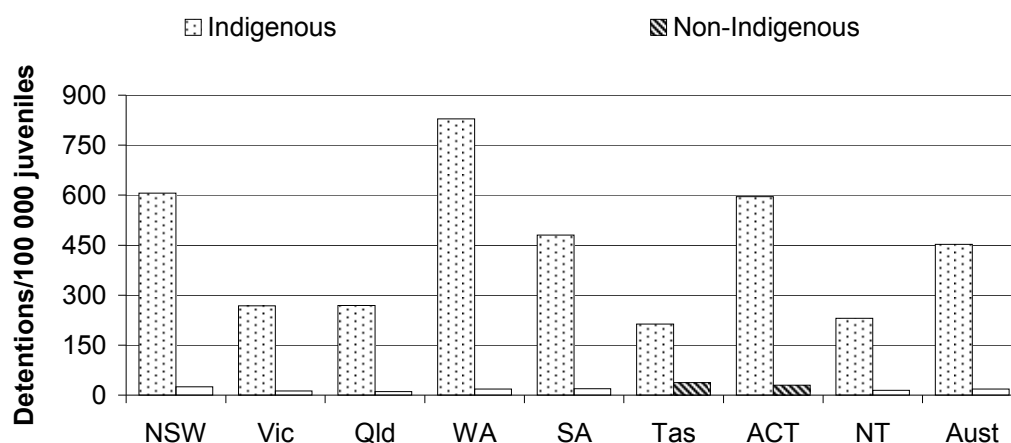
Nationally, on an average day, females comprised 17.9 per cent of the total population of young people supervised in the community during 2009-10, while males comprised 82.0 per cent (table 15A.173).

Numbers and rates of Indigenous young people subject to juvenile justice supervision

The daily average number of Indigenous young people aged 10–17 years detained in juvenile detention centres was 468 in 2009-10 (table 15A.174). Nationally, the daily average detention rate for Indigenous young people aged 10–17 years in 2009-10 was 452.6 per 100 000 Indigenous young people aged 10–17 years. The number and rate for non-Indigenous young people aged 10–17 years in 2009-10 was 398 and 18.2 per 100 000 young people respectively (table 15A.174). The over-representation of Indigenous young people in detention across jurisdictions in 2009-10 is shown in figure 15.19.

In 2011, the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs released the report *Doing Time — Time for Doing: Indigenous youth in the criminal justice system*, which highlighted that although 20 years have passed since the *Royal Commission into Aboriginal Deaths in Custody Report* (Commonwealth of Australia 1991), the incarceration rate of Indigenous Australians, including Indigenous youth, has worsened (Commonwealth of Australia 2011). Indigenous young people are far more likely to come into contact with the criminal justice system and to be incarcerated than non-Indigenous young people, despite Indigenous people representing approximately 2.5 per cent of the Australian population.

Figure 15.19 Average daily rate of detention of Indigenous and non-Indigenous young people aged 10–17 years, per 100 000 young people aged 10–17 years, 2009–10^{a, b, c}

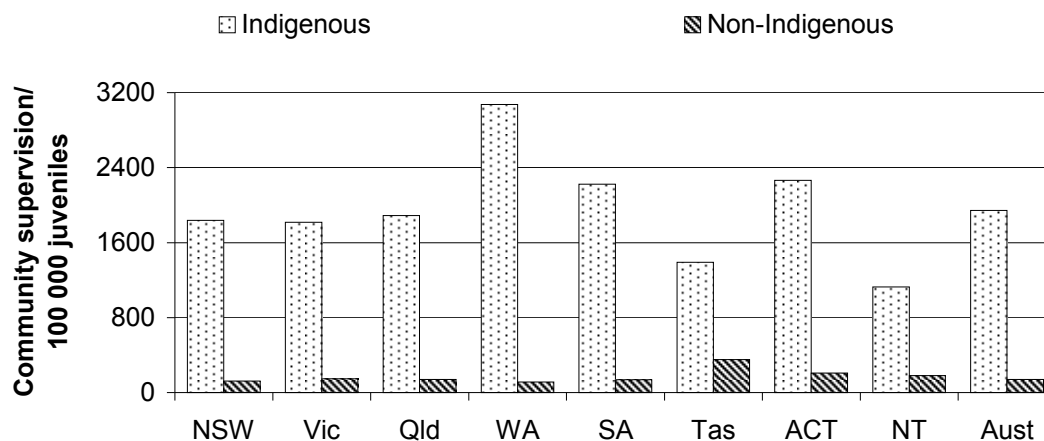


^a Refer to table 15A.174 for detailed footnotes. ^b The ACT rate for Indigenous young people should be treated with caution due to the small Indigenous population in the ACT. ^c The Indigenous and non-Indigenous rate ratio in table 15A.176 should also be taken into account.

Source: AIHW 2011, *Juvenile justice in Australia 2009–10*, Juvenile justice series no. 8, Cat. no. JUV 8, Canberra: AIHW; WA and NT governments (unpublished); table 15A.174.

Indigenous young people are also over-represented in community-based supervision (figure 15.20). The daily average number of Indigenous young people aged 10–17 years supervised in the community was 2011 in 2009–10 (table 15A.175). Nationally, the daily average rate of Indigenous young people aged 10–17 years subject to community-based supervision in 2009–10 was 1943.8 per 100 000 Indigenous young people aged 10–17 years. The number and rate for non-Indigenous young people aged 10–17 years in 2009–10 was 3044 and 139.5 per 100 000 young people respectively (table 15A.175).

Figure 15.20 **Average daily rate of Indigenous and non-Indigenous young people aged 10–17 years subject to community supervision, per 100 000 young people aged 10-17 years, 2009-10^{a, b}**



^a Refer to table 15A.175 for detailed footnotes. ^b In Tasmania, there are regional inconsistencies in the recording of some community supervision orders, which may result in a slight over-count of young people supervised in the community in 2009-10.

Source: AIHW 2011, *Juvenile justice in Australia 2009–10*, Juvenile justice series no. 8, Cat. no. JUV 8, Canberra: AIHW; WA and NT governments (unpublished); table 15A.175.

15.6 Framework of performance indicators for juvenile justice services

The performance indicator framework for juvenile justice services is based on a set of shared government objectives (box 15.30).

Box 15.30 Objectives for juvenile justice services

Juvenile justice services aim to contribute to a reduction in the frequency and severity of youth offending, recognise the rights of victims and promote community safety. Juvenile justice services seek to achieve these aims by:

- assisting young people to address their offending behaviour and take responsibility for the effect their behaviour has on victims and the wider community
- enabling the interests and views of victims to be heard
- contributing to the diversion of young offenders to alternative services
- recognising the importance of the families and communities of young offenders, particularly Indigenous communities, in the provision of services and programs
- providing services that are designed to rehabilitate young offenders and reintegrate them into their community.

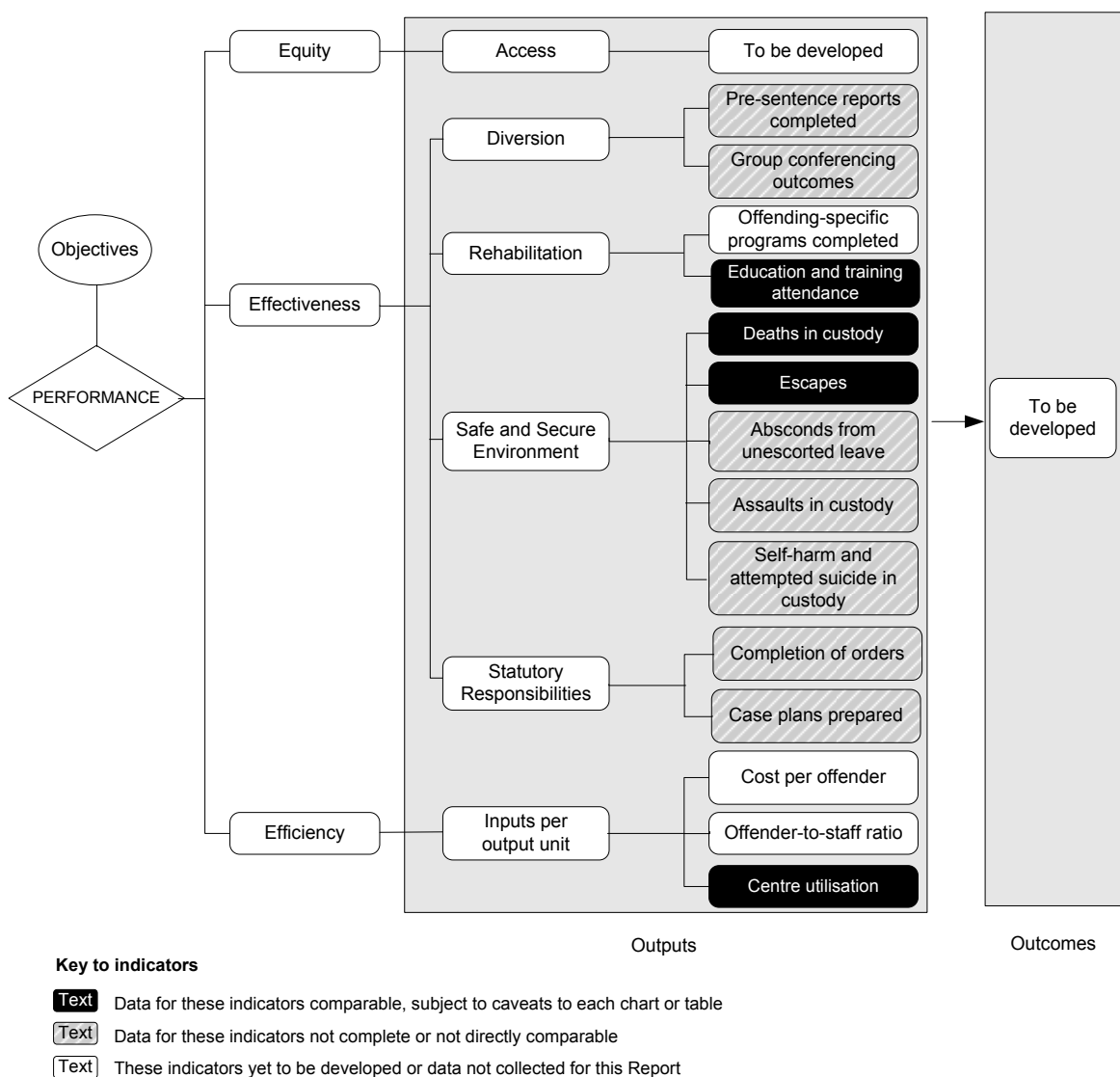
Juvenile justice services should be provided in an equitable, efficient and effective manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of juvenile justice services (figure 15.21). The performance indicator framework shows which data are comparable in the 2012 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).

Further development of the framework and reporting for indicators included in the framework is being undertaken according to a staged process. Data for 11 performance indicators are included in this Report. The remaining performance indicators in the juvenile justice performance indicator framework, and additional efficiency and outcome indicators, will be developed for inclusion in future Reports.

The Report's statistical appendix 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) (appendix A).

Figure 15.21 **Juvenile justice services performance indicator framework**



Outputs

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

Equity and access

Equity and access indicators are a key area for further development in future reports. These will be indicators of governments' objective to ensure that all clients have fair and equitable access to services on the basis of relative need and available resources. These indicators are under development.

Effectiveness

Diversion — pre-sentence reports completed

‘Pre-sentence reports completed’ is an indicator of governments’ objective to ensure that accurate and timely advice is provided to a court to inform decision-making (box 15.31).

Box 15.31 Pre-sentence reports completed

‘Pre-sentence reports completed’ is defined as the number of written reports provided by juvenile justice agencies to a court in response to a request for a pre-sentence report, as a proportion of all court requests to juvenile justice agencies for written pre-sentence reports. A pre-sentence report is a written report that provides a court with pertinent information about the assessed factors that contributed to a young person’s offence and explores programs and services that could be provided to address a young person’s offending behaviour. A pre-sentence report is prepared when ordered by a court after a young person has pleaded or has been found guilty of an offence.

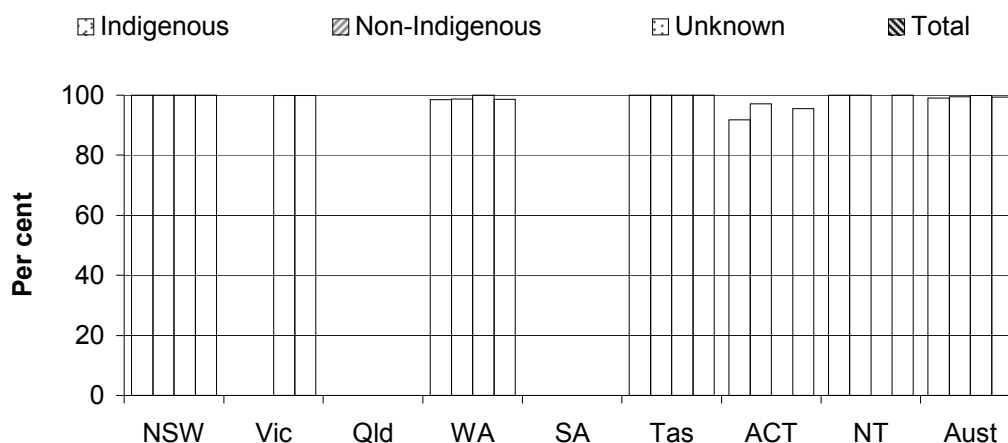
A high or increasing percentage of pre-sentence reports completed is desirable.

Data reported for this indicator are comparable but not complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

The percentage of pre-sentence reports completed varied across jurisdictions (figure 15.22). Nationally, in 2010-11, 99.4 per cent of all court requests for pre-sentence reports were completed.

Figure 15.22 **Proportion of pre-sentence reports completed by juvenile justice agencies, by Indigenous status (2010-11)^{a, b, c, d, e}**



^a Data for Victoria were unable to be disaggregated by Indigenous status. ^b Queensland could not provide the denominator for this indicator, hence proportions could not be calculated. ^c Data were not available for SA. ^d The proportion of pre-sentence reports completed by juvenile justice agencies in Tasmania includes some cases where the report was not provided by the initial request and the court extended the required date of the report. ^e Refer to table 15A.178 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.178.

Diversion — group conferencing outcomes

‘Group conferencing outcomes’ is an indicator of governments’ objective to divert young people from the juvenile justice system and address their offending needs (box 15.32).

Box 15.32 Group conferencing outcomes

'Group conferencing outcomes' is defined as the number of young people who receive group conferencing and who as a result reach an agreement, as a proportion of all young people who receive group conferencing. Typically, a group conference involves the young offender and victim (or victims) and their families, police, and a juvenile justice agency officer, all of whom attempt to agree on a course of action required of the young offender to make amends for his or her offence. Group conferences are decision-making forums that aim to minimise the progression of young people into the juvenile justice system, and provide restorative justice.

Data for this indicator should be interpreted with caution as the provision of group conferencing differs across jurisdictions in relation to: (a) its place in the court process (for example, whether young people are referred by police before court processes begin, or by the court as an alternative to sentencing), (b) the consequences for young people if they do not comply with the outcome plans of a conference, and (c) eligibility.

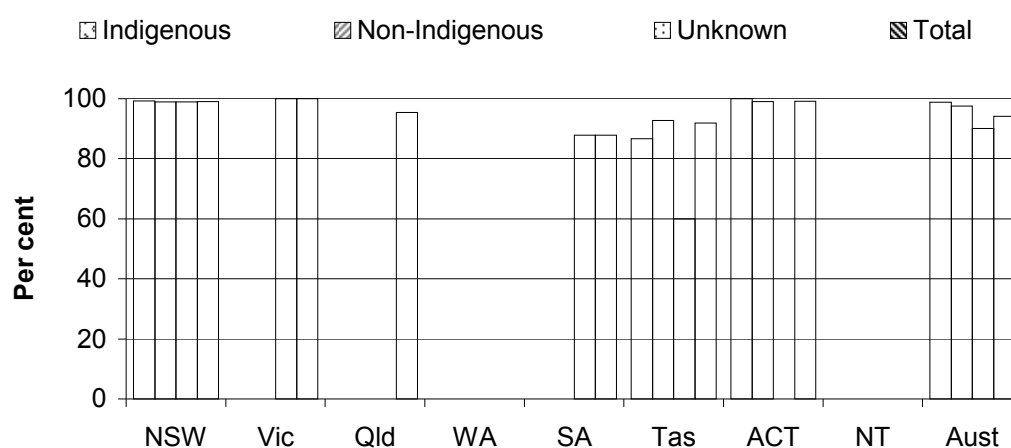
A high or increasing rate for this indicator is desirable.

Data reported for this indicator are not complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, 94.2 per cent of all concluded group conferences resulted in an agreement, with proportions varying across jurisdictions (figure 15.23).

Figure 15.23 **Proportion of group conferences resulting in an agreement, by Indigenous status (2010-11)^{a, b, c}**



^a Data were not available for WA or the NT. ^b Queensland was able to disaggregate the number of concluded group conferences by Indigenous status, but not the number of group conferences resulting in an agreement by Indigenous status. Therefore, for Queensland, proportions are calculated only for the total number of group conferences resulting in agreement. Further, with the exception of the total number of concluded group conferences and total number of group conferences resulting in agreement, disaggregated data for Queensland are excluded from national totals. ^c Refer to table 15A.179 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.179.

Rehabilitation — offending-specific programs completed

‘Offending-specific programs completed’ is an indicator of governments’ objective to provide program interventions that are designed to rehabilitate young offenders and reintegrate them into their community (for example, the Changing Habits and Reaching Targets program, drug counselling programs and sex offender treatment programs) (box 15.33).

Box 15.33 Offending-specific programs completed

‘Offending-specific programs completed’ is defined as the percentage of young people who completed an offending-specific program while completing a supervised sentenced order (whether a community-based order or a detention order) as a proportion of all young people completing a supervised sentenced order who were assessed as requiring an offending-specific program to address their criminogenic behaviour.

A high or increasing rate of offending-specific programs completed is desirable.

Data for this indicator were not available for the 2012 Report. Offending-specific programs data are expected to be available for inclusion in the 2013 Report.

Data quality information for this indicator is under development.

Box 15.34 provides information regarding offending-specific programs in operation in each jurisdiction.

Box 15.34 Offending-specific programs

NSW

The Violence Offender Program (VOP) addresses the criminogenic needs of violent offenders, thereby reducing their offending behaviours, contact with the justice system and rates of recidivism. The Sexual Offending Program (SOP) provides comprehensive, individualised assessment for adolescents convicted of offences of a sexual nature, as well as individual and group interventions. The Alcohol and Other Drug (AOD) Program aims to address the needs of clients whose pattern of alcohol and other drug use is related to their offending behaviour. The Intensive Supervision Program (ISP) focuses on juveniles who commit serious and/or repeat offences, or whose severe antisocial behaviour increases their likelihood of offending. ISP is based on the Multisystemic Therapy Model that has delivered significant reductions in the long-term rates of re-offending in WA, New Zealand, the United States, Canada and nine countries throughout Europe. 'Dthina Yuwali' is an Aboriginal-specific staged AOD program based on the relationship between substance use and pathways to offending.

Vic

Victoria offers a range of offending-specific programs in conjunction with a comprehensive individualised case planning framework (including assessment and client service planning). 'Changing Habits and Reaching Targets' (CHART) is a structured intervention program which challenges offending behaviour. CHART is used as part of casework intervention with individuals or in small groups. The 'Male Adolescent Program for Positive Sexuality' is an intensive individual, group and family treatment program for young people found guilty of sexual offences. The 'Be Real About Violence' and 'Relationships and Violence' programs address violent offending and related behaviours by increasing offenders' understanding of patterns of violence and their pro-social coping skills. The 'Motor Vehicle Offending Program' is provided in conjunction with the Transport Accident Commission and Road Trauma Support Unit. It addresses specific behaviours related to motor vehicle offences. Better Outcomes Result in Valuable Outcomes (BRAVO) is a behaviour change program developed in consultation with the community service organisations selected to provide the Youth Support Service focused on knife crime or knife related behaviours. BRAVO is a strength based program consisting of six modules covering motivational interviewing, education, young people and the law, personal development, goal setting, goal planning, revisit and review.

(Continued on next page)

Box 15.34 (Continued)

- Qld** In the Queensland youth justice system, a young person's risk, needs and protective factors are assessed using the Youth Level of Service Case Management Inventory (YLS-CMI) to determine both suitability for programs and outcome efficacy. Queensland has implemented two State-wide programs in regional service centres and in youth detention that address offending behaviour — Changing Habits and Reaching Targets (CHART) and Aggression Replacement Training (ART). Both programs are informed by a sound evidence base and are being evaluated. Additionally, Queensland's two youth detention centres and 16 youth justice service centres develop tailored offending-specific programs that align with the Queensland Youth Justice Intervention Framework. This framework details an evidence-based process for the development, implementation and evaluation of programs. To ensure the provision of holistic and effective responses to young offenders, the framework encompasses the delivery of offence-focussed and developmental interventions and support services alongside the supervision of court orders.
- WA** WA offers a range of offending-specific programs to address the needs of young offenders. Programs are run on an as needs basis according to suitability criteria for specific programs. Examples of the offending-specific programs provided in WA include: 'Healthy Relationships', which explores adolescent relationships and issues such as sexism, stereotypes and consent; 'Protective Behaviours', which examines safety warning signs and discusses who young people can turn to for help; 'Drumbeat', a therapeutic program which incorporates music; and other conflict, parenting and sex education programs. These programs can be conducted in community settings, but are most commonly conducted in custodial settings.
- SA** SA offers offending-specific programs in addition to individualised case management programs to address assessed client risk and need. 'Systematic Training for Anger Reduction' (STAR) is based on principles of cognitive behaviour therapy. The program seeks to assist young people to develop awareness about anger and skills of self control. The 'Problem-solving: Learning Usable Skills' program (Plus+) employs cognitive-behavioural methods of problem solving, skill-training and self-management, which have been shown to be effective in reducing juvenile offending. The Victim Awareness program raises awareness of the effects of crime on individuals and the community. The 'Alcohol and Other Drug' (AOD) program explores the risks of offending while under the influence of AOD. Moral Reconation Therapy (Little and Robinson 1988), which seeks to develop concern for social rules and others, is also used. The SA Police Safe Driving program targets 'high speed' drivers with the aim of reducing motor vehicle crime.

(Continued on next page)

Box 15.34 (Continued)

- Tas* Tasmania has completed piloting the Youth Level of Service Case Management Inventory (YLS/CMI) risk assessment tool and the Changing Habits and Reaching Targets (CHART) case management tool, and both tools are being implemented on a State-wide basis. The tools support a modular and structured approach to working with young people who are at a high risk of reoffending. To maximise the ability to learn from rehabilitative interventions, working with young people is tailored to their individual learning style, motivation and bio-social characteristics using the CHART structured intervention program. Tasmania also sources expertise from existing services within the Department of Health and Human Services, to provide offending specific programs to young people based on their assessed risk and need. In addition, the services of private professionals and professionals in other programs across a range of Government services are sourced as required.
- ACT* The ACT's main offending-specific program is CHART, which is designed specifically for young people assessed as moderate to high-risk of re-offending. This behaviour program is used by youth justice staff as part of their casework intervention either with individuals or with small groups of two to three clients. CHART is evidence-based and is informed by the 'What Works' approach to offender rehabilitation. This approach is characterised by the application of five basic principles of good practice for effective interventions: risk, needs, responsivity, program integrity and professional discretion.
- NT* The NT's main offending-specific programs are the 'Anger Management Program' and 'Cognitive Skills Program'. Both programs are based on cognitive behavioural therapy and are designed to provide a basic understanding of thoughts, feelings, actions and consequences. In facilitating these programs, caseworkers use a 'hands on' approach incorporating role plays and artwork to discuss issues. Caseworkers take this approach because the vast majority of juveniles undertaking these programs are Indigenous with low literacy levels. Other treatment programs which address sexual offending and alcohol and drug use are also provided either by caseworkers or by external agencies.

Source: State and Territory governments (unpublished).

Rehabilitation — education and training attendance

‘Education and training attendance’ is an indicator of governments’ objective to provide program interventions in education and training to rehabilitate young offenders and increase their chances of successfully re-integrating into the community (box 15.35).

Box 15.35 Education and training attendance

‘Education and training attendance’ is defined by two measures:

- the number of young people of compulsory school age in detention attending an education course, as a percentage of all young people of compulsory school age in detention
- the number of young people not of compulsory school age in detention attending an education or training course, as a percentage of all young people not of compulsory school age in detention.

Compulsory school age refers to specific State and Territory governments’ requirements for a young person to participate in school, which are based primarily on age (see chapter 4 School education for further information). Education or training course refers to school education or an accredited education or training course under the Australian Qualifications Framework.

A high or increasing percentage of young people attending education and training is desirable.

Exclusions include young people not under juvenile justice supervision (for example, in police custody) and young people whose situation might exclude their participation in education programs (including young people who are: on temporary leave such as work release, medically unable to participate, in isolation, and on remand or sentenced for fewer than 7 days).

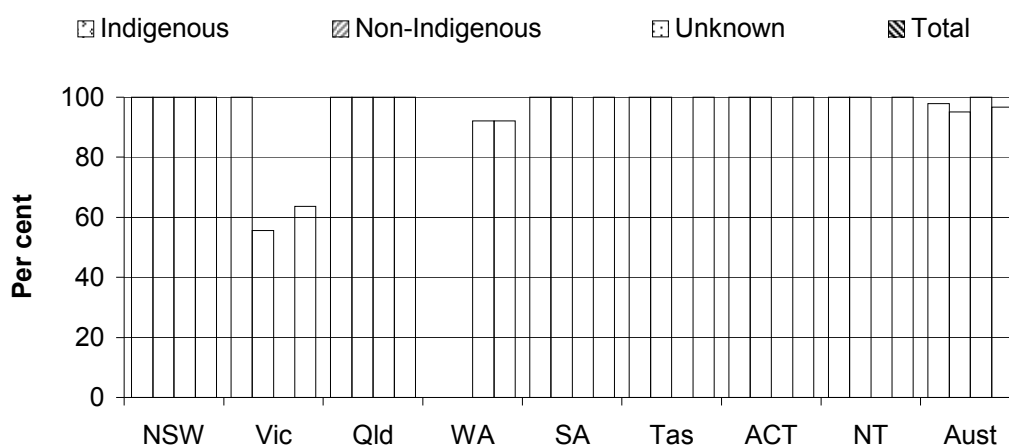
Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

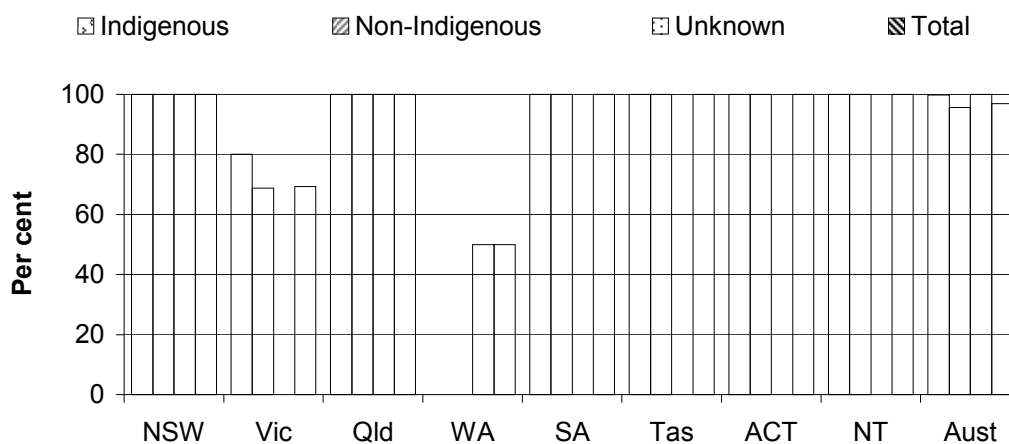
Nationally, 97.4 per cent of young people of compulsory school age in detention were attending an education course in 2010-11, while 96.9 per cent of young people in detention not of compulsory school age were attending an accredited education or training course (figure 15.24). Proportions varied across jurisdictions.

Figure 15.24 Proportion of young people in detention attending an accredited education or training course, by Indigenous status (2010-11)^{a, b, c}

(a) Proportion of young people of compulsory school age in detention attending an accredited education or training course



(b) Proportion of young people not of compulsory school age in detention attending an accredited education or training course



^a WA could not disaggregate young people in detention not of compulsory school age attending education or training by Indigenous status. As a result, WA's total proportion of young people in detention not of compulsory school age attending education or training only is included in the national total. ^b Victoria's data for 2010-11 compared with 2009-10 more clearly distinguishes between participation in *accredited* education programs as distinct from participation in other planned educative and rehabilitative programs. Only accredited educational programs are included in the 2010-11 data. All Victorian young people who were not participating in an accredited educational program in 2010-11 were participating in planned educative and rehabilitative programs. ^c Refer to table 15A.181 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.181.

Safe and secure environment — deaths in custody

‘Deaths in custody’ is an indicator of governments’ objective to ensure that juvenile justice agencies provide a safe and secure environment for young people in custody (box 15.36).

Box 15.36 Deaths in custody

‘Deaths in custody’ is defined as the number of young people who died while in custody.

A zero or decreasing deaths in custody rate is desirable.

The scope of this indicator is restricted to those young people who died while in the legal and/or physical custody of a juvenile justice agency and those who died in, or en route to, an external medical facility as a result of becoming ill or being injured in custody (even if not escorted by juvenile justice agency workers).

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

One young person died while in the legal or physical custody of an Australian juvenile justice agency in 2010-11 (table 15A.180).

Safe and secure environment — escapes

‘Escapes’ is an indicator of governments’ objective to ensure that juvenile justice agencies provide a safe and secure environment for young people in custody, and the community (box 15.37).

Box 15.37 Escapes

‘Escapes’ is defined by two measures:

- the number of escapes from a juvenile justice detention centre, as a proportion of all young people in custody
- the number of escapes during periods of escorted movement, as a proportion of all periods of escorted movement.

An escape from a juvenile justice detention centre is defined as a breach of a secure perimeter or defined boundary of a juvenile justice detention centre by a young person under the supervision of the centre.

(Continued on next page)

Box 15.37 (Continued)

A period of escorted movement is defined as a period of time during which a young person is in the custody of the juvenile justice agency while outside a detention centre. The period of escorted movement ends when the young person is returned to the detention centre, or is no longer in the legal or physical custody of the juvenile justice agency. An escape from an escorted movement is defined as the failure of a young person to remain in the custody of a supervising juvenile justice worker or approved service provider during a period of escorted movement. An escape is counted each time a young person escapes. For example, if a young person escapes three times in a counting period, three escapes are recorded. If three young people escape at the same time, three escapes are recorded.

A zero or decreasing escape rate is desirable.

Data reported for this indicator are comparable but not complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, there were three escapes from juvenile justice detention in 2010-11, which was equivalent to 0.1 escapes per 10 000 custody nights in 2010-11 (table 15.6). The number of escapes from detention varied across jurisdictions.

Table 15.6 Number and rate of escapes from juvenile justice detention centres, by Indigenous status (2010-11)^a

	NSW	Vic	Qld	WA	SA	Tas ^b	ACT ^c	NT
Number of escapes								
Indigenous	–	–	–	1.0	–	1.0	–	–
Non-Indigenous	–	–	–	–	–	–	1.0	–
Unknown	–	–	–	–	–	–	–	–
Total	–	–	–	1.0	–	1.0	1.0	–
Rate per 10 000 custody nights								
Indigenous	–	–	–	0.2	–	4.3	–	–
Non-Indigenous	–	–	–	–	–	–	2.0	–
Unknown	–	–	–	–	–	–	–	–
Total	–	–	–	0.2	–	1.1	1.2	–

^a Refer to table 15A.182 for detailed footnotes. ^b Tasmania has only one juvenile justice detention centre with relatively small numbers in detention, therefore, Tasmania's rates may be volatile. ^c The ACT has only one juvenile justice detention centre with relatively small numbers in detention, therefore, the ACT's rates may be volatile. **na** Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.182.

Nationally, there were four escapes from escorted movements in 2010-11 (table 15.7). The number of escapes from escorted movement varied across jurisdictions.

Table 15.7 Number and rate of escapes from escorted movement, by Indigenous status (2010-11)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas^b</i>	<i>ACT</i>	<i>NT^c</i>
Number of escapes								
Indigenous	2.0	–	–	–	–	–	–	1.0
Non-Indigenous	–	–	–	–	–	1.0	–	–
Unknown	–	–	–	–	–	–	–	–
Total	2.0	–	–	–	–	1.0	–	1.0
Rate per 10 000 periods of escorted movement								
Indigenous	8.4	–	–	–	–	–	–	na
Non-Indigenous	–	–	–	–	–	na	–	–
Unknown	–	–	–	–	–	–	–	–
Total	3.4	–	–	–	–	13.4	–	na

^a Refer to table 15A.182 for detailed footnotes. ^b Tasmania could not disaggregate the number of periods of escorted movement by Indigenous status, hence a rate could only be calculated for total number of escapes from escorted movement. Further, Tasmania has only one juvenile justice detention centre with relatively small numbers in detention, therefore, Tasmania's rates may be volatile. ^c The NT could not provide the denominator (number of periods of escorted movement) hence a rate could not be calculated. **na** Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.182.

Safe and secure environment — absconds from unescorted leave

'Absconds from unescorted leave' is an indicator of governments' objective to appropriately manage young people while they are in the legal custody of a juvenile justice detention centre (box 15.38). Management of young people includes the provision of appropriate assessment, planning and supervision to enable young people to undertake unescorted temporary leave from detention centres. Unescorted leave may be undertaken for the purposes of providing rehabilitation interventions and activities such as education, training and employment.

Box 15.38 Absconds from unescorted leave

'Absconds from unescorted leave' is defined as the number of young people who have unescorted temporary leave and fail to return to custody, as a proportion of all young people who have unescorted temporary leave.

A zero or low, or decreasing rate of absconds from unescorted leave is desirable.

Data reported for this indicator are comparable but not complete.

Data quality information for this indicator is under development.

No young people absconded from unescorted leave in 2010-11 (table 15A.183).

Safe and secure environment — assaults in custody

‘Assaults in custody’ is an indicator of governments’ objective to provide a custodial environment that is safe and secure in order to rehabilitate young offenders and reintegrate them into their community (box 15.39).

Box 15.39 Assaults in custody

‘Assaults in custody’ is defined by two measures:

- the rate of detainees and staff (by Indigenous status) who are seriously assaulted (that is, sustain an injury that requires overnight hospitalisation and any act of sexual assault) due to an act perpetrated by one or more detainees, as a proportion of the number of detainees in custody
- the rate of detainees and staff (by Indigenous status) who are assaulted (that is, sustain an injury, but do not require hospitalisation) due to an act perpetrated by one or more detainees, as a proportion of the number of detainees in custody.

A zero or low, or decreasing assaults in custody rate is desirable.

Data reported for this indicator are not complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, no detainees were reported as injured in custody due to a serious assault in 2010-11 (table 15A.184). However, two staff were reported as injured due to a serious assault in 2010-11 (table 15.8). Proportions varied across jurisdictions.

Table 15.8 Number and rate of staff injured as a result of a serious assault, by Indigenous status (2010-11)^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>
Number of staff injured as a result of a serious assault								
Indigenous	—	—	—	na	na	—	—	—
Non-Indigenous	—	—	2.0	na	na	—	—	—
Unknown	—	na	—	na	na	—	—	—
Total	—	—	2.0	na	na	—	—	—
Rate per 10 000 custody nights								
Indigenous	—	—	—	na	na	—	—	—
Non-Indigenous	—	—	0.9	na	na	—	—	—
Unknown	—	na	—	na	na	—	—	—
Total	—	—	0.4	na	na	—	—	—

^a Data were not available for WA and SA. **na** Not available. — Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.184.

Nationally, 66 detainees were reported as injured in custody due to an assault in 2010-11 (table 15.9). Proportions varied across jurisdictions.

Table 15.9 Number and rate of detainees injured as a result of an assault, by Indigenous status (2010-11)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^c</i>	<i>NT</i>
Number of detainees injured as a result of an assault								
Indigenous	9.0	na	5.0	na	na	na	6.0	16.0
Non-Indigenous	14.0	na	3.0	na	na	na	7.0	–
Unknown	6.0	na	–	na	na	na	–	–
Total	29.0	na	8.0	na	na	na	13.0	16.0
Rate per 10 000 custody nights								
Indigenous	1.3	na	1.8	na	na	na	np	11.6
Non-Indigenous	1.9	na	1.4	na	na	na	np	–
Unknown	16.8	na	–	na	na	na	–	–
Total	2.0	na	1.6	na	na	na	np	11.3

^a Data reported for this indicator are not comparable and need to be interpreted with caution. Methods of data collection vary across jurisdictions (for example, manual case file review compared to the collation of electronic incident reports) and jurisdictions' ability to report on this measure is dependent on relevant incidents having first been documented. ^b Data were not available for Victoria, WA, SA and Tasmania. ^c The ACT has only one juvenile justice detention centre with relatively small numbers in detention. Data are not converted to a rate due to the small number of detainees in the ACT. **na** Not available. **np** Not published. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.185.

Nationally, 46 staff were reported as injured due to an assault while supervising detainees in 2010-11 (table 15.10). Proportions varied across jurisdictions.

Table 15.10 Number and rate of staff injured as a result of an assault, by Indigenous status (2010-11)^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^d</i>	<i>NT</i>
Number of staff injured as a result of an assault								
Indigenous	na	na	4.0	na	na	na	–	–
Non-Indigenous	na	na	5.0	na	na	na	4.0	1.0
Unknown	32.0	na	–	na	na	na	–	–
Total	32.0	na	9.0	na	na	na	4.0	1.0
Rate per 10 000 custody nights								
Indigenous	na	na	1.4	na	na	na	–	–
Non-Indigenous	na	na	2.3	na	na	na	np	32.3
Unknown	89.3	na	–	na	na	na	–	–
Total	2.2	na	1.8	na	na	na	np	0.7

^a Data reported for this indicator are not comparable and need to be interpreted with caution. Methods of data collection vary across jurisdictions (for example, manual case file review compared to the collation of electronic incident reports) and jurisdictions' ability to report on this measure is dependent on relevant incidents having first been documented. ^b Data were not available for Victoria, WA, SA and Tasmania. ^c Data report the Indigenous status of staff who were reported as injured due to an assault. ^d The ACT has only one juvenile justice detention centre with relatively small numbers in detention. Data are not converted to a rate due to the small number of detainees in the ACT. **na** Not available. **np** Not published. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.185.

Safe and secure environment — self-harm and attempted suicide in custody

'Self-harm and attempted suicide in custody' is an indicator of governments' objective to provide a custodial environment that is safe and secure in order to rehabilitate young offenders and reintegrate them into their community (box 15.40).

Box 15.40 Self-harm and attempted suicide in custody

'Self-harm and attempted suicide in custody' is defined by four measures:

- the number of incidents of self-harm or attempted suicide in custody requiring hospitalisation
- the number of incidents of self-harm or attempted suicide in custody not requiring hospitalisation
- the number of detainees who self-harmed or attempted suicide in custody requiring hospitalisation
- the number of detainees who self-harmed or attempted suicide in custody not requiring hospitalisation.

(Continued on next page)

Box 15.40 (Continued)

The number of incidents of self-harm or attempted suicide and the number of detainees who self-harm or attempt suicide will differ when one detainee has self-harmed on two or more occasions as each occasion will be counted as a separate incident.

A zero, low, or decreasing self-harm and attempted suicide in custody rate is desirable.

Data reported for this indicator are not complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, five detainees in five separate incidents were reported as having self-harmed or attempted suicide in custody requiring hospitalisation in 2010-11. Proportions varied across jurisdictions (table 15.11).

Table 15.11 Number and rate of detainees who self-harmed or attempted suicide in custody requiring hospitalisation, by Indigenous status (2010-11)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^c</i>	<i>NT</i>
Number of detainees who self-harmed or attempted suicide in custody requiring hospitalisation								
Indigenous	–	–	–	na	na	–	2.0	–
Non-Indigenous	–	1.0	–	na	na	–	1.0	–
Unknown	1.0	na	–	na	na	–	na	–
Total	1.0	1.0	–	na	na	–	3.0	–
Rate per 10 000 custody nights								
Indigenous	–	–	–	na	na	–	np	–
Non-Indigenous	–	0.2	–	na	na	–	np	–
Unknown	2.8	na	–	na	na	–	–	–
Total	0.1	0.2	–	na	na	–	np	–

^a Data were not available for WA and SA. ^b Refer to table 15A.188 for detailed footnotes. ^c The ACT has only one juvenile justice detention centre with relatively small numbers in detention. Data are not converted to a rate due to the small number of detainees in the ACT. **na** Not available. **np** Not published. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.186.

Nationally, 55 detainees were reported as having self-harmed or attempted suicide in 71 separate incidents during 2010-11, none of which required hospitalisation (tables 15.12 and 15.13). Proportions varied across jurisdictions.

Table 15.12 Number and rate of detainees who self-harmed or attempted suicide in custody not requiring hospitalisation, by Indigenous status (2010-11)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas^c</i>	<i>ACT^d</i>	<i>NT</i>
Number of detainees who self-harmed or attempted suicide in custody not requiring hospitalisation								
Indigenous	13.0	–	2.0	na	na	2.0	3.0	2.0
Non-Indigenous	13.0	9.0	1.0	na	na	3.0	2.0	–
Unknown	5.0	na	–	na	na	–	–	–
Total	31.0	9.0	3.0	na	na	5.0	5.0	2.0
Rate per 10 000 custody nights								
Indigenous	1.9	–	0.7	na	na	8.2	np	1.4
Non-Indigenous	1.8	1.6	0.5	na	na	4.3	np	–
Unknown	14.0	na	–	na	na	–	–	–
Total	2.2	1.4	0.6	na	na	5.3	np	1.4

^a Data were not available for WA and SA. ^b Data reported for this indicator are not comparable and need to be interpreted with caution. Methods of data collection vary across jurisdictions (for example, manual case file review compared to the collation of electronic incident reports) and jurisdictions' ability to report on this measure is dependent on relevant incidents having first been documented. ^c Tasmania has only one juvenile justice detention centre with relatively small numbers in detention, therefore, Tasmania's rates may be volatile. ^d The ACT has only one juvenile justice detention centre with relatively small numbers in detention. Data are not converted to a rate due to the small number of detainees in the ACT. **na** Not available. **np** Not published. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.186.

Table 15.13 Number and rate of incidents of self-harm or attempted suicide in custody not requiring hospitalisation, by Indigenous status (2010-11)^{a, b}

	NSW	Vic	Qld	WA	SA	Tas ^c	ACT ^d	NT
Number of incidents of self-harm or attempted suicide in custody not requiring hospitalisation								
Indigenous	13.0	–	2.0	na	na	6.0	4.0	2.0
Non-Indigenous	13.0	17.0	1.0	na	na	5.0	3.0	–
Unknown	5.0	na	–	na	na	–	–	–
Total	31.0	17.0	3.0	na	na	11.0	7.0	2.0
Rate per 10 000 custody nights								
Indigenous	1.9	–	0.7	na	na	24.5	np	1.4
Non-Indigenous	1.8	3.1	0.5	na	na	7.2	np	–
Unknown	14.0	na	–	na	na	–	–	–
Total	2.2	2.6	0.6	na	na	11.7	np	1.4

^a Data were not available for WA and SA. ^b Data reported for this indicator are not comparable and need to be interpreted with caution. Methods of data collection vary across jurisdictions (for example, manual case file review compared to the collation of electronic incident reports) and jurisdictions' ability to report on this measure is dependent on relevant incidents having first been documented. ^c Tasmania has only one juvenile justice detention centre with relatively small numbers in detention, therefore, Tasmania's rates may be volatile. ^d The ACT has only one juvenile justice detention centre with relatively small numbers in detention. Data are not converted to a rate due to the small number of detainees in the ACT. **na** Not available. **np** Not published. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.186.

