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Suggestions:

The Steering Committee welcomes suggestions on the performance indicators contained in this Report. Please direct your suggestions to the Productivity Commission Secretariat at the above address.

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Contents

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

Volume 1

Volume 2

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAT	Aged Care Assessment Team
ACCHS	Aboriginal Community Controlled Health Service
ACHS	Australian Council on Healthcare Standards
ACIR	Australian Childhood Immunisation Register
ACPR	Australian Centre for Policing Research
ACSAA	Aged Care Standards and Accreditation Agency
ACSQHC	Australian Council for Safety and Quality in Health Care
ACT	Australian Capital Territory
ADR	Alternative Dispute Resolution
AFAC	Australasian Fire Authorities Council
AFP	Australian Federal Police
AGCCCS	Australian Government Census of Child Care Services
AGPAL	Australian General Practice Accreditation Limited
AHCA	Australian Health Care Agreements
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
ANTA MINCO	Australian National Training Authority Ministerial Council
ANTA	Australian National Training Authority
AQF	Australian Qualifications Framework
AR-DRG	Australian refined diagnosis related group
ARHP	Aboriginal Rental Housing Program
ARIA	Accessibility and Remoteness Index for Australia
ASGC	Australian Standard Geographical Classification
ATSIC	Aboriginal and Torres Strait Islander Commission

ATSIS	Aboriginal and Torres Strait Islander Services
Aust	Australia
AVETMISS	Australian Vocational Education and Training Management Information Statistical Standard
BEACH	Bettering the Evaluation and Care of Health
CAA	Convention of Ambulance Authorities
CACP	Community Aged Care Package (program)
CAD	computer aided dispatch
CD ARIA Plus	Census District Accessibility and Remoteness Index for Australia (upgraded version)
CD-ROM	Compact Disc Read Only Memory
CHINS	Community Housing and Infrastructure Needs Survey
CI	confidence interval
COAG	Council of Australian Governments
CRA	Commonwealth Rent Assistance
CRS	Commonwealth Rehabilitation Services
CSDA	Commonwealth/State Disability Agreement
CSDMAC	Community Services and Disabilities Ministers' Advisory Council
CSHA	Commonwealth State Housing Agreement
CSTDA	Commonwealth State/Territory Disability Agreement
Cwlth	Commonwealth
DCIS	Ductal carcinoma in situ
DEA	data envelopment analysis
DEST	Department of Education, Science and Training
DFaCS	Department of Family and Community Services
DHA	Department of Health and Ageing
DOTARS	Department of Transport and Regional Services
DSE	Department of Sustainability and Environment
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home (program)

EBA	Enterprise Bargaining Agreement
EMA	Emergency Management Australia
EPC	Enhanced Primary Care
ERP	estimated resident populations
ESL	Emergency Services Levy
ESO	emergency service organisation
FDCQA	Family Day Care Quality Assurance
FESA	Fire and Emergency Services Authority of WA
FRS	Fire and Rescue Service
FTE	full time equivalent
FWE	full time workload equivalent
GDP	gross domestic product
GP	general practitioner
GST	goods and services tax
HACC	Home and Community Care (program)
HbA1c	glycated haemoglobin
HMAC	Housing Ministers' Advisory Committee
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
ICD-10-AM	Australian modification of the International Standard Classification of Diseases and Related Health Problems, version 10.
IHANT	Indigenous Housing Authority of the NT
IMP	Information Management Plan (SAAP)
ITAB	Industry Training Advisory Bodies
JJNMDS	Juvenile Justice National Minimum Data Set
K10	Kessler – 10 scale
KiDS	Key Information Directory System (NSW)
LBOTE	Language background other than English
LMO	local medical officer
LSI	Likert Summation Index

MAB	Management Advisory Board
MBS	Medicare Benefits Schedule
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MDS	minimum data set
NCAC	National Childcare Accreditation Council
NCAG	National Corrections Advisory Group
NCPASS	National Child Protection and Support Services
NCVER	National Centre for Vocational Education Research
NDCA	National Data Collection Agency
NESB	non-English speaking background
NFD	not further defined
NHCDC	National Hospital Cost Data Collection
NIDP	National Information Development Plan
NMDS	national minimum data set
NMHS	National Mental Health Strategy
NOOSR	National Office of Overseas Skills Recognition
NRCP	National Respite for Carers Program
NSCSP	National Survey of Community Satisfaction with Policing
NSMHS	National Survey of Mental Health Services
NSW	New South Wales
NT	Northern Territory
OMP	other medical practitioner
OSHCQA	Outside School Hours Care Quality Assurance
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentives Program
PISA	Program for International Student Assessment
QFRS	Queensland Fire and Rescue Service
QIAS	Quality Improvement and Accreditation System
Qld	Queensland

QPA	Quality Practice Accreditation
RACGP	Royal Australian College of General Practitioners
RCS	Resident Classification Scale
RRMA	Rural, Remote and Metropolitan Areas
RSE	relative standard error
RTO	Registered Training Organisation
SA	South Australia
SAAP	Supported Accommodation Assistance Program
SAAS	SA Ambulance Service
SAR	service activity reporting
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SCRGSP	Steering Committee for the Review of Government Service Provision
SDA	service delivery area
SE	standard error
SES/TES	State Emergency Service/Territory Emergency Service
SLA	statistical local area
SMART	SAAP Management and Reporting Tool
TAFE	technical and further education
Tas	Tasmania
UCC	user cost of capital
ULN	upper limit of normal
VET	vocational education and training
VHC	Veterans' Home Care
Vic	Victoria
WA	Western Australia
WHO	World Health Organisation

Glossary

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

Access A reflection of how easily the community can obtain a delivered service (output).

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

Capability In the context of the health performance framework, the capacity of an organisation, program or individual to provide health care services based on appropriate skills and knowledge (see the 'Health preface').

Constant prices See 'real dollars'.

Continuity In the context of the health performance framework, the provision of uninterrupted, timely, coordinated healthcare, interventions and actions across programs, practitioners and organisations (see the 'Health preface').

Cost effectiveness A measure of 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 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 A reflection of how well the outputs of a service achieve the stated objectives of that service (also see program effectiveness).

Efficiency A reflection of how resources are used to produce outputs and outcomes, expressed as a ratio of inputs to outputs (technical efficiency), or inputs to outcomes (cost effectiveness). (Also see 'cost effectiveness' and 'technical efficiency'.)

Equity Equity indicators reflect 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, box 1.5 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 is **not** adjusted to remove the effects of inflation. Nominal dollars do not allow for inter-year comparisons because reported changes may reflect changes to financial levels (prices and/or expenditure) and adjustments to maintain purchasing power due to inflation.

Output The service provided 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. 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	The way in which a service is produced or delivered.
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.
Responsiveness	In the context of the health performance framework, the provision of services that are client oriented and respectful of clients' dignity, autonomy, confidentiality, amenity, choices, and social and cultural needs (see the 'Health preface').
Safety	In the context of the health performance framework, 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 (see the 'Health preface').
Sustainability	In the context of the health performance framework, the capacity to provide infrastructure (such as workforce, facilities and equipment), be innovative and respond to emerging needs (see the 'Health preface').

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	Average cost — an indicator of efficiency, as used throughout this Report.

E Health preface

Health services are concerned with promoting, restoring and maintaining a healthy society. They involve illness prevention, health promotion, the detection and treatment of illness and injury, and the rehabilitation and palliative care of individuals who experience illness and injury. Broadly defined, the health system includes a range of activities that raise awareness of health issues, thereby reducing the risk and onset of illness and injury (box E.1).

Health services in Australia are delivered by a variety of government and non-government providers in a range of service settings. The Report primarily concentrates on the performance of public hospitals (see chapter 9) and primary and community health services (including general practice) (see chapter 10) because these services represent a significant component of government recurrent expenditure on health care. Australian governments spent $28.8 billion (in 2001-02 dollars)[1] on public (non-psychiatric) hospitals, medical services (including payments to general practitioners [GPs] and other specialist practitioners) and community and public health in 2002-03. These three areas of health care activity accounted for 65.0 per cent of government recurrent health expenditure in 2002-03 (table EA.2 and chapter 10).

The Report also examines the interactions among different service mechanisms for dealing with two health management issues: mental health and breast cancer (see chapter 11). There are no specific estimates of government expenditure on the detection and management of breast cancer but government recurrent expenditure on specialist mental health services was estimated to be around $3.2 billion in 2002-03. Some of this expenditure was on psychiatric care provided by public (non-psychiatric) hospitals (see chapters 9 and 11).

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

[1] The published source data from the Australian Institute of Health and Welfare (AIHW) use 2001-2002 as the base year. The same base year is used here for consistency.

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

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

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

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

primary health care: services that:

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

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

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

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

- government support for pharmaceuticals (the PBS)
- public health programs, other than those for breast cancer and mental health
- funding for specialist medical practitioners.

A range of government services — such as education, public housing, sanitation and water supply — also influence health outcomes. These are not formally part of

Australia's health system and are not the subject of the health chapters. Education (see chapters 3 and 4) and public housing (see chapter 16), however, are included in other chapters of the Report.

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

The remainder of this preface provides a summary of the nature of Australia's health care system, an overview of Indigenous health, and data on health outcomes. It also foreshadows future directions in reporting.

Supporting tables

Supporting tables for the health preface are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel format as \Publications\Reports\2005\AttachEA.xls and in Adobe PDF format as \Publications\Reports\2005\AttachEA.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table EA.3 is table 3 in the electronic files). These files can be found on the Review web page also (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

Profile of health services

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

Roles and responsibilities

The Australian Government's health services activities include:

- funding public hospital services, GPs, some specialist medical services and public health programs
- funding the PBS

- funding high level residential aged care services
- funding private health insurance rebates
- funding Aboriginal Community Controlled Health Services (ACCHSs)
- promulgating and coordinating health regulations
- undertaking health policy research and policy coordination across Australian, state and territory governments.

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

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

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

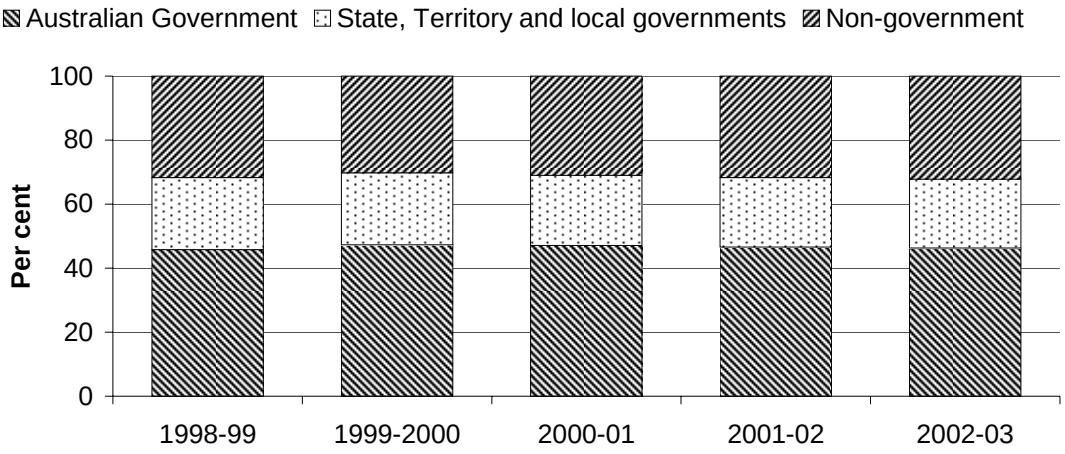
Funding

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

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

Australian, state, territory and local governments spent $49.0 billion on health services (67.9 per cent of total health expenditure) in 2002-03. The remainder was paid by individuals, health insurance funds, and workers compensation and compulsory motor vehicle third party insurance providers. The Australian Government accounts for the largest proportion of health care expenditure in Australia — $33.4 billion (or 46.2 per cent of the total) in 2002-03. State, territory and local governments contributed $15.6 billion (or 21.6 per cent of total health expenditure) in that year (figure E.1 and table EA.1).

Figure E.1 **Total health expenditure, by source of funds**[a, b, c, d, e]



a Includes recurrent and capital expenditure. **b** Includes expenditure on high level residential aged care (reported in chapter 12) and ambulance services (reported in chapter 8). **c** Expenditure by Australian Government and non-government sources has been adjusted for tax expenditure in relation to private health incentives claimed through the taxation system. **d** 'Non-government' includes expenditure by individuals, health insurance funds, and workers compensation and compulsory motor vehicle third party insurers. **e** Expenditure for 2002-03 is based on preliminary estimates by the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS).

Source: AIHW (2004); table EA.1.

Size and scope of sector

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be $72.2 billion in 2002-03 (AIHW 2004; table EA.1). This total was estimated to account for 9.5 per cent of gross domestic product in 2002-03, up from 9.3 per cent in 2001-02 and 8.2 per cent in 1992-93 (AIHW 2004). This indicates that health expenditure grew faster than the whole economy over the decade to 2002-03.

The growth of total health expenditure over the past decade was partly the result of an increase in expenditure by the Australian Government, which grew proportionally faster than expenditure by state, territory and local governments, and non-government sources. Between 1992-93 and 2002-03, the average annual rate of growth in real expenditure was 5.7 per cent for the Australian Government, 4.5 per cent for state, territory and local governments, and 2.9 per cent for non-government sources (AIHW 2004).

The introduction of programs supporting private health insurance was a significant factor in the increase in expenditure by the Australian Government in the late 1990s. On 1 January 1998, the Australian Government replaced the Private Health Insurance Incentive Scheme with a 30 per cent rebate on private health insurance premiums. Australian Government expenditure on the rebate has increased each year, from $1.6 billion in 1999-2000 to $2.3 billion in 2002-03 (AIHW 2004).

Public (non-psychiatric) hospitals were the single largest item of recurrent health care expenditure by government and non-government sources in 2002-03. Total real expenditure on public (non-psychiatric) hospitals was $16.9 billion, of which governments paid $15.6 billion (in 2000-01 dollars)[2] (tables EA.2 and EA.3). Public (non-psychiatric) hospitals accounted for 35.2 per cent of government recurrent expenditure on health care services in 2002-03. Medical services accounted for $9.0 billion of government expenditure (20.3 per cent) and pharmaceuticals accounted for $5.1 billion (11.6 per cent) (figure E.2 and table EA.2).

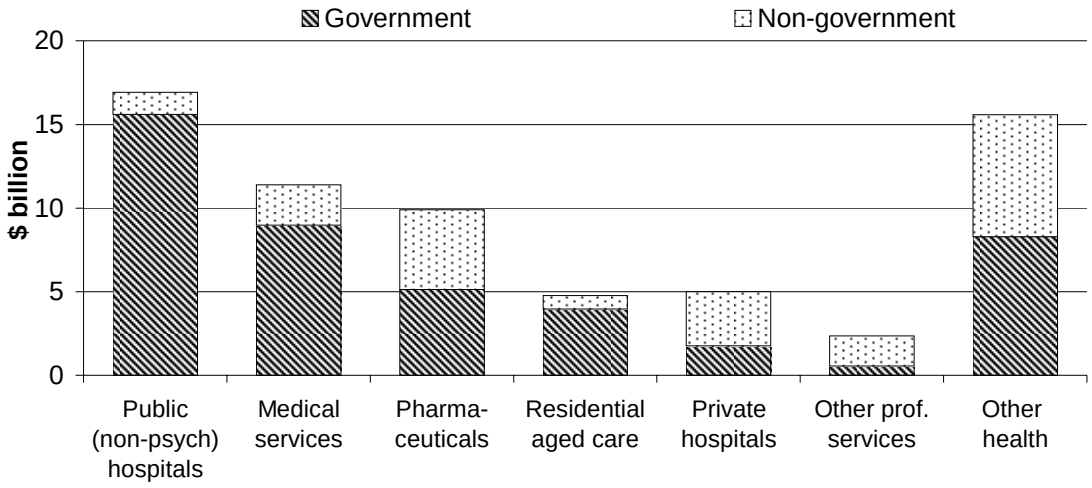
The relative share of government recurrent health expenditure allocated to public hospitals has fallen since 1992-93, when it was 40.6 per cent. This decline reflects the more rapid growth over the decade of government expenditure on private hospitals and pharmaceuticals (figure E.3 and table EA.2). The average annual growth rate of government real recurrent expenditure on private hospitals was 23.7 per cent between 1992-93 and 2002-03, compared with 10.5 per cent for

[2] The published source data from the AIHW use 2001-02 as the base year. The same base year is used here for consistency.

pharmaceuticals and 3.7 per cent for public hospitals (AIHW 2004). Policy measures introduced over the decade that were aimed at restraining growth in government health expenditure included the restriction of Medicare provider numbers, initiatives to encourage the use of generic pharmaceutical brands, and increases in co-payments for pharmaceuticals.

The high annual growth in expenditures on pharmaceuticals and private hospitals meant they also grew as a proportion of government health care expenditure over the period 1992-93 to 2002-03. Government expenditure on pharmaceuticals increased from 7.1 per cent of government health expenditure in 1992-93 to 11.6 per cent in 2002-03, while expenditure on private hospitals increased from 0.8 per cent to 4.0 per cent over the same period (table EA.2).

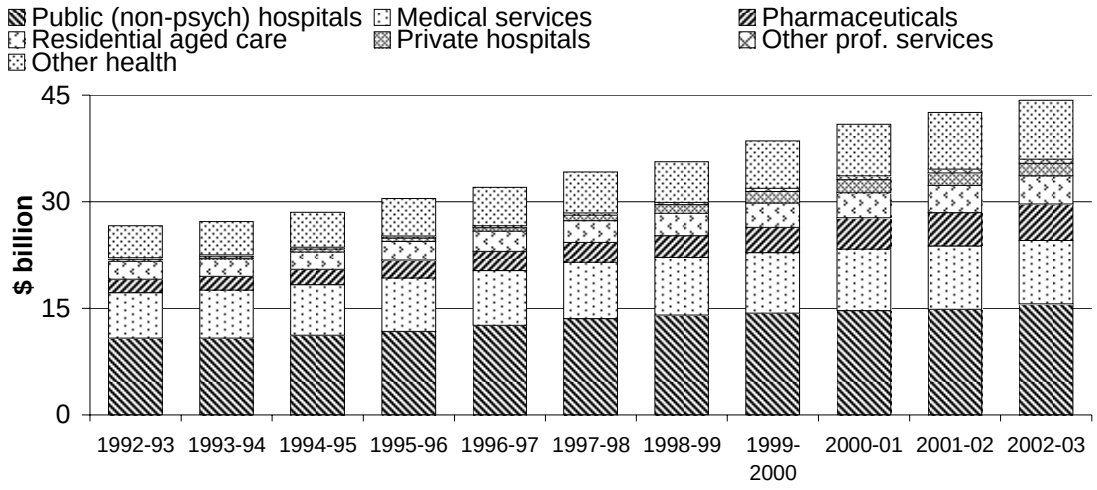
Figure E.2 **Recurrent health expenditure, by area of expenditure, 2002-03 (2001-02 dollars)[a, b, c, d]**



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

Source: AIHW (2004); tables EA.2 and EA.3.

Figure E.3 **Government recurrent expenditure, by area of expenditure (2001-02 dollars)[a, b, c, d, e]**



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

Source: AIHW (2004); tables EA.2, EA8.

Health expenditure per person

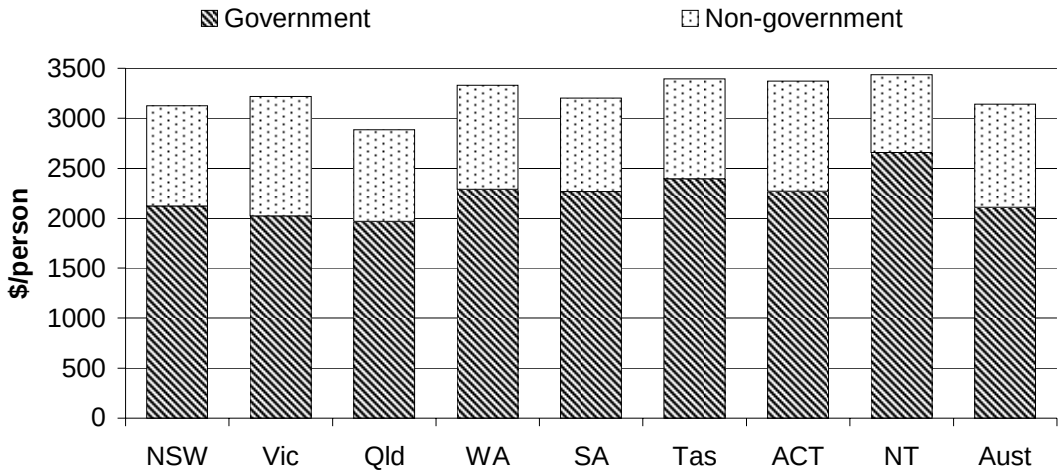
Health expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics. Nationally, total health expenditure (recurrent and capital) per person in 2002-03 was $3652, rising by 32.9 per cent in nominal terms in the five years since 1998-99 (when it was $2748). Across jurisdictions, it was highest in the NT ($4126 per person) and lowest in Queensland ($3392 per person) (table EA.5).

The most recent data on recurrent health expenditure per person by jurisdiction are for 2001-02. Real recurrent health expenditure per person in Australia increased from $2637 (in 2001-02 dollars) in 1997-98 to $3142 in 2001-02. In 2001-02, total recurrent health expenditure per person was highest in the NT ($3437) and lowest in Queensland ($2885) (figure E.4 and table EA.6). If spending on high level residential aged care is removed from these data, then total recurrent health expenditure per person ranged from $3383 in NT to $2659 in Queensland in 2001-02 (table EA.7).

Government real recurrent health expenditure per person in Australia increased from $1776 in 1997-98 to $2112 in 2001-02 (in 2001-02 dollars). In 2001-02 it was highest in the NT ($2658) and lowest in Queensland ($1972) (figure E.4 and table EA.6). If spending on high level residential aged care is removed from these data, then government recurrent health expenditure per person ranged from $2614 in the NT to $1784 in Queensland in 2001-02 (table EA.7).

Non-government recurrent expenditure per person in Australia rose from $862 in 1997-98 to $1030 in 2001-02 (in 2001-02 dollars). In 2001-02, it was highest in Victoria ($1193 per person) and lowest in the NT ($778 per person) (figure E.4 and table EA.6). If spending on high level residential aged care is removed from these data, then non-government recurrent health expenditure per person ranged from $1155 in Victoria to $769 in the NT in 2001-02 (table EA.7).

Figure E.4 **Recurrent expenditure per person, 2001-02[a, b, c]**



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

Source: AIHW (2004); table EA.6.

Overview of Indigenous health

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

Indigenous people are more likely to experience disability and reduced quality of life due to ill health, and to die at younger ages than other Australians (WHO 2001; SIMC 2004). These patterns are reflected in Australian data on: mortality, life expectancy and birthweights (later in this preface); hospital separation rates; hospitalisation rates for diabetes, assault and infectious pneumonia; fetal, neonatal and perinatal death rates (see chapter 9); and suicide (see chapter 11).

Other recent publications, such as the *National Summary of 2001 and 2002 Jurisdictions Reports against Aboriginal and Torres Strait Islander Health Performance Indicators* (SIMC 2004), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* (ABS and AIHW 2003) and *Overcoming Indigenous Disadvantage: Key Indicators 2003* (SCRGSP 2003), include more comprehensive data on the health status of Indigenous people and Indigenous health-related factors.

International comparisons

It has been estimated that there are over 300 million Indigenous people worldwide. They are located mainly in Asia and South America but also in many 'first world' countries such as Australia, Canada and the United States. Despite improvements in Indigenous health outcomes in recent decades, the health status of Indigenous peoples has not kept pace with global health improvements. Their health status remains significantly lower than that of non-Indigenous peoples in almost every country they inhabit (Paradies and Cunningham 2002; UNICEF 2004; WHO 2001).

Based on key population health indicators such as mortality and life expectancy, the average health status of Indigenous Australians appears to be lower than that of Indigenous people in countries such as New Zealand, the United States and Canada. During 1996–2001, for example, it appears that life expectancy at birth for Indigenous people in Australia was at least 10 years lower than that for Indigenous people in New Zealand and Canada (SIMC 2004).[3] Caution is needed in making international comparisons of Indigenous health outcomes because the quality of international Indigenous health data is variable and coverage may be incomplete.

[3] Indigenous population data reported in SIMC 2004 and quoted in this Report do not reflect ABS revised Indigenous population estimates for 1999 and 2000.

Contributing factors

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

- language and cultural barriers to accessing health and health-related services
- relatively low education levels — in the 2001 Census, 28 per cent of Indigenous males and 32.6 per cent of Indigenous females aged 20–24 years had completed year 12 or equivalent, compared with 64.1 per cent of non-Indigenous males and 74.2 per cent of non-Indigenous females aged 20–24 years (SIMC 2004)
- relatively low employment and income levels that lead to financial barriers to accessing health services — in 2001, the median gross weekly equivalised household income[4] of Indigenous people was 56 per cent of that of non-Indigenous people (SCRGSP 2003)
- relatively high imprisonment rates — in June 2002, Indigenous people were 15 times more likely than non-Indigenous people to be in prison (SCRGSP 2003)
- relatively high rates for health risk factors such as obesity, smoking, harmful alcohol use, substance abuse and violence — in the 2001 Australian Bureau of Statistics (ABS) National Health Survey for example, 53 per cent of Indigenous people aged 18 years or over said they were current smokers (compared with around 22 per cent of non-Indigenous people) and 48 per cent reported being obese or overweight (SIMC 2004)
- geographic distance to health services, particularly in remote and very remote areas — in 2001, 606 discrete Indigenous communities were located 25 kilometres or more from the nearest primary health care centre, and 943 communities were 50 kilometres or more from the nearest acute care hospital (SIMC 2004)
- inadequate and overcrowded housing, particularly in remote and very remote regions — based on 2001 Census data and AIHW definitions of 'overcrowded', Indigenous people were estimated to be more than five times as likely as non-Indigenous people to live in overcrowded households (SCRGSP 2003)
- inadequate water supply, sewerage and other health-related infrastructure, particularly in very remote areas (SCRGSP 2003).

These influences on the health status of Indigenous people vary across regions and across urban, rural and remote areas. Geographic and environmental health factors, for example, are less relevant in urban areas (ABS and AIHW 2003). The extent to

[4] Weekly household income adjusted for household size and composition.

which differences across jurisdictions in the reported health outcomes for Indigenous people can be attributed to the performance of government funded health services alone is limited, given the complexity of these influences on Indigenous health, and ongoing data quality problems (discussed below).

In addition, a wide range of government provided or funded services (other than health services) seek to address the environmental, socioeconomic and other factors that affect Indigenous health. These services include government schools, housing, justice and correctional services, which are discussed elsewhere in this Report. The Steering Committee publication, *Overcoming Indigenous Disadvantage: Key Indicators 2003* (SCRGSP 2003), examines these and other multiple contributors (and their complex cross-links) to health outcomes for Indigenous people.

Government policy and programs

The majority of government expenditure on Indigenous health is made through mainstream health programs (AIHW 2001). In addition, the Australian, state and territory governments fund Indigenous-specific health programs and undertake coordination and research activities. Most Australian Government expenditure on Indigenous-specific health programs is directed to ACCHSs. State and territory governments fund a range of community and public health programs that specifically target Indigenous people within their jurisdiction (see chapter 10).

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

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

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

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

The national strategic framework is to be further complemented by a National Strategic Framework for Aboriginal and Torres Strait Islander Social and Emotional Wellbeing, which was agreed by the Australian Health Ministers Advisory Council in March 2004. This will be implemented through social health teams in the ACCHSs and through State and Territory government programs (Department of Health and Ageing 2004).

Expenditure

The most recent estimates of health services expenditure for Indigenous people are for 1998-99 (AIHW 2001). These estimates were examined in previous reports (2002 and 2003), with key issues listed in the 2004 Report also. In summary, the Indigenous health expenditure estimates for 1998-99 (in 1998-99 dollars) showed that national real recurrent health expenditure (that is, recurrent expenditure by all governments) per person was higher for Indigenous people than for non-Indigenous people ($3065 per person and $2518 per person respectively).[5] Health status, geographic, demographic, socioeconomic, linguistic and other factors contributed to the higher average health service costs for Indigenous people (AIHW 2001).

[5] Recurrent expenditure only, not including capital costs.

The 1998-99 expenditure data indicated that Indigenous Australians use secondary/tertiary care (that is, hospitals) at a higher rate than they use primary care (such as doctors and community health services), and at a higher rate than non-Indigenous Australians use secondary/tertiary health care (AIHW 2001). This pattern of use may reflect lower levels of access to primary healthcare (particularly in remote areas), as well as higher incidences of health conditions that require hospital care rather than primary care among Indigenous Australians.

Indigenous people are less likely than other Australians to use private health services for both primary and secondary/tertiary healthcare. In 1998-99, government public hospital expenditure per person was twice as much for Indigenous people as for non-Indigenous people. In community and public health services, expenditure per person was more than five times as much for Indigenous people as for non-Indigenous people (AIHW 2001). The AIHW has published data on government expenditure in 2000-01 and 2001-02 on specific Indigenous health programs, such as programs to promote social and emotional wellbeing and mental health (SIMC 2004).

Data quality

Good quality data are needed to assess the effectiveness of programs and to evaluate policies designed to improve health services and outcomes for Indigenous people. Despite recent improvements, Indigenous health data remain limited in availability, timeliness and quality. The following problems are associated with Indigenous health data in Australia (ABS 2004; ABS and AIHW 2003; SIMC 2004).

- Indigenous people are not always accurately or consistently identified in administrative health data collections (such as hospital records and birth and death registrations), given variation in definitions, different data collection methods and inaccurate or incomplete recording of Indigenous status.
- The ABS has introduced a program of three yearly Indigenous household surveys with sample sizes designed to support the production of reliable state and territory level data, so every three years, some health status and health risk factors are measured. Every six years, more detailed health status information is collected, together with health service use, health actions, health related aspects of lifestyle and other health risks. Other health related surveys, which may include an Indigenous identifier, do not necessarily provide reliable data on Indigenous people, because of their small sample size, geographic coverage or survey design (although considerable improvement has been made in this area in recent years).

- Inconsistent administrative data definitions and collection methods mean comprehensive comparisons between jurisdictions and/or between surveys have rarely been possible.
- Experimental estimates of the Indigenous population are re-based by the ABS every five years to take account of unexplained population growth (that is, other than natural increase). This requires re-estimation of various rates and rate ratios.

Similar problems of quality and availability of Indigenous health data have been identified in international data also (Paradies and Cunningham 2002; WHO 2001).

In Australia, the National Aboriginal and Torres Strait Islander Health Council is finalising an Aboriginal and Torres Strait Islander Health Performance Framework to provide a nationally consistent basis for reporting against outcomes under the national strategic framework (see above). Improving the quality of Indigenous health data is, in itself, a performance indicator in the draft framework. Jurisdictional outcomes have been published against the draft and interim versions of this performance framework (SIMC 2004).

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

Framework for measuring the performance of the health system

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

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

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

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

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

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

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

Medical intervention strategies are implemented after a diagnosis.

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

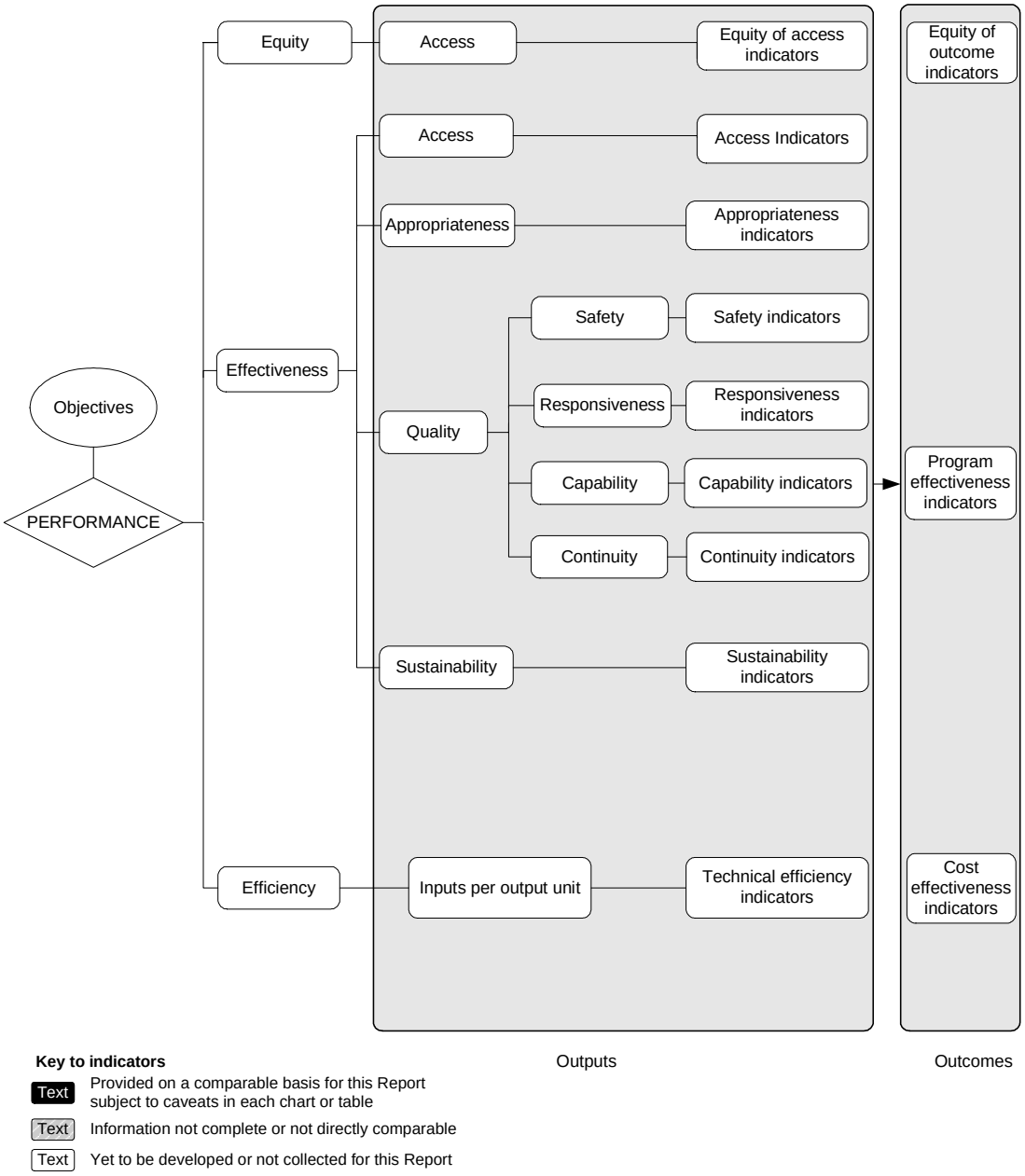
In the 2004 Report, the Steering Committee sought to align the general Review framework with the National Health Performance Framework as far as possible, for application to government health services. Complete alignment was not possible, given the different terms of reference of the two committees.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

sustainability (figure E.5). These additions are intended to address the following key performance dimensions of the health system in the National Health Performance Framework that were not explicitly covered in the general Review framework:

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

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

Figure E.5 **Performance indicator framework for health services**



Selected indicators of health outcomes

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

geographic dispersion, age and ethnicity profiles, and socioeconomic status. Appendix A summarises some of the demographic and socioeconomic factors that can influence health outcomes and government expenditure.

Data on health outcomes presented in this preface include self-assessed health status, mortality rates (for infants and all people), causes of death, life expectancy at birth, median age at death and birthweight. Where possible, data are presented for Indigenous people as well as the Australian population as a whole. It is important to remember the limits of these data as indicators of health services given the effects of other non-health-related factors and services (see above).

Self-assessed health status

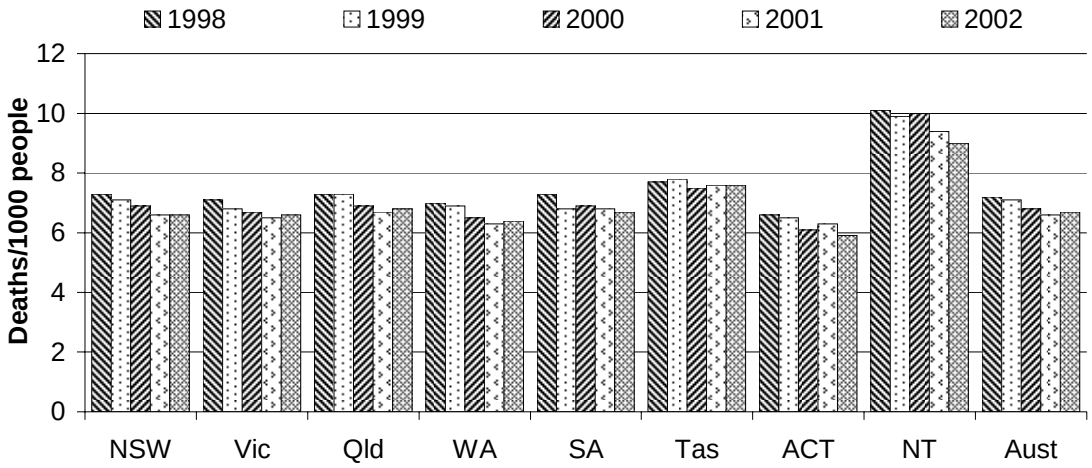
The 1995 and 2001 National Health Surveys conducted by the ABS provided information on people's perceptions of their own health status. These data were presented in the 2004 Report. In summary, around half of all Australians aged 18 years or over assessed their health as being excellent or very good in 2001, with the proportion being highest in the ACT (54.2 per cent) and lowest in SA (47.7 per cent). For all people aged 15 years or over, the proportion who assessed their health as excellent or very good fell from 55.0 per cent in 1995 to 51.7 per cent in 2001 (table EA.9). The proportion of people with a self-assessed health status of excellent or very good declined with age (ABS 2002b), so differences in age profiles across jurisdictions and across the two surveys (1995 and 2001) affected these results.

Mortality rates

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

There were 133 707 deaths in Australia in 2002 (ABS 2003a), which translated into an age standardised mortality rate of 6.7 per 1000 people (figure E.6). Across jurisdictions, mortality rates were highest in the NT (9.0 per 1000) and lowest in the ACT (5.9 per 1000). They fell between 2001 and 2002 in SA, the ACT and NT. In other states, mortality rates increased or remained stable between 2001 and 2002.

Figure E.6 **Mortality rates, age standardised[a]**



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

Source: ABS (2003a); table EA.10.

Indigenous mortality rates

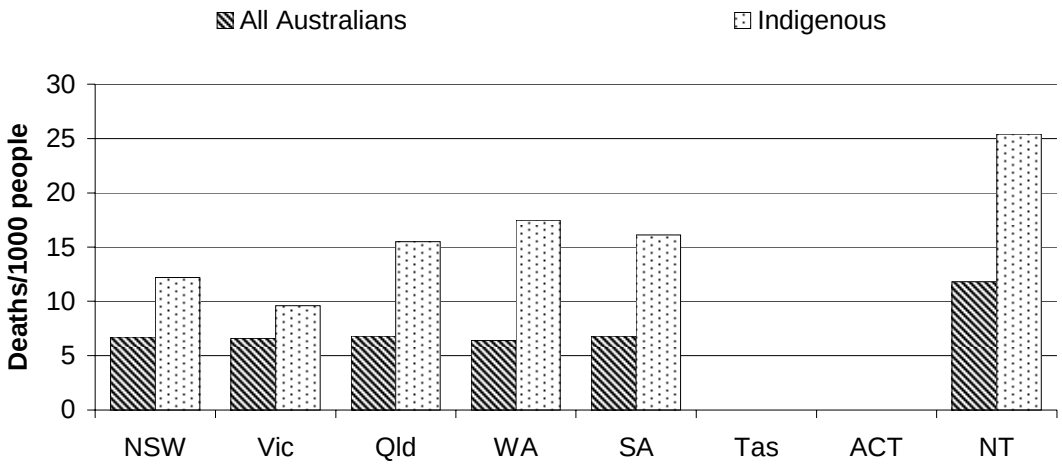
Data on Indigenous mortality are collected through State and Territory death registrations. Although these data collections have good data for the total Australian population, the completeness of the identification of Indigenous Australians in these collections varies significantly across states and territories. The NT, WA, SA and Queensland are generally considered to have the best coverage (in that order) of death registrations for Indigenous people.[6] Each jurisdiction has different levels of coverage however, so care is required in drawing conclusions from the data. Raw deaths data for Indigenous people in NSW and Victoria are included in ABS publications but are not considered suitable for most analyses (ABS unpublished).

The ABS recently announced changes to its methodology for experimental Indigenous population estimates and projections. In making these changes, the ABS noted that, due to incomplete identification of Indigenous deaths in the underlying source data, changes over time in mortality rates for Indigenous people cannot be determined. The ABS Indigenous population estimates and projections assume, for each jurisdiction, constant age-specific mortality rates across the period 1991–2009 (ABS 2004). It can be useful to look at Indigenous mortality data, provided these different levels of Indigenous identification (or coverage) are taken into account.

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

Due to the relatively small number of Indigenous deaths and the consequent volatility in annual mortality rates, the data are presented for the three year period 2000–02. To improve the comparability of age-related mortality rates, indirect age standardisation methods have been used for both the Indigenous and total population rates. Comparisons between mortality rates for the Indigenous and 'all Australian' populations are significantly affected by the incompleteness of Indigenous death rates in all jurisdictions except the NT. Comparisons of Indigenous mortality rates across jurisdictions are similarly affected. Despite the under-identification of Indigenous deaths, in all jurisdictions for which data are available, mortality rates for Indigenous people were much higher than for all Australians in 2000-02 (figure E.7).

Figure E.7 **Mortality rates, age standardised, by Indigenous status, three year average, 2000–02[a, b, c]**



a Calculated using indirect methods of age standardisation, based on the 2001 Census, for NSW, Victoria, Queensland, WA, SA and the NT. Rates are not adjusted for differences across jurisdictions in the extent of identification of Indigenous deaths. **b** Estimated data coverage of Indigenous deaths in NSW and Victoria are below 50 per cent. **c** No data are available for Tasmania and the ACT.

Source: ABS (unpublished); table EA.10.

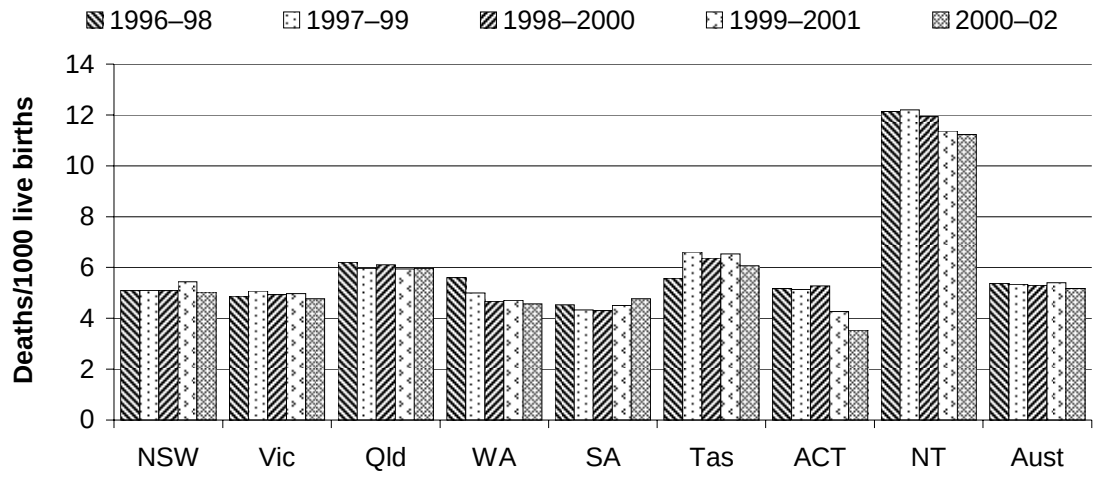
Infant mortality rates

Infant mortality rates are presented in this Report as an average over three years to reduce the volatility inherent in the annual rates due to small numbers and annual fluctuations (figure E.8). The infant mortality rate[7] in Australia declined from 6.3 deaths per 1000 live births in 1992–94 to 5.2 per 1000 live births in 2000–02,

[7] The number of deaths of children under 1 year of age in a calendar year per 1000 live births in the same year.

although the rate has been relatively static in recent years (table EA.11). The rate in 2000–02 was highest in the NT (11.2 per 1000 live births) and lowest in the ACT (3.5 per 1000 live births) (figure E.8).

Figure E.8 **Infant mortality rate, three year average**



Source: ABS (2002a, 2003a); table EA.11.

Indigenous infant mortality rates

For the period 2000–02, the average infant mortality rate for Indigenous Australians is publishable for NSW, Queensland, WA, SA and the NT. For these five jurisdictions, the coverage of Indigenous infant deaths was 80 per cent or higher for this time period. The accuracy of Indigenous mortality data is variable, however, due to varying rates of coverage across jurisdictions and over time. Further, the ability to detect changes in Indigenous infant mortality is affected by the small numbers involved. In all jurisdictions for which data are published (and taking data quality issues into account) Indigenous infant mortality rates do not appear to have changed significantly between 1999–2001 and 2000–02. Indigenous infant mortality rates were markedly higher than the national average for all Australians in both time periods (table EA.11).

Principal causes of death

The most common causes of death among Australians in 2002 (measured as an age standardised death rate per 100 000 people) were: diseases of the circulatory system including heart disease, heart attack and stroke (250 deaths per 100 000 people); cancers (188 deaths per 100 000 people); and diseases of the respiratory system

including influenza, pneumonia and chronic lower respiratory diseases (58 deaths per 100 000 people). External causes, including suicides and transport and other accidents, accounted for 39 deaths per 100 000 people (ABS 2003b; table E.1).

Table E.1 **Cause of death, age standardised death rates, 2002[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Cancers[b]	182	193	190	188	188	225	170	193	188
Lung cancer[c]	36	35	39	40	33	49	24	55	37
Diabetes mellitus	14	20	15	18	16	18	13	52	17
Mental and behavioural disorders	15	17	13	15	18	15	17	47	16
Diseases of the nervous system	24	23	22	28	16	24	26	21	23
Diseases of the circulatory system	256	240	262	223	247	283	226	276	250
Heart disease[d]	129	124	145	117	129	145	103	149	130
Heart attack[e]	70	67	81	64	78	73	49	79	71
Stroke[f]	67	57	66	52	59	69	63	57	62
Diseases of the respiratory system	57	55	57	56	70	64	54	107	58
Influenza and pneumonia	14	14	15	14	27	13	13	23	15
Chronic lower respiratory diseases	30	31	34	29	28	42	30	70	31
Diseases of the digestive system	22	22	22	23	22	25	15	21	22
Accidents	25	22	27	24	22	30	22	53	25
Transport accidents	9	9	10	10	11	10	5	30	10
Suicide[g]	10	11	15	13	11	15	8	28	12
All causes	**664**	**660**	**679**	**641**	**666**	**758**	**594**	**900**	**667**

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

Source: ABS (2003b).

The death rate from all causes was highest in the NT (900 per 100 000 people) and lowest in the ACT (594 per 100 000 people). Death rates from lung cancer, diabetes, mental and behavioural disorders, diseases of the respiratory system, accidents and suicides were all highest in the NT (table E.1). These causes of death affect the whole population in the NT, but are especially significant among Indigenous people due to a combination of demographic, social, economic, environmental and health system-related factors (tables E.2 and EA.13).

National data on causes of death are also presented as proportions of actual deaths that can be attributed to particular causes (table EA.12). These data are less comparable across jurisdictions, given the different age profiles of the populations.

Causes of death for Indigenous people

The number of deaths of Indigenous people from some causes in some jurisdictions is very small or is not identifiable. In the jurisdictions for which age standardised death rates are available by Indigenous status (Queensland, WA, SA and NT), death rates were far higher for Indigenous people than for non-Indigenous people during the period 1999–2001, for all causes of death identified in the refined National Performance Indicators for Aboriginal and Torres Strait Islander Health. In particular, Indigenous people died from rheumatic heart disease at a rate that was up to 19.4 times that for non-Indigenous people. They died from diabetes at a rate that was up to 15.9 times higher than that for non-Indigenous people; from pneumonia at a rate that was up to 14.3 times that for non-Indigenous people; and from assault at a rate that was up to 12.6 times that for non-Indigenous people (table E.2).[8]

A more basic measure of deaths from different causes is the proportion of registered deaths in each year that are attributed to each cause. External causes of death accounted for a higher proportion of deaths of Indigenous people in 2002 (19.0 per cent of Indigenous males and 11.4 per cent of Indigenous females) than of all Australians (7.7 per cent for males and 3.9 per cent for females). Similarly, diabetes mellitus caused 6.7 per cent of deaths of Indigenous males and 8.7 per cent of deaths of Indigenous females in 2002, compared with 2.6 per cent of all male deaths and 2.4 per cent of all female deaths. By contrast, malignant cancers accounted for a smaller proportion of Indigenous deaths (13.9 per cent of males and 16.7 per cent of females) than of all deaths (30.5 per cent of males and 25.6 per cent of females) (tables EA.12 and EA.14). These data are not age standardised, so some of the differences in the proportions of deaths from particular causes are due to differences in the age distribution of the Indigenous and total Australian populations.

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

Table E.2 **Cause of death, age standardised Indigenous mortality ratios, 1999–2001[a, b, c]**

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

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

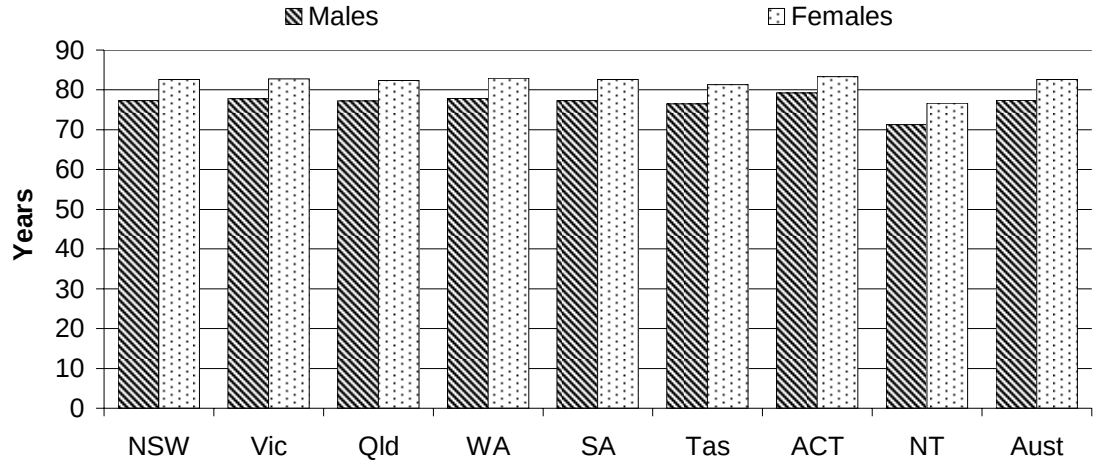
Source: SIMC (2004); table EA.13.

Life expectancy

The life expectancy of Australians improved dramatically during the twentieth century. The average life expectancy at birth in the period 1901–10 was 55.2 years for males and 58.8 years for females (ABS 2002a). It has risen steadily in each decade since, reaching 77.4 years for males and 82.6 years for females in 2000–02 (figure E.9).

Life expectancy at birth was similar across most jurisdictions in 2000–02, being at least 77 years for males and 82 years for females in all states and territories except Tasmania and the NT. Lower average life expectancy in the NT reflects the larger proportion of Indigenous people in the NT population (compared with other jurisdictions) and the shorter life expectancy of Indigenous people generally (figure E.9 and table EA.15).

Figure E.9 **Average life expectancy at birth, by sex, three year average, 2000–2002**



Source: ABS (2002a, 2003a); table EA.15.

Indigenous life expectancy

The life expectancies of Indigenous Australians are considerably lower than those of non-Indigenous Australians. ABS experimental population estimates indicate a life expectancy at birth of 59.4 years for Indigenous males and 64.8 years for Indigenous females born from 1996 to 2001 (ABS 2004; table EA.15). Care needs to be taken when interpreting these data because they are estimates. The ABS noted that, due to incomplete identification of Indigenous deaths in the underlying source data, changes over time in mortality rates for Indigenous people cannot be determined. ABS Indigenous population estimates and projections assume, for each jurisdiction, constant age specific mortality rates across the period 1991–2009. These data are not comparable to — and replace — life expectancy estimates for Indigenous people previously published by the ABS. They should not be subjected to 'over-precise analysis … as measures of Indigenous health outcomes' (ABS 2004, p. 18).

Another life expectancy measure is the probability of a person dying before the age of 55 years (sometimes known as 'early adult death'). This measure is also based on ABS experimental life tables and carries similar caveats to those data on life expectancy at birth. For the jurisdictions in which Indigenous life expectancy data were available, Indigenous males aged 20–24 years in 1999–2001 had from 40 per cent (in SA) to 36 per cent (in Queensland) chance of dying before the age of 55 years, whereas all Australian males in that age group had from 14 per cent (in the NT) to 7 per cent (in Queensland) probability. Indigenous females aged 20–24 years

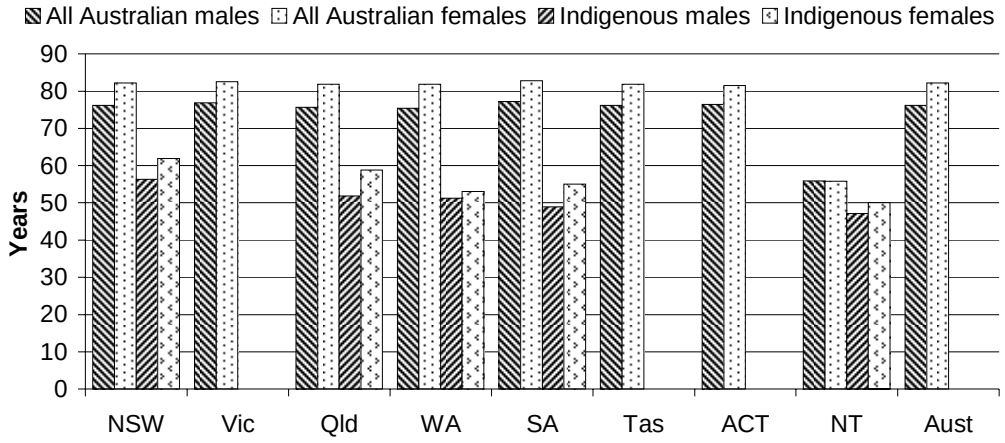
in 1999–2001 had from 27 per cent (in SA) to 22 per cent (in both Queensland and WA) probability of dying before the age of 55 years, whereas all Australian females in that age group had from 8 per cent (in the NT) to 4 per cent (in Queensland, WA and SA) (SIMC 2004). The same caveats as noted above in relation to data for 'Indigenous causes of death' from SIMC 2004 apply to these data also.

Median age at death

The median age at death is a measure of the distribution of deaths by age. Comparisons of the median age at death for Indigenous and non-Indigenous people are affected by different age structures in the populations and by differences in the extent of identification of Indigenous deaths across jurisdictions and across age groups. Identification of Indigenous status for infant deaths is high, but it falls significantly in older age groups. The median age of death for Indigenous people is therefore an underestimate (ABS unpublished).

In 2002, the median age at death was 76.2 years for males and 82.2 years for females among all Australians. For both males and females in 2002, the median age at death was highest in SA (77.2 years and 82.7 years respectively) and lowest in the NT (55.9 years and 55.8 years respectively). In the jurisdictions for which the data were available for Indigenous people in 2002, the median age at death for both male and female Indigenous Australians was highest in NSW (56.3 years and 61.9 years respectively) and lowest in the NT (47.1 and 50 years respectively) (figure E.10 and table EA.16).

Figure E.10 **Median age at death, by sex and Indigenous status, 2002[a, b]**



a Data for Australia include 'Other territories'. **b** Median age at death is available for Indigenous males and females in NSW, Qld, WA, SA and the NT only. The accuracy of Indigenous mortality data is variable as a result of varying rates of coverage across jurisdictions and age groups, and of changes in the estimated Indigenous population caused by changing rates of identification in the Census and births data.

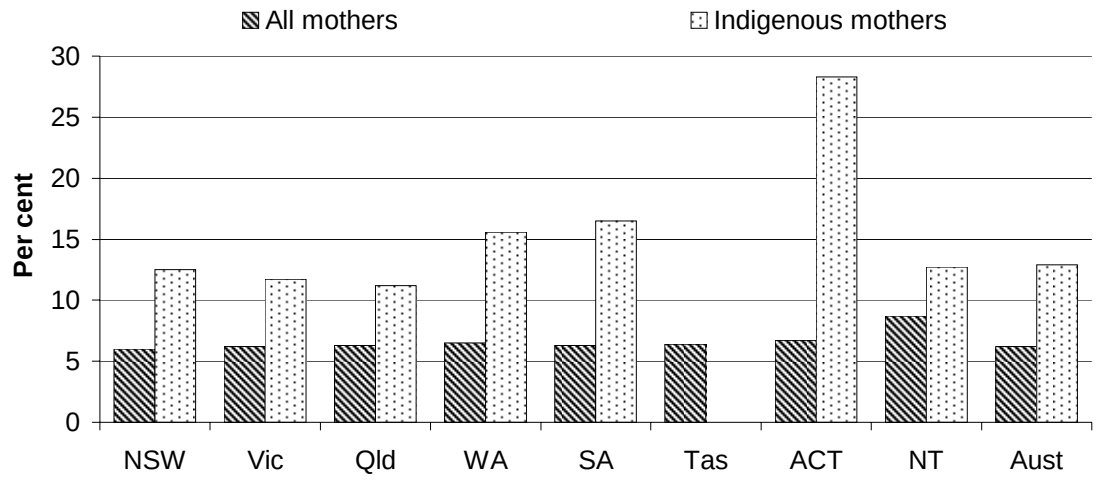
Source: ABS (2003b); table EA.16.

Birthweight of babies

The birthweight of a baby is an important indicator of its health status and future wellbeing. In 2001 (the latest year for which data are available), 91.9 per cent of liveborn babies in Australia weighed between 2500 and 4499 grams (Laws and Sullivan 2004). The mean birthweight for all live births was 3375 grams. Across jurisdictions, the mean birthweight of liveborn babies ranged from 3395 grams in Tasmania to 3268 grams in the NT. The mean birthweight of live babies born to Indigenous mothers was lower than that of babies born to all mothers nationally and in all jurisdictions for which data were available (tables EA.17 and EA.18).

Babies are defined as low birthweight if they weigh less than 2500 grams, very low birthweight if they weigh less than 1500 grams and extremely low birthweight if they weigh less than 1000 grams (Laws and Sullivan 2004). In 2001, 6.2 per cent of all liveborn babies in Australia weighed less than 2500 grams (figure E.11). They included 1.1 per cent of babies who weighed less than 1500 grams and 0.5 per cent of babies who weighed less than 1000 grams (table EA.17).

Figure E.11 **Babies with birthweights under 2500 grams, by Indigenous status, 2001[a, b, c, d]**



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

Source: Laws and Sullivan (2004); tables EA.17 and EA.18.

Among live babies born to Indigenous mothers in 2001, the proportions with low and very low birthweights were more than twice the proportions born to all Australian mothers, with 12.9 per cent weighing less than 2500 grams and 2.4 per cent weighing less than 1500 grams (figure E.11 and table EA.18). Across jurisdictions, the proportion of live babies who weighed less than 2500 grams who were born to Indigenous mothers ranged from 28.3 per cent in the ACT to 11.2 per cent in Queensland (figure E.11).[9]

Future directions

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

Improving reporting on Indigenous health is a common priority across all of the health chapters. Performance indicators for health services used by Indigenous Australians were first published in the 2000 Report. A strategy to improve reporting on Indigenous health was then developed in 2003, and improvements have since been made where possible. In this Report, Indigenous data are reported for fetal, neonatal and perinatal death rates for the first time (see chapter 9). The Steering Committee will consider the Aboriginal and Torres Strait Islander Health Performance Framework (see above) once it is finalised, with a view to adopting new Indigenous health and environmental health indicators in the Review.

In preparation for the 2006 Report, the Steering Committee will commence a 'stocktake' of the performance indicators used in the health chapters of the Report, including the outcome indicators reported in the 'Health preface'. This review will aim to better coordinate performance indicators across the health services chapters and to address the remaining gaps in reporting against the performance framework.

[9] These data are only for babies born to Indigenous mothers and do not include babies with Indigenous fathers and non-Indigenous mothers.

References

ABS (Australian Bureau of Statistics) 2002a, *Experimental Projections of the Indigenous Population*, Cat. no. 3231.0, ABS, Canberra.

—— 2003a, *Deaths, Australia*, Cat. no. 3302.0, ABS, Canberra.

—— 2003b, *Causes of Death, Australia*, Cat. no. 3303.0, ABS, Canberra.

——2002b, *National Health Survey: Summary of Results*, Cat. no. 4364.0, ABS, Canberra.

—— 2004, *Calculating Experimental Life Tables for Use in Population Estimates and Projections of Aboriginal and Torres Strait Islander Australians*, Demography Working Paper 2004-3, Cat. no. 3106.0.55.003, ABS, Canberra.

—— and AIHW (Australian Institute of Health and Welfare) 2003, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2001*, ABS Cat. no. 4704.0, ABS, Canberra.

AIHW (Australian Institute of Health and Welfare) 2001, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, Cat. no. 7, AIHW Australian Department of Health and Aged Care, AIHW, Canberra.

—— 2004, *Health Expenditure Australia 2002-03*, Cat. no. HWE 27, Health and Welfare Expenditure Series no. 17, AIHW, Canberra.

Department of Health and Ageing 2004, *Health and Ageing Portfolio Budget Statements 2004-05*, Budget related paper no. 1.11, Australian Government, Canberra.

Laws, P. and Sullivan, E. 2004, *Australia's Mothers and Babies 2001*, AIHW Cat. no. PER 25, Perinatal Statistics Unit (Perinatal Statistics Series no. 13), AIHW, Sydney.

NHPC (National Health Performance Committee) 2001, *National Health Performance Framework Report*, Queensland Health, Brisbane.

Paradies, Y. and Cunningham, J. 2002, 'Placing Aboriginal and Torres Strait Islander mortality in an international context', *Australia New Zealand Journal of Public Health*, vol. 26, pp. 11–16.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2003, *Overcoming Indigenous Disadvantage: Key Indicators 2003*, Productivity Commission, Canberra.

SIMC (Statistical Information Management Committee) 2004, *National Summary of the 2001 and 2002 Jurisdictional Reports against the Aboriginal and Torres Strait Islander Health Performance Indicators*, Cat. no. IHW 12, AIHW, Canberra.

UNICEF (United Nations Children's Fund) 2004, *Ensuring the Rights of Indigenous Children,* UNICEF Innocenti Research Centre Digest no. 11, Florence.

WHO (World Health Organisation) 2001, *International Decade of the World's Indigenous People*, Report by the Secretariat to the 54th World Health Assembly, Agenda Paper A54/33, Geneva.

9 Public hospitals

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

Public hospital systems are described in section 9.1. A framework of performance indicators and the key performance indicator results for public hospitals are outlined in section 9.2. Section 9.3 includes a profile of maternity services provided by public hospitals, along with a performance indicator framework and key results for public hospital maternity services. Future directions in reporting are discussed in section 9.4. Terms and definitions are summarised in section 9.5.

Significant improvements in the reporting of public hospitals in this Report are:

- a change to the performance framework to remove three indicators that did not adequately reflect the performance of public hospitals. The data for these indicators relate to hospital separations (that is, the number of admitted patients) and are now included in the descriptive section of the chapter (section 9.1)
- fetal, neonatal and perinatal death rates are now reported by Indigenous status.

Supporting tables

Supporting tables for chapter 9 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel format as \Publications\Reports\2005\Attach9A.xls and in Adobe PDF format as \Publications\Reports\2005\Attach9A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 9A.3 is table 3 in the electronic files). These files can be found on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

9.1 Profile of public hospital systems

Definition

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

- acute care services to admitted patients
- sub-acute and non-acute services to admitted patients (for example, rehabilitation or palliative care, or long stay maintenance care)
- emergency, outpatient and other services to non-admitted patients[1]
- mental health services, including services provided to admitted patients by designated psychiatric/psychogeriatric units
- public health services
- teaching and research activities.

This chapter focuses on acute care services provided to admitted patients and emergency services provided to non-admitted patients in public hospitals. These services comprise the bulk of public hospital activity and, in the case of acute care services to admitted patients, have the most reliable data available. Some data in the chapter include sub-acute and non-acute care services where they cannot yet be separately identified from acute care. In some instances, stand-alone psychiatric hospitals are also included, although their role is diminishing in accordance with the National Mental Health Strategy. Under the strategy, the provision of psychiatric treatment is shifting away from specialised psychiatric hospitals to mainstream public hospitals and the community sector. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in 'Health management' (chapter 11). Some common health terms relating to hospitals are defined in box 9.1.

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

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

Patients

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

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

Types of care

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

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

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

Hospital outputs

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

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

non-admitted occasions of service: clinical services provided by hospitals to non-admitted patients. Services may include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.

(Continued on next page)

Box 9.1 **(Continued)**

Other common health terms

AR-DRG (Australian refined diagnosis related group): a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG versions 4.1 and 4.2 are based on the ICD-10-AM classification.

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

Source: DHAC (1998); NCCH (1998); NHDC (2001, 2003).

Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was $18.3 billion in 2002-03 (table 9A.1).[2] In real terms, expenditure increased by 5.1 per cent between 2001-02 and 2002-03 (AIHW 2004a).

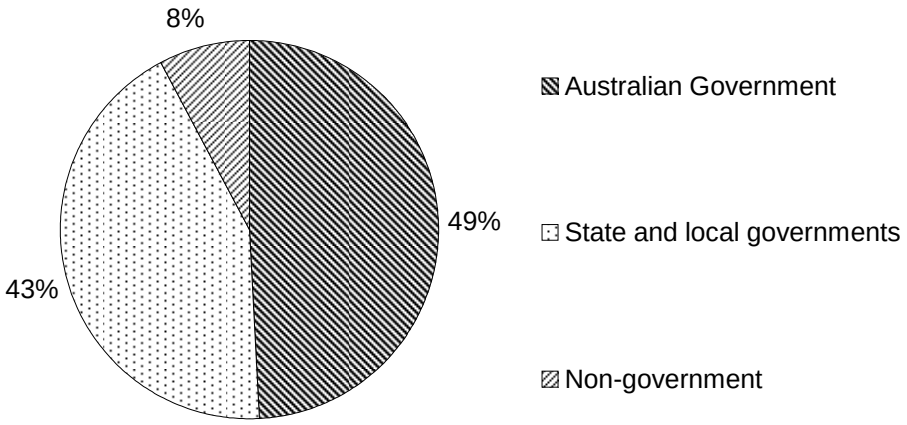
Funding for public hospitals comes from a number of sources. The Australian, State and Territory governments, health insurance funds, individuals, and workers compensation and compulsory motor vehicle third party insurance contribute to expenditure on public hospitals. Based on preliminary data, governments contributed about 92.1 per cent of funding for public (non-psychiatric) hospitals in 2002-03 (figure 9.1).[3] Public (non-psychiatric) hospitals accounted for 35.2 per cent of government recurrent expenditure on health services in 2002-03 (AIHW 2004b).

For selected public hospitals, recurrent expenditure on admitted patients (based on the inpatient fraction) in 2002-03 ranged from 70 per cent to 77 per cent of total recurrent expenditure across jurisdictions (AIHW 2004b). In 2002-03, government real recurrent expenditure on public hospitals (in 2001-02 dollars) was $895 per person for Australia, up from $791 in 1998-99. It ranged from $1165 per person in the NT to $712 per person in Queensland in 2002-03 (figure 9.2).

2 This figure includes spending on patient transport.

3 These expenditure data (figure 9.1) are from *Health Expenditure Australia* (AIHW 2004b). They are not directly comparable with the expenditure data drawn from *Australian Hospital Statistics* (AIHW 2004a). The data in *Health Expenditure Australia* have a broader scope and include some expenditures (such as those relating to blood transfusion services) that are not included in expenditure reported in *Australian Hospital Statistics* (AIHW unpublished).

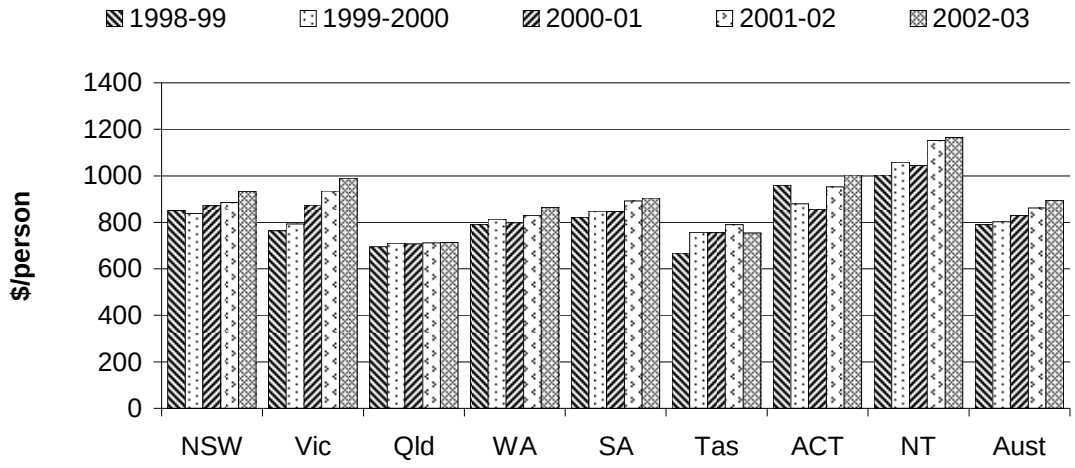
Figure 9.1 **Recurrent expenditure, public (non-psychiatric) hospitals, by source of funds, 2002-03[a]**



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

Source: AIHW (2004b).

Figure 9.2 **Real recurrent expenditure per person, public hospitals (including psychiatric) (2001-02 dollars)[a, b, c]**

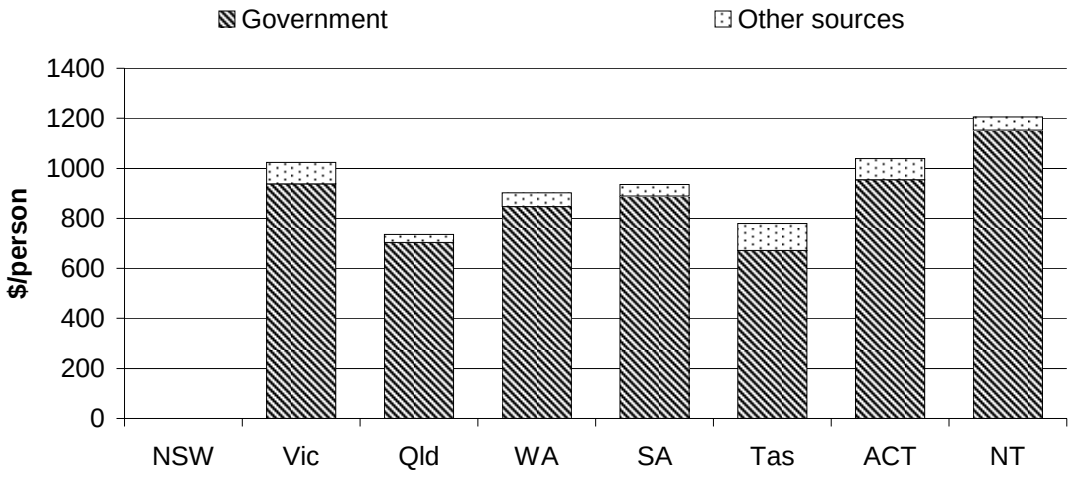


a Expenditure excludes depreciation and interest payments. **b** Data for 2002-03 for NSW are preliminary. NSW hospital expenditure recorded against special purposes and trust funds is excluded. NSW expenditure against primary and community care programs is included from 2000-01. **c** For 2001-02, Tasmanian data for two small hospitals are not supplied and data for one small hospital are incomplete. For 2000-01, data for six small Tasmanian hospitals are incomplete. For 2002-03, Tasmanian data for one small hospital were not supplied and data for five other small hospitals were incomplete.

Source: AIHW (2004a and various years); ABS (unpublished); tables 9A.2 and A.2.

In 2001-02, public hospitals (including psychiatric hospitals) received $1.5 billion in revenue from non-government sources[4] — an amount that accounted for 9.1 per cent of all recurrent expenditure (excluding depreciation). (More recent data are not yet available.) Total revenue in each jurisdiction comprised patient revenue (including income from private and compensable patients), recoveries (including fees from private practitioners treating private patients in public hospitals, staff meals and accommodation) and other revenue (investment income, charities and bequests). Some Australian Government health insurance subsidy payments are indirectly included in non-government revenue via health insurance payments received as part of patient revenue. The proportion of hospital revenue per person funded from non-government sources varied across jurisdictions in 2002-03 (figure 9.3).

Figure 9.3 **Source of public hospital revenue per person, 2002-03[a, b, c, d]**



a Expenditure excluding depreciation. **b** Includes psychiatric hospitals. **c** Non-government revenue for NSW and Australia were not available. **d** Revenue data for five small Tasmanian hospitals were not supplied.

Source: AIHW (2004a); ABS (unpublished); tables 9A.1, 9A.5 and A.2.

Size and scope of sector

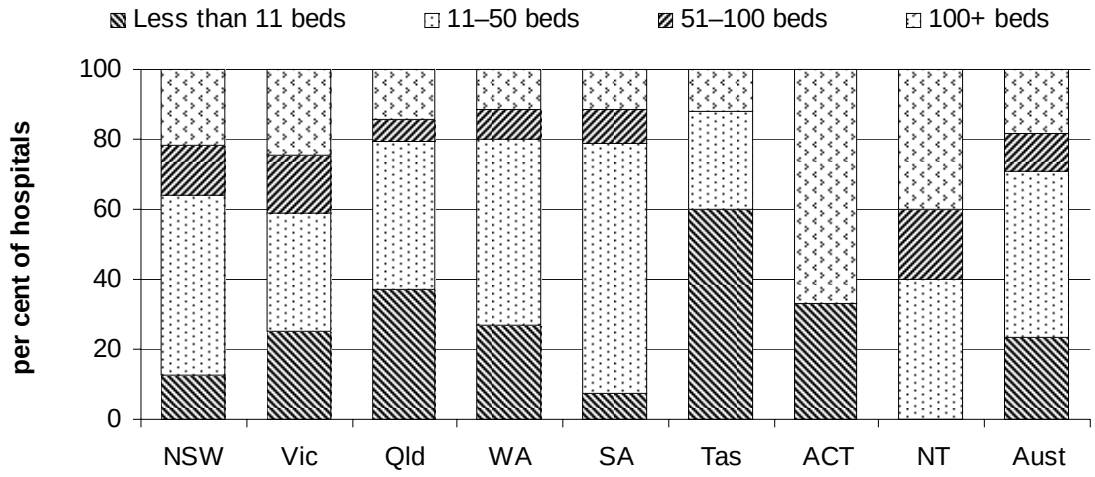
There are several ways to measure the size and scope of Australia's public hospital sector. This Review reports on: the number and size of hospitals; the number and location of public hospital beds; the number and types of public hospital separation; the number and types of separation by Indigenous status;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

[4] Public hospital non-government revenue in 2001-02 for all states and territories except NSW.

Hospitals

In 2002-03, Australia had 748 public hospitals (including 19 psychiatric hospitals). Although 70.7 per cent of hospitals had 50 or fewer beds, these smaller hospitals represented only 18.6 per cent of total available beds (figure 9.4).

Figure 9.4 **Public hospitals, by size, 2002-03**[a, b, c, d]



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

Source: AIHW (2004a); table 9A.3.

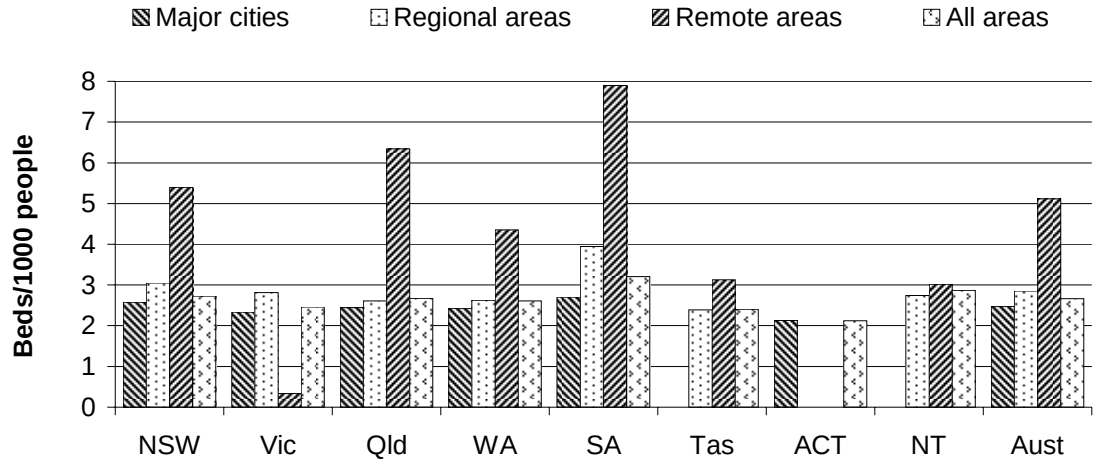
Beds

There were 52 200 available beds in public hospitals in 2002-03 (AIHW 2004a). The concept of an available bed, however, is becoming less important in the overall context of hospital activity, particularly in light of increasing same day hospitalisations and the provision of hospital-in-the-home care (AIHW 2003a). There are also differences in how available beds are counted, both across jurisdictions and over time.

On average, there were 2.7 beds per 1000 people in 2002-03 (figure 9.5). The rate was highest in SA (3.2) and lowest in the ACT (2.1). The comparability of bed numbers can be affected by the casemix of hospitals with, for example, different proportions of beds available for special or general purposes. Nationally, more beds were available per 1000 people in remote areas, although this finding does not indicate regional access to particular types of service or the distance required to travel to these services. These data need to be viewed in the context of the age and

sex structure (see appendix A) and the morbidity and mortality (see Health preface) of the population in each State and Territory.

Figure 9.5 **Available beds, public hospitals, by location, 2002-03[a, b, c]**



a An 'available bed' is one that is immediately available to be used by an admitted patient. A bed is immediately available for use if it is located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period. Both occupied and unoccupied beds are included. Surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded, and beds designated for same day non-admitted patient care are excluded. Beds in wards that were closed for any reason (except weekend closures for beds/wards staffed and available on weekends only) are also excluded (NHDC 2003). **b** 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. **c** Data need to be viewed in the context of the age and sex structure, morbidity and mortality of the population in each jurisdiction (see appendix A and the Health preface).

Source: AIHW (2004a); table 9A.6.

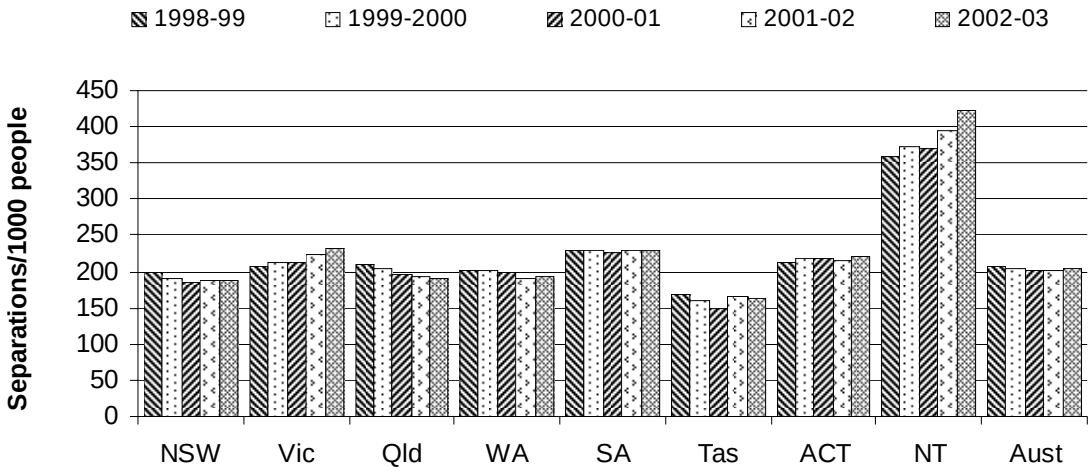
Total separation rates

There were approximately 4.0 million separations from public (non-psychiatric) hospitals in 2002-03 (table 9A.8). Nationally, this translates into 204.8 separations per 1000 people, ranging from 422.5 per 1000 in the NT to 163.9 per 1000 in Tasmania (figure 9.6).

Differences across jurisdictions in separation rates reflect variations in the health profiles of the people living in each State and Territory, the decisions made by medical staff about the type of care required and people's access to services other than public hospitals (for example, primary care and private hospitals). Variations in admission rates also reflect different practices in classifying patients as either admitted same day patients or outpatients. The extent of differences in classification practices can be inferred from the variation in the proportion of same day separations across jurisdictions. Jurisdictions that have a high proportion of same

day separations are likely to have a lower threshold for admitting patients, so will tend to have higher separation rates. This is particularly true of medical separations.

Figure 9.6 **Separation rates in public (non-psychiatric) hospitals[a, b]**



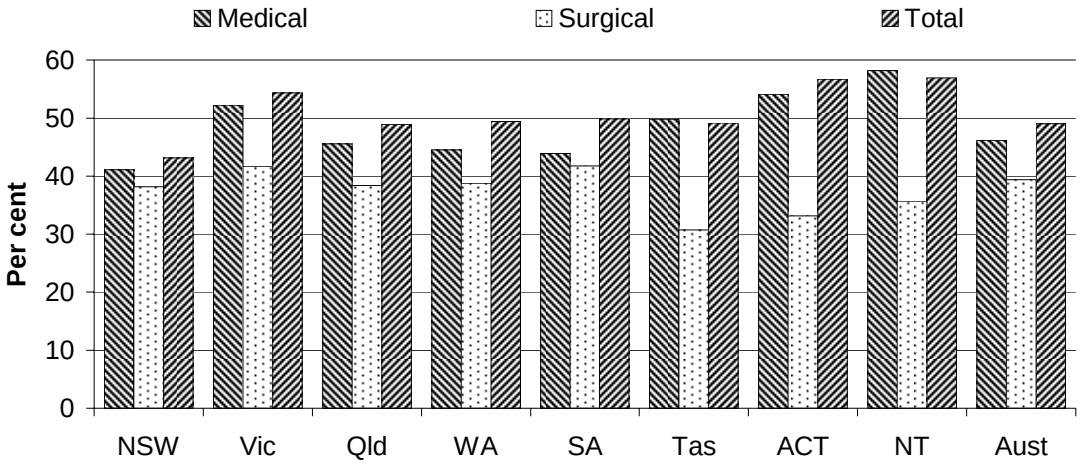
a Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement. **b** Data are directly age standardised to the Australian population at 30 June 2001.

Source: AIHW (2004a and various years); table 9A.14.

The national proportion of medical separations that were same day was 46.2 per cent in 2002-03. The NT had the highest proportion of same day medical separations (58.2 per cent), while NSW had the lowest (41.1 per cent) (figure 9.7). Lower jurisdictional variation is likely in admission practices for surgical procedures, as reflected by the lower variability in the proportion of same day separations (figure 9.7).

Same day separations in public (non-psychiatric) hospitals increased by 5.9 per cent between 2001-02 and 2002-03, and the proportion of separations that were same day increased from 47.7 per cent to 49.0 per cent over this period. In contrast, overnight separations in public (non-psychiatric) hospitals remained virtually unchanged between 2001-02 and 2002-03 (table 9A.14).

Figure 9.7 **Proportion of medical, surgical and total separations that were same day, public (non-psychiatric) hospitals, 2002-03[a]**



a 'Total' includes medical, surgical, chemotherapy, radiotherapy and 'other' separations based on AR-DRG categories (see table 9A.15).

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

Separation rates for Indigenous patients

Data on Indigenous people are limited by the accuracy and extent to which Indigenous people are identified in hospital records. Identification varies across states and territories. In 1998, a pilot study in 11 hospitals found that the accuracy with which a person's Indigenous status was recorded varied greatly from hospital to hospital, ranging from 55 per cent to 100 per cent (ATSIHWIU 1999). The quality of data improved from 2000-01 because all jurisdictions used consistent categories and definitions for Indigenous status from that year. Nevertheless, the quality of data for 2002-03 is considered acceptable only for SA, WA and the NT (AIHW 2004a). In addition, difficulties in estimating the size of the Indigenous population limit the comparability of data over time.

In 2002-03, separations for Indigenous people accounted for around 3.0 per cent of total separations in 2002-03 and 4.7 per cent of separations in public hospitals (table 9.1), but the Indigenous population made up only around 2.4 per cent of the total population. Most Indigenous separations (96 per cent) occurred in public hospitals. The low proportion of private hospital separations for Indigenous people may be due partly to a lower proportion of Indigenous patients being correctly identified in private hospitals and partly to this group's lower use of private hospitals. Data in table 9.1 need to be interpreted with care given that only data from WA, SA and the NT are considered to be of acceptable quality (AIHW 2004a).

Table 9.1 **Separations, by Indigenous status and hospital sector, 2002-03[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Public hospital separations ('000)									
Indigenous [b]	37.9	9.2	51.7	37.2	13.1	1.8	1.4	41.9	194.3
Non-Indigenous	1245.3	1140.7	638.2	330.6	345.5	73.0	60.2	26.1	3859.6
Not reported	7.9	0.0	12.3	0.0	9.3	5.4	2.1	0.2	37.1
Total	**1291.2**	**1149.8**	**702.2**	**367.8**	**367.9**	**80.2**	**63.7**	**68.1**	**4091.0**
Private hospital separations ('000)									
Indigenous [b]	0.4	0.3	3.6	3.9	0.2	na	na	na	8.6
Non-Indigenous	707.6	650.8	465.0	276.7	207.3	na	na	na	2360.2
Not reported	1.0	0.0	133.5	0.0	4.3	na	na	na	194.0
Total	**709.0**	**651.1**	**602.2**	**280.6**	**211.7**	**na**	**na**	**na**	**2562.8**
Separations in public hospitals as a proportion of separations in all hospitals (%)									
Indigenous [b]	99	97	94	91	99	na	na	na	96
Non-Indigenous	64	64	58	54	63	na	na	na	62

a Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement. **b** Identification of Indigenous patients is not considered complete and completeness varies across jurisdictions. The AIHW advised that only data from WA, SA and the NT are of acceptable quality. **na** Not available.

Source: AIHW (2004a); table 9A.21.

In 2002-03, on an age standardised basis, 657.2 separations (including same day separations) for Indigenous patients were reported per 1000 Indigenous people in public hospitals (tables 9.2 and 9A.22). This rate was markedly higher than the corresponding rate for the total population of 205.7 per 1000. Public hospital separation rates for Indigenous patients were highest in the NT (1223.3 per 1000 Indigenous people) (table 9.2). Incomplete identification of Indigenous people limits the validity of comparisons over time, as well as across jurisdictions.

Information about the conditions for which Indigenous people are hospitalised is presented in figures 9.8 and 9.9. These data do not signal the performance of hospitals, but reflect a range of factors, such as: the spectrum of public, primary care and post-hospital care available; Indigenous access to this care as well as hospital services; social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disease between the Indigenous and non-Indigenous populations.

Standardised hospital separation ratios are calculated by dividing Indigenous separations by expected separations. Expected separations are calculated as the product of the all Australian separation rates and the Indigenous population. They illustrate differences between the rates of Indigenous hospital admissions and those of the total Australian population, accounting for differences in age distributions. Ratios are presented for six major conditions: circulatory diseases, injury and poisoning, respiratory diseases and lung cancer, diabetes, tympanoplasty associated

with otitis media, and mental health conditions and selected associated ICD-9-CM and ICD-10-CM codes (tables 9A.23 and 9A.24).

Table 9.2 **Estimates of public hospital separations per 1000 people, by reported Indigenous status[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[c]	*NT*	*Aust*
1998-99									
Indigenous	337.3	344.0	594.6	809.8	673.1	22.9	27.3	920.5	557.1
Total population	199.5	207.7	209.1	204.0	232.3	170.5	212.8	359.6	207.1
1999-2000									
Indigenous	363.4	413.1	708.3	868.9	875.5	132.2	1461.7	1105.0	652.4
Total population	192.1	211.7	205.0	202.0	232.6	160.1	219.2	372.9	204.6
2000-01									
Indigenous	403.8	461.4	671.6	852.2	772.6	110.6	858.0	1031.6	637.5
Total population	187.9	213.6	195.5	199.7	228.8	150.5	217.0	370.9	201.1
2001-02									
Indigenous	361.1	416.0	676.5	752.7	743.6	139.4	982.8	1129.6	614.3
Total population	188.6	222.5	192.5	190.7	229.7	165.0	216.3	394.3	202.8
2002-03									
Indigenous	406.7	476.0	685.2	809.4	788.1	173.1	1200.0	1223.3	657.2
Total population	190.2	231.3	189.4	195.4	231.0	164.5	219.7	422.5	205.7

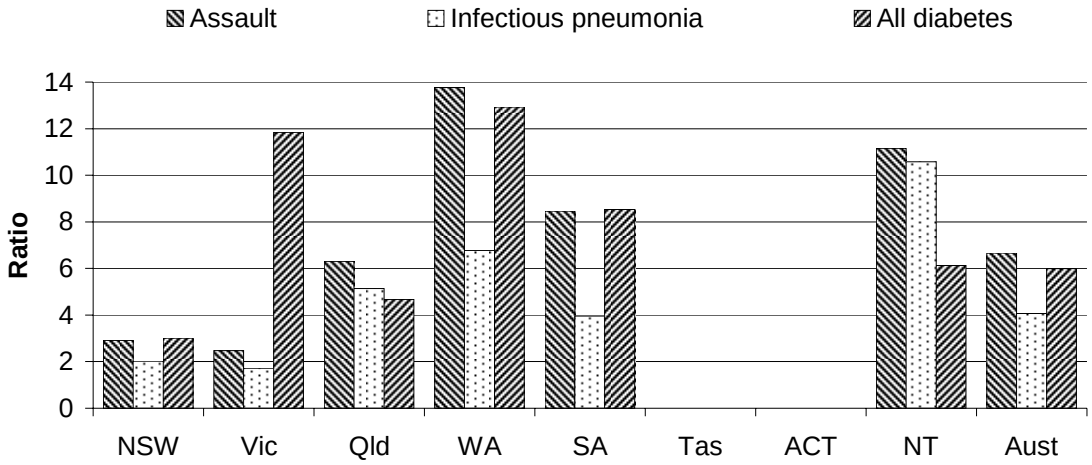
a The rates are directly age standardised to the Australian population at 30 June 2001. **b** Identification of Aboriginal and Torres Strait Islander patients is not considered complete and completeness varies across jurisdictions. The AIHW advised that only data from WA, SA and the NT are of acceptable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

Source: AIHW (unpublished); AIHW (2004a); table 9A.22.

In 2002-03, there was a marked difference between the separation rates for Indigenous males and those of all males for assault (separation rates for Indigenous males were 6.7 times higher than for all males), all diabetes[5] (separation rates for Indigenous males were 6.0 times higher than for all males), and infectious pneumonia (separation rates for Indigenous males were 4.1 times higher than for all males) (figure 9.8). While the 2002-03 standardised rates for rheumatic heart disease for Indigenous males also appeared to be markedly higher than for the total male population, the number of separations for Indigenous males with this condition was very small (table 9A.23).

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

Figure 9.8 **Ratio of age standardised hospital separation rates, Indigenous males to all males, by selected conditions, 2002-03[a, b, c, d, e]**



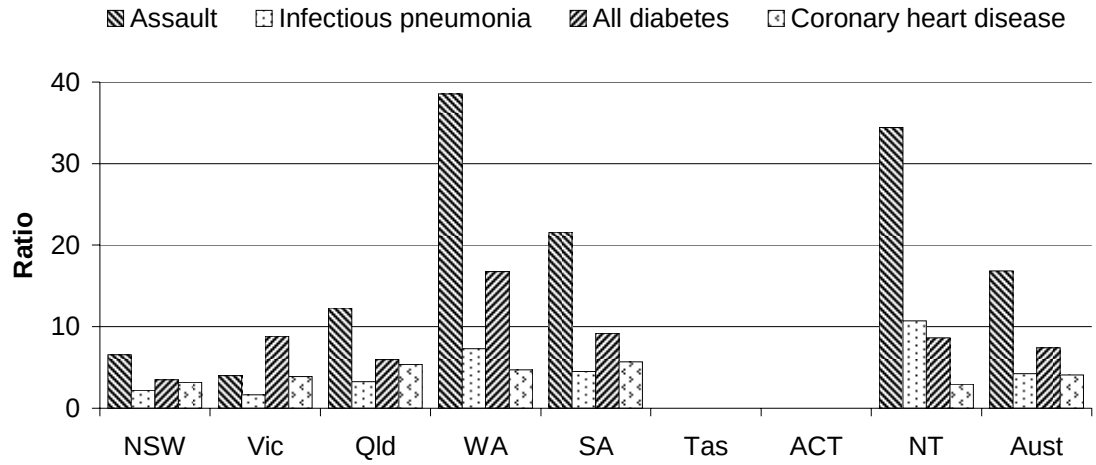
a The ratios are indirectly age standardised using the Census based estimated resident population of Indigenous males at 30 June 2001, the hospital separation rates for Australian males aged 0–74 years for 2000-01 and the male population at 30 June 2001. **b** Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among jurisdictions. The variation in the number of Indigenous separations per 1000 Indigenous population across the states and territories suggests variation in the proportion of Indigenous persons who were identified as such in the hospital morbidity data collections and/or in the total population. **c** Data for Tasmania and the ACT are not available, given the small size of the Indigenous population in those jurisdictions. **d** 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes. **e** These data do not signal the performance of hospitals, but reflect a range of factors such as: the spectrum of public, primary care and post-hospital care available; Indigenous access to this care as well as hospital services; social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disease between the Indigenous and non-Indigenous populations (see appendix A).

Source: AIHW (unpublished); table 9A.23.

In 2002-03, separation rates for Indigenous females were markedly higher than those for all females for: assault (16.8 times higher); all diabetes[6] (7.4 times higher); infectious pneumonia (4.3 times higher) and coronary heart disease (4.1 times higher) (figure 9.9). While the standardised rates for rheumatic heart disease, substance use disorder and tympanoplasty associated with otitis media for Indigenous females also appeared markedly higher than for all females, the number of separations for these conditions was very small (table 9A.24).

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

Figure 9.9 **Ratio of age standardised hospital separation rates, Indigenous females to all females, by selected conditions, 2002-03[a, b, c, d, e]**



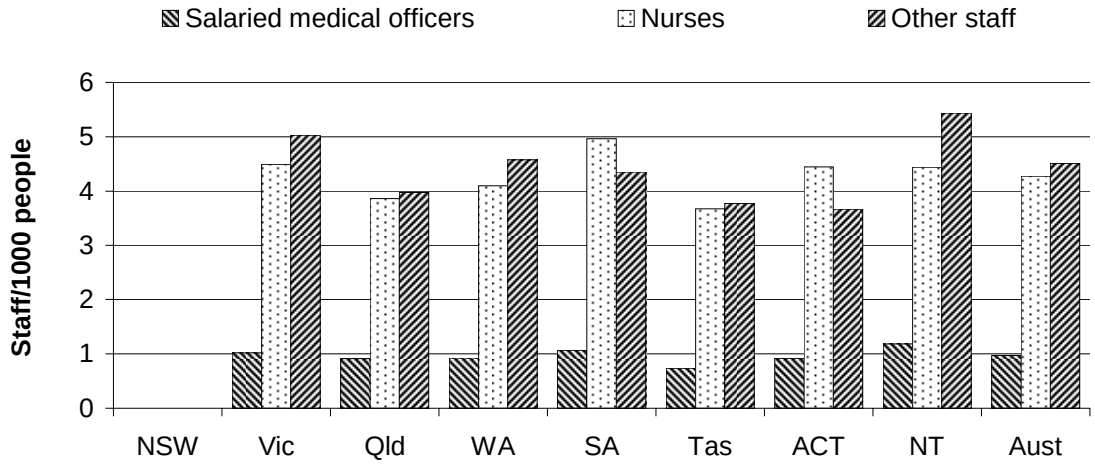
a The ratios are indirectly age standardised using the Census based estimated resident population of Indigenous males at 30 June 2001, the hospital separation rates for Australian males aged 0–74 years for 2000-01 and the male population at 30 June 2001. **b** Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies among jurisdictions. The variation in the number of Indigenous separations per 1000 Indigenous population across the states and territories suggests variation in the proportion of Indigenous persons who were identified as such in the hospital morbidity data collections and/or in the total population. **c** Data for Tasmania and the ACT are not available, given the small size of the Indigenous population in those jurisdictions. **d** 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes. **e** These data do not signal the performance of hospitals, but reflect a range of factors such as: the spectrum of public, primary care and post-hospital care available; Indigenous access to this care as well as hospital services; social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disease between the Indigenous and non-Indigenous populations (see appendix A).

Source: AIHW (unpublished); table 9A.24.

Staff

Data for staff in NSW public hospitals in 2002-03 were not available for this Report. In those states and territories for which data were available for 2002-03, registered nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (4.3 per 1000 people in Australia, excluding NSW). Excluding NSW, the NT had the most FTE staff per 1000 people (11.1) while Tasmania had the least (8.2) (figure 9.10). These data need to be viewed with care because they are affected by differences across jurisdictions in the recording and classifying of staff. The outsourcing of services with a large labour related component (for example, food services and domestic services) can have a large impact on hospital staffing figures. Differences in outsourcing may explain some of the differences in FTE staff in some staffing categories and across jurisdictions (AIHW 2004a).

Figure 9.10 **Average full time equivalent staff per 1000 people, public hospitals, 2002-03[a, b, c, d, e, f, g]**



'Other staff' include diagnostic and allied health professionals, other personal care staff, administrative and clerical staff, and domestic and other staff. **a** Where average FTE staff numbers were not available, staff numbers at 30 June 2003 were used. Staff contracted to provide products (rather than labour) are not included. Staff per 1000 people are calculated from ABS population data at 31 December 2002 (table A.2). **b** Data for NSW were not available for this Report. **c** For Victoria, FTEs may be slightly understated. **d** For Queensland, pathology services are provided by staff employed by the State pathology service and are not reported here. **e** Other personal care staff for WA excludes staff on retention who do not work regular hours. **f** Data for two small Tasmanian hospitals were not supplied. **g** Data for Australia excludes NSW hospital staff and population.

Source: AIHW (2004a); table 9A.7; table A.2.

Activity — admitted patient care

There were around 4.1 million acute, sub-acute and non-acute separations in public hospitals in 2002-03 (table 9A.8). Of these, acute separations accounted for 95.6 per cent, newborns with some qualified days accounted for 1.1 per cent and rehabilitation care accounted for 1.7 per cent (table 9A.9).[7] (Palliative care, non-acute care and other care made up the residual.) Public psychiatric hospitals accounted for around 0.4 per cent of total separations in public hospitals in 2002-03. Of the total number of separations in public (non-psychiatric) hospitals, 49.0 per cent were for same day patients (table 9A.8).

Table 9.3 shows the 10 AR-DRGs with the highest number of overnight acute separations in public hospitals for 2002-03. These 10 AR-DRGs accounted for 16.1 per cent of all overnight acute separations.

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

Table 9.3 **Ten AR-DRGs with the most overnight acute separations, public hospitals, 2002-03[a, b, c]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Separations for AR-DRGs as a proportion of all overnight acute separations (%)									
Vaginal delivery w/o cd	4.7	4.5	5.3	4.1	3.3	4.4	6.1	1.3	4.6
Chest pain	2.0	1.7	2.2	1.2	1.7	1.0	0.9	1.6	1.8
Oesophagitis, gastroenteritis and miscellaneous digestive system disorders, age >9 years, w/o cat/sev cc	1.9	1.6	1.7	1.8	1.7	1.5	1.1	0.8	1.7
Cellulitis age >59 years, w/o cat/sev cc	1.2	1.2	1.6	1.5	1.0	0.9	1.4	4.4	1.3
Respiratory infection/ inflammations w/o cc	1.4	1.1	1.2	1.3	0.9	1.0	1.4	2.1	1.2
Caesarean delivery w/o cd	1.1	1.3	1.5	1.1	1.0	1.1	1.3	1.3	1.2
Other antenatal admission with moderate or no cd	1.3	1.0	1.1	1.0	0.9	0.9	1.1	1.6	1.1
Chronic obstructive airway disease w/o cat or sev cc	1.3	0.9	1.0	0.9	0.9	1.1	0.7	1.1	1.1
Bronchitis and asthma age <50 w/o cc	1.1	0.9	0.9	1.2	1.3	0.7	0.8	0.9	1.1
Heart failure and shock w/o cat cc	1.1	1.0	1.1	1.0	1.1	1.0	0.8	0.6	1.1
Ten AR-DRGs with the most overnight acute separations (%)	**17.1**	**15.0**	**17.5**	**15.2**	**13.7**	**13.5**	**15.6**	**15.8**	**16.1**
Total overnight acute separations ('000)	700	493	343	179	175	39	26	29	1 985

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

Source: AIHW (2004a); table 9A.10.

Table 9.4 lists the 10 AR-DRGs that accounted for the most patient days (17.8 per cent of all patient days recorded) in 2002-03. Schizophrenic disorders associated with involuntary mental health legal status accounted for the largest number of patient days, followed by vaginal delivery without complicating diagnosis.

Table 9.4 **Ten AR-DRGs with the most patient days, public hospitals, 2002-03[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Patient days for AR-DRGs as a proportion of all patient days (%)									
Schizophrenia disorders with involuntary mental health legal status	2.8	3.5	3.8	3.3	3.7	2.1	1.4	1.0	3.2
Vaginal delivery w/o cd	2.5	2.4	2.6	2.4	1.8	2.6	2.8	3.0	2.4
Tracheostomy any age, any condition	2.1	2.3	2.1	2.2	2.6	2.1	1.9	2.6	2.2
Major affective disorders age<70 w/o cat or sev cc	1.9	2.0	2.3	3.2	2.7	2.5	2.9	1.4	2.2
Schizophrenia disorders w/o involuntary mental health legal status	1.6	1.6	1.3	1.8	1.2	3.2	0.9	1.6	1.6
Chronic obstructive airways disease with cat or sev cc	1.5	1.6	1.5	1.7	1.6	1.8	0.8	1.5	1.5
Stroke with sev or cd/procedure	1.2	1.5	1.0	1.4	1.5	1.7	1.2	0.5	1.3
Dementia and other chronic disturbances of cf	1.0	1.3	0.8	1.2	2.3	1.9	0.4	0.1	1.2
Heart failure and shock w/o cat cc	1.3	1.0	1.2	1.0	1.2	1.2	0.9	0.5	1.2
Chronic obstructive airways disease w/o cat or sev cc	1.3	0.8	1.1	1.0	0.9	1.5	0.6	1.0	1.1
Ten AR-DRGs with the most patient days (%)	**17.3**	**18.0**	**17.7**	**19.1**	**19.3**	**20.6**	**13.8**	**13.1**	**17.8**
Total patient days ('000)	3 944	2 709	1 707	982	979	253	158	158	10 890

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

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

Activity — non-admitted patient services

There is no agreed classification system for services to non-admitted patients, so activity is difficult to measure and cannot be compared across jurisdictions. As well as differences in the way in which data are collected, differing admission practices will lead to variation in the services reported across jurisdictions. In addition, states and territories may differ in the extent to which these types of service are provided in non-hospital settings (such as community health centres) (AIHW 2003a). Differences in the complexity of the occasion of service are also not taken into account — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids (AIHW 2001a).

A total of 40.7 million individual occasions of service were provided to non-admitted patients in public hospitals in 2002-03 (table 9.5). In addition, public

hospitals also delivered 406 301 group sessions during this time (where a group session is defined as a service provided to two or more patients, excluding services provided to two or more family members) (table 9A.12). In public hospitals in 2002-03, accident and emergency services comprised 14.2 per cent of all occasions of service to non-admitted patients. Other medical, surgical and obstetric services, pathology services and allied health were the most common types of outpatient care (table 9.5).

Table 9.5 **Ten most common types of individual non-admitted patient care, public hospitals, 2002-03[a]**

	NSW[b]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[c]	*Aust*[d]
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	11.8	17.7	13.8	13.4	21.4	12.5	23.4	26.5	14.2
Outpatient services									
Other medical/surgical/ obstetric	22.7	20.2	25.6	12.9	38.3	29.1	45.8	24.2	23.1
Pathology	15.2	9.6	27.2	15.7	na	24.3	8.1	19.9	16.2
Allied health	8.7	14.2	6.3	20.1	10.6	12.7	2.0	3.7	10.4
Radiology and organ imaging	4.7	8.5	8.4	7.9	11.6	8.8	14.8	19.2	7.2
Pharmacy	5.0	5.2	8.1	3.7	..	7.2	0.1	6.6	5.3
Mental health	3.6	11.0	0.9	0.7	0.9	0.2	1.4	..	3.7
Dental	3.9	2.1	4.5	0.2	0.3	0.2	..	..	3.0
Other non-admitted services									
Community health	12.0	6.3	2.4	17.9	..	0.2	0.1	..	8.4
District nursing	5.2	4.7	0.7	4.3	..	..	..	..	3.6
Ten most common types of non-admitted patient care (%)	**92.7**	**99.6**	**98.0**	**96.9**	**83.0**	**95.4**	**95.6**	**100.0**	**95.1**
Total occasions of service for non-admitted patients ('000)	16 826	7 118	8 843	4 252	2 209	770	411	356	40 786

a Individual non-admitted patient care services. Excludes group sessions. Reporting arrangements varied significantly across years and across jurisdictions. **b** Data for NSW are preliminary. **c** Radiology figures for the NT are underestimated and pathology figures relate to only three of the five hospitals. **d** Includes only those states and territories for which data are available. **..** Not applicable.

Source: AIHW (2004a); table 9A.12.

9.2 Public hospitals

Framework of performance indicators

The performance indicator framework is based on the shared government objectives for public hospitals (box 9.2). The performance indicator framework shows which data are comparable in the 2005 Report (figure 9.11). For data that are not considered directly comparable, the text includes relevant caveats and supporting

commentary. Chapter 1 discusses data comparability from a Report-wide perspective. The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions of quality and sustainability that have been added to the standard Review framework for health services.

Box 9.2 **Objectives for public hospitals**

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

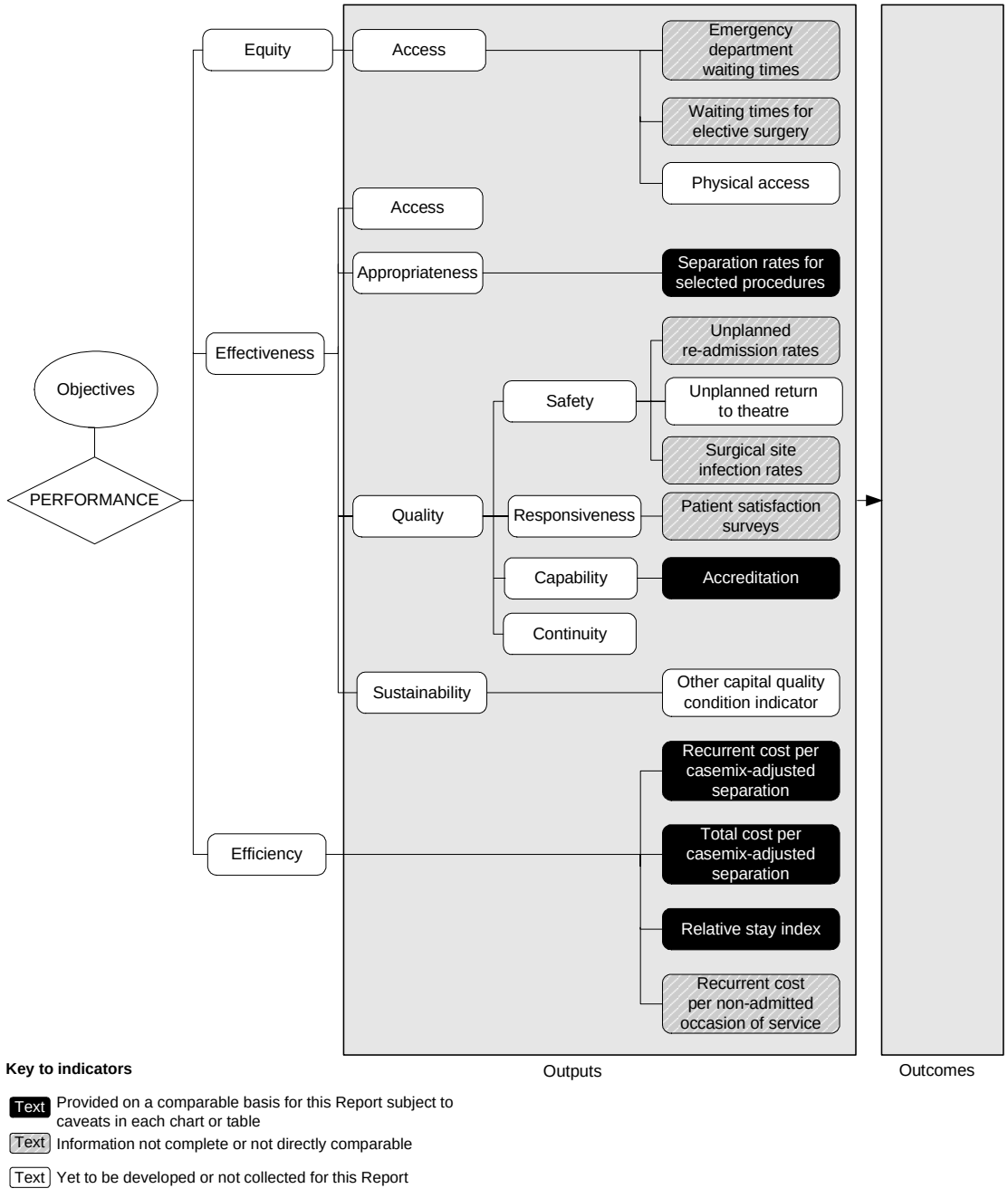
- safe and of high quality
- responsive to individual needs
- accessible
- equitably and efficiently delivered.

This year, the performance framework for public hospitals has been revised to exclude three previous indicators — 'total separation rates', 'separation rates by target group' and 'labour cost per casemix-adjusted separation'. These three data items are now included in the profile of this chapter as contextual information.

- 'Total separation rates' were previously reported as an indicator of appropriateness, with the intention of reflecting tendencies to overservice or underservice public hospital patients. As an indicator, however, these data were difficult to interpret. First, there is no agreed benchmark for 'appropriate' separation rates — high separation rates can indicate, for example, overservicing or better access. Second, variations in separation rates reflect different practices in classifying patients as either admitted same day patients or outpatients. Third, comparisons are complicated by different access to substitutable health services (such as private hospitals or community care). Last, 'total separation rates' do not reflect differences in casemix across jurisdictions.
- 'Separation rates by target group' were included in the public hospitals framework as an indicator of equity of access, comparing separation rates for Indigenous people with those for all Australians. These data have been removed as an indicator because separation rates by Indigenous status do not reflect the performance of public hospitals, but of the health system more generally in addressing the complexity, incidence and prevalence of disease amongst Indigenous Australians. Differences between hospital separation rates for Indigenous and non-Indigenous people highlight differences between the health profiles of the two populations, differences in their access to the range of health services available (primary and community health services, and hospitals), and differences in aspects of their environmental health (see Health preface).

- ‘Labour cost per casemix-adjusted separation’ was previously included in the public hospitals framework as an indicator of efficiency. As an indicator, however, labour costs are only partial in nature, representing a subset of total costs. Labour costs are retained as a data item in the chapter, but recurrent costs and total costs per casemix-adjusted separation are more useful indicators.

Figure 9.11 **Performance indicators for public hospitals**



Key performance indicator results

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

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

Outputs — equity

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

Access

Two indicators of equity of access to public hospitals are presented in this Report: 'emergency department waiting times' (box 9.3) and 'elective surgery waiting times' (box 9.4). Separation rates for Indigenous people are discussed in the profile of this chapter (see section 9.1).

Emergency department waiting times

There is some variation in how public hospital 'emergency department waiting times' are calculated across jurisdictions, which may slightly affect the comparability of the data. Victoria, Queensland, WA and the ACT use the national definition (box 9.3). The NT uses the time of registration as the starting point, while NSW, SA and Tasmania use the time of triage. In SA, patients are always triaged before being clerically registered (AIHW 2004a). There may also be differences in the precision with which the starting time of treatment is recorded. There are also differences in data coverage across jurisdictions, with the estimated proportion of

emergency visits covered ranging from 100 per cent in the ACT and the NT, to 57 per cent in Victoria in 2002-03 (table 9.6).

Box 9.3 **Emergency department waiting times**

'Emergency department waiting times' measure the proportion of patients seen within the benchmarks set according to the urgency of treatment required.

The nationally agreed definition for measuring 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[8], whichever occurs earlier) from the time of commencement of service by a treating medical officer or nurse. Patients who do not wait for care after being triaged or clerically registered are excluded from the data.

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

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

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

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

For triage category 1, NSW, Victoria, the ACT and the NT had the highest proportion of patients seen within the triage timeframe in 2002-03 (100 per cent) and Tasmania had the lowest proportion (91 per cent). For triage category 2, Victoria had the highest proportion of patients seen within the relevant timeframe (84 per cent) and Tasmania had the lowest (55 per cent). Victoria and NSW generally had a higher than average proportion of emergency department patients who were subsequently admitted (table 9A.17). The proportion of patients in each category who were subsequently admitted may indicate the comparability of the triage categorisation.

[8]The triage category indicates the urgency of the patient's need for medical and nursing care.

Table 9.6 **Emergency department patients seen within triage category timeframes, public hospitals (per cent), 2002-03[a]**

Triage category	*NSW*[b]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1 — Resuscitation	100	100	99	94	99	91	100	100	99
2 — Emergency	77	84	73	73	65	55	82	60	75
3 — Urgent	57	76	55	64	47	61	74	64	61
4 — Semi-urgent	62	65	55	68	49	59	67	58	61
5 — Non-urgent	86	85	80	87	84	90	79	88	85
Total	**65**	**73**	**60**	**73**	**53**	**64**	**74**	**65**	**66**
Data coverage: estimated proportion of emergency visits[c]	73	57	64	96	75	84	100	100	71

a Care needs to be taken in interpreting these data. Nationally agreed definitions exist, but there may be differences in how data are collected. Data may vary across jurisdictions as a result of differences in clinical practices. **b** Emergency department occasions of service data for NSW are preliminary so the estimated proportion of emergency visits covered is preliminary. **c** The ratio of the number of occasions of service for hospitals reporting to the emergency department waiting times collection divided by the accident and emergency occasions of service reported to the National Public Hospitals Establishments Database as part of the non-admitted patient data collection.

Source: AIHW (2004a); table 9A.17.

Waiting times for elective surgery

The Steering Committee has identified 'waiting times for elective surgery' as an indicator of equity of access in public hospitals (box 9.4). Two measures of this indicator are reported. Data were not available from all jurisdictions for all measures of this indicator in this Report.

The two measures of 'waiting times for elective surgery' are affected by variations across jurisdictions in the method used to calculate waiting times for patients who:

- changed clinical urgency category while on the waiting list
- transferred from a waiting list managed by one hospital to a waiting list managed by a different hospital (AIHW 2004a).

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

Box 9.4 **Waiting times for elective surgery**

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

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

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

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

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

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

Patients on waiting lists who were not subsequently admitted to hospital are excluded from both measures. Patients may be removed from waiting lists because they are admitted as emergency patients for the relevant procedure, no longer need the surgery, die, are treated at another location, decline to have the surgery, or cannot be contacted by the hospital (AIHW 2004a). In 2002-03, 14.0 per cent of patients were removed from waiting lists for reasons other than admission (AIHW 2004a).

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

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 may not be included in the waiting time reported (AIHW 2004a). NSW, Queensland, WA and the ACT

reported the total time waited on all waiting lists. This approach may have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions. SA has stated that patients do not commonly switch between waiting lists managed by different hospitals in SA (AIHW 2004a).

Table 9.7 presents data for 'overall waiting times' — the number of days within which 50 per cent (that is, the 50th percentile) and 90 per cent (the 90th percentile) of patients are admitted. In 2002-03, the days waited at the 50th percentile ranged from 48 days in the ACT to 21 days in Queensland. The days waited at the 90th percentile ranged from 389 in Tasmania to 113 in Queensland. The proportion of patients waiting more than 365 days ranged from 10.9 per cent in Tasmania to 2.6 per cent in Queensland (table 9.7).

Table 9.7 **Elective surgery waiting times, public hospitals, 2002-03**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of days waited at:										
50th percentile	no.	29	28	21	27	34	42	48	45	28
90th percentile	no.	227	197	113	207	181	389	300	305	197
Proportion who waited more than 365 days	%	4.2	4.2	2.6	3.9	3.0	10.9	7.1	7.0	4.0
Estimated coverage of elective surgery separations[a]	%	100	71	96	77	64	100	100	100	85

[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 an elective urgency of admission and a surgical procedure for all public hospitals.

Source: AIHW (2004a); table 9A.18.

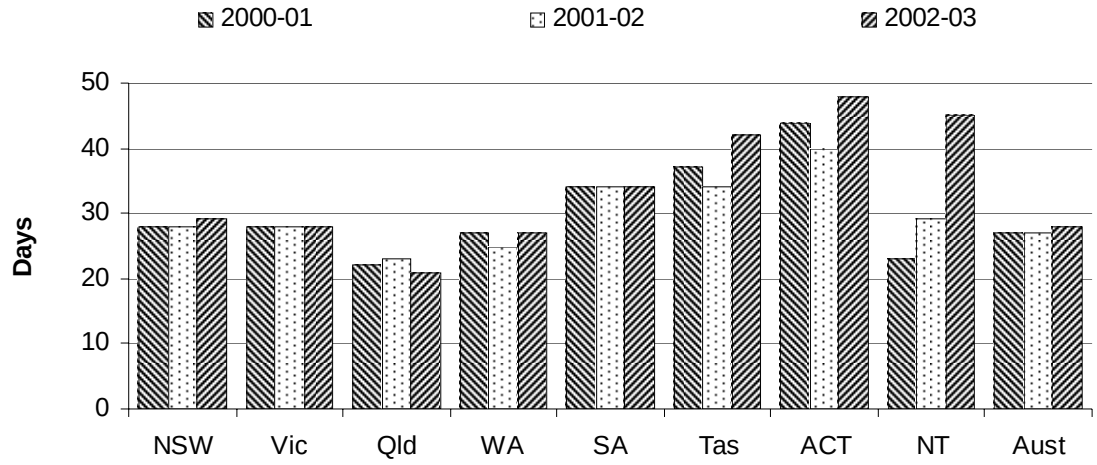
Nationally, 27 days were waited at 50th percentile in 2000-01 and 2001-02 and 28 days in 2002-03. There were variations among jurisdictions, with waiting times increasing in NSW, Tasmania, ACT and NT (figure 9.12).

Attachment 9A includes more information on 'elective surgery waiting times'. Data on 'elective surgery waiting times' by hospital peer group, specialty of surgeon and indicator procedure are contained in tables 9A.18, 9A.19 and 9A.20 respectively.

'Elective surgery waiting times by urgency category' are not comparable across jurisdictions because clinicians have systematically different approaches to categorisation by urgency. Figures 5.12 and 5.13 of the 2002 Report illustrate differences across jurisdictions in the classification of patients to urgency categories for 1999. States and territories with large proportions of patients in category 1 were also the states and territories that had relatively large proportions of patients 'not seen on time'. The apparent variation in performance is thus related to the

classification practices employed (SCRCSSP 2002). Jurisdictional differences in the classification of patients by urgency category in 2002-03 are shown in table 9.8.

Figure 9.12 **Days waited for elective surgery by the 50th percentile, public hospitals**



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

Table 9.8 **Classification of patients, by clinical urgency category, 2002-03 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Patients on waiting lists								
Category 1	na	2.0	6.4	na	7.9	na	2.9	4.8
Category 2	na	38.2	29.9	na	17.2	na	41.8	30.5
Category 3	na	59.8	63.6	na	74.9	na	55.3	64.7
Total[a]	na	100.0	100.0	na	100.0	na	100.0	100.0
Patients admitted from waiting lists								
Category 1	na	20.5	37.6	na	33.0	na	32.8	33.6
Category 2	na	45.6	43.3	na	22.0	na	39.8	35.3
Category 3	na	33.9	19.1	na	45.0	na	27.5	31.1
Total[a]	na	100.0	100.0	na	100.0	na	100.0	100.0

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

Source: State and Territory governments (unpublished).

For this Report, Victoria, Queensland, SA, the ACT and the NT supplied 'elective surgery waiting times data by clinical urgency category'. (For more information on 'elective surgery waiting times by urgency category', see DHA 2004b.) For jurisdictions that provided data for this Report:

- Public hospital census data for Victoria at 30 June 2003 suggest that no category 1 patients on the waiting list were subject to extended waits, as were

39.1 per cent of category 2 patients, 27.1 per cent of category 3 patients and 31.1 per cent of all patients. Of patients admitted to hospital from waiting lists in 2002-03, no category 1 patients were subject to extended waits. 22.6 per cent of category 2 patients, 8.8 per cent of category 3 patients and 12.4 per cent of all patients were subject to extended waits (table 9A.64).

- Public hospital census data for Queensland at 1 July 2003 suggest that 2.3 per cent of category 1 patients on the waiting list were subject to extended waits, as were 5.3 per cent of category 2 patients, 38.2 per cent of category 3 patients and 26.0 per cent of all patients. Of patients admitted to hospital from waiting lists in 2002-03, 9.3 per cent of category 1 patients were subject to extended waits, as were 11.8 per cent of category 2 patients, 13.0 per cent of category 3 patients and 11.1 per cent of all patients (table 9A.70).
- Public hospital census data for SA at 30 June 2003 suggest that 17.0 per cent of category 1 patients on the waiting list were subject to extended waits, as were 22.1 per cent of category 2 patients, 18.3 per cent of category 3 patients and 18.8 per cent of all patients. Of patients admitted to hospital from waiting lists in 2002-03, 13.5 per cent of category 1 patients were subject to extended waits, as were 15.6 per cent of category two patients, 4.9 per cent of category 3 patients and 10.1 per cent of all patients (table 9A.78).
- Public hospital census data for the ACT at 30 June 2003 suggest that 0.4 per cent of category 1 patients on the waiting list were subject to extended waits, as were 56.3 per cent of category 2 patients, 43.3 per cent of category 3 patients and 41.5 per cent of all patients. Of patients admitted from waiting lists in 2002-03, 10.8 per cent of category 1 patients were subject to extended waits, as were 70.8 per cent of category 2 patients, 18.4 per cent of category 3 patients and 26.7 per cent of all patients (table 9A.85).
- Public hospital census data for the NT at 30 June 2003 suggest that 57.8 per cent of category 1 patients on the waiting list were subject to extended waits, as were 52.0 per cent of category 2 patients, 26.5 per cent of category 3 patients and 35.8 per cent of all patients. Of patients admitted from waiting lists in 2002-03, 14.5 per cent of category 1 patients were subject to extended waits, as were 24.0 per cent of category 2 patients, 14.6 per cent of category 3 patients and 17.9 per cent of all patients (table 9A.87).

Victoria, Queensland, SA, the ACT and the NT also provided data on waiting times by clinical specialty and urgency category for 2002-03 (tables 9A.65, 9A.71, 9A.79, 9A.88 and 9A.90).

Physical access

The Steering Committee has identified 'physical access to public hospitals' as an indicator of the equity of access to public hospitals for development in future reports (box 9.5).

Box 9.5 **Physical access**

An indicator of physical access to public hospitals is yet to be developed.

Outputs — effectiveness

Access

The Steering Committee has identified access to public hospitals as an area for development in future reports (box 9.6).

Box 9.6 **Access effectiveness**

An indicator of the effectiveness of access to public hospitals is yet to be developed.

Appropriateness

Separation rates for selected procedures

The Steering Committee has identified 'separation rates for selected procedures' as an indicator of the appropriateness of public hospital services (box 9.7).

The 'separation rates for selected procedures' reported here include all hospitals and reflect the activities of both public and private health systems.[9] The most common procedures in 2002-03 were endoscopies, lens insertions, arthroscopic procedures and caesarean sections (table 9.9). For all procedures, separation rates varied across jurisdictions. Separation rates were frequently below the national average in the ACT and the NT. Statistically significant and material differences in the separation

[9] Data include public acute, public psychiatric, private acute, private psychiatric and private free-standing day hospital facilities. Some private hospitals are not included, resulting in under-reporting of some procedures, particularly procedures more likely to be performed in private hospitals. These types of procedure are thus undercounted for some jurisdictions (AIHW 2002a).

rates for these procedures may highlight variations in treatment methods across jurisdictions. Table 9A.16 presents standardised separation rate ratios — comparing the separation rate in each jurisdiction with the national rate — along with confidence intervals for each ratio.

Box 9.7 **Separation rates for selected procedures**

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

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

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

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

Table 9.9 **Separations per 1000 people, all hospitals, by selected procedure or diagnosis, 2002-03[a, b, c, d]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[e]
Procedure/diagnosis									
Appendectomy	1.2	1.3	1.5	1.6	1.3	1.4	1.2	1.5	1.3
Coronary artery bypass	0.8	0.8	0.8	0.5	0.7	0.7	0.5	0.7	0.8
Coronary angioplasty	1.3	1.6	1.1	1.3	1.2	1.2	0.9	1.1	1.3
Caesarean section:									
separation rate	3.4	3.4	4.0	3.7	3.6	3.0	2.9	4.1	3.5
separations per 100 in-hospital births[f]	30.2	28.1	30.3	30.1	29.5	22.9	24.8	27.2	29.3
Cholecystectomy	2.2	2.3	2.4	2.2	2.4	2.2	1.7	2.0	2.3
Diagnostic gastrointestinal endoscopy	26.0	32.1	31.9	27.3	25.1	19.8	13.6	21.0	28.3
Hip replacement	1.3	1.5	1.1	1.5	1.4	1.8	1.4	0.7	1.3
Revision of hip replacement	0.2	0.2	0.1	0.2	0.1	0.2	0.2	0.1	0.2
Hysterectomy[g]	1.4	1.4	1.5	1.9	1.7	1.8	1.4	1.3	1.5
Lens insertion	7.7	6.9	8.0	8.3	7.0	5.6	6.7	7.7	7.5
Tonsillectomy	1.6	1.8	1.6	1.9	2.2	0.9	1.2	0.7	1.7
Myringotomy	1.3	2.0	1.4	2.3	2.9	1.1	1.3	0.7	1.7
Knee replacement	1.5	1.1	1.2	1.4	1.4	1.2	1.5	0.8	1.3
Prostatectomy	1.1	1.4	1.0	1.2	1.1	1.3	0.9	1.2	1.2
Arthroscopic procedures[h]	4.9	5.9	4.4	7.1	8.3	5.1	4.3	6.9	5.5

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

Source: AIHW (2004a); table 9A.16.

Quality

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

There has been considerable debate and research to develop suitable indicators of the quality of healthcare both in Australia and overseas. The Steering Committee reports data on clinical indicators of safety ('unplanned re-admission rates' and 'surgical site infection rates'), patient satisfaction and the accreditation of public hospital beds. More information on the Steering Committee's proposals for improving reporting on quality for public hospitals are outlined in section 9.4.

Various states and territories publicly report performance indicators for public hospital quality. Some have adopted the same indicators as reported here. In NSW for example, reporting of Australian Council on Health Care Standards (ACHS) 'surgical site infection rates' is mandatory for public hospitals (box 9.11). Both the WA and Tasmanian health department annual reports include information on 'unplanned re-admission rates'. All Victorian hospitals are required to publish annual quality care reports that include safety and quality indicators for infection control, medication errors, falls monitoring and prevention, and pressure wound monitoring and prevention. Currently, Victoria is the only State that publicly reports sentinel events (see section 9.4). 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.

Safety

Improving patient safety is an important issue for all hospitals. Studies on medical errors have indicated that adverse healthcare related events occur in public hospitals in Australia and internationally, and that their incidence is potentially high (for example, Brennan *et al.* 1991; Wilson *et al.* 1995; Thomas *et al.* 2000; and Davis *et al.* 2001). These adverse events can result in serious consequences for individual patients, and the associated costs can be considerable (Kohn *et al*., 1999).

Data for the 'safety' indicators come from the ACHS Comparative Report Service (Clinical Indicators). The ACHS data are collected for internal clinical review by individual hospitals. They are predominantly used to demonstrate the potential for improvement across Australian hospitals, if all hospitals could achieve the same outcomes as the hospitals that achieve the best outcomes for patients. When interpreting results of these indicators, emphasis needs to be given to the potential for improvement. Statewide conclusions cannot be drawn because participation in the Comparative Report Service (Clinical Indicators) is voluntary, so the data are not necessarily drawn from representative samples of hospitals (box 9.8).

Box 9.8 **Reporting of ACHS clinical indicators**

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

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

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

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

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

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

Source: ACHS (unpublished, 2003).

Unplanned re-admission rates

'Unplanned re-admission rates' are reported as an indicator of hospital safety (box 9.9). These estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are particularly unreliable. The statistical terms used to describe this indicator are explained in box 9.10.

Box 9.9 **Unplanned re-admission rates**

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

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

The 'unplanned re-admission rate' is the total number of unplanned and unexpected re-admissions within 28 days of separation as a percentage of the total number of separations (excluding patient deaths) (see section 9.5). High rates for this indicator suggest the quality of care provided by hospitals, or post-discharge care or planning, should be examined because there may be scope for improvement.

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

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

Box 9.10 **Definition of terms for ACHS clinical indicators**

centile: value separating one 100th parts of a distribution in order of size. The 20th centile of hospitals for the unplanned re-admissions indicator would represent the best performing 20 per cent of hospitals (with the lowest number of re-admissions); the 20th centile of hospitals for the infections indicators would represent the best performing 20 per cent of hospitals (with the lowest number of infections).

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

(Continued on next page)

Box 9.10 **(Continued)**

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

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

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

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

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

stratum rate: mean rates for a particular jurisdiction.

Source: ACHS (2001).

New South Wales

Among those NSW public hospitals participating in the ACHS Comparative Report Service in 2003, the mean rate of 'unplanned re-admissions' was 3.6 per 100 admissions (subject to a standard error of 0.2). The ACHS estimated that if the performance of all NSW public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 2.7 per cent fewer re-admissions to NSW public hospitals (table 9.10). The terms in table 9.10 are defined in box 9.10.

Table 9.10 **Unplanned re-admissions per 100 admissions, public hospitals, NSW, 2003[a]**

Hospitals	*Reports*	*Numerator (re-admissions)*	*Denominator (separations)*	*Rate*	*Standard error* (±)
57	88	15 426	433 906	3.6	0.2

National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (re-admissions)*	*Change represented by potential gains (%)*	*Potential outlier gains (re-admissions)*	*Potential stratum gains (re-admissions)*
4.7	0.9	11 695	2.7	4 665	12 401

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

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

Victoria

Among those Victorian public hospitals participating in the ACHS Comparative Report Service in 2003, the mean rate of 'unplanned re-admissions' was 2.8 per 100 admissions (subject to a standard error of 0.3). The ACHS estimated that if the performance of all Victorian public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 1.9 per cent fewer re-admissions to Victorian public hospitals (table 9.11). The terms in table 9.11 are defined in box 9.10.

Table 9.11 **Unplanned re-admissions per 100 admissions, public hospitals, Victoria, 2003[a]**

Hospitals	*Reports*	*Numerator (re-admissions)*	*Denominator (separations)*	*Rate*	*Standard error* (±)
36	60	6 022	217 702	2.8	0.3

National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (re-admissions)*	*Change represented by potential gains (%)*	*Potential outlier gains (re-admissions)*	*Potential stratum gains (re-admissions)*
4.7	0.9	4 150	1.9	1 107	4 504

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

Source: ACHS (unpublished); table 9A.61.

Queensland

Among those Queensland public hospitals participating in the ACHS Comparative Report Service in 2003, the mean rate of 'unplanned re-admissions' was 4.0 per 100 admissions (subject to a standard error of 0.4). The ACHS estimated that if the performance of all Queensland public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 3.1 per cent fewer re-admissions to Queensland public hospitals (table 9.12). The terms in table 9.12 are defined in box 9.10.

Table 9.12 **Unplanned re-admissions per 100 admissions, public hospitals, Queensland, 2003[a]**

Hospitals	*Reports*	*Numerator (re-admissions)*	*Denominator (separations)*	*Rate*	*Standard error* (±)
11	20	4 998	125 108	4.0	0.4
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (re-admissions)*	*Change represented by potential gains (%)*	*Potential outlier gains (re-admissions)*	*Potential stratum gains (re-admissions)*
4.7	0.9	3 922	3.1	1 440	4 126

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

Source: ACHS (unpublished); table 9A.67.

Western Australia

Among those WA public hospitals participating in the ACHS Comparative Report Service in 2003, the mean rate of 'unplanned re-admissions' was 1.7 per 100 admissions (subject to a standard error of 0.4). The ACHS estimated that if the performance of all WA public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.8 per cent fewer re-admissions to WA public hospitals (table 9.13). The terms in table 9.13 are defined in box 9.10.

Table 9.13 **Unplanned re-admissions per 100 admissions, public hospitals, WA, 2003[a]**

Hospitals	*Reports*	*Numerator (re-admissions)*	*Denominator (separations)*	*Rate*	*Standard error* (±)
13	20	1 955	115 103	1.7	0.4
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (re-admissions)*	*Change represented by potential gains (%)*	*Potential outlier gains (re-admissions)*	*Potential stratum gains (re-admissions)*
4.7	0.9	965	0.8	217	1 152

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

Source: ACHS (unpublished); table 9A.72.

South Australia

Among those SA public hospitals participating in the ACHS Comparative Report Service in 2003, the mean rate of 'unplanned re-admissions' was 4.9 per 100 admissions (subject to a standard error of 0.6). The ACHS estimated that if the performance of all SA public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 4.1 per cent fewer re-admissions to SA public hospitals (table 9.14). The terms in table 9.14 are defined in box 9.10.

Table 9.14 **Unplanned re-admissions per 100 admissions, public hospitals, SA, 2003[a]**

Hospitals	*Reports*	*Numerator (re-admissions)*	*Denominator (separations)*	*Rate*	*Standard error* (±)
10	15	2 397	48 505	4.9	0.6
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (re-admissions)*	*Change represented by potential gains (%)*	*Potential outlier gains (re-admissions)*	*Potential stratum gains (re-admissions)*
4.7	0.9	1 980	4.1	987	2 059

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

Source: ACHS (unpublished); table 9A.76.

Australia

Data for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals reported 'unplanned re-admissions' to the ACHS Comparative

Report Service in each of those jurisdictions in 2003. Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2003, the mean rate of 'unplanned re-admissions' was 3.1 per 100 admissions. The ACHS estimated that if the performance of all Australian public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 2.2 per cent (or 23 714) fewer re-admissions (ACHS unpublished).

Surgical site infection rates

Data for 'surgical site infections rates', like the 'unplanned re-admissions' data, are collected for internal clinical review by individual hospitals. 'Surgical site infection rates' are reported for four frequently performed procedures — hip prosthesis, knee prosthesis, lower segment caesarean section and abdominal hysterectomy. Statewide conclusions cannot be drawn from the data because healthcare organisations contribute to the ACHS on a voluntary basis and the data are not necessarily drawn from representative samples. These estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that the data may be particularly unreliable (box 9.11).

Box 9.11 **Surgical site infection rates**

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

This indicator is calculated as the average (that is, mean) rate of post-operative in-hospital occurrence of surgical site infection rates for selected surgical procedures (see section 9.5). Rates are reported for hip and knee prosthesis, lower segment caesarean section and abdominal hysterectomy. Low 'surgical site infection rates' are consistent with the quality standards required in the public hospital sector.

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

New South Wales

Among those NSW public hospitals participating in the ACHS Comparative Report Service in 2003, the mean 'surgical site infection rate' for hip prosthesis was 1.4 per 100 procedures (subject to a standard error of 0.2). The performance of all NSW

public hospitals was similar to that of the top 20 per cent of public hospitals nationally (table 9.15).

The mean 'surgical site infection rate' for knee prosthesis was 0.5 per 100 procedures (subject to a standard error of 0.2). The performance of all NSW public hospitals was slightly better than that of the top 20 per cent of public hospitals nationally (table 9.15).

The mean 'surgical site infection rate' for lower segment caesarean section was 0.6 per 100 procedures (subject to a standard error of 0.4). The ACHS estimated that if the performance of all NSW public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.2 per cent fewer infections in that State following lower segment caesarean sections (table 9.15). NSW data for hysterectomy procedures in 2003 are not published due to the low number of hospitals reporting this data item to the ACHS (less than five).

Table 9.15 **Surgical site infections, public hospitals, by selected surgical procedure, NSW, 2003[a]**

	Unit	*Hip prosthesis*	*Knee prosthesis*	*Lower segment caesarean section*	*Abdominal hysterectomy*
Hospitals	no.	9	10	9	np
Infection rate	%	1.4	0.5	0.6	np
Standard error (±)		0.2	0.2	0.4	np
National performance at 80th centile	rate	2.3	1.1	1.9	np
National performance at 20th centile	rate	1.4	0.7	0.4	np
Potential centile gains	no.	–	-1.0	4.0	np
Change represented by potential gains	%	-0.2	-0.2	0.2	np
Potential outlier gains	no.	–	–	–	np
Potential stratum gains	no.	11.0	4.0	–	np

a Health organisations contribute data voluntarily to the ACHS, so the samples are not necessarily representative of all hospitals in each jurisdiction. **np** Not published. – Nil or rounded to zero.

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

Victoria

Among those Victorian public hospitals participating in the ACHS Comparative Report Service in 2003, the mean 'surgical site infection rate' for hip prosthesis was 2.6 per 100 procedures (subject to a standard error of 0.1). The ACHS estimated that if the performance of all Victorian public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 1.2 per cent fewer infections in that State following hip prosthesis surgery (table 9.16).

The mean 'surgical site infection rate' for knee prosthesis was 2.4 per 100 procedures (subject to a standard error of 0.2). The ACHS estimated that if the performance of all Victorian public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 1.7 per cent fewer infections in that State following knee prosthesis surgery (table 9.16).

The mean 'surgical site infection rate' for lower segment caesarean section was 2.8 per 100 procedures (subject to a standard error of 0.8). The ACHS estimated that if the performance of all Victorian public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 2.4 per cent fewer infections in that State following lower segment caesarean sections (table 9.16).

The mean 'surgical site infection rate' for abdominal hysterectomy was 2.1 per 100 procedures (subject to a standard error of 0.2). The ACHS estimated that if the performance of all Victorian public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.3 per cent fewer infections in that State following abdominal hysterectomies (table 9.16).

Table 9.16 **Surgical site infections, public hospitals, by selected surgical procedure, Victoria, 2003[a]**

	Unit	*Hip prosthesis*	*Knee prosthesis*	*Lower segment caesarean section*	*Abdominal hysterectomy*
Hospitals	no.	8	8	6	6
Infection rate	%	2.6	2.4	2.8	2.1
Standard error (±)		0.1	0.2	0.7	0.2
National performance at 80th centile	rate	2.3	1.1	1.9	2.5
National performance at 20th centile	rate	1.4	0.7	0.4	1.8
Potential centile gains	no.	13.0	19.0	11.3	–
Change represented by potential gains	%	1.2	1.7	2.4	0.3
Potential outlier gains	no.	–	7.2	–	–
Potential stratum gains	no.	29.0	26.0	10.0	1.0

a Health organisations contribute data voluntarily to the ACHS, so the samples are not necessarily representative of all hospitals in each jurisdiction. – Nil or rounded to zero.

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

Queensland

Among those Queensland public hospitals participating in the ACHS Comparative Report Service in 2003, the mean 'surgical site infection rate' for hip prosthesis was 1.1 per 100 procedures (subject to a standard error of 0.1). The performance of all

Queensland public hospitals was slightly better than that of the top 20 per cent of public hospitals nationally (table 9.17).

The mean 'surgical site infection rate' for knee prosthesis was 0.6 per 100 procedures (subject to a standard error of 0.1). The performance of all Queensland public hospitals was similar to that of the top 20 per cent of public hospitals nationally (table 9.17).

The mean 'surgical site infection rate' for lower segment caesarean section was 1.0 per 100 procedures (subject to a standard error of 0.2). The ACHS estimated that if the performance of all Queensland public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.6 per cent fewer infections in that State following lower segment caesarean sections (table 9.17).

The mean 'surgical site infection rate' for abdominal hysterectomy was 3.1 per 100 procedures (subject to a standard error of 0.1). The ACHS estimated that if the performance of all Queensland public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 1.3 per cent fewer infections in that State following abdominal hysterectomies (table 9.17).

Table 9.17 **Surgical site infections, public hospitals, by selected surgical procedure, Queensland, 2003[a]**

	Unit	*Hip prosthesis*	*Knee prosthesis*	*Lower segment caesarean section*	*Abdominal hysterectomy*
Hospitals	no.	10	10	8	5
Infection rate	%	1.1	0.6	1.0	3.1
Standard error (±)		0.1	0.1	0.2	0.1
National performance at 80th centile	rate	2.3	1.1	1.9	2.5
National performance at 20th centile	rate	1.4	0.7	0.4	1.8
Potential centile gains	no.	-5.0	-1.0	28.0	5.0
Change represented by potential gains	%	-0.3	-0.1	0.6	1.3
Potential outlier gains	no.	0.0	0.0	9.9	–
Potential stratum gains	no.	16.0	8.0	18.0	7.0

a Health organisations contribute data voluntarily to the ACHS, so the samples are not necessarily representative of all hospitals in each jurisdiction. – Nil or rounded to zero.

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

Australia

'Surgical site infection rates' for WA, SA, Tasmania, the ACT and the NT are not reported separately because fewer that five hospitals participated in the ACHS

Comparative Report Service. Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2003, the mean 'surgical site infection rate' for hip prosthesis surgery was 1.8 per 100 separations. The ACHS estimated that if the performance of all Australian public hospitals matched the performance of the top 20 per cent of public hospitals, there would be 0.4 per cent fewer infections following hip prosthesis surgery.

The mean 'surgical site infection rate' following knee prosthesis surgery was 1.1 per 100 separations. The ACHS estimated that if the performance of all Australian public hospitals matched the performance of the top 20 per cent of public hospitals, there would be 0.5 per cent fewer infections following knee prosthesis surgery.

The mean 'surgical site infection rate' following lower segment caesarean section surgery was 1.2 per 100 separations. The ACHS estimated that if the performance of all Australian public hospitals matched the performance of the top 20 per cent of public hospitals, there would be 0.8 per cent fewer infections following lower segment caesarean section surgery.

The mean 'surgical site infection' rate following abdominal hysterectomy surgery was 2.1 per 100 separations. The ACHS estimated that if the performance of all Australian public hospitals matched the performance of the top 20 per cent of public hospitals, there would be 0.3 per cent fewer infections following abdominal hysterectomy surgery (ACHS unpublished).

Responsiveness

Patient satisfaction surveys

The Steering Committee has identified the use of 'patient satisfaction surveys' as an indicator of responsiveness in public hospitals (box 9.12).

Table 9.18 lists the editions of this Report for which patient satisfaction data was reported for each State and Territory.

Box 9.12 **Patient satisfaction surveys**

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

'Patient satisfaction surveys' are different from other sources of hospital quality data because they provide the consumer's perspective on hospital services. High patient satisfaction is desirable because it suggests the hospital care received met the expectations and needs of patients.

Given that 'patient satisfaction surveys' differ in content, timing and scope across jurisdictions, it is not possible to compare results nationally.

Table 9.18 **Patient satisfaction data published in each edition of the Report**

Report Edition	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
1995	✓	✓	✓	✓	✗	✗	✓	✗
1999	✗	✓	✗	✓	✗	✓	✓	✓
2000	✓	✓	✓	✓	✗	✓	✓	✗
2001	✓	✗	✗	✓	✗	✓	✓	✗
2002	✗	✓	✗	✓	✓	✓	✓	✗
2003	✓	✗	✓	✓	✓	✓	✓	✗
2004	✓	✓	✗	✓	✓	✓	✓	✗
2005	✓	✓	✗	✓	✓	✗	✗	✗

Source: SCRCSSP (1995, 1999, 2000, 2001a, 2002 and 2003); SCRGSP 2004.

Jurisdictions reported the following 'patient satisfaction surveys':

- In 2003 in NSW, a phone survey was conducted of patients who had stayed for at least one night in hospital in the previous 12 months. The sample size was 2012 and the response rate was 68.2 per cent. Overall, 43.5 per cent rated the care they received as 'excellent', 30.5 per cent as 'very good', 16.9 per cent rated it as 'good', 6.3 per cent rated it as 'fair', and 2.8 per cent rated it as 'poor' (table 9A.58).
- The Victorian Patient Satisfaction Monitor was conducted from 2000 to 2004, using a mailout questionnaire of adult inpatients receiving acute care in Victorian public hospitals. For September 2002 to August 2003, the sample size was 16 349 patients and the response rate was 42.2 per cent. Overall, 95 per sent of patients surveyed across Victoria were either very satisfied or fairly satisfied with their hospital stay, 87 per cent of patients felt they were helped a great deal

or quite a bit by their stay, and 88 per cent felt they spent the right amount of time in hospital (table 9A.63).

- In Queensland, a survey will be undertaken by early 2005 targeting patients who used the State's public hospitals during May and October 2004 (table 9A.69).
- In WA, a mailout survey of inpatients at public hospitals was conducted between August 2003 and June 2004. Adults and children with short stays of two days or less, including same day patients were targeted. The total sample was 4515, with a 47 per cent response rate. For adults, the overall indicator of satisfaction (weighted by the importance of each issue as ranked by the patient) was 77.7. For children, the overall indicator of satisfaction (weighted by the importance of each issue as ranked by the patient) was 78.1 (table 9A.73).
- In SA, telephone interviews were conducted with patients aged 16–80 years who were discharged in June 2003 after staying one to 34 nights in an SA public hospital. Interviews were completed with 2620 patients, with a participation rate of 80.8 per cent. The State-wide satisfaction score was 86.3 (scored from 0 to 100, being least to most satisfied) (table 9A.77).
- In Tasmania, a survey was undertaken, with results available early 2005 (table 9A.81).
- No new survey results are available for the ACT or the NT.

Capability

Accreditation

The Steering Committee has identified 'hospital accreditation' as an indicator of capability in public hospitals (box 9.13).

Box 9.13 **Accreditation**

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

(Continued on next page)

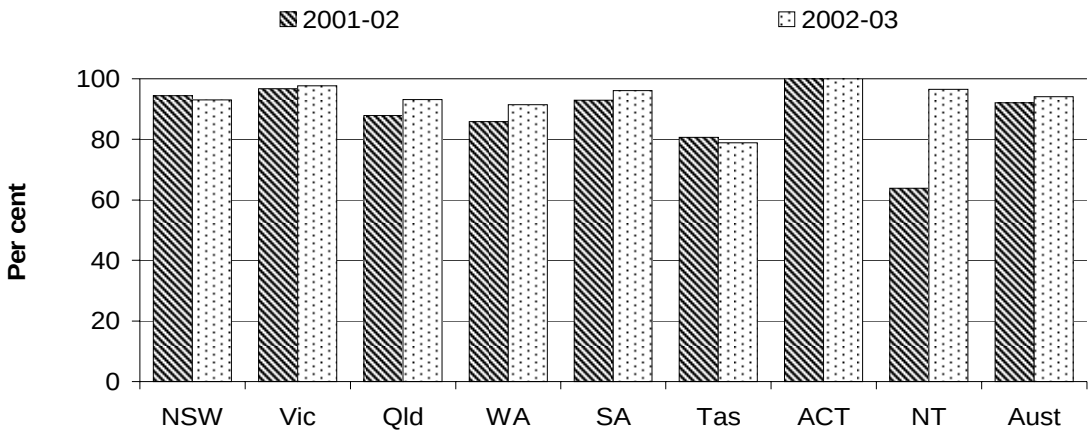
Box 9.13 **(Continued)**

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

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

Hospitals accounting for 94 per cent of public hospital beds were accredited at 30 June 2003. Across jurisdictions, the proportion of public hospital accredited beds ranged from 100 per cent in the ACT to 79 per cent in Tasmania (figure 9.13).

Figure 9.13 **Proportion of accredited beds, public hospitals[a, b]**



a Where average available beds for the year were not available, bed numbers at 30 June 2003 were used. **b** Includes psychiatric hospitals.

Source: AIHW (2004a, 2003a); table 9A.13.

Continuity

The Steering Committee has identified continuity as an area for development in future reports (box 9.14). No indicators of continuity have yet been developed.

Box 9.14 **Continuity**

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

Sustainability

The Steering Committee has identified 'capital quality' as an indicator of sustainability. This is an area for development in future reports (box 9.15). No indicators of sustainability have yet been developed.

Box 9.15 **Capital quality**

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

Outputs — efficiency

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

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

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

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

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

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

Recurrent cost per casemix-adjusted separation

The Steering Committee has identified 'recurrent cost per casemix-adjusted separation' as an indicator of the efficiency of public hospitals (box 9.16).

Box 9.16 **Recurrent cost per casemix-adjusted separation**

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

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

All admitted patient separations and their costs are included, and most separations are for acute care. Cost weights are not available for admitted patients who received non-acute care (about 2.7 per cent of total admitted patient episodes in 2002-03), so the cost weights for acute care are applied to non-acute separations also. The admitted patient cost proportion is an estimate only. Some jurisdictions have developed experimental cost estimates for non-psychiatric acute patients which are also reported here. Separations for psychiatric acute care patients are excluded because AR-DRG cost weights are a poor predictor of the cost of psychiatric separations.

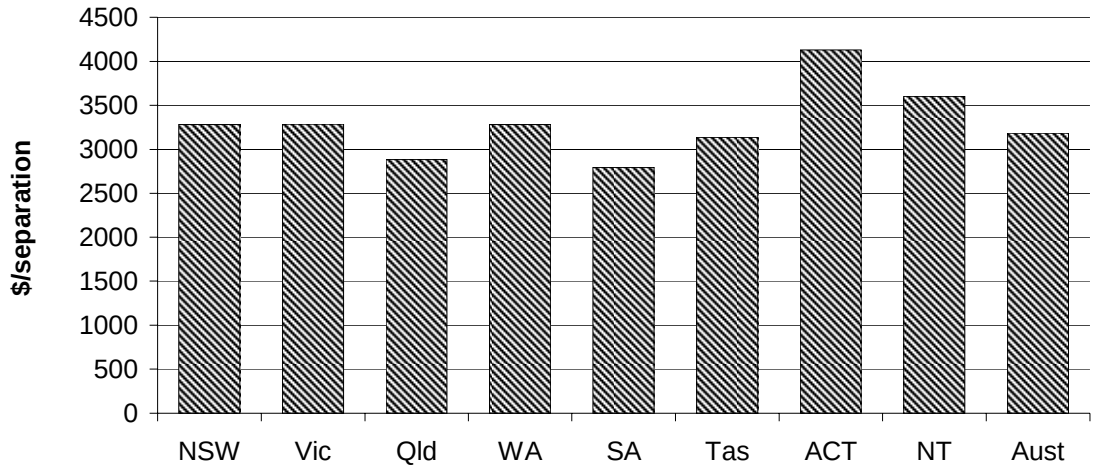
Lower 'recurrent cost per casemix-adjusted separation' may reflect more efficient service delivery in public hospitals. This indicator needs to be viewed, however, in the context of the set of performance indicators as a whole. A hospital may be an efficient provider of services, yet provide services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

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

'Recurrent cost per casemix-adjusted separation' for each jurisdiction in 2002-03 is presented in figure 9.14. 'Recurrent cost per casemix-adjusted separation' is affected by differences in the mix of admitted patient services produced by hospitals in each jurisdiction. Data are therefore presented here according to the 'peer groups' of the hospitals, to enable hospitals with similar activities to be compared.

The 'recurrent cost per casemix-adjusted separation' nationally was $3184 in 2002-03. Across jurisdictions it was highest in the ACT ($4128) and lowest in SA ($2796) (figure 9.14).

Figure 9.14 **Recurrent cost per casemix-adjusted separation, 2002-03[a, b, c, d, e, f, g]**

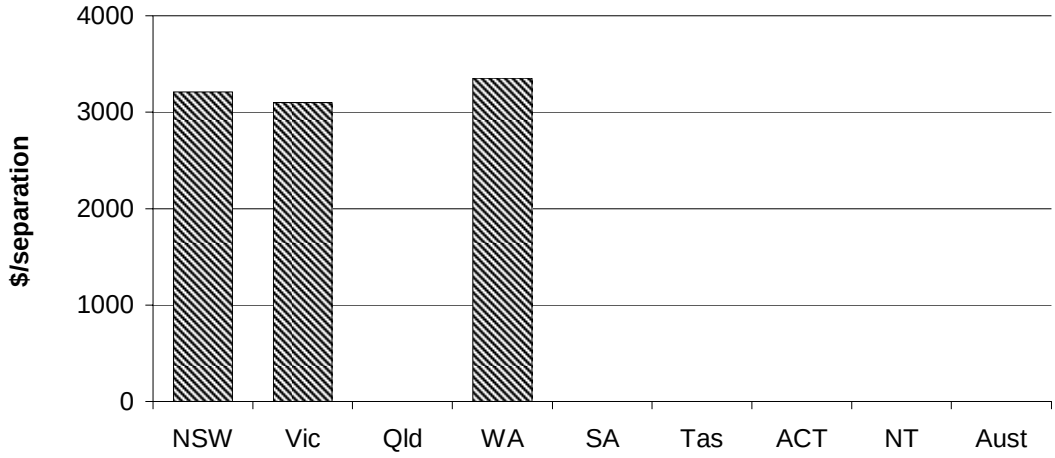


a Excludes depreciation and the user cost of capital, spending on non-admitted patient care, research costs and payroll tax. **b** Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights, from the National Hospital Morbidity Database, are based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2000-01 AR-DRG v4.2 cost weights (DHA 2003). **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** Excludes psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute hospitals and multipurpose services. **e** Data for NSW are preliminary. **f** NT data need to be interpreted in conjunction with the cost disabilities associated with hospital service delivery in the NT. **g** All hospitals in the NT, one very small hospital in Victoria and two very small hospitals in SA have had their inpatient fraction estimated using the HASAC ratio (see AIHW 2004a).

Source: AIHW (2004a); table 9A.4.

Experimental estimates of 'recurrent cost per casemix-adjusted separation' for acute, non-psychiatric patients are reported for NSW, Victoria and WA. These estimates aim to overcome the need to apply cost weights for acute care to non-acute care separations (box 9.16). Recurrent costs per acute, non-psychiatric casemix-adjusted separation in 2002-03 were $3120 in NSW, $3099 in Victoria and $3351 in WA (figure 9.15). The effect of restricting the analysis to acute non-psychiatric admitted patients was to decrease the estimated recurrent cost per casemix-adjusted separation (figure 9.14) by 3.8 per cent for NSW, 6.7 per cent for Victoria and 2.1 per cent for WA (AIHW 2004a).

Figure 9.15 **Recurrent cost per acute non-psychiatric casemix-adjusted separation, 2002-03** [a, b, c, d, e]



[a] Excludes psychiatric, mothercraft, hospices, small non-acute, unpeered and other hospitals, rehabilitation facilities, and multipurpose services. This subset excludes hospitals where the inpatient fraction was equal to the acute inpatient fraction and more than 1000 non-acute patient days were recorded. Also excludes hospitals where the apparent cost of non-acute patients exceed $1000 per day and more than 1000 non-acute patient days were recorded. [b] Expenditure data for NSW are preliminary. [c] Acute separations are those where the care type is acute, newborn with qualified days, or not reported. Psychiatric separations are those with psychiatric care days. [d] Average cost weight from the National Hospital Morbidity Database, based on acute and unspecified separations and episodes of newborn care with qualified days, using the 2001-02 AR-DRG version 4.2 cost weights (DHA 2003). [e] Cost estimates include adjustment for private patient medical costs: $139 for NSW, $80 for Victoria and $85 for WA.

Source: AIHW (2004a).

To facilitate comparisons across hospitals with similar activities (box 9.16), data are reported by peer group (table 9A.25). The dominant peer classification is the principal referral and specialist women's and children's category. In 2002-03, these hospitals accounted for 67.8 per cent of public acute and psychiatric hospital expenditure and 66.1 per cent of separations (AIHW 2004a). The data for principal referral hospitals (excluding specialist women's and children's hospitals) are presented in table 9.19. Nationally, the 'recurrent cost per casemix-adjusted separation' for principal referral hospitals in 2002-03 was $3178. For those jurisdictions with data available to be published, the 'recurrent cost per casemix-adjusted separation' for principal referral hospitals was highest in NSW ($3363) and lowest in Queensland ($2977).

Table 9.19 **Recurrent cost per casemix-adjusted separation, principal referral public hospitals, 2002-03[a, b, c]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Hospitals	no.	19	15	12	3	4	2	1	1	57
Average beds per hospital	no.	420	550	414	523	385	382	493	295	454
Average separations per hospital	no.	36 541	56 112	36 281	55 297	48 642	33 579	49 838	35 073	43 577
Average cost weight	no.	1.09	1.00	1.04	1.08	1.09	1.08	0.94	0.83	1.04
Cost per casemix-adjusted separation	**$**	**3 363**	**3 227**	**2 977**	**np**	**np**	**2 997**	**np**	**np**	**3 178**
Recurrent expenditure on principal referral hospitals	$m	3 574	3 668	1 737	np	np	285	np	np	11214
Recurrent expenditure on all public hospitals	$m	6 436	5 004	2 766	1 748	1 425	370	335	239	18 323

a Principal referral hospitals are classified as metropolitan hospitals with more than 20 000 acute casemix-adjusted separations per year and rural hospitals with more than 16 000 acute casemix-adjusted separations per year. **b** Expenditure data exclude depreciation and the user cost of capital, spending on non-admitted patient care, research costs and payroll tax. **c** Average cost weight from the National Hospital Morbidity Database, based on acute and unspecified separations, and newborn episodes of care with qualified days, using the 2000-01 AR-DRG v4.1 cost weights (DHAC, unpublished) applied to AR-DRGs v4.2. **np** Not published.

Source: AIHW (2004a); table 9A.25.

Total cost per casemix-adjusted separation

The Steering Committee has identified 'total cost per casemix-adjusted separation' as an indicator of the efficiency of public hospitals (box 9.17).

Among the jurisdictions for which all components of 'total cost per casemix-adjusted separation' were available (that is, labour, materials and capital costs), the 'total cost per casemix-adjusted separation' in 2002-03 ranged from $4626 in the ACT to $3158 in SA (figure 9.16).[10] Labour costs per casemix adjusted separation were available for all jurisdictions and accounted for the majority of total hospital costs. The labour cost per casemix-adjusted separation (including medical and non-medical labour costs) in 2002-03 was highest in the ACT ($2759) and lowest in SA ($1851) (figure 9.16 and table 9A.4).

[10] Capital costs for 2002-03 were not available for WA, Tasmania and the NT (table 9A.26).

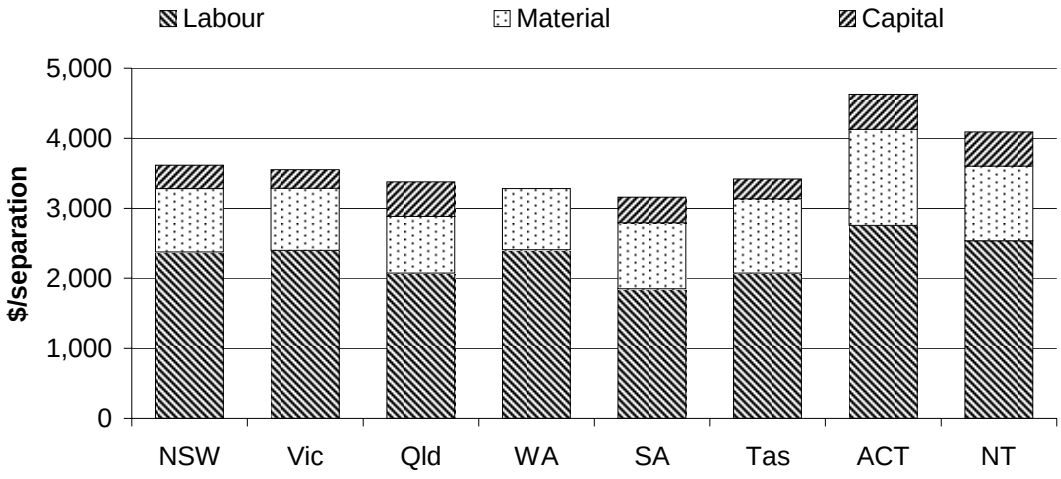
Box 9.17 **Total cost per casemix-adjusted separation**

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

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

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

Figure 9.16 **Total cost per casemix-adjusted separation, public hospitals, 2002-03[a, b, c]**



a 'Labour' includes medical and non-medical labour costs. 'Material' includes other non-labour recurrent costs. **b** 'Capital cost' includes the user cost of capital plus depreciation associated with the delivery of admitted patient services in the public hospitals described in the data for recurrent cost per casemix-adjusted separation. 'Capital cost' excludes land and the user cost of capital associated with land (reported in table 9A.26). **c** Variation across jurisdictions in the collection of capital related data suggests the data are only indicative. Capital cost per casemix-adjusted separation data are not available for WA.

Source: AIHW (2004a); State and Territory governments (unpublished); table 9A.4 and table 9A.26.

Relative stay index

The Steering Committee has identified the 'relative stay index' as an indicator of the efficiency of public hospitals (box 9.18). The 'relative stay index' for acute care patient days in public hospitals in 2002-03 was highest in the NT (1.16) and lowest in Victoria and Queensland (0.93) (figure 9.17). The 'relative stay index' by accommodation status and by medical, surgical and other AR-DRGs is reported in tables 9A.27 and 9A.28.

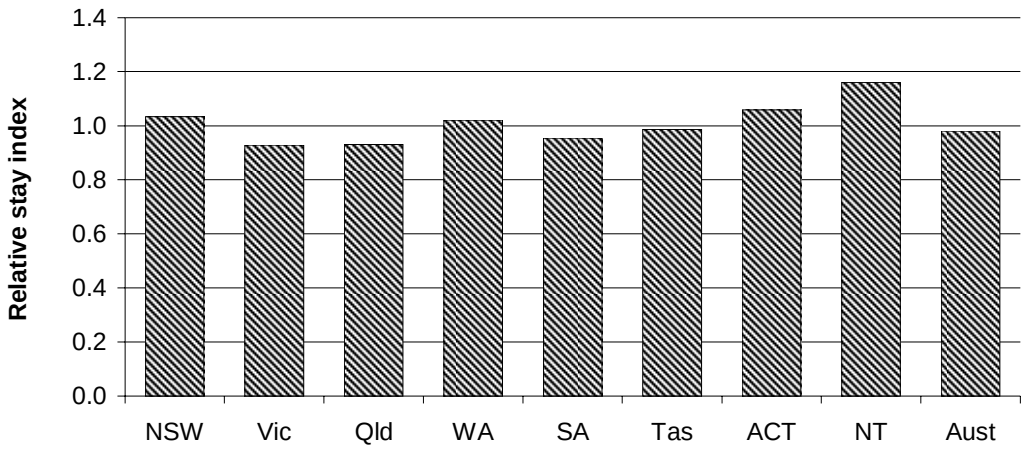
Box 9.18 **Relative stay index**

The 'relative stay index' is defined as the actual number of acute care patient days divided by the expected number of acute care patient days adjusted for casemix. Casemix adjustment allows comparisons to take account of variation in types of service provided but not other influences on length of stay, such as Indigenous status. Acute care separations only are included. Section 9.5 contains more detailed definition outlining exclusions from the analysis.

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

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

Figure 9.17 **Relative stay index, public hospitals, 2002-03[a, b]**



a Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement. **b** Based on all hospitals using the direct method.

Source: AIHW (2004a); table 9A.27.

Recurrent cost per non-admitted occasion of service

The Steering Committee has identified the 'recurrent cost per non-admitted occasion of service' as an indicator of the efficiency of public hospitals (box 9.19).

Jurisdictions able to supply 2002-03 data for this indicator reported the following results:

- In NSW, the emergency department cost per occasion of service was $171 for 2.0 million occasions, the outpatient cost per occasion of service was $79 for 10.1 million occasions and the overall cost per occasion of service was $87 for 18.5 million occasions (table 9A.60).
- In WA, the emergency department cost per occasion of service was $190 for 570 975 occasions, the outpatient cost per occasion of service was $98 for 2.6 million occasions and the overall cost per occasion of service was $100 for 4.2 million occasions (table 9A.75).
- In SA, the emergency department cost per occasion of service was $232 for 460 546 occasions, the outpatient cost per occasion of service was $160 for 1.3 million occasions and the overall cost per occasion of service was $179 for 1.7 million occasions (table 9A.80).
- In Tasmania, the emergency department cost per occasion of service was $222 for 92 132 occasions and the outpatient cost per occasion of service was $122 for 382 041 occasions (table 9A.83).
- In the ACT, the emergency department cost per occasion of service was $327 for 96 151 occasions, the outpatient cost per occasion of service was $68 for 493 650 occasions and the overall cost per occasion of service was $110 for 589 801 occasions (table 9A.86).

Box 9.19 **Recurrent cost per non-admitted occasion of service**

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

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

(Continued on next page)

Box 9.19 **(Continued)**

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

These data are not comparable across jurisdictions, given differences in practice. Reporting categories vary across jurisdictions, and further inconsistencies arise as a result of differences in outsourcing practices. In some cases, for example, outsourced occasions of service may be included in expenditure on non-admitted services, but not in the count of occasions of service. In addition, this indicator does not adjust for the complexity of service — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids (AIHW 2000).

Victoria collects data on the basis of cost per encounter. An encounter includes the clinic visit and all ancillary services provided within a 30 day period either side of the clinic visit. Based on cost data from 12–14 hospitals, the average cost per encounter was $125 in 2002-03 (table 9A.66).

Given the lack of a nationally consistent non-admitted patient classification system, the Review has included national data from the Australian Government Department of Health and Ageing's National Hospital Cost Data Collection (NHCDC) for 'cost per occasion of service for emergency departments' (table 9.20) and 'cost per occasion of service for outpatients' (table 9.21).

The NHCDC collects data on a consistent basis across a sample of hospitals that is expanding over time. The sample for each jurisdiction is not necessarily representative, however, because hospitals contribute data on a voluntary basis. The NHCDC data are affected by differences in costing and admission practices across jurisdictions and hospitals. In addition, the purpose of the NHCDC is to calculate between-DRG cost weights, not to compare the efficiency of hospitals. The emergency department data are based on figures provided by 139 public hospitals across Australia and the outpatient (tier 1) data are based on figures provided by 34 public hospitals. Outpatient tier 0 data were contributed by 137 public hospitals (table 9A.30). These data suggest that 'cost per occasion of service' for the public sector was $97 in 2002-03.

Table 9.20 **Emergency department average cost per occasion of service, public hospitals, by triage class, 2002-03 (dollars)[a, b, c, d, e]**

Triage category	*Population estimated — average cost per occasion of service* [f]	*Actual — average cost per occasion of service*
Admitted triage 1	772	783
Admitted triage 2	442	450
Admitted triage 3	388	394
Admitted triage 4	326	334
Admitted triage 5	254	266
Non-admitted triage 1	474	486
Non-admitted triage 2	365	373
Non-admitted triage 3	314	316
Non-admitted triage 4	231	230
Non-admitted triage 5	174	178
Did not wait[g]	74	74
Total	275	281

[a] Not all hospitals that submit data to the NHCDC submit emergency department data. The emergency department national database covers only acute hospitals with emergency department cost and activity. [b] Based on data from 139 public sector hospitals. [c] Victorian emergency department data are not included. Victoria is working to rectify this problem. [d] Costing and admission practices vary across jurisdictions and hospitals. [e] Depreciation costs are included. [f] Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. [g] 'Did not wait' means those presentations to an emergency department who were triaged but did not wait until the completion of their treatment, at which time they would have been either admitted to hospital or discharged home.

Source: DHA 2004a; table 9A.29.

Table 9.21 **Non-admitted clinic occasions of service for tier 1 clinics, sample results, public sector, Australia, 2002-03[a, b, c]**

	Occasions of service	*Average cost*
	no.	$/occasion of service
Allied health and/or clinical nurse specialist	762 018	75
Dental	12 663	133
Medical	830 758	244
Obstetrics and gynaecology	248 715	164
Paediatric	46 745	254
Psychiatric	38 859	229
Surgical	570 239	143
Total	2 509 997	161

[a] Includes depreciation costs. [b] Based on 33 public sector hospitals. [c] Excludes Victorian outpatient data.

Source: DHA 2004a; table 9A.31.

Outcomes

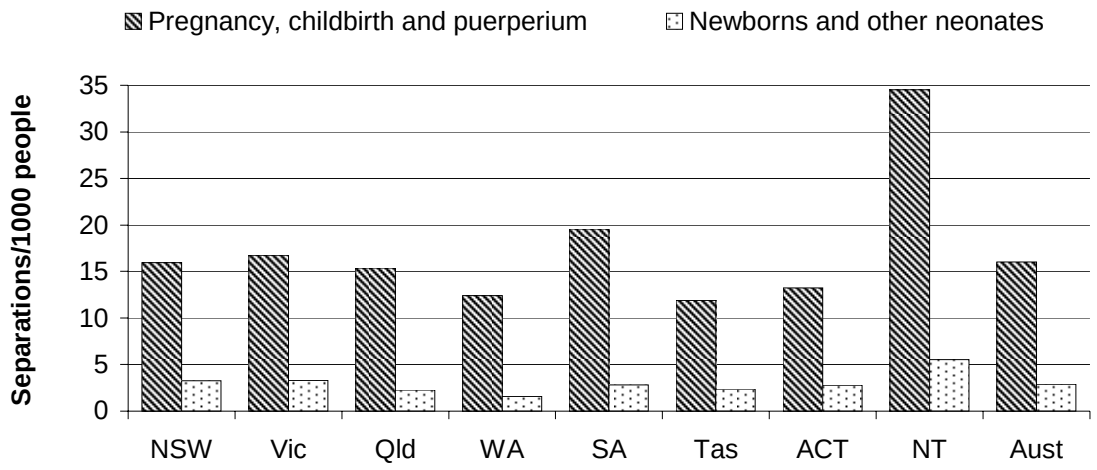
No outcome indicators are included for public hospitals in this Report. See section 9.4 for future directions for outcome indicators.

9.3 Maternity services

Profile

Maternity services (defined as AR-DRGs relating to pregnancy, childbirth and the puerperium, and newborns and other neonates) accounted for 9.4 per cent of total acute separations in public hospitals (table 9A.33) and around 10.1 per cent of the total cost of all acute separations in public hospitals in 2002-03 (table 9A.32). The NT had the highest rate of acute separations per 1000 people for maternity services (40.0) in 2002-03 and WA had the lowest (14.0) (figure 9.18).

Figure 9.18 **Separation rates for maternity services, public hospitals, 2002-03[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 1 year with admission weight of less than 2500 grams. **c** Separations for which the type of episode of care was reported as acute or newborn with qualified patient days or was not reported.

Source: AIHW (2004a); table 9A.33.

In Australian public hospitals in 2002-03, vaginal deliveries without complicating diagnosis accounted for a substantial proportion of the separations for pregnancy, childbirth and the puerperium (30.0 per cent). In the context of all AR-DRGs in public hospitals, vaginal deliveries without complicating diagnosis comprised the largest number of overnight acute separations (table 9.3) and the third highest cost ($245.6 million) (table 9A.34).

The complexity of cases across jurisdictions for maternity services is partly related to the mother's age at the time of giving birth. The mean age of mothers giving birth varied across jurisdictions in 2002 and 2003 (table 9.22).

Table 9.22 **Mean age of mothers at time of giving birth, public hospitals**

	NSW	*Vic*	*Qld* [a]	*WA*	*SA*	*Tas*	*ACT* [a]	*NT*
2002								
First birth	27.3	27.1	24.9	25.5	25.8	26.3	27.2	26.7
Second birth	29.6	29.5	27.7	28.0	28.6	28.1	29.3	27.1
Third birth	30.9	31.0	29.3	29.3	30.3	29.9	31.1	28.1
All births	29.2	29.1	27.4	27.7	28.1	28.6	28.9	27.5
2003								
First birth	27.5	27.4	25.2	25.8	26.0	26.6	na	24.8
Second birth	29.8	29.7	27.8	28.3	28.8	29.1	na	27.2
Third birth	31.1	31.2	29.6	29.8	30.5	30.2	na	28.2
All births	29.4	29.3	27.6	28.0	28.3	29.0	na	26.9

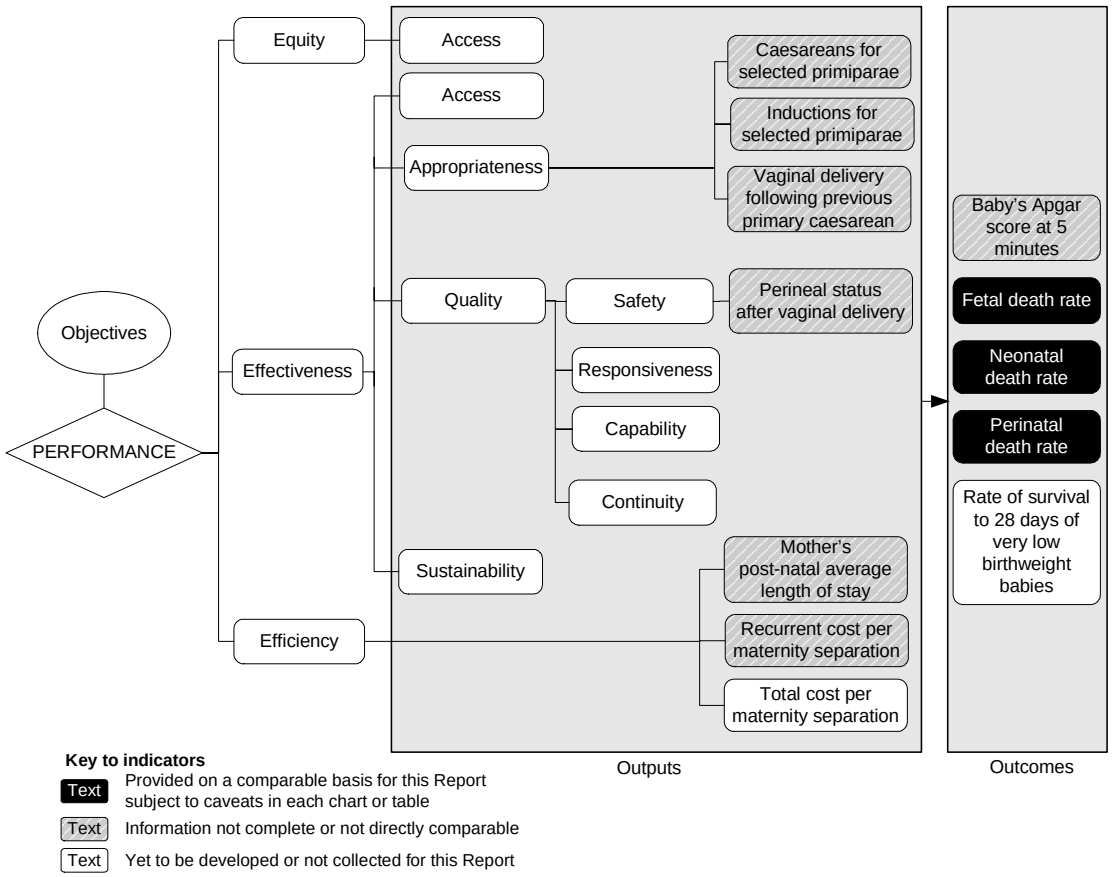
a Data are preliminary and subject to revision. **na** not available.

