Report on Government Services 2010

Volume 2:

Health; Community Services; Housing

Steering Committee for the Review of Government Service Provision

ISSN 1328 181X
ISBN 978 1 74037 287 9

This publication is available in hard copy or PDF format from the Productivity Commission website at www.pc.gov.au. If you require part or all of this publication in a different format, please contact the Secretariat (see below).

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

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

Level 28
35 Collins Street
Melbourne VIC 3000

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

Suggestions:

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

An appropriate citation for this Report is:

SCRGSP (Steering Committee for the Review of Government Service Provision) 2010, *Report on Government Services 2010*, Productivity Commission, Canberra.

Contents

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

Volume 1

PART A INTRODUCTION

PART B EARLY CHILDHOOD, EDUCATION AND TRAINING

PART C JUSTICE

PART D EMERGENCY MANAGEMENT

Volume 2

PART E HEALTH

PART F COMMUNITY SERVICES

PART G HOUSING

Acronyms and abbreviations

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

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

AQF	Australian Qualifications Framework
AQTF	Australian Quality Training Framework
AR-DRG v 5.1	Australian refined diagnosis related group, version 5.1
AR-DRGs	Australian refined diagnosis related groups
ARHP	Aboriginal Rental Housing Program
ARIA	Accessibility and Remoteness Index for Australia
ARO	Authorised Review Officer
ASGC	Australian Standard Geographical Classification
ASO	ambulance service organisation
ASOC	Australian Standard Offence Classification
ASSNP	core activity need for assistance
ATC	Australian transport Commission
Aust	Australia
AVETMISS	Australian Vocational Education and Training Management Information Statistical Standard
BBF	Building a Better Future
BEACH	Bettering the Evaluation and Care of Health
BMI	Body Mass Index
C&K	Crèche and Kindergarten
CAA	Council of Ambulance Authorities
CACP	Community Aged Care Package
CAD	computer aided dispatch
CAEPR	Centre for Aboriginal Economic Policy Research
CALD	culturally or linguistically diverse background

CAP	conditional adjustment payment
CAP	Crisis Accommodation Program
CAWG	Court Administration Working Group
CCB	Child Care Benefit
CCMS	Child Care Management System
CCR	Child Care Rebate
CCTR	Child Care Tax Rebate
CD-ROM	Compact Disc Read Only Memory
CDSMAC	Community and Disability Services Ministers’ Advisory Council
CFA	Country Fire Authority
CFCs	Child and Family Centres
CHIP	Community Housing and Infrastructure Program
CHOS	Canadian National Occupancy Standard
CI	confidence interval
CIS	Complaints Investigation Scheme
CMHC	Community Mental Health Care
COAG	Council of Australian Governments
CPG	Court Practitioners Group
CRA	Commonwealth Rent Assistance
CRC	COAG Reform Council
CRS	Commonwealth Rehabilitation Services
CRS	Complaints Resolution Scheme
CSASAW	Commonwealth-State Agreement for Skilling Australia’s Workforce

CSDWG	Children's Services Data Working Group
CSHA	Commonwealth State Housing Agreement
CSMAC	Community Services Ministers' Advisory Council
CSTDA	Commonwealth State/Territory Disability Agreement
CURF	confidentialised unit record file
DCIS	*ductal carcinoma in situ*
DDHCS	Department of Disability, Housing and Community Services
DEEWR	Department of Education, Employment and Workplace Relations
DET	Department of Education (NSW)
DGP	Divisions of General Practice
DHAC	Department of Health and Aged Care
DHS	Department of Human Services (Vic)
DHSH	Department of Human Services and Health
DiRCS	Differences in Recorded Crime Statistics
DoCS	Department of Community Services (NSW)
DoHA	Department of Health and Ageing
DPIE	Department of Primary Industries and Energy
DSE	Department of Sustainability and Environment
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EACH-D	EACH Dementia
ECD	Early Childhood Development
ECET	Early childhood, education and training

EMA	Emergency Management Australia
EMS	emergency medical service
ERP	estimated resident population
ESO	emergency services organisation
EYL	early years learning
FaCS	Department of Family and Community Services
FaCSIA	Department of Families, Community Services and Indigenous Affairs
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FDC	family day care
FDCQA	Family Day Care Quality Assurance
FESA	Fire and Emergency Services Authority of WA
FNA	fine needle aspiration
FSO	fire services organisation
FTE	full time equivalent
FWE	full time workload equivalent
FYA	Foundation for Young Australians
GDP	gross domestic product
GFS	Government Finance Statistics
GP	general practitioner
GPA Accreditation *plus*	General Practice Australia ACCREDITATION *plus*
GPII	General Practice Immunisation Incentive Scheme
GSP	gross state product
GSS	General Social Survey

GST	goods and services tax
HACC	Home and Community Care
HAF	Housing Affordability Fund
HDSC	Health Data Standards Committee
HECS	Higher Education Contribution Scheme
HELP	Higher Education Loan Program
HILDA	Household Income and Labour Dynamic Australia
HMAC	Housing Ministers' Advisory Council
HOIST	New South Wales Population Health Survey 2007
HREOC	Human Rights and Equal Opportunity Commission
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
ICD	International Classification of Diseases
ICD-10-AM	Australian modification of the International Standard Classification of Diseases and Related Health Problems, version 10
ICH	Indigenous community housing
ICHO	Indigenous Community Housing Organisation
ICT	information and communication technology
IGA	Intergovernmental Agreement
IPD	Implicit Price Deflator
IRSD	Index of Relative Socio-economic Disadvantage
ISO	International Organisation for Standardisation
ISS	Inclusion Support Subsidy
JJNMDS	Juvenile Justice National Minimum Data Set

JJRIG	Juvenile Justice Research and Information Group
K10	Kessler Psychological Distress Scale
KPIs	Key performance indicators
LBOTE	Language background other than English
LCL	lower confidence limit
LDC	long day care
LGCSA	Local Government Community Services Association of Australia
LMO	local medical officer
LOTE	Language other than English
LSAC	Longitudinal Study of Australian Children
LSAY	Longitudinal Surveys of Australian Youth
MBI	Modified Barthel Index
MBS	Medicare Benefits Schedule
MCATSIA	Ministerial Council on Aboriginal and Torres Strait Islander Affairs
MCEECDYA	Ministerial Council for Education, Early Childhood Development and Youth Affairs
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MCTEE	Ministerial Council of Tertiary Education and Employment
MCVTE	Ministerial Council on Vocational and Technical Education
MECS	Mobile Early Childhood Services
MFS	Metropolitan Fire Service

MHE	Mental Health Establishments
MHS	mental health services
MPS	multi-purpose services
NA	National Agreement
na	not available
NAHA	National Affordable Housing Agreement
NAPLAN	National Assessment Program – Literacy and Numeracy
NASWD	National Agreement for Skills and Workforce Development
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NBCC	National Breast Cancer Centre
NBOCC	National Breast and Ovarian Cancer Centre
NCAC	National Childcare Accreditation Council
NCAG	National Corrections Advisory Group
NCCH	National Centre for Classification in Health
NCIRS	National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases
NCJSF	National Criminal Justice Statistical Framework
NCPASS	National Child Protection and Support Services data working group
NCSCH	National Cancer Statistics Clearing House
NCSIMG	National Community Services Information Management Group
NCVER	National Centre for Vocational Education Research
NDA	National Disability Agreement

NEA	National Education Agreement
NEAT	Department of Natural Resources Environment and the Arts
NESB	non-English speaking background
NHA	National Healthcare Agreement
NHCDC	National Hospital Cost Data Collection
NHIMPC	National Health Information Management Principal Committee
NHMP	National Homicide Monitoring Program
NHMRC	National Health and Medical Research Council
NHPAC	National Health Priority Action Council
NHPC	National Health Performance Committee
NHS	National Health Survey
NIDP	National Information Development Plan
NIHEC	National Indigenous Health Equality Council
NIRA	National Indigenous Reform Agreement
NISC	National Industry Skills Committee
NMDS	national minimum data set
NMHS	National Mental Health Strategy
NNDSS	National Notifiable Diseases Surveillance System
no.	number
NOOSR	National Office of Overseas Skills Recognition
NP	National Partnership
np	not published
NPAs	National Partnership Agreements

NPC	National Preschool Census
NQC	National Quality Council
NRCP	National Respite for Carers Program
NRF	National Reporting Framework
NRSS	National Road Safety Strategy
NSCSP	National Survey of Community Satisfaction with Policing
NSMHS	National Standards for Mental Health Services
NSOC	National Senior Officials Committee
NSSC	National Schools Statistics Collection
NSW RFS	New South Wales Rural Fire Service
NSW	New South Wales
NSWFB	New South Wales Fire Brigade
NT	Northern Territory
NTES	National Territory Emergency Services
NTSC	National Training Statistics Committee
NYPR	National Youth Participation Requirement
OCYFS	Office for Children, Youth and Family Support (ACT)
OECD	Organisation for Economic Co-operation and Development
OID	Overcoming Indigenous Disadvantage
OMP	other medical practitioner
OSHC	outside school hours care
OSHCQA	Outside School Hours Care Quality Assurance
PBS	Pharmaceutical Benefits Scheme

PC	Productivity Commission
PDF	Portable Document Format
PDWG	Performance and Data Working Group
PhARIA	Pharmacy Access/Remoteness Index of Australia
PHCRIS	Primary Health Care Research and Information Service
PIP	Practice Incentives Program
PIRP	Preschool Investment and Reform Plan
PISA	Program for International Student Assessment
PMRT	Performance Measurement and Reporting Taskforce
PSM	ABS Population Survey Monitor
PWI	personal wellbeing index
QFRS	Queensland Fire and Rescue Service
QIAS	Quality Improvement and Accreditation System
Qld	Queensland
QMP	Quality Management Framework
RACGP	Royal Australian College of General Practitioners
RAV	Rural Ambulance Victoria
RCS	resident classification scale
RFDS	Royal Flying Doctor Service
ROGS	Report on Government Services
ROSC	return of spontaneous circulation
RPBS	Repatriation Pharmaceutical Benefits Scheme
RPL	recognition of prior learning
RRMA	Rural, Remote and Metropolitan Areas

RSE	relative standard error
RTO	Registered Training Organisation
S/TES	State Emergency Service/Territory Emergency Service
SA	South Australia
SAAP CAD	SAAP Coordination and Development Committee
SAAP NDCA	SAAP National Data Collection Agency
SAAP	Supported Accommodation Assistance Program
SAAS	SA Ambulance Services
SAR	Service Activity Reporting
SAT	school-based apprenticeships and traineeship
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SCRGSP	Steering Committee for the Review of Government Service Provision
SDAC	Survey of Disability, Ageing and Carers
SE	standard error
SEIFA	Socio Economic Indexes for Areas
SEM	standard error of the mean
SES	socioeconomic status
SES	State Emergency Services
SEWB	National Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004-05
SEWB	Social and Emotional Wellbeing
SIQ	standard Indigenous question

SLA	statistical local area
SMHWB	National Survey of Mental Health and Wellbeing
SMR	standardised mortality ratios
SOMIH	state owned and managed Indigenous housing
SPP	special purpose payment
SPRC	Social Policy Research Centre
SSAT	Social Security Appeals Tribunal
SWPE	standardised whole patient equivalent
TAFE	technical and further education
Tas	Tasmania
TAS	Tasmanian Ambulance Service
TCP	Transition Care Program
TFS	Tasmania Fire Service
TGR	total growth rate
TIMSS	Trends in International Mathematics and Science Study
TVET	technical and vocational education and training
UCC	user cost of capital
UCL	upper confidence limit
URTI	upper respiratory tract infection
USAR	Urban Search and Rescue
VCAT	Victorian Civil and Administrative Tribunal
VET	vocational education and training
VF	ventricular fibrillation
VHC	Veterans' Home Care

Vic	Victoria
VT	ventricular tachycardia
WA	Western Australia
WGIR	Working Group on Indigenous Reform
WHO	World Health Organisation
YPIRAC	Younger people in residential aged care

Glossary

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

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

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

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

PART E

HEALTH

E Health preface

CONTENTS

Attachment tables

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

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

Health services in Australia are delivered by a variety of government and non-government providers in a range of service settings (box E.1). The Report primarily concentrates on the performance of public hospitals (chapter 10), primary and community health services (including general practice) (chapter 11) and the interactions among different service mechanisms for dealing with two health management issues: mental health and breast cancer (chapter 12). These services are selected for reporting as they:

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

The Australian, State, Territory and local governments spent $58.3 billion (expressed in 2007-08 dollars) on selected health services, including public hospitals, medical services (including payments to general practitioners [GPs] and other specialist practitioners), community and public health, medications and public dental services in 2007-08. These areas of health care activity accounted for 84.9 per cent of government recurrent health expenditure in 2007-08 (table EA.4). Total public health expenditure by Australian, State and Territory governments on breast cancer screening was $150 million in 2007-08 (table 12A.6). This includes funding by the Australian Government to states and territories through the Public Health Outcome Funding Agreements (PHOFAs). Government recurrent expenditure on specialist mental health services was estimated to be around $5.1 billion in 2007-08 (tables 12A.31 and 12A.32). Some of this expenditure was on psychiatric care provided by public (non-psychiatric) hospitals (chapters 10 and 12).

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

Box E.1 Some common health terms

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

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

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

Primary health care: services that:

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

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

Public hospital: a hospital that provides treatment free of charge and accommodation to eligible admitted people who elect to be treated as public patients. It also provides services free of charge 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 NHA (for example, charges for aids and appliances).

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

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

Other government services — such as education, public housing, sanitation and water supply — also influence health outcomes. These are not formally part of Australia's health system and are not the subject of the health chapters. Education (chapters 4 and 5) and public and community housing (chapter 16) are included in other chapters of the Report.

There is a complex relationship between health behaviours, health outcomes, and the socioeconomic and physical environment in which they occur. It has been well documented that Indigenous people are at a higher risk of experiencing social and economic disadvantage, which may impact negatively on health behaviours and outcomes. It is a priority of the Steering Committee to improve reporting on the performance of government provided health care services for Indigenous people and for residents in regional and remote Australia.

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

The measurement details of relevant National Agreement reporting were under development at the time of preparing this Report. It is anticipated that the information reported in this preface will be revised to align with the performance indicators in the National Agreements for the 2011 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 10, 11 and 12 respectively.

Roles and responsibilities

The Australian Government's health services activities include:

- funding States and Territories through the NHA to deliver public hospital services
- providing rebates to patients for medical services provided by GPs and specialists and delivering public health programs

- funding the PBS
- funding high level residential aged care services
- funding private health insurance rebates
- funding improved access to primary health care, specialist services and infrastructure for rural and remote communities
- funding Indigenous-specific primary health
- promulgating and coordinating health regulations
- undertaking health policy research and policy coordination across the Australian, State and Territory governments
- funding hospital services and the provision of other services through the Department of Veterans' Affairs
- funding the Medicare Safety Net.

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

- public hospital services
- public health programs (such as health promotion programs and disease prevention)
- community health services
- public dental services
- mental health programs
- patient transport
- the regulation, inspection, licensing and monitoring of premises, institutions and personnel
- health policy research and policy development
- specialist palliative care
- the Home and Community Care (HACC) program
- aged care.

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

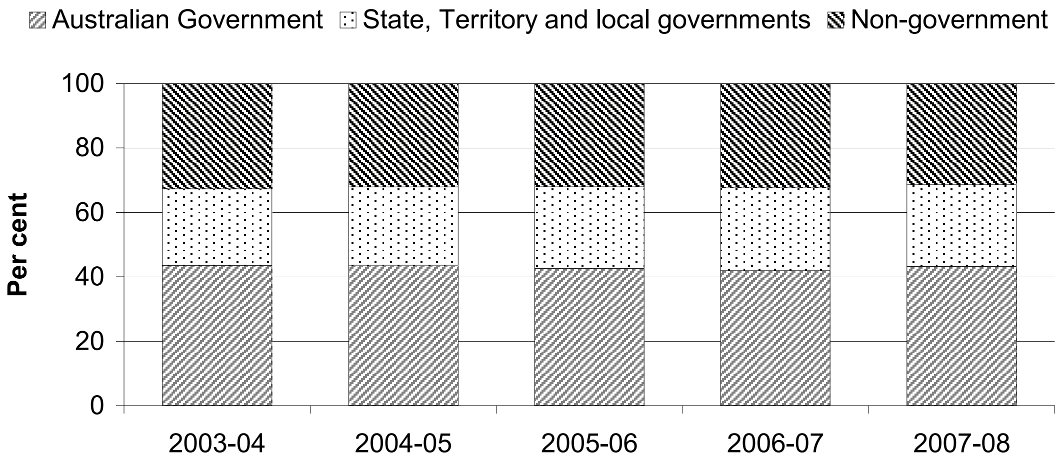
Funding

Funding the components of Australia's health care system is a complicated process. The Australian Government subsidises many of the services provided by the non-government sector (mostly through the MBS, the PBS, the private health insurance rebate and the Medicare Safety Net) and contributes funding to a number of nationally coordinated public health programs. It also provides funding under the NHA (formerly the Australian Health Care Agreements [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 payments received from the Australian Government, contribute funds to public health, community health services and public hospitals (through casemix and other payments), which in turn fund specialists (through limited fee-for-service or sessional arrangements). Private individuals, health insurance funds and other non-government institutions also contribute funding to a range of health care providers, both government and non-government.

In 2007-08, the Australian, State, Territory and local governments spent $71.2 billion on total health services, which represents 68.7 per cent of total health expenditure. The Australian Government accounted for the largest proportion of health care expenditure in Australia — $44.8 billion or 43.2 per cent of the total in 2007-08. State, Territory and local governments contributed $26.4 billion or 25.5 per cent of total health expenditure in that year (AIHW 2009a). These shares have remained relatively constant over the past 10 years. The remainder was paid by individuals, health insurance funds and workers compensation and compulsory motor vehicle third party insurance providers (figure E.1 and tables EA.1 and EA.7).

Figure E.1 **Total health expenditure, by source of funds (2007-08 dollars)**[a, b, c, d]



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

Source: AIHW (2009) *Health Expenditure Australia 2007-08*, Cat. no. HWE 46, Health and Welfare Expenditure Series no. 37, Canberra; table EA.1.

Size and scope of sector

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be $103.6 billion in 2007-08 (table EA.1). This total was estimated to account for 9.1 per cent of gross domestic product in 2007-08, the same percentage as the previous year and an increase of 1.3 per cent from the 7.8 per cent of GDP in 1997-98 (AIHW 2009a). This indicates that health expenditure grew faster than the economy as a whole over the decade to 2007-08.

The growth of total health expenditure over the past decade was largely the result of an increase in expenditure by the Australian, State, Territory and local governments, which grew proportionally faster than expenditure by non-government sources. Between 1997-98 and 2007-08, the average annual rate of growth in real expenditure was 5.4 per cent for the Australian Government, 5.4 per cent for State, Territory and local governments, and 4.8 per cent for non-government sources (AIHW 2009).[1]

---

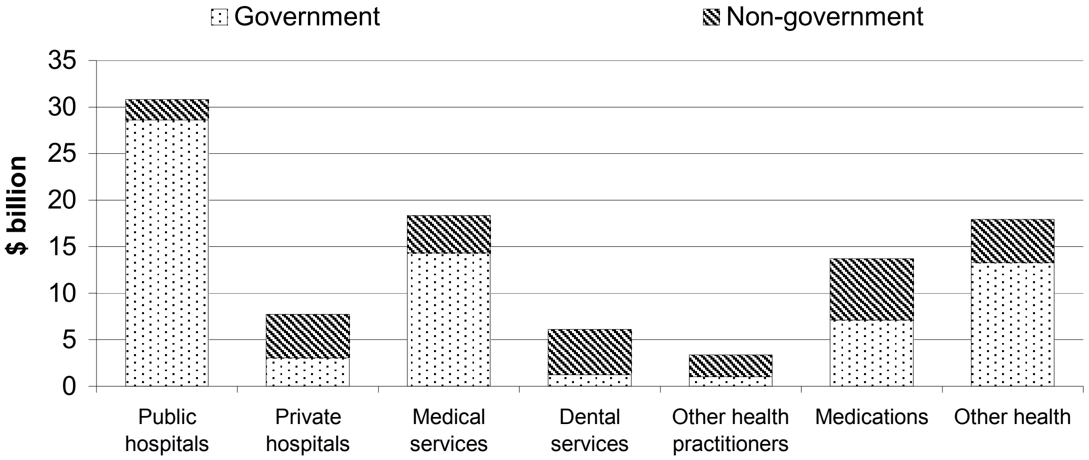
[1] There was a break in series due to differences in definitions of public hospital and public hospital services between 2002-03 and 2003-04.

The introduction of programs supporting private health insurance was a significant factor in the increase in expenditure by the Australian Government in the late 1990s. On 1 January 1999, the Australian Government replaced the Private Health Insurance Incentive Scheme with a 30 per cent rebate on private health insurance premiums. Australian Government expenditure on the rebate has increased each year from $2.4 billion in 2003-04 to $3.6 billion in 2007-08 in current prices (that is, not adjusted for inflation) (AIHW 2009a).

The Medicare Safety Net, introduced in March 2004, has also contributed to increased Australian Government expenditure. Under the Medicare Safety Net, patients are reimbursed for 80 per cent of their out-of-pocket costs for medical treatment received in a non-hospital setting, once a certain threshold is reached in a calendar year. Total Medicare Benefits Schedule Medicare Safety Net expenditure was $257.8 million in the year ending 31 December 2006 (DoHA 2008b).

Public hospitals were the single largest item of recurrent health care expenditure by government and non-government sources in 2007-08. Total real expenditure on public hospitals (which excludes expenditure on community and public health services, dental and ambulance services and health research undertaken by public hospitals) was $30.8 billion, of which governments paid $28.6 billion (figure E.2). Public hospitals accounted for 41.7 per cent of government recurrent expenditure on health care services in 2007-08. Medical services accounted for $14.3 billion of government expenditure (20.9 per cent of total health expenditure) and medications accounted for $7.1 billion (10.3 per cent) (table EA.2).

Figure E.2 Recurrent health expenditure, by area of expenditure, 2007-08[a, b, c, d, e, f]



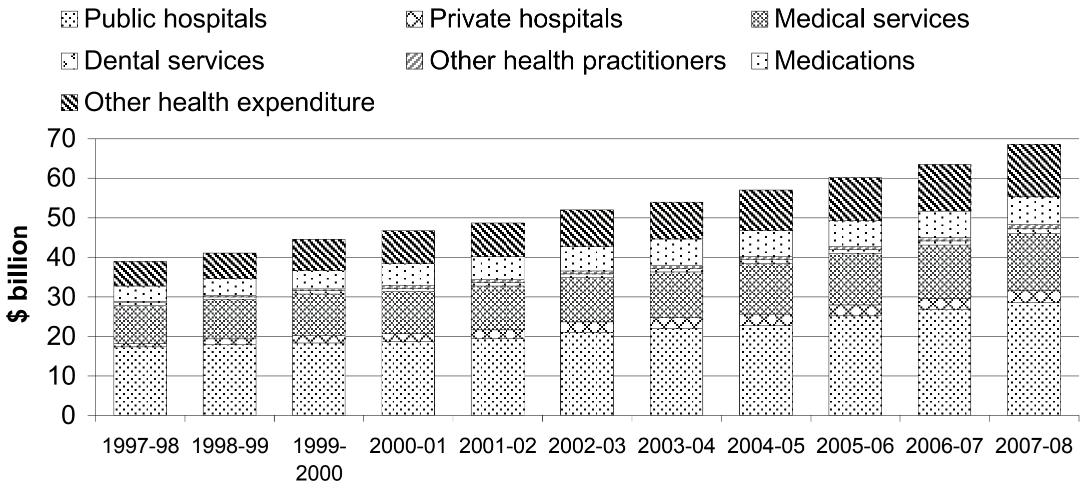
[a] Government funding of recurrent health expenditure has been adjusted for non-specific tax expenditure. [b] Almost all expenditure on medical services relates to services provided by practitioners on a fee-for-service basis, including those provided to private patients in hospitals. Excluded are the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

Source: AIHW (2009) *Health Expenditure Australia 2007-08*, Cat. no. HWE 46, Health and Welfare Expenditure Series no. 37, Canberra; tables EA.2 and EA.3.

The relative share of government recurrent health expenditure allocated to public hospitals has fallen from 44.4 per cent in 1997-98 to 41.7 per cent in 2007-08. This decline reflects the more rapid growth over the decade of government expenditure on private hospitals and medications (figure E.3 and table EA.2). The average annual growth rate of government real recurrent expenditure on private hospitals was 13.3 per cent between 1997-98 and 2007-08 (albeit from a relatively low base), compared with 6.2 per cent for medications and 5.1 per cent for public hospitals (table EA.2). Policy measures introduced over the decade that were aimed at restraining growth in government health expenditure included the restriction of Medicare provider numbers, initiatives to encourage the use of generic medication brands, and increases in co-payments for medications.

The high annual growth in expenditure on private hospitals meant it also grew as a proportion of government health care expenditure over the period 1997-98 to 2007-08. Government expenditure on private hospitals increased from 2.2 per cent of government health expenditure in 1997-98 to 4.5 per cent in 2007-08, and the proportion of expenditure on medication also slightly increased from 10.0 per cent to 10.3 per cent over the same period (table EA.2).

Figure E.3 Government recurrent expenditure, by area of expenditure (2007-08 dollars)[a, b, c, d, e]



[a] Medications include (but are not limited to) those provided under the PBS. [b] Almost all expenditure on medical services relates to services provided by practitioners on a fee-for-service basis, including those provided to private patients in hospitals. Excluded are the medical component of hospital care provided to public hospital inpatients, and the outpatient medical services provided at public hospitals. [c] High level residential aged care is reported in chapter 13. [d] Other health comprises patient transport services, community health, public health, aids and appliances, other non-institutional health nec., administration and research. [e] Real (constant price) estimates have been calculated by applying the AIHW total health price index (table EA.7).

Source: AIHW (2009) *Health Expenditure Australia 2007-08*, Cat. no. HWE 46, Health and Welfare Expenditure Series no. 37, Canberra; table EA.2.

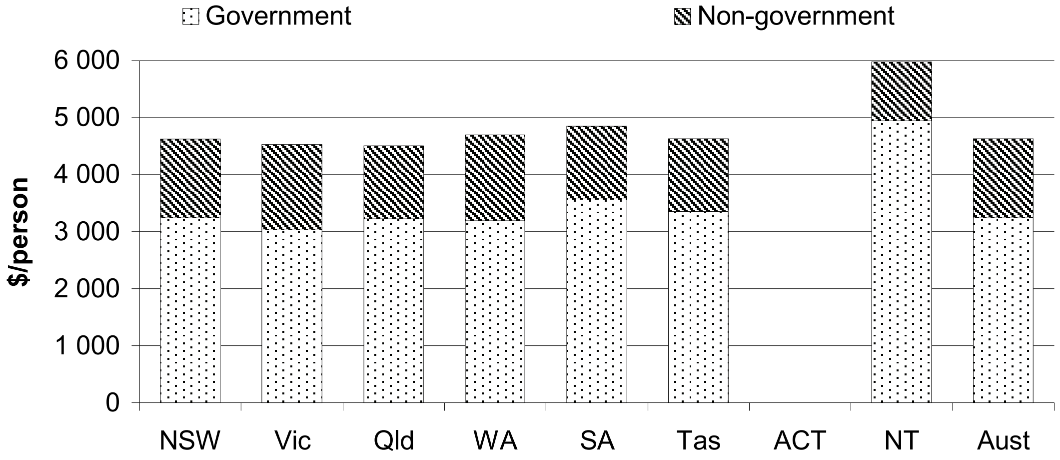
Health expenditure per person

Health expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics. Nationally, total health expenditure (recurrent and capital) per person in 2007-08 (expressed in 2007-08 dollars) was $4890 (table EA.5). Total health expenditure per person in Australia increased from $4207 in 2003-04 to $4890 in 2007-08 (expressed in 2007-08 dollars) (table EA.5). The average annual growth rate in average health expenditure per person (expressed in 2007-08 dollars) from 2003-04 to 2007-08 was 3.8 per cent (table EA.5).

Government real recurrent health expenditure per person in Australia increased from $2696 in 2003-04 to $3241 in 2007-08 (expressed in 2007-08 dollars). Non-government recurrent expenditure per person in Australia rose from $1257 in

2003-04 to $1386 in 2007-08 (expressed in 2007-08 dollars) (figure E.4 and table EA.6).

Figure E.4 **Recurrent health expenditure per person by source of funds, excluding high level residential aged care, 2007-08 (2007-08 dollars)[a, b, c]**



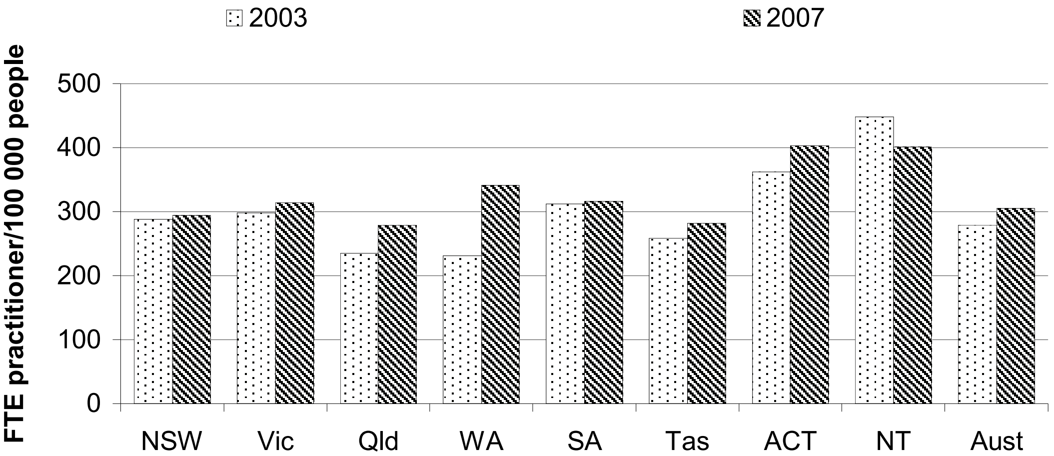
[a] Includes expenditure on high level residential aged care (reported in chapter 13) and ambulance services (reported in chapter 9). [b] Government expenditure includes expenditure by the Australian, State, Territory and local governments. [c] ACT per person figures are not calculated, as the expenditure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

Source: AIHW (2009) *Health Expenditure Australia 2007-08*, Cat. no. HWE 46, Health and Welfare Expenditure Series no. 37, Canberra; table EA.6.

Health workforce

In 2007, there were 67 208 registered medical practitioners in Australia working in medicine. A further 1604 were in the medical labour force but on extended leave or looking for work. The majority of employed practitioners working in medicine were clinicians (93.2 per cent), of whom 38.5 per cent were primary care practitioners (mainly general practitioners), 34.6 per cent were specialists, 14.1 per cent were specialists-in-training, 11.8 per cent were hospital non-specialists and 0.9 per cent were other clinicians (AIHW 2009b). The number of full time equivalent (FTE) practitioners per 100 000 people by jurisdiction is illustrated in figure E.5.

Figure E.5 **Employed medical practitioners**[a, b]



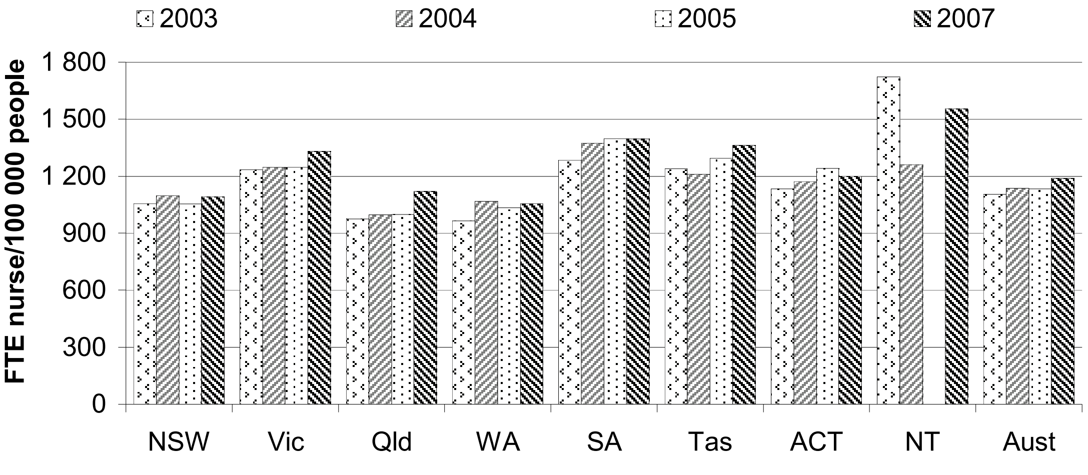
---

[a] FTE rate (FTE per 100 000 people) is based on standard full-time working week of 45-hours. [b] Number of 'employed medical practitioners' does not include medical practitioners on extended leave.

Source: AIHW (2009) *Medical Labour Force 2007*, Cat. no. HWL 45, National Health Labour Force Series no. 44; table EA.8.

The number of FTE nurses per 100 000 people by jurisdiction is illustrated in figure E.6. The national increase in the FTE nurse rate in Australia arose from both an increase in the number of nurses employed and an increase in average hours worked (AIHW 2009c).

Figure E.6 **Employed nurses**[a, b, c, d]



---

[a] FTE nurse rate (per 100 000 people) based on a 35-hour week. [b] Number of 'employed nurses' does not include nurses on extended leave. [c] Data for the NT for 2005 are not published. [c] Data for 2006 are not available.

Source: AIHW (2009) *Nursing and Midwifery Labour Force 2007*, AIHW Cat. no. HWL 44, National Health Labour Force Series no. 43; AIHW (2008) *Nursing and Midwifery Labour Force 2005*, AIHW Cat. no. HWL 40, National Health Labour Force Series no. 39; AIHW (2005) *Nursing and Midwifery Labour Force 2003*, AIHW Cat. no. HWL 31, National Health Labour Force Series no. 31; table EA.9.

Overview of Indigenous health

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

Australian Indigenous people are more likely to experience disability and significantly lower quality of life due to poorer health, and to have shorter life expectancies than the rest of the Australian population (SCRGSP 2009). These patterns are reflected in Australian data on: mortality, life expectancy and birthweight (later in this preface); hospital separation rates; fetal, neonatal and perinatal death rates (chapter 10); and suicide (chapter 12).

A number of recent publications include more comprehensive data on the health status of Indigenous people and Indigenous health-related factors. These include *Aboriginal and Torres Strait Islander Health Performance Framework — 2008 Report* (DoHA 2008a), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* [Australian Bureau of Statistics (ABS) and AIHW 2008], *Australia's Health 2008* (AIHW 2008b) *Overcoming Indigenous Disadvantage: Key Indicators 2009* (SCRGSP 2009) and *National Aboriginal and Torres Strait Islander Social Survey, 2008* (ABS 2009d).

Contributing factors

Many Indigenous Australians live today in conditions of clear social and economic disadvantage, which, along with other geographic, environmental and cultural factors, may contribute to poor health.

Educational attainment levels are relatively low for the Indigenous population compared with all Australians. School retention rates for Indigenous school students remain considerably lower than those for non-Indigenous school students, although the disparity between the two groups is slowly lessening (ABS and AIHW 2008). In 2008, the apparent retention rate for Indigenous full-time students from years 7 or 8 to year 10 was 89.2 per cent and to year 12 was 46.5 per cent. This compares with apparent retention rates for non-Indigenous students of 99.8 per cent to year 10 and 75.6 per cent to year 12. Apparent retention rates for Indigenous students from the beginning of secondary school to year 12 increased from 39.8 per cent in 2004 to 46.5 per cent in 2008, while the rate for non-Indigenous Australians remained steady at around 76 per cent (SCRGSP 2009).

Indigenous people have relatively low employment and income levels that may create financial barriers to accessing health services. Average weekly income for Indigenous people was $549 in 2006, while the weekly income for non-Indigenous people was $769 (see Statistical appendix tables AA.2, AA.7, AA.16 and AA.17). Between 2001 and 2006, for those aged 15–64 years the employment to population ratio increased for Indigenous people from 43 per cent to 48 per cent, and for non-Indigenous people from 68 per cent to 72 per cent. The gap remained around 25 percentage points. In the same time period, the unemployment rate for Indigenous people aged 15–64 years decreased from 20 per cent to 16 per cent. However, the unemployment rate for Indigenous Australians was still three times the rate for non-Indigenous Australians (16 per cent compared with 5 per cent), similar to the rate ratios from the 2001 Census (20 per cent compared with 7 per cent) (SCRGSP 2009).

There are high imprisonment rates among Indigenous people. Indigenous prisoners represented 25 per cent of the total prisoner population in 2008-09 (see chapter 8, table 8A.1). After adjusting for age differences, Indigenous adults were 13 times as likely as non-Indigenous adults to be imprisoned in 2008, compared to 10 times in 2000. The Indigenous juvenile detention rate increased by 27 per cent between 2001 and 2007. As at 30 June 2007, Indigenous juveniles were 28 times as likely as non-Indigenous juveniles to have been detained. High imprisonment rates may contribute to the poorer health status of Indigenous people (SCRGSP 2009).

There are close associations between socioeconomic factors and exposure to health risk factors. Indigenous Australians have relatively high rates for some health risk factors such as obesity, substance abuse and violence. In 2008, 47 per cent of Indigenous people aged 18 years and over were daily cigarette smokers (ABS 2009d). Indigenous adults were less likely than non-Indigenous adults to have consumed alcohol in the week prior to interview in 2004-05 (53 per cent compared with 36 per cent). Among those who drank alcohol, rates of long-term risky/high risk alcohol consumption were similar for Indigenous and non-Indigenous Australians after adjusting for age. However, Indigenous adults were twice as likely to consume alcohol at short-term risky/high risk levels at least once a week over the previous 12 month period. Hospitalisation rates for all alcohol-related conditions were higher for Indigenous people than non-Indigenous people in 2006-07 (SCRGSP 2009).[2]

Geographic distance to health services, particularly in remote and very remote areas, contributes to the health disadvantage of Indigenous people. In 2006, a total

---

[2] Short term risk is the risk of harm associated with given levels of alcohol consumption on any one occasion. Long term risk is associated with regular daily patterns of alcohol consumption and defined by the average daily intake of alcohol over 7 days of the reference week.

of 417 (35 per cent) discrete Indigenous communities[3], with a combined population of 25 486, were located 100 kilometres or more from the nearest Aboriginal Primary Health Care Centre and of those, 92 (22 per cent) were larger communities with a population of 50 or more people. A total of 372 discrete Indigenous communities (31 per cent) were located 100 kilometres or more from the nearest other (State-funded) health centre and of these, 90 (24 per cent) were larger communities. A total of 755 (64 per cent) discrete Indigenous communities were located 100 kilometres or more from the nearest hospital. On a population basis, 25 per cent of Indigenous people living in communities were 100 kilometres or more from the nearest hospital (ABS 2007).

Many Indigenous people live in inadequate and overcrowded housing, particularly in remote and very remote areas. Indigenous people were around five times as likely as non-Indigenous people to live in overcrowded housing in 2006. Overcrowding was highest in very remote areas (65.1 per cent) and lowest in major cities (15.1 per cent) (SCRGSP 2009). There were around 20 700 overcrowded Indigenous households (14 per cent), and 102 400 Indigenous people (27 per cent) living in overcrowded conditions in 2006 (ABS and AIHW 2008). There has been some improvement in housing overcrowding, with the proportion of Indigenous people living in overcrowded housing falling from 31 per cent to 27 per cent between 2001 and 2006 (SCRGSP 2009).

Government policies and programs

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

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

---

[3] A geographic location, bounded by physical or cadastral (legal) boundaries, and inhabited or intended to be inhabited predominantly (that is, greater than 50 per cent of usual residents) by Indigenous people, with housing or infrastructure that is managed on a community basis.

In October 2008, COAG agreed to six long-term targets for closing the gap between Indigenous and non-Indigenous Australians on health, early childhood development, education, housing, and economic outcomes. The NIRA provides the overarching framework for the six closing the gap targets across the Indigenous-specific National Partnership Agreements (NPAs), and is underpinned by key performance indicators and benchmarks. These performance indicators and benchmarks will be used to monitor progress through annual public reporting and analysis by the COAG Reform Council from 2009-10.

The Australian Government recognises that a multifaceted and sustained approach addressing factors both within and beyond the health system is required to address Indigenous disadvantage. COAG has identified seven ‘building blocks’ which are the strategic platforms that need to be in place in order to comprehensively address the current state of Indigenous disadvantage, and they include:

- healthy homes
- safe communities
- health
- early childhood
- schooling
- economic participation
- governance and leadership.

The ‘building block’ approach integrates policy reforms and implementation to comprehensively address Indigenous disadvantage.

On 29 November 2008, COAG agreed to a $1.6 billion investment through the National Partnership on Closing the Gap in Indigenous Health Outcomes to help close the gap in life expectancy between Indigenous and non-Indigenous Australians. The Australian Government’s contribution of $805.5 million (over 4 years) from 2009-10 will address chronic disease risk factors; encourage better management of chronic disease in primary health care services; improve follow up care; and increase the capacity of the primary care workforce to deliver effective health care to Indigenous people.

The Australian Government has established the National Indigenous Health Equality Council (NIHEC) to provide advice on strategic priorities that contribute towards achieving more equitable and sustainable health outcomes for Indigenous people.

All State and Territory governments and the Australian Government are developing an implementation plan under the National Strategic Framework. Taking a whole of government approach, these plans detail information on existing and planned action by each government to improve health outcomes for Indigenous people. They outline programs and policy approaches which are the primary responsibility of each government both within the health department and in other portfolios. Each jurisdiction reports to health ministers on health portfolio progress under the plan every year and on the whole of government contribution every 2 years.

The Aboriginal and Torres Strait Islander Health Performance Framework has been developed under auspices of the Australian Health Ministers' Advisory Council to monitor progress in Indigenous health. The Health Performance Framework is designed to inform policy analysis, planning and program implementation. The first *Aboriginal and Torres Strait Islander Health Performance Framework — 2006 Report* (DoHA 2006) was released in late 2006 and the *Aboriginal and Torres Strait Islander Health Performance Framework — 2008 Report* (DoHA 2008a) was released in December 2008.

Expenditure

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

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

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

The most recent estimates of health services expenditure for Indigenous people are for 2004-05 (AIHW 2008a). Between 1995-96 and 2004-05 there has been little change in the per person health expenditure ratio for Indigenous people compared to non-Indigenous people. Total recurrent government and non-government expenditure on health services for Indigenous people was estimated at $2304 million in 2004-05 or 2.8 per cent of national expenditure on health services, the same proportion as for 2001-02. In 2004–05, $1.17 per person was spent on Indigenous health for every $1.00 spent on the health of non-Indigenous Australians. Average total health expenditure per Indigenous person was $4718 compared with $4019 per person estimated for non-Indigenous Australians (table E.1). The three largest categories of health expenditure were hospitals, medical services and medications. Together they accounted for 66.7 per cent of all Australian health expenditure in 2004–05 and 58.8 per cent of the spending that was allocated to Indigenous people (table E.1).

Expenditure per person on public hospitals for Indigenous people was around twice that for non-Indigenous people for both admitted and non-admitted patient services. Conversely, expenditure on medical services, dental and other health practitioners and medications was less than half that for non-Indigenous people. Expenditure on aids and appliances was 29 per cent of the non-Indigenous average. However, spending on community health services was over 6.5 times that for other Australians and expenditure for both patient transport and public health were well above the national average (table E.1). Indigenous people tend to rely disproportionately on public hospitals for reasons of access, cost and culture as well as health. In many of the areas where Indigenous people live, hospital admission is the only practical way of receiving anything but the simplest services, and hospital emergency rooms are the most accessible source of affordable medical treatment, including GP-type care. Indigenous people were admitted to public hospitals at nearly 2.5 times the rate for non-Indigenous Australians (AIHW 2008a). More detailed data on Indigenous health expenditure will be reported in the Indigenous Expenditure Report forthcoming in 2010.

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

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

[a] Public hospital services exclude any dental services, community health services, patient transport services, public health and health research undertaken by the hospital. .. Not applicable.

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

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

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

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

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

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

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

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

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

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

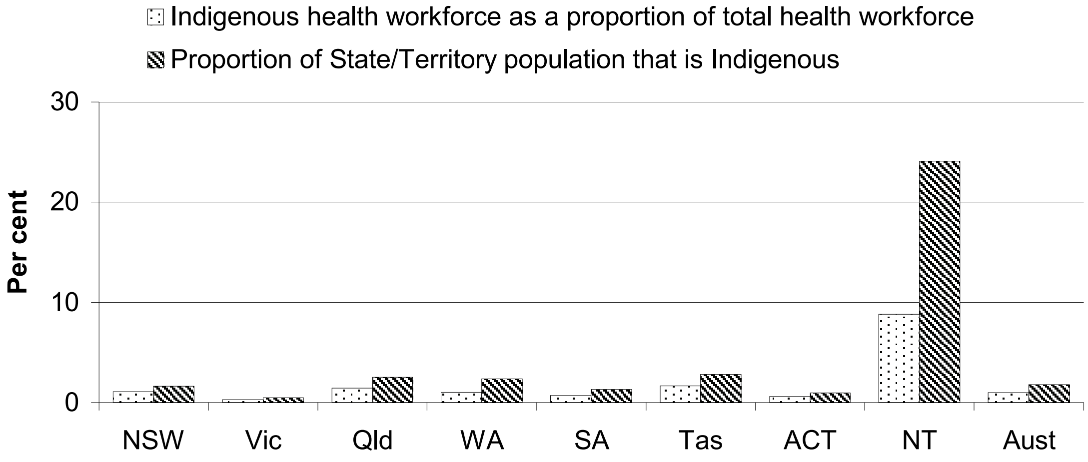
Source: AIHW (2008) *Expenditure on Health for Aboriginal and Torres Strait Islander Peoples 2004-05*, Cat. no. HWE 40, Health and Welfare Expenditure Series no. 32, Canberra.

Indigenous health workforce

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

In 2006, Indigenous people accounted for 1.0 per cent of the health workforce, but comprised 1.8 per cent of the total population (aged 15 years and over). Indigenous health workers are under-represented in each State and Territory (figure E.7). There have, however, been some improvements over time with increases in the number of Indigenous Australians in the health workforce as a proportion of the total health workforce (DoHA 2008a).

Figure E.7 **Indigenous health workforce as a proportion of total health workforce, by jurisdiction, 2006**[a, b, c]

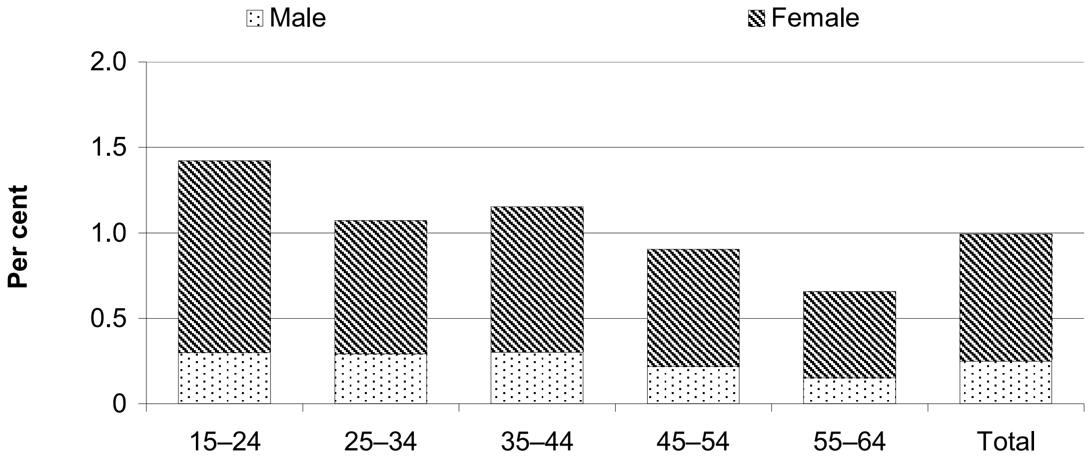


[a] Aged 15 years and over. [b] Cells in this table have been randomly adjusted to avoid the release of confidential data. [c] Australian total data include other territories.

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

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

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



[a] Total includes data for the 65 plus age group.

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

Indigenous health workforce by occupation

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

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

Table E.4 Indigenous persons employed in selected health-related occupations (per cent), 2006[a, b]

	Indigenous people	*All persons*	*Per cent of Indigenous people in selected health-related occupations*
Health and welfare services managers	141	10 807	1.3
Psychologists	39	13 437	0.3
Health diagnostic and promotion professionals	648	48 079	1.3
Health therapy professionals	321	64 597	0.5
Medical practitioners	100	55 075	0.2
Midwifery and nursing professionals	1 223	200 400	0.6
Health and welfare support workers	2 413	99 957	2.4
Aboriginal and Torres Strait Islander health worker	965	1 010	95.5
Total aged 15 years and over	**4 891**	**492 342**	**1.0**

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

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

Self-assessed health

Results from the 2007-08 National Health Survey indicate that the majority of Australians (85 per cent) aged 15 years or over reported their health as either good, very good or excellent (ABS 2009b). In the 2008 National Aboriginal and Torres Strait Islander Social Survey, 78 per cent of Indigenous people reported their health as either good, very good or excellent (ABS 2009d). There was a significant decline in Indigenous people reporting their health as fair or poor from 2001 (down from 26 per cent in 2001 to 22 per cent in 2008) (ABS 2009b).

Indigenous people were less likely than non-Indigenous people to report very good or excellent health and the difference between the two populations was greatest in the older age groups (DoHA 2008a). Taking into account differences in age structure between the Indigenous and non-Indigenous populations, Indigenous people overall were almost twice as likely to report their health as fair or poor, than non-Indigenous Australians in 2004-05 (ABS 2006). Indigenous females were more likely to report their health as fair or poor than Indigenous males (24 per cent compared with 19 per cent) (DoHA 2008a).

Data quality

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

- Indigenous people are not always accurately or consistently identified in administrative health data collections (such as hospital records and birth and death registrations) because of variation in definitions, different data collection methods and inaccurate or incomplete recording of Indigenous status. Data on hospital separations, mortality and disease notifications are therefore likely to be underestimated for the Indigenous population.
- Inconsistent data definitions and differences in the accuracy of identifying Indigenous people have led to problems making comparisons between jurisdictions, and over time.
- Problems in accurately estimating the Indigenous population; there is an undercount of the Indigenous population in the Census, particularly in remote areas, and there are data quality problems with the births and deaths statistics which are used to adjust the Census data to produce population estimates and projections.

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

The ABS has implemented a program of three yearly Indigenous household surveys with sample sizes designed to support the production of reliable State and Territory level data, so every three years, some health status and health risk factors are measured. Every six years, and in parallel with the National Health Survey, more detailed Indigenous health status information is collected, together with health service use, health actions, health-related aspects of lifestyle and other health risks. This also enables Indigenous to non-Indigenous comparisons for relevant variables. Other health-related surveys, which may include an Indigenous identifier, do not necessarily provide reliable data on Indigenous people, because of small sample size, limited geographic coverage or survey design.

Experimental estimates of the Indigenous population are re-based by the ABS every five years following availability of new Census data. Once new Indigenous population estimates and projections have been produced by the ABS, revisions may be required to various rates and rate ratios used in previous editions of the Report where those rates data are to be carried forward in new reports. The Indigenous population estimates and projections are re-based for this Report.

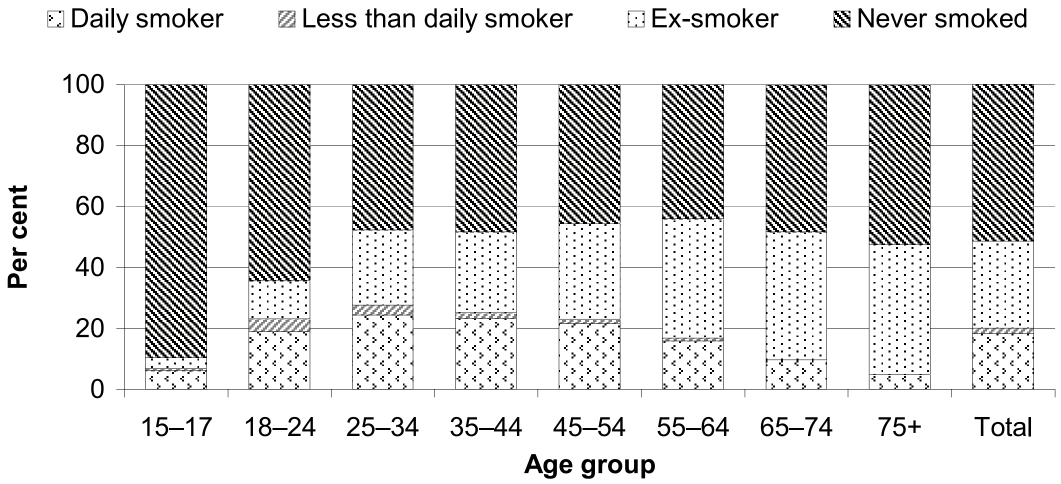
In July 2009, COAG endorsed a $46.4 million package of Indigenous data development over 4 years as part of *the Integrated Strategy for Closing the Gap in Indigenous Disadvantage*.

Health risk factors

There are a number of behaviours that are risks to health outcomes, for example, smoking, alcohol consumption, dietary habits and exercise, or other factors such as high body mass. The National Health Survey 2007-08 has collected data on these risk factors (ABS 2009b). Selected health outcomes such as life expectancy and mortality are presented in the next section. Health services are concerned with promoting, restoring and maintaining a healthy society. An important part of this activity is reducing health risk factors through activities that raise awareness of health issues to reduce the risk and onset of illness and injury.

Smoking is an important risk factor for heart disease, stroke and lung cancer. These were the three leading causes of death in Australia in 2007 (ABS 2009a). Smoking is responsible for around 80 per cent of all lung cancer deaths and 20 per cent of all cancer deaths (DoHA 2009). Daily smokers accounted for 18.3 per cent of the population in 2007-08. The highest percentages of daily smokers were in the 25–34 year age group (24.4 per cent) and the 35–44 year age group (23.2 per cent). The percentages of daily smokers is lower in older age groups (figure E.9). Males had higher rates of daily smoking than females for the total population (20.2 per cent and 16.4 per cent respectively) and across almost all age groups except those aged 55–64 years (table EA.13).

Figure E.9 **Smoker status, people, 2007-08**



Source: ABS (2009), *National Health Survey 2007-08: Summary of Results, Australia (Reissue)*, Cat. no. 4364.0, Canberra; table EA.13.

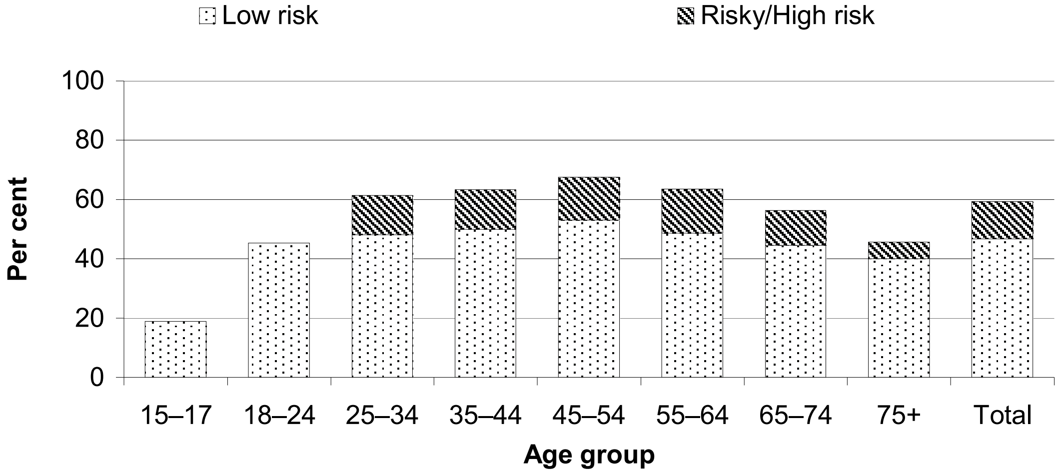
Excessive long term alcohol consumption increases the risk of heart disease, stroke, liver cirrhosis and some types of cancers. Furthermore, it can also contribute to injury and death through accidents, violence, suicide and homicide and can also contribute to financial problems, family breakdown and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

In the National Health Survey 2007-08 the ABS derived long term risk levels from the average daily alcohol consumption by people aged 15 years and over based on the most recent three drinking days in the week prior to interview (ABS 2009b). The ABS used the National Health and Medical Research Council (NHMRC) Australian alcohol guidelines of 2001 which defined risky alcohol consumption as more than 50 millilitres and up to 75 millilitres per day for males and more than 25 millilitres and up to 50 millilitres per day for females. High risk consumption was defined as more than 75 millilitres per day for males and 50 millilitres per day for females (NHMRC 2001). The NHMRC has since developed new guidelines. These include, for healthy men and women, drinking no more than two standard drinks on any day. This reduces the lifetime risk of harm from alcohol-related disease or injury (NHMRC 2009).

In 2007-08, 7.4 per cent of the population consumed alcohol at a risky level while 5.2 per cent of the population consumed alcohol at a high risk level. Risky alcohol consumption was highest for those aged 55–64 years at 9.3 per cent while high risk alcohol consumption was highest for those aged 45–54 years at 6.1 per cent (figure E.10).

Females tended to have higher risky alcohol consumption than males (7.8 per cent and 6.9 per cent respectively) in total and across all age groups for which data were reported except for the 25–34 year age group. Risky/high risk alcohol consumption for females was most prevalent in the age groups 18–24 and 45–54 years. Males had higher rates of risky/high risk alcohol consumption than females for all ages (14.4 per cent compared to 10.8 per cent). Risky/high risk alcohol consumption was most prevalent among younger males, accounting for 17.4 per cent of those aged 25–34 years (table EA.13).

Figure E.10 **Alcohol risk, people, 2007-08**[a]



[a] Risky alcohol consumption has been defined by the National Health and Medical Research Council in 2001 as more than 50 millilitres and up to 75 millilitres for males and more than 25 millilitres and up to 50 millilitres for females. High risk consumption has been defined as more than 75 millilitres for males and 50 millilitres for females (NHMRC 2001).

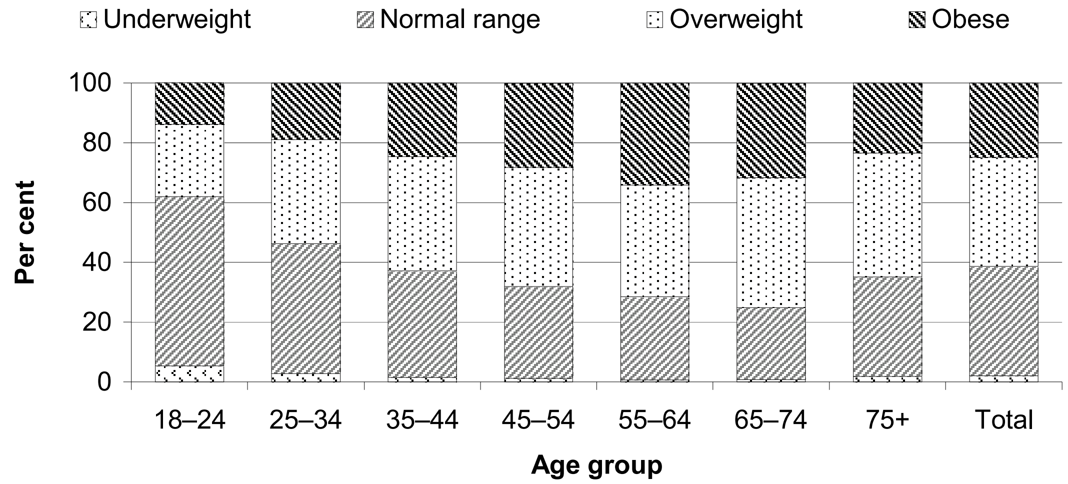
Source: ABS (2009), *National Health Survey 2007-08: Summary of Results, Australia (Reissue)*, Cat. no. 4364.0, Canberra; table EA.13.

Being overweight or obese increases the risk of an individual developing, among other things, heart disease, stroke and type 2 diabetes. The National Health Survey 2007-08 reported measured Body Mass Index (BMI). BMI is calculated as weight (kg) divided by the square of height (m). BMI values are grouped according to World Health Organization (WHO) and NHMRC guidelines. Among adults, a BMI of less than 18.5 is considered underweight, a BMI of 18.5 to less than 25 is considered normal weight, a BMI of 25 to less than 30 is considered overweight and a BMI of 30 and over is considered to be obese (WHO 2000; NHMRC 2003).

Over a third of Australians' measured BMI was in the overweight range and almost a quarter were obese in 2007-08. The percentage of people who were overweight or obese tended to be higher in older age groups, peaking at age 65–74 for those that are overweight (43.5 per cent) and 55–64 for those that are obese (34.2 per cent).

There was a higher percentage of overweight males (42.1 per cent) than females (30.9 per cent), however, the percentage of those who were obese was similar for both males (25.6 per cent) and females (24.0 per cent) (figure E.11 and table EA.13).

Figure E.11 **Body mass index (measured), persons, 2007-08**[a]



[a] BMI is calculated as weight (kg) divided by the square of height (m). BMI values are grouped according to WHO and NHMRC guidelines. Among adults, a person with a BMI less than 18.5 is considered underweight, with a BMI between 18.5 and 25 is considered normal weight, with a BMI between 25 and 30 is considered overweight and over 30 is considered to be obese (WHO 2000; NHMRC 2003).

Source: ABS (2009), *National Health Survey 2007-08: Summary of Results, Australia (Reissue)*, Cat. no. 4364.0, Canberra; table EA.13.

Diet and exercise are also important behaviours that can reduce health risks and improve health outcomes. The NHMRC Australian dietary guidelines recommend a minimum of two serves of fruit per day for adults and five serves of vegetables (NHMRC 2003). A serve of fruit is approximately 150 grams of fresh fruit or 50 grams of dried fruit while a serve of vegetables is approximately 75 grams. Around half of Australians surveyed in the National Health Survey were consuming the recommended two or more serves of fruit per day in 2007-08 and only 8.8 per cent were consuming the recommended five or more serves of vegetables per day (table EA.13). Over a third of all Australians surveyed in the National Health Survey were sedentary in the two weeks prior to interview in 2007-08 with a further 36.9 per cent undertaking a low level of exercise, 21.6 per cent undertook a moderate level of exercise and 6.2 per cent a high level of exercise (table EA.13).

Framework for measuring the performance of the health system

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

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

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

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

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

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

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

Medical intervention strategies are implemented after a diagnosis.

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

In the 2004 Report, the Steering Committee sought to align the general Review framework with the National Health Performance Framework as far as possible, for application to government health services. Complete alignment was not possible, given the different terms of reference of the two committees. The performance framework for health services in this Report thus reflects both the general Review framework and the National Health Performance Framework. It differs from the general Review framework (see chapter 1) in two respects. First, it includes four subdimensions of quality — safety, responsiveness, capability and continuity — and, second, it includes an extra dimension of effectiveness — sustainability (figure E.12). These additions are intended to address the following key performance dimensions of the health system in the National Health Performance Framework that were not explicitly covered in the general Review framework:

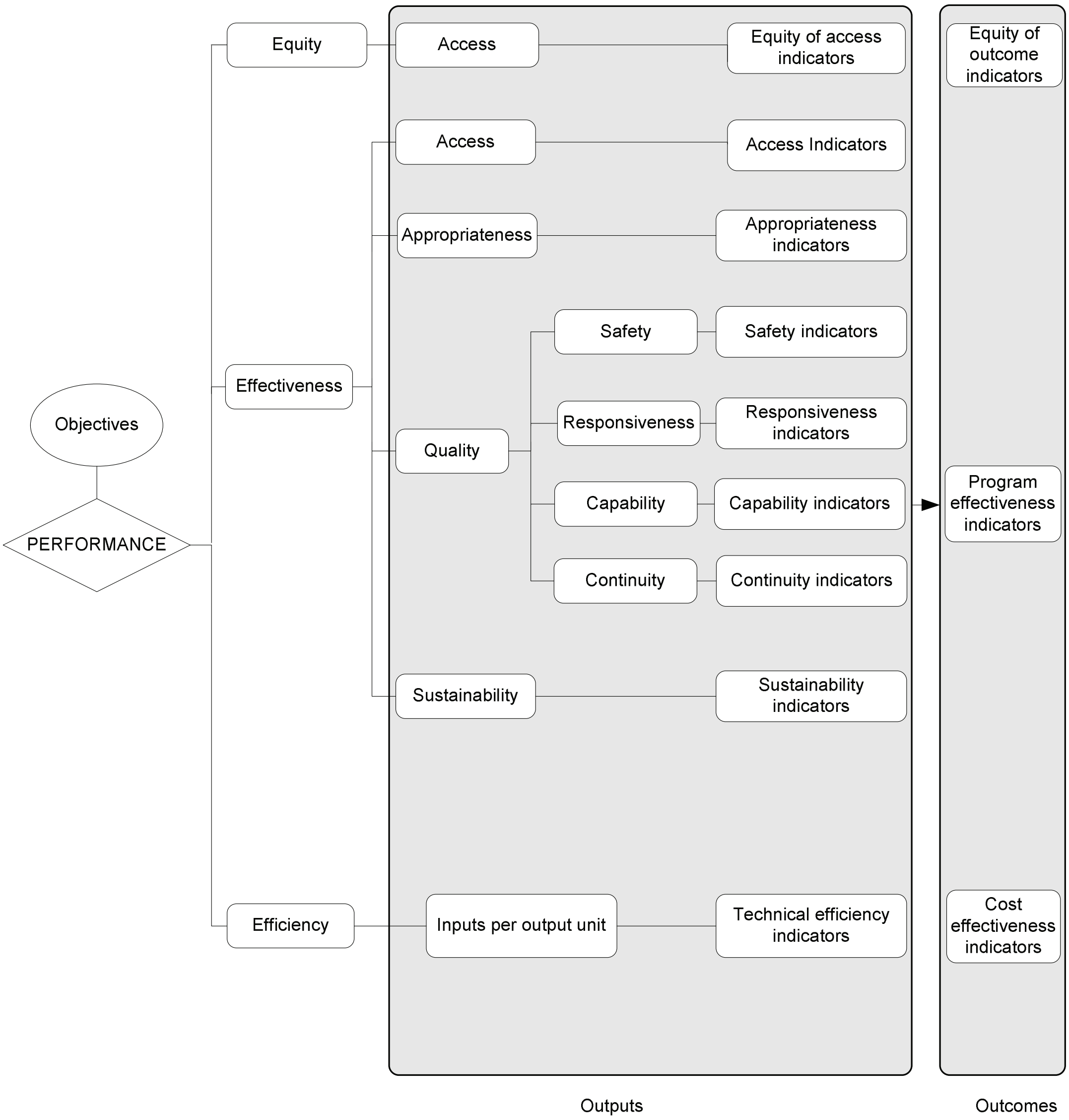
- *safety*: the avoidance, or reduction to acceptable levels, of actual or potential harm from health care services, management or environments, and the prevention or minimisation of adverse events associated with health care delivery
- *responsiveness*: the provision of services that are client oriented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

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

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

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure E.12 **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.

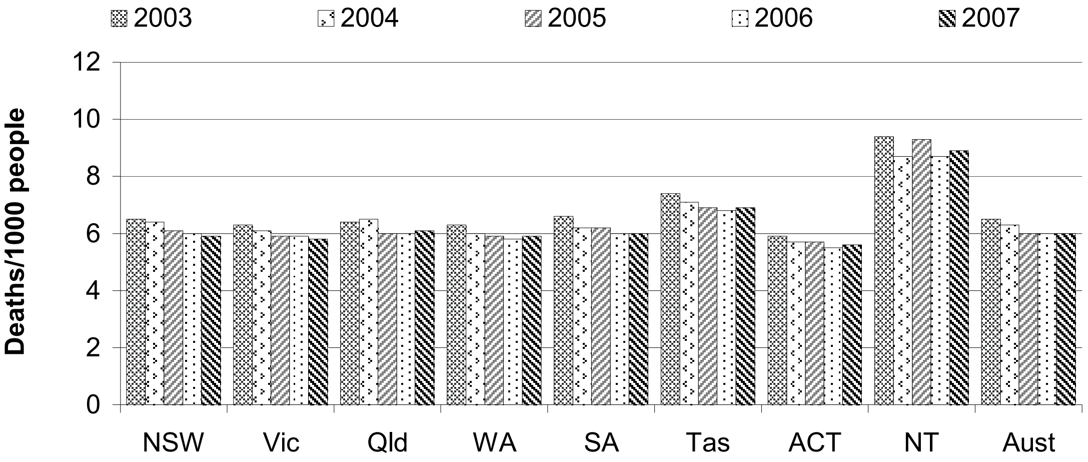
Data on health outcomes presented in this preface include mortality rates (for infants and all people), causes of death, life expectancy at birth, median age at death and birthweight. Where possible, data are presented for Indigenous people as well as the Australian population as a whole.

Mortality rates

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

There were 137 900 deaths in Australia in 2007 (ABS 2008a), which translated into an age standardised mortality rate of 6.0 per 1000 people (figure E.13). Death rates over the last 20 years have declined for all states and territories (ABS 2008a).

Figure E.13 **Mortality rates, age standardised**[a]



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

Source: ABS (2008) *Deaths Australia, 2007*, Cat. no. 3302.0, Canberra; table EA.14.

Indigenous mortality rates

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

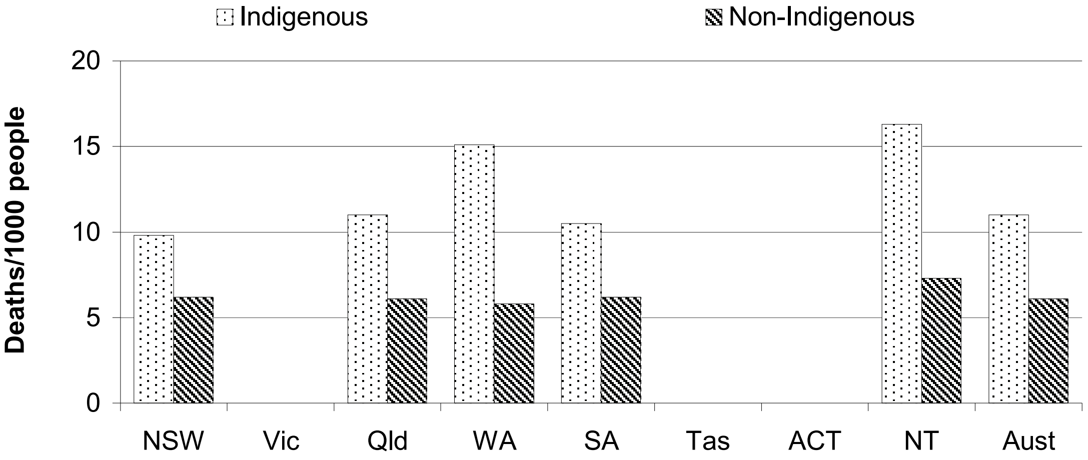
Due to the relatively small number of Indigenous deaths and the consequent volatility in annual mortality rates, the data are presented for the five year period 2003–2007. To improve the comparability of age-related mortality rates, indirect age standardisation methods have been used for both the Indigenous and total population rates.

NSW, Queensland, WA, SA and NT are currently generally considered to have the best coverage of death registrations for Indigenous people (ABS 2009c).[4] For these five jurisdictions combined, the overall rates of mortality for Indigenous people were nearly twice as high as mortality rates for non-Indigenous people based on data for 2003–2007 (figure E.14 and table EA.14). Given issues with identification, mortality rates presented here are likely to be under-estimates of the true mortality of Indigenous Australians (ABS and AIHW 2008).

---

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

Figure E.14 **Mortality rates, age standardised, by Indigenous status, five year average, 2003–2007**[a, b, c, d]



---

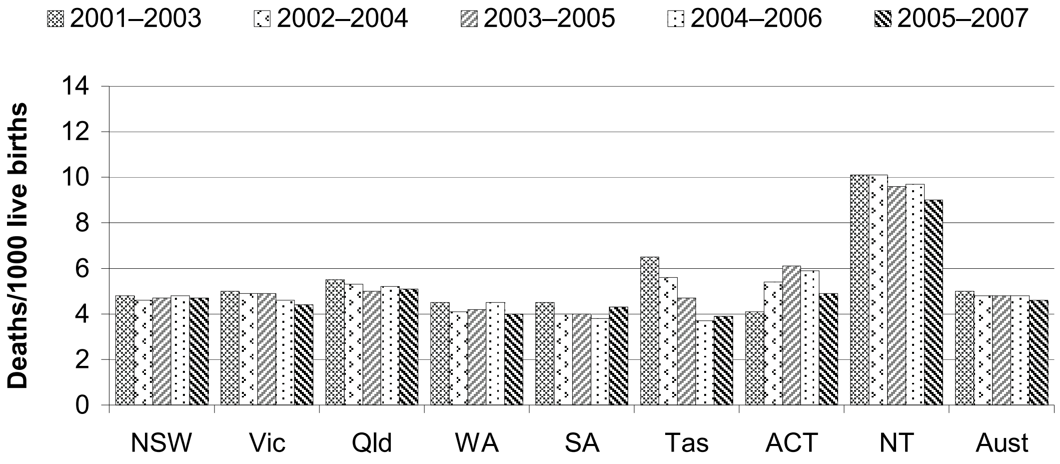
[a] Deaths are based on year of registration of death. [b] Deaths per 1000 standard population. Standardised death rates use total persons in the 2001 Australian population as the standard population.[c] The Australian totals for Indigenous and non-Indigenous data includes all states and territories.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

Source: ABS (unpublished) *Deaths Australia, 2007*; table EA.14.

Infant mortality rates

The infant mortality rate is defined as the number of deaths of children under 1 year of age in a calendar year per 1000 live births in the same year. Infant mortality rates are presented in this Report as an average over three years to reduce the volatility inherent in the annual rates due to small numbers and annual fluctuations. The infant mortality rate in Australia declined from 5.0 deaths per 1000 live births over the period 2001–2003 to an average of 4.6 deaths per 1000 live births over the period 2005–2007 (figure E.15).

Figure E.15 **Infant mortality rate, three year average**[a, b]



---

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

Source: ABS (2008) *Deaths Australia, 2007, Australia,* Cat. no. 3302.0, Canberra.; table EA.15.

Indigenous infant mortality rates

For the period 2005–2007, the average infant mortality rate for Indigenous children was 8.9 per cent for NSW, 9.1 per cent for Queensland, 10.2 per cent for WA, 8.9 per cent for SA and 15.7 per cent for the NT (tables EA.15 and EA.16). For WA, SA and the NT, longer-term trends suggest that the mortality rate for Indigenous infants decreased by 47 per cent between 1991 and 2006. Despite this significant improvement in infant mortality for Indigenous children, rates are still markedly higher than for non-Indigenous Australians (ABS 2008a).

Principal causes of death

The most common causes of death among Australians in 2007 were: diseases of the circulatory system (including heart disease, heart attack and stroke), cancers, and diseases of the respiratory system (including influenza, pneumonia and chronic lower respiratory diseases) (tables E.5 and EA.17). In 2007, malignant neoplasms (cancers) were the main underlying cause of death of 30 per cent of all registered deaths and ischaemic heart disease was the primary cause of a further 16 per cent of deaths (ABS 2009a).

Table E.5 Cause of death, age standardised death rates, 2007 (per 100 000 standard population)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Cancers[c]	174	175	165	175	175	198	170	225	174
Lung cancer[d]	34	34	33	35	33	45	28	53	34
Diabetes mellitus	14	18	15	19	18	23	19	51	17
Mental and behavioural disorders	25	24	19	21	25	28	31	40	24
Diseases of the nervous system	22	25	22	29	26	25	30	16	24
Diseases of the circulatory system	202	185	201	184	203	229	179	249	197
Heart disease[e]	98	93	95	95	101	111	81	109	96
Heart attack[f]	49	44	52	49	50	48	26	50	48
Stroke[g]	51	44	53	40	50	50	46	70	48
Diseases of arteries, arterioles and capillaries	10	9	9	10	10	14	10	10	10
Diseases of the respiratory system	49	47	58	45	45	59	38	67	50
Influenza and pneumonia	9	11	17	10	9	13	7	7	11
Chronic lower respiratory diseases	25	26	23	23	24	35	22	50	25
Diseases of the digestive system	20	20	21	23	20	22	18	39	21
Accidents	34	32	37	44	39	48	37	92	36
Transport accidents	4	5	6	13	9	10	6	21	6
Suicide[h]	8	8	7	12	13	14	9	29	9
All causes	**593**	**574**	**607**	**587**	**603**	**691**	**563**	**889**	**595**

[a] Standardised death rate per 100 000 of the June 2006 population. Rounded to whole numbers. [b] Data are preliminary and will be subject to revision process. See *Causes of Death, 2007, 3303.0 Explanatory Notes 4* for further information. [c] Malignant neoplasms. [d] Cancer of the trachea, bronchus and lung. [e] Ischaemic heart disease and heart attacks. [f] Acute myocardial infarction. [g] Cerebrovascular diseases. [h] Intentional self-harm. Care needs to be taken in interpreting figures relating to suicide due to data limitations. See *Causes of Death, 2007, 3303.0 Explanatory Notes 78-79 and Technical Note: ABS coding of suicide deaths* for further information.

Source: ABS (2009) *Causes of Death Australia, 2007*, Cat. no. 3303.0, Canberra; table EA.17.

Causes of death for Indigenous people

In the jurisdictions for which age standardised death rates are available by Indigenous status (NSW, Queensland, WA, SA and the NT) death rates were significantly higher for Indigenous Australians than for non-Indigenous Australians during the period 2003–2007. In particular, Indigenous people died: from diabetes at a rate of up to 7.1 times that for non-Indigenous people; from cirrhosis and other diseases of the liver at a rate of up to 6.4 times that for non-Indigenous people; and from diseases of the urinary system at a rate of 4.2 times that for non-Indigenous people. The standardised death rate per 100 000 people for all causes was 2.3 times higher for Indigenous people than for non-Indigenous people (tables E.6 and EA.18).

Table E.6 **Leading causes of death, indirect age-standardised death rate ratio of Indigenous to non-Indigenous population, 2003–2007 (per 100 000 standard population)**[a, b, c, d]

	NSW	*Qld*	*WA*	*SA*	*NT*	*Aust*[e]
Underlying causes of death						
Trachea and lung cancers	1.9	1.8	1.9	1.7	2.3	1.9
Diabetes	4.2	9.9	11.7	7.7	7.9	7.1
Ischeamic heart diseases	2.2	2.6	3.3	3.2	3.4	2.6
Strokes	1.8	1.8	3.1	1.7	3.1	2.0
Influenza and pneumonia	1.9	2.4	6.4	3.4	8.2	3.1
Chronic lower respiratory diseases	3.1	2.9	4.6	2.7	4.1	3.4
Cirrhosis and other diseases of liver	4.3	5.1	10.5	5.5	9.1	6.4
Diseases of the urinary system	2.5	4.1	5.7	3.9	9.7	4.2
Certain conditions originating in the perinatal period	1.3	2.0	2.9	2.5	3.0	1.9
Symptoms, signs and ill-defined conditions	3.3	1.8	6.4	4.1	2.0	3.5
Land transport accidents	1.4	1.8	4.0	2.0	2.7	2.7
Intentional self-harm (suicide)	1.3	2.4	2.2	4.4	2.7	2.2
All causes	**1.8**	**2.3**	**3.3**	**2.4**	**3.3**	**2.3**

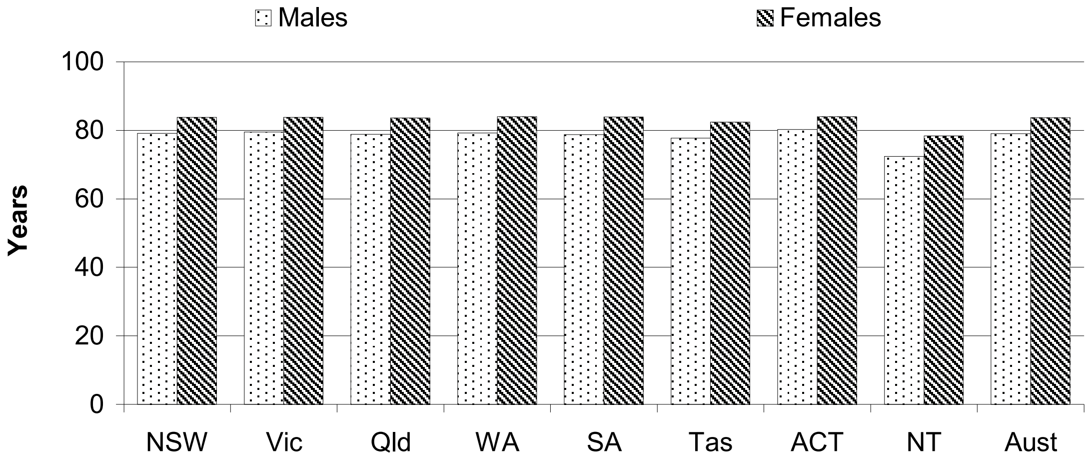
[a] Indirect standardised death rate per 100 000 population. [b] Denominators used in the calculation of rates for the Indigenous population are *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians* (ABS Cat. no. 3238.0, series B, 2006 base). There are no comparable population data for the non-Indigenous population. Denominators used in the calculation of rates for comparison with the Indigenous population have been derived by subtracting Indigenous population estimates/projections from total estimated resident population and should be used with care, as these data include population units for which Indigenous status was not stated. [c] Data on deaths of Aboriginal and Torres Strait Islander Australians are affected by differing levels of coverage of deaths identified as Indigenous across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between the Indigenous and non-Indigenous data. [d] Ratio is determined as the number of Indigenous deaths for each non-Indigenous death. To calculate rate ratio, divide the Indigenous death rate by the non-Indigenous death rate. [e] Includes Victoria, Tasmania, Australian Capital Territory and Other Territories. Rates for these jurisdictions are not available.

Source: ABS (unpublished) *Causes of Death Australia, 2007*; table EA.18.

Life expectancy

The life expectancy of Australians improved dramatically during the twentieth century and so far during the twenty-first century. The average life expectancy at birth in the period 1901–1910 was 55.2 years for males and 58.8 years for females (ABS 2008b). It has risen steadily in each decade since, reaching 79.0 years for males and 83.7 years for females in 2005–2007 (figure E.16).

Figure E.16 **Average life expectancy at birth, 2005–2007**[a, b]



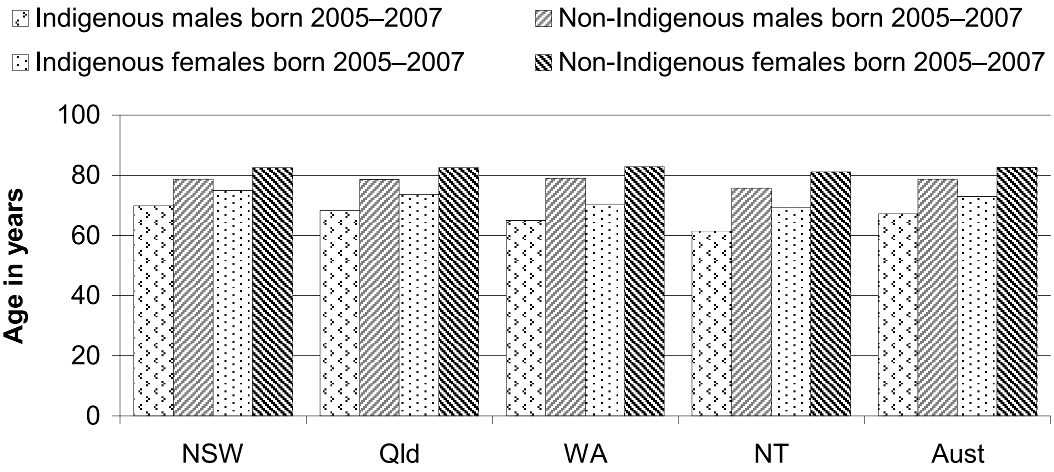
[a] Figures for Australia include 'other territories'. [b] Three year average.

Source: ABS (2008) *Deaths Australia, 2007, Australia,* Cat. no. 3302.0, Canberra; table EA.19.

Indigenous life expectancy

The life expectancies of Indigenous Australians are considerably lower than those of non-Indigenous Australians. ABS experimental estimates indicate a life expectancy at birth of 67.2 years for Indigenous males and 72.9 years for Indigenous females born from 2005 to 2007 (figure E.17 and table EA.20). In the same time period, life expectancy at birth for non-Indigenous males was 78.7 and for non-Indigenous females was 82.6 years (figure E.17 and table EA.20). The methodology used for estimating Indigenous life expectancy has changed since 2009 Report.

Figure E.17 **Indigenous and non-Indigenous life expectancy at birth (years)**[a, b, c, d]



---

[a] Due to significant changes in methodology, estimates of life expectancy at birth for 2005-2007 are not comparable to previously published estimates. [b] Data are not available for all jurisdictions. [c] Estimates of life expectancy at birth for the total population presented in the ABS Cat. no. 3106.0.55.003 differ from estimates in *Deaths, Australia, 2006* (Cat no. 3302.0). [d] Australia includes all states and territories.

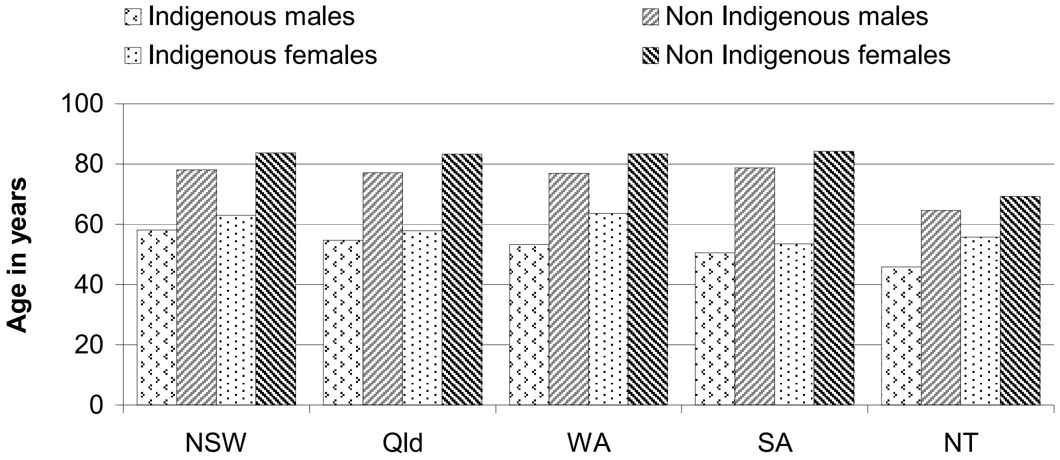
Source: ABS (2009), *Experimental Life Tables for Aboriginal and Torres Strait Islander Australians 2005–2007*, Australia, Cat. no. 3302.0.55.003, Canberra; table EA.20.

Median age at death

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

For all Australian males and females in 2007, the median age at death was 77.7 and 83.6 years of age, respectively (figure E.18 and table EA.21). In the jurisdictions for which data were available for Indigenous people the median age at death for male Indigenous Australians was between 45.9 and 58.1 years of age. The median age at death for female Indigenous Australians was between 55.7 and 63.0 years of age (figure E.18 and table EA.21).

Figure E.18 **Median age at death, by sex and Indigenous status, 2007**[a]



[a] Median age at death by Indigenous status is not available for Victoria, Tasmania and the ACT due to data quality issues. [b] The accuracy of Indigenous mortality data is variable as a result of varying rates of coverage across jurisdictions and age groups, and of changes in the estimated Indigenous population caused by changing rates of identification in the Census and births data.

Source: ABS (2008) *Deaths Australia, 2007*, Cat. no. 3302.0, Canberra; table EA.21.

Birthweight of babies

The birthweight of a baby is an important indicator of its health status and future wellbeing. In 2006, 91.8 per cent of liveborn babies in Australia weighed between 2500 and 4499 grams (Laws and Hilder 2008). The average birthweight for all live births was 3370 grams. In 2006, the average birthweight of liveborn babies of Indigenous mothers was 3169 grams (tables EA.22 and EA.23). This was 209 grams lighter than the average of 3378 grams for liveborn babies of non-Indigenous mothers (Laws and Hilder 2008).[5]

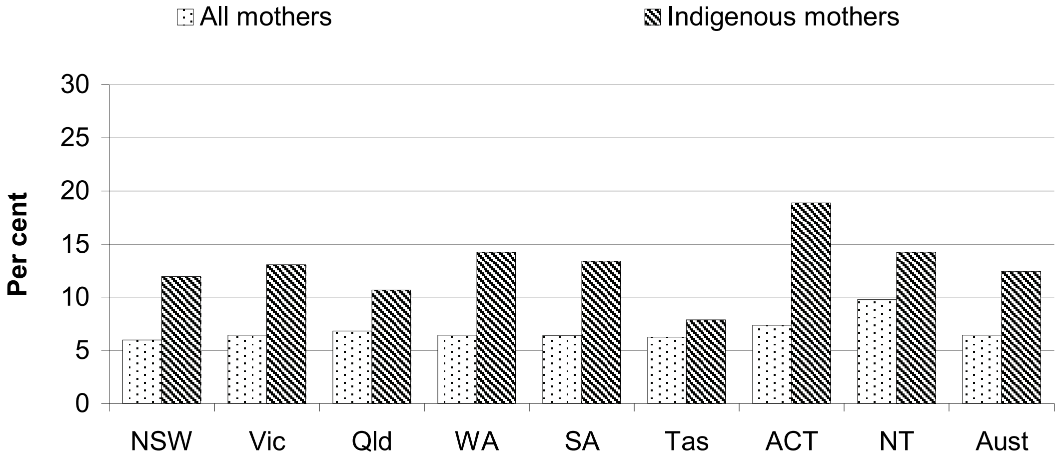
Babies are defined as low birthweight if they weigh less than 2500 grams, very low birthweight if they weigh less than 1500 grams and extremely low birthweight if they weigh less than 1000 grams (Laws and Hilder 2008). In 2006, 6.4 per cent of all liveborn babies in Australia weighed less than 2500 grams (figure E.19). This included 1.1 per cent of babies who weighed less than 1500 grams (table EA.22).

Among live babies born to Indigenous mothers in 2006, the proportions with low birthweight (12.4 per cent) and very low birthweight (2.3 per cent) were around twice the proportions born to all Australian mothers (figure E.19 and table EA.23).

---

[5] Figures for births to Indigenous mothers exclude Tasmania.

Figure E.19 **Low birthweight babies (under 2500 grams), by Indigenous status, 2006**[a, b]



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

Source: Laws, P. and Hilder, L. (2008) *Australia's Mothers and Babies 2006*, AIHW Cat. no. PER 46, National Perinatal Statistics Unit (Perinatal Statistics Series no. 22), AIHW, Sydney; tables EA.22 and EA.23.

Future directions

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

Improving reporting on Indigenous health is a priority across all of the health chapters. This work is informed by the new Aboriginal and Torres Strait Islander Health Performance Framework and by National Health Agreement reporting.

COAG developments

Report on Government Services alignment with National Agreement reporting

Future editions of the Health preface will align with applicable National Health Agreement indicators and the NIRA. Further alignment between the Report and National Agreement indicators, and other reporting changes, might result from future developments in National Agreement and National Partnership reporting.

Outcomes from review of Report on Government Services

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the Intergovernmental Agreement on Federal Financial Relations.

No significant changes from this review are reflected in the 2010 Report. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 Report.

Attachment tables

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

Table EA.1	Total health expenditure, by source of funds (2007-08 dollars)
Table EA.2	Government recurrent health expenditure, by area of expenditure (2007-08 dollars)
Table EA.3	Non-government recurrent health expenditure by area of expenditure (2007-08 dollars)
Table EA.4	Recurrent health expenditure, by source of funds and area of expenditure, 2007-08
Table EA.5	Total health expenditure per person (2007-08 dollars)
Table EA.6	Recurrent health expenditure per person by source of funds, excluding high level residential aged care (2007-08 dollars)
Table EA.7	Total health price index
Table EA.8	Employed medical practitioners
Table EA.9	Employed nurses
Table EA.10	Indigenous health workforce, by State/Territory, 2006
Table EA.11	Indigenous people in health workforce as a proportion of total health workforce, by age group and sex, 2006
Table EA.12	Indigenous persons employed in selected health-related occupations, 2006
Table EA.13	Health risk factors, percent, 2007-08
Table EA.14	Mortality rates, age standardised for all causes (per 1000 people)
Table EA.15	Infant mortality rate, three year average (per 1000 live births)
Table EA.16	Indigenous infant mortality rates, three year average
Table EA.17	All Australians causes of death, standardised death rates 2007 (per 100 000 standard population)
Table EA.18	Leading causes of death, indirect age standardised death rate ratio, 2003–2007 (per 100 000 standard population)
Table EA.19	All Australians average life expectancy at birth (years)
Table EA.20	Indigenous and non-Indigenous life expectancy at birth (years)
Table EA.21	Median age at death (years)
Table EA.22	Birthweights, live births, all mothers, 2006
Table EA.23	Birthweights of babies of Indigenous mothers, live births, by State and Territory 2006

References

ABS (Australian Bureau of Statistics) 2006, *National Aboriginal and Torres Strait Islander Health Survey 2004-05, Australia*, Cat. no. 4715.0, Canberra.

—— 2007, *Housing and Infrastructure in Aboriginal and Torres Islander Communities 2006, Australia, (Reissue)*, Cat. no. 4710.0, Canberra.

—— 2008a, *Deaths Australia 2007*, Cat. no. 3302.0, Canberra.

—— 2008b, *Australian Historical Population Statistics,* Cat. no. 3105.0.65.001, Canberra.

—— 2009a, *Causes of Death Australia, 2007*, Cat. no. 3303.0, Canberra.

—— 2009b, *National Health Survey: Summary of Results, Australia (Reissue*), Cat. no. 4364.0, Canberra.

—— 2009c, *Experimental Life Tables for Aboriginal and Torres Strait Islander Australians 2005–2007*, Australia, Cat. no. 3302.0.55.003, Canberra.

—— 2009d, *National Aboriginal and Torres Strait Islander Social Survey, 2008*, Australia, Cat. no. 4714.0, Canberra.

—— and AIHW (Australian Institute of Health and Welfare) 2008, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2008*, ABS Cat. no. 4704.0, Canberra.

AIHW 2008a, *Expenditure on Health for Aboriginal and Torres Strait Islander Peoples 2004-05*, Cat. no. HWE 40, Health and Welfare Expenditure Series no. 32, AIHW, Canberra.

—— 2008b, *Australia's Health 2008*, Cat. no. AUS 99, AIHW, Canberra.

—— 2009a, *Health Expenditure Australia 2007-08*, Cat. no. HWE 46, Health and Welfare Expenditure Series no. 37, Canberra.

—— 2009b, *Medical Labour Force 2007*, Cat. no. HWL 45, National Health Labour Force Series no. 44, Canberra.

—— 2009c, *Nursing and Midwifery Labour Force 2007*, Cat. no. HWL 44, National Health Labour Force Series no. 43, Canberra.

DoHA (Department of Health and Ageing) 2006, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2006*, Australian Health Ministers' Advisory Council (AHMAC), Canberra.

—— 2008a, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2008*, Australian Health Ministers' Advisory Council (AHMAC), Canberra.

—— 2008b, *Medicare Safety Nets by electorate (based on patient enrolment postcode), 2006*, http://www.health.gov.au/internet/main/publishing.nsf/content/electoratereport-index/$FILE/Medicare%20Safety%20Nets%202006.rtf

—— 2009, http://www.healthinsite.gov.au/topics/Health_Effects_of_Smoking, Australian Government, Canberra (accessed 30 September 2009).

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

NHMRC (National Health and Medical Research Council) 2001, *Australian Alcohol Guidelines Health Risks and Benefits*, Canberra

—— 2003, *Dietary Guidelines for Australian Adults*, Canberra.

—— 2009*, Australian Guidelines to Reduce Health Risks from Drinking Alcohol,* Canberra.

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

SCRGSP (Steering Committee for the Review of Government Service Provision) 2009, *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commission, Canberra.

WHO (World Health Organization) 2000, *Obesity: Preventing and Managing the Global Epidemic*, WHO Technical Report Series No. 894, Geneva.

10 Public hospitals

CONTENTS

Attachment tables

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

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

Reporting on public hospitals has been enhanced this year as a result of improvements to the definition of one of the sentinel event categories, which in turn has led to better data comparability across jurisdictions for this measure.

10.1 Profile of public hospitals

Definition

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

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

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

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

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

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

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

Patients

admitted patient: a patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients can 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 childbirth, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.

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

Hospital outputs

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

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

(Continued on next page)

Box 10.1 **(Continued)**

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

Other common health terms

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

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

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

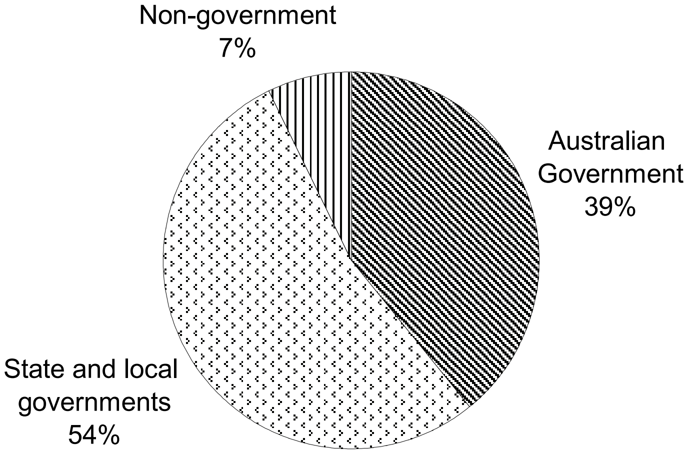
Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was $28.9 billion in 2007-08 (table 10A.1). In real terms, expenditure increased by 6.1 per cent between 2006-07 and 2007-08 (AIHW 2009a).

The majority of total public hospital recurrent expenditure is spent on admitted patients. Non-admitted patients account for a much smaller share. For selected public hospitals, in 2007-08, the proportion of total public hospital recurrent expenditure that related to the care of admitted patients (based on the admitted patient cost proportion) ranged from 69.0 per cent to 77.0 per cent across jurisdictions (AIHW 2009a).

Funding for public hospitals comes from a number of sources. The Australian, State and Territory governments, health insurance funds, individuals, and workers compensation and compulsory motor vehicle third party insurance contribute to expenditure on public hospitals. Governments contributed about 92.8 per cent of funding for public hospitals in 2007-08 (figure 10.1). Public hospitals accounted for 41.7 per cent of government recurrent expenditure on health services in 2007-08 (AIHW 2009b).

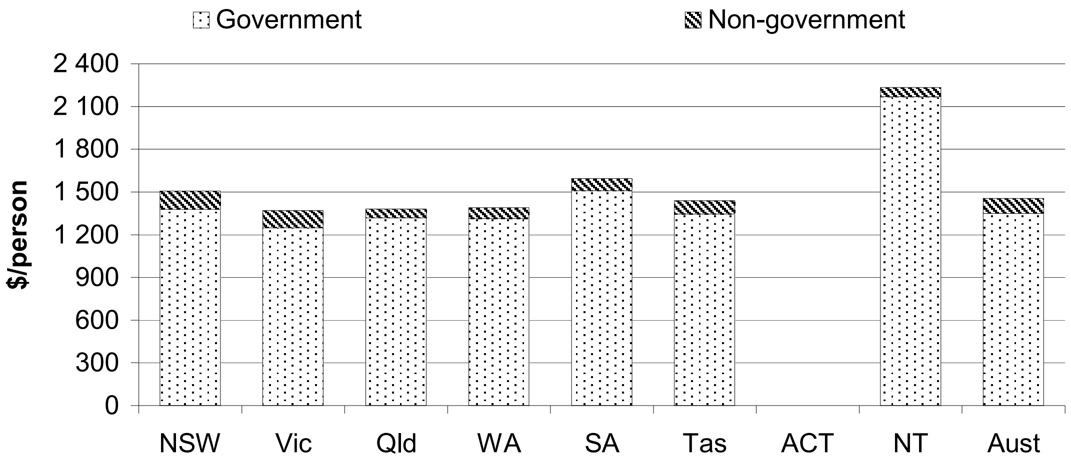
Figure 10.1 **Recurrent expenditure, public hospitals, by source of funds, 2007-08**



Source: AIHW (2009), *Health expenditure Australia 2007–08*, Health and Welfare Expenditure Series No. 37, Cat. no. HWE 46.

In 2007-08, public hospitals received $2.2 billion from non-government sources — an amount that accounted for 7.2 per cent of all recurrent expenditure (figure 10.2 and table 10A.2). Non-government expenditure in each jurisdiction comprised revenue from health insurance funds, individuals and workers' compensation and compulsory third-party motor vehicle insurers as well as other sources. The proportion of hospital revenue per person funded from non-government sources varied across jurisdictions in 2007-08 (figure 10.2).

Figure 10.2 **Source of public hospital recurrent expenditure, 2007-08**[a, b, c]



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

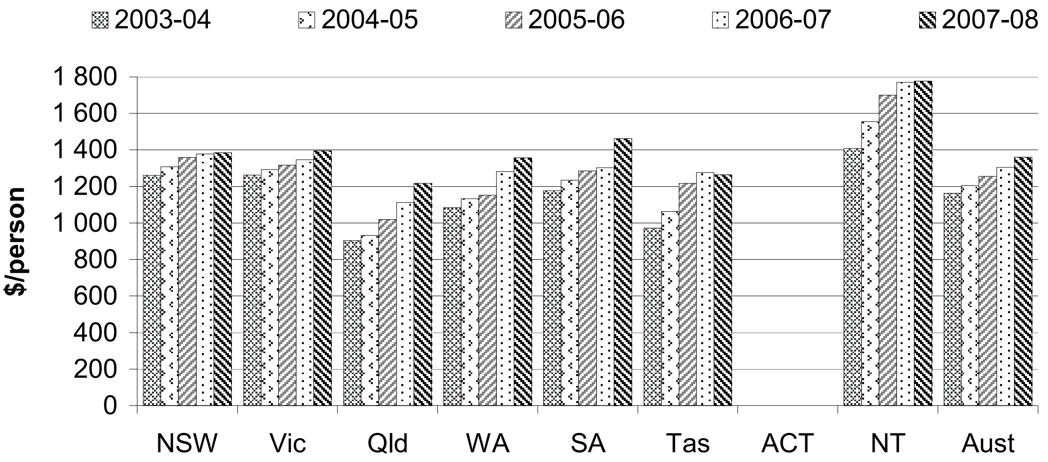
Source: AIHW (2009), *Health expenditure Australia 2007–08*, Health and Welfare Expenditure Series No. 37, Cat. no. HWE 46; ABS (unpublished), Australian Demographic Statistics, December Quarter 2007, Cat. no. 3101.0; table 10A.2.

Expenditure data in figures 10.1 and 10.2 are from *Health Expenditure Australia 2007-08* (AIHW 2009b) and are not directly comparable with other expenditure data used in this chapter, which are drawn from *Australian Hospital Statistics 2007-08* (AIHW 2009a). The data in Health Expenditure Australia have a broader scope than the data in Australian Hospital Statistics and include some additional expenditures (such as those relating to blood transfusion services) (AIHW unpublished).

In 2007-08, government real recurrent expenditure on public hospitals was $1360 per person for Australia, up from $1163 in 2003-04 (in 2007-08 dollars) (figure 10.3). It is difficult to make comparisons between jurisdictions based on these recurrent expenditure data due to differences in the coverage of the data. Some of the differences are:

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

Figure 10.3 **Real recurrent expenditure per person, public hospitals (including psychiatric) (2007-08 dollars)**[a, b, c, d, e, f, g, h]



---

[a] Expenditure data exclude depreciation and interest payments. [b] Recurrent expenditure on purchase of public hospital services at the State, or area health service level, from privately owned and/or operated hospitals is excluded. [c] Expenditure data are deflated using the hospital/nursing home care price index from AIHW (2009b). [d] From 2003-04, NSW hospital expenditure recorded against special purposes and trust funds is excluded. [e] Queensland pathology services were purchased from a statewide pathology service rather than being provided by hospital employees. [f] Data for WA from 2006-07 include expenditure for public patients at Joondalup and Peel Health Campuses. Expenditures for these patients are not included in previous years. [g] For 2003-04, data for five small Tasmanian hospitals are not included. For 2004-05 and 2005-06, data for one hospital are not included. [h] ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditures for NSW residents. Thus the ACT population is not the appropriate denominator.

Source: AIHW (various years), *Australian hospital statistics*, Health Services Series, Cat. nos HSE 37, 41, 50, 55 and 71; AIHW (various years), *Health expenditure Australia*, Health and Welfare Expenditure Series, Cat. no. HWE 46; ABS (unpublished), Australian Demographic Statistics, December Quarter 2007, Cat. no. 3101.0; table 10A.3.

Size and scope of sector

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

Hospitals

In 2007-08, Australia had 762 public hospitals (table 10A.4) (including 20 psychiatric hospitals) (AIHW 2009a). Although 71.7 per cent of hospitals had 50 or fewer beds, these smaller hospitals represented only 16.9 per cent of total available beds (figure 10.4 and table 10A.4).

Figure 10.4 **Public hospitals, by size, 2007-08**[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 (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; table 10A.4.

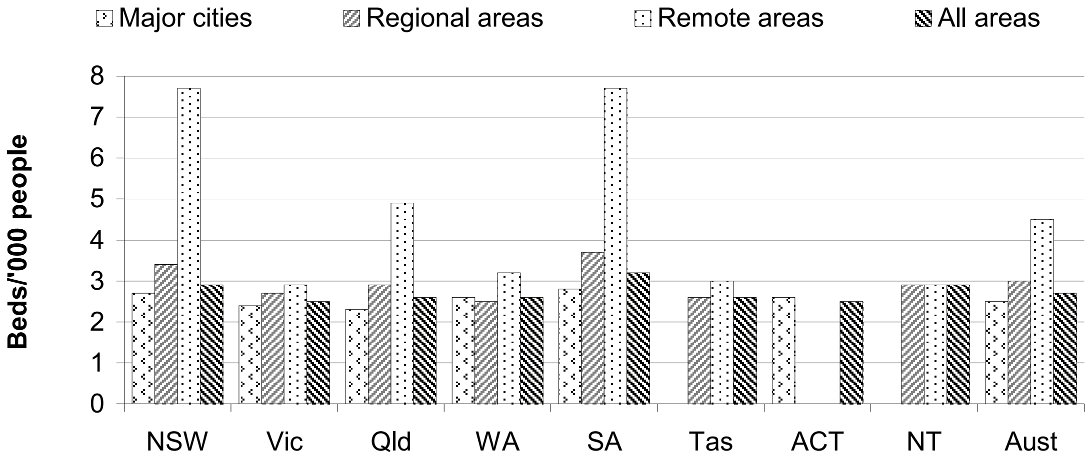
Beds

There were 56 467 available beds in public hospitals in 2007-08 (table 10A.4). The concept of an available bed is becoming less important in the overall context of hospital activity, particularly in respect of increasing same day hospitalisations and the provision of hospital-in-the-home care (AIHW 2009a).

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

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

Figure 10.5 **Available beds, public hospitals, by location, 2007-08**[a, b, c, d]



---

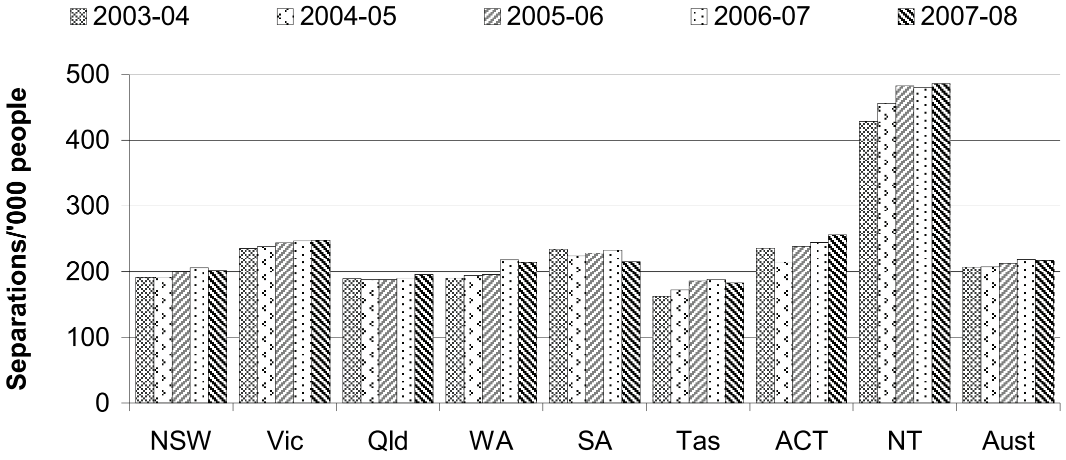
[a] An 'available bed' is one that is immediately available to be used by an admitted patient. A bed is immediately available for use if it is located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period. Both occupied and unoccupied beds are included. Surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded, and beds designated for same day non-admitted patient care are excluded. Beds in wards that were closed for any reason (except weekend closures for beds/wards staffed and available on weekends only) are also excluded (HDSC 2008). [b] Analysis by remoteness area is of less relevance to geographically smaller jurisdictions and those jurisdictions with small populations residing in remote areas (such as Victoria) (AIHW 2009a). [c] Tasmania and the NT do not have major cities and the ACT does not have remote areas. [d] There were no available beds in regional areas in the ACT.

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; table 10A.5.

Total separation rates

There were approximately 4.7 million separations from public (non-psychiatric) hospitals in 2007-08 (table 10A.6). Nationally, this translates into 216.9 separations per 1000 people (figure 10.6).

Figure 10.6 **Separation rates in public (non-psychiatric) hospitals**[a, b, c]



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

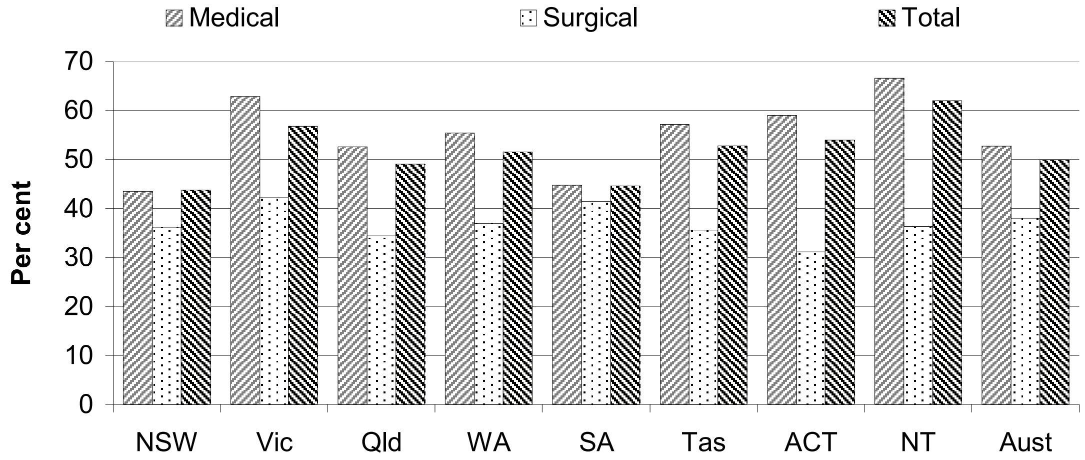
Source: AIHW (various years), *Australian Hospital Statistics,* Health Services Series, Cat. nos HSE 37, 41, 50, 55 and 71; table 10A.7.

Same day separations in public (non-psychiatric) hospitals increased by 1.3 per cent between 2006-07 and 2007-08, although same day separations as a proportion of total separations remained relatively constant over this period. Overnight separations in public (non-psychiatric) hospitals increased by 2.2 per cent between 2006-07 and 2007-08 (table 10A.7).

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

Variations in admission rates can reflect different practices in classifying patients as either admitted same day patients or outpatients. The extent of differences in classification practices can be inferred from the variation in the proportion of same day separations across jurisdictions for certain conditions or treatments. This is particularly true of medical separations. Significant variation across jurisdictions in the proportion of same day medical separations was evident in 2007-08 (figure 10.7). Lower jurisdictional variation is likely in admission practices for surgical procedures, as reflected by the lower variability in the proportion of same day surgical separations.

Figure 10.7 **Proportion of medical, surgical and total separations that were same day, public (non-psychiatric) hospitals, 2007-08**[a]



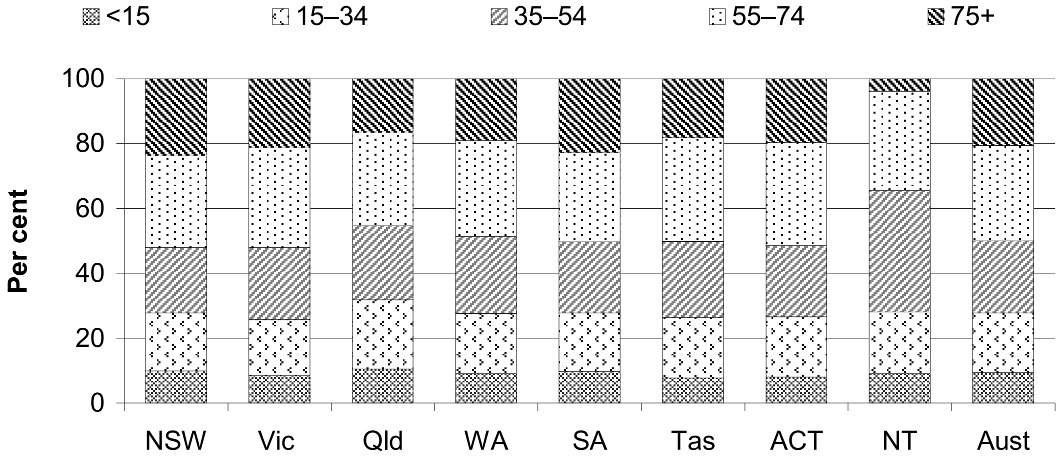
[a] 'Total' includes medical, surgical, chemotherapy, radiotherapy and 'other' separations based on AR-DRG version 5.1 categories.

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

Separations by age group

Persons aged 55 years and over accounted for half of the separations in public hospitals (50.0 per cent) in 2007-08, even though they accounted for only 24.3 per cent of the estimated resident population at 31 December 2007 (figure 10.8 and AIHW 2009a). The proportion of hospital separations for this and other age groups varies across states and territories (figure 10.8). This variation largely reflects differences in the age profiles of jurisdictions (table AA.1).

Figure 10.8 **Separations by age group, public hospitals, 2007-08**[a]



---

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

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; table 10A.9.

Separation rates for Indigenous patients

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

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

In 2007-08, separations for Indigenous people accounted for around 3.6 per cent of total separations and 5.5 per cent of separations in public hospitals in NSW, Victoria, Queensland, WA, SA and the NT combined (table 10.1). Indigenous people made up only around 2.2 per cent of the population in these jurisdictions (tables AA.2 and AA.7). Most separations involving Indigenous patients (92.9 per cent) in these jurisdictions occurred in public hospitals (table 10.1).

Table 10.1 Separations, by Indigenous status of patient and hospital sector, 2007-08[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]
Public hospital separations ('000)									
Indigenous	53.1	12.4	64.9	42.7	17.3	2.6	1.9	61.6	252.0
Non-Indigenous	1 399.2	1 327.1	749.6	415.5	339.2	91.2	77.7	28.7	4 259.3
Not reported	14.4	11.8	17.5	–	11.8	2.4	1.6	–	55.4
Total	1 466.7	1 351.2	832.0	458.2	368.3	96.3	81.1	90.3	4 566.7
Private hospital separations ('000)									
Indigenous	1.1	0.6	4.4	12.1	1.1	np	np	np	19.3
Non-Indigenous	843.1	791.5	701.8	313.3	228.2	np	np	np	2 877.9
Not reported	13.8	10.1	74.1	–	14.3	np	np	np	112.3
Total	857.9	802.3	780.3	325.4	243.6	np	np	np	3 009.5
Indigenous separations as proportion of total separations (%)									
Public hospitals	3.6	0.9	7.8	9.3	4.7	2.7	2.3	68.2	5.5
Private hospitals	0.1	0.1	0.6	3.7	0.5	np	np	np	0.6
All hospitals	2.3	0.6	4.3	7.0	3.0	np	np	np	3.6
Separations in public hospitals as a proportion of separations in all hospitals (%)									
Indigenous	98.1	95.2	93.6	77.9	94.0	np	np	np	92.9
Non-Indigenous	62.4	62.6	51.6	57.0	59.8	np	np	np	59.7

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

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; table 10A.10.

In 2007-08, on an age standardised basis, 807.7 public hospital separations (including same day separations) for Indigenous patients were reported per 1000 Indigenous people in NSW, Victoria, Queensland, WA, SA and the NT combined (table 10.2). This rate was markedly higher than the corresponding rate of 217.6 per 1000 for these jurisdictions' combined total population (table 10.2). Incomplete identification of Indigenous people limits the validity of comparisons over time, as well as across jurisdictions.

Table 10.2 Estimates of public hospital separations per 1000 people, by Indigenous status of patient[a, b]

	NSW[c]	*Vic*	*Qld*[c]	*WA*[c,d]	*SA*[c]	*Tas*	*ACT*	*NT*[c]	*Total*[e]
2003-04									
Indigenous	np	np	710.9	789.3	853.9	np	np	1286.2	np
Total population	np	np	189.3	191.0	235.9	np	np	428.9	np
2004-05									
Indigenous	np	np	733.6	821.5	822.2	np	np	1 441.0	907.0
Total population	np	np	188.1	195.2	225.3	np	np	456.2	205.2
2005-06									
Indigenous	495.6	np	745.4	845.2	875.0	np	np	1 548.0	792.1
Total population	204.7	np	188.5	198.8	229.7	np	np	491.4	205.7
2006-07									
Indigenous	528.0	624.3	756.7	876.5	929.3	np	np	1 584.8	787.5
Total population	205.9	246.6	218.7	218.1	232.6	np	np	480.6	218.7
2007-08									
Indigenous	550.5	629.8	785.7	869.4	908.9	np	np	1 670.6	807.7
Total population	202.8	247.8	195.7	215.1	216.4	np	np	486.4	217.6

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

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

Separations with a procedure recorded for Indigenous patients

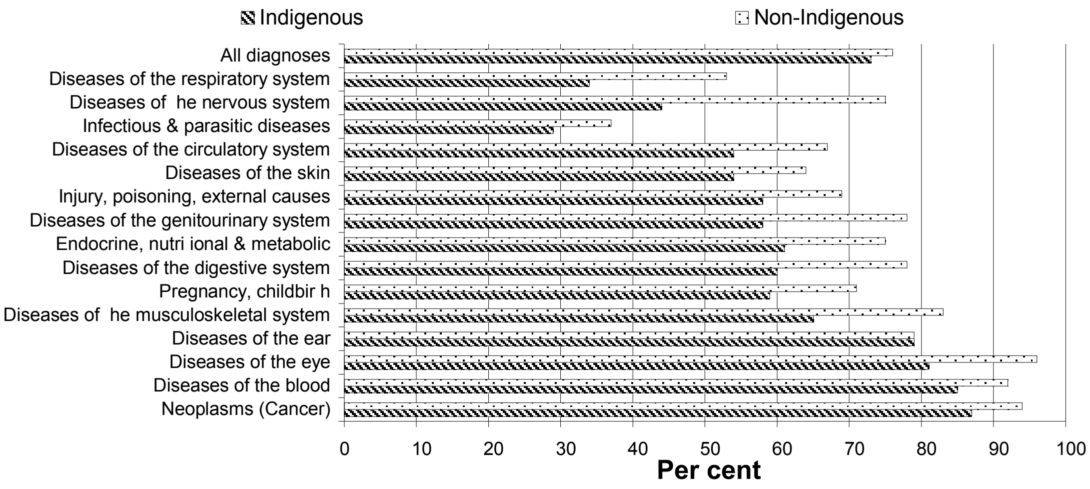
While Indigenous Australians are more likely to be hospitalised than non-Indigenous Australians, they are less likely to undergo procedures while in hospital. The underlying reasons for this are not well understood and are likely to reflect a range of factors, including, for example, clinical judgements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

Data for NSW, Victoria, Queensland, WA, SA and NT public hospitals for separations with a procedure recorded by principal diagnosis are presented in figure 10.9. Separations with a procedure recorded both by jurisdiction and by remoteness are presented in figures 10.10 and 10.11, and include data for all patients treated in public hospitals and public patients treated in private hospitals. Private hospital data are not published for the NT, but the extent to which public patients are treated in private hospitals in that jurisdiction is limited.

In the period July 2006–June 2008, excluding care involving dialysis, consistently lower proportions of separations with a procedure were recorded for Indigenous patients compared with non-Indigenous patients in almost all categories of principal diagnosis (figure 10.9). The differences can be observed across all jurisdictions for which data are available (figure 10.10). While remoteness is associated with progressively reduced rates of separation with a procedure recorded for all patients, differences were more pronounced for Indigenous patients (figure 10.11).

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

Figure 10.9 **Separations with a procedure recorded by principal diagnosis, by Indigenous status of patient, July 2006–June 2008[a, b]**

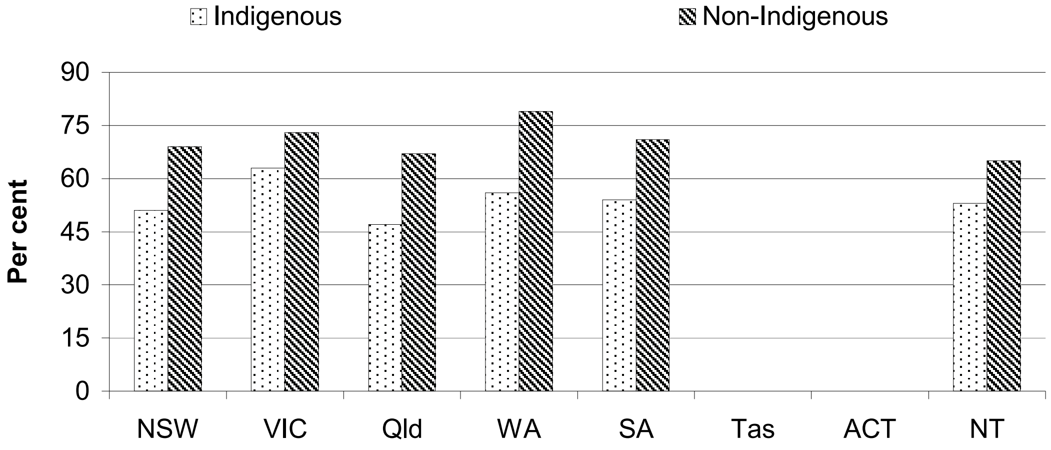


---

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

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

Figure 10.10 Separations with a procedure recorded, by Indigenous status of patient, July 2006–June 2008[a, b, c]

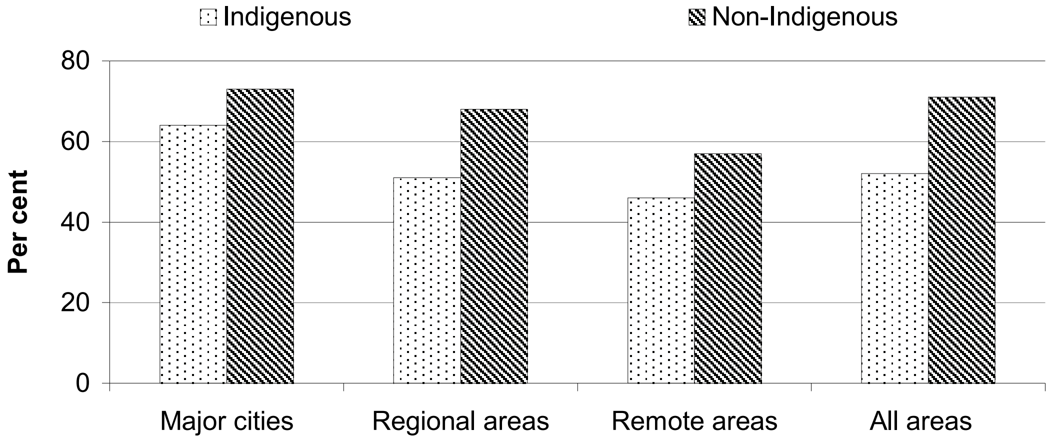


---

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

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

Figure 10.11 Separations with a procedure recorded, by Indigenous status of patient and remoteness, July 2006–June 2008[a, b]



---

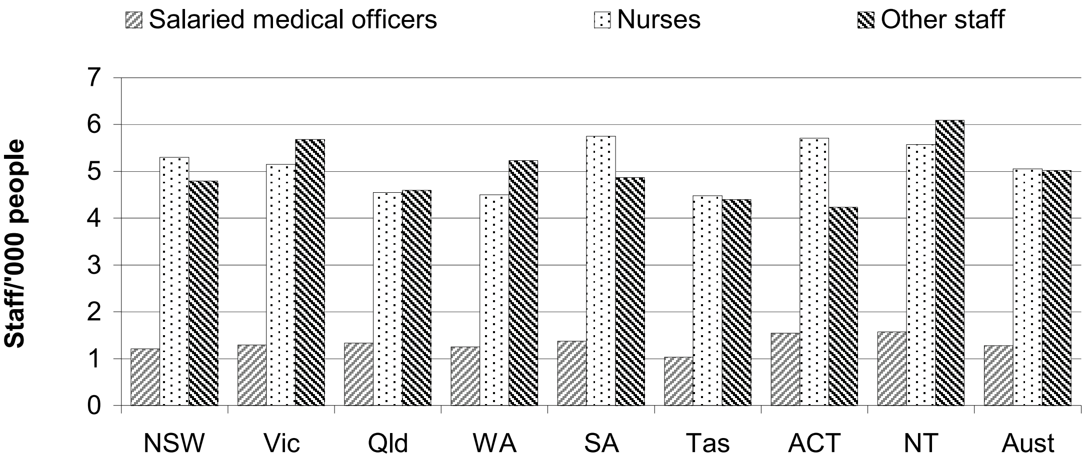
[a] Includes all patients treated in public hospitals and public patients treated in private hospitals in NSW, Victoria, Queensland, WA, SA and NT. Private hospital data for NT were not available therefore results for NT include public hospital data only. [b] 'All diagnoses' excludes care involving dialysis.

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

Staff

In 2007-08, nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (5.1 per 1000 people in Australia) (figure 10.12). Comparing data on FTE staff across jurisdictions needs to be undertaken with care because these data are affected by differences across jurisdictions in the recording and classifying of staff. The outsourcing of services with a large labour related component (for example, food services and domestic services) can have a large impact on hospital staffing figures and can explain some of the differences in FTE staff in some staffing categories and across jurisdictions (AIHW 2009a).

Figure 10.12 **Average FTE staff per 1000 people, public hospitals, 2007-08**[a, b, c, d, e]



[a] ‘Other staff’ include diagnostic and allied health professionals, other personal care staff, administrative and clerical staff, and domestic and other staff. [b] Staff per 1000 people are calculated from ABS population data at 31 December 2006 (table AA.2). [c] For Victoria, FTEs can be slightly understated. [d] Queensland pathology services staff employed by the State pathology service are not included. [e] Data for two small Tasmanian hospitals are not included.

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; ABS (unpublished), Australian Demographic Statistics, December Quarter 2007, Cat. no. 3101.0; tables 10A.15 and AA.2.

Activity — admitted patient care

There were around 4.7 million acute, sub-acute and non-acute separations in public hospitals in 2007-08. Of these, acute separations accounted for 96.1 per cent, newborns with some qualified days accounted for 1.0 per cent and rehabilitation care accounted for 1.8 per cent (table 10A.16). Palliative care, non-acute care and other care made up the remainder. Public psychiatric hospitals accounted for around 0.3 per cent of total separations in public hospitals in 2007-08. Of the total number of separations in public (non-psychiatric) hospitals, 49.9 per cent were for same day patients (table 10A.6).

Table 10.3 shows the 10 AR-DRGs with the highest number of overnight acute separations in public hospitals for 2007-08. These 10 AR-DRGs accounted for 17.5 per cent of all overnight acute separations.

Table 10.3 Ten AR-DRGs (version 5.1) with the most overnight acute separations, public hospitals, 2007-08[a, b]

	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 catastrophic or severe CC	4.4	4.9	4.6	4.6	3.4	4.1	5.3	3.9	4.5
Chest pain	2.4	2.1	2.7	1.8	2.7	1.6	1.1	1.9	2.3
Oesophagitis, gastroent & misc digestive systm disorders age>9 W/O Cat/Sev CC	1.9	1.7	1.9	1.7	2.1	1.8	1.3	1.1	1.9
Caesarean delivery W/O catastrophic or severe CC	1.8	1.8	2.1	1.8	1.5	1.8	1.8	1.5	1.8
Cellulitis (Age >59 W/O catastrophic or severe CC) or age <60	1.4	1.3	1.9	1.9	1.2	1.2	1.3	4.8	1.5
Antenatal & other obstetric admission	1.4	1.1	1.8	1.9	1.2	1.6	1.5	2.4	1.5
Vaginal delivery single uncomplicated W/O other condition	1.2	0.6	1.7	1.0	0.8	1.2	1.2	1.3	1.1
Chronic obstructive airways disease W catastrophic or severe CC	1.0	1.0	0.9	0.8	1.1	1.0	0.5	1.1	1.0
Abdominal pain or mesenteric adenitis W/O CC	1.0	1.0	1.0	0.9	1.0	0.9	0.7	0.7	1.0
Chronic obstructive airway disease W/O catastrophic or severe CC	1.0	0.7	1.0	1.0	1.0	1.3	0.4	1.4	0.9
Total overnight separations accounted for by top 10 AR-DRGs (%)	**17.6**	**16.4**	**19.6**	**17.3**	**16.0**	**16.5**	**15.0**	**20.2**	**17.5**
Total overnight acute separations ('000)[c]	**792**	**552**	**405**	**210**	**197**	**44**	**33**	**33**	**2265**

Cat = catastrophic. CC = complications and comorbidities. Sev = severe. W/O = without. W = with. [a] Includes separations for which the care type was reported as 'acute' or 'newborn with qualified days', or was not reported. [b] Excludes same day separations and separations where patients stayed over 365 days. [c] Total is for all overnight separations (not just the 10 listed in the table).

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

Table 10.4 lists the 10 AR-DRGs that accounted for the most patient days (18.1 per cent of all patient days recorded) in 2007-08. Schizophrenic disorders associated with mental health legal status accounted for the largest number of patient days, followed by vaginal delivery without complicating diagnosis (table 10.4 and table 10A.18).

Table 10.4 **Ten AR-DRGs (version 5.1) with the most patient days, public hospitals, 2007-08[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Patient days for AR-DRGs as a proportion of patient days (%)									
Schizophrenia disorders W mental health legal status	3.1	3.8	4.6	4.2	3.3	2.0	2.7	1.8	3.6
Vaginal delivery W/O catastrophic or severe CC	2.3	2.5	2.3	2.6	1.8	2.0	2.6	2.5	2.3
Tracheostomy any age, any condition	2.3	2.4	2.3	2.2	2.3	2.4	2.5	2.0	2.3
Major affective disorders Age<70 W/O catastrophic or severe CC	2.0	1.7	1.9	2.5	2.5	2.0	2.6	1.0	2.0
Schizophrenia disorders W/O mental health legal status	1.9	1.1	0.9	1.6	1.6	3.4	1.0	1.1	1.5
Chronic obstructive airways disease W catastrophic or severe CC	1.6	1.4	1.4	1.1	1.6	1.5	0.6	1.5	1.5
Caesarean delivery W/O catastrophic or severe CC	1.4	1.5	1.6	1.5	1.2	1.2	1.3	1.5	1.4
Cellulitis (age >59 W/O catastrophic or severe CC) or Age <60	1.1	1.2	1.4	1.5	1.1	0.8	1.0	3.2	1.2
Respiratory infections/inflammations W catastrophic CC	1.2	1.4	0.9	0.9	1.2	0.8	1.3	1.1	1.2
Respiratory infections/inflammations W severe or moderate CC	1.2	1.0	0.9	1.1	0.9	0.9	1.1	2.1	1.1
Ten AR-DRGs with the most patient days (%)	**18.0**	**18.1**	**18.3**	**19.2**	**17.6**	**17.0**	**16.9**	**17.8**	**18.1**
Total patient days ('000)[c]	**4 464**	**2 867**	**2 003**	**1 097**	**1 078**	**262**	**172**	**186**	**12 129**

Cat = catastrophic. CC = complications and comorbidities. Sev = severe. W/O = without. W = with. [a] Includes separations for which the care type was reported as 'acute' or 'newborn with qualified days', or was not reported. [b] Excludes same day separations and separations where patients stayed over 365 days. [c] Total is for all overnight separations (not just the ten listed in table).

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

Activity — non-admitted patient services

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

A total of 48.4 million individual occasions of service were provided to non-admitted patients in public acute hospitals in 2007-08 (table 10.5). In addition, public hospitals also delivered 428 851 group sessions during this time (a group session is defined as a service provided to two or more patients, excluding services provided to two or more family members) (table 10A.19). In public acute hospitals in 2007-08, accident and emergency services comprised 14.7 per cent of all individual occasions of service to non-admitted patients. ‘Other medical, surgical and obstetric services’ (23.9 per cent), ‘pathology services’ (16.7 per cent) and ‘pharmacy’ (9.8 per cent) were the most common types of non-admitted patient care (table 10.5).

Table 10.5 **Non-admitted patient occasions of service, by type of non-admitted patient care, public acute hospitals, 2007-08[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT[b]*	*Aust*
Occasions of service for the most common types of non-admitted patient care as a proportion of all occasions of service for non-admitted patients (%)									
Accident and emergency	11.4	20.3	13.8	16.3	24.7	14.2	18.0	28.3	14.7
Pathology	13.2	10.3	34.3	10.6	..	22.0	6.6	20.8	16.7
Radiology and organ imaging	4.2	8.7	9.0	8.9	10.5	8.7	13.8	15.3	7.0
Pharmacy[c]	15.7	6.5	5.7	3.9	..	9.2	0.2	7.9	9.8
Other medical/surgical/ obstetric	23.8	21.0	23.0	15.0	45.1	36.9	49.2	25.5	23.9
Mental health	3.5	9.2	0.9	1.1	1.2	..	0.3	..	3.3
Dental	2.5	3.0	2.5	0.2	0.4	..	..	..	2.1
Allied health	3.7	14.1	5.5	20.4	8.3	8.8	4.7	2.3	7.7
Other non-admitted services									
Community health	7.0	3.5	1.8	16.6	0.3	..	3.0	..	5.7
District nursing[d]	7.0	2.9	1.1	3.8	0.3	..	..	..	4.2
Most common types of non-admitted patient care (%)	**91.9**	**99.6**	**97.8**	**96.8**	**90.8**	**99.8**	**95.9**	**100.0**	**95.1**
Total occasions of service for non-admitted patients ('000)	**21 232**	**7 502**	**10 664**	**4 763**	**2 204**	**1 002**	**546**	**442**	**48 355**

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

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; table 10A.19.

10.2 Framework of performance indicators for public hospitals

The performance indicator framework is based on the shared government objectives for public hospitals (box 10.2). The performance indicator framework shows which data are comparable in the 2010 Report (figure 10.13). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective. The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions of quality and sustainability that have been added to the standard Review framework.

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

The measurement details of relevant National Agreement reporting were under development at the time of preparing this Report. It is anticipated that the performance indicator results reported in this chapter will be revised to align with the performance indicators in the National Agreements for the 2011 Report.

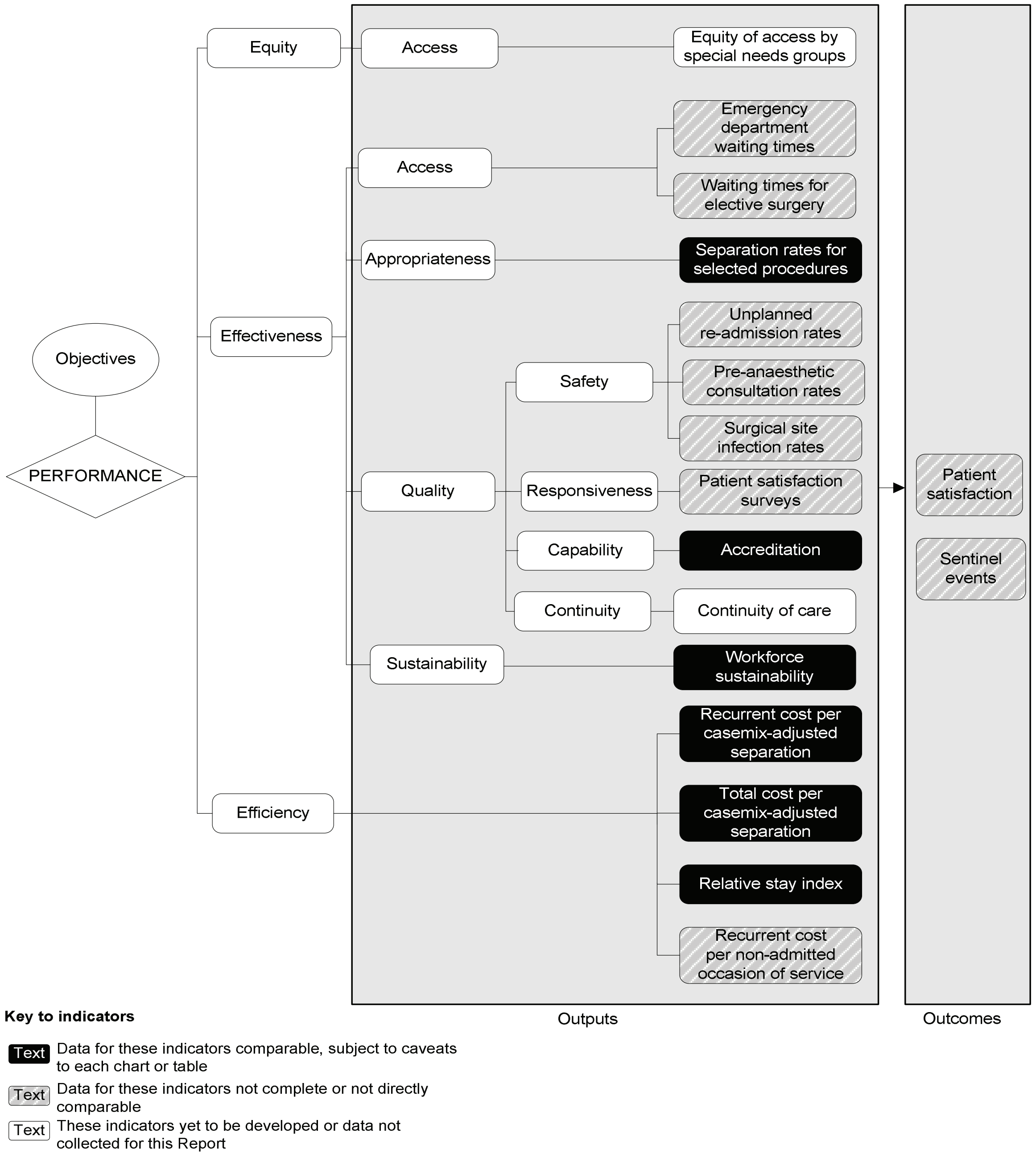
The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Box 10.2 **Objectives for public hospitals**

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

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

Figure 10.13 **Performance indicators for public hospitals**



10.3 Key performance indicator results for public hospitals

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

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

Outputs

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

Equity — access

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

Equity of access by special needs groups

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

Box 10.3 **Equity of access by special needs groups**

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

'Equity of access by special needs groups' has been identified as a key area for development in future Reports.

Effectiveness — access

Emergency department waiting times

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

Box 10.4 **Emergency department waiting times**

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

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

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

- triage category 1: need for resuscitation — patients seen immediately
- triage category 2: emergency — patients seen within 10 minutes
- triage category 3: urgent — patients seen within 30 minutes
- triage category 4: semi-urgent — patients seen within 60 minutes
- triage category 5: non-urgent — patients seen within 120 minutes (HDSC 2008).

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 can experience poor health outcomes as a result of extended waits.

Data reported for this indicator are not directly comparable.

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

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

Nationally, in 2007-08, 100 per cent of patients were seen within the triage category 1 timeframe and 76 per cent of patients were seen within the triage category 2 timeframe. For all triage categories combined, 69 per cent of patients were seen within triage category timeframes (table 10.6).

Table 10.6 Emergency department patients seen within triage category timeframes, public hospitals, 2007-08 (per cent)

Triage category	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1 — Resuscitation[a]	100	100	98	99	100	99	100	100	100
2 — Emergency	81	79	69	69	72	74	81	59	76
3 — Urgent	69	71	56	56	54	54	52	47	63
4 — Semi-urgent	75	65	61	59	60	58	51	47	66
5 — Non-urgent	90	86	87	86	80	86	78	86	87
Total	**76**	**71**	**63**	**61**	**61**	**60**	**58**	**52**	**69**
Data coverage[b]	81	89	64	72	67	88	100	100	78

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

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; table 10A.20.

Waiting times for elective surgery

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

Box 10.5 **Waiting times for elective surgery**

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

- 'Overall elective surgery waiting times' are calculated by comparing the date on which patients are added to a waiting list with the date on which they are admitted. Days on which the patient was not ready for care are excluded. 'Overall waiting times' are presented as the number of days within which 50 per cent of patients are admitted and the number of days within which 90 per cent of patients are admitted. The proportion of patients who waited more than one year is also shown.
- 'Elective surgery waiting times by clinical urgency category' reports the proportion of patients who were admitted from waiting lists after an extended wait. The three generally accepted clinical urgency categories for elective surgery are:
  - category 1 — admission is desirable within 30 days
  - 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.

For 'Overall elective surgery waiting times' fewer days waited at the 50th and 90th percentile and a smaller proportion of people waiting more than 365 days are desirable. For 'Elective surgery waiting times by clinical urgency category' a smaller proportion of patients who have experienced extended waits at admission is desirable. However, variation in the way patients are classified to urgency categories should be taken into account. Rather than comparing jurisdictions, the results for individual jurisdictions should be viewed in the context of the proportions of patients assigned to each of the three urgency categories (table 10.8).

Data reported for this indicator are not directly comparable.

The elective surgery waiting times data are provided for waiting lists managed by public acute hospitals. The data collection covers most public hospitals that undertake elective surgery. In 2007-08, the elective surgery waiting times data covered 91 per cent of separations for elective surgery in public acute hospitals (table 10.7).

Patients on waiting lists who were not subsequently admitted to hospital are excluded from both measures. Patients can be removed from waiting lists because they are admitted as emergency patients for the relevant procedure, no longer need the surgery, die, are treated at another location, decline to have the surgery, or cannot be contacted by the hospital (AIHW 2009a). In 2007-08, 14.5 per cent of patients were removed from waiting lists for reasons other than elective admission (AIHW 2009a).

Comparisons between jurisdictions should be made with caution due to differences in clinical practices and classification of patients across Australia. The two measures are affected by variations across jurisdictions in the method used to calculate waiting times for patients who transferred from a waiting list managed by one hospital to a waiting list managed by a different hospital. For patients who were transferred from a waiting list managed by one hospital to that managed by another, the time waited on the first list is included in the waiting time reported for some but not all states and territories (AIHW 2009a). NSW, Victoria, Queensland, WA, SA and the ACT reported the total time waited on all waiting lists. This approach can have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions. Queensland has indicated that patients rarely switch between waiting lists managed by different hospitals in their jurisdiction (AIHW 2009a).

Nationally, in 2007-08, 90 per cent of patients were admitted within 235 days and 50 per cent were admitted within 34 days (table 10.7). The proportion of patients who waited more than a year was 3.0 per cent. Nationally, waiting times at the 50th percentile increased by six days between 2003-04 and 2007-08, from 28 to 34 days. However, there were different trends in different jurisdictions and for different sized hospitals over that period (figure 10.14 and table 10A.21).

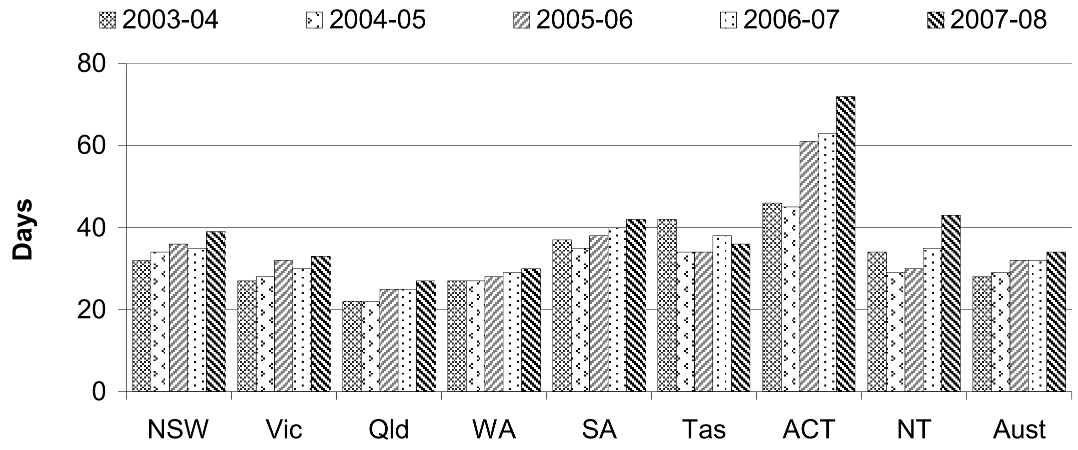
Table 10.7 **Elective surgery waiting times, public hospitals, 2007-08**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of days waited at:										
50th percentile	no.	39	33	27	30	42	36	72	43	34
90th percentile	no.	278	221	137	206	208	369	372	337	235
Proportion who waited more than 365 days	%	1.8	3.6	2.3	3.0	3.9	10.1	10.3	8.6	3.0
Estimated coverage of elective surgery separations[a]	%	100.0	80.0	98.0	79.0	70.0	100.0	100.0	100.0	91.0

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

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; table 10A.21.

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



Source: AIHW (various years), *Australian Hospital Statistics,* Health Services Series, Cat nos. HSE 37, 41, 50, 55 and 71; table 10A.21.

‘Elective surgery waiting times by urgency category’ data not only provide an indication of the extent to which patients are seen within a clinically desirable time, but also draw attention to the variation in the way in which patients are classified across jurisdictions. Jurisdictional differences in the classification of patients by urgency category in 2007-08 are shown in table 10.8. The states and territories with lower proportions of patients in category 1 also had relatively smaller proportions of patients in this category who were ‘not seen on time’. NSW, Victoria and the ACT, for example, had the lowest proportions of patients in category 1 and also had the lowest proportions of patients in category 1 who had extended waits (tables 10.8, 10A.24, 10A.26 and 10A.35).

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

Table 10.8 **Classification of elective surgery patients, by clinical urgency category, 2007-08 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Patients on waiting lists								
Category 1	3.7	2.8	9.2	6.2	8.6	6.9	3.1	9.4
Category 2	22.1	47.4	42.1	34.2	23.8	48.4	53.7	43.2
Category 3	74.2	49.7	48.7	59.6	67.5	44.7	43.2	47.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	30.1	26.1	38.6	31.8	35.8	44.5	28.7	42.7
Category 2	35.0	46.4	43.5	33.7	29.9	35.8	49.7	39.9
Category 3	34.9	27.5	17.9	34.5	34.3	19.7	21.6	17.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: State and Territory governments (unpublished).

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

Of patients admitted from waiting lists in NSW in 2007-08, the percentage of patients classified to each category and the percentage with an extended wait were:

- 30.1 per cent were classified to category 1, of whom 7.9 per cent had an extended wait
- 35.0 per cent were classified to category 2, of whom 24.3 per cent had an extended wait
- 34.9 per cent were classified to category 3, of whom 4.6 per cent had an extended wait.

Overall in NSW, 12.5 per cent of all patients experienced extended waits (table 10.8 and table 10A.24).

Of patients admitted from waiting lists in Victoria in 2007-08, the percentage of patients classified to each category and the percentage with an extended wait were:

- 26.1 per cent were classified to category 1, of whom zero per cent had an extended wait
- 46.4 per cent were classified to category 2, of whom 29.9 per cent had an extended wait

- 27.5 per cent were classified to category 3, of whom 9.7 per cent had an extended wait.

Overall in Victoria, 16.5 per cent of all patients experienced extended waits (table 10.8 and table 10A.26).

Of patients admitted from waiting lists in Queensland in 2007-08, the percentage of patients classified to each category and the percentage with an extended wait were:

- 38.6 per cent were classified to category 1, of whom 14.7 per cent had an extended wait
- 43.5 per cent were classified to category 2, of whom 16.9 per cent had an extended wait
- 17.9 per cent were classified to category 3, of whom 11.2 per cent had an extended wait.

Overall in Queensland, 15.0 per cent of all patients experienced extended waits (table 10.8 and table 10A.28).

Of patients admitted from waiting lists in WA in 2007-08, the percentage of patients classified to each category and the percentage with an extended wait were:

- 31.8 per cent were classified to category 1, of whom 12.3 per cent had an extended wait
- 33.7 per cent were classified to category 2, of whom 30.2 per cent had an extended wait
- 34.5 per cent were classified to category 3, of whom 5.4 per cent had an extended wait.

Overall in WA, 16.0 per cent of all patients experienced extended waits (table 10.8 and table 10A.30).

Of patients admitted from waiting lists in SA in 2007-08, the percentage of patients classified to each category and the percentage with an extended wait were:

- 35.8 per cent were classified to category 1, of whom 21.5 per cent had an extended wait
- 29.9 per cent were classified to category 2, of whom 27.1 per cent had an extended wait
- 34.3 per cent were classified to category 3, of whom 11.4 per cent had an extended wait.

Overall in SA, 19.2 per cent of all patients experienced extended waits (table 10.8 and table 10A.32).

Of patients admitted from waiting lists in Tasmania in 2007-08, the percentage of patients classified to each category and the percentage with an extended wait were:

- 44.5 per cent were classified to category 1, of whom 23.4 per cent had an extended wait
- 35.8 per cent were classified to category 2, of whom 51.2 per cent had an extended wait
- 19.7 per cent were classified to category 3, of whom 28.8 per cent had an extended wait.

Overall in Tasmania, 34.4 per cent of all patients experienced extended waits (table 10.8 and table 10A.34).

Of patients admitted from waiting lists in the ACT in 2007-08, the percentage of patients classified to each category and the percentage with an extended wait were:

- 28.7 per cent were classified to category 1, of whom 4.1 per cent had an extended wait
- 49.7 per cent were classified to category 2, of whom 53.4 per cent had an extended wait
- 21.6 per cent were classified to category 3, of whom 29.0 per cent had an extended wait.

Overall in the ACT, 34.0 per cent of all patients experienced extended waits (table 10.8 and table 10A.35).

Of patients admitted from waiting lists in NT in 2007-08, the percentage of patients classified to each category and the percentage with an extended wait were:

- 42.7 per cent were classified to category 1, of whom 19.6 per cent had an extended wait
- 39.9 per cent were classified to category 2, of whom 37.9 per cent had an extended wait
- 17.4 per cent were classified to category 3, of whom 29.1 per cent had an extended wait.

Overall in the NT, 28.6 per cent of all patients experienced extended waits (table 10.8 and table 10A.37).

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

Effectiveness — appropriateness

Separation rates for selected procedures

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

Box 10.6 **Separation rates for selected procedures**

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

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

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

Data reported for this indicator are comparable.

The ‘separation rates for selected procedures’ reported here include all hospitals and reflect the activities of both public and private health systems. The most common procedures of those reported in 2007-08 were lens insertions, caesarean sections and cholecystectomies (table 10.9).

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

Table 10.9 **Separations for selected procedures or diagnoses per 1000 people, all hospitals, by patient's usual residence, 2007-08**[a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[d]
Procedure/diagnosis									
Coronary artery bypass	0.6	0.6	0.7	0.4	0.7	0.5	0.4	0.6	0.6
Coronary angioplasty	1.6	1.6	1.3	1.4	1.4	1.4	1.6	0.9	1.5
Caesarean section:									
separation rate	4.2	4.1	4.9	4.8	4.3	4.4	3.6	3.2	4.4
separations per 100 in-hospital births[e]	31.7	30.6	33.2	33.4	31.6	28.6	28.2	27.3	31.8
Cholecystectomy	2.1	2.2	2.3	2.1	2.2	2.2	1.8	1.4	2.2
Hip replacement	1.3	1.4	1.2	1.5	1.4	1.6	1.5	0.8	1.4
Revision of hip replacement	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.2
Hysterectomy[f]	1.2	1.2	1.3	1.2	1.5	1.4	1.2	0.6	1.3
Lens insertion	8.3	7.9	9.6	8.9	7.3	7.6	5.7	6.5	8.4
Tonsillectomy	2.1	1.9	2.0	2.2	2.8	1.3	2.2	0.7	2.1
Myringotomy	1.4	1.6	1.4	1.9	2.7	1.3	1.7	0.4	1.6
Knee replacement	1.7	1.3	1.6	1.7	1.7	1.5	1.8	0.7	1.6
Prostatectomy	1.3	1.5	1.2	1.2	1.3	1.5	1.2	0.8	1.3

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

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; table 10A.39.

Effectiveness — quality

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

There has been considerable debate and research to develop suitable indicators of the quality of healthcare both in Australia and overseas. All Australian health ministers agreed to the establishment of the Australian Council for Safety and Quality in Health Care in January 2000, with a view to taking a systematic approach to assessing and improving the quality of healthcare. The Australian Council for Safety and Quality in Health Care was replaced in January 2006 by the ACSQHC. A key objective of the ACSQHC is to achieve safe, effective and responsive care for consumers. The ACSQHC has maintained the Council's focus on improving the safety of hospitals and sought to improve the quality of primary healthcare and the private health sector.

Various states and territories publicly report performance indicators for public hospital quality. Some have adopted the same indicators reported in this chapter. For example:

- In NSW reporting of Australian Council on Health Care Standards (ACHS) 'surgical site infection rates' is mandatory for public hospitals.
- All Victorian hospitals are required to publish annual quality care reports that include safety and quality indicators for infection control, medication errors, falls monitoring and prevention, and pressure wound monitoring and prevention.
- Queensland Health releases an annual public hospitals performance report, which shows a wide range of hospital performance information including clinical performance, efficiency and patient satisfaction. There are currently 31 clinical indicators that monitor clinical performance in Queensland Health hospitals spanning medical, surgical and obstetrics, and gynaecology.
- Both the WA and Tasmanian health departments' annual reports include information on 'unplanned re-admission rates' and WA also includes a section on patient satisfaction.
- SA Health publishes an annual report on patient safety which provides a summary of the types of incidents that occurred in public hospitals, actions taken on coronial findings and progress against priority areas in The South Australian Patient Safety Framework and Strategy 2007-2011.

Safety

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

Data for the 'safety' indicators come from the ACHS Comparative Report Service (Clinical Indicators). The ACHS data are collected for internal clinical review by individual hospitals. They are predominantly used to demonstrate the potential for improvement across Australian hospitals, if all hospitals could achieve the same outcomes as the hospitals that achieve the best outcomes for patients. When interpreting results of these indicators, emphasis needs to be given to the potential for improvement. Statewide conclusions cannot be drawn because participation by public hospitals in the Comparative Report Service (Clinical Indicators) is generally voluntary, so the data are not necessarily drawn from representative samples of hospitals (box 10.7).

Box 10.7 **Reporting of ACHS clinical indicators**

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

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

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

(Continued next page)

Box 10.7 **(continued)**

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

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

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

Source: ACHS (unpublished, 2003).

Safety — unplanned re-admission rates

'Unplanned re-admission rates' is an indicator of governments' objective to provide public hospital services that are safe and of high quality. The aim of this indicator is to measure unintentional additional hospital care (box 10.8).

Box 10.8 **Unplanned re-admission rates**

'Unplanned re-admission rates' show the rate at which patients unexpectedly return to hospital within 28 days for further treatment of the same condition or a condition related to the initial admission. The 'unplanned re-admission rate' is the total number of unplanned and unexpected re-admissions within 28 days of separation as a percentage of the total number of separations (excluding patient deaths).

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). High rates for this indicator suggest the quality of care provided by hospitals, or post-discharge care or planning, should be examined, because there may be scope for improvement.

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

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

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

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2008, the mean rate of 'unplanned re-admissions' was 3.7 per 100 admissions (table 10.10). The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 2.3 per cent (or 19 622) fewer re-admissions to these public hospitals (ACHS unpublished). National performance at the 20th centile shows the rate at, or below which, the best performing 20 per cent of ACHS reporting hospitals performed.

These estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are potentially unreliable. The statistical terms used to describe this indicator are explained in box 10.9.

Box 10.9 **Definition of terms for ACHS clinical indicators**

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

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

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

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

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

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

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

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

stratum rate: mean rates for a particular jurisdiction.

Source: ACHS (2001).

These national results are based on approximately one fifth of total public hospital separations. The number of ACHS reported hospital separations used to derive this indicator was 840 480 in 2008 (ACHS unpublished), whereas the total number of separations in 2007-08 was around 4.7 million (AIHW 2009a). For jurisdictions with five or more hospitals reporting ‘unplanned re-admissions’ to the ACHS Comparative Report Service, the mean rates of unplanned re-admissions in 2008 are shown in table 10.10. The coverage of the ACHS data can differ across these states. Data for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals reported ‘unplanned re-admissions’ in each of those jurisdictions.

Table 10.10 Unplanned re-admissions, ACHS reporting public hospitals, 2008[a]

	Unit	*Results*
National rate (per 100 separations)	%	3.7
National performance at 80th centile (rate)	(%)	5.4
National performance at 20th centile (rate)	(%)	1.3
NSW		
Numerator (re-admissions)	no.	9 992
Denominator (separations)	no.	288 392
Rate (per 100 separations)	%	3.5
Standard error (±)		0.5
ACHS reporting hospitals	no.	56
Victoria		
Numerator (re-admissions)	no.	10 694
Denominator (separations)	no.	172 576
Rate (per 100 separations)	%	6.2
Standard error (±)		0.7
ACHS reporting hospitals	no.	30
Queensland		
Numerator (re-admissions)	no.	3 288
Denominator (separations)	no.	107 862
Rate (per 100 separations)	%	3.0
Standard error (±)		0.8
ACHS reporting hospitals	no.	15
WA		
Numerator (re-admissions)	no.	2 089
Denominator (separations)	no.	99 431
Rate (per 100 separations)	%	2.1
Standard error (±)		0.9
ACHS reporting hospitals	no.	24
SA		
Numerator (re-admissions)	no.	823
Denominator (separations)	no.	28 862
Rate (per 100 separations)	%	2.9
Standard error (±)		1.6
ACHS reporting hospitals	no.	5

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

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

Safety — pre-anaesthetic consultation rates

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

Box 10.10 **Pre-anaesthetic consultation rates**

'Pre-anaesthetic consultation rate' is the number of procedures where there is documented evidence that the patient has seen an anaesthetist before entering the operating theatre suite, anaesthetic room, or procedure room, as a percentage of the total number of procedures with an anaesthetist in attendance.

Consultation by an anaesthetist is essential for the medical assessment of a patient before anaesthesia for surgery (or another procedure), to ensure that the patient is in an optimal state for anaesthesia and surgery. Low rates for this indicator suggest the quality of pre-anaesthetic care provided by hospitals should be examined because there can be scope for improvement.

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

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

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

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2008, the mean rate of 'pre-anaesthetic consultations' was 72.1 per 100 procedures (table 10.11). The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 80th centile, there would be 27.9 per cent (or 6970) more pre-anaesthetic consultations in these public hospitals (ACHS unpublished). National performance at the 80th centile shows the rate at, or above which, the best performing 20 per cent of ACHS reporting hospitals performed.

These national results are based on approximately 1.7 per cent of total public acute hospital anaesthetic procedures. The number of ACHS reporting hospital procedures used to derive this indicator was 24 998 in 2007 (ACHS unpublished). The estimated total number of anaesthetic procedures in 2007-08 was 1.5 million (AIHW unpublished).

NSW was the only jurisdiction with five or more hospitals reporting 'pre-anaesthetic consultations' to the ACHS Comparative Report Service in 2008 (table 10.11). Data for 2008 for other jurisdictions are not reported separately because fewer than five hospitals reported 'pre-anaesthetic consultations' in each of those jurisdictions. Data for 2006 are reported for Victoria in table 10A.46.

Table 10.11 **Pre-anaesthetic consultation rates, ACHS reporting public hospitals, 2008**[a]

	Unit	*Results*
National rate (per 100 separations)	%	72.1
National performance at 80th centile (rate)	(%)	100.0
National performance at 20th centile (rate)	(%)	31.7
New South Wales		
Numerator (pre anaesthetic consultations)	no.	7 800
Denominator (procedures)	no.	10 833
Rate (per 100 separations)	%	72
Standard error (±)		17
ACHS reporting hospitals	no.	6.0

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

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

Safety — surgical site infection rates

'Surgical site infection rates' is an indicator of governments' objective to provide public hospital services that are safe and of high quality (box 10.11).

Box 10.11 **Surgical site infection rates**

'Surgical site infection rates' is calculated as the average (that is, mean) rate of post-operative in-hospital occurrence of surgical site infection rates for selected surgical procedures (see section 10.8 for definitions). Rates are reported for four frequently performed procedures — hip and knee prosthesis, lower segment caesarean section and abdominal hysterectomy.

Surgical site infections can result in serious consequences for individual patients, place a significant burden on the health system and are influenced by the safety of hospital practices and procedures. 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. Only infections that occur within the patient's admission period are included. Post-discharge infections are excluded. Surgical infection rates are not reported for each procedure where fewer than five hospitals are included in the data.

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

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2008, the mean 'surgical site infection rate' for hip prosthesis surgery was 1.3 per 100 separations (table 10.12). The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 0.18 per cent (or 16) fewer infections after hip prosthesis surgery in these public hospitals (ACHS unpublished). National performance at the 20th centile shows the rate at, or below which, the best performing 20 per cent of ACHS reporting hospitals performed.

These estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that the data can be potentially unreliable. The statistical terms used to describe this indicator are explained in box 10.9.

The mean 'surgical site infection rate' following knee prosthesis surgery was 0.7 per 100 separations (table 10.12). The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 0.23 per cent (or 22) fewer infections following knee prosthesis surgery in these public hospitals (ACHS unpublished).

The mean 'surgical site infection rate' following lower segment caesarean section surgery was 0.9 per 100 separations (table 10.12). The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 0.57 per cent (or 146) fewer infections following lower segment caesarean section surgery in these public hospitals (ACHS unpublished).

The mean ‘surgical site infection rate’ following abdominal hysterectomy surgery was 1.3 per 100 separations (table 10.12). The ACHS estimated that if the performance of all Australian public hospitals matched national performance at the 20th centile, there would be 0.35 per cent (or 5) fewer infections following abdominal hysterectomy surgery (ACHS unpublished).

These national results are based on approximately 59.7 per cent of hip prosthesis, 77.3 per cent of knee prosthesis, 46.7 per cent of lower segment caesarean section and 19.4 per cent of abdominal hysterectomy surgical procedures. The number of ACHS reporting hospital surgical procedures in 2008 used to derive this indicator was 8680 for hip prosthesis, 9511 for knee prosthesis, 25 509 for lower segment caesarean section and 1530 for abdominal hysterectomy. The total number of these surgical procedures in 2007-08 was 14 551 for hip prosthesis, 12 298 for knee prosthesis, 54 644 for lower segment caesarean section and 7872 for abdominal hysterectomy surgical procedures (AIHW unpublished).

For jurisdictions with five or more hospitals reporting ‘surgical site infections’ to the ACHS Comparative Report Service, the mean rates in 2008 are shown in table 10.12. The coverage of the ACHS data can differ across these states. ‘Surgical site infection rates’ for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals participated in the ACHS Comparative Report Service in each jurisdiction.

Table 10.12 **Surgical site infections, ACHS reporting public hospitals, by selected procedure, 2008**[a, b]

	Unit	*Hip prosthesis*	*Knee prosthesis*	*Lower segment caesarean section*	*Abdominal hysterectomy*
National rate (per 100 separations)	%	1.3	0.7	0.9	1.3
National performance at 80th centile (rate)	(%)	1.5	1.1	1.6	1.2
National performance at 20th centile (rate)	(%)	1.2	0.5	0.3	1.0
NSW					
Numerator (infections)	no.	37	23	35	–
Denominator (procedures)	no.	2 643	3 139	6 543	470
Infection rate (per 100 separations)	%	1.4	0.7	0.5	–
Standard error (±)		0.0	0.1	0.0	0.2
ACHS reporting hospitals	no.	16	16	14	7
Victoria					
Numerator (infections)	no.	31	7	np	np
Denominator (procedures)	no.	1 764	1 287	np	np
Infection rate (per 100 separations)	%	1.8	0.5	np	np
Standard error (±)		0.1	0.1	np	np
ACHS reporting hospitals	no.	7	8	np	np
Queensland					
Numerator (infections)	no.	6	5	70	np
Denominator (procedures)	no.	1 430	1 944	8 516	np
Infection rate (per 100 separations)	%	0.4	0.3	0.8	np
Standard error (±)		0.1	0.1	17.0	np
ACHS reporting hospitals	no.	9	9	10	np
WA					
Numerator (infections)	no.	21	17	29	np
Denominator (procedures)	no.	1 083	1 387	2 778	np
Infection rate (per 100 separations)	%	1.9	1.2	1.0	np
Standard error (±)		0.1	0.1	1.0	np
ACHS reporting hospitals	no.	6	7	8	np

(Continued on next page)

Table 10.12 **(Continued)**

	Unit	*Hip prosthesis*	*Knee prosthesis*	*Lower segment caesarean section*	*Abdominal hysterectomy*
SA					
Numerator (infections)	no.	12	8	30	np
Denominator (procedures)	no.	1 080	1 114	4 602	np
Infection rate (per 100 separations)	%	1	1	1	np
Standard error (±)		0.1	0.1	0.0	np
ACHS reporting hospitals	no.	6	6	5	np

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

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

Responsiveness — patient satisfaction surveys

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

Box 10.12 **Patient satisfaction surveys**

'Patient satisfaction surveys' provides information on how jurisdictions used patient satisfaction surveys to improve public hospital quality in recent years.

Surveys can be useful for obtaining information on patient views of both clinical and non-clinical hospital care (such as whether patients feel they were treated with respect and provided with appropriate information regarding their treatment). If public hospitals respond to patient views and modify services, service quality can be improved to better meet patients' needs. The more public hospitals use patient satisfaction surveys the greater the potential for increasing the quality of public hospital services to better meet patients' needs.

Data reported for this indicator are not directly comparable.

Some jurisdictions have provided general information about use of patient satisfaction surveys. Over time this information will be refined to identify more specific examples of how public hospital quality has improved. Jurisdictions provided the following information in relation to their most recent survey.

- In NSW a mailout survey was conducted for patients treated during February 2009 in the categories of overnight inpatients, day only patients, paediatric inpatients, outpatients, non-admitted emergency patients, community health patients, adult rehabilitation inpatients and inpatients treated for cancer. Area health services produced an annual action plan in response to the 2007 and 2008 surveys. Data are used to inform statewide service improvement programs. A key performance indicator regarding the patient survey results is included in the annual Area Health Service Performance Agreements (table 10A.73).
- In Victoria a survey was conducted between 1 March 2008 and 28 February 2009 using a mailout questionnaire to admitted adult patients in public acute and sub acute care hospitals. Hospitals are provided with a six monthly report (if they have had more than 30 respondents), which provides them with information and an Overall Care Index score as well as scores for six sub-indices. The scores are benchmarked with similar hospitals and the state average for all hospitals. Using this information the health services can identify areas for improvement (table 10A.74).
- In Queensland, computer assisted telephone interviews were conducted from September 2008 to April 2009 of surgical patients discharged between July and December 2008. Each hospital's detailed results are fed back and are used in planning service improvements as follows:
  - hospital survey results are provided to hospitals
  - hospitals review their results in detail and determine areas for improvement
  - hospitals develop Management Action Plans to address areas for improvement
  - hospitals implement Management Action Plans
  - governance units at a district or State level monitor the implementation of Action Plans (table 10A.75).
- In WA, a computer assisted telephone interview survey was conducted between February 2009 and June 2009 for admitted patients and emergency department patients. Each participating hospital receives detailed information from the survey, which is used to inform service improvement. Hospitals can also request a workshop to assist in the interpretation of the survey results. Many hospitals use patient satisfaction as a performance indicator and as part of their accreditation process. Some examples of how hospitals have used the survey to

improve public hospital quality include: a process to record and cross reference for food allergies; improved communication with patients on rights and services available; employment of a Customer Liaison Officer to increase patient involvement; improved access to patient care plans; improved discharge coordination procedures; and the introduction of brochures to inform patients on how the emergency department works (table 10A.76).

- In SA, a computer assisted telephone interview survey was conducted between May 2008 and July 2008 of adult patients aged 16 years and over who received at least one night of care in the SA public hospital system in May through to July 2008. The survey results have been provided to the relevant hospitals and will inform the public hospital system of the key areas of care and service that are important to patients presenting for an overnight stay in hospital, as well as the areas of care and service that require improvement from the patients' perspective (table 10A.77).
- Tasmania is currently reviewing its approach to conducting consumer satisfaction surveys and therefore has not conducted a statewide survey since 2007 (table 10A.78).
- In the ACT, the two most recent surveys were conducted in 2009 at two different hospitals. One survey was conducted in February to May 2009 and another survey was conducted in March to June 2009. Survey 1 involved discharged patients from clinical areas of inpatients, emergency department, palliative care, day surgery and mental health. Survey 2 involved eligible patients who had consented and who had been discharged from the hospital during the reporting period. Survey 1 introduced a program called Simply Better that seeks to improve patient and staff satisfaction through aligned goals, behaviours and processes. Targets were set including 'increase patient satisfaction' and 'improve staff satisfaction' (table 10A.79).
- In the NT, face to face surveys were conducted at various times of the year in 2009 of admitted patients and emergency department attendees in public acute care hospitals. Survey information is provided to relevant hospital staff and committees for review and development of action plans to address identified issues. Examples of outcomes include development of resources in Indigenous languages, improved access to Aboriginal Liaison Officers and/or interpreters, introduction of a bed dial to measure the angle of elevation of patient beds, changed meal times and the identification of a need for cultural training for staff (table 10A.80).

Capability — hospital accreditation

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

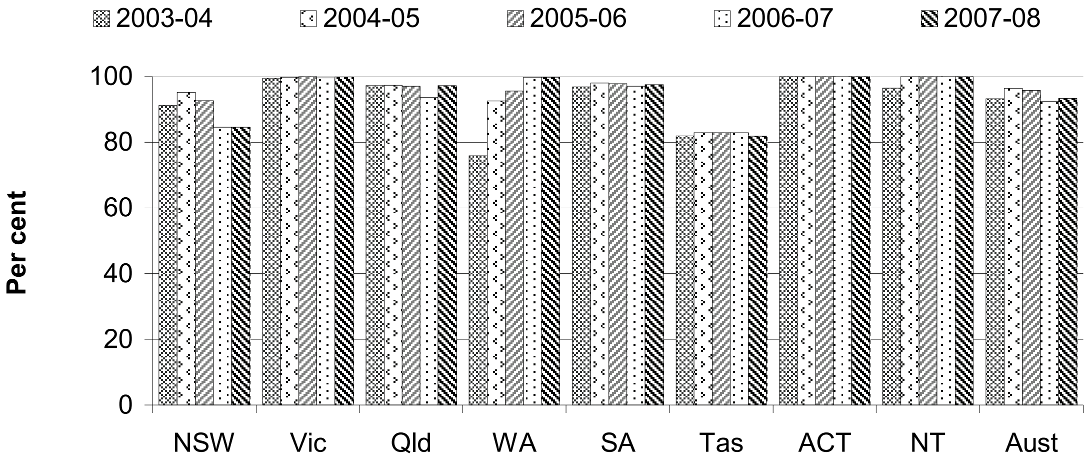
Box 10.13 **Accreditation**

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

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

Data reported for this indicator are comparable.

Figure 10.15 **Proportion of accredited beds, public hospitals**[a, b]



---

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

Source: AIHW (various years), *Australian Hospital Statistics,* Health Services Series, Cat nos. HSE 37, 41, 50, 55 and 71; table 10A.54.

Continuity — continuity of care

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

Box 10.14 **Continuity of care**

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

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

Effectiveness — sustainability

Workforce sustainability

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

Box 10.15 **Workforce sustainability**

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

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

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

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

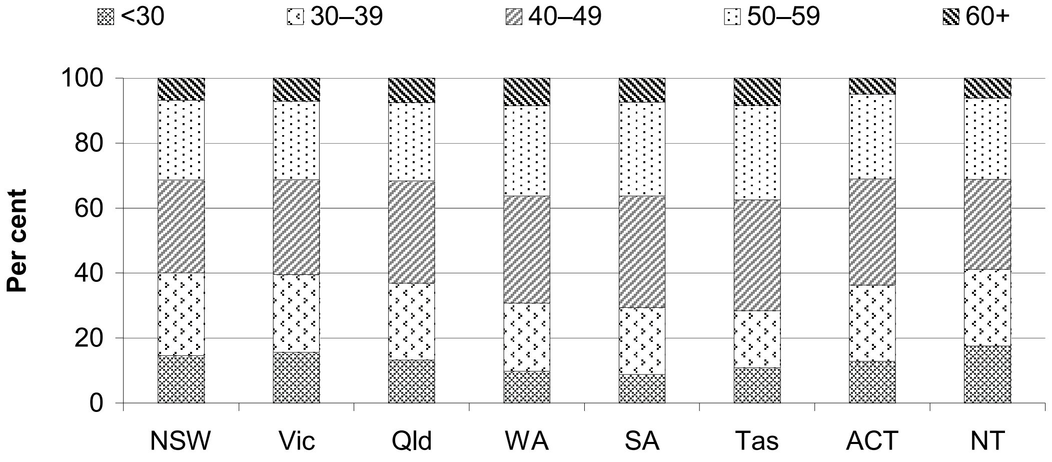
These measures are not a substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. They can, however, indicate that further attention should be given to workforce sustainability for public hospitals.

Data reported for this indicator are comparable.

Source: National Health Performance Committee (2004).

The age profile of the nursing workforce for 2007 (which includes midwives) for each jurisdiction is shown in figure 10.16. Nursing workforce data by remoteness area for 2007 are shown in figure 10.17.

Figure 10.16 **Nursing workforce, by age group, 2007**[a, b]

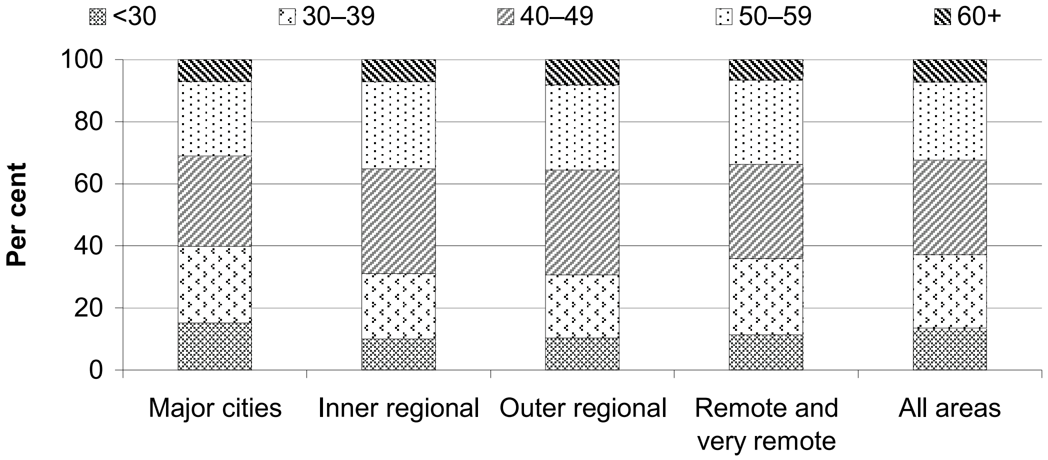


---

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

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

Figure 10.17 **Nursing workforce, by age group and remoteness area, 2007**[a]



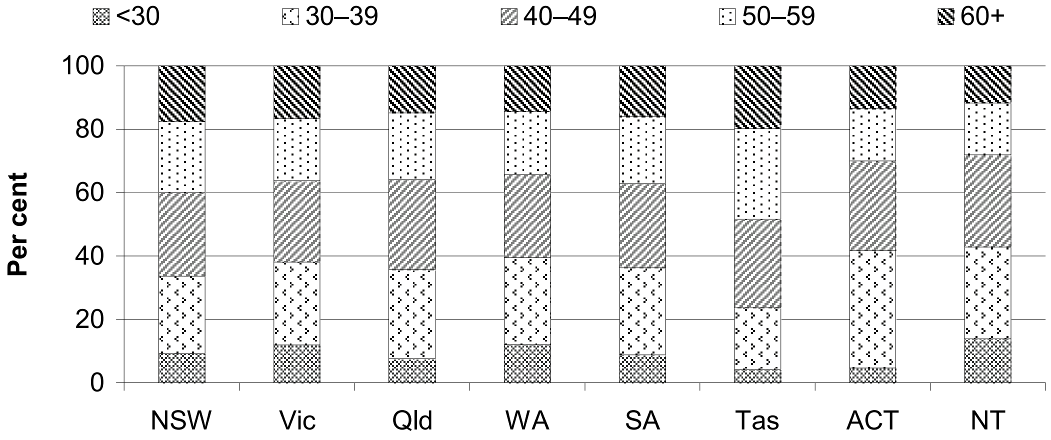
---

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

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

The age profile of the medical practitioner workforce in 2007 for each jurisdiction is shown in figure 10.18. Medical practitioner workforce data for 2007 by remoteness area are shown in figure 10.19.

Figure 10.18 **Medical practitioner workforce, by age group, 2007[a, b]**

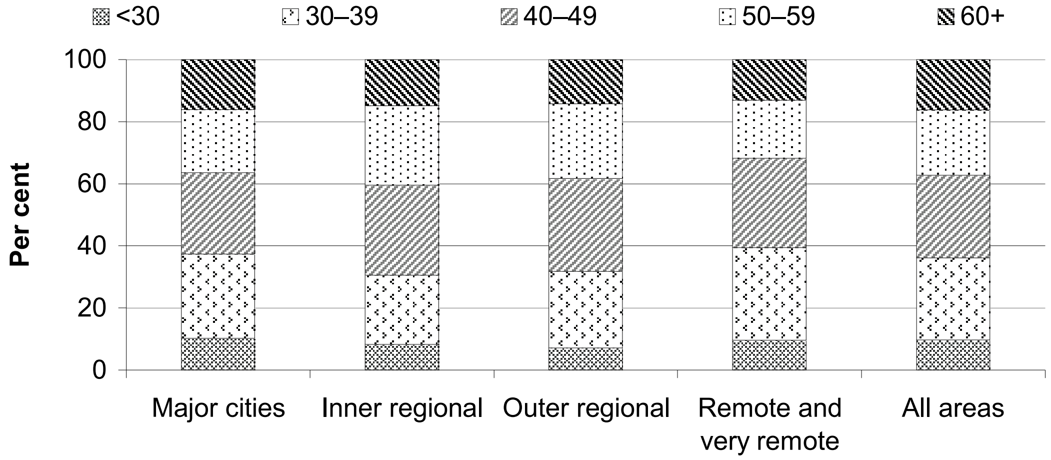


---

[a] Includes employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine. [b] Estimates for the NT should be treated with caution due to the low response rate (27.1 per cent) in that jurisdiction to the AIHW Medical Labour Force Survey.

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

Figure 10.19 **Medical practitioner workforce, by age group and remoteness area, 2007[a]**



---

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

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

Efficiency

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

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

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

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

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

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

Recurrent cost per casemix-adjusted separation

‘Recurrent cost per casemix-adjusted separation’ is an indicator of governments’ objective to deliver services in a cost effective manner (box 10.16). ‘Recurrent cost per casemix-adjusted separation’ data are presented in figure 10.20.

Box 10.16 **Recurrent cost per casemix-adjusted separation**

‘Recurrent cost per casemix-adjusted separation’ measures the average cost of providing care for an admitted patient (overnight stay or same day) adjusted with AR-DRG cost weights for the relative complexity of the patient’s clinical condition and of the hospital services provided (AIHW 2000).

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

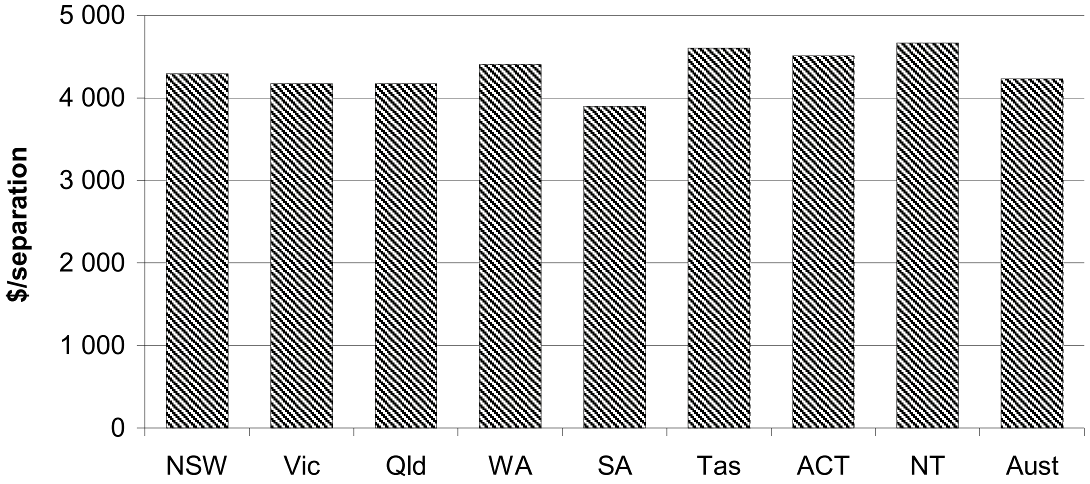
All admitted patient separations and their costs are included, and most separations are for acute care. Cost weights are not available for admitted patients who received non-acute care (2.3 per cent of total separations in 2006-07), so the same cost weights for acute care are applied to non-acute separations.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

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

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

Data reported for this indicator are comparable.

Figure 10.20 **Recurrent cost per casemix-adjusted separation, 2007-08**[a, b, c, d, e, f, g]

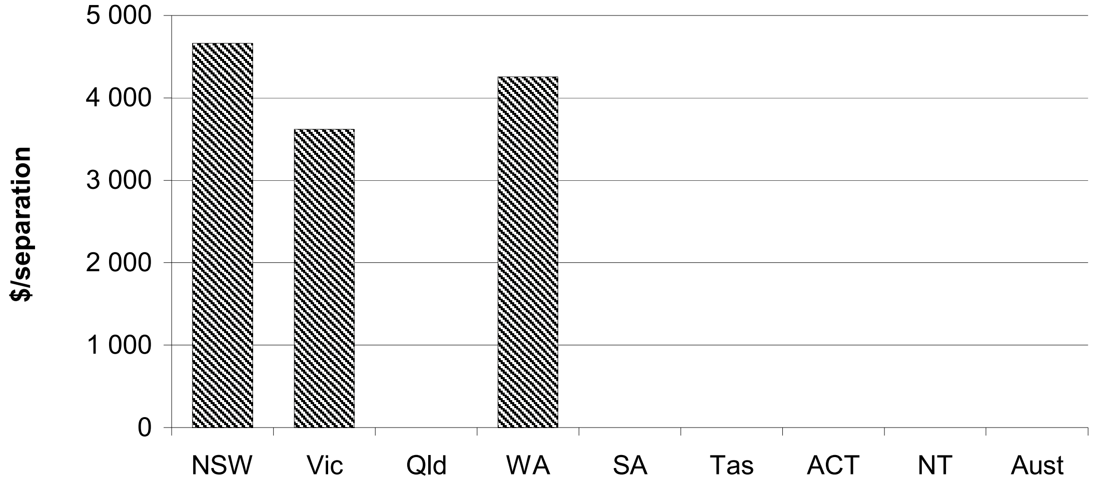


[a] Excludes depreciation and the user cost of capital, spending on non-admitted patient care and research costs. [b] Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights are from the National Hospital Cost Data Collection, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2006-07 AR-DRG v 5.1 cost weights (DoHA 2006). [c] Excludes separations for which the care type was reported as 'newborn with no qualified days', and records for hospital boarders and posthumous organ procurement. [d] Psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute hospitals and multi-purpose services are excluded from these data. The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included. [e] Of the selected hospitals, three small hospitals had their admitted patient cost proportion estimated by the Health and Allied Services Advisory Council ratio. Admitted patient cost proportion was previously called the inpatient fraction. [f] Hospital recurrent expenditures on Indigenous and non-Indigenous people can differ. These differences can influence jurisdictional variation in unit costs. [g] NT data need to be interpreted in conjunction with the cost disabilities associated with hospital service delivery in the NT.