Statutory responsibilities — completion of community-based orders

'Completion of community-based orders' is an indicator of governments' objective to rehabilitate young offenders (box 15.41).

Box 15.41 Completion of community-based orders

'Completion of community-based orders' is defined as the proportion of sentenced community-based supervision orders successfully completed. An order is counted as successfully completed where the earliest order expiry date or the order termination date is reached and breach is neither pending nor finalised.

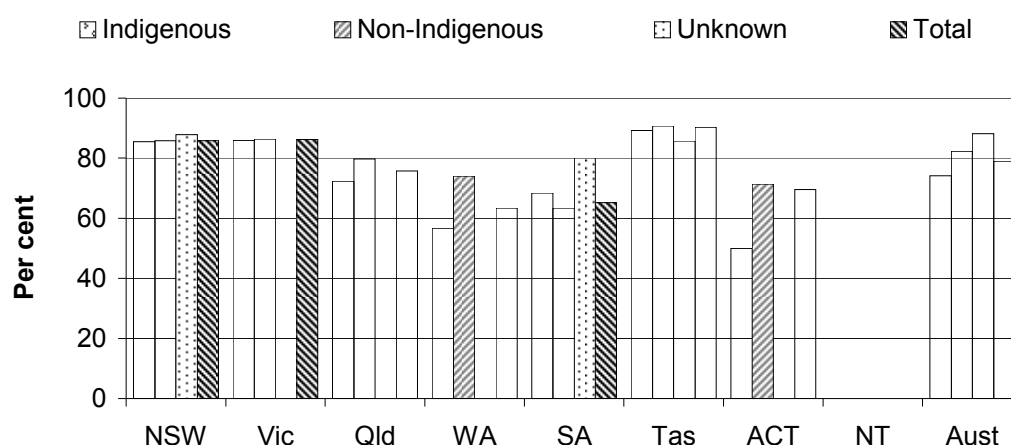
A high or increasing proportion of orders successfully completed is desirable. However, where offenders are non-compliant and pose a risk, breach action (an unsuccessful completion) may be warranted. As a result, a completion rate less than 100 per cent may not necessarily indicate poor performance, and may reflect appropriate supervision of young people on community-based supervision orders.

Data reported for this indicator are comparable but not complete.

Data quality information for this indicator is under development.

Nationally, 79.0 per cent of community-based orders were successfully completed in 2010-11. The proportion of community-based orders successfully completed varied across jurisdictions (figure 15.25).

Figure 15.25 Proportion of community-based orders successfully completed, by Indigenous status (2010-11)^{a, b, c}



^a Data were not available for the NT. ^b In Tasmania, there are regional inconsistencies in breaching procedures and recording practices, which may result in an undercount of orders successfully completed in 2010-11. ^c Refer to table 15A.187 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.187.

Statutory responsibilities — case plans prepared

‘Case plans prepared’ is an indicator of governments’ objective to ensure that juvenile justice agencies support young people to minimise the likelihood of re-offending by addressing their offending-related needs (box 15.42).

Box 15.42 Case plans prepared

‘Case plans prepared’ is defined as the number of eligible young people who had a documented case plan prepared or reviewed within six weeks of commencing:

- a sentenced detention order, as a proportion of all young people commencing a sentenced detention order
- a sentenced community-based order, as a proportion of all young people commencing a sentenced community-based order.

An eligible young person is one who is serving a sentenced order that requires case management.

A high or increasing rate of case plans prepared is desirable.

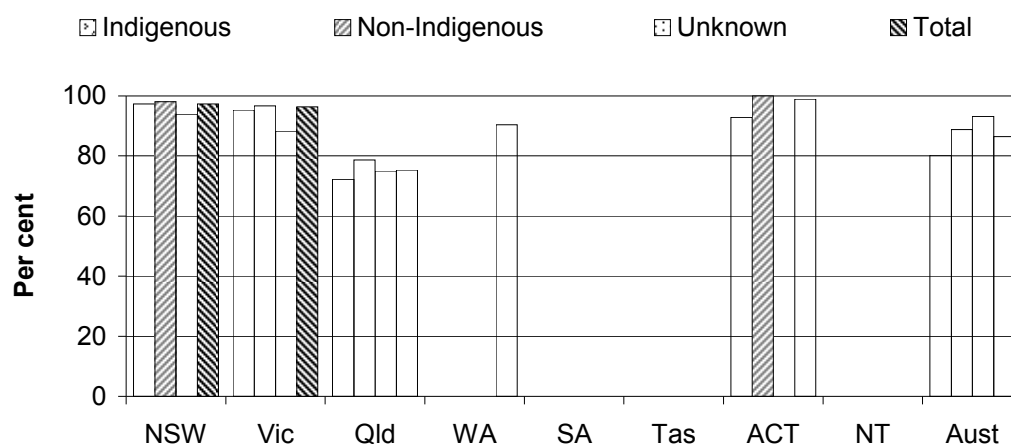
Data reported for this indicator are comparable but not complete.

Data quality information for this indicator is under development.

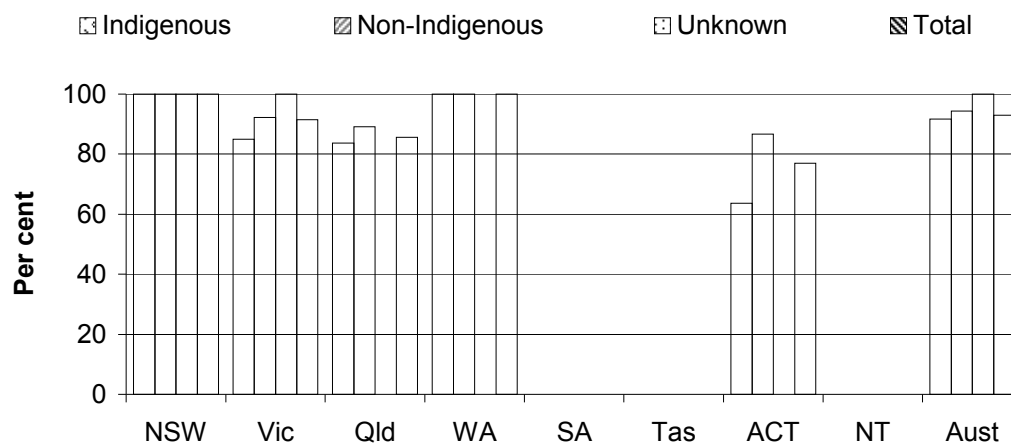
Nationally, 86.4 per cent of case plans were prepared within six weeks of commencing a sentenced community-based order in 2010-11 (figure 15.26(a)). Nationally, 93.0 per cent of case plans were prepared within six weeks of commencing a sentenced detention order in 2010-11 (figure 15.26(b)). Proportions varied across jurisdictions.

Figure 15.26 Proportion of case plans prepared within 6 weeks of commencing sentenced detention orders and sentenced community-based orders, by Indigenous status (2010-11)^{a, b, c}

(a) Proportion of case plans prepared within 6 weeks of commencing a sentenced community-based order



(b) Proportion of case plans prepared within 6 weeks of commencing a sentenced detention order



^a Data were not available for SA, Tasmania and the NT. ^b For case plans prepared within 6 weeks of commencing a sentenced community-based order, WA could not disaggregate the numerator by Indigenous status. Therefore, a proportion is only calculated for the total number of case plans prepared in WA. ^c Refer to table 15A.188 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.188.

Efficiency

Cost per offender

‘Cost per offender’ is an indicator of governments’ objective to provide juvenile justice services in an efficient manner (box 15.43).

Box 15.43 Cost per offender

‘Cost per offender’ is yet to be defined.

Data for this indicator were not available for the 2012 Report. Cost per offender data are expected to be available for inclusion in the 2013 Report.

Data quality information for this indicator is under development.

Offender-to-staff ratio

‘Offender-to-staff ratio’ is an indicator of governments’ objective to provide juvenile justice services in an efficient manner (box 15.44).

Box 15.44 Offender-to-staff ratio

‘Offender-to-staff ratio’ comprises two measures:

- the number of young people requiring community-based supervision relative to the number of community-based staff
- the number of young people in detention relative to the number of detention centre staff.

The number of offenders relative to the number of staff provides a measure of efficient resource management by juvenile justice agencies. A high or increasing ratio (that is, a higher number of offenders per staff member) suggests better performance towards achieving efficient resource management. However, this indicator needs to be interpreted with caution as a low or decreasing offender-to-staff ratio may result in more effective performance, particularly with high risk young offenders who possess significant offence-related needs. Further, in some cases, efficiencies may not be possible due to remote geographic locations that limit opportunities to reduce overheads through economies of scale.

Data for this indicator were not available for the 2012 Report. Offender-to-staff ratio data are expected to be available for inclusion in the 2013 Report.

Data quality information for this indicator is under development.

Centre utilisation

‘Centre utilisation’ is an indicator of governments’ objective to provide juvenile justice services in an efficient manner (box 15.45).

Box 15.45 Centre utilisation

‘Centre utilisation’ is defined as the number of detainees in all detention centres as a proportion of the number of permanently funded beds.

This indicator partially measures both effective and efficient performance. Detention centres operating at higher capacities is desirable from an efficient resource management perspective. However, detention centres operating at or above capacity might be ineffective due to the consequences for rehabilitation when centres are over crowded. Centres also need to make provision for separately detaining various classes of young offenders (for example, males and females, offenders requiring different security levels, offenders of different ages, and young people on remand and young people who have been sentenced). In order to make provision for separately detaining various classes of young people, detention centres require utilisation rates that are below full capacity.

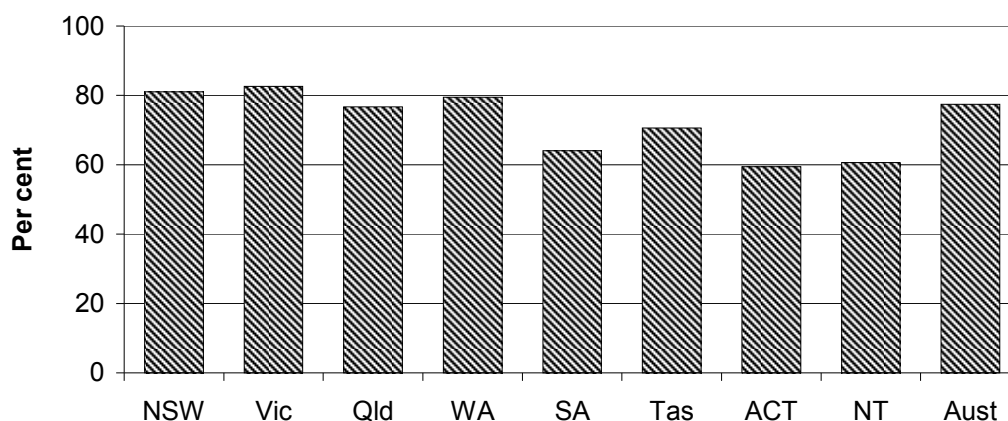
This indicator also has application to the efficient use of publicly funded resources. Centres that are built at a point in time need to be able to justify significant under use, if that occurs in future years, where that under use cannot reasonably be explained by the need to make provision for detaining different classes of young offenders.

Data reported for this indicator are comparable and complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, 77.5 per cent of centre capacity (that is, permanently funded beds) was utilised in 2010-11. Proportions varied across jurisdictions (figure 15.27).

Figure 15.27 Centre utilisation rate (2010-11)^{a, b}



^a In 2009-10, Tasmania's centre utilisation rate was based on the number of physical beds at its juvenile detention centre. In 2010-11, Tasmania's rate is based on the number of permanently funded beds and is therefore consistent with the national counting rules for this indicator. ^b Refer to table 15A.189 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.189.

Outcomes

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

Outcome indicators for juvenile justice services are yet to be developed. The Steering Committee has identified outcome indicators as an important element of the juvenile justice performance indicator framework to develop for future reports.

15.7 Future directions in juvenile justice performance reporting

The Juvenile Justice Research and Information Group (JJ RIG), a working group of the AJJA, is responsible for developing national performance indicators for juvenile justice. The indicators are being developed in stages. The remaining items of development include: refinement of reporting for existing indicators, the development and refinement of an expenditure data collection tool to enable comparable, national reporting for agreed efficiency indicators, and the identification of suitable outcome measures for future reporting.

COAG developments

Outcomes from review of Report on Government Services

The COAG endorsed recommendations (December 2009) of the review of the RoGS implemented during 2010 and 2011 are reflected in this Report. Implementation of other recommendations will be reflected in future reports.

15.8 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter.

New South Wales Government comments

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Child protection and out-of-home care

The NSW Government is progressively implementing a suite of reforms in response to the Report of Special Commission of Inquiry into Child Protection Services in NSW. To focus the statutory child protection system on children most in need, a new risk of significant harm reporting threshold came into effect in early 2010. The new threshold has been supported by the introduction of Structured Decision Making tools to support shared and consistent child protection across NSW.

The NSW Government believes a greater focus on prevention and early intervention is essential in reducing numbers of child protection reports and entries into out-of-home care. An additional 400 places for families in the Brighter Futures program will be created over the next four years. A realigned Early Intervention and Placement Prevention Program is providing services along a continuum from lower-level parenting to intensive family interventions. Two new Aboriginal Intensive Family Based Services have been established and a further two are planned in high need areas of the State to respond to the over-representation of Aboriginal children in the child protection system.

The Government is committed to growing and delivering a quality, sustainable, non-government out-of-home care service system for NSW. Work is well underway for the transition of out-of-home care service provision to the non-government sector to commence from January 2012.

Juvenile justice

Following the change of NSW State Government in March 2011, the Juvenile Justice agency moved from the Human Services portfolio to the Department of Attorney General and Justice. A number of legislative reviews were subsequently initiated, including reviews of the Young Offenders Act 1997, the Children (Criminal Proceedings) Act 1987 and the Bail Act 1978. A system-wide strategic project was also instigated which will review the broad NSW juvenile justice system within the context of evidence based research and best practice.

Juvenile Justice received \$11.2 million over four years to reduce the number of young people held on remand by helping courts to speed up bail hearings and assist young people to meet their bail conditions. The Waratah Pre-Release Unit located at Reiby Juvenile Justice Centre was opened in December 2010. It prepares young offenders for their release from detention and improve their chances of successful reintegration into the community.

Juvenile Justice established additional Youth Justice Conferencing positions across the state, and developed its Aboriginal Strategic Plan 2011-2013 to ensure a coordinated approach to addressing the over-representation of Aboriginal young people in the juvenile justice system. Juvenile Justice is enhancing its Client Information Management System to improve reporting on the effectiveness of and participation in programs.

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Victorian Government comments

“ *Child protection and out-of-home care*

An independent inquiry into Victoria's child protection system, Protecting Victoria's Vulnerable Children, chaired by the Hon P. D. Cummins has begun and recommendations to prevent abuse and improve outcomes for those who have experienced neglect and abuse will be presented to the Coalition Government before the end of January 2012.

In addition to the inquiry, priority actions include helping young people in out-of-home care get the support they need while in care and ensure their effective transition to independent living. This will include:

- ensuring young people get a health and education assessment on entering residential care, and then have access to the services they need to address the identified health, developmental or education issues
- supporting young care leavers up to 21 years of age to transition from care, with a particular focus on intensive support to improve their access to education and employment opportunities
- enhancing placement capacity and care arrangements in addition to responding to the out-of-home care shortages
- providing increased support to foster carers, particularly in rural Victoria, and funding a full-time telephone helpline, and
- implementing a long-term study assessing the impact of out-of-home care.

Juvenile justice

The Victorian Government committed \$26.2 million over four years in the 2011-12 budget to improve youth justice outcomes and better tailor services to young offenders, including:

- \$13.3 million for 23 new youth justice workers to ensure community based orders for young people are better monitored and enforced and significant expansion of the youth justice group conferencing program — an extra 650 young people will be diverted to Youth Justice Group Conferencing over the next four years
- \$1.1 million for intensive bail supervision for young people at risk of being remanded to be released on bail and case managed in the community
- \$4.15 million to enhance the recruitment, training and development of staff at youth justice centres
- \$7.6 million to provide drug and alcohol, health and rehabilitative services to young offenders.

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Queensland Government comments

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Child protection and out-of-home care

In 2010, the Queensland Parliament passed the *Child Protection and Other Acts Amendment Act 2010 (The Act)*. A key focus of the amendments to the *Child Protection Act 1999* was enhancing the capacity of non-government services to intervene earlier and more effectively with at-risk children or families and link them to support services or other assistance before their issues escalate and they become involved in the statutory child protection system. These amendments enabled the introduction of the Helping Out Families initiative.

Since its introduction in 2010, the Helping Out Families initiative has delivered three new Family Support Alliances in the South East Region; introduced new Intensive Family Support Services to 276 families as at 30 June 2011; and delivered enhanced Domestic and Family Violence services.

The Queensland Government has also released the *Blueprint for Implementation Strategy* to assist in reducing the over-representation of Indigenous children in Queensland's child protection system. The Blueprint focuses on: prevention and early intervention services; community development through partnering with Aboriginal and Torres Strait Islander communities and the sector; reforming components of the child protection system, which impact on Indigenous children and families; and taking a holistic approach in policy planning and service implementation.

Juvenile justice

The Queensland Government continued to address the causes of youth offending through delivering evidence based initiatives within a contemporary legislative framework. The amended *Youth Justice Act 1992* commenced on 29 March 2010, resulting in a strengthened approach to the application of curfews, an increase in the minimum detention times for young people sentenced to life imprisonment for multiple murders (from 15 to 20 years) and powers for police to arrest young people and take them to court when Youth Justice Conferencing fails or an agreement is breached.

Offence-focussed programs, such as Aggression Replacement Training (ART) and Changing Habits and Reaching Targets (CHART), continued to be delivered by Youth Justice Services and Youth Detention Centres while non-government organisations were funded to deliver bail support services; services to address the developmental needs of young people in the youth justice system; and specialist counselling services for young people who have committed sexual offences. Two new community-based programs for young offenders commenced during the year — a fully supervised accommodation service for young people exiting youth detention located in Townsville and the South West Queensland Indigenous Family and Youth Coaching and Mentoring Service. In previous years, Youth Justice Conferencing has evidenced a steady increase in referral numbers. In 2010-11, Youth Justice Conferencing program referrals began to stabilise.

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Western Australian Government comments

“ *Child protection and out-of-home care*

The Department for Child Protection continues to make substantial progress towards building capacity, improving performance, reforming and becoming a learning organisation. A number of amendments to the *Children and Community Services Act 2004* came into effect in 2010-11. The Signs of Safety Child Protection Practice Framework continues to be implemented across service delivery. A revised assessment and investigation policy and process has resulted in streamlined practice and administration of child protection work. Development of secondary family support networks and an *At Risk Youth Strategy* are underway, which will further enhance the State's ability to improve outcomes for vulnerable children and their families.

Annual health and education planning for children in care has been implemented State-wide. A permanency planning policy was implemented to ensure that timely consideration be given to whether a child can be reunified with their family, or whether long-term care is required. Reform of residential care services has resulted in three tiers of service delivery to respond to children with different levels of need. Non-government family group home places have increased to 72. A secure care facility was opened which provides planned, short-term, intensive intervention for young people aged 12–17 years at immediate and substantial risk of harming themselves or others. Leaving care planning has been introduced for children in care from the age of 15 years. Referral to leaving care services from 16 years of age has been streamlined. Post-care support is available up to 25 years of age, and fees for vocational educational and training courses are waived by State training providers. Special Guardianship Orders came into effect in February 2011.

Juvenile justice

Through its Youth Justice Services (YJS), the Department of Corrective Services administers the Young Offenders Act 1994. Its primary focus is the management of young people (10-18 years of age) subject to community orders and in detention. YJS also works to divert young people from the formal justice system, working closely with families and providing rehabilitation for at-risk young people, all of which abides by the Act's principles of detention as a last resort. During 2010-11, YJS completed the expansion of services to East and West Kimberley and began establishing services in the Pilbara. These service areas provide juvenile justice teams which steer at-risk youth away from the justice system, after-hours outreach family support services and after-hours bail services. The cross-agency Youth Justice Framework was completed and a Memorandum of Understanding drafted. Work continued on the redevelopment of Banksia Hill Youth Detention Centre. The Department took responsibility (for a 12 month trial) for the management of transportation of young people from the WA Police. The Metropolitan Bail Services was expanded to improve eligible young people's access to bail.”

South Australian Government comments

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Child protection and out-of-home care

During 2010-11 SA has continued to progress integrating the safety of children and young people with a broader approach to strengthening child, family and community wellbeing. Across sector Information Sharing Guidelines are supporting collaborative practice and early intervention for child safety. Recent changes to legislation expand the range of organisations providing services to children who are required to create and maintain child safe environments. Policy and practice changes to accompany the electronic connected client case management system are part of a cycle of continuous improvement and quality assurance measures. Children's Centres for Early Childhood are an innovative concept in the delivery of early childhood services. Services and programs, which reflect community needs and include care and education as well as links to health services, from birth through to the early years of school. Twenty three Children's Centres are currently operational across SA. The *Directions for Alternative Care 2011-2015* provides the plan and focus to drive improvements across the alternative care sector and aims to deliver quality, needs led services in kinship, relative, foster and residential care. The Rapid Response Framework for whole-of-government service response for children and young people under Guardianship facilitates access to the supports and services necessary to ensure their health, education and general wellbeing. In 2010-11 there has been greater emphasis placed upon transitioning from care, with particular attention to education and training opportunities. On 21 October 2011 child protection and services from Families SA were brought together with the education and child development functions of the Department for Education and Child Development.

Juvenile justice

Youth Justice in SA is now administered separately to child protection and out-of-home care, and sits as a unit within the Department for Communities and Social Inclusion (DCSI). New administrative arrangements came into effect on 21 October 2011. DCSI Youth Justice continues with a range of program development and reform, first initiated in 2008 following recommendations contained in the 'To Break the Cycle Report', by Monsignor David Cappo (2007). A major current initiative is the development of a new service design to enable administration of an open campus facility currently being built at Goldsborough Drive, Cavan. The new facility is due for completion mid-2012. DCSI Youth Justice is also working closely with SA Health and the Department for Education and Child Development to develop a service hub approach to work with youth detained in Training Centres. All Youth Justice staff State-wide now access a common electronic case management system (C3MS). The C3MS tool has been rolled out State-wide to support a through-care approach to case management of youth, particularly youth transitioning between custodial and community environments. Case management reform has focused on the development of interventions to address offending risks and equip, support and resource young people to reintegrate back into the community.

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Tasmanian Government comments

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Child protection and out-of-home care

Reforms to the Tasmanian child protection, family support and out-of-home care services continue to be implemented by Children and Youth Services with a focus on early intervention.

The Gateway and Integrated Family Support services have been operating since August 2009, supporting children and families in need through a single point of access within each of the four service delivery areas across the State. This major reform is underpinned by legislative changes that facilitate greater integration of services and improve the exchange of information.

Increased infrastructure for vulnerable families has recently been supported by the launch of the new Agenda for Children and Young People, *Our Children Our Young People Our Future*. Also in 2011, Children and Youth Services (CYS) implemented the new HEARTS (Health, Education, Activities, Records, Tracking and Supports) project in cooperation with the Community Paediatrician. Through this work an holistic approach is adopted to ensure the health and wellbeing needs of children and young people in care are met. Further, CYS established routine data exchange with the Department of Education as a means to improve educational outcomes for children on care and protection orders.

Juvenile justice

Youth Justice Services in Tasmania are focussed on case management practices to meet the needs of young people who engage in youth offending. The collaborative case coordination model evolves partnerships with key stakeholders, drawing on the experience of the Inter-Agency Support Teams and the Safe at Home initiative.

In 2011, the electronic risk assessment tool YLS/CMI (Youth Level of Service/Case Management Inventory) was implemented. This complements the implementation of the cognitive and behavioural case management tool CHART (Changing Habits And Reaching Targets) across all service centres. The Community Supervision Practice Pilot is further driving the reform of practice supervision and the development of practice guidelines. Quality assurance practices are also being integrated into the delivery of community youth justice services.

Within the community, non-government organisations have been funded to provide Targeted Youth Support Services. This initiative aims to prevent escalation into the statutory system for young people displaying multiple risk factors by providing individualised, intensive and targeted support.

In January 2011, the Specialist Youth Justice Magistrate's Court Pilot was implemented, with a single Magistrate designated to deal with youth justice matters. The pilot is intended to improve timeliness to finalisation, provide better coordination of youth justice services to the court, and ensure consistency in sentencing of young people on youth justice matters.

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Australian Capital Territory Government comments

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Child protection and out-of-home care

During 2010-11 there has continued to be a focus in the ACT on improving the planning, integration and alignment of services for vulnerable children and young people and their families. A new out-of-home care framework was implemented to provide a range of placement and case management options for children and young people in care. This included residential, foster and kinship care options and the introduction of a new therapeutic carer model. A restructure of funding arrangements for youth and family support programs commenced and work continued on improving the service model for young people transitioning from care. Supporting kinship carers was also a focus.

Diversion from the statutory pathway and the importance of early intervention and prevention also continues to be a policy focus with the opening of a third Child and Family Centre in the ACT in May 2011 as part of the Indigenous Early Childhood National Partnership. The centre has a specialist focus on the provision of services for the Aboriginal and Torres Strait Islander community.

Juvenile justice

The ACT government has been working on a range of measures to improve outcomes for young people in Youth Justice in 2010-11. A change management program was introduced at Bimberi Youth Justice Centre in November 2010 which focused on risk management and safety of young people and staff, improving service delivery standards; and establishing a culture of learning and increasing support to staff at the youth justice centre. This program resulted in a number of significant changes at the centre.

In December 2010, a Human Rights Commission review into Bimberi Youth Justice Centre was announced. Work progressed on the review in the first half of 2011 and the report was finalised outside the reporting period.

In 2010-11, the ACT Government also advanced policy work to divert young people from custody including development of a single youth justice case management policy and planning for the commencement of an after hours bail service.

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Northern Territory Government comments

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Child protection and out-of-home care

In November 2009, in response to growing evidence that the child protection system in the NT was not working in the best interests of Territory children and families, the Government commissioned a Board of Inquiry into the Child Protection System. In October 2010, the Board of Inquiry presented its report to the NT Government. The report, 'Growing them strong, together' contained 147 recommendations for fundamental reform to all areas of the child protection system in the Northern Territory.

The NT Government immediately announced in-principle support for the recommendations and directed the then Department of Health and Families to start implementing these recommendations. This included establishing a new agency dedicated to child safety and wellbeing in order to better respond to the Board of Inquiry's recommendations — the NT Department of Children and Families (DCF) was established on 1 January 2011. In addition, a Child Protection External Monitoring and Reporting Committee was established by Ministerial appointment and met for the first time in February 2011.

As of 30 June 2011, significant activities have been undertaken in response to the Board of Inquiry recommendations. Notably, the backlog of child protection investigations identified by the Board of Inquiry was reduced from 870 cases in October 2010 to zero by the end of May 2011. Additional front line child protection workers have been recruited to the Department and new positions have been created to meet child protection needs. Legislative changes have been made to the Care and Protection of Children Act 2007 to extend the powers of the Children's Commissioner and a major review of the Act started in June 2011. The Department provided funding to the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) to support the development of an Aboriginal and Torres Strait Islander Children, Youth and Families peak body. This peak body will support the development of Aboriginal child and family wellbeing and safety, and child protection agencies.

Juvenile justice

The Family Responsibility Program (FRP), a cross Government initiative led by DCF, has continued to support families to address youth anti-social behaviour. The DCF Darwin and Alice Springs Family Support Centres (FSC), as the service arm of the FRP, are supporting an increasing number of families; and the Darwin FSC has secured two additional Advanced Practitioners under the Palmerston Youth Action Plan, and co-location of a Police Officer and Department of Education and Training Officer to strengthen the whole-of-government approach to the FRP. A FRP Strategic Interagency Group, represented by the involved Government agencies, has also been established.

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15.9 Definitions of key terms and indicators

Child protection and out-of-home care services

Activity Group 1 (pathways)

Receipt and assessment of initial information about a potential protection or support issue

Activities that are typically associated with receipt and assessment of initial information including receipt and recording of information, review of department databases, initial assessment of information and decisions about the appropriate response. This activity can also include consultation, with possible provision of advice. Activities by non-government organisations (NGO) may be included if appropriate.

Activity Group 2 (pathways)

Provision of generic/non-intensive family support services

Activities that are typically associated with provision of lower level family support services at various stages including identification of family needs, provision of support services and diversionary services, some counselling and active linking of the family to support networks. Services are funded by government but can be delivered by either the relevant agency or a NGO. This bundle of services does not involve planned follow-up by the relevant agency after initial service delivery. The services will be delivered under voluntary arrangements between the relevant agency and family. Clients may receive these services more than once.

Activity Group 3 (pathways)

Provision of intensive family support services

Activities that are typically associated with provision of complex or intensive family support services including provision of therapeutic and in-home supports such as counselling and mediation, modelling of positive parenting strategies, referrals to intensive support services that may be provided by NGOs, advocacy on behalf of clients and intensive support for a family in a residential setting. This includes protection and treatment support services. These services may be provided if diversionary services are inappropriate to the case and may lead to statutory services being provided to the client.

Activity Group 4 (pathways)

Secondary information gathering and assessment

Activities that are typically associated with secondary information gathering and assessment are currently counted as 'investigations' in the Report on Government Services. As part of this activity group a decision may be made to substantiate or not substantiate. Information gathering activities include:

- sighting the child
- contacting people with relevant information about the child or family (for example, teachers, police, support services)
- interviewing the child, sibling(s) and parents
- observing family interactions
- obtaining assessments of the child and/or family
- conducting family group conferences
- liaising with agencies providing services to the child and family
- recording a substantiation or non-substantiation decision
- case conferences with partners and contributors in the investigation and assessment process.

Activity Group 5 (pathways)

Provision of short-term protective intervention and coordination services

Activities that are typically associated with provision of short-term protective intervention and coordination services including:

- working with the family to address protective issues
- developing networks of support for the child
- monitoring and reviewing the safety of the child
- monitoring and reviewing family progress against case planning

for children not on an order

goals

- case conferences with agencies providing services to the child and/or family, internal discussions and reviews
- specialist child-focused therapeutic support.

Activity Group 6 (pathways)

Seeking an order

Activities that are typically associated with seeking orders (court orders or voluntary/administrative orders) including:

- preparing applications for the order
- preparing reports for the court
- obtaining assessment reports to submit to the court
- informing parties to the court proceedings, including parents, the child, and lawyers
- informing and briefing legal counsel or internal court groups
- going through internal pre-court review processes
- attending court
- conducting family group conferences.

Activity Group 7 (pathways)

Provision of protective intervention, support and coordination services for children on an order

Activities that are typically associated with provision of longer-term protective intervention and coordination services including:

- monitoring the child or young person's progress and development (for example, social development and education progress) and undertaking activities that facilitate progress and development
- meeting any specific requirements of any court order
- reviewing appropriateness of the order for the circumstances of the child or young person. This usually occurs at intervals established by the court or in legislation
- reporting back to court
- long term cases involving out-of-home care.

Activity Group 8 (pathways)

Provision of out-of-home care services

Activities that are typically associated with provision of out-of-home care services including:

- finding suitable placement(s) for the child
- assisting the child or young person to maintain contact with his/her family
- in some cases, staff payments for recruiting and training carers
- assessing suitability of potential kinship carers
- assisting the child or young person to maintain contact with their family
- working to return the child home
- assisting the child or young person as they prepare to leave care as the end of the order approaches.

Care and protection orders

Care and protection orders are legal orders or arrangements which give child protection departments some responsibility for a child's welfare. The scope of departmental involvement mandated by a care and protection order is dependent on the type of order, and can include:

- responsibility for overseeing the actions of the person or authority caring for the child
- reporting or giving consideration to the child's welfare (for example, regarding the child's education, health, religion, accommodation and financial matters).

Types of care and protection orders:

- Finalised guardianship or custody orders – involve the transfer of legal guardianship to the relevant state or territory department or

non-government agency. These orders involve considerable intervention in a child's life and that of his or her family, and are sought only as a last resort. Guardianship orders convey responsibility for the welfare of a child to a guardian (for example, regarding a child's education, health, religion, accommodation and financial matters). Guardianship orders do not necessarily grant the right to the daily care and control of a child, or the right to make decisions about the daily care and control of a child, which are granted under custody orders. Custody orders generally refer to orders that place children in the custody of the state or territory, or department responsible for child protection or non-government agency. These orders usually involve the child protection department being responsible for the daily care and requirements of a child, while his or her parent retains legal guardianship. Custody alone does not bestow any responsibility regarding the long-term welfare of the child.

- Finalised third party parental responsibility orders – transfer all duties, powers, responsibilities and authority parents are entitled to by law, to a nominated person(s) considered appropriate by the court. The nominated person may be an individual such as a relative or an office of the state or territory department. Third party parental responsibility may be ordered when a parent is unable to care for a child, and as such parental responsibility is transferred to a relative. 'Permanent care orders' are an example of a third party parental responsibility order and involve the transfer of guardianship to a third party carer. It can also be applied to the achievement of a stable arrangement under a long-term guardianship order to 18 years without guardianship being transferred to a third party. These orders are only applicable in some jurisdictions.
- Finalised supervisory orders – give the department responsible for child protection some responsibility for a child's welfare. Under these orders, the department supervises and/or directs the level and type of care that is to be provided to the child. Children under supervisory orders are generally under the responsibility of their parents and the guardianship or custody of the child is unaffected. Finalised supervisory orders are therefore less intrusive than finalised guardianship orders but require the child's parent or guardian to meet specified conditions, such as medical care of the child.
- Interim and temporary orders – generally cover the provision of a limited period of supervision and/or placement of a child. Parental responsibility under these orders may reside with the parents or with the department responsible for child protection. Orders that are not finalised (such as an application to a court for a care and protection order) are also included in this category, unless another finalised order is in place.
- Administrative arrangements – are agreements between a parent (or parents) and the relevant child protection department, which have the same effect as a court order in transferring custody or guardianship. These arrangements can also allow a child to be placed in out-of-home care without going through the courts.

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 departments responsible for child protection regarding concerns about a child, as distinct from notifications of child abuse and neglect. The distinction between the two differs across and within jurisdictions.
Children in out-of-home care during the year	The total number of children who were in at least one out-of-home care placement at any time during the year. A child who is in more than one placement is counted only once.
Dealt with by other means	A notification that is responded to by means other than an investigation, such as the provision of advice or referral to services.
Exited out-of-home care	Where a child does not return to care within two months.
Family based care	Home-based care (see 'Out-of-home care').
Family group homes	Family group homes are care settings that provide care to children in a departmentally or community sector agency provided home. These homes have live-in, non-salaried carers who are reimbursed and/or subsidised for the provision of care.
Foster care	Care of a child who is living apart from his or her natural or adoptive parents in a private household, by one or more adults who act as 'foster parents' and are paid a regular allowance by a government authority or non-government organisation for the child's support. The authorised department or non-government organisation provides continuing supervision or support while the child remains in the care of foster parents.
Foster parent	Any person (or such a person's spouse) who is being paid a foster allowance by a government or non-government organisation for the care of a child (excluding children in family group homes).
Guardian	Any person who has the legal and ongoing care and responsibility for the protection of a child.
Indigenous person	Person of Aboriginal or Torres Strait Islander descent who identifies as being an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he or she is associated. If Indigenous status is unknown, then a person is considered to be non-Indigenous.
Investigation	An investigation of child abuse and neglect that involves identifying harm or risk of harm to the child, determining an outcome and assessing protective needs. It includes the interviewing or sighting of the subject child where practicable.
Investigation finalised	Where an investigation is completed and an outcome of 'substantiated' or 'not substantiated' is recorded by 31 August.
Investigation in process	Where an investigation is commenced but an outcome is not recorded by 31 August.
Investigation closed – no outcome possible	Where an investigation is commenced but is not able to be finalised in order to reach the outcome of 'substantiated' or 'not substantiated'. These files would be closed for administrative purposes. This may happen in instances where the family has relocated.

Length of time in continuous out-of-home care	The length of time for which a child is in out-of-home care on a continuous basis. A return home of less than seven days is not considered to break the continuity of placement.
Non-respite care	Out-of-home care for children for child protection reasons.
Notification	Contact with an authorised department by persons or other bodies making allegations of child abuse or neglect, or harm to a child. Notifications can be counted at different points in the response to a report, ranging from the point of initial contact with the source of the report to the end of a screening and decision making process.
Other relative	A grandparent, aunt, uncle or cousin, whether the relationship is half, full, step or through adoption, and can be traced through or to a person whose parents were not married to each other at the time of the child's birth. This category includes members of Aboriginal communities who are accepted by that community as being related to the child.
Out-of-home care	Overnight care, including placement with relatives (other than parents) where the government makes a financial payment. Includes care of children in legal and voluntary placements (that is, children on and not on a legal order) but excludes placements made in disability services, psychiatric services, juvenile justice facilities and overnight child care services. There are five main out-of-home care placement types: • Residential care – where placement is in a residential building with paid staff. • Family group homes – provide care to children in a departmentally or community sector agency provided home. These homes have live-in, non-salaried carers who are reimbursed and/or subsidised for the provision of care. • Home-based care – where placement is in the home of a carer who is reimbursed (or who has been offered but declined reimbursement) for expenses for the care of the child. This is broken down into three subcategories: (1) <i>Relative/kinship care</i> – includes family members (other than parents) or a person well known to the child and/or family (based on a pre-existing relationship) who is reimbursed (or who has been offered but declined reimbursement) by the state/territory for the care of the child; (2) <i>foster care</i> – where the care is authorised and carers are reimbursed (or were offered but declined reimbursement) by the state/territory and supported by an approved agency. There are varying degrees of reimbursement made to foster carers; (3) <i>other</i> – home-based care which does not fall into either of the above categories. • Independent living – including private board and lead tenant households. • Other – includes placements that do not fit into the above categories and unknown living arrangements. This includes boarding schools, hospitals, hotels/motels and defence force.
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	Respite care is a form of out-of-home care that is used to provide short-term accommodation for children whose parents are ill or unable to care for them on a temporary basis. Not all jurisdictions can identify which children in out-of-home care are in respite care.

Stability of placement

Children may also be placed in respite care while being placed with a foster carer.

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.

Juvenile justice services**Juvenile justice centre**

A place administered and operated by a juvenile justice department, where young people are detained whilst under the supervision of the relevant juvenile justice department on a remand or sentenced detention episode.

Juvenile justice department

Refers to those departments in each State and Territory that are responsible for juvenile justice matters.

Supervision period

A period of time during which a young person is continuously under juvenile justice supervision of one type or another. A supervision period is made up of one or more contiguous episodes.

Police caution

Refers to when a police officer administers a caution to the child instead of bringing the child before a court for the offence.

Pre-sentence community

Pre-sentence arrangements where the juvenile justice department is responsible for the case management or supervision of a young person (such as supervised or conditional bail where the juvenile justice department is involved with monitoring or supervising a young person).

Pre-sentence detention

Remanded or held in a juvenile justice centre or police watch house prior to appearing in court or to being sentenced.

Sentenced community-based supervision

Includes probation, recognisance and community service orders which are supervised or case managed by the juvenile justice department. May be supervision with or without additional mandated requirements, requiring some form of obligation or additional element that a young person is required to meet. This obligation could be community work such as in a community service order, a developmental activity or program attendance. The juvenile justice department may or may not directly supervise any additional mandated requirements, but remains responsible for the overall case management of a young person.

Youth justice conference / group conference

A youth justice conference is a facilitated meeting resulting in a formal agreement to repair the harm caused by the offence. Participants can include the victim, offender, convenor, police and other key stakeholders. Referrals may be initiated by the police or the courts.

15.10 List of attachment tables

Attachment tables are identified in references throughout this chapter by a '15A' prefix (for example, table 15A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

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PART G

HOUSING AND HOMELESSNESS SERVICES



G Housing and homelessness services sector summary

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Attachment tables

Attachment tables are identified in references throughout this sector summary by a 'GA' prefix (for example, table GA.1). A full list of attachment tables is provided at the end of this sector summary, and the attachment tables are available on the Review website at www.pc.gov.au/gsp.

G.1 Introduction

This sector summary provides an introduction to the 'Housing' (chapter 16) and 'Homelessness services' (chapter 17) chapters of this Report. It provides an overview of the 'housing and homelessness' sector, presenting both contextual information and high level performance information.

Major improvements in reporting on housing and homelessness this year are identified in each of the service-specific housing and homelessness chapters.

Policy context

Shelter is a fundamental human need, and housing and homelessness assistance plays an important role in enabling social and economic participation. This assistance is an important element of governments' social policy and welfare frameworks.

Housing assistance and services to people who are homeless and at risk of homelessness are closely interconnected:

The concepts of 'homelessness' and 'housing' are culturally bound, and ... in order to define homelessness it is necessary to identify shared community standards about minimum housing (Homelessness Australia 2010).

Australian, State and Territory governments assist people to meet their housing needs through direct services, funding support and other initiatives, including assistance for people who are homeless or at risk of homelessness. Many non-government organisations also provide housing assistance and services to people who are homeless or at risk of homelessness.

The National Affordable Housing Agreement (NAHA) provides the current framework for Australian, State and Territory governments' housing policy, and funds many housing and homelessness services. The NAHA is focused on achieving improved housing outcomes for all Australians and acknowledges the contribution of these outcomes to economic and social participation (COAG 2008). Commencing on 1 January 2009, the NAHA replaced the Commonwealth State Housing Agreement (CSHA) and Supported Accommodation Assistance Program (SAAP) V Agreement.

Sector scope

This Report includes detailed information on two specific services: social housing and homelessness services. Social housing broadly encompasses public housing, State owned and managed Indigenous housing (SOMIH), community housing and Indigenous community housing, and is reported in chapter 16 (box G.1). Homelessness services in this Report encompass government funded specialist homelessness services, and is reported in chapter 17 (box G.2).

This Report focuses on social housing and homelessness services funded under the National Affordable Housing Specific Purpose Payment (NAH SPP) and related National Partnership Agreements, and provided through these related National Partnership Agreements in support of the NAHA (formerly, the CSHA and the SAAP V Agreement). Governments provide other forms of support for housing and

homelessness, including home purchase assistance and private rental assistance, but these are not considered in detail in this Report.

Housing and homelessness outcomes are influenced by many factors apart from government assistance. Section G.6 (Appendix) presents contextual information on some of these factors, including housing affordability and home ownership.

Box G.1 Scope of social housing

Social housing is rental housing provided by government or non-government organisations (including not-for-profit) to assist people who are unable to access suitable accommodation in the private rental market (AIHW 2010). The forms of social housing included in this Report are:

- *Public housing* (PH): dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation.
- *State owned and managed Indigenous housing* (SOMIH): dwellings owned and managed by State housing authorities that are allocated only to Indigenous households.
- *Community housing* (CH): rental housing provided to low to moderate income or special needs households, managed by community based organisations that have received capital or recurrent subsidy from government. Community housing models vary across jurisdictions, and the housing stock may be owned by a variety of groups, including local government.
- *Indigenous community housing* (ICH): dwellings owned or leased and managed by ICH organisations and community councils in major cities, regional areas and remote areas. Indigenous community housing models vary across jurisdictions and can also include dwellings funded or registered by government.