Source: State and Territory governments (unpublished).

Framework of performance indicators

The performance framework for maternity services is outlined in figure 9.19, and has the same objectives as those for public hospitals in general. The framework is under development by the Steering Committee and, as with all the performance indicator frameworks, will be subject to regular review. The performance indicator framework shows which data are comparable in the 2005 Report (figure 9.19). 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. The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability that have been added to the standard Review framework for health services.

Figure 9.19 **Performance indicators for maternity services**



Key performance indicator results

Outputs — equity

Access

The Steering Committee has identified equity of access as an area for development in future reports (box 9.20).

Box 9.20 **Equity of access**

An indicator of the equity of access to maternity services is yet to be developed.

Outputs — effectiveness

Access

The Steering Committee has identified the effectiveness of access to maternity services as an area for development in future reports (box 9.21).

Box 9.21 **Effectiveness of access**

An indicator of the effectiveness of access to maternity services is yet to be developed.

Appropriateness

The Steering Committee has developed two indicators of the appropriateness of maternity services: 'caesarean and induction rates for selected primiparae' (box 9.22) and the 'rate of vaginal delivery following primary caesarean' (box 9.23).

Caesareans and inductions for selected primiparae

Box 9.22 **Caesareans and inductions for selected primiparae**

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

'Caesareans and inductions for selected primiparae' are reported for women aged between 25–29 years who have had no previous deliveries, with a vertex presentation (that is, the crown of the baby's head is at the lower segment of the mother's uterus) and a gestation length of 37–41 weeks. This group is considered to be low risk parturients,[11] so caesarean or induction rates should be low in their population.

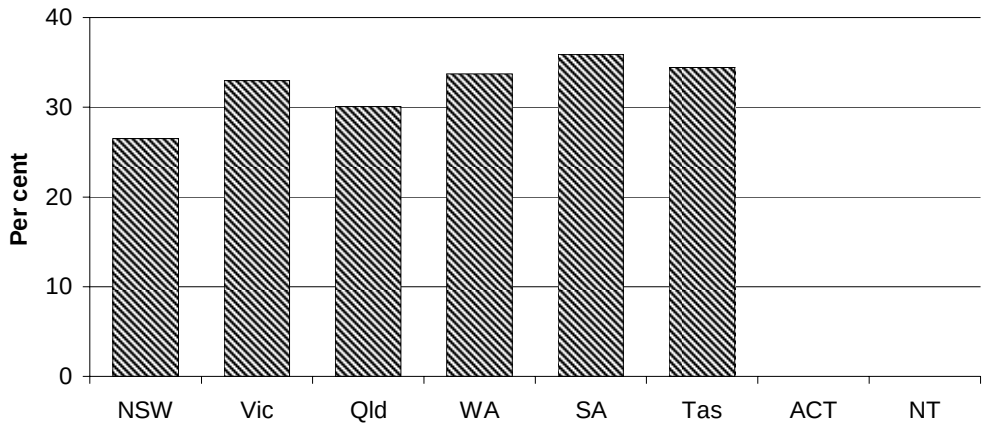
The indicator is defined as the number of inductions or caesareans for the selected primiparae divided by the number of the selected primiparae who give birth. High intervention rates may indicate a need for investigation.

In those jurisdictions that provided selected primiparae data for 2003, the proportion of selected primiparae whose deliveries were induced in public hospitals was highest in SA (35.9 per cent) and lowest in NSW (26.5 per cent) (figure 9.20). Induction rates for private hospitals are shown in table 9A.36 for comparison. They

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

are higher than the rate for public hospitals in all jurisdictions. Data for the ACT and NT for earlier years are included in tables 9A.43 and 9A.44.

Figure 9.20 **Inductions for selected primiparae, public hospitals, 2003[a]**

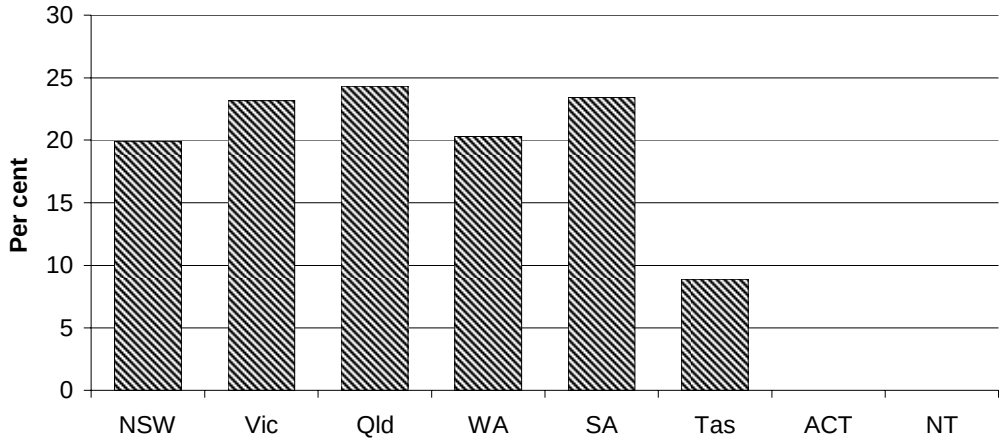


a 2003 data for the ACT and NT are not available. Data for Queensland are preliminary and subject to revision.

Source: State and Territory governments (unpublished); table 9A.36

In those jurisdictions that provided data for 2003, the proportion of selected primiparae whose deliveries were by caesarean section was highest in Queensland (24.3 per cent) and lowest in Tasmania (8.9 per cent) (figure 9.21). Caesarean rates for private hospitals are shown in table 9A.36 for comparison. They are higher than the rate for public hospitals in all jurisdictions. Data for the ACT and NT for earlier years are included in tables 9A.43 and 9A.44.

Figure 9.21 **Caesareans for selected primiparae, public hospitals, 2003[a]**



a 2003 data for the ACT and NT are not available. Data for Queensland are preliminary and subject to revision.

Source: State and Territory governments (unpublished); table 9A.36

Vaginal birth following previous primary caesarean

Box 9.23 **Vaginal birth following previous primary caesarean**

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

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

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

The data for 'vaginal birth following a primary caesarean' are sourced from the ACHS Comparative Report Service (Clinical Indicators) and collected for internal clinical review by individual hospitals. The ACHS data are predominantly used to demonstrate the potential for improvement across Australian hospitals if all hospitals could achieve the same outcomes as those of hospitals with the best outcomes for patients. Statewide conclusions cannot be drawn from the data because healthcare organisations contribute to the ACHS on a voluntary basis, so the data are not necessarily drawn from representative samples (box 9.8). Estimated rates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are particularly unreliable. Box 9.10 explains the reporting of the clinical indicators sourced from the ACHS.

New South Wales

Among those NSW public hospitals participating in the ACHS Comparative Report Service in 2003 the mean rate of 'vaginal delivery following a primary caesarean' was 18.7 per 100 deliveries (subject to a standard error of 0.5). The ACHS estimated that if the performance of all NSW public hospitals matched the performance of those at the 80th centile nationally, the rate of 'vaginal delivery following a primary caesarean' would be 2.3 per cent higher in that State (table 9.23). The terms in table 9.23 are defined in box 9.10.

Table 9.23 **Rate of vaginal delivery following primary caesarean per 100 deliveries, public hospitals, NSW, 2003[a, b]**

Hospitals	*Reports*	*Numerator (no. of VBACs)*	*Denominator (no. of deliveries)*	*Rate*	*Standard error* (±)
40	63	577	3 083	18.7	0.5
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. of VBACs)*	*Change represented by potential gains (%)*	*Potential outlier gains (no. of VBACs)*	*Potential stratum gains (no. of VBACs)*
21	14.9	70	2.3	–	220

VBAC = vaginal birth following primary caesarean. **a** Defined as the number of patients delivering vaginally following a previous primary caesarean section divided by the total number of patients delivering who had had a previous primary caesarean section and no intervening pregnancies of longer than 20 weeks gestation. **b** Health organisations contribute data voluntarily to the ACHS, so the samples are not necessarily representative of all hospitals in each jurisdiction. **–** Nil or rounded to zero.

Source: ACHS (unpublished); table 9A.45.

Victoria

Among those Victorian public hospitals participating in the ACHS Comparative Report Service in 2003, the mean rate of 'vaginal delivery following a primary caesarean' was 17.9 per 100 deliveries (subject to a standard error of 0.7). The ACHS estimated that if the performance of all Victorian public hospitals matched the performance of those at the 80th centile nationally, the rate of 'vaginal delivery following a primary caesarean' would be 3.1 per cent higher in that State (table 9.24). The terms in table 9.24 are defined in box 9.10.

Table 9.24 **Rate of vaginal delivery following primary caesarean per 100 deliveries, public hospitals, Victoria, 2003[a, b]**

Hospitals	*Reports*	*Numerator (no. of VBACs)*	*Denominator (no. of deliveries)*	*Rate*	*Standard error* (±)
20	34	295	1 646	17.9	0.7
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. of VBACs)*	*Change represented by potential gains (%)*	*Potential outlier gains (no. of VBACs)*	*Potential stratum gains (no. of VBACs)*
21.0	14.9	50	3.1	–	104

VBAC = vaginal birth following primary caesarean. **a** Defined as the number of patients delivering vaginally following a previous primary caesarean section divided by the total number of patients delivering who had had a previous primary caesarean section and no intervening pregnancies of longer than 20 weeks gestation. **b** Health organisations contribute data voluntarily to the ACHS, so the samples are not necessarily representative of all hospitals in each jurisdiction. **–** Nil or rounded to zero.

Source: ACHS (unpublished); table 9A.46.

Queensland

Among those Queensland public hospitals participating in the ACHS Comparative Report Service in 2003, the mean rate of 'vaginal delivery following a primary caesarean' was 16.2 per 100 deliveries (subject to a standard error of 0.8 per cent). The ACHS estimated that if the performance of all Queensland public hospitals matched the performance of those at the 80th centile nationally, the rate of 'vaginal delivery following a primary caesarean' would be 4.8 per cent higher in that State (table 9.25). The terms in table 9.25 are defined in box 9.10.

Table 9.25 **Rate of vaginal delivery following primary caesarean per 100 deliveries, public hospitals, Queensland, 2003[a, b]**

Hospitals	*Reports*	*Numerator (no. of VBACs)*	*Denominator (no. of deliveries)*	*Rate*	*Standard error* (±)
9	15	217.0	1 337.0	16.2	0.8
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. of VBACs)*	*Change represented by potential gains (%)*	*Potential outlier gains (no. of VBACs)*	*Potential stratum gains (no. of VBACs)*
21.0	14.9	64.0	4.8	–	62.0

VBAC = vaginal birth following primary caesarean. **a** Defined as the number of patients delivering vaginally following a previous primary caesarean section divided by the total number of patients delivering who had had a previous primary caesarean section and no intervening pregnancies of longer than 20 weeks gestation. **b** Health organisations contribute data voluntarily to the ACHS, so the samples are not necessarily representative of all hospitals in each jurisdiction. **–** Nil or rounded to zero.

Source: ACHS (unpublished); table 9A.47.

Western Australia

Among those WA public hospitals participating in the ACHS Comparative Report Service in 2003, the mean rate of 'vaginal delivery following a primary caesarean' was 13.5 per 100 deliveries (subject to a standard error of 0.9 per cent). The ACHS estimated that if the performance of all WA public hospitals matched the performance of those at the 80th centile nationally, the rate of 'vaginal delivery following a primary caesarean' would be 7.5 per cent higher in that State (table 9.26). The terms in table 9.26 are defined in box 9.10.

Table 9.26 **Rate of vaginal delivery following primary caesarean per 100 deliveries, public hospitals, WA, 2003[a, b]**

Hospitals	*Reports*	*Numerator (no. of VBACs)*	*Denominator (no. of deliveries)*	*Rate*	*Standard error* (±)
11	17	148	1 097	13.5	0.9
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. of VBACs)*	*Change represented by potential gains (%)*	*Potential outlier gains (no. of VBACs)*	*Potential stratum gains (no. of VBACs)*
21.0	14.9	82	7.5	–	21

VBAC = vaginal birth following primary caesarean. **a** Defined as the number of patients delivering vaginally following a previous primary caesarean section divided by the total number of patients delivering who had had a previous primary caesarean section and no intervening pregnancies of longer than 20 weeks gestation. **b** Health organisations contribute data voluntarily to the ACHS, so the samples are not necessarily representative of all hospitals in each jurisdiction. **–** Nil or rounded to zero.

Source: ACHS (unpublished); table 9A.48.

South Australia

Among those SA public hospitals participating in the ACHS Comparative Report Service in 2003, the mean rate of 'vaginal delivery following a primary caesarean' was 28.9 per 100 deliveries (subject to a standard error of 1.1 per cent). The ACHS estimated that if the performance of all SA public hospitals matched the performance of those at the 80th centile nationally, the rate of 'vaginal delivery following a primary caesarean' would be 7.9 per cent lower in that State (table 9.27). The terms in table 9.27 are defined in box 9.10.

Table 9.27 **Rate of vaginal delivery following primary caesarean per 100 deliveries, public hospitals, SA, 2003[a, b]**

Hospitals	*Reports*	*Numerator (no. of VBACs)*	*Denominator (no. of deliveries)*	*Rate*	*Standard error* (±)
7	12	194	671	28.9	1.1
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. of VBACs)*	*Change represented by potential gains (%)*	*Potential outlier gains (no. of VBACs)*	*Potential stratum gains (no. of VBACs)*
21.0	14.9	–53	–7.9	–	116

VBAC = vaginal birth following primary caesarean. **a** Defined as the number of patients delivering vaginally following a previous primary caesarean section divided by the total number of patients delivering who had had a previous primary caesarean section and no intervening pregnancies of longer than 20 weeks gestation. **b** Health organisations contribute data voluntarily to the ACHS, so the samples are not necessarily representative of all hospitals in each jurisdiction. **–** Nil or rounded to zero.

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

Australia

Data for Tasmania, the ACT and the NT are not published separately because fewer that five hospitals reported to the ACHS Comparative Report Service in each of those jurisdictions. Nationally, among those public hospitals participating in the ACHS Comparative Report Service in 2003, the mean rate of 'vaginal delivery following a primary caesarean' was 18.1 per 100 deliveries. The ACHS estimated that if the performance of all Australian public hospitals matched the performance of the top 20 per cent of public hospitals, the rate of 'vaginal delivery following a primary caesarean' would be 2.8 per cent higher.

Quality

The Steering Committee has identified four subdimensions of quality for health services: safety; responsiveness; capability; and continuity. For maternity services, data are reported against the subdimension of safety only.

Safety

Perineal status after vaginal delivery

The Steering Committee has identified 'perineal status after vaginal delivery' as an indicator of the safety of maternity services in public hospitals (box 9.24).

Box 9.24 **Perineal status after vaginal delivery**

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

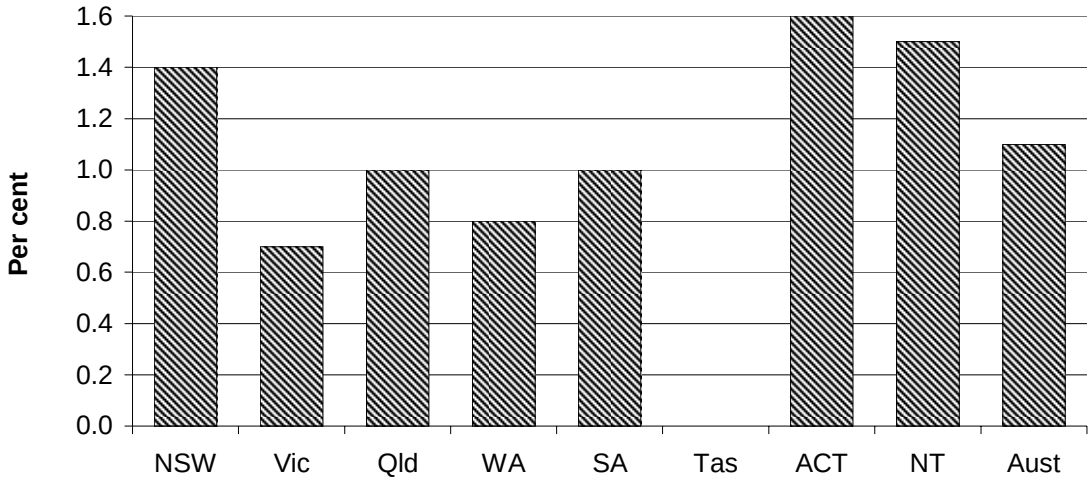
'Perineal status after vaginal delivery' is the state of the perineum following a vaginal birth (NHDC 2003). A third or fourth degree laceration is a perineal laceration or rupture (or tear following episiotomy) extending to at least the anal sphincter (NCCH 1998) (see section 9.5).

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.

In 2001, a third or fourth degree laceration occurred in 1.1 per cent of mothers nationally. Data were not available for Tasmania, but across other jurisdictions, the

proportion ranged from 1.6 per cent in the ACT to 0.7 per cent in Victoria (figure 9.22). More information on 'perineal status after vaginal delivery' (including the proportion of mothers with intact perineums following vaginal deliveries) is contained in attachment table 9A.35.

Figure 9.22 **Perineal status — mothers with third or fourth degree lacerations after vaginal delivery, all hospitals, 2001[a, b]**



a For multiple births, the perineal status after delivery of the first born child was used. **b** Data for Tasmania are not available.

Source: AIHW NPSU perinatal data collection (unpublished); table 9A.35.

Responsiveness

The Steering Committee has identified the responsiveness of maternity services as an area for development in future reports (box 9.25).

Box 9.25 **Responsiveness**

There is currently no indicator for the responsiveness of maternity services, but the patient satisfaction surveys reported on earlier in this chapter generally cover maternity patients.

Capability

The Steering Committee has identified the capability of maternity services as an area for development in future reports (box 9.26).

Box 9.26 **Capability**

There is currently no indicator for the capability of maternity services.

Continuity

The Steering Committee has identified the continuity of care provided by maternity services as an area for development in future reports (box 9.27).

Box 9.27 **Continuity**

There is currently no indicator of the continuity of care provided by maternity services.

Sustainability

The Steering Committee has identified the sustainability of maternity services as an area for development in future reports (box 9.28).

Box 9.28 **Sustainability**

There is currently no indicator of the sustainability of maternity services.

Outputs — efficiency

Recurrent cost per maternity separation

The Steering Committee has identified 'recurrent cost per maternity separation' as an indicator of the efficiency of maternity services in public hospitals (box 9.29).

'Recurrent cost per maternity separation' (for caesarean delivery without complicating diagnosis and for vaginal delivery without complicating diagnosis) is shown in figure 9.23. Data for a number of other maternity related AR-DRGs are shown in table 9A.55. Data are sourced from the NHCDC. As noted in section 9.2, the NHCDC is a voluntary annual collection, the purpose of which is to calculate between-DRG cost weights. The samples are not necessarily representative of the set of hospitals in each jurisdiction.

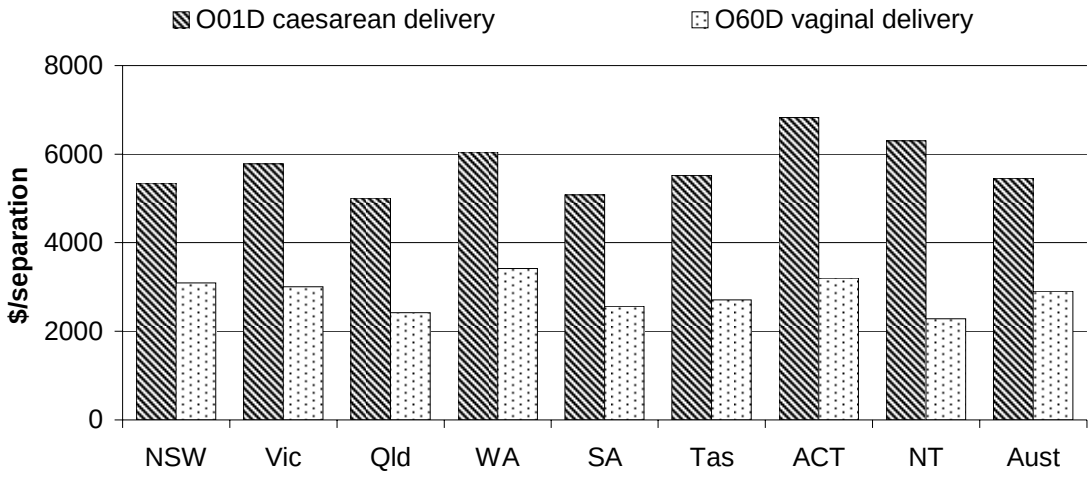
Box 9.29 **Recurrent cost per maternity separation**

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

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

Nationally, the 'recurrent cost per maternity separation' for caesarean delivery without complications in public hospitals was $5456 in 2002-03 (figure 9.23). Across jurisdictions, the highest average cost was in the ACT ($6833) and the lowest was in Queensland ($5009). The 'recurrent cost per maternity separation' for vaginal delivery without complications was $2899 nationally in 2002-03. Across jurisdictions, it was highest in WA ($3416) and lowest in the NT ($2283).

Figure 9.23 **Estimated average cost per separation for selected maternity-related AR-DRGs, public hospitals, 2002-03**[a, b, c]



a Includes AR-DRG O01D caesarean delivery without complicating diagnosis and AR-DRG O60D vaginal delivery without complicating diagnosis. **b** Average cost is affected by a number of factors including admission practices, sample size, remoteness and the types of hospital contributing to the collection. Direct comparisons between jurisdictions are difficult because there are differences in hospital costing systems. **c** In accordance with NHCDC methodology, depreciation and some capital costs are included in these data, except for Victoria which does not include depreciation.

Source: DHA 2004a; table 9A.55.

Total cost per maternity separation

The Steering Committee has identified the 'total cost per maternity separation' as an indicator of the efficiency of public hospital maternity services, but no data are available (box 9.30).

Box 9.30 **Total cost per maternity separation**

A method for calculating the capital cost component of the 'total cost per maternity separation' indicator has not yet been determined, so no data can be reported.

Mother's average length of stay

The Steering Committee has identified 'mother's average length of stay in hospital' as an indicator of the efficiency of maternity services in public hospitals (box 9.31).

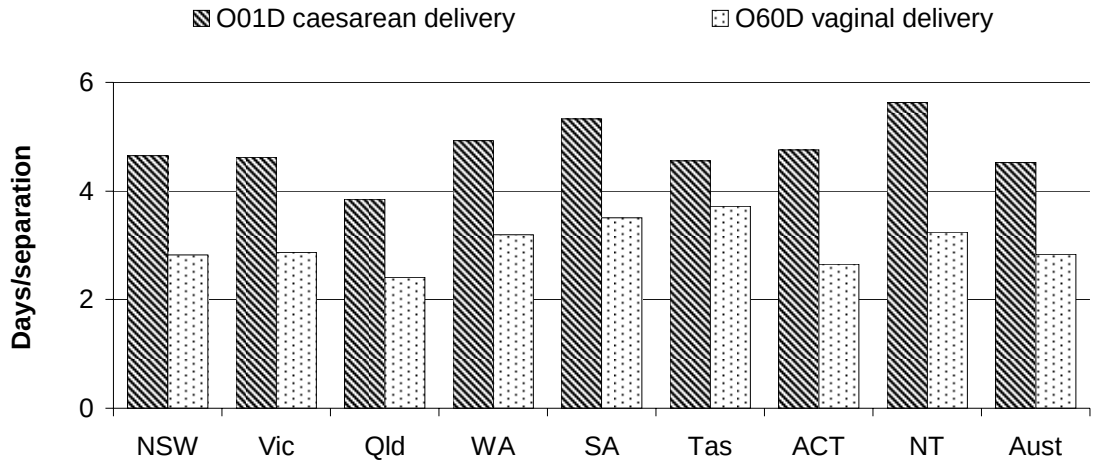
Box 9.31 **Mother's average length of stay**

A 'mother's average length of stay' in hospital is an indicator of efficiency. It is reported for two common maternity AR-DRGs: caesarean delivery without complications and vaginal delivery without complications.

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

The 'mother's average length of stay' for caesarean delivery without complications was 4.5 days for Australia in 2002-03. The longest average length of stay was in the NT (5.6 days) and the shortest was in Queensland (3.9 days). Nationally, the average length of stay for vaginal delivery without complications in 2002-03 was 2.8 days. The longest average length of stay was in Tasmania (3.7 days) and the shortest was in Queensland (2.4 days) (figure 9.24).

Figure 9.24 **Average length of stay for selected maternity-related AR-DRGs, public hospitals, 2002-03[a, b, c]**



a Includes AR-DRG O01D caesarean delivery without complicating diagnosis and AR-DRG O60D vaginal delivery without complicating diagnosis. **b** Average cost is affected by a number of factors including admission practices, sample size, remoteness and the types of hospital contributing to the collection. Direct comparisons between jurisdictions are difficult because there are differences in hospital costing systems. **c** In accordance with NHCDC methodology, depreciation and some capital costs are included in these data, except for Victoria which does not include depreciation.

Source: DHA 2004a; table 9A.55.

Outcomes

Apgar score

The Steering Committee has identified the 'Apgar score of babies at five minutes after birth' as an indicator of the outcomes of maternity services (box 9.32).

Table 9.28 illustrates the relationship between low birth weight and a low Apgar score. Of those jurisdictions that provided data in 2003, the NT had the highest proportion of babies weighing less than 1500 grams and reporting an Apgar score of 3 or less, five minutes after delivery (23.3 per cent), while Tasmania reported the smallest proportion (5.8 per cent). For babies weighing 1500–1999 grams, the NT reported the highest proportion of babies with an Apgar score of 3 or less (3.6 per cent) and SA reported the lowest (zero). For other birthweights, Apgar scores of 3 or less were relatively rare, and the proportion was fairly similar across all jurisdictions (equal to or less than 1 per cent). In the NT, the rates were considerably higher, at 1.9 per cent for babies of 2000-2499 grams and 0.5 per cent for babies weighing 2500 grams and over.

Box 9.32 **Baby's Apgar score at five minutes**

The Apgar score is a numerical score that indicates a baby's condition shortly after birth. The future health of babies with lower Apgar scores is often poorer than those with higher scores. The management of labour and resuscitation in hospitals can influence Apgar scores.

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

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

Table 9.28 **Live births with an Apgar score of 3 or lower, five minutes post-delivery, public hospitals, 2003**

Birthweight (grams)	*Unit*	*NSW*	*Vic*	*Qld*[a]	*WA*	*SA*	*Tas*	*ACT*	*NT*
Less than 1500	no.	787	539	481	208	191	52	na	47
Low Apgar	%	13.5	19.3	11.0	7.7	12.0	5.8	na	23.3
1500–1999	no.	913	627	492	251	204	66	na	53
Low Apgar	%	0.9	1.8	1.6	1.6	–	1.5	na	3.6
2000–2499	no.	2 596	1 878	1 444	712	534	133	na	210
Low Apgar	%	0.5	0.4	0.3	0.7	1.1	0.8	na	1.9
2500 and over	no.	60 606	40 478	31 667	13 300	11 715	2 901	na	2 539
Low Apgar	%	0.1	0.1	0.2	0.1	0.1	0.2	na	0.5

a Data are preliminary and subject to revision. **na** Not available. **–** Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 9A.50.

Fetal death rate

The Steering Committee has identified the 'fetal death rate' as an indicator of the outcomes of maternity services (box 9.33).

Box 9.33 **Fetal death rate**

Fetal death (stillbirth) is the birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths by definition include only infants weighing at least 400 grams or of a gestational age of at least 20 weeks. The rate of fetal deaths is expressed per 1000 total births.

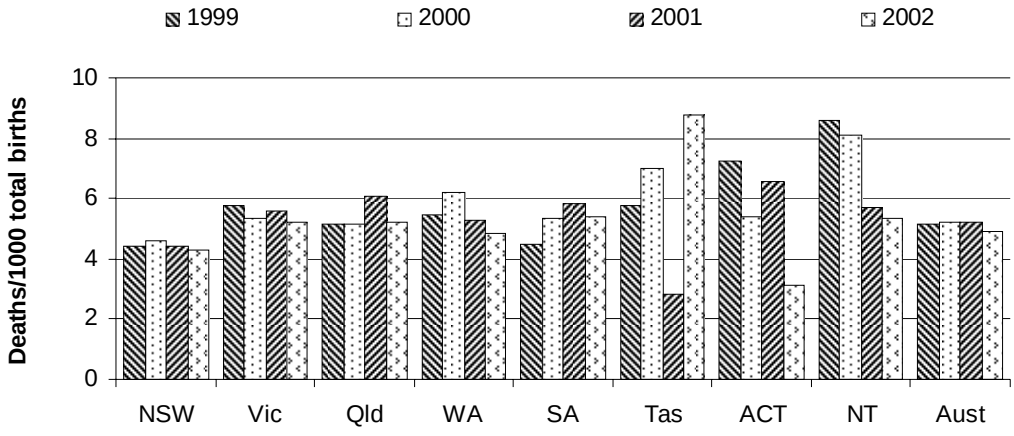
'Fetal death rate' is reported as an indicator because maternity services for admitted patients have some potential to reduce the likelihood of fetal deaths. This potential is limited, however, and other factors (such as the health of mothers and the progress of pregnancy before hospital admission) are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

The 'fetal death rate' is calculated as the number of fetal deaths divided by the total number of births (live births and fetal deaths combined), by State or Territory of usual residence of the mother. Low fetal death rates may indicate high quality maternity services. In jurisdictions where the number of fetal deaths is low, small annual fluctuations in the number affect the annual rate of fetal deaths.

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

In 2002, the national 'fetal death rate' was 4.9 per 1000 births. Across jurisdictions it was highest in Tasmania (8.8 deaths per 1000 births) and lowest in the ACT (3.2 deaths per 1000 births) (figure 9.25). The national 'fetal death rate' for babies of Indigenous mothers in 2002 was 6.6 per 1000 births (table 9A.51).

Figure 9.25 **Fetal death rate[a, b]**



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

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

Neonatal death rate

The Steering Committee has identified the 'neonatal death rate' as an indicator of the outcomes of maternity services (box 9.34).

Box 9.34 **Neonatal death rate**

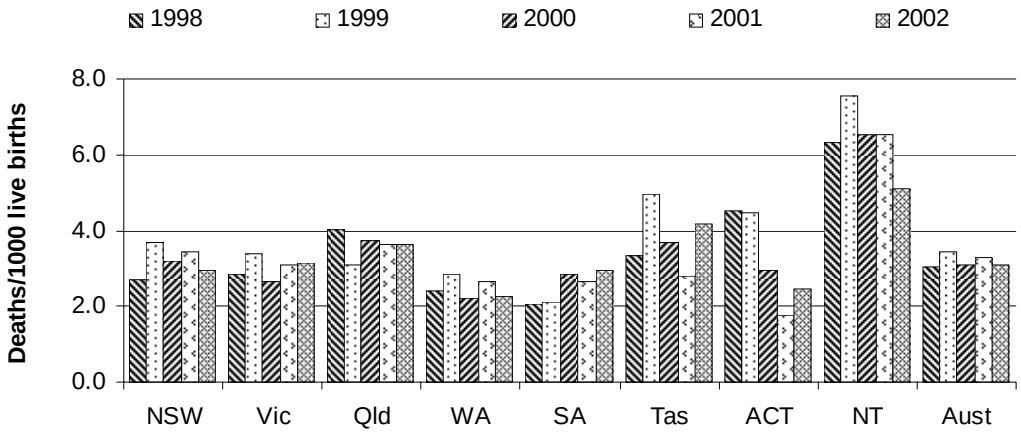
As for fetal deaths, a range of factors contribute to neonatal deaths. The influence of maternity services for admitted patients, however, is greater for neonatal deaths than for fetal deaths, through the management of labour and the care of sick and premature babies.

Neonatal death is the death of a live born infant within 28 days of birth (see section 9.5 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 in which the mother usually resides. This indicator is reported by the Indigenous status of the mother.

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

In 2002, the national 'neonatal death rate' was 3.1 deaths per 1000 live births. Across jurisdictions, the rate was highest in the NT (5.1 deaths per 1000 live births) and lowest in WA (2.2 deaths per 1000 live births) (figure 9.26). The national 'neonatal death rate' for babies of Indigenous mothers in 2002 was 4.8 per 1000 births (table 9A.53).

Figure 9.26 **Neonatal death rate[a, b]**



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

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

Perinatal death rate

The Steering Committee has identified the 'perinatal death rate' as an indicator of the outcomes of maternity services (box 9.35).

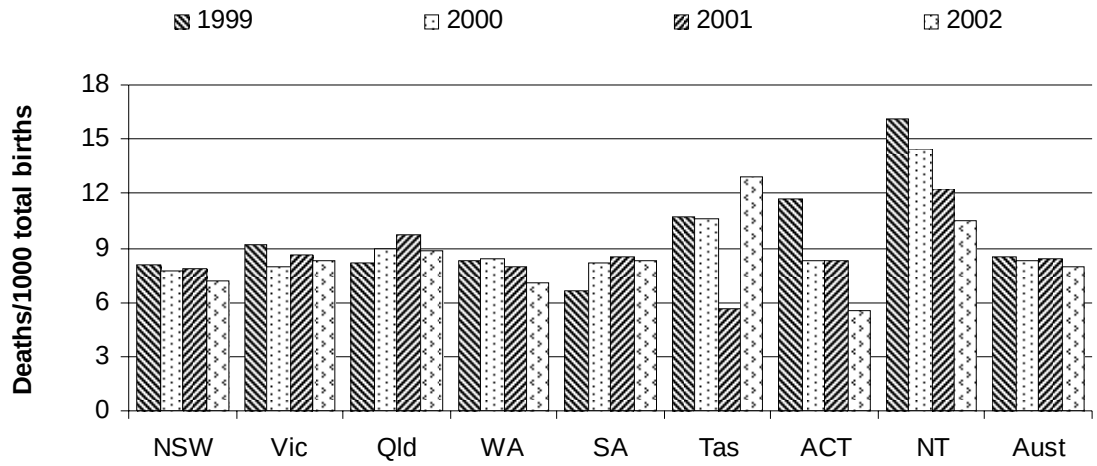
Box 9.35 **Perinatal death rate**

A perinatal death is a fetal or neonatal death (boxes 9.33 and 9.34). The caveats that apply to fetal and neonatal death rates also apply to perinatal death rates.

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

In 2002, the national 'perinatal death rate' was 8.0 deaths per 1000 total births. Across jurisdictions, the rate was highest in Tasmania (12.9 deaths per 1000 total births) and lowest in the ACT (5.6 deaths per 1000 total births) (figure 9.27). The national 'perinatal death rate' for babies of Indigenous mothers was 11.3 deaths per 1000 total births (table 9A.52). Time series data for neonatal, fetal and perinatal death rates are included in table 9A.52.

Figure 9.27 **Perinatal death rate[a, b]**



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

Source: ABS (unpublished); table 9A.54.

Rate of survival to 28 days of very low birthweight babies

The Steering Committee has identified the 'rate of survival to 28 days of very low birthweight babies' as an indicator of the outcomes of maternity services (box 9.36). No data for this indicator are currently available.

Box 9.36 **Rate of survival to 28 days of very low birthweight babies**

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

9.4 Future directions in performance reporting

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

- improving the comprehensiveness of reporting by filling in gaps in the performance indicator frameworks. Important gaps in reporting for public hospitals include indicators of outcomes, indicators of equity of access to services for special needs groups (particularly Indigenous people), indicators of continuity of care and indicators of sustainability. Gaps in the maternity services

framework include three aspects of quality — responsiveness, capability and continuity — and the effectiveness subdimension of sustainability.

- improving currently reported indicators for public hospitals and maternity services where data are not complete or not directly comparable. There is scope to improve reporting of the quality and access dimensions of the public hospitals framework, and the output indicators for maternity services.

In preparation for the 2006 Report, the Steering Committee will commence a 'stocktake' of the performance indicators reported in the health chapters. This exercise will aim to improve the coordination of performance indicators across the health chapters and to address the remaining gaps in reporting against the Review's performance framework.

Quality indicators for public hospitals

The Steering Committee has previously elucidated its concerns about the paucity of comparable performance information on the quality of care provided by Australian public hospitals. Consequently, the Steering Committee convened a workshop in July 2004, to examine indicators of quality for Australian public hospitals. The workshop was organised jointly by the Steering Committee for the Review and the Australian Council for Safety and Quality in Health Care (ACSQHC). It was supported by the Australian Health Ministers Advisory Council and the National Health Performance Committee. Over 30 health administrators and professionals from around Australia attended and contributed to the discussions.

The aim of the workshop was to consider new performance indicators of public hospital quality for this Report. The Steering Committee will examine a number of options, including those outlined below, for long term development.

Patient satisfaction (or experience) survey

The most popular proposal raised at the workshop was a nationally consistent patient satisfaction (or experience) survey. This would need to augment or replace current local or small scale patient surveys. It would need to be consistent with other clinical and hospital data collection processes and to have the full support of all jurisdictions' health sectors. International examples and research (such as by the World Health Organisation) could provide a model for developing a national patient survey for Australia.

Augmenting hospital accreditation reporting

Workshop participants discussed ways of building on existing hospital accreditation data and processes. This work would extend the accreditation data currently reported in the Review to also discuss 'how' hospitals meet accreditation standards. It would involve reporting, for example, whether hospitals exceed accreditation standards by a large or small margin, or whether they practice 'continuous improvement'. The ACSQHC is examining hospital accreditation processes to explore how safety and quality can be improved through this system.

Hospital safety — adverse events and sentinel events

Workshop participants also discussed options for reporting hospital incident data, including (but not limited to) adverse event data and sentinel event data. In 2004, the AIHW reported the number of separations with external causes for adverse events as a performance indicator of the safety of hospital services (AIHW 2004a). Adverse events are defined as incidents in which harm resulted to a person receiving healthcare. They include infections, falls and other injuries, and medication and medical device problems, some of which may be preventable. The data do not incorporate all adverse events that occurred in hospitals, but represent a selection that have resulted in, or affected, hospital admissions. The data are not yet reported by jurisdiction, and are not comparable over time because recording practices are inconsistent. In addition, there is no adjustment for risk. In 2002-03, there were 209 140 separations with an adverse event (5.1 per 100 separations) in Australian public hospitals (AIHW 2004a).

All Australian health ministers have agreed on a national core set of sentinel events, which are defined as those adverse events that cause serious harm to patients and that have the potential to seriously undermine public confidence in the healthcare system (box 9.37). By the end of 2005, all public hospitals are to report the agreed national core set and contribute to a national report on sentinel events. Victoria is the only State that has reported sentinel events publicly so far. Sentinel events data would be a valuable addition to this Report as an indicator of hospital quality and safety.

Box 9.37 **Agreed national core set of sentinel events**

1. Procedures involving the wrong patient or body part
2. Suicide of a patient in an inpatient unit
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure
4. Intravascular gas embolism resulting in death or neurological damage
5. Haemolytic blood transfusion reaction resulting from ABO (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 wrong family

Source: ACSQHC (2002).

9.5 Definitions of key terms and indicators

Accreditation	Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals may seek accreditation through the ACHS Evaluation and Quality Improvement Program, the Australian Quality Council (now known as Business Excellence Australia), the Quality Improvement Council, the International Organisation for Standardization 9000 Quality Management System or other equivalent programs.
Acute care	Clinical services provided to admitted or non-admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.
Admitted patient	A patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients may receive acute, sub-acute or non-acute care services.
Allied health (non-admitted)	Occasions of service to non-admitted patients at units/clinics providing treatment/counselling to patients. These include units providing physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy.
Apgar score	Numerical score used to evaluate a baby's condition after birth. The definition of the indicator is the number of babies born with an Apgar score of 3 or lower at 5 minutes post-delivery, as a proportion of the total number of babies born. Excludes fetal deaths in utero before commencement of labour.
AR-DRG	Australian Refined Diagnosis Related Group — a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG versions 4.1 and 4.2 are based on the ICD-10-AM classification.
Average length of stay	The mean length of stay for all patient episodes, calculated by dividing total occupied bed days by total episodes of care.
Caesarean section	Operative birth through an abdominal incision.
Casemix adjusted	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted by AR-DRG into categories of patients with similar clinical conditions and requiring similar hospital services. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.
Casemix-adjusted separations	The number of separations adjusted to account for differences across hospitals in the complexity of episodes of care.
Catastrophic	An acute or prolonged illness usually considered to be life threatening or with the threat of serious residual disability. Treatment may be radical and is frequently costly.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Cost of capital	The return foregone on the next best investment, estimated at a rate of 8 per cent of the depreciated replacement value of buildings, equipment and land. Also called the 'opportunity cost' of capital.
Cost per casemix-adjusted separation	Recurrent expenditure multiplied by the inpatient fraction and divided by the total number of casemix-adjusted separations plus estimated private patient medical costs.

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

Non-acute episode of care	Clinical services provided to admitted and non-admitted patients, including planned geriatric respite, palliative care, geriatric evaluation and management and services for nursing home type patients. Clinical services delivery by designated psychiatric or psychogeriatric units, designated rehabilitation units and mothercraft services are also considered non-acute.
Non-admitted occasions of service	Clinical services provided by hospitals to non-admitted patients. Services may include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.
Non-admitted patient	A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.
Perinatal death	Fetal death or neonatal death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Perinatal death rate	Perinatal deaths divided by the total number of births (that is, live births registered and fetal deaths combined).
Perineal laceration (third or fourth degree)	A 'third degree' laceration or rupture during birth (or a tear following episiotomy) involves the anal sphincter, rectovaginal septum and sphincter NOS. A 'fourth degree' laceration, rupture or tear also involves the anal mucosa and rectal mucosa (NCCH 1998).
Perineal status	The state of the perineum following a birth.
Primary care	Essential healthcare based on practical, scientifically sound and socially acceptable methods made universally accessible to individuals and families in the community.
Primipara	Pregnant woman who has had no previous pregnancy resulting in a live birth or a still birth.
Public hospital	A hospital that provides free treatment and accommodation to eligible admitted persons who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and may provide (and charge for) treatment and accommodation services to private patients. Charges to non-admitted patients and admitted patients on discharge may be levied in accordance with the Australian Health Care Agreements (for example, aids and appliances).
Puerperium	The period or state of confinement after labour.
Real expenditure	Actual expenditure adjusted for changes in prices.
Relative stay index	The actual number of acute care patient days divided by the expected number of acute care patient days, adjusted for casemix. Includes acute care separations only. Excludes: separations for renal dialysis and chemotherapy (because they are overwhelmingly same day); AR-DRGs with a length of stay component in the definition; rehabilitation AR-DRGs; error AR-DRGs 960Z, 961Z, 962Z and 963Z; separations of patients who died or were transferred within two days of admission; and separations with a length of stay greater than 120 days.
Same day patients	A patient whose admission date is the same as the separation date.

Sentinel events	Adverse events that cause serious harm to patients and that have the potential to undermine public confidence in the healthcare system.
Separation	A total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change in the type of care for an admitted patient (for example, from acute to rehabilitation). Includes admitted patients who receive same day procedures (for example, renal dialysis).
Separation rate	Hospital separations per 1000 people or 100 000 people.
Selected primipara	Primipara with no previous deliveries, aged 25–29 years, singleton, vertex presentation and gestation of 37–41 weeks (inclusive).
Sub-acute and non-acute care	Clinical services provided to patients suffering from chronic illnesses or recovering from such illnesses. Services include rehabilitation, planned geriatric care, palliative care, geriatric care evaluation and management, and services for nursing home type patients. Clinical services delivered by designated psychogeriatric units, designated rehabilitation units and mothercraft services are considered non-acute.
Surgical site infection rate for selected surgical procedures	The number of surgical site infections for a selected procedure (hip and knee prosthesis, lower segment caesarean section or abdominal hysterectomy) performed during the surveillance period divided by the total number of the selected procedure performed during the surveillance period.
Triage category	The urgency of the patient's need for medical and nursing care: category 1 — resuscitation (immediate within seconds) category 2 — emergency (within 10 minutes) category 3 — urgent (within 30 minutes) category 4 — semi-urgent (within 60 minutes) category 5 — non-urgent (within 120 minutes).
Unplanned hospital re-admission	An unexpected hospital admission for treatment of: the same condition for which the patient was previously hospitalised; a condition related to one for which the patient was previously hospitalised; or a complication of the condition for which the patient was previously hospitalised.
Unplanned hospital re-admission rate	The number of unplanned re-admissions to the same hospital within 28 days of separation, during the time period under study, divided by the total number of separations (excluding deaths) for the same time period, including day stay patients.
Urgency category for elective surgery	Category 1 patients — admission is desirable within 30 days for a condition that has the potential to deteriorate quickly to the point that it may become an emergency. Category 2 patients — admission is desirable within 90 days for a condition that is causing some pain, dysfunction or disability, but that is not likely to deteriorate quickly or become an emergency. Category 3 patients — admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, that is unlikely to deteriorate quickly and that does not have the potential to become an emergency.

9.6 References

ACSQHC (Australian Council for Safety and Quality in Health Care) 2002, *Safety Through Action: Improving Patient Safety in Australia*, Third report to the Australian Health Ministers Conference, 19 July.

ACHS (Australian Council for Healthcare Standards) 2001, *Determining the Potential to Improve the Quality of Care in Australian Health Care Organisations: Results from the ACHS Clinical Indicator Data 1998-2000*, Ultimo, NSW.

—— 2002, *Clinical Indicator Users' Manual 2002*, Ultimo, NSW.

—— 2003, *Determining the Potential to Improve Quality of Care*, Ultimo, NSW.

AIHW (Australian Institute of Health and Welfare) 2000, 2001a, 2002a, 2003a, 2004a, *Australian Hospital Statistics*, AIHW, Canberra.

—— 2001b, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, AIHW Cat. no. 7, Canberra.

—— 2002b, 2003b, 2004b, *Health Expenditure Australia*, AIHW, Canberra.

—— 2002c *Waiting Times for Elective Surgery in Australia 1999-00*, AIHW Cat. no. HSE 18, Health Services Series no. 18, Canberra.

ATSIHWIU (Aboriginal and Torres Strait Islander Health and Welfare Information Unit) 1999, *Assessing the Quality of Identification of Aboriginal and Torres Strait Islander People in Hospital Data*, AHMAC, AIHW and ABS, Canberra.

Brennan, T.A., Leape, L.L. and Laird, N.M., 1991, 'Incidence of adverse events and negligence in hospitalised patients: results of the Harvard medical practice study I', *New England Journal of Medicine*, vol. 324, pp. 370–6.

Davis, P., Lay-Yee, R. and Briant, R., 2001, *Adverse Events in New Zealand Public Hospitals: Principal Findings from a National Survey*, NZ Ministry of Health, Wellington.

Day, P., Sullivan, E.A., Ford, J. and Lancaster, P. 1999, *Australia's Mothers and Babies 1997*, AIHW Cat. no. PER 12, AIHW NPSU, Sydney.

DHA (Department of Health and Ageing) 2003, *National Hospital Cost Data Collection Cost Report, Round 6 (2001-02)*, Australian Government, Canberra.

—— 2004a, *National Hospital Cost Data Collection Cost Report, Round 7 (2002-03)*, Australian Government, Canberra.

—— 2004b, *The State of Our Public Hospitals, June 2004 Report*, Australian Government, Canberra.

DHAC (Department of Health and Aged Care) 1998, *Australian Refined Diagnosis Related Groups, Version 4.1*, Australian Government, Canberra.

Kohn, L.T., Corrigan, J.M., and Donaldson, M.S. (eds) 1999, *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, National Academy Press, Washington DC.

Laws, P. and Sullivan, E. 2004, *Australia's Mothers and Babies 2001*, Cat. no. PER 25, AIHW Perinatal Statistics Unit (Perinatal Statistics Series No. 13), Sydney.

Lohr, K.N. and Shroeder, S.A. 1990, 'A strategy for quality assurance in Medicare', *New England Journal of Medicine*, vol. 322, pp. 707–12.

NCCH (National Centre for Classification in Health) 1998, *The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM)*, Sydney.

NHDC (National Health Data Committee) 2001, *National Health Data Dictionary, Version 10*, AIHW Cat. no. HWI 30, AIHW, Canberra.

—— 2003, *National Health Data Dictionary, Version 12*, AIHW Cat. no. HWI 43, AIHW, Canberra.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 1995, *Report on Government Service Provision*, Productivity Commission, Canberra.

—— 1999, 2000, 2001a 2002, 2003, *Report on Government Services*, Productivity Commission, Canberra.

—— 2001b, *Asset Measurement in the Costing of Government Services*, Productivity Commission, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2004, *Report on Government Services 2004*, Productivity Commission, Canberra.

Thomas, E.J., Studdert, D.M. and Burstin, H.R., 2000, 'Incidence and types of adverse events and negligent care in Utah and Colorado', *Medical Care*, vol. 38. pp. 261–71.

Wilson, R.M., Runciman, W.B., Gibberd, R.W., Harrison, B.T., Newby, L. and Hamilton, J.D. 1995, 'The quality in Australian healthcare study', *Medical Journal of Australia*, vol. 163, pp. 458–71.

10 Primary and community health

Editions of this report before 2004 included a chapter on general practice. In the 2004 Report, the chapter was expanded to include community health, to achieve a more comprehensive coverage of the primary health services supported by government. This chapter now covers general practice, primary healthcare services for Indigenous people, drug and alcohol treatment, public dental services, maternal and child health, and a range of other community health services. The scope of this chapter does not extend to:

- Home and Community Care program services (see chapter 12, 'Aged care')
- public hospital emergency departments and outpatient services (see chapter 9, 'Public hospitals')
- community mental health services (see chapter 11, 'Health management issues')
- government funding of pharmacies or the Pharmaceutical Benefits Scheme (PBS).

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

Descriptive information about primary and community health services is contained in section 10.1. A framework of performance indicators is presented in section 10.2, and key performance indicator results are discussed in section 10.3. Future directions for reporting are covered in section 10.4, and relevant terms are defined in section 10.5.

Supporting tables

Supporting tables for chapter 10 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel format as \Publications\Reports\2005\Attach10A.xls and in Adobe PDF format as \Publications\Reports\2005\Attach10A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 10A.3 is table 3 in the electronic files). These files can be found on the Review web page (www.pc.gov.au/gsp). Users without Internet access

can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

10.1 Profile of primary and community health

Definitions, roles and responsibilities

General practitioners (GPs) are a significant part of the medical practitioner workforce. The medical practitioner workforce comprises doctors trained in a specialty (including general practice) and other medical practitioners (OMPs). The Royal Australian College of General Practitioners (RACGP) defines a GP as 'a medical practitioner who provides primary comprehensive and continuing care to patients and their families within the community' (Britt *et al.* 2004, p. 135). Most of the data in this chapter include two types of medical practitioner who provide GP services:

- registered GPs — medical practitioners who are vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or equivalent (Fellowship of the RACGP has been required since 1996, to achieve vocational registration), hold a recognised training placement, or are otherwise entitled to bill Group A1 Medicare Benefits Schedule (MBS) items.
- OMPs — medical practitioners who have at least half of the schedule fee value of their Medicare billing from non-referred attendances, consisting solely or predominantly of Group A2 MBS items.

One exception to this scope is the data from the Bettering the Evaluation and Care of Health (BEACH) survey, which includes registered GPs but not OMPs. For this reason, data from the BEACH survey may not be directly comparable with the other data on medical practitioners that are reported in this chapter.

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

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

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

Funding

General practice

Almost all of the services provided by private GPs are at least partly funded by the Australian Government through Medicare and the Department of Veterans' Affairs (DVA). This is illustrated by data from the annual BEACH survey of general practice activity in Australia. The BEACH survey found that 93.8 per cent of all encounters with GPs in 2003-04 were for services at least partly funded by Medicare or the DVA (table 10.1). The Australian Government also provides payments to GPs through the Divisions of General Practice Program, the Practice Incentives Program (PIP) and the GP Immunisation Incentives Scheme (DHAC 2000). These payments are included in the data for Australian Government expenditure presented below (figure 10.1).

The Australian Government spent approximately $3.6 billion on general practice in 2003-04, including through Medicare, non-Medicare funding, expenditure by the DVA and other funding programs. This was equivalent to expenditure of $178 per person in 2003-04 (figure 10.1). Figure 10.1 does not give a complete picture of government expenditure on primary health because it does not include expenditure on Aboriginal Community Controlled Health Services (ACCHSs), other community

health services, and services delivered through hospital accident and emergency departments. These types of primary healthcare are more prevalent in rural and remote areas. Accordingly, figure 10.1 understates expenditure on primary health, particularly in jurisdictions with larger proportions of Indigenous people and people living in rural and remote areas.

Table 10.1 **GP encounters, by source of funding, 2003-04[a, b]**

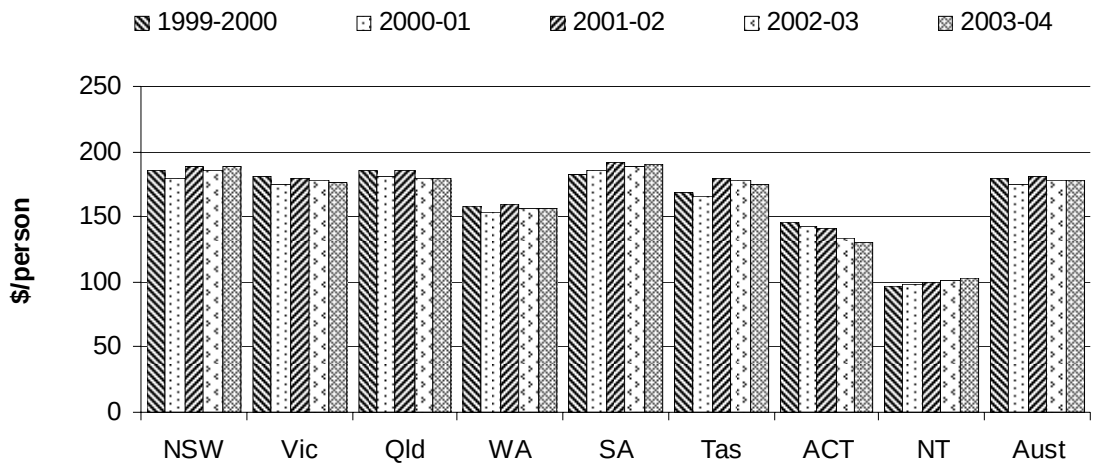
	Number[c]	*Rate*[d]	*95% LCL*	*95% UCL*
	no.	no./100	no./100	no./100
GPs participating in the BEACH survey	1 000	..	..	..
Total encounters for which BEACH data were recorded	98 877	..	..	..
Encounters with missing data	6 912	..	..	..
Direct consultations	89 160	97.0	96.6	97.3
No charge	463	0.5	0.3	0.7
Medicare paid[e]	86 244	93.8	93.3	94.2
Workers compensation	1 872	2.0	1.8	2.3
Other paid (hospital, State, etc.)	581	0.6	–	1.4
Indirect consultations[f]	2 805	3.1	2.5	3.6

UCL = upper confidence limit. LCL = lower confidence limit. [a] April 2003 to March 2004. [b] An 'encounter' is any professional interchange between a patient and a GP (Britt *et al*. 2000). [c] Number of encounters after post-stratification weighting for GP activity and GP age and sex. [d] Missing data removed. Percentage base (N = 91 965). [e] Includes Australian Government payments made through the DVA. [f] Indirect consultations are those at which the patient is not seen by the GP but that generate a prescription, a referral, a certificate or another service. They are usually the result of a phone call by a patient. .. Not applicable. – Nil or rounded to zero.

Source: Britt *et al.* (2004); table 10A.1.

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

Figure 10.1 **Australian Government real expenditure per person on GPs (2003-04 dollars)[a]**



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

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

Community health services

Expenditure data are not available for all of the community health services covered in this chapter. The Australian Institute of Health and Welfare (AIHW) publishes expenditure data on community and public health, and dental services. The former category, however, includes public health activities that are not covered in this chapter, such as food safety regulation and media campaigns to promote health awareness. The dental services category includes private dental services (funded by insurance premium rebates and non-government expenditure) that are also not reported in this chapter. In 2002-03, government expenditure on community and public health was $4.4 billion, with State, Territory and local government providing 74.7 per cent and the Australian Government providing 25.3 per cent of this expenditure (table 10.2). Australian Government direct outlay expenditure on dental services was $78 million in 2002-03, and State, Territory and local government expenditure was $342 million (table 10.2).

Table 10.2 **Estimated expenditure on community and public health, and dental services, 2002-03 ($ million)[a, b]**

	Australian Government						
	Direct outlays	*Premium rebates*	*Total*	*State and local govt*	*Total govt*	*Non-govt*	*Total*
Community and public health[c]	1 100	–	1 101	3 249	4 351	8	4 358
Dental services[d]	78	298	376	342	718	3 656	4 374

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

Source: AIHW (2004c).

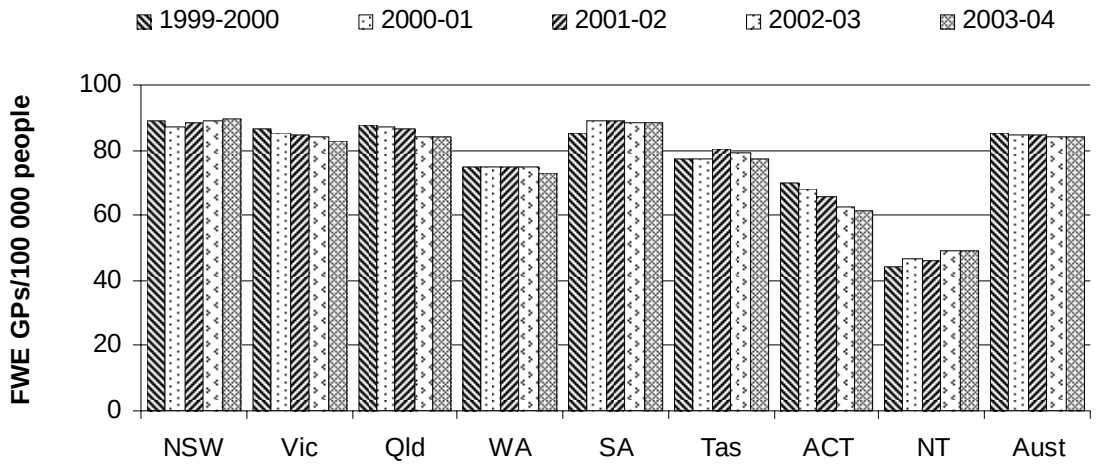
Size and scope

General practice

There were 24 323 registered GPs and OMPs billing Medicare in Australia in 2003-04. On a full time workload equivalent (FWE) basis, there were 16 872 registered GPs and OMPs. This was equal to 83.8 registered GPs and OMPs per 100 000 people — a decline from 85.5 per 100 000 people in 1999-2000 (table 10A.3). These data exclude services provided by GPs working with the Royal Flying Doctor Service and GPs working in ACCHSs and public hospitals without the right of private practice. In addition, the data are based on Medicare claims, which for some GPs (particularly in rural areas) pay for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid through Medicare. In 2003-04, the highest number of FWE registered GPs and OMPs per 100 000 people was in NSW (89.3) and the lowest was in the NT (49.2) (figure 10.2).

A national survey conducted by the Australian Bureau of Statistics (ABS) in 2001 found that 24 per cent of people had consulted a GP in the two weeks before the survey. This was an increase from 23 per cent in 1995 and from 20 per cent in 1989-90 (ABS 2002). The average consultation with a GP lasted just under 15 minutes (Britt *et al*. 2002).

Figure 10.2 **Availability of GPs (full time workload equivalent)[a, b]**



a Data include registered GPs and OMPs who are allocated to a jurisdiction based on the postcode of their practice. **b** Data for 2002-03 have been revised.

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

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 10A.39–10A.47 provide information on community health programs in each jurisdiction. The more significant of these programs are described below. Other community health programs provided by some jurisdictions include:

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

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

Maternal and child health

All jurisdictions provide maternal and child health services through their community health programs. These services include: parenting support programs (including antenatal and postnatal programs); early childhood nursing programs; disease prevention programs (including childhood immunisations); and early

intervention and treatment programs related to child development and health. Some jurisdictions also provide specialist programs through child health services, including hearing screening programs, and mothers and babies residential programs. Performance indicators for maternity services in public hospitals are reported in chapter 9.

Public dental services

All jurisdictions provide some form of public dental service for primary school children. Some jurisdictions also provide dental services to secondary school students. In SA, Tasmania, and the NT, for example, general dental care (including preventative care) is provided for school children up to 18 years of age (tables 10A.44, 10A.45 and 10A.47). States and Territories also provide some general dental services and a limited range of specialist dental services to disadvantaged adults (holders of concession cards issued by Centrelink). In some States, specialist dental services are provided mainly by qualified dental specialists; in others, they are provided in dental teaching hospitals as part of training programs for dental specialists (National Advisory Committee on Oral Health 2004).

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 2004a). This report excluded some treatment activities, including opioid pharmacotherapy treatment where it is the only treatment provided. The report also excluded data for the majority of Indigenous substance use services and Indigenous community healthcare services that also provide alcohol and other drug treatment services and are funded by the Australian Government.

A total of 587 alcohol and other drug treatment services contributed 2002-03 data for the National Minimum Data Set. Of these, 264 (45.0 per cent) identified as government providers and 323 (55.0 per cent) identified as non-government providers (table 10A.8). All of the non-government providers received some government funding for 2002-03. A total of 108 042 clients were registered for treatment in 2002-03, of whom 65.8 per cent were male (AIHW 2004a). Alcohol was reported as the most common principal drug of concern for which clients sought treatment (38.0 per cent of treatment episodes). Cannabis was the next most common drug of concern (22.0 per cent of treatment episodes), followed by heroin

(18.4 per cent of treatment episodes) and amphetamines (10.7 per cent of treatment episodes) (AIHW 2004a). Further information on alcohol and other drug treatment services funded by governments is included in tables 10A.40–10A.47.

Indigenous community healthcare services

Primary healthcare services are delivered to Indigenous people through ACCHSs and government provided community health services. (The use of general practice services by Indigenous people is discussed separately below.) There are ACCHSs in all jurisdictions. These services are planned and governed by local Indigenous communities and aim to deliver holistic and culturally appropriate health and health-related services. Funding for ACCHSs is provided by Australian, State and Territory governments.

In addition to the ACCHSs, specific health programs for Indigenous Australians are funded by jurisdictions:

- NSW provides Indigenous health services, including health information and promotion programs, pre- and post-natal programs, and early childhood nursing programs (table 10A.40).
- Victoria provides Indigenous-specific and mainstream community health services funded by the Department of Human Services. They provide medical, alcohol and drug, maternity and early childhood services (table 10A.41).
- Queensland provides primary and community healthcare services and activities that address prevention and health management/maintenance for Indigenous communities. Services offered include: health prevention and promotion services; men's and women's health programs; child and adolescent health services; alcohol, tobacco and other drug services; sexual health services; allied health services; and patient transport provided to increase access to healthcare (table 10A.42).
- Western Australia provides community health services that are also available to Indigenous people in various age groups (table 10A.43).
- South Australia provides Indigenous health services that include: strategies to improve the outcomes for females giving birth, home support, and programs that provide health screenings and diabetes care (table 10A.44).
- Tasmania provides population and health priorities programs to prevent and manage chronic conditions, and to promote nutrition, physical activity and injury prevention in identified population groups, including the Indigenous population (table 10A.45).

- The NT provides primary care for the Indigenous population directly and by funding community controlled Indigenous health services. It also provides remote health services such as 24 hour emergency services, medical and allied health specialist services, and access to essential medications (table 10A.47).
- The ACT provides funding for a non-government Aboriginal Health Service and a variety of programs for Aboriginals and Torres Strait Islanders.

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

For 2001-02, SAR data are reported for 128 Indigenous primary healthcare services (table 10A.4). Of these services, 53 (41.4 per cent) were located in remote or very remote areas (table 10A.5). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 10A.6).

An episode of healthcare is defined in the SAR data collection as contact between an individual client and a service by one or more staff to provide healthcare. Over 1.4 million episodes of healthcare were provided by participating services in 2001-02 (table 10.3). Of these, 573 340 (40.8 per cent) were in remote or very remote areas (table 10A.5).

The services included in the SAR data collection employed approximately 1601 full time equivalent health staff (on 30 June 2002). Of these health staff, 1036 were Indigenous (64.7 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous, however, were relatively low (2.3 per cent and 15.1 per cent respectively) (table 10A.7).

Table 10.3 **Estimated episodes of healthcare by surveyed services[a, b]**

	NSW and ACT	*Vic and Tas*	*Qld*	*WA*	*SA*	*NT*	*Aust*
	'000	'000	'000	'000	'000	'000	'000
1998-99	265.8	143.5	149.3	247.1	131.4	124.2	1 061.3
1999-2000	286.8	172.5	176.3	295.0	129.7	163.0	1 223.2
2000-01	348.6	143.5	186.9	326.7	147.4	189.4	1 342.5
2001-02	356.9	154.3	214.1	313.1	144.3	233.1	1 415.7

a An episode of healthcare involves contact between an individual client and a service by one or more staff, for the provision of healthcare. Group work is not included. Transport is included only if it involves provision of healthcare/information by staff. Episodes of healthcare provided at outreach locations are included — for example, episodes at outstation visits, park clinics and satellite clinics — as are episodes delivered over the phone. **b** 2001-02 data are estimates.

Source: DHA SAR (unpublished).

Use of general practice services by Indigenous people

An overview of health factors and outcomes for Indigenous people is provided in the 'Health preface'. Data on national expenditure on general practice services for Indigenous people in 1998-99 (the most recent year for which expenditure data are available by Indigenous status) indicate:

- expenditure on Medicare and the PBS per Indigenous person was about 39 per cent of expenditure per non-Indigenous person
- Indigenous Australians used secondary/tertiary care (such as hospitals) at a higher rate than they used primary care and at a higher rate than used by non-Indigenous people (AIHW 2001; see 'Health preface').

Data from the annual BEACH survey indicate the nature of encounters between Indigenous people and GPs. This survey relies on the self-reporting of an individual's Indigenous status to the GP, so is likely to underestimate the actual number of GP encounters with Indigenous people. In addition, these data need to be treated with care because the BEACH survey was not designed to produce statistically significant results for Indigenous people and may under-identify them. Further, the Indigenous Australians included in the BEACH survey do not necessarily have the same characteristics as other Indigenous Australians. For these reasons, the 2003 BEACH survey aggregated Indigenous data over a five year period to improve reliability.

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

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

The most common health problem managed in GP encounters with Indigenous people over the five years of the BEACH survey was diabetes, which accounted for 7.1 per 100 GP encounters with Indigenous people, compared with 2.8 per 100 GP encounters with all people. Other problems with significantly higher management rates in GP encounters with Indigenous people included acute otitis media/myringitis, asthma, and pre- and post-natal care (table 10.4). Further information about the location, remoteness and management activities of BEACH survey encounters between Indigenous patients and GPs is included in tables 10A.10, 10A.11 and 10A.12.

Table 10.4 **Selected health problems in encounters with GPs, by Indigenous status, 1998-99 to 2002-03**

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

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

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

10.2 Framework of performance indicators

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

Box 10.1 **Objectives for primary and community health**

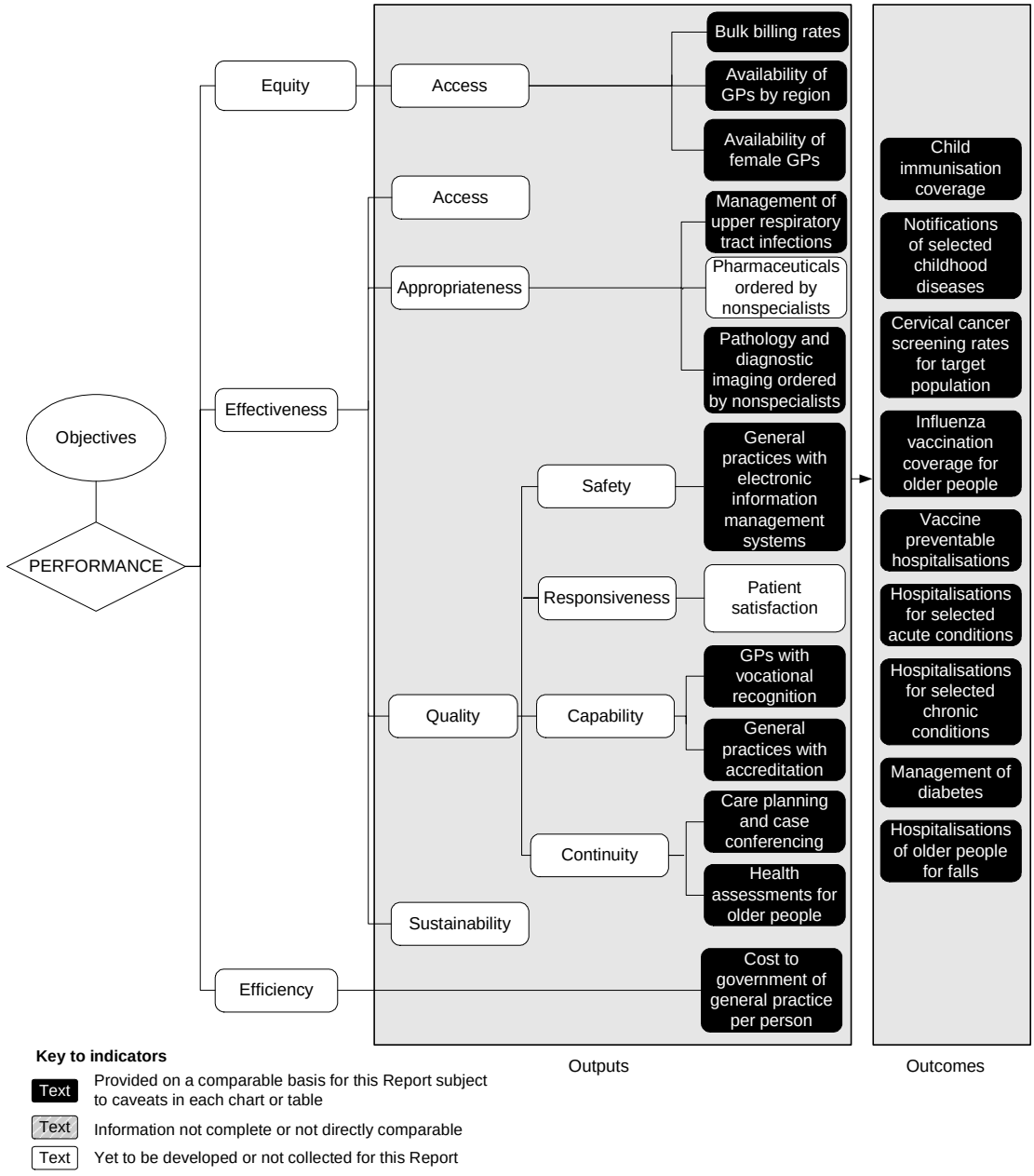
Primary and community health services aim to promote the health of Australians by:

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

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

The performance indicator framework shows which data are comparable in the 2005 Report (figure 10.3). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability that have been added to the standard Review framework for health services.

Figure 10.3 **Performance indicators for primary and community health**



10.3 Key performance indicator results

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

Equity

Problems with accessing primary health services have contributed to the generally poor health status of Indigenous people relative to other Australians (see the 'Health preface'). Financial, geographic and other barriers can also have an impact on the equity of access to primary health services for other groups, including people with low socioeconomic status and people living in rural and remote areas.

Access

Three indicators of equity of access in GP service delivery are reported here: bulk billing rates (box 10.2), the availability of FWE GPs by region (box 10.3) and the availability of female GPs (box 10.4).

Bulk billing rates

Box 10.2 **Bulk billing rates**

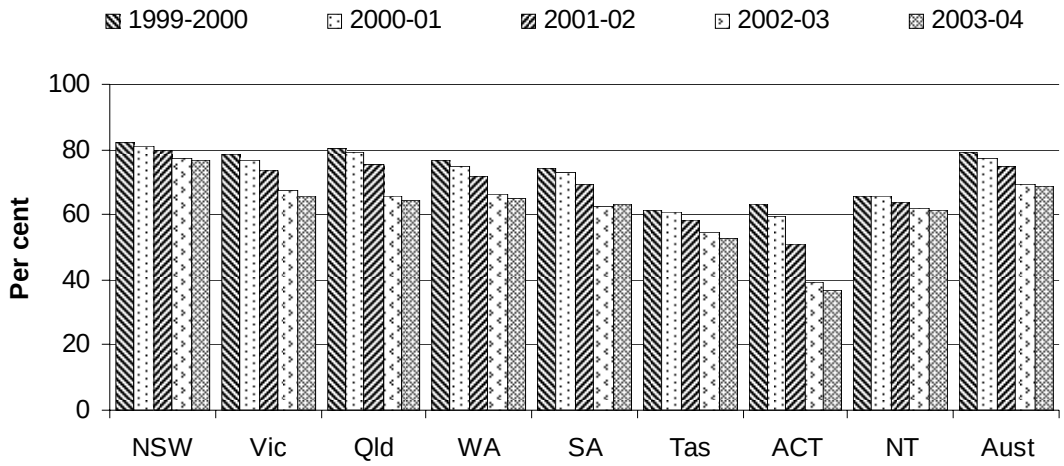
Patient visits to GPs are classed as non-specialist non-referred attendances under Medicare. Patients are either bulk billed or required to pay part of the cost of the non-referred attendance. In most cases where a patient is bulk billed, the GP bills the Health Insurance Commission (Medicare) directly and currently receives 85 per cent of the Schedule fee (the patient's rebate) as full payment for the service. The patient makes no out-of-pocket contribution. The bulk billed proportion of non-specialist non-referred attendances indicates the affordability of GP services.

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

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

In 2003-04, NSW had the highest proportion of non-specialist non-referred attendances that were bulk billed (76.7 per cent), while the ACT had the lowest (36.8 per cent). Australia-wide, the bulk billed proportion of non-specialist non-referred attendances declined from 79.1 per cent in 1999-2000 to 68.5 per cent in 2003-04 (figure 10.4).

Figure 10.4 **Non-specialist non-referred attendances that were bulk billed[a]**



a Data for 2003-04 include attendances by practice nurses.

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

The bulk billed proportion of non-specialist non-referred attendances was generally lower in rural and remote centres than in capital cities or other metropolitan centres. In 2003-04, 73.0 per cent of attendances in capital cities were bulk billed, compared with 54.7 per cent in large rural centres and 55.7 per cent in other rural areas (table 10A.14).

Availability of GPs by region

Box 10.3 **Availability of GPs by region**

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

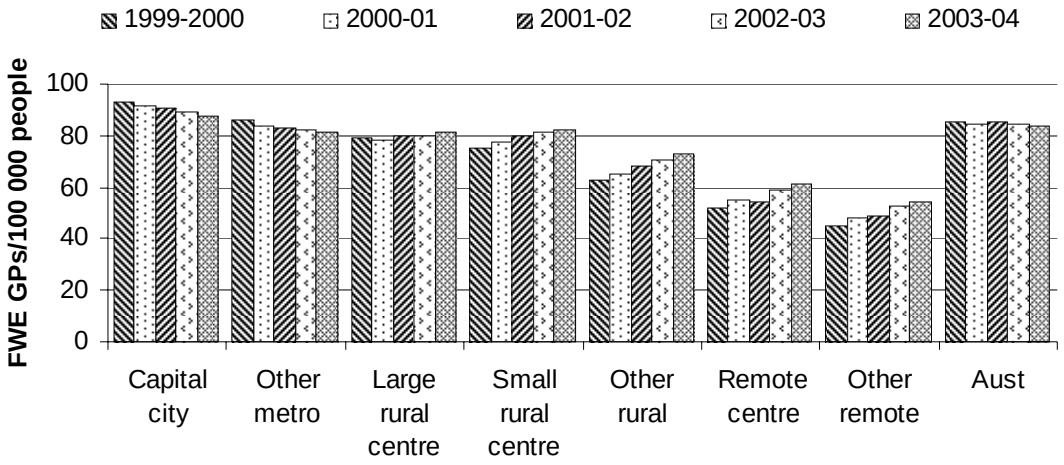
The indicator is defined as the number of FWE GPs per 100 000 people by region.

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

There were 83.8 FWE GPs per 100 000 people in Australia in 2003-04. By region the rate was 87.8 FWE GPs per 100 000 in capital cities, 61.5 FWE GPs per 100 000 in remote centres, and 54.3 per 100 000 in other remote areas

(figure 10.5). Over the five years to 2003-04, the number of FWE GPs per 100 000 people fell in metropolitan areas and rose in rural and remote regions (except in large rural centres, where FWE GP numbers per 100 000 remained relatively constant up to 2002-03, then increased in 2003-04) (figure 10.5).

Figure 10.5 **Availability of GPs (full time workload equivalent), by region[a, b, c]**



a Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; large rural centre = statistical local areas (SLAs) where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone. **b** Data for 2002-03 have been revised. **c** FWE GP numbers include registered GPs and OMPs, who are allocated to a jurisdiction based on the postcode of their practice.

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

Availability of female GPs

Box 10.4 **Availability of female GPs**

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

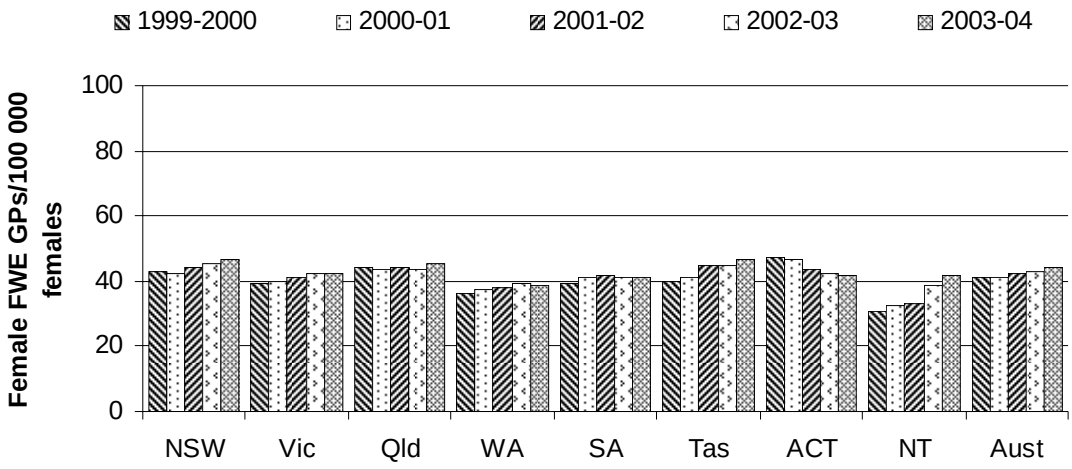
The indicator is defined as the number of female FWE GPs per 100 000 females.

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

Approximately one third of Australia's GPs were female in 2003-04 (8805 of 24 323). This represented approximately one quarter of FWE GPs (tables 10A.15

and 10A.16). In 2003-04, there were 44.2 female FWE GPs per 100 000 females in Australia, with the rate highest in NSW (46.9 per 100 000 females) and lowest in WA (38.9 per 100 000 females) (figure 10.6).

Figure 10.6 **Availability of female GPs (full time workload equivalent)[a, b]**



a Data for 2002-03 have been revised. **b** Data relate to registered GPs and OMPs.

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

Effectiveness

Appropriateness

Two indicators of the appropriateness of GP services are reported here: the 'management of upper respiratory tract infections' (box 10.5), and 'pathology tests and diagnostic imaging ordered by non-specialists' (box 10.7).

The Steering Committee has also identified 'pharmaceuticals ordered by non-specialists' as an indicator of the appropriateness of GP services (box 10.6). Data for this indicator, however, were not available for the 2005 Report.

Management of upper respiratory tract infections

The prescription rate for the oral antibiotics used most commonly to treat upper respiratory tract infection in 2003-04 was highest in NSW (1443.3 per 1000 PBS concession card holders) and lowest in the NT (477.3 per 1000 PBS concession card holders) (figure 10.7). Australia-wide, the prescription rate decreased by 14.2 per cent between 1999-2000 and 2003-04 (but increased slightly between 2002-03 and 2003-04). All jurisdictions experienced a decrease over the first four

years of this period, although the rate increased between 2002-03 and 2003-04 in all jurisdictions except Queensland and the NT (figure 10.7).

Box 10.5 **Management of upper respiratory tract infections**

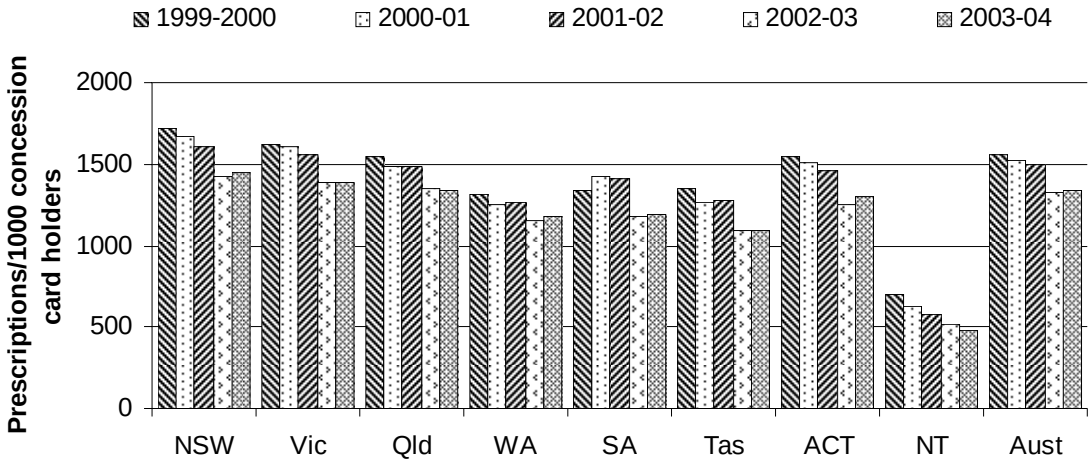
Upper respiratory tract infections without complications are most often caused by viruses. Antibiotics have no efficacy in the treatment of viral infections but are still frequently prescribed when viruses occur. Unnecessarily high antibiotic prescription rates for upper respiratory tract infections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

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

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

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

Figure 10.7 **Rate of prescription of the oral antibiotics used most commonly to treat upper respiratory tract infections**



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

Pharmaceuticals ordered by non-specialists

Box 10.6 **Pharmaceuticals ordered by non-specialists**

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

Pathology tests and diagnostic imaging ordered by non-specialists

Box 10.7 **Pathology tests ordered and diagnostic imaging referrals by non-specialists (registered GPs and OMPs)**

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

Four measures are reported:

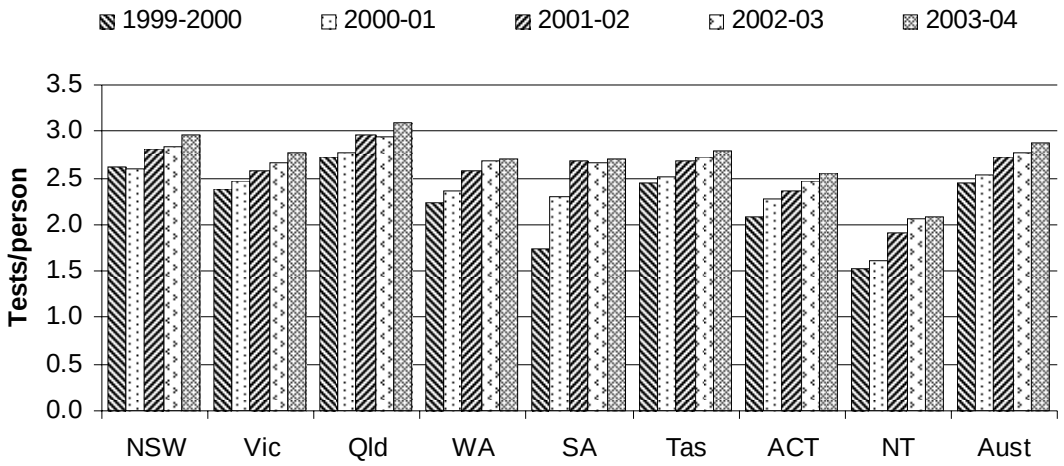
- pathology tests ordered by registered GPs and OMPs per person
- diagnostic imaging referrals from registered GPs and OMPs per person
- benefits paid per person for pathology tests
- benefits paid per person for diagnostic imaging.

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

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

Nationally, the number of pathology tests ordered per person increased from 2.5 in 1999-2000 to 2.9 in 2003-04 (figure 10.8). In 2003-04, Queensland had the highest rate of pathology tests ordered (3.1 per person) and the NT had the lowest (2.1 per person). These data represent only pathology tests paid through Medicare. In general, Medicare benefits are payable for a maximum of three tests performed on a specimen. Data on the number of tests performed but not rebated are not available. Pathology services for some areas of WA, SA, the ACT and the NT were funded by the Australian Government through health program grants until 2001-02, so these data may underestimate the number of pathology tests ordered in some jurisdictions before 2002-03 (although the amounts are relatively insignificant).

Figure 10.8 **Pathology tests ordered by GPs[a]**



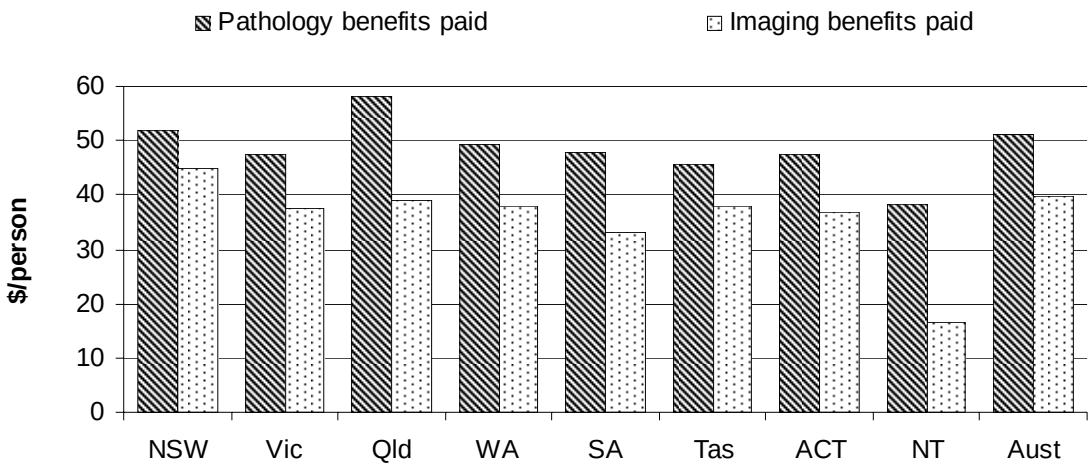
a Data include tests ordered by registered GPs and OMPs. Data include tests ordered at the request of a patient (patient episode initiated items).

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

Australian Government expenditure (under Medicare) on pathology tests amounted to over $1 billion in 2003-04, equal to $51 per person. The benefits paid per person for pathology tests in 2003-04 were highest in Queensland ($58) and lowest in the NT ($38) (figure 10.9). Nationally, these benefits per person increased in real terms by 4.8 per cent over the five years to 2003-04 (table 10A.18). Nationally, Medicare benefits worth over $800 million were paid for diagnostic imaging in 2003-04, equal to $40 per person. Across jurisdictions, the benefits paid per person were highest in NSW ($45) and lowest in the NT ($17) (figure 10.9). Nationally, these benefits decreased in real terms by 5.1 per cent over the five years to 2003-04 (table 10A.19).

Nationally, the number of diagnostic imaging referrals per person remained relatively constant over the five years to 2003-04 (figure 10.10). In 2003-04, NSW had the highest number of referrals per person (0.5) and the NT had the lowest (0.2). The marked difference in the number of pathology tests ordered per person and the imaging referrals per person might be because up to three tests can be ordered with one pathology specimen, whereas each imaging referral results in only one test.

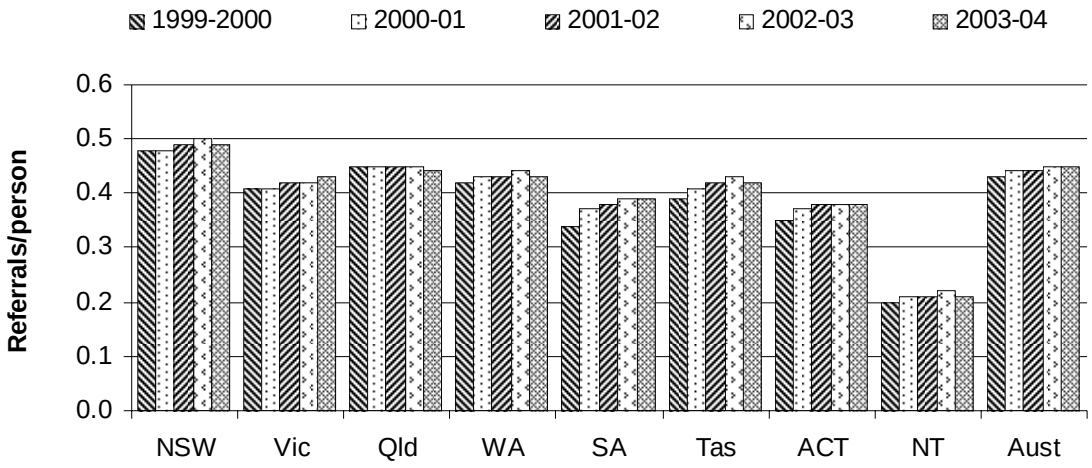
Figure 10.9 **Benefits paid for pathology tests and diagnostic imaging, 2003-04[a]**



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

Source: DHA (unpublished); tables 10A.18 and 10A.19.

Figure 10.10 **Diagnostic imaging referrals from GPs[a]**



a Data relate to registered GPs and OMPs.

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

General practices with electronic information management systems

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

Under the PIP Information Management, Information Technology program, two incentives encourage the computerisation of practices: first, the electronic prescribing incentive paid for the use of bona fide electronic prescribing software to generate the majority of prescriptions, and second, an incentive paid for the use of computer systems to send and/or receive clinical information. Computerisation of general practices can improve the safety (in terms of quality and effectiveness) of GP services (box 10.8).

Box 10.8 **General practices with electronic clinical information management systems**

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

Two measures of this indicator are reported:

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

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

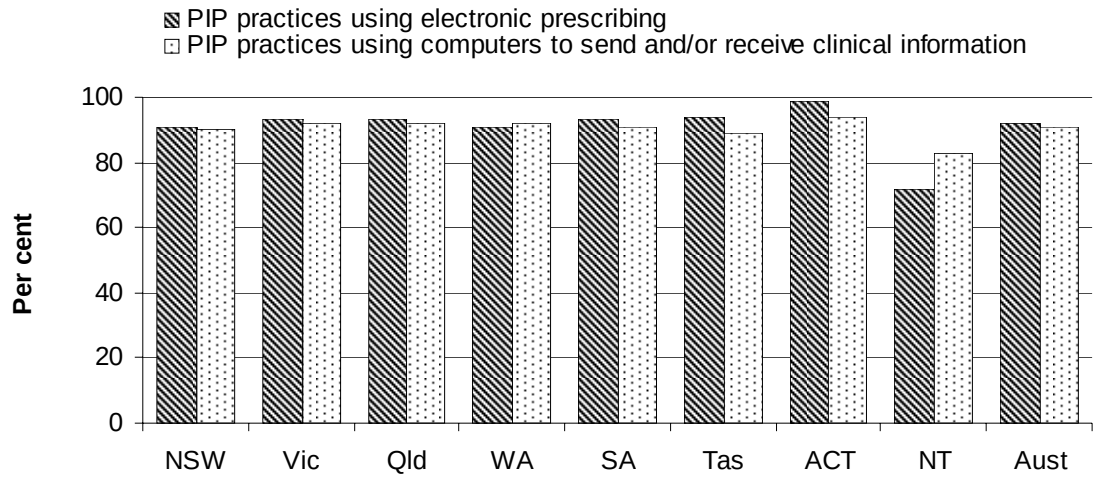
The PIP does not include all practices in Australia. PIP practices covered around 80 per cent of Australian patients (measured as standardised whole patient equivalents) in May 2004 (DHA unpublished).

Australia-wide, 92.0 per cent of PIP practices used electronic prescribing systems in May 2004 (an increase from 90.5 per cent in May 2003). Of PIP practices, 91.0 per

cent had the capacity to send and/or receive clinical information via use of computer technology in May 2004 (an increase from 89.7 per cent in May 2003) (table 10A.21).

In May 2004, PIP practices in the ACT were the most likely to use computers to send and/or receive clinical information and to use electronic prescribing software (94.0 per cent and 99.0 per cent respectively). PIP practices in the NT were the least likely to send and/or receive clinical information electronically and to use electronic prescribing software (83.0 per cent and 72.0 per cent respectively) (figure 10.11).

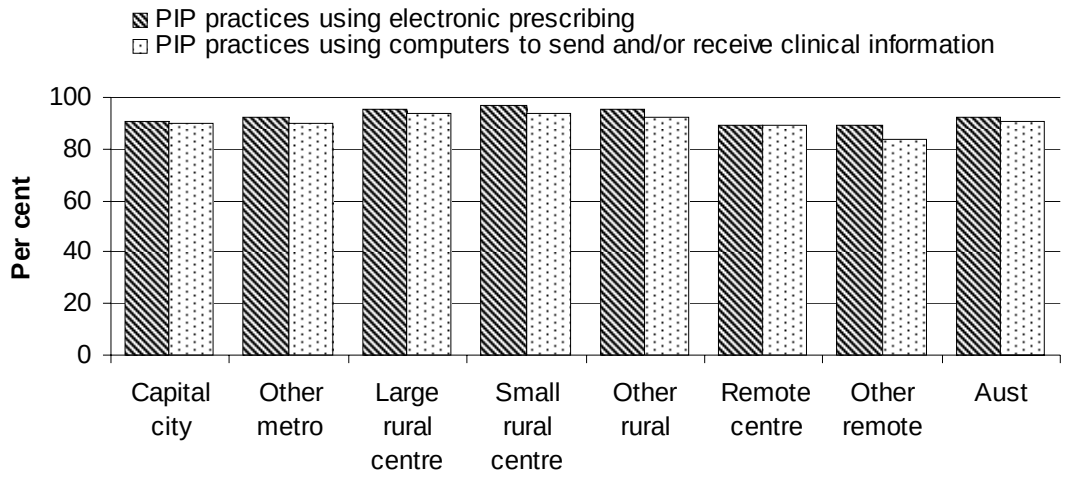
Figure 10.11 **PIP practices using computers for clinical purposes, May 2004**



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

In May 2004, PIP practices in rural areas were more likely than PIP practices in metropolitan areas or remote areas to use computers to send and/or receive clinical information and to use electronic prescribing. PIP practices in remote areas were the least likely to use electronic prescribing systems (figure 10.12). Remote practices in the NT have difficulty meeting the accreditation requirements to qualify for the PIP, which affects the coverage of these data.

Figure 10.12 **PIP practices using computers for clinical purposes, by area, May 2004[a]**



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

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

Quality — responsiveness

Patient satisfaction

The Steering Committee has identified 'patient satisfaction' as an indicator of the quality of GP services in terms of their responsiveness to patients (box 10.9). Data for this indicator, however, were not available for the 2005 Report.

Box 10.9 **Patient satisfaction**

'Patient satisfaction' has been identified as a indicator of responsiveness, but no data are currently available.

Quality — capability

Two indicators of the quality of GP services, in terms of the GPs' capability to provide services, are reported here: first, the proportion of GPs with vocational

registration (box 10.10) and second, the proportion of general practices with accreditation (box 10.11).

GPs with vocational registration

Box 10.10 **GPs with vocational registration**

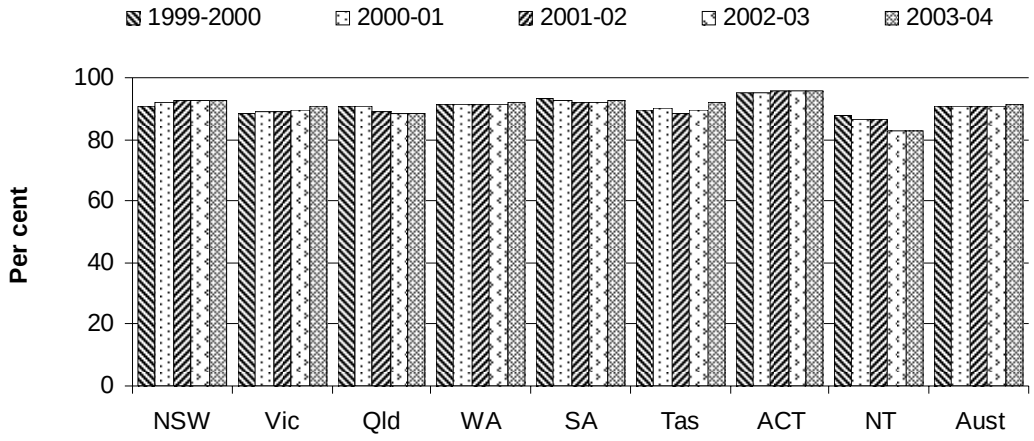
Since 1996, a GP can only achieve vocational registration by attaining Fellowship of the RACGP. GPs can attain Fellowship through the successful completion of a formal general practice training program or through the 'practice eligible' route. Once vocational registration is achieved, GPs must demonstrate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

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

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

The proportion of GPs with vocational registration remained relatively constant over the five years to 2003-04 (figure 10.13). In 2003-04, the ACT had the highest proportion of GPs with vocational registration (95.5 per cent) and the NT had the lowest proportion (82.7 per cent) (figure 10.13). Across regions, the proportion of GPs with vocational registration was highest in capital cities (93.7 per cent) and lowest in other remote areas (68.3 per cent) in 2003-04 (table 10A.22).

Figure 10.13 **GPs (full time workload equivalent) with vocational registration[a]**



a Data for 2002-03 have been revised.

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

General practices with accreditation

Box 10.11 **General practices with accreditation**

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

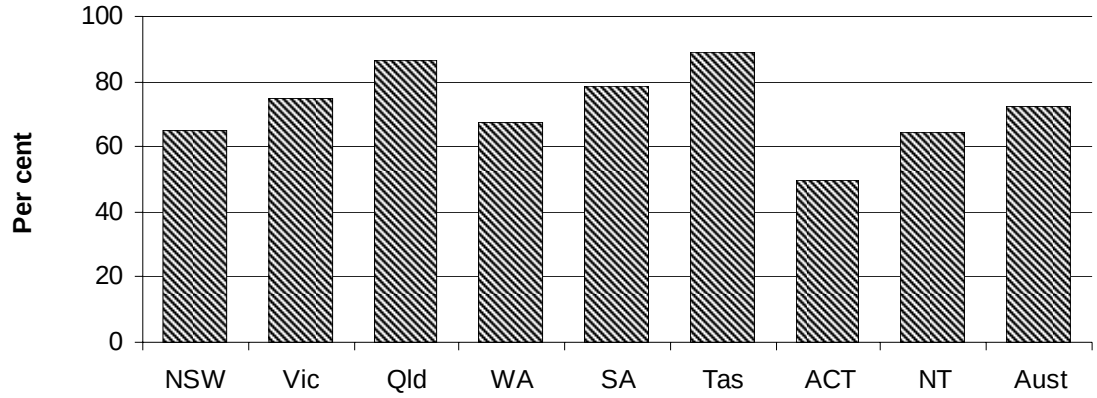
The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and Quality Practice Accreditation (QPA). This indicator is defined as the number of general practices accredited by AGPAL as a proportion of all general practices in Australia.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

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

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

In June 2004, 4300 general practices (representing 72.5 per cent of general practices) were accredited with AGPAL. Across jurisdictions, Tasmania had the highest proportion of practices accredited (88.9 per cent) and the ACT had the lowest (49.5 per cent) (figure 10.14).

Figure 10.14 **Australian general practices that are AGPAL accredited, June 2004**



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

Quality — continuity

The continuity aspect of the quality of primary healthcare services relates to the sector's ability to provide uninterrupted, coordinated services across programs, practitioners, organisations and levels over time. Two indicators of this aspect of quality are reported here: first, the use of care planning and case conferencing (box 10.12) and second, the use of health assessments for older people (box 10.13).

Care planning and case conferencing

Box 10.12 **Care planning and case conferencing**

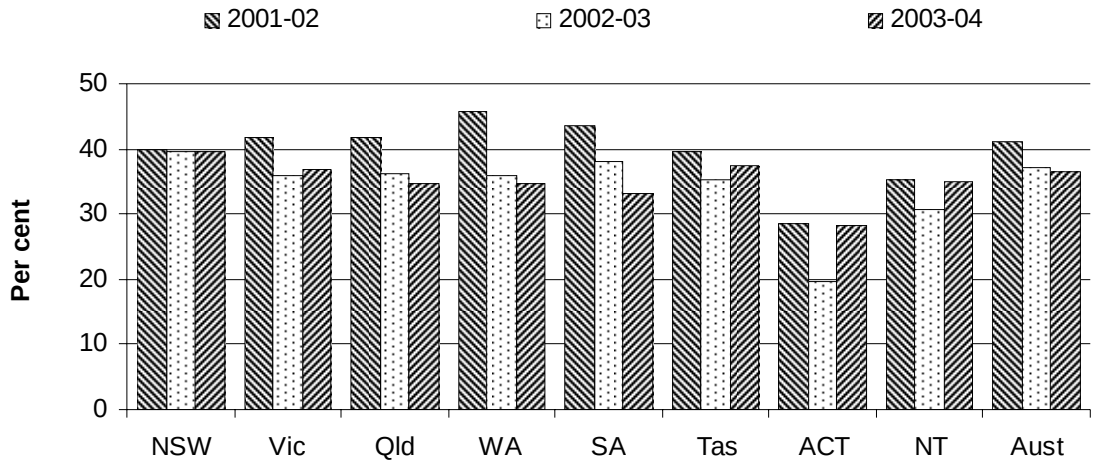
Care planning and case conferencing are Enhanced Primary Care (EPC) items in the MBS. They provide a framework for a multidisciplinary approach to healthcare for people with chronic or terminal medical conditions and complex, multidisciplinary care needs. The rationale for the indicator is that GPs with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

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

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

In 2003-04, the proportion of GPs who used the EPC items for care planning and case conferencing was highest in NSW (39.5 per cent) and lowest in the ACT (28.1 per cent). Nationally, the proportion of GPs using these EPC items declined from 41.3 per cent in 2001-02 to 36.6 per cent in 2003-04 (figure 10.15). Three policy changes occurred during this period that might have affected the use of EPC items for care planning and case conferencing: first, the tightening of the criteria for Medicare funding of EPC items in 2001; second, the clarification of the Medicare requirements for care planning services in May 2002; and third, the withdrawal of a specific care planning incentive payment under the PIP from November 2002.

Figure 10.15 **GP use of EPC Medicare items for care planning and case conferencing[a]**



a The number of active GPs who claimed at least one of the EPC items for care planning and case conferencing during the financial year, as a proportion of all active GPs. Active GPs are registered GPs or OMPs who claimed 375 or more non-referred attendances on average per quarter.

Source: DHA (unpublished); table 10A.25.

Health assessments for older people

Box 10.13 **Health assessments for older people**

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

(Continued on next page)

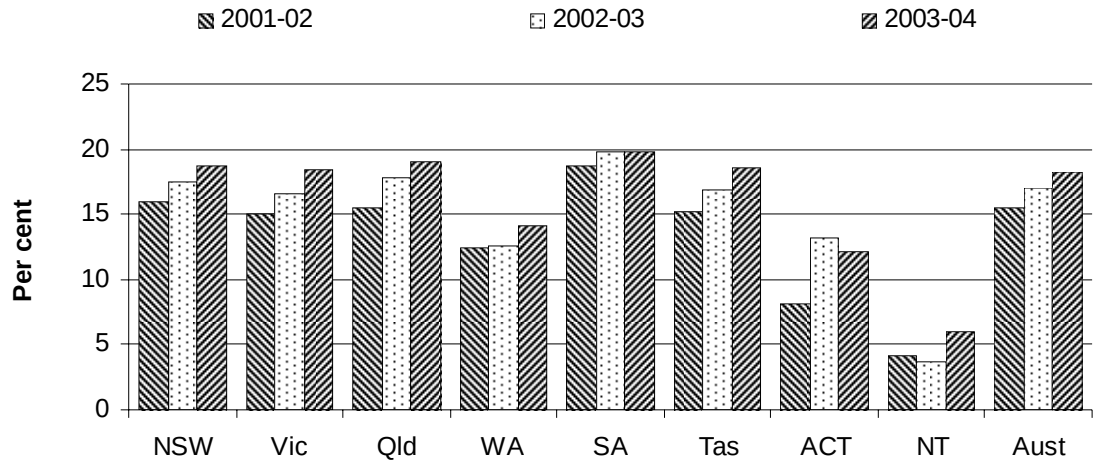
Box 10.13 **(Continued)**

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

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

In 2003-04, the proportion of older people who received a voluntary health assessment was highest in SA (19.8 per cent) and lowest in the NT (6.0 per cent). Nationally, the proportion increased from 15.4 per cent in 2001-02 to 18.2 per cent in 2003-04 (figure 10.16). Between 2002-03 and 2003-04, the proportion increased in all jurisdictions except the ACT.

Figure 10.16 **Older people who received a voluntary health assessment[a]**



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

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

Sustainability

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

Efficiency

Cost to government of general practice per person

The 'cost to government of general practice per person' is one indicator of the efficiency of general practice (box 10.14). Nationally, the recurrent cost to the Australian Government of general practice was $178 per person in 2003-04 (figure 10.1). Across jurisdictions, it was highest in SA ($190 per person) and lowest in the NT ($103 per person) (table 10A.2).

Box 10.14 **Cost to government of general practice per person**

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

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

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

Outcomes

Indicators of both intermediate and final primary and community health outcomes are reported here. 'Child immunisation coverage', for example, indicates the intermediate outcome of immunisation against disease (box 10.15). 'Notifications of selected childhood diseases' indicate the final outcome — the incidence of diseases — that child immunisation can prevent (box 10.16). The other reported outcome indicators relate to cervical screening (box 10.17), influenza vaccinations (box 10.18) and potentially preventable hospitalisations (box 10.19).

Child immunisation coverage

Box 10.15 **Child immunisation coverage**

The 'child immunisation coverage' indicator is an indicator of outcomes for primary and community health services because one of the objectives of GPs and community health services is the achievement of high immunisation coverage levels for children. Many providers deliver child immunisation services (table 10.5). GPs are encouraged to achieve high immunisation coverage levels under the General Practice Immunisation Incentives Scheme, which provides incentives for the immunisation of children under seven years of age.

Two measures of this indicator are reported:

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

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

Data from the Australian Childhood Immunisation Register (ACIR) suggest GPs have played a major role (since data were first collected in 1996) in immunising children under 7 years of age in NSW, Queensland, WA, SA and Tasmania. In Victoria, local governments share the main immunisation provider role with GPs. In the ACT and the NT, governments are the significant immunisation providers through community health centres (table 10.5).

Around 90.9 per cent of Australian children aged 12 months to less than 15 months at 30 June 2004 were assessed as fully immunised, down from 91.2 per cent at 30 June 2003. Tasmania recorded the highest proportion of children aged 12 months to less than 15 months at 30 June 2004 who were assessed as being fully immunised (93.4 per cent), while the NT recorded the lowest (85.2 per cent) (figure 10.17).

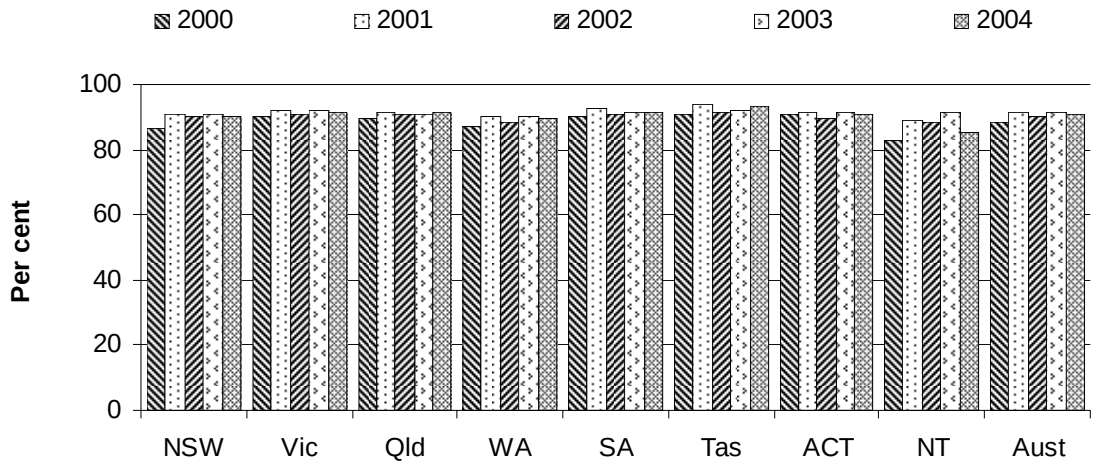
Table 10.5 **Valid vaccinations supplied to children under 7 years of age, by provider type, 1996–2004 (per cent)[a, b]**

Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP	83.0	51.0	66.0	63.0	68.0	85.0	37.0	3.0	67.0
Council	7.0	48.0	15.0	8.0	18.0	14.0	–	–	20.0
State or Territory health department	–	–	–	5.0	–	–	31.0	–	1.0
Flying doctor service	–	–	1.0	–	–	–	–	–	–
Public hospital	3.0	–	6.0	5.0	4.0	–	1.0	8.0	3.0
Private hospital	–	–	–	–	–	–	–	1.0	–
Indigenous health service	–	–	1.0	1.0	–	–	–	7.0	1.0
Indigenous health worker	–	–	1.0	–	–	–	–	–	–
Community health centre	7.0	1.0	10.0	18.0	10.0	1.0	31.0	81.0	8.0
Community nurse	–	–	–	–	–	–	–	–	–
Total[c]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

a On 30 June 2004. Data collected since 1 January 1996. Data relates to the State or Territory in which the immunisation provider was located. **b** A valid vaccination is a National Health and Medical Research Council's Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. **c** Data for Australia include 4161 vaccinations (less than 0.1 per cent of the total) for which State or Territory is unknown. – Nil or rounded to zero.

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

Figure 10.17 **Children aged 12 months to less than 15 months who were fully immunised[a, b, c]**

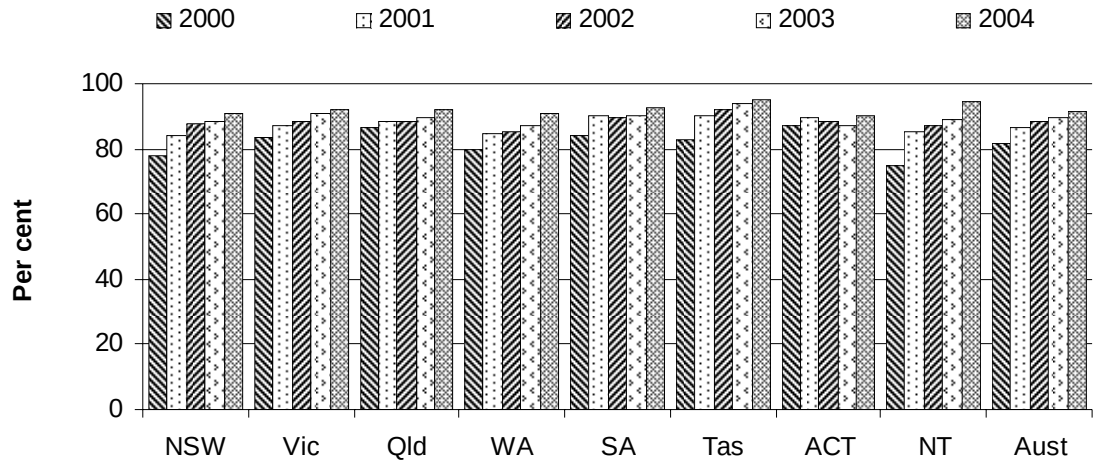


a Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. **b** The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000). **c** There may be some under-reporting by providers, so vaccine coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

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

Nationally, 91.7 per cent of children aged 24 months to less than 27 months at 30 June 2004 were assessed as being fully immunised — an increase from 89.3 per cent at 30 June 2003. Tasmania recorded the highest proportion of children aged 24 months to less than 27 months at 30 June 2004 who were assessed as being fully immunised (94.9 per cent), while the ACT recorded the lowest (90.0 per cent) (figure 10.18).

Figure 10.18 **Children aged 24 months to less than 27 months who were fully immunised[a, b, c]**



a Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child was located. **b** The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000). **c** There may be some under-reporting by providers, so vaccine coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

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

Notifications of selected childhood diseases

In 2004, there was only one notification of measles in Australia. This represented a national notification rate for measles of 0.1 per 100 000 children aged 0–14 years (figure 10.19) — a large decline from the high rates of the mid-1990s (table 10A.30). In 1994, for example, there were 3088 notifications of measles for children aged 0–14 years, representing a rate of 80.0 per 100 000 children in that age group. Since 2000, the number of annual notifications for measles in Australia has been below 100, with some jurisdictions reporting no notifications in some years.

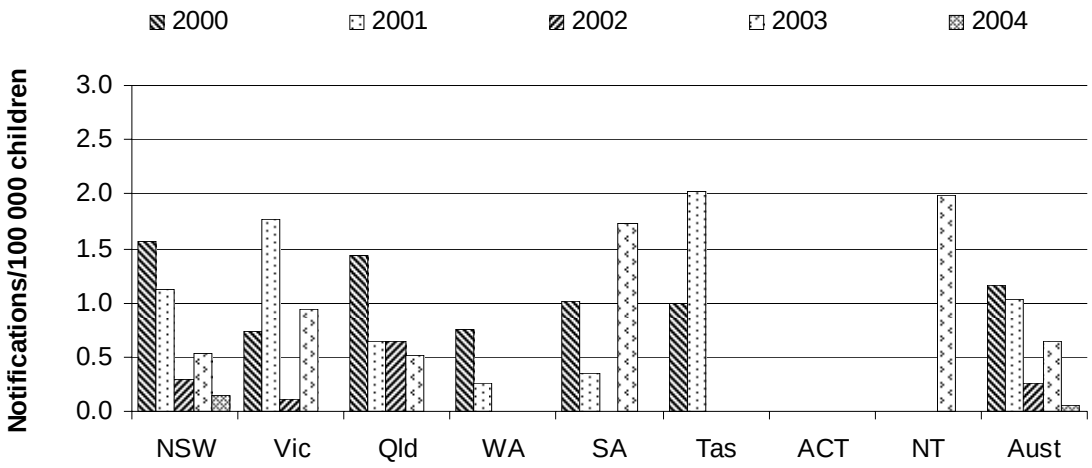
Box 10.16 **Notifications of selected childhood diseases**

Notification rates for selected childhood vaccine preventable diseases (measles, pertussis [whooping cough] and *Haemophilus influenzae* type b) are an outcome indicator of primary and community health because the activities of GPs and community health services can influence the prevalence of these diseases through immunisation (and consequently the notification rates). These childhood diseases are nationally notifiable diseases — that is, if they are diagnosed, there is a requirement to notify the relevant State or Territory authorities. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs for one in 25 cases.

For each disease, the rate of notifications is defined as the number of notifications for children aged 0–14 years per 100 000 children in that age group.

A reduction in the notification rate for the selected diseases indicates the effectiveness of the immunisation program.

Figure 10.19 **Notifications of measles among children aged 0–14 years[a, b]**

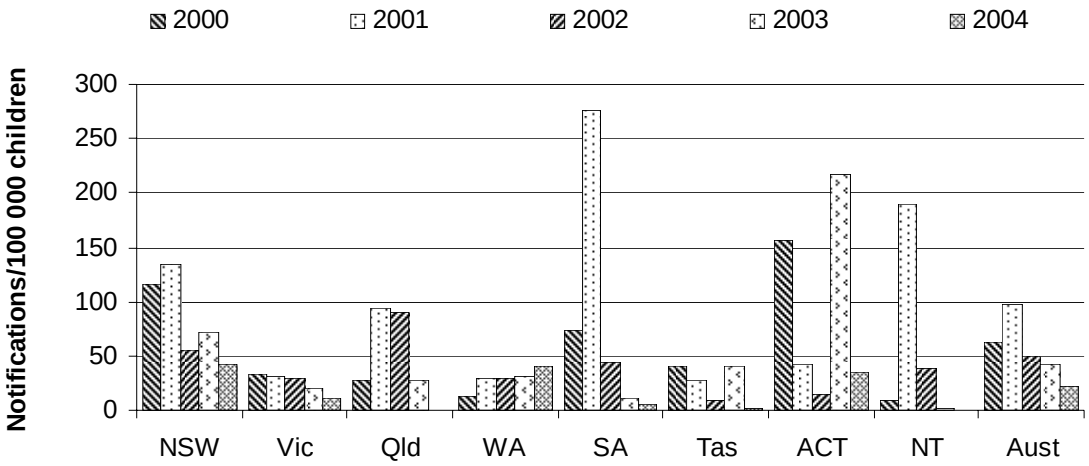


a Notifications for 2004 are to June only and have been adjusted to annual rates for comparison. **b** Where a notification rate for a particular year is nil, no notifications were made in that jurisdiction.

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

In 2004, there were 439 notifications of pertussis (whooping cough) across Australia. This represented a notification rate of 22.1 per 100 000 children aged 0–14 years. Across jurisdictions, the notification rate was highest in NSW (42.1), and lowest in Queensland and the NT (zero) (figure 10.20).

Figure 10.20 **Notifications of pertussis (whooping cough) among children aged 0–14 years[a, b]**

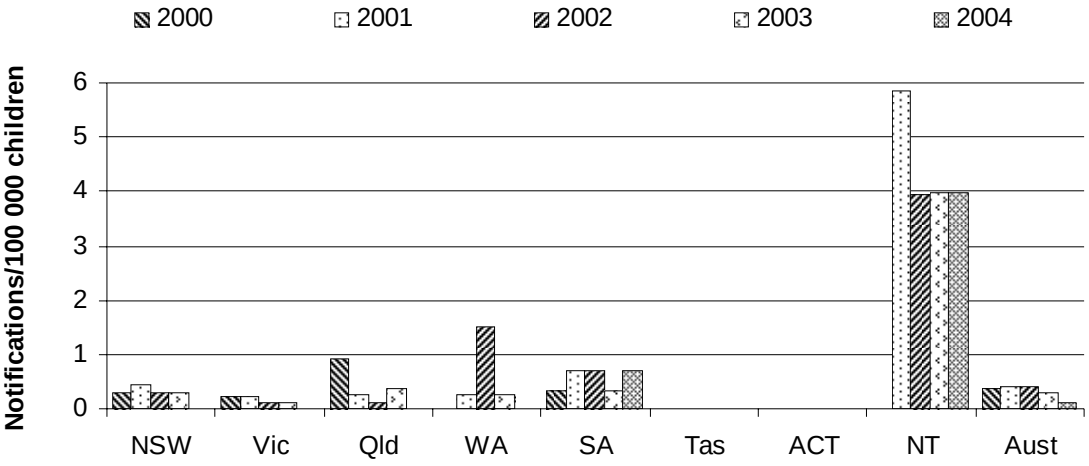


a Notifications for 2004 are to June only and have been adjusted to annual rates for comparison. **b** Where a notification rate for a particular year is nil, no notifications were made in that jurisdiction.

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

In recent years, notification rates for *Haemophilus influenzae* type b have remained low in all jurisdictions except the NT. In 2004, the notification rate Australia-wide was 0.1 per 100 000 children aged 0–14 years. South Australia and the NT each had one case; all other jurisdictions had zero notifications (figure 10.21)

Figure 10.21 **Notifications of *Haemophilus influenzae* type b among children aged 0–14 years[a, b]**



a Notifications for 2004 are to June only and have been adjusted to annual rates for comparison. **b** Where a notification rate for a particular year is nil, no notifications were made in that jurisdiction.

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

Cervical cancer screening rates for target population

The 'cervical cancer screening rates for target population' is an indicator of primary and community healthcare outcomes (box 10.17).

Box 10.17 **Cervical cancer screening rates for women aged 20–69 years**

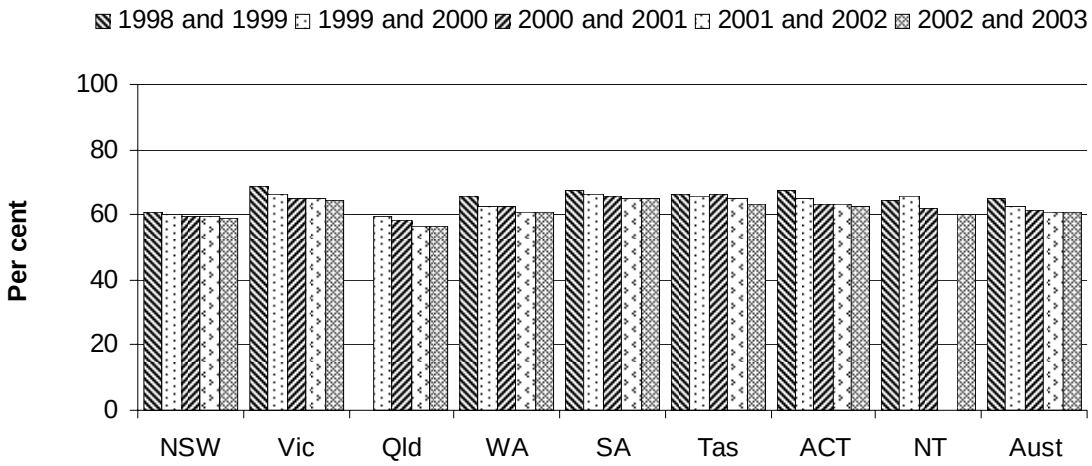
The 'cervical cancer screening rate for target population' (women aged 20–69 years) is an outcome indicator for primary and community healthcare. It is estimated that up to 90 per cent of the most common type of cervical cancer (squamous cervical cancer) may be prevented if cell changes are detected and treated early. As for child immunisation, a range of healthcare providers offer cervical cancer screening tests (Pap smears). The National Cervical Screening Program involves GPs, gynaecologists, family planning clinics and hospital outpatient clinics.

This indicator is defined as the number of women aged 20–69 years who are screened for cervical cancer over a two year period, as a proportion of all women aged 20–69 years. Adjustments are made to account for differences in the female age distribution across states and territories, and to remove from the population of women 20–69 years old (the rate denominator) those who have had a hysterectomy.

An increase in the proportion of women aged 20–69 years who have been screened for cervical cancer would be expected to result in a reduction in the number of women dying from this disease.

During 2002 and 2003, the age standardised proportion of women aged 20–69 years who were screened for cervical cancer was highest in SA (65.1 per cent) and lowest in Queensland (56.6 per cent). Nationally, the proportion declined from 64.8 per cent in the 1998 and 1999 period to 60.6 per cent in the 2002 and 2003 period (figure 10.22). As explained in the notes to figure 10.22, at least part of this decline is likely to be due to changes in the method used to calculate the cervical screening rates.

Figure 10.22 **Age standardised proportion of women aged 20–69 years screened for cervical cancer[a, b, c, d, e, f]**



a In 2001, the ABS carried out a full population Census and a National Health Survey. These led to the revision of the ABS estimated resident population (ERP) data, the introduction of a new Australian standard population for use in age standardisation, and the production of new estimates of hysterectomy status among Australian women. The denominators for participation rates for 2001 and 2002, and 2002 and 2003 have been calculated using the 2001 ABS National Health Survey hysterectomy fractions and the revised ERP values, and age adjusted using the 2001 Australian standard population. The denominators for the equivalent rates for previous years were calculated using the 1995 ABS National Health Survey hysterectomy fractions and unrevised ERP values, and age adjusted using the 1991 Australian standard population. The combined effect of these changes is that participation rates before 2001 and 2002 are on average 1–2 percentage points higher than equivalent rates for subsequent years. **b** Recent fluctuations in participation rates over time and across jurisdictions may be influenced by improvements in record linkage procedures in the State and Territory screening registers. These allow more accurate tracking of individual screening participants over time and may lead to an apparent decrease of up to 3 percentage points in recorded participation rates. **c** NT data were unavailable for 2001 and 2002. **d** Rates for Australia before 1999 and 2000 have been calculated excluding Queensland because the Queensland Health Pap Smear Register did not start operating until February 1999. **e** Some State and Territory cervical cytology registers register only women with a valid address in that State or Territory. Victoria began registering resident women from 2000-01, WA only registered resident women up to, and including, 2000–01, while the ACT has consistently only registered women with a valid ACT address. **f** All data are adjusted to exclude women who have had a hysterectomy.

Source: AIHW analysis of State and Territory Cervical Cytology Registry data (unpublished); table 10A.33.

Influenza vaccination coverage for older people

The 'influenza vaccination coverage for older people' is an indicator of primary and community healthcare outcomes (box 10.18).

Box 10.18 **Influenza vaccination coverage for older people**

Each year, influenza and its consequences result in many older people being hospitalised, as well as a considerable number of deaths. Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (National Health Performance Committee unpublished). GPs provide the majority of influenza vaccinations for older people.

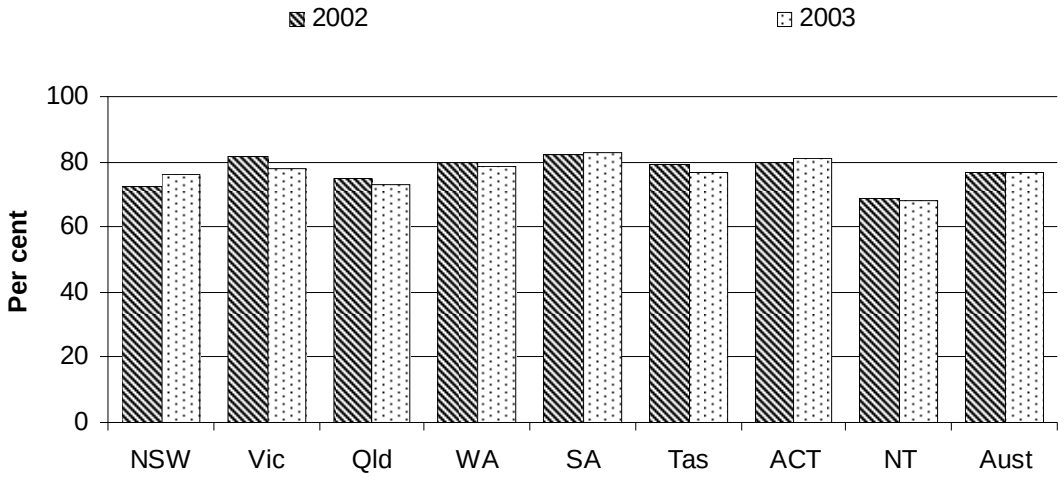
The indicator is defined as the proportion of people aged 65 years or over who have been vaccinated against influenza.

An increase in the proportion of older people vaccinated against influenza reduces the risk of older people contracting influenza and suffering consequent complications.

In 2002, the national age standardised death rate for influenza and pneumonia was 15.3 per 100 000 of the mid-year 2001 population, up from 13.9 per 100 000 people in 2001 (ABS 2003). The hospitalisation rate of people for influenza and pneumonia is included as a separate indicator (box 10.20).

Through the National Influenza Vaccine Program for Older Australians, the Australian Government funds free vaccines for Australians aged 65 years or over (AIHW 2004d). A survey conducted in 2003 found that 76.9 per cent of people aged 65 years or over were vaccinated against influenza in Australia. The same proportion was vaccinated in 2002 (AIHW 2003). Across jurisdictions, the proportion of people aged 65 years or over who were vaccinated in 2003 was highest in SA (82.8 per cent) and lowest in the NT (68.1 per cent) (figure 10.23).

Figure 10.23 **Influenza vaccination coverage, people aged 65 years or over**



Source: AIHW (2003, 2004d); table 10A.34.

Potentially preventable hospitalisations

The following five outcome indicators relate to potentially preventable hospitalisations for a range of conditions. The first three indicators — hospitalisations for vaccine preventable conditions (box 10.20), selected acute conditions (box 10.21) and selected chronic conditions (box 10.22) — were developed by the National Health Performance Committee, based on empirical research (box 10.19). The two other outcome indicators in this category relate to the management of diabetes (box 10.23) and the hospitalisation of older people for falls (box 10.24).

Box 10.19 **Development of, and rationale for, potentially preventable hospitalisation indicators**

The definitions adopted for vaccine preventable conditions, acute conditions and chronic conditions indicators were based on the *Victorian Ambulatory Care Sensitive Conditions Study* (DHS 2002). This study built on research into ambulatory care sensitive conditions (for example, Billings, Anderson and Newman 1996; Bindman *et al.* 1995; Weissman, Gatsonis and Epstein 1992), which was recently the subject of systematic review and empirical analysis.

These studies show that the availability of non-hospital care explains a significant proportion of the variation between geographic areas in hospitalisation rates for the specified conditions. Other explanations for this variation include variation in the underlying prevalence of the conditions, clinical coding standards, and the likelihood that patients will be treated as an outpatient rather than an admitted patient. Potentially preventable hospitalisations will never be entirely eliminated, but the variation across geographic areas demonstrates considerable potential for strengthening the effectiveness of non-hospital care.

Source: National Health Performance Committee (unpublished).

Vaccine preventable hospitalisations

In 2002-03, the age standardised hospital separation rate for all vaccine preventable conditions was highest in the NT (185.8 per 100 000 people) and lowest in the ACT (33.1 per 100 000 people) (table 10.6). Nationally, influenza and pneumonia accounted for 81.3 per cent of age standardised hospitalisations for vaccine preventable conditions in 2002-03, up from 78.3 per cent in 2001-02.

Box 10.20 **Vaccine preventable hospitalisations**

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for vaccine preventable conditions. This influence occurs mainly through the provision of vaccinations and the encouragement of high rates of vaccination coverage for target populations.

This indicator is defined as the number of hospital separations for influenza and pneumonia, and other vaccine preventable conditions per 100 000 people. (Adjustments are made to account for differences in the age structure of populations across states and territories.)

A reduction in hospitalisation rates may indicate improvements in the effectiveness of the vaccination program. Effective treatment by primary health providers may also reduce hospitalisations.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation for vaccine preventable conditions. Examples are the number and virulence of influenza strains from year to year.

Table 10.6 **Standardised hospital separations for vaccine preventable conditions, per 100 000 people[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2001-02									
Influenza and pneumonia	65.6	50.9	73.1	93.9	67.2	67.8	42.9	141.4	66.8
Other conditions	22.3	15.8	14.7	14.4	25.9	10.7	6.3	61.4	18.6
Total[b]	**87.8**	**66.7**	**87.8**	**108.1**	**92.8**	**78.5**	**49.2**	**202.0**	**85.3**
2002-03									
Influenza and pneumonia	61.1	52.1	76.1	82.0	53.7	54.7	30.3	144.0	63.3
Other conditions	16.5	14.6	13.2	9.9	15.6	10.8	2.9	41.8	14.5
Total[b]	**77.5**	**66.7**	**89.3**	**92.0**	**69.3**	**65.5**	**33.1**	**185.8**	**77.9**

a Separation rates are directly age standardised to the Australian population at 30 June 2001. **b** Totals may not equal the sum of the individual conditions due to rounding.

Source: AIHW (2004b).

Box 10.21 **Hospitalisations for selected acute conditions**

The effectiveness of primary and community healthcare services has a significant influence on the rates of hospitalisation for the following selected acute conditions: dehydration and gastroenteritis; pyelonephritis (kidney inflammation caused by bacterial infection); perforated/bleeding ulcer; cellulitis; pelvic inflammatory disease; ear, nose and throat infections; dental conditions; appendicitis; convulsions and epilepsy; and gangrene.

Hospital separation rates for the selected acute conditions are calculated per 100 000 people and adjusted to account for differences in age distributions across State and Territory populations.

A reduction in hospitalisation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation. An example is the underlying prevalence of the conditions. Public health measures not covered in this chapter may also influence the hospitalisation rates.

The age standardised hospital separation rate in 2002-03 for all selected acute conditions was highest in the NT (1771.0 per 100 000 people) and lowest in the ACT (788.8 per 100 000 people). Of the selected acute conditions, dental conditions, and dehydration and gastroenteritis had the highest rates of hospitalisation nationally in 2002-03 (223.0 and 204.7 per 100 000 people respectively) (table 10.7).

Table 10.7 **Standardised hospital separations for potentially preventable acute conditions, per 100 000 people, 2002-03[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Dehydration and gastroenteritis	184.6	241.1	214.8	193.2	201.0	173.0	100.9	185.6	204.7
Pyelonephritis[b]	178.4	194.7	187.7	205.8	183.8	144.0	117.9	329.6	186.5
Perforated/bleeding ulcer	26.1	28.6	21.8	31.6	30.2	21.8	19.7	15.2	26.6
Cellulitis	137.5	144.7	148.5	137.4	126.8	119.5	109.0	318.8	141.4
Pelvic inflammatory disease	30.0	34.9	32.9	32.8	29.3	30.8	24.4	60.1	32.2
Ear, nose and throat infections	164.4	142.1	184.1	185.1	211.7	128.5	88.2	196.9	166.5
Dental conditions	173.3	233.1	246.0	327.3	257.4	164.8	123.4	202.4	223.0
Appendicitis	118.4	121.0	131.8	141.2	116.2	121.8	108.5	143.8	123.9
Convulsions and epilepsy	167.5	154.2	155.2	144.9	150.7	156.4	89.4	269.9	157.8
Gangrene	17.1	24.3	24.0	16.9	18.7	23.8	7.4	48.8	20.7
Total[c]	**1 197.3**	**1 318.5**	**1 346.9**	**1 416.1**	**1 325.6**	**1 084.3**	**788.8**	**1 771.0**	**1 283.4**

a Separation rates are directly age standardised to the Australian population at 30 June 2001. **b** Kidney inflammation caused by bacterial infection. **c** Totals may not equal the sum of the individual conditions due to rounding.

Source: AIHW (2004b).

Hospitalisations for selected chronic conditions

Box 10.22 **Hospitalisations for selected chronic conditions**

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for the following selected chronic conditions: asthma; congestive cardiac failure; diabetes complications; chronic obstructive pulmonary disease; iron deficiency anaemia; hypertension; and nutritional deficiencies. (Diabetes is considered in detail in a separate indicator.)

Hospital separation rates for the selected chronic conditions are calculated per 100 000 people and adjusted to account for differences in age distributions across State and Territory populations.

A reduction in hospitalisation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

Factors outside the control of the primary healthcare sector, however, also influence the rates of hospitalisation. An example is the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

The age standardised hospital separation rate in 2002-03 for all selected chronic conditions was highest in the NT (3513.5 per 100 000 people) and lowest in the ACT (1012.9 per 100 000 people). Of the selected chronic conditions (excluding diabetes, which is discussed below) chronic obstructive pulmonary disease and angina had the highest rates of hospitalisation nationally in 2002-03 (277.5 and 226.4 per 100 000 people respectively). The hospitalisation rate for diabetes complications, however, was more than two and a half times higher than the rate for either of these conditions (table 10.8).

Table 10.8 **Standardised hospital separations for potentially preventable chronic conditions, per 100 000 people, 2002-03[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Asthma	192.1	175.8	170.3	202.1	259.3	107.7	101.8	194.9	186.3
Congestive cardiac failure	197.1	219.8	219.8	193.9	219.0	178.0	136.2	271.8	208.2
Diabetes complications	555.5	975.2	827.8	969.3	776.6	1398.0	425.4	2 208.3	799.8
Chronic obstructive pulmonary disease	273.1	277.0	289.6	274.1	263.3	299.1	161.1	604.8	277.5
Angina	212.2	234.9	284.7	172.3	204.0	222.1	139.1	244.6	226.4
Iron deficiency anaemia	66.9	115.2	79.2	112.8	74.5	83.9	63.8	94.5	86.9
Hypertension	33.2	29.4	37.0	28.2	27.8	27.8	13.3	18.8	31.6
Nutritional deficiencies	0.5	0.6	0.7	1.3	0.2	2.5	1.0	6.1	0.7
Total[b]	**1 488.0**	**1 949.8**	**1 845.4**	**1 891.2**	**1 765.2**	**2 267.0**	**1 012.9**	**3 513.5**	**1 757.9**

a Separation rates are directly age standardised to the Australian population at 30 June 2001. **b** The total is not the sum of the individual conditions because diabetes complications overlap other categories.

Source: AIHW (unpublished).

Box 10.23 **Management of diabetes**

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

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

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

- the proportion of adults with diabetes who have been diagnosed and placed on a Divisions of General Practice diabetes register. An increase in this proportion indicates improved patient management and monitoring.
- the proportion of people on the Divisions' diabetes registers who have had a glycaemic control assessment. An increase in this proportion indicates improved patient management and monitoring.
- the proportion of those who have had a glycaemic control assessment who are at risk of future complications — that is, they have glycated haemoglobin (HbA1c) greater than 2 per cent above the upper limit of normal (ULN). A decrease in this proportion indicates improved disease control.
- hospital separation rates for patients with diabetes mellitus as the principal diagnosis, and for patients with a lower limb amputation and a principal or additional diagnosis of diabetes. These rates are calculated per 100 000 people and adjusted to account for differences in the age distribution of State and Territory populations. A reduction in these rates may indicate an improvement in GPs and community health providers' management of patients' diabetes.

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

Management of diabetes — diabetes register

The National Divisions Diabetes Program Data Collation Project was carried out in 2002-03 and had several components. One component was the collation of the quality of care and health outcomes data from the Divisions of General Practice that

had a diabetes program and a diabetes register that had operated for at least three years. Divisions participated on a voluntary basis, and 16 supplied complete data.

Nationally in 2002, 17.9 per cent of adults with diabetes were on the Divisions' diabetes registers (table 10.9). These data are based on a small and not necessarily representative number of Divisions of General Practice that voluntarily took part in a national data collection.

Table 10.9 **Management of adults with diabetes by participating Divisions of General Practice, 2002[a, b, c, d, e]**

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

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

Source: Centre for GP Integration Studies (2003).

Management of diabetes — glycaemic control assessments

Where a patient has been diagnosed with Type 2 diabetes, accepted clinical guidelines suggest that GPs should regularly monitor a number of important elements, including glycaemic control, blood pressure, weight, foot status, lipids, microalbumin level and eye status. The RACGP/Diabetes Australia guidelines recommend assessment every three to six months for insulin treated patients (Type 1, sometimes referred to as juvenile diabetes because peak onset is much earlier in life) and every six to 12 months for non-insulin treated patients (Type 2, sometimes

referred to as mature age onset diabetes), and a target of HbA1c within 1 per cent of the ULN. Evidence from the UK Prospective Diabetes Study demonstrated that keeping HbA1c within 1 per cent of the ULN reduces the risk of developing complications from diabetes. Where levels are more than 2 per cent above the ULN, early intensive intervention is important to prevent complications.

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

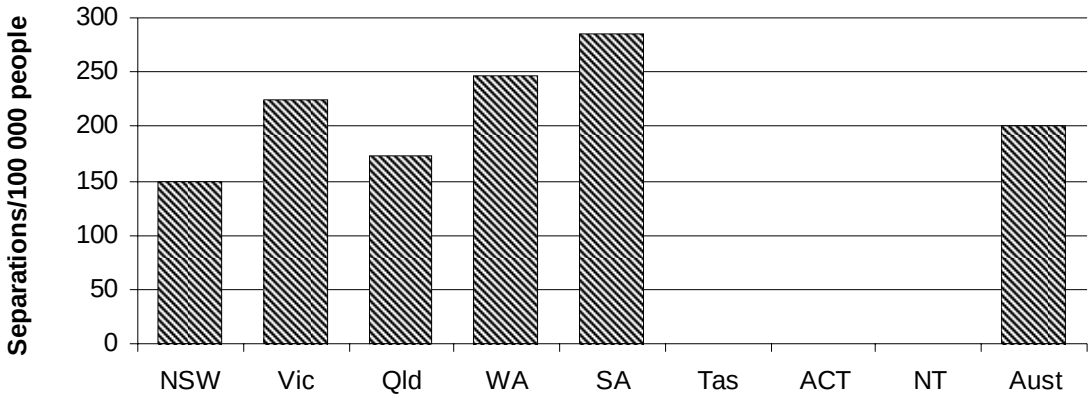
Management of diabetes — patients at risk of complications

Of the people who had undergone a glycaemic control assessment in 2002, 18.7 per cent had HbA1c levels above the point at which there is an increased likelihood of complications (2 per cent above the ULN) (table 10.9). The proportion of adults with Type 2 diabetes with HbA1c levels in this range may initially reflect an increase in the impact of risk factors on changing population cohorts. Over time, however, regular testing and good management by GPs is likely to result in a decline in the proportion of people with diabetes in the category most at risk of complications.

Management of diabetes — hospital separation rates

Across the jurisdictions for which data were published, the age standardised hospital separation rate in 2002-03 where the principal diagnosis was Type 2 diabetes mellitus was highest in SA (285.8 separations per 100 000 people) and lowest in NSW (148.6 separations per 100 000 people). Nationally, there were 201.5 separations per 100 000 people in 2002-03 (figure 10.24).

Figure 10.24 **Standardised hospital separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2002-03[a, b, c, d, e, f, g, h, i, j, k, l, m]**

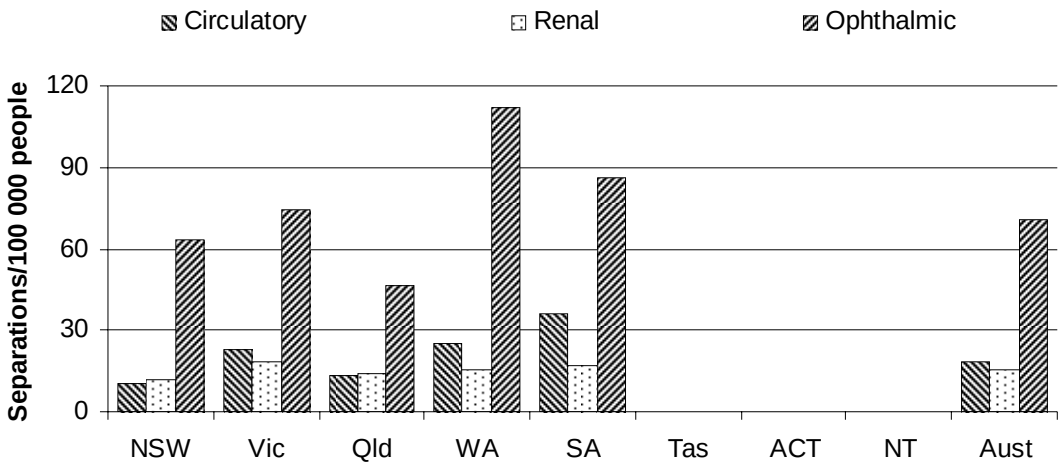


a Separation rates are directly age standardised to the Australian population at 30 June 2001. **b** Figures include unspecified diabetes. **c** Totals include separations for unspecified complications. **d** Crude rates for each jurisdiction were calculated using ABS ERP by age group for the respective jurisdiction. **e** The figures are based on the ICD-10-AM classification. The codes are E11.x and E14.x, where x=2 renal complications, x=3 ophthalmic complications, x=5 peripheral circulatory complications, x=7 multiple complications, x=8 unspecified complications, x=9 without complications and x=0,1,4,6 other specified complications. **f** The data are not person-based, but episode-based. A person who is admitted to hospital, say, three times in the year will be counted three times. **g** The principal diagnosis data are episode-based, but the secondary diagnosis data are diagnosis-based. A separation is represented three times in secondary diagnosis if given three different diabetes codes. **h** Age standardisation tends to exaggerate the effect of multiple episodes for individual patients, particularly in small populations. **i** Although same day admissions for dialysis are not normally coded with a principal diagnosis of Type 2 diabetes, the data could include miscoded separations in several jurisdictions. The results for small jurisdictions reflect both this type of distortion and unreliability arising from small numbers. **j** Results for individual complications may be affected by small numbers, particularly in the smaller jurisdictions, and need to be interpreted with care. **k** 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. **l** Morbidity data are coded under coding standards that may differ over time and across jurisdictions. **m** Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

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

The three most common complications from Type 2 diabetes that led to hospitalisation in 2002-03 were circulatory, renal and ophthalmic complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 10.25). Of the jurisdictions for which data were published, SA had the highest hospital separation rate for multiple complications (56.0 per 100 000 people) and NSW had the lowest (15.9 per 100 000 people) (table 10A.35). Each patient may have one or more complication (circulatory, renal and ophthalmic) for each diabetes hospital separation.

Figure 10.25 **Standardised hospital separations for Type 2 diabetes mellitus as principal diagnosis, by selected complications, all hospitals, 2002-03**[a, b, c, d, e, f, g, h, i, j, k, l, m]



[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Figures include unspecified diabetes. [c] Totals include separations for unspecified complications. [d] Crude rates for each jurisdiction were calculated using ABS ERP by age group for the respective jurisdiction. [e] The figures are based on the ICD-10-AM classification. The codes are E11.x and E14.x, where x=2 renal complications, x=3 ophthalmic complications, x=5 peripheral circulatory complications, x=7 multiple complications, x=8 unspecified complications, x=9 without complications and x=0,1,4,6 other specified complications. [f] The data are not person-based, but episode-based. A person who is admitted to hospital, say, three times in the year will be counted three times. [g] The principal diagnosis data are episode-based, but the secondary diagnosis data are diagnosis-based. A separation is represented three times in secondary diagnosis if given three different diabetes codes. [h] Age standardisation tends to exaggerate the effect of multiple episodes for individual patients, particularly in small populations. [i] Although same day admissions for dialysis are not normally coded with a principal diagnosis of Type 2 diabetes, the data could include miscoded separations in several jurisdictions. The results for small jurisdictions reflect both this type of distortion and unreliability arising from small numbers. [j] Results for individual complications may be affected by small numbers, particularly in the smaller jurisdictions, and need to be interpreted with care. [k] 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. [l] Morbidity data are coded under coding standards that may differ over time and across jurisdictions. [m] Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

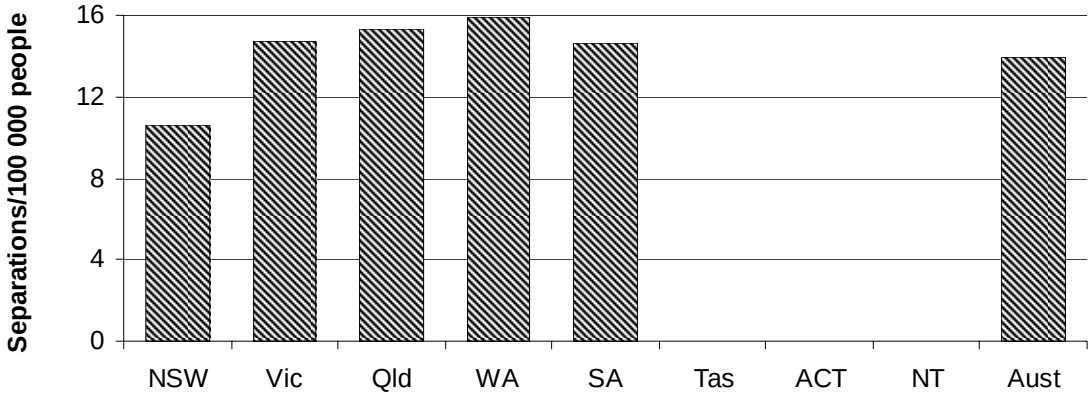
Source: AIHW unpublished; table 10A.35.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings, but the number of people accessing ambulatory services is not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect hospital separations rates. This effect is partly reflected in the substantial variation in the proportion of separations that are 'same day' across jurisdictions. Of the jurisdictions for which data were published, SA had the highest proportion of separations (for principal diagnosis of Type 2 diabetes mellitus) in 2002-03 that were same day (50.5 per cent), while Queensland had the lowest (35.9 per cent)

(table 10A.36). Nationally, 43.7 per cent of separations for Type 2 diabetes were same day in 2002-03 (table 10A.36).

Amputation of a lower limb can be a serious outcome of diabetes-related complications. In 2002-03, there were 13.9 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis. Across the jurisdictions for which data were published, the rate was highest in WA (15.9 per 100 000 people) and lowest in NSW (10.6 per 100 000 people) (figure 10.26).

Figure 10.26 **Standardised hospital separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2002-03[a, b, c]**



a Includes unspecified diabetes. Separation rates are directly age standardised to the Australian population at 30 June 2001. The figures are based on the ICD-10-AM classification. The codes are E11.x and E14.x, where x=0–9 for diabetes, and Blocks 1533, 44367, 44370 and 44373 for amputations. **b** The data are not person-based, but episode-based. A person who is admitted to hospital, say, three times in the year will be counted three times. **c** Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

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

Standardised hospital separation ratios for selected conditions illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in age distributions (see chapter 9, 'Public hospitals'). For males, there was a marked difference in 2002-03 between the separation rate for Indigenous people and those for the total population for all diabetes diagnoses[1] (the separation rate for Indigenous males was 6.0 times higher than those for all Australians males) (table 9A.23). The hospital separation rate for Indigenous females was also markedly higher than for the total female population

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

for all diabetes diagnoses (with the rate for Indigenous females being 7.4 times the rate for all females) (table 9A.24). The 'Health preface' contains data on deaths from diabetes for Indigenous people.

Hospitalisations of older people for falls

Box 10.24 **Hospitalisation of older people for falls**

The effectiveness of primary healthcare has a significant influence on the rates of hospitalisation of older people for falls.

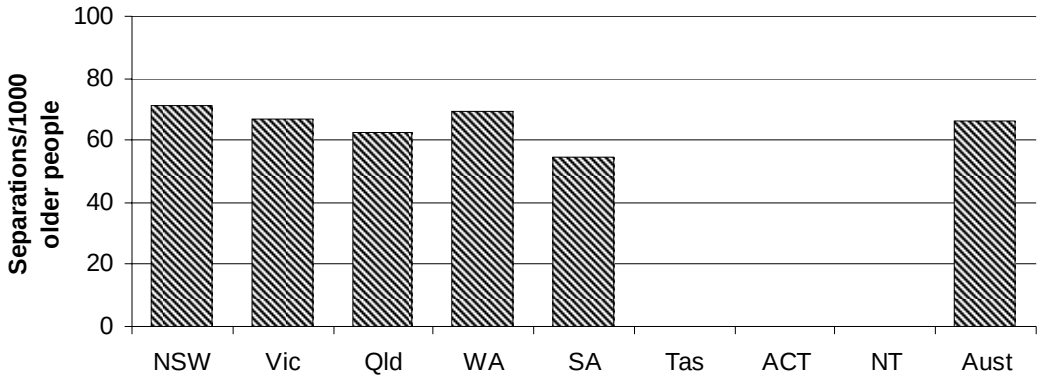
The indicator is defined as the number of hospital separations of older people for falls per 1000 older people, adjusted to take account of differences in State and Territory age distributions. Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over.

A reduction in the rate of hospitalisation due to falls may indicate improvements in the effectiveness of primary healthcare services provided to older people who are at risk of falls.

Factors outside the control of the primary healthcare system, however, also influence the rates of hospitalisation. These include the support available to older people from family and friends, and the provision of aged care services such as Home and Community Care program services and residential care.

Across the jurisdictions for which data were published, the age standardised hospital separation rate in 2002-03 for older people with injuries due to falls was highest in NSW (71.4 per 1000 older people) and lowest in SA (54.6 per 1000 older people) (figure 10.27). Nationally, the rate was 66.1 per 1000 older people.

Figure 10.27 **Standardised hospital separations for older people for injuries due to falls, 2002-03[a, b, c]**



a Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over. **b** Separation rates are directly age standardised to the Australian population at 30 June 2001. **c** Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

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

10.4 Future directions in performance reporting

While the topic of this chapter is all primary and community health services, the indicators still focus heavily on general practice services. This focus partly reflects the lack of data that are available on a nationally consistent basis to support reporting against indicators for other primary and community health services. The National Health Performance Committee has recognised this issue and is working to develop a broader range of primary and community health indicators. Where appropriate, these indicators will be adopted and reported in future editions of the report.

Possible areas for which indicators may be available for inclusion in the 2006 Report or future reports include:

- dental health services
- community-based drug and alcohol treatment services
- additional indicators relating to the use of the MBS EPC items.

The scope of this chapter may also be further refined to ensure the most appropriate reporting of primary health services against the Review's terms of reference and reporting framework (see chapter 1).

Indigenous health

Barriers to accessing primary health services contribute to the poorer health status of Indigenous people compared to other Australians (see the 'Health preface'). In recognition of this issue, the Steering Committee has identified primary and community health services for Indigenous people as a priority area for future reporting. Accordingly, the Steering Committee will examine options for including indicators of the accessibility of primary and community health services to Indigenous people. The Aboriginal and Torres Strait Islander Health Performance Framework that is being developed by the National Aboriginal and Torres Strait Islander Health Council will help inform the selection of future indicators of primary and community health services to Indigenous people (see the 'Health preface').

10.5 Definitions of key terms and indicators

Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Cervical screening rates for target population	Proportion of women screened against cervical cancer who are aged 20–69 years.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Divisions of General Practice	Geographically-based networks of GPs. Currently, there are 120 Divisions of General Practice. The Divisions of General Practice Program evolved from the former Divisions and Projects Grants Program established in 1992. The aim of the Divisions of General Practice Program is to improve health outcomes for communities by encouraging GPs to work together and link with other health professionals to upgrade the quality of health service delivery at the local level.
Full time workload equivalents	A measure of medical practitioner supply based on claims processed by Medicare in a given period, calculated by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that period. Full time equivalents are calculated in the same way as FWE except that full time equivalents are capped at 1 for each practitioner.
Fully immunised at 12 months	A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine and three doses of HbOC (HibTITER) (or two doses of PRP-OMP [PedvaxHIB]).
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine, four doses of HbOC (HibTITER) (or three doses of PRP-OMP [PedvaxHIB]) and one dose of measles, mumps, rubella vaccine.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.

General practitioner (GP)	Registered GPs — medical practitioners who, for the purposes of Medicare, are vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or equivalent, hold a recognised training placement or are otherwise entitled to bill Group A1 MBS items. OMPs — medical practitioners who have at least half of the schedule fee value of their Medicare billing from non-referred attendances, consisting solely or predominantly of Group A2 items.
Health management	An ongoing process beginning with initial client contact and including all actions relating to a client. Includes: assessment/evaluation; education of the person, family or carer(s); diagnosis and treatment; management of problems associated with adherence to treatment; and liaison with, or referral to, other agencies.
Immunisation coverage	A generic term indicating the proportion of a target population that is fully immunised with a particular vaccine or the specified vaccines from the National Immunisation Program for that age group.
Management of upper respiratory tract infections	Number of prescriptions ordered by GPs for the oral antibiotics most commonly used in the treatment of upper respiratory tract infections per 1000 people with PBS concession cards.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive Medicare reimbursement.
Non-specialist non-referred attendances that are bulk billed	Number of non-referred non-specialist attendances that are bulk billed and provided by non-specialist medical practitioners, divided by the total number of non-referred non-specialist attendances.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (DHA 2004). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.
Notifications of selected childhood diseases	Number of cases of measles, pertussis and *Haemophilus influenzae* type b notified to State and Territory health authorities.
Other medical practitioner	A medical practitioner other than a registered GP who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendance items consisting solely or predominantly of Group A2 items.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.
Per person benefits paid for GP ordered pathology	Total benefits paid for pathology tests ordered by GPs, divided by the population.

Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging tests referred by GPs, divided by the population.
Primary healthcare	The primary and community healthcare sector includes services that: • provide the first point of contact with the health system • have a particular focus on illness prevention or early intervention • are intended to maintain people's independence and maximise their quality of life through care and support at home or in local community settings.
Prevalence	The proportion of the population suffering from a disorder at a given point in time (point prevalence) or during a given period (period prevalence).
Proportion of GPs who are female	Number of all FWE GPs who are female, divided by the total number of FWE GPs.
Proportion of GPs with vocational registration	Number of FWE GPs who are vocationally registered, divided by the total number of FWE GPs.
Proportion of general practices registered for accreditation	Number of practices that have registered for accreditation through AGPAL, divided by the total number of practices in the Divisions of General Practice.
Proportion of general practices with electronic information management systems	Number of practices with electronic prescribing and/or electronic connectivity that are registered under the PIP, divided by the total number of practices registered.
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Reasons for encounter	The expressed demand of the patient for care, as perceived and recorded by the GP.
Registered general practitioner	A vocationally registered GP, a Fellow of the RACGP or equivalent, a general practice registrar in a training placement, or a medical practitioner who is otherwise entitled to bill Group A1 MBS items.
Recognised immunisation provider	A provider recognised by the Health Insurance Commission as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist on the Medicare database earning at least half of his/her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than would otherwise be possible without the test.
Vocational registration	GPs who are registered separately for Medicare purposes and who receive higher Medicare benefits for services.

10.6 References

ABS (Australian Bureau of Statistics) 2002, *2001 National Health Survey: Summary of Results*, Cat. no. 4364.0, Canberra.

—— 2003, *Causes of Death, Australia*, Cat. no. 3303.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 2001, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, Cat. no. 7, Canberra.

—— 2003, *2002 Influenza Vaccine Survey: Summary Results*, Cat. no. PHE 46, Canberra.

—— 2004a, *Alcohol and Other Drug Treatment Services in Australia 2002–03: Report on the National Minimum Data Set*, Cat. no. HSE 33, Drug Treatment Series no. 3, Canberra.

—— 2004b, *Australian Hospital Statistics*, AIHW, Canberra.

—— 2004c, *Health Expenditure Australia 2002-03*, Cat. no. HWE 24, Health and Welfare Expenditure Series no. 17, Canberra.

—— 2004d, *2003 Influenza Vaccine Survey: Summary Results*, Cat. no. PHE 51, Canberra.

Billings, J., Anderson, G.M. and Newman, L.S. 1996, 'Recent findings on preventable hospitalisations', *Health Affairs*, vol. 15, no. 3.

Bindman, A.B., Grumbach, K., Osmond, D., Komaromy, M., Vranizan, K., Lurie, N., Billings and J., Stewart, A. 1995, 'Preventable hospitalisations and access to health care', *Journal of the American Medical Association*, vol. 274, no. 3.

Britt, H., Miller, G.C., Charles, J., Knox, S., Sayer, G.P., Valenti, L., Henderson, J. and Kelly, Z. 2000, *General Practice Activity in Australia 1999-2000*, AIHW Cat. no. GEP 5, Australian Institute of Health and Welfare, Canberra.

——, Miller, G.C., Knox, S., Charles, J., Valenti, L., Henderson, J., Pan, Y., Bayram, C. and Harrison C. 2003, *General Practice Activity in Australia 2002-03*, Cat. no. GEP 14, Australian Institute of Health and Welfare, Canberra.

——, Miller, G.C., Knox, S., Charles, J., Valenti, L., Pan, Y., Henderson, J., Bayram, C., O'Halloran, J. and Ng, A. 2004, *General Practice Activity in Australia 2003–04*, Cat. no. GEP 16, Australian Institute of Health and Welfare, Canberra.

——, Valenti, L., Miller, G.C. 2002, 'Time for care: length of GP-patient encounters in general practice in Australia', *Australian Family Physician*, vol. 31, no. 9, pp. 876–80.

Centre for GP Integration Studies 2003, *Diabetes Health Outcomes, National Divisions Diabetes Program: Divisions Diabetes and CVD Quality Improvement Project*, School of Public Health and Community Medicine, University of New South Wales, Sydney.

DHAC (Australian Government Department of Health and Aged Care) 2000, *General Practice in Australia: 2000*, Canberra.

DHA (Australian Government Department of Health and Ageing) 2004, 'Australian national notifiable diseases list and case definitions', www.health.gov.au/internet/wcms/publishing.nsf/Content/cda_surveil-nndss-dislist.htm#pagetop (accessed 17 November 2004).

DHS 2002, *Victorian Ambulatory Care Sensitive Conditions Study: Preliminary Analyses*, Victorian Government, Melbourne.

DHFS (Australian Government Department of Health and Family Services) 1996, *General Practice in Australia: 1996*, Canberra.

Hull, B. and McIntyre, P. 2000, 'A re-evaluation of immunisation coverage estimates from the Australian Childhood Immunisation Register', *Communicable Diseases Intelligence*, vol. 24, no. 6.

National Advisory Committee on Oral Health 2004, *Healthymouths Healthy Lives: Australia's National Oral Health Plan 2004–2013*, Report prepared for the Australian Health Ministers' Conference, Government of South Australia, Adelaide.

NCIRS (National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases) 2000, *Vaccine Preventable Diseases and Vaccination Coverage in Australia, 1993–1998*, University of Sydney, Royal Alexandra Hospital for Children and Australian Government Department of Health and Aged Care, Canberra.

Quality Improvement Council 1998, *Australian Health and Community Service Standards: Community and Primary Health Care Services Module*, Melbourne.

Weissman, J.S., Gatsonis, C. and Epstein, A.M. 1992, 'Rates of avoidable hospitalisation by insurance status in Massachusetts and Maryland', *Journal of the American Medical Association*, vol. 268, no. 17.

11 Health management issues

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the management of breast cancer and mental health, and represents some activities of the Australian, State and Territory governments in health management.

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

Improvements this year to the reporting of mental health management include presenting Indigenous suicide deaths data averaged over three year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions.

Supporting tables

Supporting tables for chapter 11 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel format as \Publications\Reports\2005\Attach11A.xls and in Adobe PDF format as \Publications\Reports\2005\Attach11A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 11A.3 is table 3 in the electronic files). These files can be found on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

11.1 Overview of health management

Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. This chapter seeks to examine the performance of a number of services in influencing outcomes for women with breast cancer and for people with a mental illness. Measuring performance in the management of a health problem involves measuring the performance of service providers and the overall management of a spectrum of services, including prevention, early detection and treatment programs.

Breast cancer and mental illness are significant causes of morbidity and mortality in Australia. Cancer control and mental health are identified by governments as national health priority areas, as are asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and musculoskeletal conditions. These areas represent almost 80 per cent of the total burden of disease and injury in Australia, and their management offers considerable scope for reducing this burden (AIHW 2003b).

Appropriate management of breast cancer and mental health will have a large effect on the health and wellbeing of many Australians. Both are the subject of programs designed to improve public health. Public health programs require the participation of public hospitals, primary and community health services, and other services. The performance of public hospitals is discussed in chapter 9 and the performance of primary and community health services generally is discussed in chapter 10.

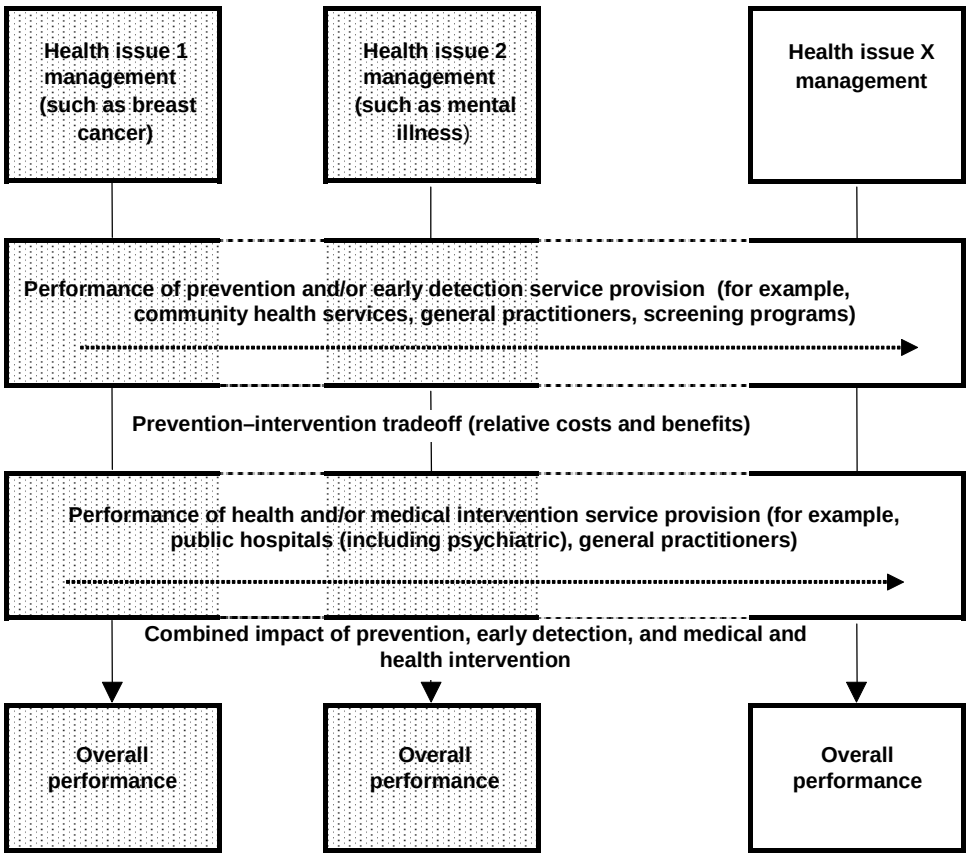
11.2 Framework for measuring the performance of health management

The 'Health preface' of this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and primary and community health services report the performance of particular service delivery mechanisms. The appropriateness of the mix of services (prevention versus intervention) and the appropriateness of the mix of delivery mechanisms (hospital-based versus community-based) are the focus of reporting in this chapter. The measurement approach adopted is represented diagrammatically in figure 11.1.

The appropriate mix of services — including the prevention of illness and injury, medical treatment and the appropriate mix of service delivery mechanisms — is measured by focusing on a health management issue (represented by the vertical arrows). As in previous years, the chapter covers breast cancer detection and

management, and specialised mental health services. The breast cancer management framework integrates the early detection and medical intervention strategies, which should inform the tradeoffs in the allocation of resources between these two strategies. The mental health framework provides information on the interaction and integration arrangements between community-based and hospital-based providers in meeting the needs of Australians with a mental illness.

Figure 11.1 **The Australian health system — measurement approach**



11.3 Breast cancer

Profile

Breast cancer is a disease whereby uncontrolled or malignant cell division leads to the formation of a tumour or tumours in a woman's breast (box 11.1).[1] Tumours may expand locally by invading surrounding tissue, or they may spread via the

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

lymphatic or vascular systems to the rest of the body. If left untreated, most malignant tumours result in the death of the affected person (AIHW 2003a). The focus of this Report is on invasive cancers, although some data are reported on *ductal carcinoma in situ* (DCIS — noninvasive tumours residing in the ducts of the breast).

Box 11.1 **Some common health terms used in breast cancer detection and management**

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

BreastScreen Australia: a national program that undertakes nationwide breast cancer screening. Services provided by BreastScreen Australia include all screening and assessment services to the point of diagnosis. The program includes health promotion activities, information provision, counselling and data collection across the screening pathway. BreastScreen Australia is jointly funded by the Australian, State and Territory governments.

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

health management: an ongoing process beginning with initial client contact and including all actions relating to the client: assessment/evaluation; education of the person, family or carer(s); diagnosis; and treatment. Problems associated with adherence to treatment and liaison with, or referral to, other agencies are also included.

incidence rate: the proportion of the population newly diagnosed with a particular disorder or illness during a given period (often expressed per 100 000 people).

invasive cancer: a tumour whose cells invade healthy or normal tissue.

prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

screening: the performance of tests on apparently well people to detect disease at an earlier stage than would otherwise be the case.

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

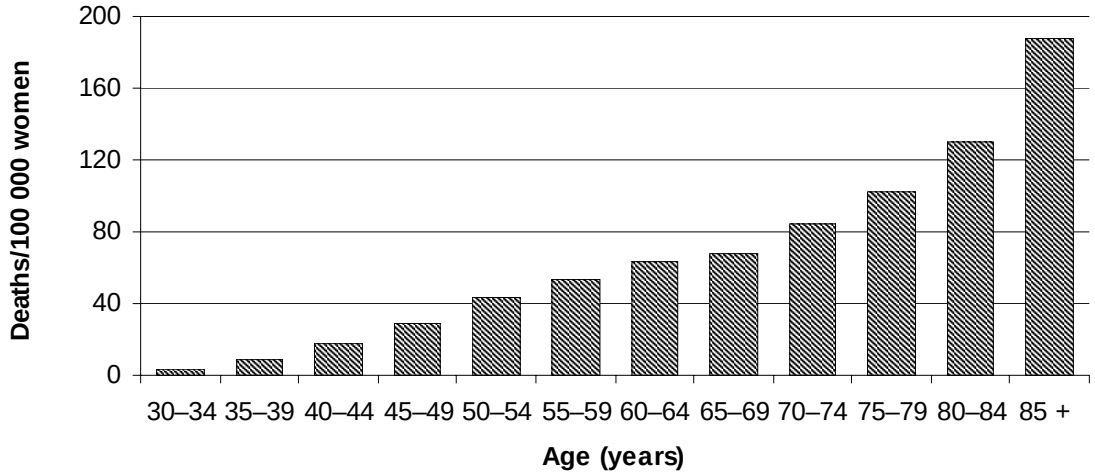
screening round (subsequent): a woman's second or subsequent visit to a BreastScreen Australia service.

total mastectomy: removal of the breast (also known as a simple mastectomy).

Breast cancer was responsible for 2698 female deaths in 2002, making it the most frequent cause of death from cancer for females (ABS 2003). The strong

relationship between age and the mortality rate from breast cancer is shown for the period 1998–2002 in figure 11.2. Women aged 40–44 years had an annual average mortality rate over this period of 17.2 per 100 000, whereas women aged 75–79 years had an annual average mortality rate of 102.2 per 100 000.

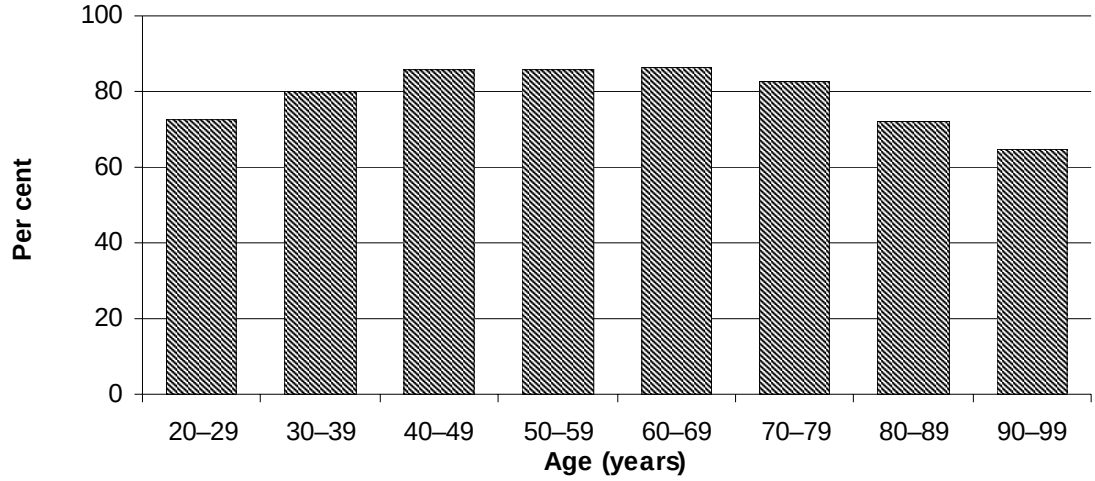
Figure 11.2 **Annual average mortality rates from breast cancer, by age group, 1998–2002**



Source: AIHW (unpublished); table 11A.19.

Relative survival after diagnosis of breast cancer in females is good compared with other cancers. Over the period 1992–97, for women of all ages in Australia, relative survival was 96.4 per cent one year after diagnosis, and 84.0 per cent five years after diagnosis. Relative survival 10 years after diagnosis was 68.3 per cent in the period 1987–91 (AIHW and AACR 2001). Five year relative survival for breast cancer in Australia at diagnosis over the period 1992–97 increased with age from the age group 20–29 years (72.4 per cent) to a peak for the age groups 40–49 years (85.8 per cent), 50–59 years (85.7 per cent) and 60–69 years (86.1 per cent). The five year relative survival rate declined with age for women over 70 years (figure 11.3).

Figure 11.3 **Breast cancer five year relative survival at diagnosis, by age group, 1992–97[a]**



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

Source: AIHW and AACR (2001)*;* table 11A.1.

Incidence and prevalence

Breast cancer is the most prevalent type of cancer affecting Australian women. For the period 1992–96, the risk of a woman in Australia developing breast cancer before the age of 75 years was one in 12 (AIHW *et al.* 1999). The number of new cases of breast cancer diagnosed in Australian women increased from an annual average of 9695 over the period 1993–97 to an annual average of 10 522 over the period 1996–2000 (table 11.1). The increase in the number of cases detected reflected both an increase in the underlying rate of breast cancer, as well as the early detection of cancers that previously would not have been discovered for some years, primarily through the introduction of BreastScreen Australia (AIHW 2003a).

Annual average age standardised incidence rates of breast cancer are presented in figure 11.4. Breast cancer incidence data are averaged over five year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases but relatively large variations in rates from year to year. The Australian incidence rate increased from an annual average of 108.5 per 100 000 women for the period 1992–96 to an annual average of 112.4 for the period 1996–2000. Over the latter period, the annual average incidence rate for women of all ages (standardised by age) was highest in the ACT (118.0 per 100 000 women) and lowest in the NT (93.1 per 100 000 women).