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; table 10A.59.

Experimental estimates of 'recurrent cost per casemix-adjusted separation' for acute non-psychiatric patients are reported for NSW, Victoria and WA (figure 10.21). (These estimates relate to a subset of the selected public hospitals reported in figure 10.20 and are not available for other jurisdictions.) The experimental estimates aim to overcome the need to apply cost weights for acute care to non-acute care separations (box 10.16). The effect of restricting the analysis to acute non-psychiatric admitted patients was to increase the estimated recurrent cost per casemix-adjusted separation for the subset of hospitals by 3.4 per cent for NSW, and to decrease this cost by 13.5 per cent for Victoria and 5.0 per cent for WA (AIHW 2009a).

Figure 10.21 **Recurrent cost per acute non-psychiatric casemix-adjusted separation, subset of hospitals, 2007-08**[a, b, c, d, e]



[a] Excludes psychiatric hospitals, sub-acute, non-acute and unpeered hospitals. This subset excludes hospitals where the inpatient fraction was equal to the acute inpatient fraction and more than 1000 non-acute patient days were recorded. Also excludes hospitals where the apparent cost of non-acute patients exceeded $1000 per day and more than $1 million of apparent expenditure on non-acute patients days was reported. [b] Separations are those where the care type is acute, newborn with qualified days, or not reported. Psychiatric separations are those with psychiatric care days. [c] Average cost weight from the National Hospital Cost Data Collection, based on acute, newborn with at least one qualified day, or not reported, using the 2006-07 AR-DRG version 5.1 cost weights (DoHA 2006). [d] Cost estimates include adjustment for private patient medical costs: $258 for NSW, $127 for Victoria and $173 for WA. [e] These estimates are not available for Queensland, SA, Tasmania, the ACT or the NT.

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; table 10A.59.

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

The dominant peer classification is the 'Principal referral and Specialist women's and children's' category. The 80 hospitals representing this group had an average of 42 163 separations each at a cost of $4223 (table 10A.60 and table 10.13). Data for each of the hospital peer groups are presented in table 10.13. Detailed data for all peer groups are presented in table 10A.60.

Table 10.13 **Recurrent cost per casemix-adjusted separation, by hospital peer group, 2007-08**[a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Hospital peer group									
Principal referral and Specialist women's and children's	4 295	4 178	4 201	4 315	3 883	4 449	np	4 561	4 223
Large	4 102	3 985	3 975	4 329	4 144	np	np	..	4 160
Medium	4 430	4 080	3 561	4 683	3 723	..	..	..	4 199
Small acute	4 716	4 941	4 822	5 133	3 847	4 436	..	5 520	4 803
All hospitals[d]	4 295	4 172	4 172	4 405	3 900	4 605	4 513	4 668	4 232

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

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; table 10A.60.

Total cost per casemix-adjusted separation

'Total cost per casemix-adjusted separation' is an indicator of governments' objective to deliver services in a cost effective manner (box 10.17).

Box 10.17 **Total cost per casemix-adjusted separation**

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

(Continued on next page)

Box 10.17 **(Continued)**

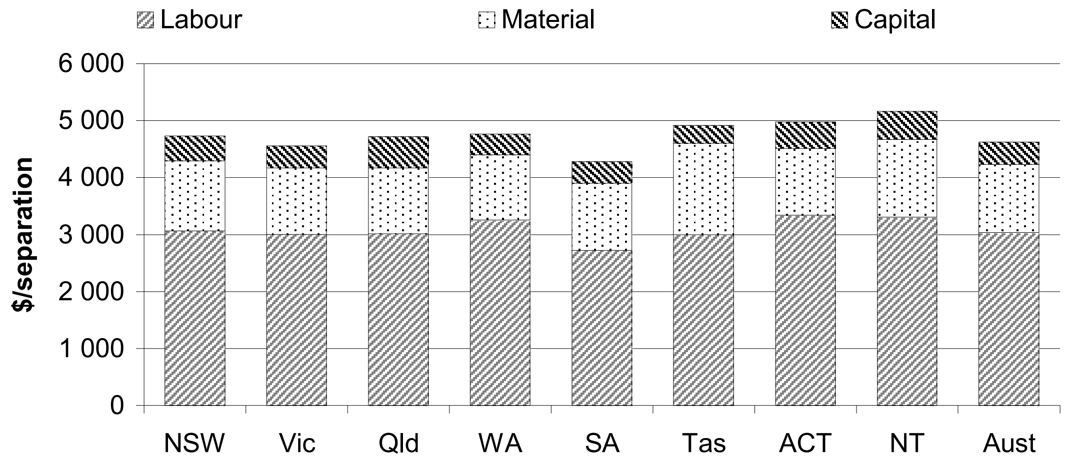
Depreciation is defined as the cost of consuming an asset's services. It is measured by the reduction in value of an asset over the financial year. The user cost of capital is the opportunity cost of the capital invested in an asset, and is equivalent to the return foregone from not using the funds to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

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

Data reported for this indicator are comparable.

Total cost includes both the recurrent costs (as discussed above) and the capital costs associated with hospital services. Results for this indicator in 2007-08 are reported in figure 10.22. Labour costs accounted for the majority of costs in all jurisdictions.

Figure 10.22 **Total cost per casemix-adjusted separation, public hospitals, 2007-08**[a, b, c]



[a] Labour includes medical and non-medical labour costs. Material includes other non-labour recurrent costs, such as repairs and maintenance (table 10A.59). [b] Capital cost includes depreciation and the user cost of capital for buildings and equipment that is associated with the delivery of admitted patient services in the public hospitals as described in the data for recurrent cost per casemix-adjusted separation. Capital cost excludes the user cost of capital associated with land (reported in table 10A.61). [c] Variation across jurisdictions in the collection of capital related data suggests the data are only indicative. The capital cost per casemix-adjusted separation is equal to the capital cost adjusted by the inpatient fraction, divided by the number of casemix-adjusted separations.

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; State and Territory governments (unpublished); tables 10A.59 and 10A.61.

Relative stay index

'Relative stay index' is an indicator of governments' objective to deliver services efficiently (box 10.18).

Box 10.18 **Relative stay index**

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

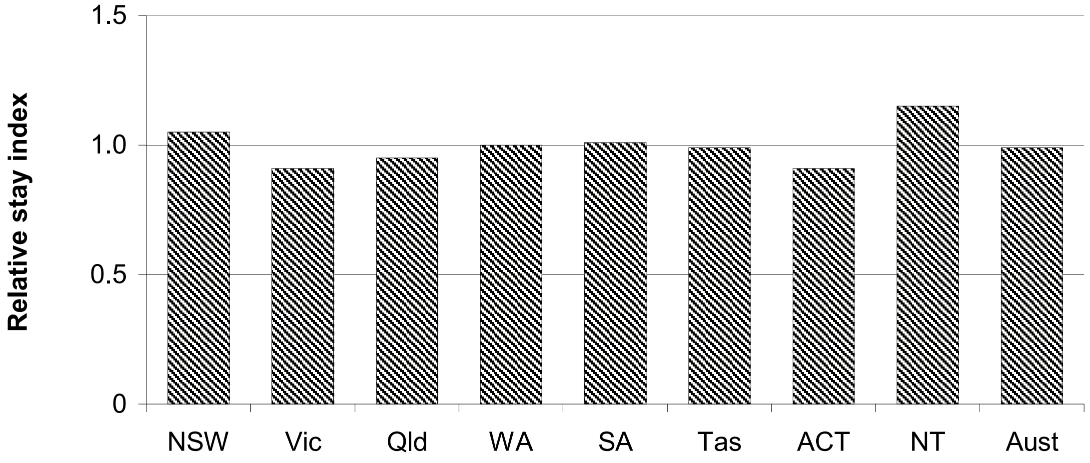
'Relative stay index' for Australia for all hospitals (public and private) is one. A 'relative stay index' greater than one indicates that average length of patient stay is higher than expected given the jurisdiction's casemix distribution. A 'relative stay index' of less than one indicates that the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

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

Data reported for this indicator are comparable.

Data for this indicator are reported in figure 10.23. The 'relative stay index' is reported by patient election status and by medical, surgical and other AR-DRGs in tables 10A.62 and 10A.63 respectively.

Figure 10.23 **Relative stay index, public hospitals, 2007-08**[a, b]



---

[a] Separations exclude newborn with unqualified days, organ procurement posthumous and hospital boarders.
[b] The relative stay index is based on all hospitals and is estimated using the indirect standardisation method and AR-DRG version 5.1. The indirectly standardised relative stay index is not strictly comparable between jurisdictions but is a comparison of the jurisdiction with the national average based on the casemix of the jurisdiction.

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; table 10A.62.

Recurrent cost per non-admitted occasion of service

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

Box 10.19 **Recurrent cost per non-admitted occasion of service**

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

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

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

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

These data are not comparable across jurisdictions. Reporting categories vary across jurisdictions, and further inconsistencies arise as a result of differences in outsourcing practices. In some cases, for example, outsourced occasions of service can be included in expenditure on non-admitted services, but not in the count of occasions of service. Jurisdictions able to supply 2007-08 data for this indicator reported the following results for non-admitted patient services:

- In NSW, the emergency department cost per occasion of service was $197 for 2.3 million occasions, the outpatient cost per occasion of service was $92 for 15.3 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was $104 for 20.5 million occasions (table 10A.64).
- In WA, the emergency department cost per occasion of service was not available. The outpatient cost per occasion of service was $186 for 3.0 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was $182 for 4.1 million occasions (table 10A.66).
- In SA, the emergency department cost per occasion of service was $302 for 527 000 occasions, the outpatient cost per occasion of service was $261 for 1.4 million occasions and the overall cost per occasion of service (emergency plus outpatient) was $272 for 1.9 million occasions (table 10A.67).
- In Tasmania, the emergency department cost per occasion of service was not available. The outpatient cost per occasion of service was $164 for 460 000 occasions. An overall cost per occasion of service was not available (table 10A.68).

- In the ACT, the emergency department cost per occasion of service was $600 for 98 000 occasions, the outpatient cost per occasion of service was $102 for 254 000 occasions and the overall cost per occasion of service (emergency plus outpatient) was $170 for 729 000 occasions (table 10A.69).

Victoria collects data on the basis of cost per non-admitted patient encounter. An encounter includes the clinic visit and all ancillary services provided within a 30 day period either side of the clinic visit. Based on cost data from 14 hospitals, the average cost per encounter was $158 for 1.2 million encounters in 2007-08 (table 10A.65).

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

Outpatient data were contributed by 177 public hospitals for all types of public hospital outpatient clinics (tier 0). These data suggest that 'cost per non-admitted clinic occasions of service' for the public hospitals sector in 2007-08 was $246 for 10.0 million occasions (table 10A.70). 'Cost per non-admitted clinic occasions of service' data are also shown for seven categories of outpatient clinics (tier 1) (table 10.14). These tier 1 outpatient clinics data were provided by 177 public hospitals. Emergency department data, provided by 153 public hospitals, show the 'cost per occasion of service for emergency departments' by triage class (table 10.15).

Table 10.14 Non-admitted clinic occasions of service for tier 1 clinics, sample results, public sector, 2007-08[a, b, c, d, e]

	Occasions of service	*Average cost*
	no.	$/occasion of service
Allied health and/or clinical nurse specialist	1 429 222	143
Dental	21 271	250
Medical	3 290 546	380
Obstetrics and gynaecology	1 647 903	145
Paediatric	334 393	294
Psychiatric	239 824	276
Surgical	2 406 795	190
Total	**9 369 954**	**248**

[a] Not all hospitals that submit data to the NHCDC submit emergency department data. The emergency department national database contains only acute hospitals with emergency department cost and activity. [b] Costing and admission practices vary across jurisdictions and hospitals. [c] Includes depreciation costs. [d] Based on 177 public sector hospitals. [e] Excludes Victorian outpatient data.

Source: DoHA (2009), *National Hospital Cost Data Collection Cost Report, Round 12 (2007-08)*; table 10A.72.

Table 10.15 Emergency department average cost per occasion of service, public hospitals, by triage class, 2007-08 (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	1 170	1 188
Admitted triage 2	640	652
Admitted triage 3	544	558
Admitted triage 4	443	456
Admitted triage 5	241	237
Non-admitted triage 1	702	739
Non-admitted triage 2	492	505
Non-admitted triage 3	416	431
Non-admitted triage 4	311	321
Non-admitted triage 5	184	197
Did not wait[g]	31	32
Total	**363**	**383**

[a] Not all hospitals that submit data to the NHCDC submit emergency department data. The emergency department national database contains only acute hospitals with emergency department cost and activity. [b] Based on data from 153 public sector hospitals. [c] Victorian emergency department data are not included. [d] Costing and admission practices vary across jurisdictions and hospitals. [e] Depreciation costs are included. [f] Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. [g] 'Did not wait' means those presentations to an emergency department who were triaged but did not wait until the completion of their treatment, at which time they would have been either admitted to hospital or discharged home.

Source: DoHA (2009), *National Hospital Cost Data Collection Cost Report, Round 12 (2007-08)*; table 10A.71.

Outcomes

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

Patient satisfaction

'Patient satisfaction' provides a proxy measure of governments' objective to deliver services that are high quality and responsive to individual patient needs (box 10.20).

Box 10.20 **Patient satisfaction**

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

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

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

Data reported for this indicator are not directly comparable.

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

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

Jurisdictions reported the following results from patient satisfaction surveys:

- In NSW, a mailout survey was conducted in February 2007, 2008 and 2009 of overnight inpatients, day only inpatients, paediatric inpatients, outpatients, non-admitted emergency patients, community health patients, adult rehabilitation inpatients and admitted patients with cancer. The sample size was 216 000 and the response rate was 38 per cent. In 2009, 90 per cent of patients rated their care very positively (good, very good or excellent) when asked how they would rate their overall care. In 2009 66 per cent reported they would definitely recommend the service to others. Both measures have increased from 2007 when 88 per cent rated overall care as good, very good or excellent and 62 per cent reported they would recommend the service to others (table 10A.73).
- In Victoria, a survey was conducted between 1 March 2008 and 28 February 2009 using a mailout questionnaire to admitted adult patients in public acute and sub acute care hospitals. The sample size was 15 587 and the response rate was 39 per cent. The overall care index was 78.2 out of a possible range of 20–100 (table 10A.74).
- In Queensland, computer assisted telephone interviews were conducted from Septembers 2008 to April 2009 of surgical patients discharged between July and December 2008. The sample size was 6201 and the response rate was 86 per cent. Across Queensland 95 per cent of patients were either very satisfied or fairly satisfied with all aspects of their hospital stay, with 68 per cent stating they were very satisfied (table 10A.75).
- In WA, a computer assisted telephone interview survey was conducted between February 2009 and June 2009 for admitted patients and emergency department patients. The sample size was 6863 admitted patients and 1593 emergency patients and the response rate was 92 per cent for both admitted and emergency patients. The overall indicator of satisfaction score was 77.8 for admitted patients and 77.4 for emergency department patients (table 10A.76).
- In SA, a computer assisted telephone interview survey was conducted between May 2008 and July 2008 of adult patients aged 16 years and over who received at least one night of care in the SA public hospital system in May through to July 2008. The sample size was 4785 and the response rate was 73 per cent. The overall satisfaction score for the 2008 Public Hospital Inpatients, Patient Satisfaction Survey was 88.0 (scored from 0 to 100, being least to most satisfied) (table 10A.77).
- Tasmania is currently reviewing its approach to conducting consumer satisfaction surveys and therefore has not conducted a statewide survey since 2007 (table 10A.78).

- In the ACT, the two most recent surveys were conducted in 2009 at two different hospitals. One survey was conducted in February to May 2009 and another survey was conducted in March to June 2009. Survey 1 involved discharged patients from clinical areas of inpatients, emergency department, palliative care, day surgery and mental health. Survey 2 involved eligible patients who had consented and who had been discharged from the hospital during the reporting period. Survey 1 used samples of 172 inpatients, 120 emergency department patients, 191 day surgery patients, 23 mental health patients and 112 palliative care patients. Survey 1 had a 35.8 per cent response rate for inpatients, a 24 per cent response rate for emergency department patients, a 54 per cent response rate for day surgery patients and a 23.9 per cent response rate for mental health patients. Data are not yet available for survey 2. Survey 1 overall satisfaction results were as follows:
  - 78.2 mean points out of 100 for inpatients
  - 77.8 mean points out of 100 for emergency department patients
  - 88.2 mean points out of 100 for day surgery patients
  - 77.8 mean points out of 100 for public mental health patients
  - 88.6 mean points out of 100 for palliative care patients (table 10A.79).
- In the NT, face to face surveys were conducted at various times of the year in 2009 of admitted patients and emergency department attendees in public acute care hospitals. Sample sizes have varied and response rates have been low. The overall satisfaction with hospital stay was 83 per cent (table 10A.80).

Sentinel events

'Sentinel events' is an indicator of governments' objective to deliver public hospital services that are safe and of high quality (box 10.21).

Box 10.21 **Sentinel events**

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

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

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

A high number of sentinel events can indicate hospital system and process deficiencies that compromise the quality and safety of public hospitals.

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

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

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

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

Data for 2007-08 are shown in table 10.16. Data for 2006-07 are reported in table 10A.81. The definition of sentinel event 1 has been revised for the 2010 Report to include only those events that result in death or major permanent loss of function. In previous reports less serious events had been included by some jurisdictions for this event. As a result, data reported for this event in the 2010 Report are not comparable with the data reported in previous Reports.

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

Table 10.16 **Nationally agreed core sentinel events, 2007-08 (number)**[a]

Sentinel event	*NSW*	*Vic*	*Qld*	*WA*[b]	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1. Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.[c, d]	4	1	8	1	1	–	–	–	15
2. Suicide of an admitted patient	5	7	5	9	5	1	–	–	32
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure	14	11	–	3	3	1	np	–	32
4. Intravascular gas embolism resulting in death or neurological damage	–	–	–	–	1	–	–	–	1
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility	–	2	–	2	–	–	–	–	4
6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs	6	2	5	4	–	1	–	–	18
7. Maternal death or serious morbidity associated with labour or delivery	–	6	1	5	2	–	–	1	15
8. Infant discharged to the wrong family	–	–	–	2	–	–	–	–	2
Total	**29**	**29**	**19**	**26**	**12**	**3**	**np**	**1**	**119**

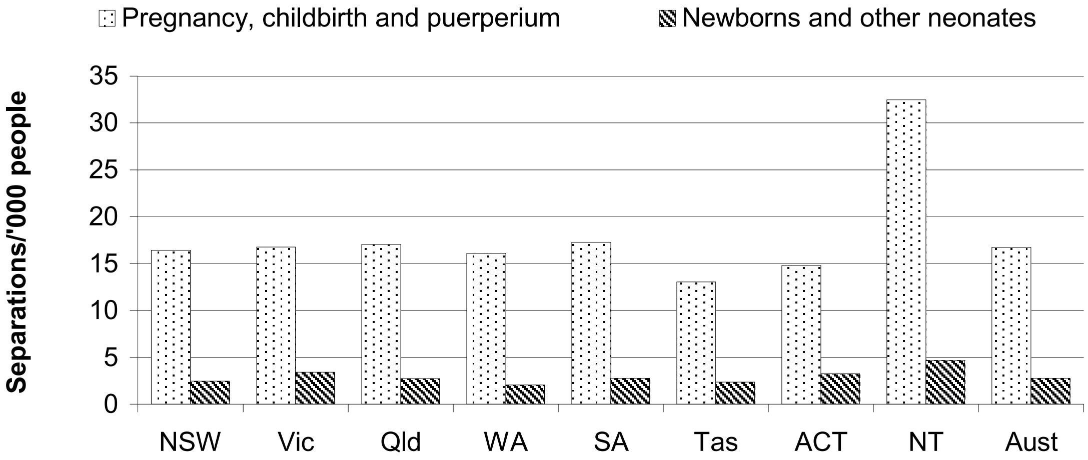
[a] Sentinel event definitions can vary across jurisdictions. [b] Includes public and private hospitals. [c] The definition of sentinel event 1 has been revised for the 2010 Report to include only those events that result in death or major permanent loss of function. In previous reports less serious events had been included by some jurisdictions for this event. [d] Data reported for this event in the 2010 Report are not comparable with the data reported in previous Reports. – Nil or rounded to zero. **np** Not published.

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

10.4 Profile of maternity services

Maternity services (defined as AR-DRGs relating to pregnancy, childbirth and the puerperium, and newborns and other neonates) accounted for 9.0 per cent of total acute separations in public hospitals (table 10A.83) and around 10.8 per cent of the total cost of all acute separations in public hospitals in 2007-08 (table 10A.82). Figure 10.24 shows the rate of acute separations per 1000 people for maternity services across jurisdictions in 2007-08.

Figure 10.24 **Separation rates for maternity services, public hospitals, 2007-08**[a, b]



---

[a] The puerperium refers to the period of confinement immediately after labour (around six weeks). [b] Newborns and other neonates include babies aged less than 28 days or babies aged less than one year with admission weight of less than 2500 grams.

Source: AIHW (2009), *Australian Hospital Statistics 2007-08,* Health Services Series No. 33, Cat no. HSE 71; ABS (unpublished), Australian Demographic Statistics, December Quarter 2007, Cat. no. 3101.0; tables AA.2 and 10A.83.

In Australian public hospitals in 2007-08, vaginal deliveries without complicating diagnosis accounted for a substantial proportion of the separations for pregnancy, childbirth and the puerperium (29.5 per cent) (tables 10A.83 and 10A.84). In the context of all AR-DRGs in public hospitals, vaginal deliveries without complicating diagnosis comprised the largest number of overnight acute separations (2.3 per cent of all separations) (table 10.3) and the third highest cost of all separation categories ($451.3 million) (table 10A.84).

The complexity of cases across jurisdictions for maternity services is partly related to the mother's age at the time of giving birth. The mean age of mothers giving birth varied across jurisdictions in 2006, 2007 and 2008 (table 10.17).

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

	NSW	*Vic*	*Qld*[a]	*WA*	*SA*[b]	*Tas*	*ACT*[c]	*NT*
2006								
First birth	27.1	27.7	25.5	26.0	26.8	24.8	27.7	23.8
Second birth	30.4	29.9	28.1	28.5	29.4	27.7	30.1	26.3
Third birth	31.6	31.5	29.6	29.8	31.0	29.6	31.5	28.2
All births	29.3	29.5	27.9	28.1	29.0	27.2	29.6	26.5
2007								
First birth	28.1	27.8	25.6	26.0	26.9	26.0	27.7	24.1
Second birth	30.2	30.0	28.0	28.5	29.4	28.5	30.2	26.4
Third birth	31.4	31.5	29.7	30.0	31.1	29.9	31.4	27.8
All births	29.1	29.6	27.9	28.1	29.0	28.1	29.6	26.6
2008								
First birth	27.9	27.7	25.5	26.0	26.9	na	28.1	24.5
Second birth	30.2	30.0	28.1	28.6	29.5	na	30.2	26.4
Third birth	31.5	31.5	29.8	32.0	31.0	na	31.9	28.5
All births	29.8	29.6	28.0	28.2	29.1	na	29.8	26.8

a The 2006 data exclude mothers whose age was 'not stated'. **b** Age is based on exact age (years) to 4 decimal places. **c** ACT 2008 data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. Between 2006 and 2008, 16.2 per cent of women who gave birth in the ACT were not ACT residents. **na** Not available.

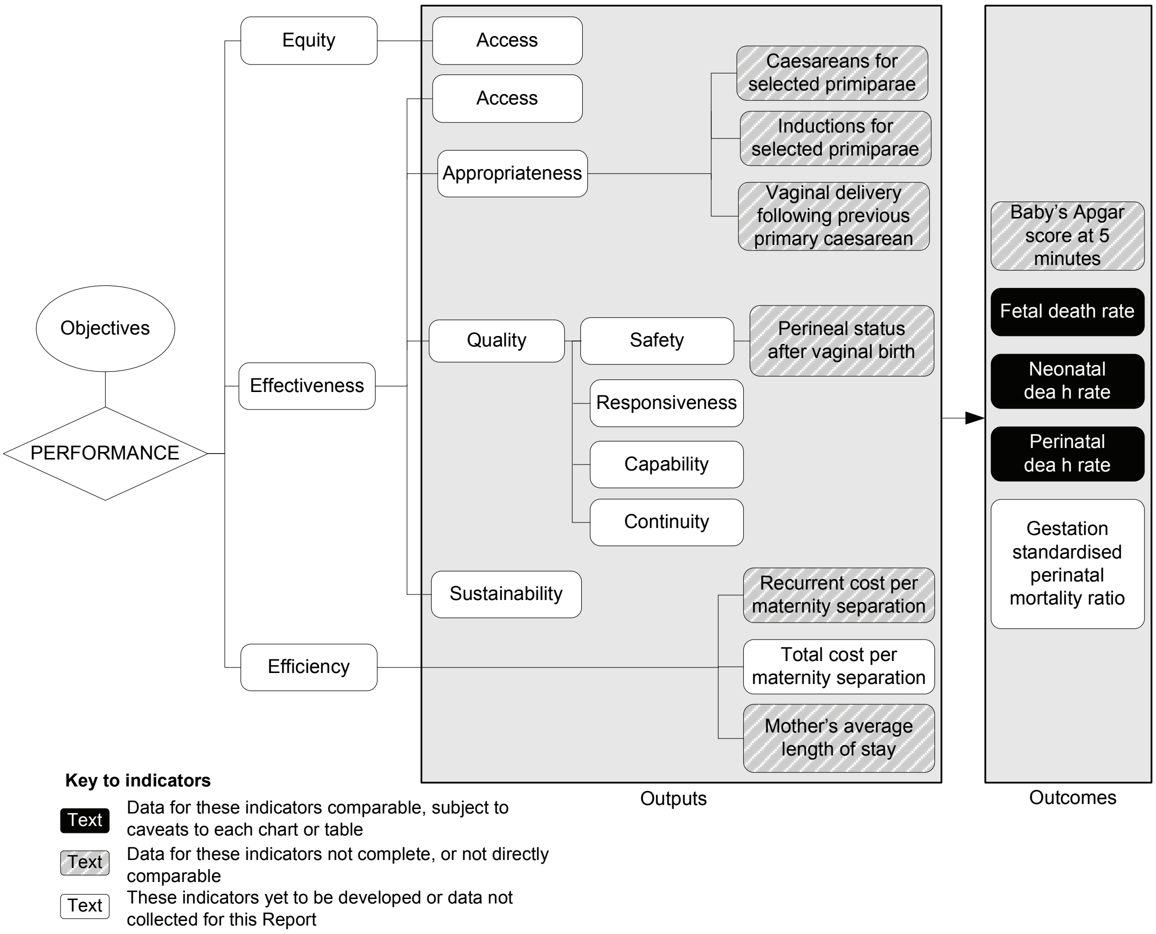
Source: State and Territory governments (unpublished).

10.5 Framework of performance indicators for maternity services

The performance framework for maternity services is outlined in figure 10.25, and is based on 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 2010 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability that have been added to the standard Review framework for health services.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 10.25 **Performance indicators for maternity services**



10.6 Key performance indicator results for maternity services

Outputs

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

Equity — access

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

Effectiveness — access

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

Effectiveness — appropriateness

Caesareans and inductions for selected primiparae

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

Box 10.22 **Caesareans and inductions for selected primiparae**

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

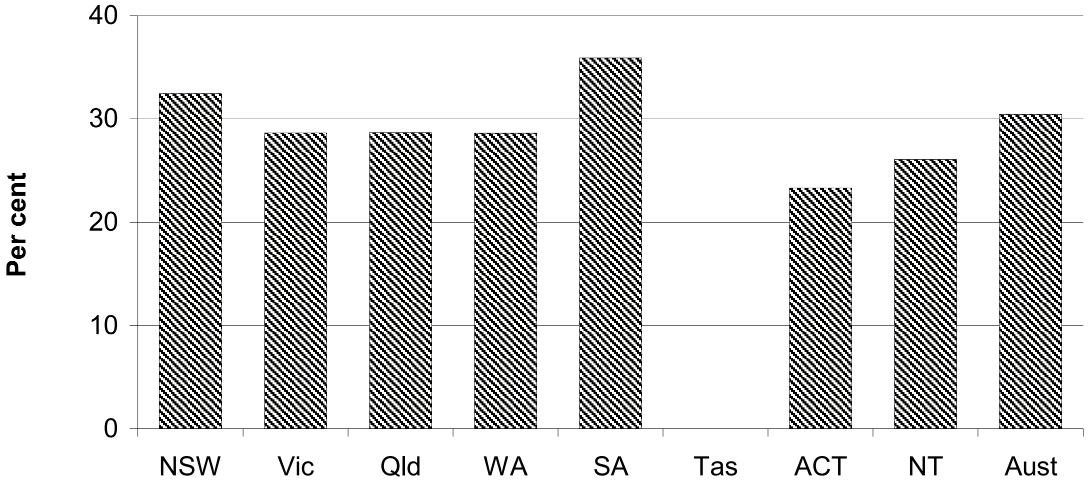
These indicators are defined as the number of inductions or caesareans for the selected primiparae divided respectively by the number of the selected primiparae who give birth. High intervention rates can indicate a need for investigation, although labour inductions and birth by caesarean section are interventions that are appropriate in some circumstances, depending on the health and wellbeing of mothers and babies.

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

[a] Parturient means 'about to give birth'. Primiparae refers to pregnant women who have had no previous pregnancy resulting in a live birth or stillbirth (Laws and Hilder 2008).

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

Figure 10.26 **Inductions for selected primiparae, public hospitals, 2008**[a, b, c]



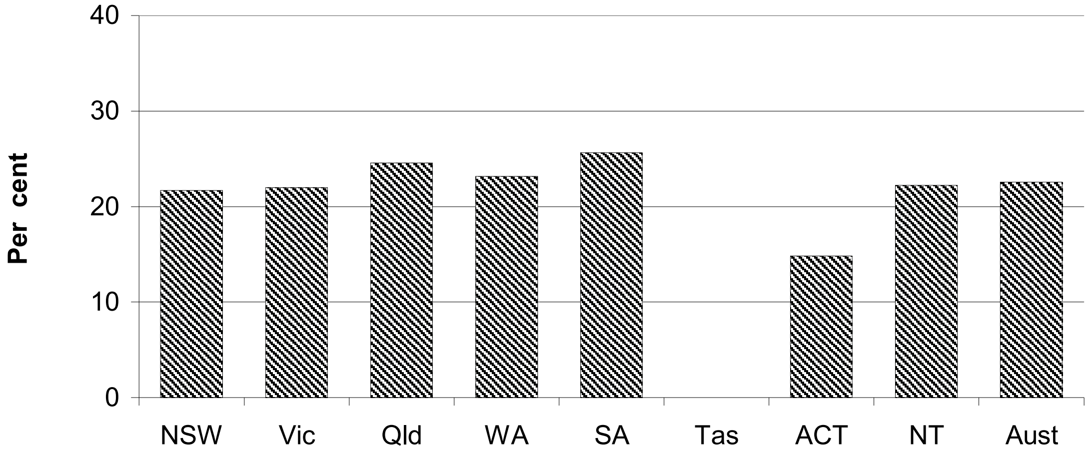
---

[a] Data for Tasmania are not available. [b] ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2008, 15.7 per cent of women who gave birth in the ACT were not ACT residents. [c] Rate for Australia includes only jurisdictions for which data are available.

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

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

Figure 10.27 **Caesareans for selected primiparae, public hospitals, 2008**[a, b, c]



a Data for Tasmania are not available. **b** ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2008, 15.7 per cent of women who gave birth in the ACT were not ACT residents. **c** Rate for Australia includes only jurisdictions for which data are available.

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

Vaginal birth following previous primary caesarean

'Vaginal birth following previous primary caesarean' is an indicator of the appropriateness of maternity services in public hospitals (box 10.23).

Box 10.23 **Vaginal birth following previous primary caesarean**

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

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

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

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

The mean rates of ‘vaginal birth following a primary caesarean’ in 2008 are shown in table 10.18 for jurisdictions with five or more hospitals reporting to the ACHS Comparative Report Service. The coverage of the ACHS data can differ across these states. Data for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals reported ‘vaginal birth following a primary caesarean’ in each of those jurisdictions.

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2008, the mean rate of ‘vaginal birth following a previous primary caesarean’ was 17.0 per 100 deliveries (table 10.18). Given the uncertainty regarding whether high/low rates of vaginal birth following a previous primary caesarean are desirable, this Report does not include potential centile gains for this indicator.

Table 10.18 **Vaginal births following previous primary caesarean, ACHS reporting public hospitals, 2008**[a, b]

	Unit	*Results*
National rate	(%)	17.0
National performance at 80th centile (rate)	(%)	19.9
National performance at 20th centile (rate)	(%)	13.0
NSW		
Numerator (no. of VBACs)	no.	258
Denominator (no. of DACs)	no.	1 905
Rate	%	13.5
Standard error (±)		0.9
ACHS reporting hospitals	no.	25
Victoria		
Numerator (no. of VBACs)	no.	453
Denominator (no. of DACs)	no.	2 627
Rate	%	17.2
Standard error (±)		0.8
ACHS reporting hospitals	no.	22
Queensland		
Numerator (no. of VBACs)	no.	297
Denominator (no. of DACs)	no.	1 770
Rate	%	16.8
Standard error (±)		1.0
ACHS reporting hospitals	no.	9
WA		
Numerator (no. of VBACs)	no.	234
Denominator (no. of DACs)	no.	1 232
Rate	%	19.0
Standard error (±)		1.2
ACHS reporting hospitals	no.	9
SA		
Numerator (no. of VBACs)	no.	152
Denominator (no. of DACs)	no.	781
Rate	%	19.5
Standard error (±)		1.5
ACHS reporting hospitals	no.	9

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

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

Effectiveness — quality

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

Safety — perineal status after vaginal birth

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

Box 10.24 **Perineal status after vaginal birth**

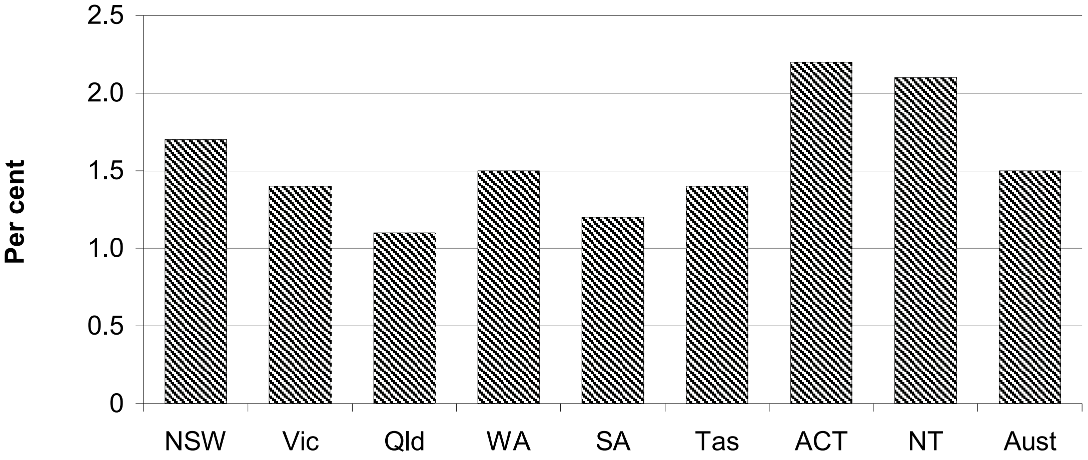
'Perineal status after vaginal birth' is the state of the perineum following a vaginal birth (HDSC 2008). A third or fourth degree laceration is a perineal laceration or rupture (or tear following episiotomy) extending to, or beyond, the anal sphincter (see section 10.8 for definitions) (NCCH 2008).

Perineal lacerations caused by childbirth are painful, take time to heal and can result in ongoing discomfort and debilitating conditions such as faecal incontinence. Maternity services staff aim to minimise lacerations, particularly more severe lacerations (third and fourth degree), through labour management practices. Severe lacerations (third and fourth degree laceration) of the perineum are not avoidable in all cases and so safe labour management is associated with a low (rather than zero) proportion of third or fourth degree lacerations.

Data reported for this indicator are not directly comparable.

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

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



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

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

Responsiveness, capability, continuity

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

Effectiveness — sustainability

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

Efficiency

Recurrent cost per maternity separation

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

Box 10.25 **Recurrent cost per maternity separation**

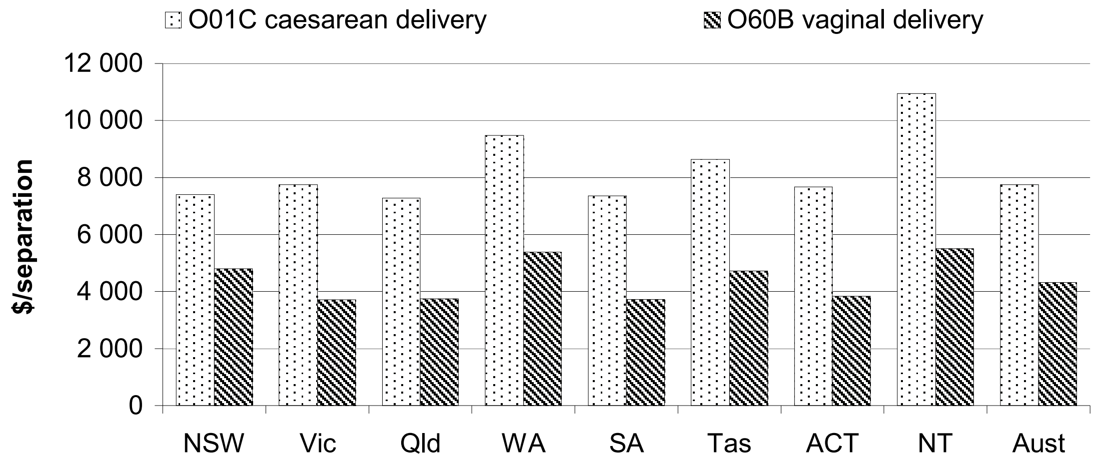
'Recurrent cost per maternity separation' is presented for the two AR-DRGs (version 5.1) that account for the largest number of maternity patient days: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications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

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

Data reported for this indicator are not directly comparable.

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

Figure 10.29 **Estimated average cost per separation for selected maternity related AR-DRGs, public hospitals, 2007-08**[a, b]



---

[a] Includes AR-DRG O01C caesarean delivery without catastrophic or severe complications and comorbidities and AR-DRG O60B vaginal delivery without catastrophic or severe complications and comorbidities. [b] Average cost is affected by a number of factors including admission practices, sample size, remoteness and the types of hospital contributing to the collection. Direct comparisons between jurisdictions are difficult because there are differences in hospital costing systems.

Source: DoHA (2009), *National Hospital Cost Data Collection Cost Report, Round 12 (2007-08)*; table 10A.100.

Total cost per maternity separation

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

Box 10.26 **Total cost per maternity separation**

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

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

Mother's average length of stay

'Mother's average length of stay' is an indicator of governments' objective to deliver services efficiently (box 10.27).

Box 10.27 **Mother's average length of stay**

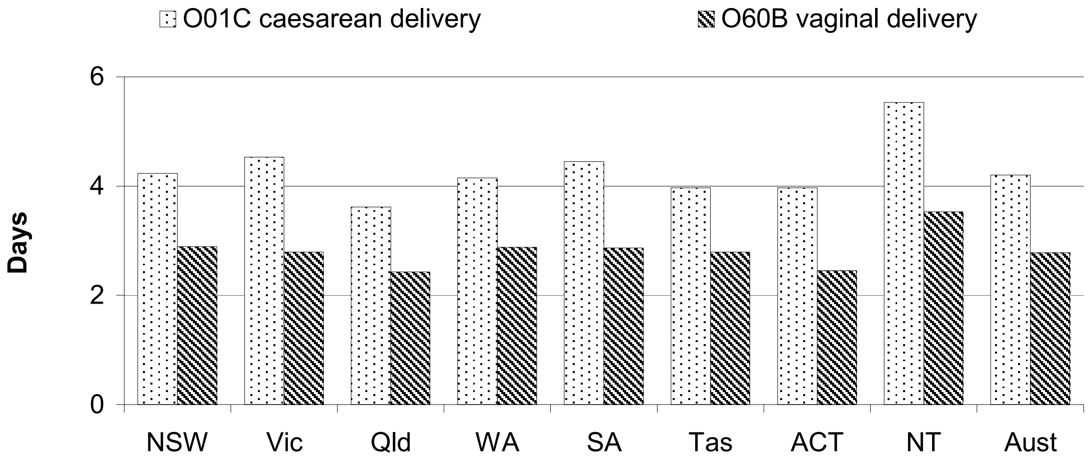
'Mother's average length of stay' is defined as the total number of patient days for the selected maternity AR-DRG (version 5.1), divided by the number of separations for that AR-DRG.

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

Data reported for this indicator are not directly comparable.

Data are reported for the two most common maternity AR-DRGs: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities (figure 10.30).

Figure 10.30 **Average length of stay for selected maternity-related AR-DRGs, public hospitals, 2007-08**[a]



---

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

Source: DoHA (2009), *National Hospital Cost Data Collection Cost Report, Round 12 (2007-08)*; table 10A.100.

Outcomes

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

Apgar score

‘Apgar score at five minutes’ is an indicator of governments’ objective to deliver maternity services that are safe and of high quality (box 10.28).

Box 10.28 **Apgar score at five minutes**

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

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

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

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

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

‘Low’ Apgar scores for babies by birthweight category are contained in table 10.19. The range of Apgar scores for 2004 to 2008 are reported in table 10A.101.

Table 10.19 Live births with an Apgar score of 3 or lower, 5 minutes post-delivery, public hospitals, 2008

Birthweight (grams)	*Unit*	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[a]	*NT*
Less than 1500	no.	849	584	562	297	204	na	66	47
Low Apgar	%	20.1	15.8	16.0	8.8	15.7	–	15.2	21.3
1500-1999	no.	1 052	626	600	332	240	na	72	43
Low Apgar	%	1.1	0.7	1.5	0.9	0.8	–	np	2.3
2000-2499	no.	2 880	1 914	1 703	817	605	na	158	185
Low Apgar	%	0.7	0.3	0.5	0.7	0.3	–	–	–
2500 and over	no.	67 810	46 496	39 328	16 366	13 402	na	3 353	2 742
Low Apgar	%	0.1	0.1	0.1	0.1	0.1	–	0.4	0.2

[a] ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2008, 15.7 per cent of women who gave birth in the ACT were not ACT residents. **na** Not available. **np** Not published. – Nil or rounded to zero.

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

Fetal death rate

'Fetal death rate' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.29).

Box 10.29 **Fetal death rate**

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

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

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

(Continued on next page)

Box 10.29 **(Continued)**

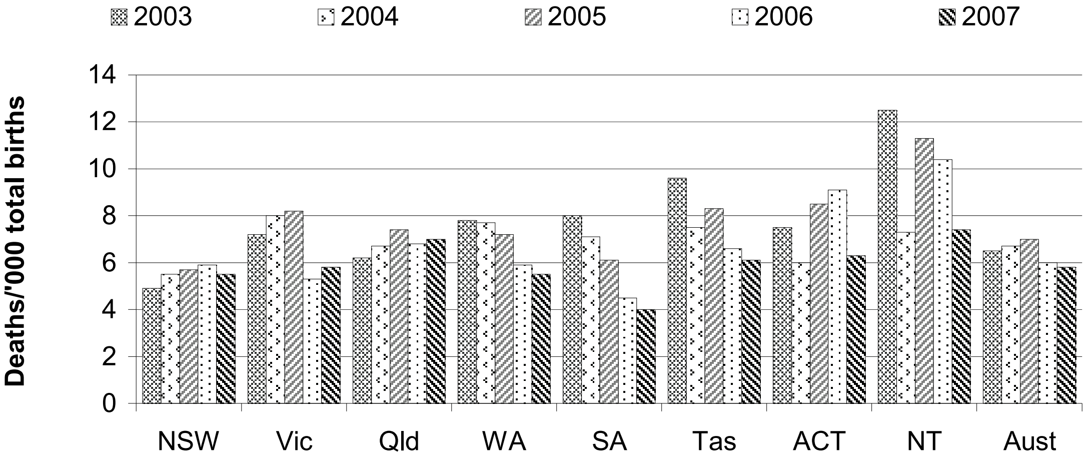
Low fetal death rates can indicate high quality maternity services. In jurisdictions where the number of fetal deaths is low, small annual fluctuations in the number affect the annual rate of fetal deaths.

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 can have an influence include outpatient services, general practice services and maternity services.

Data reported for this indicator are comparable.

Fetal death rates are reported in figure 10.31. Nationally, fetal death rates remained reasonably stable over the period 2003–2007. National time series for fetal death rates for the period 1995 to 2007 are included in table 10A.104. Fetal deaths rates by the Indigenous status of the mother are shown in figure 10.34.

Figure 10.31 **Fetal death rate**[a,]



---

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

Source: ABS (unpublished*) Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.102.

Neonatal death rate

'Neonatal death rate' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.30).

Box 10.30 **Neonatal death rate**

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

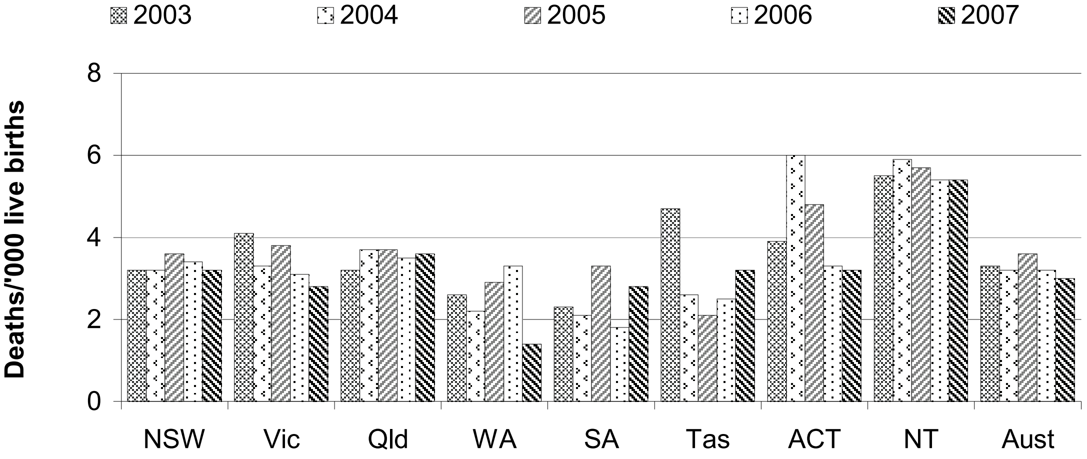
The 'neonatal death rate' is calculated as the number of neonatal deaths divided by the number of live births registered. The rate of neonatal deaths is expressed per 1000 live births, by state or territory of usual residence of the mother. This indicator is also reported by the Indigenous status of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

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

Data reported for this indicator are comparable.

Neonatal death rates are reported in figure 10.32. Nationally, neonatal death rates have been reasonably steady over the period 2003–2007. National time series for neonatal death rates for the period 1995 to 2007 are included in table 10A.104. Neonatal death rates by the Indigenous status of the mother are shown in figure 10.34.

Figure 10.32 **Neonatal death rate**[a]



---

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

Source: ABS (unpublished*) Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.103.

Perinatal death rate

'Perinatal death rate' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.31).

Box 10.31 **Perinatal death rate**

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

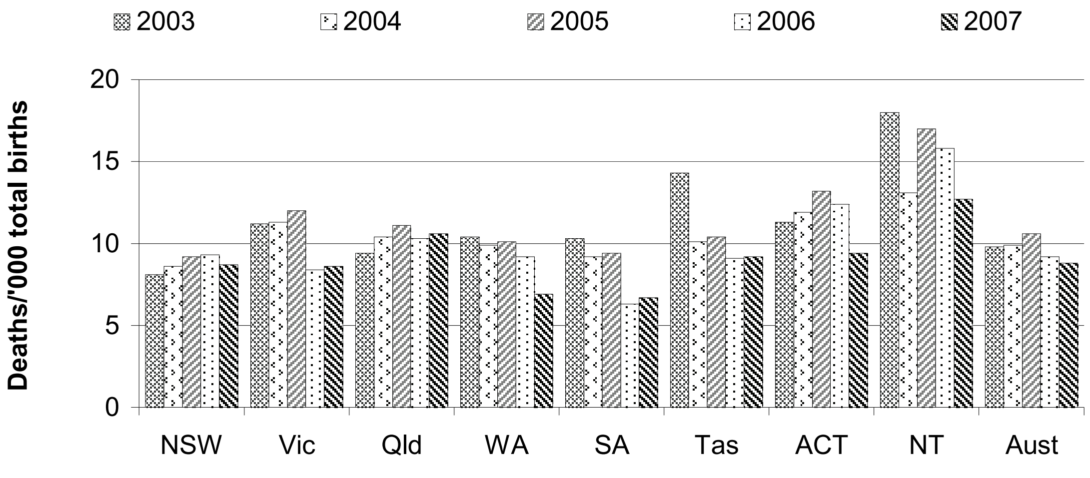
The 'perinatal death rate' is calculated as the number of perinatal deaths divided by the total number of births (live births registered and fetal deaths combined) in each jurisdiction. It is expressed per 1000 total births. This indicator is also reported by the Indigenous status of the mother.

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

Data reported for this indicator are comparable.

Perinatal death rates are shown in figure 10.33. Perinatal death rates by the Indigenous status of the mother are shown in figure 10.34. National time series for perinatal death rates for the period 1995 to 2007 are included in table 10A.104.

Figure 10.33 **Perinatal death rate**[a]



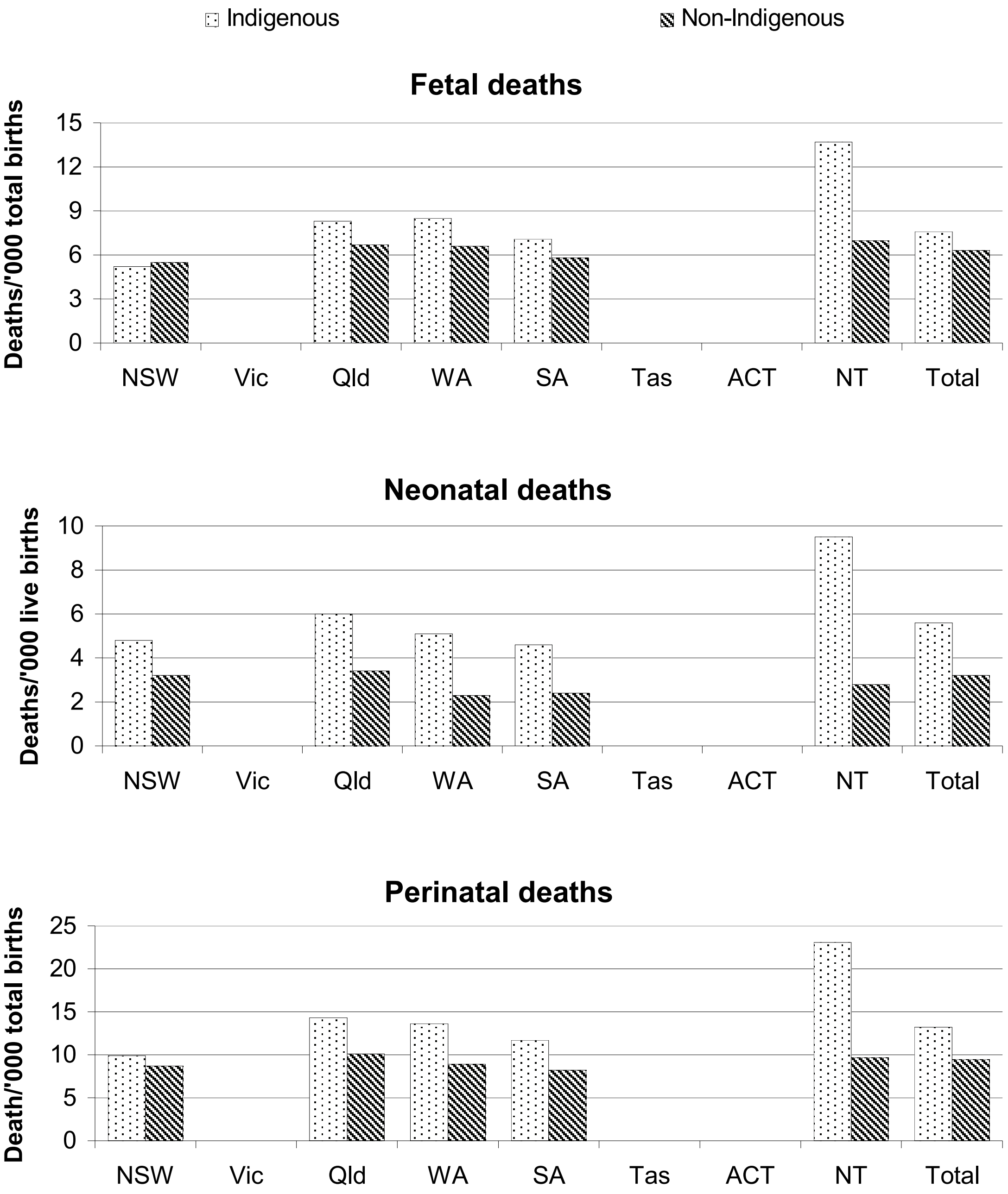
[a] Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of perinatal deaths.

Source: ABS (unpublished*) Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.105.

Fetal, neonatal and perinatal deaths for Indigenous people

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

Figure 10.34 **Fetal, neonatal and perinatal deaths, by Indigenous status of mother 2003–2007**[a]



---

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

Source: ABS (unpublished*) Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.106.

Gestation standardised perinatal mortality ratio

The Steering Committee has identified Gestation standardised perinatal mortality ratio an indicator of the outcomes of maternity services (box 10.32).

Box 10.32 **Gestation standardised perinatal mortality ratio**

This measure of perinatal mortality (box 10.31) is standardised according to gestational age. It excludes infants less than 20 weeks gestation or where gestation is unknown, weighing less than 400 grams, terminations of pregnancy and deaths due to congenital malformations (DHS 2007). This indicator has been identified for development and reporting in the future. Data were not available for the 2010 Report.

10.7 Future directions in performance reporting

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

- Improving the comprehensiveness of reporting by filling in gaps in the performance indicator frameworks. Important gaps in reporting for public hospitals include indicators of equity of access to services for special needs groups (particularly Indigenous people), and indicators of continuity of care. Gaps in the maternity services framework include equity of access, effectiveness of access, three aspects of quality — responsiveness, capability and continuity — and the effectiveness subdimension of sustainability.
- Improving currently reported indicators for public hospitals and maternity services where data are not complete or not directly comparable. There is scope to improve reporting of the quality and access dimensions of the public hospitals framework, and the output indicators for maternity services.
- Improving the reporting of elective surgery waiting times by urgency category in order to achieve greater comparability across jurisdictions in assessing the extent to which patients are seen within a clinically desirable period.
- Improving the reporting of hospital accreditation in order to provide more meaningful comparative information about the capability of public hospitals across jurisdictions. The ACSQHC is currently undertaking a review of safety and quality accreditation standards in Australia with a view to recommending an alternative model for accreditation including a national set of health standards by which health services would be assessed. The outcomes of the review may inform options for future reporting in this area.

COAG developments

Report on Government Services alignment with National Agreement reporting

It is anticipated that future editions of the Health chapters and preface will align with applicable National Agreement indicators, including the NIRA. Further alignment between the Report and National Agreement indicators, and other reporting changes, might result from future developments in National Agreement and National Partnership reporting.

Outcomes from review of Report on Government Services

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the Intergovernmental Agreement on Federal Financial Relations.

No significant changes from this review are reflected in the 2010 Report. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 Report.

10.8 Definitions of key terms and indicators

Accreditation	Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals can seek accreditation through the ACHS Evaluation and Quality Improvement Program, the Australian Quality Council (now known as Business Excellence Australia), the Quality Improvement Council, the International Organisation for Standardization 9000 Quality Management System or other equivalent programs.
Acute care	Clinical services provided to admitted or non-admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.
Admitted patient	A patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients can receive acute, sub-acute or non-acute care services.
Admitted patient cost proportion	The ratio of admitted patient costs to total hospital costs, also known as the inpatient fraction.
Allied health (non-admitted)	Occasions of service to non-admitted patients at units/clinics providing treatment/counselling to patients. These include units providing physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy.
Apgar score	Numerical score used to evaluate a baby's condition after birth. The definition of the reported indicator is the number of babies born with an Apgar score of 3 or lower at 5 minutes post delivery, as a proportion of the total number of babies born. Excludes fetal deaths in utero before commencement of labour.
AR-DRG	Australian Refined Diagnosis Related Group - a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 5.1 is based on the ICD-10-AM classification.
Average length of stay	The mean length of stay for all patient episodes, calculated by dividing total occupied bed days by total episodes of care.
Caesarean section	Operative birth through an abdominal incision.
Casemix adjusted	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted by AR-DRG into categories of patients with similar clinical conditions and requiring similar hospital services. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.
Casemix adjusted separations	The number of separations adjusted to account for differences across hospitals in the complexity of episodes of care.
Catastrophic	An acute or prolonged illness usually considered to be life threatening or with the threat of serious residual disability. Treatment can 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 can include services for specific populations, such as women’s health or Indigenous health.
ICD-10-AM	The Australian modification of the International Standard Classification of Diseases and Related Health Problems. This is the current classification of diagnoses and procedures in Australia.
Inpatient fraction	The ratio of admitted patient costs to total hospital costs, also known as the admitted patient cost proportion.
Labour cost per casemix-adjusted separation	Salary and wages plus visiting medical officer payments, multiplied by the inpatient fraction, divided by the number of casemix-adjusted separations.
Length of stay	The period from admission to separation less any days spent away from the hospital (leave days).
Live birth	Birth of a child who, after delivery, breathes or shows any other evidence of life, such as a heartbeat. Includes all registered live births regardless of birthweight.
Medicare	Australian Government funding of private medical and optometrical services (under the Medicare Benefits Schedule). Sometimes defined to include other forms of Australian Government funding such as subsidisation of selected pharmaceuticals (under the Pharmaceutical Benefits Scheme) and public hospital funding

	(under the Australian Health Care Agreements), which provides public hospital services free of charge to public patients.
Mortality rate	The number of deaths per 100 000 people.
Neonatal death	Death of a live born infant within 28 days of birth. Defined in Australia as the death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Neonatal death rate	Neonatal deaths divided by the number of live births registered.
Nursing workforce	Registered and enrolled nurses who are employed in nursing, on extended leave or looking for work in nursing.
Medical practitioner workforce	Registered medical practitioners who are employed as medical practitioners, on extended leave or looking for work as a medical practitioner.
Non-acute episode of care	Clinical services provided to admitted and non-admitted patients, including planned geriatric respite, palliative care, geriatric evaluation and management and services for nursing home type patients. Clinical services delivery by designated psychiatric or psychogeriatric units, designated rehabilitation units and mothercraft services are also considered non-acute.
Non-admitted occasions of service	Occasion of examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service establishment. Services can include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.
Non-admitted patient	A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.
Perinatal death	Fetal death or neonatal death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Perinatal death rate	Perinatal deaths divided by the total number of births (that is, live births registered and fetal deaths combined).
Perineal laceration (third or fourth degree)	A ‘third degree’ laceration or rupture during birth (or a tear following episiotomy) involves the anal sphincter, rectovaginal septum and sphincter NOS. A ‘fourth degree’ laceration, rupture or tear also involves the anal mucosa and rectal mucosa (NCCH 2008).
Perineal status	The state of the perineum following a birth.
Pre-anaesthetic consultation rate	The number of procedures where there is documented evidence that the patient has seen an anaesthetist before entering the operating theatre suite, anaesthetic room, or procedure room as a percentage of the total number of procedures with an anaesthetist in attendance (ACHS 2004).
Primary care	Essential healthcare based on practical, scientifically sound and socially acceptable methods made universally accessible to individuals and families in the community.
Primipara	Pregnant woman who has had no previous pregnancy resulting in a live birth or a still birth.

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

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

10.9 Attachment tables

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

Table 10A.16 Separations, by type of episode of care, public hospitals (including psychiatric), 2007-08

Table 10A.17 Australian refined diagnosis related groups (AR-DRGs) version 5.1 with the highest number of overnight acute separations, public hospitals, 2007-08

Table 10A.18 Top 10 AR-DRGs (version 5.1) with the most patient days, excluding same day separations, public hospitals, 2007-08

Table 10A.19 Non-admitted patient occasions of service, by type of non-admitted patient care, public hospitals, 2007-08

Table 10A.20 Emergency department waiting times, by triage category, public hospitals, 2007-08

Table 10A.21 Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals

Table 10A.22 Elective surgery waiting times, by specialty of surgeon

Table 10A.23 Elective surgery waiting times, by indicator procedure

Table 10A.24 NSW elective surgery waiting times by clinical urgency category, public hospitals (per cent)

Table 10A.25 NSW elective surgery waiting times, public hospitals, by specialty, 2007-08

Table 10A.26 Victorian elective surgery waiting times by clinical urgency category, public hospitals (per cent)

Table 10A.27 Victorian elective surgery waiting times, public hospitals, by specialty, 2007-08

Table 10A.28 Queensland elective surgery waiting times, by clinical urgency category, public hospitals (per cent)

Table 10A.29 Queensland elective surgery waiting times, public hospitals, by specialty, 2007-08

Table 10A.30 WA elective surgery waiting times, by clinical urgency category, public hospitals (per cent)

Table 10A.31 WA elective surgery waiting times, public hospitals, by specialty, 2007-08

Table 10A.32 SA elective surgery waiting times, by clinical urgency category, public

10.10 References

ABS (Australian Bureau of Statistics) 2004, *Deaths, Australia 2003*, Cat. no. 3302.0, Canberra.

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.

—— 2004, *ACHS Clinical Indicator Users' Manual 2005*, Sydney, NSW.

—— 2007, *Clinical Indicator Report for Australia and New Zealand 1998-2005: Determining the Potential to Improve Quality of Care 7th Edition*, Ultimo, NSW.

AHMAC (Australian Health Ministers' Advisory Council) 2006, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2006*, AHMAC, Canberra.

AIHW (Australian Institute of Health and Welfare) 2000, 2001, 2006, 2009a, *Australian Hospital Statistics*, Cat. nos HSE 11, 14, 41 and 71, AIHW, Canberra.

—— 2005, *Improving the Quality of Indigenous Identification in Hospital Separations Data*, AIHW Cat. no. HSE 101, Canberra.

—— 2008 METeOR AIUHW Metadata Online Registry http://meteor.aihw.gov.au/content/index.phtml/itemId/181162 (accessed 12 November 2008).

—— 2009b, *Health expenditure Australia 2007–08*, AIHW Cat. no. HWE 37, Health and Welfare Expenditure Series No.30, Canberra.

AIHW (Australian Institute of Health and Welfare) and ACSQHC (Australian Commission on Safety and Quality in Health Care 2007). *Sentinel events in Australian public hospitals 2004–05*. Cat. no. HSE. 51 Canberra: AIHW.

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.

DoHA (Department of Health and Ageing) 2006, *National Hospital Cost Data Collection Cost Report, Round 9 (2004-05)*, Australian Government, Canberra.

—— 2009, *National Hospital Cost Data Collection Cost Report, Round 12 (2007-08)*, Australian Government, Canberra.

DHS (Department of Human Services) 2004, *Sentinel events program: Annual Report 2003-04*, Victorian Government, Melbourne.

—— 2007, *Victorian Maternity Services Performance Indicators: Complete Set 2005-06*, Victorian Government, Melbourne.

HDSC (Health Data Standards Committee) 2008, *National health data dictionary. Version 14.* Cat. no. HWI 101. AIHW, 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 Hilder L., 2008, Australia's Mothers and Babies 2006, AIHW Cat. No. PER 46, AIHW National Perinatal Statistics Unit (Perinatal Statistics Series No. 22), Sydney.

National Health Performance Committee 2004, *National Report On Health Sector Performance Indicators 2003*, AIHW Cat. no. HWI 78, Australian Institute of Health and Welfare: Canberra.

NCCH (National Centre for Classification in Health) 2008, *The International Statistical Classification of Diseases and Related Health Problems, 10th Revision*, Australian Modification, 6th edition (ICD-10-AM), Sydney.

NSW Department of Health 2005, *Patient Safety and Clinical Quality Program, First Report on Incident Management in the NSW Public Health System 2003-2004*, North Sydney.

Pearse 2005, *Review of patient satisfaction and experience surveys conducted for public hospitals in Australia*, A Research Paper for the Steering Committee for the Review of Government Service Provision, prepared by Jim Pearse, Health Policy Analysis Pty Ltd.

Runciman, W., Webb, R., Helps, S., Thomas, E, Sexton, E., Studdert, D., and Brennan, T. 2000, 'A comparison of iatrogenic injury studies in Australia and the USA. II: reviewer behaviour and quality of care', *International Journal for Quality Health Care*; vol. 12, pp.379–88.

Runciman W. and Moller J. 2001, *Iatrogenic Injury in Australia*, A report prepared by the Australian Patient Safety Foundation. Australian Patient for the National Health Priorities and Quality Branch of the Department of Health and Aged Care of the Commonwealth Government of Australia, http://www.apsf.net.au/dbfiles/Iatrogenic_Injury.pdf (accessed 20 April 2006).

Runciman W. 2006, The Safety and Quality of Health Care: Where Are We Now?, *Medical Journal of Australia*; vol. 184, no. 10: S41-S43.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2001, *Asset Measurement in the Costing of Government Services*, 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.

11 Primary and community health

CONTENTS

Attachment tables

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

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

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

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

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

- The objectives have been revised to better reflect current understanding of primary and community health (box 11.1).
- Three previously separate indicators have been combined into a single indicator, ‘potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions’, consistent with other current national reporting conventions.

11.1 Profile of primary and community health

Definitions, roles and responsibilities

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

General practice

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

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

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

Services provided in general practice include:

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

Definitions for common health terms are provided in section 11.5.

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

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

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

The Australian Government subsidises the cost of around 80 per cent of prescription medicines through the PBS (DoHA 2009a). The PBS aims to provide affordable, reliable and timely access to prescription medicines for all Australians. Users make a co-payment, currently $5.30 for concession card holders and $32.90 for general consumers. The Australian Government pays the remaining cost of medicines that are eligible for the subsidy. Co-payment amounts are normally adjusted by the rate of inflation on 1 January each year.

Co-payments are also subject to a safety net threshold. Once consumer spending within a calendar year has reached the threshold, PBS medicines are generally cheaper or fully subsidised for the rest of the calendar year. The 2009 safety net threshold was $1264.90 for general consumers and $318.00 for concession card holders (DoHA 2009b).

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

Community health services

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

Allied health services

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

Dental services

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

Funding

General practice

The Australian Government funds the majority of general practice services, primarily through Medicare and the DVA. The annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia found that 95.2 per cent of all encounters with GPs in 2008-09 were for services at least partly funded by Medicare or the DVA (Britt *et al*. 2009) (table 11.1).

Table 11.1 **GP encounters, by source of funding, 2008-09**[a, b, c]

	Number[d]	*Per cent of all encounters*[e]	*95% LCL*	*95% UCL*
GPs participating in the BEACH survey	1011	..	..	..
Total encounters for which BEACH data were recorded	96 688	100.0	..	..
Encounters with missing data	6 197	..	..	..
Direct encounters	89 185	98.6	98.3	98.8
No charge	424	0.5	0.4	0.6
Medicare paid[f]	86 118	95.2	94.8	95.6
Workers compensation paid	1 950	2.2	2.0	2.3
Other paid (for example, hospital, State)	707	0.8	0.5	1.0
Indirect encounters[g]	1 303	1.4	1.2	1.7

LCL = lower confidence limit. UCL = upper confidence limit. [a] April 2008 to March 2009. [b] An 'encounter' is any professional interchange between a patient and a GP (Britt *et al*. 2009). [c] Data from the BEACH survey may not be directly comparable with the other data on medical practitioners that are reported in this chapter. [d] Number of encounters after post stratification weighting for GP activity and GP age and sex. [e] Missing data removed. [f] Includes Australian Government payments made through the DVA. [g] Indirect encounters are encounters at which the patient is not seen by the GP but a service is provided (for example, a prescription or referral). .. Not applicable.

Source: Britt *et al*. (2009) *General practice activity in Australia 2008-09*, Cat. no. GEP 25; table 11A.1.

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

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

Australian Government expenditure on general practice in 2008-09 was $5.8 billion, or $269 per person (figure 11.26).

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

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

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on the PBS and RPBS was around $7.0 billion, or $325 per person, in 2008-09. Expenditure on the PBS was around $6.6 billion in 2008-09, of which 77.9 per cent was for concessional patients (table 11.2). Government expenditure on pharmaceuticals data are also presented in the Health preface.

Table 11.2 **PBS and RPBS expenditure, 2008-09 ($ million)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[b]	479.4	341.7	287.8	155.2	105.5	30.7	29.1	8.5	1 437.8
PBS concessional[c]	1 791.3	1 285.5	963.8	423.6	448.3	146.7	51.2	15.2	5 125.6
PBS doctor's bag	5.0	3.5	3.3	1.1	1.1	0.3	0.2	0.1	14.5
PBS total	2 275.7	1 630.7	1 254.9	579.8	554.9	177.7	80.5	23.8	6 577.9
RPBS total[d]	164.2	98.0	106.1	36.8	35.7	13.9	7.1	0.9	462.7
Total	**2 439.9**	**1 728.6**	**1 361.0**	**616.6**	**590.6**	**191.6**	**87.6**	**24.7**	**7 040.6**
$ per person	346.5	322.2	312.9	279.8	366.4	383.0	251.8	111.2	325.3

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

Source: DoHA (unpublished) PBS data collection.

Community health services

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

In 2007-08, government expenditure on community and public health was $7.0 billion, of which State, Territory and local governments provided 71.5 per cent, and the Australian Government 28.5 per cent (table 11.3). Australian Government direct outlay expenditure on dental services, predominantly through the DVA and DoHA, was $222 million in 2007-08. State, Territory and local government expenditure on dental services in 2007-08 was $580 million. Additional expenditure is incurred by some states and territories through schemes that fund the provision of dental services to eligible people by private practitioners.

Table 11.3 **Estimated funding on community and public health, and dental services, 2007-08 ($ million)**

	Australian Government							
	DVA	*DoHA and other*[a]	*Insurance premium rebates*[b]	*Total*[c]	*State, Territory and local government*	*Total government*	*Non-government*	*Total government and non-government*
Community and public health[d]	2	1 996	1	1 998	5 009	7 008	451	7 459
Dental services	108	114	423	645	580	1 225	4 881	6 106

[a] 'Other' comprises Australian Government expenditure on capital consumption and health research not funded by DoHA. [b] Government expenditure on insurance premium rebates relates to private health and dental services that are not within the scope of this chapter. [c] Totals may not add due to rounding. [d] Includes expenditure on other recurrent health services (not elsewhere classified) in addition to expenditure on community and public health services.

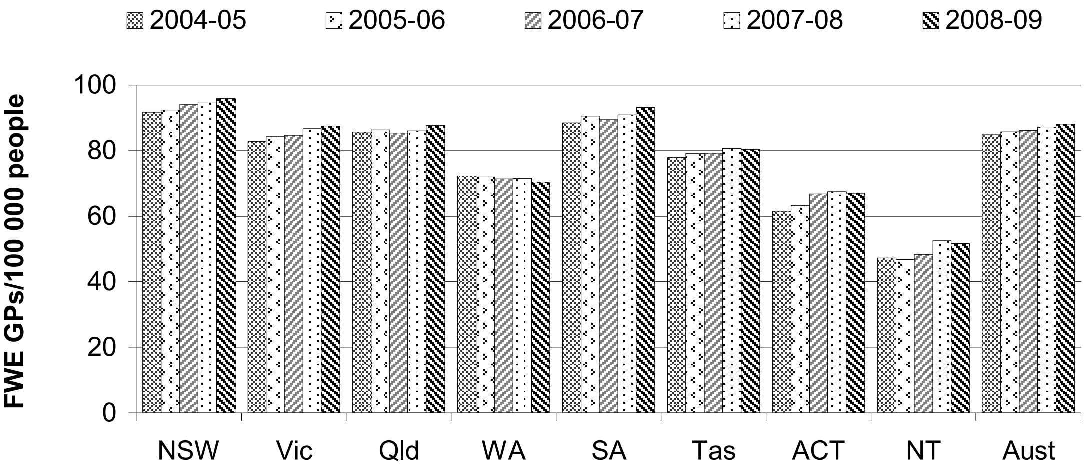
Source: AIHW (2009) *Health Expenditure Australia 2007-08*, Cat. no. HWE 46.

Size and scope

General practice

There were 25 726 vocationally recognised GPs and OMPs billing Medicare in Australia in 2008-09. On a full time workload equivalent (FWE) basis, there were 19 231 vocationally recognised GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 88.1 FWE recognised GPs and OMPs per 100 000 people (table 11A.3). These data exclude services provided by GPs working with the Royal Flying Doctor Service and GPs working in Indigenous primary healthcare services and public hospitals. In addition, the data are based on Medicare claims, which for some GPs (particularly in rural areas) pay for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid through Medicare. The numbers of FWE vocationally recognised GPs and OMPs per 100 000 people across jurisdictions are shown in figure 11.1.

Figure 11.1 **Availability of GPs (full time workload equivalent)**[a]



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

Source: DoHA (unpublished) MBS data collection; table 11A.3.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

There were around 196 million services provided under the PBS and RPBS in 2008-09, amounting to 9.1 prescriptions per person. There were around 182 million services provided under the PBS in 2008-09, of which 85.3 per cent were concessional (table 11.4).

Table 11.4 **PBS and RPBS services, 2008-09 (million services)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[a]	8.8	6.3	5.3	2.7	1.9	0.6	0.6	0.2	26.3
PBS concessional[b]	53.2	39.8	29.5	12.8	13.4	4.5	1.4	0.5	155.1
PBS doctor's bag	0.1	0.1	0.1	–	–	–	–	–	0.4
PBS total	62.1	46.2	34.9	15.6	15.3	5.1	2.0	0.6	181.8
RPBS total[c]	4.9	3.2	3.3	1.1	1.1	0.5	0.2	–	14.3
Total	67.1	49.4	38.2	16.7	16.4	5.5	2.2	0.6	196.2
Services per person	9.5	9.2	8.8	7.6	10.2	11.1	6.3	2.9	9.1

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

Source: DoHA (unpublished) PBS data collection.

Community health services

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

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

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

Maternal and child health

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

Public dental services

All jurisdictions provide some form of public dental service for primary school children. Some jurisdictions also provide dental services to secondary school students (tables 11A.52–11A.60).

State and Territory governments also provide some general dental services and a limited range of specialist dental services to disadvantaged adults who are holders of concession cards issued by Centrelink. In some jurisdictions, specialist dental services are provided mainly by qualified dental specialists; in others, they are provided in dental teaching hospitals as part of training programs for dental specialists (National Advisory Committee on Oral Health 2004). Most jurisdictions provided public dental services in 2008-09 targeted at disadvantaged people (tables 11A.52–11A.60).

Alcohol and other drug treatment

Alcohol and other drug treatment activities range from a brief intervention to long term residential treatment. Types of treatment include detoxification, pharmacological treatment (also known as substitution or maintenance treatment), counselling and rehabilitation. The data included here have been sourced from a report on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AIHW 2009a). Treatment activities excluded from that report include treatment with medication for dependence on opioid drugs such as heroin (opioid pharmacotherapy treatment) where no other treatment is provided, the majority of services for Indigenous people that are funded by the Australian Government, treatment services within the correctional system, and treatment units associated with acute care and psychiatric hospitals.

A total of 658 alcohol and other drug treatment services reported 2007-08 data to the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS). Of these, 330 (50.2 per cent) identified as government providers and 328 (49.8 per cent) identified as non-government providers (table 11A.8). All of these non-government providers received some government funding for 2007-08. There were 153 998 reported closed treatment episodes in 2007-08 (see section 11.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use, 67.7 per cent of whom were male, accounted for 147 721 closed treatment episodes (AIHW 2009a).

Alcohol was the most commonly reported principal drug of concern in closed treatment episodes for clients seeking treatment for their own substance abuse (44.5 per cent). Cannabis was the next most common drug of concern (21.6 per cent), followed by opioids (14.5 per cent — heroin accounted for 10.5 per cent) and amphetamines (11.2 per cent) (AIHW 2009a). Further information on alcohol and other drug treatment services funded by governments is included in tables 11A.52–11A.60.

Indigenous community healthcare services

Indigenous Australians use a range of primary healthcare services, including private GPs and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services in all jurisdictions. These services are planned and governed by local Indigenous communities and aim to deliver holistic and culturally appropriate health and health-related services. Funding is provided by Australian, State and Territory governments. In addition to these healthcare services, health programs for Indigenous Australians are funded by a number of jurisdictions. In 2007-08, these programs included services such as health information, promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 11A.52–11A.60).

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

For 2007-08, SAR data are reported for 155 Indigenous primary healthcare services (table 11A.4). Of these services, 56 (36.1 per cent) were located in remote or very remote areas (table 11A.5). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 11A.6). An episode of healthcare is defined in the SAR data collection as contact between an individual client and staff of a service to provide healthcare. Over 1.8 million episodes of healthcare were provided by participating services in 2007-08 (table 11.5). Of these, around 641 000 (34.6 per cent) were in remote or very remote areas (table 11A.5).

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

	NSW and ACT[b]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*Aust*
2003-04	430	169	267	302	142	22	280	1 612
2004-05	415	151	254	274	145	23	323	1 585
2005-06	505	179	240	281	101	29	347	1 681
2006-07	440	173	251	284	114	31	352	1 644
2007-08[c]	420	167	267	306	111	36	543	1 850

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

Source: DoHA (unpublished) SAR data collection.

The services included in the SAR data collection employed 2603 full time equivalent health staff (as at 30 June 2008). Of these, 1496 were Indigenous (57.5 per cent). The proportions of doctors and nurses employed by services surveyed who were Indigenous were relatively low (2.1 per cent and 9.7 per cent, respectively) (table 11A.7).

11.2 Framework of performance indicators

The performance indicator framework is based on the shared government objectives for primary and community health (box 11.1). The framework provides information on equity, effectiveness and efficiency, and distinguishes outputs from outcomes. This approach is consistent with the general performance indicator framework for the 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.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations). The *National Healthcare Agreement* covers the areas of health and aged care services, while the *National Indigenous Reform Agreement* establishes specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. The agreements include sets of performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council.

The measurement details of relevant National Agreement reporting were under development at the time of preparing this Report. It is anticipated that the performance indicator results reported in this chapter will be revised to align with the performance indicators in the National Agreements for the 2011 Report.

Box 11.1 **Objectives for primary and community health**

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

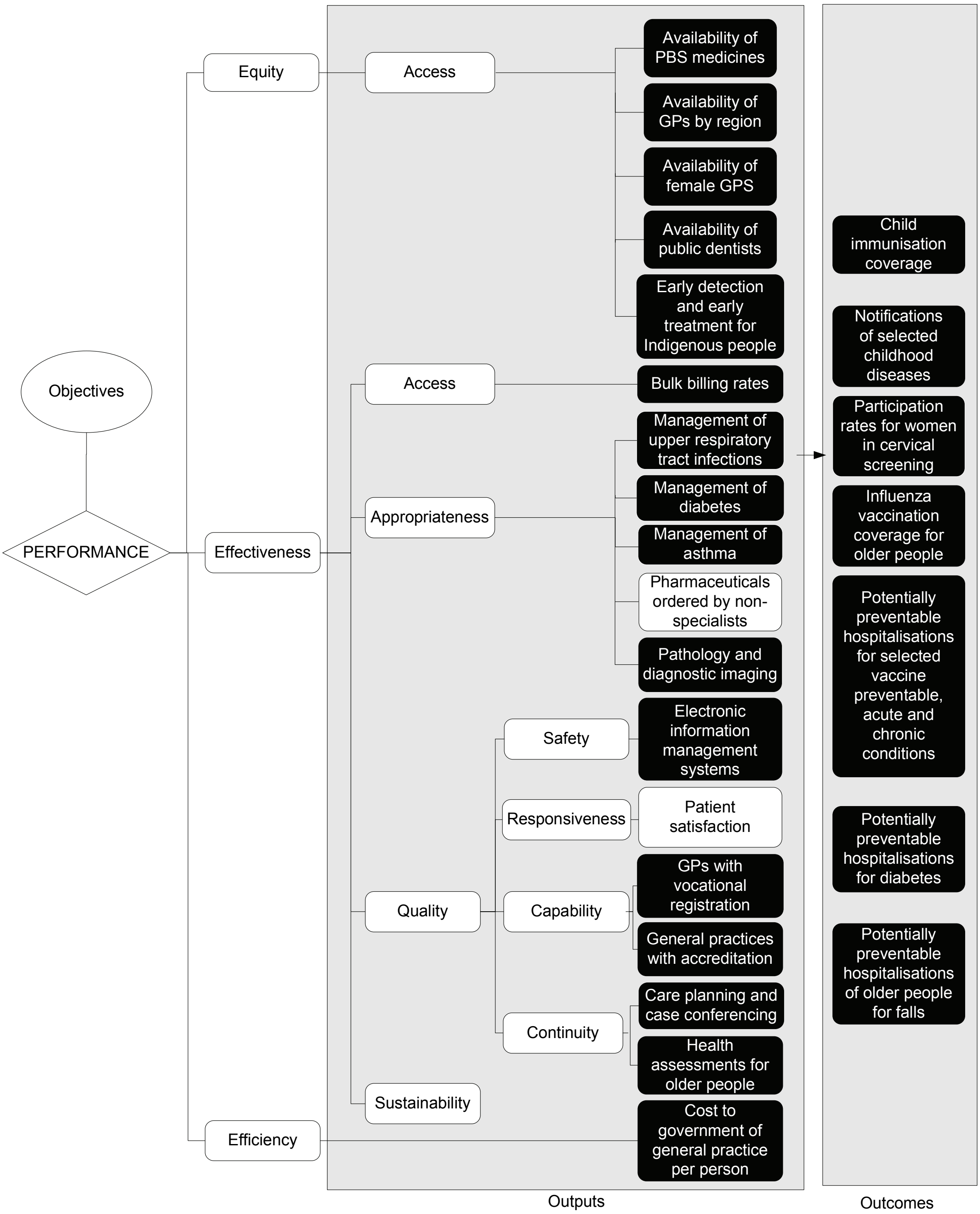
- providing a universally accessible point of entry to the healthcare system
- promoting health and preventing illness
- providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s)
- coordinating service provision to ensure continuity of care where more than one service type, and/or ongoing service provision, is required to meet individuals' healthcare needs.

In addition, governments aim to ensure that interventions provided by primary and community health services are based on best practice evidence and delivered in an equitable and efficient manner.

The performance indicator framework shows which data are comparable in the 2010 Report (figure 11.2). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see section 1.6). The Health preface explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability consistent with the standard Review framework.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 11.2 **Performance indicators for primary and community health**



Key to indicators

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

▨ Text Data for these indicators not complete or not directly comparable

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

11.3 Key performance indicator results

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

Outputs

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

Equity

For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. Access to primary and community health services can be affected through factors such as disability, socioeconomic circumstance, age, geographic distance, cultural issues and English language proficiency (see chapter 1). Such issues have contributed to the generally poor health status of Indigenous people relative to other Australians (see the Health Preface and SCRGSP 2009).

Access

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

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

Availability of PBS medicines

'Availability of PBS medicines' is an indicator of governments' objective to provide equitable access to PBS medicines (box 11.2).

Box 11.2 Availability of PBS medicines

'Availability of PBS medicines' is defined by the following three measures:

- 'People per pharmacy by region', defined as the estimated resident population (ERP), divided by the number of pharmacies, in urban and in rural regions.
- 'PBS expenditure per person by region', defined as expenditure on PBS medicines, divided by the ERP, in urban and in rural regions.
- 'Proportion of PBS prescriptions filled at a concessional rate', defined as the number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled.

Medicines are important in treating illness and can also be important in preventing illness from occurring. The availability of medicines is therefore a significant determinant of people's health and medicines should be available to those who require them, regardless of residential geolocation or socioeconomic circumstance.

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

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

Data for this indicator are comparable.

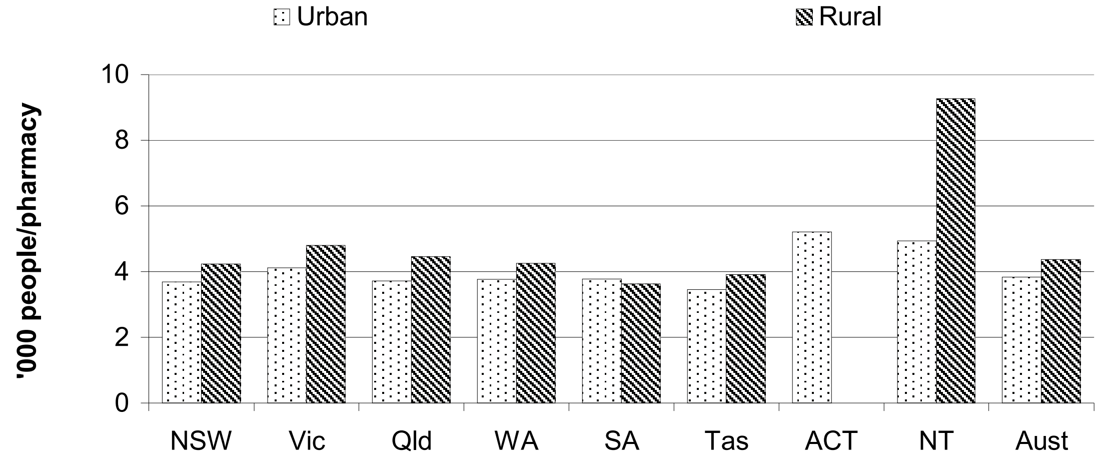
Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, there were 3836 people per pharmacy in urban areas and 4367 in rural areas in 2008-09. In most states and territories, the number of people per pharmacy was higher in rural areas than in urban areas (figure 11.3).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 60 medical practitioners and 250 hospitals — 80 private and 170 public[1] — approved to supply PBS medicines to the community in 2008-09. The medical practitioners as well as 78 of the public hospitals were located in rural areas (table 11A.9).

---

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

Figure 11.3 **People per pharmacy, 2008-09**[a]



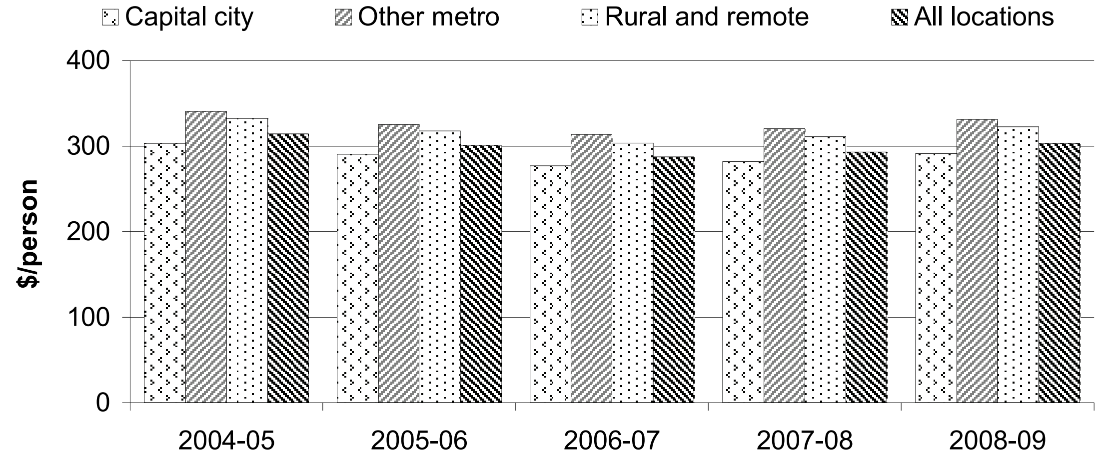
---

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

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

Nationally, PBS expenditure per person increased from $293 in 2007-08 to $303 in 2008-09 (figure 11.4). PBS expenditure per person was higher in rural and remote areas than in capital cities for the period 2004-05 to 2008-09 (in 2008-09 dollars).

Figure 11.4 **PBS expenditure per person (2008-09 dollars)**[a]



---

[a] Locality level data are only available on a cash basis for general and concessional categories. Data are not directly comparable to those published in DoHA’s annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications dispensed under s.100 of the *National Health Act 1953* [Cwlth]).

Source: DoHA (unpublished) PBS data collection; table 11A.11.

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 11A.10. These data are not available by regional location. Nationally, 85.3 per cent of prescriptions subsidised under the PBS were concessional in 2008-09.

Availability of GPs by region

'Availability of GPs by region' is an indicator of governments' objective to provide equitable access to primary healthcare services (box 11.3).

Box 11.3 **Availability of GPs by region**

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

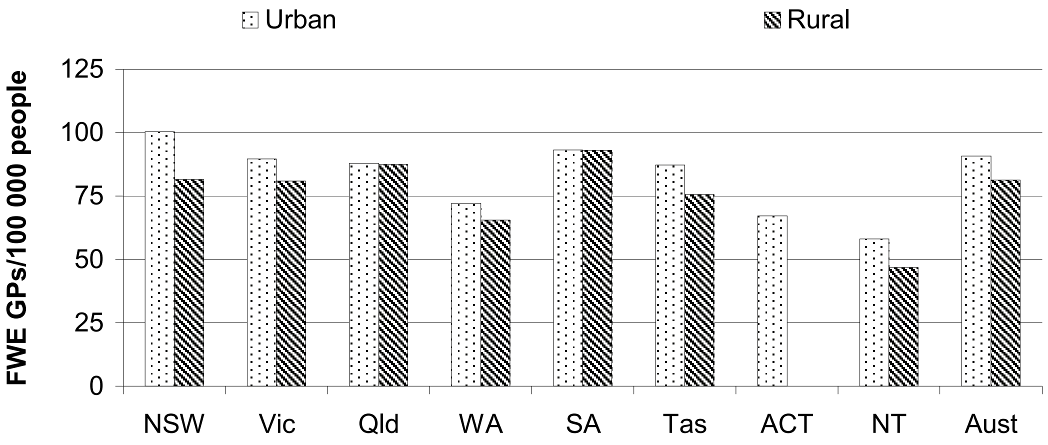
Low availability of GPs can be associated with an increase in distance travelled and waiting times to see a GP, and increased difficulty in booking long consultations. Reduced competition for patients can also reduce bulk billing rates. State and Territory governments seek to influence the availability of GPs through incentives to recruit and retain GPs in rural and remote areas. An increase in the availability of GPs can indicate improved access to GP services.

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

Data for this indicator are comparable.

In terms of FWE GPs per 100 000 people, there were more GPs available in urban areas than in rural areas in almost all states and territories in 2008-09 (figure 11.5). The bulk billed proportion of non-referred attendances was generally lower in rural and remote areas, excepting 'other remote' areas, than in capital cities and 'other metropolitan centres' (table 11A.20).

Figure 11.5 **Availability of GPs (full time workload equivalent), 2008-09**[a, b, c]



---

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

Source: DoHA (unpublished) MBS data collection; table 11A.12.

Availability of female GPs

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

Box 11.4 **Availability of female GPs**

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

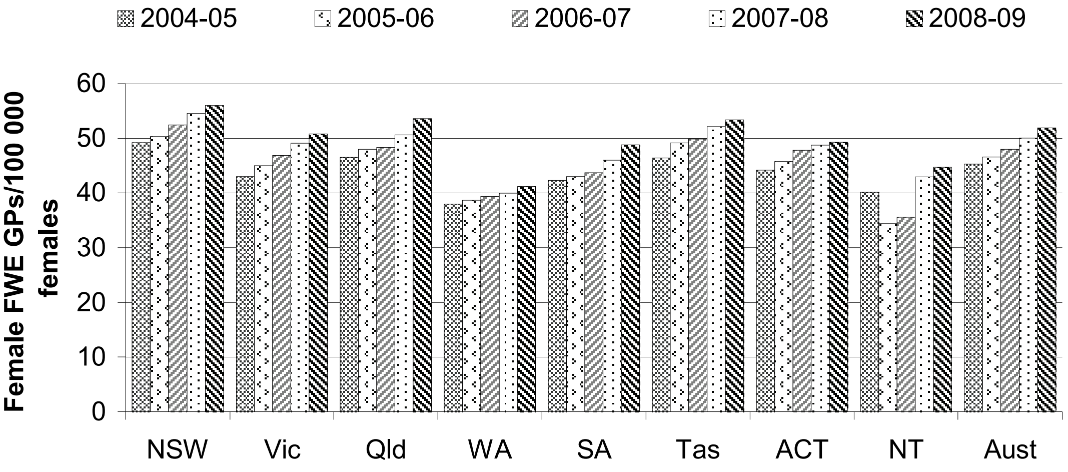
A higher rate means it is more likely that female patients who prefer to visit female GPs will have their preference met.

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

Data for this indicator are comparable.

In 2008-09, 39.5 per cent of Australia's GPs — 29.6 per cent of FWE GPs — were female (tables 11A.3 and 11A.13). The number of FWE GPs per 100 000 females increased from 45.3 to 51.9 in the period 2004-05 to 2008-09 (figure 11.6).

Figure 11.6 **Availability of female GPs (full time workload equivalent)**[a]



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

Source: DoHA (unpublished) MBS data collection; table 11A.13.

Availability of public dentists

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

Box 11.5 **Availability of public dentists**

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

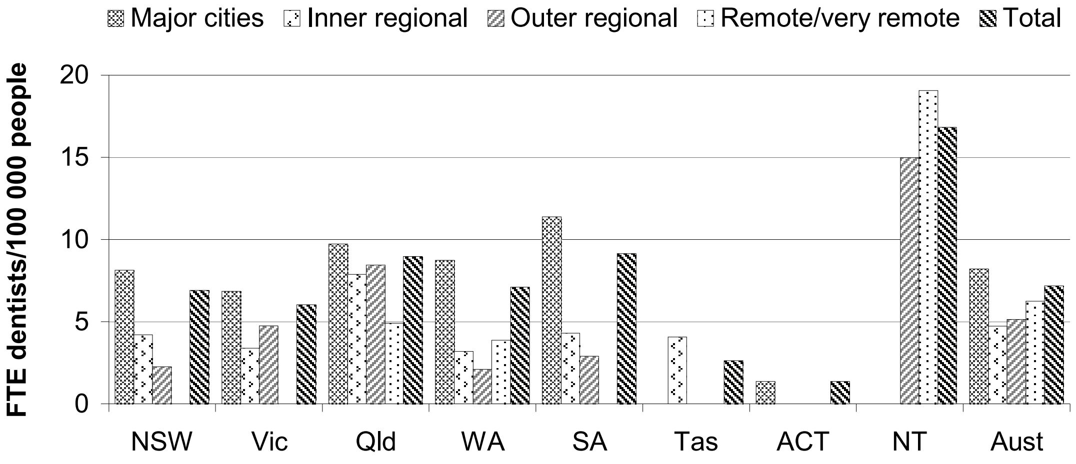
The availability of public dentists by region affects people's access to public dental services, particularly in rural and remote areas. Low availability can result in increased travel distance to a dentist and increased waiting times to see a dentist. An increase in the availability of public dentists indicates improved access to dental services.

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

Data for this indicator are comparable.

Data for 2007 were not available for this indicator. Nationally, there were more FTE public dentists per 100 000 people in major cities than in regional or remote areas in 2006 (figure 11.7, table 11A.14).

Figure 11.7 **Availability of public dentists, 2006**[a, b, c]



---

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

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

Early detection and early treatment for Indigenous people

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

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

'Early detection and early treatment for Indigenous people' is defined by the following four measures:

- Older people who received a voluntary health assessment by Indigenous status, defined as the proportion of older people who received a voluntary health assessment by Indigenous status. Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The relatively young age at which Indigenous people become eligible for 'older' people's services recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health preface).
- Older Indigenous people who received a voluntary health assessment, time series, defined as the proportion of older Indigenous people who received a voluntary health assessment in successive years of a five year period.
- Indigenous people who received a voluntary health assessment or check by age group, defined as the proportion of Indigenous people who received a voluntary health assessment/check, in each of the three age groups for which they are available (0–14 years, 15–54 years and 55 years or over).
- Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services, defined as the proportion of Aboriginal and Torres Strait Islander primary healthcare services that included early detection activities in the services provided.

A reduction in the gap between the proportion of all older people and older Indigenous people that received a health assessment indicates more equitable access to early detection and early treatment services for Indigenous people. An increase over time in the proportion of older Indigenous people who received a voluntary health assessment is desirable as it indicates improved access to these services. A reduction in the gap between the proportion of Indigenous people in different age groups that received a health assessment/check can indicate more equitable access to early detection and treatment services within the Indigenous population. An increase in the proportion of Aboriginal and Torres Strait Islander primary healthcare services that included early detection activities is desirable as it indicates improved access to early detection and treatment services for Indigenous Australians.

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

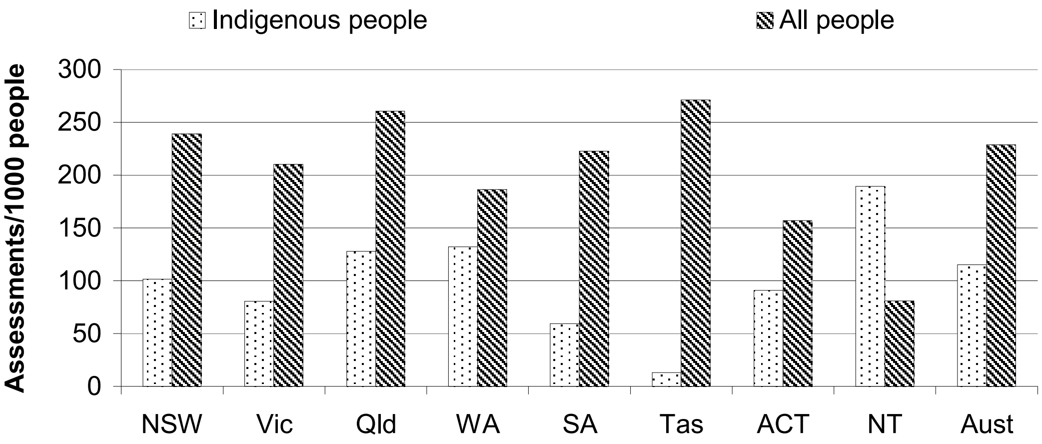
Data for this indicator are comparable.

The high prevalence of preventable and/or treatable health conditions in the Indigenous population is strongly associated with relatively poor health outcomes for Indigenous people (AIHW 2008a; SCRGSP 2009). Early detection and early treatment refers to the identification of individuals who are at high risk for, or in the early stages of, such conditions. Early detection and early treatment services provide opportunities for timely prevention and intervention measures, and their availability and uptake is understood to be a significant determinant of people's health.

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

In 2008-09 the proportion of Indigenous older people who received an annual health assessment was considerably lower than the proportion of all older people who received an annual health assessment (figure 11.8). This suggests that access to early detection and early treatment services may not be equitable.

Figure 11.8 **Older people who received an annual health assessment by Indigenous status, 2008-09**[a, b]



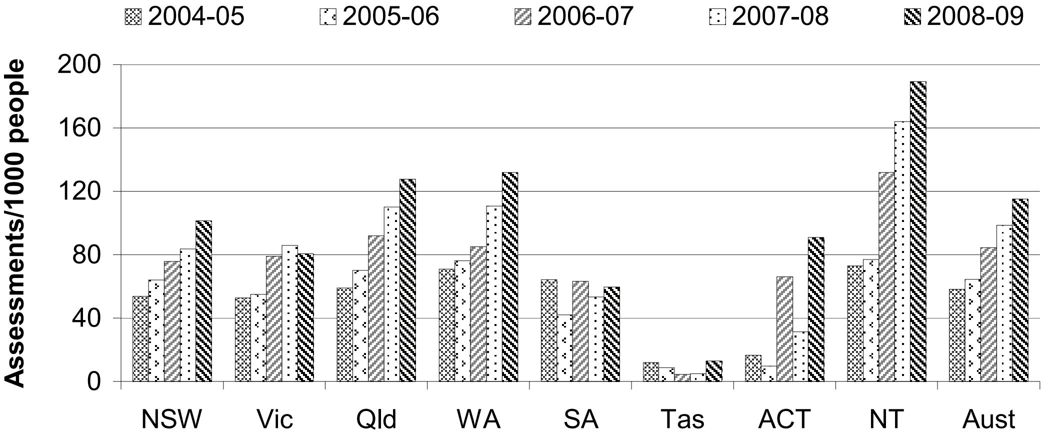
---

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

Source: Derived from DoHA (unpublished) MBS data collection, ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0 and ABS 2009 *Australian demographic statistics March quarter 2009*, Cat. no. 3101.0; table 11A.16.

The proportion of older Indigenous people who received an annual health assessment steadily increased in most jurisdictions between 2004-05 and 2008-09 (figure 11.9). This indicates that access to early detection and early treatment services for this population has improved in these jurisdictions and nationally.

Figure 11.9 **Older Indigenous people who received an annual health assessment**[a, b]



---

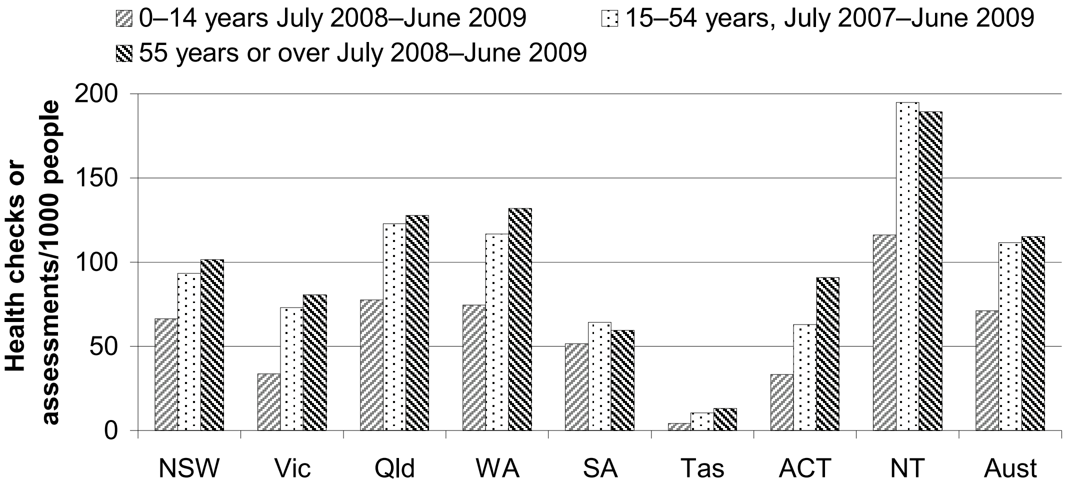
[a] Older people are defined as Indigenous people aged 55 years or over. Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items, although this is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous people. [b] Historical rates in this figure may differ from those in previous Reports, as new ABS Indigenous population estimates and projections have been used following the 2006 Census of Population and Housing.

Source: Derived from DoHA (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.17.

Health check MBS items were introduced for Indigenous people aged 15–54 years in May 2004, and for Indigenous children aged 0–14 years in May 2006. Health checks are available annually for children aged 0–14 years, and biennially for 15–54 year olds.

The proportion of the eligible Indigenous population that received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions (figure 11.10). This can, in part, reflect differences in how long the items have been available, as factors such as awareness and administrative requirements affect the uptake of new MBS items (AIHW 2008a).

Figure 11.10 Indigenous people who received a health check or assessment by age[a, b]



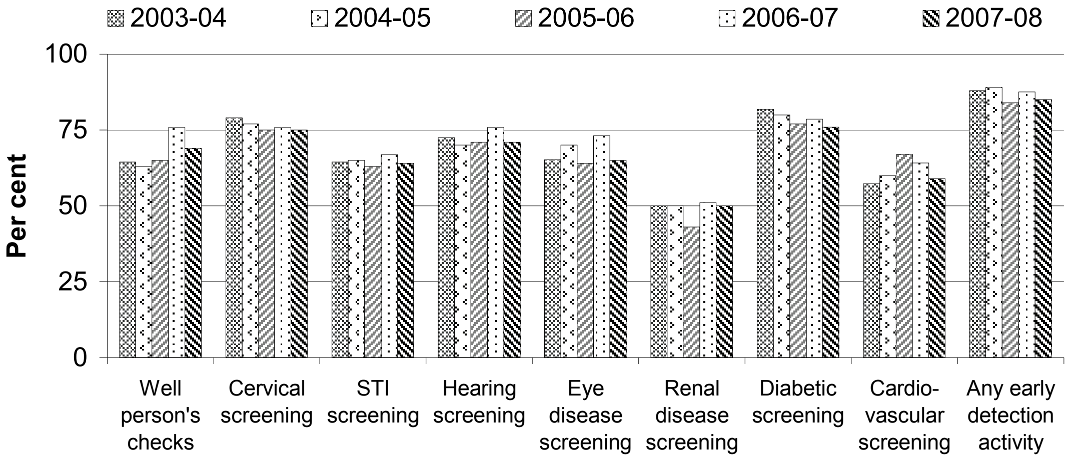
---

[a] Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the ‘all older people’ MBS items, although this is considered unlikely to significantly affect overall proportions due to the relatively low average life expectancy of Indigenous people. [b] Health checks for 0–14 year olds, and health assessments for those aged 55 years or over, are available annually. Data for these age groups are for the period 1 July 2008 to 30 June 2009. Health checks for 15–54 year olds are available biennially, and these data are for the period 1 July 2007 to 30 June 2009.

Source: Derived from DoHA (unpublished) MBS data collection and ABS (2009) *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, Cat. no. 3238.0; table 11A.18.

Figure 11.11 shows the proportion of Indigenous primary healthcare services for which SAR data are reported that provided various early detection services over the five year period to 2007-08.

Figure 11.11 **Indigenous primary healthcare services for which SAR data are reported that provided early detection services**



Source: DoHA (unpublished) SAR data collection; table 11A.19.

Effectiveness

Access

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

Bulk billing rates

‘Bulk billing rates’ is an indicator of governments’ objective to provide affordable access to GP services (box 11.7).

Box 11.7 Bulk billing rates

'Bulk billing rates' is defined as the number of non-referred attendances that were bulk billed as a proportion of all non-referred attendances.

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

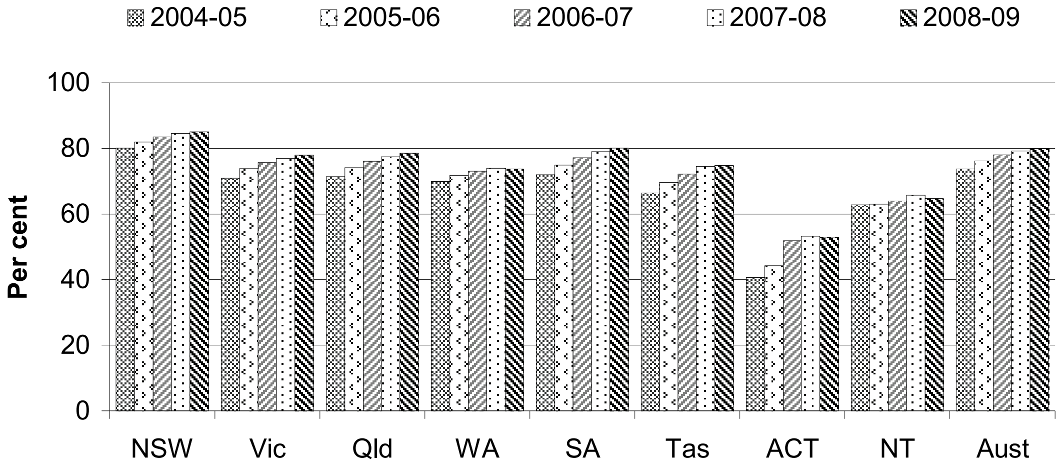
A higher proportion of bulk billed attendances indicates greater affordability of GP services.

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

Data for this indicator are comparable.

Nationally, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 79.9 per cent in 2008-09. For all jurisdictions, this proportion increased in the period 2004-05 to 2008-09 (figure 11.12). The bulk billed proportion of non-referred attendances was highest in capital cities and other remote areas (table 11A.20).

Figure 11.12 **Non-referred attendances that were bulk billed**[a]



[a] Includes attendances by practice nurses.

Source: DoHA (2009) *Medicare Statistics - June Quarter 2009*; table 11A.21.

Appropriateness

Four indicators of the appropriateness of GP services are reported:

- ‘Management of upper respiratory tract infections’
- ‘Management of diabetes’
- ‘Management of asthma’
- ‘Pathology tests and diagnostic imaging ordered by non-specialists’.

Management of upper respiratory tract infections

‘Management of upper respiratory tract infections’ is an indicator of governments’ objective to ensure that antibiotics are used appropriately and effectively (box 11.8).

Box 11.8 **Management of upper respiratory tract infections**

‘Management of upper respiratory tract infections’ is defined as the number of prescriptions for selected antibiotics (those oral antibiotics most commonly prescribed to treat upper respiratory tract infection [URTI]) that are provided to PBS concession card holders, per 1000 PBS concession card holders.

Upper respiratory tract infection (URTI) without complication is most often caused by a virus. Antibiotics have no efficacy in the treatment of viral infections, but are nevertheless frequently prescribed for viral infections. Unnecessarily high rates of antibiotic prescription for URTI have the potential to increase pharmaceutical costs and to increase antibiotic resistance in the community.

A downward trend in the prescription rate can indicate that GPs’ management of URTI more closely follows guidelines.

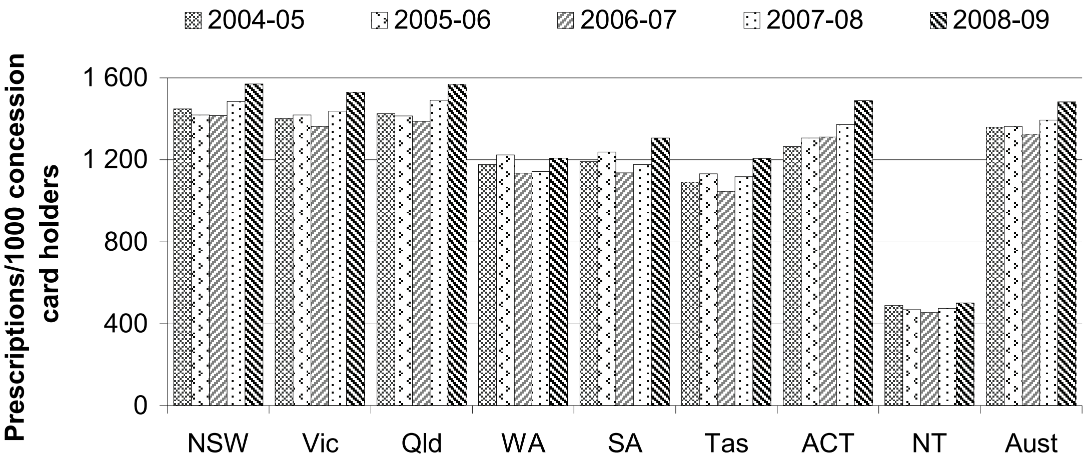
The selected antibiotics are also prescribed for illnesses other than URTI; the indicator provides no information about the condition for which they were prescribed. Data are available only for PBS concession card holders.

Data for this indicator are comparable.

Caution should be used in the interpretation of this indicator over time, as pharmaceutical needs of concession card holders can increase in complexity due to the effects of population ageing.

Nationally, the prescription rate for the oral antibiotics most commonly used to treat upper respiratory tract infection in 2008-09 was 1483 per 1000 PBS concession card holders. Prescription rates for these antibiotics appear overall to have increased in most states and territories between 2004-05 and 2008-09 (figure 11.13).

Figure 11.13 Rate of prescription of the oral antibiotics used most commonly to treat upper respiratory tract infection



Source: DoHA (unpublished) PBS data collection; table 11A.22.

Management of diabetes

‘Management of diabetes’ is an indicator of governments’ objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 11.9).

Box 11.9 Management of diabetes

‘Management of diabetes’ is defined as the proportion of people with diabetes mellitus who have received an annual cycle of care within general practice. This is the number of MBS items for completion of a cycle of care for patients with established diabetes mellitus that are claimed, divided by the estimated number of people with diabetes mellitus.

The MBS annual cycle of care is generally based on RACGP clinical guidelines for the management of Type 2 diabetes in general practice. A high or increasing proportion of people with diabetes mellitus who have received an annual cycle of care within general practice is desirable. Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Various factors influence the uptake of MBS items by GPs. As appropriate management of diabetes mellitus by GPs who do not claim the rebates is not captured in this measure, these data should be considered as minimum estimates.

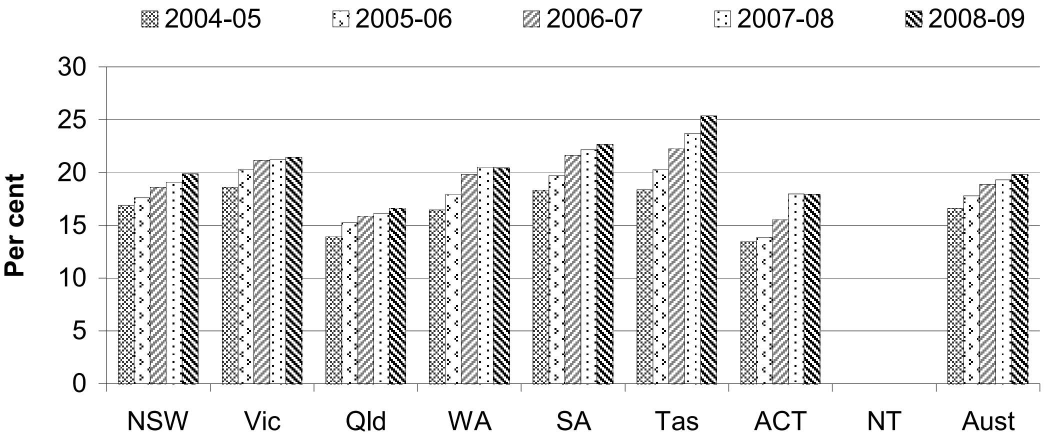
Data reported against this indicator are comparable.

Diabetes mellitus, a chronic disease of increasing prevalence, is an identified National Health Priority Area for Australia. People with diabetes ('diabetes' refers to diabetes mellitus; this report does not consider diabetes insipidus) are at high risk of serious complications such as cardiovascular, eye and kidney disease. Appropriate management in the primary and community health sector can prevent or minimise the severity of such complications (AIHW 2008c). Type 2 diabetes is the most common form of diabetes and is largely preventable.

Since 2001, rebates have been available to GPs under the MBS on completion of an annual cycle of care for diabetes. The 'required annual cycle of care' is generally based on the RACGP's clinical guidelines for the management of Type 2 diabetes in general practice (but requires less frequent testing of glycosolated haemoglobin). Clinical guidelines represent the minimum required level of care. The need for a standard definition of 'annual cycle of care' has been identified (AIHW 2007b).

The proportion of people with diabetes mellitus receiving an annual cycle of care within general practice increased for all jurisdictions for which data are available in the period 2004-05 to 2008-09 (figure 11.14). Nationwide, 19.8 per cent of people with diabetes received the annual cycle of care in 2008-09 (excluding the NT).

Figure 11.14 **People with diabetes mellitus who have received an annual cycle of care within general practice**[a, b, c, d]



---

[a] Data are minimum estimates as GPs may provide the annual cycle of care but not claim the MBS rebate. [b] Clinical guidelines are for Type 2 diabetes, while the MBS items do not specify a particular type of diabetes. [c] The number of people with diabetes is estimated by applying diabetes prevalence data from the ABS 2007-08 National Health Survey (NHS) to the ERP. Estimates should be treated with caution as the prevalence of diabetes changes over time. Historical estimates may differ from previous Reports, which reported estimates based on 2004-05 NHS prevalence data. [d] 2007-08 NHS data are not available for the NT.

Source: Derived from Medicare Australia (2009) *MBS Item Statistics Reports*; ABS (2009) *National Health Survey: Summary of Results, 2007-2008*, Cat. No. 4364.0; ABS (2009) *National Health Survey: Summary of Results; State Tables, 2007-08*, Cat. No. 4362.0; ABS (2009) *Australian demographic statistics March quarter 2009*, Cat. no. 3101.0; table 11A.23.

Management of asthma

‘Management of asthma’ is an indicator of governments’ objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 11.10).

Box 11.10 **Management of asthma**

‘Management of asthma’ is defined as the number of people with asthma who have a written asthma action plan, divided by the estimated number of people with asthma.

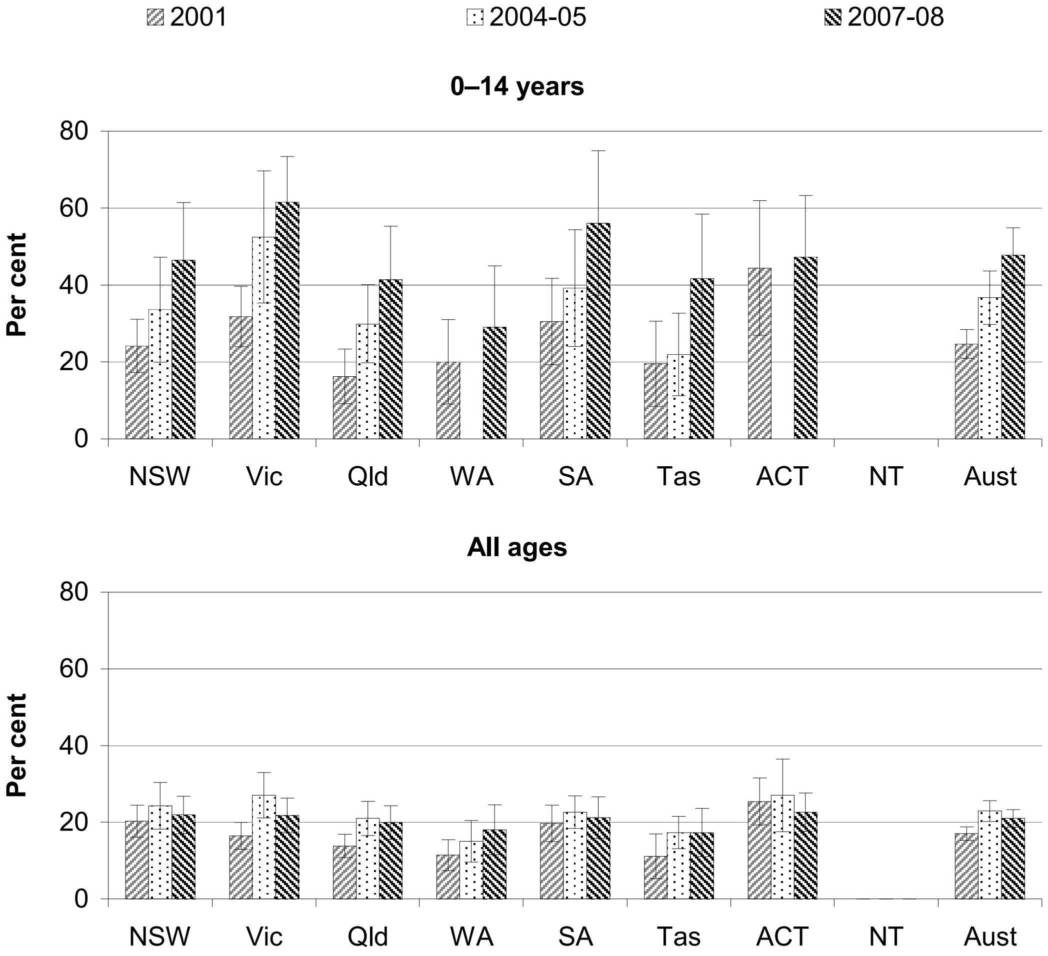
Asthma is an identified National Health Priority Area for Australia. It is a common chronic disease among Australians, particularly children, and is associated with wheezing and shortness of breath. Asthma can be intermittent or persistent, and varies in severity. Written asthma action plans enable people with asthma to recognise and respond quickly and appropriately to deteriorating asthma symptoms, preventing or reducing the severity of acute asthma episodes (ACAM 2008). Written asthma action plans have been associated with a reduction in hospitalisations and urgent GP visits for asthma and have been included in clinical guidelines for asthma management for nearly 20 years (ACAM 2008).

A high or increasing proportion of people with asthma who have a written asthma action plan is desirable.

Data reported against this indicator are comparable.

Nationally, the proportion of NHS respondents with current asthma who reported having a written asthma action plan was 21.0 per cent in 2007-08, compared with 17.0 per cent in 2001 and 22.9 per cent in 2004-05 (figure 11.15). The proportion of children aged 0–14 years with current asthma who reported having a written asthma action plan rose from 24.7 per cent in 2001 to 36.7 per cent in 2004-05 and 47.8 per cent in 2007-08.

Figure 11.15 **Proportion of people with asthma who have a written asthma action plan**[a, b]



[a] Separate estimates for the NT are not available for this survey, but the NT sample contributes to the national estimates. [b] Data from the 2004-05 survey for children aged 0–14 years for WA and the ACT have relative standard errors greater than 50 per cent. They are considered too unreliable for general use and are not published, but the data contribute to the national estimates.

Source: ABS (2009) *National Health Survey: Summary of Results, 2007-2008*, Cat. No. 4364.0; ABS (2009) *National Health Survey: Summary of Results; State Tables, 2007-08*, Cat. No. 4362.0; ABS (unpublished) *National Health Survey 2001, 2004-05,* Cat. no. 4364.0; table 11A.24.

Pharmaceuticals ordered by non-specialists

'Pharmaceuticals ordered by non-specialists' has been identified as an indicator of governments' objective to ensure the appropriateness of primary healthcare services (box 11.11).

Box 11.11 **Pharmaceuticals ordered by non-specialists**

‘Pharmaceuticals ordered by non-specialists’ is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Pathology tests and diagnostic imaging ordered by non-specialists

‘Pathology tests and diagnostic imaging ordered by non-specialists’ is an indicator of governments’ objective to ensure that primary healthcare services are appropriate (box 11.12).

Box 11.12 **Pathology tests ordered and diagnostic imaging referrals by non-specialists (vocationally recognised GPs and OMPs)**

‘Pathology tests ordered and diagnostic imaging referrals by non-specialists’ is defined by the following four measures:

- pathology tests ordered by vocationally recognised GPs and OMPs, that are rebated through Medicare, per person
- diagnostic imaging referrals by vocationally recognised GPs and OMPs, that are rebated through Medicare, per person
- Medicare benefits paid per person for pathology tests
- Medicare benefits paid per person for diagnostic imaging.

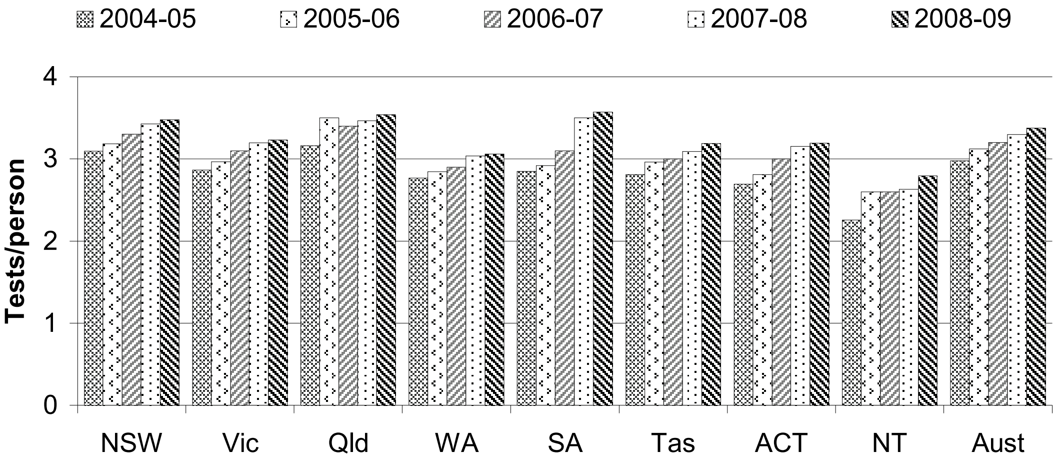
Pathology tests and diagnostic imaging are important tools used by GPs in the diagnosis of many diseases, and in monitoring response to treatment. Low levels of use can contribute to the misdiagnosis of disease, and to relatively poor treatment decisions. High levels of use can reflect overreliance on tools to support the diagnostic process. What constitutes appropriate levels of use cannot be determined. However, reporting differences across jurisdictions and over time contributes to the discussion of these issues.

Data for this indicator are comparable.

Pathology tests and diagnostic imaging ordered by vocationally recognised GPs and OMPs and rebated through Medicare Australia is used as a proxy in reporting against this indicator. While data for the total number of pathology tests ordered and diagnostic imaging referrals made by GPs are not available from Medicare, data are available for those that are rebated through Medicare. The number of pathology tests ordered can be higher than the number rebated through Medicare (where multiple tests are ordered, rebates are provided only for the three most expensive tests). Radiologists can identify a need for more or different imaging procedures than those for which patients are referred. Information about differences between the number of pathology tests ordered and the number of rebates claimed, and differences between the number of imaging procedures ordered by GPs and the number of rebates claimed, is not available.

Nationally, the number of pathology tests ordered and rebated through Medicare per person increased from 3.0 in 2004-05 to 3.4 in 2008-09 (figure 11.16).

Figure 11.16 **Pathology tests ordered by GPs and rebated through Medicare**[a]



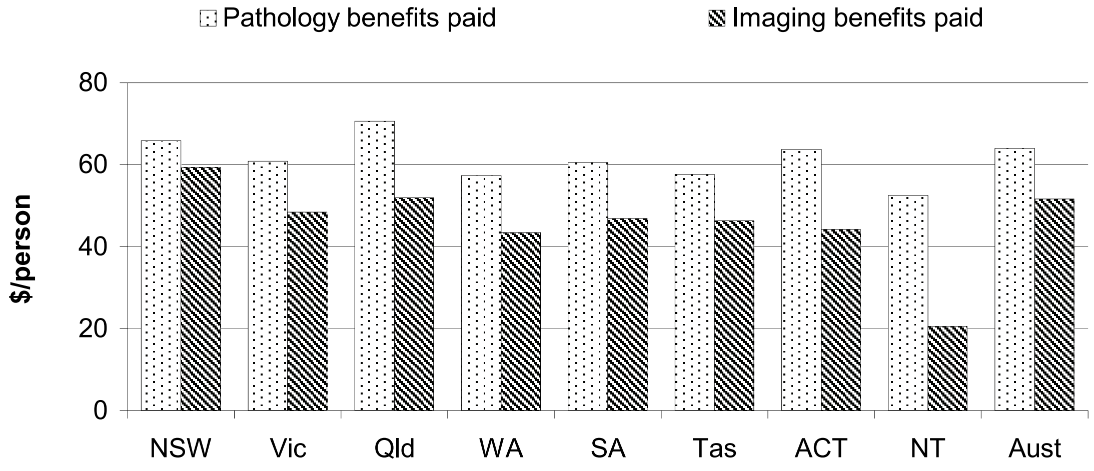
---

[a] Data include tests ordered by vocationally recognised GPs and OMPs and rebated through Medicare. Data include patient episode initiated items.

Source: DoHA (unpublished) MBS and DVA data collections; table 11A.25.

Australian Government expenditure (under Medicare) on pathology tests amounted to $1.4 billion in 2008-09, equal to $64 per person. Nationally, Medicare benefits worth $1.1 billion were paid for diagnostic imaging in 2008-09, equal to $52 per person (figure 11.17).

Figure 11.17 Benefits paid for pathology tests and diagnostic imaging, 2008-09[a]



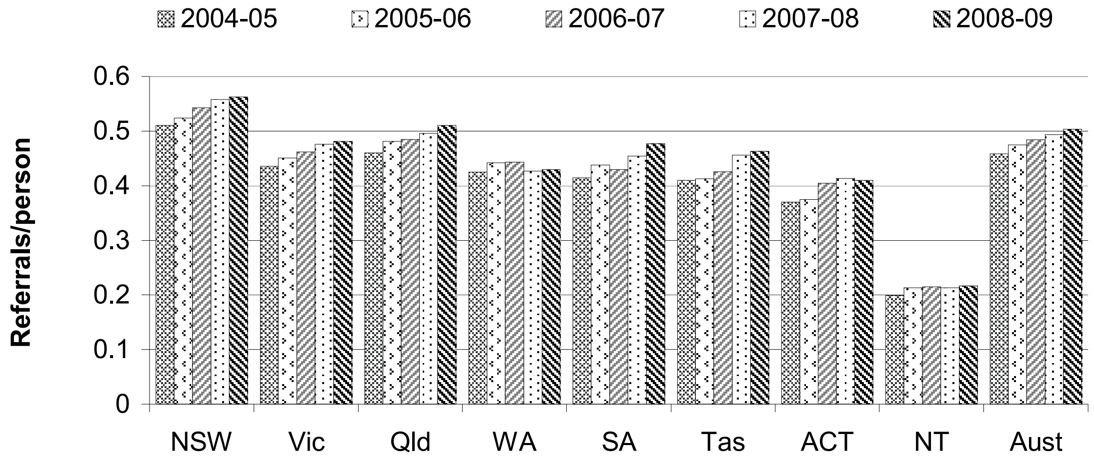
---

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

Source: DoHA (unpublished) MBS and DVA data collections; tables 11A.25 and 11A.26.

Nationally, there has been a gradual upward trend in the number of diagnostic imaging referrals per person between 2004-05 and 2008-09 (figure 11.18).

Figure 11.18 Diagnostic imaging referrals from GPs[a]



---

[a] Data relate to vocationally recognised GPs and OMPs.

Source: DoHA (unpublished) MBS and DVA data collections; table 11A.26.

Quality — safety

General practices with electronic information management systems

'General practices with electronic information management systems' is an indicator of governments' objective to improve patient safety through minimising prescribing and dispensing errors that can cause adverse drug reactions (box 11.13).

Box 11.13 **General practices with electronic information management systems**

'General practices with electronic information management systems' is defined by the following two measures:

- 'proportion of practices enrolled in the Practice Incentives Program (PIP) that maintain secure electronic patient records'
- 'proportion of PIP practices that manage patient records predominantly using secure electronic management systems'.

An increase in these proportions can indicate that the likelihood of patient harm due to prescribing or dispensing errors in general practice is reduced.

The PIP does not include all practices in Australia. PIP practices provided around 82 per cent of general practice patient care in Australia (measured as standardised whole patient equivalents) in 2007-08 (DoHA unpublished; table 11A.32).

Data for this indicator are comparable.

Electronic information management systems can also improve other dimensions of quality, by providing access to timely clinical data and improving the maintenance of patient health records. Use of such technology can, for example, facilitate best practice chronic disease management and preventative health activities such as screening (DHAC 2000).

The PIP provides financial incentives to general practices to support quality care, and improve access and health outcomes. The PIP promotes activities such as:

- use of electronic information management systems
- the provision of after hours care
- teaching medical students
- employment of practice nurses
- improving management for patients with diabetes and/or asthma.

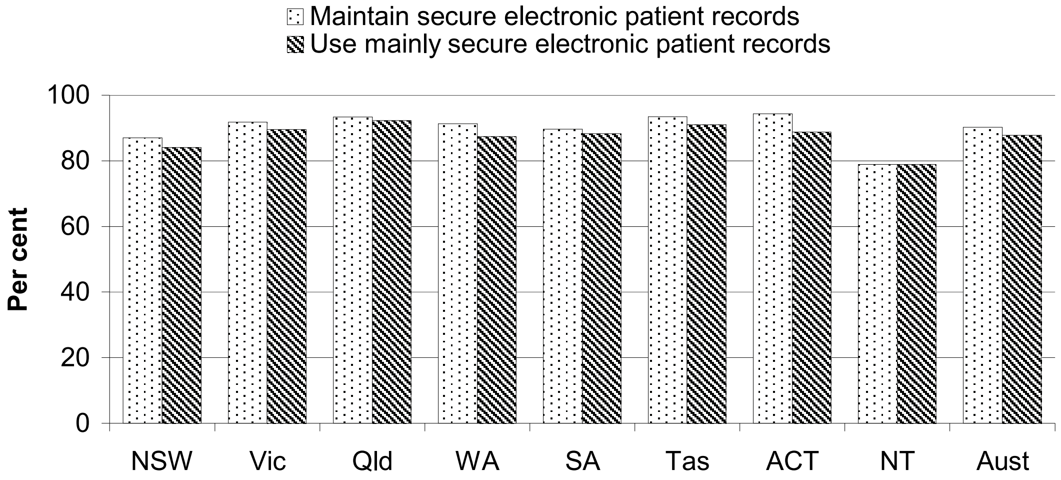
The PIP Information Management, Information Technology Incentive was available from November 2006 to August 2009, when it was replaced with the new PIP eHealth Incentive. It provided two payment tiers to encourage the computerisation of practices:

- The first tier required practices to maintain electronic patient records, including clinical data on allergies/sensitivities for the majority of active patients, and implement appropriate information security measures.
- The second tier required practices to use electronic patient records to record and store clinical information on the majority of active patients, including current and past major diagnoses and current medications.

These replaced previous incentives for electronic prescribing and transmission of clinical data in November 2006. Data relating to previous incentives are reported in tables 11A.27 and 11A.28.

Nationally, 90.2 per cent of PIP practices maintained secure electronic patient records in May 2009. Patient records were managed predominantly using secure electronic management systems in 87.8 per cent of PIP practices (figure 11.19).

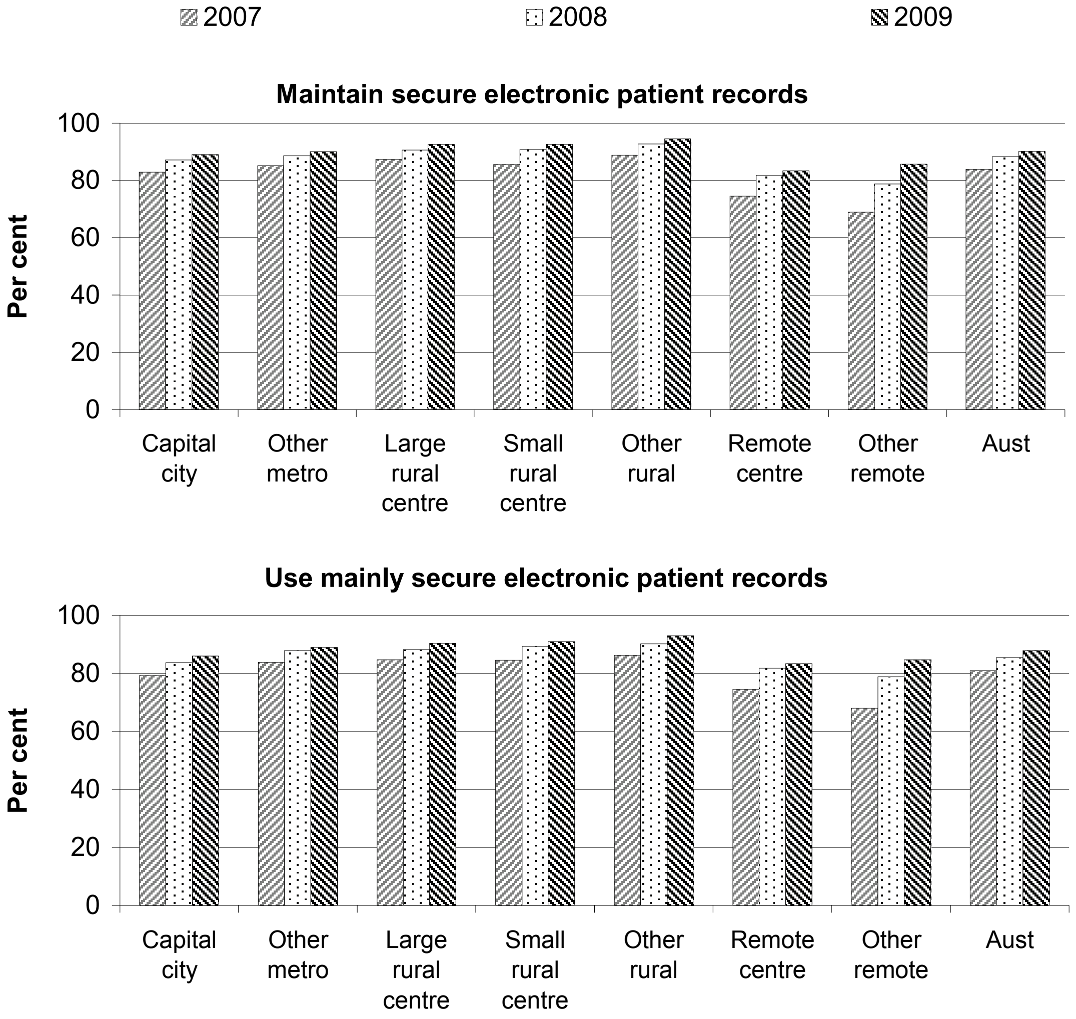
Figure 11.19 **PIP practices using computers for clinical purposes, May 2009**



Source: DoHA (unpublished) MBS and PIP data collections; table 11A.27.

There was an increase in the proportion of PIP practices that maintained secure electronic patient records, and that predominantly used secure electronic systems to manage patient records in all geographical areas from 2007 to 2009 (figure 11.20).

Figure 11.20 **PIP practices using computers for clinical purposes by area, May[a]**



---

[a] Geographical locations are based on the Rural, Remote and Metropolitan Areas (RRMA) classification. Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more SLAs that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone. SLA = statistical local area.

Source: DoHA (unpublished) MBS and PIP data collections; table 11A.28.

Quality — responsiveness

Patient satisfaction

‘Patient satisfaction’ has been identified for development as an indicator of governments’ objective to ensure GP services are responsive to the needs of patients (box 11.14).

Box 11.14 **Patient satisfaction**

‘Patient satisfaction’ is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Quality — capability

Two indicators of the quality of GP services, relating to GPs’ capability to provide services, are reported:

- ‘proportion of GPs with vocational registration’
- ‘proportion of general practices with accreditation’.

GPs with vocational registration

‘GPs with vocational registration’ is an indicator of governments’ objective to ensure the GP workforce has the capability to deliver high quality services (box 11.15).

Box 11.15 **GPs with vocational registration**

‘GPs with vocational registration’ is defined as the proportion of FWE GPs with vocational registration.

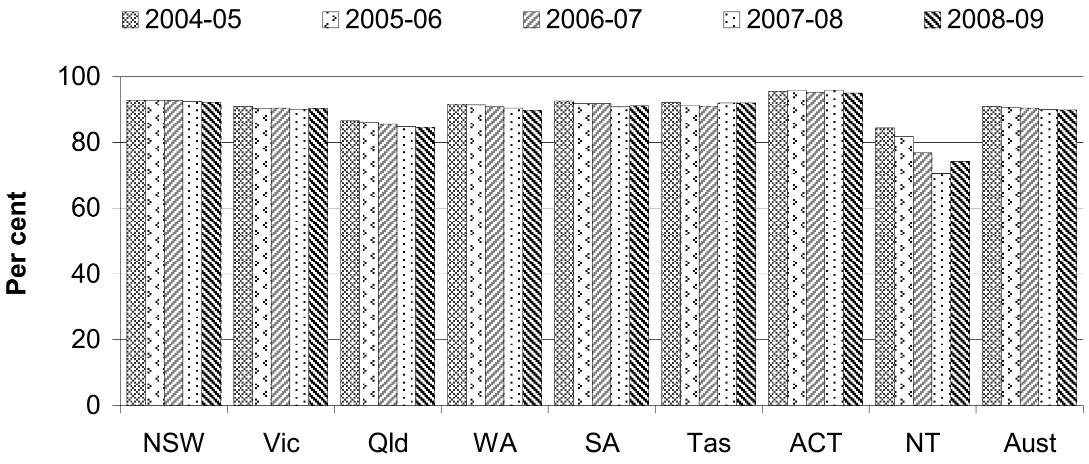
Vocationally registered GPs are considered to have the values, skills and knowledge necessary for competent unsupervised general practice within Australia (RACGP 2007). An increase in the proportion of FWE GPs with vocational registration can indicate an improvement in the capability of the GP workforce to deliver high quality services. However, GPs without vocational registration can deliver services of equally high quality.

Data for this indicator are comparable.

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

The proportion of FWE GPs with vocational registration remained relatively constant over the five years to 2008-09 (figure 11.21). The proportion of FWE GPs with vocational registration was highest in capital cities and other metro centres, and lowest in other remote areas, in 2008-09 (table 11A.29).

Figure 11.21 **GPs (full time workload equivalent) with vocational registration**



Source: DoHA (unpublished) MBS data collection; table 11A.30.

General practices with accreditation

'General practices with accreditation' is an indicator of governments' objective to ensure the general practitioner workforce has the capability to provide high quality services (box 11.16).

Box 11.16 **General practices with accreditation**

'General practices with accreditation' is defined as the number of general practices that are accredited as a proportion of all general practices in Australia.

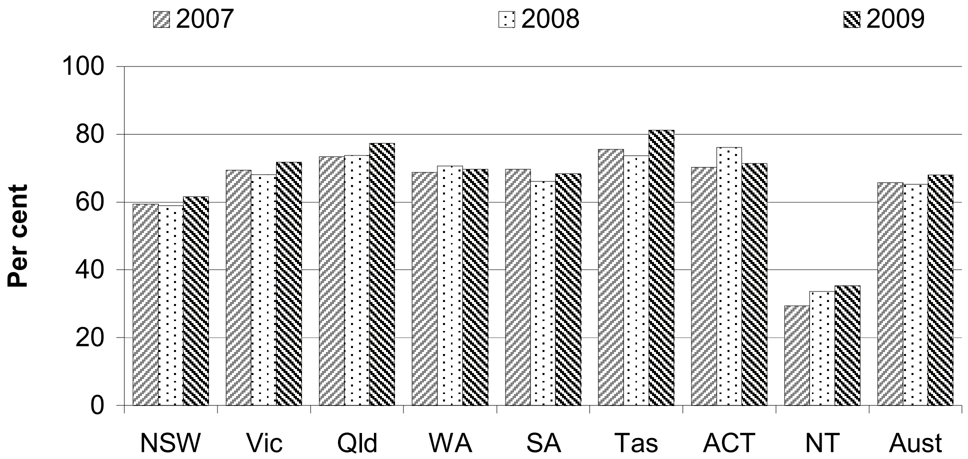
Accreditation of general practice is a voluntary process of peer review that involves the assessment of general practices against a set of standards developed by the RACGP. Accredited practices, therefore, have been assessed as complying with a set of national standards. An increase in the proportion of practices with accreditation can indicate an improvement in the capability of general practice to deliver high quality services. However, general practices without accreditation can deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.

Data for this indicator are comparable.

The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and General Practice Australia ACCREDITATION *plus* (GPA Accreditation *plus*).

In June 2009, 4835 general practices — representing 68.0 per cent of general practices — were accredited nationally (figure 11.22).

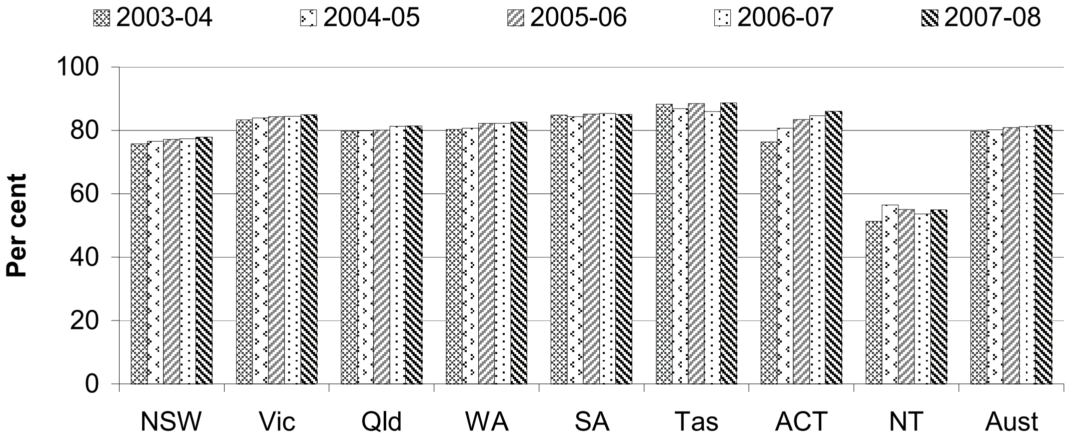
Figure 11.22 **General practices with accreditation, at 30 June**



Source: AGPAL (unpublished); GPA Accreditation *plus* (unpublished); Primary Health Care Research and Information Service and DoHA (unpublished) *Annual Survey of Divisions of General Practice* 2008-09; table 11A.31.

The proportion of patients attending accredited practices provides useful additional information relating to accreditation. For this measure, PIP practices provide a proxy for accredited practices, as accreditation is a requirement for PIP registration. Nationally, the proportion of general practice patient care — measured as standardised whole patient equivalents (SWPEs) — provided by PIP practices has been relatively constant in the period from 2003-04 to 2007-08 (figure 11.23).

Figure 11.23 **Proportion of general practice patient care provided by PIP practices**[a]



---

[a] Patients are measured as SWPEs. A SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

Source: DoHA (unpublished) PIP and MBS data collections; table 11A.32.

Quality — continuity

The continuity aspect of the quality of primary healthcare services relates to the timely, coordinated provision of services that address the needs of individual patients. For example, chronic disease imposes a significant burden on the health and wellbeing of Australians. Patients can require a range of services from within and outside the health sector. Continuity of care can help prevent or delay the progression of many circulatory, respiratory, endocrine, nutritional and metabolic diseases (NHPAC 2006). Two indicators of this aspect of the quality of GP services are reported:

- ‘use of care planning and case conferencing’
- ‘use of health assessments for older people’.

Care planning and case conferencing

'Care planning and case conferencing' is an indicator of governments' objective to improve the continuity of care provided to people with chronic or terminal medical conditions (box 11.17).

Box 11.17 **Care planning and case conferencing**

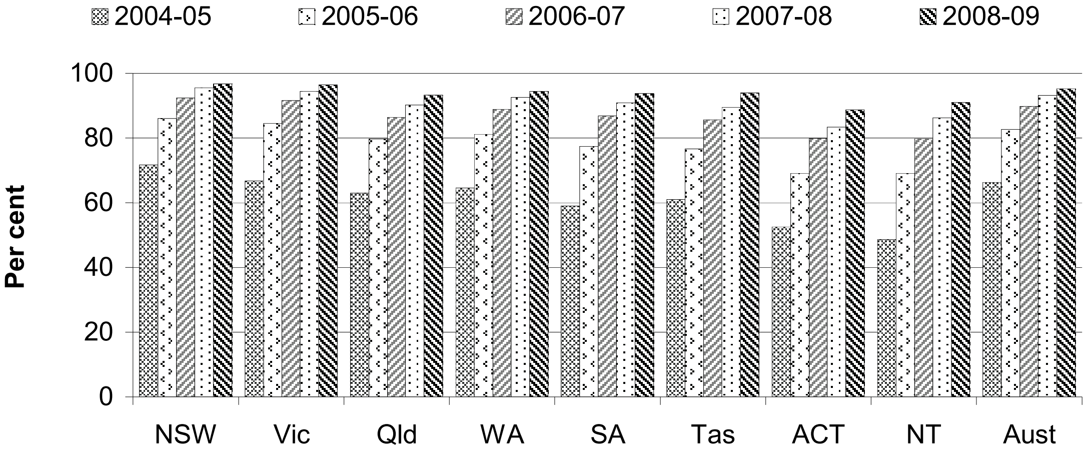
'Care planning and case conferencing' is defined as the proportion of GPs who used the MBS chronic disease management items for care planning or case conferencing at least once during a 12 month period.

Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team-based care. An increase in the proportion of GPs who use chronic disease management items can indicate an improvement in the continuity of care provided to people with complex, multidisciplinary care needs.

Data for this indicator are comparable.

Nationally, 95.3 per cent of GPs used the chronic disease management items for care planning or case conferencing in 2008-09 (figure 11.24).

Figure 11.24 **GP use of chronic disease management Medicare items for care planning and case conferencing**[a]



[a] The increase in the number of GPs using chronic disease management MBS items for care planning or case conferencing between 2004-05 and 2005-06 can reflect increasing awareness of the Strengthening Medicare initiative, introduced on 1 July 2004. This initiative provided access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP. The continued increase in subsequent years may be linked to the introduction of additional chronic disease management MBS items on a number of occasions.

Source: DoHA (unpublished) MBS data collection; table 11A.33.

Health assessments for older people

‘Health assessments for older people’ is an indicator of governments’ objective to improve population health outcomes through the provision of prevention as well as early detection and treatment services (box 11.18).

Box 11.18 **Health assessments for older people**

‘Health assessments for older people’ is defined as the proportion of older people who received a voluntary health assessment. Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities.

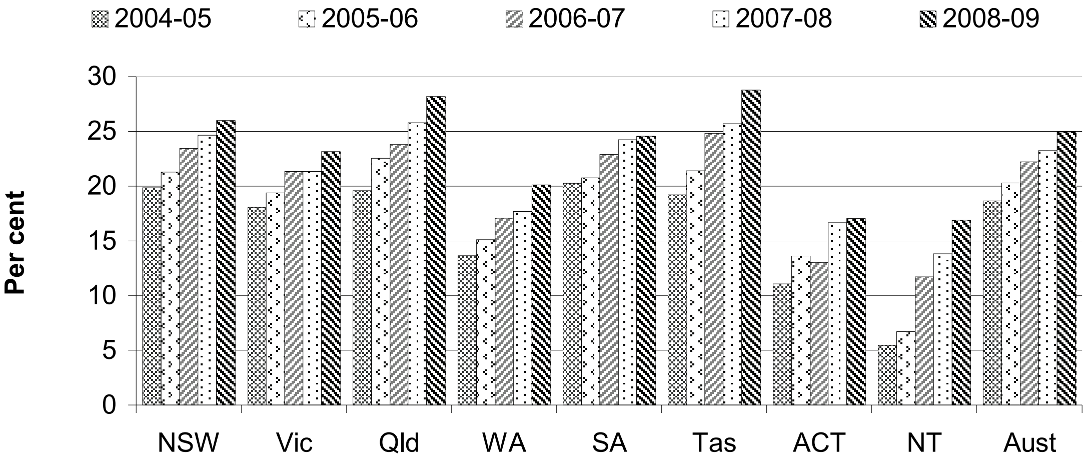
Annual voluntary health assessments for older people are MBS items that allow a GP to undertake an in-depth assessment of a patient’s health. Health assessments cover the patient’s health and physical, psychological and social functioning, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient (see also box 11.6). An increase in the proportion of eligible older people who received a voluntary health assessment can indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.

Data for this indicator are comparable.

The targeted age range for Indigenous people of 55 years or over recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the Health preface). Results for Indigenous people are reported under equity indicators (box 11.6).

There has been a steady increase in the proportion of older people receiving a voluntary health assessment in most jurisdictions, in the period 2004-05 to 2008-09. Nationwide, this proportion increased from 18.7 per cent in 2004-05 to 24.9 per cent in 2008-09 (figure 11.25).

Figure 11.25 **Older people who received a voluntary health assessment**[a]



---

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

Source: DoHA (unpublished) MBS data collection; table 11A.34.

Sustainability

The Steering Committee has identified the sustainability of primary and community health as a key area for development in future reports.

Efficiency

Cost to government of general practice per person

'Cost to government of general practice per person' is an indicator of governments' objective to provide primary healthcare services in an efficient manner (box 11.19).

Box 11.19 **Cost to government of general practice per person**

'Cost to government of general practice per person' is defined as the cost to government of general practice per person in the population.

A lower or decreasing cost per person can indicate higher efficiency. However, this is likely to be the case only where the lower cost is associated with services of equal or superior effectiveness.

(Continued on next page)

Box 11.19 **(Continued)**

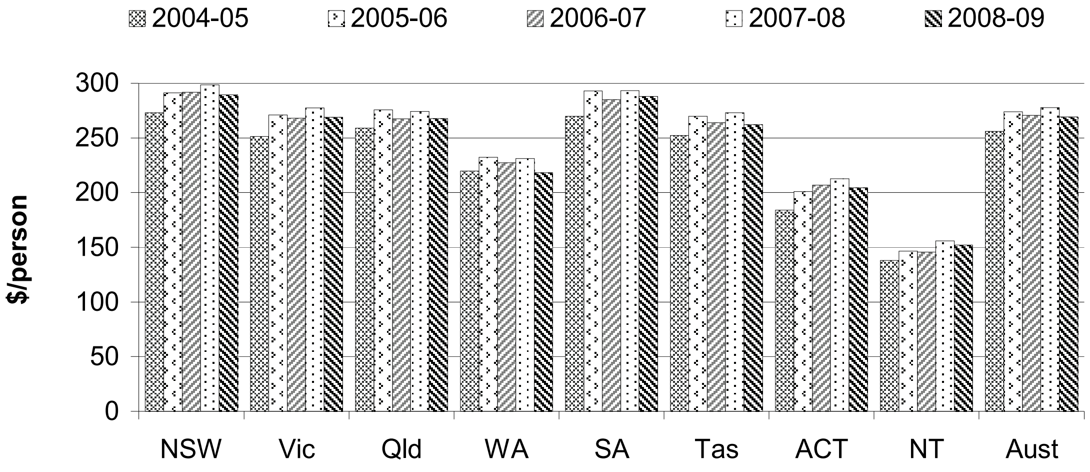
This indicator needs to be interpreted with care because a lower cost per person can reflect service substitution between primary healthcare and hospital services or specialist services (at potentially higher cost than primary care).

Data for this indicator are comparable.

This indicator does not include costs for all primary healthcare services. Some primary healthcare services are provided by salaried GPs in community health settings, particularly in rural and remote areas, through accident and emergency departments, and Indigenous-specific primary healthcare services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.

Nationally, the recurrent cost to the Australian Government of general practice was $269 per person in 2008-09 (figure 11.26).

Figure 11.26 **Australian Government real expenditure per person on GPs (2008-09 dollars)[a]**



---

[a] The data include Medicare, DVA, PIP, DGP and GPII payments. DVA data cover consultations by local medical officers (LMOs), whether vocationally recognised GPs or not. From available files, it is not possible to extract the amounts paid to LMOs (distinct from specialists) for procedural items. It is expected, however, that the amounts for these services are small compared with payments for consultations.

Source: DoHA (unpublished) MBS, PIP, GPII, DGP and DVA data collections; table 11A.2.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5). Intermediate outcomes (such as vaccination coverage within a target group) moderate final outcomes (such as the incidence of vaccine preventable diseases). Both intermediate and final primary and community health outcome indicators are reported.

Child immunisation coverage

'Child immunisation coverage' is an indicator of governments' objective to achieve high immunisation coverage levels for children to prevent selected vaccine preventable diseases (box 11.20).

Box 11.20 **Child immunisation coverage**

'Child immunisation coverage' is defined by two measures:

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

A high or increasing proportion of children who are fully immunised indicates a reduction in the risk of children contracting a range of vaccine preventable diseases, including measles, whooping cough and *Haemophilus influenzae* type b.

Data for this indicator are comparable.

Many providers deliver child immunisation services (table 11.6). GPs are encouraged to achieve high immunisation coverage levels under the General Practice Immunisation Incentive Scheme, which provides incentives for the immunisation of children under seven years of age.

Table 11.6 Valid vaccinations supplied to children under 7 years of age, by provider type, 2004–2009 (per cent)[a, b]

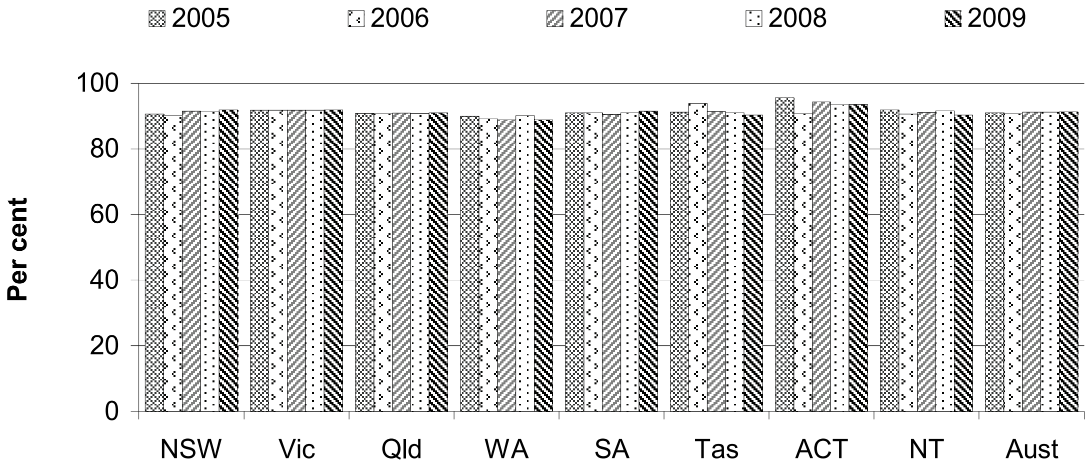
Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP	86.0	56.0	83.0	66.0	69.0	90.0	50.0	5.0	73.0
Council	4.4	43.0	6.0	4.0	21.0	9.0	–	–	15.0
State or Territory health department	–	–	–	8.0	–	–	–	1.0	1.0
Flying doctor service	–	–	–	–	–	–	–	–	–
Public hospital	1.2	1.0	3.0	2.0	1.0	–	1.0	8.0	2.0
Private hospital	–	–	–	–	–	–	–	1.0	–
Indigenous health service	1.0	–	1.0	1.0	–	–	–	14.0	1.0
Indigenous health worker	–	–	–	–	–	–	–	–	–
Community health centre	8.0	–	7.0	19.0	9.0	1.0	49.0	71.0	8.0
Community nurse	–	–	–	–	–	–	–	–	–
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

[a] 1 July 2004 to 30 June 2009. Data relate to the State or Territory in which the immunisation provider was located. [b] A valid vaccination is a National Health and Medical Research Council's Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. – Nil or rounded to zero.

Source: DoHA (unpublished) Australian Childhood Immunisation Register (ACIR) data collection; table 11A.35.

Around 91.3 per cent of Australian children aged 12 months to less than 15 months at 30 June 2009 were assessed as fully immunised (figure 11.27).

Figure 11.27 Children aged 12 months to less than 15 months who were fully immunised[a, b, c]

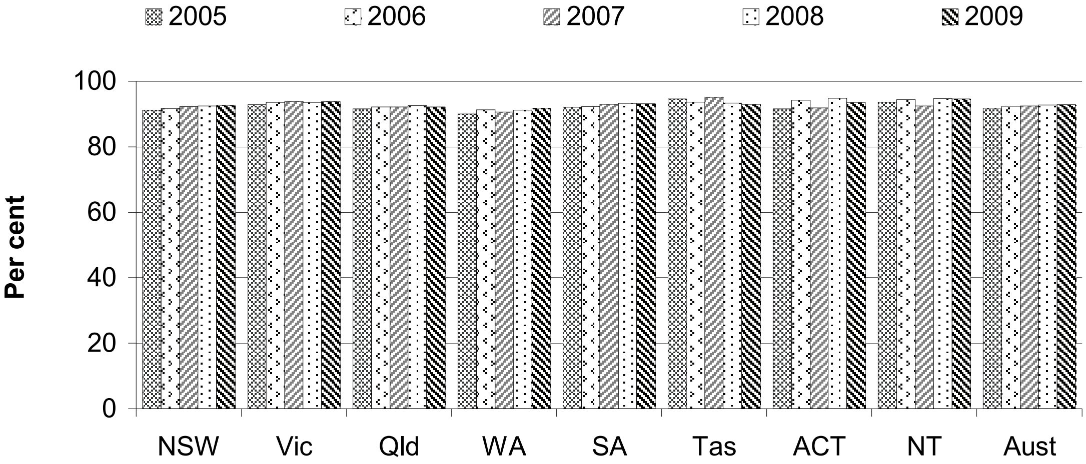


[a] Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. [b] The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare. [c] There can be some under-reporting by providers, so vaccination coverage estimates based on ACIR data are considered minimum estimates (NCIRS 2000).

Source: DoHA (unpublished) ACIR data collection; table 11A.36.

Nationally, 92.9 per cent of children aged 24 months to less than 27 months at 30 June 2009 were assessed as being fully immunised (figure 11.28).

Figure 11.28 **Children aged 24 months to less than 27 months who were fully immunised**[a, b, c]



---

[a] Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child was located. [b] The ACIR includes all children under 7 years of age who are registered with Medicare Australia. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare Australia (NCIRS 2000). [c] There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

Source: DoHA (unpublished) ACIR data collection; table 11A.37.

Notifications of selected childhood diseases

‘Notifications of selected childhood diseases’ is an indicator of governments’ objective to improve population health outcomes through the prevention of selected vaccine preventable childhood diseases (box 11.21).

Box 11.21 **Notifications of selected childhood diseases**

'Notifications of selected childhood diseases' is defined as the number of notifications of measles, pertussis and *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years, per 100 000 children in that age group.

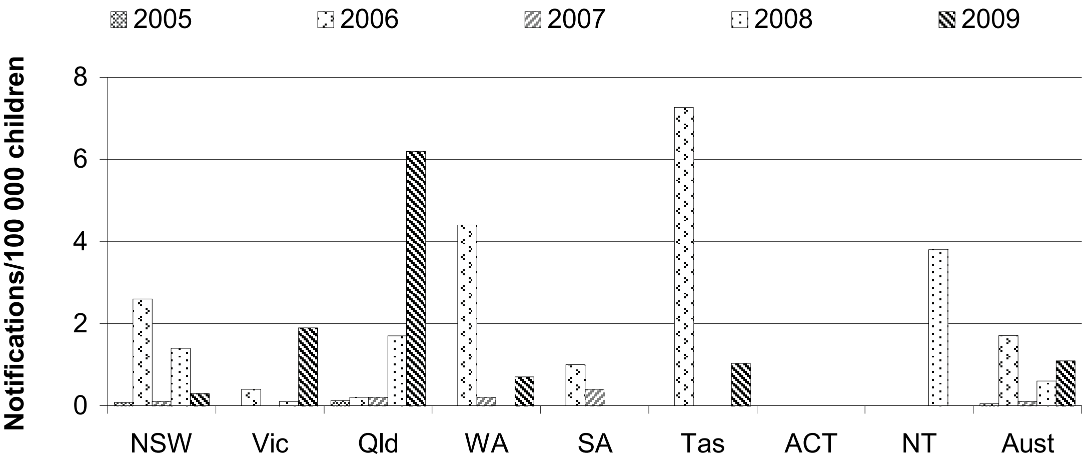
Measles, pertussis (whooping cough) and *Haemophilus influenzae* type b are nationally notifiable vaccine preventable diseases. Notification of the relevant State or Territory authority is required when a nationally notifiable disease is diagnosed. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs in one in 25 cases. The activities of GPs and community health services can reduce the prevalence of these diseases through immunisation (and consequently the notification rates).

A low or reducing notification rate for the selected diseases indicates greater effectiveness of the immunisation program.

Data for this indicator are comparable.

In 2009, there were 45 notifications of measles across Australia to 31 August (table 11A.38). This was the third time in the five year period 2005–2009 that notifications numbered more than 25 — there were 68 notifications in 2006 and 26 in 2008. The national notification rate in 2009 was 1.1 per 100 000 children aged 0–14 years (figure 11.29).

Figure 11.29 **Notifications of measles per 100 000 children aged 0–14 years**[a, b]

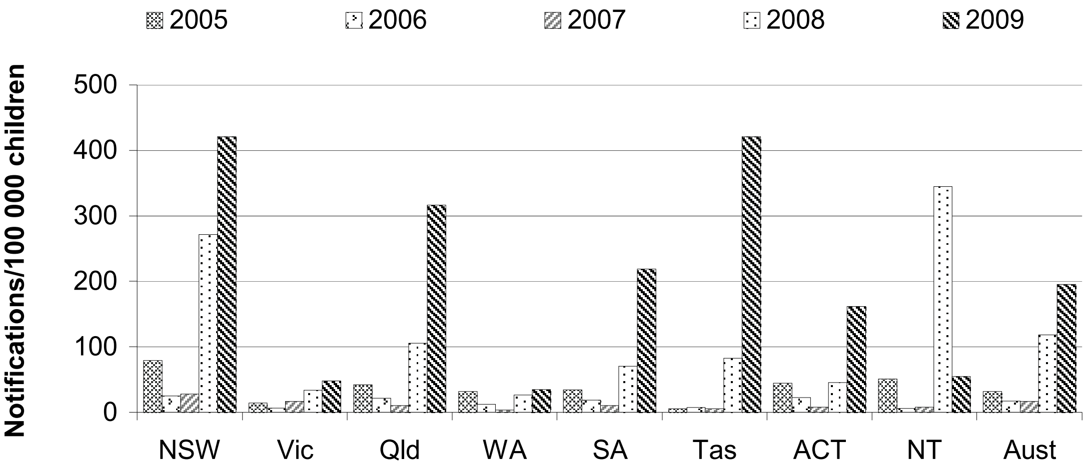


[a] Notifications for 2009 are to 31 August. [b] Where a notification rate for a particular year is zero, no notifications were made in that jurisdiction.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.38.

Nationally, there were 8045 notifications for pertussis (whooping cough) to 31 August in 2009. The national notification rate in 2009 was 195.4 per 100 000 children aged 0–14 years (figure 11.30).

Figure 11.30 Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years[a]

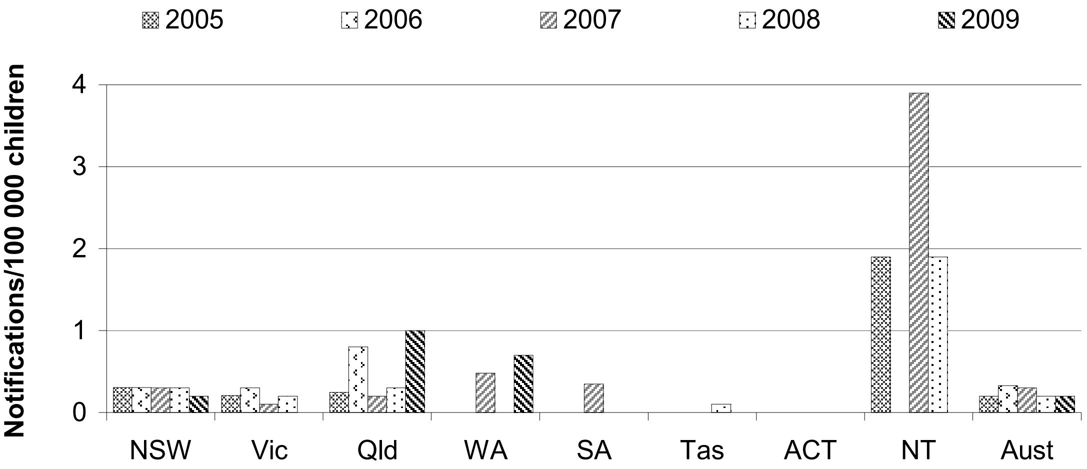


[a] Notifications for 2009 are to 31 August.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.39.

In recent years, notification rates for *Haemophilus influenzae* type b have remained low. In 2009, the notification rate nationally to 31 August was 0.2 per 100 000 children aged 0–14 years (figure 11.31).

Figure 11.31 **Notifications of *Haemophilus influenzae* type b among children aged 0–14 years**[a, b]



[a] Notifications for 2009 are to 31 August. [b] Where a notification rate for a particular year is zero, no notifications were made in that jurisdiction.

Source: DoHA (unpublished) NNDSS, *ABS Population by Age and Sex*, *Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.40.

Participation rates for women in cervical screening

'Participation rates for women in cervical screening' is an indicator of governments' objective to reduce morbidity and mortality attributable to cervical cancer through the provision of early detection services (box 11.22).

Box 11.22 **Participation rates for women aged 20–69 years in cervical screening**

'Participation rates for women in cervical screening' is defined as the number of women aged 20–69 years who are screened over a two year period, as a proportion of all eligible women aged 20–69 years. Eligible women are those who have not had a hysterectomy.

A high or increasing proportion of eligible women aged 20–69 years who have been screened is desirable.

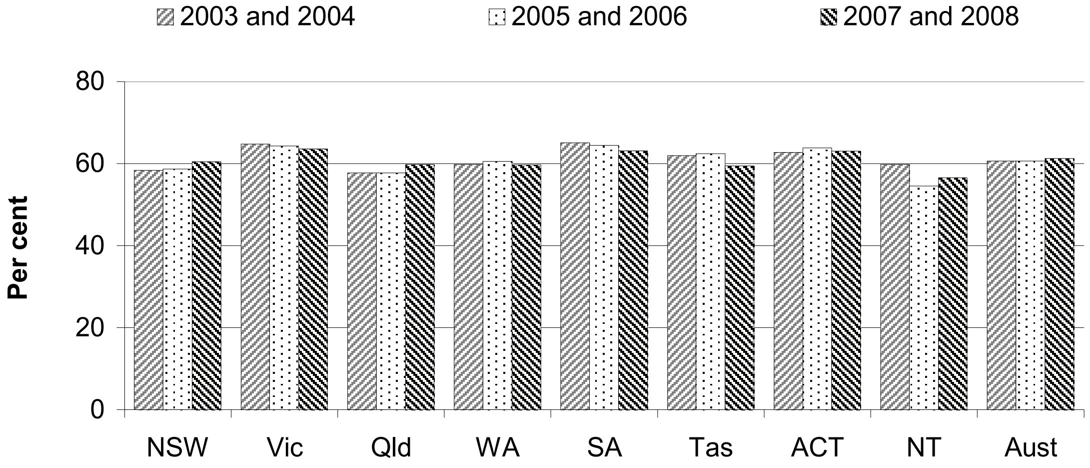
Data for this indicator are comparable.

It is estimated that up to 90 per cent of the most common type of cervical cancer (squamous cervical cancer) can be prevented if cell changes are detected and treated early (DoHA 2006; Mitchell, Hocking and Saville 2003). A range of healthcare providers offer cervical screening tests (pap smears). The National Cervical

Screening Program involves GPs, gynaecologists, family planning clinics and hospital outpatient clinics.

The national age-standardised participation rate for women aged 20–69 years in cervical screening was 61.2 per cent for the 24 month period 1 January 2007 to 31 December 2008 (figure 11.32). For most jurisdictions, participation rates have remained relatively constant since the screening period of 2003 and 2004.

Figure 11.32 **Participation rates for women aged 20–69 years in cervical screening[a, b, c, d]**



[a] Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the ABS ERP and age-standardised to the 2001 Australian population. [b] Eligible female population adjusted for estimated proportion who have had a hysterectomy. [c] Excludes women who have opted off the cervical cytology register. [d] Data include all women screened except for Victoria and the ACT, where data are based on residence.

Source: AIHW (2009) *Cervical screening in Australia 2006–2007*, Cat. no. CAN 43; AIHW (unpublished) State and Territory Cervical Cytology Registry data collections; table 11A.41.

Influenza vaccination coverage for older people

'Influenza vaccination coverage for older people' is an indicator of governments' objective to reduce the morbidity and mortality attributable to vaccine preventable disease (box 11.23).

Box 11.23 **Influenza vaccination coverage for older people**

'Influenza vaccination coverage for older people' is defined as the proportion of people aged 65 years or over who have been vaccinated against seasonal influenza. This does not include pandemic influenza such as H1N1 Influenza (commonly known as 'swine flu').

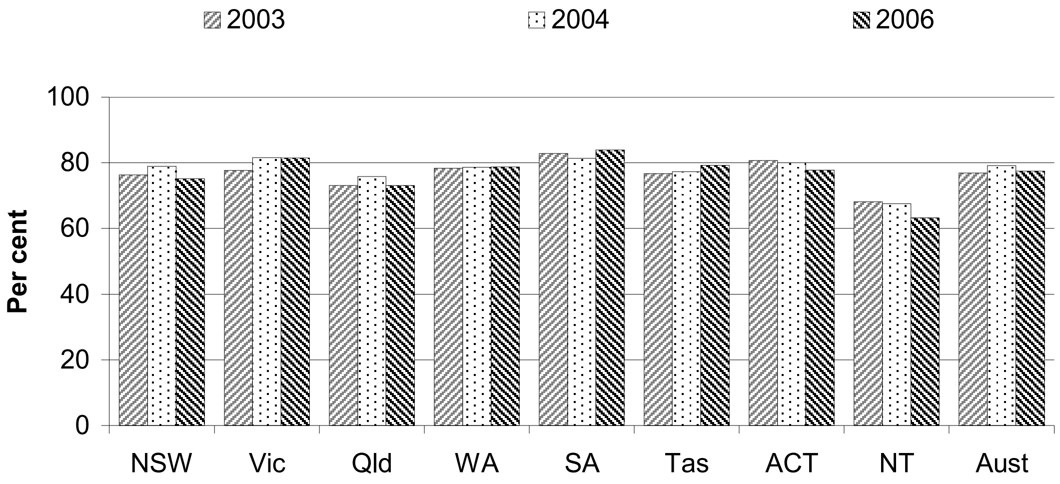
Each year, influenza and its consequences result in the hospitalisation of many older people, as well as a considerable number of deaths. An increase in the proportion of older people vaccinated against influenza reduces the risk of older people contracting influenza and suffering consequent complications.

Data for this indicator are comparable.

Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (DoHA and NHMRC 2008). GPs provide the majority of influenza vaccinations for older people.

Through the National Influenza Vaccine Program for Older Australians, the Australian Government funds free vaccines for Australians aged 65 years or over (AIHW 2005a). In 2006, 77.5 per cent of people in Australia aged 65 years or over were vaccinated against influenza (figure 11.33).

Figure 11.33 **Influenza vaccination coverage, people aged 65 years or over**[a]



---

[a] The Adult Vaccination Survey was not conducted in 2005, 2007 or 2008.

Source: AIHW 2004, 2005 *Influenza Vaccine Survey: Summary Results*, Cat. no. PHE 51, PHE 56; DoHA (unpublished) *2006 Adult Vaccination Survey*; table 11A.42.

Potentially preventable hospitalisations

Potentially preventable hospitalisations refer to hospital admissions that may be avoided through appropriate management in the primary healthcare sector and/or the broader community (AIHW 2008b, 2009b) (box 11.24).

Box 11.24 **Potentially preventable hospitalisation indicators**

Potentially preventable hospitalisations include hospitalisations for:

- preventable illness and injury
- potentially preventable exacerbations and/or complications of illness and injury.

Studies have shown that a significant proportion of variation between geographic areas in hospitalisation rates for selected vaccine preventable, acute and chronic conditions is explained by the availability of care in the primary and community healthcare sector (DHS 2002).

Hospitalisation rates also reflect the underlying prevalence of the conditions (AIHW 2008b, 2009b). In addition, some variation in rates can be due to different clinical coding and admission protocols.

While not all hospitalisations for these conditions can be prevented, strengthening the effectiveness of primary and community healthcare has considerable potential to reduce the need for hospitalisation.

Three indicators of potentially preventable hospitalisations are presented:

- potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions
- potentially preventable hospitalisations for diabetes
- potentially preventable hospitalisations of older people for falls.

The indicator ‘potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions’ combines three measures that in previous Reports were included as separate indicators — ‘hospitalisations for vaccine preventable conditions’, ‘hospitalisations for selected acute conditions’ and ‘hospitalisations for selected chronic conditions’. This is consistent with current national reporting conventions, for example, the *National Healthcare Agreement*.

Data are also reported against the first two potentially preventable hospitalisations indicators by Indigenous status. Adjustments are made to account for differences in the age structures of these populations across states and territories. The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. The *Improving the Quality of Indigenous Identification* *in Hospital Separations Data* report found that Indigenous admitted patient data were of acceptable quality for analytical purposes only for Queensland, WA, SA, and public hospitals in the NT (AIHW 2005b). Following new assessments of the quality of Indigenous identification, the National Health Information Management Principal Committee (NHIMPC, now the National e-Health and Information Principal Committee [NEHIPC]) has approved Indigenous admitted patient data for NSW and Victoria, from the 2004-05 reference year, as acceptable in quality for analytical purposes. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered to be acceptable for analysis.

Reported data are not necessarily representative of other jurisdictions. Indigenous patients are underidentified to an extent that varies across jurisdictions. Because of improvements in data quality over time, caution also should be used in time series analysis.

Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions

'Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions' is an indicator of governments' objective to reduce potentially preventable hospitalisations through the delivery of effective primary healthcare services (box 11.25).

Box 11.25 **Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions**

'Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions' is defined by three measures:

- Hospitalisations for vaccine preventable conditions, defined as the number of hospital separations for influenza and pneumonia, and other vaccine preventable conditions, per 1000 people.
- Hospitalisations for selected acute conditions, defined as the number of hospital separations per 1000 people for the following conditions: dehydration and gastroenteritis; pyelonephritis (kidney inflammation caused by bacterial infection); perforated/bleeding ulcer; cellulitis; pelvic inflammatory disease; ear, nose and throat infections; dental conditions; appendicitis; convulsions and epilepsy; and gangrene.

(Continued on next page)

Box 11.25 **(Continued)**

- Hospitalisations for selected chronic conditions, defined as the number of hospital separations per 1000 people for the following conditions: asthma; congestive cardiac failure; diabetes complications; chronic obstructive pulmonary disease; angina; iron deficiency anaemia; hypertension; nutritional deficiencies; and rheumatic heart disease.

Selected conditions are defined according to the Victorian Ambulatory Care Sensitive Conditions Study (AIHW 2009b; DHS 2002).

Low or reducing separation rates for vaccine preventable conditions may indicate improvements in the effectiveness of the vaccination program. Low or reducing separation rates for selected acute conditions may indicate more effective treatment of these conditions in the primary and community healthcare sector. Low or reducing separation rates for selected chronic conditions may indicate more effective management of these conditions in the primary and community healthcare sector.

Data are reported for each measure for all people and by Indigenous status. A reduction in the gap in hospital separation rates between Indigenous and all people can indicate greater equity of access to primary healthcare services.

Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions, for example, the underlying prevalence of conditions, patient compliance with treatment, and the number and virulence of influenza strains. Public health measures that are not reported in this chapter can also influence hospitalisation rates.

Data for this indicator are comparable.

Vaccine preventable hospitalisations

Nationally, the age standardised hospital separation rate for all vaccine preventable conditions was 0.7 per 1000 people in 2007-08. Nationally, influenza and pneumonia accounted for 78.9 per cent of hospital separations for vaccine preventable conditions in 2007-08 (table 11.7).

Table 11.7 **Separations for vaccine preventable conditions per 1000 people, 2007-08**[a, b]

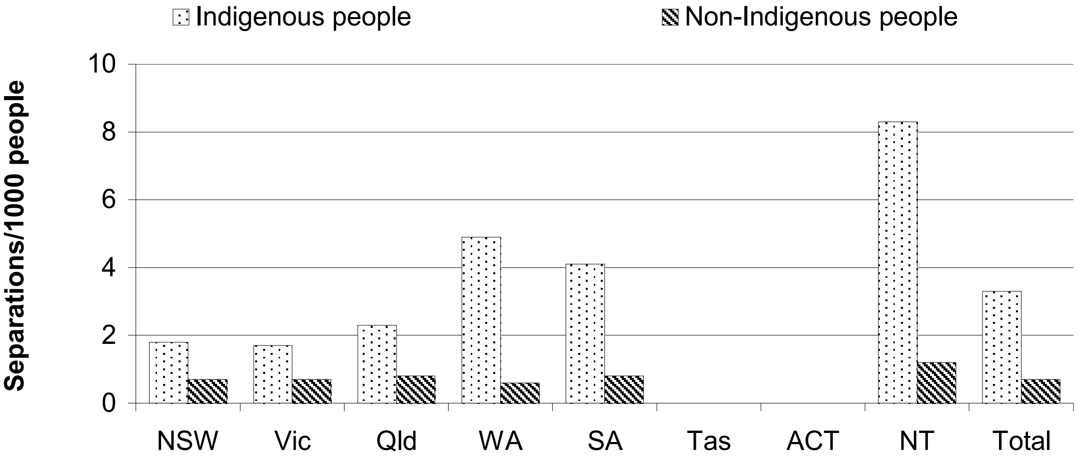
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Influenza and pneumonia	0.5	0.5	0.7	0.5	0.7	0.4	0.7	1.7	0.6
Other conditions	0.1	0.2	0.1	0.1	0.1	0.0	0.1	0.6	0.2
Total[d]	0.7	0.7	0.8	0.6	0.8	0.4	0.8	2.3	0.7

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Rates are based on state/territory of usual residence. [c] Includes other territories and excludes overseas residents and unknown state of residence. [d] Totals may not add due to rounding.

Source: AIHW (2009) *Australian Hospital Statistics 2007-08*, Cat. no. HSE 71; table 11A.43.

The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous people than for non-Indigenous people in 2007-08 in all jurisdictions for which data were published (figure 11.34).

Figure 11.34 **Separations for vaccine preventable conditions by Indigenous status, 2007-08**[a, b, c, d, e]



[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [c] Indigenous separation rates are based on state of hospitalisation while non-Indigenous rates are based on state of usual residence. [d] NT data for Indigenous people are for public hospitals only. [e] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for analysis.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.43.

Age standardised hospital separation rate ratios for infectious pneumonia illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in the age structures of the populations. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. For both males and females there was a marked difference in 2007-08 between the separation rates for Indigenous people and those for the total population for infectious pneumonia diagnoses. For NSW, Victoria, Queensland, WA, SA and the NT combined, the separation rate for Indigenous males was higher than that for all Australian males, and the separation rate for Indigenous females was higher than the rate for all females (tables 11A.46 and 11A.47).

Hospitalisations for selected acute conditions

Of the selected acute conditions, dental conditions and dehydration and gastroenteritis recorded the highest rates of hospitalisation nationally in 2007-08 (table 11.8).

Table 11.8 **Separations for selected acute conditions per 1000 people, 2007-08**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Appendicitis	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.2	0.2
Cellulitis	1.7	1.7	1.9	1.5	1.5	1.4	1.3	3.7	1.7
Convulsions and epilepsy	1.6	1.5	1.6	1.3	1.6	1.7	1.4	3.1	1.6
Dehydration and gastroenteritis	2.1	3.1	2.5	2.1	3.5	2.2	1.7	2.0	2.5
Dental conditions	2.4	3.1	2.7	3.4	3.2	1.9	2.0	2.2	2.8
Ear, nose and throat infections	1.7	1.6	1.8	1.7	2.5	1.4	1.2	2.1	1.7
Gangrene	0.1	0.3	0.2	0.3	0.2	0.2	0.1	0.7	0.2
Pelvic inflammatory disease	0.2	0.2	0.3	0.2	0.2	0.2	0.3	0.5	0.2
Perforated/bleeding ulcer	0.2	0.2	0.2	0.3	0.3	0.2	0.2	0.2	0.2
Pyelonephritis[d]	2.1	2.4	2.3	2.1	2.1	1.7	2.2	3.3	2.2
Total[e]	**12.3**	**14.3**	**13.6**	**13.1**	**15.2**	**11.0**	**10.5**	**17.9**	**13.3**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Rates are based on state/territory of usual residence. [c] Includes other territories and excludes overseas residents and unknown state of residence. [d] Kidney inflammation caused by bacterial infection. [e] Totals may not add as more than one acute condition may be reported for a separation.

Source: AIHW (2009) *Australian Hospital Statistics 2007-08*, Cat. no. HSE 71; table 11A.44.

The age standardised hospital separation rate for the selected acute conditions was higher for Indigenous people than for non-Indigenous people in 2007-08 in all jurisdictions for which data were published (figure 11.35).

Figure 11.35 **Separations for selected acute conditions by Indigenous status, 2007-08**[a, b, c, d, e]

---

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [c] Indigenous separation rates are based on state of hospitalisation while non-Indigenous rates are based on state of usual residence. [d] NT data for Indigenous people are for public hospitals only. [e] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for analysis.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.44.

Hospitalisations for selected chronic conditions

Of the selected chronic conditions, diabetes complications, chronic obstructive pulmonary disease, congestive cardiac failure, asthma and angina recorded the highest rates of hospitalisation nationally in 2007-08. The hospitalisation rate for diabetes complications was more than three times higher than the rate for any other of the selected conditions (table 11.9).