Crisis and transitional housing is an additional form of social housing, but it is not separately identified in this Report. Crisis and transitional housing may be indirectly reported for some jurisdictions through the other forms of social housing described above.

Source: Chapter 16.

Box G.2 **Scope of homelessness**

Government funded specialist homelessness services provide assistance to individuals and families who are homeless or at risk of becoming homeless. This Report presents information on homelessness services provided under the NAHA and the SAAP V Agreement. Although the SAAP V Agreement ended on 31 December 2008, data have continued to be reported from the SAAP collection, as data from the new specialist homelessness services (SHS) collection are not yet available for reporting. The SHS data collection became operational on 1 July 2011 and data for 2011-12 are expected to be available for the 2013 Report.

Definition of homelessness

The term 'homelessness' can be used to describe the extent to which housing needs are unmet, including people without conventional accommodation and those staying in accommodation that is below minimum community standards. The most widely accepted, broad definition of homelessness describes three categories of homelessness:

- Primary homelessness is experienced by people without conventional accommodation (for example, sleeping rough or in improvised dwellings).
- Secondary homelessness is experienced by people who frequently move from one temporary shelter to another (for example, emergency accommodation, youth refuges, 'couch surfing').
- Tertiary homelessness is experienced by people staying in accommodation that is below minimum community standards (for example, boarding houses and caravan parks).

The Commonwealth Advisory Committee on Homelessness has adopted tertiary homelessness (incorporating primary and secondary homelessness) as the general definition of homelessness. This definition differs from the SAAP definition of homelessness used for reporting in chapter 17, where a 'homeless person' is:

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:

- has 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.

Source: Chamberlain & MacKenzie (2008); Homelessness Australia (2010); Chapter 17.

Profile of the housing and homelessness sector

Detailed profiles for the services within the housing and homelessness services sector are reported in chapters 16 and 17, and cover:

- size and scope of the individual service types
- roles and responsibilities of each level of government
- funding and expenditure.

Roles and responsibilities

The Australian, State and Territory governments share responsibility for housing and homelessness assistance provided under the NAHA.

- The Australian, State and Territory governments jointly fund specialist homelessness services.
- The Australian Government provides funding for housing and homelessness services to State and Territory governments through the NAH SPP and related National Partnership Agreements. The Australian Government influences the housing market through direct and indirect means, including providing CRA, home purchase assistance, financial sector regulations and taxation.
- State and Territory governments fund, administer and deliver social housing and homelessness services, and provide financial support to renters through private rental assistance. State and Territory governments are also responsible for land use and supply policy, urban planning and development policy, housing related taxes and charges (such as land taxes and stamp duties) and residential tenancy legislation and regulation.
- Local governments are responsible for building approval, urban planning and development processes, and may be involved in providing community housing.
- Non-government agencies deliver most homelessness services with some local government participation.

Government funding and expenditure

Most government funding for housing and homelessness services is provided through the NAH SPP. This funding is based on outcomes rather than tied to programs, so it is not possible to identify NAH SPP funding used for specific programs. In 2010-11, the Australian Government provided \$2.0 billion to State and Territory governments for housing and homelessness services through the NAH

SPP and related National Partnership agreements covering social housing; homelessness; and Remote Indigenous Housing (table GA.1). In addition, the Australian Government provided a further \$3.1 billion for CRA (table 16A.54). The Australian Government provided a further \$1.3 billion for the social housing initiative component of the National Building Economic Stimulus Package to aid the construction of new social housing dwellings, and repairs and maintenance of existing dwellings (table GA.1).

Australian, State and Territory governments' total expenditure on social housing and homelessness services was \$3.3 billion in 2009-10 (table G.1). Other descriptive data for social housing and homelessness services for 2009-10 are presented in table G.1, and data for each jurisdiction are reported in tables GA.3 and GA.4. Further information, including 2010-11 financial data for public housing, SOMIH and homelessness services, is presented in chapters 16 and 17.

Table G.1 Housing and homelessness services sector, selected descriptive statistics, Australia, 2009-10^a

	<i>Net recurrent expenditure</i>	<i>No. units</i>	<i>No. households</i>
	<i>\$m</i>	<i>Dwellings ('000)^b</i>	<i>'000</i>
<i>Social housing</i>			
Public housing	2 230.7	333.4	325.7
SOMIH	113.6	12.0	11.5
Community housing	443.9	44.3	42.6
Indigenous community housing ^c	85.2	18.7	na
Total	2 873.5	408.4	379.7
	<i>\$m</i>	<i>Clients ('000)</i>	
<i>Homelessness services</i>	461.1	135.7	..
Total	3 334.6	..	..

^a Data may not be comparable across jurisdictions or service areas and comparisons could be misleading. Chapters 16 and 17 provide further information. ^b The total number of dwellings at 30 June. ^c Data for ICH are likely to be underestimated because complete data were not available for all jurisdictions. The number of ICH dwellings are 'funded, permanent dwellings'. **na** Not available. **..** Not applicable.

Source: Chapters 16 and 17; table GA.2.

Commonwealth Rent Assistance

CRA is an Australian Government payment to people on low and moderate incomes who are renting in the private housing market, to assist with the cost of housing. It is a non-taxable income supplement, paid 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 market. CRA may be payable to people living in community housing

or Indigenous community housing but it is not payable to people renting housing from State or Territory housing authorities (that is, people living in public housing and SOMIH), as housing authorities separately subsidise rent for eligible tenants.

CRA is paid at 75 cents for every dollar above a minimum rental threshold until a maximum rate is reached. The minimum threshold and maximum rates vary according to an income unit's family situation and number of children (table 16.3). Information on the eligibility and payment scales for CRA are presented in table 16A.56.

Australian Government expenditure on CRA was \$3.1 billion in 2010-11, increasing from \$2.6 billion in 2006-07 (in real terms) (table 16A.54). The average government expenditure per income unit receiving CRA was \$2778 in 2010-11 (table 16A.55).

At 3 June 2011:

- there were 1 138 000 income units receiving CRA (table 16A.57)
- the median CRA payment was \$113 per fortnight (table 16A.64)
- 74.5 per cent of all CRA recipients were paying enough rent to be eligible to receive the maximum rate of CRA (table 16A.65).

Though funded separately to the NAH SPP, CRA contributes to NAHA outcomes relating to housing affordability. CRA assists with reducing the cost of housing and the incidence of rental stress (defined as more than 30 per cent of household income is being spent on rent) for people on low incomes. Nationally in 2011, 68.3 per cent of CRA recipients would have paid more than 30 per cent of their gross income on rent if CRA were not provided. However, with CRA, 40.1 per cent of CRA recipients spent more than 30 per cent of their income on rent (table 16A.66).

Further information on CRA can be found in chapter 16 and attachment 16A (tables 16A.54–16A.76).

Social and economic factors affecting demand for services

Demand for housing and homelessness services is influenced by a shortage of affordable housing, long term unemployment and financial hardship, mental health issues, substance abuse, and family and relationship breakdown. Among women, domestic and family violence is the main reason for seeking help from specialist homelessness services (Homelessness Taskforce 2008, p.viii).

Research shows the pathways to homelessness are varied and complex. For Indigenous people, longitudinal factors (for example, influences from early childhood) can compound with situational factors, leading to homelessness. For young people, factors such as family conflict or abuse, drug use, unstable employment, participating in education and training, combining work and study, and financial pressure (for example, tension between paying rent, food and utility costs) can potentially lead to unstable housing and increase the risk of homelessness (Memmott and Chambers 2010; CHP 2005).

Demand for housing assistance may continue even after recipients have gained stable employment and financial circumstances are improved. A study of workforce participation of women living in public housing in Australia found that job insecurity and low wages are the main incentives for tenants to continue to live in public housing (Saugeres and Hulse 2010).

Service-sector objectives

The overarching service sector objectives in box G.3 draw together the objectives from each of the specific services (described in chapters 16 and 17), as well as reflecting the objectives set out in the NAHA.

Box G.3 Objectives for housing and homelessness services

The overarching objective of housing and homelessness services is that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation. Further, government services are to be provided in a collaborative, equitable and efficient manner.

The specific objectives of the services that comprise the housing and homelessness services sector are summarised below:

- *Social housing* aims to assist people unable to access alternative suitable housing options, through the delivery of affordable, appropriate, flexible and diverse social housing. Some forms of social housing specifically aim to contribute to Indigenous community wellbeing, by improving housing outcomes for Indigenous people, especially those living in remote communities (chapter 16).
- *Government funded specialist homelessness services* aim 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 self-reliance and independence (chapter 17).

Source: COAG (2008), Chapters 16 and 17.

G.2 Sector performance indicator framework

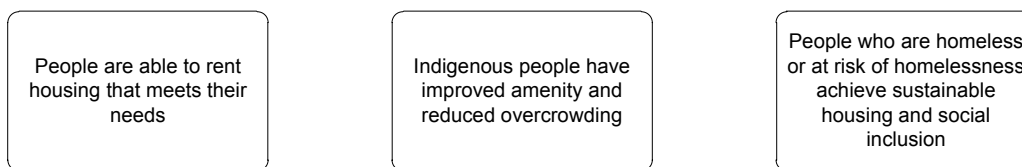
This sector summary is based on a sector performance indicator framework (figure G.1). This framework is made up of the following elements:

- Sector objectives — three sector objectives are a précis of the key objectives of housing and homelessness services and reflect the outcomes in the NAHA (box G.3).
- Sector-wide indicators — three sector-wide indicators relate to the overarching service sector objectives.
- Information from the service-specific performance indicator frameworks that relate to housing and homelessness services. Discussed in more detail in chapters 16 and 17, the service-specific frameworks provide comprehensive information on the equity, effectiveness and efficiency of these services.

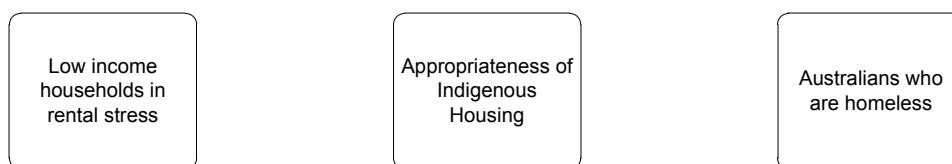
This sector summary provides an overview of relevant performance information. Chapters 16 and 17 and their associated attachment tables provide more detailed information.

Figure G.1 Housing and homelessness services sector performance indicator framework

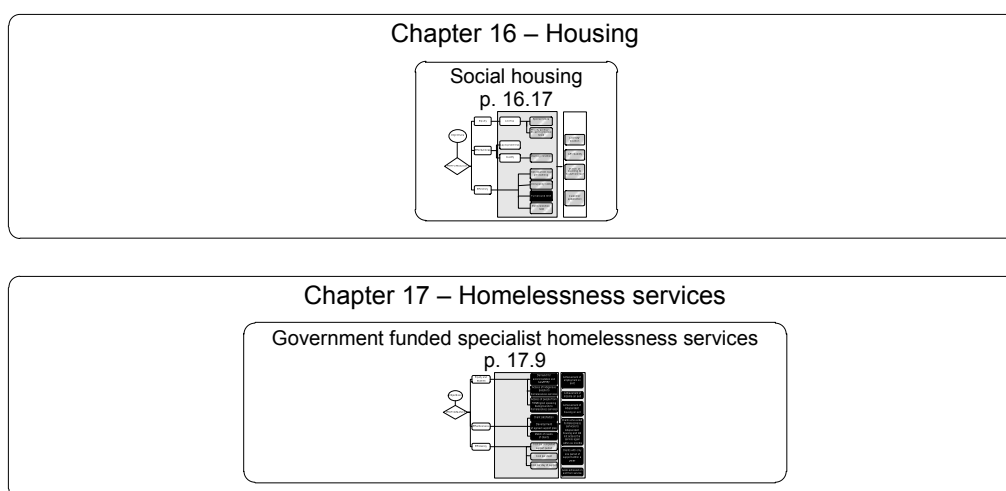
Sector objectives



Sector-wide indicators



Service specific performance indicator frameworks



Sector-wide indicators

This section includes high level indicators of housing and homelessness outcomes. Many factors are likely to influence these outcomes — not solely the performance of government services. However, these outcomes inform the development of appropriate policies and the delivery of government services.

Low income households in rental stress

‘Low income households in rental stress’ is an indicator of governments’ objective to provide affordable housing to assist people who are unable to access suitable housing (box G.4).

Box G.4 Low income households in rental stress

‘Low income households in rental stress’ is defined as the proportion of low income households spending more than 30 per cent of their gross household income on rent.

Low income households are defined as those in the bottom 40 per cent of equivalised disposable household incomes (that is, the bottom two income quintiles). Equivalised disposable income is an indicator of disposable household income after taking into account household size and composition (ABS 2010a). Household income and rent expenditure exclude CRA.

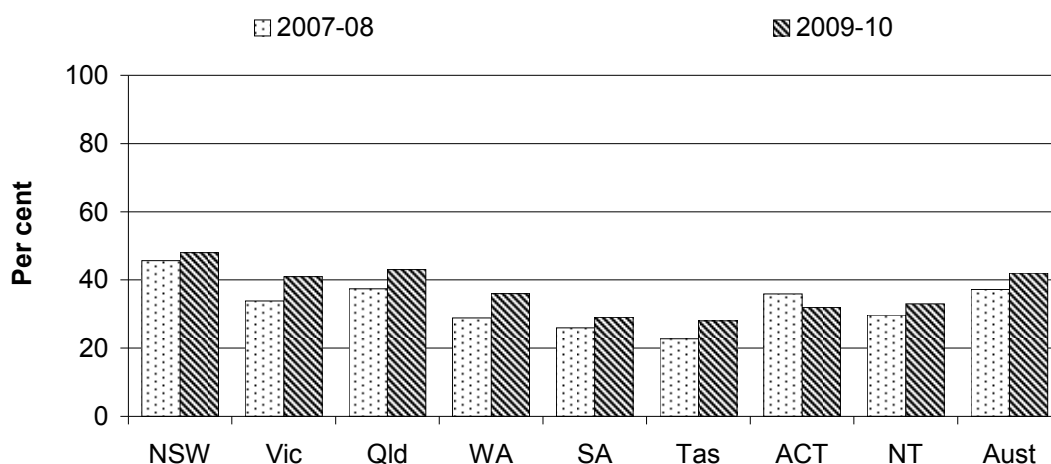
A low or decreasing proportion of households in rental stress implies greater housing affordability.

The social housing outcome indicator ‘affordability’ provides additional information on rental stress (chapter 16).

Data reported for this indicator are comparable and complete. Data quality information for this indicator are at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, the proportion of low income households in rental stress increased from 37.2 per cent in 2007-08 to 41.7 per cent in 2009-10, though this varied across jurisdictions (figure G.2).

Figure G.2 Proportion of low income households in rental stress



Source: ABS (unpublished) *Survey of Income and Housing 2007-08 and 2009-10*; table GA.5.

Appropriateness of Indigenous housing

‘Appropriateness of Indigenous housing’ is an indicator of governments’ objective to ensure all Australians have access to affordable, safe, appropriate and sustainable

housing (box G.5). Governments have a specific interest in improving amenity and reducing overcrowding for Indigenous people, particularly those living in remote and discrete communities (COAG 2008).

Box G.5 Appropriateness of Indigenous housing

‘Appropriateness of Indigenous housing’ is an indicator of the effectiveness and quality of Indigenous housing. Two measures are reported:

- proportion of Indigenous households living in overcrowded conditions
- proportion of Indigenous households living in houses of an acceptable standard.

A low or decreasing proportion of households living in overcrowded conditions is desirable. A high or increasing proportion of Indigenous households living in houses of an acceptable standard is desirable.

Data comparability and completeness vary for this indicator:

- data for overcrowding are neither comparable nor complete
- data for housing of acceptable standard are comparable but not complete.

Related information on the appropriateness of social housing is presented for the outcome indicators ‘match of dwelling to household size’ ‘and amenity/location’ in chapter 16.

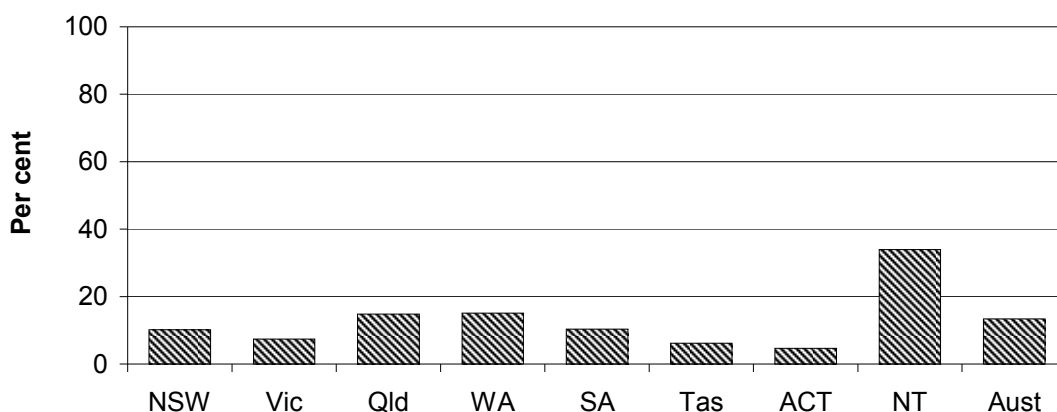
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Indigenous households living in overcrowded conditions

Overcrowding is deemed to occur if one or more bedrooms are required to meet the Canadian National Occupancy Standard (explained in chapter 16). Overcrowding is a significant issue for many Indigenous people. Nationally in 2008:

- the proportion of Indigenous people living in overcrowded conditions (27.5 per cent) exceeded that for non-Indigenous people (5.7 per cent) (SCRGSP 2011)
- 13.4 per cent of Indigenous households were overcrowded (figure G.3).

Figure G.3 **Proportion of overcrowded Indigenous households, 2008**

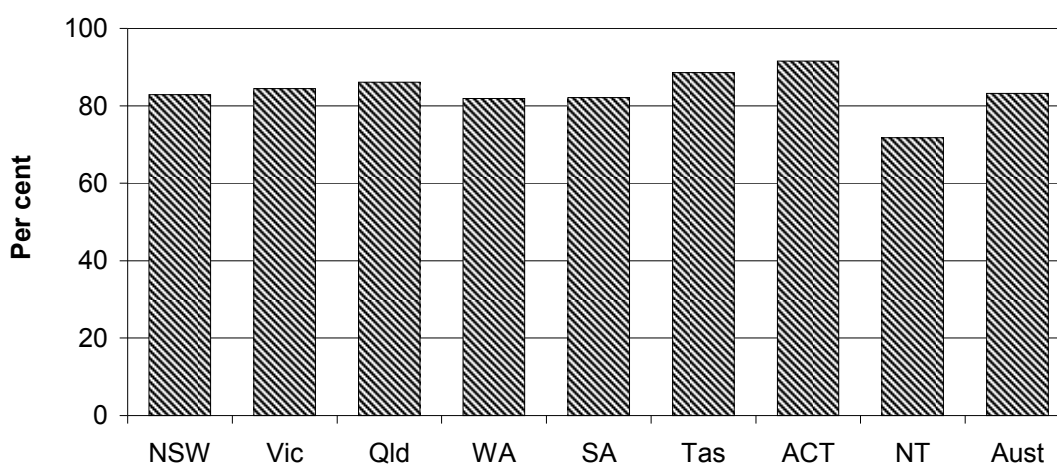


Source: ABS (unpublished) *National Aboriginal and Torres Strait Islander Social Survey 2008*; table GA.6.

Indigenous households living in houses of an acceptable standard

A house is assessed as being of an acceptable standard if it has all four basic facilities working: for washing people; for washing clothes/bedding; for storing/preparing food; and sewerage; and not more than two major structural problems. In 2008, 83.2 per cent of Indigenous households were living in houses of an acceptable standard (figure G.4).

Figure G.4 **Proportion of Indigenous households living in houses of an acceptable standard, 2008**



Source: ABS (unpublished) *National Aboriginal and Torres Strait Islander Social Survey 2008*; table GA.7.

Australians who are homeless

‘Australians who are homeless’ is an indicator of governments’ objective to ensure all Australians have access to affordable, safe and sustainable housing (box G.6).

Box G.6 Australians who are homeless

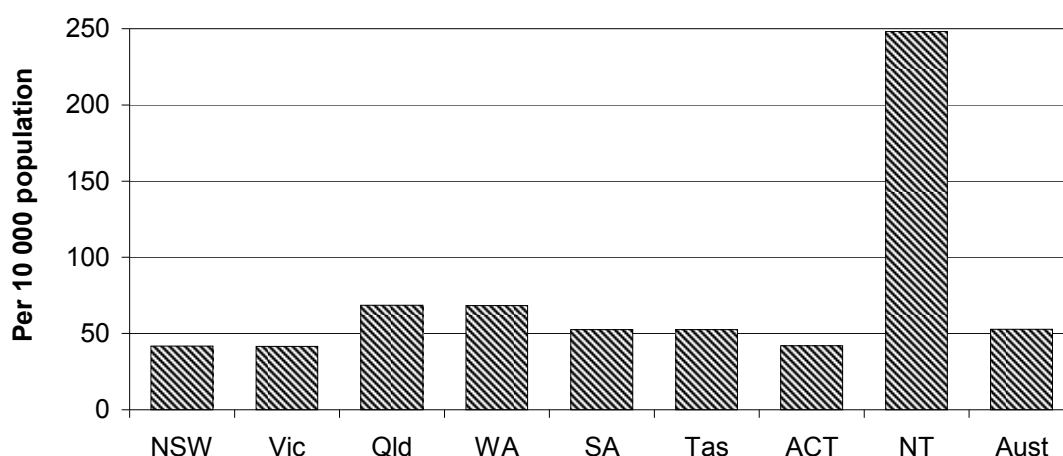
‘Australians who are homeless’ is defined as the proportion of Australians who are homeless. For this indicator, homeless people are defined as those who experience primary, secondary or tertiary homelessness (see box G.2).

A low or decreasing proportion of Australians who are homeless is desirable.

Data for this indicator are comparable but not complete. The calculation of homelessness used for these data are currently under review. Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally in 2006, approximately 53 Australians per 10 000 people in the population were homeless on Census night (figure G.5). Of people experiencing homelessness, an estimated 16 per cent, or 16 375 people, were identified as sleeping rough (Chamberlain & MacKenzie 2008). There are some difficulties associated with identifying and counting homeless people in the population and these data should be interpreted with care. The method for counting homeless people in the Census is under review and estimates are expected to be revised in future Reports.

Figure G.5 Rate of homelessness, 2006 (per 10 000 population)



Source: AIHW (unpublished) SAAP Client Collection 2006; Chamberlain, C. and MacKenzie, D. 2008, *Counting the homeless*, 2006, Australian Bureau of Statistics, Cat. No. 2050.0; table GA.8.

Service-specific performance indicator frameworks

This section summarises information from the performance indicator frameworks for social housing (chapter 16) and government funded specialist homelessness services — SAAP (chapter 17). Additional information is available to assist the interpretation of these results:

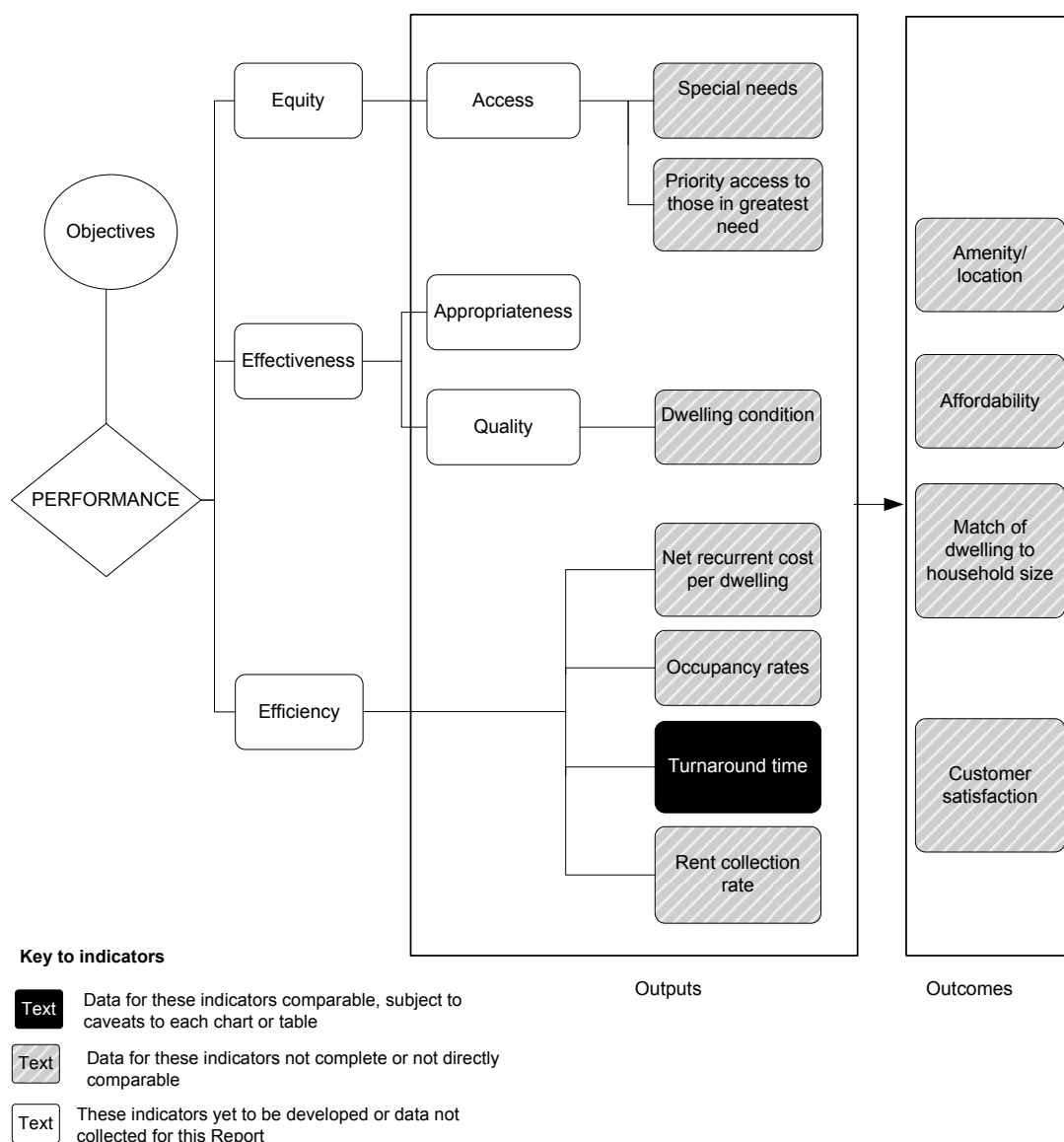
- indicator interpretation boxes, which define the measures used and indicate any significant conceptual or methodological issues with the reported information (chapters 16 and 17)
- caveats and footnotes to the reported data (chapter 16 and attachment 16A; chapter 17 and attachment 17A)
- additional measures and further disaggregation of reported measures (for example, by Indigenous status, remoteness, disability and age data (chapter 16 and attachment 16A; chapter 17 and attachment 17A)
- data quality information for many indicators, based on the ABS Data Quality Framework.

A full list of attachment tables and available data quality information is provided at the end of chapters 16 and 17.

Social housing

The performance indicator framework for social housing is presented in figure G.6. This framework provides information on equity, efficiency, effectiveness, and outcomes of social housing.

Figure G.6 Social housing performance indicator framework



An overview of the performance indicator results for the most recent reporting period is presented in table G.2. Results are reported separately for public housing, SOMIH, community housing and Indigenous community housing. Data for Indigenous community housing are not reported for a number of performance indicators due to issues with data quality and availability. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 16 and in the footnotes in attachment 16A.

Table G.2 Performance indicators for social housing^{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>

Equity (access) indicators

Special needs – proportion of new tenancies allocated to households with special needs (%)

Data comparability and completeness vary for this indicator.

PH 2010-11	65.4	67.5	71.5	62.3	69.8	66.8	55.7	64.8	66.7
SOMIH 2010-11	56.1	..	57.0	..	48.7	82.4	..	..	56.4
CH 2010-11	64.3	50.7	42.5	50.5	84.9	55.9	47.9	na	56.1

Source: tables 16A.9–16A.11.

Priority access to those in greatest need– proportion of new allocations of housing to those in greatest need (%)

Data comparability and completeness vary for this indicator.

PH 2010-11	66.2	73.1	92.1	61.2	78.2	96.2	92.5	45.2	74.4
SOMIH 2010-11	31.2	..	93.6	..	84.6	na	..	..	58.6
CH 2010-11	70.2	87.3	73.0	62.3	42.8	91.1	75.1	na	71.6

Source: tables 16A.12–16A.14.

Effectiveness indicators

Dwelling condition

Data for this indicator not complete or not directly comparable.

Dwellings in need of repair (%)^c

ICH 2006	18.8	24.7	26.3	27.9	22.4	30.6	..	21.0	23.4

Dwellings in need of replacement (%)^c

ICH 2006	2.7	4.5	5.9	10.1	5.8	–	..	10.2	7.2

Source: table 16A.15.

Efficiency indicators

Net recurrent cost per dwelling (\$)

Data comparability and completeness vary for this indicator.

PH 2010-11	6 977	5 658	6 043	8 191	6 994	8 777	8 167	12 769	6 888
SOMIH 2010-11	7 630	..	10 581	..	11 670	7 780	..	..	9 410
CH 2009-10	10 175	8 445	7 263	8 062	7 459	21 312	10 268	na	9 120
ICH 2009-10	14 226	8 991	4 479	6 800	3 967	10 812	na	na	7 491

Source: tables 16A.17–16A.20.

Occupancy rates (%)

Data comparability and completeness vary for this indicator.

PH 2010-11	99.9	96.9	98.6	96.1	95.9	98.4	97.9	96.1	98.0
SOMIH 2010-11	99.9	..	95.7	..	94.6	98.0	..	..	97.4
CH 2010-11	97.6	93.6	94.6	93.8	98.1	95.6	91.4	100.0	95.9
ICH 2009-10	97.0	95.7	96.4	73.7	87.8	90.2	na	na	90.8

Source: tables 16A.21–16A.24.

(Continued)

Table G.2 (continued)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Turnaround time (days)									
Data for this indicator are comparable and complete, subject to caveats.									
PH 2010-11	31.3	29.2	27.8	26.9	27.5	29.3	38.2	58.8	30.0
SOMIH 2010-11	20.4	..	40.9	..	26.4	39.5	..	..	27.7
Source: tables 16A.25 and 16A.26.									
Rent collection rate (%)									
Data comparability and completeness vary for this indicator.									
PH 2010-11	99.2	98.7	100.9	100.7	100.0	99.0	99.5	96.7	99.6
SOMIH 2010-11	104.0	..	99.3	..	99.9	99.0	..	..	101.7
CH 2009-10	96.1	98.1	99.3	99.6	99.7	100.2	101.6	na	97.7
ICH 2009-10	90.3	92.3	83.5	84.7	na	97.0	na	93.6	88.1
Source: tables 16A.27–16A.30.									
Amenity/location (%)									
Data comparability and completeness vary for this indicator.									
Amenity important and meeting needs (%)									
PH 2010	79.7	78.6	84.7	84.8	84.7	79.8	78.4	82.6	81.6
CH 2010	83.1	85.2	83.1	84.9	86.9	91.0	88.9	na	84.3
Location important and meeting needs (%)									
PH 2010	86.5	87.4	89.9	87.9	87.8	85.2	83.8	86.4	87.5
CH 2010	87.6	89.7	87.2	87.6	88.5	94.5	94.5	na	88.3
Source: tables 16A.31–16A.35.									
Affordability – proportion of low income households spending more than 30 per cent of their gross income on rent (%)									
Data comparability and completeness vary for this indicator.									
PH 2010-11	0.2	np	0.1	1.4	–	np	0.8	1.8	0.3
SOMIH 2010-11	0.3	..	0.2	..	–	–	..	..	0.2
CH 2010-11	10.8	12.2	na	32.2	1.2	35.5	2.0	na	12.5
Source: table 16A.39.									
Match of dwelling to household size – proportion of overcrowded households (%)									
Data comparability and completeness vary for this indicator.									
PH 2010-11	4.3	4.1	5.0	4.5	2.4	4.7	7.2	8.2	4.3
SOMIH 2010-11	7.0	..	14.7	..	11.1	4.7	..	..	10.3
CH 2010-11	1.5	2.6	na	1.2	2.6	1.4	0.3	na	1.8
ICH 2009-10	na	6.3	43.8	28.4	48.4	na	na	na	na
Source: tables 16A.44–16A.47.									

(Continued)

Table G.2 (continued)

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Customer satisfaction (%)										
Data for this indicator are comparable and complete, subject to caveats.										
PH	2010	64.2	74.5	84.4	73.9	81.6	68.0	75.0	74.3	73.1
SOMIH	2007	58.6	64.8	74.8	60.2	57.9	72.8	..	..	63.5
CH	2010	76.7	79.2	81.4	78.7	84.3	90.4	78.0	na	79.1

Source: tables 16A.33, 16A.52 and 16A.53.

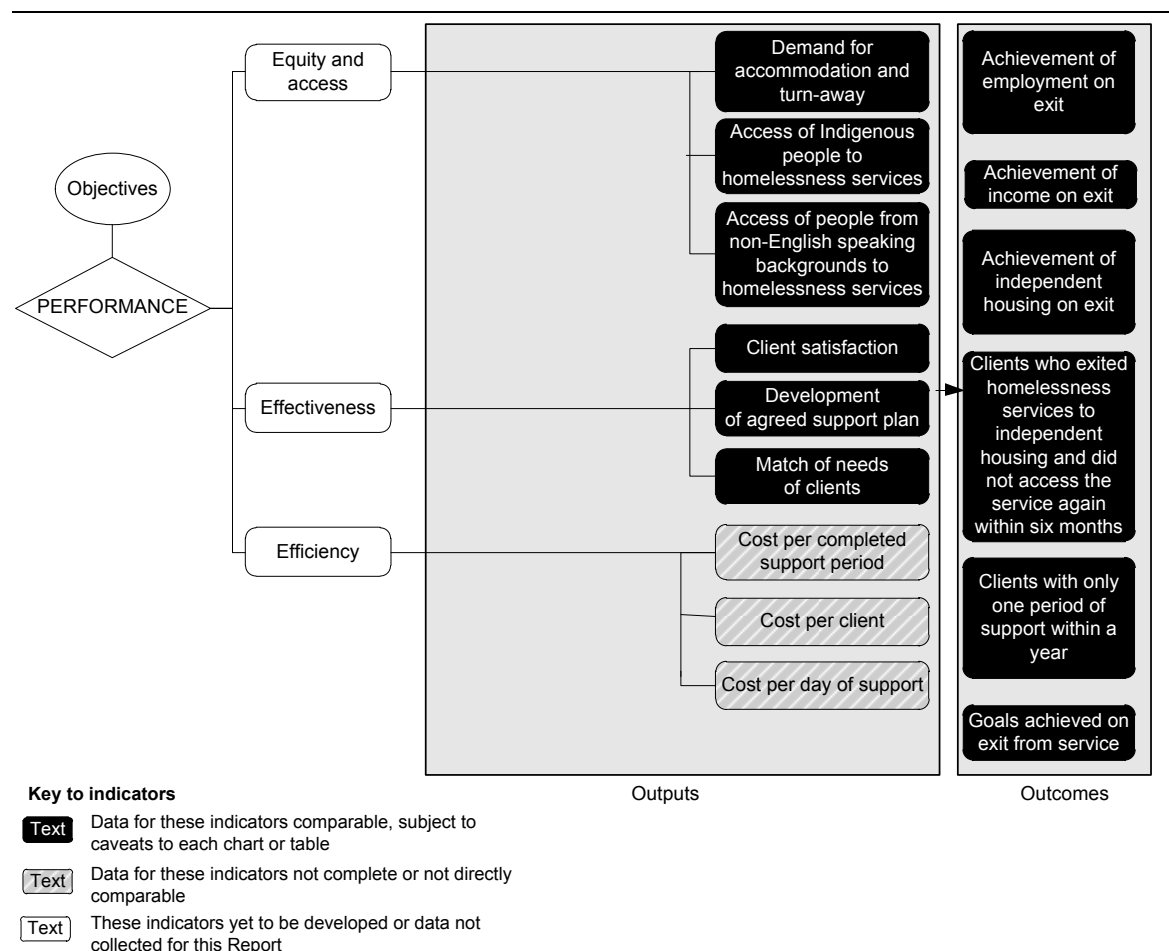
^a Caveats for these data are available in Chapter 16 and Attachment 16A. Refer to the indicator interpretation boxes in chapter 16 for information to assist with the interpretation of data presented in this table. ^b Some data are derived from detailed data in Chapter 16 and Attachment 16A. ^c NSW data includes ACT. **na** Not available. .. Not applicable. – Nil or rounded to zero.

Source: Chapter 16 and Attachment 16A.

Homelessness services

The performance indicator framework for government funded specialist homelessness services is presented in figure G.7. This framework provides information on equity, efficiency, and outcomes of homelessness services. The 2013 Report is expected to include data from the specialist homelessness services data collection, and incorporate any performance indicator framework developments to reflect the NAHA.

Figure G.7 Government funded specialist homelessness services performance indicator framework



An overview of the performance indicator results for 2009–10 are presented in table G.3. Data reported are for homelessness services provided under the NAHA and are sourced from the SAAP data collection. Information to the interpretation of these data can be found in the indicator interpretation boxes in chapter 17 and in the footnotes in attachment 17A.

Table G.3 Performance indicators for government funded specialist homelessness services^{a, b}

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Equity (access) indicators										
<i>Demand for accommodation and turn-away</i>										
Data for this indicator comparable, subject to caveats.										
Turn-away as proportion of people requiring new, immediate accommodation										
2009-10	%	45.5	na	55.2	55.2	66.0	71.2	73.1	47.3	53.4
Turn-away as % of total demand for homelessness services accommodation										
2009-10	%	1.9	na	3.4	3.3	2.2	5.6	2.1	3.4	2.6
Source: tables 17A.7 and 17A.8.										
<i>Access of Indigenous people to homelessness services</i>										
Data for this indicator comparable, subject to caveats.										
Representation among all accommodated clients										
2009-10	%	16.9	7.5	23.7	37.2	20.7	12.0	15.3	69.2	22.4
Representation among people whose valid requests for accommodation were unmet										
2009-10	%	28.4	na	29.1	45.7	20.7	7.7	16.7	55.6	29.1
Source: table 17A.9.										
<i>Access of people from non-English speaking backgrounds to homelessness services</i>										
Data for this indicator comparable, subject to caveats.										
Representation among all accommodated clients										
2009-10	%	13.9	20.3	7.8	11.1	8.7	3.4	19.9	4.4	11.8
Representation among people whose valid requests for accommodation were unmet										
2009-10	%	7.8	na	4.1	6.2	6.9	5.1	16.7	–	5.9
Source: table 17A.10.										
Effectiveness indicators										
<i>Development of agreed support plan</i>										
Data for this indicator comparable, subject to caveats.										
2009-10	%	69.4	53.5	60.7	52.8	66.6	61.6	75.6	66.5	60.6
<i>Match of needs of clients (provided and referred)</i>										
Data for this indicator comparable, subject to caveats.										
2009-10	%	98.2	95.8	96.6	97.4	89.8	96.8	98.4	99.0	96.5
Source: tables 17A.11 and 17A.13.										
Efficiency indicators										
<i>Cost per completed support period</i>										
Data for this indicator not complete or not directly comparable.										
2009-10	\$	2 490	1 620	3 190	2 530	2 050	3 050	7 770	3 600	2 350
<i>Cost per client</i>										
Data for this indicator not complete or not directly comparable.										
2009-10	\$	3 020	2 710	3 770	3 530	2 800	3 450	7 770	4 520	3 260

(Continued)

Table G.3 (continued)

		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Cost per day of support</i>										
Data for this indicator not complete or not directly comparable.										
2009-10	\$	23	30	44	39	22	35	52	47	30

Source: Tables 17A.17, 17A.18 and 17A.19.

Outcome indicators*Achievement of employment on exit (change in employed)*

Data for this indicator comparable, subject to caveats.

2009-10	%	9.7	9.1	11.0	12.5	7.2	8.4	9.1	14.2	9.8

Source: table 17A.23.

Achievement of income on exit (change in 'has an income')

Data for this indicator comparable, subject to caveats.

2009-10	%	7.3	11.5	9.5	10.9	8.6	16.8	13.5	5.8	9.1

Source: table 17A.28.

Achievement of independent housing on exit (change in independent housing)

Data for this indicator comparable, subject to caveats.

2009-10	%	7.6	9.4	9.1	9.6	9.0	20.6	15.3	4.4	9.0

Source: table 17A.21.

Clients with only one period of support within a year

Data for this indicator comparable, subject to caveats.

2009-10	%	76.6	68.4	76.1	73.6	70.5	77.2	80.1	75.2	72.8

Source: table 17A.25.

Goals achieved on exit on service (all or most goals achieved)

Data for this indicator comparable, subject to caveats.

2009-10	%	72.0	69.5	60.2	50.9	59.8	44.7	61.1	60.2	65.7

Source: table 17A.30.

^a Caveats for these data are available in Chapter 17 and Attachment 17A. Refer to the indicator interpretation boxes in chapter 17 for information to assist with the interpretation of data presented in this table. ^b Some data are derived from detailed data in Chapter 17 and Attachment 17A. **na** Not available. – Nil or rounded to zero.

Source: Chapter 17 and Attachment 17A.

G.3 Cross-cutting and interface issues

Australian and international research identifies a strong association between housing, health status, living standards and well-being (Morris 2010; Bridge et al 2003; Quine et al 2004; Waters 2001). A lack of adequate and affordable housing contributes to housing stress and homelessness, and is detrimental to people's physical and mental health. People who are homeless have a much higher prevalence of mental illness than the general population (Mental Health Council of

Australia 2009). Homelessness affects life expectancy, with homeless people estimated to live 15–20 years less than the mainstream population (Quine et al 2004).

The provision of housing assistance and homelessness services can improve people's education, health and employment outcomes, community cohesion and reduce crime (King 2002; Bridge et al 2003; AHURI 2008; Morris 2010).

Studies have found that housing assistance affects education outcomes by reducing housing costs and increasing financial resources available for education and training, and providing security of tenure to create stable learning environment (Bridge et al 2003). Conversely, housing assistance may reduce the incentives to participate in the labour market, with security of tenure reducing willingness to relocate for employment purposes (Bridge et al 2003).

There is evidence to suggest that effective housing assistance programs reduce the burden on health and justice services, leading to reduced expenditure for hospital, ambulance, police and court services (AHURI 2008).

National research developments

The National Homelessness Research Agenda 2009–2013 was released on 20 November 2009. The Agenda provides a framework for building an evidence base to prevent and respond to homelessness. It reflects the Australian Government's strategic research priorities and lists key research questions for the development of an evidence base to drive reform (FaHCSIA 2010).

The Australian Housing and Urban Research Institute's (AHURI) national research agenda reflects the integrated, 'whole of housing system' approach of the housing and homelessness policy environment and emphasises the importance of establishing the links between housing and the broader social context (AHURI 2011). Eight strategic research issues are identified, and research responding to these strategic issues will assist national housing policy development.

G.4 Future directions in performance reporting

This housing and homelessness sector summary will continue to be developed in future reports.