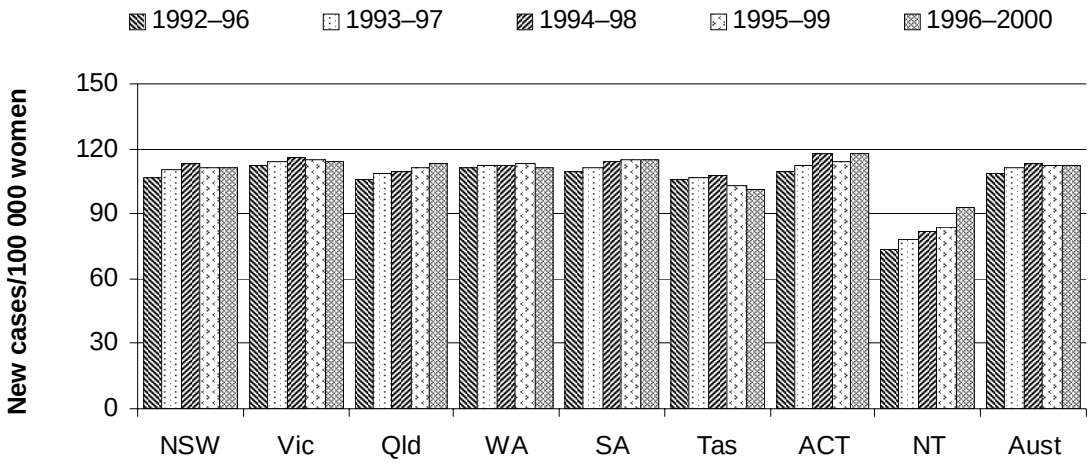
Table 11.1 **Annual average new cases of breast cancer diagnosed (number)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1993–97	3 356	2 561	1 629	872	850	249	136	41	9 695
1994–98	3 491	2 657	1 701	903	888	255	147	44	10 087
1995–99	3 520	2 685	1 781	937	910	247	148	44	10 271
1996–2000	3 585	2 731	1 873	949	929	248	157	50	10 522

a A new case is defined as a person who has a cancer diagnosed for the first time. One person may have more than one cancer, so may be counted twice in incidence statistics if it is decided that the two cancers are not of the same origin.

Source: AIHW (unpublished); table 11A.2.

Figure 11.4 **Annual average age standardised incidence rates of breast cancer for women of all ages[a, b]**

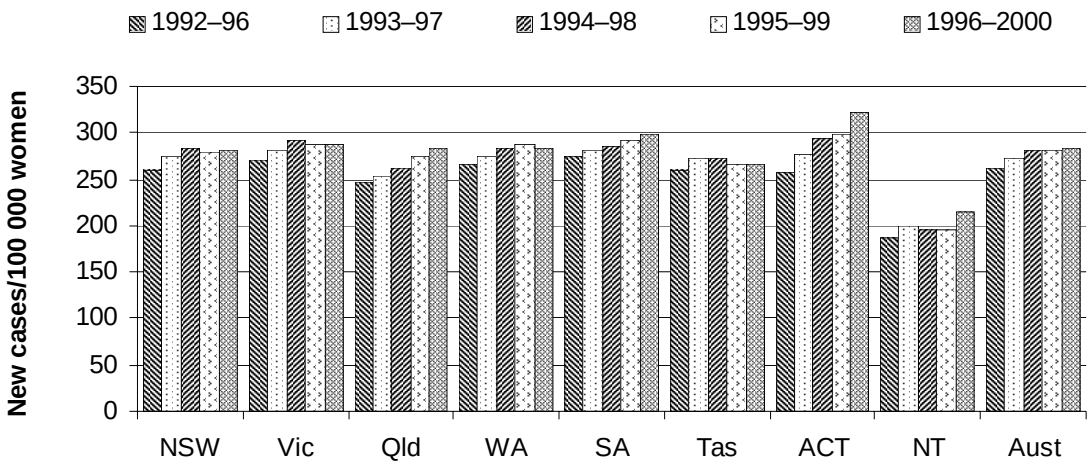


a Incidence refers to the number of new cases of breast cancer per 100 000 women. **b** Rates are age standardised to the Australian 2001 population standard.

Source: AIHW (unpublished); table 11A.3.

Annual average age standardised incidence rates of breast cancer for women aged 50–69 years are shown in figure 11.5. For 1996–2000, annual average incidence rates were highest in the ACT (322.5 per 100 000 women) and lowest in the NT (214.7 per 100 000 women).

Figure 11.5 **Annual average age standardised incidence rates of breast cancer for women aged 50–69 years[a, b]**



a Incidence refers to the number of new cases of breast cancer per 100 000 women. **b** Rates are age standardised to the Australian 2001 population standard.

Source: AIHW (unpublished); table 11A.3.

Size and scope of breast cancer detection and management services

Breast cancer detection and management services comprise a number of major components: primary care and community-based services, including general practitioner (GP) services and community-based women's health services; screening services; acute services based in hospitals, including both inpatient and outpatient services; private consultations for a range of disciplines; and post-acute services, including home-based and palliative care (DHS 1999).

A fundamental component of breast cancer control is the use of screening mammography to enable early detection of breast cancer. There is evidence that population-based screening of women aged 50–69 years can reduce deaths from breast cancer. According to the National Breast Cancer Centre, women whose cancer is diagnosed before it has spread outside the breast have a 90 per cent chance of surviving five years. The five year survival rate drops to 20 per cent if the cancer spreads to other parts of the body before diagnosis (NBCC 2003). It is generally argued that cancers detected early may be treated more conservatively and that these women have a higher likelihood of survival.

A 2001 review of mammography screening research cast doubt on the evidence that screening for breast cancer reduces mortality, raising questions about the positive impact of screening on population health. It also suggested that screening may lead to aggressive treatment that may be unnecessary in some cases (Olsen and Gotzsche

2001). Further, some morbidity is associated with breast cancer screening, such as false positives, discomfort and anxiety. In addition, screening techniques have improved to the extent that very small growths can now be detected, but the risk of such growths posing a future danger is uncertain (Gorman 2002).

In response to these doubts, a working group convened by the International Agency for Research on Cancer of the World Health Organisation evaluated the available research on breast cancer screening in March 2002. The working group concluded that there is sufficient evidence of the efficacy of mammography screening for women aged 50–69 years. The reduction in mortality from breast cancer among women who choose to participate in organised screening programs was estimated to be around 35 per cent. For women aged 40–49 years, there is only limited evidence of a reduction in mortality. When considering population screening models, the working group concluded that the effectiveness of national screening programs varies as a result of differences in the coverage of the female population, the quality of mammography, the quality and appropriateness of treatment, and other factors. Organised screening programs are more effective in reducing deaths than is sporadic screening of selected groups of women. The working group also concluded that there is insufficient evidence that clinical breast examination or self-examination reduces mortality from breast cancer (WHO 2002).

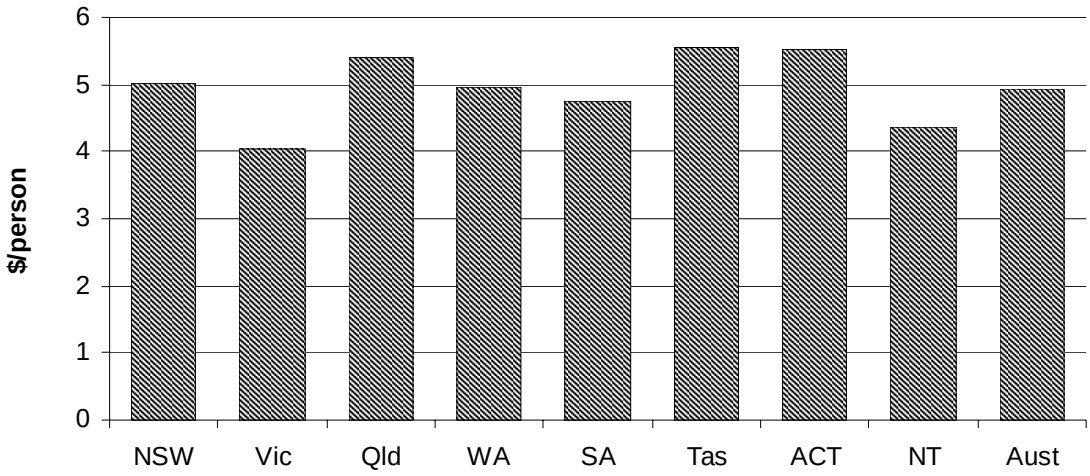
BreastScreen Australia, jointly funded by the Australian, State and Territory governments, undertakes nationwide breast cancer screening. It targets women aged 50–69 years for screening once every two years. The program aims to have 70 per cent or more women aged 50–69 years participating in screening over a 24 month period. All recruitment activities undertaken by BreastScreen Australia specifically target women in this age group, although women aged 40–49 years and those over 70 years may also use the service.

Services provided by BreastScreen Australia in each State and Territory include all screening and assessment services to the point of diagnosis. The program includes health promotion activities, information provision, counselling and data collection across the screening pathway. Each jurisdiction manages a central BreastScreen registry to ensure women with a screen detected abnormality receive follow-up treatment and to enable women to be invited for re-screening at the appropriate interval. Data collected from the registries allow for quality assurance, monitoring and evaluation of the program. All jurisdictions perform fine needle aspiration biopsy and core biopsies as part of their assessment services, but some jurisdictions do not include open biopsies in the funded program (table 11A.4).

Information on BreastScreen Australia program performance is published by the Australian Institute of Health and Welfare (AIHW) in the BreastScreen Australia monitoring reports, the most recent of which was published in 2003 (AIHW 2003a).

Governments spent around $97.8 million on breast cancer screening in 2001-02 (table 11A.5). Estimates of government expenditure on breast cancer screening per person are presented by jurisdiction in figure 11.6. These estimates include Australian, State and Territory government expenditure. Differences across jurisdictions partly reflect variation in the proportion of women in the target age group for breast cancer screening, data deficiencies and collection methods, as well as the nature of the services and their relative efficiency. Some differences may also be due to the geography of a State or Territory, and to the proportion of target women living in rural and remote areas. The data thus need to be viewed with care.

Figure 11.6 **Public health expenditure on breast cancer screening, 2001-02**[a, b, c, d, e, f, g]



a In every jurisdiction, BreastScreen Australia is a joint initiative funded by both the State or Territory government and the Australian Government under the Public Health Outcome Funding Agreements. **b** The data need to be viewed with care as a result of data deficiencies, differences across jurisdictions relating to the use of cash accounting and accrual methods, the treatment of corporate and central office costs, differences in methods used to collect expenditure figures, and differences in the interpretation of public health expenditure definitions. **c** The Australian total includes Australian Government direct project expenditure, database or registry and other program support, population health non-grant program costs and running costs. **d** Medicare funding for radiographic breast examinations is excluded because it is not public health expenditure. **e** Victorian data include depreciation. **f** Data for the ACT include expenditure on BreastScreen ACT and the Cancer Registry. **g** Data for the NT for direct expenditure include public health information systems, disease surveillance and epidemiological analysis, public health communication and advocacy, public health policy, program and legislation development, and public health workforce development.

Source: AIHW (2004c); ABS, Cat. no. 3101.0 (unpublished); tables A.2 and 11A.5.

The number of women aged 40 years or over screened by BreastScreen Australia indicates the size of the BreastScreen Australia program. Around 842 000 women in this age group were screened in 2003, compared with 759 103 in 1999 (table 11.2).

Table 11.2 **Number of women screened by BreastScreen Australia[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1999	273 995	171 389	153 870	59 999	64 195	19 333	12 255	4 067	759 103
2000	277 400	177 232	163 731	65 593	65 494	21 344	11 463	4 148	786 405
2001	297 372	188 677	171 337	71 432	69 774	20 702	12 160	4 416	835 870
2002	294 011	187 714	177 281	69 697	68 571	22 204	11 793	4 166	835 437
2003	289 912	188 782	180 396	76 059	69 182	22 424	10 651	4 548	841 954

a First and subsequent screening rounds, for women aged 40 years or over.

Source: State and Territory governments (unpublished); table 11A.6.

A number of services assist in the management of breast cancer once diagnosed. GPs are critical as the initial point of referral to specialists for diagnosis and treatment services. Hospitals provide initial treatment for breast cancer and help manage ongoing care and follow-up. Relevant clinical disciplines include surgery, plastic and reconstructive surgery, pathology, radiation and medical oncology, nursing, diagnostic radiology, radiography, physiotherapy, allied health, and psychological and psychiatric services. Post-acute services include a range of further treatments, such as radiotherapy and chemotherapy (most of which take place on a same day or outpatient basis) and a range of follow-up and palliative care services (DHS 1999).

Inpatient separations in public hospitals for selected breast-cancer related Australian refined diagnosis related groups (AR-DRGs)[2] in 2002-03 are presented in table 11.3. Most of the data relating to breast cancer detection and management in this Report are provided by BreastScreen Australia. At present, data for services other than breast cancer screening are limited.

[2] AR-DRGs are a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG versions 4.1 and 4.2 are based on the ICD-10-AM classification (see chapter 9 for more detail).

Table 11.3 **Separations for selected AR-DRGs related to breast cancer, public hospitals, 2002-03 (per 10 000 people)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major procedures for malignant breast conditions									
	0.9	0.7	0.5	0.3	0.2	0.1	–	–	2.7
Minor procedures for malignant breast conditions									
	0.4	0.3	0.2	0.1	0.1	–	–	–	1.3
Skin, subcutaneous tissue and plastic breast procedures									
	0.9	0.8	0.7	0.3	0.5	–	–	–	3.2
Other skin, subcutaneous tissue and breast procedures									
	4.5	5.6	4.6	2.0	2.6	0.3	0.1	0.1	19.8
Malignant breast disorders (age >69 years w CC)									
	0.1	0.1	–	–	–	–	–	–	0.3
Malignant breast disorders (age <70 years w CC) or (age >69 years w/o CC)									
	0.2	0.4	0.2	–	0.1	–	–	–	0.9
Malignant breast disorders (age <70 years w/o CC)									
	0.1	0.2	0.1	0.1	–	–	–	–	0.4
Total separations in public hospitals									
	1 871.8	2 273.3	1 802.1	1 855.8	2 337.7	1 658.0	1 937.1	3 394.5	2 003.1

w/o CC = without complications and co-morbidities. w CC = with complications and co-morbidities. **a** Care needs to be taken when comparing jurisdictions because admission practices vary. **b** AR-DRG version 4.2. – Nil or rounded to zero.

Source: AIHW (2004a, www.aihw.gov.au/publications/index.cfm/title/10015/ahs02-03-xd11.xls, accessed 11 November 2004); table 11A.7.

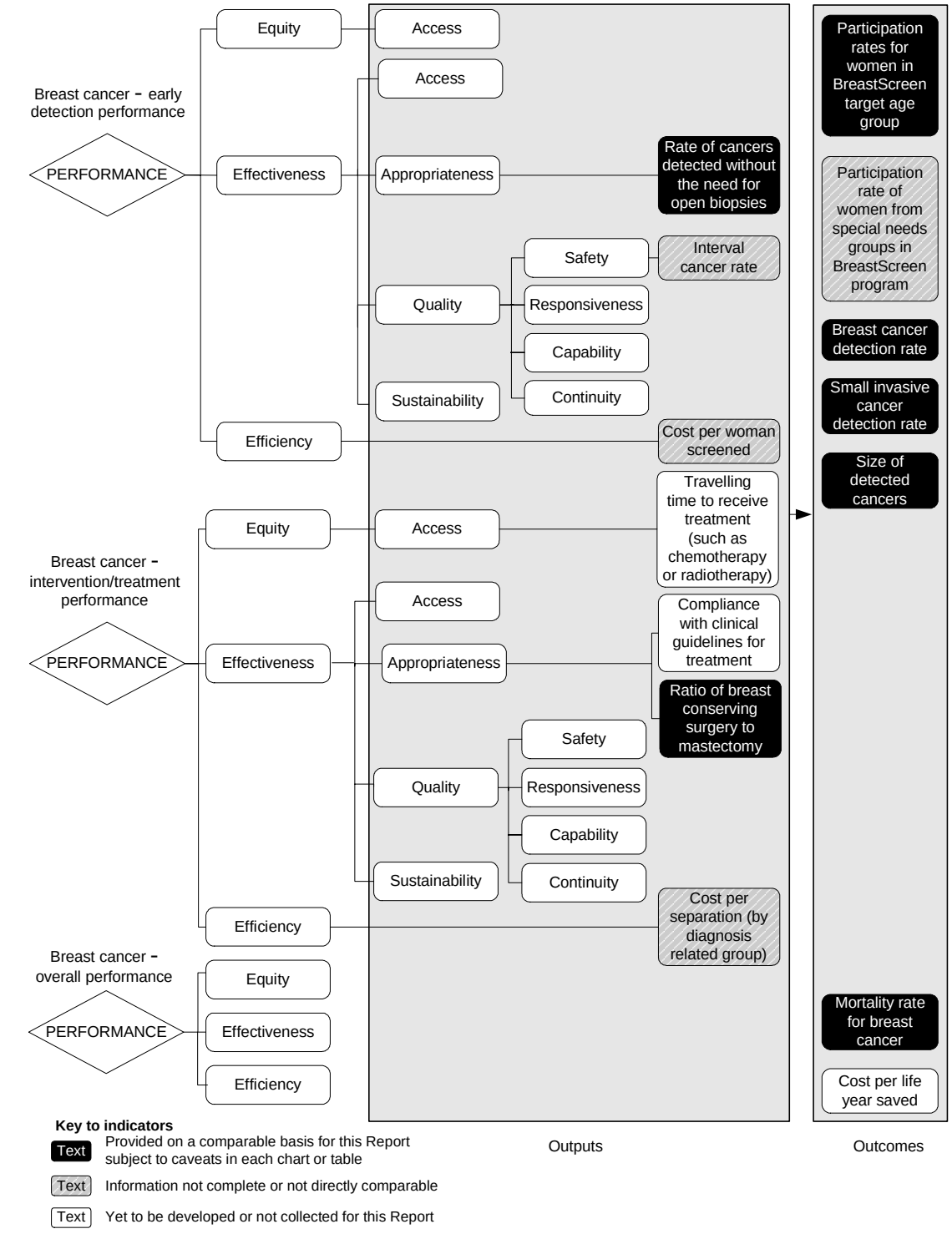
Framework of performance indicators

The indicators developed to report on the performance of breast cancer detection and management are based on the shared government objectives for managing the disease (box 11.2). The performance indicator framework shows which data are comparable in the 2005 Report (figure 11.7). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Box 11.2 **Objectives for breast cancer detection and management**

The objectives for breast cancer detection and management are to reduce morbidity and mortality attributable to breast cancer, and to improve the quality and duration of life of women with breast cancer in a manner that is equitable and efficient.

Figure 11.7 **Performance indicators for breast cancer detection and management**



The framework for breast cancer detection and management focuses on achieving a balance between early detection of the disease and treatment. It has a tripartite structure — that is, performance indicators presented relate to early detection,

intervention and overall performance. The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability that have been added to the standard Review framework for health services.

Key performance indicator results

Given the significant amounts of available data relating to breast cancer screening, screening is the focus of reporting. Data relating to the management and treatment of breast cancer are less readily available, and a Review priority is to extend reporting in this area in future.

Outputs

Early detection — rate of cancers detected without the need for open biopsies

The 'rate of cancers detected without the need for open biopsies' is an indicator of the effectiveness of early detection performance (box 11.3).

Box 11.3 **Rate of cancers detected without the need for open biopsies**

The 'rate of cancers detected without the need for open biopsies' is an indicator of the effectiveness of BreastScreen Australia in diagnosing breast cancer without the need for invasive procedures.

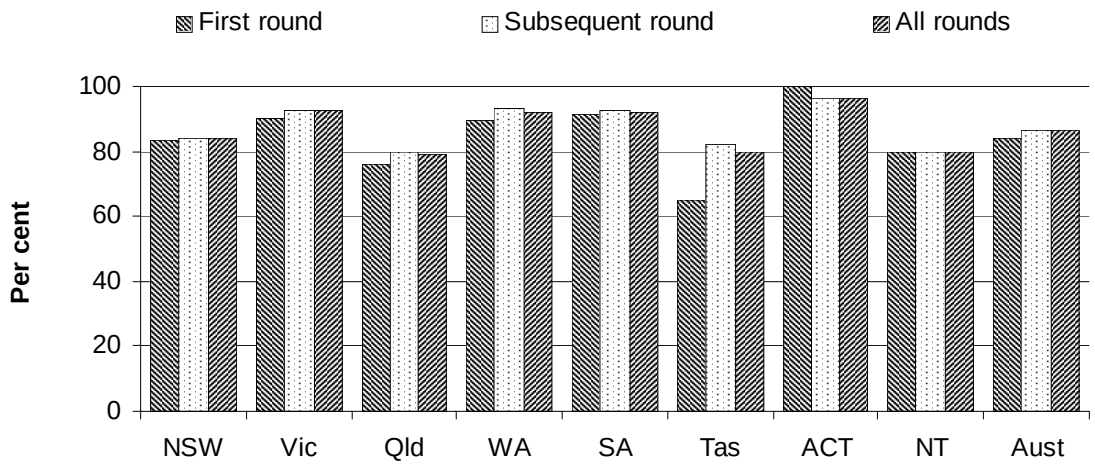
This indicator is defined as the number of diagnoses made without a diagnostic open biopsy, as a proportion of all breast cancers detected (invasive and DCIS). High rates of cancers detected without the need for open biopsies indicates effectiveness in detecting malignancies while minimising the need for invasive procedures.[3]

The BreastScreen Australia National Accreditation Standards (July 2002) state that 75 per cent or more of invasive cancers or DCIS should be diagnosed without the need for a diagnostic open biopsy.

In 2003, for women attending their first screening round, the rate of cancers detected without the need for open biopsies was highest in the ACT (100 per cent) and lowest in Tasmania (65.0 per cent). In the subsequent round, the rate was highest in the ACT (96.1 per cent) and lowest in Queensland and the NT (80.0 per cent) (figure 11.8).

[3] A breast biopsy is a procedure for obtaining a breast tissue specimen for microscopic examination to establish a diagnosis.

Figure 11.8 **Rate of cancers detected without the need for open biopsies, all women, 2003**



Source: State and Territory governments (unpublished); table 11A.8.

Early detection — interval cancer rate

The 'interval cancer rate' is an indicator of the effectiveness of early detection performance (box 11.4).

Box 11.4 **Interval cancer rate**

An interval cancer is an invasive breast cancer diagnosed in the interval between a negative screening result and the next scheduled screening examination. The purpose of the 'interval cancer rate' indicator is to help determine how effective the BreastScreen Australia program is in detecting breast cancer at an early stage. Measuring the interval cancer rate helps to obtain an early measure of the likely impact of the screening program on mortality.

The 'interval cancer rate' is defined as the number of interval cancers per 10 000 women screened. A low interval cancer rate is desirable because it suggests the breast screening process is effective in detecting breast cancer.

This rate needs to be interpreted in conjunction with the breast cancer detection indicators.

There is a time lag in obtaining data for this indicator, because the detection period falls between the last screening visit in the reference screening year and the next scheduled screening appointment. Following that period, a further time lag is required for the reporting of those cancers to the cancer registry, before a process of data matching can occur between each jurisdiction's screening program and its

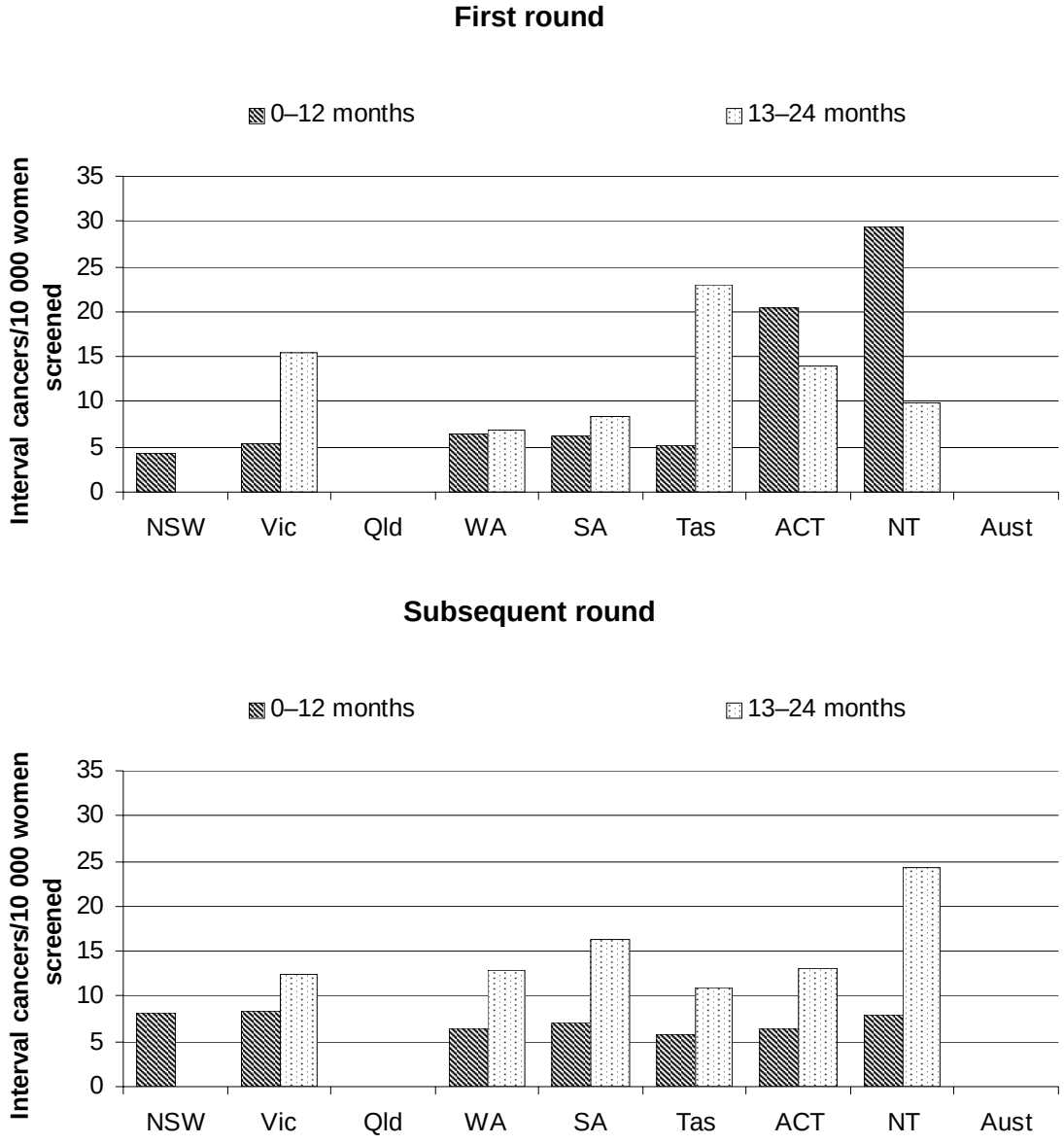
cancer registry. As a result, the most recent data available for this Report are for women screened during 2000. Stratification is by first and subsequent screening rounds to allow for expected variation in interval cancer rates between rounds.

Figure 11.9 presents the age standardised interval cancer rate by screening round for women aged 50–69 years. Differences in the rates across jurisdictions may be caused by differences in the policies of the BreastScreen services in each jurisdiction. Some jurisdictions (such as SA and some services in NSW) do not further investigate an abnormality of the breast, even when a symptom is reported, if the mammogram appears normal. These women are advised to visit their GP for a referral to a diagnostic service. This could have the effect of increasing the jurisdiction's interval cancer rate and reducing their cancer detection rate if an invasive breast cancer is subsequently diagnosed outside the breast cancer screening program. Comparisons across jurisdictions thus need to be made with care.

In 2000, for women aged 50–69 years in the first round of screening, the interval cancer rate 0–12 months following screening was highest in the NT (29.4 per 10 000 women screened) and lowest in NSW (4.2 per 10 000 women screened). In the subsequent screening round, the interval cancer rate 0–12 months following screening was highest in Victoria (8.5 per 10 000 women screened) and lowest in Tasmania (5.8 per 10 000 women screened). Data for Queensland were not available for the first or subsequent round.

In the first round, the interval cancer rate 13–24 months following screening was highest in Tasmania (23.0 per 10 000 women screened) and lowest in WA (6.9 per 10 000 women screened). In the subsequent screening round, the interval cancer rate 13–24 months following screening was highest in the NT (24.3 per 10 000 women screened) and lowest in Tasmania (10.9 per 10 000 women screened). Data for NSW and Queensland were not available for the first or subsequent round.

Figure 11.9 **Age standardised interval cancer rate, women aged 50–69 years, 2000[a, b, c, d, e]**



a Rates are expressed as the number of interval cancers per 10 000 women screened. **b** The numbers used to measure this indicator were small, resulting in large variations from year to year. It is reasonable to view this indicator over time rather than from one year to the next. **c** Data for NSW for 13–24 months in both the first and subsequent rounds were not available. **d** Data for Queensland were not available. **e** Data for the NT were zero in the first round for 13–24 months. All other NT data were not available.

Source: State and Territory governments (unpublished); table 11A.9.

Early detection — cost per woman screened

The 'cost per woman screened' indicator is an indicator of the efficiency of early detection performance (box 11.5).

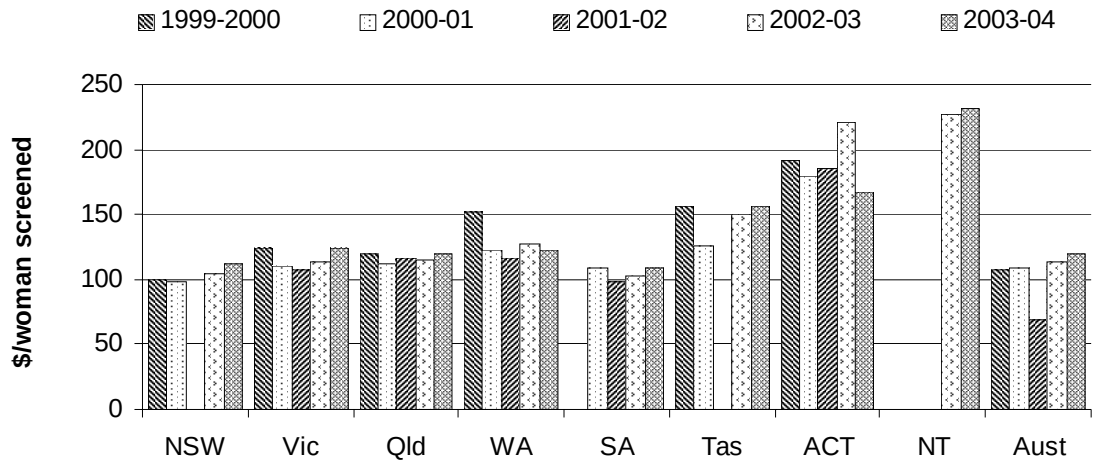
Box 11.5 **Cost per woman screened**

The 'cost per woman screened' is an indicator of the efficiency of the breast cancer screening program. An objective of breast cancer detection and management is that services are provided in an efficient manner.

'Cost per woman screened' measures the total cost per woman of providing services (including screening, assessment and program management), divided by the number of women screened. A low 'cost per woman screened' can indicate efficiency, but caution must be used when interpreting indicators in this way because the cost does not provide any information on the quality of service provided.

Care needs to be taken when making comparisons across jurisdictions. There are potential differences in the items included in the measures of cost (particularly in the treatment of depreciation and capital asset charges, and the inclusion of subsidies). There may also be differences across jurisdictions in the scope of activities being costed. The Review is working to identify these differences across jurisdictions to improve data comparability in future (table 11A.11). Preliminary estimates of costs in each jurisdiction are presented in figure 11.10. Real cost per woman screened in 2003-04 was highest in the NT ($232) and lowest in SA ($108).

Figure 11.10 **Real cost per woman screened, BreastScreen Australia services (2003-04 dollars)[a, b, c, d, e]**



a Constant price expenditure (in 2003-04 dollars) using the Gross Domestic Product price deflator (table A.26). The number of women screened used to calculate the cost per woman screened is calendar year data rather than financial year. **b** Data for NSW do not include subsidies. Data for NSW not available for 2001-02. **c** Data for Queensland include depreciation and user cost of capital for 2000-01, 2001-02 and 2002-03, but not for 1999-2000. **d** Data for SA are calculated on an accrual basis. Data are not available for 1999-2000. **e** Data for the NT are not available for 1999-2000 to 2001-02.

Source: State and Territory governments (unpublished); ABS, Cat. no. 5206.0 (unpublished); tables A.26 and 11A.10.

Intervention/treatment — travelling time to receive treatment

The Steering Committee has identified a woman's 'travelling time to receive treatment' as an indicator of the equity of intervention and treatment performance (box 11.6). Data on this indicator, however, were not available for the 2005 Report.

Box 11.6 **Travelling time to receive treatment**

The Steering Committee has identified the 'travelling time to receive treatment' indicator for development and reporting in future. This indicator relates to access to breast cancer intervention and treatment services such as chemotherapy or radiotherapy. A fast 'travelling time to receive treatment' suggests that intervention and treatment services are accessible in terms of distance travelled to breast cancer sufferers. A fast travelling time also implies that services are well located in terms of the population served.

Intervention/treatment — compliance with clinical guidelines for treatment

The Steering Committee has identified 'compliance with clinical guidelines for treatment' as an indicator of the effectiveness of intervention and treatment performance (box 11.7). Data on this indicator, however, were not available for the 2005 Report.

Box 11.7 **Compliance with clinical guidelines for treatment**

The Steering Committee has identified the 'compliance with clinical guidelines for treatment' indicator for development and reporting in future. This indicator relates to the appropriateness of breast cancer intervention and treatment. Compliance with clinical guidelines and treatment suggests breast cancer intervention and treatment are appropriate.

Intervention/treatment — ratio of conserving surgery to mastectomy

The ratio of 'conserving surgery to mastectomy' is an indicator of the effectiveness of intervention and treatment performance (box 11.8).

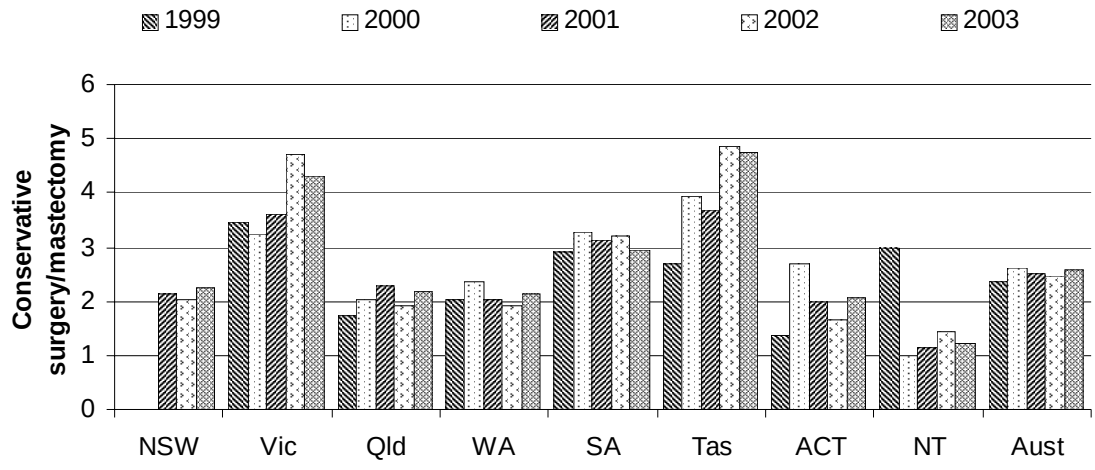
Box 11.8 **Ratio of conserving surgery to mastectomy**

The ratio of 'conserving surgery to mastectomy' is an indicator of the appropriateness of breast cancer intervention and treatment that aims to reduce morbidity and mortality. It can also reflect the early detection of breast cancer, because breast conserving surgery is more likely to be possible when cancers are detected at an early stage.

The ratio is defined as the number of cases for which no surgery or breast conserving surgery was performed, divided by the number of cases requiring mastectomy. Breast conserving surgery removes the breast cancer but not the whole breast. In terms of intervention and treatment, the ratio should reflect the appropriate mix of treatment. In terms of early detection of breast cancer, a high ratio is desirable. Other factors — such as the surgeon's judgment as to the best treatment for the patient — can also affect the type of surgery undertaken.

Data for this indicator are derived from BreastScreen Australia and represent only a portion of the total possible treatment information available. BreastScreen Australia aims to diagnose small cancers that can be treated more effectively and with reduced morbidity for women, so these data are not necessarily a good indication of general clinical practice relating to breast cancer. Based on BreastScreen Australia data in 2003, the ratio of conserving surgery to mastectomy was highest in Tasmania (4.7:1) and lowest in the NT (1.2:1) (figure 11.11).

Figure 11.11 **Ratio of conserving surgery to mastectomy[a, b]**



a Data for NSW are not available for 1999 and 2000. **b** Applies for women of all ages.

Source: State and Territory governments (unpublished); table 11A.12.

Intervention/treatment — cost per separation by diagnosis related group

The 'cost per separation by diagnosis related group' is an indicator of the efficiency of intervention and treatment performance (box 11.9).

Box 11.9 **Cost per separation by diagnosis related group**

'Cost per separation by diagnosis related group' is a proxy indicator of efficiency. An objective of breast cancer detection and management is to provide services in an efficient manner.

This indicator is defined as the cost of care per separation in public hospitals for selected breast cancer related conditions. A low cost per separation can indicate efficiency, but caution must be used when interpreting the indicator in this way, because the cost per separation does not provide any information on the quality of service provided. In addition, not all intervention strategies are reported.

Data for this indicator are sourced from the National Hospital Cost Data Collection (NHCDC) and are based on the AR-DRG classification version 4.2. The NHCDC is an annual collection of hospital cost and activity data covering the financial year before the collection period. Participation in the NHCDC is voluntary, so the samples are not necessarily representative of all hospitals in each jurisdiction (although this is improving over time). In addition, the purpose of the NHCDC is to calculate DRG cost weights, not to compare the efficiency of hospitals (DHA 2004).

Table 11.4 summarises costs per separation for selected breast cancer AR-DRGs. The average cost of major procedures for malignant breast conditions across Australia was $5244 per separation in 2002-03; minor procedures for malignant breast conditions cost $2514 per separation on average. Table 11A.13 also summarises the average length of stay (in public hospitals) associated with each AR-DRG.

Table 11.4 **Average cost per separation, public hospitals by selected breast cancer AR-DRGs, 2002-03 (dollars)[a, b, c]**

AR-DRG	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major procedures for malignant breast conditions									
	4 677	6 009	5 014	5 295	4 832	5 452	6 882	6 756	5 244
Minor procedures for malignant breast conditions									
	2 334	2 417	2 805	2 545	2 583	2 679	3 373	3 464	2 514
Malignant breast disorders, age> 69 years w CC									
	4 054	3 108	3 465	7 326	3 991	1 958	np	–	3 497
Malignant breast disorders, age <70 years w CC or age>69 w/o CC									
	3 326	1 547	1 897	3 271	2 326	2 688	3 578	3 237	2 226
Malignant breast disorders, age <70 years w/o CC									
	1 491	1 140	1 373	407	1 367	1 701	1 923	np	1 101

w CC = with complications and co-morbidities. w/o CC = without complications and co-morbidities. **a** Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. **b** Average cost is affected by a number of factors, some of which are admission practices, sample size, remoteness and the types of hospital contributing to the collection. Direct comparison across jurisdictions is difficult because there are differences in hospital costing systems. **c** In accordance with NHCDC methodology, depreciation and some capital costs are included in these figures, except for Victoria, which does not include depreciation. **np** Not published due to low volume and privacy concerns. – Nil or rounded to zero.

Source: Australian Government Department of Health and Ageing, NHCDC, Round 7 (2002-03); table 11A.13.

Outcomes

Early detection — participation rate of women in the BreastScreen target age group

The 'participation rate of women in the BreastScreen target age group' is an outcome indicator of early detection performance (box 11.10).

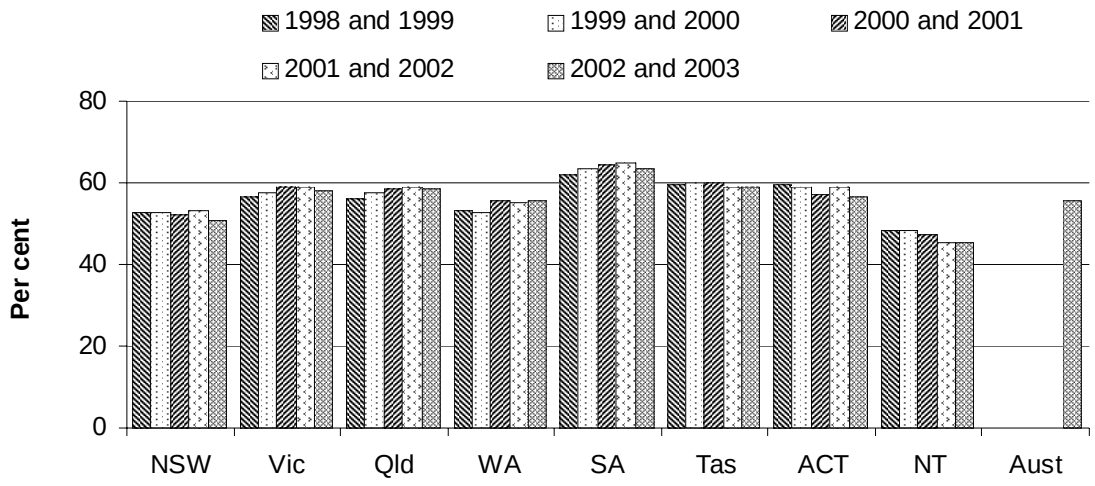
Box 11.10 **Participation rate of women in the BreastScreen target age group**

The 'participation rate of women in the BreastScreen target age group' of 50–69 years is included as an indicator to reflect the importance of screening to the early detection of breast cancers. Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

The participation rate measures the proportion of the eligible population attending the screening program within a 24 month period. Higher participation rates in screening are more desirable. The aim under the National Accreditation Standards (July 2002) is that at least 70 per cent of women aged 50–69 years participate in screening over a 24 month period. Recruitment activities undertaken by BreastScreen specifically target women in this age group although access to the program is also provided for women aged 40–49 years and 70 years or over (BreastScreen Australia 2002).

In the 24 month period 2002 and 2003, the participation of women aged 50–69 years in BreastScreen Australia screening programs was highest in SA (63.6 per cent) and lowest in the NT (45.6 per cent) (figure 11.12).

Figure 11.12 **Age standardised participation rates of women aged 50–69 years in BreastScreen Australia screening programs (24 month period)[a]**



a The participation rate is the number of women resident in the catchment area of the jurisdiction who were screened during the reference period, divided by the number of women resident in the catchment area, using the ABS estimated resident population. This value represents the estimated population at the midpoint of the reference period. It is an average of the two estimated resident populations for the two calendar years (by adding both years and dividing by two). The catchment area is a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or statistical local area.

Source: State and Territory governments (unpublished); table 11A.14.

Early detection — participation rate of women from selected community groups in BreastScreen programs

The 'participation rate of women from selected community groups in BreastScreen programs' is an outcome indicator of early detection performance (box 11.11).

Box 11.11 **Participation rate of women from selected community groups in BreastScreen programs**

The 'participation rate of women from selected community groups' — that is, Indigenous women, women from non-English speaking backgrounds (NESB) and women living in rural and remote areas — in breast cancer screening is an indicator because screening is important in the early detection of breast cancers. Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality. Women from selected community groups may experience particular language, cultural and geographic barriers to accessing breast cancer screening. This indicator measures the performance of the BreastScreen program in overcoming these barriers.

The participation rate measures the proportion of the eligible population in the community group attending the screening program within a 24 month period. Participation rates for community groups that are at, or close to, those for the total population indicate success in overcoming group-specific barriers to access.

For the 24 month period 2002 and 2003, the age standardised participation rate for Indigenous women aged 50–69 years was markedly lower than the rate for all females in that age group, although this may be influenced by problems with the identification of Indigenous status. The largest gap between the participation rates of Indigenous women and all women was in Tasmania (29.0 percentage points); the smallest gap was in the ACT (1.1 percentage points) (table 11.5).

For the same 24 month period and age group, the participation rate for NSEB women was lower than that for the total female population except in Queensland, WA and the ACT (table 11.5). The largest gap between the participation rate for women from a NESB and that for all women was in the NT (19.7 percentage points). The participation rate for women in rural and remote areas was below that for all women in NSW, Queensland and the NT, with the largest gap being in the NT (28.1 percentage points) (table 11.5).

Care needs to be taken when comparing data across jurisdictions, given differences in the collection of data by Indigenous, NESB, and rural and remote status across jurisdictions.

Table 11.5 **Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2002 and 2003 (24 month period) (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous[b]	39.4	50.9	53.6	39.7	41.2	29.9	55.5	17.7	40.6
Non-English Speaking Background[c]	43.5	40.4	64.7	59.3	59.7	46.5	59.7	25.9	46.6
Metropolitan or capital city[d]	61.0	57.0	76.8	55.1	63.3	56.1	56.7	49.4	61.2
Rural and remote, or rest of State[e]	35.9	60.2	44.5	56.9	64.4	59.3	–	17.5	46.8
All women aged 50–69 years	50.8	57.9	58.5	55.7	63.6	58.9	56.7	45.6	55.8

a First and subsequent rounds. **b** Those women who self-identify as being of Aboriginal or Torres Strait Islander descent. **c** Women who speak a language other than English at home. **d** Includes 'capital city' (State and Territory capital city statistical divisions) and 'other metropolitan centre' (one or more statistical subdivisions that have an urban centre with a population of 100 000 or more). **e** Includes 'large rural centre' statistical local areas where most of the population resides in urban centres with a population of 25 000 or more); 'small rural centre' (statistical local areas in rural zones containing urban centres with populations between 10 000 and 24 999); 'other rural area' (all remaining statistical local areas in the rural zone); 'remote centre' (statistical local areas in the remote zone containing populations of 5000 or more) and 'other remote area' (all remaining statistical local areas in the remote zone). – Nil or rounded to zero.

Source: State and Territory governments (unpublished); tables 11A.14 and 11A.15.

Early detection — breast cancer detection rate

The 'breast cancer detection rate' is an outcome indicator of early detection performance (box 11.12).

Box 11.12 **Breast cancer detection rate**

The 'breast cancer detection rate' is an indicator of the effectiveness of screening services in identifying breast cancers at an early stage. Early detection of cancers while they are still small and localised to the breast is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

The 'detection rate' is the number of detected cancers per 10 000 women screened. While a high incidence of breast cancer is not desirable, a high rate of detecting these cancers is desirable.

The following are the relevant BreastScreen Australia National Accreditation Standards for detection rates (BreastScreen Australia 2002):

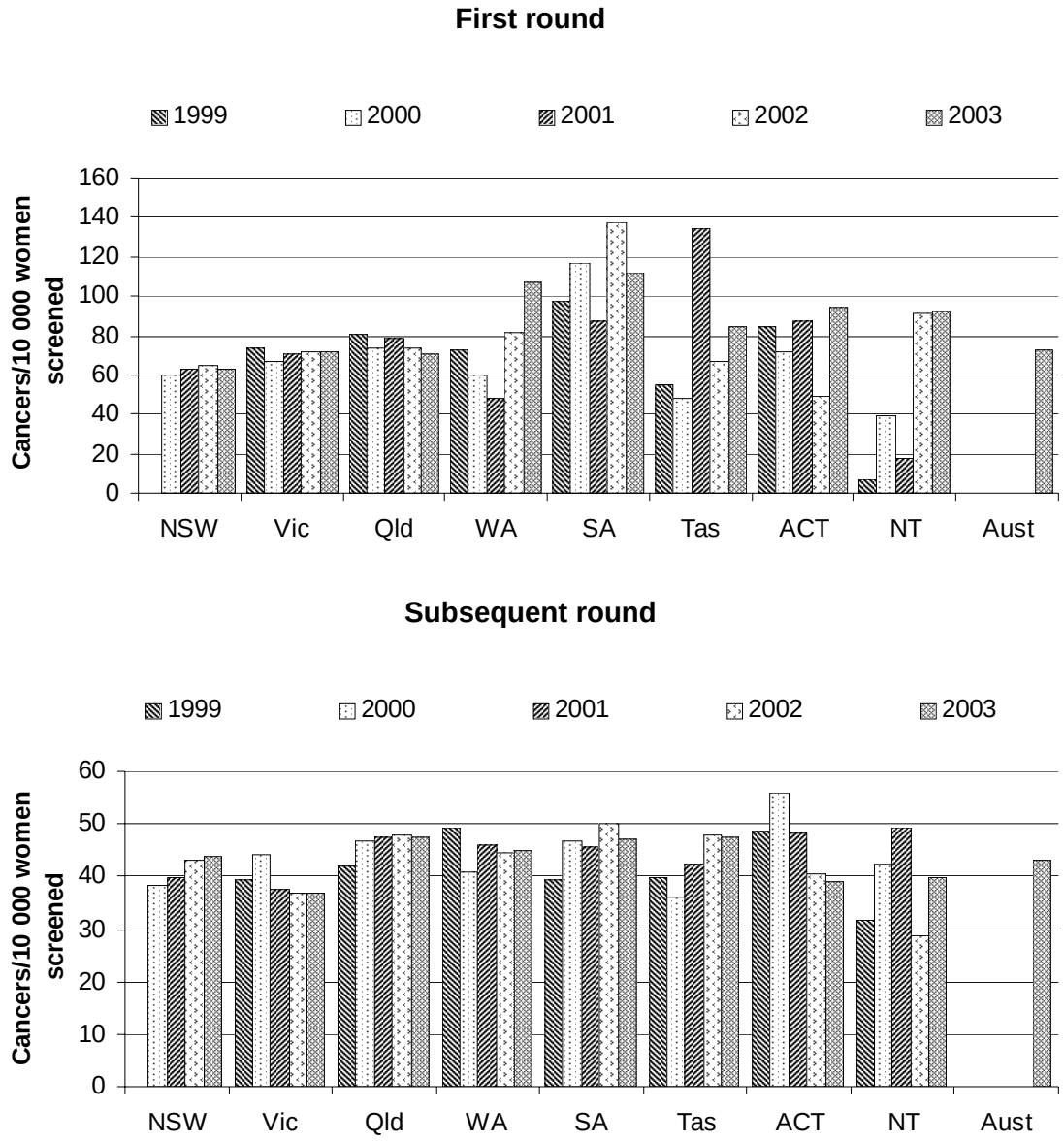
- Greater than or equal to 50 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with invasive breast cancer.
- Greater than or equal to 35 per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with invasive breast cancer.
- Greater than or equal to 12 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with DCIS.
- Greater than or equal to seven per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with DCIS.

It is important to consider together all of the following rates: the invasive cancer detection rate, the small invasive cancer detection rate, the DCIS detection rate and the interval cancer rate.

Figure 11.13 reports the age standardised number of invasive cancers detected per 10 000 women screened aged 50–69 years, by screening round. DCIS detected per 10 000 women screened is reported in table 11A.16. (Definitions can be found in box 11.1 and section 11.7.)

For women aged 50–69 years, in the first round in 2003, SA had the highest detection rate (111.6 cancers per 10 000 women) and NSW had the lowest (62.6 cancers per 10 000 women). In the subsequent round in 2003, Tasmania had the highest detection rate (47.4 cancers per 10 000 women) and Victoria had the lowest (36.8 cancers per 10 000 women) (figure 11.13).

Figure 11.13 **Age standardised breast cancer detection rate for women aged 50–69 years, invasive cancers[a]**



a Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen service in 1998.

Source: State and Territory governments (unpublished); table 11A.16.

Early detection — small invasive cancer detection rate

The 'small invasive cancer detection rate' is an outcome indicator of early detection performance (box 11.13).

Box 11.13 **Small invasive cancer detection rate**

The 'small (less than 15 millimetres in diameter) invasive cancer detection rate' is an indicator of the early detection of breast cancers. Early detection of cancers while they are still small and localised to the breast is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

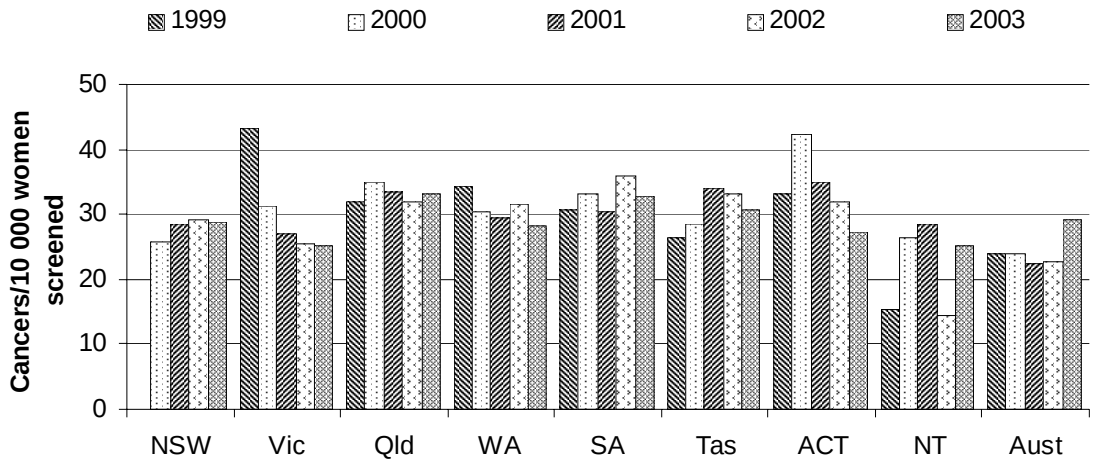
The 'small invasive cancer detection rate' is defined as the number of invasive cancers detected with a diameter of 15 millimetres or less, per 10 000 women screened. It is desirable that a high proportion of cancers detected are small cancers: detection of small cancers is generally associated with increased survival rates and reduced morbidity and mortality, leading to some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998).

The BreastScreen Australia National Accreditation Standards (July 2002) specify that 25 or more women per 10 000 women aged 50–69 years who attend screening are diagnosed with a small (15 millimetres or less) invasive breast cancer (BreastScreen Australia 2002).

It is important to consider together all of the following rates: the invasive cancer detection rate, the small invasive cancer detection rate, the DCIS detection rate and the interval cancer rate.

Age standardised rates for small invasive cancer detection are reported in figure 11.14. For women aged 50–69 years screened by BreastScreen Australia in 2003, the highest rate of detection of small invasive cancers was in Queensland (33.0 cancers per 10 000 women screened) while the lowest was in the NT (25.0 cancers per 10 000 women screened).

Figure 11.14 **Age standardised small diameter cancer detection rate for women aged 50–69 years, all rounds of screening[a, b]**



a Small diameter cancers are defined as invasive cancers up to and including 15 millimetre diameter. Prior to the 2003 Report, small diameter cancers were defined as 10 millimetre in diameter or less, so data are not comparable to data published before the 2003 Report. **b** Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen service in 1998.

Source: State and Territory governments (unpublished); table 11A.17.

Early detection — size of detected cancers

The 'size of detected cancers' is an outcome indicator of early detection performance (box 11.14).

Box 11.14 **Size of detected cancers**

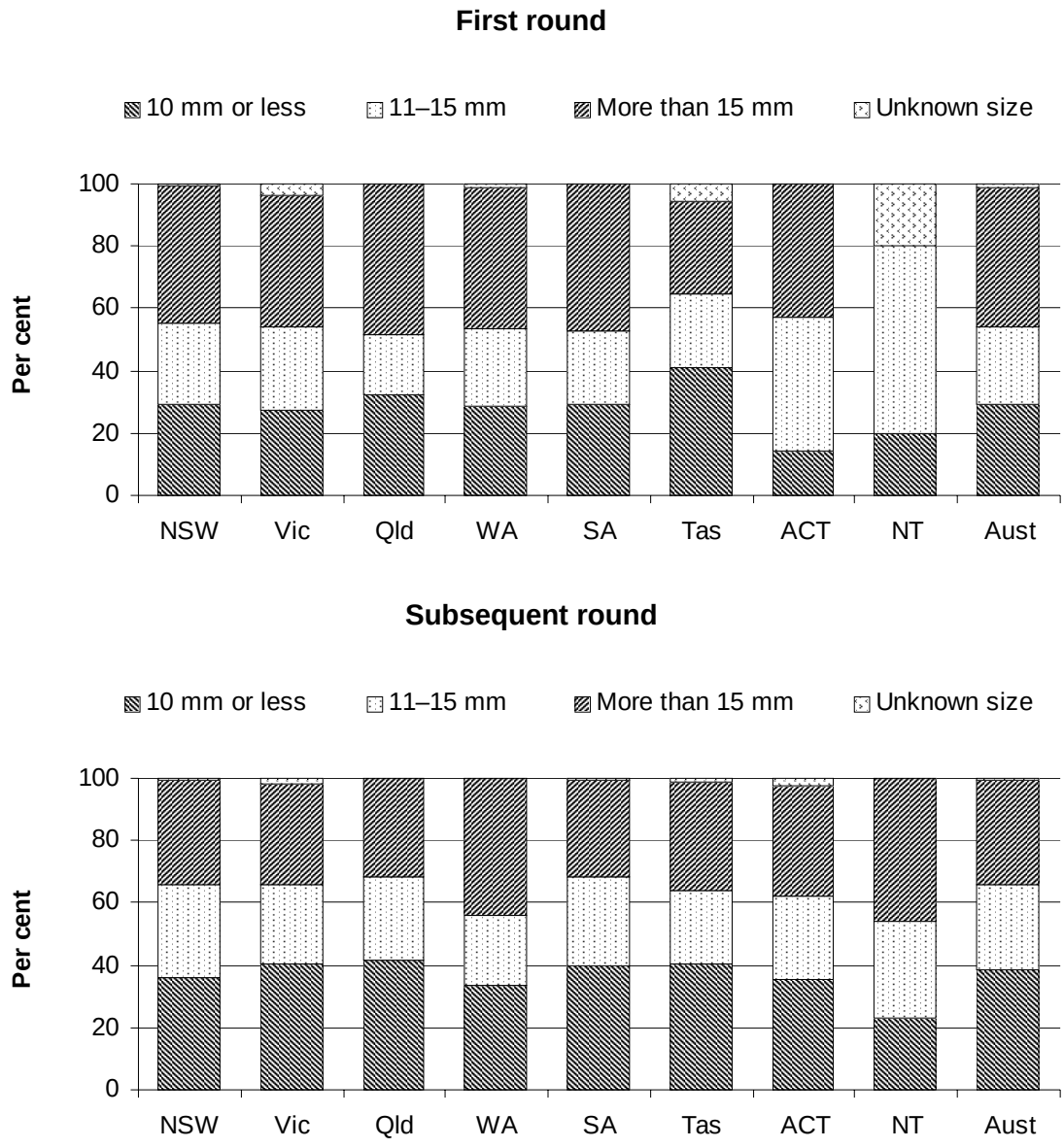
The 'size of detected cancers' is an indicator of the early detection of breast cancers. Detection of small cancers (those with a diameter of 15 millimetres or less) is generally associated with increased survival rates and reduced morbidity and mortality, leading to some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998).

This indicator measures detected invasive cancers by size of cancer, as a proportion of total detected invasive cancers for women aged over 40 years. High detection of small cancers relative to large cancers is desirable because it is likely to result in reduced morbidity and mortality.

Data are reported by round because larger cancers are expected to be found in the first round of screening. In subsequent rounds, cancers should be smaller if the program is achieving its objective (that is, early detection of small cancers through regular two yearly screening).

Figure 11.15 presents the proportion of cancers by size by screening round for 2003. The data are from BreastScreen Australia and cover only its clients. The data for 2003 reflect that larger cancers tend to be discovered in the first round and that smaller cancers tend to be detected in subsequent rounds.

Figure 11.15 **Detected invasive cancers, women aged over 40 years, by screening round and size of cancer 2003[a, b]**



a Non-breast malignancies were not counted. **b** For small jurisdictions, fluctuations due to small numbers can make comparisons unreliable.

Source: State and Territory governments (unpublished); table 11A.18.

Overall performance — mortality rate for breast cancer

The 'mortality rate for breast cancer' is an outcome indicator of overall performance (box 11.15).

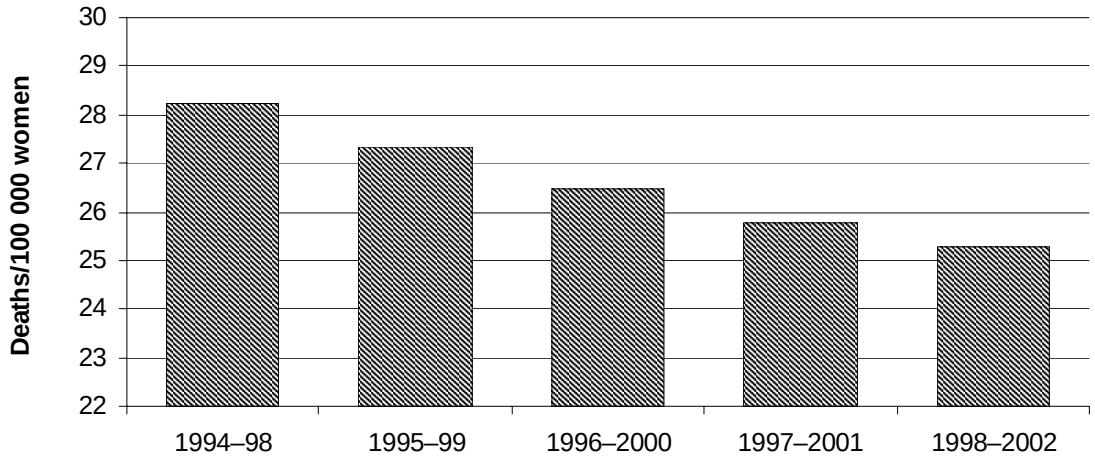
Box 11.15 **Mortality rate for breast cancer**

The 'mortality rate for breast cancer' is an outcome indicator of the effectiveness of both early detection and treatment services for breast cancer. It expresses mortality from breast cancer per 100 000 women as a five year rolling average.

Breast cancer mortality data are averaged over five year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases but relatively large variation in rates from year to year. Caution still needs to be used, however, when comparing results for smaller jurisdictions.

Age standardised mortality rates are the most appropriate measure for looking at changes in mortality rates. The average annual age standardised mortality rate declined from a peak of 28.2 per 100 000 women over the period 1994–98 to an average of 25.3 per 100 000 women over the period 1998–2002 (figure 11.16).

Figure 11.16 **Annual average age standardised mortality rate from breast cancer, all ages[a]**

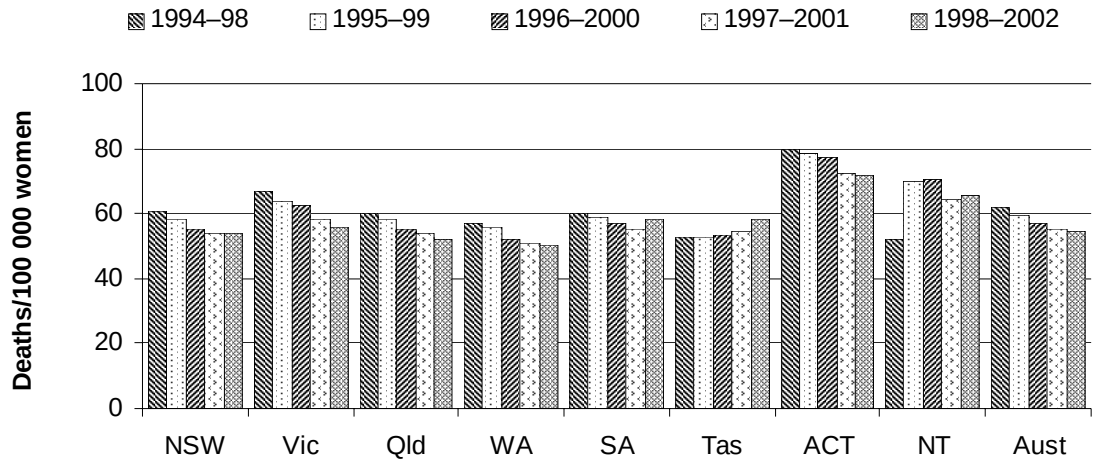


a Age standardised to the Australian population at 30 June 2001.

Source: AIHW (unpublished); table 11A.19.

The annual average age standardised mortality rate from breast cancer for women aged 50–69 years over the period 1998–2002 was highest in the ACT (71.8 per 100 000 women) and lowest in WA (50.4 per 100 000 women) (figure 11.17).

Figure 11.17 **Annual average age standardised mortality rate from breast cancer, women aged 50–69 years[a, b]**



a Age standardised to the Australian population at 30 June 2001. **b** ACT Health reviewed the ACT's high reported age standardised mortality rate from breast cancer in detail. The review found that the higher rate of mortality in the ACT was unlikely to be due to the major modifiable determinants of mortality — namely, participation in screening, or treatment by experienced surgeons according to established guidelines (ACT Health 2003). In addition, data are by place of registration. This may result in an exaggerated mortality rate for the ACT because a substantial number of cross-border residents use ACT health services. The extent to which this is happening is unclear.

Source: AIHW (unpublished); table 11A.19.

Overall performance — cost per life year saved

The Steering Committee has identified 'cost per life year saved' as an outcome indicator of the equity of overall performance (box 11.16). Data for this indicator, however, were not available for the 2005 Report.

Box 11.16 **Cost per life year saved**

The Steering Committee has identified the 'cost per life year saved' as an indicator for development and reporting in future. The indicator is a measure of the efficiency of breast cancer detection and management services.

11.4 Mental health

Profile

This section covers specialist mental health care services that treat mostly low prevalence but severe disorders. GPs are also important service providers for people with a mental disorder (see chapter 10), but this Report does not include performance information on GPs' services for people with a mental illness. Alcohol and drug treatment services are not covered here, but they are briefly described in chapter 10. Some common terms used in mental health management are outlined in box 11.17.

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). Problems and disorders that interfere with this ability and diminish quality of life and productivity include cognitive, emotional and behavioural disorders. Some of the major mental disorders perceived to be public health problems are schizophrenia, depression, anxiety disorders, dementia and substance use disorders (DHAC and AIHW 1999). Each of these disorders is unique in terms of its incidence across the lifespan, causal factors and treatments.

This chapter reports on specialist mental health care services only. The performance of non-specialist service providers is examined more closely in chapter 9 ('Public hospitals'), chapter 10 ('Primary and community health') and chapter 12 ('Aged care services'). Mental health patients often have complex needs and may access a number of other services, such as, those covered in chapter 3 ('School education'), chapter 7 ('Corrective services'), chapter 8 ('Emergency management') and chapter 13 ('Services for people with a disability').

Box 11.17 **Some common terms relating to mental health**

acute services: the National Survey of Mental Health Services (NSMHS) defines acute services as specialist psychiatric care for people who present with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that this treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide short term treatment. Acute services may focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms.

ambulatory care services: mental health services dedicated to the assessment, treatment, rehabilitation and/or care of non-admitted inpatients, but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.

community residential services: staffed residential units established in community settings that provide specialised treatment, rehabilitation and/or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must provide residential care to people with a psychiatric illness or disability, be located in a community setting external to the campus of a general hospital or psychiatric institution, employ onsite staff for at least some part of the day, and be government funded.

inpatient services: stand-alone psychiatric hospitals or specialist psychiatric units located within non-psychiatric hospitals.

mental disorder: a diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.

mental health: the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.

mental health problem: diminished cognitive, emotional and/or social abilities, but not to the extent that the criteria for a mental disorder are met.

mental health promotion: activities designed to improve the mental health functioning of people through prevention, education and intervention activities and services.

(Continued on next page)

Box 11.17 **(Continued)**

mental illness prevention: interventions that occur before the initial onset of a disorder.

non-acute services: rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services focus on disability and the promotion of personal recovery. They are also characterised by an expectation of substantial improvement over the short term to medium term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. Non-acute services also consist of extended care services that provide care over an indefinite period for patients who have a stable but severe level of functional impairment and inability to function independently without extensive care and support. Patients of extended care services usually show a relatively stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness. Treatment effort focuses on preventing deterioration and reducing impairment. Improvement is expected only over a long period.

non-government organisations: private not-for-profit community managed organisations that receive State and Territory government funding specifically to provide community support services for people affected by a mental illness or psychiatric disability. Programs provided by the non-government organisation sector may include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.

outpatient services (community-based): services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings physically separated within hospital sites. Services provided may also include outreach or domiciliary care as an adjunct to services provided from the centre base.

outpatient services (hospital-based): services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. Services provided may also include outreach or domiciliary care as an adjunct to services provided from the clinic base.

prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

specialised care service: services whose primary function is specifically to provide treatment, rehabilitation or community support targeted to people affected by a mental disorder or psychiatric disability. This criterion is applicable regardless of the source of funds. Such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function.

Source: DHA (2002).

Prevalence

As part of the National Health Survey in 2001, the ABS surveyed adults on the level of psychological distress that they had experienced in the four weeks before the survey. This survey used the Kessler-10 (K10) scale, which measures non-specific psychological distress. The scale consists of 10 questions about non-specific psychological distress and seeks to measure the level of current anxiety and depressive symptoms that a person might have experienced in the four weeks before the interview (ABS 2002b).[4] The 2001 data showed that almost all adults aged 18 to 64 years had experienced some form of psychological distress. Nationally, 61.4 per cent of those aged 18–64 years had experienced a low level of distress, 23.5 per cent had experienced moderate distress and 13.0 per cent had experienced a high or very high level of distress. Generally, people aged 65 years or over were less likely to experience moderate and high to very high levels of distress, compared with the younger age group (table 11.6). Overall, in percentage terms, more males than females had experienced lower levels of distress, and more females than males had experienced moderate and high to very high levels of distress (table 11A.20).

In the 2003 ABS Survey of Disability, Ageing and Carers (ABS 2004), 8.4 per cent of all people with a disability, (that is 636 900 out of 3.9 million people) reported a mental or behavioural disorder as the main health condition causing their disability. Among people who had a disability that caused a profound or severe core activity limitation (around 1.2 million people or 49.3 per cent of all people with a disability), however, 12.3 per cent reported a mental or behavioural disorder as their main health condition (ABS 2004). Data indicating the prevalence of mental disorders from earlier ABS and other surveys were presented in the 2004 Report.

[4] Respondents were asked whether in the previous four weeks they had felt: tired for no good reason; nervous; so nervous nothing could calm them down; hopeless; restless or fidgety; so restless they could not sit still; depressed; everything was an effort; so sad that they could not be cheered up; and worthless. For each question, there is a five level response scale based on the amount of time that the respondent reported experiencing the particular problem. Generally, each item was scored from 1 for 'none of the time', to 5 for 'all of the time'. Scores of the 10 questions were then summed, yielding a minimum possible score of 10 and a maximum possible score of 50. Low scores indicated low levels of psychological distress and high scores indicated high levels of psychological distress (ABS 2002b).

Table 11.6 **K10 level of psychological distress, 2001 (per cent of population)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[b]	*Aust*
18–64 years									
Low	61.1	62.0	62.2	61.5	60.0	61.9	62.8	na	61.4
Moderate	24.1	23.6	22.4	24.7	23.2	22.8	23.8	na	23.5
High and very high	13.4	13.2	12.4	11.1	14.8	13.8	9.8	na	13.0
Total	98.6	98.8	97.0	97.2	97.9	98.4	96.4	na	97.9
65 years or over									
Low	65.8	68.8	71.1	68.9	65.2	65.0	74.7	na	67.7
Moderate	18.4	13.8	15.8	15.1	18.3	15.7	14.3	na	16.3
High and very high	8.9	9.9	6.2	9.4	8.4	12.9	4.4 [c]	na	8.7
Total	93.1	92.6	93.1	93.3	91.9	93.7	93.3	na	92.8
Total adults									
Low	61.9	63.1	63.6	62.6	61.0	62.5	64.2	na	62.4
Moderate	23.1	22.0	21.3	23.2	22.2	21.5	22.7	na	22.3
High and very high	12.6	12.7	11.5	10.8	13.6	13.6	9.2	na	12.3
Total	97.7	97.8	96.4	96.6	96.8	97.6	96.0	na	97.1

a Psychological distress as measured by the K10 scale. **b** Separate estimates for the NT are not available for this survey, but the NT contributed to national estimates. **c** Estimate has a relative standard error of 25–50 per cent and needs to be interpreted with caution. **na** Not available.

Source: ABS (unpublished); table 11A.20.

Roles and responsibilities

Specialist mental health care providers include a range of government and non-government service providers offering promotion, prevention, treatment and management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, public hospitals with specialist psychiatric units and stand-alone psychiatric hospitals all provide specialist mental health care. In addition, a number of health services provide care to mental health patients in a non-specialist health setting — for example, GPs, public hospital emergency departments and outpatient departments, and public hospital general wards (as opposed to specialist psychiatric wards). Some people with a mental disorder are cared for in residential aged care services.

State and Territory governments are the primary sources of funding and service delivery for specialist public mental health services. The Australian Government also provides funding to states and territories via the Australian Health Care Agreements and the Medicare Benefits Schedule (private psychiatrists and GPs), the Pharmaceutical Benefits Schedule and the Department of Veteran's Affairs (DVA).

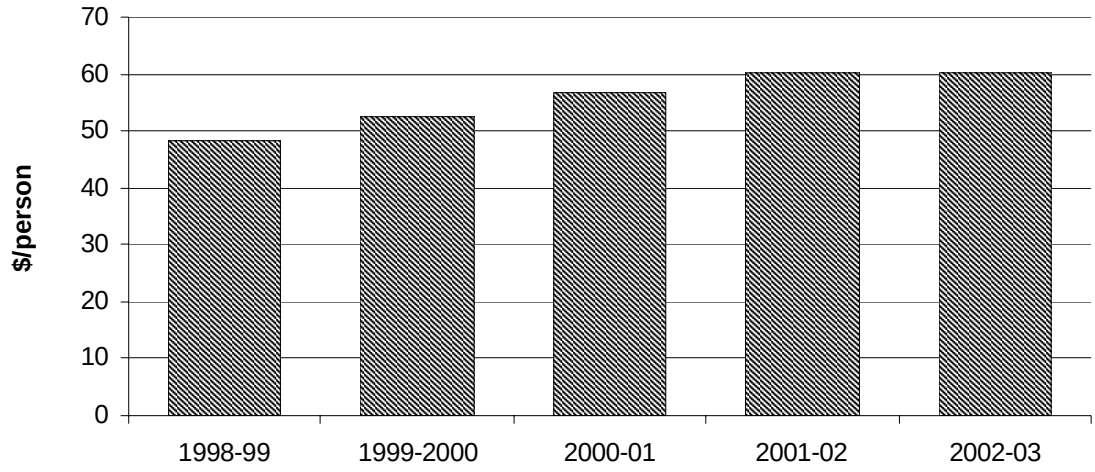
The Australian, State and Territory governments also fund other services that people with mental disorders can access, such as emergency relief, employment, accommodation, income support, rehabilitation, residential aged care and other services for people with a disability (see chapters 12 and 13).

Funding

Real Government recurrent expenditure of around $3.2 billion was allocated to mental health services in 2002-03 (tables 11A.21 and 11A.22).[5] State and Territory governments made the largest contribution ($2.0 billion, or 62.5 per cent), although this included some Australian Government funds under the Australian Health Care Agreements (table 11A.22). The Australian Government spent $1.2 billion. Real Australian Government expenditure per person in 2001-02 and 2002-03 remained steady at around $60 (figure 11.18).

Data in this Report relating to public mental health services come from State and Territory governments. These data for 2002-03 are preliminary (and will be further validated as part of the production of the annual National Mental Health Report), so need to be treated with care.

Figure 11.18 **Real Australian Government recurrent expenditure on mental health services per person (2002-03 dollars)[a, b]**



a 2002-03 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*. **b** Constant price expenditure for all years (2002-03 dollars), using the implicit price deflator for non-farm gross domestic product — see table 11A.56.

Source: Australian Government (unpublished); table 11A.23; DHA (unpublished); table 11A.56.

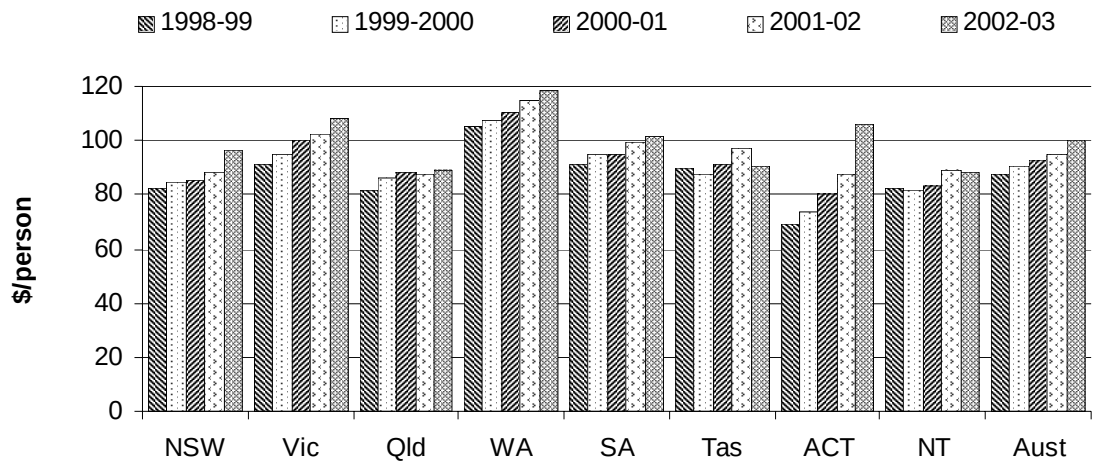
5 The data include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Australian Government funds'.

The largest component of Australian Government expenditure on mental health services in 2002-03 was expenditure under the Pharmaceutical Benefits Schedule for psychiatric medication (541.3 million). Expenditure on psychiatric medication increased at an annual average rate of 12.7 per cent between 1998-99 and 2002-03 and rose from 36.9 per cent of Australian Government expenditure on mental health services in 1998-99 to 45.5 per cent in 2002-03. While annual growth in psychiatric medication has averaged 12.7 per cent, the rate of growth has been declining steadily over the reporting period (from 36.9 per cent in 1998-99 to 5.7 per cent in 2002-03). In 2002-03, Medicare Benefits Schedule payments for consultant psychiatrists accounted for a further 16.6 per cent of Australian Government expenditure on mental health services, followed by expenditure for mental health care by GPs (14.2 per cent). The residual was provided by DVA (10.4 per cent), the National Mental Health Strategy (NMHS) (8.0 per cent), private hospital insurance premium rebates (4.1 per cent), research and other time limited program and project support (table 11A.21).

Real expenditure per person at State and Territory discretion has increased over time (figure 11.19). Data in figure 11.19 for State and Territory government expenditure include Australian Government funds provided as part of base grants under the Australian Health Care Agreements, but exclude special purpose grants provided for mental health reform and also funding provided to states and territories by the DVA. The data are thus referred to as expenditure 'at State and Territory discretion'.

In 2002-03, WA spent the most on mental health services ($119 per person) and Queensland and the NT spent the least ($89 per person). The data in figure 11.19 exclude depreciation. Estimates of depreciation are presented in table 11A.25. State and Territory government expenditure estimates (excluding revenue from other sources and other Australian Government funds) are presented in table 11A.24. The revenue categories are subject to minimal validation and may be inconsistently treated across jurisdictions. In addition, it is not possible to extract revenue from other sources and other Australian Government funds uniformly across time.

Figure 11.19 **Real recurrent expenditure at the discretion of State and Territory governments (2002-03 dollars)[a, b, c, d, e]**

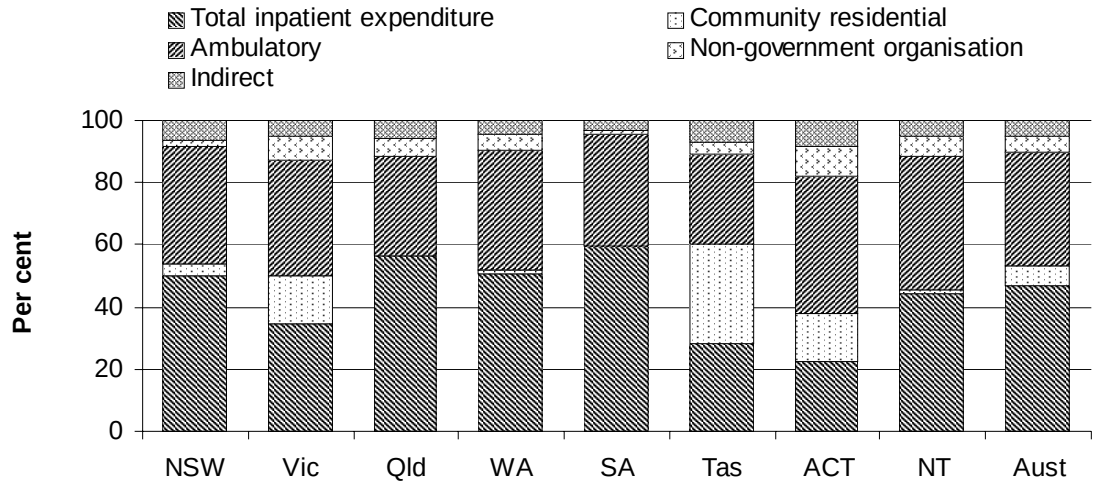


a 2002-03 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*. **b** Constant price expenditure (2002-03 dollars), using government final consumption expenditure on hospital and clinical services as the deflator — see table 11A.55. **c** Estimates of State and Territory government spending include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Australian Government funds', but exclude Australian Government funding provided under the NMHS and through the DVA. **d** Depreciation is excluded for all years. Depreciation estimates are reported in table 11A.25. **e** Funding is a mix of Australian Government funds provided under the base grants of the Australian Health Care Agreements, funds provided by State and Territory governments and revenue from other sources noted above (footnote c).

Source: State and Territory governments (unpublished); table 11A.22; DHA (unpublished); table 11A.55.

Figure 11.20 shows how expenditure at the discretion of State and Territory governments was distributed across the range of mental health services in 2002-03. It does not show the distribution of the Australian Government expenditure discussed under figure 11.18. Recurrent expenditure allocated to total inpatient expenditure (including both psychiatric hospitals and psychiatric units in public [non-psychiatric] hospitals) was highest in SA (59.5 per cent) and lowest in the ACT (22.7 per cent). (Tasmania, the ACT and the NT do not have public psychiatric hospitals.) Recurrent expenditure allocated to ambulatory services was highest in the ACT (44.5 per cent) and lowest in Tasmania (28.8 per cent).

Figure 11.20 **State and Territory recurrent expenditure, by service category, 2002-03**[a, b, c, d, e, f]



a 2002-03 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*. **b** Includes all spending regardless of source of funds. **c** Depreciation is excluded. Depreciation estimates are reported in table 11A.25. **d** Community residential is defined as all staffed community-based units (external to the campus of a general hospital or psychiatric institution) regardless of the number of hours that staff are present. **e** The differential reporting of clinical service providers and non-government organisations artificially segregates the mental health data. Given that the role of non-government organisations varies across jurisdictions, the level of non-government organisations resourcing does not accurately reflect the level of community support services available. **f** Queensland does not fund community residential services, but it funds a number of extended treatment services (both campus and non-campus-based), which provide longer term inpatient treatment and rehabilitation services with full clinical staffing for 24 hours a day, seven days a week.

Source: State and Territory governments (unpublished); table 11A.26.

Size and scope of sector

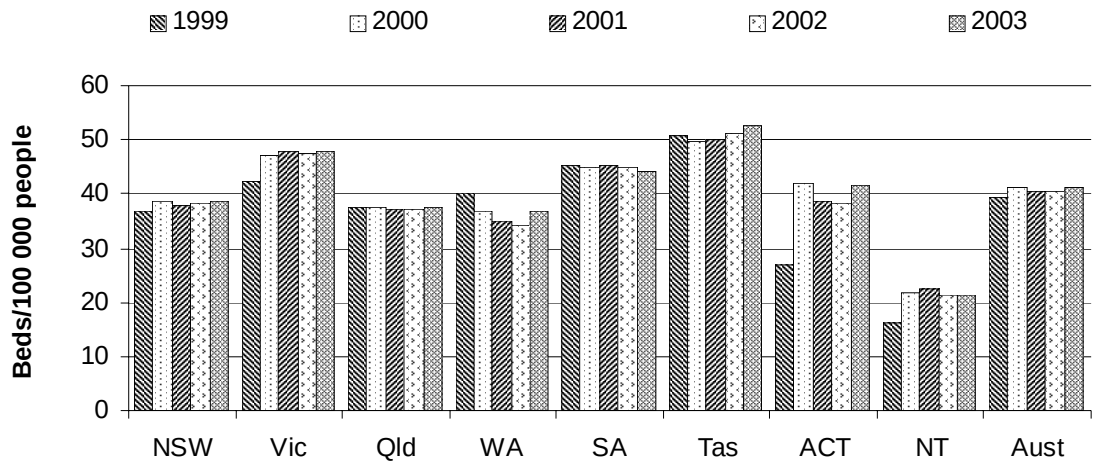
The number of beds

Beds are counted as those immediately available for use at 30 June by admitted patients if required. They are available immediately — or within a reasonable period of time — for use if located in a suitable place for care with nursing or other auxiliary staff available. Also included are beds in wards that are temporarily closed for reasons such as renovation or strike, but that would normally be open.

Figure 11.21 presents the number of beds per 100 000 people for public hospitals and community residential facilities combined. There was a definitional change for community residential facilities in 1999-2000, which caused a break in the series. Prior to 1999-2000, 'community residential' was defined as government funded 24 hour staffed residential units in community settings (external to the campus of a public hospital or psychiatric institution). From 1999-2000, the definition has been

broadened to incorporate all staffed community-based units, regardless of the number of hours that staff are present. In 2003, Tasmania had the highest number of beds per 100 000 people (52.5) and the NT had the lowest (21.3).

Figure 11.21 **Beds in public hospitals and publicly funded community residential units, 30 June[a, b, c]**



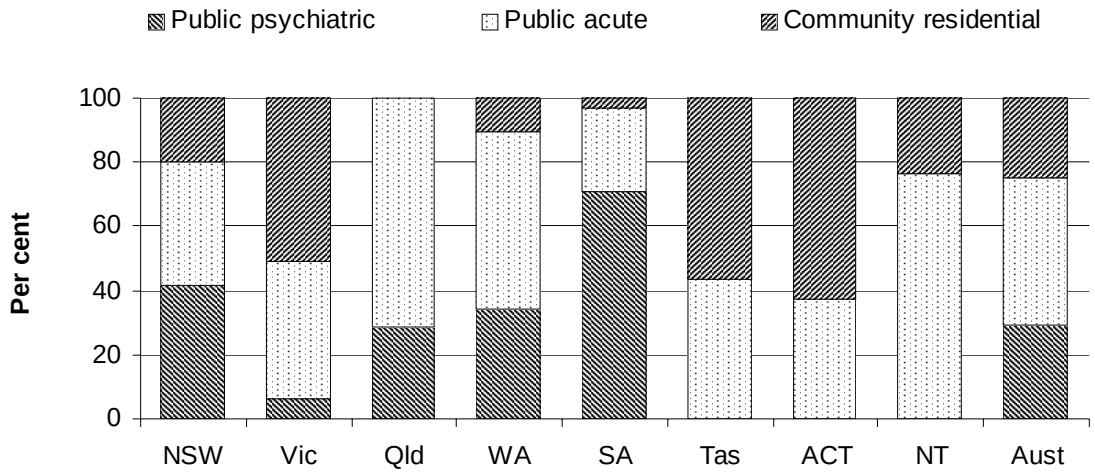
a 2003 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*. **b** Includes beds in public hospitals and publicly funded community residential units. **c** Prior to 1999-2000, 'community residential' was defined as government funded 24 hour staffed residential units in community settings (external to the campus of a public hospital or psychiatric institution). From 1999-2000, the definition has been broadened to incorporate all staffed community-based units, regardless of the number of hours that staff are present.

Source: State and Territory governments (unpublished); table 11A.27.

Figure 11.22 presents the number of beds by service category for 2003. These data show the differences in service mix across states and territories. In 2003, SA had the highest proportion of beds in public psychiatric hospitals (70.8 per cent) and Victoria had the lowest (6.1 per cent). Tasmania, the ACT and the NT did not have public psychiatric hospitals. The ACT had the highest proportion of beds in community residential services (62.7 per cent) and SA had the lowest (3.0 per cent).

Queensland does not fund community residential services, but it funds a number of extended treatment services (both campus- and non-campus-based) that provide longer term inpatient treatment and rehabilitation services with full clinical staffing for 24 hours a day, seven days a week. Queensland does not report these beds as community residential beds because it considers them to be substantially different from beds described as such in other states and territories.

Figure 11.22 **Beds, by service category, 30 June 2003[a, b]**



a 2003 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*. **b** Queensland does not fund community residential services, but it funds a number of campus-based and non-campus-based extended treatment services. These services are reported either as beds in public acute hospitals or beds in public psychiatric hospitals.

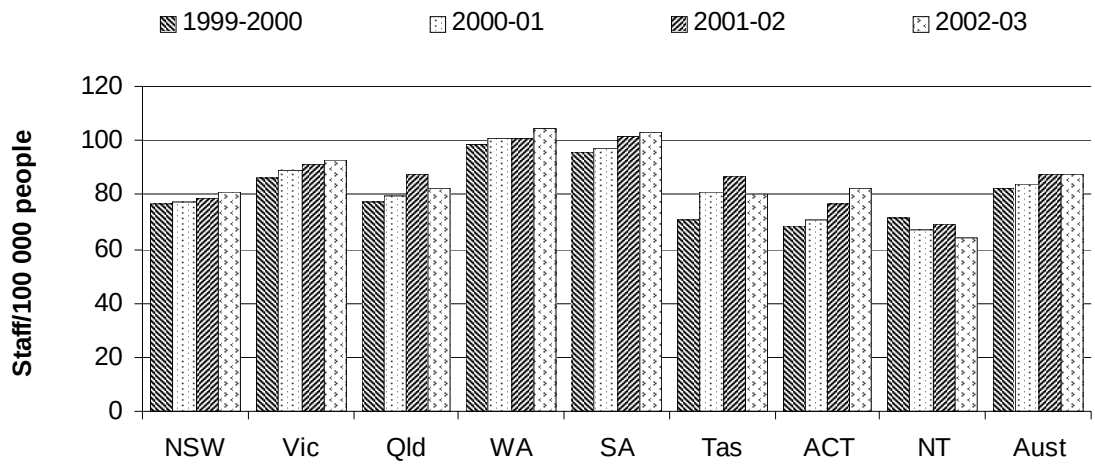
Source: State and Territory governments (unpublished); table 11A.27.

Staff

Figure 11.23 reports full time equivalent (FTE) direct care staff per 100 000 people and includes only staff within the health professional categories of 'medical', 'nursing' and 'allied health'. 'Other personal care' direct care staff are excluded. Medical staff consist of consultant psychiatrists, psychiatry registrars, and other medical officers who are neither registered as psychiatrists within the State or Territory, nor are formal trainees of the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program. Nursing consists of registered and non-registered nurses. Allied health consists of occupational therapists, social workers, psychologists and other allied health staff. Other personal care staff include attendants, assistants, home companions, family aides, ward helpers, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents and who are not formally qualified or are still training in nursing or allied health professions. Definitions for staffing categories are provided in more detail in section 11.7.

In 2002-03, WA had the highest number of FTE direct care staff per 100 000 people in specialist mental health services (104.2) and the NT had the lowest (63.7).

Figure 11.23 **FTE health professional direct care staff per 100 000 people[a, b, c, d]**



a 2002-03 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*. **b** Includes health professional occupational categories only. **c** Community residential incorporates all staffed community-based units, regardless of the number of hours that staff are present. **d** The apparent drop in FTE staff for Queensland was due in part to the completion of the downsizing and redevelopment of two of the psychiatric hospital campuses, which resulted in substantial staff movements and some overall reduction in staffing.

Source: State and Territory governments (unpublished); table 11A.28.

Nursing staff comprise the largest FTE component of health care professionals employed in mental health services. Across Australia in 2002-03, 57.2 nurses per 100 000 people were working in specialised mental health services, compared with 21.0 allied health care staff and 9.7 medical staff (table 11A.28). FTE direct care staff employed in specialised mental health services, by service setting, are reported in table 11A.29.

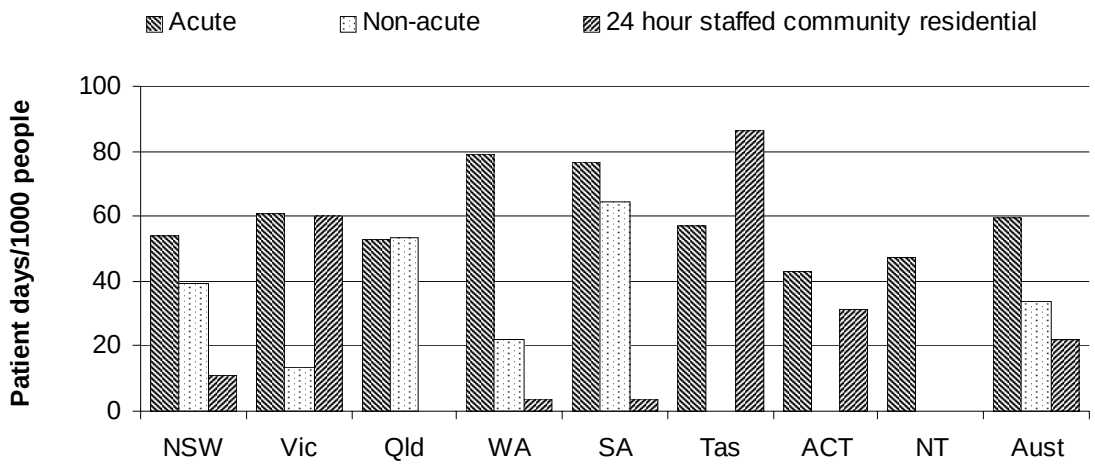
Services provided

Estimating activity across the specialised mental health services sector is problematic. Data for patient days are provided in figure 11.24 by acute, non-acute and 24 hour staffed community residential care (as defined in box 11.17).[6] Hospital inpatient days and community residential patient days are included in figure 11.24, but other types of community service are not covered. Collection of data outlining community mental health care patient contacts commenced in July 2000 as part of the national minimum data set, although there are difficulties with data quality.

6 Under the NSMHS, patient days are all days or part days for which the patient was in hospital during the survey period, regardless of the original date of admission or discharge.

In 2002-03, patient days per 1000 people in acute units were highest in WA (79.0) and lowest in the ACT (43.2). In non-acute units, patient days per 1000 people were highest in SA (64.5) and lowest in Victoria (13.4). Tasmania, the ACT and the NT did not provide mental health care in non-acute units in 2002-03. Tasmania had the most patient days per 1000 people in 24 hour staffed community residential facilities (86.3) and SA had the least (3.4) (figure 11.24). The NT did not provide mental health care in 24 hour staffed community residential facilities in 2002-03. The earlier caveat for the apparent absence of community residential beds in Queensland also applies to the data in figure 11.24.

Figure 11.24 **Mental health patient days, 2002-03**[a, b, c, d]



a 2002-03 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*. **b** Queensland does not fund community residential services, but it funds a number of campus-based and non-campus-based extended treatment services. Data from these services are included as non-acute. **c** The ACT and the NT did not provide mental health care in non-acute units. **d** The NT did not provide mental health care in 24 hour staffed community residential facilities.

Source: State and Territory governments (unpublished); table 11A.30.

In public psychiatric hospitals in 2001-02, there were 13 246 overnight separations with specialised psychiatric care and 631 same day separations (AIHW 2004b). In public acute hospitals there were 66 937 overnight separations with specialised psychiatric care and 4954 same day separations. Schizophrenia accounted for a large proportion of overnight separations related to mental disorders in public hospitals (23.2 per cent in public acute hospitals and 25.9 per cent in public psychiatric hospitals) (table 11A.31).

The high level of same day separations reflected varying same day admission practices rather than overnight admissions to hospital. Unlike the general acute hospital sector, mental health has few procedural same day admissions, these being mainly related to electroconvulsive therapy treatment of people living in the

community which represented 6–10 per cent of all same day separations. Work for the Mental Health Classification and Service Costs Project suggested that the majority of same day hospitalisations are better described as ambulatory care and involve consumer attendance at a variety of day and group-based programs that otherwise could be provided in community settings (Buckingham *et al*. 1998).

Services by general practitioners

Limited data are available on GP care of mental health patients. The following data are collected from a sample of 1000 GPs. In 2002-03, the reason most frequently reported by mental health related patients for an encounter with a GP was depression (1.9 per 100 encounters).[7] Sleep disturbance was the next most common reason (1.2 per 100 encounters), followed by anxiety (0.9 per 100 encounters). In total, 7.3 per 100 encounters involved mental health problems reported by patients as a reason for an encounter with a GP (AIHW 2004b).

In 2002-03, 10.3 of every 100 encounters with a GP involved mental health problems. The most frequently reported mental health related problem managed in GP encounters was depression (3.5 per 100 GP encounters). Sleep disturbance and anxiety were the next most common problems managed (1.6 and 1.5 per 100 encounters respectively), followed by acute stress reaction and drug abuse (both 0.5 per 100 encounters) (AIHW 2004b). In 2003-04, depression was the fourth most frequently managed problem by a GP (Britt *et al.* 2004).[8]

Indigenous patients

Limited data are available on specialised psychiatric care of Indigenous patients in hospital. Comparisons are difficult because data on Indigenous status are incomplete and Indigenous people and other Australians may differ in their use of hospital services relative to other health services. The data reflect a range of factors, such as the spectrum of public, primary care and post-hospital care available; Indigenous people's access to these as well as hospital services; social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disorders. Indigenous Australians were nearly twice as likely as the rest of the population to be admitted for overnight psychiatric care. The

[7] In the Bettering the Evaluation and Care of Health study, participating GPs were asked to record at least one, and up to three, patient reasons for the encounter (Britt *et al.* 2004). Reasons for the encounter reflected the patient's demand for care and could indicate service use patterns.

[8] A GP often managed more than one problem at a single encounter. Problems managed reflect the GP's understanding of the health problem presented by the patient.

average length of stay for Indigenous people was slightly less, however, than that for the rest of the population (table 11.7).

Table 11.7 **Specialised psychiatric care, by Indigenous status, 2001-02[a, b]**

	Same day separations	*Overnight separations*	*Total separations*	*Total patient days*	*Total psychiatric care days*	*Average length of stay (overnight)*	*Psychiatric care days per overnight separation*
No.							
Indigenous	130	3 567	3 697	72 386	71 723	20.3	20.1
Total population	8 536	102 433	110 969	2 458 483	2 421 286	23.9	23.6
Per 1000 population[c]							
Indigenous	0.4	9.1	9.6	199.3	198.0	..	..
Total population	0.4	5.2	5.6	124.1	122.2	..	..

a The completeness of data on Indigenous status varies, so these data need to be used with care. **b** Specialised psychiatric care refers to separations in which at least one day of specialised psychiatric care was received. **c** Separations per 1000 population are indirectly age standardised rates based on the projected Aboriginal and Torres Strait Islander population for 30 June 2001 and the estimated resident population for 30 June 2001. **..** Not applicable.

Source: AIHW (2004b); table 11A.32.

Schizophrenia disorders accounted for a large proportion of overnight specialised psychiatric care separations reported for Indigenous patients in Australia in 2001-02 (26.1 per cent). They also accounted for around 47.3 per cent of patient days for Indigenous patients and a similar percentage of psychiatric care days (47.6 per cent) (table 11A.33).

Framework of performance indicators

The distinction between prevention and intervention is difficult in the case of mental illness. Preventing the onset of mental illness is challenging, primarily because individual disorders have many origins. Most efforts have been directed at treating mental illness when it occurs, particularly at determining the most appropriate setting for providing treatment, as well as emphasising early intervention. The indicators used in this Report focus on service delivery reforms that commenced under the First National Mental Health Plan (1993–1998) and were extended under the second plan (1998–2003). The second plan emphasised promoting mental health and preventing mental illness. The performance indicator framework will be redeveloped in future reports to reflect these components of mental illness management and the new mental health plan.

The framework of performance indicators for mental health services builds on government objectives for mental health service delivery (box 11.18) as encompassed in the NMHS. The framework reports on the equity, effectiveness and efficiency of specialised mental health services. It covers a number of service delivery types (institutional and community-based services) and indicators of systemwide performance. Improving the framework is a priority of the Review and the Australian Health Ministers Advisory Council's National Mental Health Working Group.

Box 11.18 **Objectives for mental health service delivery**

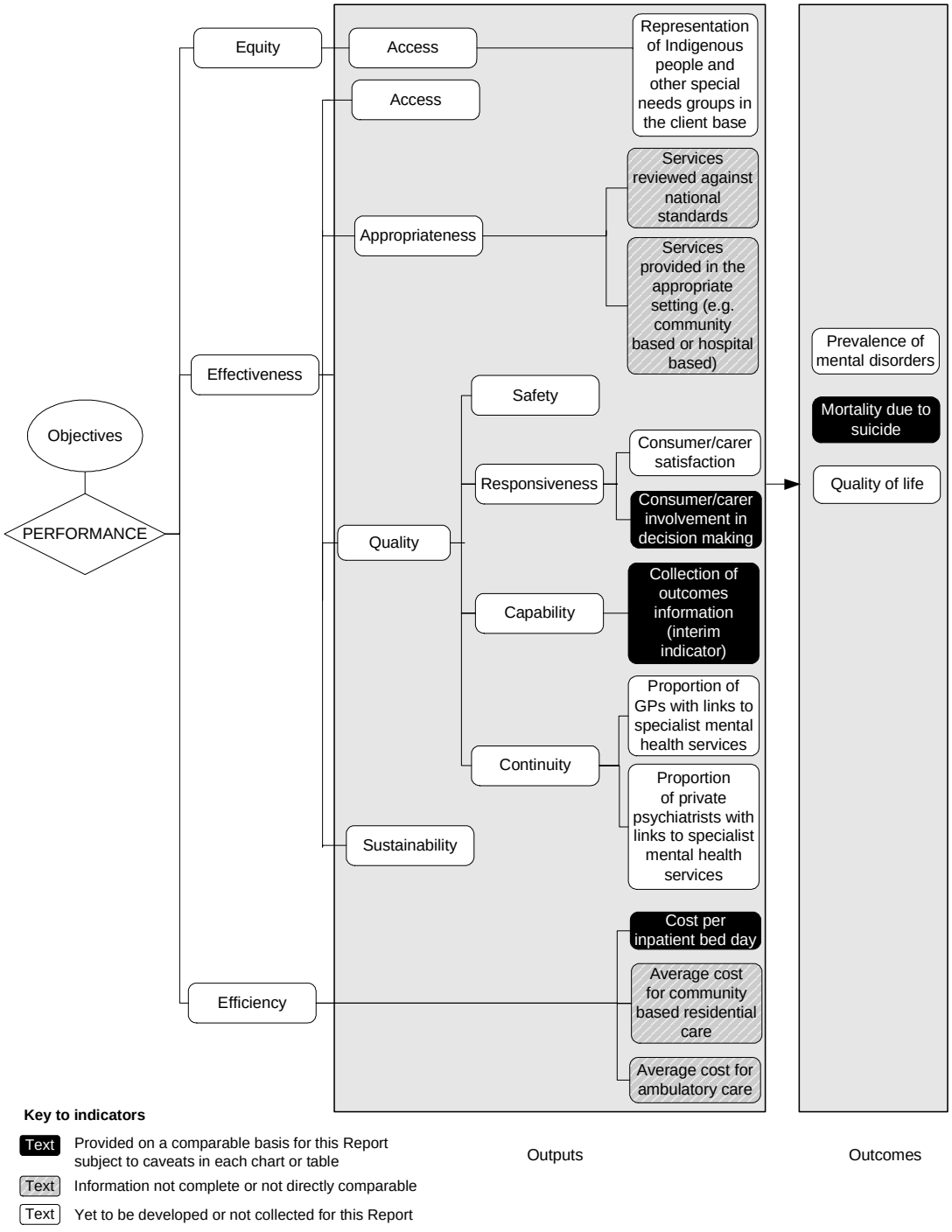
Key objectives include to:

- improve the effectiveness and quality of service delivery and outcomes
- promote, where appropriate, community awareness of mental health problems
- prevent, where possible, the development of mental health problems and mental disorders
- undertake, where appropriate, early intervention of mental health problems and mental disorders
- reduce, where possible, the impact of mental disorders on individuals, families and the community
- assure the rights of persons with mental disorders
- encourage partnerships among service providers and between service providers and the community.

Governments also aim to provide services in an equitable and efficient manner.

The performance indicator framework shows which data are comparable in the 2005 Report (figure 11.25). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The 'Health preface' explains the performance indicator framework for health services as a whole, including the sub-dimensions for quality and sustainability that have been added to the standard Review framework for health services.

Figure 11.25 **Performance indicators for mental health management**



Key performance indicator results

Outputs

Equity — representation of Indigenous people and others in the client base

The Steering Committee has identified the 'representation of Indigenous people and other special needs groups in the client base' as a key area for development in future reports (box 11.19).

Box 11.19 **Representation of Indigenous people and other special needs groups in the client base**

The 'representation of Indigenous people and other special needs groups in the client base' is an indicator of governments' aim to provide mental health services in an equitable manner, including access to services by special needs groups such as Indigenous people.

Access

The Steering Committee has identified access as an area for reporting, but no indicators have yet been developed.

Appropriateness — services reviewed against the national standards

'Services reviewed against the national standards' is an effectiveness indicator of mental health management (box 11.20).

Box 11.20 **Services reviewed against the national standards**

'Services reviewed against the national standards' is a process indicator of appropriateness, reflecting progress towards accreditation against the national standards for mental health care. The national standards are outlined in box 11.21.

This indicator is defined as the proportion of commenced and completed reviews of specialised public mental health services that are undertaken by an external accreditation agency against the National Standards for Mental Health Services. A high proportion of reviews completed by an external accreditation agency is desirable.

External accreditation agencies, such as the Australian Council on Healthcare Standards, undertake accreditation of a parent health organisation (for example, a hospital) that may cover a number of specialist services, including mental health services. Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the national standards. Accreditation *per se* does not assess or provide information on the implementation of the National Standards for Mental Health Services; rather, assessment against the national standards must be specifically requested and involves a separate review process.

Data in table 11.8 show the percentage of specialised public mental health services that have participated in, or are currently participating in, an in-depth review by an external accreditation agency against the National Standards for Mental Health Services. Such reviews may take place in conjunction with, or separate to, overall accreditation of a parent organisation. Review against the national standards will, in some cases and in some jurisdictions, be delayed until an appropriate point is reached within the overarching accreditation cycle (for example, a mid-term review).

Box 11.21 **The National Standards for Mental Health Services**

The National Standards for Mental Health Services were developed under the First National Mental Health Plan for use in assessing service quality and as a guide for continuous quality improvement in all Australian mental health services. They comprise 11 major criteria:

1. rights
2. safety
3. consumer and carer participation
4. promoting community acceptance
5. privacy and confidentiality
6. prevention and mental health promotion
7. cultural awareness
8. integration
9. service development
10. documentation
11. delivery of care.

Source: DHA (2002).

The extent to which reviews were completed varied across jurisdictions at June 2003: they were completed in all of the ACT specialist mental health

organisations, whereas no reviews had been completed in the NT. At the end of June 2003, 80.9 per cent of services had commenced a review and 41.3 per cent had completed a review. It cannot be concluded at this time whether services yet to complete a review were necessarily of poorer quality (table 11.8).

Table 11.8 **Specialised public mental health services reviewed against the National Standards for Mental Health Services (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
June 2001									
Review commenced	36.6	28.0	100.0	12.5	47.5	–	100.0	–	41.8
Review completed	9.4	28.0	36.8	–	26.3	–	100.0	–	17.6
June 2002									
Review commenced	64.2	42.9	100.0	65.6	47.5	16.7	100.0	–	61.4
Review completed	16.2	38.5	85.6	15.6	26.3	–	100.0	–	29.4
June 2003									
Review commenced	70.4	100.0	100.0	100.0	64.6	100.0	100.0	100.0	80.9
Review completed	26.6	49.7	90.2	53.1	46.5	22.2	100.0	–	41.3

a 'Review commenced' means the percentage of specialised public mental health services that had formally registered for review by an external accreditation agency against the National Standards for Mental Health Services; 'review completed' means the percentage of specialised public mental health services that had formally completed a review by an external accreditation agency against the National Standards for Mental Health Services. **–** Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 11A.34.

Appropriateness — services provided in the appropriate setting

'Services provided in the appropriate setting' is an effectiveness indicator of mental health management (box 11.22).

Box 11.22 **Services provided in the appropriate setting**

'Services provided in the appropriate setting' is an indicator of the development of local comprehensive mental health service systems advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental disorders and of providing continuity of care, so consumers can move between services as their needs change. The strategy advocates:

- a reduced reliance on stand-alone psychiatric hospitals

(Continued on next page)

Box 11.22 **(Continued)**

- the expanded delivery of community-based care integrated with inpatient care
- mental health services being mainstreamed with other components of health care.

By encouraging the treatment of patients in community settings and public (non-psychiatric) hospitals rather than in stand-alone psychiatric hospitals — that is, to substitute the service settings — more appropriate treatment options can be provided.

Two measures of 'services provided in the appropriate setting' are used:

- recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total spending on mental health services. A low proportion for this indicator is desirable, reflecting a low reliance on stand-alone hospitals.
- acute patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals. A high proportion for this indicator is desirable, reflecting greater mainstreaming of mental health services.

Figure 11.26 shows recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total expenditure on mental health services. In 2002-03, the proportion was highest in SA (43.8 per cent) and lowest in Victoria (6.1 per cent). (As noted, Tasmania, the ACT and the NT had no public psychiatric hospitals in 2002-03.)

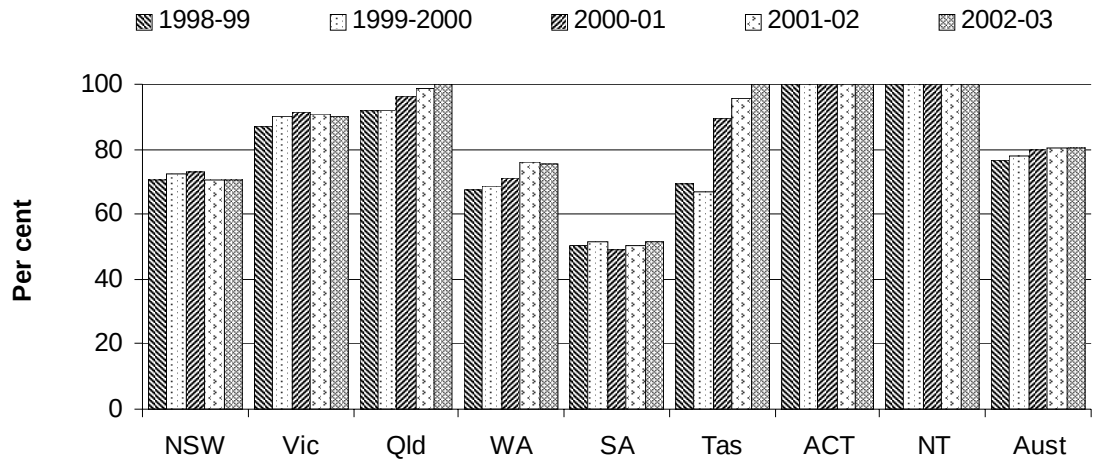
Figure 11.26 **Recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total expenditure on mental health services[a, b]**

a 2002-03 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*. **b** The ACT and the NT do not have public psychiatric hospitals. Tasmania did not have public psychiatric hospitals in 2002-03.

Source: State and Territory governments (unpublished); table 11A.35.

Figure 11.27 shows acute patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals. In 2002-03, aside from Tasmania and the territories (none of which had psychiatric hospitals), the highest proportion of acute patient days in public acute hospitals was in Queensland (100.0 per cent) and the lowest was in SA (51.5 per cent).

Figure 11.27 **Acute patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals[a]**



a 2002-03 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*.

Source: State and Territory governments (unpublished); table 11A.35.

Quality — consumer and carer satisfaction

The Steering Committee has identified 'consumer and carer satisfaction' as a key area for development in future reports (box 11.23).

Box 11.23 **Consumer and carer satisfaction**

'Consumer and carer satisfaction' is an indicator of satisfaction with both clinician's responses and with services provided in all areas of mental health. Both are important aspects of the NMHS.

Quality — consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' is an effectiveness indicator of mental health management (box 11.24).

Box 11.24 **Consumer and carer involvement in decision making**

'Consumer and carer involvement in decision making' is an important aspect of the NMHS. It is an indicator of consumers' and carers' involvement at the service delivery level, where they have the opportunity to influence the services they receive.

The indicator relates to the arrangements that allow consumers and carers to contribute to local service planning and delivery in specialised mental health services. Arrangements are grouped into four categories:

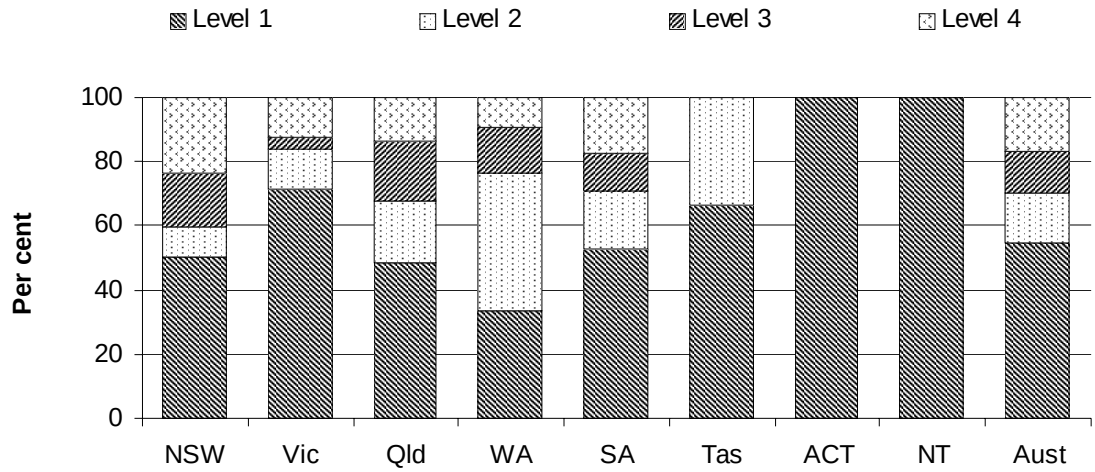
- level 1 — appointment of a person to represent the interests of consumers and carers on the organisation management committee, or a specific consumer and carer advisory group to advise on all aspects of service delivery
- level 2 — a specific consumer and carer advisory group to advise on some aspects of service delivery
- level 3 — participation of consumers and carers in broad-based committees
- level 4 — other/no arrangements.

An organisation can be classified at only one level. A high proportion of organisations with level 1 arrangements is desirable, while a high proportion of organisations with level 4 arrangements is undesirable.

In 2003, the ACT and the NT had the highest proportion of organisations with a level 1 rating (100 per cent). (Data for both jurisdictions are for three organisations.) WA had the lowest proportion (33.3 per cent of 21 organisations). NSW had the highest proportion of organisations reporting no consumer and carer involvement in decision making (level 4) (23.6 per cent of 89 organisations) (figure 11.28).

The *National Mental Health Report 2002* includes additional indicators on consumer and carer participation arrangements (DHA 2002). The Review will investigate including these indicators in the mental health management indicator framework and reporting them in future reports.

Figure 11.28 **Organisations with consumer and carer participation in decision making, 2003[a, b, c, d]**



a 2003 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*. Non-government organisations are included. **b** NSW advised that the government has no authority to require consumer participation in services delivered through the primary care program. **c** Victoria advised that its model of consumer consultants fits poorly with the Australian Health Care Agreement categories. It has paid consumer consultants working in mental health services. Many agencies report these consultants in the 'other' category, which has a low ranking and, according to Victoria, does not reflect the active role played by consumer consultants in service operation. **d** WA advised that the National Survey of Mental Health Services does not accurately represent consumer and carer participation strategies used in WA. At the State and regional levels, the Office of Mental Health gives high priority to the involvement of consumers and carers in developing a responsive mental health service. Several key consumer and carer advisory groups are supported and provided with financial assistance by the Office of Mental Health. Collectively, these groups provide advice and representation on consumer and carer issues.

Source: State and Territory governments (unpublished); table 11A.36.

Quality — collection of outcomes information (interim indicator)

The 'Collection of outcomes information' is an effectiveness indicator of mental health management (box 11.25).

Box 11.25 **Collection of outcomes information (interim indicator)**

The 'Collection of outcomes information' is an interim indicator until information on client outcomes is available. Establishing a system for the routine monitoring of consumer outcomes was introduced as part of the National Mental Health Plan 2003–2008. Jurisdictions are introducing a collection that will enable reporting in future (see section 11.5).

(Continued on next page)

Box 11.25 **(Continued)**

States and territories have taken the following approach to introducing consumer outcome measurement as part of day-to-day service delivery:

- measures to include ratings by clinicians and self-ratings by consumers
- all clinical staff to have undergone training
- processes established to ensure uniformity in collection
- funding for information systems to store, analyse and report on the data
- a national approach to data analysis, reporting and benchmarking (DHA 2002).

This indicator is the proportion of specialised mental health services that have introduced routine collection of consumer outcome measurement. A high proportion is desirable for this indicator.

The percentages of specialised mental health services that have introduced routine consumer outcome measurement are shown in table 11.9.

Table 11.9 **Specialised mental health services that introduced the routine collection of consumer outcome measurement (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*[b]	*SA*	*Tas*	*ACT*	*NT*	*Aust*
June 2001	–	11.3	–	–	–	–	–	–	1.4
June 2002	55.8	11.3	–	–	–	17.6	–	–	32.2
June 2003	77.3	72.6	41.8	7.4	–	94.4	81.3	100.0	68.1

a Data are based on reports from jurisdictions. Jurisdictions report at varying levels, reflecting differences in service structure — for example, data may be reported at area health service level or at hospital level, with each level containing a number of specialist mental health services. Data are thus aggregated. **b** There has been a significant delay in the expected Statewide implementation of the new mental health clinical information system, due to technical and system complexity issues. Implementation is expected to be completed by June 2004. All sites that have the new mental health clinical information system implemented are now collecting consumer outcome measurements, with other sites using an interim paper-based collection. – Nil or rounded to zero.

Source: State and Territory governments; table 11A.37.

Quality — proportion of general practitioners with links to specialist mental health services

The Steering Committee has identified the 'proportion of GPs with links to specialist mental health services' as an indicator of the effectiveness of mental health management (box 11.26). Data for this indicator, however, were not available for the 2005 Report.

Box 11.26 **Proportion of general practitioners with links to specialist mental health services**

The 'proportion of GPs with links to specialist mental health services' is an indicator of the objective of mental health service delivery to provide continuity of care. GPs can be an important first point of contact for those with a mental illness.

Quality — proportion of private psychiatrists with links to specialist mental health services

The Steering Committee has identified the 'proportion of private psychiatrists with links to specialist mental health services' as an indicator of the effectiveness of mental health management (box 11.27). Data for this indicator, however, were not available for the 2005 Report.

Box 11.27 **Proportion of private psychiatrists with links to specialist mental health services**

The 'proportion of private psychiatrists with links to specialist mental health services' is an indicator of the objective of mental health service delivery to provide continuity of care.

Sustainability

The Steering Committee has identified sustainability as an area for reporting but no indicators have yet been identified.

Efficiency

As noted, the data for 2002-03 are preliminary and will be further validated as part of the production of the annual National Mental Health Report. Data for 2002-03, therefore, need to be treated with caution.

Efficiency — cost per inpatient bed day

'Cost per inpatient bed day' is an efficiency indicator of mental health management (box 11.28).

Box 11.28 **Cost per inpatient bed day**

The 'cost per inpatient bed day' is a proxy indicator of the efficiency of mental health service delivery. An aim of mental health service delivery is to provide services in an efficient manner.

This indicator is defined as the cost of providing inpatient services per inpatient bed day. A low cost per inpatient bed day can indicate efficiency, although caution must be used because the cost per inpatient bed day does not provide any information on the quality of service provided.

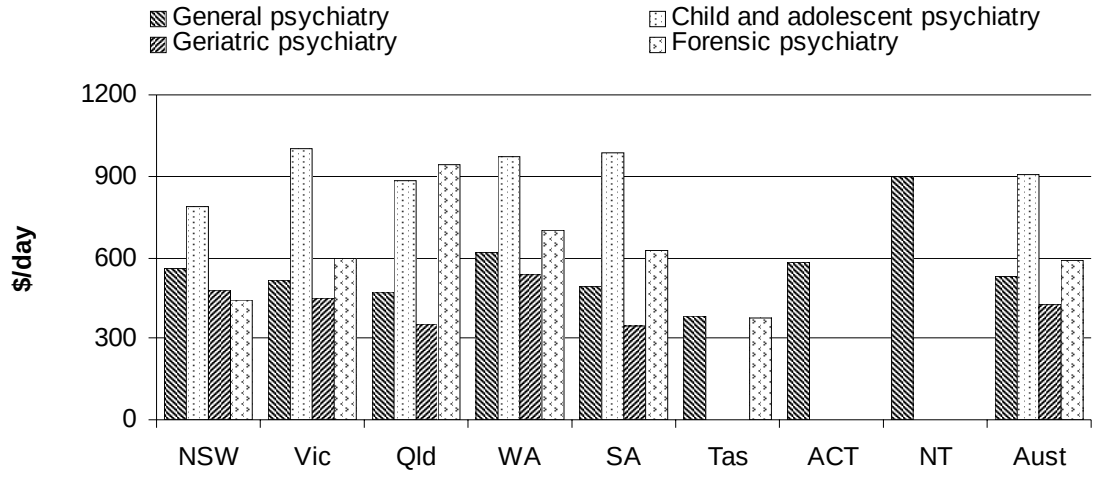
This indicator is affected by factors such as differences in the client mix and average length of stay. The client mix in inpatient settings may differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings rather than in the community. Longer lengths of stay may also be associated with lower average inpatient day costs because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care.

The most suitable indicator for mental health services would be to adjust the number of separations by the type and complexity of cases, to develop a cost per casemix-adjusted separation similar to that presented for public hospitals (see chapter 9), but casemix data for specialised mental health services are not available.

Reported real inpatient costs per day are disaggregated by inpatient program type (general psychiatry, child and adolescent psychiatry, geriatric psychiatry, and forensic psychiatry) and hospital type (psychiatric hospitals [acute units], psychiatric hospitals [non-acute units] and general hospitals). Disaggregating these data improves comparability across jurisdictions. Real inpatient costs per day are presented in figures 11.29 and 11.30. Changes over time partly reflect institutional change in accordance with the NMHS.

In terms of inpatient program type in 2002-03, average general psychiatry patient day costs were highest in the NT ($897) and lowest in Tasmania ($381) (figure 11.29). Average patient day child and adolescent psychiatry costs were highest in Victoria ($1001) and lowest in NSW ($789). (In 2002-03, child and adolescent psychiatry programs were not available, or could not be separately identified, in Tasmania, the ACT and the NT.) Geriatric psychiatry costs were highest in WA ($539) and lowest in SA ($346). (Geriatric psychiatry programs were not available, or could not be separately identified, in Tasmania, the ACT and the NT.) Forensic psychiatry costs were highest in Queensland ($940) and lowest in Tasmania ($378). Queensland advised that its high bed day cost of forensic psychiatry beds was due to bed day costs associated with a new 21 bed forensic service set up in Townsville in 2002-03. (Forensic psychiatry programs were not available or could not be separately identified in the ACT and the NT.)

Figure 11.29 **Real average recurrent cost per inpatient bed day, public hospitals, by inpatient program type, 2002-03 (2002-03 dollars)[a, b, c, d, e, f]**



a 2002-03 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*. **b** Depreciation is excluded. **c** Costs are not adjusted for differences in the complexity of cases across jurisdictions and may reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). **d** Constant price expenditure (in 2002-03 dollars), using government final consumption expenditure on hospital and clinical services as the deflator — see table 11A.55. **e** Queensland advised that it provides geriatric psychiatry inpatient services using different service models, including campus-based and non-campus-based options. All service types are reported as geriatric psychiatry inpatient services, which may have the effect of lowering the average patient day costs compared with the costs of jurisdictions that report aged care units separately. Queensland has also advised that its high bed day cost of forensic psychiatry beds was due to inflated bed day costs associated with a new 21 bed forensic service set up in Townsville in 2002-03. **f** In 2002-03, child and adolescent psychiatry programs were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Geriatric psychiatry programs were not available, or could not be separately identified, in the ACT and the NT. Tasmanian figures include child and adolescent psychiatry within the general psychiatry category. Forensic psychiatry were not available, or could not be separately identified, in the ACT and the NT.

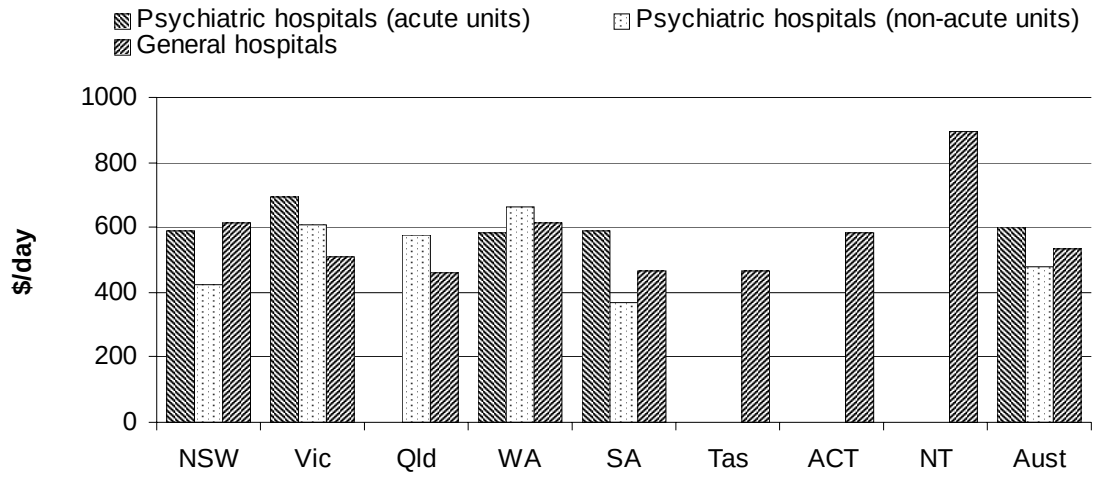
Source: State and Territory governments (unpublished); table 11A.38; DHA (unpublished); table 11A.55.

In terms of hospital type in 2002-03, average patient day costs in psychiatric hospitals (acute units) were highest in Victoria ($694) and lowest in WA ($584). Average costs in psychiatric hospitals (non-acute units) were highest in WA ($661) and lowest in SA ($371). Tasmania, the ACT and the NT did not have psychiatric hospitals. Average patient day costs in public general hospitals were highest in the NT ($897) and lowest in Queensland ($461) (figure 11.30).

Efficiency — average cost for community-based residential care

The 'Average cost for community-based residential care' is an efficiency indicator of mental health management (box 11.29).

Figure 11.30 **Real average recurrent cost per inpatient bed day, public hospitals, by hospital type, 2002-03 (2002-03 dollars)[a, b, c, d, e, f, g]**



a 2002-03 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*. **b** Depreciation excluded. **c** Costs are not adjusted for differences in the complexity of cases across jurisdictions and may reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). **d** Constant price expenditure (in 2002-03 dollars), using government final consumption expenditure on hospital and clinical services as the deflator — see table 11A.55. **e** Mainstreaming has occurred at different rates in different jurisdictions. Victoria advised that the data for psychiatric hospitals comprise mainly forensic services, because nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means the client profile and service costs are very different from those of a jurisdiction in which general psychiatric treatment still occurs mostly in psychiatric hospitals. **f** Queensland data for general hospitals include costs associated with extended treatment units that report through general acute hospitals. **g** The ACT and the NT do not have psychiatric hospitals. Tasmania did not have any psychiatric acute or psychiatric non-acute units in 2002-03.

Source: State and Territory governments (unpublished); DHA (unpublished); tables 11A.39 and 11A.55.

Box 11.29 **Average cost for community-based residential care**

The 'average cost for community-based residential care' is an indicator of the efficiency of mental health service delivery. An aim of mental health service delivery is to provide services in an efficient manner.

This indicator is defined as the cost of providing community-based residential care per patient day. A low average cost can indicate efficiency, although caution must be used because the average cost does not provide any information on the quality of service provided.

These data are likely to be affected by institutional changes occurring as a result of the NMHS. In addition, differences across jurisdictions in the types of patient admitted to community residential care affect average costs in these facilities. Average recurrent costs to government per patient day for these services are reported for both the care of adults and the care of older people. The distinction is made to reflect the differing unit costs of treating the two groups.

The average recurrent cost to government per patient day for community residential services is presented in table 11.10. For general adult units in 2002-03, the average cost to government per patient day for 24 hour staffed community residential services was an estimated $307 nationally (table 11.10). Across jurisdictions, it was highest in the ACT ($646) and lowest in SA ($111). In the NT, there were no 24 hour staffed residential services in 2002-03. For non-24 hour staffed community residential units, the average cost to government per patient day was $87 nationally. Across jurisdictions, it was highest in Victoria ($127) and lowest in NSW ($41). Non-24 hour staffed residential services were not available in SA and Tasmania in 2002-03. As stated, Queensland does not fund community residential services.

For jurisdictions that had community-based aged care units in 2002-03, the average recurrent cost to government per patient day for 24 hour staffed community residential services was $259 nationally. For non-24 hour staffed community residential aged care units, the average cost to government per patient day was $88 in NSW.

Table 11.10 **Average recurrent cost to government per patient day for community residential services, 2002-03[a, b, c]**

	NSW	*Vic*	*Qld*[d]	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
General adult units									
24 hour staffed units	296.1	280.8	na	249.3	110.9	495.5	646.4	..	307.3
Non-24 hour staffed units	40.9	127.4	na	125.8	..	..	59.2	79.1	86.5
Aged care units									
24 hour staffed units	316.1	245.9	na	..	..	284.2	56.2	..	258.6
Non-24 hour staffed units	87.9	..	na	..	..	..	..	..	87.9

a 2002-03 data are preliminary only; final validation is ongoing before publication in the *National Mental Health Report 2005*. **b** Depreciation is excluded, although treated differently across jurisdictions. **c** Costs are not adjusted for differences in the complexity of cases across jurisdictions and may reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). **d** Queensland does not fund community residential services, although it funds a number of campus-based and non-campus-based extended treatment services. **na** Not available. **..** Not applicable.

Source: State and Territory governments (unpublished); table 11A.40.

Efficiency — average cost for ambulatory care

The 'Average cost for ambulatory care' is an efficiency indicator of mental health management (box 11.30).

Box 11.30 **Average cost for ambulatory care**

The 'average cost for ambulatory care' is an indicator of the efficiency of mental health service delivery. An objective of mental health service delivery is to provide services in an efficient manner.

This indicator is defined as the cost of providing ambulatory care per treated patient in the community. A low average cost can indicate efficiency, although caution must be used because the average cost does not provide any information on the quality of service provided.

The provision of ambulatory treatment, rehabilitation and support to non-inpatients, and post-acute care are important components of service provision, and it is a priority for the Steering Committee to continue improving reporting in these areas.

Unit costs (dollars per treated patient in the community) for 2002-03 are presented here for all states and territories. The data reported for this indicator are unreliable, however, and comparisons across jurisdictions are not possible for several reasons. First, information about service costs across jurisdictions is incomplete. Second, the absence of unique patient identifiers in many jurisdictions means clients who use mental health services other than their usual service may be counted twice. This double counting may artificially reduce average costs in some states or territories. Victoria, WA and the NT have statewide systems of unique identifiers, so the extent of overcounting of patients in these jurisdictions is relatively low compared with that in other jurisdictions. Third, differences across jurisdictions in the complexity of cases treated, the service options available for treatment and the admission practices reduce the comparability of data across states and territories. Finally, cost components such as depreciation are not measured consistently across jurisdictions.

- NSW reported ambulatory care unit costs of $955 per treated patient in the community in 2002-03, with 20.1 per cent of services not reporting (table 11A.41).
- Victoria reported ambulatory care unit costs of $1759, with 30.6 per cent of services not reporting (table 11A.42).
- Queensland reported ambulatory care unit costs of $1515, with all services reporting (table 11A.43).
- WA reported ambulatory care unit costs of $2048, with all services reporting (table 11A.44).
- SA reported ambulatory care unit costs of $1647, with 17.6 per cent of services not reporting (table 11A.45).
- Tasmania reported ambulatory care unit costs of $703, with 4.8 per cent of services not reporting (table 11A.46).

- The ACT reported ambulatory care unit costs of $1875, with 11.8 per cent of services not reporting (table 11A.47).
- The NT reported ambulatory care unit costs of $1581, with all services reporting (table 11A.48).
- Across Australia, ambulatory care unit costs were $1326, with 17.0 per cent of services not reporting (table 11A.49).

Outcomes

Prevalence of mental disorders

The Steering Committee has identified the 'prevalence of mental disorders' as a key indicator for development in future reports (box 11.31).

Box 11.31 Prevalence of mental disorders

The 'prevalence of mental disorders' is an outcome indicator of the objective of mental health service delivery to prevent and reduce mental health problems where possible.

While the performance of mental health services is important in reducing suicide, other government services also play a significant role. Any impact on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including police, education, housing, justice and community services agencies. In addition, many factors outside the control of mental health services may influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors. There can also be a lack of knowledge of how to prevent many of the mental illnesses that make up most of the work of the specialist public sector.

There are no nationally comparable data on the prevalence of mental disorders treated by specialised mental health services, other than the data discussed in the profile for section 11.4 and the in the 2004 Report (SCRGSP 2004).

Mortality due to suicide

'Mortality due to suicide' is an outcome indicator of mental health management (box 11.32).

Box 11.32 **Mortality due to suicide**

'Mortality due to suicide' is an indicator because evidence indicates that people with a mental disorder are at a higher risk of suicide than are the general population. (They are also at a higher risk of death from other causes, such as cardiovascular disease.)

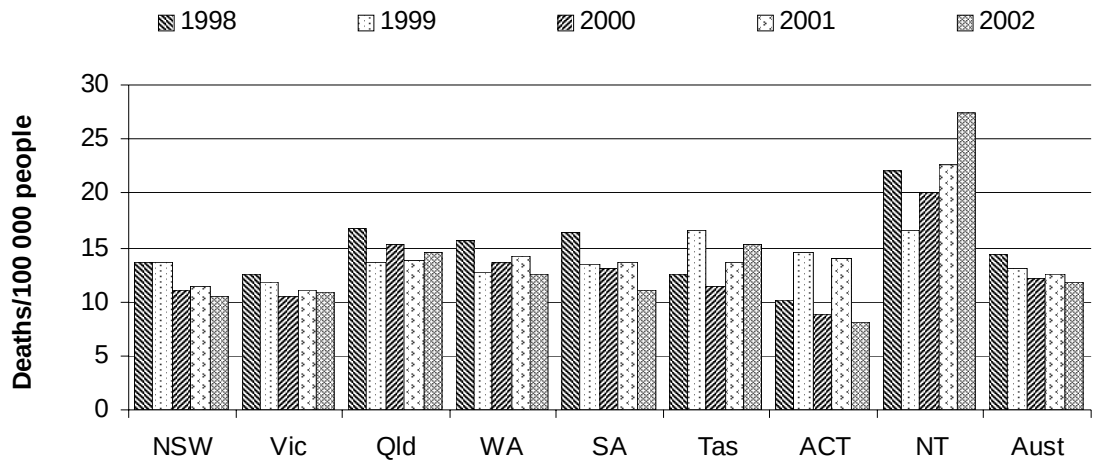
This indicator is reported as the rates per 100 000 people for all people, people aged 15–24 years, people living in capital cities, people living in other urban areas, people living in rural areas and Indigenous people. While the performance of mental health services is important in reducing suicide, other government services also play a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by serious mental illness, some of whom have either attempted, or indicated the intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government departments, non-government organisations and other special interest groups. Any impact on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including police, education, housing, justice and community services agencies.

In addition, many factors outside the control of mental health services may influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often, a combination of these factors can increase the risk of suicidal behaviour.

Not all of those who commit suicide are patients of mental health services. An improved indicator would be restricted to suicide by patients of mental health services.

In 2002, 2320 deaths by suicide were recorded in Australia — equivalent to 11.8 deaths per 100 000 people. The national rate fell each year from 1997 to 2000, followed by a slight increase in 2001 and then a fall in 2002. The rate for males was almost four times that for females in 2002 — a ratio that was constant over the 10 years to 2002 (table 11A.50). The NT had the highest suicide rate in 2002 (27.4 suicides per 100 000 people) and the ACT had the lowest rate (8.1) (figure 11.31).

Figure 11.31 **Suicide rate**[a, b, c]



a By year of registration of death. Year-to-year variation can be influenced by coronial workloads. **b** For 1998 to 2000 the death rate is age standardised to the mid-year 1991 population. For 2001 and 2002 the death rate is age standardised to the mid-year 2001 population. **c** Low populations can result in small variations in the number of suicides appearing as large changes in rates (which are not statistically significant).

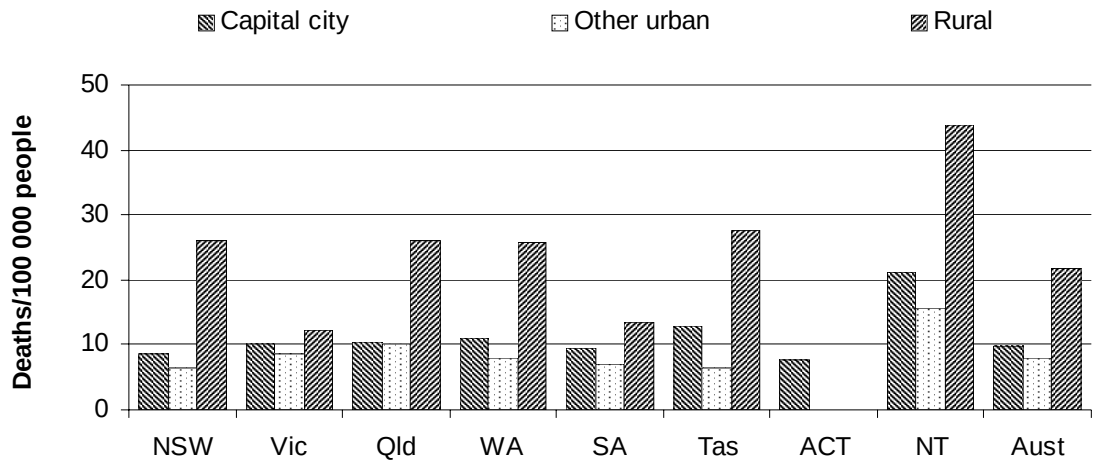
Source: ABS (various issues, cat. No. 3303.0); table 11A.51.

In 2002, suicide was the second leading cause of death (after transport accidents) for people aged 15–24 years, accounting for 22.0 per cent of deaths in this age group (ABS 2003). The NT recorded the highest suicide rate per 100 000 people aged 15–24 years (39.5 deaths) (table 11A.52). Suicide was the leading cause of death for 25–34 year olds in 2002, with 24.9 per cent of deaths in this age group resulting from suicide (ABS 2003).

The suicide rate in 2002 was generally higher in rural areas. Nationally, there were 9.8 suicides per 100 000 people in capital cities and 8.1 suicides per 100 000 people in other urban areas, compared with 21.8 suicides per 100 000 people in rural areas (figure 11.32).

The Indigenous suicide rate is presented for the period 2000–2002 for four jurisdictions: Queensland, WA, SA and the NT. The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions. The suicide rate for Indigenous people for the period 2000–2002 in the jurisdictions for which data are presented in table 11A.54 is considerably higher than the rate for the total population in 2002.

Figure 11.32 **Suicide rate, by area, 2002**[a, b, c, d]



[a] 'Other urban' comprises centres with more than 20 000 population. 'Rural' comprises all areas except capital cities and other urban. [b] Death rate is age standardised to the mid-year 2001 population. [c] By year of registration of death. Year-to-year variation can be influenced by coronial workloads. [d] The ACT rate for rural was zero. The ACT did not have any 'other urban' areas.

Source: ABS (unpublished); table 11A.53.

Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some jurisdictions are not published. Estimating the Indigenous population is difficult given the low number of suicides among Indigenous people and the varying propensity of people across jurisdictions and over time to identify as Indigenous. In addition, Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The 'Health preface' discusses the quality of Indigenous mortality and other data.

Quality of life

The Steering Committee has identified 'quality of life' as an indicator for development in future reports (box 11.33).

Box 11.33 **Quality of life**

'Quality of life' is an outcome indicator of the objective of mental health service delivery to prevent and reduce mental health problems so as to improve the quality of life for people with mental illness.

11.5 Future directions in performance reporting

Breast cancer

Key challenges for improving reporting of breast cancer include:

- expanding the scope of reporting to include management of breast cancer
- further developing indicators of outcomes
- improving data and the measurement of existing indicators.

Expanding the scope of reporting

Existing performance data for breast cancer management place relatively more emphasis on the performance of State and Territory BreastScreen Australia programs, than on the treatment and ongoing management of breast cancer. This emphasis is largely due to the relative availability of breast cancer screening data across jurisdictions. The Review aims to expand reporting to incorporate treatment and clinical outcomes data.

The AIHW is working with BreastScreen Australia on a data linkage project to support the mortality feasibility study. This project could begin to broaden the emphasis of the chapter from breast screening towards overall breast cancer management.

Developing indicators of outcomes

A number of international studies have found evidence linking screening to a reduction in breast cancer mortality — in the United Kingdom, for example, Alexander *et al*. (1999) and Moss *et al.* (1999) — although there is some doubt about breast self-examination (Moss *et al.* 1999). Neither of the two United Kingdom studies noted, however, used economic evaluation tools. At present, there are no Australian studies of this nature.

The Australian Screening Advisory Committee Monitoring and Evaluation Working Group has developed an evaluation plan and monitoring plan that will facilitate reporting of outcomes in future.[9]

[9] The Australian Screening Advisory Committee advises all Australian governments on specific policy, quality, data management, clinical and administrative issues arising out of the management of the BreastScreen Australia program.

Improving data and the measurement of existing indicators

Work was undertaken this year to identify the comparability of some expenditure items in the calculation of the cost per woman screened across jurisdictions. Further work will be undertaken for the 2006 Report to improve the comparability of these cost data.

BreastScreen Australia's policy on symptomatic women was reviewed in 2000-01. BreastScreen Australia is a population-based mammographic screening program for women without symptoms. Its current policy states that it is preferable for women with symptoms, such as breast lumps or nipple discharge, to be referred by their medical practitioner to a diagnostic service.

The Screening Advisory Committee considered the outcomes of the policy review in July 2001. It agreed that further work is required to implement a flexible policy framework responsive to the needs of women with symptoms who present to BreastScreen Australia services. It also determined that standardised definitions of symptoms are critical for the local monitoring of symptomatic women in the program, and for consistent national monitoring and reporting.

Interval cancer rates have previously been reported by symptom status. Since the 2002 Report, stratification of reporting by symptom status has been discontinued until symptom status can be more accurately defined.

Victoria has developed a set of clinical performance indicators for breast cancer management as part of a comprehensive approach to quality improvement through performance monitoring and reporting. BreastCare Victoria (Department of Human Services) commissioned the project, which a BreastScreen Victoria Inc. team is undertaking. A collaborative approach has been adopted in the development and field testing of the indicators, to maximise key stakeholder participation in, and ownership of, the project. Involvement of consumers is also a key feature of the method.

BreastScreen Victoria Inc. conducted a comprehensive review of the national and international literature in this area, and the recommended performance indicators are based on a combination of internationally accepted best practice and consensus among stakeholders. Nine rate-based indicators measure aspects of patient care across the continuum, and three 'critical events' are recommended for review by a breast service on a case-by-case basis. The indicators are supported by a data dictionary and framework for reporting. Further work will be undertaken to undertake a phased implementation and model, and to evaluate these indicators as a quality improvement tool at the service level. Details on the recommended set of

indicators are available from the Victorian Department of Human Services or BreastScreen Victoria Inc.

Mental health

Key challenges for improving the reporting of mental health management are similar to those of the past year:

- improving the reporting of effectiveness and efficiency indicators for Indigenous, rural/remote and other special needs groups
- revising the performance indicator framework to account for the Third National Mental Health Plan, to ensure reporting remains consistent with government policy objectives for mental health
- improving the reporting of effectiveness/efficiency indicators for community-based mental health care.

The National Mental Health Working Group Information Strategy Committee is working on specifying and piloting a number of performance indicators that could be reported in future. The *National Mental Health Report 2002* includes additional indicators on consumer and carer participation arrangements (DHA 2002). The Review will investigate including these indicators in the mental health management indicator framework and reporting them in future reports.

Information structures are being developed under the NMHS that will enable improved performance reporting in future. At present, while community-based mental health care is expanding in accordance with the NMHS, performance reporting in this area is limited by the quality of data.

The Australian Council for Safety and Quality in Health Care was formed by the Australian Government with the support of all Australian Health Ministers in 2000 to establish a safety and quality agenda across health care in Australia. The Australian Council for Safety and Quality in Health Care is working with the Australian Health Ministers Advisory Council's National Mental Health Working Group's Safety and Quality Partnership Group (which includes other key mental health stakeholders) to develop a Safety Action Plan for the mental health sector. The draft plan draws on the work of the Council and has identified the following priorities for immediate focus:

- suicide and intentional self harm in mental health and related settings
- seclusion and restraint
- adverse medication events

- safe transport of people with mental illness

The *Mental Health Information Development Plan: National Information Priorities and Strategies under the Second Mental Health Plan 1998–2003* was released in September 1999 and includes the introduction of routine consumer outcome measurement in mental health services. To strengthen the focus on consumer outcomes the plan puts forward information development strategies, which include: developing agreed measurement standards; developing national reporting guidelines; establishing a national network of accredited organisations to provide clinician training in the use of outcome measures; encouraging broad adoption by service organisations of outcome measurement as an integral part of service delivery; and agencies' regular reporting of core measures.

In addition, all jurisdictions have undertaken to begin collecting unit record consumer outcomes data, so as to develop the mental health casemix classification system and to collect data on the implementation of standards. Delays in the adoption of a consistent mental health casemix classification system are a particular constraint on comparable performance reporting, but all states and territories are now collecting outcomes data, and comprehensive coverage is expected in 2005.

Australian, State and Territory governments are also required to agree on performance indicators under the Australian Health Care Agreements. Work by the Australian Health Ministers' Advisory Council National Mental Health Working Group will contribute to performance reporting in the medium to longer term.

All of these initiatives will facilitate improvements in both the performance framework and data used by the Review to report on mental health care.

11.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this section of the Report. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status).

Australian Government comments

“ The Australian Government welcomes this edition of the Report on Government Services and supports the continued commitment to expanding the data being presented on key health priorities.

The Australian Government continues its strong focus on mental health, both in funding major national initiatives such as beyondblue, MindMatters and the Better Outcomes in Mental Health Care Initiative, and through its role in national reporting and strengthening accountability in the delivery of mental health services across Australia. Under the current Australian Health Care Agreements, $331 million is to be provided directly to states and territories to assist them in meeting their reform commitments under the National Mental Health Strategy, with a further $66 million to advance national activities.

The Strengthening Medicare package invests more than $4 billion over five years in Australia’s primary care system. It provides more opportunities for Australians to be bulk billed, introduces an extended and comprehensive Government funded safety net to cover all Australians against high out-of-pocket medical costs for Medicare Benefits Schedule services provided out-of-hospital, substantially increases the supply of doctors and practice nurses and provides more services for people in aged care homes. Strengthening Medicare will be further complemented by the Government’s 100 per cent Medicare and Medicare Round the Clock commitments. Together these commitments will strengthen and protect Medicare.

Through the 2003-08 Australian Health Care Agreements the Australian Government will maintain its commitment to the public hospital system. Assistance will be provided to the states and territories of up to $42 billion over five years, representing a real increase of 17 per cent over the previous Agreements. This includes funding for Mental Health, Palliative Care and the Pathways Home program. State and Territory governments are responsible for ensuring the provision of public hospital services free of charge to public patients on the basis of clinical need and within clinically appropriate times.

In the 2004-05 Budget, the Australian Government reaffirmed its support to rural health and aged care by providing renewed funding for what is now retitled the Rural Health Strategy. The funding of $830 million over the next four years gives continuing support for programs to provide increased access to doctors and other health professionals in rural areas. The Rural Health Strategy will support a flexible package of health and aged care services and workforce measures. ”

New South Wales Government comments

“In 2003-04, NSW Health spent $9.7 billion on the public health system. In particular, the budget provided $2.6 billion for public health services in rural and regional communities.

In November 2003, the Department was restructured to improve its focus on providing strategic direction for the NSW health system. Responsibility for delivering health services was devolved to Area Health Services and other appropriate bodies.

During 2004, the Department developed proposals to improve the way Area Health Services deliver health services. The Minister for Health announced the Planning Better Health reforms on 27 July 2004.

Planning Better Health involves the most significant reshaping of the health system since Area Health Services were established in 1986. The key principle that underpins these reforms is that more of NSW Health's resources should be spent on direct patient care, and less on administration. They will encourage the building of better clinical networks, enhance academic and teaching links and improve the distribution of the health workforce. The benefits of these reforms for NSW will be reflected in later versions of this Report.

NSW is pleased with the developmental work for new performance indicators, particularly those relating to the quality in public hospital performance undertaken by the Health Working Group. We look forward to having better indicators in this and other health service areas in the near future.

NSW continues not to provide waiting times for elective surgery by urgency category. As raised with the Health Working Group and other groups previously, NSW does not believe that these data are comparable within and across jurisdictions, and this position is supported by most other jurisdictions. Investigations locally and nationally have shown that urgency category is inconsistently applied by clinicians, and therefore not comparable between jurisdictions. This issue was raised with the Australian Health Ministers Advisory Council (AHMAC) in 2001, an alternative, the reporting of the number of days waiting at the 50th and 90th percentiles, was developed by the Australian Institute of Health and Welfare. This was endorsed by jurisdictions at the November National Health Information Management Group 2001 meeting (as referred by AHMAC). Although these new indicators have been included in the report, which NSW is pleased about, the waiting times by urgency category remain.

NSW recommends that unless significant resources are invested into a substantial review of urgency category and a process that results in data being comparable between and within jurisdictions, that reporting waiting times for elective surgery by urgency category be dropped from the Report.”

Victorian Government comments

“ The 2005 Report on Government Services continues to provide valuable insights into the performance of key areas of public service provision. A key challenge continues to be the development of the Report so that it better reflects performance and outcomes of changing models of care both within and across traditional service systems. Victoria's Community Health policy is strengthening community health services to provide an expanded range of ambulatory care services. These services will range from proactive health promotion to delivery of multidisciplinary care for people with chronic and complex conditions. Victoria is also currently developing an Ambulatory Care Framework that seeks to further expand the provision of community-based care/service options and improve the integration of care across traditional organisational and program boundaries.

Some existing performance measures for public hospitals, including separation rates and recurrent costs per casemix-adjusted separation, are becoming less useful in measuring performance, due to differences across states and territories in how services are provided. One clear illustration of this occurs in the data on breast cancer separation rates, where differences in admission practices and service provision outside the hospital setting may largely account for what otherwise might appear to be significant differences in the level of provision of chemotherapy and radiotherapy services across jurisdictions. Another example relates to the continuing validity of available beds as a measure of health system capacity. This measure is being rendered less meaningful due to the growing shift of services from hospital to the community (for example, dialysis, rehabilitation and hospital in the home), together with new models of care such as short stay units in or near emergency departments and the growing trend to same day services.

Victoria strongly supports the expansion of the Report to provide a greater focus on the interrelationships between services across the health and aged care systems. This reflects the reality that many consumers will use multiple services and their satisfaction and health outcomes will be impacted by performance dimensions related to continuity of care, timely referral between services, and coordinated management of care and information.

A focus on interface issues is also important in recognising that, even for consumers without complex care needs, the availability of one type of health or aged care service can strongly influence the utilisation of related services. Victorian data demonstrate the direct relationship between access to affordable general practice services and the demand on public hospital emergency departments for primary-care type services. Similarly, the utilisation of acute hospitals by older people is impacted by the availability of timely assessment, rehabilitation and aged care services across different service settings. ”

Queensland Government comments

“Queensland Health provides a wide range of health services to Queensland’s population of over 3.5 million people. Services include health promotion, disease prevention, acute hospital and non-admitted patient services, rehabilitation, mental health services, community-based care, and aged care. By international standards, Queenslanders enjoy good health and have access to quality care from highly skilled professionals.

The Report on Government Services continues to provide a valuable source of comparison on key publicly provided health services and the increased emphasis on Indigenous health issues in this year’s Report is a welcome addition. However, as in previous Reports, considerable data comparability issues across jurisdictions remain.

Queensland Health continues to deliver one of the most accessible and efficient health care systems with the achievement of the shortest waiting times for elective surgery patients in public hospitals and one of the lowest average costs for services provided in public hospitals in Australia.

However, over the next two decades the health care system in Queensland will confront a complex array of challenges. In particular, Queensland’s growing and ageing population has major policy implications for the delivery and sustainability of health care services.

In response to these challenges and to ensure that Queensland’s health system remains healthy and sustainable, Queensland Health has recently released it’s Strategic Plan 2004-10. The Plan outlines Queensland Health’s mission to promote a healthier Queensland. To achieve this mission Queensland Health will focus activities on key strategic intents including: an increased emphasis on prevention and health promotion; improving partnerships with all levels of government, the community and other health providers; providing the highest quality acute services, integrated with community-based services; optimising staffing levels, training and support; and ensuring that funding is used to maximum advantage.

Further to these strategic intents, the government will undertake a range of initiatives including increases in elective surgery to further reduce waiting lists and additional resources to reduce pressure on emergency departments. In addition there will be increased investments in preventative programs and acute treatments for kidney disease, cancer, stroke, and heart disease, together with investments in dental care, home and community services, and improved mental health services.”

Western Australian Government comments

“ The increased focus on primary and community care in this report is greatly appreciated by Western Australia as it coincides with the State's continuing efforts to increase awareness of health promotion and illness prevention both in the community and among service providers. Work to better measure service quality and safety including the workshop that involved quality and safety interest groups were welcome initiatives in an environment where significant resources are devoted to producing numerous statistics of varying degrees of reliability and consistency. These efforts will be certain to enhance the Report's credibility and increase its utility among its audience.

In Western Australia, the year 2004 has seen a number of strategies put in place to facilitate more efficient and effective service provision. For instance, in the metropolitan area, an Emergency Demand Management Strategy was initiated to assist in dealing with the call on emergency services particularly during the winter months. The program included opening additional beds and working in collaboration with general practitioners to offer alternatives to services provided in hospital Emergency Departments in order to ease the demand for these services particularly after hours.

A series of waiting list management strategies were funded in 2004 specifically to address the lists of extended wait patients. The strategies included programs aimed at patients waiting longer than 500 days for surgical treatment, patients who had waited longer than 14 months for dental treatment and a general blitz on elective surgery waiting lists. These initiatives have resulted in a significant reduction in the number of long wait cases.

Population Health programs continued to receive particular attention during the year. As an example, a special Whooping Cough Vaccination Program was implemented in the fourth school term of 2004 to vaccinate all high school students in the State to reinforce immunity among this cohort of the population.

Early in the year, the system wide review of services under the auspice of a Government Health Reform Committee, produced its report. The Government endorsed 85 of the 86 recommendations in the report which provides a blueprint for taking the public health system forward into the next 10 to 15 years. An action plan and implementation strategy were prepared. The Health Reform Implementation Taskforce commenced the process of reform initiatives implementation in the second half of 2004. ”

South Australian Government comments

“The Generational Health Review was a comprehensive review of South Australia’s health system including its interface with the private and non-government sectors. The SA Government’s initial response to this review identifies three key areas; building better governance, building better services and building better system support. These First Steps Forward will provide immediate action to two thirds of the reviews recommendations.

On 1 July 2004 the SA Department of Human Services was split into the Department of Health and the Department of Families and Communities, a move which will give greater strength and focus to the priorities of implementing the First Steps Forward initiatives. The Department of Health continues to provide a quality health service for the South Australian community. The Department maintains its efforts to ensure that appropriate health care is provided to all who need it.

Metropolitan Adelaide has been divided into two health regions, the Central/Northern Adelaide Health Service and the Southern Adelaide Health Service, with each region overseen by a new Board responsible for coordinating all the health services within the region. In addition, a third Board was created to oversee the newly combined operations of the Women’s and Children’s Hospital and Child and Youth Health. The new Boards will be instrumental in creating a system which will allow funding, resourcing and service-delivery decisions to be made in a coordinated way, based more on the total health needs of local communities instead of individual health institutions operating in isolation from each other.

South Australia’s Strategic Plan was launched by the SA Government in March 2004. The Plan is about improving the wellbeing of South Australians, which means improved prosperity and economic growth and better access to important services such as health and education. The six key objectives of the plan are; growing prosperity, improving wellbeing, attaining sustainability, fostering creativity, building communities and expanding opportunity. The whole-of-state Plan includes a number of quantifiable indicators to measure and track the state's economic, social and environmental health; and specifies targets for improvement, including health related targets.

A strategy for Chronic Disease: Prevention and Management Opportunities for SA was released in January 2004 in response to the GHR recommendation to reorientate the current health system from acute to primary health care, with an emphasis on prevention and early intervention, and a focus on the consumer rather than on institutions. The strategy recommends reinforcing the role of integrated care planning, the role of self-management, and the role of primary prevention and early intervention. The SA Government has approved a renewed primary health care policy to underpin health system reform in SA, in particular to strengthen primary health care. The policy draws on the substantial evidence of the contribution primary health care can make to improve health outcomes.”

Tasmanian Government comments

“ All Australian governments face challenges in providing health services that meet changing needs, including the ageing of the population, the increasing cost of new health technologies, the increasing cost of recruiting and retaining specialist staff, and the need to maintain the highest standards of patient care.

In addition, Australian Institute of Health and Welfare data indicate that, in a number of health care professions, Tasmania is at a disadvantage compared to most other jurisdictions. Tasmania has less than the national per capita average number of dentists, employed medical practitioners (clinicians and non-clinicians), hospital non-specialists, physiotherapists, registered and enrolled nurses, and specialists.

Currently, Tasmania has a heavy reliance on overseas-trained medical staff, particularly in the rural and regional areas of the state, but also in Launceston and Hobart. While this mitigates the problems of recruitment, some overseas-trained health care professionals do not possess full Australian registration. Reliance upon this workforce is an unsure and risky strategy in the long term.

In September 2003, the Tasmanian Minister for Health and Human Services announced the formation of an Expert Advisory Group to examine the operation of Tasmania’s major public and private hospitals. The Expert Advisory Group, chaired by Professor Jeff Richardson, conducted a process of public consultation over an eight month period and produced a report, ‘The Tasmanian Hospital System: Reforms for the 21st Century’, containing 34 major recommendations concerning the future of hospital services in Tasmania. The report warned against an indiscriminate increase in funding and instead urged that Tasmania should start by reforming the system to ensure that the resource benefits are maximised.

In terms of primary health care, the prevention and management of chronic conditions is a priority in Tasmania due to the increasing prevalence of prolonged illnesses, injuries and social problems and their associated costs to the community and health and human service system. Reducing chronic conditions and the risk behaviours that influence them also feature in the Tasmania Together goals and targets. A highlight during 2004 has been the work of a whole-of-government Health and Wellbeing Group, under the auspices of Tasmania Together, a 20-year social and economic plan for the State. This group has overseen the funding and implementation of projects in various settings such as schools, workplaces and local communities focusing on the prevention of chronic conditions.

The Department of Health and Human Services acknowledges the value of the Report on Government Services and uses information from the Report in monitoring its own performance. ”

Australian Capital Territory Government comments

“The ACT provides a near complete range of health services to its own residents as well as to many people living in adjoining regions of NSW. While the ACT continues to support the reporting of data across jurisdictions, readers should take care when comparing states and territories.

The small population of the ACT can lead to substantial year on year variations in indicator measures for selected services and target groups. Published data for certain population groups may not provide reliable insights into population health needs or service utilisation. For example, reported separations for Aboriginals and Torres Strait Islanders for the ACT are problematic. In 2002-03, approximately 60 per cent of separations for this group were for maintenance dialysis. Approximately one third of these dialysis episodes were for people living in NSW, and almost all of the remainder were for regular dialysis given to fewer than five persons.

Readers should also note the effect of cross border patients in the ACT when considering reported mortality due to breast cancer. In the Review, these rates are reported by place of registration. The mortality rate for the ACT is distorted by a number of deaths of women from NSW that were reported through the ACT registration service.

Comparison of hospital costs remains a particular concern for the ACT. There is substantial variation across jurisdictions in costing methodology. Cost drivers such as economies of scale also vary substantially across the states and territories.

In 2004, the ACT Government launched its Social Plan. This plan included a number of whole of government projects to address issues such as childhood obesity, health issues among marginalised youth, Aboriginal and Torres Strait Islander people’s health, and mental health problems. The Social Plan places a special emphasis on community consultation, health promotion, and early intervention. The ACT hopes that the Review will pay increasing attention to service interface reporting, which is of particular relevance in responses to health issues affecting disadvantaged groups.”

Northern Territory Government comments

“ The Department of Health and Community Services (DHCS) is responsible for health planning and delivery of community-based and hospital services in the Northern Territory (NT).

The NT faces unique challenges in the delivery of health services. Close to 30 per cent of the NT population are Aboriginal or Torres Strait Islanders (ATSI), a much larger proportion than elsewhere in Australia. About 80 per cent of Aboriginal people live in remote or very remote areas of the NT. Remoteness, along with diseconomies of scale, an environment ranging from desert to tropical and the special needs of a culturally diverse population, require unique ways of providing health and community services in the NT.

There is only one private hospital in the NT. Limited availability of private sector health services such as GPs in rural and remote communities combined with reduced access to bulk billing, increases the demand on the public hospital system. The unavailability of some clinical specialists in the NT leads to significant additional health expenditure. An example is BreastScreenNT that contracts for interstate specialist services contributing to higher unit costs than elsewhere.

While the Report aims to present comparable data across jurisdictions, the differences may not necessarily be due to service delivery variation, but rather data definition and collection issues. One example is the variation across jurisdictions in the classification of nonsurgical same day admissions. Some states classify these patients as ‘admitted’ patients while others as outpatients. This variation distorts a number of indicators. Jurisdictions that apply lower thresholds for treating some patients as admitted patients show a higher per capita separation rate. This is particularly the case in the NT where 30 per cent of all admissions are for renal dialysis.

Aboriginal and Torres Strait Islanders have the greatest health and welfare needs of any Territorians. ATSI people account for more than half of the Department’s budget representing 64 per cent of hospital separations. Comparisons across jurisdictions adjusted for casemix may not take into account Indigenous status therefore these comparisons can be distorted, for example the relative stay index.

The NT supports strategies to improve data definition, collection and reporting particularly in relation to Indigenous, rural/remote and other population groups to ensure continuous improvement of this Report. ”

11.7 Definitions of key terms and indicators

AR-DRG v4.1 (Australian refined diagnosis related group, version 4.1)	A patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG v4.1 is based on the ICD-10-AM classification and replaces the earlier AN-DRG v3.0/3.1.
Casemix adjustment	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted into diagnosis related groups (AR-DRGs) that represent a class of patients with similar clinical conditions requiring similar hospital services.
General practice	The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients. This definition includes medical practitioners who work solely with one specific population, such as women's health and Indigenous health.
Health management	The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.
Incidence rate	Proportion of the population suffering from a disorder or illness for the first time during a given period (often expressed per 100 000 people).
Separation	The process whereby an admitted patient completes an episode of care.

Breast cancer

Adjuvant therapy	Treatment given after the primary treatment to increase the chances of a cure. Adjuvant therapy may include chemotherapy, radiation therapy or hormone therapy.
Breast conserving surgery	An operation to remove the breast cancer but not the breast. Types of breast conserving surgery include lumpectomy (removal of the lump), quadrantectomy (removal of one quarter of the breast) and segmental mastectomy (removal of the cancer as well as some of the breast tissue around the tumour and the lining over the chest muscles below the tumour).
Cost per woman screened	The total cost of the provision of breast screening services, divided by the number of women screened. The total cost should include the cost of providing the BreastScreen Australia program in each jurisdiction, in addition to the cost of providing the program to women.
Detection rate for small cancers	The rate of small (less than or equal to 15 millimetres) invasive breast cancers detected per 10 000 women screened.
Ductal carcinoma in situ	Abnormal cells that involve only the lining of a duct. The cells have not spread outside the duct to other tissues in the breast. Also known as intraductal carcinoma.
Invasive cancer	A tumour whose cells invade healthy or normal tissue.
Modified radical mastectomy	Surgery for breast cancer in which the breast, some of the lymph nodes under the arm, the lining over the chest muscles, and sometimes part of the chest wall muscles are removed.

Mortality rate from breast cancer	The age-specific and age standardised mortality rates of women who die as a result of breast cancer, expressed per 100 000 women in the population.
Participation	The number of women resident in the catchment area screened, divided by the number of women resident in the catchment area, expressed as a per cent. If a woman is screened more than once during the reference period, then only the first screen is counted.. Catchment area is a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or statistical local area.
Radiation therapy	The use of high energy radiation from X-rays, gamma rays, neutrons, and other sources to kill cancer cells and shrink tumours. Radiation may come from a machine outside the body (external beam radiation therapy) or from materials called radioisotopes. Radioisotopes produce radiation and can be placed in or near the tumour or in the area near cancer cells. This type of radiation treatment is called internal radiation therapy, implant radiation, interstitial radiation or brachytherapy. Systemic radiation therapy uses a radioactive substance (such as a radiolabeled monoclonal antibody) that circulates throughout the body.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than otherwise would be the case.
Screening round (first)	A woman's first visit to a BreastScreen Australia mammography screening service.
Screening round (subsequent)	A woman's visit to a BreastScreen Australia mammography screening service when she has previously attended such a service.
Size of detected cancers	The percentage of invasive cancers detected, classified according to tumour size.
Total mastectomy	Removal of the breast — also known as simple mastectomy.

Mental health

Acute services	Services that provide specialist psychiatric care for people who present with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services may: • focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms • target the general population or be specialist in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, and forensic psychiatry services.
Affective disorders	A mood disturbance, including mania, hypomania, bipolar affective disorder, depression and dysthymia.

Agoraphobia	Fear of being in public places from which it may be difficult to escape. A compelling desire to avoid the phobic situation is often prominent.
Ambulatory care services	Mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted inpatients, but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.
Antidepressant	A drug that alleviates depression, usually by energising the person and thus elevating mood.
Anxiety disorders	Feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive–compulsive disorder and post-traumatic stress disorder.
Anxiolytics	Tranquillisers; drugs that reduce anxiety.
Available beds	The number of immediately available beds for use by admitted patients if required at 30 June. Beds are immediately available for use if located in a suitable place of care with nursing or other auxiliary staff available within a reasonable period. Includes beds in wards that are temporarily closed due to factors such as renovations or strikes but that would normally be open and, therefore, available for admission of patients. In many cases, available beds will be less than the number of approved beds, with the former controlled by utilisation factors and resourcing levels, while the latter refers to the maximum capacity allowed for the hospital, given sufficient resources and community demand.
Bipolar disorder	A mood disorder characterised by a history of manic (or hypomanic) episodes usually alternated with depressive episodes.
Child and adolescent psychiatry services	Services principally targeted at children and young people up to the age of 18 years. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on children or adolescents.
Co-located services	Psychiatric inpatient services established physically and organisationally as part of a general hospital.
Community-based residential services	Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must: provide residential care to people with psychiatric illness or disability; be located in a community setting external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded.
Co-morbidity	The simultaneous occurrence of two or more disorders such as depressive disorder with anxiety disorder, or depressive disorder with anorexia.
Consumer and carer involvement in decision making	Consumer and carer participation arrangements in public sector mental health service organisations according to the scoring hierarchy (levels 1–4) developed for monitoring State and Territory performance under Medicare Agreements Schedule F1 indicators.

Cost per inpatient bed day	The average patient day cost according to the inpatient type.
Depression	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration may be affected.
Dysthymia	Constant or constantly recurring chronic depression of mood, (lasting at least two years) that is not sufficiently severe, or whose episodes are not sufficiently prolonged, to qualify as recurrent depressive disorder. The person feels tired and depressed, sleeps badly and feels inadequate, but usually can cope with the basic demands of everyday life.
Forensic psychiatry services	Services principally providing assessment, treatment and care of mentally disordered individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained.
General psychiatry services	Services that principally target the general adult population (18–65 years old) but that may provide services to children, adolescents or the aged. Includes, therefore, those services that cannot be described as specialist child and adolescent, geriatric or forensic services. General psychiatry inpatient services include hospital units whose principal function is to provide of some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, post-natal depression, anxiety disorders).
Generalised anxiety disorder	Unrealistic or excessive anxiety and worry about two or more life circumstances for six months or more, during which the person has these concerns or more days than not.
Geriatric psychiatry services	Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged persons. Excludes general psychiatry services that may treat older people as part of a more general service.
Hypomania	A lesser degree of mania characterised by a persistent, mild elevation of mood and increased activity lasting for at least four days. Increased sociability, overfamiliarity and a decreased need for sleep are often present, but not to the extent that they lead to severe disruption.
Inpatient services	Stand-alone psychiatric hospitals or specialist psychiatric units located within general hospitals.
Mental disorder	A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental disorder.
Mental health promotion	Activities designed to improve the mental health functioning of persons through prevention, education and intervention activities and services.

Mental illness prevention	Interventions that occur before the initial onset of a disorder.
Mortality rate from suicide	The percentage of the population who die as a result of suicide.
Non-acute services	Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services focus on disability and the promotion of personal recovery. They are also characterised by an expectation of substantial improvement over the short to medium term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. Non-acute services also consist of extended care services that provide care over an indefinite period for patients who have a stable but severe level of functional impairment and inability to function independently without extensive care and support. Patients of extended care services usually show a relatively stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness. Treatment effort focuses on preventing deterioration and reducing impairment. Improvement is expected only over a long period.
Non-government organisations	Private not-for-profit community managed organisations that receive State and Territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the non-government organisation sector may include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.
Obsessive–compulsive disorder	*Obsessions*: recurrent, persistent ideas, thoughts, images or impulses that intrude into the person's consciousness against his or her will. The person experiences these as being senseless or repugnant, but cannot ignore or suppress them. *Compulsions*: recurrent, stereotyped behaviours performed according to certain rules. The person often views them as preventing some unlikely event, often involving harm to, or caused by, themselves. The person generally recognises the senselessness of the behaviour, attempts to resist it and does not derive any pleasure from carrying out the activity.
Outpatient services — community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They may include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services — hospital-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They may include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Panic disorder	Panic (anxiety) attacks that occurs suddenly and unpredictably. A panic attack is a discrete episode of intense fear or discomfort.
Patient days (occupied bed days)	All days or part days for which patient was in hospital during the reporting year (1 July to 30 June), regardless of the original data of admission or discharge. Key definitional rules include the following:

	• For a patient admitted and discharged on different days, only the day of admission is counted as a patient day. • Admission and discharge on the same day are equal to one patient day. • Leave days are not included when they involve an overnight absence. • A patient day is recorded on the day of return from leave.
Percentage of facilities accredited	The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services.
Post-traumatic stress disorder	A delayed and/or protracted response to a psychologically distressing event that is outside the range of usual human experience.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of disorders.
Psychiatrist	A medical practitioner with specialist training in psychiatry.
Public health	The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional services.
Schizophrenia	A combination of signs and symptoms that may include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour.
Social phobia	A persistent, irrational fear of being the focus of attention, or fear of behaving in a way that would be embarrassing or humiliating.
Specialised mental health services	Services whose the primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental disorder or psychiatric disability. This criterion applies regardless of the source of funds. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function.
Specialised residential services	Services provided in the community that are staffed by mental health professionals on a 24 hour basis.
Staffing categories (mental health)	*Medical officers:* all medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee-for-service basis. *Other medical officers:* medical officers employed or engaged by the organisation who are not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant state or territory medical registration board.

Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Nursing staff: all categories of registered nurses, enrolled nurses, student nurses or trainee/pupil nurses employed or engaged by the organisation.

Registered nurses: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialist categories of registered nurses.

Non-registered nurses: enrolled nurses and student nurses not included in the previous category.

Diagnostic and health professionals: qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, pharmacists, speech pathologists and dieticians.

Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.

Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.

Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, wardsmen, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.

Administrative and clerical staff: staff engaged in administrative and clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories.

Domestic and other staff: staff involved in the provision of food and cleaning services. Includes all staff not elsewhere included (for example, maintenance staff, tradespersons, gardening staff).

Stand-alone hospitals

Beds within health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under

	the management control of a general hospital.
Substance use disorders	Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive, social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug may be psychological (as in substance misuse) or physiological (as in substance dependence).

11.8 References

ABS (Australian Bureau of Statistics) 1999, 2000, 2001, 2002a, 2003, *Causes of Death, Australia*, Cat. no. 3303.0, Canberra.

—— 2002b, *National Health Survey, 2001*, Cat. no. 4364.0, Ausinfo, Canberra.

—— 2004, *Disability, Ageing and Carers: Summary of Findings*, Cat. no. 4430.0, Canberra.

ACT Health 2003, *Breast Cancer in the ACT*, Health Series no. 31, Population Health Research Centre, Canberra.

AIHW (Australian Institute of Health and Welfare) 2003a, *BreastScreen Australia Monitoring Report 2000-2001*, Cat. no. CAN 20, Cancer Series no. 25, Canberra.

—— 2003b, *National Health Priority Areas* www.aihw.gov.au/nhpa/index.html (accessed 12 November 2003).

—— 2004a, *Australian Hospital Statistics 2002-03*, Cat. no. HSE 32, Health Services Series no.17, Canberra.

—— 2004b, *Mental Health Services in Australia 2001-02*, Cat. no. HSE 31, Mental Health Series no. 5, Canberra.

—— 2004c, *National Public Health Expenditure Report 2001–02*, Health and Welfare Expenditure Series, Canberra.

AIHW, AACR (Australasian Association of Cancer Registries), NHMRC (National Health and Medical Research Council) and NBCC (National Breast Cancer Centre) 1999, *Breast Cancer in Australian Women, 1982–1996*, Cat. no. CAN 6, AIHW, Cancer Series, Canberra.

AIHW and AACR 2001, *Cancer Survival in Australia, 2001, Part 1: National Summary Statistics*, Cat. no. CAN 13, Cancer Series No. 18, Canberra.

AIHW, BreastScreen Australia and the NCSP (National Cervical Screening Program) 1998, *Breast and Cervical Cancer Screening in Australia 1996 and 1997*, Cat. no. CAN 3, AIHW, Canberra.

Alexander, F.E., Anderson. T.J., Brown, H.K., Forrest, A.P., Hepburn, W., Kirkpatrick, A.E., Muir, B.B., Prescott, R.J. and Smith, A. 1999, 'Fourteen years of follow-up from the Edinburgh randomised trial of breast-cancer screening', *Lancet*, vol. 353, pp. 1903–8.

BreastScreen Australia 2002, *BreastScreen Australia National Accreditation Standards*, July 2002, BreastScreen Australia.