Table 11.9 Separations for selected chronic conditions per 1000 people, 2007-08[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[c]
Angina	1.4	1.7	2.4	1.4	1.6	1.4	1.1	2.4	1.7
Asthma	1.9	1.9	1.7	1.5	2.6	1.5	1.0	1.4	1.8
Chronic obstructive pulmonary disease	2.6	2.6	2.9	2.4	3.1	2.7	1.5	6.3	2.7
Congestive cardiac failure	1.9	2.2	2.0	1.7	1.9	1.7	1.8	2.3	2.0
Diabetes complications	7.0	9.3	10.3	29.0	7.6	12.6	5.5	13.2	10.6
Hypertension	0.3	0.2	0.3	0.2	0.3	0.3	0.1	0.1	0.3
Iron deficiency anaemia	1.0	1.6	1.1	1.4	1.0	1.4	0.7	0.7	1.2
Nutritional deficiencies	–	–	0.0	0.0	–	0.0	–	0.1	0.0
Rheumatic heart disease[d]	0.1	0.1	0.2	0.1	0.1	0.1	0.2	0.8	0.1
Total[e]	**15.2**	**18.4**	**19.7**	**36.6**	**16.9**	**20.9**	**11.1**	**25.5**	**19.2**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Rates are based on state/territory of usual residence. [c] Includes other territories. Excludes overseas residents and unknown state of residence. [d] Includes acute rheumatic fever as well as the chronic disease. [e] Totals may not add as more than one chronic condition may be reported for a separation. – Nil or rounded to zero.

Source: AIHW (2009) *Australian Hospital Statistics 2007-08*, Cat. no. HSE 71; table 11A.45.

The age standardised hospital separation rate for the selected chronic conditions was higher for Indigenous people than for non-Indigenous people in 2007-08 in all jurisdictions for which data were published (figure 11.36).

Figure 11.36 Separations for selected chronic conditions by Indigenous status, 2007-08[a, b, c, d, e]

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [c] Indigenous separation rates are based on state of hospitalisation while non-Indigenous rates are based on state of usual residence. [d] NT data for Indigenous people are for public hospitals only. [e] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for analysis.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.45.

Potentially preventable hospitalisations for diabetes

‘Potentially preventable hospitalisations for diabetes’ is an indicator of governments’ objective to reduce hospitalisations due to diabetes through the provision of high quality, appropriate and effective management of diabetes in the primary and community health sector (box 11.26).

Box 11.26 **Potentially preventable hospitalisations for diabetes**

‘Potentially preventable hospitalisations for diabetes’ is defined by two measures:

- the number of hospitalisations for diabetes mellitus as the principal diagnosis, per 100 000 people
- the number of hospitalisations for lower limb amputation with a principal or additional diagnosis of diabetes, per 100 000 people.

Rates are adjusted to account for differences in the age structures of State and Territory populations.

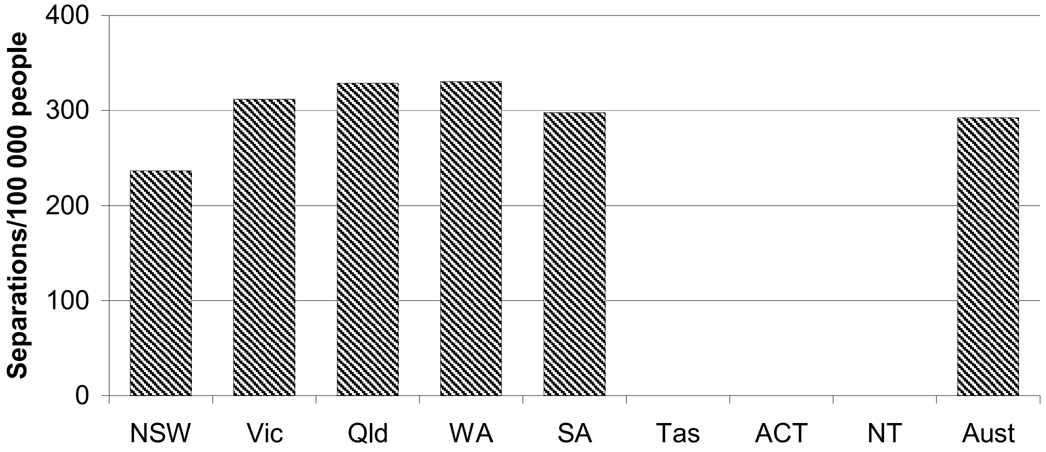
Low or reducing rates can indicate an improvement in GPs’ and community health providers’ management of patients’ diabetes. A comparison is made between Indigenous and all other people in the ratio of age standardised hospital separation rates of Indigenous people to all people. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, patient compliance with measures to manage diabetes, and the underlying prevalence of diabetes.

Data for this indicator are comparable.

Nationally, the age standardised hospital separation rate in 2007-08 where the principal diagnosis was Type 2 diabetes mellitus was 292.3 separations per 100 000 people (figure 11.37).

Figure 11.37 Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2007-08[a, b, c]

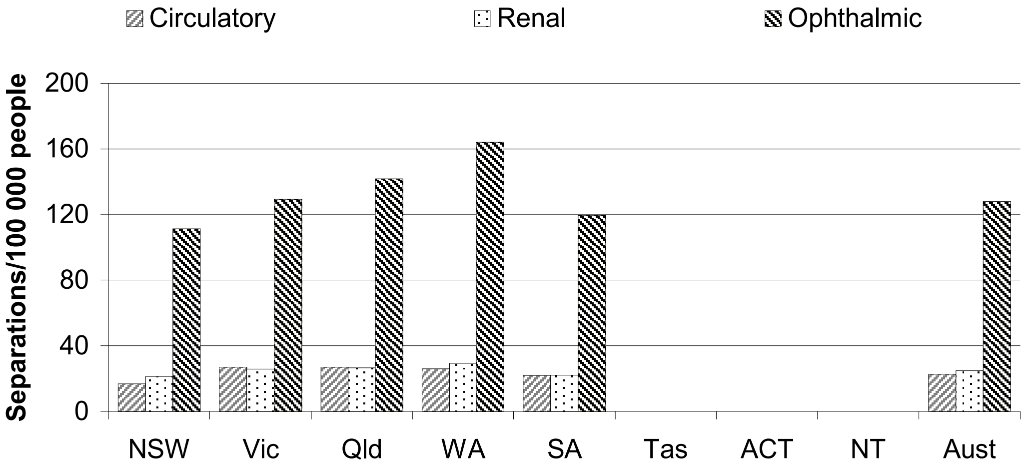


[a] Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. [b] Morbidity data are coded under coding standards that can differ over time and across jurisdictions. [c] Data for Tasmania, the ACT and the NT are not published separately (due to hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.48.

The three most common complications from Type 2 diabetes that led to hospitalisation in 2007-08 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.38). Each patient can have one or more complication(s) (circulatory, renal and ophthalmic) for each diabetes hospital separation.

Figure 11.38 **Proportion of separations for principal diagnosis of Type 2 diabetes mellitus by selected complications, all hospitals, 2008-09**[a, b, c, d]



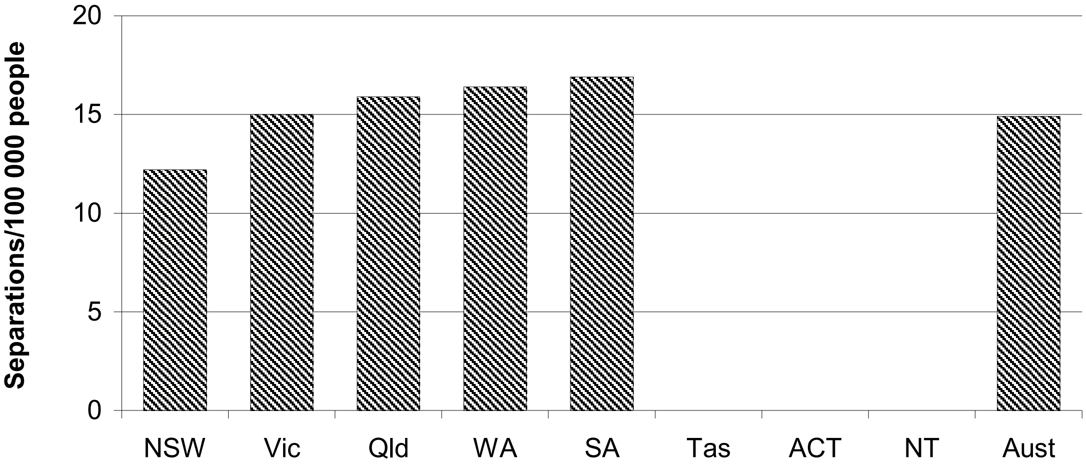
[a] Results for individual complications can be affected by small numbers, and need to be interpreted with care. [b] Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. [c] Morbidity data are coded under coding standards that can differ over time and across jurisdictions. [d] Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.48.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but the number of people accessing ambulatory services is not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients affect hospital separation rates. This effect is partly reflected in the variation in the proportion of separations that are 'same day' across jurisdictions. Nationally, 49.9 per cent of separations for Type 2 diabetes were same day separations in 2007-08 (table 11A.49).

Amputation of a lower limb can be an outcome of serious diabetes-related complications. In 2007-08, there were 14.9 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 11.39).

Figure 11.39 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2007-08**[a, b, c]



[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation. [c] Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

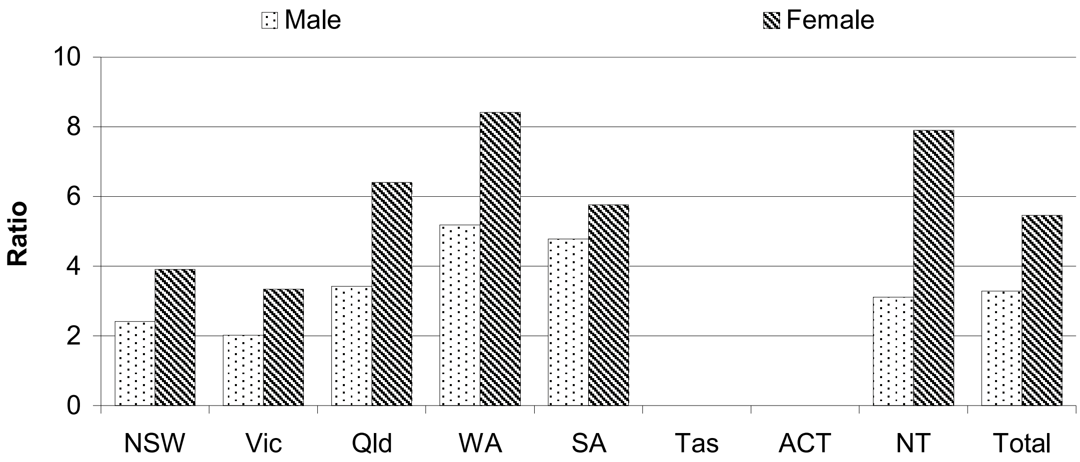
Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.50.

Age standardised hospital separation ratios for all diabetes diagnoses[2] illustrate differences between the rate of hospital admissions for Indigenous people and that for all Australians, taking into account differences in the age structures of the two populations. For both males and females there was a marked difference in 2007-08 between the separation rates for Indigenous people and those for the total population for all diabetes diagnoses. The quality of Indigenous identification is considered acceptable for analysis only for NSW, Victoria, Queensland, WA, SA and the NT. For these jurisdictions combined, the separation rate for Indigenous males was 3.3 times higher than the separation rate for all Australian males. The separation rate for Indigenous females was 5.5 times the rate for all females (figure 11.40).

---

[2] 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes, except where dialysis is the principal diagnosis.

Figure 11.40 **Ratio of separation rates of Indigenous people to all people for all diabetes diagnoses, 2007-08**[a, b, c, d, e, f, g]



[a] Ratios are directly age standardised to the Australian population at 30 June 2001. [b] Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. [c] 'All diabetes' refers to separations with a principal and/or additional diagnosis of diabetes, except where dialysis is the principal diagnosis. [d] Patients aged 75 years and over are excluded. [e] Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. [f] NT data are for public hospitals only. [g] Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT because the quality of Indigenous identification is not considered acceptable for purposes of analysis.

Source: AIHW (unpublished) National Hospital Morbidity Database; tables 11A.46 and 11A.47.

Potentially preventable hospitalisations of older people for falls

'Potentially preventable hospitalisations of older people for falls' is an indicator of governments' objective to reduce preventable hospitalisations through the delivery of effective primary and community health services (box 11.27). Effective primary and community healthcare can reduce the likelihood of falls and/or assist in reducing the severity of injury.

Box 11.27 **Potentially preventable hospitalisations of older people for falls**

'Potentially preventable hospitalisations of older people for falls' is defined as the number of hospital separations for older people with a reported external cause of falls per 1000 older people, adjusted to take account of differences in State and Territory age distributions. Older people are defined as aged 65 years or over for this indicator.

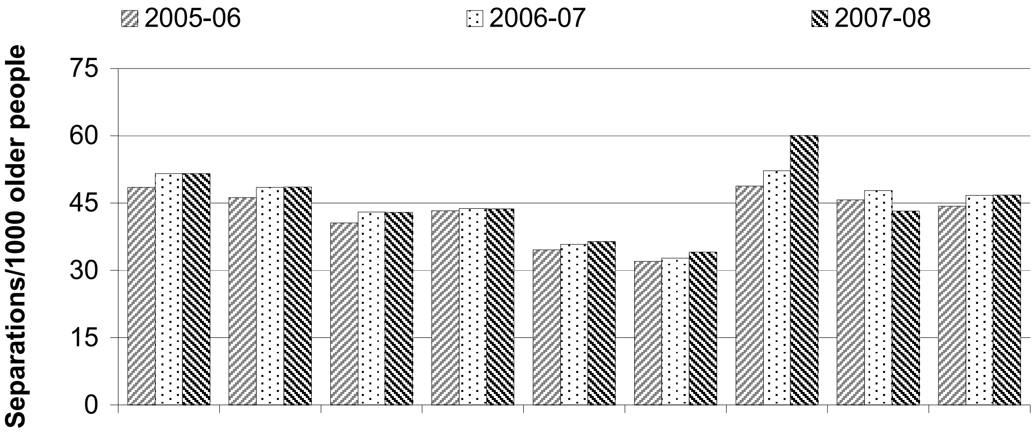
A low or reducing rate of hospitalisation due to falls can indicate improvements in the effectiveness of primary and community healthcare services provided to older people who are at risk of falls or, have fallen.

Factors outside the control of the primary healthcare system also influence the rates of hospitalisation. These include the support available to older people from family and friends, and the provision of aged care services such as Home and Community Care program services and residential care.

Data for this indicator are comparable.

In all jurisdictions for which data are published, age standardised separation rates for older people with injuries due to falls have gradually increased in the period 2005-06 to 2007-08 (figure 11.41). Nationally, the separation rate per 1000 older people increased from 44.3 in 2005-06 to 46.8 in 2007-08.

Figure 11.41 **Separations for older people with a reported external cause of falls**[a, b, c]



---

[a] Older people are defined as people aged 65 years or over. [b] Separation rates are age standardised to the Australian population aged 65 years or over at 30 June 2001. [c] Excludes separations records for hospital boarders and posthumous organ procurement.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.51.

11.4 Future directions in performance reporting

The topic of this chapter is all primary and community health services. However, the indicators remain heavily focused on general practice services. This partly reflects the lack of data available on a nationally consistent basis to support reporting against indicators for other primary and community health services. The Steering Committee has identified possible areas for which indicators may be available for inclusion in the 2011 Report or future reports. These include:

- dental health services
- community-based drug and alcohol treatment services
- additional indicators relating to the use of the MBS chronic disease management items.

In addition, the currently reported indicator ‘management of upper respiratory tract infection’ has been identified for reporting improvements.

The scope of this chapter can also be further refined to ensure the most appropriate reporting of primary health services against the Review’s terms of reference and reporting framework (see chapter 1).

Indigenous health

Barriers to accessing primary health services contribute to the poorer health status of Indigenous people compared to other Australians (see the Health preface). The Steering Committee has identified primary and community health services for Indigenous people as a priority area for future reporting and will continue to examine options for the inclusion of further such indicators. The Aboriginal and Torres Strait Islander Health Performance Framework developed under the auspices of the Australian Health Ministers’ Advisory Council will inform the selection of future indicators of primary and community health services to Indigenous people.

Continued efforts to improve Indigenous identification are necessary to better measure the performance of primary and community health services in relation to the health of Indigenous Australians. Work being undertaken by the ABS and AIHW includes an ongoing program to improve identification of Indigenous status in Australian, State and Territory government administrative systems.

COAG developments

Report on Government Services alignment with National Agreement reporting

It is anticipated that future editions of health services chapters and the Health preface will align with applicable National Agreement indicators, including the *National Indigenous Reform Agreement*. Further alignment between the Report and National Agreement indicators, and other reporting changes, might result from future developments in National Agreement and National Partnership reporting.

Outcomes from review of Report on Government Services

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report on Government Services in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the *Intergovernmental Agreement on Federal Financial Relations*.

No significant changes from this review are reflected in the 2010 Report. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 Report.

11.5 Definitions of key terms and indicators

Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Annual cycle of care for people with diabetes mellitus within general practice	The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice. based on RACGP guidelines. MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines.
Asthma Action Plan	An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional. *Source*: ACAM (Australian Centre for Asthma Monitoring) 2007, *Australian asthma indicators: Five-year review of asthma monitoring in Australia*. Cat. no. ACM 12, AIHW, Canberra.
Cervical screening rates for target population	Proportion of eligible women aged 20–69 years who are screened for cervical cancer over a 2 year period. Eligible women are those who have not had a hysterectomy.
Closed treatment episode	A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for three months or more. Clients may be involved in more than one closed treatment episode in a data collection period.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Divisions of General Practice	Geographically-based networks of GPs. There are 109 Divisions of General Practice (DGP), 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN). The DGP Program evolved from the former Divisions and Projects Grants Program established in 1992. The DGP Program aims to contribute to improved health outcomes for communities by working with GPs and other health services providers to improve the quality and accessibility of healthcare at the local level.
Full time workload equivalents (FWE)	A measure of medical practitioner supply based on claims processed by Medicare in a given period, calculated by dividing the practitioner’s Medicare billing by the mean billing of full time practitioners for that period. Full time equivalents (FTE) are calculated in the same way as FWE except that FTE are capped at 1 per practitioner.

Fully immunised at 12 months	A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine and three doses of HbOC (HibTITER) (or two doses of PRP-OMP [PedvaxHIB]).
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine, four doses of HbOC (HibTITER) (or three doses of PRP-OMP [PedvaxHIB]) and one dose of measles, mumps and rubella vaccine.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.
General practitioner (GP)	Vocationally recognised GPs — medical practitioners who are vocationally recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP, ACRRM, or equivalent (from 1996 vocational registration was available only to GPs who attained Fellowship of the RACGP; since April 2007, it has also been available to Fellows of the ACRRM), or hold a recognised training placement. Other medical practitioners — medical practitioners who are not vocationally recognised GPs.
***Haemophilus influenzae* type b**	A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (DoHA 2008).
Immunisation coverage	The proportion of a target population fully immunised with National Immunisation Program specified vaccines for that age group.
Management of upper respiratory tract infections	Number of prescriptions ordered by GPs for the oral antibiotics most commonly used in the treatment of upper respiratory tract infections per 1000 people with PBS concession cards.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive Medicare reimbursement.
Non-referred attendances that are bulk billed	Number of non-referred attendances that are bulk billed and provided by medical practitioners, divided by the total number of non-referred non-specialist attendances.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (DoHA 2004). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.
Notifications of selected childhood diseases	Number of cases of measles, pertussis and *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System by State and Territory health authorities.
Other medical practitioner (OMP)	A medical practitioner other than a vocationally recognised GP who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.

Per person benefits paid for GP ordered pathology	Total benefits paid 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 given period (period prevalence).
Proportion of GPs who are female	Number of all FWE GPs who are female, divided by the total number of FWE GPs.
Proportion of GPs with vocational recognition	Number of FWE GPs who are vocationally recognised, divided by the total number of FWE GPs.
Proportion of general practices registered for accreditation	Number of practices registered for accreditation through either of the two accreditation bodies (AGPAL and GPA ACCREDITATION *plus*), divided by the total number of practices in the DGP.
Proportion of general practices with electronic information management systems	Number of practices that maintain and/or use predominantly secure electronic patient records, that are registered under the PIP, divided by the total number of practices registered.
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Reasons for encounter	The expressed demand of the patient for care, as perceived and recorded by the GP.
Recognised immunisation provider	A provider recognised by Medicare Australia as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist on the Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition earlier than would otherwise be possible.
Vocationally recognised general practitioner	A medical practitioner who is vocationally recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances.

11.6 Attachment tables

Attachment tables are identified in references throughout this chapter by a '11A' suffix (for example, table 11A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Table 11A.48	Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2007-08 (per 100 000 people)
Table 11A.49	Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2007-08 (per cent)
Table 11A.50	Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2007-08
Table 11A.51	Separation rates of older people for injuries due to falls, 2007-08

Community health programs

Table 11A.52	Australian Government, community health services programs
Table 11A.53	New South Wales, community health services programs
Table 11A.54	Victoria, community health services programs
Table 11A.55	Queensland, community health services programs
Table 11A.56	Western Australia, community health services programs
Table 11A.57	South Australia, community health services programs
Table 11A.58	Tasmania, community health services programs
Table 11A.59	Australian Capital Territory, community health services programs
Table 11A.60	Northern Territory, community health services programs

11.7 References

ACAM (Australian Centre for Asthma Monitoring) 2008, *Asthma in Australia 2008*, Cat. no. ACM 14, AIHW Asthma Series 3, Canberra.

AIHW (Australian Institute of Health and Welfare) 2005a, *2004 Adult Vaccination Survey: summary results*. AIHW Cat. no. PHE 56, Canberra.

—— 2005b, *Improving the Quality of Indigenous Identification in Hospital Separations Data*, Cat. no. HSE 101, Health Services Series no. 25, Canberra.

—— 2007b, *National indicators for monitoring diabetes: report of the Diabetes Indicators Review Subcommittee of the National Diabetes Data Working Group*, Cat. no. CVD 38, Diabetes series no. 6, Canberra.

—— 2008a, *Aboriginal and Torres Strait Islander Health Performance Framework, 2008 report: detailed analyses*, AIHW Cat. no. IHW 22, Canberra.

—— 2008b, *Australia's health 2008*, Cat. no. AUS 99, Canberra.

—— 2008c, *Diabetes: Australian facts*, Cat. no. CVD 40, Diabetes series no. 8, Canberra.

—— 2009a, *Alcohol and other drug treatment services in Australia 2007-08: report on the National Minimum Data Set*, Cat. no. HSE 73, Canberra.

—— 2009b, *Australian hospital statistics 2007–08*, Cat. no. HSE 71, Canberra.

Britt, H., Miller, G.C., Charles, J., Henderson, J., Bayram, C., Pan, Y., Valenti, L., Harrison, C., Fahridin, S. and O'Halloran, J. 2009, *General practice activity in Australia 2008–09*, Cat. no. GEP 25, General practice series no. 25, AIHW, Canberra.

DHAC (Australian Government Department of Health and Aged Care) 2000, *General Practice in Australia: 2000*, Canberra.

DoHA (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 12 September 2007).

—— 2006, *The Pap smear*, www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/papsmear#5 (accessed 12 October 2009).

—— 2008, *Immunisation Myths and Realities: responding to arguments against immunisation*, 4th edn, Canberra.

—— 2009a, *About the PBS*. www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-general-aboutus.htm-copy2 (accessed 10 August 2009).

—— 2009b, *Pharmaceutical Benefits Safety Net Arrangements*, www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-general-pbs-phbensna.htm-copy2 (accessed 10 August 2009).

—— 2009c, *Medicare Statistics - June Quarter 2009*, www.health.gov.au/internet/main/publishing.nsf/Content/medstat-jun09-contents (accessed 18 November 2009).

DoHA and NHMRC (National Health and Medical Research Council) 2008, *The Australian Immunisation Handbook*, 9th edn, Canberra.

DHS (Department of Human Services) 2002, *Victorian Ambulatory Care Sensitive Conditions Study: Preliminary Analyses*, Victorian Government, Melbourne.

Mitchell, H. Hocking, J. Saville, M. 2003, 'Improvement in protection of adenocarcinoma of the cervix resulting from participation in cervical screening', *Cancer Cytopathology*, vol. 99, no. 6, pp. 336–341.

National Advisory Committee on Oral Health 2004, *Healthy mouths Healthy Lives: Australia's National Oral Health Plan 2004–2013*, Report endorsed by 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.

NHPAC (National Health Priority Action Council) 2006, *National Chronic Disease Strategy*, Australian Government Department of Health and Ageing, Canberra.

Quality Improvement Council 1998, *Australian Health and Community Service Standards: Community and Primary Health Care Services Module*, Melbourne.

RACGP (Royal Australian College of General Practitioners) 2005, *What is general practice?* www.racgp.org.au/whatisgeneralpractice (accessed 19 October 2008).

—— 2007, *Vocational Training*, www.racgp.org.au/vocationaltraining (accessed 12 October 2009).

SCRGSP (Steering Committee for the Review of Government Service Provision) 2009, *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commission, Canberra.

Van Konkelenberg, R. Esterman, A. Van Konkelenberg, J. 2003, *Literature Reviews: Factors Influencing use of Emergency Departments and Characteristics of Patients Admitted Through Emergency Departments*, www.library.health.sa.gov.au/Portals/0/literature-reviews-factors-influencing-use-of-emergency-departments.2003.doc (accessed 1 November 2006).

12 Health management issues

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the management of breast cancer and mental health, which represent some activities of the Australian, State and Territory governments in health management.

12.1 Overview of health management

Health management is the ongoing process beginning with initial client contact and including all actions relating to the client: assessment/evaluation; education of the person, family or carer(s); diagnosis; and treatment. Problems associated with adherence to treatment and liaison with, or referral to, other agencies are also included.

This chapter examines the performance of a number of services in influencing outcomes for women with breast cancer and for people with a mental illness. Breast cancer and mental illness are significant causes of morbidity and mortality in Australia. Cancer control and mental health are identified by governments as national health priority areas (as are asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and musculoskeletal conditions and, since 2008, obesity). The national health priority areas represented over 70 per cent of the total burden of disease and injury in Australia in 2003, and their management offers considerable scope for reducing this burden (Begg *et al.* 2007).

Breast cancer detection and management services comprise a number of major components: primary care and community-based services, including general practitioner (GP) services and community-based women's health services; screening services; acute services based in hospitals, including both inpatient and outpatient services; private consultations for a range of disciplines; and post-acute services, including home-based and palliative care (DHS 1999). Relevant clinical disciplines include surgery, plastic and reconstructive surgery, pathology, radiation and medical oncology, nursing, diagnostic radiology, radiography, physiotherapy, allied health, and psychological and psychiatric services. Post-acute services include a range of further treatments, such as radiotherapy and chemotherapy (most of which take place on a same day or outpatient basis) and a range of follow up and palliative care services (DHS 1999).

Specialised mental health management services include a range of government and non-government service providers offering promotion, prevention, treatment and management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, Aboriginal health workers, Aboriginal mental health workers, public hospitals with specialised psychiatric units and stand-alone psychiatric hospitals all provide specialised mental health care. In addition, a number of health services provide care to mental health patients in a non-specialised health setting — for example, GPs, Aboriginal community controlled health services, public hospital emergency departments and outpatient departments, and public hospital general wards (as distinct from specialist psychiatric wards). Some people with a mental illness are cared for in residential aged care services.

Both breast cancer and mental health are the subject of programs designed to improve public health. Public health programs require the participation of public hospitals, primary and community health services, and other services. The performance of public hospitals is reported in chapter 10 and the performance of primary and community health services generally is reported in chapter 11.

The following improvements have been made to the chapter this year:

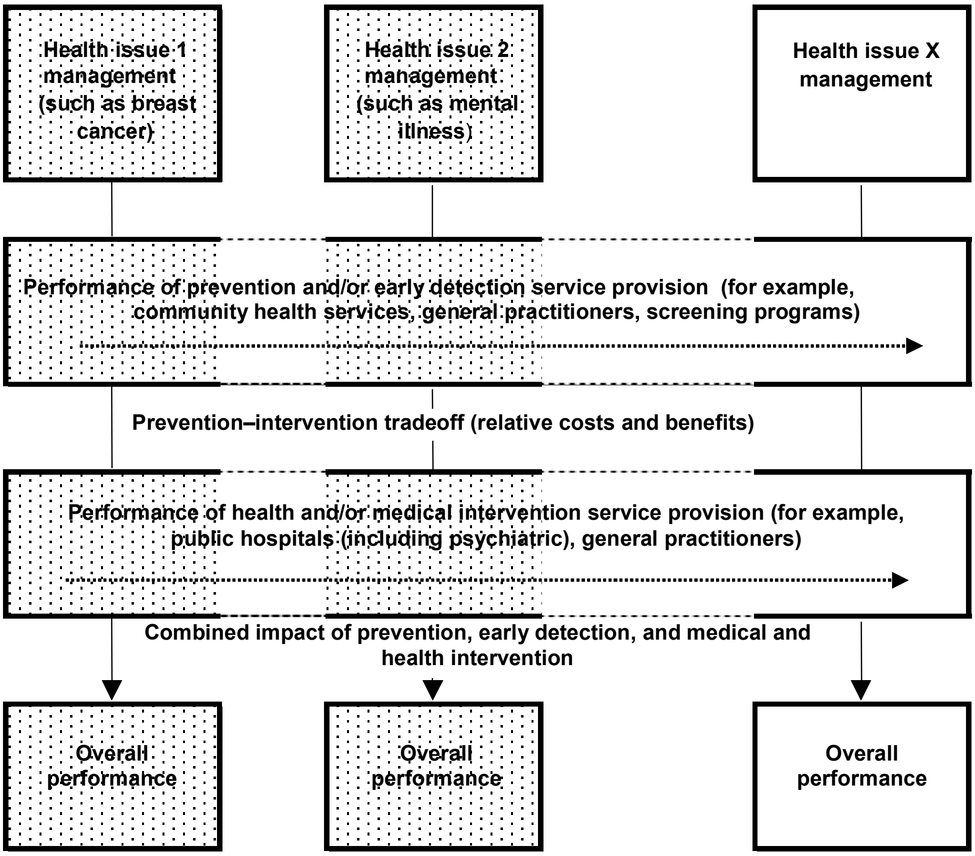
- Breast cancer detection rate data are reported as annual averages for the first time.
- Two measures replace the previously reported measure for the 'Average cost of ambulatory care' indicator (cost per treated patient in the community). Work on the new measures is ongoing; however, they are from the agreed set of *National Mental Health Key Performance Indicators* and are more comparable than the previous measure.
- Data from the *2007 National Survey of Mental Health and Wellbeing* (SMHWB) are now reported under the indicator 'prevalence of mental illness', previously these data were in the profile section.

12.2 Framework for measuring the performance of health management

Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. Measuring performance in the management of a health problem involves measuring the performance of service providers, and the overall management of a spectrum of services, including prevention, early detection and treatment programs.

The 'Health preface' of this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and primary and community health services report the performance of particular service delivery mechanisms. The appropriateness of the mix of services (prevention versus intervention) and the appropriateness of the mix of delivery mechanisms (hospital-based versus community-based) are the focus of reporting in this chapter. The measurement approach is summarised in figure 12.1.

Figure 12.1 **The Australian health system — measurement approach**



The appropriate mix of services — including the prevention of illness and injury, medical treatment and the appropriate mix of service delivery mechanisms — is measured by focusing on a specific health management issue (represented by the vertical arrows). The chapter covers breast cancer detection and management, and specialised mental health services. The breast cancer management framework integrates early detection and medical intervention strategies, which should inform the decisions in the allocation of resources between these two strategies. The mental health framework provides information on the interaction and integration arrangements between community-based and hospital-based providers in meeting the needs of Australians with a mental illness.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (see chapter 1 for more detail on reforms to federal financial relations). The *National Healthcare Agreement* (NHA) covers the areas of health and aged care services, while the *National Indigenous Reform Agreement* establishes specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. The agreements include sets of performance indicators, for which the

Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC).

The measurement details of relevant National Agreement reporting were under development at the time of preparing this Report. It is anticipated that the performance indicator results reported in this chapter will be revised to align with the performance indicators in the National Agreements as appropriate for the 2011 Report.

12.3 Breast cancer

Profile

Breast cancer is a disease whereby abnormal cells in the ducts (that carry milk to the nipple) or lobules (where milk is produced) of the breast grow and multiply out of control (box 12.1). Breast cancer can be invasive or non-invasive. Non-invasive breast cancer remains in the ducts or lobules. Invasive breast cancer spreads beyond the ducts or lobules to invade surrounding breast tissue, and can spread to other parts of the body, or metastasize (AIHW 2009a). If left untreated, most invasive cancers (tumours) are life-threatening (AIHW 2009a). The focus of this Report is on invasive cancer, although some data are reported for non-invasive cancer. Breast cancer in males is rare, and is not examined in this Report.

Box 12.1 Some common health terms used in breast cancer detection and management

Some common breast cancer detection and management related terms are defined below.

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).

(Continued on next page)

Box 12.1 **(Continued)**

BreastScreen Australia: BreastScreen Australia is the national mammographic population screening program. It is aimed at healthy women without symptoms of breast cancer. It provides free screening mammograms at two-yearly intervals for women aged 50–69 years with the aim of reducing deaths from breast cancer in this target group through early detection of the disease. Women aged 40–49 years and 70 years or over are eligible to attend but are not actively targeted. Services provided by BreastScreen Australia include all screening and assessment services to the point of diagnosis. The program includes health promotion activities, information provision, counselling and data collection across the screening and assessment pathways. BreastScreen Australia is jointly funded by the Australian, State and Territory governments.

Ductal carcinoma in situ **(DCIS):** a non-invasive tumour of the mammary gland (breast) arising from cells lining the ducts. Also known as intraductal carcinoma.

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 cancer (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.

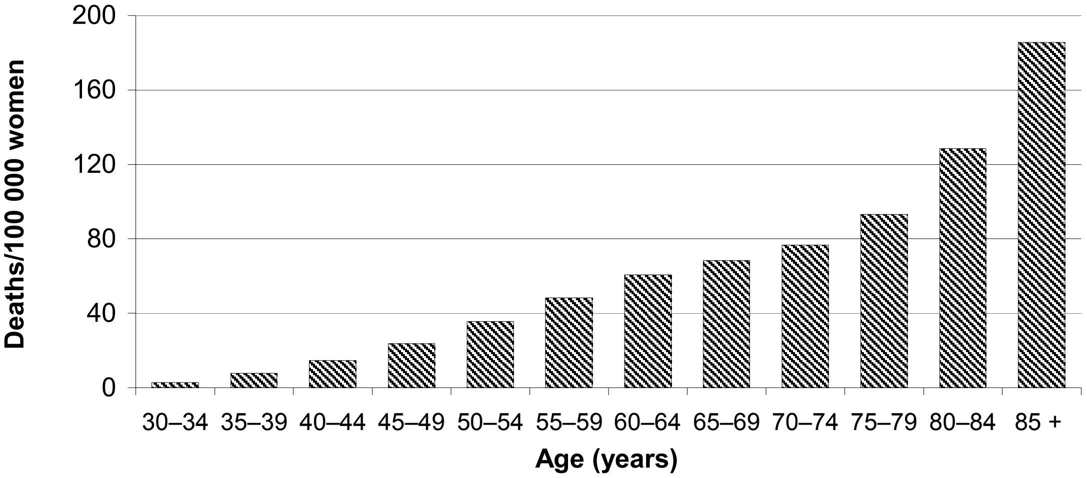
Screening round (first): a woman’s first visit to a BreastScreen Australia service.

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 the cause of 2618 female deaths in 2006, making it one of the most common causes of death from cancer for females (AIHW and NBOCC 2009). The strong relationship between age and the mortality rate from breast cancer is shown for the period 2003–2007 in figure 12.2. For women aged 40–44 years at diagnosis the annual average mortality rate over this period was 14.5 per 100 000, whereas for women aged 75–79 years at diagnosis, the annual average mortality rate was 93.2 per 100 000.

Figure 12.2 **Annual average mortality rates from breast cancer, by age group, 2003–2007**

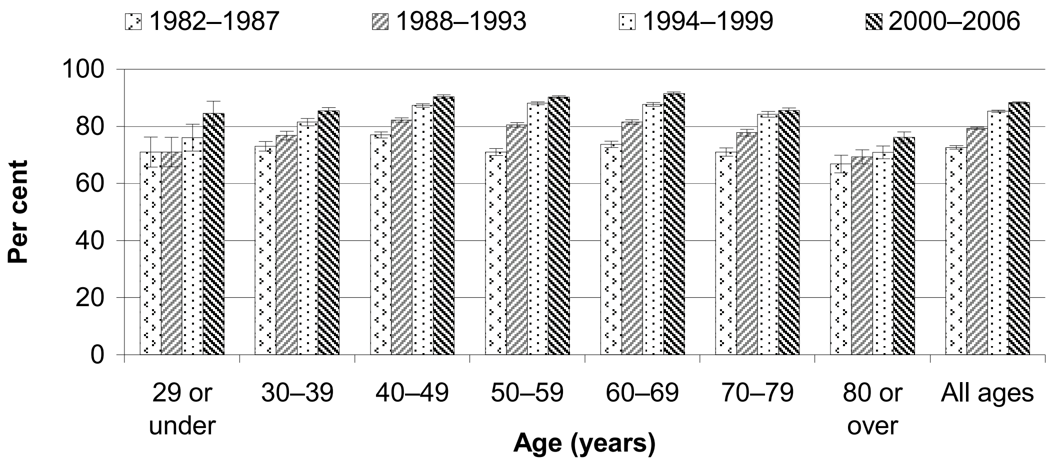


Source: Australian Bureau of Statistics (ABS) (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0; table 12A.1.

Survival after diagnosis of breast cancer in females is better than for other cancers. The relative survival rate 10 years after diagnosis was 77.8 per cent for women diagnosed in 1994–1999. For women diagnosed during the period 2000–2006, the relative survival rate was 97.4 per cent one year after diagnosis and 88.3 per cent five years after diagnosis (AIHW and NBOCC 2009).

There was a significant increase in the five year relative survival rate after diagnosis of breast cancer in females between 1982–1987 and 2000–2006 (figure 12.3). Five year relative survival for breast cancer in Australia diagnosed over the period 2000–2006 increased with age at diagnosis from the age group 29 years or under (84.5 per cent) to a peak for the age group 60–69 years (91.5 per cent) and were similar for the age groups 40–49 and 50–59 years (90.4 and 90.3 per cent, respectively). The five year relative survival rate declined with age at diagnosis for women over 70 years (figure 12.3).

Figure 12.3 Breast cancer five year relative survival at diagnosis, by age group



Source: AIHW and NBOCC (2009) *Breast cancer in Australia: an overview, 2009*, Cancer series no. 50, Cat. no. CAN 46; table 12A.2.

Incidence and prevalence

Breast cancer is the second most common cancer affecting Australian women (AIHW 2009a). In 2005, the estimated risk of a woman in Australia developing breast cancer before the age of 75 years was one in eleven (AIHW and AACR 2008). The number of new cases of breast cancer diagnosed in Australian women increased from an annual average of 11 318 over the period 1998–2002 to an annual average of 12 185 over the period 2002–2006 (table 12.1). The number of cases detected reflects both the underlying rate of breast cancer and the early detection of cancers that previously would not have been discovered for some years, primarily through the activity of BreastScreen Australia (AIHW 2003).

Table 12.1 Annual average new cases of breast cancer diagnosed (number)[a]

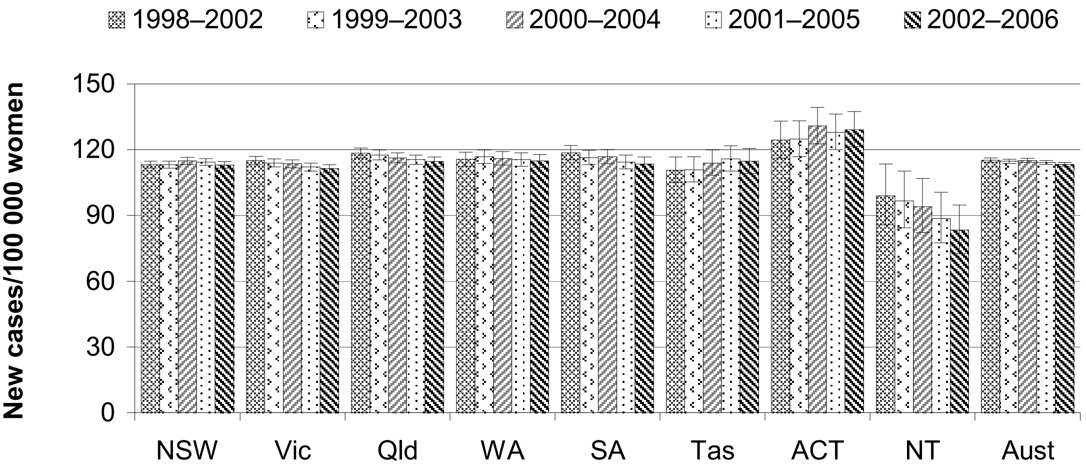
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1998–2002	3 819	2 864	2 083	1 046	991	282	178	55	11 318
1999–2003	3 900	2 894	2 138	1 089	989	288	184	59	11 542
2000–2004	4 033	2 943	2 188	1 114	1 010	303	198	60	11 849
2001–2005	4 084	2 967	2 247	1 142	1 010	314	198	61	12 022
2002–2006	4 101	3 009	2 304	1 168	1 022	317	204	59	12 185

[a] A new case is defined as a person who has a cancer diagnosed for the first time. One person can have more than one cancer, so can be counted twice in incidence statistics if it is decided that the two cancers are not of the same origin.

Source: AIHW (unpublished) Australian Cancer Database (formerly the National Cancer Statistics Clearing House [NCSCH]); table 12A.3.

Annual average age standardised incidence rates of breast cancer are presented in figure 12.4. Breast cancer incidence data are averaged over five year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases and relatively large variations in rates from year to year. Australia-wide, the annual average incidence rate from the period 1998–2002 to the period 2002–2006 fluctuated between 113.2 and 115.2 per 100 000 women.

Figure 12.4 **Annual average age standardised incidence rates of breast cancer for women of all ages**[a, b]



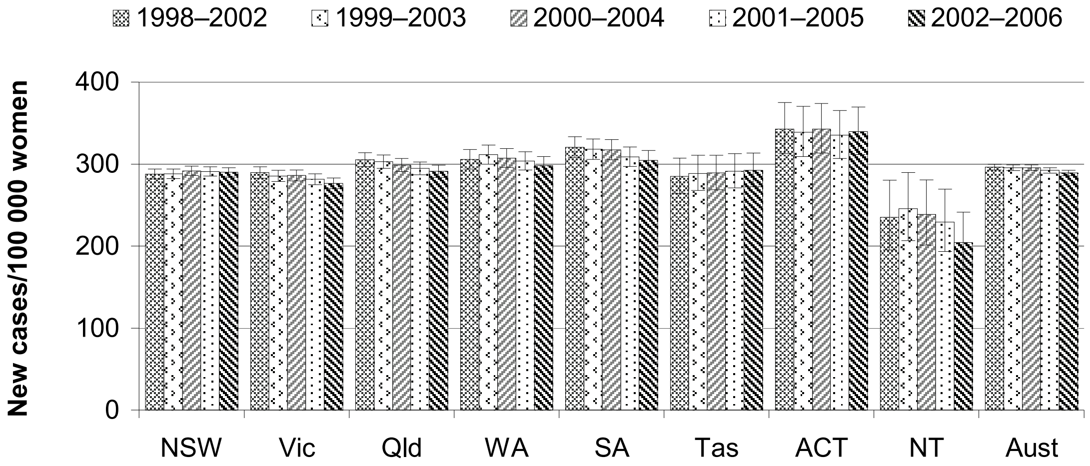
---

[a] Incidence refers to the number of new cases of breast cancer per 100 000 women. [b] Rates are age standardised to the Australian 2001 population standard.

Source: AIHW (unpublished) Australian Cancer Database (formerly the NCSCH); table 12A.4.

Annual average age standardised incidence rates of breast cancer for women aged 50–69 years are shown in figure 12.5.

Figure 12.5 **Annual average age standardised incidence rates of breast cancer for women aged 50–69 years**[a, b]



[a] Incidence refers to the number of new cases of breast cancer per 100 000 women. [b] Rates are age standardised to the Australian 2001 population standard.

Source: AIHW (unpublished) Australian Cancer Database (formerly the NCSCH); table 12A.4.

Size and scope of breast cancer detection and management services

A fundamental component of breast cancer control is the use of screening mammography to enable early detection of breast cancer. There is evidence that population-based screening of women aged 50–69 years can reduce deaths from breast cancer. An Australian study found that women aged 50–69 years whose cancer was diagnosed before it had spread outside the breast had a 97 per cent chance of surviving five years relative to all Australian women aged 50–69 years and for women whose cancer had spread to other parts of the body before diagnosis, relative survival was 83 per cent (AIHW and NBCC 2007). It is generally accepted that cancers detected early can be treated more conservatively and that these women have a higher likelihood of survival.

The BreastScreen Australia Program, jointly funded by the Australian, State and Territory governments, undertakes nationwide breast cancer screening. It targets women aged 50–69 years for screening once every two years, aiming for a participation rate of at least 70 per cent. Recruitment activities undertaken by BreastScreen Australia specifically target women in this age group, although the service is also available to women aged 40–49 years, and 70 years or over.

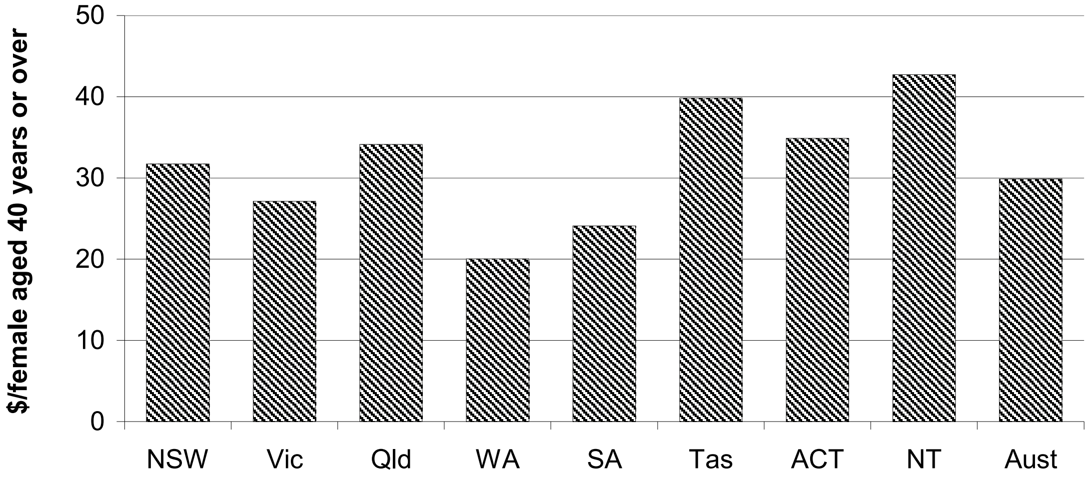
Services provided by BreastScreen Australia in each State and Territory include all screening and assessment services to the point of diagnosis. The Program includes health promotion activities, information provision, counselling, and data collection across the screening and assessment pathways. Assessment services funded under the BreastScreen Australia Program include fine needle aspiration (FNA) and core biopsies and, in some states and territories, open biopsies. Open biopsies are funded outside the Program in Queensland, SA, Tasmania and the NT (table 12A.5).

Each jurisdiction manages a central BreastScreen Australia registry to ensure women with an abnormality detected at screening are recalled for assessment and to enable women to be invited for re-screening at the appropriate interval. Data collected from the registries allow for quality assurance, monitoring and evaluation of the Program. Information on BreastScreen Australia performance is published by the Australian Institute of Health and Welfare (AIHW) in the *BreastScreen Australia monitoring* reports, the most recent of which was published in 2009 (AIHW 2009a).

A recent evaluation of the BreastScreen Australia Program found that it has been successful in reducing mortality from breast cancer in the target age group (women aged 50–69 years) by approximately 21–28 per cent since screening commenced in 1991 (DoHA 2009a). The evaluation also found that participation in the Program reduces treatment-related morbidity, associated with a relatively high proportion of cancers detected early and treated by breast conserving surgery.

Governments spent around $150 million on breast cancer screening in 2007-08 (table 12A.6). Estimates of government expenditure on breast cancer screening per woman aged 40 years or over are presented by jurisdiction in figure 12.6. These estimates include Australian, State and Territory government expenditure. Differences across jurisdictions partly reflect variation in the proportion of women in the target age group for breast cancer screening, data deficiencies and collection methods, as well as the nature of the services and their relative efficiency. Some differences can also be due to the geography of a State or Territory, and to the proportion of the target population living in rural and remote areas. The data therefore need to be interpreted with care.

Figure 12.6 **Public health expenditure on breast cancer screening, 2007-08**[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. [b] The data need to be interpreted with care because of data deficiencies, differences across jurisdictions relating to the use of cash accounting and accrual methods, the treatment of corporate and central office costs, differences in methods used to collect expenditure figures, and differences in the interpretation of public health expenditure definitions. In addition, the data do not account for variation between jurisdictions in either population age structure or the proportion of eligible women (40 years or over) outside the target population (50–69 years) who are screened. [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 include public health information systems, disease surveillance and epidemiological analysis, public health communication and advocacy, public health policy, program and legislation development, and public health workforce development.

Source: AIHW (unpublished) AIHW Health Expenditure Database; ABS (unpublished) *Estimated Residential Population*, Cat. no. 3101.0; tables AA.1 and 12A.6.

The number of women aged 40 years or over screened by BreastScreen Australia indicates the size of the BreastScreen Australia Program. Over 855 000 women in this age group were screened in 2008, compared with around 846 000 in 2004 (table 12.2).

Table 12.2 Number of women aged 40 years or over screened by BreastScreen Australia[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2004	270 598	198 743	191 084	78 773	69 882	23 107	9 995	4 045	846 227
2005	235 812	197 627	199 981	81 351	70 909	25 440	11 901	4 481	827 502
2006	257 211	202 462	200 992	88 667	67 476	24 963	11 446	4 136	857 353
2007	249 193	195 288	202 372	81 629	67 508	24 041	12 277	4 635	836 943
2008	253 118	183 098	217 534	86 829	74 259	25 003	11 225	4 375	855 441

[a] First and subsequent screening rounds, for women aged 40 years or over.

Source: State and Territory governments (unpublished); table 12A.7.

Breast cancer is diagnosed outside the BreastScreen Australia Program when women access mammographic services privately, are outside the age range for the program, or have symptoms which make it inappropriate for them to attend for screening. For these women, GPs are critical as the initial point of referral to specialists for diagnosis and treatment services.

Inpatient separations in public hospitals for selected breast cancer related Australian refined diagnosis related groups (AR-DRGs) in 2007-08 are presented in table 12.3.

Table 12.3 Separations for selected AR-DRGs related to breast cancer, public hospitals, 2007-08 (per 10 000 people)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Breast cancer related conditions									
Major procedures for malignant breast conditions	3.2	3.1	2.9	2.6	3.1	2.9	2.8	1.3	3.0
Minor procedures for malignant breast conditions	0.9	1.1	1.2	1.0	0.8	1.6	0.8	0.4	1.0
Skin, subcutaneous tissue and breast plastic operating room procedures	3.0	3.1	3.3	3.5	6.1	3.1	2.0	2.7	3.4
Other skin, subcutaneous tissue and breast procedures	12.4	22.8	18.4	19.4	21.3	16.2	8.3	11.4	17.5
Malignant breast disorders (Age >69 W CC) or W (Cat or Sev CC)	0.5	0.6	0.5	0.5	1.0	0.9	0.4	0.5	0.6
Malignant breast disorders (Age>69 W/O CC) or W/O (Cat or Sev CC)	0.2	0.8	0.4	1.6	0.5	0.6	0.1	0.3	0.6
All conditions[c]	**2 050.2**	**2 506.0**	**1 894.7**	**2 080.5**	**2 242.0**	**1 902.0**	**2 235.2**	**4 092.4**	**2 169.7**

W=with. W/O=without. CC=complications and co-morbidities. Cat or Sev=catastrophic or severe. [a] Care needs to be taken when comparing jurisdictions because admission practices vary. [b] AR-DRG version 5.1. [c] The total includes separations for which the care type was reported as acute, or newborn with qualified patient days, or was not reported. Crude rate based on the Australian population as at 31 December 2007.

Source: AIHW (2009) *Australian hospital statistics 2007–08*, Cat. no. HSE 71; table 12A.8.

Framework of performance indicators

The indicators developed to report on the performance of breast cancer detection and management are based on the shared government objectives for managing the disease (box 12.2). The Health preface explains the performance indicator framework for health services as a whole, including the health services subdimensions for quality and sustainability that have been added to the standard Report framework. The framework for breast cancer detection and management focuses on achieving a balance between early detection and treatment. It has a tripartite structure — that is, performance indicators presented relate to early detection, intervention and overall performance. Breast cancer prevention is excluded from the framework in the absence of definitive primary preventative measures, although there are known associated risk factors. There are ongoing trials examining possible preventative interventions for the small proportion of the population at high risk of breast cancer due to the presence of BRCA1 or BRCA2 genetic variations.

Box 12.2 **Objectives for breast cancer detection and management**

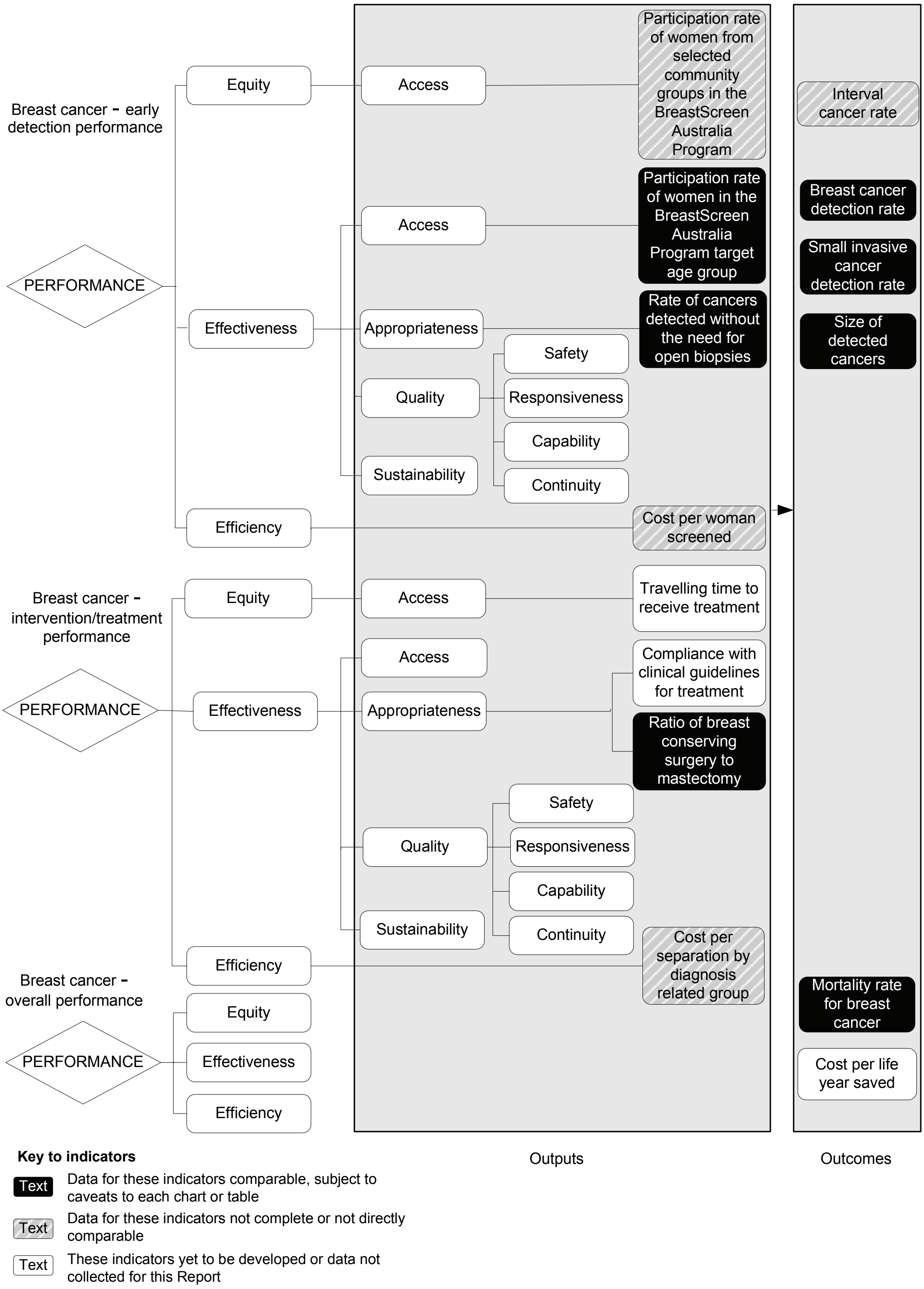
The objectives for breast cancer detection and management are:

- to reduce morbidity and mortality attributable to breast cancer
- to improve the quality and duration of life of women with breast cancer
- through delivering services in a manner that is equitable and efficient.

The performance indicator framework shows which data are comparable in the 2010 Report (figure 12.7). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 12.7 **Performance indicators for breast cancer detection and management**



Key performance indicator results

Data relating to breast cancer screening are readily available through the BreastScreen Australia Program, while data relating to the management and treatment of breast cancer are limited. Hence, most of the breast cancer detection and management data in this Report are provided by BreastScreen Australia, and screening is currently the main focus of reporting. It is a Steering Committee priority to extend reporting in the area of the management and treatment of breast cancer.

Ongoing monitoring of BreastScreen Australia involves reporting Program performance against specific indicators such as participation, detection of small invasive cancers, sensitivity, detection rate for *ductal carcinoma in situ* (DCIS), recall to assessment and rescreening rates. Data are collected at the jurisdictional level and provide an overview of the performance of the Program.

In addition, each BreastScreen Australia service is assessed against 173 National Accreditation Standards as part of their accreditation process. These Standards include a number of indicators that collectively assess the safety of the services provided by individual BreastScreen Australia services.

Outputs

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

Early detection — participation rate of women from selected community groups in the BreastScreen Australia Program

'Participation rate of women from selected community groups in the BreastScreen Australia Program' is an indicator of governments' objective to reduce morbidity and mortality attributable to breast cancer through early detection strategies, in a manner that is equitable (box 12.3).

Box 12.3 Participation rate of women from selected community groups in the BreastScreen Australia Program

'Participation rate of women from selected community groups in the BreastScreen Australia Program' is defined as the proportion of the target population in each selected community group attending the screening program within a 24 month period.

Participation rates for community groups that are at, or close to, those for the total population indicate equitable access to early detection services.

Data reported for this indicator are not directly comparable.

Early detection is associated with reduced morbidity and mortality for women with breast cancer. Indigenous women, women from non-English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas can experience particular language, cultural and geographic barriers to accessing breast cancer screening.

In the 24 month period 2007 and 2008, the national age standardised participation rate for Indigenous women aged 50–69 (35.8 per cent) was below the total participation rate in that age group (54.9 per cent), although this can be influenced by the quality of Indigenous identification in screening program records. For NESB women for the same 24 month period and age group, the national participation rate of 48.1 per cent was also lower than that of the national total female population (table 12.4). Care needs to be taken when comparing data across jurisdictions as there is variation in the collection of Indigenous and NESB identification data.

Table 12.4 Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2007 and 2008 (24 month period) (per cent)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*[c]	*ACT*	*NT*	*Aust*
Indigenous[d]	37.0	27.6	46.4	30.8	31.6	39.5	44.2	23.5	35.8
NESB[e]	53.0	34.6	66.6	62.5	55.1	22.2	17.3	38.5	48.1
All women aged 50–69 years	54.6	53.1	57.1	55.2	57.4	54.5	53.8	39.8	54.9

[a] First and subsequent rounds. [b] Rates are standardised to the 2001 Australian population standard. [c] Participation rates for NESB women may be understated due to a change in the BreastScreen Tasmania client registration form in the 2005-2006 screening period. This saw self-reporting of NESB status drop by 40 per cent between the 2004-2005 24 month reporting period and the 2006-2007 24 month reporting period. Actual NESB participation is not believed to have changed significantly compared to previous reporting periods. [d] Women who self-identify as being of Aboriginal and/or Torres Strait Islander descent [e] NESB is defined as speaking a language other than English at home.

Source: State and Territory governments (unpublished); ABS (2009) *Population by Age and Sex, Australian States and Territories, June 2008*, Cat. no. 3201.0; ABS (unpublished) *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2021*, Cat. no. 3238.0; ABS (unpublished) *2006 Census of Population and Housing*; tables 12A.9–12A.12.

Updated data for participation rates by geographic location were not available for the 2010 Report. Historical data are presented in table 12A.13.

Early detection — participation rate of women in the BreastScreen Australia Program target age group

'Participation rate of women in the BreastScreen Australia target age group' is an indicator of governments' objective to reduce morbidity and mortality attributable to breast cancer through early detection strategies (box 12.4).

Box 12.4 **Participation rate of women in the BreastScreen Australia Program target age group**

'Participation rate of women in the BreastScreen Australia Program target age group' is defined as the number of women aged 50–69 years attending the screening program within a 24 month period, divided by the estimated population of women aged 50–69 years.

A high or increasing screening participation rate is desirable.

Data reported for this indicator are comparable.

Early detection is associated with improved outcomes for women with breast cancer, in terms of morbidity and mortality. The aim under the National Accreditation Standards 2004, is that at least 70 per cent of women aged 50–69 years participate in screening over a 24 month period. Recruitment activities undertaken by BreastScreen Australia specifically target women in this age group (BreastScreen Australia 2004). Access to the program is also provided for women aged 40–49 years and 70 years or over.

The national participation rate of women aged 50–69 years in BreastScreen Australia screening programs was 54.8 per cent in the 24 month period 2007 and 2008. At a national level, the participation rate has been relatively steady since the 24 month period 2003 and 2004, well below the 70 per cent aim under the National Accreditation Standards (figure 12.8).

Figure 12.8 **Age standardised participation rate of women aged 50–69 years in BreastScreen Australia screening programs (24 month period)**[a, b, c, d]

---

[a] The participation rate is the number of women aged 50–69 years resident in the jurisdiction who were screened during the reference period, divided by the estimated number of women aged 50–69 years resident in the jurisdiction midway through the reference period. [b] Women resident in the jurisdiction represent over 99 per cent of the women screened in each jurisdiction except the ACT (91.4 per cent) and the NT (98.6 per cent). [c] The estimated resident population (ERP) is computed as the average of the ERP in each calendar year of the reference period. [d] Rates are standardised to the 2001 Australian population standard.

Source: State and Territory governments (unpublished); ABS (2009) *Population by Age and Sex, Australian States and Territories, June 2008*, Cat. no. 3201.0; tables 12A.9, 12A.10.

Early detection — rate of cancers detected without the need for open biopsies

'Rate of cancers detected without the need for open biopsies' is an indicator of governments' objective to provide appropriate early detection services (box 12.5).

Box 12.5 **Rate of cancers detected without the need for open biopsies**

'Rate of cancers detected without the need for open biopsies' is defined as the number of cancers detected without open biopsy as a proportion of all breast cancers detected (invasive and DCIS).

A high or increasing rate of cancers detected without the need for open biopsies is desirable.

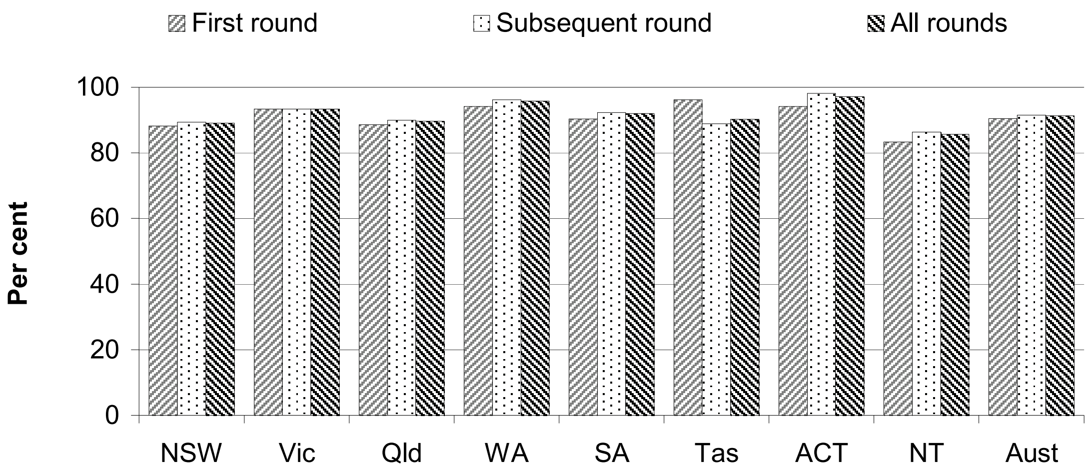
Data reported for this indicator are comparable.

Diagnosis of breast cancer involves histological examination of tissue samples collected by FNA, core biopsy or open biopsy. Open biopsy is the most invasive of these procedures.

High rates of cancers detected without the need for open biopsies indicates effectiveness in detecting malignancies while minimising the need for invasive procedures. The BreastScreen Australia National Accreditation Standards 2004 state that 75 per cent or more of invasive cancers or DCIS should be diagnosed without the need for a diagnostic open biopsy (BreastScreen Australia 2004).

In 2008, for women attending their first screening round, the rate of cancers detected without the need for open biopsies was 90.4 per cent Australia wide. For women attending a subsequent round the rate was 91.5 per cent Australia wide, well above the National Accreditation Standard of 75 per cent (figure 12.9).

Figure 12.9 **Rate of cancers detected without the need for open biopsies, all women, 2008**



Source: State and Territory governments (unpublished); table 12A.14.

Early detection — cost per woman screened

'Cost per woman screened' is an indicator of governments' objective to provide early detection services in an efficient manner (box 12.6).

Box 12.6 **Cost per woman screened**

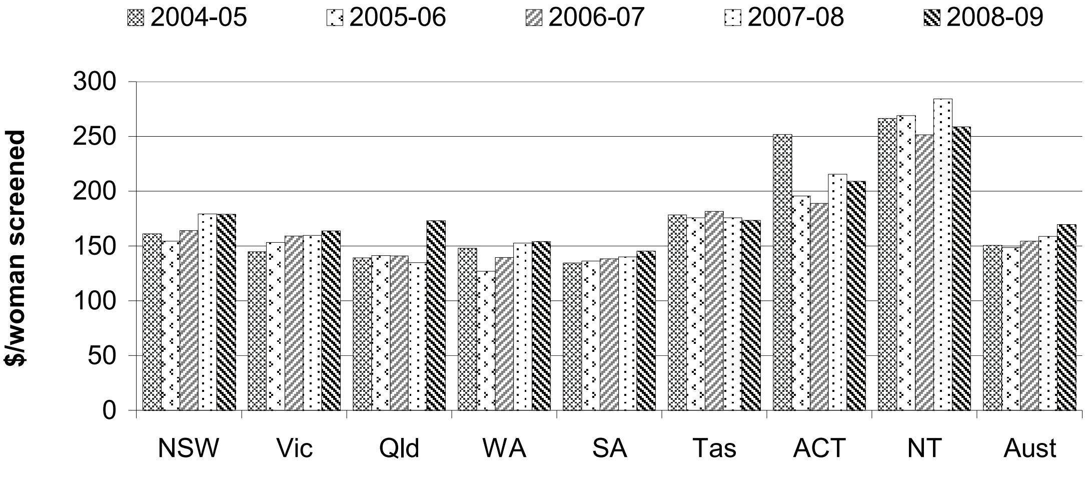
'Cost per woman screened' is defined as the total cost of providing early detection services (including screening, assessment and program management) divided by the number of women screened.

Caution should be used when interpreting this indicator. While a low or decreasing cost per woman screened can reflect high or increasing efficiency, it can also reflect low or decreasing quality of service. Cost per women screened can also be influenced by characteristics of the target population, for example, the number and type of barriers to service access.

Data reported for this indicator are not directly comparable.

Care needs to be taken when making comparisons across jurisdictions. There are potential differences in the items included in the measures of cost (particularly in the treatment of depreciation and capital asset charges, and the inclusion of subsidies). There can also be differences across jurisdictions in the scope of activities being costed. The Review is working to identify these differences across jurisdictions to improve data comparability in future (table 12A.16). Preliminary estimates of costs in each jurisdiction are presented in figure 12.10. The average cost per woman screened in Australia in 2008-09 was around $170.

Figure 12.10 **Real cost per woman screened, BreastScreen Australia services (2008-09 dollars)[a, b]**



---

[a] Real expenditure based on the ABS gross domestic product price deflator (2008-09 = 100) (table AA.26). [b] Data for NSW do not include subsidies.

Source: State and Territory governments (unpublished); tables AA.26 and 12A.15.

Intervention/treatment — travelling time to receive treatment

'Travelling time to receive treatment' has been identified for development as an indicator of governments' objective to provide breast cancer intervention and treatment services in an equitable manner (box 12.7).

Box 12.7 **Travelling time to receive treatment**

'Travelling time to receive treatment' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Intervention/treatment — compliance with clinical guidelines for treatment

'Compliance with clinical guidelines for treatment' has been identified as an indicator of governments' objective to reduce morbidity and mortality attributable to breast cancer, and to improve the quality and duration of life of women with breast cancer, through provision of effective and appropriate intervention and treatment services (box 12.8).

Box 12.8 **Compliance with clinical guidelines for treatment**

'Compliance with clinical guidelines for treatment' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Intervention/treatment — ratio of breast conserving surgery to mastectomy

'Ratio of breast conserving surgery to mastectomy' is an indicator of governments' objective to improve the quality of life of women with breast cancer through appropriate intervention and treatment services (box 12.9).

Box 12.9 **Ratio of breast conserving surgery to mastectomy**

'Ratio of breast conserving surgery to mastectomy' is defined as the number of cases for which breast conserving surgery or no surgery was performed divided by the number of cases for which a mastectomy was performed.

Breast conserving surgery removes the breast cancer but not the whole breast. Caution should be used in interpreting this indicator, as clinical and familial factors are important determinants of the most appropriate treatment. For cases identified through early detection services such as BreastScreen Australia, a higher ratio can indicate more appropriate intervention and treatment services.

Data reported for this indicator are comparable.

Cancer size and localisation to the breast are two of the clinical determinants for appropriate treatment of breast cancer (NBOCC 2004). A recent evaluation of the BreastScreen Australia Program found that breast cancers detected through the Program are significantly more likely to be smaller than those diagnosed outside the Program, and that a higher proportion are treated with breast conserving surgery rather than mastectomy (DoHA 2009a).

Data for this indicator are for women diagnosed only within the BreastScreen Australia Program. They represent only a portion of breast cancer treatment information, and are not necessarily representative of general clinical practice.

In 2008, the ratio of conserving surgery to mastectomy averaged 2.7:1 nationally, but varied across jurisdictions (figure 12.11).

Figure 12.11 Ratio of conserving surgery to mastectomy[a, b]

---

[a] Applies for women of all ages diagnosed by the Breastcreen Australia Program. [b] Small numbers result in fluctuations from year to year. It is advisable to view changes in the indicator over a period of several years (rather than consecutive years).

Source: State and Territory governments (unpublished); table 12A.17.

Intervention/treatment — cost per separation by diagnosis related group

'Cost per separation by diagnosis related group' is an indicator of governments' objective to provide breast cancer intervention and treatment services in an efficient manner (box 12.10).

Box 12.10 Cost per separation by diagnosis related group

'Cost per separation by diagnosis related group' is a proxy indicator of efficiency, defined as the cost of care per separation in public hospitals for selected breast cancer related conditions.

Caution must be used when interpreting this indicator. While a low cost per separation can indicate efficiency, no information on the quality of service is provided.

Data reported for this indicator are not directly comparable.

The National Hospital Cost Data Collection (NHCDC) is an annual collection of hospital cost and activity data. Participation in the NHCDC is voluntary, and participating hospitals are not necessarily a representative sample of the hospitals in each jurisdiction (although coverage is improving over time). An estimation process has been carried out to create representative national activity figures from the sample data. Further, the purpose of the NHCDC is to calculate DRG cost weights, not to compare the efficiency of hospitals (DoHA 2009b).

Table 12.5 summarises costs per separation for selected breast cancer AR-DRGs. The average cost of major procedures for malignant breast conditions across Australia was $6765 per separation in 2007-08 and minor procedures for malignant breast conditions cost $3318 per separation on average. Table 12A.18 summarises the average length of stay (in public hospitals) associated with each AR-DRG.

Table 12.5 **Average cost per separation, public hospitals by selected breast cancer AR-DRGs, 2007-08 (dollars)**[a, b, c, d]

AR-DRG	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major procedures for malignant breast conditions									
	6 014	7 253	7 168	7 814	6 272	6 271	6 271	7 721	6 765
Minor procedures for malignant breast conditions									
	2 814	3 167	3 827	3 971	3 353	3 426	2 863	2 669	3 318
Malignant breast disorders (Age >69 W CC) or W (Cat or Sev CC)									
	5 371	3 932	5 632	7 152	5 872	10 982	10 499	6 096	5 538
Malignant breast disorders (Age>69 W/O CC) or W/O (Cat or Sev CC)									
	2 171	3 028	2 005	1 548	1 416	4 803	1 883	4 673	2 270

W = with. W/O = without. CC = complications and co-morbidities. Cat or Sev = catastrophic or severe. **a** Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. **b** Data are based on the AR-DRG classification version 5.1. **c** Average cost is affected by a number of factors, including admission practices, sample size, remoteness and the types of hospital contributing to the collection. Direct comparison across jurisdictions is difficult because there are differences in hospital costing systems. **d** In accordance with NHCDC method, depreciation and some capital costs are included in these figures, except for Victoria, which does not include depreciation.

Source: DoHA (2009) *National Hospital Cost Data Collection Cost Report Round 12 (2007-08), v5.1*; table 12A.18.

Outcomes

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

Early detection — interval cancer rate

‘Interval cancer rate’ is an outcome indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer, through provision of effective early detection services (box 12.11).

Box 12.11 **Interval cancer rate**

'Interval cancer rate' is defined as the number of interval cancers per 10 000 women years at risk of interval or screen-detected breast cancer, where:

- an interval cancer is an invasive breast cancer diagnosed in the interval between a negative screening result and the next scheduled screening examination
- women years at risk of interval or screen-detected breast cancer are all women with no personal history of breast cancer, in the period between a negative screening result and the next scheduled screening examination.

A lower interval cancer rate is desirable because it suggests that early detection of breast cancer services are effective. Caution should be applied when comparing data as differences in the interval cancer rate can also reflect different policies regarding diagnostic and administrative procedures.

This indicator should be interpreted in conjunction with the breast cancer detection indicators.

Data reported for this indicator are not directly comparable.

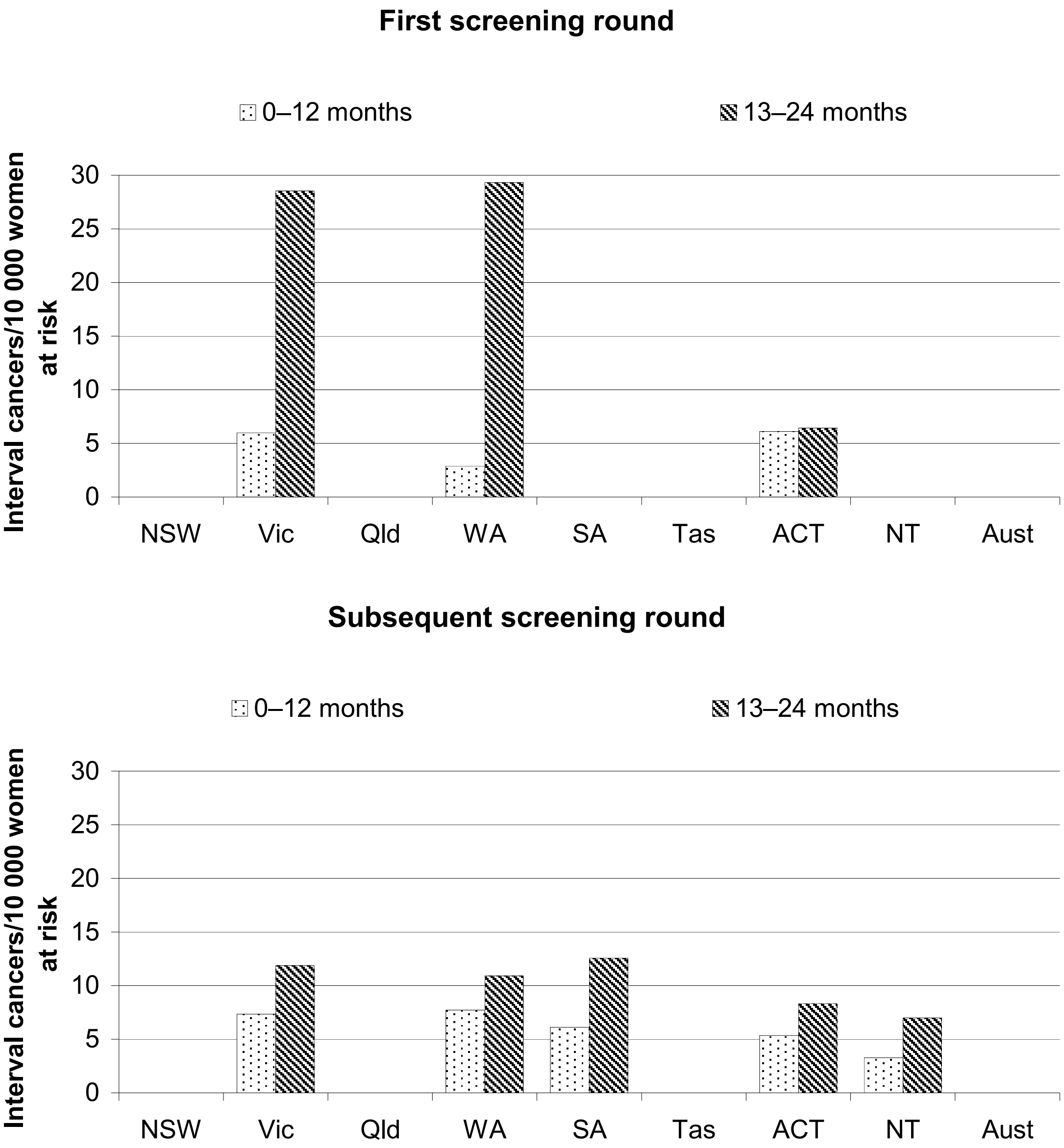
An interval cancer is an invasive breast cancer diagnosed in the interval between a negative screening result and the next scheduled screening examination, a period of 24 months in the case of routine screening (less in the case that more frequent screening is recommended) (AIHW 2009a). The cancer can have been present (but not detected) at the most recent screening episode, or may not have been present. A high rate of interval cancer can suggest that screening services are not optimally effective in the early detection of breast cancer.

There is a time lag in data availability for this indicator. Interval cancer can be detected up to 24 months following a routine negative screening episode. It can then be several months before the diagnosis of invasive cancer is recorded in the cancer registry. BreastScreen Australia programs identify interval cancers diagnosed outside the program through a process of data matching between cancer registry and BreastScreen Australia data. Thus, for women screened in any given year, the number of interval cancers cannot be determined until several years later. The most recent data available for this Report are for women screened during 2005.

Policy variation between jurisdictions can be reflected in interval cancer rates, and comparisons across jurisdictions need to be made with care. For example, policies differ in relation to women whose mammograms appear normal but who report symptoms of breast abnormalities. Some jurisdictions conduct further diagnostic procedures, which can be reflected in a higher cancer detection rate and lower interval cancer rate. Where these women are instead advised to visit their GP for referral to a diagnostic service (such as in SA and some services in NSW) cancers subsequently detected can be reflected in increased interval cancer rates.

Figure 12.12 presents the age standardised interval cancer rate by screening round and time since screened for women aged 50–69 years.

Figure 12.12 **Age standardised interval cancer rate, women aged 50–69 years, 2005**[a, b, c, d]



---

[a] Rates are expressed as the number of interval cancers per 10 000 women years at risk, and age standardised to the Australian population of women attending a BreastScreen Australia service in 1998. [b] Small numbers result in fluctuations from year to year. It is advisable to view the indicator over several years rather than from one year to the next. [c] Data were not available for NSW, Queensland or Tasmania. [d] No interval cancers were reported for women aged 50–69 years in SA and the NT in the first round for 0–12 and 13–24 months.

Source: State and Territory governments (unpublished); table 12A.19.

Early detection — breast cancer detection rate

'Breast cancer detection rate' is an indicator of governments' objective to reduce morbidity and mortality attributable to breast cancer, through the provision of effective early detection services (box 12.12).

Box 12.12 **Breast cancer detection rate**

'Breast cancer detection rate' is defined as the number of detected cancers per 10 000 women screened.

A higher rate of breast cancer detection is desirable in terms of the effectiveness of breast screening services (although a high incidence of breast cancer is not desirable). The breast cancer detection rate should be considered in conjunction with detection rates for invasive cancer, small invasive cancer, DCIS and interval cancer.

Data reported for this indicator are directly comparable.

Early detection of cancers that are small and localised to the breast is associated with reduced morbidity and mortality for women with breast cancer (DoHA 2009a; NBOCC 2004). Changes in breast cancer detection rates can also reflect changes in the incidence of breast cancer.

BreastScreen Australia National Accreditation Standards for detection rates are based on expected Australian rates (BreastScreen Australia 2004):

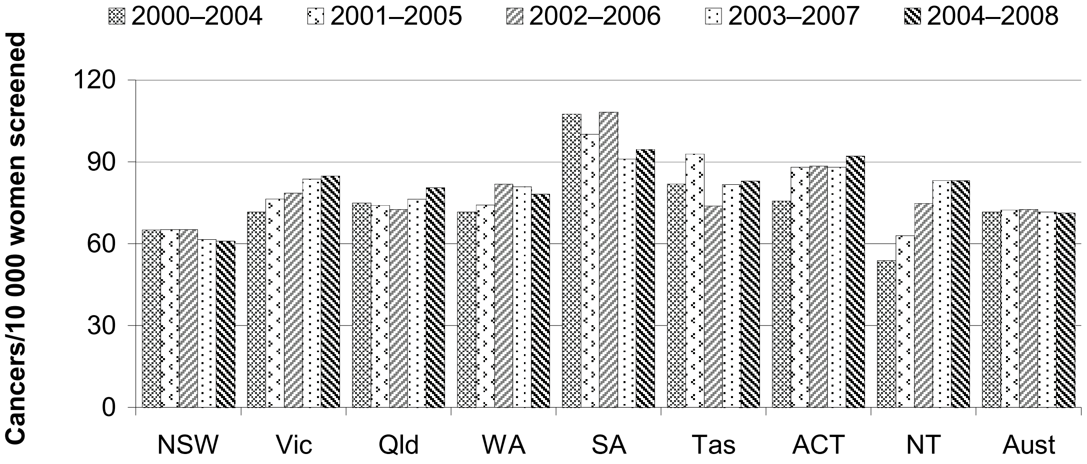
- greater than or equal to 50 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with invasive breast cancer
- greater than or equal to 35 per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with invasive breast cancer
- greater than or equal to 12 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with DCIS
- greater than or equal to 7 per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with DCIS.

Figure 12.13 reports the annual average age standardised number of invasive cancers detected per 10 000 women screened aged 50–69 years, by screening round. These data are averaged over 5 year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases and relatively large variation in rates from year to year.

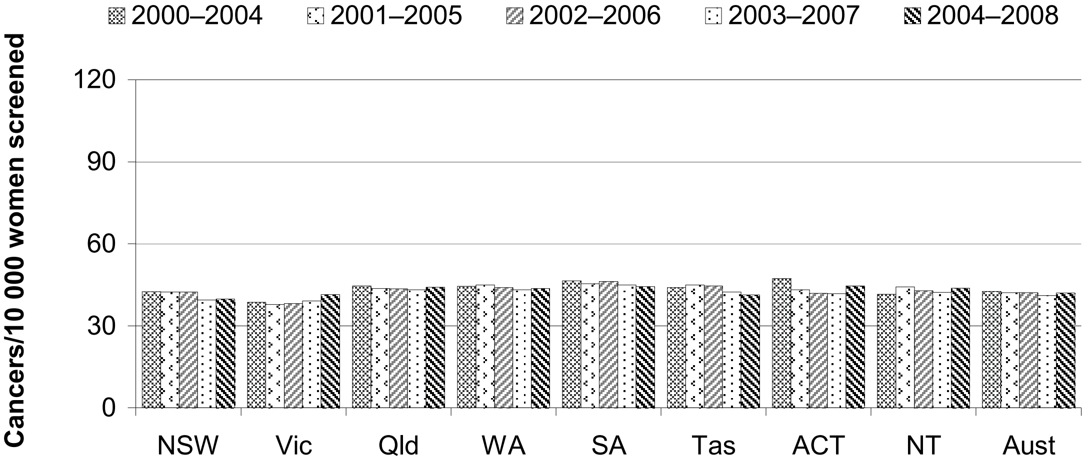
Nationally, in 2004–2008, the age standardised invasive breast cancer detection rate was 71.2 per 10 000 women aged 50–69 years attending their first screen. This was above the Breastscreen Australia National Accreditation Standard of greater than or equal to 50 per 10 000 women aged 50–69 years who attend for their first screen being diagnosed with invasive breast cancer. Nationally, the annual average age standardised invasive breast cancer detection rate was 41.8 per 10 000 women aged 50–69 years attending the second or subsequent screen. This was above the National Accreditation Standard of greater than or equal to 35 per 10 000 women aged 50–69 years who attend for their second or subsequent screen being diagnosed with invasive breast cancer (figure 12.13). The rate of DCIS detected per 10 000 women screened is reported in table 12A.20. (Definitions are in box 12.1 and section 12.7.)

Figure 12.13 **Annual average age standardised breast cancer detection rate for women aged 50–69 years, invasive cancers**[a]

First screening round



Subsequent screening round



[a] Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen Australia service in 1998.

Source: State and Territory governments (unpublished); table 12A.20.

Early detection — small invasive cancer detection rate

'Small invasive cancer detection rate' is an indicator of governments' objective to reduce morbidity and mortality attributable to breast cancer through the provision of effective early detection services (box 12.13).

Box 12.13 **Small invasive cancer detection rate**

'Small invasive cancer detection rate' is defined as the number of invasive cancers detected with a diameter of 15 millimetres or less, per 10 000 women screened.

It is desirable that a high proportion of cancers detected are small cancers. The small invasive cancer detection rate should be considered in conjunction with detection rates for invasive cancer, DCIS and interval cancer.

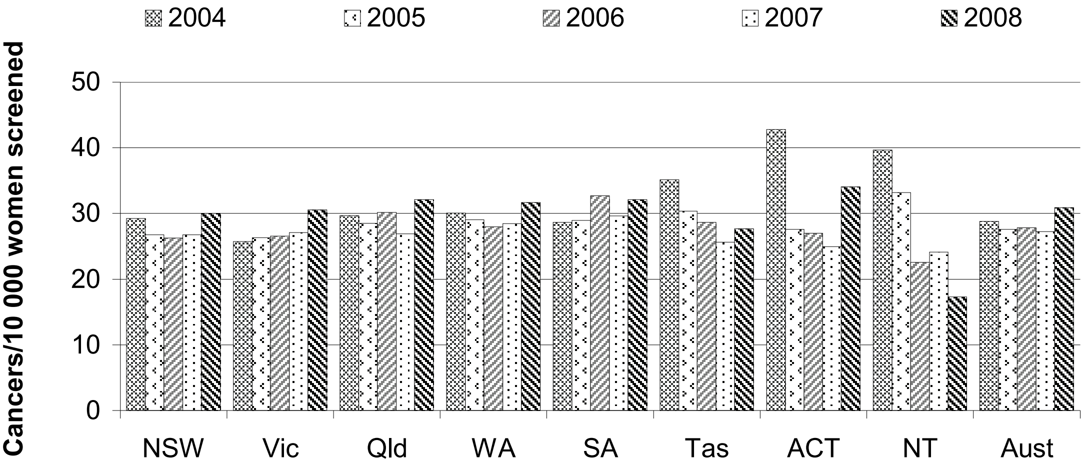
Data reported for this indicator are comparable.

Early detection of cancers that are small and localised to the breast is associated with reduced morbidity and mortality, as well as cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998; DoHA 2009a).

The BreastScreen Australia National Accreditation Standards 2004 specify that 25 or more women per 10 000 women aged 50–69 years who attend screening are expected to be diagnosed with a small (15 millimetres or less) invasive breast cancer (BreastScreen Australia 2004).

Age standardised rates for small invasive cancer detection for women aged 50–69 years screened by BreastScreen Australia in 2008 are reported in figure 12.14. The rate for Australia was 30.9 cancers per 10 000 women aged 50–69 years attending screening in 2008, above the National Accreditation Standard of 25 or more.

Figure 12.14 **Age standardised small diameter cancer detection rate for women aged 50–69 years, all rounds of screening**[a, b]



[a] Small diameter cancers are defined as invasive cancers up to and including 15 millimetre in diameter. [b] Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen Australia service in 1998.

Source: State and Territory governments (unpublished); table 12A.21.

Early detection — size of detected cancers

'Size of detected cancers' is an indicator of governments' objective to provide effective services for the early detection of breast cancer (box 12.14).

Box 12.14 **Size of detected cancers**

'Size of detected cancers' is defined as the number of detected invasive cancers by cancer size, as a proportion of total detected invasive cancers for women aged 40 years or over.

High rates of detection of small cancers, relative to rates of detection of large cancers, are desirable.

Data reported for this indicator are comparable.

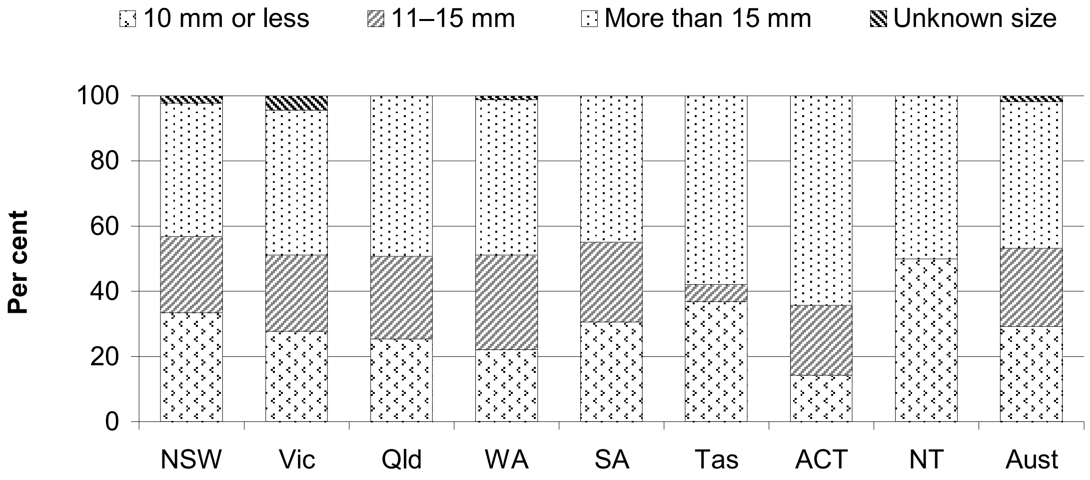
Detection of small cancers (those with a diameter of 15 millimetres or less) is generally associated with increased survival rates and reduced morbidity and mortality, as well as some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998; DoHA 2009a).

Data are reported by round because larger cancers are expected to be found in the first round of screening. In subsequent rounds, cancers should be smaller if the program is achieving its objective (that is, early detection of small cancers through regular two yearly screening).

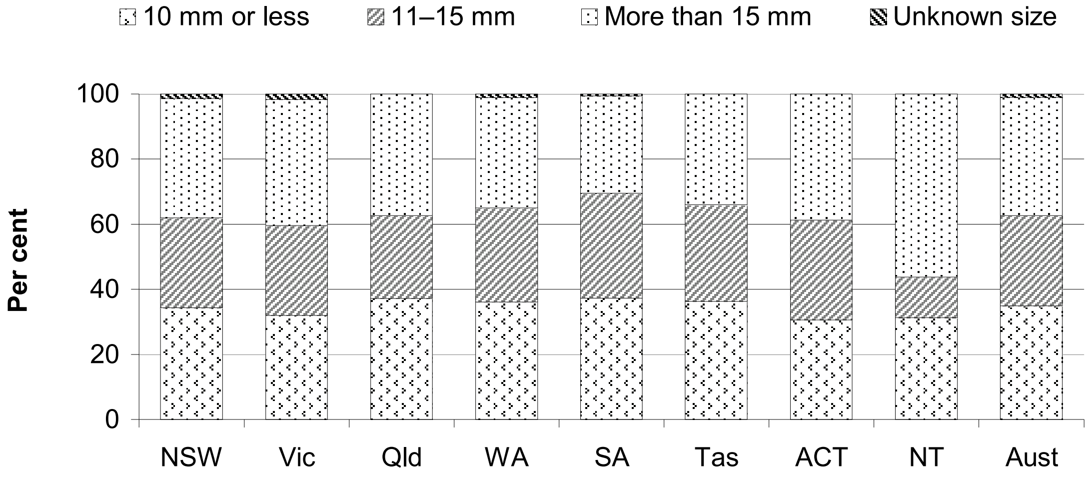
Figure 12.15 presents the proportion of cancers by size, by screening round, for 2008.

Figure 12.15 **Detected invasive cancers, women aged 40 years or over, by screening round and size of cancer 2008**[a, b, c]

First screening round



Subsequent screening round



---

[a] Data are for BreastScreen Australia clients only. [b] Non-breast malignancies were not counted. [c] For small jurisdictions, fluctuations due to small numbers can make comparisons unreliable.

Source: State and Territory governments (unpublished); table 12A.22.

Overall performance — mortality rate for breast cancer

'Mortality rate for breast cancer' is an indicator of governments' objective to reduce mortality attributable to breast cancer, through the provision of effective early detection, and treatment, services (box 12.15).

Box 12.15 **Mortality rate for breast cancer**

'Mortality rate for breast cancer' is defined as the age standardised mortality from breast cancer per 100 000 women, expressed as a 5 year rolling average.

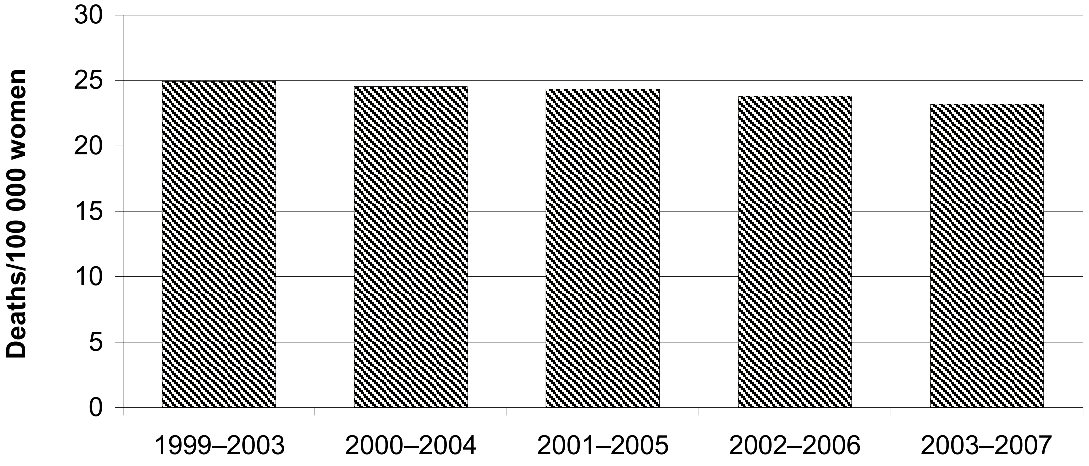
A lower mortality rate for breast cancer is desirable.

Data reported for this indicator are comparable.

Breast cancer mortality data are averaged over 5 year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases and relatively large variation in rates from year to year. Caution should nevertheless be used when comparing results for smaller jurisdictions (table 12A.1).

The average annual age standardised mortality rate for breast cancer declined from 24.9 per 100 000 women in the period 1999–2003 to 23.2 per 100 000 women in the period 2003–2007 (figure 12.16).

Figure 12.16 **Annual average age standardised mortality rate from breast cancer, all ages**[a, b]



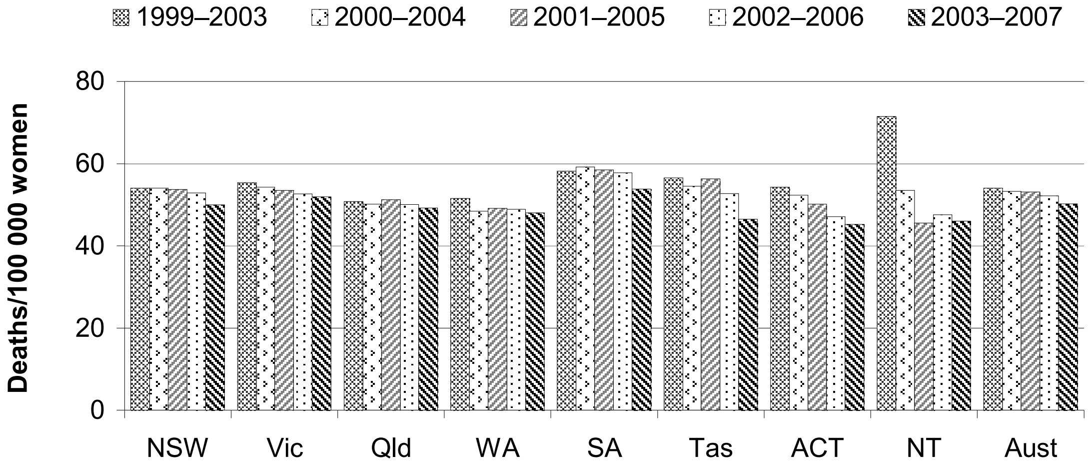
---

[a] Age standardised to the Australian population at 30 June 2001. [b] Data for the period 2003 to 2007 were not available from the AIHW due to delayed release of causes of death data by the ABS. Data for the period 2003 to 2007 are sourced from the ABS. Data for all other periods are sourced from the AIHW.

Source: ABS (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0; AIHW (unpublished) AIHW National Mortality Database; table 12A.1.

The annual average age standardised mortality rate from breast cancer for women aged 50–69 years also declined, from 54.0 per 100 000 women over the period 1999–2003 to 50.2 per 100 000 women over the period 2003–2007 (figure 12.17).

Figure 12.17 **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] Data for the period 2003 to 2007 were not available from the AIHW due to delayed release of causes of death data by the ABS. Data for the period 2003 to 2007 are sourced from the ABS. Data for all other periods are sourced from the AIHW.

Source: ABS (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0; AIHW (unpublished) AIHW National Mortality Database; table 12A.1.

Overall performance — cost per life year saved

‘Cost per life year saved’ has been identified for development as an indicator of the efficiency of overall performance of services in detection and management of breast cancer (box 12.16).

Box 12.16 **Cost per life year saved**

‘Cost per life year saved’ is yet to be defined.

Data for this indicator were not available for the 2010 Report.

12.4 Mental health

Profile

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). The World Health Organization (WHO) describes positive mental health as:

> ... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

There is a wide range of mental illnesses that can affect an individual's mental health, functioning and quality of life. Each mental illness is unique in terms of its incidence across the lifespan, causal factors and treatments.

This section focuses on publicly funded specialised mental health services that treat mostly low prevalence but severe mental illnesses. The quality of data relating to these services, collected under the *Mental Health Establishments (MHE) National Minimum Data Set* (*NMDS*) or the *Community Mental Health Care* (*CMHC*) *NMDS* continues to improve. However, data are subject to ongoing historical validation. Results reported in this section might therefore differ slightly to those in the *Mental Health Services in Australia* publications and the *National Mental Health Report*.

Other health and related services are also important for people with a mental illness, including GPs and alcohol and drug treatment services (chapter 11), public hospitals (chapter 10), and aged care services (chapter 13). This Report does not include specific performance information on these services' treatment of people with a mental illness. Mental health patients often have complex needs that can also affect other government services they receive, such as those covered in chapter 4 ('School education'), chapter 8 ('Corrective services'), chapter 9 ('Emergency management') and chapter 14 ('Services for people with a disability').

Some common terms used in mental health management are outlined in box 12.17.

Box 12.17 Some common terms relating to mental health

Some common mental health management related terms are defined below.

Acute services: mental health services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. Acute episodes are characterised by the recent onset of severe clinical symptoms of mental illness, that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that treatment effort is focused on the short term. Acute services can focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing mental illness for whom there has been an acute exacerbation of symptoms.

Ambulatory care services: mental health services dedicated to the assessment, treatment, rehabilitation and/or care of non-admitted patients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.

Community residential services: mental health services that employ mental health-trained staff on-site; provide rehabilitation, treatment or extended care to residents in a domestic-like environment and that is intended to be on an overnight basis; and encourage the resident to take responsibility for their daily living activities. All these services employ on-site mental health trained staff for some part of each day. Some services employ mental health trained staff on-site for 24 hours per day. Services that are not staffed for 24-hours per day must provide mental health trained staff on-site for a minimum of 6 hours per day and at least 50 hours per week.

Early intervention: actions that are appropriate for and specifically target people displaying the early signs and symptoms of a mental health problem or mental illness and people developing or experiencing a first episode of mental illness.

Inpatient services: mental health services that provide admitted patient care. These are stand-alone psychiatric hospitals or specialised psychiatric units located within general (non-psychiatric) hospitals.

Mental illness: a diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities. Sometimes described as mental disorder.

Mental health: the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.

Mental health problem: diminished cognitive, emotional and/or social abilities, but not to the extent that the criteria for a mental illness are met.

(Continued on next page)

Box 12.17 **(Continued)**

Mental health promotion: action taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the 'coping' capacity of communities, families and individuals by giving power, knowledge, skills and the necessary resources.

Mental illness prevention: interventions that occur before the initial onset of an illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and illnesses.

Non-acute services: provide rehabilitation and extended care services to patients who usually show a relatively stable pattern of clinical symptoms. Rehabilitation focuses on intervention to reduce functional impairments that limit the independence of patients and seek to promote personal recovery. They are also characterised by an expectation of substantial improvement over the short to medium term. Extended care services 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 (including those with high levels of severe unremitting symptoms of mental illness). Treatment effort focuses on preventing deterioration and reducing impairment. Improvement is expected only over a long period.

Non-government organisations: private not-for-profit community managed organisations that receive State and Territory government funding specifically to provide community support services for people affected by a mental illness. Programs provided by non-government organisations can include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.

Prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

Specialised care service: services whose primary function is to provide treatment, rehabilitation or community support targeted to people with mental illness. This criterion is applicable irrespective of the source of funds. Such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function.

Source: AIHW (2006); DoHA (2005).

Prevalence of mental illness

Prevalence of mental illness data are from the SMHWB. The term mental disorder is used when referring directly to SMHWB data (as it is used in that survey). Elsewhere, the term mental illness is used to describe the illness associated with mental disorders.

The SMHWB data are reported with 95 per cent confidence intervals. These intervals assist with making comparisons between jurisdictions, and between different mental disorder status groups. Confidence intervals are a standard way of expressing the degree of uncertainty associated with survey estimates. An estimate of 80 (for example, mean age 80 years) with a confidence interval of ± 4 means that if another sample had been drawn there is a 95 per cent chance that the result would lie between 76 and 84. Where ranges do not overlap, there is a statistically significant difference. A statistically significant difference means there is a high probability that there is an actual difference — it does not imply that the difference is necessarily large or important.

According to the SMHWB, in 2007, 20.0 ± 1.1 per cent of adults aged 16–85 years (or approximately 3.2 million adults) met the criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months before the survey (the SMHWB refers to this as a '12-month mental disorder'). A further 25.5 ± 1.4 per cent of adults aged 16–85 years had experienced a mental disorder at some point in their life, but did not have symptoms in the previous 12 months (table 12A.56). Additional data on the prevalence of selected mental illnesses are reported under the indicator 'prevalence of mental illness'.

Impact of mental illness

Mental illnesses contribute significantly to the total burden of disease and injury in Australia (13.3 per cent of the total burden in 2003) (Begg *et al.* 2007). The total burden comprises the amount of 'years' lost due to fatal events (years of life lost due to premature death) and non-fatal events (years of 'healthy' life lost due to disability). Mental illness is also the leading cause of 'healthy' life years lost due to disability (24 per cent of the total non-fatal burden in 2003) (Begg *et al.* 2007).

Mental illness can affect an individual's functioning and quality of life. According to the SMHWB, in 2007, people with a lifetime mental disorder who had symptoms in the previous 12 months (20.0 ± 1.1 per cent of the total population), were significantly overrepresented in the populations who:

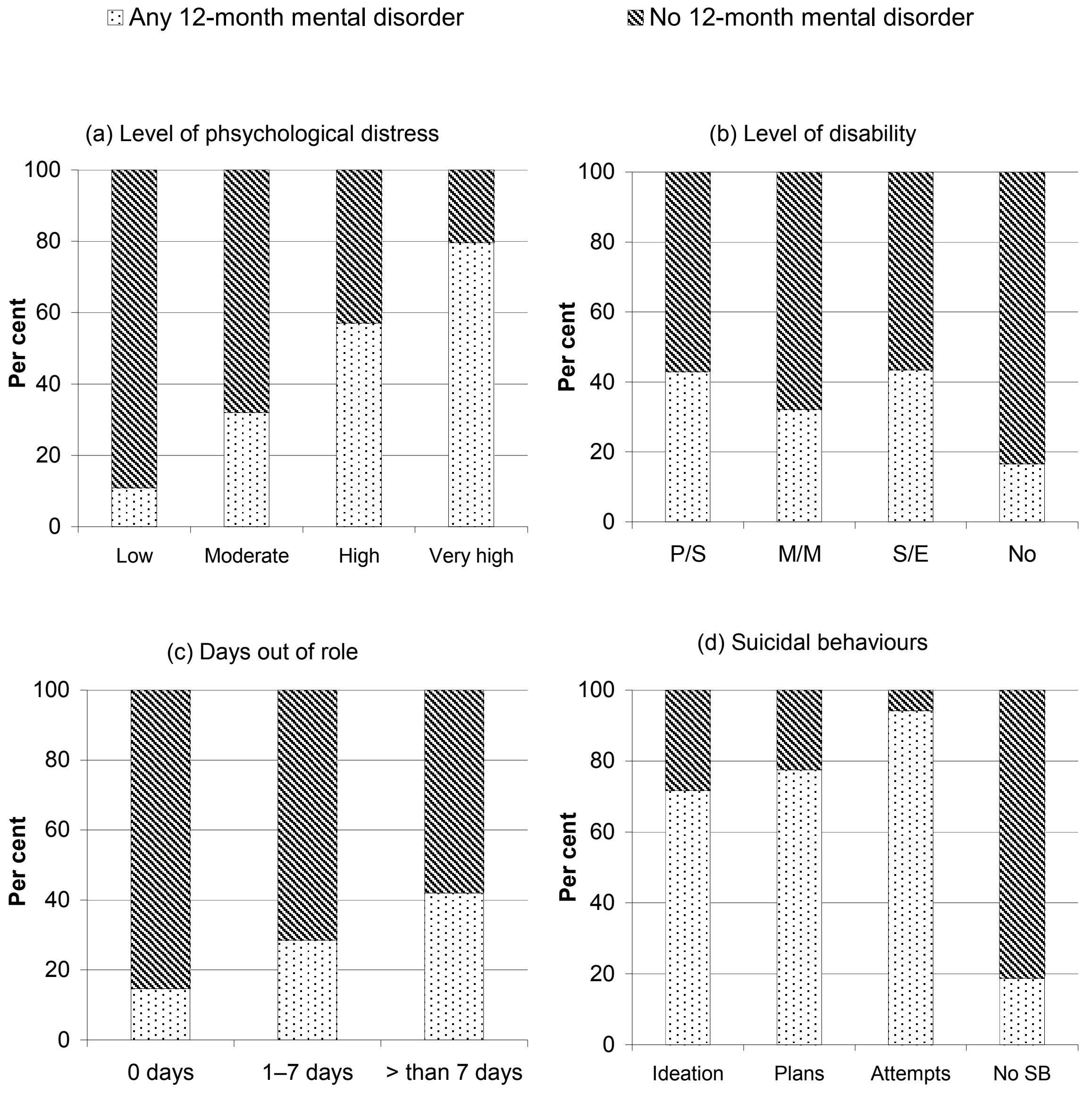
- had high to very high levels of psychological distress — 57.1 ± 5.1 per cent and 79.6 ± 7.2 per cent of these populations respectively (figure 12.18a)
- had a profound/severe core activity limitation or a school/employment restriction — 42.9 ± 8.2 per cent and 43.4 ± 7.1 per cent of these populations respectively (figure 12.18b)
- for more than 7 in the last 30 days were unable to work or carry out normal activities or had to cut down on what they did because of their health — 42.0 ± 5.2 per cent of this population (figure 12.18c)

- exhibited suicidal behaviours — 71.7 ± 8.7 per cent of those who had suicidal ideation, 77.5 ± 12.6 per cent of those who planned suicide and 94.2 ± 9.0 per cent of those who had attempted suicide (figure 12.18d).

Information on levels of psychological distress across states and territories, by age and sex, are available from the 2007-08 National Health Survey (table 12A.24). Nationally, the proportion of people with reported high/very high levels of psychological distress was significantly higher for females than males, and higher for people aged 18–64 years of age than for people aged 65 years or over (figure 12.19).

The *National Aboriginal and Torres Strait Islander Health Survey* conducted in 2004-05 found that after adjusting for age, approximately 27 per cent of Indigenous Australians reported high levels of psychological distress (AHMAC 2008). This was more than twice the rate for non-Indigenous adults (13 per cent).

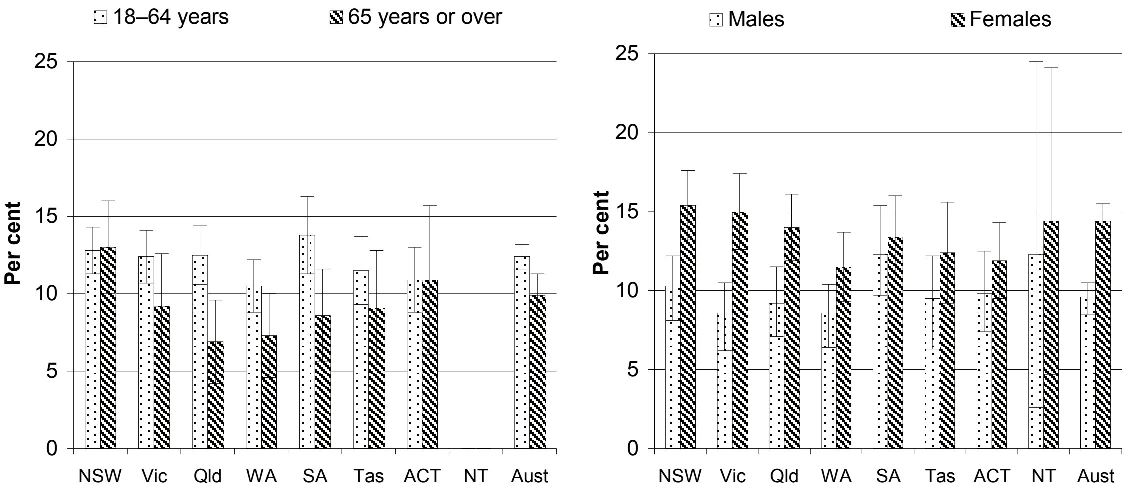
Figure 12.18 **Functioning and quality of life measures, by 12-month mental disorder status, 2007**[a, b, c, d]



P/S = profound or severe core activity limitation, M/M = moderate or mild core activity limitation, S/E = schooling/employment restriction only, No = No disability/No specific limitations or restrictions, No SB = no suicidal behaviours. [a] Level of psychological distress is measured by the Kessler Psychological Distress Scale (K10), from which a score of 10 to 50 is produced. Higher scores indicate a higher level of distress; lower scores indicate a low level of distress. Scores are grouped as follows: Low 10–15, Moderate 16–21, High 22–29, and Very high 30–50. [b] Suicidal ideation refers to the presence of serious thoughts about committing suicide. [c] The estimated proportion of people who planned suicide with no 12-month mental disorder has a relative standard error (RSE) of 25 to 50 per cent and should be used with care. The estimated proportion of people who attempted suicide with no 12-month mental disorder has a RSE greater than 50 per cent and is considered too unreliable for general use. [d] Confidence intervals are not shown in the figure, but are reported in table 12A.25.

Source: ABS (2008) *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Cat. no. 4326.0; table 12A.23.

Figure 12.19 K10 high/very high levels of psychological distress, people aged 18 years or over, by age and sex, 2007-08[a, b]



---

[a] Level of psychological distress is measured by the K10, from which a score of 10 to 50 is produced. Higher scores indicate a higher level of distress; lower scores indicate a low level of distress. Scores are grouped as follows: Low 10–15, Moderate 16–21, High 22–29, and Very high 30–50. [b] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *National Health Survey 2007-08*, Cat. no. 4364.0; table 12A.24.

Mental illness can act as a barrier to gaining and maintaining employment (AHMC 2008). Nationally, in 2007, the labour force participation rate for people who had a 12-month mental disorder was 73.6 ± 2.7 per cent, statistically significantly below the rate of those who did not have a lifetime mental disorder (78.4 ± 1.6 per cent) (table 12A.25). Of those in the labour force, 94.5 ± 1.7 per cent of people who had a 12-month mental disorder were employed compared to the 96.8 ± 0.9 per cent of those without a lifetime mental disorder (table 12A.25).

Mental illness in early adult years can lead to disrupted education and premature exit from school or tertiary training, or disruptions in the transition from school to work (AHMC 2008). The impact of these disruptions can be long term, restricting the person's capacity to participate in a range of social and vocational roles over their lifetime (AHMC 2008). Nationally, in 2007, the proportion of people aged 16–30 years who had a 12-month mental disorder who were participating in study was 42.0 ± 4.9 per cent, statistically significantly lower than the rate for those without a lifetime mental disorder (51.6 ± 3.8 per cent) (table 12A.26). Further data on the participation of people aged 16–30 years in the labour force and study are in tables 12A.26 and 12A.27.

Roles and responsibilities

State and Territory governments are responsible for the funding, delivery and management of public specialised mental health services including admitted patient care in hospitals; ambulatory care services and community residential care (for further detail see box 12.17). As noted above, performance information in this section focuses on these specialised mental health services.

The Australian Government is responsible for the funding of the following mental health related services and programs:

- Medicare Benefits Schedule (MBS) services provided by GPs (both general and specific mental health items), private psychiatrists and allied mental health professionals (clinical psychologists, psychologists, social workers and occupational therapists)
- Pharmaceutical Benefits Scheme (PBS) funded mental health related medications
- other specific programs designed to increase the level of social support and community-based care for people with a mental illness and to prevent suicide.

In addition, the Australian Government provides funding for mental health related services through the Medicare Safety Net, the Department of Veteran's Affairs (DVA) and the Private Hospital Insurance Premium Rebates.

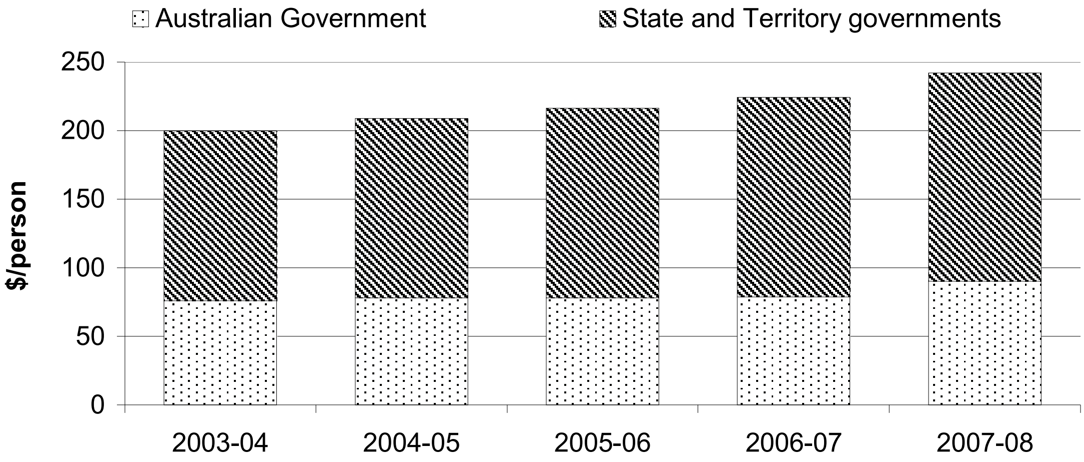
The Australian Government also provides a special purpose payment (SPP) to State and Territory governments under the new NHA, which was effective from 1 July 2009. According to the *Intergovernmental Agreement on Federal Financial Relations*, under which this SPP is provided, State and Territory governments must expend the SPP on the health sector, but they have full budget flexibility to allocate funds within that sector as they deem appropriate. Under the previous Australian Health Care Agreements (AHCA) the Australian Government provided State and Territory governments with base grants and specific funding to undertake reforms in the directions advocated by the National Mental Health Strategy (NMHS) for mental health services (DoHA 2007). Data reported in this chapter relate to services provided up to 2007-08 and were therefore provided under the previous AHCA arrangements.

The Australian, State and Territory governments also fund/provide other services that people with mental illnesses can access, such as employment, accommodation, income support, rehabilitation, residential aged care and other services for older people and people with disability (see chapters 13 and 14, respectively).

Funding

Real government recurrent expenditure of around \$5.1 billion was allocated to mental health services in 2007-08 (tables 12A.28 and 12A.29). State and Territory governments made the largest contribution (\$3.2 billion, or 62.8 per cent), although this included some Australian Government base grant funds under the AHCA (table 12A.29). The Australian Government spent \$1.9 billion (table 12A.28). Real Australian Government expenditure per person increased from an average \$76 in 2003-04 to \$90 in 2007-08. National average State and Territory governments' expenditure per person in 2007-08 was \$152, an increase from \$124 in 2003-04 (figure 12.20).

Figure 12.20 **Real government recurrent expenditure on mental health services per person (2007-08 dollars)**[a, b]



---

[a] Real expenditure for all years (2007-08 dollars), using the implicit price deflator for non-farm gross domestic product (table 12A.66) for Australian Government expenditure, and the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services for State and Territory governments' expenditure (table 12A.65). [b] Includes expenditure sourced from patient fees and reimbursement by third party compensation insurers and 'other Australian Government funds'.

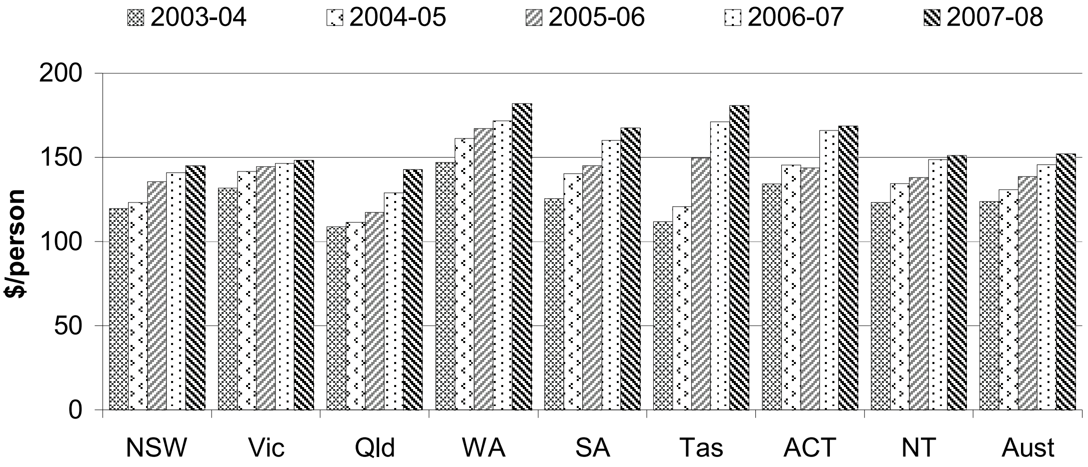
Source: Department of Health and Ageing (DoHA) (unpublished); State and Territory governments (unpublished); AIHW (unpublished) *MHE NMDS*; tables 12A.29 and 12A.30.

The largest component of Australian Government expenditure on mental health services in 2007-08 was expenditure under the PBS for psychiatric medication (\$701.7 million). Expenditure on psychiatric medication decreased by an annual average rate of 0.2 per cent between 2003-04 and 2007-08 and decreased from 46.5 per cent of Australian Government expenditure on mental health services in 2003-04 to 36.8 per cent in 2007-08 (table 12A.28). The decrease in expenditure on psychiatric medication is due to a number of frequently prescribed medications coming off patent, which allowed lower cost generic medicines to be used. For most patients, these lower cost medicines are not counted in the PBS data because their costs fall below the PBS subsidy threshold.

In 2007-08, the next largest component of Australian Government expenditure for mental health services was MBS payments for consultant psychiatrists (12.6 per cent) followed by NMHS funds (9.9 per cent). The residual included expenditure on MBS payments for clinical psychologists and other allied health professionals (9.3 per cent) (2007-08 was the first full year that these items were available), DVA services (7.4 per cent), GPs (6.9 per cent) and private hospital insurance premium rebates (3.5 per cent) (table 12A.28).

Real expenditure per person at State and Territory governments discretion has increased over time (figure 12.21). Data in figure 12.21 for State and Territory governments expenditure include Australian Government base grant funds provided under the AHCA, but exclude special purpose grants provided for mental health reform (NMHS funds) and also funding provided to State and Territory governments by the DVA. Data on NMHS and DVA funding are reported in table 12A.33. The data are referred to as expenditure 'at State and Territory governments' discretion'. The data in figure 12.21 also exclude depreciation. Estimates of depreciation are presented in table 12A.32. State and Territory governments expenditure estimates excluding revenue from other sources and other Australian Government funds are presented in table 12A.31. The revenue categories are subject to minimal validation and might be inconsistently treated across jurisdictions. In addition, it is not possible to extract revenue from other sources and other Australian Government funds uniformly across time.

Figure 12.21 **Real recurrent expenditure at the discretion of State and Territory governments (2007-08 dollars)**[a, b, c]



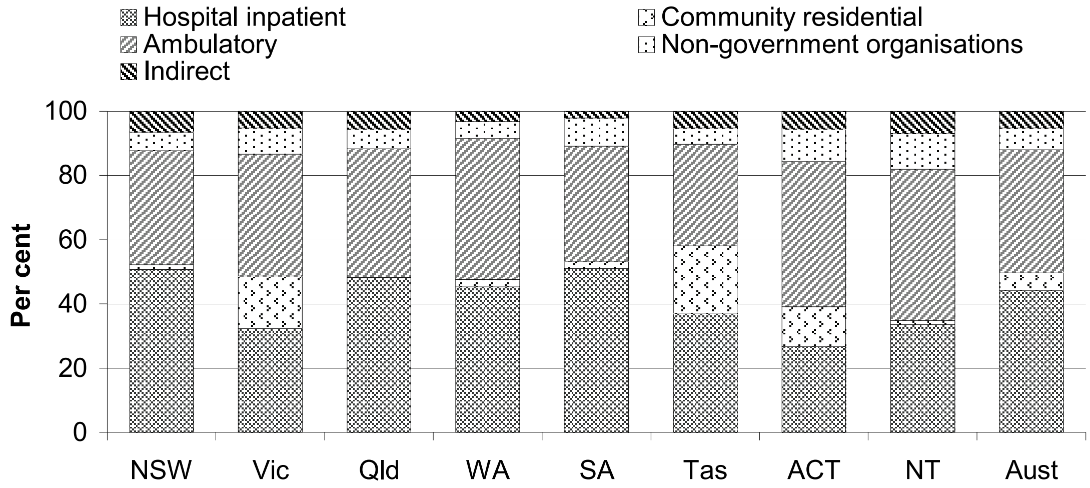
---

[a] Real expenditure (2007-08 dollars), using State and Territory implicit price deflators for general government final consumption on hospital clinical services (table 12A.65). [b] Estimates of State and Territory government spending include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Australian Government funds', but exclude Australian Government funding provided under the NMHS and through the DVA. NMHS and DVA funding data are reported in table 12A.33. [c] Depreciation is excluded for all years. Depreciation estimates are reported in table 12A.32.

Source: DoHA (unpublished); State and Territory governments (unpublished); AIHW (unpublished) *MHE NMDS*; table 12A.29.

Figure 12.22 shows how expenditure at the discretion of State and Territory governments was distributed across the range of mental health services in 2007-08.

Figure 12.22 **State and Territory governments' recurrent expenditure, by service category, 2007-08**[a, b, c, d]



---

[a] Includes all State and Territory governments' expenditure on mental health services, regardless of source of funds. [b] Depreciation is excluded. Depreciation estimates are reported in table 12A.32. [c] 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 states and territories, the level of expenditure on non-government organisations does not necessarily reflect the level of community support services available. [d] Queensland does not fund community residential services, but it funds a number of extended treatment services (both campus-based and non-campus-based) that provide longer term inpatient treatment and rehabilitation services with full clinical staffing for 24 hours a day, 7 days a week.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.36.

Size and scope

In 2007-08, 4.8 per cent and 1.5 per cent of the total population received Medicare-funded and State and Territory clinical mental health care services, respectively (figure 12.23). These data need to be interpreted carefully. Data for State/Territory mental health services are based on people who received one or more ambulatory mental health services (most people who have received a State and Territory inpatient service have also received an ambulatory mental health service). States and territories also differ in the way they count the number of people under care (AHMC 2010).

Figure 12.23 **Population receiving clinical mental health care, 2007-08**[a, b, c, d]

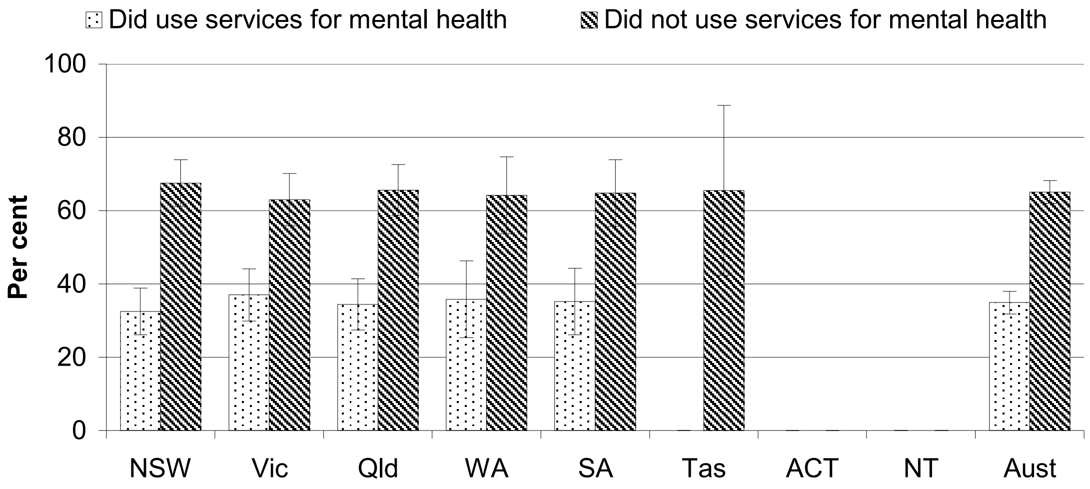
---

[a] Estimates are preliminary only and based on unique counts of individuals receiving care from the particular services within the year. An individual is only counted once, irrespective of the number of services received. An individual could have received a Medicare-funded and a State/Territory mental health service in the given year. [b] Person counts for State and Territory mental health services are confined to those receiving one or more contacts provided by ambulatory mental health services. All service contacts are counted in defining whether a person receives a service, including those delivered 'on behalf' of the consumer. [c] Jurisdictions differ in their capacity to provide accurate estimates of people receiving services due to the lack of unique patient identifiers, or data matching systems. Tasmania and SA data are derived without use of a unique patient identifier or data matching approaches. [d] All Medicare funded data are based on year of processing, as provided by the Australian Government (DoHA) and billing data maintained by Medicare Australia.

Source: AHMC (2010) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2007-08*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (forthcoming); table 12A.37.

Nationally, in 2007, 34.9 ± 3.1 per cent of people with a 12-month mental disorder used a service for mental health (figure 12.24). People with a mental illness can have low rates of service use due to them choosing not to access services, unavailability of appropriate services, lack of awareness that services are available and negative experiences associated with the previous use of services (AHMC 2008). In addition, it might not be appropriate for all people with a mental illness to use a service, for example, some can seek and receive assistance from outside the health system (AHMC 2008).

Figure 12.24 **People with 12-month mental disorder, use of services for mental health, 2007**[a, b, c]



[a] Services used for mental health included hospitals, GPs, psychiatrists, psychologists, other mental health professionals and other health professionals. [b] Error bars represent the 95 per cent confidence interval associated with each point estimate. [c] Estimates with RSEs over 25 per cent are not published. This is the case for Tasmanian data for the category 'did use services for mental health', the ACT and the NT.

Source: ABS (unpublished) *2007 SMHWB,* Cat. no. 4326.0; table 12A.35.

According to the SMHWB, service use was more common among people with more severe disorders. Almost two thirds (64.8 per cent) of people with severe mental disorders used services, compared to 40.2 per cent of those with moderate mental disorders and 17.9 per cent of people with mild mental disorders (Slade *et al.* 2009). For people who did not use services, the SMHWB examined whether there were services or types of help that they thought they needed, but had not received. For those with a 12-month mental disorder who did not use a service, 85.7 per cent reported that they had no need for any of the types of help asked about in the survey (information, medication, talking therapy, social intervention, or skills training) (Slade *et al.* 2009). Data on the proportion of people with a mental disorder with symptoms in the previous 12 months who used different types of health services are reported in table 12A.34.

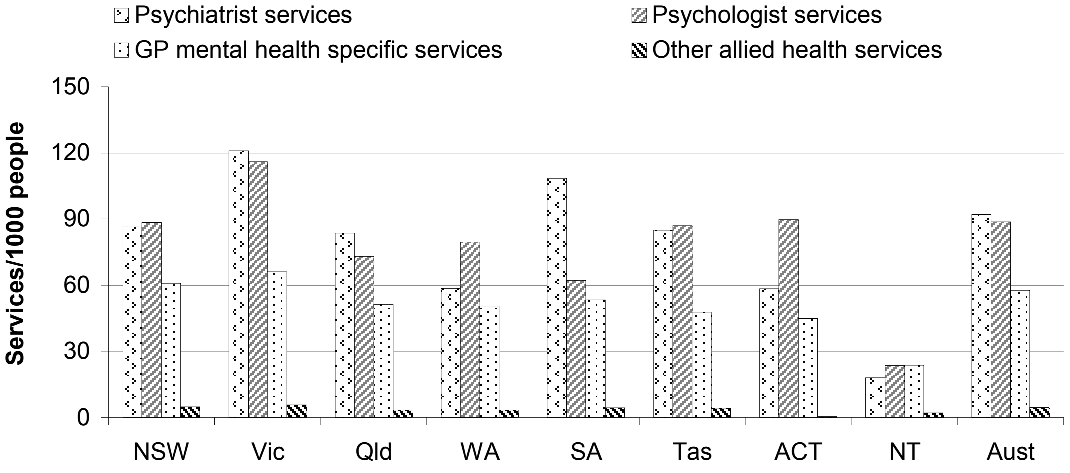
MBS-subsidised mental health services

MBS-subsidised mental health services are mental health services provided by a GP, psychiatrist or an allied health professional (psychologists, social workers and occupational therapists) on a fee-for-service basis that are partially or fully funded under Medicare. GPs provide mental health-related services under specific mental health MBS items (GP Mental Health Care Plans and Focussed Psychological

Strategies) and through other mental health-related encounters such as, through a standard surgery consultation.

In 2007-08, there were 1.2 million services provided by GPs (under specific mental health MBS items), 1.9 million services provided by psychiatrists, 1.9 million services provided by psychologists and 94 709 services provided by other allied health professionals (table 12A.38). This was equivalent to 57.6 GP services, 92.1 psychiatrist services, 88.7 psychologist services and 4.5 other allied health services per 1000 people (figure 12.25).

Figure 12.25 **MBS-subsidised mental health services, 2007-08[a]**



---

[a] Crude rates based on the preliminary Australian ERP as at 31 December 2007.

Source: AIHW (2009) *Mental health services in Australia 2006–07*, Mental health series no. 11, Cat. no. HSE 74; table 12A.38.

Information on GPs mental health-related encounters is also available from the *Bettering the Evaluation and Care of Health* (BEACH) survey data. Data for the BEACH survey are collected from a sample of 1000 GPs. Under the BEACH, a mental health-related encounter is defined as one at which a mental health-related problem is managed.

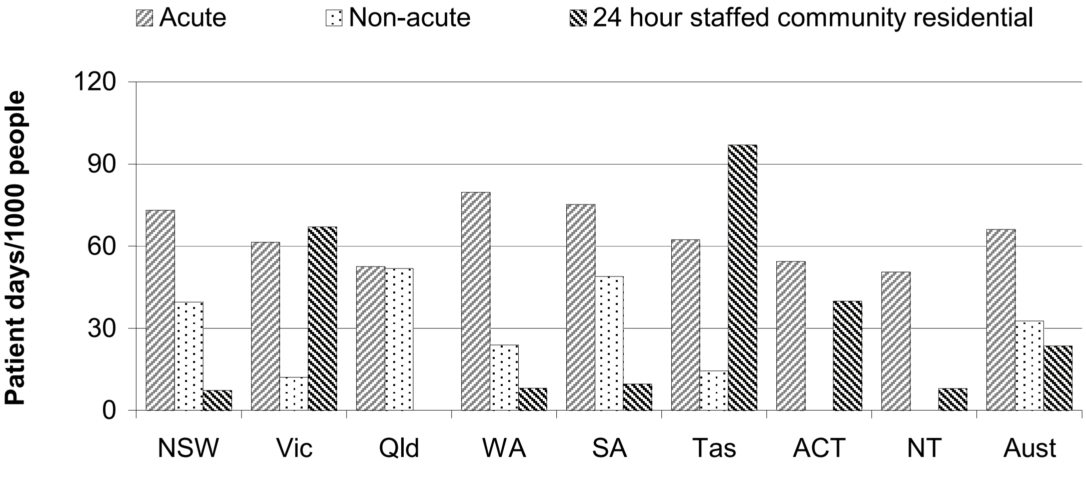
In 2007–08, 10.8 per cent of all GP encounters reported for the BEACH data were mental health-related encounters. The BEACH survey asks GPs to record an MBS item for each encounter. These encounters were most often recorded as standard surgery consultations (over 90 per cent of all encounters for which an MBS item was recorded). The GP mental health-specific MBS items (reported above), represented only 6.6 per cent of MBS items recorded for mental health-related encounters in the 2007–08 BEACH survey (AIHW 2009b).

In 2007-08, on average 11.5 psychological/mental health problems were managed by GPs in every 100 encounters (more than one problem can be managed in a single encounter). The most frequently reported mental health related problem managed was depression (4.0 per 100 GP encounters). Anxiety (1.8 per 100 GP encounters) and sleep disturbance (1.6 per 100 GP encounters) were the next most common psychological problems managed. In 2007-08, depression was the fifth most frequently managed problem by a GP (Britt *et al.* 2008). A GP may manage more than one problem at a single encounter. Problems managed reflect the GP's understanding of the health problem presented by the patient.

State and Territory publicly funded specialised mental health services — service activity

Estimating activity across the publicly funded specialised mental health services sector is problematic. Data for accrued mental health patient days are provided in figure 12.26 by acute, non-acute and 24 hour staffed community residential care (as defined in box 12.17). Hospital inpatient days and community residential accrued patient days are included in figure 12.26, but other types of community services are not covered.

Figure 12.26 **Accrued mental health patient days, 2007-08**[a, b]



[a] Queensland does not fund community residential services, but funds a number of campus-based and non-campus-based extended treatment services. Data from these services are included as non-acute. [b] The ACT and the NT did not provide mental health care in non-acute units.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.39.

Other measures of service activity include separations for admitted patient care, episodes for community residential care and contacts for community mental health services. In 2006-07, there were:

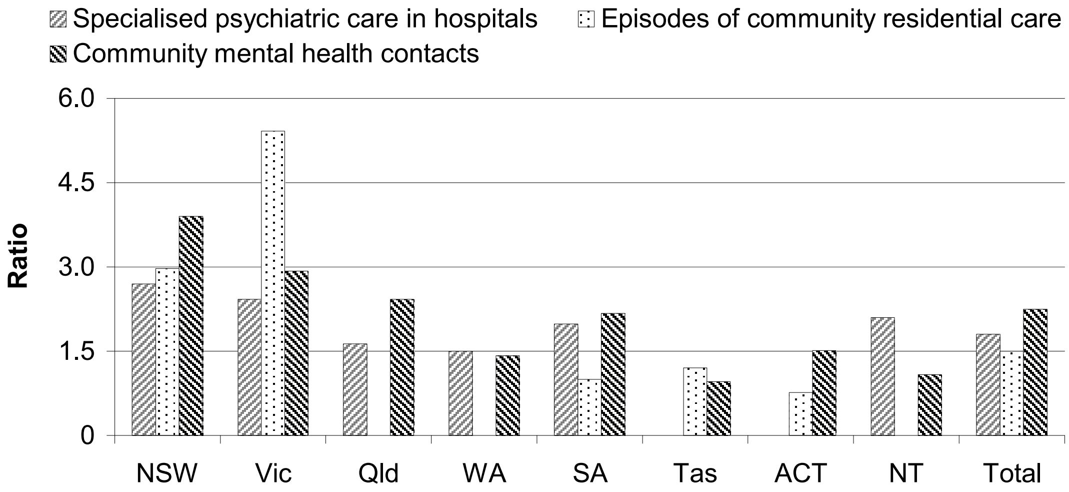
- 79 738 separations with specialised psychiatric care in public acute hospitals and 12 771 specialised psychiatric care separations in public psychiatric hospitals (table 12A.40). Schizophrenia accounted for a large proportion of separations with specialised psychiatric care in public hospitals (22.1 per cent in public acute hospitals and 23.6 per cent in public psychiatric hospitals) (table 12A.40). There were a further 4937 ambulatory equivalent same day separations with specialised psychiatric care in public acute hospitals and 1547 in public psychiatric hospitals (AIHW 2009b)
- 2531 episodes of community residential mental health care. Schizophrenia, schizotypal and other delusional disorders accounted for the largest proportion of these episodes with a principal diagnosis (72.2 per cent) (AIHW 2009b)
- 6.0 million community mental health care patient contacts, equivalent to 288 contacts per 1000 people (table 12A.41). Community mental health care service contacts are not restricted to face-to-face communication but can include telephone, video link or other forms of direct communication. For those contacts where a principal diagnosis were available, the largest proportion was for schizophrenia (31.8 per cent) (AIHW 2009b).

Service use by Indigenous status of patient

Data on service use by the Indigenous status of patients are available, but comparisons are difficult because Indigenous patients are not always correctly identified. Differences in rates of service use could also reflect other factors, including the range of social and physical infrastructure services available to Indigenous people, and differences in the complexity, incidence and prevalence of illnesses.

Combined data for the jurisdictions for which data are available, show that Indigenous people were 1.8 times more likely to receive specialised psychiatric care in hospitals (both public and private hospitals), 1.5 times more likely to have an episode of community residential care and 2.2 times more likely to have a community mental health contact than non-Indigenous people (figure 12.27). Table 12A.42 contains further information on use of these services by Indigenous status.

Figure 12.27 Ratio of Indigenous to non-Indigenous specialised mental health service use, 2006-07[a, b, c, d, e, f]



[a] Data for episodes of community residential care should be interpreted with caution due to the varying quality and completeness of Indigenous identification across jurisdictions. Of the jurisdictions for which data are available, only Tasmania and the ACT considered their Indigenous data to be of acceptable quality. [b] Data for community mental heath contacts should be interpreted with caution. Across jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown. Data are considered of acceptable quality for Queensland, WA, Tasmania, the ACT and the NT. [c] The ratio is equal to the service use rate (episodes, contacts or separations) for Indigenous people divided by the service use rate for non-Indigenous people. Data for non-Indigenous includes people whose Indigenous status was 'not stated'. [d] Data for specialised psychiatric care in hospitals includes both public and private hospitals. [e] Queensland does not fund community residential services, but funds a number of campus-based and non-campus-based extended treatment services. [f] Data by Indigenous status are not published for WA and the NT for episodes of community residential care and for Tasmania and the ACT for specialised psychiatric care in hospitals.

Source: AIHW (2009) *Mental health services in Australia 2006–07*, Mental health series no. 11, Cat. no. HSE 74 (internet only tables); table 12A.42.

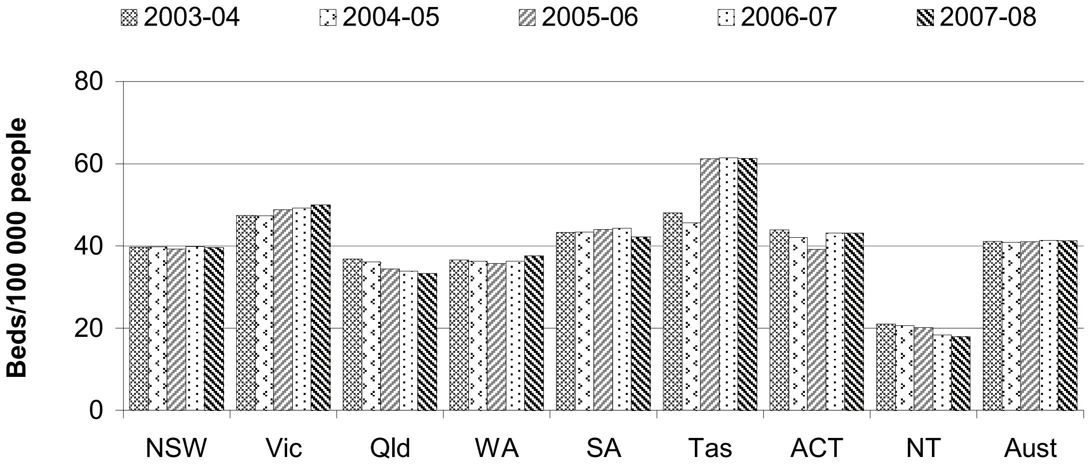
State and Territory publicly funded specialised mental health services — mental health beds

Beds are counted as those immediately available for use by admitted patients if required. They are available for use immediately — or within a reasonable period of time — if located in a suitable place for care with nursing or other auxiliary staff available.

Available beds are counted differently across years. For data from 2005-06, available beds are counted as the average of monthly available bed numbers. For previous years, available beds are counted at 30 June. In addition, for data from 2005-06, available beds counts excluded beds in wards that were closed for any reason (except weekend closures for beds/wards staffed and available on weekdays only). For previous years, available beds counts included wards that were temporarily closed for reasons such as renovation or strike, but that would normally be open.

Figure 12.28 presents the number of beds per 100 000 people for public hospitals and community residential facilities combined.

Figure 12.28 **Mental health beds in public hospitals and publicly funded community residential units**[a, b, c, d]



---

[a] Includes beds in public hospitals and publicly funded community residential units. [b] In 2005-06, there was a temporary closure of acute beds in one Queensland hospital and some transitional extended treatment beds were permanently closed. In addition, Queensland did not change the method for counting beds until 2007-08. [c] Beds numbers in WA include publicly funded mental health beds in private hospitals for all years. Bed numbers in WA from 2005-06 include emergency department observation beds in one hospital. [d] In Tasmania, for 2005-06, non-government organisations' residential beds funded by government are included for the first time in the publicly funded community residential facilities category. This has led to a significant change in the bed numbers between 2004-05 and 2005-06.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.43.

Figure 12.29 presents the number of beds by service setting for 2007-08. These data show the differences in service mix across states and territories.

Figure 12.29 **Available beds, by service setting, 2007-08**[a, b]

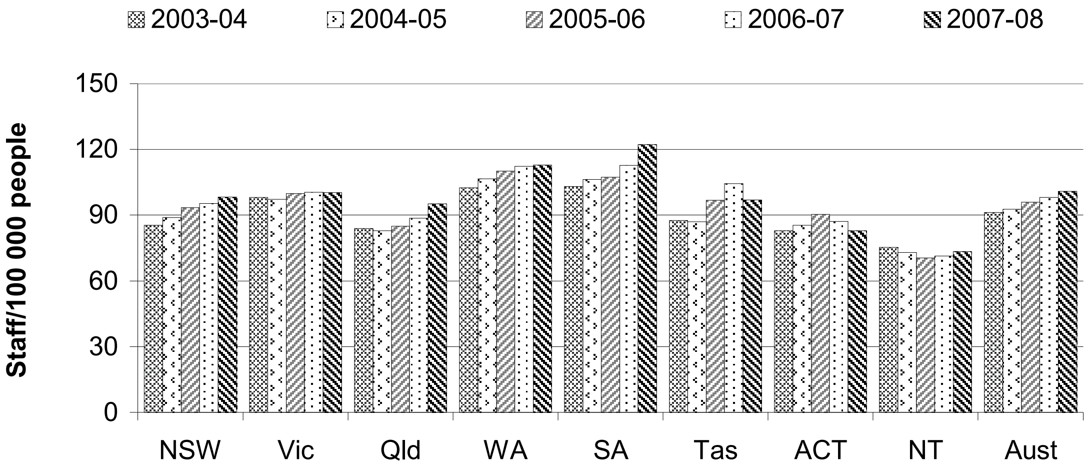
[a] Queensland does not fund community residential services, but it funds a number of campus-based and non-campus-based extended treatment services. These services are reported either as beds in public acute hospitals or beds in public psychiatric hospitals. [b] Tasmania, the ACT and the NT do not have public psychiatric hospitals.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.43.

State and Territory publicly funded specialised mental health services — staff

Figure 12.30 reports full time equivalent (FTE) health professional direct care staff per 100 000 people.

Figure 12.30 **FTE health professional direct care staff**[a]



---

[a] Includes staff within the health professional categories of ‘medical’, ‘nursing’ and ‘allied health’. ‘Medical’ staff consist of consultant psychiatrists, psychiatry registrars, and other medical officers who are neither registered as psychiatrists within the State or Territory, nor are formal trainees of the Royal Australian and New Zealand College of Psychiatrists’ Postgraduate Training Program. ‘Nursing’ staff consist of registered and non-registered nurses. ‘Allied health’ staff consist of occupational therapists, social workers, psychologists and other allied health staff. ‘Other personal care’ direct care staff are excluded. ‘Other personal care’ staff include attendants, assistants, home companions, family aides, ward helpers, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents and who are not formally qualified or are still training in nursing or allied health professions. Definitions for staffing categories are provided in more detail in section 12.7.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.44.

Nursing staff comprise the largest FTE component of health care professionals employed in mental health services. Across Australia in 2007-08, 64.8 nurses per 100 000 people were working in specialised mental health services, compared with 24.1 allied health care staff and 11.9 medical staff (table 12A.44). FTE direct care staff employed in specialised mental health services, by service setting, are reported in table 12A.45.

Framework of performance indicators

Preventing the onset of mental illness is challenging, primarily because individual illnesses have many origins. Most efforts have been directed at treating mental illness when it occurs, determining the most appropriate setting for providing treatment and emphasising early intervention.

The framework of performance indicators for specialised mental health services draws on governments’ broad objectives for national mental health policy, as encompassed in the NMHS and the COAG National Action Plan on Mental Health (box 12.18). The framework reports on the equity, effectiveness and efficiency of specialised mental health services. It covers a number of service delivery types (admitted patient and community-based services) and includes outcome indicators of system wide performance. Improving the framework is a priority of the Steering Committee.

Box 12.18 **Broad objectives of National Mental Health Policy**[a]

Key broad objectives include to:

- improve the effectiveness and quality of service delivery and outcomes
- promote, where appropriate, community awareness of mental health problems
- prevent, where possible, the development of mental health problems and mental illness
- undertake, where appropriate, early intervention for mental health problems and mental illness
- promote recovery from mental health problems and mental illness
- reduce, where possible, the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community
- assure the rights of people with mental illness
- encourage partnerships among service providers and between service providers and the community
- provide services in an equitable (including improved access to mental health services, particularly in Indigenous and rural communities) and efficient manner
- improve mental health and facilitate recovery from illness through more stable accommodation and support and meaningful participation in recreational, social, employment and other activities in the community.

[a] These objectives are based on the National Mental Health Policy 2008. They represent a paraphrased interpretation of aspects of the Policy.

In 1991, Australian Health Ministers signed the *Mental Health Statement of Rights and Responsibilities*. This Statement seeks to ensure that consumers, carers, advocates, service providers and the community are aware of their rights and responsibilities and can be confident in exercising them (Australian Health Ministers 1991). The Statement underpins the NMHS endorsed by Australian, State and Territory governments in 1992 (AIHW 2008).

The NMHS was established to guide the reform agenda for mental health in Australia across the whole-of-government. The NMHS consists of the National Mental Health Policy and the National Mental Health Plan.

- The National Mental Health Policy describes the broad aims and objectives of the NMHS. The revised *National Mental Health Policy 2008* includes a renewed emphasis on whole-of-government mental health reform and commits the Australian, State and Territory governments to the continual improvement of Australia's mental health system. Under the Policy, these governments will seek to ensure Australians with a mental illness have access to services that detect and intervene early in illness, promote recovery and provide effective and appropriate treatment and community supports to enable them to fully participate in the community.

- The National Mental Health Plan describes the approach to implementing the aims and objectives of the Policy. A fourth plan (2009–2014) was endorsed by all Australian Health Ministers in September 2009. This plan consolidates reforms begun under the first three plans (the first operated from 1993–1998, the second from 1998–2003 and the third from 2003–2008). The plan strengthens the accountability framework with Australian, State and Territory governments agreeing to develop targets and data sources for a set of indicators and to provide annual progress reports to COAG (AHMC 2009). These indicators will be the primary vehicle for monitoring the progress of these governments in achieving national mental health reform under the fourth plan.

In 2006, COAG agreed to the *National Action Plan on Mental Health 2006–2011* (COAG 2006). This plan involves a joint package of measures and new investments by all governments aimed at promoting improved mental health and providing additional support to people with mental illness, their families and their carers. The Action Plan is designed to further promote mental health reform and focuses on areas that have not progressed sufficiently under the NMHS. The Action Plan is directed at achieving four outcomes:

- reducing the prevalence and severity of mental illness in Australia
- reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery
- increasing the proportion of people with an emerging or established mental illness who are able to access appropriate health care and other relevant community services at the necessary time, with a particular focus on early intervention
- increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

A series of measures have been identified to monitor progress against these outcomes. Australian Health Ministers agreed to report annually to COAG on implementation of the Plan, and on progress against the agreed outcomes.

Governments also agreed to an independent evaluation and review of the Plan after 5 years (COAG 2006).

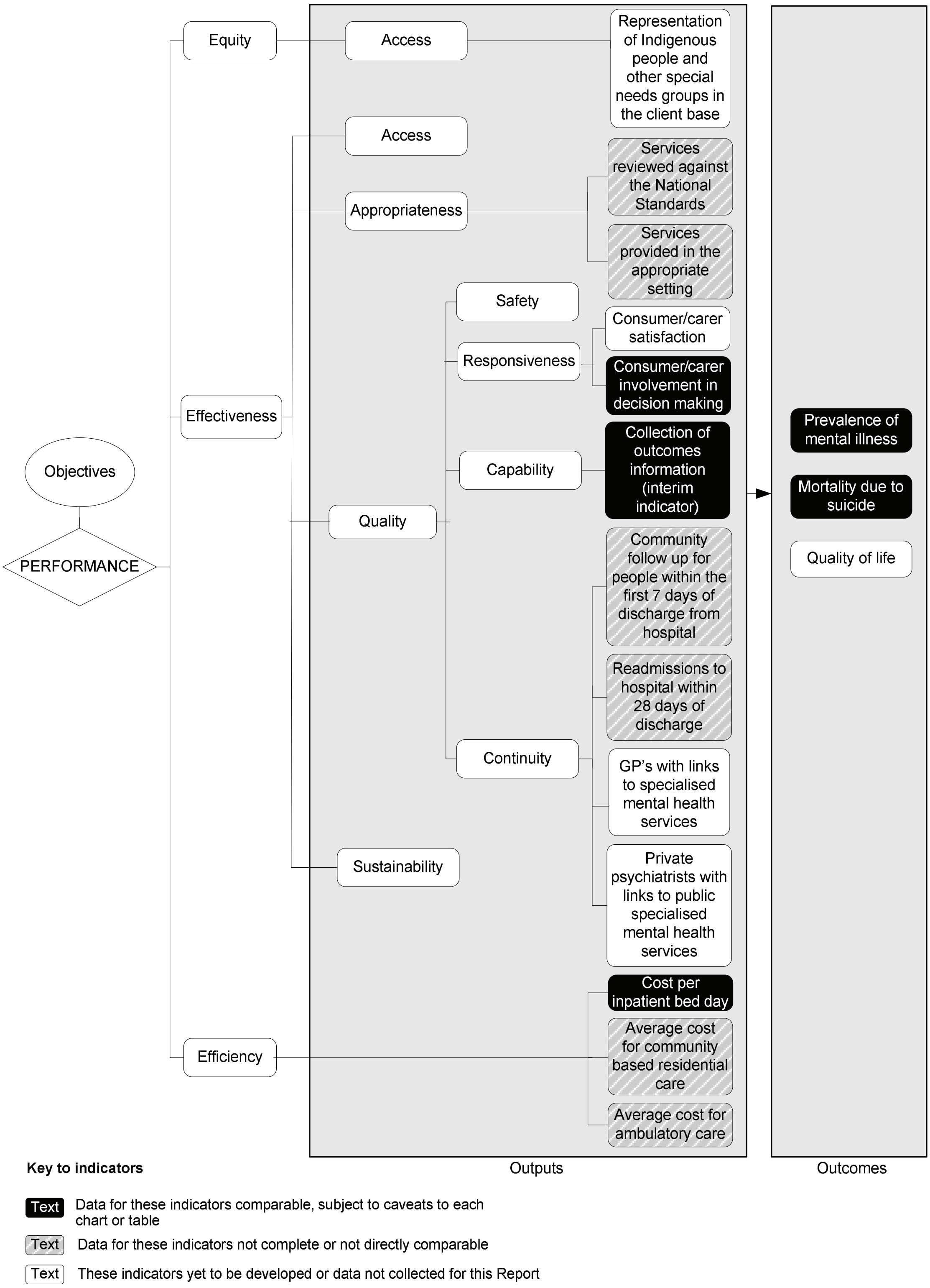
Over the period 2004–2009, the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2004–2009* (the Social and Emotional Well Being Framework) provided a basis for action by all governments and communities to improve the social and emotional well being and mental health needs of Indigenous Australians. Ongoing monitoring is provided under the *Aboriginal and Torres Strait Islander Health Performance Framework*. This framework includes 71 performance indicators that measure progress against closing the gap in Indigenous health outcomes. Of these indicators, two relate specifically to social and emotional well being. The performance indicators are reported on biennially.

The performance indicator framework shows which data are comparable in the 2010 Report (figure 12.31). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The Health preface explains the performance indicator framework for health services as a whole, including the sub-dimensions for quality and sustainability that have been added to the standard Review framework.

Some changes have been made to the mental health framework for the 2010 Report. The measure used in previous reports for the 'Average cost of ambulatory care' indicator (cost per treated patient in the community) has been replaced by two measures from the set of National Mental Health Key Performance Indicators. This is the first time these measures have been reported and work on them is ongoing. The Steering Committee will continue to seek advice on possible modifications and improvements to their formulation for future reports.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 12.31 **Performance indicators for mental health management**



Key performance indicator results

Outputs

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

Equity — representation of Indigenous people and other special needs groups in the client base

'Representation of Indigenous people and other special needs groups in the client base' is an indicator of governments' objective to provide mental health services in an equitable manner, including access to services by special needs groups such as Indigenous people (box 12.19).

Box 12.19 **Representation of Indigenous people and other special needs groups in the client base**

'Representation of Indigenous people and other special needs groups in the client base' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Access

The Steering Committee has identified access as an area for reporting, but no indicators have yet been developed.

Appropriateness — services reviewed against the National Standards

'Services reviewed against the National Standards' is an indicator of governments' objective to provide mental health services that are appropriate (box 12.20). It is a process indicator of appropriateness, reflecting progress made in meeting the national standards for mental health care.

Box 12.20 **Services reviewed against the National Standards**

‘Services reviewed against the National Standards’ is defined as the proportion of specialist mental health services that had completed a review by an external accreditation agency against the *National Standards for Mental Health Services* (NSMHS). Services were assessed as level 1 or level 2, where these levels are defined as:

- *Services assessed at level 1* — reviewed by an external accreditation agency against the NSMHS and assessed as meeting all Standards
- *Services assessed at level 2* — reviewed by an external accreditation agency against the NSMHS and assessed as meeting some, but not all Standards.

A high or increasing proportion of specialist mental health services that had completed a review by an external accreditation agency against the NSMHS and that had been assessed as level 1 or level 2 is desirable. It suggests an improvement in the quality of services.

The indicator does not provide information on whether the standards or assessment process are appropriate. In addition, services that had not been assessed do not necessarily deliver services of lower quality. Some services that had not completed an external review included those that were undergoing a review and those that had booked for review and were engaged in self-assessment preparation.

Data reported for this indicator are not directly comparable.

The NSMHS are outlined in box 12.21. A comprehensive review of these Standards was completed in May 2008. The review was conducted to align the Standards with developments in mental health reform, current legislation and to assist mental health services to provide quality care for people with a mental illness (consumers) that is evidence-based, integrated and recovery-focussed. A revised set of standards has been developed. Implementation strategies for the different service sectors are being developed to accompany the release of the revised Standards.

External accreditation agencies, such as the Australian Council on Healthcare Standards, undertake accreditation of a parent health organisation (for example, a hospital) that can cover a number of specialised services, including mental health services. Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the National Standards; rather, assessment against the National Standards must be specifically requested and involves a separate review process.

Box 12.21 **The *National Standards for Mental Health Services***

The NSMHS were developed under the *First National Mental Health Plan* for use in assessing service quality and as a guide for continuous quality improvement in all Australian mental health services. They comprise 11 major criteria:

1. Rights.
2. Safety.
3. Consumer and carer participation.
4. Promoting community acceptance.
5. Privacy and confidentiality.
6. Prevention and mental health promotion.
7. Cultural awareness.
8. Integration.
9. Service development.
10. Documentation.
11. Delivery of care.

Source: DoHA (2002).

Table 12.6 shows the percentage of specialised public mental health services that had completed an external review against the NSMHS. Services were assessed as meeting 'all Standards' (level 1) or as meeting 'some but not all Standards' (level 2).

Table 12.6 Specialised public mental health services reviewed against the NSMHS, 30 June (per cent)[a, b]

	NSW	*Vic*[c]	*Qld*	*WA*[d]	*SA*	*Tas*	*ACT*	*NT*
2004								
Level 1	na	100.0	74.2	na	49.5	na	81.3	50.0
Level 2	na	–	8.3	na	5.6	na	–	–
2005								
Level 1	73.4	100.0	75.0	64.5	72.7	46.9	87.5	50.0
Level 2	0.6	–	6.7	12.9	2.7	–	–	50.0
2006								
Level 1	78.0	100.0	78.5	51.6	62.9	36.4	100.0	100.0
Level 2	0.9	–	1.7	9.7	3.4	15.2	–	–
2007								
Level 1	77.5	96.0	82.8	44.1	71.8	37.9	100.0	100.0
Level 2	0.9	–	0.8	41.2	1.8	6.9	–	–
2008								
Level 1	86.0	100.0	83.1	31.4	50.9	39.4	100.0	100.0
Level 2	2.3	–	4.2	34.3	1.8	–	–	–

[a] Services that had not completed a review by an external accreditation agency included those that were undergoing a review and those that had booked for review and were engaged in self-assessment preparation. [b] NSW, Queensland, SA, Tasmania and the ACT report at the service unit level. Victoria, WA and the NT report at the organisation level. [c] In Victoria, two agencies did not report at 'Level 1' for 2007. However, both agencies were in the process of re-accreditation and therefore can be deemed as having gained accreditation. [d] WA data include public sector services only. In 2008, WA had 11 services booked for review by an external accreditation agency and were engaged in self-assessment preparation prior to the formal external review. These services are not included. **na** Not available. – Nil or rounded to zero.

Source: AIHW (unpublished) MHE NMDS; State and Territory governments (unpublished); table 12A.46.

Appropriateness — services provided in the appropriate setting

‘Services provided in the appropriate setting’ is an indicator of governments’ objective to provide mental health services in mainstream or community settings wherever possible (box 12.22).

Box 12.22 **Services provided in the appropriate setting**

'Services provided in the appropriate setting' is defined by two measures:

- recurrent expenditure on community-based services as a proportion of total expenditure on mental health services (excluding aged care community residential expenditure)
- acute mental health patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals.

A high or increasing proportion of recurrent expenditure expended on community-based services is desirable, reflecting a greater reliance on services that are based in community settings. A high or increasing proportion of acute patient days that were provided in public acute hospitals is desirable, reflecting a reduced reliance on stand-alone psychiatric hospitals and greater mainstreaming of mental health services.

Data reported for this indicator are not directly comparable.

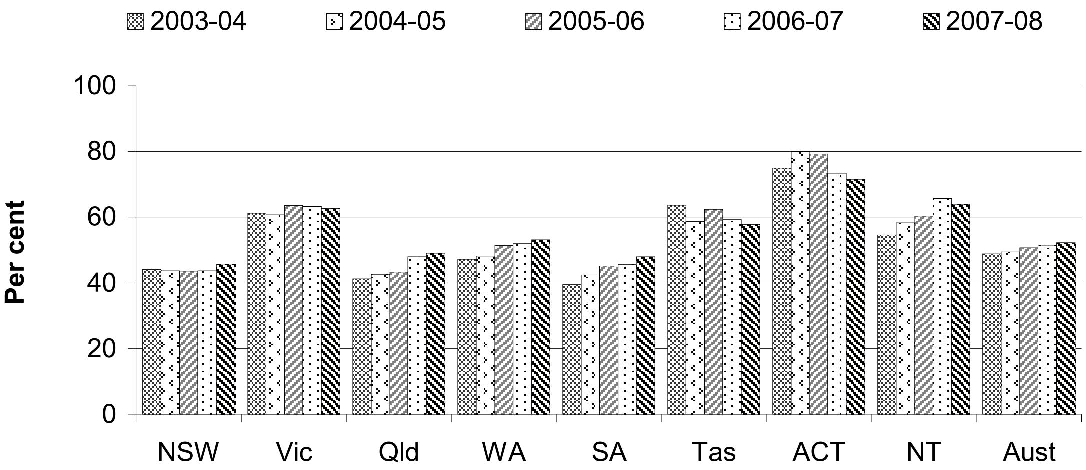
The development of local, comprehensive mental health service systems is advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental illnesses and of providing continuity of care to enable consumers to move between services as their needs change. The Strategy advocates:

- a reduced reliance on stand-alone psychiatric hospitals
- the expanded delivery of community-based care integrated with inpatient care
- increased mainstreaming of mental health services with other components of health care.

More appropriate treatment options can be provided by encouraging the treatment of patients in community settings and public (non-psychiatric) hospitals, rather than in stand-alone psychiatric hospitals.

Figure 12.32 shows recurrent expenditure on community-based services as a proportion of total expenditure on mental health services. Nationally, recurrent expenditure on community-based services as a proportion of total expenditure on mental health services increased over the period from 2003-04 to 2007-08.

Figure 12.32 **Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services**[a, b, c]

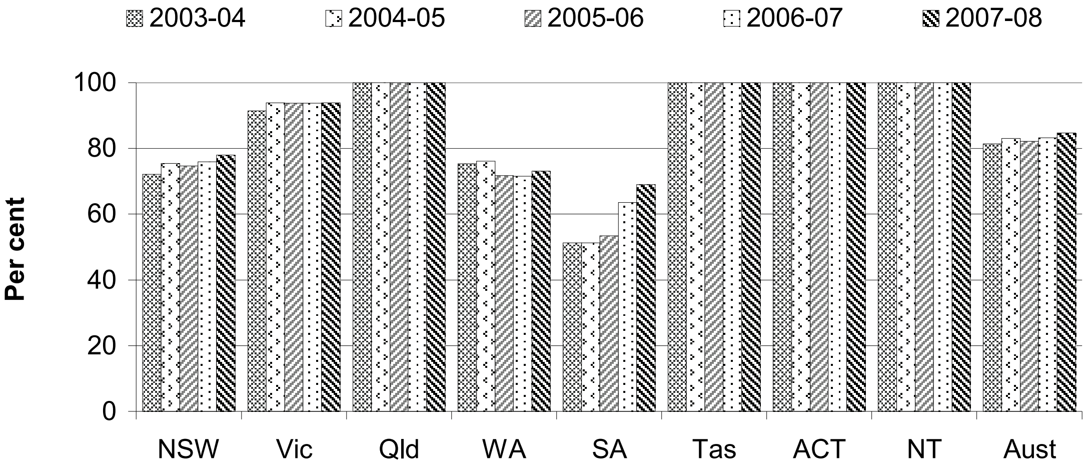


a Community-based expenditure includes expenditure on ambulatory, non-government and adult community residential services. Aged care community residential expenditure is excluded to improve comparability. **b** Total expenditure on mental health services excludes indirect/residual expenditure that could not be apportioned directly to services and aged care community residential expenditure. **c** Queensland does not fund community residential services, but funds a number of extended treatment (campus-based and non-campus-based) services that provide longer term inpatient treatment and rehabilitation services with clinical staffing for 24 hours a day, 7 days a week.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.47.

Figure 12.33 shows acute mental health patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals. Nationally, the proportion of acute patient days in public acute hospitals as a proportion of total acute inpatient bed days (in both public acute and psychiatric hospitals) increased over the period from 2003-04 to 2007-08.

Figure 12.33 **Acute mental health patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals**



Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.47.

Quality — consumer and carer satisfaction

'Consumer and carer satisfaction' is an indicator of governments objective that services are responsive to the needs of consumers and their carers (box 12.23). Consumers and their carers should be satisfied with both clinicians' responses and with services provided, in all areas of mental health. Both are important aspects of the NMHS.

Box 12.23 **Consumer and carer satisfaction**

'Consumer and carer satisfaction' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Quality — consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' is an indicator of governments' objective that consumers' and carers' are involved at the service delivery level, where they have the opportunity to influence the services they receive (box 12.24). Consumer and carer involvement is an important aspect of the NMHS.

Box 12.24 **Consumer and carer involvement in decision making**

‘Consumer and carer involvement in decision making’ is defined by two measures:

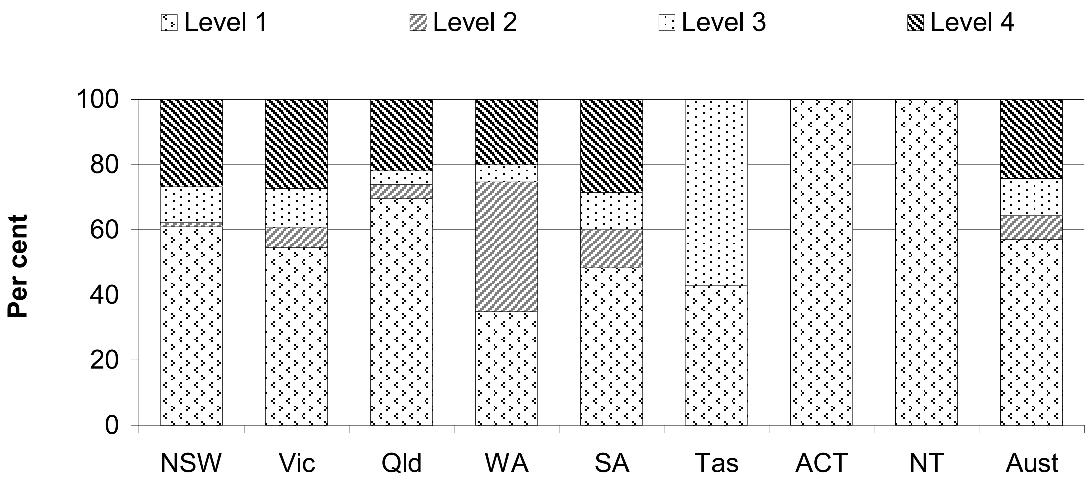
- The proportion of organisations that have in place arrangements that allow consumers to contribute to local service planning and delivery in specialised mental health services. An organisation can be classified at only one level. Arrangements are grouped into four categories:
  - level 1 — organisation has a formal position for mental health consumers on the management committee or a specific mental health consumer advisory group exists to advise on all aspects of service delivery
  - level 2 — organisation has a specific mental health consumer advisory group to advise on some but not all aspects of service delivery
  - level 3 — organisation includes mental health consumers on a broadly based advisory committee
  - level 4 — organisation has minimal/no arrangements for mental health consumer participation in planning and evaluation of services.
- The number of paid FTE consumer consultants per 10 000 clinical staff and the number of paid FTE carer consultants per 10 000 FTE clinicians.

A high or increasing proportion of organisations with level 1 arrangements is desirable, while a high or increasing proportion of organisations with level 4 arrangements is undesirable. High or increasing numbers of paid FTE consumer/carer consultants implies a greater opportunity for consumers and carers to be involved in decision making.

Data reported for this indicator are comparable.

Figure 12.34 illustrates the degree of consumer participation in decision making. Current categories do not match all State or Territory governments’ arrangements for consumer participation in decision making. The Steering Committee has identified that work to improve reporting in this area is needed.

Figure 12.34 Organisations with consumer participation in decision making, 2007-08[a, b]



[a] Non-government organisations are included only where they provide staffed residential services. [b] WA data are for public sector services only.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.48.

Table 12.7 illustrates the number of paid FTE consumer and carer consultants per 10 000 FTE clinicians.

Table 12.7 Paid FTE consumer and carer consultants per 10 000 FTE clinical staff

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Paid consumer consultants per 10 000 clinicians									
2005-06	43.0	38.6	28.5	2.2	16.7	–	43.3	–	31.1
2006-07	37.9	36.6	28.1	3.4	11.8	–	–	–	27.9
2007-08	40.9	38.1	24.1	5.1	24.2	0.6	–	–	29.7
Paid carer consultants per 10 000 clinicians									
2005-06	4.3	23.0	1.2 |	–	–	–	–	–	7.5
2006-07	13.2	26.2	2.5	–	–	–	–	–	11.3
2007-08	10.2	29.5	3.7	3.2	9.5	–	–	–	12.4

– Nil or rounded to zero.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.48.

Quality — collection of outcomes information (interim indicator)

'Collection of outcomes information' is an indicator of governments' objective that consumer outcomes be monitored (box 12.25). It is an interim process indicator, reflecting the capability of services in establishing systems to collect consumer outcomes information. It will be replaced by information on consumer outcomes when they become available.

Box 12.25 **Collection of outcomes information (interim indicator)**

'Collection of outcomes information (interim indicator)' is defined as the proportion of specialised mental health services that have introduced routine collection of consumer outcomes information.

A high or increasing proportion of services that are collecting consumer outcomes information is desirable.

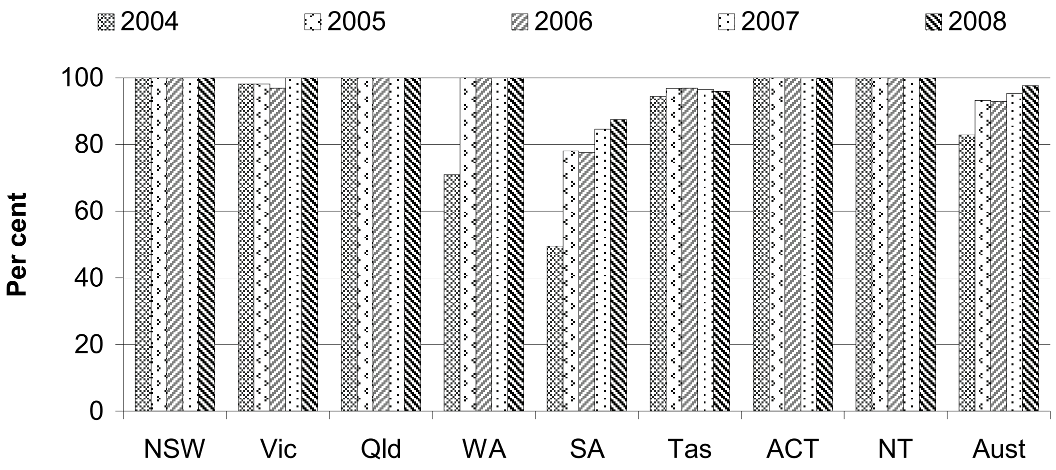
Data reported for this indicator are comparable.

Establishing a system for the routine monitoring of consumer outcomes was introduced as part of the *National Mental Health Plan 2003–2008*. State and Territory governments have taken the following approach to introduce consumer outcomes measurement as part of day-to-day service delivery:

- Introduced measures to include ratings by clinicians and self-ratings by consumers.
- Ensured that all clinical staff have undergone training in collection.
- Established processes to ensure uniformity in collection.
- Funded information systems to store, analyse and report on the data.
- Taken a national approach to data analysis, reporting and benchmarking (DoHA 2002).

The proportions of specialised mental health services that have introduced routine consumer outcomes measurement are shown in figure 12.35.

Figure 12.35 Specialised mental health services that routinely collect consumer outcomes measures, June[a]



---

[a] Data are based on reports from jurisdictions. Jurisdictions report at varying levels, reflecting differences in service structure — for example, data can be reported at area health service level or at hospital level, with each level containing a number of specialised mental health services. Data are thus aggregated.

Source: State and Territory governments (unpublished); table 12A.49.

Quality — community follow up for people within the first 7 days of discharge from hospital

'Community follow up for people within the first 7 days of discharge from hospital' is an indicator of governments' objective to provide continuity of care in the delivery of mental health services (box 12.26).

Box 12.26 Community follow up for people within the first 7 days of discharge from hospital

'Community follow up for people within the first 7 days of discharge from hospital' is defined as the proportion of admitted patient overnight separations from State and Territory psychiatric inpatient services for which a community mental health contact was recorded in the 7 days following separation.

A high or increasing rate of community follow up within the first 7 days of discharge from hospitals is desirable.

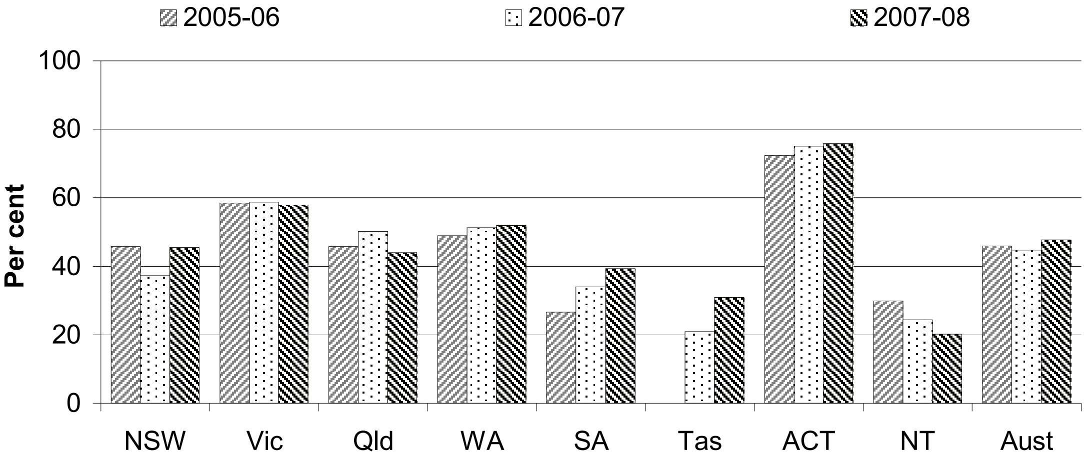
This indicator does not measure the frequency of contacts recorded in the 7 days following separation. It also does not distinguish qualitative differences between phone and face-to-face community contacts.

Data reported for this indicator are not directly comparable.

Continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital (AHMC 2008). A community support system for people who are discharged from hospital after an acute psychiatric episode is essential to maintain clinical and functional stability (NMHWG 2005). Patients leaving hospital with a discharge plan, involving linkages with community services and supports, are less likely to need early readmission.

Data on the rates of community follow up for people within the first 7 days of discharge from hospital are reported in figure 12.36.

Figure 12.36 **Community follow up for people within the first 7 days of discharge from hospital**[a, b, c, d]



[a] Data for 2005-06 and 2006-07 are for the full year, but data for 2007-08 are based on the first 9 months of the year. [b] Community mental health contacts counted for determining whether follow up occurred are restricted to those in which the consumer participated, except for the NT where the data include all contacts (the NT has advised that the impact on the indicator is marginal). Contacts made on the day of discharge are also excluded. [c] Data are not comparable across jurisdictions. SA and Tasmania are not able to accurately track post-discharge follow up between hospitals and community service organisations, due to the lack of unique patient identifiers or data matching systems. For these states, post discharge follow up is regarded to have occurred only when the community mental health contact was recorded by the discharging organisation. Results for these jurisdictions could appear 'lower' relative to jurisdictions that are able to track utilisation across services. [d] Tasmanian data for 2005-06 are not available.

Source: AHMC (2010) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2007-08*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (forthcoming); table 12A.50.

Quality — readmissions to hospital within 28 days of discharge

'Readmissions to hospital within 28 days of discharge' is an indicator of the governments' objective to provide effective care and continuity of care in the delivery of mental health services (box 12.27).

Box 12.27 **Readmissions to hospital within 28 days of discharge**

‘Readmissions to hospital within 28 days of discharge’ is defined as the proportion of admitted patient overnight separations from State and Territory psychiatric inpatient services that were followed by readmission to psychiatric inpatient services within 28 days of discharge.

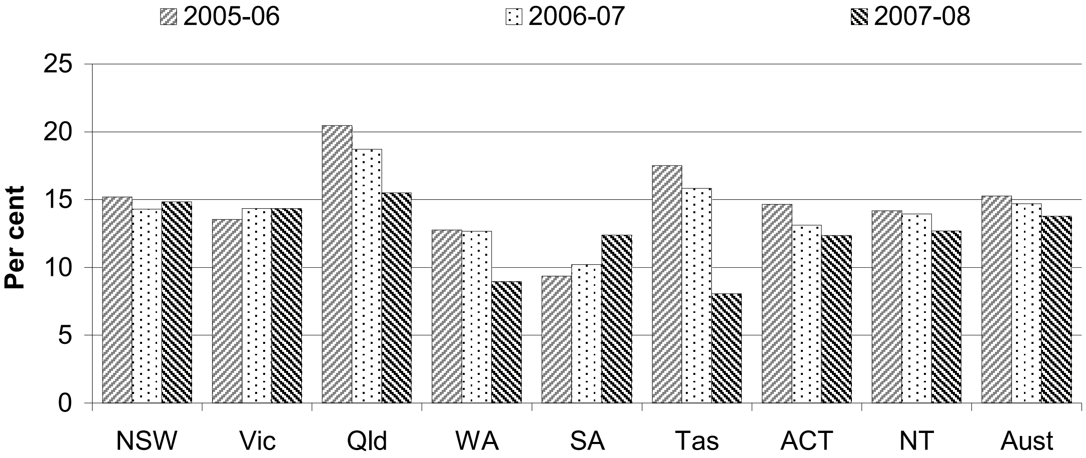
A low or decreasing rate of readmissions to hospital within 28 days of discharge from hospitals is desirable. Higher rates can indicate deficiencies in hospital treatment or community follow up, or a combination of the two (NMHWG 2005).

Readmission rates are affected by factors other than deficiencies in specialised mental health services, such as the cyclic and episodic nature of some illnesses or other issues that are beyond the control of the mental health system (NMHWG 2005). While inpatient services aim to provide treatment that enables individuals to return to the community as soon as possible, readmissions following a recent discharge can indicate that inpatient treatment was either incomplete or ineffective, or that follow up care was inadequate to maintain the person out of hospital (AHMC 2008).

Data reported for this indicator are not directly comparable.

Data on the rates of readmission to hospital within 28 days of discharge are reported in figure 12.37.

Figure 12.37 **Readmissions to hospital within 28 days of discharge**[a, b, c]



---

[a] Data for 2005-06 and 2006-07 are for the full year, but data for 2007-08 are based on the first 9 months of the year. [b] No distinction is made between planned and unplanned readmissions because data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission to hospital. [c] Data are not comparable across jurisdictions. SA and Tasmania can only track readmission back to the same hospital from which the person was discharged. For these states, readmissions are regarded to have occurred only when it is recorded by the discharging organisation. Results for these states, could appear 'lower' relative to jurisdictions that are able to track utilisation across services.

Source: AHMC (2010) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2007-08*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (forthcoming); table 12A.51.

Quality — GPs with links to specialised mental health services

'GPs with links to specialised public mental health services' is an indicator of governments' objective to provide continuity of care in the delivery of mental health services. GPs can be an important first point of contact for those with a mental illness (box 12.28).

Box 12.28 **GPs with links to specialised public mental health services**

'GPs with links to specialised public mental health services' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Quality — private psychiatrists with links to public specialised mental health services

'Private psychiatrists with links to public specialised mental health services' is an indicator of governments' objective to provide continuity of care in the delivery of mental health services (box 12.29).

Box 12.29 **Private psychiatrists with links to public specialised mental health services**

'Private psychiatrists with links to public specialised mental health services' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Sustainability

The Steering Committee has identified sustainability as an area for reporting but no indicators have yet been identified.

Efficiency

Efficiency — cost per inpatient bed day

'Cost per inpatient bed day' is an indicator of governments' objective that mental health services be delivered in an efficient manner (box 12.30).

Box 12.30 **Cost per inpatient bed day**

'Cost per inpatient bed day' is defined as the cost of providing inpatient services per inpatient bed day. Reported real inpatient costs per day are disaggregated by inpatient program type (general mental health services, child and adolescent mental health services, older peoples' mental health services and forensic mental health services) and hospital type (psychiatric hospitals (acute units), psychiatric hospitals (non-acute units) and general hospitals).

A low or decreasing cost per inpatient bed day can indicate efficiency, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

(Continued next page)

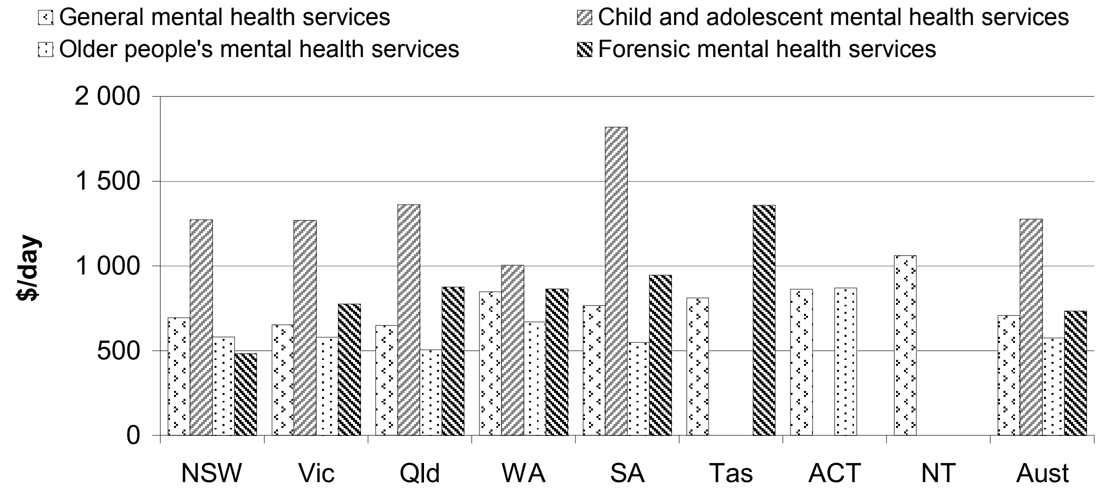
Box 12.30 (continued)

This indicator does not account for differences in the client mix and average length of stay. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. Longer lengths of stay can also be associated with lower average inpatient day costs because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care. A more suitable indicator for mental health services would be to adjust the number of separations by the type and complexity of cases, to develop a cost per casemix adjusted separation similar to that presented for public hospitals (chapter 10), but as casemix funding has not been applied to specialised mental health services data are not available.

Data reported for this indicator are comparable.

Inpatient costs per day are presented in figures 12.38 (by inpatient target population) and 12.39 (by hospital type). Changes over time partly reflect institutional change in accordance with the NMHS (for example, a shift to the delivery of services in mainstream settings).