Review of National Agreements and National Partnership Agreements

COAG has agreed to progress the recommendations of the Heads of Treasuries (HoTs) Review of National Agreements, National Partnerships and Implementation Plans and reports of the COAG Reform Council (CRC). A working group, led by Senior Officials from First Ministers' and Treasury agencies, will review the performance frameworks of a limited number of agreements, including the NAHA. The reviews will be concluded by June 2012. The recommendations of the review of the NAHA will be considered by the Steering Committee and may be reflected in future reports.

The Housing and Homelessness services chapters contain a service specific section on future directions in performance reporting.

G.5 List of attachment tables

Attachment tables are identified in references throughout this service sector summary by a 'GA' prefix (for example, table GA.1). Attachment tables are provided on the Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Table GA.1	Australian Government nominal expenditure relating to the National Affordable Housing Agreement (NAHA) and Nation Building Economic Stimulus Package (\$million)
Table GA.2	Housing and homelessness services sector, descriptive statistics, Australia, 2009-10
Table GA.3	Social housing descriptive statistics, 2009-10
Table GA.4	Homelessness services descriptive statistics, 2009-10
Table GA.5	Proportion of low income households in rental stress
Table GA.6	Proportion of Indigenous households living in overcrowded conditions
Table GA.7	Proportion of Indigenous households living in houses of an acceptable standard
Table GA.8	Australians who are homeless, 2006
Table GA.9	Supplementary contextual data

G.6 Appendix – Private housing market contextual information

Housing market demand, supply and affordability

The private housing market encompasses rented accommodation, home ownership and housing investment. A range of factors influence demand and supply in the private housing market:

- Factors affecting the demand for housing include population growth, household income and employment, investor demand, household preferences for size, quality and location of housing, the price and availability of housing, government taxes, concessions and transfers, and the cost and availability of finance (NHSC 2010).
- Factors affecting the supply of housing include land tenure arrangements, land release and development processes, construction and infrastructure costs, government taxes, concessions and transfers, and the availability and price of land (NHSC 2010). The availability of credit to finance the development of new housing can also affect the supply of housing (RBA 2009).

An efficient housing market refers to achieving a balance between housing supply and demand (CRC 2010, p. 75). Nationally in 2009, there was an estimated cumulative gap between underlying demand for housing and housing supply, as a proportion of growth in underlying demand, of 14.7 per cent. A estimated 178 400 dwellings were required in Australia to meet growth in demand (NHSC 2010: tables 7.2 and 7.3).

Housing affordability

A shortage of affordable housing is likely to affect demand for housing and homelessness services. Governments provide support to ensure people can access affordable rental housing, either in the private market or in social housing, and many governments provide support to those purchasing houses, particularly first home buyers (box G.7).

Box G.7 **Government assistance for affordable housing**

A range of government initiatives and programs are designed to help households to pay for housing, and to increase the supply of affordable housing. These initiatives include:

- direct assistance to first home buyers through schemes such as the First Home Owners Grant and the First Home Owners Boost. These schemes are funded by the Australian Government and administered by State and Territory governments
- funding for Indigenous home ownership programs (the Home Ownership Program funded and administered by Indigenous Business Australia and the Home Ownership on Indigenous Land Program jointly funded by FaHCSIA and IBA)
- stamp duty concessions or exemptions for first home buyers
- incentives to save for first home ownership through First Home Saver Accounts
- State and Territory Government funding to assist low income households with home purchases or mortgage repayments
- Commonwealth Rent Assistance paid on an ongoing basis to income support and family tax benefit recipients in the private rental market
- funding for provision and management of social (public and community) housing and related reforms through the National Affordable Housing Agreement
- incentives for institutional investors and community housing providers to build new affordable rental properties
- Commonwealth, State and Territory land and planning measures to increase the supply of affordable housing
- Housing Affordability Fund grants to improve planning and infrastructure provision.

Source: Australian, State and Territory Governments (unpublished).

The Housing chapter (chapter 16) reports on government assistance for social housing, but does not report on government assistance for purchasing housing or other forms of housing assistance. Information on housing affordability by region in Australia is available in the State of the Regions Report 2011–12: the housing shortage and housing affordability (ALGA 2011). The Steering Committee's annual report to the COAG Reform Council on NAHA performance information includes a range of housing data, some of which are reported below.

Affordable housing for low and moderate income households

Low income households are more likely to be adversely affected by relatively high housing costs than households with higher disposable incomes (Yates and Gabriel 2006; Yates and Milligan 2007).

Housing stress is considered to occur when households spend more than 30 per cent of their income on rent or mortgage payments. Nationally in 2009-10, 41.7 per cent of low income households were experiencing rental stress and 37.4 per cent of low income households were experiencing mortgage stress (tables GA.5 and GA.9). These data should be interpreted with care, because Australian household real incomes have increased strongly over time, allowing households to devote a larger proportion of their income to housing while still maintaining living standards (RBA 2008).

The proportion of homes sold that are affordable by low and moderate income households indicates whether people can purchase affordable housing. Nationally in 2010-11, 28.6 per cent of homes sold were affordable by low and moderate income households (table GA.9).

Home ownership and government assistance to home buyers

In 2009-10, 68.8 per cent of Australian households owned or were purchasing a home (table GA.9). Home ownership is not necessarily an aspiration for all Australian households, but is often considered desirable because of the benefits associated with home ownership, including wealth accumulation and security of tenure (CRC 2010, p. 60). The rate of home ownership in Australia is similar to many developed countries, but is comparatively higher than some European countries, which may reflect different cultural and economic incentives, such as income security for retirement (ABS 2010b; Frick and Headey 2009).

Governments provide financial assistance to people purchasing homes, particularly first home owners and low income home owners. Nationally in 2010-11, 103 598 people received the First Home Owner Scheme grant, compared to 168 562 people in 2009-10 (table GA.9).

G.7 References

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16 Housing

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Attachment tables

Attachment tables are identified in references throughout this chapter by a '16A' prefix (for example, table 16A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available on the Review website at www.pc.gov.au/gsp.

Governments play a significant role in the Australian housing market, directly through housing assistance and indirectly through policies associated with land planning and taxation. Direct assistance includes social housing, home purchase assistance and rent assistance. Housing assistance is provided by governments because many Australian households face problems in acquiring or accessing suitable private accommodation — either through renting from a private landlord or through owner occupation — for reasons of cost, discrimination, availability, location and/or adequacy. The Australian, State and Territory governments share responsibility for housing assistance.

This chapter focuses on the performance of governments in providing social housing, which broadly encompasses public housing, State owned and managed Indigenous housing, community housing, and Indigenous community housing. These services are outlined in box 16.1.

Box 16.1 Forms of social housing

Social housing is rental housing provided by not-for-profit, non-government or government organisations to assist people who are unable to access suitable accommodation in the private rental market. The forms of social housing included in this Report are:

- *Public housing* (PH): dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation.
- *State owned and managed Indigenous housing* (SOMIH): dwellings owned and managed by State housing authorities that are allocated only to Indigenous households.
- *Community housing* (CH): rental housing provided for low to moderate income or special needs households, managed by community-based organisations that have received a capital or recurrent subsidy from government. Community housing models vary across jurisdictions, and the housing stock may be owned by a variety of groups including government.
- *Indigenous community housing* (ICH): dwellings owned or leased and managed by ICH organisations and community councils in major cities, regional and remote areas. Indigenous community housing models vary across jurisdictions and can also include dwellings funded or registered by government.

Crisis and transitional housing is an additional form of social housing, but it is not separately identified in this Report. Crisis and transitional housing might be indirectly reported through the other forms of social housing described above.

Social housing is provided under the National Affordable Housing Agreement (NAHA). The NAHA is the overarching agreement between Australian, State and Territory governments for providing assistance to improve housing outcomes for Australian people. Prior to commencement of the NAHA on 1 January 2009, social housing was provided under the Commonwealth State Housing Agreement (CSHA) (box 16.2).

Box 16.2 National Affordable Housing Agreement and Commonwealth State Housing Agreement

The NAHA commenced on 1 January 2009 as part of the Intergovernmental Agreement on Federal Financial Relations. It is a broad, ongoing agreement that provides a framework to improve housing affordability and homelessness outcomes for Australians. The objective of the NAHA is that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation (COAG 2009).

In relation to housing assistance, the parties to the NAHA agreed to a range of outcomes, including:

- providing social housing; assistance to people in the private rental market; and home purchase assistance
- improving coordination across housing related programs to make better use of existing housing stock and assets
- improving the integration between housing and human services, including health and disability services.

The NAHA replaced the CSHA, which concluded on 31 December 2008. The aim of the CSHA was to provide appropriate, affordable and secure housing for those in greatest need, for the duration of their need.

Source: FaCS (2003); COAG (2009).

This chapter also includes descriptive information on Commonwealth Rent Assistance (CRA). CRA makes an important contribution to achieving the NAHA outcomes for housing affordability.

Links to other government services

Close links exist between social housing and other government programs and support services discussed elsewhere in the Report, such as:

- assistance to people who are homeless or at risk of homelessness (chapter 17)
- various health and community services, including mental health services (chapter 12), aged care services (chapter 13) and services for people with disability (chapter 14).

Improvements in the 2012 Report

Major improvements in the chapter this year are:

-
- inclusion of a single social housing performance indicator framework, replacing the separate performance indicator frameworks for public housing, SOMIH, community housing and Indigenous community housing
 - simplifying and restructuring CRA reporting as contextual material
 - inclusion of new ‘data quality information’ (DQI).

Data sources

This Report presents data for up to 10 years, reflecting housing assistance provided under the NAHA and the CSHA. Data from 2009-10 onward relate to the NAHA, data for 2008-09 relate to both the NAHA and CSHA, and data for 2007-08 and preceding years relate to the CSHA.

Social housing data reported in this chapter were obtained from 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 tables that are available on the AIHW website. CRA data were obtained from the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).

Housing assistance not reported

The focus of this chapter is social housing. A range of government housing assistance is not reported in this chapter, including:

- services and programs for people who are homeless or at risk of homelessness (reported in chapter 17)
- crisis and transitional housing (unless it is indirectly reported through the other forms of social housing)
- community housing and other housing programs not provided under the NAHA, such as those provided by the Department of Veterans’ Affairs (DVA)
- CRA paid by the DVA, or paid to Abstudy recipients on behalf of the Department of Education, Employment and Workplace Relations (DEEWR)
- private rent assistance funded by State and Territory governments
- the National Rental Affordability Scheme (NRAS) and the Housing Affordability Fund (although some NRAS dwellings are included in the community housing data collection and reported as community housing)
- some Indigenous specific housing and infrastructure assistance (such as the Home Ownership Program funded and administered by Indigenous Business

Australia (IBA) and the Home Ownership on Indigenous Land Program jointly funded by FaHCSIA and IBA)

- home purchase assistance, such as first home owner grants.

16.1 Profile of housing assistance

Service overview

The Australian Bureau of Statistics (ABS) Survey of Income and Housing 2009-10 identified 8.4 million households in Australia, where 'household' is classified as 'a person living alone' or as a group of people who usually live in the same private dwelling (ABS 2011). Of these households, 68.8 per cent owned or were purchasing their own home, 23.7 per cent rented in the private sector, and 3.9 per cent rented from public rental accommodation (table 16A.77).

The composition of Australian households is changing. There are 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 2006, while the proportion of single person households increased from 18.1 per cent to 24.4 per cent over this period (ABS 2007).

The average Indigenous household is larger than the average non-Indigenous household. In 2006, the average household with at least one Indigenous person was 3.4 people, whereas the average non-Indigenous household was 2.6 people (ABS 2007).

Roles and responsibilities

Australian, State and Territory governments share responsibility for housing assistance provided under the NAHA, as they did under the CSHA. Each level of government has different roles and responsibilities:

- The Australian Government influences the housing market through direct and indirect means, including providing CRA, home purchase assistance, financial sector regulations and taxation.
- State and Territory governments administer and deliver housing services, such as public housing, community housing, SOMIH and other Indigenous housing. They also provide financial support to renters through private rental assistance

and to buyers through home purchase assistance, and some jurisdictions provide home lending programs. State and Territory governments are also responsible for land use and supply policy, urban planning and development policy, housing-related taxes and charges (such as land taxes and stamp duties) and residential tenancy legislation and regulation.

- Local governments are responsible for building approval, urban planning and development processes and may be involved in providing community housing.

Government funding and expenditure

Australian, State and Territory government recurrent expenditure on housing assistance was at least \$8.2 billion in 2010-11. This included Australian Government expenditure of \$3.1 billion for CRA and State and Territory government net recurrent expenditure of \$5.0 billion on social housing (tables 16A.1 and 16A.54).

In addition to CRA expenditure, the Australian Government also provided \$2.0 billion in 2010-11 to State and Territory governments for housing assistance through the National Affordable Housing Specific Purpose Payment (NAH SPP) and related National Partnership agreements, of which \$675.0 million was provided for remote Indigenous housing (table GA.1). NAH SPP funding is outcome based and not tied to specific programs, and Australian Government funding is reflected in data for State and Territory government net recurrent expenditure.

State and Territory government net recurrent expenditure on social housing was \$5.0 billion in 2010-11, increasing from \$4.4 billion in 2009-10 (2010-11 dollars) (table 16.1). In 2010-11, this expenditure included \$2.3 billion for public housing and \$92.4 million for SOMIH (table 16A.1).

Table 16.1 State and Territory government net recurrent expenditure on social housing (\$million) (2010-11 dollars)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2009-10	1 327.0	999.6	639.3	595.0	347.6	111.3	100.1	320.8	4 440.7
2010-11	2 066.9	903.0	648.6	567.7	334.2	112.6	95.2	290.8	5 019.0

^a The Australian Government provides funding to State and Territory governments for social housing assistance which is included in State and Territory government expenditure data.

Source: State and Territory governments (unpublished); table 16A.2.

Governments provide funding for the construction of social housing dwellings. The Australian Government provided \$1.3 billion for the social housing initiative

component of the Nation Building Economic Stimulus Package, to aid the construction of new social housing dwellings, and repairs and maintenance of existing dwellings in 2010-11 (table GA.1). State and Territory government capital expenditure for social housing was \$4.1 billion in 2010-11, which was partly funded by the Australian Government through the NAH SPP and the Nation Building Economic Stimulus Package (table 16A.1).

Size and scope

Public housing

Public housing comprises those dwellings owned (or leased) and managed by State and Territory housing authorities. Public housing is generally provided to people on low incomes and to those with special needs, and aims to provide a choice of housing location, physical type and management arrangements. At 30 June 2011, there were 324 583 households occupying 330 987 public housing dwellings nationally (tables 16A.3 and 16A.4). Table 16A.78 presents the proportion of all households residing in public housing in each jurisdiction (4.5 per cent nationally in 2007-08).

The NAHA is the main source of funding for public housing, but it does not specify the amount to be spent on public housing (NAHA funding is based on outcomes and is not tied to specific programs). In 2010-11, State and Territory government net recurrent expenditure on public housing was \$2.3 billion nationally (table 16A.1).

Public housing rents are generally set at market levels. To provide affordable housing, public housing rents are subsidised (or rebated) for eligible low income tenants so that they pay no more than 30 per cent of their gross income on rent. Information on the proportion of income paid in rent by public housing tenants is contained in table 16A.41.

State owned and managed Indigenous housing

State owned and managed Indigenous housing dwellings are defined as those rental housing dwellings owned and managed by government and allocated only to Indigenous Australians (AIHW 2006). They include dwellings managed by government Indigenous housing agencies for allocation to Indigenous tenants. At 30 June 2011, there were 9564 households occupying 9820 SOMIH dwellings nationally (tables 16A.3 and 16A.4).

SOMIH is partly funded under the NAHA, but because NAHA funding is not tied to specific programs, the amount attributed to SOMIH cannot separately identified. In 2010-11, State and Territory government net recurrent expenditure on SOMIH was \$92.4 million nationally (table 16A.1).

The SOMIH program does not operate in all jurisdictions. In 2010-11, SOMIH is reported for NSW, Qld, SA and Tasmania.

- In NSW, a separate statutory organisation — the Aboriginal Housing Office (AHO) — is responsible for planning, administering and expanding policies, programs and the asset base for Aboriginal housing.
- In Victoria, the SOMIH program ended on 30 September 2010, when management of tenancies in SOMIH properties was transferred to Aboriginal Housing Victoria. These dwellings are now classified as Indigenous community housing. A small number of SOMIH tenants and properties transferred to public housing. No SOMIH dwellings are reported for Victoria for 2009-10 onwards.
- In WA, from 2010-11 SOMIH dwellings ceased to be funded separately and were combined with public housing. In 2010-11, SOMIH dwellings in WA are reported as public housing.
- The ACT does not have a separately identified or funded Indigenous housing program. Social housing assistance for Indigenous people is provided through public housing and Indigenous community housing.
- In the NT, Indigenous housing was provided through community housing (prior to 2010-11) or public housing (2010-11 onwards). During 2008-09, approximately 4000 dwellings were transferred from Indigenous housing to remote public housing. These dwellings are not included in either the community housing data collection or the public housing data collection.

Community housing

Community housing is delivered by not-for-profit organisations that develop, own and/or manage affordable rental housing for people on low or moderate incomes. Community housing organisations typically receive some form of government assistance, such as direct funding or the provision of land and property, but a number of community housing organisations are entirely self-funded. Increasingly, community housing organisations are seeking funding through alternative, non-government means, such as leveraging and partnership arrangements.

A major objective of community housing is to increase social capital by encouraging local communities to take a more active role in providing affordable housing. Community housing programs may also establish links between housing

and services managed at the community level, including services for people with disability, and home and community care. It 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. Notwithstanding their common objectives, community housing programs vary within and across jurisdictions in their administration and types of accommodation (box 16.3).

The role of community housing in the housing sector is expanding, driven primarily by changes in government policy that encourage the sector to play a larger role in the provision of affordable housing (Productivity Commission 2010). Community housing organisations are working in partnership with the Australian, State and Territory governments, and the private sector, to increase the supply of affordable housing, and many of the new dwellings constructed under the NRAS and other Australian Government social housing initiatives are or will be owned or managed by community housing organisations.

Box 16.3 Models of community housing

Community housing models vary across jurisdictions in scale, organisational structure and financing arrangements, and the extent to which community organisations or government has management responsibility and ownership of the housing stock. Table 16A.84 lists the community housing programs in each jurisdiction.

Some models of community housing are:

- *housing cooperatives*, providing tenancy management and maintenance of housing that is owned by government, a central finance company or an individual cooperative
- *local government housing associations*, providing low cost housing within a particular municipality, are closely involved in policy, planning, funding and/or monitoring roles, and can directly manage the housing stock
- *regional or local housing associations*, providing property and tenancy management services, and support services to tenants
- *State and Territory government housing entities* are community housing organisations established and controlled by State and Territory governments
- *specialist providers* are organisations with a specific purpose or function, such as tenancy management, housing development, or for specific target groups
- *broad service delivery* are organisations that provide housing and other welfare services, such as aged care and disability services

(Continued next page)

Box 16.3 (Continued)

- *vertically integrated providers of affordable housing* are involved in all stages of providing affordable housing, from construction to property and tenancy management
- *community management and ownership*, where housing is owned and managed by not-for-profit or community housing associations
- *joint ventures and housing partnerships*, where church and welfare entities, local government, private sector and other organisations provide resources in cooperation with State and Territory governments; or where groups of community housing providers form partnerships to maximise growth opportunities, share resources and/or manage risk
- *equity share rental housing*, where 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: Australian, State and Territory governments (unpublished).

At 30 June 2011, 54 911 households were assisted with community housing and there were 59 777 community housing tenancy rental units in Australia (tables 16A.3 and 16A.4). Table 16A.79 presents the proportion of all households residing in community housing in each jurisdiction in 2006 (0.7 per cent nationally).

Indigenous community housing

Indigenous community housing is housing funded by Australian, State and Territory governments that are generally managed and delivered by ICH organisations (although some ICH dwellings are managed by State and Territory housing authorities). The commencement of the NAHA on 1 January 2009 resulted in changes to the funding and administrative arrangements for ICH.

Under the CSHA, the Australian Government funded ICH through the Aboriginal Rental Housing Program (ARHP), Community Housing and Infrastructure Program (CHIP) and the National Aboriginal Health Strategy. State and Territory governments also provided funding for ICH under the CSHA. ICH was administered by the Australian Government in Victoria, Queensland and Tasmania. State and Territory governments administered ICH in all jurisdictions (including Victoria and Queensland), except Tasmania.

From 1 January 2009, ICH was funded through the NAHA and the associated National Partnership Agreement on Remote Indigenous Housing (NPA RIH), and delivered by State and Territory governments. In 2010-11, the Australian

Government provided funding of \$675.0 million for ICH through the NPA RIH, though some of this funding was allocated to other forms of social housing (table GA.1). State and Territory governments assumed responsibility for administering ICH in urban and regional areas, and arrangements varied across jurisdictions. Some ICH dwellings were transferred to other social housing programs.

ICH data for 2009-10 include only funded dwellings, whereas data for previous years included funded and unfunded dwellings.¹

Descriptive information on ICH is contained in table 16A.8.

Diversity of State and Territory government social housing

State and Territory governments have similar broad objectives for providing social housing. Individual jurisdictions, however, emphasise different objectives depending on their historical precedents and ways of interacting with community sector providers. Jurisdictions also have different private housing markets. These differences lead to a variety of policy responses and associated forms of assistance. It is important to consider the various assistance provided in each State and Territory, the differences in urban, regional and remote area concentration, and the various eligibility criteria for the different assistance types when analysing performance information. Some information on the context for public housing and SOMIH are included at tables 16A.82 and 16A.83.

Urban, regional and remote concentrations

The proportion of social housing located in urban, regional and remote areas, for public housing, SOMIH and community housing, using the Australian Standard Geographical Classification remoteness area structure (ASGC remoteness areas) is shown in table 16.2. Data for Indigenous community housing may be included in future reports.

¹ In NSW, data reflect those ICH organisations and dwellings registered with the NSW government.

Table 16.2 Regional and remote area concentrations of social housing, at 30 June 2011 (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Public housing</i>									
Major cities	83.5	72.3	67.1	66.8	77.2	..	99.9	..	72.7
Inner regional	13.3	22.5	16.4	9.8	6.7	73.3	0.1	..	15.8
Outer regional	2.9	5.1	14.3	10.6	14.1	26.0	..	70.6	9.0
Remote	0.2	–	1.7	8.3	1.8	0.5	..	25.8	1.8
Very remote	–	..	0.5	4.5	0.2	0.2	..	3.6	0.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>SOMIH</i>									
Major cities	43.4	..	13.5	..	60.6	..	..	..	34.8
Inner regional	32.1	..	18.7	..	7.8	82.9	..	..	24.7
Outer regional	18.9	..	39.9	..	18.2	17.1	..	..	26.0
Remote	4.8	..	10.4	..	5.2	–	..	..	6.6
Very remote	0.7	..	17.5	..	8.2	–	..	..	7.9
Total	100.0	..	100.0	..	100.0	100.0	..	..	100.0
<i>Community housing</i>									
Major cities	66.9	75.5	50.1	68.4	85.6	..	99.7	..	65.7
Inner regional	26.4	20.8	23.2	12.1	8.2	71.1	0.3	..	22.3
Outer regional	6.6	3.6	19.9	11.3	4.8	27.8	..	48.0	9.4
Remote	0.1	0.1	2.9	6.4	1.3	1.1	..	50.2	1.7
Very remote	–	..	3.9	1.7	0.1	–	..	1.8	0.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

^a Further information pertinent to these data is provided in tables 16A.5–16A.7. Data are calculated as the proportion of total dwellings. **na** Not available. **..** Not applicable. **–** Nil or rounded to zero.

Source: AIHW (unpublished); tables 16A.5–16A.7.

Eligibility criteria for access to social housing

Eligibility criteria for access to social housing varies across the forms of social housing and across jurisdictions.

For public housing, in most cases, jurisdictions require that applicants are Australian citizens or permanent residents and do not own or partially own residential property. All jurisdictions require eligible applicants to reside in the respective State or Territory. Most jurisdictions provide security of tenure after an initial probationary period and most jurisdictions have periodic reviews of eligibility. Rebated rents generally result in the majority of households paying no more than 30 per cent of their gross income in rent (the rent to income ratio). Tenants who do not provide updated income information may forfeit their rebate and be required to pay market rent. Information on the eligibility criteria for income and asset limits for each jurisdiction is presented in table 16A.82.

Eligibility criteria for access to SOMIH are generally consistent with those for public housing (table 16A.83), once an applicant has been confirmed as Indigenous. Terms of tenure are the same as those for public housing for most jurisdictions.

Eligibility criteria for community housing are generally consistent with those for public housing in each jurisdiction.

Waiting lists

All State and Territory governments prioritise access to social housing by segmenting their waiting lists in some way. Segments are defined differently across jurisdictions, but generally reflect urgent need to avoid homelessness and an inability to access appropriate private market accommodation.

The management of waiting lists varies across jurisdictions. NSW, Queensland, WA, ACT and the NT have adopted an integrated social housing waiting list and do not segment by public housing, SOMIH and community housing. Progress towards adopting an integrated waiting list varies for the remaining jurisdictions. For this report, data for integrated waiting lists are not yet available and waiting list data are reported separately for public housing, SOMIH and community housing.

Private rental markets

Tight private rental markets were evident in June 2011, with vacancy rates in capital cities ranging between 1.5 per cent and 3.5 per cent (table 16A.80). Capital city median rents in the private market varied across jurisdictions. Data for median rents for three bedroom houses and two bedroom flats or units in capital cities in the June quarter of 2011 are reported in table 16A.81.

Commonwealth Rent Assistance

Commonwealth Rent Assistance (CRA) is a non-taxable income support payment provided by the Australian Government to people on low incomes who are renting in the private market, to assist with the cost of housing. It is payable to recipients of income support payments or people who receive more than the base rate of the Family Tax Benefit Part A, who rent in the private market and whose rent is above a minimum threshold.

Private rent includes rent paid under both formal tenancy agreements and informal arrangements, such as board and lodging paid to a family member. It can also

include mooring and site fees (for boats and caravans) and payments for retirement village services.

Eligible people living in community housing or Indigenous community housing may receive CRA. People living in public housing and SOMIH and renting from State or Territory housing authorities are not eligible to receive CRA, but may receive other rental assistance. State and Territory governments provide rental assistance through their housing authorities.

CRA is paid at 75 cents for every dollar above a minimum threshold until a maximum rate is reached. The minimum threshold and maximum rates vary according to an income unit's² 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.

The Australian Government seeks to ensure that CRA recipients who have the same income unit characteristics and who pay the same amount of rent receive the same amount of assistance wherever they live.

**Table 16.3 Eligibility and payment scales for CRA,
20 March 2011 to 19 September 2011 (\$ per fortnight)**

<i>Income unit type</i>	<i>Minimum rent to be eligible for CRA</i>	<i>Minimum rent to be eligible for maximum CRA</i>	<i>Maximum CRA</i>
	\$	\$	\$
Single, no dependent children	103.60	258.80	116.40
Single, no children, sharer	103.60	207.07	77.60
Couple, no dependent children	168.60	315.00	109.80
Single, one or two dependent children	136.36	318.73	136.78
Single, three or more dependent children	136.36	342.44	154.56
Partnered, one or two dependent children	201.74	384.11	136.78
Partnered, three or more dependent children	201.74	407.82	154.56
Partnered, illness separated	103.60	258.80	116.40
Partnered, temporarily separated	103.60	250.00	109.80

Source: FaHCSIA (unpublished); table 16A.56.

Tables 16A.54–16A.76 present a range of detailed data on CRA. Information on Australian Government expenditure on CRA is presented in tables 16A.54 and

² Where an income unit is defined as either a single person or a couple with or without dependents. Dependent children are defined throughout this chapter as those for whom the person or partner receives Family Tax Benefit Part A at more than the base rate.

16A.55. Various information on CRA recipients, including information on Indigenous recipients and those with special needs, the amount of rent paid and the proportion of income spent on rent by CRA recipients are presented in tables 16A.56–16A.76.

Nationally, at 3 June 2011:

- there were 1 138 000 income units entitled to receive CRA, of which 46 230 were Indigenous income units (tables 16A.57 and 16A.59)
- of all CRA recipients, 21.1 per cent received the Disability Support Pension, 18.0 per cent received the Newstart Allowance and 17.9 per cent received the Age Pension (table 16A.60)
- the median CRA payment was \$113 per fortnight and the median rent paid by CRA recipients was \$360 per fortnight (table 16A.64)
- of all CRA recipients, 74.5 per cent were paying enough rent to be eligible for the maximum rate of assistance (table 16A.65).

CRA aims to reduce the cost of housing for people on low incomes. Nationally at 3 June 2011, 68.3 per cent of CRA recipients would have paid more than 30 per cent of their income on rent if CRA were not provided. Even with the provision of CRA, 40.1 per cent of CRA recipients spent more than 30 per cent of their gross income on rent (table 16A.66).

16.2 Framework of performance indicators

The performance indicator framework provides information on equity, efficiency and effectiveness, distinguishes the outputs and outcomes and reflects the objectives of social housing (box 16.4). A single social housing framework is presented in this Report, replacing the separate performance indicator frameworks for public housing, SOMIH, community housing and Indigenous community housing that were presented in previous Reports.

The performance indicator framework shows which data are comparable in the 2012 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).

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (see chapter 1 for more detail on reforms to federal financial relations). The NAHA includes a set of performance indicators, for which the Steering Committee collates

annual performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with relevant performance indicators in the NAHA.

Different delivery contexts and locations influence the equity, effectiveness and efficiency of social housing. The Report's statistical appendix 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) (appendix A).

Box 16.4 Objectives for social housing

Social housing aims to assist people unable to access alternative suitable housing options through the delivery of affordable, appropriate, flexible and diverse social housing. Some forms of social housing aim specifically to contribute to Indigenous community wellbeing by improving housing outcomes for Indigenous people, especially those living in remote communities.

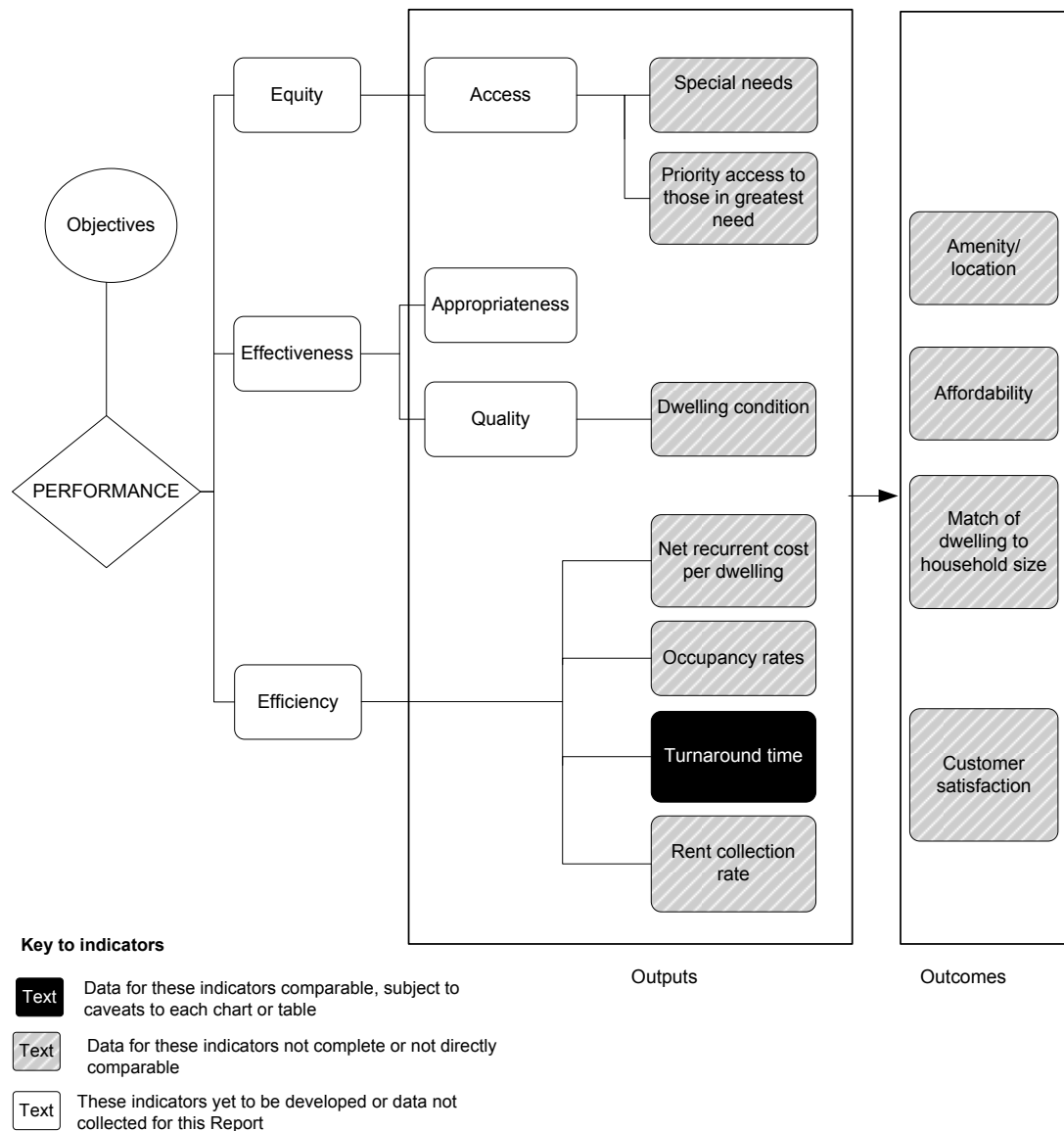
The NAHA and previously the CSHA provide the overarching framework for the delivery of social housing in Australia:

- The objective of the NAHA is that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation.
- The guiding principles of the CSHA (2003) included maintaining a social housing sector and providing appropriate housing assistance, improving housing outcomes for Indigenous people, improving links with other programs and support to people with complex needs, promoting social and economic participation, managing housing programs efficiently and effectively, ensuring cooperative relationships between levels of governments, and promoting a national approach to affordable housing.

Source: FaCS (2003); COAG (2009).

The performance indicator framework for social housing is presented in figure 16.1.

Figure 16.1 Social housing performance indicator framework



16.3 Key performance indicator results

Results for each performance indicator are presented separately for public housing, SOMIH, community housing and Indigenous community housing. Generally, performance indicator results are comparable between public housing and SOMIH. Public housing and SOMIH results are not comparable to community housing and Indigenous community housing because of differences in data quality, timing and coverage.

Data presented in this Report are collected from a variety of sources and the quality and coverage of each collection varies.

-
- Public housing and SOMIH data are sourced from State and Territory government unit record collections, and are complete and comparable. As outlined in section 16.1, Victoria (from 2009-10), WA (from 2010-11), the ACT and the NT are not included in the SOMIH data collection.
 - Community housing data are sourced from jurisdictions' administrative data (provided by State and Territory governments), community housing provider surveys and the National Social Housing Survey (NSHS). Queensland and the NT do not survey their community housing providers, and provide administrative data and data from the NSHS only. Data are not directly comparable across jurisdictions or over time, due to varying response rates and changes to the definitions and counting rules used over time for the provider surveys. Table 16A.86 and related data quality information outline the survey response rates and associated information for each jurisdiction.
 - Indigenous community housing data are a combination of administrative data and survey data collected from Indigenous community housing organisations. Complete data for all jurisdictions are not available, and Indigenous community housing data should be interpreted with caution. Details for all ICH dwellings were not known and ICH data reflect only those dwellings for which details were known. ICH data are not reported for a number of the social housing performance indicators due to issues with data quality and availability.

This Report includes additional descriptive data for social housing in tables 16A.5 (public housing), 16A.6 (SOMIH), 16A.7 (community housing) and 16A.8 (Indigenous community housing).

Outputs

The following indicators measure the outputs of social housing. Outputs are the services delivered, while outcomes are the impact of those services on the status of an individual or group (see chapter 1, section 1.5).

Special needs

'Special needs' is an indicator of governments' objective to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing (box 16.5).

Box 16.5 Special needs

‘Special needs’ is defined as the proportion of new tenancies allocated to households with special needs. The proportion of new tenancies with special needs is reported as a proxy for measuring all households with special needs.

Households with special needs are defined as:

- for public and community housing — those households that have either a household member with disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members
- for SOMIH — those households that have either a household member with disability or a principal tenant aged 24 years or under, or 50 years or over.

A high or increasing proportion indicates a high degree of access by these special needs households.

Data for this indicator are reported for public housing, SOMIH and community housing. Data comparability and completeness vary for this indicator. Data reported:

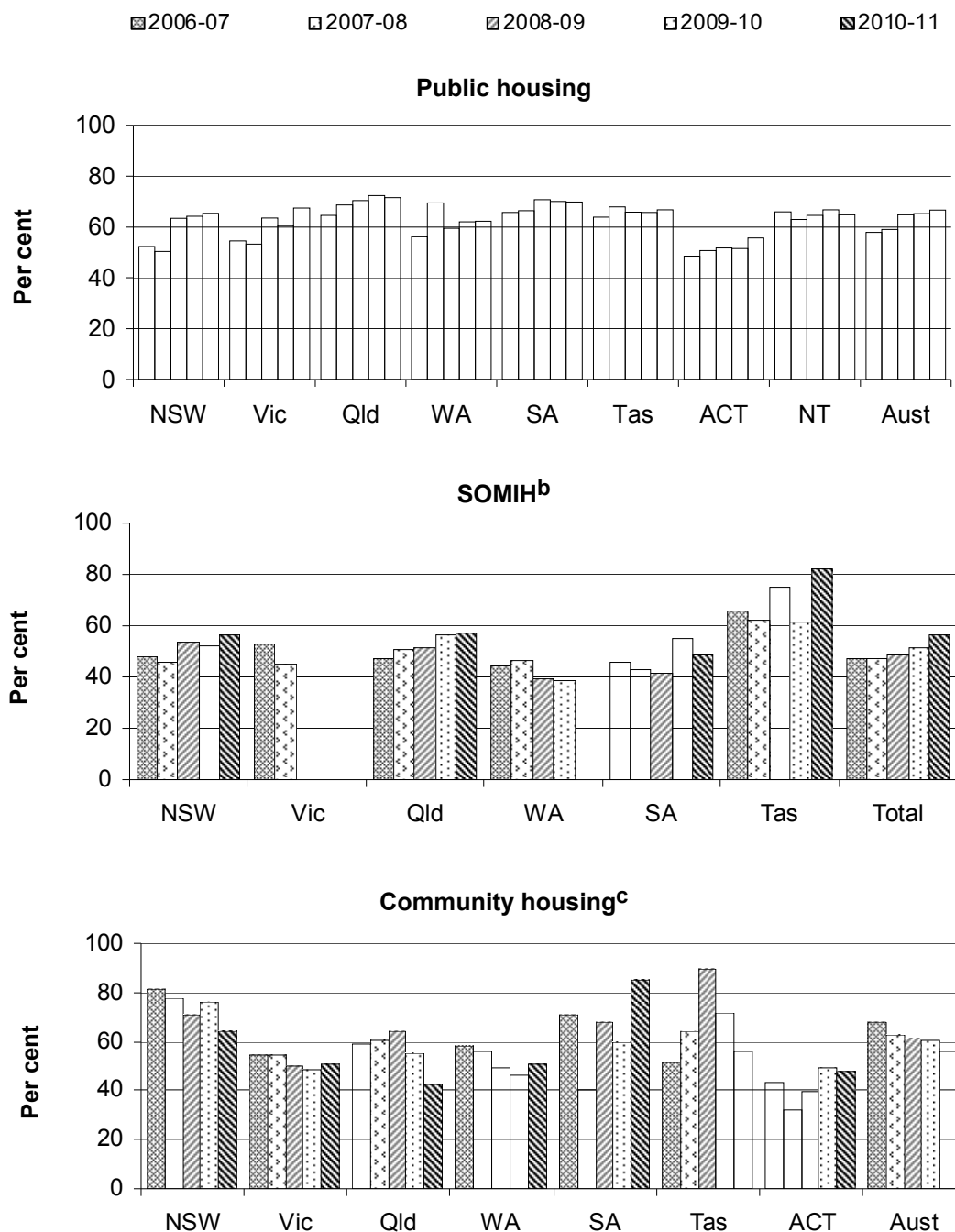
- are not comparable across public housing, SOMIH and community housing
- for public housing and SOMIH are comparable across jurisdictions, but not over time
- for community housing are neither comparable nor complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011.

The proportions of new housing tenancies that were allocated to households with special needs varies across the forms of social housing, across jurisdictions and over time. Nationally in 2010-11:

- 66.7 per cent of new public housing tenancies were allocated to households with special needs, increasing from 57.8 per cent in 2006-07
- 56.4 per cent of new tenancies for SOMIH were allocated to households with special needs, increasing from 47.4 per cent in 2006-07
- 56.1 per cent of new community housing tenancies were allocated to households with special needs, decreasing from 67.7 per cent in 2006-07 (figure 16.2).

Figure 16.2 New tenancies allocated to households with special needs (per cent)^a



^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Tables 16A.9–16A.11 provide further information. ^b There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs. ^c Data for the NT are not available.

Source: AIHW (unpublished); AIHW (various years) *CSHA national data report*; AIHW (various years) *Housing assistance in Australia* (Cat. no. HOU 236); tables 16A.9–16A.11.

Priority access to those in greatest need

‘Priority access to those in greatest need’ is an indicator of governments’ objective 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 ensure that those in greatest need have priority access to housing (box 16.6).

Box 16.6 Priority access to those in greatest need

‘Priority access to those in greatest need’ is defined as the proportion of new allocations of housing to households in greatest need.

Greatest need households are defined as households that at the time of allocation are either homeless, in housing inappropriate to their needs, in housing that is adversely affecting their health or placing their life and safety at risk, or that has very high rental housing costs.

The following measures are reported:

- the proportion of new allocations that were to households in greatest need
- the proportion of new allocations to households in greatest need (of all new allocations) that were waiting for periods of: less than three months; three months to less than six months; six months to less than one year; one year to less than two years; two years or more. These percentages are not cumulative, because time to allocation for this measure reflects greatest need allocations as a percentage of all new allocations for the time period.

High or increasing values for these measures, particularly for short timeframes, indicate a high degree of access for those households in greatest need.