Britt, H., Sayer, G.P., Miller, G.C., Charles, J., Scahill, S., Horn, F., Bhasale, A. and McGeechan, K. 2004, *General Practice Activity in Australia 2003-04*, Cat. no. GEP 16, AIHW, Canberra.

Buckingham, W., Burgess, P., Solomon, S., Pirkis, J. and Eagar, K. 1998, *Developing a Casemix Classification for Mental Health Services*, vol. 1, p. 141, Department of Health and Family Services, Canberra.

DHA (Department of Health and Ageing) 2002, *National Mental Health Report 2002*, Australian Government, Canberra.

—— 2004, *National Hospital Cost Data Collection Cost Report Round 7, 2002-03*, Canberra.

DHAC (Australian Government Department of Health and Community Services) and AIHW 1999, *National Health Priority Areas Report: Mental Health 1998*, AIHW Cat. no. PHE 13, Canberra.

DHS (Department of Human Services Victoria) 1999, *Breast Disease Service Redevelopment Strategy. A Report by the Breast Care Implementation Advisory Committee 1999-2003*, Victorian Government Publishing Service, Melbourne.

Gorman, C. 2002, 'Rethinking breast cancer', *Time*, 18 February, pp. 42–50.

Mathers, C., Vos, T. and Stevenson, C. 1999, *The Burden of Disease and Injury in Australia: Summary Report*, Cat. no. PHE, AIHW, Canberra.

Moss, S.M., Coleman, D.A., Chamberlain, J., Mapp, T.J., Preece, P.E., Alexander, F.E., Alexander, T.J., Kirkpatrick, A.E. and Forrest, A.P. 1999, 'Sixteen-year mortality from breast cancer in the UK trial of early detection of Breast Cancer', *Lancet*, vol. 353, pp. 1909–14.

NBCC (National Breast Cancer Centre) 2003, www/nbcc.org.au/bestpractice/statistics/index.htm (accessed 15 November 2003).

Olsen, O. and Gotzsche, P. 2001, 'Cochrane review on screening for breast cancer with mammography', *Lancet*, vol. 358, pp. 1340–42.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2004, *Report on Government Services 2004*, Productivity Commission, Canberra.

WHO (World Health Organisation) 2002, *Mammography Screening Can Reduce Deaths from Breast Cancer*, Media release no. 139, 18 March, WHO, Lyon, France.

F Community services preface

Families are the principal providers of care for children, older people and people with a disability (ABS 2001). Community services aim to help families to undertake this role and can fulfil this role when families are not in a position to provide care. Community services covered by this Report encompass aged care services (see chapter 12), services for people with a disability (see chapter 13), children's services (see chapter 14), and protection and support services (child protection, supported placements, and supported accommodation and assistance) (see chapter 15).

Community service activities (box F.1) typically include those activities 'which assist or support members of the community in personal functioning as individuals or as members of the wider community' (AIHW 1997, p. 3). They may include financial assistance and relief to people in crisis, and housing assistance of a short term or transitional nature, but they exclude acute health care services (see chapters 9–11), long term housing assistance (see chapter 16) and income support (such as social security pensions and allowances).

The definition of community service activities contained in this preface is based on the National Classification of Community Services developed by the Australian Institute of Health and Welfare (AIHW 2003) (box F.1). Community services expenditure data were derived from the expenditure data collated for the individual chapters in the Report.

As in previous years, this preface includes descriptive data obtained from the Australian Institute of Criminology (AIC) on the number and detention rates of juveniles in correctional facilities. In addition, it includes data on the number of juveniles on community-based orders in each jurisdiction. It is anticipated that the Report will contain performance reporting on juvenile justice in future years.

Performance information on community services as a whole is not currently reported. While there are many interactions among the various community services, the services and their funding and delivery systems are too varied to enable aggregate community services reporting.

Box F.1 **Community service activities**

Personal and social support — activities that provide support for personal or social functioning in daily life. Such activities promote the development of personal skills for successful functioning as individuals, family members and members of the wider community. Personal and social support includes the provision of information, advice and referral, personal advocacy, counselling, domestic assistance and personal assistance. The purpose of such support may be to enable individuals to live and function in their own homes or normal places of residence.

Support for children, families and carers — the provision of care, educational, developmental and recreational activities for children (usually aged 0–12 years) by paid workers. Activities are included that seek to protect children from child abuse and neglect or harm, through statutory intervention and support for families.

Training, vocational rehabilitation and employment — activities that assist people who are disadvantaged in the labour market by providing training, job search skills, help in finding work, placement and support in open employment or, where appropriate, supported employment.

Financial and material assistance — activities that enhance personal functioning and facilitate access to community services, through the provision of emergency or immediate financial assistance and material goods.

Residential care and supported accommodation — activities provided in special purpose residential facilities, including accommodation in conjunction with other types of support, such as assistance with necessary day-to-day living tasks and intensive forms of care such as nursing care.

Corrective services — activities that involve correctional and rehabilitative supervision and the protection of public safety, through corrective arrangements and advice to courts and parole boards, in relation to young people and people with intellectual and psychiatric disabilities on court orders.

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.

Source: AIHW (2003).

Profile of community services

Roles and responsibilities

Government involvement in community services includes:

- funding non-government community service organisations (which then provide community services to clients)
- providing services to clients directly
- regulating non-government providers
- undertaking policy development and administration.

The relative contribution of government to the direct provision of services varies across community service activities. Statutory protection and placement, and corrective services are provided primarily by government, while residential care and accommodation support, and other community services activities are provided primarily by non-government organisations.

Expenditure

Total expenditure by governments has been calculated based on the 2003-04 expenditure totals for aged care services, services for people with a disability, children's services and protection and support services. Community services expenditure in this preface, therefore, relates to only the activities as defined in these individual chapters.

Total expenditure on community services covered by this Report was estimated to be $13.2 billion in 2003-04. This was equivalent to 1.6 per cent of gross domestic product in that year, and 9.0 per cent of total government outlays (ABS 2004a).

Between 1999-2000 and 2003-04, real community services expenditure increased by $ 2.7 billion, or 25.3 per cent (table F.1). The biggest increases were in children's services and protection and support services, for which real expenditure rose by 39.3 per cent and 38.9 per cent respectively over the period. The smallest increase was in aged care services, for which real expenditure rose by 17.2 per cent. Real expenditure on disability services increased by 27.2 per cent over the period.

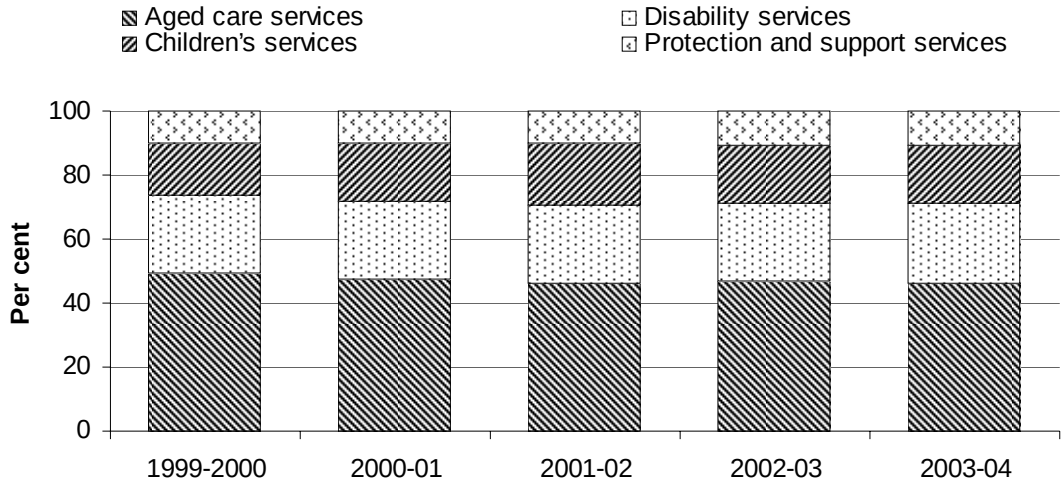
Table F.1 **Real recurrent expenditure on community services (2003-04 dollars) ($ million)**

	Aged care services	*Disability services*	*Children's services*	*Protection and support services*	***Total***
1999-2000	5 210	2 569	1 701	1 027	10 507
2000-01	5 278	2 697	1 974	1 118	11 066
2001-02	5 584	2 917	2 296	1 209	12 007
2002-03	5 889	3 080	2 307	1 309	12 585
2003-04	6 104	3 267	2 369	1 426	13 166

Source: Australian, State and Territory governments (unpublished); tables 12A.45–12A.51, 13A.38, 14.A.4, 15A.1 and 15A.166.

In 2003-04, almost half (46.4 per cent) of community services expenditure related to aged care services, 24.8 per cent related to disability services, 18.0 per cent related to children's services, and 10.8 per cent related to protection and support services (figure F.1).

Figure F.1 **Government real recurrent expenditure on community services covered by the Report on Government Services**



Source: Australian, State and Territory governments (unpublished); tables 12A.45–51,13A.38, 14.A.4, 15A.1 and 15A.166.

Size and scope

Data on the number of organisations that provide community services are obtained from the Australian Bureau of Statistics (ABS) Community Services Survey, which was last conducted in 1999-2000 and will be conducted again in 2005-06. Almost 9300 organisations were providing community services (covering the not-for-profit, government and for-profit sectors) at 30 June 2000. Across the three sectors, these

organisations employed 341 400 people, including 277 300 employed in direct service provision. A further 299 400 volunteers assisted in community service activities (ABS 2001). (For information on the size and scope of the community services sector and output measures for community services in 1999-2000, see SCRGSP 2004, p. F.4.)

An important issue for governments is to determine how to assist community service clients in meeting their complex needs and how to assess performance in meeting these needs. Governments have introduced case management and policy coordination at a more central level to improve the delivery of services.

There are also links between community services and other government services. The performance of community services may influence outcomes for clients of education, health, housing and justice sector services; in turn, these other service areas affect outcomes for clients of community services. A broader discussion of these links is contained in chapters 1 and 2.

Juvenile justice

The juvenile justice system is responsible for dealing with young people (predominantly aged 10–17 years) who have committed or allegedly committed an offence while considered by law to be a juvenile. Each jurisdiction has its own legislation that dictates the policies and practices of its juvenile justice system. While this legislation varies in detail, its intent is similar across jurisdictions. Key elements of juvenile justice systems in all jurisdictions, for example, include: the diversion of young people from the more formal criminal justice system (court) where appropriate; incarceration as a last resort; victim's rights; the acceptance of responsibility by the offender appropriate to developmental stage for his or her behaviour; and community safety.

The juvenile justice system in each jurisdiction comprises several organisations, with each having a different primary role and responsibility in dealing with young offenders. These include:

- police, who are usually the young person's first point of contact with the system. Where considered appropriate, the police may administer warnings or cautions and, in some jurisdictions, use conferencing to divert the juvenile from proceeding to court.
- courts (usually a special children's or youth court), where matters relating to the charges against the young person are heard. The courts are largely responsible for decisions regarding bail (and remand) and sentencing options if the young person admits guilt or is found guilty by the court.

- juvenile justice agencies, which are responsible for the supervision and case management of juveniles on a range of community-based legal arrangements and in detention, and for the provision of a wide range of services aimed at crime prevention and diversion. Many of the services provided by juvenile justice agencies are aimed at: rehabilitating offenders; minimising the level of, and future involvement of, young people in the justice system; reducing the over-representation of Indigenous young people in the justice system; maintaining the clients' connection with family, culture and community; providing clients with an appropriate level of care and safety (duty of care); increasing client accountability to victims; and improving community safety.

Diversion of young offenders

In most jurisdictions, the majority of young offenders are diverted through a range of mechanisms such as police cautions, conferences and unsupervised orders, and do not become clients of juvenile justice agencies. Informal warnings, police cautions, and community, family or youth justice conferences are now part of the spectrum of legislated responses to juvenile crime. Additionally, some jurisdictions use infringement notices as a response to a wide range of regulatory, transport and environmental offences allegedly committed by juveniles. Responsibility for administering the options available for more minor offences — warnings (informal cautions), formal cautions, and infringement notices — falls on police in all jurisdictions.

Responsibility for administering the diversionary processes available for more serious offences lies with juvenile justice authorities in departments ranging from Juvenile Justice (NSW) to Courts Administration (SA). Conference referrals can originate from both police and courts in most jurisdictions. Conditions of entitlement and eligibility, along with the range and/or definition of offences that can be dealt with via conferencing, vary from jurisdiction to jurisdiction.

While comparable national data are not yet available to illustrate the level of diversion, some data have been provided by individual jurisdictions. Diverting appropriate young offenders from the formal court system, or minimising the involvement of young people with the justice system through a conferencing process, can take considerable resources, depending on the judicial system in the jurisdiction and the number of young offenders involved. The juvenile justice agencies in NSW, Queensland and Tasmania have provided examples of the number of young offenders dealt with by means of diversion (although data are not comparable across jurisdictions).

The 2002-03 data from the NSW Bureau of Crime Statistics and Research that are available to the NSW Department of Juvenile Justice show that 1090 police referrals to youth justice conferences were made, 9880 cautions were given and 19 529 warnings were administered to young offenders. The NSW Department of Juvenile Justice data show 1357 conferences (including police referrals) were convened for young offenders in 2002-03, up from 1227 in 2003-04.

In Queensland, 524 conferences were convened and completed for people aged 10–17 years in 2002-03, rising to 1438 in 2003-04 when the availability of conferencing services expanded (Department of Communities unpublished). In Tasmania, there were 355 conferences in 2002-03 for young people aged 10–17 years (Department of Health and Human Services unpublished).

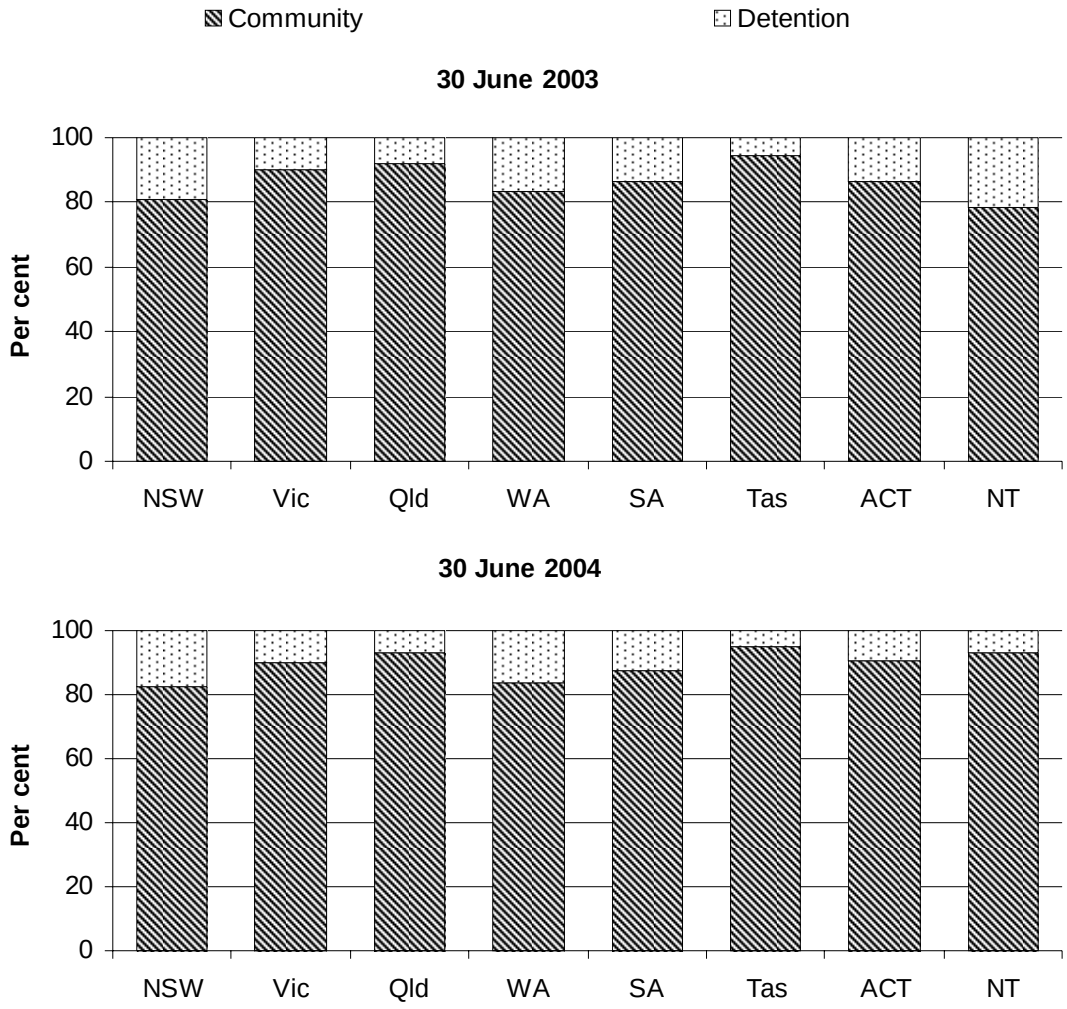
In addition to conferences, juvenile justice agencies in all jurisdictions provide pre-sentence reports for young people (who may or may not go on to become clients) to the courts as required. In 2002-03, the Tasmanian Department of Health and Human Services provided 500 pre-sentence reports, while in Queensland, the number of pre-sentence reports prepared by the Department of Communities rose from 620 in 2002-03 to 792 in 2003-04.

Clients of juvenile justice agencies

Detailed national data are currently available only on the number of young people held in juvenile detention centres (either on remand or sentenced), at the end of each quarter. These are the only data published in this Report. Detention data, however, illustrate only one aspect of the juvenile justice system, and are not representative of the full workload or breadth of services provided by the juvenile justice system or even by juvenile justice agencies. The need for more representative national data has been one of the main factors driving the development of the Juvenile Justice National Minimum Data Set (JJ NMDS). The JJ NMDS is currently being implemented, with detailed reporting for the period 2001-02 to 2003-04 due to be published in late 2005.

Of those juvenile offenders who become clients of juvenile justice agencies, most are diverted from detention via community-based orders, including parole. Figure F.2 shows that at June 2003 the majority of young people aged 10–17 years who were supervised by juvenile justice agencies — between 78.5 per cent and 94.5 per cent — were in the community, rather than in detention.

Figure F.2 **Proportion of juvenile justice clients aged 10–17 years who were supervised in the community and in detention centres[a, b, c, d, e, f]**



a Includes only those young people who were under the supervision or case management of juvenile justice agencies on a pre- or post-sentence legal arrangement or order (for example, young people on supervised bail, remand, a community services order, parole and in detention). **b** Juvenile justice agencies also have additional clients in detention and community supervision who are over 17 years of age. The graph does not include those juvenile justice clients over 17 years of age at 30 June 2003 or 30 June 2004. **c** Clients may be on multiple orders at any one time. The distribution in the graph therefore, is based not on order type but on where the client was located at 30 June 2003 or 30 June 2004. **d** Children's court legislation in Victoria applies to persons aged 10–16 years. However, Victoria is examining legislation amendments that would raise the age jurisdiction of the Criminal Division of the Children's Court to include 17 year olds. Victoria's detention count excludes clients on imprisonment and Adult Correction Orders. Clients in detention do not include those custodial clients who have escaped, but these clients are included in calculating 100 per cent of Victoria's clientele. **e** In Queensland, juvenile justice legislation applies to those young people who were aged 10–16 years at the time of the offence. These data, however, include those 17 year olds who were still on supervision in the juvenile justice system at 30 June 2003 or 30 June 2004. **f** WA counts exclude persons subject to Juvenile Justice Team Referrals.

Source: AIHW unpublished (data supplied by State and Territory governments).

At June 2004, between 82.6 per cent and 94.8 per cent of young people supervised by juvenile justice agencies were in the community, rather than in detention (figure F.2). These data were collected at a point in time, so they need to be interpreted with care, particularly for jurisdictions with smaller populations where a small change to the number of young people in detention can make a significant difference to their proportion of the population. Additionally, it is important to note that the proportion of juvenile justice clients aged 18 years or over varies across jurisdictions, and that data presented in figure F.2 do not include these clients.

Juvenile detentions

This Report includes descriptive data on the number and detention rates of juveniles in correctional facilities. The following data relate to juvenile custodial services only and do not describe the operation of community-based services, which supervise the majority of juvenile offenders. Jurisdictions also have different definitions of a juvenile, which may have an impact on the number and rates reported for people aged 10–17 years.

Data on the number of juveniles include those on remand as well as those sentenced. In some jurisdictions (for example, WA), juveniles who have been arrested and have not yet appeared before a court are also held in a detention centre.

The AIC uses ABS experimental projections for its estimates of the Indigenous population (ABS 2004b). These data include a range of estimates (low and high), and data in this Report are based on high level estimates.

Nationally, the daily average number of people aged 10–17 years detained in juvenile corrective institutions fell from 716 to 616 between 1998-99 and 2002-03 (table F.2).

Table F.2 **Daily average population of people aged 10–17 years in juvenile corrective institutions (number)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1998-99	285	72	133	125	42	29	9	23	716
1999-2000	251	63	112	116	47	31	11	15	647
2000-01	223	62	87	103	59	43	17	17	611
2001-02	217	62	89	108	56	27	17	16	590
2002-03	220	64	96	106	65	25	17	24	616

a Average based on population of juvenile corrective institutions on the last day of each quarter of the financial year.

Source: AIC (unpublished).

Nationally, the rate of detention of people aged 10–17 years in juvenile corrective institutions fell from 34.0 per 100 000 in 1998-99 to 28.1 per 100 000 in 2002-03, although there were substantial differences across jurisdictions (table F.3).

Table F.3 **Average rate of detention of people aged 10–17 years in juvenile corrective institutions, per 100 000 people[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1998-99	40.6	14.2	32.9	57.5	25.6	51.7	24.8	92.5	34.0
1999-2000	35.5	12.4	27.2	52.8	29.1	45.7	30.2	61.2	30.4
2000-01	31.1	12.0	21.0	46.2	36.4	61.8	46.6	68.6	28.4
2001-02	30.0	11.9	20.9	47.9	34.1	48.6	47.4	63.0	27.2
2002-03	30.3	12.1	22.3	47.0	40.2	45.1	45.9	94.0	28.1

a Detention rates based on average population of juvenile corrective institutions on the last day of each quarter of the financial year.

Source: AIC (unpublished).

Nationally, the proportion of females detained as a proportion of the total population of juveniles in juvenile corrective institutions did not vary greatly over the five year period to June 2003 (fluctuating between 8.9 per cent and 10.4 per cent) and was 8.9 per cent at 30 June 2003. Nationally, the proportion of males detained as a proportion of the total population of juveniles in juvenile corrective institutions varied between 89.6 and 91.1 per cent over the period, and was 91.1 per cent at 30 June 2003 (table F.4).

Table F.4 **Males and females as a proportion of the total population aged 10–17 years in juvenile corrective institutions (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Males									
30 June 1999	91.0	95.0	92.7	89.6	85.3	96.8	75.0	85.7	90.9
30 June 2000	91.6	82.7	91.2	89.6	83.1	91.9	93.3	100.0	90.0
30 June 2001	90.5	89.4	91.8	83.5	87.5	97.3	88.0	100.0	89.6
30 June 2002	92.1	93.0	84.5	89.9	85.1	96.2	80.0	100.0	90.1
30 June 2003	92.8	93.4	89.1	90.5	85.9	89.5	87.0	100.0	91.1
Female									
30 June 1999	9.0	5.0	7.3	10.4	14.7	3.2	25.0	14.3	9.1
30 June 2000	8.4	17.3	8.8	10.4	16.9	8.1	6.7	–	10.0
30 June 2001	9.5	10.6	8.2	16.5	12.5	2.7	12.0	–	10.4
30 June 2002	7.9	7.0	15.5	10.1	14.9	3.8	20.0	–	9.9
30 June 2003	7.2	6.6	10.9	9.5	14.1	10.5	13.0	–	8.9

– Nil or rounded to zero.

Source: AIC (unpublished).

The daily average number of Indigenous people aged 10–17 years detained in juvenile corrective institutions was 295 in 2002-03 (table F.5).

Table F.5 **Daily average population of Indigenous people aged 10–17 years in juvenile corrective institutions (number)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1998-99	96	9	77	80	14	na	2	17	295
1999-2000	91	8	60	77	13	na	2	10	261
2000-01	86	7	53	71	13	na	4	12	246
2001-02	92	7	53	71	19	na	5	12	259
2002-03	98	10	54	80	28	na	4	19	295

a Average based on population of juvenile corrective institutions on the last day of each quarter of the financial year. **na** Not available.

Source: AIC (unpublished).

Nationally, the daily average detention rate for Indigenous people aged 10–17 years in 2002-03 was 326.6 per 100 000 Indigenous people (table F.6). This rate compared to 14.9 per 100 000 people for the non-Indigenous population aged 10–17 years (figure F.3).

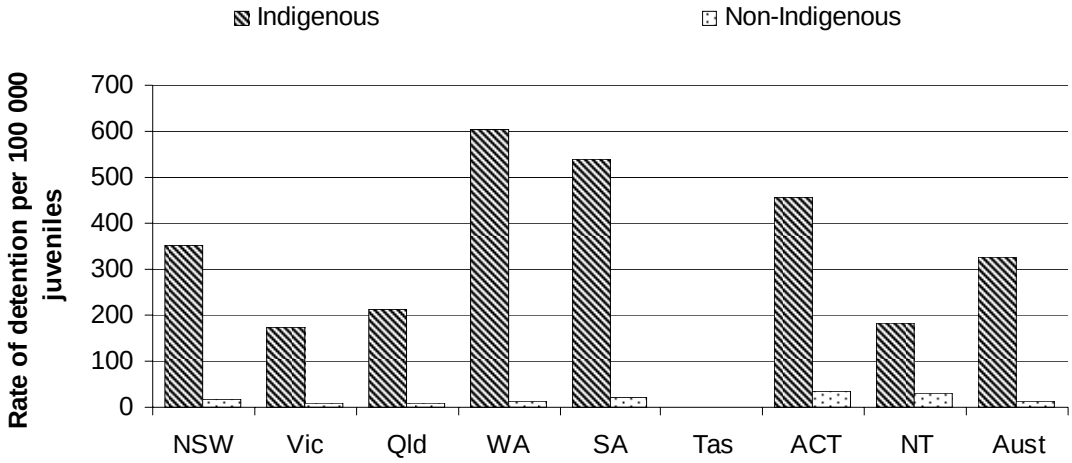
Table F.6 **Average rate of detention of Indigenous people aged 10–17 years in juvenile corrective institutions, per 100 000 people[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1998-99	393.9	201.8	347.1	677.7	314.7	na	236.1	173.5	378.6
1999-2000	343.5	181.9	250.8	624.1	266.2	na	284.1	97.6	315.1
2000-01	324.9	142.4	222.2	565.4	265.9	na	524.7	121.4	294.5
2001-02	351.4	135.8	221.1	555.6	388.2	na	624.4	119.9	307.9
2002-03	353.8	173.6	212.0	604.7	538.1	na	458.6	182.6	326.6

a Detention rates based on average population of juvenile corrective institutions on the last day of each quarter of the financial year. **b** Note that Indigenous rates for 2001, 2002 and 2003 were calculated using high series population data provided by the ABS. Any variation in derived rates may be due to the assumptions and limitations of the base population data. **na** Not available.

Source: AIC (unpublished).

Figure F.3 **Average rate of detention of juveniles aged 10–17 years, per 100 000 people, 2002-03[a, b, c, d]**



a Detention rate is based on the average population of juvenile corrective institutions on the last day of each quarter of the financial year. **b** Note that Indigenous rates for 2001, 2002 and 2003 were calculated using high series population data provided by the ABS. Any variation in derived rates may be due to the assumptions and limitations of the base population data. **c** Jurisdictional comparisons need to be treated with caution, especially for those States and Territories with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions. **d** Data were not available for Tasmania.

Source: AIC (unpublished).

References

ABS (Australian Bureau of Statistics) 2001, *Community Services, 1999-2000*, Cat. no. 8696.0, Canberra.

—— 2004a, *Australian National Accounts: National Income, National Expenditure and Product*, Cat. no. 5206.0, Canberra.

—— 2004b, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians 1991-2009*, Cat. no. 3238.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 1997, *National Classification of Community Services, Version 1.0*, Cat. no. HWI 7, Canberra.

—— 2003, *National Classifications of Community Services, Version 2.0*, Cat. no. HWI-40, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2004, *Report on Government Services 2004*, Productivity Commission, Canberra.

12 Aged care services

The aged care system comprises all services specifically designed to meet the care and support needs of frail older Australians. This chapter focuses on government funded residential and community care for older people; services designed for the carers of older people are also within the scope of this chapter. Some government expenditure on aged care is not currently reported, but continual improvements are being made to the coverage and quality of the data. The services currently covered include:

- residential services, which provide high care, low care and residential respite care (box 12.1)
- community care services, which include Home and Community Care (HACC) program services, Community Aged Care Packages (CACPs), the Extended Aged Care at Home (EACH) program and Veterans' Home Care (VHC)[1]
- respite services, which include HACC respite and centre-based day care and the National Respite for Carers Program (NRCP)
- assessment services, which are largely provided by Aged Care Assessment Teams (ACATs).

A profile of aged care services appears in section 12.1. A framework of performance indicators is outlined in section 12.2 and key performance results are discussed in section 12.3. Future directions in performance reporting are discussed in section 12.4. Jurisdictions' comments are reported in section 12.5. Section 12.6 contains a discussion of age standardisation of aged care data, and definitions for data and indicators are provided in section 12.7.

A number of additions and improvements have been made to the chapter this year:

- Reporting on access has been augmented with the addition of data on Indigenous people's access to Commonwealth Carelink Centres.
- New data are available for the indicator 'unmet need' from the Australian Bureau of Statistics (ABS) 2003 Survey of Disability, Ageing and Carers. (This survey is conducted every five years.)

[1] Unless otherwise stated, HACC expenditure excludes the Department of Veterans' Affairs expenditure on VHC.

- The indicator 'intensity of care' has been expanded to incorporate information on the impact of ageing in place on the residential care sector as a whole.
- Payroll tax on residential aged care has been separately identified in expenditure data for 2003-04.
- New outcome indicators have been identified and included in the performance indicator framework. Further development work is required, however, before data for these indicators can be reported.
- In the profile, experimental estimates of State and Territory expenditure on residential aged care services have been included.

Older Australians also use other government services covered in this Report, including disability services (see chapter 13), specialised mental health services (see chapter 11), public housing (see chapter 16) and services across the full spectrum of the health system (see the Health preface and chapters 9–11). There are also interactions among these services that are likely to affect performance results in this Report — for example, between residential aged care and public hospital services, the number of operational residential places may affect demand for public hospital beds, and changes in service delivery in the public hospitals sector may affect demand for residential aged care.

Supporting tables

Supporting tables for chapter 12 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel format as \Publications\Reports\2005\Attach12A.xls and in Adobe PDF format as \Publications\Reports\2005\Attach12A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the electronic files). These files can be found on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

Box 12.1 **Interpreting residential aged care data**

This chapter describes the characteristics and performance of residential aged care in terms of residential services, residents (clients), places and locality.

- *Residential services data*. This chapter groups residential services for reporting purposes based on the eight level Resident Classification Scale (RCS) profile of their clients.
  - Aged care homes with 80 per cent or more residents classified as RCS 1–4 are described as high care services.
  - Aged care homes with 80 per cent or more residents classified as RCS 5–8 are described as low care services.
  - A service that is not high care or low care as defined above is called a mixed service.

  These categories have been used for descriptive purposes and do not have any legal foundation under the *Aged Care Act 1997* (Cwlth). Similarly, the choice of 80 per cent as a cut-off is arbitrary but considered appropriate for descriptive purposes.
- *Resident data*. This chapter classifies clients as high care or low care based on their RCS assessment. High care residents have been assessed as RCS levels 1–4, and low care residents have been assessed as RCS levels 5–8.
- *Place data*. Part 2.2 of the Aged Care Act details the processes for planning and allocating subsidised services to meet residential aged care needs and community care needs. Planning is based on a national formula for people aged 70 years or over for high and low care. High care places are planned to meet the needs of residents with care needs equivalent to RCS levels 1–4. Low care places are planned to meet the needs of residents with care needs equivalent to RCS levels 5–8.

  Although there must be a needs match between residents entering vacant places (that is, vacant low care places should usually be filled by low care residents), this can change over time with 'ageing in place', which allows a low care resident who becomes high care within the same service to occupy a low care place until he or she is discharged.
- *Locality data.* Geographic data are based on the ABS Australian standard geographic classification of remoteness areas (ABS 2003). Data are classified according to an index of remoteness that rates each ABS Census district based on the number and size of towns, and the distance to major towns and urban centres.

12.1 Profile of aged care services

Service overview

Services for older people are provided on the basis of the frailty or functional disability of the recipients rather than specific age criteria. Nevertheless, without more specific information, this Report uses people aged 70 years or over as a proxy for the likelihood of a person in the general population requiring these services. Certain groups (notably Indigenous people) may require various services at a younger age. For Indigenous people, those aged 50 years or over are used as a proxy for the likelihood of requiring aged care services. The Australian Government also uses these age proxies for planning the allocation of residential care, CACPs and EACH packages.

Government funded aged care services covered in this chapter relate to the three levels of government (Australian, State and Territory, and some local) involved in service funding and delivery. The formal publicly funded services covered represent only a small proportion of total assistance provided to frail older people. Extended family and partners are the largest source of emotional, practical and financial support for older people: more than 90 per cent of older people living in the community in 2003 who required help with self-care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 2004). Many people receive assistance from both formal aged care services and informal sources. Older people also purchase support services in the private market, and these services are not covered in this chapter.

Roles and responsibilities

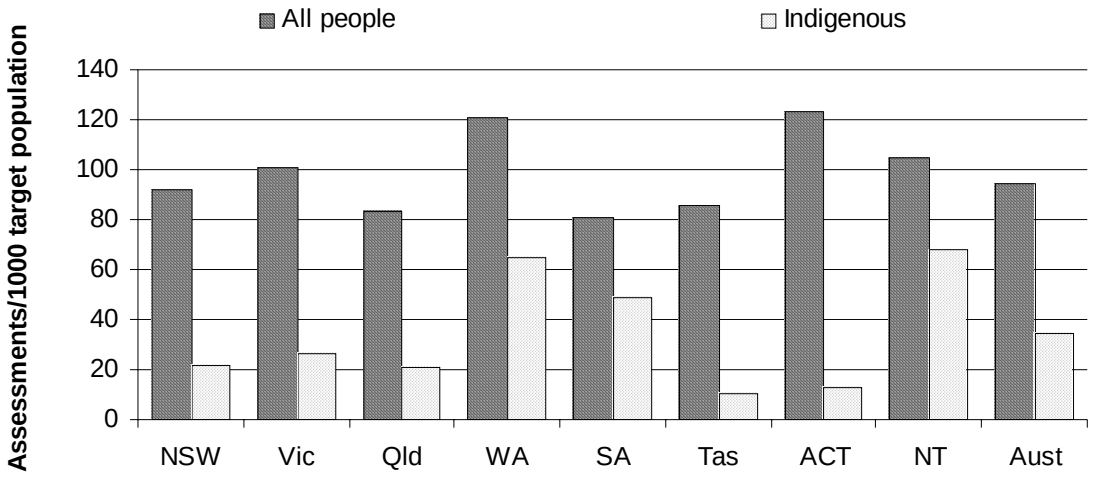
Assessment services

The Australian Government established the Aged Care Assessment Program (ACAP) in 1984, based on the assessment processes used by State and Territory health services to determine (1) eligibility for admission into residential care and (2) the level of care required (and thus the subsidy paid to such services). The core objective of the ACAP is to assess the needs of frail older people and recommend appropriate services. Assessment and recommendation by ACATs are mandatory for admission to residential care or receipt of a CACP or an EACH package. People may also be referred by ACATs to other services, such as those funded by the HACC program. An ACAT referral is not mandatory for receipt of other services, such as HACC and VHC services.

State and Territory governments are responsible for the day-to-day operation and administration of the ACAP and provide the necessary accommodation and support services. The role and scope of the teams differs across and within jurisdictions, however, partly reflecting the service location (for example, whether the team is attached to a residential service, a hospital or a community service).

The number of assessments per 1000 target population varied across jurisdictions in 2002-03. The ACT had the highest number of assessments of people aged 70 years or over per 1000 people aged 70 years or over (122.9) and the lowest rate of assessment was in SA (81.2). The NT had the highest rate of assessments for Indigenous people aged 50 years or over per 1000 Indigenous people aged 50 years or over (68.2) in 2002-03, and Tasmania had the lowest rate (10.6) (figure 12.1).

Figure 12.1 **Aged Care Assessment Team assessment rates, 2002-03[a, b, c]**



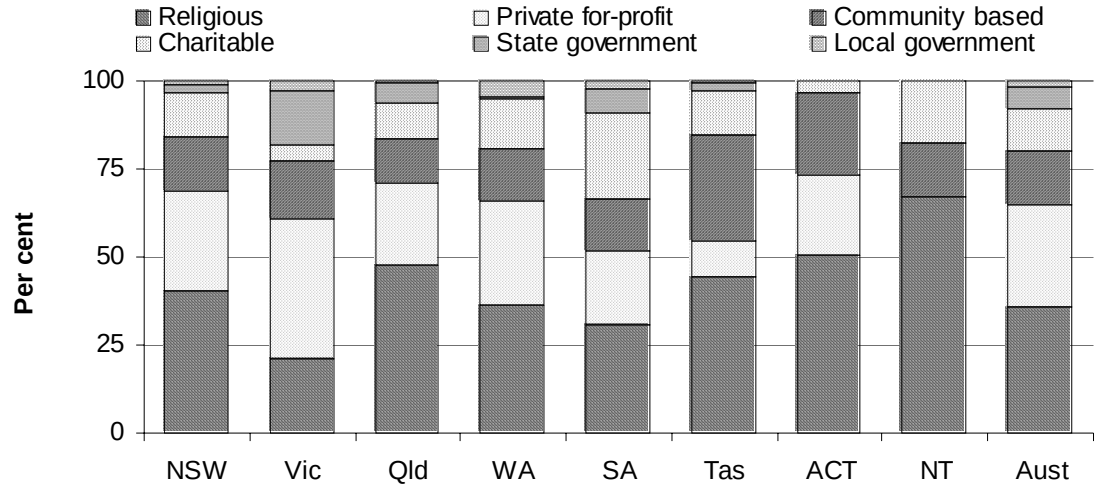
a Includes ACAT assessments for all services. **b** 'All people' includes all assessments of people aged 70 years or over per 1000 people aged 70 years or over. **c** 'Indigenous' includes all assessments of Indigenous people aged 50 or over per 1000 Indigenous people aged 50 years or over.

Source: Lincoln Centre for Ageing and Community Care Research (2004); table 12A.39.

Residential care services

Religious and private for-profit organisations were the main providers of residential care at June 2004, accounting for 35.7 per cent and 29.4 per cent respectively of all subsidised residential aged care places. Community-based organisations and not-for-profit charitable organisations accounted for a further 15.3 per cent and 11.4 per cent respectively. State, Territory and local governments provided the remaining 8.2 per cent (figure 12.2).

Figure 12.2 **Ownership of residential places, June 2004[a, b]**



a 'Community-based' residential services provide a service for an identifiable community based on locality or ethnicity, not for individual financial gain. **b** 'Charitable' residential services provide a service for the general community or an appreciable section of the public, not for individual financial gain.

Source: Department of Health and Ageing (DHA) (unpublished); table 12A.4.

The Australian Government is responsible for most of the regulation of Australian Government subsidised residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local governments also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 12.2).

Community care services

The main community care programs reported in this chapter — the HACC, CACP and VHC programs — fund services that aim to provide practical assistance to enable frail older people (HACC and CACP), people with a disability (HACC) and veterans (VHC) to continue living in the community. These services also provide assistance to carers. They are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers.

Box 12.2 **Examples of regulatory arrangements for residential services**

The Australian Government controls the number of subsidised places. A target of 40 high care places, 50 low care places and 10 community care places (CACPs and EACH packages) per 1000 people aged 70 years or over applies to the data in this Report.

In May 2004, following a recommendation of the Review of Pricing Arrangements in Residential Aged Care, the Australian Government adopted a new ratio of 108 places for each 1000 people in the population aged 70 years or over. Of the 108 places, 88 are residential care places and 20 are community care places.

- Services are expected to meet regional targets for places for concessional residents. These targets range from 16 per cent to 40 per cent of places, and aim to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care. (The criteria for being deemed a concessional resident are based on home ownership and occupancy, receipt of income support and the level of assets held at entry.)
- Extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted.
- To receive an Australian Government subsidy, an operator of an aged care service must be approved under the Aged Care Act as a provider of aged care.
- Principles (regulations) created under the Aged Care Act establish the obligations of approved providers relating to quality of care and accommodation.

Various Commonwealth, State and Territory laws govern regulatory arrangements for residential care. State and Territory legislation may prescribe matters such as staffing, the dispensing of medication and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, and fire prevention and firefighting measures. Staff wages and conditions are generally set by jurisdiction-based awards. Local government by-laws may also apply (for example, waste disposal rules).

Flexibly funded services

Flexible care addresses the needs of care recipients in ways other than the care provided through mainstream residential and community care. Three types of flexible care are currently provided for under the Aged Care Act: EACH packages, Innovative Care places and Multipurpose Service program places. In addition, flexible models of care are provided under the National Aboriginal and Torres Strait Islander Aged Care Strategy (see below).

- The Multipurpose Service program supports the integration and provision of health and aged care services for small rural and remote communities. Nationally, the number of Multipurpose Services increased from 83 in June 2003 to 88 in June 2004.

- The Aged Care Innovative Pool provides flexible care subsidies for alternative care options. Nationally, there were 1351 Innovative Pool places at 30 June 2004.
- The EACH program provides high level aged care to people in their own homes, complementing CACPs, which provide low level care. There were 858 operational EACH places at 30 June 2004.

Indigenous-specific services

Under the Aged Care Act, 29 Indigenous aged care services are funded, providing approximately 700 places. Most of these places are available in Indigenous-specific aged care services, but some are available in aged care services catering to the broader community. In addition, 599 flexibly funded aged care places were provided at 30 June 2004 through the National Aboriginal and Torres Strait Islander Aged Care Strategy, often in remote areas where no aged care services are otherwise available. Services delivered under the strategy are outside the Aged Care Act.

The Australian Government actively targets community aged care places to Indigenous communities and contracts Aboriginal Hostels Ltd to provide ongoing assistance to ensure services in rural and remote areas remain viable.

Funding

Assessment services

The Australian Government provided grants to State and Territory governments to operate 119 ACATs (at 30 June 2004) and evaluation units. In 2003-04, the Australian Government provided funding of $47.1 million nationally for aged care assessment (table 12A.49). Expenditure per person aged 70 years or over, (plus per Indigenous person aged 50–69 years) was markedly higher in the NT ($82) than in the other jurisdictions where expenditure ranged from $23 to $25 per person during 2003-04 (table 12A.50). Some states and territories also contribute funding for ACATs.

Residential care services

The Australian Government provides the majority of annual funding for residential aged care services — $4.6 billion in 2003-04 (table 12A.45 and 12A.47). State and Territory governments also provide some funding for public sector beds. Residents

provide most of the remainder of service revenue, with some income derived from charitable sources and donations.

Experimental estimates of State and Territory government expenditure have been collected for some states and territories for the first time in this Report, for three categories (table 12.1). The categories are defined in section 12.7. The data definitions need further development, so comparisons across jurisdictions need to be made with care.

Table 12.1 **Experimental estimates of State and Territory government expenditure on residential aged care ($ million)**

	NSW	*Vic*[a]	*Qld*[b]	*WA*[c]	*SA*	*Tas*[d]	*ACT*	*NT*	*Total*
Adjusted subsidy reduction supplement	1.3	20.6	6.0	2.1	na	1.5	..	na	31.5
EBA supplement	..	30.4	14.7	na	na	..	..	na	45.1
Rural small nursing home supplement	na	3.4	na	2.4	na	8.0	..	na	13.8

EBA = enterprise bargaining agreement. **a** Victorian data are for 2002-03 for the adjusted subsidy reduction supplement, for the EBA supplement for 2003-04 and for 2003-04 rural small nursing home supplement. The EBA supplement includes $30.4 million in respect of generic aged care places, plus an amount of up to $5.0 million that could be determined for specialist mental health services. **b** Queensland Health's supplementation of $14.7 million to its 20 residential aged care facilities recognises the extra costs associated with public sector EBA, the different classification systems in place, and staffing numbers. **c** WA data are for 2002-03. **d** Tasmanian data are for 2003-04. **na** Not available. **..** Not applicable.

Source: State and Territory governments (unpublished).

The Australian Government annual RCS subsidy for each occupied place varies according to the client's level of dependency. At June 2004, the average RCS subsidy per residential place was $28 604 nationally. Across jurisdictions, it ranged from $30 075 in Tasmania to $27 712 in NT (table 12.2). Variations in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents. Low care subsidy rates (RCS levels 5–8) are the same in all states and territories. High care subsidy rates (RCS levels 1–4) are being adjusted towards a uniform national rate by July 2006, under the Australian Government's Funding Equalisation and Assistance Package.

The combined number of operational high care and low care residential places per 1000 people aged 70 years or over at June 2004 ranged from 110.0 in the NT to 73.9 in the ACT. There were proportionally more high care places in the NT (57.8 per cent), while the ACT had proportionally more low care places (59.1 per cent) (table 12.3). In all jurisdictions except the NT, the proportion of low care places relative to high care places rose between 2000 and 2004 (table 12A.10).

Table 12.2 **Average annual Australian Government RCS subsidy per occupied place, and the dependency level of aged care residents, June 2004**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average annual Australian Government RCS subsidy per residential place[a]										
All RCS levels	$	28 518	29 617	29 442	27 979	28 829	30 075	27 718	27 712	28 604
Proportion of high care residents[b]										
RCS 1	%	22.0	24.3	17.9	23.9	22.0	16.6	27.1	14.9	21.9
RCS 2	%	26.8	21.5	24.8	20.2	25.5	28.0	19.8	34.2	24.4
RCS 3	%	14.3	11.9	17.8	12.2	15.5	20.7	13.5	18.8	14.5
RCS 4	%	4.4	4.2	5.9	4.9	4.4	6.2	5.4	6.8	4.7
Proportion of low care residents										
RCS 5	%	10.8	14.1	10.8	14.7	11.6	10.0	10.1	6.8	12.0
RCS 6	%	9.8	11.8	9.9	12.7	9.9	8.9	11.7	5.0	10.6
RCS 7	%	10.9	11.6	11.7	10.5	10.5	9.3	11.5	12.0	11.1
RCS 8	%	0.9	0.6	1.1	0.8	0.7	0.3	0.9	1.6	0.8

a Includes only subsidies based on the RCS. Average Australian Government payments, including subsidies and supplements totalled $41 518 per high care resident (RCS 1–4) and $14 217 per low care resident (RCS 5–8). **b** Differences in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents.

Source: DHA (unpublished); table 12A.5.

Table 12.3 **Operational high care and low care residential places, 30 June 2004[a, b]**

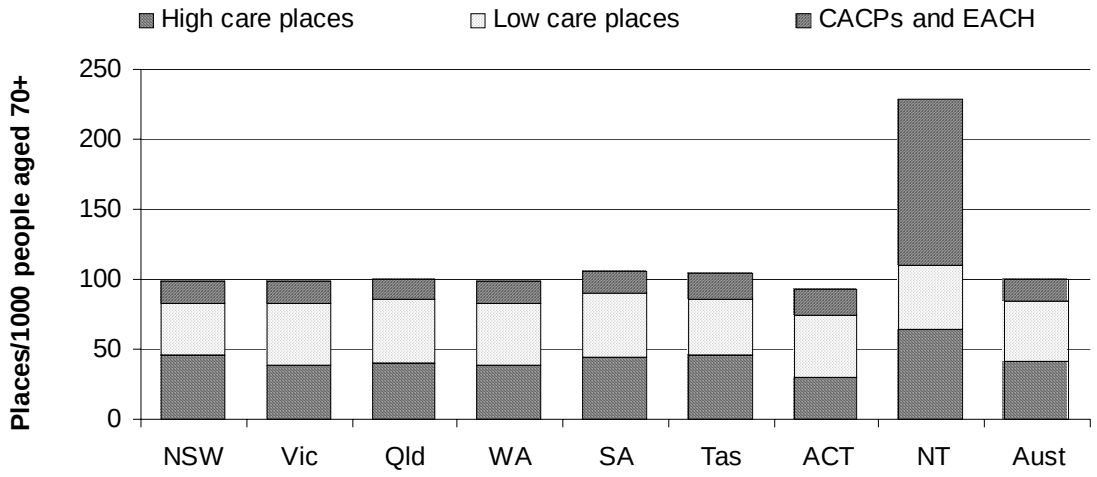
	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of places per 1000 people aged 70 years or over										
High care places	no.	45.2	38.0	39.8	38.2	44.2	45.4	30.2	63.6	41.6
Low care places	no.	37.7	44.5	46.0	45.2	45.2	41.0	43.7	46.4	42.4
Total places	**no.**	**82.9**	**82.5**	**85.8**	**83.4**	**89.4**	**86.4**	**73.9**	**110.0**	**84.0**
Proportion of places										
High care places	%	54.5	46.1	46.4	45.8	49.4	52.5	40.9	57.8	49.5
Low care places	%	45.5	53.9	53.6	54.2	50.6	47.5	59.1	42.2	50.5

a Excludes places that have been 'approved' but are not yet operational. Includes multipurpose and flexible services attributed as high care and low care places. **b** For this Report, Australian Government planning targets are based on providing 100 places per 1000 people aged 70 years or over. In recognition of poorer health among Indigenous communities, however, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT).

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

Figure 12.3 shows the combined number of high care residential places, low care residential places, CACPs and EACH packages. Box 12.2 sets out the Australian Government's targets for the provision of residential places, CACPs and EACH packages.

Figure 12.3 **Operational residential places, CACPs and EACH packages per 1000 people aged 70 years or over, 30 June 2004[a, b, c, d]**



a Excludes places that have been approved but are not yet operational. **b** 'Ageing in place' may result in some low care places being filled by high care residents. **c** For this Report, Australian Government planning targets are based on providing 100 places per 1000 people aged 70 years or over. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). **d** CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (see boxes 12.1 and 12.2 for an interpretation of residential care data and Australian Government planning targets).

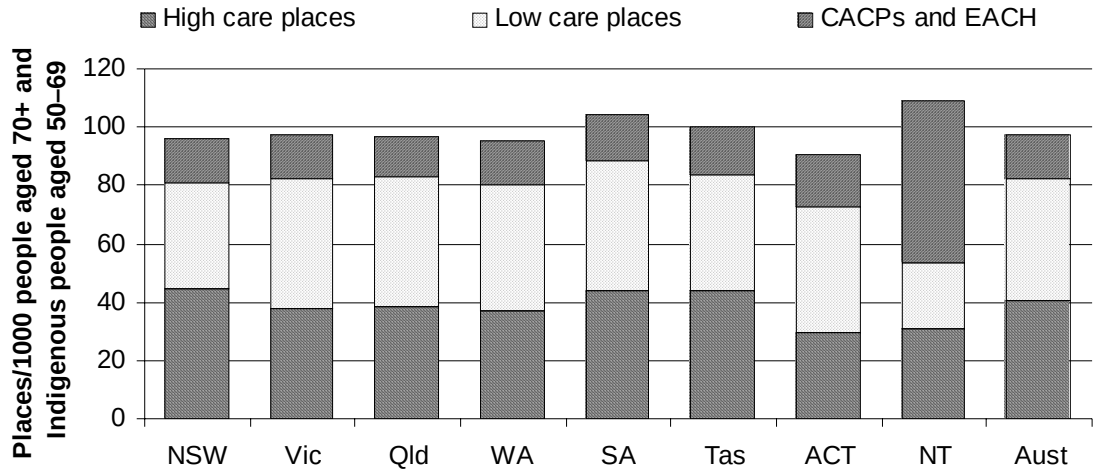
Source: DHA (unpublished); table 12A.10.

The number of operational places can also be shown using a target population that incorporates Indigenous 50–69 year olds (figure 12.4). Use of this 'adjusted' target population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Community care services

Total national expenditure on HACC was $1.2 billion in 2003-04 — consisting of $732.4 million from the Australian Government and $471.3 million from the State and Territory governments. The Australian Government contributed 60.8 per cent, while State and Territory governments funded the remainder (table 12A.46). Recipients may also contribute towards the cost of their care.

Figure 12.4 **Operational residential places, CACPs and EACH packages per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 30 June 2004[a, b, c, d]**



a Places do not include those that have been approved but are not yet operational. **b** 'Ageing in place' may result in some low care places being filled by high care residents. **c** CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (see boxes 12.1 and 12.2 for an interpretation of residential care data and Australian Government planning targets). **d** CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas with a high Indigenous population (such as the NT) may have a higher proportion of CACPs.

Source: DHA (unpublished); table 12A.11.

The NRCP provides community care services and is funded by the Australian Government. Expenditure on this program was $99.7 million in 2003-04 (table 12A.49). The Department of Veterans' Affairs (DVA) also provided $72.9 million for the VHC program during 2003-04 (table 12A.48), which does not include expenditure for in-home and emergency respite home care.

The Australian Government funds the CACP and EACH programs, spending $307.9 million and $15.5 million respectively on the programs in 2003-04 (table 12A.49). CACPs and EACH packages are also part funded by client contributions. Australian Government expenditure data on a range of other community care programs targeting older people are contained in tables 12A.49 and 12A.50.

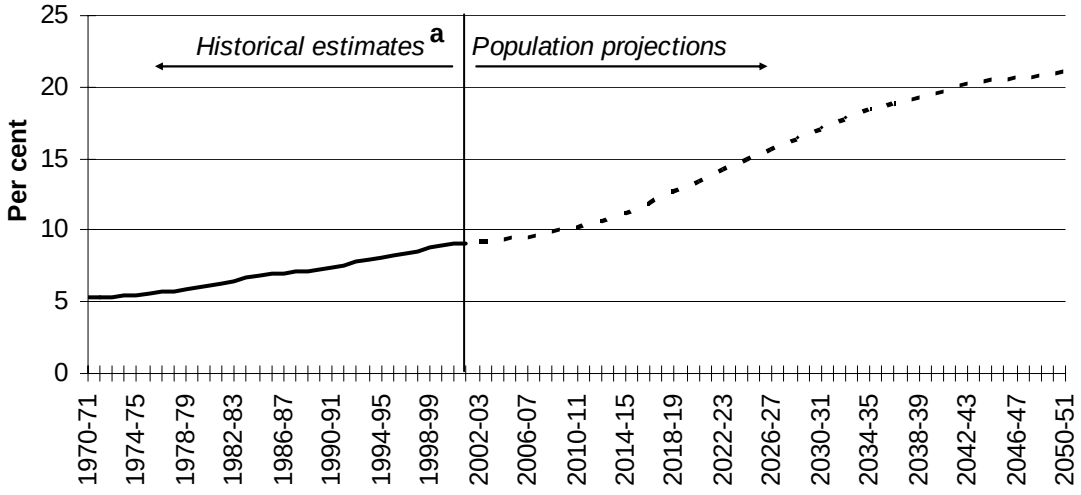
Size and scope of sector

Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of people aged 70 years or over in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically in the 21st century (figure 12.5). The distribution of older people, however, varies across jurisdictions. At June 2004, SA recorded the highest proportion of older people (11.1 per cent), while the NT recorded the lowest (2.4 per cent) (figure 12.6). Higher life expectancy for females was reflected in all jurisdictions having a higher proportion of older females than older males.

Demographic profiles affect the demand for aged care services because females use aged care services (particularly residential services) more than males do. Females are more likely to use residential services partly because they tend to live longer (that is, there are more women than men in the older population) and are less likely to have a partner to provide care.

Figure 12.5 **Persons aged 70 years or over as a proportion of the total population**



a Historical estimates are based on the ABS Census of Population and Housing that is held at five year intervals.

Source: ABS (unpublished) Cat. no. 3201.0; ABS (unpublished) Cat. no. 3202.0.

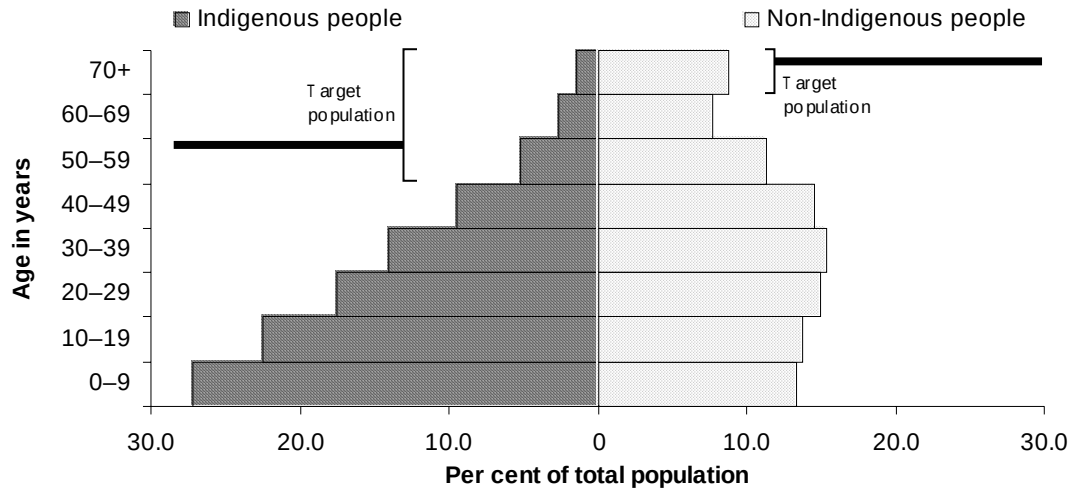
Figure 12.6 **Estimated proportion of population aged 70 years or over, by gender, June 2004**

Source: ABS *Population Projections by SLA 2002–2022* (unpublished); table 12A.1.

Characteristics of older Indigenous people

The ABS estimated that about 50 800 Indigenous people were aged 50 years or more in Australia at 30 June 2004. The majority were located in NSW (30.9 per cent), Queensland (26.6 per cent), WA (14.6 per cent) and the NT (11.8 per cent) (table 12A.2). Although the Indigenous population is also ageing, there are marked differences in the age profile of Indigenous Australians compared with the non-Indigenous population (figure 12.7). Previous ABS estimates of the life expectancy of Indigenous males and females for June 2001 suggested it was nearly 20 years below that recorded for the total Australian population. (New methodology recently adopted by the ABS has led to revisions of these estimates — see the Health preface.) In any case, Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 12.7 **Age profile and target population differences between Indigenous and other Australians, June 2001**



Source: ABS (2001 and unpublished).

Residential care services

The size and location of residential services — which may influence the costs of service delivery — vary across jurisdictions. Nationally, there were approximately 153 963 operational places (permanent and respite) in residential care services (70 955 in predominantly high care services, 31 600 in predominantly low care services and 51 408 in services with a mix of high care and low care residents) at June 2004 (tables 12A.6, 12A.7, 12A.8 and 12A.9).

As the trend towards 'ageing in place' (box 12.3) increases, there has been a steady increase in the number of services categorised as services providing a mix of high care and low care places. In June 2000, 15.7 per cent of all places were located in services offering both high care and low care places; this proportion rose to 25.2 per cent of all places in June 2001, 30.5 per cent of places in June 2002 and 36.5 per cent of places in June 2003, then fell to 33.4 per cent in June 2004 (tables 12A.6 and 12A.9; SCRCSSP 2001, 2002, 2003; SCRGSP 2004).

Box 12.3 **Ageing in place**

In its Objects, the *Aged Care Act 1997* (Cwlth) aims to:

> *... encourage diverse, flexible and responsive aged care services that:*
>
> *(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and*
>
> *(ii) facilitate the independence of, and choice available to, those recipients and carers.*

Further, the Aged Care Act aims explicitly to encourage and facilitate 'ageing in place'. It does not define 'ageing in place', but one useful definition is 'the provision of a responsive and flexible care service in line with the person's changing needs in a familiar environment'. In effect, 'ageing in place' refers to a resident remaining in the same residential aged care service as his or her care needs increase from low level to high level. Over time, this may change the profile of people in services.

The Aged Care Act does not require any residential aged care service to offer ageing in place; or establish any 'program'. Rather, it creates the opportunity for providers to choose to provide the full continuum of care, by removing the legislative and administrative barriers that prevented this outcome in the past.

The concept of 'ageing in place' is linked to the outcomes of increasing choice and flexibility in residential aged care service provision. These are difficult outcomes to measure. Data on 'ageing in place' is reported for the indicator 'intensity of care'.

Source: DHA (unpublished).

The client profile of services that had predominantly low care residents in 2000 has changed, with low care residents staying in their current service as their dependency levels rise over time, and with aged care services expanding and diversifying. Low care services are generally smaller (as measured by number of places) than high care services. At June 2004, 64.3 per cent of low care services had 60 or fewer places (table 12A.8), compared with 49.3 per cent of high care services (table 12A.7).

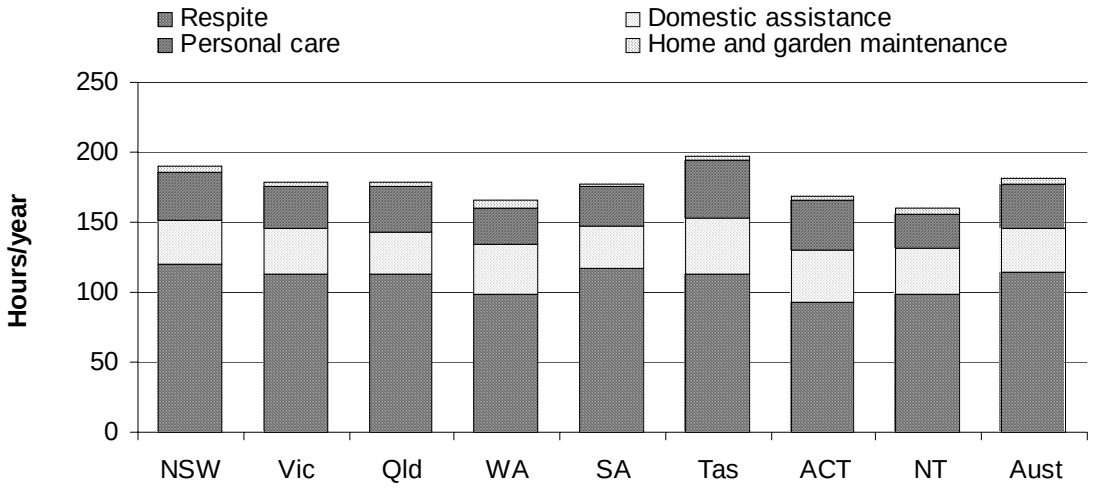
Community care services

Services provided under the HACC program include domestic assistance and home maintenance, personal care, food services, respite care, transport, allied health care and community nursing. The target population is defined as people living in the community who are at risk, without basic maintenance and support services, of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with a disability, and their carers. Approximately 70 per cent of the program's recipients are aged 70 years or

over, but the program is also an important source of community care for younger people with a disability and their carers (DHA unpublished). (Chapter 13 covers services for people with a disability [which manifests before the age of 65 years] that were provided under the Commonwealth State/Territory Disability Agreement.)

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 69 164 people approved for VHC services in 2003-04 (table 12A.48). The program offers veterans and war widows/widowers home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport, social support and delivered meals, are also available under the DVA's arrangements with State and Territory governments. Eligibility for VHC services is not automatic, but based on assessed need. Figure 12.8 shows the average number of hours approved per year for veterans who were eligible to receive home care services in 2003-04.

Figure 12.8 **Average number of hours approved for Veterans' Home Care, 2003-04[a]**



a VHC recipients fall into two categories: those veterans who transferred to the VHC program from the HACC program (transitional veterans) and those that did not (non-transitional veterans). The number of hours approved per year is for non-transitional veterans and relates to services that were approved to occur in 2003-04. The number of average hours actually provided will be lower.

Source: DVA (unpublished); table 12A.48.

Community Aged Care Packages provide an alternative home-based service for older people who ACATs assess as eligible for care equivalent to low level residential care (RCS levels 5–8). The main distinctions between the HACC, CACP and EACH programs are summarised in table 12.4. EACH is now a mainstream program funded by the Australian Government to provide a community alternative to high level residential aged care services. The program provides individually planned and coordinated packages of care designed to meet older people's daily

care needs in the community. The EACH program differs from the CACP program in that it targets frail older people who would otherwise be eligible for high level residential aged care. An EACH package typically provides 15–20 hours of direct assistance each week.

Community care is likely to continue to play an increasing role in aged care services, given the longer term policy objective of improving the capacity of aged care services to support people at home — an objective that reflects a strong consumer preference.

Table 12.4 **Distinctions between the HACC, CACP and EACH programs**

	HACC	*CACPs*	*EACH*
Range of services[a]	Wider range of services available	Narrower range of services available	Narrower range of services available
Relationship to residential care	Aims to prevent premature or inappropriate admission	Substitutes for a low care residential place	Substitutes for a high care residential place
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory	ACAT assessment mandatory
Funding	Cost shared by the Australian, State and Territory governments and client contributions	Funded by the Australian Government and client contributions	Funded by the Australian Government and client contributions
Target client groups[b]	Available to people with a greater range of care needs	Targets people with care needs similar to low level residential care	Targets people with care needs similar to high level residential care
Size of program	$1.2 billion funding in 2003-04	$307.9 million funding in 2003-04	$15.5 million funding in 2003-04
	Approximately 707 207 clients in 2003-04[c]	28 921 operational places in 2003-04	858 operational places at 30 June 2004

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care — for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have levels of need that would exceed the level available under CACPs. [c] Based on 83 per cent of HACC funded agencies that submitted Minimum Data Set data for 2003-04. Consequently, the total number of clients will be higher than those reported here.

Source: DHA (unpublished); tables 12A.32, 12A.35, 12A.45 and 12A.46.

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards home-based care — have meant that the HACC, VHC, CACP and EACH programs have become increasingly important components of the aged care system. During 2003-04, the HACC program delivered approximately 10 514 hours per 1000 people aged

70 years or over plus Indigenous people aged 50–69 years (table 12A.20). The total number of CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2000 and June 2004, from 10.7 to 15.2 (table 12A.11).

12.2 Framework of performance indicators

The framework of performance indicators aims to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the revised general performance indicator framework and service process diagram outlined in chapter 1 (figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicators relate to government objectives in the aged care sector (box 12.4). At this stage, no outcome indicators are reported for aged care services.

Box 12.4 **Objectives for aged care services**

The aged care system aims to promote the health, wellbeing and independence of frail older people and their carers through the funding and delivery of care services that are:

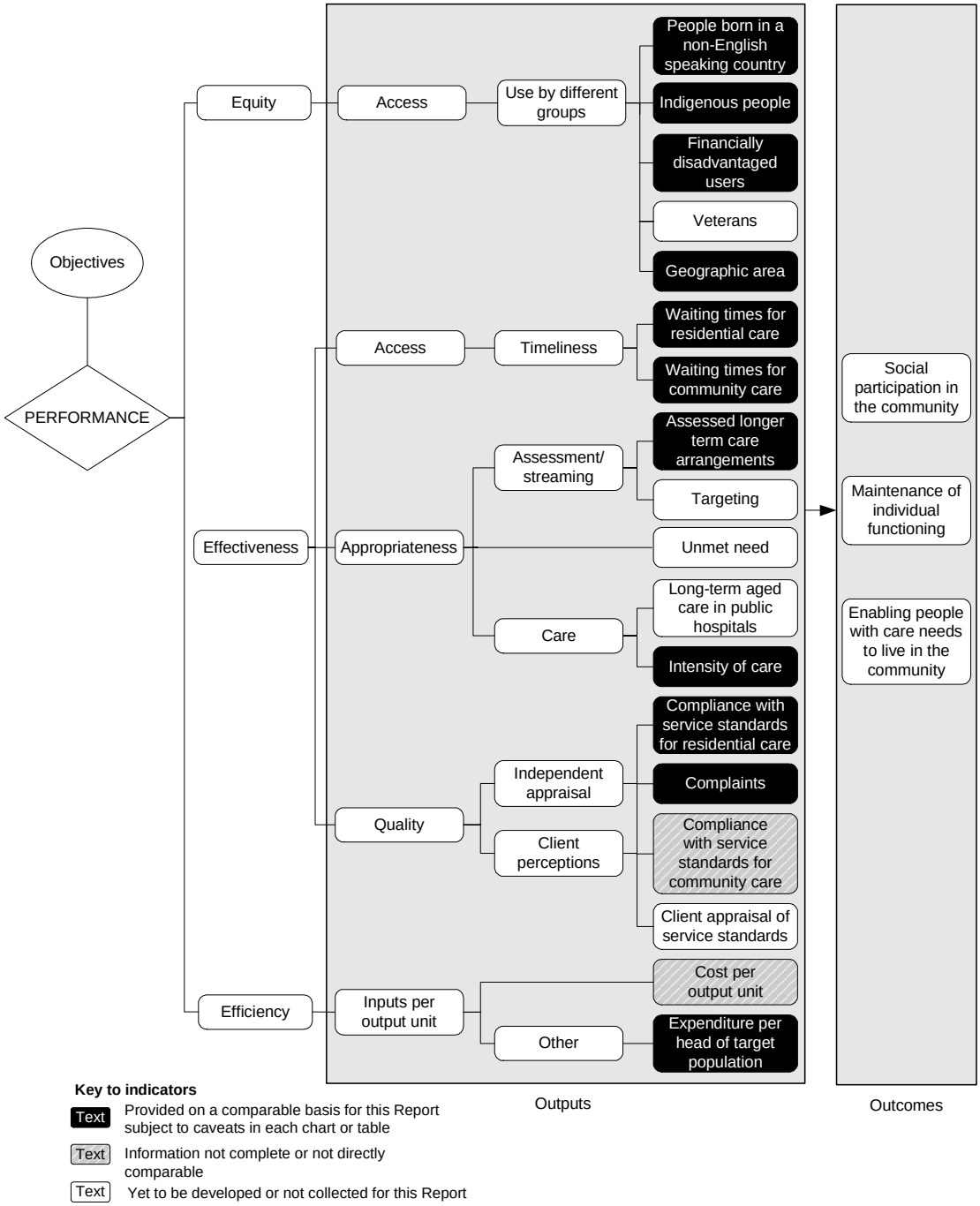
- accessible
- appropriate to needs
- high quality
- efficient.

The performance indicator framework shows which data are comparable in the 2005 Report (figure 12.9). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

12.3 Key performance indicator results

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

Figure 12.9 **Performance indicators for aged care services**



Outputs

Equity

Access — use by different groups

The access indicator 'use by different groups' is explained in box 12.5.

Box 12.5 **Use by different groups**

A key national objective of the aged care system is to provide equitable access to aged care services for all people who require these services. 'Use by different groups' is a proxy indicator of equitable access. Various groups are identified by the Aged Care Act and its principles (regulations) as having special needs, including people from Indigenous communities, people born in non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans (including widows and widowers of veterans). The indicator is reported for each special needs group except veterans, and the definitions are as follows:

- the number of people born in non-English speaking countries using residential services, CACPs, EACH and HACC services, divided by the number of people born in non-English speaking countries aged 70 years or over.
- the number of Indigenous people using residential services, CACP, EACH and HACC services, divided by the number of Indigenous people aged 50 years or over (because Indigenous people tend to require aged care services at a younger age than the general population).
- for financially disadvantaged users: the indicator measures only access to residential services, and is defined as the number of new residents classified as concessional or assisted divided by the number of new residential places.
- for people living in rural and remote areas: the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 70 years or over plus Indigenous people aged 50-69 years for major cities, inner regional areas, outer regional areas, remote areas and very remote areas.
- the rate of contacts with Commonwealth Carelink Centres for Indigenous people compared with all people.

(Continued on next page)

Box 12.5 **(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:

- There is evidence that Indigenous people have higher disability prevalence rates than those of the general population, which suggests a greater level of need for services compared with those in the broader aged care population.
- For financially disadvantaged users, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional residents. These targets range from 16 per cent to 40 per cent of new places, depending on the service's region. Use rates equal to or higher than the minimum rates are desirable.

Several factors need to be considered in interpreting the results for this set of indicators.

- Cultural differences may influence the extent to which people born in non-English speaking countries use different types of services.
- Cultural differences and geographic location may influence the extent to which Indigenous people use different types of services.
- The availability of informal care and support may influence the use of aged care services in different population groups.

Access to residential services

This indicator is explained in box 12.5. In all jurisdictions at 30 June 2004, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services, compared with the rest of the population (figure 12.10).

Access to services by financially disadvantaged users

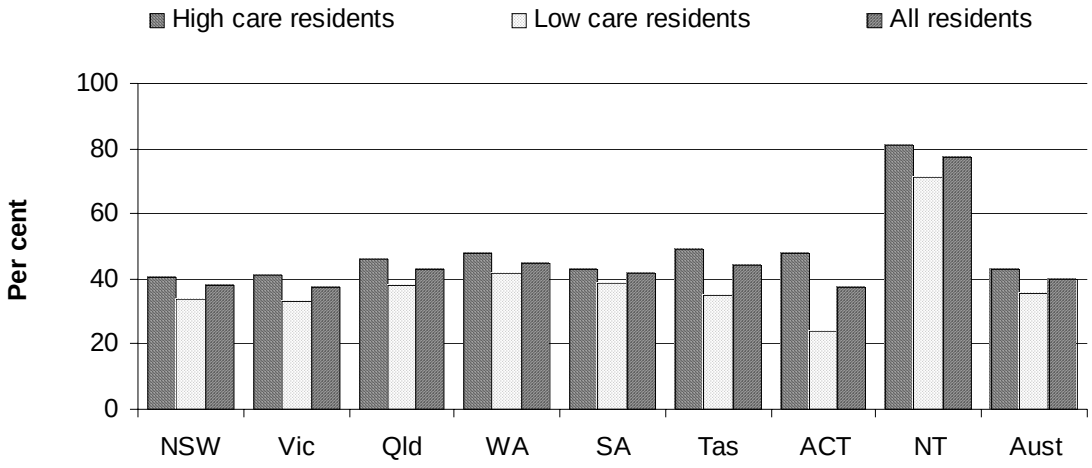
This indicator is explained in box 12.5. The NT had the highest proportion of all new residents classified as concessional or assisted residents during 2003-04 (77.3 per cent) and Victoria had the lowest (37.3 per cent) (figure 12.11).

Figure 12.10 **Residents per 1000 target population, 30 June 2004[a, b, c]**

a All residents data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. **b** Indigenous residents data are per 1000 Indigenous people aged 50 years or over. **c** Data for residents from a non-English speaking country are per 1000 people from non-English speaking countries aged 70 years or over.

Source: DHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Figure 12.11 **New residents classified as concessional or assisted residents, 30 June 2004 (per cent)[a]**



a Concessional residents are those who receive an income support payment and have not owned a home for the previous two or more years (or whose home is occupied by a 'protected' person, such as, the care recipient's spouse or long term carer), and have assets of less than 2.5 times the annual single basic age pension. Assisted residents are those meeting the above criteria, but with assets between 2.5 and 4.0 times the annual single basic age pension.

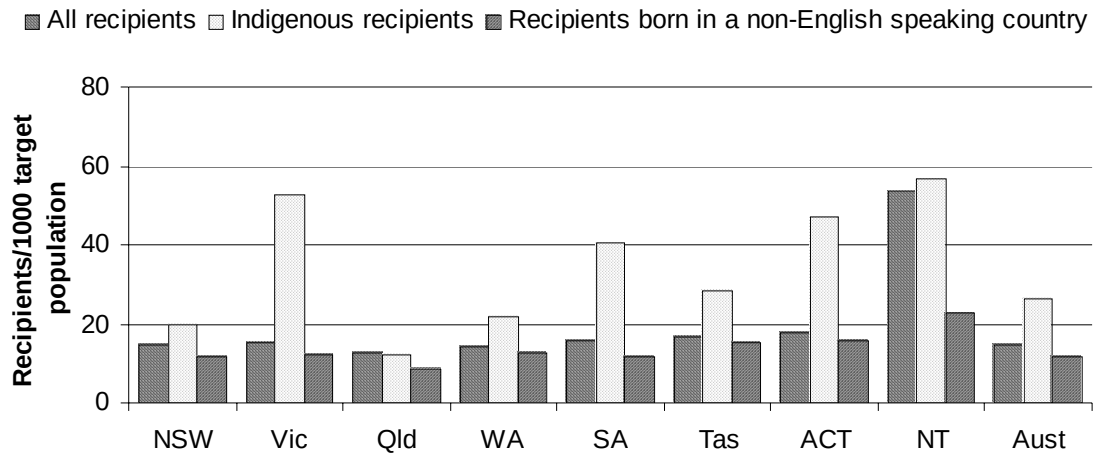
Source: DHA (unpublished); table 12A.19.

Access to community aged care packages

This indicator is explained in box 12.5. The number of CACP recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years has grown in recent years, but was small relative to the total number of recipients of residential care at June 2004 (14.7 CACP recipients compared with 78.7 total recipients of residential care) (table 12A.12).

The NT had the highest number of CACP recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years at June 2004 (53.8) and Queensland had the lowest (12.9). The NT had the highest number of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over (56.8) and Queensland had the lowest (12.2) (table 12A.16). The NT also had the highest number of CACP recipients from non-English speaking countries per 1000 people aged 70 years or over from non-English speaking countries (22.9) and Queensland had the lowest (8.6) (figure 12.12). The Australian Government's allocation of CACPs in every jurisdiction at June 2004 exceeded 10 CACPs per 1000 target population.

Figure 12.12 **Community Aged Care Package recipients per 1000 target population, 30 June 2004**[a, b, c, d, e]



[a] All recipients data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. [b] Indigenous recipients data are per 1000 Indigenous people aged 50 years or over. [c] Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 70 years or over. [d] The ACT has a very small Indigenous population aged 50 years or over (table 12A.2), and a small number of packages will result in a very high provision ratio. [e] CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas such as the NT have a higher rate of CACP recipients per 1000 people.

Source: DHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Access to the Home and Community Care program

This indicator is explained in box 12.5. HACC services are provided in the client's home or community for frail older people with a severe, profound or moderate disability, and their carers.

Around 68.5 per cent of HACC recipients were aged 70 years or over during 2003-04 (table 12A.32). Nationally in 2003-04, 10 514 hours of HACC services were provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years ranged from 18 114 hours in the NT to 6295 hours in NSW. The number of meals provided per 1000 people aged 70 years or over, plus Indigenous people aged 50–69 years was highest in the NT (9348 meals) and lowest in SA (2929 meals) (table 12.5).

Table 12.5 **HACC services received, 2003-04 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)[a, b]**

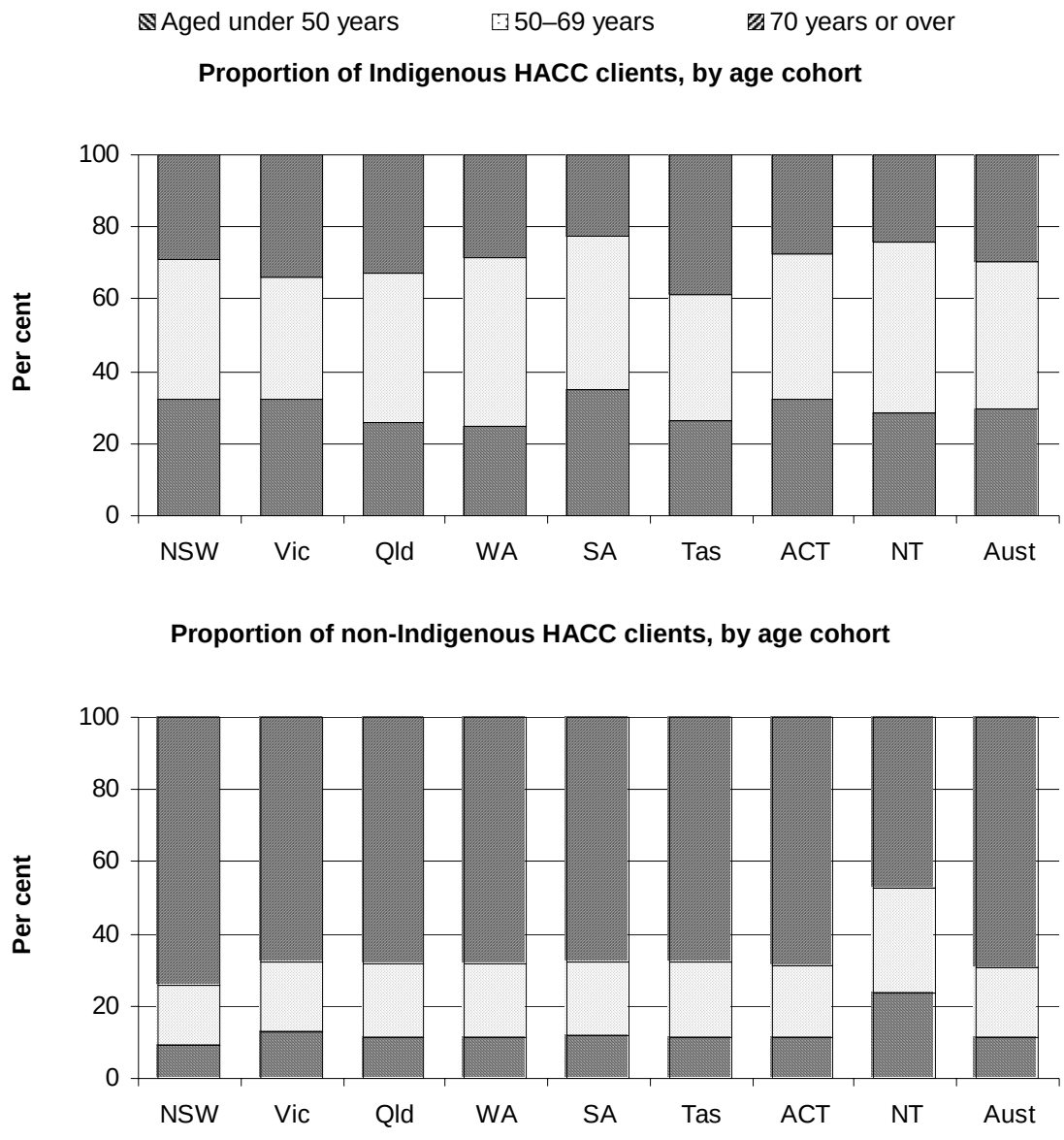
	NSW	*Vic*	*Qld*	*WA*	*SA*[c]	*Tas*	*ACT*	*NT*	*Aust*
Percentage of agencies that reported MDS data	77	86	93	99	85	83	99	77	83
Total hours[d]									
Major cities	5 885	12 082	12 576	17 400	8 160	..	9 894	..	9 966
Inner regional	6 571	15 865	10 345	14 579	8 856	9 898	na	..	10 496
Outer regional	8 226	19 381	13 196	15 991	10 179	12 225	..	17 862	12 623
Remote	11 663	22 355	15 575	16 730	10 003	15 319	..	16 546	14 401
Very remote	23 174	..	18 540	26 222	56 531	39 527	..	39 404	28 954
All areas	**6 295**	**13 429**	**12 084**	**17 003**	**8 853**	**10 885**	**9 924**	**18 114**	**10 514**
Total meals[e]									
Major cities	3 867	5 345	6 556	6 786	3 185	..	4 781	..	4 885
Inner regional	5 097	7 094	5 615	5 630	643	5 532	na	..	5 561
Outer regional	5 442	6 268	6 845	5 981	2 537	7 503	..	4 421	5 843
Remote	5 788	7 579	9 477	7 037	2 109	6 849	..	6 980	6 524
Very remote	1 866	..	13 070	21 181	39 500	7 315	..	46 976	23 569
All areas	**4 302**	**5 805**	**6 429**	**6 718**	**2 929**	**6 207**	**4 794**	**9 348**	**5 229**

a Data represents HACC services received by people aged 70 years or over plus Indigenous people aged 50–69 years (tables 12A.20–12A.25), rather than HACC services received by all age groups (tables 12A.26–12A.31). **b** The proportion of HACC funded agencies that submitted MDS data for 2003-04 differed across jurisdictions, ranging from 77 per cent to 99 per cent. Consequently, actual service levels will be higher than those reported here **c** SA advised that the number of meals may be understated due to slow implementation of the Minimum Data Set by Meals on Wheels. **d** See table 12A.20 for a full list of categories. **e** Includes home meals and centre meals. **na** Not available. **..** Not applicable.

Source: DHA (unpublished); tables 12A.20–12A.31.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2003-04. This reflects the difference in morbidity and mortality trends between Indigenous people and the general population (figure 12.13).

Figure 12.13 **Recipients of HACC services by age and Indigenous status, 2003-04**

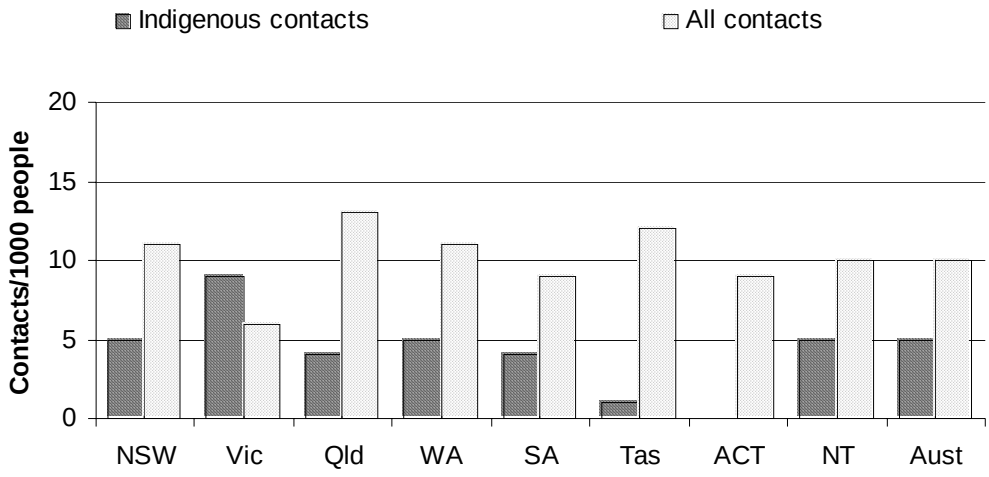


Source: DHA (unpublished); table 12A.33.

Access by Indigenous people to Commonwealth Carelink Centres

This indicator is explained in box 12.5. Commonwealth Carelink Centres are information centres for older people, people with disabilities and those who provide care and services. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. Figure 12.14 provides information on the rate at which Indigenous people contacted Carelink Centres at 30 June 2004, compared with the rate for all clients. The rate at which Indigenous people were able to access these centres was less than for all Australians except in Victoria. Victoria had the highest number of contacts by Indigenous people per 1000 Indigenous population in 2003-04 (8.7 per cent), while Tasmania had the lowest (1.3 per cent).

Figure 12.14 **Commonwealth Carelink centres, contacts per 1000 people, by Indigenous status, 30 June 2004**[a, b, c, d]



[a] Contacts with Carelink include phone calls, visits, emails and facsimiles. [b] Indigenous contacts refer to contacts by Indigenous people per 1000 Indigenous population. [c] All contacts refers to contacts per 1000 total population. [d] Data for the ACT for Indigenous clients were not available in 2003-04.

Source: Population Projections by SLA 2002-2022 (unpublished); table 12A.59.

Effectiveness

Timeliness of access — waiting times for residential care

The indicator 'waiting times for residential care' is explained in box 12.6. On average, 71.8 per cent of all people entering residential care during 2003-04 did so within three months of being assessed by an ACAT, and 44.6 per cent entered

within one month of their ACAT assessment. Across jurisdictions, the proportion of people who entered care within three months of assessment ranged from 75.0 per cent in NSW to 50.3 per cent in the ACT (table 12A.37).

Box 12.6 **Waiting times for residential care**

'Waiting times for residential care' is an output measure of effectiveness, reflecting the timeliness with which people are able to access residential care.

The indicator 'elapsed time between ACAT approval and entry into residential care service' measures the period between a client's approval for care and his or her entry into care and is defined as the percentage of people who are admitted to residential care within three months of their ACAT approval. The relevant terms are defined as follows:

- ACAT approval — the approval date of an ACAT assessment
- entry into a residential care service — the date of admission to a residential care service.

Shorter waiting times are desirable (or higher rates of admission to residential care within three months of ACAT approval).

This indicator needs to be interpreted with care. It may be influenced by a range of factors, such as:

- 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
- hospital discharge policies and practices.

The Steering Committee acknowledges the limitations of the current indicator (box 12.7) and supports redevelopment for improvement. The current indicator will continue to be reported until improved data are available.

Box 12.7 **Entry period for residential care**

The Australian Institute of Health and Welfare (AIHW) conducted a detailed study of 1999-2000 ACAT assessment data and entry into residential care (AIHW 2002*)*. The 'entry period' is the time between ACAT assessment of a person as eligible for residential aged care, and that person's entry into a residential aged care service.

The study found that one of the main determinants of a short entry period is whether the resident has an ACAT assessment performed while in hospital rather than when living at home. A longer entry period is also strongly related to whether the resident used a CACP or residential respite care before admission.

Some people assessed by an ACAT and recommended for residential aged care may not take up a residential place. Others receive recommendations for both residential aged care and a CACP, and take up the latter. Recommendations for residential care remain active for 12 months. Some people assessed by an ACAT and recommended for residential aged care may not take up a residential place within this period. People often do not act on the recommendation immediately. They may believe they are quite capable of continuing to manage at home and that they do not need admission.

The AIHW found that many factors affect the entry period but are not linked to the performance of the aged care system. It recommended that the entry period for residential care not be used as a performance indicator.

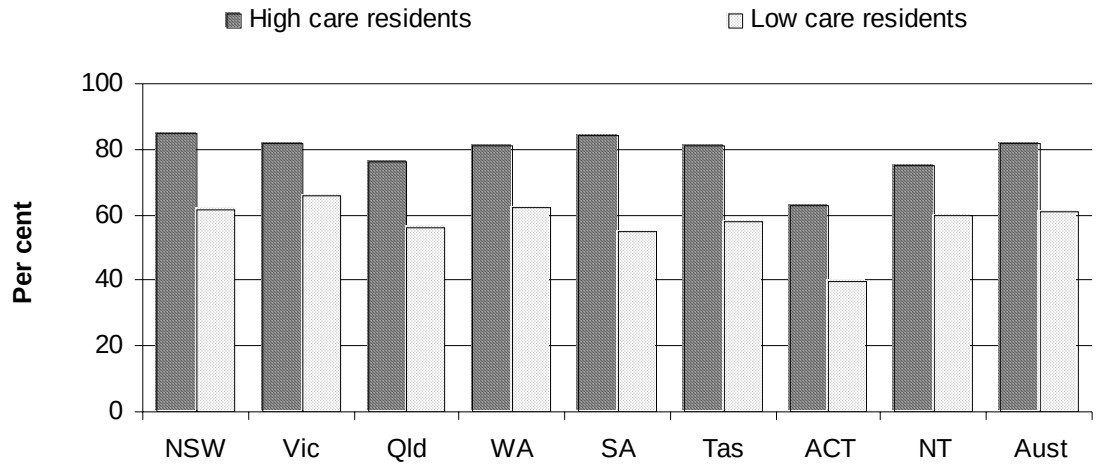
Source: AIHW (2002).

Nationally, a greater proportion of people entering high care residential services entered within three months of assessment (82.0 per cent), compared with the proportion entering low care residential services within that time (60.9 per cent) (table 12A.37). Across jurisdictions, the proportion of people entering high care residential services within three months of being assessed ranged from 85.0 per cent in NSW to 62.6 per cent in the ACT. The proportion of people entering low care residential services within three months of being assessed ranged from 65.8 per cent in Victoria to 39.5 per cent in the ACT (figure 12.15).

Timeliness of access — waiting times for community care

The 'waiting times for community care' indicator is explained in box 12.8 and reported using CACP data. On average, 67.0 per cent of all people receiving a CACP during 2003-04 received it within three months of being assessed by an ACAT, and 36.6 per cent started receiving a CACP within one month of their ACAT assessment (table 12A.37). Across jurisdictions, the proportion of people who received a CACP within three months of assessment ranged from 77.5 per cent in WA to 55.7 per cent in SA (figure 12.16).

Figure 12.15 **People entering residential care within three months of their ACAT assessment, 2003-04**



Source: DHA (unpublished); table 12A.37.

Box 12.8 **Waiting times for community care**

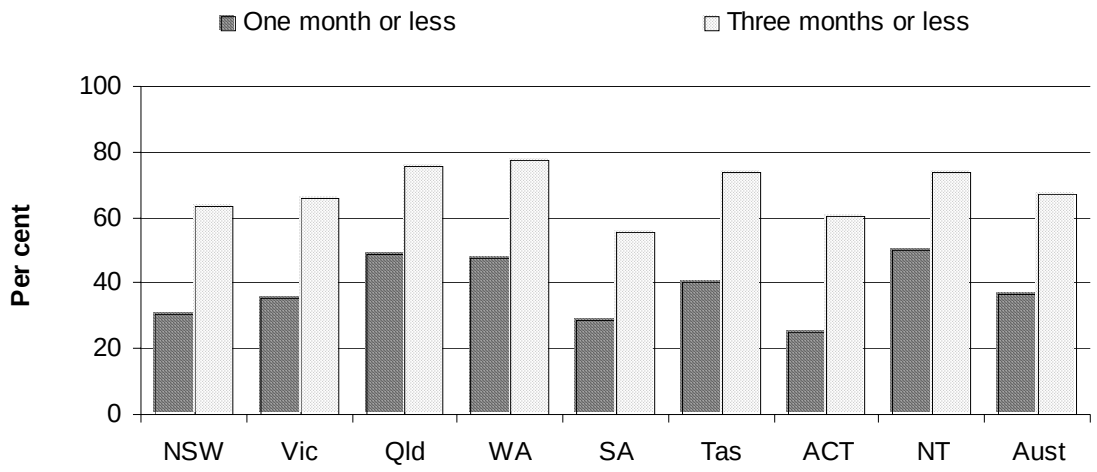
'Waiting times for community care' is an output measure of effectiveness and reflects the timeliness with which people are able to access CACPs. The indicator measures the period between a client's approval for care and his or her receipt of care, and is defined as the elapsed time between an ACAT approval and receipt of a CACP. Shorter waiting times are desirable (or higher rates of receipt of a CACP within one month or within three months of an ACAT approval).

This indicator needs to be interpreted with care. Some ACAT assessed clients may choose not to receive a CACP: alternative community care options may be available, or varying fee regimes might influence choice.

Appropriateness — assessed longer term care arrangements

This indicator is explained in box 12.9. Information on the proportion of assessed people referred to community or residential care is provided in figure 12.17. Tasmania had the highest proportion of ACAT clients referred to residential care in 2002-03 (61.3 per cent), while the ACT had the highest proportion of clients referred to community care (68.4 per cent).

Figure 12.16 **Elapsed time between ACAT approval and the receipt of a CACP service, 2003-04**



Source: DHA (unpublished); table 12A.37.

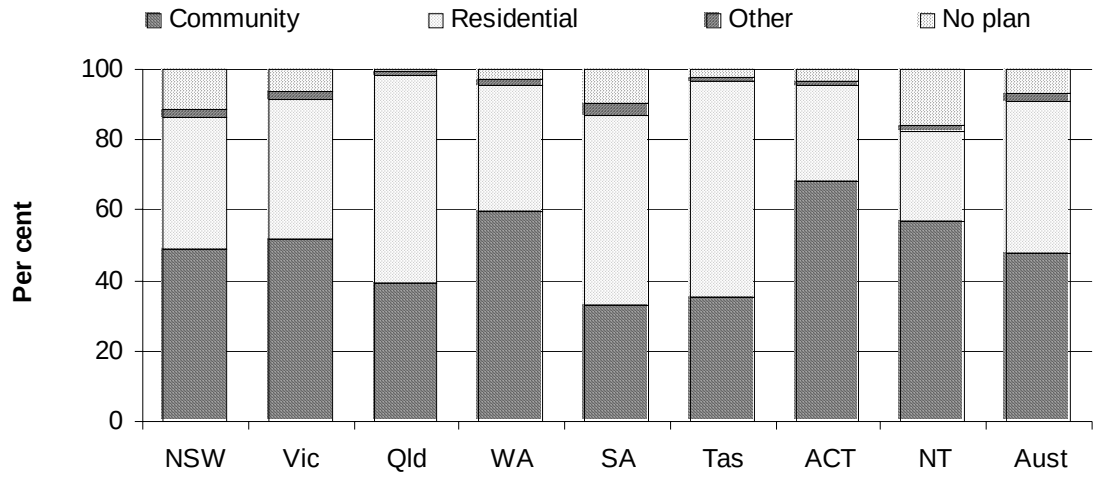
Box 12.9 **Assessed longer term care arrangements**

'Assessed longer term care arrangements' is an indicator of appropriateness. The purpose is to measure how effectively clients are allocated to the services that best meet their needs.

This indicator is defined as the number of ACAT clients referred to community care (CACPs or EACH packages) or residential care (permanent or respite). (Aged care assessments are mandatory for admission to residential care or for receipt of a CACP or an EACH package.)

The results for this indicator show the distribution of recommended living arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions may reflect external factors such as geographic dispersion of clients and service availability, but also client preferences and views on the types of client best served by community-based services. The distribution of ACAT recommendations for various living arrangements are influenced by the degree to which any pre-selection process refers people requiring residential care to ACATs for assessment. Jurisdictions with lower overall assessment rates may operate a filtering process to focus assessments on individuals who are more likely to require residential care.

Figure 12.17 **Recommended longer term care arrangements of ACAT clients, 2002-03[a]**



a 'No plan' includes deaths, cancellations and transfers.

Source: Lincoln Centre for Ageing and Community Care Research (2004); table 12A.38.

Appropriateness — targeting

The 'targeting' indicator has not yet been developed (box 12.10).

Box 12.10 **Targeting**

The Steering Committee has identified 'targeting' as an indicator of appropriateness. It will be developed for reporting in future.

Appropriateness — unmet need

The indicator 'unmet need' is explained in box 12.11. The total number of persons aged over 65 years living in households who needed assistance with at least one everyday activity in 2003 are shown in table 12.6. Older people whose needs for assistance were not met comprised over one third (35.7 per cent) of all those needing assistance. Victoria reported the highest proportion of unmet need in 2003 and SA reported the lowest.

Box 12.11 **Unmet need**

'Unmet need' is an appropriateness indicator. The purpose of the indicator is to measure the extent to which demand for services to support older people requiring assistance with daily activities is met.

Defining and determining the level of need at an individual level, let alone at a population level, are complex tasks. Perceptions of need and unmet need are often subjective. Data for this indicator are drawn from the ABS 2003 Survey of Disability, Ageing and Carers and reflect people aged over 65 years who self-identified as having a need for assistance with at least one everyday activity, and the extent to which that need was met (fully, partly or not at all).

While low rates of unmet need is theoretically desirable, direct inferences about the demand for services from these data need to be made with care, because the data do not:

- reveal the intensity of care required by those who identify an unmet need — there is no indication of whether the need can readily be met informally or by formal home care, or whether the person may require residential care
- reflect the degree of unmet demand for a specific type of service. Differences across jurisdictions in the proportion of unmet need can reflect different policy approaches to targeting services. Some governments may choose to focus on those with the greatest degree of need for care and on fully meeting their needs. By contrast, other governments may choose to provide a lower level of service to a greater number of people, while only partly meeting the needs of those with the greatest need for care. Both policy approaches to the targeting of services are valid.
- reflect the past and possible future duration of the need — that is, whether it is long term or transitory
- reflect whether the need relates to a disability support service, aged care service or medical care, and thus whether it is a State, Territory or Australian Government responsibility.

Table 12.6 **Older persons needing assistance with at least one everyday activity: extent to which need was met, 2003[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[b]
Persons with a need not fully met	'000	108.0	98.8	76.3	29.0	30.1	9.6	na	na	358.6
All persons needing assistance	'000	306.9	269.8	214.7	80.8	92.2	27.8	na	na	1005.2
Self - reported total or partial unmet need	%	35.2	36.6	35.5	35.9	32.6	34.5	na	na	35.7

a Aged 65 years or over, living in households. **b** Australian total includes data for the ACT and the NT. **na** Not available.

Source: ABS (unpublished); table 12A.40.

Appropriateness — long term aged care in public hospitals

An indicator 'long term aged care in public hospitals' has not yet been developed (box 12.12).

Box 12.12 **Long term aged care in public hospitals**

'Long-term aged care in public hospitals' is an indicator of the appropriateness of care. Acute inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term. Low incidence is desirable.

The Steering Committee has identified this indicator for development and reporting in future.

Appropriateness — intensity of care

The indicator 'intensity of care' is explained in box 12.13. Figure 12.18 shows the proportion of people who stayed in the same residential aged care service when changing from low care to high care. From 2000-01 to 2003-04, there was a steady increase in this proportion, across the jurisdictions, with the exception of the NT (figure 12.18). In 2003-04, the highest proportion of residents who had 'aged in place' was in Tasmania (86.3 per cent) and the lowest was in NSW (60.4 per cent).

The proportion was higher in regional and remote areas than in major cities (table 12A.56).

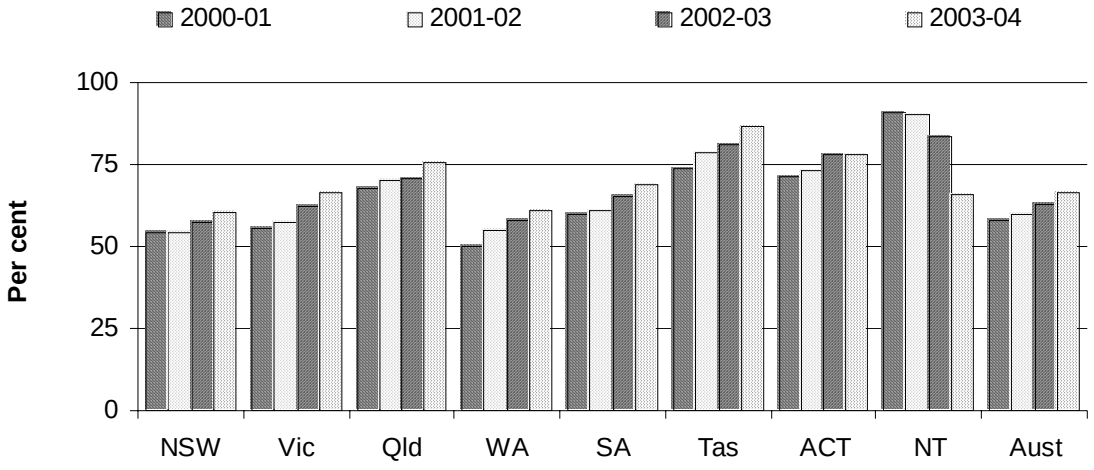
Box 12.13 **Intensity of care**

'Intensity of care' is an indicator of appropriateness, reflecting the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The Aged Care Act aims explicitly to encourage 'ageing in place' to increase choice and flexibility in residential aged care service provision (see box 12.3).

This indicator needs to be viewed from the perspective of the system as a whole. The implication of ageing in place is that some places that were allocated for low care will be occupied by high care residents (or, conversely, allocated for high care and occupied by low care residents). Information about the use of operational residential aged care places is provided to demonstrate the impact of ageing in place on the aged care service system over time.

Higher rates of ageing in place are desirable, in the context of a flexible system that meets the need for low level care either in residential facilities or in the community.

Figure 12.18 **Proportion of residents who changed from low care to high care and remained in the same aged care service**



Source: DHA (unpublished); table 12A.56.

Overall, 25.4 per cent of low care places in 2003-04 were occupied by residents with high care needs. Across jurisdictions, the proportion was highest in Tasmania (35.4 per cent) and lowest in Victoria (20.6 per cent) (table 12.7). These data are provided by remoteness area in table 12A.60.

Table 12.7 **Utilisation of operational residential places, 30 June 2004 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of places allocated as low care and used for high care	22.0	20.6	33.8	22.9	32.0	35.4	35.2	30.8	25.4
Places used for high care as a proportion of all places	61.0	54.3	61.2	57.4	62.9	65.2	59.2	65.1	59.3

Source: DHA (unpublished); table 12A.60

Quality — compliance with service standards for residential care

The indicator 'compliance with service standards for residential care' is explained in box 12.14.

Box 12.14 **Compliance with service standards for residential care**

'Compliance with service standards' is an indicator of the quality of care. The purpose of the indicator is to monitor the extent to which residential care facilities are complying with accreditation or certification standards. The extent that they comply, implies a certain level of care and service quality.

Since 2001, Australian Government funded residential services have been required to meet accreditation standards (which comprise 44 expected outcomes), against which each residential service is assessed. The accreditation indicator reflects the period of accreditation granted. High rates of approval for accreditation for three years or more are desirable.

Average certification safety scores and residents per room are also presented as output indicators of quality. Higher rates are desirable because they imply a higher level of care and service quality.

There are three basic steps in the accreditation process.

- First, residential services apply for accreditation by completing a self-assessment of their performance against the accreditation standards, and submitting this with other relevant information to the Aged Care Standards and Accreditation Agency (ACSAA).
- Second, a team of registered quality assessors reviews the application (the 'desk audit') and then conducts an onsite assessment of the residential service (the site audit). During the site audit, the team observes the living environment and

practices of the residential service, reviews relevant documentation such as care plans, and interviews residents, relatives, staff and management. The team gives a draft report to the residential service at the end of the site audit, and a final 'site audit report' is prepared and submitted to the ACSAA within two weeks. During that two week period, the residential service has the opportunity to comment on the draft report or provide additional information.

- Third, an authorised decision maker from ACSAA (not the team) considers the site audit report, in conjunction with submissions from the residential service and any other relevant information (including information from DHA), and decides whether to accredit and, if so, for how long.

Accreditation decisions and other information relating to the accreditation standards, the aged care standards and ACSAA are publicly available via the ACSAA's web site (www.accreditation.aust.com). Table 12.8 summarises the accreditation decisions at 30 June 2004. The highest proportion of three year approvals was in the ACT (100.0 per cent) and the lowest was in Queensland (84.6 per cent).

Table 12.8 **Accreditation decisions on residential aged care services, 30 June 2004**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Accreditation approvals										
One year	%	3.8	4.6	3.6	2.7	5.4	1.1	–	6.7	3.9
Two years	%	4.1	5.2	11.8	8.1	7.1	3.3	–	–	6.3
Three years	%	92.1	90.1	84.6	89.2	87.5	95.6	100.0	93.3	89.8
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Accredited services	no.	943	820	499	260	297	92	23	15	2 949

– Nil or rounded to zero.

Source: ACSAA (unpublished); table 12A.41.

Certification aims to improve the physical quality of residential aged care services. The certification framework is underpinned by part 2.6 of the Aged Care Act and by the certification principles. Certified services gain access to accommodation payments and are eligible for Australian Government funding supplements for concessional and assisted residents. The certification program has established minimum standards of building quality, which the sector is to achieve progressively. To achieve certification, services are assessed against seven aspects of building quality.

All services were assessed for certification in 1997 and are now working to achieve continuous improvement targets, which were introduced in 1999 as part of a 10 year

plan to improve building quality. The targets require services to achieve a safety score of 19 out of 25 by the end of 2003, and an overall score of 60 out of 100. Existing services are also required to meet privacy and space requirements by 2008. All new services must meet these targets from the time of construction. The average number of residents per room at July 2004 varied from 1.6 in NSW to 1.1 in Tasmania. Average safety scores ranged from 21.4 in SA to 16.3 in the ACT (table 12.9).

Table 12.9 **Average certification safety score and residents per room, July 2004**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Safety score[a]	19.4	20.8	19.2	19.4	21.4	19.0	16.3	20.3	19.9
Residents per room	1.60	1.38	1.35	1.30	1.31	1.13	1.15	1.21	1.42

a Maximum score is 25; a target score of 19 was to be achieved by the end of 2003.

Source: DHA (unpublished); tables 12A.42 and 12A.43.

Quality — complaints

The indicator 'complaints' is explained in box 12.15. In 2003-04, the Complaints Resolution Scheme received approximately 967 new complaints, compared with 1227 in 2002-03. Of these, 73 per cent were lodged as open complaints, 16 per cent as confidential and 11 per cent as anonymous. Of all complaints handled by the Scheme, 97 per cent related to residential aged care services (DHA 2004). The number of complaints registered per 1000 residents in 2003-04 ranged from 12.3 in the ACT to 3.0 in Queensland (figure 12.19).

Quality — compliance with service standards for community care

The indicator 'compliance with service standards for community care' is explained in box 12.16. The total number of HACC agencies operating and the number of appraisals undertaken over the three year cycle 2001-02 to 2003-04 are shown in table 12.10. Future reports are expected to include more detailed data on the outcomes of the service standards appraisals.

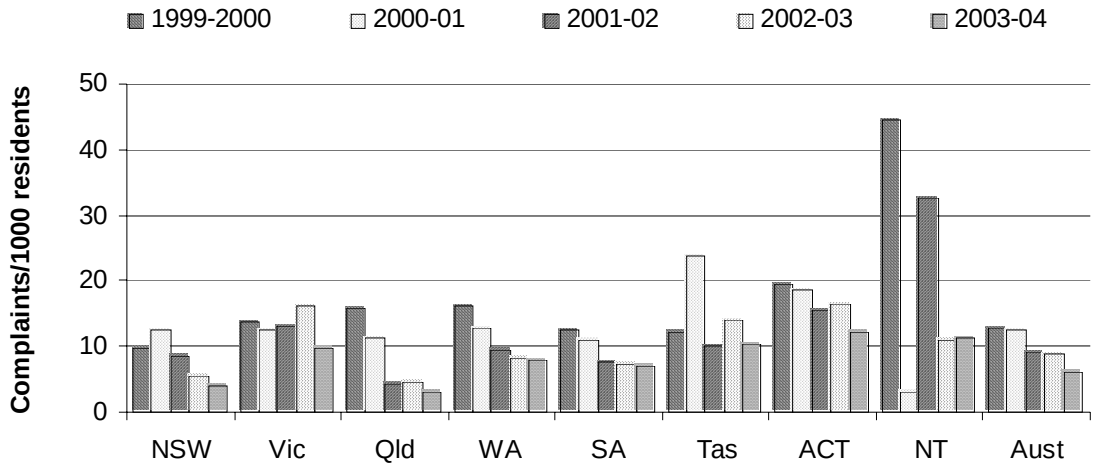
Box 12.15 **Complaints**

'Complaints' is an output indicator of quality. The purpose of the indicator is to monitor the level of complaints received by the Complaints Resolution Scheme in each State and Territory. If service recipients make official complaints, they may be unhappy with an element of the service provided and, therefore, service quality.

All aged care services are required to have an internal complaints system. The Aged Care Complaints Resolution Scheme is a free complaints system run by the DHA and overseen by an independent Commissioner for Complaints. The scheme is available to anyone who wishes to make a complaint about an Australian Government funded aged care service, including residents of aged care facilities and their families, staff and people receiving CACPs and EACH packages. The indicator measures the number of complaints per 1000 residents. A low rate of complaints is desirable.

The rate at which complaints occur is influenced by the propensity of clients and their families or service staff to complain, their knowledge of the complaints system, and perceptions of the effectiveness of the complaints system. In many cases, complaints may be resolved without the need to involve the Complaints Resolution Scheme.

Figure 12.19 **Aged Care Complaints Resolution Scheme complaints per 1000 residents**



Source: DHA (unpublished); table 12A.44.

Box 12.16 **Compliance with service standards for community care**

'Compliance with service standards for community care' is an output indicator of quality. The purpose of the indicator is to monitor the extent to which individual agencies are complying with service agreement standards.

The HACC national service standards provide HACC funded agencies with a common reference point for internal quality control, by defining aspects of service quality and expected outcomes for consumers. States and territories are required to include the standards in all service agreements. The HACC national service standards instrument has been developed to measure through a service appraisal process the extent to which individual agencies are complying with the standards. Monitoring and compliance with the standards are now a major part of service reviews.

In future, the indicator will measure the percentage of individual agencies that comply with the service standards, but data on the outcomes of service standard appraisals are not yet available. Meanwhile, the indicator is defined as the number of HACC agencies *appraised* against the standards divided by the total number of HACC agencies. It should be noted that the standards are not an accreditation system.

Table 12.10 **HACC national service standards appraisals over the three year cycle ending 2003-04[a, b]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*[c]	*SA*[d]	*Tas*[e]	*ACT*	*NT*	*Aust*
Appraisals	no.	1 074	481	706	168	162	58	31	11	2 691
HACC agencies	no.	1 487	481	730	178	162	58	31	88	3215
Proportion of agencies assessed	%	72	100	97	94	100	100	100	21	84

a Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those listed. **b** Data in this table are preliminary and may be revised in the future. **c** The number of WA agencies appraised is lower than expected because some agencies amalgamated. **d** SA has an additional 21 exempt agencies. **e** Two agencies were exempt from the appraisal process in Tasmania.

Source: State and Territory governments (unpublished); table 12A.36.

Quality — client appraisal of service standards

The indicator 'client appraisal of service standards' has not yet been developed (box 12.17).

Box 12.17 **Client appraisal of service standards**

'Client appraisal of service standards' is an output indicator of quality. This indicator aims to monitor client satisfaction with services received. The Steering Committee has identified this indicator for development and reporting in future.

Efficiency

Inputs per output unit — cost per output unit

'Cost per output unit' is explained in box 12.18. Preliminary unit cost data have been calculated for aged care assessments. Cost per assessment during 2002-03 averaged $212 nationally, and was highest in the NT ($865) and lowest in the ACT ($156) (table 12.11).[2]

Box 12.18 **Cost per output unit**

A proxy efficiency indicator, 'cost per assessment', has been developed as work in progress in measuring efficiency for ACATs. It is defined as expenditure on ACATs divided by the number of ACAT assessments completed.

This indicator needs to be interpreted with care. While high or increasing expenditure per assessment may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as greater time spent with clients) or changes in the characteristics of clients (such as their geographic location). Similarly, low or declining expenditure per assessment may reflect improving efficiency or less time spent with clients (for example).

Table 12.11 **Aged care assessment unit costs, 2002-03 (dollars)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT[c]*	*Aust*
Cost per assessment	210	196	233	184	235	260	156	865	212

a Only includes Australian Government expenditure on ACAT. **b** ACAT referrals and operations vary across jurisdictions. **c** The high cost for each assessment in the NT may be influenced by the remoteness of people requiring assessments, clients having English as a second or third language, and a lack of supporting health and community services infrastructure to assist with assessments.

Source: DHA (unpublished), Lincoln Centre for Ageing and Community Care Research (2004); table 12A.57.

[2] Cost per assessment is calculated using the total number of assessments and includes clients aged less than 70 years.

Inputs per output unit — expenditure per head of target population

The indicator 'expenditure per head of target population' is explained in box 12.19. Australian Government expenditure (including expenditure by the DVA) on residential care services per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions in 2003-04, ranging from $2653 in SA to $1496 in the NT. Nationally, it increased from $2357 (in 2003-04 dollars) in 1999-2000 to $2416 in 2003-04 (figure 12.20).

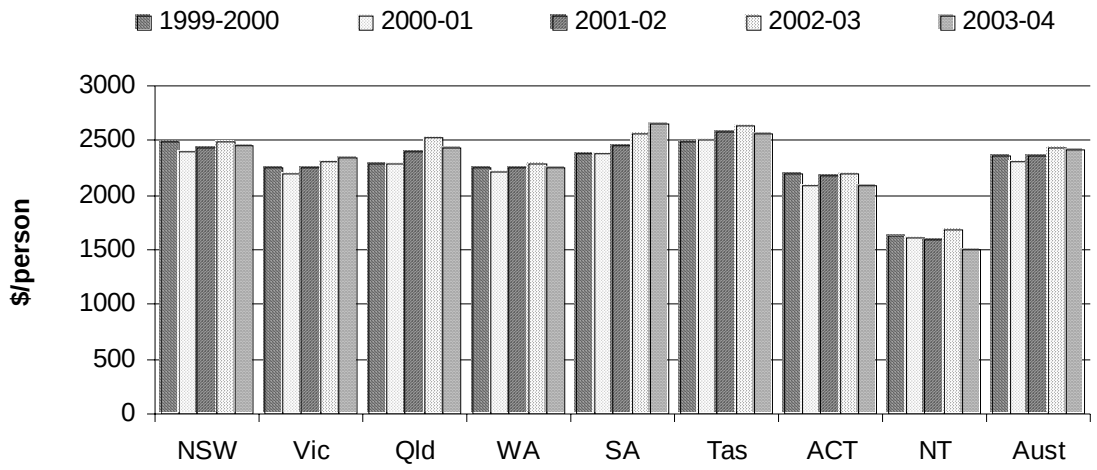
Box 12.19 **Expenditure per head of target population**

A proxy indicator of efficiency is 'expenditure per head of target population'. It reflects the objective to ensure services for frail older people are provided efficiently. The indicator is defined as government inputs (expenditure) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years. Expenditure per person in the target population is reported for three main service types: residential services, CACP, EACH and HACC services.

This indicator needs to be interpreted with care. While high or increasing expenditure per person may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as better quality of services) or in the characteristics of clients receiving the service (such as their geographic location or level of care need). Similarly, low or declining expenditure per assessment may reflect improving efficiency or a decrease in service standards.

Payroll tax has been separately identified in Australian Government DHA expenditure on residential aged care for the first time in this Report. Table 12.12 contains data including and excluding payroll tax for DHA expenditure on residential aged care per person aged 70 or over plus Indigenous people aged 50–69 years.

Figure 12.20 **Australian Government real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2003-04 dollars)[a, b]**



a Includes payroll tax. **b** Includes expenditure by DVA.

Source: DHA (unpublished); DVA (unpublished); table 12A.52.

Table 12.12 **Australian Government (DHA) expenditure on residential aged care, per person aged 70 years or over plus Indigenous people aged 50–69 years (2003-04 dollars)[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Excluding payroll tax)	$/person	2 045	1 970	2 008	1 865	2 248	2 089	1 736	1 413	2 017
Including payroll tax	$/person	2098	2015	2043	1920	2289	2110	1774	1424	2062

a Data in this table exclude DVA expenditure on residential aged care.

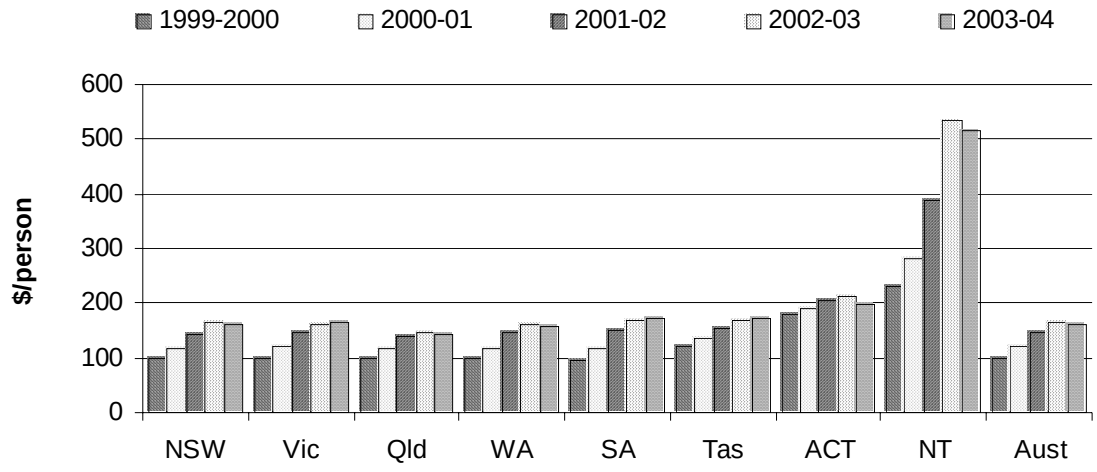
Source: DHA (unpublished), table 12A.51.

Australian Government expenditure on CACPs per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions in 2003-04, and was highest in the NT ($515) and lowest in Queensland ($142). Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50-69 years increased from $100 (in 2003-04 dollars) in 1999-2000 to $162 in 2003-04 (figure 12.21).

Australian, State and Territory government expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years was highest in the ACT ($822) and lowest in NSW ($576). Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years

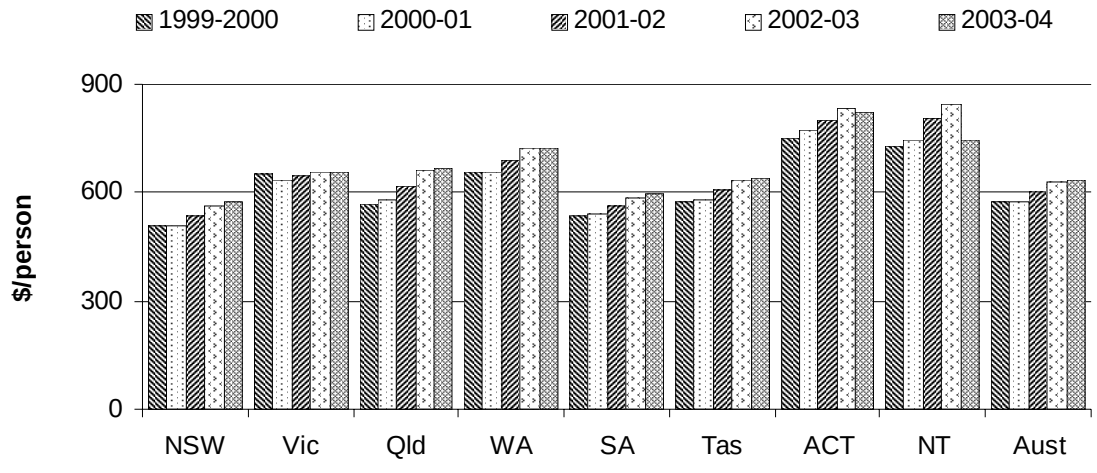
increased from $576 (in 2003-04 dollars) in 1999-2000 to $633 in 2003-04 (figure 12.22).

Figure 12.21 **Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2003-04 dollars)**



Source: DHA (unpublished); table 12A.55.

Figure 12.22 **Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2003-04 dollars)[a]**



a People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person in the HACC target population is contained in table 12A.53.

Source: DHA (unpublished); table 12A.54.

Outcomes

New outcomes indicators have been identified this year for development and reporting in future (boxes 12.20, 12.21 and 12.22).

Social participation in the community

Box 12.20 **Social participation in the community**

'Social participation in the community' promotes the wellbeing and independence of frail older people. An indicator will be developed to show the extent to which older people participated in community, cultural or leisure activities. Higher rates of participation in the community are more desirable.

The Steering Committee has identified this indicator for development and reporting in future.

Maintenance of individual functioning

Box 12.21 **Maintenance of individual functioning**

'Maintenance of individual functioning' is an outcome indicator that reflects the objective for aged care services to promote the health, wellbeing and independence of frail older people. The Steering Committee has identified this indicator for development and reporting in future.

Two indicators would be reported:

- maintenance of, or minimised decline in residents' level of functioning reflected by a movement of clients to a higher level of need as indicated by a change in classification on the resident classification scale.
- length of stay in residential care for a given level of frailty or age at entry.

Enabling people with care needs to live in the community

Box 12.22 **Enabling people with care needs to live in the community**

This outcome indicator reflects the objective of community care to delay entry to residential care and will measure levels of dependency on entry to residential care for those who have been receiving community care. The Steering Committee has identified this indicator for development and reporting in future.

12.4 Future directions in performance reporting

For several aspects of aged care services, indicators are not fully developed and there is little performance reporting. Priorities for the future include:

- continue improving efficiency indicators, including for HACC services and assessment services
- further develop reporting of outcome indicators
- improve reporting of waiting times for residential aged care
- continue working on reporting the indicator 'long term aged care in public hospitals'
- improve reporting of State and Territory expenditure on residential aged care
- examine whether to adjust data in the chapter for differences across jurisdictions in the age structure of the population. The appendix to this chapter (see section 12.6) provides some information on the impact of standardising some data in the chapter for age.

12.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data about each jurisdiction that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

“ Professor Warren Hogan presented the *Final Report*[1] of the Review of Pricing Arrangements in Residential Aged Care to the Australian Government on 5 April 2004. The Review examined the effectiveness of current and alternative funding arrangements, the level of efficiency of the industry and the long-term sustainability of current and alternative funding arrangements for the aged care sector.

In response to the Review, the Government announced a substantial package of measures,[2] providing $2.2 billion over 2003-04 and the four forward years. The package builds on the reforms of residential aged care from 1997 and addresses a number of short and medium term pressures facing aged care. It continues the provision of high quality aged care services for older Australians and positions Australia to meet the care needs of an ageing population by:

- expanding the provision of care;
- providing a significant increase in additional recurrent and capital funding for aged care services;
- supporting workforce initiatives;
- streamlining the administration of aged care;
- providing more support to services in rural and remote areas; and
- improving the hospital/aged care interface.

A review of community care was conducted during 2003-04 to develop an overarching framework within which all community care programs may operate. The framework will seek to develop greater consistency and common arrangements across community care programs in the key areas of assessment of need and eligibility, access to services, eligibility criteria, a common approach to determining consumer fees, accountability, quality assurance, information management and data collection, and planning.[3]

The Reviews complement the Australian Government’s focus on our ageing population, which is addressing issues such as retirement incomes, continuing workforce productivity, and the need to deliver affordable, equitable, flexible high quality aged care.

1. Review of Pricing Arrangements in Residential Aged Care. *Final Report.* Canberra, 2004.
2. *Investing in Australia’s Aged Care: More Places, Better Care.* Minister for Ageing. May 2004.
3. *A New Strategy for Community Care — The Way Forward.* Canberra, Department of Health and Ageing, 2004. ”

New South Wales Government comments

“ The NSW Government continues its commitment to improving the health and wellbeing of older people living in NSW and to enhancing services to respond to the increasing needs of an ageing population. The Home and Community Care program delivered more than $382 million of services in 2003-04 – an increase of $32 million from 2002-03. A significant proportion of this additional funding has been used to increase access to basic support services, including personal care, domestic assistance, centre-based day care and respite care.

NSW continues to improve services for people in rural and remote areas and for people from an Indigenous background. An example of this was the Wilcannia Polly Pineo Multi Service Outlet, which provides a range of services in the isolated township of Wilcannia. The local provision of culturally appropriate services has dramatically improved the wellbeing of the population — 95 per cent of which is Aboriginal — and strengthened Wilcannia’s unity and self-sufficiency.

The NSW Government hosted a Forum on Ageing during 2004. The aim of the Forum was to bring together key stakeholders to discuss issues around ageing and to identify current and emerging issues across the ageing spectrum, to stimulate public debate on ageing issues and proposed solutions, and to progress new directions in ageing policy, planning, practise and evaluation.

Dementia Awareness Week was again successful in raising awareness of issues for people with dementia and their carers, including a focus on Indigenous people with the release of a new set of resources for Indigenous communities.

The NSW health system is responding to the unique and complex needs of older people within an aged care policy framework. *The Framework for Integrated Support and Management of Older People in the NSW Health Care System*, released in 2004, is driving system-wide changes in policy and practice. A number of information sessions, workshops and inter-jurisdictional discussions have been conducted to support its objectives. Each Area Health Service is developing and implementing an aged care strategy. Developing new models of care for older people is part of a wider approach to develop sustainable management of the demand for hospital services via the Sustainable Access Plan developed by NSW Health. The NSW Government is also implementing transitional care models for older people, to assist at the interface between acute care, residential and community care services.

NSW Health continues to invest in innovative aged care services such as Aged Care Service Evaluation Teams in public hospitals, Emergency Medical Units and COMPACKS which broker packages of community care. This is in addition to the Aged Care Assessment Teams which receive funding from both Australian and NSW Governments, and the comprehensive range of acute, community, rehabilitation, mental health and geriatric services targeting older people. NSW also established the NSW Carers Program with $12.9 million over 4 years to provide practical information, training and support for carers, many of whom are older people. ”

Victorian Government comments

“ The data presented in chapter 12 sheds light on the workings of elements of the aged care system within their particular jurisdictional context. Victoria has a strong sub-acute and rehabilitation system, which assists older people to return to the community after acute health episodes. That is supported by a particularly strong community care system with higher expenditure per head of population than other jurisdictions. However, the strength of those parts of the system means that people tend to enter residential care at a higher level of need.

Victoria has the lowest rate of residential place provision and importantly, the lowest rate of high care places of any State. This is exacerbated by a lower rate of ageing in place than other jurisdictions. The resultant pressure on other parts of the system has encouraged Victoria to introduce its own system of interim care places. Victoria's response to the Australian Government's transition care initiative will reflect the needs and opportunities particular to this environment.

The Victorian Government has made a number of initiatives during 2003-04 in response to an older population growing twice as fast as the general Victorian population. The 85+ cohort is expected to grow at a rate of 4.2 per cent per annum to 2006. A linking theme in the initiatives is to ensure that older Victorians receive care in the most appropriate setting.

The recently launched Public Sector Residential Aged Care Policy confirms the Victorian Government commitment to public sector residential age care services and sets out the Government's role in residential aged care, signalling directions for public provision. Priorities include: access for rural Victorians to residential aged care; client groups with specialised care needs; better integration of health and aged care systems; responding to changing community care preference; quality of care; and good management and financial outcomes.

Supported Residential Services (SRS) are significant providers of supported accommodation services in Victoria, their role regulated and supported by the Victorian Government. The Government has introduced reform in the SRS industry based on five key directions: support to SRS residents and to SRS proprietors, facilitating sustainability within the pension-only segment of the industry, improved regulatory processes and building relationships with key stakeholders. Substantial funds have been committed to a range of research and pilot projects. A key objective is to facilitate industry sustainability in order to increase capacity of SRS to provide services to medium to higher care residents.

The Culturally Equitable Gateways Strategy aims to improve access to mainstream HACC services for people from Culturally and Linguistically Diverse backgrounds. Local governments and ethno specific agencies will work in local partnerships. In excess of $6 million of Victorian unmatched funding has been committed. ”

Queensland Government comments

“Queensland recognises that the preference for many older people and their carers is to live independently for as long as practicable and considers enabling people to act on that preference to be a key objective. Consumer and provider organisations support the need for a continuum of community care that enables older people to age in place with support increasing in direct proportion to need. The Queensland Government achieves this through the HACC program, which is at the beginning of the aged care continuum, and is instrumental in helping older people to remain in their own homes. HACC is jointly funded by the Australian and Queensland Governments.

Planning for current and future generations has become essential as the Queensland population ages, with the number of older people expected to increase from 11.5 per cent in 2001 to more than 23 per cent in 2051. Extensive Statewide consultation with aged care service providers and their staff, general practitioners, aged care advocacy and member organisations, individual consumers/carers and volunteers informed the development of Queensland Health's *Directions for Aged Care 2004-2011*. This document provides a clear vision to guide Queensland Health and its partners towards providing even better health and support services to older people.

Queensland has established a multi-disciplinary Peer Support Network to tackle elder abuse. The Network works directly with older people who are abused or are at risk of abuse and brings together social workers, counsellors, nurses and other professionals and volunteers in the ageing and family violence sectors. The Network ensures older Queenslanders have access to the best possible services to help them prevent or put an end to abusive situations.

A person's connection with their community can be influenced by individual, social, cultural and environmental factors; when the community fails to connect with someone the consequence can be social isolation. Queensland considers the reduction of social isolation of older people to be a priority and has commenced a project to identify practice models which reduce social isolation of older people.

The Queensland Government has also embarked on a capital works program for aged care. Construction of a new $13.6 million aged care centre at Kirwan in Townsville has begun and will provide a safe and comfortable environment for 70 residents in what is promised be one of the country's most modern aged care facilities.

Queensland is committed to improving the quality of life of older people and views the upcoming review of the community care sector, including the renegotiation of the HACC Amending Agreement, as a positive process with real opportunities to improve the ways in which older people in Australia receive care and assistance. Queensland welcomes the opportunity to work with the Australian Government and all State and Territory jurisdictions to develop a new HACC Amending Agreement and to improve the delivery of aged care services in Australia through the review of the Community Care Sector.”

Western Australian Government comments

“ Western Australia continues to refine its range of programs and services according to the principle of supporting older people in the community and recommending for residential care only when other support systems are not able to meet specific needs. In line with the expressed preference of older people to remain in their own homes for as long as possible, Western Australia has implemented a range of flexible options aimed at maximising the independence of the frail elderly while minimising the need for ongoing services.

The 18-month pilot of HACC-funded ‘Enablement Packages’ designed to provide a rapid response to HACC eligible clients who are ready for discharge from hospital has had successful outcomes, with demonstrated improvement in the health status of clients. Interventions were initiated within 24 to 48 hours of admission to the program and care plans and goals for independence were based on assessed needs and negotiation with the individual client, with 60 per cent achieving their goals for independence within eight weeks. The pilot demonstrated a reduced ongoing demand for HACC services: 72 per cent (84 of the 116 clients) who received HACC services both before and after the package required reduced services afterwards.

The WA Transitional Care Service, a flexible model of care for older people at risk of premature admission to long-term services, provides short-term rehabilitation and support services either in the client’s home/hostel or temporarily in a residential aged care facility. Of the 343 admissions until 30 September 2004, 60 per cent of discharged clients returned home, with or without aged care support services.

Innovative models of service delivery to better meet the needs of specific target groups continue to be initiated through the HACC program. In April 2004, a pilot program targeting homeless HACC eligible clients commenced, and early indications are that the service is meeting previously unmet basic support needs, and is also providing an important link to housing for many clients.

Considerable recent effort has been focused on streamlining assessment procedures. With the progressive implementation of the HACC Assessment Strategy through the roll-out of the HACC Needs Identification Instrument (HNI), HACC and Aged Care Assessment Program officers are collaborating to guide implementation of the next phase in which ACATs will be the preferred providers of comprehensive assessment for the HNI. The operations of the ACATs are now being supported by the *ACAT: Towards Best Practice Manual (2004)*, which is designed to support best possible outcomes for clients and consistent ACAT assessment practices across the State. ”

South Australian Government comments

“ The Report again highlights the relatively high proportion of people aged 70 years and over in SA compared with the rest of Australia (11.1 per cent in SA compared to 9.2 per cent in Australia). As people age, there is an increased likelihood of service use, either through community care or admission to residential care.

HACC in SA nevertheless continues to have a lower expenditure per person aged 70+ than the national average, even though the expenditure per 1000 HACC target population is on a par with the national figure. SA will therefore continue to focus on improving services for frail older people in 2005.

The effectiveness of prioritising Indigenous people in HACC over a considerable number of years is now better reflected in the data. In 2002, 1.4 per cent of HACC service recipients were Aboriginal, compared to 2.2 per cent in 2004. Despite a similar emphasis for older people born in mainly non-English speaking countries, this is not as yet well reflected in the data. The reasons for this would likely be the more recent service development, and less reliable data as small volunteer community organisations become proficient in recording their activity.

The Australian and SA governments have agreed to extend the jointly funded Home Rehabilitation and Support Service until June 2005. The service provides short-term rehabilitation and support for older people who have either had an unnecessarily long stay or are at risk of an extended stay in the acute hospital system, and who are assessed as eligible for residential care. To date, the project has resulted in a return home for 60 per cent of clients, with varying levels of support, and fewer than 17 per cent being discharged to residential aged care.

The SA Government has also significantly increased funding for the Hospital Avoidance and Demand Management Program. The program involves a range of strategies and interventions broadly aimed towards providing alternative care options to people who would otherwise be hospitalised. Whilst the program is not aged care per se, it will improve the quality of life for many older people by supporting their health and immediate daily living needs in their homes and communities. In addition, the program has established an Advanced Care in Residential Living program which provides alternative acute and primary care interventions within the residential care setting to avoid the disruption of hospital admission where this is appropriate. ”

Tasmanian Government comments

“ The Tasmanian Government has continued with its reform of the State's health system. The 2004-05 Budget for health and human services now exceeds $1 billion. In addition the State Government has announced additional funding under a $75 million 'Better Hospitals Package', nearly $60 million in the transfer back to State control of, and in upgrading services at, the Mersey Community Hospital and $47 million for Mental Health Services. In total the Government has committed well over $400 million extra to health services over the next four years with the promise that there is more to come.

The State Government has recognised the challenges facing the State's hospitals and community health services, which include the need to maintain the highest standards of patient care in the face of the ageing of the population and increasing costs of new health technologies and recruiting and retaining specialist staff. The Government also acknowledges that pressures may be greater in Tasmania because the State's population is ageing more rapidly than the rest of Australia, and because of the difficulties in serving a dispersed population with the resulting diseconomies of scale.

The 'Better Hospitals Package' includes funding to establish a new non-acute service in Hobart that will complement the State's Extended Rehabilitation Service pilot and contracted 'waiting placement beds' at private residential aged care services.

The development of a partnership agreement between the Australian, State and local governments is nearing completion. The agreement details agreed action items with specified timeframes for completion. The outcomes resulting from these actions are aimed at improving community capacity in addressing issues of an ageing population, providing greater access to information; and planning and implementation processes for aged care services, in context of bed readiness and land usage.

The State Government is keen to work with the Australian Government on programs that address the needs of an ageing population, particularly in those areas at the interface between health services and aged care services. The Department of Health and Human Services' projects within the Pathways Home Program have received final approval and are being implemented in line with the five-year strategic plan. The projects will increase step-down services, increase and improve rehabilitation services and provided additional health services for the elderly.

The implementation of the Australian Government's community care strategy, 'The Way Forward', the Transition Care Program and the new Home and Community Care Agreement will have significant implications for the State. These programs need to compliment and be coherent with the State Government's health service reforms and implemented in a framework that will ensure capacity and flexibility that enables appropriate support and care is provided to Tasmania's ageing and wide disbursed population. ”

Australian Capital Territory Government comments

“ The ACT Government has undertaken a number of initiatives to support older Canberrans to maximise their independence to remain in the community.

The ACT Transitional Care Program has been established to look at innovative ways to improve the interface between hospital and home for older people. This program now has eleven residential places and eight community packages and will continue to run as a pilot until June 2005.

Community Options Transitional Support Program was introduced in 2002 as a pilot and is now recurrently funded. This program provides integrated support services to people in need of assistance following discharge from hospital for a maximum of twelve weeks.

A new position of Residential Aged Care Liaison nurse has been valuable in improving the system wide management of people waiting in hospital for nursing home placement. The nurse has built relationships across the hospital, community and residential care sector and coordinates a centralised waiting list for residential care.

A number of innovative respite care models have been introduced to support families in very flexible ways. One of these projects provides overnight respite care for aged and younger people with a disability from culturally and linguistically diverse backgrounds.

A new intermittent care service has been allocated 25 places from the Australian Government’s Aged Care Innovative Pool for 2003-04. ACT Health will provide 25 community-based packages to provide a restorative, therapeutic and social model of care for older people to improve their physical functioning and mobility to assist them to regain and maintain their activities of daily living.

A specialist stroke unit opened in November 2004 and provides intensive support to clients in a multidisciplinary team for seven days.

The Home and Community Care program will be enhanced by an additional $1.6 million in 2004-05 to support people to remain at home with access to a broad range of community-based based services.

The ACT Legislative Assembly’s Standing Committee on Health and Community Care conducted an inquiry into the prevalence of and options to prevent elder abuse in the ACT. In response to the recommendations that ACT Government has allocated $411 000 over four years to provide for a single contact telephone number to report incidences of elder abuse. The service has also developed an information and education resource kit concerning elder abuse prevention and has completed an extensive community-based based education program. ”

Northern Territory Government comments

“ The Northern Territory Government faces a major challenge in providing community care services to the most remote and most sparsely populated areas in Australia. However, the NT continues to deliver some innovative services to frail aged Territorians. Some of these innovative services models include restructuring services and pooling resources from various program sources such as Home and Community Care, Community Aged Care Packages (CACP), Allied Health Services and the Commonwealth State & Territory Disability Agreement.

New Trans-disciplinary Allied Health services for the frail aged and people with disabilities have been established in rural and remote communities in Katherine, East Arnhem and Darwin regions. A similar service model is currently being rolled out in Central Australia.

The Katherine Transitional Care Unit was launched in March 2003. The restructured Aged and Disability Team in the Katherine region now provides specialist allied health services to the Unit and has increased services to residents of remote communities in the region.

The Northern Territory is developing plans for a Multi Purpose Service (MPS) in Nhulunbuy, East Arnhem Land, which is one of the most isolated regions in Australia. The MPS will provide support and coordination to existing Aged and Disability programs in the region. Greater coordination and support between the visiting and existing services will improve the overall care in the region. A community-based based forensic disability service has been established to meet the needs of people with disabilities that had serious involvement with the criminal justice system.

It is worth noting that the report reveals major achievements that these innovations have delivered. These include the NT having the highest rate of HACC service hours and Indigenous recipients of CACPs in all jurisdictions.

It is also worth noting that Australian Government expenditure on residential care services per person in the target group in the NT is almost half that of SA. Most of the residential aged care facilities in the Northern Territory have a small number of places and are facing critical viability problems. The NT is establishing a project officer position to assist service providers in Tennant Creek to consolidate ancillary services of various providers and assist with viability issues. It is crucial that the Australian Government address the serious viability problems faced small facilities in remote and rural areas.

The NT Government is committed to working with local service providers, other jurisdictions and the Australian Government on improving outcomes for the frail aged and people with disabilities in the Northern Territory. ”

12.6 Appendix: Age standardisation of aged care data

How age profiles can distort observed service usage patterns

The age profile of Australians varies across jurisdictions and across different cultural and linguistic backgrounds, (see for example the different age profiles of Indigenous and non-Indigenous Australians — figure 12.7). Variations in age profiles are important because the likelihood of needing aged care services increases with age (table 12.13). As a result, observed differences in service usage rates by different cohorts within the community may arise from different age profiles, rather than from different usage patterns. One method of eliminating this distortion from the data is to standardise for the age profiles of different groups.

Method of standardisation

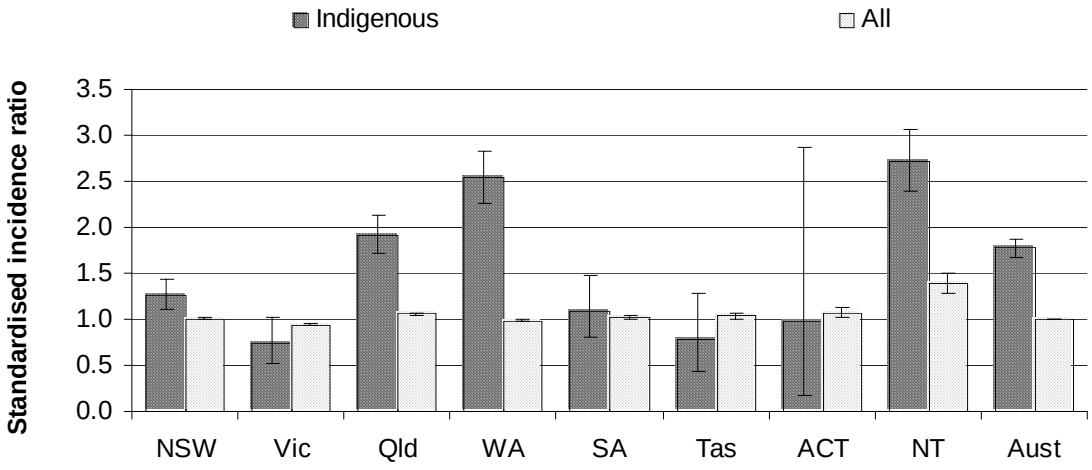
Either direct or indirect standardisation can be used; indirect standardisation is presented here because it is more appropriate when comparing small populations. This method applies standard age-specific usage rates (in this case, average Australian rates) to actual populations (different groups within states and territories), and compares observed numbers of clients with the numbers that would have been expected if average rates had applied. Comparisons are made via the standardised incidence ratio. A value greater than 1.0 in this ratio means that use is higher than expected if the particular group has the same usage rate as that of the Australian population as a whole; a value below 1.0 means use is lower than expected. Age standardisation generally covers use by all age groups, so the resulting standardised incidence ratios compare use by complete population groups, not just by those aged 70 years or over.

Application of indirect standardisation

In the following illustration, 2001 data are used. Within each State and Territory, the combined use of permanent residential aged care and CACPs by Indigenous people is compared with average service use by all Australians. The resulting standardised incidence ratios are presented in figure 12.23. The error bars in the figure show how accurate the comparisons are; if an error bar goes across the value of 1.0, then the usage rate by that population group is not significantly different from the average use by all Australians. People (Indigenous people in particular) also use long stay hospital beds, flexible places and other services not covered in the analysis; consequently, these results do not represent all the services available to people.

Figure 12.23 shows that, Indigenous people had a higher than average combined use of CACPs and permanent residential aged care — nationally, about 80 per cent higher. This result reflects the higher age-specific usage rates of CACPs for Indigenous people at all ages, and of permanent residential aged care for those Indigenous people aged under 75 years (table 12.13). The picture, however, changes from State to State: combined use of the services is not significantly different from the national average for Indigenous people in Victoria, SA, Tasmania and the ACT, but is higher than the average in NSW (about 25 per cent higher), Queensland (90 per cent higher), WA (150 per cent higher) and the NT (170 per cent higher). Looking at both Indigenous and non-Indigenous people, Victorians generally use residential aged care at a slightly lower rate than the national average, while people from Queensland, SA, Tasmania, the ACT and the NT have slightly higher than average usage rates.

Figure 12.23 **Standardised incidence ratio for use of CACP and permanent residential aged care (combined), 30 June 2001[a, b]**



a Indigenous ratio is per 1000 Indigenous people aged 50 or over, all ratio is per 1000 Indigenous people aged 50 or over and non-Indigenous people aged 70 or over **b** Uses indirect age standardisation against use by all people Australia-wide.

Source: AIHW (unpublished); table 12A.58.

Table 12.13 **Age-specific usage rates of CACPs and permanent residential aged care (per 1000 people), 30 June 2001[a, b]**

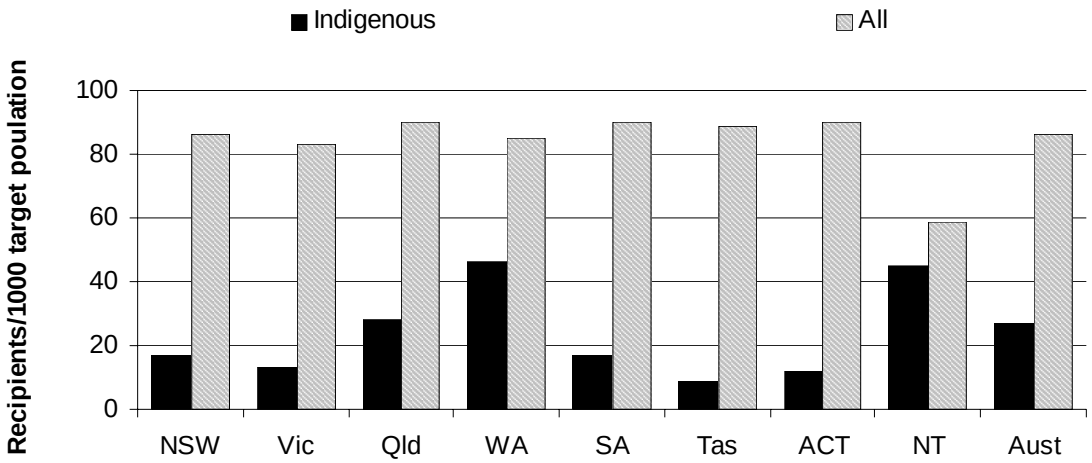
	CACP recipients		*Permanent aged care residents*	
Age (years)	*Indigenous*	*Non-Indigenous*	*Indigenous*	*Non-Indigenous*
50–54	1.7	0.1	3.3	0.7
55–59	4.1	0.3	4.2	1.4
60–64	8.6	0.7	9.5	2.9
65–69	16.3	1.5	11.4	6.1
70–74	30.1	3.2	25.2	14.5
75–79	33.7	7.1	66.3	35.3
80+	36.7	20.7	116.3	160.8

a Excludes clients of multipurpose and flexible services. **b** Cases with missing data on Indigenous status have been pro rated within gender/age groups.

Source: AIHW (unpublished).

The above picture is quite different from that given when comparing use with the target group population (clients per 1000 in the target group — figure 12.24; also used in figures 12.10 and 12.12). This measure suggests that, combined use of CACPs and permanent residential aged care is much lower for Indigenous people than for all people in all jurisdictions except the NT; even in the NT, for Indigenous people the ratio of clients to target population is about 25 per cent lower than that for all people from the NT. Figure 12.24 also suggests that combined use of the two services is generally much lower in the NT than in other jurisdictions; this difference is not apparent after age standardisation (figure 12.24), indicating that the difference in this measure is the result of the relatively young age structure of the NT.

Figure 12.24 **Ratio of CACP recipients and permanent residents (combined) to 1000 persons in target population, 30 June 2001[a]**



a Indigenous ratio is per 1000 Indigenous people aged 50 years or over, 'all' ratio is per 1000 Indigenous people aged 50 years or over and non-Indigenous people aged 70 years or over.

Source: AIHW (unpublished); table 12A.58.

12.7 Definitions of key terms and indicators

Adjusted subsidy reduction supplement

Payments made to equalise the recurrent funding paid by the Australian Government as adjusted subsidy reduction places to public sector residential care operators. The states and territories provide top-up funding for residential aged care places at a rate set by the Department of Health and Ageing from 1 July each year.

Aged care

Formal services funded and/or provided by governments, that respond to the functional and social needs of frail older people, and the needs of their carers. Community aged care services aim to optimise independence and to assist frail older people to stay in their own homes, while residential care services provide accommodation and care for those who can no longer be assisted to stay at home.

The majority of aged care services assist in activities of daily living such as personal care (for example. bathing and dressing), housekeeping and meal provision, and are delivered by trained aged care workers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists. These services generally aim to maintain function rather than treat illness or rehabilitate, and are distinguished from the health services described in Part E of this report. Assessment of care needs is also an important component of aged care.

Aged care services may be funded through programs specifically or mainly directed to older people, or through programs that address the needs of people of different ages. Generally, the target groups of aged care services are people over the age of 70 years and Indigenous people aged over 50 years.

Ageing in place

An approach that aims to provide residents with appropriate care and increased choice by allowing them to remain in the same facility regardless of their levels of care needs. It also allows couples with different levels of care needs to be cared for in the same facility. The main facet of 'ageing in place' is that funding is tied to the assessed care needs of the client rather than to the services provided by the facility.

One of the objectives of Commonwealth aged care legislation is 'to promote ageing in place through the linking of care and support services to the places where older people prefer to live' (*Aged Care Act 1997* (Cwlth), s.2-1 [1j]).

Centre day care

Respite care provided from a facility such as a day care or health centre. Respite care is usually combined with social support services to maintain the functional capabilities of the person receiving care.

Complaint

A complaint by the affected care recipient or his or her representative, or anyone else, to the Secretary about anything that:

- may be a breach of the relevant approved provider's responsibilities under the *Aged Care Act 1997* or the Aged Care Principles
- the complainant thinks is unfair or makes the affected care recipient dissatisfied with the service.

Disability	A limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.
EBA supplement	Payments made to supplement services for the extra costs associated with public sector enterprise bargaining agreements over and above those required by other wage Awards.
Elapsed time between ACAT approval and entry into a residential care service	The measure of the elapsed time between ACAT approval and entry into a residential care service. It has been used in past years as an indicator of access to residential care.
High/low care recipient	Recipient of a high level of residential care (that is, a level to RCS levels 1–4) or a recipient of a low level of residential care (that is, a level corresponding to RCS levels 5–8). If the person is approved as a recipient of a high level of care, that person can receive care at any care classification level (*Approval of Care Recipients Principles 1997*, s.5-9). A person approved as a recipient of a low level of care can be classified only as RCS 5–8 (*Classification Principles 1997*, s.9-19).
In-home respite	A short term alternative for usual care.
People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Where a person does not need assistance, but has difficulty with self care, mobility or communication.
People with a profound disability	Where a person is unable to perform self-care, mobility and/or communication tasks, or always needs assistance.
People with a severe disability	Where a person sometimes needs assistance with self-care, mobility or communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing).
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (*Aged Care Act 1997* (Cwlth)); also refers to 'beds' (*Aged Care (Consequential Provisions) Act 1997* (Cwlth), s.16).
Real expenditure	Actual expenditure adjusted for changes in prices, using the GDP(E) price deflator and expressed in terms of final year prices.
Resident	For the purposes of the *Aged Care Act 1997*, a person who is being provided with residential care through an aged care service conducted by an approved provider under the Act.
Respite care	Alternative care arrangements for dependent people living in the community, with the primary purpose of giving their carer a short term break from their usual caring commitments.
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 Aged Care Act, specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from non-English speaking countries; people who live in rural or remote areas; and people who are financially or socially disadvantaged. Principles (Regulations) made under s. 11-3 also specify veterans as a special needs group.

Veterans	Veterans, their war widows, widowers and dependents who are eligible for treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlements Act 1986* (Cwlth).

12.8 References

ABS (Australian Bureau of Statistics) 2001, *Estimated Residential Population, by Age and Sex*, Cat no. 3101.0, Canberra.

—— 2003, *Australian Standard Geographic Classification*, Cat no. 1216.0, Canberra.

—— 2004, *Survey of Disability, Ageing and Carers, 2003*, Cat no. 4430.0, Canberra.

—— unpublished, *Population Projections by Statistical Local Area, 2002-2022*, Canberra.

—— unpublished, Australian Demographic Statistics, Cat no. 3101.0, Canberra.

—— unpublished, *States and Population by Age and Sex, Australian Territories*, Cat no. 3201.0, Canberra.

—— unpublished, *Population Projections, Australia*, Cat no. 3202.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 2002, *Entry Period for Residential Aged Care*, Cat. no. AGE 24, AIHW Aged Care Series no. 7, Canberra.

DHA (Department of Health and Ageing) 2004, *Report on the Operation of the Aged Care Act 1997, 1 July 2003 to 30 June 2004*, Canberra.

Lincoln Centre for Ageing and Community Care Research 2004, *Aged Care Assessment Program: National Minimum Data Set Report: July 2002 – June 2003*, La Trobe University, Melbourne.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2001, *Report on Government Services 2001*, Productivity Commission, Canberra.

—— 2002, *Report on Government Services 2002*, Productivity Commission, Canberra.

—— 2003, *Report on Government Services 2003*, Productivity Commission, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision), 2004, *Report on Government Services 2004*, Productivity Commission, Canberra.

13 Services for people with a disability

The Australian, State and Territory governments aim to maximise opportunities for people with a disability to participate actively in the community, by providing services and support for people with a disability, their families and carers. A definition of disability is provided in box 13.1.

Following negotiations among the Australian, State and Territory governments in 2003, all jurisdictions entered a third five year disability services agreement — the Commonwealth State/Territory Disability Agreement (CSTDA) — for the period 1 July 2002 to 30 June 2007.[1] This agreement forms the basis for the provision and funding of specialist services for people with a disability who require ongoing or long term episodic support.

This chapter focuses on services covered by the CSTDA, examining the performance of the Australian, State and Territory governments in providing services and supports for people with a disability where the disability manifests before the age of 65 years. Psychiatric services are excluded to improve data comparability.

Services for people with a disability can be grouped into income support, disability support services and relevant generic services provided to the community as a whole. The Review of Government Service Provision generally does not report information on income support. Disability support services are primarily delivered under the CSTDA, as well as through programs such as Home and Community Care (HACC). The HACC program aims to prevent inappropriate or premature admission to residential care by providing basic maintenance and support services to frail older people, younger people with a disability, and their carers. An estimated 68.5 per cent of HACC clients in 2003-04 were aged 70 years or over, while 31.5 per cent were aged under 70 years (table 12A.32). Performance information on the HACC program is provided in the 'Aged care services' chapter. This Report does not provide performance information on rehabilitation services for people with a disability.

[1] While the CSTDA was negotiated in 2003, it applied retrospectively to the funding and provision of services from 1 July 2002.

Box 13.1 **Definition of disability**

Disability is conceptualised as being a multidimensional experience for the person involved, relating to body functions and structures, activities, and the life areas in which the person participates (WHO 2001). The International Classification of Functioning, Disability and Health also recognises the role of physical and social environmental factors in affecting disability.

The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers was conducted in 1981, 1988, 1993, 1998 and 2003, and was based on the International Classification of Functioning, Disability and Health and its predecessor. The 2003 survey defined a disability as a limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.

Self-care, mobility and communication are defined as core activities. The ABS defines levels of core activity limitation as follows:

- mild — where a person does not need assistance and has no difficulty with self-care, mobility and/or communication, but uses aids or equipment
- moderate — where a person does not need assistance, but has difficulty with self-care, mobility and/or communication
- severe — where a person sometimes needs assistance with self-care, mobility and/or communication tasks; has difficulty understanding or being understood by family or friends; or can communicate more easily using sign language or other non-spoken forms of communication
- profound — where a person is unable, or always needs assistance, to perform self-care, mobility and/or communication tasks.

The CSTDA (2003, p. 9) defines people with a disability (who would receive CSTDA funded services) as:

> People with disabilities attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is likely to be permanent and results in substantially reduced capacity in at least one of the following:
>
> - self-care/management
> - mobility
> - communication,
>
> requiring significant ongoing and/or long term episodic support and which manifests itself before the age of 65.

Source: ABS (2004a); WHO (2001); CSTDA (2003).

Some mainstream services provided to the community as a whole — for example, vocational education and training (VET), school education, public hospital care, specialised mental health services and public housing — are covered elsewhere in this Report (box 13.2). Other mainstream services provided to people with a

disability — such as transport and utility services at concessional rates — are outside the scope of this Report.

Box 13.2 **Other disability reporting in the 2005 Report**

'School education' (chapter 3) reports data on students with a disability in the student body mix.

'Vocational education and training' (VET) (chapter 4) reports the proportion of government funded VET students who are known to have a disability, and the load pass rates of VET students who are known to have a disability.

'Health management issues' (chapter 11) reports performance data on specialised mental health services.

The 'Community services preface' reports data on recurrent expenditure on services for people with a disability.

'Aged care services' (chapter 12) reports data on the level of HACC services received by people with a profound, severe or moderate core activity limitation, disaggregated by jurisdiction and geographic location.

'Children's services' (chapter 14) reports data on the representation of children with a disability in Australian Government approved child care.

'Housing' (chapter 16) reports data on access to public, community and State owned and managed Indigenous housing by special needs households, which include households that have at least one member with a disability. Also reported are Disability Support Pension recipients by the proportion of their income spent on rent with and without Commonwealth Rent Assistance.

In recognition of the changing information needs in the disability services field, a redeveloped national minimum data set (NMDS) collection under the CSTDA was implemented during 2002-03 (box 13.6). Given this redevelopment, data for 2002-03 collected under the new NMDS were available for reporting for most jurisdictions only for the period 1 January 2003 to 30 June 2003. Full year data will be reported in the 2006 Report. The redevelopment of the NMDS under the CSTDA has resulted in some reductions in data quality in the first collection that impose limitations on the ability to generalise from the data (box 13.7)

This Report includes 2003-04 expenditure data that were provided directly by jurisdictions. Efficiency indicators (cost per service user) are reported for 2002-03, however, because 2003-04 service user data from the new CSTDA NMDS collection were not available for this Report. The 2002-03 expenditure data used to calculate some of the efficiency indicators were adjusted to account for some of the quality issues related to the first collection under the CSTDA NMDS (box 13.7). The efficiency results using these adjustments provide only indicative estimates.

Social participation, labour force participation and employment rate data for 2003 are reported for all jurisdictions, and 2004 social participation data is also included for WA. Information on quality assurance processes for disability services providers in 2003-04 are available for four jurisdictions — the Australian Government, Victoria, WA and Tasmania.

A profile of services for people with a disability provided under the CSTDA appears in section 13.1. All jurisdictions have developed and agreed to report against comparable performance indicators. A framework of performance indicators is outlined in section 13.2. The performance of jurisdictions is discussed in section 13.3 and future directions for performance reporting are discussed in section 13.4. The chapter concludes with jurisdictions' comments in section 13.5 and definitions of the data descriptors and indicators in section 13.6.

Supporting tables

Supporting tables for chapter 13 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel format as \Publications\Reports\2005\Attach13A.xls and in Adobe PDF format as \Publications\Reports\2005\Attach13A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 13A.3 is table 3 in the electronic files). These files can be found on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

13.1 Profile of disability services

Service overview

The Australian, State and Territory governments fund both government provided and non-government provided services for people with a disability. Regimes for the funding and delivery of disability services differ across jurisdictions as a result of policy differences and other factors described in the statistical appendix (see appendix A). The Australian Government administers employment services, and the State and Territory governments administer accommodation support, community access, community support and respite care services. Advocacy, information and print disability services are jointly administered by the Australian, State and Territory governments. Details of these services are outlined below.

Roles and responsibilities

The CSTDA between the Australian, State and Territory governments defines their roles and responsibilities in the provision of specialist disability services to people with a disability. The third national agreement, the CSTDA, is effective from 1 July 2002 to 30 June 2007. Its agreed aims are listed in box 13.3. Specialist disability services are defined under the CSTDA as services that are specially designed from time to time to meet the needs of people with a disability.

The Australian Government administers the following services:

- Open employment services provide employment assistance to people with a disability in obtaining and/or retaining paid employment in the open labour market.
- Supported employment services provide support and employ people with a disability within the same organisation.
- Open and supported employment services provide both open and supported employment assistance.

Box 13.3 **The purposes of the CSTDA**

The purposes of the CSTDA are to:

- provide a national framework to underpin the provision of specialist disability services across Australia, and outline a means for measuring and publicising the progress of governments towards achieving this national framework
- outline the respective and collective roles and responsibilities of governments in the planning, policy setting and management of specialist disability services
- provide for accountability to funders in respect of funds contributed by one government which are expended by another government
- establish the financial arrangements for making funds available for the provision of specialist disability services
- define the persons eligible for services under this Agreement and acknowledge they may require services provided outside the Agreement
- provide for a nationally consistent approach to quality across specialist disability services
- provide for funds to address key national and strategic research, development and innovation priorities.

Source: CSTDA (2003).

The State and Territory governments administer the following services:

- Accommodation support services provide support services to people with a disability in accommodation settings (hostels, institutions and group homes), and in their own home (attendant care and in-home support).
- Community access services provide opportunities for people with a disability to gain and use their abilities to enjoy their full potential for social independence. They include learning and life skills development and recreation/holiday programs.
- Respite care services provide relief or support (for limited periods) to families and carers of people with a disability living in the community.
- Community support services help people with a disability to integrate and participate in the community, and include case management, counselling, early intervention therapy and other therapy services.

Services for which the Australian, State and Territory governments share administration include:

- advocacy services, which enable people with a disability to increase their control over their lives by representing their interests and views in the community
- information services, which provide accessible information to people with a disability, their carers, their families and related professionals about disabilities, specific and generic services, and equipment, and promote the development of community awareness
- print disability services, which produce alternative communication formats for people who, by reason of their disability, are unable to access information provided in a print medium
- research and development services.

The CSTDA does not apply to the provision of:

- disability services and activities provided under the *Veterans' Entitlements Act 1986* (Cwlth)
- services with a specialist clinical focus, regardless of whether those services are provided to people eligible to receive other services under this agreement.

Family and friends meet most needs of people with a disability. In 2003, an estimated 474 600 primary carers provided the majority of help with self-care, mobility and communication for people with a disability — an increase of 5.3 per cent on the number in 1998 (ABS 1999, 2004a). Recognising the cost of providing such informal support, the Australian Government provides income support in the form of the Carer Payment and other financial assistance through the

Carer Allowance to families and carers of people with a disability (box 13.4). This financial assistance is not included under the CSTDA funding arrangements.

Accommodation support, respite, and community access and support services provided under the CSTDA from 1 January 2003 to 30 June 2003 had 102 240 service users (table 13A.4). Employment services provided under the CSTDA from 1 January 2003 to 30 June 2003 had 54 952 service users (table 13A.4). The proportion of users who received services from non-government organisations from 1 January 2003 to 30 June 2003 varied across jurisdictions, from 89.8 per cent in Tasmania to 61.8 per cent in NSW, with the national average at 76.9 per cent (table 13A.4).

Box 13.4 **Australian Government supplementary and income support arrangements**

The Australian Government funds payments for people with a disability, those caring for people with a disability and those temporarily incapacitated from work as a result of illness. These payments include the Disability Support Pension, the Carer Payment, the Carer Allowance, the Sickness Allowance and the Mobility Allowance. Outlays on payments to people with a disability in 2003-04 (on an accrual basis) amounted to $7.5 billion for the Disability Support Pension, $921.0 million for the Carer Payment (including a one-off bonus announced in the 2004-05 budget), $965.4 million for the Carer Allowance (including a one-off bonus announced in the 2004-05 budget), $85.4 million for the Sickness Allowance and $82.2 million for the Mobility Allowance (Department of Family and Community Services (DFaCS) unpublished). These income support arrangements do not constitute a CSTDA service.

At 30 June 2004, there were over 696 700 recipients of the Disability Support Pension, 84 100 recipients of the Carer Payment, 315 100 recipients of the Carer Allowance, and 46 800 recipients of the Mobility Allowance. There were also 8700 recipients of the Sickness Allowance (table 13A.51).

Source: DFaCS (unpublished); table 13A.51.

Funding

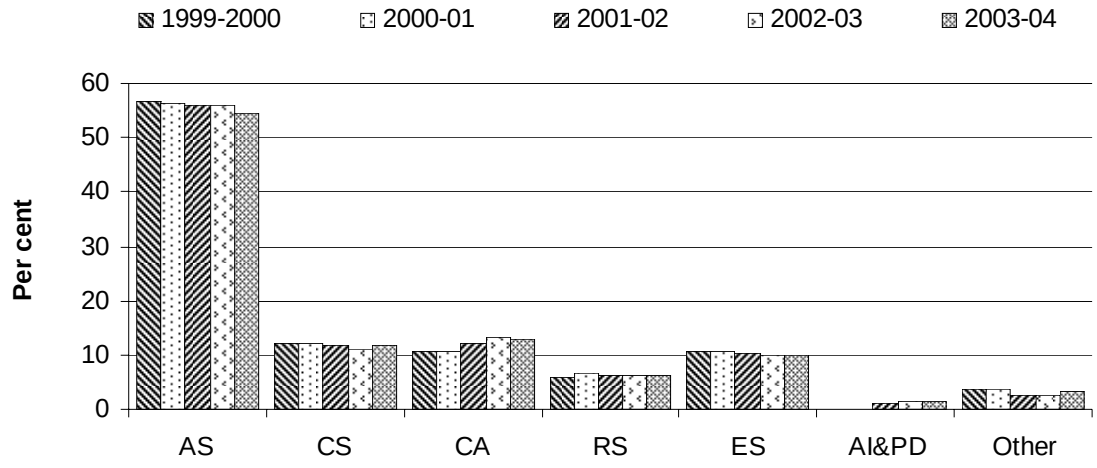
Governments fund both government and non-government providers of services for people with a disability under the CSTDA, the HACC program and Commonwealth Rehabilitation Services (CRS) Australia. HACC services are reported in the 'Aged care services' chapter but CRS Australia's services are not covered in this Report. The Australian Government contributed $199.2 million in 2003-04 to services provided by CRS Australia (DFaCS unpublished).

Total government expenditure on CSTDA services was $3.3 billion in 2003-04 — a real increase of 6.0 per cent on the expenditure in 2002-03 ($3.1 billion) (table 13A.38). State and Territory governments funded the majority (71.6 per cent, or $2.3 billion) of total CSTDA expenditure in 2003-04 (tables 13A.37 and 13A.39). The Australian Government funded the remainder (28.4 per cent, or $928.8 million), which included $550.3 million in transfer payments to states and territories, and $378.5 million in employment assistance and other services (table 13A.37).

State and Territory governments spent $2.6 billion directly on CSTDA services in 2003-04, which included $1.6 billion on accommodation support services, $380.6 million on community access services and $625.6 million on other services for people with a disability. The Australian Government spent $350.6 million directly on CSTDA services, which included $301.3 million on employment services (table 13A.37).

The distribution of expenditure across CSTDA services varied across jurisdictions in 2003-04. The main areas of State and Territory government expenditure were accommodation support services (54.6 per cent of total direct service delivery expenditure by government) and community access services (12.9 per cent of total direct service delivery expenditure by government). Employment services were the main area of Australian Government expenditure in 2003-04 (10.1 per cent of total direct service delivery expenditure by government) (figure 13.1).

Figure 13.1 **Distribution of expenditure, by disability service type[a]**



AS = accommodation support; CS = community support; CA = Community access; RS = respite services; ES = employment services; AI&PD = advocacy, information and print disability. **a** See table 13A.37 for detailed notes accompanying expenditure data.

Source: Australian, State and Territory governments (unpublished); table 13A.39.

In recent years, governments have increased funding for community-based accommodation support services to further enable people with a disability to participate in the community. In addition, some jurisdictions have developed programs that provide funding directly to service users. These programs allow service users to choose a customised package of services that better reflects their needs (SCRCSSP 1998).

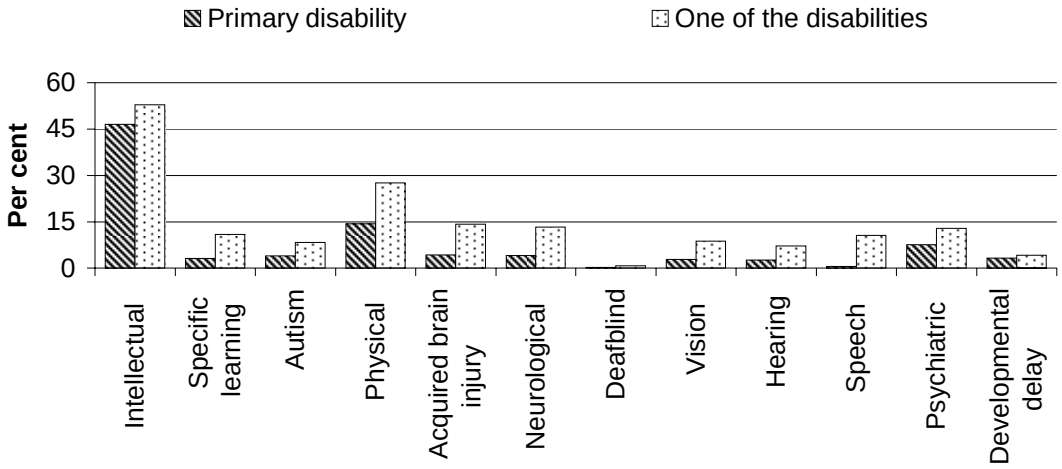
Size and scope

Performance indicators on services provided under the CSTDA in 2002-03 are reported in this chapter, based on service user data for the period 1 January 2003 to 30 June 2003. These indicators focus mainly on accommodation support and employment services, which accounted for 65.8 per cent of total government direct expenditure on services provided under the CSTDA in 2002-03 (table 13A.39).

The 2003 ABS Survey of Disability, Ageing and Carers estimated that people with a core activity limitation, schooling or employment restriction accounted for 13.0 per cent of the total Australian population aged 5–64 years in 2003 (ABS 2004a). Tables 13A.1 and 13A.2 contain additional information from that survey on people with a disability.

Data provided by the Australian Institute of Health and Welfare (AIHW) for 1 January 2003 to 30 June 2003 indicate that 52.8 per cent of CSTDA service users had an intellectual disability and 46.6 per cent of service users had an intellectual disability as a primary disability (figure 13.2).

Figure 13.2 **Service users by disability group, 1 January 2003 to 30 June 2003[a, b, c]**



a Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Totals might not be the sum of the components because individuals may have accessed services from more than one State or Territory over the six month period. **b** Data for service users of CSTDA services funded by the states and territories exclude psychiatric services identified by the jurisdiction. **c** These data need to be viewed with care, being the first data available under the new CSTDA NMDS. Data will improve in future years as the collection process is refined.

Source: AIHW (2004a, 2004b); tables 13A.6 and 13A.8.

13.2 Framework of performance indicators

The Australian, State and Territory governments will continue to work cooperatively and independently to implement the policy priorities progressively over the life of the CSTDA, and they will regularly report progress against achievements. The framework of performance indicators is based on shared government objectives of CSTDA funded services for people with a disability (box 13.5).

Box 13.5 **Objectives of government funded services for people with a disability**

The 2002-03 performance data for this Report cover services provided under the CSTDA. Through this agreement, governments strive to enhance the quality of life experienced by people with a disability by assisting them to live as valued and participating members of the community. In working towards this objective, governments have five policy priorities:

- Strengthen access to generic services for people with disabilities.
- Strengthen across-government links. (Bilateral agreements between the Australian Government and each State and Territory have been negotiated to improve the interface between employment and community access services).
- Strengthen individuals, families and carers.
- Improve accountability, performance reporting and quality.
- Improve long term strategies to respond to, and manage demand for, specialist disability services.

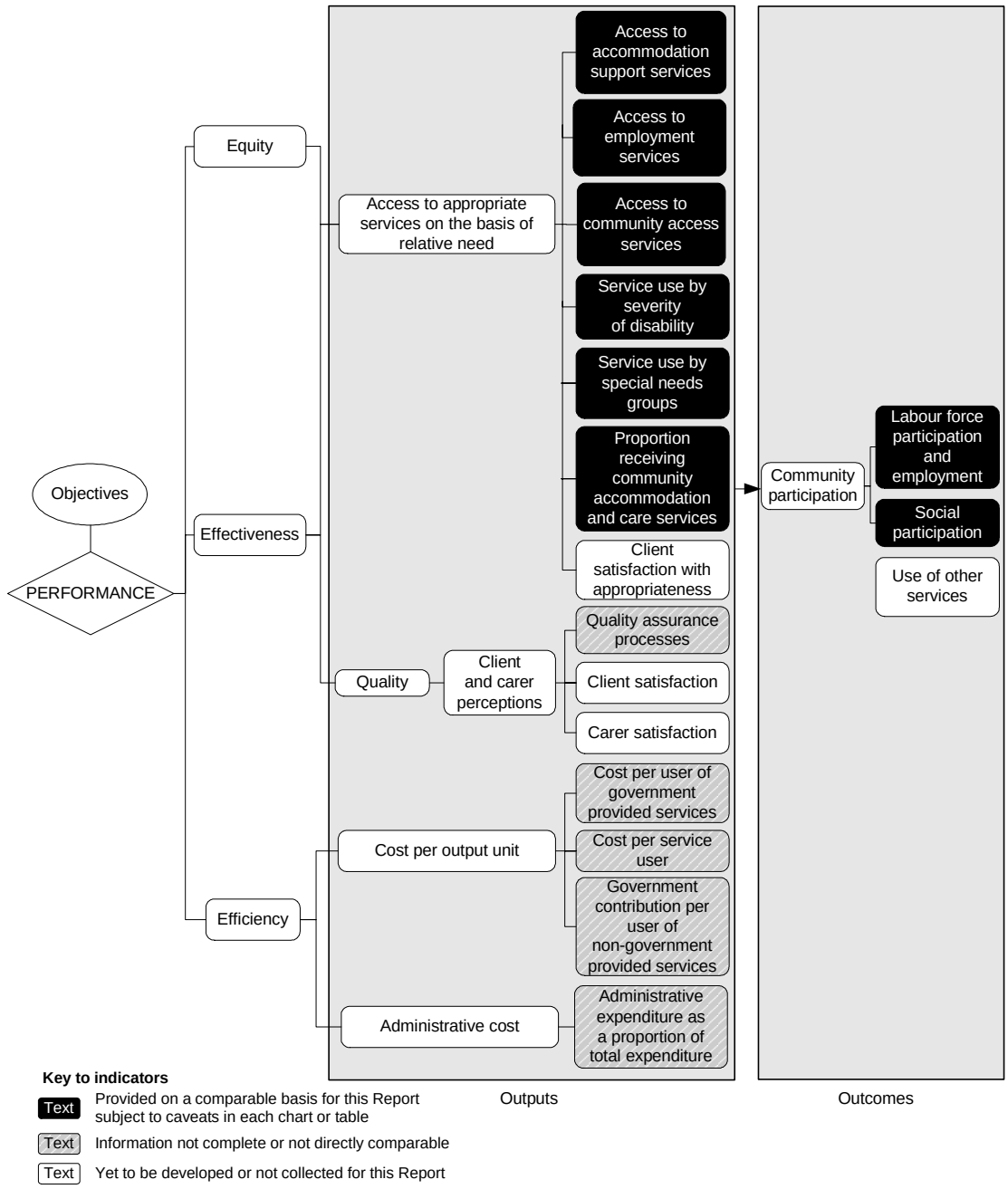
Source: CSTDA (2003).