Figure 12.38 **Average recurrent cost per inpatient bed day, public hospitals, by target population, 2007-08**[a, b, c, d, e]

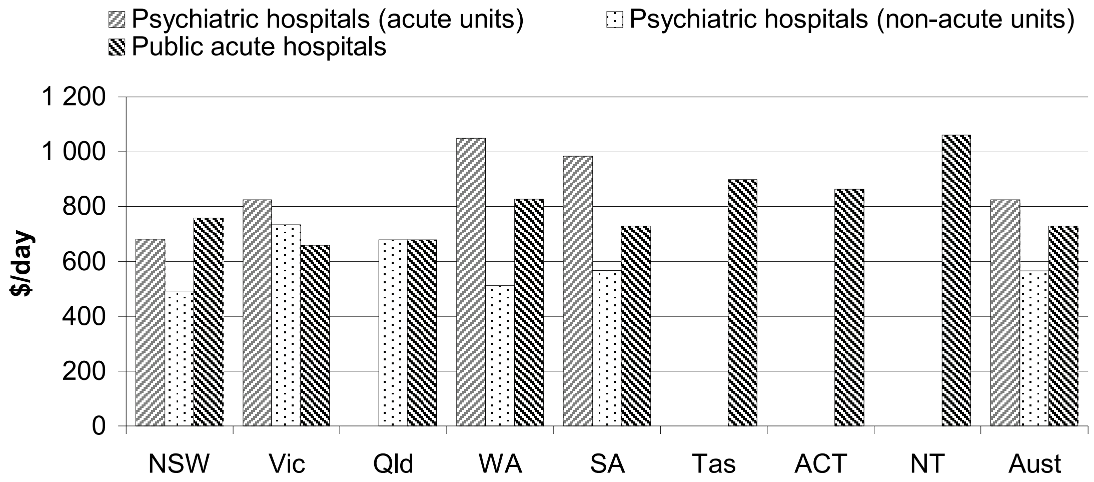


---

[a] Depreciation is excluded. [b] Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [c] Queensland provides older people's mental health services using a variety of different service models, including extended treatment services co-located with other services. These different service models are all reported as older people's mental health services, which lowers the average patient day costs, and limits comparability with the costs of jurisdictions that report these services differently. [d] Tasmania and the NT do not provide, or cannot separately identify, child and adolescent mental health services or older people's mental health services. [e] The ACT does not have separate forensic or child and adolescent mental health inpatient services.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.52.

Figure 12.39 **Average recurrent cost per inpatient bed day, public hospitals, by hospital type, 2007-08**[a, b, c, d, e]



[a] Depreciation is excluded. [b] Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [c] Mainstreaming has occurred at different rates across jurisdictions. Victorian data for psychiatric hospitals comprise mainly forensic services, because nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means the client profile and service costs are very different from those of a jurisdiction in which general psychiatric treatment still occurs mostly in psychiatric hospitals. [d] Queensland data for public acute hospitals include costs associated with extended treatment services (campus-based and non-campus-based) that report through general acute hospitals. Queensland does not provide acute services in psychiatric hospitals. [e] Tasmania, the ACT and the NT do not have psychiatric hospitals.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.53.

Efficiency — average cost for community-based residential care

‘Average cost for community-based residential care’ is an indicator of governments’ objective that mental health services be delivered in an efficient manner (box 12.31).

Box 12.31 **Average cost for community-based residential care**

‘Average cost for community-based residential care’ is defined as the cost of providing community-based residential care per inpatient day.

A low or decreasing average cost can indicate efficiency, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

The indicator does not account for differences in the client mix. The client mix in community-based residential care can differ across states and territories — for example, some jurisdictions treat a higher proportion of more complex patients in community-based residential settings.

Data reported for this indicator are not directly comparable.

These data are likely to be affected by institutional changes occurring as a result of the NMHS (for example, a shift to the delivery of services in mainstream settings). Differences across jurisdictions in the types of patient admitted to community 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 12.8. For general adult units in 2007-08, the average cost to government per patient day for 24 hour staffed community-based residential services was an estimated $362 nationally. For non-24 hour staffed community residential units, the average cost to government per patient day was $123 nationally. For State or Territory governments that had community-based older people’s care units in 2007-08, the average recurrent cost to government per patient day for 24 hour staffed community residential services was $304 nationally (table 12.8).

Table 12.8 **Average recurrent cost per inpatient day for community-based residential services, by target population and staffing provided, 2007-08**[a, b]

	NSW	*Vic*	*Qld*[c]	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
General adult units									
24 hour staffed	207	405	..	438	357	332	529	263	362
Non-24 hour staffed	93	130	..	123	438	..	98	..	123
Older people's care units									
24 hour staffed	465	287	..	..	..	722	165	..	304
Non-24 hour staffed	154	284	..	..	..	..	..	..	198

[a] Depreciation is excluded. [b] Costs are not adjusted for differences in the complexity of cases across states and territories and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [c] Queensland does not fund community residential services, although it funds a number of campus-based and non-campus-based extended treatment services. .. Not applicable.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.54.

Efficiency — average cost for ambulatory care

'Average cost for ambulatory care' is an indicator of governments' objective that mental health services be delivered in an efficient manner (box 12.32).

Box 12.32 **Average cost for ambulatory care**

'Average cost for ambulatory care' indicator is defined by two measures:

- Average cost per episode of ambulatory care provided by community mental health services.
- Average number of community treatment days per episode of ambulatory care provided by community mental health services. This measure is provided along with average costs as frequency of servicing is the main driver of variation in community care costs. It is equivalent to the 'length of stay' efficiency measure for public hospitals.

An episode of ambulatory care is a three month period of ambulatory care for an individual registered patient where the patient was under 'active care' (one or more *treatment* days in the period). Community care periods relate to the following four fixed three monthly periods: January to March, April to June, July to September, and October to December. Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode.

(Continued next page)

Box 12.32 **(continued)**

A low or decreasing average cost or fewer community treatment days can indicate greater efficiency. However, efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

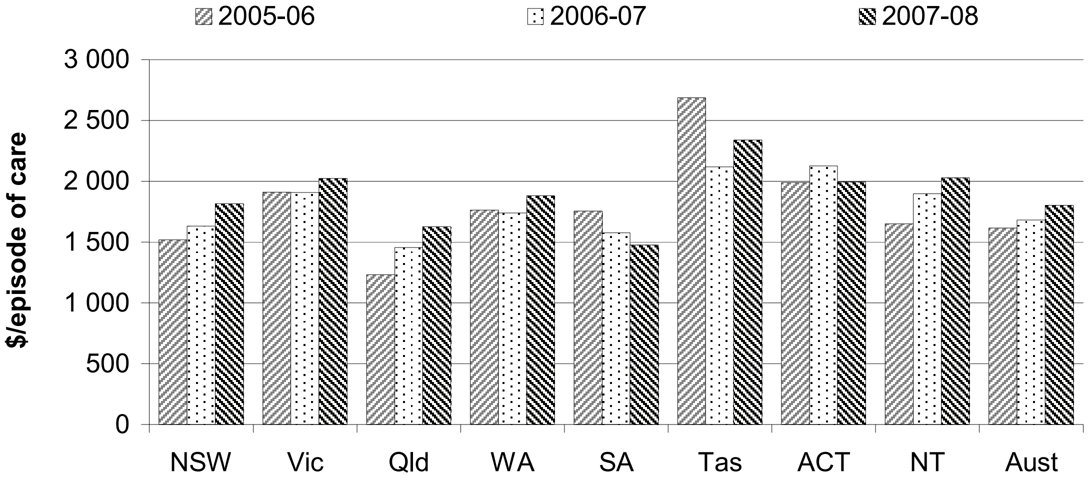
The measures do not account for differences in the client mix. The client mix in community care can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of more complex patients in community settings.

Data reported for this indicator are not directly comparable.

For this year's Report, two measures from the set of *National Mental Health Key Performance Indicators* replace the measure reported in previous reports. This is the first time these new measures have been reported and work on them is ongoing. The Steering Committee will continue to seek advice on possible modifications and improvements to their formulation for future reports.

Average recurrent cost per episode of ambulatory care data are shown in figure 12.40 and average treatment days per episode of ambulatory care are shown in figure 12.41.

Figure 12.40 **Average recurrent cost per episode of ambulatory care (2007-08 dollars)**[a, b]

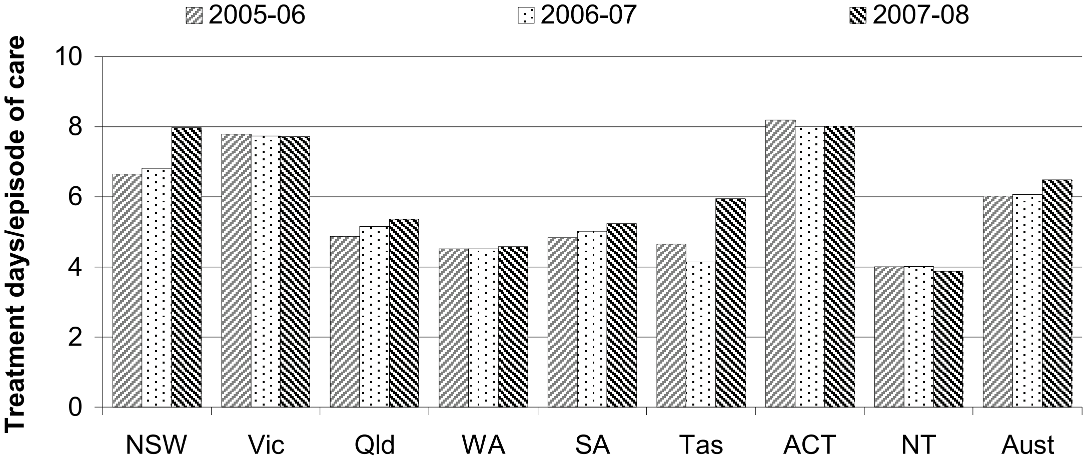


---

[a] Recurrent expenditure data used to derive this measure have been adjusted (that is, reduced) to account for the proportion of clients in the *CMHC NMDS* that were defined as 'unregistered (or insufficiently identified)'. Therefore, it does not match recurrent expenditure on ambulatory care reported elsewhere. [b] Unregistered (or insufficiently identified) patients have been excluded from the episodes of ambulatory care.

Source: AIHW (unpublished) *CMHC NMDS*; AIHW (unpublished) *MHE NMDS*; table 12A.55.

Figure 12.41 **Average treatment days per episode of ambulatory care**[a]



[a] Unregistered (or insufficiently identified) patients have been excluded from the episodes of ambulatory care and treatment days data.

Source: AIHW (unpublished) *CMHC NMDS*; AIHW (unpublished) *MHE NMDS*; table 12A.55.

Outcomes

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

The output indicators reported above focus on specialised mental health services funded by State and Territory governments. The outcome indicators identified and/or reported here are not direct measures of the outcomes for people who access these services. The outcomes identified and/or reported here tend to reflect the performance of governments (including the mental health sector) against the broad objectives of the NMHS.

The whole-of-government approach within the *Fourth National Mental Health Plan 2009–2014* acknowledges that many of the determinants of good mental health, and of mental illness, are influenced by factors beyond the health system. The fourth plan identifies that the mental health sector must form partnerships with other sectors in order to develop successful interventions (AHMC 2009).

Prevalence of mental illness

'Prevalence of mental illnesses' is an indicator of governments' objective under the NMHS to prevent the development of mental health problems and mental illness where possible (box 12.33).

Box 12.33 **Prevalence of mental illness**

‘Prevalence of mental illness’ is defined as the proportion of the total population who have a mental illness. Proportions are reported for all people, for males and females and for people of different ages, by disorder type.

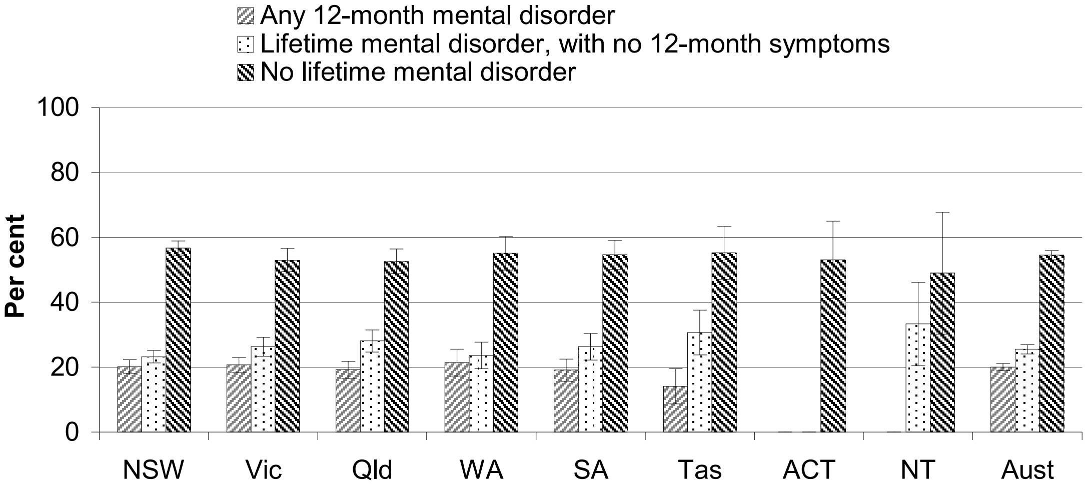
A low or decreasing prevalence of mental illness can indicate that measures to prevent mental illness have been effective.

Reduction in prevalence can be brought about by preventative efforts to stop an illness occurring, or by increasing access to effective treatments for those in whom the illness has begun (AHMC 2008). Many of the risk and protective factors that impact on the development of mental health problems and mental illness lie outside the ambit of the mental health system, in sectors that impact on the daily lives of individuals and communities. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of mental illness, whereas employment is recognised as important in supporting good mental health. A reduction in the prevalence of mental illness, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services. Not all mental illnesses are preventable and a reduction of the impact of symptoms and an improved quality of life will be a positive outcome for many people with a mental illness.

Data reported for this indicator are comparable.

Data on the prevalence of mental illness are available from the ABS 2007 SMHWB. The 2007 SMHWB was designed to provide reliable estimates at the national level, not at State and Territory level, however, some jurisdictional data are available and are reported in figure 12.42. The Survey was designed to provide prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders (such as social phobia), affective disorders (such as depression) and substance use disorders (such as harmful alcohol use). The Survey does not measure the prevalence of some severe mental disorders, such as schizophrenia and bipolar disorder.

Figure 12.42 **Prevalence of mental disorders, 2007**[a, b]



---

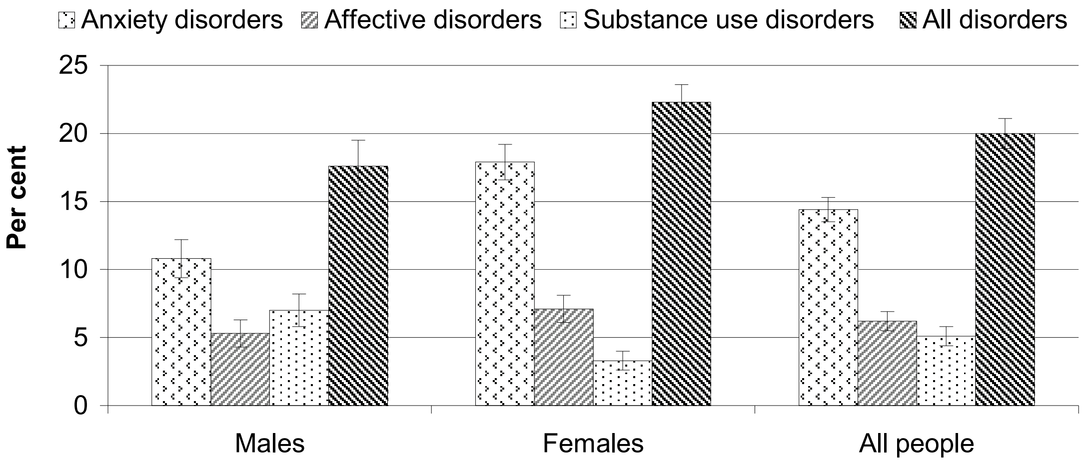
[a] Error bars represent the 95 per cent confidence interval associated with each point estimate. [b] Estimates with RSEs greater than 25 per cent are not published.

Source: ABS (unpublished) *2007 SMHWB,* Cat. no. 4326.0; table 12A.56.

There were differences in the prevalence of 12-month mental disorders between males and females (figure 12.43). Females most commonly experienced anxiety disorders (17.9 ± 1.3 per cent), followed by affective disorders (7.1 ± 1.0 per cent) and substance abuse (3.3 ± 0.7 per cent). Males most commonly suffered anxiety disorders (10.8 ± 1.4 per cent), followed by substance use disorders (7.0 ± 1.2 per cent) and affective disorders (5.3 ± 1.0 per cent).

The prevalence of mental illness was higher among younger people than older people (figure 12.44). Of adults aged 16–24 years, 26.4 ± 2.7 per cent experienced a 12-month mental disorder compared with 8.6 ± 1.6 per cent of people aged 65–74 years and 5.9 ± 2.1 per cent of people aged 75–85 years.

Figure 12.43 **Prevalence of 12-month mental disorders, by sex, 2007[a, b, c]**

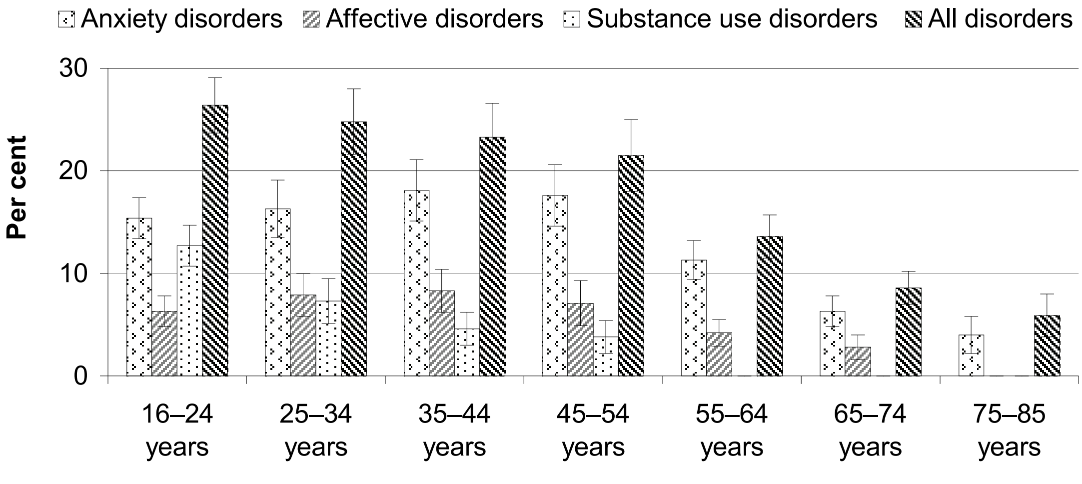


---

[a] Error bars represent the 95 per cent confidence interval associated with each point estimate. [b] A person can have more than one mental disorder. Therefore, the components might not add to the total of all disorders. [c] People who had a mental disorder with symptoms in the 12 months prior to the survey.

Source: ABS (unpublished) *2007 SMHWB,* Cat. no. 4326.0; table 12A.57.

Figure 12.44 **Prevalence of 12-month mental disorders, by age, 2007[a, b, c, d]**



---

[a] Error bars represent the 95 per cent confidence interval associated with each point estimate. [b] A person can have more than one mental disorder. Therefore, the components may not add to the total of all disorders. [c] People who had a mental disorder with symptoms in the 12 months prior to the survey. [d] Estimates with RSEs over 25 per cent are not published.

Source: ABS (unpublished) *2007 SMHWB,* Cat. no. 4326.0; table 12A.58.

Mortality due to suicide

'Mortality due to suicide' is an indicator of governments' objective under the NMHS to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk (box 12.34).

Box 12.34 **Mortality due to suicide**

'Mortality due to suicide' is defined as the suicide rate per 100 000 people. The suicide rate is reported for all people, for males and females, for people of different ages (including those aged 15–24 years), people living in capital cities, people living in other urban areas, people living in rural areas, Indigenous and non-Indigenous people.

A low or decreasing suicide rate per 100 000 people is desirable.

While mental health services contribute to reducing suicides, other government services also have a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by severe mental illness, some of whom have either attempted, or indicated 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 education, housing, justice and community services agencies.

Many factors outside the control of mental health services can influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often a combination of these factors can increase the risk of suicidal behaviour.

Data reported for this indicator are comparable.

People with a mental illness are at a higher risk of suicide than are the general population. They are also at a higher risk of death from other causes, such as cardiovascular disease (Coghlan *et al.* 2001; Joukamaa *et al.* 2001; Sartorius 2007).

Australian Bureau of Statistics mortality data are the source of suicide statistics in this chapter (ABS 2009). Care needs to be taken in interpreting these suicide statistics as there are indications that suicide deaths in recent years could be underestimated by between 3–16 per cent (Harrison *et al.* 2009). The ABS is one of three main agencies involved in the complex process that generates these statistics. The two other main agencies involved are coroner's offices and the *National*

Coroners Information System. The processes and practices of these agencies have the potential to influence the ways a death is recorded in national mortality data, and consequently whether an 'actual' suicide is reported as a suicide in national statistics. It is also possible that some suicides are not referred to a coroner as they appear similar to death due to natural causes. Harrison J.E. *et al.* (2009) contains a comprehensive discussion of the potential sources of errors that can impact on the quality of suicide statistics.

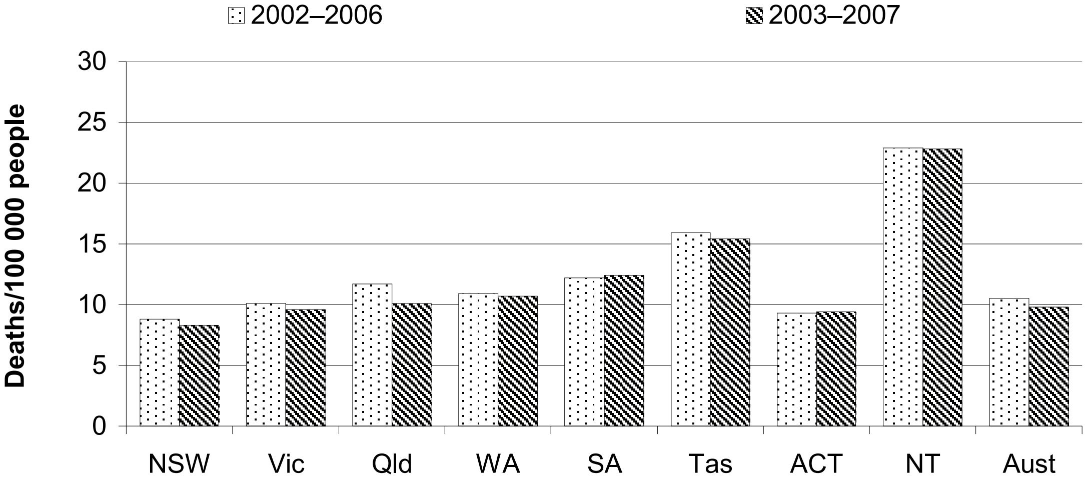
As a response to concerns regarding data quality, the ABS has undertaken a number of investigations (ABS 2007, 2008) and made the changes listed below:

- All coroner certified deaths registered after 1 January 2007 will be subject to a revision process. Previously all ABS processing of causes of death data for a particular reference period was finalised approximately 13 months after the end of the reference period. Where insufficient information was available to code a cause of death (for example, a coroner certified death was yet to be finalised by the Coroner) less specific International Classification of Diseases (ICD) codes were assigned as required by the ICD coding rules. The revision process will enable the use of additional information relating to coroner certified deaths as it becomes available over time resulting in increased specificity of the assigned ICD-10 codes.
- Improved quality assurance processes particularly aimed at assessing and improving the quality of suicide coding have been implemented.
- ABS suicide coding instructions have been revised to ensure greater consistency in coding outcomes.

In the period 2003–2007, 10 094 deaths by suicide were recorded in Australia (table 12A.61) — equivalent to 9.8 deaths per 100 000 people (figure 12.45). The rate for males (15.6 per 100 000 males) was almost four times that for females (4.3 per 100 000 females) in that period — a ratio that was relatively constant over all age groups, except for those aged over 85 years where the male suicide rate was over 9 times the female rate (figure 12.46). Table 12A.62 shows suicide death rates per 100 000 people aged 15–24 years for all jurisdictions.

Nationally the suicide rate in the period 2003–2007 was higher in rural areas. There were 9.1 suicides per 100 000 people in capital cities and 9.9 suicides per 100 000 people in other urban areas, compared with 12.7 suicides per 100 000 people in rural areas in Australia (figure 12.47).

Figure 12.45 **Suicide rates, 5 year average**[a, b]

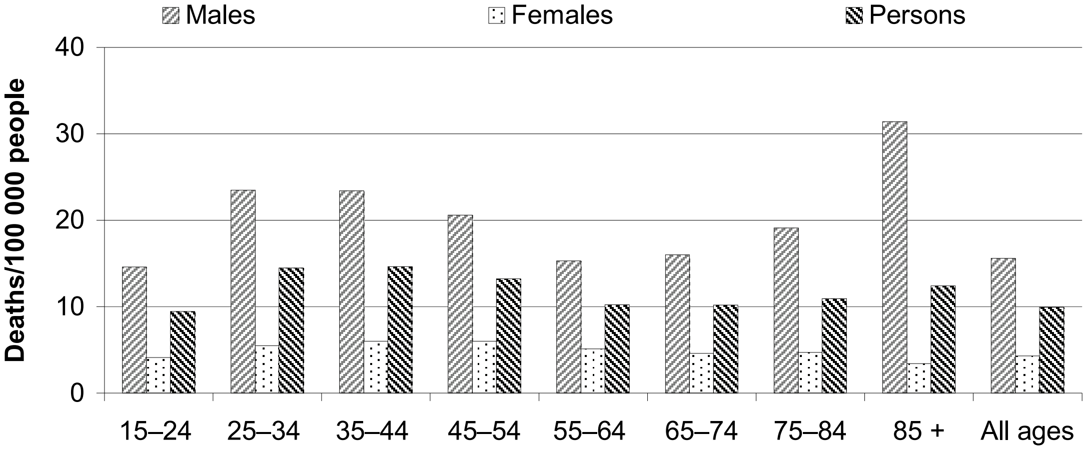


---

[a] By year of registration of death. Year-to-year variation can be influenced by coronial workloads. [b] The death rate is age standardised to the mid-year 2001 population.

Source: ABS (unpublished) *Causes of Deaths, Australia;* Cat. no. 3303.0; table 12A.61.

Figure 12.46 **Suicide rates, by age and sex, 2003–2007**[a, b, c]

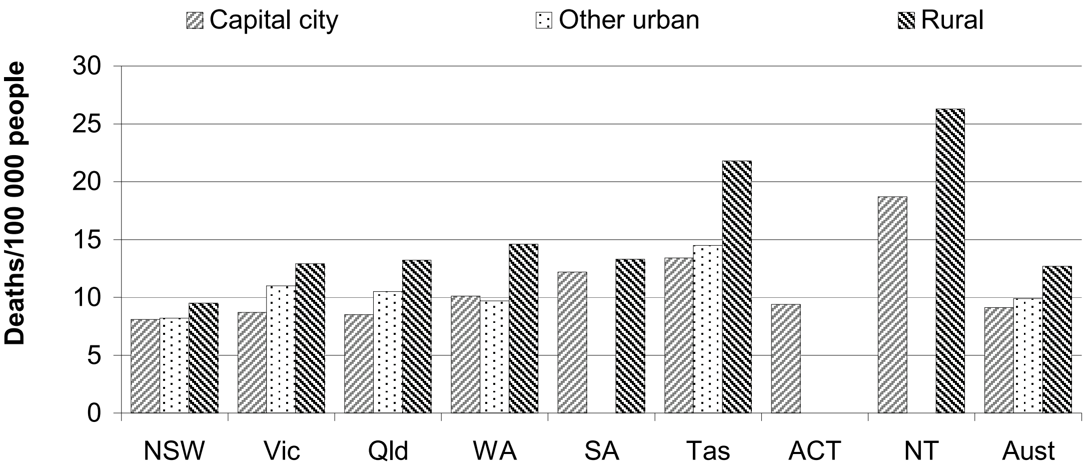


---

[a] By year of registration of death. Year-to-year variation can be influenced by coronial workloads. [b] The death rate is age standardised to the mid-year 2001 population. [c] Age specific death rates are calculated as the number of suicides for an age group per 100 000 population in the same age group, for the period 2003–2007.

Source: ABS (unpublished) *Causes of Deaths, Australia;* Cat. no. 3303.0; table 12A.60.

Figure 12.47 **Suicide rates, by area, 2003–2007**[a, b, c, d]



---

[a] Area categories are defined as follows: ‘capital cities’ — comprising capital city statistical divisions; ‘urban centres’ — based on ‘statistical districts’ that are urban centres with population >25 000 people, excluding capital city statistical divisions, (three statistical districts cross state boundaries and have to be split across the relevant states/territories — Albury–Wodonga, Canberra–Queanbeyan and Gold Coast–Tweed); ‘rural’ — balance of State, that is all areas other than capital cities and urban centres. [b] The suicide rate is age standardised to the mid-year 2001 population. [c] Suicides are reported by year of registration of death. [d] SA, the ACT and the NT do not have any ‘other urban’ areas. The ACT did not have any recorded suicide deaths in ‘rural’ areas.

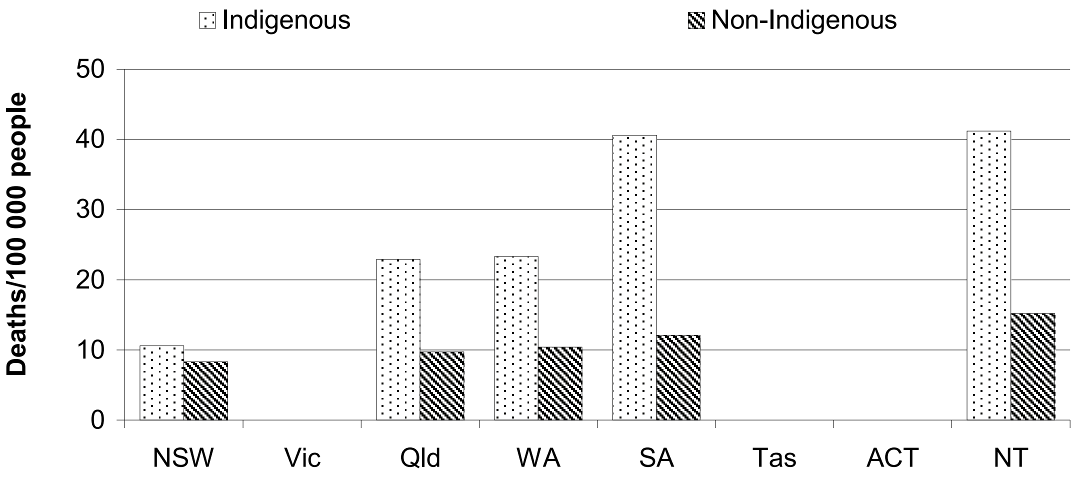
Source: ABS (unpublished) *Causes of Deaths, Australia;* Cat. no. 3303.0; table 12A.63.

Tables 12A.59–63 contain single year time series suicide data.

Indigenous suicide rates are presented for NSW, Queensland, WA, SA and the NT (figure 12.48). After adjusting for differences in the age structure of the two populations, the suicide rates for Indigenous people for the period 2003–2007 were higher than the corresponding rates for non-Indigenous people.

Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some jurisdictions are not published. Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions. The Health preface discusses the quality of Indigenous mortality and other data.

Figure 12.48 **Suicide rates, by Indigenous status, 2003–2007**[a, b]



---

[a] Indigenous population figures are based on ABS's *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians* (series B, 2006 base). There are no comparable population data for the non-Indigenous population. The non-Indigenous population figures are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care. Rates are calculated on an age standardised basis. [b] Data for Victoria, Tasmania and the ACT are not reported due to varying coverage in the identification of Indigenous deaths in death registrations.

Source: ABS (unpublished) *Causes of Deaths, Australia;* Cat. no. 3303.0; table 12A.64.

Quality of life

'Quality of life' is an indicator of governments' objective to prevent and reduce mental health problems so as to improve the quality of life for people with a mental illness (box 12.35).

Box 12.35 **Quality of life**

'Quality of life' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

12.5 Future directions in performance reporting

Breast cancer

Key challenges for improving reporting of breast cancer include:

- improving the measurement and comparability of existing indicators
- expanding reporting on intervention and treatment and overall performance
- further developing indicators of outcomes.

Existing performance data for breast cancer management place more emphasis on the performance of the BreastScreen Australia Program than on the treatment and ongoing management of breast cancer. This emphasis is largely due to the relative availability of breast cancer screening data across jurisdictions. The Steering Committee aims to expand reporting to incorporate treatment and clinical outcomes data.

Mental health

Key challenges for improving the reporting of mental health management are similar to those of previous years:

- improving the reporting of effectiveness and efficiency indicators for Indigenous, rural/remote and other special needs groups
- improving the reporting of effectiveness/efficiency indicators for community-based mental health care
- revising the performance indicator framework to ensure reporting remains consistent with government policy objectives for mental health.

A set of key performance indicators for use in Australia's public sector mental health services has been developed, based on the *National Health Performance Framework* and linked to the strategic directions of the *National Mental Health Plan 2009–2014*. Further work is required to develop indicators and data collections in the areas of safety and responsiveness of services. This will then provide data covering all the domains of the *National Health Performance Framework*. Further information can be found in National Mental Health Working Group Information Strategy Committee Performance Indicator Drafting Group (2005).

COAG developments

Report on Government Services (ROGS) alignment with National Agreement reporting

It is anticipated that future editions of health chapters will align with applicable National Agreement (NA) indicators, including the *National Indigenous Reform Agreement*. Further alignment between the ROGS and NA indicators, and other reporting changes, might result from future developments in NA and National Partnership reporting.

Outcomes from review of ROGS

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the Intergovernmental Agreement on Federal Financial Relations.

No significant changes from this review are reflected in the 2010 Report. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 Report.

12.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this section of the Report.

Australian Government comments

Through the Council of Australian Governments (COAG), the Australian, State and Territory governments are continuing to work together on the development of initiatives in priority health and aged care reform areas. These include driving improvements in hospitals, health workforce and infrastructure, maternity services, mental health and health services provided in rural areas.

Major reform will continue through the new *National Healthcare Agreement*. This new agreement goes beyond the scope of previous agreements, setting objectives for prevention, primary and community health, hospital and related care, and aged care. The new Agreement has a stronger focus on achieving and monitoring outcomes and provides more funding for public hospitals and the training of doctors and nurses. As part of COAG's $64 billion boost to health and hospital funding, the Agreement offers $60 billion over five years, an increase of $22 billion over previous agreements.

A Healthier Future for all Australians, the final report by the National Health and Hospitals Reform Commission tasked to provide long term, comprehensive options for health care reform, was released in July 2009. Recommendations from this report, together with the draft *National Primary Health Care Strategy* and the *National Preventative Health Strategy* are being used as the basis for direct consultation with the health sector and the Australian public. These consultations will inform a reform plan to be put to the states and territories in 2010. A public communication website, www.yourhealth.gov.au, has been launched to enable members of the public and organisations in the health sector to provide their views about options for health reform.

Australian Government funding commitments in the 2009-10 budget will contribute to further health reform with delivery of:

- $3.2 billion Health and Hospitals Fund which includes $1.3 billion investment in cancer infrastructure, $1.5 billion to upgrade hospitals and clinical training infrastructure, and $430.3 million in translational research and clinical training facilities
- $120.5 million package to improve maternity services
- $134.4 million package to further support rural and remote based doctors
- 35 per cent increase in GP training places and growing the nursing workforce.

The Government continues to work through COAG's *Indigenous Health National Partnership* to improve access to primary health care and follow-up services, providing targeted prevention activities to reduce the burden of chronic disease on Indigenous Australia.

New South Wales Government comments

The continued growth in demand for health services from an ageing population, the need for care of the chronically ill and the increased use of emergency department services are constant pressures on the NSW health system. The NSW Government is striving to provide the best possible care for the people of NSW and, to assist in meeting these demands and expectations, is implementing new models of care to provide greater flexibility and efficiency in the treatment of patients.

The results of these initiatives has seen a marked increase in the number of patients seen within clinical benchmark times in our emergency departments, to be one of the best performing jurisdictions, with 76 per cent of NSW emergency department patients seen within triage category timeframes compared with 69 per cent of patients seen within triage category timeframes across Australia. This high level performance has also been achieved in the reduction of patients waiting more than 365 days for elective surgery, through the strategies of the Predictable Surgery Program.

The NSW Government has been active across a number of cross-jurisdictional and interagency forums, including the Council of Australian Governments (COAG) and the Australian Health Ministers' Conference, and will continue to work with the Commonwealth through COAG to ensure the interests of the people of NSW are represented in the delivery of the reform agenda.

During 2008, a Commission of Inquiry was undertaken into the delivery of acute care services within the NSW public health system, with the development of *Caring Together: The Health Action Plan for NSW*, which includes measures that will be put in place to help improve not just clinical care, but the environment in which that care is delivered, and the compassion and sensitivity with which it is delivered. The plan also includes further work to be undertaken in partnership with the community, doctors, nurses, midwives, allied health and other health workers to develop initiatives aimed at delivering greater sustainability for the public health system. Following on from this, an intergenerational plan will be developed to build on these improvements and deliver a system better able to respond to increases in demand and one that can be passed on with pride to future generations.

The NSW Government is also working to create better experiences for those using public health services by ensuring services are of high quality, appropriate, safe, available when and where needed, and coordinated to meet individual needs. The health system will aim to provide ready access to health services while keeping patients and their carers informed and involved in decisions.

Victorian Government comments

Victorian Government health priorities are in the areas of cancer, infrastructure, providing more services for elective surgery patients and improving access to services for all Victorians. A growing population together with its relative ageing, increasing patient complexity and continued growth in emergency and inpatient activity combine to drive significant increases in demand for health services.

More Victorians are receiving elective surgery as the Victorian Government continues to focus on elective surgery activity and reducing waiting times for patients. In 2008-09, the State and Australian governments provided a combined total of $60 million one-off funding to treat additional elective surgery patients as part of the Elective Surgery Waiting List Reduction Plan.

The *Sustaining Health Service Capacity* initiative ($780.9 million over five years from 2008-09) will significantly boost the capacity for hospitals to provide treatment in the key areas of cancer treatment, acute care and sub-acute services.

In March 2009 the Victorian Government released *Because mental health matters — Victorian mental health reform strategy 2009–19*. Developed through extensive consultation with those who live with mental illness, their families, friends, carers and those who work to support them, the reform strategy represents a commitment by the Government to ensure all Victorians have the opportunities they need to maintain good mental health while also supporting those with a mental illness to access high quality, timely care and live successfully in the community. Implementation of this agenda has already begun, with initiatives announced in the 2009-10 State Budget totalling $182 million over four years.

Victoria has a well established primary health sector which provides significant access to services for the most vulnerable groups in the community, promotes good health, and seeks to intervene early to maximise health outcomes and to prevent or slow progression of ill health. Primary Care Partnerships are a core component of the primary health care sector.

There is a continued focus on working with organisations to:

- close the gap in Indigenous health outcomes by improving access to primary health care
- continue to improve primary health care in Victoria, strengthening agencies' engagement with general practice to support client care, developing and reviewing specific program guidelines to support best practice, and strengthening workforce capacity though a range of development initiatives.

With the continued hard work and dedication of Victoria's health professionals, delivering world class public hospitals and innovation in service delivery the Government is committed to invest and respond to the challenges and increasing demand for hospital services.

Queensland Government comments

Queensland's hospitals and health system have undergone significant reform since the release of the Queensland Government's five-year *Action Plan — Building a better health service for Queensland* in October 2005. The Queensland Government's *Toward Q2: Tomorrow's Queensland and Advancing Health Action* sets ambitious health targets including that Queensland will have the shortest public hospital waiting times in Australia and will cut by one-third obesity, smoking, heavy drinking and unsafe sun exposure.

Queensland Health has implemented a range of initiatives to reduce the number of patients waiting too long for surgery, including using private sector capacity through the Surgery Connect program, as well as increasing internal public hospital capacity through the provision of additional operating theatres. Funding was committed this year to meet increasing demand and provide extra services including $80 million for extra elective surgery procedures and emergency department services.

A total of $122.5 million was invested in 2008-09 to develop clinical solutions to support direct patient care, upgrade supporting infrastructure including telecommunications and develop Queensland Health's e-Health strategy.

These initiatives contributed to the treatment of 125 412 elective surgery patients in 2008-09, a 10 per cent increase on the 114 015 patients who received elective surgery in the previous year. Additionally, the number of 'long-wait' patients on elective surgery waiting lists has fallen by 19.1 per cent from 7510 at 1 July 2008 to 6079 at 1 July 2009.

Queensland Health is committed to faster emergency care in its hospitals with funding allocated for expanded emergency departments ($125.7 million capital and $19.5 million operational over three years), expanded rehabilitation and step down facilities ($69.9 million operational and $14.7 million capital funding over four years) and more nurse practitioners ($7.9 million total operational funding over three years).

In 2008-09, Queensland public hospitals provided 547 929 new case specialist outpatient occasions of service — an increase of 1.8 per cent on the 538 438 occasions of service provided in 2007-08.

Funding of $20 million in 2008-09 has enabled the implementation of strategies to improve outpatient services, including strategies to reduce waiting times for specialist outpatient services in Queensland public hospitals and the development of innovative and complementary models of care.

Our focus on closing the gap on Indigenous health outcomes saw the development and rollout of innovative, award-winning programs such as *Deadly Ears, Deadly Kids, Deadly Communities: 2009–2013*, a commitment to better manage ear health conditions affecting Aboriginal and Torres Strait Islander children across Queensland.

In 2009-10, the Queensland Health budget will grow to $9.04 billion, an increase of 8.2 per cent on the 2008-09 budget.

Western Australian Government comments

“ WA Health — the Western Australian public health system — works to ensure healthier and better lives for all Western Australians and to protect the health of the WA community by providing a safe, high quality, accountable and sustainable health care system. WA Health has been implementing innovative solutions to improve access to appropriate health care within constraints resulting from global and local economic conditions, growing demand for healthcare services, a worldwide shortage of healthcare personnel, burgeoning technology costs and growth of lifestyle diseases.

Managing unplanned care — To counter the increasing number of attendances, innovative reforms are being implemented to improve emergency care and manage the demand on the emergency departments. The *Four-hour Rule* program will ensure that the majority of patients arriving at emergency departments are admitted, discharged or transferred within a four-hour timeframe, unless the patient needs to remain in the emergency department for clinical reasons. Additionally, the FINE (*Friend in Need – Emergency*) program is another innovation to aid the reduction of emergency departments’ traffic by providing alternative care arrangements to hospitalisation for older and chronically ill patients. Under this program, service liaison staff in emergency departments ensure timely arrangement of service delivery in community settings.

Elective surgery — Population growth and improvements in outpatient processes have seen the demand on surgical waitlists increased. Reform over the past year has seen WA Health performing more elective surgery procedures.

Health Workforce — In addressing changing population demographics, accelerating retirement rates and workforce sustainability, WA Health has increased the number of medical interns employed and introduced initiatives to expand nurse numbers and support professional development.

Aboriginal health — WA Health has continued to work towards the improvement of Aboriginal health by developing and implementing appropriate strategies to progress initiatives under the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*. WA Health is committed to ensuring Aboriginal community involvement which is central to achieving improved health outcomes for Aboriginal individuals, families and communities.

Health Promotion, Protection and Prevention — WA Health has continued to work towards improving lifestyles, preventing ill-health and implementing long term, integrated health promotion campaigns to combat childhood obesity and prevent chronic disease. Initiatives that have been implemented to combat childhood obesity include *Unplug and Play*, the *School Breakfast Program* and *Make Tracks2 School*.

Primary Care and chronic disease management — Substantial progress has been made in primary health, care and management of long-term conditions, and the application and implementation of health and medical research. ”

South Australian Government comments

Following *South Australia's Health Care Plan 2007–2016*, several new action plans to enhance the health of South Australians were released including the *Chronic Disease Action Plan*, the *HIV Action Plan* and the *Hepatitis C Action Plan*. The action plans make practical recommendations to address the continued and emerging challenges of chronic disease, HIV and Hepatitis C, and ultimately decrease the burden on our health system. These plans include priorities and actions that complement existing initiatives by the South Australian and Australian governments in a partnership approach with non-government organisations, health professionals, research organisations and the community.

SA Health undertook initiatives during 2009 to make preventative health a focus and priority. A multitude of projects concentrated on achieving healthy weight for South Australians of all ages, reducing cigarette smoking and providing support for new parents and their newborn babies. The *Obesity Prevention and Lifestyle* initiative was commenced, a three way partnership between Australian, State and local governments to promote healthy eating and physical activity.

On 17 May 2009 the Australian Government announced, in response to a proposal by the South Australian Government, that a $200 million state of the art Health and Medical Research Institute would be built close to the new Royal Adelaide Hospital on North Terrace. This is an exciting development bringing significant benefits to South Australia's economy and ensuring South Australia has a leading role on the global health and medical research stage.

Planning for the most advanced hospital in Australia, the $1.7 billion new Royal Adelaide Hospital continues with the development of a *Model of Care* and the release of an Expression of Interest for services in design, construction, commissioning, finance and facilities management. The *Model of Care* strives for clinical excellence and quality of care through a patient centred approach. The site remediation plan being developed will contribute to rehabilitation of the environment, improved access to the River Torrens, and new cultural and open spaces.

During 2008-09 $78 million was invested in capital projects to redevelop metropolitan hospitals and health service infrastructure. The investment includes: continued refurbishment of the Flinders Medical Centre Coronary Care Unit and construction of a new south wing extension, completion of the research facilities and infrastructure upgrades as part of the stage 2B redevelopment of The Queen Elizabeth Hospital and continued redevelopment of the Lyell McEwen Hospital including a 30 bed adult acute mental health unit, a 20 bed aged acute mental health unit and the completion of a SA Pathology facility. An additional $17 million was invested in the purchase of major medical equipment.

The *Mental Health Act 2009* (SA) was passed by Parliament in June 2009. The new Act expands and protects the rights of people with mental illness. It recognises the needs of people from culturally and linguistically diverse backgrounds, the role of carers and the circumstances of children who are experiencing or who are affected by people with a serious mental illness.

Tasmanian Government comments

“ The Tasmanian Government is focused on putting its patients and clients at the centre of all it does.

In May 2007, the Tasmanian Government released *Tasmania’s Health Plan* — the most significant health reform the State has ever undertaken. *Tasmania’s Health Plan* is based on providing services as close as possible to where people live, as long as sustainability, quality and safety standards are met in all cases.

The principles of *Tasmania’s Health Plan* have now been built into the ongoing work of the Department of Health and Human Services and are reflected in the reform agenda in *09–12 Strategic Directions*. *Tasmania’s Health Plan* is one of six key *Future Health* strategic reforms to be implemented over the next three years.

The others include: the reform of mental health services (*Bridging The Gap*); safety and quality reforms (*Keeping Our Services Safe*); Tasmania’s elective surgery improvement plan (*Improving Time to Treatment*); a strategic approach to health promotion (*Working in Health Promoting Ways*); and strategies for an adaptive health professional workforce (*Leading the Way*).

For the period 2009–12, the Agency has set the following five key strategic objectives:

- Supporting individuals, families and communities to have more control over what matters to them.
- Promoting health and wellbeing and intervening early when needed.
- Developing responsive, accessible and sustainable services.
- Creating collaborative partnerships to support the development of healthier communities.
- Shaping our workforce to be capable of meeting changing needs and future requirements.

Practically, this approach is reflected in the recent establishment of the three Area Health Services, providing local management and accountability. Health Department central administration has been reduced in size and accounts for less than 3 per cent of the health budget.

Significant funding has been provided in 2009-10 for major initiatives including: upgrades at the Royal Hobart Hospital, Launceston General Hospital, North West Regional Hospital and several Community Health Centres; developments of the Clarence GP Super Clinic and Integrated Care Centre (ICC) and the Launceston ICC (in partnership with the Australian Government); improvements in health information technology; improving the alcohol and drug sector and continuing the implementation of the Better Dental Care package. ”

Australian Capital Territory Government comments

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

In 2007, the ACT Government published *access health*, a key health document which sets the future direction for ACT public health services until 2010. *access health* is about ensuring that people have access to the right type of health care with better collaboration with the primary health care sector to ensure the provision of health services that meet people's needs.

The year 2007-08 demonstrated a more efficient public hospital system in the ACT with the public hospitals exceeding the Government's objective of reducing the ACT's average cost of hospital services to within 10 per cent of the national average ahead of the deadline of 2011-12. The ACT's 2007-08 average cost per casemix-adjusted separation is now about 6.6 per cent above the national average. This demonstrates a major improvement from the 2002-03 figure of 30 per cent above the national average cost.

In the year 2007-08, the ACT's bed capacity also increased by 8 per cent from 785 beds in 2006-07 to 851 beds in 2007-08.

The most exciting development for the ACT's public health care system was the completion of the Capital and Asset Development Plan (CADP). The CADP was requested by the ACT Minister for Health as an assessment of the projected health system demands up to 2021-22. The CADP was a total assessment of capital stock, workforce and infrastructure requirements across the ACT health care system.

As a result of the CADP, the ACT Government has committed to a $1 billion plus overhaul of the health system, and appropriated $300 million as the first tranche in the 2008-09 Budget. This program will take seven to 10 years to complete, and will be one of the most significant investments in public health infrastructure across Australia.

Northern Territory Government comments

- The Northern Territory is a culturally diverse and geographically dispersed jurisdiction where 30 per cent of the population are Aboriginal. Together with acknowledged health and wellbeing challenges a range of factors place a significant impost on service design, delivery and evaluation efforts. The Department of Health and Families is the major provider and funder for hospital and community services in the Territory and is responsible for the majority of primary care to Territorians. Aboriginal Territorians consume the majority of health and wellbeing services provided by the department.

- Local demographic, cultural and market circumstances demand innovative approaches to service design and delivery. Building an integrated health system inclusive of community controlled providers and which bridges the space between health centres and families and individuals has been critical. The introduction of transdisciplinary Aboriginal Community Workers, a Cultural Security framework and strengthened community engagement frameworks and functions have created further opportunities for gain.

- The department has an extensive collaborative relationship with many non-government organisations to ensure optimal service coverage for Territorians. The NT has well established partnerships with the Aboriginal community controlled health sector and the Australian Government through which significant levels of joint primary care planning, service development and performance monitoring occurs.

- With responsibility for the five public hospitals located in each of the major population centres, Darwin, Nhulunbuy, Katherine, Tennant Creek and Alice Springs, and inpatient mental health services available in Darwin and Alice Springs, the department works closely with the Darwin Private Hospital and other jurisdictions to meet acute care needs. Territorians sometimes have to travel to access medical care and this is supported by an expanding Shared Electronic Health records service and specialist health access programs for travel to hospital, between hospitals and interstate when required.

- A priority for this jurisdiction is to help and support people to better manage their health and wellbeing closer to home and where possible in a non-acute setting. The Palmerston Urgent Care After Hours Service has commenced operation to take pressure off the Emergency Department at Royal Darwin Hospital. Some remote communities now have access to relocatable self care renal dialysis facilities. Midwifery Group Practice has been developed to allow for the continuity of care through the later stage of pregnancy, labour, birth and early postnatal period for women travelling to urban centres to give birth. Substantial progress has been made on the construction of the radiation Oncology unit and accommodation. This will allow care closer to home for patients requiring this service.

12.7 Definitions of key terms and indicators

AR-DRG v5.1 (Australian refined diagnosis related group, version 5.1)	A patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG v5.1 is based on the ICD-10-AM classification.
Casemix adjustment	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted into diagnosis related groups (AR-DRGs) that represent a class of patients with similar clinical conditions requiring similar hospital services.
General practice	The organisational structure in which one or more GPs provide and supervise health care for a ‘population’ of patients. This definition includes medical practitioners who work solely with one specific population, such as women’s health or Indigenous health.
Health management	The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.
Incidence rate	Proportion of the population experiencing a disorder or illness for the first time during a given period (often expressed per 100 000 people).
Separation	An episode of care for an admitted patient, which can be a total hospital stay, or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care.

Breast cancer

Breast conserving surgery	An operation to remove the breast cancer but not the breast. Types of breast conserving surgery include lumpectomy (removal of the lump), quadrantectomy (removal of one quarter of the breast) and segmental mastectomy (removal of the cancer as well as some of the breast tissue around the tumour and the lining over the chest muscles below the tumour).
Cost per woman screened	The total cost of the provision of breast screening services, divided by the number of women screened. The total cost includes the cost of providing the BreastScreen Australia program in each jurisdiction, in addition to the cost of providing the program to women.
Detection rate for small cancers	The rate of small (less than or equal to 15 millimetres in diameter) invasive breast cancers detected per 10 000 women screened.
Ductal carcinoma in situ	A non-invasive tumour of the mammary gland (breast) arising from cells lining the ducts. Also known as intraductal carcinoma.
Invasive cancer	A tumour whose cells invade healthy or normal tissue.
Modified radical mastectomy	Surgery for breast cancer in which the breast, some of the lymph nodes under the arm, the lining over the chest muscles, and sometimes part of the chest wall muscles are removed.
Mortality rate from breast cancer	The age-specific and age standardised mortality rates of women who die as a result of breast cancer, expressed per 100 000 women in the population.
Participation	The number of women resident in the catchment area screened, divided by the number of women resident in the catchment area, expressed as a percentage. If a woman is screened more than once during the reference period, then only the first screen is counted.

	Catchment area is a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or statistical local area.
Radiation therapy	The use of high energy radiation from X-rays, gamma rays, neutrons, and other sources to kill cancer cells and shrink tumours. Radiation can come from a machine outside the body (external beam radiation therapy) or from materials called radioisotopes. Radioisotopes produce radiation and can be placed in or near the tumour or in the area near cancer cells. This type of radiation treatment is called internal radiation therapy, implant radiation, interstitial radiation or brachytherapy. Systemic radiation therapy uses a radioactive substance (such as a radiolabelled monoclonal antibody) that circulates throughout the body.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than otherwise would be the case.
Screening round (first)	A woman’s first visit to a BreastScreen Australia mammography screening service.
Screening round (subsequent)	A woman’s visit to a BreastScreen Australia mammography screening service when she has previously attended such a service.
Size of detected cancers	Invasive cancers detected, classified according to tumour size.
Total mastectomy	Removal of the breast — also known as simple mastectomy.

Mental health

Acute services	Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services can: • focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric illness for whom there has been an acute exacerbation of symptoms • target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, and forensic mental health services.
Affective disorders	A mood disturbance, including mania, hypomania, bipolar affective disorder, depression and dysthymia.
Ambulatory care services	Mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted inpatients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.
Anxiety disorders	Feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive–compulsive disorder and post-traumatic stress disorder.
Available beds	The number of immediately available beds for use by admitted

	patients if required. Beds are immediately available for use if located in a suitable place of care with nursing or other auxiliary staff available within a reasonable period. In many cases, available beds will be less than the number of approved beds, with the former controlled by utilisation factors and resourcing levels, while the latter refers to the maximum capacity allowed for the hospital, given sufficient resources and community demand.
Child and adolescent mental health services	Services principally targeted at children and young people up to the age of 18 years. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on children or adolescents. These services can include a forensic component.
Co-located services	Psychiatric inpatient services established physically and organisationally as part of a general hospital.
Community-based residential services	Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must: provide residential care to people with mental illnesses or psychiatric disability; be located in a community setting external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded.
Co-morbidity	The simultaneous occurrence of two or more illnesses such as depressive illness with anxiety disorder, or depressive disorder with anorexia.
Consumer involvement in decision making	Consumer participation arrangements in public sector mental health service organisations according to the scoring hierarchy (levels 1–4) developed for monitoring State and Territory performance under Medicare Agreements Schedule F1 indicators.
Cost per inpatient bed day	The average patient day cost according to the inpatient type.
Depression	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration can be affected.
Forensic mental health services	Services principally providing assessment, treatment and care of mentally ill individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.
General mental health services	Services that principally target the general adult population (18–65 years old) but that can provide services to children, adolescents or older people. Includes, therefore, those services that cannot be described as specialised child and adolescent, older people's or forensic services. General mental health services include hospital units whose principal function is to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, post-natal depression, anxiety disorders).
Mental illness	A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.

Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness.
Mental health promotion	Actions taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the ‘coping’ capacity of communities, families and individuals by giving power, knowledge, skills and necessary resources.
Mental illness prevention	Interventions that occur before the initial onset of a illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental illnesses.
Mortality rate from suicide	The percentage of the population who die as a result of suicide.
Non-acute services	Non-acute services are defined by two categories: • Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. • Extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which can include high levels of severe unremitting symptoms of mental illness. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.
Non-government organisations	Private not-for-profit community managed organisations that receive State and Territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the non-government organisation sector can include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.
Older people’s mental health services	Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged people. These services can include a forensic component. Excludes general mental health services that may treat older people as part of a more general service.
Outpatient services — community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They can include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals.

— hospital-based	They can include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Patient days (occupied bed days)	All days or part days for which patient was in hospital during the reporting year (1 July to 30 June), regardless of the original date of admission or discharge. Key definitional rules include the following: • For a patient admitted and discharged on different days, only the day of admission is counted as a patient day. • Admission and discharge on the same day are equal to one patient day. • Leave days are not included when they involve an overnight absence. • A patient day is recorded on the day of return from leave.
Percentage of facilities accredited	The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of illnesses.
Psychiatrist	A medical practitioner with specialist training in psychiatry.
Public health	The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional services.
Schizophrenia	A combination of signs and symptoms that can include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour.
Specialised mental health inpatient services	Services provided to admitted patients in stand-alone psychiatric hospitals or specialised psychiatric units located within general hospitals.
Specialised mental health services	Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds.
Specialised residential services	Services provided in the community that are staffed by mental health professionals on a 24 hour basis.
Staffing categories (mental health)	Medical officers: all medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee-for-service basis. Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant State or Territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health

Insurance Commission as a specialist in Psychiatry.

Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Other medical officers: medical officers employed or engaged by the organisation who are not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Nursing staff: all categories of registered nurses and enrolled nurses, employed or engaged by the organisation.

Registered nurses: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialised categories of registered nurses.

Enrolled nurses: Refers to people who are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).

Diagnostic and health professionals: qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, and other diagnostic and health professionals.

Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.

Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.

Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.

Administrative and clerical staff: staff engaged in administrative and clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories. Civil engineers and computing staff are included in this category.

Domestic and other staff: staff involved in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.

Stand-alone psychiatric hospitals

Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus can also be a stand-alone hospitals if the following criteria are not met:

- a single organisational or management structure covers the acute care hospital and the psychiatric hospital
- a single employer covers the staff of the acute care hospital and the psychiatric hospital
- the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus
- the patients of the psychiatric hospital are regarded as patients of the single integrated health service.

Substance use disorders

Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive, social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug can be psychological (as in substance misuse) or physiological (as in substance dependence).

12.8 Attachment tables

Attachment tables are identified in references throughout this chapter by a '12A' suffix (for example, table 12A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Breast cancer

Mental health

Table 12A.48	Consumer and carer participation
Table 12A.49	Specialised mental health services that have introduced routine consumer outcome measurement (per cent)
Table 12A.50	Rates of community follow up for people within the first seven days of discharge from hospital
Table 12A.51	Readmissions to hospital within 28 days of discharge
Table 12A.52	Average recurrent costs per inpatient bed day, public hospitals, by target population (2007-08 dollars)
Table 12A.53	Average recurrent cost per inpatient bed day, by public hospital type (2007-08 dollars)
Table 12A.54	Average recurrent cost to government per patient day for community residential services (2007-08 dollars)
Table 12A.55	Average cost of ambulatory care (per cent)
Table 12A.56	Prevalence of lifetime mental disorders among adults aged 16–85 years, 2007 (per cent)
Table 12A.57	Prevalence of lifetime mental disorders among adults aged 16–85 years, by sex, 2007 (per cent)
Table 12A.58	Prevalence of lifetime mental disorders among adults, by age, 2007 (per cent)
Table 12A.59	Suicides and mortality rate, by sex, Australia
Table 12A.60	Suicides and mortality rate, by sex, Australia
Table 12A.61	Suicide deaths and death rate
Table 12A.62	Suicide deaths and death rate, 15–24 year olds
Table 12A.63	Suicide deaths and suicide death rate, by area
Table 12A.64	Suicide deaths, by Indigenous status
Table 12A.65	Deflators used to calculate real state and territory mental health expenditure
Table 12A.66	Deflator used to calculate real Australian Government mental health expenditure
Table 12A.67	Estimated resident populations used in mental health per head calculations

12.9 References

ABS (Australian Bureau of Statistics) 2007, *Information Paper: External Cause of Death Data Quality,* Cat. no. 3317.0.55.001, Canberra.

—— 2008, *Information Paper: ABS Causes of Death Statistics: Concepts, Sources and Methods,* Cat. no. 3317.0.55.002, Canberra.

—— 2009, *Causes of Deaths, Australia*, Cat. no. 3303.0, Canberra.

Australian Health Ministers 1991, *Mental Health Statement of Rights and Responsibilities*, Australian Government Publishing Service, Canberra.

AHMC (Australian Health Ministers' Conference) 2008, *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-07*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council, www.coag.gov.au/reports/docs/AHMC_COAG_mental_health.doc (accessed 10 December 2008).

—— 2009, *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009–2014*, Canberra.

—— 2010, *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2007-08*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (forthcoming).

AHMAC (Australian Health Ministers' Advisory Council) 2008, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2008*, AHMAC, Canberra.

AIHW (Australian Institute of Health and Welfare) 2003, *BreastScreen Australia Monitoring Report 2000-2001*, Cancer series no. 25, Cat. no. CAN 20, Canberra.

—— 2006, *Mental health establishments NMDS 2005-2006*, Exported from METeOR (AIHW's Metadata Online Registry), Canberra.

—— 2008, *Mental health services in Australia 2005–06*, Mental health series no. 10, Cat. no. HSE 56, Canberra.

—— 2009a, *BreastScreen Australia Monitoring Report 2005-2006*, Cancer series no. 48, Cat. no. CAN 44, Canberra.

—— 2009b, *Mental health services in Australia 2006–07*, Mental health series no. 11, Cat. no. HSE 74, 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.

AIHW and AACR (Australasian Association of Cancer Registries) 2008, *Cancer in Australia: an overview, 2008*. Cancer series no. 46, Cat. no. CAN 42, AIHW, Canberra.

AIHW and NBCC (National Breast Cancer Centre) 2007, *Breast cancer survival by size and nodal status in Australia*, Cancer series no. 39, Cat. no. CAN 34, AIHW, Canberra.

AIHW and NBOCC (National Breast and Ovarian Cancer Centre, formerly the NBCC) 2009, *Breast cancer in Australia: an overview, 2009*, Cancer series no. 50, Cat. no. CAN 46, AIHW, Canberra.

Begg S., Vos T., Barker B., Stevenson C., Stanley L. and Lopez A. 2007, *The burden of disease and injury in Australia, 2003*, Cat. no. PHE 82, Canberra.

Harrison J.E., Pointer S. and Elnour A.A. 2009, *A review of suicide statistics in Australia*, Injury research and statistics series no. 49, Cat. no. INJCAT 121, AIHW, Adelaide.

BreastScreen Australia 2004, *BreastScreen Australia National Accreditation Standards*, July 2004, BreastScreen Australia.

Britt H., Miller G.C., Charles J., Henderson J., Bayram C., Harrison C., Valenti L., Fahridin S., Pan Y. and O'Halloran J. 2008, *General practice activity in Australia 2007–08*, General practice series no. 22, Cat. no. GEP 22, Canberra.

Coghlan R., Lawrence D., Holman D. and Jablensky A. 2001, *Duty to Care: Physical Illness in People with Mental Illness*, University of Western Australia, Perth.

COAG (Council of Australian Governments) 2006, *National Action Plan on Mental Health 2006–2011,* COAG meeting 14 July 2006, www.coag.gov.au /coag_meeting_outcomes/2006-07-14/docs/nap_mental_health.rtf (accessed 10 December 2008).

DoHA (Department of Health and Ageing) 2002, *National Mental Health Report 2002*, Australian Government, Canberra.

—— 2005, *National Mental Health Report 2005*, Australian Government, Canberra.

—— 2007, *National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2005*, Australian Government, Canberra.

—— 2009a, *Evaluation of the BreastScreen Australia Program – Evaluation Final Report*, Australian Government, Canberra.

—— 2009b, *National Hospital Cost Data Collection Cost Report Round 12 (2008-09), v5.1*, 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.

Joukamaa M., Heliovaara M., Knekt P., Aromaa A., Raitasalo R. and Lehtinen V. 2001, 'Mental disorders and cause-specific mortality', *The British Journal of Psychiatry*, vol. 179, no. 6, pp. 498–502.

NBOCC (National Breast and Ovarian Cancer Centre) 2004, *Early detection of breast cancer*, Position statement, www.nbocc.org.au/our-organisation/position-statements/early-detection-of-breast-cancer (accessed 18 November 2009).

National Mental Health Working Group (NMHWG) Information Strategy Committee Performance Indicator Drafting Group 2005, *Key Performance Indicators for Australian Public Mental Health Services*, ISC Discussion Paper no. 6., Australian Government Department of Health and Ageing, Canberra.

Sartorius, N. 2007, 'Physical illness in people with mental disorders', *World Psychiatry*, vol. 6, no. 1, pp. 3-4.

Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J. and Saw, S. 2009, *The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing*, Department of Health and Ageing, Canberra.

WHO (World Health Organization) 2001, *Strengthening mental health promotion*, Fact sheet no. 220, Geneva.

PART F

COMMUNITY SERVICES

F Community services preface

CONTENTS

Families are the principal providers of care for children, older people and people with disability (ABS 2001; Australian Government 2008a). Community services aim to:

- support families to fulfil their caring roles
- provide care when families are unable to
- provide interventions where individual needs are not able to be met within the community without special intervention.

Community services provide support to sustain and nurture the functioning of individuals, families and groups, to maximise their potential for development and to enhance community well being (Australian Council of Social Service 2009). Although community services generally target individuals, they can be delivered at an institutional level. Services are typically provided by government and the not-for-profit sector, but the for-profit sector also has an important role (for example, as owners of aged care facilities). Community services also contribute to the development of community infrastructure to service needs (AIHW 2005).

Community service activities

Although there is a broad understanding of the nature of community services, the sector is complex, and consistent aggregate reporting across the community services sector is not possible at this time.

Definitions of the sector vary in their scope and can change over time. Community service activities typically include activities that support individual and family functioning. They can include financial assistance and relief to people in crisis, and housing assistance of a short term or transitional nature, for example, the Supported Accommodation Assistance Program (SAAP). Community services activities exclude acute health care services, long term housing assistance and income support (such as social security pensions and allowances). Some of these interventions are included elsewhere in this Report; for example, Public hospitals (chapter 10), Health management issues (chapter 12) and Housing, including Commonwealth Rent Assistance (chapter 16).

In earlier reports, children's services and juvenile justice data were included in the community services section and preface respectively. From the 2008 Report onwards, the Children's services chapter has been moved to the renamed 'Early childhood, education and training' section. Where possible, children's services material previously in the community services preface has been moved to the Early childhood, education and training preface. However, due to the aggregate nature of much of the statistical material used, some community services data continue to reflect some elements of child care and preschool services. Juvenile justice data have been moved from the Community services preface to the Protection and support services chapter (chapter 15).

The definition of community services activities in this preface is based on the National Classification of Community Services developed by the Australian Institute of Health and Welfare (AIHW 2003) (box F.1). The scope of the preface is therefore somewhat broader than the three service specific chapters in this section of the Report (Aged care services, Services for people with disability, and Protection and support services).

Other definitions of community services have even broader scope. The National Community Services Information Agreement, managed by the National Community Services Information Management Group (NCSIMG), includes income support and concessions in its definition (NCSIMG 2008). Alternative definitions include activities such as advocacy, public transport, community safety and emotional support.

Box F.1 Community services activities

Community services activities include:

Personal and social support — activities that provide support for personal or social functioning in daily life. Such activities promote the development of personal skills for successful functioning as individuals, family members and members of the wider community. Personal and social support activities include the provision of information, advice and referral, personal advocacy, counselling, domestic assistance, provision of services that enable people to remain in their homes, disability services and other personal assistance services. The purpose of such support is to enable individuals to live and function in their own homes or normal places of residence.

Support for children, families and carers — activities that seek to promote child and family welfare by supporting families and protecting children from abuse and neglect or harm through statutory intervention.

Training, vocational rehabilitation and employment — activities that assist people who are disadvantaged in the labour market by providing training, job search skills, help in finding work, placement and support in open employment or, where appropriate, supported employment.

Financial and material assistance — activities that enhance personal functioning and facilitate access to community services, through the provision of emergency or immediate financial assistance and material goods.

Residential care and supported accommodation — activities that are provided in special purpose residential facilities, including accommodation in conjunction with other types of support, such as assistance with necessary day-to-day living tasks and intensive forms of care such as nursing care.

Corrective services — activities in relation to young people and people with intellectual and psychiatric disabilities on court orders that involve correctional and rehabilitative supervision and the protection of public safety, through corrective arrangements and advice to courts and releasing authorities.[a]

Service and community development and support — activities that provide support aimed at articulating and promoting improved social policies; promoting greater public awareness of social issues; developing and supporting community based activities, special interest and cultural groups; and developing and facilitating the delivery of quality community services. Activities include the development of public policy submissions, social planning and social action, the provision of expert advice, coordination, training, staff and volunteer development, and management support to service providers.

[a] This Report uses the term ‘juvenile justice’ to refer to detention and community based supervision services for young people who have committed or allegedly committed an offence while considered by law to be a juvenile (chapter 15).

Source: AIHW (2003); State and Territory governments (unpublished).

Profile of community services

This section examines the size and scope of the community services sector and the role of government in providing community services.

Roles and responsibilities

The Australian, State and Territory governments have a major role in the provision of community services. This role is based on a mandate to ensure basic rights and an acceptable standard of living, and a requirement to protect and support vulnerable people in society. Local governments are also important funders and providers of community services (AIHW 2005). However, community services funded solely by local government are outside the scope of this Report.

Government involvement in community services includes:

- providing services directly to clients
- funding non-government community service providers (which then provide services to clients)
- legislating for, and regulating, government and non-government providers
- undertaking policy development and administration
- undertaking evaluation of community services programs.

The roles and funding arrangements for community services vary across service areas and programs:

- statutory child protection and juvenile justice services are primarily funded by State and Territory governments and services are primarily delivered by State and Territory governments, with some non-government sector involvement, particularly in the delivery of out-of-home care services
- specialist disability services are funded in large part by State and Territory governments (with some Australian Government contribution) and are primarily delivered by State and Territory governments and the non-government sector
- supported accommodation and assistance services are funded by Australian, State and Territory governments, and are delivered primarily by non-government organisations
- residential care is primarily funded by the Australian Government and services are primarily delivered by State and Territory governments and the non-government sector.

Effective regulation of non-government agencies (through licensing, accreditation and quality assurance) enables agencies to provide services within an appropriate framework of agreed standards. Examples include the accreditation of residential aged care services and the National Standards for the Home and Community Care (HACC) program.

Expenditure

Community services expenditure

Estimates of community services expenditure are influenced by the scope of the services to be included. The following broad estimates of community services expenditure provide context for material included in the relevant chapters of this Report.

Welfare expenditure Australia 2005-06 (AIHW 2007a) analyses community services expenditure incurred by governments, non-government organisations and individual households in providing services to assist members of the community with special needs (limited to families and children, older people, people with disability and other disadvantaged groups). It estimates that:

- expenditure on welfare services (excluding welfare payments) in 2005-06 was \$28.9 billion (\$1404 per person), which represented 3.0 per cent of Gross Domestic Product (GDP) in that year. In 1998-99, welfare services expenditure represented 2.9 per cent of GDP. Over this period, the average annual growth in expenditure on these services was similar to the average annual growth of GDP (AIHW 2007a)
- governments were the source of 70.8 per cent of all funding of welfare services in 2005-06, with the non-government sector providing the remaining 29.2 per cent of funding. Of this 29.2 per cent, households contributed approximately 20.3 per cent and non-government community service organisations contributed approximately 9.0 per cent (AIHW 2007a).

In 2007-08, social security and welfare expenditure continued to be a significant area of government spending. Social security and welfare expenditure of \$107.6 billion amounted to 27.8 per cent of total general government expenses (for all levels of government). Social security payments constituted the majority of government expenditure on social security and welfare expenditure (\$85.0 billion), followed by welfare services (\$19.0 billion), and other services (\$3.6 billion) (ABS 2009b).

The most recent Australian Bureau of Statistics (ABS) survey of community services (ABS 2001) identified government and non-government expenditure for the sector in 1999-2000. Information from the survey was included in the 2009 Report (SCRGSP 2009). The next ABS survey of community services is to be released in 2010.

Further analysis of community services expenditure data compiled as part of the *Indigenous Expenditure Report*, and data derived from the ABS General Government Expenses by Purpose collection will be included in future Reports.

Community services expenditure included in this Report

The following community services expenditure analysis relates only to the expenditure reported in the community services chapters of this Report (box F.2).

Box F.2 **Major programs included in Community services expenditure in the Report**

The major programs reported on include:

- aged care services — aged care assessment, residential care and community care programs and HACC
- services for people with disability — services under the third Commonwealth State/Territory Disability Agreement and the National Disability Agreement
- protection and support services — child protection and out-of-home care services and Supported Accommodation Assistance Program (SAAP) services.

Each chapter includes more detailed analysis of expenditure items reported.

Recurrent expenditure included in the Report

Total Australia, State and Territory government recurrent expenditure on community services covered by this Report was estimated to be $18.0 billion in 2008-09 (table F.1). This was equivalent to 1.5 per cent of GDP in that year, and 8.3 per cent of total government outlays (table F.1 and ABS 2009a).

Table F.1 Real government recurrent expenditure on community services (2008-09 dollars)[a, b, c, d, e]

	Unit	Aged care services	Services for people with disability	Protection and support services	Total
2004-05	$m	8 343.8	4 348.3	1 932.9	14 625.1
2005-06	$m	8 565.2	4 476.0	2 050.0	15 091.1
2006-07	$m	8 951.1	4 777.5	2 319.9	16 048.5
2007-08	$m	9 708.1	4 971.4	2 589.5	17 269.0
2008-09	$m	10 079.3	5 245.1	2 631.3	17 955.7
Increase 2004-05 to 2008-09	%	20.8	20.6	36.1	22.8

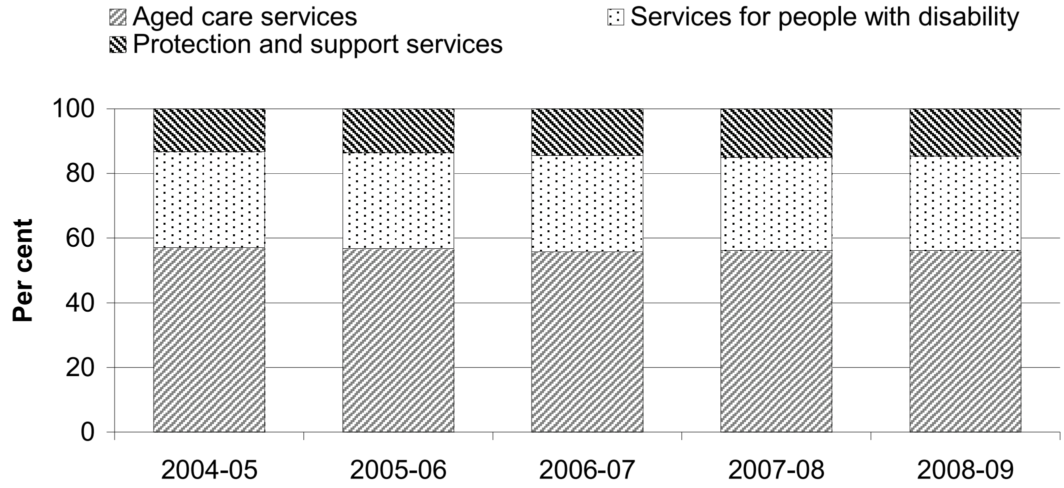
[a] Data for 2004-05 to 2007-08 have been adjusted to 2008-09 dollars using the gross domestic product (GDP) price deflator in table AA.26 of appendix A. [b] Data for aged care services published in the 2008, and earlier, reports differ due to revised data and the inclusion of additional expenditure items in the 2008, 2009 and 2010 reports. The 2010 Report included new expenditure data for the Community Visitors Scheme, the Innovative Care Pool, CALD programs and Specific Purpose Payments. [c] Totals may not add as a result of rounding. [d] See box F.2 for the major programs included in expenditure for each service. [e] More detailed expenditure data can be found in the relevant chapters of the Report.

Source: Australian, State and Territory governments (unpublished); tables 13A.43, 14A.4, 15A.1, 15A.186 and AA.26.

Between 2004-05 and 2008-09, real government recurrent expenditure on community services increased by $3.3 billion, or 22.8 per cent. The largest proportional increase in real expenditure was on protection and support services, which increased by 36.1 per cent between 2004-05 and 2008-09. The largest absolute dollar increase for a particular service between 2004-05 and 2008-09 was $1.7 billion for aged care services (table F.1).

In 2008-09, 56.1 per cent of government recurrent expenditure on community services related to aged care services, 29.2 per cent related to services for people with disability, and 14.7 per cent related to protection and support services. These proportions have been fairly consistent from 2004-05 to 2008-09 (figure F.1).

Figure F.1 **Government recurrent expenditure on community services**[a, b]



[a] Data for aged care services published in the 2008 Report, and earlier reports differ due to revised data and additional expenditure items collected for aged care services in the 2008 and 2009 Reports. [b] See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report.

Source: Australian, State and Territory governments (unpublished); tables 13A.43, 14A.4, 15A.1 and 15A.186.

Expenditure available for reporting at a State and Territory level

Table F.2 and Figure F.2 identify expenditure on community services included in this Report, by jurisdiction, for 2008-09. This is expenditure by State and Territory governments and Australian Government expenditure available for reporting at the State and Territory level.

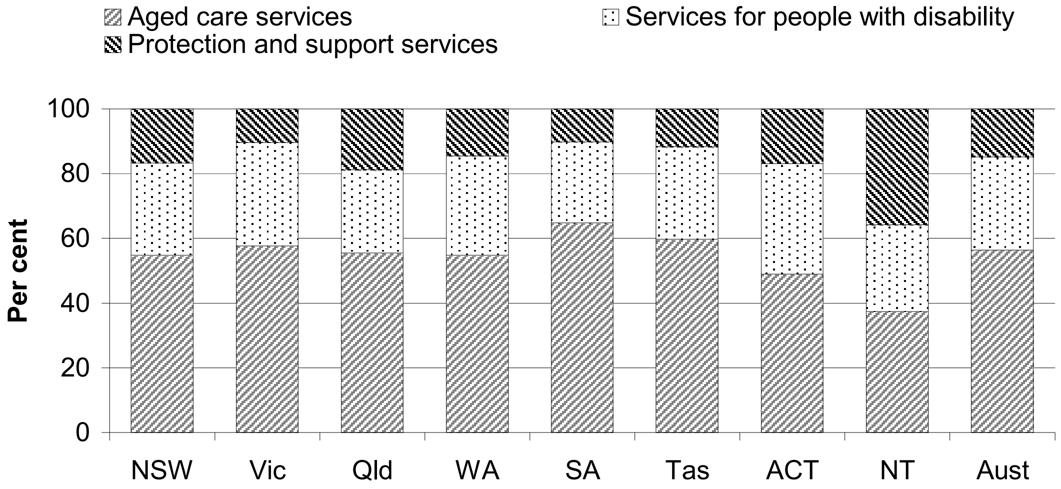
Table F.2 Government recurrent expenditure on community services, 2008-09[a, b, c, d, e, f]

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Recurrent expenditure on community services										
Aged care services	$m	3 327.9	2 528.5	1 848.1	863.5	995.0	281.2	112.8	58.5	10 015.4
Services for people with disability	$m	1 731.2	1 398.8	857.5	483.7	383.6	134.3	78.7	41.8	5 109.7
Protection and support services	$m	1 013.4	457.5	624.3	229.2	157.1	54.9	39.0	55.9	2 631.3
Total	**$m**	6 072.5	4 384.8	3 329.9	1 576.4	1 535.7	470.4	230.5	156.2	17 756.4
Proportion of recurrent expenditure by service										
Aged care services	%	54.8	57.7	55.5	54.8	64.8	59.8	49.0	37.4	56.4
Services for people with disability	%	28.5	31.9	25.8	30.7	25.0	28.5	34.1	26.8	28.8
Protection and support services	%	16.7	10.4	18.7	14.5	10.2	11.7	16.9	35.8	14.8
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Recurrent expenditure on community services per person in the population[e]										
Expenditure per person	$	862.4	817.3	765.6	715.2	952.6	940.3	662.5	704.6	820.4

[a] For aged care services and services for people with disability, Australian Government expenditure available for reporting at a State and Territory level is included in the analysis for the relevant jurisdiction. Australian Government expenditure not allocated to a State or Territory is not included ($63.9 million in aged care services and $135.4 million in services for people with disability). [b] Collection and reporting methods may vary across jurisdictions and services in this analysis, therefore, these data should be interpreted with care. [c] See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report. [d] Totals may not add due to rounding. [e] Population at 31 December 2008. [f] Expenditure for aged care does not include capital expenditure.

Source: Australian, State and Territory governments (unpublished); tables 13A.43, 14A.4, 15A.1, 15A.186 and AA.2.

Figure F.2 **Government recurrent expenditure on community services, 2008-09 (per cent)**[a, b, c]

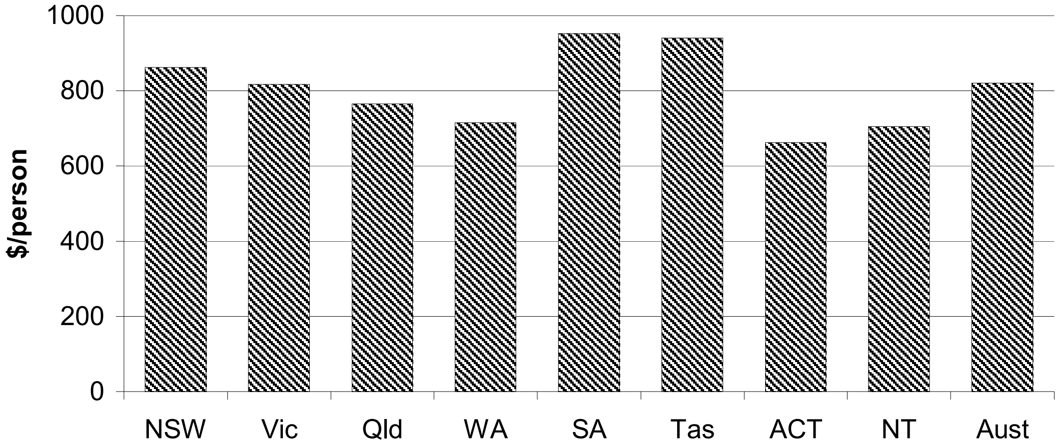


[a] For aged care services and services for people with disability, Australian Government expenditure available for reporting at a State and Territory level is included in the analysis for the relevant jurisdiction. Australian Government expenditure not allocated to a State or Territory is not included ($63.9 million in aged care services and $135.4 million in services for people with disability). [b] Collection and reporting methods may vary across jurisdictions and services in this analysis, therefore, these data should be interpreted with care. [c] See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report.

Source: Australian, State and Territory governments (unpublished); table F.2.

In 2008-09, community services government recurrent expenditure was $820 per person nationally. Expenditure varied across jurisdictions (figure F.3).

Figure F.3 Government recurrent expenditure on community services, per person in the population, 2008-09[a, b, c, d]



[a] For aged care services and services for people with disability, Australian Government expenditure available for reporting at a State and Territory level is included in the analysis for the relevant jurisdiction. Australian Government expenditure not allocated to a State or Territory is not included ($63.9 million in aged care services and $135.4 million in services for people with disability). [b] Collection and reporting methods may vary across jurisdictions and services in this analysis, therefore, these data should be interpreted with care. [c] See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report. [d] Population at 31 December 2008.

Source: Australian, State and Territory governments (unpublished); table F.2.

Size and scope

Current data on the size and scope of the community services sector are limited. The ABS Survey of Community Services collected data on the number of organisations that provided community services in 2000. Almost 9300 organisations were providing community services (covering the not-for-profit, government and for-profit sectors) as at 30 June 2000. Of these, 30 per cent were for-profit organisations, 63 per cent were not-for-profit organisations and 6 per cent were government organisations. If non-government sector child care services are excluded, 14 per cent were for-profit organisations, 76 per cent were not-for-profit organisations and 10 per cent were government organisations (ABS 2001). From 1995-96 to 1999-2000, the number of for-profit and not-for-profit organisations across the sector increased by 32 per cent and 10 per cent respectively.

Workforce information

There are difficulties identifying the true dimensions of the community services workforce, including identifying the community services sector in data sets (the varying measurements in this preface reflect these difficulties), data gaps relating to sub-sectors of community services and the lack of regular and consistent data (AIHW 2006a).

Available information suggests increasing levels of employment within the community services sector over the past decade.

The ABS survey of community services provides a detailed description of the workforce. In 1999-2000, not-for-profit, government and for-profit organisations employed a total of 341 400 people. Of these, 59 246 were employed by government organisations, and 277 300 people were employed in direct service provision. If child care services are excluded from this analysis, 300 300 people were employed, including 238 900 in direct service provision. A further 299 400 volunteers (288 000 excluding child care services) assisted in community service activities (ABS 2001).

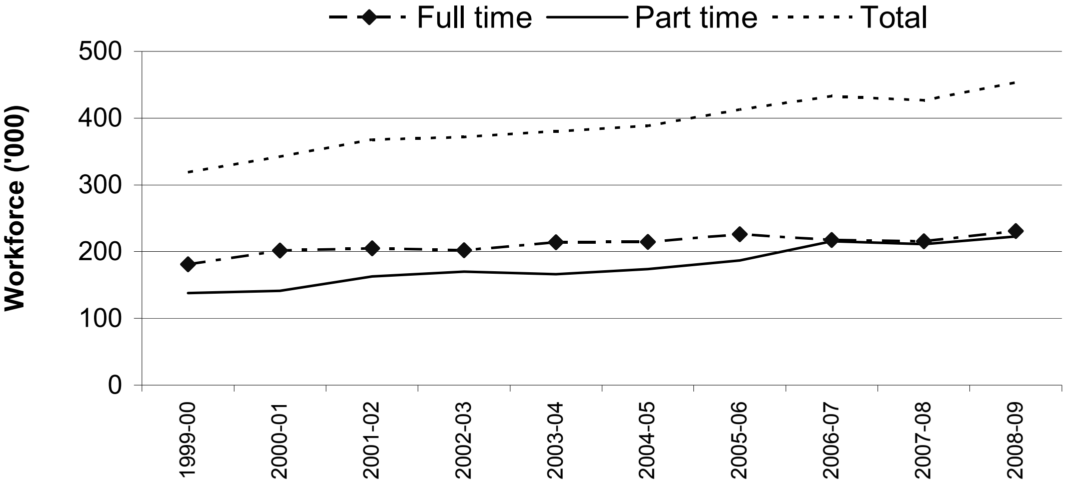
Subsequent developments in the community services workforce can be observed through ABS labour force survey data. These data provide a quarterly estimate of the full and part time workforce for the community services sector, within the broader industry classifications 'residential care services' and 'other social assistance services'. These industry classifications include people working in the following sub-categories:

- residential care services — aged care residential services; children's homes, hostels, crisis care accommodation, refuges, and respite care
- other social assistance services — disability assistance services, soup kitchens, marriage guidance, and adult and youth welfare services.

Industry classifications in the ABS labour force survey are based on the Australian and New Zealand Standard Industrial Classification (ANZSIC). Prior to the 2010 Report, ABS labour force data were based on the 1993 ANZSIC. For the 2010 Report, ABS labour force data are based on the revised 2006 ANZSIC. Therefore, workforce data in previous editions of this Report are not comparable to the data contained in figure F.4.

Quarterly ABS labour force data have been averaged for each year to measure annual trends in employment in the community services industry for the 10 year period 1999-2000 to 2008-09. Employment in the community services industry has grown from 331 800 people (57.8 per cent full time and 42.2 per cent part time) to 453 800 people (50.9 per cent full time and 49.1 per cent part time). This represents an average annual increase in employment in the community services sector of 4.0 per cent (figure F.4).

Figure F.4 **Full time, part time and total employment in residential care and other social assistance services, 1999-2000 to 2008-09** [a]



[a] Time series workforce data have been re-cast using the 2006 ANZSIC and are not comparable to workforce data in previous editions of this Report.

Source: ABS 2009, *Labour Force*, *Australia, Detailed, Quarterly, May 2009*, Cat. no. 6291.0.55.003, Canberra.

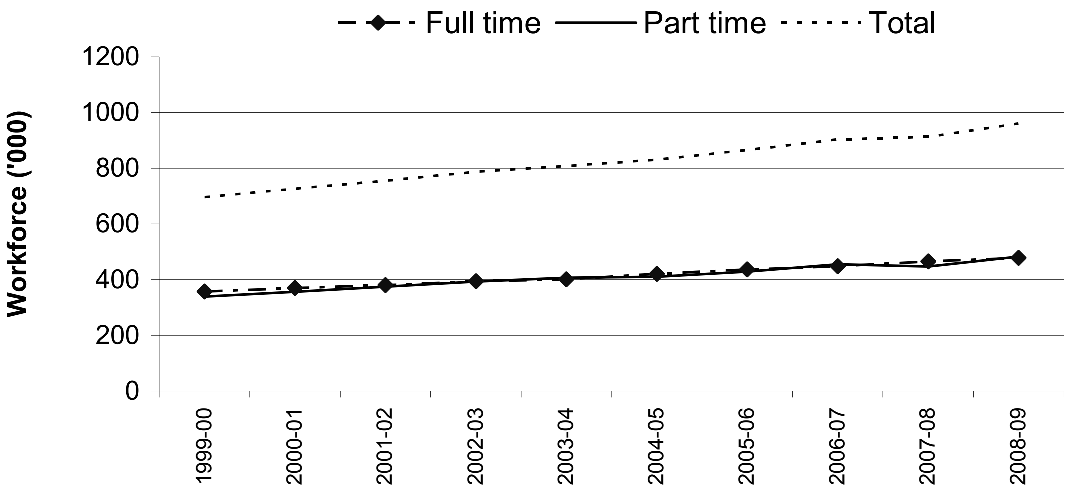
Caution should be exercised in using these data to estimate the size of the community services workforce. The number of people employed in a particular industry does not necessarily reflect the number of people employed in particular occupations. Employment in occupations typically associated with community services industries also occurs in other industries, for example, in education and health services. The AIHW reported that in 2006, over 188 000 workers were employed in community services occupations in other industries (AIHW 2007b).

Figure F.5 plots the average annual number of people employed in 'community and personal service occupations' for the period 1999-2000 to 2008-09. Occupation classifications in the ABS labour force data are based on the Australian and New Zealand Standard Classification of Occupations (ANZSCO). According to the ANZSCO, the category 'community and personal service workers' comprises:

- health and welfare support workers
- carers and aides
- hospitality workers
- protective service workers
- sports and personal service workers.

Employment in 'community and personal service occupations' has increased over the past 10 years from 690 300 people (51.8 per cent full time and 48.2 per cent part time) to 961 300 people (49.8 per cent full time and 50.2 per cent part time). This represents an average annual increase in employment in 'community and personal service occupations' of 3.6 per cent (figure F.5).

Figure F.5 **Full time, part time and total employment in community and personal service occupations, 1999-2000 to 2008-09**



Source: ABS 2009, *Labour Force*, *Australia, Detailed, Quarterly, May 2009*, Cat. no. 6291.0.55.003, Canberra.

The Australian Community Sector Survey 2009 recorded an estimated 3.4 per cent increase in the community services workforce during 2007-08. This same survey found that demand for a broad range of community services (measured by the number of people assisted by agencies) increased by 19 per cent from 2006-07 to 2007-08 (Australian Council of Social Service 2009).

Volunteers

Although this Report focuses on government provision of services, it is important to recognise that volunteering provides a significant contribution to the community services sector, not generally identified in workforce data. In 2006, 16.3 per cent of all voluntary involvement was in the 'community/welfare' sector (which includes community services), and 90.4 per cent of this volunteer work occurred in the not-for-profit sector. The highest proportion of volunteers in this sector were aged 65 years and over. Just over 7 per cent of all people in the community aged 18 years and over volunteered in this sector (ABS 2007).

The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) [previously the Department of Families, Community Services and Indigenous Affairs (FaCSIA)] estimated that the total imputed dollar value of the time donated to welfare services by volunteers in 2001-02 ($27.4 billion) was almost double the total cash amount spent by all governments and non-government sources ($13.7 billion). Informal help to family, friends and neighbours generated over two thirds of the imputed value of the services (FaCSIA 2006).

The ABS 2003 *Survey of Disability, Ageing and Carers* (ABS 2004a) found that the number of people with reported disability or with a profound or severe core activity limitation receiving assistance from informal providers (predominantly families), is significantly greater than the number of people receiving formal services (from government or non-government providers). The survey found that approximately 16 per cent of the Australian population aged 15 years or over provided regular or sustained care to another person. Data from the 2009 *Survey of Disability, Ageing and Carers* are expected to be available in 2010.

A range of financial supports are available to carers, some of which are mainstream benefits, for example, the Age Pension and Rent Assistance. The Carer Allowance and Carer Payment are specifically available to carers. In June 2008, approximately 422 900 people were receiving Carer Allowance and 130 700 people were receiving Carer Payment (AIHW 2009). The number of people receiving carer-specific payments has increased significantly over the past decade. This is attributable to population ageing, greater demand for home-based care and greater awareness of carer-specific payments (AIHW 2009).

Community services developments

The continued growth of the community services sector is, in part, a response to changes occurring more broadly in society. Although these developments are not necessarily readily quantified, the following discussion summarises some of the trends observed in recent years.

The community services sector is influenced by demographic changes. For example, increases in the number and proportion of older people in the population might have an impact on demand for aged care and disability services, and the ability of the community to respond to these demands. Disability prevalence increases with age. Of the population aged 0–34 years, an estimated 9.2 per cent had a disability, whereas 21.9 per cent of the population aged 35–64 years were estimated to have a disability. Of the population aged 65 years or over in 2003, an estimated 55.7 per cent had a disability (AIHW 2006b).

The Australian Government's second Intergenerational Report (Australian Government 2007a) provides an indication of the extent to which such demographic changes might influence the sector in the future, and the impact of these changes on revenue and expenditure (box F.3). The Australian Government's third Intergenerational Report is expected to be released prior to the 2010-2011 Budget.

Box F.3 **Future demographics and the Intergenerational Report 2007**

Projections in the Intergenerational Report 2007 show that over the next 40 years:

- the Australian population will continue to increase in size but with a higher proportion of older people. The proportion of those over 65 is predicted to nearly double to 25 per cent of the population
- economic growth per person will slow as the proportion of the population of traditional working age falls
- substantial fiscal pressures will emerge due to projected increases in government spending, particularly in the areas of health, age pensions and aged care.

The report identifies productivity, population and participation as contributors to real GDP, which in turn, is a key factor in the ability of the economy to sustain service provision, including provision of community services.

Source: Australian Government (2007a).

In addition to an ageing population, other pertinent economic, demographic and social changes that might have influenced demand for community services include:

- labour market changes, such as greater numbers of women entering paid employment
- changing family structures, characterised by lower birth rates, increased family breakdown and less reliance on extended families
- decreasing engagement in neighbourhood and community life.

These developments can provide some explanation of the increase in demand for a range of community services, although the explanations for changes in demand for any given service or an individual's demand for a particular service are likely to be complex (de Vaus 2004; Davies and Taylor 2005; Human Rights and Equal Opportunity Commission 2007; Office for Women 2007). For example, an individual or family's awareness of and capacity to access a particular service will influence their demand for and use of a service.

Social capital and social inclusion

The concepts of 'social capital' and 'social inclusion' are of increasing interest nationally and internationally. Box F.4 defines and explains these concepts. Social capital and social inclusion are multifaceted concepts which can be difficult to measure. The ABS (2006) has identified some broad indicators of social capital, which include social participation, community support, economic participation and reciprocity. In addition, the Australian Government's Social Inclusion Board has released a compendium of social inclusion indicators, which comprise measures related to poverty and low income, employment, the availability of social networks, accessibility and health (Australian Government 2009).

Box F.4 **Social capital and social inclusion**

Social capital

The OECD defines social capital as 'the norms and social relations embedded in societal structures that enable people to co-ordinate action to achieve desired goals'.

Social capital can generate benefits for a community in a number of ways:

- by reducing the costs of conducting day-to-day affairs and of doing business
- by facilitating the spread of knowledge and innovation
- by promoting cooperative and/or socially-minded behaviour in situations where self-interest alone does not generate good outcomes for society
- through individual benefits — people with good access to social capital are more likely to be 'hired, housed, healthy and happy' than those without
- through associated social spill-overs, such as lower health and welfare expenditures, and higher tax receipts.

Social inclusion

Although interpretations vary, definitions of social inclusion (or conversely, social exclusion) commonly concern access to opportunities such as education and employment and the capacity required to capitalise on those opportunities. Specific dimensions used to measure social inclusion or exclusion often include the presence or absence of: geographic disadvantage (for example, having limited or no access to public transport and other community and neighbourhood resources), joblessness, intergenerational disadvantage, child poverty, chronic ill-health and homelessness.

Source: ABS (2004b); Australian Government (2008b; 2009); Hunter (2009); Productivity Commission (2003); Scutella, Wilkins and Horn (2009).

The Steering Committee plans to expand reporting in this preface on measures of social capital and social inclusion, particularly with reference to reporting arising from the Australian Government's Social Inclusion Board and other such initiatives across Australian State and Territory governments.

Cross-cutting community services issues

Community services pathways

Although this Report discusses three areas of community services in separate chapters, it is recognised that there are many linkages between different community services. Governments are increasingly emphasising the need for integrated, client centred community services.

Many community services are linked by the provision of different services to individuals at different stages of life. Other services are not as strictly age-specific and some individuals may receive multiple services at the same time — for example, a child who is in receipt of juvenile justice services together with homelessness, child protection or disability services. Disability services can continue throughout an individual's lifetime and overlap with the provision of aged care services.

The sequence of interventions or services can be referred to as 'pathways' of community service provision. However, there is limited information on the patterns of access by individuals to the range of community services, either concurrently or in succession over a lifetime. A greater understanding of the links between the use of various community services, the nature of these links, and whether interventions in one area of service provision result in reduced need for other services, will help to inform government social policy agendas.

Examples of relevant research include:

- a cohort study carried out in Queensland, which found a correlation between contact with child protection services and the juvenile justice system. Of the 24 255 children born in 1983 or 1984 who had a contact with one or more of child protection services, police cautioning or children's courts, 6.2 per cent had both a child protection services contact and a children's court appearance. These 1500 children represented 28.7 per cent of those with a children's court appearance and 15.7 per cent of those with a child protection history (Stewart, Dennison and Hurren 2005)
- a Community and Disability Services Ministers' Advisory Council (CDSMAC) funded project being undertaken by the AIHW involving the linkage of three national data collections: Supported Accommodation Assistance Program

(SAAP) data, juvenile justice data and child protection data. At present, linked data are being used to analyse the pathways and characteristics of clients who are common to both SAAP and juvenile justice services. Future phases of this project will extend data linkage to include child protection data (when unit record data become available for this service area) and include more years of data so that longitudinal analyses can be carried out. It is anticipated that the project will contribute to the long term outcome of reducing the extent to which clients of child protection become clients of juvenile justice and SAAP, or to which clients of SAAP services become clients of child protection and juvenile justice

- a FaHCSIA longitudinal study of Indigenous children (*Footprints In Time*) into the links between early childhood experiences and later life outcomes for Aboriginal and Torres Strait Islander children, covering areas such as health, culture, education, housing and family relationships (FaHCSIA 2008)
- an ARC linkage grant project entitled *Accommodating the Needs of People with Lifelong Intellectual Disability in Residential Aged Care*, which is being conducted by the Australian Catholic University and La Trobe University. The aims of the research project are to: analyse pathways into residential aged care; identify important decision-making points and factors that influence those decisions; and examine the consequences of placing people with intellectual disabilities in residential aged care settings. For a period of three years, the project will track people with intellectual disabilities as they transition from the disability sector to the residential aged care sector. It is expected that the findings will inform the aged care, disability and health sectors about the support needs of this client group (Webber et al., 2006).

In addition, in September 2009, the Australian Government launched the Australian Institute for Population Ageing Research (AIPAR), based at the University of New South Wales. The AIPAR will bring together cross-disciplinary research on the issue of population ageing to inform economic and social policy. The AIPAR will also maintain a ‘Longevity Index’ to track the extent to which Australians are able to maintain their living standards over their lifetime (UNSW 2009).

There are also links between community services and other government services. Access to effective community services can influence outcomes for clients of education, health, housing and justice sector services. In turn, access to these other service areas may affect community services outcomes.

The community services and health sectors are closely related and their effective interaction assists the provision of services in both sectors. The disability sector is also strongly linked to health services by the needs of clients, as people with disability tend to have a larger number of poor health conditions than the general population (AIHW 2006b). Other links, such as the role of medical and other health professional staff as a source of child protection notifications, also reinforce the importance of the relationship between community services and health.

HACC across the community services sector

Within the Report, HACC services are included in the Aged care services chapter, but the scope of the program is wider than aged care. Provision of HACC services is primarily to older people, but younger people with disability and their carers are also important recipients of HACC assistance. The HACC National Program Guidelines note that the Program provides funding for services that support both frail aged people and younger people with disability and their carers:

- who live at home and whose capacity for independent living is at risk
- who are at risk of premature or inappropriate admission to long term residential care (Australian Government 2007b).

In 2008-09, 23.1 per cent of HACC clients were aged under 65 years (up from 22.5 per cent in 2005-06). Analysis of data from the HACC program in 2008-09 indicates that clients aged under 65 years were significantly over-represented in particular assistance types, including carer counselling support (38.1 per cent), nursing care (centre) (33.2 per cent), and respite care (52.0 per cent) (DoHA unpublished).

In 2008-09, 14.0 per cent of HACC clients nationally were in receipt of a Disability Support Pension. This proportion had increased from 13.2 per cent in 2005-06. In 2008-09, 32.4 per cent of HACC clients classified as care recipients reported that they were also receiving assistance from a relative or friend/carer (DoHA unpublished).

Future directions in performance reporting

The Steering Committee intends to continue expanding reporting in this preface on the characteristics of the community services sector. In particular, developments that span various community services, such as measures of social capital and social inclusion, will be considered. Ongoing investigation of cross-cutting issues might allow improved reporting for community services as a whole.

COAG developments

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (see chapter 1 for more detail on reforms to federal financial relations). The National Healthcare Agreement, the National Disability Agreement, and the National Affordable Housing Agreement cover the areas of aged care, disability, and homelessness (formerly SAAP) services, while the National Indigenous Reform Agreement establishes specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. The agreements include sets of performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC).

Report on Government Services alignment with National Agreement reporting

It is anticipated that future editions of the Community services preface will align with applicable National Agreement indicators, including the National Indigenous Reform Agreement (NIRA). Further alignment between the Report and National Agreement indicators, and other reporting changes, might result from future developments in National Agreement and National Partnership reporting.

Outcomes from review of Report on Government Services

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report on Government Services in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the Intergovernmental Agreement on Federal Financial Relations.

No significant changes from this review are reflected the 2010 Report. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 Report.

References

ABS (Australian Bureau of Statistics) 2001, *Community Services Australia, 1999-2000*, Cat. no. 8696.0, Canberra.

—— 2004a, *Survey of Disability, Ageing and Carers, 2003*, Cat no. 4430.0, Canberra.

—— 2004b, *Measuring Social Capital — An Australian Framework and Indicators,* Cat. no. 1378.0, Canberra.

—— 2006, *Aspects of Social Capital Australia, 2006*, Cat. no. 4911.0, Canberra.

—— 2007, *Voluntary work, Australia, 2006*, Cat. no. 4441.0, Canberra.

—— 2009a, *Australian National Accounts: National Income, National Expenditure and Product*, Cat. no. 5206.0, Canberra.

—— 2009b, *Government Finance Statistics, Australia, 2007-08*, Cat. no. 5512.0, Canberra

Australian Council of Social Service 2009, *Australian Community Sector Survey Report 2009*, Strawberry Hills.

Australian Government 2007a, *Intergenerational Report 2007*, Commonwealth of Australia, Canberra.

—— 2007b, *National Program Guidelines for the Home and Community Care Program,* Commonwealth of Australia, Canberra.

—— 2008a, *Families in Australia: 2008*, Commonwealth of Australia, Canberra.

—— 2008b, *Social inclusion: origins, concepts and key themes:* Paper prepared by the Australian Institute of Family Studies for the Social Inclusion Unit, Department of the Prime Minister and Cabinet, Commonwealth of Australia, Canberra.

—— 2009, *Social inclusion: A compendium of social inclusion indicators*, Social Inclusion Board, Department of the Prime Minister and Cabinet, Commonwealth of Australia, Canberra.

AIHW (Australian Institute of Health and Welfare) 2003 (and previous issues), *National Classifications of Community Services, Version 2.0*, Cat. no. HWI 40, Canberra.

—— 2005, *National Community Services Information Strategic Plan 2005–2009*, Cat. no. AUS 68, Canberra.

—— 2006a, *Information relating to the community services workforce*. Cat. no. HWL 33. Canberra.

—— 2006b, *Disability and disability services in Australia*. Cat. no. DIS 43. Canberra.

—— 2007a, *Welfare expenditure Australia 2005–06.* Health and Welfare Expenditure Series no. 31. Cat. no. HWE 38. Canberra.

—— 2007b, *Australia's welfare 2007*, Cat. no. AUS 93, Canberra.

—— 2009, *Australia's welfare 2009,* Cat. no. AUS 117, Canberra.

Davies, A. and Taylor, C. 2005, *Stronger Families and Communities Strategy — Communities for Children*, Australian Social Policy 2005, FaCSIA, Canberra.

de Vaus, D. 2004, *Diversity and change in Australian families: Statistical profiles*, Australian Institute of Family Studies, Melbourne.

FaCSIA (Department of Families, Community Services and Indigenous Affairs) 2006, Social Research Policy paper no. 28, *Exploring the economic and social value of present patterns of volunteering in Australia*, Canberra.

FaHCSIA (Department of Families, Housing, Community Services and Indigenous Affairs) 2008, *Research News*, Issue 31, Canberra.

HREOC (Human Rights and Equal Opportunity Commission) 2007, *It's About Time: Women, men, work and family, Final Paper 2007*, Canberra.

Hunter, B. 2009, 'Indigenous social exclusion: Insights and challenges for the concept of social inclusion', *Family Matters*, no. 82, pp. 52-61.

NCSIMG (National Community Services Information Management Group) website, http://www.aihw.gov.au/committees/ncsimg/index.cfm (accessed 10 October 2008).

Office for Women 2007, *Women: Decade of achievements for Australian women*, Canberra.

Productivity Commission 2003, *Social Capital: Reviewing the Concept and its Policy Implications,* Research Paper, AusInfo, Canberra.

Scutella, R., Wilkins, R., and Horn, M. 2009, *Measuring Poverty and Social Exclusion in Australia: A Proposed Multidimensional Framework for Identifying Socio-Economic Disadvantage*, Melbourne Institute Working Paper Series, Working Paper no. 4/09, Melbourne.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2009, *Report on Government Services 2009,* Productivity Commission, Canberra.

Stewart, A., Dennison, S., and Hurren, E. 2005, *Final Report, Juvenile Offending Trajectories: Pathways from Child Maltreatment to Juvenile Offending, and Police Cautioning in Queensland,* Griffith University.

UNSW (University of New South Wales), Australian Institute for Population Ageing Research website, http://www2.business.unsw.edu.au/nps/servlet/portalservice?GI_ID=System.LoggedOutInheritableArea&maxWnd=T_AIPAR_home (accessed 2 October 2009).

Webber, R., Bigby, C., McKenzie-Green, B., and Bowers, B. 2006, *Mapping the terrain: Ageing people with lifelong intellectual disability living in residential aged care facilities in Victoria,* Australian Catholic University and La Trobe University.

13 Aged care services

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 13A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

The aged care system comprises all services specifically designed to meet the care and support needs of frail older people living in Australia. This chapter focuses on government funded residential and community care for older people and services designed for the carers of older people. Some government expenditure on aged care is not reported, but continual improvements are being made to the coverage and quality of the data. The services covered include:

- residential services, which provide high care, low care and residential respite care

- community care services and flexible services, which include Home and Community Care (HACC) program services, Community Aged Care Packages (CACP), the Extended Aged Care at Home (EACH) program, the EACH Dementia (EACH-D) program, the Transition Care Program (TCP), and the Department of Veterans' Affairs (DVA) Veterans' Home Care (VHC)[1] Community Nursing programs and Multi-purpose Service Program (MPS)
- respite services, which include HACC respite and centre-based day care and the National Respite for Carers Program (NRCP)
- assessment and information services, which are largely provided by the Aged Care Assessment Program (ACAP).

Additions and improvements made to the chapter this year include:

- inclusion of data for the first time on access to aged care residential services for veterans, within the indicator 'use by different groups'
- inclusion of additional data for the first time for EACH-D services including:
  - aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years as a proportion of all residents, by locality and recipients from a non-English speaking country
  - Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over and as a proportion of all recipients and by locality
  - EACH-D recipients by age-sex specific usage rates per 1000 people by jurisdiction and remoteness
- replacing the measure 'average residents per room' with a more comprehensive measure 'percentage of compliant services' for the indicator 'compliance with service standards for residential care'
- redefining HACC services received per 1000 people to only include people aged 70 years and over plus Indigenous people aged 50 to 69. In previous years, all people in receipt of HACC services regardless of age were reported
- inclusion of an additional attachment table to summarise Government expenditure on aged care services and revisions to supporting attachment tables to report more comprehensive data and to better reflect expenditure categories for assessment and information services, residential care, community care and services delivered in mixed delivery settings.

Older Australians may also use other government services covered in this Report, including disability services (chapter 14), specialised mental health services

---

[1] Unless otherwise stated, HACC expenditure excludes the DVA expenditure on VHC.

(chapter 12), housing assistance (chapter 16) and services across the full spectrum of the health system (preface E and chapters 10–12). Interactions between these services are likely to affect performance results in this Report, for example, the number of operational residential aged care places may affect demand for public hospital beds, and changes in service delivery in the public hospital sector may affect demand for residential and community aged care.

This chapter also describes the characteristics and performance of residential aged care in terms of residential services, places and locality (box 13.1).

Box 13.1 Interpreting residential aged care data

Aged Care Funding Instrument and the characteristics of residents

On 20 March 2008, the Aged Care Funding Instrument (ACFI) was introduced to replace the Resident Classification Scale (RCS). Transition arrangements from the RCS to the ACFI are now complete.

The ACFI measures each resident's need for care (high, medium, low or nil) in each of three domains. This chapter classifies residents as 'high' or 'low' care based on their Aged Care Assessment Team (ACAT) assessment and their approved provider's appraisal of their care needs under the ACFI. Residents whose ACAT approval is not limited to low care are classified as high care if they have an ACFI appraisal of:

- medium or high in activities of daily living; or
- high in behaviour; or
- medium or high in complex health care.

All other ACAT approval and ACFI appraisal combinations result in a classification of low level care.

A residents care needs may change over time resulting in a change in classification from low to high level care (ageing in place).

Residential services data

- Aged care homes with 80 per cent or more residents classified as high care are described as high care services.
- Aged care homes with 80 per cent or more residents classified as low care are described as low care services.
- A service that is neither high care, nor low care, as defined above is called a mixed care service.

(Continued next page)

Box 13.1 **(continued)**

These categories have been used for descriptive purposes and do not have any legal foundation under the *Aged Care Act* 1997 (Cwlth) (the Aged Care Act). Similarly, the choice of 80 per cent as a cut-off point is arbitrary but considered appropriate for descriptive purposes.

Places data

The Aged Care Act (part 2.2) details the processes for planning and allocating Australian Government subsidised services to meet residential aged care needs and community care needs. Planning is based on a national ratio of places per 1000 people aged 70 years or over for both high and low care. High care places are planned to meet the needs of residents equivalent to high care. Low care places are planned to meet the needs of residents equivalent to low care.

Although a needs match is expected when residents enter vacant places (that is, for example, vacant low care places should usually be filled by low care residents) this can change over time with ‘ageing in place’, which allows a low care resident who becomes high care to remain within the same service.

Locality data

Geographic data are based on the Australian Bureau of Statistics (ABS) Australian Standard Geographic Classification of Remoteness Areas (ABS 2006). Data are classified according to an index of remoteness that rates each ABS census district based on the number and size of towns, and the distance to major towns and urban centres.

13.1 Profile of aged care services

Service overview

Services for older people are provided on the basis of the frailty or functional disability of the recipients, as distinct from specific age criteria. Nevertheless, in the absence of more specific information, this Report uses people aged 70 years or over as a proxy for the likelihood of a person in the general population requiring these services. Particular groups (notably Indigenous people) can require various services at a younger age. For Indigenous people, those aged 50 years or over are used as a proxy for the likelihood of requiring aged care services. The Australian Government also uses these age proxies for planning the allocation of aged care places under the Act.

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

Aged Care Assessment Program

The Australian Government established the ACAP in 1984, based on the assessment processes used by State and Territory health services to determine (1) eligibility for admission into residential care and (2) the level of care required. The core objective of the ACAP is to assess the needs of frail older people and assist them to gain access to the most appropriate type of care. Assessment and approval by an ACAT is mandatory for admission to Australian Government subsidised residential care or to receive a CACP, EACH package, EACH-D package or TCP. People can also be referred by the ACAT to other services, such as those funded by the HACC program (although an ACAT referral is not mandatory for receipt of these other services).

State and Territory governments are responsible for the day to day operation and administration of the ACAP, and for provision of the necessary accommodation and support services. The scope and practice of the ACATs differ across and within jurisdictions, partly reflecting the service setting and location (for example, whether the team is attached to a residential service, a hospital or a community service) and this has an effect on program outputs.

The number of assessments of people aged 70 years or over and Indigenous people aged 50-69 years per 1000 target population varied across jurisdictions in 2007-08. The national rate was 86.9 assessments per 1000 people aged 70 years or over and Indigenous people aged 50-69 years. The rate for Indigenous people aged 50 years and over was 36.8 per 1000 Indigenous people aged 50 years or over (figure 13.1).

Figure 13.1 **Aged Care Assessment Team assessment rates, 2007-08**[a, b, c, d, e]

[a] Includes ACAT assessments for all services. [b] 'All people' includes all assessments of people aged 70 years or over and Indigenous people aged 50 years or over per 1000 people aged 70 years or over and Indigenous people aged 50 years or over. [c] 'Indigenous' includes all assessments of Indigenous people aged 50 years or over per 1000 Indigenous people aged 50 years or over. [d] The number of Indigenous assessments is based on self-identification of Indigenous status. [e] See table 13A.39 for further explanation of these data.

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.39.

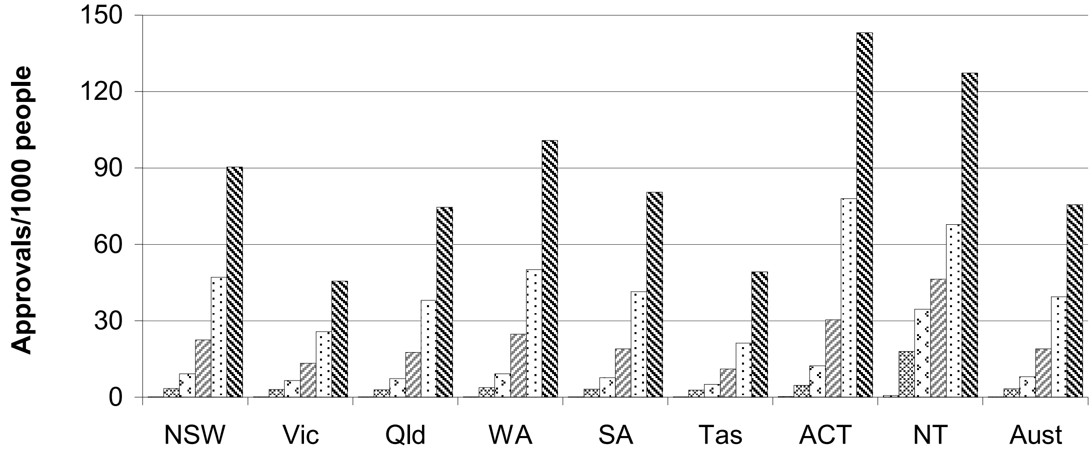
ACAT assessments which result in approvals of eligibility for various types of care can be shown by age-specific rates, for a series of age groups in the population. Data are provided for residential care and for community care (CACP, EACH and EACH-D).

The approval rates for both residential and community care services vary across jurisdictions and increase with age (figure 13.2). These data reflect the numbers of approvals, which are a subset of assessments, as some assessments will not result in a recommendation or an approval for a particular level of care.

Figure 13.2 **Age-specific approval rates, per 1000 people in the population, 2007-08**[a, b]

Permanent residential aged care

Community care (CACP, EACH and EACH-D) programs



---

[a] Population numbers and the proportions of the population for older age groups in the ACT and the NT are smaller than other jurisdictions, and may show variation between years, so results should be interpreted with caution. [b] The age category population data for this table are derived from ABS estimated resident population figures as at 30 June 2008.

Source: DoHA (unpublished); table 13A.40.

The Council of Australian Governments (COAG) has agreed to improve aged care assessment services as part of its national health agenda (box 13.2).

Box 13.2 **Improved performance and streamlining of assessment processes**

In February 2006, COAG agreed to establish an initiative to simplify access to care services for the elderly, people with a disability and people leaving hospital.

The initiative consists of two components:

- ACAP — more timely and consistent assessments for frail older people by ACATs
- simplified entry and assessment processes for the HACC Program.

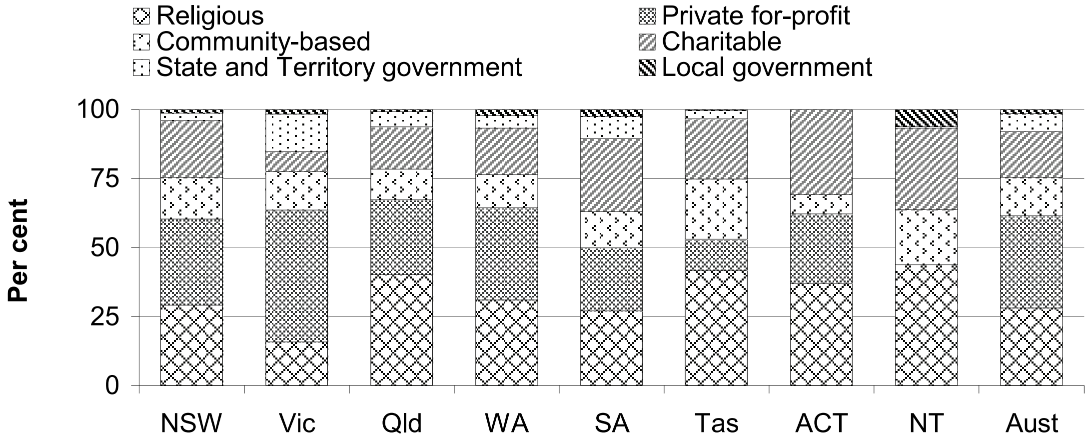
The ACAP component has enabled the implementation of a range of activities to improve the timeliness, quality and consistency of ACAT recommendations, at the national level and with the states and territories. Many of the national and State and Territory activities from earlier years of the measure were continued in 2008-09. Additional initiatives that were implemented include: the capacity for ACATs to electronically submit the Aged Care Client Record to Medicare Australia; the development of the National Training for ACAT Delegates workbook and e-learning site; national workshops to introduce the Delegates workbook and to provide training in administrative law for ACAT by the Senior Commonwealth Lawyer; a project to identify a set of comprehensive clinically validated assessment tools; the conduct of a national ACAP Conference in May 2010; the development of an overarching Implementation Plan for the recommendations of the National Review of ACAT; and improved communication to ACAT by enhancing the format and content of written communications with ACAT nationally. States and territories continue to undertake a range of projects to improve the management and operation of ACATs.

Source: DoHA (unpublished).

Residential care services

Religious and private for-profit organisations were the main providers of residential care at June 2009, accounting for 28.0 per cent and 33.5 per cent respectively of all Australian Government subsidised residential aged care places. Community-based organisations and not-for-profit charitable organisations accounted for a further 13.7 per cent and 16.7 per cent respectively. State, Territory and local governments provided the remaining 8.1 per cent (figure 13.3).

Figure 13.3 **Ownership of operational residential places, June 2009**[a, b]



---

[a] ‘Community-based’ residential services provide a service for an identifiable community based on locality or ethnicity, not for financial gain. [b] ‘Charitable’ residential services provide a service for the general community or an appreciable section of the public, not for financial gain.

Source: DoHA (unpublished); table 13A.4.

The Australian Government is responsible for most of the regulation of Australian Government subsidised residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local governments may also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 13.3).

Box 13.3 Examples of regulatory arrangements for residential services

The Australian Government controls the number of subsidised places. In February 2007, the Australian Government announced an increase in the provision ratio from 108 (adopted in 2004 following a recommendation of the Review of Pricing Arrangements in Residential Aged Care) to 113 operational places per 1000 people aged 70 years or over, to be achieved by June 2011. The proportion of places offered has been adjusted from 20 to 25 places for community care (which includes CACP and EACH packages and other flexible care places), with 4 of these places to be for high level care. In residential care, the provision ratio for high level care was increased from 40 to 44 places, while the ratio for low level residential care was adjusted from 48 to 44 places.

Under the arrangements:

- services are expected to meet regional targets for places for concessional, assisted and supported residents. These targets range from 16 per cent to 40 per cent of places and are intended to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care. (The criteria for being deemed a concessional resident are based on the date of the resident's entry to care, home ownership and occupancy, receipt of income support and the level of assets held at entry. The criteria for being deemed a supported resident is based on the resident's entry date and level of assets held at entry)
- extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted
- to receive an Australian Government subsidy, an operator of an aged care service must be approved under the Aged Care Act as a provider of aged care
- principles (regulations) created under the Aged Care Act establish the obligations of approved providers relating to quality of care and accommodation.

Various Australian, State and Territory laws govern regulatory arrangements for residential care. State and Territory legislation may prescribe matters such as staffing, the dispensing of medication and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, and fire prevention and firefighting measures. Staff wages and conditions are generally set by jurisdiction-based awards., Local government bylaws may also apply (for example, waste disposal rules).

Source: DoHA (unpublished).

Community care services

The main community care programs reported in this chapter — the HACC, CACP and VHC programs — fund services that aim to provide practical assistance to enable frail older people (HACC and CACP), people with disability (HACC) and veterans (VHC) to continue living in, or return to, the community. These services also provide assistance to carers. They are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers. The number of operational places for CACP at 30 June 2009 was 40 195 (table 13A.36). There were 79 691 people approved for VHC services in 2008-09 (table 13A.48) and at least 862 488 HACC clients in 2008-09 (table 13A.33). High level community care is also available in the form of EACH and EACH-D.

Flexibly funded services

Flexible care addresses the needs of care recipients in ways other than that provided through mainstream residential and community care. Flexible care provided under the Aged Care Act includes EACH packages, EACH-D packages, innovative care places, MPS and the TCP. In addition, flexible models of care are provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. These services are funded and operate outside the regulatory framework of the Aged Care Act 1997.

- The EACH program provides high level care to people in their own homes, complementing CACPs, which provide low level care. EACH-D provides high level care in the home to people with complex care needs associated with dementia, as an alternative to high level residential care. There were 4478 operational EACH places and 2036 operational EACH-D places at 30 June 2009 (table 13A.36).
- The Aged Care Innovative Pool is designed to test new approaches to providing aged care. It supports the development and testing of flexible models of service delivery in areas where mainstream aged care services might not appropriately meet the needs of a location or target group. For example, the TCP is built on the lessons learned from two pilot programs developed through the innovative pool, which addressed the interface between aged care and hospital care — the Innovative Care Rehabilitation Services and the Intermittent Care Services (DoHA unpublished).
- The MPS program supports the integration and provision of health and aged care services for small rural and remote communities. At 30 June 2009, there were 126 operational services with a total of 3076 operational flexible aged care places. Some of the MPS serve more than one location (DoHA unpublished).

Transition care services

The TCP provides goal-oriented, time-limited and therapy-focused care to help eligible older people complete their recovery after a hospital stay. The TCP is intended to:

- enable a significant proportion of care recipients to return home, rather than prematurely enter residential care
- optimise the functional capacity of those older people who are discharged from transition care to residential care
- reduce inappropriate extended lengths of hospital stay for older people.

The TCP is jointly funded by the Australian, State and Territory governments. Its operation is overseen by the Transition Care Working Group, which includes representatives from all states and territories and the Australian Government.

Transition care can be provided in either a home-like residential setting or in the community, and targets older people who would otherwise be eligible for residential care. A person may only enter the TCP directly upon discharge from hospital. The average duration of care is 7 weeks, with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks.

The TCP operates with some differences across jurisdictions including differences in service systems, local operating procedures and implementation timetables, which are reflected in national data collections. An evaluation of the impact of the Transition Care Program on clients and systems and its cost effectiveness has been undertaken. Key findings of the evaluation were that functional improvement occurred and that older people who received Transition Care had fewer readmissions to hospital and were less likely to move into permanent residential aged care (DoHA 2008).

Transition care will expand up to 4000 places by 2010-11. At 30 June 2009, the Australian Government had allocated 2698 places to transition care, of which 2228 were operational, amongst 79 services across all jurisdictions. The average length of stay in 2008-09 was 58 days nationally (table 13A.51).

Long Stay Older Patient Initiative

As part of the COAG national health and aged care agenda the Long Stay Older Patient Initiative has been funded since 2006-07 (box 13.4).

Box 13.4 **Long Stay Older Patient Initiative**

From July 2006, a new four-year program commenced to assist older public patients who no longer require acute care or rehabilitation and are in hospital waiting for residential aged care by:

- providing more appropriate care for long-stay older patients in public hospitals, particularly in rural areas
- improving the capacity of rural hospitals to provide more age friendly services, including through making capital improvements such as establishing new multi purpose services
- reducing avoidable or premature admission of older people to hospitals
- assisting older public patients requiring long-term care to take up appropriate care options.

Source: COAG (2006).

Indigenous-specific services

Aboriginal and Torres Strait Islander people access mainstream services under the Aged Care Act, including those managed by Aboriginal and Torres Strait Islander organisations, and services funded outside the Act, including those funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program (the Flexible Program) aims to provide quality, flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and community. Flexible Aged Care services deliver a mix of residential and community aged care services to meet the needs of the community. At 30 June 2009, there were 29 aged care services funded to deliver over 650 flexible aged care places. These services are funded and operate outside the regulatory framework of the Aged Care Act 1997.

Some services managed by non-Indigenous approved providers also have significant numbers of Aboriginal and Torres Strait Islander clients. All aged care services that are funded under the Aged Care Act are required to provide culturally appropriate care. Whether they are located in a community or residential setting, services may be subject to specific conditions of allocation in relation to the proportion of care to be provided to particular groups of people, including Aboriginal and Torres Strait Islander people.

Funding

Recurrent expenditure on aged care services reported in this chapter was $10.1 billion in 2008-09 (table 13.1). Table 13.1 does not include all State and Territory government expenditure, for example, the experimental estimates of expenditure on non-HACC post acute packages of care (table 13A.46), or any Australian Government or State and Territory government capital expenditure (table 13A.73).

Table 13.1 Expenditure on aged care services reported in the Aged care services chapter, 2008-09

Expenditure category	*$ million*
Assessment and information services[a]	93.4
Residential care services[b]	6 653.7
Community care services[c]	2 935.0
Services provided in mixed delivery settings[d]	397.2
Total	**10 079.3**

[a] Assessment and information services include only Australian Government expenditure. [b] Residential care services include DoHA and DVA (including payroll tax supplement) and State and Territory governments expenditure. [c] Community care services include HACC, CACP, EACH and EACH-D, NRCP, Community care grants, VHC, DVA Community Nursing, Assistance with Care and Housing for the Aged. [d] Services provided in mixed delivery settings include the Transition Care Program, MPS and residential ATSI flexible services, Day Therapy Centres, Continence Aids Assistance Scheme, National Continence Management Strategy, Innovative Care Pool and Dementia Education and Support, Long Stay Older Patient Initiative, Community Visitors Scheme and Culturally and Linguistically Diverse expenditure.

Source: Table 13A.43.

Assessment services

There were 116 ACATs (115 Australian Government funded) at 30 June 2009 (DoHA unpublished). In 2008-09, the Australian Government provided funding of $74.5 million nationally for the aged care assessment program (table 13A.43). Australian Government ACAT expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years was $35.3 nationally during 2008-09 (table 13A.52). State and Territory governments also contribute funding for ACATs, but this expenditure is not included in the chapter.

Aged care assessment program activities and costs for 2007-08 are reported in table 13A.59.

Residential care services

The Australian Government provides most of the recurrent funding for residential aged care services. State and Territory governments also provide some funding for public sector beds. Residents provide most of the remaining service revenue, with some income derived from charitable sources and donations.

Australian Government expenditure

Australian Government expenditure on residential aged care was $6.5 billion in 2008-09, comprising DoHA expenditure of $5.5 billion (table 13A.44) and Department of Veterans' Affairs (DVA) expenditure of $959.7 million (table 13A.45).

Australian Government basic subsidy

The Australian Government annual basic subsidy for each occupied place varies according to clients' levels of dependency and includes the Conditional Adjustment Payment (CAP) (box 13.5).

Box 13.5 **Conditional Adjustment Payment**

The CAP was introduced in 2004-05 as part of the Australian Government's initial response to the Review of Pricing Arrangements in Residential Aged Care.

The CAP is intended to provide medium term financial assistance to residential aged care providers, while encouraging them to implement improved management practices. Consequently, providers are only eligible to receive the CAP if they meet certain reporting conditions, such as preparing general purpose financial reports. All but a few providers currently meet these conditions and receive the payment.

The amount of CAP payable in respect of a resident is calculated as a percentage of the basic subsidy amount payable in respect of a resident. In 2004-05 this percentage was 1.75 per cent. It then rose annually in 1.75 per cent increments, to 3.5 per cent in 2005-06; 5.25 per cent in 2006-07; and 7.0 per cent in 2007-08.

In the 2008-09 Budget, the Australian Government provided $407.6 million over four years to increase the level of the CAP to 8.75 per cent ongoing.

Source: DoHA (unpublished).

At June 2009, the average annual subsidy per residential place, including the CAP, was $36 387 nationally (table 13.2). Variations across jurisdictions in average annual subsidies reflect differences in the dependency of residents. Rates for aged care services by the level of high and low care places are in table 13A.5.

Table 13.2 Average annual Australian Government basic subsidy (all levels) per occupied place at June 2009[a]

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Subsidy level (includes CAP)	$	36 903	35 751	35 203	35 721	39 231	35 638	35 658	37 369	36 387

[a] See footnotes to table 13A.5 for further information.

Source: DoHA (unpublished); table 13A.5.

The dependency levels of all residents are at table 13.3. Each resident has a dependency level for each of three domains. These dependency levels vary across jurisdictions. These data, categorised by the proportion of high and low care places provided are included in table 13A.5.

Table 13.3 Dependency levels of permanent residents, June 2009[a, b]

		NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportions of residents										
Aged Care Funding Instrument										
Activities of daily living										
High	%	34.9	32.7	31.6	32.8	35.3	31.2	31.3	41.0	34.0
Medium	%	27.8	31.5	27.1	31.4	25.7	29.0	28.5	24.8	28.0
Low	%	27.8	26.8	30.6	26.8	32.6	28.7	31.6	28.6	28.8
Nil	%	9.5	9.0	10.7	9.1	6.3	11.2	8.6	5.7	9.2
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Behaviours										
High	%	37.9	37.1	31.8	39.2	45.4	26.9	38.6	24.0	37.1
Medium	%	24.7	26.3	24.9	25.3	26.5	22.8	24.9	30.2	25.3
Low	%	22.1	22.5	24.5	22.1	18.8	26.7	22.1	29.9	22.5
Nil	%	15.2	14.2	18.8	13.5	9.3	23.6	14.4	15.9	15.1
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Complex health care										
High	%	12.9	13.0	10.3	10.6	17.6	13.6	11.3	10.0	12.7
Medium	%	28.2	28.3	24.0	28.7	30.4	23.7	27.1	21.8	27.6
Low	%	39.6	40.4	42.3	42.8	38.5	41.2	41.5	44.5	40.5
Nil	%	19.4	18.2	23.5	18.0	13.5	21.5	20.0	23.7	19.2
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Numbers of residents										
Total High	no.	40 428	28 993	20 751	9 524	12 284	2 931	1 138	309	116 358
Total Low	no.	15 253	13 023	8 246	3 995	3 449	1 269	564	105	45 904
All High/Low	**no.**	**55 681**	**42 016**	**28 997**	**13 519**	**15 733**	**4 200**	**1 702**	**414**	**162 262**

[a] See footnotes to table 13A.5 for further information. [b] Totals may not add as a result of rounding.

Source: DoHA (unpublished); table 13A.5.

State and Territory government recurrent expenditure

State and Territory government expenditure has been collected for three categories of residential care expenditure (adjusted subsidy reduction supplement, enterprise bargaining agreement supplement, and rural small nursing home supplement). Reported expenditure in these three categories was $179.7 million in 2008-09 (table 13A.46).

Capital expenditure

The Australian Government provided $40.6 million in 2008-09 to fund an ongoing program of targeted capital assistance to residential aged care services. This assistance is provided to services that, as a result of their rural or remote location or because the services target financially disadvantaged people, are unable to meet the cost of necessary capital works from the income they receive through resident accommodation payments and the general capital component of Australian Government recurrent funding (table 13A.73). In addition, capital expenditure by some State and Territory governments on residential aged care services in 2008-09 was $88.1 million (table 13A.73).

Capital expenditure on aged care services in 2008-09 is summarised in table 13A.73. These capital funds are in addition to the funding reported in table 13.1, which is total recurrent expenditure.

Community care services

Following is a summary of expenditure on community care programs. More detailed data is found in the attachment tables referenced. Data on Australian Government expenditure per person in the target population by jurisdiction are contained in table 13A.52. Recipients of community care services can also contribute towards the cost of their care.

Expenditure on HACC, CACP, NRCP and DVA programs

Total government expenditure on HACC was $1.8 billion in 2008-09, consisting of $1.1 billion from the Australian Government and $698.2 million from the State and Territory governments. The Australian Government contributed 61.0 per cent, while State and Territory governments funded the remainder (table 13A.49). Recipients of HACC services can also contribute towards the cost of these services.

The Australian Government funds the CACP program, spending $479.7 million on the program in 2008-09 (table 13A.47). CACPs are also part funded by client contributions. The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was $193.3 million in 2008-09 (table 13.4). The NRCP assisted 127 504 people in 2008-09 (table 13A.36). A disaggregation of Australian Government expenditure on the NRCP by State and Territory is reported in table 13.4.

Table 13.4 **Australian Government expenditure, National Respite for Carers Program, 2008-09 ($million)**[a, b, c, d, e]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*National*	*Aust*
Commonwealth Carer Respite Centres										
	16.9	12.3	11.0	5.0	4.7	2.4	1.1	1.5	na	54.9
Respite services										
	39.1	27.7	21.3	10.2	10.3	3.6	2.9	3.1	na	118.2
Demonstration day respite										
	2.0	1.3	1.3	1.2	1.3	0.7	–	0.5	1.0	9.2
National projects										
	–	–	–	–	–	–	–	–	11.0	11.0
Total	**58.0**	**41.3**	**33.7**	**16.4**	**16.3**	**6.6**	**4.0**	**5.0**	**12.0**	**193.3**

[a] Commonwealth Carer Respite Centres coordinate respite services, help carers access them, and arrange individual respite when needed. [b] Respite services reports funding for services directly providing respite care. [c] Demonstration day respite will add an extra 62 400 days of respite for carers of frail older people over the next four years. [d] National project is for Carers Australia. [e] Totals may not add as a result of rounding. **na** Not available. – Nil or rounded to zero.

Source: DoHA (unpublished); table 13A.47.

The DVA also provided $101.8 million for the VHC program and $106.0 million for the Veterans Community Nursing program during 2008-09 (table 13A.48). VHC recipients can also contribute towards the cost of these services.

Flexibly funded services

The Australian Government funds the EACH and EACH-D programs, spending $172.7 million and $83.6 million respectively on these programs in 2008-09 (table 13A.47). EACH and EACH-D packages are also part funded by client contributions.

The Australian, State and Territory governments fund the TCP. In 2008-09, the Australian Government spent $76.1 million and the State and Territory governments spent $74.8 million on TCP (table 13A.51). The Australian Government also funds the MPS program and Indigenous specific services. In 2008-09, $95.0 million and $23.0 million were spent on these programs, respectively (table 13A.50).

Services in mixed delivery settings

Australian Government expenditure data by jurisdiction on a range of other services provided in mixed delivery settings targeting older people are contained in table 13A.50. Australian Government expenditure on these programs was $113.7 million in 2008-09. These programs include Day Therapy Centres, Continence Aids Assistance Scheme, the National Continence Management Strategy, Dementia Education and Support, Community Visitors Scheme, Innovative Care Pool, Culturally and Linguistically Diverse aged care (CALD) and Indigenous specific services, (table 13A.50). In addition, Australian Government expenditure on the Long Stay Older Patient Initiative (see box 13.4) was $37.5 million in 2008-09 (table 13A.50).

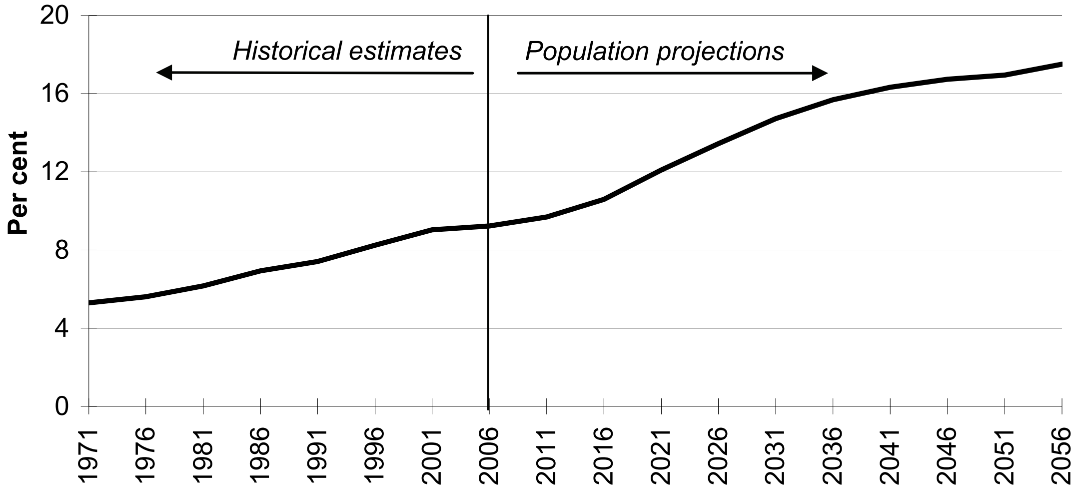
Size and scope of sector

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 13.4). The proportion of older people is 9.5 per cent nationally but varies across jurisdictions (figure 13.5). A disaggregation by remoteness categorisation is provided in table 13A.3. Higher life expectancy for females resulted in all jurisdictions (except the NT, where the rate was similar) having a higher proportion of older females than older males in the total population (table 13A.1).

Demographic profiles affect the demand for aged care services because females use aged care services (particularly residential services) more than males. Females are more likely to use residential services partly because they tend to live longer (that is, there are more women than men in the older population) and they are less likely to have a partner to provide them with care.

Figure 13.4 **People aged 70 years or over as a proportion of the total population**[a]



---

[a] Population projections are derived from the ABS 'B' series population projections.

Source: ABS *Australian Historical Population Statistics, 2008*, Cat. no. 3105.0.65.001, Canberra; ABS *Population Projections Australia 2006–2101*, Cat. no. 3222.0, Canberra.

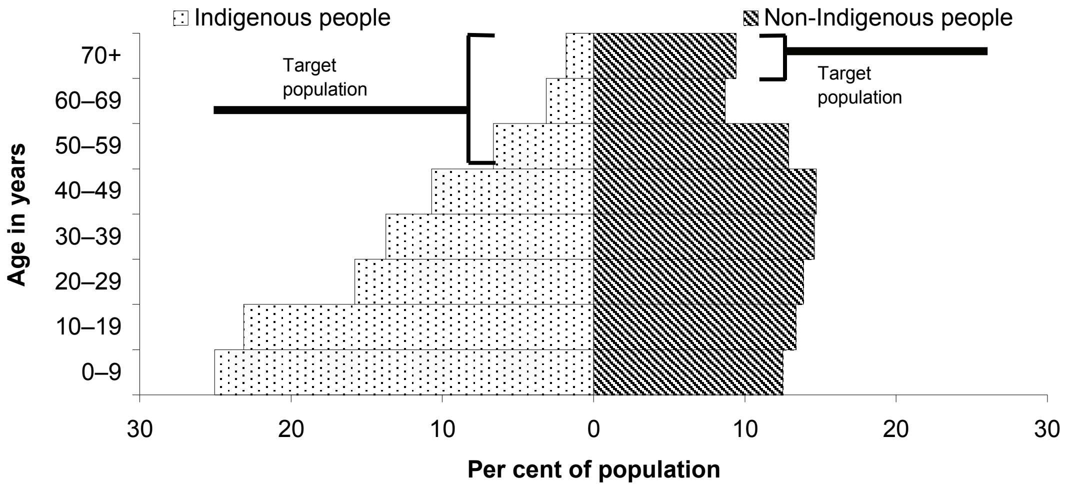
Figure 13.5 **Estimated proportion of population aged 70 years or over, by gender, June 2009**

Source: Population projections prepared by the ABS using preliminary rebased estimated resident populations based on the 2006 Census according to assumptions agreed to by the Treasury and Department of Health and Ageing (unpublished); table 13A.1.

Characteristics of older Indigenous people

The DoHA estimates that about 65 300 Indigenous people were aged 50 years or over in Australia at 30 June 2009 (table 13A.2). Although the Indigenous population is also ageing, there are marked differences in the age profile of Indigenous Australians compared with non-Indigenous Australians (figure 13.6). Estimates show life expectancy at birth in the Indigenous population is around 11.5 years less for males and 9.7 years less for females when compared to the total Australian population (ABS 2009). These figures indicate that Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 13.6 **Age profile and target population differences between Indigenous and other Australians, June 2006**



Source: ABS *Experimental Estimates of Aboriginal and Torres Strait Islander Australians*, June 2006, Cat no. 3238.0.55.001, Canberra.

Residential care services

The size and location of residential services — which can influence the costs of service delivery — vary across jurisdictions. Nationally, there were 175 225 mainstream operational places in residential care services (75 145 in predominantly high care services, at least 5568 in predominantly low care services and 94 512 in services with a mix of high care and low care residents) at June 2009 (tables 13A.6–9). These figures exclude flexible care places in a residential setting.

Low care services are generally smaller (as measured by number of places) than high care services. At June 2009, 60.5 per cent of low care services had 60 or fewer places (table 13A.8), compared with 39.7 per cent of high care services (table 13A.7).

As the trend towards 'ageing in place' in residential care (box 13.6) increases, there has been a steady increase in the number of services with a mix of high care and low care residents. In June 2005, 39.6 per cent of all places were located in services offering both high care and low care places. This proportion increased to 53.9 per cent in June 2009 (table 13A.10).

Box 13.6 **Ageing in place in residential care**

In its Objects, the Aged Care Act aims to:

> *... encourage diverse, flexible and responsive aged care services that:*
>
> *(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and*
>
> *(ii) facilitate the independence of, and choice available to, those recipients and carers.*

Further, the Aged Care Act explicitly aims to encourage and facilitate 'ageing in place'. The Act does not define 'ageing in place', but one useful definition is 'the provision of a responsive and flexible care service in line with the person's changing needs in a familiar environment'. In effect, 'ageing in place' refers to a resident remaining in the same residential aged care service as his or her care needs increase from low level to high level. This is changing the profile of people in services.

The Aged Care Act does not establish any 'program' or require any residential aged care service to offer ageing in place. Rather, it creates the opportunity for providers to choose to provide the full continuum of care, by removing the legislative and administrative barriers that prevented this outcome in the past.

The concept of 'ageing in place' is linked to the outcomes of increasing choice and flexibility in residential aged care service provision. These are difficult outcomes to measure. Data on 'ageing in place' is reported for the indicator 'intensity of care'.

Source: DoHA (unpublished).

The combined number of all operational high care and low care residential places per 1000 people aged 70 years or over at June 2009 was 86.9 (42.6 high care and 44.2 low care) on a national basis (table 13.5). Nationally, the proportion of low care places relative to high care places has remained constant between 2005 to 2009 (table 13A.11).

Table 13.5 Operational high care and low care residential places, 30 June 2009[a, b, c, d, e]

	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.	45.0	41.2	39.5	37.3	49.4	45.2	33.2	54.3	42.6
Low care places	no.	42.3	46.8	45.1	44.0	44.3	41.1	39.7	43.3	44.2
Total places	**no.**	**87.3**	**88.0**	**84.6**	**81.3**	**93.7**	**86.3**	**72.9**	**97.6**	**86.9**
Proportion of places										
High care places	%	51.5	46.9	46.7	45.8	52.8	52.4	45.5	55.6	49.1
Low care places	%	48.5	53.1	53.3	54.2	47.2	47.6	54.5	44.4	50.9

[a] Excludes places that have been ‘approved’ but are not yet operational. Includes multi-purpose and flexible services attributed as high care and low care places. [b] For this Report, Australian Government planning targets are based on providing 113 residential places per 1000 people aged 70 years or over. In recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). [c] Includes residential places categorised as high care or low care. [d] See table 13A.11 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2008-09. [e] Data in this table may not add due to rounding

Source: DoHA (unpublished); table 13A.11.

During 2008-09, the numbers of people (of all ages) who used permanent residential care services was 211 332 nationally (including both high and low care) and 41 864 nationally for respite residential care. These figures reflect the number of individuals who utilised these services during the year, for any length of time, rather than the number of places available (table 13A.72).

Age specific usage rates for these services, by jurisdiction and remoteness, at 30 June 2009 are included in tables 13A.62, 13A.64-65 and 13A.67 respectively. Indigenous usage by remoteness category is identified in table 13A.68.

Community care services

Services provided under the HACC program include domestic assistance, home maintenance, personal care, food services, respite care, transport, allied health care and community nursing (box 13.7).

Box 13.7 **Home and Community Care Services**

Home and Community Care (HACC) services are basic maintenance and support services, including allied health care, assessment, case management and client care coordination, centre-based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, personal and respite care, social support, meals, home modification, linen service, goods and equipment, and transport.

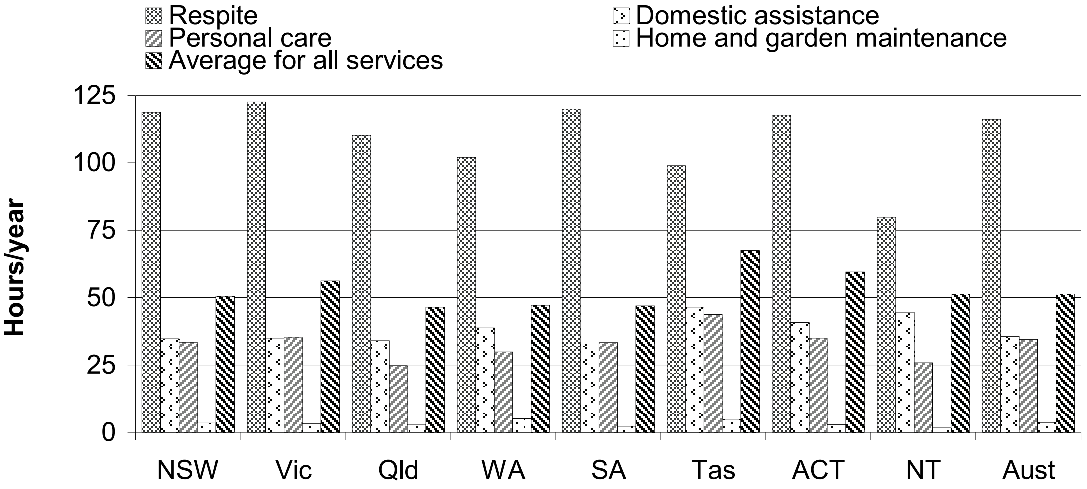
Not all HACC services are directed towards the ageing population described in this chapter. The HACC target population is defined as people living in the community who are at risk, without these services, of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with disability. Carers may also receive HACC services.

Over 69 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 disability and their carers, with 11.0 per cent of recipients under 50 years of age (table 13A.34). (Chapter 14 reports on services for people with disability, which manifests before the age of 65 years, that were provided under the Commonwealth State/Territory Disability Agreement) and the National Disability Agreement from 1 January 2009.

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 79 691 people approved for VHC services in 2008-09 (table 13A.48). The program offers veterans and war widows/widowers who hold a Gold or White Repatriation Health Card home support services, including domestic assistance, personal care, home and garden maintenance, and respite care.

Eligibility for VHC services is not automatic, but based on assessed need. The average number of hours provided per year for veterans who were eligible to receive home care services was 51.3 nationally in 2008-09 (figure 13.7).

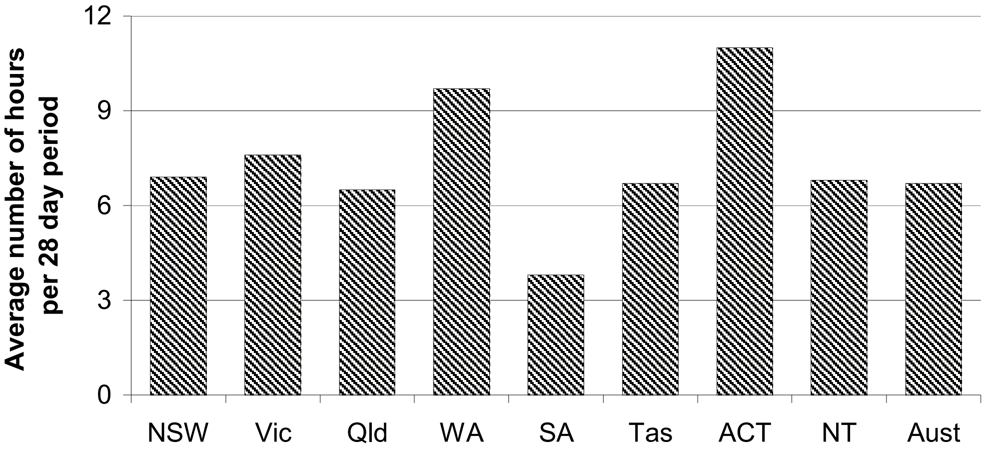
Figure 13.7 Average number of hours approved for Veterans' Home Care, 2007-08



Source: DVA (unpublished); table 13A.48.

The DVA also provides community nursing services to veterans and war widows/widowers. These services include acute/post acute, support and maintenance, personal care, medication management and palliative care. In 2008-09, 32 320 veterans received these services (table 13A.48), and the average number of hours provided for each recipient was 6.7 nationally per 28 day period (figure 13.8).

Figure 13.8 Average number of hours provided for DVA Community Nursing, 2008-09



Source: DVA (unpublished); table 13A.48.

Provision of CACPs is an alternative home-based service for older people assessed by ACATs as eligible for care equivalent to low level residential care. A CACP typically provides 5 to 6 hours of direct assistance per week. The EACH program is similar to the CACP program but targets people who would be eligible for high level residential aged care. An EACH package typically provides 15 to 20 hours of direct assistance each week. The main distinctions between the HACC, CACP, EACH and EACH-D programs are summarised in table 13.6.

Table 13.6 **Distinctions between the HACC, CACP, EACH and EACH-D programs**

	HACC	*CACPs*	*EACH and EACH-D*
Range of services[a]	Wider range of services available	Narrower range of services available	Narrower range of services available
Relationship to residential care	Aims to prevent premature or inappropriate admission	Substitutes for a low care residential place	Substitutes for a high care residential place
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory	ACAT assessment mandatory
Funding	Cost shared by the Australian, State and Territory governments and client contributions	Funded by the Australian Government and client contributions	Funded by the Australian Government and client contributions
Target client groups[b]	Available to people with profound, severe and moderate disability and their carers. Not age specific	Targets older people with care needs similar to low level residential care	Targets older people with care needs similar to high level residential care
Size of program	$1.79 billion funding in 2008-09 At least 862 488 clients in 2008-09[c]	$479.7 million funding in 2008-09 40 195 operational places in 2008-09	$256.3 million funding in 2008-09 6514 operational places in 2008-09

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care, for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have needs that would exceed the level available under CACPs and EACH. [c] The proportion of HACC funded agencies that submitted Minimum Data Set data for 2008-09 differed across jurisdictions and ranged from 81 per cent to 100 per cent. Consequently, the total number of clients will be higher than those reported.

Source: DoHA (unpublished); tables 13A.33, 13A.36, 13A.47 and 13A.49.

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, EACH and EACH-D programs have become increasingly important components of the aged care system. During 2008-09, the HACC program delivered approximately 12 830 hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years (table 13A.21). The total number of CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2005 and June 2009, from 16.0 to 19.4 (table 13A.12).

The number of clients (of all ages) nationally for a range of community services are included in table 13.7. These figures reflect the number of individuals who utilised these services during the year, for any length of time, rather than the number of places available.

Combined residential and community care services rates

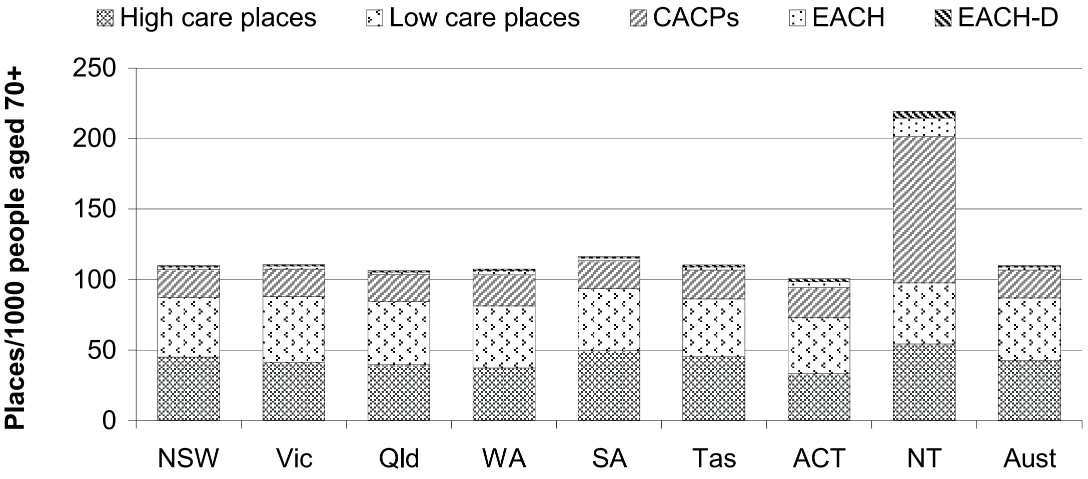
The combined number of high care residential places, low care residential places, CACPs, flexible care places excluding Transition Care places, and places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program at 30 June 2009, was 110.0 per 1000 people aged 70 years or over (figure 13.9). Transition Care places add an additional 1.1 packages per 1000 people aged 70 years or over (table 13A.11). The Australian Government's targets for the provision of residential and community care places are outlined in box 13.4.

Table 13.7 **Number of clients, aged care programs, 2008-09**

Program	*Number of clients*
Residential Care – Permanent	211 322
Residential Care – Respite	41 864
CACP	54 354
EACH	6 449
EACH-D	3 296
TCP	12 631
HACC	862 488

Source: DoHA (unpublished); table 13A.72.

Figure 13.9 **Operational residential places, CACPs, EACH and EACH-D packages, 30 June 2009**[a, b, c, d, e, f, g, h]

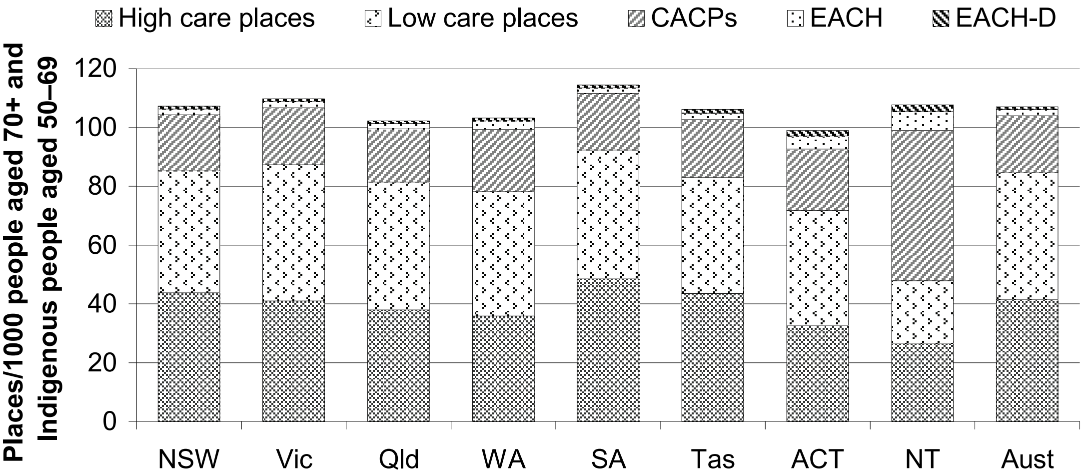


[a] Excludes places that have been approved but are not yet operational. [b] Ageing in place may result in some low care places being filled by high care residents. [c] For this Report, Australian Government planning targets are based on providing 113 places per 1000 people aged 70 years or over by 2011. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). [d] Includes residential places categorised as high care or low care. [e] CACPs, EACH and EACH-D packages are not residential services but are included in the Australian Government planning targets (see boxes 13.2 and 13.4 for an interpretation of residential care data and Australian Government planning targets). [f] CACPs include community care places under the National Aboriginal and Torres Strait Islander Aged Care Program, Multipurpose Services and Innovative Care. [g] TCP are not shown. [h] See table 13A.11 for further information regarding the calculation of provision ratios.

Source: DoHA (unpublished); table 13A.11.

The number of operational places can also be shown using the target population that incorporates Indigenous people aged 50–69 years (figure 13.10). Use of this ‘adjusted’ target population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Figure 13.10 Operational residential places, CACPs, EACH and EACH-D packages adjusted for Indigenous people aged 50–69, 30 June 2009[a, b, c, d, e, f, g]



---

[a] Excludes places that have been approved but are not yet operational. [b] Ageing in place may result in some low care places being filled by high care residents. [c] CACPs, EACH and EACH-D packages are not residential services but are included in the Australian Government planning targets (boxes 13.2 and 13.4 contain an interpretation of residential care data and Australian Government planning targets). [d] Includes residential places categorised as high care or low care [e] CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas with a high Indigenous population (such as the NT) may have a higher proportion of CACPs. [f] CACPs include community care places under the National Aboriginal and Torres Strait Islander Aged Care Program, Multipurpose Services and Innovative Care. [g] TCP places are not shown (table 13A.12).

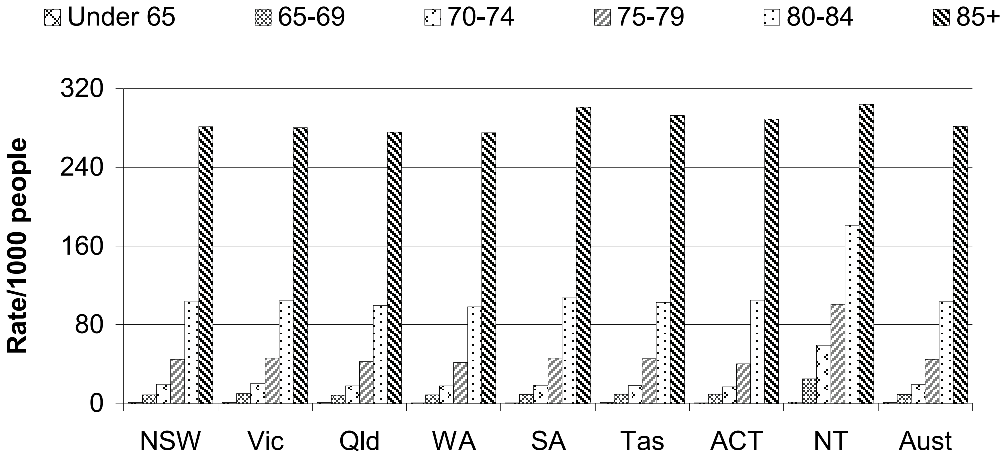
Source: DoHA (unpublished); table 13A.12.

Age-specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage, at 30 June 2009 are reported in tables 13A.62 to 13A.68.

Presentation of age-specific usage rates raises particular data issues. In particular, if the numbers of people within a particular range for a given service are small, this can lead to apparently large fluctuations in growth rates. This can be seen from some of the usage rates identified for the EACH and EACH-D programs, which, whilst growing rapidly, are doing so from a relatively small base.

The national age specific usage rates per 1000 people for high and low residential care, CACP, EACH and EACH-D in combination at 30 June 2009 is 0.5 for people under 65 years of age and 281.7 for people aged 85 years or older. These rates vary across jurisdictions (figure 13.11).

Figure 13.11 Permanent aged care residents, CACP, EACH and EACH-D recipients at 30 June 2009: age specific usage rates per 1000 people[a, b]



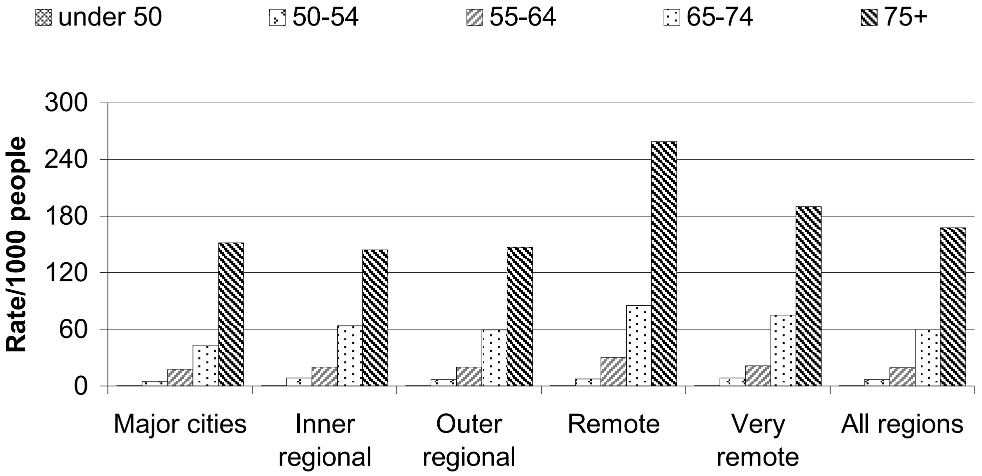
---

[a] Population data for June 2009 are population projections by SLA for 2007–2027 based on the 2006 Census prepared for DoHA by ABS according to assumptions agreed to by DoHA (see table 13A.2). [b] These figures exclude places funded by multi-purpose services and those provided by flexible funding under the Aboriginal and Torres Strait Islander Aged Care Program.

Source: DoHA (unpublished); table 13A.64.

The national age specific usage rates per 1000 Indigenous people for high and low residential care, CACP, EACH and EACH-D in combination at 30 June 2009 is 0.2 for people aged under 50 years and 167.7 for people aged over 75 years. The data show that Indigenous people tend to access these services at a younger age than the population as a whole. These rates vary by remoteness category (figure 13.12).

Figure 13.12 Indigenous permanent residents classified as high or low care and Indigenous CACP, EACH and EACH-D at 30 June 2009: age specific usage rates per 1000 people by remoteness[a, b, c, d]



[a] Geographical data are based on the ABS Australian Standard Geographic Classification of Remoteness Areas. Data are classified according to an index of remoteness which rates each ABS census district based on the number and size of towns, the distance to major towns and urban centres. See table 13A.2 for more detail. [b] Historical rates in this figure may differ from those in previous Reports, as historical population data have been revised using Final Rebased Estimated Resident Population (ERP) data following the 2006 Census of Population and Housing (for 31 December 2002 to 2006). Similarly, new ABS Indigenous population estimates and projections have been used. [c] Includes residential places categorised as high care or low care [d] These figures exclude places and packages funded by Multi-purpose services and those provided by flexible funding under the Aboriginal and Torres Strait Islander Flexible Aged Care Program.

Source: DoHA (unpublished); table 13A.68.

13.2 Framework of performance indicators

The framework of performance indicators aims to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the general performance indicator framework and service process diagram outlined in chapter 1 (see figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicators relate to government objectives in the aged care sector (box 13.8).

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

The measurement details of relevant National Agreement reporting were under development at the time of preparing this Report. It is anticipated that the performance indicator results reported in this chapter will be revised to align with the performance indicators in the National Agreements for the 2011 Report.

Box 13.8 **Objectives for aged care services**

The aged care system aims to promote the wellbeing and independence of frail older people and their carers through the funding and delivery of care services that are:

- accessible
- appropriate to needs
- high quality
- efficient.

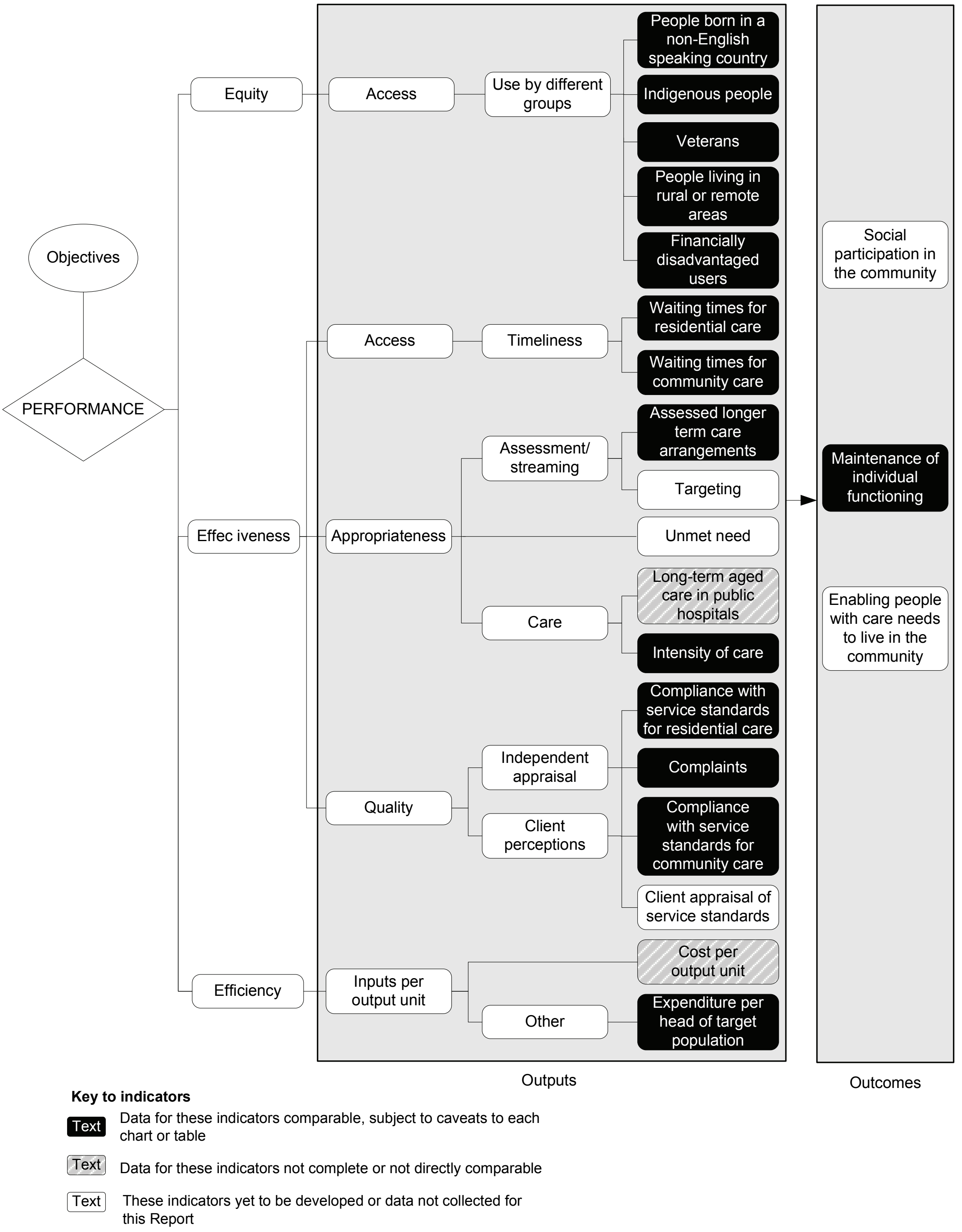
The performance indicator framework shows which data are comparable in the 2010 Report (figure 13.13). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

13.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of aged care services.

Appendix A contains 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).

Figure 13.13 **Performance indicators for aged care services**



Outputs

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

Equity — Access

Use by different groups

'Use by different groups' is an indicator of governments' objective for the aged care system to provide equitable access to aged care services for all people who require these services (box 13.9).

Box 13.9 **Use by different groups**

'Use by different groups' is defined as:

- the number of people born in non-English speaking countries using residential services, CACPs, EACH, EACH-D and HACC services, divided by the number of people born in non-English speaking countries aged 70 years or over, benchmarked against the rate at which the general population (number of people aged 70 years or over plus Indigenous people aged 50–69 years) accesses the service
- the number of Indigenous people using residential services, CACP, EACH, EACH-D and HACC services, divided by the number of Indigenous people aged 50 years or over (because Indigenous people tend to require aged care services at a younger age than the general population) benchmarked against the rate at which the general population (number of people aged 70 years or over plus Indigenous people aged 50–69 years) accesses the service
- the rate of contacts with Commonwealth Carelink Centres for Indigenous people benchmarked against the rate for all people
- the number of veterans aged 70 years and over in residential care divided by the total number of eligible veterans aged 70 years and over, where a veteran is defined as a DVA Gold or White card holder
- access to HACC services for people living in rural or remote areas — the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years for major cities, inner regional areas, outer regional areas, remote areas and very remote areas
- the number of new residents classified as concessional or assisted or supported, divided by the number of new residents.

(Continued on next page)

Box 13.9 **(Continued)**

In general, usage rates for special needs groups similar to those for the broader aged care population are desirable, but interpretation of results differs for some special needs groups because:

- there is evidence that Indigenous people have higher disability rates than those of the general population, which suggests a greater level of need for services compared with those in the broader aged care population
- for financially disadvantaged users, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional, assisted or supported residents. These targets range from 16 per cent to 40 per cent of places, depending on the service's region. Usage rates equal to, or higher than, the minimum rates are desirable.

Use by different groups is a proxy indicator of equitable access. Various groups are identified by the Aged Care Act and its principles (regulations) as having special needs, including people from Indigenous communities, people born in non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans (including widows and widowers of veterans).

Several factors need to be considered in interpreting the results for this set of indicators:

- Cultural differences may influence the extent to which people born in non-English speaking countries use different types of services.
- Cultural differences and geographic location may influence the extent to which Indigenous people use different types of services.
- The availability of informal care and support may influence the use of aged care services in different population groups.

Data to report on veterans for this indicator has been included for the first time.

Data reported for this indicator are comparable.

Data presented for this indicator are organised by the type of service provided, with sub-sections for the relevant special needs groups reported against that service.

Access to residential care services, CACP and HACC services by Indigenous people and people born in a mainly non-English speaking country

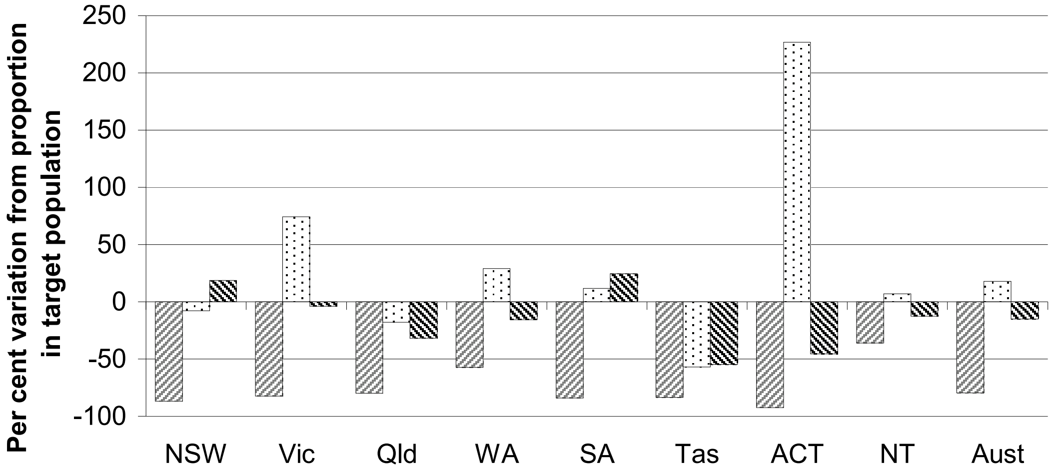
In general, Indigenous people and people born in a mainly non-English speaking country are under-represented in some aspects of access to residential care, CACP and HACC services in comparison to their proportion of the target population as a whole.

However, in relation to the CACP program in the majority of jurisdictions and nationally, Indigenous people and people born in a mainly non-English speaking country are over-represented, compared to the proportion of this group in the target population. Figure 13.14 demonstrates this over- and under-representation by reflecting the variation in the rate of access of the special needs target population from their proportion in the target population as a whole. If the special needs group accessed services in proportion to their general representation in the target population, no percentage variation would be observed. If they access services at a greater rate, a positive percentage from the benchmark rate will be observed, or, if services are accessed at a lower rate, the bar will be negative (figure 13.14).

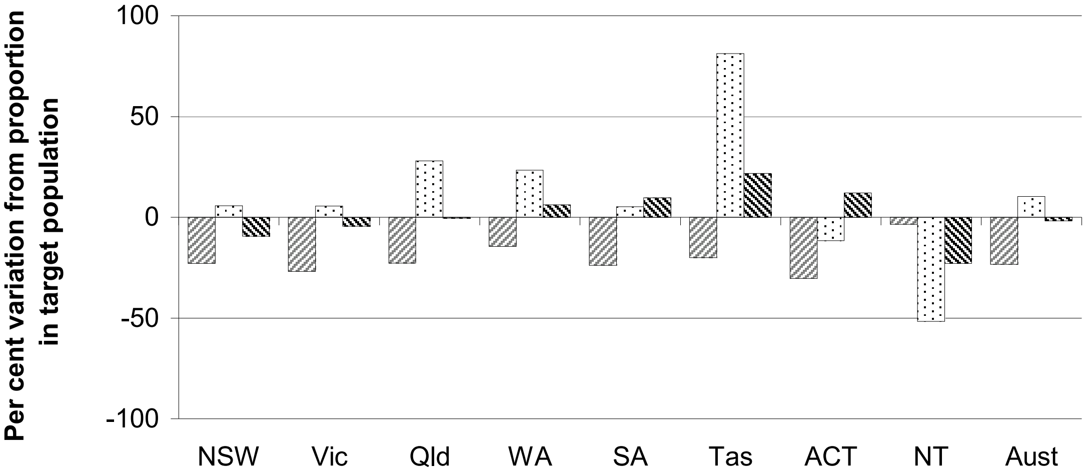
Figure 13.14 **Variation in the proportions of special needs target populations accessing aged care services from their proportion in the target population as a whole, June 2009**[a, b]

▨ Aged care residents ⁙ CACP recipients ▧ HACC recipients

Proportion of Indigenous people aged 50 years or over receiving services[c]



Proportion of people born in a mainly non-English speaking country aged 70 years or over receiving services



---

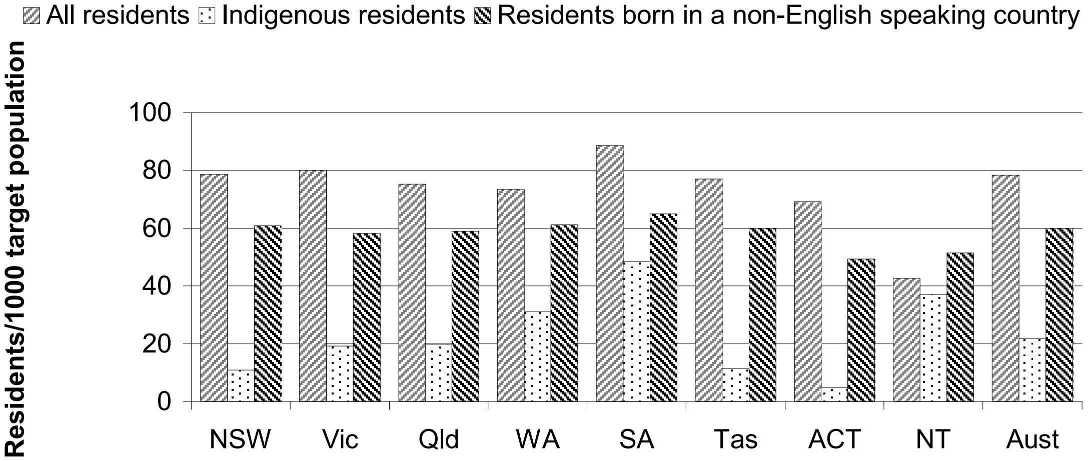
[a] The proportion of HACC funded agencies that submitted Minimum Data Set data for 2008-09 differed across jurisdictions and ranged from 89 per cent to 100 per cent. Consequently, actual service levels were higher than stated. [b] Reports provisional HACC data that have not been validated and may be subject to revision. [c] The ACT has a very small Indigenous population aged 50 years or over (table 13A.2) and a small number of packages result in a very high provision ratio.

Source: DoHA (unpublished); table 13A.19.

Access to residential aged care services by Indigenous people and people born in a mainly non-English speaking country

In all jurisdictions at 30 June 2009, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services (21.7 and 60.0 per 1000 of the relevant target populations respectively), compared with the population as a whole (78.4 per 1000) (figure 13.15).

Figure 13.15 **Residents per 1000 target population, 30 June 2009**[a, b, c]



[a] 'All residents' data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. [b] 'Indigenous residents' data are per 1000 Indigenous people aged 50 years or over. [c] Data for residents from a non-English speaking country are per 1000 people from non-English speaking countries aged 70 years or over.

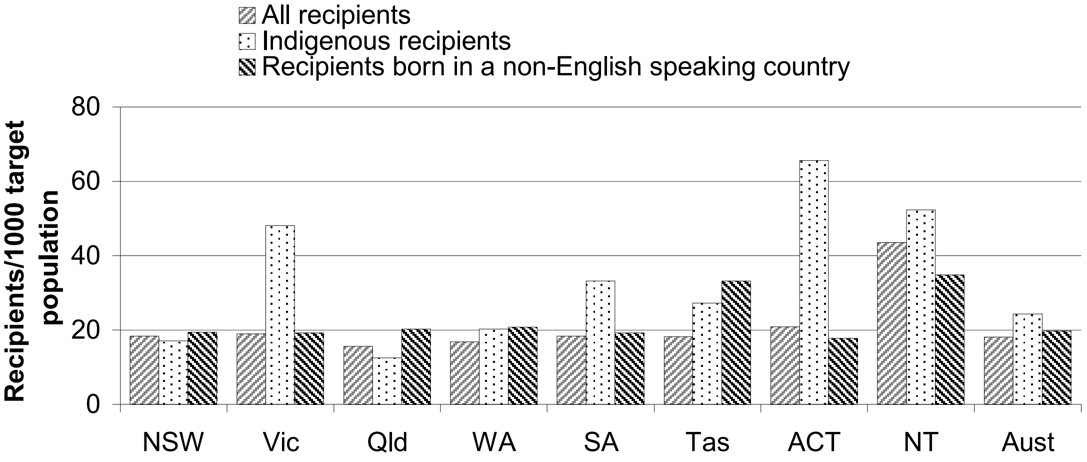
Source: DoHA (unpublished); tables 13A.13, 13A.15 and 13A.17.

Age specific usage rates for these services, by jurisdiction and remoteness are included in the Report. These data suggest there is significant variation in usage rates by remoteness area. In general, differences amongst jurisdictions are less marked than differences between remoteness areas (tables 13A.14, 13A.16, 13A.18, 13A.62, 13A.64-65, 13A.67-68).

Access to aged care community programs by Indigenous people and people born in a mainly non-English speaking country

The number of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over was 24.3 nationally and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 19.7 nationally. These figures compare to a total of 18.1 per 1000 of the target population (people aged 70 years or over plus Indigenous people aged 50–69 years) (figure 13.16).

Figure 13.16 **Community Aged Care Package recipients per 1000 target population, 30 June 2009**[a, b, c, d, e]



---

[a] ‘All recipients’ data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. [b] ‘Indigenous recipients’ data are per 1000 Indigenous people aged 50 years or over. [c] Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 70 years or over. [d] The ACT has a very small Indigenous population aged 50 years or over (table 13A.2), and a small number of packages result in a very high provision ratio. [e] CACPs provide a more flexible model of care, more suitable to remote Indigenous communities, so areas such as the NT have a higher rate of CACP recipients per 1000 people.

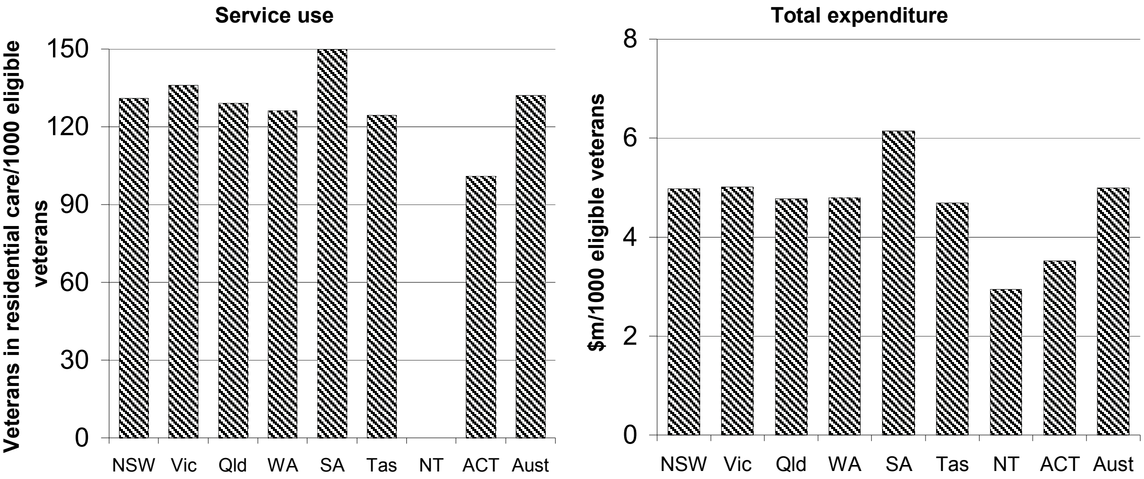
Source: DoHA (unpublished); tables 13A.13, 13A.15 and 13A.17.

Age–sex specific usage rates by jurisdiction, remoteness and Indigenous usage vary between jurisdictions and remoteness categories for CACP. For EACH and EACH-D, the differences are less marked. However, the EACH and EACH-D programs are small and growing rapidly (tables 13A.63-64 and 13A.66–68).

Access by veterans

The total number of veterans 70 years and over who were in the DVA treatment population at 30 June 2009 was 192 267. (table 13A.45) The number of veterans 70 years and over in residential care per 1000 eligible veterans 70 years and over at 30 June 2009 was 132.1 (figure 13.17). Nationally, total DVA expenditure for veterans 70 years and over was $467.3 (table 13A.45).

Figure 13.17 **Number of veterans aged 70 years and over in residential care and total expenditure on veterans aged 70 years and over per 1000 eligible veterans 70 years and over, 2008-09**[a, b, c, d]



[a] Data are subject to lag and may be subject to revision. [b] Number of veterans is the number of DVA Gold and White card holder residents as at June 2009. [c] Clients' data from the NT have been included with SA data due to the small number of clients. [d] Veterans 70 years and over includes those whose age is unknown.

Source: DVA (unpublished); DoHA (unpublished); table AA.26; table 13A.45.

Access to the HACC program

HACC services are provided in the client's home or community for people with a moderate, severe or profound disability and their carers. The focus of this chapter is all people 70 years or over and Indigenous people aged 50–69 years. The proportion of HACC recipients aged 70 years or over during 2008-09 was 69.1 per cent (table 13A.33).