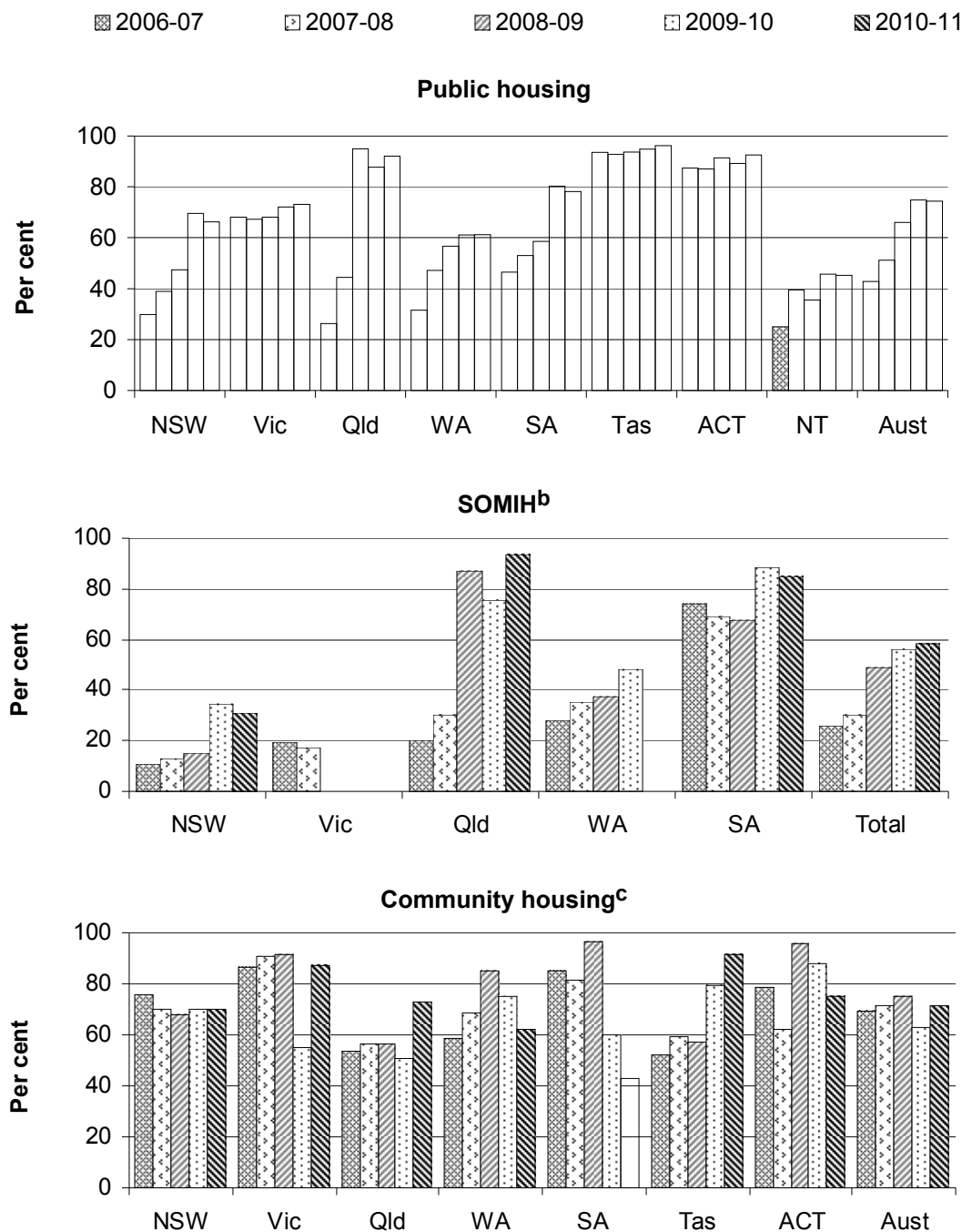
Data for this indicator are reported for public housing, SOMIH and community housing. Data comparability and completeness vary for this indicator. Differences in State and Territory housing assessment policies and community housing allocation policies can influence comparability for this indicator. Data reported:

- for public housing and SOMIH are comparable across jurisdictions, but not over time
- for community housing are neither comparable nor complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

The proportions of new allocations to those households in greatest need for public housing, SOMIH and community housing are reported in figure 16.3. Nationally in 2010-11, 74.4 per cent of new public housing allocations, 58.6 per cent of new SOMIH allocations and 71.6 per cent of new community housing allocations were to those households in greatest need (figure 16.3).

Figure 16.3 Proportion of new allocations to those in greatest need^a



^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Tables 16A.12–14 provide further information. ^b There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs. Data for Tasmania were not available. ^c Data for the NT are not available.

Source: AIHW (unpublished); AIHW (various years) *CSHA national data report*; AIHW (various years) *Housing assistance in Australia* (Cat. no. HOU 236); tables 16A.12–16A.14.

Table 16.4 presents information on the proportion of new public housing and SOMIH allocations made to households in greatest need for the year ending 30 June 2011, within particular timeframes. Nationally, of all new households that were allocated public housing within three months at 30 June 2011, 82.6 per cent were households in greatest need. Nationally, of all new households that were allocated SOMIH within three months at 30 June 2011, 73.6 per cent were households in greatest need (table 16.4).

Table 16.4 Proportion of new allocations to those in greatest need, for year ending 30 June 2011^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Public housing</i>									
Under 3 months	77.7	79.8	95.4	64.4	85.5	93.5	96.7	31.3	82.6
3 < 6 months	80.5	74.4	94.7	84.3	84.1	99.4	91.9	39.1	84.0
6 months to < 1 year	78.6	74.7	90.2	75.9	83.1	98.9	93.0	69.1	82.1
1 < 2 years	67.4	75.8	89.9	79.1	81.0	99.0	91.7	62.8	77.8
2+ years	40.8	49.2	82.9	35.9	49.5	91.9	88.7	34.3	46.0
Overall	66.2	73.1	92.1	61.2	78.2	96.2	92.5	45.2	74.4
<i>SOMIH</i>									
Under 3 months	41.0	..	97.3	..	86.4	na	..	..	73.6
3 < 6 months	33.8	..	94.4	..	100.0	na	..	..	61.4
6 months to < 1 year	36.3	..	91.3	..	83.3	na	..	..	60.5
1 < 2 years	24.7	..	86.0	..	100.0	na	..	..	48.1
2+ years	18.7	..	90.9	..	53.3	na	..	..	27.3
Overall	31.2	..	93.6	..	84.6	na	..	..	58.6

^a Further information pertinent to these data is provided in tables 16A.12 and 16A.13. **na** Not available.
.. Not applicable

Source: AIHW (unpublished); table 16A.12 and 16A.13.

Effectiveness — quality

Dwelling condition

‘Dwelling condition’ is an indicator of governments’ objective to provide quality housing (box 16.7).

Box 16.7 Dwelling condition

'Dwelling condition' is defined as the proportion of Indigenous community housing dwellings in poor condition and in need of major repair or replacement. It is measured as the number of permanent Indigenous community housing dwellings in need of either major repair or replacement as a percentage of the total number of permanent dwellings.

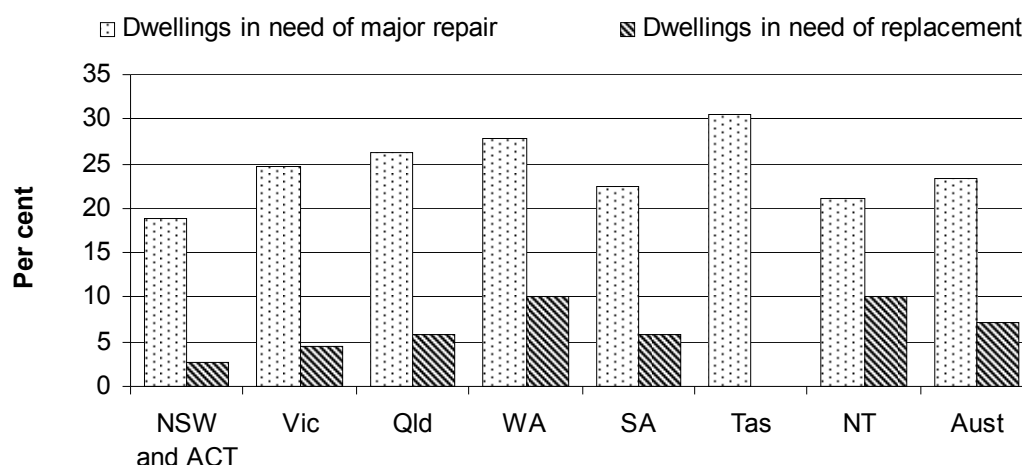
A low or decreasing proportion suggests higher housing quality.

Data for this indicator are reported for Indigenous community housing. No data are available for other forms of social housing for the 2012 Report.

Data reported for this indicator are comparable. Data quality information for this indicator is under development.

Nationally in 2006, 23.4 per cent of Indigenous community housing dwellings were in need of major repair and 7.2 per cent of dwellings were in need of replacement (figure 16.4).

Figure 16.4 **Proportion of Indigenous community housing dwellings in need of major repair and dwellings in need of replacement, 2006^a**



^a The proportion of dwellings in need of replacement in Tasmania was nil, or rounded to zero.

Source: ABS (2007) *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities 2006*; table 16A.15.

Efficiency

Net recurrent cost per dwelling

‘Net recurrent cost per dwelling’ is an indicator of governments’ objective to undertake efficient and cost effective management (box 16.8).

Box 16.8 Net recurrent cost per dwelling

‘Net recurrent cost per dwelling’ is defined as the cost of providing assistance per dwelling — total recurrent expenses (including administration and operational costs), divided by the total number of dwellings.

Measures are reported for public housing, SOMIH, community housing and Indigenous community housing. Net recurrent cost per dwelling for public housing is reported, both including and excluding the cost of capital. Reporting for SOMIH, community housing and Indigenous community housing excludes the cost of capital.

The total number of dwellings for Indigenous community housing is the number of permanent dwellings.

Holding other factors equal, a low or decreasing net recurrent cost per dwelling suggests an improvement in efficiency.

Cost per dwelling measures do not provide any information on the quality of service provided (for example, the standard of dwellings).

Data comparability and completeness vary for this indicator. Data reported:

- for public housing and SOMIH are comparable
- for community housing and Indigenous community housing are neither comparable nor complete

Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

The cost incurred by jurisdictions in providing social housing includes:

- 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 cost of capital (the cost of the funds tied up in the capital used to provide social housing). For this Report, information on the cost of capital was only available for public housing.

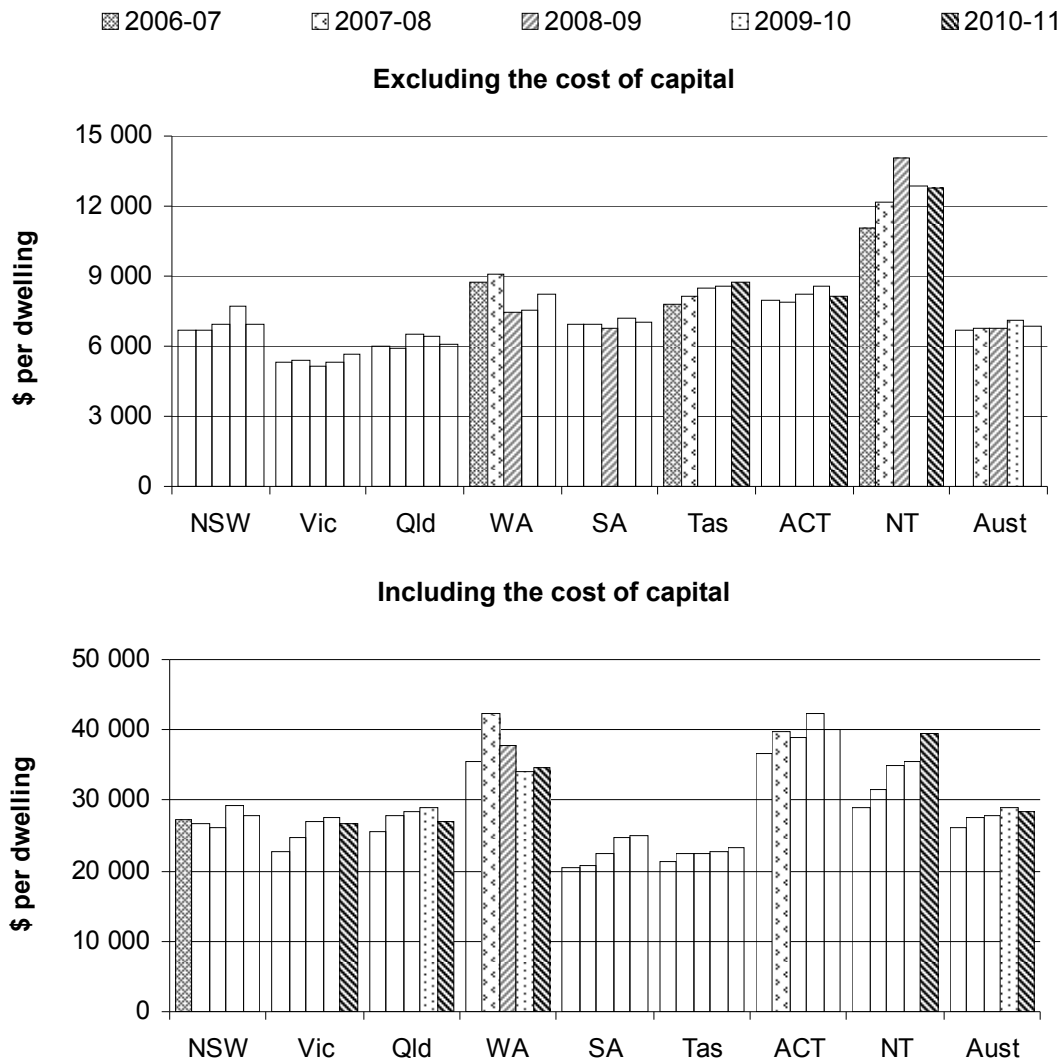
Care needs to be taken in interpreting the cost of delivering public housing. Cost data for some jurisdictions are either more complete than for other jurisdictions or collected on a more consistent basis. Administration costs and operating costs, for example, may not capture all costs incurred by government, and could therefore understate the total cost of public housing. In addition, some jurisdictions are unable to separate costs for public housing from those for other housing and homelessness 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.

Due to a high level of capital expenditure in housing, cost per dwelling is predominantly driven by the cost of capital. There are different cost of capital and service delivery models across jurisdictions, and cost of capital data reported should be interpreted with caution. Information on the treatment of assets by housing agencies for each jurisdiction is presented in table 16A.85.

Payroll tax is excluded from total recurrent cost for public housing to improve comparability across jurisdictions. (Chapter 2 elaborates on the reasons for excluding payroll tax from the cost calculations.)

Nationally in 2010-11, net recurrent cost per dwelling (excluding the cost of capital) for public housing was \$6888 and the cost per dwelling including capital costs was \$28 328 (figure 16.5). More detailed information on public housing expenditure is reported in nominal terms in table 16A.16 and in real terms in table 16A.17, including data from 2001-02 to 2010-11.

Figure 16.5 Net recurrent cost per dwelling — public housing (2010-11 dollars)^{a, b}



^a Further information pertinent to these data is provided in table 16A.17. ^b Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2010-11 = 100) (table AA.39).

Source: State and Territory governments (unpublished); tables 16A.17 and AA.39.

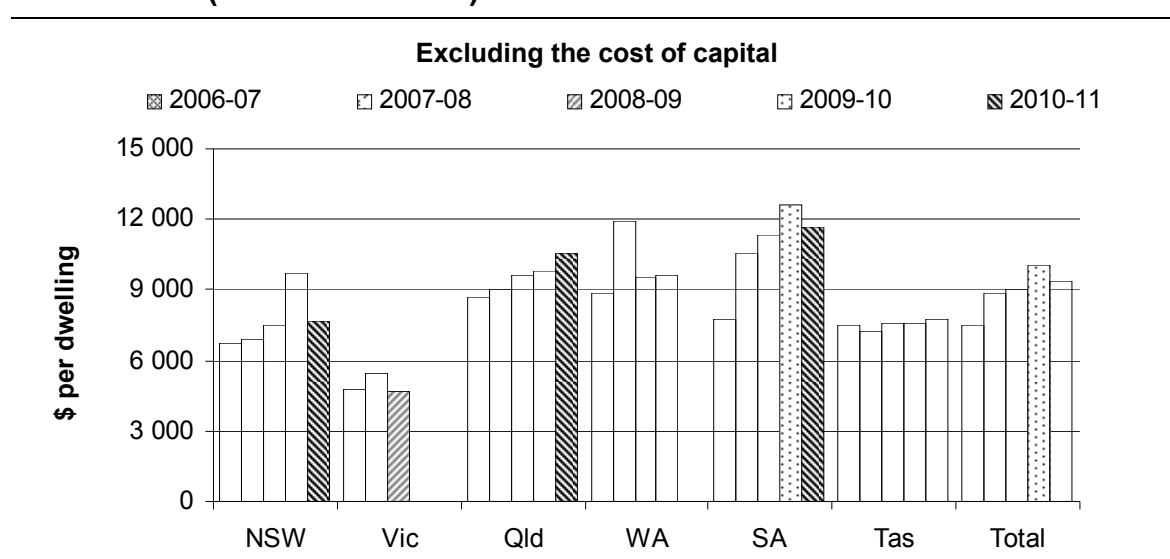
Capital cost data for SOMIH are not available for this Report. Nationally, the net recurrent cost of providing assistance (excluding the cost of capital) per dwelling for SOMIH was \$9410 in 2010-11 (figure 16.6). Table 16A.18 contains data for the years 2001-02 to 2010-11.

As with other indicators, it is not appropriate to compare the net recurrent cost per dwelling for public housing with that for SOMIH, because:

- there is greater scope for economies of scale in administration costs with public housing, which is a much larger program overall

- SOMIH dwellings are slightly more concentrated in regional and remote areas, where the cost of providing housing assistance is potentially greater
- the need to construct culturally appropriate housing (possibly requiring different amenities) can affect the cost per dwelling
- different cost structures can apply to the programs. For example, construction of dwellings under SOMIH can involve a skills development element to allow for training of Indigenous apprentices in regional areas.

Figure 16.6 Net recurrent cost per dwelling — SOMIH (2010-11 dollars)^{a, b, c}



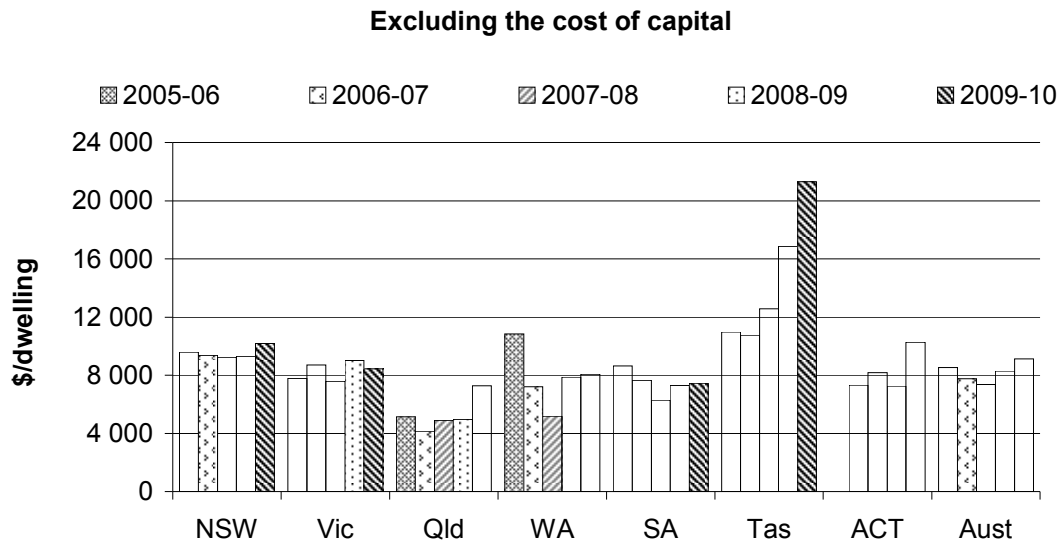
^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.18 provides further information. ^b Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2010-11 = 100) (table AA.39). ^c There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs.

Source: State and Territory governments (unpublished); tables 16A.18 and AA.39.

Capital cost data for community housing are not available for this Report. Data on net recurrent cost per dwelling for community housing are reported with a one year lag to allow community housing providers an extra year to collate financial data.

Nationally, the net recurrent cost per dwelling at 30 June 2010 was \$9120 (figure 16.7). Table 16A.19 contains data from 2001-02 to 2009-10.

Figure 16.7 Net recurrent cost per dwelling — community housing (2009-10 dollars)^{a, b, c}



^a Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.19 provides further information. ^b Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2009-10 = 100) (table AA.39). ^c Data for the ACT were not available prior to 2006-07. Data for the NT are not available.

Source: AIHW (unpublished); AIHW (various years) *CSHA national data report*; AIHW (various years) *Housing assistance in Australia* (Cat. no. HOU 236); tables 16A.19 and AA.39.

Nationally in 2009-10, the net recurrent cost per Indigenous community housing dwelling was \$7491 (table 16.5). However, complete data were not available for all jurisdictions, and these figures may be an underestimate.

Table 16.5 Net recurrent cost per dwelling (excluding the cost of capital) — Indigenous community housing (2009-10 dollars)^{a, b, c}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus Gov ^d	Aust
2005-06	8 014	..	na	na	7 397	..	25 766	652	7 916	na
2006-07	8 675	..	3 576	na	3 553	..	na	na	na	5 439
2007-08	6 890	3 151	7 131	13 773	2 697	..	7 139	na	8 264	7 808
2008-09	5 992	5 907	3 709	6 345	3 279	..	10 098	na	7 508	5 261
2009-10	14 226	8 991	4 479	6 800	3 967	10 812	na	na	..	7 491

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.20 provides further information. ^b Data were presented in current prices based on the ABS Gross Domestic Product price deflator (index) (2009-10 = 100) (table AA.39). ^c Results for this indicator are based on the total number of dwellings for which details were known (not the total number of dwellings). ^d Contains data from Victoria, Queensland and Tasmania not published separately, and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey. **na** Not available. **..** Not applicable.

Source: AIHW (2011) *Housing Assistance in Australia* (Cat No. HOU 236); AIHW (various years) *Indigenous Community Housing*; table 16A.20.

Occupancy rate

‘Occupancy rate’ is an indicator of governments’ objective to ensure efficient housing utilisation (box 16.9).

Box 16.9 Occupancy rate

‘Occupancy rate’ is defined as the proportion of dwellings occupied. The term ‘occupied’ refers to rental housing stock occupied by tenants who have a tenancy agreement with the relevant housing authority (for public housing and SOMIH) or community housing organisation (for community housing and Indigenous community housing).

A high or increasing proportion suggests greater efficiency of housing utilisation.

Occupancy is influenced by both turnover and housing supply and demand.

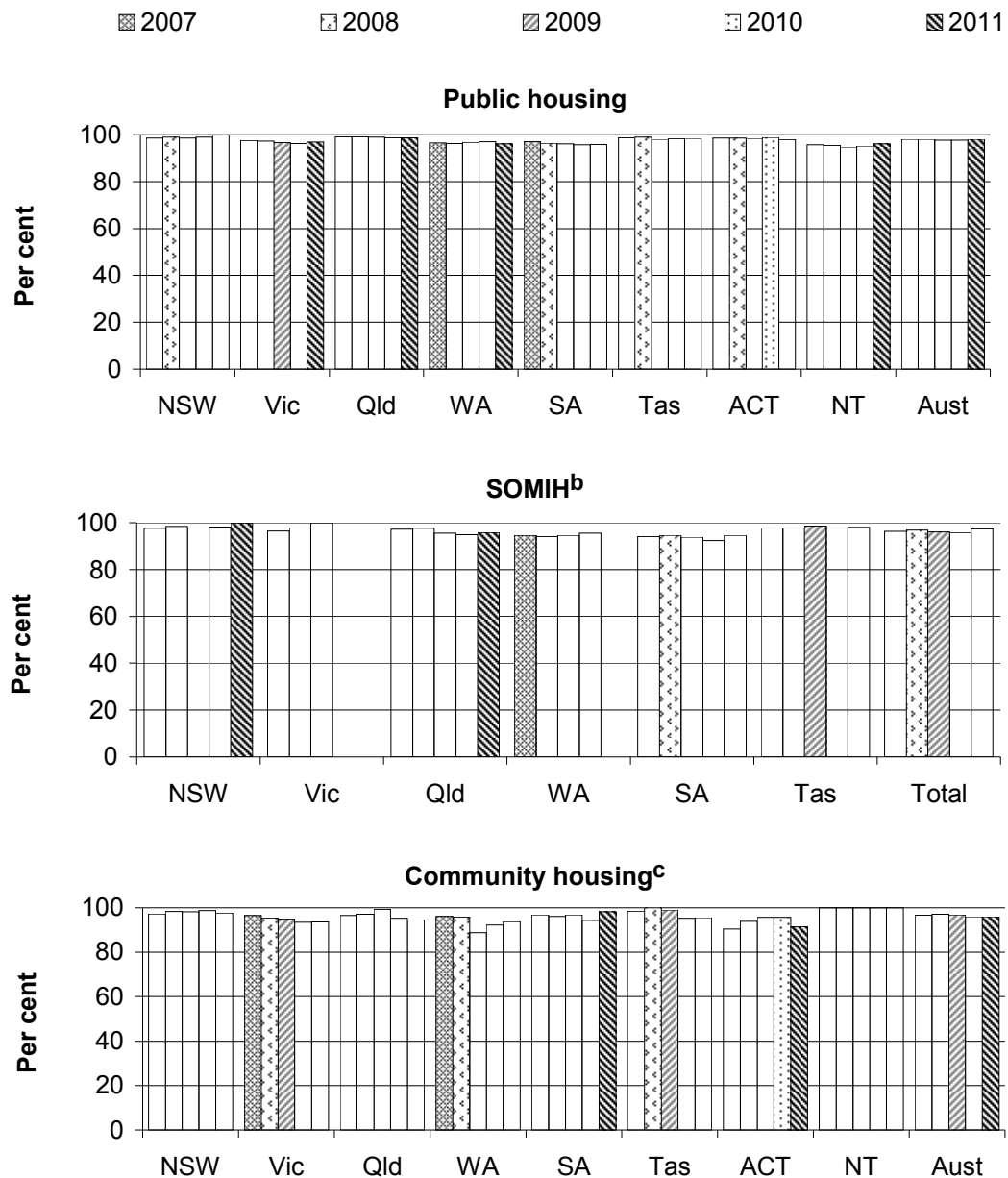
Data for this indicator are reported for public housing, SOMIH, community housing and Indigenous community housing. Data comparability and completeness vary for this indicator. Data reported:

- for public housing and SOMIH are comparable
- for community housing and Indigenous community housing are neither comparable nor complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally at 30 June 2011, the proportion of total rental stock occupied was 98.0 per cent for public housing, 97.4 per cent for SOMIH, and 95.9 per cent for community housing (figure 16.8). Occupancy rates for public housing, SOMIH and community housing at 30 June are presented in figure 16.8.

Figure 16.8 Occupancy rates, at 30 June (per cent)^a



^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Tables 16A.21–16A.23 provide further information. ^b There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs. ^c Occupancy rates in the NT are based on the assumption that all dwellings are occupied.

Source: AIHW (unpublished); AIHW (various years) *CSHA national data report*; AIHW (various years) *Housing assistance in Australia* Cat. no. HOU 236; tables 16A.21–16A.23.

Nationally, 90.8 per cent of Indigenous community housing was occupied at 30 June 2010, though this varied across jurisdictions (table 16.6). However, complete data were not available for all jurisdictions, and these figures may be an underestimate.

Table 16.6 Occupancy rates for Indigenous community housing, at 30 June (per cent)^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus Gov ^c	Aust
2006	96.6	..	95.7	77.9	88.3	..	95.7	87.0	94.1	89.6
2007	98.3	..	100.0	91.0	89.0	..	100.0	na	94.9	96.2
2008	96.0	99.1	98.1	na	93.3	..	100.0	100.0	96.6	98.3
2009	99.2	97.9	96.8	89.8	87.7	..	100.0	na	95.3	96.5
2010	97.0	95.7	96.4	73.7	87.8	90.2	na	na	..	90.8

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.24 provides further information. ^b Results for this indicator are based on those dwellings for which occupancy status was known. ^c Contains data from Victoria, Queensland and Tasmania not published separately, and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey. **na** Not available. **..** Not applicable.

Source: AIHW (2011) *Housing Assistance in Australia* (Cat No. HOU 236); AIHW (various years) *Indigenous Community Housing*; table 16A.24.

Turnaround time

‘Turnaround time’ is an indicator of governments’ objective to undertake efficient and cost effective management (box 16.10).

Box 16.10 Turnaround time

‘Turnaround time’ is defined as the average time taken for occupancy of available dwelling stock to rent through normal processes.

A low or decreasing turnaround time suggests efficient housing allocation.

Properties that were offline, undergoing major redevelopment or for which there was no suitable applicant are excluded from the calculation. Hard-to-let properties, however, were included.

This indicator may be affected by changes in maintenance programs and stock allocation processes, and some jurisdictions may have difficulty excluding stock upgrades. Cultural factors may also influence the national average turnaround time for SOMIH dwellings relative to public housing dwellings. Following the death of a significant person, for example, a dwelling may need to be vacant for a longer period of time (Morel and Ross 1993). A higher proportion of SOMIH dwellings in regional and remote areas may also contribute to delays in completing administrative tasks and maintenance before dwellings can be re-tenanted.

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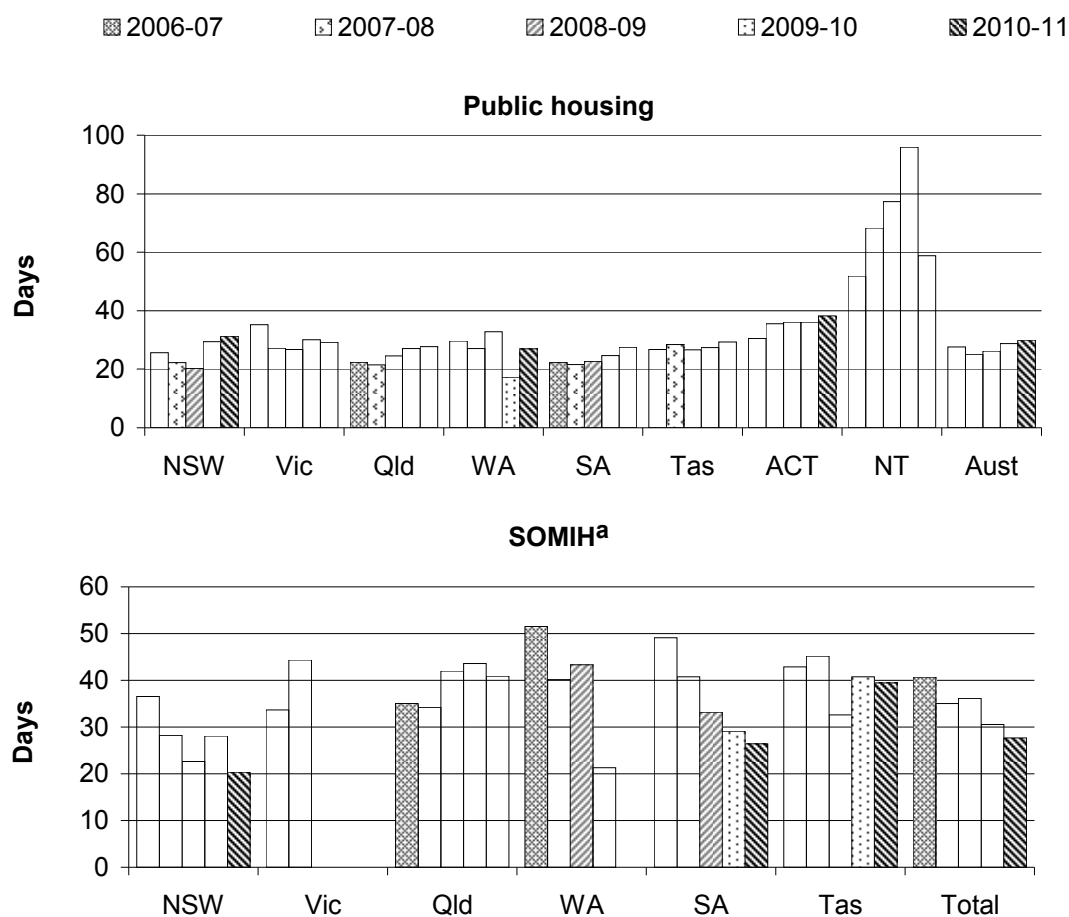
Box 16.10 (Continued)

Data for this indicator are reported for public housing and SOMIH. No data were available for community housing or Indigenous community housing for the 2012 Report.

Data reported for this indicator are comparable and complete. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, vacant stock remained unallocated for an average of 30 days for public housing and 28 days for SOMIH in 2010-11 (figure 16.9).

Figure 16.9 Average turnaround time



^a There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs.

Source: AIHW (unpublished); AIHW (various years) *CSHA national data report*; AIHW (various years) *Housing assistance in Australia* (Cat. no. HOU 236); tables 16A.25 and 16A.26.

Rent collection rate

‘Rent collection rate’ is an indicator of governments’ objective to undertake efficient and cost effective management (box 16.11).

Box 16.11 Rent collection rate

‘Rent collection rate’ is defined as the total rent collected as a percentage of the total rent charged. A high or increasing percentage suggests higher efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a percentage of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements can affect the comparability of reported results. Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period can be higher than rent charged over that period.

Data for this indicator are reported for public housing, SOMIH, community housing and Indigenous community housing.

Data comparability and completeness vary for this indicator. Data reported:

- for public housing and SOMIH are comparable
- for community housing and Indigenous community housing are neither comparable nor complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

In 2010-11, the national rent collection rate was 99.6 per cent for public housing and 101.7 per cent for SOMIH. In 2009-10, the national rent collection rate was 97.7 per cent for community housing, and 88.1 per cent for Indigenous community housing (table 16.7). However, complete data for ICH were not available for all jurisdictions, and these figures may be an underestimate.

Table 16.7 Rent collection rate (per cent)^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus Gov ^b	Aust
<i>Public housing</i>										
2006-07	97.8	97.0	99.4	102.1	100.3	101.5	100.1	100.9	..	98.8
2007-08	100.0	97.2	98.9	101.0	99.6	101.9	99.9	101.7	..	99.5
2008-09	100.2	98.5	99.3	101.3	100.0	99.0	99.9	100.8	..	99.8
2009-10	100.0	99.0	100.3	101.2	99.8	99.0	99.5	103.8	..	99.9
2010-11	99.2	98.7	100.9	100.7	100.0	99.0	99.5	96.7	..	99.6
<i>SOMIH^c</i>										
2006-07	101.8	97.3	97.3	105.3	103.0	102.1	..	..	..	100.6
2007-08	96.8	99.6	99.6	104.3	103.7	99.8	..	..	..	99.0
2008-09	99.8	97.2	97.2	103.6	99.7	99.0	..	..	..	99.7
2009-10	101.5	..	101.5	104.5	100.7	101.7	..	..	..	101.8
2010-11	104.0	..	99.3	..	99.9	99.0	..	..	..	101.7
<i>Community housing</i>										
2005-06	98.8	99.6	99.6	100.5	98.0	98.5	97.3	na	..	99.1
2006-07	99.8	99.5	100.3	100.3	98.4	95.7	98.1	na	..	99.6
2007-08	98.3	99.2	98.6	100.9	98.6	97.9	97.0	na	..	98.7
2008-09	96.6	99.1	99.0	98.8	100.3	99.7	95.8	na	..	98.1
2009-10	96.1	98.1	99.3	99.6	99.7	100.2	101.6	na	..	97.7
<i>Indigenous community housing</i>										
2005-06	89.4	..	97.4	94.1	102.7	..	100.0	103.8	84.7	94.2
2006-07	90.0	..	96.6	96.8	65.5	..	100.0	111.5	92.0	96.2
2007-08	89.8	95.4	90.8	101.1	63.5	..	100.4	114.4	93.2	97.6
2008-09	90.4	94.1	115.8	64.2	60.3	..	100.0	115.6	97.9	96.3
2009-10	90.3	92.3	83.5	84.7	na	97.0	na	93.6	..	88.1

^a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Tables 16A.27–30 provide further information. ^b Contains data from Victoria, Queensland and Tasmania not published separately, and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey. ^c There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs. **na** Not available. **..** Not applicable.

Source: State and Territory Governments (unpublished); AIHW (various years) *CSHA national data report*; AIHW (various years) *Housing assistance in Australia* Cat. no. HOU 236; AIHW (various years) *Indigenous Community Housing*; tables 16A.27–16A.30.

Outcomes

The following indicators measure the outcomes of social housing. Outcomes are the impact of services on the status of an individual or group, while outputs are the services delivered (see chapter 1, section 1.5).

Amenity/location

‘Amenity/location’ is an indicator of governments’ objective to provide housing assistance that is appropriate to the needs of different households (box 16.12).

Box 16.12 Amenity/location

‘Amenity/location’ is defined as the percentage of tenants rating amenity/location aspects of their dwelling as important and as meeting their needs.

A high or increasing level of satisfaction with amenity and location suggests that the provision of housing assistance satisfies household needs.

Data for this indicator are reported for public housing, SOMIH and community housing. There are no data available for Indigenous community housing for the 2012 Report.

Data comparability and completeness vary for this indicator. Data reported:

- for public housing and SOMIH are comparable
- for community housing are neither comparable nor complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Data for this indicator are sourced from the National Social Housing Survey, which seeks to determine tenants’ level of satisfaction with various aspects of service, and to measure housing outcomes. Public housing, SOMIH and community housing tenants were asked whether particular aspects of the amenity and location of their dwellings were important to them and, if so, whether they felt their needs were met. Data from the 2010 survey are reported for public housing and community housing, and data from the 2007 survey are reported for SOMIH.

Caution should be used when comparing the public housing, SOMIH and community housing results, due to the different demographic profile of Indigenous tenants and the different time periods and methods of data collection. Information on public and community housing was collected through mail-out, online and telephone surveys, and information on SOMIH was collected via interviews. These differences may affect the comparability of the results.

The NSHS found that:

- for public housing in 2010, 81.6 per cent of tenants rated amenity as important and meeting their needs, and 87.5 per cent rated location as important and meeting their needs (tables 16A.31 and 16A.32)

- for SOMIH in 2007, 78.1 per cent of tenants rated amenity as important and meeting their needs and 88.7 per cent of tenants rated location as important and meeting their needs (table 16A.33)
- for community housing in 2010, 84.3 per cent of tenants rated amenity as important and meeting their needs, and 88.3 per cent rated location as important and meeting their needs (tables 16A.34 and 16A.35).

The precision of survey estimates depends on the survey sample size and further information is presented tables 16A.33, 16A.52 and 16A.53.

Affordability

‘Affordability’ is an indicator of governments’ objective to provide affordable housing to assist people who are unable to access suitable housing (box 16.13).

Box 16.13 Affordability

‘Affordability’ is defined as tenants’ financial ability to access suitable housing. Two measures of affordability are reported:

- Average weekly rental subsidy per rebated household.
 - This measure is reported for public housing and SOMIH. It is calculated as the total rental rebate amount divided by the total number of rebated households.
 - The amount of a rental rebate is influenced by market rent. High market rents will result in high rental rebates and low market rents will result in low rental rebates. A high or increasing value of the subsidy might imply that governments are spending more to ensure housing affordability.
- Proportion of low income households in social housing spending more than 30 per cent of their gross income on rent.
 - This measure is reported for public housing, SOMIH and community housing. It is calculated as number of low income rental households spending more than 30 per cent of their gross income on rent, divided by the total number of low income rental households.
 - Low income households are defined as those in the bottom 40 per cent of equivalised gross household incomes (that is, the bottom two income quintiles). Low income households are more likely to be adversely affected by relatively high housing costs than households with higher disposable incomes (Yates and Gabriel 2006; Yates and Milligan 2007).

(Continued next page)

Box 16.13 (Continued)

- Households in public housing and SOMIH who do not receive rental rebates are included in this measure. A low or decreasing proportion of households spending more than 30 per cent of their income on rent implies greater housing affordability.

Data for this indicator are reported for public housing, SOMIH and community housing. No data were available for reporting on 'affordability' for Indigenous community housing. New measures of affordability is a key area for development in future reports.

Data comparability and completeness vary for this indicator. Data reported:

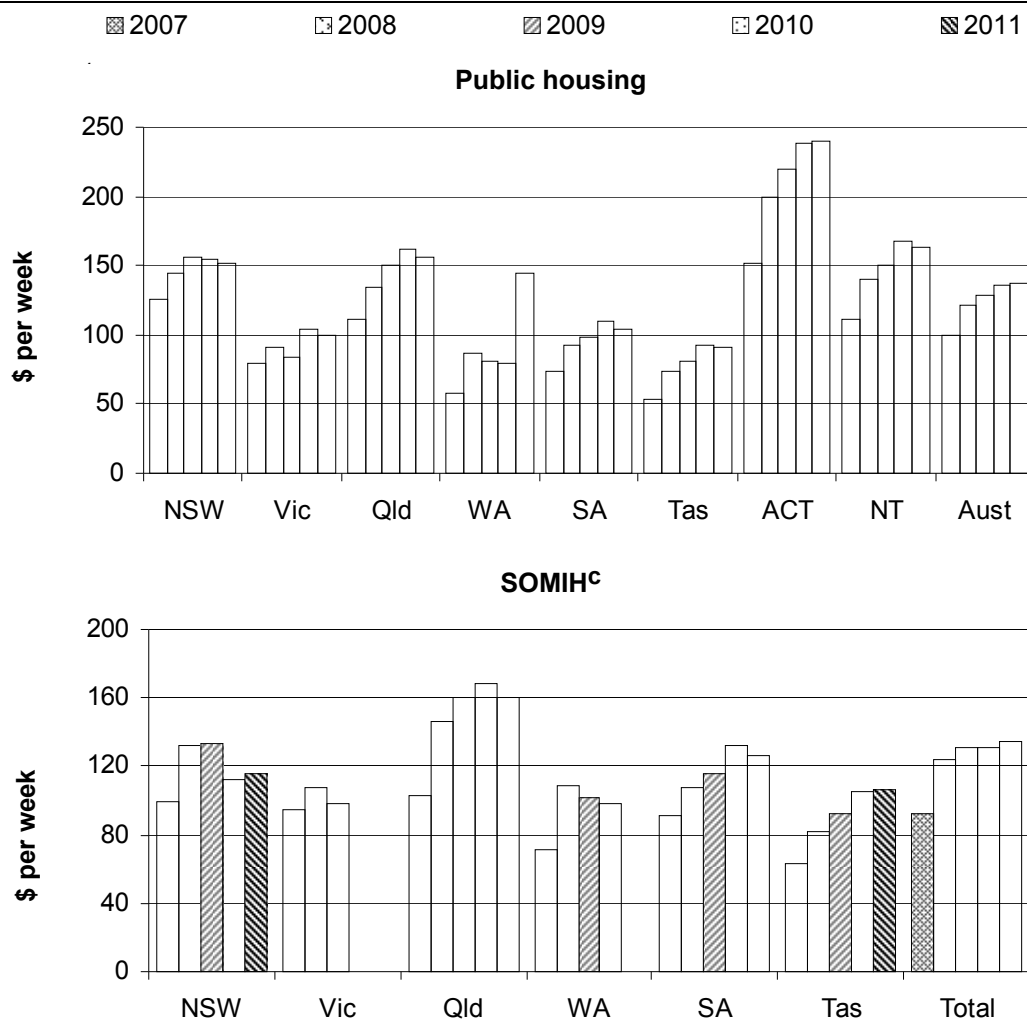
- for public housing and SOMIH are comparable
- for community housing are neither comparable nor complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Average weekly rental subsidy

Nationally, the average weekly subsidy per rebated household in public housing was \$138 at 30 June 2011, increasing from \$100 at 30 June 2007 (in real terms). For SOMIH, the average weekly subsidy per rebated household was \$135 at 30 June 2011, increasing from \$93 at 30 June 2007 (in real terms) (figure 16.10). These subsidies varied across jurisdictions.

Figure 16.10 Average weekly subsidy per rebated household at 30 June (2010-11 dollars)^{a, b}



^a Data may not be comparable across jurisdictions and comparisons could be misleading. Tables 16A.36 and 16A.37 provide further information. ^b Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2010-11 = 100) (table AA.39). ^c There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs.

Source: AIHW (unpublished); AIHW (various years) *CSHA national data report*; AIHW (various years) *Housing assistance in Australia* (Cat. no. HOU 236); tables 16A.36, 16A.37 and AA.39.