The performance indicator framework shows which disability services data are comparable in the 2005 Report (figure 13.3). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of government funded services for people with a disability. This is consistent with the general performance indicator framework and service process diagram (figures 1.2 and 1.3, chapter 1) on which the Steering Committee has agreed.

Proxy efficiency indicators focus on unit costs and administrative costs. Effectiveness and equity indicators focus on service quality and appropriateness. Outcome indicators focus on the ability of people with a disability to participate in the community.

Figure 13.3 **Performance indicators for disability services**



13.3 Key performance indicator results

Different delivery contexts, locations and client characteristics may affect the equity, effectiveness and efficiency of disability services. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter.

The performance indicator results reported in this chapter relate to CSTDA services only. The CSTDA NMDS coordinated by the AIHW was the main source for most of the 2002-03 data reported. As stated, the reporting period for these data was 1 January 2003 to 30 June 2003. As the reporting time frame is six months, the 2002-03 data will not be comparable to future reports that will use whole-of-year data. There are also issues regarding the quality of the CSTDA NMDS 2002-03 data (box 13.7). Most notably, the proportion of service users and service outlets that provided data (response rates), and the 'not stated' rates of particular data items varied across jurisdictions. Expenditure data for the efficiency indicators were sourced from the Australian, State and Territory governments.

The performance indicator data for before 2002-03 were sourced mainly from the Commonwealth/State Disability Agreement (CSDA) minimum data set (MDS), which was based on a snapshot day collection. The main differences between the CSTDA and the CSDA data sets are discussed in box 13.6. The change from the CSDA MDS to the CSTDA NMDS means that performance information for 2002-03 (collected under the CSTDA) is not comparable to performance information for years before 2002-03 (collected under the CSDA). While these data sets are not comparable, data from the CSDA MDS up to 2002 (contained in previous reports) is provided for information in tables 13A.3, 13A.5, 13A.7, 13A.9, 13A.13, 13A.15, 13A.17, 13A.19, 13A.21, 13A.23, 13A.25, 13A.27, 13A.29, 13A.31, 13A.33, 13A.35, 13A.40, 13A.41, 13A.44, 13A.45 and 13A.47.

Box 13.6 **Development of the CSTDA NMDS**

Since 1994, the CSDA MDS snapshot collections have provided funding bodies, funded agencies (service providers), service users and other stakeholders with information about services delivered under the CSDA and the people receiving those services. This information was collected, however, only on one snapshot day in the year.

In 1999, the National Disability Administrators and the AIHW began to review and redevelop the CSDA MDS collection. The redeveloped collection was fully implemented nationally in October 2002 and is now referred to as the CSTDA NMDS. The first collection period for the CSTDA NMDS ended 30 June 2003.

Given the time taken to redevelop and implement the collection, the 2002-03 CSTDA data include only part-year data (from 1 January 2003 to 30 June 2003) for all jurisdictions, with whole-of-year data expected for post 2002-03 collections. As with its predecessor, the CSTDA NMDS has an agreed set of data items of national significance, and an agreed framework for collection and national collation. Data items relate to the equity, efficiency and effectiveness of services.

(Continued on next page)

Box 13.6 **(Continued)**

The most significant change from the CSDA MDS to the CSTDA NMDS collection is that for most service types, funded agencies are required to provide information about all service users throughout the year (rather than just those who received a service on a snapshot day). Less detail, however, is asked about service users for some service types than others. Accommodation and community support services, for example, provide all data items relating to service users, whereas recreation or holiday program providers provide minimal information (for example, selected letters of name, sex and date of birth). As with the previous collection, services such as advocacy and print services are not required to provide service user details.

A small number of new data items have been introduced into the CSTDA NMDS, including items on informal carers (in recognition of the mutual support among people with a disability, informal carers and formal services) and the fact that program goal statements are recognising the importance of ageing carers in particular.

In specifying revised core data items for ongoing collection by all service providers funded under the CSTDA, the CSTDA NMDS:

- aims to meet critical data needs across the disability field, and to be consistent with other major data developments such as the HACC MDS
- integrates data collation with the operations of agencies and funding departments
- uses statistical linkage keys to enable data from various sources to be related and collated without duplication of effort
- uses statistical linkage keys to account for double counting of service users.

Source: AIHW (2003a).

Data in this Report sourced from the CSTDA NMDS may differ from information reported elsewhere because the data here exclude users of psychiatric services. Expenditure data sourced from jurisdictions' collections might also differ from information reported elsewhere (such as in departmental annual reports) because the financial counting rules and definitions used to calculate expenditure may differ.

The number of service users receiving accommodation support services from 1 January 2003 to 30 June 2003 has been estimated from the data collected from service type outlets and agencies, using a statistical linkage key to remove double counting for service users who received services from more than one service type outlet or agency. This is possible because the statistical linkage key enables, with a small degree of error, the identification of multiple data records belonging to the same individual, but without identifying the individual.

The expenditure data used to calculate some of the efficiency indicators (cost per service user) were adjusted to account for differences across jurisdictions in the proportion of service outlets that provided data for the CSTDA NMDS collection.

The proportion of service outlets that provided data for government provided accommodation support services in group homes, for example, ranged from 100.0 per cent to 74.4 per cent across jurisdictions (table 13A.43). The expenditure data were also adjusted to account for differences in the period for which expenditure and service user data were collected (12 months and six months respectively). The results derived using the expenditure adjustments provide only indicative estimates of jurisdictional efficiency. Box 13.7 outlines the method used to adjust the expenditure data.

Box 13.7 **Data quality issues and method for adjusting expenditure**

The development of the CSTDA NMDS has meant that the volume and complexity of the data are much greater than in previous snapshot day collections. As usual with major changes to data collections, some data quality reductions have thus resulted in the first collection. In particular, the proportion of service users and service outlets that provided data (response rates) and the 'not stated' rates of particular data items vary across jurisdictions. These issues limit the potential to generalise from the data. The 2002–03 CSTDA NMDS collection also has the limitation that national data are available only for a six month period.

The 2002-03 expenditure data used to calculate the efficiency indicators (cost per service user) were adjusted to account for differences in:

- the proportion of service outlets that provided service user data across jurisdictions
- the time period for which expenditure and service user data were collected (12 months and six months respectively). Under the CSTDA NMDS, service user data were collected only for the period 1 January 2003 to 30 June 2003.

The first expenditure adjustment improved the comparability of the efficiency indicators across jurisdictions by weighting expenditure by the estimated proportion of service user data provided. The adjustment was made for each accommodation support service type and jurisdiction by multiplying net expenditure by the proportion of service outlets that provided service user data. The proportion of service outlets that provided data was used as the best available estimate of the proportion of service user data provided. That is, if 70 per cent of outlets provided data, it is assumed that only 70 per cent of service user data had been provided. In using this proportion, it is assumed that non-responding service outlets, on average, had the same number of users as had those outlets that responded. This approach does not account for service users who accessed services from responding service outlets but were not recorded.

(Continued on next page)

Box 13.7 **(Continued)**

The second adjustment will improve the comparability of the 2002-03 efficiency indicators with those in future reports (which will be based on full year CSTDA NMDS collections). The adjustment was made for each service type by multiplying the 12 month net expenditure data by a factor calculated to allow for the six month service user data. The factors for each of the accommodation support services were based on WA data, as WA was one of the jurisdictions that collected a full 12 months of service user data. These factors were calculated by taking the ratio of the number of service users in the six month period to the number of service users over the 12 month period.

The results derived using these adjustments provide only indicative estimates of jurisdictional efficiency.

Source: AIHW (2004b).

Outputs

Equity and effectiveness — access to appropriate services on the basis of relative need

Indicators relating to access to disability services on the basis of relative need are reported for accommodation support services, employment services and community access services. One indicator of access to services on the basis of relative need is the proportion of the potential population using the service. The potential populations for accommodation support, employment and community access services are defined in section 13.6. Data are also reported on access to accommodation support and employment services by severity of disability and for special needs groups.

Access to accommodation support services

The 'access to accommodation support services' indicator is explained in box 13.8.

Box 13.8 **Access to accommodation support services**

The proportion of people using accommodation support services relative to estimated potential population is included as an output (access) indicator of governments' objective to provide access to government funded or provided disability services on the basis of relative need and available resources.

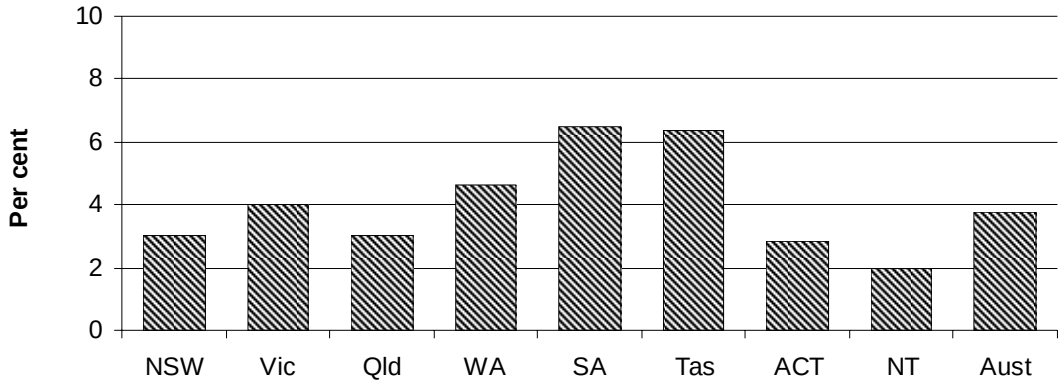
This indicator is defined as the number of people using CSTDA funded accommodation support services divided by the estimated potential population (total population of people with a profound or severe disability who are aged 0–64 years, adjusted for the Indigenous factor for each jurisdiction).

A higher proportion of the potential population using accommodation support services suggests greater access to these services.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. The need for services is assumed to vary according to the level of core activity limitation, so core activity limitation is used as a proxy for relative need.

Nationally, 3.7 per cent of the estimated potential population were using CSTDA funded accommodation support services from 1 January 2003 to 30 June 2003. Across jurisdictions, the proportion was highest in SA (6.5 per cent) and lowest in the NT (2.0 per cent) (figure 13.4).

Figure 13.4 **Users of accommodation support services as a proportion of the estimated potential population for accommodation support services, 1 January 2003 to 30 June 2003[a, b, c, d, e]**



a Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. **b** Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Totals might not be the sum of the components because individuals may have accessed services from more than one State or Territory over the six month period. **c** The potential population estimates (national age and sex rates applied to each jurisdiction) for accommodation support services are the number of people aged less than 65 years, who have a profound or severe core activity limitation, adjusted for the Indigenous factor for each jurisdiction. **d** Data for service users of CSTDA funded accommodation support services exclude psychiatric services identified by the jurisdiction. **e** The service user data used to derive this indicator have quality issues related to the development of the new CSTDA NMDS. These issues include differences in the proportion of service outlets that responded across jurisdictions (box 13.7). This indicator thus needs to be interpreted with care.

Source: ABS (2002a, 2004b); AIHW (2004a, 2004b); AIHW analysis of the 2003 ABS Survey of Disability, Ageing and Carers data; table 13A.14.

Access to employment services

During the reporting period, the Australian Government had responsibility for employment services under the CSTDA and provided most services through funding non-government organisations. The 'access to employment services' indicator is explained in box 13.9.

Box 13.9 **Access to employment services**

The proportion of people using employment services relative to the estimated potential labour force is included as an output (access) indicator of governments' objective to provide access to government funded or provided disability services on the basis of relative need and available resources.

(Continued on next page)

Box 13.9 **(Continued)**

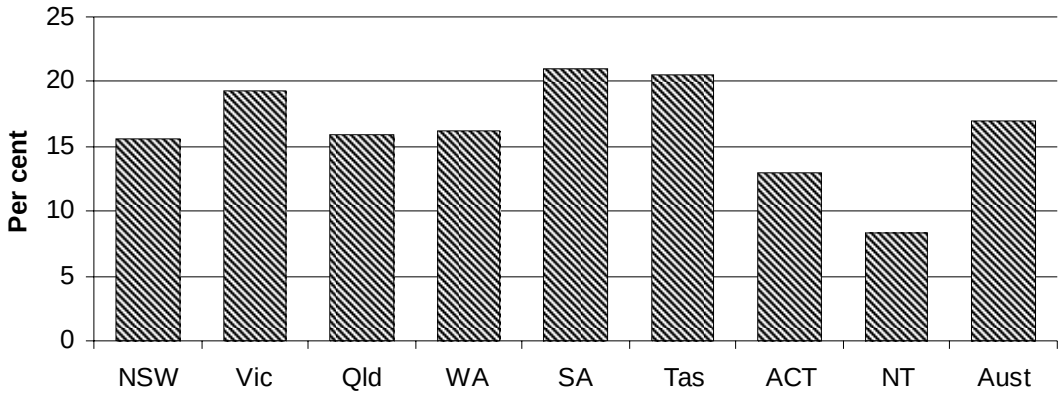
This indicator is defined as the number of people using CSTDA funded employment services divided by the estimated total population of people with a profound or severe disability who are aged 15–64 years, adjusted for the labour force participation rate and the Indigenous factor for each jurisdiction.

A higher proportion of people using employment services suggests greater access to these services.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. The need for services is assumed to vary according to the level of core activity limitation, so core activity limitation is used as a proxy for relative need.

Nationally, 17.0 per cent of the estimated potential population were using employment services from 1 January 2003 to 30 June 2003. Across jurisdictions, the proportion was highest in SA (21.0 per cent) and lowest in the NT (8.3 per cent) (figure 13.5).

Figure 13.5 **Users of employment services as a proportion of the estimated potential population for employment services, 1 January 2003 to 30 June 2003[a, b, c]**



a Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. **b** Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Totals might not be the sum of the components because individuals may have accessed services from more than one State or Territory over the six month period. **c** The potential population estimates (national age and sex rates applied to each jurisdiction) for employment services are the number of people aged 15-64 years who have a severe or profound core activity limitation, multiplied by both the Indigenous factor and the labour force participation rate for each jurisdiction.

Source: ABS (2002a, 2002b, 2004b); AIHW (2004a, 2004b); AIHW analysis of the 2003 ABS Survey of Disability, Ageing and Carers data; table 13A.16.

Access to community access services

The 'access to community access services' indicator is explained in box 13.10.

Box 13.10 **Access to community access services**

The proportion of people using community access services relative to the estimated potential population is included as an output (access) indicator of governments' objective to provide access to government funded or provided disability services on the basis of relative need and available resources.

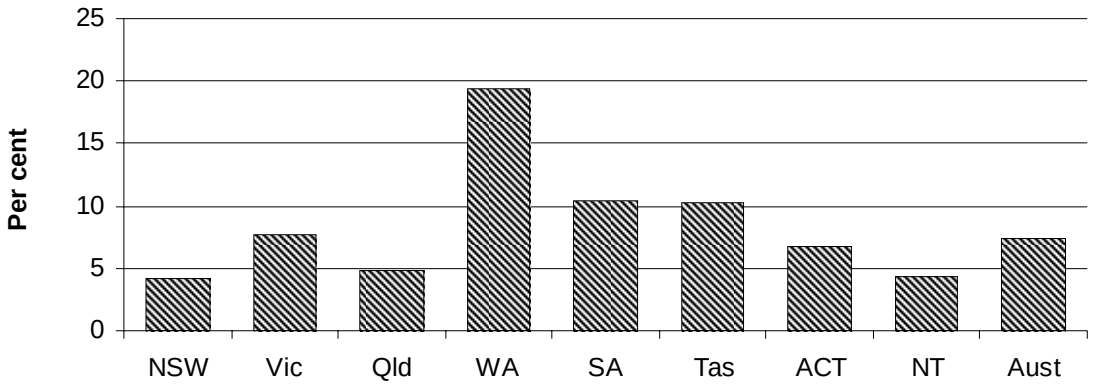
This indicator is defined as the number of people using CSTDA funded community access services (such as learning and life skills development) divided by the estimated total population of people with a profound or severe disability who are aged 15–64 years, adjusted for the Indigenous factor for each jurisdiction.

A higher proportion of people using community access services suggests greater access to these services.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. The need for services is assumed to vary according to the level of core activity limitation, so core activity limitation is used as a proxy for relative need.

Nationally, 7.3 per cent of the estimated potential population were using a community access service from 1 January 2003 to 30 June 2003. Across jurisdictions, WA had the highest proportion of users (19.3 per cent) and NSW had the lowest (4.2 per cent) (figure 13.6).

Figure 13.6 **Users of community access services as a proportion of the estimated potential population for community access services, 1 January 2003 to 30 June 2003[a, b, c, d, e]**



a Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. **b** Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Totals might not be the sum of the components because individuals may have accessed services from more than one State or Territory over the six month period. **c** The potential population estimates (national age and sex rates applied to each jurisdiction) for community access services are the number of people aged 15–64 years, who have a severe or profound core activity limitation, multiplied by the Indigenous factor for each jurisdiction. **d** Data for users of CSTDA funded community access services exclude psychiatric services specifically identified by the jurisdiction. **e** The service user data used to derive this indicator have quality issues related to the development of the new CSTDA NMDS. These issues include differences in the proportion of service outlets that responded across jurisdictions (box 13.7). This indicator thus needs to be interpreted with care.

Source: ABS (2002a, 2004b); AIHW (2004a, 2004b); AIHW analysis of the 2003 ABS Survey of Disability, Ageing and Carers data; table 13A.18.

Service use by severity of disability

The 'service use by severity of disability' indicator is explained in box 13.11.

Box 13.11 **Service use by severity of disability**

The proportion of people accessing CSTDA funded services by severity of core activity limitation is included as an output indicator of governments' objective to use available resources to target services to people with the greatest level of need.

This indicator is defined as the proportion of people, by level of core activity limitation, accessing CSTDA funded services. Data are reported for people with a profound, severe and moderate to no core activity limitation, and are reported for accommodation support and employment services.

(Continued on next page)

Box 13.11 **(Continued)**

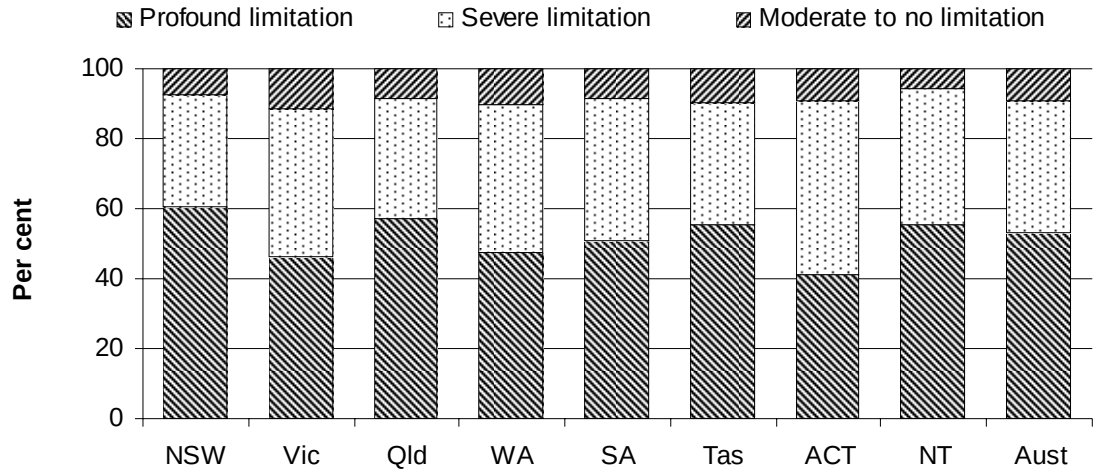
A higher proportion of people with a profound or severe core activity limitation using accommodation support or employment services suggests greater access to these services for those with the greatest level of need.

This indicator does not provide information on whether a lower proportion of the users of these services by people with a profound or severe core activity limitation results from unmet need (and inappropriate targeting), or whether it reflects the relatively small number of people in these disability categories. People with a profound or severe core activity limitation, for example, may account for only 50 per cent of the users of a disability service, but could represent 100 per cent of people with a profound or severe core activity limitation who have a need for that service.

This indicator also does not provide information on whether the services are appropriate for the needs of the people receiving them or appropriately targeted to those with the greatest level of need in terms of access to other formal and informal support. The need for services is assumed to vary according to the level of core activity limitation, so core activity limitation is used as a proxy for relative need.

Nationally, 9.2 per cent of users of accommodation support services from 1 January 2003 to 30 June 2003 had moderate to no core activity limitations, 37.6 per cent had a severe core activity limitation and 53.2 per cent had a profound core activity limitation (figure 13.7). Across jurisdictions, Victoria had the highest proportion of accommodation support service users with moderate to no core activity limitations (11.4 per cent) and the NT had the lowest (5.7 per cent). The highest proportion of service users with a severe core activity limitation was in the ACT (49.8 per cent) and the lowest was in NSW (32.0 per cent). The highest proportion of service users with a profound core activity limitation was in NSW (60.4 per cent) and the lowest was in the ACT (41.1 per cent).

Figure 13.7 **Users of accommodation support services, by severity of core activity limitation, 1 January 2003 to 30 June 2003[a, b, c, d, e]**

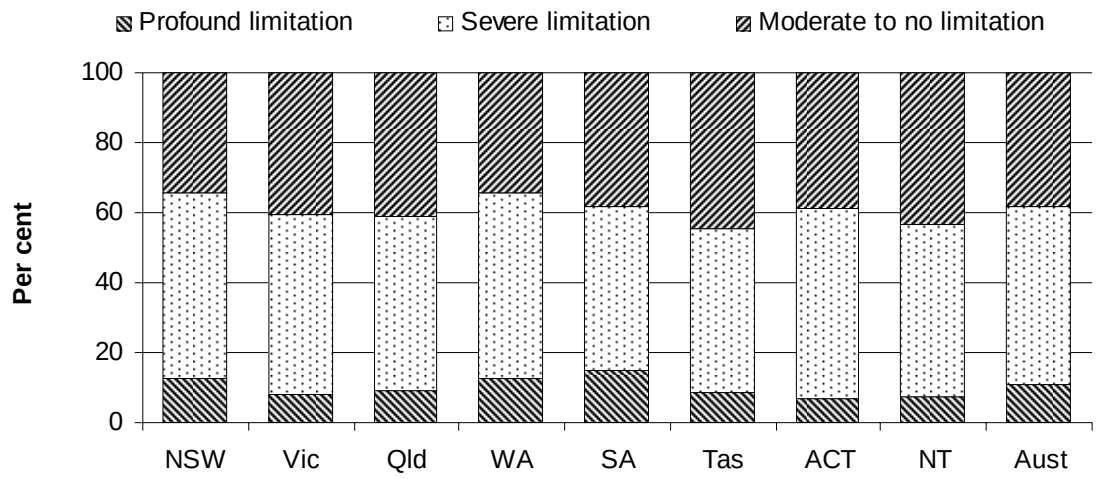


a Severity of core activity limitation was derived using data on the level of support needed in one or more of the support areas: self-care, mobility and communication. Service users with a profound core activity limitation reported always needing support in one or more of these areas. Service users with a severe core activity limitation reported sometimes needing support in one or more of these areas. Service users with a moderate or no core activity limitation reported needing no support in all of these areas. **b** Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Totals might not be the sum of the components because individuals may have accessed services from more than one State or Territory over the six month period. **c** Data exclude 1287 service users who did not report on needing support with: self-care, mobility, or communication. **d** Data for service users of CSTDA funded accommodation support services exclude psychiatric services identified by the jurisdiction. **e** The service user data used to derive this indicator have quality issues related to the development of the new CSTDA NMDS. These issues include differences in the proportion of service outlets that responded across jurisdictions (box 13.7). This indicator thus needs to be interpreted with care.

Source: AIHW (2004a, 2004b); table 13A.20.

Nationally, 38.1 per cent of users of employment services from 1 January 2003 to 30 June 2003 had moderate to no core activity limitations, 51.2 per cent had a severe core activity limitation and 10.7 per cent had a profound core activity limitation. Across jurisdictions, Tasmania had the highest proportion of service users with moderate to no core activity limitations (44.7 per cent) and NSW had the lowest (34.3 per cent). The highest proportion of service users with a severe core activity limitation was in the ACT (54.3 per cent) and the lowest was in SA (46.4 per cent). The highest proportion of service users with a profound core activity limitation was in SA (15.1 per cent) and the lowest was in the ACT (7.1 per cent) (figure 13.8).

Figure 13.8 **Users of employment services, by severity of core activity limitation, 1 January 2003 to 30 June 2003**[a, b, c, d]



a Severity of core activity limitation was derived using data on the level of support needed in one or more of the support areas: self-care, mobility and communication. Service users with a profound core activity limitation reported always needing support in one or more of these areas. Service users with a severe core activity limitation reported sometimes needing support in one or more of these areas. Service users with a moderate or no core activity limitation reported needing no support in all of these areas. **b** Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Totals might not be the sum of the components because individuals may have accessed services from more than one State or Territory over the six month period. **c** Data exclude 1294 service users who did not report needing support with: self-care, mobility, or communication. **d** Severity of core activity limitation relates to the level of support needed in the areas of self care, mobility and communication. It does not necessarily relate to the level of support needed to find or maintain employment.

Source: AIHW (2004a, 2004b); table 13A.22.

Service use by special needs groups

An important indicator of access is the comparison between the representation of all people with a disability who use CSTDA funded services and the representation of people with a disability from special needs groups (box 13.12). The three special needs groups reported here are:

- people from outer regional and remote locations
- people who have an Indigenous background
- people who were not born in Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland or the United States — that is, people born in a non-English speaking country.

Box 13.12 **Service use by special needs groups**

The representation of people from special needs groups accessing CSTDA funded services is included as an output (access) indicator of governments' objective that access to appropriate services should be equitable for all members of the community. The special needs groups are people from outer regional and remote locations, people who have an Indigenous background, and people who were born in a non-English speaking country.

This indicator compares the proportion of service users per 1000 people from a particular special needs group with the proportion of all service users per 1000 people in the Australian population. The disability service types reported are accommodation support, employment and community access services. For accommodation support services, only people aged under 65 years are included in the population counts for both the special needs groups and the Australian population. For employment and community access services, only people aged 15–64 years are included in these population counts.

Holding other factors constant, the proportion of service users per 1000 people from a special needs group should not vary significantly from the proportion of all service users per 1000 people in the Australian population. While a markedly lower proportion may represent reduced access for a special needs group, it may also represent strong alternative support networks (and thus a lower level of need), or the individual choice of people with a disability not to access CSTDA funded services. Similarly, while a higher proportion may suggest poor service targeting or the lack of alternate support networks, it may also reflect the special needs group having a greater prevalence of disability.

CSTDA funded services are provided on the basis of need and available resources. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. The indicator also does not take account for informal assistance that may be significant for special needs groups. Results for outer regional and remote users of accommodation support services, for example, need to be considered with care because alternatives to government funded accommodation support services are available in these areas. Specifically, accommodation support services in outer regional and remote areas are largely provided informally, making use of local area coordinators and local community resources.

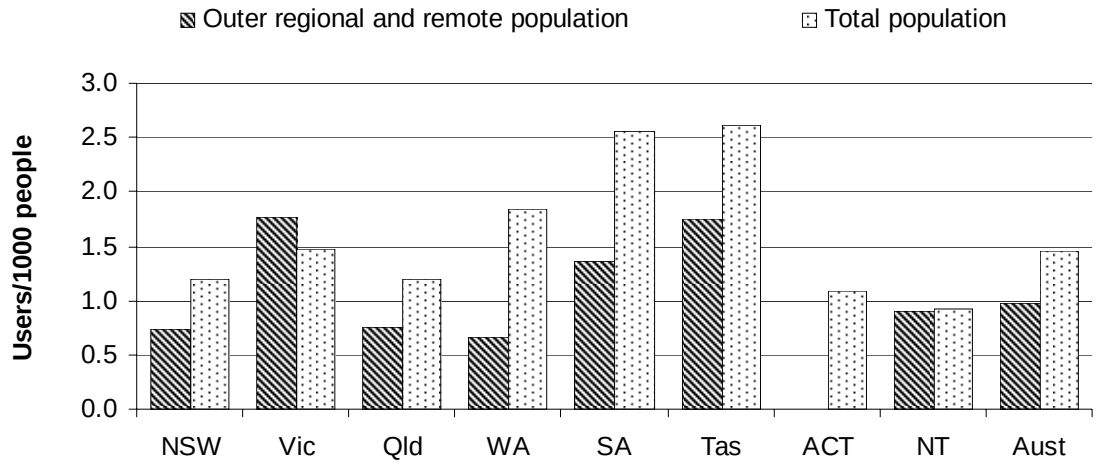
Service use by special needs groups — people in outer regional and remote areas

Nationally, the proportion of the outer regional and remote population who used accommodation support services from 1 January 2003 to 30 June 2003 (1.0 service user per 1000 people aged under 65 years) was lower than that of the total population (1.5 service users per 1000 people aged under 65 years). A lower proportion of the outer regional and remote population than of the total population

used accommodation support services in all jurisdictions except Victoria. The proportion of the outer regional and remote population using accommodation support services ranged from 1.8 service users per 1000 people in Victoria to 0.7 service users per 1000 people in both NSW and WA (figure 13.9).

Outer regional and remote population data in 2003 were derived by the AIHW from ABS statistical local area (SLA) population estimates, while data on outer regional and remote service users were estimated by the AIHW based on service users' residential postcodes.

Figure 13.9 **Users of accommodation support services per 1000 people, by geographic location, 1 January 2003 to 30 June 2003**[a, b, c, d, e, f, g, h]



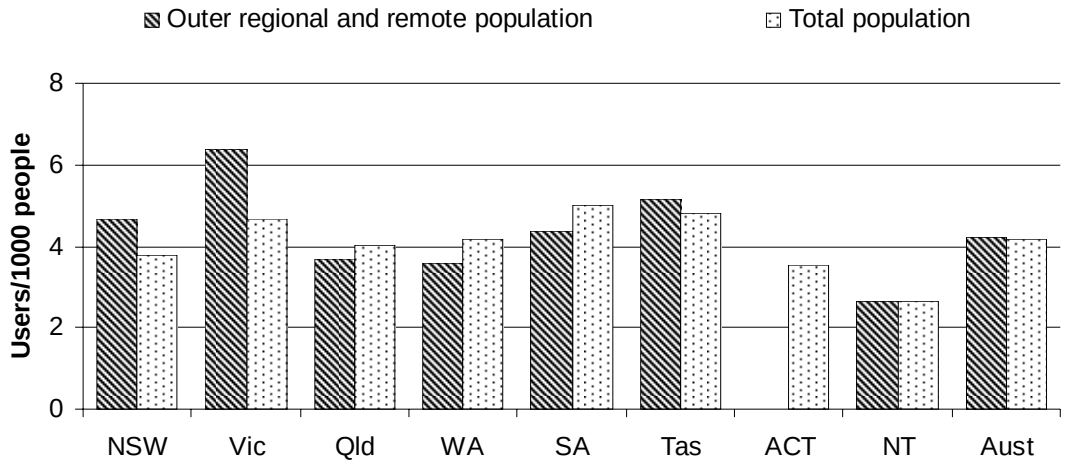
a Data on outer regional and remote users per 1000 were derived by dividing the number of outer regional and remote service users by the number of outer regional and remote people aged under 65 years, multiplied by 1000. The 'outer regional and remote' classification was derived by adding outer regional, remote and very remote data. **b** The ACT does not have outer regional and remote areas. **c** The State and Territory data on the Australian population were derived by the AIHW from ABS SLA population estimates for June 2002. **d** The number of service users in each geographic location was estimated based on service users' residential postcodes. Some postcode areas were split between two or more geographic locations; in this case, the data were weighted according to the proportion of the population of the postcode area in each geographic location. **e** Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Totals might not be the sum of the components because individuals may have accessed services from more than one State or Territory over the six month period. **f** Data for all service users exclude 357 service users whose postcode was not reported, so totals may differ from other tables. **g** Data for service users of CSTDA funded accommodation support services exclude psychiatric services identified by the jurisdiction. **h** The service user data used to derive this indicator have quality issues related to the development of the new CSTDA NMDS. These issues include differences in the proportion of service outlets that responded across jurisdictions (box 13.7). This indicator thus needs to be interpreted with care.

Source: AIHW analysis of ABS SLA population estimates for June 2002; AIHW (unpublished); table 13A.34.

Nationally, the proportion of the outer regional and remote population who used employment services from 1 January 2003 to 30 June 2003 (4.2 service users

per 1000 people aged 15–64 years) was the same as the proportion of the total population (4.2 service users per 1000 people aged 15–64 years). A lower proportion of the outer regional and remote population than of the total population used employment services in Queensland, WA, SA and the NT. The proportion of the outer regional and remote population accessing employment services was highest in Victoria (6.4 per 1000 people) and lowest in the NT (2.6 per 1000 people) (figure 13.10).

Figure 13.10 **Users of employment services per 1000 people, by geographic location, 1 January 2003 to 30 June 2003**[a, b, c, d, e]



a Data on outer regional and remote users per 1000 were derived by dividing the number of outer regional and remote service users by the number of outer regional and remote people aged 15-64 years, multiplied by 1000. The 'outer regional and remote' classification was derived by adding outer regional, remote and very remote data. **b** The ACT does not have outer regional and remote areas. **c** The State and Territory data on the Australian population were derived by the AIHW from ABS SLA population estimates for June 2002. **d** The number of service users in each geographic location was estimated based on service users' residential postcodes. Some postcode areas were split between two or more geographic locations; in this case, the data were weighted according to the proportion of the population of the postcode area in each geographic location. **e** Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Individuals might have accessed services from more than one State or Territory over the six month period.

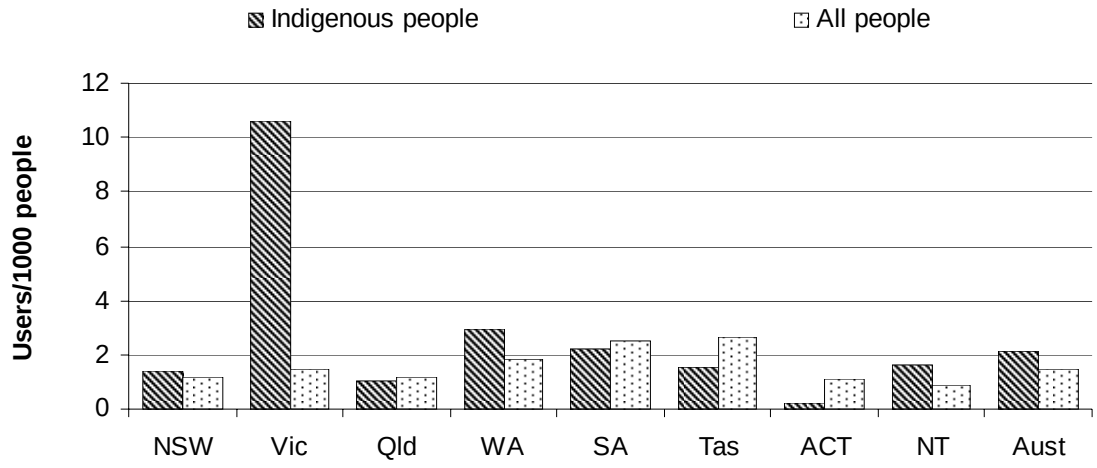
Source: AIHW analysis of ABS SLA population estimates for June 2002; AIHW (unpublished); table 13A.36.

Service use by special needs groups — Indigenous people

Nationally, the proportion of the Indigenous population who used accommodation support services from 1 January 2003 to 30 June 2003 (2.1 Indigenous service users per 1000 Indigenous people aged under 65 years) was higher than the proportion of the total population who used these services (1.4 service users per 1000 people aged under 65 years in the total population). A lower proportion of the Indigenous population than of the total population used accommodation support services in

Queensland, SA, Tasmania and the ACT. Across jurisdictions, the proportion of Indigenous people using accommodation support services ranged from 10.6 per 1000 Indigenous people in Victoria to 0.3 per 1000 Indigenous people in the ACT (figure 13.11).

Figure 13.11 **Users of accommodation support services per 1000 people, by Indigenous status, 1 January 2003 to 30 June 2003**[a, b, c, d, e, f]

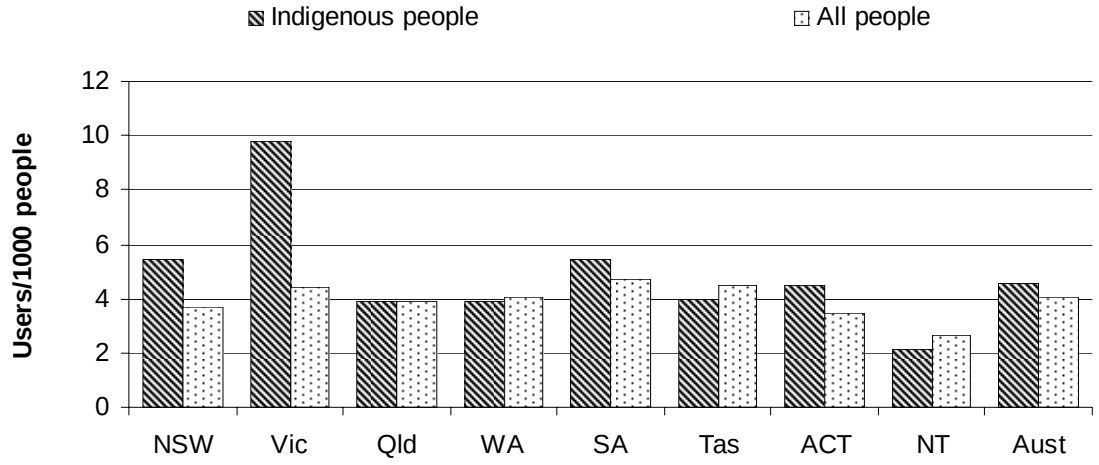


[a] Data for Indigenous users per 1000 were derived by dividing the number of Indigenous service users by the number of Indigenous Australians aged under 65 years, multiplied by 1000. [b] Where Indigenous status was inconsistently recorded for the same user, the user was counted as an Indigenous Australian. [c] Data for all service users exclude 588 service users whose Indigenous status was not reported, so totals may differ from other tables. [d] Data for users of CSTDA funded accommodation support services exclude psychiatric services identified by the jurisdiction. [e] Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Individuals might have accessed services from more than one State or Territory over the six month period. [f] The service user data used to derive this indicator have quality issues related to the development of the new CSTDA NMDS. These issues include differences in the proportion of service outlets that responded across jurisdictions (box 13.7). This indicator thus needs to be interpreted with care.

Source: ABS (2002a, 2004b); AIHW (unpublished); table 13A.24.

Nationally, the proportion of the Indigenous population who used employment services from 1 January 2003 to 30 June 2003 (4.6 Indigenous service users per 1000 Indigenous people aged 15–64 years) was higher than the proportion of the total population who used these services (4.0 service users per 1000 people aged 15–64 years). A higher proportion of the Indigenous population than of the total population used employment services in all jurisdictions except Queensland, WA, Tasmania and the NT. Across jurisdictions, the proportion of the Indigenous population accessing employment services ranged from 9.8 service users per 1000 Indigenous people in Victoria to 2.2 service users per 1000 Indigenous people in the NT (figure 13.12).

Figure 13.12 **Users of employment services per 1000 people, by Indigenous status, 1 January 2003 to 30 June 2003**[a, b, c, d]

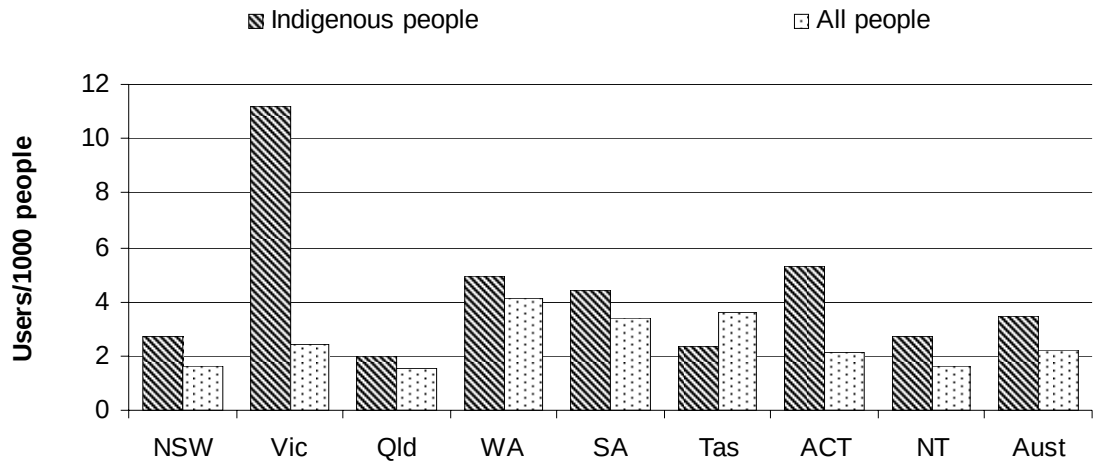


a Data for Indigenous users per 1000 were derived by dividing the number of Indigenous service users by the number of Indigenous Australians aged 15–64 years, multiplied by 1000. **b** Where Indigenous status was inconsistently recorded for the same user, the user was counted as an Indigenous Australian. **c** Data for all service users exclude 2117 service users whose Indigenous status was not reported, so employment services users per 1000 total population aged 15–64 years may differ from other figures. **d** Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Individuals might have accessed services from more than one State or Territory over the six month period.

Source: ABS (2002a, 2004b); AIHW (unpublished); table 13A.26.

Nationally, the proportion of the Indigenous population who used community access services from 1 January 2003 to 30 June 2003 (3.5 Indigenous service users per 1000 Indigenous people aged 15–64 years) was higher than the proportion of the total population who used these services (2.2 service users per 1000 people aged 15–64 years). A higher proportion of the Indigenous population than of the total population used community access services in all jurisdictions except Tasmania. Across jurisdictions, the proportion of the Indigenous population accessing community access services ranged from 11.2 service users per 1000 Indigenous people in Victoria to 2.0 service users per 1000 Indigenous people in Queensland (figure 13.13).

Figure 13.13 **Users of community access services per 1000 people, by Indigenous status, 1 January 2003 to 30 June 2003**[a, b, c, d, e, f, g]



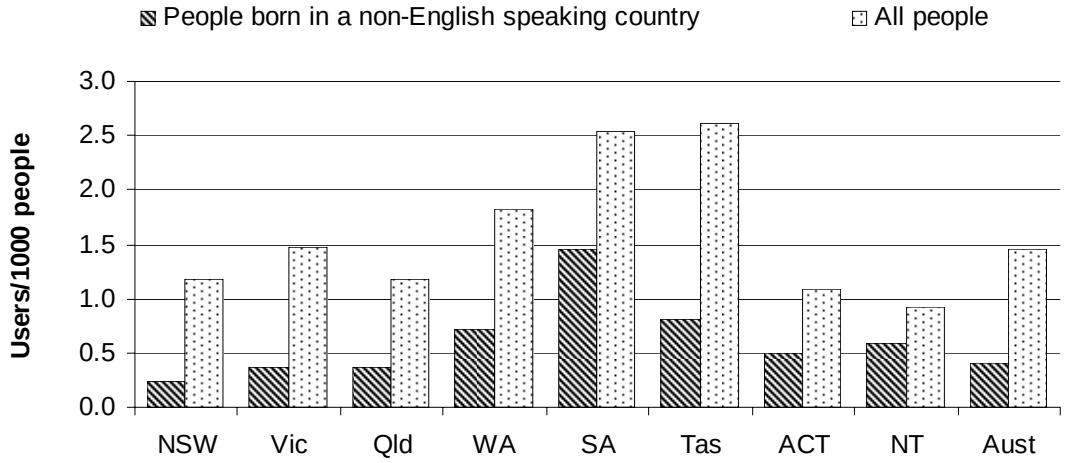
a Data for Indigenous users per 1000 were derived by dividing the number of Indigenous service users by the number of Indigenous Australians aged 15–64 years, multiplied by 1000. **b** Where Indigenous status was inconsistently recorded for the same user, the user was counted as an Indigenous Australian. **c** Data for all service users exclude 7615 service users whose Indigenous status was not reported, so totals may differ from other tables. **d** Service users who accessed the service type 'recreation/holiday programs' (service type 3.02) were not required to complete the item on Indigenous status; however those who did provide a response are included in the data. **e** Data for users of CSTDA funded community access services exclude psychiatric services specifically identified by the jurisdiction. **f** Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Individuals might have accessed services from more than one State or Territory over the six month period. **g** The service user data used to derive this indicator have quality issues related to the development of the new CSTDA NMDS. These issues include differences in the proportion of service outlets that responded across jurisdictions (box 13.7). This indicator thus needs to be interpreted with care.

Source: ABS (2002a, 2004b); AIHW (unpublished); table 13A.28.

Service use by special needs groups — people born in a non-English speaking country

Nationally, the proportion of people born in a non-English speaking country who used accommodation support services from 1 January 2003 to 30 June 2003 (0.4 service users per 1000 people aged under 65 years) was lower than the proportion of the total population who used these services (1.4 service users per 1000 people aged under 65 years). This was the case in all jurisdictions. Across jurisdictions, the proportion of people born in a non-English speaking country who used accommodation support services ranged from 1.5 service users per 1000 people in SA to 0.2 service users per 1000 people in NSW (figure 13.14).

Figure 13.14 **Users of accommodation support services per 1000 people, by country of birth, 1 January 2003 to 30 June 2003**[a, b, c, d, e, f, g]

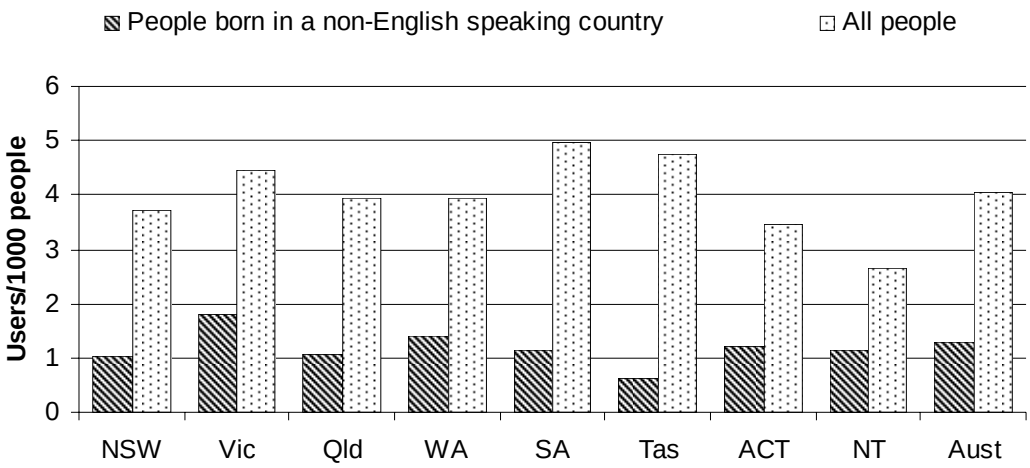


a Data for service users born in a non-English speaking country per 1000 were derived by dividing the number of service users born in a non-English speaking country by the number of Australians aged under 65 years who were born in a non-English speaking country, multiplied by 1000. **b** Data for service users born in a non-English speaking country were based on responses for country of birth in English Proficiency Groups 2–4 (which includes all countries except Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States). **c** The State and Territory data on people born in a non-English speaking country were derived from country of birth data for the corresponding 2001 Australian Census proportional distribution of the population of states and territories. Estimates exclude people whose country of birth was not stated or who were visitors to Australia from overseas. **d** Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Individuals might have accessed services from more than one State or Territory over the six month period. Where country of birth was inconsistently recorded for the same service user, the service user was counted as having been born in a non-English speaking country. **e** Data for all service users exclude 574 service users whose country of birth was not reported. **f** Data for service users of CSTDA funded accommodation support services exclude psychiatric services identified by the jurisdiction. **g** The service user data used to derive this indicator have quality issues related to the development of the new CSTDA NMDS. These issues include differences in the proportion of service outlets that responded across jurisdictions (box 13.7). This indicator thus needs to be interpreted with care.

Source: ABS (2002a); ABS (unpublished), from the 2001 Australian Census of Population and Housing; AIHW (unpublished); table 13A.30.

Nationally, the proportion of people born in a non-English speaking country who used employment services from 1 January 2003 to 30 June 2003 (1.3 service users per 1000 people aged 15–64 years) was lower than the proportion of the total population who used these services (4.1 service users per 1000 people aged 15–64 years). This was the case in all jurisdictions. The proportion of people born in a non-English speaking country who used employment services ranged from 1.8 service users per 1000 people in Victoria to 0.6 service users per 1000 people in Tasmania (figure 13.15).

Figure 13.15 **Users of employment services per 1000 people, by country of birth, 1 January 2003 to 30 June 2003[a, b, c, d, e]**



a Data for service users born in a non-English speaking country per 1000 were derived by dividing the number of service users born in a non-English speaking country by the number of Australians aged under 65 years who were born in a non-English speaking country, multiplied by 1000. **b** Data for service users born in a non-English speaking country were based on responses for a country of birth in English Proficiency Groups 2–4 (which includes all countries except Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States). **c** The State and Territory data on people born in a non-English speaking country were derived from country of birth data for the corresponding 2001 Australian Census proportional distribution of the population of states and territories. Estimates exclude people whose country of birth was not stated or who were visitors to Australia from overseas. **d** Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Totals may not be the sum of the components as individuals might have accessed services from more than one State or Territory over the six month period. Where country of birth was inconsistently recorded for the same service user, the service user was counted as having been born in a non-English speaking country. **e** Data for all service users exclude 1555 service users whose country of birth was not reported, thus employment services users per 1000 total population aged 15–64 years might differ from other figures.

Source: ABS (2002a); ABS (unpublished), from the 2001 Australian Census of Population and Housing; AIHW (unpublished); table 13A.32.

Proportion of accommodation support service users receiving community accommodation and care services

The indicator 'proportion of accommodation support service users receiving community accommodation and care services' is explained in box 13.13.

Box 13.13 **Proportion of accommodation support service users receiving community accommodation and care services**

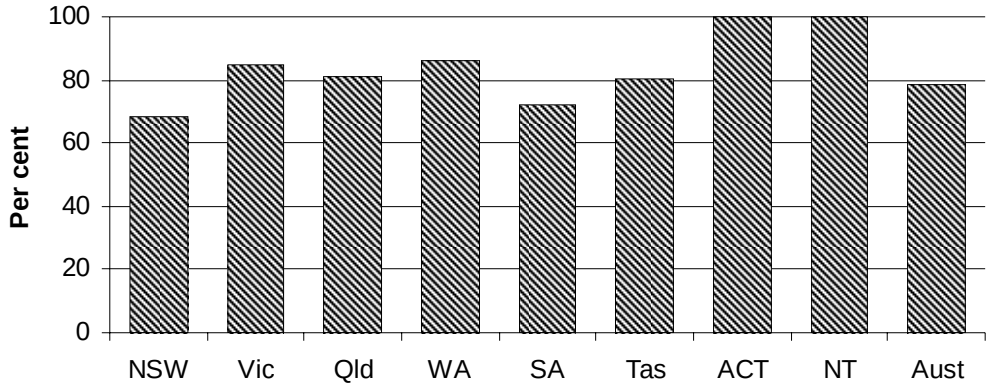
The 'proportion of accommodation support service users using community accommodation and care services' (that is, accommodation support services in group homes and other community settings) is included as an output (access) indicator of governments' objective to assist people with a disability to live as valued and participating members of the community. State and Territory governments have generally sought to increase the provision of accommodation support services outside institutional/residential settings for people with a disability. Community accommodation and care services are considered to provide better opportunities for people with a disability to be involved in their community.

This indicator is defined as the number of people using a CSTDA funded community accommodation and care service divided by the total number of people using CSTDA funded accommodation support services (excluding psychiatric services). An increase in the proportion of people accessing community accommodation and care services is likely to increase the ability of these people to integrate and be involved in the community.

CSTDA funded services are provided on the basis of need and available resources. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

Nationally, 78.4 per cent of accommodation support service users received community accommodation and care services from 1 January 2003 and 30 June 2003 (figure 13.16). Across jurisdictions, the ACT and the NT had the highest proportion of accommodation support service users receiving community accommodation and care services (both 100.0 per cent) and NSW had the lowest (68.5 per cent) (figure 13.16).

Figure 13.16 **Users of community accommodation and care services as a proportion of all accommodation support service users, 1 January 2003 to 30 June 2003**[a, b, c, d]



[a] Service user data are estimates after a statistical linkage key is used to account for individuals who received services from more than one service type outlet from 1 January 2003 to 30 June 2003. Totals may not be the sum of the components because individuals might have accessed services from more than one State or Territory and/or from both accommodation service types over the six month period. [b] Data for service users of CSTDA funded accommodation support services exclude psychiatric services identified by the jurisdiction. [c] Community accommodation and care services include group homes, attendant care/personal care, in-home accommodation support, alternative family placement and other accommodation support. [d] The service user data used to derive this indicator have quality issues related to the development of the new CSTDA NMDS. These issues include differences in the proportion of service outlets that responded across jurisdictions (box 13.7). This indicator thus needs to be interpreted with care.

Source: AIHW (2004a and 2004b); table 13A.10.

Client satisfaction with appropriateness

The indicator 'client satisfaction with appropriateness' is explained in box 13.14.

Box 13.14 **Client satisfaction with appropriateness**

'Client satisfaction with appropriateness' will provide an output indicator of government's objective to provide services to people with a disability that are appropriate to their needs and goals. This indicator will measure the appropriateness of these services relative to the service user's need, from the service user's perspective.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Equity and effectiveness — quality of services

Quality assurance processes

All services funded under the CSTDA are required to comply with national standards, so most jurisdictions have been examining ways of implementing quality assurance monitoring systems for disability services programs. The 'quality assurance processes' indicator is explained in box 13.15.

Box 13.15 **Quality assurance processes**

'Quality assurance processes' are an indicator of quality related to governments' objective to deliver and fund services for people with a disability that meet a certain standard of quality.

This indicator is defined as the proportion of government and non-government disability service outlets that have been assessed (either by an assessing agency or through a self-assessment process) against service standards or performance indicators.

A higher proportion of disability service outlets that have been accredited against service standards or performance indicators suggests a strengthening in the quality of disability services delivered or funded by government.

This indicator does not provide information on whether the standards and performance indicators of the quality assurance processes are appropriate. In addition, service outlets that are not quality assessed do not necessarily deliver services of lower quality.

Data on quality assurance monitoring in 2003-04 are reported for the Australian Government, Victoria, WA and Tasmania (box 13.16). These quality assurance data relate to service providers from all disability service types provided under the CSTDA. Data come from service quality reviews and self-assessment processes. The four jurisdictions implementing quality assurance monitoring are expected to review all service providers in a rolling process over several years.

Box 13.16 **Quality assurance for disability services**

The quality assurance data reported below relate to CSTDA funded services.

Australian Government

Australian Government funded disability employment assistance organisations are required to meet quality standards. In July 2002, revised disability services standards were introduced, comprising 12 standards and 26 key performance indicators. All organisations must be assessed by independent accredited certification bodies and achieve certification against the revised standards by 31 December 2004 as a prerequisite for continued funding. All 397 disability employment assistance organisations have registered their intention to be certified by 31 December 2004. At 5 November 2004, 92.7 per cent of organisations (368 of 397) had been audited and 68.3 per cent (271 of 397) had achieved certification.

Victoria, WA and Tasmania

In 2003-04, different quality assurance monitoring systems were in place in Victoria, WA and Tasmania, but these jurisdictions collect data on similar indicators. Disability services providers (outlets and organisations) refer to providers of accommodation support; community support; community access; respite; advocacy, information and print disability; and other support services. The evaluation processes relate to both government and non-government service outlets.

In Victoria, by December 2003, 40 government and non-government disability service organisations (which operate at least one service outlet) had participated in an independent strategic review, and 97 per cent of eligible service outlets (those receiving more than $20 000 in disability funding) had undertaken a self-assessment against the Victorian Standards for Disability Services and implemented a quality plan.

In WA, 25.3 per cent (178 of 703) of total service outlets had been independently monitored (comprehensive and abridged monitoring) against the service standards, and 74.2 per cent (132 of 178) of the assessed disability service outlets had been quality assured against all assessed service standards. Outlets that are not independently assessed are required to provide a self-assessment.

In Tasmania, 9.6 per cent of total service outlets (20 of 207) had been comprehensively assessed against the service standards and 100 per cent (20 of 20) of the comprehensively assessed disability services outlets had been quality assured against all assessed service standards. Of the total service outlets, 19.7 per cent (41 of 207) are being monitored following evaluation through a service development plan.

Source: Australian, Victorian, WA and Tasmanian governments (unpublished).

Client and carer satisfaction

The ‘client and carer satisfaction’ indicator is explained in box 13.17.

Box 13.17 **Client and carer satisfaction**

'Client and carer satisfaction' is an output (quality) indicator designed to provide information on satisfaction with the quality of services received. It is an indicator of governments' objective to deliver and fund quality services for people with a disability that meet the needs and goals of the client (or carer of the client) receiving them.

The Steering Committee has identified this indicator for development and reporting in future.

The 2000 Report provided some survey data on client and carer satisfaction with services provided to people with a disability (SCRCSSP 2000). These data have not been updated at a national level, although Western Australia conducted a carer and client satisfaction study in 2004. In this study, 688 disability services clients or their carers were asked whether they were satisfied with services. Questions about specific services were combined with two global satisfaction questions. Across the six CSTDA service types, 70–87 per cent of clients were satisfied with the services they received. Overall, 76 per cent of people responded that the services had enhanced their quality of life (WA Government unpublished).

Efficiency — cost per output unit

It is an objective of the Review to report comparable estimates of costs. Ideally, such comparisons would include the full range of costs to government. Where the full costs cannot be counted, costs are best estimated on a consistent basis. The jurisdictional expenditure data included in this Report do not yet include the user cost of capital, so do not reflect the full costs of government funded services.

Considerable effort has been made to document any differences in calculating the reported efficiency indicators. Some concerns remain over the comparability of the results, because jurisdictions use somewhat different methods of data collection (table 13.1). Expenditure data reported in this section are from individual jurisdictions' collections and may differ from cost per service user data reported elsewhere.

Table 13.1 **Comparability of expenditure estimates for government provided disability services, by items included, 2003-04**

Expenditure	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[b]	*Aus Gov*
Superannuation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basis of estimate	Accrual	Accrual	Accrual	Accrual	Cash	Accrual	Accrual	Accrual	Accrual
Workers compensation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Payroll tax[a]									
Actual	✓	✓	✓			✓		✓	
Imputed		✓		✓	✓		✓		..
Apportioned umbrella department costs	✓	✓	✓	..	✓	✓	✓	✓	✓
Basis of apportioning									
Departmental formula	✓	✓	✓	..	✓	✓	×	✓	✓
% of FTE employees	×	×	×	..	×	✓	✓	×	×
Long service leave									
Entitlements	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basis of estimate	Accrual	Accrual	Accrual	Accrual	Cash	Accrual	Accrual	Accrual	Accrual
Depreciation	✓	✓	✓	✓	×	×	×	×	✓

FTE = full time equivalent. [a] Actual payroll tax amounts are included in cost (expenditure) per user data for NSW, Victoria, Queensland, Tasmania and the NT because the actual payroll tax amounts are not separately identified at the service delivery area level. For the other jurisdictions, no payroll tax amounts (actual or imputed) are included. [b] In 2003-04, the NT changed the apportioning of umbrella departmental costs from the percentage of FTE employees to a departmental formula. .. Not applicable.

Source: State and Territory governments (unpublished).

Institutional or residential accommodation support services are provided in both institutions and hostels. Community accommodation and care services are provided in group homes and other community settings. The accommodation support services provided in other community settings are attendant care/personal care, in-home accommodation support, alternative family placement and other accommodation support. In recent years, there has been an ongoing process of relocating people with a disability from institutional/residential accommodation to community accommodation. As a result, total government expenditure on accommodation support services in institutional/residential settings has decreased, with a corresponding increase in expenditure on community accommodation and care services.

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 provided under the auspices of an Australian, State, Territory or local government department or agency. Non-government provision means that a government department or agency purchases, or contributes funding to, a service provided by a non-government organisation. Non-government service providers may receive funds from the private sector and the general public in addition to funding, grants and input tax concessions (such as payroll tax exemptions) from governments. Data on funds received by non-government service providers from the private sector and the general public are not included in this Report.

Cost per user of government provided services

Governments provide accommodation support services to people with a disability in institutional/residential settings, group homes and other community settings. The 'cost per user of government provided services' indicator is explained in box 13.18.

Box 13.18 **Cost per user of government provided services**

'Cost per user of government provided services' is included as an output (efficiency) indicator of governments' objective to provide disability services in an efficient manner. A set of indicators are reported under this heading for a range of service types.

This indicator is defined as the net government expenditure per user of government provided accommodation support services in institutional/residential settings, group homes and other community settings.

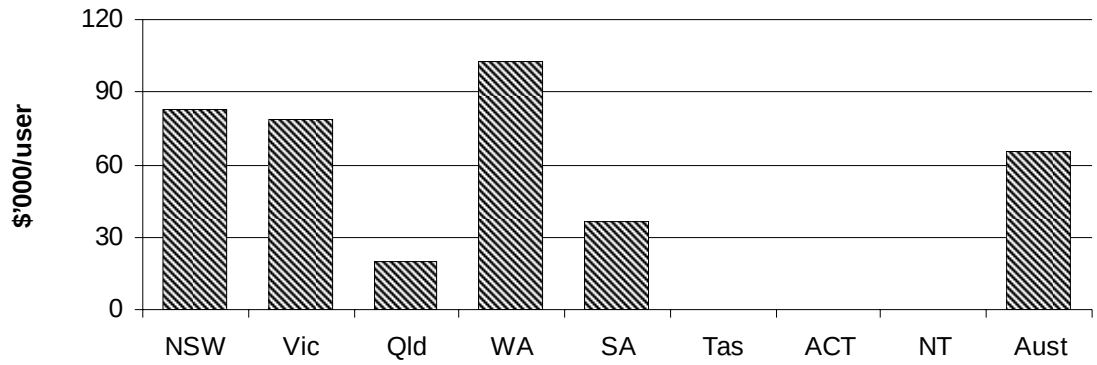
Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service.

Efficiency data are difficult to interpret. While high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided. Increasing expenditure may also reflect the changing needs of service users — for example, as the population of accommodation support service users ages, their support needs are also likely to increase. Similarly, low or declining expenditure per unit of output may reflect improving efficiency or lower quality, less effective services. Efficiency data thus need to be always interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Cost per user of government provided services — institutional/residential settings

Nationally, estimated annual government expenditure on accommodation support services in institutional/residential settings was $65 786 per service user in 2002-03. Across jurisdictions, estimated government expenditure per service user was highest in WA ($102 684) and lowest in Queensland ($19 651). There were no government provided accommodation support services in institutional/residential settings in Tasmania, the ACT or the NT in 2002-03 (figure 13.17).

Figure 13.17 **Estimated annual government expenditure per user of government provided accommodation support services in institutional/residential settings, 2002-03[a, b, c, d]**



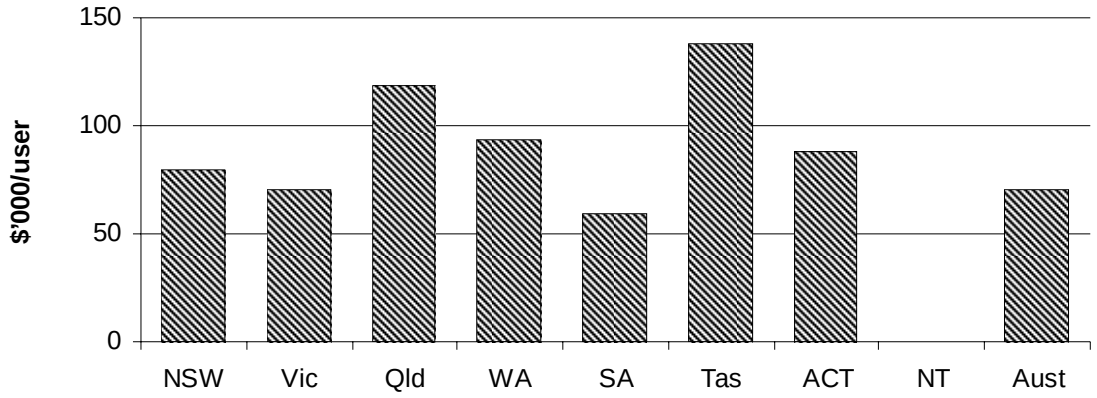
a Estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. **b** There were no government provided accommodation support services in institutional/residential settings in Tasmania, the ACT and the NT. **c** In Victoria, expenditure on institutional accommodation support services reflects current institutional redevelopments. **d** The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Source: State and Territory governments (unpublished); table 13A.42.

Cost per user of government provided services — group homes

Nationally, estimated annual government expenditure on government provided accommodation support services in group homes was $70 432 per service user in 2002-03. Across jurisdictions, government expenditure per service user was highest in Tasmania ($137 604) and lowest in SA ($59 043). There were no government providers of accommodation support services in group homes in the NT (figure 13.18).

Figure 13.18 **Estimated annual government expenditure per user of government provided accommodation support services in group homes, 2002-03[a, b, c, d]**



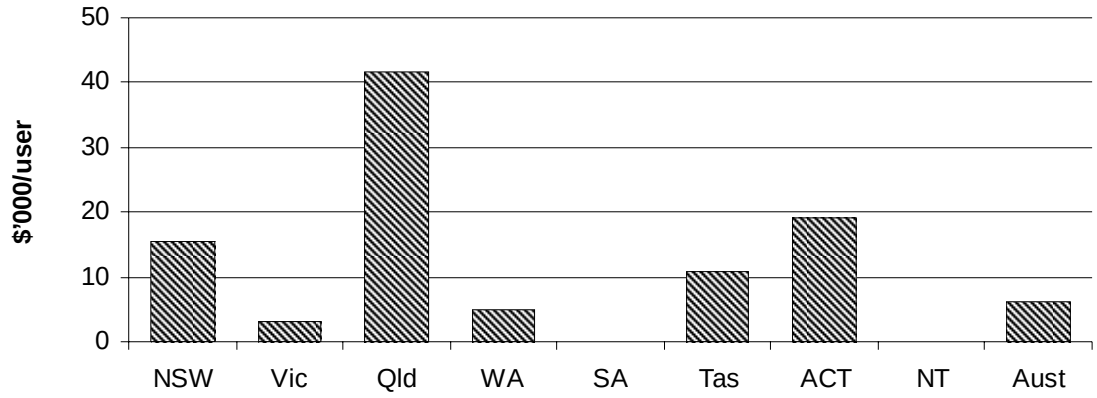
a Estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. **b** There were no government provided accommodation support services in group homes in the NT. **c** Data exclude three service users in WA whose agency sector (government/non-government) was not stated. **d** The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Source: State and Territory governments (unpublished); table 13A.42.

Cost per user of government provided services — other community settings

Nationally, estimated annual government expenditure on government provided accommodation support services in other community settings was $6078 per service user in 2002-03. Across jurisdictions, government expenditure per service user was highest in Queensland ($41 623) and lowest in Victoria ($2991). There were no government providers of accommodation support services in other community settings in SA and the NT (figure 13.19).

Figure 13.19 **Estimated annual government expenditure per user of government provided accommodation support services in other community settings, 2002-03[a, b, c, d]**



a Estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. **b** There were no government provided accommodation support services in other community settings in SA and the NT. **c** Data exclude 44 service users in Victoria whose agency sector (government/non-government) was not stated. **d** The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Source: State and Territory governments (unpublished); table 13A.42.

Government contribution per user of non-government provided services

Governments contributed funding to, or purchased, the following non-government provided services for people with a disability:

- accommodation support services in:
  - institutional/residential settings
  - group homes
  - other community settings
- employment services.

The indicator 'government contribution per user of non-government provided services' is explained in box 13.19.

Box 13.19 **Government contribution per user of non-government provided services**

Governments directly provide services to service users and also fund non-government service providers to deliver these services. The government contribution per user of non-government provided services is included as an output (efficiency) indicator of governments' objective to provide disability services in an efficient manner. The focus on the contribution of governments reflects the Steering Committee's terms of reference, which require it to report on services delivered by government.

A set of indicators are reported under this heading for a range of funded service types. This indicator is defined as the net government expenditure per user of the following non-government provided services:

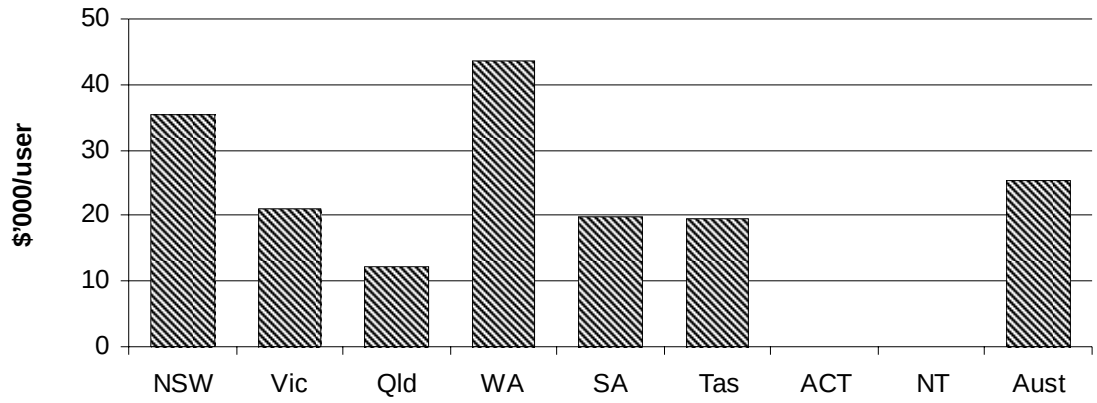
- accommodation support services in:
  - institutional/residential settings
  - group homes
  - other community settings
- employment services (reported per employment service user assisted).

Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service. Efficiency data are difficult to interpret, however. While high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of service users. Similarly, low or declining expenditure per unit of output may reflect improving efficiency or lower quality, less effective services. Efficiency data thus need to be always interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Government contribution per user of non-government provided services — institutional/residential settings

Nationally, estimated annual government funding of non-government provided accommodation support services in institutional/residential settings was $25 234 per service user in 2002-03. Across jurisdictions, government funding per service user was highest in WA ($43 585) and lowest in Queensland ($12 313). There were no non-government provided accommodation support services in institutional/residential settings in the ACT or the NT (figure 13.20).

Figure 13.20 **Estimated annual government funding per user of non-government provided accommodation support services in institutional/residential settings, 2002-03[a, b, c, d, e]**



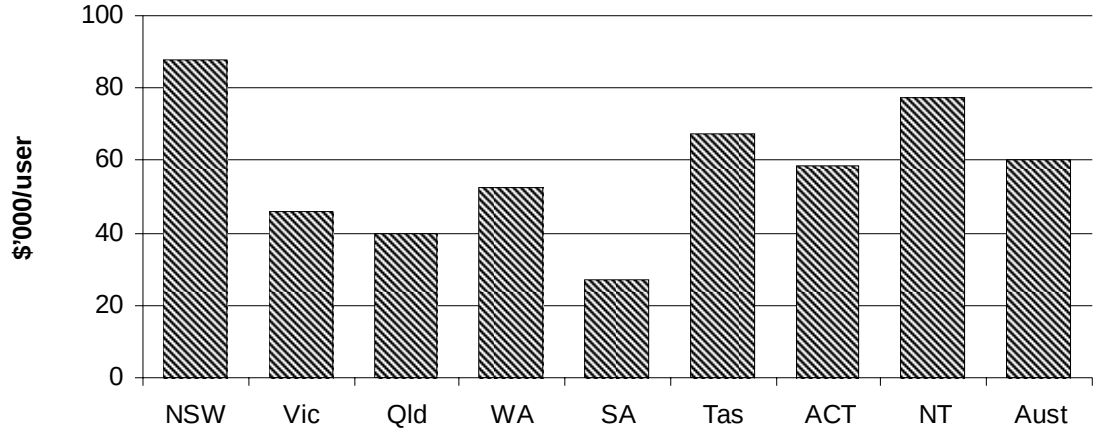
a Estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. **b** There were no non-government provided accommodation support services in institutional/residential settings in the ACT and the NT. **c** In Victoria, expenditure on institutional accommodation support services reflects current institutional redevelopments. **d** Data reflect government contributions to non-government provided services. **e** The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Source: State and Territory governments (unpublished); table 13A.42.

Government contribution per user of non-government provided services — group homes

Nationally, estimated annual government funding of non-government provided accommodation support services in group homes was $60 357 per service user in 2002-03. Across jurisdictions, government funding per service user ranged from $87 940 in NSW to $26 872 in SA (figure 13.21).

Figure 13.21 **Estimated annual government funding per user of non-government provided accommodation support services in group homes, 2002-03[a, b, c, d]**



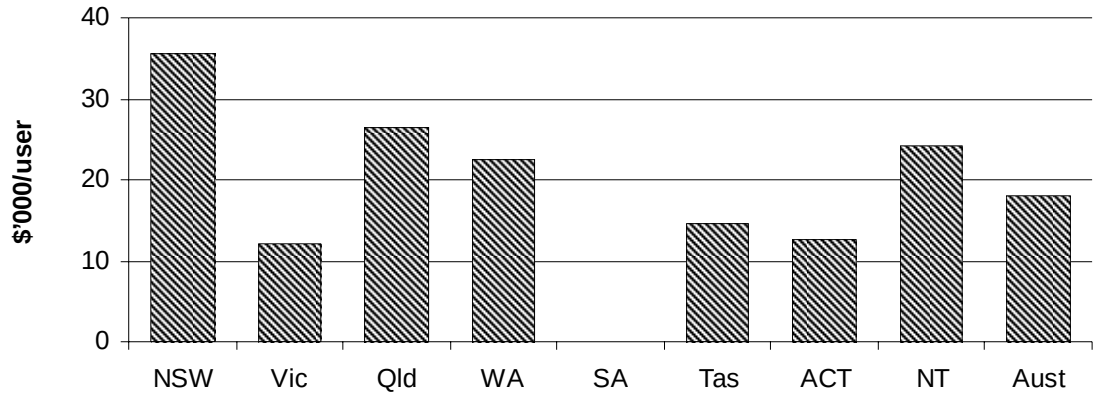
a Estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. **b** Data reflect government contributions to non-government provided services. **c** Data exclude three service users in WA whose agency sector (government/non-government) was not stated. **d** The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Source: State and Territory governments (unpublished); table 13A.42.

Government contribution per user of non-government provided services — other community settings

Nationally, estimated annual government funding of non-government provided accommodation support services in other community settings was $18 038 per service user in 2002-03. Across jurisdictions, government funding per service user ranged from $35 491 in NSW to $33 in SA (figure 13.22).

Figure 13.22 **Estimated annual government funding per user of non-government provided accommodation support services in other community settings, 2002-03[a, b, c, d, e]**



a Estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. **b** In SA, government funding per user of non-government provided accommodation support services in other community settings was $33. **c** Data reflect government contributions to non-government provided services. **d** Data exclude 44 service users in Victoria whose agency sector (government/non-government) was not stated. **e** The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

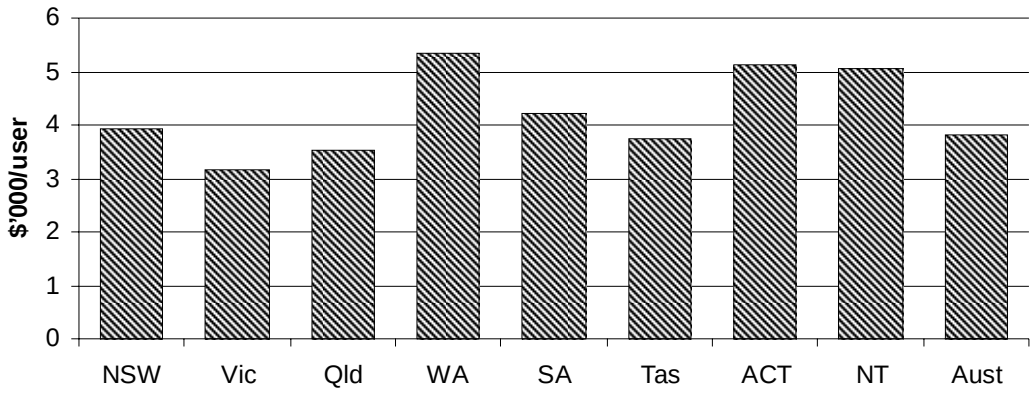
Source: State and Territory governments (unpublished); table 13A.42.

Government contribution per user of non-government provided services — per employment service user assisted

Assistance with employment for people with a disability was the responsibility of the Australian Government under the CSTDA in 2002-03. Nationally, for all employment services, government expenditure per service user assisted was $3817 in 2002-03. Across jurisdictions, government expenditure per service user was highest in WA ($5347) and lowest in Victoria ($3175) (figure 13.23).

Nationally, estimated annual government expenditure per service user in 2002-03, by employment service type, was $3016 on the open program, $6203 on the supported program and $3983 on the open and supported program (table 13A.46).

Figure 13.23 **Government funding per user of non-government provided employment services, 2002-03[a]**



a Based on the number of employment service users assisted.

Source: DFaCS (unpublished); table 13A.48.

Cost per service user

The 'cost per service user' indicator is explained in box 13.20.

Box 13.20 **Cost per service user**

Cost per service user is included as an output (efficiency) indicator of governments' objective to provide disability services in an efficient manner.

This indicator is defined as government expenditure on CSTDA State and Territory administered services, per service user. Data are reported separately for government expenditure net of payroll tax and for government expenditure including actual and/or imputed payroll tax.

Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service. Efficiency data are difficult to interpret, however. While high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of service users. Similarly, low or declining expenditure per unit of output may reflect improving efficiency or lower quality, less effective services. Efficiency data thus need to be always interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Total estimated government expenditure per user of CSTDA State and Territory administered disability services in 2002-03 is reported both net of payroll tax and including actual and/or imputed payroll tax. Nationally, estimated expenditure per service user was $25 639 excluding payroll tax and $26 150 including actual and/or imputed payroll tax. Across jurisdictions, NSW had the highest expenditure per service user, both when excluding payroll tax ($35 712) and when including it ($36 469). The lowest expenditure per service user was in WA, when payroll tax was both excluded ($13 780) and included ($14 065) (figure 13.24).

Figure 13.24 **Estimated annual government expenditure per service user of CSTDA State and Territory administered services, 2002-03[a, b, c, d, e, f]**

a In some jurisdictions (NSW, Victoria in part, Queensland, Tasmania and the NT), payroll tax is paid directly by the service; in other jurisdictions (Victoria in part, WA, SA and the ACT), payroll tax is not paid directly by the service. **b** Payroll tax data for Queensland includes paid payroll tax and accrued payroll tax. **c** In the NT, payroll tax relates to government service provision and excludes expenditure for program management and administration. **d** Estimated annual figures were derived from 2002-03 financial year data and service user data collected from 1 January 2003 to 30 June 2003. **e** Government expenditure per service user for Australia excludes Australian Government expenditure on State and Territory administered services that was not provided as transfer payments. **f** The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Source: AIHW (2004a, 2004b); State and Territory governments (unpublished); table 13A.50.

Efficiency — administrative cost

Administrative expenditure as a proportion of total expenditure

The proportion of total expenditure on administration is not yet comparable across jurisdictions because different methods are used to apportion it. Administrative expenditure data are useful, however, for indicating trends within jurisdictions over

time. The indicator 'administrative expenditure as a proportion of total expenditure' is explained in box 13.21.

Box 13.21 **Administrative expenditure as a proportion of total expenditure**

Administrative expenditure as a proportion of total expenditure is included as an output (efficiency) indicator of governments' objective to provide disability services in an efficient manner. Administrative expenditure in this context represents the costs incurred by government agencies in administering CSTDA funded services.

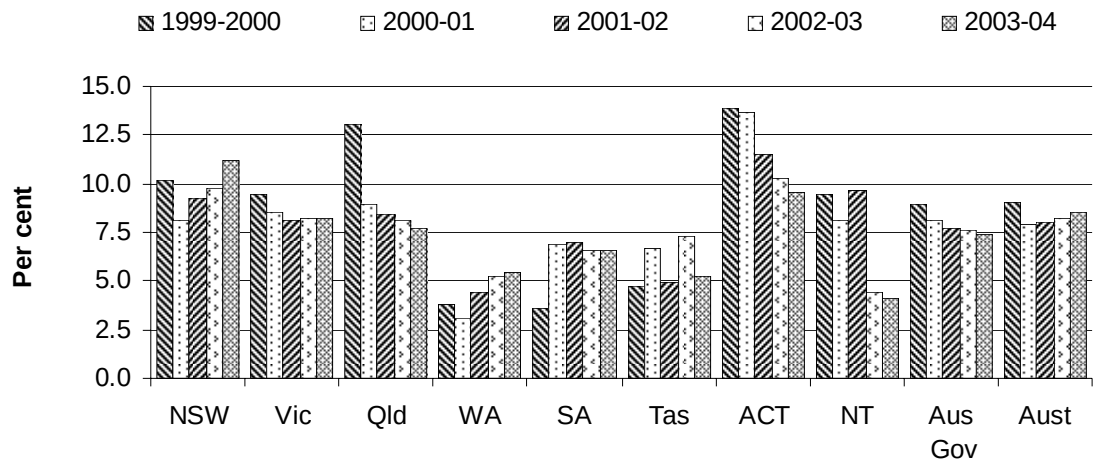
This indicator is defined as government expenditure on administration as a proportion of total CSTDA expenditure.

Holding other factors constant (such as service quality and accessibility), a decrease in administrative expenditure as a proportion of total CSTDA expenditure may reflect an increase in administrative efficiency.

Efficiency data are difficult to interpret. While high or increasing administrative expenditure as a proportion of total expenditure may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the administrative services provided. Similarly, low or declining administrative expenditure as a proportion of total expenditure may reflect improving efficiency or lower quality, less effective services. Efficiency data thus need to always be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Nationally, administrative expenditure as a proportion of total government expenditure on disability services rose from 8.2 per cent in 2002-03 to 8.6 per cent in 2003-04 when actual payroll tax is included in total CSTDA expenditure for NSW, Victoria (in part), Qld, Tasmania and the NT. Across jurisdictions, however, the proportion decreased between 2002-03 and 2003-04 for all jurisdictions except NSW, WA and SA. The highest proportion in 2003-04 was in NSW (11.2 per cent) and the lowest was in the NT (4.1 per cent) (figure 13.25).

Figure 13.25 **Administrative expenditure as a proportion of total expenditure**
a, b, c, d, e, f, g, h



a See table 13.1 for an explanation of different methods of apportioning departmental costs. **b** Data include actual payroll tax amounts for NSW, Victoria (in part), Queensland, Tasmania and the NT. **c** The method of apportioning government administration expenditure in Queensland changed in 2000-01 as a result of improved financial reporting systems and with the establishment of Disability Services Queensland. Payroll tax data for Queensland include paid payroll tax and accrued payroll tax. **d** The decrease in WA 2000-01 administration expenditure reflects a reduction in corporate services costs and the elimination of costs associated with the implementation of the GST in 1999-2000. The increase in WA 2001-02 administration expenditure mainly reflects the realignment of policy costs previously allocated across all outputs. The increase in WA administration expenditure for 2003-04 reflects a growth in funds and indexation (including wage increases). **e** Data for SA include administration expenses (indirect service delivery costs) relating to all government agencies receiving funding from the department. Reports in previous years included only the Central Office and Intellectual Disability Services Council administrative costs. Improved allocation of corporate overheads occurred from 2000-01 within the government sector. **f** The ACT incurred additional one-off overhead costs in 2000-01 due to the Inquiry into Disability Services in the ACT. **g** The NT administrative expenditure before 2001-02 is estimated, based on average staffing levels. Financial reporting in the NT improved in 2001-02 due to operation within a funder/purchaser/provider framework. The 2000-01 expenditure data include advance payments in the first quarter of 2001-02, resulting in underreporting of expenditure in 2001-02. For 2002-03, the method of apportioning administrative expenditure changed, resulting from a re-alignment of some costs previously reported under this category to direct service delivery; the NT changed from cash to accrual accounting in 2002-03, limiting the comparability of expenditure with previous years. Payroll tax relates to government service provision and excludes expenditure for program management and administration. **h** Australian Government administrative expenditure is an estimate, based on average staffing levels.

Source: Australian, State and Territory governments (unpublished); table 13A.49.

Data that account for differences in payroll tax regimes across jurisdictions are included in this Report (table 13A.49) to improve the comparability of reported costs. Payroll tax data need to be interpreted with caution, however, because some jurisdictions (NSW, Victoria [in part], Queensland, Tasmania and the NT) have provided payroll or payroll tax data on the basis of direct service delivery expenditure for government provided services, and others (WA, SA and the ACT) have provided the data on the basis of total expenditure for government provided

services. Specifically, total CSTDA expenditure is reported in table 13A.37 and 13A.38, both excluding and including actual or imputed payroll tax amounts.

When payroll tax is excluded, average national administrative expenditure as a proportion of total CSTDA expenditure was 8.7 per cent in 2003-04. When actual or imputed payroll tax is included, the proportion was 8.5 per cent (table 13A.49).

Outcomes

Labour force participation and employment of people with a disability

The indicator 'labour force participation and employment of people with a disability' is explained in box 13.22. Detailed definitions and calculations of labour force participation and employment rates are provided in section 13.6.

Box 13.22 **Labour force participation and employment of people with a disability**

'Labour force participation and employment of people with a disability' has been chosen as outcome indicator, given the importance of participation in the labour force and employment to the overall wellbeing of people with a disability, particularly in terms of the opportunity for self-development and interaction with people outside the home.

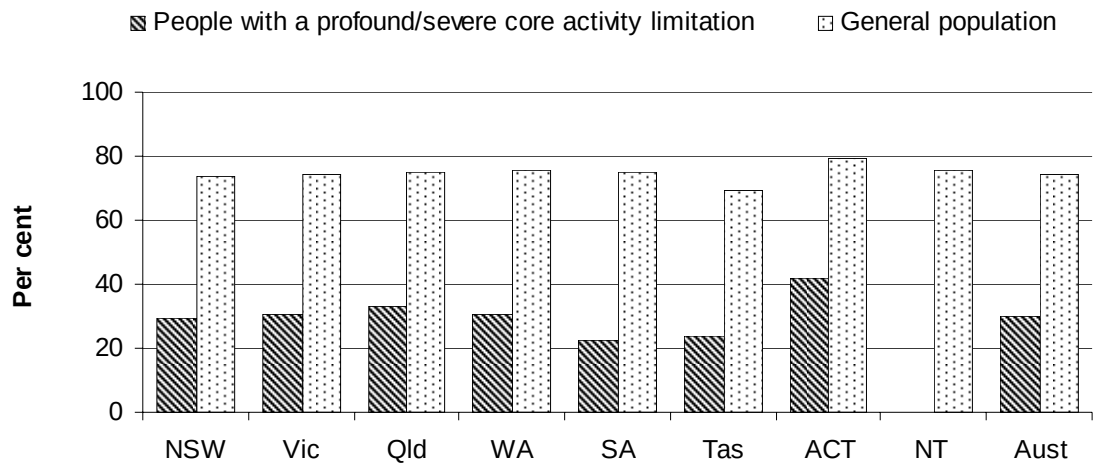
For this indicator, data on labour force participation rates and employment rates of people aged 15–64 years with a profound or severe core activity limitation who live in households are compared with the rates of people aged 15–64 years in the general population.

A higher labour force participation or employment rate for people with a disability is likely to increase the quality of life for these people by providing greater opportunities for self-development and interaction with people outside the home.

This indicator does not provide information on why people cannot find the work they are looking for. It also does not provide information on why people choose not to participate in the labour force. Finally, it does not provide information on whether the jobs that people find are appropriate or fulfilling.

Nationally, the estimated labour force participation rate of people aged 15–64 years with a profound or severe core activity limitation in 2003 (30.0 per cent) was below that of general population aged 15–64 years (74.4 per cent). This was the case in all jurisdictions. Across jurisdictions, the difference between the estimated labour force participation rate of people with a profound or severe core activity limitation and that of the general population was highest in SA (52.2 percentage points) and lowest in the ACT (37.3 percentage points) (figure 13.26).

Figure 13.26 **Estimated labour force participation rates of people aged 15–64 years, 2003[a]**

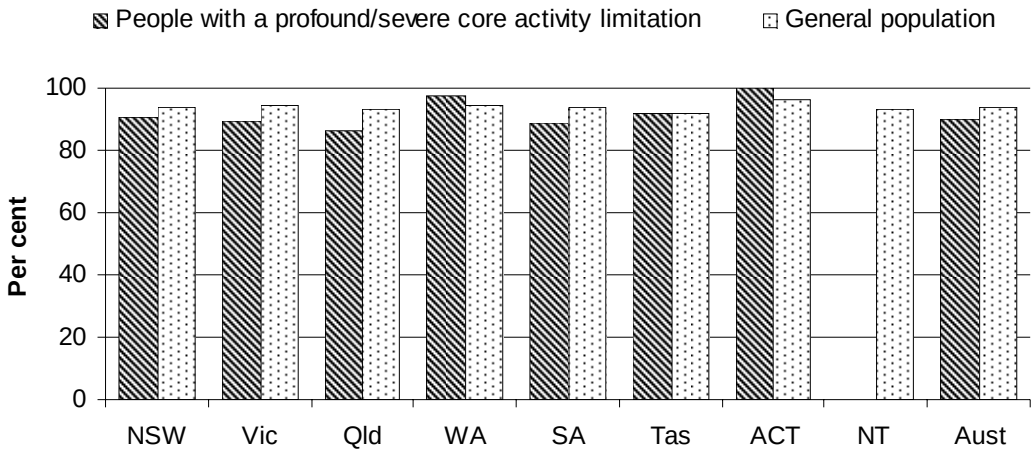


a Data for people with a disability in the NT are not published.

Source: ABS (Labour Force Survey Cat. no. 6291.0.55.001 [Supertable LM8], unpublished, from the 2003 Disability, Ageing and Carers Survey); table 13A.11.

Nationally, the estimated employment rate of people aged 15–64 years with a profound or severe core activity limitation in 2003 (89.9 per cent) was below that of the general population aged 15–64 years (93.9 per cent) (table 13A.11). This was the case in all jurisdictions except in WA and the ACT. Across jurisdictions, the difference between the estimated employment rate of people with a profound or severe core activity limitation and that of the general population was highest in Queensland (6.8 percentage points) (figure 13.27).

Figure 13.27 **Estimated employment rates of people aged 15–64 years, 2003[a]**



a Data for people with a disability in the NT are not published.

Source: ABS (Labour Force Survey Cat. no. 6291.0.55.001 [Supertable LM8], unpublished, from the 2003 Disability, Ageing and Carers Survey); table 13A.11.

Social participation of people with a disability

The indicator 'social participation of people with a disability' is explained in box 13.23.

Box 13.23 **Social participation of people with a disability**

'Social participation of people with a disability' is an outcome indicator of governments' objective to assist people with a disability to live as valued and participating members of the community.

This indicator is defined as the proportion of people aged 5–64 years with a profound or severe core activity limitation who participate in social or community activities both in and away from home.

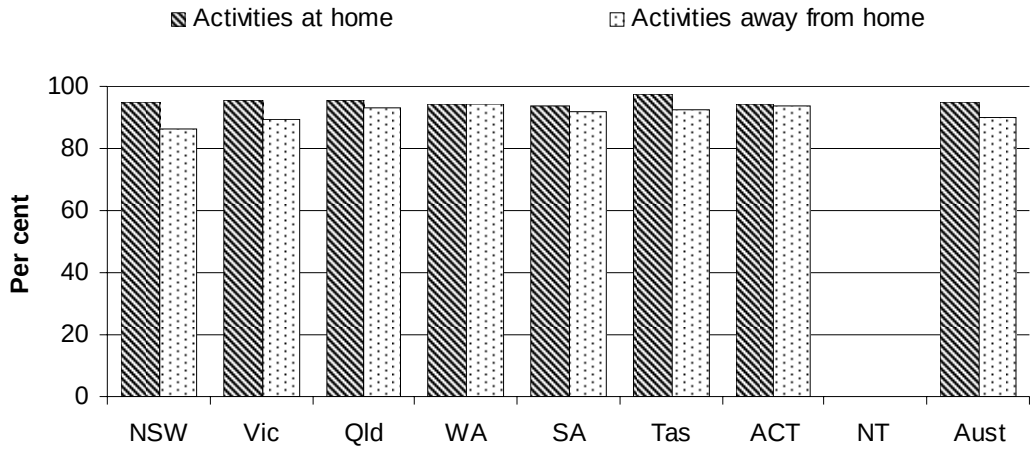
A higher proportion of people aged 5–64 years with a profound or severe core activity limitation who participate in social activities reflects their greater integration in the community.

This indicator does not provide information on the degree to which the identified types of social participation contribute to people's quality of life. It also does not provide information on why some people did not participate.

Nationally, the estimated proportion of people aged 5–64 years with a profound or severe core activity limitation who participated in social activities at home was 95.3 per cent in 2003, and the estimated proportion who participated in social

activities away from home was 90.3 per cent (figure 13.28). The estimated proportion who participated was similar across jurisdictions, for both activities at home and activities away from home. Table 13A.12 includes detail of the types of activity in which people with a profound or severe core activity limitation participated.

Figure 13.28 **Estimated proportion of people aged 5–64 years with a severe or profound core activity limitation who participated in social activities, 2003[a, b]**



a Data for people with a disability in the NT are not published. **b** Data for the ACT contain relative standard errors over 25 per cent.

Source: ABS (unpublished, from the 2003 Disability, Ageing and Carers Survey); table 13A.12.

In 2004, Western Australia conducted a survey of users of disability services (or their carers) on their participation in various social activities. Results of this survey are provided in box 13.24.

Box 13.24 **Social participation of people with a disability**

Western Australia

In 2004, 688 randomly selected users of disability services (or their carers) were surveyed on their participation in a range of social activities. The questions used in the survey were based largely on previous surveys but were modified to align with the International Classification of Functioning categorisation of functions.

(Continued on next page)

Box 13.24 **(Continued)**

The surveyed service users (or carers) were asked if they participated in the activities 'often', 'sometimes', 'rarely' or 'never'. The 'often' and 'sometimes' categories were combined to indicate participation in these activities. Surveyed service users were also asked whether they wanted to participate in the activities 'more often', 'less often' or 'not change'.

The following are the reported results of service users' participation:

- 67 per cent reported going out to entertainment (for example, movies, restaurants and concerts), 15 per cent reported never going out to entertainment and 45 per cent reported wanting to participate in these activities more often.
- 56 per cent reported being involved in group leisure or sport, 35 per cent reported never being involved in group leisure or sport and 34 per cent reported wanting to participate in these activities more often.
- 77 per cent reported being involved in individual activities such as going to the park, walking or swimming, 9 per cent reported never being involved in individual activities and 41 per cent reported wanting to participate in these activities more often.
- 33 per cent reported attending cultural, religious or community events, 57 per cent reported never being involved in these events and 11 per cent reported wanting to participate in these activities more often.
- 62 per cent reported communicating with people other than carers, friends or family members, 24 per cent reported never communicating with these people and 24 reported wanting to communicate with these people more often.

Source: WA Government (unpublished).

Use of other services

The indicator 'use of other services' is explained in box 13.25.

Box 13.25 **Use of other services**

'Use of other services' is included as an outcome indicator of governments' objective of enhancing the quality of life experienced by people with a disability by assisting them to gain access to other government and community services and facilities.

Data on the participation by people with a disability in various services are incorporated into the performance indicator frameworks for those service areas in other chapters of this Report. Participation is reported for VET (see chapter 4), children's services (see chapter 14) and public, community and State owned and managed Indigenous housing (see attachment 16A).

13.4 Future directions in performance reporting

Significant development and refinement of reporting against performance indicators will result from improved, ongoing data being available from the CSTDA NMDS from 2002-03. While only six months of data are reported for 2002-03 in this Report, this is an improvement from the previous CSDA MDS snapshot day collection. In future reports, 12 months of data will be reported.

Notwithstanding these developments, there is scope for further improvements in reporting against the current framework, including improving the data on service quality (for example, client and carer satisfaction). The Steering Committee intends to address limitations over time by:

- expanding reporting to cover other government funded services used by people with a disability
- examining reporting on younger people with a disability in residential aged care
- reporting client and carer satisfaction with service quality
- reporting ongoing social participation data
- reporting more complete, current, ongoing quality assurance data.

Under the umbrella of the multilateral CSTDA, the Australian Government has signed individual agreements with each of the State and Territory governments. In these agreements, the governments (with the exception of the NT) have agreed to work in partnership to improve the access of younger people with a disability in residential aged care to appropriate disability services and supports, and to explore alternative support models that meet the individual needs of young people in residential aged care.

The Steering Committee will consider the need for an indicator on younger people in residential aged care. Recent work on this issue includes:

- National Disability Administrators projects on:
  - disability and ageing
  - people with high clinical/medical support needs.
- a Senate inquiry into aged care, which includes in its terms of reference an examination of the appropriateness of younger people with a disability being accommodated in residential aged care facilities.

Reporting on quality assurance processes is expected to become more complete and comparable over time, with refinements to performance indicators and data

collections. Additional reporting of disability services other than accommodation support, employment and community access may be achievable in future reports.

13.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

The Australian Government comments

“ The implementation of the redeveloped NMDS in 2002-03 was an important step towards the agreement by all governments under the CSTDA to improve accountability, performance reporting and quality.

The Australian Government has been collecting whole-of-year data through its Disability Services Census for some time. Data is collected for outcomes measurement and statistical information for the full financial year of operation of each service. As this involves data being collected for every consumer assisted by an employment service throughout the financial year, collection of data cannot commence until the end of that financial year.

Due to the implementation of the new NMDS across all jurisdictions, data reported for the 2002-03 financial year is only for the 6 months 1 January 2003 to 30 June 2003. This move towards whole-of-year data reporting by all jurisdictions already provides more comprehensive information on service activity than data for one ‘snapshot’ day.

Whole-of-year data will be available in the future and will provide a more complete picture of the disability services sector.

Additional information on whole-of-year disability services census data as collected by the Australian Government is available on the FaCS website at http://www.facs.gov.au. ”

New South Wales Government comments

“ The NSW Government continued its commitment to providing services to people with a disability and their carers to allow them to live independently and participate in community life.

Work during 2003-04 focused on maintaining and sustaining the extensive support system for people with high support needs and on improving and developing approaches to early intervention and prevention.

Expenditure on disability services in NSW increased by almost 10 per cent in 2003-04 to $992 million. Additional resources have been used to meet growing demand for disability services and ensure that existing levels of access to services are maintained. Significant resources were also invested in new flexible respite services, the expansion of the Local Support Coordination Program and the expansion of the Attendant Care Program to enable people with severe physical disabilities to live in their own homes.

Over the next few years, NSW will be introducing a number of initiatives to support families with children with a disability, including those who have very high support needs. These include initiatives to increase support to assist children and young people to remain at home and to encourage their development; to provide a broader range of intensive support options for children with a disability; and to appoint additional children’s case managers to improve the quality of assistance to clients.

NSW continues its commitment to promoting opportunities for community participation by clients in supported accommodation. To this end, NSW is continuing to work with clients in large disability residences, and their families, to facilitate their move to community-based accommodation. A substantial injection of capital funding in 2003-04 finalised relocation from large residential centres for up to 400 people.

Reform of pathways between school and post school continued with the development of a service response for young people leaving school who are not readily able to enter the workforce.

The new CSTDA NMDS, implemented in NSW in October 2002, will provide NSW and other jurisdictions with more meaningful data on disability service outputs and clients, and will allow future planning for people with a disability to be significantly strengthened. However, NSW considers that data from the initial 2002-03 collection — reported in this chapter — is of poor quality and should be interpreted with caution. NSW will continue to work with service providers to improve the quality and completeness of data collected in future NMDS collections. ”

Victorian Government comments

“ In 2003-04, a range of initiatives was undertaken as part of the Victorian State Disability Plan 2002–2012 implementation. Victoria continues to build on previous improvements in the collection and provision of data that is comparable on a national basis. Enhanced data collection sits alongside other significant initiatives.

The *Support and Choice* individualised planning and support initiative, is improving quality of life outcomes and is also promoting stronger links between disability services and local networks. The *Signposts for Building Better Behaviour* program is assisting parents of children with an intellectual disability to manage the difficult behaviours of their school aged children and strengthening early intervention to increase family resilience and reduce dependence on specialist disability services. In August 2003, deaf access Victoria was launched, which together with RuralAccess and MetroAccess initiatives, are supporting communities to become more welcoming and inclusive of people with disabilities.

The redevelopment of Kew Residential Services (KRS) continues with the preliminary evaluation of the first residents relocated from KRS being overwhelmingly positive, with residents and their families reporting high levels of satisfaction.

An extensive consultation for the review of Victorian disability legislation was completed with the recommendations released for public comment in late 2004. The draft revised Victorian Standards for disability services, which will form the basis for quality principles applicable to a range of individualised, flexible and community-based support options, were also released for comment.

The implementation of the new, whole-of-year, NMDS is an important step forward and will provide a comprehensive source of information for a range of planning, policy development and reporting purposes. Notwithstanding improvements in nationally comparable information, like all reports of this kind, some cautionary notes regarding the interpretation of data are necessary. There are important considerations that need to be made regarding the quality of data presented throughout this report, most notably the lower than desirable response rates and the various missing rates of data items for service users and service type outlets. These impose limitations on the ability to generalise from the data. Whilst the new whole-of-year data collection is an improvement over previous ‘snapshot’ collections, it is important to note that the six months of data in the 2005 Report is limited and not comparable to previous reports based on snapshot data nor will it be comparable to future reports that will use whole-of-year data.

Victoria continues to invest heavily in the implementation of the new NMDS by refining tools and providing ongoing training and support to assist disability agencies to collect data. Many issues that impacted on the quality of the six months of data collected for 2002-03 have been addressed and the quality of the 2003-04 data will be greatly improved. ”

Queensland Government comments

“ The Queensland Government policy framework, *Future Directions for Disability Services*, outlines this Government's investment from 2003-04 to 2006-07 to support an efficient and responsive disability services system that delivers quality outcomes for people with a disability. In 2003-04:

- the provision of funded services included support to over 1150 people through adult lifestyle support, 588 people through direct accommodation, 1385 young people through post-school services, 570 children through family and early childhood services and 715 families through family support:
- initiatives were expanded to strengthen families and communities to build formal and informal supports for families and an inclusive Queensland community. For example, the Family Support Program was extended to include families with adults with a disability who have high and critical support needs and who live at home. An additional 13 Local Area Coordination positions were established to assist people with a disability to live and participate in their local community, and improvements were made to respite services in over 20 locations. The *Queensland Government Carer Recognition Policy* was released, providing Queensland Government agencies with a framework to recognise the important role of carers; and
- work progressed on the design and development of a new Disability Information System to support the management of disability service delivery and facilitate interaction between Disability Services Queensland, its clients and service provider.

Queensland's implementation of a Disability Sector Quality System commenced in June 2004. All Disability Services Queensland operated and funded services will undertake a cycle of continuous improvement and external assessment to meet ten *Queensland Disability Services Standards*. Queensland has taken a developmental approach in implementing the Quality System and is working with all stakeholders to develop their understanding of the Quality System and its impact on their organisation and people with a disability, their families and carers.

Extensive public consultation on the review of Queensland's principal disability legislation, the *Disability Services Act 1992*, was undertaken in 2003-04, with people with a disability, their families and carers and other key stakeholders participating. The review is scheduled for completion by November 2005.

In implementing *Future Directions*, the Queensland Government, in partnership with other stakeholders, is advancing the achievement of the five strategic policy priorities that underpin the CSTDA to improve services for people with a disability. Improvements in data collection through the CSTDA NMDS will continue to assist with future planning, monitoring and evaluation of outcomes for people with a disability, their families, carers and communities. ”

Western Australian Government comments

“Western Australia has continued to collect complete whole-of-year data for the NMDS. Western Australia also carried out a consumer survey, covering issues related to satisfaction with service provision, quality of life and social participation. Some data from this survey have been made available in this Report.

Much of our work this year has been guided by the implementation of recommendations from the Local Area Coordination review and the Accommodation Blueprint Report, as well as progressing the draft amendments for the *Disability Services Act 1993*. In addition, considerable work has been done to ensure services are accessible and appropriate for indigenous people with disabilities. Statewide consultations have resulted in a clear policy direction to further develop culturally appropriate services. Raising awareness of the services and support that can be provided within diverse and often remote indigenous communities remains a priority in the immediate future.

Support to individuals, families and carers continued to be directly expanded through increased funding for accommodation and family support, greater funding for school leavers with disabilities through the Post School Options program and the expansion of therapy services.

The right point to access disability services, especially for people whose children have been recently diagnosed with a disability, is being addressed through the release of tenders for the development of a one-stop shop to provide information and support to people with disabilities and their families.

Inclusion and access has been a recurring theme in Western Australia this year. A number of important initiatives have commenced including: preparation of a feasibly report on the introduction of a Companion Card concept based on the Victorian Government model; development of a major community awareness campaign focused on the rights of people with disabilities and their role in the community; organisation of the ‘You Can Do It’ sport and recreation expo, a first for Western Australia, with the Department of Sport and Recreation, ACROD and other stakeholders; production of a new advocacy video, Speaking Out, to help people with disabilities tackle discrimination in an effective manner; and increased funding for advocacy services.

A new resource, the ‘Making a Difference’ newsletter, was produced to communicate directly with service providers on issues as diverse as forthcoming tenders for grants, information on lunchtime forums and emerging policy and processes that impact on the sector.”

South Australian Government comments

“ The Disability Services Office of the South Australian Government continued to focus on the development of strategies to directly promote independent living and social integration for people with a disability during 2003-04. Particular emphasis was placed on the needs of the disabled in regional and remote communities. As a direct response to this, several regional service planning groups have been established in key country locations and a regionally based supported accommodation framework has been initiated to support regional planning.

Several targeted initiatives were implemented to support Indigenous people with disabilities, particularly those in remote communities. These include:

- Establishment of a pilot project to investigate potential disability/family care needs in a remote Aboriginal community
- Priority funding made available for Aboriginal family cares. This combined with a lowering of eligibility age has improved access and support overall.
- An analysis of the demand for supported accommodation options for Indigenous people aged 18 years or over was commenced.

Other achievements during the year include:

- Funding allocated to two pilot projects aimed at developing service delivery models for disabled people retiring from business services
- The provision of purpose built aged care accommodation for ageing people with intellectual disabilities
- Developing accommodation options for people at risk of inappropriate referral to aged cared services cluster housing
- A study of physical activity in group homes initiated with a focus to improving general health of the disabled.
- Inclusion of competency based training relating to ‘Engagement and Physical Activity Certificate 3 and 4’ to the sector.
- Continued work towards the allocation of special access cards to carers of lifelong disabled people in order to improve access to public transport, entertainment and sporting venues for cases where a dedicated carer is required.
- Formation of partnerships with community health as part of the key outcome of improving access for people with a disability to mainstream and primary health services.
- Completion of the Strategic Framework consultation process to enable finalisation of the report for Ministerial approval. ”

Tasmanian Government comments

“In Tasmania the Disability Services Sector Reform process (1999–2003) has been completed. This reform process saw many positive outcomes for service delivery in our State. These included the broadening of the eligibility criteria, the development of a comprehensive evaluation process which focuses on client outcomes, the establishment of an independent Advisory body and the implementation of a range of protocols with other programs and Agencies to enhance access to services for people with disabilities in Tasmania.

A number of projects from the Sector Reform process have also been carried over into the Draft Disability Services Strategic Framework and Strategic Plan for 2004–2009. This five year plan developed through consultation with the disability sector has a vision of Disability Services continuing to work towards a society where all people with disabilities are able to achieve their maximum potential. A number of key initiatives will be progressed under the strategic directions of strengthening individuals, families and communities; service system development; improving service quality; improving resource utilisation and working collaboratively.

Disability Services Tasmania is currently involved in Working Parties with the Australian Government, as outlined through bilateral agreements of the CSTDA, around issues of appropriateness of accommodation, younger people in aged care facilities, and flexible pathways between community access and employment options.

Individualised funding is an area of our service delivery model that continues to demand significant growth in our State. In particular the focus of community-based accommodation support through the Individual Support Program continues to lead to positive outcomes for people with disabilities in Tasmania.

The redeveloped Minimum Data Set has led to more a more accurate picture of service delivery across all service types. Noting the constraints of the first year of data following the redevelopment, Disability Services Tasmania will look forward to more reliable and comparable data in future years.”

Australian Capital Territory Government comments

“ The ACT Government has articulated its direction for disability over the next four years, with *Future Directions: A Framework for the ACT 2004–2008*. The strategies identified within this Framework recognise the broader responsibilities of government and community to improve outcomes for people with disabilities. To enhance and improve opportunities for people with disabilities, partnerships have been developed in the ACT with people with disabilities, their families and carers, the sector, and the broader community and all areas of government. Implementation of the strategic framework will require consolidation and collaboration with the community to confirm key priorities and develop action plans.

Future Directions sets out the framework for continuing and building on the reforms already achieved as a result of the implementation of the Government's Response to the *Board of Inquiry into Disability Services* Recommendations. Disability ACT continues to respond to challenges associated with implementing initiatives, including improvement of government administrative efficiency, whilst improving the effectiveness of government funded services and responding to unmet need within a small jurisdiction.

Some of the initiatives targeted towards meeting these challenges over the last twelve months include:

- Implementation of the *Access to Government Strategy*, aimed at improving the accessibility of ACT Government services to people with a disability, and the launch and implementation of the ACT *Public Service Employment Framework for People with a Disability*.
- Allocated the 2003-04 round of innovation grants for small pilot projects. The innovation fund is designed to encourage families, individuals and organisations to explore initiatives that will result in sustained improvements for people with a disability in the ACT.
- Piloting of a Community Linking and Needs Assessment Service to support individuals and families to identify their own needs and work with them to develop support networks.
- Ongoing development of a workforce strategy, in partnership with the community sector, to strengthen the sustainability and responsiveness of the service delivery sector.

Over the next four years, the ACT will continue to ensure that service options for people with disabilities, their families and carers are flexible and respond to identified need. In response to the unmet support needs of people with disabilities, the ACT provided $1.25 million growth monies in the 2004-05 budget increasing to $1.5 million in 2005-06 to introduce Local Area Coordination and fund support for people with unmet needs. ”

Northern Territory Government comments

“Despite the significant challenges the Northern Territory Government faces in providing specialist disability services to the most remote and most sparsely populated areas in Australia, the NT continues to deliver innovative services to Territorians with disabilities. Some of these innovative service models include restructuring and pooling resources from various programs such as the CSTDA, HACC, Community Aged Care Packages and Allied Health Services.

The Northern Territory Government undertook major strategic, policy and program initiatives both at the local and at national levels.

NT initiatives focused on improved equity and access for remote Aboriginal people with disabilities and children with disabilities and their families. Trans-disciplinary Allied Health services were established in rural and remote communities in Katherine, East Arnhem and Darwin Regions; community-based specialist support services for people with Machado Joseph Disease has been established in East Arnhem and a review of services for children with disabilities in Darwin had improved their access to services. Other NT initiatives focused on services for people with complex needs. A Positive Behaviour Support Team has been established in Central Australia to assist people with disabilities and complex challenging behaviours and their families and to maintain them in their communities. A review of Post School Options programs resulting in increased funding and an expansion of services for young people with significant disabilities leaving school in Alice Springs and Darwin.

At the national level the Northern Territory had a lead role in National Disability Administrators’ research project, ‘Sharing Stories’ which documented innovative service delivery to Aboriginal people with disabilities in remote communities. NT also played a key role in the National Disability Administrators’ development work in the interfaces between employment and post-school options, disability and aged care and HACC.

The data related to NT potential population estimates needs to be interpreted with caution. The small NT population results in small sample size and subsequent high standard of error.

The NT Government is committed to working with local services provider, other jurisdictions and the Australian Government on improving outcomes for people with disabilities in the Northern Territory and their families and communities.”

13.6 Definitions of key terms and indicators

Accommodation support service users receiving community accommodation and care services	People using CSTDA NMDS service types 1.04–1.08 as a proportion of all people using CSTDA accommodation services (excludes psychiatric services). See AIHW (2003a) for more information on service types 1.04–1.08.
Administration expenditure as a proportion of total expenditure	The numerator — expenditure (accrual) by jurisdictions on administering the disability service system as a whole (including the regional program management and administration, the central policy and program management and administration, and the disability program share of corporate administration costs under the umbrella department, but excluding administration expenditure on a service that has been already counted in the direct expenditure on the service) — divided by the denominator — total government expenditure on services for people with a disability (including expenditure on both programs and administration, direct expenditure and grants to government service providers, and government grants to non-government service providers).
Core activities as per the ABS Survey of Disability, Ageing and Carers	Self-care — bathing or showering, dressing, eating, using the toilet, and managing incontinence; mobility — moving around at home and away from home, getting into or out of a bed or chair, and using public transport; and communication — understanding and being understood by strangers, family and friends in own native language or via most effective method of communication.
Cost per user of government provided services — group homes	The numerator — government expenditure (accrual) on government provided group homes (as defined by CSTDA NMDS service type 1.04) — divided by the denominator — the number of users of government provided group home services.
Cost per user of government provided services — institutional/residential settings	The numerator — government expenditure (accrual) on government provided institutional (residential) accommodation as defined by CSTDA NMDS service types 1.01, 1.02 and 1.03 — divided by the denominator — the number of users of these services. See AIHW (2003a) for more information on service types 1.01–1.03.
Cost per user of government provided services — other community settings	The numerator — government expenditure (accrual) on government provided other community accommodation and care (as defined by CSTDA NMDS service types 1.05–1.08) divided by the denominator — the number of users of these services.
Disability	A multidimensional experience that may involve effects on organs or body parts, and effects on a person's participation in areas of life. Correspondingly, three dimensions of disability are recognised in the International Classification of Functioning, Disability and Health final draft classification: body structure and function (and impairment thereof), activity (and activity restrictions) and participation (and participation restriction) (WHO 2001). The classification also recognises the role of physical and social environmental factors in affecting disability outcomes. The ABS 2003 Survey of Disability, Ageing and Carers defined 'disability' as the presence of one or more of 17 limitations, restrictions or impairments, which have lasted, or are likely to last, for a period of six months or more: loss of sight (not corrected by glasses or contact lenses); loss of hearing where communication is restricted; or an aid to

	assist with, or substitute for, hearing is used; speech difficulties; shortness of breath or breathing difficulties causing restriction; chronic or recurrent pain or discomfort causing restriction; blackouts, fits or loss of consciousness; difficulty learning or understanding; incomplete use of arms or fingers; difficulty gripping or holding things; incomplete use of feet or legs; nervous or emotional condition causing restriction; restriction in physical activities or in doing physical work; disfigurement or deformity; mental illness or condition requiring help or supervision; long term effects of head injury; stroke or other brain damage causing restriction; receiving treatment or medication for any other long term conditions or ailments and still restricted; any other long term conditions resulting in a restriction.
Employment rate for people with a severe or profound disability	Total estimated number of people aged 15–64 years with a severe or profound disability who are employed, divided by the total estimated number of people aged 15–64 years with a severe or profound disability in the labour force, multiplied by 100.
Employment rate for total population	Total estimated number of people aged 15–64 years who are employed, divided by the total number of people aged 15–64 years in the labour force, multiplied by 100.
Funded agency	An organisation that delivers one or more CSTDA service types (service type outlets). Funded agencies are usually legal entities. They are generally responsible for providing CSTDA NMDS data to jurisdictions. Where a funded agency operates only one service type outlet, the service type outlet and the funded agency are the same entity.
Geographic location	Geographic location is based on the ABS's Australian Standard Geographical Classification of Remoteness Areas which categorises areas as 'major cities', 'inner regional', 'outer regional', 'remote' and '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' classification used in this Report was derived by adding outer regional, remote and very remote data. In previous reports, the geographic location data were based on the Rural, Remote and Metropolitan Areas (RRMA) classification [see DPIE and DHSH (1994) for more information on the RRMA classification].
Government contribution per user of non-government provided employment services	The numerator — Australian Government grant and case-based funding expenditure (accrual) on specialist disability employment services as defined by CSTDA NMDS service types 5.01 (open), 5.02 (supported), 5.03 (combined open and supported) — divided by the denominator — number of service users who received assistance. See AIHW (2003a) for more information on service types 5.01–5.03.
Government contribution per user of non-government provided services — group homes	The numerator — government expenditure (accrual) on non-government provided group home services as defined by CSTDA NMDS service type 1.04 — divided by the denominator — the number of users of these services.

Government contribution per user of non-government provided services — institutional/residential settings	The numerator — government expenditure (accrual) to non-government provided institutional (residential) accommodation and care as defined by CSTDA NMDS service types 1.01, 1.02 and 1.03 — divided by the denominator — the number of users of these services.
Government contribution per user of non-government provided services — other community settings	The numerator — government expenditure (accrual) on non-government provided other community accommodation and care services as defined by CSTDA NMDS service types 1.05–1.08 — divided by the denominator — the number of users of these services.
Labour force participation rate for people with a profound or severe disability	The total number of people with a severe or profound disability in the labour force (where the labour force includes employed and unemployed people), divided by the total number of people with a severe or profound disability 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 (as per the ABS 2003 Survey of Disability, Ageing and Carers)	Having no difficulty performing a core activity, but using aids or equipment as a result of a disability.
Moderate core activity limitation (as per the 2003 ABS Survey of Disability, Ageing and Carers)	Not needing assistance but having difficulty performing a core activity.
Non-English speaking country of birth	People with a country of birth other than Australia and classified in English proficiency groups 2, 3 or 4 (DIMA 1999). These countries include countries other than New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States.
Potential population	Potential population estimates are used as the denominators for performance indicators on access to accommodation support services, access to employment services, and access to community access services. The term 'potential population' is not the same as the population

	needing the services. Rather, it indicates those with the potential to require disability support services, which include individuals who meet the service eligibility criteria but who do not demand the services. The potential population for CSTDA funded accommodation support services is the number of people aged less than 65 years who have a profound and/or severe core activity limitation, adjusted for the Indigenous factor for that jurisdiction. The potential population for CSTDA funded employment services is the number of people aged 15–64 years with a severe or profound core activity limitation, adjusted for the Indigenous factor and the labour force participation rate for that jurisdiction. The potential population for CSTDA funded community access services is the number of people aged 15–64 years with a severe or profound core activity limitation, adjusted for the Indigenous factor for that jurisdiction. The ABS concept of a 'severe or profound' core activity limitation that relates to the need for assistance with everyday activities of self-care, mobility and verbal communication was argued to be the most relevant population figure for disability services. The relatively high standard errors in the prevalence rates for smaller jurisdictions, as well as the need to adjust for the Indigenous population necessitated the preparation of special estimates of the 'potential population' for disability services. These estimates, prepared by the AIHW, have been used in the performance indicators when population data are needed in the denominator. Briefly, the 2003 national age- and sex-specific rates of severe and profound core activity limitation for people aged under 65 years have been applied to the age and sex structure of each jurisdiction in the current year to give an 'expected current estimate' of people with a severe or profound core activity limitation who are aged under 65 years in that jurisdiction. People of Indigenous status have been given a weighting of 2 in these estimates, in recognition of their greater prevalence rates of disability and their relatively greater representation in CSTDA services (AIHW 2000).
Primary carer	A primary carer is a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities (communication, mobility and self-care) (ABS 2004a).
Primary disability group	Disability group that most clearly expresses the experience of disability by a person. The primary disability group can also be considered as the disability group causing the most difficulty to the person (overall difficulty in daily life, not just within the context of the support offered by a particular service).
Profound core activity limitation (as per the ABS 2003 Survey of Disability, Ageing and Carers)	Refers to being unable, or always needing assistance, to perform a core activity (comprising communication, mobility and self-care).
Proportion of people with a disability employed	Total number of people with a disability aged 15 years or over who are employed, divided by the total number of people with a disability who are aged 15 years or over in the labour force, multiplied by 100.
Proportion of people with a disability unemployed	Total number of people with a disability aged 15 years or over who are unemployed, divided by the total number of people with a disability who are aged 15 years or over in the labour force, multiplied by 100.

Proportion of the total population employed	Total number of people aged 15–64 years who are in the labour force and employed, divided by the total number of people aged 15–64 years in the labour force.
Proportion of the total population unemployed	Total number of people aged 15–64 years who are in the labour force but unemployed, divided by the total number of people aged 15–64 years in the labour force.
Real expenditure	Actual expenditure (accrual) adjusted for changes in prices, using the GDP(E) price deflator, and expressed in terms of the current year dollars.
Schooling or employment restriction	*Schooling restriction*: as a result of disability, being unable to attend school; having to attend a special school; having to attend special classes at an ordinary school; needing at least one day a week off school on average; and/or having difficulty at school. *Employment restriction*: as a result of disability, being permanently unable to work; being restricted in the type of work they can do; needing at least one day a week off work on average; being restricted in the number of hours they can work; requiring an employer to provide special equipment, modify the work environment or make special arrangements; needing to be given ongoing assistance or supervision; and/or finding it difficult to change jobs or to get a better job.
Service	A service is a support activity provided to a service user, in accord with the CSTDA. Services within the scope of the collection are those for which funding has been provided during the specified period by a government organisation operating under the CSTDA.
Service type	The support activity that the service type outlet has been funded to provide under the CSTDA. The NMDS classifies services according to 'service type'. The service type classification groups services into seven categories: accommodation support; community support; community access; respite; employment; advocacy, information and print disability; and other support services. Each of these categories has subcategories.
Service type outlet	A service type outlet is the unit of the funded agency that delivers a particular CSTDA service type at or from a discrete location. If a funded agency provides, for example, both accommodation support and respite services, it is counted as two service type outlets. Similarly, if an agency is funded to provide more than one accommodation support service type (for example, group homes and attendant care), then it is providing (and is usually separately funded for) two different service types — that is, there are two service type outlets for the funded agency.
Service user	A service user is a person with a disability who receives a CSTDA funded service. A service user may receive more than one service over a period of time or on a single day.
Service users with different levels of severity of core activity limitation	Data on service users with different levels of severity of core activity limitation are derived by the AIHW based on the level of support needed in one or more of the three areas of daily living: self-care, mobility and communication. Service users with: • a profound core activity limitation reported 'always needing support' in one or more of these areas • a severe core activity limitation reported 'sometimes needing support' in one or more of these areas, and

	• moderate to no core activity limitations reported needing 'no support' in all of these areas.
Severe core activity limitation (as per the ABS 2003 Survey of Disability, Ageing and Carers)	Sometimes needing assistance to perform a core activity task.
Specific limitation or restriction (as per the ABS 2003 Survey of Disability, Ageing and Carers)	Core activity limitations and schooling or employment restrictions.
Users of CSTDA accommodation support services	Accommodation support services provide people with a disability with accommodation (group homes, hostels and institutions) or services needed to support and enable a person with a disability to remain in their existing accommodation (attendant care and in-home support). People using one or more services that correspond to the following CSTDA NMDS service types: 1.01 large residentials/institutions (more than 20 places); 1.02 small residentials /institutions (7–20 places); 1.03 hostels; 1.04 group homes (less than seven places); 1.05 attendant care/personal care; 1.06 in-home accommodation support; 1.07 alternative family placement; and 1.08 other accommodation support.
Users of CSTDA community access services	People using one or more services that correspond to the following CSTDA NMDS service types: 3.01 learning and life skills development; 3.02 recreation/holiday programs; and 3.03 other community access. See AIHW (2003a) for more information on service types 3.01–3.03. Community access services data reported for 2001 included access to community service types that focus on developing learning and life skills for people with a disability. Example of these services included: continuing education/independent living training/adult training centre, post-school options/social and community support/community access, and other community access and day programs. Data for 2002 include the following community access service types: learning and life skills development, and other community access (but not recreation/holiday programs).
Users of CSTDA community support services	People using one or more services that correspond to the following CSTDA NMDS service types: 2.01 therapy support for individuals; 2.02 early childhood intervention; 2.03 behaviour/specialist intervention; 2.04 counselling; 2.05 regional resource and support teams; 2.06 case management, local coordination and development; and 2.07 other community support. See AIHW (2003a) for more information on service types 2.01–2.07.
Users of CSTDA employment services	People using one or more services that correspond to the following CSTDA NMDS service types: 5.01 open employment; 5.02 supported employment; and 5.03 combined open and supported employment.
Users of CSTDA respite services	People using one or more services that correspond to the following CSTDA NMDS service types: 4.01 own home respite; 4.02 centre-based respite/respite homes; 4.03 host family respite/peer support respite; 4.04 flexible/combination respite; and 4.05 other respite. See AIHW (2003a) for more information on service types 4.01–4.05.

13.7 References

ABS (Australian Bureau of Statistics) 1999, *Disability, Ageing and Carers Australia: Summary of Findings 1998*, Cat. no. 4430.0, Canberra.

—— 2001, *Australian Standard Geographical Classification (ASGC)*, Cat. no. 1216.0, Canberra.

—— 2002a, *Australian Demographic Statistics*, Cat no. 3101.0, Canberra.

—— 2002b, *Labour Force Australia, June 2002*, Cat. no. 6203.0, Canberra.

—— 2004a, *Disability, Ageing and Carers Australia: Summary of Findings 2003*, Cat. no. 4430.0, Canberra.

—— 2004b, *Experimental projections of the Aboriginal and Torres Strait Islander population 30 June 2001 to 30 June 2009*, Cat. no. 3238.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 2000, *First National Results on Services Provided under the Commonwealth–State Disability Agreement: National Data, 2000*, Cat. no. DIS 21, Canberra.

—— 2001, *First National Results on Services Provided under the Commonwealth–State Disability Agreement: National Data*, Cat. no. DIS 24, Canberra.

—— 2002, *First National Results on Services Provided under the Commonwealth–State Disability Agreement: National Data*, Cat. no. DIS 27, Canberra.

—— 2003a, *Data Guide: Data Items and Definitions 2003–04*, Commonwealth State/Territory Disability Agreement National Minimum Data Set, Canberra.

—— 2003b, *Disability Support Services: Revisions to the CSDA MDS Data and Reports 1996 to 2000*, Cat. no. DIS 29, Canberra.

—— 2004a, *CSTDA NMDS Tables Prepared for the CSTDA Annual Public Report 2002–03*, Cat. no. 36, Canberra.

—— 2004b, *Disability Support Services 2002–03: the First Six Months of Data from the Commonwealth State/Territory Disability Agreement National Minimum Data Set*, Cat. no. 35, Canberra.

CSTDA (Commonwealth State/Territory Disability Agreement) 2003, *Agreement between the Commonwealth of Australia and the States and Territories of Australia in Relation to Disability Services*, Australian Government Department of Family and Community Services, Canberra.

DIMA (Department of Immigration and Multicultural Affairs) 1999, *1996 Classification of Countries into English Proficiency Group*, Statistical focus C96.1A revised, Australian Government Canberra.

DPIE (Department of Primary Industries and Energy) and DHSH (Department of Human Services and Health) 1994, *Rural, Remote and Metropolitan Areas Classification, 1991 Census Edition*, Australian Government, Canberra.

Madden, R., Black, K., Choi, C., Wen, X. and Eckerman, S. 1997, *Effectiveness Indicators and Descriptors: First Results*, Welfare Division Working Paper no. 15, Australian Institute of Health and Welfare, Canberra.

SCRCSSP (Steering Committee for the Review of Commonwealth State Service Provision) 1998, *Report on Government Services*, Productivity Commission, Canberra.

—— 2000, *Report on Government Services*, Productivity Commission, Canberra.

WHO (World Health Organisation) 2001, *ICIDH-2: International Classification of Functioning, Disability and Health*, Final draft, Full version, Geneva.

14 Children's services

Children's services aim to meet the care, education and development needs of children, although the emphasis on these broad objectives may differ across the services. Child care services reported in this chapter include those provided to children aged less than 13 years, usually by someone other than the child's parents or guardian. Preschool services are provided to children mainly in the year or two before they commence full time schooling.

This chapter presents performance and descriptive information for government funded and/or delivered child care and preschool services. Unless otherwise stated, the data relate to services that are supported by the Australian, State and Territory governments and provided for children aged less than 13 years. Local governments also plan, fund and deliver children's services. Given data limitations, however, this chapter records data on local government activities only where Australian, State and Territory government funding and licensing are involved. The chapter does not include services that do not receive government funding (unless otherwise noted).

A profile of children's services is presented in section 14.1. This provides a context for assessing the performance indicators presented later in the chapter. All jurisdictions have agreed to develop, and aim to report, comparable indicators; a framework of performance indicators is outlined in section 14.2. The data are discussed in section 14.3 and future directions for performance reporting are discussed in section 14.4. The chapter concludes with jurisdictions' comments in section 14.5. Definitions of terms specific to children's services are found in section 14.6.

Changes to reporting on children's services this year include reporting against two performance indicators for the first time and improvements to data quality and comparability. Major changes include the reporting for the first time of data on service costs and demand for additional services, and the adoption for geographic data of the Australian Standard Geographical Classification of Remoteness Areas.

Supporting tables

Supporting tables for chapter 14 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel format as

\Publications\Reports\2005\Attach14A.xls and in Adobe PDF format as \Publications\Reports\2005\Attach14A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 14A.3 is table 3 in the electronic files). These files can also be found on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

14.1 Profile of children's services

Service overview

Children's services are provided using a variety of service delivery types that can be grouped into the following six broad categories:

- *Centre-based long day care* — comprises services aimed primarily at 0–5 year olds, provided in a centre usually by a mix of qualified and other staff. Educational, care and recreational programs are provided based on the developmental needs, interests and experience of each child. In some jurisdictions, primary school children may also receive care before and after school, and during school vacations. Centres typically operate for at least eight hours per day on normal working days, for a minimum of 48 weeks per year.
- *Family day care* — comprises services provided in the carer's home. The care is largely aimed at 0–5 year olds, but primary school children may also receive care before and after school, and during school vacations. Central coordination units in all states and territories organise and support a network of carers, often with the help of local governments.[1]
- *Occasional care* — comprises services usually provided at a centre on an hourly or sessional basis for short periods or at irregular intervals for parents who need time to attend appointments, take care of personal matters, undertake casual and part time employment, study or have temporary respite from full time parenting. These services provide developmental activities for children and are aimed primarily at 0–5 year olds. Centres providing these services usually employ a mix of qualified and other staff.

[1] In WA, family day care licences can be issued for groups aged 0–5 years and 5–12 years, allowing for licence holders to provide vacation care, before and after school hours care, as well as long day care.

- *Preschool* — comprises services usually provided by a qualified teacher on a sessional basis in dedicated preschools. Preschool programs or curricula may also be provided in long day care centres and other settings. These services are primarily aimed at children in the year before they commence full time schooling (that is, when children are 4 years old in all jurisdictions), although younger children may also attend in all jurisdictions except Victoria and the NT.[2]
- *Outside school hours care* — comprises services provided for school aged children (5–12 year olds) outside school hours during term and vacations. Care may be provided on student free days and when school finishes early.
- *Other services* — comprise government funded services to support children with additional needs or in particular situations (including children from an Indigenous or non-English speaking background, children with a disability or of parents with a disability, and children living in regional and remote areas).

Roles and responsibilities

The Australian Government and the State and Territory governments have different but complementary roles in supporting children's services. Both levels of government help fund services, provide information and advice to parents and service providers, and help plan, set and maintain operating standards.

The Australian Government's roles and responsibilities for child care include:

- assisting families to participate in the social and economic life of the community by providing child care services and payments (such as Child Care Benefit)
- planning the location of services, in conjunction with other levels of government
- providing information and advice to parents and providers about the availability of Australian Government funded services and some State and Territory funded services
- helping to enhance the quality of child care by funding the National Childcare Accreditation Council (NCAC) to administer the following quality assurance systems for children's services:
  - the Quality Improvement and Accreditation System (QIAS) for long day care centres
  - Family Day Care Quality Assurance (FDCQA) for family day care schemes

[2] In Tasmania, the flexibility to enrol children of pre-kindergarten age is permitted only under limited circumstances (such as for gifted children or children previously enrolled in another State or Territory who now reside in Tasmania).

– Outside School Hours Care Quality Assurance (OSHCQA) for outside school hours care services.

Participation in the quality assurance systems is required to remain eligible for continued Child Care Benefit funding approval from the Australian Government:

- providing information, support and training to service providers by funding organisations
- providing operational and capital funding to some providers.

State and Territory governments' roles and responsibilities vary across jurisdictions and may include:

- providing operational and capital funding to non-government service providers
- delivering some services directly (especially preschool services)
- developing new child care and preschool services
- licensing and setting standards for children's services providers
- monitoring and resourcing licensed and/or funded children's services providers
- providing information, support, training and development opportunities for children's services providers
- assisting services in enhancing quality by providing curriculum and policy support and advice, as well as training and development for management and staff
- planning to ensure the appropriate mix of services is available to meet the needs of the community
- providing information and advice to parents and others about operating standards and the availability of services
- providing dispute resolution and complaints management processes.

State and Territory governments' roles in, and objectives for, children's services differ from those of the Australian Government. The Australian Government provides financial support to families principally through payment of Child Care Benefit. The benefit is payable to families using approved child care services or registered informal carers. Currently, it is generally the case that State and Territory governments are responsible for providing educational and developmental opportunities, such as preschool services.

Quality of care

Both levels of government are active in maintaining the quality of care provided by children's services. The mechanisms used include licensing, quality assurance, the measurement of performance against standards, and outcomes linked to funding. These mechanisms are used in addition to the provision of curriculum and policy support and advice, and the training and development of management and staff.

Licensing

State and Territory governments set legislative and regulatory requirements for the licensing of children's services and monitor adherence to these requirements. These regulations include safety standards, staff qualifications, child/staff ratios and health and safety requirements.

The Australian, State and Territory governments have jointly developed national standards for centre-based long day care, family day care and outside school hours care services. These standards express a national view about the level of care all Australians should expect from the different types of child care service available to them. The types of service covered, the standards that apply, and the extent of implementation of these standards vary across jurisdictions.

Quality assurance

The Australian Government has implemented quality assurance systems for Australian Government funded centre-based long day care services, family day care services and outside school hours care services. These quality assurance systems focus on quality outcomes for children. They are processes of self-study and improvement against principles of good quality care. To be eligible for Child Care Benefit and other funding support, child care services are required to register and satisfactorily participate in quality assurance. Quality assurance is designed to build on and complement the State and Territory government licensing requirements (where they exist).

Funding performance standards and outcomes

State and Territory governments impose varying performance requirements for funding children's services. These requirements may include: the employment of higher qualified staff than required by licensing or minimum standards; self-assessment of quality; and a demonstration of the delivery of quality educational and recreational programs.

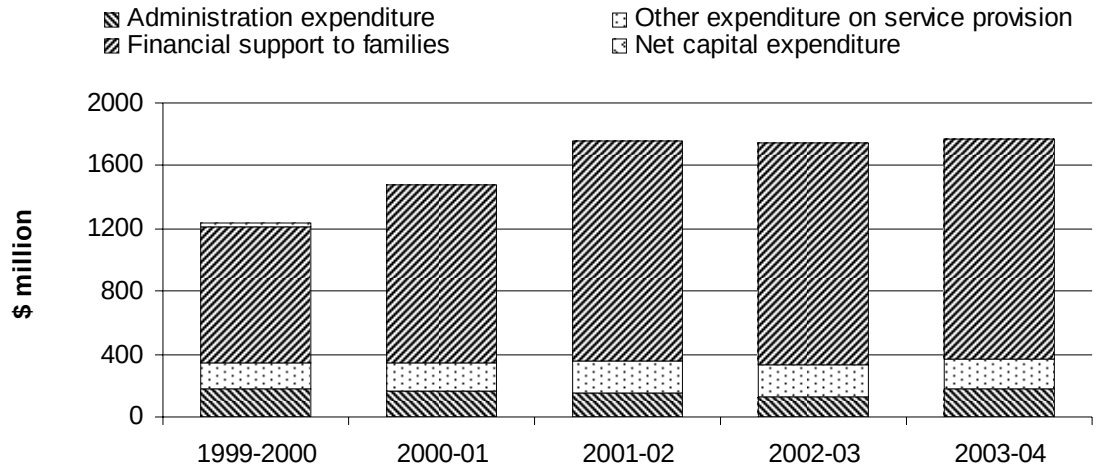
Funding

Total Australian, State and Territory government expenditure on children's services was approximately $2.4 billion in 2003-04, compared with $2.3 billion (in real terms) in 2002-03 (table 14A.4).

Australian Government expenditure accounted for 74.5 per cent ($1.8 billion) of total government expenditure on children's services in 2003-04. The major component of Australian Government expenditure was financial support to families through assistance with fees, which accounted for 78.8 per cent ($1.4 billion) of Australian Government expenditure on children's services. Administration expenditure accounted for a further 9.8 per cent ($173.8 million), and other expenditure on service provision and net capital expenditure accounted for the remaining 10.9 per cent ($193.1 million) and 0.5 per cent ($9.2 million) respectively (figure 14.1).

State and Territory government expenditure on children's services in 2003-04 was approximately $608.3 million, of which other expenditure on service provision comprised around 50.3 per cent ($306.0 million). Administration expenditure, financial support to families and net capital expenditure accounted for 40.3 per cent ($245.3 million), 7.6 per cent ($46.1 million) and 1.2 per cent ($7.2 million) respectively (table 14A.4).

Figure 14.1 **Australian Government real expenditure on children's services (2003-04 dollars)**



Source: Department of Family and Community Services (DFaCS) (unpublished); table 14A.4.

In the distribution of total State and Territory government expenditure across all children's service types, the provision of preschool services accounted for the

largest proportion (around 80.6 per cent, or $490.1 million, for those jurisdictions for which data are available) (tables 14A.24, 14A.33, 14A.42, 14A.51, 14A.60, 14A.69, 14A.78 and 14A.87). The Australian Government provides supplementary funding for the preschool education of Indigenous children in all jurisdictions.

Size and scope

Child care services

The Australian Government supported 561 876 child care places in 2004 — an increase of 8.5 per cent on the number in 2003 (table 14A.7). The majority of Australian Government supported child care places were outside school hours care places (45.2 per cent), followed by centre-based long day care places (40.9 per cent), family day care places (13.3 per cent), occasional care places (0.5 per cent) and other care places (0.2 per cent). State and Territory governments supported at least 180 000 preschool places in 2003-04 (tables 14A.25, 14A.34, 14A.43, 14A.52, 14A.61, 14A.70, 14A.79 and 14A.88).

Approximately 839 000 children (24.4 per cent of children aged 12 years or younger) used Australian, State and Territory government funded and/or provided child care in 2003-04 (tables 14A.1, 14A.9, 14A.26, 14A.35, 14A.44, 14A.53, 14A.62, 14A.71, 14A.80 and 14A.89). Of these children, around 568 000 were aged 5 years or younger. Changes to data collection approaches and the exclusion of certain services funded by some jurisdictions reduce the comparability of these data across jurisdictions.

Table 14.1 **Children using Australian, State and Territory government funded and/or provided child care, 2003-04 (per cent)[a]**

Age	*NSW* [b]	*Vic*	*Qld*	*WA*	*SA*[c]	*Tas*	*ACT*	*NT*	*Aust*
0–5 years	48.9	26.8	39.4	24.5	31.1	33.4	38.0	22.5	37.1
6–12 years	12.9	13.4	16.7	8.6	22.0	14.7	22.6	13.9	14.2

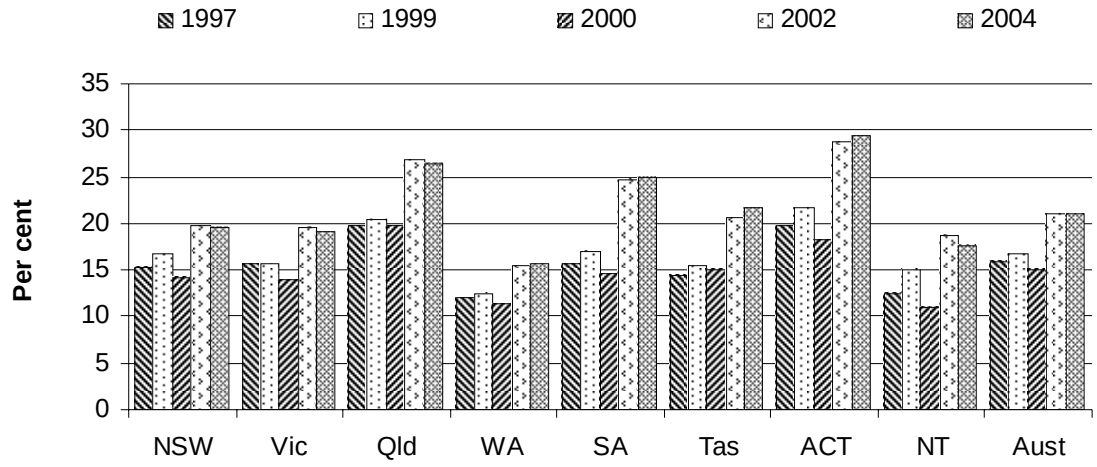
a Australian Government data are drawn from the March 2004 Australian Government Census of Child Care Services (AGCCCS). **b** NSW used a revised method of calculating the number of children receiving child care and preschool services. This new method of calculation will provide clear trend data for each age group for child care and preschool. The data include estimates based on the rate of survey return for each year. NSW data are not comparable with data for other states and territories. **c** SA excludes children in non-government preschools.

Source: Australian Bureau of Statistics (ABS) (unpublished), Cat. no. 3201.0; ABS (unpublished), Cat. no. 3222.0; AGCCCS, March 2004 (unpublished); State and Territory governments (unpublished); tables 14A.1, 14A.9, 14A.26, 14A.35, 14A.44, 14A.53, 14A.62, 14A.71, 14A.80 and 14A.89.

Nationally, 722 292 children aged 12 years or younger (21.0 per cent of all children in this age group) attended Australian Government approved child care services in 2004 (figure 14.2). The majority (approximately 471 000 nationally, or 65.1 per cent) of those children were aged 0–5 years. Approximately 30.7 per cent of children aged 5 years or younger attended Australian Government funded and/or provided child care services in 2003-04 (table 14A.9).

The average hours of attendance in child care in 2004 varied considerably across jurisdictions, for all types of service. The average attendance per child at centre-based long day care centres ranged from 28.6 hours per week in the NT to 15.6 hours per week in Tasmania, while the average attendance per child at family day care ranged from 26.1 hours per week in the NT to 14.6 hours per week in Tasmania. The average attendance per child at occasional care services ranged from 17.0 hours per week in the NT to 7.1 hours per week in Victoria, and the average attendance at vacation care during school holidays ranged from 3.9 days per week in the NT to 2.5 days per week in Tasmania (table 14A.8).

Figure 14.2 **Proportion of children aged 0–12 years using Australian Government approved child care[a, b, c, d]**



a Excludes children cared for in neighbourhood model services. **b** Australian total includes children in other Territories. **c** Data for 1997, 1999, 2002 and 2004 are drawn from the respective AGCCCS, while data for 2000 are drawn from Centrelink administrative data. The AGCCCS and Centrelink data are not fully comparable and such comparisons need to be treated with care. **d** Data for WA exclude children attending Department of Education provided kindergartens for 4 year olds, who would otherwise be in child care.

Source: ABS (unpublished), Cat. no. 3201.0; ABS (unpublished), Cat. no. 3222.0; AGCCCS, March 2004 (unpublished); Centrelink administrative data, August 2000 (unpublished); table 14A.9.

Preschool services

Preschools provide a range of educational and developmental programs (generally on a sessional basis) to children in the year immediately before they commence full time schooling and also, in some jurisdictions, to children aged 3 years or under (children aged 4 years in WA). The age from which children may attend preschools varies across jurisdictions. Victoria contributes funding towards a preschool program for all 4-year-old children, which is the year before they commence schooling. Children in the NT are usually funded by government to attend preschool in the year before they commence schooling. Younger children in NSW, Queensland, WA, SA, Tasmania and the ACT may also access government funded preschool services.[3]

Younger Indigenous children living in remote areas in the NT and Queensland also may attend preschools. In SA, a pre-entry program provides one session of preschool a week for 10 weeks in the term before preschool, and children from Indigenous backgrounds may attend preschool at 3 years of age. In the ACT, children from Indigenous backgrounds, children with English as a second language, and children with a hearing impairment and/or whose parents have a hearing impairment may be eligible for early entry into preschool (for 5.25 hours per week) at 3 years of age.

This disparity in the age from which children may access preschool services reduces the comparability of preschool data across jurisdictions. Preschool data are presented for two categories to improve comparability:

- children attending preschool in the year immediately before they commence full time schooling (data that are largely presented on a comparable basis for all jurisdictions)
- younger children attending preschool services.

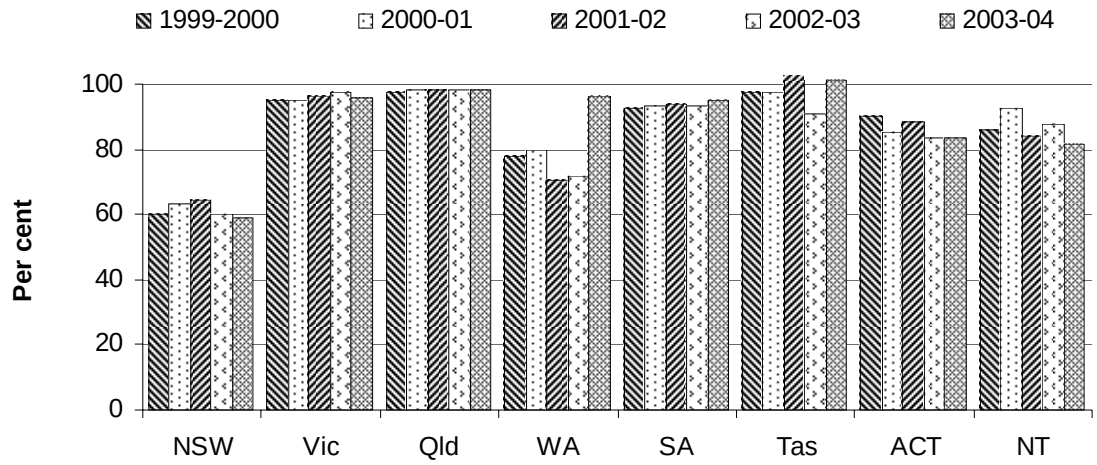
Approximately 246 000 children attended State and Territory funded and/or provided preschool services in 2003-04. The majority (88.6 per cent, or approximately 218 000 children) were to begin full time schooling the following year (tables 14A.26, 14A.35, 14A.44, 14A53, 14A.62, 14A.71, 14A.80 and 14A.89).

Some jurisdictions differ in their age criterion for access to preschool services; as a result, the following data need to be interpreted with caution. Nationally in 2003-04, 83.7 per cent of children of 4 years of age attended funded and/or provided preschool in the year immediately before they commenced school. This proportion

[3] See footnote 2.

ranged from about 100 per cent in Tasmania to 59.1 per cent in NSW. There is some double counting in several jurisdictions, as well as issues with synchronisation of data collection times, leading to overestimation of the attendance rates being reported (figure 14.3).

Figure 14.3 **Children in the population who attended State and Territory government funded and/or provided preschool services immediately before the commencement of full time schooling[a, b, c, d, e, f]**



a The denominator — the population of preschool aged children — is defined as persons aged 4 years in all states and territories. Percentages are distorted by the data for estimated residential population being six months out of sequence with the data for children using State or Territory government funded and/or provided preschool services in year before full time school. Year before full time school includes a number of non-4 year olds. **b** There is some double counting of children in jurisdictions (except in Victoria, SA, Tasmania and the ACT) because some children moved in and out of the preschool system throughout the year and, as a result, the number of children reported in preschool exceeds the number of children in the target population. There is no double counting for Victoria, SA, Tasmania and the ACT because a snapshot is used for each year's data collection (so children appear in only one preschool centre in one year at the time of the snapshot). **c** NSW used a revised method of calculating the number of children receiving child care and preschool services. This new method of calculation will provide clear trend data for each age group for child care and preschool. The data include estimates based on the rate of survey return for each year. NSW data are not comparable with data for other states and territories. **d** Victorian data include some children attending funded preschool services conducted in a centre-based long day care centre. **e** WA data for 1999-2000 to 2002-03 exclude the non-government sector. Data for 2003-04 include the non-government sector for the first time, resulting in a significant jump in the time series. Changes to the school entry age (and the associated move to full time schooling for pre-year 1 children) have resulted in changes in the reporting of data from 2001-02. From 2002, pre-year 1 students in non-compulsory schooling are not included. **f** Data for SA exclude children in non-government preschools.

Source: ABS (unpublished), Cat. no. 3201.0; ABS (unpublished), Cat. no. 3222.0; State and Territory governments (unpublished); tables 14A.1, 14A.26, 14A.35, 14A.44, 14A.53, 14A.62, 14A.71, 14A.80 and 14A.89.

Younger children in NSW, Queensland, SA, the ACT and the NT were able to attend government funded preschool services in 2003-04. Around 17.1 per cent of children aged 3 years attended preschool services in that year (approximately

28 100 children). Participation in 2003-04 differed across jurisdictions, reflecting variation in policies on access to funded preschool services: the proportion was 14.0 per cent in NSW, 21.1 per cent in Queensland, 24.9 per cent in SA (where younger children may attend a pre-entry program for one term in the year before preschool), 4.0 per cent in the ACT and 13.7 per cent in the NT (tables 14A.1, 14A.26, 14A.44, 14A.62, 14A.80 and 14A.89).

All jurisdictions except NSW and Victoria provided data on the average hours of attendance for government funded and/or provided preschool services in 2003-04. The average attendance of children in the year immediately before they commenced full time schooling ranged from 14.0 hours per week in Queensland to 10.5 hours per week in Tasmania (tables 14A.43, 14A.52, 14A.61, 14A.70, 14A.79 and 14A.88).

Employment status of parents

Access to children's services differs according to the service type. The workforce and employment status of parents are factors that may influence children's access to services. Those services eligible for Child Care Benefit, for example, gave a high priority to children at risk and children of parents with work-related child care needs. Occasional care gives priority to parents requiring care to meet other requirements (such as to attend appointments, take care of personal matters or have temporary respite from full time parenting). Details of the labour force and employment status of parents whose children use these services are shown in table 14A.13.

Services by management type

Children's services are managed by the government (State, Territory and local), community and private sectors. The management structure of services indicates the involvement of these sectors in the direct delivery of children's services. The limited data on the management type of child care need to be interpreted with care because the scope of the data collection varies across jurisdictions. Available data on the management type of preschool services in 2003-04, although more complete, also indicate considerable variation across jurisdictions (table 14.2).

Table 14.2 **Proportion of State and Territory licensed and/or registered children's services, by management type, 2003-04 (per cent)[a]**

	NSW	*Vic*[b]	*Qld*	*WA*	*SA*	*Tas*[c]	*ACT*	*NT*[d]
Child care								
Community managed[e]	33.1	39.2	26.0	25.1	40.3	58.8	84.2	77.4
Private[f]	63.5	45.9	70.5	70.9	33.7	18.4	15.8	22.6
Government managed	3.4	14.9	3.5	4.0	26.0	22.8	–	na
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Preschool								
Community managed[e]	90.0	74.5	22.9	na	4.7	..	8.0	4.3
Private[f]	10.0	8.4	21.8	na	–	22.7	–	na
Government managed	na	17.2	55.3	100.0	95.3	77.3	92.0	95.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

a Includes all Australian, State and Territory government supported services. Most services receive both Australian Government and State/Territory funding. **b** All government managed preschools in Victoria are managed by local government. **c** Preschools include funded non-government preschools. **d** Preschool services are provided by the Department of Education directly, but a range of management functions are devolved to school councils and parent management committees. **e** Community managed services include not-for-profit services provided or managed by parents, churches or co-operatives. **f** Private for-profit services provided or managed by a company, private individual or non-government school. **na** Not available. **..** Not applicable. **–** Nil or rounded to zero.

Source: State and Territory governments (unpublished); tables 14A.29, 14A.38, 14A.47, 14A.56, 14A.65, 14A.74, 14A.83 and 14A.92.

14.2 Framework of performance indicators

The framework of performance indicators is based on common objectives for children's services which the Community Services and Disabilities Ministers' Advisory Council (CSDMAC) endorsed (box 14.1). The relative emphasis placed on each objective varies across jurisdictions.

Box 14.1 **Objectives for children's services**

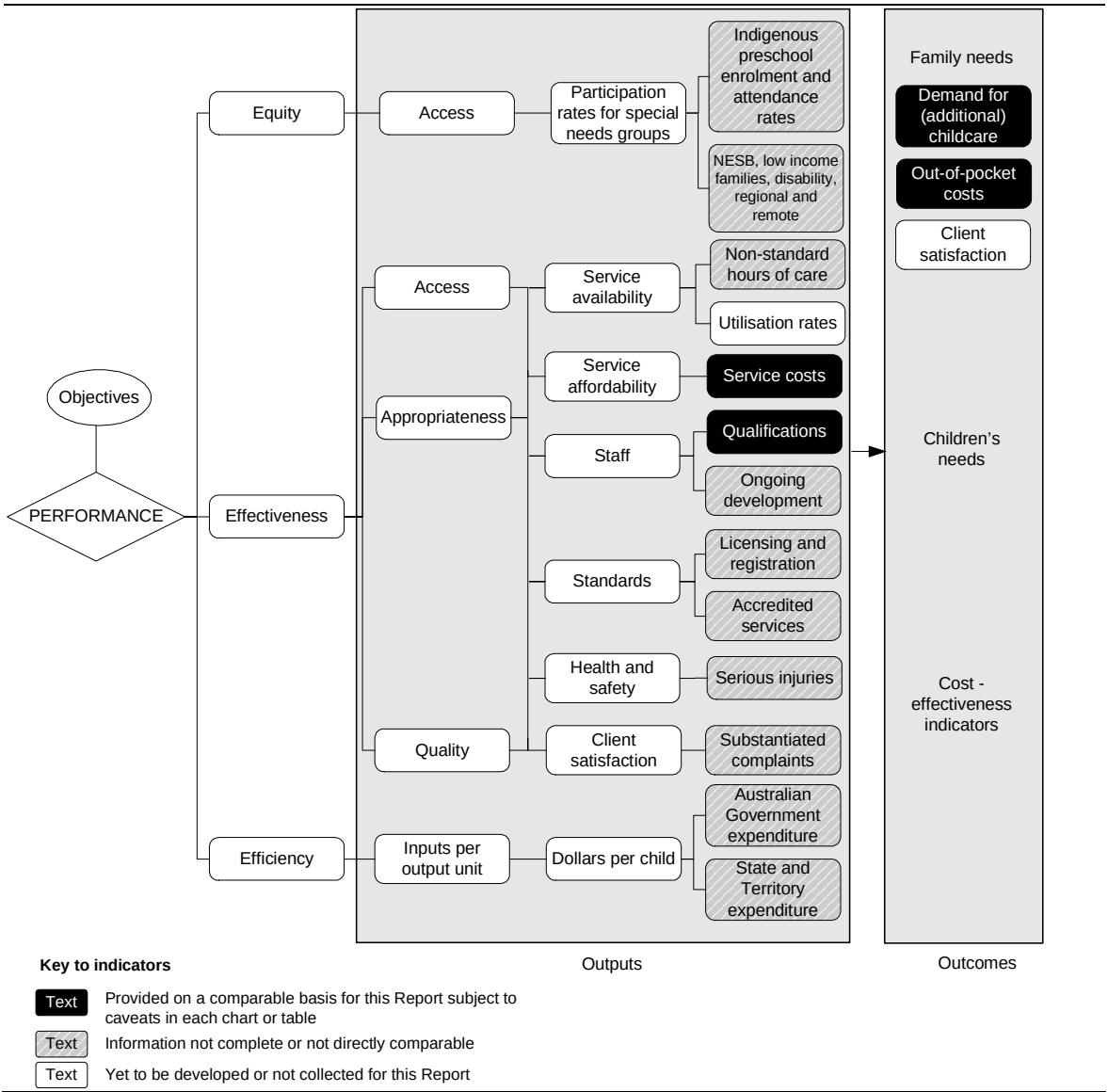
Children's services aim to:

- meet the care, education and development needs of children in a safe and nurturing environment
- provide support for families in caring for their children
- provide these services in an equitable and efficient manner.

A performance indicator framework consistent with these objectives is summarised in figure 14.4. The framework shows which data are provided on a comparable basis in the 2005 Report. For data that are not considered directly comparable, the

text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 14.4 **Performance indicators for children's services**



14.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the equity, effectiveness and efficiency of children's services. Most of the data available for reporting in this chapter are not comparable across jurisdictions. Appendix A contains contextual information, which may assist in interpreting the performance indicators presented in this chapter. Definitions of key terms and indicators are in section 14.6.

Outputs

Equity

Access — participation rates for special needs groups

The 'participation rates for special needs groups' indicator is explained in box 14.2.

Box 14.2 **Participation rates for special needs groups**

'Participation rates for special needs groups' are included as an output (equity — access) indicator of governments' objective to ensure that all Australian families have equitable access to child care and preschool services, that there is no discrimination between groups, and that there is consideration of the needs of those groups who may have special difficulty accessing services.

This indicator is defined as the proportion of children using child care services who are from targeted special needs groups, compared with the representation of these groups in the community. Data are reported separately for child care and preschool services. Targeted special needs groups include children from a non-English speaking background, children from an Indigenous background, children from low income families, children with a disability and children from regional and remote areas.

The representation of special needs groups among children's services users would be expected to be broadly similar to their representation in the community.

The data indicate that the representation of children in special needs groups among users of Australian Government supported child care is sometimes substantially different across jurisdictions. This variation largely reflects jurisdictional differences in the representation of children from special needs groups in the community (table 14.3).

The proportion of children using child care services in 2004 who were from a non-English speaking background (NESB) ranged from 17.3 per cent in NSW (where representation of NESB children in the population was 8.8 per cent) to 3.4 per cent in Tasmania (where the representation of NESB children in the population was 1.1 per cent). Nationally, the representation of NESB children among child care users was higher than this group's overall representation in the community (table 14.3).

The proportion of children using child care services in 2004 who were from an Indigenous background ranged up to 11.0 per cent in the NT (where the representation of Indigenous children in the population was 36.7 per cent).

Nationally, the representation of children from an Indigenous background among child care users was lower than this group's overall representation in the community (table 14.3).

Table 14.3 **Proportion of children (aged 0–12 years) from special needs groups attending Australian Government approved child care services, 2004 (per cent)**

Representation	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Children from non-English speaking backgrounds									
In child care services	17.3	13.5	6.3	8.0	6.7	3.4	12.0	8.4	11.6
In the community[a, b]	8.8	8.0	2.7	3.6	3.0	1.1	2.1	4.1	6.1
Children from Indigenous backgrounds									
In child care services	1.6	0.5	2.4	1.7	1.3	1.0	0.7	11.0	1.6
In the community[c, d]	3.6	1.0	5.9	5.8	3.1	6.4	2.1	36.7	4.1
Children from low-income families									
In child care services	27.3	27.5	32.6	31.7	32.2	31.1	11.9	18.5	29.1
In the community[e]	23.3	21.2	24.7	25.2	30.8	26.7	10.3	24.1	23.7
Children with a disability									
In child care services	2.1	2.1	1.9	1.7	3.5	2.2	2.0	2.4	2.2
In the community[f]	8.6	7.2	7.9	9.2	9.9	7.3	7.2	na	8.2
Children from regional and remote areas									
Children from regional areas									
In child care services	25.7	22.5	38.7	18.4	16.1	99.5	–	72.6	28.7
In the community[a, d]	30.0	29.1	45.6	24.0	26.9	97.6	0.3	48.9	33.4
Children from remote areas									
In child care services	0.4	0.1	1.5	5.0	1.9	0.5	..	27.4	1.4
In the community[a, d]	0.8	0.1	4.7	9.2	4.8	2.4	..	51.1	3.2

a Data for 1999-2000 to 2002-03 relate to children aged 0–14 years at June 2001 and were obtained from the ABS 2001 Census of Population and Housing. Data for 2003-04 relate to children aged 0–11 years and were obtained from the ABS 2002 Survey of Child Care. These data are not strictly comparable to the proportion of children from a non-English speaking background using the services. **b** Estimates for the smaller jurisdictions are based on small sample sizes and are consequently subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution. **c** Data relate to children aged 0–14 years at June 2001 and were obtained from the ABS 2001 Census of Population and Housing. **d** These numbers do not include innovative or flexible services that receive direct funding from the Australian Government and are targeted towards children from these groups. **e** Data relate to children aged 0–12 years and were obtained from the ABS 1999-2000 Survey of Income and Housing. **f** Data are estimated from the ABS 2003 Survey of Disability, Ageing and Carers and relate to children aged 0–14 years, and are thus not strictly comparable to the proportion of child care service users with a disability. **na** Not available. – Nil or rounded to zero. .. Not applicable.

Source: AGCCCS (unpublished); ABS (unpublished) 1999-2000 Survey of Income and Housing; ABS (unpublished) 2003 Survey of Disability, Ageing and Carers; ABS (unpublished) 2002 Child Care Survey; table 14A.17.

The representation of children from low income families among attendees of Australian Government supported child care in 2003 ranged from 32.6 per cent in

Queensland (where their representation in the population was 24.7 per cent) to 11.9 per cent in the ACT (where their representation in the population was 10.3 per cent) (table 14.3). Nationally, the representation of children from low income families among child care users was greater than this group's representation in the community.

The proportion of child care attendees with a disability in 2004 varied from 3.5 per cent in SA (where the representation of children with a disability in the community was 9.9 per cent) to 1.7 per cent in WA (where the representation in the community was 9.2 per cent). Across all jurisdictions for which data were available, the representation of children with a disability among child care users was lower than their overall representation in the community (table 14.3).

The proportion of child care attendees from regional areas in 2004 ranged from 99.5 per cent in Tasmanian (where the representation of children from regional areas in the community was 97.6 per cent) to 16.1 per cent in SA (where the representation in the community was 26.9 per cent) (excluding the ACT, which has an extremely small regional population) (table 14.3).

In all jurisdictions except SA and the NT, the proportion of child care attendees from regional areas was within 7 percentage points of this group's representation among children aged 0–12 years in the community. In SA, the proportion of child care attendees from regional areas was 10.8 percentage points below this group's representation in the community, while in the NT it was 23.7 percentage points above (table 14.3).

The proportion of child care attendees from remote areas in 2004 ranged from 27.4 per cent in the NT (where the representation of children from remote areas in the community was 51.1 per cent) to less than 2 per cent in all other jurisdictions except WA (where the representation in the community was 5.0 per cent) and the ACT (which has no remote areas) (table 14.3). In all jurisdictions except the NT, the proportion of child care attendees from remote areas was within 4.5 percentage points of this group's representation among children aged 0–12 years in the community (table 14.3).

Data on the proportion of preschool attendees from the specified special needs groups are less extensive for all jurisdictions. Across jurisdictions, the proportion of preschool attendees in 2003-04 who were Indigenous was broadly similar to the representation of Indigenous children in the community (table 14.4).

The proportion of preschool attendees from Indigenous backgrounds has been relatively constant over time within jurisdictions, except in the NT, where it has increased steadily since 1999-2000 (figure 14.5). Data on the representation of other

special needs groups among government funded preschool attendees are provided in table 14.4.

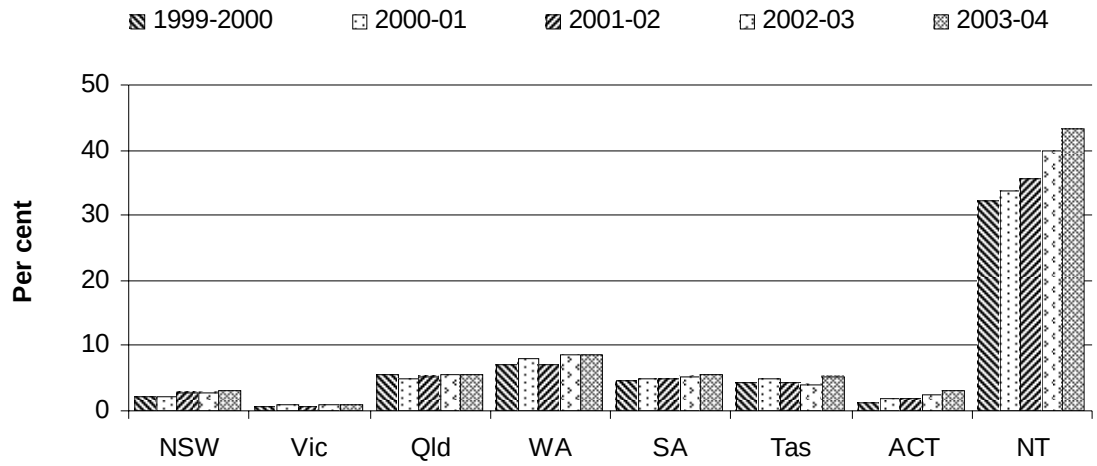
Table 14.4 **Proportion of children (aged 0–12 years) from special needs groups attending State and Territory funded or provided preschools, 2003-04 (per cent)**

Representation	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Children from non-English speaking backgrounds									
In preschool services	6.6	13.5	1.0	na	9.3	na	7.5	na	6.2
In the community[a, b]	8.8	8.0	2.7	3.6	3.0	1.1	2.1	4.1	6.1
Children from Indigenous backgrounds									
In preschool services	3.0	0.9	5.6	8.7	5.5	5.3	2.9	43.1	4.5
In the community[c, d]	3.6	1.0	5.9	5.8	3.1	6.4	2.1	36.7	4.1
Children with a disability									
In preschool services	6.8	3.7	1.4	2.5	14.3	na	4.6	5.9	4.7
In the community[e]	8.6	7.2	7.9	9.2	9.9	7.3	7.2	na	8.2
Children from regional and remote areas									
Children from regional areas									
In preschool services	32.2	29.3	na	23.5	29.1	98.6	0.9	na	23.1
In the community[d]	30.0	29.1	45.6	24.0	26.9	97.6	0.3	48.9	33.4
Children from remote areas									
In preschool services	1.2	0.1	na	9.9	5.7	1.4	..	na	1.9
In the community[d]	0.8	0.1	4.7	9.2	4.8	2.4	..	51.1	3.2

a Data for 1999-2000 to 2002-03 relate to children aged 0–14 years at June 2001 and were obtained from the ABS 2001 Census of Population and Housing. Data for 2003-04 relate to children aged 0–11 years and were obtained from the ABS 2002 Survey of Child Care. These data are not strictly comparable to the proportion of children from a non-English speaking background using the services. **b** Estimates for the smaller jurisdictions are based on small sample sizes and are consequently subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution. **c** Data relate to children aged 0–14 years at June 2001 and were obtained from the ABS 2001 Census of Population and Housing. **d** These numbers do not include innovative or flexible services that receive direct funding from the Australian Government and are targeted towards children from these groups. **e** Data are estimated from the ABS 2003 Survey of Disability, Ageing and Carers and relate to children aged 0–14 years, and are thus not strictly comparable to the proportion of preschool users with a disability. **na** Not available. .. Not applicable.

Source: ABS (2001); State and Territory governments (unpublished); tables 14A.30, 14A.39, 14A.48 14A.57, 14A.66, 14A.75, 14A.84 and 14A.93.

Figure 14.5 **Preschool attendees from Indigenous backgrounds**



Source: State and Territory governments (unpublished); tables 14A.30, 14A.39, 14A.48, 14A.57, 14A.66, 14A.75, 14A.84 and 14A.93.

Effectiveness

Service availability — non-standard hours of care

An indicator of the appropriateness of, and community access to, children's services is the proportion of services offering 'non-standard hours of care' (box 14.3). What constitutes non-standard hours varies across service types, and a full explanation can be found in the definitions section (14.6).

Box 14.3 **Non-standard hours of care**

The prevalence of services providing 'non-standard hours of care' is included as an output (service availability) indicator of governments' objective to ensure government funded and/or provided children's services meet the needs of all users.

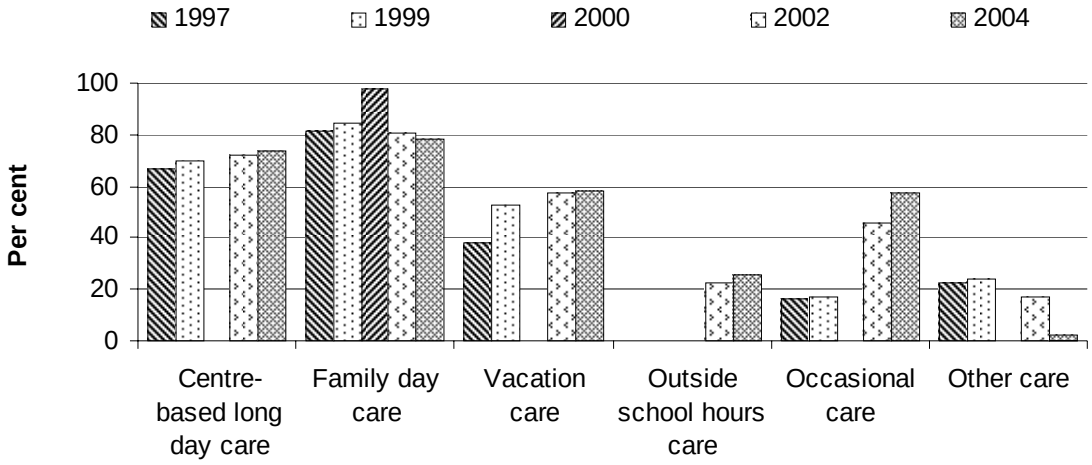
This indicator is defined as the number of services providing non-standard hours of care divided by the total number of services. Data are reported by service type.

A higher proportion of services providing non-standard hours of care may suggest a greater flexibility of services to meet the needs of families.

This indicator does not provide information on the demand for non-standard hours of care. It also provides no information on how closely these non-standard hours services match the needs of users.

Nationally, 78.0 per cent of family day care services provided non-standard hours of care in 2004. Centre-based long day care had the next highest proportion of services providing non-standard hours of care (73.7 per cent), followed by vacation care (58.1 per cent), occasional care (57.1 per cent) and outside school hours care (25.2 per cent) (figure 14.6).

Figure 14.6 **Australian Government approved child care services providing non-standard hours of care, by service type[a, b]**



a Only family day care data can be reported for 2000. **b** Comparison between 2000 data and data for other years is not possible, given different data collection methods and time frames.

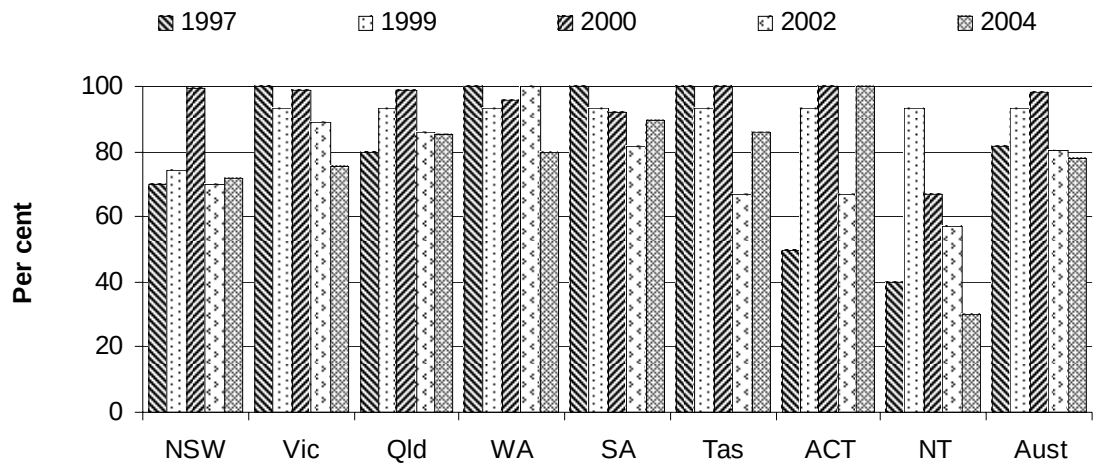
Source: AGCCCS, August 1997, May 1999, May 2002 and March 2004 (unpublished); Centrelink administrative data, August 2000 (unpublished); table 14A.14.

In the ACT, 100 per cent of family day care schemes offered non-standard hours in 2004. In all other jurisdictions, less than 90 per cent of these schemes offered non-standard hours of care (figure 14.7).

Limited data are available on services not included in the Australian Government Census of Child Care Services (AGCCCS) that were offering non-standard hours of care. New South Wales, SA and the ACT were able to provide data on the proportion of their preschools that offered non-standard hours in 2003-04: 70.1 per cent in NSW (table 14A.66), 70.9 per cent in SA (table 14A.30)[4] and no preschools in the ACT (table 14A.84).

4 In SA, preschools are encouraged to offer back-to-back preschool services to assist parents, particularly in country regions where the need to travel long distances makes it impractical for children to attend preschool more frequently (see footnotes to table 14A.66).

Figure 14.7 **Australian Government approved family day care services providing non-standard hours of care[a]**



a Comparison between 2000 data and data for other years is not possible, given different data collection methods and time frames.

Source: AGCCCS, August 1997, May 1999, May 2002 and March 2004 (unpublished); Centrelink administrative data, August 2000 (unpublished); table 14A.14.

Service availability — utilisation rates

The Steering Committee has identified 'utilisation rates' as an indicator of the effectiveness of children's services (box 14.4). Data for this indicator, however, were not available for the 2005 Report.