The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years was 12 830 nationally, and the number of meals provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 was 5001 nationally (table 13.8). The proportion of HACC agencies that submitted the data vary across jurisdictions and comparisons between jurisdictions should be made with care.

Table 13.8 HACC services received, 2008-09 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)[a, b, c]

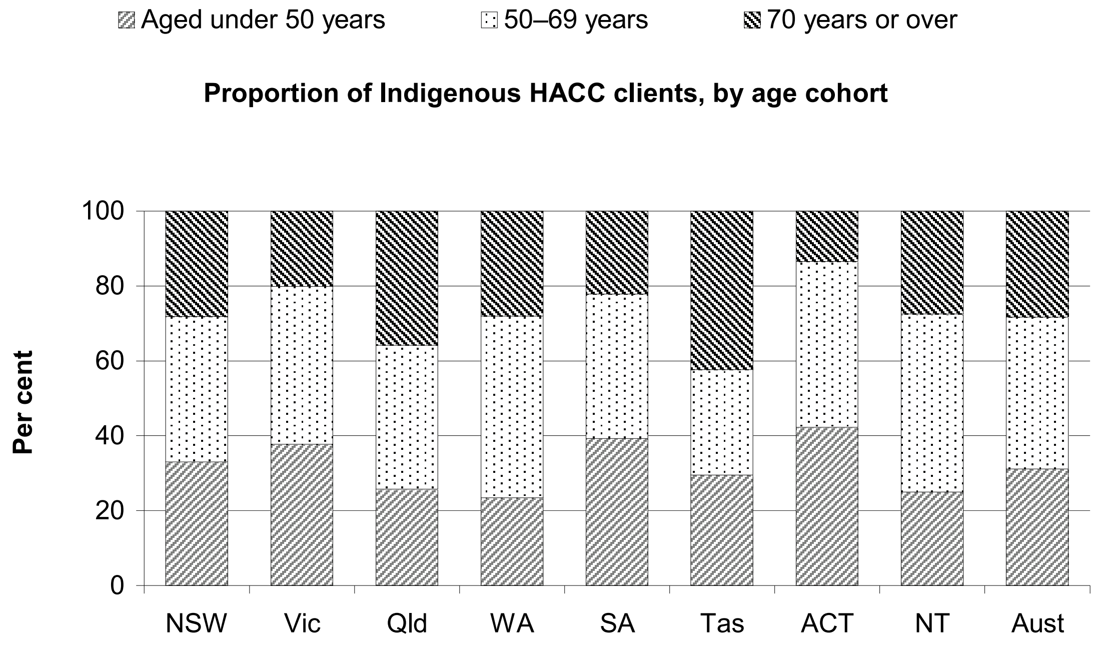
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Percentage of agencies that reported minimum data set data									
	89	95	95	99	98	99	100	99	93
Total hours (no.)[d]									
Major cities	9 941	14 200	14 790	15 943	12 435	..	10 114	..	12 739
Inner regional	9 068	15 927	12 013	13 355	11 321	12 350	..	..	11 987
Outer regional	12 320	19 007	13 789	19 476	12 705	10 111	..	8 943	14 144
Remote	16 821	24 827	19 876	17 872	16 292	11 717	..	9 912	17 058
Very remote	16 030	..	19 576	29 384	32 613	21 279	..	16 473	21 965
All areas	**9 968**	**14 912**	**14 113**	**16 194**	**12 581**	**11 646**	**10 114**	**11 733**	**12 830**
Total meals (no.)[e]									
Major cities	3 517	4 766	5 093	4 230	6 752	..	3 563	..	4 503
Inner regional	4 636	6 360	5 365	4 240	4 612	4 721	..	..	5 194
Outer regional	6 038	6 464	5 419	6 374	8 617	5 444	..	4 390	6 158
Remote	7 528	8 105	7 613	9 491	8 184	6 296	..	14 860	8 937
Very remote	6 826	..	8 628	23 446	30 361	7 733	..	33 536	21 022
All areas	**4 021**	**5 238**	**5 297**	**4 956**	**6 926**	**5 001**	**3 563**	**16 747**	**5 001**

[a] Data represent HACC services received by people aged 70 years or over, plus Indigenous people aged 50-69 years, divided by people aged 70 years or over, plus Indigenous people aged 50–69 years (tables 13A.21–26) as distinct from HACC services received divided by HACC target population in all age groups (tables 13A.27–32). [b] The proportion of HACC funded agencies that submitted Minimum Data Set data for 2008-09 differed across jurisdictions and ranged from 89 per cent to 100 per cent. Consequently, actual service levels were higher than stated. [c] Reports provisional HACC data that have not been validated and may be subject to revision. [d] See table 13A.21 for a full list of categories. [e] Includes home meals and centre meals. .. Not applicable.

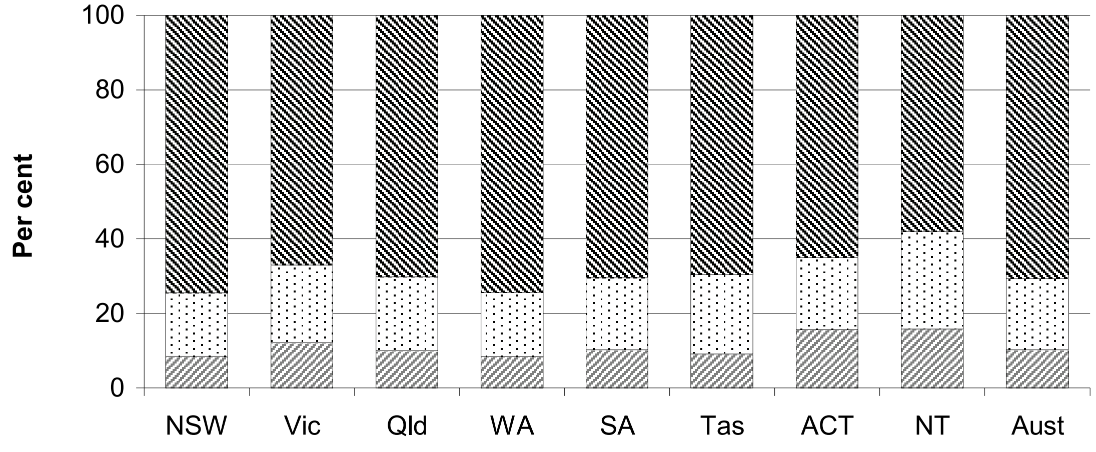
Source: DoHA Home and Community Care Minimum Data Set 2008-09 (unpublished); DoHA HACC National Data Repository (unpublished); tables 13A.21–26.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2008-09. This reflects the difference in morbidity and mortality trends between Indigenous people and the general population. The proportion of Indigenous HACC clients who are aged 70 years or over is 28.3 per cent and the proportion of non-Indigenous HACC clients who are aged 70 years or over is 70.6 per cent (figure 13.18).

Figure 13.18 Recipients of HACC services by age and Indigenous status, 2008-09[a, b]


Proportion of Indigenous HACC clients, by age cohort

Proportion of non-Indigenous HACC clients, by age cohort



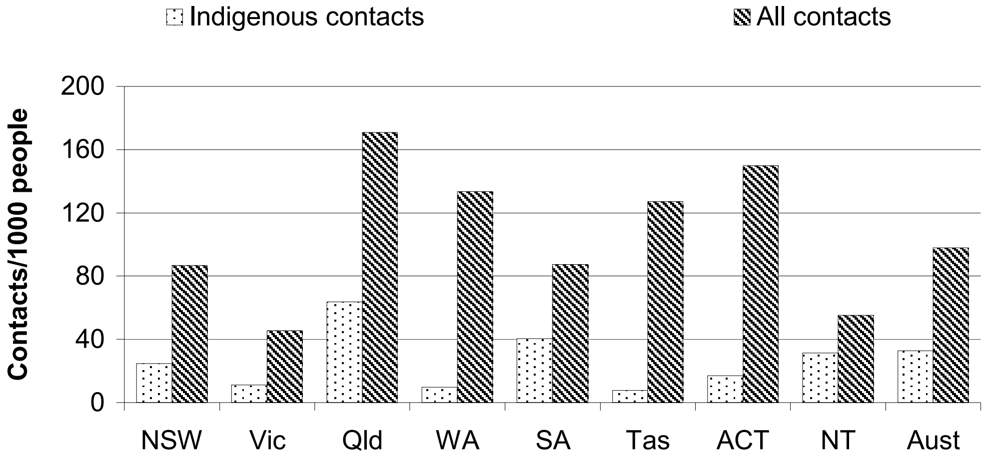
[a] Reports provisional HACC data that have not been validated and may be subject to revision. [b] The proportion of HACC clients with 'nil' and 'not stated' Indigenous status differed across jurisdictions and ranged from 6.3 per cent to 14.8 per cent. Nationally, the proportion of HACC clients with 'nil' and 'not stated' Indigenous status was 9.7 per cent

Source: DoHA (unpublished); table 13A.34.

Access by Indigenous people to Commonwealth Carelink Centres

Commonwealth Carelink Centres are information centres for older people, people with disabilities, carers and service providers. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. The national rate at which Indigenous people contacted Carelink Centres at 30 June 2009, was 32.8 people per 1000 Indigenous people in the Indigenous target population (Indigenous people aged 50 years and over). The rate for all Australians was 97.9 per 1000 people in the target population (people aged 70 years or over plus Indigenous people aged 50–69). These figures varied across jurisdictions (figure 13.19).

Figure 13.19 **Commonwealth Carelink Centres, contacts per 1000 target population, by Indigenous status, 30 June 2009**[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 people in the target population. [c] 'All contacts' refers to contacts per 1000 target population. [d] People making contact self identify as Indigenous. Therefore, there is likely to be substantial under-reporting of Indigenous status.

Source: DoHA (unpublished); table 13A.60.

Access to residential services by financially disadvantaged users

The financial assistance arrangements for financially disadvantaged users were changed on 20 March 2008, to include a new category known as supported residents (box 13.10).

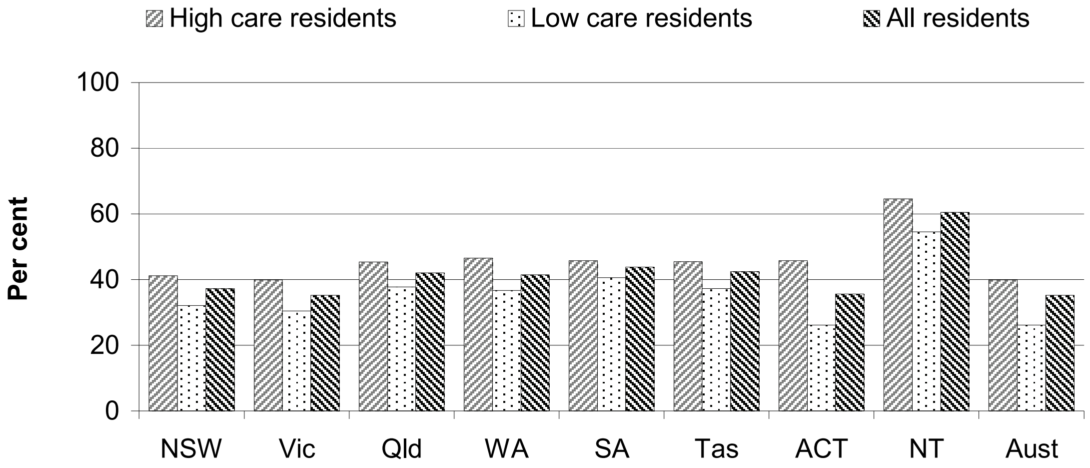
Box 13.10 **Supported residents**

In 2008, new arrangements governing residents' contributions to their accommodation costs and the supplements the Australian Government pays for residents who cannot meet all or part of their own accommodation costs were introduced. These new arrangements only apply to residents who first enter permanent residential care on or after 20 March 2008, or who re-enter care on or after 20 March 2008, after a break in care of more than 28 days.

New residents who are assessed as eligible to receive subsidised accommodation costs are known as supported residents. Residents who entered care prior to 20 March 2008 are still subject to the eligibility criteria for 'concessional' or 'assisted' resident status.

The proportion of all new residents classified as supported residents during 2008-09 was 35.2 per cent nationally but varied across jurisdictions (figure 13.20). Targets for financially disadvantaged users range from 16 per cent to 40 per cent of places, depending on the service's region.

Figure 13.20 **New residents classified as supported residents, 2008-09**[a]



---

[a] Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re-enter care on or after 20 March 2008 after a break in care of more than 28 days) and have assets of up to a set value ($90 910.40 as at 30 June 2009).

Source: DoHA (unpublished); table 13A.20.

Effectiveness — timeliness of access

Waiting times for residential care

'Waiting times for residential care' is an indicator of governments' objective to maximise the timeliness with which people are able to access residential care (box 13.11).

Box 13.11 **Waiting times for residential care**

'Waiting times for residential care' is defined as the number of people who are admitted to residential high care within three months of their ACAT approval as a proportion of the total number of people with an ACAT approval to enter high care. ACAT approval refers to the approval date of the most recent ACAT assessment prior to admission into care. Entry into a residential care service refers to the date of admission to a residential care service. In the calculation of waiting time, the most recent ACAT approval prior to entry is used.

Shorter waiting times (measured by higher rates of admission to high residential care within three months of ACAT approval) are desirable.

This indicator needs to be interpreted with care. The measure of 'elapsed time' is utilised because the period of time between the ACAT approval and entry into residential care may be due to factors which cannot be categorised as 'waiting' time. These include:

- clients with ACAT approvals who do not enter residential care (for example, who die before entering care)
- residential placement offers that are not accepted
- the availability of alternative community care, informal care and respite services
- the availability and distribution of operational residential care services
- building quality and perceptions about quality of care, which influence client choice of preferred service
- delays between the date of ACAT assessments and their approval
- priority allocations (for example, special needs groups)
- hospital discharge policies and practices
- the impact on clients of programs which provide alternatives to residential care, such as EACH and EACH-D
- client choice not to enter residential care immediately but to take up the option at a later time.

(Continued on next page)

Box 13.11 **(Continued)**

The measure focuses on high care services because, as a proxy for waiting time, the link between entry to residential care and elapsed time is stronger for high care residents than for low care residents. This is due to the urgency for high care residents' needs, and the greater number of alternatives for people with ACAT approvals for low care only. Waiting time measures for low care are included in the attachment tables.

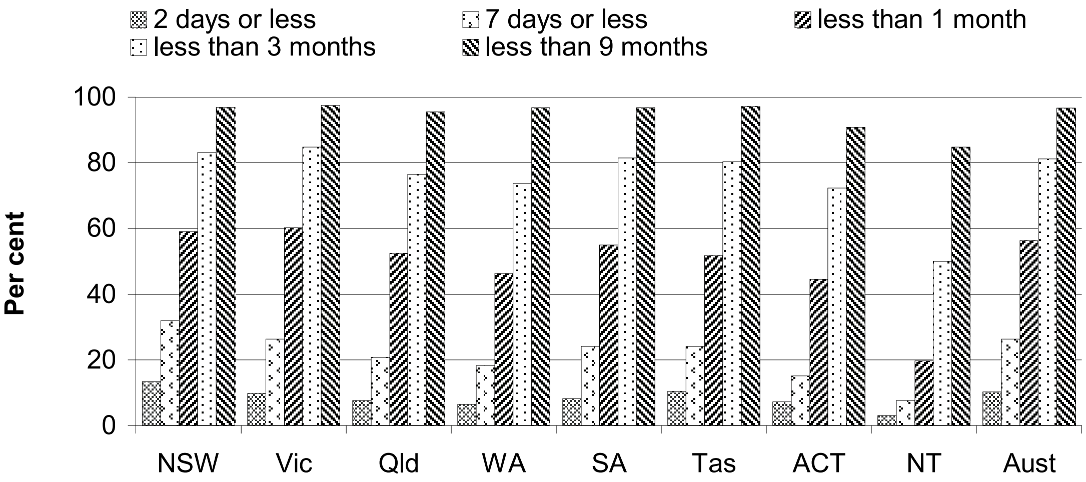
It is recognised that this indicator has limitations and work is underway to review the data. This indicator will continue to be reported until improved data are available.

Data reported for this indicator are comparable.

Overall, 26.3 per cent of all people entering residential high care during 2008-09 did so within 7 days of being approved by an ACAT compared with 22.9 per cent in 2007-08. In 2008-09, 56.3 per cent entered within one month of their ACAT approval and 81.2 per cent entered within 3 months of their approval compared with 51.5 per cent and 77.3 per cent respectively in 2007-08. These proportions varied across jurisdictions (figure 13.21) (SCRGSP 2009, table 13A.37). The median time for entry into high care residential services was 23 days in 2008-09 compared with 28 days in 2007-08 (table 13A.37) (SCRGSP 2009, table 13A.37).

Nationally, a greater proportion of people entering high care residential services entered within 3 months of approval (81.2 per cent), compared with the proportion entering low care residential services within that time (61.4 per cent). These proportions varied across jurisdictions (table 13A.37).

Figure 13.21 People entering high care residential care within specified time periods of their ACAT approval, 2008-09[a]



[a] Includes residential places categorised as high care.

Source: DoHA (unpublished); table 13A.37.

Waiting times for community care

'Waiting times for community care' is an indicator of governments' objective to maximise the timeliness with which people are able to access community care (box 13.12).

Box 13.12 Waiting times for community care

'Waiting times for community care' is defined as the number of people who are commencing a CACP within one month or within three months of their ACAT approval as a proportion of the total number of people with an ACAT approval to commence a CACP. ACAT approval refers to the approval date of the most recent ACAT assessment prior to admission into care. Entry into a CACP service refers to the date of commencement of a CACP service. In the calculation of waiting time, the most recent ACAT approval prior to entry is used.

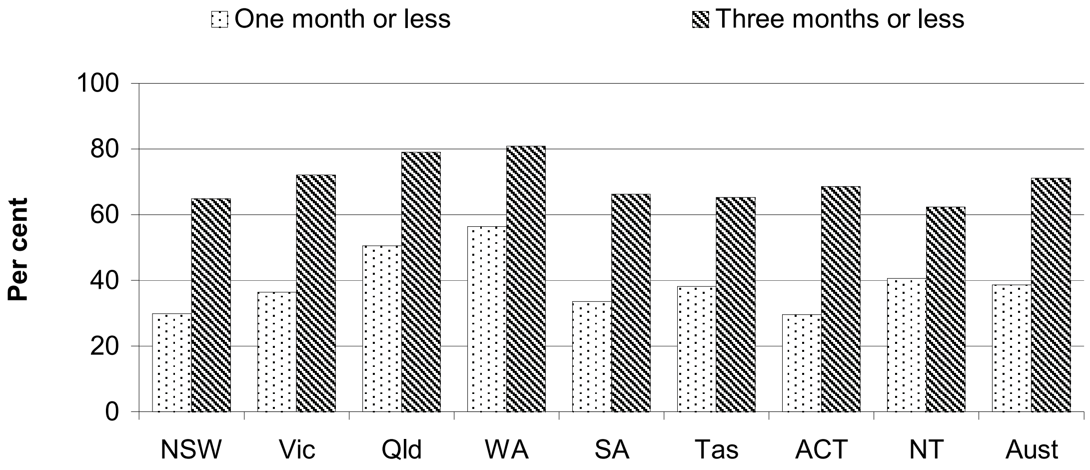
Shorter waiting times (measured by higher rates of commencement of a CACP service within one or three months of ACAT approval) are desirable.

This indicator needs to be interpreted with care. Some ACAT approved clients may choose not to receive a CACP, alternative community care options may be available, or varying fee regimes might influence choice.

Data reported for this indicator are comparable.

Overall, 71.1 per cent of all people receiving a CACP during 2008-09 received it within three months of being approved by an ACAT. This proportion varied across jurisdictions. On average, 38.6 per cent started receiving a CACP within one month of their ACAT approval (figure 13.22).

Figure 13.22 **People commencing a CACP within one or three months of their ACAT approval, 2008-09**



Source: DoHA (unpublished); table 13A.37.

Effectiveness — appropriateness

Assessed longer term care arrangements

'Assessed longer term care arrangements' is an indicator of governments' objective to meet clients' needs through provision of appropriate aged care services (box 13.13).

Box 13.13 **ACAT recommended longer term living arrangements**

'Assessed longer term care arrangements' is defined as the proportions of ACAT clients recommended to remain at home or in residential care (permanent or respite), as aged care assessments are mandatory for admission to Australian Government subsidised residential care or for receipt of a CACP, EACH, EACH-D or TCP package.

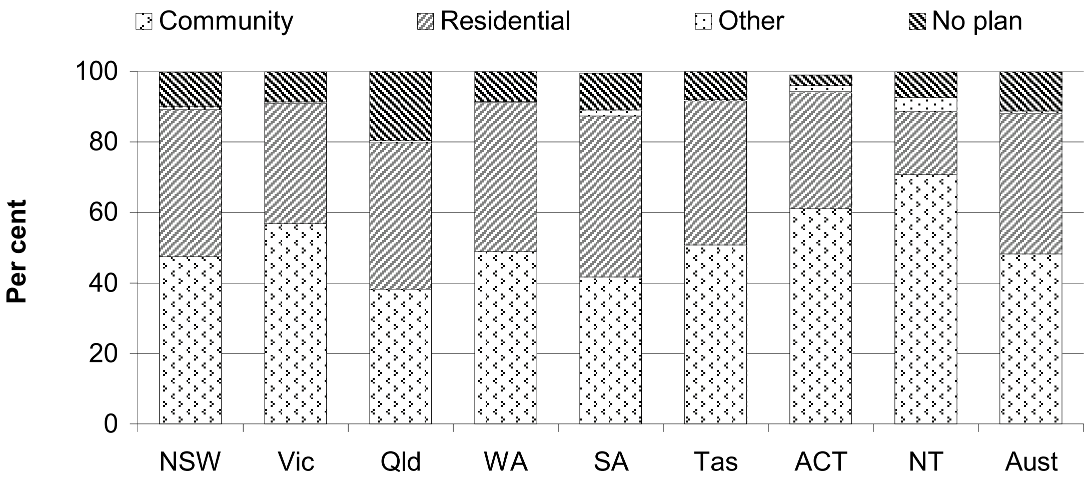
Higher or increasing proportions of clients remaining in the community are desirable.

The results for this indicator show the distribution of recommended living arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions may reflect external factors such as geographic dispersion of clients and service availability, but also client preferences and views on the types of client best served by community-based services. The distribution of ACAT recommendations for various living arrangements are influenced by the degree to which any pre-selection process refers people requiring residential care to ACATs for assessment. Jurisdictions with lower overall assessment rates may operate a filtering process to focus assessments on individuals who are more likely to require residential care.

Data reported for this indicator are comparable.

The national proportion of ACAT clients approved for residential care in 2007-08 was 39.8 per cent and the proportion recommended to remain in the community was 48.3 per cent (13A.38). No long term plan was made for 11.0 per cent, which included deaths, cancellations and transfers. These proportions varied across jurisdictions (figure 13.23).

Figure 13.23 **Recommended longer term living arrangements of ACAT clients, 2007-08**[a]



[a] 'No plan' includes deaths, cancellations and transfers.

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.38.

Targeting

‘Targeting’ has been identified for development as an indicator of governments’ objective to ensure that services are allocated to those people in greatest need (box 13.14).

Box 13.14 **Targeting**

‘Targeting’ has yet to be defined.

Data for this indicator were not available for the 2010 Report.

Unmet need

‘Unmet need’ is an indicator of governments’ objective of ensuring aged care services are allocated to meet clients’ needs (box 13.15).

Box 13.15 **Unmet need**

‘Unmet need’ is defined as the extent to which demand for services to support older people requiring assistance with daily activities is not met.

While low rates of unmet need are desirable, defining and determining the level of need at an individual level, let alone at a population level, is complex. Perceptions of need and unmet need are often subjective.

Data for this indicator are drawn from the ABS 2003 Survey of Disability, Ageing and Carers. Data are for people aged 70 years or over who self-identified as having a need for assistance with at least one everyday activity, and the extent to which that need was being met (fully, partly or not at all).

Direct inferences about the demand for services need to be made with care, because the measure used does not:

- reveal the intensity of care required by those who identify an unmet need — there is no indication of whether the need can readily be met informally or by formal home care, or whether the person may require residential care
- reflect the degree of unmet demand for a specific type of service. Differences across jurisdictions in the proportion of unmet need can reflect different policy approaches to targeting services. Some governments may choose to focus on those with the greatest degree of need for care and on fully meeting their needs. By contrast, other governments may choose to provide a lower level of service to a greater number of people, while only partly meeting the needs of those with the greatest need for care — both are valid policy approaches
- reflect the past and possible future duration of the need — that is, whether it is long term or transitory
- reflect whether the need relates to a disability support service, aged care service or health care.

Although data are included here, this indicator is regarded as yet to be developed, because of the extent of the caveats.

Of those people aged 70 years or over in 2003, who were living in households and who self-identified as having a need for assistance with at least one everyday activity, over one third (36.1 per cent) reported that their needs for assistance were not fully met (table 13A.70 and SCRGSP 2009).

Long term aged care in public hospitals

‘Long term aged care in public hospitals’ is an indicator of governments’ objective to minimise the incidence of older people staying in public hospitals when their care needs may be met through residential or community care services (box 13.16).

Box 13.16 **Long term aged care in public hospitals**

Long term aged care in public hospitals' is defined as the proportion of completed hospital separations for people aged 70 years or over plus Indigenous people aged 50–69 years where:

- the care type was maintenance, and
- the diagnosis (either principal or additional) was either 'person awaiting admission to residential aged care service' or 'need for assistance at home and no other household member able to render care', and
- where the length of stay was 35 days or longer.

A low proportion of stays of 35 days or more is desirable.

Hospital inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term.

This measure should be interpreted with care.

- Patients who have not completed their hospital stay are not included.
- Although the diagnosis codes reflect a care type, they do not determine a person's eligibility for residential aged care (this is determined by an ACAT assessment) or necessarily reliably reflect access issues for residential aged care from the acute care sector.
- Diagnosis codes may not be applied consistently across jurisdictions or over time.
- Reported hospital separations do not necessarily reflect the full length of hospital stay for an individual patient. If a change in the type of care occurs during a patient's hospital stay (for example, from acute to maintenance) then two separations are reported for that patient.
- The code 'need for assistance at home and no other household member able to render care' may also be used for respite care for aged care residents or those receiving community care, and some jurisdictions may have a high proportion of this type of use. This is particularly relevant in some rural areas where there are few alternative options for these clients.

(Continued on next page)

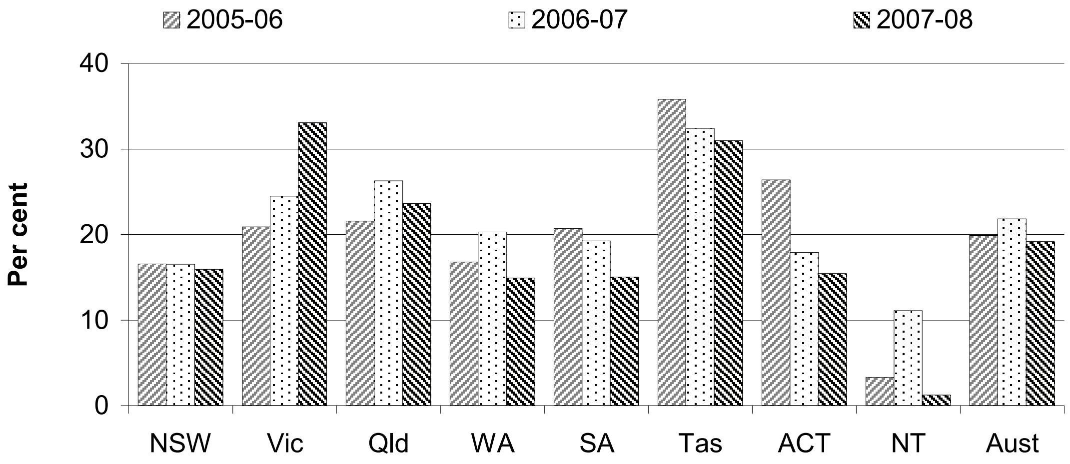
Box 13.16 **(Continued)**

- The measure does not necessarily reflect alternative strategies in place by states and territories to manage the older person into appropriate residential aged care facilities from acute care hospitals.
- The measure is regarded as a proxy, as the desired measures (utilising appropriate linked hospital separations and ACAT approvals) are not available at this time. Further development is underway to improve available data sets and associated measures for future Reports.

Data reported for this indicator are not directly comparable.

The proportion of separations for patients aged 70 years or over plus Indigenous people aged 50–69 years who had a care type of maintenance with a diagnosis (either principal or additional) of either ‘person awaiting admission to residential aged care service’ or ‘need for assistance at home and no other household member able to render care’, and whose separation was 35 days or longer was 19.2 per cent nationally, in 2007-08. This proportion varied across jurisdictions (figure 13.24). These data reflect only a small proportion of all public hospital separations for patients aged 70 years or over plus Indigenous people aged 50–69 years (10 843 separations of a total of 1.4 million nationally) (table 13A.71).

Figure 13.24 Proportion of long term separations for aged care patients, in public hospitals[a, b, c, d, e, f, g]



[a] Data are for hospital separations with a care type of maintenance and a diagnosis (either principal or additional) of either 'person awaiting admission to residential aged care service' or 'need for assistance at home and no other household member able to render care' and where the separation lasted 35 days or longer. [b] Age of patients is 70 years or over, plus Indigenous patients 50–69 years. [c] Although the diagnosis codes reflect a care type, they do not determine a person's eligibility for residential aged care. [d] Diagnosis codes may not be applied consistently across jurisdictions or over time. [e] These data only account for completed unlinked separations. [f] The code 'need for assistance at home and no other household member able to render care' may also be used for respite care for either residential or community care patients. [g] An individual patient may have multiple hospital separations during a single hospital stay, for example, if a change in the type of care occurs during a patient's hospital stay. Data on length of stay relate to each separation and not to the whole hospital stay.

Source: AIHW (unpublished); table 13A.71.

Intensity of care

'Intensity of care' is an indicator of governments' objective to encourage 'ageing in place' to increase choice and flexibility in residential aged care service provision (box 13.17).

Box 13.17 **Intensity of care**

‘Intensity of care’ is defined by two measures:

- the proportion of people who stayed in the same residential aged care service when changing from low care to high care
- the proportion of low care places occupied by residents with high care needs, compared with the proportion of all operational places taken up by residents with high care needs.

Higher rates of ageing in place are desirable, in the context of a flexible system that also meets the need for low level care either in residential facilities or in the community.

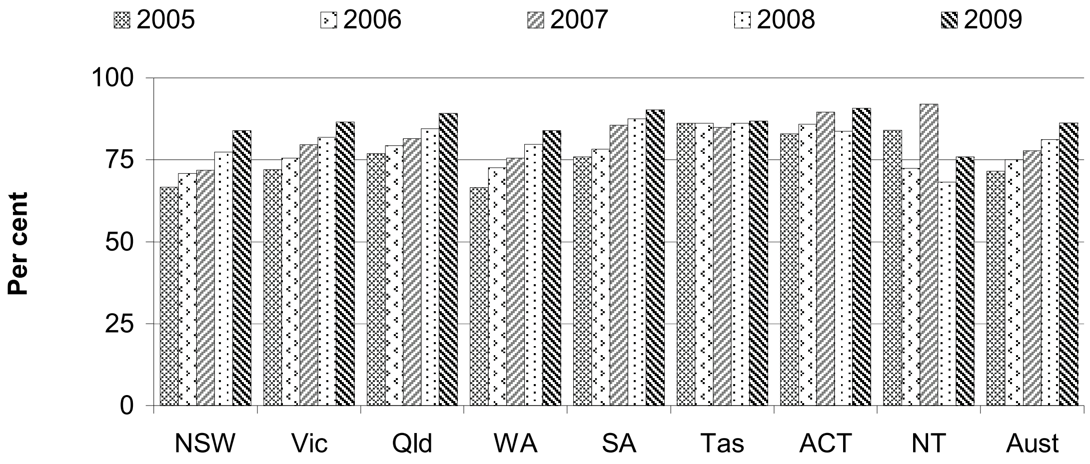
These measures reflect the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The Aged Care Act aims explicitly to encourage ageing in place to increase choice and flexibility in residential aged care service provision (box 13.6).

This indicator needs to be viewed from the perspective of the system as a whole. The implication of ageing in place is that some places that were allocated for low care will be occupied by high care residents (or, conversely, allocated for high care and occupied by low care residents). Information about the use of operational residential aged care places is provided to demonstrate the impact of ageing in place on the aged care services system over time.

Data reported for this indicator are comparable.

Nationally, from June 2005 to June 2009, there was a steady increase in the proportion of people who stayed in the same residential aged care service when changing from low care to high care, from 71.5 per cent to 86.2 per cent (figure 13.25). In June 2009 the proportion was higher in inner regional areas (88.1 per cent), outer regional areas (86.8 per cent), remote areas (93.3 per cent) and very remote areas (95.0 per cent) than in major cities (85.4 per cent) (table 13A.58).

Figure 13.25 Proportion of residents who changed from low care to high care and remained in the same aged care service, June[a]



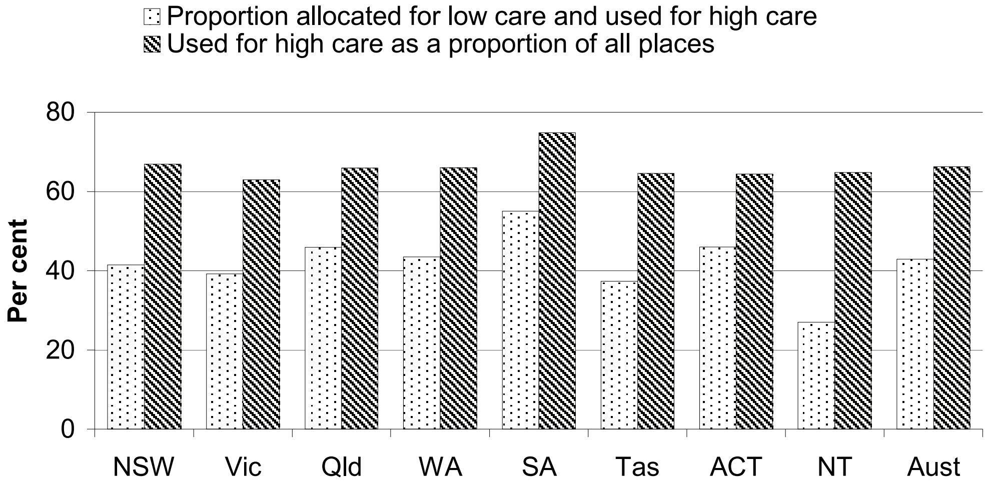
---

[a] For June 2009, includes residential places categorised as high care or low care.

Source: DoHA (unpublished); table 13A.58.

Nationally, 42.9 per cent of low care places in 2008-09 were occupied by residents with high care needs. The proportion of all operational places taken up by residents with high care needs was 66.3 per cent (figure 13.26). These data are provided by remoteness area in table 13A.61.

Figure 13.26 Utilisation of operational residential places, 30 June 2009[a]



---

[a] Includes residential places categorised as high care or low care.

Source: DoHA (unpublished); table 13A.61.

Effectiveness — quality

Compliance with service standards for residential care

'Compliance with service standards for residential care' is an indicator of governments' objective to ensure residential care services attain high levels of service quality, through compliance with certification and accreditation standards (box 13.18).

Box 13.18 **Compliance with service standards for residential care**

'Compliance with service standards for residential care' is defined by two measures:

- the proportion of accredited services which have received 3 year re-accreditation, by meeting accreditation standards
- the percentage of aged care services that are compliant with building certification, fire safety and privacy and space requirements.

The extent to which residential care services comply with service standards implies a certain level of care and service quality.

High or increasing rates of approval for three year re-accreditation are desirable.

Since 2001, each Australian Government funded residential service has been required to meet accreditation standards (which comprise 44 expected outcomes). The accreditation indicator reflects the period of accreditation granted. The accreditation process is managed by the Aged Care Standards and Accreditation Agency Ltd (ACSAA). A service must apply to ACSAA for accreditation and its application is based on a self-assessment of performance against the accreditation standards. Following an existing residential service applying for accreditation, a team of registered quality assessors reviews the application, conducts an onsite assessment and prepares a report based on these observations, interviews with residents, relatives, staff and management, and relevant documentation. An authorised decision maker from ACSAA then considers the report, in conjunction with any submission from the residential service and other relevant information (including information from DoHA) and decides whether to accredit and, if so, for how long. Commencing services are subject to a desk audit only, and are accredited for one year.

A home must be certified to be able to receive accommodation payments and extra service charges. Residents expect high quality and safe accommodation in return for their direct and indirect contributions, therefore all aged care homes are required to meet fire safety and privacy and space targets to be eligible to receive the maximum level of the accommodation supplement.

(Continued on next page)

Box 13.18 **(Continued)**

While certification is not time limited, it is based on the principle of continuous improvement and an agreed 10-year plan, introduced in 1999, provides homes with a clear framework for improving safety, privacy and space standards. Every aged care home that was constructed prior to July 1999 is required to have no more than four residents accommodated in any room, no more than six residents sharing each toilet and no more than seven residents sharing each shower or bath.

Under the privacy and space requirements, all new buildings constructed since July 1999, are required to have an average, for the whole aged care home, of no more than 1.5 residents per room. No room may accommodate more than two residents. There is also a mandatory standard of no more than three residents per toilet, including those off common areas, and no more than four residents per shower or bath.

Data reported for this indicator are comparable.

Accreditation decisions and further information relating to the accreditation standards and ACSAA are publicly available (ACSAA 2009). The accreditation process is summarised in box 13.18.

At 30 June 2009, 92.9 per cent of residential aged care services had been granted a re-accreditation approval for a period of three years. This proportion varied across jurisdictions (table 13.9).

Table 13.9 **Re-accreditation decisions on residential aged care services, 30 June 2009[a, b]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Re-accreditation period										
<2 years	%	1.1	2.7	6.6	3.7	5.6	–	4.2	14.3	3.2
2 years or more (but <3 years)	%	2.5	3.9	7.4	1.6	3.0	8.3	4.2	7.1	3.9
3 years	%	96.4	93.4	86.0	94.7	91.5	91.7	91.7	78.6	92.9
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total re-accredited services	**no.**	**880**	**770**	**471**	**244**	**270**	**84**	**24**	**14**	**2 757**

[a] Data for 2007-08 relate only to re-accreditations, and do not include accreditation periods for commencing services (37 in 2008-09). Earlier reports included both initial accreditations and re-accreditations. [b] Note that 'accreditation period' shows the decision in effect at 30 June 2009. The figures in this table will not necessarily agree with the accreditation decisions made in 2008-09, because those decisions may not yet have taken effect, or may have been superseded. – Nil or rounded to zero.

Source: ACSAA (unpublished); table 13A.41.

The measure 'average residents per room' has been replaced with the more comprehensive measure 'the percentage of aged care services that are compliant with building certification, fire safety and privacy and space requirements' (box 13.18).

Nationally, as at 30 June 2009, 98.5 per cent of aged care services were compliant as outlined in table 13.10.

Table 13.10 **Residential aged care services compliant with building certification, fire safety and privacy and space requirements at 30 June 2009**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[a]	*Aust*
Total residential services	no	889	780	477	245	271	82	25	14	2783
Total compliant services	no	867	776	468	243	270	81	24	14	2 743
Proportion of compliant services	**%**	**97.5**	**99.4**	**98.1**	**99.1**	**99.6**	**98.7**	**96.0**	**100.0**	**98.5**

[a] NT data are variable due to small numbers.

Source: DoHA Report on the Operation of the Aged Care Act 1997 – 1 July 2008 to 30 June 2009.

Complaints

'Complaints' is an indicator of governments' objective to ensure aged care services provide a high quality of care (box 13.19).

Box 13.19 **Complaints**

‘Complaints’ is defined as the number of breaches under the Aged Care Act identified by the Complaints Investigation Scheme (CIS) per 1000 residents.

A low or decreasing rate of breaches is desirable.

This indicator is a proxy of the quality of care. It counts the number of breaches identified by the CIS. Official complaints may indicate dissatisfaction about an element of the service provided, but do not always result in the finding of a breach.

The CIS investigates any potential breach of an approved provider’s responsibilities in residential and community care; requires the service provider, where appropriate, to take action; and is able to refer issues that may be more appropriately dealt with by others (for example, the Aged Care Standards and Accreditation Agency, police, nursing and medical registration boards). The CIS is able to issue Notices of Required Action where an approved provider is found to be in breach of their responsibilities under the Aged Care Act and where the breach has not been rectified immediately.

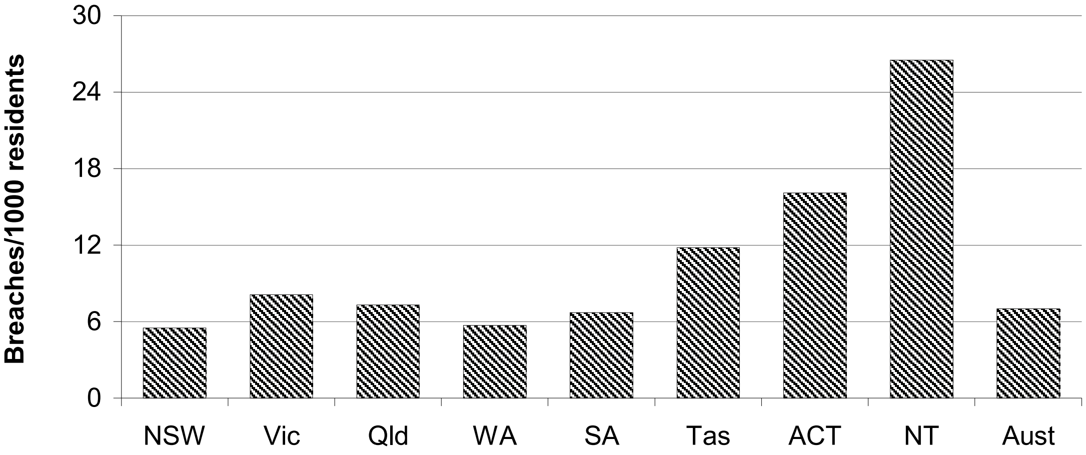
The rate at which complaints occur can be influenced by the propensity of clients and their families or service staff to complain, their knowledge of the complaints system and perceptions of the effectiveness of the complaints system.

Data reported for this indicator are comparable.

From 1 July 2008 to 30 June 2009, the CIS identified 1093 breaches under the Aged Care Act (table 13A.42). The number of breaches identified per 1000 residents from 1 July 2008 to 30 June 2009 was 7.0 nationally. This varied across jurisdictions (figure 13.27).

In the period 1 July 2008 to 30 June 2009, DoHA also dealt with 12 573 matters of which 7962 were within the scope of the CIS to investigate, although not all of these were complaints. Of the 7962 in scope cases dealt with by the CIS, 94 per cent related to residential care services. The increased number of calls reflects the broader nature of the new scheme, which deals with information from a range of sources (DoHA unpublished).

Figure 13.27 **Complaints Investigation Scheme breaches, 2008-09**[a, b]



a Data for NT and ACT will be variable due to small numbers. **b** Data relate to permanent residents as at 31 December 2008.

Source: DoHA (unpublished); table 13A.42.

Compliance with service standards for community care

'Compliance with service standards for community care' is an indicator of governments' objective to ensure that community aged care programs provide a high quality of service (box 13.20).

Box 13.20 **Compliance with service standards for community care**

'Compliance with service standards for community care' is defined by two measures:

- the number of HACC agencies appraised against the standards as a percentage of the total number of HACC agencies
- the proportions of agencies which achieve high, good, basic, or poor ratings, and the average score in each jurisdiction.

A high proportion of agencies appraised, higher ratings and high average scores are desirable.

The indicator monitors the extent to which individual agencies are complying with service agreement standards. The HACC national service standards provide HACC funded agencies with a common reference point for internal quality control by defining aspects of service quality and expected outcomes for consumers. States and territories are required to include the standards in all service agreements. The HACC national service standards instrument has been developed to measure through a service appraisal process the extent to which individual agencies are complying with the standards. Monitoring and compliance with the standards are now a major part of service reviews. This indicator also measures the percentage of individual agencies that comply with the service standards, through the outcomes of service standard appraisals. It should be noted that the standards are not an accreditation system.

Data reported for this indicator are comparable.

A total of 3534 HACC agencies were identified for appraisal over the second appraisal cycle (the four year cycle 2004-05 to 2007-08). The ACT completed this four year cycle in 2008-09. The number of these agencies appraised was 3390 (95.9 per cent). This proportion varied across jurisdictions (table 13.11). The outcomes of these appraisals was a national average score of 17.3 out of 20 (table 13.12).

Table 13.11 HACC National Service Standards appraisals over the four year cycle ending 2007-08[a]

	Unit	*NSW*[b]	*Vic*[c]	*Qld*[d]	*WA*	*SA*	*Tas*	*ACT*[e]	*NT*[f]	*Aust*[d]
Appraisals	no.	1 692	338	965	123	179	53	30	10	3 390
HACC agencies	no.	1 785	460	801	135	179	53	30	91	3 534
Proportion of agencies assessed	%	94.8	73.5	100.0	91.1	100.0	100.0	100.0	11.0	95.9

[a] Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those reported. [b] Validation of 343 HACC services auspiced and/or administered by NSW Health occurred from February–October 2005. Monitoring of all other NSW HACC services commenced in November 2005 under the Integrated Monitoring Framework, and was completed by June 2009. The total number of HACC agencies is the number of HACC services funded in 2007-08. The proportion of agencies appraised is indicative only, as agencies may equate to services or outlets. In NSW, the appraisal methodology differs slightly under the Integrated Monitoring Framework, though is closely aligned to the HACC Standards Instrument. Scores are derived from equivalent performance questions. [c] Victoria has completed appraisals for 338 agencies. The remaining 122 agencies are Quality Improvement Council or Australian Council on Healthcare Standards accredited. Victoria has contracted with the licensee of these systems to conduct appraisals against HACC standards as part of their major review. These appraisals will be finalised by mid 2010. [d] In Queensland the number of appraisals exceeds the number of agencies because some service providers were reviewed twice in the four year period. Therefore calculation of the Australian total of appraisals and the proportion of agencies assessed only includes 801 Queensland agencies. [e] Quality Assessments in the ACT occurred in 2008-09 with data being included in the four year cycle ending 2007-08. [f] NT data are variable due to small numbers.

Source: State and Territory governments (unpublished).

Table 13.12 HACC National Service Standards results of appraisals over the four year cycle ending 2007-08 (number)[a, b, c]

	NSW	*Vic*	*Qld*[d]	*WA*	*SA*	*Tas*[e]	*ACT*[f]	*NT*	*Aust*
High (17.5 – 20)	1 166	162	683	88	89	29	18	1	2 236
Good (15 – 17.4)	276	74	176	11	42	9	9	4	601
Basic (10 -14.9)	217	71	85	16	34	10	3	4	440
Poor (less than 10)	33	31	21	8	14	5	–	1	113
Average score	17.6	16.0	18.3	17.0	16.1	16.2	17.6	15.0	17.3

[a] Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those listed. [b] The results of the appraisals will reflect the individual approaches adopted by each State and Territory. [c] For details about the method of determining the average score, see table 13A.69. [d] In Queensland some agencies were reviewed twice in the four year period. This table includes outcomes of all appraisals during the cycle. [e] One agency in Tasmania declined to participate in the appraisal process and was therefore scored as zero. [f] Quality Assessments in the ACT occurred in 2008-09 with data being included in the four year cycle ending 2007-08. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 13A.69.

Client appraisal of service standards

'Client appraisal of service standards' is an indicator of governments' objective to ensure high levels of client satisfaction with aged care services (box 13.21).

Box 13.21 **Client appraisal of service standards**

'Client appraisal of service standards' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Efficiency — inputs per output unit

Cost per ACAT assessment

'Cost per ACAT assessment' is an indicator of governments' objective to deliver efficient ACAT assessment services (box 13.22).

Box 13.22 **Cost per ACAT assessment**

'Cost per ACAT assessment' is defined as Australian Government expenditure on ACATs divided by the number of ACAT assessments completed.

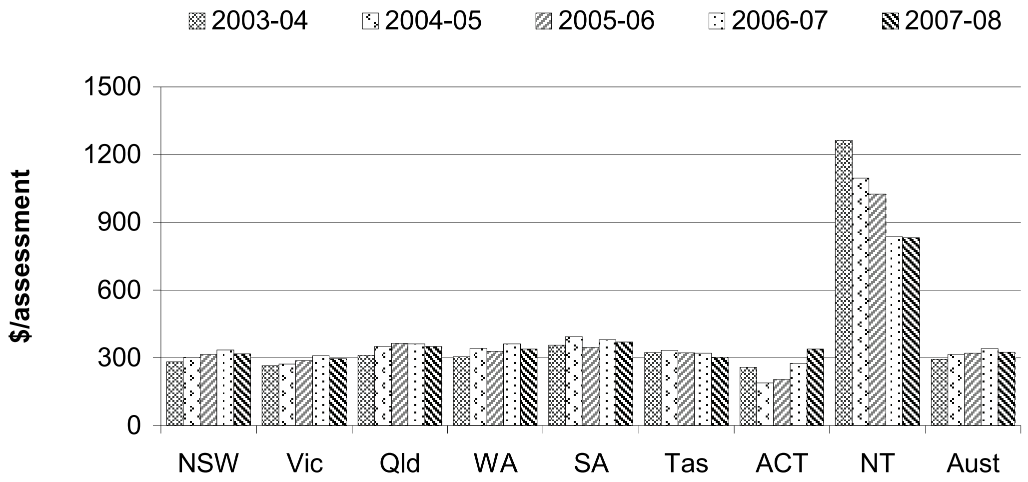
This is a proxy indicator of efficiency and needs to be interpreted with care. This indicator includes only Australian Government expenditure, although states and territories also contribute to the cost of ACAT assessments. While high or increasing expenditure per assessment may reflect deteriorating 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.

Cost per ACAT assessment has been developed as a proxy and work is in progress to measure efficiency for ACATs.

Data reported for this indicator are not directly comparable.

Australian Government expenditure per aged care assessment during 2007-08 averaged $325 nationally (figure 13.28). Nationally, real expenditure increased from 2003-04 to 2007-08. The cost per assessment is calculated using the total number of assessments and therefore includes clients aged less than 70 years.

Figure 13.28 Australian Government expenditure on aged care assessments, per assessment (2007-08 dollars)[a, b, c]



---

[a] Only includes Australian Government expenditure on ACATs. [b] ACAT referrals and operations vary across jurisdictions. [c] The high cost for each assessment in the NT may be influenced by the remoteness of people requiring assessments, clients having English as a second or third language, and a lack of supporting health and community services infrastructure to assist with assessments.

Source: DoHA (unpublished); table 13A.59.

Expenditure per head of target population

'Expenditure per head of target population' is an indicator of governments' objective to deliver efficient aged care services (box 13.23).

Box 13.23 Expenditure per head of target population

'Expenditure per head of target population' is defined as government inputs (expenditure) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years. Expenditure per person in the target population is reported for three main service types: residential services, CACP and HACC services.

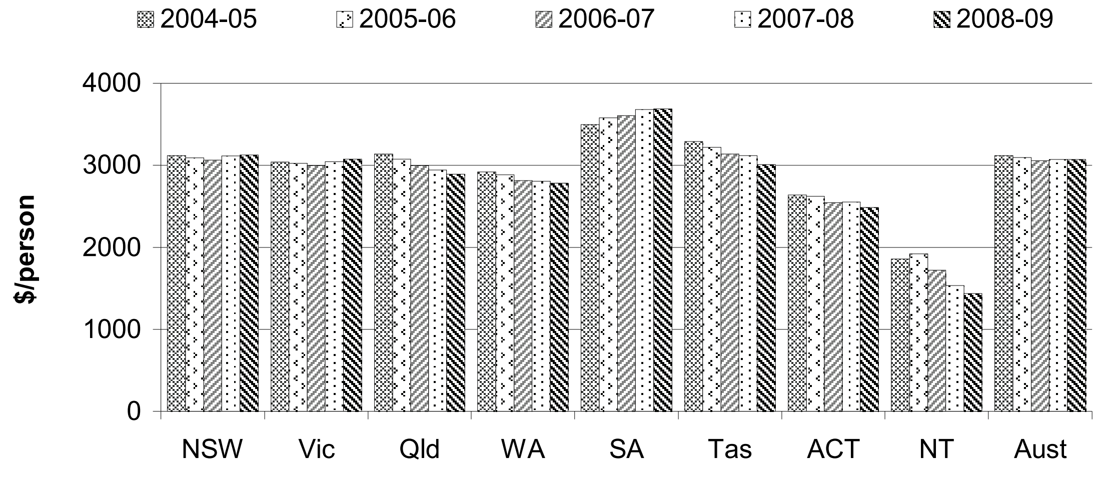
This is a proxy indicator of efficiency and needs to be interpreted with care as it measures cost per target population, not cost per unit of service. While high or increasing expenditure per person can reflect deteriorating efficiency, it can also reflect changes in aspects of the service (such as better quality of services) or in the characteristics of clients receiving the service (such as their geographic location or level of care need). Similarly, low or declining expenditure per assessment can reflect improving efficiency or a decrease in service standards.

Data reported for this indicator are comparable.

Nationally, Australian Government real expenditure by both DoHA and DVA on residential care services per person aged 70 years or over plus Indigenous people aged 50–69 years decreased slightly from $3117 in 2004-05 to $3070 in 2008-09 (figure 13.29). If the payroll tax supplement paid by the Australian Government is excluded, this expenditure decreased nationally from $3127 in 2004-05 to $3082 in 2008-09 (table 13A.54).

DoHA expenditure on residential care per person aged 70 years or over plus Indigenous people aged 50–69 years in 2008-09 was $2615 including the payroll tax supplement and $2573 excluding the payroll tax supplement (table 13A.53). DVA expenditure on residential care per person aged 70 years or over in 2008-09 was $467 including the payroll tax supplement and $459 excluding the payroll tax supplement (table 13A.45).

Figure 13.29 **Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2008-09 dollars)**[a, b]

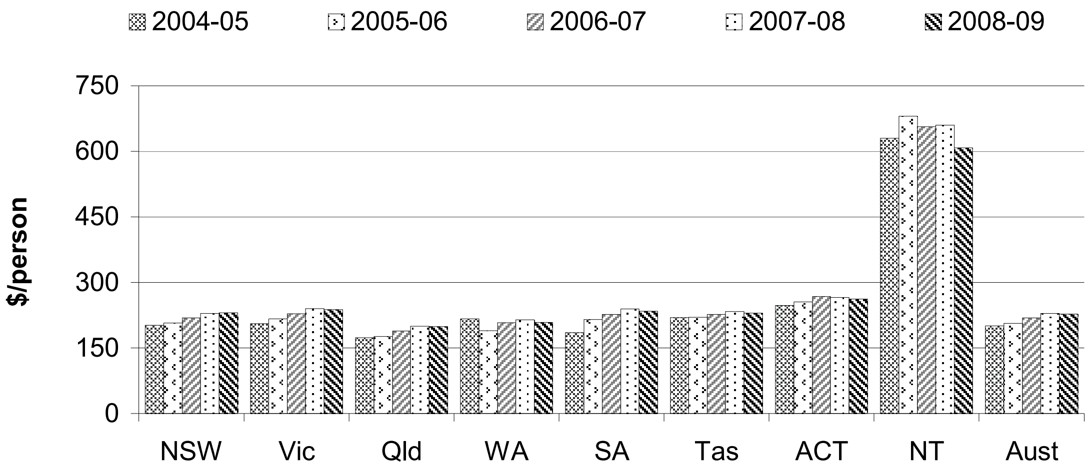


[a] Includes a payroll tax supplement provided by the Australian Government. Actual payroll tax paid may differ. [b] Population data for June 2008 and June 2009 are based on ratios from ABS 2006 Census data applied to population projections by SLA 2006–2026 and 2007–2027, respectively. Population data for earlier years are based on 2001 Census data applied to population projections by SLA 2002–2022. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); DVA (unpublished); table 13A.54.

Australian Government expenditure on CACPs per person aged 70 years or over plus Indigenous people aged 50–69 years was similar in most jurisdictions except the NT in 2008-09. Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from $201 in 2004-05 to $227 in 2008-09 (figure 13.30).

Figure 13.30 Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2008-09 dollars)[a]



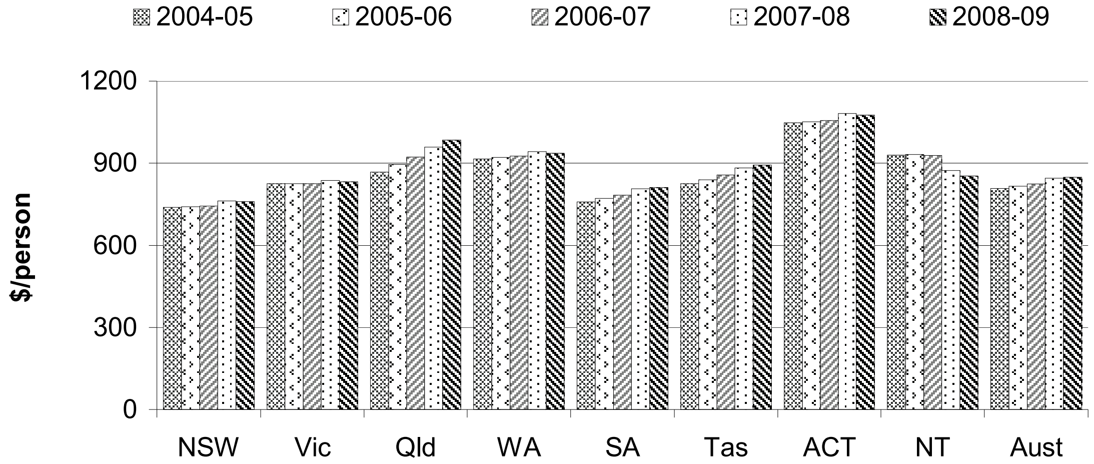
---

[a] Population data for June 2008 and June 2009 are based on ratios from ABS 2006 Census data applied to population projections by SLA 2006–2026 and 2007–2027, respectively. Population data for earlier years are based on 2001 Census data applied to population projections by SLA 2002–2022. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); table 13A.57.

Australian, State and Territory government expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions. Nationally, real expenditure increased from $808 in 2004-05 to $850 in 2008-09 (figure 13.31). These figures reflect expenditure against the population used as the proxy in this chapter (see section 13.1), which is not the same as the HACC target population. Expenditure per person in the HACC target population is reported in table 13A.55.

Figure 13.31 Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2008-09 dollars)[a, b, c, d, e]



---

[a] People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person and the definition of the HACC target population are contained in table 13A.55. [b] This figure only represents expenditure under HACC Agreements. [c] Reports provisional HACC data that have not been validated and may be subject to revision. [d] Expenditure reflects an equalisation strategy. See notes to table 13A.56 for more detail. [e] Population data for June 2008 and June 2009 are based on ratios from ABS 2006 Census data applied to population projections by SLA 2006–2026 and 2007–2027, respectively. Population data for earlier years are based on 2001 Census data applied to population projections by SLA 2002–2022. See footnotes to table 13A.2 for more information.

Source: DoHA (unpublished); table 13A.56.

Outcomes

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

Social participation in the community

'Social participation in the community' has been identified for development as an indicator of governments' objective to encourage the wellbeing and independence of frail older people (box 13.24).

Box 13.24 **Social participation in the community**

‘Social participation in the community’ is yet to be defined.

Higher rates of participation in the community are more desirable.

When developed for future Reports, this indicator will show the extent to which older people participated in community, cultural or leisure activities.

Maintenance of individual functioning

‘Maintenance of individual functioning’ is an indicator of governments’ objective for aged care services to promote the health, wellbeing and independence of frail older people (box 13.25).

Box 13.25 **Maintenance of individual functioning**

‘Maintenance of individual functioning’ is defined as improvement in Transition Care Program (TCP) clients level of functioning, reflected in the movement from the average Modified Barthel Index (MBI) score on entry to the average MBI score on exit from the TCP. The minimum MBI score is 0 (fully dependent) and the maximum score is 100 (fully independent).

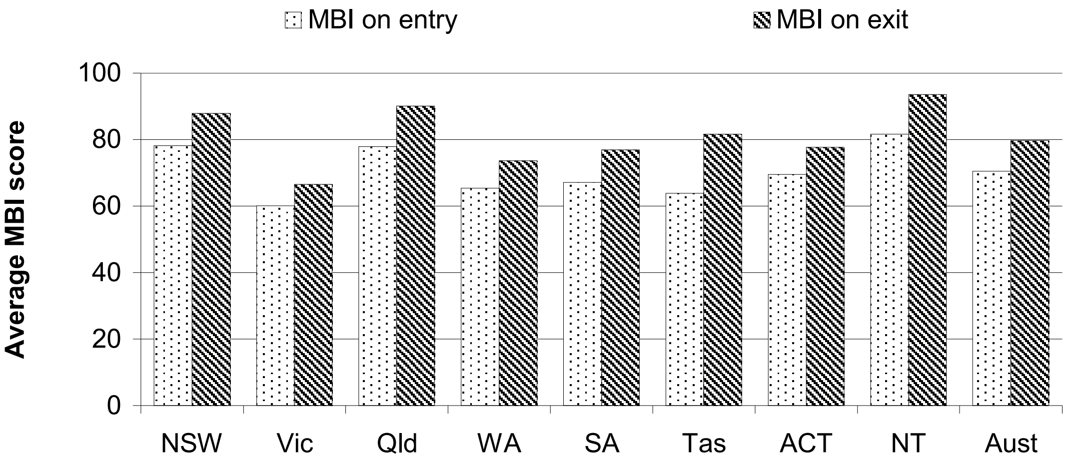
This indicator needs to be interpreted with care. The TCP is one aged care program where it is possible to measure a change in a client’s level of functioning. Variation in the average MBI scores on entry and exit from the program may reflect a range of target client groups for the program across jurisdictions.

The TCP is a small program at the interface of the health and aged care systems. It may be possible to develop measures for other aged care programs such as residential aged care and community aged care services which would be indicators of maintenance of individual functioning.

Data reported for this indicator are comparable.

The average MBI score on entry to the TCP in 2008-09 was 70.5 nationally. The average MBI score on exit from the TCP was 79.7 nationally. These results varied across jurisdictions (figure 13.32).

Figure 13.32 **Transition care program — average Modified Barthel Index score on entry and exit, 2008-09**[a]



MBI: Modified Barthel Index. [a] The MBI is a measure of activities of daily functioning, ranging from 0 (fully dependent) to 100 (fully independent). Data are reported for Transition Care Program recipients who successfully completed a Transition Care episode.

Source: DoHA (unpublished); table 13A.51.

Enabling people with care needs to live in the community

'Enabling people with care needs to live in the community' has been identified for development as an indicator of governments' objective to delay entry to residential care (box 13.26).

Box 13.26 **Enabling people with care needs to live in the community**

'Enabling people with care needs to live in the community' is yet to be defined.

Higher rates of people with care needs remaining and participating in the community are more desirable.

When developed for future Reports, this indicator will show the extent to which older people's entry to residential care is delayed and the extent to which older people participate in community, cultural or leisure activities.

13.4 Future directions in performance reporting

States and Territories began reporting on five agreed Key Performance Indicators (KPIs) for HACC in 2007-08. In 2008-09 an additional two KPIs will be reported on, they are:

- percentage of HACC funded organisations that have supplied acquittals, and
- unit cost to refer to the full cost of delivering a service for key service types.

For several other aspects of aged care services, indicators are not fully developed and there is little performance reporting available. Priorities for the future include:

- continued improvement of efficiency indicators, including for HACC services and assessment services
- improved reporting of waiting times for residential aged care
- improved reporting of long term aged care in public hospitals
- further development of outcome indicators.

COAG Developments

Report on Government Services alignment with National Agreement reporting

It is anticipated that future editions of the Aged care services chapter will align with applicable NHA indicators, and the NIRA. Further alignment between the Report and NA indicators, and other reporting changes, might result from future developments in NA and National Partnership reporting.

Outcomes from review of Report on Government Services

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the Intergovernmental Agreement on Federal Financial Relations.

No significant changes from this review are reflected in the 2010 Report. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 Report.

13.5 Jurisdictions' comments

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

Australian Government comments

“ A major achievement in 2008-09 was the implementation of the first round of zero real interest loans to residential aged care providers. This initiative aims to improve the affordability of capital works in high need regions by providing low cost finance to encourage care providers to make places available sooner than would otherwise be the case. The Department assessed the first round of loan applications in September 2008, which resulted in offers of loans for 1348 residential aged care places around the country. The Department will seek applications for a second round of loans next financial year, in conjunction with the 2009-10 Aged Care Approvals Round.

Work also commenced on the Australian Government’s commitment to double the number of transition care places available from 2000 to 4000 places by 2011-12. The implementation of this initiative is progressing well with the first batch of 228 additional transition care places becoming operational during 2008-09 and the second batch of 470 places being allocated to states and territories in March 2009.

Another major achievement was the implementation of changes to make the income test for residents fairer and simpler. Previously, self-funded retirees paid higher income-tested fees because most of their income was counted under the income test. These changes ensure that pensioners and self-funded retirees are now treated in the same way, irrespective of whether they are on a pension or private income.

A new federal financial framework began on 1 January 2009. The changes include a major rationalisation of the number of payments to the states for Specific Purpose Payments, reducing the number of such payments from over 90 to 5. Under these arrangements Australian Government payments to state and territory governments for the home and community care and aged care assessment programs are now paid by the Commonwealth Treasury to state and territory treasuries. These payments are recorded as payments by the Department of Health and Ageing in this report. ”

New South Wales Government comments

Towards 2030: Planning for our changing population is the whole of government strategy to manage demographic change. All NSW Government agencies are responsible for implementing actions under this strategy, which include building workforce, capacity to respond to changing demographics and improving service delivery to ensure that NSW continues to offer the quality care and support needed by an ageing population.

NSW Health is successfully developing the joint State and Commonwealth Transitional Aged Care Program which provides time-limited, low intensity therapy and support to older people in order to reduce unnecessary extended stays in hospital and/or premature admission to residential aged care. Implementation of the Long Stay Older Patients (LSOP) program in partnership with the Australian Government Department of Health and Ageing (DoHA) has also enabled NSW Health to enhance its Aged Care Services in Emergency Team (ASET) services and to implement a new Acute to Aged-Related Care Service (AARCS) across the State to coordinate effective and timely discharge planning for older inpatients in accordance with their needs.

NSW Health continues to pursue a range of COAG Aged Care Assessment Program (ACAP) structural reforms. These include: standardising ACAT business practices; developing a NSW ACAT Assessor Accreditation System to improve the consistency and quality of ACAT assessments statewide; and working with DoHA to enhance the e-business capability of all ACATs in NSW through implementation of an electronic Aged Care Client Record (eACCR).

In 2008-09 the NSW Home and Community Care program continued to expand with a total budget of $546 million, an increase of $36 million or 7.1 per cent over 2007-08. The increased funds provided a significant boost to Home and Community Care services across NSW, with expansion of services to improve independence at home, access to community transport and the availability of centre based day care programs for frail older people, young people with disability and their carers. Services for special needs groups also received a substantial increase in funding.

New and innovative ‘independence’ models of service delivery for Home and Community Care clients are being explored which are responsive to individual need and focus on early intervention and building client abilities.

Key strategic directions for the Home and Community Care program in NSW include the simplification of access and pathways, developing a streamlined, risk based approach to the monitoring of performance and quality assurance for providers and building the evidence base to support ongoing development of the HACC program. The NSW Community Care Access Point demonstration project in the Hunter Local Planning Area is the most comprehensive and extensive of its type and is leading the way in promoting clearer pathways to Home and Community Care services and visible access points for people seeking services.

Victorian Government comments

> The rapid ageing of our population is driving focused activity in Victoria's aged care portfolio to ensure that service systems are shaped to meet future needs. Examination of alternatives for future policy and funding responsibilities has been a subject of discussion this year. It will be important that the model finally adopted facilitates integration with primary health services and promotes continuity of care.
>
> It is becoming increasingly clear that providing services that substitute for a person’s own effort as that person experiences an 'inevitable' decline in function associated with ageing is both unsustainable and may be detrimental to the person's wellbeing. We are turning to a 'reablement' approach to shape future services. That approach encourages independence and motivates improvement by providing positive expectations, opportunities for development and positive experiences. Reablement involves improving health and functional capacity together with reconnecting people into community involvement and social relationships.
>
> The summer of 2008-09 brought extraordinary heatwave conditions and Victoria's Aged Care Program acted quickly to help providers of community and residential aged care to prepare and to support vulnerable older people. Authoritative public health information was distributed by a range of media, incorporating advice on strategies to maintain hydration and control body temperature. On particularly hot days, there was direct targeting to providers of services to the most vulnerable clients. Some funds were also provided to assist older people plan for future heatwave events, such as by installing shade cloths.
>
> An assessment of health impacts of the heatwave of January 2009 showed 374 excess deaths, of which the greatest number were among people aged over 75 years. During extremely high temperatures over the period Wednesday 28 January to Sunday 1 February 2009, the Personal Alert Victoria service increased staff resources to respond to increased demand. Capacity was also provided to enable call centre staff to remind clients who made telephone contact to drink water and keep cool. Personal Alert Victoria reported an increase in missed daily calls, significantly increased numbers of medical emergencies, and higher than average number of cancellations as a result of clients being deceased during the heatwave.
>
> Ongoing work between the Department's Health Protection and Aged Care program areas will provide heatwave information and resources for older Victorians and service providers in preparation for next summer.

Queensland Government comments

> Queensland has continued to support the programs and services that improve the quality of life of older people and their carers and has worked closely with the Australian Government in implementing national programs.
>
> In 2008-09, the State Government contributed over $135 million to the HACC program. The priorities for the HACC Queensland Triennial Plan 2008–2011 include a particular focus on improving service accessibility and delivery for Aboriginal and Torres Strait Islander people, people living with dementia, people from culturally and linguistically diverse backgrounds, and carers.
>
> New services funded in 2008-09 included: seven regional HACC Multicultural Advisory Services – to help break down cultural and language barriers to improve access to HACC services for people from diverse backgrounds; and seven regional HACC Dementia Advisory and Support Services – designed to support both HACC-eligible people who have dementia, their carers and also through education and training to HACC service providers.
>
> The Rockhampton Access Point Demonstration Project catchment area was expanded in early 2009, which resulted in a usage increase of 50 per cent.
>
> Queensland has continued to implement places approved under the Transition Care Program under the first and second phases. As at 30 June 2009, 389 of these places were operational. During 2008-09, Queensland Health contributed over $16 million towards the cost of Transition Care.
>
> Queensland Health is implementing local based initiatives under the Long Stay Older Patients' Program. These initiatives include capital works at 12 rural sites. Activities such as Hospital in the Home, Interim Care, Early Intervention and Hospital Avoidance are also being implemented across metropolitan and major provincial sites.
>
> Queensland supports 20 State owned and operated residential aged care facilities. In 2008-09, the State Government contributed in excess of $79 million of an overall expenditure of over $152 million. Further capital expenditure of $5 million was expended on the upgrade of these facilities.
>
> During 2008-09, over 35 000 aged care assessments were completed by the Aged Care Assessment Teams operating across Queensland. Four projects were progressed from funding provided by COAG to address the timeliness and consistency of aged care assessments.
>
> Queensland also contributed $10 million in 2008-09 for the Healthier Ageing Program aimed at addressing lifestyle factors impacting on the health of older people. In excess of $800 000 was also provided for the Strengthening Aged Care initiative.

Western Australian Government comments

> The Western Australian Government continued to progress reforms outlined in the WA Health Clinical Services Framework 2005–2015 relating to the health needs of older people. An overarching policy document, 'Models of Care for the Older Person in WA' outlines the service redesign, aimed at developing a service system that provides clients with a coordinated pathway to a range of care.
>
> The WA Home and Community Care (HACC) Program 'Assessment Framework Service Redesign' document was developed in April 2009 as an outcome of the ongoing implementation of the 'Wellness Approach' and the National evaluation of the Access Network Demonstration Projects. The 'Assessment Framework' advocates the need for service redesign within HACC to facilitate the emerging thinking and trends in access and assessment in community care.
>
> At the Council of Australian Governments meeting in December 2008, the WA Premier and the Federal Minister for Health and Ageing signed an agreement for the improved delivery of subacute care services under the National Health Partnership Agreement. As part of the agreement, WA has committed to increase subacute care services in the areas of rehabilitation, geriatric evaluation and management, psychogeriatric care and palliative care.
>
> Work has also commenced on the development and implementation of the Friend In Need – Emergency (FINE) scheme that aims to deliver care and support to people in need enabling them to remain in their own home (including residential aged care). Most importantly, for the person 'at risk' and their carer, benefits of the FINE scheme will include maintaining quality of life, addressing challenges of functional decline, and receiving care at home rather than presenting to an emergency department or being admitted to hospital.
>
> The expansion of the Transitional Care Program has continued across WA with a total of 178 transition care places being operational. On average, 53 per cent of transition care clients have been discharged home with or without the support of community care services and 14 per cent discharged to permanent residential aged care.
>
> On a foundation of work aimed at implementing the Age-friendly principles and practices of the Australian Health Ministers' Advisory Committee's National Action Plan, WA continues to support the implementation of the 'Long Stay Older Patients' initiative. A key component of the WA COAG 'Long Stay Older Patients Initiative' is to strengthen multidisciplinary Care Coordination Teams in metropolitan hospital emergency departments and for WA Country Health Services the strategy focuses on strengthening rural hospital emergency departments' capacity to risk screen and access allied health in a timely fashion.

South Australian Government comments

The Department for Families and Communities through the Office for the Ageing continues to lead the development and implementation of ‘Improving with Age — Our Ageing Plan for South Australia’. State of the Ageing in South Australia brought together researchers and academic expertise to collaborate on understanding the implications of the rapidly ageing population in South Australia. The report was launched in September 2009.

In keeping with the national community care reforms and COAG’s initiative to improve access to community care, South Australia established Access2HomeCare, a community care access point demonstration project. The project covers a metropolitan (western Adelaide) and a country site (Gawler, Barossa, Lower North and Yorke Peninsula communities). A screening tool was developed for consistency across the two sites. A database has been developed to assist in the allocation of referrals to providers who have the capacity to accept clients and provide the services required.

The Aged Care Assessment Program projects are developed under the COAG initiative. These projects aim to improve timeliness and consistency of assessments. Specific initiatives undertaken in SA include:

- decreasing the number of clients on Aged Care Assessment Team (ACAT) waitlists by providing additional assessment staff and support
- streamlining ACAT business processes and improving data quality and the consistency and timeliness of ACAT assessments across South Australia through a State-wide approach to change management.

The South Australian HACC program continues to take a strategic approach to funding allocation, with the introduction of a number of new initiatives aimed at improving the evidence base for funding planning and allocation. The South Australian HACC program continued to expand, with $11.1 million in additional funding bringing the total budget to $149.7 million in 2008-09. This funding was distributed according to priorities documented in the Triennial Plan (2008-09 to 2010-11), which included target group priorities of:

- people with dementia including younger onset and their carers
- frail older people including those with complex needs and their carers
- older people living in supported residential facilities
- frail older people from culturally and linguistically diverse (CALD) backgrounds and their carers
- frail older Aboriginal people and their carers.

Additional funding was allocated for services for Aboriginal people and people from CALD backgrounds, with CALD-specific funding increasing from $2.5 million in 2001-02 to $7.25 million in 2008-09. Funding was also allocated to specific projects for carers and to implement the State-wide Dementia Action Plan.

Tasmanian Government comments

“The Tasmanian Government is building a health and human services system that will withstand the impact of demographic change, and provide the care and assistance Tasmanians need. The Government’s reform agenda is vital to the future health and wellbeing of the Tasmanian community. It includes putting Tasmania’s Health Plan into action and implementing changes to children and family services, disability services and housing, with the aim of increasing social inclusion and improving health and social outcomes in the State.

Implementation of Tasmania’s Health Plan involves more than 100 projects, many of which have already commenced and others which will commence within 5 years.

Service development and redesign initiatives during 2009 have been implemented in a restructured Department of Health and Human Services aimed at better integrating and strengthening acute, primary and community health services within three newly-established regional area health services.

The establishment of an Aged Care and Rehabilitation Clinical Network is also anticipated to promote the involvement of clinicians, service providers, and consumers in the State-wide planning, delivery, evaluation and improvement of aged care and rehabilitation services in Tasmania.

The joint-funded Transition Care Program for older patients in hospitals has achieved over 40 per cent growth across Tasmania during 2009, offering valuable alternative care to older people in hospital requiring slow stream rehabilitation and waiting for discharge either to residential aged care or home.

In addition to the Transition Care Program, the co-funded Long Stay Older Patients Initiative supports aged care liaison teams and augments State funded aged care services such as geriatric evaluation and management units, rehabilitation services and transition care for older people.

Hospitals have also employed a number of other State funded strategies to provide for improved transition of older people who are assessed and approved for residential aged care, including the purchase of beds in private aged care facilities to provide transition type care for patients awaiting permanent transfer to residential aged care.

Considerable progress has also been achieved over 2009, in commissioning a centralised contact, referral, filtering, and screening contact point for older Tasmanians into aged and community care services across the State.”

Australian Capital Territory Government comments

The ACT continues to support older people and their carers through programs and services that promote health and wellbeing, optimise independence and improve the quality of life of older people. The ACT is committed to working closely with the Australian Government in the implementation of national programs.

Additional resources were made available in 2008-09 to expand a range of health-care services offered to older people in the ACT. The Rapid Assessment of the Deteriorating Aged at Risk service developed into a multidisciplinary team with the addition of allied health support. The service has been successful in reducing avoidable hospital admissions and was the winner of the 'Innovative Model of Care' category of the ACT Health Quality Awards, as well as being the overall winner for 2008.

The ACT Equipment Loan Service was enhanced in 2008-09 to improve client outcomes and an Older Person's Dietetic Service was established to identify and treat malnutrition in the elderly and to provide post-discharge guidance and support.

On 1 July 2008, the ACT Transition Care Program expanded to 37 operational places. During 2008-09 219 older people were assisted by the service and over 70 per cent were able to return to their own homes with or without the support of aged care or Home and Community Care (HACC) program services.

2008-09 was the commencement of the first Triennial Plan for the ACT HACC Program. The plan outlines the strategic directions and funding priorities for the HACC Program in the ACT over 3 years to June 2011. ACT priorities for growth funding in 2008-09 were directed to expanding direct client service provision. Promotion of continuous quality improvement across the community care sector continued in 2008-09 with all ACT HACC agencies being evaluated by external evaluators using the HACC National Service Standards Instrument and Guidelines.

In 2008-09 the ACT Aged Care Assessment Team (ACAT) progressed four COAG funded projects to improve the quality, efficiency and consistency of ACAT assessments in the ACT. These projects included new information technology, dementia training, development of the ACAT Education Officer role to support ACAT training needs and attendance of ACT ACAT members at the national conference.

Northern Territory Government comments

“ The NT is committed to supporting people as they age and encouraging them to take responsibility for their own health and financial wellbeing. As part of this commitment, the NT has continued to progress issues of ageing under the Active Ageing Framework (the Framework). The Framework focuses on how people can maintain their good health, continue to remain mentally and physically active and retain their independence regardless of their age.

Though the aged population numbers in the NT are not as high in comparison to other jurisdictions, the prospective increase of growth in this population across the NT is the largest in Australia. The NT’s projected growth rate for people aged 65 years and over is 4.5 per cent per annum over the next 20 years. In addition to this, the NT experiences unique constraints that affect the servicing of the aged population. These constraints include geographic, climatic and cultural barriers, as well as the recruitment and retaining of an aged trained workforce.

During 2008-09 the NT implemented changes that were introduced as part of the amalgamation of community government councils to larger shire councils. There was minimal impact on service delivery under the new arrangements. Work commenced on streamlining the reporting requirements for remote communities to a shire based model which will come into effect in 2009-10.

In 2008-09 the number of allocated places under the Transition Care Program were increased by 6 to bring the NT’s total allocation to 22. The additional 6 places are community based, increasing the flexibility of the program in the NT. The other 16 places continued to be residential based with 4 places each in Darwin and Alice Springs and 8 places in Katherine.

The NT operated 6 Aged Care Assessment Teams (ACATs) during 2008-09. These teams undertook assessments across the NT including in remote communities. The ACATs are jointly funded by the NT and Australian governments, with the NT providing a significant investment to ensure that the frail aged in regional and remote areas receive this service. This investment is also ensuring that clients receive comprehensive aged care assessment and case coordination where considered necessary as part of a best practice.

The NT had a combined HACC funding pool of $11 0 million for 2008-09. 90 non-government providers were funded to provide services to the frail aged and younger people with disabilities, and their carers.

The Community Development Employment Projects Program for positions in HACC services in remote communities was managed by the NT during 2008-09. This initiative provided the NT with $6.2 million in funding for wages for 304 Aboriginal and/or Torres Strait Islander people to work in part time positions in HACC services.

As in previous years, indicators based on the estimated number of people with severe, profound and/or core activity limitations in the NT need to be interpreted with caution. Small variations in service and population data appears in magnified proportions to the small population in the NT. ”

13.6 Definitions of key terms and indicators

Adjusted subsidy reduction supplement	Payments made to equalise the recurrent funding paid by the Australian Government as adjusted subsidy reduction places to public sector residential care operators. The states and territories provide top-up funding for residential aged care places at a rate set by the Minister for Health from 1 July each year
Accreditation	Accreditation is a key component of the Australian Government's quality framework for federally funded residential aged care and is a quality assurance system for residential aged care services — based on the principle of continuous improvement. Accreditation requires assessment against the 44 expected outcomes used for accreditation assessment — grouped into four standards: management systems, staffing and organisational development; health and personal care; residential lifestyle; and physical environment and safety systems.
Aged care	Formal services funded and/or provided by governments that respond to the functional and social needs of frail older people, and the needs of their carers. Community aged care services aim to optimise independence and to assist frail older people to stay in their own homes, while residential care services provide accommodation and care for those who can no longer be assisted to stay at home. Assessment of care needs is an important component of aged care. The majority of aged care services assist in activities of daily living such as personal care (for example, bathing and dressing), housekeeping and meal provision. Other services aim to promote social participation and connectedness. These services are delivered by trained aged care workers and volunteers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists. Aged care services generally aim to promote wellbeing and foster function rather than to treat illness. Although some aged care services such as transition care have a specific restorative role, they are distinguished from the health services described in Part E of this Report. Aged care services may be funded through programs specifically or mainly directed to older people, or through programs that address the needs of people of different ages. Generally, the target groups of aged care services are people aged 70 years or over and Indigenous people aged 50 years or over.
Ageing in place in residential care	An approach that aims to provide residents with appropriate care and increased choice by allowing them to remain in the same facility regardless of changes in their level of care needs. It also allows couples with different levels of care needs to be cared for in the same facility. The main facet of 'ageing in place' is that funding is tied to the assessed care needs of the client rather than to the services provided by the facility. One of the objectives of Australian Government aged care legislation is 'to promote ageing in place through the linking of care and support services to the places where older people prefer to live' (*Aged Care Act 1997* (Cwlth), s.2-1 [1j]).
Capital expenditure on residential services	Expenditure on building and other capital items, specifically for the provision of Australian government funded residential aged care.

Centre day care	Respite care provided from a facility such as a day care or health centre. Respite care is usually combined with social support services to maintain the functional capabilities of the person receiving care.
Complaint	A complaint by the affected care recipient or his or her representative, or anyone else, to the Secretary of the Department of Health and Ageing about anything that: • may be a breach of the relevant approved provider's responsibilities under the *Aged Care Act 1997* or the Aged Care Principles • the complainant thinks is unfair or makes the affected care recipient dissatisfied with the service.
Dementia services program	Includes flexible and innovative support, respite, counselling, information and referral services, education and leisure. The program includes meeting individual and immediate needs which cannot be met by other services, through carer respite services and other carer support agencies. Inpatient services are excluded.
Disability	A limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.
EBA supplement	Payments made to supplement services for the extra costs associated with public sector enterprise bargaining agreements over and above those required by other wage Awards.
HACC target population	The HACC Target population is people in the Australian community who, without basic maintenance and support services provided under the scope of the HACC Program, would be at risk of premature or inappropriate long term residential care, including (i) older and frail people with moderate, severe or profound disabilities; (ii) younger people with moderate, severe or profound disabilities; and (iii) such other classes of people as are agreed upon, from time to time, by the Commonwealth Minister and the State Minister. The HACC Target Population is estimated by applying the proportion of people in households with a moderate, severe, or profound disability as reported in the ABS 2003 *Survey of Disability, Ageing and Carers* to the ABS Population Projections by SLA 2002–2022.
High/low care recipient	On entry, a resident is classified as high or low care based on their ACAT assessment and their approved provider's appraisal of their care needs under the ACFI. Residents whose ACAT approval is not limited to low care are classified as high care if they have an ACFI appraisal of: • medium or high in activities of daily living • high in behaviour or • medium or high in complex health care. All other ACAT approval and ACFI appraisal combinations result in a classification of low level care. A residents care needs may change over time resulting in a change in classification from low to high level care (ageing in place).
In-home respite	A short term alternative for usual care.
People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Where a person does not need assistance, but has difficulty with self-care, mobility or communication.
People with a profound disability	Where a person is unable to perform self-care, mobility and/or communication tasks, or always needs assistance.

People with a severe disability	Where a person sometimes needs assistance with self-care, mobility or communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing).
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (*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)*.
Waiting times	The measure of the elapsed time between ACAT approval and entry into a residential care service. It has been used in past years as an indicator of access to residential care.

13.7 Attachment tables

Attachment tables are identified in references throughout this chapter by an '13A' suffix (for example, table 13A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Table 13A.1	Males and females aged 70 years or over, June 2009
Table 13A.2	Target population data, by location ('000)
Table 13A.3	Proportion of people aged 70 years and over by locality, June 2009
Table 13A.4	Ownership of operational aged care residential places, June 2009
Table 13A.5	Average annual Australian Government basic subsidy amount, including Conditional adjustment payment, per occupied place and the dependency level of aged care residents, June 2009
Table 13A.6	Size and distribution of all residential aged care services, June 2009
Table 13A.7	Size and distribution of residential aged care services with over 80 per cent high care residents, June 2009
Table 13A.8	Size and distribution of residential aged care services with over 80 per cent low care residents, June 2009
Table 13A.9	Size and distribution of mixed residential aged care services, June 2009
Table 13A.10	Proportion of residential aged care places, by location in high care, low care and mixed care services
Table 13A.11	Operational number of aged care places per 1000 people aged 70 years or over, 30 June
Table 13A.12	Operational number of aged care places per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 30 June
Table 13A.13	Aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years, 30 June
Table 13A.14	Aged care recipients per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years by locality, 30 June
Table 13A.15	Aged care recipients from a non-English speaking country, 30 June
Table 13A.16	Aged care recipients from a non-English speaking country per 1000 people from a non-English speaking country aged 70 years and over by locality, 30 June
Table 13A.17	Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over and as a proportion of all recipients, 30 June
Table 13A.18	Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over by locality, 30 June
Table 13A.19	Aged care recipients from special needs groups, June 2009 (per cent)
Table 13A.20	Proportion of new permanent residents classified as supported residents, 2008-09 (per cent)

13.8 References

ABS (Australian Bureau of Statistics) 2006, *Australian Standard Geographic Classification*, Cat no. 1216.0, Canberra.

—— 2004, *Survey of Disability, Ageing and Carers*, 2003, Cat no. 4430.0, Canberra.

—— 2009, *Experimental Life Tables for Aboriginal and Torres Strait Islander Australians, Australia, 2005-2007*, Cat no. 3302.0.55.003, Canberra.

ACSAA (Aged Care Standards and Accreditation Agency Ltd) 2009, http://www.accreditation.org.au/accreditation/ (accessed 12 October 2009).

COAG (Council of Australian Governments), 2006, *Better Health For All Australians Action Plan Attachment D to COAG meeting*, 10 February 2006, http://www.coag.gov.au/meetings/100206/attachment_d_better_health.rtf.

DoHA (Department of Health and Ageing) 2008, *National Evaluation of the Transition Care Program RFT 206/0506 Final Evaluation Report,* Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2009, *Report on Government Services 2009,* Productivity Commission, Canberra.

14 Services for people with disability

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 14A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

The Australian, State and Territory governments aim to ensure that people with disability and their carers have an enhanced quality of life and participate as valued members of the community. The *National Disability Agreement* (NDA), effective from 1 January 2009, provides the national framework and key areas of reform for the provision of government support and services for people with disability. The NDA replaced the third *Commonwealth State Territory Disability Agreement* (CSTDA), which commenced on 1 July 2002 and was due to expire on 30 June 2007. To enable negotiations for the new NDA to be finalised, the third CSTDA was extended to 31 December 2008. Box 14.1 provides an overview of the CSTDA and the NDA.

Box 14.1 *Commonwealth State Territory Disability Agreement* and the *National Disability Agreement*

Up until 31 December 2008, the CSTDA formed the basis for the provision and funding of specialist services for people with disability, where the person's disability manifested before the age of 65 years and for which they required ongoing or long-term episodic support. The purposes of the CSTDA were to:

- provide a national framework to underpin the provision of specialist disability services across Australia, and outline a means for measuring and publicising the progress of governments towards achieving this national framework
- outline the respective and collective roles and responsibilities of governments in the planning, policy setting and management of specialist disability services
- provide for accountability to funders in respect of funds contributed by one government which are expended by another government
- establish the financial arrangements for making funds available for the provision of specialist disability services
- define the persons eligible for services under the Agreement and acknowledge they may require services provided outside the Agreement
- provide for a nationally consistent approach to quality across specialist disability services
- provide for funds to address key national and strategic research, development and innovation priorities.

On 1 January 2009, the NDA replaced the CSTDA. The NDA is a schedule to the broader Intergovernmental Agreement on Federal Financial Relations between the Australian, State and Territory governments. The NDA clarifies the roles and responsibilities of the Australian, State and Territory governments in the provision of government support to people with disability and provides the basis for reforms to the disability services system.

The focus of the NDA is on the provision and funding of specialist disability services. The NDA also acknowledges that specialist disability services are complemented by mainstream services and income support measures.

(Continued on next page)

Box 14.1 **(Continued)**

Reforms under the NDA are directed at creating a disability services system that is effective, efficient and equitable, and has a focus on: early intervention; timely, person-centred approaches; and lifelong planning. Ten priority areas have been identified to underpin the policy directions and achieve these reforms:

- better measurement of need
- population benchmarking for disability services
- making older carers a priority
- quality improvement systems based on disability standards
- service planning and strategies to simplify access
- early intervention and prevention, lifelong planning and increasing independence and social participation strategies
- increased workforce capacity
- increased access for Indigenous Australians
- access to aids and equipment
- improved access to disability care.

Other specific details relating to the NDA (such as roles and responsibilities of different governments) are provided throughout the chapter.

Source: COAG (2009); CSTDA (2003).

To reflect the transition from the CSTDA to the NDA, the approach taken in this chapter is described below:

- Information on the general policy context draws on aspects of both Agreements. The roles and responsibilities, for example, are those defined under the NDA. The service overview includes a detailed list of service groups that were specified under the CSTDA and which underpin the collection of data on specialist disability services. As latest performance results cover services provided under the CSTDA (2007-08) and the CSTDA/NDA (2008-09), objectives for both Agreements are included.
- Financial data for 2008-09 includes expenditure on services under the NDA that was not expended under the CSTDA, for example, aids and equipment funding and expenditure on the ‘Younger people in residential aged care (YPIRAC)’ program.
- Results based on the National Minimum Data Set (NMDS) service user data for 2007-08 (the latest year for which data are available) are reported using the specifications developed and agreed under the CSTDA.

This chapter provides information on the assistance provided by governments to people with disability and their carers.

- Specialist disability services provided under the CSTDA/NDA are the focus. Specialist psychiatric disability services are excluded to improve data comparability across jurisdictions. Disability support services are also provided by programs such as Home and Community Care (HACC) and Commonwealth Rehabilitation Services (CRS) Australia. Information on the HACC program is provided in 'Aged care services' (chapter 13). CRS Australia's services are not covered in this Report.
- Some performance information on access by people with disability to mainstream services is provided. Further information on access by people with disability to mainstream services is also included elsewhere in this Report — for example, school education (chapter 4), vocational education and training (VET) (chapter 5), public hospital care (chapter 10), specialised mental health services (chapter 12) and public housing (chapter 16). Other mainstream services and supports provided to people with disability — such as transport and utility services at concessional rates — are outside the scope of this Report.
- Descriptive information on income support to people with disability and their carers is included. This Report generally does not include performance information on income support.

Significant improvements in the reporting of services for people with disability in this year's Report include:

- further refinement of the potential populations used to derive the 'Service use by special needs groups' measures; these populations are used to account for differences in the need for services across the relevant groups
- the redevelopment of the quality assurance processes section to include information for jurisdictions on their legislative frameworks that govern service quality, features of their quality assurance systems and the relevant disability service standards that apply
- the inclusion of a 'yet to be developed' indicator on the program for YPIRAC and additional descriptive information on:
  - the YPIRAC program
  - admissions of younger people to permanent residential aged care.

14.1 Profile of disability services

Service overview

Government assistance for people with disability and their carers comprises provision of specialist disability services, access to mainstream services and provision of income support.

Definitions of disability are provided in box 14.2.

Box 14.2 **Definitions of disability**

The United Nation's *Convention on the Rights of Persons with Disabilities,* ratified by Australia on 17 July 2008, defines 'persons with disabilities' as those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The World Health Organisation (WHO) defines 'disabilities' as impairments, activity limitations, and participation restrictions: an impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; and a participation restriction is a problem experienced by an individual in involvement in life situations. Disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives (WHO 2009).

The Australian Bureau of Statistics (ABS) *Survey of Disability, Ageing and Carers* (SDAC) 2003 defines 'disability' as a limitation, restriction or impairment that has lasted, or is likely to last, for at least 6 months and restricts everyday activities. Examples range from hearing loss that requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision. The SDAC reports on the spectrum of disability experiences using three main 'categories' of disability:

- with a disability, but without a specific limitation or restriction — includes people who need assistance with health care, cognition and emotion, paperwork, transport, housework, property maintenance or meal preparation
- with a schooling or employment restriction
- with a specific core activity limitation (mild, moderate, severe and profound).

(Continued on next page)

Box 14.2 **(Continued)**

Self care, mobility and communication are defined as core activities. The ABS defines levels of core activity limitation as:

- mild — where a person does not need assistance and has no difficulty with self care, mobility and/or communication, but uses aids or equipment. They may also not be able to easily walk 200m, walk up and down stairs without a handrail, bend to pick up objects from the floor or use public transport easily or without help or supervision
- moderate — where a person does not need assistance, but has difficulty with self care, mobility and/or communication
- severe — where a person sometimes needs assistance with self care, mobility and/or communication tasks; has difficulty understanding or being understood by family or friends; or can communicate more easily using sign language or other non-spoken forms of communication
- profound — where a person is unable, or always needs assistance, to perform self care, mobility and/or communication tasks.

The third CSTDA (2003, p. 9) defined ‘people with disabilities’ as those whose disability manifests itself before the age of 65 years and for which they require significant ongoing and/or long-term episodic support. For these people, the disability will be attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is likely to be permanent and results in substantially reduced capacity in at least one of the following:

- self care/management
- mobility
- communication.

The NDA does not have a specific definition of ‘people with disability’.

Source: ABS (2004a); WHO (2009); CSTDA (2003).

Specialist disability services

Specialist disability services are services specially designed to meet the needs of people with disability. These services tend to be targeted at those who have profound or severe core activity limitations. There are seven broad categories of specialist disability services outlined below. These categories underpin the collection of NMDS and expenditure data on specialist disability services:

- *accommodation support services* that provide support to people with disability in accommodation settings (hostels, institutions and group homes), and in their own home (including attendant/personal care, in home support and alternative family placements)

- *community support services* that provide the support needed for a person with disability to live in a non-institutional setting — including therapy support, counselling and early childhood intervention
- *community access services* that provide opportunities for people with disability to gain and use their abilities to enjoy their full potential for social independence — including learning and life skills development and recreation/holiday programs
- *respite care services* that provide a short-term and time-limited break for families and other voluntary caregivers of people with disability, to assist in supporting and maintaining the primary care-giving relationship, while providing a positive experience for the person with disability
- *employment services* for people with disability that provide:
  - open employment services — assistance in obtaining and/or retaining paid employment in the open labour market
  - supported employment services — support and employment within the same organisation
  - targeted support — structured training and support to work towards social and community participation or opportunities to develop skills for, or retrain for, paid employment
- *advocacy, information and print disability services*
  - advocacy services enable people with disability to increase their control over their lives by representing their interests and views in the community
  - information services provide accessible information to people with disability, their carers, families and related professionals about disabilities, specific and mainstream services and equipment; and promote the development of community awareness
  - print disability services produce alternative communication formats for people who are by reason of their disability, unable to access information provided in a print medium
- *other support services* that include research and evaluation, and training and development projects.

Mainstream services

Mainstream services are services provided to the community as a whole. Governments acknowledge that specialist disability services are complemented by mainstream services. Under the NDA, all Australian governments have agreed to 'strive' to ensure that all people with disability have access to mainstream government services within their jurisdictions. It is recognised that improved outcomes for people with disability, their families and their carers, are contingent upon the effective coordination of efforts across government services. Some mainstream services give priority to people with disability (for example, public housing) or have programs to meet the special needs of people with disability (for example, school education).

Income support and allowances

Income support for people with disability and their carers contributes to the outcomes of the NDA. The Australian Government is responsible for the provision of income support targeted to the needs of people with disability, their families and carers (box 14.3). Income support is provided to those who meet the relevant eligibility criteria. Income support payments and allowances include the Disability Support Pension, Carer Payment, Carer Allowance, Sickness Allowance, Mobility Allowance and Child Disability Assistance Payment.

Details of the roles and responsibilities of the Australian, State and Territory governments in relation to assistance for people with disability are outlined in the following section.

Box 14.3 Australian Government supplementary and income support arrangements

Under the NDA, provision of income support for people with disability, their families and carers is a key responsibility of the Australian Government (see 'roles and responsibilities' section). Outlays on income support payments and allowances to people with disability and their carers in 2008-09 (on an accrual basis) amounted to $10.9 billion for the Disability Support Pension, $1.9 billion for the Carer Payment, $1.8 billion for the Carer Allowance, $92.6 million for the Sickness Allowance, $118.5 million for the Mobility Allowance, $142.8 million for the Child Disability Assistance Payment and $408.0 million for the Carer Supplement (Australian Government unpublished).

At 30 June 2009, there were around 757 100 recipients of the Disability Support Pension, 146 900 recipients of the Carer Payment, 474 700 recipients of the Carer Allowance, 56 100 recipients of the Mobility Allowance, 7000 recipients of the Sickness Allowance, 142 100 recipients of the Child Disability Assistance Payment and 478 000 recipients of the Carer Supplement (table 14A.1).

Source: Australian Government (unpublished); table 14A.1.

Roles and responsibilities

Australian, State and Territory governments

The NDA defines the roles and responsibilities of the Australian, State and Territory governments in the provision of services and supports to people with disability and their carers.

The Australian Government is responsible for:

- provision of employment services for people with disability (which includes regulation, service quality and assurance, assessment, policy development service planning, and workforce and sector development) in a manner that most effectively meets the needs of people with disability consistent with local needs and priorities
- provision of income support targeted to the needs of people with disability, their families and carers
- provision of funds to states and territories to contribute to the achievement of the objective and outcomes
- where appropriate, investing in initiatives to support nationally agreed policy priorities, in consultation with State and Territory governments

- ensuring that Commonwealth legislation and regulations are aligned with the national policy, reform directions and the *United Nations Convention on the Rights of People with Disabilities*.

State and Territory governments are responsible for:

- the provision of specialist disability services, except disability employment services (which includes regulation, service quality and assurance, assessment, policy development, service planning, and workforce and sector development) in a manner which most effectively meets the needs of people with disability, their families and carers, consistent with local needs and priorities
- ensuring that State and Territory legislation and regulations are aligned with the national policy and reform directions
- where appropriate, investing in initiatives to support nationally agreed policy priorities, in consultation with the Australian Government.

Australian, State and Territory governments are jointly responsible for:

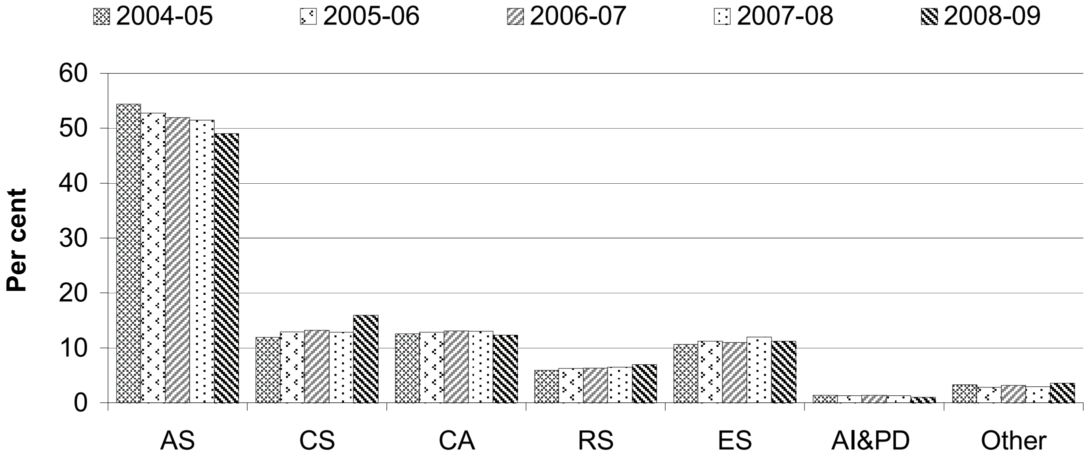
- development of national policy and reform directions to meet the agreed objectives and outcomes of the NDA
- funding and pursuing research that provides an evidence base for national policy and reform directions
- developing and implementing reforms to improve outcomes for Indigenous people with disability
- the provision of data, including a commitment to providing data for the NMDS and a commitment to the improvement of data.

Funding

Australian and State and Territory governments funded both government and non-government providers of specialist disability services under the CSTDA/NDA. Total government expenditure on these services was \$5.2 billion in 2008-09 — a real increase of 5.6 per cent on the expenditure in 2007-08 (\$5.0 billion) (table 14A.4). State and Territory governments funded the majority of this expenditure in 2008-09 (71.1 per cent, or \$3.7 billion). The Australian Government funded the remainder (28.9 per cent, or \$1.5 billion), which included \$856.9 million in transfer payments to states and territories (tables 14A.5 and 14A.6). Table 14A.7 provides data on total government expenditure including and excluding payroll tax.

Direct government expenditure on specialist disability services (excluding expenditure on administration) under the CSTDA/NDA was \$4.8 billion in 2008-09 (table 14A.8). The distribution of direct government expenditure varied across jurisdictions. The main areas of State and Territory government expenditure were accommodation support services (49.0 per cent of total direct service expenditure), and community support (15.9 per cent of total direct service expenditure) (figure 14.1). Employment services were the main area of Australian Government expenditure in 2008-09 (11.2 per cent of total direct service expenditure and 88.2 per cent of Australian Government direct service expenditure) (table 14A.9).

Figure 14.1 **Direct expenditure on CSTDA/NDA funded specialist disability services, by service type[a]**



AS = accommodation support; CS = community support; CA = community access; RS = respite services; ES = employment services; AI&PD = advocacy, information and print disability. [a] See table 14A.8 for detailed notes accompanying expenditure data.

Source: Australian, State and Territory governments (unpublished); table 14A.9.

Size and scope

Disability prevalence

The ABS estimates that 1 in 5 people in Australia (3 958 300 or 20.0 per cent) had one or more disabilities (that is, a core activity limitation, a schooling or employment restriction or an impairment) in 2003 (ABS 2004a). Of the population aged 5–64 years in 2003, an estimated 13.0 per cent had a core activity limitation or specific restriction. This proportion comprised 4.0 per cent who had a profound or severe core activity limitation, 6.6 per cent who had a mild to moderate core activity limitation and 2.4 per cent who had a schooling or employment restriction only (ABS 2004a). Table 14A.10 contains additional information on disability prevalence, and table 14A.11 contains information on the estimated number of people with a profound or severe core activity limitation who received help as a proportion of those who needed help.

Aboriginal and Torres Strait Islander people

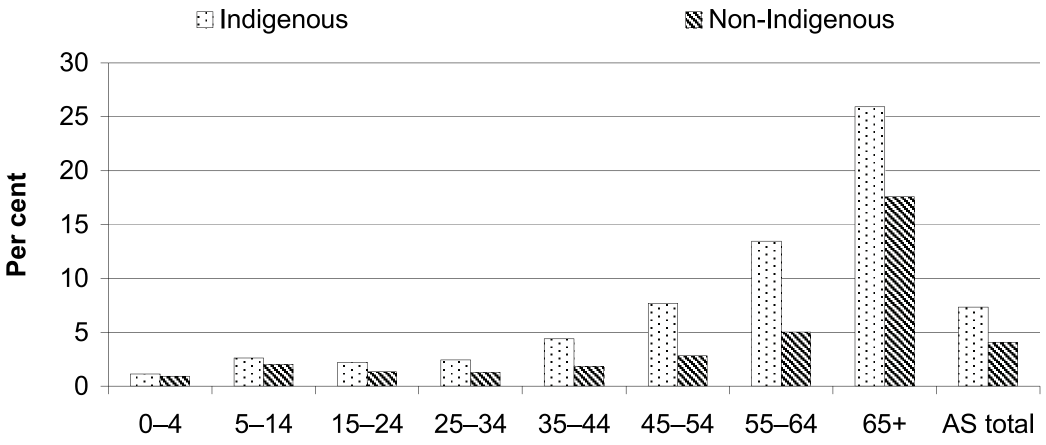
Indigenous people have significantly higher rates of profound or severe core activity limitation than non-Indigenous people. Disability data on 'core activity need for assistance' are available from the ABS 2006 Census. The concept of 'core activity need for assistance' (ASSNP[1]) is similar to the concept of profound or severe core activity limitations, but the relevant data are not suitable for direct comparison due to differences in the questions asked and the methods of data collection.

Nationally, across all age groups in 2006, Indigenous people were 1.8 times as likely (on an age standardised basis) as non-Indigenous people to need assistance with core activities. The disparity between Indigenous and non-Indigenous people increased with age. The gaps were highest in the age groups 45–54 years and 55–64 years. In these age groups, Indigenous people were 2.7 times as likely as non-Indigenous people to need assistance with core activities (figure 14.2). See AIHW (2006) for similar rate ratio estimates based on data from the ABS's *General Social Survey* (GSS) and *National Aboriginal and Torres Strait Islander Social Survey* (NATSISS) (ABS 2003, ABS 2004b).

---

[1] The acronym ASSNP is the variable name used by the ABS to define 'core activity need for assistance'. It appears to incorporate a shortened version of 'assistance need' and the letter 'P' indicates that the classification describes a characteristic of a person. This acronym is used throughout the chapter to denote 'core activity need for assistance'.

Figure 14.2 **People with a need for assistance with core activities, by age group, 2006[a]**



AS = age standardised. [a] Excludes overseas visitors.

Source: SCRGSP (2009) *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commission.

Informal carers

Family and friends provide most help and/or care assistance to people with disability. Information about informal carers enables governments to plan ahead for the future demand for services that support carers and the people they assist. Support services that assist people with disability to live in the community, such as in-home accommodation support and community support, often complement and are contingent upon the availability of informal care. In turn, the provision of informal care may rely on access to formal support services including respite services and a range of other services for the person with disability.

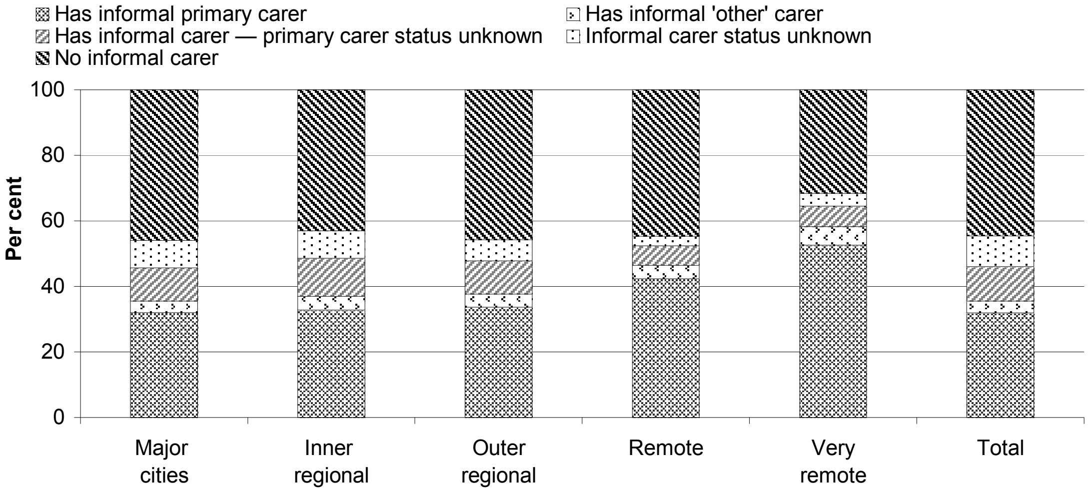
Information on informal carers is available from the ABS SDAC and for CSTDA service users from the NMDS. The definition of informal carers differs slightly across these data collections:

- The ABS SDAC defines an informal primary carer as a person who provides the most informal help or supervision assistance to a person with disability. The assistance must be ongoing, or likely to be ongoing, for at least 6 months and be provided for at least one of the core activities (communication, mobility and self care).
- The NMDS defines an informal carer as someone such as a family member, friend or neighbour, who is identified as providing regular and sustained care and assistance to a person with disability (see section 14.7 for further details).

Informal carers who provide assistance with core activities (self care, mobility and communication) are defined as primary carers.

An estimated 474 600 informal primary carers provided the majority of assistance with self care, mobility and communication for people with disability, including older people in 2003 — an increase of 5.3 per cent since 1998 (ABS 1999, 2004a). Of people with disability who accessed CSTDA funded specialist disability services in 2007-08, 46.1 per cent reported having an informal carer and 31.9 per cent reported having an informal carer who was a primary carer (figure 14.3). Service users in remote or very remote locations were more likely to report having an informal carer than those in other areas. Figure 14.4 shows the proportions of informal primary carers who are in different age groups, by location.

Figure 14.3 **Users of CSTDA funded specialist disability services, by whether they had an informal carer and geographic location, 2007-08**[a, b, c]

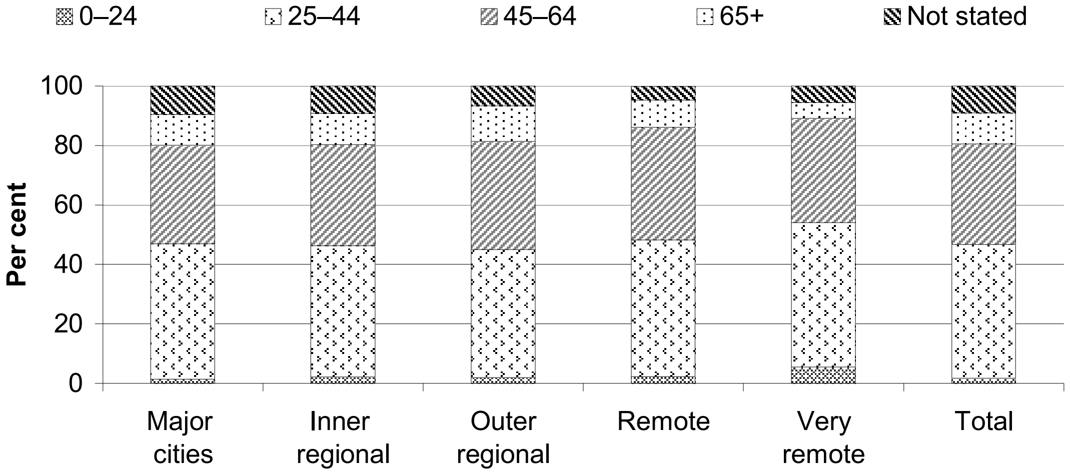


---

[a] Total includes data for service users whose location was not collected/identified. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] Data relating to primary carers are not reported for all service users. Some service types are not required to collect all service user data items. For example, employment services are not required to collect selected informal carer information, including primary status.

Source: Australian Institute of Health and Welfare (AIHW) (unpublished) *CSTDA NMDS*; table 14A.2.

Figure 14.4 **Age distribution of primary carers of people accessing CSTDA funded specialist disability services, by location, 2007-08**[a, b]



---

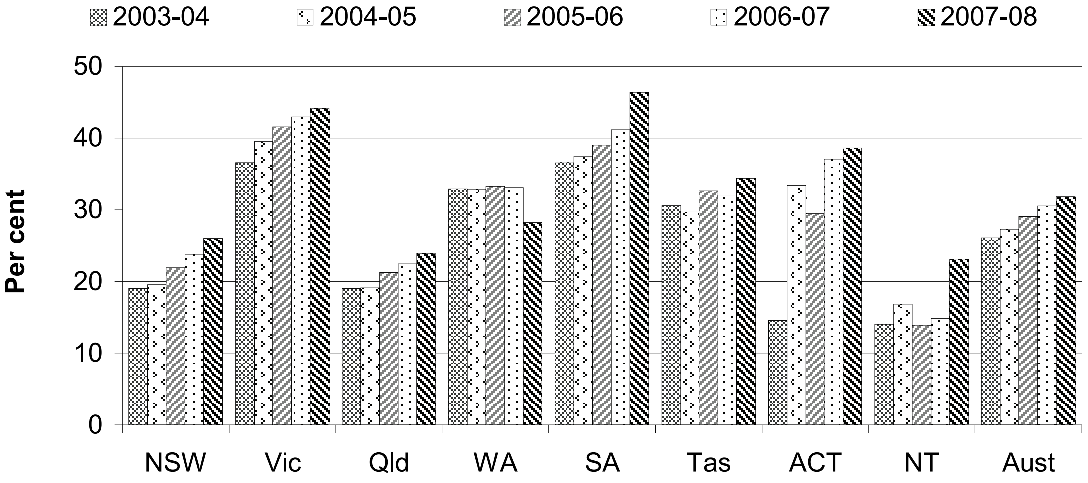
[a] Total includes data for service users whose location was not collected/identified. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *CSTDA NMDS*; table 14A.3.

Use of CSTDA funded services

In 2007-08, 232 985 people were reported as using specialist disability services provided under the CSTDA (excluding service users who received specialist psychiatric disability services only) (table 14A.12). Nationally, this is 31.8 per cent of the estimated potential population (see section 14.7 for information on how the potential population is defined) (figure 14.5).

Figure 14.5 **Users of CSTDA funded specialist disability services as a proportion of the estimated potential population**[a, b]

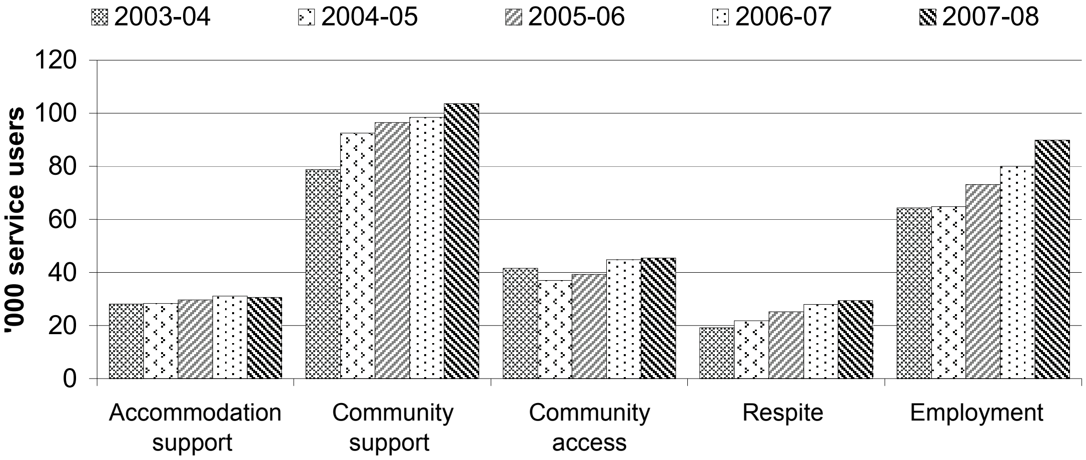


[a] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [b] For the ACT, improved data capture for therapy services resulted in an increased service user count between 2003-04 and 2004-05. The decreased service user rate for 2005-06 was due to incomplete data collection for therapy services.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (2009 and previous years) *Disability Support Services 2007-08, 2006-07, 2005-06, 2004-05, 2003-04: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications); table 14A.12.

Service user numbers varied across service types (figure 14.6). Accommodation support, community access, community support and respite services reported 156 343 users and employment services reported 89 935 users, in 2007-08.

Figure 14.6 **Users of CSTDA funded specialist disability services, by service type**[a, b]



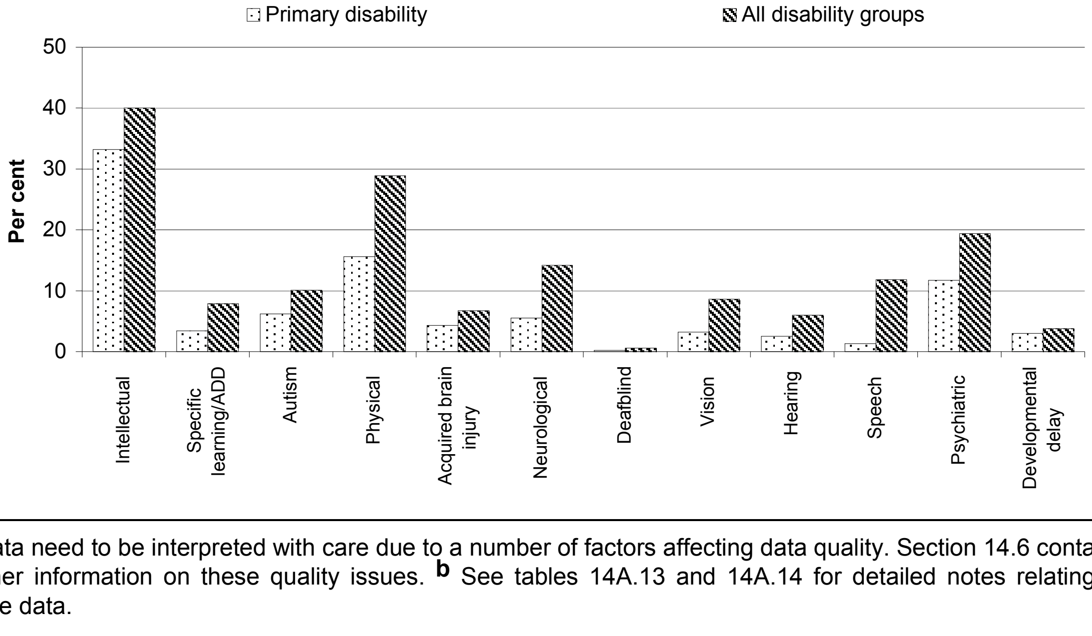
---

[a] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [b] See table 14A.12 for detailed notes relating to these data.

Source: AIHW (unpublished) *CSTDA NMDS*; table 14A.12.

In 2007-08, the most commonly reported disability of CSTDA service users was an intellectual disability (40.0 per cent of service users, including 33.2 per cent who reported it as their primary disability) (figure 14.7).

Figure 14.7 **CSTDA funded specialist disability service users, by disability group, 2007-08**[a, b]



---

[a] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [b] See tables 14A.13 and 14A.14 for detailed notes relating to these data.

Source: AIHW (unpublished) *CSTDA NMDS*; tables 14A.13 and 14A.14.

Program for younger people in residential aged care

At its February 2006 meeting, COAG made a commitment to reduce the number of younger people with disability living in residential aged care, and agreed to establish a 5 year program, beginning in July 2006. The initial priority for the program is younger people aged under 50 years. Participation in the YPIRAC program is voluntary and there are three elements that correspond to three of the four groups of YPIRAC service users:

- *Group 1* — agreed to or has moved from residential aged care to alternative YPIRAC-funded accommodation and support (element 1 — move younger people out of residential aged care)
- *Group 2* — deemed 'at risk' of entry into residential aged care (element 2 — divert younger people from entering residential aged care)
- *Group 3* — choose to remain in or enter residential aged care with additional disability support services (element 3 — provide YPIRAC with enhanced services)
- *Group 4* — choose to remain in or enter residential aged care without additional disability support services.

Four broad categories of services have been provided under the YPIRAC program: assessment/individual care planning, client monitoring, alternative accommodation and support services packages. Nationally, in 2007-08, there were a total of 580 YPIRAC services users. Table 14.1 shows YPIRAC service users, by service user group and specific services received.

Table 14.1 **YPIRAC service users, by specific services received, 2007–08[a]**

	YPIRAC-specific services received							
YPIRAC target group	*Assessment/care planning/client monitoring*		*Alternative accommodation*		*Support services package*		*All YPIRAC service users*	
	no.	%	no.	%	no.	%	no.	%
Group 1	295	99.7	33	11.1	123	41.6	296	100.0
Group 2	124	99.2	46	36.8	90	72.0	125	100.0
Group 3	134	100.0	..	..	51	38.1	134	100.0
Group 4	13	100.0	..	..	..	..	13	100.0
Not stated	11	91.7	..	..	1	8.3	12	100.0
Total	**577**	**99.5**	**79**	**13.6**	**265**	**45.7**	**580**	**100.0**

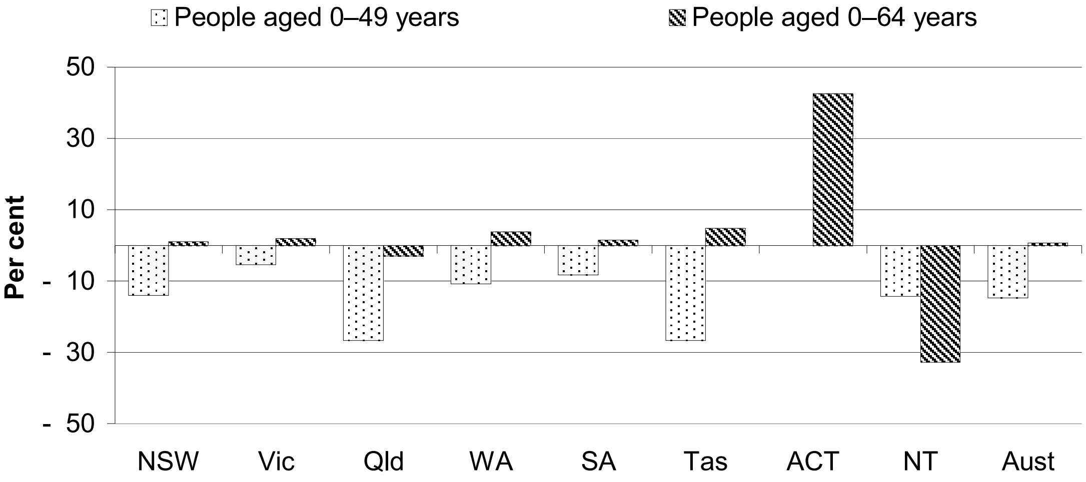
[a] Totals may not be the sum of the components as service users may have accessed more than one service type during the period. .. Not applicable.

Source: AIHW (2009) *Younger People with Disability in Residential Aged Care program: Final report on the 2007–08 Minimum Data Set*, Disability series, Cat. no. DIS 53.

On 30 June 2008, there were 858 people aged under 50 years living in permanent residential aged care nationally (table 14A.41). This is a 14.8 per cent decrease on the number of people aged under 50 years living in permanent residential aged care on 30 June 2006 (figure 14.8). These data need to be interpreted with care. Some younger people choose to remain in residential aged care because their physical and nursing needs can be met and they are:

- satisfied with their current living situation (that is, it is the preferred facility)
- the facility is located close to family and friends
- it is a familiar home environment.

Figure 14.8 **Younger people in residential aged care, percentage change in numbers between 2006–2008, by age group**[a, b, c]



[a] Data are for permanent residents in aged care. [b] These data should be interpreted with care (particularly for the NT). There may be issues related to the age of Indigenous residents being incorrectly recorded. An assessment of the data set in the NT has previously shown that approximately half of Indigenous peoples ages were incorrectly recorded. [c] The percentage change for the number of people aged 0–49 years in the ACT is zero.

Source: Derived from AIHW (2009) *Younger People with Disability in Residential Aged Care program: Final report on the 2007–08 Minimum Data Set*, Disability series, Cat. no. DIS 53; table 14A.41.

Nationally, in 2007-08, the number of younger people who were admitted to permanent residential aged care was 1942. This included 217 people aged under 50 years and 1725 people aged 50–64 years (table 14.2).

Table 14.2 **New admissions to permanent residential aged care for people aged under 65 years, by age group, 2007-08**[a, b, c, d, e]

Age group	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
< 50 years	84	57	29	19	18	5	np	np	217
50–64 years	608	380	344	150	166	50	np	np	1 725
Total < 65 years	**692**	**437**	**373**	**169**	**184**	**55**	**20**	**12**	**1 942**

[a] Admissions to permanent residential aged care do not include admissions to residential respite care. [b] Transfers and readmissions during 2007-08 are excluded. [c] Where a person had multiple admissions to permanent care in 2007-08 only the first is counted. [d] Age reported at admission. [e] Regular updating of the Department of Health and Ageing (DoHA) Aged and Community Care Management Information System (ACCMIS) database can result in revisions to data for previous financial years. **np** not published.

Source: AIHW (unpublished) *ACCMIS*.

14.2 Framework of performance indicators

The performance framework and related indicators reflect governments' objectives and priorities under the third CSTDA and the NDA (box 14.4).

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations). The NDA covers the area of disability services. The agreement includes sets of performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC).

The measurement details of the NDA were under development at the time of preparing this Report. It is anticipated that the performance indicators reported in this chapter will be revised to align with the performance indicators in the NDA for the 2011 Report.

Box 14.4 **Objective of government funded services for people with disability**

Most of the performance data for this year's Report cover services provided under the third CSTDA. Through the CSTDA, governments strove to enhance the quality of life experienced by people with disability by assisting them to live as valued and participating members of the community.

In working towards this objective, governments had five policy priorities, to:

- strengthen access to generic (mainstream) services for people with disability
- strengthen cross government linkages — bilateral agreements between the Australian Government and each State and Territory government were negotiated to improve services
- strengthen individuals, families and carers
- improve long term strategies to respond to, and manage, demand for specialist disability services
- improve accountability, performance reporting and quality.

The following long-term objective under the NDA is similar to the previous broad objective under the third CSTDA:

> People with disability and their carers have an enhanced quality of life and participate as valued members of the community.

All aspects of the NDA contribute to or measure progress towards this objective. The objective is enhanced by three specific outcomes as well as a set of revised priority reform areas (outlined in box 14.1). The outcomes are that:

- people with disability achieve economic participation and social inclusion
- people with disability enjoy choice, wellbeing and the opportunity to live as independently as possible
- families and carers are well supported.

In support of the agreed NDA outcomes, governments will contribute to the following outputs:

- services that provide skills and support to people with disability to enable them to live as independently as possible
- services that assist people with disability to live in stable and sustainable living arrangements
- income support for people with disability and their carers
- services that assist families and carers in their caring role.

Source: CSTDA (2003); COAG (2009).

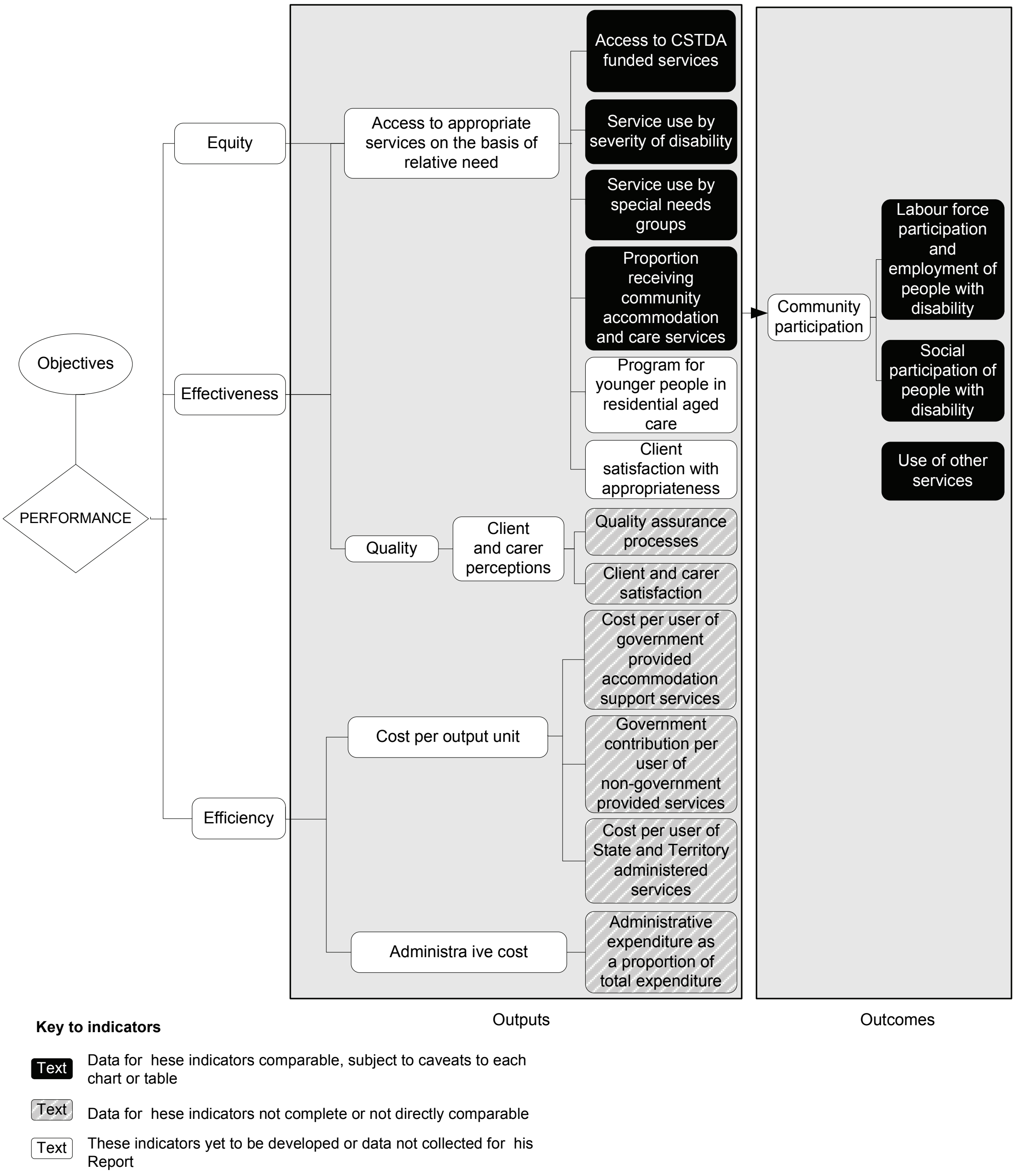
The performance indicator framework shows which data on services for people with disability are comparable in the 2010 Report (figure 14.9). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see section 1.6).

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of government funded services for people with 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.

Effectiveness and equity indicators focus on access to appropriate services and service quality. Proxy efficiency indicators focus on unit costs and administrative costs. Outcome indicators focus on the participation of people with disability in the community.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 14.9 **Performance indicators for services for people with disability**



14.3 Key performance indicator results

The performance indicator results reported in this chapter mainly relate to CSTDA funded services, because this Report includes service user data for 2007-08. These data were sourced from the CSTDA NMDS collection which is managed by

Australian, State and Territory governments at the service and jurisdictional level and by the AIHW at the national level. Under the NDA, governments have committed to the ongoing improvement of and the ongoing provision of data for the NMDS (renamed the Disability Services NMDS).

When considering the performance indicator results derived from service user data, comparisons between jurisdictions and across years should be undertaken with care. While the implementation of the NMDS continues to improve, data quality is still affected by a number of factors, including that:

- the proportion of service users and service outlets that provided data (response rates) and the 'not stated' rates of particular data items vary across jurisdictions and years (see section 14.6 for further details)
- the interpretation of NMDS service definitions can differ across jurisdictions (for example, the target group for services classified as 'early intervention' can differ).

Outputs

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

Equity and effectiveness — access to appropriate services on the basis of relative need

The following equity and effectiveness access indicators are reported:

- 'Access to CSTDA funded services'
- 'Service use by severity of disability'
- 'Service use by special needs groups'
- 'Proportion of accommodation support service users receiving community accommodation and care services'.

Access to CSTDA funded services

'Access to CSTDA funded services' is an indicator of governments' objective to provide access to government funded or provided specialist disability services on the basis of relative need and available resources. Measures are reported for accommodation support, community support, community access, respite services and employment (box 14.5).

Box 14.5 **Access to *Commonwealth State Territory Disability Agreement* funded services**

‘Access to CSTDA funded services’ is defined as the number of people using a particular CSTDA funded service divided by the ‘potential population’ for that service. The potential population is an estimate that broadly indicates the number of people with the potential to require specialist disability services at some time.

The potential population estimate for accommodation support, community access and community support services is the number of people aged under 65 years with profound or severe core activity limitations, multiplied by the Indigenous factor for a jurisdiction. The potential population estimate for employment services is the number of people aged 15–64 years with severe or profound core activity limitations, multiplied by both the Indigenous factor and the labour force participation rate for a jurisdiction. The potential population estimate for respite services is the number of people aged under 65 years with profound or severe core activity limitations who also reported a primary carer, multiplied by the Indigenous factor for a jurisdiction. The potential populations are further defined in section 14.7.

A higher or increasing proportion of the relevant estimated potential population using a particular CSTDA service suggests greater access to that service.

Not all people in the estimated ‘potential population’ will need the service or seek to access the service in the relevant period. In addition, this indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or accessed by those most in need.

Data reported for this indicator are comparable.

The numerators and denominators of this access measure apply to different age groups. The numerator of an access measure is service users of all ages. The denominator is the estimated potential population:

- for people aged under 65 years for accommodation support, community support, community access and respite services
- for people aged 15–64 years for employment services.

Nationally, 4.2 per cent of the estimated potential population were using CSTDA funded accommodation support services in 2007-08 (figure 14.10).

Figure 14.10 Users of CSTDA funded accommodation support services as a proportion of the estimated potential population[a, b]

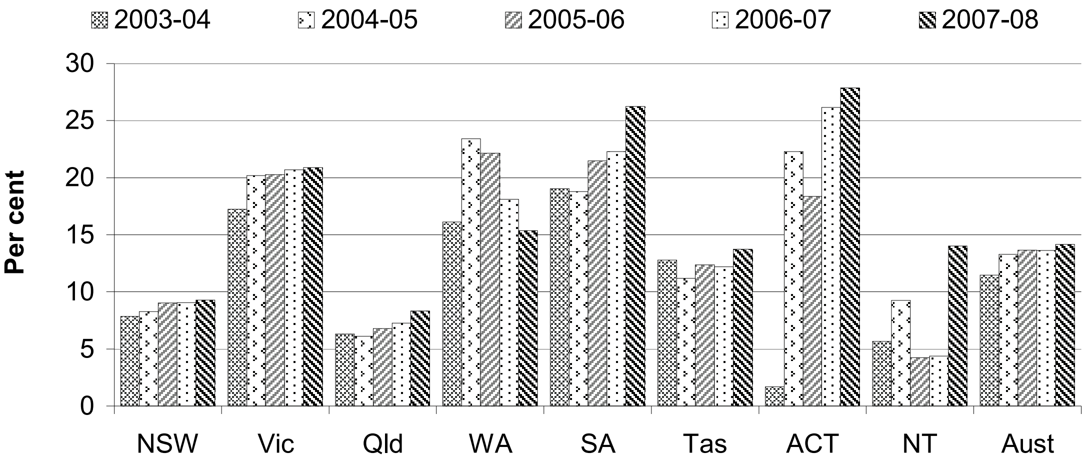
---

[a] See table 14A.15 for detailed notes relating to service user data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (2009 and previous years) *Disability Support Services 2007-08, 2006-07, 2005-06, 2004-05, 2003-04: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications); table 14A.15.

Nationally, 14.2 per cent of the estimated potential population were using CSTDA funded community support in 2007-08 (figure 14.11).

Figure 14.11 **Users of CSTDA funded community support services as a proportion of the estimated potential population**[a, b, c, d]



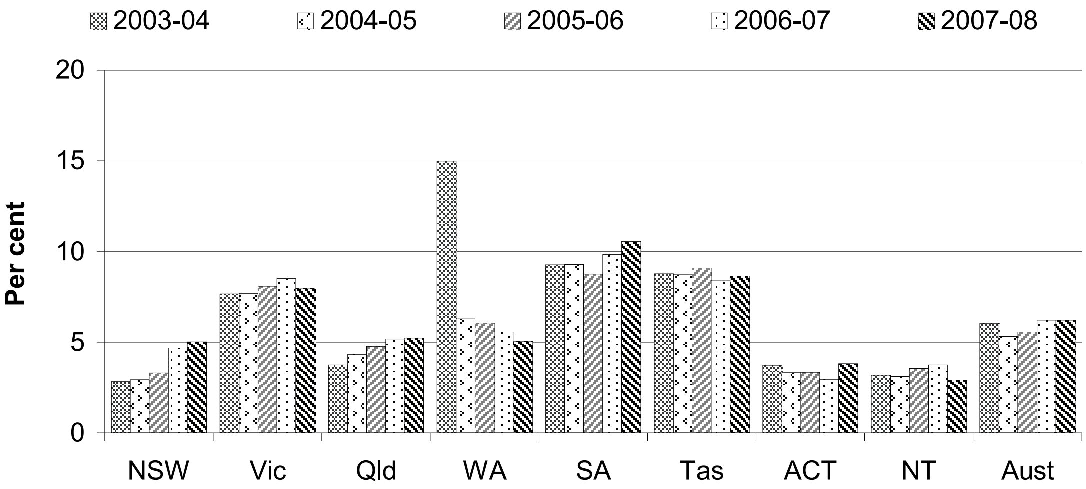
---

[a] See table 14A.16 for detailed notes relating to service user data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] For WA, the increase in the number of service users between 2003-04 and 2004-05 is due to the inclusion of data from a new electronic database for the first time. The decrease in the number between 2006-07 and 2007-08 is due to a refining of the counting rules that has led to the exclusion of some data. [d] For the ACT, improved data capture for therapy services resulted in an increased service user count between 2003-04 and 2004-05. The decrease in the community support services rate for 2005-06 was due to the incomplete data collection for therapy services.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (2009 and previous years) *Disability Support Services 2007-08, 2006-07, 2005-06, 2004-05, 2003-04: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications); table 14A.16.

Nationally, 6.2 per cent of the estimated potential population were using CSTDA funded community access services in 2007-08 (figure 14.12).

Figure 14.12 **Users of CSTDA funded community access services as a proportion of the estimated potential population**[a, b, c]



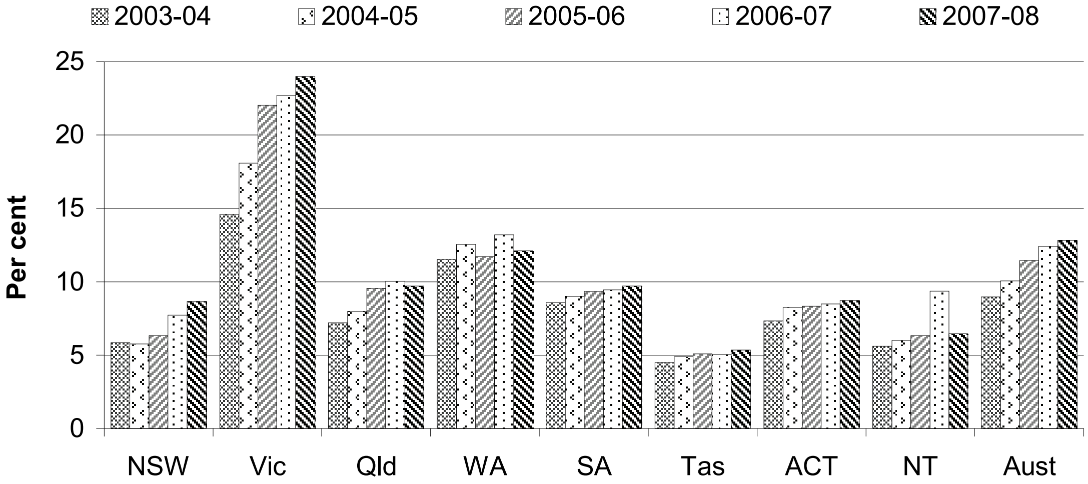
---

[a] See table 14A.17 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] The decrease in the number of WA service users between 2003-04 and 2004-05 is due to a change in reporting by one recreation agency.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (2009 and previous years) *Disability Support Services 2007-08, 2006-07, 2005-06, 2004-05, 2003-04: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications); table 14A.17.

Nationally, 12.8 per cent of the estimated potential population who reported having a primary carer were using CSTDA funded respite services in 2007-08 (figure 14.13).

Figure 14.13 **Users of CSTDA funded respite services as a proportion of the estimated potential population for respite services a, b**

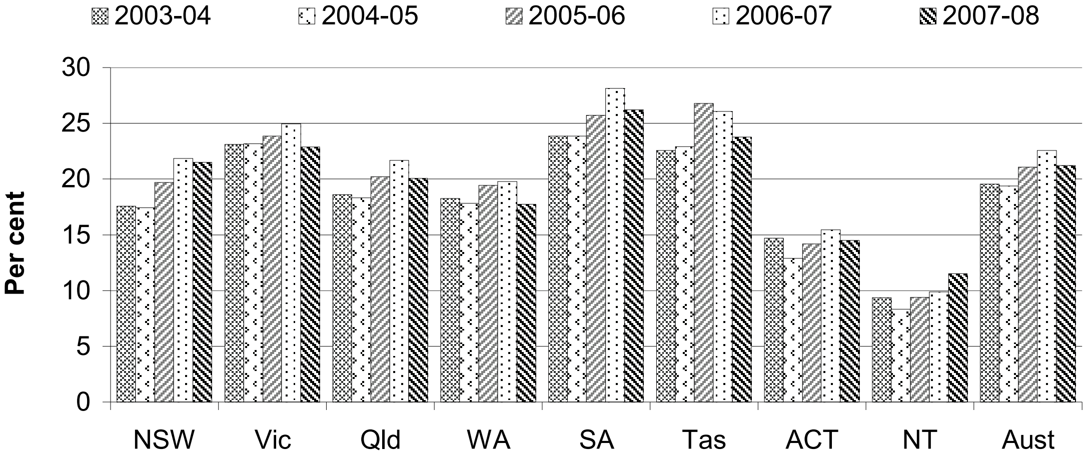


[a] See table 14A.18 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (2009 and previous years) *Disability Support Services 2007-08, 2006-07, 2005-06, 2004-05, 2003-04: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications); table 14A.18.

Nationally, 21.2 per cent of the estimated potential population for CSTDA funded employment services were using these services in 2007-08 (figure 14.14).

Figure 14.14 Users of CSTDA funded employment services as a proportion of the estimated potential population for employment services[a, b]



[a] See table 14A.19 for detailed notes relating to these data. [b] Data for 2007-08 are not comparable with previous years as the potential populations for that year were derived using labour force participation rates for people aged 15–64 years, not the participation rate for people aged 15 years and over that was used in previous years. Applying the participation rate for people aged 15–64 years to derive the 2007-08 data increased the number of people in the estimated potential population relative to previous years (by around 15 per cent).

Source: AIHW (2009 and previous years) *Disability Support Services 2007-08, 2006-07, 2005-06, 2004-05, 2003-04: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications); table 14A.19.

Service use by severity of disability

'Service use by severity of disability' is an indicator of governments' objective to use available resources to provide services to people on the basis of relative need, where need for services is assumed to vary according to the need for help with the activities of daily living (ADL) (box 14.6). This indicator provides additional information for interpreting the access to CSTDA funded accommodation support, community support, community access, employment and respite services measures reported above.

Data on the need for help with ADL are derived using information on the level of support needed in one or more of the core support areas: self care, mobility, and communication. Service users who need help with ADL reported always/sometimes needing help in one or more of these areas (people who need help with ADL are 'conceptually comparable' with people who have a profound or severe core activity limitation). Service users who did not need help with ADL, reported needing no support in all the core activity support areas. For these service users, help may be needed in other areas, for example, with interpersonal interactions, learning, and community and economic life.

Box 14.6 **Service use by severity of disability**

'Service use by severity of disability' is defined as the proportion of people who access CSTDA funded services, by need for help with ADL. Three categories are reported: need help with ADL, does not need help with ADL and information on ADL not stated/collected. Measures are reported for accommodation support, community support, community access, employment and respite services.

A higher or increasing proportion of people using a particular service type who need help with ADL, suggests greater access to this service type for those with the greatest level of need.

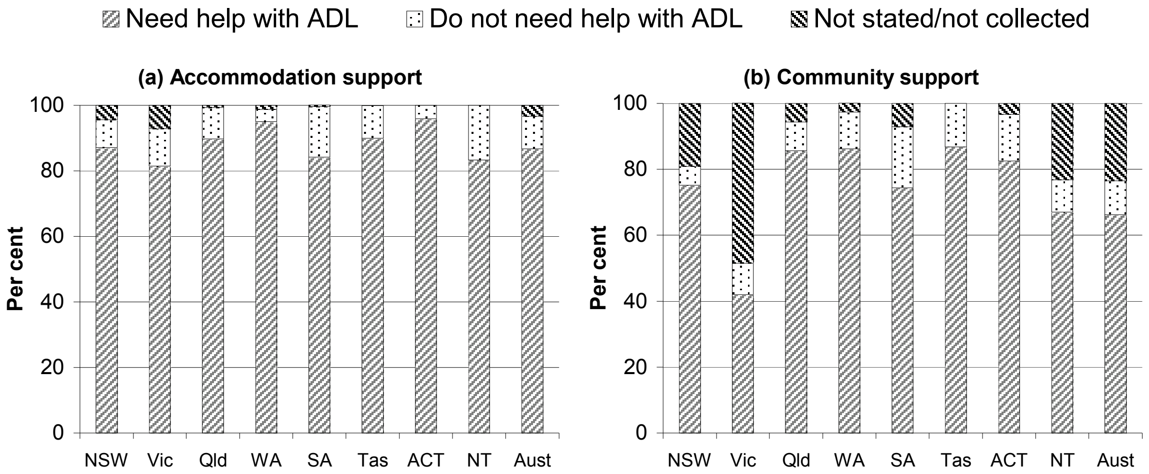
This indicator does not provide information on whether services are appropriate for the needs of the people receiving them or appropriately targeted based on relative need taking into account access to other formal support and access to informal support networks. The need for services is assumed to vary according to the need for help with ADL. Data on ADL are self/carer identified, not based on formal clinical assessments of individual limitations. There are other factors that may also be important in determining relative need, such as the complexity of a service user's needs in other activity areas.

Data reported for this indicator are comparable.

Nationally, in 2007-08:

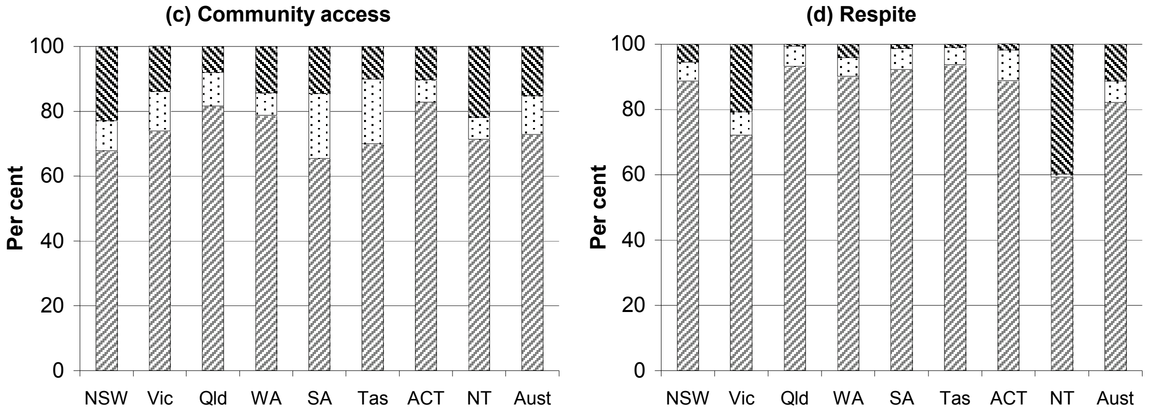
- 86.7 per cent of users of CSTDA funded accommodation support services needed help with ADL, 10.0 per cent did not need help with ADL and for 3.3 per cent information on ADL was not collected/not stated (figure 14.15a)
- 66.2 per cent of users of CSTDA funded community support services needed help with ADL, 10.3 per cent did not need help with ADL and for 23.5 per cent information on ADL was not collected/not stated (figure 14.15b)
- 72.9 per cent of users of CSTDA funded community access services needed help with ADL, 11.9 per cent did not need help with ADL and for 15.2 per cent information on ADL was not collected/not stated (figure 14.15c)
- 82.2 per cent of users of CSTDA funded respite services needed help with ADL, 6.5 per cent did not need help with ADL and for 11.3 per cent information on ADL was not collected/not stated (figure 14.15d)
- 28.1 per cent of users of CSTDA funded employment services needed help with ADL, 66.9 per cent did not need help with ADL and for 5.0 per cent information on ADL was not collected/not stated (figure 14.15e).

Figure 14.15 Users of CSTDA funded services, by need for help with ADL, 2007-08[a, b, c]


▨ Need help with ADL ⊡ Do not need help with ADL ▧ Not stated/not collected

(a) Accommodation support

(b) Community support


(c) Community access

(d) Respite


(e) Employment

---

[a] Need for help with ADL 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 or with other activities. [b] See tables 14A.20, 14A.21, 14A.22, 14A.23 and 14A.24 for detailed notes relating to these data. [c] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *CSTDA NMDS*; tables 14A.20, 14A.21, 14A.22, 14A.23 and 14A.24.

Service use by special needs groups

‘Service use by special needs groups’ is an indicator of governments’ objective that access to services should be equitable for all members of the community and provided on the basis of relative need (box 14.7). The Report compares access for people from special needs groups with access for people from outside the special needs group of the total population and the ‘potential population’. The potential population is an estimate, derived using a range of data sources, of the number of people with the potential to require disability support services, including individuals who meet the service eligibility criteria but who do not demand the services. Results are reported on the basis of the potential population to account for differences in the prevalence of disability between people in the special needs group and people outside the special needs group. For information on how the potential populations for the special needs groups were derived see section 14.6.

Box 14.7 **Service use by special needs groups**

‘Service use by special needs groups’ is defined by two measures:

- the proportion of service users per 1000 total population in a particular special needs group, compared to the proportion of service users per 1000 total population outside the special needs group
- the proportion of service users per 1000 potential population in a particular special needs group, compared to the proportion of service users per 1000 potential population outside the special needs group.

Both measures are reported for accommodation support, community support, community access and employment services. For respite services, data are reported per 1000 total population only due to data limitations.

Data are reported for three special needs groups:

- people from outer regional and remote/very remote locations
- people identified as Indigenous Australians
- people who were born in a non-English speaking country (that is, not born in Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland, the United States or Zimbabwe).

Holding other factors constant, the proportion of service users per 1000 people (or per 1000 potential population) in a special needs group should not differ significantly from the proportion of service users per 1000 people (or per 1000 potential population) outside the special needs group.

(Continued on next page)

Box 14.7 **(Continued)**

For both measures, while a markedly lower proportion can indicate reduced access for a special needs group, it can also represent strong alternative informal support networks (and a consequent lower level of otherwise unmet need), or a lower tendency of people with disability in a special needs group to choose to access CSTDA funded services. Similarly, a higher proportion can suggest poor service targeting, the lack of alternative informal support networks or a greater tendency of people with disability in a special needs group to choose to access CSTDA funded services. For the measure that compares access per 1000 population, significant differences in access can also reflect the special needs group having a higher/lower prevalence of disability.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted on the basis of relative need. The indicator does not take into account differences in the level of informal assistance that is available for people in special needs groups and outside the special needs groups. Results for outer regional and remote/very remote users of accommodation support services, for example, need to be considered with care because alternatives to government funded accommodation support services are likely to be more readily available in these areas. Specifically, accommodation support services in outer regional and remote/very remote areas are largely provided informally, making use of local area coordinators and local community resources.

Data reported for this indicator are comparable.

The numerators and denominators of this access measure apply to different age groups. The numerator of an access measure is service users of all ages. The denominator is the estimated population/potential population:

- for people aged under 65 years for accommodation support, community support, community access and respite services
- for people aged 15–64 years for employment services.

Data for access per 1000 potential population need to be interpreted with care due to a number of factors affecting data quality. Potential sources of error include:

- that there are service users for whom ‘special needs group’ status (for example, Indigenous status) is not stated or not collected — poor and/or inconsistent levels of Indigenous identification between states and territories would affect comparisons
- the assumptions underlying the method used to derive the potential populations
- for the Indigenous estimates, differential Census undercount between states and territories might also introduce bias in the results that could affect the comparability of estimates across jurisdictions.

Section 14.6 contains more detailed information on these quality issues.

Service use by special needs groups — people in outer regional and remote/very remote areas

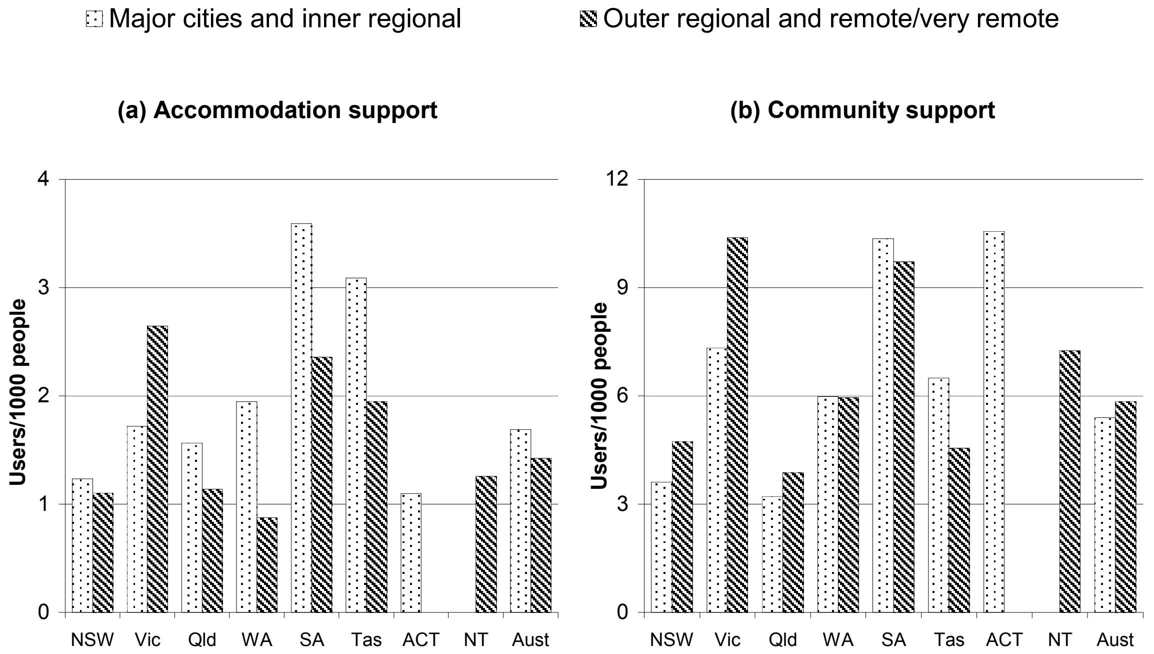
Nationally, in 2007-08, the proportion of the outer regional and remote/very remote population who used CSTDA funded accommodation support services was 1.4 service users per 1000 population, lower than the proportion of the major cities and inner regional population who used these services (1.7 service users per 1000 population) (figure 14.16a). The proportion of the outer regional and remote/very remote potential population who used CSTDA funded accommodation support services (33.7 service users per 1000 potential population) was lower than that of the major cities and inner regional potential population who used these services (42.5 service users per 1000 potential population) (figure 14.17a).

Nationally, in 2007-08, the proportion of the outer regional and remote/very remote population who used CSTDA funded community support services was 5.8 service users per 1000 population, higher than the proportion of the major cities and inner regional population who used these services (5.4 service users per 1000 population) (figure 14.16b). The proportion of the outer regional and remote/very remote potential population who used CSTDA funded community support services (138.6 service users per 1000 potential population) was higher than the proportion of the major cities and inner regional potential population who used these services (135.9 service users per 1000 potential population) (figure 14.17b).

Nationally, in 2007-08, the proportion of the outer regional and remote/very remote population who used CSTDA funded community access services was 2.0 service users per 1000 population, lower than the proportion of the major cities and inner regional population who used these services (2.4 service users per 1000 population) (figure 14.16c). The proportion of the outer regional and remote/very remote potential population who used CSTDA funded community access services (47.8 service users per 1000 potential population) was lower than the proportion of the major cities and inner regional potential population who used these services (60.6 service users per 1000 potential population) (figure 14.17c).

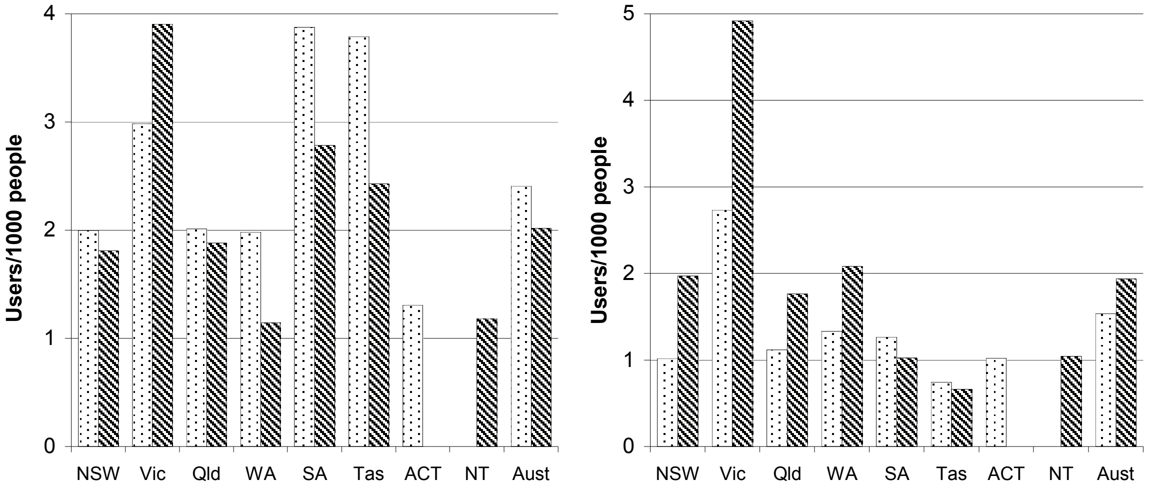
Nationally, in 2007-08, the proportion of the outer regional and remote/very remote population who used CSTDA funded respite services was 1.9 service users per 1000 population), higher than the proportion of the major cities and inner regional population who used these services (1.5 service users per 1000 population) (figure 14.16d). Access to respite as a proportion of the potential population is not reported. To derive an estimate of the respite potential populations across the relevant groups Census data on people with a ASSNP who had a primary carer are needed. These data were not collected.

Figure 14.16 Users of State and Territory administered CSTDA funded services per 1000 people, by geographic location, 2007-08[a, b, c, d, e]



(a) Accommodation support

(b) Community support



(c) Community access

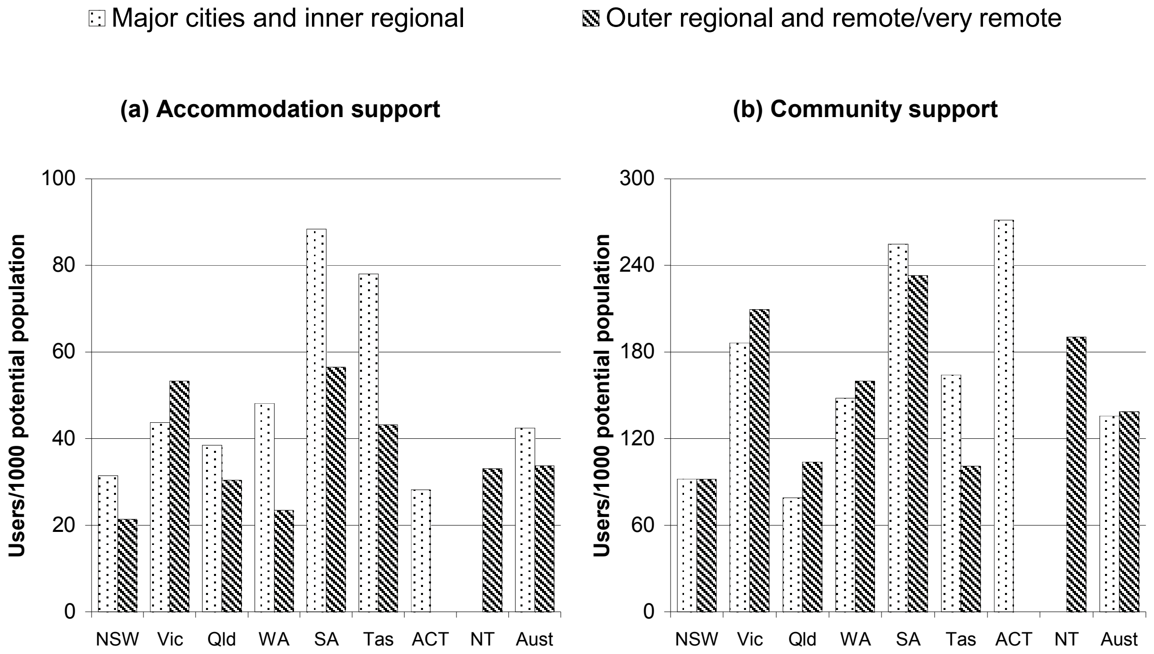
(d) Respite

---

[a] See tables 14A.25, 14A.26, 14A.27 and 14A.28 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] Tasmania does not have major cities. [d] The ACT does not have outer regional and remote/very remote areas. [e] The NT does not have major cities and inner regional areas.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (unpublished) derived from ABS (2008) *Population by Age and Sex, Regions of Australia, 2007*; Cat. no. 3235.0; tables 14A.25, 14A.26, 14A.27 and 14A.28.

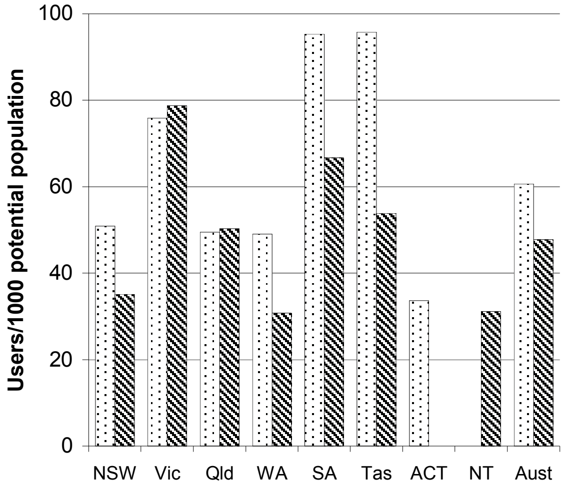
Figure 14.17 Users of State and Territory administered CSTDA funded services per 1000 potential population, by geographic location, 2007-08[a, b, c, d, e]



(a) Accommodation support

(b) Community support

(c) Community access



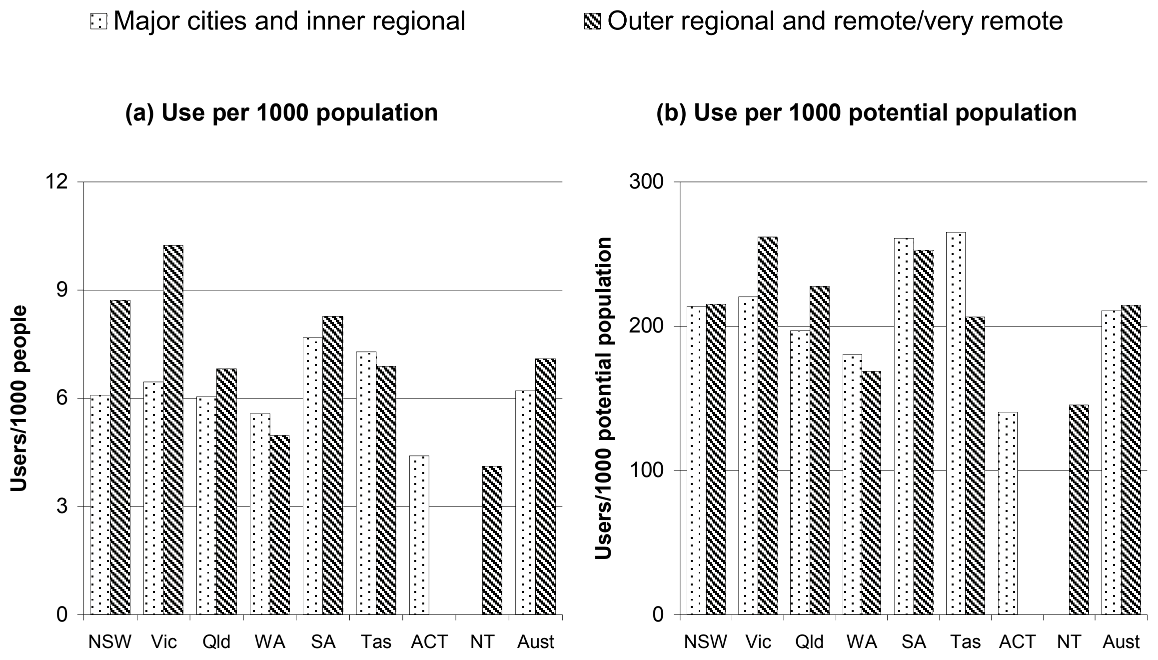
---

[a] See tables 14A.25, 14A.26 and 14A.27 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] Tasmania does not have major cities. [d] The ACT does not have outer regional and remote/very remote areas. [e] The NT does not have major cities and inner regional areas.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (unpublished) derived from ABS (2004) *2003 SDAC,* Cat. no. 4430.0, ABS *2006 Census of Population and Housing (CDATA Online)* and ABS (2008) *Population by Age and Sex, Regions of Australia, 2007*; Cat. no. 3235.0; tables 14A.25, 14A.26 and 14A.27.

Nationally, in 2007-08, the proportion of the outer regional and remote/very remote population who used CSTDA funded employment services (7.1 service users per 1000 population) was higher than that of the major cities and inner regional population (6.2 service users per 1000 population) (figure 14.18a). The proportion of the outer regional and remote/very remote potential population who used CSTDA funded employment services (214.6 service users per 1000 potential population) was higher than that of the major cities and inner regional potential population (210.9 service users per 1000 potential population) (figure 14.18b).

Figure 14.18 **Users of CSTDA funded employment services, by geographic location, 2007-08**[a, b, c, d, e]



[a] See table 14A.29 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] Tasmania does not have major cities. [d] The ACT does not have outer regional and remote/very remote areas. [e] The NT does not have major cities and inner regional areas.

Source: AIHW (unpublished) CSTDA NMDS; AIHW (unpublished) derived from ABS (2004) *2003 SDAC*, Cat. no. 4430.0, *ABS 2006 Census of Population and Housing (CDATA Online)*, ABS (2007) *Labour Force Australia, Detailed Electronic Delivery*, *June 2007*, Cat. no. 6291.0.55.001 and ABS (2008) *Population by Age and Sex, Regions of Australia, 2007*, Cat. no. 3235.0; table 14A.29.

Service use by special needs groups — Indigenous people

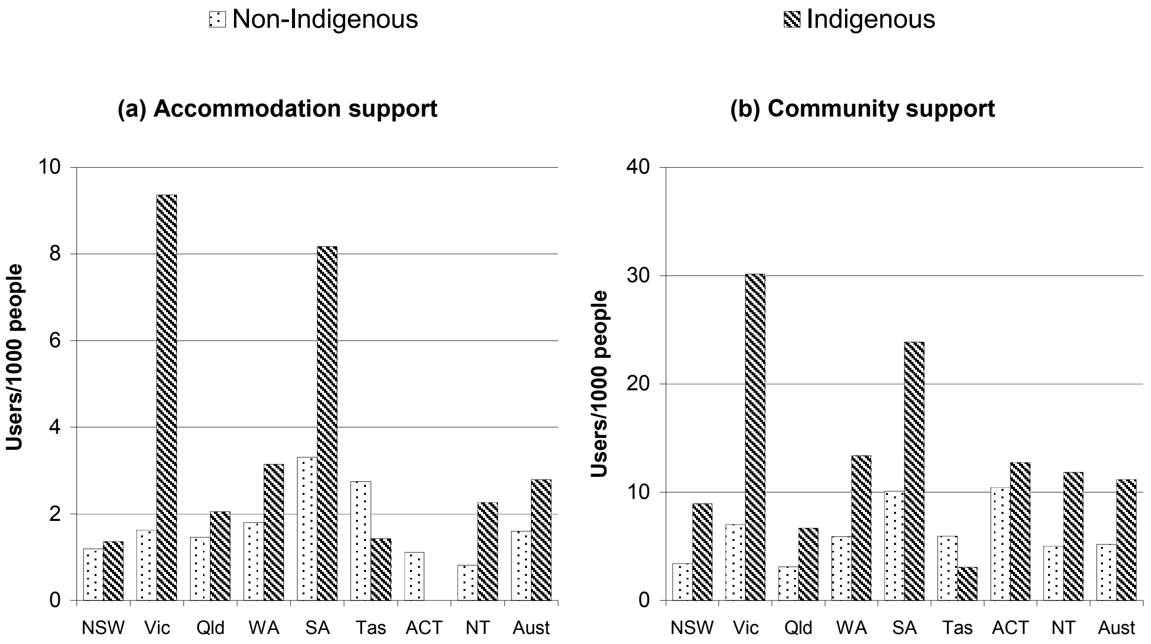
Nationally, in 2007-08, the proportion of the Indigenous population who used CSTDA funded accommodation support services was 2.8 service users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (1.6 service users per 1000 population) (figure 14.19a). The proportion of the Indigenous potential population who used CSTDA funded accommodation support services (39.9 service users per 1000 potential population) was lower than the non-Indigenous potential population who used these services (40.5 service users per 1000 potential population) (figure 14.20a).

Nationally, in 2007-08, the proportion of the Indigenous population who used CSTDA funded community support services was 11.2 service users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (5.2 service users per 1000 population) (figure 14.19b). The proportion of the Indigenous potential population who used CSTDA funded community support services (159.9 service users per 1000 potential population) was higher than the proportion of the non-Indigenous potential population who used these services (131.0 service users per 1000 potential population) (figure 14.20b).

Nationally, in 2007-08, the proportion of the Indigenous population who used CSTDA funded community access services was 3.1 service users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (2.3 service users per 1000 population) (figure 14.19c). The proportion of the Indigenous potential population who used CSTDA funded community access services (44.9 service users per 1000 potential population) was lower than the proportion of the non-Indigenous potential population who used these services (57.4 service users per 1000 potential population) (figure 14.20c).

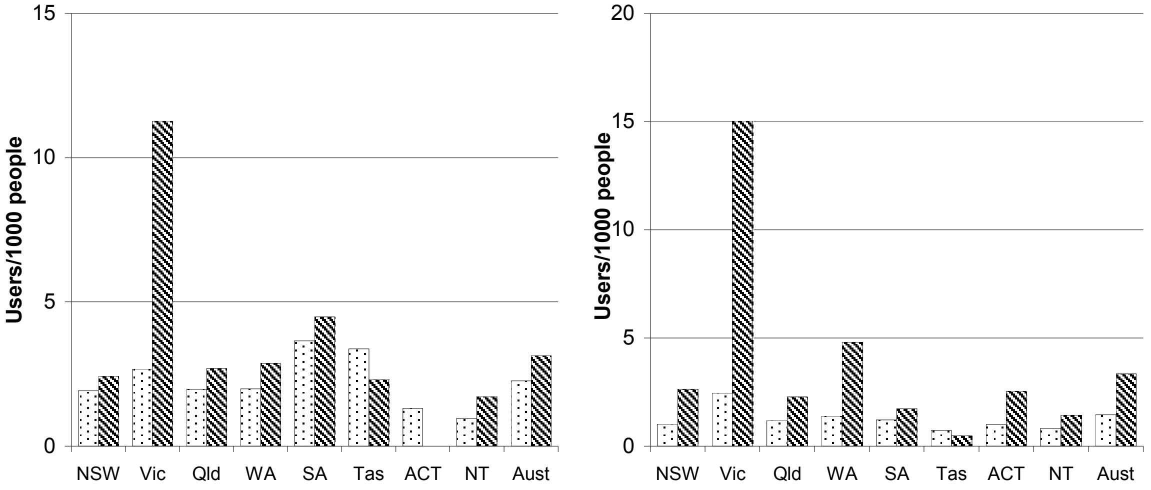
Nationally, in 2007-08, the proportion of the Indigenous population who used CSTDA funded respite service was 3.3 users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (1.5 service users per 1000 population) (figure 14.19d). Access to respite as a proportion of the potential population is not reported. To derive an estimate of the respite potential populations across the relevant groups Census data on people with a ASSNP who had a primary carer are needed. These data were not collected.

Figure 14.19 Users of State and Territory administered CSTDA funded services per 1000 people, by Indigenous status, 2007-08[a, b, c]



(a) Accommodation support

(b) Community support



(c) Community access

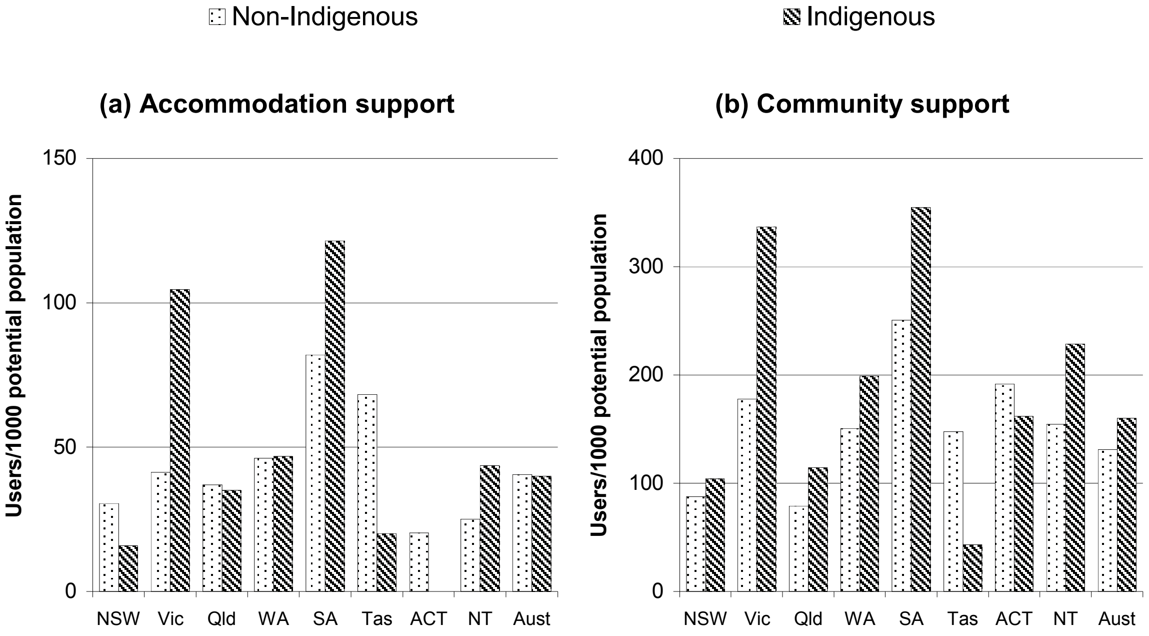
(d) Respite

---

[a] See tables 14A.30, 14A.31, 14A.32 and 14A.33 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] ACT data for service users per 1000 Indigenous people for accommodation support and community access are not published as they are based on a small number of service users.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (unpublished) derived from ABS (2007) *Population by Age and Sex, Australian States and Territories, Jun 2007,* Cat. no. 3201.0 and ABS (2009) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021,* Cat. no. 3238.0; tables 14A.30, 14A.31, 14A.32 and 14A.33.

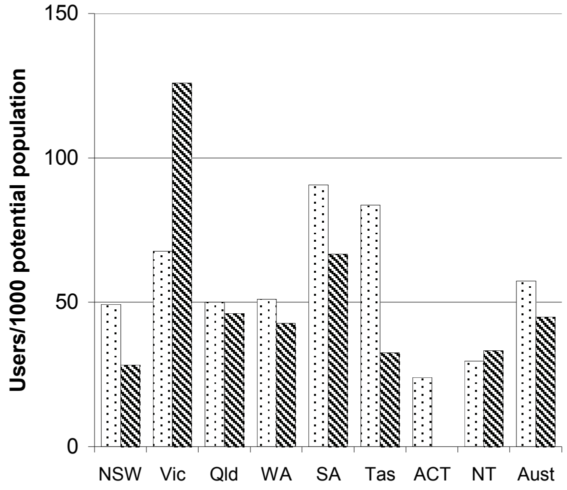
Figure 14.20 **Users of State and Territory administered CSTDA funded services per 1000 potential population, by Indigenous status, 2007-08**[a, b, c]



(a) Accommodation support

(b) Community support

(c) Community access



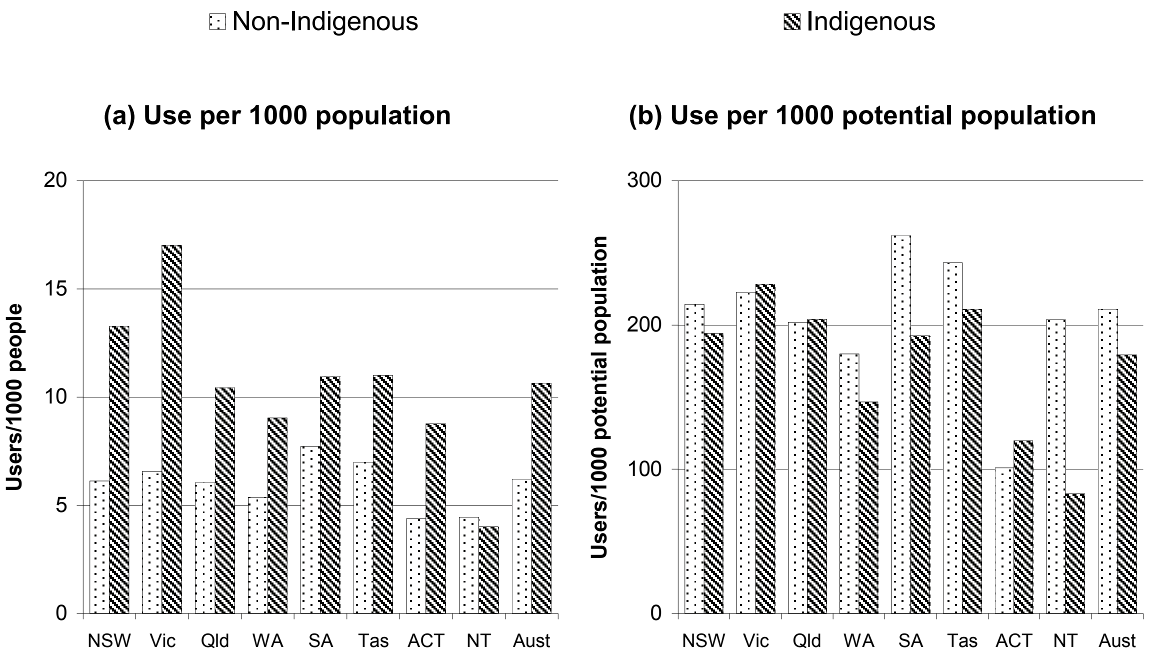
---

[a] See tables 14A.30, 14A.31 and 14A.32 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. [c] ACT data for service users per 1000 Indigenous potential population are not published for accommodation support and community access as they are based on a small number of service users.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (2009) *Disability Support Services 2007-08 National Data on Services Provided under the* CSTDA, Cat. no. DIS 56; tables 14A.30, 14A.31 and 14A.32.

Nationally, in 2007-08, the proportion of the Indigenous population who used CSTDA funded employment services (10.6 service users per 1000 population) was higher than that of the non-Indigenous population (6.2 service users per 1000 population) (figure 14.21a). The proportion of the Indigenous potential population who used CSTDA funded employment services (179.3 service users per 1000 potential population) was lower than that of the non-Indigenous potential population (210.9 service users per 1000 potential population) (figure 14.21b).

Figure 14.21 **Users of CSTDA funded employment services, by Indigenous status, 2007-08**[a, b]



(a) Use per 1000 population

(b) Use per 1000 potential population

[a] See table 14A.34 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) CSTDA NMDS; AIHW (unpublished) derived from ABS (2004) *2003 SDAC*, Cat. no. 4430.0, ABS *2006 Census of Population and Housing (CDATA Online)*, ABS (2007) *Labour Force Australia, Detailed Electronic Delivery, June 2007*, Cat. no. 6291.0.55.001, ABS (2009) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, Cat. no. 3238.0 and ABS (2007) *Population by Age and Sex, Australian States and Territories, Jun 2007*, Cat. no. 3201.0; table 14A.34.

Service use by special needs groups — people born in a non-English speaking country

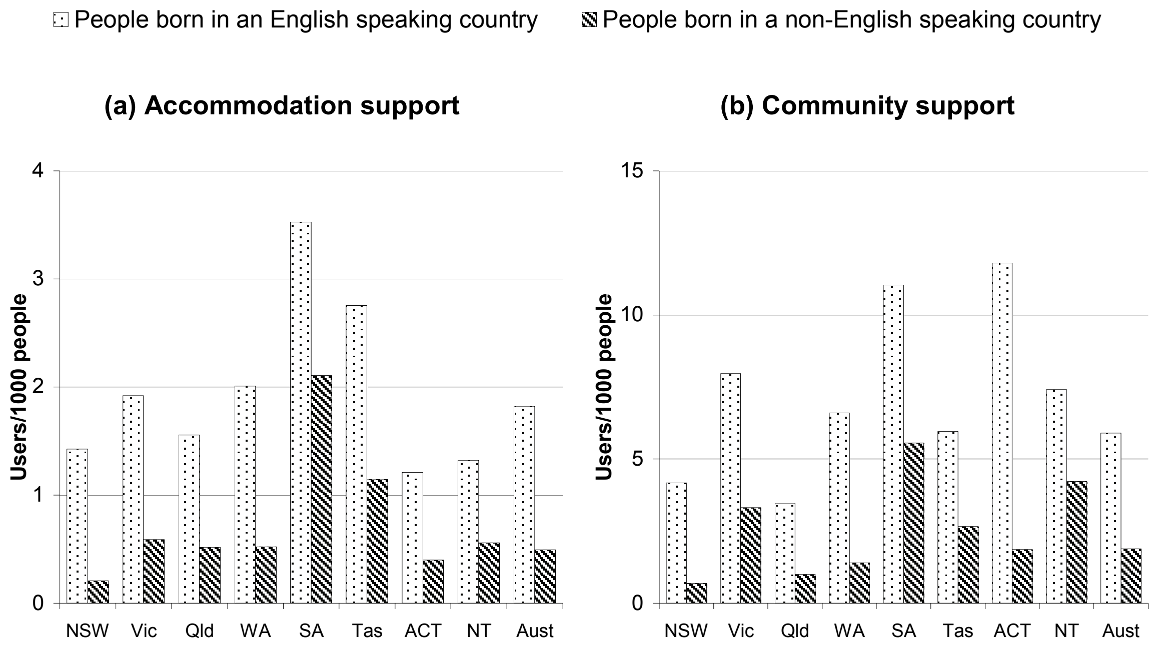
Nationally, in 2007-08, the proportion of people born in a non-English speaking country who used CSTDA funded accommodation support services was 0.5 users per 1000 population, lower than the proportion of people born in an English speaking country (1.8 service users per 1000 population) (figure 14.22a). The proportion of the potential population born in a non-English speaking country who used CSTDA funded accommodation support services (12.8 users per 1000 potential population) was lower than the proportion of people born in an English speaking country who used these services (45.3 service users per 1000 potential population) (figure 14.23a).

Nationally, in 2007-08, the proportion of people born in a non-English speaking country who used CSTDA funded community support services was 1.9 service users per 1000 population, lower than the proportion of people born in an English speaking country who used these services (5.9 service users per 1000 population) (figure 14.22b). The proportion of the potential population born in a non-English speaking country who used community support services (48.8 service users per 1000 potential population) was lower than the proportion of people born in an English speaking country who used these services (146.6 service users per 1000 potential population) (figure 14.23b).