Proportion of low income households spending more than 30 per cent of their income on rent

Information on the proportion of low income households in social housing are presented in table 16A.38.

At 30 June 2011:

- 98.1 per cent of all households in public housing were low income households, of which 0.3 per cent were spending more than 30 per cent of their gross income on rent
- 95.6 per cent of all households in SOMIH were low income households, of which 0.2 per cent were spending more than 30 per cent of their gross income on rent
- 92.1 per cent of all households in community housing were low income households, of which 12.5 per cent were spending more than 30 per cent of their gross income on rent (table 16A.38 and table 16.8).

These results should be interpreted with care, as income data for some public housing and SOMIH households are not updated annually and this may result in overestimating the proportion of household income spent on rent. Further, differences in the treatment of CRA in rent assessment can affect the comparability of the results reported for community housing (CRA should be excluded from household income, but data for some households may include CRA in household income).

Further information on the proportion of income paid in rent by low income households is provided in tables 16A.40–16A.43.

Table 16.8 Proportion of low income households spending more than 30 per cent of their gross income on rent, at 30 June (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>
<i>Public housing</i>									
2010	0.1	3.9	–	1.1	1.7	–	0.9	5.8	1.3
2011	0.2	np	0.1	1.4	–	np	0.8	1.8	0.3
<i>SOMIH</i>									
2010	0.1	..	0.1	2.0	2.2	–	..	..	0.8
2011	0.3	..	0.2	..	–	–	..	..	0.2
<i>Community housing</i>									
2010	12.9	20.3	na	59.7	7.1	28.0	23.6	na	18.4
2011	10.8	12.2	na	32.2	1.2	35.5	2.0	na	12.5

^a Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.39 provides further information. ^b There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs. **na** Not available. **..** Not applicable. **–** Nil or rounded to zero. **np** Not published.

Source: AIHW (unpublished); AIHW (various years) *Housing assistance in Australia* (Cat. no. HOU 236); table 16A.39.

Match of dwelling to household size

‘Match of dwelling to household size’ is an indicator of governments’ objective to provide housing assistance that is appropriate to the needs of different households (box 16.14). The objectives of community housing providers in providing housing assistance may be different to those of governments.

Box 16.14 Match of dwelling to household size

‘Match of dwelling to household size’ is defined as the proportion of households that are overcrowded. Since 2010, this Report has measured overcrowding using the Canadian National Occupancy Standard (CNOS), under which overcrowding is deemed to have occurred if one or more additional bedrooms are required to meet the standard.

The CNOS specifies that:

- no more than two people shall share a bedroom
- parents or couples may share a bedroom
- children under 5 years, either of the same sex or opposite sex may share a bedroom
- children under 18 years of the same sex may share a bedroom
- a child aged 5 to 17 years should not share a bedroom with a child under 5 of the opposite sex
- single adults 18 years and over and any unpaired children require a separate bedroom.

Households living in dwellings where this standard cannot be met are considered to be overcrowded. The CNOS enables a comparison of the number of bedrooms required with the actual number of bedrooms in the dwelling and is sensitive to both household size and household composition. A low or decreasing proportion of overcrowded households is desirable.

State and Territory governments’ housing authorities bedroom entitlement policies may differ from the CNOS.

Data for this indicator are reported for public housing, SOMIH, community housing and Indigenous community housing. The comparability and completeness of data reported for the indicator vary. Data reported:

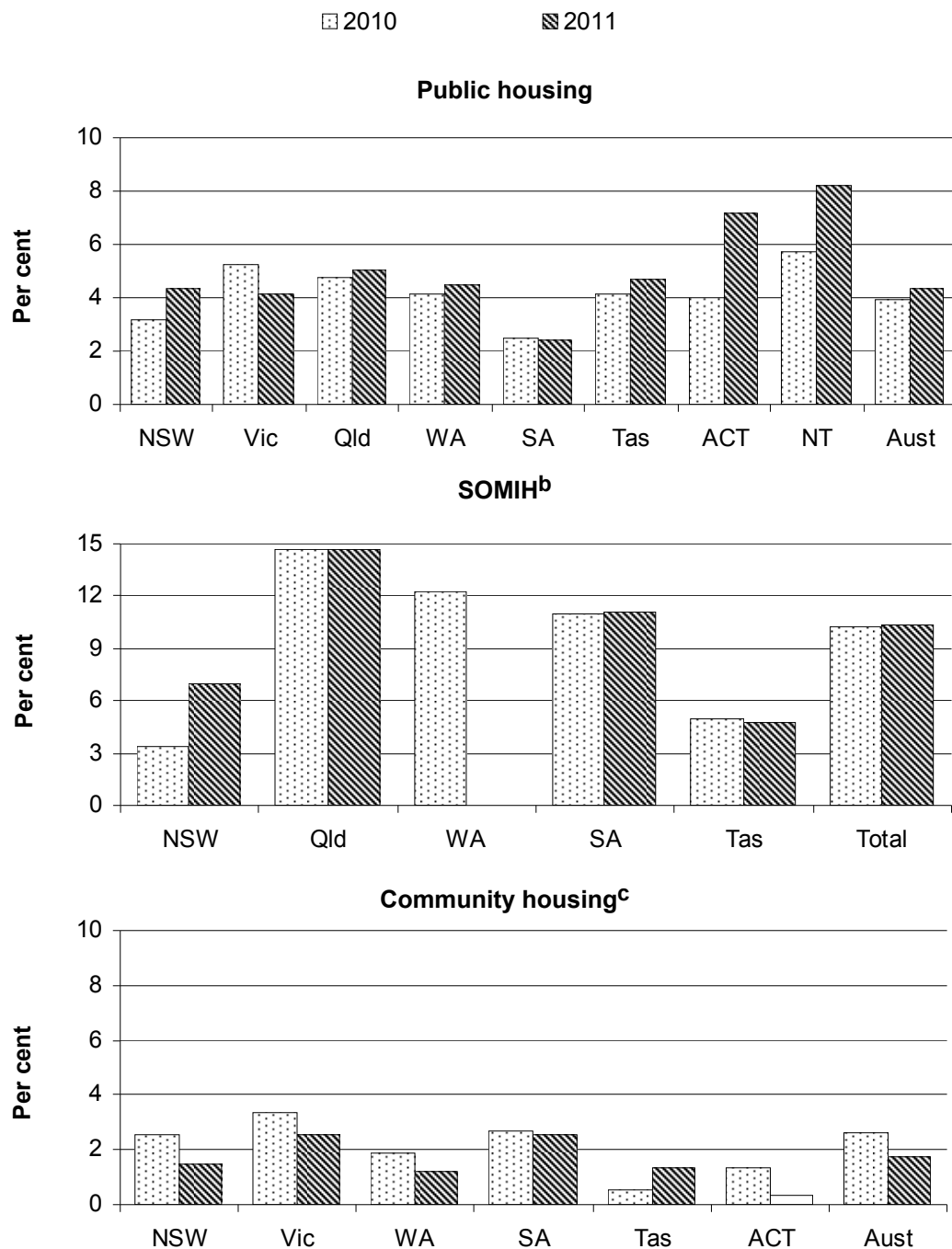
- for public housing and SOMIH are comparable
- for community housing and Indigenous community housing are neither comparable nor complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

The proportion of overcrowded households varied across social housing programs and across jurisdictions. At 30 June 2011, 4.3 per cent of households in public housing were overcrowded, 10.3 per cent of SOMIH households were overcrowded and 1.8 per cent of households in community housing were overcrowded (figure 16.11).

Information on underutilisation in public housing, SOMIH and community housing dwellings is reported at table 16A.51.

Figure 16.11 **Proportion of overcrowded households, at 30 June^a**



^a Data may not be comparable across jurisdictions and comparisons could be misleading. Tables 16A.44–16A.46 provide further information. ^b There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs. ^c Data for Queensland and the NT were not available.

Source: AIHW (unpublished); AIHW (various years) *Housing assistance in Australia* (Cat. no. HOU 236); tables 16A.44–16A.46.

Table 16.9 illustrates the proportion of overcrowded households in Indigenous community housing. However, complete data were not available for all jurisdictions, and these figures may be an underestimate.

Table 16.9 Proportion of overcrowded households in Indigenous community housing, at 30 June (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>
2010	na	6.3	43.8	28.4	48.4	na	na	na	na

^a Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.47 provides further information. **na** Not available.

Source: AIHW (2011) *Housing Assistance in Australia* (Cat No. HOU 236); table 16A.47.

This report contains a range of other information relating to overcrowding of Indigenous people in social housing, including:

- Indigenous people living in overcrowded conditions in public housing and SOMIH, by remoteness area (table 16A.48 and 16A.49)
- the number of bedrooms required for people living in overcrowded conditions in Indigenous community housing (table 16A.50).

Customer satisfaction

‘Customer satisfaction’ is an indicator of governments’ objective to provide housing assistance that is appropriate for different households (box 16.15).

Box 16.15 Customer satisfaction

‘Customer satisfaction’ is defined as tenants’ satisfaction with the overall service provided.

A high or increasing percentage for customer satisfaction can imply better housing assistance provision.

Data are reported for public housing, SOMIH and community housing. There were no data available for Indigenous community housing for the 2012 Report.

Data comparability and completeness vary for this indicator

- data reported for public housing and SOMIH are comparable
- data reported for community housing are neither comparable nor complete.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Data for this indicator are sourced from the National Social Housing Survey. Data from the 2010 survey are reported for public and community housing and data from the 2007 survey are reported for SOMIH.

The NSHS found that:

- for public housing in 2010, 73.1 per cent of tenants in public housing were either satisfied (45.9 per cent) or very satisfied (27.2 per cent) with the service provided by the State or Territory housing authority (table 16A.52)
- for SOMIH in 2007, 63.5 per cent of SOMIH respondents were either satisfied (44.5 per cent) or very satisfied (19.0 per cent) with the service provided by the State housing authority (table 16A.33)
- for community housing in 2010, 79.1 per cent of tenants were either satisfied (41.0 per cent) or very satisfied (38.1 per cent) with the services provided by their community housing organisation (table 16A.53).

The levels of satisfaction varied across jurisdictions.

16.4 Future directions in performance reporting

COAG developments

Outcomes of the review of Report on Government Services

The COAG endorsed recommendations (December 2009) of the review of the RoGS implemented during 2010 and 2011 are reflected in this Report. Implementation of other recommendations will be reflected in future reports.

Review of National Agreements and National Partnership Agreements

COAG has agreed to progress the recommendations of the Heads of Treasuries (HoTs) Review of National Agreements, National Partnerships and Implementation Plans and reports of the COAG Reform Council (CRC). A working group, led by Senior Officials from First Ministers' and Treasury agencies, will review the performance frameworks of a limited number of agreements, including the NAHA. The review of the NAHA will be concluded by June 2012. The recommendations of the review of the NAHA will be considered by the Steering Committee and may be reflected in future reports.

Further developing indicators and data

The Housing and Homelessness Working Group will continue to improve the quality of community housing, Indigenous community housing and financial data that are published in this Report.

16.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter.

Australian Government comments

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The NAHA is a framework for governments to work together to improve housing affordability, reduce homelessness and reduce Indigenous housing disadvantage. As part of the Agreement, governments have committed to undertake a number of reforms in the housing sector. The NAHA is supported by three National Partnership Agreements:

- the \$400 million National Partnership Agreement on Social Housing will deliver around 1960 dwellings by mid-2012. This includes 1785 social housing dwellings and an additional 175 affordable housing dwellings. As at 30 June 2011, 1540 dwellings were completed
- the \$1.1 billion National Partnership Agreement on Homelessness will deliver new expanded services to reduce homelessness across Australia. *A Place to Call Home*, a joint initiative under the National Partnership Agreement on Homelessness, will deliver over 600 new homes in conjunction with wrap-around support services
- the \$5.5 billion National Partnership on Remote Indigenous Housing will help address significant overcrowding, homelessness and poor housing conditions over 10 years. Up to 4200 new houses will be constructed and up to 4800 existing houses will be rebuilt or refurbished. In the 2010-11 financial year, 490 new houses and 2288 refurbishments were completed.

In addition the \$5.6 billion Social Housing Initiative under the *Nation Building — Economic Stimulus Plan* will deliver around 19 600 social housing dwellings and has completed repairs and maintenance to around 80 000 existing social housing dwellings. As at 30 June 2011, construction had begun on over 19 200 dwellings, and over 15 400 had been completed.

The Australian Government has continued to implement several other initiatives to improve housing affordability and help Australians buy their first home. These include the Housing Affordability Fund, the National Rental Affordability Scheme, First Home Savers Accounts, releasing surplus Commonwealth land and over \$3 billion a year on Commonwealth Rent Assistance. Commonwealth Financial Counselling and Centrelink's Financial Information Service also help people in financial difficulty to make informed choices to address their problems.

COAG is considering a Housing Supply and Affordability Reform report from the Standing Council on Federal Financial Relations. This report examines planning and zoning issues, residential development infrastructure charges, the efficiency of housing supply and land release targets, as well as the impact of government policies on housing supply and demand.

Growing community housing is critical to help address the growing demand for affordable and social housing across Australia. In June 2011, a blueprint for a national regulatory system was agreed in principle for community housing providers. This agreement is an important milestone in the introduction of a nationally consistent regulatory framework, which will promote the growth of the not-for-profit housing sector across Australia.

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New South Wales Government comments

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The NSW Government manages the largest portfolio of public housing in Australia with approximately 112 000 properties and tenancies. The community housing sector's role in the provision of social housing continues to grow with close to 24 000 properties now being managed in this sector. The Aboriginal Housing Office currently owns over 4200 properties and registered and non-actively registered Aboriginal housing providers manage more than 4400 properties.

NSW 2021 highlights the NSW Government's commitment to deliver integrated and responsive services to support some of the most vulnerable members of our community. Focusing on early intervention and strong collaboration, across portfolios and with the non-government sector, NSW will design and deliver tailored support services to individuals and families.

NSW 2021 also includes a commitment to supporting people in need and dealing with the underlying causes of rising household costs. An Affordable Housing Taskforce has been established to identify options within the planning system to improve housing affordability. In addition, NSW is working with the Australian Government to improve the supply of affordable housing. In June 2011, the NSW Government approved an additional \$102 million for National Rental Affordability Scheme applications, which will deliver more than 2600 additional new homes for people in need.

Growing a strong and sustainable social housing system is a key priority for the NSW Government. Following the end of the transitional period for community housing providers to be registered in order to continue receiving assistance from Housing NSW, the Registrar of Community Housing's focus has now moved from registering to regulating community housing providers. The regulatory system for community housing provides assurance for a viable and diverse community housing sector that supports people in need in NSW.

The NSW Government is also committed to ensuring that the community housing sector is a flexible component of the NSW social housing system that is able to offer more housing for people, tailored to their needs.

Under the *Build and Grow Aboriginal Community Housing Strategy*, NSW is committed to better meeting the needs of Aboriginal tenants and communities. Key features of the Strategy are removing the backlog of maintenance in community-owned homes, developing an Aboriginal community housing provider registration system, introducing a new rent policy and providing time-limited capacity subsidies for registered providers.

NSW is also ensuring that Aboriginal clients are offered culturally appropriate social housing products and services, are supported to sustain their tenancies and experience less homelessness, overcrowding and housing affordability stress.

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Victorian Government comments

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During 2010-11, Victoria has continued to grow the social housing portfolio and provide support for homeless people and those living in public housing.

In 2010-11, the Victorian Government created over 3700 new public and social housing properties across Victoria. New homes have been added across the state close to services and transport so people have the opportunity and support to thrive in the community.

Through the Australian Government's *Nation Building — Economic Stimulus Plan*, Victoria has delivered a total of 3470 homes as at June 2011.

In addition to the acquisition program a total of eight major redevelopment projects aimed to redevelop outdated public housing neighbourhoods to offer an integrated mix of public, social and private homes with landscaped parks, gardens and community services are underway. Victoria successfully completed the first stage of the Carlton housing redevelopment in June 2011, replacing old walk-up units with a new precinct of 84 public housing apartments and 90 privately owned apartments.

Victoria is committed to maintaining and improving public housing; in 2010-11 major upgrades to 1975 homes were completed, making these properties safer and more comfortable for residents and extending the life of ageing properties.

The Public Tenant Employment Program and the Neighbourhood Renewal program created more than 800 jobs and 3000 training opportunities for public housing tenants in 2010-11. This program continues to improve community engagement and participation in highly disadvantaged areas.

Victoria has continued to work closely with not-for-profit housing agencies to provide more accommodation options for people in need. In 2010–11, there were 40 registered housing agencies, including nine registered housing associations. The community housing sector now manages around 17 600 properties, including owning over 8900 dwellings.

Victoria also supported 488 households with access to the private rental market through the National Rental Affordability Scheme, which is a joint Commonwealth and State initiative which allows these homes to be rented to low and medium income families at a minimum of 20 per cent below local market rents.

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Queensland Government comments

“ Queensland is committed to delivering a social housing system that provides safe, affordable and appropriate housing for Queenslanders. Queensland is progressing the national reform agenda to ensure it makes best long-term use of assets and to improve client outcomes.

Early in 2011, Queensland was affected by major natural disasters and the Department of Communities provided much needed housing assistance in response. By the end of June 2011, 263 affected households had been provided with social rental housing and 4791 bond loans and 901 rental grants had been provided to assist affected households in the private market.

Across Queensland, the department provided assistance to more than 81 000 low-to-moderate income households to address their housing needs in 2010-11. New households with a very high or high housing need comprised 96 per cent of households provided with government managed social rental housing. A total of 205 391 households were assisted to access or sustain private market tenure.

Under the Social Housing Initiative of the *Nation Building — Economic Stimulus Plan*, during 2010-11 Queensland expended \$490.4 million and completed 2406 dwellings. The final 1280 dwellings are due for completion by June 2012.

Queensland is committed to the implementation of the NAHA and supporting National Partnership Agreements (NPA). Under the NPA Social Housing Agreement, Queensland is expending \$80.1 million federal funding over two years to commence construction on 306 dwellings with 286 completed at 30 June 2011.

Queensland continues to address overcrowding, homelessness, poor housing conditions and housing shortages in remote Indigenous communities. Under the 10 year National Partnership Agreement on Remote Indigenous Housing, 62 new dwellings and 425 upgrades were completed in 2010-11.

During 2010-11, Queensland's private market assistance included:

- *RentConnect* assistance to 3860 new households to find and secure a tenancy
- 26 new loans to home purchasers experiencing difficulties in obtaining loans from a financial institution and to those wishing to purchase a share of their social rental property. Also, 72 new mortgage relief loans to assist households with their home loan repayments
- funding to non-profit organisations and local councils to provide tenant advice and advocacy services which assisted 84 830 new households
- bond loans to 21 817 new households to move into private rental accommodation and 2873 new rental grants to assist with moving costs
- under the National Rental Affordability Scheme 6944 dwellings were approved, 804 dwellings became available and 744 dwellings were tenanted.

Western Australian Government comments

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The year 2010-11 was a very successful year in view of the difficult task the Housing Authority faced in implementing a massive construction program while consolidating many of its other activities. A major feature of the year's activities was one of continuing change to help those most in need in our community. Our ever increasing population has raised the demand for affordable housing and, despite economic growth, many people in the community are in need.

Substantial additional funding, primarily through Stimulus package investments, has shown Government's enormous determination to do things better and to better meet demand.

A large commitment was the 10 year Affordable Housing Strategy ('Opening doors') introduced by the State Government in May 2011. As part of this strategy the Authority plays a pivotal role in connecting stakeholders and partners from the private and not-for-profit sectors, local government authorities and other State Government agencies. The aim is to work together to deliver at least 20 000 more affordable homes by 2020 for low to moderate income earners. The release of this strategy provides a government-wide response to housing affordability that greatly affects households in the income range of between \$36 000 and \$90 000.

A major initiative to be launched under the strategy was the release of an Expression of Interest (EOI) for builder and developers to bring affordable housing proposals to Government. To coincide with the availability of new housing stock under the EOI, the Authority also expanded the Keystart shared equity loan scheme. This scheme benefits not only low-income earners but the building industry as well. In this way, the strategy will see the State Government lead the way to drive long term solutions — often in partnership — to increase affordable housing for low-to-moderate income earners.

Major achievements in building a stronger social housing system included implementing Community Housing Agreements (CHAs). Under this agreement more than 1041 dwellings, funded largely by the Australian Government's Nation Building program, were transferred to seven community housing organisation in this financial year. Performance agreements ensure that each property is efficiently managed and that any surplus income generated from the properties is used to attract investment in projects to house people in need.

There were important accomplishments on other fronts too. The Authority had great success in rebuilding the Kimberley town of Warnum, which was destroyed by floods in March.

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South Australian Government comments

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When the NAHA and its associated National Partnership Agreements were established in 2009, Housing SA embarked upon one of the largest social housing new build programs SA has seen for many years. Through the *Nation Building — Economic Stimulus Plan* (NBESP), SA achieved practical completion of 1023 dwellings by 30 June 2011, with a further 306 dwellings under construction. SA continues to work closely with not-for-profit (NFP) housing providers to facilitate the reform and expansion of the social housing sector. Over the next 12 months, more than 600 NBESP properties will be transferred to NFP providers, offering a high level of tenancy and property management linked with appropriate support services.

A number of projects were delivered during the year as a part of the National Partnership Agreement on Homelessness. One such project, Ladder St Vincent Street, has provided supported housing to 23 young people. Retail/commercial units were also developed for the purpose of leasing to businesses supporting the principles of mentoring the tenants in work experience and life skills.

SA met its 2010-11 National Partnership Agreement on Remote Indigenous Housing (NPA RIH) targets by constructing 28 new, and refurbishing a further 58 houses on the APY Lands. Through the NPA RIH, States and Territories have committed to achieving an average 20 per cent local Indigenous employment for the procurement of new housing construction. SA surpassed this target, with a significant 37.3 per cent Indigenous employment on capital works projects delivered through the NPA RIH during 2010-11.

SA continued to expand its affordable housing programs through the commitment of 2194, or over 15 per cent, affordable home purchase and rental opportunities across significant new developments. A total of 674 homes have been sold exclusively to eligible low and moderate income home buyers through the Affordable Homes Property Locator.

Many South Australians were assisted through the Private Rental Assistance Program during the year. In today's tight property market, the program offers support to customers seeking to enter into private rental housing or maintain their existing tenancy and has become a significant part of Housing SA's business. We assisted 24 920 customers with financial support during 2010-11, a significant increase of 16.2 per cent from the previous year.

Housing SA maintained 49 932 lettable public, Aboriginal and community housing properties across the state during 2010-11. New public and Aboriginal housing applications increased 2.3 per cent and waiting list numbers increased 1.2 per cent from the previous year. We now have the highest number of households awaiting housing since 2006-07. New public and Aboriginal housing allocations in 2010-11 increased 11 per cent from the previous year. In recognition of some of the challenges facing the social housing sector within our state, SA has established the Access Project to undertake a range of reforms to improve and streamline customer access to housing products and services that are provided, regulated or subsidised by the State Government.

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Tasmanian Government comments

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Governments play an important role in the provision of affordable housing to the community, in particular, in assisting the most vulnerable. While housing affordability is a complex issue underpinned by wider macroeconomic influences, jurisdictions play a critical role in the provision of public housing, affordable home purchase options, private rent assistance and facilitating the supply of land to further increase affordable housing stock.

During 2010-11, Housing Tasmania focused on increasing the supply of affordable housing across a range of tenure forms, improving the amenity and energy efficiency of existing homes, preparing for the proposed increase in the size of the community housing sector, and reforming, developing and strengthening homeless services in the State. (Achievements in the homelessness area are reported in the Homelessness services chapter).

Achievements in 2010-11 in terms of supply were the construction of 386 units of stock at a cost of \$72.2 million from the *Nation Building — Economic Stimulus Plan*. In addition, a further \$48.8 million was spent on capital projects and upgrades to deliver 171 additional properties across a range of programs.

In August 2010, Housing Tasmania implemented a new asset management system enabling better analysis of the portfolio, more informed decision making, and a strategic approach to addressing the deferred maintenance liability. A planned maintenance process has now commenced, and a number of energy efficiency initiatives have been undertaken with up to 3000 public housing properties receiving energy improvements, such as ceiling and under-floor insulation upgrades, window replacements, and the replacement of direct electric heaters, thereby reducing costs for tenants. One hundred tenants have also been selected as Energy Champions to monitor reduced energy consumption through the use of solar hot water and other energy-efficient modifications.

As part of the national reform agenda, Tasmania is also seeking to increase the size of the community housing sector. Significant work has been undertaken in preparing a regulatory framework, and planning the Tasmanian Housing Register (THR) which will eventually provide on line coordination and allocation functions across the entire Tasmanian social housing sector.

In June 2011, the Minister announced the introduction of a new flat 25 per cent rent model to replace the previous complex, and in some cases unfair, rent policy. The new model – 25 per cent of assessable household income – brings Tasmania into line with every other State Housing Authority and was implemented in October 2011.

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Australian Capital Territory Government comments

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The NAHA, associated National Partnership Agreements and the Nation Building and Jobs Plan stimulus package provided funding and support for the ACT to continue the implementation of its reform process for the delivery of housing and homelessness services, providing innovative programs to better meet clients' needs.

Capital funding provided under the Nation Building and Jobs Plan stimulus package was supplemented with ACT land, enabling the delivery of substantially more dwellings than required by the Commonwealth. In 2010-11, 337 dwellings were constructed. When the final dwellings are completed in 2011-12, a total of 421 dwellings will have been constructed under this initiative. Around three quarters of these were purpose built for older tenants to better meet their housing needs in later life. The relocation of older tenants to more suitable housing created opportunities for families in greatest need to find an affordable home in a social housing property. Measures such as this, to maximise the effectiveness of social housing to meet demand, are important in a context in which demand continues to exceed supply due to high private rental costs and a shortage of low cost housing in the ACT. Assets returned from the community sector allowed the provision of 174 apartments for students in 2011. The Social Housing Register, a combined waiting list for public and community housing, provides an effective means for government and community partners to ensure that appropriate housing is allocated to those in greatest need as it becomes available.

Working with its community partners, the ACT supports those in need by creating a continuum of support from early intervention, support in crisis to sustained tenancies, through to social and economic participation and inclusion. Among the programs achieving these aims in 2010-11 were:

- Refugee Transitional Housing Program, providing support and short term accommodation for newly arrived refugees
- Youth Housing Program, assisting young people, particularly those exiting youth justice, care and protection or homelessness, to sustain their tenancies and engage with education, employment and the community
- Housing and Accommodation Support Initiative, delivering ten integrated packages for housing, mental health and personal support for people with moderate to severe mental health issues
- Home to Work Project, providing training, education and employment opportunities for long term unemployed public housing tenants.

A number of initiatives to strengthen the community housing sector were implemented in 2010-11, including installation of high energy and water efficient appliances, tenancy management payments to three organisations providing housing to tenants with special needs, 124 properties built under stimulus package to be transferred to community housing providers, and the sign up of six organisations to Regulatory Framework for Not-for-Profit Housing Providers.

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Northern Territory Government comments

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The Territory Government is continuing to implement the *Housing the Territory* strategy, which incorporates action to increase land supply, homes for purchase and rent, and public housing. As part of the *Territory 2030 Strategic Plan*, the Territory Government will facilitate a balanced housing market across all market segments, and increase the availability of appropriate and affordable housing options.

The Territory Government is committed to substantially increasing housing supply through a 20 year land release program and accelerated land releases for residential housing. In addition, 15 per cent of all new crown land releases will be reserved for social and affordable housing. Planning continues for the new city of Weddell.

The Territory Government also announced the establishment of an affordable housing rental company, with the aim of increasing the supply of affordable accommodation options across the Territory. Under Round 4 of the National Rental Affordability Scheme, the Territory Government supported three applications to potentially provide up to 496 new affordable rental properties in the Darwin region.

In 2010-11, 420 new dwellings for low to middle income earners were constructed including:

- 257 new homes and 1248 refurbishments in remote Indigenous communities and urban Indigenous community living areas as part of the \$1.7 billion ten year National Partnership Agreement on Remote Indigenous Housing
- 163 new dwellings were completed under Stage Two of the Social Housing Initiative. Another 45 units in the Village@Parap development are on track to be completed in mid 2012.

The Territory Government is investing \$49 million over three years, delivering 150 public housing dwellings including new seniors villages.

In addition, in 2010-11, 106 households were assisted to purchase a home through Homestart NT. To increase access to affordable housing for low and middle income earners, the income and price caps for Homestart NT were raised in May 2011.

The Territory Government also offers stamp duty exemptions for first home buyers and stamp duty concessions for senior Territorians, veterans and carers looking to purchase or build a new home.

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16.6 Definitions of key terms

Social 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.

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.

Canadian National Occupancy Standard (CNOS)

A measure of the appropriateness of housing which is sensitive to both household size and composition. The CNOS specifies that:

- no more than two people shall share a bedroom
- parents or couples may share a bedroom
- children under 5 years, either of the same sex or opposite sex may share a bedroom
- children under 18 years of the same sex may share a bedroom
- a child aged 5 to 17 years should not share a bedroom with a child under 5 of the opposite sex
- single adults 18 years and over and any unpaired children require a separate bedroom.

Depreciation costs

Depreciation calculated on a straight-line basis at a rate that realistically represents the useful life of the asset (as per the Australian Accounting Standards 13–17).

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

A structure or a discrete space within a structure intended for people to live in or where a person or group of people live. Thus a structure that people actually live in is a dwelling regardless of its intended purpose, but a vacant structure is only a dwelling if intended for human residence. A dwelling may include one or more rooms used as an office or workshop provided the dwelling is in residential use.

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, SOMIH and ICH collections, the number of tenancy agreements is the proxy for counting the

	number of households. A tenancy agreement is defined as a formal written agreement between a household (a person or group of people) and a housing provider, specifying details of a tenancy for a particular dwelling.														
Indigenous household	A household with one or more members (including children) who identify as Aboriginal and/or Torres Strait Islander.														
Low income household	Low income households are generally defined in this Report as those in the bottom 40 per cent of equivalised gross household incomes (that is, the bottom two income quintiles). Equivalised gross income is an indicator of disposable household income after taking into account household size and composition.														
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.														
New household	Households that commence receiving assistance during the relevant reporting period (financial year).														
Occupancy rate	The proportion of dwellings occupied.														
Occupied dwelling	Dwellings occupied by tenants who have a tenancy agreement with the relevant housing authority.														
Overcrowding	Where one or more bedrooms are required to meet the Canadian National Occupancy Standard.														
Priority access to those in greatest need	Allocation processes to ensure those in greatest need have first access to housing. This is measured as the proportion of new allocations to those in greatest need.														
Principal tenant	The person whose name appears on the tenancy agreement. Where this is not clear, it should be the person who is responsible for rental payments.														
Proxy occupancy standard	A measure of the appropriateness of housing related to the household size and tenancy composition. The measure specifies the bedroom requirements of a household. <table> <tr> <th><i>Household structure</i></th><th><i>Bedrooms required</i></th></tr> <tr> <td>Single adult only</td><td>1</td></tr> <tr> <td>Single adult (group)</td><td>1 (per adult)</td></tr> <tr> <td>Couple with no children</td><td>2</td></tr> <tr> <td>Sole parent or couple with one child</td><td>2</td></tr> <tr> <td>Sole parent or couple with two or three children</td><td>3</td></tr> <tr> <td>Sole parent or couple with four children</td><td>4</td></tr> </table> For sole parent or couple households with four or more children the dwelling size in terms of bedrooms should be the same value as the number of children in the household.	<i>Household structure</i>	<i>Bedrooms required</i>	Single adult only	1	Single adult (group)	1 (per adult)	Couple with no children	2	Sole parent or couple with one child	2	Sole parent or couple with two or three children	3	Sole parent or couple with four children	4
<i>Household structure</i>	<i>Bedrooms required</i>														
Single adult only	1														
Single adult (group)	1 (per adult)														
Couple with no children	2														
Sole parent or couple with one child	2														
Sole parent or couple with two or three children	3														
Sole parent or couple with four children	4														
Rebated household	A household that receives housing assistance and pays less than the market rent value for the dwelling.														
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.														
Special needs household	Low income households that have either a household member with disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members. For SOMIH, special needs households are those that have either a														

	household member with disability or a principal tenant aged 24 years or under, or 50 years or over.
Tenancy rental unit	A tenancy (rental) unit is defined as the unit of accommodation on which a tenancy agreement can be made. It is a way of counting the maximum number of distinct rentable units that a dwelling structure can contain.
Tenantable dwelling	A dwelling where maintenance has been completed, whether occupied or unoccupied at 30 June. All occupied dwellings are tenantable.
Total gross household income	The value of gross weekly income from all sources (before deductions for income tax, superannuation etc.) for all household members, expressed as dollars per week. The main components of gross income are current usual wages and salary; income derived from self-employment, government pensions, benefits and allowances; and other income comprising investments and other regular income. CRA payments are not included as income.
Transfer household	A household, either rebated or market renting, that relocates (transfers) from one dwelling to another within the same social housing program.
Turnaround time	The average time taken in days for vacant dwellings, which are available for letting, to be occupied.
Underutilisation	Where there are one or more bedrooms additional to the number required in the dwelling to satisfy CNOS.
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

Dependent child	Dependent child has a wider meaning under Social Security and Family Assistance law than is used in this chapter in relation to CRA. In this chapter, a dependent child is one in respect of whom an adult member of the income unit receives Family Tax Benefit part A (FTB (A)) at more than the base rate. At June 2011, children aged 16 or older attract the base rate of FTB (A) only, so are not included in the count of dependent children. Some children aged under 16 may also attract only the base rate of FTB (A) because of the maintenance income test, the maintenance action test, or because they are overseas.
Income support recipient	Recipients in receipt of a payment made under social security law. The main income support payments administered by FaHCSIA are Age Pension, Disability Support Pension and Carer Payment, while the main income support payments administered by Department of Education, Employment and Workplace Relations are Newstart Allowance, Youth Allowance, Austudy, Parenting Payment (Single) and Parenting Payment (Partnered). Family Tax Benefit is paid under family assistance law and is not an income support payment.
Income unit	An income unit may consist of: • a single person with no dependent children • a sole parent with one or more dependent children • a couple (married, registered or defacto) with no dependent children • a couple (married, registered or defacto) with one or more dependent children. A non-dependent child living at home, including one who is receiving an income support payment in their own right, is regarded as a separate income unit. Similarly, a group of non-related adults sharing accommodation are counted as separate income units.

Low and moderate incomes	Individuals and families receive CRA with either an income support payment or a FTB Part A. While income support recipients are generally thought of as low income, those receiving FTB (A) can have higher incomes and still be eligible for a part rate of Rent Assistance. For this reason, CRA recipients are not defined as those on low incomes.
Primary payment type	Each income unit receiving CRA is assigned a primary payment type, based on the payment(s) received by each member. The primary payment is determined using a hierarchy of payment types, with precedence given to pensions, then other social security payments and then the Family Tax Benefit part A. No extra weight is given to the payment type with which CRA is paid. Specifically, the hierarchy for the main payments is: • Disability Support Pension • Carer Payment • Age Pension • Parenting Payment (Single) • Newstart Allowance • Youth Allowance • Austudy • Parenting Payment (Partnered) • Family Tax Benefit part A.
Rent	Amount payable as a condition of occupancy of a person's home. Rent 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.
Sharer	Some single people are subject to a lower maximum (sharer) rate of CRA. The lower rate may apply to a single person (with no dependent children) who shares a major area of accommodation. The lower rate does not apply to those receiving Disability Support Pension or Carer Payment, those in nursing homes or boarding house accommodation, or those paying for both board and lodgings.
Special needs	Individuals and families with at least one member who either self-identifies as Indigenous; receives a Disability Support Pension; is aged 24 years or under; or is aged 75 years or over.
Total income from all sources	Income received by the recipients or partner, excluding income received by a dependent. It includes regular social security payments and any maintenance and other private income taken into account for income testing purposes. It does not include: • one-time payments • arrears payments • advances • Employment or Education Entry Payments • Mobility Allowance • Baby Bonus • Child Care Tax 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 part A but no income support payment.

16.7 List of attachment tables

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17 Homelessness services

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Attachment tables

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Homelessness has multiple causes. Some of the social factors associated with homelessness include a shortage of affordable housing, family and relationship breakdown, unemployment and financial hardship, mental health problems, and drug and alcohol abuse (COAG Reform Council 2010).

Australian, State and Territory governments fund services to assist people who are homeless or at risk of homelessness.

Between 1985 and 2009, the Australian Government and State and Territory governments funded the Supported Accommodation Assistance Program (SAAP) to alleviate the difficulties of people who are homeless or at risk of homelessness and reduce the potential for their recurrence. SAAP services provided assistance to individuals and families who were in crisis or experienced difficulties that hindered personal or family functioning. The SAAP program concluded on 31 December 2008 at the expiry of the SAAP V Multilateral Agreement (2005–2010).

The National Affordable Housing Agreement (NAHA) commenced on 1 January 2009 as part of the Intergovernmental Agreement on Federal Financial Relations. To support the NAHA, the National Partnership Agreement on Homelessness (NPAH) commenced on 1 July 2009. Government funding for specialist homelessness services is provided through the NAHA and NPAH.

The NAHA and NPAH provide the framework for Australian Government and State and Territory governments to reduce homelessness and improve housing outcomes for Australians. The NAHA aims to ensure all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation. Australian, State and Territory governments agreed to a number of outcomes relating to homelessness, including:

- providing support and accommodation for people who are homeless or at risk of homelessness
- reducing the rate of homelessness
- preventing and intervening early to break the cycle of homelessness
- improving and expanding the service response to homelessness (COAG 2008a; 2008b).

The NPAH outlines the roles and responsibilities of Australian Government and State and Territory governments in relation to reducing and preventing homelessness, and contributes to achieving the NAHA outcomes in relation to homelessness.

This chapter reports data on government funded specialist homelessness services and the people accessing these services. Homelessness services that do not receive government funding, and those people accessing such services, are excluded from this Report.

The SAAP program concluded on 31 December 2008, but the SAAP data collection was continued to enable reporting on homelessness while a new specialist homelessness services (SHS) data collection was developed for reporting on the NAHA and NPAH. This chapter reports homelessness data from the SAAP

collection, as data from the SHS collection are not yet available for reporting. The SHS data collection became operational on 1 July 2011 and SHS data for the 2011-12 period, along with SAAP data for 2010-11, are expected to be available for the 2013 Report.

This Report includes data for 2009-10, as there is a one year lag in reporting from the SAAP data collection, though some financial data are reported for 2010-11. There were no major improvements to the reporting of government funded specialist homelessness services this year.

17.1 Profile of homelessness services

Homelessness services aim to provide support to people who are homeless or are at risk of becoming homeless. Non-government, community and local government agencies deliver a variety of homelessness services to clients, including supported accommodation, counselling, advocacy, links to housing, health, education and employment services, outreach support, brokerage and meals services, and financial and employment assistance.

Supported Accommodation Assistance Program

Homelessness services provided under the SAAP aimed to assist people who were homeless or at imminent risk of becoming homeless as a result of a crisis, including women and children escaping domestic violence.

The SAAP was established in 1985 to bring homelessness programs funded by individual State and Territory governments and the Australian Government under one nationally coordinated program. The final program (SAAP V 2005–2010) was governed by the *Supported Accommodation Assistance Act 1994* (Cth). The Act specified that the overall aim of SAAP was to provide transitional supported accommodation and related support services to assist people who are homeless to achieve self-reliance and independence. Within this broad aim, the goals of the SAAP were to resolve crises, to re-establish family links where appropriate, and to re-establish a capacity to live independently of SAAP services.

Homelessness services and the link with other services

In 2009-10, 84 100 children accompanied a parent or guardian who received substantial support from homelessness services (AIHW 2011).¹ Research indicates that in almost half of support periods involving adults with accompanying children, domestic violence was the main reason SAAP support was sought (AIHW 2006). As a result, some children assisted by homelessness services may have also had contact with child protection and out-of-home care services, or may have been subject to a current or past care and protection order. Child protection and support services are reported in chapter 15 of this Report.

Close links also exist between homelessness services and other forms of housing assistance reported in the Housing chapter of this Report (chapter 16). Some individuals and families used both homelessness and housing services, as people can move from homelessness to social housing, or might be in receipt of homelessness services and accommodated in social housing.² For example, in 2009-10, approximately 13.7 per cent of former clients who had requested assistance with obtaining or maintaining independent housing, had moved to public housing (table 17A.21). The Housing and homelessness sector summary provides some information on the interconnections between these services.

Size and scope

On Census night in 2006, there were approximately 105 000 homeless people (that is, approximately one in every 190 Australians) (Chamberlain and MacKenzie 2008). This number includes people who were without conventional accommodation (for example, sleeping rough), who were living in temporary shelter (for example, youth refuges or ‘couch surfing’), and who were staying in accommodation that is below minimum community standards (for example, boarding houses and caravan parks). According to the *Counting the Homeless 2006* report, SAAP provided accommodation to approximately 19 per cent of the homeless population on Census night in 2006 (Chamberlain and MacKenzie 2008). The method for counting homeless people in the Census is under review and estimates are expected to be revised in future Reports.

¹ The term ‘substantial’ in ‘substantial support’ is a term used in the SAAP data collection to denote support for a person defined as a client during a support period (see section 17.6 for definitions of ‘client’ and ‘support period’). ‘Substantial’ is not meant to convey a measure of the number of distinct support services or duration of support.

² Social housing includes public and community housing. For further information on these forms of housing assistance, see chapter 16 (box 16.1).

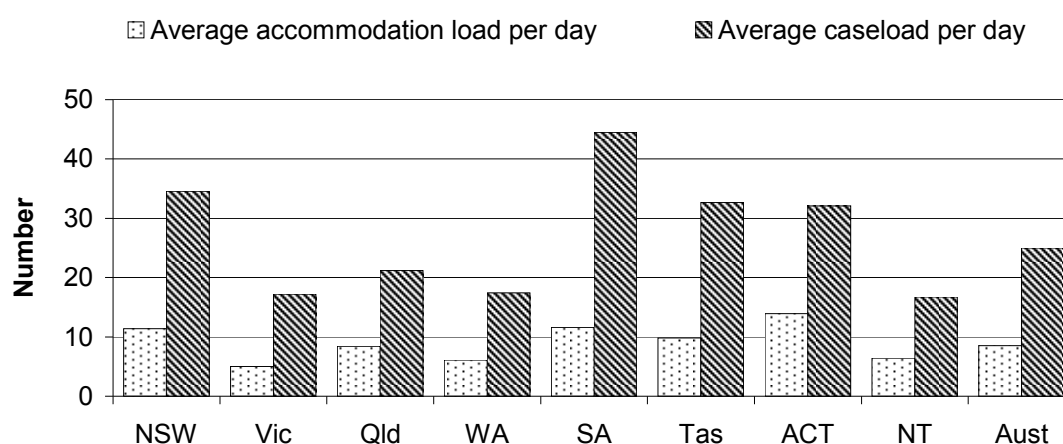
Agencies providing homelessness services delivered a range of support services to various client groups throughout the year, including families, single men and women, and unaccompanied children and young people. Nationally, agencies provided support to 219 900 people, of which 135 700 (62 per cent) were clients and 84 100 (38 per cent) were children accompanying clients in 2009-10 (AIHW 2011).

In 2009-10, 1559 agencies were funded under the NAHA, including non-government, community and local government agencies (table 17A.2). Services were delivered by agencies primarily targeting:

- young people (33.2 per cent of agencies)
- women escaping domestic violence (24.3 per cent)
- families (8.6 per cent)
- single men (5.8 per cent)
- single women (2.8 per cent)
- multiple client groups (25.3 per cent) (table 17A.2).