Box 14.4 **Utilisation rates**

This indicator will provide an output (service availability) indicator of governments' objective to ensure all Australian families have equitable and adequate access to children's services.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Service affordability — service costs

An indicator of the affordability (and thus accessibility) of children's services is the 'service cost', represented by average weekly fees (box 14.5). Nationally, average weekly fees for 50 hours of care in 2004 were higher for centre-based long day care services ($210 per week) than for family day care services ($186 per week) (table

14A.23). Across jurisdictions, average weekly fees for centre-based long day care ranged from $227 per week in the ACT to $183 per week in the NT. For family day care, the average ranged from $217 per week in the ACT to $175 per week in both Queensland and the NT (figure 14.8).

Box 14.5 **Service costs**

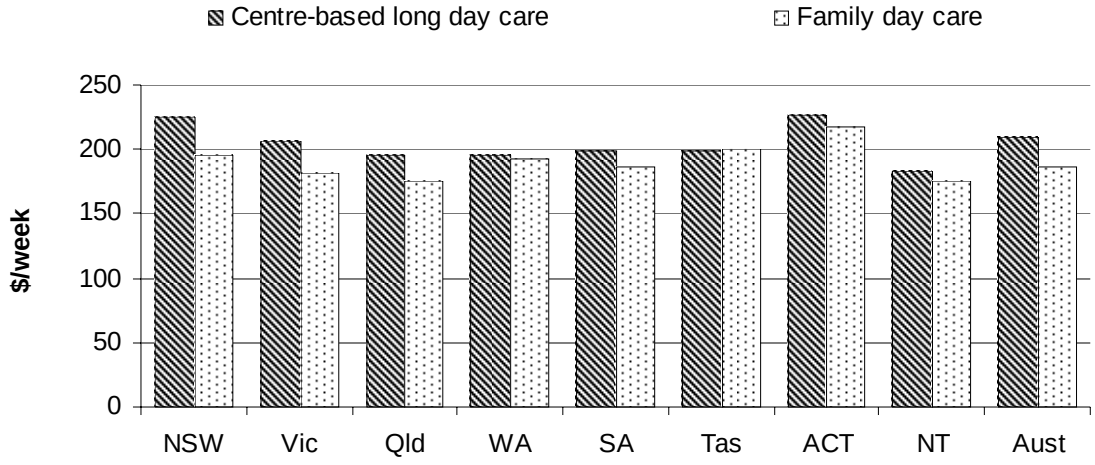
This indicator is included as an output (service affordability) indicator of governments' objective to ensure all Australian families have equitable access to children's services regardless of their financial circumstances.

This indicator is defined as average weekly fees for 50 hours of care by service type.

Provided the service quality is held constant, lower service costs are more desirable.

Fee data need to be interpreted with care because fees are independently set by service providers. Charging practices, including fees, are commercial decisions made by individual services, so there is significant variation in the fees charged by services. Fee variation occurs as a result of factors including State and Territory licensing requirements, award wages, and whether fees include charges for additional services such as nappies and meals.

Figure 14.8 **Average fees charged by Australian Government funded child care services, 2004[a]**



a Average fees based on 50 hours of care in the Census reference week.

Source: AGCCCS, March 2004 (unpublished); table 14A.23.

Quality

An important focus of Australian, State and Territory governments is to set and maintain appropriate quality standards in child care and preschool services.

Indicators of the quality of children's services are the proportion of qualified staff, the rate of ongoing staff development, the extent of licensing and registration, the proportion of services that have achieved accreditation, the number of serious injuries, and the number of substantiated complaints per registered or licensed service, by service type. These data need to be treated with caution because there are differences in reporting among jurisdictions.

Staff — qualifications

Staff qualifications are an important indicator of staff quality (box 14.6).

Box 14.6 **Qualifications**

The qualifications of staff in children's services is included as an output (staff) indicator of governments' objective to ensure staff in government funded or provided children's services are able to provide services which meet the needs of children. In particular, this means ensuring staff have the training and experience to provide a safe and nurturing environment that fulfils the educational and development needs of children.

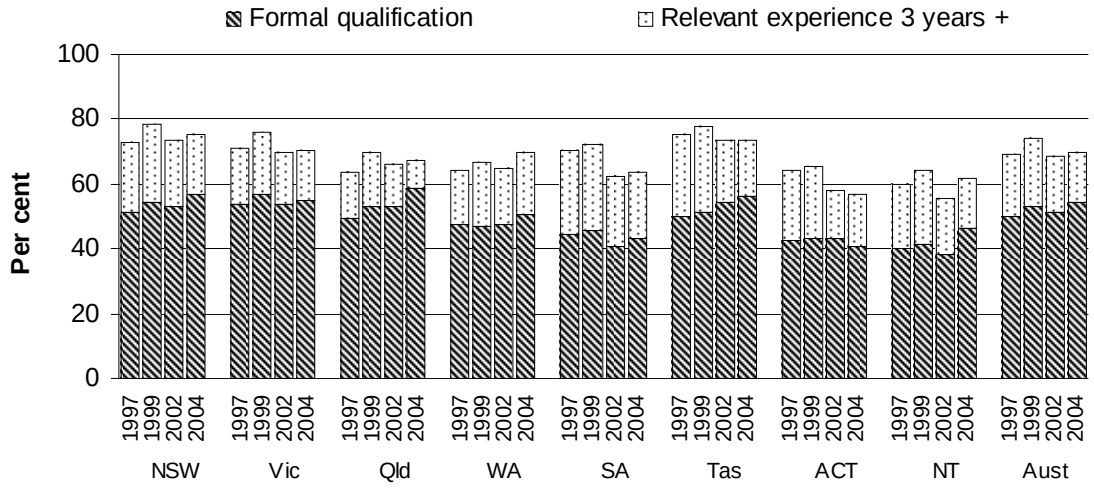
This indicator is defined as the proportion of primary contact staff with relevant formal qualifications or three or more years of relevant experience.

Some studies and research have shown a link between a higher proportion of qualified and experienced primary contact staff and a higher quality service.

Nationally, the proportion of primary contact staff with formal qualifications in Australian Government approved child care was 54.6 per cent in 2004. A further 15.4 per cent had no formal qualifications but three or more years of relevant experience (figure 14.9). Across jurisdictions, the proportion of staff with either a formal qualification or three or more years of relevant experience ranged from 75.2 per cent in NSW to 56.6 per cent in the ACT in 2004. Between 1997 and 2004, this proportion increased in NSW, Queensland and WA, remained relatively constant in Victoria and the NT, and declined in all other jurisdictions (figure 14.9).

Some data are available on the qualifications of staff employed by preschool services that received funding from State and Territory governments. The comparability of these data is limited, however, by the different licensing and funding arrangements across jurisdictions. Across those jurisdictions for which 2003-04 data are available, the proportion of staff in preschool services with relevant formal qualifications ranged from 68.6 per cent in the NT to 46.4 per cent in Victoria (figure 14.10).

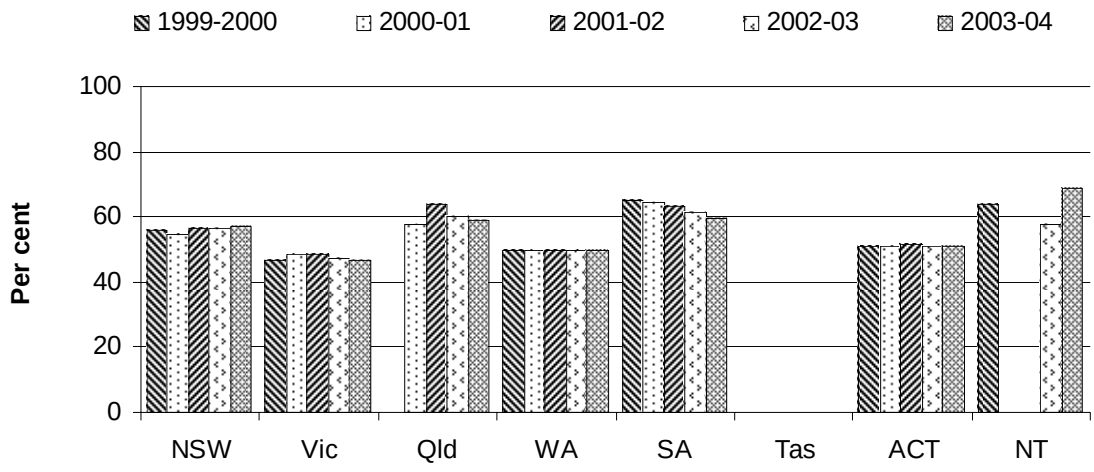
Figure 14.9 **Paid primary contact staff employed by Australian Government approved child care services, by qualification, 2004[a, b]**



a Excludes Aboriginal play groups, mobile and toy libraries, and in-home care. **b** 'Three or more years relevant experience' category excludes staff with a relevant formal qualification.

Source: AGCCCS, March 2004 (unpublished); table 14A.11.

Figure 14.10 **Paid primary contact staff with a relevant formal qualification employed by State/Territory funded and/or managed preschools[a]**



a All funded preschool services in Victoria must have at least two staff but only the preschool teacher must be qualified. Preschools in Queensland must have at least two staff, of whom one must have a relevant formal qualification.

Source: State and Territory governments (unpublished); tables 14A.28, 14A.37, 14A.46, 14A.55, 14A.64, 14A.73, 14A.82 and 14A.91.

Staff — ongoing development

Ongoing development of the skills and competencies of child care and preschool staff is an important indicator of staff quality (box 14.7). The number of staff who undertook relevant in-service training in the previous 12 months is reported in figure 14.11. It includes formal training only — that is, structured training sessions conducted either in-house or externally.

Box 14.7 **Ongoing development**

The ongoing development of staff in children's services is included as an output (staff) indicator of governments' objective to ensure staff in government funded or provided children's services are able to provide services that meet the needs of children. In particular, this means ensuring staff have the training and experience to provide a safe and nurturing environment that fulfils the educational and development needs of children.

This indicator is defined as the proportion of staff who undertook relevant in-service training in the previous 12 months.

A high rate of in-service training suggests a relatively high quality of service.

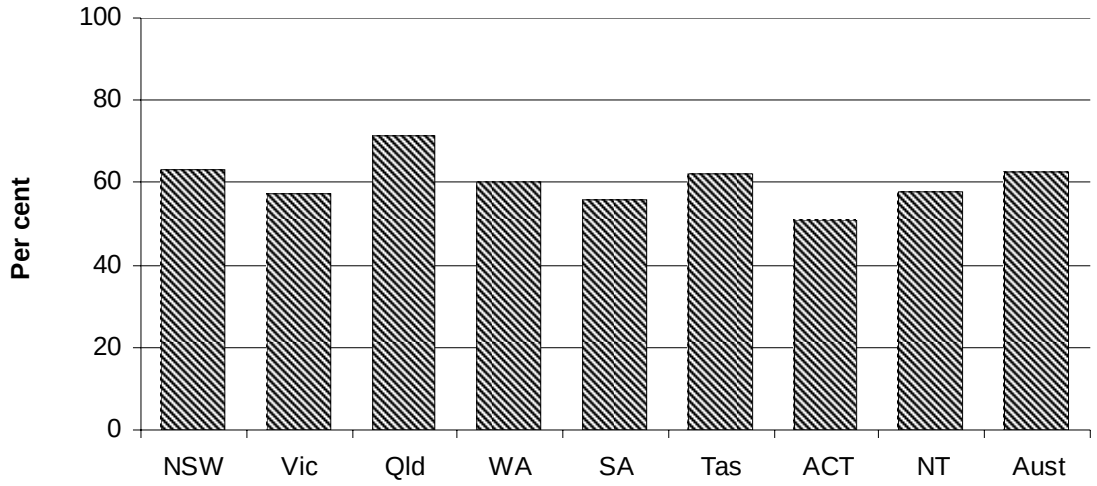
This indicator does not provide information on whether the ongoing development undertaken by staff is adequate or sufficiently relevant to improve the quality of the service provided.

For 2004, Queensland reported the highest level of child care staff having undertaken in-service training in the previous 12 months (71.5 per cent) and the ACT reported the lowest (50.9 per cent) (figure 14.11).

Standards

The Australian Government and the State and Territory governments are active in maintaining the quality of care provided by children's services by setting quality standards. The mechanisms used to maintain quality are accreditation, licensing, the measurement of performance against standards, and funding linked to outcomes. These mechanisms are used in addition to the provision of curriculum and policy support and advice, and the training and development of management and staff.

Figure 14.11 **Staff in Australian Government child care services who undertook relevant in-service training in previous 12 months, 2004[a]**



a Excludes Aboriginal play groups, mobile and toy libraries, and in-home care.

Source: AGCCCS, March 2004 (unpublished); table 14A.12.

Standards — licensing and registration

State and Territory governments are responsible for licensing children's services in their jurisdiction (box 14.8).

Box 14.8 **Licensing and registration**

'Licensing and registration' is included as an output (standards) indicator of governments' objective to ensure government funded or provided children's services meet the minimum standards considered necessary to provide a safe and nurturing environment, and to meet the educational and development needs of children.

Data are currently not reported on this indicator. The Steering Committee has identified this indicator for development and reporting in future. Descriptive information is reported for some jurisdictions as an interim measure. This information includes the number of licensed services, and whether jurisdictions have incorporated the national standards for centre-based child care, family day care and outside school hours care into the licensing requirements.

A higher proportion of licensed services is desirable.

This indicator does not provide information on the degree to which licensing and registration translates into higher quality service outcomes above the minimum standards of care.

State and Territory governments also undertake activities aimed at the promotion of quality, such as publishing curriculum materials and other resources, and undertaking consumer education. The types of service covered by legislation vary across jurisdictions, as do the standards that apply (table 14.5).

Table 14.5 **State and Territory licensing and registration of child care services, 2004**

Service type	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Long day care[a]	✓	✓	✓	✓	✓	✓	✓	✓
Occasional care[a]	✓	✓	✓	✓	✓	✓	✓	✓
Family day care schemes[b]	✓	*x*	✓	✓	✓	✓	✓	*x*
Family day care carers[c]	✓	*x*	*x*	✓	*x*	✓	*x*	*x*
Outside school-hours care[b, d]	*x*	*x*	✓	✓	*x*	✓	✓	*x*
Other/home-based care[e]	✓	*x*	*x*	✓	✓	✓	✓	*x*

a In the ACT, licensed as centre-based children's services. **b** Legislation requiring licensing of services commenced on 1 September 2003 in Tasmania, but does not take effect until early 2005. **c** Family day care providers in NSW and WA are individually licensed. Family day carers in Queensland, SA and Tasmania are not required to be licensed, provided they are registered through a family day care scheme. Legislation requiring licensing of services commenced on 1 September 2003 in WA; services have until 31 August 2005 to apply for a licence. **d** On the introduction of the regulations in WA on 28 August 2003, existing service providers became registered to be licensed; by 28 August 2005, all service providers must be licensed. **e** Includes baby sitting agencies in SA. Includes playschools and independent preschools in the ACT.

Source: State and Territory governments (unpublished).

State and Territory licensing requirements establish the foundations for quality of care by stipulating enforceable standards to support the health, safety, welfare and developmental needs of children in formal child care settings. Accreditation of services is built on this platform.

Licensed children's services may include centre-based long day care, occasional care, preschools, family day care and outside school hours care. Australian, State and Territory governments have developed national standards for centre-based long day care, family day care and outside school hours care. Jurisdictions refer to these standards when writing regulations. The extent of implementation of these standards varies across Australia.

Standards — accredited services

The NCAC administers quality assurance systems for long day care centres, family day care schemes and outside school hours care services across Australia (box 14.9).

Box 14.9 **Accredited services**

'Accredited services' is included as an output (standards) indicator of governments' objective to ensure government funded or provided children's services meet the minimum standards considered necessary to provide a safe and nurturing environment, and to meet the educational and development needs of children. Accredited services have been independently evaluated against a series of national quality standards for the specific child care service type.

This indicator is defined as the proportion of child care services participating in the quality assurance systems that are accredited by NCAC. Data are reported for centre-based long day care services, family day care schemes and outside school hours care services.

A higher proportion of centres that have been accredited is more desirable.

This indicator does not provide information on the degree to which accreditation translates into higher quality service outcomes.

The Australian Government also funds resource and advisory services across Australia to assist services participating in the quality assurance systems. State and Territory government initiatives include quality assurance or improvement systems for government preschools (SA and Victoria) and non-government preschools (Queensland). Some other jurisdictions are exploring similar systems.

The QIAS for long day child care centres commenced in 1994 and was revised in January 2002. Family Day Care Quality Assurance was introduced on 1 July 2001. Outside School Hours Care Quality Assurance commenced on 1 July 2003.

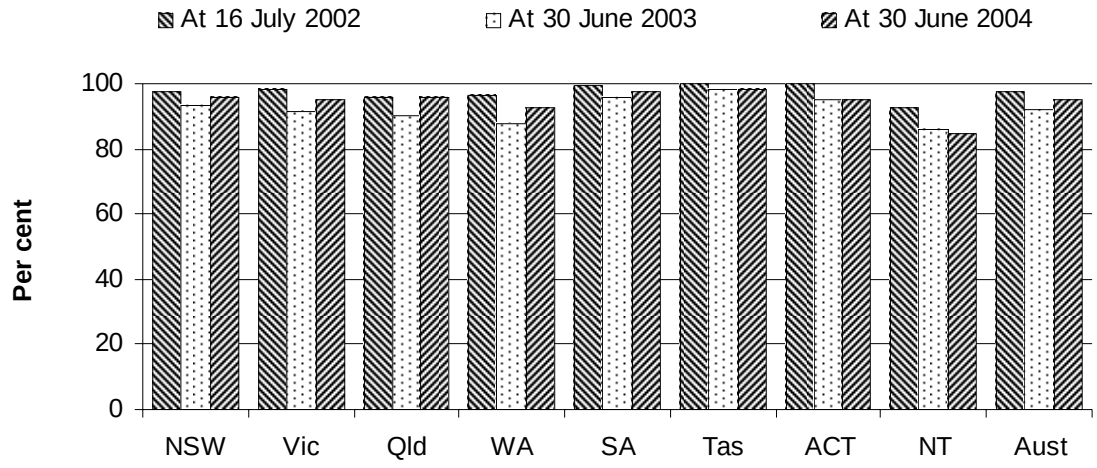
Long day child care services participating in the QIAS receive a 'quality profile' as part of their accreditation decision, which details their performance against the following ten 'quality areas':

- relationships with children
- respect for children
- partnerships with families
- staff interactions
- planning and evaluation
- learning and development
- protective care
- health
- safety
- managing to support quality.

The NCAC accreditation systems are Australian Government initiatives linked to Child Care Benefit funding. All centre-based long day child care services are required to participate in the QIAS to receive Child Care Benefit, so the majority of all centre-based long day child care services do participate.

Nationally, 4473 centres were registered to participate in the QIAS at 30 June 2004. Of the 4039 centres that had received an accreditation decision at 30 June 2004, 95.2 per cent (3845) were successful in achieving accreditation. This proportion varied from 98.2 per cent in Tasmania to 84.4 per cent in the NT. The relatively small number of services in these jurisdictions, however, may unduly influence the results (figure 14.12).

Figure 14.12 **Accredited centres as a proportion of centres fully assessed under the Quality Improvement and Accreditation System[a, b]**



a Figures may change daily and are updated every six weeks following an NCAC meeting. **b** Results for Tasmania, the ACT and the NT may be unduly influenced by the relatively small number of services (54, 77 and 38 respectively at 30 June 2004) participating in the process.

Source: NCAC (unpublished); table 14A.2.

At 30 June 2004, a further 434 centres were in self-study, review or moderation, or awaiting an accreditation decision (9.7 per cent). Some 194 centres were not accredited (4.3 per cent) (table 14A.2). Centres that do not meet accreditation standards are required to submit another self study report to NCAC within six months of the date of NCAC's accreditation decision.

Self-study reports from family day care schemes were submitted from July 2002, with 299 schemes accredited at 30 June 2004 (table 14A.2). Family day care schemes also receive a quality profile, which details their performance against the following six quality areas:

- interactions
- physical environments
- children's experiences, learning and development
- health, hygiene, nutrition, safety and wellbeing
- carers and coordination unit staff
- management and administration.

The quality standards (detailed in NCAC 2001) were revised in 2004 based on feedback and consultation with family day care schemes. The revised standards (detailed in NCAC 2004) come into effect from 1 January 2005.

All services providing before school, after school and vacation care were required to register with NCAC by 30 September 2003. Each registered outside school hours care service is required to submit a self-study report to the NCAC between July 2004 and December 2006.

Outside school hours care services receive a quality profile, which details their performance against the following eight quality areas:

- respect for children
- staff interactions and relationships with children
- managing to support quality
- programming and evaluation
- play and development
- health, nutrition and wellbeing
- protective care and safety
- partnerships with families and community links.

There were 2656 outside school hours care services registered at 30 June 2004 to participate in OSHCQA (table 14A.2). Accreditation data for this sector are expected to be available for inclusion in the 2006 Report.

Health and safety — serious injuries

'Serious injuries' is an important indicator of child care services' success in providing a safe environment (box 14.10).

Box 14.10 **Serious injuries**

'Serious injuries' is included as an output (health and safety) indicator of governments' objective to ensure children's services provide high quality care that meets the care, educational and development needs of children in a safe and nurturing environment.

This indicator is defined as the number of serious injuries per registered or licensed service provider. A serious injury is defined as an injury requiring hospitalisation or a visit to, or by, a doctor.

A low injury rate may indicate a high level of safety.

A higher rate of injury does not provide information on whether a jurisdiction has lower service safety and quality, or a more effective reporting and monitoring regime.

Data on the number of serious injuries and the number of serious injuries per registered or licensed service provider were limited for 2003-04. Although all jurisdictions except SA and Tasmania could provide some information, the small

incident numbers and the differences in data collection approaches mean direct comparisons across jurisdictions are problematic. Tables 14A.31, 14A.40, 14A.49, 14A.58, 14A.85 and 14A.94 provide a breakdown of the available information for each jurisdiction.

Client satisfaction — substantiated complaints

'Substantiated complaints' is an important indicator of community satisfaction with child care services (box 14.11). All jurisdictions except NSW and SA provided data on the number of substantiated complaints and allegations of regulation breaches made to the State and Territory government regulatory bodies in 2003-04 (tables 14A.32, 14A.41, 14A.50, 14A.59, 14A.68, 14A.77, 14A.86 and 14A.95).

Box 14.11 **Substantiated complaints**

'Substantiated complaints' is an output (client satisfaction) indicator of governments' objective to ensure government funded or provided children's services meet the needs and expectations of users.

This indicator is defined as the number of substantiated complaints per service divided by the total number of registered or licensed services. Results are presented by service type. Data on the proportion of substantiated complaints against which action was taken are also reported.

A higher rate of complaints may suggest a lower quality service.

Complaints data need to be interpreted with care.

- Some jurisdictions give priority to developing client groups who are well informed, as part of improving their service delivery. Clients who are well informed may be more likely to make a complaint than are clients without access to this information.
- The number of approved care providers or parent users per service differs in each service across states and territories.
- Complaints management systems vary across jurisdictions. In SA, for example, the Department of Education and Children's Services is the sole sponsor of family day care and deals with all complaints that may be managed at a scheme level in other states and territories and, as such, may not be reported.

Efficiency

Differences in the indicator results across jurisdictions may reflect differences in counting and reporting rules for financial data and in reported expenditure, which are partly due to different treatments of various expenditure items. Information on the comparability of the expenditure is shown in table 14A.5.

The level of government input per unit of output(s) (unit costs) is a proxy indicator of efficiency. The indicators used here are:

- Australian Government total expenditure on children's services per child aged 0–12 years in Australia (box 14.12)
- State and Territory government total expenditure on children's services per child aged 0–12 years in the relevant jurisdiction (box 14.13).

Data were sought from all governments on their expenditure by service type. Incomplete data and changes in collection method, however, make it difficult to compare expenditure across jurisdictions and over time. Unit cost data for children's services do not yet contain an estimate of user cost of capital.

Inputs per output unit — Australian Government expenditure (dollars per child)

Box 14.12 **Australian Government expenditure**

'Australian Government expenditure' is included as an output (efficiency) indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources.

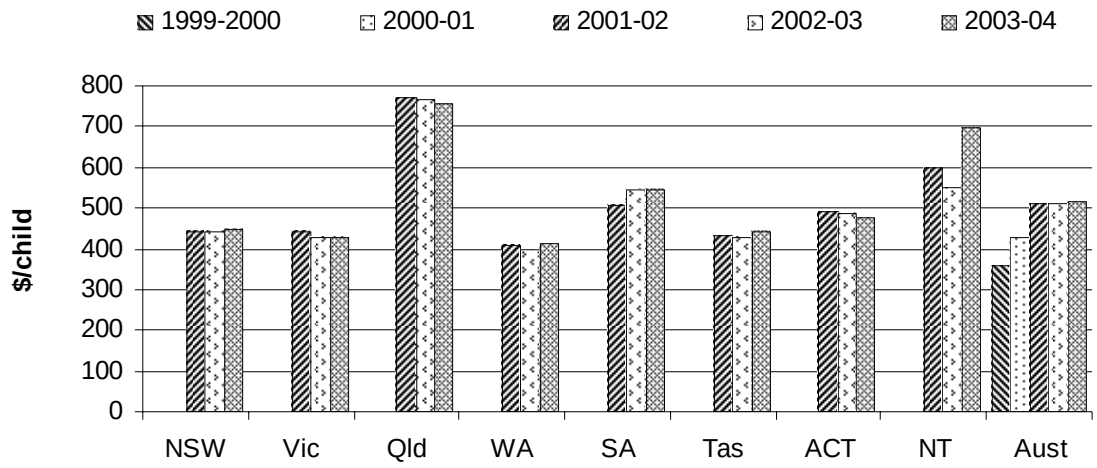
This indicator is defined as Australian Government expenditure on children's services per child aged 0–12 years in Australia.

Provided the level and quality of, and access to, services remains unchanged, lower expenditure per child can indicate greater efficiency of government expenditure.

All efficiency data need to be interpreted with care, however. Changes in expenditure per child could represent changes in government funding policy. While high or increasing unit costs may reflect deteriorating efficiency, they may also reflect increases in the quality of service provided. Similarly, low or declining expenditure per child may reflect improving efficiency or lower quality.

Australian Government expenditure in 2003-04 ranged from $755 per child in Queensland to $413 per child in WA (figure 14.13).

Figure 14.13 **Total Australian Government real expenditure on children's services per child aged 0–12 in the jurisdiction (2003-04 dollars)[a, b]**



a Includes administration expenditure, other expenditure on service provision, financial support to families and net capital expenditure on child care and preschool services. **b** Data by State and Territory were not available for 1999-2000 and 2000-01.

Source: Australian Government (unpublished); table 14A.18.

Inputs per output unit — State and Territory government expenditure (dollars per child)

Box 14.13 **State and Territory government expenditure**

'State and Territory government expenditure' is included as an output (efficiency) indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources.

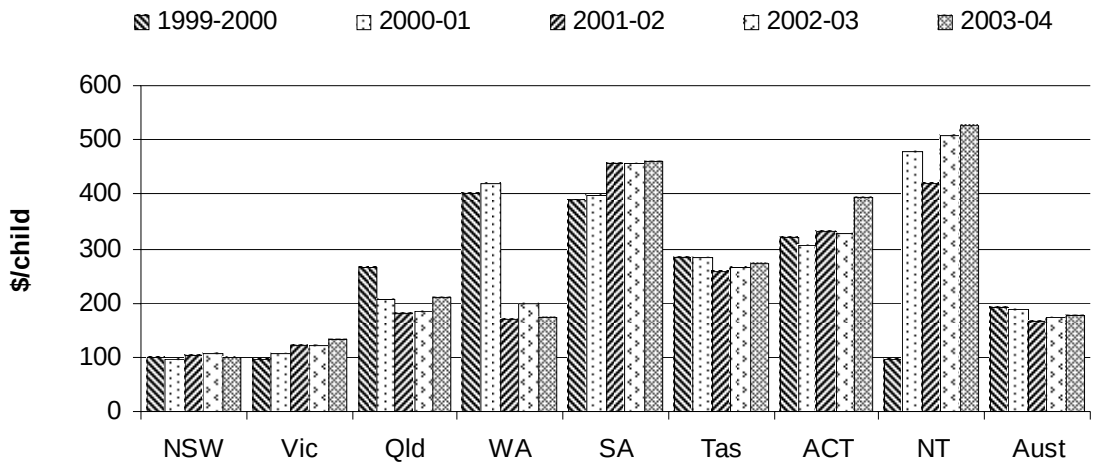
This indicator is defined as State or Territory government expenditure on children's services per child aged 0–12 years in the jurisdiction.

Lower expenditure per child represents greater efficiency of government expenditure, provided the level and quality of, and access to, services remains unchanged.

All efficiency data need to be interpreted with care, however. Changes in expenditure per child could represent changes in government funding policy. While high or increasing unit costs may reflect deteriorating efficiency, they may also reflect increases in the quality of service provided. Similarly, low or declining expenditure per child may reflect improving efficiency or lower quality.

State and Territory government total expenditure per child aged 0–12 years by jurisdiction in 2003-04 (figure 14.14) ranged from $525 per child in the NT to $100 per child in NSW (table 14A.19).

Figure 14.14 **Total State and Territory real expenditure on children's services per child aged 0–12 in the jurisdiction (2003-04 dollars)[a, b, c]**



a Includes administration expenditure, other expenditure on service provision, financial support to families, and net capital expenditure on child care and preschool services. **b** WA expenditure for 2001-02 declined in response to the changes in the school entry age and the associated move to full time schooling for pre-year 1 children. **c** Data for 2003-04 exclude expenditure on the non-government sector.

Source: State and Territory governments (unpublished); table 14A.19.

Outcomes

Demand for (additional) child care

Data on the 'demand for additional child care services' provides an important indicator of the success of children's services in meeting the needs of the community (box 14.14).

Box 14.14 **Demand for (additional) child care**

This indicator provides an outcome indicator of governments' objective to ensure children's services meet the requirements of all Australian families. Expressed need for child care indicates the extent to which children's services are meeting demand by families.

(Continued on next page)

Box 14.14 **(Continued)**

The indicator is defined as the proportion of children aged under 12 years for whom additional services were required in the four weeks before the survey interview.

A lower proportion of children for whom additional services were required indicates demand by families is being met to a greater extent.

One available indicator is the expressed need for additional child care services, which is collected in the ABS 2002 Child Care Survey (box 14.15).

Box 14.15 **ABS 2002 Child Care Survey**

The 2002 ABS Child Care Survey was conducted throughout Australia in June 2002, as a supplement to the Labour Force Survey.

Information was obtained from a sample of dwellings through interviews conducted over a two week period with usual residents with children under 12 years of age. In each selected household, detailed information about each child's child care was collected for a maximum of two children. Data were collected for a sample of approximately 10 000 children in total.

The survey included information about whether parents' needs for child care were met. Those families not already using child care or preschool services were asked whether there was any time in the previous four weeks when they wanted to use any child care or preschool services for their child but did not. Those families already using child care or preschool services were asked a similar question to determine whether they had wanted to use any more services in the previous four weeks.

Given that estimates from the 2002 survey are based on information obtained from a sample of dwellings, they are subject to sampling variability. They may differ from those estimates that would have been produced by a census. Estimates for the smaller jurisdictions are based on small sample sizes and, consequently, are subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution.

Aggregated survey data need to be interpreted with care, because over- and under supply of child care places can be specific to particular areas, including small and remote communities. Further, the data will not reflect changes in population in some areas since June 2002.

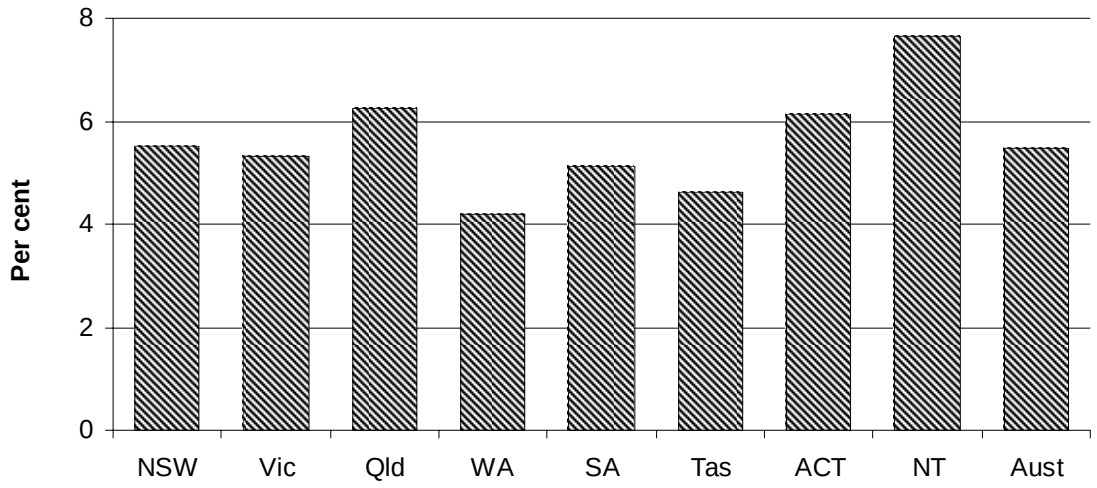
The next ABS Child Care Survey will be conducted in June 2005.

Nationally, no additional child care or preschool services were required for the majority (94.4 per cent) of children aged under 12 years in 2002 (table 14A.20). Additional services were required, however, for approximately 174 500 children

aged under 12 years (table 14A.21). Additional preschool services were required for less than 3 per cent of children aged under 12 years.

The proportion of children aged under 12 years for whom additional child care services were required ranged from 7.7 per cent in the NT to 4.2 per cent in WA (table 14A.20) (figure 14.15).

Figure 14.15 **Proportion of children aged under 12 years for whom additional formal child care was required, 2002[a]**



a Estimates for the smaller jurisdictions are based on small sample sizes and, consequently, are subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution.

Source: ABS (unpublished) 2002 Child Care Survey; table 14A.20.

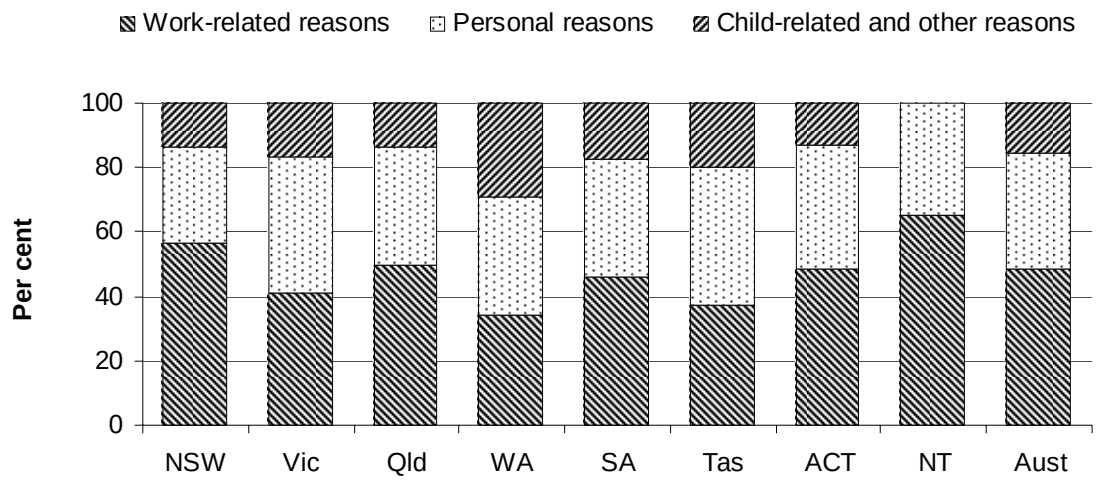
The reasons given for additional services being desired varied between those requiring additional child care services and those requiring additional preschool services. The needs of the parent, including the need to work, was the major reason for desiring additional child care services. Nationally, work-related reasons were cited in 48.4 per cent of circumstances, with personal reasons accounting for an additional 35.8 per cent of cases (figure 14.16). Child-related and other reasons were cited in the remaining 15.8 per cent of cases (table 14A.21).

Across jurisdictions, work-related reasons for desiring additional child care services ranged from 65.2 per cent in the NT to 34.4 per cent in WA. Personal reasons ranged from 42.9 per cent in Tasmania to 29.4 per cent in NSW (table 14A.21).

The most common reason given for not being able to access additional child care services was lack of available places ('booked out or no places', table 14A.22), accounting for 34.8 per cent of the national total. No services being available (or known of) in the area, and the cost of services were also significant reasons,

accounting for 25.3 per cent and 17.3 per cent respectively of the number of children requiring additional child care services (figure 14.17).

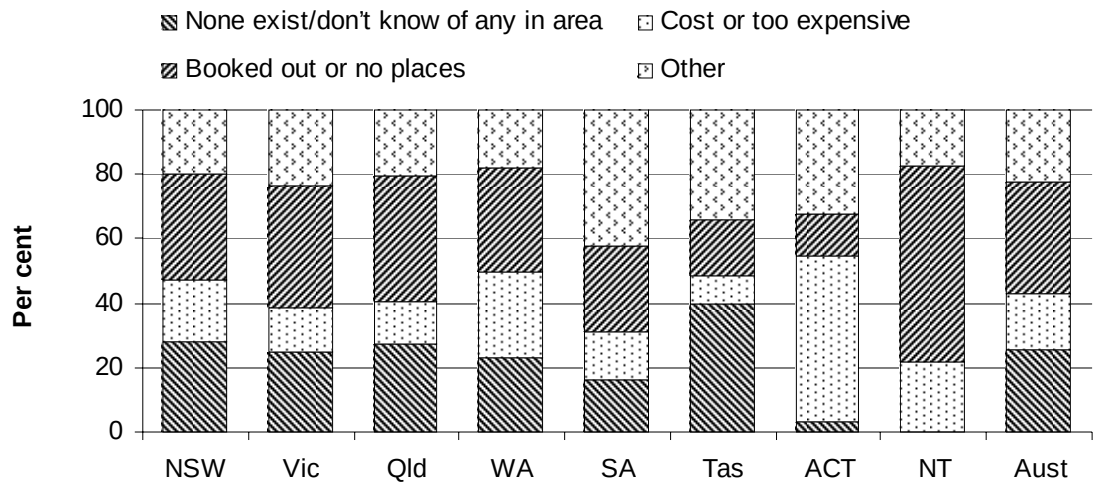
Figure 14.16 **Children aged under 12 years who required additional child care services by main reason required, 2002[a]**



a Estimates for the smaller jurisdictions are based on small sample sizes and, consequently, are subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution.

Source: ABS (unpublished) 2002 Child Care Survey; table 14A.21.

Figure 14.17 **Children aged under 12 years by main reason additional child care services not used, 2002[a, b]**



a 'None exist/don't know of any in area' includes 'not known whether care available'. 'Other' includes 'other service related', 'child related' and 'other'. **b** Estimates for the smaller jurisdictions are based on small sample sizes and, consequently, are subject to high sampling error. Data for Tasmania, the ACT and the NT, in particular, need to be interpreted with caution.

Source: ABS (unpublished) 2002 Child Care Survey; table 14A.22.

Out-of-pocket costs

'Out-of-pocket costs' of child care is an important indicator of the affordability and accessibility of child care services (box 14.16).

Box 14.16 **Out-of-pocket costs**

'Out-of-pocket costs' is included as an outcome indicator of governments' objective that all Australian families have equitable access to children's services regardless of their financial circumstances.

This indicator is defined as the proportion of weekly disposable income that representative families spend on child care services before and after the payment of child care subsidies. Data are estimated for families with a 60:40 income split and gross annual income of $27 000, $35 000, $45 000, $55 000 and $65 000. Families are assumed to have either one or two children who attend full time care (equal to 50 hours per child per week) in centre-based long day care and family day care.

Lower out-of-pocket costs for child care as a proportion of weekly disposable income (after child care subsidies) represents more affordable child care. Similar percentages across income groups suggest a more equitable outcome.

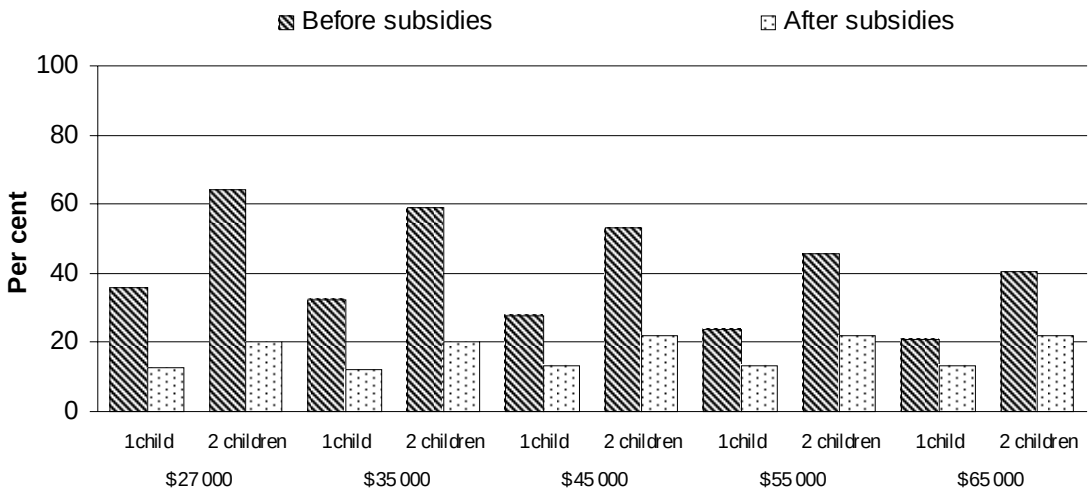
Care needs to be exercised when interpreting results, however, because a variety of factors may influence child care fees.

After the payment of child care subsidies, out-of-pocket costs as a proportion of weekly family income generally increase with gross annual family income. Nationally, families with one child in full time centre-based long day care at June 2004 and an annual gross family income of $27 000 spent 12.5 per cent of their weekly disposable income on child care (compared with 35.8 per cent before payment of child care subsidies) (figure 14.18).

By contrast, families with one child in care and an annual gross family income of $65 000 spent 13.4 per cent of their weekly disposable income on child care (compared with 20.5 per cent before payment of child care subsidies) (figure 14.18).

For families with two children in full time centre-based long day care, the proportion of weekly disposable income spent on child care was 20.5 per cent for those on an annual income of $27 000 (compared with 64.0 per cent before payment of child care subsidies) and 22.0 per cent for those on an annual income of $65 000 (compared with 40.2 per cent before payment of child care subsidies) (figure 14.18).

Figure 14.18 **Out-of-pocket costs of child care for families with children in full time centre-based long day care, as a proportion of weekly disposable income, by gross annual family income, 2004[a, b]**



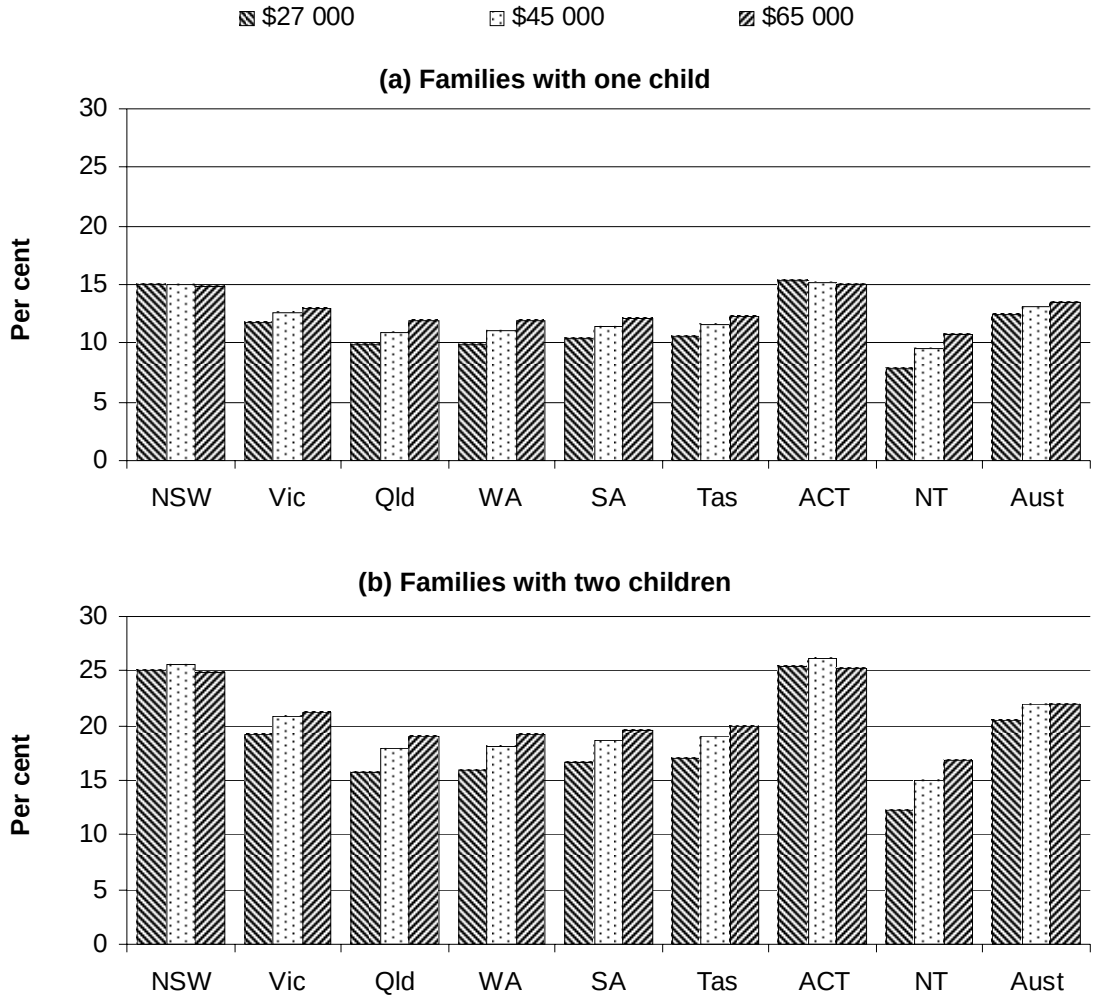
a Disposable income calculations are based on 20 March 2004 tax and payment parameters. Calculations are modelled on couple families with dual incomes (60:40 income split) with one or two dependent children aged under 5 years. **b** Out-of-pocket cost calculations are based on June 2004 average fees.

Source: DFaCS, AGCCCS March 2004 (unpublished data); table 14A.15.

Across jurisdictions in June 2004, out-of-pocket costs (after subsidies) for centre-based long day care for families with a gross annual income of $27 000 and one child in care ranged from 15.3 per cent of weekly disposable income in the ACT to 7.9 per cent in the NT. Out-of-pocket costs (after subsidies) for families with a gross annual income of $65 000 and one child in care ranged from 15.0 per cent of weekly disposable income in the ACT to 10.8 per cent in the NT (figure 14.19a).

For families with two children and a gross annual income of $27 000, the out-of-pocket costs (after subsidies) for centre-based long day care ranged from 25.5 per cent of weekly disposable income in the ACT to 12.2 per cent in the NT. The corresponding proportion for families with two children in care and a gross annual income of $65 000 ranged from 25.2 per cent in the ACT to 16.9 per cent in the NT (figure 14.19b).

Figure 14.19 **Out-of-pocket costs for centre-based long day care (after subsidies), as a proportion of weekly disposable income, by gross annual family income, 2004[a, b]**



a Disposable income calculations are based on 20 March 2004 tax and payment parameters. Calculations are modelled on couple families with dual incomes (60:40 income split) with one or two dependent children aged under 5 years. **b** Out-of-pocket cost calculations are based on June 2004 average fees, after subsidies.

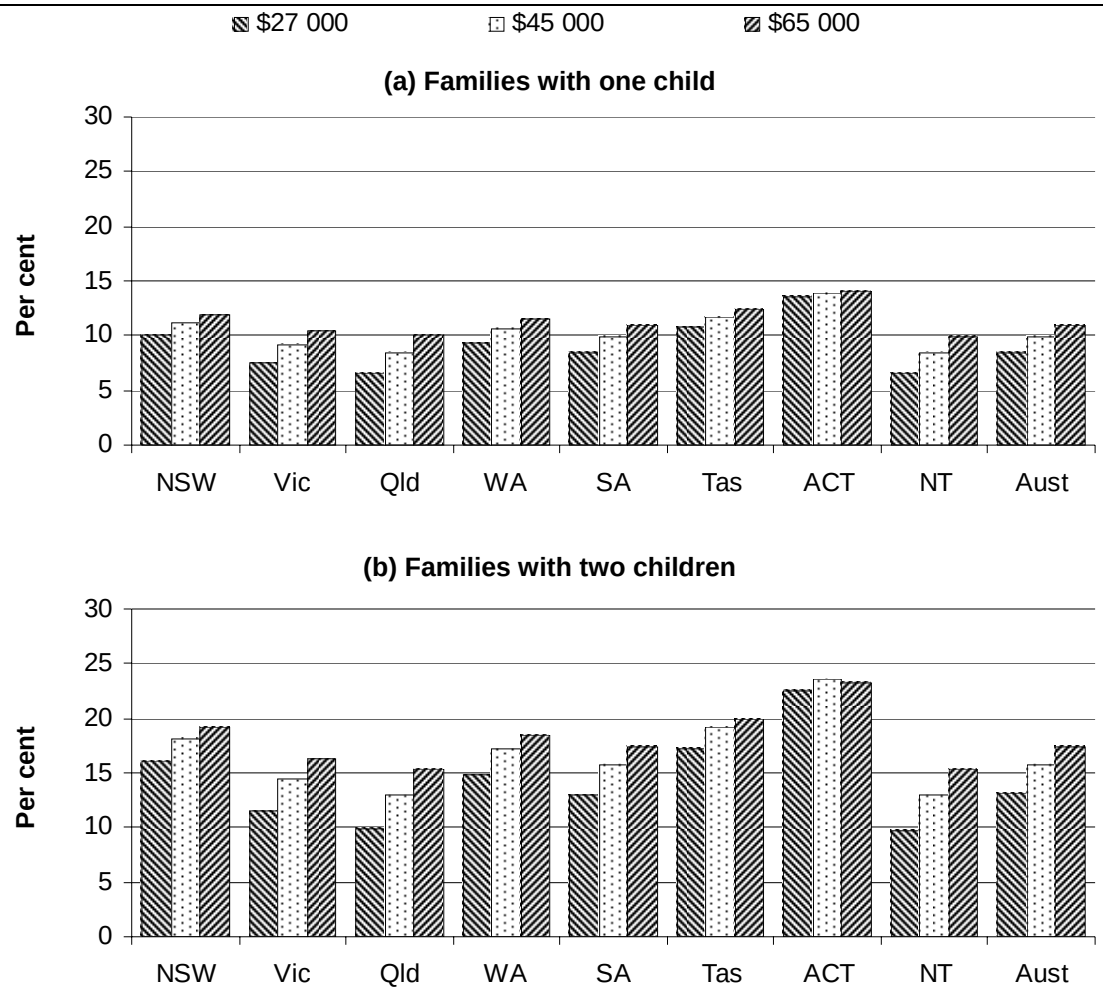
Source: DFaCS, AGCCCS March 2004 (unpublished data); table 14A.15.

In 2004, the out-of-pocket costs (after subsidies) for family day care for a family with a gross annual income of $27 000 and one child in full time care ranged from 13.6 per cent of weekly disposable income in the ACT to 6.5 per cent in both Queensland and the NT (figure 14.20a). The corresponding proportion for families with the same income and two children in care ranged from 22.5 per cent in the ACT to 9.8 per cent in both Queensland and the NT (figure 14.20b).

The proportion of weekly disposable income spent on child care (after subsidies) for a family with a gross annual income of $65 000 and one child in full time family day care ranged from 14.0 per cent in the ACT to 10.0 per cent in both Queensland

and the NT (figure 14.20a). The corresponding proportion for a family with the same income and two children in care ranged from 23.3 per cent in the ACT to 15.3 per cent in both Queensland and the NT (figure 14.20b).

Figure 14.20 **Out-of-pocket costs for family day care (after subsidies), as a proportion of weekly disposable income, by gross annual family income, 2004[a, b]**



a Disposable income calculations are based on 20 March 2004 tax and payment parameters. Calculations are modelled on couple families with dual incomes (60:40 income split) with one or two dependent children aged under 5 years. **b** Out-of-pocket cost calculations are based on June 2004 average fees, after subsidies.

Source: DFaCS, AGCCCS March 2004 (unpublished data); table 14A.16.

Client satisfaction

The Steering Committee has identified 'client satisfaction' as an outcome indicator of children's services meeting family needs (box 14.17). Data for this indicator, however, were not available for the 2005 Report.

Box 14.17 **Client satisfaction**

'Client satisfaction' will provide an outcome indicator of governments' objective to ensure children's services meet the needs and expectations of all users.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

14.4 Future directions in performance reporting

The Steering Committee is committed to continually improving the comparability, completeness and overall quality of reported data for all indicators included within the performance indicator framework.

Improving reporting of existing indicators

Processes for refining definitions, estimating methods and counting rules are continuing. Further work is planned to improve the consistency and comparability of performance information across jurisdictions. Changes in the children's services industry have required jurisdictions to revise collection methods, and these revisions have reduced the comparability of historical data across years and across jurisdictions. It will take some time before the improvements are reflected in the chapter.

Future indicator development

The Review will continue to improve the appropriateness and completeness of the performance indicator framework. Future work on indicators will focus on:

- developing an access indicator for Indigenous preschool enrolment and attendance rates
- developing a service availability indicator for utilisation rates
- completing the quality indicators for licensing, accreditation and registration
- improving the government expenditure efficiency indicators
- revising the quality indicators for health and safety, and client satisfaction
- developing indicators to measure the extent to which children's services meet family needs, including investigating an outcome indicator of client satisfaction

- developing indicators to measure the extent to which children's services meet children's needs
- conducting a rolling revision of all indicators within the framework.

Options for reporting on service appropriateness in future reports will also be investigated. While these areas have been identified as requiring further work, improvements to the chapter and progress on performance reporting will not be limited to these indicators.

Improving the completeness and comparability of data

National Minimum Data Set

The National Community Services Information Management Group's Children's Services Data Working Group, under the auspices of the CSDMAC, is developing a National Minimum Data Set (NMDS) for children's services. When completed, this data set will provide a framework for collecting a minimum set of nationally comparable data and assist the development of measurable performance indicators and descriptors.

The first stage of the NMDS was pilot tested in 2002. It set out to test data elements assessing the characteristics of the children who use child care and preschool services, the organisations providing these services, and their primary contact staff. The results of the pilot were positive in terms of a national data collection.

The second stage of the NMDS for children's services was pilot tested in September 2004 across 46 services. Stage 2 items included further characteristics of organisations providing child care and preschool services, characteristics of workers delivering these services, and additional characteristics of children who use services, and their families. The second pilot test covered all data items from both stage 1 and stage 2. A full report on the development phase of the NMDS will be released at the end of June 2005, and the Working Group is assessing options for implementing a national data collection in 2006-07.

Data collection

Consistency in the data collected by State and Territory governments is an important goal in terms of data comparability. One way of improving comparability is to collect data in a (preferably common) sample week that is representative of a typical standard week (and does not include any public holidays) in each State and Territory. There is still room for improvement in the data collection process.

14.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

“The Australian Government is committed to the development of a National Agenda for Early Childhood which will provide the overarching structure to guide future Australian Government investment to improve outcomes for children and will serve as the vehicle for collaboration with state and territory governments in supporting young children and their families.

The 2004-05 Budget saw further investment in child care including an increase of 40 000 Outside School Hours Care places and 4000 Family Day Care places. Additional funds were made available to improve access to child care for children with high support needs and increase support for rural, regional and Indigenous communities.

The Child Care Support Program (CCSP) announced in June 2004, is the culmination of an extensive consultative review of the Child Care Broadband. The review identified a number of gaps in child care provision particularly for families in rural and remote Australia, children with disabilities, Indigenous families, and families from diverse backgrounds. The CCSP addresses these issues and provides clear objectives and principles and better targeted and transparent funding arrangements for child care services.

The development of an Indigenous child care strategy was also announced in June 2004. The Indigenous child care strategy aims to provide flexible funding for Indigenous services, guide future development of Indigenous child care and identify resources, roles and responsibilities of agencies in the Indigenous child care sector. A process for consultation on the development of the strategy is being developed.

The Australian Government is implementing new measures to improve the affordability of child care. The child care tax rebate will provide families receiving Child Care Benefit (CCB) and who use approved child care with a 30 per cent tax rebate for out-of-pocket expenses from 1 January 2005. Increased assistance is also being provided to grandparents with primary care of their grandchildren. From 1 November 2004, the work test was waived for eligible grandparent carers, allowing access to up to 50 hours of CCB as opposed to the normal 20 hours for carers who do not meet the work test. Subject to passage of legislation, from 1 January 2005, free approved child care will be available to eligible grandparent carers receiving an income support payment.”

New South Wales Government comments

“ The central feature of the NSW Government's Early Childhood Services Policy is its focus on the importance of the early years of life though a system of good quality children's services that are responsive to the needs of children in the context of their families and the communities in which they live.

NSW's regulatory framework recognises the integrated nature of early childhood education and care. All licensed early childhood services are required by regulation to provide an education program tailored to each child's intellectual, physical, social and emotional development and to employ appropriately qualified teaching staff.

For this reason, the structure of the children's services chapter continues to pose difficulties in comparing the performance of NSW with that of other jurisdictions and in accurately reporting NSW data. The chapter is based on distinguishing preschool from child care, which does not reflect the integrated delivery of early childhood education in NSW. NSW urges caution in any use or interpretation of this data in relation to the number of children that access a preschool program.

After extensive review and consultation with child care providers, parents and early childhood professionals, the new Children's Services Regulation 2004 came into effect on 30 September 2004. There is a 15-month transition period for the new Regulation for existing children's services providers.

Some key changes under the new Regulations include: services are required to install safety glass in areas accessible to children; maximum group size for children 3–5 years is reduced from 25 to 20; venue management plans have been introduced for mobile children's services; two primary care staff must check children are not left in a centre at the end of the day; probity checks on anyone engaged in the operation or management of children's service; and video monitoring equipment is no longer allowed for remote viewing such as over the internet.

A review of the Children's Services Affordability Policy for fee relief in preschools, funded by the Department of Community Services, was commenced in 2003 and has since been broadened in scope, taking into account all funding sources for preschools. The Stage 2 Review of Preschool Funding commenced in April 2004 and will focus on more effective use of existing funding resources, having regard to the joint goals of access to preschool and affordability of those preschool places. ”

Victorian Government comments

“The Victorian Government’s commitment to building stronger communities and ensuring the wellbeing of all children wherever they live, play or are cared for is articulated in its *Children First* policy. The focus is on providing services in ways that are integrated, accessible and affordable.

The integration of early childhood services is being assisted through the establishment of new kindergartens and children’s centres. These capital projects bring together services such as kindergarten, child care, maternal and child health and early intervention, in areas of high need and in growth corridors. A total of $16 million over three years has been committed and already 27 projects have been funded.

This initiative is supported by a $5 million project that is providing computers and information technology support for community-based kindergartens and community-based long day care centres that provide kindergarten services.

The implementation of Best Start continues, with two Aboriginal demonstration projects established, bringing the total number of projects to thirteen. These demonstration projects have established partnerships that are working to improve the health, development, learning and wellbeing of children from pregnancy through to transition to school. Action plans focus on activities such as improving access to and participation in universal services, strengthening local communities, establishing playgroups and early literacy projects.

Implementation of kindergarten cluster management, which groups individual, community-based kindergartens together under a single employer organisation, continues. It is easing the pressures on voluntary committees of management and providing stable employment arrangements for staff.

A range of quality initiatives have been introduced including an integrated early years training strategy which delivered training to 1200 early years professionals on a multidisciplinary basis; implementation of a mentoring initiatives for kindergarten teachers; and the development of resources and training for outside school hours care services and children’s services.

In Victoria there is a strong partnership between State and Local Government in relation to early childhood services. It is within this context that Local Governments are developing individual Municipal Early Years Plans to articulate the strategic direction for the development and coordination of educational, care and health programs and other local activities that impact on children 0–6 years. These plans will support Local Government to work in partnership with the community to improve health and wellbeing outcomes for young children.”

Queensland Government comments

“ The Queensland Government continued its commitment to work towards a child care system for Queensland children and families that is responsive, sustainable and of a high quality, by introducing the *Child Care Act 2002* and the *Child Care Regulation 2003* on 1 September 2003.

The licensing of school age care services and increased qualification requirements for centre-based child care workers are important features of the new legislation. The continued implementation of the Child Care Statewide Training Strategy supports the implementation of the legislation by providing access to subsidised and flexible training programs to more than 4000 child care workers. By June 2004, more than 1571 workers (including 68 from Indigenous communities in Far North Queensland) had gained an approved child care qualification which meets the legislative requirements.

The Queensland Government's 'Education and Training Reforms for the Future' package of initiatives collectively aim to maximise students' educational outcomes. The trial of a full-time preparatory year, through the *Preparing for School* trial is a critical component of this initiative.

From 2007 the Queensland Government will implement a full-time, universally available, non-compulsory preparatory year. The decision to implement the preparatory year, which will replace the current sessional preschool program in Queensland State schools, was based on evidence gathered during the initial phase of the *Preparing for School* trial. From 2005, 96 schools will be offering a preparatory year as part of a statewide phase-in leading to full implementation in 2007. An additional 25 schools will come on line for the 2006 school year. The Queensland Studies Authority has developed a draft *Early Years Curriculum Guidelines and draft Early Learning and Development Framework* for use by teachers when planning, implementing and monitoring preparatory programs.

The Queensland Government continues to work with the child care sector to implement priorities identified in the *Queensland Child Care Strategic Plan 2000–2005*. In 2003-04, an additional six services were recommended for funding of more than $500 000 under the successful Child Care and Family Support Hub Strategy which supports the delivery of integrated child care and family support services. In addition, $1.1 million was allocated for the upgrade of school age care services and more than $500 000 was allocated for the upgrade of community-based child care services in rural, remote and Indigenous communities.

The Queensland Government has demonstrated a commitment to engaging with the sector by providing information sessions relating to the new legislative standards, distributing a regular newsletter to all child care services and engaging with the Child Care Forum to discuss and develop strategies to address issues impacting on children and families. The Queensland Government remains committed to using data and research to inform planning and decision making and is working to enhance the availability, integrity and comparability of data for future reports. ”

Western Australian Government comments

“The Department for Community Development is continuing to strengthen the management of its licensing and monitoring functions. All licensing staff have attained *Certificate IV in Government: Statutory Investigation and Enforcement* to improve the Department's ability to mount successful prosecution cases. The Department is introducing a new information system which will improve the storage and access to information about services and applicants and support the Child Care Licensing Unit's new work processes.

The Child Care Advisory Committee has been established to provide the Minister for Community Development with information and advice on matters related to licensing and quality assurance in child care. Members consist of government, community, sector and academic representatives chosen for their ability to represent the interests of a broad cross section of the child care sector, in particular, children and parents.

The *Children and Community Services Act 2004* recognises the changing nature of the child care sector and will provide more flexibility in the ways services can be prescribed. The Act will provide the legislative base to develop new regulations for child care that are consistent with contemporary theory and practice. The development of the regulations will commence early in 2005 with sector-wide consultations.

The Department for Community Development won a contract to provide the training associated with the introduction of the Australian Government's quality assurance system to outside school hours care services in Western Australia. Thus the Department is providing a coordinated approach to the introduction of the *Community Services (Outside School Hours Care) Regulations 2002* and quality assurance.

With the introduction of the new outside school hours licensing system, child care providers in Western Australia now apply for: a centre or family day care licence (OSHC 5–12 years); or for a centre or family day care licence (child care 0–5 years). Individual family day carers are licensed in Western Australia.”

South Australian Government comments

“ In South Australia, education and children’s services are aligned within the same portfolio. This offers unique opportunities for drawing together child care, preschool and schooling, and for building better relationships with other agencies and services involved with young children.

During 2003-04, site based research, shared learning and critical collaboration across children’s services and the early years of school have supported the implementation of the state-wide curriculum framework (South Australian Curriculum Standards and Accountability framework). Improved early literacy learning for children in the context of their families is also being facilitated through the Learning Together Project.

It is recognised that working families require greater access to child care, particularly in communities where young children and families are at greater risk of social exclusion. It was announced this year that the State would support and strengthen families and communities by reopening closed child care centres in high need locations. The first centre will open in July 2004, with another two sites expected to open during the next 12 months when building works are complete.

With the aim of increasing the overall level of qualifications within the Children’s Services workforce, the government has introduced incentives for staff to pursue formal qualifications. The Child Care Qualification Scholarship Fund offers financial assistance and work release subsidies for child care workers to undertake training in the form of a Diploma of Community Services (Children’s Services).

This year the department has implemented innovative new models of integrated child care and preschool in rural communities. In a joint State and Federal government initiative, the sixth rural care site was opened which provides long day care to families in small rural communities. The government is also exploring new models of integrated delivery of child care, preschool and schooling in locations such as Sturt Street Community School. In doing so, the government is further developing interagency partnerships, thereby linking child care, child health and family services such as the Children and Families Everywhere service at Enfield Primary School.

The Minister for Education and Children’s Services has announced an early childhood services inquiry. The steering committee will report to the South Australian Government on such issues as: the availability, adequacy and quality of services; the most effective relationships with other family policy settings; the affordability of child care; and how best to support young children and families through seamless service delivery. ”

Tasmanian Government comments

“The State Government continues to extend and implement relevant supportive strategies in recognition of the importance of the early years. There has also been a restructure within the Department of Education bringing together child care and education responsibilities under the Early Years banner.

The *Child Care Act 2001* commenced on 1 September 2003 and all centre based care services for children 0–5 years have been licensed against the new standards. Standards for Approved Registration Bodies (Family Day Care Schemes) and home based care are in final stages of development. An audit of Outside School Hours Care services in 2004 demonstrated that many services were not fully aware of basic requirements such as duty of care and health and safety. It was therefore decided that the first round of licensing would be against five only core standards, with the remainder to be implemented in 2005-06. Additional training for Outside School Hours Care services will be arranged through a 2004-05 State budget initiative of $20 000.

Five million dollars from the sale of Government assets is being used to build child care centres on school premises where there is an identified community demand for child care. One service opened in 2004 with five more expected to open early 2005, increasing the number of child care places by more than 280.

The Government retains strong support for the early childhood sector through the implementation of the *Essential Learnings* curriculum:

- In the 2002-03 State Budget two pilots, to support families with young children under the Strong Start Program, were announced. These initiatives are at the stage of implementation, in consultation with stakeholders,
- *A Policy for the Early Years* has been developed as a working document, linking supportive early years programs, interagency collaboration and children’s later learning success,
- The Essential Connections research, publications, projects and associated professional development, focusing on the new curriculum framework in child care settings and schools, are nearing completion.
- Cluster Groups of carers and teachers continue to provide opportunities for professional learning and partnership collaboration,
- Discussions between the Department of Health and Human Services and the Department of Education have led to the trial of new prior-to-school health screening procedures,
- A collaborative project between the Department of Education and the University of Tasmania was undertaken to develop an early childhood resource linking the Kindergarten Development Check with the *Essential Learnings* Framework.

Other inter-agency initiatives are being planned for 2004 through the work of the Our Kids Bureau in collaboration with Department of Education.”

Australian Capital Territory Government comments

“ Quality education and care for children from birth provides the foundation for development and lifelong learning. The ACT Government supports the provision of quality programs that give children the opportunity to have a fulfilling childhood and every chance to realise their full potential.

The Department of Education and Training, in partnership with parent communities, is responsible for providing preschool services for all eligible children in the year immediately prior to their entry to school.

The Office for Children, Youth and Family Support is responsible for licensing and monitoring children's services in the ACT to ensure they meet the requirements of the *Children and Young People Act 1999*. These services include centre based children's services, school age care, family day care, independent preschools and playschools. Funding is also provided to assist with the provision of a range of children's services programs, including early intervention programs.

In June 2004, Minister Katy Gallagher MLA launched the whole of government *ACT Children's Plan 2004–14*. Extensive consultation informed the Plan's development, with over 2500 Canberra children sharing their views on what they want for the future. The Plan focuses on three main areas: children now and in the future; children and their families; and children and their community. The *ACT Children's Plan* is based on a shared commitment between government, community, parents and carers to provide an integrated approach to planning with and for Canberra children, to meet children's diverse and changing needs and circumstances.

The development of the Preschool Strategic Plan 2005–2010 has taken place in 2004 for the management of ACT Government preschools. A consultation phase with key stakeholders in early childhood in the ACT included questionnaires and focus groups facilitated by an independent facilitator. Feedback from the consultation has contributed to the development of the plan. The plan will provide a way forward for preschool education in the longer term, and direction for ongoing operations in the shorter term. The plan is due to be released early 2005.

The provision of preschool education across two longer days was expanded from a successful trial of two preschool groups in 2003 to six groups in 2004. Feedback received on this initiative from families during the Preschool Strategic Plan consultation phase was positive. ”

Northern Territory Government comments

“Children’s services in the Northern Territory aim to support families and communities in caring for and educating their children.

The Territory has a small and young population dispersed across one-sixth of the national landmass. About 40 per cent of the 0–12 population are Indigenous children, some 75 per cent of whom live in small remote communities and towns. Diseconomies of scale, an environment ranging from desert to tropical climates, and the particular interests and needs of the population have resulted in unique approaches to providing children’s services in the Northern Territory.

Comparability for reporting purposes therefore continues to be difficult. For example, this and previous reports indicate a considerably lower participation level of Indigenous children in child care services, however the data do not include participation in other services and activities such as innovative child care centres, ‘Jobs, Education and Training’ creches, playgroups and informal care services, which are preferred service models in a number of communities.

A low proportion of services offering non-standard hours of operation may be due to comparatively reduced travel to work times in the major urban areas.

In 2003–2004, the focus of the program was on continuing to expand access to appropriate children’s care and education services in remote Indigenous communities and tailoring services to better meet family needs. The number of child care staff with formal qualifications is increasing, this will continue to be an focus of work for 2004–2005.

2004–2005 will see the finalising and implementation of new legislation for regulating children’s services in the Northern Territory. Work will also progress to implement a new framework for supporting children and families across the education, health, disability and child care sectors.”

14.6 Definitions of key terms and indicators

Administration expenditure	All expenditure by the departments responsible for the provision of licensing, advice, policy development, grants administration and training services. Responsible departments include those that administer policy for, fund and license/accredit child care and preschool services in each jurisdiction.
Centre-based long day care	Services aimed primarily at 0–5 year olds that are provided in a centre, usually by a mix of qualified and other staff. Educational, care and recreational programs are provided based on the developmental needs, interests and experience of each child. In some jurisdictions, primary school children may also receive care before and after school, and during school vacations. Centres typically operate for at least eight hours per day on normal working days, for a minimum of 48 weeks per year.
Child care	The meeting of a child's care, education and developmental needs by a person other than the child's parent or guardian. The main types of service are centre-based long day care, family day care, outside school hours care (vacation, before/after school hours and 'pupil free days' care), occasional care and other care.
Children	All resident male and female Australians aged 12 years or younger at 30 June of each year.
Children from Indigenous backgrounds	Children of Indigenous descent who identify as being Indigenous and are accepted as such by the community in which they live.
Children from a non-English speaking background (NESB)	Children living in situations where the main language spoken is not English.
Children from single parent families	Dependent children who are resident in households of lone parent (either father or mother) families.
Children's services	All government funded and/or provided child care and preschool services (unless otherwise stated).
Counting rules	Prescribed standards, definitions and mathematical methods for determining descriptors and performance indicators for monitoring government services.
Expenditure on assets	Expenditure on the acquisition or enhancement of fixed assets, less trade-in values and/or receipts from the sale of replaced or otherwise disposed of items.
Disability related care	Care of children who have a developmental delay or disability (including a intellectual, sensory or physical impairment), or who have parent(s) with a disability.
Family day care	Services provided in the carer's home. The care is largely aimed at 0–5 year olds, but primary school children may also receive care before and after school, and during school vacations. Central coordination units in all states and territories organise and support a network of carers, often with the help of local governments.

Financial support to families	Any form of fee relief paid by governments to the users of children's services (for example, Child Care Benefit).
Formal child care	Organised care provided by a person other than the child's parent or guardian, usually outside of the child's home — for example, centre-based long day care, family day care, outside school hours care, vacation care and occasional care (excluding babysitting).
Formal qualifications	Early childhood-related teaching degree (three or four years), a child care certificate or associate diploma (two years) and/or other relevant qualifications (for example, a diploma or degree in child care [three years or more], primary teaching, other teaching, nursing [including mothercraft nursing], psychology and social work). Some jurisdictions do not recognise one year certificates.
Full time equivalent staff numbers	A measure of the total level of staff resources used. A full time staff member is employed full time and engaged solely in activities that fall within the scope of children's services covered in the chapter. The full time equivalent of part time staff is calculated on the basis of the proportion of time spent on activities within the scope of the data collection compared with that spent by a full time staff member solely occupied by the same activities.
Government funded or/and provided	All government financed services — that is, services that receive government contributions towards providing a specified service (including private services eligible for Child Care Benefit) and/or services for which the government has primary responsibility for delivery.
Informal child care	Child care arrangements provided privately (for example, by friends, relatives, nannies) for which no government assistance (other than the minimum rate of Child Care Benefit for Registered Care) is provided. Such care is unregulated in most states and territories.
In-home care	Care provided by an approved carer in the child's home. Families eligible for in-home care include those where the parent(s) or child has an illness/disability, those in regional or remote areas, those where the parents are working shift work or non-standard hours, those with multiple births (more than two) and/or more than two children under school age, and those with a breastfeeding mother working from home.
In-service training	Formal training only (that is, structured training sessions that may be conducted in-house or externally), including training in work or own time but not training towards qualifications included in obtaining formal qualifications. It includes: • management or financial training • training for additional needs children (such as children with a disability, Aboriginal or Torres Strait Islander children and children from a culturally diverse background • other child care-related training • other relevant courses (such as a first aid certificate).
Licensed services	Those services that comply with the relevant State or Territory licensing regulations. These regulations cover matters such as the number of children whom the service can care for, safety requirements and the required qualifications of carers.

Non-standard hours of care	Defined by service type as: • centre-based long day care —providers of service for more than 10 hours per day on Monday to Friday and/or service on weekends • preschool —providers of service for more than six hours per day • family day care — providers of service for more than 50 hours per week and/or service overnight and/or on weekends • vacation care — providers of service for more than 10 hours per day • before school hours care — providers of service for more than two hours before school • after school care — providers of service for more than three hours after school • occasional care — providers of service for more than eight hours per day • other — providers of service for more than 10 hours per day.
Occasional care	Services usually provided at a centre on an hourly or sessional basis for short periods or at irregular intervals for parents who need time to attend appointments, take care of personal matters, undertake casual and part time employment, study or have temporary respite from full time parenting. These services provide developmental activities for children and are aimed primarily at 0–5 year olds. Centres providing these services usually employ a mix of qualified and other staff.
Operational place	A licensed place (where a licensing system exists, or in receipt of government funding where not licensed) able to accept children at 30 June each year.
Other services	Government funded services to support children with additional needs or in particular situations (including children from an Indigenous or non-English speaking background, children with a disability or of parents with a disability, and children living in regional and remote areas).
Other expenditure on service provision	All recurrent expenditure on government funded and/or provided child care and preschool services. It also includes one-off, non-capital payments to peak agencies that support child care and preschool service providers.
Outside school hours care	Services provided for school aged children (5–12 year olds) outside school hours during term and vacations. Care may be provided on student free days and when school finishes early.
Preschools	Services usually provided by a qualified teacher on a sessional basis in dedicated preschools. Preschool programs or curricula may also be provided in long day care centres and other settings. These services are primarily aimed at children in the year before they commence full time schooling (that is, when children are 4 years old in all jurisdictions), although younger children may also attend in most jurisdictions.
Primary contact staff	Staff whose primary function is to provide care and/or preschool services to children.
Program support activities	Administration expenditure associated with the licensing of services that do not receive government funding.

Real expenditure	Actual expenditure adjusted for changes in prices. Adjustments were made using the GDP price deflator and expressed in terms of final year prices.
Recurrent expenditure	Expenditure that does not result in the creation or acquisition of fixed assets (new or second hand). It consists mainly of expenditure on wages, salaries and supplements, purchases of goods and services, and the consumption of fixed capital (depreciation).
Regional and remote areas	Geographic location is based on the ABS's Australian Standard Geographical Classification of Remoteness Areas, which categorises areas as 'major cities', 'inner regional', 'outer regional', 'remote', 'very remote' and 'migratory'. The criteria for remoteness areas are based on the Accessibility/Remoteness Index of Australia, which measures the remoteness of a point based on the physical road distance to the nearest urban centre in each of five size classes (ABS 2001). The 'regional' classification used in this chapter was derived by adding data for inner regional and outer regional areas. The 'remote' classification was derived by adding data for remote, very remote and migratory areas. In previous reports, geographic location data was based on the rural, remote and metropolitan areas classification (DPIE and DHSH 1994).
Serious injury	Injury requiring hospitalisation or a visit to (or by) a doctor.
Service	The type of service provided. Preschool service, for example, is a package of educational and developmental services received by a child in the year or two before full time schooling. Preschool services may be provided by either a preschool service provider or a child care service provider.
Service type	The categories for which data were collected, namely: • centre-based long day care • family day care • outside school hours care – vacation care – before/after school care • occasional care • 'other' care • preschool services.
Substantiated complaint	An expression of concern about a child care or preschool service, made orally, in writing or in person, which constitutes a failure by the service to abide by the State or Territory legislation, regulations or conditions. This concern is investigated and subsequently considered to have substance by the regulatory body.
Vacation care	Care and developmental activities provided for school age children during school vacation periods
Proportion of services providing non-standard hours of care	The number of services providing non-standard hours of care, divided by the total number of services, by service type.
Proportion of special needs groups using services relative to their population proportions	The number of children from special needs groups using children's services, divided by the total number of children using children's services. Results are presented separately for child care and preschool services, with special needs groups divided into children from a non-English speaking background, children from an Indigenous

	background, children from low income families, children with a disability, and children from regional or remote areas. These results are compared with these groups' representation in the community.
Serious injuries sustained per registered or licensed service	The total number of serious injuries sustained by children divided by the total number of licensed services.
Substantiated complaints per registered or licensed service	The number of substantiated complaints divided by the total number of licensed services. Results are presented separately by service type. The proportion of substantiated complaints against which action was taken is also reported.
Out-of-pocket costs relative to family income for children's services	Modelling undertaken by the Department of Family and Community Services for families with one child and two children respectively in full time care (defined as 50 hours per week for each child) for a range of indicative annual incomes. Out-of-pocket costs are based on the average weekly fee for one child and two children in full time care, and are calculated as a proportion of weekly disposable income, after the payment of child care subsidies. The gross annual income levels used are $27 000, $35 000, $45 000, $55 000 and $65 000, with a 60:40 income split.

14.7 References

ABS (Australian Bureau of Statistics) 2003, *Child Care*, Cat. nos 4402.0, 4402.1.40.001–4402.8.40.001, Canberra.

DPIE (Department of Primary Industries and Energy) and DHSH (Department of Human Services and Health) 1994 *Rural, Remote and Metropolitan Areas Classification 1991 Census Edition*, Australian Government, Canberra.

NCAC (National Childcare Accreditation Council) 2001, *FDCQA Quality Practices Guide*.

—— 2004, *FDCQA Quality Practices Guide*, 2nd edition.

15 Protection and support services

Protection and support services aim to assist individuals and families who are in crisis or experiencing difficulties that hinder personal or family functioning. They do this by alleviating the difficulties and reducing the potential for their recurrence.

This chapter reports on:

- *child protection services*: the functions of government that receive and assess allegations of child abuse and neglect, and/or harm to children and young people, provide and refer clients to family support and other relevant services, and intervene to protect children
- *out-of-home care services*: care for children placed away from their parents for protective or other family welfare reasons
- *supported accommodation and assistance services*: services to assist young people, adults and families who are homeless or at imminent risk of becoming homeless.

A profile of child protection and out-of-home care services appears in section 15.1. A framework of performance indicators is outlined in section 15.2 and data are discussed in section 15.3. Future directions in performance reporting are outlined in section 15.4.

A profile of accommodation and assistance services funded under the Supported Accommodation Assistance Program (SAAP) appears in section 15.5. A framework of performance indicators for these services is outlined in section 15.6 and data are discussed in section 15.7. Future directions in performance reporting are discussed in section 15.8.

Jurisdictions' comments on both child protection and out-of-home care services, and supported accommodation and assistance services are reported in section 15.9. Definitions of data descriptors and indicators are provided in section 15.10.

New South Wales was unable to provide data for a significant number of items for the 2005 Report due to the introduction of a new client information system, the Key Information Directory System (KiDS) in 2003-04. KiDS represents a significant change in the reporting framework for child protection and out-of-home care data for NSW. An Information Quality Framework was introduced as part of the KiDS

implementation process to ensure that all published information based on KiDS data are accurate and consistent. The information quality process was still underway for a number of key data items when data were collected for the 2005 Report, resulting in limited data being available.

Supporting tables

Supporting tables for chapter 15 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel format as \Publications\Reports\2005\Attach15A.xls and in Adobe PDF format as \Publications\Reports\2005\Attach15A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 15A.3 is table 3 in the electronic files). These files can be found on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

15.1 Profile of child protection and out-of-home care services

Service overview

Child protection services

Child protection services are provided to protect children and/or young people aged 0–17 years who are at risk of harm within their families, or whose families do not have the capacity to protect them. These services include:

- receiving and responding to reports of concern about children or young people, including investigation and assessment where appropriate
- providing support services (directly or through referral) where harm or a risk of significant harm is identified, to strengthen the capacity of families to care safely for children
- initiating intervention where necessary, including applying for a care and protection order through a court and, in some situations, placing children or young people in out-of-home care to secure their safety
- ensuring the ongoing safety of children and young people by working with families to resolve protective concerns

- working with families to reunite children (who were removed for safety reasons) with their parents as soon as possible. (In some jurisdictions, restoration may occur in voluntary placements as well.)
- securing permanent out-of-home/alternative care when it is determined that a child is unable to be returned to the care of his or her parents, and working with young people to identify alternative supported living arrangements where family reunification is not possible.

Recent research suggests that the children and families who come into contact with the protection and support system often share common social and demographic characteristics. Families with low incomes or reliant on pensions and benefits, those who experienced alcohol and substance abuse, or a psychiatric disability, and those that have a family history of domestic violence were over-represented in the families that came into contact with the protection and support system (DHS 2002). Recent studies have also highlighted the incidence of child abuse and neglect within the Indigenous communities (Gordon Report 2002, box 15.1).

Box 15.1 **Western Australian Gordon Inquiry**

During 2002, the WA State Government received the findings from the Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities (the Gordon Inquiry). The Inquiry examined the circumstances surrounding the death of a 15-year-old girl in February 1999 at the Swan Valley Nyungah Community in Lockridge.

The final report of the Gordon Inquiry, released publicly in September 2002, showed that the incidence of violence and child abuse in Aboriginal communities was 'shocking and difficult to comprehend'. It stated that reported statistics show:

- Aboriginal women accounted for 50 per cent of all domestic violence incidents reported to police but represent only 3 per cent of the population
- Aboriginal communities experienced substantiated child abuse at more than seven times the rate of non-Aboriginal communities
- Aboriginal women living in rural and remote areas were 45 times more likely than non-Aboriginal women to be victims of domestic violence (Gordon Report 2002).

The report also noted that the incidence of child abuse and family violence in Aboriginal communities was significantly under-reported. It found an urgent need for greater coordination across government agencies, more training for staff (including cross cultural training) and more and better resourced services, especially in remote areas. It also found that a lack of trust between Aboriginal communities and government agencies was a significant barrier to complaints of violence and abuse being made.

(Continued on next page)

Box 15.1 **(Continued)**

The WA Government accepted the challenges posed by the Gordon Inquiry and is implementing recommendations arising from the inquiry, in consultation with other major stakeholders. The recommendations attempt to address:

- the urgent need to strengthen responses to abuse and violence in Aboriginal communities
- the need for long term strategies to address the endemic nature of abuse and violence in many communities
- the needs of current and future generations of Aboriginal children through long term environmental, social and economic improvements leading to sustainable communities.

The new initiatives aimed at combating child abuse and family violence in Aboriginal communities have been funded over a four year period and involve the employment of more than 100 additional staff across a range of government agencies.

In addition, the government is exploring new ways of working across the public sector — for example, the Specialist Child Interviewing Unit involves a collaborative approach by the Department for Community Development, the WA Police Service and the Department of Health.

Source: Department for Community Development (unpublished); Gordon Report (2002).

Out-of-home care services

Out-of-home care services provide care for children and young people aged 0–17 years who are placed away from their parents or family home for reasons of safety or family crisis. These reasons include abuse, neglect or harm, illness of a parent and the inability of parents to provide adequate care. The placements may be voluntary or made in conjunction with care and protection orders.

Out-of-home care services are either home-based care (such as foster care, care with the child's extended family or other home-based arrangements), facility-based care (such as community residential care) or independent living (which is often intensively supported) as a transition to full independence or supported placements. Across jurisdictions, there has been a shift away from the use of facility-based (or residential) care towards foster care and other forms of home-based care, including relative/kinship care. Intensive family support services are increasingly perceived as an alternative to the removal of the child from his or her home for child protection reasons (box 15.2).

Box 15.2 **Intensive family support services**

Intensive family support services are specialist services established in each jurisdiction that aim to:

- prevent the imminent separation of children from their primary caregivers as a result of child protection concerns
- reunify families where separation has already occurred.

In 2003-04, at least 71 intensive family support programs and subprograms were operating across Australia (three in NSW, 46 in Victoria, four in Queensland, eight in WA, six in SA, two in Tasmania and two in the ACT). The NT does not fund any intensive family support services.

Intensive family support services differ from other types of child protection and family support service referred to in this chapter, in that they:

- are funded or established explicitly to prevent the separation of, or to reunify, families
- provide a range of services as part of an integrated strategy focusing on improving family functioning and skills, rather than providing a single type of service
- are intensive in nature, averaging at least four hours of service provision per week for a specified short term period (usually less than six months)
- generally receive referrals from a child protection service.

Intensive family support services may use some or all of the following strategies: assessment and case planning; parent education and skill development; individual and family counselling; anger management; respite and emergency care; practical and financial support; mediation, brokerage and referral services; and training in problem solving.

Expenditure data indicate that recurrent expenditure on intensive family support services across all jurisdictions was at least $81.1 million in 2003-04 (table 15A.21). Table 15A.21 provides additional information about families and children who were involved with intensive family support services during 2003-04.

Source: Australian Institute of Health and Welfare (AIHW) (unpublished).

Roles and responsibilities

State and Territory governments fund child protection, out-of-home care, family support (including intensive family support) and other relevant services that may be delivered by the government or the non-government sector. State and Territory community services departments are responsible for investigating and assessing reports to the department, referring families to support services and intervening

where necessary (including making court applications when an order is required to protect a child and placing children in out-of-home care).

Other areas of government also have a role in child protection and provide services for children who have come into contact with community services departments for protective reasons. Examples include:

- police services, which investigate serious allegations of child abuse and neglect, particularly criminal matters, and may also work on child protection assessments with State and Territory community services departments
- courts, which decide whether a child will be placed on an order
- education and child care services, which provide services for these children and also conduct mandatory reporting and protective behaviours education in some jurisdictions
- health services, which support the assessment of child protection matters and deliver therapeutic, counselling and other services.

Size and scope

The child protection system

Child protection legislation, policies and practices vary among jurisdictions, but the broad processes in the child protection system are similar (figure 15.1).[1] State and Territory community services departments are advised of concerns about the wellbeing of children through reports to the department. Reports may be made by people mandated to report (such as medical practitioners, police services, and school teachers and principals) or by other members of the community. These reports are then assessed and classified as child protection notifications, child concern reports or matters requiring some other kind of response. The most common sources of notification for finalised investigations in 2002-03 were school personnel, police, parents and guardians, other relatives and friends, and neighbours (AIHW 2005).

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

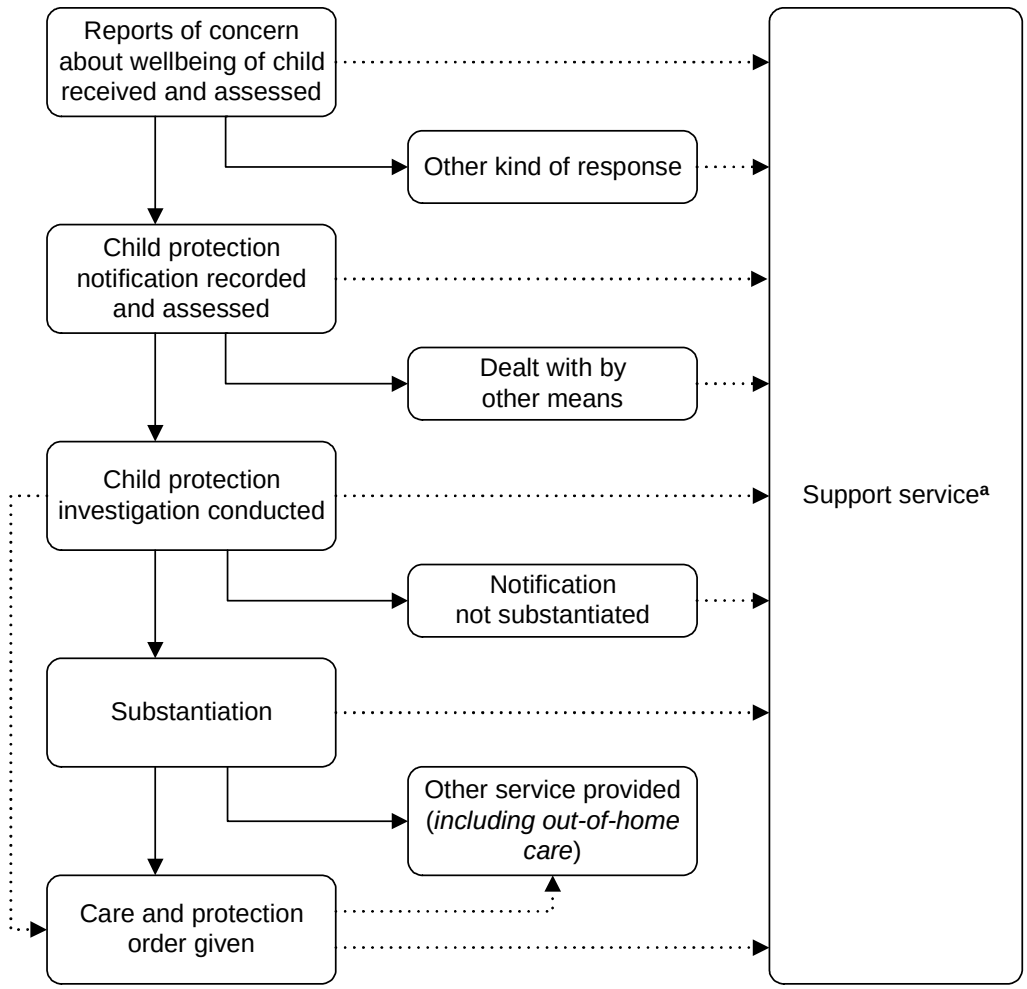
[1] Child protection services, care and protection orders and out-of-home care relate to children aged 0–17 years. Rates of children subject to notifications, investigations and substantiations, however, are calculated for children aged 0–16 years, given differences in jurisdictions' legislation, policies and practices regarding children aged 17 years.

screening and decision making process. This means the number of notifications is not strictly comparable across jurisdictions.

Notification

All jurisdictions except Victoria, Tasmania, the ACT and the NT screen incoming reports before deciding whether they will be designated and counted as a notification, thus reducing the proportion of reports that become notifications. WA undertakes a further screening process designed to differentiate between reports about harm/maltreatment and child and family concerns. This reduces the number of notifications, in that only reports about child harm/maltreatment are the subject of this report.

Figure 15.1 **Child protection system**



Note: Dashed lines indicate that clients may or may not receive these services, depending on need.

[a] Support services include family support or family preservation services provided by community service departments and referrals to other agencies.

In all jurisdictions, notifications are investigated when deemed appropriate, based on the policies and practices in that jurisdiction. Once it has been decided that an investigation is required, the investigation process is similar across jurisdictions. The community services department may obtain further information about the child and his or her family by checking information systems for any previous history, undertaking discussion/case planning with agencies and individuals, interviewing/ sighting the child and/or interviewing the caregivers/parents. At a minimum, the child is sighted whenever practicable, and the child's circumstances and needs are assessed. This investigation process determines whether the notification is substantiated or not substantiated (figure 15.1).

Although notifications are defined differently across jurisdictions, around 144 942 children aged 0–16 years were the subject of child protection notifications in 2003-04. Nationally, the rate of notifications per 1000 children in the population aged 0–16 years was 32.0 in 2003-04. Across jurisdictions, the rate was highest in Tasmania (47.0) and lowest in WA (4.9) (table 15A.8).

Indigenous children

Data on the number of notifications are collected very early in the child protection process and often before the agency has full knowledge of the child's family circumstances. This lack of full knowledge and the inherent difficulties in identifying Indigenous status mean it is not possible to collect reliable data on the number of notifications by Indigenous status.

Substantiation

The criteria for substantiation vary across jurisdictions. In the past, child protection legislation and policy focused on the identification and investigation of narrowly defined incidents that were broadly grouped as types of abuse or neglect. Across all jurisdictions, however, the focus is shifting away from the actions of parents and guardians, towards the desired outcomes for the child, the identification and investigation of actual and/or likely harm to the child, and the child's needs.

If an investigation results in substantiation, intervention by the relevant community services department may be needed to protect the child. This intervention can take a number of forms, including one or more of: referral to other services, supervision and support, an application to court, and a placement in out-of-home care.

Across Australia, at least 23 862 children were the subject of a substantiation in 2003-04 (excluding NSW, which could not provide substantiation data for 2003-04). The rate of children who were the subject of a substantiation per 1000

children in the population aged 0–16 years was 7.9. Across jurisdictions, this rate ranged from 14.0 per 1000 in Queensland to 2.0 per 1000 in WA (table 15A.8).

Indigenous children

Nationally in 2003-04, at least 3086 Indigenous children and 20 776 non-Indigenous children were the subject of a substantiation (excluding NSW, which could not provide substantiation data for 2003-04). The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–16 years was 21.8 for Indigenous children and 7.2 for non-Indigenous children (table 15A.8).

Care and protection orders

Although child protection substantiations are often resolved without the need for a court order (which is usually a last resort), recourse to the court may take place at any point in the child protection investigation process (figure 15.1). The types of order available vary across jurisdictions.

Across Australia, at least 14 627 children were on care and protection orders at 30 June 2004 (excluding NSW, which could not provide care and protection order data for 30 June 2004). The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 4.6. Across jurisdictions, this rate ranged from 5.8 per 1000 in the NT to 3.4 per 1000 in WA (table 15A.8).

Indigenous children

Nationally, at least 2944 Indigenous children and 11 683 non-Indigenous children were on care and protection orders at 30 June 2004 (excluding NSW, which could not provide care and protection order data for 30 June 2004). The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 19.6 for Indigenous children and 3.8 for non-Indigenous children (table 15A.8).

Out-of-home care

Out-of-home care is one of a range of services provided to families and children where there is a need to provide safe care for a child. The current emphasis in policy and practice is to maintain the child within the family if possible and to place a child in out-of-home care only if this will improve the outcome for the child. If it is necessary to remove the child from his or her home, then placement with the wider family or community is sought where possible, particularly in the case of

Indigenous children (AIHW 2005). Continued emphasis is being placed on improving case planning and case management processes, to facilitate the safe return home of children in out-of-home care and to maximise case workers' contact time with children and families.

Across Australia, 21 795 children were in out-of-home care at 30 June 2004. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 4.5. Across jurisdictions, this ranged from 5.7 per 1000 in NSW to 3.5 per 1000 in SA and WA (table 15A.11).

Indigenous children

Nationally, 5059 Indigenous children and 16 736 non-Indigenous children were in out-of-home care at 30 June 2004. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 23.7 for Indigenous children and 3.7 for non-Indigenous children (table 15A.11).

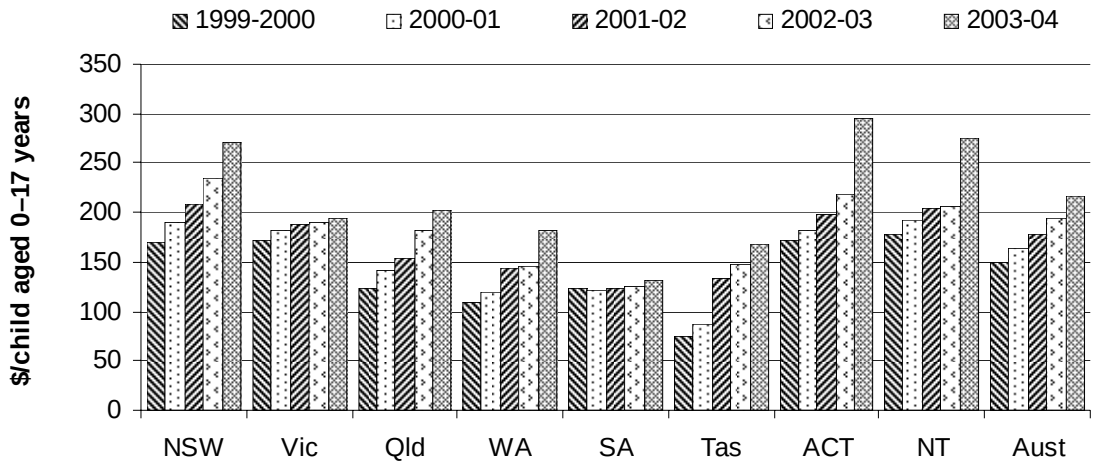
Funding

Recurrent expenditure on child protection and out-of-home care services was at least $1041.4 million across Australia in 2003-04 — a real increase of $110.8 million (11.9 per cent) from the 2002-03 expenditure. Nationally, out-of-home care services accounted for the majority (61.3 per cent, or $638.6 million) of this expenditure. Some jurisdictions have difficulty in separating expenditure on child protection from expenditure on out-of-home care services (table 15A.1).

Nationally, real recurrent expenditure per child aged 0–17 years was $217 in 2003-04. This varied across jurisdictions, from $296 in the ACT to $131 in SA (figure 15.2). Real recurrent expenditure on child protection and out-of-home care services per child aged 0–17 years increased in all jurisdictions between 2002-03 and 2003-04.

It is an objective of the Review to report comparable estimates of costs. Ideally, the full range of costs to government would be determined on a comparable basis across jurisdictions. Where the full costs cannot be counted, costs should be estimated on a consistent basis across jurisdictions. In the area of child protection, however, there are differences across jurisdictions in the expenditure reported. (Table 15A.4 identifies the level of consistency across jurisdictions for a number of expenditure items.) The scope of child protection systems also varies across jurisdictions, and expenditure on some services may be included for some jurisdictions and not for others (see page 15.6 for a discussion of the child protection system).

Figure 15.2 **Real recurrent expenditure on child protection and out-of-home care services (2003-04 dollars)**



Source: State and Territory governments (unpublished); table 15A.1.

15.2 Framework of child protection and out-of-home care services performance indicators

The framework of performance indicators for child protection and out-of-home care services is based on shared government objectives (box 15.3).

Box 15.3 **Objectives for child protection and out-of-home care services**

The aims of child protection services are to:

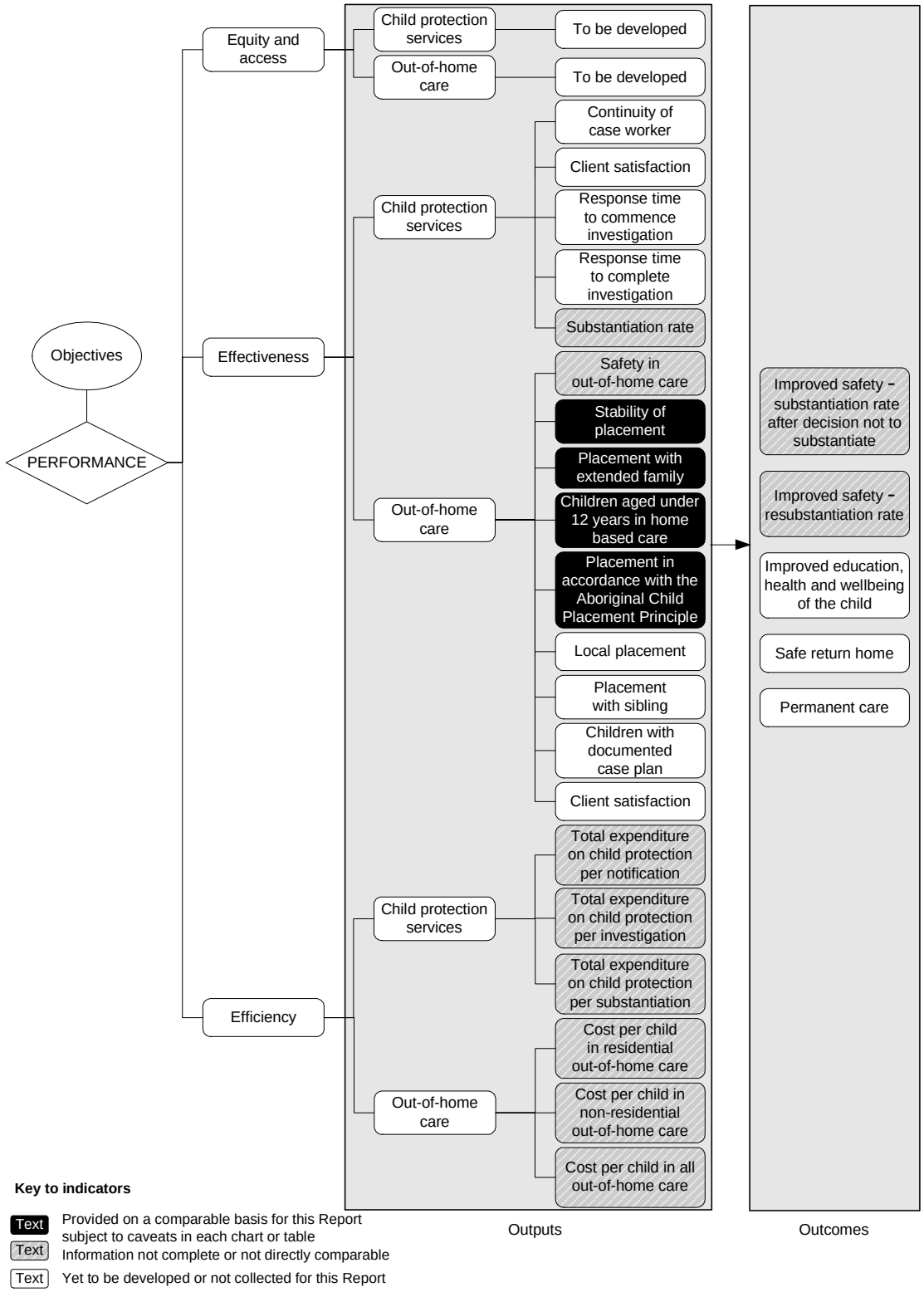
- protect children and young people at risk of harm within their family or in circumstances in which the family of the child or young person does not have the capacity to protect them
- assist families to protect children and young people.

The aim of out-of-home care services is to provide quality care for children and young people aged 17 years or under who cannot live with their parents for reasons of safety or family crisis.

Child protection and out-of-home care services should be provided in an efficient and effective manner.

The performance indicator framework and those indicators that are comparable in the 2005 Report are shown in figure 15.3. For data that are not considered strictly

Figure 15.3 **Performance indicators for child protection and out-of-home care services**



comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

15.3 Key child protection and out-of-home care services performance indicator results

Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of child protection services. Appendix A contains detailed statistics that may assist in interpreting the performance indicators.

Outputs

Equity and access

The Steering Committee has identified equity and access as a key area for further development in future reports (box 15.4).

Box 15.4 **Access to child protection and out-of-home care services by different groups**

These indicators will provide output indicators of governments' objective to ensure that all clients have fair and equitable access to services on the basis of relative need and available resources.

These indicators are under development and data are currently not collected. The Steering Committee has identified this indicator for development and reporting in future.

Effectiveness

Child protection services — continuity of case worker

The Steering Committee has identified 'continuity of case worker' as an indicator of the effectiveness of child protection services (box 15.5). No data on this indicator, however, were available for the 2005 Report.

Box 15.5 **Continuity of case worker**

This indicator will provide an output indicator of governments' objective to ensure child protection services are delivered in an effective manner. The turnover of workers is a frequent criticism of the quality of child protection services. Effective intervention requires a productive working relationship to be developed between the worker and the child and family. Some changes in case worker, however, are requested by the family and are outside the control of the child protection service.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Child protection services — client satisfaction

The Steering Committee has identified 'client satisfaction' as an indicator of the effectiveness of child protection services (box 15.6). No data on this indicator, however, were available for the 2005 Report.

Box 15.6 **Client satisfaction**

This indicator will provide an output indicator of governments' objective to provide high quality services that meet the needs of recipients.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Child protection services — response time to commence investigation

The Steering Committee has identified 'response time to commence investigation' as an indicator of the effectiveness of child protection services (box 15.7). No data on this indicator, however, were available for the 2005 Report.

Box 15.7 **Response time to commence investigation**

This indicator will provide an output indicator of governments' objective to minimise the risk of harm to the child by responding to notifications of possible child protection incidents by commencing investigations in a timely manner.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Child protection services — response time to complete investigation

The Steering Committee has identified 'response time to complete investigation' as an indicator of the effectiveness of child protection services (box 15.8). No data on this indicator, however, were available for the 2005 Report.

Box 15.8 **Response time to complete investigation**

This indicator will provide an output indicator of governments' objective to minimise the risk of harm to the child by responding to notifications of possible child protection incidents by completing investigations in a timely manner.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Child protection services — substantiation rate

The 'substantiation rate' measures the effective targeting of child protection services (box 15.9).

Box 15.9 **Substantiation rate**

The 'substantiation rate' is included as an output (effectiveness) indicator of governments' objective to target investigations to those notifications where a substantive child abuse/neglect incident has occurred. It also provides an indication of the extent to which government has avoided the human and financial costs of an investigation where no harm has occurred.

This indicator is defined as the proportion of finalised investigations where harm or risk of harm was substantiated.

The 'substantiation rate' should be neither 'extremely high' nor 'extremely low'.

A very low 'substantiation rate' may suggest that notifications and investigations are not accurately targeted at appropriate cases, with the undesirable consequence of distress to families and undermining the chances that families will voluntarily seek support. Low substantiation rates may also indicate that the scarce resources of the child protection system are being overwhelmed and that screening should be tightened. On the other hand, a very high 'substantiation rate' may indicate that either some appropriate cases are being overlooked at notification and investigation or that the criteria for substantiation are bringing 'lower risk' families into the statutory system.

(Continued on next page)

Box 15.9 **(Continued)**

Finalised investigations that were substantiated may fluctuate because of policy, funding and practice change, such as better targeting of investigative resources, the impact of mandatory reporting or other factors such as increased community awareness and willingness to notify suspected instances of child abuse, neglect or harm.

Due to the method difficulties in identifying the source of annual fluctuations in substantiation rates, differences across jurisdictions (when comparable data are available) and changes over time within jurisdictions are more appropriately used to prompt further analysis, rather than to be considered as definitive performance information.

Data that are comparable across jurisdictions were not available for this indicator because definitions of substantiation vary across jurisdictions, but data are comparable within each jurisdiction over time unless otherwise stated (figure 15.4).

In 2003-04, the proportion of finalised child protection investigations that were substantiated increased in all jurisdictions except WA and SA, where it declined slightly, from the 2002-03 proportion (figure 15.4) (excluding NSW, which could not provide substantiation data for 2003-04).

Out-of-home care — safety in out-of-home care

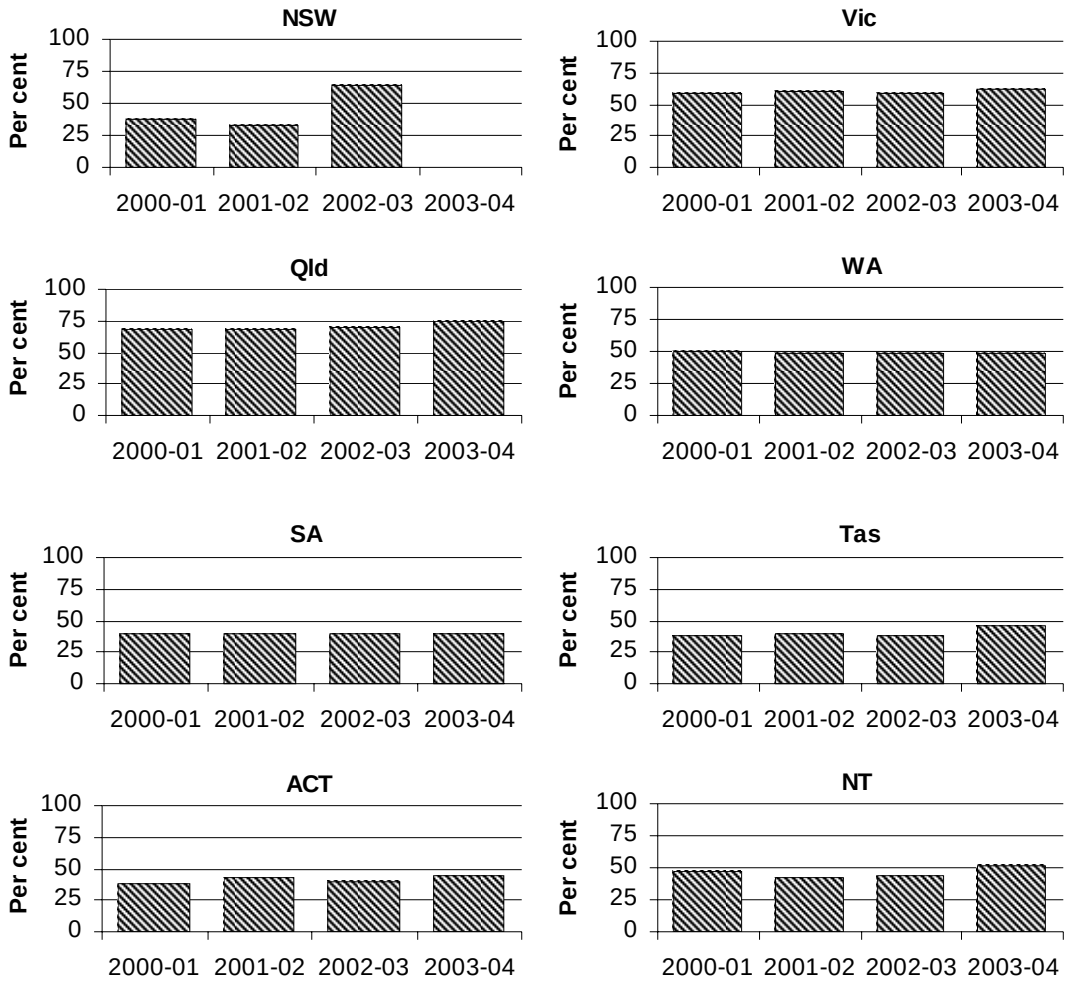
One indicator of the effectiveness of out-of-home care is the safety of clients in care situations (box 15.10).

Box 15.10 **Safety in out-of-home care**

'Safety in out-of-home care' is included as an output (effectiveness) indicator of governments' objective to provide children who are under the care of the State with a safe home environment.

This indicator is defined as the proportion of substantiations where those responsible for harm or risk were carers or other people living in households providing out-of-home care. A low proportion is desirable.

Figure 15.4 **Proportion of finalised child protection investigations that were substantiated[a, b, c]**



a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates should not be compared across jurisdictions. **b** NSW child protection data from 2002-03 onwards are not comparable with data for previous years. **c** NSW was only able to provide limited data for 2003-04 due to the introduction of a new client information system. Full data are expected to be available for the 2006 Report.

Sources: AIHW (unpublished) *Child protection notifications, investigations and substantiations, Australia* data collection; tables 15A.33, 15A.50, 15A.67, 15A.84, 15A.101, 15A.118, 15A.135 and 15A.152.

Queensland, WA, Tasmania and the ACT provided 2003-04 data on the incidence of child protection substantiations where the person believed responsible for harm or risk to the child was either the carer or another person living in the household providing out-of-home care. These substantiations generally made up less than 1 per cent of total substantiations, except in Queensland where it was 8.1 per cent (table 15A.20). For WA, the data include abuse by foster carers or workers in placement services, but not abuse by others living in the household.

Out-of-home care — stability of placement

'Stability of placement' for children placed away from their family for protective reasons is an important indicator of service quality, particularly for those children who require long term placements (box 15.11). Data were collected on the number of different placements for children on a care and protection order who exited out-of-home care in 2003-04. Data were grouped according to the length of time in care (less than 12 months and 12 months or more).

Box 15.11 **Stability of placement**

'Stability of placement' is included as an output (effectiveness) indicator of governments' objective to provide high quality services that meet the needs of recipients on the basis of relative need and available resources.

This indicator is defined as the number of placements that a child has had during a period of continuous out-of-home care. Data are collected only for children who are on orders and who exit care during the reporting period.

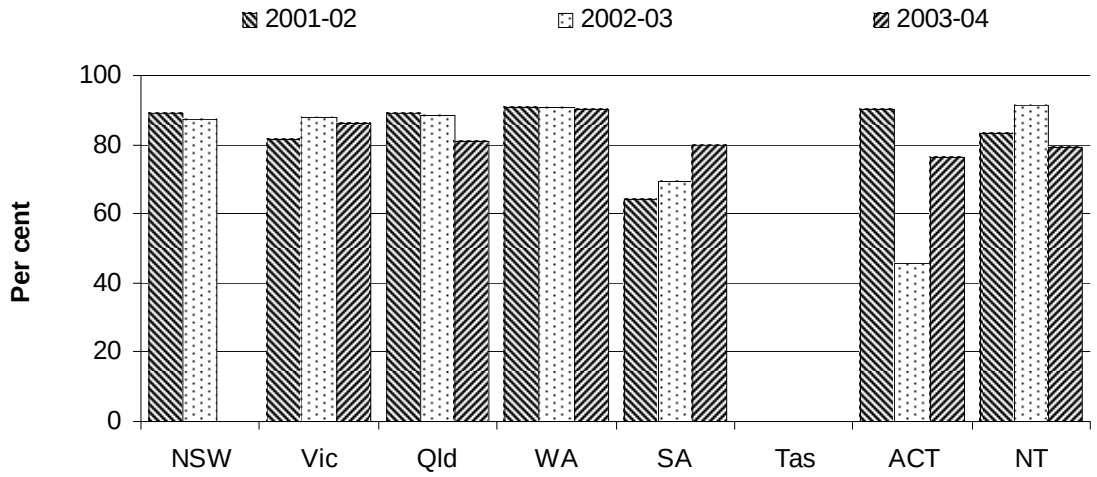
A low number of child placements (one or two) per period of care is desirable, but must be balanced against other placement quality indicators, such as placements in compliance with the Aboriginal Child Placement Principle, local placements, and placements with siblings.

It needs to be noted that children may have multiple placements for good reasons, (for example, an initial placement followed by a longer term placement) or it may be desirable to change placements to achieve better child–family compatibility. It is not desirable for a child to stay in an unsatisfactory or unsupportive placement. Also, older children are more likely to have multiple placements as they move towards independence and voluntarily seek alternate placements.

There are limitations to counting placement stability using an exit cohort rather than entry cohort longitudinal data, because the sample is biased to children from recent entry cohorts with relatively short stays in care, and these children are likely to have experienced fewer placements. This indicator should be interpreted in conjunction with other placement indicators.

In all jurisdictions able to provide data, except the ACT and the NT, more than 80 per cent of the children on a care and protection order who exited care after less than 12 months experienced only one or two placements in 2003-04. The proportion of children experiencing only one or two placements ranged from 90.3 per cent in WA to 76.1 per cent in the ACT (figure 15.5).

Figure 15.5 **Proportion of children on a care and protection order exiting care after less than 12 months, who had 1 or 2 placements[a, b, c, d, e]**



a Data refer to children exiting care during the relevant financial year. **b** Refer to footnotes in the source table for information about what each jurisdiction's data include. **c** Data for Tasmania were not available. **d** NSW child protection data from 2002-03 onwards are not comparable with data for previous years. **e** NSW was only able to provide limited data for 2003-04 due to the introduction of a new client information system. Full data are expected to be available for the 2006 Report.

Source: AIHW (unpublished) *Children in out-of-home care, Australia* data collection; table 15A.19.

Across jurisdictions, children who had been in out-of-home care longer tended to have had more placements. The proportion of children exiting care in 2003-04 after 12 months or more who had experienced one or two placements ranged from 66.4 per cent in Victoria to 31.5 per cent in SA (figure 15.6).

Out-of-home care — placement with extended family

The type of placement is another indicator of the quality of child placement. Placing children with their relatives or kin is generally preferred for children in out-of-home care (box 15.12).

Box 15.12 **Placement with extended families**

'Placement with extended families' is included as an output (effectiveness) indicator of governments' objective to provide services that meet the needs of the recipients on the basis of relative need and available resources. Placing children with their relatives or kin is generally the preferred out-of-home care placement option. This option is

(Continued on next page)

Box 15.12 **(Continued)**

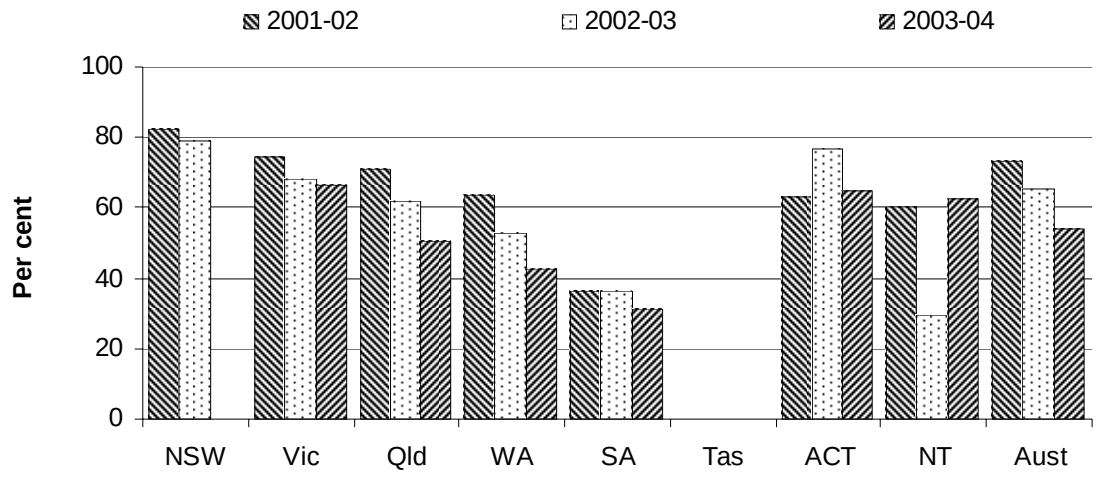
generally associated with better long term outcomes due to increased continuity, familiarity and stability for the child. Relatives are more likely to have or form long term emotional bonds with the child. Placement with familiar people can help to overcome the loss of attachment and belonging that can occur when children are placed out-of-home.

This indicator is defined as the proportion of all children in out-of-home care who are placed with relatives or kin who receive government financial assistance to care for that child.

A reasonably high rate for this indicator is considered desirable, but this is one factor among many that must be considered in the placement decision.

Placements with extended family may not always be the best option: long standing family dynamics may undermine the pursuit of case goals such as reunification; and the possibility of intergenerational abuse must be considered. In addition, depending on the individual circumstances of children, it may be more important to have a local placement that enables continuity at school, for example, rather than a distant placement with relatives.

Figure 15.6 **Proportion of children on a care and protection order exiting care after 12 months or more, who had 1 or 2 placements[a, b, c, d, e]**

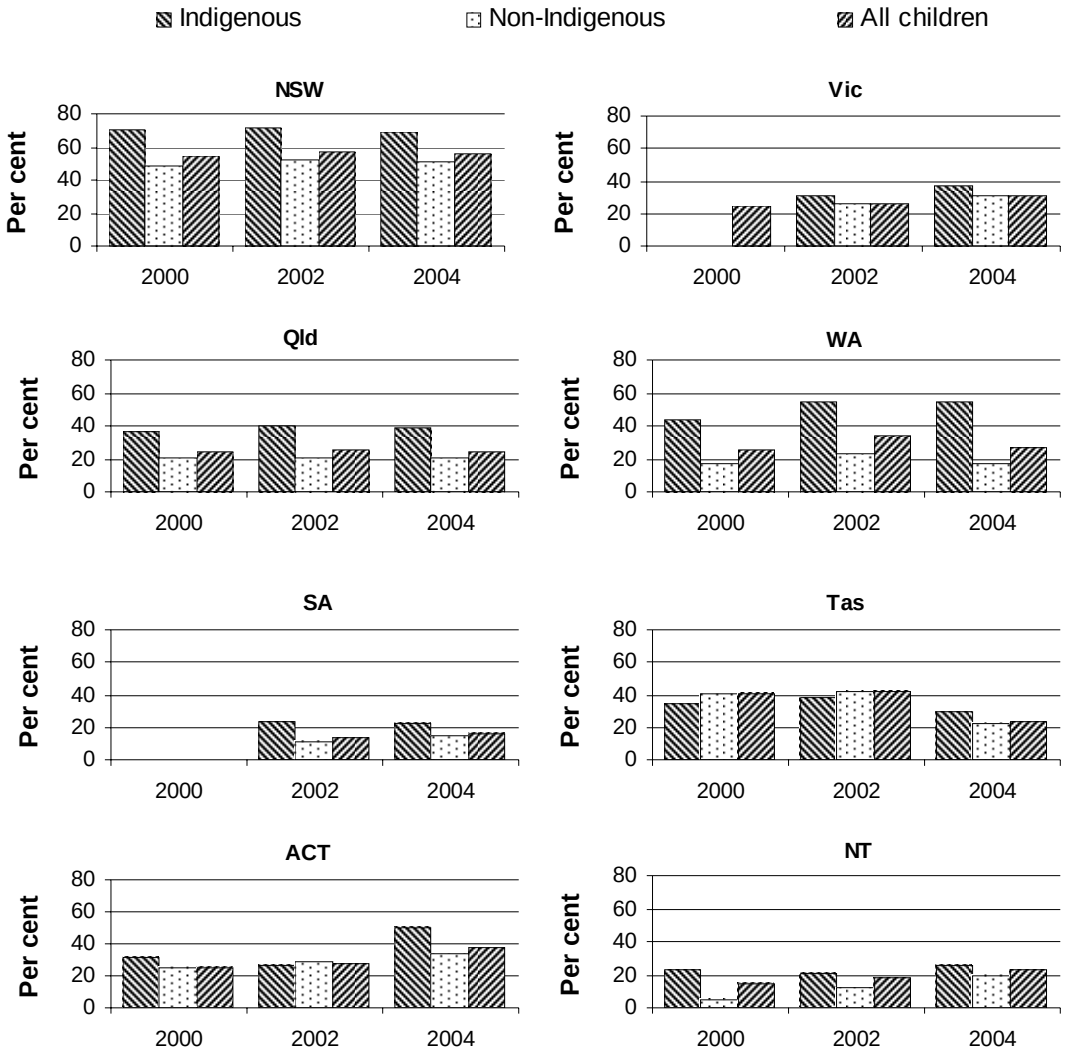


a Data refer to children exiting care during the relevant financial year. **b** Refer to footnotes in the source table for information about what each jurisdiction's data include. **c** Data for Tasmania were not available. **d** NSW child protection data from 2002-03 are not comparable with data for previous years. **e** NSW was only able to provide limited data for 2003-04 due to the introduction of a new client information system. Full data are expected to be available for the 2006 Report.

Source: AIHW (unpublished) *Children in out-of-home care, Australia* data collection; table 15A.19.

The proportion of children placed with relatives or kin at 30 June 2004 ranged from 55.5 per cent in NSW to 16.1 per cent in SA. The proportion was greater for Indigenous children than for non-Indigenous children in all jurisdictions (figure 15.7).

Figure 15.7 **Proportion of children in out-of-home care placed with relatives/kin, by Indigenous status, 30 June[a]**



a Victoria could not provide data by Indigenous status before 2001. SA could not provide data for 2000.

Sources: AIHW (unpublished) *Children in out-of-home care, Australia* data collection; table 15A.16.

Out-of-home care — children aged under 12 years in home-based care

Placing children in home-based care is generally considered to be in their best interests, particularly for younger children (box 15.13).

Box 15.13 **Children aged under 12 years in home-based care**

'Children aged less than 12 years in home-based care' is included as an output (effectiveness) indicator of governments' objective to provide services which meet the needs of the recipients.

Placing children in home-based care is generally considered to be in their best interests, particularly for younger children. Children will generally make better developmental progress (and have more ready access to normal childhood experiences) in family settings rather than in residential care.

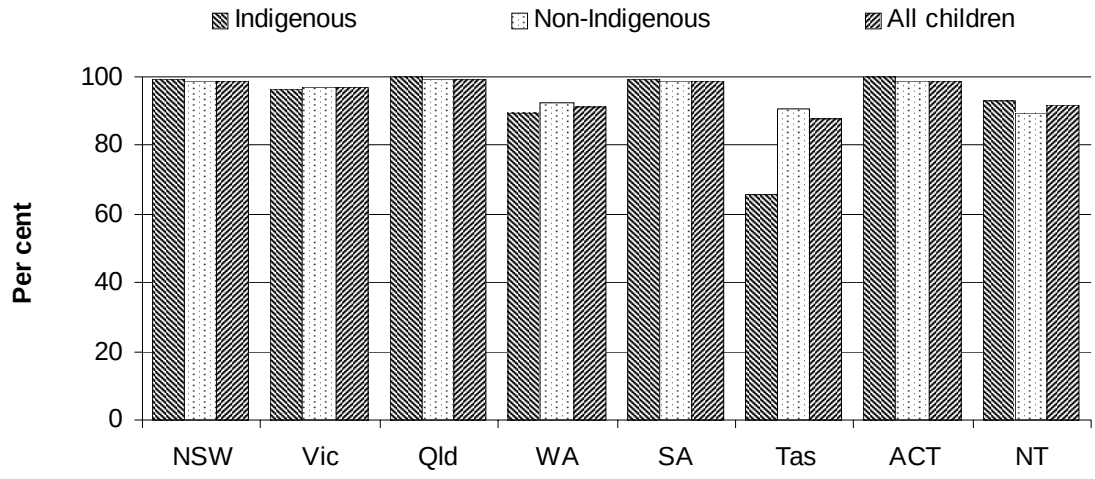
This indicator is defined as the proportion of children less than 12 years of age placed in home-based care divided by the total number of children under 12 years in out-of-home care.

A high rate for this indicator is considered desirable.

This indicator should be interpreted in conjunction with other placement indicators.

The proportion of children aged under 12 years in care who were placed in home-based care (excluding family group homes) at 30 June 2004 ranged from 99.6 per cent in Queensland to 87.9 per cent in Tasmania. In all jurisdictions except WA, Tasmania and the NT, the proportion of Indigenous children aged under 12 years who were placed in home-based care was broadly similar to that of non-Indigenous children. In WA and Tasmania, a greater proportion of non-Indigenous children were placed in home-based care. In the NT, a greater proportion of Indigenous children were placed in home-based care (figure 15.8).

Figure 15.8 **Proportion of children aged under 12 years in out-of-home care and in a home based placement, by Indigenous status, 30 June 2004[a]**



a Excluding family group homes.

Source: AIHW (unpublished) *Children in out-of-home care, Australia* data collection; table 15A.18.

Out-of-home care — placement in accordance with the Aboriginal Child Placement Principle

Placing Indigenous children in circumstances consistent with the Aboriginal Child Placement Principle is generally considered to be in their best interests (box 15.14).

According to the Aboriginal Child Placement Principle (NLRC 1997), the following hierarchy or placement preference should be pursued in protecting the safety and welfare of Indigenous children:

- placement with the child's extended family (which includes Indigenous and non-Indigenous relatives/kin)
- placement within the child's Indigenous community
- placement with other Indigenous people.

Box 15.14 **Placement in accordance with the Aboriginal Child Placement Principle**

'Placement in accordance with the Aboriginal Child Placement Principle' is included as an output (effectiveness) indicator of governments' objective to protect the safety and welfare of Indigenous children while maintaining the cultural ties and identity of Indigenous children in out-of-home care.

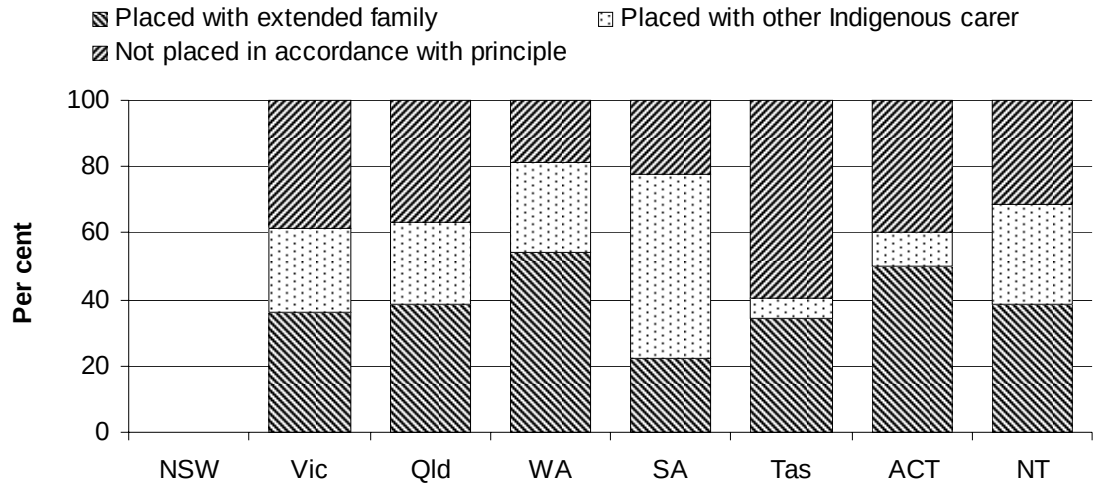
This indicator is defined as the number of Indigenous children placed with the child's extended family, Indigenous community or other Indigenous people, divided by the total number of Indigenous children in out-of-home care. Data are reported separately for children placed (i) with extended family, (ii) with other Indigenous carers, and (iii) not in accord with the Principle.

A high proportion of children placed in accordance with the principle is desirable, but this is one factor among many that must be considered in the placement decision.

All jurisdictions have adopted this principle, either in legislation or policy. The proportion of Indigenous children in out-of-home care at 30 June 2004 who were placed in accordance with the principle ranged from 81.0 per cent in WA to 40.4 per cent in Tasmania (figure 15.9).

The proportion of Indigenous children in out-of-home care who were placed with extended family at 30 June 2004 ranged from 54.3 per cent in WA to 22.0 per cent in SA. Placement with other Indigenous care providers (the child's Indigenous community or other Indigenous people) also complies with the principle. The proportion placed with other Indigenous care providers ranged from 55.5 per cent in SA to 6.4 per cent in Tasmania (table 15A.17).

Figure 15.9 **Placement of Indigenous children in out-of-home care, 30 June 2004[a, b, c, d]**



a Excludes Indigenous children living independently and those whose living arrangements were unknown. **b** 'Placed with another Indigenous carer' includes those living in Indigenous residential care. **c** Data for Tasmania and the ACT relate to a small number of Indigenous children (47 and 58 respectively) in care at 30 June 2004. **d** NSW was only able to provide limited data for 2003-04 due to the introduction of a new client information system. Full data are expected to be available for the 2006 Report.

Source: AIHW (unpublished) *Children in out-of-home care, Australia* data collection; table 15A.17.

Out-of-home care — local placement

The Steering Committee has identified 'local placement' as an indicator of the effectiveness of out-of-home care services (box 15.15). Data on this indicator, however, were not available for the 2005 Report.

Box 15.15 **Local placement**

This indicator will provide an output indicator of governments' objective to provide services which meet the needs of the recipients.

Although data are currently not collected on this indicator, it is defined as the proportion of children attending the same school after entering care. Data will be provided for 3 and 12 months after entering care.

A placement close to where they lived prior to entering out-of-home care is believed to enhance the stability, familiarity and security of the child. It enables some elements of the child's life to remain unchanged (for example, they can continue attending the same school and retain their friendship network). It may also facilitate family contact if the child's parents continue to live nearby.

(Continued on next page)

Box 15.15 **(Continued)**

There is a need to balance this against other quality indicators of this type. For example, placement with a sibling or relative might preclude a 'local placement'. Also, a child might move to a new school in accordance with their progress at school (that is, a move from primary to secondary school).

A high rate of 'local placement' is desirable but this is one factor among many that must be considered in the placement decision.

Out-of-home care — placement with sibling

The Steering Committee has identified 'placement with sibling' as an indicator of the effectiveness of out-of-home care services (box 15.16). No data on this indicator, however, were available for the 2005 Report.

Box 15.16 **Placement with sibling**

This indicator will provide an output indicator of governments' objective to provide services which meet the needs of the recipients.

Placement of siblings together promotes stability and continuity. It is a long standing placement principle that siblings should be placed together, where possible, in the interests of their emotional wellbeing. Children are likely to be more secure and have a sense of belonging within their family when placed with siblings.

Although data are currently not collected on this indicator, it is defined as the proportion of children who are on finalised orders and in out-of-home care at 30 June who have siblings also on orders and in out-of-home care, who are placed with at least one of their siblings.

A high rate of placement with siblings is desirable but this is one factor among many that must be considered in the placement decision. In circumstances of sibling abuse, or when a particular child in a family has been singled out as the target for abuse or neglect, keeping siblings together might not be appropriate.

Out-of-home care — children with documented case plan

The Steering Committee has identified 'children with documented case plan' as an indicator of the effectiveness of out-of-home care services (box 15.17). No data on this indicator, however, were available for the 2005 Report.

Box 15.17 **Children with documented case plan**

This indicator will provide an output indicator of governments' objective to provide services that meet the needs of the recipients.

Case planning is essential to structured and purposeful work to support children's optimal development. Case plans outline intervention goals such as improved parent–child attachments, reunification or other forms of permanency, and set out the means to achieve these goals such as frequency of family contact and any remedial or special services considered appropriate for the individual child. Case plans also allow for the monitoring of a child's time in care.

Although data are currently not collected on this indicator, it is defined as the proportion of children on a finalised guardianship or custody order and in out-of-home care who have a documented case plan.

A high rate is desirable. All children should have a case plan.

The quality of the case plan must also be considered: the mere existence of the case plan does not guarantee that appropriate case work is occurring that meets the child's needs.

Out-of-home care — client satisfaction

The Steering Committee has identified 'client satisfaction' as an indicator of the effectiveness of out-of-home care services (box 15.18). No data on this indicator, however, were available for the 2005 Report.

Box 15.18 **Client satisfaction**

This indicator will provide an output indicator of governments' objective to provide high quality services that meet the needs of recipients.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Efficiency

Understanding the efficiency of the child protection systems that they administer helps State and Territory governments to identify the key cost drivers of their systems and to weigh the efficacy of options for addressing child protection issues.

Challenges in reporting efficiency for child protection systems

Reporting comparable and meaningful efficiency data for child protection services is problematic for a number of reasons, including:

- *different systems and priorities across jurisdictions*: child protection systems in Australia have evolved independently under the auspices of State and Territory governments (section 15.1). This has resulted in variations in the processes and emphases placed on different service delivery paradigms (the different approaches to diversionary options, for example, see figure 15.1).
- *limitations of current information systems*: in most jurisdictions, it is not easy to explicitly identify resources expended on child protection services, out-of-home care services and other support services for families. This is partly due to the historic structure of information systems and the embedding of the government agencies responsible for child protection issues within larger community services departments. (Table 15A.4 identifies the level of consistency in expenditure data across jurisdictions.)

In response to these difficulties, in April 2002 the Review initiated a project to develop a method for annual reporting of efficiency data for a national framework of protection and support pathways (box 15.19).

Box 15.19 **The pathways project — outcomes**

The pathways project developed and tested a model that will ultimately allow jurisdictions to calculate more meaningful, comparable and robust efficiency measures (the 'pathways method'). The model is based on a top–down application of the activity–based costing method. A set of eight national pathways has been developed as a high level representation of the services that a protection and support client could receive in any jurisdiction. Each pathway consists of common activity groups for which an operational and non-operational resource allocation can be made. These activity groups act as the 'building blocks' for each of the pathways. The aggregate cost of each activity group within the pathway will allow for the unit cost of an individual pathway to be determined. The activity groups are:

- receipt and assessment of initial information about a potential protection and support issue
- provision of initial family support services
- provision of intensive family support services
- secondary information gathering and assessment
- provision of short term protective intervention and coordination services

(Continued on next page)

Box 15.19 **(Continued)**

- seeking a court order
- provision of longer term protective intervention, support and coordination services
- provision of out-of-home care services.

Before reporting against the activity groups can be undertaken with confidence, further refinement of activity group definitions and counting rules is required. Over the coming 12 months, the Review's Protection and Support Working Group will continue its development work in these areas. Implementation of the model has the potential to significantly improve the quality of national reporting of protection and support services efficiency measures.

Source: SCRCSSP (2003).

Although the framework was endorsed by all jurisdictions, refinement of counting rules and changes to information systems will be necessary before full reporting is possible for all jurisdictions. Partial reporting against the framework is anticipated for the 2006 Report.

Limitations of reported indicators

A preferred efficiency indicator would relate expenditure on particular child protection activities to a measure of output of those activities. As discussed, the pathways method is expected to deliver these data for future reports. In the interim, this Report includes broad proxy indicators for child protection (box 15.20) and out-of-home care efficiency (box 15.21).

Box 15.20 **Child protection efficiency indicators**

Three different child protection efficiency measures are included as output (efficiency) indicators of governments' objective to maximise the benefit to the community through the efficient use of taxpayer resources: total expenditure on child protection per notification; total expenditure on child protection per investigation; and total expenditure on child protection per substantiation. All three measures are imperfect proxy indicators and have real limitations. They are included as interim measures only, and will be replaced by a more robust method under development.

The three indicators are defined respectively as:

- the total expenditure on all child protection activities divided by the number of notifications

(Continued on next page)

Box 15.20 **(Continued)**

- the total expenditure on all child protection activities divided by the number of investigations
- the total expenditure on all child protection activities divided by the number of substantiations.

In each case, low expenditure per notification/investigation/substantiation suggests more efficient services but may indicate lower quality or different service delivery models.

These indicators do not represent the unit costs and need to be interpreted with care. Also, they cannot be added together to determine overall child protection efficiency indicators.

Better efficiency indicators would relate expenditure on particular child protection activities to a measure of output of those activities. Work is in progress to develop an activity-based costing method that will allow this type of reporting from existing information systems.

Box 15.21 **Out-of-home care efficiency indicators**

Three different out-of-home care efficiency measures are included as an output (efficiency) indicator of governments' objective to maximise the benefit to the community through the efficient use of taxpayer resources: expenditure per child in residential out-of-home care; expenditure per child in non-residential out-of-home care; and expenditure per child in all out-of-home care.

The three indicators are defined respectively as:

- the total annual expenditure on residential out-of-home care divided by the number of children in residential out-of-home care at 30 June
- the total annual expenditure on non-residential out-of-home care divided by the number of children in non-residential out-of-home care at 30 June
- the total annual expenditure on all out-of-home care divided by the number of children in all out-of-home care at 30 June

In each case, lower expenditure per child in care suggests more efficient services but may also indicate lower service quality.

These indicators needs to be interpreted with care because they do not represent unit cost measures. Expenditure per child in care at 30 June overstates the cost per child

(Continued on next page)

Box 15.21 **(Continued)**

because significantly more children are in care during a year than at a point in time. In addition, the indicator does not reflect the length of time that a child spends in care.

Better efficiency indicators would relate expenditure on particular out-of-home care activities to a measure of output of those activities. Work is currently in progress to develop an activity based costing method which will allow this type of reporting from existing information systems.

Child protection efficiency indicator results

Total expenditure on child protection per notification in 2003-04 ranged from $7669 in WA to $668 in Tasmania (figure 15.10a).

Total expenditure on child protection per investigation in 2003-04 ranged from $7997 in WA to $3052 in Queensland (excluding NSW, which could not provide data on investigations for 2003-04) (figure 15.10b).

Total expenditure on child protection per substantiation in 2003-04 ranged from $19 149 in WA to $5121 in Queensland (excluding NSW, which could not provide data on substantiations for 2003-04) (figure 15.10c).

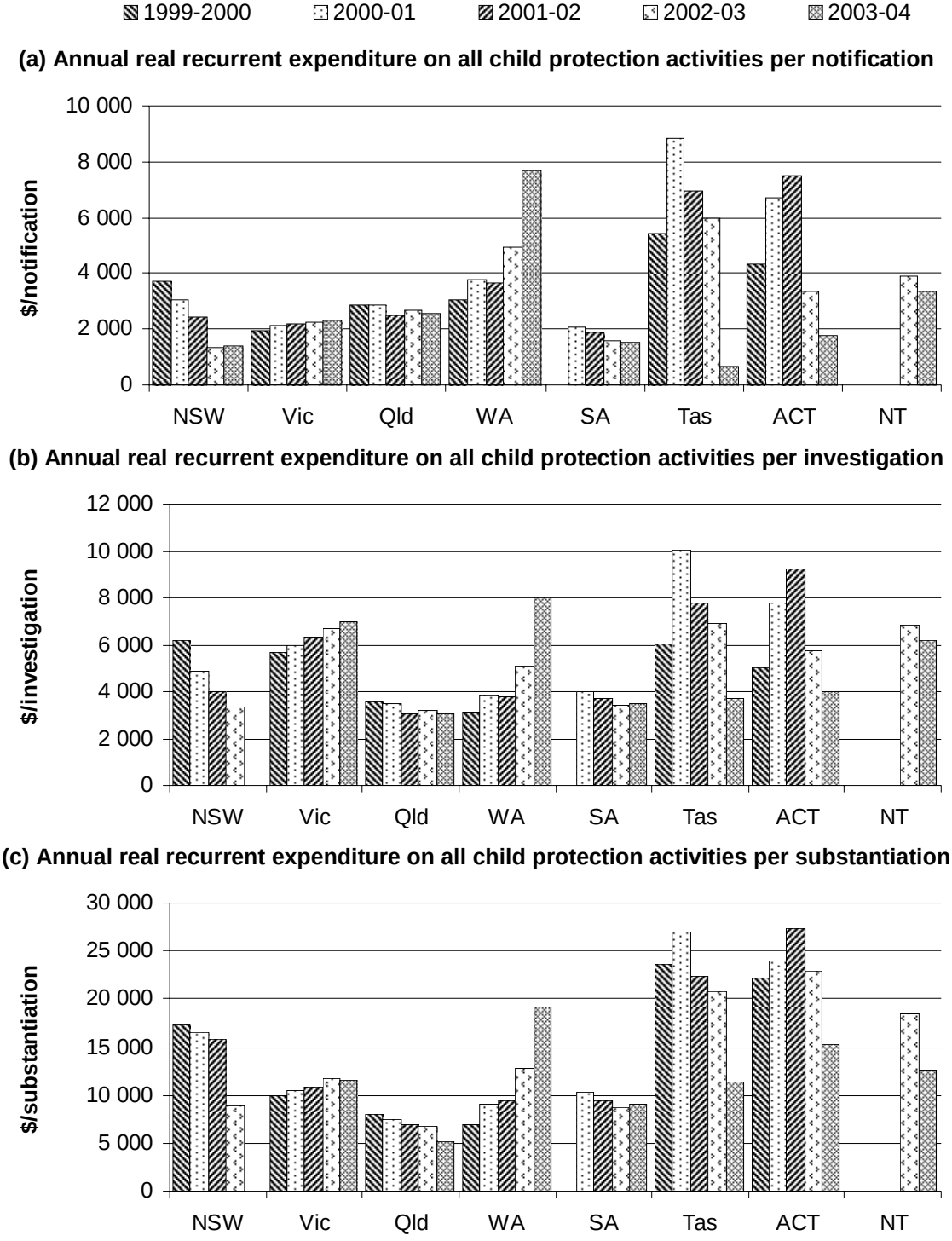
Out-of-home care efficiency indicator results

Victoria, WA, SA and the ACT were able to separate expenditure on out-of-home care into residential care and non-residential care. Across these four jurisdictions, expenditure on residential care at 30 June 2004 ranged from $172 895 per child in residential care in Victoria to $73 564 per child in SA at 30 June 2004 (figure 15.11a).

For those jurisdictions that provided data, expenditure on non-residential care ranged from $40 279 per child in non-residential care in the ACT to $17 167 per child in SA at 30 June 2004 (figure 15.11b).

All jurisdictions provided data on total expenditure on out-of-home care per child in care at 30 June 2004, which ranged from $44 131 in the ACT to $19 136 in SA (figure 15.11c).

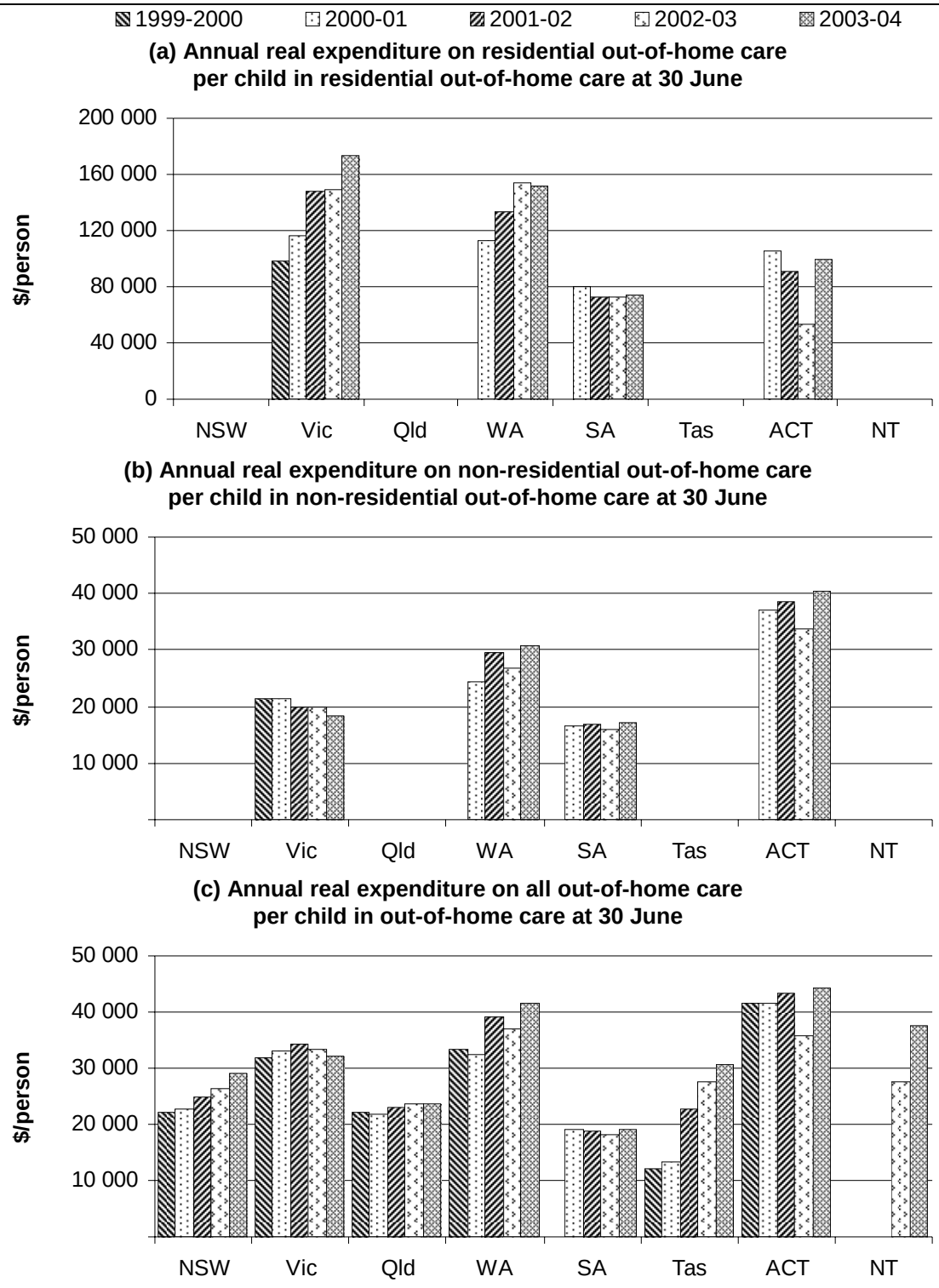
Figure 15.10 **Child protection efficiency indicators (2003-04 dollars)[a, b, c, d]**



a Real expenditure based on ABS gross domestic product price deflator (2003-04 = 100) (table A.26). **b** These data cannot be interpreted as the 'expenditure per notification', 'expenditure per investigation' or 'expenditure per substantiation' because each is based on the total expenditure of all child protection activities. Differences across jurisdictions reflect the quantity of the three activities rather than a difference in unit costs. **c** NSW child protection data from 2002-03 onwards are not comparable with data for previous years. **d** NSW was only able to provide limited data for 2003-04 due to the introduction of a new client information system. Full data are expected to be available for the 2006 Report.

Source: State and Territory governments (unpublished); table 15A.2.

Figure 15.11 **Out-of-home care efficiency indicators (2003-04 dollars)[a, b]**



a Real expenditure based on ABS gross domestic product price deflator (2003-04 = 100) (table A.26). **b** ACT data are affected by the higher subsidy levels for carers, higher award costs in the ACT due to a more recently negotiated agreement, and the effect of a small number of children in care with special high support needs.

Source: State and Territory governments (unpublished); table 15A.3.

Outcomes

Improved safety — substantiation rate after a decision not to substantiate

Substantiation rate after a decision not to substantiate' is important because it partly reveals the extent to which an investigation has not succeeded in identifying the risk of harm to a child who is subsequently the subject of substantiated harm (box 15.22).

Box 15.22 **Improved safety — substantiation after a decision not to substantiate**

'Improved safety — substantiation after a decision not to substantiate' is included as an outcome indicator of governments' objective to reduce the risk of harm to children by appropriately assessing notifications of possible child protection incidents.

It also provides a measure of the adequacy of intervention offered to children in terms of protecting them from further harm.

This indicator is defined as the proportion of children who were the subject of an investigation in the previous financial year that led to a decision not to substantiate, and who were later the subject of a substantiation within three or 12 months of the initial decision not to substantiate.

A low rate for this indicator is desirable.

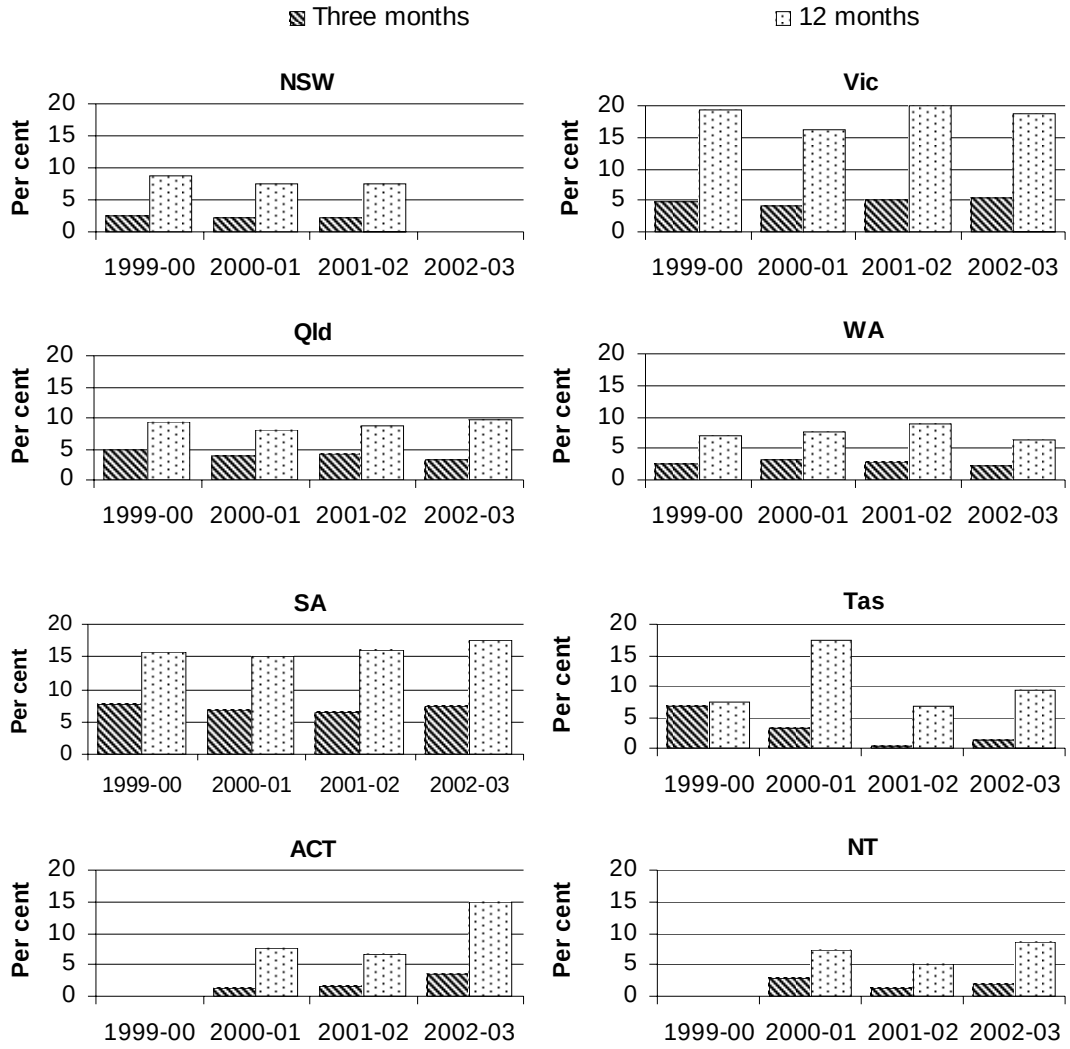
A demonstrable risk of harm might not have existed in the first instance. As such, reported results may be affected by factors beyond the control of child protection services, and circumstances might have changed after the initial decision not to substantiate was made. In addition, this indicator does not distinguish between subsequent substantiations which are related to the initial notification (that is, the same source of risk of harm), and those which are unrelated to the initial notification (that is, a different source of risk of harm).

Data that are comparable across jurisdictions were not available for this indicator, but data are comparable within each jurisdiction over time (figure 15.12).

In all jurisdictions except Queensland and WA, the proportion of children who were the subject of an investigation within three months after a decision not to substantiate increased in 2002-03 compared with the proportion in the previous year (excluding NSW, which did not provide data for 2002-03) (figure 15.12).

The proportion of children who were the subject of an investigation within 12 months after a decision not to substantiate also increased in 2002-03 in all jurisdictions except Victoria and WA (excluding NSW which did not provide data for 2002-03) (figure 15.12).

Figure 15.12 **Improved safety — substantiation rate 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** NSW was only able to provide limited data for 2003-04 due to the introduction of a new client information system. Full data are expected to be available for the 2006 Report.

Source: AIHW (unpublished) *Child protection notifications, investigations and substantiations, Australia* data collection; tables 15A.31, 15A.48, 15A.65, 15A.82, 15A.99, 15A.116, 15A.133 and 15A.150.

Improved safety — resubstantiation rate

The 'resubstantiation rate' is important because it partly reveals the extent to which child protection services succeed in preventing the recurrence of abuse and neglect or harm to children (box 15.23).

Box 15.23 **Resubstantiation rate**

'Resubstantiation rate' is included as an outcome indicator of governments' objective to reduce the risk of harm, and to prevent the recurrence of abuse and neglect or harm to children.

This indicator also partly reveals the extent to which intervention by child protection services has succeeded in preventing further harm.

This indicator is defined as the proportion of children who were the subject of a substantiation in the previous financial year, who were subsequently the subject of a further substantiation within the following three or 12 months.

A low rate for this indicator is desirable.

Reported results may be affected, however, by factors beyond the control of child protection services, such as changes in the family situation (for example, illness, unemployment or a new partner). In addition, this indicator does not distinguish between subsequent substantiations that are related to the initial notification (that is, the same source of risk of harm) and those that are unrelated to the initial notification (that is, a different source of risk of harm).

Data that are comparable across jurisdictions were not available for this indicator, but data are comparable within each jurisdiction over time (figure 15.13).

In WA, SA, the ACT and the NT, the proportion of children who were the subject of a resubstantiation within three months of an initial substantiation increased in 2002-03 compared with the proportion in the previous year; the proportion remained unchanged in Tasmania and fell in all other jurisdictions (excluding NSW, which did not provide data for 2002-03) (figure 15.13).

The proportion of children who were the subject of a resubstantiation within 12 months of an initial substantiation increased in all jurisdictions except Victoria, WA and the NT (excluding NSW, which did not provide data for 2002-03) (figure 15.13).

Improved education, health and wellbeing of the child

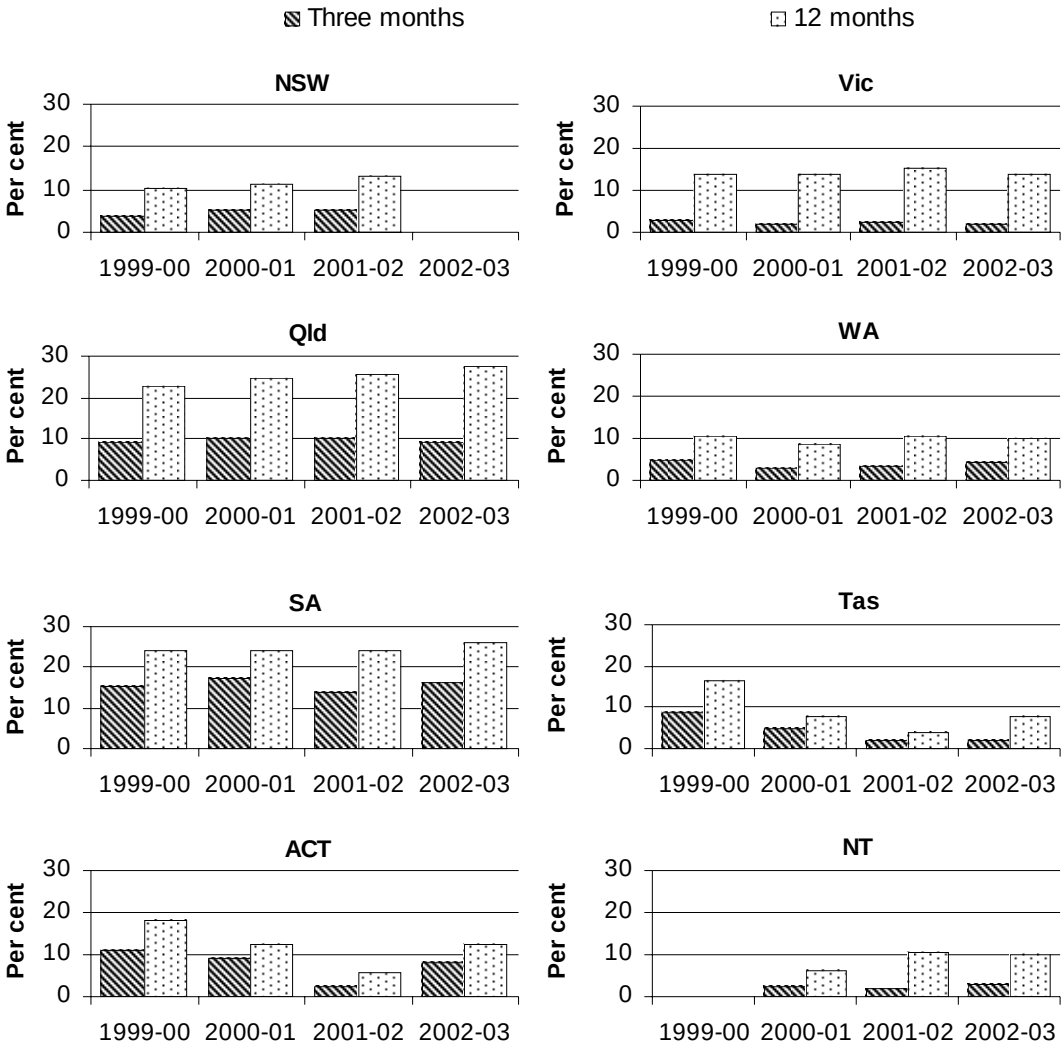
The Steering Committee has identified 'improved education, health and wellbeing of the child' as a key outcome indicator for development for future reports (box 15.24).

Box 15.24 **Improved education, health and wellbeing of the child**

These indicators will provide an indicator of governments' objective to maximise children's life chances by ensuring children in care have their educational, health and wellbeing needs met.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Figure 15.13 **Improved safety — resubstantiation rate[a, b]**



a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. **b** NSW was only able to provide limited data for 2003-04 due to the introduction of a new client information system. Full data are expected to be available for the 2006 Report.

Source: AIHW (unpublished) *Child protection notifications, investigations and substantiations, Australia* data collection; tables 15A.32, 15A.49, 15A.66, 15A.83, 15A.100, 15A.117, 15A.134 and 15A.151.

Safe return home

The Steering Committee has identified 'safe return home' as a key area for further development of outcome indicators for future reports (box 15.25).

Box 15.25 **Safe return home**

This indicator will provide an indicator of governments' objective to remove the risk of harm to the child while maintaining family cohesion. For children who cannot be protected within their family and are removed from home, often the best outcome is when effective intervention to improve their parents' skills or capacity to care for them enables them to return home.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Permanent care

The Steering Committee has identified 'permanent care' as a key area for further development of outcome indicators for future reports (box 15.26).

Box 15.26 **Permanent care**

This indicator will provide an indicator of governments' objective to provide appropriate care for children who cannot be safely reunified with their families. Appropriate services are those that minimise the length of time before secure, permanent placement is achieved.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

15.4 Future directions in child protection and out-of-home care services performance reporting

Improving national child protection data

Between 2000 and 2003, the National Child Protection and Support Services (NCPASS) Data Working Group, under the auspice of the National Community Services Information Management Group, reviewed the reporting framework used

to collect the national child protection data. The review aimed to establish the feasibility of updating the national reporting framework so the national data:

- more accurately reflect the current responses of states and territories to child protection and child concern reports
- present a more comprehensive data set, and
- increase the consistency and comparability of the data reported.

The review resulted in the development of a broader framework to count responses to calls received by community services departments about the safety and wellbeing of children. The responses include those that occur outside the formal child protection system. The new framework incorporates data elements such as the provision of advice and information, the assessment of needs, and the provision of general and intensive family support services.

The Australian Institute of Health and Welfare, in conjunction with NCPASS, is developing data dictionaries to support the new reporting framework. It is envisaged that these dictionaries will be tested during 2005 and subsequently used by jurisdictions to provide unit record data. This will increase the richness of child protection and out-of-home care data that are currently available with aggregated data.

Client satisfaction

Client views can be used to report on service delivery and to learn important information about how to improve services. Although the use of client surveys in child protection services is not yet common, the Victorian Department of Human Services has measured customer satisfaction in the past. This survey assessed customer satisfaction with client involvement, levels of care, services offered and links to other services, and perceptions of child protection workers. The survey outcomes revealed specific strengths, as well as areas for improvement in service delivery.

15.5 Profile of supported accommodation and assistance

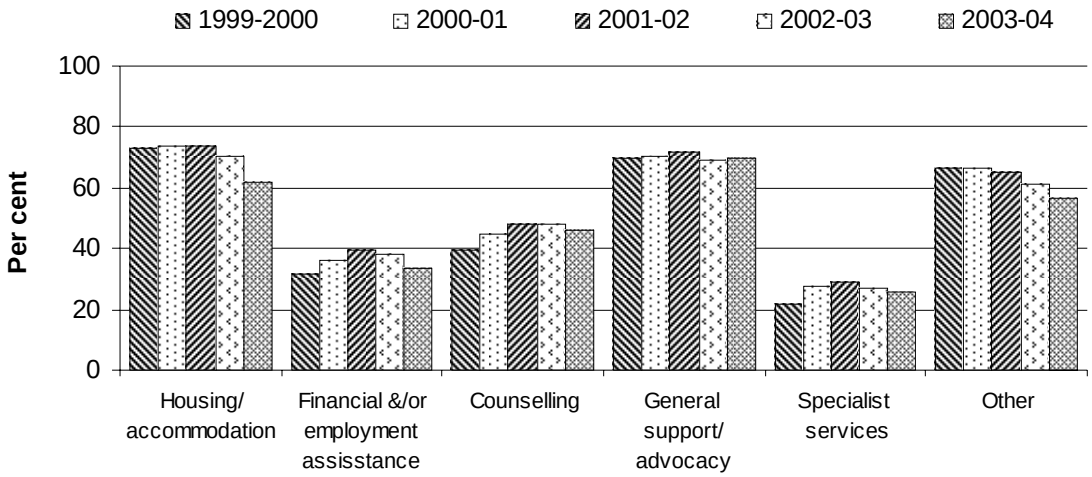
Service overview

Supported accommodation and assistance services aim to assist people who are homeless or at imminent risk of becoming homeless as a result of a crisis, including

women and children escaping domestic violence. Sections 15.5–15.8 report on services provided under SAAP. Data descriptors, indicators and terms are defined in section 15.10.

The primary focus of SAAP is to use a case management approach to support homeless people, and adults and children escaping domestic violence. Through this process, clients are offered a range of services, including supported accommodation; counselling; advocacy; links to housing, health, education and employment services; outreach support; brokerage; and meals services. Housing and accommodation services were provided in 62.0 per cent of support periods in 2003-04. General support and advocacy (provided in 69.9 per cent of support periods), counselling (46.2 per cent), financial and employment assistance (33.6 per cent) and specialist services (25.7 per cent) were also commonly provided (figure 15.14).

Figure 15.14 **Services received during a SAAP support period[a]**



a Agencies may provide more than one type of service as part of a single support period, so services provided during a period do not sum to 100 per cent.

Source: SAAP National Data Collection Agency (NDCA) (unpublished) Administrative Data and Client Collections; table 15A.163.

Size and scope

Support services funded by SAAP are provided by agencies to a range of groups, such as homeless families, single men, single women, young people, and adults and children escaping domestic violence. At least 1293 agencies are funded under the SAAP program, and most target principally one client group. Services were delivered in 2003-04 by agencies targeting:

- young people (36.7 per cent of agencies)
- women escaping domestic violence (22.2 per cent)
- families (9.5 per cent)
- single men (7.5 per cent)
- single women (3.6 per cent).

Agencies targeting multiple client groups or providing general support accounted for 20.5 per cent of service providers in 2003-04 (table 15A.164).

Agencies also vary in their service delivery model. The most common models in 2003-04 were the provision of medium term to long term supported accommodation (36.7 per cent of agencies) and the provision of crisis or short term supported accommodation (35.2 per cent). Agencies also provided services other than accommodation, such as outreach support (5.3 per cent of agencies), day support (1.9 per cent), and telephone information and referral (1.2 per cent). A further 12.8 per cent of agencies provided multiple services and 1.9 per cent provided agency support (table 15A.165).

Roles and responsibilities

Non-government agencies, with some local government participation, deliver most SAAP services. The Australian, State and Territory governments jointly fund SAAP, which was established in 1985 to consolidate a number of existing programs. The State and Territory governments have responsibility for the day-to-day management of SAAP, including distributing funding to SAAP funded agencies. Research, strategy, and other planning and development activities are coordinated at the national level by the SAAP National Coordination and Development Committee (which includes representatives of the Australian Government and each State and Territory government).

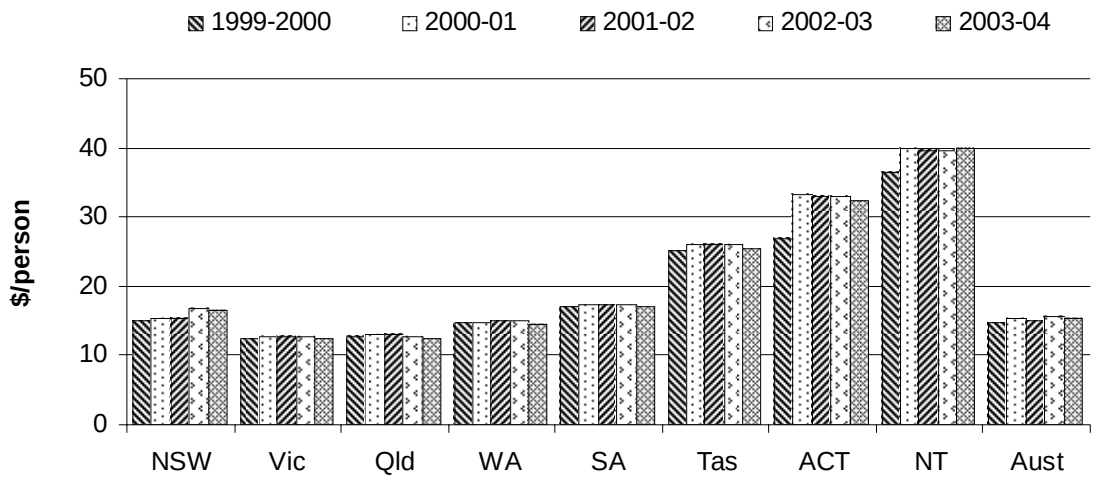
Funding

Recurrent funding of SAAP services was $303.8 million in 2003-04, of which the Australian Government contributed 56.4 per cent and the states and territories contributed 43.6 per cent (table 15A.166). Recurrent SAAP funding per person in the total population was $15 nationally in 2003-04. It ranged from $40 in the NT to $12 in Victoria and Queensland (figure 15.15).

Combined Australian, State and Territory government funding per person for the period 1999-2000 to 2003-04 increased (in real terms) in NSW, the ACT and the

NT, and remained relatively stable in all other jurisdictions. The largest increase was experienced in the ACT with a rise from $27 to $32 over the period (table 15A.168).

Figure 15.15 **Real recurrent SAAP funding in the residential population (2003-04 dollars)[a, b, c]**



a Includes total recurrent allocations (including State and Territory level allocations for program administration). **b** The total population figure is not indicative of the demand for these services. **c** Real expenditure, based on the ABS gross domestic product price deflator 2003-04 = 100 (table A.26).

Source: Department of Family and Community Services (DFaCS) (unpublished); table 15A.168.

15.6 Framework of supported accommodation and assistance performance indicators

The performance indicator framework is based on the shared government objectives for SAAP services (box 15.27).

Box 15.27 **Objectives for SAAP services**

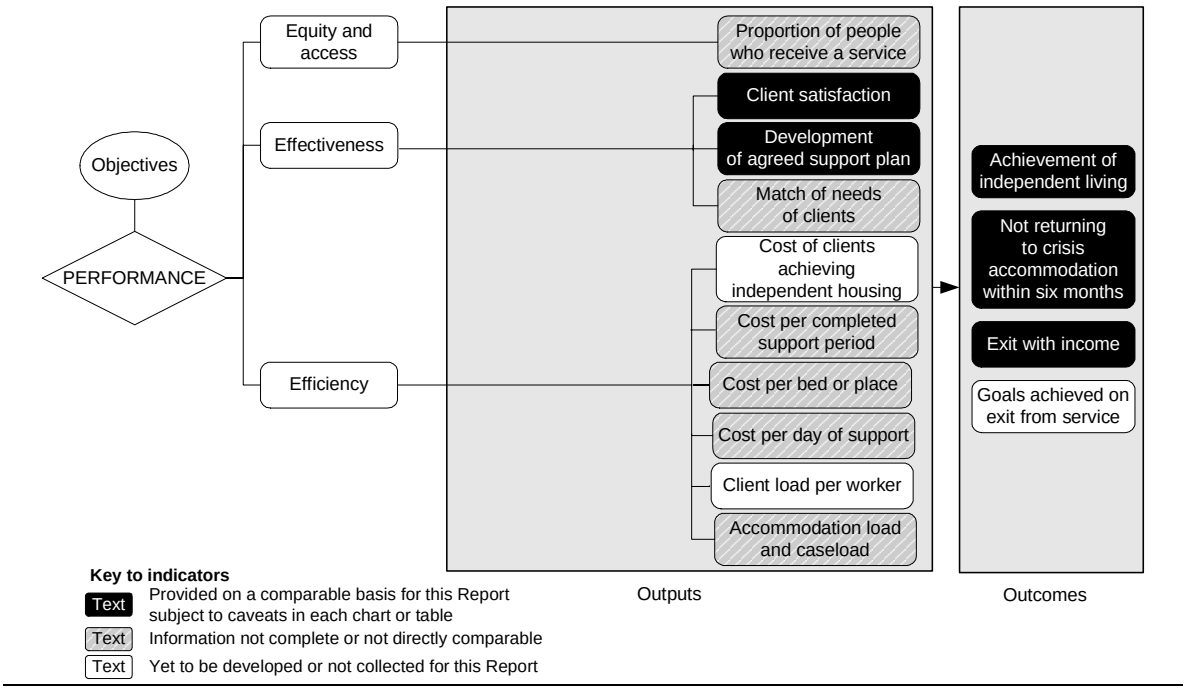
The overall aim of SAAP is to provide transitional supported accommodation and a range of related support services, so as to help people who are homeless or at imminent risk of homelessness to achieve the maximum possible degree of self-reliance and independence. Within this aim, the goals are to:

- resolve crises
- re-establish family links where appropriate
- re-establish the capacity of clients to live independently of SAAP.

These services should be provided in an equitable and efficient manner.

The performance indicator framework shows which data are comparable in the 2005 Report (figure 15.16). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 15.16 **Performance indicators for SAAP services**



15.7 Key supported accommodation and assistance performance indicator results

The data collection for SAAP allows for the measurement of the number of clients and of the number and types of service provided to clients (box 15.28).

Outputs

Equity and access

Proportion of people who receive a service

Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as Indigenous people and people from non-English speaking backgrounds) is particularly important (box 15.29).

Box 15.28 **Issues when analysing SAAP data**

The following three important issues need to be considered when analysing SAAP data.

- Informed consent is an essential component of the integrity of the data. The principle of client/consumer rights (which underpins informed consent) recognises that clients do not receive services under a mandatory order. They have the right to accept or reject the services offered, as they have the right to provide or not provide information while receiving SAAP services.
- Comprehensive information cannot be collected for all clients, such as casual clients and clients of high volume agencies (those accommodating 50 or more clients per night, telephone referral agencies, day centres, and information and referral centres).
- Clients consented to provide personal details for the SAAP client collection for 88 per cent of support periods in 2003-04. A weighting system has been developed to adjust for agency non-participation (93 per cent of agencies participated in the client collection) and non-consent.