Nationally, in 2007-08, the proportion of people born in a non-English speaking country who used CSTDA funded community access services was 0.9 users per 1000 population, lower than the proportion of people born in an English speaking country who used these services (2.5 service users per 1000 population) (figure 14.22c). The proportion of the potential population born in a non-English speaking country who used community access services (22.3 service users per 1000 potential population) was lower than the proportion of people born in an English speaking country who used these services (61.0 service users per 1000 population) (figure 14.23c).

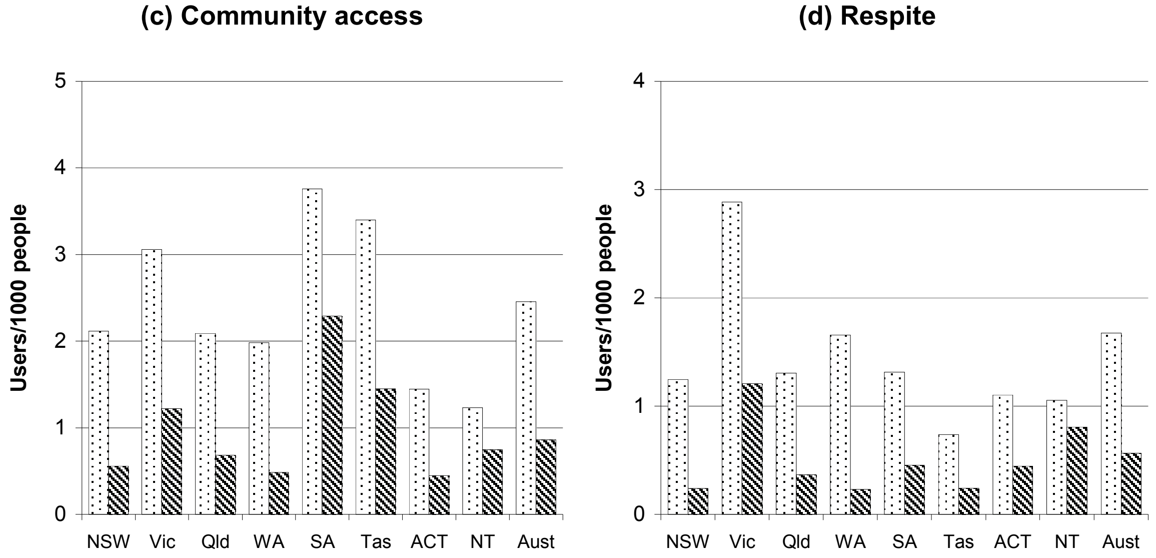
Nationally, in 2007-08, the proportion of people born in a non-English speaking country who used CSTDA funded respite services was 0.6 service users per 1000 population, lower than the proportion of people born in an English speaking country who used these services (1.7 service users per 1000 population) (figure 14.22d). Access to respite as a proportion of the potential population is not reported. To derive an estimate of the respite potential populations across the relevant groups Census data on people with a ASSNP who had a primary carer are needed. These data were not collected.

Figure 14.22 Users of State and Territory administered CSTDA funded services per 1000 people, by country of birth, 2007-08[a, b]



(a) Accommodation support

(b) Community support



(c) Community access

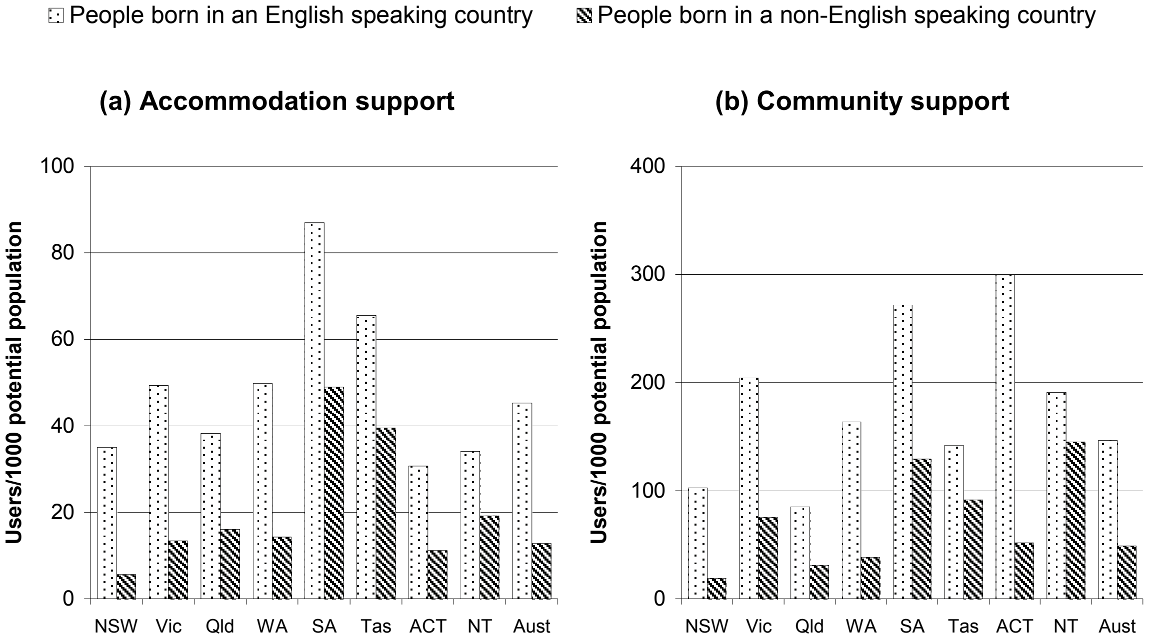
(d) Respite

---

[a] See tables 14A.35, 14A.36, 14A.37 and 14A.38 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (unpublished) derived from ABS *2006 Census of Population and Housing (CDATA Online)* and ABS (2007) *Population by Age and Sex, Australian States and Territories, Jun 2007,* Cat. no. 3201.0; tables 14A.35, 14A.36, 14A.37 and 14A.38.

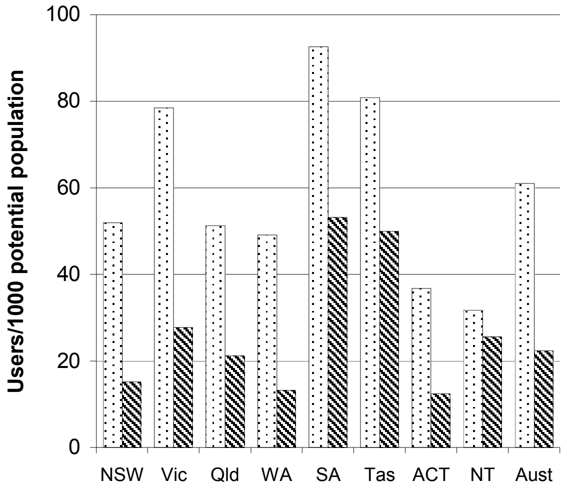
Figure 14.23 **Users of State and Territory administered CSTDA funded services per 1000 potential population, by country of birth, 2007-08**[a, b]



(a) Accommodation support

(b) Community support

(c) Community access



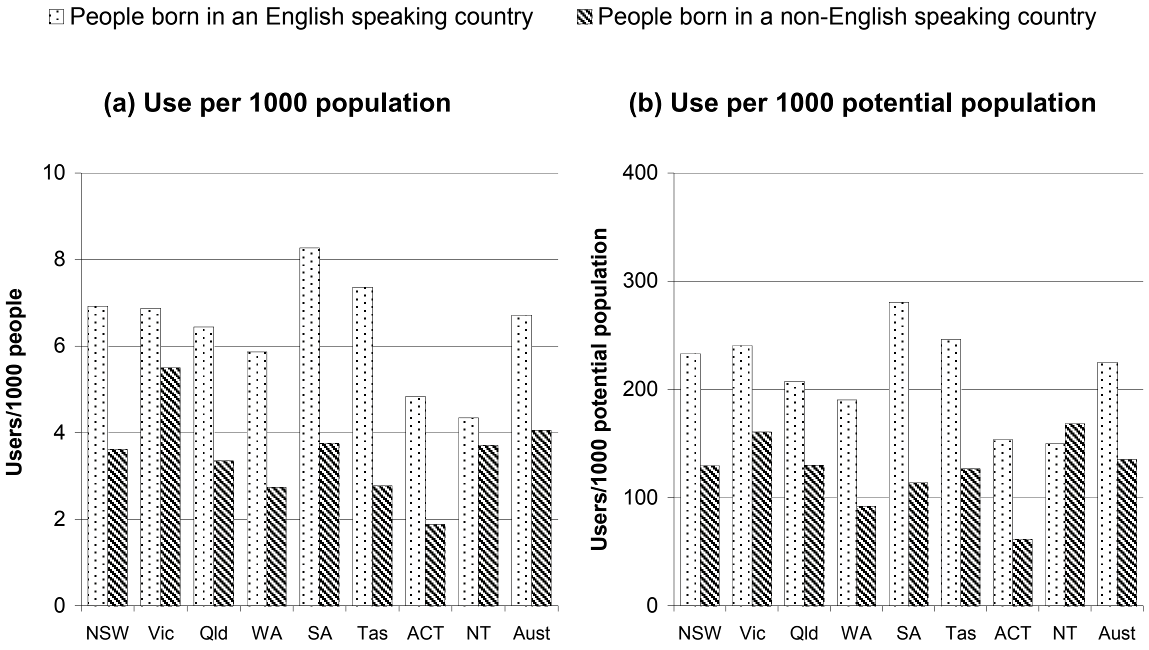
---

[a] See tables 14A.35, 14A.36 and 14A.37 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *CSTDA NMDS*; AIHW (unpublished) derived from ABS (2004) *2003 SDAC*, Cat. no. 4430.0; ABS *2006 Census of Population and Housing (CDATA Online)* and ABS (2007) *Population by Age and Sex, Australian States and Territories, Jun 2007,* Cat. no. 3201.0; tables 14A.35, 14A.36 and 14A.37.

Nationally, in 2007-08, the proportion of people born in a non-English speaking country who used CSTDA funded employment services (4.1 service users per 1000 population) was lower than that of people born in an English speaking country (6.7 service users per 1000 population) (figure 14.24a). The proportion of the potential population of people born in a non-English speaking country who used CSTDA funded employment services (135.2 service users per 1000 potential population) was lower than that of the potential population of people born in an English speaking country (225.1 service users per 1000 potential population) (figure 14.24b).

Figure 14.24 **Users of CSTDA funded employment services, by country of birth, 2007-08**[a, b]



(a) Use per 1000 population

(b) Use per 1000 potential population

[a] See table 14A.39 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) CSTDA NMDS; AIHW (unpublished) derived from ABS (2004) *2003 SDAC*, Cat. no. 4430.0, ABS *2006 Census of Population and Housing,* ABS (2007) *Labour Force Australia, Detailed Electronic Delivery, June 2007*, Cat. no. 6291.0.55.001 and ABS (2007) *Population by Age and Sex, Australian States and Territories, Jun 2007,* Cat. no. 3201.0; table 14A.39.

Proportion receiving community accommodation and care services

'Proportion receiving community accommodation and care services' is an indicator of governments' objective to assist people with disability to live as valued and participating members of the community (box 14.8). Governments provide or fund accommodation support services to people with disability in institutional/residential settings and through community accommodation and care services. Institutional or residential accommodation support services are provided in both institutions and hostels. Community accommodation and care services are provided in group homes and other community settings. The services provided in other community settings are attendant care/personal care, in home accommodation support, alternative family placement and other accommodation support.

State and Territory governments generally seek, if possible, to provide accommodation support services to people with disability outside of institutional/residential settings. Community accommodation and care services are considered to provide better opportunities for people with disability to be involved in their community.

Box 14.8 **Proportion receiving community accommodation and care services**

‘Proportion receiving community accommodation and care services’ is defined as the number of people using a CSTDA funded community accommodation and care service divided by the total number of people using CSTDA funded accommodation support services (excluding people who use specialist psychiatric disability services only).

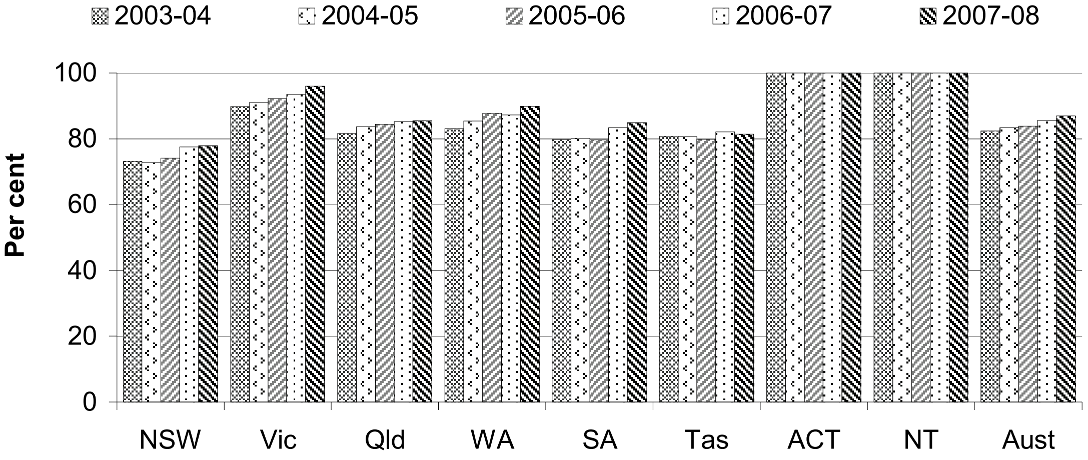
A higher proportion of people accessing CSTDA funded community accommodation and care services is likely to provide better opportunities for people with disability (who need accommodation support) to be involved in their community.

CSTDA funded services are provided on the basis of need and available resources. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted on the basis of relative need.

Data reported for this indicator are comparable.

Nationally, 87.0 per cent of users of CSTDA funded accommodation support services received community accommodation and care services in 2007-08 (figure 14.25).

Figure 14.25 **Users of community accommodation and care services as a proportion of all CSTDA funded accommodation support service users**[a, b]



---

[a] See table 14A.40 for detailed notes relating to these data. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Source: AIHW (unpublished) *CSTDA NMDS*; table 14A.40.

Program for younger people in residential aged care

'Program for younger people in residential aged care' has been identified for development as an indicator of governments' objective to provide services to people with disability that are appropriate to their needs (box 14.9).

Box 14.9 **Program for younger people in residential aged care**

'Program for younger people in residential aged care' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Client satisfaction with appropriateness

'Client satisfaction with appropriateness' has been identified for development as an indicator of governments' objective to provide services to people with disability that are appropriate to their needs (box 14.10). This indicator will seek to measure the appropriateness of these services relative to the service user's need, from the service user's perspective.

Box 14.10 **Client satisfaction with appropriateness**

‘Client satisfaction with appropriateness’ is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Equity and effectiveness — quality of services

The following equity and effectiveness quality indicators are reported:

- ‘Quality assurance processes’
- ‘Client and carer satisfaction’.

Quality assurance processes

‘Quality assurance processes’ are an indicator related to governments’ objective to deliver and fund services for people with disability that meet a particular standard of quality (box 14.11).

Box 14.11 **Quality assurance processes**

‘Quality assurance processes’ is defined as the proportion of CSTDA/NDA disability service outlets that have been assessed (either by an external agency or through a self-assessment process) against service standards.

A higher proportion of disability service outlets that have been assessed against the standards (and are found to be compliant) suggests an improvement in the quality of government delivered or funded specialist disability services.

This indicator does not provide information on whether the standards or the quality assurance processes are appropriate. In addition, service outlets that are not quality assessed do not necessarily deliver services of lower quality.

Data reported for this indicator are neither complete nor directly comparable.

A set of eight minimum National Disability Service Standards were developed in 1992 in the context of the first Commonwealth State Disability Agreement (box 14.12). Under that Agreement, the Australian Government and all State and Territory governments agreed to implement these minimum standards.

- The Australian Government has implemented a quality assurance system for funded disability employment and rehabilitation services that requires service providers to be certified as compliant against 12 standards (which include the eight minimum standards). Each standard has a least one key performance indicator (table 14A.50).

- Most State and Territory governments have undertaken work to interpret the standards (such as developing supporting standards) and to develop related performance indicators and/or guidance on how to meet the standards. Most State and Territory governments have adopted additional standards to the eight minimum National Standards. Five jurisdictions have adopted a specific standard relating to 'Protection of human rights and freedom from abuse', for example. Some have also introduced specific outcome standards for service users or generic standards that apply to all community sector organisations including disability services (tables 14A.42–49).
- All State and Territory governments have also developed, or are in the process of developing/re-developing, mechanisms for assessing compliance with standards (tables 14A.42–49).

Box 14.12 **National Disability Service Standards**

Standard 1 Service access

Each consumer seeking a service has access to a service on the basis of relative need and available resources.

Standard 2 Individual needs

Each person with a disability receives a service which is designed to meet, in the least restrictive way, his or her individual needs and personal goals.

Standard 3 Decision making and choice

Each person with a disability has the opportunity to participate as fully as possible in making decisions about the events and activities of his or her daily life in relation to the services he or she receives.

Standard 4 Privacy, dignity and confidentiality

Each consumer's right to privacy, dignity and confidentiality in all aspects of his or her life is recognised and respected.

Standard 5 Participation and integration

Each person with a disability is supported and encouraged to participate and be involved in the life of the community.

(Continued on next page)

Box 14.12 **(Continued)**

Standard 6 Valued status

Each person with a disability has the opportunity to develop and maintain skills and to participate in activities that enable him or her to achieve valued roles in the community.

Standard 7 Complaints and disputes

Each consumer is free to raise and have resolved, any complaints or disputes he or she may have regarding the agency or the service.

Standard 8 Service management

Each agency adopts sound management practices which maximise outcomes for consumers.

The quality assurance processes differ across jurisdictions. Most processes include some form of self-assessment. Many expect, or are working toward implementing, an external third party audit/certification process.

Data on quality assurance processes in 2008-09 are reported in box 14.13. These results should be interpreted with reference to tables 14A.42–50 that contain information on the legislation under which jurisdictions' implement standards, the relevant disability service standards and how quality is monitored.

Under the NDA, there is a performance benchmark that all services should be subject to quality improvement systems consistent with National Standards by 2010. Quality improvement systems are an identified priority area on which parties have agreed to concentrate initial national efforts (box 14.1). On 11 September 2009, the Community and Disability Services Ministers' Conference endorsed the interim National Quality Framework for Disability Services, including revising the National Standards for Disability Services. Under this Framework, a national approach to quality assurance and the continuous improvement of disability services will be introduced.

Box 14.13 Quality assurance processes for specialist disability services[a]

The quality assurance processes data reported below relate to CSTDA/NDA funded services.

Australian Government

Australian Government funded disability employment assistance organisations are required to meet 12 quality standards and 26 key performance indicators, as a prerequisite for continued funding. In order to verify that the standards have been met, independent accredited certification bodies perform initial certification as well as annual surveillance audits for each organisation. In 2008-09, all 420 organisations funded to provide disability employment assistance (100 per cent) were audited by independent certification bodies.

NSW, Victoria, Queensland, WA, SA and the ACT

In 2008-09, different quality assurance processes were in place in NSW, Victoria, Queensland, WA, SA and the ACT. The evaluation processes relate to both government and non-government service outlets, although in some jurisdictions the requirements are different across service sectors.

NSW

In NSW, the *Integrated Monitoring Framework* (IMF) provides an integrated approach to compliance, quality and performance reporting for all funded services. Each year all service providers (100 per cent) are required to report their compliance with contractual obligations including adherence to legislation, policy and program guidelines. The quality component of the IMF includes a provider self-assessment and a desk top review, followed by an on-site service review of the provider's outlets. As part of the on-site review, service providers are required to demonstrate adherence to 23 key performance indicators (KPIs). By June 2009, 2849 outlets had been assessed through an on-site review. Over 16 per cent of outlets fully met the requirements of all 23 KPIs. The majority of the remaining outlets met most of the 23 KPIs. Providers were expected to develop Action Plans against any partially met or unmet KPI.

Victoria

In 2008-09, Victoria continued the transition towards a personal outcomes focus and the introduction of independent monitoring that are core elements of the *Quality Framework for Disability Services in Victoria (2007)*. During 2008-09, all registered disability service providers (100 per cent) were required to undertake a self-assessment and report compliance with the standards. A mechanism for independent monitoring and certification against the Standards has also been developed.

(Continued on next page)

Box 14.13 **(Continued)**

Queensland

Introduced on 1 July 2004, the *Disability Sector Quality System* requires all disability service providers recurrently funded by government to achieve certification through an external certification body. The quality system also provides a framework to support service providers to develop, implement and maintain their own quality management system. Of the established 239 recurrently funded service providers, 100 per cent have achieved certification and undergo annual surveillance audits to ensure that certification is maintained and that a continuous improvement plan has been developed. Currently there are 19 new service providers who are in the process of implementing their quality management systems in preparation for external audit.

WA

In WA, the *Quality Management Framework* (QMF) was implemented in 2009. Under the QMF, recurrently funded service providers are evaluated against disability service standards and outcome standards. In 2008-09, 21 per cent (or 218 of 1042) of total disability service outlets had been independently monitored against the standards, and 73.4 per cent (160 of 218) of these assessed service outlets had been quality assured against all assessed standards. Outlets that had not been independently assessed were required to provide a self-assessment.

SA

In SA, non-government service providers are required to meet quality assurance criteria before they may provide NDA funded services. From 2006-07, this included participation in an independently audited quality assurance system, the *Service Excellence Framework*. The *Service Excellence Program* is the Department for Families and Communities preferred quality improvement program. As at June 2009, 77 per cent (86 of 112) of approved disability providers are engaged in the Service Excellence Framework, with a further 14 per cent (16 of 112) involved in other independently assessed quality assurance programs. Disability SA, the government disability services provider, self-assesses against the *Business Excellence Framework* adopted across all areas of the Department for Families and Communities.

ACT

In 2008-09, the ACT continued implementation of the quality improvement system for all funded agencies. All individual agencies (100 per cent) are required to undertake an annual baseline self-assessment against the National Disability Service Standards, with quality improvement action plans being developed and implemented on the basis of any identified issues.

[a] Information on quality assurance processes for providers of specialist disability services in 2008-09 are not available for Tasmania and the NT.

Source: Australian, NSW, Victoria, Queensland, WA, SA and the ACT governments (unpublished).

Client and carer satisfaction

‘Client and carer satisfaction’ is an indicator of governments’ objective to deliver and fund quality services for people with disability that meet the needs and goals of the client (or carer of the client) receiving them (box 14.14).

Box 14.14 **Client and carer satisfaction**

Overall client and carer satisfaction ratings and satisfaction with individual services are reported. Results are taken from a client and carer satisfaction survey and are expressed in percentage terms.

A higher proportion of clients and carers satisfied is desirable, as it suggests the service received was of a higher quality and better met the needs and goals of the client (or carer).

Data reported for this indicator are neither complete nor directly comparable.

Data are available for reporting for Victoria, Queensland, SA, Tasmania and the ACT only (box 14.15). It is anticipated that data for other jurisdictions will be included in future reports.

Box 14.15 Client and carer satisfaction with specialist disability services

The client and carer satisfaction processes data reported below relate to CSTDA/NDA funded services.

Victoria

In 2008-09, Victoria conducted a survey to measure carers' satisfaction with the respite services they received. The results show that 69 per cent of the households surveyed were satisfied with the services they received.

Queensland

Queensland conducted a *Disability and Mental Health Service Users and Carers Satisfaction Survey* during February to April 2009. Overall, of the 2147 service users, proxies and carers who were surveyed, 73 per cent of service users and proxies and 66 per cent of carers reported that they were satisfied with the services they received. The survey provides results according to the type of disability and mental health services received and shows the following:

- 80 per cent of service users and their proxies and 74 per cent of carers were satisfied with accommodation support services
- 66 per cent of service users and their proxies and 61 per cent of carers were satisfied with community support services
- 76 per cent of service users and their proxies and 65 per cent of carers were satisfied with community access services
- 81 per cent of service users and their proxies and 77 per cent of carers were satisfied with respite services.

SA

In SA, customer satisfaction surveys are undertaken every 6 months across all government agencies. In the March 2009 survey, a total of 396 people responded to the Disability SA survey, of which 181 were clients of Disability SA and 215 were family carers or advocates. The results of the survey indicate that 83 per cent of respondents were satisfied with the accessibility of the service provided and 63 per cent were satisfied with the amount of time it took to get the service provided. Overall, 41 per cent were very satisfied and a further 38 per cent were satisfied with the quality of service delivery. Of the respondents, 69 per cent said they received what they needed from Disability SA and 22 per cent received part of what they needed.

(Continued on next page)

Box 14.15 **(Continued)**

Tasmania

In 2008-09, Tasmania conducted client and family satisfaction surveys across a range of group homes and community access services. For group homes, 117 clients and 272 families were surveyed and for community access services, 63 clients and 153 families were surveyed. The proportion of clients who were satisfied with the quality of services was 91 per cent for group homes and 96 per cent for community access services. Families indicated similar levels of satisfaction with the quality of services with 98 per cent satisfied in group homes and 95 per cent satisfied in community access services.

ACT

In 2009, the ACT conducted several satisfaction surveys for clients of government provided disability services. These surveys asked clients to rate their overall satisfaction levels with the quality of the services they had received. The proportion of service users reporting that they were satisfied or very satisfied was:

- 76 per cent for accommodation support services
- 82 per cent for respite service users
- 87 per cent for community support service users.

Source: Victoria, Queensland, SA, Tasmanian and the ACT governments (unpublished).

Efficiency — cost per output unit

The following cost per output unit efficiency indicators are reported:

- 'Cost per user of government provided accommodation support services'
- 'Government contribution per user of non-government provided services'
- 'Cost per user of State and Territory administered services'.

This Report includes 2008-09 expenditure data provided by Australian, State and Territory governments. However, as 2008-09 service user data from the NMDS collection were not available for this Report, the cost per service user efficiency indicators are reported for 2007-08. Expenditure data might differ from information reported elsewhere (such as in departmental annual reports) because the financial counting rules and definitions used to calculate expenditure can differ. Data in this Report might also differ from information reported elsewhere because the data here exclude users of specialist psychiatric disability services only.

It is an objective of the Review to report comparable estimates of costs. Ideally, such comparisons would include the full range of costs to government. Where the full costs cannot be counted, costs are estimated on a consistent basis. The jurisdictional expenditure data included in this chapter do not yet include the user cost of capital, and so do not reflect the full costs of government funded services. (User cost of capital is defined in chapter 2.)

Considerable effort has been made to document any differences in calculating the reported efficiency indicators. Concerns remain over the comparability of the results, because jurisdictions use different methods of data collection (table 14A.51).

Financial data — expenditure items included/excluded

Financial data reported in this chapter include/exclude various expenditure items depending on the context in which the data are reported. When specific service types are discussed, only direct recurrent expenditure on those specific services is included (this may include administrative costs that can be directly attributed to a specific service/s). When the disability services system as a whole is discussed, expenditure includes general administrative overheads that cannot be allocated to a specific service/s and major capital grants to non-government service providers. Capital grants to non-government service providers are excluded from total recurrent expenditure for the indicator 'administrative expenditure as a proportion of total recurrent expenditure', as they are not strictly a 'recurrent' expense. Exclusion of these grants improves the comparability of the indicator across jurisdictions and over time.

Government and non-government provided services

Efficiency indicators are reported for both government and non-government provided services. Government provision means that a service is both funded and directly provided by a government department, agency or local government. Non-government provision is a service purchased or part-funded by a government department or agency, but provided by a non-government organisation. Non-government service providers may receive funds from the private sector and the general public in addition to funding, grants and input tax concessions (such as payroll tax exemptions) from governments. Data on funds that non-government service providers received from the private sector and the general public are outside the scope of this Report.

Accommodation support services

Governments provide or contribute funding to accommodation support services for people with disability in institutional/residential settings and through community accommodation and care. There has been an ongoing process of relocating people with disability from institutional/residential accommodation to community accommodation (including group homes and other community accommodation). As a result, total government expenditure on accommodation support services in institutional/residential settings has decreased, with a corresponding increase in expenditure on community accommodation and care services.

Cost per user of government provided accommodation support services

'Cost per user of government provided accommodation support services' is an indicator of governments' objective to provide specialist disability services in an efficient manner (box 14.16).

Box 14.16 **Cost per user of government provided accommodation support services**

'Cost per user of government provided accommodation support services' is defined as the net government expenditure per user of government provided CSTDA accommodation support services in:

- institutional/residential settings
- group homes
- 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 can reflect deteriorating efficiency, it can also reflect improvements in the quality or attributes of the services provided. Increasing expenditure can 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 can reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

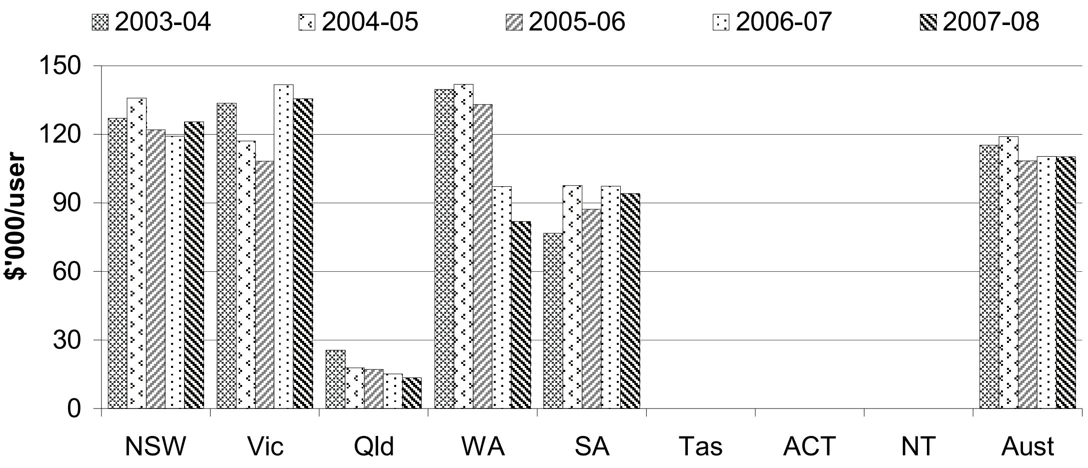
Data reported for this indicator are not directly comparable.

The data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Cost per user of government provided accommodation support services — institutional/residential settings

Nationally, estimated annual government expenditure on accommodation support services in institutional/residential settings was $110 158 per service user in 2007-08 (figure 14.26).

Figure 14.26 **Estimated annual government expenditure per user of government provided accommodation support services in institutional/residential settings (2007-08 dollars)**[a, b, c, d, e]



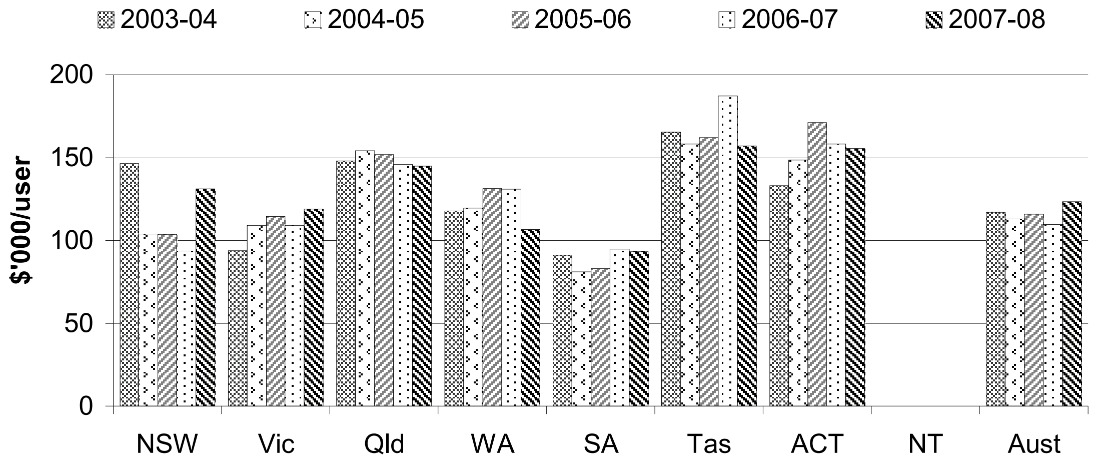
[a] See table 14A.52 for detailed notes relating to these data. [b] Service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. [c] In NSW, the change in expenditure per user between 2006-07 and 2007-08 is largely caused by a correction in the NMDS service user data. Some users of non-government provided services were coded as government users in the reports of previous years and this has been rectified for 2007-08. [d] WA service user data for 2007-08 were provided directly by WA and have not been validated by the AIHW. The revisions correct for a coding error related to users allocation to government or non-government services. [e] There were no government provided accommodation support services in institutional/residential settings in Tasmania, the ACT or the NT.

Source: AIHW (unpublished) *CSTDA NMDS*; State and Territory governments (unpublished); table 14A.52.

Cost per user of government provided accommodation support services — group homes

Nationally, estimated annual government expenditure on government provided accommodation support services in group homes was $123 367 per service user in 2007-08 (figure 14.27). For 2003-04 and 2004-05, the denominators and the numerators used to derive this measure do not match for NSW, Victoria, WA and SA, as the service user data include services provided by local governments and the expenditure data exclude services provided by local governments. Thus, historical data for this measure need to be interpreted with care.

Figure 14.27 **Estimated annual government expenditure per user of government provided accommodation support services in group homes (2007-08 dollars)**[a, b, c, d, e, f]



---

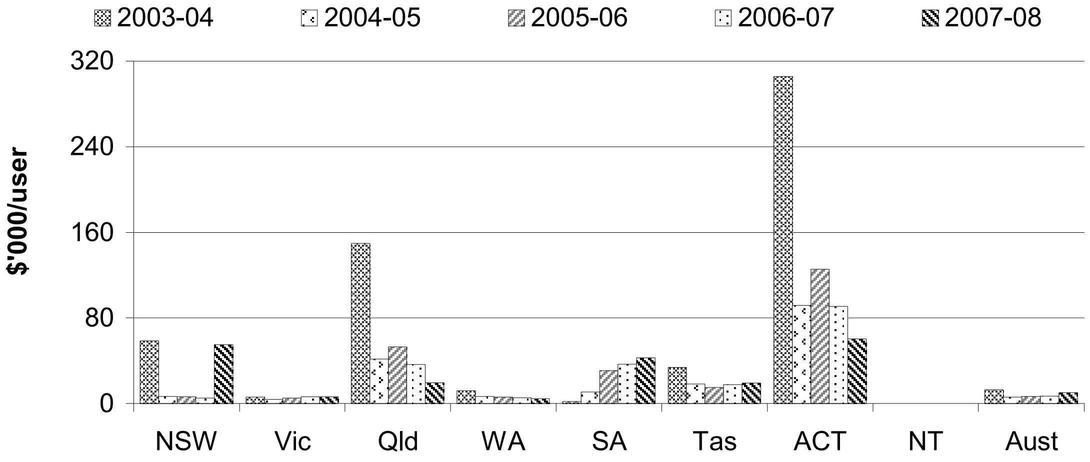
[a] See table 14A.52 for detailed notes relating to these data. [b] Service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. [c] In NSW, the change in expenditure per user between 2006-07 and 2007-08 is largely caused by a correction in the NMDS service user data. Some users of non-government provided services were coded as government users in the reports of previous years and this has been rectified for 2007-08. [d] WA service user data for 2007-08 were provided directly by the WA Government and have not been validated by the AIHW. The revisions correct for a coding error related to users allocation to government or non-government services. [e] In the ACT, the increase in expenditure between 2004-05 to 2005-06 is the result of a combination of factors including service user information being excluded as a result of data cleansing analyses of the NMDS forms or being reclassified to 'other community settings'. [f] There were no government providers of accommodation support services in group homes in the NT.

Source: AIHW (unpublished) *CSTDA NMDS*; State and Territory governments (unpublished); table 14A.52.

Cost per user of government provided accommodation support services — other community settings

Nationally, estimated annual government expenditure on government provided accommodation support services in other community settings was $10 042 per service user in 2007-08 (figure 14.28). For 2003-04 and 2004-05, the denominators and the numerators used to derive this measure do not match for NSW, Victoria, WA and SA, as the service user data include services provided by local governments and the expenditure data exclude services provided by local governments. Thus, historical data for this measure need to be interpreted with care.

Figure 14.28 Estimated annual government expenditure per user of government provided accommodation support services in other community settings (2007-08 dollars)[a, b, c, d, e, f]



---

[a] See table 14A.52 for detailed notes relating to these data. [b] Service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. [c] In NSW, the change in expenditure per user between 2006-07 and 2007-08 is largely caused by a correction in the NMDS service user data. Some users of non-government provided services were coded as government users in the reports of previous years and this has been rectified for 2007-08. [d] WA service user data for 2007-08 were provided directly by WA and have not been validated by the AIHW. The revisions correct for a coding error related to users allocation to government or non-government services. [e] In the ACT, the change in expenditure per user between 2003-04 and 2004-05 is the result of care arrangement changes for a small number of high care need service users. The increase in cost per user between 2004-05 and 2005-06 is the result of data cleansing as some services users were not counted. [f] There were no government providers of accommodation support services in other community settings in the NT.

Source: AIHW (unpublished) *CSTDA NMDS*; State and Territory governments (unpublished); table 14A.52.

Government contribution per user of non-government provided services

‘Government contribution per user of non-government provided services’ is an indicator of governments’ objective to provide specialist disability services in an efficient manner (box 14.17).

Box 14.17 Government contribution per user of non-government provided services

'Government contribution per user of non-government provided services' is defined as the net government expenditure per CSTDA service user. Measures are reported for the following non-government provided services:

- accommodation support services in:
  - institutional/residential settings
  - group homes
  - other community settings
- employment services (reported per employment service user assisted).

Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service.

Efficiency data are difficult to interpret. Although high or increasing expenditure per unit of output can reflect deteriorating efficiency, it can also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of users. Similarly, low or declining expenditure per unit of output can reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

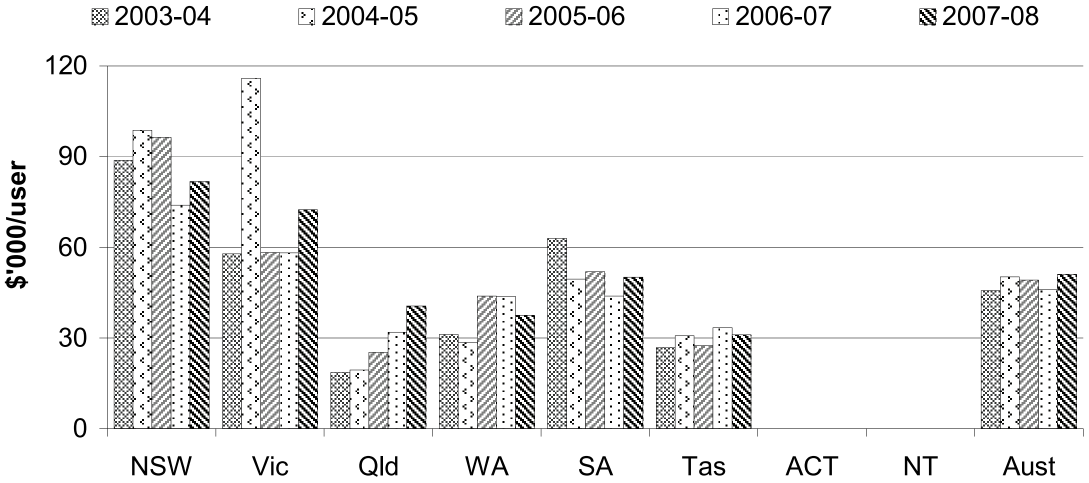
Data reported for this indicator are not directly comparable.

The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Government contribution per user of non-government provided services — accommodation support services in institutional/residential settings

Nationally, estimated annual government funding of non-government provided accommodation support services in institutional/residential settings was $51 043 per service user in 2007-08 (figure 14.29).

Figure 14.29 **Estimated annual government funding per user of non-government provided accommodation support services in institutional/residential settings (2007-08 dollars)**[a, b, c, d, e, f]



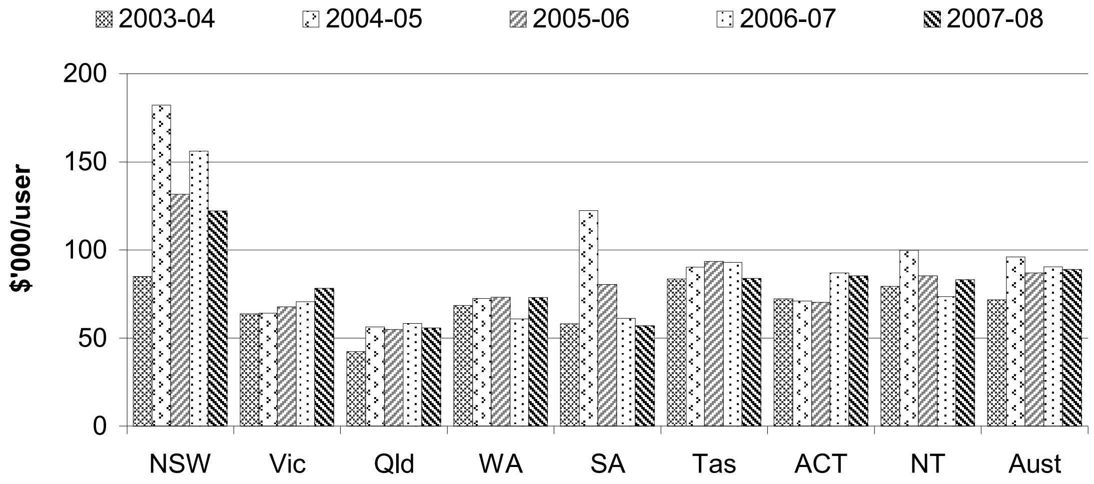
[a] See table 14A.52 for detailed notes relating to these data. [b] Service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. [c] In NSW, the change in expenditure per user between 2006-07 and 2007-08 is largely caused by a correction in the NMDS service user data. Some users of non-government provided services were coded as government users in the reports of previous years and this has been rectified for 2007-08. [d] The Victorian cost per service user for 2004-05 is overstated due to a significant proportion of service users having moved from institutional settings to community based and individualised settings, while expenditure continued to be similar to previous years. [e] WA service user data for 2007-08 were provided directly by the WA Government and have not been validated by the AIHW. The revisions correct for a coding error related to users allocation to government or non-government services. [f] There were no non-government provided accommodation support services in institutional/residential settings in the ACT and the NT.

Source: AIHW (unpublished) *CSTDA NMDS*; State and Territory governments (unpublished); table 14A.52.

Government contribution per user of non-government provided services — accommodation support services in group homes

Nationally, estimated annual government funding of non-government provided accommodation support services in group homes was $88 854 per service user in 2007-08 (figure 14.30). For 2003-04 and 2004-05, the denominators and the numerators used to derive this measure do not match for NSW, Victoria, WA and SA, as the service user data exclude services provided by local governments and the expenditure data include services provided by local governments. Thus historical data for this measure need to be interpreted with care.

Figure 14.30 Estimated annual government funding per user of non-government provided accommodation support services in group homes (2007-08 dollars)[a, b, c, d]



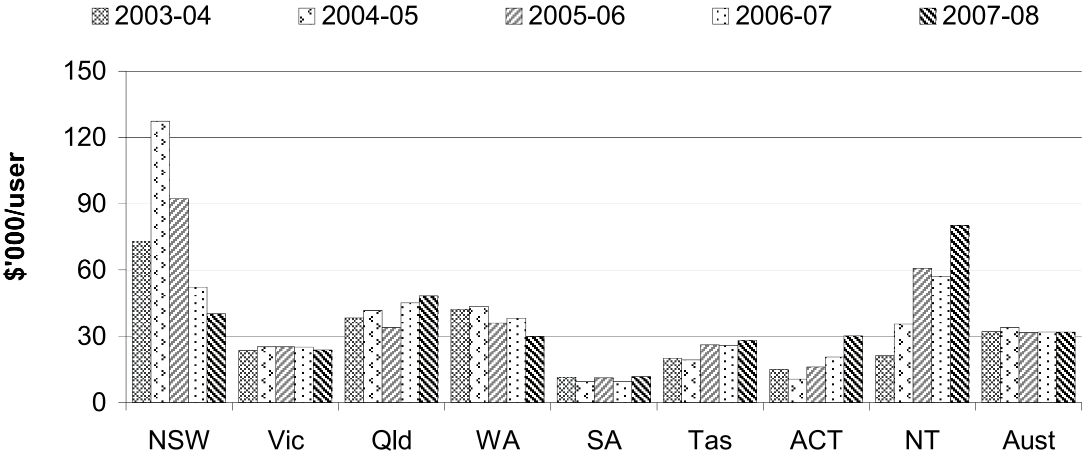
[a] See table 14A.52 for detailed notes relating to these data. [b] Service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. [c] In NSW, the change in expenditure per user between 2006-07 and 2007-08 is largely caused by a correction in the NMDS service user data. Some users of non-government provided services were coded as government users in the reports of previous years and this has been rectified for 2007-08. [d] WA service user data for 2007-08 were provided directly by the WA Government and have not been validated by the AIHW. The revisions correct for a coding error related to users allocation to government or non-government services.

Source: AIHW (unpublished) *CSTDA NMDS*; State and Territory governments (unpublished); table 14A.52.

Government contribution per user of non-government provided services — accommodation support services in other community settings

Nationally, estimated annual government funding of non-government provided accommodation support services in other community settings was $31 861 per service user in 2007-08 (figure 14.31). For 2003-04 and 2004-05, the denominators and the numerators used to derive this measure do not match for NSW, Victoria, WA and SA, as the service user data exclude services provided by local governments and the expenditure data include services provided by local governments. Thus historical data for this measure need to be interpreted with care.

Figure 14.31 **Estimated annual government funding per user of non-government provided accommodation support services in other community settings (2007-08 dollars)** a, b, c, d



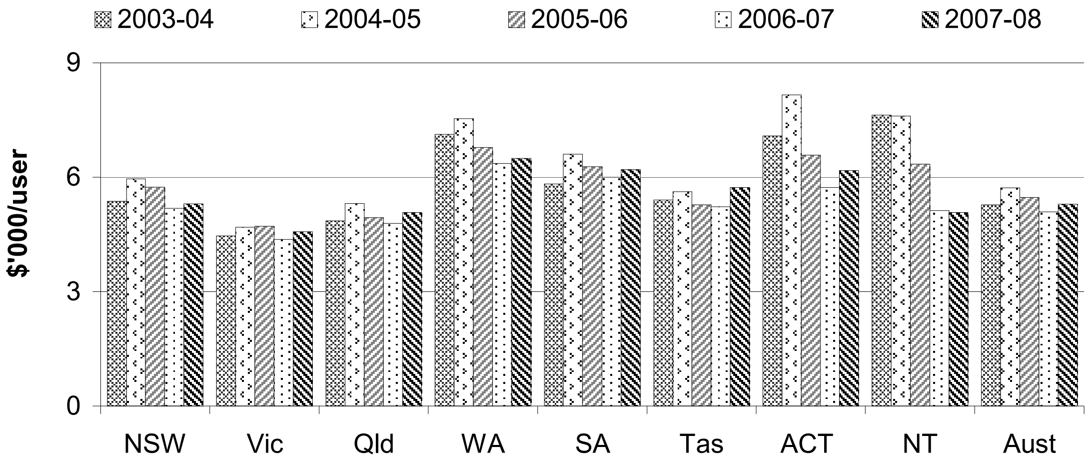
[a] See table 14A.52 for detailed notes relating to these data. [b] Service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. [c] In NSW, the change in expenditure per user between 2006-07 and 2007-08 is largely caused by a correction in the NMDS service user data. Some users of non-government provided services were coded as government users in the reports of previous years and this has been rectified for 2007-08. [d] WA service user data for 2007-08 were provided directly by the WA Government and have not been validated by the AIHW. The revisions correct for a coding error related to users allocation to government or non-government services.

Source: AIHW (unpublished) *CSTDA NMDS*; State and Territory governments (unpublished); table 14A.52.

Government contribution per employment service user assisted

Nationally, for all employment services, estimated government expenditure per service user assisted was $5295 in 2007-08 (figure 14.32). Nationally, estimated annual government expenditure per service user in 2007-08, by employment service type, was $4555 on open services (employed or seeking employment in the open labour market) and $9711 on supported services (employed by the service provider) (table 14A.54).

Figure 14.32 **Government contribution per employment service user assisted (2007-08 dollars)**[a, b]



[a] See table 14A.53 for detailed notes relating to these data. [b] Cost per employment service user data reported here might differ from those reported in the Australian Government's annual report, where different rules are used to count the number of employment service users.

Source: Australian Government (unpublished); AIHW (unpublished) *CSTDA NMDS;* table 14A.53.

Cost per user of State and Territory administered services

'Cost per user of State and Territory administered services' is an indicator of governments' objective to provide specialist disability services in an efficient manner (box 14.18).

Box 14.18 **Cost per user of State and Territory administered services**

‘Cost per user of State and Territory administered services’ is defined as government expenditure on CSTDA State and Territory administered services per service user. Data are reported separately for government expenditure net of payroll tax and for government expenditure including actual and/or imputed payroll tax.

Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service.

Efficiency data are difficult to interpret. Although high or increasing expenditure per unit of output can reflect deteriorating efficiency, it can also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of service users. Similarly, low or declining expenditure per unit of output can reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Data reported for this indicator are not directly comparable.

Total estimated government expenditure per user of CSTDA State and Territory administered specialist disability services in 2007-08 is reported both net of payroll tax and including actual and/or imputed payroll tax. Nationally, estimated expenditure per service user was $26 153 excluding payroll tax and $26 617 including actual and/or imputed payroll tax (figure 14.33).

Figure 14.33 **Estimated annual government expenditure per user of CSTDA State and Territory administered services, 2007-08**[a, b, c, d]

---

[a] In some jurisdictions (NSW, Victoria and SA in part, Queensland, Tasmania and the NT), payroll tax data are actual; in other jurisdictions (Victoria and SA in part, WA, and the ACT), payroll tax data are imputed. [b] Government expenditure per service user for Australia excludes Australian Government expenditure on State and Territory administered services that was not provided as transfer payments. [c] Payroll tax data for Queensland includes paid payroll tax and accrued payroll tax. [d] In the NT, payroll tax relates to government service provision and excludes expenditure for program management and administration.

Source: AIHW (unpublished) *CSTDA NMDS*; State and Territory governments (unpublished); table 14A.55.

Efficiency — administrative cost

Administrative expenditure as a proportion of total recurrent expenditure

'Administrative expenditure as a proportion of total recurrent expenditure' is an indicator of governments' objective to provide specialist disability services in an efficient manner (box 14.19). The proportion of total expenditure on administration is not yet comparable across jurisdictions as it is apportioned by jurisdictions using different methods (table 14A.51). However, administrative expenditure data can indicate trends within jurisdictions over time.

Box 14.19 **Administrative expenditure as a proportion of total recurrent expenditure**

‘Administrative expenditure as a proportion of total recurrent expenditure’ is defined as government expenditure on administration as a proportion of total recurrent CSTDA/NDA expenditure. Major capital grants to non-government service providers are excluded to improve comparability across jurisdictions and over time.

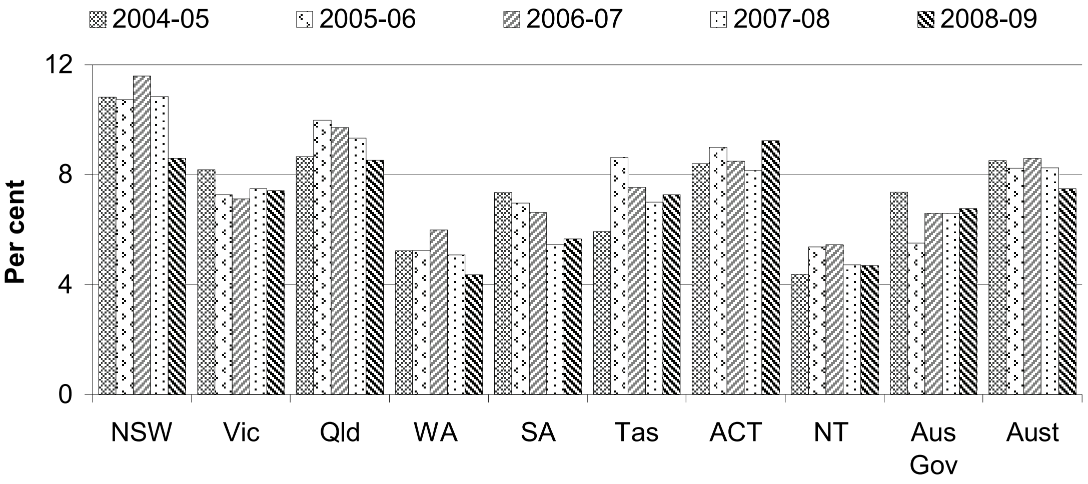
Holding other factors constant (such as service quality and accessibility), lower or decreasing administrative expenditure as a proportion of total recurrent CSTDA/NDA expenditure might reflect an increase in administrative efficiency.

Efficiency data are difficult to interpret. Although high or increasing administrative expenditure as a proportion of total expenditure may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the administrative services provided. Similarly, low or declining administrative expenditure as a proportion of total expenditure may reflect improving efficiency, or lower quality and less effective administrative services. This may in turn affect service delivery effectiveness. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Data reported for this indicator are not directly comparable.

Nationally, administrative expenditure as a proportion of total government expenditure on specialist disability services (excluding payroll tax) decreased from 8.2 per cent in 2007-08 to 7.5 per cent in 2008-09 (figure 14.34). When actual or imputed payroll tax is included, the average national administrative expenditure as a proportion of total CSTDA expenditure was 7.4 per cent in 2008-09 (table 14A.56). Real total CSTDA expenditure is reported in table 14A.7, both excluding and including actual or imputed payroll tax amounts.

Figure 14.34 **Administrative expenditure as a proportion of total recurrent expenditure**[a, b, c, d, e, f]



[a] See table 14A.51 for an explanation of different methods of apportioning departmental costs. [b] Data exclude payroll tax. [c] Australian Government administrative expenditure is an estimate, based on average staffing levels. [d] The decrease in NSW administrative expenditure as a proportion of total recurrent expenditure on services in 2008-09 reflects an improved overhead allocation model which results in better allocation of funding to direct and non-direct service expenditures. [e] The decrease in WA administrative expenditure in 2007-08 mainly reflects the abolition of the capital user charge by the Department of Treasury and Finance. [f] In Tasmania, the Department of Health and Human Services underwent a restructure in 2006-07. This resulted in a reduction in administration expenditure in 2006-07.

Source: Australian, State and Territory governments (unpublished); table 14A.56.

Outcomes

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

The following outcome indicators are included in the performance framework:

- ‘Labour force participation and employment of people with disability’
- ‘Social participation of people with disability’
- ‘Use of other services by people with disability’.

The measures and data sources for the ‘labour force participation and employment of people with disability’, ‘social participation of people with disability’ and ‘use of other services’ indicators differ across report years.

Interpreting data for some outcome indicators

For the outcome indicators derived using survey data, 95 per cent confidence intervals are presented. These intervals assist with making comparisons between jurisdictions, and between different disability status groups. Confidence intervals are a standard way of expressing the degree of uncertainty associated with survey estimates. An estimate of 80 with a confidence interval of ± 4, for example, means that if another sample had been drawn there is a 95 per cent chance that the result would lie between 76 and 84. Where ranges do not overlap, there is a statistically significant difference. If one jurisdiction's results range from 78–80 and another's from 82–89, then it is possible to say that one differs from the other (because there is a statistically significant difference). To say that there is a statistically significant difference means there is a high probability that there is an actual difference — it does not imply that the difference is necessarily large or important.

Labour force participation and employment of people with disability

'Labour force participation and employment of people with disability' is an indicator of governments' objective of assisting people with disability to participate fully in the community (box 14.20). Participation in the labour force and employment is important to the overall wellbeing of people with disability, particularly in terms of the opportunity for self development, community participation, occupying a valued role and financial independence.

Box 14.20 **Labour force participation and employment of people with disability**

‘Labour force participation and employment of people with disability’ is defined as the labour force participation and employment rates of people aged 15–64 years with disability. Labour force participation rates and employment rates of people without disability are also reported.

Higher or increasing labour force participation and employment rates for people with disability are desirable. Higher rates are likely to increase the quality of life of people with disability by providing greater opportunities for self-development and for economic and social participation.

This indicator does not provide information on why people choose not to participate in the labour force and why people are not employed. It also does not provide information on whether the employment positions are appropriate or fulfilling.

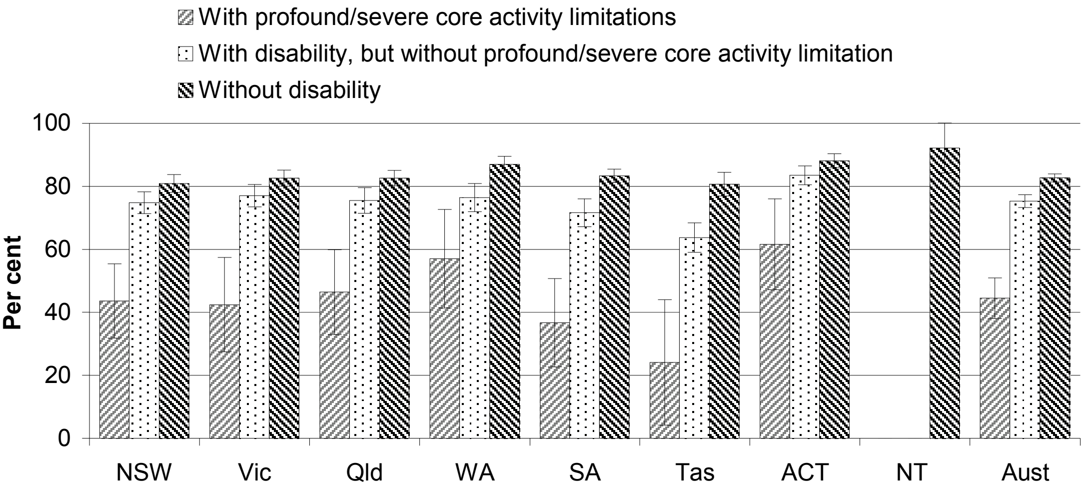
Data reported for this indicator are comparable.

Labour force participation and employment rate data from the ABS’s *2007-08 National Health Survey* (NHS) are reported for all jurisdictions. The NHS uses a short disability module to collect data on people with disability. Due to this collection methodology, estimates from the NHS may not be consistent with those that could be obtained from the more detailed SDAC. The NHS’s disability population relates to a broader ‘disability and long-term health condition’ population than the ‘disability’ population obtained from the SDAC — however, the characteristics of the populations are similar.

Labour force participation

Nationally, in 2007-08, the estimated labour force participation rate of people aged 15–64 years with a profound or severe core activity limitation (44.5 ± 6.4 per cent) was statistically significantly lower than the rate for other people with disability (without a profound or severe core activity limitation) (75.3 ± 2.0 per cent) and the rate for people without a disability (82.7 ± 1.3 per cent) (figure 14.35). The detailed definition of the labour force participation rate and its calculation method is provided in section 14.7. Other data on the labour force participation of people with disability are reported in tables 14A.58–63.

Figure 14.35 **Estimated labour force participation rates of people aged 15–64 years, by disability status, 2007-08**[a, b, c, d]



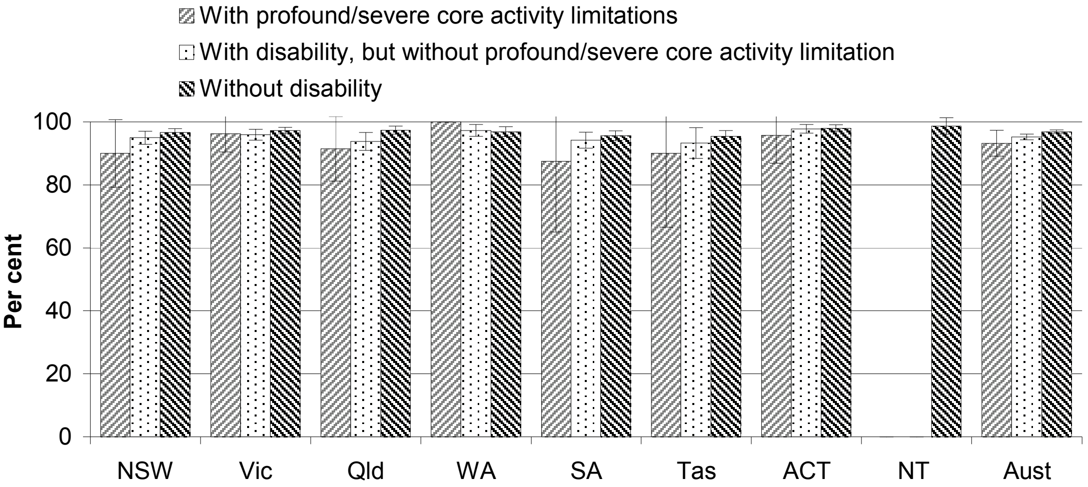
[a] Due to different collection methods, in particular those used to identify disability, these estimates may not be consistent with those that could be obtained from the SDAC. The data collected by the NHS relate to a broader ‘disability and long-term health condition’ population than the ‘disability’ population obtained from the more detailed SDAC — however, the characteristics of the populations are similar. [b] Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self care. [c] Error bars represent the 95 per cent confidence interval associated with each point estimate. [d] NT data for people with disability are not available for separate publication, but are included in Australian totals.

Source: ABS (unpublished) *NHS 2007-08*, Cat. no. 4364.0; table 14A.57.

Employment

Nationally, in 2007-08, the estimated employment rate of people aged 15–64 years with a profound or severe core activity limitation (93.2 ± 4.1 per cent) was similar to the rate for other people with disability (but without a profound or severe core activity limitation) (95.2 ± 0.9 per cent) and the rate for people without a disability (96.9 ± 0.6 per cent) (figure 14.36). The detailed definition of the employment rate and its calculation method is provided in section 14.7. Employment rates should be interpreted in conjunction with labour force participation rates. Other data on the employment of people with disability are reported in tables 14A.58–63.

Figure 14.36 **Estimated employment rates of people aged 15–64 years, by disability status, 2007-08**[a, b, c, d]



[a] Due to different collection methods, in particular those used to identify disability, these estimates may not be consistent with those that could be obtained from the SDAC. The data collected by the NHS relate to a broader 'disability and long-term health condition' population than the 'disability' population obtained from the more detailed SDAC — however, the characteristics of the populations are similar. [b] Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self care. [c] Error bars represent the 95 per cent confidence interval associated with each point estimate. [d] NT data for people with disability are not available for separate publication, but are included in Australian totals.

Source: ABS (unpublished) *NHS 2007-08*, Cat. no. 4364.0; table 14A.57.

Social participation of people with disability

'Social participation of people with disability' is an indicator of governments' objective to assist people with disability to live as valued and participating members of the community (box 14.21).

Box 14.21 **Social participation of people with disability**

'Social participation of people with disability' is defined as the proportion of people with disability who participate in selected social or community activities. The proportion of people without disability who participate in these activities is also reported.

A higher or increasing proportion of people with disability who participate in social or community activities reflects their greater inclusion in the community.

This indicator does not provide information on the degree to which the identified types of social or community activities contribute to people's quality of life. It also does not provide information on why some people did not participate.

Updated data for this indicator were not available for the 2010 Report.

Nationally, in 2006, the estimated proportions of people with a profound or severe core activity limitation aged 18–64 years who had face-to-face contact with family and friends at least once a month was 91.9 ± 3.2 per cent, compared to 91.7 ± 2.0 per cent for other people with a limitation or restriction, excluding profound or severe core activity limitation and 94.4 ± 0.6 per cent for people without a limitation or restriction (table 14A.64). Other data on participation of people with disability in selected social and community activities are reported in tables 14A.64–69.

Use of other services by people with disability

'Use of other services by people with disability' is an indicator of governments' objective of enhancing the quality of life experienced by people with disability by assisting them to gain access to mainstream government services (box 14.22).

Box 14.22 **Use of other services by people with disability**

'Use of other services by people with disability' is defined by two measures:

- the proportion of people aged 0–64 years with a ASSNP who lived in State or Territory housing authority dwellings (data are also reported for people without ASSNP and the proportions living in other dwelling tenure types)
- the proportion of people aged 15–64 years with disability who visited a GP at least once in the last 6 months (data are also reported for people without disability).

A higher or increasing proportion of people with disability who use the selected mainstream government services suggests greater access to these services.

This indicator does not provide information on whether the service accessed is the most appropriate, or the degree to which the services contribute to people's quality of life. It also does not provide information on why some people do not access these services.

Data reported for this indicator are comparable.

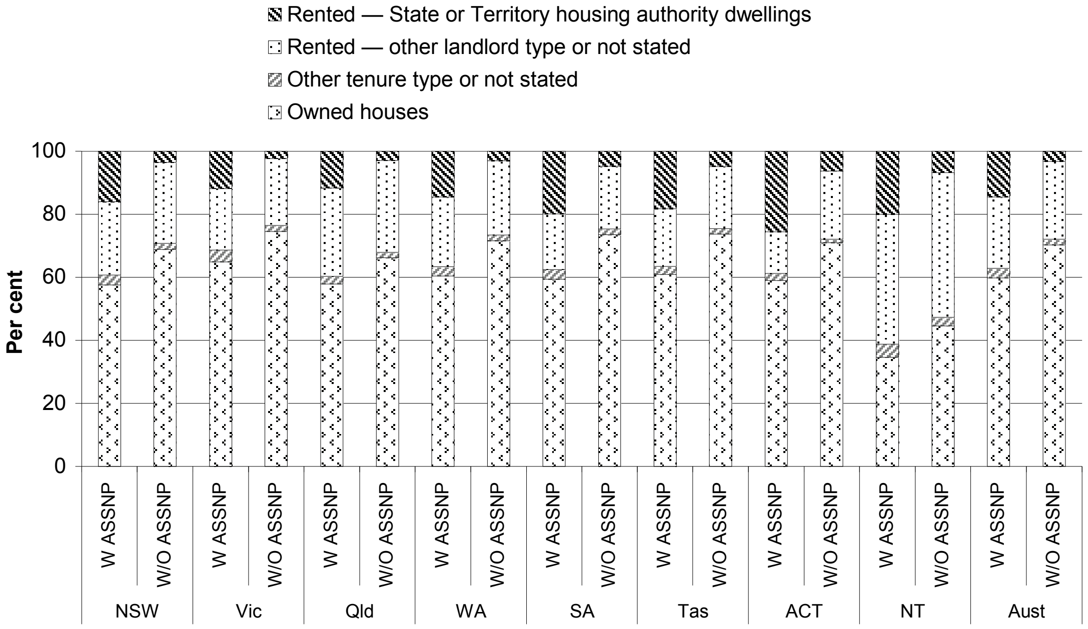
Three data sources of people with disabilities access to other services are included:

- Data from the ABS's *2006 Census* on access to State or Territory housing authority dwellings are reported for all jurisdictions by need for assistance with core activities. The ABS 2006 Census contained questions in relation to people's need for assistance with core activities. Using these questions, individuals with a ASSNP can be identified. The concept of ASSNP is similar to the concept of the SDAC profound or severe core activity limitations population, but the relevant data are not suitable for direct comparison due to differences in the questions asked and the methods of data collection. Data on the use of public housing by people with a ‘core activity need for assistance’ were reported in the 2009 Report, but the measure has been modified and additional data on home ownership has also been incorporated.

- Data from the NHS on the use by people with disability of general practitioner (GP) services are reported for all jurisdictions (except the NT).

Nationally, the proportion of people aged 0–64 years with a ASSNP who lived in State or Territory housing authority dwellings was 14.6 per cent, higher than the proportion of people aged 0–64 years without a ASSNP who lived in these dwellings (3.3 per cent) (figure 14.37).

Figure 14.37 **Proportion of people aged 0–64 years residing in dwellings, by tenure type and ASSNP status, 2006[a, b]**

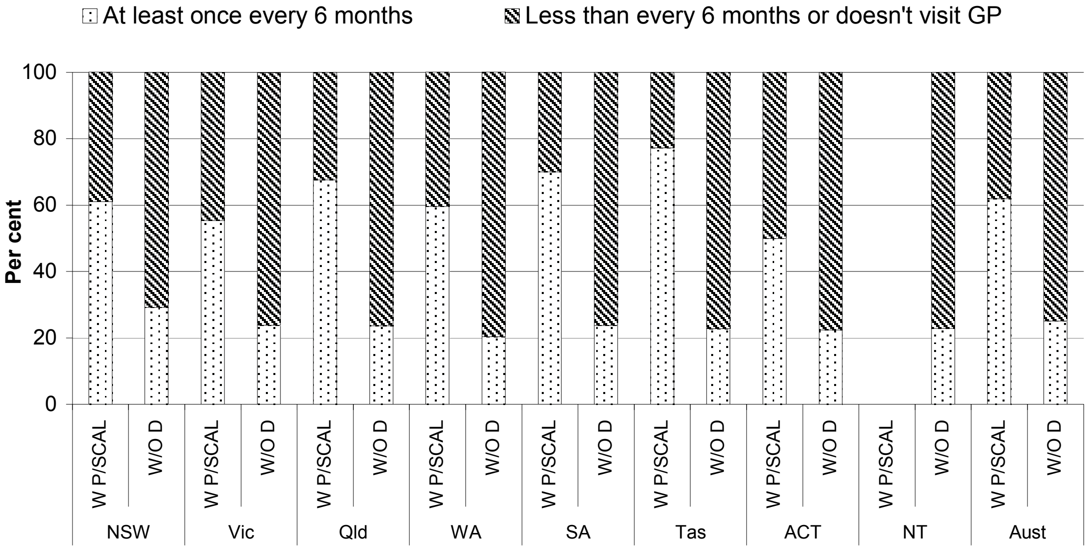


W ASSNP = with a need for assistance with core activities. W/O ASSNP = without a need for assistance with core activities. [a] The ABS 2006 Census module was designed to measure ASSNP. This population is conceptually comparable with the SDAC and ABS disability module population of people who have a profound or severe core activity limitation, but due to the different collection method and shortening of the question set used, the population identified is smaller (but displays similar characteristics). [b] Results include people who usually reside in the dwelling and who were present on Census night only. People who were visitors and those people who were not present in the household were excluded.

Source: ABS (unpublished) *2006 Census of Population and Housing*; table 14A.70.

Nationally, the estimated proportion of people aged 15–64 years with a profound or severe core activity limitation who visit a GP at least once every 6 months was (61.9 ± 5.8 per cent), statistically significantly higher than the proportion for people without disability (25.1 ± 1.3 per cent) (figure 14.38 and table 14A.71). Data on the proportion of other people with disability (but without profound or severe core activity limitations) who visit a GP at least once every 6 months are in table 14A.71.

Figure 14.38 **Visits to a GP by people aged 15–64 years, by frequency of visits and disability status, 2007-08**[a, b, c, d]



W P/SCAL = with profound/severe core activity limitations. W/O D = without disability. [a] Due to different collection methods, in particular those used to identify disability, these estimates may not be consistent with those that could be obtained from the SDAC. The data collected by the NHS relate to a broader 'disability and long-term health condition' population than the 'disability' population obtained from the more detailed SDAC — however, the characteristics of the populations are similar. [b] Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities communication, mobility and self care. [c] NT data for people with profound/severe core activity limitations are not available for publication, but are included in Australian totals. [d] See table 14A.71 for the 95 per cent confidence intervals associated with the estimates.

Source: ABS (unpublished) *NHS 2007-08*, Cat. no. 4364.0; table 14A.71.

Additional data on the use of other services by people with disability are reported in tables 14A.72–77.

'Use of other services' data reported elsewhere in this Report

Data on the participation of people with disability in various government services are incorporated in the performance indicator frameworks for other chapters of this Report. Participation is reported for children's services (chapter 3); VET (chapter 5); public, community and State owned and managed Indigenous housing and Commonwealth Rent Assistance (chapter 16). In addition, the following chapters include data on services provided to people with disability:

- 'School education' (chapter 4) reports data on students with disability in the student body mix

- 'Health management issues' (chapter 12) reports performance data on specialised mental health services
- 'Aged care services' (chapter 13) reports data on HACC services received, including those received by people with a profound, severe or moderate core activity limitation, disaggregated by jurisdiction and geographic location.

14.4 Future directions in performance reporting

Scope for further improvements to current framework

There is scope for further improvements in reporting against the current framework, including improvements to the data on service quality. The Steering Committee intends to address limitations over time by:

- considering the development of an indicator on quality of life
- reporting of improved service user data, as a result of anticipated improvements in data quality and comparability
- reporting more comprehensive social and community participation data, when available
- reporting national client and carer satisfaction with service quality
- reporting more complete, current, ongoing quality assurance processes data, which are expected to become more complete and comparable under the NDA upon implementation of a National Disability Quality Framework with a National Quality Assurance system by mid-2010.

COAG developments

Report on Government Services alignment with National Agreement reporting

It is anticipated that future editions of the Services for people with disability chapter will align with applicable NA indicators. Further alignment between the Report and NA indicators, and other reporting changes, might result from future developments in NA and National Partnership reporting.

Outcomes from review of the Report on Government Services

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the Intergovernmental Agreement on Federal Financial Relations.

No significant changes from this review are reflected in the 2010 Report. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 Report.

14.5 Jurisdictions' comments

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

Australian Government comments

“

- During 2008-09 the Australian Government funded over 23 000 supported places for people with disability in 337 Australian Disability Enterprise outlets across Australia.
- The Parliamentary Secretary for Disabilities and Children’s Services is undertaking work on the vision for Disability Enterprises under the *National Mental Health and Disability Employment Strategy* — identifying attributes of improved Disability Enterprises, possible strategies and challenges to be faced and how they will be overcome.
- In 2008-09, $5.1 million in temporary viability support was fully expended on support to the sector. $5.2 million allocated for 2009-10 has been approved to provide funds where unforeseen events occur.
- In late 2008, the Australian Government revised the Commonwealth Procurement Guidelines. The new Guidelines provide an exemption from the mandatory procurement provisions, therefore providing flexibility for departments and agencies to purchase from Disability Enterprises. A $900 000 funding package provided each outlet with a $2500 marketing payment.
- FaHCSIA is working on reducing red tape initiatives for service providers.
- In 2008-09, the *Disability Employment Network* (DEN) capped stream provided employment assistance to more than 60 000 job seekers with disability who required ongoing support to find and maintain employment. The demand driven DEN uncapped stream assisted over 29 000 job seekers receiving income support and who were required to look for work to meet part-time participation requirements. The proportion of DEN job seekers who received assistance during 2008-09 who achieved a sustainable employment outcome (8 hours of work per week for 26 weeks) in the capped stream was 38.3 per cent and 25.4 per cent in the uncapped stream.
- As part of its *Social Inclusion Agenda*, the Australian Government has conducted a review of disability employment services, including Disability Employment Network and Vocational Rehabilitation Services. The review involved extensive consultations with key stakeholders, including people with disability and their advocates, peak welfare and industry associations, employment services providers and employers.
- Under the new Disability Employment Services, services for job seekers with a disability, their families and carers, employers and employment service providers will be substantially improved. Existing caps on services will be removed, so that job seekers with disability will no longer have to wait for the services they need to find work. Job seekers will receive more personalised employment services better suited to their needs and with stronger links to skills development and training.

”

New South Wales Government comments

> “2008-09 is the third year in the initial 5 year phase of *Stronger Together: A new direction for disability services in NSW.* Under the program, additional funding for disability services of $282 million brought the total expenditure to nearly $1.6 billion in 2008-09.
>
> Significant efforts have been made to deliver strong support for the clients and families in need. These include 2500 new early childhood intervention places, 5625 therapy places, over 500 new day program places, 522 specialist accommodation support places, and more than 2000 respite places.
>
> The first 3 years of *Stronger Together* have also seen a significant move towards person centred approaches in planning of services. The new approaches give clients and their families and carers a greater voice in planning their supports. A new person centred planning practice guide has been developed and workshops held with service providers across the State.
>
> The NSW Government continued its commitment to respond to the demands from people with disability, their families and carers. Over 1000 young people were supported in the *Transition to Work program*. An estimated 7000 people received community living support at a total cost of $530 million. 280 specialist accommodation support places have come on line between 2005 and 2009 as permanent solutions for clients receiving temporary support from the *Emergency Response program*. Specific programs targeting people leaving the care of the Minister for Community Services, people in contact with the criminal justice system, and younger people in or at risk of entering residential aged care have been developed. Several major redevelopments of large residences are at various stages of planning and construction across the State.
>
> The NSW Government provided more early intervention and prevention type support to a greater proportion of the target group. This includes the investment of an additional $6 million in early childhood supports through the *EarlyStart — Diagnosis Support program,* aiming to improve the developmental outcomes of children and increase the capacity of families to care. Another $5 million was announced for the *Extended Family Support* and *Flexible Out of Home Placements Program*, which will enable the development of flexible support packages designed to help families at risk of relinquishing care.
>
> The NSW Government began piloting a new packaged support program *My Plan My Choice* for older carers in northern NSW. It includes a number of areas for developing and sustaining supportive networks for carers and people with disability.
>
> The NSW Government also worked with providers on a new quality framework responding to the need for an independent accreditation system based on quality principles, and an Industry Development and Capacity Building Fund has been established to assist with implementing improvements and reforms in the disability sector.”

Victorian Government comments

In 2008-09, the Department of Human Services continued activities to support the implementation of the Disability Act 2006 (the Act) including:

- Review and revision of policies and guidelines developed to support the Act.
- Comprehensive evaluation of the Act's implementation commenced to inform initiatives that support the sector to achieve compliance and cultural change.
- Development of tools and resources to raise the awareness of people with disability of their rights under the Act.

2008–09 was also a year of continued reform through partnerships in areas supporting people with disability, their families and carers. More opportunities were created for people to live independently, with greater levels of support for individuals, their families and carers. Improvements to disability supports have continued to be delivered through increased emphasis on self-directed approaches, delivering more innovative accommodation options, and developing more age-appropriate services for younger high-needs clients who are in or at risk of entering residential aged care services.

Key achievements for 2008-09 included:

- Expansion of flexible self-directed supports that enable people with disability and their families to plan services in a more individualised way.
- Expansion of direct payments, allowing people with disability (or their family or carer) to self-manage their funding and have more control of their lives.
- Continued implementation of the *my future, my choice* initiative to establish more appropriate housing and support for younger people living in residential aged care.
- New and better approaches to meet the growing needs of people with Autism Spectrum Disorder. The *10-year Autism State Plan* identifies priority actions, including making it easier to receive support, strengthening workforce expertise, and facilitating successful community participation.
- A strengthened Senior Practitioner Strategy to protect the rights of people with disability subject to restrictive interventions and compulsory treatment.
- *Continued Senior Practitioner Research Partnership and Promoting Dignity* grants to promote the development of strategies consistent with the Charter of Human Rights and Responsibilities as alternatives to restrictive practices.
- The launch of the Workforce strategy, improving supports for people with disability, which recognises diversity among people with disability and aims to strengthen the role of the workforce in responding to this diversity.
- Continued activity to support implementation of the *Quality Framework for Disability Services in Victoria*, including the *Independent Monitoring Demonstration Project* evaluation, and roll out of a comprehensive learning and development strategy.

Queensland Government comments

The Queensland Government is pursuing a broad agenda to promote rights and equity of access for people with disability and their carers — one which seeks to improve the accessibility and responsiveness of the State's specialist disability service system as well as the community in general.

In 2008-09, Queensland continued with reforms to create a simpler and fairer way for people to access specialist disability services, through the *Growing Stronger* initiative. A trial of a new methodology for assessment and prioritisation commenced and will be independently evaluated, to ensure that it achieves the desired outcomes for people with disability and their carers.

Queensland is also investing in improving service access and responsiveness at high risk, key transition points in people's lives, through initiatives such as the:

- *Younger People in Residential Aged Care* initiative, with the Australian Government, including providing alternative accommodation and support for younger people with disability deemed at risk of entering aged care
- *Spinal Cord Injuries Response* initiative, which provides coordinated access to services to assist people to return to their communities following rehabilitation and discharge from hospital
- *Young Adults Exiting the Care of the State* program, which supports young adults with disability in their transition from the care of the State to adult living arrangements.

In July 2008, a new *Specialist Response Service* commenced to increase specialist support for protecting the rights of adults, with an intellectual or cognitive disability, who exhibit behaviours that cause harm and who are subject to restrictive practices.

Such initiatives are aimed at improving the quality of services and the outcomes achieved by individuals by way of skills for community living and participation.

At a community level, Queensland has advanced initiatives that seek to create conditions in the social environment that can support access by people with disability, and encourage social inclusion and development.

Queensland has introduced the *Companion Card* program, which entitles people with disability who need lifelong attendant care support to buy two tickets for the price of one at participating activities and venues across Australia. In July 2009, new laws commenced in Queensland to ensure that every person who relies on a guide, hearing or assistance dog has the same access rights as others to public places and public passenger vehicles. New laws to recognise the contribution of carers also commenced. The Carers (Recognition) Act 2008 includes the *Queensland Carers Charter*, which aims to help carers be heard by government and their issues better understood in the community.

Improvements in the measurement of the outcomes achieved through such initiatives are a priority under the *National Disability Agreement* (2009).

Western Australian Government comments

Key initiatives implemented in 2008-09 include:

- completion of the review of the Disability Services Act 1993, which was tabled in Parliament on 14 May 2009. Under legislation, the Act is reviewed every 5 years. A significant recommendation from the review is the introduction of a seventh outcome under the *Disability Access and Inclusion Plan* requirements for all State and local government instrumentalities, focussing on employment opportunities for people with disabilities
- implementation of the new *Community Living* initiative — providing an innovative approach to creative options that fit the needs and aspirations of people with disabilities to live good lives in their local community
- finalisation of Western Australia's State Disability Plan — *Count Me In — Disability Future Directions* — taking the Commission to 2025. At the heart of the Plan lies the vision of a Western Australia where all people live in welcoming communities that actively promote citizenship, friendship, mutual support and a fair go for everyone. *Disability Future Directions* outlines three key areas in which to achieve the vision: (1) economic independence for people with disabilities and the opportunity to live in well designed and accessible communities and homes; (2) ensuring the participation and contribution of people with disabilities in all aspects of life; and (3) ensuring personalised disability supports and services are available to those who need them
- introduction in the *Local Area Coordination* program of 'shared agreements' — brief statements that clarify the expectations between each individual/family and their Local Area Coordinator — which is proving to be an effective means of focusing attention on the important issue for people with disabilities and their families and carers
- expansion of the *Alternatives to Employment* program, with the provision of additional funding totalling $43 million over 4 years to provide additional support approved for almost 800 young adults
- continued development of the *Quality Management Framework*, which will enhance consumer input into the continual improvement of services.

South Australian Government comments

Disability SA continues to support people with disability, both directly and in partnership with non-government organisations. Opportunities for people with disability to actively engage in the community are promoted and developed.

Highlights for 2008-09 include:

- the commencement of a 5 year strategy for the Supported Residential Facilities (SRF) aimed at balancing sustainment with reform. Key outcomes included:
  - the provision of a supplementary payment for private operators in the SRF sector to address critical viability issues
  - the establishment of task groups to engage with the sector on developing the quality agenda focusing on a set of standards
- 80 people have moved from institutions to supported community or more appropriate accommodation
- the development of *Service Standard 13, A Cultural and Competency and Inclusion Standard* to improve access to disability services for Aboriginal and Torres Strait islander people
- the phased expansion of self managed funding arrangements within Disability SA. Selective consultations have been undertaken with stakeholders. Work on the development of an assessment and allocation tool is well progressed. Implementation of Phase one commenced in October 2009
- the creation of a single statewide equipment program to service the equipment and home modification needs of clients of Disability Services and Domiciliary Care SA
- the introduction of key performance indicators within the non-government sector with the aim to increase client participation in the planning and delivery of services and quality improvement activity within services
- a review of *Disability SA After Hours Service* to ensure a responsive and highly adaptable service meets the needs of all clients
- the expansion of the *Person Centred Active Support* model across accommodation services in Disability SA. This model is a way of helping people with disabilities to engage in meaningful activity and relationships as active participants
- the *Companion Card* program, in partnership with National Disability Services, continues to recruit affiliates, increasing the number of organisations to 87, as well as 161 venues and one accommodation facility.

Tasmanian Government comments

As a result of the *Review of Tasmanian Disability Services* completed in 2008 the Minister launched the *Disability Operational Framework* in February 2009. The Framework will help shape the future of Disability Service provision in Tasmania.

The Framework will reorient the Tasmanian Disability Services system to support greater responsiveness to the needs of people with disability. It will also bring the system into stronger alignment with contemporary best practice, both nationally and internationally.

A number of initiatives commenced in 2008-09 to begin the long term reform process. These included:

- creation of the *Disability Child Youth and Family Services* program within Human Services to enhance services to all clients
- establishment of area advisory groups to share governance of services at an area level
- commencement of a project to look at new and innovative community access models
- a needs analysis to determine the current level of demand and need for children's respite services prior to devolution to the Community Sector
- commencement of the *Resource Allocation and Unit Pricing Project*. This will result in a new framework for funding that will be based on an equitable and transparent mechanism. This will allow the Department to identify, quantify and distribute resources to ensure the continued delivery of high quality services. It is expected that the framework will define how much service providers will be paid for the delivery of these services, whilst promoting efficiency in the allocation of resources and a financially viable service system
- establishment of four *Gateway Services*. The Gateway will provide a single access point for family support and specialist disability services in each of the four areas in Tasmania. Services will be accessed by people with disability and their families through the Gateway. The Gateways opened in 2009 for family services and will begin operation for people with disability in June 2010
- the delivery of an additional 75 individual support packages, 50 extra community access packages, 70 respite places and 12 new accommodation places.

Australian Capital Territory Government comments

“In 2008-09 the Department of Disability, Housing and Community Services, through Disability ACT continued to advance its strategic plan for disability services in the ACT through the following activities:

- Disability ACT continued to respond to known priority need through the delivery of additional ACT and Commonwealth Government funding allocated in the 2008-09 Budget to build service capacity to meet increased demand for a range of services for young people and adults with high level intellectual and physical disabilities.
- The ACT Government worked to establish a new policy framework to improve outcomes and opportunities for people with disability in the ACT. The policy will guide priority areas for disability policy and service delivery through to 2014. The updated framework builds on the work of the current ACT disability framework, *Future Directions: A Framework for the ACT 2004–2009* as well as assists in achieving goals outlined in *Challenge 2014 — A ten year vision for disability in the ACT*.
- Disability ACT worked proactively with ACT Government agencies and community sector organisations on the implementation of the ACT *Policy Framework for Children and Young People with a Disability and their Families*. Drawing together the principles and commitments of key ACT Government agencies the Framework outlines core principles, clarifies roles and responsibilities, provides guidance for coordination, and establishes joint planning mechanisms across and between agencies.
- The Business Leaders Innovative Thoughts and Solutions (BLITS) Advisory Board continued to promote initiatives that value people with disability as customers, suppliers, employees and employers in business, the arts and sport. Over 2008-09, BLITS hosted three premier events: the launch of the ACT BLITS Champions Program comprising national and local identities who have agreed to promote and champion the rights and opportunities for people with disability; an Industry Mini Roundtable on enhancing access for people with disability through a more ‘disability friendly’ National Tourism Accreditation Framework; and the 2008 Chief Minister’s Inclusions Awards.
- Disability ACT undertook preliminary work on the development of a disability awareness program. The program will target the next generation of decision makers (the age group 4–17 years) through a Civics based curriculum to be delivered in ACT schools. Stage 2 of this program, involving the development of ‘Youth Civics’ learning modules will be undertaken in 2009-10. These modules will include session and learning outcomes and methods of knowledge assessment and will align to the National Curriculum Standards and the ACT Curriculum Framework *Every chance to learn*.”

Northern Territory Government comments

"The NT Government recognises that people with disability need extra support to participate as citizens within their communities. Disability support provision is based on contemporary practice underpinned by partnerships and collaborative approaches. Principles that guide services include: person centred, culture secure, collaborative, outcomes driven, future focused, equitable, sustainable, flexible and responsive. The NT's vision is for a society where people with disabilities have productive and fulfilling lives as valued members of their communities.

During 2008-09, the NT implemented changes that were introduced as part of the amalgamation of community government councils to larger shire councils which consolidated disability service delivery in these areas. Work commenced on streamlining the reporting requirements for remote communities to a shire based model to come into effect in 2009-10.

Focused services reform was undertaken through the development of a Disability Coordination and Case Manager model which included standardised intake of all clients across the service spectrum. Additional positions were created to support the reform.

Standardised assessment for eligibility and a prioritising mechanism for all clients were introduced. This included establishing a dedicated central intake point of contact with an 1800 number. The individualised support planning approach for people with disabilities was reviewed, with assessment and planning processes streamlined.

The *National Disability Agreement* (NDA) came into effect on 1 January 2009, replacing the previous *Commonwealth State Territory Disability Agreement*. The other major funding agreement between the NT Government and the Australian Government is the *Home and Community Care (HACC) Program*. The NT had a combined HACC funding pool of $11.0 million for 2008-09. The combined number of non-government service providers funded under HACC and the NDA was 114 for 2008-09.

Consultations were undertaken in 2008-09 as part of the development of the NT's strategy for the employment of people with disability in the NT public sector. The consultations assisted in informing the priority areas and set directions for the strategy which is due to be released in 2009-10.

As in previous years, indicators based on the estimated number of people with severe or profound core activity limitations in the NT need to be interpreted with caution. Small variations in service and population data appears in magnified proportions to the small population in the NT."

14.6 Service user data quality and other issues

Data quality

Data quality considerations should be taken into account when interpreting the CSTDA NMDS service user data used in this chapter. In particular, data quality should be considered when making comparisons across jurisdictions and across years.

There are three aspects of quality that affect the accuracy and reliability of the data reported in this chapter:

- service type outlet response rates
- service user response rates
- 'not stated' rates for individual data items.

The first two of these affect the service user counts — nationally, by jurisdiction and service type — and all three affect the accuracy of analyses of individual data items (AIHW 2009).

Service type outlet response rates

Response rates are based on the number of service type outlets responding divided by the total number of outlets in the jurisdiction. Service user data are collected quarterly from service type outlets. A service type outlet is considered a responding outlet even if they provide service use data for one quarter only.

The overall national service type outlet response rate for the 2007-08 collection was 95 per cent (table 14.3). This was the slightly higher than for the 2006-07 collection.

Table 14.3 **Service type outlet response rates**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*	*Aust*
2003-04	80	94	97	100	100	100	93	95	100	93
2004-05	85	92	99	100	100	96	98	70	100	94
2005-06	89	90	99	100	100	100	100	100	100	94
2006-07	89	90	100	100	100	100	100	100	100	94
2007-08	90	93	100	99	99	100	100	99	100	95

Source: AIHW (2009 and previous years) *Disability Support Services 2007-08, 2006-07, 2005-06, 2004-05, 2003-04: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications).

Service user response rates

Service user information may be missing from the data set for a number of reasons. There are outlets that do not respond (table 14.4) and outlets that, through administrative or other error, neglect to report on all of their service users (AIHW 2009). Estimates of the total number of service users who may be missing from the data set are not available.

Response rates based on the number of service type outlets responding who provided service user data are available for accommodation support services by type and government sector for 2003-04, 2004-05, 2005-06, 2006-07 and 2007-08 (table 14.4). While helpful, these response rates do not account for service users who received services from:

- responding outlets, but whose data were not included
- non-responding outlets.

Table 14.4 **Service user data response rates for CSTDA funded accommodation support service type outlets (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003-04									
Institutions/large residential or hostel									
Government	92	86	67	100	80	–	–	–	89
Non-government	83	84	99	100	100	100	–	–	94
Group homes									
Government	98	99	100	100	94	100	98	–	98
Non-government	96	98	100	100	96	100	100	100	98
Community based									
Government	100	82	100	100	100	75	100	–	89
Non-government	96	85	94	100	95	98	100	100	93
2004-05									
Institutions/large residential or hostel									
Government	100	100	100	100	100	–	–	–	100
Non-government	100	100	100	100	100	100	–	–	100
Group homes									
Government	100	100	100	100	100	100	98	100	100
Non-government	100	100	100	100	100	100	100	100	100
Community based									
Government	100	100	100	100	50	100	–	100	99
Non-government	100	100	100	100	100	100	88	100	100

(Continued on next page)

Table 14.4 **(Continued)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06									
Institutions/large residential or hostel									
Government	100	100	100	100	100	–	–	–	100
Non-government	100	100	100	100	100	100	–	–	100
Group homes									
Government	100	100	100	100	100	100	98	100	100
Non-government	100	100	100	100	100	100	100	100	100
Community based									
Government	100	100	100	100	50	100	–	100	99
Non-government	100	100	100	100	100	100	88	100	100
2006-07									
Institutions/large residential or hostel									
Government	100	100	100	100	100	100	100	100	100
Non-government	100	100	100	100	100	100	100	100	100
Group homes									
Government	100	100	100	100	100	100	100	100	100
Non-government	100	100	99	92	100	97	100	100	99
Community based									
Government	100	100	100	100	75	100	100	100	99
Non-government	100	100	99	94	100	98	100	100	99
2007-08									
Institutions/large residential or hostel									
Government	100	100	100	100	100	–	–	–	100
Non-government	100	100	100	100	100	100	–	–	100
Group homes									
Government	100	100	100	100	100	100	100	100	100
Non-government	100	100	100	100	100	100	100	100	100
Community based									
Government	100	100	100	100	100	100	100	100	100
Non-government	100	100	100	100	100	98	100	100	100

[a] Percentages are based on the number of service type outlets providing service user data. The denominator is the total number of outlets that provided service type outlet data; the numerator is the number of outlets that provided service user data. – Nil or rounded to zero.

Source: AIHW (unpublished) *CSTDA NMDS*.

'Not stated' rates

'Not stated' rates for individual data items vary between jurisdictions (AIHW 2009). One reason for the higher level of 'not stated' responses to some data items may be the increased efforts to improve the coverage and completeness of the CSTDA NMDS collection overall. For example, therapy services (a community support service) in the ACT participated for the first time in the 2004-05 collection. In an effort to include all users of these services, provisional data collection processes were used that meant minimal data were provided for each user (AIHW 2009).

Table 14.5 shows the total 'not stated' rates for the relevant individual data items used in this chapter. Results reported in this chapter are not adjusted to account for these 'not stated' rates.

Table 14.5 **'Not stated' rates for individual data items (per cent)**

Data item	*Accommodation support*	*Employment*	*Community access*	*Community support*	*Respite*
2003-04					
Need for assistance with ADL	17.4	3.2	32.3	..	..
Indigenous status	3.4	7.0	17.5	..	..
Country of birth	3.6	3.9	..	..	..
Geographic location	1.0	–	..	..	..
2004-05					
Need for assistance with ADL	5.1	3.1	12.2	32.7	13.0
Indigenous status	8.6	4.1	14.1	29.5	16.8
Country of birth	3.1	3.5	..	..	..
Geographic location	1.0	–	..	..	..
2005-06					
Severity of core activity limitation	3.9	14.5	11.8	28.4	12.8
Indigenous status	2.3	1.8	7.8	15.6	7.1
Country of birth	2.8	6.8	..	..	..
Geographic location	0.7	0.3	..	..	..
2006-07					
Need for assistance with ADL	3.2	7.0	13.0	24.0	11.6
Indigenous status	2.8	–	7.2	5.5	6.7
Country of birth	2.7	1.3	9.9	6.2	5.6
Geographic location	1.2	–	3.9	1.7	1.9
2007-08					
Need for assistance with ADL	3.3	5.0	15.2	23.5	11.3
Indigenous status	2.2	0.1	7.7	5.6	6.4
Country of birth	2.0	0.8	10.0	5.6	5.4
Geographic location	0.9	0.2	4.8	3.6	1.6

.. Not applicable. – Nil or rounded to zero.

Source: AIHW (unpublished) *CSTDA NMDS*.

Other issues

Service user data/data items not collected

Service user data are not collected for the following CSTDA funded service types: advocacy, information/referral, combined information/advocacy, mutual support/self-help groups, print disability/alternative formats of communication, research and evaluation, training and development, peak bodies and other support services. In addition, some service types are not required to collect all service user data items. In particular:

- ‘recreation/holiday programs’ (service type 3.02) are required to collect only information related to the statistical linkage key (selected letters of name, date of birth, sex, commencement date and date of last service)
- employment services (service types 5.01 and 5.02) are not required to collect selected informal carer information, including primary status (AIHW 2007).

Specialist psychiatric disability services

Data for specialist psychiatric disability services are excluded to improve the comparability of data across jurisdictions. People with psychiatric disability may use a range of CSTDA funded service types. In some jurisdictions (Victoria, Queensland and WA), specialist psychiatric disability services are funded specifically to provide such support (AIHW 2009). Nationally, in 2007-08, there were 12 761 people who used only specialist psychiatric disability services (AIHW 2009). Data for these services are included in other publications on the CSTDA NMDS, such as AIHW (2009). Therefore, service user data for Victoria, Queensland and WA in this chapter will differ to other publications.

Statistical linkage key

A statistical linkage key is used to derive the service user counts in this chapter. The statistical linkage key enables the number of service users to be estimated from data collected from different service outlets and agencies (AIHW 2009). Using the linkage key minimises double counting of service users who use more than one service outlet during the reporting period.

The statistical linkage key components of each service record are compared with the statistical linkage key components of all other records. Records that have matching statistical linkage keys are assumed to belong to the same service user.

As the statistical linkage key is not a unique identifier, some degree of false linking is expected. A small probability exists that some of the linked records do not actually belong to the same service user and, conversely, that some records that did not link do belong to the same service user. The statistical linkage key does not enable the linking of records to the extent needed to be certain that a 'service user' is one individual person.

Missing or invalid statistical linkage keys cannot be linked to other records and so must be treated as belonging to separate service users. This may result in the number of service users being overestimated (AIHW 2009).

Deriving potential populations for the special needs groups

Potential populations have been estimated for each of the special needs groups (outer regional and remote/very remote areas, Indigenous and people born in a non-English speaking country) and for those outside of the special needs groups (major cities and inner regional areas, non-Indigenous and people born in an English speaking country). These potential populations are estimates of the number of people with the potential to require disability support services in the relevant group, including individuals who meet the service eligibility criteria but who do not demand the services.

The approach used to derive the potential population estimates by country of birth and geographic location involved the following steps:

- Deriving State/Territory based 10-year age and sex specific proportions of people with ASSNP by geographic location and country of birth using the 2006 Census.
- Multiplying these State/Territory based 10-year age and sex specific proportions by the 10-year age specific estimates of the number of people with severe/profound core activity limitations in each State/Territory.
- Summing the resultant 10-year age and sex group counts to derive the total potential populations for the geographic locations, people born in Australia, people born in another English speaking country and people born in a non-English speaking country. Summing the potential populations for people born in Australia and people born in another English speaking country to derive the total potential population for people born in an English speaking country.
- For employment, repeating the above steps, but restricting the calculations to those people aged 15–64 years, then multiplying each State/Territory total by State/Territory specific labour force participation rates for people aged 15–64 years.

The approach used to derive the potential populations by Indigenous status involved the following steps:

- Deriving current State/Territory based 10-year age and sex specific rate ratios of people with ASSNP by Indigenous status using the 2006 Census.
- Multiplying the current State/Territory Indigenous and non-Indigenous 10-year age and sex population estimates by national 10-year age and sex specific rates of severe/profound core activity limitation from the 2003 SDAC. Then multiplying the Indigenous and non-Indigenous counts for each 10-year age and sex group by the 10-year age and sex specific rate ratios of people with ASSNP to obtain an Indigenous/non-Indigenous potential population within each age and sex group.
- Summing the 10-year age and sex group counts to derive a total Indigenous and non-Indigenous potential population for each State/Territory.
- For employment, repeating the above steps, but restricting the calculations to those people aged 15–64 years, then multiplying each State/Territory total by State/Territory specific labour force participation rates for people aged 15–64 years.

Data quality issues

Data measuring the potential populations of the special needs groups are not explicitly available for the required time periods and have been estimated using several different data sources (as noted above), under several key assumptions. Some issues with this approach are outlined below:

- The method used to estimate the potential populations assumes:
  - that disability rates vary only by age and sex, and there is no effect of remoteness, disadvantage, or any other variable — this is likely to affect the reliability of comparisons across states and territories, however, it is currently not possible to detect the size or direction of any potential bias
  - that age- and sex- specific disability rates do not change significantly over time.
- The rate ratio/proportion adjustments (that is, multiplication) assumes consistency between the rate ratio/proportion as calculated from the 2006 Census and the corresponding information if it were collected from the 2003 SDAC. Two particular points to note with this assumption are that:
  - information about people with ASSNP is based on the self-enumeration (interview in Indigenous communities) of four questions under the 2006 Census, whereas in SDAC 2003 people are defined as having a

severe/profound core activity limitation on the basis of a comprehensive interviewer administered module of questions — the two populations are different, but are conceptually related

  - the special needs groups identification may not be the same between the 2006 Census and the 2003 SDAC (ABS research indicates, for example, that the Indigenous identification rate differs across the Census and interviewer administered surveys).

- It is not known if the data collection instruments are culturally appropriate for all special needs groups; nor is it known how this, combined with different data collection methods, impacts on the accuracy of the estimated potential population.
- There are a number of potential sources of error related to the Census that stem from failure to return a Census form or failure to answer every applicable question. Information calculated from 2006 Census data exclude people for whom data item information is not available. As with any collection, should the characteristics of interest (for example, ASSNP and/or special needs group status) of the people excluded differ from those people included, a potential for bias is introduced. In particular, for Indigenous estimates, differential undercount of Indigenous Australians across states and territories may introduce bias into the results that would affect the comparability of estimates across jurisdictions, if those missed by the Census had a different rate of disability status to those included (table 14.6).

Table 14.6 **Estimated 2006 Census Indigenous net undercount (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas.*	*ACT*	*NT*	*Aust*
Undercount rate	8.6	9.4	11.6	16.6	8.6	8.8	8.8	16.0	11.5

Source: ABS (2008) *Experimental Estimates of Aboriginal and Torres Strait Islander Australians, Jun 2006*, Cat. no. 3238.0.55.001.

14.7 Definitions of key terms and indicators

Accommodation support service users receiving community accommodation and care services	People using the following CSTDA accommodation support services: group homes; attendant care/personal care; in-home accommodation support; alternative family placement and other accommodation support (types 1.04–1.08), as a proportion of all people using CSTDA accommodation support services (excludes service users of specialist psychiatric disability services only). See AIHW (2009) for more information on service types 1.04–1.08.
Administration expenditure as a proportion of total expenditure	The numerator — expenditure (accrual) by jurisdictions on administering the disability service system as a whole (including the regional program management and administration, the central policy and program management and administration, and the disability program share of corporate administration costs under the umbrella department, but excluding administration expenditure on a service that has been already counted in the direct expenditure on the service) — divided by the denominator — total government expenditure on services for people with disability (including expenditure on both programs and administration, direct expenditure and grants to government service providers, and government grants to non-government service providers (except major capital grants).
Core activities as per the 2003 ABS SDAC	Self care — showering or bathing, dressing, eating, toileting and bladder or bowel control; mobility — getting into or out of a bed or chair, moving about the usual place of residence, going to or getting around a place away from the usual residence, walking 200 metres, walking up and down stairs without a handrail, bending and picking up an object from the floor, using public transport (the first three tasks contribute to the definitions of profound and severe core-activity limitation); and communication — understanding and being understood by strangers, family and friends.
Cost per user of government provided accommodation support services — group homes	The numerator — government expenditure (accrual) on government provided accommodation support services in group homes (as defined by CSTDA NMDS service type 1.04) — divided by the denominator — the number of users of government provided accommodation support services in group homes.
Cost per user of government provided accommodation support services — institutional/residential settings	The numerator — government expenditure (accrual) on government provided accommodation support services in institutional/residential settings (as defined by CSTDA NMDS service types 1.01, 1.02 and 1.03) — divided by the denominator — the number of users of accommodation support services in institutional/residential settings. See AIHW (2009) for more information on service types 1.01–1.03.
Cost per user of government provided accommodation support services — other community settings	The numerator — government expenditure (accrual) on government provided accommodation support services in other community settings (as defined by CSTDA NMDS service types 1.05–1.08) divided by the denominator — the number of users of government provided accommodation support services in other community settings.

Disability	The United Nation’s *Convention on the Rights of Persons with Disabilities*, ratified by Australia on 17 July 2008, defines ‘persons with disabilities’ as those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. The WHO defines ‘disabilities’ as impairments, activity limitations, and participation restrictions: an impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; and a participation restriction is a problem experienced by an individual in involvement in life situations. Disability is a complex phenomenon, reflecting an interaction between features of a person’s body and features of the society in which he or she lives (WHO 2009). The ABS SDAC 2003 defined ‘disability’ as the presence of at least one of 17 limitations, restrictions or impairments, which have lasted or are likely to last for a period of 6 months or more: loss of sight (not corrected by glasses or contact lenses); loss of hearing where communication is restricted; or an aid to assist with, or substitute for, hearing is used; speech difficulties; shortness of breath or breathing difficulties causing restriction; chronic or recurrent pain or discomfort causing restriction; blackouts, fits or loss of consciousness; difficulty learning or understanding; incomplete use of arms or fingers; difficulty gripping or holding things; incomplete use of feet or legs; nervous or emotional condition causing restriction; restriction in physical activities or in doing physical work; disfigurement or deformity; mental illness or condition requiring help or supervision; long-term effects of head injury; stroke or other brain damage causing restriction; receiving treatment or medication for any other long-term conditions or ailments and still restricted; any other long-term conditions resulting in a restriction. The third CSTDA (2003, p. 9) defined ‘people with disabilities’ as those whose disability manifests itself before the age of 65 years and for which they require significant ongoing and/or long-term episodic support. For these people, the disability will be attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is likely to be permanent and results in substantially reduced capacity in at least one of the following: self care/management, mobility and communication.
Employment rate for people with a profound or severe core activity limitation	Total estimated number of people aged 15–64 years with a profound or severe core activity limitation who are employed, divided by the total estimated number of people aged 15–64 years with a profound or severe core activity limitation in the labour force, multiplied by 100.
Employment rate for total population	Total estimated number of people aged 15–64 years who are employed, divided by the total number of people aged 15–64 years in the labour force, multiplied by 100.
Funded agency	An organisation that delivers one or more CSTDA service types (service type outlets). Funded agencies are usually legal entities. They are generally responsible for providing CSTDA NMDS data to jurisdictions. Where a funded agency operates only one service type outlet, the service type outlet and the funded agency are the same entity.

Geographic location

Geographic location is based on the ABS's Australian Standard Geographical Classification of Remoteness Areas, which categorises areas as 'major cities', 'inner regional', 'outer regional', 'remote', 'very remote' and 'migratory'. The criteria for Remoteness Areas are based on the Accessibility/Remoteness Index of Australia, which measures the remoteness of a point based on the physical road distance to the nearest urban centre in each of five size classes (ABS 2001).

The 'outer regional and remote/very remote' classification used in this Report was derived by adding outer regional, remote and very remote data.

Government contribution per user of non-government provided employment services

The numerator — Australian Government grant and case based funding expenditure (accrual) on specialist disability employment services (as defined by CSTDA NMDS service types 5.01 (open) and 5.02 (supported)) — divided by the denominator — number of service users who received assistance. (For data prior to 2005-06, service type 5.03 (combined open and supported) is also included.) See AIHW (2009) for more information on service types 5.01–5.03.

Government contribution per user of non-government provided services — accommodation support in group homes

The numerator — government expenditure (accrual) on non-government provided accommodation support services in group homes (as defined by CSTDA NMDS service type 1.04) — divided by the denominator — the number of users of non-government provided accommodation support services in group homes.

Government contribution per user of non-government provided services — accommodation support in institutional/residential settings

The numerator — government expenditure (accrual) on non-government provided accommodation support services in institutional/residential settings (as defined by CSTDA NMDS service types 1.01, 1.02 and 1.03) — divided by the denominator — the number of users of non-government provided accommodation support services in institutional/residential settings.

Government contribution per user of non-government provided services — accommodation support in other community settings

The numerator — government expenditure (accrual) on non-government provided accommodation support services in other community settings (as defined by CSTDA NMDS service types 1.05–1.08) — divided by the denominator — the number of users of non-government provided accommodation support services in other community settings.

Indigenous factor

The potential populations were estimated by applying the 2003 national age- and sex- specific rates of profound or severe core activity limitation to the age and sex structure of each jurisdiction in the current year. As Indigenous people have significantly higher disability prevalence rates and greater representation in some CSTDA funded services than non-Indigenous people, and there are differences in the share of different jurisdictions' populations who are Indigenous, a further Indigenous factor adjustment was undertaken. The Indigenous factor was multiplied by the 'expected current population estimate' of people with a profound or severe core activity limitation in each jurisdiction to derive the 'potential population'.

The following steps were undertaken to estimate the Indigenous factors.

- Data for all people (weighted) were calculated by multiplying the data for Indigenous Australians by 2.4 and adding the data for non-Indigenous Australians. Hence Indigenous Australians are weighted at 2.4 and non-Indigenous Australians at one.

- Data for all people (weighted per person) were calculated by dividing the all people (weighted) data by the sum of the Indigenous Australians data and the non-Indigenous Australians data.
- The Indigenous factors were then calculated by multiplying the all people (weighted per person) data by 100 and dividing by the all people (weighted per person) total for Australia (AIHW 2009).

Informal carer

ABS informal carer: A person of any age who provides any informal assistance, in terms of help or supervision, to persons with disabilities or long-term conditions, or older persons (that is, aged 60 years and over). This assistance has to be ongoing, or likely to be ongoing, for at least 6 months. Assistance to a person in a different household relates to 'everyday types of activities', without specific information on the activities. Where the care recipient lives in the same household, the assistance is for one or more of the following activities: cognition or emotion, communication, health care, housework, meal preparation, mobility, paperwork, property maintenance, self care and transport (ABS 2004a).

CSTDA NMDS informal carer: an informal carer is someone such as a family member, friend or neighbour, who has been identified as providing regular and sustained care and assistance to the person. Each service user can only record one informal carer (it is expected that the carer recorded will be the one who provides the most significant care and assistance related to the service user’s capacity to remain living in their current environment). Informal carers include those people who receive a pension or benefit for their caring role but do not include paid or volunteer carers organised by formal services.

See also primary carer.

Labour force participation rate for people with a profound or severe core activity limitation

The total number of people with a profound or severe core activity limitation in the labour force (where the labour force includes employed and unemployed people), divided by the total number of people with a profound or severe core activity limitation who are aged 15–64 years, multiplied by 100.

An employed person is a person who, in his or her main job during the remuneration period (reference week):

- worked one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (including employees, employers and self-employed persons)
- worked one hour or more without pay in a family business, or on a farm (excluding persons undertaking other unpaid voluntary work), or
- was an employer, employee or self-employed person or unpaid family helper who had a job, business or farm, but was not at work.

An unemployed person is a person aged 15–64 years who was not employed during the remuneration period, but was looking for work.

Labour force participation rate for the total population

Total number of people aged 15–64 years in the labour force (where the labour force includes both employed and unemployed people) divided by the total number of people aged 15–64 years, multiplied by 100.

Mild core activity limitation

Not needing assistance with, and has no difficulty performing, core activity tasks, but uses aids and equipment (as per the 2003 SDAC).

Moderate core activity limitation

Not needing assistance but having difficulty performing a core activity task (as per the 2003 SDAC).

Non-English speaking country of birth

People with a country of birth other than Australia and classified in English proficiency groups 2, 3 or 4 (DIMA 1999, 2003). For 2003-04 and 2004-05 data these countries include countries other than New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States. For 2005-06 onwards, data include Zimbabwe as an ‘English-speaking country’.

Payroll tax

A tax levied on employers based on the value of wages and certain supplements paid or payable to, or on behalf of, their employees (SCRCSSP 1999). Payroll tax arrangements for government funded and delivered services differ across jurisdictions. Differences in the treatment of payroll tax can affect the comparability of unit costs across jurisdictions and services. These differences include payroll tax exemptions, marginal tax rates, tax-free thresholds and clawback arrangements (see SCRCSSP 1999).

There are two forms of payroll tax reported:

- *actual* — payroll tax actually paid by non-exempt services
- *imputed* — a hypothetical payroll tax amount estimated for exempt services. A jurisdiction’s estimate is based on the cost of salaries and salary related expenses, the payroll tax threshold and the tax rate.

Potential population

Potential population estimates are used as the denominators for the performance measures reported under the indicator ‘access to CSTDA funded services’.

The ‘potential population’ is the number of people with the potential to require disability support services, including individuals who meet the service eligibility criteria but who do not demand the services. In practice, the number of people with profound or severe core activity limitation is used as the basis to measure the potential population (see definition of core activities above).

The potential population for CSTDA funded accommodation support, community access and community support services is measured by the number of people aged under 65 years who have a profound or severe core activity limitation, adjusted for the Indigenous factor. The potential population for CSTDA funded employment services is measured by the number of people aged 15–64 years with a profound or severe core activity limitation, adjusted for the Indigenous factor and the labour force participation rate. The potential population for CSTDA funded respite services data is measured by the number of people under 65 years with a profound or severe core activity limitation who have a primary carer, adjusted for the Indigenous factor.

The ABS concept of a ‘profound or severe’ core activity limitation that relates to the need for assistance with everyday activities of self care, mobility and communication currently underpins the measurement of the population in need of specialist disability services. The relatively high standard errors in the prevalence rates for smaller jurisdictions, as well as the need to adjust for the Indigenous population necessitated the preparation of special estimates of the ‘potential population’ for specialist disability services.

Briefly, the potential population was estimated by applying the 2003 national age- and sex- specific rates of profound or severe core

	activity limitation to the age and sex structure of each jurisdiction in the current year, to give an ‘expected current estimate’ of people with a profound or severe core activity limitation in that jurisdiction. These estimates were adjusted by the Indigenous factor to account for differences in the proportion of jurisdictions’ populations who are Indigenous. Indigenous people have been given a weighting of 2.4 in these estimates, in recognition of their greater prevalence rates of disability and their relatively greater representation in CSTDA funded services (AIHW 2006).
Primary carer	*ABS SDAC primary carer*: A primary carer is a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least 6 months and be provided for one or more of the core activities (communication, mobility and self care). In the SDAC, primary carers only include persons aged 15 years and over for whom a personal interview was conducted. Persons aged 15 to 17 years were only interviewed personally if parental permission was granted (ABS 2004a). *CSTDA NMDS primary carer*: an informal carer who assists the person requiring support, in one or more of the following ADL: self care, mobility or communication. See also informal carer.
Primary disability group	Disability group that most clearly expresses the experience of disability by a person. The primary disability group can also be considered as the disability group causing the most difficulty to the person (overall difficulty in daily life, not just within the context of the support offered by a particular service).
Profound core activity limitation	Unable to, or always needing assistance to, perform a core activity task (as per the 2003 SDAC).
Real expenditure	Actual expenditure (accrual) adjusted for changes in prices, using the Gross Domestic P(E) price deflator, and expressed in terms of current year dollars.
Schooling or employment restriction	*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 preferred job.
Service	A service is a support activity provided to a service user, in accord with the CSTDA. Services within the scope of the collection are those for which funding has been provided during the specified period by a government organisation operating under the CSTDA.

Service type	The support activity that the service type outlet has been funded to provide under the CSTDA. The NMDS classifies services according to ‘service type’. The service type classification groups services into seven categories: accommodation support; community support; community access; respite; employment; advocacy, information and print disability; and other support services. Each of these categories has subcategories.
Service type outlet	A service type outlet is the unit of the funded agency that delivers a particular CSTDA service type at or from a discrete location. If a funded agency provides, for example, both accommodation support and respite services, it is counted as two service type outlets. Similarly, if an agency is funded to provide more than one accommodation support service type (for example, group homes and attendant care), then it is providing (and is usually separately funded for) two different service types — that is, there are two service type outlets for the funded agency.
Service user	A service user is a person with 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 need for assistance with ADL	Data on service users with different levels of need for assistance with ADL are derived using information on the level of support needed in one or more of the core support areas: self care, mobility, and communication. Service users who need help with ADL reported always/sometimes needing help in one or more of these areas (people who need help with ADL are ‘conceptually comparable’ with people who have a profound or severe core activity limitation). Service users who did not need with ADL reported needing no support in all the core activity support areas.
Severe core activity limitation	Sometimes needing assistance to perform a core activity task (as per the SDAC 2003).
Users of CSTDA accommodation support services	People using one or more accommodation support services that correspond to the following CSTDA NMDS service types: 1.01 large 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 (2009) for more information on service types 3.01–3.03.
Users of CSTDA community support services	People using one or more services that correspond to the following CSTDA NMDS service types: 2.01 therapy support for individuals; 2.02 early childhood intervention; 2.03 behaviour/specialist intervention; 2.04 counselling; 2.05 regional resource and support teams; 2.06 case management, local coordination and development; and 2.07 other community support. See AIHW (2009) for more information on service types 2.01–2.07.

Users of CSTDA employment services	People using one or more services that correspond to the following CSTDA NMDS service types: 5.01 open employment and 5.02 supported employment. (For data prior to 2005-06, people using service type 5.03 [combined open and supported] are also included.)
Users of CSTDA respite services	People using one or more services that correspond to the following CSTDA NMDS service types: 4.01 own home respite; 4.02 centre-based respite/respite homes; 4.03 host family respite/peer support respite; 4.04 flexible/combination respite; and 4.05 other respite. See AIHW (2009) for more information on service types 4.01–4.05.

14.8 Attachment tables

Attachment tables are identified in references throughout this chapter by a ‘14A’ suffix (for example, table 14A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

14.9 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.

—— 2003, *General Social Survey*, Cat. no. 4159.0, Canberra.

—— 2004a, *Disability, Ageing and Carers Australia: Summary of Findings 2003,* Cat. no. 4430.0, Canberra.

—— 2004b, *National Aboriginal and Torres Strait Islander Social Survey*, Cat. no. 4714.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 2006, *'Potential Population' — Updating the Indigenous Factor in Disability Services Performance Indicator Denominators*, Welfare Working Paper Series Number 50, Cat. no. DIS 45, Canberra.

—— 2007, *Disability Support Services 2005-06: National Data on Services Provided under the CSTDA*, Cat. no. DIS 51, Canberra.

—— 2009, *Disability Support Services 2007-08: National Data on Services Provided under the CSTDA*, Cat. no. DIS 56, 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.

COAG (Council of Australian Governments) 2009, *National Disability Agreement*, Council of Australian Governments, www.coag.gov.au/intergov_agreements/federal_financial_relations/index.cfm (accessed 14 October 2009).

DIMA (Department of Immigration and Multicultural Affairs) 1999, *1996 Classification of Countries into English Proficiency Group*, Statistical focus C96.1A revised, Australian Government, Canberra.

—— 2003, *2001 classification of countries into English Proficiency Groups*, Statistical focus C01.2.0, Australian Government, Canberra.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 1999, *Payroll Tax in the Costing of Government Services*, AusInfo, Canberra.

WHO (World Health Organisation) 2009, *Disabilities*, Health topics, Geneva, www.who.int/topics/disabilities/en/ (accessed 13 October 2009).

15 Protection and support services

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by a '15A' suffix (for example, table 15A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

Protection and support services aim to assist individuals and families who are in crisis or experiencing difficulties that hinder personal or family functioning. These services assist by alleviating the difficulties and reducing the potential for their recurrence.

This chapter reports on:

- *child protection services*: functions of government that receive and assess allegations of child abuse and neglect, and/or harm to children and young people, provide and refer clients to family support and other relevant services, and intervene to protect children
- *out-of-home care services*: care for children placed away from their parents for protective or other family welfare reasons
- *juvenile justice services*: services to promote community safety and reduce youth offending by assisting young people to address their offending behaviour
- *supported accommodation and assistance services*: services to assist young people, adults and families who are homeless or at imminent risk of becoming homeless.

Improvements to the reporting of protection and support services this year include:

- five jurisdictions reporting performance data for the 'safety in out-of-home care' effectiveness indicator, compared with two previously
- seven jurisdictions reporting performance data for the two child protection 'response time' effectiveness indicators, compared with six previously
- all jurisdictions reporting for the efficiency indicator 'out-of-home care expenditure per placement night', compared with seven previously
- for the first time, performance data are included for six juvenile justice performance indicators and performance indicator boxes are included for a further seven performance indicators.

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 care when it is determined that a child is unable to be returned to the care of his or her parents, and working with young people to identify alternative supported living arrangements where family reunification is not possible.

Research suggests that children and families who come into contact with the protection and support services system often share common social and demographic characteristics. Families with low incomes or that are reliant on pensions and benefits, those that experience alcohol and substance abuse, or a psychiatric disability, and those that have a family history of domestic violence are over-represented in the families that come into contact with the protection and support services system (Department of Human Services 2002; The Allen Consulting Group 2008).

Child protection concerns and Indigenous communities

Studies have highlighted the high incidence of child abuse and neglect within some Indigenous communities, compared with non-Indigenous communities. Indigenous families across Australia have been found to experience high levels of violence, compared with non-Indigenous families (AIHW 2006a). The final report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse (2007), identified child sexual abuse as a significant issue for many of the remote NT Aboriginal communities consulted as part of the Inquiry. The final report of the WA Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities (Gordon Report 2002), also found high levels of violence and child abuse within Aboriginal communities in WA.

Out-of-home care services

Out-of-home care services provide care for children and young people aged 0–17 years who are placed away from their parents or family home for reasons of safety or family crisis. These reasons include abuse, neglect or harm, illness of a parent and the inability of parents to provide adequate care. Placements may be voluntary or made in conjunction with care and protection orders.

Out-of-home care services comprise home-based care (for example, foster care, care with a child's extended family or other home-based arrangements), facility-based care (for example, community residential care) or independent living (which is often intensively supported) as a transition to full independence or supported placements. Across jurisdictions, there has been a shift away from the use of facility-based (or residential) care towards foster care and other forms of home-based care, including relative/kinship care.

Intensive family support services are increasingly perceived as an alternative to the removal of a child from his or her home for child protection reasons (box 15.1).

Box 15.1 **Intensive family support services**

Intensive family support services are specialist services, established in each jurisdiction, that aim to:

- prevent the imminent separation of children from their primary caregivers as a result of child protection concerns
- reunify families where separation has already occurred.

(Continued on next page)

Box 15.1 **(Continued)**

Intensive family support services differ from other types of child protection and family support services referred to in this chapter, in that they:

- are funded or established explicitly to prevent the separation of, or to reunify, families
- provide a range of services as part of an integrated strategy focusing on improving family functioning and skills, rather than providing a single type of service
- are intensive in nature, averaging at least four hours of service provision per week for a specified short term period (usually less than six months)
- generally receive referrals from a child protection service.

Intensive family support services may use some or all of the following strategies: assessment and case planning; parent education and skill development; individual and family counselling; anger management; respite and emergency care; practical and financial support; mediation, brokerage and referral services; and training in problem solving.

Expenditure on intensive family support services

Recurrent expenditure on intensive family support services across all jurisdictions was $254.5 million in 2008-09. This expenditure has increased in real terms each year from $71.7 million in 2004-05 (table 15A.26). This represents an average annual increase in expenditure of 37.2 per cent over this four year period. Tables 15A.26–29 provide additional information about families and children who were involved with intensive family support services, including the cost of providing these services per child commencing intensive family support services.

Child protection treatment and support services

A complementary suite of services not currently included in this Report, but intended for inclusion in future Reports, are known as child protection treatment and support services. These services target at-risk families where there are concerns about the safety and wellbeing of children. They may be less intensive in nature and include services that strengthen family relationships in response to concerns about the welfare of a child and may focus on either early intervention or reunification support.

Child protection treatment and support services provide educational services, clinical services including counselling, group work and other therapeutic interventions, and domestic violence services.

The Australian Institute of Health and Welfare (AIHW), with the support of State and Territory governments, is studying the feasibility of a national data collection for child protection treatment and support services.

Source: AIHW (unpublished).

Roles and responsibilities

State and Territory governments fund child protection, out-of-home care, family support (including intensive family support) and other relevant services (see box 15.2 for responsible State and Territory government departments during 2008-09). These services may be delivered by the government or the non-government sector. State and Territory departments responsible for child protection investigate and assess reports, provide, or refer families to, support services, and intervene where necessary (including making court applications when an order is required to protect a child, and placing children in out-of-home care).

Box 15.2 Child protection and out-of-home care services

NSW	Department of Community Services (DOCS) (now the Department of Human Services)
VIC	Department of Human Services (DHS)
QLD	QLD Department of Child Safety (DCS) (now the Department of Communities)
WA	Department for Child Protection (DCP)
SA	Department for Families and Communities (DFC)
TAS	Department of Health and Human Services (DHHS)
ACT	Department of Disability, Housing and Community Services (DHCS)
NT	Department of Health and Families (DHF)

Other areas of government also have roles in child protection and provide services for children who have come into contact with relevant departments for protective reasons. These include:

- police services, which investigate serious allegations of child abuse and neglect, particularly criminal matters, and may also work on child protection assessments with State and Territory departments responsible for child protection
- courts, which decide whether a child will be placed on an order
- education and child care services, which provide services for these children and also conduct mandatory reporting and protective behaviours education in some jurisdictions
- health services, which support the assessment of child protection matters and deliver therapeutic, counselling and other services.

A range of appointments, schemes and charters have been introduced by jurisdictions in recent years, to enable additional protection for clients of child protection systems. Examples of these are listed in box 15.3.

Box 15.3 **Initiatives to enable additional protection for clients**

NSW	The Commission for Children and Young People initiates and influences broad and positive change for children and young people. The Office of the Children's Guardian promotes the best interests and rights of all children in out-of-home care, through accreditation and monitoring of out-of-home care agencies to ensure services are of the highest standard.
VIC	The Child Safety Commissioner promotes child safe practices and environments across the community through a charter of rights for children in care. Part of the Commissioner's role is to monitor the quality of out-of-home care services.
QLD	The Commission for Children and Young People and Child Guardian has a range of legislated functions designed to oversee children's wellbeing in the child protection system. One of these enables Community Visitors to regularly visit children in out-of-home care to independently assess their safety and wellbeing. The Department of Communities has a complaints management system so that clients, family members, advocates and members of the Queensland public can raise enquiries, concerns, or complaints about their contact and interactions with the department.
WA	The Advocate for Children in Care provides advocacy and complaints management services for children and young people in care. The Department's Complaints Management Unit is available to all customers. Formal monitoring of protection and care service standards by a Standards Monitoring Unit began on 1 July 2007. Seventeen Districts are monitored on a two-year cycle and the monitoring regime will be extended across all placement service providers commencing 1 July 2010.
SA	The Office of the Guardian monitors and assesses care, advocates for, and advises on, the circumstances and needs of children and systemic issues affecting the quality of out-of-home care.
TAS	The Commissioner for Children's functions include promoting the rights and wellbeing of children, examining the policies, practices and services provided for children and any laws affecting the health, welfare, care, protection and development of children.

(Continued on next page)

Box 15.3 **(Continued)**

ACT The Public Advocate of the ACT monitors the provision of services, and protects and advocates for the rights of children and young people. Systemic issues are referred by the Public Advocate to the Commissioner for Children and Young People. The Commissioner consults with and promotes the interests of children. The Official Visitor's role is to visit and inspect places of care, of detention or therapeutic protection, and receive and inquire about complaints made concerning the care provided to children and young people at these locations. In addition, an ACT Charter of Rights for children and young people in out-of-home care was launched in November 2009. The Charter is consistent with the United Nations Convention on the Rights of the Child, the ACT Human Rights Act 2004, and the Children and Young People Act 2008, all of which emphasise the basic human rights to which children and young people are entitled.

NT Provisions for the new Care and Protection of Children Act 2007 commenced in 2008 and included establishment of a Children's Commissioner to investigate complaints and oversight administration of the Act, enhanced regulations of children's services, establishment of a Child Deaths Review and Prevention Committee, and additional support for children leaving care.

Source: State and Territory governments (unpublished).

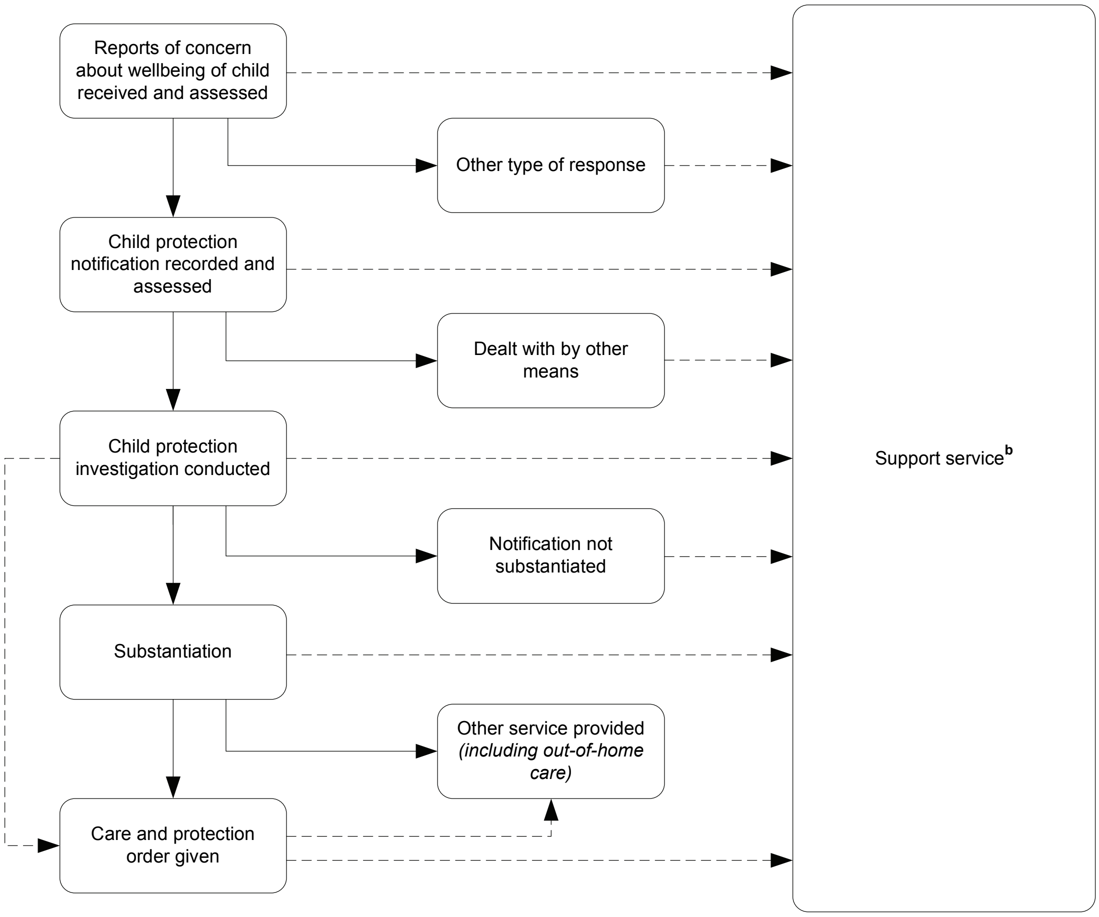
Size and scope

The child protection system

Child protection legislation, policies and practices vary across jurisdictions. However, the broad processes in child protection systems are similar (figure 15.1).

State and Territory departments with responsibility for child protection are advised of concerns about the wellbeing of children through reports to these departments. Reports may be made by people mandated to report or by other members of the community. Individuals and organisations mandated to report vary across states and territories, and may include medical practitioners, police services, school teachers and principals. These reports are assessed and classified as child protection notifications, child concern reports, or matters requiring some other kind of response. The most common source of notifications in 2008-09 in all jurisdictions were the police. The second most common source of notifications varied across jurisdictions and included social workers and school personnel (AIHW 2010).

Figure 15.1 **The child protection system**[a]



---

[a] Dashed lines indicate that clients may or may not receive these services, depending on need. [b] Support services include family support or family preservation services provided by departments responsible for child protection and referrals to other agencies.

Source: Australian State and Territory governments (unpublished).

Notification

Jurisdictions count notifications at different points in the response to a report, ranging from the point of initial contact with the source of the report to the end of a screening and decision making process. This means the number of notifications is not strictly comparable across jurisdictions.

Most jurisdictions assesses incoming reports to determine whether they meet the threshold for recording a notification. Notifications are subsequently investigated based on the policies and practices in each jurisdiction. Once it has been decided that an investigation is required, the investigation process is similar across jurisdictions. The department responsible for child protection may obtain further information about the child and his or her family by checking information systems for any previous history, undertaking discussion with agencies and individuals, interviewing/sighting the child and/or interviewing the caregivers/parents. At a minimum, the child is sighted whenever practicable, and the child's circumstances and needs are assessed. Where possible, an investigation determines whether a notification is substantiated or not substantiated (figure 15.1).

Rates of children subject to notifications, investigations and substantiations are calculated for children aged 0–16 years, given differences across jurisdictions' in legislation, policies and practices regarding children aged 17 years. Rates of children on care and protection orders and in out-of-home care are calculated for children aged 0–17 years.

Nationally, 204 463 children aged 0–16 years were the subject of child protection notifications in 2008-09. The rate of notifications per 1000 children in the population aged 0–16 years was 43.1 in 2008-09 (table 15A.8). The total number of notifications for each jurisdiction for 2008-09 (including cases where a child is the subject of more than one child protection notification) by Indigenous status of the child is reported in table 15A.5.

Notifications data are collected early in the child protection process and often before an agency has full knowledge of a child's family circumstances. This lack of information and the inherent difficulties in identifying Indigenous status mean that data on the number of notifications by Indigenous status need to be interpreted with care.

Substantiation

The legal definition of harm or risk of harm, abuse or risk of abuse are similar across jurisdictions. Traditionally, child protection legislation and policy focused on the identification and investigation of narrowly defined incidents that were broadly grouped as types of abuse or neglect. Across all jurisdictions, the focus has now shifted away from the actions of parents and guardians, toward the desired outcomes for the child, the identification and investigation of actual and/or likely harm or risk to the child, and the child's needs. While the legal criteria for substantiating such matters are now similar across jurisdictions, there remain some differences in practice, including different thresholds for recording a substantiation related to risk of harm.

If an investigation results in a substantiation, intervention by child protection services might be needed to protect the child. This intervention can take a number of forms, including one or more of: referral to other services; supervision and support; an application to court; and a placement in out-of-home care.

Nationally, 32 478 children aged 0–16 years were the subject of a substantiation in 2008-09. The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–16 years was 6.9 (table 15A.8). The number and rate of children aged 0–16 years who were the subject of a substantiation has fluctuated since 2004-05. Nationally, 33 871 children were the subject of a substantiation in 2004-05. This represented a rate of 7.5 per 1000 children in the population aged 0–16 years (SCRGSP 2006).

Nationally, 8135 Indigenous and 24 343 non-Indigenous children were the subject of a substantiation in 2008-09. The rate of children who were the subject of a substantiation per 1000 children in the target population aged 0–16 years was 36.8 for Indigenous children and 5.4 for non-Indigenous children (table 15A.8).

Care and protection orders

Although child protection substantiations are often resolved without the need for a court order (which is usually a last resort) recourse to a court may take place at any point in the child protection investigation process. The types of orders available vary across jurisdictions and may include guardianship or custody orders, supervisory orders, and interim and temporary orders.

Nationally, 35 409 children aged 0–17 years were on care and protection orders at 30 June 2009. The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 7.0 (table 15A.8). The number and rate of children aged 0–17 years who were the subject of a care and protection order has increased since 2004-05. At 30 June 2005, 24 075 children were the subject of a care and protection order, which represented a rate of 4.8 per 1000 children in the population aged 0–17 years (AIHW 2010).

Nationally, 10 271 Indigenous and 25 138 non-Indigenous children were on care and protection orders at 30 June 2009. The rate of children on care and protection orders per 1000 children in the target population aged 0–17 years was 43.8 for Indigenous children and 5.2 for non-Indigenous children (table 15A.8).

Further information regarding children on care and protection orders is included in the attachment tables. Table 15A.6 identifies the number of children admitted to and discharged from care and protection orders by Indigenous status, 2008-09. Table 15A.7 identifies the number of children on care and protection orders by type of order and Indigenous status at 30 June 2009.

Out-of-home care

Out-of-home care is one of a range of services provided to children and families where there is a need to provide safe care for a child. Children are placed in out-of-home care as a last resort when it is not in their best interests to remain with their family (for example, because they are not safe or because no one is able or willing to provide care). Where children are placed in out-of-home care, placement with the extended family or community is sought where possible, particularly in the case of Indigenous children (AIHW 2006b). Continued emphasis is placed on improving case planning and case management processes to facilitate the safe return home of children in out-of-home care and to maximise case workers' contact time with children and families.

Nationally, 34 069 children were in out-of-home care at 30 June 2009. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 6.7 (table 15A.16). The number and rate of children aged 0–17 years in out-of-home care has increased since 2004-05. At 30 June 2005, 23 695 children were in out-of-home care. This represented a rate of 4.9 per 1000 children in the population aged 0–17 years (SCRGSP 2006).

Nationally, 10 512 Indigenous children and 23 557 non-Indigenous children were in out-of-home care at 30 June 2009. The rate of children in out-of-home care per 1000 children in the target population aged 0–17 years was 44.8 for Indigenous children and 4.9 for non-Indigenous children (table 15A.16).

Further information on children in out-of-home care is included in the attachment tables. Table 15A.17 identifies the number of children in out-of-home care by Indigenous status and placement type at 30 June 2009. Table 15A.18 identifies the number of children in out-of-home care by Indigenous status and whether they were on a care and protection order at 30 June 2009. Table 15A.19 identifies the number of children in out-of-home care by Indigenous status and length of time in continuous out-of-home care as at 30 June 2009. Table 15A.20 identifies the number of children who exited care during 2008-09, by Indigenous status and length of time spent in care.

Funding

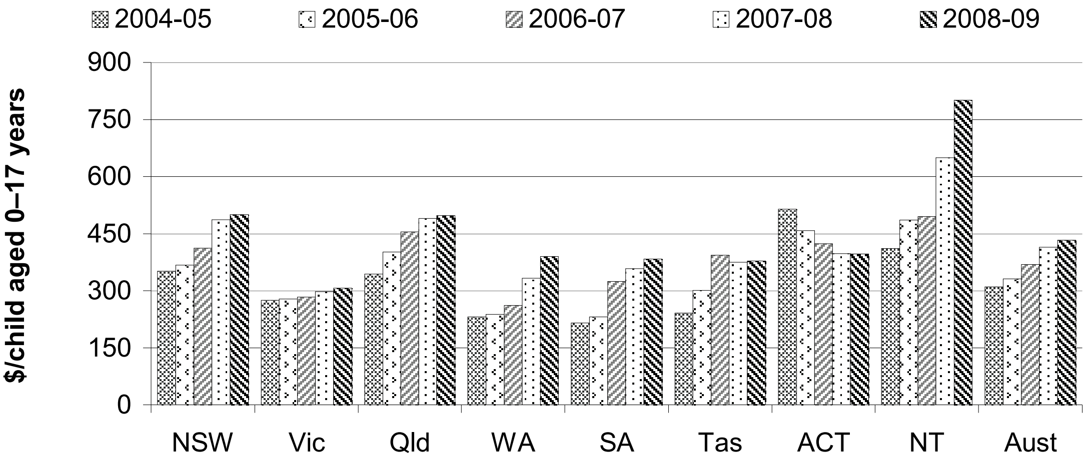
Recurrent expenditure on child protection and out-of-home care services was approximately $2.2 billion across Australia in 2008-09 — a real increase of $123.6 million (6.0 per cent) from 2007-08. Of this expenditure, out-of-home care services accounted for the majority (66.0 per cent, or $1.4 billion). Nationally, annual real expenditure on child protection and out-of-home care services has increased by $696.6 million from $1.5 billion since 2004-05, an average annual increase over the 4 year period of 10.1 per cent (table 15A.1).

In 2008-09, real recurrent expenditure per child aged 0–17 years in child protection and out-of-home care services was $432 nationally (figure 15.2). Real recurrent expenditure per child aged 0–17 years increased in most jurisdictions between 2004-05 and 2008-09 and has increased nationally each year since 2004-05. In 2004-05 the real recurrent expenditure per child aged 0–17 years was $310 (table 15A.1). This represents an average annual increase over the 4 year period of 9.9 per cent.

It is an objective of the Review to report comparable estimates of costs. Ideally, the full range of costs to government would be determined on a comparable basis across jurisdictions. Where full costs cannot be calculated, costs should be estimated on a consistent basis across jurisdictions. However, in the area of child protection, there are differences across jurisdictions in the calculation of expenditure.

Table 15A.4 identifies the level of consistency across jurisdictions for a number of expenditure items. The scope of child protection systems also varies across jurisdictions, and expenditure on some services may be included for some jurisdictions, but not for others.

Figure 15.2 **Real recurrent expenditure on child protection and out-of-home care services per child (2008-09 dollars)**[a]



---

[a] Refer to table 15A.1 for detailed jurisdiction-specific footnotes on expenditure data and table 15A.4 for information on the comparability of expenditure data.

Source: State and Territory governments (unpublished); table 15A.1.

15.2 Framework of performance indicators for child protection and out-of-home care services

The framework of performance indicators for child protection and out-of-home care services is based on shared government objectives (box 15.4).

Box 15.4 **Objectives for child protection and out-of-home care services**

The aims of child protection services are to:

- protect children and young people at risk of harm within their family or in circumstances in which the family of the child or young person does not have the capacity to protect them
- assist families to protect children and young people.

The aim of out-of-home care services is to provide quality care for children and young people aged 0–17 years who cannot live with their parents for reasons of safety or family crisis.

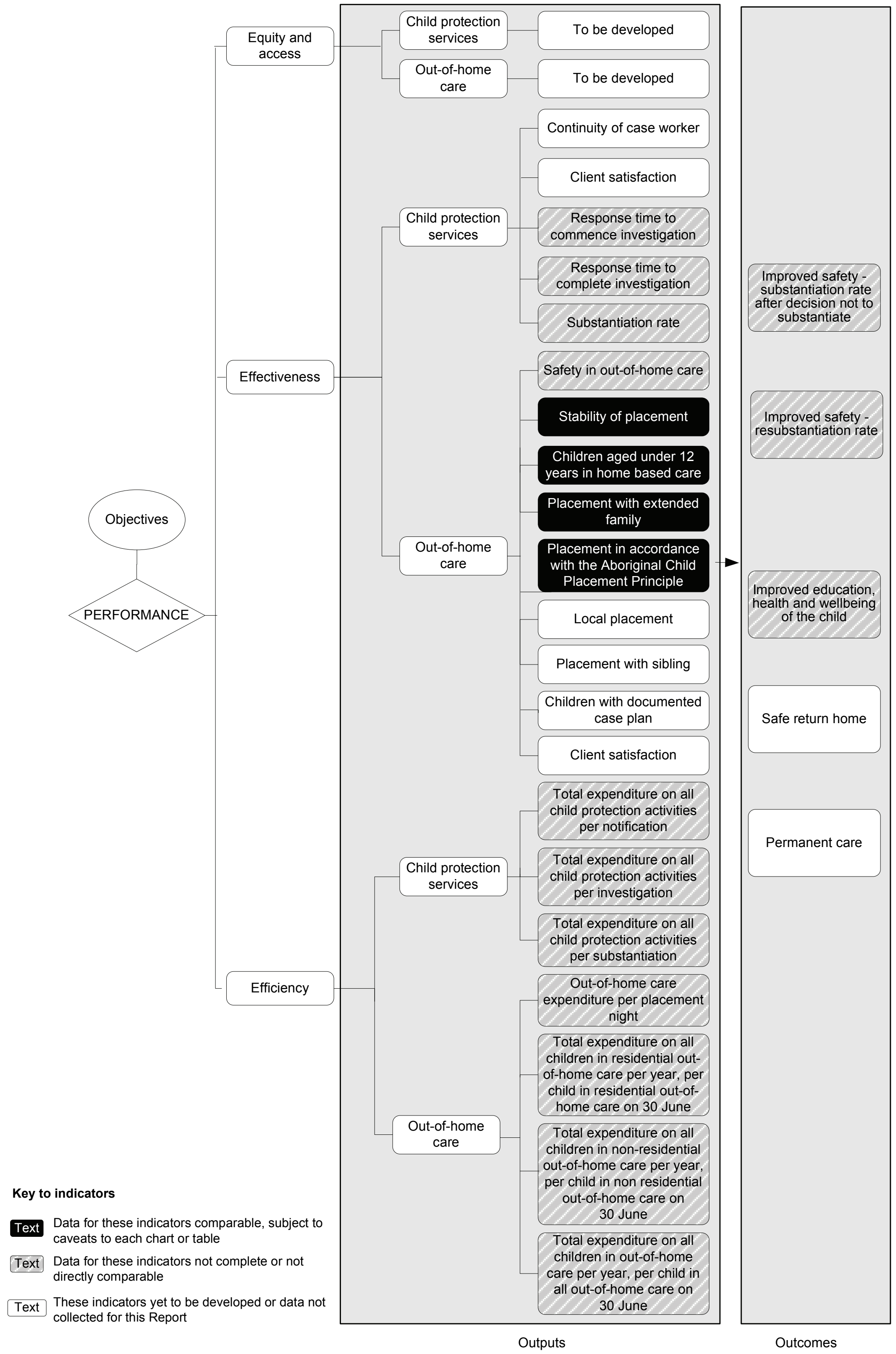
Child protection and out-of-home care services should be provided in an efficient and effective manner.

The performance indicator framework shows which data are comparable in the 2010 Report (figure 15.3). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

15.3 Key child protection and out-of-home care services performance indicator results

Different delivery contexts, locations and types of client may affect the equity/access, effectiveness and efficiency of child protection services. The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 15.3 **Performance indicators for child protection and out-of-home care services**



Outputs

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

Equity and access

Equity and access indicators are indicators of governments' objective to ensure that all clients have fair and equitable access to services on the basis of relative need and available resources (box 15.5).

Box 15.5 **Access to child protection and out-of-home care services by equity groups**

'Access to child protection and out-of-home care services by equity groups' are yet to be defined.

These indicators have been identified for development in future reports.

Effectiveness

Child protection services — continuity of case worker

'Continuity of case worker' is an indicator of governments' objective to ensure child protection services are delivered in an effective manner (box 15.6).

Box 15.6 **Continuity of case worker**

'Continuity of case worker' is yet to be defined.

The turnover of workers is a frequent criticism of the quality of child protection services. Effective intervention requires a productive working relationship between the worker and the child and family.

This indicator has been identified for development and reporting in future.

Child protection services — client satisfaction

'Client satisfaction' is an indicator of governments' objective to provide high quality services that meet the needs of recipients (box 15.7).

Box 15.7 **Client satisfaction**

‘Client satisfaction’ is yet to be defined.

This indicator has been identified for development and reporting in future.

Box 15.8 provides examples of steps taken across jurisdictions to monitor, assess and promote client satisfaction in relation to child protection and out-of-home care.

Box 15.8 **Developments in client satisfaction**

NSW A large scale evaluation is being undertaken of the Brighter Futures early intervention program, which targets vulnerable families with children under 9 years of age. As part of the evaluation, a sample of 168 families participated in a survey assessing satisfaction with the services provided. In summary, 92 per cent stated that they were satisfied or completely satisfied with case management; 97 per cent stated that they were satisfied or completely satisfied with home visits; 59 per cent stated that they were satisfied with the child care service (with 35 per cent stating that it was not applicable); and 48 per cent stated that they were satisfied with parenting programs (with 46 per cent stating that it was not applicable).

VIC Survey findings of child protection clients and families in 2001 on their experience of child protection identified areas for practice improvement and a range of strengths in child protection practice, including that in the majority of cases, child protection intervention improved the safety and life circumstances of young people. A further survey of child protection, out-of-home care and intensive family support services clients is to take place in 2010 and again in 2012. Client feedback is also routinely sought by Community Services Organisations as part of meeting Victorian out-of-home care service registration standards.

Qld The views of children in care are regularly sought through surveys undertaken by the Commission for Children and Young People and Child Guardian. The surveys inform systems monitoring indicators and contribute to policy and practice development. The Department also supports 'Be Heard' programs delivered by the CREATE Foundation. These programs gather information from children and young people in care at a local level and provide feedback and training to the relevant child safety service centre. This includes recommendations to staff about how they can overcome barriers and address issues that have been raised by children and young people.

(Continued on next page)

Box 15.8 **(Continued)**

WA The Department for Child Protection undertook an on-line survey of foster carers in early 2008 and is responding to the feedback obtained from this stakeholder group. The Department introduced new complaints policy and procedures in March 2008. Formal monitoring of service standards has continued and all districts were assessed by June 2009. A pilot standards monitoring regime for residential and non-government placement services was completed in June 2009. WA's first Commissioner for Children and Young People was appointed in December 2007 and has legislative powers to consult, investigate, research, advise and report independently to the Parliament about issues that concern children and young people and those supporting them.

SA Based on recommendations arising from the Mullighan Inquiry (Mullighan 2008), the SA Government has commenced drafting legislation to strengthen prevention and early intervention. Families SA has also updated its customer complaints system. In addition, a survey of foster carers undertaken in 2007 revealed that in dealing with departmental staff the majority of carers reported being treated fairly, staff were competent and that foster carers received the information they sought. A further survey of carers will be undertaken in 2009. The SA Office of the Guardian has also conducted interviews with children and young people in care to identify what they want from their case workers. Overwhelmingly, children and young people value a positive relationship with their case worker (SA Government 2009).

TAS Tasmania engaged the CREATE Foundation in March 2009 to report the views of children in care as part of the ‘Be Heard’ project. The project’s interim report indicates that children in care value being involved in decision making about their situation. They also value placements in which they feel part of a family and are respected. In June 2009 the Commissioner for Children commenced an audit of complaints in care with a focus on the level and quality of worker visitation and care planning. The Commissioner reported that children in care value equality of treatment by carers and benefit when a meaningful relationship is established with their child protection worker. Tasmania also launched a Charter of Rights for Children in Out-of-Home Care in June 2009. The Charter materials are distributed to children, young people, and others involved in the provision of Out-of-Home Care in Tasmania.

ACT The CREATE Foundation released a report in July 2004 based on qualitative interviews of children and young people in out-of-home care in the ACT. This report recommended the development of a charter of rights for children and young people in care in the ACT. This charter has been developed in consultation with children, young people, the out-of-home care sector, foster carers, kinships carers, and other government and non-government agencies. The Charter was launched in November 2009.

(Continued on next page)

Box 15.8 **(Continued)**

NT	In June 2008 a Children's Commissioner was appointed. The Children's Commissioner can receive and investigate complaints about services, usually for children for whom care orders are in place. It may also include any child that Northern Territory Families and Children (Department of Health and Families) has accepted as requiring further assessment, case management, intervention or support services following a notification.

Source: State and Territory governments (unpublished).

Child protection services — response time to commence investigation

'Response time to commence investigation' is an indicator of governments' objective to minimise the risk of harm to children by responding to notifications of possible child protection incidents and commencing investigations in a timely manner (box 15.9).

Box 15.9 **Response time to commence investigation**

'Response time to commence investigation' is defined as the length of time (measured in days) between the date a child protection department records a notification and the date an investigation is subsequently commenced.

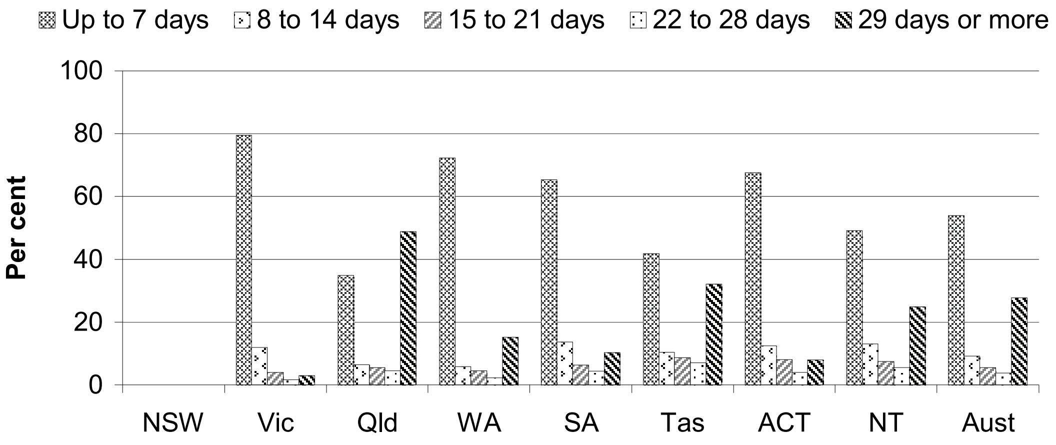
A short or decreasing length of time between recording a notification and commencing an investigation is desirable. The length of time between recording a notification and commencing an investigation indicates a department's promptness in effectively responding to child protection concerns.

This indicator needs to be interpreted with care as jurisdictions record notifications at different stages in response to a report, and jurisdictions have policy and legislation outlining the time recommended for commencing investigations, based on the seriousness of the child protection concern.

Data reported for this indicator are neither directly comparable nor complete.

For most jurisdictions, the majority of investigations were commenced within seven days of notification in 2008-09 (figure 15.4).

Figure 15.4 **Proportion of investigations commenced, by time taken to commence investigation (2008-09)**[a]



[a] Data for NSW were not available.

Source: AIHW data collection (unpublished); table 15A.14.

Child protection services — response time to complete investigation

'Response time to complete investigation' is an indicator of governments' objective to minimise the risk of harm to the child by responding to notifications of possible child protection incidents and completing investigations in a timely manner (box 15.10).

Box 15.10 **Response time to complete investigation**

'Response time to complete investigation' is defined as the length of time (measured in days) between the date a child protection department records a notification and the date an investigation is completed (that is, the date an investigation outcome is determined by a department).

A short or decreasing length of time between recording a notification and completing an investigation is desirable. The length of time between recording a notification and completing an investigation indicates the effectiveness of the department in conducting investigations in a timely manner.

(Continued on next page)

Box 15.10 (Continued)

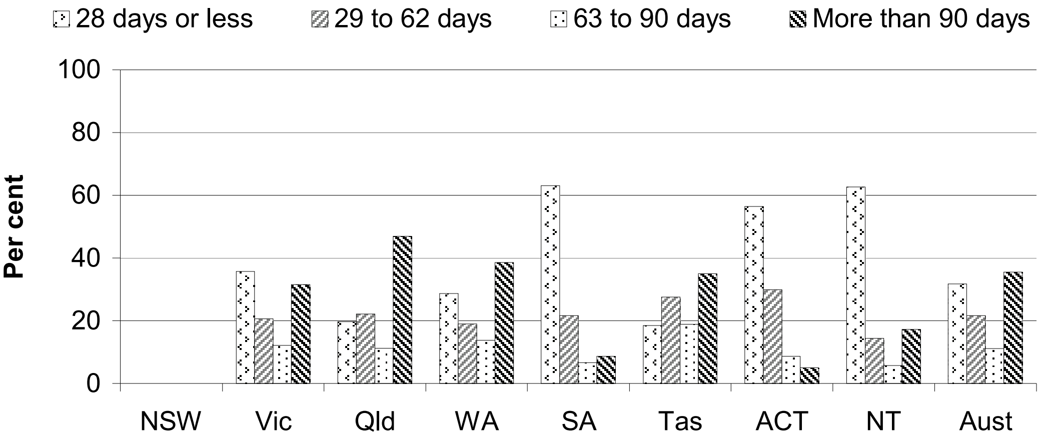
This indicator needs to be interpreted with care as jurisdictions record notifications at different stages in response to a report, and jurisdictions have policy and legislation outlining the time recommended for commencing investigations, based on the seriousness of the child protection concern. Furthermore, while investigations should be conducted in a timely manner, it is important that expediency does not undermine a thorough and accurate assessment of the case. In addition, a number of factors outside the control of a department can affect the timeliness of investigations, including involvement by external parties (for example, police, schools) and an inability to locate a child and/or family.

Data reported for this indicator are neither directly comparable nor complete.

Investigation is the process whereby the relevant department obtains more detailed information about a child who is the subject of a notification (for the 2010 Report this is between 1 July 2008 and 30 June 2009) and makes an assessment about the harm or degree of harm to the child, and his or her protective needs. An investigation includes sighting or interviewing the subject child where it is practical to do so.

The response time to complete investigation varied across jurisdictions in 2008-09, with the majority of investigations completed in either less than 28 days or more than 90 days (figure 15.5).

Figure 15.5 **Proportion of investigations finalised, by time taken to complete investigation (2008-09)**[a]



[a] Data for NSW were not available.

Source: AIHW data collection (unpublished); table 15A.15.

Child protection services — substantiation rate

'Substantiation rate' is an indicator of governments' objective to target investigations to those notifications where a substantive child abuse/neglect incident has occurred or is at risk of occurring (box 15.11).

Box 15.11 **Substantiation rate**

'Substantiation rate' is defined as the proportion of finalised investigations where harm or risk of harm was substantiated.

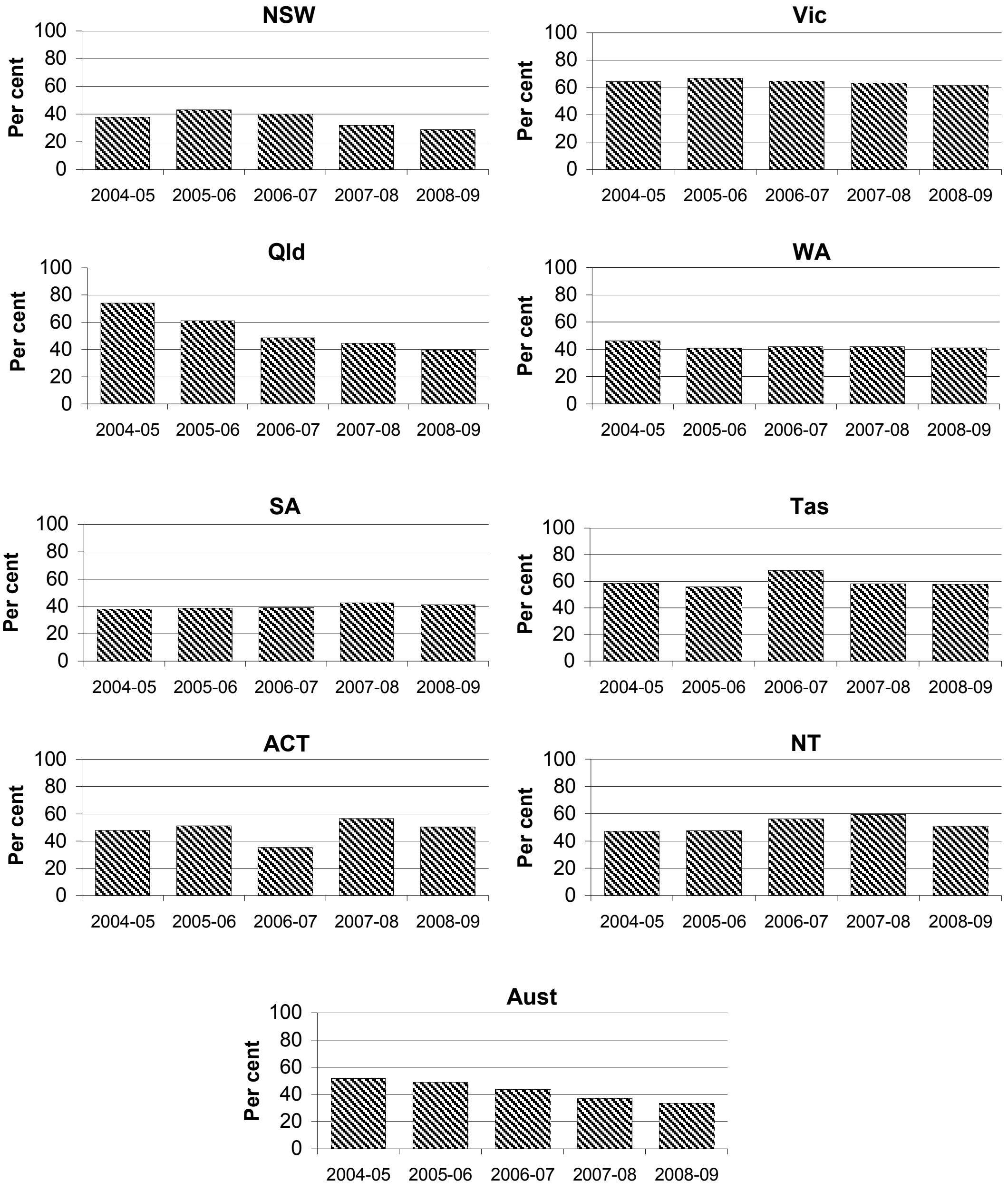
Neither a very high nor very low substantiation rate is desirable. The 'substantiation rate' provides an indication of the extent to which government avoided the human and financial costs of an investigation where no harm had occurred or was at risk of occurring. A very low substantiation rate might indicate that notifications and investigations are not accurately targeted at appropriate cases, with the undesirable consequence of distress to families and undermining the likelihood that families will voluntarily seek support. It might also reflect a greater propensity to substantiate abuse incidents rather than situations of risk. A very high substantiation rate might indicate that either some appropriate cases are being overlooked at notification and/or investigation, or that the criteria for substantiation are unnecessarily bringing 'lower risk' families into the statutory system.

The rate of finalised investigations that were substantiated is influenced by a range of factors and might fluctuate because of policy, funding and practice changes, such as better targeting of investigative resources, the impact of mandatory reporting or other factors such as increased community awareness and willingness to notify suspected instances of child abuse, neglect or harm.

Data reported for this indicator are not directly comparable.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.6).

Figure 15.6 **Proportion of finalised child protection investigations that were substantiated**[a, b]



---

[a] Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates should not be compared across jurisdictions. [b] Refer to footnotes in the source tables for information about what each jurisdiction's data include.

Source: AIHW (unpublished), derived from *Child protection notifications, investigations and substantiations, Australia* data collection; tables 15A.39, 15A.56, 15A.73, 15A.90, 15A.107, 15A.124, 15A.141 and 15A.158.

Out-of-home care — safety in out-of-home care

'Safety in out-of-home care' is an indicator of governments' objective to provide children who are under the care of the State with a safe home environment (box 15.12).

Box 15.12 **Safety in out-of-home care**

'Safety in out-of-home care' is defined as the proportion of children in out-of-home care who were the subject of a substantiation where the person responsible was living in the household providing out-of-home care.

A low or decreasing proportion of substantiations is desirable.

This indicator reflects the safety of children in care situations. Care should be taken when interpreting this indicator as the threshold for substantiating harm or risk involving children in care is generally lower than that for substantiating harm or risk involving a child in the care of his or her own parents. This is because governments assume a duty of care for children removed from the care of their parents for protective reasons. In addition, care should be taken when interpreting these data as the scope of information captured by jurisdictions differs. Some jurisdictions include substantiations concerning visitors to the home and substantiations where abuse was perpetrated by someone outside the care setting but a carer's action or inaction contributed to the harm.

Data reported for this indicator are neither complete nor directly comparable.

Nationally, in 2008-09, 0.6 per cent of children in out-of-home care were the subject of a substantiation where the person responsible was living in the household (table 15.1). Proportions varied across jurisdictions.

Table 15.1 Rate and number of children in out-of-home care who were the subject of a substantiation and the person responsible was living in the household, 2008-09[a, b]

	Unit	*NSW*[c]	*Vic*[c]	*Qld*[d]	*WA*	*SA*	*Tas*	*ACT*	*NT*[c]	*Aust*
Children in care who were the subject of a substantiation	no.	na	na	230	4	4	16	1	na	255
Children aged 0-17 in at least one care placement during the year	no.	17 998	7 826	9 527	3 456	2 519	1 011	892	747	43 976
Children in care who were the subject of a substantiation as a proportion of all children in care	%	na	na	2.4	0.1	0.2	1.6	0.1	na	0.6

[a] Data reported for this indicator are not directly comparable across jurisdictions due to differences in policies, practices and reporting methods. [b] See table 15A.25 for detailed footnotes. [c] Data were not available for NSW, Victoria or the NT. [d] Queensland's data comprise matter of concern substantiations, which refer to children in the custody or guardianship of the Chief Executive only. Queensland's consideration of the 'person believed responsible' relates to the overall safety and risk experienced by a child in care. It includes not only allegations of actual harm inflicted by members of a household but also whether their action or inaction contributed to the risk or harm even if the person believed responsible did not reside in the household. Therefore, Queensland's data are broader than the scope of the national counting rule and should not be compared to other jurisdictions' data. **na** Not available.

Source: AIHW (unpublished), Children in Out-of-Home Care, Australia data collection (table 15A.25).

Out-of-home care — stability of placement

'Stability of placement' is an indicator of governments' objective to provide high quality services that meet the needs of recipients on the basis of relative need and available resources (box 15.13).

For children placed away from their family for protective reasons, stability of placement is an important indicator of service quality, particularly for those children who require long term placements. Data are collected on the number of different placements for children on a care and protection order who exited out-of-home care in 2008-09. Data are grouped according to the length of time in care (less than 12 months and 12 months or more).

Box 15.13 **Stability of placement**

'Stability of placement' is defined as the proportion of children who had 1 or 2 placements during a period of continuous out-of-home care.

A low number of child placements (one or two) per period of care is desirable, but must be balanced against other placement quality indicators, such as placements in compliance with the Aboriginal Child Placement Principle, local placements and placements with siblings.

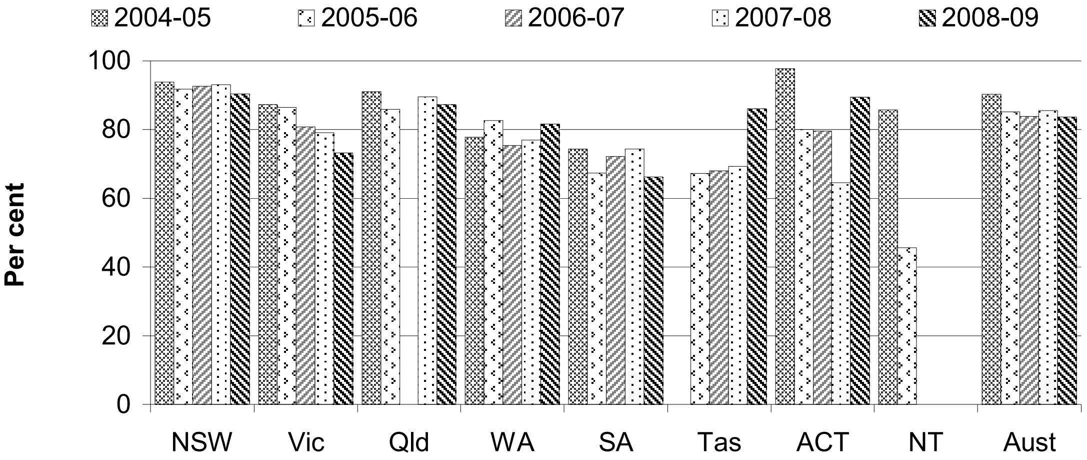
Children can have multiple short term placements for appropriate reasons (for example, an initial placement followed by a longer term placement) or it may be desirable to change placements to achieve better child–family compatibility. It is not desirable for a child to stay in an unsatisfactory or unsupportive placement. Also, older children are more likely to have multiple placements as they move towards independence and voluntarily seek alternate placements.

Data are collected only for children who are on orders and who exit care during the reporting period. There are limitations to counting placement stability using an exit cohort rather than entry cohort longitudinal data, because the population of children in an exit cohort is biased to children from recent entry cohorts with relatively short stays in care, and these children are likely to have experienced fewer placements.

Data reported for this indicator are comparable.

Nationally, 83.7 per cent of the children on a care and protection order who exited care after less than 12 months in 2008-09 experienced 1 or 2 placements. This proportion varied across jurisdictions (figure 15.7).

Figure 15.7 **Proportion of children on a care and protection order exiting care after less than 12 months, who had 1 or 2 placements**[a, b, c, d, e, f, g]



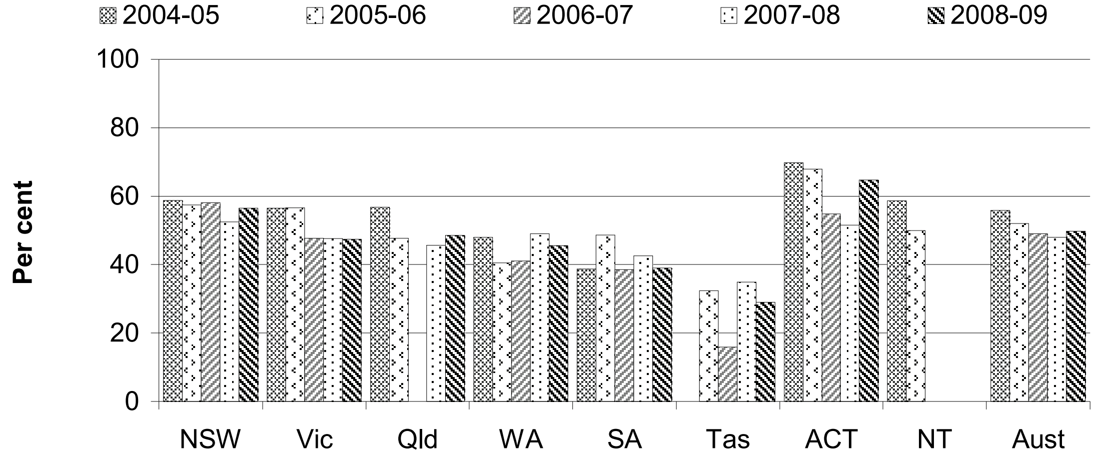
---

[a] Data refer to children exiting care during the relevant financial year. [b] Refer to footnotes in the source tables for information about what each jurisdiction's data include. [c] During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 onwards may not be fully comparable to previous years' data. [d] Queensland data for 2006-07 and NT data for 2006-07 to 2008-09 are not available. [e] Data for Tasmania were not available prior to 2005-06. [f] The apparent decline in the proportion for the ACT in 2007-08 was impacted by the small number of children involved and the placement of large sibling groups. [g] NT data for 2006-07 to 2008-09 were not available.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* collection; table 15A.24.

Across jurisdictions, children who had been in out-of-home care longer tended to have had more placements. The proportion of children exiting care in 2008-09 after 12 months or more who had experienced 1 or 2 placements was 49.7 per cent nationally but varied across jurisdictions (figure 15.8).

Figure 15.8 **Proportion of children on a care and protection order exiting care after 12 months or more, who had 1 or 2 placements**[a, b, c, d, e, f]



---

[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] During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 onwards may not be fully comparable to previous years' data. [d] Queensland data for 2006-07 were not available. [e] Data for Tasmania were not available prior to 2005-06. [f] NT data for 2006-07 to 2008-09 were not available.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* data collection; table 15A.24.

Out-of-home care — children aged under 12 years in home-based care

'Children aged under 12 years in home-based care' is an indicator of governments' objective to provide services which meet the needs of the recipients (box 15.14).

Box 15.14 **Children aged under 12 years in home-based care**

'Children aged under 12 years in home-based care' is defined as the number of children under 12 years of age placed in home-based care divided by the total number of children under 12 years in out-of-home care.

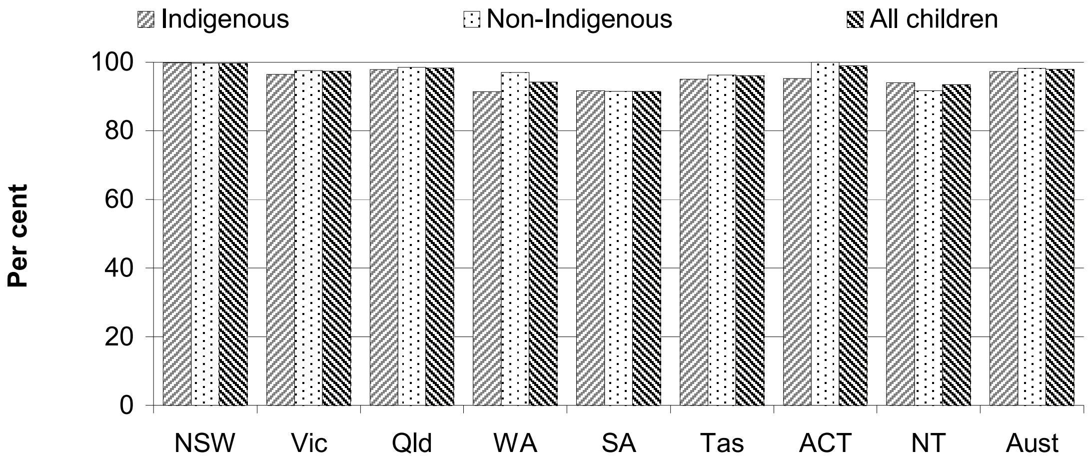
A high rate for this indicator is desirable. This indicator should be interpreted in conjunction with other placement indicators.

Placing children in home-based care is generally considered to be in their best interests, particularly for younger children. Children will generally make better developmental progress (and have more ready access to normal childhood experiences) in family settings rather than in residential care.

Data reported for this indicator are comparable.

The proportion of all children aged under 12 years in care who were placed in home-based care (excluding family group homes) at 30 June 2009 was 97.9 per cent nationally. In most jurisdictions the proportion of Indigenous children aged under 12 years who were placed in home-based care was similar to that of non-Indigenous children (figure 15.9).

Figure 15.9 **Proportion of children aged under 12 years in out-of-home care and in a home-based placement, by Indigenous status, 30 June 2009**[a, b]



---

[a] Family group homes are not classified as being home-based care. [b] Non-Indigenous status includes children whose Indigenous status is unknown or not stated.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* data collection; table 15A.23.

Out-of-home care — placement with extended family

'Placement with extended family' is an indicator of governments' objective to provide services that meet the needs of recipients on the basis of relative need and available resources (box 15.15).

Box 15.15 **Placement with extended family**

'Placement with extended family' is defined as the proportion of all children in out-of-home care who are placed with relatives or kin who receive government financial assistance to care for that child.

A high or increasing rate for this indicator is desirable. 'Placement with extended family' needs to be considered with other factors in the placement decision. Placing children with their relatives or kin is generally the preferred out-of-home care placement option. This option is generally associated with better long term outcomes due to increased continuity, familiarity and stability for the child. Relatives are more likely to have or form long term emotional bonds with the child. Placement with familiar people can help to overcome the loss of attachment and belonging that can occur when children are placed in out-of-home care.

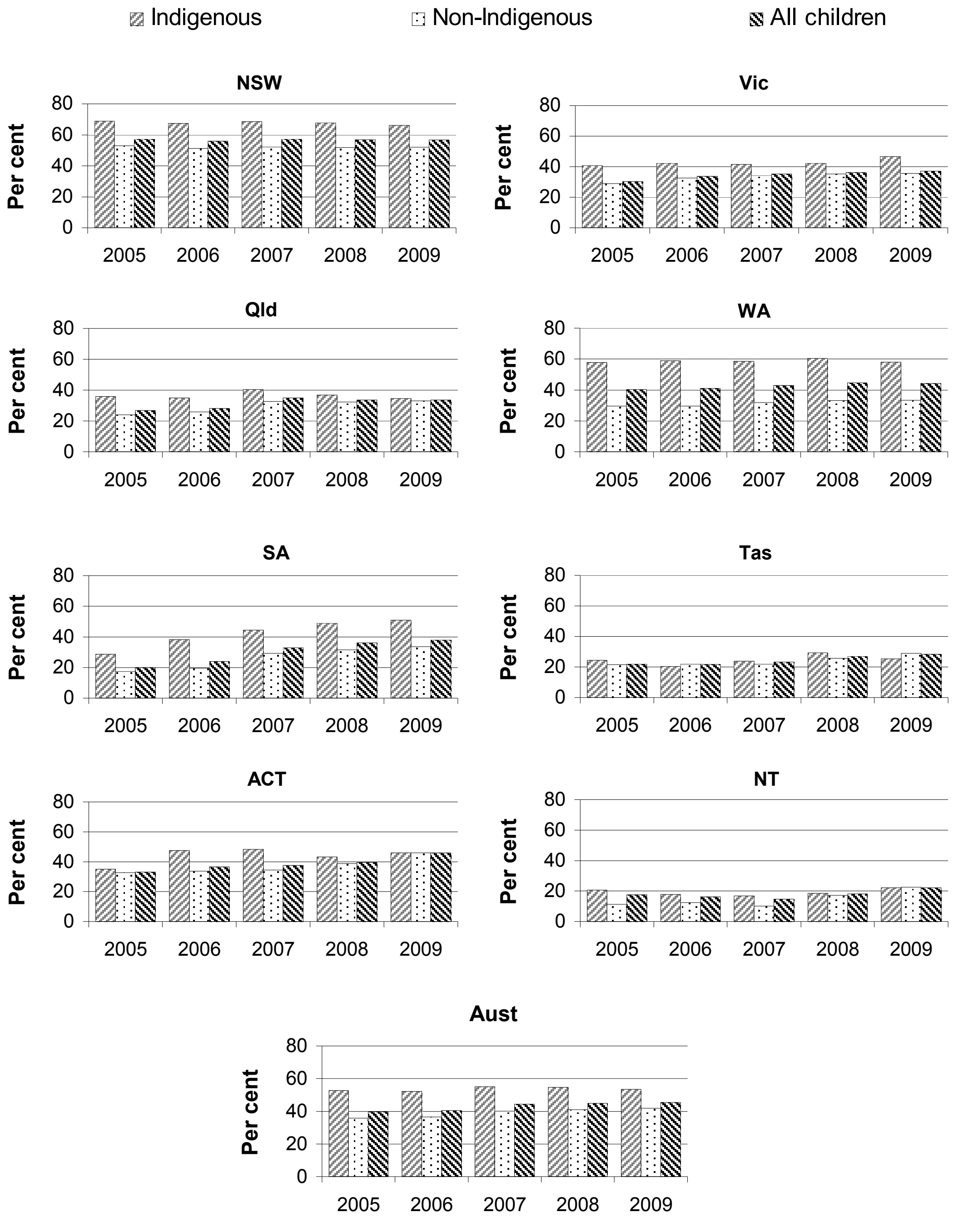
Placements with extended family may not always be the best option. Long standing family dynamics can undermine the pursuit of case goals such as reunification, and the possibility of intergenerational abuse needs to be considered. In addition, depending on the individual circumstances of the child, it may be more important to have a local placement that enables continuity at school, for example, rather than a distant placement with relatives.

Data reported for this indicator are comparable.

Figure 15.10 shows the proportion of children placed with relatives or kin by Indigenous status for the past 4 years. Although these data are comparable, each jurisdiction is shown separately for simpler presentation. The proportion of children placed with relatives or kin at 30 June 2009 was greater for Indigenous children than for non-Indigenous children in all jurisdictions and nationally (figure 15.10).

The Aboriginal Child Placement Principle places considerable emphasis on the placement of Indigenous children with extended family. This principle is discussed in box 15.16.

Figure 15.10 Proportion of children in out-of-home care placed with relatives/kin, by Indigenous status, 30 June[a]



---

[a] Non-Indigenous status includes children whose Indigenous status is unknown or not stated.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* data collection; table 15A.21.

Out-of-home care — placement in accordance with the Aboriginal Child Placement Principle

'Placement in accordance with the Aboriginal Child Placement Principle' is an indicator of governments' objective to protect the safety and welfare of Indigenous children while maintaining their cultural ties and identity (box 15.16).

Box 15.16 **Placement in accordance with the Aboriginal Child Placement Principle**

'Placement in accordance with the Aboriginal Child Placement Principle' is defined as the number of Indigenous children placed with the child's extended family, Indigenous community or other Indigenous people, divided by the total number of Indigenous children in out-of-home care. Data are reported separately for children placed (i) with relative/kin, (ii) with a non-relative Indigenous carer or in Indigenous residential care, and (iii) not placed with relative/kin, a non-relative Indigenous carer or in Indigenous residential care.

A high proportion of children placed in accordance with the principle is desirable.

Placing Indigenous children in circumstances consistent with the Aboriginal Child Placement Principle is considered to be in their best interests. However, it is one factor among many considerations for the child's safety and wellbeing that must be carefully considered in the placement decision. In the application of this principle, departments consult with and involve appropriate Indigenous individuals and/or organisations. If the preferred options are not available, the child may be placed (after appropriate consultation) with a non-Indigenous family or in a residential setting. The principle does not preclude the possibility that in some instances, placement in a non-Indigenous setting, where arrangements are in place for the child's cultural identity to be preserved, might be the most appropriate placement for the child.

This indicator needs to be interpreted with care as it is a proxy for compliance with the principle. This indicator reports the placement outcomes of Indigenous children rather than compliance with the principle. The indicator does not report whether the hierarchy was followed in the consideration of the best placement for the child, nor whether consultation was had with appropriate Indigenous individuals or organisations.

Data reported for this indicator are comparable.

According to the Aboriginal Child Placement Principle (NSW Law Reform Commission 1997) the following hierarchy of placement option should be pursued in protecting the safety and welfare of Indigenous children:

- placement with the child's extended family (which includes Indigenous and non-Indigenous relatives/kin)
- placement within the child's Indigenous community
- placement with other Indigenous people.

All jurisdictions have now adopted this principle in both legislation and policy.

Nationally, at 30 June 2009, 54.2 per cent of Indigenous children in out-of-home care were placed with a relative/kin, 18.4 per cent placed with a non-relative Indigenous carer or in Indigenous residential care, and 27.4 per cent were not placed with relative/kin, a non-relative Indigenous carer or in Indigenous residential care (figure 15.11).

The proportion of Indigenous children in out-of-home care at 30 June 2009 who were placed with Indigenous or non-Indigenous relatives or kin or with another Indigenous carer or in Indigenous residential care varied across jurisdictions (figure 15.11).

Figure 15.11 **Placement of Indigenous children in out-of-home care, 30 June 2009**[a, b]

Relative/Kin = Placed with relative/kin. Other Indigenous = Placed with other Indigenous carer or Indigenous residential care. Other = Not placed with relative/kin, other Indigenous carer or Indigenous residential care. [a] Excludes Indigenous children living independently and those whose living arrangements were unknown. [b] Data for Tasmania and the ACT relate to a small number of Indigenous children (130 and 100 respectively) in care at 30 June 2009.

Source: AIHW (unpublished), derived from *Children in out-of-home care, Australia* data collection; table 15A.22.

Out-of-home care — local placement

'Local placement' is an indicator of governments' objective to provide services which meet the needs of the recipients (box 15.17).

Box 15.17 **Local placement**

'Local placement' is defined as the proportion of children attending the same school that they were attending before entering out-of-home care as after entering out-of-home care.

A high or increasing rate of 'local placement' is desirable.

A placement close to where a child lived prior to entering out-of-home care is considered to enhance the stability, familiarity and security of the child. It enables some elements of the child's life to remain unchanged (for example, they can continue attending the same school and retain their friendship network). It may also facilitate family contact if the child's parents continue to live nearby.

This indicator should be balanced against other quality indicators. This is one factor among many that must be considered in the placement decision. For example, placement with a sibling or relative might preclude a local placement. Also, a child might move from a primary school to a secondary school or to a different local school at the same level.

Data will be provided for 3 and 12 months after entering care. Data collection for this indicator is under development. Data were not available for the 2010 Report.

Out-of-home care — placement with sibling

'Placement with sibling' is an indicator of governments' objective to provide services which meet the needs of the recipients (box 15.18).

Box 15.18 **Placement with sibling**

'Placement with sibling' is defined as the proportion of children who are on orders and in out-of-home care at 30 June who have siblings also on orders and in out-of-home care, who are placed with at least one of their siblings.

A high or increasing rate of placement with siblings is desirable. Placement of siblings together promotes stability and continuity. It is a long standing placement principle that siblings should be placed together, where possible, in the interests of their emotional wellbeing. Children are likely to be more secure and have a sense of belonging within their family when placed with siblings.

This is one factor among many that must be considered in the placement decision. In circumstances of sibling abuse, or when a particular child in a family has been singled out as the target for abuse or neglect, keeping siblings together may not be appropriate.

Data collection for this indicator is under development. Data were not available for the 2010 Report.

Out-of-home care — children with documented case plan

'Children with documented case plan' is an indicator of governments' objective to provide services that meet the needs of the recipients (box 15.19).

Box 15.19 **Children with documented case plan**

'Children with documented case plan' is defined as the proportion of children on an order and in out-of-home care who have a documented case plan.

A high or increasing rate is desirable because all children should have a case plan. The quality of a case plan must also be considered as the existence of a case plan does not guarantee that appropriate case work to meet a child's needs is occurring.

Case planning is essential to structured and purposeful work to support children's optimal development. Case plans outline intervention goals such as improved parent-child attachments, reunification or other forms of permanency, and set out the means to achieve these goals, such as frequency of family contact and any remedial or special services considered appropriate for the individual child. Case plans also allow for the monitoring of a child's time in care.

Data collection for this indicator are under development. Data were not available for the 2010 Report.