The national average accommodation load per agency was 8.5 per day and the caseload per agency was 25.0 per day in 2009-10, although these varied across jurisdictions (figure 17.1).

Figure 17.1 Average accommodation load and caseload per day, 2009-10^a



^a See notes to table 17A.20 for descriptions of how accommodation load and caseload are estimated.

Source: AIHW (unpublished) SAAP NDCA Administrative Data and Client Collections; table 17A.20.

Agencies varied in the types of services they delivered. In 2009-10, agencies were most commonly designed to provide medium term to long term supported

accommodation (40.0 per cent of agencies) and crisis or short term supported accommodation (30.5 per cent of agencies). Agencies also provided services other than accommodation, such as outreach support, day support, and telephone information and referral. The proportions of agencies delivering particular types of homelessness services remained relatively stable from 2005-06 to 2009-10 (table 17A.3).

Services commonly provided by agencies in support periods in 2009-10 included general support and advocacy (in 77.2 per cent of support periods), housing and accommodation services (52.6 per cent), counselling (58.8 per cent), and financial and employment assistance (40.4 per cent). There has been some change in the composition of services provided by agencies over time, with a decrease in housing and accommodation services (from 59.6 per cent in 2005-06), and increases in financial and employment assistance (from 36.9 per cent in 2005-06) and counselling services (from 51.5 per cent in 2005-06) (figure 17.2).

Figure 17.2 Services received during a support period^a



^a Totals do not add to 100 per cent because agencies may provide more than one type of service during a single support period.

Source: AIHW (various years) *Government-funded specialist homelessness services: SAAP National Data Collection annual report*. Cat no. HOU 219; table 17A.1.

Roles and responsibilities

Government funded specialist homelessness services are jointly funded by the Australian, State and Territory governments, through the NAHA and NPAH. The NAHA commenced on 1 January 2009 as part of the Intergovernmental Agreement on Federal Financial Relations. To support the NAHA, the NPAH commenced on 1 July 2009.

The SAAP was jointly funded by the Australian, State and Territory governments until December 2008. State and Territory governments were responsible for the daily management of the program, including the distribution of funding to SAAP funded agencies. Non-government agencies delivered most SAAP services with some local government participation.

Funding

Recurrent government expenditure on specialist homelessness services for 2010-11 was \$482.3 million (table 17A.5). Most of this expenditure (97.2 per cent) was funding provided to agencies to deliver services for people who are homeless or at risk of homelessness, while the remaining expenditure (2.8 per cent) was attributed to State and Territory governments' administration costs (table 17A.4). Nationally, real recurrent funding per person in the population was \$21 in 2010-11, though the amount of funding per person varied across jurisdictions (table 17A.6).

In addition to funding provided under the NAHA and NPAH, State and Territory governments contribute extra funding to specialist homelessness services. Where available, the additional funding is included in reporting from 2008-09.

17.2 Framework of performance indicators for government funded specialist homelessness services

The performance indicator framework for government funded specialist homelessness services is based on shared government objectives for homelessness services delivered under the SAAP (box 17.1). Though the SAAP concluded and was replaced by the NAHA on 1 January 2009, performance indicators in this chapter reflect those developed under the SAAP V Agreement.

Box 17.1 Objectives for government funded specialist homelessness services (SAAP)

The overall aim of SAAP was 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 were to:

- resolve crises
- re-establish family links where appropriate
- re-establish the capacity of clients to live independently of SAAP.

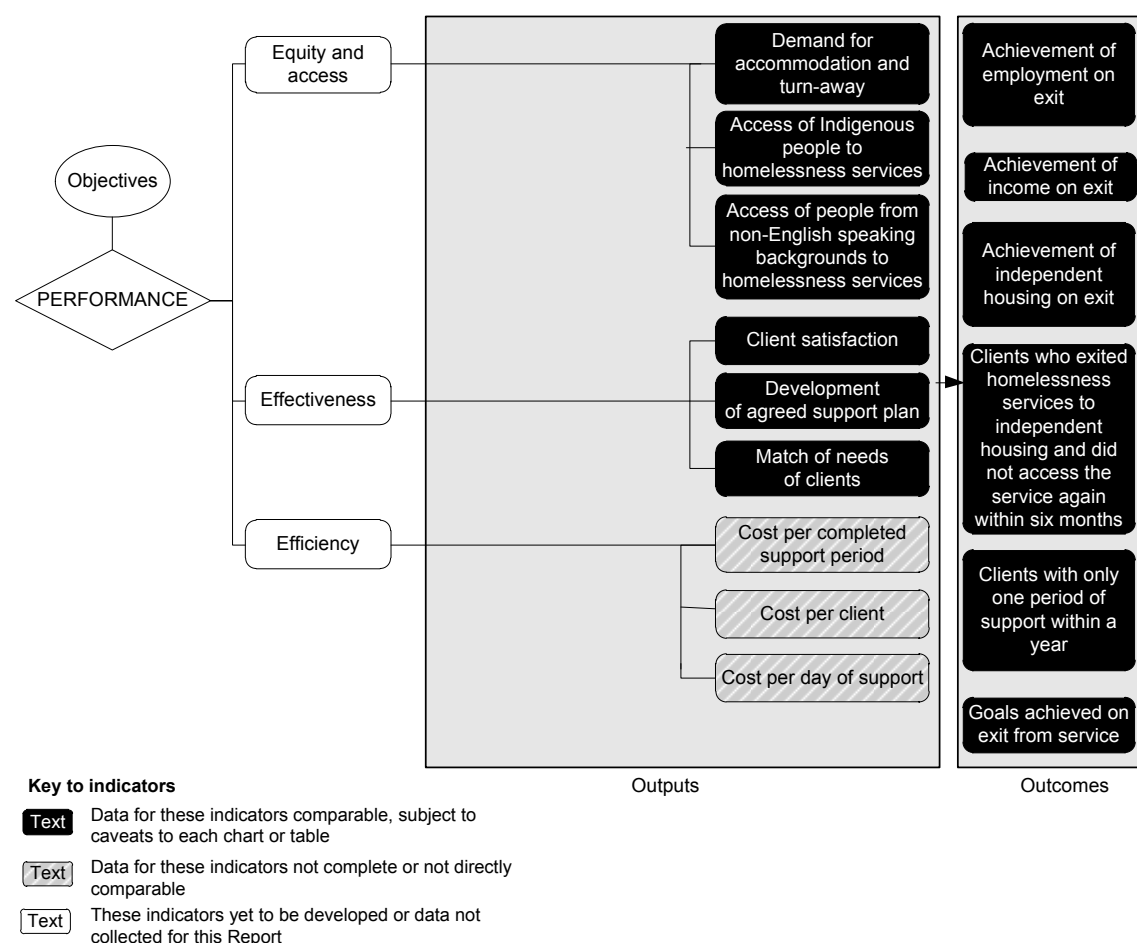
Homelessness services should be provided in an equitable and efficient manner.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations). The NAHA covers the area of housing and homelessness and includes performance indicators for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with homelessness performance indicators in the NAHA.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of government funded specialist homelessness services (figure 17.3). The performance indicator framework shows which data are comparable in the 2012 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 Report's statistical appendix 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) (appendix A).

Figure 17.3 Government funded specialist homelessness services performance indicator framework



17.3 Key performance indicator results for government funded specialist homelessness services

Data reported in this section are for government funded specialist homelessness services delivered under the NAHA and the SAAP V Agreement: data for 2009-10 reflect services provided under the NAHA; data for 2008-09 reflect services provided under the NAHA and the SAAP V Agreement; and data for 2007-08 and previous years reflect services provided under the SAAP V Agreement. Data are sourced from the SAAP data collection, which measures the number of clients and the number and types of services provided to clients, but is subject to limitations (box 17.2). Further information on the SAAP data collection for clients and demand for accommodation are available in the data quality information accompanying this chapter.

Box 17.2 Information to be considered when analysing data from the SAAP collection

Informed consent is an essential component of the integrity of the SAAP data. The principle of client/consumer rights (which underpins informed consent) recognises that clients do not receive services under a mandatory order. They have the right to accept or reject the services offered and they have the right to provide or not provide information while receiving services.

Nationally, in 2009-10, clients consented to provide personal details for the SAAP client data collection in 90.0 per cent of support periods, while 93.3 per cent of agencies participated in the client collection. A weighting system has been developed to adjust for client non-consent and agency non-participation (AIHW 2011).

Outputs

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

Equity and access

Demand for accommodation and turn-away

‘Demand for accommodation and turn-away’ is an indicator of governments’ objective to ensure all Australians have equitable access to accommodation services on the basis of relative need (box 17.3).

Box 17.3 Demand for accommodation and turn-away

‘Demand for accommodation and turn-away’ is defined as the extent to which demand for accommodation is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation cannot be provided with that assistance. Two measures of the proportion of people whose valid request for immediate accommodation cannot be met are reported:

- turn-away as the proportion of people requiring new accommodation, defined as the average daily percentage of people who could not be accommodated relative to all people making valid requests for immediate accommodation. This provides an indication of a person’s likelihood of obtaining accommodation.
- turn-away as the proportion of total demand for accommodation, defined as the average daily percentage of people who could not be accommodated relative to all people who required new and immediate accommodation or who were continuing their accommodation from the previous day. This provides a measure of the overall ability of to meet the demand for accommodation on an average day during the collection period.

A decreasing proportion of people turned away from services is desirable.

Data reported for this indicator are comparable across jurisdictions but not over time. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Data for access to services are sourced from the SAAP Demand for Accommodation collection and SAAP Client collection. The Demand for Accommodation collection measures the levels of met and unmet demand for accommodation by collecting information about requests for accommodation by individuals or groups over two separate weeks each year. These data are used in conjunction with Client collection data to calculate the ‘turn-away’ rate for demand for accommodation.

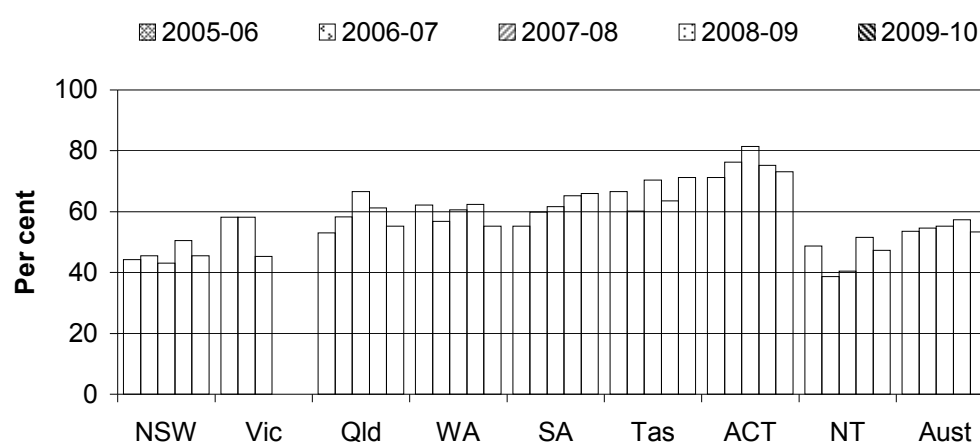
The Demand for Accommodation collection collects data on ‘valid unmet requests’ for immediate accommodation. ‘Valid unmet requests’ excludes requests made at an agency where the person or group making the request does not fall within an agency’s target client group, where there is no fee-free accommodation available at that time,³ or where assistance offered by an agency is refused. For the Client collection, the accommodation status of a client on a particular day is based on the reported periods of accommodation within a support period.

³ ‘No fee-free accommodation available’ refers to situations where the person/group is not given accommodation because they cannot meet the financial requirements (for example, fees) for that accommodation.

Demand data may understate the activities of homelessness services agencies as only data from those agencies that participated in both the Client collection and the Demand for Accommodation collection are used in the calculations. Additionally, the two week sample periods over which data are collected might not be representative of the success of clients accessing homelessness services over the full year (see notes to tables 17A.7 and 17A.8).

Data on the proportion of people with valid requests for accommodation who were turned away are reported for the years 2005-06 to 2009-10. Nationally, 53.4 per cent of adults and unaccompanied children requesting immediate new accommodation on a given day were turned away in 2009-10. This proportion varied across jurisdictions (figure 17.4).

Figure 17.4 Turn-away of adults and unaccompanied children as a proportion of people requiring new accommodation^{a, b, c, d, e}



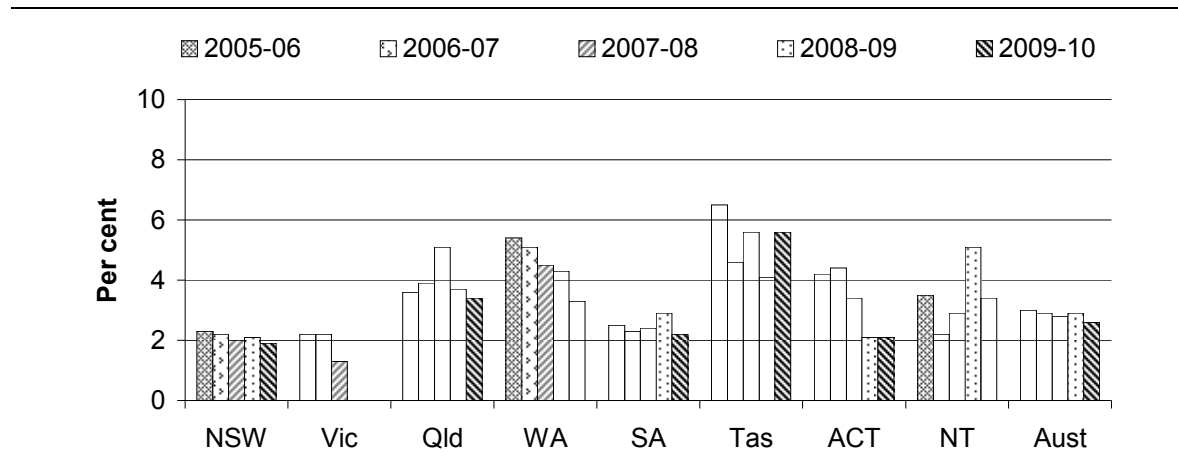
^a A two-week Demand for Accommodation collection is conducted annually, in December and May, or August and May in each financial year, to gather information about homeless people whose requests for accommodation were unable to be met by agencies. ^b Comparisons between years should be treated with caution, due to variation in participation rates, differing imputation methods and because the collections were held on different dates each year. ^c The denominator for this indicator refers to adults and unaccompanied children. ^d Most specialist homelessness accommodation in Victoria is provided through the Transitional Housing Management program. Data for this program are collected separately to the SAAP data collection. Accommodation data in Victoria are not recorded in the SAAP data collection in the same way as other jurisdictions and are not comparable to other jurisdictions. As a result, turn-away data for Victoria from 2008-09 were not available. ^e See notes to table 17A.7 and data quality information for more detailed data caveats.

Source: AIHW (various years) *Demand for government-funded specialist homelessness accommodation: A report from the SAAP national data collection*, Cat. No. HOU 230; table 17A.7.

Nationally, the number of adults and unaccompanied children who made valid requests for accommodation but could not be accommodated accounted for 2.6 per cent of the total demand for accommodation in 2009-10 (figure 17.5). Total demand includes all accommodated adults and unaccompanied children.

The difference between the percentage of people turned away on a given day as a proportion of total requests for new immediate accommodation on a given day (53.4 per cent) and the percentage of people turned away on a given day as a proportion of total demand for accommodation (2.6 per cent) suggests that agencies provide a significant number of clients with continuing accommodation (tables 17A.7 and 17A.8).

Figure 17.5 Turn-away of adults and unaccompanied children as the proportion of total demand for accommodation^{a, b, c, d, e}



^a A two-week Demand for Accommodation Collection is conducted annually to gather information about homeless people whose requests for accommodation were unable to be met by agencies. The collections were held in December and May, or August and May, of each financial year. ^b Comparisons between years should be treated with caution, due to variation in participation rates, differing imputation methods and because the collections were held on different dates each year. ^c The denominator for this indicator refers to adults and unaccompanied children. ^d Most specialist homelessness accommodation in Victoria is provided through the Transitional Housing Management program. Data for this program are collected separately to the SAAP data collection. Accommodation data in Victoria are not recorded in the SAAP data collection in the same way as other jurisdictions and are not comparable to other jurisdictions. As a result, turn-away data for Victoria from 2008-09 were not available. ^e See notes to table 17A.8 for more detailed data caveats.

Source: AIHW (various years) *Demand for government-funded specialist homelessness accommodation: A report from the SAAP national data collection*, Cat. No. HOU 230; table 17A.8.

Nationally, requests for accommodation were not met for a number of reasons in 2009-10, including lack of available accommodation (58.3 per cent), no vacancies at the referral agency (23.7 per cent), type of accommodation requested is not provided (7.7 per cent) and insufficient staff (0.9 per cent) (table 17A.16).

Access of Indigenous people to homelessness services

‘Access of Indigenous people to homelessness services’ is an indicator of governments’ objective to ensure all Australians have equitable access to homelessness services on the basis of relative need (box 17.4).

Box 17.4 Access of Indigenous people to homelessness services

‘Access of Indigenous people to homelessness services’ is defined as the comparison between the representation of Indigenous people among all people whose valid requests for accommodation were unmet and their representation among clients who were accommodated during the year.

A high or increasing proportion of Indigenous people whose valid requests for accommodation are met is desirable. Where the proportion of Indigenous people with unmet accommodation needs is higher than the proportion of people who received accommodation who were Indigenous, services might not be achieving equality of service access for Indigenous people.

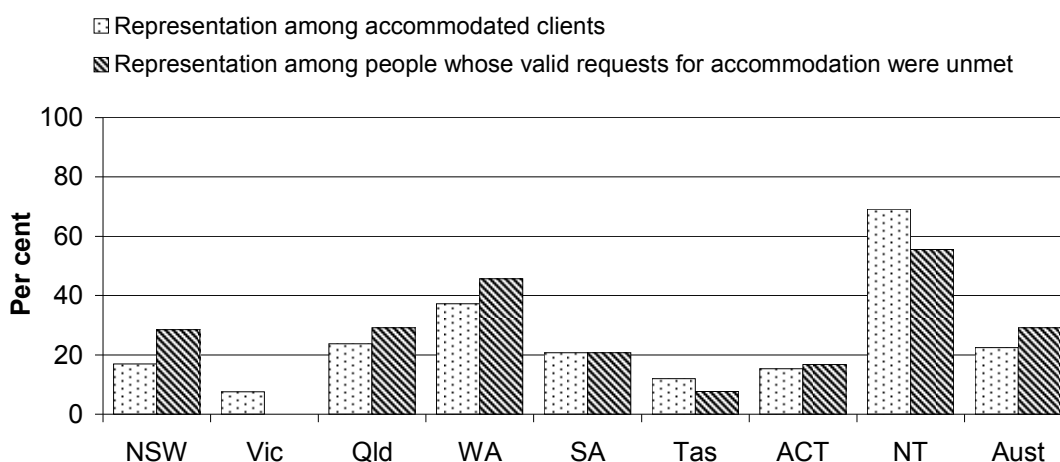
The indicator measures the extent to which the demand for assistance from Indigenous people is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation, or support, cannot be provided with that assistance.

Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as Indigenous people) is particularly important.

Data reported for this indicator are comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, Indigenous people made up 29.1 per cent of all people whose valid requests for accommodation did not result in accommodation assistance in 2009-10 — a proportion greater than Indigenous clients among all accommodated clients (22.4 per cent). This result varied across jurisdictions (figure 17.6).

Figure 17.6 Proportion of Indigenous people among all accommodated clients and among people whose valid requests for accommodation were unmet, 2009-10^{a, b}



^a Turn away data for Victoria were not available. ^b See notes to table 17A.9 for details of data definitions.

Source: AIHW (unpublished) SAAP NDCA Client and Demand for Accommodation Collections; AIHW (2011) Demand for government-funded specialist homelessness accommodation 2009-10: A report from the SAAP national data collection. Cat. No. HOU 230; table 17A.9.

Access of people from non-English speaking backgrounds to homelessness services

‘Access of people from non-English speaking backgrounds to homelessness services’ is an indicator of governments’ objective to ensure all Australians have equitable access to homelessness services on the basis of relative need (box 17.5).

Box 17.5 Access of people from non-English speaking backgrounds to homelessness services

‘Access of people from non-English speaking backgrounds (NESB) to homelessness services’ is defined as the comparison between the representation of people from NESB among all people whose valid requests for accommodation were unmet, and their representation among clients who were accommodated during the year.

A high or increasing proportion of people from NESB whose valid requests for accommodation are met is desirable. Where the proportion of people from NESB with unmet accommodation needs is higher than the proportion of people who received accommodation who were from NESB, services might not be achieving equality of service access for people of NESB.

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Box 17.5 (Continued)

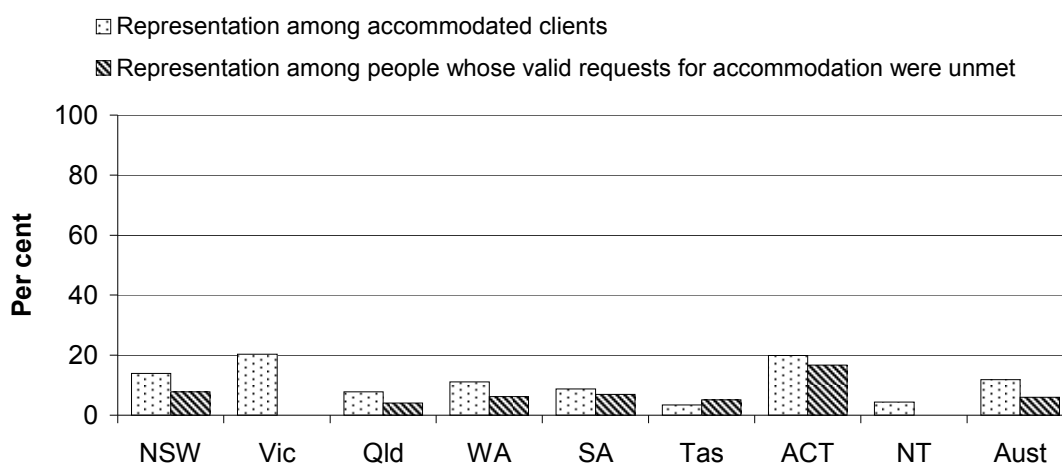
This indicator measures the extent to which the demand for assistance from people from NESB is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation, or support, cannot be provided with that assistance (although one-off assistance might be provided).

Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as people from NESB) is particularly important.

Data reported for this indicator are comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, the proportion of people from NESB among all people whose valid requests for accommodation did not result in accommodation assistance was 5.9 per cent in 2009-10 — lower than that of people from NESB among all accommodated clients (11.8 per cent). This result varied across jurisdictions (figure 17.7).

Figure 17.7 Proportion of people from NESB among all accommodated clients and among people whose valid requests for accommodation were unmet, 2009-10^{a, b}



^a Turn away data for Victoria in 2009-10 were not available. ^b See notes to table 17A.10 for details of data definitions.

Source: AIHW (unpublished) SAAP NDCA *Client and Demand for Accommodation Collections*; AIHW (2011) *Demand for government-funded specialist homelessness accommodation 2009-10: A report from the SAAP national data collection*. Cat. No. HOU 230; table 17A.10.

Effectiveness

Client satisfaction

‘Client satisfaction’ is an indicator of governments’ objective to provide high quality services that meet the needs of recipients (box 17.6).

Box 17.6 Client satisfaction

‘Client satisfaction’ is defined as the extent to which clients find homelessness services and programs to be helpful and of a high standard. Client satisfaction is measured as the proportion of clients who reported that their overall satisfaction with the assistance they received from services was either ‘good’ or ‘really good’.

A high or increasing proportion of clients reporting the assistance they received as ‘good’ or ‘really good’ suggests greater client satisfaction with the overall service.

Data reported for this indicator are comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Data for the client satisfaction indicator are sourced from the national SAAP client satisfaction survey, which was conducted in 2003. New data for this indicator were not available for this Report. Data on client satisfaction relating to a four week period beginning 11 November 2003 were included in the 2005 Report (SCRGSP 2005, pp. 15.47-48; CBSR 2004).

Development of agreed support plan

‘Development of agreed support plan’ is an indicator of governments’ objective to provide high quality services that are appropriately targeted to meet the needs of clients (box 17.7).

Box 17.7 Development of agreed support plan

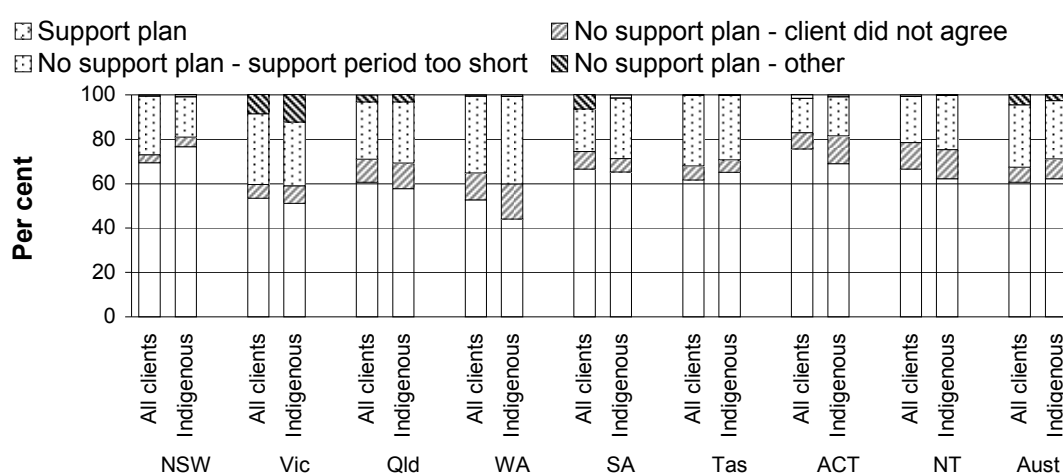
‘Development of agreed support plan’ is defined as the number of closed support periods with an agreed support plan divided by the total number of closed support periods. A closed support period is a support period that had finished on or before 30 June. Data are reported for all clients, and separately for Indigenous clients.

A high or increasing proportion of support periods with agreed support plans is desirable. However, in some instances, a support plan may be judged to be inappropriate (such as when a support period is short term).

Data reported for this indicator are comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, there was an agreed support plan for 60.6 per cent of closed support periods for all clients in 2009-10 (compared to 62.2 per cent for Indigenous clients). These proportions varied across jurisdictions (figure 17.8).

Figure 17.8 Closed support periods, by the existence of a support plan, 2009-10^a



^a See notes to tables 17A.11 and 17A.12 for more details of data definitions.

Source: AIHW (unpublished) SAAP NDCA *Client Collection*; AIHW (2011) *Government-funded specialist homelessness services: SAAP National Data Collection annual report 2009-10*. Cat no. HOU 219; tables 17A.11-12.

Match of needs of clients

‘Match of needs of clients’ is an indicator of governments’ objective to ensure that services meet client’s individual needs (box 17.8).

Box 17.8 Match of needs of clients

'Match of needs of clients' is defined as the number of distinct services required by clients that are provided, as well as those referred to another agency, divided by the total number of distinct services required by clients.

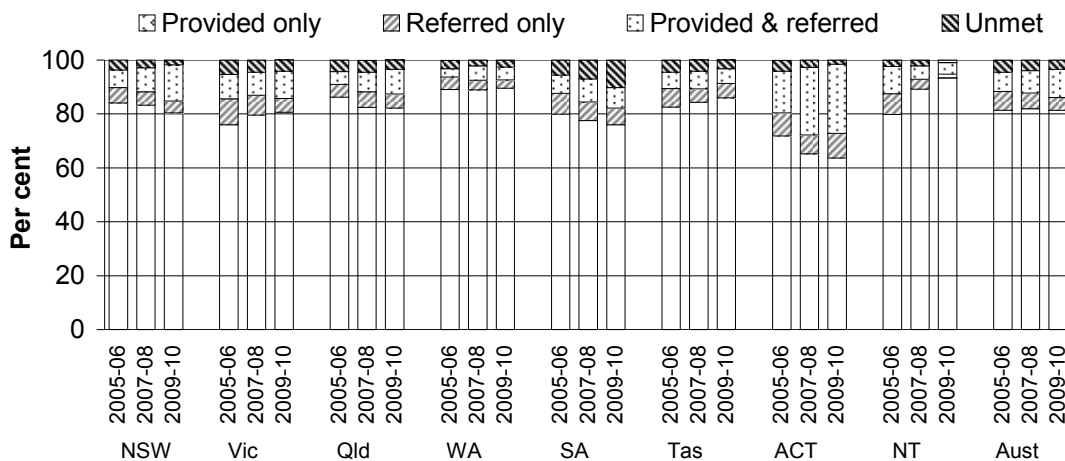
A high or increasing proportion of clients who received services they needed, or who were referred to another agency, is desirable.

The range of services needed by clients is broad (ranging from meals to laundry facilities to long term accommodation), so the effect of not providing these services varies. Data are reported for all clients, and separately for Indigenous people and people from NESB.

Data reported for this indicator are comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, the proportion of clients who received services they needed (including services provided by the initially approached agencies and/or referrals to another agency) was 96.5 per cent in 2009-10 (figure 17.9).

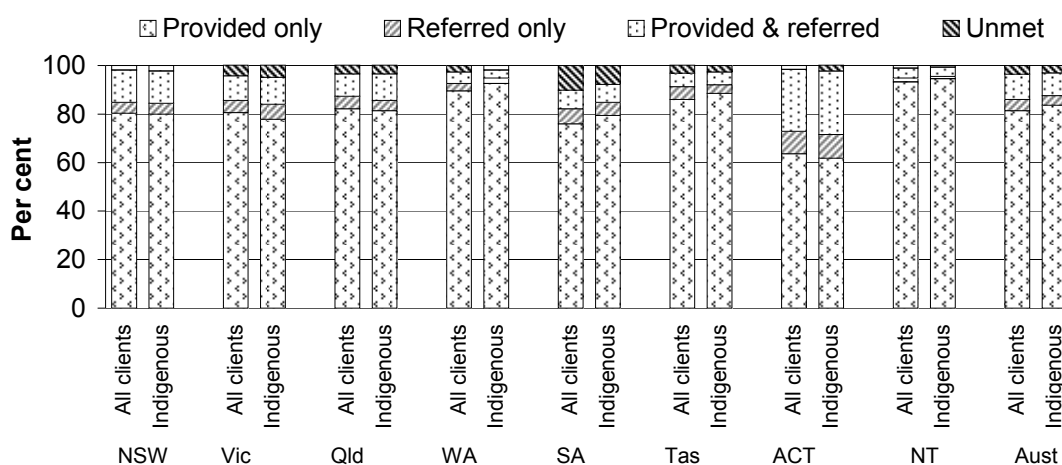
Figure 17.9 All clients, by met and unmet support needs



Source: AIHW (various years) *Government-funded specialist homelessness services: SAAP National Data Collection annual report*, Cat no. HOU 219. AIHW (various years) *Government-funded specialist homelessness services: SAAP National Data Collection annual report State/territory supplementary tables*. Cat no. HOU 222; table 17A.13.

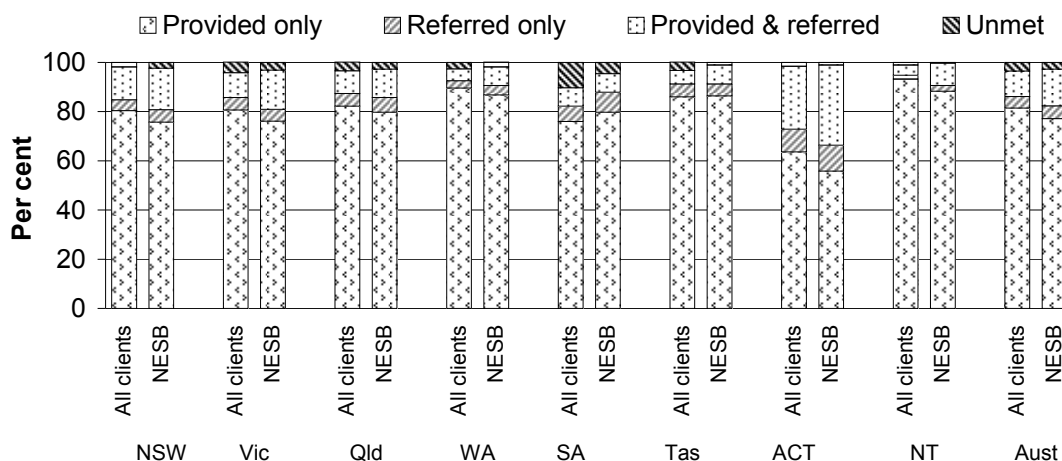
The proportions for Indigenous clients (97.0 per cent) and clients from a NESB (97.3 per cent) who received services in 2009-10 were the same or similar to that for all clients (96.5 per cent). These proportions varied across jurisdictions (figures 17.10 and 17.11).

Figure 17.10 Indigenous clients, by met and unmet support needs, 2009-10



Source: AIHW (unpublished) SAAP NDCA Client Collection; AIHW (2011) *Government-funded specialist homelessness services: SAAP National Data Collection annual report 2009-10*. Cat no. HOU 219; tables 17A.13 and 17.14.

Figure 17.11 Clients from NESB, by met and unmet support needs, 2009-10



NESB = Non-English speaking backgrounds.

Source: AIHW (unpublished) SAAP NDCA Client Collection; AIHW (2011) *Government-funded specialist homelessness services: SAAP National Data Collection annual report 2009-10*. Cat no. HOU 219; tables 17A.13 and 17A.15.

Efficiency

Across jurisdictions, there are varying treatments of expenditure items (for example, superannuation) and different counting and reporting rules for generating financial data. Differences in expenditure data across jurisdictions might to some extent

reflect differences in the way in which these data are compiled rather than true variations in expenditure.

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 public resources (box 17.9).

Box 17.9 Cost per completed support period

‘Cost per completed support period’ is defined as total expenditure on homelessness services divided by the number of completed support periods (excluding casual clients, and adults and accompanying children with a valid unmet request for accommodation).

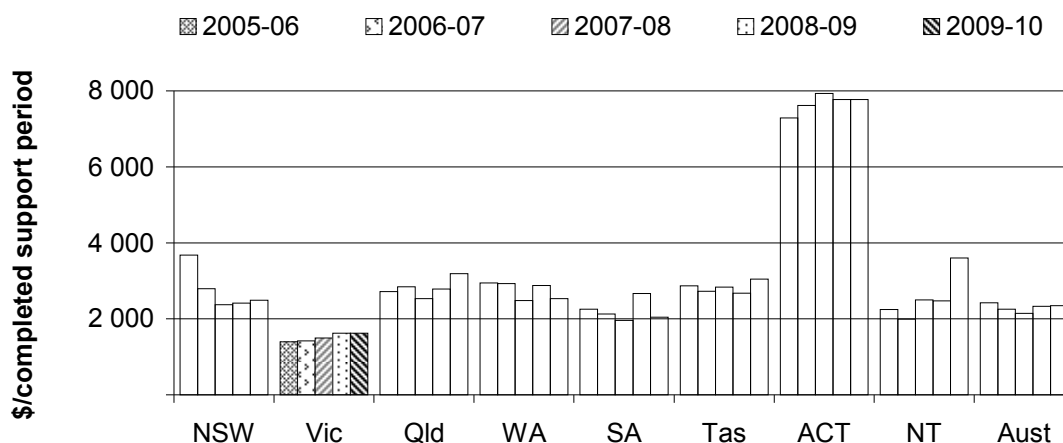
A low or decreasing cost per completed support period represents an improvement in efficiency, but can also indicate lower service quality.

This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost), including only expenditure by service delivery providers. Unit cost indicators ideally include administration costs borne by State and Territory governments in administering services, but reporting this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP was provided under the Commonwealth State Housing Agreement (CSHA) through a special purpose program — the Crisis Accommodation Program (CAP) — until end-December 2008, when all funding was rolled into the NAHA.

Data reported for this indicator are not directly comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, the recurrent cost per completed support period (excluding potential clients and accompanying children) declined from \$2420 in 2005-06 to \$2350 in 2009-10, though this varied across jurisdictions (figure 17.12).

**Figure 17.12 Real recurrent cost per completed support period
(2009-10 dollars)^a**



^a See notes to table 17A.17 for detailed data caveats.

Source: AIHW (unpublished) SAAP NDCA *Administrative Data and Client Collections*; Australian, State and Territory governments (unpublished); table 17A.17.

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 public resources (box 17.10).

Box 17.10 Cost per client

‘Cost per client’ is defined as total expenditure on homelessness services divided by the number of clients accessing a bed or place over the year.

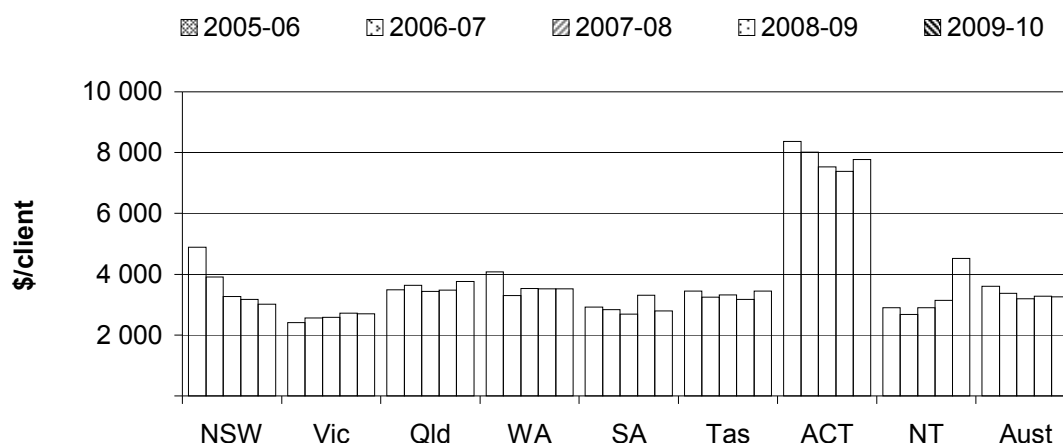
A low or decreasing cost per client represents an improvement in efficiency, but can also indicate lower service quality.

This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost), including only expenditure by service delivery providers. Unit cost indicators ideally include administration costs borne by State and Territory governments in administering services, but reporting this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP was provided under the CSHA through a special purpose program (the CAP) until end-December 2008, when all funding was rolled into the NAHA.

Data reported for this indicator are not directly comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, the recurrent cost per client accessing homelessness services declined from \$3600 in 2005-06 to \$3260 in 2009-10, though this varied across jurisdictions (figure 17.13).

Figure 17.13 Real recurrent cost per client accessing homelessness services (2009-10 dollars)^a



^a See notes to table 17A.18 for detailed data caveats.

Source: AIHW (unpublished) SAAP NDCA *Administrative Data and Client Collections*; table 17A.18.

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 public resources (box 17.11).

Box 17.11 Cost per day of support

'Cost per day of support' is defined as total expenditure on homelessness services divided by the number of days of support for clients receiving support and/or supported accommodation (excluding casual clients, and adults and accompanying children with a valid unmet request for accommodation).

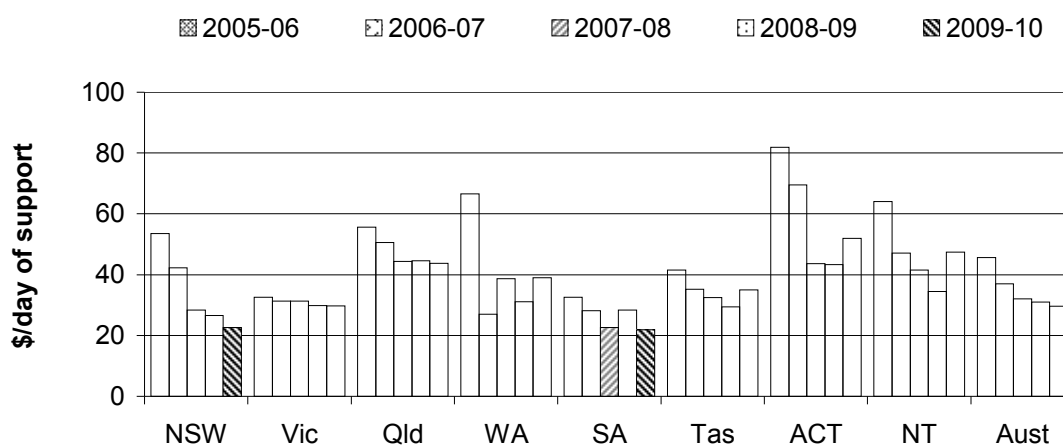
A low or decreasing cost per day of support represents an improvement in efficiency, but can also indicate lower service quality.

This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost), including only expenditure by service delivery providers. Unit cost indicators ideally include administration costs borne by State and Territory governments in administering services, but reporting this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP was provided under the CSHA through a special purpose program (the CAP) until end-December 2008, when all funding was rolled into the NAHA.

Data reported for this indicator are not directly comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

The recurrent cost per day of support for clients averaged \$30 nationally in 2009-10, declining from \$46 in 2005-06 (figure 17.14).

Figure 17.14 Real recurrent cost per day of support for clients (2009-10 dollars)^a



^a See notes to table 17A.19 for detailed data caveats.

Source: AIHW (unpublished) SAAP NDCA *Administrative Data and Client Collections*; table 17A.19.

Outcomes

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

An important outcome of homelessness services is clients' achievement of self-reliance and independence. Characteristics that may indicate whether clients can live independently include their income, housing status and workforce status. These characteristics are recorded at the end of a client's support period.

In 2006, Australian governments commissioned a research project to examine the impact of SAAP services on client self-reliance. The report based on this project, *Measuring the Impact of SAAP-funded Homelessness Services on Client Self-reliance* (FaHCSIA 2008), found that many of the problems and barriers to self-reliance cited are not overcome by quick and easy solutions, and services may need to put long-term resources into client support to achieve good outcomes.

Achievement of employment on exit

'Achievement of employment on exit' is an indicator of governments' objective to enable clients to participate as productive and self-reliant members of society at the end of their support period (box 17.12).

Box 17.12 Achievement of employment on exit

'Achievement of employment on exit' is defined as the number of closed support periods for clients who sought assistance to obtain or maintain employment and training, and achieved employment after support, divided by the total number of closed support periods for clients who sought assistance to obtain or maintain employment and training. Support periods reported relate to these clients only.

A high or increasing proportion of clients achieving employment after support is desirable.

This indicator compares clients' employment status before and after they requested support. Data are reported for all clients, and separately for Indigenous clients. This indicator relates to relatively short term outcomes — that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but more difficult to measure.

Data reported for this indicator are comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, of those clients who sought assistance to obtain or maintain employment and training when entering homelessness services in 2009-10, the proportion of clients who were employed either full time or part time increased from 10.9 per cent before support to 20.7 per cent after support. Of those employed after support, 7.8 per cent were employed full time and 12.9 per cent were employed part time. The proportion of clients who were unemployed decreased from 33.5 per cent before support to 29.6 per cent after support. The proportion of clients who were not in the labour force decreased from 55.6 per cent before support to 49.7 per cent after support. Proportions varied across jurisdictions (figure 17.15(a)).