Box 15.29 **Proportion of people who receive a service**

The 'proportion of people who receive a service' is included as an output (equity and access) indicator of governments' objective to ensure all Australians have equitable access to SAAP services on the basis of relative need. The indicator measures unmet demand for assistance. Unmet demand occurs when a homeless person seeking supported accommodation or support cannot be provided with that assistance (although one-off assistance may be provided).

This indicator is defined as the number of valid requests for services that were met, divided by the total number of valid requests made. Data are reported for all SAAP clients, and separately for Indigenous people and people from non-English speaking countries.

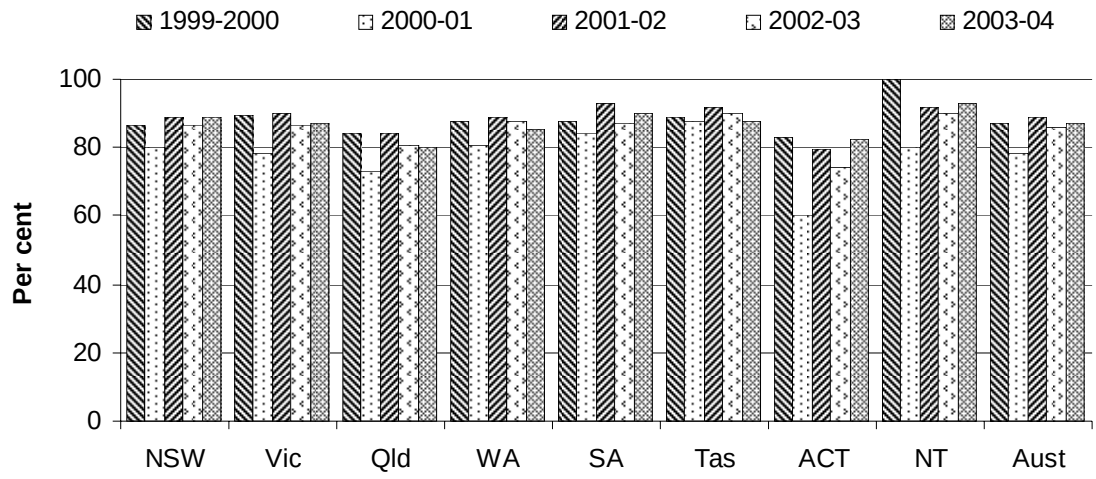
A higher proportion of valid requests receiving assistance is desirable.

Data for assessing access to SAAP services are available from the data collection on unmet demand and the data on clients. Assessing the experience of target groups using data from the unmet demand collection is, however, problematic. The client data and unmet demand data are not strictly comparable: the former count clients and each client's cultural status, whereas the latter are based on valid requests for services and record the cultural status of everyone in the group, making no distinction between adults and accompanying children. Also, the two week sample period over which data are collected may not be representative of the eventual

success of clients accessing SAAP services over the full year (see notes to tables 15A.181–15A.182).

The available data suggest around 86.9 per cent of requests for SAAP services nationally were provided with the assistance requested in the data collection period in 2003-04 (one week in December 2003 and one week in May 2004). Across jurisdictions, the proportion of requests for services that were fulfilled ranged from 92.7 per cent in the NT to 80.1 per cent in Queensland (figure 15.17).

Figure 15.17 **Proportion of requests for SAAP services that were provided with the requested support, December and May[a, b]**



a See table 15A.182 for an explanation of how the number of SAAP clients was estimated and for the definition of unmet demand. **b** Data on unmet demand need to be interpreted with care for several reasons. First, a person can make a request on more than one occasion and to more than one SAAP agency on the same day. While double counting has been limited through the exclusion of those requests where the person had made a similar request to a SAAP agency within the collection period, this information might not always have been available to record; therefore, the total number of requests does not represent the number of people making requests. Second, a number of people may receive ongoing support or accommodation from a SAAP agency at a later time, quite possibly soon after their initial request. As a result, estimates may overstate the actual level of unmet demand. Third, a number of potential clients have their needs met by other means and do not return to a SAAP agency. Many factors influence the capacity of individual SAAP agencies to meet day-to-day demand for their services; it is not possible to identify a one week period on two separate occasions per year that represents a typical week for all SAAP agencies.

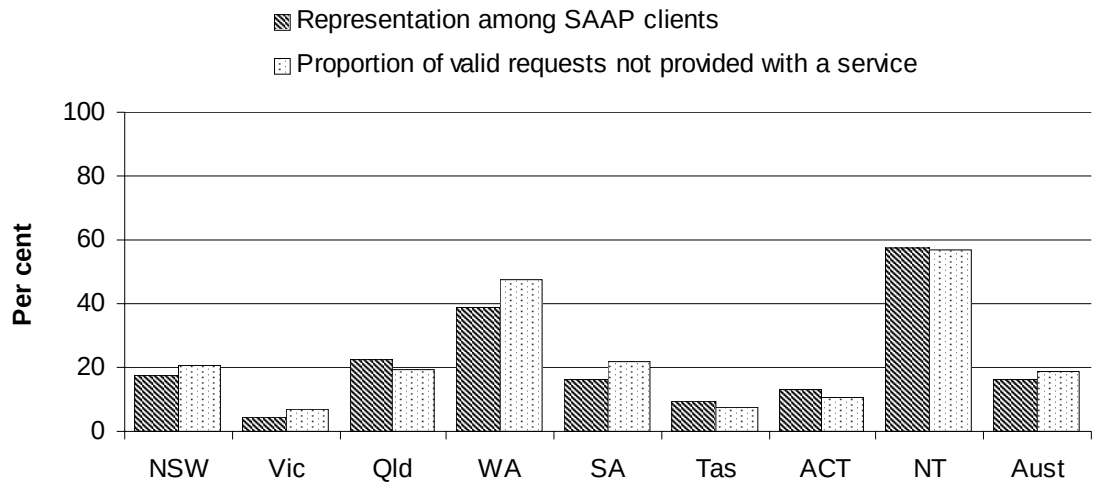
Source: SAAP NDCA (unpublished), Client and Unmet Demand Collections; table 15A.182.

Requests for SAAP services were not met for a number of reasons in 2003-04, including a lack of available accommodation (the main reason that 65.6 per cent of potential clients were not provided with services), no vacancies at the referral agency (20.4 per cent), and insufficient staff (1.8 per cent) (table 15A.181).

Nationally, 18.7 per cent of SAAP service requests by Indigenous people in the data collection period in 2003-04 did not result in the assistance requested — a proportion that was higher than the representation of Indigenous clients among

SAAP clients. In NSW, Victoria, WA and SA, the proportion of valid requests by Indigenous people that did not result in the provision of a service was higher than the representation of Indigenous people among clients (figure 15.18).

Figure 15.18 **Indigenous people as a proportion of SAAP clients, and unmet requests for accommodation made by Indigenous SAAP clients as a proportion of total unmet requests for accommodation, 2003-04[a, b]**

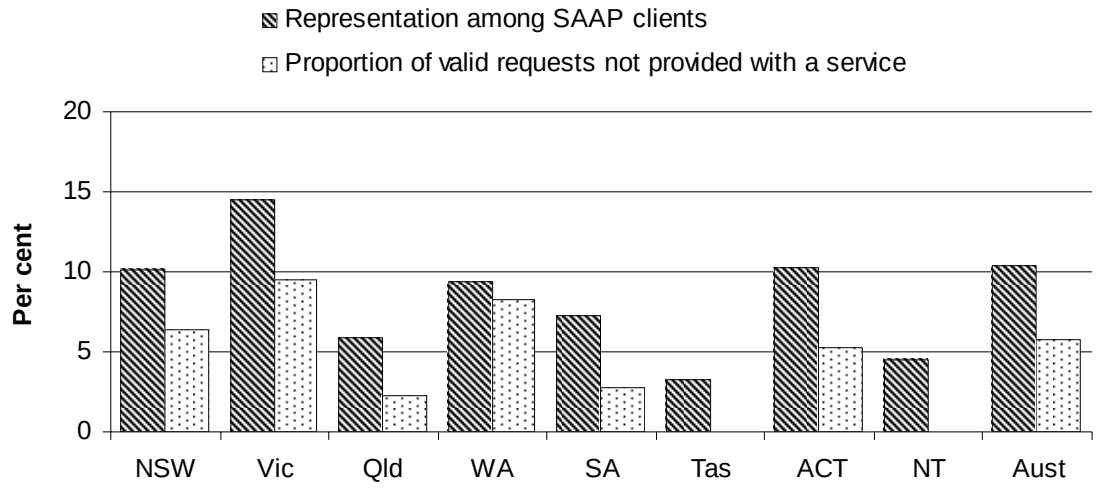


a The number of people unable to be provided with a SAAP service was the 'unmet demand'. See notes to table 15A.183 for more detail. **b** Excludes people who refused offered assistance; those who made a similar request at a SAAP funded agency within the collection period (to limit double counting); and those whose request was not met because either the referral was inappropriate (wrong target group) or the agency did not provide the type of service requested.

Source: SAAP NDCA (unpublished), Client and Unmet Demand Collections; table 15A.183.

Nationally, 5.7 per cent of SAAP service requests by people from non-English speaking backgrounds in 2003-04 did not result in the assistance requested. In all jurisdictions, the proportion of valid requests from people from non-English speaking backgrounds that did not result in the assistance requested was lower than the representation of people from non-English speaking backgrounds among clients (figure 15.19).

Figure 15.19 **People from non-English speaking backgrounds as a proportion of SAAP clients and unmet requests for accommodation made by people of non-English speaking backgrounds as a proportion of total unmet requests for accommodation, 2003-04[a, b]**



a The number of people unable to be provided with a SAAP service was the 'unmet demand'. See notes to table 15A.184 for more detail. **b** Excludes people who refused offered assistance; those who made a similar request at a SAAP funded agency within the collection period (to limit double counting); and those whose request was not met because either the referral was inappropriate (wrong target group) or the agency did not provide the type of service requested.

Source: SAAP NDCA (unpublished), Client and Unmet Demand Collections; table 15A.184.

Effectiveness

Client satisfaction

'Client satisfaction' is an important indicator of how successfully SAAP services meet the needs of clients (box 15.30).

Box 15.30 **Client satisfaction**

'Client satisfaction' is included as an output (effectiveness) indicator of governments' objective to provide high quality services that meet the needs of SAAP recipients.

The indicator is defined as the proportion of clients who thought their overall satisfaction with the assistance they had received from the SAAP service was either good or really good.

A higher proportion suggests greater client satisfaction with the overall SAAP service.

Data from the national SAAP client satisfaction survey are available for the first time in this report (box 15.31). These data relate to a four week period beginning 11 November 2003. Similar surveys are expected to be conducted periodically in the future.

Box 15.31 **National SAAP client satisfaction survey**

The inaugural SAAP client satisfaction survey was conducted in November 2003 to obtain information on client satisfaction from SAAP clients at the national level for performance information and service delivery purposes.

The survey consisted of 12 questions on client satisfaction with aspects of service provision and was implemented using a reverse call centre technique that allowed SAAP clients to initiate the phone call to the call centre. All SAAP agencies were invited to participate in the study. Over the four week period of the survey, 1000 clients from 205 agencies participated in the survey.

Despite the limitations of self-selection (both agencies and clients could opt out), the demographic characteristics of the clients who responded were broadly similar to population parameters, suggesting the non-response bias was low. The questionnaire seemed to be readily understood by clients, with low levels of non-response.

The 2003 survey suggested clients:

- felt that the help they received was better than expected (71 per cent)
- rated staff as either good (21 per cent) or really good (72 per cent). Clients were most satisfied with the ability of staff to be friendly and fair; they were least satisfied with staff availability, service timeliness and the extent of their involvement in decision-making
- were either satisfied (29 per cent) or very satisfied (57 per cent) with the time taken by agencies to provide services
- were generally happy with response times — 59 per cent rated the length of time it took to receive service as faster than expected, while only 10 per cent felt it took longer than expected
- felt their accommodation was good (26 per cent) or really good (47 per cent). Only a small proportion of clients rated their accommodation as bad. Clients were most satisfied with availability, comfort and cleanliness; they were least satisfied with accommodation modernity and the availability of workers.

The client satisfaction survey also provided information on client expectations and satisfaction with aspects of the service, such as timeliness, accommodation and staff.

Source: CBSR (2004).

Nationally, 91 per cent of respondents felt that the service they had received from SAAP services was either good or really good in 2003. Across jurisdictions, this proportion ranged from 98 per cent in WA to 87 per cent in the ACT (table 15.1).

Table 15.1 **Client satisfaction with help received from SAAP, 2003[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Really good	%	58	68	78	55	66	71	45	62	66
Good	%	31	19	19	43	26	20	42	34	25
Just OK	%	7	7	2	2	7	4	9	4	6
Bad	%	2	4	1	–	–	3	3	–	3
Don't know/ no opinion	%	1	1	–	–	1	3	–	–	1
Total	no.	230	362	150	51	99	64	22	22	999

a Data relate to survey question 2A: '*Thinking about this stay with [INSERT NAME OF AGENCY], overall, was the help you got …?*'. – Nil or rounded to zero

Source: CBSR (2004).

Development of agreed support plan

The existence of an agreed support plan is an indicator of service quality (box 15.32).

Box 15.32 **Development of an agreed support plan**

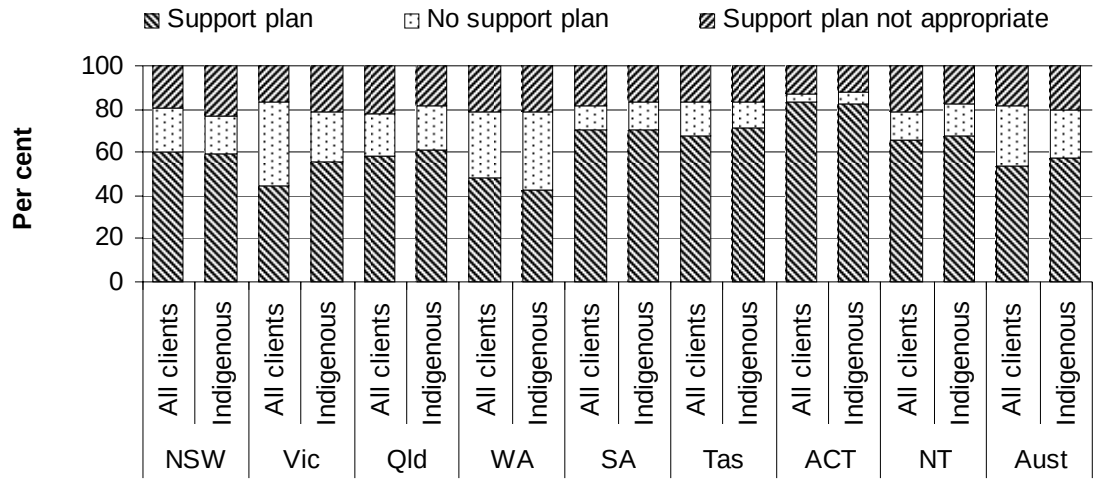
'Development of an agreed support plan' is included as an output (effectiveness) indicator of governments' objective to provide high quality services that are appropriately targeted to meet the needs of SAAP clients.

This indicator is defined as number of support periods with an agreed support plan divided by the total number of support periods. Data are reported for all SAAP clients, and separately for Indigenous people and people from non-English speaking countries.

A higher proportion of support periods with agreed support plans is desirable. In some instances, however, a support plan may be judged to be inappropriate (such as when a support period is short term).

Nationally, there was an agreed support plan for 53.8 per cent of support periods for all clients in 2003-04 (compared with 57.7 per cent for Indigenous clients) (figure 15.20). Across jurisdictions, the proportion for all clients ranged from 83.0 per cent in the ACT to 44.6 per cent in Victoria in 2003-04; for Indigenous clients, the proportion ranged from 82.4 per cent in the ACT to 42.4 per cent in WA (figure 15.20).

Figure 15.20 **Support periods, by the existence of a support plan, 2003-04[a, b]**



a Excludes high volume records because not all items are included on high volume forms. **b** See notes to table 15A.179 for more detail.

Source: SAAP NDCA (unpublished), Administrative Data and Client Collections; tables 15A.179 and 15A.180.

Match of needs of clients

The proportion of clients receiving services that they need is an indicator of appropriateness (box 15.33).

Box 15.33 **Match of needs of clients**

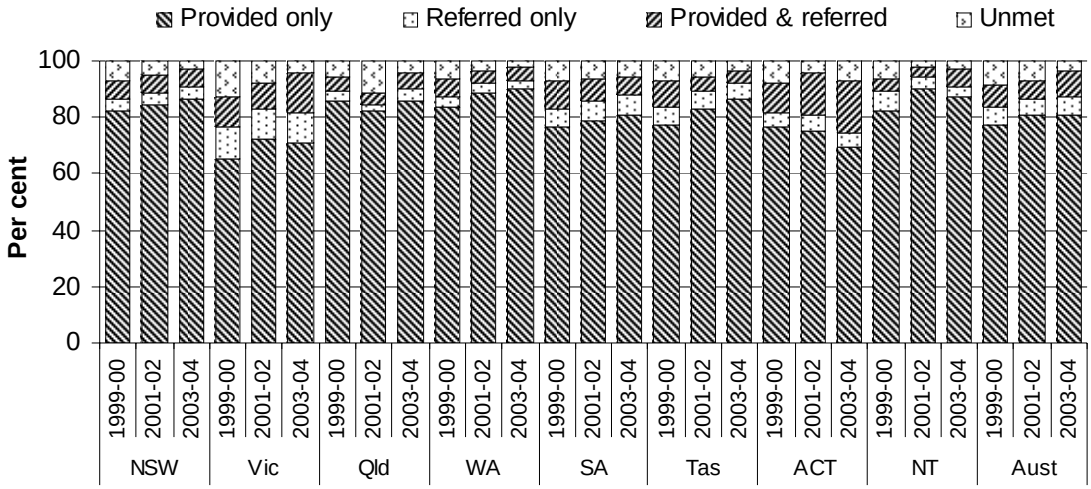
'Match of needs of clients' is included as an output (effectiveness) indicator of governments' objective to ensure that SAAP services which meet their client's individual needs. This is a measure of appropriateness. The range of needed services is broad (ranging from meals to laundry facilities to long-term accommodation), so the effect of not providing these services varies.

This indicator is defined as the proportion of clients who were provided with the services they need, clients who were referred to another agency or clients whose needs were not met. Data are reported for all SAAP clients, and separately for Indigenous people and people from non-English speaking countries.

A higher proportion of clients who received services they need or were referred to another agency is desirable.

Nationally, the proportion of clients who received needed services or were referred to another agency for needed services was 96.1 per cent in 2003-04. Across jurisdictions, the proportion ranged from 97.7 per cent in WA to 93.0 per cent in the ACT (figure 15.21).

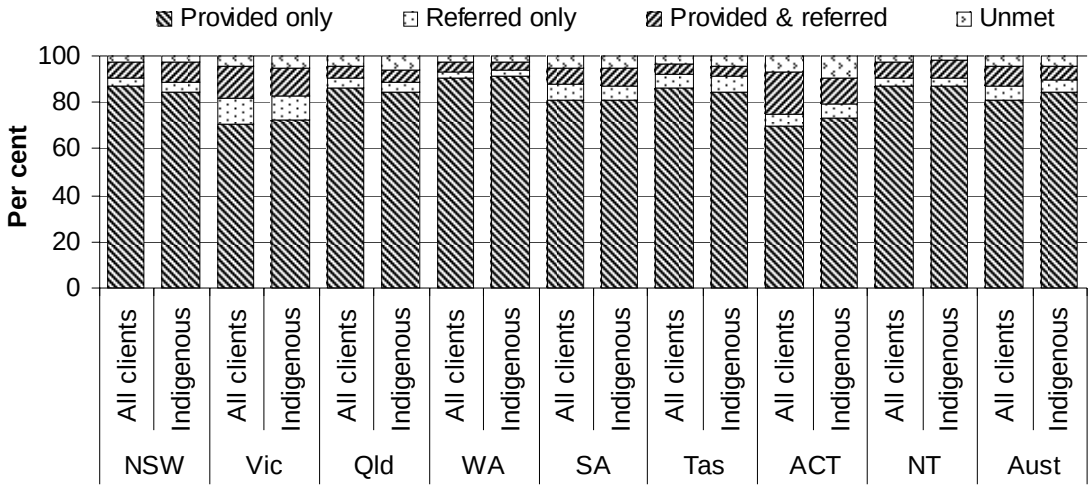
Figure 15.21 **SAAP clients, by met and unmet support needs**



Source: SAAP NDCA (unpublished), Administrative Data and Client Collections; table 15A.185.

Nationally, 96.1 per cent of Indigenous clients in 2003-04 either received needed SAAP services or were referred to another agency for these services — the same proportion as for all clients. Across jurisdictions, the proportion ranged from 98.2 per cent in the NT to 90.5 per cent in the ACT (figure 15.22).

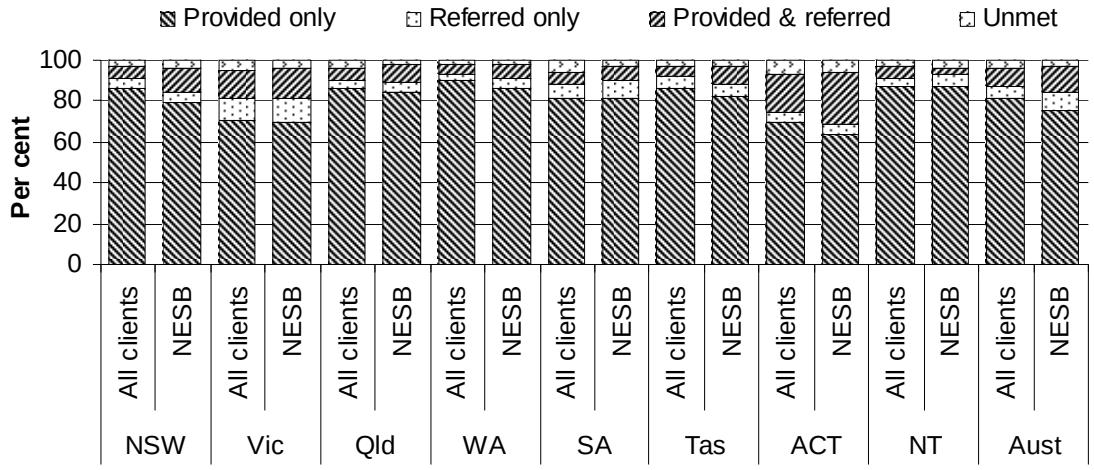
Figure 15.22 **Indigenous clients, by met and unmet support needs, 2003-04**



Source: SAAP NDCA (unpublished), Administrative Data and Client Collections; tables 15A.185 and 15A.186.

Nationally, 96.6 per cent of clients from a non-English speaking background in 2003-04 either received needed services or were referred to another agency. Across jurisdictions, the proportion ranged from 98.2 per cent in WA to 94.5 per cent in the ACT (figure 15.23).

Figure 15.23 **Clients from non-English speaking backgrounds, by met and unmet support needs, 2003-04**



NESB = Non-English speaking background

Source: SAAP NDCA (unpublished), Administrative Data and Client Collections; tables 15A.185 and 15A.187.

Efficiency

Across jurisdictions, there are varying treatments of expenditure items (for example, superannuation) and different counting and reporting rules for generating financial data. Efficiency indicators may reflect these differences.

Cost of clients achieving independent housing

The Steering Committee has identified the 'cost of clients achieving independent housing' as an indicator of the efficiency of SAAP services (box 15.34). Data for this indicator, however, were not available for the 2005 Report.

Box 15.34 **Cost of clients achieving independent housing**

The 'cost of clients achieving independent housing' will provide an output (efficiency) indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Cost per completed support period

'Cost per completed support period' provides a proxy indicator of the efficiency of SAAP services (box 15.35).

Box 15.35 **Cost per completed support period**

The 'cost per completed support period' is included as an output (efficiency) indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources. This indicator provides a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost).

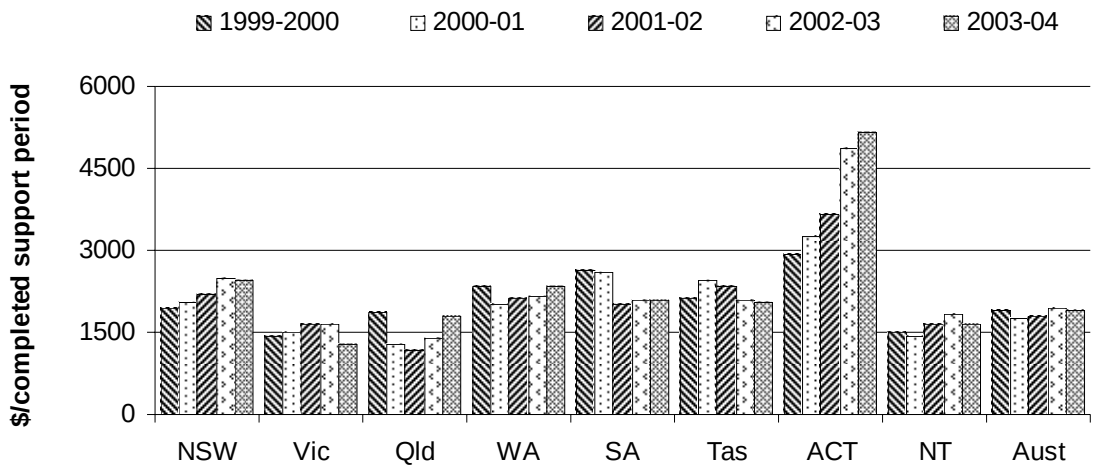
This indicator is defined as total expenditure on SAAP services divided by the number of completed support periods (excluding casual and potential clients, and accompanying children).

Lower 'cost per completed support period' is desirable, but may also indicate lesser service quality.

Unit cost analyses include only expenditure by service delivery providers. Conceptually, unit cost indicators should include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the Commonwealth State Housing Agreement through a special purpose program (the Crisis Accommodation Program).

The recurrent 'cost per completed support period' (excluding casual and potential clients, and accompanying children) averaged $1900 in 2003-04. Across jurisdictions, this cost ranged from $5160 in the ACT to $1290 in Victoria (figure 15.24).

Figure 15.24 **Real recurrent cost per completed support period (2003-04 dollars)[a]**



a See notes to table 15A.189 for a description of the analysis.

Source: SAAP NDCA (unpublished), Administrative Data and Client Collections; table 15A.189.

Cost per bed or place

'Cost per bed or place' provides a proxy indicator of the efficiency of SAAP services (box 15.36).

Box 15.36 **Cost per bed or place**

'Cost per bed or place' is included as an output (efficiency) indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources. This indicator provides a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost).

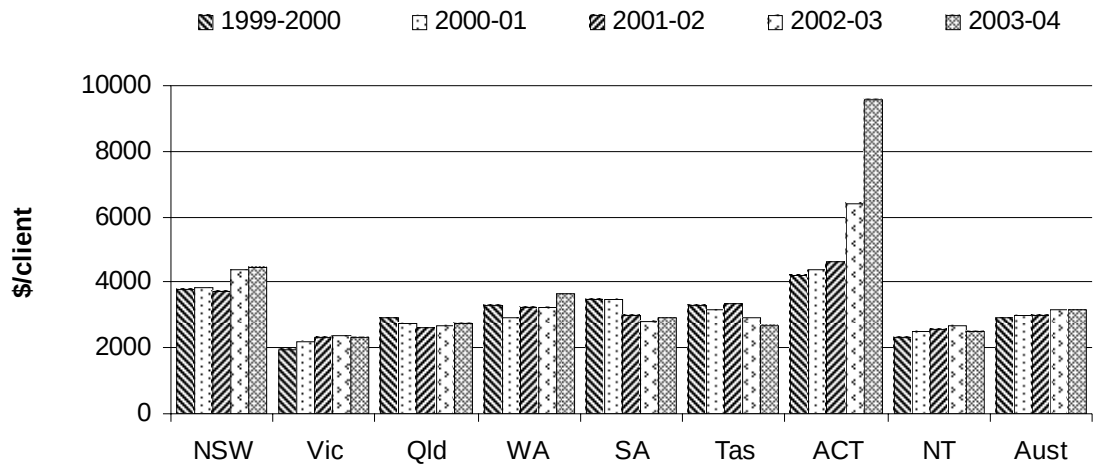
This indicator is defined as total expenditure on SAAP services divided by the number of clients accessing a bed or place over the year.

Lower 'cost per bed or place' is desirable, but may also indicate lesser service quality.

Unit cost analyses include only expenditure by service delivery providers. Conceptually, unit cost indicators should include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the Commonwealth State Housing Agreement through a special purpose program (the Crisis Accommodation Program).

Nationally, the recurrent cost per client accessing SAAP services was $3190 in 2003-04. This cost varied across jurisdictions, from $9580 in the ACT to $2340 in Victoria (figure 15.25).

Figure 15.25 **Real recurrent cost per client accessing SAAP services (2003-04 dollars)[a]**



a See notes to table 15A.190 for a description of the analysis.

Source: SAAP NDCA (unpublished), Administrative Data and Client Collections; table 15A.190.

Cost per day of support

'Cost per day of support' provides a proxy indicator of efficiency of SAAP services (box 15.37).

Box 15.37 **Cost per day of support**

The 'cost per day of support' is included as an output (efficiency) indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources. This indicator provides a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost).

This indicator is defined as total expenditure on SAAP services divided by the number of days of support for SAAP clients receiving support and/or supported accommodation (excluding casual and potential clients, and accompanying children who receive services as clients in their own right).

Lower 'cost per day of support' is desirable, but may also indicate lesser service quality.

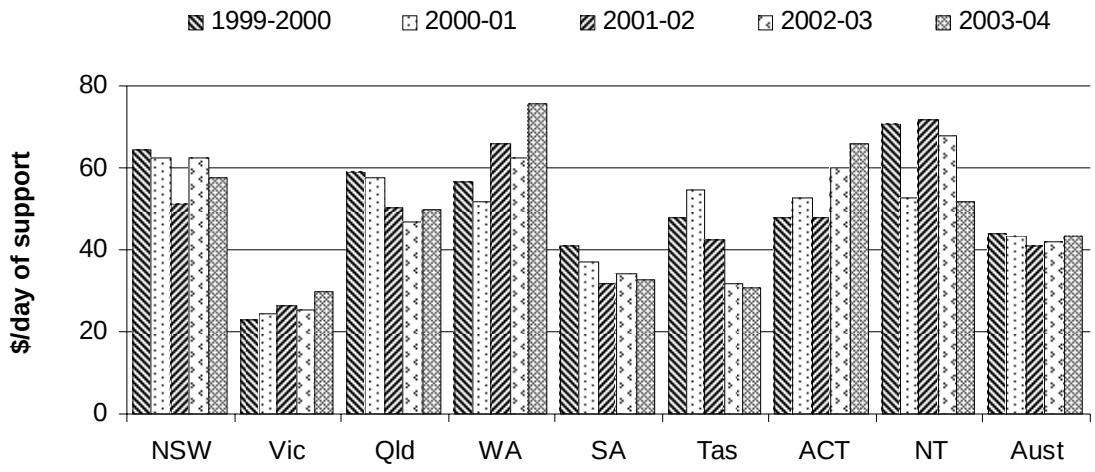
(Continued on next page)

Box 15.37 **(Continued)**

Unit cost analyses include only expenditure by service delivery providers. Conceptually, unit cost indicators should include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the Commonwealth State Housing Agreement through a special purpose program (the Crisis Accommodation Program).

The recurrent 'cost per day of support' for averaged $44 in 2003-04. Across jurisdictions, this cost ranged from $76 in WA to $30 in Victoria (figure 15.26).

Figure 15.26 **Real recurrent cost per day of support for homeless clients (2003-04 dollars)[a]**



a See notes to table 15A.188 for a description of the analysis.

Source: SAAP NDCA (unpublished), Administrative Data and Client Collections; table 15A.188.

Client load per worker

The Steering Committee has identified 'client load per worker' as an indicator of the efficiency of SAAP services (box 15.38). No data on this indicator, however, were available for the 2005 Report.

Box 15.38 **Client load per worker**

This indicator will provide an output (efficiency) indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

Accommodation load and caseload

'Accommodation load and caseload' provide proxy indicators of the efficiency of SAAP services (box 15.39).

Box 15.39 **Accommodation load and caseload**

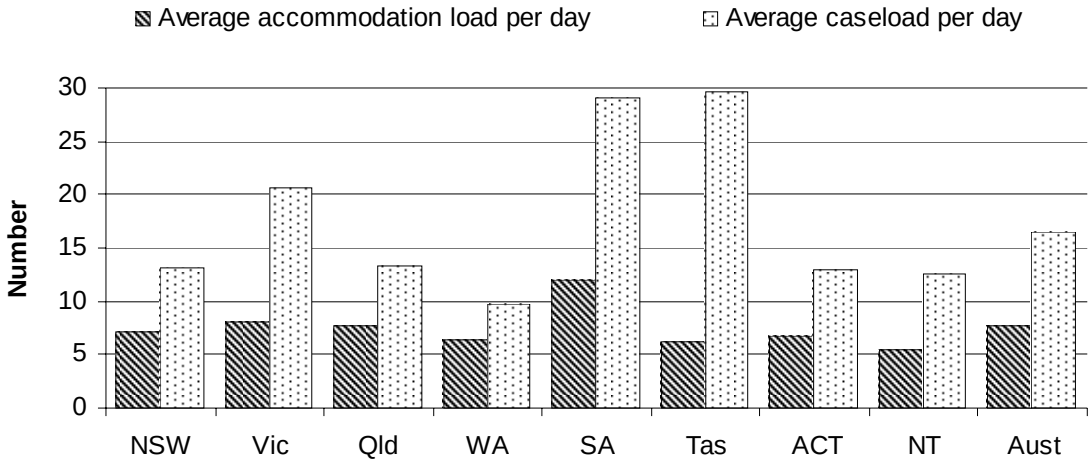
'Accommodation load and caseload' are included as output (efficiency) indicators of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources. Average accommodation load and caseload are output indicators of efficiency, and they indicate levels of output by agencies.

The average accommodation load is defined as the average number of people accommodated per day per agency. The average caseload is defined as the average number of people being supported per day per agency.

High loads may mean greater efficiency or, alternatively, a lesser quality service. Accommodation load and caseload are likely to be affected by the size of the agencies funded under the SAAP Program.

Nationally, the average accommodation load was 7.6 in 2003-04. Across jurisdictions, it ranged from 12.0 in SA to 5.5 in the NT (figure 15.27). The average caseload in 2003-04 was 16.5 nationally and ranged from 29.6 in Tasmania to 9.7 in WA (figure 15.27).

Figure 15.27 **Average accommodation load and caseload per day, 2003-04[a]**



a See notes to table 15A.191 for a description of how accommodation load and caseload were estimated.

Source SAAP NDCA (unpublished), Administrative Data and Client Collections; table 15A.191.

Outcomes

An important outcome is clients' achievement of self-reliance and independence. Characteristics that may indicate whether clients can live independently include their income, housing status and workforce status. These characteristics are recorded at the end of a client's support period.

Achievement of independent living

'Achievement of independent living' is an important indicator of clients' self-reliance and independence. Data are reported separately for clients' success in achieving independent housing and employment (box 15.40).

Box 15.40 **Achievement of independent living**

'Achievement of independent living' is included as an outcome indicator of governments' objective to enable clients to participate as productive and self-reliant members of society at the end of their support period. Two indicators of independent living are reported: achievement of independent housing and achievement of employment.

Achievement of independent housing is defined as the number of clients achieving independent housing at the end of a support period divided by the total number of completed support periods. A higher proportion of achievement of independent housing at the end of their support period is desirable.

Achievement of employment is defined as the change of labour force status of clients after their program support, compared with their labour force status before entering the program. A higher proportion of clients who were unemployed before entering SAAP, but who were able to gain employment after their program support is desirable.

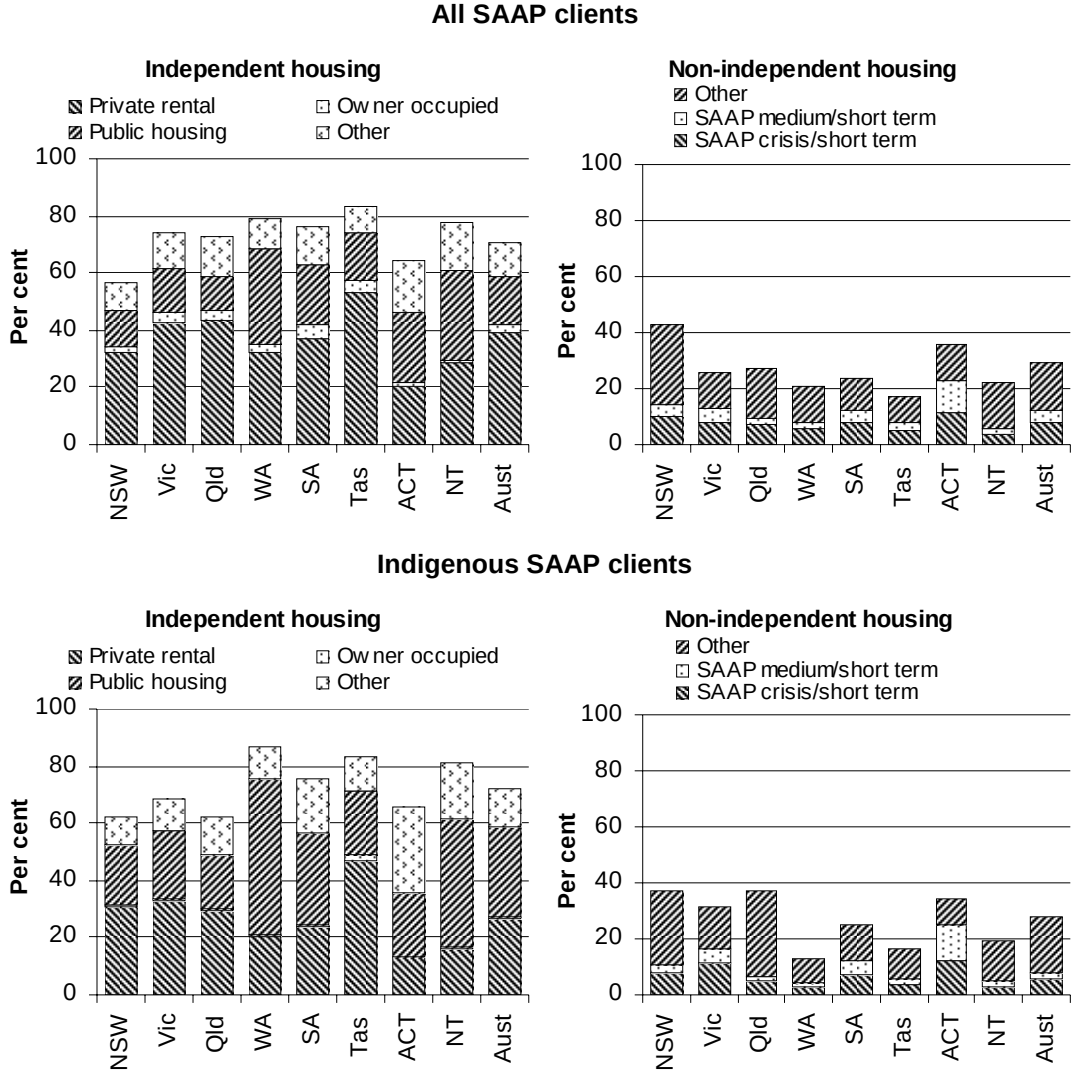
These two indicators relate to relatively short term outcomes – that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but more difficult to measure.

Data on the proportion of unemployed clients who achieved employment after support are available for only one third of completed support periods, so may not represent the total SAAP population.

Independent living — housing

Nationally, 70.8 per cent of clients achieved independent housing at the end of a support period in 2003-04. Across jurisdictions, the proportion ranged from 83.2 per cent in Tasmania to 56.7 per cent in NSW. Nationally, the proportion of Indigenous clients achieving independent housing at the end of a support period was 72.0 per cent in 2003-04 (figure 15.28).

Figure 15.28 **Accommodation type on exit from SAAP support, 2003-04[a, b]**



a Excludes high volume records because not all items are included in high volume forms. **b** 'Other' independent housing may include living rent free in a house or flat. 'Other' non-independent housing may include: SAAP funded accommodation at hostels, hotels or community placements; non-SAAP emergency accommodation; car, tent or squat; and an institutional setting.

Source: SAAP NDCA (unpublished), Administrative Data and Client Collections; tables 15A.171 and 15A.172.

By type of independent housing on exiting from SAAP, 39.0 per cent of all clients in 2003-04 moved or returned to private rental housing, 16.6 per cent were in public housing, and 3.0 per cent were in owner occupied housing. Among Indigenous clients 26.5 per cent moved or returned to private rental housing, 31.7 per cent to public housing, and 0.6 per cent to owner occupied housing. The proportion of all clients moving or returning to private rental housing was highest in Tasmania (53.4 per cent) and lowest in the ACT (20.5 per cent). The proportion moving or returning to public housing ranged from 33.3 per cent in WA to 11.8 per cent in Queensland (figure 15.28).

By type of non-independent housing on exiting from SAAP, 12.2 per cent of all clients in 2003-04 moved to or continued to live in SAAP accommodation, 7.9 per cent were in crisis or short term accommodation and 4.3 per cent were in medium term to short term accommodation. Among Indigenous clients, 8.2 per cent moved to or continued to live in SAAP accommodation, 5.9 per cent were in crisis or short term accommodation and 2.3 per cent were in medium term to short term accommodation. The proportion of all clients moving to or continuing to live in SAAP accommodation was highest in the ACT (22.6 per cent) and lowest in the NT (5.5 per cent) (figure 15.28).

Independent living — employment

Nationally, 9.0 per cent of support periods in 2003-04 involved clients who were employed before support, while 28.2 per cent involved clients who were previously unemployed (table 15A.173). Of the clients who were unemployed when entering SAAP, about 8.2 per cent were employed at the end of the support period (2.8 per cent full time, 1.8 per cent part time and 3.7 per cent on a casual basis), 83.9 per cent remained unemployed and 7.9 per cent were not in the labour force (figure 15.29). Across jurisdictions, the proportion of clients who were previously unemployed and achieved employment at the end of the support period ranged from 10.5 per cent in SA to 6.3 per cent in Tasmania (Table 15A.174).

Figure 15.29 **Unemployed SAAP clients, by labour force status after SAAP support, and Indigenous status 2003-04[a, b]**

a Data are for people who were unemployed when entering SAAP services. **b** Excludes high volume records because not all items are included on high volume forms.

Source: SAAP NDCA (unpublished), Administrative Data and Client Collections; tables 15A.174 and 15A.175.

Among Indigenous clients who were unemployed when entering SAAP in 2003-04, about 3.9 per cent were employed at the end of the support period (1.4 per cent full time, 0.9 per cent part time and 1.6 per cent on a casual basis), 87.2 per cent remained unemployed and 8.9 per cent were not in the labour force (table 15A.175).

Not returning to SAAP service within the year or six months

The proportion of clients exiting support to independent housing and not returning to SAAP is an important indicator of longer term self-reliance (box 15.41). Data on the proportion of clients who exited to independent housing and did not return within six months are available for only one third of completed support periods, so may not represent the total SAAP population.

Box 15.41 **Not returning to SAAP service within the year**

'Not returning to SAAP service within the year' is included as an outcome indicator of governments' objective to enable clients to successfully participate in society at the end of their support period. An important longer term indicator of whether clients are achieving self-reliance and independence is whether a client needs to return to SAAP services. A further medium term indicator is when the client exits to independent housing and does not return to SAAP within a specified period (in this case, six months).

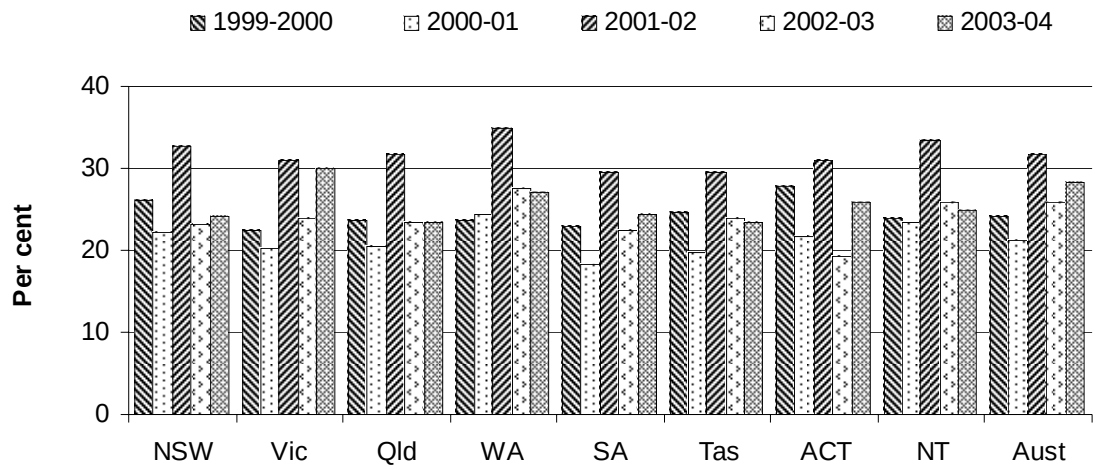
This indicator is defined as the proportion of clients returning to crisis accommodation within the year.

A low proportion of clients returning to the program within the year is desirable.

It needs to be noted that it may be appropriate for some clients to receive more than one support period (moving from crisis to medium term accommodation, for example). One group that makes multiple use of SAAP are single adults, especially older single men. A number of SAAP clients with long term problems also access SAAP services a number of times before being able to address their issues.

Nationally, 28.4 per cent of clients (28.5 per cent of Indigenous clients) returned to SAAP services during 2003-04 after having exited the program less than 12 months earlier (table 15A.176, table 15A.177). Across jurisdictions, the proportion ranged from 30.1 per cent in Victoria to 23.4 per cent in both Queensland and Tasmania (figure 15.30). Among Indigenous clients, the proportion ranged from 32.1 per cent in WA to 23.4 per cent in NSW (table 15A.177).

Figure 15.30 **Clients who returned to a SAAP service after having exited the program less than 12 months earlier[a]**



a Data from 2001-02 are based on estimated support periods per client, rather than on observed support periods per client as reported in previous years.

Source: SAAP NDCA (unpublished), Administrative Data and Client Collections; table 15A.176.

Estimates of clients exiting support to independent housing and not returning to SAAP within six months are affected by the data issues discussed in box 15.28. Current estimates may not represent all clients — for example, only 58.1 per cent of clients nationally provided information on their accommodation after exiting at least one support period in 2003-04 (table 15.2). Given the potential for data bias, these estimates need to be interpreted with care.

Table 15.2 **Indicative estimates of clients who exited SAAP to independent housing and did not return within six months, 2003-04[a]**

Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Clients who provided information on accommodation after exit from support									
no.	12 600	24 100	7 700	5 000	3 600	2 300	1 000	1 900	58 200
As a proportion of total clients[c]									
%	52.9	71.5	45.3	62.5	40.0	53.5	71.4	63.3	58.1
Clients recorded as exiting to independent accommodation and not returning within six months									
no.	4 500	9 600	3 400	2 600	1 700	1 000	400	900	24 000
Indicative estimates of clients exiting to independent housing and not returning within six months									
%	35.7	39.8	44.2	52.0	47.2	43.5	40.0	47.4	41.2

a See notes to table 15A.178 for details of how the estimates were calculated.

Source: SAAP NDCA (unpublished), Administrative Data and Client Collections; table 15A.178.

It is important to have data that represent all SAAP clients. Strategies are being implemented to improve the data quality progressively, including improving client

consent rates and the collection of exit information. It is hoped that the data will be robust enough eventually to allow comparative performance assessment.

Exit with income

The proportion of clients who experience a positive change in income source (from having no income support to obtaining some income, for example) is an indicator of independence and self-reliance (box 15.42). Data are available for only four fifths of completed support periods, so may not represent the total SAAP population.

Box 15.42 **Exit with income**

'Exit with income' is included as an outcome indicator of governments' objective to enable clients to independently participate in society at the end of their support period. Client independence is enhanced when the client moves from having no income before entering SAAP services to obtaining some income (including wages and/or benefits) on exit from SAAP services.

This indicator is defined as the proportion of clients who exited SAAP with an income source.

A higher proportion of clients exiting SAAP with an income source is desirable.

The proportion of all clients in 2003-04 who had no substantive change in income source ranged from about 94.0 per cent in Victoria to 85.2 per cent in the ACT (figure 15.31).

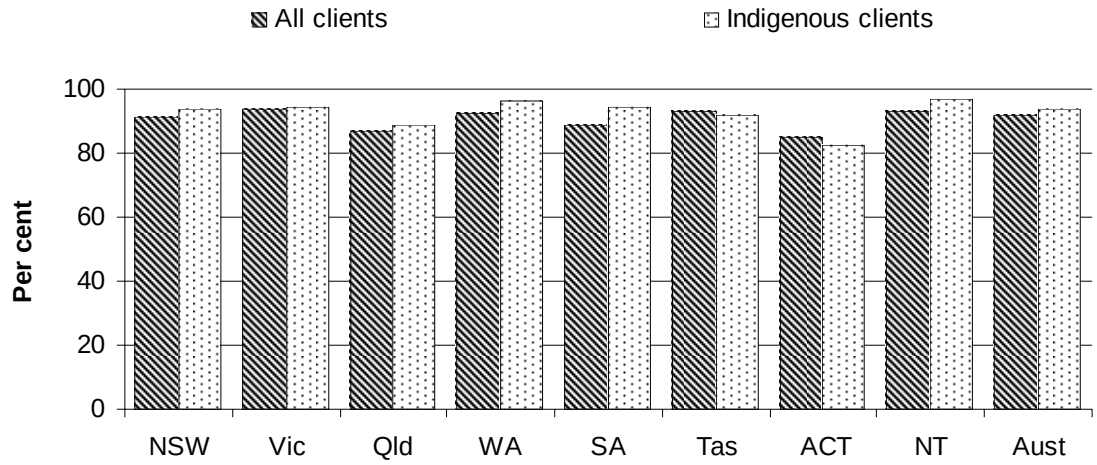
The proportion of clients who moved from having no source of income to obtaining some income in 2003-04 ranged from 3.0 per cent in the ACT to 1.0 per cent in Tasmania. The proportion who obtained their own benefit or a wage ranged from 1.8 per cent in SA to 0.8 per cent in Victoria. The proportion who had no income before or after support ranged from 8.9 per cent in the ACT to 2.7 per cent in the NT.

Nationally, 0.6 per cent of clients exiting SAAP moved from having a wage to receiving a government payment, or from having some income to having no income (table 15A.169).

The proportion of Indigenous clients who moved from having no income support to obtaining some income ranged from 2.8 per cent in the ACT to 0.2 per cent in Tasmania. The proportion who obtained their own benefit or a wage ranged from 0.8 per cent in Victoria to 0.2 per cent in WA. The proportion who had no income before or after support ranged from 14.1 per cent in the ACT to 1.8 per cent in the NT.

Nationally, 0.4 per cent of Indigenous clients exiting SAAP moved from having a wage to receiving a government payment, or from having some income to having no income (table 15A.170). The proportion who had no substantive change in income source ranged from about 97.1 per cent in the NT to 82.5 per cent in the ACT.

Figure 15.31 **Proportion of clients who had no substantive change in income source after SAAP support, by Indigenous status, 2003-04[a]**



a Excludes clients of high volume agencies (those accommodating 50 or more clients per night, telephone referral agencies, day centres, and information and referral centres) because data on income source after support were not collected.

Source: SAAP NDCA (unpublished), Administrative Data and Client Collections; tables 15A.169 and 15A.170.

Goals achieved on exit from service

The Steering Committee has identified 'goals achieved on exit from service' as an outcome indicator of SAAP services (box 15.43). No data for this indicator, however, were available for the 2005 Report.

Box 15.43 **Goals achieved on exit from service**

This indicator will provide an outcome indicator of governments' objective to ensure all SAAP services meet the needs and expectations of users.

Data are currently not collected on this indicator. The Steering Committee has identified this indicator for development and reporting in future.

15.8 Future directions in supported accommodation and assistance performance reporting

Measuring client satisfaction, client outcomes and clients with high and complex needs

'Client satisfaction' is an important indicator of quality. Work on developing measures of 'client satisfaction' within the SAAP population was conducted in two stages. The first stage involved consultation with a number of SAAP agencies, clients and stakeholders to develop options for measuring client satisfaction. The second stage of the project set out to test a measurement method through a client satisfaction survey conducted in November 2003. Results from the survey are being used for performance reporting this year. Similar surveys to measure the level of SAAP client satisfaction are expected to be conducted periodically in future.

The projects on measuring client outcomes and on clients with high and complex needs have also been completed. The client outcomes project tested the applicability of specific outcome measurement tools across a range of SAAP service types and found that a limited subset of tools was suitable for use with SAAP but that no one tool was suited to measuring all services or service types. The high and complex needs project produced a measurement tool that enables level, type and complexity of client need to be measured and reported on statistically. The implementation of these tools will require further consideration and consultation with stakeholders.

Improving data and information collection

An Information Management Plan (IMP) for SAAP IV was adopted in 2001 by the SAAP National Coordination and Development Committee. The committee has approved the guiding principles of the IMP, and work is progressing. The first stage of implementation involves defining the information needs of all stakeholders more precisely and then determining the best way in which to collect and use this information.

The implementation of the IMP will:

- place increased emphasis on electronic data capture
- reduce the data collection burden and standardise collected data items through the new core data set
- improve data reliability through the new alpha code
- enhance communication in the sector through a new SAAP website

- increase support provided to SAAP agencies through extra training
- encourage SAAP agencies' use of local data for research purposes through the Service and Regional Research Program.

Electronic data capture within SAAP agencies currently occurs through the use of specially developed software (the SAAP Management and Reporting Tool — SMART), which is provided free to SAAP agencies and supported through specially developed training and documentation, and the provision of a hot line. Agencies are encouraged to submit their data via SMART rather than via paper forms. During the implementation of the IMP process, SMART will be maintained, enhanced and supported with increased training.

The new core data set is a result of a review that took place in consultation with stakeholders and SAAP agencies. The new core data set consists of fewer data items than on the current form and will reduce the data collection burden on SAAP agencies. The high volume forms (a shorter version of the questionnaire) will be phased out, ensuring all collected data items are standardised across all types of SAAP agency.

A new alpha code is needed in SAAP data to enable longitudinal analyses of trends and patterns of client service use. The Home and Community Care program alpha code, which contains more information and has a lower rate of duplication, is likely to be adopted in SAAP. Testing of the core data set and the new alpha code has already occurred. If these trials are successful, the new changes to the data collection will be implemented from 1 July 2005.

Review of SAAP performance reporting and framework

A mid-term review of the SAAP bilateral performance reporting and performance framework was conducted in the first half of 2003. The review assessed the national performance framework (including the national performance indicators) and the bilateral reporting process used by the jurisdictions to report performance to the Australian Government. As a result of the review findings, changes have been adopted to streamline the bilateral reporting, and some enhancements and other changes will be made to the national performance indicators.

15.9 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

“2003-04 was the fourth year in the five year Support Accommodation Assistance Program (SAAP) Agreement between the Australian Government and the states and territories. This is the fourth set of SAAP Agreements (SAAP IV).

The Australian Government is providing over $800 million for SAAP IV. This represents an increase of over $260 million or some 30 per cent over total Australian Government funding for the SAAP III agreement.

As SAAP IV approaches its final year in 2004-05, its evaluation has been conducted. The evaluation involved an intensive and exhaustive investigation of all the issues that might impact on the implementation of the program, drawing together the results of a series of separate evaluations of components of the program and taking into account the views of SAAP consumers, service delivery agencies and other stakeholders, as well as data from the State/Territory Annual Performance Reports and the National Data Collection and research outputs from the SAAP IV Research Program. The evaluation describes the achievements of SAAP IV and discusses options for the future.

Work on the implementation of the Information Management Plan is continuing. The SAAP sector and stakeholders have been consulted about changes that will occur in the data collection. SAAP data continue to be a rich source of information on homeless people and their use of SAAP service. The Australian Government sponsored the July issue of the ‘Parity’ magazine specifically focusing on data and research into homelessness.

The Australian Government has progressed a number of new activities and increased support for existing activities, which are designed to support homeless people. As part of the 2004-05 budget, the Government has committed $10.4 million in new funding for the Household Organisational Management Expenses (H.O.M.E.) Advice Program. This program builds on the success of the Family Homelessness Prevention Pilots that the Government introduced as a new budget measure in 2001.

The Reconnect Program which assists young people who are homeless or at risk of being homeless will receive over $80 million over the next four years. Currently there are 97 Reconnect services across Australia run by community and local government organisations that provide help to about 7000 young people and 5000 families each year.

Through the Transitional to Independent Living Allowance (TILA), the Government provided assistance to young people leaving state-supported care by providing one-off assistance up to the value of $1000. In 2002-03 through to 2004-05 funding of $6.0 million will be distributed directly to 21 non-government organisations (NGOs) administering TILA.”

New South Wales Government comments

Child protection and supported placements

In 2003-04, the roll-out of the enhanced funding package for the NSW Department of Community Services (DoCS) commenced with the appointment of more than 150 additional child protection caseworkers during the year. The increased focus by DoCS on prevention and early intervention activity was reflected in additional funding for projects to consolidate and expand the service network supporting families participating in the Early Intervention Program. The Program is consistent with research that demonstrates the efficacy of intervening early in the life of a child, and early in the onset of family difficulties; projects include family support, centre-based child care, supported playgroups, parenting programs, home visiting and one-stop shop family centres, specialist family support services with culturally and linguistically diverse (CALD) family workers, Aboriginal playgroups and young parent groups.

Implementation of the three–stage proclamation plan for the commencement of key out-of-home care provisions of the Children and Young Persons (Care and Protection) Act 1998 was successfully completed in 2003-04 with the third and final stage occurring in March 2004. DoCS continues its program of research, development and design of improved models of care and support services to better address the needs of out-of-home care children and young people; enhancements include assessment and screening tools for children and young people with high and complex needs, professional foster care services, intensive case management, and relative and kinship care services. Additional funds were allocated this year to expand services by Aboriginal service-providers for Aboriginal children and young people.

Supported Accommodation Assistance Program (SAAP)

NSW spent 2003-04 consolidating reforms implemented in the first three years of SAAP IV, with an emphasis on improving service coordination. Finalisation of the Western Sydney Homelessness Strategic Implementation Plan, implementation of a Parramatta men's SAAP coalition and the continued roll out of the inner city SAAP Reform process are key examples of work in progress.

SAAP also became a partner in an expanded Joint Guarantee of Service for people with a mental heath disorder (JGOS). Department of Housing, NSW Health, Aboriginal Housing Office and Aboriginal Health and Medical Research Council are all strategic partners in this Agreement. Through regional agreements, SAAP services will work collaboratively with partner agencies under JGOS to sustain public, Aboriginal and community housing for clients with a mental health disorder and improve pathways for SAAP clients into public, Aboriginal and community housing.

Victorian Government comments

Child protection and supported placements

The Victorian Government has embarked on a reform process including a review of the *Children and Young Person's Act (1989)*. A series of reports were commissioned on the Victorian Child Protection and Placement system, which will contribute to the review. In September 2004 the Government released a final discussion paper, protecting Children: ten priorities for children's wellbeing and safety, which provided a framework for translating the reform directions proposed in these reports into system, policy, practice and legislative change. Key priorities include a focus on earlier and more co-ordinated service responses for vulnerable children and families, a stronger focus on children and young people's stability and developmental needs, strengthening Aboriginal self-management to improve the wellbeing and safety of Aboriginal children and more flexible, solution-focused protective interventions. Consultations on the proposals contained in the discussion paper are now concluding with new legislation planned in 2005.

To support the overall reform directions, the 2004-05 Budget provided a total of $34.8 million over four years to strengthen child protection and family support services. The budget allocation built on the success of the Family Support Innovation Projects that commenced in 2002-03 and introduced a number of targeted strategies to address areas of particular concern, including 15 Family Support Innovation Projects, a new adolescent mediation and diversion service, new Aboriginal family decision making and family violence services and additional funds to carers to meet the educational and health needs of children and young people placed in their care by the State.

Supported Accommodation Assistance Program (SAAP)

The report of the Victorian Homelessness Strategy (VHS) Directions for Change released in February 2002 provides the framework for ongoing development of homelessness assistance.

During 2003-04, the key emphasis of the VHS has been on the development and implementation of the Youth Homelessness Action Plan (YHAP).

The VHS Youth Homelessness Action Plan, launched in May 2004, has mapped the needs of young people who are homeless or at risk and provided directions for improved responses, including development of independent living skills programs for young people at risk of homelessness, especially young people leaving care; expansion of services for families and young people to assist family reconciliation; and targeted employment, education and training programs for young people with high needs.

Other significant work commenced includes the development of Homelessness Assistance Service Standards and a 'Charter of Rights for consumers using Homelessness Assistance services.

Queensland Government comments

“ *Child protection and supported placements*

In March 2004, the Queensland Government committed to the reform of the State's child protection system. This was in response to the recommendations of the January 2004 Crime and Misconduct Commission Report 'Protecting children: An inquiry Into Abuse of Children in Foster Care' and the December 2003 Audit of Foster Carers Subject to Child Protection Notifications.

The primary recommendation of the Crime and Misconduct Commission was for the creation of a system that reflected a whole-of-government approach to child protection. A central component of the new child protection system was the establishment of the Department of Child Safety to focus exclusively on child protection and to act as lead agency in facilitating a whole-of-government response to child protection.

The Department of Child Safety was officially launched on 24 September 2004. The State Government allocated $269 million operational and $35 million capital funding to the new department in the 2004-05 State Budget.

The Department of Child Safety will focus exclusively on child protection and will progress the reform agenda by implementing a number of initiatives including: training and support for foster carers; strategies to improve services to Aboriginal and Torres Strait Islander children and their families; partnerships with non-government agencies; improved external and internal accountabilities within the Department of Child Safety and the broader child protection system; and sound systemic support for front-line service delivery.

Supported Accommodation Assistance Program (SAAP)

Queensland continued to experience high unmet demand for SAAP services in 2003-04, particularly in regions of high population growth and declining housing affordability. SAAP data shows that client numbers in Queensland have increased from a total of 14 900 in 1996-97 to 16 100 in 1999-2000 and up to 18 900 in 2002-03. The figure for 2003-04 is expected to continue this trend.

A high proportion of Queenslanders who are turned away from SAAP services are homeless families and children. Indigenous people continued to make up a high proportion of SAAP service users in Queensland (22.7 per cent in 2003-04).

The Queensland Government continued the development and implementation of coordinated strategies under its Homelessness Action Plan. A Chief Executive Officers Sub-Committee on Homelessness, with a Focus on Public Intoxication has been established to coordinate responses to homelessness and public space issues.

The Department of Communities has commenced a major project to strengthen its funded non-government agencies, including SAAP–funded agencies. It is anticipated that the project will improve the quality of SAAP service delivery and establish more effective, efficient client-focused service models. ”

Western Australian Government comments

“

Child protection and supported placements

The *Children and Community Services Bill (2003)* was introduced into Parliament. The Bill reflects current research evidence and contemporary practice and gives clear direction for a model of best practice, with an emphasis on supporting family wellbeing and the capacity of families to care safely for their children.

A shared responsibility, multi-agency approach to child protection has been promoted and strengthened through the development of the Interagency Collaborative Framework for Protecting Children. This Framework is supported by agreed Reciprocal Child Protection Reporting Procedures.

An Extended Family Care Framework has been developed to promote the active support of relative carers within the context of the Department's broader statutory responsibilities for promoting and building the safety and wellbeing of children and young people, their families and communities.

Five non-government placement services have been funded to also provide reunification services for children and young people placed with them.

A Duty of Care Unit has been established within the Department. Its role is to support officers to respond appropriately to allegations of abuse in care and to review and audit all reported allegations of abuse of children in departmental care since 1993. A strategy to prevent abuse in care is being implemented that includes a central register of government and non-government carers to ensure carers are appropriately screened, assessed and registered and the mandatory training for all government and non-government carers.

Supported Accommodation Assistance Program (SAAP)

The National Evaluation of the SAAP IV agreement was a significant process during 2003-04. Consultations with SAAP funded services and the SAAP State Advisory Committee assisted in informing the Western Australian submission to the National Evaluation which identified key areas for the future direction of SAAP.

A Standardised Service Agreement across government was introduced for all funded services and an Industry Plan for the Non-Government Human Services Sector (June 2004) was developed. Other achievements during 2003-04 include: a new supported accommodation service in Broome (state funded); development of the SAAP sexual diversity and gender identity project; a range of activities to enhance SAAP services in rural and remote areas; and completion of SAAP protocols with the Western Australian Police Service.

State Homelessness Strategy initiatives included: nine support and advocacy services to assist people in private rental to maintain housing, two financial counselling services to assist young people, three new services for young people leaving care, funding for children from homeless families and country refuges, a funding increase to five services to support young homeless parents.

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South Australian Government comments

“ *Child protection and supported placements*

In 2003-04, the South Australian government implemented the following responses to the recommendations of the Layton Report, Semple Review of Alternative Care and the findings of the Family and Youth Services Workload Analysis Project:

- Additional $8.3 million over 4 years to develop service responses for vulnerable families
- Increased staffing levels in Children, Youth and Family Services
- Given all children and young people under the Guardianship of the Minister priority access to all Government services
- Assisted the release of children from Immigration Detention by providing support to live in the community
- Partnership with the Australian Government to provide housing in Port Augusta for mothers and children who were formerly residing in Baxter Detention Centre
- Completed a review of Aboriginal children who are in non-Aboriginal foster care placement and developed cultural maintenance plans for Aboriginal children and young people in foster care
- Worked with the Family Court of Australia to implement Project Magellan to speed resolution of contact and residence disputes where there are serious allegations of child abuse
- Held a state-wide ‘Shared Learning and Development Forum’ for foster carers, government and non-government service providers and community agencies including CREATE foundation
- Established a Special Investigations Unit to ensure allegations of abuse in care are independently investigated

Supported Accommodation Assistance Program (SAAP)

Across South Australia in excess of 2000 people receive support from a SAAP agency at any given time and 820 of these clients are living within SAAP accommodation. Achievements in 2003-04 include:

- Continuation of the visiting schedule of all SAAP agencies in South Australia providing information, advice for all SAAP programs
- Additional funding has been provided to City Homeless Assessment and Support Team (CHAST) to improve service provision and establish best practice
- The Central Eastern Domestic Violence Service moved to a core and cluster facility which enables a better standard of property amenity and case management for women and children escaping domestic violence. ”

Tasmanian Government comments

“ *Child protection and supported placements*

On 1 July 2003, the Department of Health and Human Services changed its method of reporting to include all notifications to care and protection services. Prior to this date, notifications of ‘child harm and maltreatment’ were counted but notifications classified as ‘child and family concern’ were not. As a consequence of the change in reporting, the number of notifications recorded in 2003-04 is significantly higher than previous years.

The Department of Health and Human Services has also introduced new rates of reimbursement for carers. The rates reflect the cost of caring for a child in Tasmania who is not in care, and recognise the additional needs of children on care and protection orders.

Other developments in out-of-home care include the introduction of Looking After Children, the development of a kinship care program and policies and guidelines that address the needs of children and young people who leave care.

At a broader level, the Department of Health and Human Services has established the Our Kids Bureau. Its aim is to develop policies, programs and services in collaboration with government and community organisations that improve the health and well-being of children in Tasmania.

Supported Accommodation Assistance Program (SAAP)

During 2003-04 Tasmania continued to develop the service system and evaluate many of the projects initiated through the restructure of the service system. In addition to this an evaluation of SAAP IV in Tasmania was initiated. This will be completed in 2004-05.

Key achievements for 2003-04 included further refinement of the Common Assessment Tool, and the enhancement of State based data collections system for client brokerage expenditure and sexual assault support services.

A significant achievement for 2002-03 was the commencement of Enhanced Client Assessment training across the sector. This is a modular-based, accredited training package being delivered by TAFE. Training is available to all SAAP workers.

A range of short-term projects also commenced in 2003-04. These projects include:

- strategies to enhance responses for clients with complex needs;
- the development of specific early intervention responses for young people;
- enhanced responses for Indigenous clients; and
- strategies to enhance collaboration with other government departments. ”

Australian Capital Territory Government comments

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Child protection and supported placements

In May 2004, The ACT Commissioner for Public Administration released her report, ‘The Territory as Parent’, which reviewed the safety of children in care. In response to that report, the Government created the Office for Children, Youth and Family Support. The Government’s aim in revising the structural arrangements and increasing resources was to improve practice and reporting standards.

The jurisdiction has had difficulty in attracting and retaining qualified staff due to the recruitment campaigns being conducted in other states. To counteract this problem, extensive recruitment campaigns were conducted locally, nationally and internationally.

Consistent with national trends, there continues to be significant growth in child protection reports in the ACT. In order to meet this growth, a single child protection contact point for the public was established. This was accompanied by the introduction of a revised risk assessment framework and a revised procedures manual.

Supported Accommodation Assistance Program (SAAP)

In 2003-04 the ACT Government allocated substantial additional resources to strengthen its response to homelessness as outlined in Breaking the Cycle – the ACT Homelessness Strategy. SAAP sector capacity has been increased by 30 per cent including the provision of additional services for families in crisis, men experiencing chronic homelessness and a range of responses to Aboriginal and Torres Strait Islander homelessness. During 2003-04, $2.4 million has been directed toward enhanced service capacity and quality, recognising unmet demand.

The ACT Government’s contribution to the response to homelessness has increased from 44.7 per cent of total funding to 55 per cent by the end of 2004. An additional $33 million was allocated to increase the range of housing stock available, including the provision of properties for families supported by SAAP. The 2003-04 data reflects this investment before client outcomes are evident. It is expected that future performance outcomes will reflect the investment strategy.

Factors influencing ACT results in the 2005 Report are consistent with those in 2004. The small size of ACT service providers leads to proportionally larger overhead and indirect costs compared to larger jurisdictions. Due to the limited availability of affordable housing options for clients leaving the SAAP, the length of stay in services is greater than in other jurisdictions. The nature of the ACT’s largest SAAP funded provider skews the performance outcomes for the ACT overall. Reform in relation to this SAAP service is progressing.

”

Northern Territory Government comments

Child protection and supported placements

The Northern Territory Government increased the Family and Children's Services' budget in December 2003 with a view to improving child protection services and systems over the next five years. Part of the increased funds has been used to employ new child protection staff, to increase foster carer rates, and to ensure quality care for children in care through a partnership project with CREATE. Another initiative resulted in the employment of additional Indigenous apprentices and cadets and providing tailored services to some of the highest need children in care and their carers.

In 2005 there are plans for a new Intensive Family Support Service in Darwin and the development of a number of remote community child and family projects in partnership with the Commonwealth, Aboriginal organisations and local government.

Supported Accommodation Assistance Program (SAAP)

This year saw a consolidation of initiatives funded under SAAP IV. The Salvation Army program 'Towards Independence', in Darwin, continued the good work providing support to 33 families, 25 per cent of whom identified as Indigenous Australians. The Anglicare Youth Housing Program – Palmerston and Rural is an effective and efficient one-worker service that provided good outcomes through a range of accommodation and support options. After support, 50 per cent of clients were boarding in private homes, 11 per cent were living rent–free and 6 per cent were in public housing. In Alice Springs, the Bill Braitling Housing enclave for people transitioning from treatment programs to independent living was reviewed and improved structures and processes are being implemented including exit options to public housing. Also in Alice Springs, The development of the Ampe Akweke (baby place) project for young pregnant Indigenous women was documented and it was found that the young women did not stay for the expected long periods but preferred to remain in the town camps and receive outreach support. The outreach support included working with the household to improve outcomes for the young woman and her child.

15.10 Definition of key terms and indicators

Child protection and out-of-home care services

Care and protection orders

Legal orders or administrative/voluntary arrangements involving the community services department, issued in respect of an individual child who is deemed to be in need of care and/or protection. Community services department involvement may include:

- total responsibility for the welfare of the child (for example, guardianship)
- responsibility for overseeing the actions of the person or authority caring for the child
- responsibility for providing or arranging accommodation, or reporting or considering the child's welfare.

The order may have been from a court, children's panel, minister of the Crown, authorised community services department officer or similar tribunal or officer.

Care and protection orders are categorised as:

- finalised guardianship and finalised custody orders sought through a court
- finalised supervision and other finalised court orders that give the department some responsibility for the child's welfare (excluding interim orders)
- interim and temporary orders (including orders that are not finalised)
- administrative or voluntary arrangements with the community services department, for the purpose of child protection.

Children are counted only once, even if they are on more than one care and protection order.

Child

A person aged 0–17 years.

Child at risk

A child for whom no abuse or neglect can be substantiated but where there are reasonable grounds to suspect the possibility of prior or future abuse or neglect, and for whom continued departmental involvement is considered warranted.

Child concern reports

Reports to community services departments regarding concerns about a child, as distinct from notifications of child abuse and neglect. The distinction between the two differs across and within jurisdictions.

Children in out-of-home care during the year

The total number of children who are in at least one out-of-home care placement at any time during the year. A child who is in more than one placement is counted only once.

Exited out-of-home care

Where a child does not return to care within two months.

Family based care

Home-based care (*see* 'placement types').

Family group homes

Residential child care single dwelling establishments that have as their main purpose the provision of substitute care to children. They are typically run like family homes, with a limited number of children who eat together as a family group and are cared for around the clock by resident substitute parents.

Foster care	Care of a child who is living apart from his or her natural or adoptive parents in a private household, by one or more adults who act as 'foster parents' and are paid a regular allowance by a government authority or non-government organisation for the child's support. The authorised department or non-government organisation provides continuing supervision or support while the child remains in the care of foster parents.
Foster parent	Any person (or such a person's spouse) who is being paid a foster allowance by a government or non-government organisation for the care of a child (excluding children in family group homes).
Guardian	Any person who has the legal and ongoing care and responsibility for the protection of a child.
Indigenous person	Person of Aboriginal or Torres Strait Islander descent who identifies as being an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he or she is associated. If Indigenous status is unknown, then a person is considered to be non-Indigenous.
Investigation	An investigation of child abuse and neglect that involves identifying harm or risk of harm to the child, determining an outcome and assessing protective needs. It includes the interviewing or sighting of the subject child where practicable.
Investigation finalised	Where an investigation is completed and an outcome is recorded by 31 August.
Investigation not finalised	Where an investigation is commenced but an outcome is not recorded by 31 August.
Length of time in continuous out-of-home care	The length of time for which a child is in out-of-home care on a continuous basis. A return home of less than seven days is not considered to break the continuity of placement.
Non-respite care	Out-of-home care for children for child protection reasons.
Notification	Contact with an authorised department by persons or other bodies making allegations of child abuse or neglect, or harm to a child.
Other relative	A grandparent, aunt, uncle or cousin, whether the relationship is half, full, step or through adoption, and can be traced through or to a person whose parents were not married to each other at the time of the child's birth. This category includes members of Aboriginal communities who are accepted by that community as being related to the child.
Out-of-home care	Overnight care, including placement with relatives (other than parents) where the government makes a financial payment. Includes care of children in legal and voluntary placements (that is, children on and not on a legal order) but excludes placements made in disability services, psychiatric services, juvenile justice facilities and overnight child care services.
Placement types	Four main categories: • facility-based care (placement in a residential building where the purpose is to provide placement for children and where there are paid staff, including placements in family group homes) • home-based care (placement in the home of a carer who is reimbursed for expenses for the care of the child). The three subcategories of home-based care are foster care/community care, relative/kinship care and other

- independent living (including private board)
- other (including unknown).

Relatives/kin

Family members other than parents, or a person well known to the child and/or family (based on an existing relationship).

Respite care

Out-of-home care on a temporary basis for reasons other than child protection — for example, when parents are ill. Excludes emergency care provided to children who are removed from their homes for protective reasons.

Safety in out-of-home care

The proportion of children in out-of-home care who are the subject of a child protection substantiation, where the person believed responsible for the child abuse, neglect or harm is living in the household (or was a worker in a residential care facility).

Stability of placement

Number of placements for children who have exited out-of-home care and do not return within two months. Placements exclude respite or temporary placements lasting less than seven days. Placements are counted separately where there is:

- a change in the placement type — for example, from a home-based to a facility-based placement
- within placement type, a change in venue or a change from one home-based placement to a different home-based placement.

A particular placement is counted only once, so a return to a previous placement is another placement.

Substantiation

Notification for which an investigation concludes there is reasonable cause to believe that the child has been, is being or is likely to be abused, neglected or otherwise harmed. It does not necessarily require sufficient evidence for a successful prosecution and does not imply that treatment or case management is, or is to be, provided.

Supported accommodation and assistance

Accommodation

Crisis or short term accommodation, medium term to long term accommodation, and other SAAP funded accommodation (which comprises accommodation at hostels, motels and hotels, accommodation in caravans, community placements and other SAAP funded arrangements).

Accommodation load (of agencies)

The number of accommodation days divided by the number of days for which the agency is operational during the reporting period, where the number of accommodation days equals the sum of accommodation days for all clients of an agency who are supported during the reporting period. The average accommodation load is the mean value of all agencies' accommodation loads. Support periods without valid accommodation dates are assigned the interquartile modal duration of accommodation for agencies of the same service delivery model in the same jurisdiction.

Agency

The body or establishment with which the State or Territory government or its representative agrees to provide a SAAP service. The legal entity has to be incorporated. Funding from the State or Territory government could be allocated directly (that is, from the government department) or indirectly (that is, from the auspice of the agency). The SAAP service could be provided at the agency's location

	or through an outlet at a different location.
Caseload (of agencies)	The number of support days (the sum of support days for all clients of the agency who are supported during the reporting period) divided by the number of days for which the agency is operational during the reporting period. The average caseload is the mean value of all agencies' caseloads. Support periods without valid support dates are assigned the interquartile modal duration of support for agencies of the same service delivery model in the same jurisdiction.
Casual client	A person who is in contact with a SAAP agency and receives one-off assistance for generally not more than one hour, and who does not establish an ongoing relationship with an agency.
Client	A person who receives supported accommodation or support.
Crisis or short term supported accommodation	Supported accommodation for periods of generally not more than three months (short term), and for persons needing immediate short term accommodation (crisis).
Cross-target/multiple/ general services	SAAP services targeted at more than one primary client group category — for example, SAAP services for single persons regardless of their gender.
Day support	Support provided only on a walk-in basis — for example, an agency that provides a drop-in centre, showering facilities and a meals service at the location of the SAAP agency.
Homeless person	A person who does not have access to safe, secure and adequate housing. A person is considered to not have such access if the only housing to which he or she has access: • is damaged, or is likely to damage, the person's health • threatens the person's safety • marginalises the person by failing to provide access to adequate personal amenities or the economic and social supports that a home normally affords • places the person in circumstances that threaten or adversely affect the adequacy, safety, security and affordability of that housing • is of unsecured tenure. A person is also considered homeless if living in accommodation provided by a SAAP agency or some other form of emergency accommodation.
Indigenous person	A person who is of Aboriginal and/or Torres Strait Island descent, who identifies as being an Aboriginal and/or Torres Strait Islander, and who is accepted as such by the community with which they are associated.
Medium term to long term supported accommodation	Supported accommodation for periods over three months. Medium term is around three to six months and long term is longer than six months.
Multiple service delivery model	SAAP agencies that use more than one service delivery model to provide SAAP services — for example, crisis or short term accommodation and support, as well as day support (that is, the provision of meals).
Non-English speaking background services	Services that are targeted at persons whose first language is not English.

Non-recurrent funds	SAAP funds received for non-recurrent purposes, such as funds for research, a special one-off project or replacement of capital items (for example, furniture and motor vehicles).
Non-SAAP accommodation places	Accommodation places in the form of permanent beds (owned or managed by the agency) that use funds other than SAAP funds.
One-off assistance	Assistance provided to a person who is not a client, such as the provision of a meal, a shower, transport, money, clothing, telephone advice, information or a referral.
Ongoing support period	A support period for which, at the end of the reporting period, no support end date and no after-support information are provided.
Other special characteristics	Primary or secondary characteristics that are not included in those of a service's primary client or group, or in other categories of the secondary client group — for example, a service specifically targeted at homeless persons with a disability.
Outlet	A premise owned/managed/leased by an agency at which SAAP services are delivered. Excludes accommodation purchased using SAAP funds (for example, at a motel).
Outreach support services	Services that exist to provide support and other related assistance specifically to homeless people. These clients may be isolated and able to receive services and support from a range of options that enhance their flexibility (for example, advocacy, life skills and counselling). Generalist support and accommodation services may also provide outreach support in the form of follow-up to clients where they are housed. In this context, support is provided 'off site'.
Providers	Agencies that supply support and accommodation services.
Real expenditure	Actual expenditure adjusted for changes in prices. Adjustments are made using the GDP(E) price deflator and expressed in terms of final year prices.
Recurrent funding	Funding provided by the Australian, State and Territory governments to cover operating costs, salaries and rent.
Referral	When a SAAP agency contacts another agency and that agency accepts the person concerned for an appointment or interview. A referral is not provided if the person is not accepted for an appointment or interview.
SAAP service	Supported accommodation, support or one-off assistance that is provided by a SAAP agency and intended to be used by homeless persons.
Service delivery model	The mode or manner in which a service is provided through an agency. The modes of service delivery could be described as crisis or short term accommodation and support; medium term to long term accommodation and support; day support; outreach support; telephone information; and referral or agency support. An agency may deliver its services through one or more of these means of delivery.
Service provider	A worker or volunteer employed and/or engaged by a SAAP agency, who either directly provides a SAAP service or in some way contributes to the provision of a SAAP service. Includes administrative staff of an agency, whether paid or not paid.
Single men services	Services provided for males who present to the SAAP agency without a partner or children.

Single women services	Services provided for females who present to the SAAP agency without a partner or children.
Support	SAAP services, other than supported accommodation, that are provided to assist homeless people or persons at imminent risk of becoming homeless to achieve the maximum possible degree of self-reliance and independence. Support is ongoing and provided as part of a client relationship between the SAAP agency and the homeless person.
Support period	The period that commences when a SAAP client establishes or re-establishes (after the cessation of a previous support period) an ongoing relationship with a SAAP agency. The support period ends when: • support ceases because the SAAP client terminates the relationship with the SAAP agency • support ceases because the SAAP agency terminates the relationship with the SAAP client • no support is provided to the SAAP client for a period of three months. A support period is relevant to the provision of supported accommodation or support, not the provision of one-off assistance.
Supported accommodation	Accommodation provided by a SAAP agency in conjunction with support. The accommodation component of supported accommodation is provided in the form of beds in particular locations or accommodation purchased using SAAP funds (for example, at a motel). Agencies that provide accommodation without providing support are considered to provide supported accommodation.
Telephone information and referral	Support delivered via telephone without face-to-face contact. Support provided may include information and/or referral.
Total funding	Funding for allocation to agencies (not available at the individual client group level) for training, equipment and other administration costs.
Unmet demand	A homeless person who seeks supported accommodation or support, but is not provided with that supported accommodation or support. The person may receive one-off assistance.
Women escaping domestic violence services	Services specifically designed to assist women and women accompanied by their children, who are homeless or at imminent risk of becoming homeless as a result of violence and/or abuse.
Youth/young people services	Services provided for people who are independent and above the school leaving age for the State or Territory concerned, and who present to the SAAP agency unaccompanied by a parent/guardian.

15.11 References

AIHW (Australian Institute of Health and Welfare) 2005, *Child Protection Australia, 2003-04*, Cat. no. CWS 24, Child Welfare Series No. 36, Canberra.

CBSR (Colmar Brunton Social Research) 2004, *National SAAP Client Satisfaction Survey Report of Findings*, Consultant report prepared for the Australian Government Department of Family and Community Services, Canberra.

DHS (Department of Human Services) 2002, *An Integrated Strategy for Child Protection and Placement Services*, Government of Victoria, Melbourne.

Gordon Report (Commission of Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities, chaired by Mrs Sue Gordon) 2002, *Putting the Picture Together*, State Law Publishers, Perth.

NLRC (NSW Law Reform Commission) 1997, *The Aboriginal Child Placement Principle*, Research Report no. 7, Sydney.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2003, *Efficiency Measures for Child Protection and Support Pathways: Reforms in Government Service Provision*, Productivity Commission, Canberra.

16 Housing

Government plays a significant role in the Australian housing market, directly through housing assistance and indirectly through policies associated with land planning and taxation. The Australian, State and Territory governments share responsibility for housing assistance. Direct assistance includes public and community housing, home purchase and home ownership assistance, Indigenous housing, State and Territory rental assistance (such as State and Territory provided bond loans, guarantees and assistance with rent payments and advance rent payments, relocation expenses and other one-off grants) and Commonwealth Rent Assistance (CRA).

This chapter focuses on the performance of governments in providing public, Indigenous and community housing under the Commonwealth State Housing Agreement (CSHA) (box 16.1) and CRA. Close links exist between public and community housing services and other government programs and support services discussed elsewhere in the Report, such as:

- the Supported Accommodation Assistance Program (SAAP), which provides accommodation and other services for homeless people or those at imminent risk of becoming homeless (chapter 15)
- services delivered by the Australian, State and Territory governments and community organisations to promote independent living, including disability services (see chapter 13), mental health services (see chapter 11) and aged care services, such as, the Home and Community Care Program (see chapter 12).

A profile of housing and housing assistance is presented in section 16.1 to provide the context for assessing the performance indicators presented later in the chapter. All jurisdictions have agreed to develop and report comparable indicators, and a framework of performance indicators is outlined in section 16.2. The data are discussed in section 16.3, and future directions for performance reporting are discussed in 16.4. The chapter concludes with jurisdictions' comments in section 16.5 and definitions in section 16.6.

Box 16.1 **Commonwealth State Housing Agreement**

The CSHA is an agreement made between the Australian, State and Territory governments under the *Housing Assistance Act 1996* (Cwlth) to provide strategic direction and funding certainty for the provision of housing assistance. The aim of this agreement is to provide appropriate, affordable and secure housing assistance for those who most need it, for the duration of their need.

The 2003 CSHA came into effect on 1 July 2003 and will run until 30 June 2008, and includes bilateral agreements between the Australian Government and each State and Territory government and an overarching multilateral agreement. There are generally separate bilateral agreements for mainstream and Indigenous housing in each jurisdiction. Bilateral agreements are intended to provide greater flexibility for states and territories to respond to their particular housing needs.

A national ten year strategy to improve Indigenous housing, Building a Better Future, was agreed in 2001 by Australian, State and Territory ministers. The State Indigenous Bilateral Agreements are the primary vehicle for implementation of the national Building a Better Future strategy. The desired strategy outcomes are better housing and housing services, more housing, improved partnerships, greater effectiveness and efficiency, and improved performance linked to accountability and coordination of services.

Funding arrangements

The majority of funding under the 2003 CSHA is provided by the Australian Government taking the form of general assistance funding (public housing, home purchase assistance and private rental assistance) and specified funding for identified programs: the Aboriginal Rental Housing Program (ARHP), the Crisis Accommodation Program and the Community Housing Program. The majority of CSHA funding is distributed to State and Territory governments on a modified per person basis, with the State and Territory governments contributing additional funding from their own resources to partly 'match' Australian Government funding allocations.

Roles and responsibilities

Under the CSHA, the Australian Government has responsibility for:

- ensuring the outcomes pursued through the agreement are consistent with broader national objectives, particularly in relation to support for individuals and communities
- advising State and Territory governments of Australian Government objectives to be achieved under the agreement
- reporting to the Commonwealth Parliament on performance against agreed outcomes and targets of housing assistance provided under the agreement.

State and Territory governments have responsibility for:

- developing housing assistance strategies that are consistent with Australian, State and Territory government objectives and that best meet the circumstances of the State or Territory
- implementing and managing services and programs to deliver agreed outcomes
- reporting on a basis that enables performance assessment by the Australian, State or Territory governments, based on agreed performance indicators.

Source: CSHA (2003).

Public, community and State owned and managed Indigenous housing information has been obtained from the State and Territory governments, except where otherwise indicated. The Australian Institute of Health and Welfare (AIHW) collects and collates these data and produces annual data collection manuals and reports. The data manuals and data reports are available from the AIHW web site at www.aihw.gov.au (AIHW 2004d, 2004e and 2004f). This year, most data items for public rental housing and for State owned and managed Indigenous housing were compiled from unit record data under the National Housing Data Repository at the AIHW. CRA data were obtained from the Department of Family and Community Services (DFaCS).

Housing assistance not covered

The chapter does not cover a number of government funded and provided housing services, including:

- the Crisis Accommodation Program, including the Victorian Transitional Housing Management Program under the CSHA, which provides capital funding for accommodation for homeless people
- home purchase assistance and private rental assistance provided under the CSHA
- non-CSHA programs, including those provided by the Department of Veterans' Affairs (DVA) and Aboriginal and Torres Strait Islander Services/Aboriginal and Torres Straight Islander Commission (ATSIS/ATSIC)
- CRA paid by the DVA or the Department of Education, Science and Training (DEST)
- the First Home Owners Grant, provided by the Australian Government and delivered through State and Territory governments
- some Indigenous housing and infrastructure assistance provided by ATSIS/ATSIC, State and Territory governments, land councils and Indigenous community organisations
- non-Indigenous community housing not funded under the CSHA.

Supporting tables

Supporting tables for chapter 16 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel format as \Publications\Reports\2005\Attach16A.xls and in Adobe PDF format as \Publications\Reports\2005\Attach16A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 16A.3 is table 3 in the electronic files). These files also can be found on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

16.1 Profile of housing and housing assistance

Service overview

The Australian Bureau of Statistics (ABS) 2001 Census of Population and Housing identified just under 7.1 million households in Australia, where 'household' is classified as a person living alone or as a group of related or unrelated people who usually reside and eat together. Of these households, 66.2 per cent owned or were purchasing their own home, 21.8 per cent rented in the private sector, 4.5 per cent were in public rental accommodation, and 2.8 per cent resided in other tenure types (table 16A.67). Due to non-response, Census data are likely to underestimate the number of tenants in public housing.[1] Approximately 0.4 per cent of Australian households live in community housing.[2]

The composition of Australian households is changing. There is an increasing number of smaller households, including a rising number of single person households. The average Australian household size fell from 3.3 people to 2.6 people between 1971 and 2001, while the proportion of single person households increased from 18.1 per cent to 22.9 per cent over this period (ABS 2002a).

The average Indigenous household is larger than the average non-Indigenous household. In 2001, the average non-Indigenous Australian household size was 2.6 people, whereas the average household with at least one Indigenous person was 3.5 people (ABS and AIHW 2003).

Why government provides housing assistance

Australia's private housing stock houses the majority of the population. Most Australian households can access accommodation either through owner occupation

[1] Public housing tenants appear to be undercounted in the 2001 Census (and in previous censuses).

[2] This estimate is based on data received from jurisdictions regarding the number of community housing dwellings in each jurisdiction, combined with data from the ABS 2001 Census on the total number of dwellings in each jurisdiction.

or by renting from a private landlord. Many households, however, face problems in acquiring or accessing suitable private accommodation for reasons of cost, discrimination, availability and/or adequacy. The price of rental dwellings can be prohibitive for people on lower incomes. Further, stock may not be available in the private rental market for households with special accommodation needs. Housing assistance from the Australian, State and Territory governments can help these households.

Roles and responsibilities

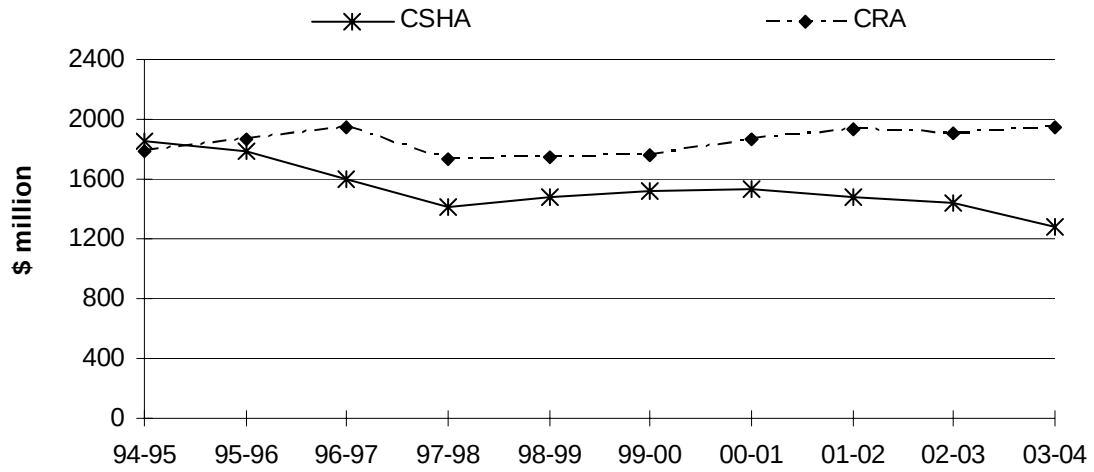
Each level of government has different roles and responsibilities in housing and housing assistance:

- The Australian Government provides CRA and shares responsibility with State and Territory governments for housing assistance provided under the CSHA (box 16.1). The Australian Government also influences the housing market through other direct and indirect means, including taxation and home purchase assistance.
- State and Territory governments provide housing assistance under the CSHA, such as assistance for the homeless, public housing, community housing, Indigenous rental housing, private rental assistance and home purchase assistance. Some also contribute to the delivery of housing assistance through mechanisms such as home lending programs and joint ventures with the private sector. State and Territory governments are also responsible for land taxes, stamp duties and residential tenancy legislation.
- Local governments implement planning regulations and are sometimes involved in providing community housing.

Funding

The Australian, State and Territory governments provided just under $1.3 billion (contributing 72.4 per cent and 27.6 per cent respectively) for housing programs under the CSHA in 2003-04. Public and community housing accounted for the majority of CSHA funding in 2003-04. The Australian Government also provided over $1.9 billion for CRA in 2003-04. Real expenditure on CSHA assistance declined by approximately 30.9 per cent between 1994-95 and 2003-04 (figure 16.1). Real expenditure on CRA increased by 9.2 per cent over the same period (table 16A.74).

Figure 16.1 **Real government expenditure on CSHA assistance and CRA (2003-04 dollars)[a, b, c]**



a Care needs to be taken in interpreting data because CRA is a demand driven recurrent expenditure program, whereas CSHA expenditure includes a component for capital investment that has resulted in around $54 billion of public housing assets that are continually used for housing assistance. **b** CSHA data are not comparable to data published before the 2001 Report. The data for 1994-95 and 1995-96 have been adjusted to enable comparability (see the 2002 Report for explanation). Australian Government CSHA expenditure differed from Australian Government budgetary allocations for the three years from 1996-97 to 1998-99 because some states and territories chose CSHA funds as the source to offset their State fiscal contributions to the Australian Government's debt reduction program, which was agreed at the 1996 Premiers' Conference. **c** CSHA expenditure in the three years from 2000-01 to 2002-03 contained $89.7 million of goods and services tax — GST compensation paid to State and Territory governments. No GST compensation is included in 2003-04 expenditure.

Source: CSHA (1999); DFaCS (1999, 2000b); DFaCS (various years), Housing Assistance Act Annual Report; DFaCS (unpublished); table 16A.74.

Public housing is the largest form of assistance provided under the CSHA. Given the capital intensive nature of public housing, assistance additional to annual funding is provided through the use of $54 billion of housing stock owned by housing authorities in 2002-03 (calculated from 2002-03 State and Territory financial statements). Reduced funding in any given year may not necessarily result in a decline in the level of housing stock provided for that year, although it may affect levels of maintenance and the ability to reconfigure stock, and may result in fewer dwelling constructions or acquisitions.

Nationally, total government recurrent expenditure on public housing per person in the population was approximately $81 in 2003-04. Across jurisdictions, it ranged from $283 in the NT to $46 in Victoria in 2003-04. Including annualised capital costs, total government expenditure on public housing per person ranged from $1004 in the ACT to $234 in Victoria. Average total government expenditure on public housing per person nationally was $331.

It is important to note the differences in housing assistance operations across jurisdictions when discussing expenditure per person on public housing. It is also important to note that the per person data could have been influenced by historic arrangements (such as previous years' investment) that might have influenced the overall size of the public housing sector relative to the size of the population. Recurrent expenditure per dwelling can be used to overcome this data issue. Recurrent expenditure per dwelling in 2003-04 ranged from $9992 in the NT to $3465 in Victoria. Including capital costs, the recurrent expenditure per dwelling ranged from $29 090 in the ACT to $12 031 in SA. Table 16.1 also includes CRA per income unit to indicate the overall level of government assistance. CRA per income unit varied from to $2116 in Queensland to $1964 in the NT (table 16.1).

Table 16.1 **Government housing assistance, 2003-04 ($ million)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Government expenditure on public housing[a]									
Per person									
Recurrent	89	46	56	75	139	146	265	283	81
Recurrent including capital costs[b]	437	234	234	244	368	301	1004	594	331
Per dwelling									
Recurrent	4 784	3 465	4 365	4 646	4 560	5 970	7 667	9 992	4 652
Recurrent including capital costs[b]	23 402	17 717	18 105	15 112	12 031	12 314	29 090	20 959	19 056
CRA expenditure[c]									
Per income unit	2 107	2 058	2 116	2 060	2 021	1 974	2 000	1 964	2 083

[a] Expenditure for community and State owned and managed Indigenous housing is not included. Payroll tax is excluded. [b] These numbers are not comparable to those in the 2002 Report because interest payments from capital costs were excluded to avoid double counting. It was not possible to avoid this double counting in previous reports. [c] Actual expenditure on CRA is monitored only at a national level. Estimated expenditure at the State and Territory level has been derived by apportioning actual expenditure between states and territories based on the distribution of regular payments.

Source: AIHW (2004c); DFaCS (unpublished); State and Territory governments (unpublished); table 16A.81.

Size and scope

Housing assistance is provided in various forms, and models for delivering assistance can vary within and across jurisdictions. The main forms of assistance are outlined in box 16.2. This chapter focuses on four forms of assistance: public housing, community housing, State owned and managed Indigenous housing, and CRA.

Box 16.2 **Forms of housing assistance**

There are several main forms of CSHA housing assistance.

- *Public housing*: dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation. The CSHA is the main source of grant funding for public housing, data with internally generated rental revenues and the proceeds of asset sales.
- *Community housing*: rental housing provided for low to moderate income or special needs households, managed by community-based organisations that are at least partly subsidised by government. Community housing models vary across jurisdictions.
- *Indigenous housing*: State owned housing targeted at Indigenous households (referred to as 'State owned and managed Indigenous housing' in this report) and houses owned or leased and managed by Indigenous community housing organisations and community councils in major cities, regional and remote areas
- *Crisis accommodation*: accommodation services to help people who are homeless or in crisis. Services are generally provided by non-government organisations and many are linked to support services funded through SAAP. Sources of government funding include the Crisis Accommodation Program of the CSHA, which provides funding for accommodation, and SAAP funding for live-in staff, counselling and other support services.
- *Home purchase assistance*: assistance provided by State and Territory governments to low to moderate income households to help with first home purchases or mortgage repayments
- *Private rental assistance*: assistance funded by State and Territory governments to low income households experiencing difficulty in securing or maintaining private rental accommodation. This assistance may include ongoing or one-off payments to help households meet rent payments, one-off payments for relocation costs, guarantees or loans to cover the cost of bonds, and housing assistance advice and information services. Assistance may be provided by community-based organisations funded by government.
- The chapter also reports on CRA, which is a non-taxable income support supplement paid by the Australian Government to income support recipients or people who receive more than the base rate of the Family Tax Benefit Part A and who rent in the private rental market.

Source: CSHA (2003); DFaCS (2003).

Public housing

Public housing comprises those dwellings owned (or leased) and managed by State and Territory housing authorities. The CSHA is the main source of funding for

public housing. A total of 336 238 public housing dwellings were occupied at 30 June 2004. Public housing is available to people on low incomes and those with special needs. Although people with a disability represented 20 per cent of the total population in 2003, 40.8 per cent of public housing allocations during 2001-02 were to people with a disability (ABS 2004; AIHW 2003h).[3]

Public housing rents are generally set at market levels, and rebates are granted to low income tenants (so they generally pay no more than 25 per cent of their assessable income in rent), to provide affordable housing. Public housing allocations are constrained by the amount of housing stock available and are income tested. The proportion of total households residing in public housing in 2001 ranged from 8.6 per cent in the ACT to 3.2 per cent in Victoria (table 16A.70). Information on the proportion of income paid in rent by public housing tenants is contained in table 16A.75.

Community housing

Community housing is generally managed by not-for-profit organisations or local governments, which perform asset and tenancy management functions. A major objective of community housing is to increase social capital by encouraging local communities to take a more active role in planning and managing appropriate and affordable transitional and long term rental accommodation. Community housing is also intended to provide a choice of housing location, physical type and management arrangements. Some forms of community housing also allow tenants to participate in the management of their housing.

The community housing programs aim to achieve links between housing and services that are best managed at the community level, including services for people with a disability, and home and community care. Notwithstanding their common objectives, community housing programs vary within and across jurisdictions in their administration and types of accommodation (box 16.3).

[3] Disability is defined as any restriction or lack of ability (resulting from an impairment) to perform an action in the manner or within the range considered normal for a human being.

Box 16.3 **Models of community housing**

Community housing models vary across jurisdictions in terms of their scale, organisational structure and financing arrangements, and the extent to which the community or government has management responsibility and ownership of the housing stock. Table 16A.71 lists the relevant community housing programs in each jurisdiction.

Some community housing models are:

- *regional or local housing associations,* whereby the associations provide property and tenancy management services, and community groups provide support services to tenants
- *joint ventures and housing partnerships,* whereby a range of church, welfare, local government agencies and other organisations provide resources in cooperation with State and Territory government organisations
- *housing cooperatives*, which are responsible for tenant management and maintenance, while government, a central finance company or an individual cooperative owns the housing stock
- *community management and ownership,* whereby not-for-profit or community housing associations both own and manage housing
- *local government housing associations,* which provide low cost housing within a particular municipality, are closely involved in policy, planning, funding and/or monitoring roles, and may directly manage the housing stock
- *equity share rental housing,* whereby housing cooperatives wholly own the housing stock and lease it to tenants (who are shareholders in the cooperative and, therefore, have the rights and responsibilities of cooperative management).

Source: State and Territory governments (unpublished).

Funding for community housing is typically either fully or partly provided by governments to not-for-profit organisations or local governments. Australian Government funding for community housing amounted to 6.9 per cent ($64.0 million) of total CSHA funding provided by the Australian Government in 2003-04 (DFaCS unpublished). There were 26 753 CSHA community housing dwellings in Australia at June 2004,[4] or 7.2 per cent of the total public and community housing stock supported under the CSHA (table 16.6).

[4] Data are based on survey results except for the NT. Results, therefore, are affected by survey non-response.

Indigenous housing

Government funded Indigenous housing includes both State managed and community managed housing. The State managed component is generally funded by the ARHP and may be supplemented by untied CSHA funds and State matching funds. Community managed Indigenous housing may be financed from ARHP funds, supplementary State funds, untied CSHA funds, ATSIS/ATSIC funds and funds from other sources.

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 to only Indigenous Australians (AIHW 2004d).[5] They include dwellings managed by government Indigenous housing agencies for allocation to Indigenous tenants. There were 12 725 dwellings identified in the 2003-04 State owned and managed Indigenous housing collection (table 16A.27).

State owned and managed Indigenous housing is only one of a number of programs designed to provide housing assistance to Indigenous people. Indigenous Australians are eligible for assistance under Indigenous community managed housing (where community agencies carry out tenancy management functions), the mainstream public and community housing programs, CRA and other government housing programs (both Indigenous specific and mainstream). At 30 June 2004 there were 27 CSHA funded community housing providers that nominated Indigenous people as their primary target group.

The ACT and the NT are not included in the State owned and managed Indigenous housing data collection. The ACT does not receive funding for, or administer, any Territory owned and managed Indigenous housing programs; in the NT, ARHP funding is directed to community managed Indigenous housing. All Indigenous housing programs in the NT are community managed and administered, and specific management issues (such as eligibility and waiting lists) are the responsibility of Indigenous housing organisations that manage permanent dwellings for people in discrete Indigenous communities. The approaches of these organisations may differ significantly, depending on the size of the organisations, the socioeconomic circumstances of particular communities, and cultural considerations. The Indigenous Housing Authority of the NT allocates funds to the seven ATSIS/ATSIC regional councils in the NT, which in turn allocate funds to

[5] The territories are not included in the data collection for this program, so are not included in the section heading.

those communities most in need. The NT government cannot differentiate between the various funding sources, given its commitment under the CSHA Indigenous Agreement to 'pool' all funds earmarked for Indigenous housing and associated infrastructure in the NT.

In NSW, a separate statutory organisation — the Aboriginal Housing Office — is responsible for planning, administering and expanding policies, programs and the asset base for Aboriginal housing in that State. Funding for the office comes from the CSHA, ATSIS/ATSIC and the State Government (in addition to its CSHA commitments).

Some other jurisdictions are increasingly pooling funding but currently report State owned and managed Indigenous housing data separately. Queensland administers a separate Aboriginal and Torres Strait Islander Housing Program, which includes ARHP funds, untied CSHA funds and State funds, and does not report separately against the ARHP component of the program funds (which forms more than one third of total expenditure).

Indigenous community housing

In August 2003 the Housing Ministers Advisory Committee (HMAC) endorsed the National Reporting Framework as the performance indicator framework that would be used to report against both Indigenous community housing and State owned and managed Indigenous housing. The framework includes the State owned and managed Indigenous housing indicators used in this Report.

A national report against a subset of the National Reporting Framework was produced in 2002-03. It was based on data from the 2001 Census, the 2001 ATSIC/ABS Community Housing and Infrastructure Needs Survey (CHINS), CSHA administrative data and additional information provided by states and territories. The 2003-04 report (in preparation) provides national data on a larger number of National Reporting Framework indicators, with less reliance on the Census and CHINS. Consideration is being given to reporting on the National Reporting Framework for Indigenous community housing in future editions of the Report on Government Services.

The data from the ATSIC/ABS CHINS (ABS 2002b) are reported again. The CHINS data provide a snapshot of the sector, covering housing managed by Indigenous community housing organisations, including discrete community councils. Readers should not compare CHINS data and State owned and managed Indigenous housing data. The former is a survey of communities, while the latter are based on household level administrative data. The data from CHINS were collected

between March and June 2001, to provide information on all discrete Indigenous communities and Indigenous organisations that provide housing to Indigenous people in urban, rural and remote locations in most states and territories. The response rate was 98.1 per cent for discrete Indigenous communities and 98.6 per cent for Indigenous housing organisations. Trained ABS officers collected information via personal interviews with key community and Indigenous housing organisation representatives. Some results from CHINS are reported in attachment tables 16A.38–16A.41.

Commonwealth Rent Assistance

Commonwealth Rent Assistance (CRA) is a non-taxable supplementary payment to help with the cost of private rental housing. It is available to recipients of income support payments, including those who receive more than the base rate of the Family Tax Benefit Part A and who pay private rent above minimum thresholds. Private rent includes rent paid under both formal tenancy agreements and informal arrangements, such as board and lodgings paid to a family member. It also includes mooring and site fees (for boats and caravans) and payments for retirement village services. Community housing tenants may also be eligible for CRA.

Commonwealth Rent Assistance is paid at 75 cents for every dollar above the threshold until a maximum rate is reached. The maximum rates and thresholds vary according to a client's family situation and number of children (table 16.2). For single people without dependent children, the maximum rate may also vary according to whether accommodation is shared with others. Rent thresholds and maximum rates are indexed twice per year (March and September) to reflect changes in the consumer price index.

Because CRA is a national payment, the DFaCS seeks to ensure CRA clients who have the same household characteristics and who pay the same amount of rent receive the same amount of assistance wherever they live. There were 949 698 income units (where an income unit is defined as either a single person or a couple with or without dependents)[6] receiving CRA at 11 June 2004 (table 16.22). The maximum rate of assistance was received by 62.4 per cent of CRA recipients at 6 March 2004 (table 16A.59). This outcome and the national payment objective of CRA resulted in little variation in the average level of assistance across locations at 6 March 2004 (table 16A.58), even though rents varied considerably by location. At

[6] Dependents are defined as young persons for whom the person or partner receives the Family Tax Benefit. The benefit is not payable for children receiving Youth Allowance or any other income security payment. Children aged over 16 years for whom the Family Tax Benefit is not payable are regarded as separate income units.

6 March 2004, the average payment across Australia was $77 per fortnight (approximately $2014 per year). On a capital city/rest of State or Territory basis, Sydney had the highest average CRA payment ($80 per fortnight). Excluding other Australian territories, non-capital city SA had the lowest average CRA payment ($73 per fortnight) (table 16A.58).

Table 16.2 **Eligibility and payment scales for CRA, 2004 ($ per fortnight)[a, b]**

Income unit type [c]	*Minimum rent to be eligible for CRA*	*Minimum rent to be eligible for maximum CRA*	*Maximum CRA*	*Average CRA paid*
Single, no dependent children[d]	84.80	212.00	95.40	76.14
Single, no children, sharer	84.80	169.60	63.60	55.20
Couple, no dependent children	138.20	258.47	90.20	73.86
Single, one or two dependent children	111.72	261.24	112.14	86.43
Single, three or more dependent children	111.72	280.65	126.70	100.23
Partnered, one or two dependent children	165.34	314.86	112.14	84.72
Partnered, three or more dependent children	165.34	334.27	126.70	94.86
Partnered, illness separated, no dependent children	84.80	212.00	95.40	95.24
Partnered, temporarily separated, no dependent children	84.80	205.07	90.20	93.32

a At 11 June. Average fortnightly CRA is for 6 March 2004. **b** Income units are analogous to family units except that non-dependent children and other adults are treated as separate income units (see section 16.6 for more detail). Rates of assistance depend on the number of dependent children aged under 16 years for whom the Family Tax Benefit is paid at more than the basic rate. **c** A child is regarded as dependent on an adult only if the adult receives the Family Tax Benefit for the care of the child. **d** The maximum rate of assistance is lower for some single persons without dependent children who share accommodation. (For a definition of 'sharer' see section 16.6.)

Source: DFaCS (unpublished); table 16A.42.

Diversity of State and Territory housing assistance operations

State and Territory governments have similar broad objectives for providing housing assistance. Individual jurisdictions, however, emphasise different objectives depending on their historical precedents and ways of interacting with community sector providers. Jurisdictions also face differing private housing markets. These differences lead to a variety of policy responses and associated

assistance products. It is important to be aware of all the housing assistance operations in each State and Territory when analysing performance information.

Appendix A contains information on each State and Territory that may help in interpreting the performance indicators presented in this chapter. State and Territory governments have provided the following additional information on the key operating parameters characterising housing assistance provision in their jurisdictions.

Public housing

Eligibility criteria for access to public housing, such as income and asset definitions and limits, vary across jurisdictions. In most cases, jurisdictions require that applicants must be Australian citizens or permanent residents and must not own or part own residential property. All jurisdictions require eligible applicants to be resident in the respective State or Territory. All State and Territory governments prioritise access to public housing by segmenting their waiting lists in some way. Segments are defined differently across jurisdictions, but generally reflect urgent need/homelessness and an inability to access appropriate private market accommodation. Most jurisdictions provide security of tenure after an initial probationary period. Most jurisdictions also have periodic reviews of eligibility to ensure that tenants are meeting the other terms of their tenancy agreement. Rebated rents in all jurisdictions are based on the majority of households paying no more than 25 per cent of their assessable income in rent (the rent-to-income ratio). Definitions of assessable income vary across jurisdictions (table 16.3).

Table 16.3 **Public housing policy context, 2004[a]**

	NSW[b]	*Vic*[c]	*Qld*[d]	*WA*[e]	*SA*[f]	*Tas*[g]	*ACT*	*NT*[h]
Eligibility								
Income limit per week ($)[i]	395	339	582	390	585	336	483	529
'Other' asset limits ($)[i]	None	30 000	None	36 400 cash	257 500	34 473	40 000 liquid assets	38 100
Minimum age	18	15	18	18	None	16	16	None
Waiting list[j]								
Segmented by:	Wait turn and priority (five segments)	Priority (four segments)	Priority (two segments)	Priority (three segments)	Need (four segments)	Need (four segments)	Priority (four segments)	Priority (two segments)
Tenure								
Probationary period	1 year then 3 years then 3 years	None	None	None	6 months	3–6 months	None	3–6 months
Fixed term	3 or 6 months	5 years	6 months	3 months	None	1–3 years	None	2 year then 5 year
Ongoing	Ongoing after probation	Lifetime after age 65	Yes	Ongoing	Ongoing after probation	In some cases, particularly older persons	Lifetime tenure	None
Tenancy review	Reviewed at end of each term	To commence in 2008	None	Annual	None	Fixed term leases reviewed at end of each term	None	Prior to each new lease

(Continued on next page)

Table 16.3 **Continued**

	NSW[b]	*Vic*[c]	*Qld*[d]	*WA*[e]	*SA*[f]	*Tas*[g]	*ACT*	*NT*[h]
Rebated rent setting								
Rent-to-income ratio	25	25	25	23 or 25	25	23–25	25	18 or 23

[a] At 30 June. [b] Interest accrued from cash assets is assessed as income. Applicants under the age of 18 years must demonstrate living skills to be eligible for housing. Since November 2002, NSW has introduced renewable tenancies to all public housing tenants. A fixed term may be offered to clients who have an urgent, short term need for housing but do not meet housing eligibility criteria. Fixed term tenancies are also offered to unsatisfactory former tenants and less than satisfactory former tenants, to establish their current ability to sustain a successful tenancy. For rebated rents, varied concessional rates are applicable to certain sources of income. [c] For households that require major disability modifications, the asset limit is $60 000. [d] While no formal eligibility review exists, it is an ongoing requirement for clients to meet property ownership limitations. [e] Income limit for those in north west remote areas is $550 per week. Those aged over 60 years are subject to a cash asset limit of $80 000. A rent-to-income ratio of 23 per cent can apply for groups such as seniors, people with disabilities and people living in remote locations. [f] The same definition as the Centrelink asset test threshold at 30 June 2004 for a single person who does not own their own home is used. Most households pay a rent-to-income ratio of 25 per cent of assessable income in rent, except aged residents in cottage flat and bedsitter flat accommodation (for whom the ratio is 19 per cent and 17 per cent respectively) and households receiving less than the single Newstart Allowance (for whom the ratio is 19.5 per cent).[g] For people aged over 55 years, the asset limit is $35 000. [h] While the NT does not have a minimum age, people must be over 16 years to enter into a tenancy agreement under the *Residential Tenancies Act.* The rent-to-income ratio is 18 per cent for aged pension recipients. [i] Limits are for a single person. [J] Two segment lists generally consist of 'priority' and 'wait turn'.

Source: State and Territory governments (unpublished).

The proportion of public housing tenants in receipt of a rebated rent at 30 June is shown in table 16.4.

Table 16.4 **Public housing — rebated rents, 2004 (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Tenants in receipt of rebated rent	90.0	87.6	84.0	90.0	84.4	82.9	85.0	90.0	87.6

a At 30 June.

Source: AIHW (2004c); table 16A.1.

The proportion of public housing located in regional and remote areas using the Australian Standard Geographical Classification remoteness area structure (ASGC remoteness areas) is shown in table 16.5.

Table 16.5 **Public housing — regional and remote area concentrations, 2004 (per cent)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major cities	80.4	71.8	61.7	69.9	76.9	..	99.9	..	71.3
Regional[c]	19.2	28.1	36.0	19.5	21.1	99.1	0.1	68.3	26.5
Remote[d]	0.4	–	2.4	10.6	1.9	0.9	..	31.7	2.2

a At 30 June. **b** Under ASGC remoteness areas. **c** Comprises inner and outer regional areas. **d** Comprises remote and very remote areas. – Nil or rounded to zero. **..** Not applicable.

Source: AIHW (2004c); table 16A.1.

Community housing

Eligibility criteria for community housing are generally consistent with those for public housing in each jurisdiction. Most jurisdictions do not require community housing organisations to segment waiting lists. Community housing dwellings as a proportion of total public and community housing dwellings at June 2004 are shown in table 16.6.

Table 16.6 **Community housing dwellings as a proportion of all public and community housing dwellings, 2004 (per cent)[a, b, c]**

NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
7.1	5.3	9.6	10.1	7.9	3.3	3.5	1.7	7.2

a At 30 June. **b** Based on survey data provided for all but the NT (which is based on administrative data), these results are affected by survey non-response. **c** Excluding Crisis Accommodation Program dwellings and the Victorian Transitional Housing Management program.

Source: AIHW (2004b; 2004e); table 16A.15.

For the data that are available, the proportions of community housing located in regional and remote areas using (ASGC remoteness areas) are shown in table 16.7.

Table 16.7 **Community housing — regional and remote area concentrations, 2004 (per cent)[a, b]**

	NSW[c]	*Vic*[d]	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major cities	71.5	62.5	36.4	56.9	86.3	..	100.0	..	61.8
Regional[e]	28.1	37.0	52.2	28.7	12.6	99.3	–	61.9	32.8
Remote[f]	0.4	0.6	11.4	14.4	1.0	0.7	..	38.1	5.4

a At 30 June. **b** Under the ASGC remoteness areas. **c** Postcode data are available to the Office for capital properties and a small number of leasehold properties (for example, Long Term Leasing Program and Surplus Government Leasehold Program). **d** In Victoria, the interpretation of the definition of a 'dwelling' varied for providers. Some larger agencies also advised that they were unable to provide tenancy units by postcode. For consistency and accuracy, properties have been counted by postcode from the internal administrative system, so the dwelling postcode count will not match the number of tenancy units because group housing program arrangements have multiple tenancies per property. **e** Comprises inner and outer regional areas. **f** Comprises remote and very remote areas. – Nil or rounded to zero. **..** Not applicable.

Source: AIHW (2004b); table 16A.15.

State owned and managed Indigenous housing

Eligibility criteria for access to State owned and managed Indigenous housing are generally consistent with those for public housing once an applicant has been confirmed as Indigenous. Queensland is an exception, having no income or age eligibility limits on State owned and managed Indigenous housing. The management of waiting lists varies across jurisdictions — for example, a number of jurisdictions use the same list for both State owned and managed Indigenous housing and public housing. Terms of tenure are the same as those for public housing for a number of jurisdictions (table 16.8).

Table 16.8 **State owned and managed Indigenous housing policy context, 2004**[a]

	NSW[b]	*Vic*[c]	*Qld*[d]	*WA*[e]	*SA*[f]	*Tas*[g]
Eligibility						
Income limit per week ($)[h]	395	339	None	390	585	336
'Other' asset limits ($)[h]	None	30 000	None	36 400 in cash	257 500	34 473
Minimum age	18	15	None	18	None	16
Waiting list						
Details	Combined with public housing	Combined with public housing	Wait turn	Combined with public housing	Need (Four segment)	Priority, similar to public housing
Tenure						
Probationary period	None	None	None	None	6 months	3–6 months
Fixed term	3 or 6 months	5 years	None	3 months	None	1–3 years
Ongoing	Yes	Lifetime after age 65	Yes	Ongoing	Ongoing after probation	Dependant on housing history
Tenancy review	Not regularly	To commence in 2008	None	Annual	None	Fixed term leases reviewed at end of each term

a At 30 June. **b** Interest accrued from cash assets is assessed as income. Applicants under the age of 18 years must demonstrate living skills to be eligible for housing. Since November 2002, NSW has introduced renewable tenancies to all public housing tenancies. A fixed term may be offered to clients who have an urgent, short term need for housing but do not meet housing eligibility criteria. Fixed term tenancies are also offered to unsatisfactory former tenants and less than satisfactory former tenants to establish their current ability to sustain a successful tenancy. Tenancies are reviewed as part of normal tenancy management processes. **c** For households that require major disability modifications, the asset limit is $60 000. Indigenous households generally access long term accommodation through the General Rental program or housing managed by the Aboriginal Housing Board of Victoria. **d** Ten per cent of applicants can be housed ahead of turn in urgent circumstances. While no formal eligibility review exists, it is an ongoing requirement for clients to meet property ownership limitations. **e** The income limit for those in north west remote areas is $550 per week. Those aged over 60 years are subject to a cash asset limit of $80 000. **f** The same definition as the Centrelink asset test threshold at 30 June 2004 for a single person who does not own their own home is used. Includes 21 indigenous households with other special needs (including youth, disability, aged etc.). **g** For people aged over 55 years the asset limit is $35 000. Applications outside the guidelines may be considered where there are extenuating circumstances in relation to income, asset and age criteria. **h** Limits are for a single person.

Source: State and Territory governments (unpublished).

The proportions of State owned and managed Indigenous housing located in regional and remote areas (using ASGC remoteness areas) are shown in table 16.9.

Table 16.9 **State owned and managed Indigenous housing — regional and remote area concentrations, 2004 (per cent)[a, b]**

	NSW[c]	*Vic*[d]	*Qld*	*WA*	*SA*	*Tas*	*Aust*
Major cities	40.9	37.7	12.9	29.1	60.6	..	34.1
Regional[e]	51.9	61.9	59.6	30.3	25.6	100.0	48.0
Remote[f]	7.2	0.4	27.6	40.7	13.8	–	17.9

a At 30 June. **b** Under the ASGC remoteness areas. **c** The number of properties in NSW classified by ASGC is less than the total number of properties reported elsewhere. **d** In Victoria, the interpretation of the definition of a 'dwelling' varied for providers. Some larger agencies also advised they were unable to provide tenancy units by postcode. For consistency and accuracy, properties have been counted by postcode from the internal administrative system, so the dwelling postcode count will not match the number of tenancy units because group housing program arrangements have multiple tenancies per property. **e** Comprises inner and outer regional areas. **f** Comprises remote and very remote areas. – Nil or rounded to zero. **..** Not applicable.

Source: AIHW (2004a); table 16A.27.

Private rental markets

Capital city vacancy rates in the private rental market at June 2004 ranged from 6.0 per cent in Darwin to 1.5 per cent in Adelaide. Tight private rental markets (vacancy rates below 3.0 per cent) were evident in Brisbane, Adelaide and Hobart (table 16A.68). Capital city median rents for three bedroom houses at June 2004 were highest in Canberra at $290 per week and lowest in Perth at $186 per week. For two bedroom flats or units, median rents ranged from $280 per week in Sydney to $149 per week in Perth (table 16A.69).

16.2 Framework of performance indicators

Public, community and State owned and managed Indigenous housing adopt a common performance indicator framework based on the framework developed for the 1999 CSHA (which ran from 1 July 1999 to 30 June 2003) (figures 16.2, 16.3 and 16.4). The CSHA framework reflects the national objectives of the agreement to improve the quality of national performance information and to recognise the need for balanced reporting at the national and bilateral levels as outlined in a number of guiding principles (CSHA 1999).

The new CSHA took effect on 1 July 2003 and will run until 30 June 2008 (box 16.4). Many aspects of this agreement, including the aims and objectives, are similar to those of the previous agreement. The new CSHA places greater emphasis on Australian, State and Territory governments improving housing outcomes for Indigenous people. Governments will work towards improving access to

mainstream housing options for Indigenous people living in urban and rural areas. This is the first year that data are reported under the new agreement. Work will be undertaken on the performance indicator framework to reflect changes in the new agreement and to improve the quality and scope of national performance information.

Box 16.4 **Objectives for public and community housing under the 2003 CSHA**

The principles guiding the 2003 CSHA are to:

1. maintain a core Social Housing sector to assist people unable to access alternative suitable housing options
2. develop and deliver affordable, appropriate, flexible and diverse housing assistance responses that provide people with choice and are tailored to their needs, local conditions and opportunities
3. provide assistance in a manner that is non-discriminatory and has regard to consumer rights and responsibilities, including consumer participation
4. commit to improving housing outcomes for Indigenous people in urban, rural and remote areas, through specific initiatives that strengthen the Indigenous housing sector and the responsiveness and appropriateness of the full range of mainstream housing options
5. ensure housing assistance links effectively with other programs and provides better support for people with complex needs, and has a role in preventing homelessness
6. promote innovative approaches to leverage additional resources into Social Housing, through community, private sector and other partnerships
7. ensure that housing assistance supports access to employment and promotes social and economic participation
8. establish greater consistency between housing assistance provision and outcomes, and other social and economic objectives of government, such as welfare reform, urban regeneration, and community capacity-building
9. undertake efficient and cost-effective management which provides best value to governments
10. adopt a cooperative partnership approach between levels of government towards creating a sustainable and more certain future for housing assistance
11. promote a national, strategic, integrated and long term vision for affordable housing in Australia through a comprehensive approach by all levels of government.

Source: CSHA (2003, p.4).

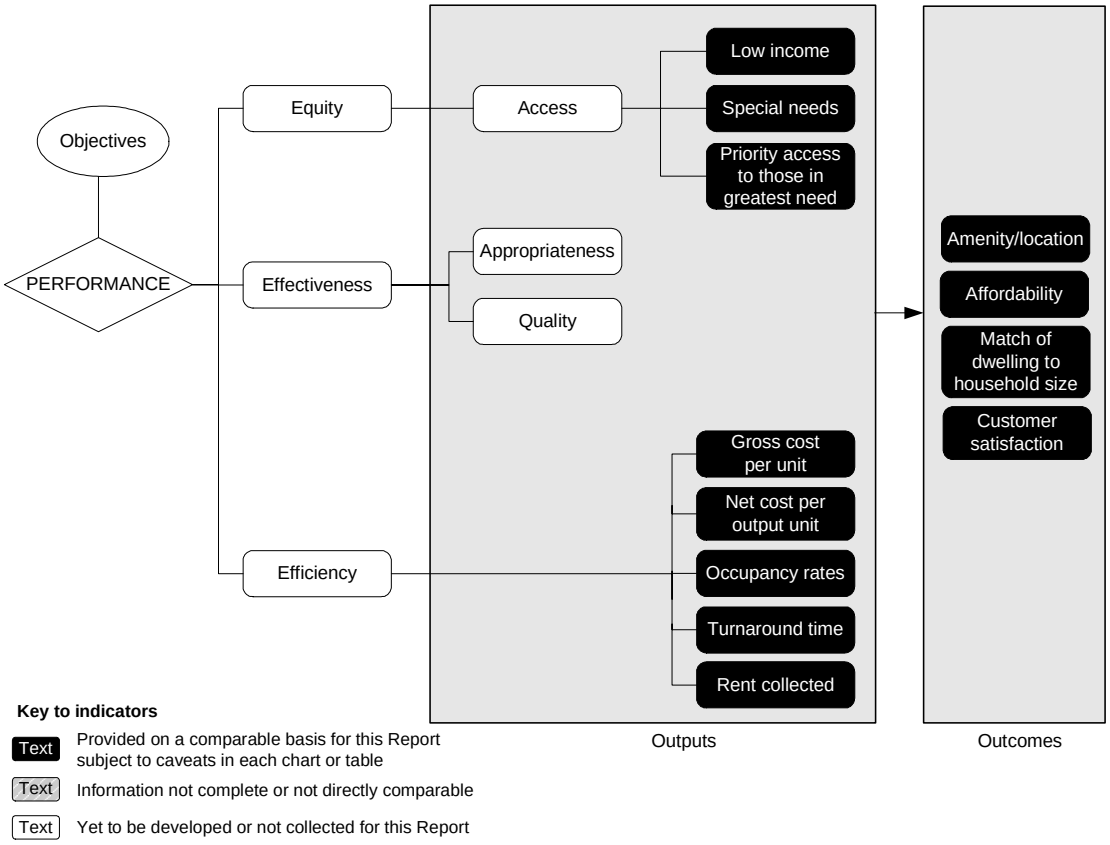
The performance indicator framework shows which data are comparable in the 2005 Report (figures 16.2, 16.3, 16.4 and 16.5). For data that are not considered

directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

The framework reflects the adoption by governments of accrual accounting and depicts the Review's focus on outcomes, consistent with demand by governments for outcome oriented performance information. The framework also accentuates the importance of equity and draws out the distinction between equity and access. More detail on the general report framework, along with the differences between outputs and outcomes, can be found in chapter 1.

Comparable public housing data are presented for the full range of indicators in the performance measurement framework (figure 16.2). It has not been possible, however, to obtain nationally comparable performance information for community housing given current data standards and data collection capacity (figure 16.3).

Figure 16.2 **Performance indicators for public housing**



While public, community and State owned and managed Indigenous housing use a common framework, the delivery method for community housing differs from that for public and State owned and managed Indigenous housing. Community organisations and sometimes local government deliver community housing, while

State and Territory governments deliver public and State owned and managed Indigenous housing. The performance indicator framework for State owned and managed Indigenous housing is shown in figure 16.4.

Figure 16.3 **Performance indicators for community housing**

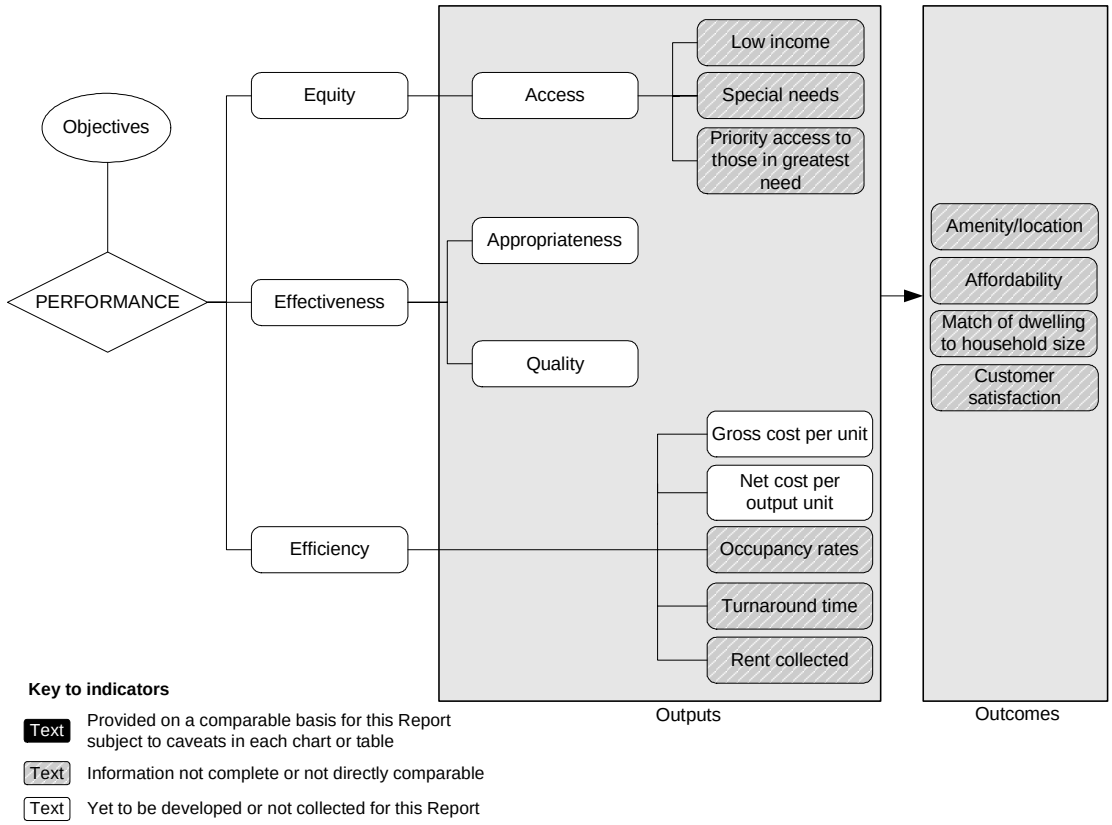
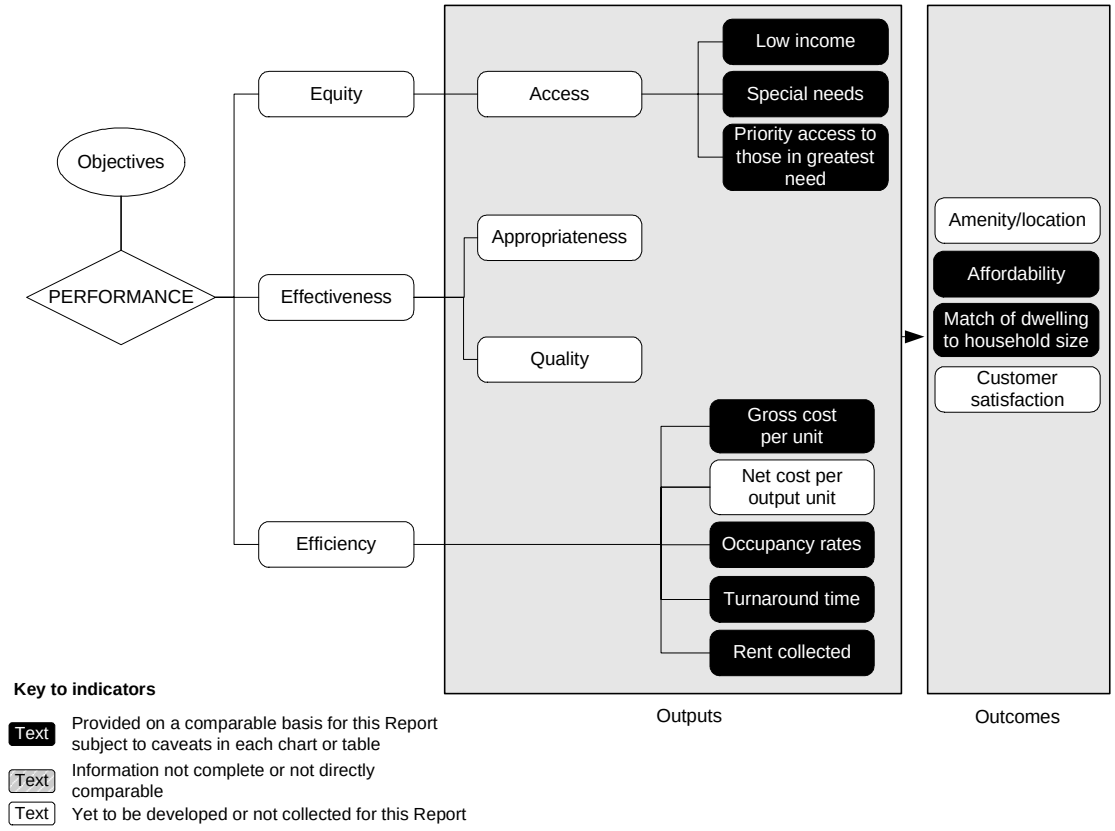


Figure 16.4 **Performance indicators for State owned and managed Indigenous housing**

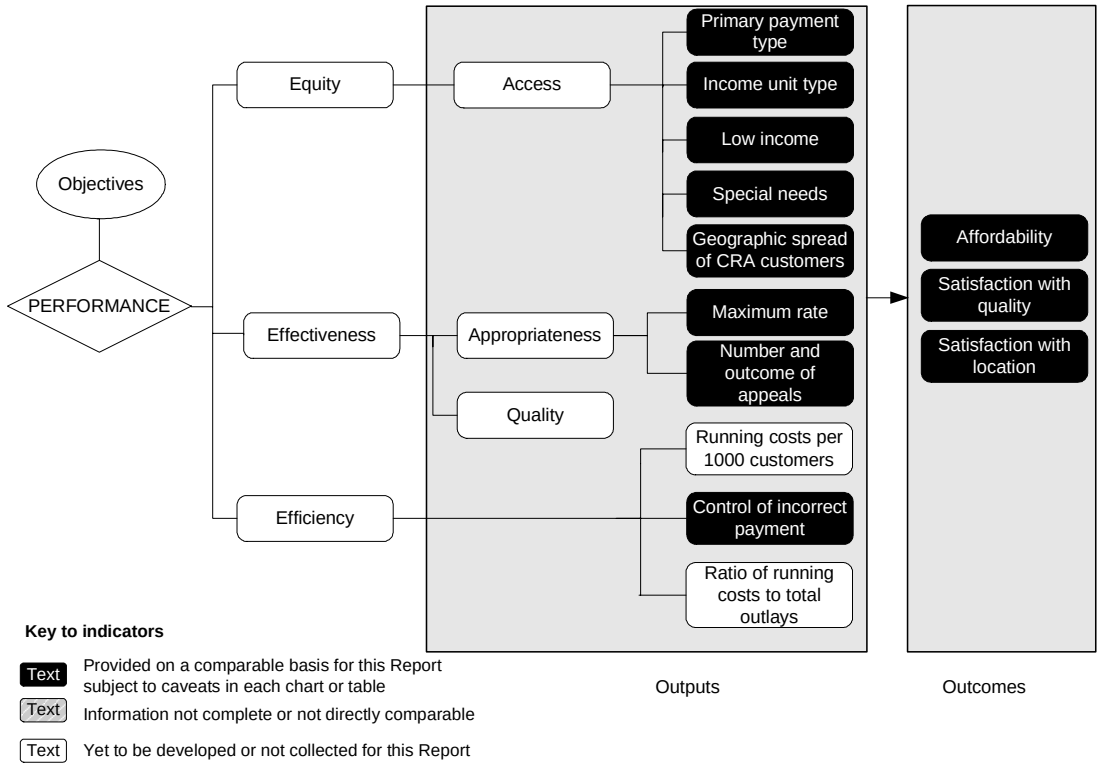


The performance indicators for CRA differ from those for public, community and State owned and managed Indigenous housing because CRA has different objectives and delivery methods. Reporting for CRA uses a performance indicator framework (figure 16.5) based on the CRA objective outlined in box 16.5. All indicators are defined in section 16.6.

Box 16.5 **Objective of CRA**

The objective of CRA is to provide income support recipients and low income families in the private rental market with additional financial assistance, in recognition of the housing costs that they face (Newman 1998). This assistance should be provided in an equitable and efficient manner. CRA is also governed by other objectives relating to the primary income support payment.

Figure 16.5 **Performance indicators for CRA**



16.3 Key performance indicator results

Performance indicator results are not comparable across the public, community and State owned and managed Indigenous housing sections because data quality and coverage can differ. More information on indicator definitions are provided in each indicator section.

Public housing

Different delivery contexts, locations and types of client may affect the performance of public housing reported in this chapter. Care thus needs to be taken in interpreting performance indicator results, and the qualifications presented with the data need to be considered. Some descriptive information on public housing can be found in table 16A.1.

Outputs

Equity — low income

The first equity indicator reported for public housing is 'low income' (box 16.6).

Box 16.6 **Low income**

'Low income' is included as an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing.

It measures three low income components:

- new low income households as a proportion of all new households
- new low income households plus special needs (not low income) households, as a proportion of all new households
- households paying less than market rent and special needs households paying market rent, as a proportion of all households (new and existing).

Special needs households are those that have either a household member with a disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members.

The two household income measures for the purpose of this indicator are:

- low income A households — households where all members receive an income equivalent to or below 100 per cent of the government income support benefits at the pensioner rate (pension rates have been selected for calculating this indicator because they are higher than allowance rates)
- low income B households — households with an income above 100 per cent of the government income support benefits at the pensioner rate, but below the effective cut-off for receiving any government support benefits.

Households with incomes below these levels are included in the measure, although they may not necessarily receive income support benefits.

High values for the three measures indicate high degrees of targeting of low income (and special needs) households.

The proportion of new tenancies allocated to low income A households in 2003-04 ranged from 94.7 per cent in NSW to 87.5 per cent in SA. The proportion of new tenancies allocated to low income A plus special needs (not low income) households varied from 97.0 per cent in NSW to 91.3 per cent in the ACT

(table 16.10). Information on both low income A and low income B households is contained in table 16A.2.

Table 16.10 **Public housing — low income and special needs households as a proportion of all new households (per cent)[a]**

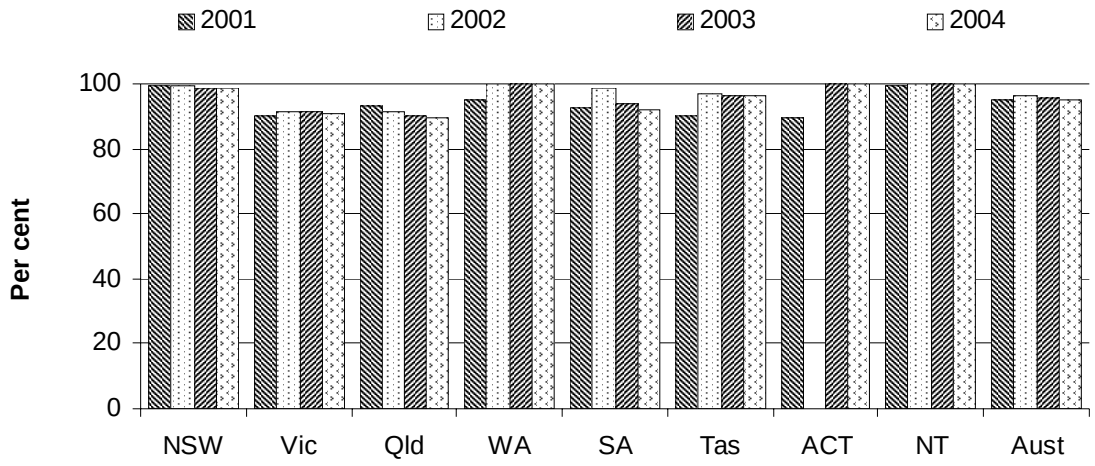
	NSW[b,c]	*Vic*[b,d]	*Qld*[b]	*WA*[d]	*SA*[b]	*Tas*[d]	*ACT*[d]	*NT*[d]	*Aust*
New low income A households									
2000 01	94.1	86.1	90.0	85.8	89.3	84.6	np	83.6	89.5
2001-02	94.6	93.0	90.4	83.8	89.7	93.1	92.0	87.0	91.4
2002-03	92.9	90.4	90.3	86.8	89.6	90.6	88.9	87.4	90.4
2003-04	94.7	92.4	90.5	87.9	87.5	89.1	87.7	87.6	91.2
New low income A households plus special needs (not low income) households									
2000-01	97.3	90.6	93.4	89.7	94.6	85.9	np	np	93.3
2001-02	97.4	95.6	93.7	89.5	94.2	96.2	94.3	93.4	94.9
2002-03	96.1	94.0	93.3	91.9	94.1	94.2	84.0	92.1	93.9
2003-04	97.0	95.6	94.5	92.7	93.5	94.4	91.3	93.9	95.0

a For details of newly allocated: mixed composition, non-rebated and other households excluded, see table 16A.82. **b** Data for NSW, Victoria, Queensland and SA are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for NSW, Victoria, Queensland and SA cannot be made. For details of these changes, see the NSW, Victoria, Queensland and SA footnotes in table 16A.2. **c** Data for NSW for 2003-04 are based on different a methodology from that used for other data presented and needs to be interpreted with caution. For details of these variations, see the NSW footnote in table 16A.2. **d** Data for Victoria, WA, Tasmania, the ACT and the NT for 2003-04 are not comparable with the other data presented and cannot be directly compared with other jurisdictions' data. For details of non-comparability, see the Victoria, WA, Tasmania, ACT and NT footnotes in table 16A.2. **np** Not published.

Source: AIHW (various years) CSHA National Data Reports: Public Rental Housing; table 16A.2.

At 30 June 2004, all households paying less than market rent and special needs households paying market rent as a proportion of all households (new and existing), ranged from 100.0 per cent in WA, the ACT and the NT to 89.5 per cent in Queensland (figure 16.6).

Figure 16.6 **Public housing — households paying less than market rent and special needs households paying market rent, as a proportion of all households (new and existing)[a, b, c, d, e]**



a At 30 June. **b** Data for NSW, WA and SA are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for NSW, WA and SA cannot be made. For details of these changes, see the NSW, WA and SA footnotes in table 16A.3. **c** Data for Victoria for 2003-04 are not directly comparable to the previous years' data, and any direct comparison of 2003-04 data with previous years for Victoria needs to be done with caution. For details of these changes, see the Victoria footnotes in table 16A.3. **d** Data for WA and the ACT for 2003-04 are not comparable with the other data presented and cannot be directly compared with other jurisdictions' data. For details of non-comparability, see the WA and ACT footnotes in table 16A.3. **e** Data for the ACT for 2002 were not available.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.3.

Equity — special needs

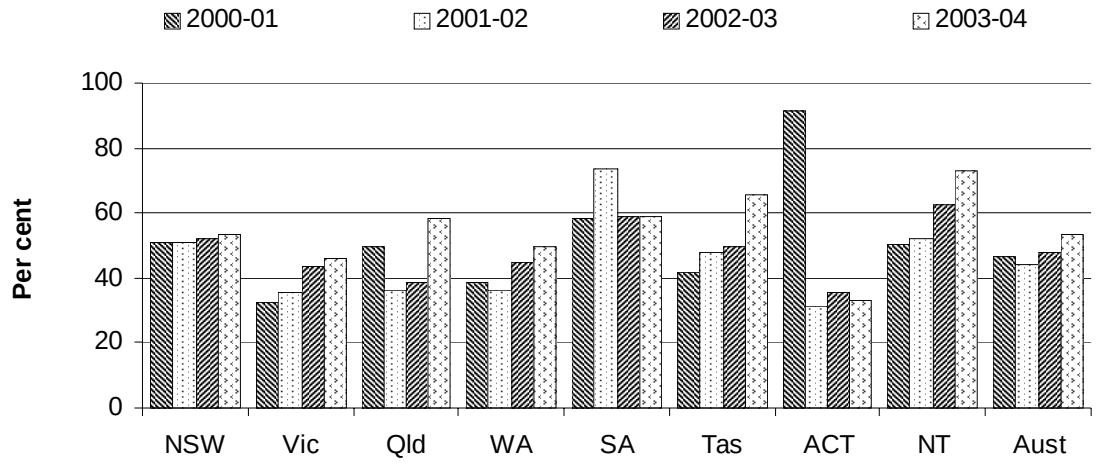
The second equity indicator reported for public housing is 'special needs' (box 16.7).

Box 16.7 **Special needs**

'Special needs' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures the proportion of new tenancies allocated to special needs households. New tenancies are reported as a proxy for all households receiving assistance. Special needs households are those that have either a household member with a disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members. A high proportion indicates a high degree of targeting of the special needs households.

In 2003-04, the proportion of new tenancies allocated to special needs households ranged from 73.0 per cent in the NT to 33.0 per cent in the ACT (figure 16.7).

Figure 16.7 **Public housing — new tenancies allocated to households with special needs[a, b, c]**



a Data for NSW, WA and SA for 2003-04 are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for NSW, WA and SA cannot be made. For details of these changes, see the NSW, Victoria, WA and SA footnotes in table 16A.4. **b** Data for Victoria and Queensland for 2003-04 are not directly comparable to the previous years' data, and any direct comparison of 2003-04 data with previous years for Victoria and Queensland needs to be done with caution. For details of these changes, see the Victoria and Queensland footnotes in table 16A4. **c** Data for WA, the ACT and the NT for 2003-04 are not comparable with the other data presented and should not be directly compared with other jurisdictions' data. For details of non-comparability, see the WA, ACT and NT footnotes in table 16A.4.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.4.

Equity — priority access to those in greatest need

The final equity indicator reported for public housing is 'priority access to those in greatest need' (box 16.8).

The proportion of new allocations to those in greatest need in 2003-04 varied from 89.7 per cent in Tasmania to 12.2 per cent in Queensland (table 16.11). Differences in State and Territory housing allocation policies can influence comparability.

Box 16.8 **Priority access to those in greatest need**

'Priority access to those in greatest need' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes are such that those in greatest need have first access to housing. It measures the proportion of new allocations to those in greatest need. Greatest need households are defined as low income households that at the time of allocation are homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs.

Table 16.11 shows the proportion of new allocations to those in greatest need by time to allocation. Data are provided for tenants waiting for less than three months to more than two years. These numbers are not cumulative. A high value for this indicator, particularly for short time frames, represents a high degree of targeting of those in greatest need without these people waiting long periods of time.

This indicator, however, does not provide information on the number of greatest need applicants on the waiting list, or an allocations to those in greatest need as a proportion of all greatest need applicants on the waiting list.

Table 16.11 **Public housing — proportion of new allocations to those in greatest need, 2004 (per cent)**

	NSW[a]	*Vic*	*Qld*[a]	*WA*	*SA*[a]	*Tas*	*ACT*	*NT*[a]	*Aust*
Total for year ending 30 June	**23.7**	**68.4**	**12.2**	**24.2**	**40.1**	**89.7**	**86.2**	**17.0**	**36.3**
Proportion of new allocations to those in greatest need, by time to allocation									
<3 months	50.3	78.6	37.2	40.9	54.7	90.8	95.1	20.6	58.4
3–<6 months	45.3	72.1	26.6	49.8	58.2	91.5	92.0	19.9	57.0
6 months–<1 year	29.6	74.8	15.7	13.3	54.0	87.2	84.9	15.2	42.8
1–<2 years	14.1	62.5	5.3	0.2	34.6	83.8	67.9	14.8	22.4
2+ years	2.6	17.4	1.4	0.0	1.2	82.6	47.1	4.4	3.5

[a] For a more detailed explanation of data for these jurisdictions, see table 16A.5. – Nil or rounded to zero.

Source: AIHW (2004c); table 16A.5.

Efficiency — gross and net cost per unit

The two efficiency indicators reported for public housing are 'gross cost per unit' and 'net cost per unit' (outputs) (box 16.9).

Box 16.9 **Gross and net cost per unit**

'Gross cost per unit' and 'net cost per unit' are included as output indicators of the CSHA guiding principle to undertake efficient and cost-effective management. They measure the cost of providing assistance per dwelling. Cost per dwelling is broken down into the gross cost to government (administration and operating costs plus capital costs) and the net cost to government (cost excluding rents received from tenants).

A low cost per dwelling can indicate greater efficiency. Caution must be used, however, when interpreting indicators in this way, because the cost per dwelling indicator does not provide any information on the quality of service provided (for example, the standard of dwellings). Caution must also be used when interpreting this indicator because service delivery models differ across jurisdictions.

The costs incurred by jurisdictions in providing public housing include:

- administration costs (the cost of the administration offices of the property manager and tenancy manager)
- operating costs (the costs of maintaining the operation of the dwelling, including repairs and maintenance, rates, the costs of disposals, market rent paid and interest expenses)
- depreciation costs
- the user cost of capital (the cost of the funds tied up in the capital used to provide public housing). Box 16.10 provides a discussion of the user cost of capital.

The indicative user cost of capital for land per public housing dwelling in 2003-04 was highest in the ACT ($14 254) and lowest in Tasmania ($1460). The total cost of capital per dwelling ranged from $21 424 in the ACT to $6 344 in Tasmania (table 16.12).

In 2001, the Steering Committee completed a research project to assess the impact of asset measurement factors (such as depreciation and asset valuation methods) on the comparability of cost data in the Report. The results of this study are summarised in chapter 2. Box 16.11 summarises the results relating to housing.

Box 16.10 **The user cost of capital**

The 'user cost of capital' for government services is the cost of having funds tied up in the capital used to deliver services (for example, houses and land in public housing). It makes explicit the opportunity cost of using the funds to deliver services rather than investing them elsewhere or using them to retire debt. It is calculated by applying a jurisdictional cost of capital rate to the value of government assets (see chapter 2 for details of the determination of a cost of capital rate). The costs of capital for land and other assets are shown separately, to allow users to consider any differences in land values across jurisdictions when assessing the results. Land values make up a large part of the user cost of capital and are largely beyond the control of jurisdictions.

When comparing costs of government services, it is important to account for the user cost of capital because it is often:

- a significant component of the cost of services
- treated inconsistently (that is, included in the costs of services delivered by many non-government service providers, but effectively costed at zero for most budget sector agencies).

The Steering Committee accepts that asset valuation data are imperfect. It also recognises that non-recognition of the cost of capital used by departments to deliver services can result in a significant underestimation of costs for those services for which government capital is a major input. While the measurement of capital costs in this Report is not perfect, using an imputed costing is preferable to not costing government capital at all.

Box 16.11 **Asset measurement in the costing of government services**

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

The relative capital intensity associated with the provision of public housing increases the potential for differences in asset measurement techniques to have a material impact on total unit costs. The results of this study suggest, however, that the adoption under the CSHA of a uniform accounting framework has largely avoided this impact. The results are discussed in more detail in chapter 2.

Source: SCRCSSP (2001).

Interest payments have been subtracted from other capital costs (that is, depreciation and the indicative user cost of capital) to obtain the total capital cost, and the full gross cost and net cost to government, rendering these data not comparable with those published before the 2002 Report. Interest payments are included in recurrent costs, and reported capital costs must be reduced by the amount of interest payments to avoid double counting of capital costs once the indicative user cost of capital is included. Prior to the 2002 Report, it had not been possible to avoid this double counting.

Payroll tax is excluded from total recurrent cost for public housing. This was done for the first time in the 2004 Report and, as a result, the cost data are not comparable with the data published in reports before the 2004 Report (see chapter 2 for a discussion of the reasons for excluding payroll tax from the cost calculations).

The gross cost to government per dwelling in 2003-04 ranged from $29 090 in the ACT to $12 031 in SA. The net cost to government per dwelling ranged from $24 012 in the ACT to $7975 in SA (table 16.12).

Care needs to be taken in interpreting the total cost of delivering public housing. Some cost data are either more complete than other cost data or collected on a more consistent basis. Administration costs and operating costs, for example, may not capture all costs incurred by government, so could understate the total costs of public housing. In addition, some jurisdictions had difficulty separating costs for public housing from those for other housing assistance activities. There may also be double counting of some expenditure items in the cost calculations for some jurisdictions. The user cost of capital, for example, is intended to capture all the costs of funding assets used to produce the services, but reported operating costs (apart from interest payments, which have been adjusted for) may already include some of these costs.

Table 16.12 **Public housing — costs per dwelling, 2003-04 (dollars)[a]**

	NSW[b]	*Vic*[b]	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total recurrent costs	4 822	3 515	4 394	4 693	4 609	6 021	7 746	10 053	4 695
Total recurrent costs (excluding payroll tax)	4 784	3 465	4 365	4 646	4 560	5 970	7 667	9 992	4 652
Depreciation	1 789	1 752	1 240	1 392	1 031	1 254	1 191	2 440	1 538
Indicative user cost of capital[c]									
Land	10 881	5 784	7 287	4 678	3 168	1 460	14 254	4 657	7 493
Other assets	6 336	6 716	5 510	5 154	4 210	4 629	6 495	6 222	5 840
Total assets	17 217	12 500	12 797	9 832	7 378	6 088	20 749	10 879	13 333
Interest payments[d]	388	–	296	758	938	999	516	2 352	467
Total capital costs	18 618	14 252	13 740	10 466	7 471	6 344	21 424	10 967	14 405
Full gross costs (excluding payroll tax)	23 402	17 717	18 105	15 112	12 031	12 314	29 090	20 959	19 056
Rent collected from tenants	4 184	4 100	3 954	3 771	4 056	3 554	5 079	4 430	4 092
Full net costs (excluding payroll tax)	19 218	13 617	14 152	11 341	7 975	8 760	24 012	16 529	14 964
Dwellings (no.)	124 735	64 855	49 144	31 470	46 695	11 679	11 139	5 618	345 335

a Issues surrounding the comparability of capital cost data are discussed in the Steering Committee research paper, *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001). **b** For a more detailed description of data method, please see table 16A.6 notes. **c** The rate used to calculate the user cost of capital is currently 8 per cent. See chapter 2 for a discussion of capital costs. **d** Interest payments are included in total recurrent costs, but they must be excluded from total capital costs, full gross costs and full net costs to avoid double counting of capital costs once the indicative user cost of capital is included. Before the 2002 Report, it had not been possible to avoid this double counting. – Nil or rounded to zero.

Source: AIHW (2004c); State and Territory governments (unpublished); table 16A.6.

Efficiency — occupancy rate

The third efficiency indicator reported for public housing is the 'occupancy rate' (box 16.12).

The proportion of public rental stock occupied at 30 June 2004 ranged from 98.7 per cent in NSW and Queensland to 93.8 per cent in the NT. National average occupancy was 97.4 per cent (table 16.13).

Box 16.12 **Occupancy rate**

The 'occupancy rate' is included as an output indicator of the efficiency of housing utilisation. It represents the proportion of dwellings occupied. The term 'occupied dwelling' refers to dwellings occupied by tenants who have a tenancy agreement with the relevant housing authority. High occupancy suggests housing is being utilised efficiently, although this indicator should be interpreted with the match of dwelling to household size indicator because there could be unused bedrooms. Low occupancy suggests that dwellings are underutilised and that there is a high opportunity cost in retaining them. Occupancy is influenced by both turnover and housing supply and demand.

Table 16.13 **Public housing — occupancy rates (per cent)[a]**

	NSW[b]	*Vic*	*Qld*	*WA*	*SA*	*Tas*[c]	*ACT*	*NT*	*Aust*
2001	98.2	96.2	96.6	95.6	94.4	94.3	95.7	95.2	96.6
2002	98.1	96.4	97.5	95.4	94.2	95.7	98.7	95.0	96.8
2003	98.3	96.5	97.9	95.7	94.9	96.8	98.7	93.9	97.1
2004	98.7	96.6	98.7	95.3	95.4	97.4	97.2	93.8	97.4

a Proportion of public housing dwellings occupied at 30 June. **b** Data for NSW for 2002-03 and 2003-04 are not directly comparable to the previous years' data, and any direct comparison of 2002-03 and 2003-04 data with previous years for NSW needs to be done with caution. For details of these changes, see the NSW footnote in table 16A.7. **c** Data for Tasmania for 2003-04 are not directly comparable to the previous years' data, and any direct comparison of 2003-04 data with previous years for Tasmania needs to be done with caution. For details of these changes, see the Tasmania footnote in table 16A.7. Data for Tasmania for 2003-04 are based on a different methodology from the other data presented and need to be interpreted with caution. For details of these variations, see the Tasmania footnote in table 16A.7.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.7.

Efficiency — turnaround time

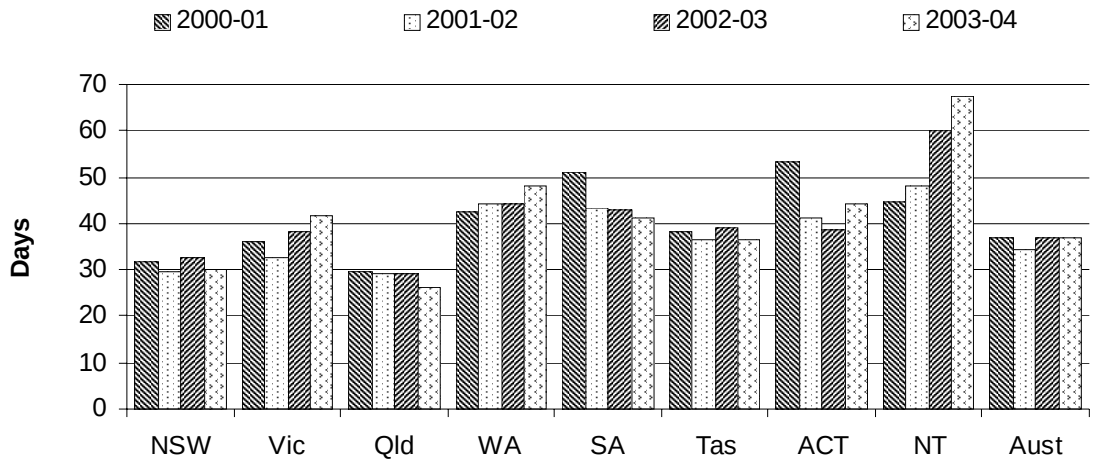
The fourth efficiency indicator reported for public housing is 'turnaround time' (box 16.13).

Box 16.13 **Turnaround time**

'Turnaround time' is included as an output indicator of the time taken to reallocate vacant properties after they have been vacated, acquired or newly constructed. The indicator measures the average time taken in days for vacant dwellings to be occupied. The length of time taken to rent untenanted dwellings affects allocations of housing, waiting times, the length of waiting lists and rent foregone. A low turnaround time suggests efficient housing allocation and asset management. All jurisdictions aim to minimise turnaround times.

The average number of days for vacant stock to be allocated in 2003-04 varied from 68 days in the NT to 26 days in Queensland (figure 16.8). This indicator may be affected by changes in maintenance programs and allocation policies, and some jurisdictions may have difficulty excluding relevant stock.

Figure 16.8 **Public housing — average turnaround times**[a, b, c]



[a] Data for Queensland for 2003-04 are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for Queensland cannot be made. For details of these changes, see the Queensland footnote in table 16A.8. [b] Data for Victoria for 2003-04 are based on a different methodology from the other data presented and need to be interpreted with caution. For details of these variations, see the Victoria footnote in table 16A.8. [c] Data for Queensland and WA for 2003-04 are not comparable with the other data presented and cannot be directly compared with other jurisdictions' data. For details of non-comparability, see the Queensland and WA footnotes in table 16A.8.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.8.

Efficiency — rent collected

The final efficiency indicator reported for public housing is 'rent collected' (box 16.14).

Box 16.14 **Rent collected**

'Rent collected' is included as an output indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It is the total rent collected as a proportion of the rent charged. A high proportion suggests efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a proportion of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of this indicator's reported results. Further, payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

Rent collected as a proportion of the rent charged in 2003-04 varied from 102.2 per cent in Tasmania to 99.3 per cent in Victoria and the ACT (table 16.14).

Table 16.14 **Public housing — total rent collected as a proportion of total rent charged (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2000-01	100.0	99.6	99.4	101.4	98.6	101.4	98.2	97.4	99.7
2001-02	99.2	99.8	98.8	101.0	97.8	100.7	100.0	97.9	99.3
2002-03	100.5	99.8	99.3	101.0	98.3	99.7	99.9	97.5	99.8
2003-04	99.7	99.3	99.8	101.9	100.0	102.2	99.3	99.9	99.9

a Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.9.

Outcomes

Amenity/location

'Amenity location' is an outcome indicator (box 16.15).

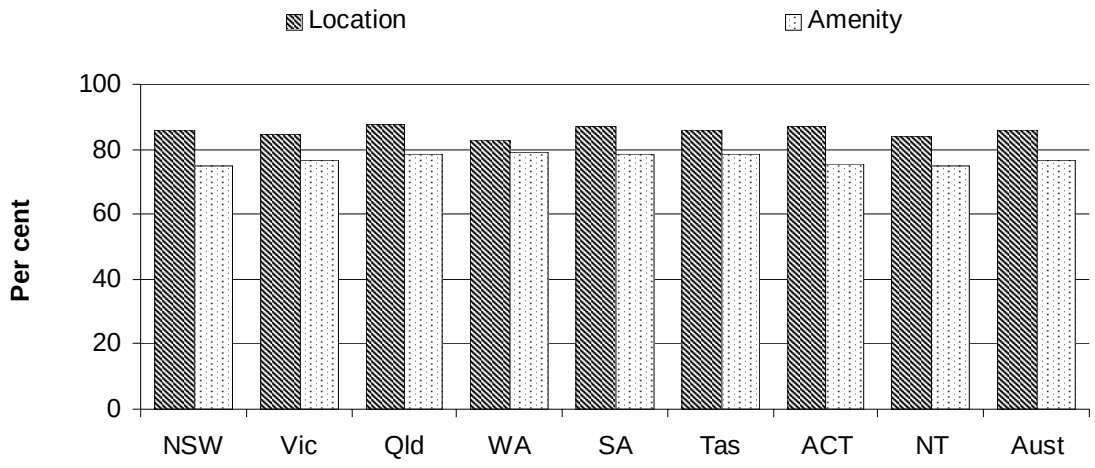
Box 16.15 **Amenity/location**

'Amenity/location' is included as an outcome indicator of the CSHA's aim to provide housing assistance that is appropriate to the needs of different households. The amenity/location indicator is a survey-based measure of the proportion of tenants rating amenity and location aspects as important and as meeting their needs.

The results are taken from the 2003 National Social Housing Survey for public rental housing. (The survey was not conducted in 2004, so results for 2003 are reported again this year.) Public housing tenants were asked whether particular aspects of the location and amenity of their dwellings were important to them and, if so, whether they felt their needs were met. The precision of survey estimates depends on the survey sample size and the sample estimate. Larger sample sizes result in higher precision, as do larger sample estimates. If, for example, 90 per cent of surveyed respondents chose an answer, then there would be more certainty about the actual population's views than if 50 per cent of respondents chose it. Care thus needs to be taken in interpreting small differences in results. Further information on the sample size is provided in tables 16A.10 and 16A.11.

There was little difference across jurisdictions in the proportion of tenants satisfied with the location or amenity of their dwelling in 2003. Satisfaction with the location of dwellings was above the national average in Queensland, SA, Tasmania and the ACT. Satisfaction with the amenity of dwellings was above the national average in Queensland, WA, SA and Tasmania (figure 16.9). More detail on this indicator can be found in tables 16A.10 and 16A.11.

Figure 16.9 **Public housing — tenants satisfied with location or amenity aspects of their dwelling, 2003[a]**



a Care needs to be taken in interpreting small differences in the results that are affected by sample and estimate size.

Source: AIHW (2003f); tables 16A.10 and 16A.11.

Affordability

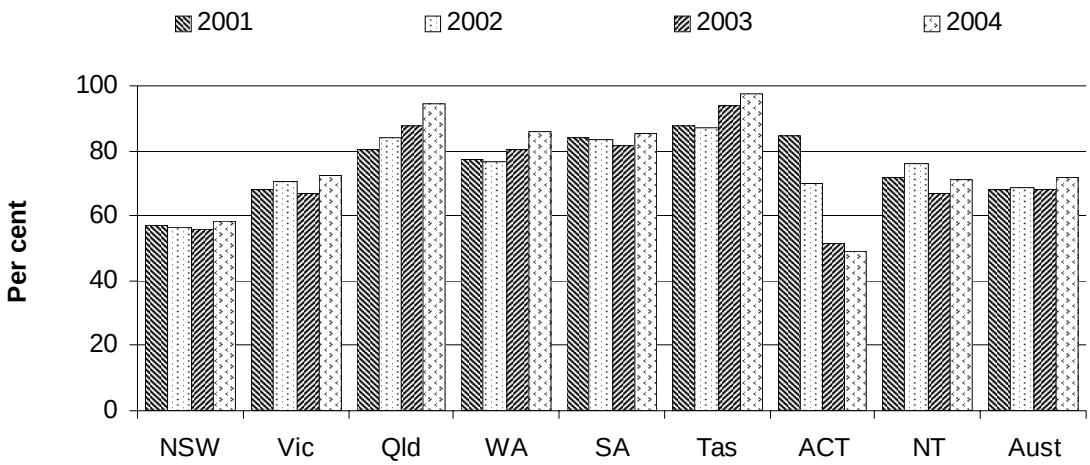
'Affordability' is an outcome indicator (box 16.16).

Box 16.16 **Affordability**

'Affordability' is included as an outcome indicator of the CSHA's aim to assist people who are unable to access suitable housing. It measures the rent charged to tenants as a proportion of the market rent for each dwelling, adjusted for CRA. A low proportion implies a high level of subsidy from the State or Territory housing authority over and above CRA. This largely reflects the differing levels of market rent across jurisdictions.

The rent charged at 30 June 2004 as a proportion of the market rent for each dwelling (adjusted for CRA) ranged from 97.8 per cent in Tasmania to 48.9 per cent in the ACT (figure 16.10). Related information on affordability, measured as the proportion of household income spent on housing costs, can be found at table 16A.75.

Figure 16.10 **Public housing — rent charged as a proportion of market rent, adjusted for CRA[a, b, c, d, e, f]**



a At 30 June. **b** The methodology used for calculations has changed and now uses more complex modelling developed for CSHA renegotiations. Caution, therefore, needs to be used in comparing results between 2001 and later years. **c** For details of mixed composition, non-rebated and other households excluded, see table 16A.82. **d** Data for NSW are not comparable over the four years (see detailed footnotes in table 16A.12). **e** Data for NSW, Victoria and Queensland for 2003-04 are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for NSW, Victoria and Queensland cannot be made. For details of these changes, see the NSW, Victoria and Queensland footnotes in table 16A.12. **f** Data for Tasmania for 2003-04 are not directly comparable to the previous years' data, and any direct comparison for 2003-04 data with previous years for Tasmania need to be done with caution. For details of these changes, see the Tasmania footnotes in table 16A.12. Data for Tasmania for 2003-04 are not comparable with the other data presented and cannot be directly compared with other jurisdictions' data. For details of non-comparability, see the Tasmania footnote in table 16A12.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.12.

Match of dwelling to household size

'Match of dwelling to household size' is an outcome indicator (box 16.17).

Box 16.17 **Match of dwelling to household size**

'Match of dwelling to household size' is included as an outcome indicator of the CSHA's aim to provide housing assistance that is appropriate to the needs of different households, such as household size. It measures the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

Proxy occupancy standard for appropriate sized dwelling, by household structure

Household structure	*Bedrooms required*
Single adult only	1
Single adult (group)	1 (per adult)
Couple with no children	2
Sole parent or couple with one child	2
Sole parent or couple with two or three children	3
Sole parent or couple with four+ children	4

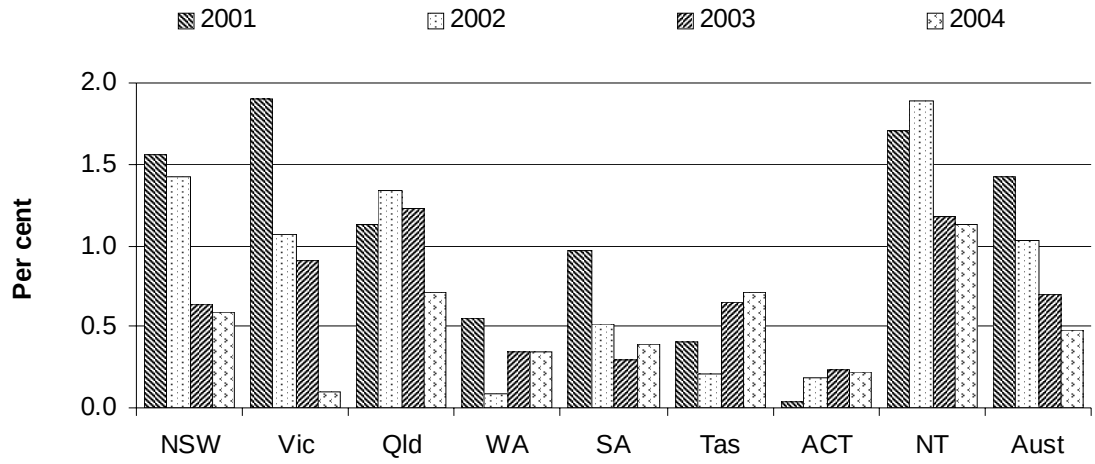
Source: AIHW (2003g).

A low proportion indicates a low proportion of overcrowded households.

The proxy occupancy standard shown above may differ from the specific criteria used by State and Territory housing authorities to match households to dwelling types, affecting interpretation of this indicator. This indicator does not reveal the proportion of stock that were underutilised.

The proportion of dwellings that were overcrowded was similar across jurisdictions at 30 June 2004. The NT had the highest proportion of overcrowded dwellings at 30 June 2004 (1.1 per cent), while Victoria (0.1 per cent) had the lowest proportion. Overcrowded dwellings represented 0.5 per cent of public housing dwellings nationally (figure 16.11). Information on moderate overcrowding and underuse can be found in table 16A.80.

Figure 16.11 **Public housing — overcrowded dwellings**[a, b, c, d, e]



a At 30 June. **b** Changes in data collection methods between years may affect results for some jurisdictions. **c** For details of mixed composition, non-rebated and other households excluded, see table 16A.82. **d** Data for NSW, Victoria and Queensland for 2003-04 are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for NSW, Victoria and Queensland cannot be made. For details of these changes, see the NSW, Victoria and Queensland footnotes in table 16A.13. **e** Data for SA for 2002-03 and 2003-04 are not directly comparable to the previous years' data, and any direct comparison of 2002-03 and 2003-04 data with previous years for SA needs to be done with caution. For details of these changes, see the SA footnote in table 16A.13.

Source: AIHW (various years), CSHA National Data Reports: Public Rental Housing; table 16A.13.

Customer satisfaction

'Customer satisfaction' is an outcome indicator (box 16.18).

Box 16.18 **Customer satisfaction**

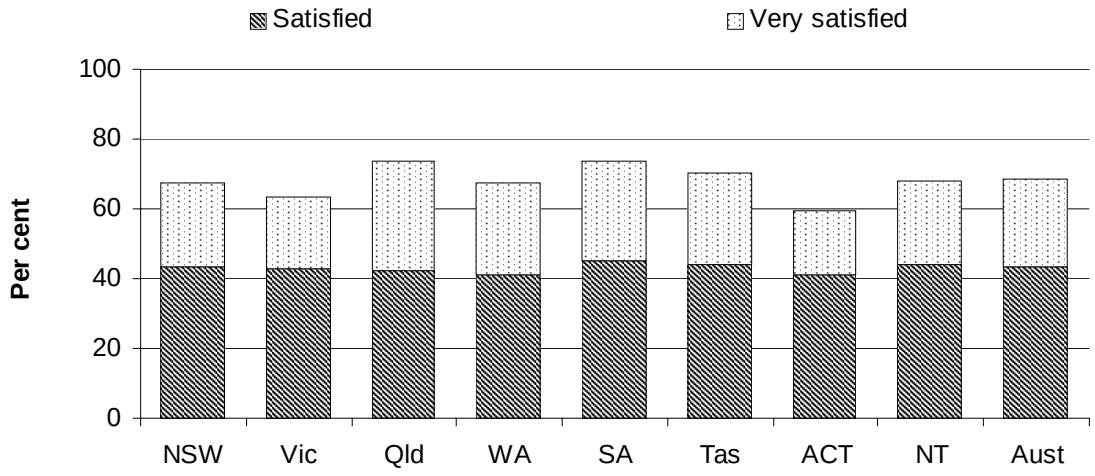
'Customer satisfaction' is included as an outcome indicator because one aim of the CSHA is to provide housing assistance that is appropriate for different households. Customer satisfaction is a survey measure of satisfaction with the overall service provided by the State or Territory housing authority. Results are expressed in percentage terms.

The results are taken from the 2003 National Social Housing Survey for public rental housing. (The survey was not conducted in 2004, so results for 2003 are reported again this year.) Nationally in 2003, 68.4 per cent of tenants were either satisfied or very satisfied with the housing provided. This proportion varied from 73.9 per cent and 73.6 per cent in Queensland and SA respectively, to 59.4 per cent in the ACT (figure 16.12). The proportion increased slightly in NSW between 2001 (when survey data were last available) and 2003, but decreased in all other

jurisdictions except Tasmania, where it remained constant. The largest change occurred in the ACT, where the proportion of tenants who were satisfied or very satisfied with the housing provided decreased by 2.6 percentage points over the period (table 16A.14). The proportion of public housing tenants surveyed in 2003 who were very satisfied with the housing provided was the same as or above the national average in Queensland, WA, SA, Tasmania and NT (figure 16.12).

A more comprehensive discussion of customer satisfaction results is provided in the National Social Housing Survey of Public Housing Tenants 2003, which is available on the DFaCS website (www.facs.gov.au).