Out-of-home care — client satisfaction

'Client satisfaction' is an indicator of governments' objective to provide high quality services that meet the needs of recipients (box 15.20).

Box 15.20 **Client satisfaction**

'Client satisfaction' is yet to be defined.

This indicator has been identified for development and reporting in future.

Some information on jurisdictions' development of initiatives which may assist to measure client satisfaction in the future is included in box 15.8.

Efficiency

Understanding the efficiency of child protection systems broadly — and the different components of child protection systems, such as early intervention and out-of-home care services — enables State and Territory governments to identify key service cost drivers. Efficiency measures coupled with outcome measures ultimately enable State and Territory governments to compare the relative cost effectiveness of broad system approaches and the cost effectiveness of different components of child protection systems.

Challenges in reporting efficiency for child protection systems

Current efficiency data for child protection services have several limitations, including:

- *different systems and priorities across jurisdictions* — child protection systems in Australia have evolved independently under the auspices of State and Territory governments. This has resulted in variations in the processes and emphases placed on different service delivery paradigms, such as different approaches to diversionary options
- *limitations of current information systems* — in most jurisdictions, it is difficult to identify resources directed specifically to child protection services, out-of-home care services and other support services for families. This is due in part to the historic structure of information systems and the embedding of government agencies responsible for child protection services within larger community services departments. Table 15A.4 identifies the level of consistency in expenditure data across jurisdictions.

As a result of these limitations, cost allocations reflect the historic nature of information systems and do not necessarily provide an accurate reflection of the costs involved in provision of various child protection and out-of-home care services.

In April 2002, the Review initiated a project to improve efficiency data for a national framework of protection and support pathways (the 'Pathways' project) (box 15.21). Until this can be fully implemented, reporting on efficiency has been limited to proxy indicators (box 15.22 and box 15.24).

Box 15.21 **The ‘Pathways’ project**

The Pathways project developed and tested a model that will ultimately allow jurisdictions to calculate more meaningful, comparable and robust efficiency measures (the ‘pathways method’). The model is based on a top-down application of the activity-based costing method. Eight national pathways have been developed as a high level representation of the services that a protection and support client could receive in any jurisdiction. Each pathway consists of common activity groups which act as the ‘building blocks’ for each of the pathways. The aggregate cost of each activity group within the pathway will allow the unit cost (including direct and indirect expenditure) of an individual pathway to be determined.

These activity groups and pathways will provide additional utility for jurisdictions in managing the business of child protection services. Implementation of the model has the potential to improve the quality of national reporting of protection and support services efficiency measures. Activity-based data can also result, over time, in measures of the cost savings associated with early intervention strategies.

The activity groups are:

- Activity Group 1 Receipt and assessment of initial information about a potential protection and support issue.
- Activity Group 2 Provision of generic/non-intensive family support services.
- Activity Group 3 Provision of intensive family support services.
- Activity Group 4 Secondary information gathering and assessment.
- Activity Group 5 Provision of short term protective intervention and coordination services for children not on an order.
- Activity Group 6 Seeking an order.
- Activity Group 7 Provision of protective intervention, support and coordination services for children on an order.
- Activity Group 8 Provision of out-of-home care services.

Detailed definitions of activity groups are included in section 15.13.

Before jurisdictional reporting against the activity groups can be undertaken with confidence, further refinement of activity group definitions and counting rules is required. Development work, including further data testing in these areas will continue.

Source: SCRCSSP (2003) and SCRGSP (unpublished).

Experimental results from the Pathways model, provided by five jurisdictions, are included in table 15.2. These data are preliminary and are subject to further analysis and refinement for future Reports. These data do not represent unit costs and should be interpreted with caution. Due to differing internal management systems across jurisdictions, there can be significant variation between jurisdictions in relation to specific activities or expenditures that are included in each activity group.

These data reflect a combination of allocation of direct costs (those costs which can be clearly identified by a jurisdiction to a particular activity group) and indirect costs (which form part of the overall expenditure base, but which cannot be identified in a specific activity group). Indirect allocations have been approximated by jurisdictions across the eight activity groups.

Table 15.2 provides an approximation of the proportionate allocation of expenditure across the eight activity groups for each participating jurisdiction. The expenditure base used for the pathways project differs from the expenditure base used to calculate the existing proxy efficiency indicators for child protection and out-of-home care services (box 15.22 and box 15.24).

The proportion of expenditure allocated to Activity group 8 (Out-of-home care) is the most significant and varies from 39 per cent to 51 per cent across reporting jurisdictions. The proportions allocated to Activity groups 1 (Receipt and assessment of initial information about a potential protection and support issue) and 6 (Seeking an order) both accounted for less than 10 per cent across all reporting jurisdictions.

Table 15.2 **Proportion of expenditure by activity group — experimental estimates (per cent)**[a, b]

	AG1	*AG2*[c]	*AG3*	*AG4*	*AG5*	*AG6*	*AG7*	*AG8*	*Total*[d]
NSW (2005-06)	7	17	18	6	2	3	2	46	**100**
Victoria (2005-06)	3	24	4	5	4	7	8	44	**100**
WA (2008-09)[e]	9	8	5	8	3	4	12	51	**100**
SA (2005-06)	4	8	4	13	10	8	7	45	**100**
Tasmania (2004-05)	5	9	3	11	15	8	9	39	**100**

AG = Activity Group (box 15.21). [a] Participating jurisdictions' experimental data relate to expenditure allocations across different years. Activity Group definitions have been refined over time, therefore, experimental estimates from earlier years are not strictly comparable with more recent data. [b] Experimental percentage allocations are derived from total expenditure allocations which vary from totals used to derive costs presented elsewhere in the chapter. [c] Expenditure items included in calculating proportional expenditure for Activity Group 2 can vary across jurisdictions, for example the inclusion/exclusion of expenditure on services outsourced to non-government organisations. [d] Totals may not add to 100 as a result of rounding. [e] In 2007-08, the WA Department for Child Protection was created in addition to the Department for Communities. A substantial amount of Activity Group 2 services are funded and provided by the Department for Communities and these data are not included in the above estimates. It is anticipated that these data will be included in future years.

Source: NSW, Victorian, WA, SA and Tasmanian governments (unpublished).

Total expenditure on all child protection activities per notification, investigation and substantiation

'Total expenditure on all child protection activities, per notification', 'total expenditure on all child protection activities, per investigation', and 'total expenditure on all child protection activities, per substantiation' are reported as proxy indicators of governments' objective to maximise the benefit to the community through the efficient use of public resources (box 15.22).

Box 15.22 **Total expenditure on all child protection activities per notification, investigation and substantiation**

'Total expenditure on all child protection activities per notification, investigation and substantiation' is defined as:

- total expenditure on all child protection activities divided by the number of notifications
- total expenditure on all child protection activities divided by the number of investigations
- total expenditure on all child protection activities divided by the number of substantiations.

Low or decreasing expenditure per notification/investigation/substantiation can suggest more efficient services but may indicate lower quality or different service delivery models. These indicators are proxy indicators and need to be interpreted with care. Because each of these proxy indicators is based on total expenditure on child protection activities, they do not represent, and cannot be interpreted as, unit costs for notifications, investigations or substantiations. These proxy indicators cannot be added together to determine overall cost of child protection services.

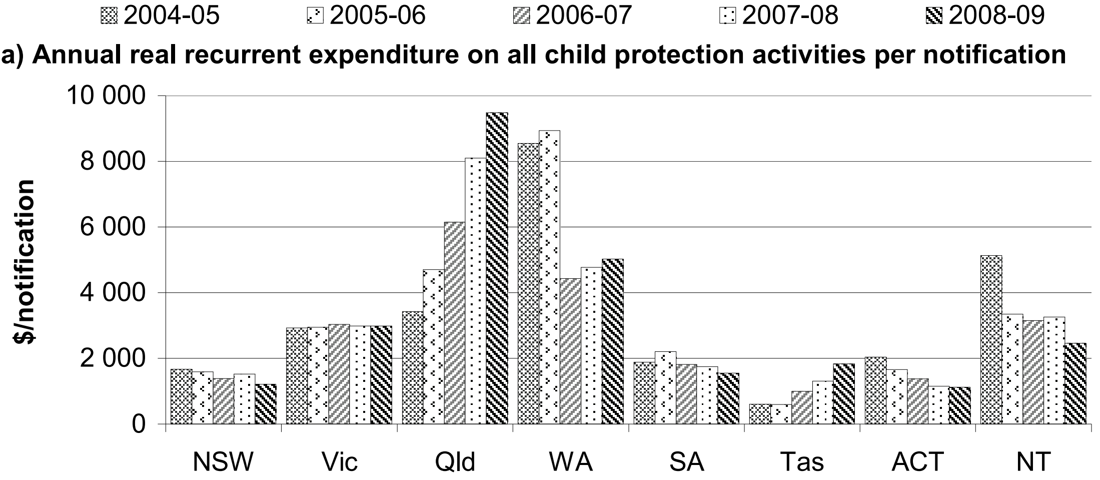
More comprehensive and accurate efficiency indicators would relate expenditure on particular child protection activities to a measure of output of those activities. Work is in progress to develop an activity-based costing method that will allow this type of reporting from existing information systems (box 15.21).

Data reported for this indicator are not directly comparable.

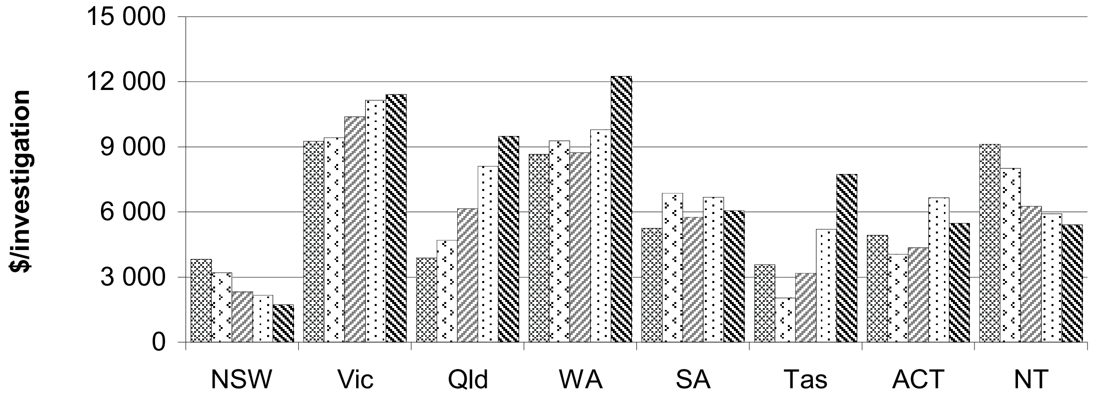
Total expenditure on all child protection activities per notification, per investigation and per substantiation from 2004-05 to 2008-09 varied across jurisdictions (figure 15.12).

Figure 15.12 **Child protection efficiency indicators (2008-09 dollars)**[a, b]

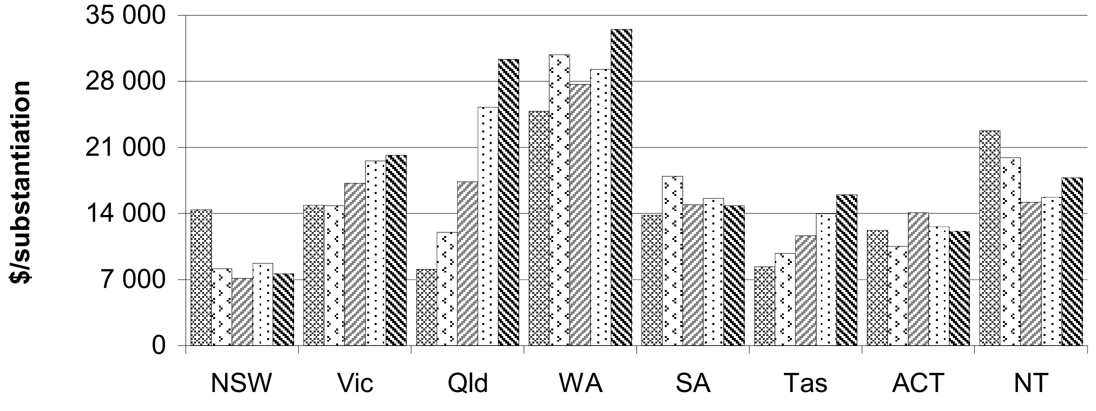
(a) Annual real recurrent expenditure on all child protection activities per notification



(b) Annual real recurrent expenditure on all child protection activities per investigation



(c) Annual real recurrent expenditure on all child protection activities per substantiation



[a] Real expenditure based on ABS gross domestic product price deflator (2008-09 = 100) (table AA.26). [b] See table 15A.2 for detailed jurisdiction-specific footnotes.

Source: State and Territory governments (unpublished); table 15A.2.

Out-of-home care expenditure per placement night

'Out-of-home care expenditure per placement night' is an indicator of governments' objective to maximise the availability and quality of services through the efficient use of public resources (box 15.23).

Box 15.23 **Out-of-home care expenditure per placement night**

'Out-of-home care expenditure per placement night' is defined as total real recurrent expenditure on out-of-home care services divided by the total number of placement nights in out-of-home care.

Low or decreasing expenditure per placement night can suggest more efficient services but may indicate lower service quality or different service delivery models. Further, in some cases, efficiencies may not be able to be realised due to remote geographic locations that limit opportunities to reduce overheads through economies of scale.

Data reported for this indicator are not directly comparable.

Out-of-home care expenditure per placement night varied across jurisdictions (table 15.3).

Table 15.3 **Out-of-home care expenditure per placement night, 2008-09**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*[c]	*ACT*	*NT*
Real expenditure on out-of-home care services ($m)								
	552.4	246.0	309.0	154.9	100.0	25.8	20.2	34.8
Placement nights in out-of-home care (no. '000)								
	5276.2	2129.9	2498.9	957.9	713.4	269.4	170.1	162.0
Out-of-home care program expenditure per placement night ($)								
	104.7	115.5	123.6	161.7	140.1	95.6	118.9	214.9

[a] These data should not be interpreted as unit costs for Activity Group 8 as they are derived using reported program expenditure and not activity group expenditure. [b] Caution should be used when interpreting results due to the variety of activities included in out-of-home care services. [c] Children in facility-based care placements contribute to a significant proportion of out-of-home care expenditure and can inflate the average unit cost.

Source: State and Territory Governments (unpublished); table 15A.32.

These indicative unit costs are derived using total real recurrent program expenditure on out-of-home care services (table 15A.1) and not expenditure allocated to an activity group. It is anticipated that unit costs for out-of-home care services derived from Activity group 8 expenditure will be available in future Reports, as development work continues on definitions, counting rules and a pilot data collection for the pathways project.

Expenditure on all out-of-home care services per child in out-of-home care, by residential and non-residential care

'Total expenditure on all children in residential out-of-home care per year, per child in residential out-of-home care on 30 June', 'total expenditure on all children in non-residential out-of-home care per year, per child in non-residential out-of-home care on 30 June', and 'total expenditure on all children in out-of-home care per year, per child in all out-of-home care on 30 June' are reported as proxy indicators of governments' objective to maximise the benefit to the community through the efficient use of public resources (box 15.24).

Box 15.24 **Expenditure on all out-of-home care services per child in out-of-home care, by residential and non-residential care**

'Expenditure on all out-of-home care services per child in out-of-home care, by residential and non-residential care is defined as:

- total expenditure on residential out-of-home care divided by the number of children in residential out-of-home care at 30 June
- total expenditure on non-residential out-of-home care divided by the number of children in non-residential out-of-home care at 30 June
- total expenditure on all out-of-home care divided by the number of children in all out-of-home care at 30 June.

Low or decreasing expenditure per child in care can suggest more efficient services but may indicate lower quality or different service delivery models. These indicators are proxy indicators and need to be interpreted with care as they do not represent a measure of unit costs. Expenditure per child in care at 30 June overstates the cost per child because significantly more children are in care during a year than at a point in time. In addition, the indicator does not reflect the length of time that a child spends in care.

More comprehensive and accurate efficiency indicators would relate expenditure on particular out-of-home care activities to a measure of output of those activities. Work is currently in progress to develop an activity-based costing method which will allow this type of reporting from existing information systems (box 15.21).

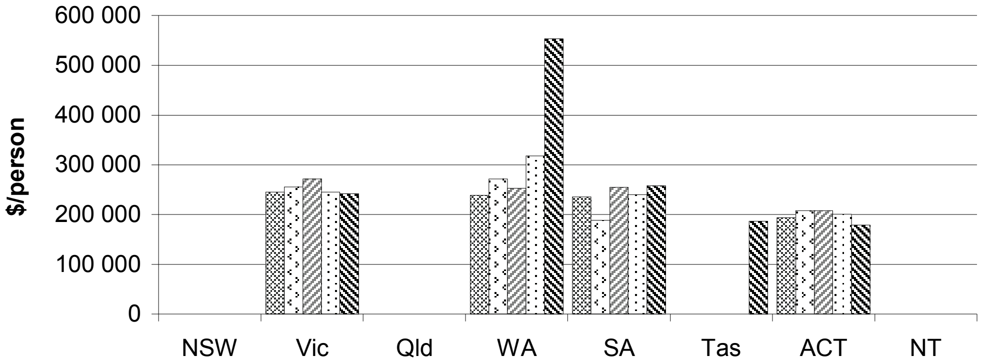
Data reported for this indicator are not directly comparable.

Total expenditure on residential care and non-residential care for the period 2004-05 to 2008-09, per child in residential care and non-residential care at 30 June, varied across jurisdictions (figures 15.13(a) and figure 15.13(b)). Total expenditure on all out-of-home care per child in care at 30 June for 2004-05 to 2008-09 also varied across jurisdictions (figure 15.13(c)).

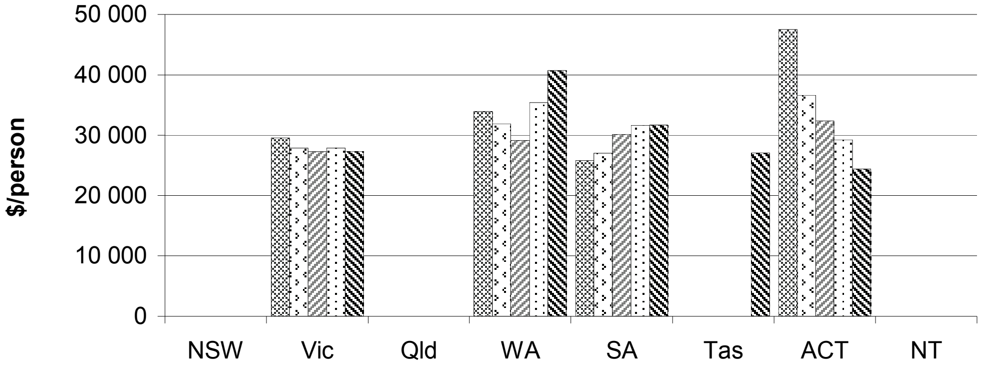
Figure 15.13 **Out-of-home care efficiency indicators (2008-09 dollars)**[a, b]

▩ 2004-05　　⁚ 2005-06　　▨ 2006-07　　⁚ 2007-08　　▧ 2008-09

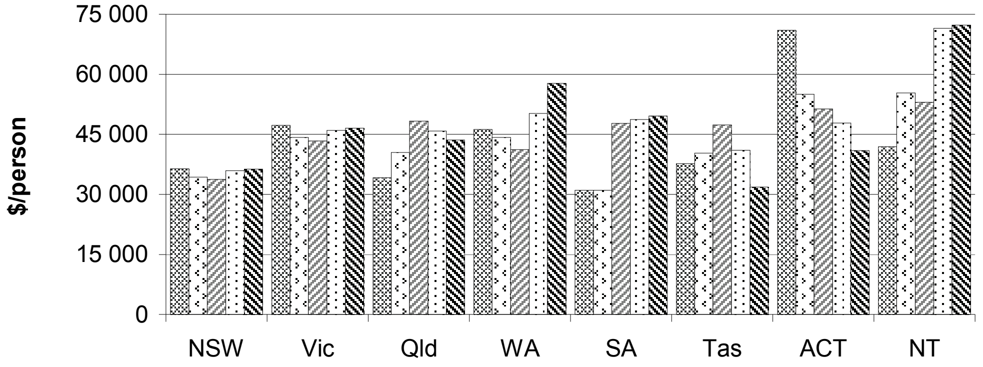
(a) Annual real expenditure on residential out-of-home care per child in residential out-of-home care at 30 June



(b) Annual real expenditure on non-residential out-of-home care per child in non-residential out-of-home care at 30 June



(c) Annual real expenditure on all out-of-home care per child in out-of-home care at 30 June



---

[a] Real expenditure based on ABS gross domestic product price deflator (2008-09 = 100) (table AA.26). [b] NSW, Qld, and the NT could not disaggregate expenditure on out-of-home care into residential care and non-residential care. Tasmania could only disaggregate these data for 2008-09.

Source: State and Territory governments (unpublished); table 15A.3.

Outcomes

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

Improved safety — substantiation rate after decision not to substantiate

'Improved safety — substantiation rate after decision not to substantiate' is an indicator of governments' objective to reduce the risk of harm to children by appropriately assessing notifications of possible child protection incidents (box 15.25).

Box 15.25 **Improved safety — substantiation rate after decision not to substantiate**

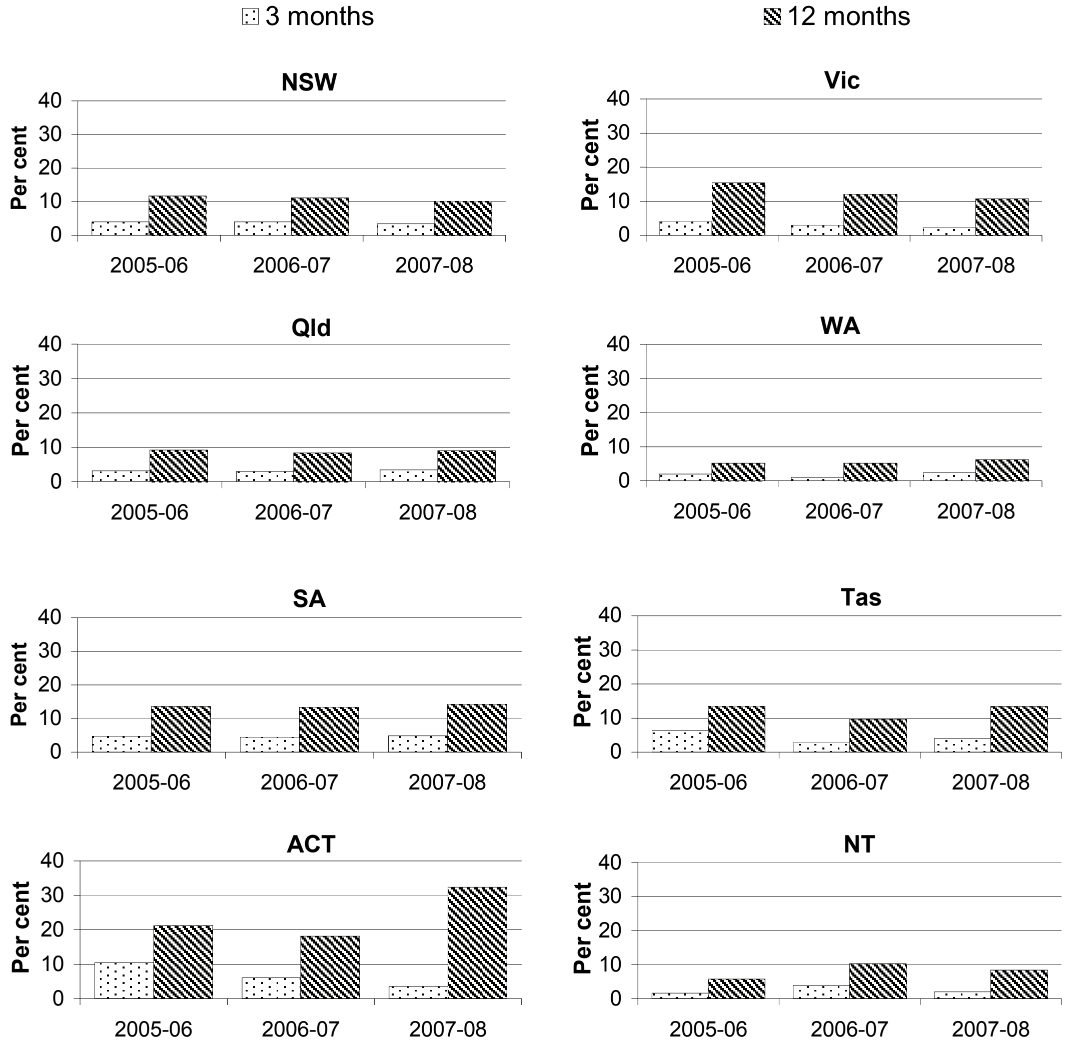
'Improved safety — substantiation rate after decision not to substantiate' is defined as the proportion of children who were the subject of an investigation in the previous financial year that led to a decision not to substantiate, and who were later the subject of a substantiation within 3 or 12 months of the initial decision not to substantiate. The year reported relates to the year of the initial decision not to substantiate.

A low or decreasing rate for this indicator is desirable. However, reported results can be affected by the finalisation of investigations, factors beyond the control of child protection services, or a change in circumstances after the initial decision not to substantiate was made. A demonstrable risk of harm might not have existed in the first instance. In addition, this indicator does not distinguish between subsequent substantiations which are related to the initial notification (that is, the same source of risk of harm) and those which are unrelated to the initial notification (that is, a different source of risk of harm). This indicator partly reveals the extent to which an investigation has not succeeded in identifying the risk of harm to a child who is subsequently the subject of substantiated harm. It also provides a measure of the adequacy of interventions offered to children to protect them from further harm. This indicator should be considered with other outcome indicators.

Data reported for this indicator are not directly comparable.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.14).

Figure 15.14 **Improved safety — substantiation rate within 3 and/or 12 months after a decision not to substantiate**[a, b, c, d]



---

[a] Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. [b] Jurisdictions have provided the denominator for this indicator for this Report. In previous reports the denominator was derived by the AIHW. [c] During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 may not be fully comparable to previous years' data. See source table 15A.54 for more details on these arrangements. [d] Data relating to substantiations after a decision not to substantiate in Tasmania for 2006-07 should be interpreted with care due to the high proportion of investigations in process at 31 August 2007.

Source: AIHW (unpublished), derived from *Child protection notifications, investigations and substantiations, Australia* data collection; tables 15A.9, 15A.37, 15A.54, 15A.71, 15A.88, 15A.105, 15A.122, 15A.139 and 15A.156.

Improved safety — resubstantiation rate

'Improved safety — resubstantiation rate' is an indicator of governments' objective to reduce the risk of harm and to prevent the recurrence of abuse and neglect or harm to children (box 15.26).

Box 15.26 **Improved safety — resubstantiation rate**

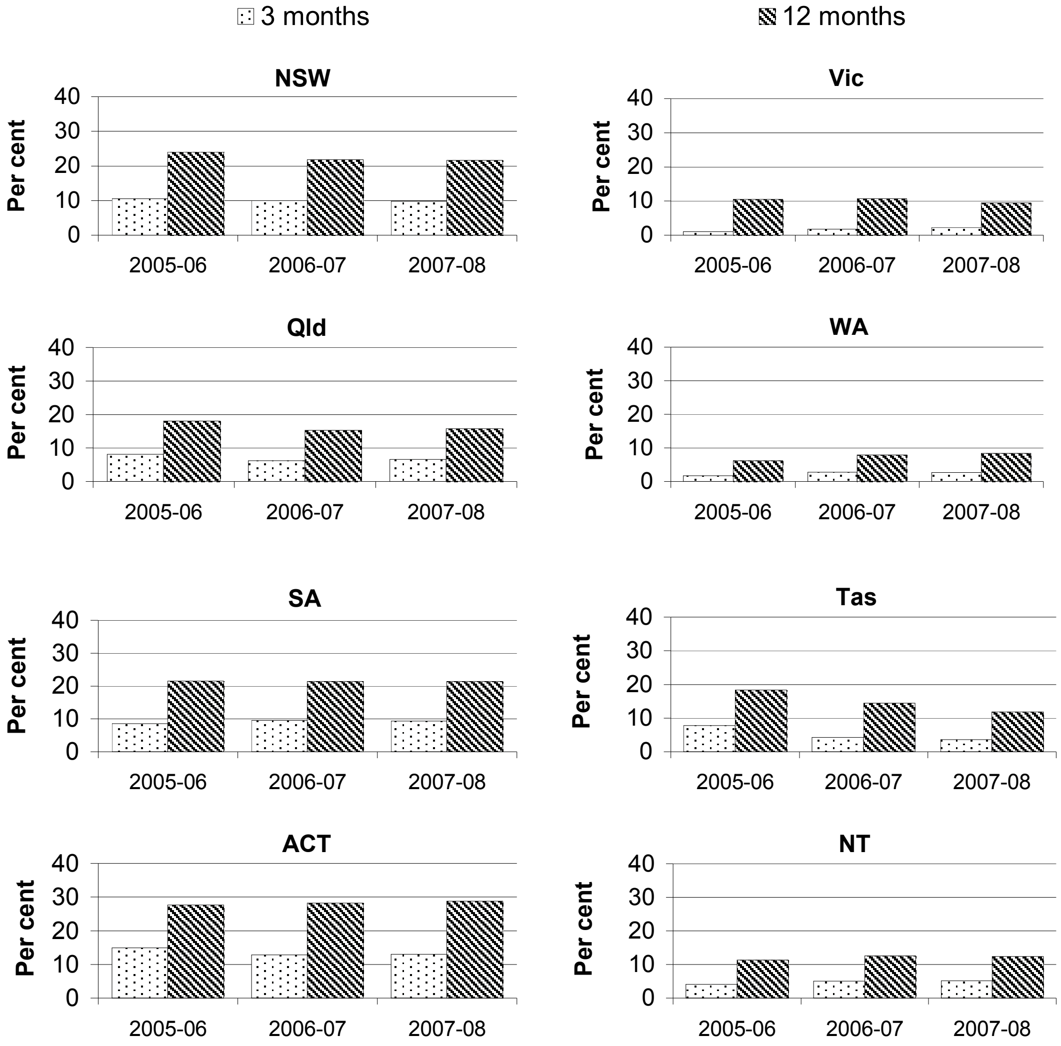
'Improved safety — resubstantiation rate' is defined as the proportion of children who were the subject of a substantiation in the previous financial year, who were subsequently the subject of a further substantiation within the following 3 or 12 months. The year reported relates to the year of the original substantiation.

A low or decreasing rate for this indicator is desirable. This indicator partly reveals the extent to which intervention by child protection services has succeeded in preventing further harm. However, reported results can be affected by the finalisation of investigations or factors beyond the control of child protection services, such as changes in the family situation (for example, illness, unemployment or a new partner). In addition, this indicator does not distinguish between subsequent substantiations that are related to the initial notification (that is, the same source of risk of harm) and those that are unrelated to the initial notification (that is, a different source of risk of harm). This indicator should be considered with other outcome indicators.

Data reported for this indicator are not directly comparable.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.15).

Figure 15.15 **Improved safety — resubstantiation rate within 3 and/or 12 months after a substantiation**[a, b, c, d]



---

[a] Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. [b] Jurisdictions provided the denominator for this indicator for the 2009 Report onwards. In reports prior to the 2009 Report, the denominator was derived by the AIHW. [c] During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 may not be fully comparable to previous years' data. See source table 15A.55 for more details on these arrangements. [d] Data relating to resubstantiations in Tasmania for 2006-07 should be interpreted with care due to the high proportion of investigations in process at 31 August 2007.

Source: AIHW (unpublished), derived from *Child protection notifications, investigations and substantiations, Australia* data collection; tables 15A.10, 15A.38, 15A.55, 15A.72, 15A.89, 15A.106, 15A.123, 15A.140 and 15A.157.

Improved education, health and wellbeing of the child

'Improved education, health and wellbeing of the child' is an indicator of governments' objective to maximise children's life chances by ensuring children in care have their educational, health and wellbeing needs met (box 15.27).

Box 15.27 **Improved education, health and wellbeing of the child**

'Improved education, health and wellbeing of the child' is defined as the change over time in the learning outcomes for children on guardianship or custody orders.

An increase in learning outcomes over time for children on guardianship or custody orders indicates that their educational outcomes are improving.

However, factors outside the control of protection and support services can also influence the educational outcomes of children on guardianship or custody orders, and care needs to be exercised when interpreting results. Further, the change over time in the learning outcomes for children on guardianship or custody orders is a partial measure of this outcome indicator.

Data reported for this indicator are not complete.

For the 2010 Report, data were reported on the proportion of children in years 3, 5 and 7 on guardianship or custody orders (attending government schools) achieving the national reading and numeracy benchmarks in 2003, relative to all children (attending government and non-government schools) achieving these benchmarks over the same period. The proportion of children on guardianship or custody orders achieving national reading and numeracy benchmarks in 2003 varied significantly across jurisdictions for which data were available (see tables 15A.11–15A.13). Information on the learning outcomes for these children is not available at a later point in time, therefore changes over time are not able to be reported.

Additional data on educational outcomes will be collected for children on guardianship or custody orders in 2004, 2005 and 2006. The longitudinal component of this study will assess any change in academic performance over time for children who were continuously on guardianship or custody orders for a two-year period (between 2003–2005 and 2004–2006). These data are anticipated to be available for the 2011 Report.

Safe return home

'Safe return home' is an indicator of governments' objective to remove the risk of harm to the child while maintaining family cohesion (box 15.28).

Box 15.28 **Safe return home**

‘Safe return home’ is yet to be defined.

For children who cannot be protected within their family and are removed from home, often the best outcome is when effective intervention to improve their parents’ skills or capacity to care for them enables them to return home.

This indicator has been identified for development and reporting in future.

Permanent care

‘Permanent care’ is an indicator of governments’ objective to provide appropriate care for children who cannot be safely reunified with their families (box 15.29).

Box 15.29 **Permanent care**

‘Permanent care’ is yet to be defined.

Appropriate services are those that minimise the length of time before stable, permanent placement is achieved.

This indicator has been identified for development and reporting in future.

15.4 Future directions in child protection and out-of-home care services performance reporting

Improving national child protection data

The Performance and Data Working Group (previously the National Child Protection and Support Services working group) has initiated a number of national projects to improve the gaps in child protection reporting and to monitor the comparability of child protection data. Such projects, approved by the National Community Services Information Management Group (NCSIMG) and funded by the Community and Disability Services Ministerial Council (CDSMC), include: *Educational Outcomes for Children on Orders*; *Treatment and Support Services*; *National Foster Carers Data Collection*; and, *Comparability of Child Protection Data*. It is expected that these projects will enable improved child protection reporting.

COAG developments

National framework for protecting Australia's children 2009—2020

In May 2008, the Australian Government released a discussion paper for consultation, *Australia's children, safe and well: A national framework for protecting Australia's children*. The discussion paper was developed by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) to canvass options for a national framework for protecting Australian children. Comments on the discussion paper were invited up until 30 June 2008. During this time, the Australian Government received almost 200 submissions. Consultations were also held across Australia. On 30 April 2009, COAG endorsed the final framework, *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020* ("the National Framework").

The National Framework argues that Australia needs to move from seeing 'protecting children' as a response to abuse and neglect to one of promoting the safety and wellbeing of children. The National Framework is intended to deliver a more integrated response to protecting Australia's children and emphasises the role of government, the non-government sector, and the community in promoting the safety and wellbeing of children.

The National Framework does not change the responsibilities of governments. State and Territory governments retain responsibility for statutory child protection and the Australian Government retains responsibility for providing income support payments.

The National Framework's main goal is to ensure that Australia's children and young people are safe and well. To measure this high-level outcome, the National Framework sets the following target: a substantial and sustained reduction in child abuse and neglect in Australia over time.

To demonstrate progress towards achieving the target of a substantial and sustained reduction in child abuse and neglect over time, the National Framework sets out four key measures:

1. Trends in key national indicators of children's health, development and wellbeing.
2. Trends in hospital admissions and emergency department visits for neglect and injuries to children under three years.
3. Trends in substantiated child protection cases.

4. Trends in the number of children in out-of-home care.

The National Framework also identifies six supporting outcomes which are designed to focus efforts and actions under the National Framework in progress towards the high level outcome of ensuring Australia's children and young people are safe and well. The six supporting outcomes are:

1. Children live in safe and supportive families and communities.
2. Children and families access adequate support to promote safety and intervene early.
3. Risk factors for child abuse and neglect are addressed.
4. Children who have been abused or neglected receive the support and care they need for their safety and wellbeing.
5. Indigenous children are supported and safe in their families and communities.
6. Child sexual abuse and exploitation is prevented and survivors receive adequate support.

The National Framework acknowledges the inherent difficulties in measuring the specific impact of services and interventions on high-level social outcomes. As such, the National Framework contains a broad suite of indicators ("indicators of change"), which will be reported on annually in order to measure progress over the life of the National Framework (2009–2020).

The Report's child protection and out-of-home care performance indicator framework already includes and reports upon several National Framework performance indicators. In addition, the Steering Committee has previously identified developments for the Report's child protection and out-of-home care performance indicator framework which are complementary to many of the measures in the National Framework. In further developing the Report's child protection and out-of-home care performance indicator framework, the Steering Committee will reflect and report consistently with applicable National Framework developments.

Report on Government Services alignment with National Agreement reporting

It is anticipated that future editions of this chapter will align with applicable National Agreement indicators, including the National Indigenous Reform Agreement (NIRA). Further alignment between the Report and National Agreement indicators, and other reporting changes, might result from future developments in National Agreement and National Partnership reporting.

Outcomes from review of Report on Government Services

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the Intergovernmental Agreement on Federal Financial Relations.

No significant changes from this review are reflected in the 2010 Report. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 Report.

15.5 Profile of juvenile justice services

Service overview

Juvenile justice systems are responsible for attending to young people (predominantly aged 10–17 years) who have committed or allegedly committed an offence while considered by law to be a juvenile. In so doing, juvenile justice systems aim to promote community safety and reduce youth offending by assisting young people to address their offending behaviour and take responsibility for the effect their behaviour has on victims and the wider community.

The juvenile justice system in each State and Territory comprises:

- police, who are usually a young person's first point of contact with the system
- courts (usually a special children's or youth court), where matters relating to the charges against young people are heard. The courts are largely responsible for decisions regarding bail, remand and sentencing
- statutory juvenile justice agencies, which are responsible for the supervision and case management of young people on a range of legal and administrative orders, and for the provision of a wide range of services aimed at crime prevention and reduction
- non-government and community service providers who may work with juvenile justice agencies to provide services and programs for young people under supervision.

The majority of young people who come into contact with the juvenile justice system do not become clients of statutory juvenile justice agencies. Instead, young people are diverted through a range of mechanisms including contact with police (who have the authority to issue warnings, formal cautions and infringement notices for minor offences) and the courts (which can issue non-supervised orders for minor offences).

The content in this chapter relates to the services provided by statutory juvenile justice agencies that are responsible for the supervision and case management of young people who have committed or allegedly committed an offence.

Most of the juvenile justice information contained in the 'size and scope' section of this chapter is sourced from the Juvenile Justice National Minimum Data Set (JJ NMDS), which is maintained by the Australian Institute of Health and Welfare (AIHW). However, in some cases, information is sourced directly from State and Territory governments.

The performance indicator data contained in section 15.6 are sourced directly from State and Territory governments (box 15.29).

Roles and responsibilities

Responsibility for the provision of juvenile justice services in Australia resides with State and Territory governments. The relevant department in each State and Territory responsible for funding and/or providing juvenile justice services in 2008-09 is listed in box 15.29. Each jurisdiction has its own legislation that determines the policies and practices of its juvenile justice system. While this legislation varies in detail, its intent is similar across jurisdictions. National coordination takes place through the Australasian Juvenile Justice Administrators (AJJA). AJJA is a Standing Committee of the Community and Disability Services Ministerial Advisory Council (CDSMAC).

Box 15.29 **Government departments responsible for the delivery of juvenile justice services**

NSW	Department of Juvenile Justice (DJJ)
VIC	Department of Human Services (DHS)
QLD	Department of Communities (DOC)
WA	Department of Corrective Services (DCS)
SA	Department for Families and Communities (DFC)
TAS	Department of Health and Human Services (DHHS)
ACT	Department of Disability, Housing and Community Services (DHCS)
NT	Department of Justice (DOJ)

Diversion of young offenders

Responsibility for administering the options available for diverting young people who have committed or allegedly committed relatively minor offences — warnings (informal cautions), formal cautions, and infringement notices — rests mainly with police in all jurisdictions. Responsibility for administering the diversionary processes available for more serious offences lies with juvenile justice authorities and courts. Comparable and extensive national data are not yet available to illustrate the nature or level of diversion undertaken by Australian jurisdictions. However, Police services (chapter 6) provides data on the number of juveniles who are diverted by police, as a proportion of all juvenile offenders formally dealt with by police (table 6A.42).

Funding

Comparable State and Territory governments’ expenditure data on juvenile justice services are not currently available. Comparable juvenile justice funding information is being developed for future Reports.

Size and scope

Clients of juvenile justice agencies

Most young people who are supervised by juvenile justice agencies are on community-based orders, which include supervised bail, probation and parole. During 2007-08, 12 102[1] young people experienced juvenile justice supervision in Australia. Of these young people, 10 948[2] experienced community-based supervision, 3945[3] experienced detention-based supervision, with some young people experiencing both (AIHW 2009a; NSW Government, unpublished).

Nationally, the majority of young people aged 10–17 years supervised by juvenile justice services were in the community (between 81.8 per cent and 95.8 per cent), (figure 15.16). These figures do not include any juveniles aged 10–17 years who were supervised in the adult correctional system.

These data were collected at a point in time, so they need to be interpreted with care, particularly for jurisdictions with smaller populations where a small change to the number of young people in detention can make a significant difference to their relative proportion.

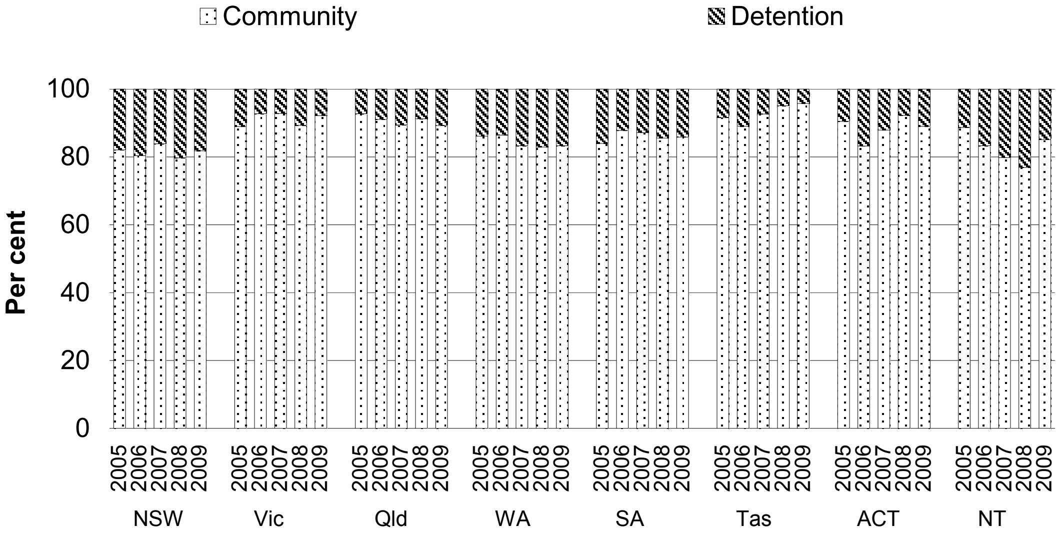
---

[1] The total number of young people who experienced juvenile justice supervision (12 102 young people) was reached by summing data sourced from the Juvenile Justice National Minimum Data Set (JJ NMDS) for all Australian States and Territories except NSW (9540 young people) and data sourced directly from the NSW Government (2562 young people).

[2] The total number of young people who experienced community-based juvenile justice supervision (10 948 young people) was reached by summing data sourced from the JJ NMDS for all Australian States and Territories except NSW (8592 young people) and data sourced directly from the NSW Government (2356 young people).

[3] The total number of young people who experienced detention-based supervision (3945 young people) was reached by summing data sourced from the JJ NMDS for all Australian States and Territories except NSW (3378 young people) and data sourced directly from the NSW Government (567 young people).

Figure 15.16 Proportion of juvenile justice clients aged 10–17 years who were supervised in the community and in detention centres, at 30 June[a, b, c, d]



[a] Includes only those young people who were under the supervision or case management of juvenile justice agencies on a pre- or post-sentence legal arrangement or order (for example, supervised bail, remand, a community services order, parole and detention). [b] Juvenile justice agencies have additional clients in detention and community supervision who are over 17 years of age. This figure does not include juvenile justice clients over 17 years of age at 30 June. [c] Clients can be on multiple orders at any one time. The distribution in the figure, therefore, is based not on order type but on where the client was located at 30 June. [d] Refer to table 15A.169 for detailed footnotes.

Source: AIHW unpublished (data supplied by State and Territory governments); table 15A.169.

Juvenile detention

As outlined above, the majority of juvenile offenders are supervised in the community. The following data sourced from the JJ NMDS and the Australian Institute of Criminology (AIC) relate to juvenile detention only (young people both on remand and sentenced). As jurisdictions have different definitions of a juvenile, this may affect the number and rates reported.

Nationally, the daily average number of people aged 10–17 years in juvenile detention centres increased from 590 to 814 between 2003-04 and 2007-08 (table 15.4).

Table 15.4 **Daily average population of people aged 10–17 years in juvenile detention (number)**[a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003-04	209	62	91	122	50	26	18	13	590
2004-05	218	53	89	110	58	33	15	22	596
2005-06	244	53	127	115	39	27	13	17	634
2006-07	277	48	138	132	42	19	14	26	696
2007-08	338	63	143	154	55	24	13	24	814

[a] Average based on population of juvenile detention centres on the last day of each quarter of the financial year. [b] Due to rounding, the Australian total may differ from the combined total of all jurisdictions. [c] Refer to table 15A.170 for detailed footnotes.

Source: AIHW Juvenile Justice National Minimum Data Set (JJ NMDS) (unpublished); AIC Juveniles in detention (unpublished); table 15A.170.

The average rate of detention of young people aged 10–17 years per 100 000 in the population aged 10–17 years increased from 26.8 per 100 000 in 2003-04 to 35.9 per 100 000 in 2007-08, with rates varying across jurisdictions (table 15A.171).

Nationally, females made up 8.5 per cent of the total population of juvenile detention centres at 30 June 2008. Males made up 91.5 per cent of the national population of juvenile detention centres at 30 June 2008 (table 15A.172).

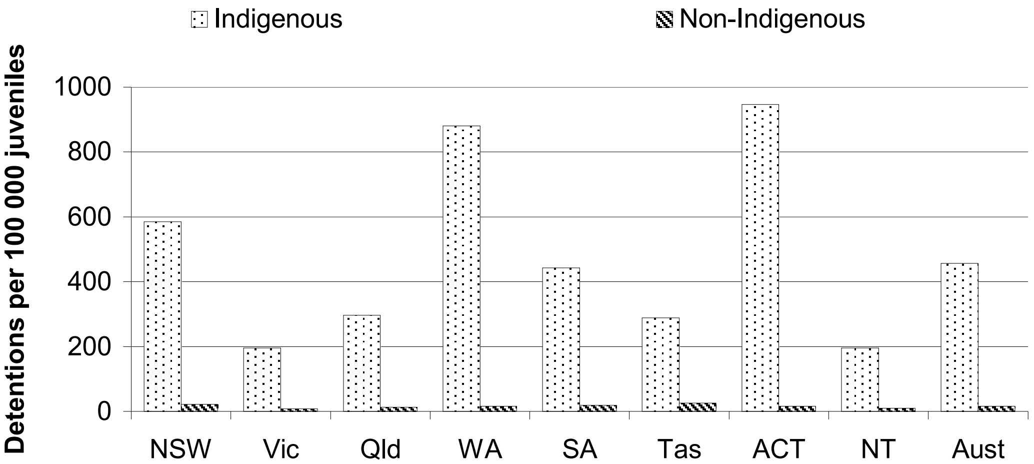
Numbers and rates of Indigenous young people placed in detention

The daily average number of Indigenous young people aged 10–17 years detained in juvenile detention centres was 469 in 2007-08 (table 15A.173). Nationally, the daily average detention rate for Indigenous people aged 10–17 years in 2007-08 was 456.1 per 100 000 Indigenous people aged 10–17 years. The rate for the non-Indigenous population aged 10–17 years in 2007-08 was 15.3 per 100 000 non-Indigenous people aged 10-17 years (table 15A.174).

Jurisdictional comparisons need to be treated with caution, especially for jurisdictions with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions.

The over-representation of Indigenous young people in detention across jurisdictions in 2007-08 is shown in figure 15.17.

Figure 15.17 **Average rate of detention of Indigenous and non-Indigenous people aged 10–17 years in juvenile detention, per 100 000 people, 2007-08[a, b]**



[a] Rates of detention for Indigenous and non-Indigenous people in NSW in each quarter in 2007-08 include young people in the care of both the NSW Department of Juvenile Justice and the Department of Corrective Services. [b] The ACT rate for Indigenous young people should be treated with caution due to the small Indigenous population in the ACT. The rate ratio at table 15A.174 should also be taken into account.

Source: AIHW JJ NMDS (unpublished); AIC Juveniles in detention (unpublished); table 15A.174.

15.6 Framework of performance indicators for juvenile justice services

The performance indicator framework for juvenile justice services is based on a set of shared government objectives (box 15.30).

Box 15.30 **Objectives for juvenile justice services**

Juvenile justice services aim to contribute to a reduction in the frequency or severity of youth offending, recognise the rights of victims and promote community safety. Juvenile justice services seek to achieve these aims by:

- assisting young people to address their offending behaviour and take responsibility for the effect their behaviour has on victims and the wider community
- enabling the interests and views of victims to be heard
- contributing to the diversion of young offenders to alternative services
- recognising the importance of the families and communities of young offenders, particularly Indigenous communities, in the provision of services and programs
- providing services that are designed to rehabilitate young offenders and reintegrate them into their community.

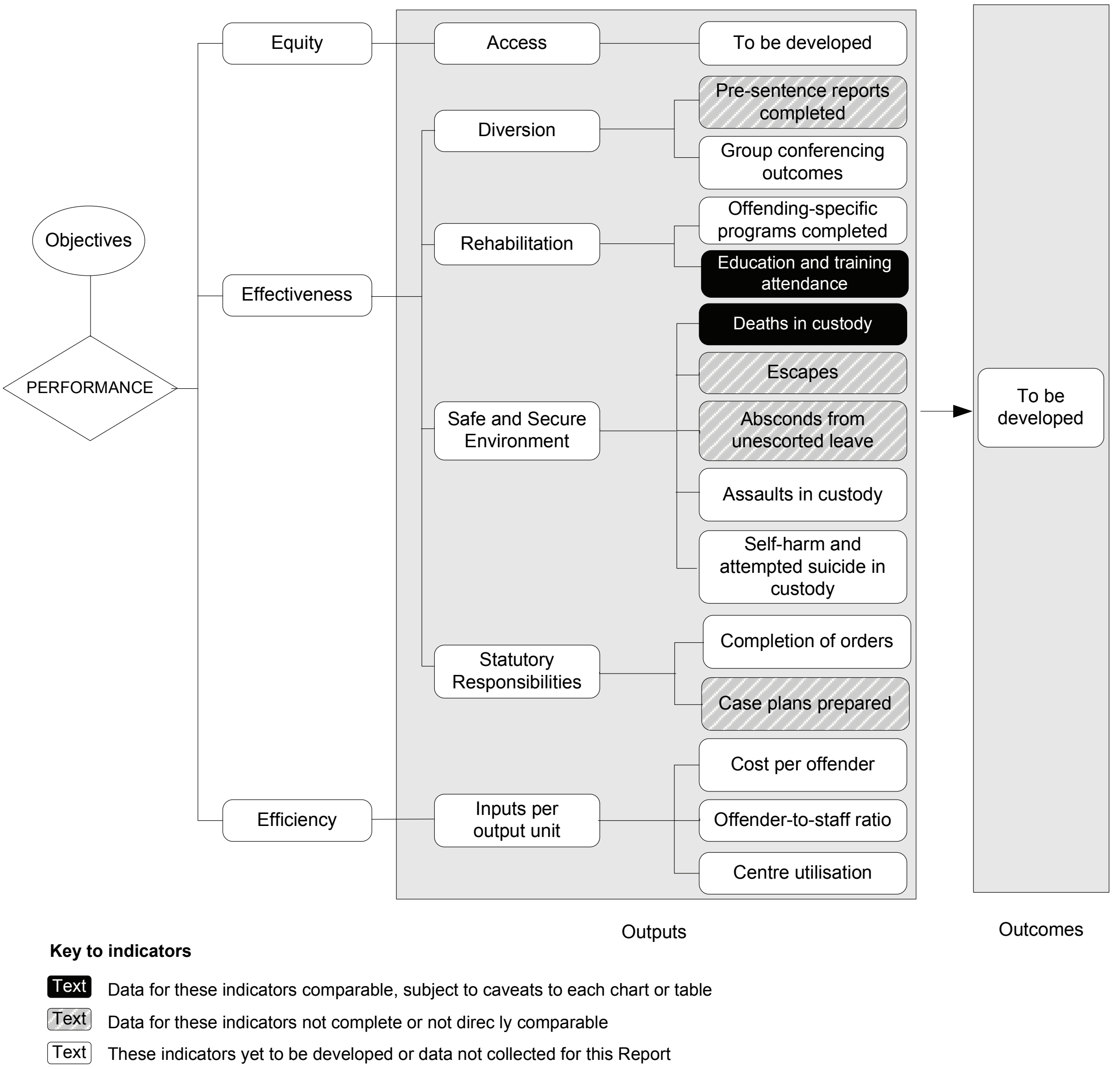
Juvenile justice services should be provided in an equitable, efficient and effective manner.

A performance indicator framework for juvenile justice services was included for the first time in the 2009 Report (figure 15.18). Further development of the framework and reporting for indicators included in the framework is being undertaken according to a staged process. Data for six performance indicators are included in this Report along with supporting text which includes relevant caveats and commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

This Report also includes new performance indicator boxes for seven other juvenile justice performance indicators. It is anticipated that data for these indicators will be available for the 2011 Report. The remaining performance indicators in the juvenile justice performance indicator framework, and additional efficiency and outcome indicators, will be developed for inclusion in future Reports.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 15.18 **Performance indicators for juvenile justice services**



Outputs

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

Equity and access

Equity and access indicators are a key area for further development in future reports. These will be indicators of governments' objective to ensure that all clients have fair and equitable access to services on the basis of relative need and available resources. These indicators are under development.

Effectiveness

Diversion — pre-sentence reports completed

Pre-sentence reports are written reports that provide a court with pertinent information to assist in sentencing. 'Pre-sentence reports completed' is an indicator of governments' objective to ensure that accurate and timely advice is provided to the court to inform decision-making (box 15.31).

Box 15.31 **Pre-sentence reports completed**

'Pre-sentence reports completed' is defined as the number of written reports provided by juvenile justice agencies to a court in response to a request for a pre-sentence report, as a proportion of all court requests to juvenile justice agencies for written pre-sentence reports.

A pre-sentence report provides a court with relevant information about the assessed factors that contributed to a young person's offence and explores programs and services that could be provided to address a young person's offending behaviour. A pre-sentence report is prepared when ordered by a court after a young person has pleaded or has been found guilty of an offence.

A high or increasing percentage of pre-sentence reports completed is desirable.

Data reported for this indicator are not complete.

The percentage of pre-sentence reports completed varied across jurisdictions (figure 15.19). Nationally, 97.7 per cent of all court requests for pre-sentence reports were completed.

Figure 15.19 Proportion of pre-sentence reports completed by juvenile justice agencies, 2008-09[a, b, c]

---

[a] Data were not available for SA and the NT. [b] Victoria was unable to provide (1) the number of court requests for pre-sentence reports during 2008-09 and (2) the number of reports provided by the juvenile justice agency. These data will be available for future Reports. For 2008-09, a total percentage was collected by surveying staff. [c] Refer to table 15A.176 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.176.

Diversion — group conferencing outcomes

Group conferences are decision-making forums that aim to minimise the progression of young people into the juvenile justice system, and provide restorative justice. 'Group conferencing outcomes' is an indicator of governments' objective to divert young people from the juvenile justice system and address their offending needs (box 15.32).

Box 15.32 **Group conferencing outcomes**

‘Group conferencing’ is defined as the number of young people who receive group conferencing and who as a result reach an agreement, as a proportion of all young people who receive group conferencing.

A high rate for this indicator is desirable.

Data for this indicator should be interpreted with caution as the provision of group conferencing differs across jurisdictions in relation to: (a) its place in the court process (for example, whether young people are referred by police before court processes begin, or by the court as an alternative to sentencing), (b) the consequences for young people if they do not comply with the outcome plans of a conference, and (c) eligibility for group conferencing.

Data for this indicator were not available for the 2010 Report. Group conferencing data are expected to be available for inclusion in the 2011 Report.

Rehabilitation — offending-specific programs completed

Offending-specific programs aim to address young offenders’ criminogenic behaviours to reduce their risk of re-offending. ‘Offending-specific programs completed’ is an indicator of governments’ objective of providing program interventions that are designed to rehabilitate young offenders and reintegrate them into their community (for example, Changing Habits and Reaching Targets program, drug counselling programs, sex offender treatment programs) (box 15.33).

Box 15.33 **Offending-specific programs completed**

‘Offending-specific programs completed’ is defined as the percentage of young people who completed an offending-specific program while completing a supervised sentenced order (whether a community-based order or a detention order) as a proportion of all young people completing a supervised sentenced order who were assessed as requiring an offending-specific program to address their criminogenic behaviour.

A high or increasing rate for offending-specific programs is desirable.

Data for this indicator were not available for the 2010 Report. Offending-specific programs data are expected to be available for inclusion in the 2011 Report.

Rehabilitation — education and training attendance

‘Education and training attendance’ is an indicator of governments’ objective to provide program interventions in education and training to rehabilitate young offenders and increase their chances of successfully re-integrating into the community (box 15.34).

Box 15.34 **Education and training attendance**

'Education and training attendance' is defined by two measures:

- the number of young people of compulsory school age in detention attending an education course, as a percentage of all young people of compulsory school age in detention
- the number of young people not of compulsory school age in detention attending an education or training course, as a percentage of all young people not of compulsory school age in detention.

Compulsory school age refers to individual State and Territory requirements for a young person to participate in school which are based primarily on age (see chapter 4 of the Report for further information).

Education or training course refers to school education or an accredited education or training course under the Australian Qualifications Framework.

Exclusions include young people not under juvenile justice supervision (for example, in police custody) and young people whose situation might exclude their participation in education programs (including young people who are: on temporary leave, work release, medically unable to participate, in isolation, and on remand or sentenced for less than 7 days).

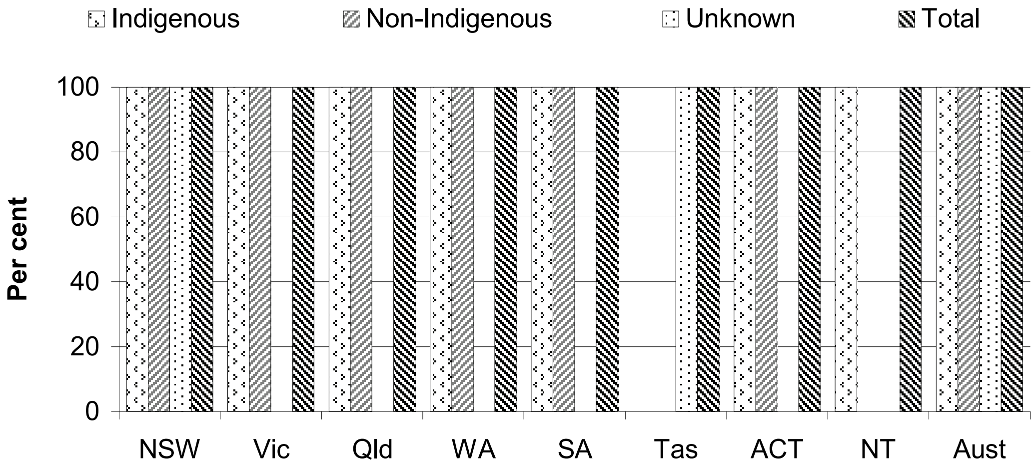
A high or increasing percentage of young people attending education and training is desirable.

Data reported for this indicator are not complete.

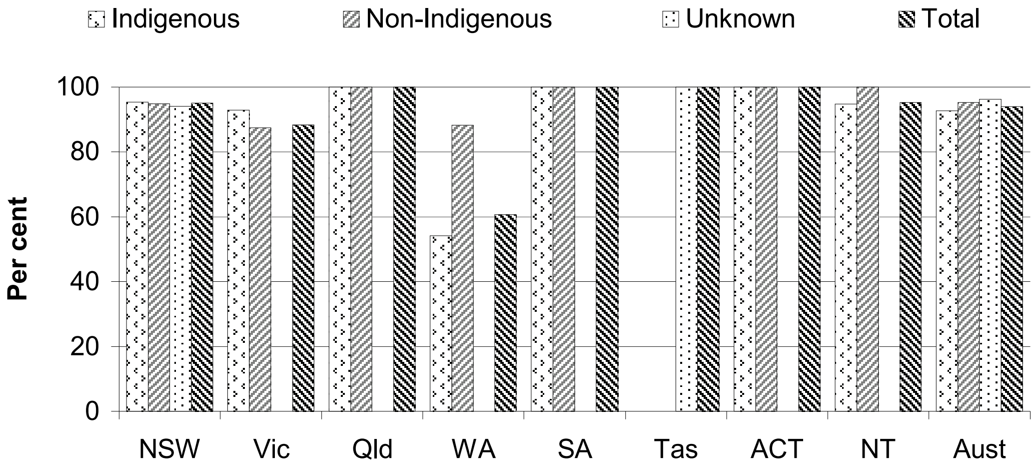
Nationally, all young people of compulsory school age in detention were attending education in 2008-09 (figure 15.20(a)). There was variation across jurisdictions in the proportion of young people *not* of compulsory school age attending an accredited education or training course. Nationally, 94.0 per cent of young people in detention not of compulsory school age were attending an accredited education or training course (figure 15.20(b)).

Figure 15.20 Proportion of young people in detention attending an accredited education or training course, 2008-09[a]

(a) School-aged young people in detention attending an education course



(b) Young people not of compulsory school age attending education or training



---

[a] Refer to table 15A.178 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.178.

Safe and secure environment — deaths in custody

'Deaths in custody' is an indicator of governments' objective to ensure that juvenile justice agencies provide a safe and secure environment for young people in custody (box 15.35).

Box 15.35 **Deaths in custody**

'Deaths in custody' is defined as the number of young people who died while in custody.

The scope of this indicator is restricted to those young people who died while in the legal and/or physical custody of a juvenile justice agency and those who died in, or en route to, an external medical facility as a result of becoming ill or being injured in custody (even if not escorted by juvenile justice agency workers).

A zero or decreasing deaths in custody rate is desirable.

Data reported for this indicator are comparable.

No young people died while in the legal or physical custody of an Australian juvenile justice agency in 2008-09 (table 15A.177).

Safe and secure environment — escapes

'Escapes' is an indicator of governments' objective to ensure that juvenile justice agencies provide a safe and secure environment for young people in custody, and the community (box 15.36).

Box 15.36 **Escapes**

'Escapes' is defined by two measures:

- the number of escapes from a juvenile justice detention centre, as a proportion of all young people in custody
- the number of escapes during periods of escorted movement, as a proportion of all periods of escorted movement.

An escape from a juvenile justice detention centre is defined as a breach of a secure perimeter or defined boundary of a juvenile justice detention centre by a young person under the supervision of the centre.

A period of escorted movement is defined as a period of time during which a young person is in the custody of the juvenile justice agency while outside a detention centre. The period of escorted movement ends when the young person is returned to the detention centre, or is no longer in the legal or physical custody or the juvenile justice agency. An escape from an escorted movement is defined as the failure of a young person to remain in the custody of a supervising juvenile justice worker or approved service provider during a period of escorted movement.

(Continued on next page)

Box 15.36 **(Continued)**

An escape is counted each time a young person escapes. For example, if a young person escapes three times in a counting period, three escapes are recorded. If three young people escape at the same time, three escapes are recorded.

A zero escape rate is desirable.

Data reported for this indicator are not complete.

Nationally, there was a total of 4 escapes from juvenile justice detention in 2008-09, which was equivalent to 0.1 escapes per 10 000 young people in juvenile justice detention in 2008-09 (table 15.5).

Table 15.5 **Rate and number of escapes from juvenile justice detention centres, by Indigenous status, 2008-09**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Rate per 10 000 detainees									
Indigenous	0.4	–	–	–	–	–	–	–	0.2
Non-Indigenous	0.1	–	–	–	–	–	–	–	0.1
Unknown	–	–	..	–	–	..	..	..	–
Total	0.3	–	–	–	–	–	–	–	0.1
Number of escapes									
Indigenous	3.0	–	–	–	–	–	–	–	3.0
Non-Indigenous	1.0	–	–	–	–	–	–	–	1.0
Unknown	–	–	–	–	–	–	–	–	–
Total	4.0	–	–	–	–	–	–	–	4.0

[a] Refer to table 15A.179 for detailed footnotes. .. Not applicable. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.179.

Nationally, there was a total of 5 escapes from escorted movements in 2008-09, which was equivalent to 3.0 escapes per 10 000 periods of escorted movement in 2008-09 (table 15.6). The number of escapes from escorted movement in 2008-09 varied across jurisdictions.

Table 15.6 **Rate and number of escapes from escorted movement, by Indigenous status, 2008-09**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Rate per 10 000 periods of escorted movement									
Indigenous	–	–	–	–	10.2	–	–	na	1.5
Non-Indigenous	5.3	–	–	–	–	na	–	na	4.6
Unknown	–	..	..	..	..	–	–	–	–
Total	3.0	–	–	–	3.6	28.1	–	–	3.1
Number of escapes									
Indigenous	–	–	–	–	1.0	–	–	na	1.0
Non-Indigenous	2.0	–	–	–	–	2.0	–	na	4.0
Unknown	–	–	–	–	–	–	–	–	–
Total	2.0	–	–	–	1.0	2.0	–	–	5.0

[a] Refer to table 15A.179 for detailed footnotes. **na** Not available. .. Not applicable. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.179.

Safe and secure environment — absconds from unescorted leave

'Absconds from unescorted leave' is an indicator of governments' objective to appropriately manage young people while they are in the legal custody of a juvenile justice detention centre (box 15.37).

This includes the provision of appropriate assessment, planning and supervision to enable young people to undertake unescorted temporary leave from detention centres. Unescorted leave may be undertaken for the purposes of providing rehabilitation interventions and activities such as education, training and employment.

Box 15.37 **Absconds from unescorted leave**

'Absconds from unescorted leave' is defined as the number of young people who have unescorted temporary leave and fail to return to custody, as a proportion of all young people who have unescorted temporary leave.

A zero or low, or decreasing rate of absconds from unescorted leave is desirable.

Data reported for this indicator are not complete.

Nationally, there were no absconds from unescorted leave in 2008-09 (table 15A.180). There were no periods of unescorted leave in Queensland and Western Australia.

Safe and secure environment — assaults in custody

'Assaults in custody' is an indicator of governments' objective to provide a custodial environment that is safe and secure in order to rehabilitate young offenders and reintegrate them into their community (box 15.38).

Box 15.38 **Assaults in custody**

'Assaults in custody' is defined as the rate of detainees and staff members who sustain an injury or who are sexually assaulted as a result of an assault perpetrated by one or more detainees, as a proportion of the number of detainees in custody.

A zero or low, or decreasing assaults in custody rate is desirable.

Data for this indicator were not available for the 2010 Report. Assaults in custody data are expected to be available for inclusion in the 2011 Report.

Safe and secure environment — self-harm and attempted suicide in custody

'Self-harm and attempted suicide in custody' is an indicator of governments' objective to provide a custodial environment that is safe and secure in order to rehabilitate young offenders and reintegrate them into their community (box 15.39).

Box 15.39 **Self-harm and attempted suicide in custody**

'Self-harm and attempted suicide in custody' is defined as the number of incidents of self-harm and attempted suicide in custody as a proportion of the number of detainees in custody.

A zero or low, or decreasing self-harm and attempted suicide in custody rate is desirable.

Data for this indicator were not available for the 2010 Report. Self-harm and attempted suicide data are expected to be available for inclusion in the 2011 Report.

Statutory responsibilities — completion of orders

'Completion of orders' is an indicator of governments' objective to effectively rehabilitate young offenders and reintegrate them into their community (box 15.40).

Box 15.40 **Completion of orders**

‘Completion of orders’ is defined as the proportion of sentenced community-based supervised orders successfully completed. An order is considered to be successfully completed where the earliest order expiry date or the order termination date is reached and breach is neither pending nor finalised.

A high or increasing proportion of orders successfully completed is desirable. However, where offenders are non-compliant and pose a risk, breach action (an unsuccessful completion) may be warranted. As a result, a completion rate less than 100 per cent may not necessarily indicate poor performance, and may reflect appropriate supervision of young people on community-based supervision orders.

Data for this indicator were not available for the 2010 Report. Completion of orders data are expected to be available for inclusion in the 2011 Report.

Statutory responsibilities — case plans prepared

‘Case plans prepared’ is an indicator of governments’ objective to ensure that juvenile justice agencies support young people to minimise the likelihood of re-offending by addressing their offending-related needs (box 15.41).

Box 15.41 **Case plans prepared**

‘Case plans prepared’ is defined as the number of eligible young people who had a documented case plan prepared or reviewed within six weeks of commencing:

- a sentenced detention order, as a proportion of all young people commencing a sentenced detention order
- a sentenced community-based order, as a proportion of all young people commencing a sentenced community-based order.

An eligible young person is one who is serving a sentenced order that requires case management.

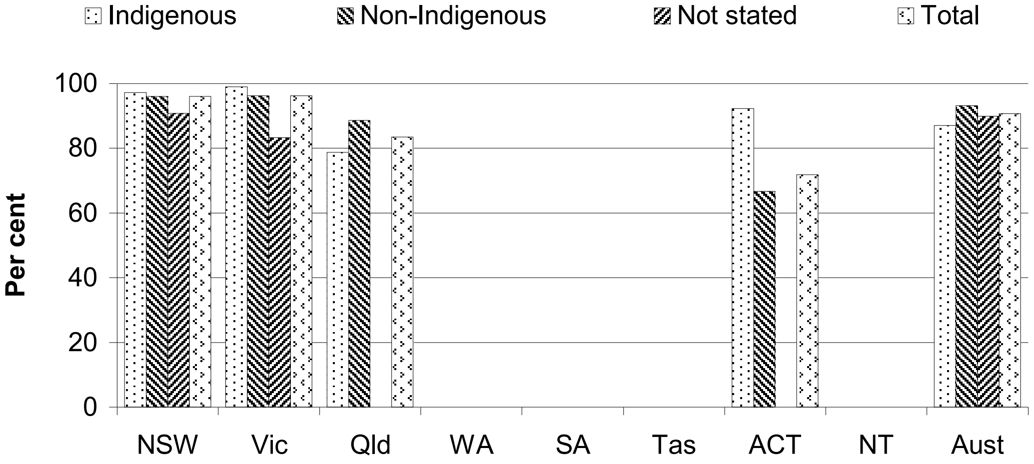
A high or increasing rate of case plans prepared is desirable.

Data reported for this indicator are not complete.

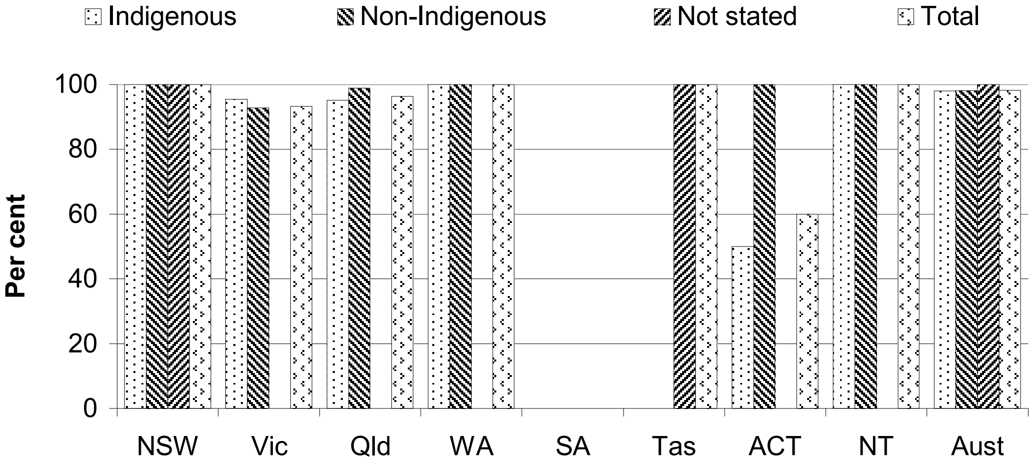
Nationally, 90.7 per cent of case plans were prepared within six weeks of commencing a sentenced community-based order in 2008-09 (figure 15.21(a)). Nationally, 98.2 per cent of case plans were prepared within six weeks of commencing a sentenced detention order in 2008-09 (figure 15.21(b)). Proportions varied across jurisdictions.

Figure 15.21 Proportion of case plans prepared within 6 weeks of commencing sentenced detention orders and sentenced community-based orders, by Indigenous status, 2008-09[a]

(a) Proportion of case plans prepared within 6 weeks of commencing a sentenced community-based order[b]



(b) Proportion of case plans prepared within 6-weeks of commencing a sentenced detention order[c]



---

[a] Refer to table 15A.181 for detailed footnotes. [b] Data for case plans prepared within 6 weeks of commencing a sentenced community-based order were not available for WA, SA, Tasmania and the NT. [c] Data for case plans prepared within 6 weeks of commencing a sentenced detention order were not available for SA.

Source: State and Territory governments (unpublished); table 15A.181.

Efficiency

Cost per offender

'Cost per offender' is an indicator of governments' objective to provide juvenile justice services in an efficient manner (box 15.42).

Box 15.42 **Cost per offender**

'Cost per offender' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Offender-to-staff ratio

'Offender-to-staff ratio' is an indicator of governments' objective to provide juvenile justice services in an efficient manner (box 15.43).

Box 15.43 **Offender-to-staff ratio**

'Offender-to-staff ratio' comprises two measures: (1) the number of young people requiring community-based supervision relative to the number of community-based staff, and (2) the number of young people in detention relative to the number of detention centre staff.

The number of staff relative to (1) the number of young people requiring community-based supervision; and (2) the number of young people in detention provides a measure of efficient resource management by juvenile justice agencies. A high ratio suggests better performance towards achieving efficient resource management. However, this indicator needs to be interpreted with caution as a lower ratio of staff to young people may result in more effective performance, particularly with high risk young offenders who possess significant offence-related needs. Further, in some cases, efficiencies may not be able to be realised due to remote geographic locations that limit opportunities to reduce overheads through economies of scale.

Data for this indicator were not available for the 2010 Report. Offender-to-staff ratio data are expected to be available for inclusion in the 2011 Report.

Centre utilisation

'Centre utilisation' is an indicator of governments' objective to provide juvenile justice services in an efficient manner (box 15.44).

Box 15.44 **Centre utilisation**

Centre utilisation is defined as the number of detainees in detention centres as a proportion of the number of permanently funded beds. This indicator partially measures both effective and efficient performance.

Detention centres operating at higher capacities is desirable from an efficient resource management perspective. However, detention centres operating at or above capacity might be ineffective due to the consequences for rehabilitation when centres are over crowded. Centres also need to make provision for separately detaining various classes of young offenders (for example, boys and girls, offenders requiring different security levels, young people of different ages and young people on remand and sentenced). These factors require utilisation rates that are below full capacity.

This indicator also has application to the efficient use of publicly funded resources. Centres that are built at a point in time need to be able to justify significant under use, if that occurs in future years, where that under use cannot reasonably be explained by the factors listed above.

Data for this indicator were not available for the 2010 Report. Centre utilisation data are expected to be available for inclusion in the 2011 Report.

Outcomes

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

Outcome indicators for juvenile justice services are yet to be developed. The Steering Committee has identified outcome indicators as an important element of the juvenile justice performance indicator framework to develop for future reports.

15.7 Future directions in juvenile justice reporting

The Juvenile Justice Research and Information Group (JJ RIG), a working group of the AJJA, is responsible for developing national performance indicators for juvenile justice.

The indicators are being developed in three stages:

- Stage 1 indicators — data for stage 1 indicators are included in section 15.6. Reporting for some of these indicators is incomplete and will be subject to further refinement in future Reports.
- Stage 2 indicators — descriptions of stage 2 indicators are included in performance indicator boxes in section 15.6. Data for these indicators are expected to be included in the 2011 Report.
- Stage 3 indicators — the development of remaining equity, efficiency, and outcome indicators will follow the completion of stages 1 and 2.

Outcomes from review of Report on Government Services

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the Intergovernmental Agreement on Federal Financial Relations.

No significant changes from this review are reflected in the 2010 Report. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 Report.

15.8 Profile of supported accommodation and assistance services

Service overview

Supported accommodation and assistance services aim to assist people who are homeless or at imminent risk of becoming homeless as a result of a crisis, including women and children escaping domestic violence.

The Supported Accommodation Assistance Program (SAAP) was established in 1985 to bring homelessness programs funded by individual State and Territory governments and the Australian Government under one nationally coordinated program. The most recent program (SAAP V 2005-2010, but replaced on 1 January 2009) was governed by the *Supported Accommodation Assistance Act 1994*. The Act specified that the overall aim of SAAP was to provide transitional supported accommodation and related support services to assist people who are homeless to achieve self-reliance and independence. Within this broad aim, the goals of the SAAP program were to resolve crises, to re-establish family links where appropriate, and to re-establish a capacity to live independently of SAAP services.

As part of the SAAP program, non-government, community and local government agencies delivered a variety of services to clients, including supported accommodation, counselling, advocacy, links to housing, health, education and employment services, outreach support, brokerage and meals services, and financial and employment assistance.

In January 2008, the Australian Government announced its intention to develop a long-term national plan to reduce homelessness. As part of this process, the Australian Government released a Green Paper in May 2008 entitled *Which way home? A new approach to homelessness*. The Green Paper sought community input on possible strategies and initiatives to address homelessness in Australia (Commonwealth of Australia 2008a).

After extensive consultation, the Australian Government released a White Paper in December 2008 entitled *The road home: A national approach to reducing homelessness* (Australian Government 2008b). The White Paper set out two main goals: (1) to halve overall homelessness by 2020; and (2) to offer supported accommodation to all 'rough sleepers' who need assistance by 2020. The White Paper is supported by a new funding package under the *National Affordable Housing Agreement* (NAHA) released by the Council of Australian Governments (COAG) in November 2008 (COAG 2008). As a result of these reforms, the

SAAP V Multilateral Agreement (2005-2010) ended on 31 December 2008, with the NAHA and associated agreements and partnerships commencing 1 January 2009.

The NAHA provides a framework for the Australian Government and State and Territory governments to work together to improve housing affordability and homelessness outcomes for Australians. The objective of the NAHA is that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation. Under the NAHA, Australian governments are committed to:

- providing direction for a range of measures including: social housing; assistance to people in the private rental market; support and accommodation for people who are homeless or at risk of homelessness; and home purchase assistance
- working towards improving coordination across housing related programs to make better use of existing stock and under-utilised government assets and achieve better integration between housing and human services, including health and disability services
- reducing the rate of homelessness (COAG 2008).

SAAP data for 2007-08 are included in this Report. These data are not affected by the introduction of the NAHA in January 2009. Selected SAAP financial data are included for the period 1 July 2008 to 31 December 2008, when the SAAP V ended.

SAAP and the link with other services

Families and children in crisis are often subject to considerable stress, violence and transience, all of which have a negative impact on children. As a result, some children assisted by SAAP may have also had contact with child protection and out-of-home care services, or may have been subject to a current or past care and protection order. In 2007-08, 76 900 children accompanied a parent or guardian who received substantial SAAP support (AIHW 2009b).[4] Research using 2004-05 data indicates that in 40.5 per cent of support periods involving adults with accompanying children, domestic violence was the main reason SAAP support was sought (AIHW 2006b).

Close links also exist with other forms of housing assistance reported in the Housing chapter of the Report (chapter 16). Chapter 16 focuses on the performance

---

[4] The term ‘substantial’ in ‘substantial SAAP support’ is a term used in the SAAP data collection to denote SAAP support for a person defined as a SAAP client during a support period (see section 15.13 for definitions of SAAP ‘client’ and ‘support period’). It does not convey a measure of the number of distinct support services or duration of support.

of government in providing public housing, State owned and managed Indigenous housing (SOMIH), community housing, and financial assistance for crisis accommodation under the Commonwealth State Housing Agreement (CSHA). As the CSHA was subsumed by the NAHA on 1 January 2009, chapter 16 of this Report includes CSHA data from 1 July 2008 to 31 December 2008, and NAHA data from 1 January 2009 to 30 June 2009 (termed CSHA/NAHA data).

Some individuals and families utilised both SAAP services and services described in the Housing chapter, as people can move from homelessness to social housing, or might be in receipt of SAAP services and accommodated in social housing.[5] For example, in 2007-08, approximately 17.1 per cent of former SAAP clients, who requested assistance with obtaining or maintaining independent housing, had moved to public housing (table 15A.202).

Size and scope

Homelessness has multiple causes and can affect anyone (Australian Government 2008b). On census night in 2006, there were approximately 105 000 homeless people (Chamberlain and MacKenzie 2008). SAAP provided accommodation to approximately 19 per cent of the homeless population on Census night in 2006 according to the ABS Counting the Homeless 2006 report (ABS, 2008).

SAAP agencies provided a range of support services to various client groups comprising people who were homeless or at risk of homelessness. SAAP clients included families, single men and women, and unaccompanied children and young people. Nationally, in 2007-08, SAAP agencies provided support to 202 500 people (125 600 clients and 76 900 accompanying children) (AIHW 2009b).

At least 1562 agencies were funded under the SAAP program in 2007-08, including non-government, community and local government agencies (AIHW 2009b) (table 15A.183). Services were delivered in 2007-08 by SAAP agencies targeting:

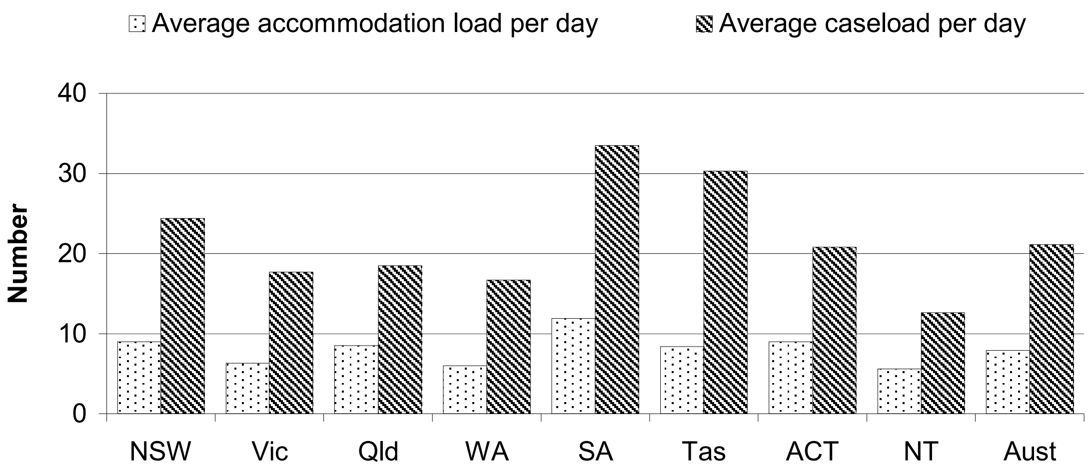
- young people (35.4 per cent of agencies)
- women escaping domestic violence (23.0 per cent)
- families (8.3 per cent)
- single men (6.5 per cent)
- single women (3.1 per cent)
- multiple client groups (23.6 per cent) (table 15A.183).

---

[5] Social housing is generally understood to include public and community housing. For further information on these forms of housing assistance, see chapter 16 (box 16.2).

The daily average accommodation load and caseload per agency was 7.9 and 21.1 respectively, and this varied across jurisdictions in 2007-08 (figure 15.22).

Figure 15.22 Average accommodation load and caseload per day, 2007—08[a]



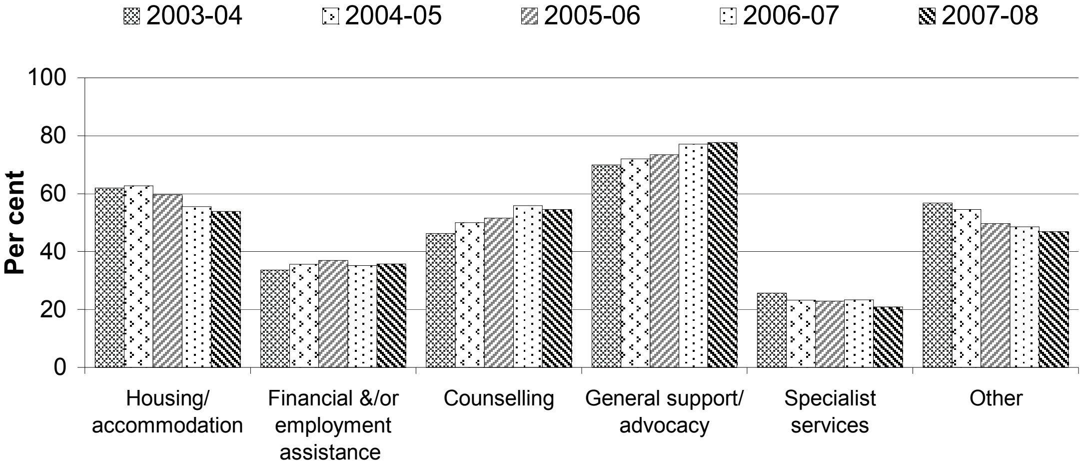
[a] See notes to table 15A.201 for descriptions of how accommodation load and caseload are estimated.

Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); table 15A.201.

SAAP agencies varied in their service delivery model. The most common models in 2007-08 were the provision of medium term to long term supported accommodation (41.2 per cent) and the provision of crisis or short term supported accommodation (30.9 per cent). SAAP agencies also provided services other than accommodation, such as outreach support, day support, and telephone information and referral. The proportions of agencies delivering particular service models remained relatively stable from 2003-04 to 2007-08 (table 15A.184).

Housing and accommodation services were provided in 53.9 per cent of support periods. General support and advocacy (77.6 per cent), counselling (54.5 per cent), financial and employment assistance (35.7 per cent), and specialist services (20.9 per cent) were also commonly provided. There has been some change in the proportions of types of services provided by SAAP agencies over time (figure 15.23). For example, in 2003-04, housing and accommodation constituted 62.0 per cent of support periods and counselling (formerly 'personal support') constituted 46.2 per cent.

Figure 15.23 **Services received during a SAAP support period**[a]



---

[a] Totals do not add to 100 per cent because agencies may provide more than one type of service during a single support period.

Source: SAAP National Data Collection Agency (NDCA), *Administrative Data and Client Collections* (unpublished); table 15A.182.

Roles and responsibilities

SAAP was jointly funded by the Australian, State and Territory governments. The Coordination and Development Committee (CAD) of senior Australian, State and Territory government officials oversaw the development and implementation of the program at the national level, including coordination of research, strategy, and other planning and development activities. State and Territory governments were responsible for the day-to-day management of the program, including the distribution of funding to SAAP funded agencies (box 15.45 contains a list of relevant departments in 2008-09). Non-government agencies delivered most SAAP services with some local government participation.

Box 15.45 Departments responsible for managing the Supported Accommodation and Assistance Program (SAAP)

NSW	Department of Community Services (DOCS) (now the Department of Human Services)
VIC	Department of Human Services (DHS)
QLD	Department of Communities (DOC)
WA	Department for Child Protection (DCP)
SA	Department for Families and Communities (DFC)
TAS	Department of Health and Human Services (DHHS)
ACT	Department of Disability, Housing and Community Services (DHCS)
NT	Department of Health and Families (DHF)
Aust	Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)

Funding

Recurrent funding of SAAP services for the period 1 July 2008 to 31 December 2008 was approximately $191.6 million (table 15A.186), of which the Australian Government contributed 50.1 per cent and State and Territory governments contributed 49.9 per cent (table 15A.185). From 2004-05 until 2007-08, the contribution from State and Territory governments increased as a proportion of the overall recurrent SAAP funding, remaining relatively stable between 2007-08 and 2008-09 (table 15A.185).

Nationally, real recurrent SAAP funding per head of population remained relatively stable from 2004-05 to 2008-09, noting that the funding per head of population provided for the period 1 July 2008 to 31 December 2008 is approximately half that recorded for previous financial years (table 15A.187). These figures varied across jurisdictions.

In 2008-09, in addition to the amounts determined in agreements between State and Territory governments and the Australian Government, some jurisdictions made recurrent allocations to SAAP services or SAAP-like activities (for example, to assist service viability). These additional funds are not included in the above figures.

15.9 Framework of performance indicators for supported accommodation and assistance services

The performance indicator framework for supported accommodation and assistance services is based on shared government objectives for SAAP services (box 15.46).

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations). The NAHA covers the area of housing and homelessness (previously SAAP) services, while the National Indigenous Reform Agreement (NIRA) establishes specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. The agreements include sets of performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC).

The measurement details of relevant National Agreement reporting were under development at the time of preparing this Report. It is anticipated that the performance indicator results reported in this chapter will be revised to align with the performance indicators in the National Agreements for the 2011 Report.

Box 15.46 **Objectives for SAAP services**

The overall aim of SAAP was to provide transitional supported accommodation and a range of related support services, to help people who are homeless or at imminent risk of homelessness to achieve the maximum possible degree of self-reliance and independence. Within this aim, the goals were to:

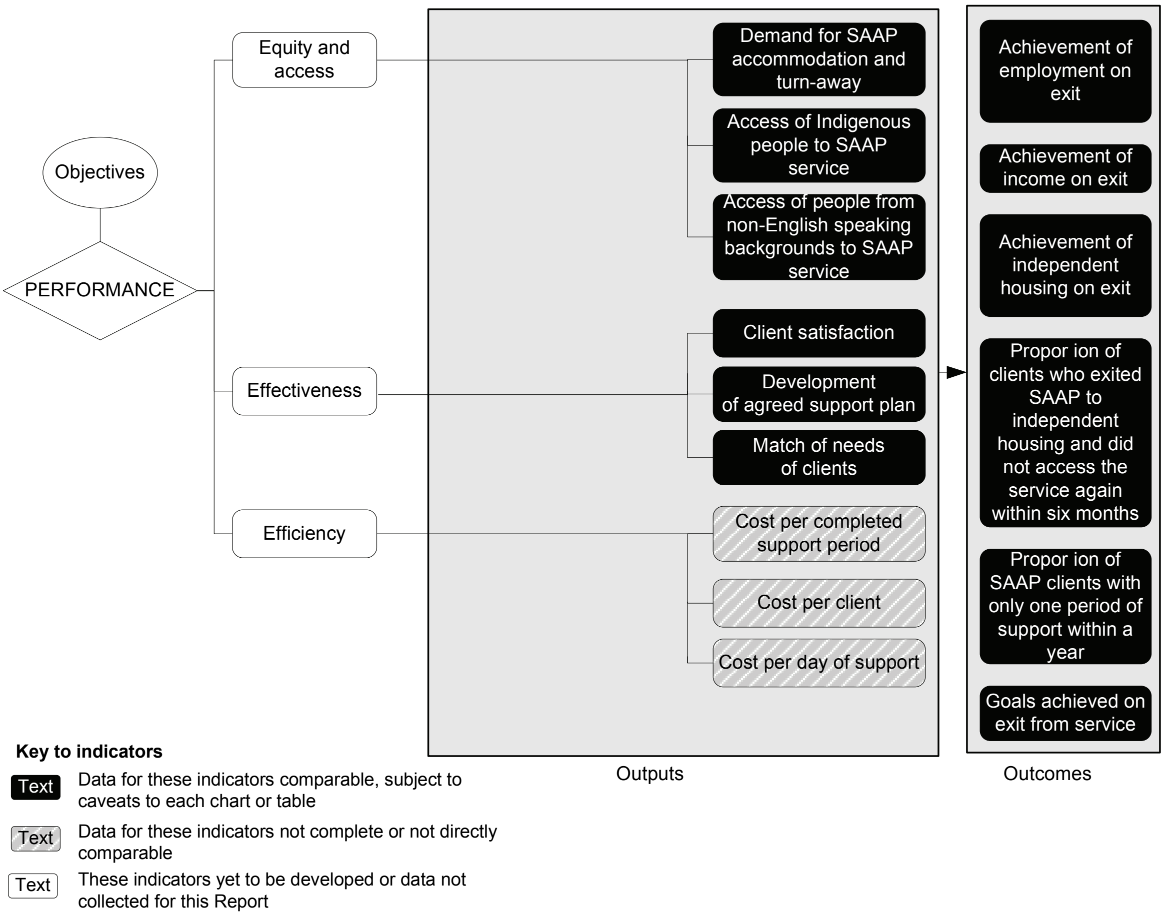
- resolve crises
- re-establish family links where appropriate
- re-establish the capacity of clients to live independently of SAAP.

SAAP services should be provided in an equitable and efficient manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of SAAP services (figure 15.24). The performance indicator framework shows which data are comparable in the 2010 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 15.24 **Performance indicators for SAAP services**



15.10 Key supported accommodation and assistance program performance indicator results

The SAAP data collection measures the number of clients and the number and types of services provided to clients, but is subject to limitations (box 15.47).

Box 15.47 **Information to be considered when analysing SAAP data**

- Informed consent is an essential component of the integrity of the data. The principle of client/consumer rights (which underpins informed consent) recognises that clients do not receive services under a mandatory order. They have the right to accept or reject the services offered and they have the right to provide or not provide information while receiving SAAP services.
- Nationally, in 2007-08, clients consented to provide personal details for the SAAP client collection in 88.6 per cent of support periods, while 92.1 per cent of agencies participated in the client collection. A weighting system has been developed to adjust for client non-consent and agency non-participation (AIHW 2009b).

Outputs

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

Equity and access

Demand for SAAP accommodation and turn-away

'Demand for SAAP accommodation and turn-away' is an indicator of governments' objective to ensure all Australians have equitable access to SAAP services on the basis of relative need (box 15.48).

Box 15.48 **Demand for SAAP accommodation and turn-away**

'Demand for SAAP accommodation and turn-away' is defined as the extent to which demand for accommodation is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation cannot be provided with that assistance (although one-off assistance might be provided). Two measures of the proportion of people whose valid request for immediate SAAP accommodation cannot be met are reported:

- turn-away as the proportion of people requiring new SAAP accommodation, defined as the average daily percentage of people who could not be accommodated relative to all people making valid requests for immediate SAAP accommodation. This provides an indication of a person's likelihood of obtaining SAAP accommodation.
- turn-away as the proportion of total demand for SAAP accommodation, defined as the average daily percentage of people who could not be accommodated relative to all people who required new and immediate SAAP accommodation or who were continuing their accommodation from the previous day. This provides a measure of the overall ability of SAAP to meet the demand for accommodation on an average day during the Demand for Accommodation Collection period.

A higher or increasing proportion of valid requests receiving accommodation is desirable.

Data reported for this indicator are comparable across jurisdictions. However, these data are not necessarily comparable over time due to different collection periods in different years.

Data for assessing access to SAAP services are sourced from the Demand for Accommodation Collection and the Client Collection. The Demand for Accommodation Collection measures the levels of met and unmet demand for SAAP accommodation by collecting information about requests for accommodation by individuals or groups over two weeks each year. These data are used in conjunction with Client Collection data to calculate the 'turn-away' rate for demand for SAAP accommodation.

The Demand for Accommodation Collection collects data on 'valid unmet requests' for immediate accommodation. 'Valid unmet requests' excludes requests made at an agency where the person or group making the request does not fall within an agency's target client group, where there is no fee-free accommodation available at that time[6], or where assistance offered by an agency is refused. For the Client Collection, the accommodation status of a client on a particular day is based on the reported periods of accommodation within a support period.

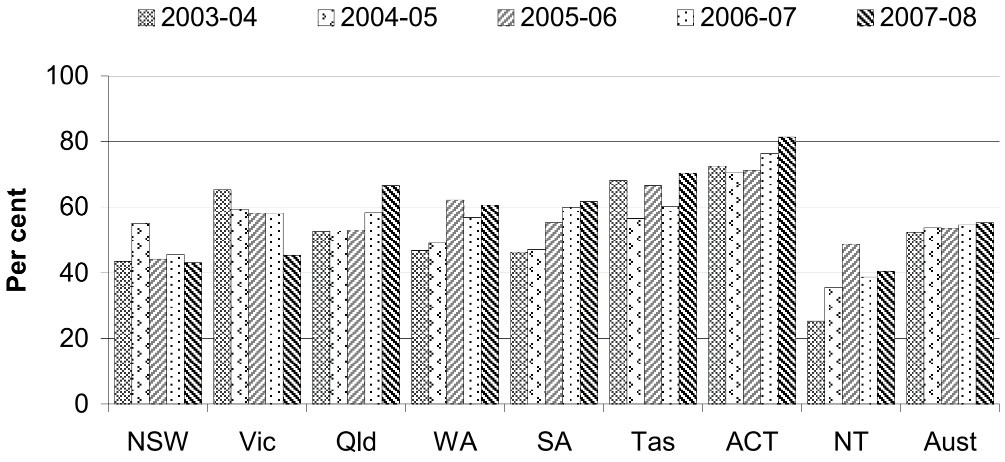
---

[6] 'No fee-free accommodation available' refers to situations where the person/group is not given accommodation because they cannot meet the financial requirements (for example, fees) for that accommodation.

Demand data may understate the activities of SAAP agencies as only data from agencies that participated in both the Client Collection and the Demand for Accommodation Collection are used in the calculations. Additionally, the two one-week sample periods over which data are collected might not be representative of the eventual success of clients accessing SAAP services over the full year (see notes to tables 15A.188-189).

Data on the proportion of people with valid requests for SAAP accommodation who were turned away are reported for the years 2003-04 to 2007-08. Nationally, 55.3 per cent of adults and unaccompanied children requesting immediate new SAAP accommodation on a given day were turned away in 2007-08. This proportion varied across jurisdictions (figure 15.25).

Figure 15.25 **Turn-away of adults and unaccompanied children as a proportion of people requiring new SAAP accommodation**[a, b, c, d]



---

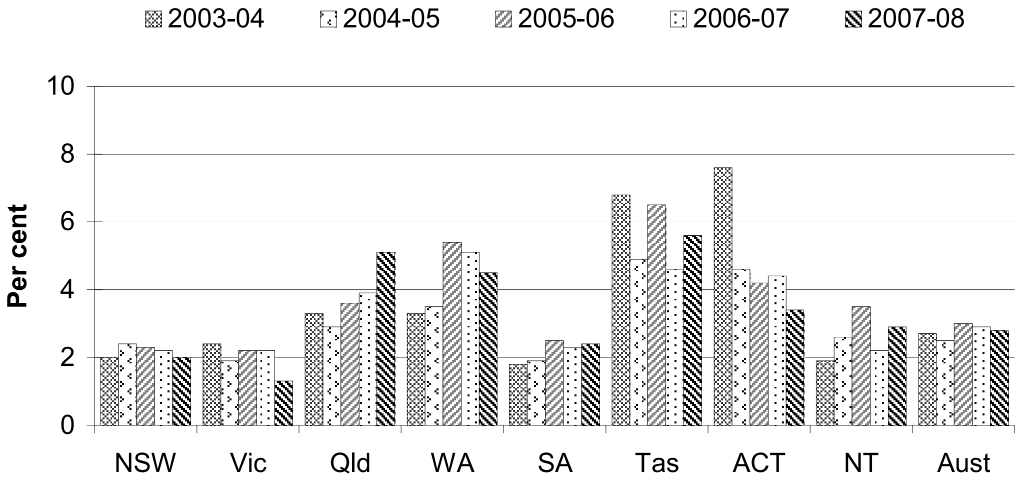
[a] A two-week Demand for Accommodation Collection is conducted annually to gather information about homeless people whose requests for accommodation were unable to be met by SAAP agencies. The collections were held in December and May, or August and May, of each financial year. [b] Comparisons between years should be treated with caution, due to variation in participation rates, differing imputation methods and because the collections were held on different dates each year. [c] The denominator for this indicator refers to adults and unaccompanied children. [d] See notes to table 15A.188 for more detailed data caveats.

Source: AIHW (2009) *Demand for SAAP accommodation by Homeless People 2007-08: A report from the SAAP national data collection.* SAAP NDCA report series 13. Cat. No. HOU 211; table 15A.188.

Nationally, the number of adults and unaccompanied children who made valid requests for SAAP accommodation but could not be accommodated accounted for 2.8 per cent of the total demand for SAAP accommodation in 2007-08 (total demand includes all accommodated adults and unaccompanied children) (figure 15.26). This proportion varied across jurisdictions.

The difference between (a) the percentage of people turned away on a given day as a proportion of total requests for new immediate SAAP accommodation on a given day (55.3 per cent) and (b) the percentage of people turned away on a given day as a proportion of total demand for SAAP accommodation suggests that SAAP agencies provide a significant number of clients with continuing accommodation.

Figure 15.26 **Turn-away of adults and unaccompanied children as the proportion of total demand for SAAP accommodation**[a, b, c, d]



[a] A two-week Demand for Accommodation Collection is conducted annually to gather information about homeless people whose requests for accommodation were unable to be met by SAAP agencies. The collections were held in December and May, or August and May, of each financial year. [b] Comparisons between years should be treated with caution, due to variation in participation rates, differing imputation methods and because the collections were held on different dates each year. [c] The denominator for this indicator refers to adults and unaccompanied children. [d] See notes to table 15A.189 for more detailed data caveats.

Source: AIHW (2009) *Demand for SAAP accommodation by Homeless People 2007-08: A report from the SAAP national data collection.* SAAP NDCA report series 13. Cat. No. HOU 211; table 15A.189.

Nationally, requests for SAAP accommodation were not met for a number of reasons in 2007-08, including lack of available accommodation (59.0 per cent), no vacancies at the referral agency (24.0 per cent), type of accommodation requested is not provided (7.8 per cent) and insufficient staff (1.3 per cent) (table 15A.197).

Access of Indigenous people to SAAP service

'Access of Indigenous people to SAAP service' is an indicator of governments' objective to ensure all Australians have equitable access to SAAP services on the basis of relative need (box 15.49).

Box 15.49 **Access of Indigenous people to SAAP service**

‘Access of Indigenous people to SAAP service’ is defined as the comparison between the representation of Indigenous people among all people whose valid requests for SAAP accommodation were unmet and their representation among SAAP clients who were accommodated during the year.

A high proportion of valid requests receiving assistance is desirable.

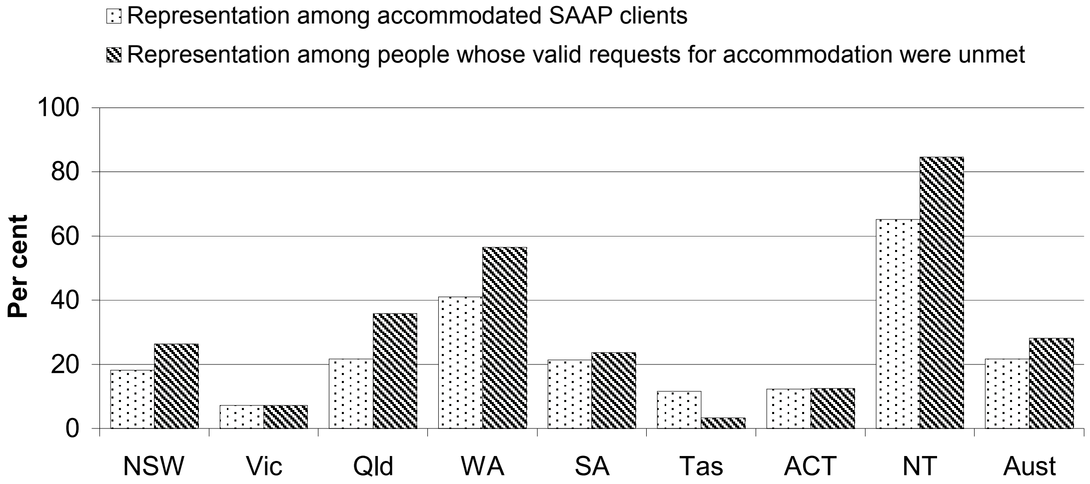
The indicator measures the extent to which the demand for assistance from Indigenous people is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation, or support, cannot be provided with that assistance (although one-off assistance might be provided).

Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as Indigenous people) is particularly important.

Data reported for this indicator are comparable.

Nationally, Indigenous people made up 28.2 per cent of all people whose valid requests for accommodation did not result in accommodation assistance in 2007-08 — a proportion greater than Indigenous clients among all accommodated SAAP clients (21.7 per cent). This result varied across jurisdictions (figure 15.27).

Figure 15.27 **Proportion of Indigenous people among all accommodated SAAP clients and among people whose valid requests for accommodation were unmet, 2007-08**[a]



[a] See notes to table 15A.190 for details of data definitions.

Source: SAAP NDCA *Client and Demand for Accommodation Collections* (unpublished); AIHW (2009) *Demand for SAAP accommodation by Homeless People 2007-08: A report from the SAAP national data collection.* SAAP NDCA report series 13. Cat. No. HOU 211; table 15A.190.

Access of people from non-English speaking backgrounds to SAAP service

'Access of people from non-English speaking backgrounds to SAAP service' is an indicator of governments' objective to ensure all Australians have equitable access to SAAP services on the basis of relative need (box 15.50).

Box 15.50 **Access of people from non-English speaking backgrounds to SAAP service**

'Access of people from non-English speaking backgrounds to SAAP service' is defined as the comparison between the representation of people from non-English speaking backgrounds among all people whose valid requests for SAAP accommodation were unmet, and their representation among SAAP clients who were accommodated during the year.

A high proportion of valid requests receiving assistance is desirable.

(Continued on next page)

Box 15.50 **(Continued)**

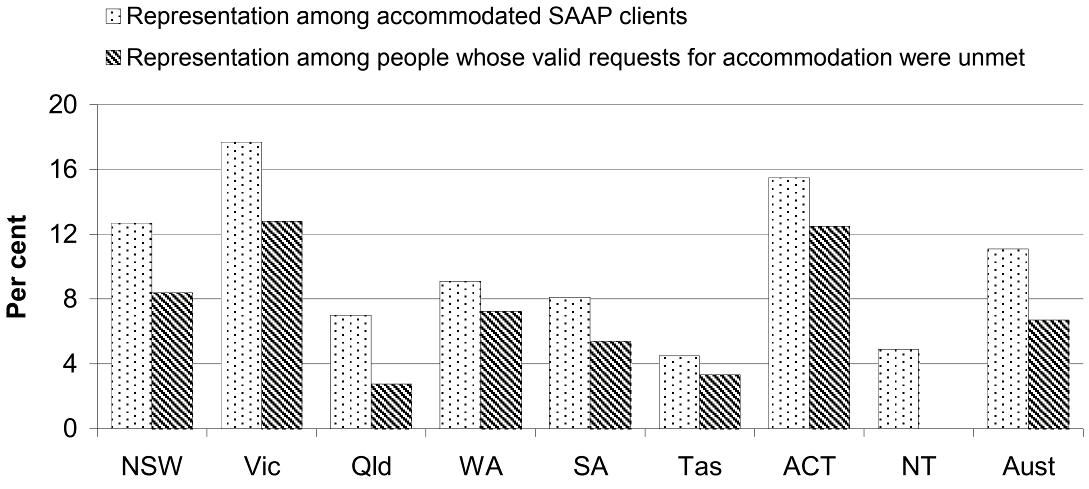
This indicator measures the extent to which the demand for assistance from people from non-English speaking backgrounds is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation, or support, cannot be provided with that assistance (although one-off assistance might be provided).

Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as people from non-English speaking backgrounds) is particularly important.

Data reported for this indicator are comparable.

Nationally, the proportion of people from non-English speaking backgrounds among all people whose valid requests for accommodation did not result in accommodation assistance was 6.7 per cent in 2007-08 — lower than that of people from non-English speaking backgrounds among all accommodated SAAP clients (11.1 per cent). This result varied across jurisdictions (figure 15.28).

Figure 15.28 **Proportion of people from non-English speaking backgrounds among all accommodated SAAP clients and among people whose valid requests for accommodation were unmet, 2007-08[a]**



---

[a] See notes to table 15A.191 for details of data definitions.

Source: SAAP NDCA *Client* and *Demand for Accommodation Collections* (unpublished); AIHW (2009) *Demand for SAAP accommodation by Homeless People 2007-08: A report from the SAAP national data collection.* SAAP NDCA report series 13. Cat. No. HOU 211; table 15A.191.

Effectiveness

Client satisfaction

'Client satisfaction' is an indicator of governments' objective to provide high quality services that meet the needs of SAAP recipients (box 15.51).

Box 15.51 **Client satisfaction**

'Client satisfaction' is defined as the extent to which clients find SAAP services and programs to be helpful and of a high standard (CBSR 2004). Client satisfaction is measured as the proportion of clients who reported that their overall satisfaction with the assistance they received from SAAP services was either 'good' or 'really good'.

A high proportion of clients reporting the assistance they received as 'good' or 'really good' suggests greater client satisfaction with the overall SAAP service.

Data reported for this indicator are comparable.

Data for the client satisfaction indicator are sourced from the national SAAP client satisfaction survey, which was conducted in 2003. New data for this indicator were not available for this Report. Data on client satisfaction relating to a four week period beginning 11 November 2003 were included in the 2005 Report (SCRGSP 2005, pp. 15.47-48; CBSR 2004).

Development of agreed support plan

'Development of agreed support plan' is an indicator of governments' objective to provide high quality services that are appropriately targeted to meet the needs of SAAP clients (box 15.52).

Box 15.52 **Development of agreed support plan**

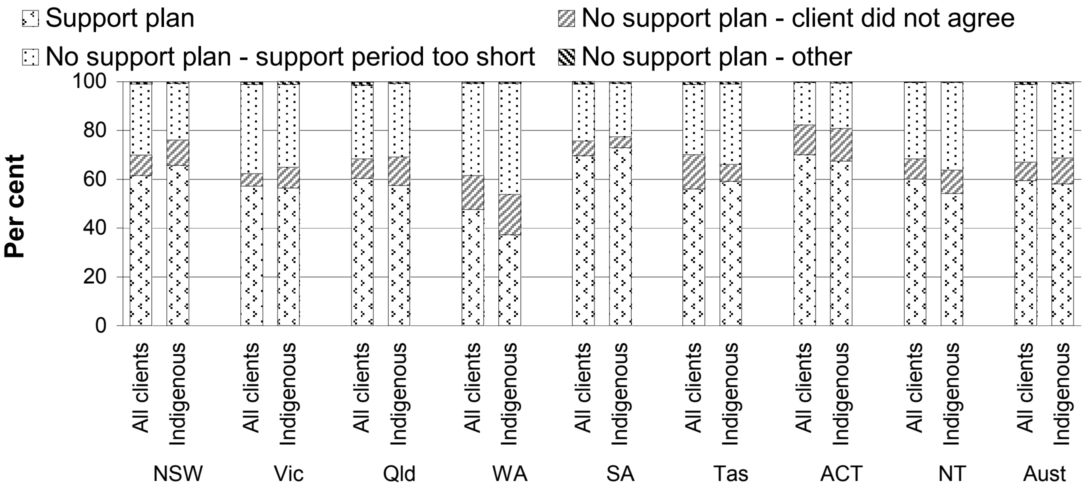
'Development of agreed support plan' is defined as the number of closed support periods with an agreed support plan divided by the total number of closed support periods. A closed support period is a support period that had finished on or before 30 June. Data are reported for all SAAP clients, and separately for Indigenous clients.

A high proportion of support periods with agreed support plans is desirable. However, in some instances, a support plan may be judged to be inappropriate (such as when a support period is short term).

Data reported for this indicator are comparable.

Nationally, there was an agreed support plan for 59.5 per cent of closed support periods for all clients in 2007-08 (compared to 58.2 per cent for Indigenous clients). These proportions varied across jurisdictions (figure 15.29).

Figure 15.29 **Closed support periods, by the existence of a support plan, 2007-08**[a]



[a] See notes to tables 15A.185-186 for more details of data definitions.

Source: SAAP NDCA *Client Collection* (unpublished); tables 15A.192-193.

Match of needs of clients

'Match of needs of clients' is an indicator of governments' objective to ensure that SAAP services meet client's individual needs (box 15.53).

Box 15.53 **Match of needs of clients**

'Match of needs of clients' is defined as the number of distinct services required by clients that are provided, as well as those referred to another agency, divided by the total number of distinct services required by SAAP clients.

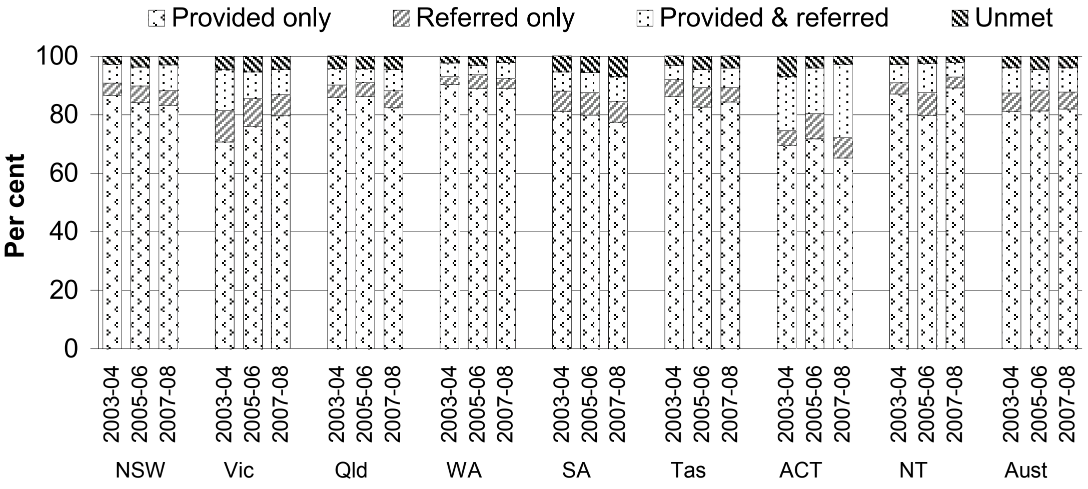
A high proportion of clients who received services they needed, or who were referred to another agency, is desirable.

The range of services needed by SAAP clients is broad (ranging from meals to laundry facilities to long term accommodation), so the effect of not providing these services varies. Data are reported for all SAAP clients, and separately for Indigenous people and people from non-English speaking backgrounds.

Data reported for this indicator are comparable.

Nationally, the proportion of clients who received services they needed (including services provided by the initially approached agencies and/or referrals to another agency) was 96.1 per cent in 2007-08 (figure 15.30).

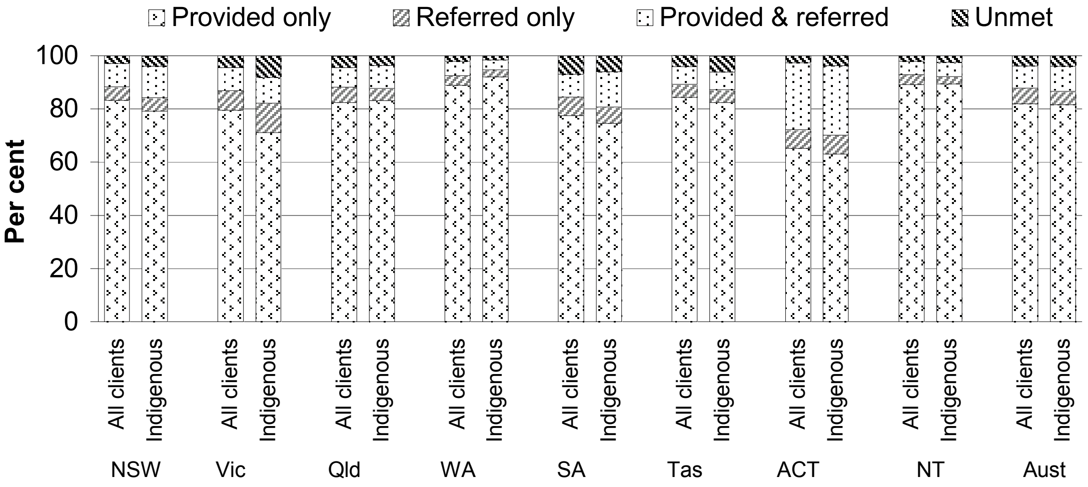
Figure 15.30 SAAP clients, by met and unmet support needs



Source: SAAP NDCA *Client Collection* (unpublished); table 15A.194.

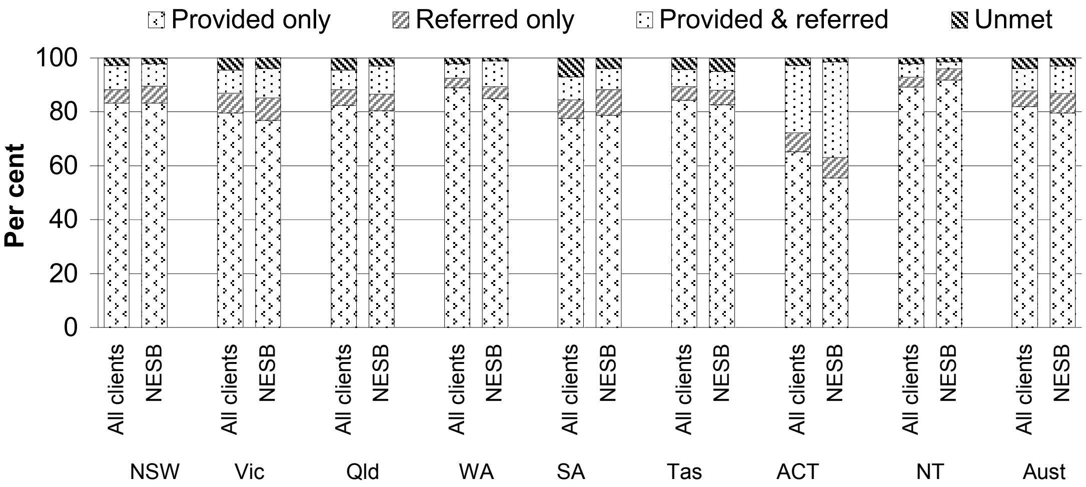
The proportions for Indigenous clients (96.0 per cent) and clients from a non-English speaking background (97.0 per cent) who received services in 2007-08 were similar to that for all clients (96.1 per cent). These proportions varied across jurisdictions (figures 15.31-32).

Figure 15.31 Indigenous clients, by met and unmet support needs, 2007-08



Source: SAAP NDCA *Client Collection* (unpublished); tables 15A.194-195.

Figure 15.32 Clients from non-English speaking backgrounds, by met and unmet support needs, 2007-08



NESB = Non-English speaking background.

Source: SAAP NDCA *Client Collection* (unpublished); tables 15A.194 and 15A.196.

Efficiency

Across jurisdictions, there are varying treatments of expenditure items (for example, superannuation) and different counting and reporting rules for generating financial data. Differences in expenditure data across jurisdictions might to some extent reflect differences in the way in which these data are compiled rather than true variations in expenditure.

The funding figures used to calculate the following efficiency indicators include recurrent allocations to agencies provided by some State and Territory governments in addition to the amounts determined in the agreements between these jurisdictions and the Australian Government.

Cost per completed support period

'Cost per completed support period' is an indicator of governments' objective to maximise the availability and quality of services through the efficient use of public resources (box 15.54).

Box 15.54 **Cost per completed support period**

'Cost per completed support period' is defined as total expenditure on SAAP services divided by the number of completed support periods (excluding casual clients, and adults and accompanying children with a valid unmet request for accommodation).

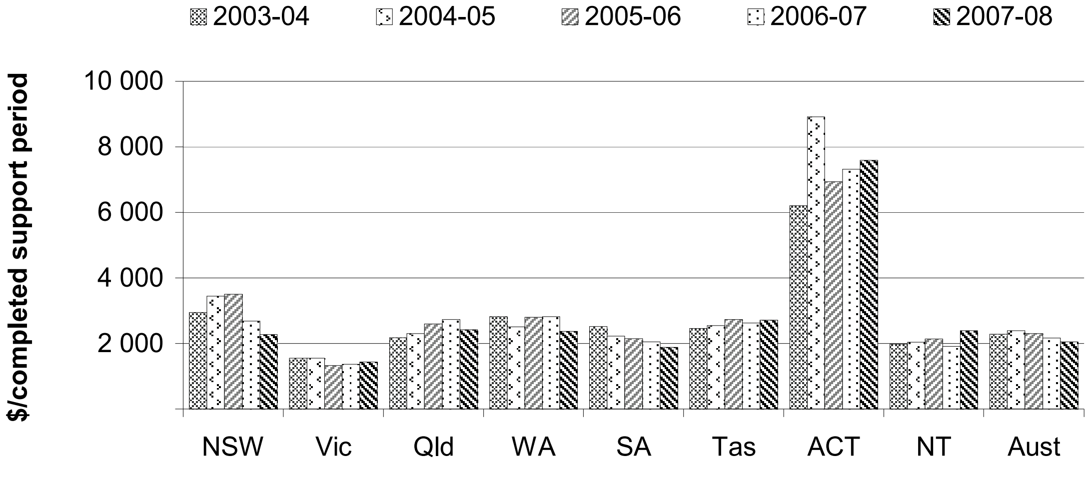
A low or decreasing cost per completed support period is desirable, but can also indicate lower service quality.

This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost), including only expenditure by service delivery providers. Unit cost indicators ideally include administration costs borne by State and Territory governments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the CSHA through a special purpose program (the CAP).

Data reported for this indicator are not directly comparable.

The recurrent cost per completed support period (excluding potential clients and accompanying children) averaged $2050 nationally and varied across jurisdictions in 2007-08 (figure 15.33).

Figure 15.33 **Real recurrent cost per completed support period (2007-08 dollars)**[a]



[a] See notes to table 15A.198 for detailed data caveats.

Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); table 15A.198.

Cost per client

'Cost per client' is an indicator of governments' objective to maximise the availability and quality of services through the efficient use of public resources (box 15.55).

Box 15.55 **Cost per client**

'Cost per client' is defined as total expenditure on SAAP services divided by the number of clients accessing a bed or place over the year.

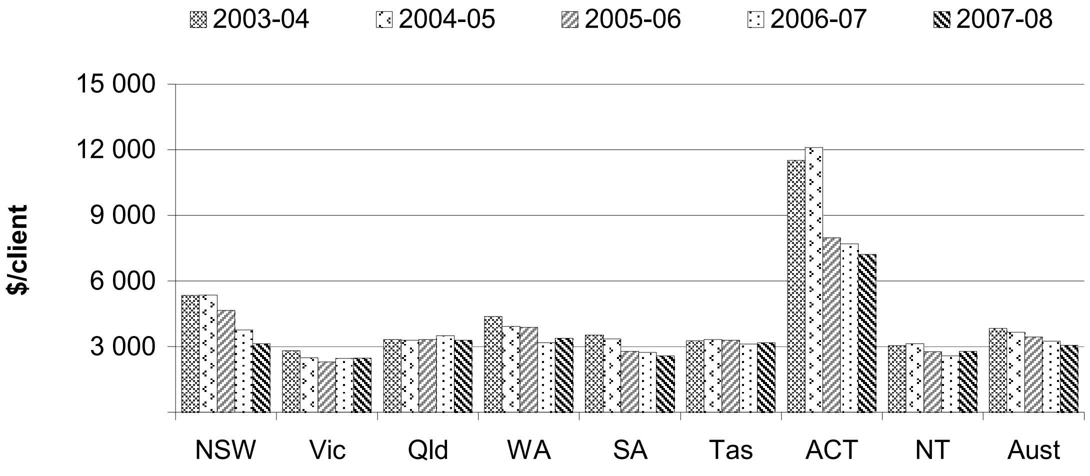
A low or decreasing cost per client is desirable, but can also indicate lower service quality.

This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost), including only expenditure by service delivery providers. Unit cost indicators ideally include administration costs borne by State and Territory governments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the CSHA through a special purpose program (the CAP).

Data reported for this indicator are not directly comparable.

Nationally, the recurrent cost per client accessing SAAP services was $3060 and varied across jurisdictions in 2007-08 (figure 15.34).

Figure 15.34 **Real recurrent cost per client accessing SAAP services (2007-08 dollars)**[a]



[a] See notes to table 15A.199 for detailed data caveats.

Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); table 15A.199.

Cost per day of support

‘Cost per day of support’ is an indicator of governments’ objective to maximise the availability and quality of services through the efficient use of public resources (box 15.56).

Box 15.56 **Cost per day of support**

‘Cost per day of support’ is defined as total expenditure on SAAP services divided by the number of days of support for SAAP clients receiving support and/or supported accommodation (excluding casual clients, and adults and accompanying children with a valid unmet request for accommodation).

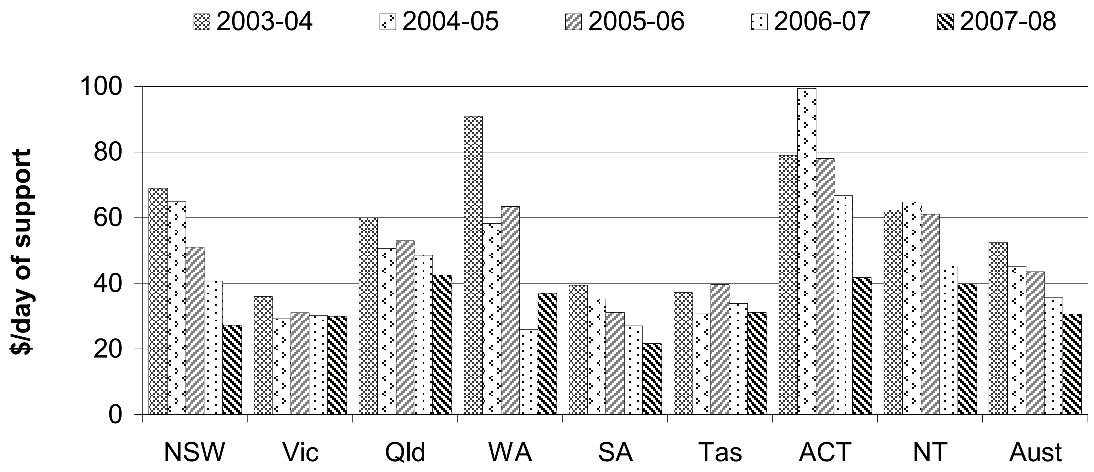
A low or decreasing cost per day of support is desirable, but can also indicate lower service quality.

This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost), including only expenditure by service delivery providers. Unit cost indicators ideally include administration costs borne by State and Territory governments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the CSHA through a special purpose program (the CAP).

Data reported for this indicator are not directly comparable.

The recurrent cost per day of support for SAAP clients averaged $31 nationally and varied across jurisdictions in 2007-08 (figure 15.35).

Figure 15.35 **Real recurrent cost per day of support for clients (2007-08 dollars)**[a]



---

[a] See notes to table 15A.200 for detailed data caveats.

Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); table 15A.200.

Outcomes

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

An important outcome of SAAP services is clients' achievement of self-reliance and independence. Characteristics that may indicate whether clients can live independently include their income, housing status and workforce status. These characteristics are recorded at the end of a client's support period.

In 2006, the SAAP CAD commissioned a research project to examine the impact of SAAP services on client self-reliance. The report based on this project, *Measuring the Impact of SAAP-funded Homelessness Services on Client Self-reliance* (FaHCSIA 2008a), found that many of the problems and barriers that led clients into homelessness were not easily fixed and could take considerable time, effort and resources to overcome.

Achievement of employment on exit

'Achievement of employment on exit' is an indicator of governments' objective to enable clients to participate as productive and self-reliant members of society at the end of their support period (box 15.57).

Box 15.57 **Achievement of employment on exit**

'Achievement of employment on exit' is defined as the number of closed support periods for SAAP clients who sought assistance to obtain or maintain employment and training, and achieved employment after SAAP support, divided by the total number of closed support periods for clients who sought assistance to obtain or maintain employment and training. Support periods reported relate to these clients only.

A high or increasing proportion of clients achieving employment after SAAP support is desirable.

This indicator compares these clients' employment status before and after they requested SAAP support. Data are reported for all SAAP clients, and separately for Indigenous clients.

This indicator relates to relatively short term outcomes — that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but more difficult to measure.

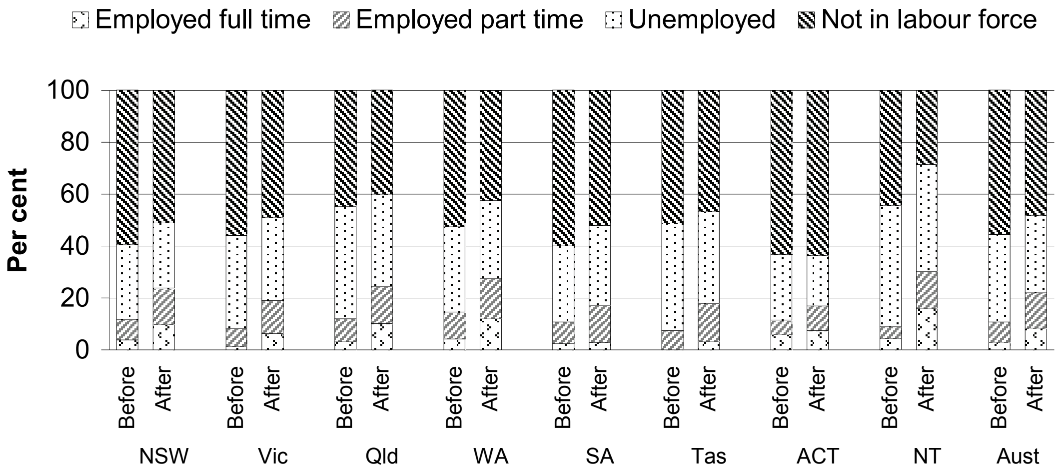
Data reported for this indicator are comparable.

Nationally, of those clients who sought assistance to obtain or maintain employment and training when entering SAAP in 2007-08, the proportion of clients who were employed either full time or part time increased from 10.8 per cent before support to 22.0 per cent after support (8.4 per cent full time and 13.6 per cent part time). The proportion of clients who were unemployed decreased from 33.7 per cent before support to 29.8 per cent after support. The proportion of clients who were not in the labour force decreased from 55.6 per cent before support to 48.2 per cent after support. Proportions varied across jurisdictions (figure 15.36(a), table 15A.204).

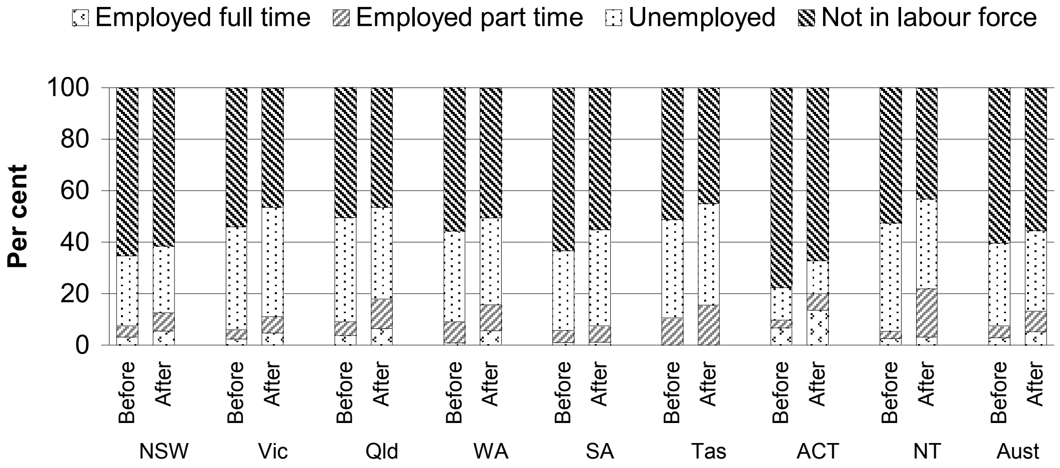
Nationally, of those Indigenous clients who sought assistance to obtain or maintain employment and training when entering SAAP in 2007-08, the proportion of clients who were employed either full time or part time increased from 7.5 per cent before support to 13.2 per cent after support (5.2 per cent full time and 8.0 per cent part time). The proportion of clients who were unemployed decreased from 32.1 per cent before support to 31.3 per cent after support. The proportion of clients who were not in the labour force decreased from 60.4 per cent before support to 55.4 per cent after support. These proportions varied across jurisdictions (figure 15.36(b) and table 15A.205).

Figure 15.36 **Changes in labour force status of clients who needed assistance to obtain/maintain employment and training before/after SAAP support, 2007-08**[a]

(a) All SAAP clients



(b) Indigenous SAAP clients



---

[a] Data are for people who requested assistance with obtaining or maintaining employment when entering SAAP services.

Source: SAAP NDCA *Client Collection* (unpublished); tables 15A.204-205.

Achievement of income on exit

'Achievement of income on exit' is an indicator of governments' objective to enable clients to participate independently in society at the end of their support period (box 15.58).

Box 15.58 **Achievement of income on exit**

‘Achievement of income on exit’ is defined as the number of closed support periods for SAAP clients who requested assistance to obtain or maintain a pension or benefit and exited SAAP with an income source, divided by the total number of closed support periods for clients who sought assistance to obtain or maintain a pension or benefit. Data are reported for all SAAP clients, and separately for Indigenous clients.

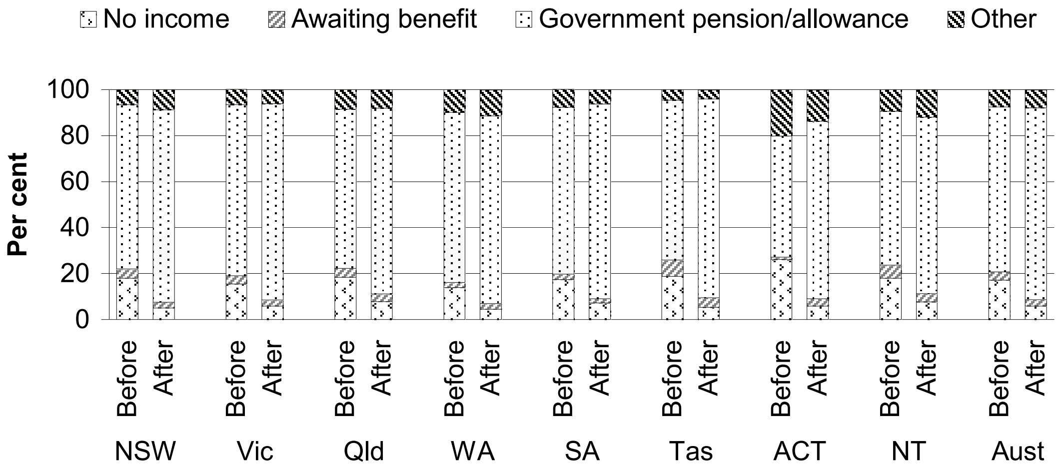
A high or increasing proportion of clients who requested income assistance and exited SAAP with an income source is desirable.

This indicator compares these clients’ income status before and after they received SAAP support. A client’s independence and self-reliance is enhanced when the client experiences a positive change in income source (for example, from having no income support to obtaining some income, including wages and/or benefits) on exit from SAAP services.

Data reported for this indicator are comparable.

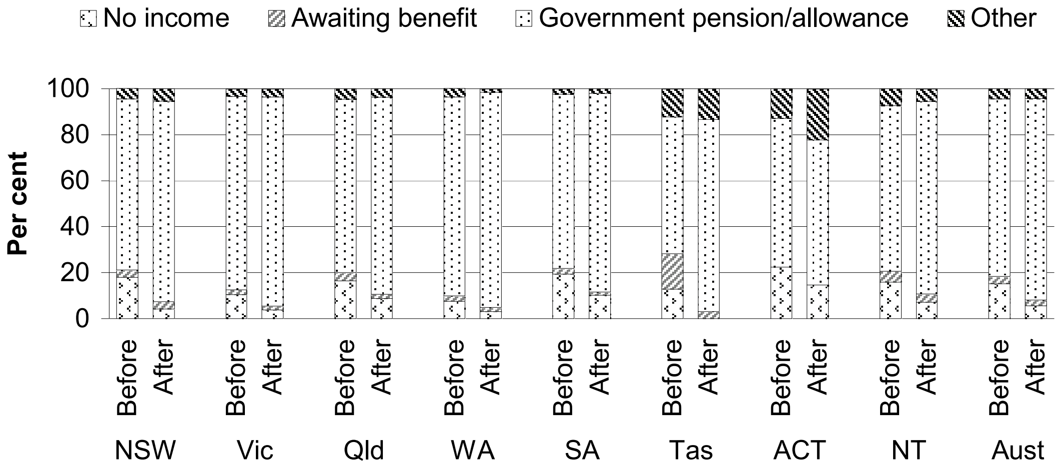
Nationally, in 2007-08 17.1 per cent of SAAP support periods in which clients who requested income assistance did not have income prior to SAAP assistance. After SAAP assistance, the proportion of SAAP support periods in which clients who had requested income assistance and had no income was 5.9 per cent (figure 15.37). The proportion of Indigenous clients who did not have income and requested income assistance also decreased after SAAP assistance (from 15.2 per cent to 5.6 per cent nationally) (figure 15.38). Both before and after SAAP assistance, the income source for the majority of SAAP clients was a government pension/benefit (figures 15.37 and 15.38).

Figure 15.37 Source of income immediately before/after SAAP support of clients who needed assistance to obtain/maintain a pension or benefit, 2007-08



Source: SAAP NDCA *Client Collection* (unpublished); table 15A.209.

Figure 15.38 Source of income immediately before/after SAAP support of Indigenous clients who needed assistance to obtain/maintain a pension or benefit, 2007-08



Source: SAAP NDCA *Client Collection* (unpublished); table 15A.210.

Achievement of independent housing on exit

'Achievement of independent housing on exit' is an indicator of governments' objective to enable clients to participate as productive and self-reliant members of society at the end of their support period (box 15.59).

Box 15.59 **Achievement of independent housing on exit**

‘Achievement of independent housing on exit’ is defined as the number of closed support periods in which clients who requested assistance with obtaining or maintaining independent housing achieved independent housing, divided by the total number of closed support periods in which clients requested assistance obtaining or maintaining independent housing.

A high or increasing proportion of SAAP closed support periods in which clients achieve independent housing is desirable.

This indicator compares the proportion of clients who were in independent housing before and after they received SAAP support. It relates to relatively short term outcomes — that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but more difficult to measure.

Data reported for this indicator are comparable.

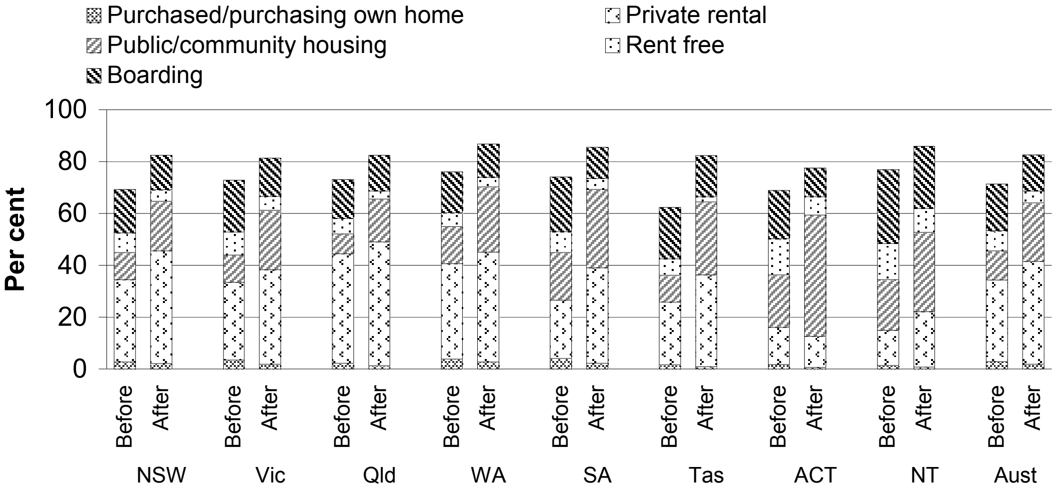
Nationally, 82.6 per cent of closed support periods in which clients requested assistance with obtaining or maintaining independent housing achieved independent housing in 2007-08. This included clients who moved or returned to private rental housing (39.7 per cent), to public or community rental housing (22.6 per cent), and those who were boarding (14.0 per cent) (figure 15.39a).

Among Indigenous clients, on a national basis, 84.4 per cent of clients who requested assistance with obtaining or maintaining independent housing achieved independent housing at the end of a support period in 2007-08, including those who moved or returned to private rental housing (29.9 per cent), to public or community rental housing (32.5 per cent), and who were boarding (17.4 per cent) (figure 15.40a).

Closed support periods in which clients did not achieve independent housing included those who moved to, or continued to live in, short to medium term SAAP accommodation and other forms of non-independent accommodation (figure 15.39b and 15.40b).

Figure 15.39 Accommodation type before and after SAAP support, for clients who requested assistance with obtaining or maintaining housing, all SAAP clients, 2007-08

(a) Independent housing



(b) Non-independent housing

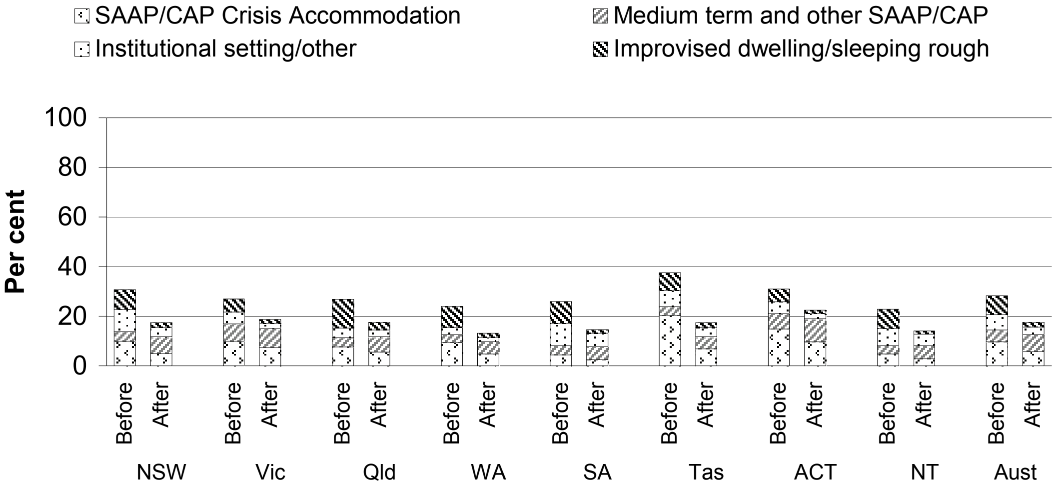
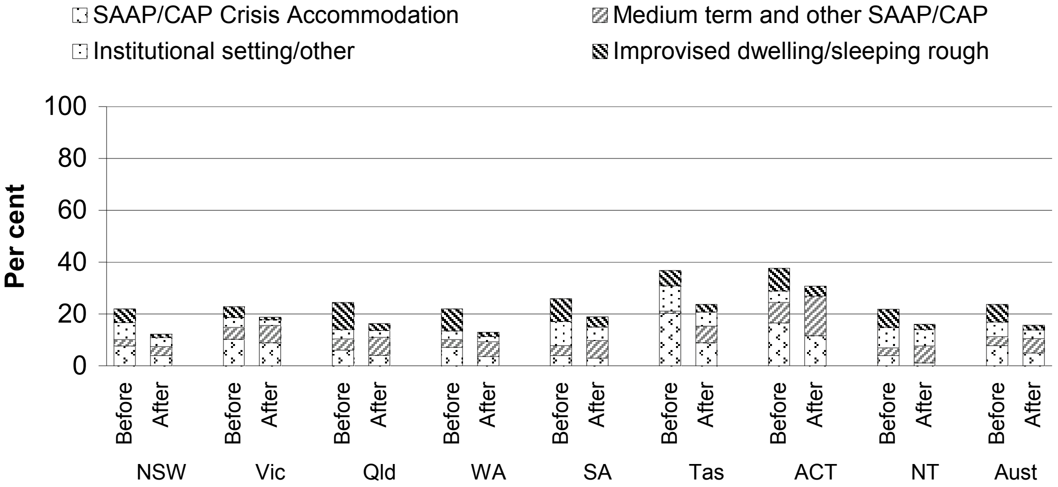


Figure 15.40 **Accommodation type before and after SAAP support, for clients who requested assistance with obtaining or maintaining housing, Indigenous SAAP clients, 2007-08**

(c) Independent housing

(d) Non-independent housing



Source: SAAP NDCA *Administrative Data and Client Collections* (unpublished); tables 15A.202-203.

Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months

'Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months' is an indicator of governments' objective to enable clients to participate independently in society at the end of their support period (box 15.60).

Box 15.60 **Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months**

‘Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months’ is defined as the number of clients who exit to independent housing and do not return to SAAP within six months, divided by the total number of SAAP clients.

A high or increasing proportion of clients not returning to the program within six months is desirable.

Many of the problems and barriers that lead people into homelessness are not easily fixed (FaHCSIA 2008a). Therefore, a number of SAAP clients might access SAAP services several times before their needs are met on a permanent basis (for example, moving from crisis accommodation to medium term accommodation).

Data reported for this indicator are comparable.

Estimates of clients exiting SAAP support to independent housing and not returning to SAAP within six months are affected by the data issues discussed in box 15.46. The most recent data available are for the period 2004-05, during which 45.4 per cent of clients who exited a SAAP service to independent housing did not access the service again within six months. These data might not be representative of all clients (table 15A.208). Given the potential for data bias, these estimates should be interpreted with care.

Proportion of SAAP clients with only one period of support within a year

‘Proportion of SAAP clients with only one period of support within a year’ is an indicator of governments’ objective to enable clients to participate independently in society at the end of their support period (box 15.61).

Box 15.61 Proportion of SAAP clients with only one period of support within a year

'Proportion of SAAP clients with only one period of support within a year' is defined as the number of clients with only one support period during the year, divided by the total number of SAAP clients. Data are reported for all SAAP clients, and separately for Indigenous clients.

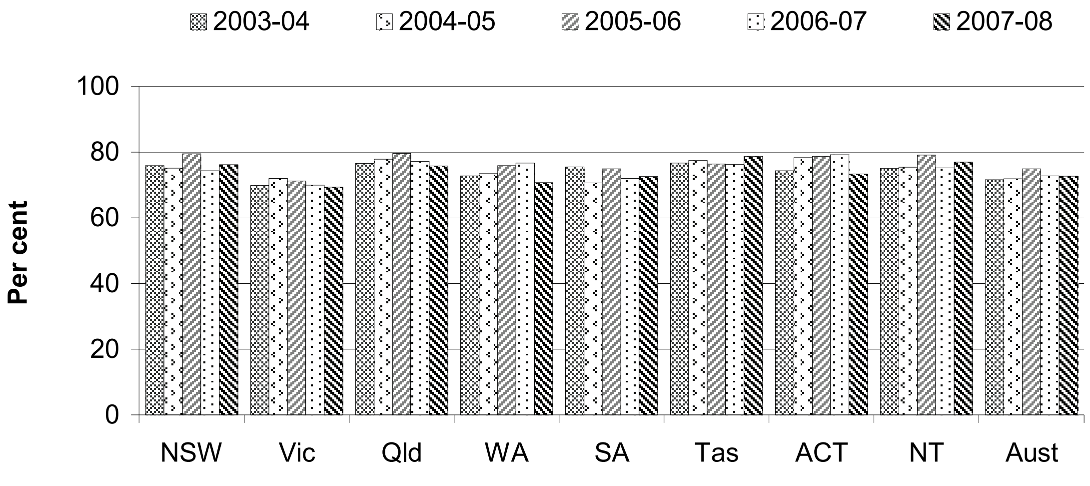
A high or increasing proportion of clients with only one support period during the year is desirable.

Many of the problems and barriers that lead people into homelessness are not easily fixed (FaHCSIA 2008a). Therefore, a number of SAAP clients might access SAAP services several times before their needs are met on a permanent basis (for example, moving from crisis accommodation to medium term accommodation).

Data reported for this indicator are comparable.

Nationally, 72.7 per cent of SAAP clients had only one support period in 2007-08 (figure 15.41). The proportion for Indigenous clients was similar (71.6 per cent) (table 15A.207).

Figure 15.41 Proportion of SAAP clients with only one period of support within a year



Source: SAAP NDCA *Client Collection* (unpublished); table 15A.206.

Goals achieved on exit from service

'Goals achieved on exit from service' is an indicator of governments' objective to ensure SAAP services meet the needs and expectations of clients (box 15.62).

Box 15.62 **Goals achieved on exit from service**

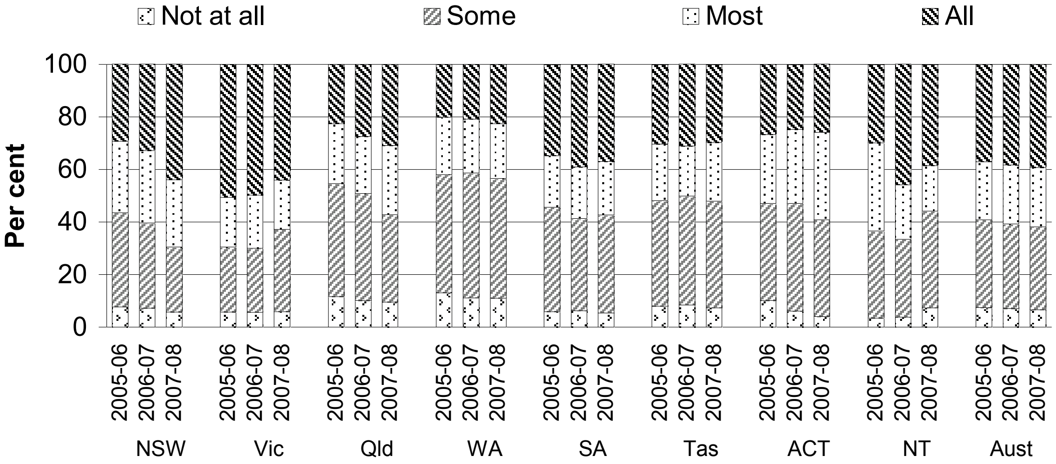
'Goals achieved on exit from service' is defined as the proportion of clients who reported that their case management goals were fully or mostly achieved by the end of their support period, divided by the total number of clients with case management goals in a given period.

A high or increasing proportion of achieved goals is desirable.

Data reported for this indicator are comparable.

Nationally, case management goals were fully or mostly achieved by the end of the support period for 61.8 per cent of clients in 2007-08 (figure 15.42).

Figure 15.42 **Goals achieved on exit from SAAP service**



Source: SAAP NDCA *Client Collection* (unpublished); table 15A.211.

15.11 Future directions in supported accommodation and assistance performance reporting

COAG developments

Report on Government Services alignment with National Agreement reporting

It is anticipated that future editions of this chapter will align with applicable National Agreement indicators, including the National Indigenous Reform Agreement. Further alignment between the Report and National Agreement indicators, and other reporting changes, might result from future developments in National Agreement and National Partnership reporting.

While relevant ministerial groups, data agencies and the Steering Committee are progressing the development of performance indicators for the NAHA and associated partnerships, an interim SAAP collection will continue until end-June 2011.

Outcomes from review of Report on Government Services

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the Intergovernmental Agreement on Federal Financial Relations.

No significant changes from this review are reflected in the 2010 Report. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 Report.

15.12 Jurisdictions' comments

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

Australian Government comments

National Framework for Protecting Australia's Children 2009–2020

In the 2008-09 Budget, the Australian Government announced they would invest a further $63 million over four years to improve the safety and wellbeing of children and young people in Australia through the National Framework for Protecting Australia's Children 2009–2020 (the National Framework).

The Council of Australian Governments (COAG) endorsed the National Framework on 30 April 2009. The National Framework is an ambitious, long term, national approach to ensuring the safety and well-being of Australian children. It will be delivered through a series of three-year action plans, with the first action plan containing over 70 actions. Commonwealth, State and Territory governments and the non-government sector worked in partnership to develop the National Framework and will continue to work together throughout its implementation.

COAG charged the Community and Disability Services Ministers' Conference (CDSMC) with the responsibility of implementing and monitoring the National Framework. On 11 September 2009, CDSMC endorsed the National Framework Implementation Plan 2009–2012, which sets out how actions under the National Framework's first action plan will be progressed, how progress will be measured and monitored, and the roles and responsibilities of key stakeholders. For the first three years of the National Framework's operation, CDSMC will present an annual report card to COAG on the progress of the first action plan. These report cards will be publicly released.

Supported Accommodation Assistance Program

The Australian Government provides homelessness assistance through the National Affordable Housing Agreement (NAHA) which subsumed funding under the previous homelessness assistance program, Supported Accommodation Assistance Program from 1 January 2009. The NAHA provides $6.1 billion Australian government funding to State and Territory governments over five years from 2008-09. The NAHA also includes social housing, assistance to people in the private rental market and home purchase assistance.

The NAHA is supplemented by the National Partnership Agreement on Homelessness which provides an additional $1.1 billion specific homelessness funding by the Australian and State and Territory governments over four years from 2009-10. These agreements and specific Australian government homelessness programs including the Household Organisational Management Expenses (HOME) Advice Program, the National Homelessness Strategy, and the Reconnect Program recognise the service system needs to prevent homelessness where possible and stop people cycling in and out of homelessness. Services need to provide enough joined up support to help people get back on their feet, into secure housing and then to participate in the community, including getting a job.

New South Wales Government comments

Child protection and supported placements

The NSW Government published the five-year Action Plan, 'Keep Them Safe: A shared approach to child wellbeing' (2009–2014) on 3 March 2009, in response to the former Justice Wood's Report of the Special Commission of Inquiry into Child Protection Services in NSW (released in November 2008).

Keep Them Safe aims to re-shape the way family and community services are delivered in NSW so that children, young people and their families receive the services they need sooner, before problems escalate. Keep Them Safe includes actions to enhance the universal service system and early intervention services, better protect children at risk, support Aboriginal children and families and strengthen partnerships with non-government organisations in delivering community services.

Juvenile justice

The majority of young people supervised by the Department of Juvenile Justice are on community-based orders and this continues an upward trend. The Department administers youth justice conferences as an alternative to formal court processes and the number of referrals from the police and courts for group conferences is growing. In 2008 the juvenile justice system in NSW experienced a significant and unprecedented increase in young people entering remand. This development along with a rising number of young people sentenced to detention had a significant impact on custodial capacity. In response to this situation a new detention centre was developed and greater capacity was provided to four of the nine existing centres. In addition to increased custodial capacity, the Department has increased bail services to assist young people to attain bail and thus avoid entering custody on remand, or lessen the time spent in remand.

Supported Accommodation Assistance Program

The number of clients, including accompanying children assisted by Supported Accommodation Assistance Program services in NSW has increased by more than 88.7 per cent since 2004–05, rising from 30 050 to 56 700 in 2007–08. This increase is primarily due to changes in reporting practices and the move towards early intervention and post crisis support in SAAP in NSW. As part of its ongoing reform of SAAP, NSW Community Services has continued implementation of funding reforms, of which the key components were:

- results-based accountability
- performance-based contracting focusing on program priorities
- a performance monitoring framework
- evidence-based approaches.

These reforms contributed to the increased number of support periods and clients.

Victorian Government comments

Child protection and supported placements

- In 2008–09, the ‘every child every chance’ reform process supported by the Children, Youth and Families Act 2005, has continued. The reforms promote prevention and support services for at-risk children and families, strengthen child protection and out-of-home care services and assist the delivery of culturally appropriate services to Aboriginal children and families.
- As part of these reforms, Child FIRST has been implemented statewide to enhance the prevention and early intervention capacity of the service system. A Best Interests Case Practice Model has been developed and is being implemented across child protection, placement services and family services to further promote and support good practice. Additional funds have been provided to increase the capacity, diversity and quality of out–of–home care services, and to enhance the capacity and responsiveness of child protection and family services.

Juvenile Justice

- In 2008–09, a discussion paper was released for the Vulnerable Youth Framework (VYF). The VYF aims to deliver better outcomes for young Victorians by ensuring the Government’s major policy commitments in this field are implemented with a shared understanding and a consistent approach.
- The Youth Justice Community Support Service is a new initiative to support young people involved in the youth justice system. Many youth justice clients require intensive support and assistance to access employment, education or training, mental health, drug and alcohol, and housing services. Taking an integrated approach, community service organisations have formed partnerships to collectively provide a broad range of services to better meet these needs of youth justice clients and enhance their rehabilitation, economic contribution and social connectedness.

Supported Accommodation Assistance Program

- In 2008–09, Victoria made significant progress in assisting people who are homeless or at risk of homelessness to transition to more stable living arrangements and active participation in the community.
- Victoria commenced statewide implementation of Opening Doors, a framework for a coordinated entry point system designed to provide the basis for a more responsive and less stressful process for people seeking support and accommodation. Victoria also continued to implement the Integrated Response to Family Violence with significant reform and strengthening of the service system.
- The Supported Accommodation Assistance Program was terminated on 31 December 2008. Funding and programs were provided through the National Affordable Housing Agreement from 1 January 2009.

Queensland Government comments

Child protection and supported placements

The Queensland Government continued to enhance the child protection system in 2008–09, amalgamating the former Department of Child Safety with the new Department of Communities, creating opportunities to work more effectively with the prevention and early intervention tier of the child protection system. Through a statewide Foster and Kinship Carer recruitment campaign, 524 new carers were recruited. Therapeutic residential services were established in Cairns and Townsville to support young people in care to overcome trauma. Family intervention services supported approximately 1 200 families to help parents care for their children where statutory intervention is required. The Department procured land and obtained capital works and grants for six safe houses and a foster care house in Queensland's remote Indigenous communities, enabling children requiring out-of-home placement to remain connected to their community, while assessment and consultation are undertaken.

Juvenile justice

Building on the work undertaken in 2007–08, the Queensland Government is targeting the causes of youth offending that will collectively result in strong and lasting positive impacts on offending rates in Queensland. The Aboriginal and Torres Strait Islander Youth Justice Strategy is one of these key activities. Major initiatives include the now operational young offender community response service and bail support service in far north Queensland and strengthening family engagement practices and training to improve the cultural competency of youth justice staff. ART (Aggression Replacement Training) and CHART (Changing Habits and Reaching Targets) have been implemented across all youth justice service centres and detention centres. Evaluation of these programs has commenced. The introduction of a risk/needs assessment tool and youth justice quality assurance framework has improved the case management of young people on supervised orders. Service delivery has been further improved with the introduction of an Integrated Case Management System, which is shared across youth justice and child protection services.

Supported Accommodation Assistance Program

In 2008–09, the Queensland Government continued to work in partnership with and fund non-government organisations under the Supported Accommodation Assistance Program. Initiatives under the Responding to Homelessness Strategy continued to operate and expand. A new client intake and assessment process for housing assistance was introduced, allowing clients who identify as homeless to be potentially streamed directly into the very high and high need segments of the housing register. The evaluation of the Responding to Homelessness Strategy has resulted in an increase in the quantum of services, accommodation and support available to homeless people. The demonstrated value and effectiveness of the strategy has provided a platform for development of Queensland's implementation plan under the National Partnership Agreement on Homelessness.

Western Australian Government comments

Child protection and supported placements

The Department continued to make progress towards implementing child protection reform projects arising from the Ford Review of the Department for Community Development, released in January 2007.

The Signs of Safety child protection practice framework is used in assessment in both the Department's statutory and child-centred family work and to engage the family, children and relevant agencies in the planning process. Income management was trialled selectively as a child protection measure and as part of the progressive rollout across areas of the State.

On 1 January 2009, the reporting of child sexual abuse became mandatory for teachers, doctors, nurses, midwives and police in Western Australia. This is managed through a centralised intake service.

Key initiatives to improve outcomes for children in the CEO's care include: the implementation of health and education plans; the reform and expansion of out-of-home care services; enhanced partnership with foster carers; and the development of policy on permanency planning which aims to ensure that timely decisions are made about children's long-term stability.

Juvenile justice

The Community and Juvenile Justice division commenced a major realignment of its services in the metropolitan area to improve its focus on youth justice, creating a balance with adult community corrections' issues. The realignment will result in distinct service delivery locations for youth justice services.

Extensive resources were placed into increasing the Department's focus on early intervention and diversionary programs and initiatives to divert young people away from the justice system. This included establishment of regional youth justice services centres in two regions to provide a full range of services, including outreach support, bail and emergency accommodation that focus on all aspects of a young person's life and also offer support to their families.

Supported Accommodation Assistance Program

The fifth Supported Accommodation Assistance Program Multilateral Agreement (SAAP V) ceased on 31 December 2008. Services previously funded under SAAP are now funded under the National Affordable Housing Agreement which commenced on 1 January 2009. In addition, the development of the Western Australian Implementation Plan for the National Partnership Agreement on Homelessness (NPA) will provide new support services to prevent and reduce homelessness. The Western Australian Implementation Plan is not about doing more of the same but rather proposes to lever change in how homelessness is responded to in Western Australia by providing a more integrated response to homelessness. The initiatives focus on intervening early, preventing the cycle of homelessness, while addressing the needs of a range of target groups across metropolitan, regional and remote Western Australia.

South Australian Government comments

Child protection and supported placements

South Australia’s child protection system is integrating child safety within a broader approach of strengthening child, family and community wellbeing. This includes a more focused partnership between Government agencies and the community sector to provide a range of protective, and support services, with increased funding to non-government agencies for targeted early intervention services, intensive placement prevention and reunification services. The demand on the alternative care system continues to grow. There has been a 52 per cent increase in the number of children in alternative care placements from 30 June 2005 to 30 June 2009. Keeping them Safe – In Our Care reforms place emphasis on improving assessment processes, strengthening relative and kinship care placements, implementing ‘wrap around’ care packages tailored to each child and expanding therapeutic foster care placements for children with complex needs.

Juvenile justice

The To Break the Cycle reform, led by the South Australian Attorney General’s Department is taking an all of Government approach to tackling serious offending and preventing early entry of children and young people into the justice system. Emphasis has been placed on strengthening delivery of case management, including intensive case management services for serious repeat offenders and an expansion of home detention services. A Community Protection Panel has been established by the Attorney General as a non-statutory advisory committee to oversee the identification, assessment and intensive case management of serious repeat offenders. South Australia is expanding the range of treatment programs for offenders, particularly for those involved in high speed car crime, drug and alcohol related crime and violent offending.

Supported Accommodation Assistance Program

The 2007–08 data indicate that South Australian Supported Accommodation Assistance Program services continued to achieve very positive results for people who are homeless or at imminent risk of homelessness on most effectiveness and efficiency indicators. In 2007–08, South Australia achieved the second highest rate of a support plan in place for all clients (69.7 per cent compared to a national average of 59.5 per cent); the highest rate of a support plan in place for Indigenous clients (73 per cent compared to the national average of 58.2 per cent); the second lowest recurrent cost per client accessing services; the lowest real recurrent cost per day of support; the highest average accommodation load per day (11.9 compared to the national average of 7.9); and the highest average caseload per day (33.5 compared to the national average of 21.1). These outcomes clarify the positive direction that South Australia has achieved in improved planning and assessment responses.

Tasmanian Government comments

Child protection and supported placements

Substantial reforms are being implemented for Tasmania's child protection, family support and out-of-home care (OOHC) services by a dedicated Reform Implementation Unit within Human Services. The Gateway Services and Integrated Family Support Services are being established to support children and families in need via a single point of access within each of the four service delivery areas across the State. Other reforms include the establishment of advisory groups and community partnership teams to strengthen partnerships between government and the community sector. A common assessment framework has been implemented and a resource allocation and 'unit pricing' framework is also being developed to promote consistency and equity across service areas. Reform of OOHC is being scoped and planning is underway to outsource rostered care in July 2010. In addition, a residential practice consultant has been appointed to work with carers to improve standards of care as well as supervise the accreditation of foster carers.

Juvenile justice

Youth justice services within Disability, Child, Youth and Family Services (DCYFS) is focusing on case management practices. Community youth justice services will trial new electronic risk assessment and case management tools and implement a project to improve the case management interface between community and custodial services. A dedicated youth at risk focus within DCYFS, and the Youth at Risk strategy is now undertaking a range of initiatives that will enhance the strategic approach to planning, funding and delivering services for this group of young people. The Review of the Youth Justice Act 1997 has produced a number of papers that are available on the DHHS website at www.dhhs.tas.gov.au. The Project Steering Committee is currently considering the submissions received and the options for change.

Supported Accommodation Assistance Program

During 2008–09, Tasmania worked to provide a seamless transition into the new National Affordable Housing Agreement and related National Partnership Agreement on Homelessness. Alongside the extensive planning leading up to the launch of Tasmania's Homelessness Implementation Plan in June 2009 were the completion of the Supported Accommodation Assistance Program Quality Development Project and the successful negotiation of new funding agreements for the sector. The new Departmental funding agreements introduced by the Office for the Community Sector incorporate a new Quality and Safety Standards Framework, which maintains the emphasis on quality in service delivery, and also have a new Integrated Finance and Performance Framework.

Australian Capital Territory Government comments

Child protection and supported placements

- The Care and Protection provisions of the new Children and Young People Act 2008 commenced on 27 October 2008. Provisions include enhanced powers to assess and respond to children and young people suspected to be at risk of abuse and neglect, a proactive framework for seeking the views and wishes of children and young people, stability proposals in care plans and long term orders, provisions to make prenatal reports and greater capacity to exchange information.
- 2008–09 has also seen a continued focus on improving collaborative service delivery, early intervention and the introduction of a permanency planning framework. Also introduced were Declared Care Teams, which promote coordinated and planned services for children, young people and their families and facilitate the sharing of information among its members if it is in their best interests.

Juvenile justice

- Bimberi Youth Justice Centre commenced operations in late 2008 and is the first human rights compliant juvenile detention centre in Australia. The centre engages young people through a rehabilitative approach, supporting them through programs including: Literacy and Numeracy; Drug and Alcohol Counselling; Indigenous Art; Music and Culture; and Living Skills.
- Legislative changes for ACT Youth Justice recently occurred through the implementation of the Children and Young People Act 2008. These have been reflected in the policies and procedures of ACT Youth Justice.
- ACT Youth Justice utilises a case management approach and continues to develop partnerships with government and non government agencies to increase the opportunities for young people and their access to support services within detention and the community.

Supported Accommodation Assistance Program

- The ACT provides high quality homelessness services, meeting the needs of many clients through reducing unemployment and improving access to sustainable housing including public and community housing.
- The establishment of a Joint Pathways Group has ensured that the sector has responses for people experiencing homelessness at all stages from crisis to independence. The reform of housing and homelessness services in the ACT, which commenced in 2006, has also resulted in significant moves away from a system where clients were required to change services or accommodation sites as their needs change. This work, undertaken in partnership with community agencies, consolidates the movement of Supported Accommodation Assistance Program to a client focussed, responsive approach, in which the availability of accommodation no longer determines the availability and nature of support provided.

Northern Territory Government comments

Child Protection and supported placements

> The majority of provisions in the new Care and Protection of Children Act 2007 commenced operation on 8 December 2008, replacing the former Community Welfare Act 1983.
>
> Features of the new Act include new principles and overriding objects for protecting children, new definitions of what constitutes abuse and neglect, new provisions to enable families to better care for their children (for example, family group conferencing), a screening system for child related employment, establishment of a Children's Commissioner to investigate complaints and oversight administration of the Act, enhanced regulation of children's services, establishment of a Child Deaths Review and Prevention Committee and additional support for young people leaving care. Day to day responsibility for administration of the Act passes to the Chief Executive of the Department of Health and Families although the Minister retains overall responsibility.
>
> A quality auditing system was introduced in 2008 to measure compliance with key policy and legislative standards and a care and protection quality subcommittee was created in 2009 to guide quality practice and governance.
>
> *Juvenile justice services*
>
> In July 2008 the Northern Territory Government announced the introduction of the Youth Justice Strategy. The strategy is a framework for working with young people up to 18 years of age who are involved in anti-social, criminal or disruptive behaviour. As part of the strategy, amendments were made to Part 6A of the Youth Justice Act which relate to "responsible care and supervision within the family". This Act allows for certain Government agencies to enter into Family Responsibility Agreements and Family Responsibility Orders with families who are struggling with their child's behaviour, where it can be shown that the actions and/or behaviour of the family may have contributed to that behaviour.
>
> Family support centres have been established in both Darwin and Alice Springs to implement the family responsibility amendments and provide support to families and young people.
>
> *Supported Accommodation Assistance Program*
>
> Transition arrangements for the National Affordable Housing Agreement and the National Partnership Agreement on Homelessness were put in place with a particular focus on initiatives to support young people and rough sleepers. Significant housing stress continues to be a feature in the Northern Territory.

15.13 Definitions of key terms and indicators

Child protection and out-of-home care services

Activity Group 1 (pathways) Receipt and assessment of initial information about a potential protection or support issue	Activities that are typically associated with receipt and assessment of initial information including receipt and recording of information, review of department databases, initial assessment of information and decisions about the appropriate response. This activity can also include consultation, with possible provision of advice. Activities by non-government organisations (NGO) may be included if appropriate.
Activity Group 2 (pathways) Provision of generic/non-intensive family support services	Activities that are typically associated with provision of lower level family support services at various stages including identification of family needs, provision of support services and diversionary services, some counselling and active linking of the family to support networks. Services are funded by government but can be delivered by either the relevant agency or a NGO. This bundle of services does not involve planned follow-up by the relevant agency after initial service delivery. The services will be delivered under voluntary arrangements between the relevant agency and family. Clients may receive these services more than once.
Activity Group 3 (pathways) Provision of intensive family support services	Activities that are typically associated with provision of complex or intensive family support services including provision of therapeutic and in-home supports such as counselling and mediation, modelling of positive parenting strategies, referrals to intensive support services that may be provided by NGOs, advocacy on behalf of clients and intensive support for a family in a residential setting. This includes protection and treatment support services. These services may be provided if diversionary services are inappropriate to the case and may lead to statutory services being provided to the client.
Activity Group 4 (pathways) Secondary information gathering and assessment	Activities that are typically associated with secondary information gathering and assessment are currently counted as ‘investigations’ in the Report on Government Services. As part of this activity group a decision may be made to substantiate or not substantiate. Information gathering activities include: • sighting the child • contacting people with relevant information about the child or family (for example, teachers, police, support services) • interviewing the child, sibling(s) and parents • observing family interactions • obtaining assessments of the child and/or family • conducting family group conferences • liaising with agencies providing services to the child and family • recording a substantiation or non-substantiation decision • case conferences with partners and contributors in the investigation and assessment process.
Activity Group 5 (pathways) Provision of short-term protective intervention and coordination services for children	Activities that are typically associated with provision of short-term protective intervention and coordination services including: • working with the family to address protective issues • developing networks of support for the child • monitoring and reviewing the safety of the child

not on an order	• monitoring and reviewing family progress against case planning goals • case conferences with agencies providing services to the child and/or family, internal discussions and reviews • specialist child-focused therapeutic support.
Activity Group 6 (pathways) Seeking an order	Activities that are typically associated with seeking orders (court orders or voluntary/administrative orders) including: • preparing applications for the order • preparing reports for the court • obtaining assessment reports to submit to the court • informing parties to the court proceedings, including parents, the child, and lawyers • informing and briefing legal counsel or internal court groups • going through internal pre-court review processes • attending court • conducting family group conferences.
Activity Group 7 (pathways) Provision of protective intervention, support and coordination services for children on an order	Activities that are typically associated with provision of longer-term protective intervention and coordination services including: • monitoring the child or young person’s progress and development (for example, social development and education progress) and undertaking activities that facilitate progress and development • meeting any specific requirements of any court order • reviewing appropriateness of the order for the circumstances of the child or young person. This usually occurs at intervals established by the court or in legislation • reporting back to court • long term cases involving out-of-home care.
Activity Group 8 (pathways) Provision of out-of-home care services	Activities that are typically associated with provision of out-of-home care services including: • finding suitable placement(s) for the child • assisting the child or young person to maintain contact with his/her family • in some cases, staff payments for recruiting and training carers • assessing suitability of potential kinship carers • assisting the child or young person to maintain contact with their family • working to return the child home • assisting the child or young person as they prepare to leave care as the end of the order approaches.
Care and protection orders	Legal orders or administrative/voluntary arrangements involving the community services department, issued in respect of an individual child who is deemed to be in need of care and/or protection. Community services department involvement may include: • total responsibility for the welfare of the child (for example, guardianship) • responsibility for overseeing the actions of the person or authority caring for the child • responsibility for providing or arranging accommodation, or reporting or considering the child’s welfare. The order may have been from a court, children’s panel, minister of the Crown, authorised community services department officer or similar tribunal or officer.

Care and protection orders are categorised as:

- finalised guardianship and finalised custody orders sought through a court
- third party parental responsibility orders
- finalised supervision and other finalised court orders that give the department some responsibility for the child’s welfare (excluding interim orders)
- interim and temporary orders (including orders that are not finalised)
- administrative or voluntary arrangements with the community services department, for the purpose of child protection.

Children are counted only once, even if they are on more than one care and protection order.

Child	A person aged 0–17 years.
Child at risk	A child for whom no abuse or neglect can be substantiated but where there are reasonable grounds to suspect the possibility of prior or future abuse or neglect, and for whom continued departmental involvement is considered warranted.
Child concern reports	Reports to departments responsible for child protection regarding concerns about a child, as distinct from notifications of child abuse and neglect. The distinction between the two differs across and within jurisdictions.
Children in out-of-home care during the year	The total number of children who were in at least one out-of-home care placement at any time during the year. A child who is in more than one placement is counted only once.
Dealt with by other means	A notification that is responded to by means other than an investigation, such as the provision of advice or referral to services.
Exited out-of-home care	Where a child does not return to care within two months.
Family based care	Home-based care (see ‘placement types’).
Family group homes	Residential child care single dwelling establishments that have as their main purpose the provision of substitute care to children. They are typically run like family homes, with a limited number of children who eat together as a family group and are cared for around the clock by resident substitute parents.
Foster care	Care of a child who is living apart from his or her natural or adoptive parents in a private household, by one or more adults who act as ‘foster parents’ and are paid a regular allowance by a government authority or non-government organisation for the child’s support. The authorised department or non-government organisation provides continuing supervision or support while the child remains in the care of foster parents.
Foster parent	Any person (or such a person’s spouse) who is being paid a foster allowance by a government or non-government organisation for the care of a child (excluding children in family group homes).
Guardian	Any person who has the legal and ongoing care and responsibility for the protection of a child.
Indigenous person	Person of Aboriginal or Torres Strait Islander descent who identifies as being an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he or she is associated. If Indigenous status is unknown, then a person is considered to be

	non-Indigenous.
Investigation	An investigation of child abuse and neglect that involves identifying harm or risk of harm to the child, determining an outcome and assessing protective needs. It includes the interviewing or sighting of the subject child where practicable.
Investigation finalised	Where an investigation is completed and an outcome of ‘substantiated’ or ‘not substantiated’ is recorded by 31 August.
Investigation in process	Where an investigation is commenced but an outcome is not recorded by 31 August.
Investigation closed – no outcome possible	Where an investigation is commenced but is not able to be finalised in order to reach the outcome of ‘substantiated’ or ‘not substantiated’. These files would be closed for administrative purposes. This may happen in instances where the family have relocated.
Length of time in continuous out-of-home care	The length of time for which a child is in out-of-home care on a continuous basis. A return home of less than seven days is not considered to break the continuity of placement.
Non-respite care	Out-of-home care for children for child protection reasons.
Notification	Contact with an authorised department by persons or other bodies making allegations of child abuse or neglect, or harm to a child. Notifications can be counted at different points in the response to a report, ranging from the point of initial contact with the source of the report to the end of a screening and decision making process.
Other relative	A grandparent, aunt, uncle or cousin, whether the relationship is half, full, step or through adoption, and can be traced through or to a person whose parents were not married to each other at the time of the child’s birth. This category includes members of Aboriginal communities who are accepted by that community as being related to the child.
Out-of-home care	Overnight care, including placement with relatives (other than parents) where the government makes a financial payment. Includes care of children in legal and voluntary placements (that is, children on and not on a legal order) but excludes placements made in disability services, psychiatric services, juvenile justice facilities and overnight child care services.
Placement types	Four main categories: • residential care (placement in a residential building where the purpose is to provide placement for children and where there are paid staff, including placements in family group homes) • non-residential care (placement in the home of a carer who is reimbursed for expenses for the care of the child). The three subcategories of non-residential care are foster care/community care, relative/kinship care and other • independent living (including private board) • other (including unknown).
Relatives/kin	Family members other than parents, or a person well known to the child and/or family (based on an existing relationship).
Respite care	Out-of-home care on a temporary basis for reasons other than child protection — for example, when parents are ill. Excludes emergency care provided to children who are removed from their homes for protective reasons.

Safety in 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.

Juvenile justice services

Juvenile justice centre	A place administered and operated by a juvenile justice department, where young people are detained whilst under the supervision of the relevant juvenile justice department on a remand or sentenced detention episode.
Juvenile justice department	Refers to those departments in each State and Territory that are responsible for juvenile justice matters.
Supervision period	A period of time during which a young person is continuously under juvenile justice supervision of one type or another. A supervision period is made up of one or more contiguous episodes.
Police caution	Refers to when a police officer administers a caution to the child instead of bringing the child before a court for the offence.
Pre-sentence community	Pre-sentence arrangements where the juvenile justice department is responsible for the case management or supervision of a young person (such as supervised or conditional bail where the juvenile justice department is involved with monitoring or supervising a young person).
Pre-sentence detention	Remanded or held in a juvenile justice centre or police watch house prior to appearing in court or to being sentenced.
Sentenced community-based supervision	Includes probation, recognisance and community service orders which are supervised or case managed by the juvenile justice department. May be supervision with or without additional mandated requirements, requiring some form of obligation or additional element that a young person is required to meet. This obligation could be community work such as in a community service order, a developmental activity or program attendance. The juvenile justice department may or may not directly supervise any additional

	mandated requirements, but remains responsible for the overall case management of a young person.
Youth justice conference / group conference	A youth justice conference is a facilitated meeting resulting in a formal agreement to repair the harm caused by the offence. Participants can include the victim, offender, convenor, police and other key stakeholders. Referrals may be initiated by the police or the courts.

Supported accommodation and assistance services

Accommodation	Crisis or short term accommodation, medium term to long term accommodation, and other SAAP funded accommodation (which comprises accommodation at hostels, motels and hotels, accommodation in caravans, community placements and other SAAP funded arrangements).
Accommodation load (of agencies)	The number of accommodation days divided by the number of days for which the agency is operational during the reporting period, where the number of accommodation days equals the sum of accommodation days for all clients of an agency who are supported during the reporting period. The average accommodation load is the mean value of all agencies' accommodation loads. Support periods without valid accommodation dates are assigned the interquartile modal duration of accommodation for agencies of the same service delivery model in the same jurisdiction.
Agency	The body or establishment with which the State or Territory government or its representative agrees to provide a SAAP service. The legal entity has to be incorporated. Funding from the State or Territory government could be allocated directly (that is, from the government department) or indirectly (that is, from the auspice of the agency). The SAAP service could be provided at the agency's location or through an outlet at a different location.
Caseload (of agencies)	The number of support days (the sum of support days for all clients of the agency who are supported during the reporting period) divided by the number of days for which the agency is operational during the reporting period. The average caseload is the mean value of all agencies' caseloads. Support periods without valid support dates are assigned the interquartile modal duration of support for agencies of the same service delivery model in the same jurisdiction.
Client (SAAP)	A person who is accommodated by a SAAP agency, or enters into an ongoing support relationship with a SAAP agency, or receives support or assistance from a SAAP agency which entails generally 1 hour or more of a worker's time.
Crisis or short term supported accommodation	Supported accommodation for periods of generally not more than three months (short term), and for persons needing immediate short term accommodation (crisis).
Cross target/multiple/ general services	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.
One-off assistance	Assistance provided to a person who is not a client, such as the provision of a meal, a shower, transport, money, clothing, telephone advice, information or a referral.
Ongoing support period	A support period for which, at the end of the reporting period, no support end date and no after-support information are provided.
Outlet	A premise owned/managed/leased by an agency at which SAAP services are delivered. Excludes accommodation purchased using SAAP funds (for example, at a motel).
Outreach support services	Services that exist to provide support and other related assistance specifically to homeless people. These clients may be isolated and able to receive services and support from a range of options that enhance their flexibility (for example, advocacy, life skills and counselling). Generalist support and accommodation services may also provide outreach support in the form of follow-up to clients where they are housed. In this context, support is provided ‘off site’.
Providers	Agencies that supply support and accommodation services.
Real expenditure	Actual expenditure adjusted for changes in prices. Adjustments are made using the GDP(E) price deflator and expressed in terms of final year prices.
Recurrent funding	Funding provided by the Australian, State and Territory governments to cover operating costs, salaries and rent.

Referral	When a SAAP agency contacts another agency and that agency accepts the person concerned for an appointment or interview. A referral is not provided if the person is not accepted for an appointment or interview.
SAAP service	Supported accommodation, support or one-off assistance that is provided by a SAAP agency and intended to be used by homeless persons.
Service delivery model	The mode or manner in which a service is provided through an agency. The modes of service delivery could be described as crisis or short term accommodation and support; medium term to long term accommodation and support; day support; outreach support; telephone information; and referral or agency support. An agency may deliver its services through one or more of these means of delivery.
Service provider	A worker or volunteer employed and/or engaged by a SAAP agency, who either directly provides a SAAP service or in some way contributes to the provision of a SAAP service. Includes administrative staff of an agency, whether paid or not paid.
Single men services	Services provided for males who present to the SAAP agency without a partner or children.
Single women services	Services provided for females who present to the SAAP agency without a partner or children.
Support	SAAP services, other than supported accommodation, that are provided to assist homeless people or persons at imminent risk of becoming homeless to achieve the maximum possible degree of self-reliance and independence. Support is ongoing and provided as part of a client relationship between the SAAP agency and the homeless person.
Support period	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 one month. A support period is relevant to the provision of supported accommodation or support, not the provision of one-off assistance.
Supported accommodation	Accommodation provided by 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.