Nationally, of those Indigenous clients who sought assistance to obtain or maintain employment and training when entering homelessness services in 2009-10, the proportion of clients who were employed either full time or part time increased from 6.8 per cent before support to 14.5 per cent after support. Of those employed after support, 5.5 per cent were employed full time and 9.0 per cent part time. The proportion of clients who were unemployed decreased from 32.3 per cent before support to 29.7 per cent after support. The proportion of clients who were not in the labour force decreased from 61.0 per cent before support to 55.8 per cent after support. These proportions varied across jurisdictions (figure 17.15(b)).

Figure 17.15 Changes in labour force status of clients who needed assistance to obtain/maintain employment and training before/after support, 2009-10^a



^a Data are for people who requested assistance with obtaining or maintaining employment when entering specialist homelessness services.

Source: AIHW (unpublished) SAAP NDCA *Client Collection*; tables 17A.23 and 17A.24.

Achievement of income on exit

‘Achievement of income on exit’ is an indicator of governments’ objective to enable clients to participate independently in society at the end of their support period (box 17.13).

Box 17.13 Achievement of income on exit

‘Achievement of income on exit’ is defined as the number of closed support periods for clients who requested assistance to obtain or maintain a pension or benefit and exited homelessness services with an income source, divided by the total number of closed support periods for clients who sought assistance to obtain or maintain a pension or benefit. Data are reported for all clients, and separately for Indigenous clients.

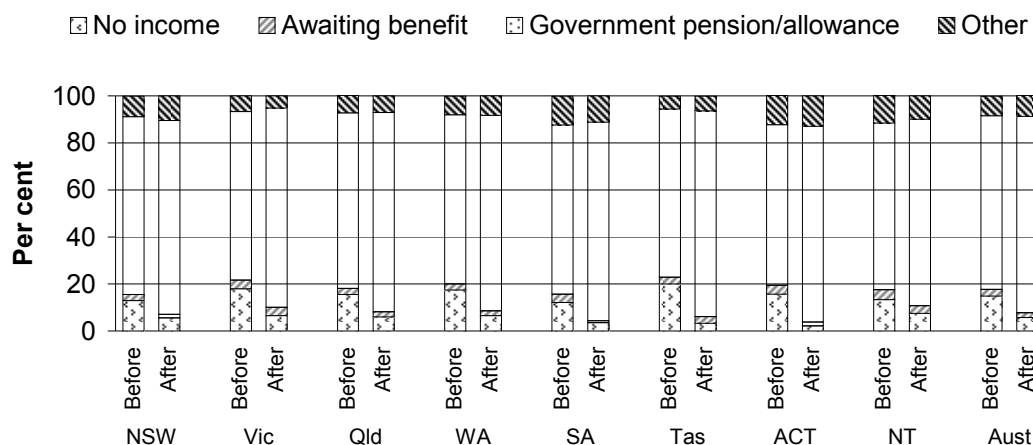
A high or increasing proportion of clients who requested income assistance and exited homelessness services with an income source is desirable.

This indicator compares these clients’ income status before and after they received support. A client’s independence and self-reliance is enhanced when the client experiences a positive change in income source (for example, from having no income support to obtaining some income, including wages and/or benefits) on exit from services.

Data reported for this indicator are comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

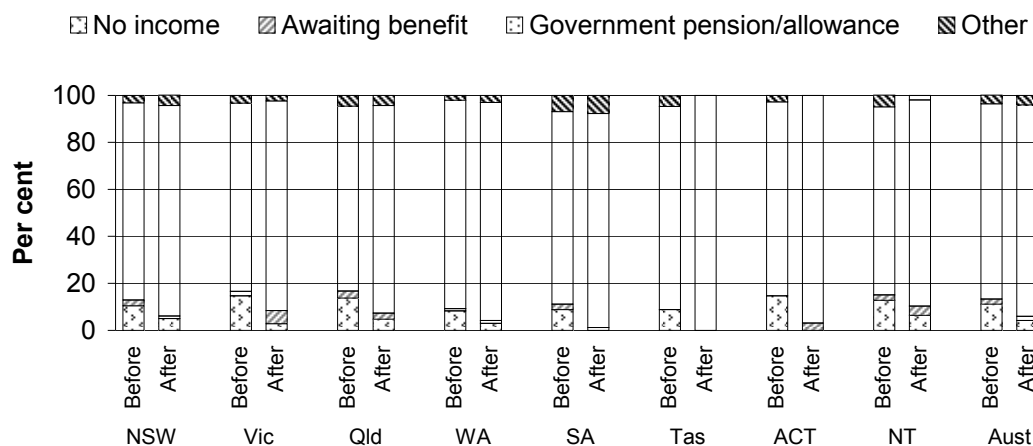
Nationally, in 2009-10, 14.8 per cent of support periods in which clients who requested income assistance did not have income prior to assistance from homelessness services. After assistance from homelessness services, the proportion of support periods in which clients who had requested income assistance and had no income was 5.7 per cent (figure 17.16). The proportion of Indigenous clients who did not have income and requested income assistance also decreased after assistance from homelessness services (from 11.2 per cent to 4.2 per cent nationally) (figure 17.17). Both before and after assistance from homelessness services, the income source for the majority of clients was a government pension/benefit (figures 17.16 and 17.17).

Figure 17.16 Source of income immediately before/after support of clients who needed assistance to obtain/maintain a pension or benefit, 2009-10



Source: AIHW (unpublished) SAAP NDCA Client Collection; table 17A.28.

Figure 17.17 Source of income immediately before/after support of Indigenous clients who needed assistance to obtain/maintain a pension or benefit, 2009-10



Source: AIHW (unpublished) SAAP NDCA Client Collection; table 17A.29.

Achievement of independent housing on exit

‘Achievement of independent housing on exit’ is an indicator of governments’ objective to enable clients to participate as productive and self-reliant members of society at the end of their support period (box 17.14).

Box 17.14 Achievement of independent housing on exit

‘Achievement of independent housing on exit’ is defined as the number of closed support periods in which clients who requested assistance with obtaining or maintaining independent housing achieved independent housing, divided by the total number of closed support periods in which clients requested assistance obtaining or maintaining independent housing.

A high or increasing proportion of closed support periods in which clients achieve independent housing is desirable.

This indicator compares the proportion of clients who were in independent housing before and after they received support from homelessness services. It relates to relatively short term outcomes — that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but more difficult to measure.

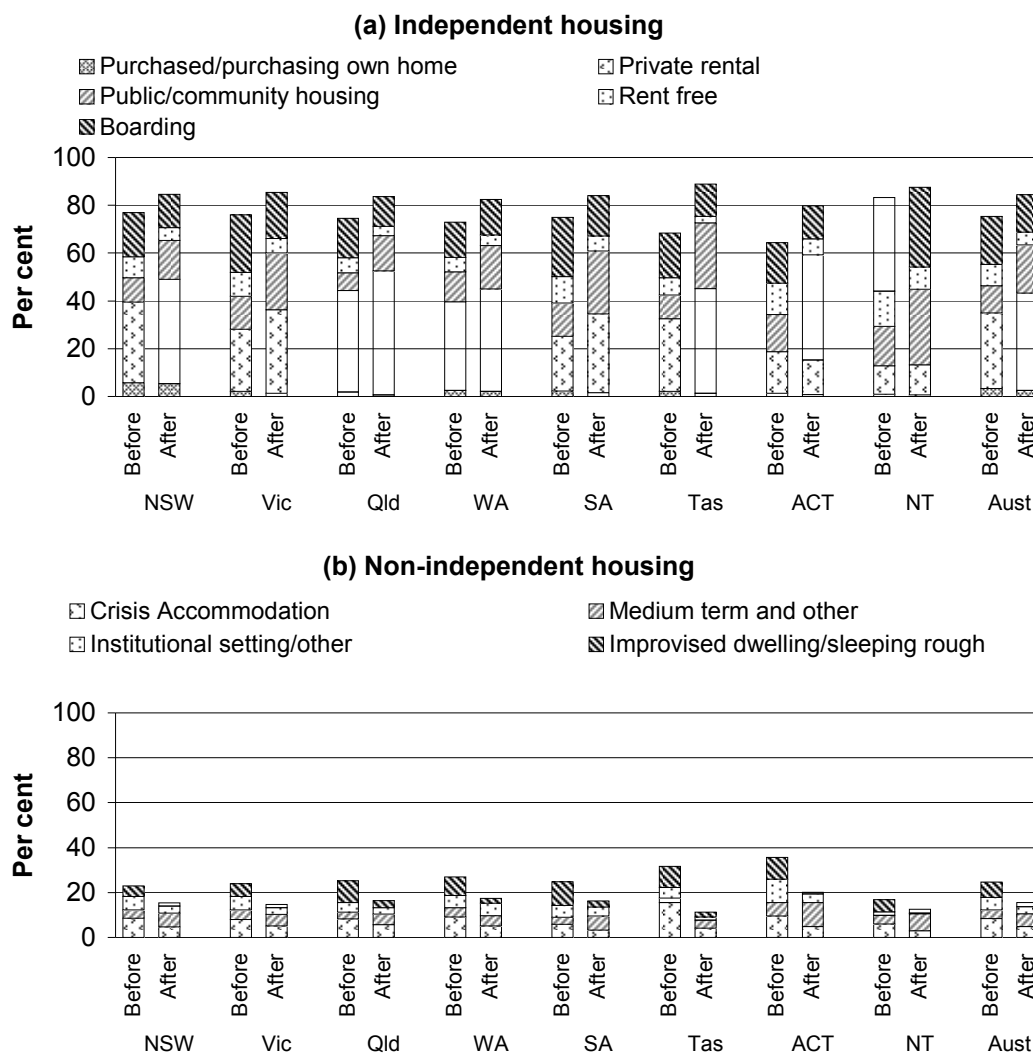
Data reported for this indicator are comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, 84.4 per cent of closed support periods in which clients requested assistance with obtaining or maintaining independent housing achieved independent housing in 2009-10. This included clients who moved or returned to private rental housing (40.7 per cent), to public or community rental housing (20.1 per cent), and those who were boarding (15.7 per cent) (figure 17.18a).

Among Indigenous clients, on a national basis, 84.7 per cent of clients who requested assistance with obtaining or maintaining independent housing achieved independent housing at the end of a support period in 2009-10, including those who moved or returned to private rental housing (29.9 per cent), to public or community rental housing (29.9 per cent), and who were boarding (18.8 per cent) (figure 17.19a).

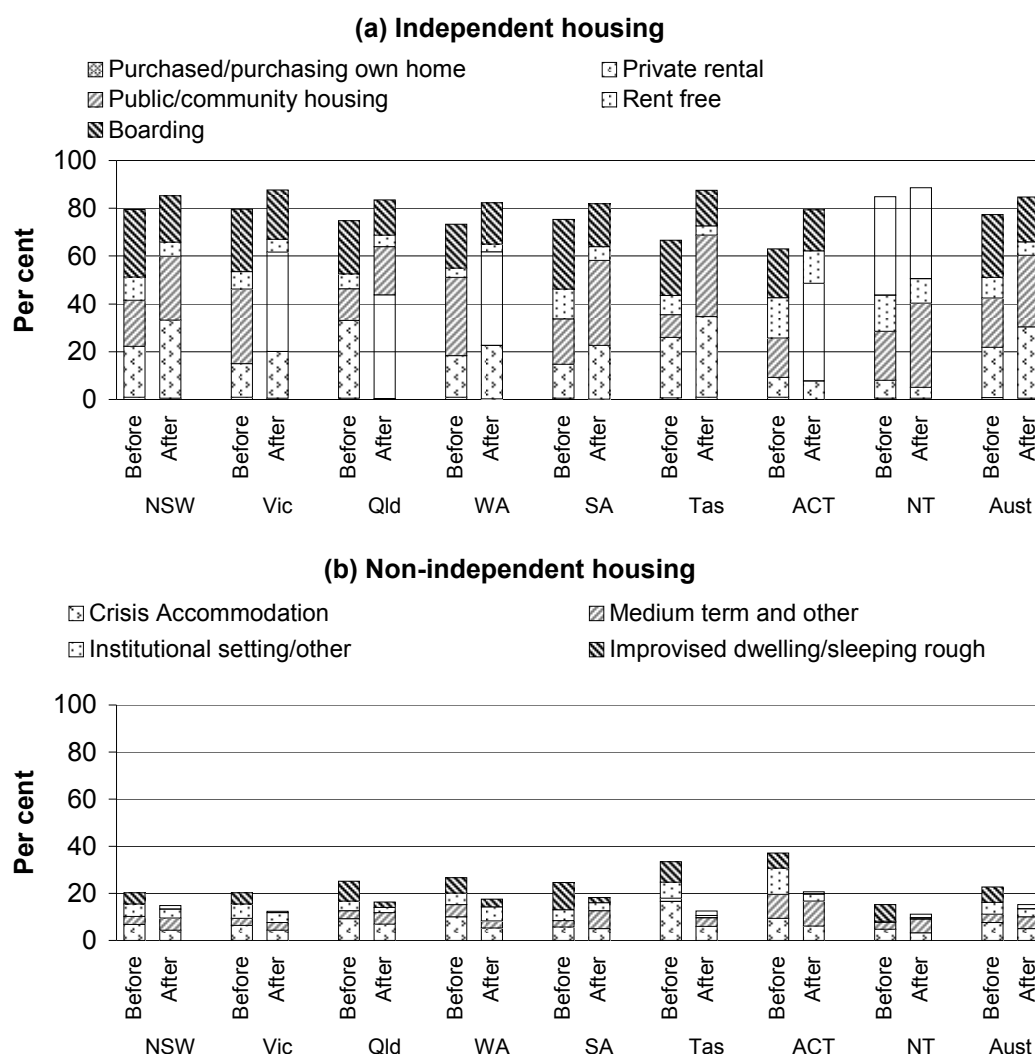
Closed support periods in which clients did not achieve independent housing included those who moved to, or continued to live in, short to medium term accommodation provided by homelessness services and other forms of non-independent accommodation (figures 17.18b and 17.19b).

Figure 17.18 Accommodation type before and after support, for clients who requested assistance with obtaining or maintaining housing, all clients, 2009-10



Source: AIHW (unpublished) SAAP NDCA Administrative Data and Client Collections; tables 17A.21.

Figure 17.19 Accommodation type before and after support, for clients who requested assistance with obtaining or maintaining housing, Indigenous clients, 2009-10



Source: AIHW (unpublished) SAAP NDCA Administrative Data and Client Collections; tables 17A.22.

Clients who exited homelessness services to independent housing and did not access the service again within six months

‘Clients who exited homelessness services to independent housing and did not access the service again within six months’ is an indicator of governments’ objective to enable clients to participate independently in society at the end of their support period (box 17.15).

Box 17.15 Clients who exited homelessness services to independent housing and did not access the service again within six months

‘Clients who exited homelessness services to independent housing and did not access the service again within six months’ is defined as the number of clients who exit to independent housing and do not return to homelessness services within six months, divided by the total number of clients.

A high or increasing proportion of clients not returning to the program within six months is desirable.

Many of the problems and barriers that lead people into homelessness are not easily fixed (FaHCSIA 2008). Therefore, a number of clients might access homelessness services several times before their needs are met on a permanent basis (for example, moving from crisis accommodation to medium term accommodation).

Data reported for this indicator are comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Estimates of clients exiting support to independent housing and not returning to homelessness services within six months are affected by the data issues discussed in box 17.2. The most recent data available are for the period 2004-05, during which 45.4 per cent of clients who exited a service to independent housing did not access the service again within six months (SCRGSP 2011, table 17A.27). These data might not be representative of all clients. Given the potential for data bias, these estimates should be interpreted with care.

Clients with only one period of support within a year

‘Clients with only one period of support within a year’ is an indicator of governments’ objective to enable clients to participate independently in society at the end of their support period (box 17.16).

Box 17.16 Clients with only one period of support within a year

‘Clients with only one period of support within a year’ is defined by two measures:

- the number of clients with only one support period during the year, divided by the total number of clients
- the number of clients who more than once required housing or accommodation support (as distinct from other types of support such as employment assistance and counselling), divided by the number of clients who required housing or accommodation support.

Data are reported for all clients, and separately for Indigenous clients.

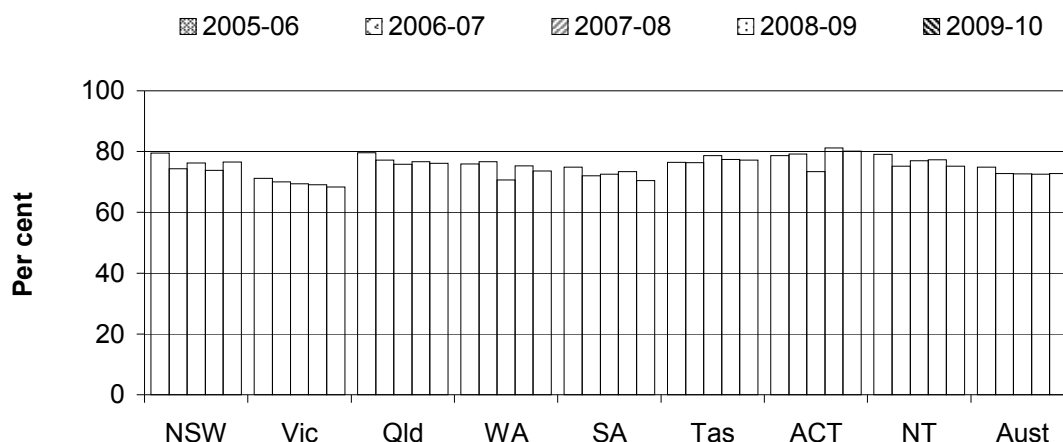
A high or increasing proportion of clients with only one support period during the year is desirable. A low or decreasing number of clients who more than once required housing or accommodation support specifically is desirable.

Many of the problems and barriers that lead people into homelessness are not easily fixed (FaHCSIA 2008). Therefore, a number of clients might access homelessness services several times before their needs are met on a permanent basis (for example, moving from crisis accommodation to medium term accommodation).

Data reported for this indicator are comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, 72.8 per cent of clients had only one support period in 2009-10 (figure 17.20). The proportion for Indigenous clients was similar (71.1 per cent) (table 17A.26).

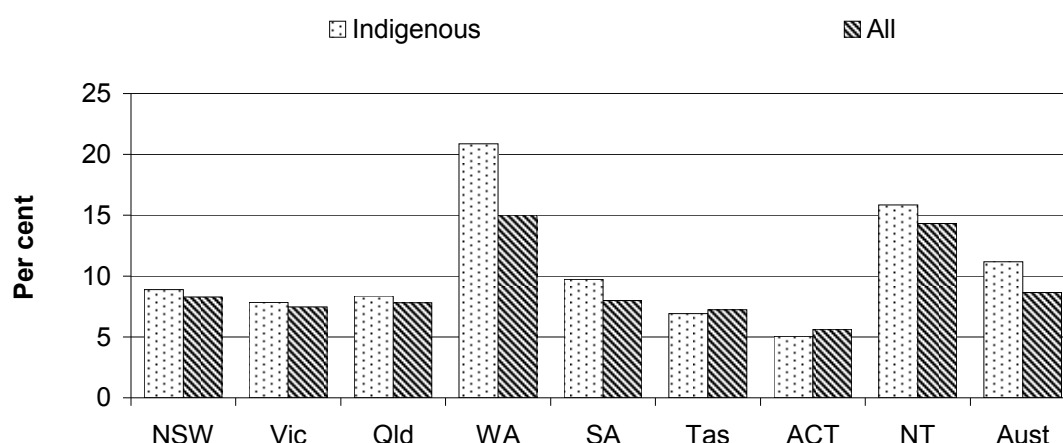
Figure 17.20 **Proportion of clients with only one period of support within a year**



Source: AIHW (various years) *Government-funded specialist homelessness services: SAAP National Data Collection annual report*. Cat no. HOU 219; table 17A.25.

Nationally, 8.7 per cent of all clients more than once required housing or accommodation support in 2009-10 (as distinct from other types of support such as employment assistance and counselling). The proportion for Indigenous clients was higher (11.2 per cent). These proportions varied across jurisdictions (figure 17.21).

Figure 17.21 Proportion of clients who more than once in 2009-10 required housing or accommodation support^a



^a All clients exclude those people for whom Indigenous status was unknown.

Source: AIHW (unpublished) SAAP NDCA Client Collection; table 17A.27.

Goals achieved on exit from service

‘Goals achieved on exit from service’ is an indicator of governments’ objective to ensure homelessness services meet the needs and expectations of clients (box 17.17).

Box 17.17 Goals achieved on exit from service

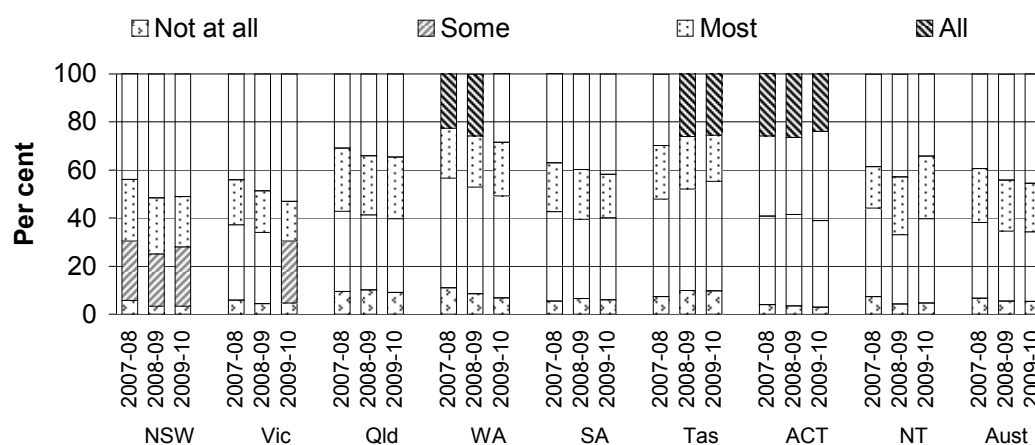
‘Goals achieved on exit from service’ is defined as the proportion of clients who reported that their case management goals were fully or mostly achieved by the end of their support period, divided by the total number of clients with case management goals in a given period.

A high or increasing proportion of achieved goals is desirable.

Data reported for this indicator are comparable. Some data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

Nationally, case management goals were fully or mostly achieved by the end of the support period for 65.7 per cent of clients in 2009-10 (figure 17.22).

Figure 17.22 Goals achieved on exit from homelessness services



Source: AIHW (unpublished) SAAP NDCA Client Collection; table 17A.30.

17.4 Future directions in homelessness services performance reporting

Homelessness data developments

Data agencies, the Australian Government and State and Territory governments have developed a specialist homelessness services (SHS) data collection to enable reporting on performance indicators in the NAHA and NPAH. The SHS became operational on 1 July 2011, and data for 2011-12 are expected to be available for reporting in the 2013 Report. The 2013 Report will include data for 2010-11 from the SAAP collection, concluding reporting from the SAAP data collection.

The SHS data collection is based on clients and differs to the SAAP collection, which is based on support periods. As a result, data from the SAAP and SHS collections will not be directly comparable.

COAG developments

Outcomes from review of Report on Government Services

The COAG endorsed recommendations (December 2009) of the review of the RoGS implemented during 2010 and 2011 are reflected in this Report. Implementation of other recommendations will be reflected in future reports.

Review of National Agreements and National Partnership Agreements

COAG has agreed to progress the recommendations of the Heads of Treasuries (HoTs) Review of National Agreements, National Partnerships and Implementation Plans and reports of the COAG Reform Council (CRC). A working group, led by Senior Officials from First Ministers' and Treasury agencies, will review the performance frameworks of a limited number of agreements, including the NAHA. The review of the NAHA will be concluded by June 2012. The recommendations of the review of the NAHA will be considered by the Steering Committee and may be reflected in future reports.

17.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter.

Australian Government comments

“ The Australian Government continues to consolidate existing programs and implement new initiatives to achieve the goals of the White Paper: *The Road Home: A National Approach to Reducing Homelessness*.

There are over 100 ‘Reconnect’ services (including 10 Indigenous services and 13 services targeting newly arrived young people) in metropolitan, regional, rural and remote locations around Australia. ‘Reconnect’ is a community-based early intervention program supporting young people aged 12 to 18 years, and newly arrived youth between the ages of 12 to 21 years who are homeless, or at risk of homelessness.

FaHCSIA, in partnership with Centrelink and community agencies, delivers ‘HOME Advice’ in 8 locations throughout Australia. This program assists families facing difficulty to maintain tenancies or home ownership.

A Place to Call Home is a \$311 million commitment funded jointly by the Commonwealth and states and territories under the National Partnership Agreement on Homelessness to build over 600 dwellings, many of which will follow innovative housing models including common ground and foyer facilities with wrap-around support services.

The Prime Minister’s Council on Homelessness (established 2009) continues to provide advice to government on progress, risks and emerging issues and monitor of the implementation of White Paper goals and targets.

A range of data development activities have been progressed through 2010-11. The AIHW, together with FaHCSIA and states and territories has developed a new specialist homelessness services collection. The ABS has progressed its review of the methodology for counting the homeless and has established a new Homelessness Statistics Reference Group to guide further data development. Centrelink is refining the use of the homelessness flag that has been deployed since January 2010 to provide better services for the homeless.

FaHCSIA is managing Research Partnership Agreements worth \$4 million, focussing on rough sleeping, improving the service delivery system for the most vulnerable groups, improving understanding of homelessness and the effectiveness of interventions, and longitudinal data development. In addition, 16 National Homelessness Research Projects worth \$1.4 million support a ‘bottom up’ approach to strengthen our understanding of factors leading to homelessness and inform service improvements, future policies and programs.

FaHCSIA is also funding the first large-scale longitudinal study in Australia to assess a broad sample of income support recipients who are homeless or at risk of, or vulnerable to, homelessness. The survey will be up to four waves, each six months apart, running from September 2011 to the first half of 2013.

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New South Wales Government comments

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The NSW Government's *NSW 2021 Plan to make NSW Number 1* aims to deliver integrated and responsive services to meet the needs of the most vulnerable members of the community, including homeless people. This includes actions to reduce homelessness by seven per cent, reduce rough sleeping by 25 per cent and reduce the number of people experiencing repeat periods of homelessness. The *NSW 2021 Plan* recognises that people who are homeless or at risk of homelessness will require access to comprehensive and integrated support services such as mental health, drug and alcohol and domestic violence services as well as housing assistance.

Under the NAHA, 357 specialist homelessness services (SHS) were funded in NSW in 2010-11 to assist people who are homeless or at risk of homelessness. This includes families in crisis, single adults, young people and women and children affected by domestic violence. The SHS budget in 2010-11 was approximately \$134.3 million, which represents a joint contribution from the Australian Government and the NSW Department of Family and Community Services. A further \$18.7 million was spent in 2010-11 on providing and maintaining 1500 dwellings for crisis accommodation.

In addition to homelessness funding under the NAHA, the National Partnership Agreement on Homelessness (NPAH), which includes *A Place to Call Home*, provides a joint Australian and State Government commitment to tackle the issue of homelessness, including Aboriginal homelessness. The NPAH is supported by a total funding commitment of up to \$392.5 million over five years — \$140.4 million in Commonwealth funding and a NSW Government contribution of up to \$252.1 million.

The *NSW Homelessness Action Plan* (HAP) puts NSW and national homelessness policy into action. A key initiative of the HAP is reform of the delivery of homeless services. With Government and non-government services working together, NSW is shifting the focus away from crisis services as its primary response to homelessness, towards early intervention services that prevent homelessness and provide long-term support to allow people to stay safely in their home.

The HAP reinforces NSW's commitment to the targets in the *NSW 2021 Plan* and the NPAH, and provides the direction for both new and existing effort in NSW. It includes initiatives funded under the NPAH and those funded through existing programs in NSW. Regional Homelessness Action Plans have been developed across ten locations to deliver the strategies and actions required at a local level to achieve the targets and objectives of the HAP.

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Victorian Government comments

“ Victoria provides accommodation for those who are homeless, at risk of homelessness or experiencing family violence. The Victorian Government funds 151 not-for-profit agencies to deliver homelessness and family violence support services across the State.

In 2010-11, the Victorian Government worked in close partnership with not-for profit-agencies to continue to roll out the initiatives funded under the National Partnership Agreement on Homelessness (NPAH). Under this jointly funded agreement Victoria has been able to direct more resources to address and prevent homelessness.

A significant achievement under the NPAH in 2010-11 has been the cross sector partnership between mental health and youth homelessness services, which is improving outcomes for common clients.

In 2010-11, particular focus was also given to those sleeping rough through the targeted assertive outreach service. In 2010-11 the assertive outreach service assisted 170 chronically homeless people, 50 of these clients that were assessed as being particularly vulnerable were provided with intensive support.

In August 2010, the first tenants moved into the innovative supporting housing development, Elizabeth Street Common Ground. Working in partnership with a range of government, community and private sector stakeholders to deliver the development, it is located on the edge of Melbourne's CBD and provides 131 affordable studio apartments and coordinated support for people who have experienced homelessness or are at risk of homelessness.

The Victorian Government has also committed \$30.1 million for the development of youth foyers. Based on an international best-practice model, these youth foyers aim to provide secure accommodation with education and employment for young people at risk of homelessness so that they can create positive changes in their lives and make a pathway out of homelessness.

Throughout 2010-11, the Victorian Government was busy developing a new Victorian Homelessness Action Plan. The Victorian Homelessness Action Plan 2011–2015 is focused on:

- supporting innovative approaches to homelessness
- investigating models that focus specifically on early intervention and prevention
- better targeting of resources when and where they are most needed and where they will make the biggest difference.

In 2010-11, Victoria worked closely with the AIHW in the development of the new specialist homelessness services data collection and significant effort went into training sector staff in preparation for the release.

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Queensland Government comments

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The Queensland Department of Communities continues to work in partnership with and fund non-government organisations to deliver services to people experiencing homelessness, and those at risk of homelessness.

In 2010-11, \$82.5 million in grants were provided in Queensland under the NAHA for the provision of 215 specialist homelessness support and accommodation services. These services are provided for a wide range of identified target groups including young people, families, single adults and women and children escaping domestic and family violence. In 2010-11, this funding resulted in 40 300 people receiving support, of which 25 100 were adults and 15 200 were accompanying children.

The Australian and Queensland Governments are providing \$284.6 million over five years (2008-09 to 2012-13) to reduce homelessness in Queensland as part of the National Partnership Agreement on Homelessness (NPAH), including \$149.5 million State funds and \$135.1 million Australian Government funds.

During 2010-11, over \$41 million was invested under the NPAH to establish and support 31 new and/or expanded initiatives and reform activities to help people who are homeless transition to stable accommodation, including:

- four street to home services for chronically homeless people and rough sleepers
- 16 services to support private and public tenants to sustain their tenancies
- two initiatives to improve service coordination and provision
- \$14.9 million for the *A Place to call Home* initiative (33 additional social housing properties with family support).

The Department of Communities continued to allocate social housing to homeless people as a priority. In 2010-11, of new households assisted in government-managed social housing, 3770 (96 per cent) were in very high or high housing need and 63 per cent were homeless or at risk of homelessness.

In 2010-11, efforts were also made to assist rough sleepers. The *50 Lives 50 Homes* campaign in inner Brisbane resulted in over 70 of the city's most vulnerable rough sleepers obtaining housing. In addition, the *Townsville Public Intoxication and Homelessness Action Plan* enhanced the capacity of services to help people obtain stable accommodation after long periods of rough sleeping.

Opening Doors, the Queensland Strategy for Reducing Homelessness 2011–14, was developed in 2010-11. The Strategy will help prevent homelessness for people exiting health facilities, child safety arrangements, prisons and youth detention centres; will help people who are homeless to get ahead through a 'housing first' approach and links with education, training and employment; and will realign specialist homelessness services to better meet clients' needs.

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Western Australian Government comments

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In WA, the Department for Child Protection (the Department) has lead agency responsibility for homelessness services, and contracts community sector organisations to provide a range of specialist homelessness services (SHS) across the state, to people who are at risk of, or are experiencing, homelessness.

Through the NAHA, the Department recurrently funds 122 specialist homelessness services. Through the National Partnership Agreement on Homelessness (NPAH), 82 new specialist homelessness services are operating across the state, providing support and assistance to people who are homeless or at risk of homelessness.

The NPAH complements and builds on the existing homeless service system and has been an important mechanism for leveraging reform in the response by mainstream and specialist homelessness services to the needs of people who are at risk of, or experiencing homelessness. Contracting arrangements have also been streamlined to ensure flexible innovative responses are easily implemented and services are not overburdened by onerous reporting requirements.

Service integration and collaboration between agencies and organisations is pivotal to ensure successful outcomes for people experiencing or at risk of homelessness, particularly those with multiple and complex needs. In WA, programs have been, and continue to be, developed collaboratively by the community services sector and relevant government agencies.

The Western Australian Council on Homelessness was instrumental in developing the Western Australia Homelessness State Plan 2010–2013 which provides a framework for an increased integrated response by Government agencies and community sector organisations to reducing homelessness throughout the state. Regional homelessness plans, complementing the State Plan, are now being finalised across the state and involve local community, government and non-government stakeholders.

The Department and the Western Australian Council on Homelessness continue to promote continuous quality improvement and best practice in service delivery through best practice forums. The forums provide an opportunity to strengthen linkages between mainstream, other government agencies and specialist homelessness services, through involvement of mainstream agencies such as Job Services Australia providers, alongside specialist homelessness service providers, to enhance service provision for mutual clients.

The new national SHS collection commenced on 1 July 2011. To ensure WA services were able to participate in the new SHS collection, the Department for Child Protection has provided training in partnership with the community services sector to NAHA and NPAH services across the state.

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South Australian Government comments

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The 2010-11 financial year has seen the implementation phase of a major strategic reform of the homelessness sector in South Australia. This structural reform was initiated in order to capitalise on new investment and consolidate previously fragmented responses.

A major re-tendering of services took place in three stages (the majority in May and September 2010, and finalised in May 2011). Services became operational on 1 July 2010 (Stage 1 tendered services) and 1 December 2010 (Stage 2 tendered services).

The reform has resulted in a significant increase in, and improved access to, support service and housing options.

The homelessness sector is now comprised of 75 specialist homelessness programs with targeted regional responses that provide support for adults, families, children, young people, Aboriginal and Torres Strait Islander people and women experiencing domestic violence.

The new homelessness sector includes three specialist state-wide gateway services that provide intake, assessment and supported referrals to crisis accommodation, local regional specialist homelessness and domestic/Aboriginal Family Violence services, and mainstream services.

The reform of the service system addressed:

- inconsistency in the spread and quality of specialised homelessness services across geographic regions
- inequity of access to services for particular high needs population groups in many regional areas
- a lack of integration amongst specialist homelessness services and between specialist and mainstream services.

Strong links have been made between the new homelessness sector and a substantial number of dwellings in SA arising from the *Nation Building — Economic Stimulus Plan*.

Throughout the year substantial developmental work was undertaken on a new, purpose designed, web based case management and data collection system (Homeless to Home — H2H) to assist in the case management of clients who are homeless or at risk of homelessness.

The new system facilitates improved access to services and reduces the need for clients to retell their stories. It will also enhance reporting at a jurisdictional level and is linked with the specialist homelessness services national data collection.

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Tasmanian Government comments

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In September 2010, the Minister formally launched the Tasmanian Homelessness Plan 2010–13: *Coming in from the cold*, which was the culmination of extensive consultation and focused on a whole-of-government and community approach to addressing homelessness. The plan outlines new supply including new constructions and upgrades, new tailored support services including a support program for ex-prisoners, and new ways of working incorporating improved integration and coordination across the social housing sector and with mainstream services, and improved data collection.

The *Same House Different Landlord* program commenced in September 2010 providing long-term supported accommodation for 100 formerly homeless people. The KEYS to the Future service provides the tenancy management for the clients, and is supplemented by the STAY program which provides a specialist intervention tenancy and support service to tenants.

In addition, work commenced in 2010-11 on establishing five new supported accommodation facilities to accommodate a further 130 people. Some of these also have a split management model with one agency providing tenancy management and another providing the support to clients. The Grove Street facility in Ulverstone (Northwest) was finalized and commenced operations in September 2011, and two facilities in Launceston (North) will commence in November 2011. Two further facilities in Hobart (South) are currently under construction, and when opened in 2012 will run on a Common Ground model.

Substantial work has been undertaken to improve service coordination and engagement of mainstream services through a Service Coordination and Improvement Project. Two key components of this are the development of a risk assessment and early intervention tool to assist mainstream services assess people who are homeless or at risk of homelessness, and planning for a Tasmanian Housing Register which eventually will provide on-line coordination and allocation functions across the entire Tasmanian social housing sector.

Significant work was also undertaken in 2010-11 to prepare for the introduction of the new specialist homelessness services data collection on 1 July 2011. Being a smaller jurisdiction Tasmania was able to train all staff in every specialist homelessness service, including relief staff. Of the 34 agencies, 28 are using the new Specialist Homelessness Information Platform (SHIP), four are using proprietary client management systems, and two are using paper collection forms.

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Australian Capital Territory Government comments

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The ACT provides a range of individually targeted homelessness services in recognition that a one-size fits all approach is inadequate to addressing the complexity of needs that lead to homelessness in the first place. The multifaceted approach includes preventative support services, crisis services, and long term accommodation options.

In 2010-11, the ACT contributed to the commitments entered into under the National Partnership Agreement on Homelessness by establishing a number of new initiatives and introducing reforms designed to improve the service system response to homelessness.

New initiatives included the establishment of First Point, the ACT's central intake service for homelessness and related services in 2010. First Point has greatly streamlined entry points into the homelessness service system, ensuring that clients do not have to negotiate multiple agencies to access services. Over 3400 clients registered with First Point in its first year of operation.

Our Place — Live, Learn, Achieve, was also established in 2011. Our Place supports young people experiencing or at risk of homelessness to remain engaged in education, training or employment by providing stable and affordable housing combined with on-site support services and mentorship opportunities.

The ACT also committed to reforming the youth homelessness sector, conducting a comprehensive review and consultation process that was used to develop a suite of new services to meet the needs of young people experiencing or at risk of homelessness.

In 2010-11, the construction of new properties under the *A Place to Call Home* program continued with a total of 13 properties constructed. In addition, the construction of 300 new residences under the right sizing program allowed for significant movement in the transitional homelessness services, providing long term accommodation options to families in need.

The Joint Pathways Group continued to provide an effective forum for senior non-government and government representatives to work in partnership to address systemic and practice issues.

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Northern Territory Government comments

“ During 2010-11, 36 non-government organisations were funded \$10.8 million under the National Affordable Housing Agreement to deliver 50 specialist homelessness services. In addition, 16 non-government organisations were funded \$19.37 million to deliver 22 initiatives under the National Partnership Agreement on Homelessness (NPAH).

Initiatives to decrease homelessness, funded through the NPAH, include:

- Intervention and Case Management services, delivered in Darwin, Katherine and Alice Springs, which assist rough sleepers to access accommodation and transport to Return to Country
- a Darwin Supported Accommodation Program, which provides transitional accommodation and case management to men who are homeless
- the Alice Springs emergency accommodation and Youth Streetwork Outreach service that provides emergency accommodation and support services to 160 at risk children and young people in 2010-11
- a Post Release Support Program which assist clients exiting correctional services to re-engage with the community and transition into stable accommodation
- Percy Court, which provides an additional 75 beds in 28 accommodation units, and the South Terrace managed accommodation facility, which provides 66 beds for short-term accommodation in Alice Springs.

Other Northern Territory initiatives that address homelessness include:

- the Apmere Mwerre Accommodation Park, which was constructed under the *Alice Springs Transformation Plan* and incorporates a mix of units, cabins, tents and open camping areas for short-term accommodation for up to 150 people per night visiting Alice Springs
 - the Rough Sleeper Study, which was commissioned in late 2010 to better understand motivations for, and patterns of, rough sleeping in Darwin and Palmerston. The study has informed development of various programs to assist rough sleepers
 - the commenced development of Regional Homelessness Action Plans (RHAPs), which aim to further support people experiencing homelessness and at risk of homelessness in Darwin, Katherine, Tennant Creek and Alice Springs.
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17.6 Definitions of key terms and indicators

Based on the SAAP data collection

Accommodation	Crisis or short term accommodation, medium term to long term accommodation, and other funded accommodation (which comprises accommodation at hostels, motels and hotels, accommodation in caravans, community placements and other government 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 inter-quartile 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 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 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.
Client	A person who is accommodated by a homelessness services agency, or enters into an ongoing support relationship with an agency, or receives support or assistance from an agency which entails generally 1 hour or more of a worker's time.
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	Services targeted at more than one primary client group category — for example, 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 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 an 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	Agencies that use more than one service delivery model to provide homelessness services — for example, crisis or short term accommodation and support, as well as day support (that is, the provision of meals).
Non-English speaking background services	Services that are targeted at persons whose first language is not English.
One-off assistance	Assistance provided to a person who is not a client, such as the provision of a meal, a shower, transport, money, clothing, telephone advice, information or a referral.
Ongoing support period	A support period for which, at the end of the reporting period, no support end date and no after-support information are provided.
Outlet	A premise owned/managed/leased by an agency at which homelessness services are delivered. Excludes accommodation purchased using government 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 an 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.
Service	Supported accommodation, support or one-off assistance that is provided by an 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 an agency, who either directly provides a service or in some way contributes to the provision of a service. Includes administrative staff of an agency, whether paid or not paid.
Single men services	Services provided for males who present to the agency without a partner or children.
Single women services	Services provided for females who present to the agency without a partner or children.
Support	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 agency and the homeless person.
Support period	The period that commences when a client establishes or re-establishes (after the cessation of a previous support period) an ongoing relationship with an agency. The support period ends when: • support ceases because the client terminates the relationship with the agency • support ceases because the agency terminates the relationship with the client • no support is provided to the client for a period of one month. 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 an 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 government 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 agency unaccompanied by a parent/guardian.

17.7 List of attachment tables

Attachment tables are identified in references throughout this chapter by an ‘17A’ prefix (for example, table 17A.1 is table 1). Attachment tables are provided on the Review website (www.pc.gov.au/gsp).

Table 17A.1	Composition of support provided in support periods
Table 17A.2	Agencies by primary target group
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Table 17A.4	Nominal expenditure on homelessness services
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Table 17A.6	Real recurrent homelessness expenditure per person in the residential population (2010-11 dollars)
Table 17A.7	Turn-away of adults and unaccompanied children as a proportion of people requiring new immediate accommodation
Table 17A.8	Turn-away of adults and unaccompanied children as the proportion of total demand for accommodation
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Table 17A.10	Proportion of people from non-English speaking backgrounds among all accommodated clients and among people whose valid requests for accommodation were unmet
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Table 17A.20	Average accommodation load and caseload per day
Table 17A.21	Closed support periods in which clients needed assistance to obtain/maintain independent housing, by type of tenure
Table 17A.22	Closed support periods in which Indigenous clients needed assistance to obtain/maintain independent housing, by type of tenure

Table 17A.23	Closed support periods: Labour force status of clients who needed employment and training assistance, before and after support
Table 17A.24	Closed support periods: Labour force status of Indigenous clients who needed employment and training assistance, before and after support
Table 17A.25	Clients who exited from the service and who returned to agencies before the end of that year
Table 17A.26	Indigenous clients who exited from the service and who returned to agencies before the end of that year
Table 17A.27	Proportion of clients who more than once had a housing/accommodation need identified by an agency worker, by Indigenous status
Table 17A.28	Source of income immediately before and after support of all clients who needed assistance to obtain/maintain a pension or benefit
Table 17A.29	Source of income immediately before and after support of Indigenous clients who needed assistance to obtain/maintain a pension or benefit
Table 17A.30	The extent that clients case management goals have been achieved

17.8 References

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