Figure 16.12 **Public housing — customer satisfaction, 2003**[a, b, c]



[a] For NSW, face-to-face interviews were conducted; mailout forms were used for all other jurisdictions. [b] Care needs to be taken in interpreting small differences in the results that are affected by sample and estimate size (see table 16A.14 for details of the sample size). [c] Data for Australia for 2003 were calculated as a simple numerical average, given a lack of raw data.

Source: AIHW (2003f); table 16A.14.

Community housing

Community housing data have three sources:

- administrative by-product data, collected by the State or Territory government body with responsibility for administering the community housing program in the jurisdiction
- survey data, collected from the community organisations (providers) that manage the service delivery
- survey data, collected via the National Social Housing Survey.

This section includes data on 10 of the 12 performance indicators in the community housing framework (figure 16.3). Community housing data are largely obtained by surveying community providers, and survey response rates, along with changes to the definitions and counting rules used over time, can influence the comparability of the data. Comparisons over time using community housing data thus need to be made with care. Table 16A.83 outlines the survey response rates and associated information for each jurisdiction for 2000-01, 2001-02, 2002-03 and 2003-04. For 2003-04, the survey response rate varied from 100.0 per cent in the ACT to 48.9 per cent in Tasmania. In addition, performance indicator results are not comparable across the public, community and State owned and managed Indigenous housing sections. The NT provided data for only one of the 10 performance indicators for which data are reported this year.

Some descriptive data on community housing are contained in table 16A.15. Table 16A.71 lists State and Territory programs included in the community housing data collected.

Outputs

Equity — low income

The first equity indicator reported for community housing is 'low income' (box 16.19).

Box 16.19 **Low income**

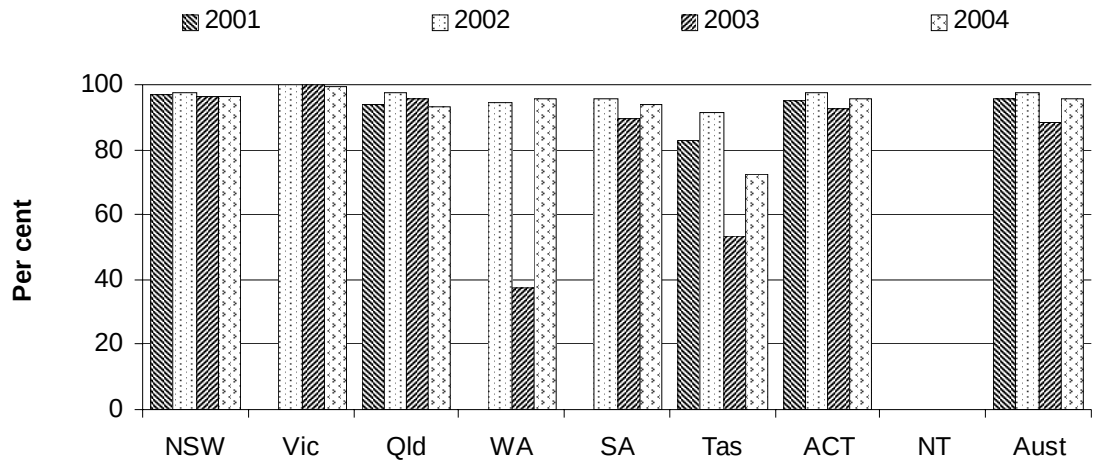
'Low income' is included as an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures households paying less than market rent and special needs households paying market rent, as a proportion of all households (new and existing). A high proportion indicates a high degree of targeting of low income (and special needs) households.

Special needs households are those that have either a household member with a disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members.

The low income indicator is measured differently for community housing as 'New low income households as a proportion of all new households'; and 'New low income households plus special needs (not low income) households' are not reported because the different definitions of low income are used and all households, rather than just new households with low income are reported.

At 30 June 2004, across those jurisdictions able to provide data, the proportion of all households paying less than market rent plus special needs households paying market rent, as a proportion of all households (new and existing), ranged from 99.5 per cent in Victoria to 72.2 per cent in Tasmania (figure 16.13).

Figure 16.13 **Community housing — households paying less than market rent plus special needs households paying market rent as a proportion of all households (new and existing)[a, b, c, d]**



a At 30 June. **b** Data may not be comparable across jurisdictions, given the considerable variation in the way in which community housing operates in each jurisdiction. For NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT, data are based on surveys (see table 16A.83 for response rates and other relevant information). **c** NSW data definitions differ from national definitions, and data for NSW are not comparable over the four years. Data for Victoria for 2003-04 are based on different methodology from that used for previous years' data and a direct comparison of 2003-04 with previous years for Victoria cannot be made. Households can be in more than one category. For details of these variations, see table 16A.16. **d** Data for Victoria, WA and SA were not available for 2001. Data for the NT were not available.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.16.

Equity — special needs

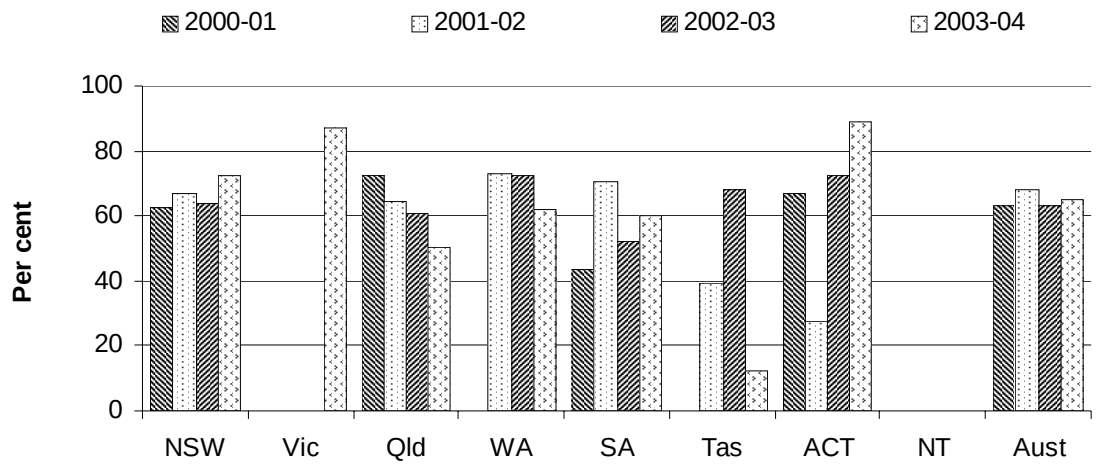
The second equity indicator reported for community housing is 'special needs' (box 16.20).

The proportion of new tenancies allocated to special needs households in 2003-04 varied for those jurisdictions able to provide data, from 89.1 per cent in the ACT to 12.5 per cent in Tasmania (figure 16.14).

Box 16.20 **Special needs**

'Special needs' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures the proportion of new tenancies allocated to special needs households. New tenancies are reported as a proxy for all households receiving assistance. Special needs households are those that have either a household member with a disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members. A high proportion indicates a high degree of targeting of these special needs households.

Figure 16.14 **Community housing — new tenancies allocated to households with special needs[a, b, c, d, e]**



a At 30 June. **b** Data may not be comparable across jurisdictions, given the considerable variation in the way in which community housing operates in each jurisdiction. For NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT, data are based on surveys (see table 16A.83 for response rates and other relevant information). **c** NSW data definitions differ from national definitions and data are based on different methodology from the other data reported. As such, data should be interpreted with caution. Data for ACT for 2003-04 are based on different methodology from that used for previous years' data and a direct comparison of 2003-04 with previous years for the ACT cannot be made. For details of these variations, see table 16A.17. **d** Data for the ACT for 2003-04 are based on a different methodology from that used for previous years' data, and a direct comparison of 2003-04 with previous years for the ACT cannot be made. For details of these variations, see table 16A.17. **e** Data Victoria for 2000-01, 2001-02 and 2002-03 were not available. Data for WA for 2000-01 were not available. Data for Tasmania for 2000-01 were not published. Data for the NT were not available.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.17.

Equity — priority access to those in greatest need

The final equity indicator reported for community housing is 'priority access to those in greatest need' (box 16.21).

Box 16.21 **Priority access to those in greatest need**

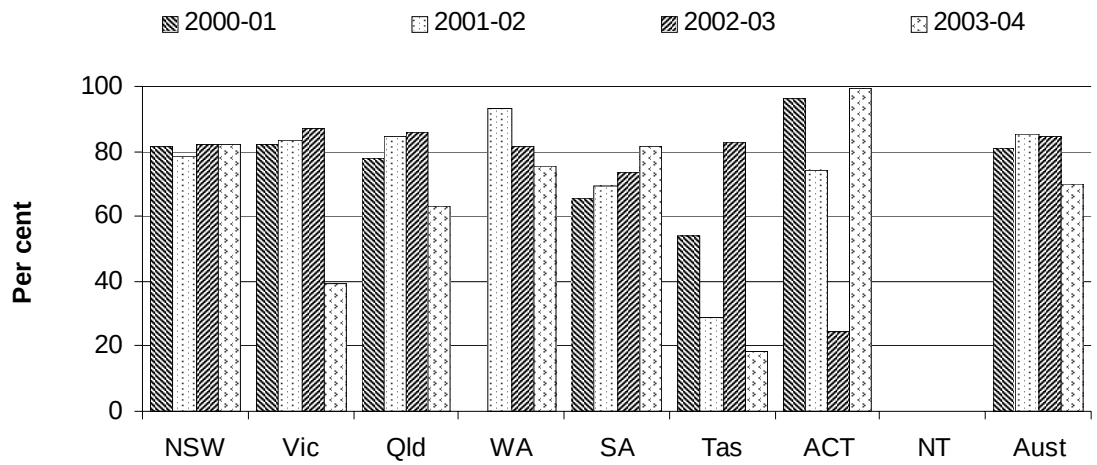
'Priority access to those in greatest need' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes are such that those in greatest need have first access to housing. It measures the proportion of new allocations to those in greatest need.

Greatest need households are defined as low income households that at the time of allocation are homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs. High values for this indicator represent a high degree of targeting of allocations to those in greatest need.

This indicator, however, does not provide information on the number of greatest need applicants on the waiting list, or on allocations to those in greatest need as a proportion of all greatest need applicants on the waiting list.

This is an abbreviated version of the indicator used in the public housing and State owned and managed Indigenous housing collections because only data for the overall total are presented and there is no breakdown into time periods. Across those jurisdictions able to supply data, the proportion of new allocations to those in greatest need in 2003-04 varied from 99.2 per cent in the ACT to 18.3 per cent in Tasmania (figure 16.15). Differences in State and Territory housing allocation policies can influence comparability for this indicator, because the majority of jurisdictions do not require community housing organisations to segment waiting lists.

Figure 16.15 **Community housing — proportion of new allocations to those in greatest need[a, b, c, d, e]**



a At 30 June. **b** Data may not be comparable across jurisdictions, given the considerable variation in the way in which community housing operates in each jurisdiction. For NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT, data are based on surveys (see table 16A.83 for response rates and other relevant information). **c** Data for NSW are based on a different methodology from that used for the other data presented and need to be interpreted with caution. For details of these variations, see table 16A.18. **d** Data for Victoria and the ACT for 2003-04 are based on a different methodology from that used for previous years, and a direct comparison of 2003-04 data with previous years cannot be made. For details of these changes, see table 16A.18. **e** Data for WA for 2000-01 were not available. Data for the NT were not available.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.18.

Efficiency — direct cost per unit

The Steering Committee has identified 'direct cost per unit' as an efficiency indicator (box 16.22). Data for this indicator, however, were not reported in this Report.

Box 16.22 **Gross and net cost per unit**

The Steering Committee has identified 'gross cost per unit' and 'net cost per unit' as indicators for development and reporting in future.

These indicators are included as output indicators of the CSHA guiding principle to undertake efficient and cost-effective management. They measure the cost of providing assistance per dwelling. Cost per dwelling is broken down into the gross cost to government and community housing providers (administration and operating costs plus capital costs) and the net cost to government and community housing providers (cost excluding rents received from tenants).

A low cost per dwelling can indicate greater efficiency. Caution must be used, however, when interpreting indicators in this way because cost per dwelling does not provide any information on the quality of service provided (for example, the standard of dwellings). Caution must also be used when interpreting this indicator because service delivery models differ across jurisdictions.

Efficiency — occupancy rate

The first efficiency indicator reported for community housing is the 'occupancy rate' (box 16.23).

Box 16.23 **Occupancy rate**

The 'occupancy rate' is included as an output indicator of the efficiency of housing utilisation. It is the proportion of dwellings occupied. The term 'occupied dwelling' refers to dwellings occupied by tenants who have a tenancy agreement with the relevant community housing organisation. High occupancy suggests housing is being utilised efficiently, although this indicator needs to be interpreted with caution because there could be unused bedrooms in dwellings. Low occupancy suggests that dwellings are underutilised and that there is a high opportunity cost in retaining them. Occupancy is influenced by both turnover and housing supply.

Across those jurisdictions able to provide data, the proportion of community housing occupied at 30 June 2004 ranged from 100.0 per cent in the NT to 95.0 per cent in Queensland (table 16.15). However, it should be noted that the NT occupancy rates are based on the assumption that all dwellings are occupied due to many organisations turning away people seeking accommodation.

Table 16.15 **Community housing — occupancy rates (per cent)**[a, b]

	NSW[c]	*Vic*	*Qld*[c]	*WA*	*SA*[c]	*Tas*[c]	*ACT*[b, c]	*NT*	*Aust*
2001	97.9	94.6	95.8	na	94.7	90.4	94.3	100.0	95.9
2002	98.2	95.6	94.8	97.2	95.8	100.0	94.7	100.0	96.5
2003	97.8	96.3	96.1	100.4	95.6	98.3	97.4	100.0	97.0
2004	98.6	98.1	95.0	99.8	95.4	99.8	95.8	100.0	97.5

a At 30 June. **b** Data may not be comparable across jurisdictions, given the considerable variation in the way in which community housing operates in each jurisdiction. Data for Victoria and the ACT for 2003-04 are based on a different methodology and, therefore, direct comparison with previous years for Victoria cannot be made. **c** NSW, Queensland, SA, Tasmania and the ACT data are based on surveys (see table 16A.83 for response rates and other relevant information). **na** Not available.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.19.

Efficiency — turnaround time

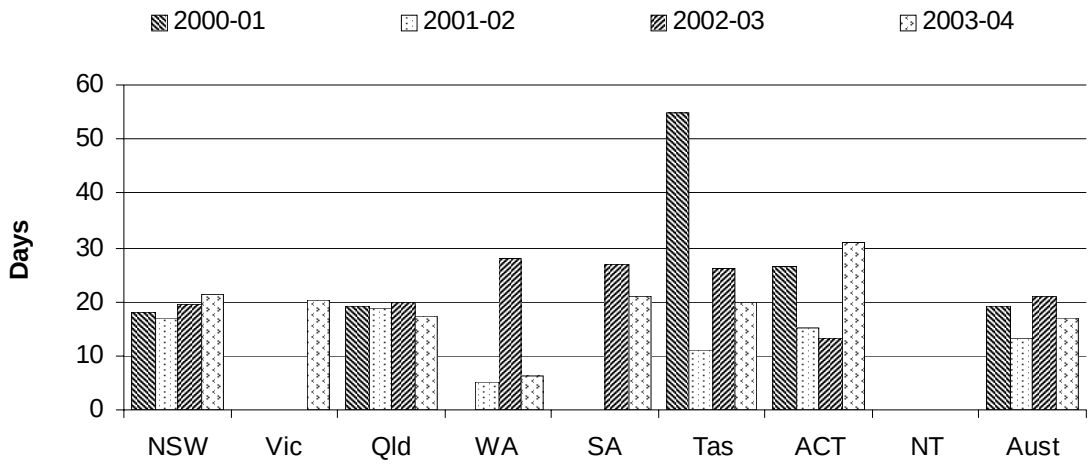
The second efficiency indicator reported for community housing is 'turnaround time' (box 16.24).

Box 16.24 **Turnaround time**

'Turnaround time' is included as an output indicator of the time taken to reallocate vacant properties after they have been vacated, acquired or newly constructed. The indicator measures the average time taken in days for vacant dwellings to be occupied. The length of time taken to rent untenanted dwellings affects allocations of housing, waiting times, the length of waiting lists and rent foregone. A low turnaround time suggests efficient housing allocation and asset management. All jurisdictions aim to minimise turnaround times.

Across those jurisdictions able to provide data, the average number of days for vacant stock to be allocated in 2003-04 varied from 31 days in ACT to 6 days in WA (figure 16.16).

Figure 16.16 **Community housing — average turnaround times**[a, b, c, d, e, f]



a At 30 June **b** Data may not be comparable across jurisdictions, given the considerable variation in the way in which community housing operates in each jurisdiction. Organisation and tenant data may vary considerably as a result of the policy and program environment and the nature of the sector. **c** For NSW, Queensland, SA, Tasmania and the ACT, data are based on surveys (see table 16A.83 for response rates and other relevant information). **d** NSW data definitions differ from national definitions, and data for NSW are not comparable over the four years. Data for ACT for 2003-04 are based on different methodology from that used for previous years' data and a direct comparison of 2003-04 with previous years for the ACT cannot be made. For details of these variations, see table 16A.20. **e** For an explanation of Victoria data, see table 16A.20. **f** Data for Victoria for 2000-01, 2001-02 and 2002-03 were not available. Data for WA for 2000-01 were not available. Data for SA for 2000-01 and 2001-02 were not available. Data for the NT were not available.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.20.

Efficiency — rent collected

The third efficiency indicator reported for community housing is 'rent collected' (box 16.25).

Box 16.25 **Rent collected**

'Rent collected' is included as an output indicator of the CSHA's guiding principle to undertake efficient and cost-effective management. It is the total rent collected as a proportion of the rent charged. A high proportion suggests efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a proportion of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of this indicator's reported results. Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

For community housing, data on rent collected are reported with a one year lag to allow community providers an extra year to collate financial data. In 2002-03, rent collected as a proportion of rent charged varied from 100.5 per cent in WA to 83.8 per cent in Queensland (table 16.16). As with public housing, payment arrangements for rent in some jurisdictions mean the rent collected over a 12 month period may be higher than rent charged over that period.

Table 16.16 **Community housing — total rent collected as a proportion of total rent charged (per cent)[a, b, c]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2000-01	92.5	na	98.6	99.2	97.8	na	97.6	na	95.5
2001-02	98.5	na	92.6	97.5	97.9	98.7	98.9	na	97.1
2002-03	98.8	98.6	83.8	100.5	97.3	98.9	99.7	na	95.7

a At 30 June **b** For NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT, data are based on surveys (see table 16A.83 for response rates and other relevant information). **c** Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period. Data for 2002-03 are reported to provide additional time to collate financial data, so data relate to a different number of providers and tenant households. Data may not be comparable across jurisdictions due to the considerable variation in the way community housing operates in each jurisdiction. Organisation and tenant data may vary considerably due to the policy and program environment and the nature of the sector. **na** Not available.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.21.

Outcomes

Amenity/location

'Amenity/location' is an outcome indicator (box 16.26).

Box 16.26 **Amenity/location**

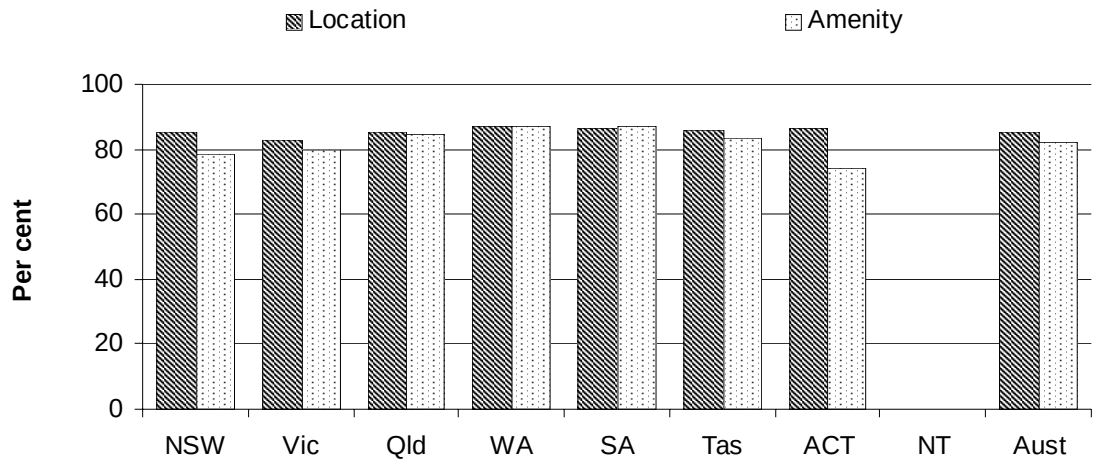
'Amenity/location' is included as an outcome indicator of the CSHA's aim to provide housing assistance that is appropriate to the needs of different households. The amenity/location indicator is a survey-based measure of the proportion of tenants rating amenity and location aspects as important and as meeting their needs. Results are expressed as percentages.

The data for this indicator are from the 2002 *National Social Housing Survey with Community Housing* (NFO Donovan Research 2002). (The survey was not conducted in 2003 or 2004, so results for 2002 are reported again this year.) Community housing tenants were asked whether particular aspects of the location and amenity of their dwellings were important to them and, if so, whether they felt their needs were met. As with public housing, the precision of survey estimates

depends on the survey sample size (see the discussion of amenity/location for public housing). More information on the sample size is provided in tables 16A.22 and 16A.23.

The proportion of tenants satisfied with the location of their dwelling in February 2002 ranged from 87.1 per cent in WA to 83.1 per cent in Victoria. Satisfaction levels were above average in NSW, Queensland, WA, SA, Tasmania and the ACT. The proportion of tenants satisfied with the amenity of their dwelling ranged from 87.3 per cent in WA and SA to 74.2 per cent in the ACT. Satisfaction levels were above average in Queensland, WA, SA and Tasmania (figure 16.17). More information on this indicator can be found in tables 16A.22 and 16A.23.

Figure 16.17 **Community housing — tenants satisfied with location or amenity aspects of their dwelling, 2002[a, b, c, d]**



a At February. **b** Care needs to be taken in interpreting small differences in the results that are affected by sample and estimate size (see attachment 16A for details of the sample size). Not applicable for the NT because it chose not to participate in the survey, given its small community housing tenant population. National total is an unweighted average. **c** Data for NSW and WA are based on a different methodology from that used for the other jurisdictions, and need to be interpreted with caution. For details of these variations (including sample size and response rates), see NFO Donovan Research (2002). **d** Data are not available for NT because it chose not to participate in the survey, given its small community housing tenant population.

Source: NFO Donovan Research (2002); tables 16A.22 and 16A.23.

Affordability

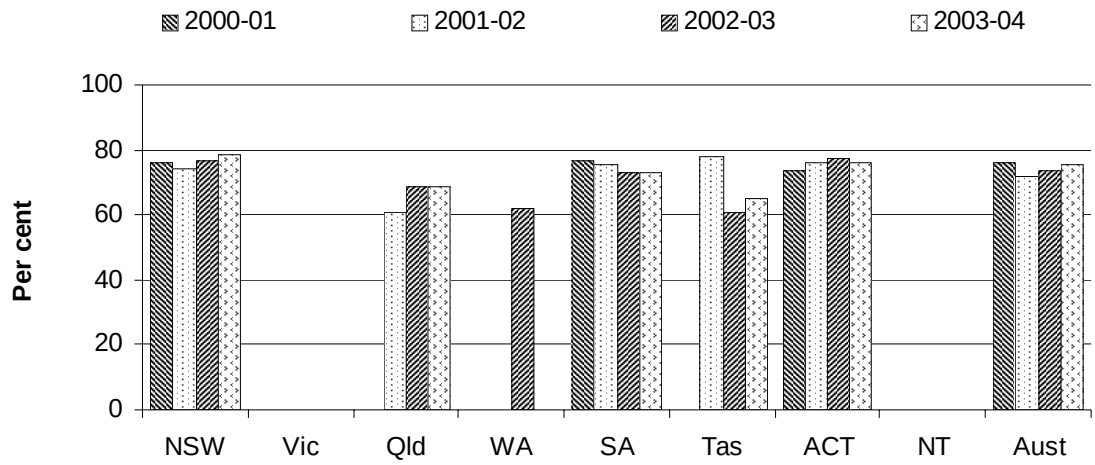
'Affordability' is an outcome indicator (box 16.27).

Box 16.27 **Affordability**

'Affordability' is included as an outcome indicator of the CSHA's aim to provide affordable housing to assist people who are unable to access suitable housing. It measures the proportion of household income left after paying rent. A high proportion indicates that housing is affordable. This affordability measure differs from that reported for public housing and State owned and managed Indigenous housing which measures the rent charged to tenants as a proportion of the market rent for each dwelling, adjusted for CRA.

In 2003-04, across those jurisdictions able to provide data, the proportion of household income left after paying rent ranged from 78.4 per cent in NSW to 64.7 per cent in Tasmania (figure 16.18). Differences in procedures across states and territories for including CRA in rent assessment may affect the comparability of this indicator's reported result. More information on affordability for community housing can be found in table 16A.76.

Figure 16.18 **Community housing — household income left after paying rent**[a, b, c, d]



a At 30 June. **b** For NSW, Victoria Queensland, WA, SA, Tasmania and the ACT, data are based on surveys (see table 16A.83 for response rates and other relevant information). **c** Data may not be comparable across jurisdictions due to the considerable variation in the way community housing operates in each jurisdiction. Organisation and tenant data may vary considerably due to the policy and program environment and the nature of the sector. For explanations of data methodology for 2003-04 for NSW, Victoria, Queensland, SA and the ACT, see table 16A.24. **d** Data for Victoria and the NT were not available. Data for Queensland for 2000-01 were not available. Data for WA were not available for 2000-01 and 2001-02, data for 2003-04 were not published. Data for Tasmania for 2000-01 were not published.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.24.

Match of dwelling to household size

'Match of dwelling to household size' is an outcome indicator (box 16.28).

Box 16.28 **Match of dwelling to household size**

'Match of dwelling to household size' is included as an outcome indicator of the CSHA's aim to provide housing assistance that is appropriate to the needs of different households, such as household size. It measures the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

Proxy occupancy standard for appropriate sized dwelling, by household structure

Household structure	*Bedrooms required*
Single adult only	1
Single adult (group)	1 (per adult)
Couple with no children	2
Sole parent or couple with one child	2
Sole parent or couple with two or three children	3
Sole parent or couple with four+ children	4

Source: AIHW (2003a).

A low proportion indicates a low proportion of overcrowded households.

The proxy occupancy standard above may differ from the specific criteria used by community housing organisations to match households to dwelling types, affecting interpretation of this indicator. This indicator does not reveal the proportion of stock that were underutilised.

Across those jurisdictions able to provide data, Queensland had the highest proportion of overcrowded dwellings (2.1 per cent) at 30 June 2004, while the ACT had the lowest (0.0 per cent) (figure 16.19). More information on overcrowding for community housing can be found in table 16A.78.

Figure 16.19 **Community housing — overcrowded dwellings[a, b, c]**

a At 30 June. **b** Data may not be comparable across jurisdictions due to the considerable variation in the way community housing operates in each jurisdiction. Organisation and tenant data may vary considerably due to the policy and program environment and the nature of the sector. Data for the ACT for 2003-04 are based on different methodology from that used for previous years' data and a direct comparison of 2003-04 with previous years for the ACT cannot be made. For NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT, data are based on surveys (see table 16A.83 for response rates and other relevant information). **c** Data for Victoria for 2001 2002 and 2003 were not available. Data for WA for 2001 and 2004 were not available. Data for the ACT for 2003 and 2004 were nil or rounded to zero. Data for the NT were not available.

Source: AIHW (various years), CSHA National Data Reports: CSHA Community Housing; table 16A.25.

Customer satisfaction

'Customer satisfaction' is an outcome indicator (box 16.29).

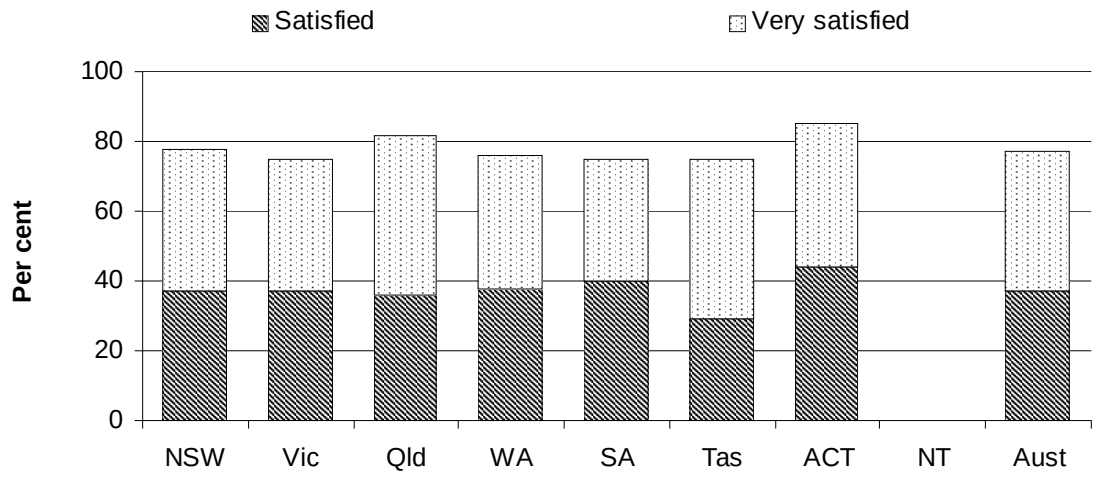
Box 16.29 **Customer satisfaction**

'Customer satisfaction' is included as an outcome indicator because one aim of the CSHA is to provide housing assistance that is appropriate for different households. Customer satisfaction is a survey measure of satisfaction with the overall service provided by the community housing organisation. Results are expressed in percentage terms.

The data for this indicator, are results from the 2002 *National Social Housing Survey with Community Housing* (NFO Donovan Research 2002). (Survey data for 2003 or 2004 are not available, so results for 2002 are reported again this year.) Nationally in February 2002, 77.0 per cent of tenants were satisfied or very satisfied with their community housing dwellings and the services provided by their community housing organisation (including benefits derived from living in community housing and involvement in the organisation). Across jurisdictions for

which robust survey data are available, this proportion ranged from 85.0 per cent in the ACT to 75.0 per cent in Victoria, SA and Tasmania (figure 16.20).

Figure 16.20 **Community housing — customer satisfaction, 2002[a, b, c]**



a At February. Care needs to be taken in interpreting small differences in the results that are affected by sample and estimate size (see table 16A.26 for details of the sample size). **b** Data for WA are based on a different methodology from that used for the other data presented and need to be interpreted with caution. For details of these variations (including sample size and survey response rate), see NFO Donovan Research (2002). **c** Data are not available for NT because it chose not to participate in the survey, given its small community housing tenant population.

Source: NFO Donovan Research (2002); table 16A.26.

State owned and managed Indigenous housing

Different delivery contexts, locations and types of client may affect the performance reported in this section. Care thus needs to be taken in interpreting performance indicator results, and the qualifications presented with the data need to be considered. Further, there might have been some difficulties in separating Indigenous housing data from public housing data. Variations in the funding and administration of State owned and managed Indigenous housing across jurisdictions may also influence the comparability of data.

In addition, performance indicator results are not comparable across the public, community and State owned and managed Indigenous housing sections. Some descriptive data on State owned and managed Indigenous housing are included in table 16A.27. (As outlined in section 16.1, the ACT and the NT are not included in the State owned and managed Indigenous housing data collection.) State owned and managed Indigenous housing dwellings are more likely than public or community housing dwellings to be located in rural or remote areas (table 16.9).

Outputs

Equity — low income

The first equity indicator reported is 'low income' (box 16.30).

Box 16.30 **Low income**

'Low income' is included as an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures three low income components:

- new low income households as a proportion of all new households
- new low income households plus special needs (not low income) households, as a proportion of all new households
- households paying less than market rent and special needs households paying market rent, as a proportion of all households (new and existing).

High values for these measures indicate high degrees of targeting of low income (and special needs) households.

The two household income measures for this indicator are:

- low income A households — households where all members receive an income equivalent to or below 100 per cent of the government income support benefits at the pensioner rate (Pension rates have been selected for calculating this indicator because they are higher than allowance rates.)
- low income B households — households with an income above 100 per cent of the government income support benefits at the pensioner rate, but below the effective cut-off for receiving any government support benefits.

Households with incomes below these levels are included in the measure, although they may not necessarily receive income support benefits.

It is not appropriate to use this indicator to compare the performance of public, community and State owned and managed Indigenous housing. State owned and managed Indigenous housing uses a definition of special needs more appropriate to the program. The special needs indicator for public housing includes Indigenous households in the definition of special needs households, so using this definition for State owned and managed Indigenous housing would result in 100 per cent of State owned and managed Indigenous housing households being regarded as having special needs.

The definition also differs for 'aged' households: households with a principal tenant aged 50 years or over are considered special needs households for State owned and managed Indigenous housing, while households with a principal tenant aged 75 years or over are considered special needs households for mainstream public and community housing. This difference reflects the lower life expectancy and higher level of illness among Indigenous Australians.

The proportion of new tenancies allocated to low income A households varied in 2003-04 from 94.4 per cent in NSW to 83.3 per cent in Queensland. The proportion of new tenancies allocated to low income A plus special needs (not low income) households varied from 98.1 per cent in Tasmania to 87.5 per cent in Queensland (table 16.17). Table 16A.28 contains information on both low income A households and low income B households.

Table 16.17 **State owned and managed Indigenous housing — low income and special needs households, as a proportion of all new households (per cent)[a]**

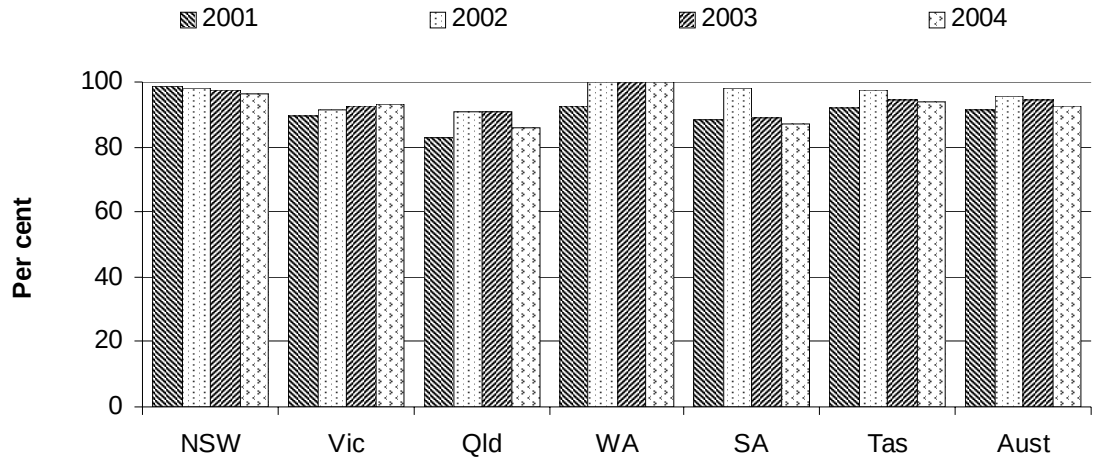
	NSW[b,c]	*Vic*[b,d]	*Qld*[b]	*WA*[d]	*SA*[b]	*Tas*[d]	*Aust*
New low income A households as proportion of all new households							
2000-01	91.3	80.0	81.4	89.3	88.9	76.8	86.5
2001-02	89.6	88.1	83.1	81.3	87.3	95.5	85.8
2002-03	91.5	87.8	89.7	89.1	86.5	87.2	89.2
2003-04	94.4	90.5	83.3	93.5	89.2	89.5	90.6
New low income A households plus special needs (not low income) households, as proportion of all new households							
2000-01	96.9	83.3	87.0	92.0	97.9	81.7	91.4
2001-02	92.6	91.7	89.5	84.4	90.1	97.0	89.6
2002-03	92.9	92.9	94.6	92.1	93.2	92.3	93.0
2003-04	96.7	96.8	87.5	95.5	92.4	98.1	94.0

[a] For details of newly allocated: mixed composition, non-rebated and other households excluded, see table 16A.84. [b] Data for NSW, Victoria, Queensland and SA are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for NSW, Victoria Queensland and SA cannot be made. For details of these changes, see the NSW, Victoria, Queensland and SA footnotes in table 16A.28. [c] Data for NSW for 2003-04 are based on a different methodology from the other data presented and need to be interpreted with caution. For details of these variations, see the NSW footnote in table 16A.28. [d] Data for Victoria, WA and Tasmania for 2003-04 are not comparable with the other data presented and cannot be directly compared with other jurisdictions' data. For details of non-comparability, see the Victoria, WA and Tasmania footnotes in table 16A.28.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.28.

The proportion of households paying less than market rent and special needs households paying market rent, as a proportion of all households (new and existing) at 30 June 2004, ranged from 100.0 per cent in WA to 85.6 per cent in Queensland (figure 16.21).

Figure 16.21 **State owned and managed Indigenous housing — households paying less than market rent and special needs households paying market rent as a proportion of all households (new and existing)[a, b, c, d]**



a At 30 June. **b** Data for NSW, WA and SA are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for NSW, WA and SA cannot be made. For details of these changes, see the NSW, WA and SA footnotes in table 16A.29. **c** Data for Victoria for 2003-04 are not directly comparable to the previous years' data, and any direct comparison of 2003-04 data with previous years for Victoria need to be done with caution. For details of these changes, see the Victoria footnotes in table 16A.29. **d** Data for WA for 2003-04 are not comparable with the other data presented and cannot be directly compared with other jurisdictions' data. For details of non-comparability, see WA footnote in table 16A.29.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.29.

Equity — special needs

'Special needs' is the second equity indicator reported for State owned and managed Indigenous housing (box 16.31).

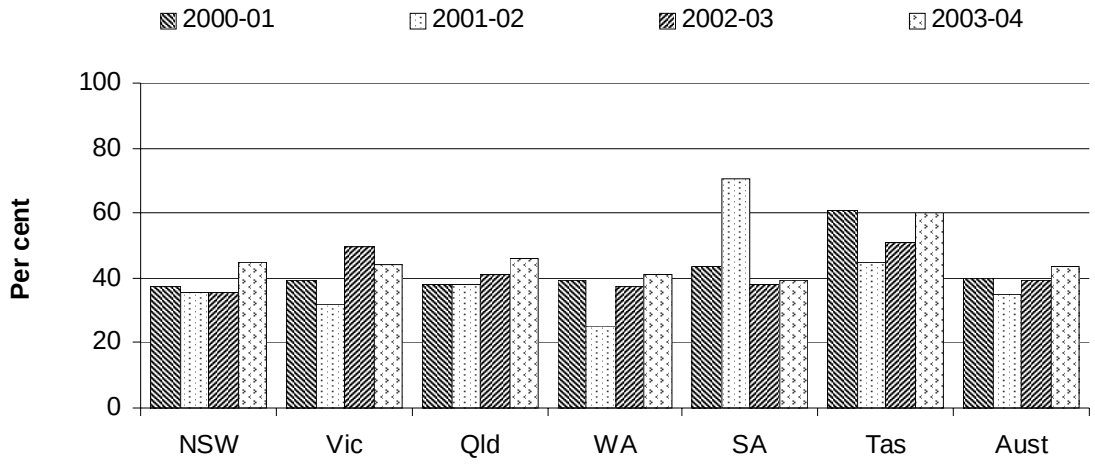
Box 16.31 **Special needs**

'Special needs' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures the proportion of new tenancies allocated to special needs households. New tenancies are reported as a proxy for all households receiving assistance. Special needs households are those that have either a household member with a disability, or a principal tenant aged 24 years or under, or 50 years or over. A high proportion indicates a high degree of targeting of special needs households.

It is not appropriate to use this indicator to compare the performance of public, community and State owned and managed Indigenous housing because the special needs category includes Indigenous people for public and community housing.

The proportion of new tenancies allocated to special needs households in 2003-04 varied from 60.3 per cent in Tasmania to 39.5 per cent in SA (figure 16.22).

Figure 16.22 **State owned and managed Indigenous housing — new tenancies allocated to households with special needs**[a, b, c]



[a] Data for NSW, WA and SA for 2003-04 are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for NSW, WA and SA cannot be made. For details of these changes, see the NSW, Victoria, WA and SA footnotes in table 16A.30. [b] Data for Victoria and Queensland for 2003-04 are not directly comparable to the previous years' data, and any direct comparison of 2003-04 data with previous years for Victoria and Queensland need to be done with caution. For details of these changes, see Victoria and Queensland footnotes in table 16A.30. [c] Data for WA for 2003-04 are not comparable with the other data presented and cannot be directly compared with other jurisdictions' data. For details of non-comparability, see the WA footnotes in table 16A.30.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.30.

Equity — priority access to those in greatest need

The final equity indicator reported for State owned and managed Indigenous housing is 'priority access to those in greatest need' (box 16.32).

The proportion of new allocations to those in greatest need varied for 2003-04, ranging from 80.9 per cent in SA to 2.7 per cent in Queensland (table 16.18). Differences in State housing allocation policies can influence comparability for this indicator. The relatively low level of priority allocations in NSW and Victoria were partly because Indigenous tenants in greatest need are likely to be housed under the State's general public housing programs.

Box 16.32 **Priority access to those in greatest need**

'Priority access to those in greatest need' is an output indicator of the CSHA's aim to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes are such that those in greatest need have first access to housing. It measures the proportion of new allocations to those in greatest need. Greatest need households are defined as low income households that at the time of allocation are homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs.

Table 16.18 shows the proportion of new allocations to those in greatest need by time on the waiting list. Data are provided for tenants waiting less than three months to more than two years. These numbers are not cumulative. A high value for this indicator, particularly for short time frames, represents a high degree of targeting of those in greatest need without these people waiting long periods of time.

This indicator, however, does not provide information on the number of greatest need applicants on the waiting list, or an allocations to those in greatest need as a proportion of all greatest need applicants on the waiting list.

It may not be appropriate to compare the performance of public, community and State owned and managed Indigenous housing in relation to this indicator. In some jurisdictions, different priority allocation guidelines may be used to allocate targeted housing. Priority access for Indigenous people is given through mainstream housing. Further, where allocation is made at the community level, reasons for allocation may not be recorded in information management systems.

Table 16.18 **State owned and managed Indigenous housing — proportion of new allocations to those in greatest need (per cent)**

	NSW[a]	*Vic*	*Qld*[a]	*WA*	*SA*	*Tas*	*Aust*
Total for year ending 30 June 2004	**15.2**	**19.4**	**2.7**	**22.7**	**80.9**	**na**	**26.5**
Proportion of greatest need allocations to new allocations, by time to allocation							
<3 months	31.6	21.0	2.7	30.0	71.9	na	36.7
3–<6 months	20.4	34.6	12.1	47.3	100.0	na	40.7
6 months–<1 year	7.1	26.3	–	11.8	97.5	na	22.8
1–<2 years	3.7	16.7	3.7	–	88.1	na	20.0
2+ years	0.9	–	–	–	50.0	na	1.1

a For details on NSW and Queensland data, see table 16A.31. – Nil or rounded to zero. **na** Not available.

Source: AIHW (2004a); table 16A.31.

Efficiency — gross cost per unit and net cost per unit

'Gross cost per unit' and 'net cost per unit' are the two efficiency indicators for State owned and managed Indigenous housing. Of these, data for gross cost per unit is currently reported. The Steering Committee has identified net cost per unit as an efficiency indicator, but data for this indicator were not available for the 2005 Report (box 16.33).

Box 16.33 **Gross and net cost per unit**

'Gross cost per unit' and 'net costs per unit' are included as output indicators of the CSHA guiding principle to undertake efficient and cost-effective management. These indicators measure the combined cost of providing assistance per dwelling. Cost per dwelling is broken down into the gross cost to government (administration and operating costs plus capital costs) and the net cost to government (gross cost excluding rents received from tenants).

Only gross cost per output unit is reported for State owned and managed Indigenous housing. The Review of Government Service Provision has identified net cost per output unit for development and reporting in future.

A low cost per dwelling can indicate greater efficiency. Caution must be used, however, when interpreting indicators in this way because the cost per dwelling indicator does not provide any information on the quality of service provided (for example, the standard of dwellings). Caution must also be used when interpreting this indicator because service delivery models differ across jurisdictions.

As with other indicators, it is not appropriate to compare the gross cost per State owned and managed Indigenous housing dwelling with the gross cost per dwelling for public housing (which would be the public housing equivalent of this indicator) because there is greater scope for economies of scale in administration costs with public housing, which is a much larger program overall.

State owned and managed Indigenous housing dwellings are also more highly concentrated in rural and remote areas where the cost of providing housing assistance is potentially greater. The need to construct culturally appropriate housing (possibly requiring a higher standard of amenities) may also affect the cost per dwelling. Finally, different cost structures may apply to the programs. Construction of dwellings, for example, under State owned and managed Indigenous housing may involve a skills development element to allow for training of apprentices in rural areas.

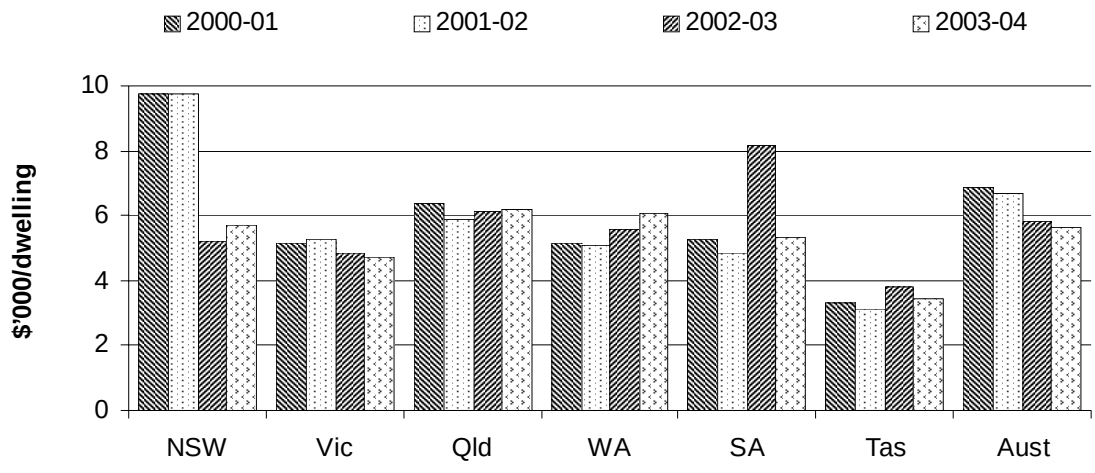
Care needs to be taken in interpreting the total cost of delivering housing. Administration costs and operating costs, for example, may not capture all costs incurred by government, so the total costs of housing provision could be understated.

The costs incurred by jurisdictions in providing State owned and managed Indigenous housing include:

- administration costs (the cost of the administration offices of the property manager and tenancy manager)
- operating costs (the costs of maintaining the operation of the dwelling, including repairs and maintenance, rates, the costs of disposals, market rent paid and interest expenses)
- depreciation costs
- the user cost of capital (the cost of the funds tied up in the capital used to provide State owned and managed housing).

Payroll tax has been excluded from gross cost per output unit calculations for State owned and managed Indigenous housing for the first time this year. Further, depreciation costs and the user cost of capital (capital costs) are not available for reporting on State owned and managed Indigenous housing. The cost per dwelling shown in figure 16.23 represents gross recurrent expenditure (that is, administration and operating costs) per dwelling. Rent received from tenants has not been deducted. In 2003-04 the gross cost per dwelling (excluding capital costs) ranged from $6188 in Queensland to $3425 in Tasmania (figure 16.23). On average, gross cost per dwelling was $5649.

Figure 16.23 **State owned and managed Indigenous housing — gross cost per dwelling, excluding capital costs (2003-04 dollars)[a, b, c]**



a Payroll tax has been excluded from gross cost per output unit calculations for State owned and managed Indigenous housing for the first time this year. **b** For details of Victoria, WA and Tasmania data see table 16A.32. **c** Data for SA for 2003-04 are based on different methodology from that used for their previous years' data and a direct comparison of 2003-04 data with previous years for SA cannot be made. For details of these changes see SA footnote in table 16A.32'.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.32.

Efficiency — occupancy rates

The second efficiency indicator reported for State owned and managed Indigenous housing is 'occupancy rates' (box 16.34).

Box 16.34 **Occupancy rates**

The 'occupancy rate' is included as an output indicator of the efficiency of housing utilisation. It is the proportion of dwellings occupied. The term 'occupied dwelling' refers to dwellings occupied by tenants who have a tenancy agreement with the relevant housing authority. High occupancy suggests housing is being utilised efficiently, although this indicator needs to be interpreted with the match of dwelling to household size indicator because there could be unused bedrooms. Low occupancy suggests dwellings are underutilised and that there is a high opportunity cost in retaining them. Occupancy is influenced by both turnover and housing supply.

The proportion of State owned and managed Indigenous housing stock (including untenantable dwellings) occupied at 30 June 2004 ranged from 98.2 per cent in Tasmania to 92.2 per cent in SA (table 16.19).

Table 16.19 **State owned and managed Indigenous housing — occupancy rates[a]**

	NSW	*Vic*	*Qld*	*WA*[b,c]	*SA*	*Tas*[b,c]	*Aust*
2001	98.0	95.4	94.0	96.0	94.3	93.1	95.8
2002	97.9	96.6	94.6	95.2	91.2	92.7	95.4
2003	97.6	96.1	94.2	94.4	91.8	95.8	95.2
2004	98.0	96.7	96.8	94.1	92.2	98.2	96.0

a At 30 June. **b** Data for WA and Tasmania for 2003-04 are not directly comparable to the previous years' data, and any direct comparison of 2003-04 data with previous years for WA and Tasmania needs to be done with caution. For details of these changes, see the WA and Tasmania footnotes in table 16A.33. **c** Data for WA, and Tasmania for 2003-04 are based on a different methodology from the other data presented and need to be interpreted with caution. For details of these variations, see the WA, and Tasmania footnotes in table 16A.33.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.33.

Efficiency — turnaround time

The third efficiency indicator reported for State owned and managed Indigenous housing is 'turnaround time' (box 16.35).

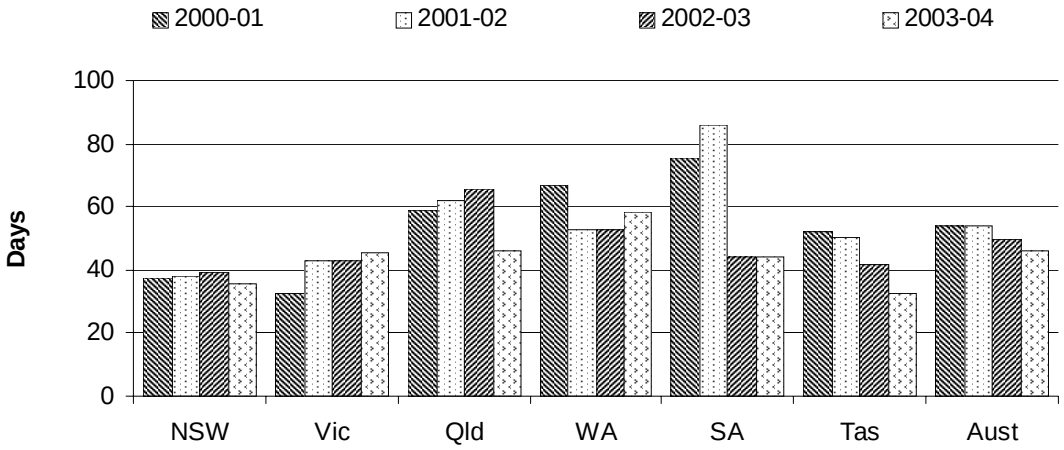
Box 16.35 **Turnaround time**

'Turnaround time' is included as an output indicator of the time taken to reallocate vacant properties after they have been vacated, acquired or newly constructed. The indicator measures the average time taken in days for vacant dwellings to be occupied. The length of time taken to rent untenanted dwellings affects allocations of housing, waiting times, the length of waiting lists and rent foregone. A low turnaround time suggests efficient housing allocation and asset management. All jurisdictions aim to minimise turnaround times.

This indicator may be affected by changes in maintenance programs and stock allocation processes, and some jurisdictions may have difficulty excluding stock upgrades. Cultural factors may also influence the national average turnaround time for State owned and managed Indigenous housing dwellings relative to public housing dwellings. Following the death of a significant person, for example, a dwelling may need to be vacant for a longer period of time (Morel and Ross 1993). The higher proportion of dwellings in rural and remote areas may also contribute to delays in completing administrative tasks and maintenance before dwellings can be re-tenanted.

The average number of days for vacant stock to be allocated in 2003-04 varied from 58 days in WA to 33 days in Tasmania (figure 16.24).

Figure 16.24 **State owned and managed Indigenous housing — average turnaround time[a, b, c]**



a Data for Queensland for 2003-04 are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for Queensland cannot be made. For details of these changes, see the Queensland footnotes in table 16A.34. **b** Data for Victoria for 2003-04 are based on a different methodology from the other data presented and need to be interpreted with caution. For details of these variations, see the Victoria footnote in table 16A.34. **c** Data for Queensland and WA for 2003-04 are not comparable with the other data presented and cannot be directly compared with other jurisdictions' data. For details of non-comparability, see the Queensland and WA footnotes in table 16A.34.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.34.

Efficiency — rent collected

The final efficiency indicator reported for State owned and managed Indigenous housing is 'rent collected' (box 16.36).

Box 16.36 **Rent collected**

'Rent collected' is included as an output indicator of the CSHA's guiding principle to undertake efficient and cost-effective management. It is the total rent collected as a proportion of the rent charged. A high proportion suggests efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a proportion of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of this indicator's reported results. Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

Rent collected as a proportion of the rent charged in 2003-04 varied from 104.1 per cent in NSW to 97.0 per cent in SA (table 16.20). Payment arrangements for rent in some jurisdictions mean that the rent collected over a 12 month period may be higher than rent charged over that period.

Table 16.20 **State owned and managed Indigenous housing — total rent collected as a proportion of total rent charged (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*[b]	*Tas*	*Aust*
2000-01	99.3	99.5	99.1	101.1	95.0	94.8	98.8
2001-02	99.9	98.8	97.3	103.0	92.6	99.1	98.5
2002-03	102.3	98.1	97.2	101.9	107.9	98.8	101.4
2003-04	104.1	99.8	101.3	103.1	97.0	102.2	101.8

a Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period. **b** Data for SA for 2003-04 are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for SA cannot be made. For details of these changes, see the SA footnotes in table 16A.35.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.35.

Outcomes

Amenity/location

The Steering Committee has identified 'amenity/location' as an outcome indicator (box 16.37). Data for this indicator were not available for the 2005 Report although

HMAC has provided in-principle support for a 2005 survey of State owned and managed Indigenous housing tenants and is considering a detailed proposal for this survey. This survey will provide nationally comparable data on amenity/location.

Box 16.37 **Amenity/location**

The Steering Committee has identified 'amenity/location' as an indicator for development and reporting in future, as an outcome indicator of the CSHA's aim to provide housing assistance that is appropriate to the needs of different households.

Affordability

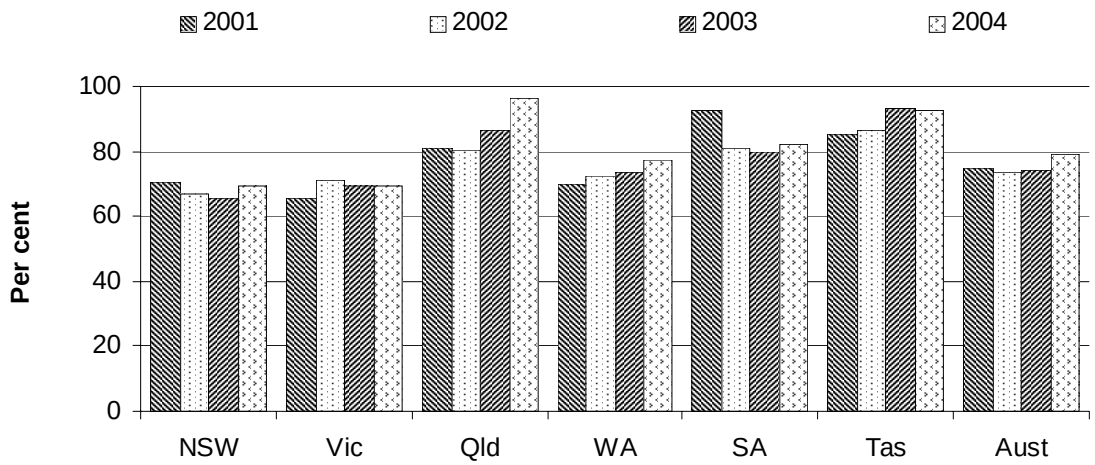
'Affordability' is an outcome indicator (box 16.38).

Box 16.38 **Affordability**

'Affordability' is included as an outcome indicator of the CSHA's aim to provide affordable housing to assist people who are unable to access suitable housing. It measures the rent charged to tenants as a proportion of the market rent for each dwelling, adjusted for CRA. A low proportion indicates a high level of subsidy from the State or Territory housing authority over and above CRA. This largely reflects the differing levels of market rent across jurisdictions.

Across those jurisdictions able to provide data, the rent charged at 30 June 2004 as a proportion of the market rent for each dwelling (adjusted for CRA) ranged from 96.3 per cent in Queensland to 69.5 per cent in Victoria (figure 16.25). Information on the amount of income paid in rent by State owned and managed Indigenous housing tenants as a proportion of income, can be found in table 16A.77.

Figure 16.25 **State owned and managed Indigenous housing — rent charged as a proportion of market rent, adjusted for CRA[a, b, c, d, e]**



a At 30 June. **b** For details of mixed composition, non-rebated and other households excluded, see table 16A.84. **c** Data for NSW, Victoria and Queensland for 2003-04 are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for NSW, Victoria and Queensland cannot be made. For details of these changes, see the NSW, Victoria and Queensland footnotes in table 16A.36. **d** Data for Tasmania for 2003-04 are not directly comparable to the previous years' data, and any direct comparison for 2003-04 data with previous years for Tasmania needs to be done with caution. For details of these changes, see the Tasmania footnotes in table 16A.36. **e** Data for Tasmania for 2003-04 are not comparable with the other data presented and cannot be directly compared with other jurisdictions' data. For details of non-comparability, see the Tasmania footnote in table 16A.36.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.36.

Match of dwelling to household size

'Match of dwelling to household size' is an outcome indicator (box 16.39).

Box 16.39 **Match of dwelling to household size**

'Match of dwelling to household size' is included as an outcome indicator of the CSHA's aim to provide housing assistance that is appropriate to the needs of different households, such as household size. It measures the proportion of households where allocated dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

Proxy occupancy standard for appropriate sized dwelling, by household structure

Household structure	*Bedrooms required*
Single adult only	1
Single adult (group)	1 (per adult)
Couple with no children	2
Sole parent or couple with one child	2
Sole parent or couple with two or three children	3
Sole parent or couple with four+ children	4

Source: AIHW (2003a).

A low proportion indicates a low proportion of overcrowded households.

The proxy occupancy standard above may differ from the specific criteria used by State housing authorities to match households to dwelling types, affecting interpretation of this indicator.

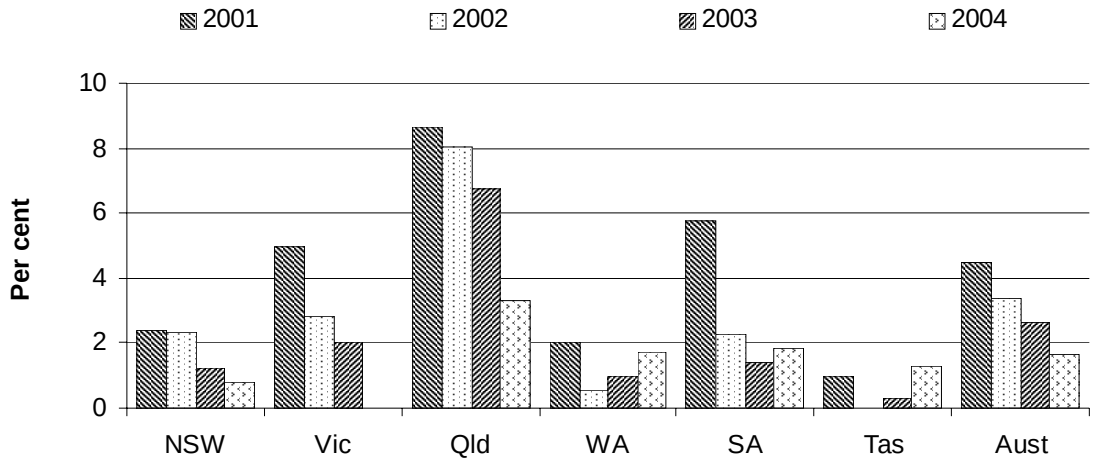
Care also needs to be taken in comparing the performance of public housing and State owned and managed Indigenous housing in relation to overcrowding. Two major factors potentially result in an apparently higher incidence of overcrowding in the latter relative to public housing dwellings:

- differences in Indigenous housing arrangements — for example, several generations living in one house, or visitors having 'right of access' in some circumstances (Pholeros, Rainow and Torzillo 1993)
- the influence of climate and culture — for example, people in rural areas may live outside houses rather than inside, while the proxy occupancy standard does not allow for verandas or larger shared living spaces (Pholeros, Rainow and Torzillo 1993).

The allocation policies of each State housing authority aim to match household size to available dwellings, to avoid overcrowding wherever possible. As household structure changes over time or cultural influences take effect, overcrowding can occur, post-allocation. This indicator does not reveal the proportion of stock that were underutilised.

Queensland had the highest proportion of overcrowded dwellings at 30 June 2004 (3.3 per cent), while Victoria had the lowest (0.0 per cent) (figure 16.26). More information on overcrowding and underuse for State owned and managed Indigenous housing can be found in table 16A.79.

Figure 16.26 **State owned and managed Indigenous housing — overcrowded dwellings**[a, b, c, d]



a At 30 June. **b** For details of mixed composition, non-rebated and other households excluded, see table 16A.84. **c** Data for NSW, Victoria and Queensland for 2003-04 are based on a different methodology from that used for their previous years' data, and a direct comparison of 2003-04 data with previous years for NSW, Victoria and Queensland cannot be made. For details of these changes, see the NSW, Victoria and Queensland footnotes in table 16A.37. **d** Data for SA for 2002-03 and 2003-04 are not directly comparable to the previous years' data, and any direct comparison for 2002-03 and 2003-04 data with previous years for SA needs to be done with caution. For details of these changes, see the SA footnotes in table 16A.37.

Source: AIHW (various years), CSHA National Data Reports: Aboriginal Rental Housing Program; table 16A.37.

Customer satisfaction

The Steering Committee has identified 'customer satisfaction' as an outcome indicator (box 16.40). Data were not available for the 2005 Report, but the proposed survey of State owned and managed Indigenous housing tenants (to be undertaken in 2005) will provide nationally comparable data on customer satisfaction.

Box 16.40 **Customer satisfaction**

'Customer satisfaction' is included as an outcome indicator because one aim of the CSHA is to provide housing assistance that is appropriate for different households. The Steering Committee has identified this indicator for development and reporting in future.

Commonwealth Rent Assistance

Data for CRA recipients are for clients of DFaCS only and generally for the fortnight ending either 6 March 2004 or 11 June 2004. Data exclude those recipients paid rental assistance by, or on behalf of, the DVA or DEST. Centrelink and DFaCS collected data centrally.

Important eligibility requirements for CRA (which is paid automatically once eligibility has been established) are (1) the receipt of an income support payment or more than the base rate of the Family Tax Benefit Part A, and (2) liability to pay rent.

Outputs

Equity — access — primary payment type

The first access indicator is 'primary payment type' (box 16.41).

Box 16.41 **Primary payment type**

CRA is a demand driven payment that has no benchmark in terms of the mix of customers. The 'primary payment type' indicator provides descriptive information only. Access to CRA by primary payment type is included as an output indicator of the CRA objective to provide income support recipients and low income families in the private rental market with additional financial assistance in an equitable manner. This indicator measures the number and proportion of eligible income support recipients receiving CRA, by type of payment received. The level of access experienced by different payment types is influenced by a number of factors, including (but not restricted to) the size of their respective base populations and the levels of home ownership.

The highest proportion of income units (where income units are analogous to family units, except that non-dependent children and other adults living in the same household are treated as separate income units) receiving CRA at 11 June 2004 were recipients of the Parenting Payment (Single) (21.1 per cent of income units receiving CRA), followed by recipients of the Newstart Allowance (19.3 per cent). These proportions were higher for Indigenous Australians (33.2 per cent and 29.9 per cent respectively). Only 3.2 per cent of Indigenous income units receiving CRA received the Age Pension, compared with 17.1 per cent for all Australians (table 16.21).

Table 16.21 **Income units receiving CRA, by primary payment type, 2004[a]**

Primary payment type	*Income units*[b]	*Proportion of CRA recipients*	*Indigenous income units*	*Proportion of Indigenous CRA recipients*
	no.	%	no.	%
Newstart	182 984	19.3	7 541	29.9
Parenting Payment, Single	200 460	21.1	8 370	33.2
Disability Support Pension	173 825	18.3	4 303	17.1
Age Pension	162 602	17.1	799	3.2
Youth Allowance	87 940	9.3	1 497	5.9
Family Tax Benefit	77 469	8.2	1 352	5.4
Parenting Payment, Partnered	27 492	2.9	764	3.0
Other qualifying payments	36 926	3.9	565	2.2
Total	**949 698**	**100.0**	**25 191**	**100.0**

a At 11 June. Data are for income units receiving CRA who were clients of DFaCS only. Data exclude those paid rental assistance by, or on behalf of, the DVA or DEST. Components may not sum to 100 per cent as a result of rounding. **b** Income units are classified as the Family Tax Benefit only if neither the person nor partner receives an income support payment. Income units are classified as Parenting Payment (Partnered) only if a partner does not receive an income support payment.

Source: DFaCS (unpublished); table 16A.43.

Equity — access — income unit type

The second access indicator is 'income unit type' (box 16.42).

Box 16.42 **Income unit type**

Access to CRA by 'income unit type' is included as an output indicator of the objective of CRA to provide financial assistance in an equitable manner. This indicator measures the number and proportion of eligible income support recipients receiving CRA by income unit type. The level of access experienced by different income unit types is influenced by a number of factors, including (but not restricted to) the size of their respective base populations and the levels of home ownership. CRA is a demand driven payment that has no benchmark in terms of the mix of customers. This indicator provides descriptive information only.

There were 949 698 income units receiving CRA at 11 June 2004. Of these, 25 191 (approximately 2.7 per cent) self-identified as Indigenous. Single people with no children represented approximately 53.7 per cent of income units receiving CRA and 42.3 per cent of Indigenous income units receiving CRA (table 16.22).

Table 16.22 **Income units receiving CRA, by income unit type, 2004[a, b]**

Type of income unit [c]	*Income units*	*Proportion of CRA recipients*	*Indigenous income units*	*Proportion of Indigenous CRA recipients*
	no.	%	no.	%
Single, no dependent children	369 998	39.0	8 024	31.9
Single, no children, sharer [d]	139 796	14.7	2 636	10.5
Single, one or two dependent children	189 543	20.0	6 890	27.4
Single, three or more dependent children	35 709	3.8	2 176	8.6
Partnered, no dependent children	79 333	8.4	1 155	4.6
Partnered, one or two dependent children	90 531	9.5	2 475	9.8
Partnered, three or more dependent children	38 201	4.0	1 570	6.2
Partnered, illness or temporarily separated, no dependant children	2465	0.2	62	0.2
Unknown income unit	4 122	0.4	203	0.8
Total	**949 698**	**100.0**	**25 191**	**100.0**

a At 11 June. Data are for income units receiving CRA who were clients of DFaCS only. Data exclude those paid rent assistance by, or on behalf of, the DVA or DEST. Components may not sum to 100 per cent as a result of rounding. **b** Income units are analogous to family units except that non-dependent children and other adults are treated as separate income units (see section 16.6 for more detail). **c** A child is regarded as dependent on an adult only if the adult receives the Family Tax Benefit for the care of the child. **d** The maximum rate of assistance is lower for some single persons without dependent children who share accommodation (see the definition of 'sharer' in section 16.6).

Source: DFaCS (unpublished); table 16A.44.

For all jurisdictions except the NT, the proportion of income units receiving CRA at 11 June 2004 who identified as Indigenous was very close to Indigenous representation in the overall community. The NT had the highest proportion of self-identified Indigenous people receiving the payment (18.3 per cent), while the Indigenous proportion of the NT population was 30.0 per cent. Victoria had the lowest proportion of self-identifying Indigenous people receiving CRA (0.8 per cent) and the lowest Indigenous population as a proportion of the State population (0.6 per cent) (table 16.23).

Table 16.23 **Income units receiving CRA, by Indigenous status and geographic location, 2004[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[b]
Non-Indigenous										
Income units	no.	307 341	204 291	225 987	84 916	65 257	22 972	na	4 550	923 558
In capital city	no.	168 209	145 007	100 319	65 762	51 157	9 746	8 244	3 546	551 990
In rest of State	no.	139 132	59 284	125 668	19 154	14 100	13 226	..	1 004	371 568
Share of all recipients	%	97.1	99.2	96.1	97.2	98.2	96.8	na	80.7	97.2
Non-Indigenous population, as a proportion of total population	%	97.9	99.4	96.5	96.4	98.2	96.2	98.7	70.0	97.6
Indigenous										
Income units	no.	9 006	1 611	8 997	2 387	1 214	744	na	1 032	25 102
In capital city	no.	2 501	790	2 577	1 336	743	261	111	568	8 887
In rest of State	no.	6 505	821	6 420	1 051	471	483	..	464	16 215
Share of all recipients	%	2.8	0.8	3.8	2.7	1.8	3.1	na	18.3	2.6
Indigenous population, as a proportion of total population	%	2.1	0.6	3.5	3.6	1.8	3.8	1.3	30.0	2.4
Total income units	no.	**316 541**	**206 041**	**235 145**	**87 405**	**66 483**	**23 737**	**8 355**	**5 636**	**949 698**

a At 11 June. **b** National total includes postcodes that could not be classified. **na** Not available. **..** Not applicable.

Source: DFaCS (unpublished); table 16A.45.

Equity — access — low income

'Low income' is the third access indicator (box 16.43).

Box 16.43 **Low income**

'Low income' access to CRA is included as an output indicator of the objective of CRA to provide income support recipients and low income families with financial assistance. This indicator shows income of income units receiving CRA, by quintiles of income received per week. This indicator provides a measure of the extent to which CRA is targeted at those with low-income. It enables a comparison of the incomes of income units receiving maximum CRA with those of income units who have lower rents and thus receive reduced CRA. Disaggregating income by income unit type helps to minimise the observed spread of incomes, because most recipients are primarily dependent on social security payments, which also vary by family structure.

Among all income unit types at 6 March 2004, the bottom 20 per cent of income units receiving CRA had income of $211 or less per week, while the top 20 per cent had income in excess of $537 per week (table 16.24).

Among those income units paying enough rent to receive maximum CRA payments at 6 March 2004, the bottom 20 per cent of income units receiving CRA had income of $214 or less per week, while the top 20 per cent had income in excess of $592 per week (table 16A.46). Data for income units receiving maximum CRA payments and for those not paying enough rent to receive maximum CRA payments are also shown in table 16A.46.

Table 16.24 **Income of income units receiving CRA, by income quintiles and income units, 2004 ($ per week)[a, b, c]**

	Income quintile			
Income unit type[d]	*20 per cent of recipients*	*40 per cent of recipients*	*60 per cent of recipients*	*80 per cent of recipients*
Single, no dependent children	195.40	229.30	230.77	261.97
Single, no children, sharer [e]	160.25	192.50	195.40	244.30
Single, one or two dependent children	354.54	404.84	469.26	620.71
Single, three or more dependent children	486.58	545.26	603.34	707.08
Partnered, no dependent children	365.57	384.36	427.41	509.41
Partnered, one or two dependent children	459.30	571.45	719.47	871.28
Partnered, three or more dependent children	603.17	736.84	898.44	1067.64
Partnered, illness separated, no dependent children	460.07	474.07	514.07	581.50
Partnered, temporarily separated, no dependent children	318.50	382.36	452.71	555.34
All income unit types	**211.00**	**239.77**	**368.82**	**537.00**

a At 6 March. Data are for income units receiving CRA who were clients of DFaCS only. Data exclude those paid rental assistance by, or on behalf of, the DVA or DEST. **b** Quintiles represent one fifth of the respective income unit type population ranked by income. Dollar amounts do not represent average income: they reflect the upper boundary that defines the quintile — for example, the lowest quintile of singles with no dependent children has income less than $195 per week, the respective second quintile has incomes between $195 and $229, and incomes for the highest quintile are above the upper boundary ($262) of the fourth quintile. **c** Income units are analogous to family units except that non-dependent children and other adults are treated as separate income units (see section 16.6 for more detail). **d** A child is regarded as dependent on an adult only if the adult receives the Family Tax Benefit for the care of the child. **e** The maximum rate of assistance is lower for some single persons without dependent children who share accommodation (see the definition of 'sharer' in section 16.6).

Source: DFaCS (unpublished); table 16A.46.

Equity — access — special needs

The fourth access indicator is 'special needs' (box 16.44).

Box 16.44 **Special needs**

'Special needs' access to CRA is included as an output indicator of the objective of CRA to provide income support recipients and low income families with financial assistance. This indicator provides the proportions of special needs income units receiving CRA, such as regional and remote Australians and Indigenous income units receiving CRA, by benefit type. It provides an overview of the level of assistance provided to disadvantaged groups and facilitates comparison with special needs groups in public housing. CRA is a demand driven payment that has no benchmark in terms of the level of assistance provided to special needs clients. Additional measures of special need, which include a geographic dimension, are reported under 'Affordability'.

Overall, 64.0 per cent of income units receiving CRA at 11 June 2004 were located in major cities, 34.6 per cent were in regional areas (as distinct from remote areas) and 1.3 per cent were in remote areas (table 16A.47). Of Indigenous income units receiving CRA, approximately 36.4 per cent were located in major cities, 54.5 per cent were in regional areas (as distinct from remote areas) and 8.9 per cent were in remote areas (table 16A.48).

Equity — access — geographic spread of CRA customers

The final access indicator is the 'geographic spread of CRA customers' (box 16.45).

Box 16.45 **Geographic spread of CRA customers**

The 'geographic spread of CRA customers' provides descriptive information about rents, average levels of assistance, and the level of representation within the social security population for a defined region. This information is useful in examining differences across states and territories, and capital cities/rest of State. Comparison can also be made at the statistical local area level within capital cities for the ratio measure between income units receiving CRA and the social security population. The indicator can provide some limited insight into the responsiveness/effectiveness of CRA to regional variations in rent.

Two measures are presented:

- income units receiving CRA as a proportion of income units in each capital city receiving a social security income support benefit or more than the base rate of the Family Tax Benefit
- the average CRA entitlement across locations.

Additional measures of geographic spread are reported under 'Affordability'.

Results for income units receiving CRA as a proportion of income units in each capital city receiving a social security income support benefit or more than the base rate of the Family Tax Benefit are shown in tables 16A.49–16A.57. Information on the average CRA entitlement across locations is contained in table 16A.58.

Effectiveness — appropriateness — maximum rate

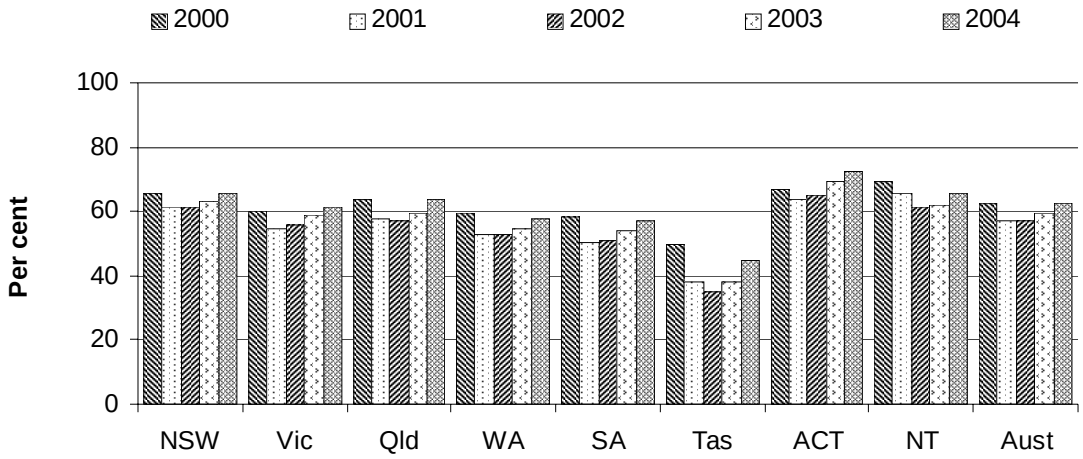
The first effectiveness indicator is the proportion of income units receiving the 'maximum rate of CRA', by jurisdiction and payment type (box 16.46).

Box 16.46 **Maximum rate of CRA**

The 'maximum rate of CRA' indicator is included as an output indicator of the appropriateness of CRA. It measures the proportion of income units receiving the maximum rate of CRA, and can be used to monitor the adequacy of CRA over time. The effectiveness of the payment against rents is reflected in increasing/decreasing proportions on the maximum rates of assistance. An increasing proportion of the maximum rate of payment suggests that CRA is decreasing in its effectiveness against rental increases, while a decreasing proportion suggests that CRA is increasing at a rate above that of rental increases.

At 6 March 2004, 62.4 per cent of income units receiving CRA across Australia qualified for the maximum rate of CRA payments. This proportion varied from 72.1 per cent in the ACT to 45.0 per cent in Tasmania (figure 16.27). Table 16A.59 contains data showing the proportion of income units receiving CRA qualifying for maximum CRA payments, by the type of primary payment received.

Figure 16.27 **Proportion of income units receiving CRA paying enough rent to receive maximum assistance[a, b, c, d]**



a Data for 2004 is at 6 March; data for all other years are near the end of the financial year. **b** Data are for income units receiving CRA who were clients of DFaCS only. Data exclude those paid rental assistance by, or on behalf of, the DVA or DEST. **c** Income units are analogous to family units except that non-dependent children and other adults are treated as separate income units (see section 16.6 for more detail). **d** Proportion of income units with ongoing entitlement to CRA paying enough rent to receive maximum assistance.

Source: DFaCS (unpublished); table 16A.60.

Effectiveness — appropriateness — number and outcome of appeals

The second effectiveness indicator is the 'number and outcome of appeals' (box 16.47).

Box 16.47 **Number and outcome of appeals**

The 'number and outcome of appeals' is included as an output indicator because it measures the appropriateness of decisions related to the payment of CRA. There is a formal review process for decisions related to the payment of CRA. Clients who are dissatisfied with a decision are encouraged to discuss the matter with the original decision maker before taking the matter further, although this is not a necessary step. Authorised review officers conduct a quick and informal internal review of the decision. Generally, customers who are dissatisfied with the authorised review officer's decision can appeal to the Social Security Appeals Tribunal, which is an independent body with decision making powers. Either the customer or DFaCS can seek an Administrative Appeals Tribunal review of the Social Security Appeals Tribunal's decisions. The indicator measures the outcomes of all CRA appeals finalised. A high proportion of original decisions affirmed would imply that the original decisions were appropriate.

There were 347 finalised appeals to an authorised review officer in 2003-04, which represented approximately 0.04 per cent of people receiving CRA. Approximately 36 per cent of finalised appeals to an authorised review officer, 37 per cent of appeals to the Social Security Appeals Tribunal and 33 per cent of appeals to the Administrative Tribunal resulted in the original decision being set aside or changed. (table 16.25).

Table 16.25 **Outcome of all CRA appeals finalised in 2003-04**

Outcome	*Appeals to ARO*		*Appeals to SSAT*		*Appeals to AAT*	
	no.	%	no.	%	no.	%
Original decision affirmed or appeal dismissed	213	61.4	39	58.2	3	33.3
Original decision set aside	80	23.1	24	35.8	3	33.3
Original decision varied	45	13.0	1	1.5	–	–
Appeal withdrawn	9	2.6	3	4.5	3	33.3
Total finalised (a)	**347**	**100.0**	**67**	**100.0**	**9**	**100.0**

ARO = authorised review officer. SSAT = Social Security Appeals Tribunal. AAT = Administrative Appeals Tribunal. **a** Totals may not add to 100 as a result of rounding. – Nil or rounded to zero.

Source: DFaCS (unpublished); table 16A.61.

Efficiency — running costs per 1000 customers

The Steering Committee has identified 'running costs per 1000 customers' as an indicator of efficiency (box 16.48). Data for this indicator, however, were not available for the 2005 Report.

Box 16.48 **Running costs per 1000 customers**

'Running costs per 1000 customers' is an output indicator because CRA aims to provide financial assistance in an efficient manner. Low running costs per 1000 customers would imply high efficiency for a given service level. The Steering Committee has identified this indicator for development and reporting in future.

Efficiency — control of incorrect payment

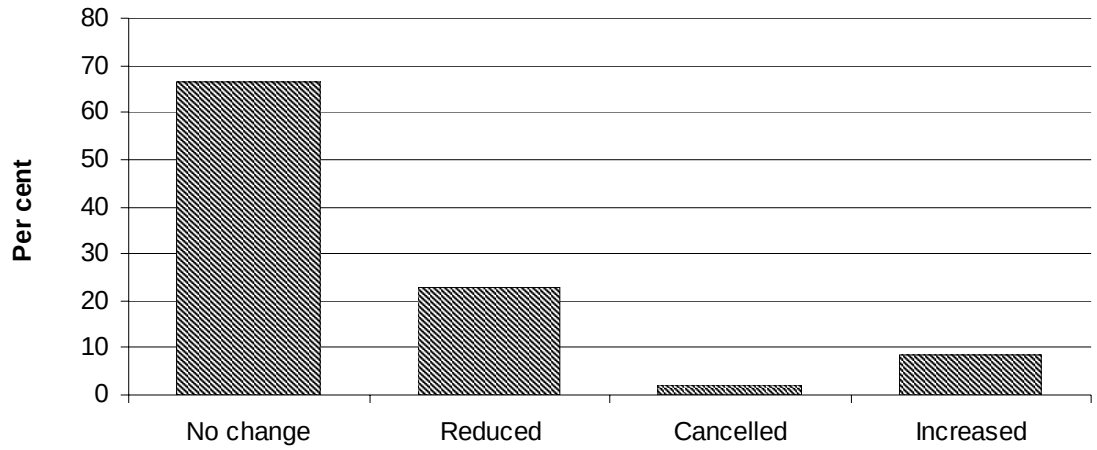
'Control of incorrect payment' is an efficiency indicator (box 16.49).

Box 16.49 **Control of incorrect payment**

'Control of incorrect payment' of CRA is included as an output indicator of the objective of CRA to provide financial assistance in an efficient manner. Centrelink relies on risk-based review activities to control overpayment, some of which are targeted at CRA. The indicator measures the proportion of CRA payment adjustments resulting from a risk-based review. A high proportion of reviews resulting in no change is desirable because it implies efficiency of the system (that is, a high proportion of recipients are receiving the correct payment). Conversely, a low proportion of reviews resulting in no change implies low efficiency because there is a high proportion of recipients receiving incorrect payment.

Centrelink conducted 154 732 risk-based reviews relating to CRA in 2003-04. CRA was cancelled in 2.3 per cent of cases, reduced in 22.7 per cent of cases and increased in 8.5 per cent of cases. For the majority of cases (66.5 per cent), there was no change (figure 16.28).

Figure 16.28 **CRA payment adjustments resulting from a risk-based review, 2003-04**



Source: DFaCS (unpublished); table 16A.62.

Efficiency — ratio of running costs to total outlays

The Steering Committee has identified the 'ratio of running costs to total outlays' as an indicator of efficiency (box 16.50). Data for this indicator, however, were not available for the 2005 Report.

Box 16.50 **Ratio of running costs to total outlays**

The 'ratio of running costs to total outlays' is included as an output indicator because CRA aims to provide financial assistance in an efficient manner. A low ratio would imply high efficiency for a given service level. The Steering Committee has identified this indicator for development and reporting in future.

Outcomes

Affordability

'Affordability' is one of three outcome indicators reported (box 16.51).

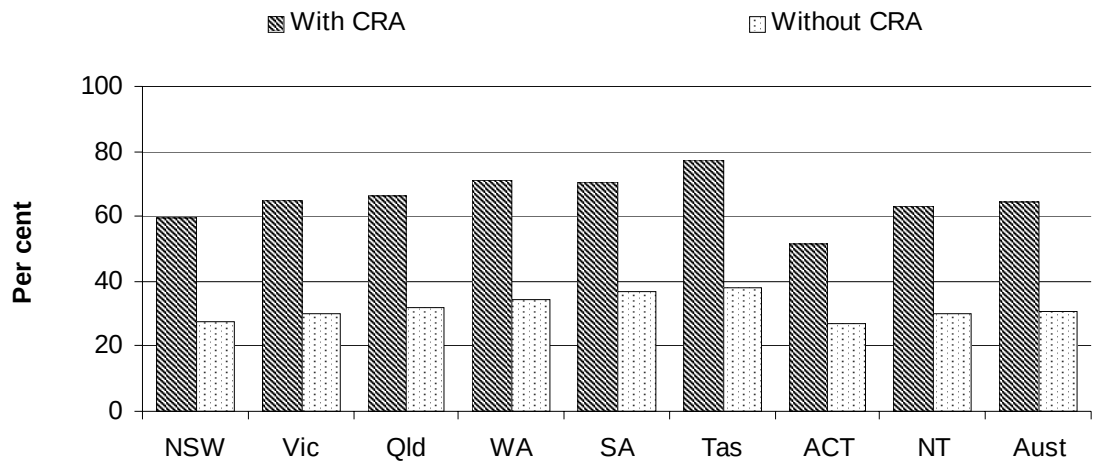
Box 16.51 **Affordability**

'Affordability' is included as an outcome indicator of the CRA objective to provide income support recipients and low income families in the private rental market with additional financial assistance. This indicator measures the proportions of income units spending more than 30 per cent and 50 per cent of their income on rent with and without CRA. A low proportion implies high affordability for recipients spending both 30 per cent and 50 per cent of income on rent with and without CRA. Affordability outcomes (with and without CRA) have been provided for all income units receiving CRA, Indigenous income units receiving CRA, and Disability Support Pension income units receiving CRA.

Nationally, 30.9 per cent of income units not receiving CRA at 6 March 2004 have spent less than 30 per cent of their income on rent. Across jurisdictions, this proportion ranged from 38.3 per cent in Tasmania to 27.0 per cent in the ACT. Accounting for CRA (thereby reducing the rent paid by the amount of the assistance), the national proportion of income units who spent less than 30 per cent of their income on rent at 6 March 2004 increases to 64.5 per cent. Across jurisdictions, this proportion ranged from 77.3 per cent in Tasmania to 51.5 per cent in the ACT (figure 16.29).

Similarly, if CRA was not payable, then 72.0 per cent of income units across Australia have spent less than 50 per cent of their income on rent at 6 March 2004. Accounting for CRA payments, this proportion increased to 90.9 per cent (table 16A.63).

Figure 16.29 **Income units receiving CRA paying less than 30 per cent of income on rent, with and without CRA, 2004[a]**

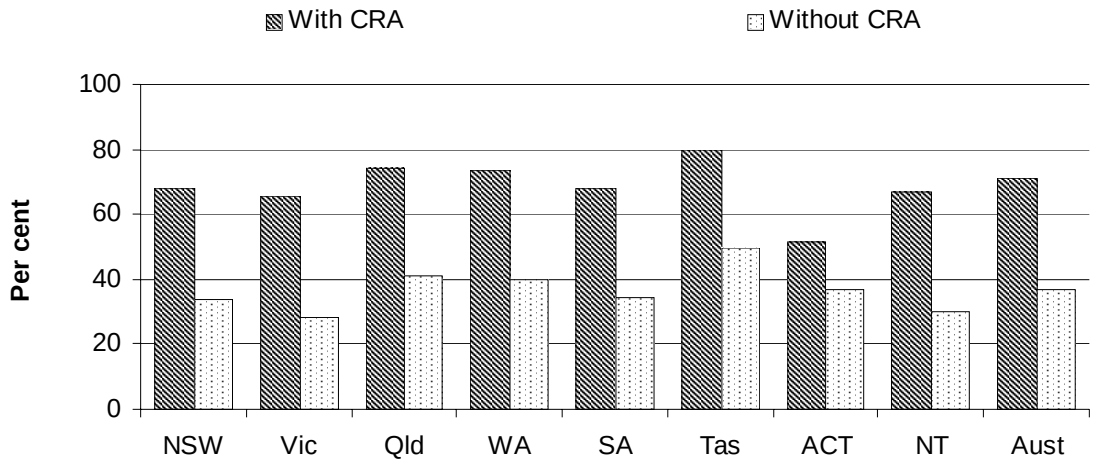


a At 6 March.

Source: DFaCS (unpublished); table 16A.63.

Data are also available on the proportion of income spent on rent (with and without CRA) by Australians living in rural and remote areas, income units where one or more members self-identify as Indigenous Australians, and income units where one or more members receive a Disability Support Pension. Nationally, if CRA was not payable, then only 36.9 per cent of those Indigenous income units receiving CRA would have spent less than 30 per cent of income on rent at 6 March 2004. Across jurisdictions, this proportion ranged from 49.7 per cent in Tasmania to 28.1 per cent in Victoria. Accounting for CRA payments (thereby reducing the rent paid by the amount of the assistance), the national proportion of Indigenous income units who spent less than 30 per cent of income on rent at 6 March 2004 increases to 70.9 per cent. Across jurisdictions, this proportion ranged from 79.6 per cent in Tasmania to 51.6 per cent in the ACT (figure 16.30). Similarly, if CRA was not payable, then 75.1 per cent of Indigenous income units across Australia would have spent less than 50 per cent of income on rent at 6 March 2004. Accounting for CRA payments, this proportion increases to 93.2 per cent (table 16A.64).

Figure 16.30 **Indigenous income units receiving CRA paying less than 30 per cent of income on rent, with and without CRA, 2004[a]**

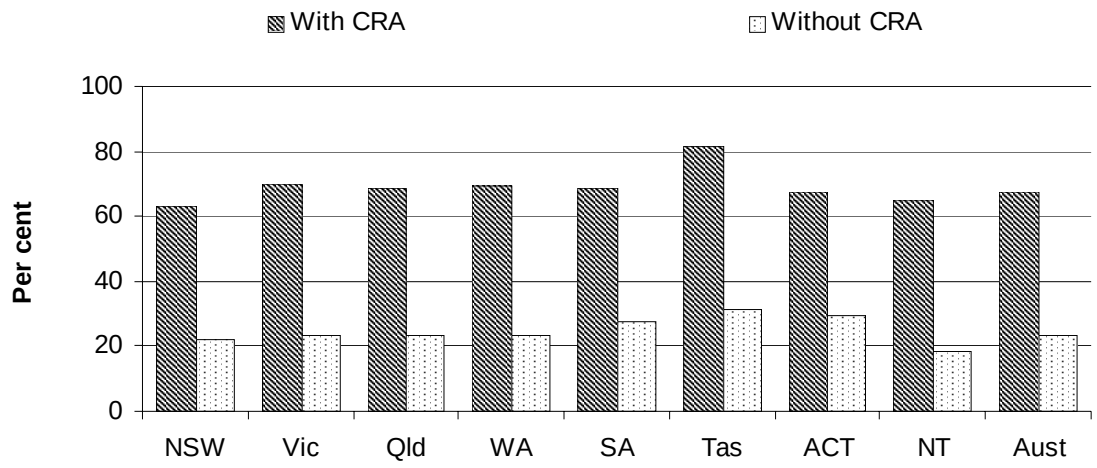


a At 6 March.

Source: DFaCS (unpublished); table 16A.64.

If CRA was not payable, then 23.5 per cent of all income units with a member receiving a Disability Support Pension would have spent less than 30 per cent of income on rent at 6 March 2004. Across jurisdictions, this proportion ranged from 31.0 per cent in Tasmania to 18.2 per cent in the NT. Accounting for CRA payments (thereby reducing the rent paid by the amount of the assistance), the proportion of income units receiving a Disability Support Pension who spent less than 30 per cent of income on rent at 6 March 2004 increases to 67.5 per cent. Across jurisdictions, this proportion ranged from 81.3 per cent in Tasmania to 63.0 per cent in NSW (figure 16.31). Similarly, if CRA was not payable, then 71.3 per cent of all income units receiving a Disability Support Pension would have spent less than 50 per cent of income on rent at 6 March 2004. Accounting for CRA payments, this proportion increases to 94.2 per cent (table 16A.65).

Figure 16.31 **Income units receiving a Disability Support Pension paying less than 30 per cent of income on rent, with and without CRA, 2004[a]**



a At 6 March.

Source: DFaCS (unpublished); table 16A.65.

Satisfaction with location and quality

The remaining two outcome indicators are 'satisfaction with location' and 'satisfaction with quality' (box 16.52).

Box 16.52 **Satisfaction with location and quality**

'Satisfaction with location' and 'satisfaction with quality' are included as outcome indicators, because customer satisfaction is an important outcome and a proxy measure of whether the housing is appropriate to the needs of the CRA recipient. The indicators measure satisfaction with the location and quality of housing, rather than with the CRA payment. They measure the proportion of respondents satisfied with the location and quality of their housing, broken down into categories of 'poor', 'just okay', 'good' and 'great'. A high proportion of respondents nominating categories of 'good' and 'great' is desirable.

The CRA survey method differs from the method used for the National Social Housing Survey for public and community housing tenants, so satisfaction parameters between the two areas should not be compared.

Data showing CRA recipients' satisfaction with both the location and quality of their housing were obtained from the most recent DFaCS customer survey conducted between March 2003 and January 2004. Results are based on 620 relevant responses from those individuals paying enough rent to qualify for CRA

and receiving a relevant primary payment type. Overall, 76.3 per cent of respondents described their location as 'good' or 'great', while 2.3 per cent described the location as 'poor'. Regarding the quality of their housing, 71.9 per cent of respondents described their housing as 'good' or 'great', and 2.4 per cent described it as 'poor' (table 16.26).

Table 16.26 **Satisfaction with location and quality of housing, 2003-04 (per cent)[a, b]**

Location				
	Poor	Just Okay	Good	Great
	2.3	21.3	40.8	35.5
Quality				
	Poor	Just Okay	Good	Great
	2.4	25.7	49.8	22.1

a Includes responses by individuals paying enough rent to qualify for CRA and receiving a relevant payment type. CRA may not be payable or may be paid to a partner. **b** The CRA survey methodology differs from the methodology used for the National Social Housing Survey for public and community housing tenants, so satisfaction parameters between the two areas should not be compared.

Source: DFaCS (unpublished); table 16A.66.

16.4 Future directions in performance reporting

Further developing indicators and data

A new CSHA took effect on 1 July 2003 and will run until 30 June 2008. The Policy Research Working Group of HMAC will undertake a review of the performance indicator framework to reflect the objectives of the new CSHA and to improve the quality and scope of the national performance indicators in some areas.

Improved reporting on housing provision to Indigenous Australians continues to be a priority, with work to be done by the National Housing Data Agreement Management Group, the National Indigenous Housing Information Implementation Committee and the National Housing Data Development Committee over the next year to improve the availability of data on Indigenous Australians accessing public and community housing. Work will also be done to improve reporting on both State owned and managed Indigenous housing and the Indigenous community housing sector. The National Indigenous Housing Information Implementation Committee has developed a national reporting framework for Indigenous housing. A survey of State owned and managed Indigenous housing tenants is also planned for 2005.

The Steering Committee has agreed that work to improve CRA reporting will be a priority during 2005. Some improvements to CRA reporting may begin to be reported in the 2006 Report.

16.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

“ The 2003 Commonwealth State Housing Agreement continues to build on the performance framework introduced under the 1999 CSHA and has a particular emphasis on timely reporting and demonstrated progress in achieving performance objectives.

Rent Assistance is provided as a financial supplement and has the flexibility to cope with changing demand and provide customers with more choice about where they live and the quality of their housing. This choice can involve a tradeoff with other expenses and with the consumer's after-housing income.

The Rent Assistance program has no specific benchmark for affordability. The adoption of an affordability benchmark would fail to recognise the element of choice exercised by customers who place a higher value on housing than others in comparable circumstances.

The Australian Government allocates $91 million annually through Aboriginal Rental Housing Program (ARHP) and $250 million annually for the Community Housing and Infrastructure Program (CHIP) for the provision of State/Territory managed and Indigenous community managed housing. CHIP funding was formerly appropriated to the Aboriginal and Torres Strait Islander Services (ATSIS).

In the 2001 Budget, an additional $75 million over four years was allocated to states and territories for Indigenous housing and housing related infrastructure. As part of the initiative, the Australian Government requires improved accountability, focusing on outcomes, for all national specific housing funds (ARHP and CHIP).

In 2003 the National Reporting Framework (NRF) was developed and agreed to by all jurisdictions as a framework for all national reporting on the Indigenous housing effort. Based on Building a Better Future: Indigenous Housing to 2010, the NRF has the capacity to improve the effectiveness and efficiency of reporting on Indigenous housing outcomes and performance. ”

New South Wales Government comments

“

Sydney has the highest rents in Australia and rents outside Sydney are also high in comparison to rural and regional centres in other states.

Reduced housing affordability during the past few years has resulted in considerable numbers of low to moderate income households in NSW experiencing housing stress — that is, paying more than 30 per cent of their income in mortgage payments or rent. Reasons for this include increases in house prices and rents, and changes in demand patterns. Rates of home purchase have also declined, suggesting a shift to rental accommodation, particularly for households in the 25 to 44 age bracket. There has been growth in the rental market, but not at the more affordable end of the market.

Despite these pressures, NSW continues to perform well against most indicators during 2003-04. In efficiency terms, NSW continues to perform above average. Turnaround times across the public, community and Aboriginal sectors have remained steady. Occupancy rates across all sectors were among the highest in the country, with public housing in NSW performing best overall.

The indicators confirm that there has been a steady increase over the past 3 years in the number of households in NSW that are eligible for the maximum rate of Commonwealth Rent Assistance. Commonwealth Rent Assistance is increasingly ineffective against rental increases, and has only a marginal impact on housing affordability in most parts of Sydney, reflecting an increasingly unaffordable private rental market.

There is continuing demand for social housing in NSW, and the social housing client base has increasingly complex needs. The indicators show that public housing is increasingly targeted to low income and special needs households. The Department of Housing continues to address the issues of increased demand and complexity of need through a range of strategies. For example, the Department is establishing a new housing company in the inner Sydney area to house people who need support services in order to live independently, and for whom it is unlikely that public housing infrastructure alone would be sustainable.

With nearly 30 per cent of Australia’s Indigenous population living in NSW, (one third in metropolitan Sydney and one quarter in northern coastal NSW), housing for Indigenous people is of great importance to the NSW Government. The Department of Housing is a signatory to Two Ways Together, the NSW Aboriginal Affairs Plan 2003 to 2012, which provides the framework for a whole of government approach to tackling Aboriginal disadvantage. The report demonstrates the continuing improvements in NSW’s service provision to Aboriginal clients.

”

Victorian Government comments

“ Victoria is focusing on innovative solutions to a variety of housing issues in an environment of declining capital funding. Major issues being addressed include problems of housing affordability in the private rental sector, increased complexity of client needs and ageing social housing assets.

The supply of affordable rental housing in the private rental market, particularly in the inner and middle suburbs of Melbourne, remains a significant issue. Growth in social housing is increasingly important in providing access to housing for low-income households. Victoria funded the acquisition of over 1000 new social housing units in 2003-04, including 35 new properties for the Aboriginal Rental Housing Program and 94 units to assist people confronted by homelessness or in housing crisis.

Victoria is engaging local government, non-government entities and private finance in facilitating the supply of additional affordable housing. In 2003-04 a regulatory framework was developed to underpin the future operation of non-government housing providers and a Registration of Intent process undertaken for parties wishing to form Housing Associations under this initiative.

Recognising continued high demand for public housing, assistance in Victoria is highly targeted to clients with significant levels of housing need such as people who are homeless, those with specific medical or support needs and those experiencing family violence. To foster greater collaboration with other areas of government in meeting the needs of vulnerable young people, the Youth Homelessness Action Plan was launched in May 2004.

Improving social and economic outcomes for disadvantaged communities is a significant focus in Victoria under the Neighbourhood Renewal Program. In 2003-04, five new Neighbourhood Renewal projects were established. Existing projects have delivered improvements in areas of housing condition, the physical environment, local education and training opportunities, community pride, government performance and crime and safety. Importantly, Neighbourhood Renewal has also improved employment and learning outcomes for residents.

Victoria recognises the importance of property maintenance in meeting community expectations and protecting the significant social housing asset base. With 30 per cent of Victoria’s current properties being in excess of 30 years old, this is a critical and ongoing challenge. In 2003-04, investment in upgrade and redevelopment programs resulted in 2798 properties receiving major upgrades, 700 of which were in Neighbourhood Renewal areas. Eight major redevelopments also took place in 2003-04 with a total project lifetime yield of approximately 1000 units.

A focus on affordable housing supply strategies, asset upgrade, homelessness support and the Neighbourhood Renewal Program is expected to continue in future years. The Victorian Government has supported this effort with an additional $283 million over its matching obligations, under the Commonwealth. State Housing Agreement. ”

Queensland Government comments

“ The commencement of the Housing Act 2003 on 1 January 2004 represented the start of a new era for the Department. The new legislation recognises the Government's role in providing direct housing assistance, while providing flexibility to deliver innovative programs and solutions, in partnership with industry, government and the community.

The Department continues to operate in an environment characterised by growing housing stress, where home ownership and private rental are increasingly less affordable for low income earners. An increase in housing prices and the continuing loss of affordable private rental housing, including the decline in boarding houses and caravan park accommodation, has exacerbated the demand for government-funded housing assistance.

The Department continues to make a real difference to people's lives through provision of integrated and sustainable housing services. In 2003-04 the Department assisted nearly 240 000 households with a diverse range of products and services including:

- providing approximately 56 000 households with Public Rental Housing and Aboriginal and Torres Strait Islander Housing; and
- funding community organisations to provide over 129 000 households with accommodation, tenancy advice and minor home modifications.

The Department continued to enhance the social housing portfolio through construction and upgrades across its major programs. It also continued to promote environmentally, socially and economically sustainable housing to government, the building industry and home-owners and renovators through its Smart Housing program.

The Department progressed a number of innovative projects in collaboration with key partners to help improve people's lives through housing. For example, the Kelvin Grove Urban Village project, which will deliver approximately 200 units of affordable housing demonstrates how partnerships with the private sector and other agencies can realise common objectives. The Brisbane Housing Company, an independent, not-for-profit organisation created by the Department in partnership with the Brisbane City Council, continued to increase the supply of affordable housing in the inner Brisbane area.

The Department has been actively engaged in the Cape York Partnership Meeting Challenges, Making Choices Strategy, to address issues affecting Indigenous communities. In addition, the Department played an important role in the Government's responses to people in housing crisis and people with disabilities through identifying and delivering a range of preventative and emergency responses to homelessness.

The Department continues to build on established foundations to better provide responsive, integrated and sustainable housing services to Queenslanders. through collaborative partnerships and innovative housing solutions. ”

Western Australian Government comments

“ The role of the State Housing Commission is to provide housing for Western Australians who cannot otherwise afford their own homes by arranging affordable home finance, rental housing and land.

Keystart is an initiative of the West Australian Government and was established to assist West Australians into affordable housing. During the year Keystart has undergone significant change so that its policies and procedures are pitched at financing those people into home ownership who would otherwise be in private or public rental. Similarly, Landstart, primarily through its joint ventures with the private sector, has ensured an adequate supply of serviced land for those seeking home ownership. During the 2003-04 financial year the Commission undertook a range of initiatives, including:

- The development of the Aboriginal Housing and Infrastructure Council Strategic Plan. The vision of this plan is to provide all Aboriginal and Torres Strait Islander Western Australians with equitable access to quality housing and services.
- Introduction of the Regional Upgrade Strategy, which aims to replace 200 houses and refurbish 50 existing houses each year for the next four years.
- A major funding boost to the Supported Housing Assistance Program of $0.5 million, which has allowed the program to expand to several other towns within the State.
- Protocols between the Commission and the Department for Community Development for the provision of support to metropolitan families facing eviction were reviewed with improvements made to the referral process. Also, during the year :
- The Commission approved 4183 home loans.
- The Bond Assistance scheme approved 14 128 loans.
- 1034 dwelling units were commenced.
- Refurbishment of 913 established dwelling units was commenced.
- Land sales generated revenue of $44.7 million.
- 86 rental properties were sold to tenants.
- Under the New Living Program 382 residential dwellings were refurbished and 427 were sold, yielding income of $48.5 million.
- The Homeless Helpline assisted 1292 families into housing.
- Two new joint venture projects at Brookdale and Neerabup.
- Introduction of practices to target rental applicants who have been waiting for more than three years.

”

South Australian Government comments

“ South Australia’s social housing sector continues to play a major role in alleviating poverty and social exclusion through the provision of affordable housing for low income and special needs households and the facilitation of a range of other housing and support services. As at June 30 2004 there were over 53 500 social housing dwellings managed through a vibrant multi-provider system. These include:

- Aboriginal Housing Authority (AHA) — 1900 dwellings managed through direct provision with support provided to Indigenous Community Housing Organisations that manage an additional 1092 dwellings.
- South Australian Community Housing Authority (SACHA) — 4216 dwellings managed by 116 Community Housing Organisations.
- South Australian Housing Trust (SAHT) — 46 695 public housing dwellings, 806 properties and 11 boarding house style properties to organisations that provide accommodation and support services for people at risk of homelessness.

South Australia is developing the State Housing Plan, which will provide a 10 year framework for the provision of housing for South Australians. It will include a range of strategies to improve housing affordability and availability through CSHA programs and other initiatives. Emphasis is being placed on extending partnerships across spheres of government, strengthening coordination with planning authorities and building capacity within the not for profit sector and private sectors.

During the year a number of major initiatives were undertaken, including:

- Progressed initiatives funded by the South Australian State Government’s Social Inclusion Unit to address homelessness including several projects to assist ‘at risk’ public and private rental households maintain a tenancy
- Managed six major urban renewal projects in areas throughout the State with the aim of improving the physical, economic and social environment of communities
- Achieved first place among housing authorities in Australia in the National Social Housing Survey with an overall satisfaction rating of 74 per cent (equal with Queensland)
- Established the Wangka Willurrara Accommodation Centre located in Ceduna providing accommodation for homeless transient Indigenous people within the regional centre.
- Progressed the Change Management Project to review and simplify elements of community housing.
- Completed construction on eight new houses within the Indigenous Community Housing program. ”

Tasmanian Government comments

“ Housing Tasmania continues to provide a range of affordable housing options, including public, community and Aboriginal housing, home ownership assistance, and ongoing support for private renters on low incomes. Housing Tasmania recognises that the provision of affordable housing plays a vital role in enabling Tasmanians to access social and economic opportunities, the support networks they need, and makes a significant contribution to improving health and well-being outcomes.

The Division's Affordable Housing Strategy 2004–2008 (AHS) was launched in December 2003. It reflects a whole of government, whole of system response to affordable housing provision. The Strategy was supported by a significant State Government injection of an additional $45 million to implement capital development and assistance programs during Stage 1. This Stage concludes in December 2005. The AHS is coordinated within Housing Tasmania and involves extensive partnership processes with other Government agencies, local government, industry and the community and non-government sectors. Many of these partnerships will encourage new models of financing housing and its delivery and management.

Community capacity building initiatives remain a priority for the Division. These activities are focussed in communities characterised by fewer opportunities to participate in the workforce, lower educational achievement, higher numbers in receipt of pensions and benefits, and poorer health outcomes. Activity throughout the year included an employment creation partnership with Mission Australia and capacity building in partnership with TAFE community services students. Over the next year, small grants will be made through the Affordable Housing Strategy, to support new and existing community groups in urban renewal and capacity building activities.

In terms of achievements against the CSHA Performance Indicator framework, the average cost of providing assistance was reduced compared to previous years, continuing the trend of incremental decreases over the period of the previous Agreement. New applicants continued to achieve timely access to public rental homes, access by households with special needs and those in greatest need also remained high compared to other states and territories.

A funding round for community housing was held during the year, with $2.1 million allocated to nine organisations to provide seventeen new places. These grants included offers of partial funding to three projects part-funded from other sources. Initiatives included accommodation to suit a range of needs with emphasis on options for people with specific or complex needs. ”

Australian Capital Territory Government comments

“ Home ownership is the primary form of housing tenure in the ACT (68% of all households). Between 1986 and 2002, the percentage of people owning their homes outright almost doubled from 18% to 33%. The AMP Banking/REIA Home Loan affordability indicator for the ACT fell 4% over the year to the June quarter 2004 to 46.2. In June 2004, the ACT recorded its lowest level of home loan affordability, with ACT rents peaking as the highest in the country. The median rent for houses in the ACT rose 3.6% over the year to the June quarter 2004 to $290 per week. Private rental housing represents about 19% of the total housing stock of the ACT. Private rental accounts for 7% of all low-cost housing, compared with 20%-40 % of low-cost housing in other capital cities.

In response to the Affordable Housing Taskforce Report and the ACT Homelessness Strategy, the ACT Government has funded a number of significant projects/programs to meet public and community housing needs:

- Allocated $13.4 million for homelessness services over four years including new supported accommodation, outreach and sector capacity enhancement models in response to this complex issue.
- Increased residential land supply, provided 500 housing sites specifically for affordable housing over the next 5 years and supplementary funding to replace the 55 rural properties destroyed in the January 2003 firestorm.
- Additional funding responding to the crisis in housing affordability and homelessness by providing an additional $33.2m to expand the supply of public and community housing.
- Additional funding of $20m over next four years commencing in 2004-05 to expand the supply of housing and to respond to issues of housing and rental affordability.
- Funded 30 Community Linkages Programmes (including some directly managed by tenants), assisted tenants in maintaining their tenancies through the Preventing Eviction Programme and established a Debt Review Committee.
- Established the Rental Bonds Assistance Scheme and the Home Buyer Concession Scheme with broadened eligibility.

The ACT Public Housing Asset Management Strategy 2003–2008 provides a framework to improve the viability of the public housing sector and to rejuvenate public housing stock through sale, redevelopment and refurbishment.

The ACT continued to implement Community Housing Framework strategies to support the development of the sector, including the injection of additional capital funding. Whilst the ACT does not receive any ARHP funding, the ACT Government is working to improve housing outcomes for Indigenous people by allocating recurrent and capital funding to develop the capacity of existing Indigenous community housing organisations. ”

Northern Territory Government comments

“ The Northern Territory aims to ensure that safe, secure and affordable housing is available for all Territorians now and into the future, in particular for those on low incomes or with special needs. Home Territory 2010 is the Northern Territory's key policy framework for achieving this vision and the details within the framework were announced in parliament in August 2004. The key objectives under the framework are:

- A sustainable social housing system;
- Improving the way we do business;
- A range of effective housing models and support services that meet the challenging needs, aspirations and housing choices of Territorians; and,
- A housing market that underpins economic growth, regional vitality and safe and secure communities.

Over 2003-04, a number of initiatives have contributed to achieving the aim of safe, secure and affordable housing for all Territorians.

- Under the Quality Landlord Strategy, $45 million over five years was committed to upgrading public housing stock. Already, 2545 houses have been security screened contributing to enhanced feelings of safety in the home, and extensive renovations have been completed on 50 houses.
- A new suite of home ownership products were developed, making it easier for first home buyers and public housing tenants to move into their own home;
- The Return to Home program successfully assisted 1265 people previously living with friends, family or in public spaces, to return to their home community offering a pathway to stability.
- An ambitious construction and upgrade program has seen 120 additional beds offering crisis accommodation and improved facilities.
- Through the partnership of the Indigenous Housing Authority of the Northern Territory (IHANT), of the projects commenced in this financial year, 70 houses were constructed and 52 renovations and upgrades were completed. $14.7 million was expended in 2003-04 to assist with the management and maintenance of these and existing houses.
- Work continued on the successful Central Remote Regional Construction program, providing economies of scale, and developing local employment and training opportunities. 44 Indigenous people were taken on as apprentices under the program over the past year.

”

16.6 Definitions of key terms and indicators

Public, community and State owned and managed Indigenous housing

Administration costs

Those costs associated with the administration offices of the property manager and tenancy manager. They include the general accounting and personnel function costs relating to:

- employee expenses (for example, superannuation, compensation, accrued leave and training)
- supplies and services expenses (including stationery, postage, telephone, office equipment, information systems and vehicle expenses)
- rent
- grants and subsidies (excluding rental subsidies)
- expenditure incurred by other government agencies on behalf of the public housing agency
- contracted public housing management services.

Affordability

The proportions of recipients spending more than 30 per cent and 50 per cent of their income on rent with and without CRA.

Amenity/location

A survey-based measure of the proportion of tenants rating amenity and location aspects as important and meeting their needs.

Assessable income

The income used to assess eligibility for housing assistance and to calculate the rental housing rebate that allows a household to pay a rent lower than the market rent. Definition may vary across jurisdictions.

Community housing rental dwelling

Includes properties covered by the CSHA. Excludes properties for which the tenancy management functions are undertaken and administered under the Public Rental Housing Program, the ARHP or transitional/emergency accommodation for people who are homeless and in crisis (the Crisis Accommodation Program).

Customer satisfaction

A survey measure of the proportion of customers expressing different degrees of satisfaction with the overall service provided.

Depreciation costs (as per the Australian Accounting Standards 13–17)

Depreciation calculated on a straight-line basis at a rate that realistically represents the useful life of the asset.

Direct costs

Total administration costs and the costs of maintaining the operation of dwellings.

Disability (as per the ABS Survey of Disability Ageing and Carers)

Any restriction or lack of ability (resulting from an impairment) to perform an action in the manner or within the range considered normal for a human being.

Dwelling

For the purpose of the public, community and State owned and managed Indigenous housing collections, a 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. A dwelling structure can be a house, townhouse, duplex, flat or boarding/rooming house.

Greatest need

Low income households that at the time of allocation were subject to one or more of the following circumstances:

- homelessness
- their life or safety being at risk in their accommodation
- their health condition being aggravated by their housing
- their housing being inappropriate to their needs
- their rental housing costs being very high.

Household

For the purpose of the public, community and State owned and managed Indigenous housing collections, a tenancy agreement. A tenancy agreement is defined as a formal written agreement between a household (a person or group of people) and a housing provider, specifying details of a tenancy for a particular dwelling. Counting the number of tenancy agreements is the proxy for counting the number of households.

Income unit

One person or a group of related people within a household who share command over income. The allowable relationships in the definition of income unit are restricted to (1) marriage (registered or *de facto*) and (2) parent and dependent child who usually reside in the same household. Operationally, an income unit is:

- a married couple (registered or de facto) or sole parent, and dependent children only
- a married couple only (registered or de facto) with no dependent children present
- a person in a private dwelling who is not related to any other household member either by marriage (registered or de facto) or by a parent/dependent child relationship.

It is defined differently for CRA.

Indigenous household

A household with one or more members (including children) who identify as Aboriginal and/or Torres Strait Islander.

Low income household

A household whose members are assessed as having a low income according to the following definitions. Households are assigned an income status based on total household gross income and the composition of the household:

- low income A households are those in public housing in which all household members have incomes at or below the maximum pension rate
- low income A households are those in public housing in which all household members have incomes at or below the maximum pension rate
- low income B households are those in public housing that have incomes that would enable them to receive government income support benefits below the maximum pension.

Maintenance costs

Costs incurred to maintain the value of the asset or to restore an asset to its original condition. The definition includes day-to-day maintenance reflecting general wear and tear, cyclical maintenance, performed as part of a planned maintenance program and other maintenance, such as repairs as a result of vandalism.

Market rent

Aggregate market rent that would be collected if the public rental housing properties were available in the private market.

Match of dwelling to household size

The proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy

	standard.
Moderate Overcrowding	Where one additional bedrooms is required to satisfy the proxy occupancy standard.
New household	Households that commence receiving assistance for the financial year and are waitlist type 'new applicant/household'.
Occupancy rate	The proportion of dwellings occupied. The term 'occupied dwelling' refers to dwellings occupied by tenants who have a tenancy agreement with the relevant housing authority.
Occupied dwelling	Any structure that people live in, regardless of its intended purpose. The structure may or may not be tenantable.
Overcrowding	Where two or more additional bedrooms are required to meet the proxy occupancy standard.
Priority access to those in greatest need	Allocation processes to ensure those in greatest need have first access to housing. This is measured as the proportion of new allocations to those in greatest need in the following timeframes: • under three months • three months to under six months • six months to under one year • one year to less than two years • two years or more • total.
Principal tenant	The person or principal person whose name appears on the tenancy agreement. Where this is not clear, it should be the person who is responsible for rental payments.
Proxy occupancy standard	The standard used to determine overcrowding/underuse. The standard used in the public and community housing collections is based on the Canadian model. (For further discussion on measuring household bedroom requirements, see Foard *et al*. 1994).
Public rental dwelling	Public rental properties covered by the CSHA. Excludes properties administered under Community Rental Housing, the ARHP or transitional/emergency accommodation for people who are homeless and in crisis (the Crisis Accommodation Program).
Relocated household	A household, either rebated or market renting, that relocates (transfers) from one public or community rental dwelling to another.
Rent charged	The amount in dollars that households are charged based on the rents they are expected to pay. The rents charged to tenants may or may not have been received.
Rent collected	The total rent collected as a proportion of the rent charged.
Special needs household	A household with a member(s) who has a disability or is aged 24 years or under, or 75 years or over (50 years or over for State owned and managed Indigenous housing), or (except for State owned and managed Indigenous housing) is Indigenous.
Special needs but not low income household	A household with a member who has a special need, but where the household income is assessed as not being low income according to a household income cut-off value.
Tenant or tenant household	The usual members of a household occupying a public, community or State owned and managed Indigenous housing dwelling where there is a tenancy agreement with the housing authority. A tenant household either receives rebated assistance or pays the market rent as

determined by the agency.

Tenantable dwelling A dwelling where maintenance has been completed, whether occupied or unoccupied at 30 June. All occupied dwellings are tenantable.

Total gross household income The value of gross weekly income from all sources (before deductions for income tax, superannuation etc.) for all household members, expressed as dollars per week. The main components of gross income are current usual wages and salary; income derived from self-employment, government pensions, benefits and allowances; and other income comprising investments and other regular income.

Turnaround time The average time taken in days for vacant dwellings to be occupied.

Underuse Where there are two or more bedrooms additional to the number required in the dwelling to satisfy the proxy occupancy standard.

Untenantable dwelling A dwelling not currently occupied by a tenant, where maintenance has been either deferred or not completed at 30 June.

Commonwealth Rent Assistance

Control of incorrect payment The proportion of CRA payment adjustments resulting from a risk-based review.

Dependent child A person under 18 years who is the dependant of another person (an adult) if the adult is legally responsible for the day-to-day care, welfare and development of the child, if the child is not a dependent child of another person, and if the child is wholly or substantially in the adult's care.

A young person aged 18–24 years may be regarded as the dependant of another person if he or she is wholly or substantially dependent on that other person. A young person aged 21 years or over cannot be regarded as a dependant unless undertaking full time study. A young person cannot be regarded as a dependant if he or she receives an income support payment.

Operationally, a child is regarded as a dependant of another person (the parent) if the parent receives the Family Tax Benefit for the care of the child. A dependent child is regarded as a member of the parental income unit.

The maximum rate of CRA depends on the number of children for whom the recipient or partner receives more than the base rate of the Family Tax Benefit Part A. Although the Family Tax Benefit may be paid for a child aged 16 years or over, it cannot be paid at more than the base rate. It may also be paid at not more than the base rate if a parent has not taken appropriate steps to obtain maintenance from a child's other parent.

Eligible income support clients Clients in receipt of an income support payment or more than the base rate of the Family Tax Benefit Part A. CRA is automatically paid once eligibility is established. The only eligible clients who are not paid are those affected by Centrelink errors in recording information or by program errors.

Geographic spread of CRA customers Two measures are presented:

- CRA recipients as a proportion of income units in each capital city receiving a social security income support benefit or more than the base rate of the Family Tax Benefit
- the average CRA entitlement across locations.

Income unit	One person or a group of related people within a household who share command over income. The only recognised relationships are (1) marriage (registered or defacto) and (2) adult and dependent child. Operationally, an income unit may consist of: • a single person with no dependent child • a sole parent with a dependent child • a couple (registered or defacto) with no dependent child • a couple (registered or defacto) and any dependent children. A non-dependent child, including any child receiving Youth Allowance or some other income support payment, is not regarded as part of the parental income unit. Rather, he or she is regarded as a separate income unit.
Income unit type	The number and proportion of eligible income support recipients receiving CRA, by income unit type.
Low income	Income of CRA recipients, by quintiles of family income received per week.
Maximum rate	Proportion of CRA recipients receiving the maximum rate of CRA.
Number and outcome of appeals	The outcomes of all CRA appeals finalised: (1) the number of customers who appealed to an authorised review officer, and (2) the proportions of appeals where the decision was affirmed, set aside or varied, or the appeal was withdrawn.
Number and proportion of CRA recipients, by income unit type	A point-in-time indicator showing the number of CRA recipients by income unit type, and the proportion of recipients within each income unit category. Includes data on Indigenous recipients.
Number and proportion of CRA recipients, by payment type	A point-in-time indicator showing the number of CRA recipients by the type of primary payments received, and the proportion of recipients within each payment type category.
Payment type	The number and proportion of income support recipients receiving CRA, by the primary payment type received.
Primary payment type	Each income unit receiving CRA is assigned a primary payment type, based on the payment(s) received by each member. This is used to monitor the extent to which assistance is provided to families and individuals that primarily depend on different forms of assistance. The primary payment is determined using a hierarchy of payment types, precedence being given to pensions, then other social security payments that attract CRA, and then the Family Tax Benefit. Within this overall structure a lower precedence is given to payments that are made only to the partners of a social security payment. If both members of a couple receive a payment of the same rating, the male is regarded as the primary member of the couple. No extra weight is given to the payment type with which CRA is paid.
Proportion of income spent on rent with and without CRA	A point-in-time indicator, measuring the proportion of income units spending less than 30 per cent and 50 per cent of their income on rent, both with and without CRA. The proportion of income spent on rent is calculated as follows: • with CRA: rent (minus CRA) divided by total income from all sources, excluding CRA • without CRA: rent divided by total income from all sources, excluding CRA.
Ratio of running costs	Total running costs for the CRA program as a proportion of total

to total outlay for CRA	outlay.
Rent	Amount payable as a condition of occupancy of a person's home. Includes site fees for a caravan, mooring fees and payment for services provided in a retirement village. Rent encompasses not only a formal tenancy agreement, but also informal agreements between family members, including the payment of board or board and lodgings. Where a person pays board and lodgings and cannot separately identify the amount paid for lodgings, two thirds of the payment is deemed to be for rent. There is no requirement that rent be paid; a person whose rent is in arrears may remain eligible for assistance, provided Centrelink is satisfied that the liability is genuine.
Running costs per 1000 CRA customers	Total running costs for the CRA program per 1000 CRA customers.
Sharer	Some single people are subject to a lower maximum (sharer) rate of CRA. The lower rate may apply to only a single person (with no dependent child) who shares a major area of accommodation. The lower rate does not apply to those receiving the Disability Support Pension or Carer Payment, those in nursing homes or boarding house accommodation, or those paying for both board and lodgings. A person is not regarded as a sharer solely because he or shares with a child (of any age) if the child does not receive CRA.
Satisfaction with location of housing	Satisfaction with the location of housing rather than with the CRA payment, as measured by the DFaCS General Customer Survey. The indicator measures the proportion of respondents satisfied with the quality of their housing, broken down into categories of 'poor', 'just okay', 'good' and 'great'.
Satisfaction with quality of housing	Satisfaction with the quality of housing rather than with the CRA payment, as measured by the DFaCS General Customer Survey. The indicator measures the proportion of respondents satisfied with the quality of their housing, broken down into categories of 'poor', 'just okay', 'good' and 'great'.
Special needs	The proportions of special needs income units receiving CRA, such as rural and remote Australians and Indigenous recipients, by benefit type.
Total income from all sources	Income received by the customer or partner, excluding income received by a dependent. Includes regular social security payments and any maintenance and other private income taken into account for income testing purposes. Excludes: • one-time payments • arrears payments • advances • Employment or Education Entry Payments • the Mobility Allowance • the Maternity Allowance • the Child Care Assistance Rebate. In most cases, private income reflects the person's current circumstances. Taxable income for a past financial year or an estimate of taxable income for the current financial year is used where the income unit receives more than the minimum rate of the Family Tax Benefit but no other income support payment.

16.7 References

ABS (Australian Bureau of Statistics) 1999b, *Experimental Projections of the Aboriginal and Torres Strait Islander Population, 1998*, Cat. no. 3231.0, Canberra.

—— 2002a, *Census of Population and Housing 2001*, Canberra.

—— 2002b, *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities, 2001*, Cat. no. 4710.0, Canberra.

—— 2004, *Disability, Ageing and Carers: Summary of Findings*, Cat. no. 4430.0, Canberra.

ABS and AIHW (Australian Institute of Health and Welfare) 2003, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2003*, ABS Cat. no. 4704.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 2000, *Agreement on National Indigenous Housing Information*, Canberra.

—— 2002a, 2003a, 2003b, 2004a, *CSHA National Data Reports: Aboriginal Rental Housing Program: State and Territory Owned and Managed Indigenous Housing*, Canberra.

—— 2002b, 2003c, 2003d, 2004b, *CSHA National Data Reports: CSHA Community Housing*, Canberra.

—— 2002c, 2003e, 2003f, 2004c, *CSHA National Data Reports: Public Rental Housing*, Canberra.

—— 2003g, *National Housing Assistance Data Dictionary Version 2*, Cat. no. HOU-89, Canberra.

—— 2003h, *Australia's Welfare 2003*, Cat. no. AUS 41, Canberra.

—— 2004d, *Aboriginal Rental Housing Program Data Manual 2003-2004, National Housing Data Agreement — CSHA 2003–2008*, Canberra.

—— 2004e, *Community Housing Data Manual 2003-2004, National Housing Data Agreement — CSHA 2003–2008*, Canberra.

—— 2004f, *Public Rental Housing Data Manual 2003-2004, National Housing Data Agreement — CSHA 2003– 2008*, Canberra.

CSHA (Commonwealth State Housing Agreement) 1999, *Commonwealth State Housing Agreement*, Australian Government, Department of Family and Community Services, Canberra.

—— 2003, *Commonwealth State Housing Agreement*, Australian Government, Department of Family and Community Services, Canberra.

DFaCS (Department of Family and Community Services) 1999, *Housing Assistance Act 1996 Annual Report 1996-97*, Australian Government, Canberra.

—— 2000a, 2001, 2002, 2003, *Housing Assistance Act Annual Report 1997-98*, Australian Government, Canberra.

—— 2000b, *Annual Report 1999-2000*, Australian Government, Canberra.

Foard, G., Karmel, R., Collett, S., Bosworth, E. and Hulmes, D. 1994, *Public Housing in Australia*, AIHW, Canberra.

Morel, P. and Ross, H. 1993, *Housing Design Assessment for Bush Communities*, Tangentyere Council, Alice Springs.

Newman, Hon. J. (Minister for Social Security) 1998, *Portfolio Budget Statements 1998-99: Social Security Portfolio*, Budget paper no. 1.14, Canberra.

NFO Donovan Research 2002, *The National Social Housing Survey with Community Housing, May 2002*, Perth.

Pholeros, P., Rainow, S. and Torzillo, P. 1993, *Housing for Health: toward a Healthy Living Environment for Aboriginal Australia*, Healthabitat, Sydney.

REIA (Real Estate Institute of Australia) 2004, *Market Facts*, Canberra, June.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2001, *Asset Measurement in the Costing of Government Services*, Productivity Commission, Canberra.

—— 2002,2003, *Report on Government Services*, Productivity Commission, Canberra.

A Statistical appendix

A.1 Introduction

This appendix contains contextual information to assist the interpretation of the performance indicators presented in the Report. The following four key factors in interpreting the performance data are addressed:

- *Australia's population*. Section A.2 presents data on population characteristics, including size, age and sex, ethnicity, geographic location and a profile of Indigenous Australians.
- *Family and household*. Section A.3 provides an overview of the family and household environment within which Australians live.
- *Income, education and employment*. Section A.4 summarises the income and employment characteristics of Australians, including educational attainment and workforce participation.
- *Statistical concepts used in the Report*. Section A.5 provides technical information on the key statistical methods used in the Report.

Supporting tables

Supporting tables for this appendix are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel format as \Publications\Reports\2005\Attach_stat_app.xls and in Adobe PDF format as \Publications\Reports\2005\Attach_stat_app.pdf. Box A.1 contains a list of the source tables.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table A.3 is table 3 in the electronic files). These files can be found on the Review web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

Box A.1 **List of source tables**

Table A.1	Estimated resident population, by age and sex, 30 June 2003
Table A.2	Estimated resident population, by calendar and financial year
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Table A.7	Preliminary estimated resident Indigenous population, by age and sex, 30 June 2001
Table A.8	Experimental projection of the Indigenous population, 2000–2009
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Most of the service areas covered by the Report use population data from tables A.1 and A.2 for descriptive information (such as expenditure per person in the population) or performance indicators (such as participation rates for vocational education and training [VET]). Financial data are often deflated by the gross domestic product (GDP) deflator data from table A.26 (except in some health chapters and chapter 4 on VET, which use service–specific deflators) to calculate real dollars.

A.2 Population

The Australian people are the principal beneficiaries of the government funded and/or provided services covered by this Report. The size, trends and characteristics of the population can have a significant influence on the demand for government services and the cost of their delivery. This section provides a limited exposition of the Australian population to support the analysis of government services provided in the Report. A more detailed exposition is provided in the Australian Bureau of Statistics (ABS) annual publication *Australian Social Trends* (ABS 2004a). In the statistical appendix and attachment tables, population totals for the same year can vary because they are drawn from different ABS sources depending on the information required — for example, some data are from the Census (ABS 2002a) and others from the Estimated Resident Population (ABS 2004c).

Population size and trends

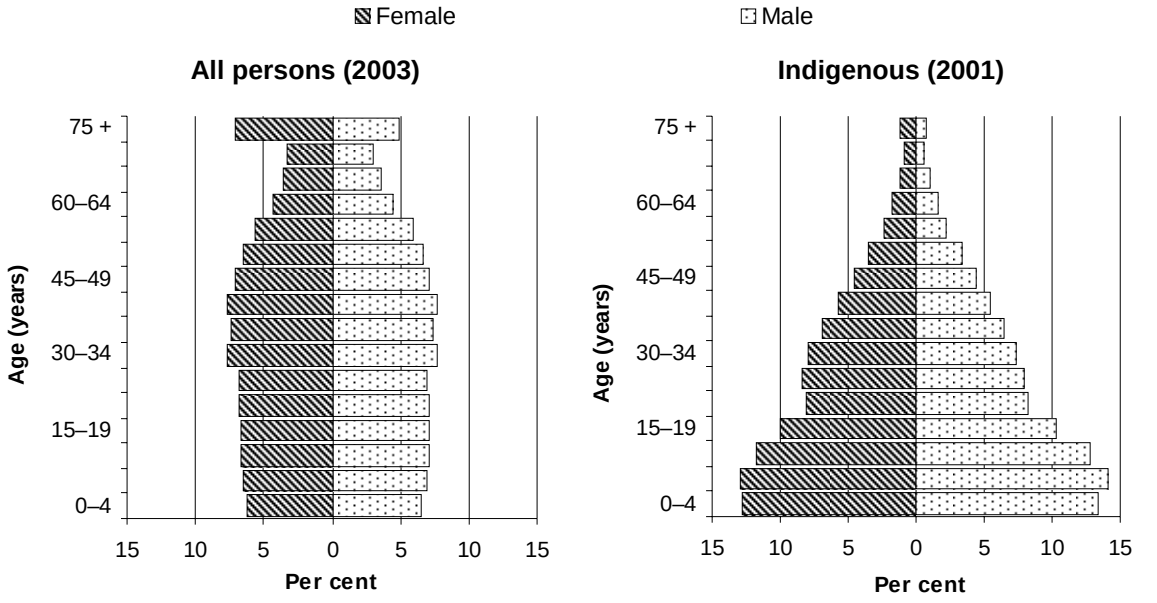
More than three quarters of Australia's 19.8 million people lived in the eastern states in June 2003, with NSW, Victoria and Queensland accounting for 33.6 per cent, 24.7 per cent and 19.1 per cent respectively of the nation's population. Western Australia and SA accounted for a further 9.8 per cent and 7.7 per cent respectively of the population, while Tasmania, the ACT and the NT accounted for the remaining 2.4 per cent, 1.6 per cent and 1.0 per cent respectively (table A.1).

Nationally, the average annual growth rate of the population between 1998 and 2003 was approximately 1.2 per cent. The growth across jurisdictions ranged from 2.0 per cent in Queensland to just over zero growth in Tasmania (table A.2, calendar year estimates).

Population, by age and sex

As in most other developed economies, greater life expectancy and declining fertility have contributed to an 'ageing' of Australia's population. The experiences of Indigenous people, however, are markedly different (figure A.1). At 30 June 2003, 9.2 per cent of Australia's population was aged 70 years or over, in contrast to 1.6 per cent of Australia's Indigenous population at 30 June 2001 (table A.7). Across jurisdictions, the proportion of people aged 70 years or over ranged from 10.9 per cent in SA to 2.5 per cent in the NT (table A.1).

Figure A.1 **Population distribution, by age and sex, 30 June[a, b]**



a Totals may not add as a result of rounding. **b** Includes other territories.

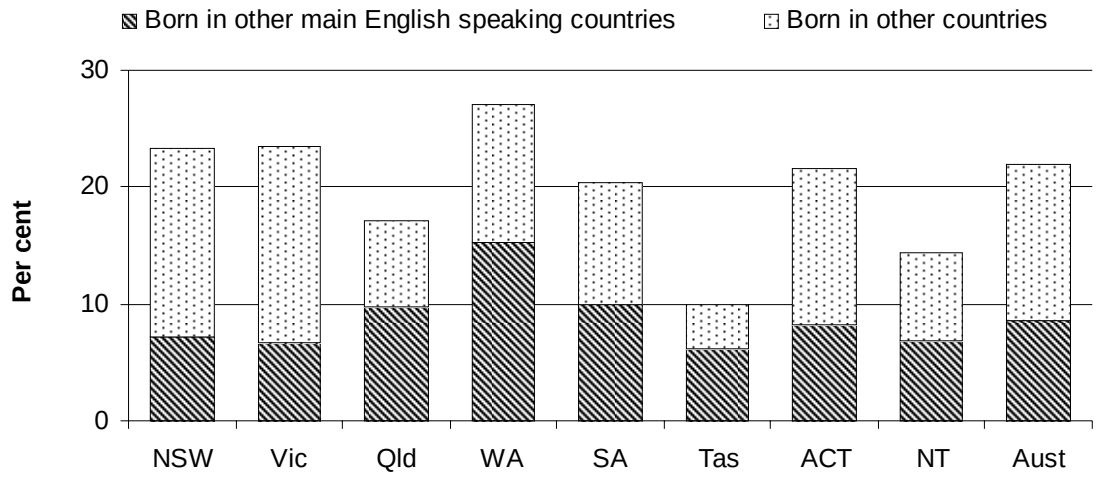
Source: ABS (2001 and 2004c); tables A.1 and A.7.

Approximately half (50.3 per cent) of the population at June 2003 was female. This distribution was similar across all jurisdictions except the NT, which had a relatively low representation of women in its population (47.5 per cent) (table A.1). The proportion of women in the population varies noticeably by age. Nationally, approximately 57.3 per cent of people aged 70 or over were female, compared with 48.7 per cent of people aged 14 years or younger. These proportions were similar across all jurisdictions except the NT, which had relatively low representation of women in the group aged 70 years or over (49.3 per cent) (table A.1).

Population, by ethnicity

New Australians face specific problems when accessing government services. Language and culture can be formidable barriers for otherwise capable people. Cultural backgrounds can also have a significant influence on the support networks offered by extended families. People born outside Australia accounted for 21.9 per cent of the population in August 2001 (8.5 per cent from the main English speaking countries and 13.3 per cent from other countries).[1] Across jurisdictions, the proportion of people born outside Australia ranged from 27.0 per cent in WA to 10.0 per cent in Tasmania. The proportion from countries other than the main English speaking countries ranged from 16.8 per cent in Victoria to 3.9 per cent in Tasmania (figure A.2).

Figure A.2 **People born outside Australia, by country of birth, August 2001[a, b, c]**



a Born outside Australia excludes overseas visitors. **b** Other main English speaking countries include the United Kingdom, Ireland, New Zealand, Canada, the United States and South Africa. **c** Born in other countries includes inadequately described, at sea and not elsewhere classified.

Source: ABS (2002a); table A.4.

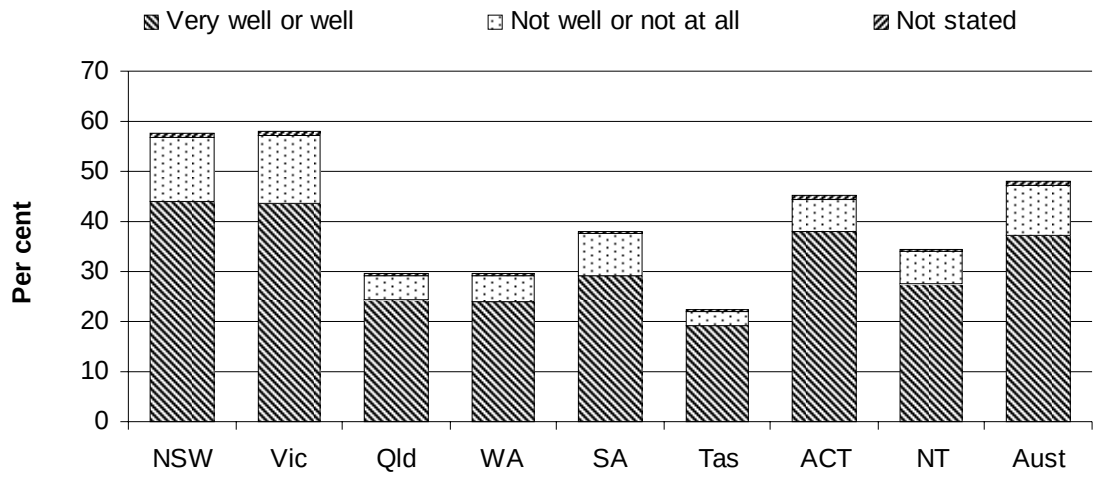
People who speak a language other than English accounted for 47.9 per cent of the population born outside Australia in August 2001 (table A.3). Of these, 21.6 per cent did not speak English well or at all. Across jurisdictions in August 2001, the proportion of the population who were born outside Australia and who spoke a language other than English ranged from 58.0 per cent in Victoria to 22.0 per cent in Tasmania. The proportion who were born outside Australia and

[1] The ABS defines the main English speaking countries as the United Kingdom, Ireland, New Zealand, Canada, the United States and South Africa.

who did not speak English well or at all ranged from 13.6 per cent in Victoria to 2.9 per cent in Tasmania (figure A.3).

Approximately 15.2 per cent of Australians spoke a language other than English at home in August 2001. Across jurisdictions, this proportion ranged from 22.8 per cent in the NT to 3.1 per cent in Tasmania (table A.5). The most common languages spoken were Chinese languages, Italian and Greek.

Figure A.3 **People born overseas who spoke English and another language, by proficiency in spoken English, August 2001[a, b, c]**



a Excludes overseas visitors and people who did not state their birthplace. **b** Australia includes other territories. **c** 'Not stated' includes cases where language spoken at home was stated but proficiency in English was not stated, and cases where both language spoken at home and proficiency in English were not stated.

Source: ABS (2002a); table A.3.

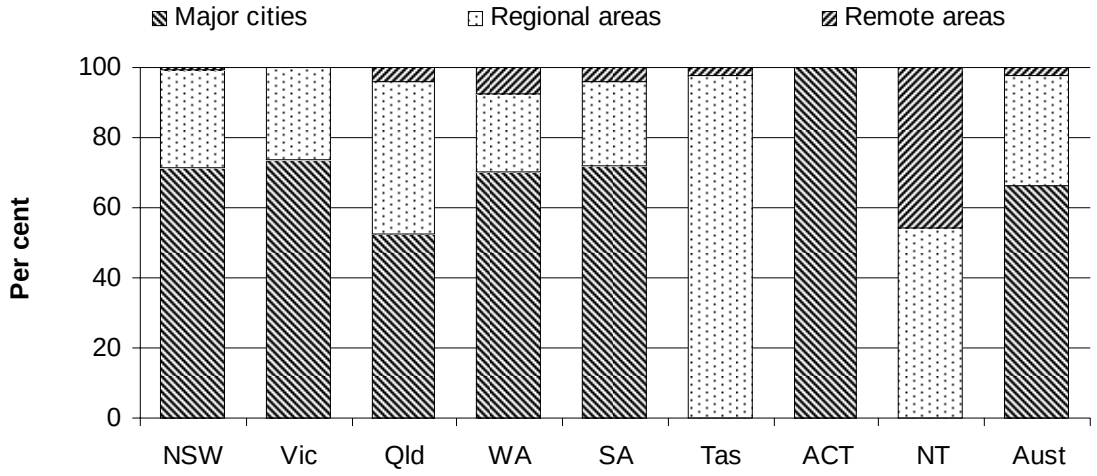
The most and least common languages other than English spoken in people's homes varied across jurisdictions in August 2001. The most extreme variation was in the NT, where 15.4 per cent of people spoke an Australian Indigenous language (67.6 per cent of the total persons who spoke a language other than English in their homes) (table A.5).

Population, by geographic location

The Australian population is highly urbanised, with 66.3 per cent of the population located in major cities in June 2003 (figure A.4). Across jurisdictions, this proportion ranged from 99.8 per cent in the ACT to 52.7 per cent in Queensland (table A.6). Tasmania and the NT by definition have no major cities. In Tasmania, 97.7 per cent of the population lived in regional areas. Australia-wide, 2.5 per cent

of people lived in remote areas. The NT was markedly above this average, with 45.6 per cent of people living in remote areas.

Figure A.4 **Estimated residential population, by geographic location, June 2003[a, b]**



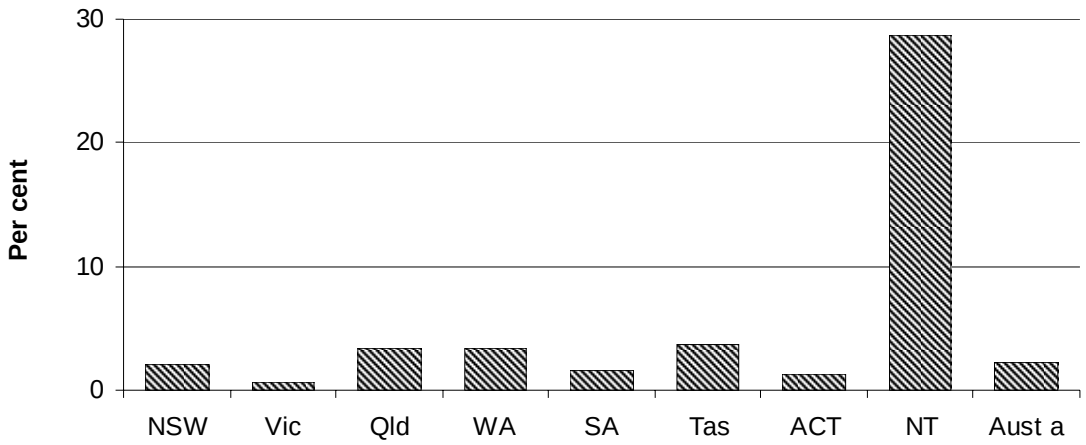
a Includes other territories. **b** The accessibility/remoteness index of Australia (ARIA) relies on road distance as a surrogate for remoteness and on the population size of a service centre as a surrogate for the availability of services. The ARIA+ method produces index values between 0 and 15. Areas with an ARIA+ index value of 0 have the highest levels of access to goods and services, and areas with an ARIA+ index value of 15 have the highest level of remoteness. Remoteness areas and their ARIA+ index value range include major cities of Australia = 0–0.2, inner regional Australia = >0.2–2.4, outer regional Australia = >2.4–5.92, remote Australia = >5.92–10.53, very remote Australia = >10.53–15.

Source: ABS (unpublished); table A.6.

Indigenous population profile

There were 458 520 (230 994 female and 227 526 male) Indigenous people in Australia at 30 June 2001, accounting for approximately 2.3 per cent of the population (tables A.1 and A.7). The proportion of people who were Indigenous was significantly higher in the NT (28.7 per cent) than in any other jurisdiction. Across the other jurisdictions, the proportion ranged from 3.6 per cent in Tasmania to 0.6 per cent in Victoria (figure A.5). Nationally, the Indigenous population is projected to grow to 528 645 people in 2009 (table A.8).

Figure A.5 **Indigenous people as a proportion of the population, 30 June 2001[a]**



a Australia includes other territories.

Source: ABS (2001, 2004c); tables A.1 and A.7.

The majority of Indigenous people (79.8 per cent) at August 2001 spoke only English at home, while 12.1 per cent spoke an Indigenous language and English, and 2.5 per cent spoke another language. At that time, 5.6 per cent did not state any specific language (table A.9).

A.3 Family and household

Family structure

There were 5.5 million families in Australia in 2003. Across jurisdictions, the number of families ranged from 1.8 million in NSW to 38 000 in the NT. The average family size across Australia was 3.0 people (the same as in 2002). Across jurisdictions, the average ranged from 3.2 people in the NT to 2.9 people in both SA and Tasmania (table A.10).

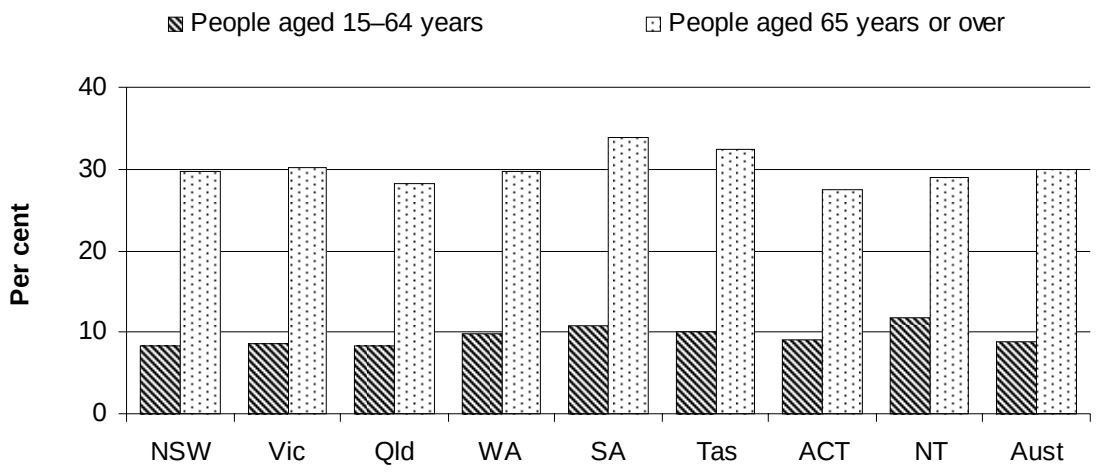
Lone parent families may have a greater need for government support and particular types of government service (such as child care for respite reasons). Nationally, 19.9 per cent of children aged under 15 years lived in one parent families in 2003; 19.3 per cent of families with children aged under 15 years were lone mother families and 2.5 per cent had a father only. Across jurisdictions, the proportion of children aged under 15 years living in one parent families ranged from 23.6 per cent in South Australia to 17.7 per cent in the Victoria (table A.11).

Employment status also has implications for the financial independence of families. Nationally, 17.4 per cent of children aged under 15 years in 2003 lived in families where no parent was employed. Across jurisdictions, the proportion ranged from 23.0 per cent in Tasmania to 8.9 per cent in the ACT (table A.12).

Household profile

There were 7.4 million households in Australia in 2001 (table A.14). Close to one quarter (24.6 per cent) of these were lone person households. Across jurisdictions, the proportion of lone person households ranged from 29.3 per cent in Tasmania to 23.1 per cent in NSW. The proportion of people aged 65 years or over who lived alone in June 2003 was considerably higher than that for people aged 15–64 years — nationally, 30.0 per cent compared with 8.9 per cent respectively. Across jurisdictions, the proportion of people aged 65 years or over who lived alone ranged from 33.8 per cent in SA to 27.4 per cent in the ACT (figure A.6).

Figure A.6 **Proportion of population who lived alone, by age group, 2003**



Source: ABS (2004a); table A.14.

Nationally, the majority of occupied private dwellings (66.2 per cent, or 4.7 million dwellings) in August 2001 were owned or were being purchased. Home ownership was highest in Victoria (70.7 per cent) and lowest in the NT (42.5 per cent). Australians rented 26.3 per cent of dwellings (21.5 per cent from private rental sources, 4.5 per cent from government and 0.3 per cent from unspecified sources) (table A.15). Across jurisdictions, the proportion of dwellings that were rented was highest in the NT (41.5 per cent) and lowest in Victoria (22.1 per cent) (figure A.7).

Figure A.7 **Occupied private dwellings, by tenure type and landlord type, August 2001[a, b]**

a 'Rented' includes rented dwellings where the landlord type was not stated. **b** 'Other' includes dwellings being occupied rent free or under a life tenure scheme.

Source: ABS (2002a); table A.15.

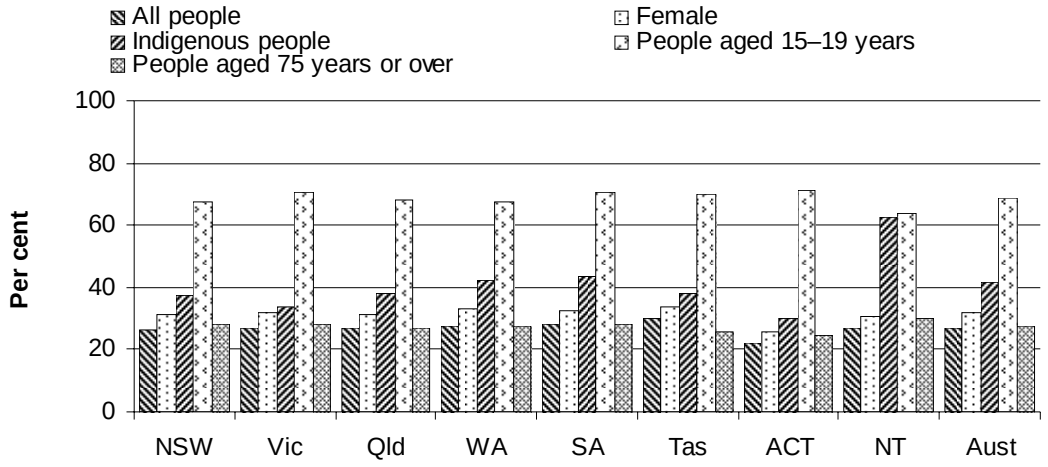
A.4 Income, education and employment

Income

Nationally, 27.1 per cent of people aged 15 years or over in August 2001 had a weekly individual income of $199 or less. The proportion was considerably higher for younger people (68.8 per cent for people aged 15–19 years), Indigenous people (41.6 per cent), females (31.7 per cent) and older people (27.7 per cent for people aged 75 years or over) (figure A.8).

Nationally, the number of people receiving income support as a proportion of the total population was 18.1 per cent in 2003. The Age Pension was received by 9.3 per cent of the population, while 3.4 per cent received a disability support pension and 2.2 per cent received a single parent payment. A further 3.2 per cent of the population received some form of labour market allowance in 2003 (figure A.9).

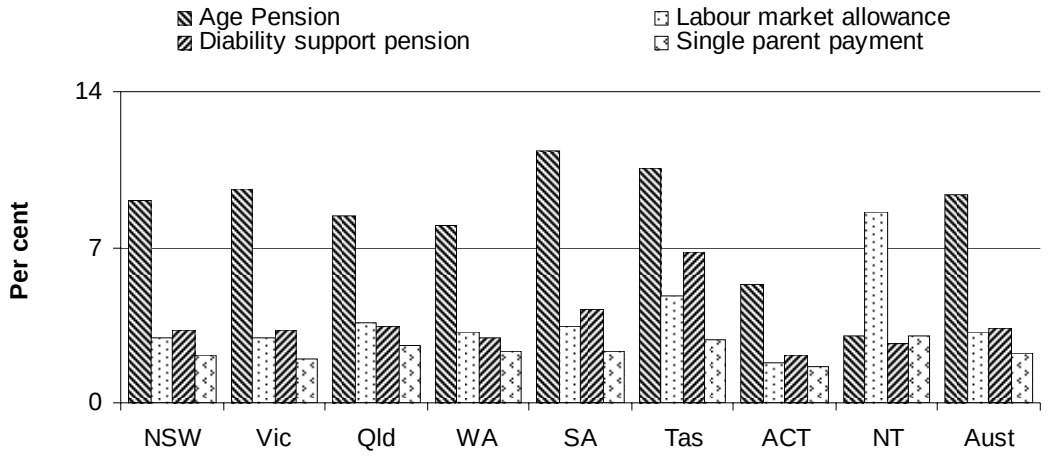
Figure A.8 **Weekly individual income of $199 or less, by sex, Indigenous status and age, August 2001[a]**



a Australia includes other territories.

Source: ABS (2002a, 2002b); tables A.16–A.18.

Figure A.9 **Proportion of total population on income support, June 2003[a, b]**



a Jurisdictions do not add to total because data for Australia include pensions paid to people living overseas. **b** Data for the labour market allowance are for a point in time that does not match the average of weekly data, which include people who receive a nil rate of payment.

Source: ABS (2004a); table A.19.

The proportion of the population receiving the Age Pension in 2003 ranged from 20.4 per cent in Tasmania to 3.0 per cent in the NT; the proportion receiving a disability support pension ranged from 6.8 per cent in Tasmania to 2.1 per cent in the ACT; and the proportion receiving a single parent payment ranged from 3.0 per cent in the NT to 1.6 per cent in the ACT. The proportion receiving a labour

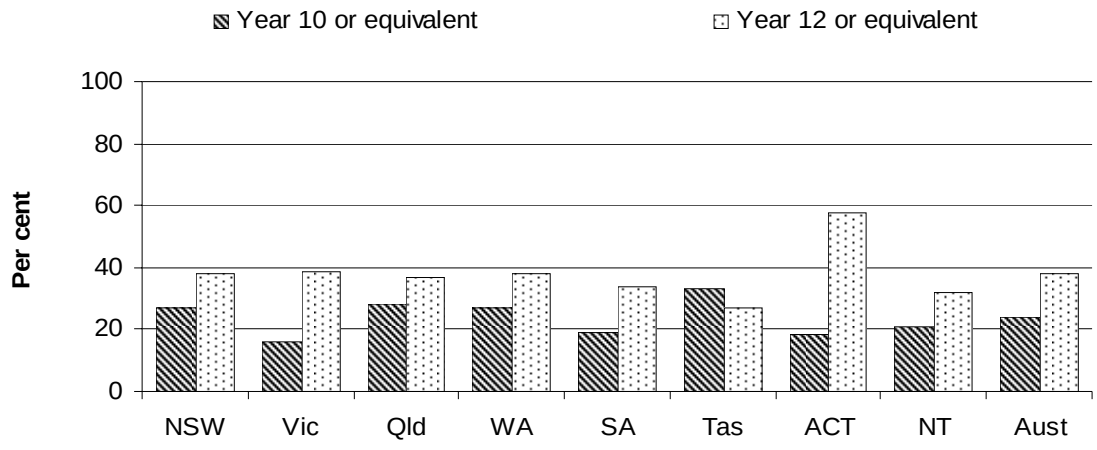
market allowance in 2003 ranged from 8.6 per cent in the NT to 1.8 per cent in the ACT.

Educational attainment

Employment outcomes and income are closely linked to the education and skill levels of individuals. At August 2001, 37.7 per cent of people aged 15 years and over (approximately 5.6 million people) had completed year 12 or equivalent as the highest level of schooling. A further 23.8 per cent (3.5 million people) had completed year 10 or equivalent schooling, excluding the 3.4 per cent (503 200 people) who were still at school (many of whom were studying in year 11 or 12, and had completed year 10). Across jurisdictions, the proportion of people aged 15 years and over who had completed year 12 or equivalent schooling ranged from 57.8 per cent in the ACT to 27.2 per cent in Tasmania (figure A.10).

The proportion of non-Indigenous people aged 15 years or over who had completed year 12 or equivalent schooling was considerably higher than the proportion of Indigenous people (39.5 per cent and 16.8 per cent respectively) in August 2001. Across jurisdictions, the proportion of Indigenous people aged 15 years or over who had completed year 12 or equivalent schooling ranged from 36.4 per cent in the ACT to 7.1 per cent in the NT. The proportion of non-Indigenous people was highest in the ACT (59.8 per cent) and lowest in Tasmania (28.4 per cent) (figure A.11).

Figure A.10 **People aged 15 years or over, by highest year of school completed, August 2001[a, b, c]**



a Refers to primary or secondary schooling. **b** Australia includes other territories. **c** All persons includes Indigenous status not stated.

Source: ABS (2002b); table A.20.

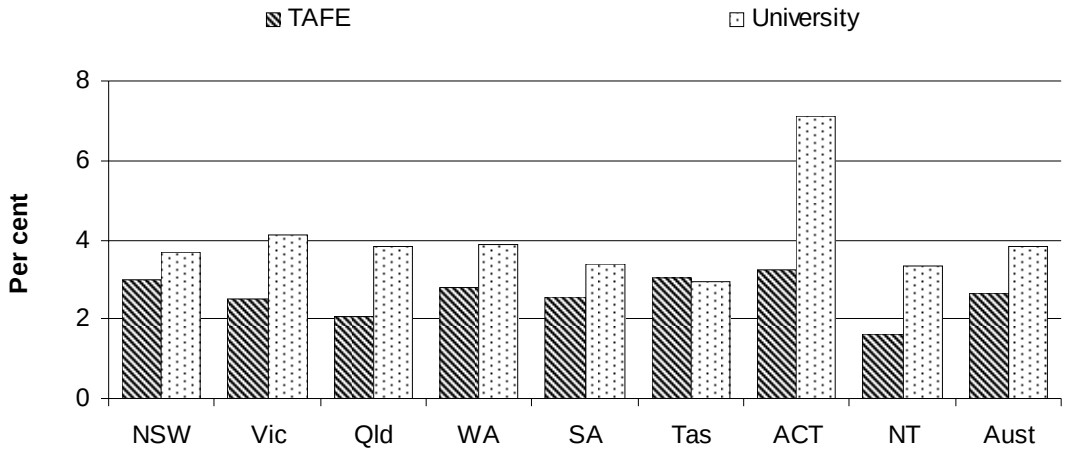
Figure A.11 **People aged 15 years or over who had completed year 12 or equivalent, by Indigenous status, August 2001[a]**

a Australia includes other territories.

Source: ABS (2002b); table A.20.

Tertiary education in Australia is principally provided by technical and further education (TAFE) institutes and universities. Nationally, 6.5 per cent of the population were attending TAFE or university in August 2001 (3.8 per cent at university and 2.6 per cent at TAFE). Across jurisdictions, the proportion of people attending TAFE ranged from 3.2 per cent in the ACT to 1.6 per cent in the NT; the proportion attending university ranged from 7.1 per cent in the ACT to 3.0 per cent in Tasmania (figure A.12)

Figure A.12 **Proportion of population attending higher education institutions, August 2001[a, b]**

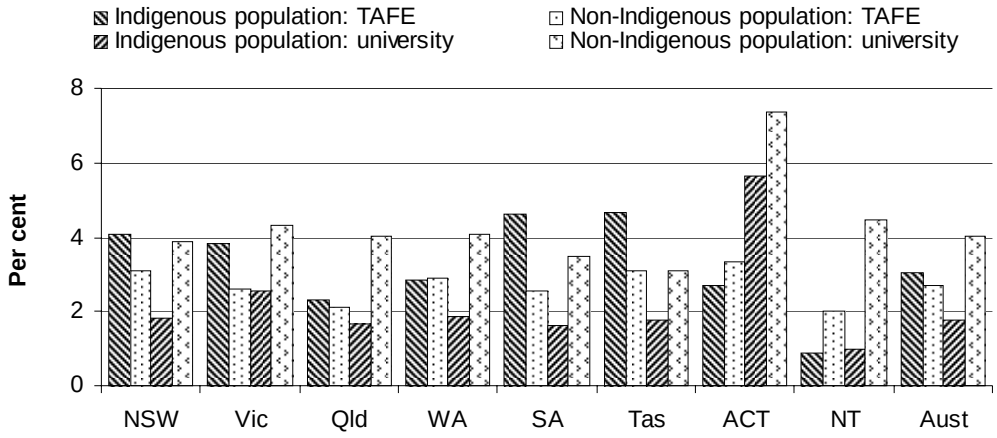


a Australia includes other territories. **b** 'University' includes other tertiary institutions.

Source: ABS (2002b); table A.21.

The proportion of the Indigenous population who were attending TAFE in August 2001 was greater than the proportion of the non-Indigenous population in all jurisdictions except WA, the ACT and the NT. Conversely, the proportion of the Indigenous population attending university was less than that of the non-Indigenous population in all jurisdictions (figure A.13).

Figure A.13 **Proportion of population attending higher education, by Indigenous status, August 2001[a, b]**



a Australia includes other territories. **b** 'University' includes other tertiary institutions.
Source: ABS (2002b); table A.21.

Employment and workforce participation

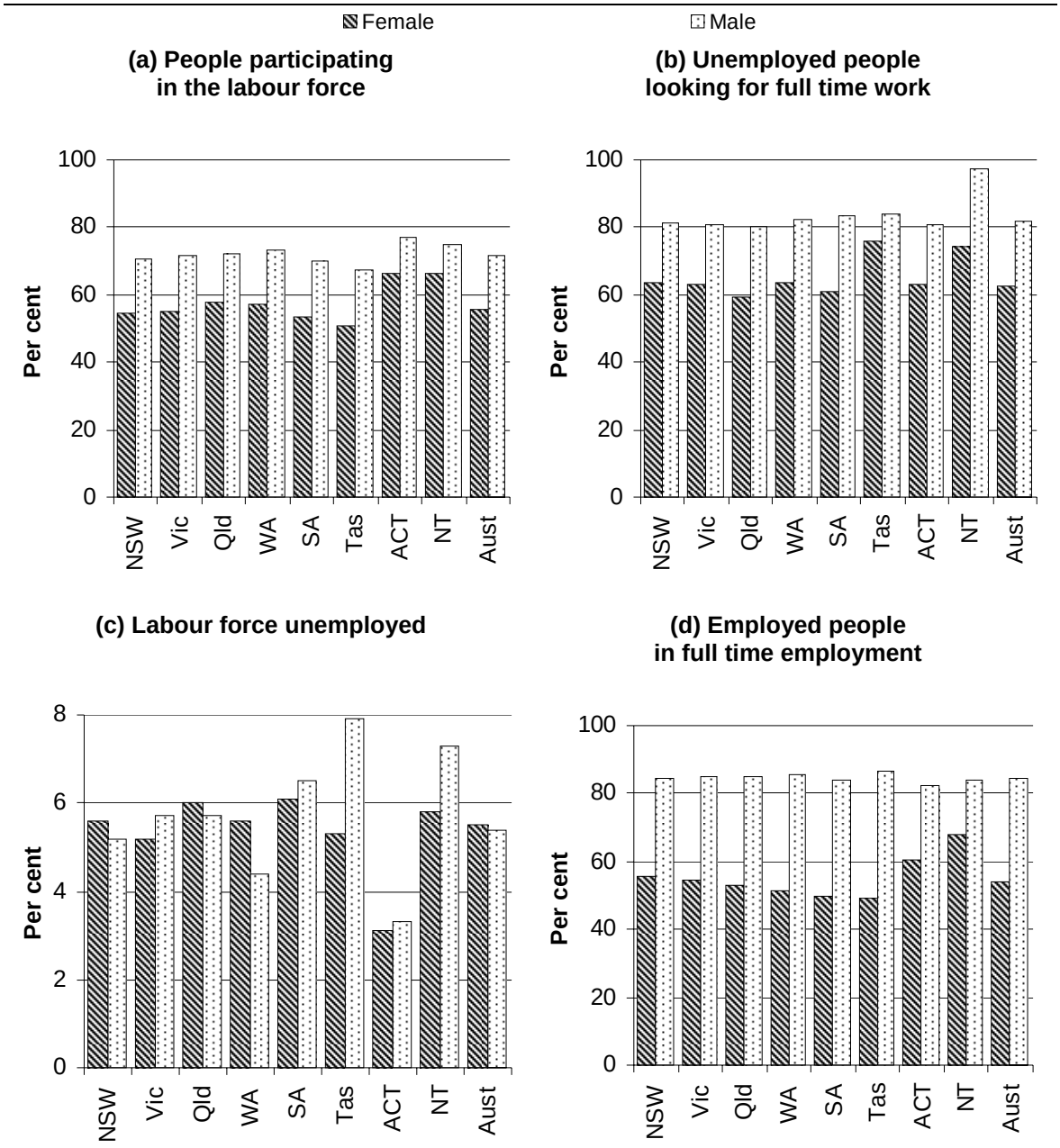
There were 9.6 million people aged 15 years or over employed in Australia in June 2004. The majority (71.0 per cent) were in full time employment. A further 562 000 were looking for either full time work (73.1 per cent) or part time work (26.9 per cent). This means 5.5 per cent of the participating labour force were unemployed at June 2004 (table A.22).

Across jurisdictions, the proportion of employed people in full time employment in June 2004 ranged from 76.4 per cent in NT to 69.7 per cent in Tasmania. The unemployment rate ranged from 6.8 per cent in Tasmania to 3.2 per cent in the ACT (tables A.22 and A.24). The proportion of unemployed people looking for full time work ranged from 88.1 per cent in the NT to 70.7 per cent in Queensland.

A greater proportion of employed males than of employed females had full time employment. The difference between male and female full time employment ranged from 37.6 percentage points in Tasmania to 15.9 percentage points in the NT (figure A.14d). Fewer unemployed females, however, were looking for full time

work. The difference ranged from 23.4 percentage points in the NT to 8.2 percentage points in Tasmania (figure A.14b).

Figure A.14 **Labour force outcomes for people aged 15 years or over, by sex, June 2004**



Source: ABS (2004b); table A.22-A.24.

The unemployment rate for females was equal to, or lower than, that for males in all jurisdictions except NSW, Queensland and WA. The greatest difference was in Tasmania (2.6 percentage points) (figure A.14c). These rates need to be interpreted within the context of labour force participation rates, which were higher for males

than for females in all jurisdictions. The difference ranged from 16.8 percentage points in Victoria to 8.3 percentage points in the NT (figure A.14a).

General economic indicators

The proportion of national gross product varied widely across the states and territories in 2002–03. The gross State product for NSW accounted for 35.3 per cent of national gross product, compared with 1.2 per cent for the NT. Growth from the previous year's gross State product was highest for Queensland (3.0 per cent) and lowest for the NT (0.3 per cent). Across Australia, the gross State product per person was $38 151 in 2002–03 (table A.25).

A.5 Statistical concepts used in the Report

Reliability of estimates

Outcome and quality indicators are reported from surveys (including surveys of client and community perception) for a number of services covered in this Report. Police services, for example, use an AC Nielsen survey to obtain an indicative level of community satisfaction with the services that police agencies provide. The presence of sampling error — that is, the error that occurs by chance because the data are obtained from only a sample and not the entire population — implies that the reported responses may not indicate the true responses.

Standard error

The standard error (SE) is one measure of the variability that occurs as a result of surveying a sample of the population. There are two chances in three (67 per cent) that a survey estimate is within one standard error of the figure that would have been obtained if the population had been included, and about 19 chances in 20 (95 per cent) that it is within approximately two standard errors. There is a 95 per cent probability that the true value of x lies within:

$$x - 1.96\,\mathrm{SE}(x) \text{ and } x + 1.96\,\mathrm{SE}(x)$$

where x is the estimate (for example, the number of persons responding either 'satisfied' or 'very satisfied'). The standard error of an estimate can be obtained from either (1) the tables reporting the estimates and relative standard errors or (2) the relative standard error tables produced at the end of each of the relevant

attachments. Linear interpolation needs to be used to calculate the standard errors of estimates falling between the sizes of estimates listed in these tables.

Relative standard error

The standard error can be expressed as a proportion of the estimate — known as the relative standard error (RSE), which is determined by dividing the standard error of the estimate SE*(x)* by the estimate *x* and expressing it as a percentage:

$$\mathrm{RSE}(x) = \frac{\mathrm{SE}(x)}{x}$$

If, for example, 4.3 million people in NSW were estimated to be satisfied with a service, and the standard error was approximately ±34 100 people, then the RSE(*x*) would be equal to 0.0078, or 0.78 per cent. The relative standard error is a useful measure in that it provides an immediate indication of the percentage errors likely to have occurred as a result of sampling.

Proportions and percentages formed from the ratio of two estimates are also subject to sampling error, as when estimating the proportion of a population that is 'satisfied' or 'very satisfied' with a service. The size of the error depends on the accuracy of both the numerator (the estimated number of persons responding as 'satisfied' or 'very satisfied') and the denominator (the estimated size of the population). The formula of a proportion is:

$$\mathrm{RSE}\left(\frac{x_1}{\mathrm{X}}\right) = \sqrt{[\mathrm{RSE}(x_1)]^2 - [\mathrm{RSE}(\mathrm{X})]^2}$$

where x_1 is estimated as the number of persons from jurisdiction *x* responding as 'satisfied' or 'very satisfied', and X is the estimated population of jurisdiction *x*.

Testing for statistical differences

The chance that an estimate falls within a certain range of the true value is known as the *confidence* of the estimate. For any particular survey, there is a tradeoff between the confidence of the estimate and the range of error (in terms of standard errors) attached to the estimate. The appropriate level of reliability chosen depends on the purpose of obtaining the estimate. The lower the level of confidence required, the more precise the estimate will be.

Confidence intervals — the value ranges within which estimates are likely to fall — can be used to test whether the reported proportions between two jurisdictions are

different. When comparing proportions, if the confidence intervals for the jurisdictions overlap, then there can be little confidence that the estimated proportions differ from each other.

If, for example, the 95 per cent confidence interval for survey data was estimated at ±3.2 per cent for NSW and ±1.5 per cent for Queensland, that would imply a 95 per cent probability that for a survey estimate of 60 per cent for NSW clients the true result would be within a 56.8–62.3 per cent confidence interval, and that the true result would be within a 56.5–59.5 per cent confidence interval for a survey estimate of 58 per cent for Queensland clients.

Expressed mathematically, the estimated response is within the 95 per cent confidence interval:

$$\left(\frac{x_1}{\mathrm{X}} - \frac{y_1}{\mathrm{Y}}\right) - 1.96\sqrt{\mathrm{RSE}\left(\frac{x_1}{\mathrm{X}}\right)\times\frac{x_1}{\mathrm{X}} + \mathrm{RSE}\left(\frac{y_1}{\mathrm{Y}}\right)\times\frac{y_1}{\mathrm{Y}}}$$

and

$$\left(\frac{x_1}{\mathrm{X}} - \frac{y_1}{\mathrm{Y}}\right) + 1.96\sqrt{\mathrm{RSE}\left(\frac{x_1}{\mathrm{X}}\right)\times\frac{x_1}{\mathrm{X}} + \mathrm{RSE}\left(\frac{y_1}{\mathrm{Y}}\right)\times\frac{y_1}{\mathrm{Y}}}$$

where x_1, X, y_1 and Y represent the estimated number of respondents and estimated populations of jurisdictions x and y respectively. If none of the values in this interval is zero, then the difference between jurisdiction x's response and jurisdiction y's response is statistically significant.

Growth rates

Average annual growth rates

Given that data in the Report cover different periods, compound annual averages have been used to facilitate more meaningful comparisons of changes over time. The formula for calculating a compound annual growth rate is:

$$\mathrm{AGR} = \left[\left(\frac{\mathrm{P_v}}{\mathrm{P_0}}\right)^{\left(\frac{1}{n-1}\right)} - 1\right]\times 100$$

where AGR is the annual growth rate
$\mathrm{P_v}$ is the present value
$\mathrm{P_0}$ is the beginning value
n is the number of periods

Summing and taking averages of growth rates

Total growth rate

The formula for calculating a total growth rate from annual growth rates is:

$$r_T = \Pi_i \ (1+r)_i - 1$$

that is, the total growth over the period, r_T, is found by taking the product of each $(1+r)_i$ and deducting 1. If, for example, the sample ranges of growth rates are:

6 per cent in 1995-96 to 1996-97
6 per cent in 1996-97 to 1997-98
8 per cent in 1997-98 to 1998-99

then the total growth over the period 1995-96 to 1998-99 can be calculated as:

$$\begin{aligned} r_T &= [\Pi_i (1+r)_i] \times 100 \\ &= [(1.06) \times (1.06) \times (1.06)] \times 100 \\ &= (1.213488 - 1) \times 100 \\ &= 21.3 \text{ per cent} \end{aligned}$$

Average growth rates

The formula for the average of growth rates is:

$$r_A = \left\{ [\Pi_i (1+r)_i]^{\left[\frac{1}{t}\right]} - 1 \right\} \times 100$$

This involves first finding the total growth over the period, then finding the average. Note that *t* is the count of growth rates being averaged, not the years. For example:

$$\begin{aligned} r_A &= \{ [(1.06 \times 1.06 \times 1.08)^{(1/3)} - 1] \times 100 \} \\ &= \{ [(1.213488)^{(1/3)} - 1] \times 100 \} \\ &= [(1.066625) - 1] \times 100 \\ &= 6.66 \text{ per cent.} \end{aligned}$$

Gross domestic product deflators

Table A.26 on the CD-ROM table contains GDP deflators for 1994–2004. The general formula used to re-base GDP deflators is as follows:

$$N_t 100 \times \frac{O_t}{B}$$

where N_t is the new index based in year t
O_t is the current index for year t
B is the current index for the year that will be the new base.

A.6 References

ABS (Australian Bureau of Statistics) 2001, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0, Canberra.

—— 2002a, *Census of Population and Housing: Basic Community Profiles*, Australia, Cat. no. 2002.0, DX Database (accessed 18 July 2002), unpublished.

—— 2002b, *Census of Population and Housing: Indigenous Community Profiles*, Australia, Cat. no. 2002.0, DX Database (accessed 18 July 2002), unpublished.

—— 2004a, *Australian Social Trends*, Cat. no. 4102.0, Canberra.

—— 2004b, *Labour Force*, Cat. no. 6291.0, unpublished.

—— 2004c, *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0, Canberra, DX Database (accessed 20 September 2004), unpublished.

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