15.14 Attachment tables

Attachment tables are identified in references throughout this chapter by an '15A' suffix (for example, table 15A.3 is table 3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

All jurisdictions data

Table 15A.1	State and Territory Government real recurrent expenditure on child protection and out-of-home care services, (2008-09 dollars)
Table 15A.2	State and Territory Government real recurrent expenditure on child protection services, per notification, per investigation and per substantiation, (2008-09 dollars)
Table 15A.3	State and Territory Government real recurrent expenditure on out-of-home care services, (2008-09 dollars)
Table 15A.4	Comparability of government recurrent expenditure — items included, 2008-09
Table 15A.5	Child protection notifications, investigations and substantiations by Indigenous status, 2008-09
Table 15A.6	Children admitted to and discharged from care and protection orders by Indigenous status, 2008-09 (number)
Table 15A.7	Children on care and protection orders by type of order and Indigenous status, at 30 June 2009 (number)
Table 15A.8	Children in notifications, investigations and substantiations and children on care and protection orders: number and rate per 1000 children in the target populations by Indigenous status, 2008-09
Table 15A.9	Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, 2007-08
Table 15A.10	Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, 2007-08
Table 15A.11	Proportion of children on guardianship/custody orders achieving the national reading and numeracy benchmarks, Year 3 level, 2003 (per cent)
Table 15A.12	Proportion of children on guardianship/custody orders achieving the national reading and numeracy benchmarks, Year 5 level, 2003 (per cent)
Table 15A.13	Proportion of children on guardianship/custody orders achieving the national reading and numeracy benchmarks, Year 7 level, 2003 (per cent)
Table 15A.14	Response time to commence investigation, 2008-09
Table 15A.15	Response time to complete investigation, 2008-09
Table 15A.16	Children in out-of-home care: number and rate per 1000 children aged 0–17 years by Indigenous status, 2008-09
Table 15A.17	Children in out-of-home care by Indigenous status and placement type, 30 June 2009 (number)

Single jurisdiction data NSW

Single jurisdiction data Vic

Single jurisdiction data Qld

Table 15A.80 Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, Queensland

Table 15A.81 Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, Queensland

Table 15A.82 Children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, Queensland (number)

Table 15A.83 Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, Queensland

Single jurisdiction data WA

Table 15A.84 Child protection notifications, investigations and substantiations by Indigenous status, Western Australia

Table 15A.85 Children admitted to and discharged from care and protection orders by Indigenous status, Western Australia (number)

Table 15A.86 Children on care and protection orders at 30 June by type of order and Indigenous status, Western Australia (number)

Table 15A.87 Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, Western Australia

Table 15A.88 Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Western Australia

Table 15A.89 Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Western Australia

Table 15A.90 Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, Western Australia

Table 15A.91 Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, Western Australia

Table 15A.92 Children in out-of-home care at 30 June, by Indigenous status and placement type, Western Australia (number)

Table 15A.91 Children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, Western Australia (number)

Table 15A.93 Children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, Western Australia (number)

Table 15A.94 Children who exited care during the year by Indigenous status and length of time spent in care, Western Australia (number)

Table 15A.95 Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, Western Australia

Table 15A.96 Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, Western Australia

Table 15A.97 Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, Western Australia

Table 15A.98 Children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, Western Australia (number)

Single jurisdiction data SA

Single jurisdiction data Tas

Table 15A.118 Child protection notifications, investigations and substantiations by Indigenous status, Tasmania

Table 15A.119 Children admitted to and discharged from care and protection orders by Indigenous status, Tasmania (number)

Table 15A.120 Children on care and protection orders at 30 June by type of order and Indigenous status, Tasmania (number)

Table 15A.121 Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, Tasmania

Table 15A.122 Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Tasmania

Table 15A.123 Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Tasmania

Table 15A.124 Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, Tasmania

Table 15A.125 Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, Tasmania

Table 15A.126 Children in out-of-home care at 30 June, by Indigenous status and placement type, Tasmania (number)

Table 15A.127 Children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, Tasmania (number)

Table 15A.128 Children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, Tasmania (number)

Table 15A.129 Children who exited care during the year by Indigenous status and length of time spent in care, Tasmania (number)

Table 15A.130 Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, Tasmania

Table 15A.131 Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, Tasmania

Table 15A.132 Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, Tasmania

Table 15A.133 Children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, Tasmania (number)

Table 15A.134 Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, Tasmania

Single jurisdiction data ACT

Table 15A.135 Child protection notifications, investigations and substantiations by Indigenous status, Australian Capital Territory

Table 15A.136 Children admitted to and discharged from care and protection orders by Indigenous status, Australian Capital Territory (number)

Table 15A.137 Children on care and protection orders at 30 June by type of order and Indigenous

Single jurisdiction data NT

Table 15A.157 Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Northern Territory

Table 15A.158 Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, Northern Territory

Table 15A.159 Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, Northern Territory

Table 15A.160 Children in out-of-home care at 30 June, by Indigenous status and placement type, Northern Territory (number)

Table 15A.161 Children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, Northern Territory (number)

Table 15A.162 Children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, Northern Territory (number)

Table 15A.163 Children who exited care during the year by Indigenous status and length of time spent in care, Northern Territory (number)

Table 15A.164 Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, Northern Territory

Table 15A.165 Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, Northern Territory

Table 15A.166 Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, Northern Territory

Table 15A.169 Children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, Northern Territory (number)

Table 15A.168 Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, Northern Territory

Juvenile justice data

Table 15A.169 Proportion of juvenile justice clients aged 10–17 years who were supervised in the community and in detention centres, at 30 June

Table 15A.170 Daily average population of people aged 10–17 years in juvenile detention (number)

Table 15A.171 Average rate of detention of people aged 10–17 years in juvenile detention, per 100 000 people aged 10–17 years

Table 15A.172 Males and females as a proportion of the total population aged 10–17 years in juvenile detention (per cent)

Table 15A.173 Daily average population of Indigenous people aged 10–17 years in juvenile detention (number)

Table 15A.174 Average rates of detention and Indigenous rate ratio, young people aged 10-17 years in juvenile detention, per 100 000 people

Table 15A.175 Custody nights, by Indigenous status, 2008-09

Table 15A.176 Proportion of pre-sentence reports completed by juvenile justice agencies, by Indigenous status, 2008-09

Table 15A.177 Deaths in custody, by Indigenous status, 2008-09

Table 15A.178 Young people in detention attending education and training, by Indigenous status, 2008-09

SAAP data

15.15 References

ABS (Australian Bureau of Statistics) 2008, *Counting the Homeless 2006*, Cat. No. 2050.0, Canberra.

AIHW (Australian Institute of Heath and Welfare) 2006a, *Family violence among Aboriginal and Torres Strait Islander peoples*, Cat. No. IHW 17, Canberra.

—— 2006b, *Homeless children in SAAP, 2004-05*, Bulletin 48, Canberra.

—— 2009a, *Juvenile Justice in Australia 2007-08*, Cat. no. JUV 4, Canberra.

—— 2009b, *Homeless people in SAAP: SAAP National Data Collection annual report 2007-08* Cat. No. HOU 185, Canberra.

—— 2010, *Child Protection Australia*, 2008-09, Cat. No. CWS 33, Child Welfare Series No. 45, 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.

Chamberlain, C., and MacKenzie, D., 2008, *Counting the homeless, 2006,* Australian Bureau of Statistics, Cat. No. 2050.0, Canberra.

COAG (Council of Australian Governments) 2008a, *Council of Australian Governments' Meeting 3 July 2008* http://www.coag.gov.au/coag_meeting outcomes/2008-07-03/docs/communique20080703.pdf (accessed 9 October 2008).

—— 2008b, *Council of Australian Governments' Meeting 29 November 2008,* http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/docs/ communiqué _20081129.pdf (accessed 1 December 2008).

DHS (Department of Human Services) 2002, *An Integrated Strategy for Child Protection and Placement Services*, Government of Victoria, Melbourne.

FaHCSIA (Department of Families, Housing, Community Services and Indigenous Affairs) 2008a, *Measuring the Impact of SAAP-funded Homelessness Services on Client Self-reliance, Final Report*, Report prepared by the Social Policy Research Centre, University of New South Wales.

—— 2008b, *Which Way Home? A New Approach to Homelessness: Summary* http://www.facsia.gov.au/internet/facsinternet.nsf/housing/which_way_home_summary.htm (accessed 9 October 2008).

—— 2008c, Australia's children: safe and well. A national framework for protecting Australia's children, http://www.fahcsia.gov.au/family/child_protection_discussion_paper/default.htm (accessed 27 October 2008).

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.

Mullighan, E. P., 2008, *Children in State care: Commission of Inquiry,* South Australian Government, Office of the Commissioner, Adelaide.

NLRC (NSW Law Reform Commission) 1997, *The Aboriginal Child Placement Principle*, Research Report no. 7, Sydney.

Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse 2007, *Ampe Akelyernemane Meke Mekarle "Little Children are Sacred"*, Northern Territory Government.

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.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2005, *Report on Government Services 2005*, Productivity Commission, Canberra.

—— 2006, *Report on Government Services 2006*, Productivity Commission, Canberra.

South Australian Government 2009, *The significant of quality contact between children and young people in care and their case workers*, South Australian Guardian for Children and Young People, Adelaide.

The Allen Consulting Group 2008, *Inverting the pyramid: Enhancing systems for protecting children,* Australian Research Alliance for Children and Youth, Australian Capital Territory.

PART G

HOUSING

16 Housing

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 16A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

Governments play a significant role in the Australian housing market, directly through housing assistance and indirectly through policies associated with land planning and taxation. The Australian, State and Territory governments share responsibility for housing assistance. Direct assistance includes public and community housing, home purchase and home ownership assistance, Indigenous housing, State and Territory private rental assistance (such as State and Territory provided bond loans, guarantees and assistance with rent payments and advance rent payments, relocation expenses and other one-off grants) and Australian Government rent assistance.

This chapter focuses on the performance of governments in providing:

- public, State owned and managed Indigenous housing (SOMIH) and community housing under the Commonwealth State Housing Agreement (CSHA) until 31 December 2008 and the National Affordable Housing Agreement (NAHA) from 1 January 2009 (termed CSHA/NAHA in this chapter) (box 16.1)
- Indigenous community housing (ICH)
- Commonwealth Rent Assistance (CRA).

Box 16.1 **Commonwealth State Housing Agreement and National Affordable 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 for those who most need it, for the duration of their need.

The 2003 CSHA came into effect on 1 July 2003 and was to operate until 30 June 2008 (but was extended to 31 December 2008, pending negotiation of the NAHA), and includes bilateral agreements between the Australian Government and each State and Territory government and an overarching multilateral agreement. There were generally separate bilateral agreements for mainstream and Indigenous housing in each jurisdiction.

The NAHA came into effect on 1 January 2009 and is an ongoing agreement that provides the framework for the parties to work together to improve housing affordability and homelessness outcomes for Australians. The objective of the NAHA is that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation.

The parties to the NAHA are committed to:

- providing direction for a range of measures including: social housing; assistance to people in the private rental market; support and accommodation for people who are homeless or at risk of homelessness; and home purchase assistance
- working towards improving coordination across housing related programs to make better use of existing stock and under-utilised Government assets and achieve better integration between housing and human services, including health and disability services
- reducing the rate of homelessness.

Source: FaCS (2003a); COAG (2009).

Close links exist between the housing services covered in this chapter and other government programs and support services discussed elsewhere in the Report, such as:

- the Supported Accommodation Assistance Program (SAAP), which until 31 December 2008, provided accommodation and other services for homeless people or those at imminent risk of becoming homeless. As of 1 January 2009, these services are provided under the NAHA (chapter 15)
- services delivered by the Australian, State and Territory governments and community organisations to promote independent living, including services for people with a disability (chapter 14), mental health services (chapter 12) and aged care services, such as the Home and Community Care program (chapter 13).

Improvements in the chapter this year include:

- reporting of data for the access indicator ‘special needs income units aged 24 years or under, or 75 years or over’ in the Commonwealth Rent Assistance (CRA) service area
- reporting of data for the affordability indicator ‘proportions of income units spending more than 30 per cent and 50 per cent of their income on rent with and without CRA’ for income units aged 24 years or under and aged 75 years or over receiving CRA.

Public housing, SOMIH, community housing and ICH information has been obtained from State and Territory governments, except where otherwise indicated. The Australian Institute of Health and Welfare (AIHW) collects and collates these data and produces annual data collection manuals. Data tables are available on the AIHW website (AIHW 2009a). CRA data were obtained from the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). Data on satisfaction, amenity and location were obtained from national social housing surveys of public housing, SOMIH and community housing tenants.

Housing assistance not covered

This chapter does not cover a number of government funded and provided housing services, including:

- the Crisis Accommodation Program (CAP), including the Victorian Transitional Housing Management Program under the CSHA/NAHA, which provides capital funding for accommodation for homeless people
- non-CSHA/NAHA programs, including those provided by the Department of Veterans’ Affairs (DVA)

- CRA paid by the DVA or paid to Abstudy recipients on behalf of the Department of Education, Employment and Workplace Relations (DEEWR)
- some Indigenous housing and infrastructure assistance
- mainstream community housing not funded under the CSHA/NAHA
- home purchase assistance, including the First Home Owners Grant, a Commonwealth initiative administered by State and Territory governments
- private rent assistance funded by State and Territory governments
- the National Rental Affordability Scheme
- other Commonwealth initiatives, such as the Housing Affordability Fund (HAF).

16.1 Profile of housing and housing assistance

Service overview

The Australian Bureau of Statistics (ABS) 2006 Census of Population and Housing (ABS 2007) identified just under 7.1 million households in Australia, where 'household' is classified as 'a person living alone' or as 'a group of related or unrelated people who usually reside and eat together'. Of these households, 68.1 per cent owned or were purchasing their own home, 19.0 per cent rented in the private sector, 3.6 per cent were in public rental accommodation, 0.7 per cent lived in community housing,[1] 2.6 per cent resided in other tenure types and 6.0 per cent did not state their tenure type (table 16A.75). For a number of reasons, including non-response and misunderstanding, Census data are likely to underestimate the number of tenants in public housing.[2]

The composition of Australian households is changing. There is an increasing number of smaller households, including a rising number of single person households. The average Australian household size fell from 3.3 people to 2.8 people between 1971 and 2006, while the proportion of single person households increased from 18.1 per cent to 24.4 per cent over this period (ABS 2007).

The average Indigenous household is larger than the average non-Indigenous household. In 2006, the average non-Indigenous Australian household size was

---

[1] This estimate is based on data received from jurisdictions regarding the number of community housing dwellings in each jurisdiction, combined with data from the ABS 2006 Census on the total number of dwellings in each jurisdiction.

[2] Public housing tenants appear to be undercounted in the 2006 Census (and in previous censuses).

2.6 people, whereas the average household with at least one Indigenous person was 3.4 people (ABS 2007).

Why government provides housing assistance

Australia's private housing stock houses the majority of the population. Most Australian households can access accommodation either through owner occupation or by renting from a private landlord. Many households, however, face problems in acquiring or accessing suitable private accommodation, for reasons of cost, discrimination, availability, location and/or adequacy. The price of rental dwellings can be prohibitive for people on lower incomes. Further, stock may not be available in the private rental market for households with special accommodation needs. Housing assistance from the Australian, State and Territory governments can help these households.

Roles and responsibilities

Each level of government has different roles and responsibilities in housing and housing assistance:

- The Australian Government provides CRA and shares responsibility with State and Territory governments for housing assistance provided under the CSHA/NAHA. It also provides funding for the Community Housing and Infrastructure Program (CHIP) that ceased in June 2008. The Australian Government also influences the housing market through other direct and indirect means, including taxation and home purchase assistance.
- State and Territory governments provide housing assistance, such as homeless assistance, public housing, community housing, SOMIH, private rental assistance and home purchase assistance. Some jurisdictions also contribute to the delivery of housing assistance through mechanisms such as home lending programs and joint ventures with the private sector. State and Territory governments are also responsible for land taxes, stamp duties and residential tenancy legislation.
- Local governments implement planning regulations and are sometimes involved in providing community housing.

Funding

The Australian, State and Territory governments provided $682.5 million for housing programs under the CSHA for the 6 months to 31 December 2008. Of this, the Australian Government provided $492.5 million or 72.2 per cent, and State and Territory governments were collectively required to provide minimum matching funds of $190.0 million or 27.8 per cent (FaHCSIA 2009). In addition, most jurisdictions provided additional funding above the minimum matching requirements. Public and community housing accounted for the majority of CSHA funding. Since 1 January 2009 the majority of funding for social housing was provided under the NAHA estimated at $1459.5 million (State and Territory governments unpublished).

Indigenous community housing is also funded by the Australian, State and Territory governments. Some of the funding for ICH comes through the CSHA/NAHA.

Public housing is the largest form of assistance provided under the CSHA/NAHA. Given the capital intensive nature of provision of social housing, additional assistance to annual funding is provided through the use of $82 billion of housing stock owned by housing authorities in 2007-08 (calculated from 2007-08 State and Territory CSHA national financial statements [unpublished]).

The Australian Government provided $2.6 billion for CRA in 2008-09. Real expenditure on CRA has increased by 19.0 per cent over a 10 year time period (FaHCSIA 2009).

Table 16.1 is a summary table that presents government expenditure including and excluding capital costs, on a per person and per dwelling basis. It also includes CRA expenditure per person and per income unit to present the overall level of government housing assistance covered in this chapter. More detailed analysis of the cost components for public housing is presented in table 16.12. Nationally, net recurrent cost per person on public housing was approximately $100 in 2008-09. Cost including capital costs per person on public housing was $319 (table 16.1). Nationally, net recurrent cost per dwelling on public housing was approximately $6366 in 2008-09. Average cost including capital cost per dwelling on public housing was $26 074 (table 16.1).

It is important to note the differences in housing assistance operations across jurisdictions when analysing expenditure per person on public housing. 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. Reporting net recurrent cost per public housing dwelling addresses some of these issues.

Table 16.1 **Government housing assistance, 2008-09 (dollars)**[a]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Government expenditure on public housing									
Per person[b]									
Net recurrent cost	112	59	73	102	168	185	242	312	100
Cost including capital cost	421	311	318	521	557	491	1 149	777	410
Per dwelling									
Net recurrent cost	6 549	4 813	6 146	7 000	6 342	7 498	7 736	13 201	6 366
Cost including capital cost	24 653	25 458	26 655	35 596	21 013	21 130	36 672	32 881	26 074
CRA expenditure									
Per person[b]	130	109	151	95	117	136	55	59	123
Per income unit	2 660	2 623	2 687	2 607	2 576	2 645	2 418	2 580	2 645

[a] Data may not be comparable across jurisdictions and comparisons could be misleading. Reasons for this are provided in tables 16A.5 and 16A.88. [b] Data are expressed as per person of the Australian population.

Source: FaHCSIA (unpublished); State and Territory governments (unpublished); table 16A.88.

Size and scope

Housing assistance is provided in various forms, and models for delivering assistance vary within and across jurisdictions. The eight main forms of assistance are outlined in box 16.2. This chapter focuses on five of these forms of assistance: public housing, SOMIH, community housing, ICH and CRA.

Box 16.2 **Forms of housing assistance**

There are several significant forms of housing assistance.

- *Public housing*: dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation.
- *Community housing*: rental housing provided for low to moderate income or special needs households, managed by community-based organisations that have received capital or recurrent subsidy from government. Community housing models vary across jurisdictions, and the housing stock may be owned by a variety of groups including government.
- *State owned and managed Indigenous housing (SOMIH)*: houses owned by the State, targeted at Indigenous households.
- *Indigenous community housing (ICH)*: dwellings owned or leased and managed by ICH organisations and community councils in major cities, regional and remote areas.

(Continued on next page)

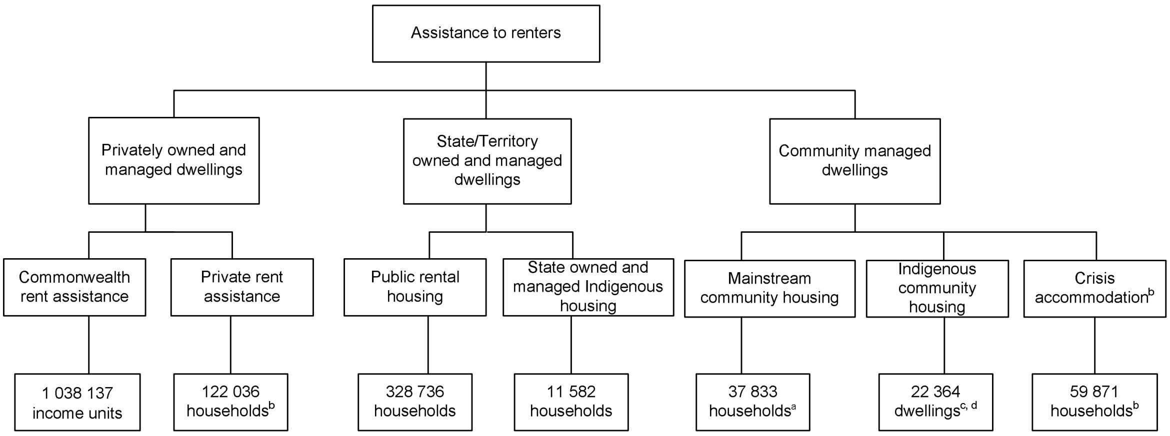
Box 16.2 **(Continued)**

- *Crisis accommodation*: accommodation services to help people who are homeless or in crisis. Services are generally provided by non-government organisations and many are linked to support services funded through SAAP/NAHA. Sources of government funding include CAP through the CSHA/NAHA, which provides funding for accommodation, and SAAP/NAHA funding for live-in staff, counselling and other support services.
- *Home purchase assistance*: assistance provided by State and Territory governments to low income households to help with home purchases or mortgage repayments.
- *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 can be provided by community-based organisations funded by government.
- *Commonwealth Rent Assistance (CRA*): 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: FaCS (2003a, 2003b).

Figure 16.1 illustrates the range of government assistance to renters.

Figure 16.1 **Assistance across the rental sector, 2009**[a]



[a] Additional dwellings are funded under programs other than CSHA/NAHA. Data about these dwellings are not available. [b] For year ending 30 June 2008. [c] At 30 June 2008. [d] Includes permanent dwellings managed by funded/actively registered and unfunded/not actively registered ICH organisations. Of these dwellings 19 583 were managed by organisations administered by the State Governments and 2781 managed by organisations administered by the Australian Government.

Source: Australian, State and Territory governments (unpublished); AIHW (2009) *Housing assistance tables*; AIHW (2009) *Indigenous housing indicators 2007-08*, Indigenous housing series no. 3, Cat. no. HOU 212; AIHW (2009) *Crisis Accommodation program 2007-08: Commonwealth State Housing Agreement national data report*, Housing assistance data development series, Cat. no. HOU 202; AIHW (2009) *Private Rent Assistance 2007-08: Commonwealth State Housing Agreement national data report*, Housing assistance data development series, Cat. no. HOU 200; tables 16A.1, 16A.14, 16A.25, 16A.37 and 16A.65.

Public housing

Public housing comprises those dwellings owned (or leased) and managed by State and Territory housing authorities. The CSHA/NAHA is the main source of funding for public housing. From 1 January 2009, funding for public housing was incorporated into the NAHA, but the NAHA does not separately identify funding for public housing. A total of 328 679 public housing dwellings were occupied at 30 June 2009 (table 16A.1). Public housing is available to people on low incomes and those with special needs. At 30 June 2008, 31.1 per cent of public housing households contained a household member with disability (AIHW 2009d).

Public housing rents are generally set at market levels, and rebates are granted to low income tenants (so they generally pay no more than 25 per cent of their assessable income in rent), to provide affordable housing. Public housing allocations are constrained by the amount of housing stock available and are income tested. The proportion of total households residing in public housing in 2006 (4.3 per cent nationally) is presented for all jurisdictions in table 16A.78. Information on the proportion of income paid in rent by public housing tenants is contained in table 16A.82. Details of multiple family composition, non-rebated and other public households excluded from data in this chapter are presented in table 16A.89.

State owned and managed Indigenous housing

State owned and managed Indigenous housing dwellings funded through CSHA/NAHA are defined as those rental housing dwellings owned and managed by government and allocated only to Indigenous Australians (AIHW 2006). They include dwellings managed by government Indigenous housing agencies for allocation to Indigenous tenants. There were 12 056 dwellings identified in the 2008-09 SOMIH collection (table 16A.14). From 1 January 2009, funding for housing was incorporated into the NAHA, but the NAHA does not separately identify funding for SOMIH.

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/NAHA and the State Government (in addition to its CSHA/NAHA commitments).

In Victoria, Aboriginal Housing Victoria (AHV) — a non-government community housing organisation — assists the government in the administration of SOMIH. Under the transition to independence strategy for AHV, tenancy management for many SOMIH properties was transferred to AHV in 2008-09. This has reduced the number of properties reported in Victoria as SOMIH and will lead to a corresponding increase in the number of properties reported as State managed ICH for 2008-09. It should be noted that while SOMIH stock is reported for the year 2008-09, ICH is reported for the year 2007-08.

The ACT and the NT are not included in the SOMIH data collection. The ACT does not receive funding for, or administer, any Territory owned and managed Indigenous housing programs. In the NT, Aboriginal Rental Housing Program (ARHP) funding is directed to ICH.

Details of multiple family composition, non-rebated and other public households excluded from SOMIH data in this chapter are presented in table 16A.90.

Community housing

Community housing is generally managed by not-for-profit organisations or local governments that perform asset and tenancy management functions. A major objective of community housing is to increase social capital by encouraging local communities to take a more active role in planning and managing appropriate and affordable transitional and long term rental accommodation. Community housing is also intended to provide a choice of housing location, physical type and management arrangements. Some forms of community housing also allow tenants to participate in the management of their housing.

Community housing programs aim to achieve links between housing and services that are best managed at the community level, including services for people with a disability, and home and community care. Notwithstanding their common objectives, community housing programs vary within and across jurisdictions in their administration and types of accommodation (box 16.3).

Box 16.3 **Models of community housing**

Community housing models vary across jurisdictions in 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.79 lists the community housing programs in each jurisdiction.

Some community housing models are:

- *regional or local housing associations*: associations provide property and tenancy management services, and community groups provide support services to tenants
- *joint ventures and housing partnerships*: a range of church, welfare, local government agencies and other organisations provide resources in cooperation with State and Territory governments
- *housing cooperatives*: 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*: not-for-profit or community housing associations both own and manage housing
- *local government housing associations*: provide low cost housing within a particular municipality, are closely involved in policy, planning, funding and/or monitoring roles, and can directly manage the housing stock
- *equity share rental housing*: housing cooperatives wholly own the housing stock and lease it to tenants (who are shareholders in the cooperative and, therefore, have the rights and responsibilities of cooperative management).

Source: State and Territory governments (unpublished).

Funding for community housing is typically either fully or partly provided by governments to not-for-profit organisations or local governments. Australian Government funding for community housing amounted to 7.0 per cent ($34.3 million) of total CSHA funding provided by the Australian Government from 1 July 2008 to 31 December 2008 (FaHCSIA unpublished). From 1 January 2009, funding for housing, was incorporated into the NAHA, but the NAHA does not separately identify funding for community housing.

There were 39 770 mainstream community housing tenancy rental units in Australia at 30 June 2009 (table 16A.25).[3] Table 16A.80 presents the proportion of all households residing in community housing in each jurisdiction in 2006 (0.7 per cent nationally).

Indigenous community housing

Indigenous community housing refers to housing funded by State or Federal governments that is managed and delivered by ICH organisations. Funding for ICH comes through Australian Government programs such as the ARHP, CHIP and the National Aboriginal Health Strategy. State and Territory governments also provide funding for ICH. The funding and administrative arrangements for ICH vary across jurisdictions. In some jurisdictions, only the states are involved in the administration of ICH; in some only the Australian Government is involved; and in others both the State or Territory and the Australian governments are involved. From 1 January 2009, funding for housing, was incorporated into the NAHA, but the NAHA does not separately identify funding for ICH.

In 2007-08, the Australian Government funded and administered ICH in three jurisdictions, Victoria, Queensland and Tasmania. At the time data for this Report were collected (2007-08), in Tasmania there was only Australian Government administered ICH housing, while in Victoria and Queensland, some ICH housing was administered by the Australian Government and some by the State governments. In the five remaining jurisdictions — NSW, WA, SA, the ACT and the NT — funding from the applicable State or Territory and the Australian Government is combined and the State or Territory government has sole responsibility for the administration of ICH (AIHW 2009b).

Descriptive information on ICH excluded from data in this chapter is contained in table 16A.37.

---

[3] Data are based on a combination of survey and administrative data. Results, therefore, are affected by survey non-response. Details of community housing survey response rates and associated information are presented in table 16A.91.

CRA

Commonwealth Rent Assistance is a non-taxable supplementary payment provided by the Australian Government to help with the cost of private rental housing. It is available to recipients of either income support payments, or Family Tax Benefit Part A at more than the base rate who pay private rent above minimum thresholds. Private rent includes rent paid under both formal tenancy agreements and informal arrangements, such as board and lodging paid to a family member. It also includes mooring and site fees (for boats and caravans) and payments for retirement village services.

Commonwealth Rent Assistance is paid at 75 cents for every dollar above the threshold until a maximum rate is reached. The maximum rates and thresholds vary according to a customer's family situation and number of children (table 16.2). 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.

Table 16.2 **Eligibility and payment scales for CRA, 20 March to 19 September 2009 ($ per fortnight)[a]**

Income unit type	*Minimum rent to be eligible for CRA*	*Minimum rent to be eligible for maximum CRA*	*Maximum CRA*
Single, no dependent children	98.80	247.07	111.20
Single, no children, sharer	98.80	197.64	74.13
Couple, no dependent children	161.00	300.73	104.80
Single, one or two dependent children	130.06	304.03	130.48
Single, three or more dependent children	130.06	326.81	147.56
Partnered, one or two dependent children	192.50	366.47	130.48
Partnered, three or more dependent children	192.50	389.25	147.56
Partnered, illness separated, no dependent children	98.80	247.07	111.20
Partnered, temporarily separated, no dependent children	98.80	238.53	104.80

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.47.

Source: FaHCSIA (unpublished); table 16A.47.

Because CRA is a national payment, FaHCSIA seeks to ensure that CRA recipients who have the same income unit characteristics and who pay the same amount of rent receive the same amount of assistance wherever they live. There were 1 038 137 income units (where an income unit is defined as either a single person or a couple with or without dependents)[4] entitled to receive CRA at 5 June 2009 (table 16A.48). The proportion of CRA recipients by income unit type is presented in table 16A.49. Data on the number and proportion of Indigenous income units receiving CRA by income unit type are presented in tables 16A.50 and 16A.51, respectively.

The maximum rate of assistance was received by 71.7 per cent of CRA recipients paid enough rent to receive the maximum rate of assistance at 5 June 2009 (table 16A.63). There was relatively little variation in the average level of assistance across locations at 5 June 2009 (table 16A.62), even though rents varied considerably by location. At 5 June 2009, the average payment across Australia was $94.79 per fortnight (approximately $2465 per year) (table 16A.62).

Housing assistance-related services not reported in the Housing chapter

Governments also provide services that aim to assist people who are homeless or at risk of being homeless, through the SAAP until 31 December 2008 and the NAHA from 1 January 2009. Under both arrangements, the AIHW manages the national data collection which provides information on people accessing services provided under these agreements who were homeless and people who were at risk of homelessness. The AIHW also collects information on the demand for services provided under the SAAP/NAHA and the ability to meet this demand. The collection provides information on people who were homeless and people who were at risk of homelessness, who accessed SAAP in 2007-08 (AIHW 2009c).

In 2007-08, 1562 non-government, community and local government organisations were funded nationally under SAAP (AIHW 2009c). These organisations ranged from small stand-alone agencies with single outlets to larger auspice bodies with multiple outlets.

On census night in 2006, there were approximately 105 000 homeless people (Chamberlain and MacKenzie 2008). Nationally, in 2007-08, SAAP agencies provided support to 202 500 people (125 600 clients and 76 900 accompanying children) (see chapter 15 for more details on SAAP services.)

---

[4] Dependents are defined as young people 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.

Data collected via the SAAP Client Collection show that SAAP or CAP accommodation was able to be provided directly to clients and their accompanying children in the majority of cases (87 per cent and 85 per cent, respectively). When accommodation could not be provided directly, clients were referred on to other organisations in 8 per cent of cases. Demand for accommodation remained unmet in 5 per cent of cases for adult clients and in 7 per cent of clients with accompanying children.

Diversity of State and Territory public housing, community housing and SOMIH services

State and Territory governments have similar broad objectives for providing housing assistance. Individual jurisdictions, however, emphasise different objectives depending on their historical precedents and ways of interacting with community sector providers. Jurisdictions also have different private housing markets. These differences lead to a variety of policy responses and associated forms of assistance. It is important to be aware of the various housing assistance operations in each State and Territory when analysing performance information, the differences in regional and remote area concentration, and the various eligibility criteria for the different assistance types.

Housing assistance reported in this chapter is closely associated with assistance provided under the SAAP (until 31 December 2008) and supported assistance and accommodation services provided under the NAHA (from 1 January 2009).

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 16.3.

Table 16.3 **Public housing — regional and remote area concentrations, at 30 June 2009 (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major cities	82.1	72.4	67.4	70.3	77.3	..	99.9	..	72.8
Inner regional	14.4	22.5	16.4	9.6	6.7	73.3	0.1	..	16.2
Outer regional	3.2	5.2	14.0	9.8	14.1	25.9	..	70.2	8.9
Remote	0.3	–	1.7	7.2	1.8	0.5	..	26.1	1.7
Very remote	–	..	0.5	3.1	0.2	0.3	..	3.7	0.5

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.1. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2009) *Housing assistance tables*; table 16A.1.

The proportions of SOMIH located by ASGC remoteness areas are shown in table 16.4.

Table 16.4 SOMIH — regional and remote area concentrations, at 30 June 2009 (per cent)[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
Major cities	41.3	34.3	14.3	27.9	60.8	..	33.3
Inner regional	32.8	29.8	19.1	7.8	7.5	83.3	21.9
Outer regional	20.2	35.9	39.4	21.0	18.0	16.7	25.3
Remote	4.9	–	10.6	20.3	5.2	–	9.1
Very remote	0.7	..	16.6	23.1	8.5	–	10.3

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.14 .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2009) *Housing assistance tables*; table 16A.14.

Eligibility criteria for access to public housing, such as income and asset definitions and limits, vary across jurisdictions (table 16A.92). In most cases, jurisdictions require that applicants be Australian citizens or permanent residents and not own or part-own residential property. All jurisdictions require eligible applicants to be resident in the respective State or Territory. All State and Territory governments prioritise access to public housing by segmenting their waiting lists in some way. Segments are defined differently across jurisdictions, but generally reflect urgent need/homelessness and an inability to access appropriate private market accommodation. Most jurisdictions provide security of tenure after an initial probationary period. Most jurisdictions also have periodic reviews of eligibility. Rebated rents result in the majority of households paying no more than 25 per cent of their assessable income in rent (the rent-to-income ratio). Definitions of assessable income vary across jurisdictions.

Eligibility criteria for access to SOMIH are generally consistent with those for public housing once an applicant has been confirmed as Indigenous (table 16A.93). The management of waiting lists varies across jurisdictions — for example, a number of jurisdictions use the same list for both public housing and SOMIH. Terms of tenure are the same as those for public housing for a number of jurisdictions.

The policy contexts of public housing and SOMIH are summarised in tables 16A.92 and 16A.93, respectively.

Eligibility criteria for community housing are generally consistent with those for public housing in each jurisdiction. Most jurisdictions do not require community housing organisations to segment waiting lists.

The proportions of community housing located by ASGC remoteness areas are shown in table 16.5.

Table 16.5 **Community housing — regional and remote area concentrations, at 30 June 2009 (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major cities	67.9	74.2	42.0	65.3	85.0	..	99.7	..	65.7
Inner regional	23.4	21.7	22.9	11.8	9.0	63.3	0.3	..	20.1
Outer regional	8.5	4.0	25.6	12.6	4.5	35.2	..	64.1	11.0
Remote	0.2	0.2	3.2	7.9	1.4	1.5	..	32.1	1.9
Very remote	–	..	6.3	2.4	0.1	–	..	3.8	1.4

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.25. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2009) *Housing assistance tables*; table 16A.25.

Private rental markets

Tight private rental markets (vacancy rates well below 3 per cent) were evident in all jurisdictions in June 2009. Capital city vacancy rates in the private rental market for all jurisdictions are reported in table 16A.76. Capital city median rents varied across jurisdictions. Median rents for three bedroom houses and two bedroom flats or units are reported in table 16A.77.

16.2 Framework of performance indicators

The performance indicator frameworks show which data are comparable in the 2010 Report (figures 16.2, 16.11, 16.18 and 16.19). 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).

Appendix A contains information on each State and Territory that may help in interpreting the performance indicators presented in this chapter.

The frameworks reflect the adoption by governments of accrual accounting and depict the Review’s focus on outcomes, consistent with demand by governments for outcome oriented performance information. The frameworks also accentuate the importance of equity. More detail on the general report framework, along with the differences between outputs and outcomes, can be found in chapter 1.

While public housing, SOMIH, community housing and ICH use a common framework, the delivery method for public housing and SOMIH differs from that for community housing and ICH. State and Territory governments deliver public housing and SOMIH, while community organisations and sometimes local governments deliver community housing and ICH.

The performance indicator frameworks are consistent with the general performance indicator framework agreed by the Steering Committee (see chapter 1). They also draw on the framework developed for the 1999 CSHA and reflect the national objectives of that agreement (and of the CSHA that took effect in 2003 [box 16.4]) and of the NAHA that took effect on 1 January 2009. This year data for 1 July 2008 to 31 December 2008 relate to the CSHA and data for 1 January 2009 to 30 June 2009 relate to the NAHA.

The Council of Australian Governments (COAG) has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (see chapter 1 for more detail on reforms to federal financial relations). The NAHA covers the area of Housing, while the National Indigenous Reform Agreement (NIRA) establishes specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. The agreements include sets of performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC). It is anticipated that the performance indicators reported in this chapter will be revised to align with the performance indicators in the National Agreements for the 2011 Report.

Box 16.4 **Objectives for public, SOMIH and community housing under the 2003 CSHA and the 2009 NAHA**

The principles guiding the 2003 CSHA are to:

1. maintain a core Social Housing sector to assist people unable to access alternative suitable housing options
2. develop and deliver affordable, appropriate, flexible and diverse housing assistance responses that provide people with choice and are tailored to their needs, local conditions and opportunities
3. provide assistance in a manner that is non-discriminatory and has regard to consumer rights and responsibilities, including consumer participation
4. commit to improving housing outcomes for Indigenous people in urban, regional and remote areas, through specific initiatives that strengthen the Indigenous housing sector and the responsiveness and appropriateness of the full range of mainstream housing options

(Continued on next page)

Box 16.4 **(Continued)**

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.

The objective of the NAHA is that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation.

Source: FaCS (2003a) p. 4; COAG (2009).

Indigenous community housing aims to achieve the outcomes listed in box 16.5 as part of the *Building a Better Future: Indigenous Housing to 2010* strategy.

Box 16.5 **Objectives for Indigenous housing and Indigenous community housing**

In May 2001, housing ministers endorsed a 10-year statement of new directions for Indigenous housing, Building a Better Future: Indigenous Housing to 2010 (BBF). BBF recognised that Indigenous housing was a major national issue requiring priority action and sought to improve housing and environmental health outcomes for Indigenous Australians. The focus of BBF was on: identifying and addressing outstanding need; improving the viability of ICH organisations; establishing safe, healthy and sustainable housing for Indigenous Australians, especially in rural and remote communities; and establishing a national framework for the development and delivery of improved housing outcomes for Indigenous Australians by State, Territory and community housing providers.

(Continued on next page)

Box 16.5 (Continued)

The National Reporting Framework (NRF) for Indigenous Housing was developed to provide a framework for reporting across all Indigenous housing programs and on the implementation and outcomes of BBF.

The guiding principles and objectives for achieving better Indigenous housing are to:

1. provide better housing that meets agreed standards, is appropriate to the needs of Aboriginal and Torres Strait Islander people, and contributes to their health and well being
2. provide better housing services that are well managed and sustainable
3. ensure housing growth in the number of houses to address both the backlog of Indigenous housing need and emerging needs of a growing Indigenous population
4. ensure improved partnerships in a way that Indigenous people are fully involved in the planning, decision making and delivery of services by governments
5. ensure greater effectiveness and efficiency in a way that assistance is properly directed to meeting objectives, and that resources are being used to best advantage
6. commit to improved performance linked to accountability for the program performance reporting based on national data collection systems and good information management
7. promote the a 'whole of government' coordination of services approach that ensures greater coordination of housing and housing-related services linked to improved health and well being outcomes.

The recent CSHA and the current NAHA (and the NIRA) place greater emphasis on Australian, State and Territory governments improving housing outcomes for Indigenous people, and governments have committed to improving access to mainstream housing options for Indigenous people living in urban and regional areas.

Source: AIHW (2009b); FaCSIA (2001).

The performance indicators for CRA differ from those for public, SOMIH, mainstream community housing and ICH because CRA has different objectives and delivery methods. The CRA performance indicator framework in figure 16.19 is based on the CRA objective outlined in box 16.6.

Box 16.6 **Objective of CRA**

The objective of CRA is to provide income support recipients and low income families in the private rental market with additional financial assistance, in recognition of the housing costs that they face (Newman 1998). This assistance should be delivered in an equitable and efficient manner. CRA is also governed by other objectives relating to the primary income support payment.

16.3 Key performance indicator results

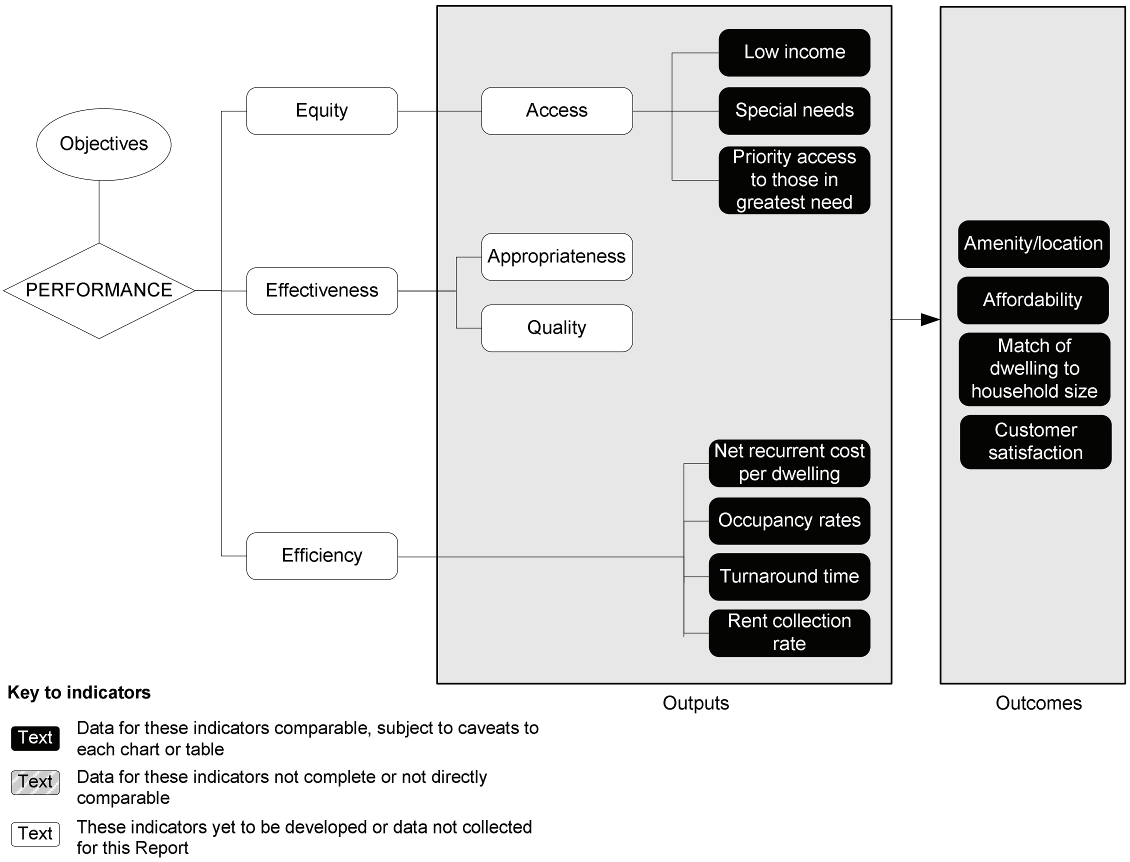
Generally, performance indicator results are comparable between public housing and SOMIH, but are not comparable to mainstream community housing and ICH because data quality and coverage can differ. More information on definitions is provided in a box for each indicator.

Public housing and SOMIH

The performance indicator framework for public housing and SOMIH is presented in figure 16.2.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 16.2 **Performance indicators for public housing and SOMIH**



Different delivery contexts, locations and differing tenant needs can affect the performance of public housing and SOMIH reported in this chapter. For example, SOMIH dwellings are more likely than mainstream public or community housing dwellings to be located in regional or remote areas (tables 16.3, 16.4 and 16.5). Care therefore needs to be taken in comparing performance indicator results, and the qualifications presented with the data need to be considered.

Appendix A contains information on each State and Territory that may help in interpreting the performance indicators presented in this chapter.

Some descriptive information on public housing are included in table 16A.1. Some descriptive data on SOMIH are included in table 16A.14. As outlined in section 16.1, the ACT and the NT are not included in the SOMIH data collection.

Outputs

The following indicators measure the outputs of public housing and SOMIH. Outputs are the actual services delivered, while outcomes are the impact of these services on the status of an individual or group (see chapter 1, section 1.5).

Equity

Low income

'Low income' is an indicator of governments' objective to assist people unable to access alternative suitable housing options (box 16.7).

Box 16.7 **Low income**

'Low income' is defined as the number of new low income households as a proportion of all new households. Two measures are reported:

- the proportion of new households with low income A — households where all members receive an income equivalent to or below 100 per cent of the government income support benefits at the pensioner rate (pension rates have been selected for calculating this indicator because they are higher than allowance rates)
- the proportion of new households with low income B — households with an income above 100 per cent of the government income support benefits at the pensioner rate, but below the effective cut-off for receiving any government support benefits.

High or increasing values for these measures indicate a high degree of access for low income households.

Data reported for this indicator are comparable.

Nationally, the proportion of new tenancies allocated to low income A households for public housing in 2008-09 was 90.0 per cent (table 16.6). The proportion of new tenancies allocated to low income B households is reported in the attachment (table 16A.2).

Table 16.6 Public housing — new low income A households, as a proportion of all new households (per cent)[a]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
New low income A households as proportion of all new households									
2004-05	94.0	92.5	88.1	85.8	87.1	80.8	89.4	85.6	90.0
2005-06	94.5	93.3	87.3	88.2	87.6	89.8	87.1	85.3	90.9
2006-07	93.6	92.5	72.9	83.6	89.5	88.9	90.2	85.2	87.7
2007-08	95.0	90.8	79.3	85.1	87.2	84.3	87.3	88.2	88.5
2008-09	95.6	93.7	83.1	85.1	92.2	84.4	87.0	82.0	90.0

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.2.

Source: AIHW (2006a, 2006b, 2008, 2009) *Public rental housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.2.

Nationally, the proportion of new tenancies allocated to low income A households for SOMIH in 2008-09 was 86.0 per cent (table 16.7). The proportion of new tenancies allocated to low income B households is reported in the attachment (table 16A.15).

Table 16.7 SOMIH — new low income A households, as a proportion of all new households (per cent)[a]

	NSW	Vic	Qld	WA	SA	Tas	Total
New low income A households as proportion of all new households							
2004-05	94.2	87.7	76.1	92.9	86.0	86.0	88.0
2005-06	95.9	88.2	89.2	88.6	86.5	93.3	90.4
2006-07	95.5	89.9	76.5	87.9	88.7	100.0	87.7
2007-08	95.0	82.4	75.4	88.3	85.5	82.4	86.0
2008-09	91.5	na	81.4	85.0	88.8	82.1	86.0

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.15. **na** Not available.

Source: AIHW (2006a, 2006b, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.15.

The ratio of low income households to all new households was similar for public housing and SOMIH. There were some variations across jurisdictions.

Special needs

'Special needs' is an indicator of governments' objective to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing (box 16.8).

Box 16.8 **Special needs**

‘Special needs’ is defined as the proportion of new tenancies allocated to special needs households. Special needs households are defined as those households that have either a household member with disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members. Special needs households for SOMIH are defined as those households that have either a household member with disability or a principal tenant aged 24 years or under, or 50 years or over.

A high or increasing proportion indicates a high degree of access by these special needs households.

Data for public housing cannot be compared with those of SOMIH or community housing.

Data reported for this indicator are comparable.

Nationally, new public housing tenancies allocated to households with special needs was 64.8 per cent in 2008-09 (table 16.8).

Table 16.8 **Public housing — new tenancies allocated to households with special needs (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2004-05	55.7	47.1	62.7	64.8	63.2	67.6	48.4	100.0	58.2
2005-06	55.7	58.9	61.9	67.7	61.1	66.1	52.7	63.1	59.8
2006-07	52.3	54.5	64.6	56.2	65.8	63.9	48.5	66.0	57.8
2007-08	50.3	53.2	68.6	69.5	66.4	68.0	50.7	63.0	59.0
2008-09	63.4	63.5	70.3	59.5	70.7	65.9	51.8	64.6	64.8

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.3.

Source: AIHW (2006a, 2006b, 2008, 2009) *Public rental housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.3.

Nationally, the proportion of new tenancies allocated to special needs households for SOMIH was 48.3 per cent in 2008-09 (table 16.9).

Table 16.9 **SOMIH — new tenancies allocated to households with special needs (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
2004-05	51.5	45.4	45.2	49.2	42.1	66.7	48.1
2005-06	48.8	42.8	46.8	53.2	45.3	62.3	48.8
2006-07	47.6	52.9	47.0	44.6	45.6	65.6	47.4
2007-08	46.0	44.7	50.6	46.4	42.9	61.9	47.2
2008-09	53.5	na	51.4	39.6	41.7	75.0	48.3

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.16. **na** Not available.

Source: AIHW (2006a, 2006b, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.16.

The proportion of new tenancies allocated to households with special needs increased between 2007-08 and 2008-09 at the national level for both public housing and SOMIH, but there were variations across the jurisdictions.

Priority access to those in greatest need

'Priority access to those in greatest need' is an indicator of governments' objective to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes ensure that those in greatest need have first access to housing (box 16.9).

Box 16.9 **Priority access to those in greatest need**

'Priority access to those in greatest need' is defined as the proportion of new allocations of housing to those in greatest need. Greatest need households are defined as households that at the time of allocation are either homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs.

The following measures are reported: the percentages of new allocations to greatest need households overall; and for greatest need households waiting for periods of less than three months; three months to less than six months; six months to less than one year; one year to less than two years; and two years or more. As time to allocation reflects greatest need allocations as a percentage of all new allocations for the time period, these percentages are not cumulative.

High or increasing values for these measures, particularly for short time frames, indicate a high degree of access for those households in greatest need.

Data reported for this indicator are comparable.

Differences in State and Territory housing assessment policies can influence comparability for this indicator. Nationally, the proportion of new allocations to those in greatest need in 2008-09 for public housing was 66.0 per cent (table 16.10).

Table 16.10 **Public housing — proportion of new allocations to those in greatest need, 2008-09 (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total for year ending 30 June	**47.4**	**68.1**	**95.0**	**56.8**	**58.5**	**93.7**	**91.4**	**35.6**	**66.0**
Proportion of new allocations to those in greatest need, by time to allocation									
<3 months	75.4	70.6	95.4	61.0	82.6	91.5	96.8	26.1	79.2
3–<6 months	68.9	70.1	95.1	83.7	78.8	98.5	91.9	47.3	79.2
6 months–<1 year	55.8	79.0	94.6	85.5	60.6	95.6	90.3	52.9	74.9
1–<2 years	26.0	68.6	95.1	66.0	45.9	92.3	89.8	46.5	58.4
2+ years	5.9	38.4	94.4	4.3	8.4	85.0	78.3	13.2	32.4

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.4.

Source: AIHW (2009) *Housing assistance tables*; table 16A.4.

Nationally, the proportion of new allocations to those in greatest need for 2008-09 for SOMIH was 48.6 per cent (table 16.11).

Table 16.11 **SOMIH — proportion of new allocations to those in greatest need, 2008-09 (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
Total for year ending 30 June	**14.9**	**na**	**86.7**	**37.5**	**67.6**	**na**	**48.6**
Proportion of greatest need allocations to new allocations, by time to allocation							
<3 months	32.9	na	85.8	20.0	80.0	na	55.6
3–<6 months	20.6	na	87.8	67.4	100.0	na	55.9
6 months–<1 year	11.8	na	80.4	65.9	80.0	na	51.4
1–<2 years	5.6	na	85.0	56.0	61.1	na	50.7
2+ years	–	na	94.7	8.5	18.5	na	27.9

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.17. **na** Not available. – Nil or rounded to zero.

Source: AIHW (2009) *Housing assistance tables*; table 16A.17.

Net recurrent cost per dwelling

'Net recurrent cost per dwelling' is an indicator of governments' objective to undertake efficient and cost-effective management (box 16.10).

Box 16.10 **Net recurrent cost per dwelling**

'Net recurrent cost per dwelling' is defined as total recurrent expenses, including administration and operational costs, divided by the total number of dwellings. It measures the average cost of providing assistance per dwelling. Cost of providing assistance (including capital) per dwelling is also reported.

Holding other factors equal, a lower or decreasing net recurrent cost per dwelling suggests an improvement in efficiency.

Cost per dwelling indicators do not provide any information on the quality of service provided (for example, the standard of dwellings).

Data reported for this indicator are comparable.

The cost incurred by jurisdictions in providing public housing and SOMIH include:

- administration costs (the cost of the administration offices of the property manager and tenancy manager)
- operating costs (the costs of maintaining the operation of the dwelling, including repairs and maintenance, rates, the costs of disposals, market rent paid and interest expenses)
- depreciation costs
- the user cost of capital (the cost of the funds tied up in the capital used to provide public housing and SOMIH). Box 16.11 provides a discussion of the user cost of capital in general and how it relates to housing.

Due to a high level of capital expenditure in housing, cost per dwelling is predominantly driven by the user cost of capital (box 16.11). Caution must therefore be used when interpreting the indicator because the user cost of capital and service delivery models differ across jurisdictions.

Treatment of assets by housing agencies for each jurisdiction is presented in table 16A.81.

Box 16.11 **Capital in the costing of public housing and SOMIH**

Capital costs are costs associated with non-current physical assets such as depreciation and the user cost of capital. These costs 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, *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001). The aim of the study was to examine the extent to which differences in asset measurement techniques applied by participating agencies affect the comparability of reported unit costs.

The relative capital intensity associated with the provision of public housing increases the potential for differences in asset measurement techniques to have a material impact on total unit costs. However, the results of the asset measurement study suggest that the adoption under the CSHA of a uniform accounting framework has largely avoided this impact. The results are discussed in more detail in chapter 2.

Source: SCRCSSP (2001).

Care needs to be taken in interpreting the cost of delivering public housing. Cost data for some jurisdictions are either more complete than for other jurisdictions or collected on a more consistent basis. Administration costs and operating costs, for example, may not capture all costs incurred by government, so could understate the total cost of public housing. In addition, some jurisdictions have difficulty separating costs for public housing from those for other housing assistance activities. There may also be double counting of some expenditure items in the cost calculations for some jurisdictions. The user cost of capital, for example, is intended to capture all the costs of funding assets used to produce the services, but reported operating costs (apart from interest payments, which have been adjusted for) may already include some of these costs.

Payroll tax is excluded from total recurrent cost for public housing. (Chapter 2 elaborates on the reasons for excluding payroll tax from the cost calculations.)

Nationally, net recurrent cost per dwelling (excluding the cost of capital) was $6366 in 2008-09. Direct cost per dwelling including capital costs was $26 074 in 2008-09 (table 16.12).

Table 16.12 Public housing — cost of providing assistance per dwelling (2008-09 dollars)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Net recurrent cost of providing assistance (excluding the cost of capital) per dwelling									
2004-05	5 700	4 489	5 379	6 153	5 871	7 422	9 799	11 389	5 770
2005-06	5 880	4 860	5 418	6 179	6 066	7 822	8 824	10 682	5 907
2006-07	6 336	4 979	5 660	8 282	6 568	7 403	7 502	10 419	6 530
2007-08	6 313	5 074	5 553	8 585	6 572	7 673	7 443	11 469	6 370
2008-09	6 549	4 813	6 146	7 000	6 342	7 498	7 736	13 201	6 366
Cost of providing assistance (including the cost of capital) per dwelling									
2004-05	27 554	21 996	22 696	20 412	17 422	21 482	36 396	28 866	23 903
2005-06	26 087	21 814	23 424	22 338	18 471	20 862	34 991	27 754	23 680
2006-07	25 764	21 473	24 225	33 517	19 230	20 091	34 667	27 425	24 909
2007-08	25 145	23 308	26 337	39 892	19 700	21 087	37 549	29 728	25 980
2008-09	24 653	25 458	26 655	35 596	21 013	21 130	36 672	32 881	26 074

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.5. [b] Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2008-09 = 100) table AA.26.

Source: AIHW (2006a, 2006b, 2008, 2009) *Public rental housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; State and Territory governments (unpublished); table 16A.5.

Nationally, the net recurrent cost of providing assistance (excluding the cost of capital) per dwelling for SOMIH was $8484 in 2008-09 (table 16.13). Capital cost data for SOMIH are not available for this Report. As with other indicators, it is not appropriate to compare the net recurrent cost of providing assistance per dwelling for public housing with the net recurrent cost of providing assistance per dwelling for SOMIH, because there is greater scope for economies of scale in administration costs with public housing, which is a much larger program overall.

SOMIH dwellings are also slightly more concentrated in regional and remote areas, where the cost of providing housing assistance is potentially greater. The need to construct culturally appropriate housing (possibly requiring different amenities) can also affect the cost per dwelling. Further, different cost structures can apply to the programs. Construction of dwellings under SOMIH, for example, can involve a skills development element to allow for training of Indigenous apprentices in regional areas.

Table 16.13 SOMIH — net recurrent cost of providing assistance per dwelling (2008-09 dollars)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
Net recurrent cost of providing assistance (excluding the cost of capital) per dwelling							
2004-05	6 078	5 762	7 373	8 242	4 947	5 873	6 552
2005-06	6 158	7 127	7 557	8 713	7 958	6 373	7 295
2006-07	6 379	4 471	8 192	8 362	7 318	7 050	7 101
2007-08	6 543	5 177	8 550	11 267	9 993	6 832	8 418
2008-09	7 052	4 436	9 019	8 981	10 620	7 141	8 484

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.18. [b] Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2008-09 = 100) table AA.26.

Source: AIHW (2006a, 2006b, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.18.

Occupancy rate

‘Occupancy rate’ is an indicator of governments’ objective to ensure efficient housing utilisation (box 16.12).

Box 16.12 Occupancy rate

‘Occupancy rate’ is defined as the proportion of rental housing stock occupied by households. The term ‘occupied’ refers to rental housing stock occupied by tenants who have a tenancy agreement with the relevant housing authority.

A high or increasing proportion suggests greater efficiency of housing utilisation.

Occupancy is influenced by both turnover and housing supply and demand.

Data reported for this indicator are comparable.

The national average proportion of total public housing rental stock occupied at 30 June 2009 was 97.6 per cent. There were only slight variations across jurisdictions and over time (table 16.14).

Table 16.14 **Public housing — occupancy rates (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005	98.7	97.3	98.6	95.6	96.1	98.0	98.1	94.1	97.7
2006	98.6	97.5	98.9	96.2	96.2	98.4	98.7	95.6	97.8
2007	98.6	97.6	99.1	96.5	97.1	98.7	98.6	95.7	98.0
2008	99.0	97.3	99.1	96.1	96.4	98.9	98.6	95.4	98.0
2009	98.6	96.6	98.9	96.7	96.1	98.1	98.4	94.7	97.7

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.6.

Source: AIHW (2006a, 2006b, 2008, 2009) *Public rental housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.6.

The national average proportion of SOMIH stock occupied at 30 June 2009 was 96.1 per cent (table 16.15).

Table 16.15 **SOMIH — occupancy rates (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
2005	97.4	95.8	96.1	94.2	91.8	97.7	95.5
2006	97.4	96.7	96.8	94.1	93.5	98.3	96.1
2007	97.7	96.4	97.2	94.5	94.1	97.7	96.4
2008	98.4	97.9	97.7	94.1	94.6	97.7	96.8
2009	97.9	100.0	95.5	94.6	93.9	98.6	96.1

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.19.

Source: AIHW (2006a, 2006b, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.19.

Turnaround time

'Turnaround time' is an indicator of governments' objective to undertake efficient and cost-effective management (box 16.13).

Box 16.13 **Turnaround time**

‘Turnaround time’ is defined as the average time taken for occupancy of available dwelling stock to rent through normal processes.

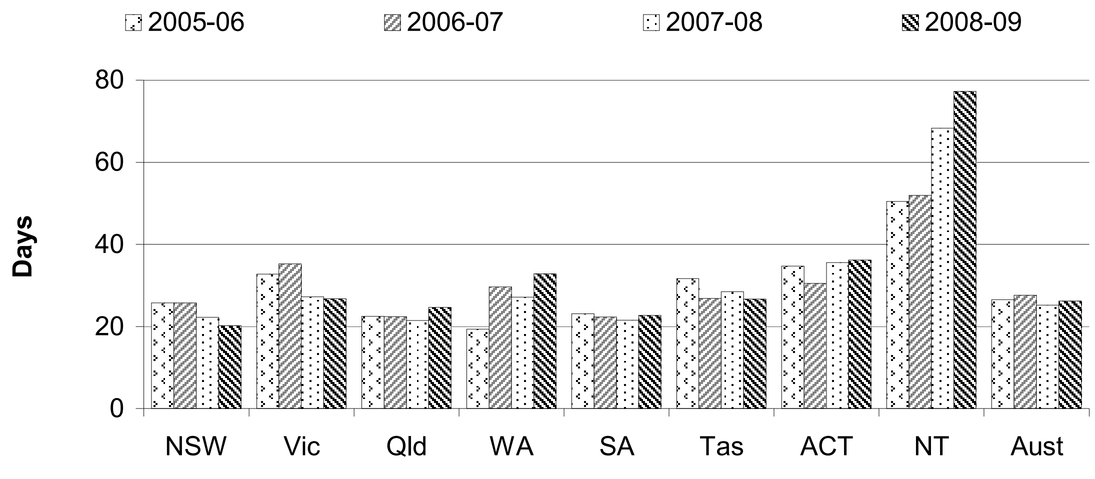
A low or decreasing turnaround time suggests efficient housing allocation.

‘Normal’ vacancies exclude properties that are offline or are undergoing major redevelopment and where there is no suitable applicant but include hard-to-let properties as this relates to tenancy management. This indicator may be affected by changes in maintenance programs and stock allocation processes, and some jurisdictions may have difficulty excluding stock upgrades. Cultural factors may also influence the national average turnaround time for SOMIH dwellings relative to public housing dwellings. Following the death of a significant person, for example, a dwelling may need to be vacant for a longer period of time (Morel and Ross 1993). A higher proportion of SOMIH dwellings in regional and remote areas may also contribute to delays in completing administrative tasks and maintenance before dwellings can be re-tenanted.

Data reported for this indicator are comparable.

Nationally, the average number of days for vacant stock to remain unallocated in 2008-09 was 26.2 days for public housing (figure 16.3) and 36.2 days for SOMIH (figure 16.4).

Figure 16.3 **Public housing — average turnaround time**[a]



[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.7.

Source: AIHW (2006b, 2008, 2009) *Public rental housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.7.

Figure 16.4 **SOMIH — average turnaround time**[a, b]

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.20. . [b] Data for Victoria for 2008-09 are not available.

Source: AIHW (2006b, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.20.

Rent collection rate

'Rent collection rate' is an indicator of governments' objective to undertake efficient and cost-effective management (box 16.14).

Box 16.14 **Rent collection rate**

'Rent collection rate' is defined as the total rent collected as a percentage of the total rent charged.

A high or increasing percentage suggests higher efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a percentage of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of reported results. Further, payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

Data reported for this indicator are comparable.

Nationally, the rent collection rate in 2008-09 is 99.8 per cent for public housing (table 16.16) and 99.7 per cent for SOMIH (table 16.17).

Table 16.16 **Public housing — rent collection rate (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2004-05	101.2	101.1	100.6	103.2	100.5	99.7	100.0	102.8	101.1
2005-06	100.1	100.1	100.2	101.7	100.8	103.8	99.8	100.7	100.4
2006-07	97.8	97.0	99.4	102.1	100.3	101.5	100.1	100.9	98.8
2007-08	100.0	97.2	98.9	101.0	99.6	101.9	99.9	101.7	99.5
2008-09	100.2	98.5	99.3	101.3	100.0	99.0	99.9	100.8	99.8

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.8.

Source: AIHW (2006a, 2006b, 2008, 2009) *Public rental housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.8.

Table 16.17 **SOMIH — rent collection rate (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
2004-05	97.7	100.6	100.4	103.9	93.8	99.6	99.2
2005-06	100.5	99.0	99.7	104.3	94.7	103.8	100.0
2006-07	101.8	92.8	97.3	105.3	103.0	102.1	100.6
2007-08	96.8	89.2	99.6	104.3	103.7	99.8	99.0
2008-09	99.8	na	97.2	103.6	99.7	99.0	99.7

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.21. **na** Not available.

Source: AIHW (2006a, 2006b, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.21.

Outcomes

The following indicators measure the outcomes of public housing and SOMIH. Outcomes are the impact of services on the status of an individual or group, while outputs are the actual services delivered (see chapter 1, section 1.5).

Amenity/location

'Amenity/location' is an indicator of governments' objective to provide housing assistance that is appropriate to the needs of different households (box 16.15).

Box 16.15 **Amenity/location**

'Amenity/location' is defined as the percentage of tenants rating amenity/location aspects of their dwelling as important and as meeting their needs.

A high or increasing level of satisfaction with amenity and location suggests the provision of housing assistance satisfies household needs.

Data reported for this indicator are comparable.

The data for public housing amenity/location are taken from the *2007 National Social Housing Survey* for public rental housing. The precision of survey estimates depends on the survey sample size. Standard errors are presented in tables 16A.9 and 16A.10. Tenants were asked whether particular aspects of the amenity and location of their dwellings were important to them and, if so, whether they felt their needs were met.

Nationally, 79.0 per cent of tenants for whom amenity was important reported that their needs were met, and of those tenants for whom location was important, 86.0 per cent reported that their needs were met (tables 16A.9 and 16A.10).

Nationally, 70.0 per cent of Indigenous and 79.0 per cent of non-Indigenous public housing tenants rated amenity aspects as important and meeting their needs. Similarly, at the national level, 80.0 per cent of Indigenous and 86.0 per cent of non-Indigenous public housing tenants rated location aspects as important and meeting their needs (AIHW 2007).

During 2006-07, all states participated in the *National Social Housing Survey* of SOMIH. As for the National Social Housing Survey undertaken biennially for public and community housing, the survey seeks to determine tenants' level of satisfaction with various aspects of service and measure housing outcomes.

SOMIH tenants were asked whether particular aspects of the amenity and location of their dwellings were important to them and, if so, whether they felt their needs were met. Nationally, 78 per cent of tenants for whom amenity was important felt that their needs were met, and of those tenants for whom location was important, 89 per cent felt that their needs were met (table 16A.22). Caution should be used when comparing the SOMIH survey results with the public housing survey results, due to the different demographic profile of Indigenous tenants and the different survey methods used. A mail-out survey is used for the public housing survey and interviews for the SOMIH survey. These differences may affect the comparability of the results.

Affordability

'Affordability' is an indicator of governments' objective to provide affordable housing to assist people who are unable to access suitable housing (box 16.16).

Box 16.16 **Affordability**

'Affordability' is defined as tenants' ability to access suitable housing. Two measures of affordability are reported:

- average weekly rental subsidy per rebated household, derived by dividing the total rental rebate amount by the total number of rebated households
- the proportion of rebated households spending less than 30 per cent of their income in rent.

A high or increasing value implies greater housing affordability.

The public housing and SOMIH affordability measure differs from that reported for community housing.

Data reported for this indicator are comparable.

Nationally, the average weekly subsidy per rebated household was $120.70 and the proportion of rebated households spending less than 30 per cent of their income in rent for public housing was 99.8 per cent at 30 June 2009 (table 16.18). More information on the proportion of income paid in rent by households is provided in table 16A.82.

Table 16.18 **Public housing — average weekly subsidy per rebated household and proportion of households spending 30 per cent or less of their income in rent, 2009**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average weekly subsidy per rebated household ($)									
2009	147.14	78.95	141.38	76.57	93.01	76.46	206.22	141.93	120.70
Proportion of rebated households spending 30 per cent or less of their income in rent									
2009	99.8	100.0	100.0	99.4	99.9	99.9	99.3	99.3	99.8

[a] Data may not be comparable across jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.11.

Source: AIHW (2009) *Housing assistance tables*; table 16A.11.

Nationally, the average weekly subsidy per rebated household was $122.90 and the proportion of rebated households spending less than 30 per cent of their income in rent was 98.9 per cent for SOMIH at 30 June 2009 (table 16.19). More information on the proportion of income paid in rent by SOMIH tenants is provided in table 16A.83.

Table 16.19 SOMIH — average weekly subsidy per rebated household and proportion of households spending 30 per cent or less of their income in rent[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
Average weekly subsidy per rebated household ($)							
2009	125.70	92.26	150.51	95.93	109.35	87.37	122.90
Proportion of rebated households spending 30 per cent or less of their income in rent							
2009	97.5	100.0	99.9	99.2	99.5	100.0	98.9

[a] Data may not be comparable across jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.23.

Source: AIHW (2009) *Housing assistance tables*; table 16A.23.

Match of dwelling to household size

'Match of dwelling to household size' is an indicator of governments' objective to provide housing assistance that is appropriate to the needs of different households (box 16.17).

Box 16.17 Match of dwelling to household size

'Match of dwelling to household size' is defined as the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

Proxy occupancy standard for appropriate sized dwelling

Household structure	*Bedrooms required*
Single adult only	1 bedroom
Single adult (group)	1 bedroom (per adult)
Couple with no children	2 bedrooms
Sole parent or couple with one child	2 bedrooms
Sole parent or couple with two or three children	3 bedrooms
Sole parent or couple with four children	4 bedrooms
Sole parent or couple with more than four children	equal to number of children

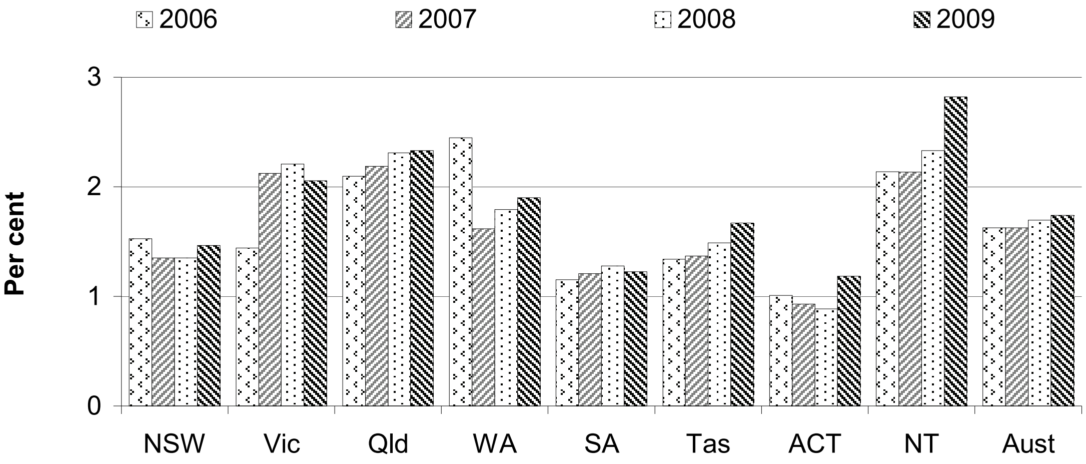
Source: AIHW (2006).

A low or decreasing proportion indicates less overcrowded households.

Data reported for this indicator are comparable.

Multi-income unit households are now included for all jurisdictions except Tasmania and the NT. Nationally, the proportion of households with overcrowding for public housing was 1.7 per cent in 2009 (figure 16.5). Information on moderate overcrowding and underutilisation for public housing is provided in table 16A.85.

Figure 16.5 **Public housing — proportion of households with overcrowding**[a]

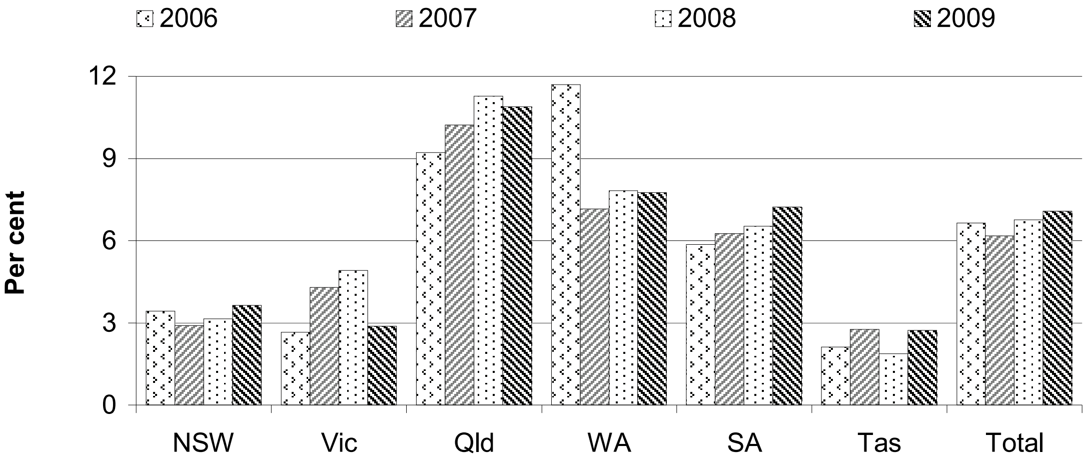


[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.12.

Source: AIHW (2006b, 2008, 2009) *Public rental housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.12.

Nationally, the proportion of households with overcrowding for SOMIH was 7.1 per cent in 2009 (figure 16.6). Information on moderate overcrowding and underutilisation for SOMIH is provided in table 16A.86.

Figure 16.6 **SOMIH — proportion of households with overcrowding**[a]



---

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.24.

Source: AIHW (2006b, 2008, 2009) *State owned and managed Indigenous housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.24.

Customer satisfaction

'Customer satisfaction' is an indicator of governments' objective to provide housing assistance that is appropriate for different households (box 16.18).

Box 16.18 **Customer satisfaction**

'Customer satisfaction' is defined as tenants' satisfaction with the overall service provided by the State or Territory housing authority.

A high or increasing percentage for customer satisfaction can imply better housing assistance provision.

Data reported for this indicator are comparable.

Data for public housing are sourced from the *2007 National Social Housing Survey* for public rental housing. Nationally in 2007, 72.0 per cent of tenants were either satisfied or very satisfied with the service provided (table 16A.13).

Nationally, 57 per cent of Indigenous and 72 per cent of non-Indigenous public housing tenants were either satisfied or very satisfied with the overall service provided by their State housing authority in 2007 (AIHW 2007).

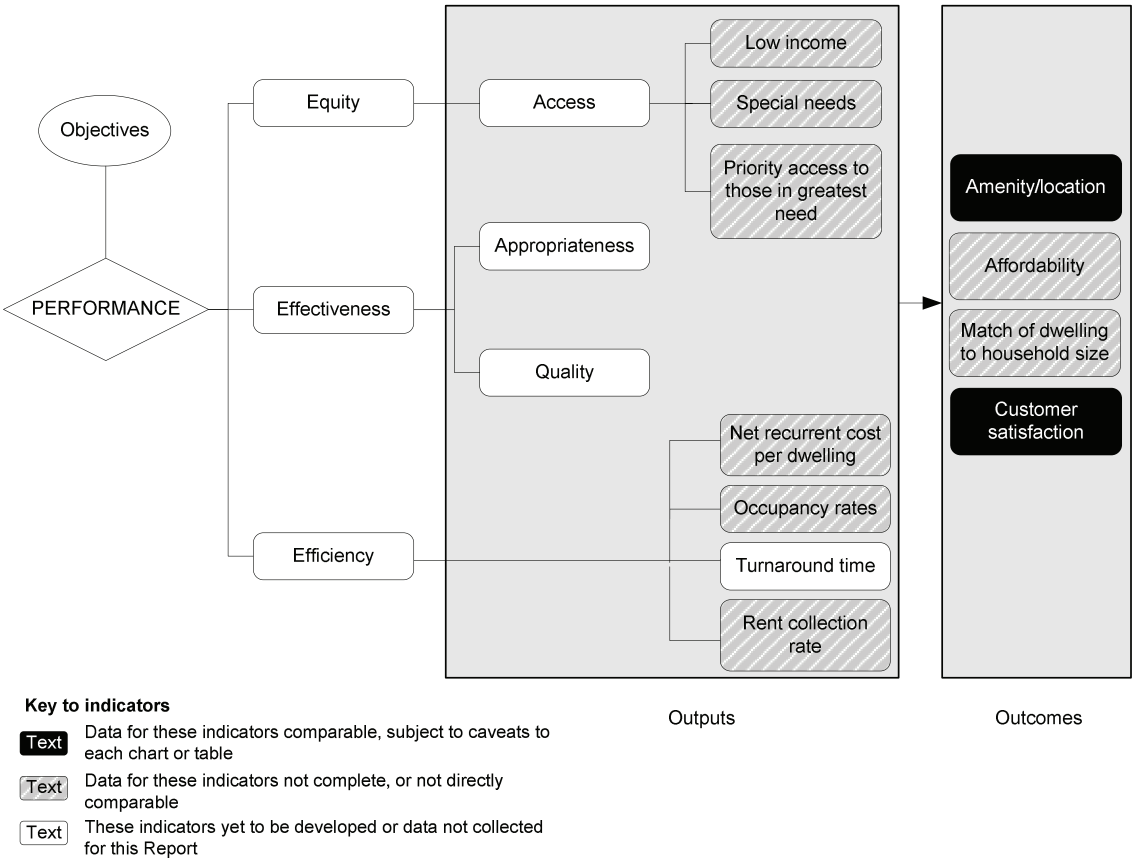
Data for SOMIH are sourced from the *2007 National Social Housing Survey* for SOMIH. Nationally in 2007, 64 per cent of respondents were either satisfied or very satisfied with the overall service provided by their State housing authority (table 16A.22).

Mainstream community housing

The performance indicator framework for mainstream community housing is presented in figure 16.7. Performance indicator results are not comparable between public, SOMIH community housing, and ICH sections.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 16.7 **Performance indicators for mainstream community housing**



Mainstream community housing data have three sources:

- jurisdictions' administrative data, provided by the State or Territory government body with responsibility for administering the community housing program in the jurisdiction. The NT provided only administrative data, as it currently does not survey its providers

- community housing provider survey data, collected from the community organisations (providers) that manage the service delivery
- survey data collected through the National Social Housing Survey.

For the mainstream community housing provider survey data, response rates, along with changes to the definitions and counting rules used over time, can influence the comparability of the data. Comparisons over time therefore need to be made with care. Table 16A.91 outlines the survey response rates and associated information for each jurisdiction for each year from 2003-04 to 2008-09.

Some descriptive data on community housing are contained in table 16A.25. Table 16A.79 lists State and Territory programs included in the mainstream community housing data collection.

Outputs

The following indicators measure the outputs of mainstream community housing. Outputs are the actual services delivered, while outcomes are the impact of these services on the status of an individual or group (see chapter 1, section 1.5).

Equity

Low income

‘Low income’ is an indicator of governments’ objective to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It assesses the low income need status of all households receiving assistance (box 16.19).

Box 16.19 **Low income**

‘Low income’ is defined as the number of low income households as a proportion of all households (new and existing).

A high or increasing proportion indicates a high degree of access by low income households.

The low income indicator is measured differently for mainstream community housing than for public housing. The mainstream community housing indicator is based on the low income B cut-offs used in the public rental housing data collection. Data are reported on all households, rather than just new households.

Data reported for this indicator are not complete nor directly comparable.

At 30 June 2009, across those jurisdictions able to provide data, the number of low income households as a proportion of all households is presented in table 16.20.

Table 16.20 **Community housing — low income households as a proportion of all households (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005	88.9	98.5	98.2	87.5	91.6	93.5	97.5	na	91.8
2006	89.8	93.8	81.9	97.8	97.3	95.1	97.7	na	90.3
2007	89.2	98.2	95.3	99.6	99.7	91.5	97.9	na	93.6
2008	88.5	99.0	93.1	99.9	99.8	96.5	98.9	na	92.9
2009	87.5	98.8	94.6	99.8	98.9	97.1	98.5	na	92.5

a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.26. **na** Not available.

Source: AIHW (2006) *CSHA national data reports: CSHA community housing*; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.26.

Special needs

'Special needs' is an indicator of governments' objective to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing (box 16.20).

Box 16.20 **Special needs**

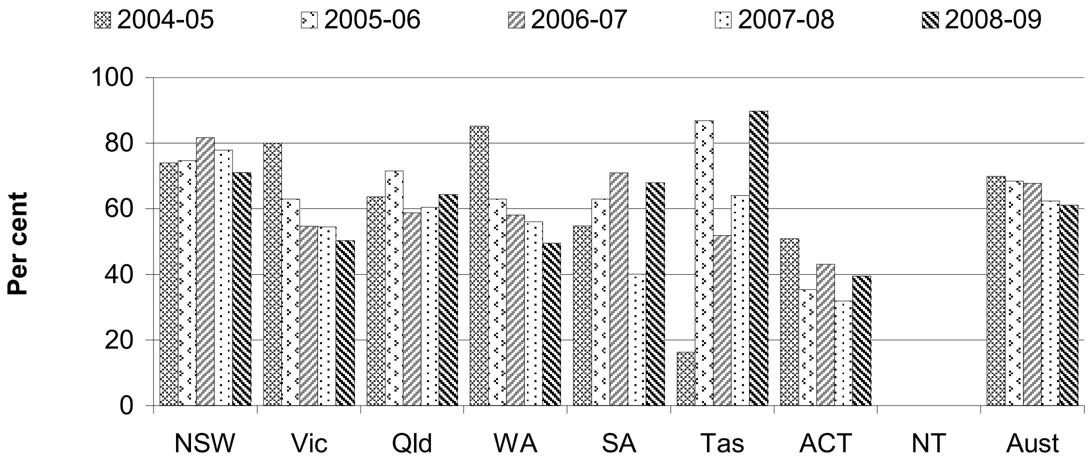
'Special needs' is defined as the proportion of new tenancies allocated to special needs households. The proportion of new tenancies with special needs are reported as a proxy for measuring all households with special needs. Special needs households are defined as those households that have either a household member with a disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members.

A high or increasing proportion indicates a high degree of access by these special needs households.

Data reported for this indicator are not complete nor directly comparable.

The proportion of new tenancies allocated to special needs households in 2008-09 is presented in figure 16.8.

Figure 16.8 **Community housing — new tenancies allocated to households with special needs**[a, b]



[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.27. [b] Data for the NT are not available.

Source AIHW (2006) *CSHA national data reports: CSHA community housing*; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.27.

Priority access to those in greatest need

'Priority access to those in greatest need' is an indicator of governments' objective to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing (box 16.21).

Box 16.21 **Priority access to those in greatest need**

'Priority access to those in greatest need' is defined as the proportion of new allocations of housing to those in greatest need. Greatest need households are defined as households that at the time of allocation are either homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs.

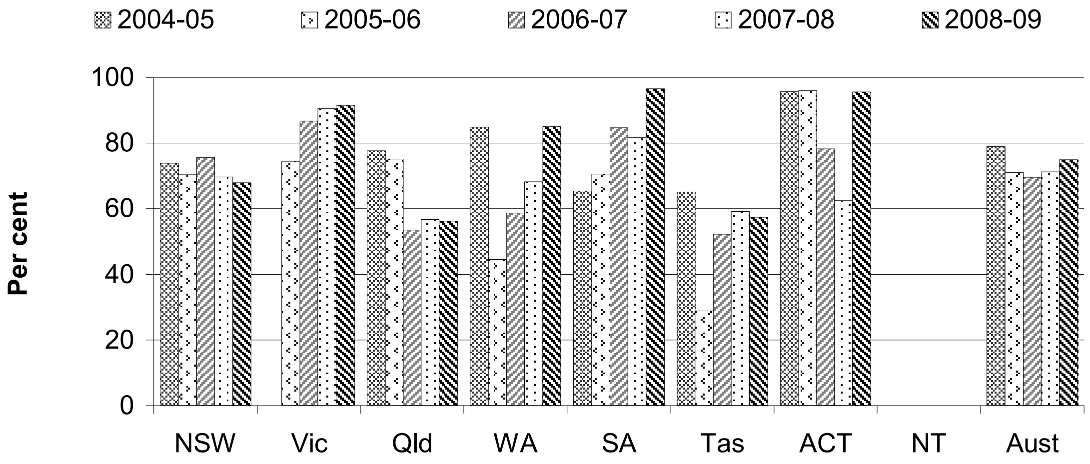
It measures the proportion of new allocations to those in greatest need.

High or increasing values for this indicator represent a high degree of access by those in greatest need.

Data reported for this indicator are not complete nor directly comparable.

The proportion of new allocations to those in greatest need is presented in figure 16.9. Differences in community housing allocation policies can influence comparability for this indicator across jurisdictions.

Figure 16.9 **Community housing — proportion of new allocations to those in greatest need**[a, b]



[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.28. [b] Data for Victoria for 2004-05 and the NT are not available.

Source: AIHW (2006) *CSHA national data reports: CSHA community housing*; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.28.

Efficiency

Net recurrent cost per dwelling

'Net recurrent cost per dwelling' is an indicator of governments' objective to undertake efficient and cost-effective management (box 16.22).

Box 16.22 **Net recurrent cost per dwelling**

'Net recurrent cost per dwelling' is defined as the average cost of providing assistance per dwelling. It includes the total administration costs and the costs of maintaining operation of dwellings. It excludes cost of capital.

Holding other factors equal, a low or decreasing net recurrent cost per dwelling suggests high efficiency.

The cost per dwelling indicators do not provide any information on the quality of service provided (for example, the standard of dwellings).

Data reported for this indicator are not complete nor directly comparable.

Capital cost data for mainstream community housing are not included in the 2010 Report as no data on value of assets are available.

For community housing, data on net recurrent cost per dwelling are reported with a one year lag to allow community housing providers an extra year to collate financial data. The net recurrent cost per dwelling at 30 June 2008 is presented in table 16.21.

Table 16.21 **Community housing — net recurrent cost per dwelling (2007-08 dollars)**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Net recurrent cost of providing assistance (excluding the cost of capital) per dwelling									
2003-04	10 942	6 129	5 090	9 325	4 450	9 149	na	na	7 745
2004-05	10 743	7 619	6 295	9 157	7 994	12 988	na	na	8 851
2005-06	9 089	7 384	4 868	10 278	8 201	10 423	na	na	8 090
2006-07	8 956	8 313	3 953	6 880	7 306	10 263	6 983	na	7 411
2007-08	8 844	7 250	4 674	4 956	6 008	12 023	7 816	na	7 045

[a] Data may not be comparable across jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.29. [b] Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2007-08 = 100) table AA.26. **na** Not available.

Source: AIHW (2006) *CSHA national data reports: CSHA community housing*; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.29.

Occupancy rate

'Occupancy rate' is an indicator of governments' objective to measure the efficiency of housing utilisation (box 16.23).

Box 16.23 **Occupancy rate**

'Occupancy rate' is defined as the proportion of dwellings occupied. The term 'occupied dwelling' refers to dwellings occupied by tenants who have a tenancy agreement with the relevant mainstream community housing organisation.

A high or increasing occupancy rate suggests high efficiency of housing utilisation.

Occupancy is influenced by both turnover and housing supply.

Data reported for this indicator are not directly comparable.

Nationally, the proportion of community housing dwellings occupied at 30 June 2009 is 96.9 per cent (table 16.22). The NT occupancy rates are based on the assumption that all dwellings are occupied.

Table 16.22 **Community housing — occupancy rates (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005	98.2	94.5	95.7	98.0	95.1	98.9	89.8	100.0	96.5
2006	98.4	93.7	97.2	94.1	96.5	99.8	89.8	100.0	96.6
2007	97.2	96.6	96.6	96.1	96.8	98.5	90.4	100.0	96.7
2008	98.4	95.4	97.0	95.8	96.1	100.0	93.9	100.0	97.1
2009	98.2	95.0	99.3	88.7	96.8	99.0	95.7	100.0	96.9

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.30.

Source: AIHW (2006) *CSHA national data reports: CSHA community housing*; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.30.

Turnaround time

'Turnaround time' is an indicator of governments' objective to undertake efficient and cost-effective management (box 16.24). Current data for turnaround time are not available for community housing due to data quality issues. Data for this indicator were last reported in the 2006 Report.

Box 16.24 **Turnaround time**

'Turnaround time' is defined as the average time taken in days for normal vacant dwellings to be occupied.

A low or reducing turnaround time suggests efficient housing allocation.

The length of time taken to rent untenanted dwellings affects allocations of housing, waiting times, the length of waiting lists and rent foregone.

'Normal' vacancies exclude properties that are offline or are undergoing major redevelopment and where there is no suitable applicant but include hard-to-let properties as this relates to tenancy management.

The turnaround time performance indicator has been removed from the mainstream community housing data collection following the review of the national performance reporting framework.

Data for this indicator were not available for the 2010 Report.

Rent collection rate

'Rent collection rate' is an indicator of governments' objective to undertake efficient and cost-effective management (box 16.25).

Box 16.25 **Rent collection rate**

‘Rent collection rate’ is defined as the total rent actually collected as a proportion of the rent charged.

A high or increasing proportion suggests efficiency in collecting rent.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of reported results. Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

Data reported for this indicator are not complete nor directly comparable.

For mainstream community housing, data on the rent collection rate are reported with a one year lag to allow mainstream community housing providers an extra year to collate financial data (table 16.23). As with public housing, payment arrangements for rent in some jurisdictions mean the rent collected over a 12 month period can be higher than rent charged over that period.

Table 16.23 **Community housing — rent collection rate (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003-04	99.4	96.1	98.6	98.0	97.8	101.2	92.6	na	98.3
2004-05	99.5	96.3	98.3	102.6	97.8	100.4	100.3	na	99.0
2005-06	98.8	99.6	99.6	100.5	98.0	98.5	97.3	na	99.1
2006-07	99.8	99.5	100.3	100.3	98.4	95.7	98.1	na	99.6
2007-08	98.3	99.2	98.6	100.9	98.6	97.9	97.0	na	98.7

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.31. **na** Not available.

Source: AIHW (2006) *CSHA national data reports: CSHA community housing*; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.31.

Outcomes

The following indicators measure the outcomes of mainstream community housing. Outcomes are the impact of services on the status of an individual or group, while outputs are the actual services delivered (see chapter 1, section 1.5).

Amenity/location

‘Amenity/location’ is an indicator of governments’ objective to provide housing assistance that is appropriate to the needs of different households (box 16.26).

Box 16.26 **Amenity/location**

‘Amenity/location’ is defined as the percentage of tenants rating amenity/location aspects of their dwelling as important and as meeting their needs.

A high or increasing level of satisfaction with amenity and location suggests the provision of housing assistance satisfies household needs.

Amenity/location is reported using a survey-based measure.

Data reported for this indicator are comparable but are not complete.

The data for this indicator are from the *2007 Community Housing National Social Housing Survey*. Mainstream community housing tenants were asked whether particular aspects of the amenity and location of their dwellings were important to them and, if so, whether they felt their needs were met. The proportions of tenants satisfied with the amenity and location of their dwelling in March/April 2007 are presented in tables 16A.32 and 16A.33.

Nationally, 86.0 per cent of tenants for whom amenity was important reported that their needs were met, and of those tenants for whom location was important, 89.0 per cent reported that their needs were met (tables 16A.32 and 16A.33). The precision of survey estimates depends on the survey sample size. Standard errors are presented in tables 16A.32 and 16A.33.

Affordability

‘Affordability’ is an indicator of governments’ objective to provide affordable housing to assist people who are unable to access suitable housing (box 16.27).

Box 16.27 **Affordability**

‘Affordability’ is defined as the proportion of household income remaining after paying rent.

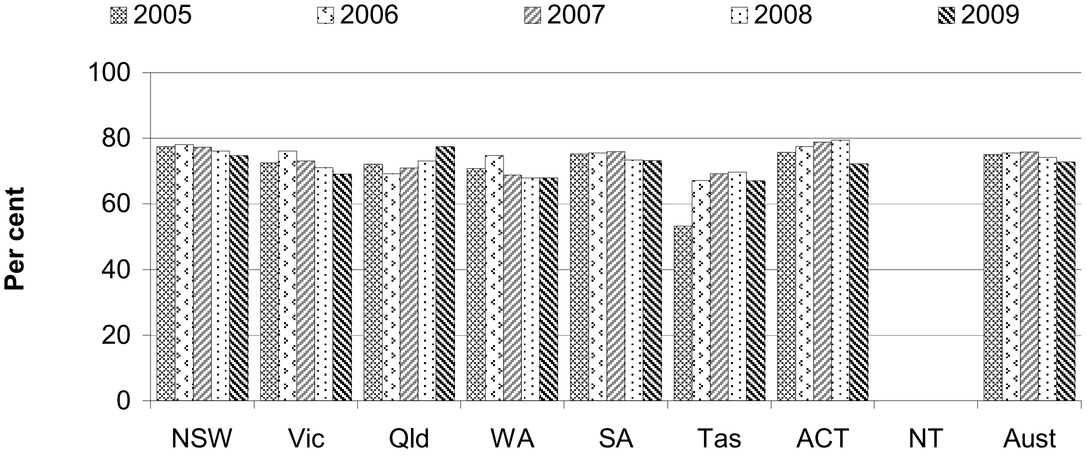
A higher or increasing proportion indicates that housing is more affordable.

The community housing affordability measure differs from that reported for public housing and SOMIH.

Data reported for this indicator are not complete nor directly comparable.

The proportion of household income left after paying rent is presented in figure 16.10. Differences in the definition of assessable income, including the treatment of CRA in rent assessment, can affect the comparability of this indicator’s reported results. More information on affordability for community housing is in table 16A.85.

Figure 16.10 **Community housing — proportion of income remaining after paying rent**[a, b]



---

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.34. [b] Data for the NT are not available.

Source: AIHW (2006) *CSHA national data reports: CSHA community housing*; AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.34.

Match of dwelling to household size

'Match of dwelling to household size' is an indicator of governments' objective to provide housing assistance that is appropriate to the needs of different households, such as household size (box 16.28).

Box 16.28 **Match of dwelling to household size**

'Match of dwelling to household size' is defined as the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

Proxy occupancy standard for appropriate sized dwelling

Household structure	*Bedrooms required*
Single adult only	1 bedroom
Single adult (group)	1 bedroom (per adult)
Couple with no children	2 bedrooms
Sole parent or couple with one child	2 bedrooms
Sole parent or couple with two or three children	3 bedrooms
Sole parent or couple with four children	4 bedrooms
Sole parent or couple with more than four children	equal to number of children

Source: AIHW (2006).

A low or decreasing proportion indicates less overcrowded households.

The proxy occupancy standard was revised in 2005-06 to remove the four bedroom cap. Data prior to 2005–06 should not be compared with data from later years.

Data reported for this indicator are not complete nor directly comparable.

The proportion of mainstream community housing households with overcrowding is illustrated in figure 16.11. Information on moderate overcrowding and underutilisation for mainstream community housing can be found in table 16A.87.

Figure 16.11 **Community housing — proportion of households with overcrowding**[a, b]

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.35. [b] Data for the NT are not available. [c] Data for WA and the ACT for 2009 are nil or rounded to zero.

Source: AIHW (2007, 2008, 2009) *Community housing: CSHA national data report*; AIHW (2009) *Housing assistance tables*; table 16A.35.

Customer satisfaction

'Customer satisfaction' is an indicator of governments' objective to provide housing assistance that is appropriate to different households (box 16.29).

Box 16.29 **Customer satisfaction**

'Customer satisfaction' is defined as satisfaction with the overall service provided by the community housing organisations.

A high or increasing proportion of satisfied customers can imply better housing assistance provision.

Customer satisfaction is a survey-based measure.

Data reported for this indicator are comparable but are not complete.

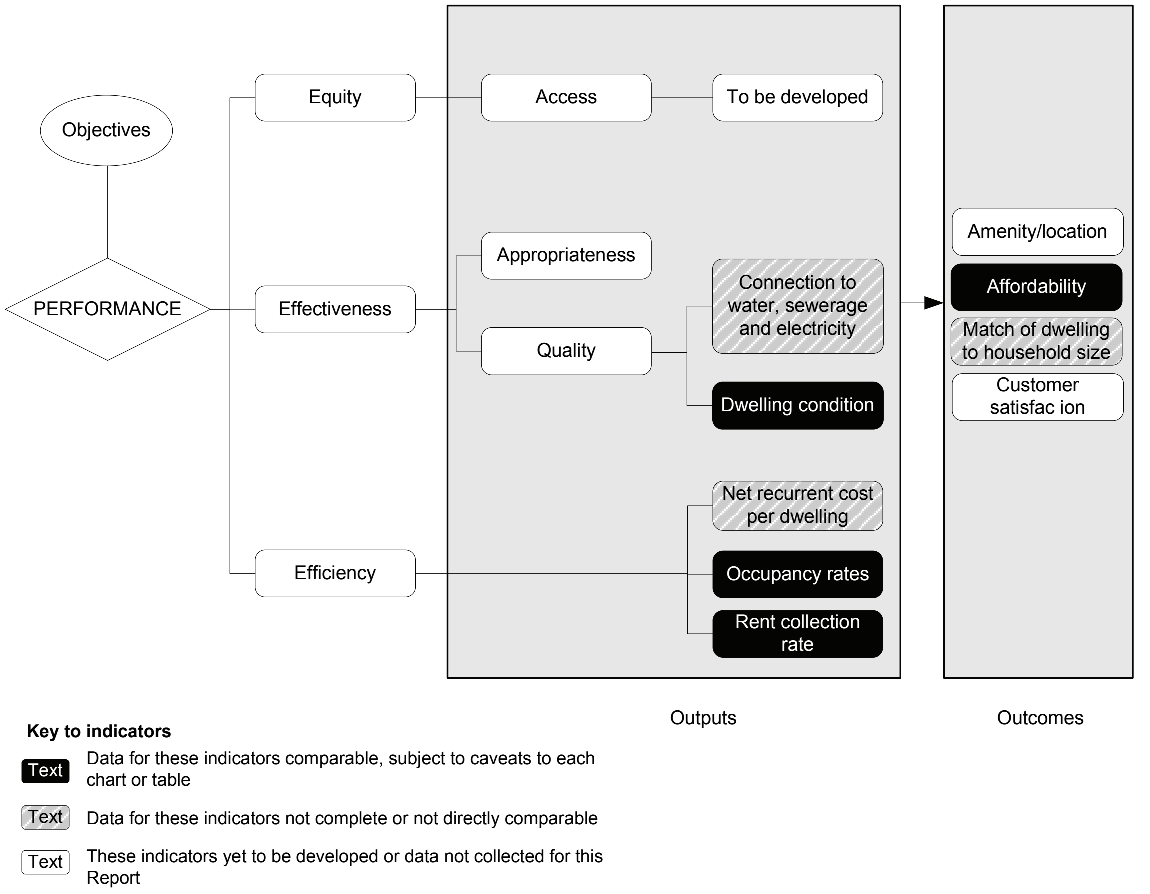
Data for this indicator are from the *2007 Community Housing National Social Housing Survey*. Nationally, in March/April 2007, 82.0 per cent of tenants were satisfied or very satisfied with the services provided by their community housing organisation (table 16A.36).

Indigenous community housing

The performance indicator framework for ICH is presented in figure 16.12.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 16.12 **Performance indicators for ICH**



Outputs

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

Equity — access

Access indicators measure equitable access to ICH (box 16.30).

Box 16.30 **Performance indicator — access**

‘Access’ indicators are output indicators of governments’ objective to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing.

Access has been identified as a key area for development in future Reports.

Effectiveness — quality

Connection to water, sewerage and electricity

‘Connection to water, sewerage and electricity’ is an indicator of governments’ objective to provide quality housing (box 16.31).

Box 16.31 **Connection to water, sewerage and electricity**

‘Connection to water, sewerage and electricity’ is defined as the proportion of ICH dwellings not connected to essential services. Specifically, it is measured as the number of permanent ICH dwellings not connected to organised water, sewerage and electricity systems as a percentage of the total number of permanent dwellings.

A low or decreasing percentage suggests high housing quality.

Data reported for this indicator are not directly comparable.

The percentage of Indigenous community houses not connected to water, sewerage and electricity at 30 June 2008 is presented in table 16.24.

Table 16.24 ICH — proportion of permanent dwellings not connected to water, sewerage and electricity (per cent)[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*	*Aust*
Water										
2005-06	–	..	–	–	–	..	–	4.7	0.1	1.7
2006-07	–	..	–	–	–	..	–	4.7	0.1	1.5
2007-08	–	–	–	–	0.4	..	–	4.6	0.1	1.6
Sewerage										
2005-06	–	..	–	–	–	..	–	6.4	0.5	2.4
2006-07	–	..	–	–	–	..	–	6.4	0.1	2.1
2007-08	–	–	–	–	0.9	..	–	6.2	0.1	2.1
Electricity										
2005-06	–	..	–	–	–	..	–	5.4	0.1	2.0
2006-07	–	..	–	–	–	..	–	5.4	0.3	1.8
2007-08	–	–	–	–	0.7	..	–	5.2	–	1.8

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in tables 16A.38, 16A.39 and 16A.40. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2009) *Indigenous housing indicators 2007-08*, Indigenous housing series no. 3, Cat. no. HOU 212; AIHW, *Indigenous housing indicators 2006-07 collection* (unpublished); AIHW (2007) *Indigenous housing indicators 2005-06*, Indigenous housing series no. 2, Cat. no. HOU 168; tables 16A.38, 16A.39 and 16A.40.

Dwelling condition

'Dwelling condition' is an indicator of governments' objective to provide quality housing (box 16.32).

Box 16.32 **Dwelling condition**

'Dwelling condition' is defined as the proportion of ICH dwellings in poor condition and in need of major repair or replacement. It is measured as the number of permanent ICH dwellings in need of either major repair or replacement as a percentage of the total number of permanent dwellings.

A low or decreasing proportion suggests higher housing quality.

Data reported for this indicator are comparable.

Nationally, there were 23.4 per cent of dwellings in need of major repair and 7.2 per cent of dwellings in need of replacement in 2006 (table 16A.41).

Efficiency

Net recurrent cost per dwelling

'Net recurrent cost per dwelling' is an output indicator of governments' objective to provide efficient and cost-effective management of housing (box 16.33).

Box 16.33 **Net recurrent cost per dwelling**

'Net recurrent cost per dwelling' is defined as total recurrent costs for ICH divided by the total number of permanent dwellings. It excludes cost of capital.

Holding other factors equal, a low or decreasing proportion suggests high efficiency.

The cost per dwelling indicators do not provide any information on the quality of service provided (for example, the standard of dwellings).

Data reported for this indicator are not complete nor directly comparable.

The net recurrent cost per dwelling for 2007-08 is presented in table 16.25.

Table 16.25 **ICH — net recurrent cost per dwelling (2007-08 dollars)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*[b]	*Aust*
2005-06	7 603	..	na	na	7 017	..	24 444	619	7 510	na
2006-07	8 286	..	3 415	na	3 394	..	na	na	na	5 195
2007-08	6 594	3 016	6 824	13 181	2 581	..	6 832	na	7 909	7 472

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.42. [b] Contains data from Victoria, Queensland and Tasmania not published separately, and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey for 2005-06, 2006-07 and 2007-08. **na** Not available. .. Not applicable.

Source: AIHW (2009) *Indigenous housing indicators 2007-08*, Indigenous housing series no. 3, Cat. no. HOU 212; AIHW, *Indigenous housing indicators 2006-07 collection* (unpublished); AIHW (2007) *Indigenous housing indicators 2005-06*, Indigenous housing series no. 2, Cat. no. HOU 168; table 16A.42.

Occupancy rate

'Occupancy rate' is an indicator of governments' objective to provide efficient housing utilisation (box 16.34).

Box 16.34 **Occupancy rate**

‘Occupancy rate’ is defined as the proportion of dwellings occupied. ‘Occupied dwelling’ refers to dwellings occupied by tenants who have a tenancy agreement with the relevant ICH organisation.

A high or increasing occupancy rate suggests high efficiency of housing utilisation.

Occupancy is influenced by both turnover and housing supply.

Data reported for this indicator are comparable but are not complete.

Nationally, the proportion of ICH occupied at 30 June 2008 was 98.3 per cent (table 16.26).

Table 16.26 **ICH — occupancy rates (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*[b]	*Aust*
2006	96.6	..	95.7	77.9	88.3	..	95.7	87.0	94.1	89.6
2007	98.3	..	100.0	91.0	89.0	..	100.0	na	94.9	96.2
2008	96.0	99.1	98.1	na	93.3	..	100.0	100.0	96.6	98.3

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.43 [b] Contains data from Victoria, Queensland and Tasmania not published separately, and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey for 2005-06, 2006-07 and 2007-08. **na** Not available. .. Not applicable.

Source: AIHW (2009) *Indigenous housing indicators 2007-08*, Indigenous housing series no. 3, Cat. no. HOU 212; AIHW, *Indigenous housing indicators 2006-07 collection* (unpublished); AIHW (2007) *Indigenous housing indicators 2005-06*, Indigenous housing series no. 2, Cat. no. HOU 168; table 16A.43.

Rent collection rate

‘Rent collection rate’ is an indicator of governments’ objective to provide efficient and cost-effective management of housing (box 16.35).

Box 16.35 **Rent collection rate**

‘Rent collection rate’ is defined as the total rent collected as a proportion of the rent charged.

A high or increasing proportion suggests efficiency in collecting rent.

As with mainstream community housing, payment arrangements for rent in some jurisdictions mean the rent collected over a 12 month period may be higher than rent charged over that period.

Data reported for this indicator are comparable but are not complete.

The national rent collection rate in 2007-08 was 97.6 per cent (table 16.27).

Table 16.27 **ICH — rent collection rate (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*[b]	*Aust*
2005-06	89.4	..	97.4	94.1	102.7	..	100.0	103.8	84.7	94.2
2006-07	90.0	..	96.6	96.8	65.5	..	100.0	111.5	92.0	96.2
2007-08	89.8	95.4	90.8	101.1	63.5	..	100.4	114.4	93.2	97.6

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.44. [b] Contains data from Victoria, Queensland and Tasmania not published separately, and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey for 2005-06, 2006-07 and 2007-08. .. Not applicable.

Source: AIHW (2009) *Indigenous housing indicators 2007-08*, Indigenous housing series no. 3, Cat. no. HOU 212; AIHW, *Indigenous housing indicators 2006-07 collection* (unpublished); AIHW (2007) *Indigenous housing indicators 2005-06*, Indigenous housing series no. 2, Cat. no. HOU 168; table 16A.44.

Outcomes

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

Amenity/location

'Amenity/location' is an indicator of governments' objective to provide housing assistance that is appropriate to the needs of different households (box 16.36).

Box 16.36 **Amenity/location**

'Amenity/location' is defined as the proportion of tenants rating amenity and location aspects as important and as meeting their needs.

Higher levels of satisfaction with amenity and location imply the provision of housing assistance that satisfies household needs.

The amenity/location indicator is a survey-based measure.

Data for this indicator were not available for the 2010 Report.

Affordability

'Affordability' is an indicator of governments' objective to provide affordable housing to assist people who are unable to access suitable housing (box 16.37).

Box 16.37 **Affordability**

'Affordability' is defined as the extent to which low income households are paying a large share of their income in rent. It is measured as the number of ICH households in the bottom 40 per cent of equivalised incomes paying 25 per cent or more of their income in rent, divided by the total number of ICH households.

A low or decreasing proportion indicates that housing is more affordable.

ABS Census data are reported for 2001 and 2006 and administrative data are reported for 2007. The ICH affordability measure differs from that reported for public housing, SOMIH and community housing.

Data reported for this indicator are comparable.

Nationally, the proportion of ICH households in the bottom 40 per cent of equivalised incomes paying 25 per cent or more of their income on rent was 3.4 per cent in 2006 (table 16.28).

Table 16.28 **ICH — proportion of low income households paying 25 per cent or more of their income on rent (per cent)**[a, b]

	NSW[c]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*Aust*
2001	28.9	31.1	20.2	12.4	12.3	20.9	5.2	15.8
2006	31.3	41.6	19.9	7.4	15.9	42.6	3.9	15.1

[a] Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.45. [b] Low income households refer to those in the bottom 40 per cent of equalised gross household income. [c] NSW data include data for the ACT.

Source: ABS (2007) *2006 Census of Population and Housing*; ABS (2002) *2001 Census of Population and Housing*; table 16A.45.

Match of dwelling to household size

'Match of dwelling to household size' is an indicator of governments' objective to provide housing assistance that is appropriate to the needs of different households, such as household size (box 16.38).

Box 16.38 **Match of dwelling to household size**

'Match of dwelling to household size' is defined as the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses the Canadian National Occupancy Standard (CNOS) which is sensitive to both household size and composition. Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the standard. The CNOS specifies that:

- no more than two people shall share a bedroom
- parents or couples may share a bedroom
- children under 5 years, either of the same sex or opposite sex may share a bedroom
- children under 18 years of the same sex may share a bedroom
- a child aged 5 to 17 years should not share a bedroom with a child under 5 of the opposite sex
- single adults 18 years and over and any unpaired children require a separate bedroom.

A low proportion indicates less overcrowded households.

Data reported for this indicator are not complete nor directly comparable.

The proportion of ICH households with overcrowding at 30 June is illustrated in table 16.29.

Table 16.29 **ICH — proportion of households with overcrowding (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*[b]	*Aust*
2006	na	..	36.6	na	5.6	..	4.5	na	19.3	na
2007	na	..	27.2	na	24.1	..	na	na	24.5	na
2008	29.1	–	36.6	na	na	..	–	na	10.2	na

[a] Data may not be comparable across jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.46. [b] Contains data from Victoria, Queensland and Tasmania not published separately, and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey for 2005-06, 2006-07 and 2007-08. **na** Not available. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2009) *Indigenous housing indicators 2007-08*, Indigenous housing series no. 3, Cat. no. HOU 212; AIHW, *Indigenous housing indicators 2006-07 collection* (unpublished); AIHW (2007) *Indigenous housing indicators 2005-06*, Indigenous housing series no. 2, Cat. no. HOU 168; table 16A.46.

Customer satisfaction

'Customer satisfaction' is an indicator of governments' objective to provide housing assistance that is appropriate to different households (box 16.39).

Box 16.39 **Customer satisfaction**

‘Customer satisfaction’ is defined as satisfaction with the overall quality of service provided.

A higher proportion of satisfied tenants can imply better housing assistance provision.

Data for this indicator were not available for the 2010 Report.

Commonwealth Rent Assistance

The performance indicator framework for CRA is presented in figure 16.13.

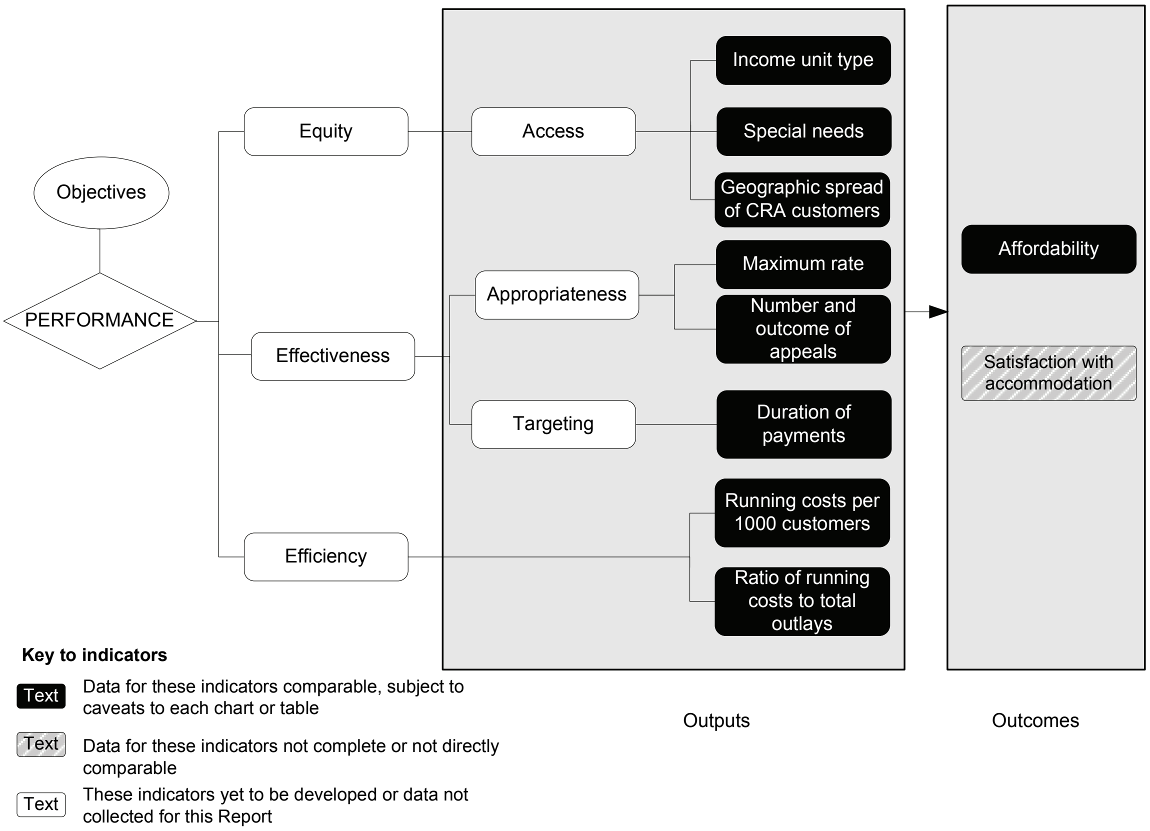
Data for CRA recipients are for individuals and families paid CRA by Centrelink under the *Social Security Act 1991* or family assistance law. CRA data do not include equivalent payments made by the Department of Veterans Affairs, or payments made with Abstudy on behalf of DEEWR.

Data are generally for those entitled to CRA at 5 June 2009. Centrelink recorded 1 038 137 individuals and families as being entitled to CRA with a social security or family assistance payment for that day (FaHCSIA unpublished). Other published figures may include individuals and families who were paid CRA in the previous fortnight, some of whom were only entitled to payment for an earlier period.

Important eligibility requirements for CRA (which is paid automatically once eligibility has been established) are (1) the receipt of an income support payment or more than the base rate of the Family Tax Benefit Part A, and (2) liability to pay rent.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 16.13 **Performance indicators for CRA**



Outputs

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

Equity — access

Income unit type

‘Income unit type’ is an indicator of the CRA’s guiding principle to provide financial assistance in an equitable manner (box 16.40).

Box 16.40 **Income unit type**

‘Income unit type’ reports the proportion of income units receiving CRA by income unit type. An income unit comprises a single person (with or without dependent children) or a couple (with or without dependent children).

Data for this indicator are difficult to interpret. CRA is a demand driven payment whose mix of customers depends upon eligibility for the primary payment.

The number of CRA recipients in terms of the income units in each State and Territory is influenced by a number of factors, including the size of the base population, dependence on welfare and levels of home ownership.

Data reported for this indicator are comparable.

Of the 1 038 137 income units entitled to receive CRA at 5 June 2009, 37 181 (approximately 3.6 per cent) self-identified as Indigenous. Single people with no children represented approximately 52.6 per cent of income units receiving CRA and 39.5 per cent of Indigenous income units receiving CRA (table 16.30). Data for the total number and proportion of income units by the income unit type disaggregated at the jurisdiction level are presented in tables 16A.48, 16A.49, 16A.50 and 16A.51.

Table 16.30 **Income units receiving CRA, by income unit type, 2009**[a]

Type of income unit	*Income units*	*CRA recipients*	*Indigenous income units*	*Indigenous CRA recipients*
	no.	%	no.	%
Single, no dependent children aged under 16	397 507	38.3	11 368	30.6
Single, no children, sharer	148 271	14.3	3 318	8.9
Single, one or two dependent children aged under 16	189 750	18.3	9 272	24.9
Single, three or more dependent children aged under 16	38 434	3.7	3 090	8.3
Partnered, no dependent children aged under 16	91 244	8.8	2 292	6.2
Partnered, one or two dependent children aged under 16	117 664	11.3	4 550	12.2
Partnered, three or more dependent children aged under 16	52 350	5.0	3 130	8.4
Partnered, illness or temporarily separated	2 707	0.3	137	0.4
Unknown income unit	..	..	..	..
Total	**1 038 137**	**100.0**	**37 181**	**100.0**

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in tables 16A.48, 16A.49, 16A.50 and 16A.51. .. Not applicable.

Source: FaHCSIA (unpublished); tables 16A.48, 16A.49, 16A.50 and 16A.51.

Special needs

'Special needs' is an indicator of the CRA's guiding principle to provide income support recipients and low income families with financial assistance (box 16.41).

Box 16.41 **Special needs**

'Special needs' is defined as the proportion of income units receiving CRA allocated to a special needs category. Special needs income units are defined as those income units that have the primary and/or secondary member who receives a Disability Support Pension, or is aged 24 years or under, or 75 years or over, or one or more Indigenous members.

Data for this indicator are difficult to interpret. The number of CRA recipients in each State and Territory is influenced by a number of factors, including the size of the base populations and levels of home ownership.

This indicator provides an overview of the level of assistance provided to disadvantaged groups and facilitates comparison with special needs groups in public housing. CRA is a demand driven payment that has no benchmark in terms of assistance provided to special needs customers. Additional measures of special need, which include a geographic dimension, are reported under affordability.

Data reported for this indicator are comparable.

Table 16.31 illustrates the number and proportion of income units receiving CRA at 5 June 2009 by jurisdiction, special needs and geographic location.

Overall, 57.5 per cent of income units receiving CRA at 5 June 2009 were in capital cities, while 42.5 per cent were in the rest of the State or Territory (FaHCSIA unpublished). For Indigenous income units receiving CRA, 32.6 per cent were located in capital cities, while 67.4 per cent lived in the rest of the State or Territory. For non-Indigenous income units receiving CRA, 58.4 per cent were located in capital cities, while 41.6 per cent lived in the rest of the State or Territory (table 16.31).

People who own their home are not entitled to CRA. Indigenous people receiving social security benefits are less likely to own their home and therefore are more likely to receive CRA. Nationally, 6.9 per cent of Indigenous income units receiving social security or family payments were homeowners, while 43.9 per cent of non-Indigenous income units receiving benefits were home owners, in 2009 (FaHCSIA unpublished).

Table 16.31 **Income units receiving CRA, by 'special needs' and geographic location, 2009**[a]

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Non-Indigenous										
Income units	no.	339 068	227 445	242 417	80 278	73 833	25 009	7 969	4 227	1 000 269
In capital city	%	55.4	69.0	41.9	74.4	76.1	42.9	99.9	81.0	58.4
In rest of State/Territory	%	44.6	31.0	58.1	25.6	23.9	57.1	0.1	19.0	41.6
Non-Indigenous income units as proportion of all CRA recipient income units	%	95.8	98.6	95.1	96.6	97.6	95.1	97.8	81.7	96.4
Non-Indigenous population, as proportion of total population	%	97.7	99.3	96.4	96.6	98.2	96.1	98.7	69.8	97.5
Indigenous										
Income units	no.	14 708	3 206	12 370	2 707	1 788	1 297	151	916	37 154
In capital city	%	26.1	40.3	26.8	53.7	59.2	38.6	100.0	52.6	32.6
In rest of State/Territory	%	73.9	59.7	73.2	46.3	40.8	61.4	..	47.4	67.4
Indigenous income units as proportion of all CRA recipient income units	%	4.2	1.4	4.9	3.3	2.4	4.9	1.9	17.7	3.6
Indigenous population, as proportion of total population	%	2.3	0.7	3.6	3.4	1.8	3.9	1.3	30.2	2.5
Disability Support Pension										
Income units	no.	68 616	48 306	47 613	15 135	15 871	5 668	1 062	1 149	203 432
In capital city	%	46.6	65.4	40.1	72.0	75.0	43.9	99.3	71.7	54.0
In rest of State/Territory	%	53.3	34.6	59.8	27.9	24.9	56.1	0.3	27.9	45.9
Income units as proportion of all CRA recipient income units	%	19.4	20.9	18.7	18.2	21.0	21.5	13.0	22.1	19.6
Disability Support Pension population, as proportion of total population	%	1.0	0.9	1.1	0.7	1.0	1.1	0.3	0.5	0.9

(Continued on next page)

Table 16.31 **(Continued)**

Aged 24 years or under										
Income units	no.	45 838	32 583	38 723	12 466	11 863	5 053	2 596	685	149 824
In capital city	%	45.0	62.8	45.6	77.0	79.1	47.3	100.0	75.6	55.5
In rest of State/Territory	%	54.9	37.2	54.3	22.9	20.9	52.7	..	23.1	44.4
Income units as proportion of all CRA recipient income units	%	12.9	14.1	15.2	15.0	15.7	19.2	31.9	13.2	14.4
Aged 24 years or under population, as proportion of total population	%	0.7	0.6	0.9	0.6	0.7	1.0	0.7	0.3	0.7
Aged 75 years or over										
Income units	no.	29 448	19 597	20 755	7 938	7 421	2 102	420	201	87 886
In capital city	%	53.1	67.3	38.5	71.4	68.6	35.1	100.0	66.2	55.6
In rest of State/Territory	%	46.8	32.7	61.4	28.5	31.3	64.9	..	33.8	44.3
Income units as proportion of all CRA recipient income units	%	8.3	8.5	8.1	9.6	9.8	8.0	5.2	3.9	8.5
Aged 75 years or over population, as proportion of total population	%	0.4	0.4	0.5	0.4	0.5	0.4	0.1	0.1	0.4
Total income units[b]	**no.**	**353 939**	**230 738**	**254 994**	**83 118**	**75 647**	**26 307**	**8 147**	**5 176**	**1 038 137**

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.52. [b] Totals will not add up to 100 per cent due to income units being included in more than one 'special needs' group. .. Not applicable.

Source: FaHCSIA (unpublished); ABS population by age and sex, Australian States and Territories, Cat. no. 3201.0, (unpublished); ABS (2007) *2006 Census of Population and Housing*; ABS (2008) *Population Projections, Australia, 2006 –2101*, Cat. no. 3222.0; table 16A.52.

Geographic spread of CRA customers

'Geographic spread of CRA customers' is an indicator of the CRA's guiding principle to ensure equitable spread of CRA customers within geographic regions (box 16.42).

Box 16.42 **Geographic spread of CRA customers**

'Geographic spread of CRA customers' is defined by two measures:

- CRA recipients as a proportion of private rental stock (from 2006 Census) across Australia and within each capital city (in map form)
- the average CRA entitlement across locations.

Descriptive information is provided about rents, average levels of assistance, and the proportion of private rental stock occupied by CRA recipients within regions.

The geographic spread of customers can provide some insight into the responsiveness of CRA to regional variations in rent and the extent to which recipients are able to exercise choice in where to live. This information is useful in examining differences across jurisdictions, and capital cities/rest of State.

Additional measures of geographic spread are reported under 'affordability'.

Data reported for this indicator are comparable.

Results for income units receiving CRA as a proportion of income units in each capital city receiving a social security income support benefit or more than the base rate of the Family Tax Benefit are mapped in tables 16A.53–16A.61. Information on the average CRA entitlement across locations is contained in table 16A.62.

The ratio of CRA recipients to private rental stock between and within capital cities varies but the patterns are complex. The maps should be interpreted with caution because they compare CRA recipients at 5 June 2009 with 2006 Census data and make no allowance for changes in private rental stock over that period (FaHCSIA unpublished).

Effectiveness — appropriateness

Maximum rate

'Maximum rate' is an indicator of the CRA's guiding principle to provide appropriate financial assistance (box 16.43).

Box 16.43 **Maximum rate**

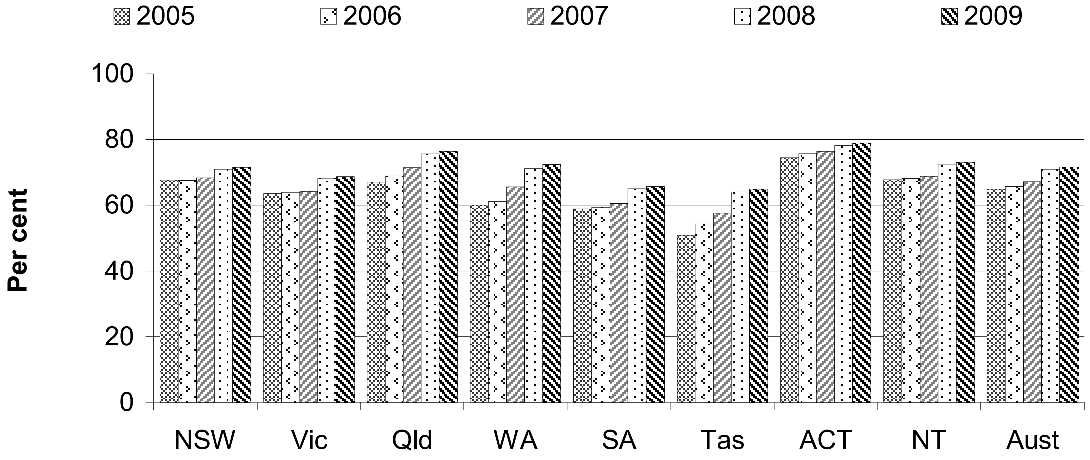
‘Maximum rate’ is defined as the proportion of income units paying enough rent to receive the maximum rate of CRA.

The effectiveness of the payment against rents is reflected in increasing/decreasing proportions of units on the maximum rates of assistance. An increasing proportion of income units receiving the maximum rate of assistance suggests that CRA is becoming less effective against rent increases. A decreasing proportion suggests that CRA is increasing faster than rents. Maximum rate can be used to monitor the adequacy of CRA over time.

Data reported for this indicator are comparable.

At 5 June 2009, 71.7 per cent of income units receiving CRA across Australia paid enough rent to receive the maximum rate of CRA (figure 16.14). Nationally, there is an upward trend in the proportion of income units receiving CRA between 2005 and 2009.

Figure 16.14 **Proportion of income units receiving CRA paying enough rent to receive maximum assistance**[a]



[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.63.

Source: FaHCSIA (unpublished); table 16A.63.

Number and outcome of appeals

‘Number and outcome of appeals’ is an indicator of the CRA’s guiding principle to ensure appropriateness of decisions related to the payment of CRA (box 16.44).

Box 16.44 **Number and outcome of appeals**

‘Number and outcome of appeals’ is defined as the outcome of all CRA appeals finalised.

A high or increasing proportion of original decisions affirmed implies that the original decisions were appropriate.

There is a formal review process for decisions related to the payment of CRA. Recipients who are dissatisfied with a decision are encouraged to discuss the matter with the original decision maker before taking the matter further, although this is not a necessary step. Authorised review officers conduct a quick and informal internal review of the decision. Generally, recipients who are dissatisfied with the authorised review officer’s decision can appeal to the Social Security Appeals Tribunal, which is an independent body with decision making powers. Either the recipients, FaHCSIA or the DEEWR can seek an Administrative Appeals Tribunal review of the Social Security Appeals Tribunal’s decisions.

Data reported for this indicator are comparable.

There were 623 finalised appeals to an authorised review officer in 2008-09, which represented approximately 0.06 per cent of income units receiving CRA. The original decision was affirmed, or appeal dismissed, for approximately 59.2 per cent of finalised appeals to an authorised review officer, 65.1 per cent of appeals to the Social Security Appeals Tribunal and 23.1 per cent of appeals to the Administrative Appeals Tribunal (table 16.32).

Table 16.32 **Outcome of all CRA appeals finalised in 2008-09**[a]

Outcome	*Appeals to ARO*		*Appeals to SSAT*		*Appeals to AAT*	
	no.	%	no.	%	no.	%
Original decision affirmed or appeal dismissed	369	59.2	69	65.1	3	23.1
Original decision set aside	125	20.1	25	23.6	1	7.7
Original decision varied	97	15.6	6	5.7	–	–
Appeal withdrawn	32	5.1	6	5.7	9	69.2
Total finalised	**623**	**100.0**	**106**	**100.0**	**13**	**100.0**

ARO = Authorised Review Officer. SSAT = Social Security Appeals Tribunal. AAT = Administrative Appeals Tribunal. [a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.64. – Nil or rounded to zero.

Source: FaHCSIA (unpublished); table 16A.64.

Duration of payments

‘Duration of payments’ is an indicator of the CRA’s guiding principle to measure targeting of the CRA payments in an efficient manner (box 16.45).

Box 16.45 **Duration of payments**

'Duration of payments' is defined as the level of short-term and long-term dependence on CRA payments. The indicator is measured by the number of recipients receiving CRA benefits at the beginning and at the end of the year, as well as the number of CRA recipients who were in receipt of CRA benefits at the beginning of the year and still in receipt a year later.

A low or decreasing level of payment duration reflects less dependence on CRA.

Data reported for this indicator are comparable.

Nationally, 946 641 income units were entitled to receive CRA payments at 6 June 2008, and 1 038 137 income units were entitled to receive CRA at 5 June 2009. Out of those, 706 658 income units or 68.1 per cent were receiving CRA at both times, implying a high degree of dependence on CRA. The remaining 331 479 income units (31.9 per cent) started to receive CRA during the year and were receiving assistance at the end of the year (table 16.33). Other income units received assistance for only part of the year. CRA was paid on average to just over 1 million income units each fortnight in 2008-09 (FaHCSIA unpublished).

Table 16.33 **Duration of CRA payments, by State and Territory (number)**[a]

	Number of income units at the beginning of the year 6 June 2008	*Number of income units at the end of the year 5 June 2009*	*Number of same income units at the beginning and the end of the year*
NSW	326 525	353 939	248 452
Victoria	210 740	230 738	157 815
Queensland	226 673	254 994	168 800
WA	75 311	83 118	54 134
SA	69 996	75 647	52 485
Tasmania	24 882	26 307	17 978
ACT	7 495	8 147	4 358
NT	4 895	5 176	2 610
Total	**946 641**	**1 038 137**	**706 658**

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.65.

Source: FaHCSIA (unpublished); table 16A.65.

Running costs per 1000 customers

'Running costs per 1000 customers' is an indicator of CRA's guiding principle to provide financial assistance in an efficient manner (box 16.46).

Box 16.46 **Running costs per 1000 customers**

'Running costs per 1000 customers' is defined as total CRA running costs divided by total CRA customers, expressed as a rate per 1000 customers.

Low or decreasing running costs per 1000 customers implies high or increasing efficiency for a given service level.

Data reported for this indicator are comparable.

Nationally, the running costs per 1000 customers were $47 721 for 2008-09, $53 466 for 2007-08, $62 829 for 2006-07 and $61 998 for 2005-06 (2008-09 dollars) (table 16A.66).

Ratio of running costs to total outlays

'Ratio of running costs to total outlays' is an indicator of CRA's guiding principle to provide financial assistance in an efficient manner (box 16.47).

Box 16.47 **Ratio of running costs to total outlays**

'Ratio of running costs to total outlays' is defined as a proportion of total CRA running costs to total CRA outlays.

A low or decreasing ratio implies high or increasing efficiency for a given service level.

Data reported for this indicator are comparable.

Nationally, the ratio of running costs to total outlays was 1.9 per cent for 2008-09, 2.1 per cent for 2007-08, 2.5 per cent for 2006-07 and 2.4 per cent for 2005-06 (table 16A.67).

Outcomes

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

Affordability

'Affordability' is an indicator of the CRA's guiding principle to provide income support recipients and low income families in the private rental market with financial assistance (box 16.48).

Box 16.48 **Affordability**

'Affordability' is defined as the proportions of income units spending more than 30 per cent and 50 per cent of their income on rent with and without CRA. Affordability outcomes (with and without CRA) are reported for all income units receiving CRA, Indigenous income units receiving CRA, Disability Support Pension income units receiving CRA, income units aged 24 years or under receiving CRA, and income units aged 75 years or over receiving CRA.

A low or decreasing proportion of recipients spending 30 per cent and 50 per cent of income on rent with CRA implies improved affordability.

CRA is intended to improve affordability, not to achieve a particular benchmark. Program performance is best judged by trends over a number of years.

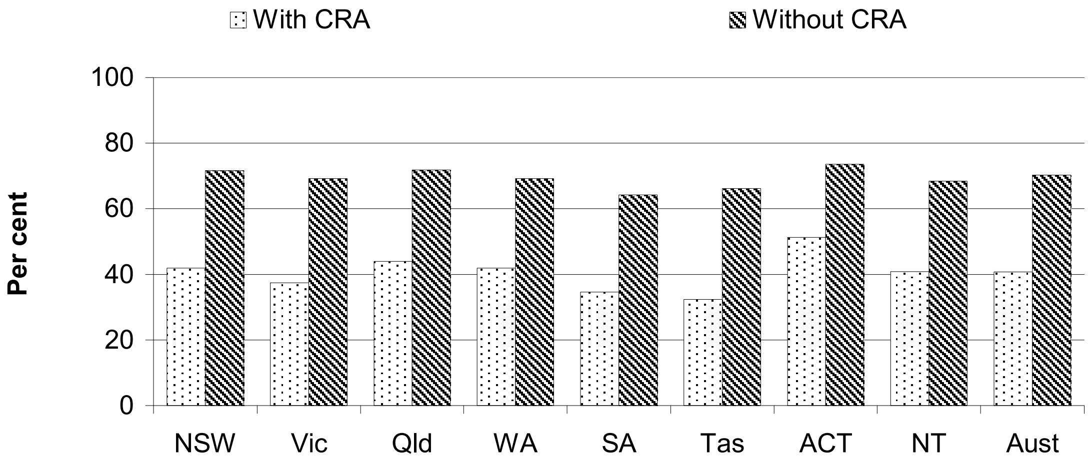
Data reported for this indicator are comparable.

Information on the proportion of income spent on rent (with and without CRA) by Australians living in State capital cities and rest of State regions, income units where one or more members' self-identify as Indigenous Australians, income units where one or more members receive a Disability Support Pension, income units aged 24 years or under, and income units aged 75 years or over is presented in tables 16A.68–16A.73.

Nationally, if CRA were not payable, then at 5 June 2009, 70.3 per cent of income units receiving CRA would have paid more than 30 per cent of their income on rent. Accounting for CRA payments (thereby reducing the rent paid by the amount of the assistance) this proportion falls to 40.7 per cent (figure 16.15).

Without CRA, 31.0 per cent of recipients across Australia would have spent more than 50 per cent of their income on rent, while with CRA the proportion is 12.6 per cent (table 16A.73).

Figure 16.15 **Income units paying more than 30 per cent of income on rent, with and without CRA, 2009**[a]



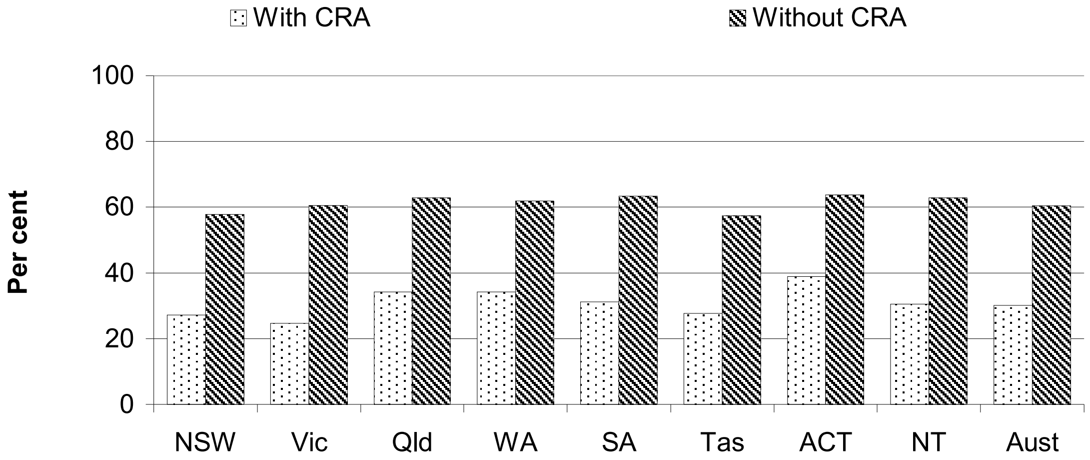
---

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.68.

Source: FaHCSIA (unpublished); table 16A.68.

Nationally, if CRA were not payable, then 60.4 per cent of the Indigenous income units receiving CRA would have spent more than 30 per cent of income on rent at 5 June 2009. Taking CRA into account, this proportion falls to 30.2 per cent (figure 16.16). Similarly, if CRA were not payable, then 22.7 per cent of Indigenous income units across Australia would have spent more than 50 per cent of income on rent at 5 June 2009. Accounting for CRA payments this proportion decreases to 7.7 per cent (table 16A.73).

Figure 16.16 Indigenous income units receiving CRA paying more than 30 per cent of income on rent, with and without CRA, 2009[a]

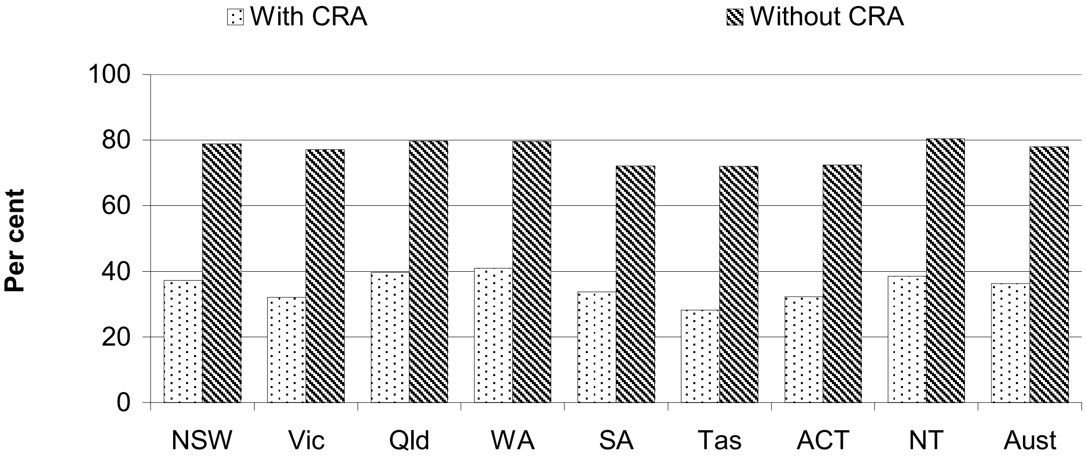


[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.69.

Source: FaHCSIA (unpublished); table 16A.69.

Nationally, if CRA were not payable, then 77.9 per cent of all income units with a member receiving a Disability Support Pension would have spent more than 30 per cent of income on rent at 5 June 2009. Accounting for CRA payments this proportion decreases to 36.3 per cent (figure 16.17). Similarly, if CRA were not payable, then 30.5 per cent of income units receiving a Disability Support Pension would have spent more than 50 per cent of income on rent at 5 June 2009. Accounting for CRA payments, this proportion decreases to 7.9 per cent (table 16A.73).

Figure 16.17 **Income units receiving a Disability Support Pension paying more than 30 per cent of income on rent, with and without CRA, 2009**[a]

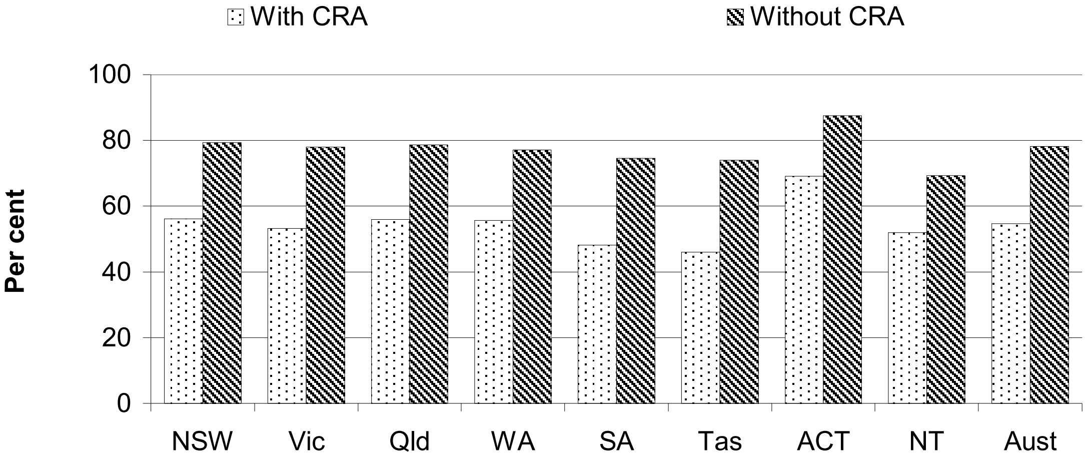


[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.70.

Source: FaHCSIA (unpublished); table 16A.70.

Nationally, if CRA were not payable, then 78.2 per cent of all income units with a member aged 24 years or under would have spent more than 30 per cent of income on rent at 5 June 2009. Accounting for CRA payments this proportion decreases to 54.7 per cent (figure 16.18). Similarly, if CRA were not payable, then 43.5 per cent of income units aged 24 years or under would have spent more than 50 per cent of income on rent at 5 June 2009. Accounting for CRA payments, this proportion decreases to 20.4 per cent (table 16A.73).

Figure 16.18 Income units aged 24 years or under paying more than 30 per cent of income on rent, with and without CRA, 2009[a]



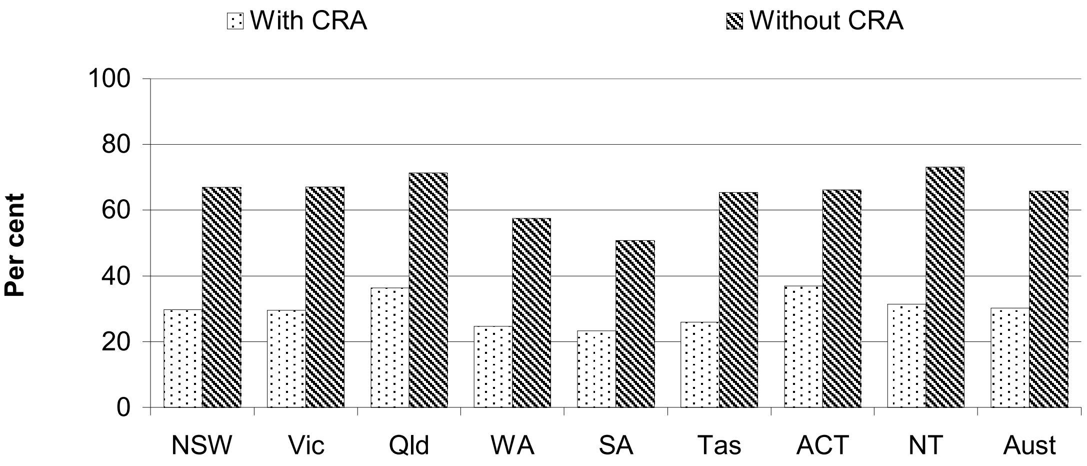
---

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.71.

Source: FaHCSIA (unpublished); table 16A.71.

Nationally, if CRA were not payable, then 65.8 per cent of all income units with a member aged 75 years or over would have spent more than 30 per cent of income on rent at 5 June 2009. Accounting for CRA payments this proportion decreases to 30.2 per cent (figure 16.19). Similarly, if CRA were not payable, then 22.6 per cent of income units aged 75 years or over would have spent more than 50 per cent of income on rent at 5 June 2009. Accounting for CRA payments, this proportion decreases to 7.2 per cent (table 16A.73).

Figure 16.19 **Income units aged 75 years or over paying more than 30 per cent of income on rent, with and without CRA, 2009**[a]



---

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.72.

Source: FaHCSIA (unpublished); table 16A.72.

Satisfaction with accommodation

‘Satisfaction with accommodation’ is an indicator of the CRA’s guiding principle to ensure that housing is appropriate to the needs of CRA recipients (box 16.49).

Box 16.49 **Satisfaction with accommodation**

‘Satisfaction with accommodation’ is defined by two measures:

- ‘satisfaction with location’, defined as the proportion of the social security recipients’ preferences to either stay or leave current location
- ‘satisfaction with quality’, defined as the proportion of the social security recipients who are satisfied with the home in which they live.

A high or increasing proportion of satisfied customers can imply better or improving accommodation provision.

Data reported for this indicator are not directly comparable.

No recent surveys have been conducted to determine CRA recipients’ satisfaction with the quality and location of their home.

However, the Household Income and Labour Dynamics in Australia (HILDA) survey identifies social security recipients living in private rental accommodation who are potentially eligible for CRA. Data on satisfaction with the home and neighbourhood in which individuals lived and satisfaction with the feeling that individuals were part of their local community, derived from the HILDA (Wave 7) conducted in 2007-08, are presented in table 16.34. Further information is provided in table 16A.74.

When asked to rate their satisfaction with the home in which they lived, 81.6 per cent expressed some level of satisfaction (with 24.3 per cent totally satisfied), while 11.4 per cent expressed dissatisfaction. When asked to rate their satisfaction with the neighbourhood in which they lived, 83.2 per cent expressed some level of satisfaction (with 22.1 per cent totally satisfied), while 7.8 per cent expressed dissatisfaction. When asked to rate their satisfaction with the feeling of being part of the local community, 60.9 per cent expressed some level of satisfaction (with 12.4 per cent totally satisfied), while 20.6 per cent expressed dissatisfaction.

Table 16.34 **Satisfaction with home and neighbourhood and satisfaction with being part of the local community (per cent), 2007-08**

	Totally dissatisfied				*Neither satisfied nor dissatisfied*					*Totally satisfied*
	0	1	2	3	4	5	6	7	8	9	10
Home lived in[a]	1.3	1.1	1.6	3.9	3.5	7.0	8.3	13.3	20.5	15.2	24.3
Neighbourhood lived in[b]	0.4	0.5	1.3	1.9	3.7	9.0	6.4	17.8	22.0	14.9	22.1
Feeling of being part of the local community[a]	2.4	2.3	4.6	3.8	7.4	18.6	9.9	14.5	15.8	8.3	12.4

[a] Satisfaction with home in which lived and satisfaction with the feeling of being part of the local community were based on 728 valid responses. [b] Satisfaction with neighbourhood in which lived was based on 726 valid responses.

Source: FaHCSIA (unpublished); table 16A.74.

16.4 Future directions in performance reporting

COAG developments

Report on Government Services alignment with National Agreement reporting

It is anticipated that future editions of the Housing chapter will align with the NAHA indicators and the NIRA. Further alignment between the Report and NA indicators, and other reporting changes, might result from future developments in NA and National Partnership reporting.

Outcomes from review of Report on Government Services

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the Intergovernmental Agreement on Federal Financial Relations.

No significant changes from this review are reflected in the 2010 ROGS. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 ROGS.

Further developing indicators and data

Improved reporting on housing provision to Indigenous Australians continues to be a priority. All Australian, State and Territory governments have committed to improve reporting against a nationally endorsed performance indicator framework for Indigenous housing. Jurisdictions have implemented action plans to improve the availability and reliability of data on Indigenous Australians accessing mainstream housing assistance.

The Housing Working Group will continue to improve the quality of mainstream community housing and financial data that are published in the report.

16.5 Jurisdictions' comments

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

Australian Government comments

The 2003 Commonwealth-State Housing Agreement (CSHA) was the mechanism by which the Australian Government provided money to the states and territories for housing assistance programs for those most in need in the community from July 2003 to December 2008. It provided $5.2 billion over the 5.5 year period.

The CSHA was replaced by the National Affordable Housing Agreement (NAHA) on 1 January 2009 and provides a framework for governments to work together to improve housing affordability, reduce homelessness and reduce Indigenous housing disadvantage. As part of the new Agreement, governments have committed to undertake reforms in the housing sector, including: to improve integration between the homelessness service system and mainstream services; reduce concentrations of disadvantage that exist in some social housing estates; improve access by Indigenous people to mainstream housing, including home ownership; enhancing the capacity and growth of the not-for-profit housing sector and planning reforms for greater efficiency in the supply of housing.

The NAHA is supported by three National Partnerships. The Social Housing National Partnership Agreement provides $400 million over 2 years to increase the supply of social housing by at least 1600 dwellings. The National Partnership on Homelessness is providing $1.1 billion over 4 years for better services and specialist supported housing. The Remote Indigenous Housing National Partnership is providing $5.5 billion over 10 years to address overcrowding, homelessness, poor housing conditions and severe housing shortages in remote Indigenous communities.

The Australian Government is also providing an additional $5.64 billion over 3.5 years for social housing under the Nation Building — Economic Stimulus Plan. Over 19 300 additional social housing dwellings will be built under the initiative with the assistance of the not-for-profit sector and repairs and maintenance undertaken to over 60 000 existing social housing dwellings. This includes significant repairs and maintenance to more than 10 000 social housing dwellings that are currently vacant or will become uninhabitable without this work.

The Australian Government has also implemented several other initiatives to improve housing affordability, particularly for low to moderate income earners. These include: the Housing Affordability Fund; the National Rental Affordability Scheme; First Home Savers Accounts; releasing surplus Commonwealth land; a National Housing Supply Council; and increases to the First Home Owners Grant, the First Home Owners Boost, the Commonwealth Financial Counselling Program and Centrelink's Financial Information Service.

Commonwealth Rent Assistance (CRA) is a non-taxable income support supplement payable to eligible Australian residents who rent accommodation in the private rental market. CRA rates are based on a customer's family situation and the amount of rent they pay.

New South Wales Government comments

- Housing NSW manages the largest portfolio of public housing in Australia with close to 125 000 properties. The community housing sector's role in the provision of social housing continues to grow with over 17 000 properties now being managed in this sector. The Aboriginal Housing Office (AHO) currently owns over 4300 properties and registered and non-actively registered Aboriginal housing providers manage more than 4400 properties.
- NSW is working to grow and reform the housing sector to develop an integrated social housing sector. NSW is working with the Australian and other State and Territory governments to progress the reform agenda under the National Affordable Housing Agreement, related National Partnerships and the National Partnership on the Nation Building Economic Stimulus Plan.
- Through the National Partnership on Nation Building Economic Stimulus Plan NSW will deliver, in two stages, over 6300 new social housing homes by 2012. This will provide more housing assistance to people most in need, particularly those people who are homeless or at risk of homelessness and Aboriginal people. The majority of these properties will be owned and managed by community housing providers. Also, under this partnership 31 000 social housing homes in NSW will be upgraded by 2010.
- Reducing homelessness is a priority for the NSW Government and in 2009 *A Way Home: Reducing Homelessness in NSW*, NSW Homelessness Action Plan 2009–2014 was launched which sets the direction to achieve better outcomes for people who are homeless or at risk of homelessness. It is a new approach to addressing and preventing homelessness including greater collaboration with the non-government sector.
- Implementation of the 5 year strategy, Planning for the Future: New Directions for Community Housing in NSW, is ensuring that the community housing sector grows as a flexible component of the NSW social housing system that is able to offer more housing for people, tailored to their needs. The target is to grow the sector from 13 000 to 30 000 homes over 10 years.
- The NSW Aboriginal Housing Office continues to focus on improving: the financial viability, asset and tenancy management, capacity and governance of Aboriginal community housing providers which are key components to the reform of the sector. AHO will continue to implement these reforms into the future. Under the Remote Indigenous Housing National Partnership, 50 new houses will be delivered in 2009-10.
- Affordable housing is a social policy priority for the NSW Government. The NSW Government is working with the Australian Government to improve the supply of affordable housing through the Housing Affordability Fund and the National Rental Affordability Scheme (NRAS). NRAS Rounds 1 and 2 will see an additional 2437 affordable rental dwellings supplied in NSW with delivery of approximately 500 anticipated in 2009-10.

Victorian Government comments

The Victorian Government continues to extend and improve social housing for clients and the community. The Department of Human Services acquired 1407 new long term social housing dwellings and upgraded 3277 existing homes during the year, improving safety and comfort for residents while also being environmentally sustainable.

Improving people's lives in some of Victoria's most disadvantaged communities was also a major focus. The Neighborhood Renewal program aims to help break the cycle of disadvantage by bringing together the resources and ideas of residents in housing estates, government, businesses and community groups, tackling disadvantage in areas with high concentrations of public housing, providing residents with training, education and employment opportunities, while developing a greater sense of community that is creating vibrant places to live.

Since its inception in 2001, the department has invested more than $310 million in Neighborhood Renewal, creating 5000 jobs and training opportunities for public housing tenants across 19 neighborhoods. Also, this year residents in the Collingwood public housing estate were helped to improve their computer skills and gain affordable internet access through the Neighborhood Renewal program, Wired Community@Collingwood which delivered free computer access to more than 900 homes across the Collingwood public housing estate with more than 60 Collingwood residents having completed the free training sessions. This innovative project recently won the Victorian and National 2009 e-Inclusions and e-Community Australian Information Industry Association iAward.

Also during 2008-09 a new fixed rent setting approach was introduced for public housing tenants, giving tenants who earn additional income a 6 month period before it affects their rent. The introduction of fixed rents was accompanied by an agreement that allows income details to be electronically transferred from Centrelink to the Department of Human Services. This takes the onus off clients to regularly supply evidence of their income and assets. Currently 47 000 households have their rent automatically adjusted through income confirmation.

In January 2009 the Government also finalised the National Affordable Housing Agreement and associated National Partnerships with the Commonwealth Government to secure $2.5 billion over 5 years to improve and expand public and social housing and services to homeless, Indigenous and low-income Victorians. The agreement paves the way for more housing options and supports development of a more coordinated service system across homelessness and social housing.

Queensland Government comments

“Continued population growth and a lack of supply of newly constructed housing has meant that significant price falls similar to those seen in other states did not occur in Queensland’s major centres. In response to the pressures placed on social housing, the Department of Communities increased the total number of social housing dwellings owned or funded by the department to 66 369 in 2008-09, an increase of 1.3 per cent.

Queensland assisted 78 600 households with social rental housing in 2008-09 and helped 185 636 households access or sustain private market tenure (up 2.8 per cent compared with last year).

In September 2008, the Department introduced a new client intake and assessment process. Those in greatest need will be assisted first and with the most appropriate product or service for their need. At 30 June 2009, 92.8 per cent of clients assisted with government-managed, long-term social housing had ‘very high’ or ‘high’ needs.

The National Affordable Housing Agreement commenced on 1 January 2009. It aims to ensure that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation. Under the Agreement, Queensland was allocated $1.1 billion over a 5 year period, and it is supported by the following National Partnership Agreements:

Social Housing, with $80.1 million over 2 years, will provide additional social housing, improved housing opportunities for Indigenous people and accommodation options to assist people who are homeless or at risk of homelessness to transition to secure long-term accommodation.

Homelessness, with $135.1 million in Australian Government funding over 5 years, will reduce homelessness, including $35.7 million over 5 years for the initiative A Place to Call Home. Queensland is complementing this investment through $149.5 million in funding over 5 years, including $46.5 million for A Place to Call Home.

Remote Indigenous Housing, with $1.156 billion in Australian Government funding over 10 years to improve housing amenity for Indigenous people and reduce overcrowding, particularly in remote areas and Indigenous communities. This agreement will result in 1141 new dwellings, 1216 major upgrades, repairs and maintenance being undertaken, and the provision of tenancy management services, housing-related infrastructure and employment outcomes.

The social housing component of the Nation Building and Jobs Plan provides $1.2 billion to increase Queensland’s social housing portfolio with an estimated 4000 dwellings, and provides funds for repairs and maintenance of existing social housing stock.

In addition, the National Rental Affordability Scheme, a Commonwealth Government initiative, will stimulate the supply of up to 10 000 new affordable rental dwellings across Queensland by 2012.”

Western Australian Government comments

On 16 December 2008, the Government announced a significant reform of the Department of Housing and Works. Effective as of 1 February 2009, the two separate portfolios, Housing and Works, were separated into two distinct service delivery areas. Works was transferred to the Department of Treasury and Finance as Building Management and Works, while the housing related functions remained as the Department of Housing.

In the current economy the housing market remains tumultuous. The last 4 years have seen a doubling of house and rental prices in Perth. This has had a major flow-on to all of the Authority’s services from affordable land development to public rental, private rental assistance in the form of bonds, and home ownership. There are also challenges in servicing remote Indigenous Communities across the State.

The extension and boost of the First Home Buyers Grant, combined with lower interest rates has increased buyers’ confidence and the Department’s level of activity in the first home buyer sector has been very positive. The Department continued to perform well in the affordable land segment with 80 per cent of sales below the median price.

While the Department manages some 40 000 residential tenancies there remains a growing waiting list for social housing and the Department has had to search beyond traditional methods to find solutions. New partnerships have been forged with Community Housing Organisations throughout the State as a way of delivering new housing economically. Six additional providers have been registered in metropolitan and regional Western Australia across the three–tier system and a further 20 applications were being assessed at the close of the 2008-09 financial year.

The Department continued to consolidate the community housing industry, ensuring strict policies and guidelines are in place to regulate the industry and that all avenues for maximising financial returns for providers are fully explored. Consolidation of WA’s community housing organisations (CHOs) continued with 233 CHOs managing 5652 units at 30 June 2009, compared with 30 June 2006 when 4500 units were managed by 241 CHOs.

The announcement of the Commonwealth and State Social Housing Stimulus Packages has created a project of unprecedented magnitude for the Department. The Commonwealth’s National Partnership Agreement on the Nation Building and Jobs Plan: Building Prosperity for the Future and Supporting Jobs Now, (February 2009) injected $608.12 million into WA to construct additional social housing, and $40.45 million to refurbish existing stock. Three quarters of the new construction must be completed by 31 December 2010.

South Australian Government comments

The new National Affordable Housing Agreement became effective from 1 January 2009, reforming historical Commonwealth-State funding agreements. South Australia provided significant input to the modernisation and development of the Agreement and is committed to achieving the targets set within the Agreement and associated National Partnership Agreements.

At 30 June 2009, work was underway on nine major upgrades and preparatory work was being undertaken on more than 100 other Housing SA properties for upgrade under the Nation Building Economic Stimulus Plan.

The 2008-09 funding allocation under the National Partnership Agreement on Social Housing will be used to deliver up to 98 homes by leveraging additional funds from the not-for-profit sector to house people who are homeless or at risk of homelessness.

South Australia’s Implementation Plan for the National Partnership Agreement on Homelessness has been launched, focussing on the four core outputs of A Place to Call Home, Street to Home initiatives, support for private and public tenants to help sustain their tenancies, and assistance for people leaving correctional, health and child protection services.

Building new houses to reduce overcrowding and upgrading existing homes to improve housing conditions in the Anangu Pitjantjatjara Yankunytjatjara (APY) communities of Mimili and Amata are the initial priority for the National Partnership Agreement on Remote Indigenous Housing. During 2008-09, agreement was reached with the APY Council for a major program of building, upgrading, and improving housing management systems and processes. This will include linkage to home maker programs and a strong focus on local employment outcomes.

Housing SA continues to foster innovative partnerships with government and non-government agencies and the development industry to provide a greater diversity in housing supply within the State. These partnerships provide the foundation to achieve affordable housing options for all South Australians.

Fourteen capital projects were approved for funding involving partnering organisations committed to delivering 163 affordable rental housing outcomes in metropolitan and regional areas. Several initiatives were also launched to extend the depth and timing of the Commonwealth’s National Rental Affordability Scheme outcomes for South Australians.

Housing SA maintained 47 656 tenantable public, Aboriginal and community housing properties for South Australians during 2008-09, as well as providing assistance to 17 498 customers to help secure affordable private rental accommodation. Demand for public, Aboriginal and community housing remained stable with 7539 new applications lodged while allocations to new tenants decreased to 2746 in 2008-09 due to decreased vacancies and competing priorities for vacant properties. Whilst total new allocations decreased in 2008-09, over 65 per cent were to greatest need customers.

Tasmanian Government comments

“ Continuing increases in property values in Tasmania over recent years have maintained higher costs for private rental and home ownership, and fewer affordable accommodation options for people on low incomes. Tasmania also has a rapidly aging population and a high proportion of people dependent on Government pensions and benefits. To meet the challenges of the housing market, the Tasmanian Government is committed to a broad housing reform agenda which will realise the construction of new homes for social housing, opportunities for affordable home ownership, private rental assistance, land development for social and affordable housing and a reduction in homelessness.

During the year, the Housing Innovations Unit was established to oversee a large building and construction program to increase the quality and supply of social and affordable housing in Tasmania. The Unit is responsible for delivering on a range of new and innovative capital programs including the National Rental Affordability Scheme, Housing Affordability Fund, QuickBuilds and targets set under the Nation Building — Economic Stimulus Plan and National Partnership Agreements on Social Housing and Homelessness, under the National Affordable Housing Agreement (NAHA). Planning to implement reforms to the social housing service system has commenced to facilitate a seamless transition into the new NAHA and related National Partnership Agreements. The Unit is also responsible for implementing the State Government’s $60 million Housing Fund.

The Accommodation Options Unit was established within Housing Tasmania to address the residential accommodation requirements of people accessing services within the Human Services group. The Unit brings together the existing strands of capital management for supported accommodation in Housing Tasmania, Disability Services, Youth Justice, Mental Health and Children and Family Services. This Unit strengthens the integration of service delivery to clients with special needs.

In excess of 7700 low income households received financial or non-financial assistance through Private Rent Assistance services during 2008-09. The number receiving financial assistance decreased 3.7 per cent from 2007-08, reflecting a shortage of affordable rental opportunities, and increased competition for available rental homes which potentially disadvantages those on low incomes.

HomeShare was implemented to provide low income earners the opportunity to purchase a home with the Director of Housing taking on some of the equity. By sharing ownership with another person, in this instance the Director, many Tasmanians may be able to purchase a home they could otherwise not afford.

During 2008-09 a review into the delivery of public housing in Tasmania has been in progress with several reform options under consideration. The outcomes of this review will be finalised during 2009-10. ”

Australian Capital Territory Government comments

In accordance with its ongoing reform in the delivery of housing assistance and homelessness services, the ACT Government has taken the opportunity provided by the additional funding and impetus for reform offered by the National Affordable Housing Agreement, the associated National Partnership Agreements and the Nation Building and Jobs Plan stimulus package, to implement further innovative housing and support programs to better meet clients' needs.

The ACT began this significant reform process in 2006. Consistent with the current reform agenda, the ACT continues to better target housing and support to those most in need and to create an integrated continuum of support from early intervention, support in crisis to sustained tenancies and on to social and economic participation and inclusion.

A new program assists women and children to remain in their home following domestic violence, still the single most common cause of homelessness. This early intervention, homelessness strategy seeks to minimise the adverse effects on the children's development to avoid lasting social and economic effects in their lives.

A new youth housing program is targeted at young people exiting care and protection, out of home care, youth justice or homelessness services. Under this strategy, Youth Housing Managers work with a young person from first contact with Housing ACT through to managing their tenancy and assisting them to engage with employment, education and training. Some 55 per cent of the young people in the program have maintained or begun study or employment whilst 35 per cent focussed on raising their young children.

The Nation Building and Jobs Plan is targeted to ACT's older tenant population through the construction of supportive accommodation close to their existing homes, allowing them to 'age in place'. It will also increase stock utilisation as vacated houses will be provided to families on the public housing waiting list.

The ACT has introduced a number of initiatives to assist the Community Housing Sector to continue its success in providing housing assistance to those in greatest need. Three organisations are in receipt of benchmark payments for tenancy management, providing housing to a range of tenants with special needs. Other organisations lease properties from Housing ACT under the Housing Asset Assistance Program and retain rent in lieu of receiving benchmark payments. The ACT Government is working in partnership with providers to provide a common waiting list for community and public housing. This is in conjunction with the work under the Homelessness National Partnership to develop a common point of access for homelessness services. These initiatives will provide significant assistance to community housing providers and homelessness services in the management of their waiting lists, create efficiencies and further enable quality services to be provided to tenants and clients, help to integrate the broader housing continuum and enhance choice for people seeking housing.

Northern Territory Government comments

In March 2009 the Chief Minister and Minister for Housing announced the 'Housing the Territory' strategy which is aimed at getting the balance of housing in the Territory right.

The Northern Territory Government is committed to ensuring there is more affordable housing available to buy and rent and the "Housing the Territory" strategy will see more land to grow, new places to buy, new places to rent and new public housing stock. In 2009 the Government is investing $390 million in housing programs. This includes strategic investment in public housing to meet the areas of most need.

With the ageing population in the Territory, there will be an increase of housing for seniors constructed in Darwin and Alice Springs.

This year will also see the establishment of an Affordable Housing Rental Company in the Territory. This Company will be a semi commercial operation and provide rental housing to low and moderate income earners at an affordable level. This will also see an increase in the range of available housing options for Territorians.

As a part of the funding received through the Commonwealth's Stimulus Package, 22 new dwellings will be constructed for public housing purposes.

On 1 June 2009, the HomeStart NT program was introduced to assist low to moderate income earners to purchase their own home. Since the introduction of this program, 44 households have been assisted to purchase their own home, and a further 27 households are awaiting settlement.

Another component of the Stimulus Package is to address the issue of Homelessness in the Territory. Three applications for this program have been approved by the Government which will allow for non-government organisations to assist with providing housing options for the homeless.

There are a number of other initiatives under the National Partnership Agreements that are currently being facilitated by the NT Government. These include a Street to Home initiative for chronic homeless people, support for public housing tenants to sustain their tenancies, which includes tenancy support, financial counselling and referral services, and assistance for people leaving correctional and health facilities.

Integral to the 'Housing the Territory' strategy is the Territory Government's commitment to meeting the current and emerging needs of Indigenous Clients.

The Strategic Indigenous Housing and Infrastructure Program (SIHIP) is the largest Indigenous housing program undertaken by the Australian and Northern Territory Governments. This joint $672 million SHIP will deliver 750 new houses, 230 rebuilds of existing houses and 2500 refurbishments across 73 remote Indigenous communities and a number of community living areas (town camps) in the Northern Territory by 2013.

16.6 Definitions of key terms and indicators

Public, SOMIH, community and ICH

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	Affordability is an outcome indicator that aims to measure housing affordability for CSHA/NAHA housing tenants. Two measures are reported: • a subsidy per rebated household derived by dividing the total rebated amount by the total number of rebated households • the proportion of households spending less than 30 per cent of their income in rent.
Amenity/location (satisfaction)	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.
Canadian National Occupancy Standard (CNOS)	A measure of the appropriateness of housing which is sensitive to both household size and composition. The CNOS specifies that: • no more than two people shall share a bedroom • parents or couples may share a bedroom • children under 5 years, either of the same sex or opposite sex may share a bedroom • children under 18 years of the same sex may share a bedroom • a child aged 5 to 17 years should not share a bedroom with a child under 5 of the opposite sex • single adults 18 years and over and any unpaired children require a separate bedroom.
Customer satisfaction	A survey measure of the proportion of customers expressing different degrees of satisfaction with the overall service provided.
Depreciation costs	Depreciation calculated on a straight-line basis at a rate that realistically represents the useful life of the asset (as per the Australian Accounting Standards 13–17).
Disability (as per the ABS Survey of Disability Ageing and Carers)	Any restriction or lack of ability (resulting from an impairment) to perform an action in the manner or within the range considered normal for a human being.

Dwelling	A structure or a discrete space within a structure intended for people to live in or where a person or group of people live. Thus a structure that people actually live in is a dwelling regardless of its intended purpose, but a vacant structure is only a dwelling if intended for human residence. A dwelling may include one or more rooms used as an office or workshop provided the dwelling is in residential use.
Greatest need	Low income households that at the time of allocation were subject to one or more of the following circumstances: • homelessness • their life or safety being at risk in their accommodation • their health condition being aggravated by their housing • their housing being inappropriate to their needs • their rental housing costs being very high.
Household	For the purpose of the public, community, SOMIH and ICH collections, the number of tenancy agreements is the proxy for counting the number of households. A tenancy agreement is defined as a formal written agreement between a household (a person or group of people) and a housing provider, specifying details of a tenancy for a particular dwelling.
Indigenous household	A household with one or more members (including children) who identify as Aboriginal and/or Torres Strait Islander.
Low income household	A public housing or SOMIH household whose members are assessed as having a low income according to the following definitions. Households are assigned an income status based on total household gross income and the composition of the household: • low income A households are those in which all household members have incomes at or below the maximum pension rate • low income B households are those that have incomes that would enable them to receive government income support benefits below the maximum pension. A community housing household which has a gross weekly income equivalent to or below the income cut-off specified for their household composition is classified as low income. The community housing low income measure is based on the low income B cut-offs as outlined above.
Maintenance costs	Costs incurred to maintain the value of the asset or to restore an asset to its original condition. The definition includes day-to-day maintenance reflecting general wear and tear, cyclical maintenance, performed as part of a planned maintenance program and other maintenance, such as repairs as a result of vandalism.
Market rent	Aggregate market rent that would be collected if the public rental housing properties were available in the private market.
Match of dwelling to household size	The proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure. Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.
Moderate overcrowding	Where one additional bedroom is required to satisfy the proxy occupancy standard.
Net recurrent cost	The average cost of providing assistance (excluding the cost of capital) per dwelling. The formula is ‘total net recurrent costs for the year ending 30 June’ divided by ‘total number of dwellings at 30 June’.

New household	Households that commence receiving assistance for the financial year.
Occupancy rate	The proportion of dwellings occupied.
Occupied dwelling	Dwellings occupied by tenants who have a tenancy agreement with the relevant housing authority.
Overcrowding	Where either two or more bedrooms are required to meet the proxy occupancy standard or the Canadian national occupancy standard.
Priority access to those in greatest need	Allocation processes to ensure those in greatest need have first access to housing. This is measured as the proportion of new allocations to those in greatest need.
Principal tenant	The person whose name appears on the tenancy agreement. Where this is not clear, it should be the person who is responsible for rental payments.
Proxy occupancy standard	A measure of the appropriateness of housing related to the household size and tenancy composition. The measure specifies the bedroom requirements of a household.

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

For sole parent or couple households with four or more children the dwelling size in terms of bedrooms should be the same value as the number of children in the household.

Rent charged	The amount in dollars that households are charged based on the rents they are expected to pay. The rents charged to tenants may or may not have been received.
Rent collection rate	The total rent actually collected as a proportion of the total rent charged.
Special needs household	Low income households that satisfy the Indigenous household definition or have a household member with a disability or where principal tenant is aged 24 years or under, or 75 years or over.
Tenancy rental unit	A tenancy (rental) unit is defined as the unit of accommodation on which a tenancy agreement can be made. It is a way of counting the maximum number of distinct rentable units that a dwelling structure can contain.
Tenantable dwelling	A dwelling where maintenance has been completed, whether occupied or unoccupied at 30 June. All occupied dwellings are tenantable.
Total gross household income	The value of gross weekly income from all sources (before deductions for income tax, superannuation etc.) for all household members, expressed as dollars per week. The main components of gross income are current usual wages and salary; income derived from self-employment, government pensions, benefits and allowances; and other income comprising investments and other regular income.
Transfer household	A household, either rebated or market renting, that relocates (transfers) from one public or community rental dwelling to another.
Turnaround time	The average time taken in days for normally vacant dwellings to be occupied.
Underutilisation	Where there are two or more bedrooms additional to the number required in the dwelling to satisfy the proxy occupancy standard.

Untenantable dwelling	A dwelling not currently occupied by a tenant, where maintenance has been either deferred or not completed at 30 June.

Commonwealth Rent Assistance

Affordability	The proportions of recipients spending more than 30 per cent and 50 per cent of their income on rent with and without CRA.
Dependent child	A person under 18 years who is the dependant of another person (an adult) if the adult is legally responsible for the day-to-day care, welfare and development of the child, if the child is not a dependent child of another person, and if the child is wholly or substantially in the adult's care. A young person aged 18–24 years may be regarded as the dependant of another person if he or she is wholly or substantially dependent on that other person. A young person aged 21 years or over cannot be regarded as a dependant unless undertaking full time study. A young person cannot be regarded as a dependant if he or she receives an income support payment. Operationally, a child is regarded as a dependant of another person (the parent) if the parent receives the Family Tax Benefit for the care of the child. A dependent child is regarded as a member of the parental income unit. The maximum rate of CRA depends on the number of children for whom the recipient or partner receives more than the base rate of the Family Tax Benefit Part A. Although the Family Tax Benefit may be paid for a child aged 16 years or over, it cannot be paid at more than the base rate. It may also be paid at not more than the base rate if a parent has not taken appropriate steps to obtain maintenance from a child's other parent.
Duration of payments	Broadly presents dependence on CRA by showing the percentage of people who are in receipt of CRA payments at a given point in time and who are still dependent on the CRA payments a year later.
Eligible income support recipient	Recipients in receipt of an income support payment or more than the base rate of the Family Tax Benefit Part A. CRA is automatically paid once eligibility is established. The only eligible recipients who are not paid are those affected by Centrelink errors in recording information or by program errors.
Geographic spread of CRA recipients	Two measures are presented. Maps show the number of individuals and families entitled to CRA at 5 June 2009 as a proportion of private rental stock in the same area. Private rental stock is taken from the 2006 Census with no adjustment for subsequent changes in the number of dwellings. The number of CRA recipients and their average rent and average CRA payments are provided for each capital city and the rest of the Sate.

Income unit	One person or a group of related people within a household who share command over income. The only recognised relationships are (1) marriage (registered or defacto) and (2) adult and dependent child. Operationally, an income unit may consist of: • a single person with no dependent child • a sole parent with a dependent child • a couple (registered or defacto) with no dependent child • a couple (registered or defacto) and any dependent children. A non-dependent child, including any child receiving Youth Allowance or some other income support payment, is not regarded as part of the parental income unit. Rather, he or she is regarded as a separate income unit.
Income unit type	The number and proportion of eligible income support recipients receiving CRA, by income unit type.
Maximum rate	Proportion of CRA recipients paying enough rent to receive the maximum rate of CRA.
Number and outcome of appeals	The outcomes of all CRA appeals finalised: (1) the number of customers who appealed to an authorised review officer, and (2) the proportions of appeals where the decision was affirmed, set aside or varied, or the appeal was withdrawn.
Number and proportion of CRA recipients, by income unit type	A point-in-time indicator showing the number of CRA recipients by income unit type, and the proportion of recipients within each income unit category. Includes data on Indigenous recipients.
Primary payment type	Each income unit receiving CRA is assigned a primary payment type, based on the payment(s) received by each member. This is used to monitor the extent to which assistance is provided to families and individuals that primarily depend on different forms of assistance. The primary payment is determined using a hierarchy of payment types, precedence being given to pensions, then other social security payments that attract CRA, and then the Family Tax Benefit. Within this overall structure a lower precedence is given to payments that are made only to the partners of a social security payment. If both members of a couple receive a payment of the same rating, the male is regarded as the primary member of the couple. No extra weight is given to the payment type with which CRA is paid.
Proportion of income spent on rent with and without CRA	A point-in-time indicator, measuring the proportion of income units spending more than 30 per cent and 50 per cent of their income on rent, both with and without CRA. The proportion of income spent on rent is calculated as follows: • with CRA: rent (minus CRA) divided by total income from all sources, excluding CRA • without CRA: rent divided by total income from all sources, excluding CRA.
Ratio of running costs to total outlay for CRA	Total running costs for the CRA program as a proportion of total outlay.
Rent	Amount payable as a condition of occupancy of a person’s home. Includes site fees for a caravan, mooring fees and payment for services provided in a retirement village. Rent encompasses not only a formal tenancy agreement, but also informal agreements between family members, including the payment of board or board and lodgings. Where a person pays board and lodgings and cannot separately identify the amount paid for lodgings, two thirds of the payment is deemed to be for rent. There is no requirement that rent be paid; a person whose rent is in arrears may remain eligible for assistance, provided Centrelink is satisfied that the liability is genuine.

Running costs per 1000 CRA customers	Total running costs for the CRA program per 1000 CRA customers.
Sharer	Some single people are subject to a lower maximum (sharer) rate of CRA. The lower rate may apply to only a single person (with no dependent child) who shares a major area of accommodation. The lower rate does not apply to those receiving the Disability Support Pension or Carer Payment, those in nursing homes or boarding house accommodation, or those paying for both board and lodgings. A person is not regarded as a sharer solely because he or shares with a child (of any age) if the child does not receive CRA.
Satisfaction with location of housing	A survey-based measure of CRA recipients' preference to stay in the area in which they live. The measure has been derived from the Household Income and Labour Dynamics (HILDA) survey conducted in 2007-08 which asked respondents about their preference to remain in the area in which they live. Respondents receiving social security payments who live in private rental dwellings have been used as a proxy for those eligible for CRA.
Satisfaction with quality of housing	A survey-based measure of CRA recipients' satisfaction with the home in which they live. The measure has been derived from the HILDA survey conducted in 2007-08 which asked respondents to rate their level of satisfaction with the home in which they live. Respondents receiving social security payments who live in private rental dwellings have been used as a proxy for those eligible for CRA.
Special needs	Individuals and families with at least one member who either self-identifies as Indigenous, receives a Disability Support Pension, is aged 24 years or under, or is aged 75 years or over.
Total income from all sources	Income received by the recipients or partner, excluding income received by a dependent. Includes regular social security payments and any maintenance and other private income taken into account for income testing purposes. Excludes: • one-time payments • arrears payments • advances • Employment or Education Entry Payments • the Mobility Allowance • the Maternity Allowance • the Child Care Assistance Rebate. In most cases, private income reflects the person's current circumstances. Taxable income for a past financial year or an estimate of taxable income for the current financial year is used where the income unit receives more than the minimum rate of the Family Tax Benefit but no other income support payment.

16.7 Attachment tables

Attachment tables are identified in references throughout this chapter by an '16A' suffix (for example, table 16A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Public housing

Table 16A.1	Descriptive data - public housing
Table 16A.2	New low income households as a proportion of all new households (per cent)
Table 16A.3	Proportion of new tenancies allocated to households with special needs (per cent)
Table 16A.4	Greatest need allocations as a proportion of all new allocations (per cent)
Table 16A.5	Financial indicators of public housing, 2004-05 to 2008-09 (2008-09 dollars) ($ per dwelling)
Table 16A.6	Occupancy rates as at 30 June (per cent)
Table 16A.7	Average turnaround times for vacant stock (days)
Table 16A.8	Rent collection rate (per cent)
Table 16A.9	Proportion of tenants rating amenity aspects as important and meeting their needs, 2007 (per cent)
Table 16A.10	Proportion of tenants rating location aspects as important and meeting their needs, 2007 (per cent)
Table 16A.11	Average weekly subsidy per rebated household and proportion of rebated households spending less than 30 per cent of their income in rent
Table 16A.12	Proportion of households with overcrowding at 30 June (per cent)
Table 16A.13	Customer satisfaction

State owned and managed Indigenous housing

Table 16A.14	Descriptive data - State owned and managed Indigenous housing
Table 16A.15	New low income households as a proportion of all new households (per cent)
Table 16A.16	Proportion of new tenancies allocated to households with special needs (per cent)
Table 16A.17	Greatest need allocations as a proportion of all new allocations (per cent)
Table 16A.18	Net recurrent cost per dwelling (2008-09 dollars)
Table 16A.19	Occupancy rates as at 30 June (per cent)
Table 16A.20	Average turnaround times for vacant stock (days)
Table 16A.21	Rent collection rate (per cent)
Table 16A.22	State owned and managed Indigenous housing satisfaction survey, 2007
Table 16A.23	Average weekly subsidy per rebated household and proportion of rebated households spending less than 30 per cent of their income in rent

Community housing

Indigenous community housing

Commonwealth Rent Assistance

Descriptive Information

16.8 References

ABS (Australian Bureau of Statistics) 2007, *2006 Census of Population and Housing*, Canberra.

AIHW (Australian Institute of Health and Welfare) 2006, *National Housing Assistance Data Dictionary Version 3*, Cat. no. HOU-147, Canberra.

—— 2007, *Public rental housing 2006-07: CSHA national data report*, Cat. no. HOU 170, Canberra.

—— 2009a, *Housing assistance tables*, www.aihw.gov.au/housing/assistance (accessed 31 December 2009).

—— 2009b, *Indigenous housing indicators 2007-08*, Indigenous housing, Series no. 3, Cat. no. HOU 212, Canberra.

—— 2009c, *Demand for SAAP accommodation by homeless people 2007-08*, A report of the SAAP National Data collection, Cat. no. HOU 211, Canberra.

—— 2009d, *Australia's welfare 2009*, Cat. no. AUS117, Canberra.

Chamberlain, C., and MacKenzie, D., 2008, *Counting the homeless, 2006,* Australian Bureau of Statistics, Cat. No. 2050.0, Canberra.

COAG (Council of Australian Governments) 2009, *National Affordable Housing Agreement*, Intergovernmental Agreement on Federal Financial Relations, Australian Government, Council of Australian Governments, Canberra.

FaCS (Department of Family and Community Services) 2003a, *Commonwealth State Housing Agreement*, Australian Government, Department of Family and Community Services, Canberra.

—— 2003b, *Housing Assistance Act 1996 Annual Report*, Australian Government, Canberra.

FaCSIA (Department of Families, Community Services and Indigenous Affairs) 2001, *Building a Better Future: Indigenous Housing 2010*, Housing Ministers' Advisory Council (HMAC) Standing Committee on Indigenous Housing Aboriginal Housing, Australian Government, Canberra.

FaHCSIA (Department of Families, Housing, Community Services and Indigenous Affairs) 2009, *Housing Assistance Act 1996 Annual Report 2008-09*, Australian Government, 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.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2001, *Asset Measurement in the Costing of Government Services*, Productivity Commission, Canberra.

Related publications

Report on Government Services

Published: December 1995	Cat. no. 9514007 (one volume)	RRP $19.95
Published: February 1997	Cat. no. 9670939 (two volumes)	RRP $29.95
Published: February 1998	Cat. no. 9719601 (two volumes)	RRP $29.95
Published: February 1999	Cat. no. 9812595 (two volumes)	RRP $39.95
Published: February 2000	Cat. no. 9938852 (three volumes)	RRP $39.95
Published: January 2001	Cat. no. 0019564 (two volumes, CD-ROM)	RRP $39.95
	Cat. no. 001933X (CD-ROM only)	RRP $10.95
Published: January 2002	Cat. no. 0417699 (two volumes, CD-ROM)	RRP $39.95
	Cat. no. 0147707 (CD-ROM only)	RRP $10.95
Published: January 2003	Cat. no. 0216482 (two volumes, CD-ROM)	RRP $39.95
	Cat. no. 0216526 (CD-ROM only)	RRP $10.95
Published: January 2004	ISBN 174037 135 6 (two volumes, CD-ROM)	RRP $39.95
	ISBN 174037 136 4 (CD-ROM only)	RRP $10.95
Published: January 2005	ISBN 174037 160 7 (two volumes, CD-ROM)	RRP $39.95
	ISBN 174037 159 3 (CD-ROM only)	RRP $10.95
Published: January 2006	ISBN 174037 191 7 (two volumes, CD-ROM)	RRP $39.95
	ISBN 174037 190 9 (CD-ROM only)	RRP $10.95
Published: January 2007	ISBN 978 1 74037 216 9 (two volumes, CD-ROM)	RRP $39.95
	ISBN 978 1 74037 215 2 (CD-ROM only)	RRP $10.95
Published: January 2008	ISBN 978 1 74037 236 7 (two volumes, CD-ROM)	RRP $34.00
	ISBN 978 1 74037 241 1 (CD-ROM only)	RRP $10.00
Published: January 2009	ISBN 978 1 74037 266 4 (two volumes, CD-ROM)	RRP $36.00
	ISBN 978 1 74037 267 1 (CD-ROM only)	RRP $10.95

The review has also produced the following reports

Report on Government Services 2003 Indigenous Compendium (2003)

Report on Government Services 2004 Indigenous Compendium (2004)

Report on Government Services 2005 Indigenous Compendium (2005)

Report on Government Services 2006 Indigenous Compendium (2006)

Report on Government Services 2007 Indigenous Compendium (2007)

Report on Government Services 2008 Indigenous Compendium (2008)

Report on Government Services 2009 Indigenous Compendium (2009)

Implementing Reforms in Government Services

Reforms in Government Service Provision: Case Studies

Published: June 1997	Cat. no. 9679960	RRP $14.95

Implementing Reforms in Government Services: Case Studies

Published: September 1998	Cat. no. 9806926	RRP $11.95

Overcoming Indigenous Disadvantage

Overcoming Indigenous Disadvantage: Key Indicators Report

Published: November 2003 ISSN 1448 9805 RRP $24.95

Overcoming Indigenous Disadvantage: Key Indicators Overview

Published: November 2003 ISSN 1448 9813 RRP $9.95

Overcoming Indigenous Disadvantage: Key Indicators Report

Published: July 2005 ISSN 1448 9805 RRP $25.00

Overcoming Indigenous Disadvantage: Key Indicators Overview

Published: July 2005 ISSN 1448 9813 RRP $10.00

Overcoming Indigenous Disadvantage: Key Indicators Report

Published: June 2007 ISSN 1448 9805 RRP $25.00

Overcoming Indigenous Disadvantage: Key Indicators Overview

Published: June 2007 ISSN 1448 9813 RRP $10.00

Overcoming Indigenous Disadvantage: Key Indicators Report

Published: July 2009 ISSN 1448 9805 RRP $24.00

Overcoming Indigenous Disadvantage: Key Indicators Overview

Published: July 2009 ISSN 1448 9813 RRP $12.00

Other

Superannuation in the Costing of Government Services

Published: September 1998 Cat. no. 9806938 RRP $7.95

Linking Inputs and Outputs: Activity Measurement by Police Services

Published: September 1999 Cat. no. 9927010 RRP $8.95

Payroll Tax in the Costing of Government Services

Published: September 1999 Cat. no. 9927071 RRP $8.95

Asset Measurement in the Costing of Government Services

Published: September 2001 Cat. no. 0144945 RRP $8.00

The Review has also commissioned the reports

Outcome Measurement in Child Protection (1998)

Review of Approaches to Satisfaction Surveys of Clients of Disability Services (1998)

Using Consumer Views in Performance Indicators for Children's Services (2000)

National Satisfaction Survey of Clients of Disability Services (2000)

Efficiency Measures for Child Protection and Support Pathways (2003)

Review of Patient Satisfaction and Experience Surveys Conducted for Public Hospitals in Australia (2005)

All reports are available from the Review's website: www.pc.gov.au/gsp